REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

SETTLEMENT AGREEMENT

UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

October 1, 2021 – March 31, 2022

Respectfully Submitted By

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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's twentieth Report on the status of compliance with the Provisions of the Settlement Agreement (Agreement) between the Parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and the status of its progress during the Twentieth Review Period, October 1, 2021 – March 31, 2022.

Throughout the COVID-19 pandemic, individuals with intellectual and developmental disabilities (IDD), together with their caregivers and service providers experienced disproportionately negative consequences across the country, and Virginia was no exception. Individuals with IDD are often immunocompromised. They and their caregivers therefore faced increased exposure to the virus. Thankfully, vaccinations and appropriate precautions significantly reduced the percentage of individuals who became severely ill. However, pre-existing human resource problems, including difficulty filling staff vacancies and high staff turnover were exacerbated throughout the nation during this time. Without sufficient, qualified and stable staff, the support services provided to individuals with IDD are rarely adequate. Again, the Commonwealth was no exception. Unfortunately, with staff vacancies and turnover among its leadership, its state agencies, Community Service Boards (CSB's) and providers' efforts to maintain compliance could not help but regress in a few areas.

When the pandemic began, Virginia had achieved many of the Agreement's requirements, but was still considerably behind the ten-year implementation schedule. The Commonwealth remains so today, particularly in two areas of the Agreement that are significantly consequential for individuals with IDD:

1. Providing adequate and appropriately implemented services for individuals with intense medical and behavioral needs, and
2. Monitoring service delivery and regulatory compliance to determine the service system's most important problems, and then implementing quality improvement initiatives to address and resolve them.

Since the Agreement was approved by the Court in Fiscal Year 2012, in order to make the substantive systemic improvements required, Virginia needed to restructure its HCBS Waiver program and to revise its DD Waiver and DBHDS Licensing regulations. The Commonwealth

took a number of years to make these essential structural changes: the DD Waiver redesign was completed in 2016, the permanent Licensing regulations were approved in 2020, and its permanent DD waiver regulations were finally approved in 2021. Prior to these essential and foundational changes, Virginia was unable to make considerable progress in the two vitally important areas indicated above. The Commonwealth has made concerted efforts since finalizing these structural reforms, but implementing effective systemic service and quality improvements that meet the requirements of the Agreement will take more time.

Even though these structural changes were completed, many familiar obstacles still remained to be resolved. Chief among them was Virginia's difficulties in producing reliable and valid data, which further hampered its ability to make needed improvements. During the Eighteenth Review Period, when its permanent DD waiver regulations were finally approved, the Commonwealth had not determined that its data sources provided reliable and valid data for compliance determinations. The lack of such data undermined Virginia's ability to make well-informed and data-driven decisions about the most important and impactful initiatives to accomplish the Agreement's Provisions.

Throughout the Twentieth Review Period, DBHDS made significant efforts and achieved important successes. These included maintaining its Quality and Risk Management (QRM) organizational structure, resources, policies and annual plans; managing serious incidents; developing more measurable quality improvement initiatives; completing retrospective reviews and providing targeted technical assistance.

With the long awaited approval of the Commonwealth's permanent DD Waiver Regulations on March 31, 2021, designed in part to improve programming for individuals with intense behavioral needs, DBHDS published its *Practice Guidelines* to establish the minimum standards for behavioral programming, and provided related training for case managers. Starting in January 2022, when a statistically significant sample was available, the Department implemented a well-developed quality review monitoring tool and process to review and monitor behavioral programming.

During the second half of the Twentieth Review Period, on January 21, 2022, the Parties agreed to a Curative Action to facilitate the pace at which Virginia would achieve the Compliance Indicators associated with data reliability and validity. DBHDS committed to completing a *Process Document* and a *Data Set Attestation Form* (*Attestation*) for each of these Indicators. The *Process Document* should include previously identified threats to data integrity, the actions taken to resolve

them, the defined data collection process, and the methods utilized to verify the integrity of the data. Completing these steps successfully then establishes the basis for DBHDS's Chief Information Officer to sign the *Attestation.* Although this Curative Action process holds significant promise, it was a complex undertaking finally agreed to with just two full months remaining in the Twentieth Review Period.

By the end of the Period, the Commonwealth had attested to the reliability and validity of the data sets for 51 of 63 relevant Indicators reviewed. This represents an impressive accomplishment, however the Independent Reviewer and his consultants determined that DBHDS did not consistently execute the agreed-upon Curative Action regarding these 51 Indicators, and were therefore not able to verify the reliability and validity of 18 of these attested data sets. Problems included initial confusion among DBHDS's senior staff about information needed for the *Process Document* and *Attestation,* and for some data sets, only one of the two required documents was provided. For others, both were provided but essential information was missing from the *Process Document*. It is important to note that DBHDS has been responsive to feedback about how to correct the *Process Documents* to demonstrate the resolution of identified data concerns.

Regarding the 12 Indicators to which DBHDS could not attest, there were too few weeks to complete some quality review cycles, given the agreement date of this Curative Action occurring so relatively close to the March 31, 2022 end date of the Review Period. This did not give the Department enough time to collect data sets and determine their reliability and validity.

At this late stage in the Agreement, it is imperative that the Commonwealth continues to complete its transparent process to correct for identified data deficiencies and to verify and attest to the reliability and validity of the data it reports for each Indicator.

Despite accomplishments and other important work in progress, long-standing and unresolved hindrances continued to delay Virginia's compliance with the remaining Provisions. For six Indicators, there was evidence of regression, and the Independent Reviewer determined that previous ratings of Met were not maintained this Period.

The Commonwealth's statewide crisis services system continued to conduct crisis assessments in hospitals or CSB offices, a process implemented by CSB Emergency Services. This approach is unsatisfactory, since it leads to unnecessary hospitalizations, and conflicts with the Agreement's commitment to conduct at least 86% of such assessments in individuals' homes or other

community locations. These settings allow professional crisis teams to de-escalate crises and provide support services to prevent future occurrences. All of this substantially reduces the likelihood of hospitalization. The Eighteenth Report to the Court showed that Virginia had not achieved this Indicator. For the Twentieth Report, rather than moving toward achievement, there was no improvement in the percentage of assessments conducted in these preferred locations. However, in December 2021, the Commonwealth launched an emergency statewide 988 Call Center with the hope of ensuring that crisis teams respond directly to the individual's home or other community-based setting.

Examples of chronically poor-performing CSBs continued. Virginia's inability to meet the relevant Indicators' measurable performance outcomes for case management is due in large part to a small number of under-performing CSBs. The Commonwealth once again struggled to demonstrate that all of its CSBs effectively and consistently implemented the assigned requirements of the Agreement.

Individuals with complex medical and/or behavioral needs continued to receive insufficient and inadequate services. This should not be the case, particularly at this stage of the Agreement. The Parties recognized at the start of the Agreement that specific initiatives were needed to address this cohort. Although over the last year individuals with complex medical needs were referred promptly to identified providers, referrals of individuals with intense behavioral needs do not yet meet the within 30 day timeline required by the Agreement. Also, Virginia's most recently available data showed that in some cases, individuals with complex medical and/or behavioral needs received only partially implemented services, or did not receive needed services at all. As well, most behavioral programming that was carried out did not include all minimum required elements. The extent of in-home services that behaviorally challenged individuals actually received was often just a small percentage of the number of service hours needed, and which the Commonwealth had already authorized for delivery. The impact of the pandemic was very likely a factor exacerbating these shortcomings.

Virginia deserves commendation for its ongoing efforts and new initiatives designed to improve existing services and quality assurance systems. However, the Commonwealth must continue to strengthen its oversight and monitoring systems to improve the adequacy and availability of services for individuals with complex behavioral and/or medical needs. To achieve such improvements, Virginia should accurately identify systemic shortcomings in its existing and newly implemented quality monitoring processes, and undertake well-targeted and measurable quality improvement initiatives.

In summary, as of the Twentieth Review Period, the Commonwealth maintained Sustained Compliance with 24 Provisions and achieved Compliance with one Provision for the first time. Virginia also made notable improvements: of the 155 Indicators reviewed, the Commonwealth met a total of 85 Indicators (55%), compared with meeting 67 Indicators (43%) in the Eighteenth Review Period. Among the 84 Indicators met were 28 (18%) that were achieved for the first time.

II. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

For this Twentieth Review Period, the Independent Reviewer prioritized the following areas in order to monitor the Commonwealth's compliance with the requirements of the Agreement:

- Quality and Risk Management;
- Case Management;
- Crisis Services;
- Individual and Family Support Program, Guidelines for Families, and Family-to-Family and Peer Programs;
- Community Living Options;
- Independent Living Options; and
- Waiver Slots.

To analyze and assess Virginia's performance across these areas and their associated Compliance Indicators, the Independent Reviewer retained seven consultants to assist in:

- Reviewing data and documentation produced by the Commonwealth in response to requests by the Independent Reviewer, his consultants and the Department of Justice;
- Discussing progress and challenges with Virginia officials;
- Examining and evaluating documentation of supports provided to individuals;
- Interviewing caregivers, provider staff, and stakeholders;

- Verifying the Commonwealth's determinations that its data sets provide reliable and valid data that are available for compliance reporting; and
- Determining the extent to which Virginia maintains documentation that demonstrates it meets all Compliance Indicators and achieves Compliance with the Provisions.

The Independent Reviewer focused all Twentieth Period studies on:

- The respective Provisions that the Commonwealth had not yet achieved and their associated Compliance Indicators, and
- Whether Virginia had maintained Sustained Compliance for the Provisions that it had previously achieved during consecutive reviews..

To ensure that the Independent Reviewer had the facts necessary to determine whether the Commonwealth had met the metrics of the Indicators and achieved Compliance, Virginia was asked to provide sufficient documentation that would:

- "Prove its Case" for having achieved all Indicators for the Provisions being studied, and
- Provide its assessments and findings that its data sets for the Provisions being studied provide reliable and valid data for compliance reporting.

To determine any ratings of Compliance for the Twentieth Review Period, the Independent Reviewer considered information provided by the Commonwealth prior to April 15, 2022, and responses to consultant requests for clarifying information up to May 5, 2022. To determine whether Virginia had met the Compliance Indicators and achieved the Provisions studied, the Independent Reviewer considered the findings and conclusions from the consultants' studies, the Commonwealth's planning and progress reports and documents, as well as other sources.

The Independent Reviewer's determinations that Compliance Indicators have or have not been met, and the extent to which Virginia has achieved Compliance, are best understood by reviewing the Discussion of Compliance Findings and the consultants' reports, which are included in the Appendices. To protect individuals' private health information, the summaries from the studies of individuals' services included in the respective consultant reports are provided to the Parties under seal.

For each study, the Commonwealth was asked to provide its records that document the proper implementation of the Provisions and the associated Compliance Indicators being reviewed. For

each Indicator with a performance measure that depends on reported data, the Commonwealth was asked to provide the completed *Process Document* and *Attestation*. With these two completed documents, the Commonwealth asserts that its reported data set has been verified as reliable and valid. If Virginia's data show that an Indicator's performance measure has been achieved but the Commonwealth did not provide these two documents, or they were incomplete, then the Independent Reviewer determined that the Commonwealth has "met*" the Indicator. This met* rating is not final and cannot be used for Compliance determinations, but rather is for illustrative purposes only.

Information that was not provided for the studies was not considered in the consultants' reports or in the Independent Reviewer's findings and conclusions. If Virginia did not provide sufficient documentation, the Independent Reviewer determined that it had not demonstrated achievement of the associated Compliance Indicator.

Finally, as required by the Agreement, the Independent Reviewer submitted this Report to the Parties in draft form for their comments. The Independent Reviewer considered any comments by the Parties before finalizing and submitting this Twentieth Report to the Court.

B. Discussion of Compliance Findings

1. Quality and Risk Management

Background

In the Agreement's Section V., the Commonwealth agreed to develop and effectively implement a statewide Quality and Risk Management (QRM) system to ensure that individuals with IDD were provided with accessible and appropriate services that are of good quality, meet their needs, and help them achieve positive outcomes. These outcomes include avoidance of harms, stable community living, and increased integration, independence, and self-determination.

Five of the 60 Provisions in this Section were the focus of previous studies.

The Seventeenth Period review of Provisions V.I.1.a.-b., V.I.2. and V.I.3. and the Eighteenth Period study of Provisions V.B. and V.C.1. were conducted by two independent consultants. In addition for the Eighteenth Period, three other consultants, including two registered nurses, completed an Individual Services Review (ISR) of individuals with complex medical needs. The

purpose of this ISR was to determine the extent to which its findings verified those of Virginia's Quality Service Reviews (QSRs) for the same individuals.

For each of these studies, DBHDS was asked to provide copies of the records that it maintains to document that it had properly implemented these Provisions, their associated Indicators, and the Court's Order (dated May 6, 2019) related to establishing a "system of documents to create a framework for implementing and sustaining each decree provision."

The Eighteenth Period review of Provisions V.B. and V.C.1 found that, overall, the Commonwealth had continued to develop a culture of quality and to mature its QRM processes. Virginia reported making progress toward meeting many of these two Provisions' 44 Indicators. The consultants' studies were able to verify, though, that the Commonwealth had achieved only 16 of these Indicators. Regarding Provisions V.I.1.–3., the ISR study's findings did not verify, and in fact identified significant discrepancies with Virginia's QSR findings related to Indictors 51.4c., 52.1a. and 52.1c. Therefore, the Commonwealth had not achieved the three QSR Indicators that were the focus of this ISR study.

DBHDS reported data and provided documentation of its progress toward achieving compliance. However, the Department did not provide the required determinations that its reported data actually met the Agreement's reliability and validity standards for compliance reporting.

Overall, Virginia reported progress in implementing the *DBHDS Quality Management Plan FY2020,* which emphasized DBHDS's commitment to continuous quality improvement. The consultants' study confirmed that the Commonwealth's accomplishments included achieving the Indicators related to establishing the Quality Management System's leadership and internal organizational committee structure, performing quality assurance functions, assessing and monitoring provider compliance with the serious incident reporting requirements, and implementing an incident management process and related protocols.

To support providers' efforts to comply with new regulatory requirements, DBHDS had published and provided access to relevant guidance documents and reference materials. The Department also significantly improved consistency in its processes and procedures to assess provider compliance with licensure regulations. In addition, DBHDS expanded and enhanced the roles and responsibilities of its Office of Licensing's (OL's) Incident Management Unit (IMU).

IMU staff had reviewed and triaged each serious incident report submitted by a licensed provider and had followed up on the issues identified.

The Eighteenth Period review noted that to achieve Indicator 30.4 in the future, DBHDS would need to show evidence that its Licensing assessment process could determine whether providers were identifying year-over-year trends and patterns and using baseline data to assess the effectiveness of risk management systems.

Despite ongoing systemic concerns with data reliability and validity and their impact on a continuous quality improvement environment, DBHDS continued to refine its systems and processes to provide clear expectations, guidance, training and technical assistance, especially to service providers who in turn needed to develop structured and effective risk management processes. However, although there were significant improvements, many Quality Improvement Initiatives (QIIs) were not written with objectively measurable terms.

Without such adequately measured plans and initiatives, impact and any further actions required could not be reliably determined. The measurability of DBHDS's QIIs is an essential component of an effective and continuous quality improvement process.

For each of these Seventeenth and Eighteenth Period studies, the Independent Reviewer determined that Virginia met* 16 of the 59 QRM Indicators. The Commonwealth did not achieve any of the five QRM Provisions.

Twentieth Period Study

The Independent Reviewer retained the same two consultants as previously to conduct the Twentieth Period study of the 59 Indicators associated with the five QRM Provisions, namely V.B., V.C.1., V.I.1.a.-b., V.I.2. and V.I.3.

Overall, this latest study found that Virginia had met* 22 of the 59 associated Indicators, compared with 16 during the Seventeenth and Eighteenth Period review.

On January 21, 2021, Virginia reached agreement with DOJ on a Curative Action to implement a revised approach toward meeting the Indicators associated with reporting valid and reliable data. For each of these particular Indicators, the Commonwealth committed to providing two documents for review and verification: a *Process Document* and a signed *Attestation*.

By the end of this latest Period, Virginia attested to the reliability and validity of data sets reported for ten of the 19 relevant Indicators. Although the consultants identified significant shortcomings with some of these determinations, it is a credit to DBHDS that significant progress was nevertheless made. The Department appropriately decided that the data sets for nine Indicators were not yet available or ready for such determinations.

This resulted in valid and reliable data sets not yet being available to support some of the quality review cycles required by the QRM Indicators. The lack of valid and reliable data across many parts of the QRM system continued to undermine the functionality of the Quality Improvement Committee (QIC) framework. It also limited the effectiveness of the Commonwealth's data-based analysis and data-driven decision making.

Provision V.B.

Virginia determined that, as of the end of the Twentieth Reporting Period, the Commonwealth had reported reliable and valid data sets for nine of the relevant 18 Provision V.B. Indicators. While this undoubtedly represented a significant improvement from previous Periods, the latest study found some misunderstanding among DBHDS staff regarding the facts and records required for Virginia to attest to the reliability and validity of the data it reports for compliance determinations. For example, some Department staff initially reported that a *Process Document* was not necessary, and that other documents (e.g., a *Performance Measure Indicator*, or PMI) could be used instead. Some *Process Documents* were unavailable, and for some of the Indicators, the Commonwealth was not able to provide completed *Process Documents* with the required factual basis and analysis needed for an *Attestation*.

Regarding the remaining nine of the 18 relevant Indicators (50%), DBHDS appropriately decided that it could not verify that its data were reliable and valid. This continued lack of available reliable and valid data remained an overarching barrier to Virginia's implementation of an environment of continuous quality improvement.

Otherwise, DBHDS again continued to make progress in the development of a culture of quality and in the maturation of its QRM processes. These include processes for serious incident management, the development of QIIs with measurable goals, and the provision of targeted technical assistance. In addition, OL had developed and continued to revise incident management protocols that govern the incident reporting process for providers and describe processes and procedures for triage, follow-up and coordination.

The Twentieth Period review confirmed that the Commonwealth maintained its CMS-approved waiver quality improvement plan, performed quality assurance functions, and assessed and monitored provider compliance with its regulatory requirements. DBHDS also maintained a quality improvement system with the required organizational structure, led by its Office of Clinical Quality and its QIC. The QIC, as the Department's lead organizational committee, coordinated the work of various quality subcommittees, each of which maintained a charter that detailed its structure and operating procedures, to ensure and provide support for DBHDS's quality improvement system. The Office of Clinical Quality supported the quality committees in their use of data for trend analysis in establishing QIIs and in developing training resources.

To address previously reported concerns regarding the lack of measurable QIIs, DBHDS took the positive step during the second half of the Twentieth Review Period to make needed improvements, including updating its QII *Toolkits* and modifying the QII template to require that future QIIs contain certain components of measurability. Overall, this template appears to provide sufficient guidance to address the identified issues. For the latest review, the QIIs using this revised structure more frequently identified measurable goals. This was not the case, however, for QIIs developed prior to February 2022, before the modified template came into effect. In December 2021, after the Independent Reviewer notified Virginia of these continuing concerns, DBHDS promptly revised and updated it QII Toolkits and made needed improvements. However, some improvement continued to be needed.

The Twentieth Period review found that DBHDS had maintained and updated its Quality Management Plan that included and described three integrated functions: Quality Assurance, Risk Management and Quality Improvement. This Plan acknowledged that quality improvement is a data-driven process and that effective implementation of a quality improvement cycle requires the use of reliable and valid data to:

- Identify areas of needed improvement,
- Devise data-based actions to address these needs,
- Evaluate and monitor whether these actions are having the desired effect, and
- Make needed revisions when required.

The latest review confirmed that DBHDS maintained its Risk Management Review Committee (RMRC), which operated according to the roles and functions described in its charter, as revised September 27, 2021. As a subcommittee of the QIC, the primary task of the RMRC is "to

establish goals and performance measure indicators that affect outcomes related to safety, freedom from harm and avoiding crises" for the individuals DBHDS serves. While Department staff developed well-thought out and comprehensive documentation of the risk management processes, DBHDS reported that it could not yet attest that its data sets for serious incidents were reliable and valid. This continued to fundamentally compromise the RMRC's and DBHDS's ability to identify and prevent, or substantially mitigate risks of harm.

RMRC meeting minutes demonstrated that the Committee was completing the required functions of reviewing and analyzing data, monitoring apparent trends and patterns in data, and identifying areas of improvement that appeared to be warranted from their review and analysis of data and trends. In addition, it was positive that the RMRC reporting reflected data for both implementation and outcomes. However, as a result of its challenges aggregating data consistent with the relevant Indicators' requirements, DBHDS appropriately determined that it could not provide the requisite *Attestations* or *Process Documents* to show that the RMRC could reliably analyze incident data for trends or make valid recommendations for improvement.

The *RMRC Annual Report FY21* indicated that the Committee continued to track and review aggregate data of provider compliance with serious incident reporting requirements. Based on the draft annual *Quality Management Report SFY 2021*, DBHDS reported performance of 95%. At face value, these data did not indicate a need for quality improvement. However, as described by their meeting minutes, the RMRC did not review serious incident or Abuse, Neglect and Exploitation (ANE) data after July 2021, due to newly identified data validity and reliability issues. As a result, the Department reported that it could not attest to the quality of the incident data sets used by the RMRC.

Regarding Indicator 29.19 and individuals at high risk due to medical or behavioral needs, this latest study showed that although DBHDS required case management providers to identify and report such individuals, the Department did not specifically obligate its residential and day/employment service providers to do likewise, as required by the Indicator. During this Review Period, the Parties worked collaboratively on the development of a Curative Action to facilitate achievement of this Indicator. This is not yet completed.

Also, for individuals with identified behavioral support needs, DBHDS did not provide a *Process Document* or *Attestation* that verified the percentage of these individuals who received adequate and appropriately delivered behavioral support services, the percentage of residential service recipients who resided in locations that were integrated in the community, the percentage of

individual service recipients who were free from neglect and abuse by paid support staff, the percentage who were adequately protected from serious injuries in service settings, or the percentage involved in seclusion and restraint.

Resolving obstacles to the reliability and validity of some data sets continued to present challenges. The latest review could not determine if DBHDS had updated the *Process Document DD_ Priority 1_VER_002* to address the eight actionable recommendations in the AVATAR source system review that DQV had completed in December 2021. In addition, the Department identified some significant issues regarding its ability to pull valid and reliable incident data and did not complete a source system assessment of the reliability and validity of data reported from its CONNECT system. DBHDS did not provide valid and reliable data to evidence achievement of the following Indicator metrics:

- That at least 75% of individuals with a job in the community chose or had some input in choosing their job,
- That at least 86% of people receiving services in residential services/their authorized representatives chose or helped decide their daily schedule,
- That at least 50% of individuals who do not live in the family home, or their authorized representatives, chose or had some input in choosing their housemates,
- That at least 75% of people receiving services who do not live in the family home or their authorized representatives chose or had some input in choosing where they live, or
- That at least 95% of individuals receiving services or their authorized representatives participated in the development of their own service plan.

In spite of ongoing concerns with data set reliability and validity, DBHDS continued to improve the refinement of Departmental systems and processes to provide clear expectations, guidance, training and technical assistance to providers to assist them in developing structured and effective risk management processes.

Regarding risk management programs at its Training Center, DBHDS's *Risk and Liability Management* Departmental Instruction, applicable to all Department-operated facilities, included most, but not all of the four Indicator-specified requirements. Overall, the Training Center had in place policies that sufficiently described the expectations and processes needed to address, reduce or eliminate risks of harm; as well as the analysis, reporting and risk reduction planning across many domains. The documentation submitted for review also provided evidence of how the Training Center actually implemented the use of risk triggers and thresholds.

Provision V.C.1.

The DBHDS Offices of Licensing (OL) and Human Rights (OHR) continued to perform quality assurance functions required by the relevant Indicators and described in the Quality Management Plan. These included conducting annual inspections, following up on serious incidents and complaints and taking action to remedy problems identified, as well as determining the extent to which providers fulfill the Department's regulatory requirements. This Period's review again confirmed that OL's IMU had strengthened DBHDS's organizational responses and effectiveness in following up on serious incidents, including requiring Corrective Action Plans and other related reporting.

DBHDS licensing regulations require providers' risk management systems to meet minimum standards that include conducting a root cause analysis within 30 days of discovery of a serious incident. The applicable Indicator requires that a root cause analysis include a detailed description of what happened, an analysis of why it happened, solutions identified to mitigate its recurrence, and, when applicable, the future risk of harm.

For the Twentieth Period study, in an attempt to verify the adequacy of the OL monitoring process, the consultants completed reviews of two randomly selected samples of licensing inspection reports related to serious incidents and of root cause analyses completed by CSBs. In one sample, the consultants determined that ten out of 21 providers (48%) were out of compliance with one or more of Virginia's requirements for conducting a review of serious incidents. In the other sample of 54 CSB root cause analyses, the consultants found that only 46% of these reports included all three of the elements required by the Indicator. The consultants found that applicable standards were met in only about half of the serious incident reviews and root cause analyses. Although this review was of a comparatively small sample, these findings identified a substantial discrepancy with, and did not verify DBHDS's Licensing Specialists' findings that approximately 90% of providers met the requirements of these same Indicators. To double check their own and the consultants' findings, the Commonwealth should review these same providers and CSB root cause analyses to determine their adherence to the relevant Indicator requirements.

DBHDS created, but eventually discontinued its *Incident Management Look Behind Process* due to concerns with its implementation. Therefore, for the Twentieth Review Period, the RMRC did not have look-behind data to evaluate.

Licensing regulations at *12VAC35-105-520.A-E* continued to require providers to develop and implement risk management processes that include the elements required by Provision V.C.1.'s Indicators. DBHDS published on its website guidance documents and recommendations on risk management requirements, including serious incident and quality improvement requirements. These documents included reference materials for providers on topics such as the development and implementation of a quality improvement program and a risk management program, as well as a serious incident reporting, follow-up, and analysis system, and information on risk screening/assessment tools on risk triggers and thresholds.

To verify that OL had determined the extent to which the requirements of Indicator 30.4 had been fulfilled, the consultants reviewed a randomly selected sample of 27 out of 275 annual licensing inspections reports completed during the latter half of 2021. They found that none of the 27 licensing specialists' reports provided any evidence that they had looked for these requirements, nor did they provide any relevant citations. The consultants' findings conflict with, and therefore cannot verify the reliability and validity of OL's reports for Calendar Year 2021related to this Indicator.

The *Summary of Compliance 30.4-30.5* and relevant data in the *RM Compliance by Regulation 520 CY21* both reported that 567 out of 911 providers (62.2%) were assessed and found to be compliant with all of the subsections of *12VAC35-105-520*. In addition, 285 of the remaining 344 providers that had been found previously to be non-compliant subsequently developed and implemented an approved corrective action plan to address cited deficiencies. This increased the number of providers that DBHDS determined had met the requirements to 852 (93.5%), which is above the 86% threshold established in this Indicator.

The Department published recommendations for best practices in monitoring serious incidents, including patterns and trends that may be used to identify opportunities for improvement. DBHDS also developed and made training available, and published other informational materials. Its webinar included guidance to providers on how to meet its regulations, as well as resources for making improvements to providers' policies, procedures and practices related to more consistent serious incident monitoring.

However, DBHDS did not describe a clear and comprehensive methodology for monitoring whether providers appropriately responded to and addressed risk triggers and thresholds. Based on this latest review, the Department did not have such adequate and functioning processes in place.

For all providers, the Commonwealth requires that their risk management systems "shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths … and take prompt action when such events occur, or the risk is otherwise identified." The consultants confirmed that Corrective Action Plans were written and implemented and, if corrective actions did not have the intended effect, DBHDS took further action.

Provisions V.I.1.–3.

Regarding these three Provisions, DBHDS continued to work with its QSR contractor to complete QSRs for a representative sample of providers and participants on an annual basis. At the conclusion of this contractor's second annual round in 2021, the Department determined that its QSR process and tools needed significant revisions to achieve the associated Indicators and to meet the overall intent of the QSR initiative. The Department's Assistant Commissioner for Developmental Services led the re-design effort, which was completed in time for implementation of the third round, which began in November 2021. Many of these changes will likely produce improved results. However, because this latest round was still ongoing and results were not yet available for review and analysis, many of this current study's findings were based on results from the second round.

For the third round of QSRs, the Twentieth Period study was able to assess the requirements of Indicators 51.3, 52.6, 53.1 and 53.3. The first three of these four Indicators were met. However, the procedures for inter-rater reliability required by Indicator 53.3 were not sufficient, so this Indicator remains unmet. Because the third round of QSRs had not been completed, the extent to which DBHDS's redesigned QSR process addressed and resolved the previously identified problems could not be determined.

The Agreement envisioned a QSR process designed to produce reliable data for DBHDS to evaluate the sufficiency, accessibility, and quality of services at an individual, service and systemic level. For the aggregated results of the first and second rounds of QSRs, the Department did not determine whether the data produced were reliable and valid. Although the Parties had agreed that data must be verified as reliable and valid for compliance reporting, DBHDS contends that these previous QSR rounds did produce useful data for associated Indicator purposes. Although there may be specific exceptions, it is the Independent Reviewer's considered opinion that use of data that has not been established as reliable and valid is not a recommended, effective or trusted

methodology for designing or prioritizing quality improvement initiatives to improve practices and the quality of services, all of which lie at the heart of the QSR process.

See Appendix A for the consultants' full report.

Conclusion

Regarding Provision V.B.'s 33 Compliance Indicators, Virginia has met* the requirements of ten of them, namely 29.3, 29.5, 29.6, 29.7, 20.9, 29.11, 29.12, 29.13*, 29.15*, 29.31, and 29.32. The Commonwealth did not achieve the remaining 24: 29.1, 29.2, 29.4, 29.8, 29.10, 29.14, 29.16–29.30, and 29.33. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V.C.1.'s 11 Indicators, the Commonwealth has met* the requirements of seven of them, namely 30.1–30.3, 30.5*, 30.6, 30.8, and 30.9, but did not achieve the remaining four: 30.4, 30.07, 30.10 and 30.11. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V.I.1.a.-b.'s five Indicators, the Commonwealth has met the requirements of one of them, namely 51.1, but did not achieve the remaining four: 51.2–51.5. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V.I.2.'s six Indicators, the Commonwealth has met the requirements of four of them, namely 52.3–52.6, but did not achieve the remaining two: 52.1 and 52.2. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V.I.3.'s four Indicators, the Commonwealth has met the requirements of one of them, namely 53.1, but did not achieve the remaining three: 53.2–53.4. Therefore, Virginia remains in Non-Compliance with this Provision.

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

2. Case Management

Background

Studies of Virginia's progress toward achieving the Agreement's four Case Management Provisions have been conducted annually since the Parties agreed in April 2019 to 19 Compliance Indicators associated with these Provisions.

For Provision III.C.5.b.i., there are ten Indicators (2.1–2.5 and 2.16–2.20, noting that 2.5 includes a subset of ten elements, 2.6–2.15). Provision III.C.5.d. includes six Indicators (6.1a., 6.1.b., and 6.1–6.4), Provision V.F.4. has two Indicators (46.1 and 46.2), and Provision V.F.5. has one Indicator (47.1).

For the last review one year ago, DBHDS data showed the Commonwealth had met seven of these 19 Indicators, namely 2.1, 2.4, 2.17, 6.1.a, 6.1, 6.2, and 6.3. Although Virginia's achievements demonstrated commitment and progress from the prior studies, it had not yet met the remaining 12 Indicators. This was largely due to three factors:

- The report *SCQR – Fiscal Year 2020* once again pre-dated finalization of the definitions, tools and implementation related to "change in status or needs" and "appropriately implemented services,"
- Most CSBs responded incompletely and performed inadequately, and
- The Office of Data Quality and Visualization (DQV) had not determined that the data sources related to Case Management provided reliable and valid data (as required by Indicator 37.7 for Provision V.D.3., which must be completed in accordance with Indicators 36.1 and 36.5 for Provision V.D.2.).

Other than these shortcomings, DBHDS had adequately completed a full annual cycle of their planned Support Coordinator Quality Review (SCQR) activities, including identifying several quality improvement initiatives. However, without reliable and complete data, the Commonwealth was not able to effectively determine needed quality improvements on the individual, provider and systems levels.

Twentieth Period Study

The Independent Reviewer retained the same consultant as previously to conduct the Twentieth Period study related to Case Management, and also retained two additional consultants to conduct an Individual Services Review (ISR).

This latest Case Management study showed that Virginia achieved ten of the 19 associated Indicators. The obstacles to meeting the requirements of the remaining nine Indicators are related to CSB effectiveness in achieving expectations for case management performance, and to establishing data integrity for data drawn from the WaMS electronic database.

The Case Management Steering Committee (CMSC) determined that for Calendar Year 2020, the CSBs did not achieve the 86% metric of the records reviewed for nine of the ten elements required by Indicators 2.6–2.15, i.e. the subset of Indicator 2.5. In fact, only three of the 40 CSBs statewide achieved the 86% level.

For the Fiscal Year 2020 SCQR, the Commonwealth's CSBs failed to provide sample reviews for 7% of those requested by DBHDS, which very likely introduced a bias into the results. The CSB response rate for the Fiscal Year 2021 SCQR improved from 93% to 100%, and so removed a major threat to data integrity. This second year of DBHDS's Office of Continuous Quality Improvement (OCQI)'s retrospective reviews showed agreement between the CSB supervisors and the OCQI reviewers ranging from 46% to 95%. These reliability scores are an improvement over the last SCQR and bode well for the monitoring tool and process used as a commonly understood vehicle to assess and measure the performance of case managers in the aggregate.

In January this year, Virginia reached agreement with DOJ on a Curative Action to implement a revised approach toward meeting the Indicators associated with reporting valid and reliable data. For each of these particular Indicators, the Commonwealth committed to providing two documents for review and verification: a *Process Document* and a signed *Attestation*. The Twentieth Period study found that for several of the case management Indicators, DBHDS did not provide either a *Process Document* or an *Attestation*.

The consultants' study of case management performance included a review of Virginia's documentation for the SCQR, the ten elements, and its sampling process related to Indicators 2.2–2.16. DBHDS had implemented Retrospective Reviews and inter-rater reliability checks to better ensure reliability and validity of the supervisory review, which is the core ingredient of the SCQR. The Department's assessment determined that seven of ten Indicators were reliably

reviewed by case management supervisors statewide. Change in Status (Indicator 2.8), Individual Supports Plans (ISPs) with measurable outcomes (Indicator 2.10), and ISPs implemented appropriately (Indicator 2.14) are items that continue to challenge supervisors in evaluating case managers' work objectively. At the time of the study, the SCQR process had gone through two complete cycles of implementation and has begun to show some value as an outcome measurement for CSB case management effectiveness. Even though the Chief Information Officer determined appropriately that two Indicators (2.10 and 2.14) lacked sufficient inter-rater reliability between the CSBs and OCQI, and therefore could not be considered valid and reliable for this Period, this was a positive development that demonstrated DBHDS's ability in this instance to determine when data sets were not reliable and valid.

The Twentieth Period review also found that Virginia made further progress toward achieving a number of Indicators (namely 6.1.a, 6.1.b, and 6.1–6.4). Examples include CMSC reports and recommendations, and the completion by DBHDS's Quality Improvement Division of retrospective reviews of a randomly selected sample, and then providing technical assistance as needed. The Department also conducted and analyzed a second full cycle of SCQR and inter-rater reliability processes. DBHDS staff visited each of the CSBs and provided technical assistance regarding needed improvements. During the past year, CMSC again issued two semi-annual reports, maintaining its trend of providing semi-annual reports over the past three Fiscal Years to the Quality Improvement Committee (QIC). Based on its review of data from the Office of Licensing, DMAS-QMR, SCQR, OCQI, QSRs and Performance Contracts, the most recent CMSC report recommended five new improvement initiatives, in addition to its five previous recommendations.

The Commonwealth's documentation for Indicator 46.1 was reviewed for case management contacts (i.e., the number, type and frequency). DBHDS had established and implemented a Data Quality Framework to review and verify a sample of CSB contact data each quarter and to provide follow-up technical assistance to CSBs. This process included a Data Quality Tool to assess sources of data error, a Root Cause Analysis format to assist CSBs in addressing data problems, and Enhanced Case Management educational materials. The Department conducted cross tabulation of data from the CCS3 database and the WaMS database to verify that the data were reliable and valid. However, DQV determined that the CCS3 was not "a valid and reliable data source for Settlement Agreement compliance reporting."

Additionally, Virginia's *Process Document* for this Indicator did not identify the actions taken to address and resolve the data reliability deficiencies that DQV found in its assessments of the reliability of data drawn from CCS3. DQV's assessment findings conflict with the Chief Information Officer who did not identify any defects in the process of collecting data from the CCS3 data source.

DBHDS's documentation for Indicator 47.1 was reviewed regarding the CMSC's semi-annual reports on case management performance. The *Process Control* document identified five main sources of data: SCQR, Regional Support Teams (RSTs), Licensing, CCS3 contacts, and WaMS. It did not, however, identify or explain the actions taken to address and resolve the data reliability and deficiencies related to data pulled from CCS3 and WaMs. For this review, the Department provided an *Attestation* for RSTs, but did not provide a *Process Document* for the SCQR.

To ensure that so future randomly selected samples reliably reflect all individuals receiving HCBS services, as required, DQV recommended including children in future SCQR. It also advised discontinuing the use of CCS3 for compliance reporting, urged providing raw data in the calculation of numerator and denominator in the SCQR, and suggested incorporation of the RST process into WaMS. DBHDS's Measurement Steward concurred and identified responsive activities to correct all issues identified by DQV.

See Appendix B for the full report.

Individual Services Review

As mentioned above, an Individual Services Review (ISR) was conducted to probe the impact of the introduction in 2021 of the On-Site Visit Tool (OSVT). This tool was designed to better shape case managers' effectiveness in assessing changes in status of the individuals served and evaluating appropriate implementation of the ISP. These are two key aspects of the ten elements (Indicators 2.6–2.15) regarding case manager performance.

This ISR was completed by two consultants, one of them an experienced nurse. They examined the ISP and OSVT for a random sample of 20 individuals with complex medical needs (Level 6 on the Support Intensity Scale). This document review was supplemented by telephone interviews with a residential contact person familiar with each individual's needs and health care services, and structured by a *Monitoring Questionnaire*. Case managers were not contacted for this study.

The ISR found that the OSVT, which is central to accurate case management assessments, was not being used effectively by case managers. For example, 12 of the 20 individuals (60%) whose services were reviewed by the consultants had a health issue, change in status, or another risk that was not identified or addressed by the relevant case manager in the documentation provided by the CSB. This finding suggests increased oversight, including spot checking, by case manager supervisors is necessary to ensure the productive use of the OSVT tool.

In addition, although required by Virginia, some case managers had not fully adopted the OVST to assist in their assessments of individuals on their caseloads. For four of the 20 individuals (20%), their caregivers expressed concern about the high rate of case manager turnover, and another nine caregivers (45%) expressed unease about the adequacy of case manager contact and involvement. Concerns about high turnover among case managers have been reported previously as a significant threat to the Commonwealth's ability to meet the requirements of the Agreement's related Provisions.

Overall, the findings of this Twentieth Period's ISR correlated closely with the poor performance by CSBs that DBHDS determined in its Fiscal Year 2021 SCQR process.

See Attachment B of Appendix B for the full ISR report.

Conclusion

Regarding Provision III.C.5.b.i.'s ten Indicators, the Commonwealth has met the requirements of four of them, namely 2.1, 2.4, 2.17 and 2.19, but has not achieved six Indicators: 2.2, 2.3. 2.5, 2.16., 2.18, or 2.20. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision III.C.5.d., the Commonwealth has met all six Indicators: 6.1.a, 6.1.b, and 6.1–6.4. Therefore, Virginia has achieved Compliance with this Provision for the first time.

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Regarding Provision V.F.4., the Commonwealth has not met either of the two Indicators: 46.1 and 46.2, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.F.5., Virginia has not met the sole Indicator 47.1, and therefore remains in non-compliance.

3. Crisis Services

Background

For the Eighteenth Period, the Independent Reviewer's consultants completed their eighth annual review of the Commonwealth's achievements related to the Agreement's Crisis Services Provisions.

That review found that Virginia had again sustained its compliance with Provisions it had previously achieved and maintained over multiple review cycles. In addition, the Commonwealth had implemented two crisis stabilization programs and out-of-home crisis therapeutic prevention host-home like services, both of which exclusively serve children. Finally, following a previously documented trend of an increased number of children and adults with IDD being hospitalized, DBHDS reported a 19% decrease in hospitalizations for children and an 8% reduction for adults.

However, the Eighteenth Period study also identified concerns that would require additional effort and accomplishments on Virginia's part to achieve Compliance with the Agreement's remaining statewide crisis services requirements. For example, rather than increasing the percentage of crisis assessments completed in the location in which the crisis occurred, this had decreased during the period January–March 2021. In addition, the Commonwealth's *Performance Contract* with CSBs did not address the preferred location for crisis assessments, nor did it set any expectation for CSB Emergency Services staff to be part of a community-based assessment. Virginia hoped to address this long-standing systemic problem in the fall of 2021 with the launch of an emergency statewide 988 Call Center to ensure that crisis teams respond directly to the individual's home or other community-based setting.

With the permanent DD Waiver regulations having been only approved March 31, 2021, DBHDS had not yet provided its new *Practice Guidelines* to its behavioral consultants. The Department reported that during the Eighteenth Period, only 45% of individuals in need of behavioral services were referred to an identified Therapeutic Consultation (TC) provider within 30 days. However, the Commonwealth was not required to achieve the 86% performance measure until April 2022, a year after these regulations were approved.

The Eighteenth Period study concluded that for individuals in need, the number of hours of in-home supports that were authorized by Virginia closely matched the number of hours in the

individuals' determined ISPs. Although DBHDS's data showed that it had authorized delivery, data were not available to verify that individuals actually received these needed services.

For its crisis services reports, DBHDS had not determined that its data sources had provided reliable and valid data. The Eighteenth Period study could not therefore verify that the Commonwealth had fully achieved any of the Indicators with performance metrics that depended on data.

Twentieth Period Review

The Independent Reviewer retained the same consultants to conduct their ninth study of Virginia's statewide crisis services system for the Twentieth Period. They again reviewed the eight Provisions that had previously been determined as being in Sustained Compliance, namely III.C.6.b.i.A. and B., III.C.6.b.ii.C.–E. and H., and III.C.6.b.iii.A. and F.

The consultants also evaluated those Provisions and associated Indicators that had not yet achieved Compliance, namely Provision III.C.6.a.i.-iii. and its 22 Indicators 7.2–7.23; Provision III.C.6.b.ii.A. and its seven Indicators 8.1–8.7; Provision III.C.6.b.iii.B. and its four Indicators 10.1–10.4; Provision III.C.6.b.iii.D. and its sole Indicator 11.1; and Provision III.C.6.b.iii.G. and its three Indicators 13.1–13.3.

For Indicators 7.2–7.7, which relate to the Commonwealth's work and contracts with its 40 Community Services Boards (CSBs), this Period's study found that Virginia maintained terms in its contracts as required by these Indicators. In addition, the Commonwealth had established criteria for CSBs to determine who is at risk of being hospitalized. Virginia had implemented a process for identifying and monitoring the number of CSB staff who take the required training related to individuals at such risk, and how to arrange for crisis risk assessments at home or at other community locations. The Commonwealth had also implemented a quality review process that measures CSB performance in identifying individuals who are at risk of crisis. DBHDS provided a *Process Document* that detailed the steps that its subject matter experts completed to address weaknesses in the WaMS and AVATAR data sources. The consultants completed a validation study with an inter-rater reliability check that verified Virginia's findings.

For Compliance Indicator 7.8, which requires that 86% of crisis assessments be completed in the individual's home or other community location, the Commonwealth provided a *Process Document* that described the process for REACH Crisis Managers to follow to collect these data and an

Attestation that the data reported are reliable and valid. The consultants conducted a validation study that found Virginia's data collection process to be sufficient and reliable.

However, the Commonwealth continued to report that far too few crisis assessments were conducted in individuals' homes or other community locations. The reported data indicated significant variations between Regions. Although the pandemic may have had a significant statewide impact, the Regions with a below-average percentage of assessments completed in community locations significantly hindered Virginia's ability to achieve this Indicator. DBHDS did not provide any analysis of the statewide or unique Regional factors that contributed to the Commonwealth's continuing shortfall.

Virginia hopes to address this systemic problem through its plan for a crisis assessment transformation, which it expects will positively impact crisis assessments for all populations, not only individuals with IDD. DBHDS reported that from June through October 2022, it plans to implement its related Curative Action, i.e., to transition from CSB Emergency Services to its new 988 Call Center. Although the Call Center commenced initial operations in December 2021, and the Commonwealth has been actively collecting data since then, Virginia did not have data to report for this latest Period on the outcomes of its implementation.

The effectiveness of this plan is a critical lynchpin in ensuring the success of the Commonwealth's statewide community crisis services system for individuals with IDD. Virginia still did not meet this Indicator's required 86% performance standard. The quarterly percentages of individuals who received REACH crisis assessments at home or other community location are listed in the table below.

The percentage of individuals who receive REACH crisis assessments at home or other community location where crisis occurs	
Fiscal Year 2021 Q3	35%
Fiscal Year 2021 Q4	42%
Fiscal Year 2022 Q1	51%
Fiscal Year 2022 Q2	36%
Fiscal Year 2022 Q3	40%

For Indicator 7.9, Virginia continued to meet the requirements. The Commonwealth had previously provided the required directive; this time, the consultants were able to verify the reliability of the data regarding the training provided to state-operated psychiatric hospitals, as

well as regarding the requirement to notify CSBs and case managers whenever there is a request for an admission for a person with a DD diagnosis.

DBHDS provided various documents showing that it had fulfilled the requirements of the four Indicators 7.10–7.13. The Department also provided a *Process Document* and signed *Attestation* for the data set used to determine compliance. The consultants completed a validation study that confirmed DBHDS's determination that the data set was reliable and valid.

Indicators 7.14 and 7.18 require Virginia to increase the number of behaviorists and to reassess this need, so that within one year of the effective date of the permanent DD Waiver regulations, 86% of individuals are referred to a service provider within 30 days of the need being identified.

From the 2015 baseline of 821 behaviorists, the Commonwealth reported for this latest study that there were 2,275 behaviorists. While this change was dramatic and significantly exceeded the 30% increase requirement of the associated Indicator, it was telling that there was not a corresponding dramatic increase in the availability and accessibility of needed behavioral services for individuals with IDD. However, data did indicate improvement. For example, during the period March through August 2021, only 35% of individuals in need were referred to an identified behaviorist within 30 days, whereas from September 2021 through January 2022, the monthly average increased to 60%. Although this progress was substantial and reflects DBHDS's improvement efforts, it was nonetheless concerning that Virginia did not complete a root cause analysis of the lack of availability of behavioral support services, nor a gap analysis with targets and dates to increase the number of available behaviorists to meet the 86% minimum requirement.

For Indicators 7.15–7.17, the Commonwealth had approved its permanent DD waiver regulations on March 31, 2021. In the months that immediately followed, DBHDS provided its *Practice Guidelines* and a training program for case managers regarding the minimum elements that constitute an adequately designed behavioral program. The training was accessible to all case managers through Virginia's Learning Center. As of February 2022, DBHDS reported that 755 CSB staff took the training.

Indicator 7.19 requires the Commonwealth to ensure that 86% of individuals authorized for Therapeutic Consultation (TC) actually receive the four service components described in sections A–D of this Indicator. As of April 2022, DBHDS determined from its review of 60 randomly selected plans that 48 individuals (80%) received TC services. (This is for the period beginning

July 1, 2021 until after the *Practice Guidelines* were in place and behaviorists were trained in the minimum expectations for the Functional Behavioral Assessment (FBA) and a Behavioral Support Plan (BSP).) DBHDS's determination, however, was based purely on the presence of documentation in each of the individuals' files that covered only two of the four service components. The Department did not verify that the FBAs and BSPs were actually minimally acceptable (i.e., that they included the minimum elements required), only that the documents related to these two service components were present. Clearly, the presence of just two documented components, that may or may not be minimally adequate, is not a sufficient basis for confirming that individuals actually received all four of the service components that are required by Virginia's permanent DD waiver regulations and its *Practice Guidelines*.

The consultants conducted a qualitative review (see Attachment 2 to Appendix C) which found that all four required components were present and minimally adequate in only 29% of the records of 103 randomly selected individuals who were receiving behavioral supports. DBHDS did not review a sufficient randomly selected sample to generalize its findings to the cohort of all individuals authorized for TC, nor did its review include all four required elements. The Department did not attest to the reliability and validity of the data set it reported, the data did not achieve the 86% performance measure, and the methodology used to determine findings was not adequate or valid. Therefore, the Commonwealth did not meet Indicator 7.19.

For Compliance Indicator 7.20, the Commonwealth designed and implemented a quality review and improvement process to assess the status of the services that are provided consistent with the five elements described in this Indicator. DBHDS developed the *Behavior Support Plan Adherence Review Instrument* (BSPARI) to determine whether the licensed behaviorists had developed the FBAs and BSPs as delineated in the *Practice Guidelines*. It is positive, however, that the quality review segment of the Department's process involves providing feedback to any behaviorist whose plan does not meet the minimum expectations adequately.

This Indicator requires that DBHDS report the number of individuals who have an identified need for TC compared to the number of individuals actually receiving these services. However, the Department reported these data without determining the extent to which, or if at all, these individuals had received TC services. Instead, DBHDS compared the number who needed services with the number who were connected to a provider within 30 days. According to the billing data for in-home, personal care and respite services during the pandemic, the number of individuals who received services did not closely match the number who were connected to a provider and authorized to receive services. The Department determined that it did not have

sufficient data to attest to its data set reliability and validity or to the process used to determine that individuals received services. Using the data DBHDS presented, the consultants found that it was not possible to verify the number of individuals receiving the required TC elements.

Regarding Indicators 7.21–7.23, DBHDS provided a detailed description for the semi-annual quality review process required by these Indicators. The Department's most recent six-month review period covered July 1 through December 31, 2021. DBHDS submitted a *Process Document* and *Attestation* that the data collected and reported were reliable and valid. The *Process Document* explained that the Office of Data Quality and Visualization's (DQV's) concerns regarding the reliability and validity of the data had been addressed. DBHDS also built into the *Process Document* a crosscheck review of the DMAS billing data to verify the extent to which these in-home support services were actually received.

In its semi-annual quality reviews, DBHDS reported that it had reviewed records and authorized the number of hours for in-home support services that matched the hours in the individuals' ISPs 95% and 99% of the time. However, the families of these individuals reported significant gaps in the services received. Over two quality review cycles, these families estimated 34% and 45% gaps in the delivery of these services. The Department also completed a crosscheck with billing claims data to determine the number of hours of in-home support that were actually delivered. The results of this crosscheck were both informative and alarming: DBHDS found that a vast majority of these individuals actually received a very small percentage (approximately 10%) of the in-home service hours that were authorized for delivery.

DBHDS met Indicators 7.21 and 7.22 by implementing the required quality review and tracking processes related to in-home and personal care services. The study found the review process to be sufficient, as it included a review of the billing data that offered more information as to whether these services were actually delivered. DQV had already determined that the data generated by the review process in the Eighteenth Period were reliable and valid for compliance reporting. Virginia also met Indicator 7.23 by making determinations to enhance and improve service delivery to children and adults with identified significant behavior support needs. The consultants' Eighteenth Period recommendations resulted in DBHDS cross-tabbing authorization and billing data that resulted in a more accurate understanding of the current status. This increases the likelihood that future recommendations to enhance and improve services will be effective.

While the Commonwealth met the requirements of these three Indicators, it is extremely concerning that so many individuals with challenging behavioral needs who were authorized to receive ancillary in-home services were actually provided with only a small portion of these services, despite their intense needs for them.

Regarding Indicators 8.6 and 8.7, DBHDS reported that there has been a continued decrease in the number of admissions to state hospitals in Fiscal Year 2022 from a peak in Fiscal Year 2019. (Fiscal Year 2022 data included reporting through December 31, 2021, the end of the second quarter.) These admissions decreased from a high of 1,018 in Fiscal Year 2019 to 180 in the first two quarters of Fiscal Year 2022. The Commonwealth therefore met Indicator 8.7, however Indicator 8.6 will not be considered fully met until corrections to the reliability and validity of the data drawn from AVATAR are verified.

For Indicator 10.1, Virginia established and has been operating two Crisis Therapeutic Homes (CTHs) for children since Fiscal Year 2019. DBHDS provided a *Process Document* and a signed *Attestation* that the data provided regarding training for those supporting these children were reliable and valid. The consultants' study confirmed that the Department had demonstrated that CTH staff were trained as required. In addition, DBHDS reported that 91% of the involved providers had received related trainings. Given the impacts of the pandemic, these two CTHs did not operate at full capacity during the Twentieth Review Period.

Regarding Indicator 10.2, DBHDS reported that during the Nineteenth and Twentieth Review Periods, 29 (38%) of the 76 waiver slots allocated for emergencies were used to support individuals who left stays in CTHs for children, Adult Transition Homes (ATHs) or psychiatric hospitals. Of the 29 emergency waiver slots that DBHDS provided for this population, 21 were used to facilitate transitions to community-based group and sponsor homes. The Department submitted the required *Process Document* that validated its data, as well as a signed *Attestation*.

For Indicator 10.3, DBHDS again used a Request for Proposal (RFP) process to select providers to develop a set number of homes/beds to serve individuals with IDD and co-occurring conditions. The RFP process utilized criteria to ensure that the providers selected have the capacity to develop and operate residential services for individuals with these needs. As of June 2021, seven homes had been developed as a result of the original RFP. With two additional homes also having been developed, DBHDS now has 41 beds specifically serving individuals with co-occurring conditions. One or more homes is located in each of DBHDS's five Regions.

For Indicators 10.4 and 11.1, DBHDS reported that 83% of the individuals known to the REACH crisis services system had a community residence identified within 30 days of admission to a CTH facility or psychiatric hospital. For Regions that had not achieved the required performance measure of 86%, DBHDS implemented a quality improvement process to determine and correct systemic problems. The Department provided a *Process Document* that addressed the data reliability and validity concerns previously identified by DQV's assessments. In July 2021, DBHDS updated the language in the REACH Data Store to more accurately depict the overall system. The Commonwealth's process validated that the data set was reliable and valid, and the Department provided a signed *Attestation*.

Indicators 10.4 and 11.1 were not met because Virginia did not achieve the requirement that 86% of the individuals who were known to REACH and who were hospitalized or placed in a CTH had a residential provider identified within 30 days.

Indicator 13.1 is similar to Indicator 10.1, but requires only that the Commonwealth establish two CTHs for children. As mentioned above, DBHDS met this requirement and so achieved this Indicator. It is important to note, however, that utilization of the beds in these two homes has remained quite low, (i.e., 27%–34%) during a time when children living in all five of the DBHDS Regions were being hospitalized. To sustain this met rating in the future, Virginia must demonstrate that these two homes are used consistent with the purpose of Crisis Stabilization Programs, that is, as a last resort offer of an alternative to. institutionalization.

Regarding Indicator 13.2, DBHDS established and operated two ATHs. The Department's data indicated that, as intended, the operation of these homes positively impacted the number of CTH stays for adults greater than 60 days.

For Indicator 13.3, by securing two providers, DBHDS implemented in 2020 the "out-of-home crisis therapeutic prevention host-home like services for children connected to the REACH system … to prevent institutionalization ..." During the Twentieth Review Period, however, only one provider was operating these services and in only one location. Also, during the past year, the sole operating host-home like service was utilized by just three individuals, all of whom lived in the Region where the host-home is located. The Department's data showed that none of the other Regions were referring children to utilize this host-home like service. The Commonwealth did not meet this Indicator this time, because the required statewide access to prevent institutionalization of children was not achieved.

For the Provisions that Virginia previously accomplished (namely III.C.6.b.i.A. and B., III.C.6.b.ii.C.–E. and H., III.C.6.b.iii.A. and F.), this latest study confirmed that although both the pandemic and increased staff turnover disrupted provision of some crisis services, the Commonwealth's statewide crisis system continued to serve children and adults and to operate 24 hours per day, seven days a week. However, because appropriate COVID-19 precautions remained in place during the Nineteenth and Twentieth Periods, the Commonwealth was not able to conduct the required on-site face-to-face responses and service provision. When once again able to respond on-site, though, the REACH teams did so within the required response time set for each Region. Virginia also maintained the structure and the level of resources needed to reinstitute on-site visits when possible to do so, without increasing the risk of infection to members of the target population. The Commonwealth continued to operate a Crisis Stabilization Home in each of the five Regions. The REACH teams also continued to train community stakeholders including case managers, CSB Emergency Services staff and law enforcement. Some of these trainings were provided remotely.

Face-to-face on-site assessments fulfill the pivotal role in a crisis system that prevents unnecessary institutionalization. and are required for 86% of children and adults known to the system. It is a problem, therefore, that DBHDS did not track and report the number of crisis assessments that were conducted remotely. The Commonwealth has fallen far short of meeting this requirement, in part because some Regions complete a below average percentage of on-site responses in the individual's home or other community location. Also, Virginia did not provide any analysis of or explanation for the wide variation across Regions of the number and percentages of assessments completed on-site versus by telephone.

Individuals with IDD continued to be admitted to psychiatric hospitals rather than utilizing, as required by the Agreement, in-home supplemental supports or crisis stabilization services as alternatives to hospitalization. The significant decrease and Regional variations in on-site responses to complete crisis assessments may indicate the Commonwealth is no longer in compliance with this Provision. Now that COVID-19 precautions that prevent on-site face-to-face responses are no longer in place, phone responses to crisis calls are contrary to Virginia's commitments to individuals with IDD and their families, and its obligations under the Agreement. If this lack of face-to-face on-site responses continues in future reviews, Compliance for these Provisions may not be Sustained.

On a positive note, the Commonwealth reported that there was a 19% decrease in the number of hospitalizations of children, and an 18% decrease for adults who were hospitalized after a crisis assessment. This continues a three-year downward trend.

As mentioned already, Virginia operates two CTHs for children. These CTHs, which are located in Regions II and IV, offer important alternatives to being institutionalized. It is therefore very concerning that so few children from Regions I, III and V utilized these alternative services and were instead disproportionately represented (85%) among those who were hospitalized. This high rate of institutionalization of children occurred when the available CTH beds were utilized less than 35% of the time.

The latest study again confirmed the value of offering mobile crisis services. For example, after receiving mobile support services, only 2% of children and 7% of adults were hospitalized; and after utilizing the CTH alternative, only 6% of children and 8% of adults were hospitalized.

During the Eighteenth Period, the Commonwealth completed a *Process Document* for each crisis services Indicator. At that time, the consultants found these were clearly written, thoroughly described and comprehensive. For this Period's review, DBHDS also provided an *Attestation* in which it determined that the crisis services data it reported are reliable and valid. (In the Eighteenth Report to the Court, the consultants had identified recommendations that DBHDS subsequently considered and generally adopted.)

For their Twentieth Period review, the consultants concluded that DBHDS's reported data included sufficient crosschecks and methods for inter-rater reliability to adjust for any problems in the data sources, except those that rely significantly on data from the AVATAR system, the most notable being Indicators 8.6 and 8.7. The findings from the consultants' validation study, which included an additional inter-rater reliability check for a selection of crisis services Indicators, confirmed the reliability and validity of the data reported.

See Appendix C for the consultants' full study and qualitative review.

Conclusion

Virginia maintained Sustained Compliance for the following eight Provisions: III.C.6.b.i.A. and B., III.C.6.b.ii.C.–E. and H., III.C.6.b.iii.A. and F.

Regarding Provision III.C.6.a.i.-iii., Virginia has met 17 of its 22 Indicators: 7.2–7.7, 7.9–7.13, 7.15–7.17 and 7.21–7.23. The Commonwealth has not achieved five Indicators: 7.8, 7.14 and 7.18–7.20. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.ii.A., the Commonwealth has met* all seven Indicators: 8.1–8.5, 8.6* and 8.7. But since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, the rating of "met*" is not yet final and cannot be used for Compliance determinations, but rather is for illustrative purposes only. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.iii.B., the Commonwealth has met three of the four Indicators: 10.1–10.3, but has not achieved Indicator 10.4. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.iii.D., the Commonwealth did not achieve its sole Indicator 11.1. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.iii.G, the Commonwealth has met two of the three Indicators: 13.1 and 13.2, but has not achieved Indicator 13.3. Therefore, Virginia remains in Non-Compliance with this Provision.

4. Individual and Family Support Program, Guidelines for Families, and Family-to-Family and Peer Programs

Background

Provisions III.C.2.a.-i, III.C.8.b. and III.D.5. of the Agreement require the Commonwealth to create an Individual and Family Support Program (IFSP) for individuals determined to be most at risk of institutionalization. These Provisions also require the publication of guidelines for families, as well as the development of family-to-family and peer programs.

Earlier reports on these obligations documented that Virginia had made steady progress by developing the IFSP Strategic Plan, creating an IFSP Coordination Program, organizing IFSP State and Regional Councils, continuing to develop enhancements to the IFSP funding program, writing the guidelines for families, and beginning an initiative for family-to-family and peer programs.

The last study of these Provisions, included in the Eighteenth Report to the Court, found that some of these efforts were still in preliminary planning or early implementation stages, but had good potential for moving the Commonwealth towards compliance. In some instances, though, Virginia had not finalized or implemented other strategies intended to achieve compliance. Significant process and policy decisions had not been concluded, nor had the Commonwealth completed the reporting, determinations of reliable data, and documentation needed to achieve the associated Indicators.

Policy decisions still to be finalized included:

- Defining who would be considered "most at risk for institutionalization" for the purposes of the IFSP;
- Determining the eligibility criteria for informing individuals on the waitlist of the case management options available;
- Developing the capacity of the family-to-family and peer programs to ensure they address the specific requirements of the Provisions and their associated Indicators; and
- Identifying measurable indicators to assess the performance and outcomes of the IFSP, including the capacity for the collection and analysis of reliable and valid data.

Virginia achieved eight of the 17 Indicators associated with the three Provisions studied during the Eighteenth Review Period. As a result, the Commonwealth achieved Compliance with Provision III.C.8.b. for the first time, but remained in Non-Compliance with Provisions III.C.2.a.-f. and III.D.5.

Twentieth Period Study

For the Twentieth Period, the same consultant was retained to once again review Virginia's status achieving the same three Provisions, III.C.2.a-f., III.C.8.b. and III.D.5. The study aimed to identify the Commonwealth's set of finalized policies, procedures, instructions, protocols and/or tools for implementing, achieving and sustaining compliance with these Provisions. In addition, the review analyzed whether Virginia's progress reports included reliable and valid data, as well as the material the Commonwealth utilized, or plans to utilize, to determine whether it is maintaining "sufficient records to document that the requirements of each Provision are being properly implemented," as measured by the relevant Compliance Indicators.

Although DBHDS continued to make some gains, there were several challenges that slowed the pace of progress or caused ground to be lost. These obstacles included significant staff turnover at the state level; the breakdown of the application portal for the second time; and the constraints imposed by the pandemic. In most instances, the Department did not finalize development and/or implementation of the strategies intended, and needed, to achieve the Indicators and/or to formalize the reporting and documentation requirements. In addition, DBHDS was re-thinking the structure and approaches in some areas where progress was stalled. Examples include:

- Changes to the operations of the Regional Councils; they were largely non-functional at the time of this report.
- Analysis of draft prioritization criteria, described in the Eighteenth Period Report, led DBHDS to decide that implementation was not feasible. At the time of this study, an alternative approach had not yet been fully conceptualized.
- DBHDS did not consistently follow its protocols applicable to annual eligibility and/or the IFSP funding notification processes.
- DBHDS did not take actions that resulted in the development of significant capacity of the family-to-family and peer programs.

Despite these problems, there was evidence of progress in key areas:

- The eligibility criteria for individuals on the waitlist to receive Case Management had been finalized and published, although some documents still needed to be updated.
- Although in a preliminary stage, DBHDS reviewed the measurable indicators in the IFSP State Plan. These are intended to assess performance and outcomes of the IFSP, including the development of capacity for the collection and analysis of valid and reliable data.
- A new module to replace the previously implemented application funding online portal is expected to be available during Fiscal Year 2023.

See Appendix D for the consultant's full report.

Conclusion

For the Twentieth Period, Virginia met five of the 17 Compliance Indicators associated with the three Provisions studied. This represents a decrease from the Eighteenth Period, when eight Indicators were met.

Regarding Provision III.C.2.a.-i.'s 12 Indicators, the Commonwealth has met the requirements of three of them, namely 1.5, 1.8, and 1.12. (This represents a decrease from the Eighteenth Period, when five Indicators were met.) Virginia has not achieved nine Indicators: 1.1–1.4, 1.6, 1.7, and 1.9–1.11. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision III.C.8.b.'s two Indicators, the Commonwealth has met both of them: 17.1 and 17.2. Therefore, the Virginia has achieved Sustained Compliance with this Provision.

Regarding Provision III.D.5.'s three Indicators, the Commonwealth did not meet any of them: 19.1–19.3. (This represents a decrease from the Eighteenth Period, when one Indicator was met.) Therefore, Virginia remains in Non-Compliance with this Provision.

5. Community Living Options

Background

Provision III.D.1. of the Agreement focuses on increasing community integration for people with IDD. For the Eighteenth Period, the Independent Reviewer's consultant completed his second study of this Provision's 23 Compliance Indicators (18.1–18.23).

At that time, the Commonwealth had provided documentation that showed achievement of 12 (52%) of these Indicators. However, because Virginia had not determined its reported data to be reliable and valid for two of the 12 Indicators, these two were considered met for illustrative purposes only.

The remaining 11 Indicators (48%) that the Commonwealth did not achieve involved making needed improvements to the delivery of nursing services, having a work group look at barriers to increasing integrated settings, and ensuring effective CSB follow through. DBHDS had reported that during both the Seventeenth and Eighteenth Periods, the pandemic environment had negatively impacted the percentage of people with IDD being served in the most integrated settings. For example, data showed the number of authorizations for Community Engagement and Community Coaching services had declined. Virginia expected, though, that suspended or cancelled authorizations for these services would return as pandemic precautions were eased.

For the Indicators where the Commonwealth's data showed achievement of the required outcomes, DBHDS did not determine that this data were reliable and valid. In addition, the consultant was not able to complete an independent verification of the methodology used to determine the accuracy of the data.

DBHDS's documentation for this last review demonstrated its concerted efforts to promote services in integrated settings. The Department's data reports, together with the Independent Reviewer's semi-annual Individual Services Review (ISR) studies showed an overall statewide increase in the percentage of individuals with IDD residing in the most integrated settings. The consultant's study also found that Virginia had made progress toward achieving many of the associated Indicators by creating reports, assessing and screening children seeking admission to nursing facilities and ICFs, tracking children who were admitted, prioritizing children for transition to community-based settings, and providing information and outreach to families.

Twentieth Period Study

The Independent Reviewer retained the same consultant to conduct a follow-up study for the Twentieth Period. Results of this review found that the Commonwealth had continued its efforts and had made considerable progress in achieving 17 of the Provision's 23 Indicators (74%).

A factor as to why the remaining six Indicators cannot yet be determined as met is that Virginia's most recent Provider Data Summary (for the first part of Fiscal Year 2022) was not completed in time. The Provider Data Summary for Fiscal Year 2021 (through April 30, 2021) was available, however, and showed that the Commonwealth's service provider network had not expanded as needed. Data that demonstrated increases in the number of individuals with IDD living in integrated settings may be driven primarily by provider agencies serving new people in smaller settings, rather than movement by individuals who continue to live in less integrated settings. Unfortunately, Virginia's data continued to show significant gaps in the availability of services in more integrated settings. While two-thirds of the Commonwealth's CSBs match or exceed the statewide average of 86.7% of individuals with IDD living in integrated settings (as of March 31, 2021), five of the 40 CSBs still had 50% or fewer of these individuals served in such settings.

DBHDS reported that it had achieved the timeliness benchmark for receipt of some nursing services (i.e., 70% within 30 days), but that it had not achieved the nursing utilization benchmark (i.e., receipt of the number of hours identified in the ISP 80% of the time). These data are from Fiscal Year 2020, which is a long time-lag for reporting. Virginia has recently determined a new

approach with the applicable Curative Action that will allow it to report data for Fiscal Year 2021 in October 2022 and for Fiscal Year 2022 in February 2023.

The Department's reports indicated that a substantial number of authorized nursing hours did not get delivered, and that shortages of nursing personnel are the root cause for most of these authorized yet unused hours. DBHDS determined that remediation lies in improved payment systems that will make this type of nursing attractive, as well as in retention and recruitment efforts. Significant rate increases, pending approval by Virginia's General Assembly, are expected July 1, 2022, so there may be observable impacts in future reviews.

DBHDS continued to focus on The Every Child Texas model, which concludes that the most compassionate and cost-effective service delivery system for children with IDD lies within a family. The Commonwealth consulted directly with the Every Child Texas program that emphasizes the importance of permanency planning. The Department made Virginia's Jump Start funding available to implement this model, which may allow providers of Sponsored Residential services to more actively consider adoption of this program. An obstacle that Virginia must resolve in order to develop these host-home like services is that, as of October 2020, there were only seven Sponsored Residential services providers, serving just 18 children statewide.

Virginia still has not made progress achieving community based services for children with IDD, who live in nursing facilities and ICF/IDDs. In the Eighteenth Review Period, a year ago, DBHDS reported that 44 children with IDD were living in nursing facilities and during this Twentieth Review Period 43 children remained. In addition, the census of children in ICF/IDDs was 111 at the end of Calendar Year 2019, compared to 109 at the end of Calendar Year 2021.

In January this year, the Commonwealth reached agreement with DOJ on a Curative Action to implement a revised approach toward meeting the Indicators associated with reporting valid and reliable data. For each of these particular Indicators, Virginia committed to providing two documents: a *Process Document* and a signed *Attestation*.

For the latest study, the status of these two documents for each relevant Indicator varied from "none being provided" to "being thorough." For some Indicators, neither document was provided. For other Indicators, the *Process Documents* that were considered thorough included a list of the potential threats to the reliability and validity of data that had been identified by the Office of Data Quality and Visualization's (DQV's) assessments. These thorough *Process Documents* not only included the list of threats, but also mentioned actions taken to address and resolve the

identified threats. In addition, the documents included the methods DBHDS has adopted or plans to adopt to verify that its data are reliable and valid. For example, one method is to cross-tabulate data between WaMS service authorizations and DMAS's Medicaid paid claims data. Some reports, such as the Provider Data Summary mentioned above, were completed with data collected before the applicable *Process Document* was finalized.

The consultant's report (see Appendix E) provides detailed information regarding the status of the *Process Documents* and *Attestations*. His Findings Table also includes facts gathered and related analyses. The specific documents that include these facts are listed in his Attachment A.

Conclusion

Regarding Provision III.D.1.'s 23 Indicators, Virginia has met* the requirements of 17 of them, namely 18.1*, 18.7, 18.8, 18.10–18.18, 18.19*, and 18.20–18.23. The Commonwealth has not achieved six: 18.2–18.6 and 18.9. Therefore, Virginia remains in Non-Compliance with this Provision.

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

6. Independent Living Options

Background

In December 2021, in the Eighteenth Report to the Court, the Independent Reviewer reported that for several years Virginia had consistently fulfilled the Agreement's requirements to increase access to independent living options for individuals in the target population.

As required by the Agreement's Provision III.D.3.a., the assigned housing coordinator at DBHDS, together with representatives from six of the Commonwealth's sister agencies, developed the Plan to Increase Independent Living Options (Plan). DBHDS had also included a term in its annual performance contract with the CSBs to require case managers to offer education at least annually about less restrictive community options. DBHDS developed a form that is completed during the Individual Support Planning process to ensure that this occurs.

This Plan, which Virginia has updated annually since 2013, includes, as required, the estimated number of individuals who might choose independent living options, as well as recommendations and an action plan to provide access to these independent housing settings. DBHDS had formalized the development of its Office of Community Housing, under the leadership of its housing coordinator, and had devoted ongoing increased resources to create Regional Implementation Teams to coordinate independent housing options in each of its five Regions.

The Independent Reviewer's last review, conducted in the spring of 2021, found that 1,512 individuals in the Agreement's target population were living in their own homes. This was an increase of 1,171 since July 2015. During this same five-year period, the Commonwealth set aside 993 rental assistance resources for the target population. Virginia had been most successful funding individuals in independent housing using resources through VHDA Vouchers, State rental assistance, and local Public Housing Authorities (PHAs), but had not listed any independent housing options in Low Income Housing Tax Credit (LIHTC) properties. The Independent Reviewer determined in his Eighteenth Report to the Court that the Commonwealth had maintained Sustained Compliance with Provisions III.D.2., III.D.3., III.D.3.a., III.D.3.b.i.-ii., III.D.4. and III.D.7.

As of March 31, 2021, Virginia finally promulgated its permanent DD waiver regulations for its HCBS waiver-funded programs that had been redesigned five years earlier. By advancing its regulatory framework, the Commonwealth conveyed to the provider community its commitment to developing, delivering and sustaining more integrated residential service models throughout the State. With DMAS's and DBHDS's future expectations clear, Virginia expected that its service providers would be less reluctant to develop the necessary new services to support individuals who choose to live, and receive their support services, in one of the Commonwealth's new independent living options (i.e., Shared Living, Independent Living Supports and Supported Living.)

Twentieth Period Review

For this Period, the Independent Reviewer sought to determine whether Virginia has continued to maintain Sustained Compliance with the Independent Living Options Provisions III.D.2., III.D.3., III.D.3.a., III.D.3.b.i.-ii., III.D.4. and III.D.7.

Virginia's annual Plan, dated January 29, 2022, had been developed and updated, as required, under the supervision of DBHDS's dedicated housing coordinator and in cooperation with the

Commonwealth's sister agencies. Representatives from these agencies formed the members of Virginia's Integrated Housing Advisory Committee. The performance contract with the CSBs continued to include the required term that case managers offer annual education about more independent living options, and DBHDS's housing coordinator produced quarterly reports of actual outcomes compared with the measurable goals included in the Plan.

The table below shows the measurable outcomes achieved by the Commonwealth between June 2015 and December 2021, followed by the percentage of the Plan's goal achieved.

Independent Housing Outcomes		
Date	**# in own home*** **(% of goal achieved)**	**# of rental resources**** **(% of goal achieved)**
June 2015	341 (baseline)	
March 2019	925 (116%)	613
December 2019	1,034 (86%)	798 (117%)
December 2020	1,512 (81%)	993 (117%)
December 2021	**1,732 (92%)**	**1,229 (145%)**

* # of people in the Agreement's target population living in their own home with a rental assistance resource created under the Settlement Agreement (after July 2015).

** # of rental assistance resources set aside for the target population.

Conclusion

Virginia has maintained Sustained Compliance with the Independent Living Options Provisions III.D.2., III.D.3., III.D.3.a., III.D.3.b.i.-ii., III.D.4. and III.D.7.

7. Waiver Slots

Background

Throughout the Agreement's ten-year implementation schedule, i.e., Virginia's Fiscal Years 2012–2021, the Independent Reviewer reported that the Commonwealth had created, and in most years exceeded, the number of Home and Community Based Services (HCBS) waiver slots

required. The Independent Reviewer's semi-annual Individual Services Review (ISR) studies consistently found that waiver slots awarded to individuals and families provided them with critical supports that significantly improved their quality of life and prevented institutionalization.

Through Fiscal Year 2021, Virginia's General Assembly had approved 6,579 waiver slots over the ten-year implementation period, which is 63% more than the 4,170 slots required by the Agreement. During this same ten-year period, though, the number of individuals with IDD who were eligible for and in need of waiver services increased at a faster pace than the number of slots. During the first four years of the Agreement, the Commonwealth created 562 slots per year to award to individuals on its waitlists. However, the waitlists actually increased by an average of 1,114 individuals per year. This significant surge was driven by the rapidly growing number of children with Autism Spectrum Disorders who Virginia determined to be eligible for waiver-funded services. In part, the Commonwealth redesigned three HCBS waiver programs because it recognized this multi-year trend.

Another purpose of Virginia's redesign was to align its HCBS DD waiver program for individuals with IDD with the goals of the Agreement, namely community integration, self-determination and quality services. To achieve these goals, the Commonwealth needed to replace waiver programs that incentivized providers to congregate individuals in large day and residential settings with a wider and more flexible array of service options. Virginia also restructured its waitlists; rather than being placed on a list based on one's disability diagnosis, the new waitlists were based on consistent determinations of the individual's level of need.

The Independent Reviewer determined in his Eighteenth Report that, for Fiscal Year 2021, the Commonwealth had Sustained Compliance with Provisions III.C.1.a.i- ix., b.i.-x., and c.i-x. by approving the creation of 810 waiver slots, exceeding the 435 required by the Agreement.

Twentieth Review Period

For this Period, the Independent Reviewer sought to determine whether Virginia has continued to maintain Sustained Compliance with the Waiver Slots Provisions III.C.1.a.i- ix., b.i.-x., and c.i-x.

At the end of Fiscal Year 2021, more than 6,500 additional individuals with IDD were receiving waiver-funded community-based services than before the Agreement began in Fiscal Year 2011. As well, more than 3,000 individuals with DD diagnoses had access to community integration

models of service. For Fiscal Year 2022, the General Assembly approved an additional 1,010 waiver slots.

When the Agreement began, there were 5,783 individuals who were eligible for services, but on waitlists. In each of the first four years of the Agreement (Fiscal Years 2012–2015), despite the Commonwealth creating more new slots than the Agreement required, the waitlists grew significantly, by more than 1,100 individuals per year. Since Virginia redesigned its DD Waiver Programs and continued to create additional slots, the pace of growth of the waitlist slowed to an annual average of 235.

During the pandemic, though, the rate of growth of individuals on the waitlist again increased. As of March 2022, there were 14,342 eligible individuals on waitlists. Access to waiver-funded services is vitally important to these individuals and their families. It is important to note that the Settlement Agreement's requirements for the Commonwealth to create specified numbers of waiver slots ended at the end of Fiscal Year 2021. The Commonwealth complied with and significantly exceeded these requirements. The Settlement Agreement does not include requirements related to the DD waiver waitlist. As the number of Virginians with significant IDD needs has grown, the General Assembly has continued to expand the number of waiver slots and the Commonwealth's agency staff has developed creative ways to expand services to address this growing need. These efforts are vitally important to individuals in need of DD waiver services and their families and should continue.

The following table below shows the number of waiver slots that were required and the number created over the ten years of the Agreement's implementation schedule.

Required by the Settlement Agreement vs. Approved through Virginia's General Assembly

Fiscal Year	Facility Transition		ID/CL		DD/FIS		DS/BI		Total	
	Required	Approved	Required	Approved	Required	Approved	Required	Approved	Required	Approved
FY 12	60	90	275	495	150	180	-	-	485	765
FY 13	160	160	225	300	25	50	-	-	410	510
FY 14	160	160	225	575	25	130	-	-	410	865
FY 15	90	90	250	25	25	15	-	-	365	130
FY 16	85	85	275	325	25	40	-	-	385	450
FY 17	90	90	300	315	25	365	-	-	415	770
FY 18	90	100	325	80	25	344	-	60	440	584
FY 19	35	60	325	154	25	414	-	-	385	628
FY 20	35	60	355	160	50	807	-	40	440	1067
FY 21	-	20	360	140	75	650	-	-	435	810
Total	805	915	2915	2569	450	2995		100	4170	6579

Conclusion

The Commonwealth has continued to maintain Sustained Compliance with the Waiver Slots Provisions III.C.1.a.i- ix., b.i.-x., and c.i-x.

III. CONCLUSION

During the Twentieth Review Period, Virginia, through its lead agencies DBHDS and DMAS, and their sister agencies, continued its diligent efforts and progress toward fulfilling the requirements of the remaining Provisions of the Agreement. The Commonwealth maintained Sustained Compliance with 24 Provisions that it had previously achieved over consecutive Review Periods, and achieved Compliance with another Provision for the first time. Of the 155 Compliance Indicators studied during this Period, Virginia met 84, including fully achieving 28 Indicators for the first time.

Throughout the Nineteenth and Twentieth Review Periods – continuing an historically challenging time due to the pandemic – DBHDS made significant efforts and achieved important successes. These include maintaining its Quality and Risk Management (QRM) organizational structure, resources, policies and annual plans. The Department also implemented improvements to the management of serious incidents and the development of more measurable quality improvement initiatives, as well as initiating new quality review processes and significantly increasing the provision of targeted technical assistance.

Although the Commonwealth has achieved many of the Agreement's requirements, it remains considerably behind the ten-year implementation schedule. Familiar and challenging obstacles persist, especially in two areas that the Agreement was designed to address and resolve: providing appropriate and adequate services for individuals with intense medical and behavioral needs, and monitoring the quality of provided services to identify the system's most impactful problems and to implement targeted quality improvement initiatives.

For the Twenty-first Review Period, the Independent Reviewer plans to study the status of Virginia's progress toward fulfilling the requirements of the Compliance Indicators that were not reviewed during the Twentieth Review Period. The areas that will be studied include:

- Case Management Face-to-Face Assessments
- Integrated Day Activities and Supported Employment

- Regional Support Teams
- Transportation
- Investigations: Office of Licensing/Office of Human Rights
- Licensing Inspections
- Quality and Risk Management
- Quality Services Review
- Mortality Review
- System of Documents

Throughout this Twentieth Review Period, the Commonwealth's staff and DOJ gathered and shared information that helped to facilitate further progress toward effective implementation of the Agreement's Provisions. Overall, the willingness of both Parties to openly and regularly discuss implementation issues and to negotiate targeted Curative Actions to facilitate achievement with specific Compliance Indicators has been impressive and productive. The involvement and contributions of advocates and other stakeholders have helped Virginia to formulate policies and processes and make measurable progress toward fulfilling its promises to all citizens of the Commonwealth, especially those with IDD and their families.

The Independent Reviewer greatly appreciates the assistance that was so generously given by the individuals at the heart of this Agreement, as well as their families, their case managers and their service providers.

IV. RECOMMENDATIONS

The Independent Reviewer recommends that the Commonwealth undertake the 13 actions listed below, and provide a report that addresses these recommendations and their status of implementation by September 30, 2022. Virginia should also consider the additional recommendations and suggestions included in the consultants' reports, which are contained in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the Twenty-second Review Period (April 1, 2022 – September 30, 2022).

Individuals with Intense Behavioral Needs

1. The Commonwealth should collect, analyze and report to DBHDS's Quality Improvement Committee the relevant data and root causes to explain why individuals with complex behavioral needs receive only a small percentage of the number of authorized hours of in-home support services. Virginia should then prioritize quality improvement initiatives to address and resolve the problems that prevent these individuals' needs from being met.

Quality and Risk Management

2. DBHDS should complete the *Process Documents* required to show data validity and reliability of the data sets used for compliance reporting and quality improvement. The Department should increase technical assistance to its subject matter experts in the development and final review of the *Process Documents* to ensure that they identify and address all known data source system deficiencies.

3. DBHDS should review both the ten of 21 providers that the Independent Reviewer's consultant found were out of compliance with one or more of the Commonwealth's requirements for conducting a review of serious incidents and the 54 CSB root cause analyses of which less than half included all three of the elements required by the Indicator. Where DBHDS confirms that Compliance Indicator requirements were not fulfilled, DBHDS should determine needed revisions to the OL inspection process.

4. DBHDS should continue to provide training and technical assistance to providers and licensing specialists regarding the content requirements for root cause analysis (RCA) reports. The technical assistance should include additional examples that meet content requirements, especially for less critical level 1 serious incidents.

5. The Department should continue to focus on improving the measurability of its quality improvement initiatives and action plans, and also on the rigorous use of reliable and valid data sets in establishing baselines, reviewing their impact and in supporting future data-driven decision-making.

Case Management

6. The Commonwealth should incorporate children into its sampling for future Service Coordinator Quality Reviews (SCQRs). This will allow DBHDS to better understand needed service improvements for what is likely to become the fastest growing segment of the HCBS DD Waiver population.

7. DBHDS should incorporate the On-Site Visit Tool (OVST) review process into the SCQR process for Indicator elements 2.8, 2.10, and 2.14 to improve CSB supervisory reviews of case managers' use of the OSVT.

Crisis Services

8. DBHDS should analyze and determine the reasons for Regional variance regarding the percentage of crisis assessments that take place in individuals' homes or other community settings where crises occur. These reasons, together with the successful approaches by those Regions with better performance ratings, should be shared with the Regions that underperform on this required and vitally important performance measure.

Individual and Family Support Program, Guidelines for Families, and Family-to-Family and Peer Programs

9. DBHDS should adhere to the full protocol described in the associated *Process Document* for its annual notifications of Individual and Family Support (IFSP) eligibility and IFSP funding periods.

10. With regard to the requirement that the Commonwealth inform individuals of their eligibility for case management when placed on the waiver waitlist, and annually thereafter, DBHDS should issue the following:

- Updated and expanded guidelines for individuals on the waitlist and their families regarding case management options and how to apply for them;
- Appropriate revisions *to Navigating the Developmental Disability Waivers, Seventh Edition: A Guide for Individuals, Families and Support Partners*, *First Steps* and the *Development Disabilities Support Coordination Manual*; and
- A *Performance Contract* revision that defines "DD or ID active support coordination/case management service criteria" and "special service need," as well as associated protocol requirements for CSB determinations of eligibility and for terminating services.

11. DBHDS should ensure that its IFSP staff receive technical assistance from its Office of Data Quality and Visualization (DQV) to confirm the measurability of its program outcome measures and to develop methodologies for the collection of reliable and valid data. The Department should consider additional methodologies for defining and measuring participant satisfaction with the IFSP funding program.

12. DBHDS should provide clear referral process expectations for the Family-to-Family and Peer programs. The referral processes should include the collection of data specific to the purposes of Provision III.C.2.a.-i. and its associated Indicators.

Community Living Options

13. The Commonwealth should study and determine the root causes of so little growth in the use of its new integrated residential service models, especially for individuals who have long received HCBS waiver-funded services and for children who continue to live in congregate nursing facilities with shift based care.

V. SUMMARY OF COMPLIANCE

Note: Previously, for greater clarity, Virginia created a numbering system that assigned a discrete number for each Compliance Indicator. The Independent Reviewer has now adopted this system; these numbers can be seen below in the Comments column for Provisions.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III	**Serving Individuals with Developmental Disabilities in the Most Integrated Setting**	Ratings prior to the 20th Period are not in bold. Ratings for the 20th Period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include the Commonwealth's status with each of the Compliance Indicators associated with the provision. The Findings Section and attached consultant reports include explanatory information regarding the Compliance Indicators. *The Comments in italics below are from a prior period when the most recent compliance rating was determined.*
III.C.1.a.i.-ix.	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community according to the… schedule (in i-ix).	**Sustained Compliance**	The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012-2021.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.1.b.i.-x.	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community, individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) according to the …schedule (in i.-x.)	**Sustained Compliance**	The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012-2021. The Parties agreed to consider the effectiveness of the discharge and transition process at Nursing Facilities (NFs) and ICFs as an indicator of compliance for III.D.1.
III.C.1.c.i.-x.	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) according to the … schedule (in i-x).	**Sustained Compliance**	*See Comment re: III.C.1.b.i-ix*
III.C.2.a.-i.	The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2021, a minimum of 1,000 individuals will be supported.	Non Compliance **Non Compliance**	The Commonwealth has fulfilled the quantitative requirement for the Fiscal Years 2013 through 2020 by providing financial support to more than 1,000 individuals each year. During the 20th Period, the Commonwealth met the requirements for three of the twelve Compliance Indicators, 1.01-1.12. The Commonwealth met Indicators 1.5, 1.8, and 1.12. It has not met 1.1–1.4, 1.6, 1.7, and 1.9 - 1.11, and therefore remains in non-compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.5.a.	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	**Sustained Compliance**	207 (100%) of the individuals reviewed in the Individual Services Review studies during the 10th, 11th, 12th, 13th, 14th, 15th, 16th, 18th., and 20th Periods had case managers and current Individual Support Plans.
III.C.5.b.	For the purpose of this agreement, case management shall mean:		
III.C.5.b.i.	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	Non Compliance **Non Compliance**	For this and four other Provisions, III.C.5.b.ii., III.C.5.b.iii.., III.C.5.c. and V.F.2., there are twelve Compliance Indicators, 2.01-2.05 and 2.16-2.22. Indicator 2.05 has ten required elements (2.06-2.15). Virginia met four of the Indicators 2.01, 2.04, 2.17 and 2.19, but has not met eight Indicators 2.02, 2.03, 2.05 (includes 2.06 – 2.15), 2.16, 2.18, 2.20– 2.22.
III.C.5.b.ii.	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP.	Non Compliance **Non Compliance**	When Virginia achieves the Indicators for III.C.5.b.i., it also achieve compliance for this Provision.
III.C.5.b.iii.	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	Non Compliance **Non Compliance**	When Virginia achieves the Indicators for III.C.5.b.i., it also achieve compliance for this Provision.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.5.c.	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	**Sustained Compliance**	The Independent Reviewer and Parties agreed in April 2020 that this provision is in Sustained Compliance.
III.C.5.d.	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	Non Compliance **Compliance**	The Commonwealth has met all four Compliance Indicators, 6.01-6.04. Therefore, Virginia has achieved Compliance for the first time.
III.C.6.a.i.-iii.	The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall: i. Provide timely and accessible support … ii. Provide services focused on crisis prevention and proactive planning … iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current placement whenever practicable.	Non Compliance **Non Compliance**	The Commonwealth met seventeen of the twenty-two Compliance Indicators 7.2-7.23. It met Indicators 7.2-7.7, 7.9-7.13, 7.15-7.17 and 7.21-7.23, but has not met the five Indicators 7.8, 7.14, and 7.18-7.20, and therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.i.A.	The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.	**Sustained Compliance**	CSB Emergency Services are utilized. Regional Education, Assessment, Crisis Services, Habilitation (REACH) hotlines are operated 24 hours per day, 7 days per week, and provide access to information for adults and children with IDD.
III.C.6.b.i.B.	By June 30, 2012, the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.	**Sustained Compliance**	REACH trained CSB staff during the past seven years. The Commonwealth requires that all Emergency Services (ES) staff and case managers are required to attend training**.**
III.C.6.b.ii.A.	Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.	Non Compliance **Non Compliance**	The Commonwealth met all of the seven Compliance Indicators 8.1-8.5, 8.6*, and 8.7*. However, its data for has been established as reliable and valid. Met* ratings are for illustrative purposes only, therefore Virginia remains in Non-Compliance.
III.C.6.b.ii.B.	Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting.	Non Compliance **Non Compliance**	The Parties agreed that the Indicators for III.C.6.a.i.-iii. and III.C.6.b.ii.A. cover this provision.
III.C.6.b.ii.C.	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement.	**Sustained Compliance**	During the 19th and 20th Review Periods, law enforcement personnel were involved. Mobile crisis team members worked with law enforcement personnel to respond regardless of whether REACH staff responded in person or remotely using telehealth.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.ii.D.	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	**Sustained Compliance**	REACH Mobile crisis teams for children and adults are available around the clock and respond on-site, or remotely due to COVID precautions, at all hours of the day and night.
III.C.6.b.ii.E.	Mobile crisis teams shall provide local and timely in-home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	**Sustained Compliance**	In each Region, the individuals are provided in-home mobile supports, or telehealth due to COVID precautions, for up to three days as required. Days of support provided ranged between a low of one and a high of sixteen days.
III.C.6.b.ii.H.	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time.	**Sustained Compliance**	The Commonwealth added staff to REACH teams in all five Regions and for five years demonstrated a sufficient number of staff to respond to on-site crises within the required average annual response times. Appropriate COVID precautions temporarily replaced many on-site responses.
III.C.6.b.iii.A.	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services.	**Sustained Compliance**	All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults and have two crisis stabilization homes for children.
III.C.6.b.iii.B.	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.	Non Compliance **Non Compliance**	The Commonwealth met the three of the Compliance Indicators 10.01, 10.2, 10.3, but did not achieve 10.4, and therefore remains in Non Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.iii.D.	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	Non Compliance **Non Compliance**	The Commonwealth did not meet the sole indicator 11.1, and therefore remains in Non Compliance.
III.C.6.b.iii.E.	With the exception of the Pathways Program at SWVTC … crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.	Compliance **Non Compliance**	The Parties agreed that the Indicators for III.C.6.b.iii.G. cover this Provision.
III.C.6.b.iii.F.	By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.	**Sustained Compliance**	Each Region developed and currently maintains a crisis stabilization program for adults with IDD in each Region and has two programs for children.
III.C.6.b.iii.G.	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	Compliance **Non Compliance**	The Commonwealth met two Compliance Indicators 13.1, and 13.2, but did not achieve 13.3, and therefore has not maintained Compliance.
III.C.7.a.	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	Non Compliance Non Compliance	*The Commonwealth has achieved Compliance Indicator 14.1.* *The Commonwealth has not met Indicators 14.2 14.3, 14.4, 14.5, 14.6, 14.7. 14.8, 14.9, and 14.10.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.7.b.	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment First policy shall, at a minimum, be based on the following principles: (1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth; (2) the goal of employment services is to support individuals in integrated work settings where they are paid minimum or competitive wages; and (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in the ISP. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.	Non Compliance Non Compliance	*The indicators for III.C.7.a. serve to measure III.C.7.b.*
III.C.7.b.i.	Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First Policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreation opportunities, and other integrated day activities.	Sustained Compliance	*The Commonwealth had previously developed plans for both supported employment and for integrated community activities. It's updated plan includes outcomes and bench marks for FY 21 –FY23*
III.C.7.b.i.A.	Provide regional training on the Employment First policy and strategies through the Commonwealth.	Sustained Compliance	*DBHDS continued to provide regional training.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.7.b.i. B.1.	Establish, for individuals receiving services *through the HCBS waivers*, annual baseline information regarding:	Sustained Compliance	*The Commonwealth has sustained its improved method of collecting data. For the fifth consecutive full year, data were reported by 100% of the employment service organizations. They continue to report the number of individuals, length of time, and earnings as required in III.C.7.b.i.B.1.a., b., c., d., and e. below.*
III.C.7.b.i. B.1.a.	The number of individuals who are receiving supported employment.	Sustained Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.b.	The length of time individuals maintain employment in integrated work settings.	Sustained Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.c.	Amount of earnings from supported employment;	Sustained Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.d.	The number of individuals in pre-vocational services.	Sustained Compliance	*See answer for III.C.7.b.i.B.1.*
III.C.7.b.i. B.1.e.	The length-of-time individuals remain in pre-vocational services.	Sustained Compliance	*See answer for III.C.7b.i.B.1.*
III.C.7.b.i. B.2.a.	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year.	Sustained Compliance	*The Parties agreed in January 2020 that this provision is in Sustained Compliance and that meeting these targets will be measured in III.D.1.*
III.C.7.b.i. B.2.b.	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	Sustained Compliance	*Th number of individuals employed and the length of time employed are both determined annually.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.7.c.	Regional Quality Councils (RQC), described in V.D.5. … shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly … Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	Sustained Compliance Sustained Compliance	*RQCs did not complete a quarterly review of employment data or employment targets. Data were not shared with the RQC to review, and not all RQCs had evidence of meaningful discussions. RQC's did not consult with providers.*
III.C.7.d.	The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.	Sustained Compliance Sustained Compliance	*RQCs did not complete a quarterly review of employment data or employment targets. RQC's did not consult with providers.*
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	Non Compliance Non Compliance	*The Commonwealth has achieved Compliance Indicators 16.1, 16.3, 16.4, 16.5, 16.6, and 16.7.* *The Commonwealth has not met Indicators 16.2 and 16.8.*
III.C.8.b.	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access	Compliance **Sustained Compliance**	The Commonwealth again met the two Compliance Indicators 17.1 and 17.2 and therefore has Sustained Compliance for the first time.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.D.1.	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	Non Compliance **Non Compliance**	The Commonwealth met seventeen*, of the twenty-three Indicators 18.1-18.23. It met 17 Indicators 18.1*, 18.7, 18.8, 18.10 – 18.18, 18.19*, 18.20 – 18.23, but did not meet the six Indicators 18.2 – 18.6, and 18.9 and therefore remains in Non-Compliance.
III.D.2.	The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources.	**Sustained Compliance**	As of 12/31/21, the Commonwealth had created new options for 1,732 individuals who are now living in their own homes. This is 1,391 more individuals than the 341 individuals who were living in their own homes as of 7/1/15. This accomplishment is 92% of its goal of 1,886 by 6/30/20.
III.D.3.	Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments.	**Sustained Compliance**	The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies.
III.D.3.a.	The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations ...	**Sustained Compliance**	DBHDS has a dedicated housing service coordinator. It has developed and updated its housing plan with these representatives and with others.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.D.3.b.i.-ii.	The plan will establish for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement: Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and recommendations to provide access to these settings during each year of this Agreement.	**Sustained Compliance**	Virginia estimated the number of individuals who would choose independent living options. It established the required baseline, updated and revised the Plan with new strategies and recommendations, and tracks progress toward achieving plan goals.
III.D.4.	Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing from a one-time fund of $800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii.	**Sustained Compliance**	The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds received permanent rental assistance.
III.D.5.	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.	Non Compliance Non Compliance	*The Commonwealth met one of the three Compliance Indicators 19.1-19.3. It met Indicator 19.1, but did not meet 19.2 and 19.3, and therefore remains in Non Compliance.*
III.D.6.	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	Non Compliance Non Compliance	*The Commonwealth has met Indicators 20.1, 20.3, 20.4*, 20.5, 20.6, 20.8*, 20.9, 20.10*, 20.11 and 20.13*; but has not achieved Indicators 20.2, 20.7 and 20.12. Therefore, Virginia remains in Non-Compliance with this Provision. See *Note below.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.D.7.	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home …	**Sustained Compliance**	The Commonwealth included this term in its annual performance contract, developed and provided training to case managers and implemented a form for the annual ISP form process regarding education about less restrictive options.
III.E.1.	The Commonwealth shall utilize Community Resource Consultant ("CRC") positions located in each Region to provide oversight and guidance to CSBs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office…The CRCs shall be a member of the Regional Support Team ...	Sustained Compliance	*Community Resource Consultants (CRCs) are located in each Region, are members of the Regional Support Teams, and are utilized for these functions*.
III.E.2.	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	Sustained Compliance	*DBHDS has sustained improved RST processes. CRCs and the RSTs continue to fulfill their roles and responsibilities.*
III.E.3.a.-d.	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	Sustained Compliance	*The RSTs, which meet monthly and fulfill their assigned functions when they receive timely referrals.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.	**Discharge Planning and Transition from Training Centers**	**COMPLIANCE*** designates the portions of the Consent Decree achieved by Virginia and relieved by the Court.	Comments explain the Commonwealth's status with each Provision.
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	COMPLIANCE*	*The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. These processes continue at SEVTC.*
IV.A.	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	COMPLIANCE*	*For the one area of Non-Compliance previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for IV.A.*
IV.B.3.	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans reviewed were well organized and well documented.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.4.	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	COMPLIANCE*	*For the one area of Non-Compliance previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for IV.B.4.*
IV.B.5.	The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan will be developed within 30 days prior to discharge.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision and its sub provisions a.-e., e.i. and e.ii. The discharge plans are well documented.*
IV.B.5.a.	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.c.	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	COMPLIANCE*	*See comment re: IV.B.5.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.5.d.	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes.	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.e.ii.	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.6.	Discharge planning will be done by the individual's PST…Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	COMPLIANCE*	*For the one area of Non-Compliance previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for IV.B.6.*
IV.B.7.	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	COMPLIANCE*	*The Commonwealth's discharge plans indicate that individuals with complex/intense needs can live in integrated settings. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.9.	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	COMPLIANCE*	*The Individual Services Review studies determined that individuals and their authorized representatives, were provided with information regarding community options and had the opportunity to discuss them with the PST. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that Commonwealth had offered a choice of providers. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.9.b.	PSTs and the CSB case manager shall coordinate with the … community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	COMPLIANCE*	*The Individual Services Review studies determined that individuals and their authorized representatives did have an opportunity to speak with individuals currently living in their communities and their family members. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.9.c.	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	COMPLIANCE*	*The Individual Services Review studies determined that PSTs and case managers assisted individuals and their Authorized Representative. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.11.	The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	COMPLIANCE*	*The Individual Services Review studies determined that individuals /Authorized Representatives who transitioned from Training Centers were provided with information regarding community options. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.11.a.	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	COMPLIANCE*	*The Independent Reviewer confirmed that training has been provided.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.11.b.	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches … will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers.	COMPLIANCE*	*The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.15.	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	COMPLIANCE*	*See Comment for IV.D.3.*
IV.C.1.	Once a specific provider is selected by an individual, the Commonwealth shall invite and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that provider staff participated in the pre-move ISP meeting and were trained in the support plan protocols. Interviews and documents reviewed indicate that this process remains in place at South Eastern Virginia Training Center (SEVTC).*
IV.C.2.	Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for discharge will be developed by the PST.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that almost all individuals had moved within 6 weeks, or reasons were documented. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.C.3.	The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring (PMM) Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.	COMPLIANCE*	*The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions.* *The Independent Reviewer's Individual Services Review studies found that PMM visits occurred. The monitors had been trained and utilized monitoring checklists.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.C.4.	The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that for almost all individuals, the Commonwealth updated discharge plans within 30 days prior to discharge.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.C.5.	The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that the Personal Support Teams (PSTs), including the Authorized Representative, had determined and documented, and the CSBs had verified, that essential supports to ensure successful community placement were in place prior to placement.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.C.6.	No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that discharge records for almost all individuals who moved to settings of five or more did so based on their informed choice after receiving options.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.C.7.	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	COMPLIANCE*	*The Independent Reviewer confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.D.1.	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	COMPLIANCE*	*The Independent Reviewer confirmed that the Facility Director job description at SEVTC specifically identifies responsibility for CIM duties and responsibilities.*
IV.D.2.a.	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that CIMs were engaged in addressing barriers to discharge.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.D.3.	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that five RSTs were functioning with the required members and were coordinated by the CIMs.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	COMPLIANCE*	*The CIM provides monthly reports and DBHDS provides the aggregated weekly and. monthly information to the Reviewer and DOJ.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.	**Quality and Risk Management System**	Ratings prior to the 20th Period are not in bold. Ratings for the 20th Period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include the Commonwealth's status with each of the Compliance Indicators associated with the provision. The Findings Section and attached consultant reports include additional explanatory information regarding the Compliance Indicators. *The Comments in* italics *below are from a prior period when the most recent compliance rating was determined.*
V.A.	To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships), and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system that is consistent with the terms of this Section.		Provision V.A. will be in Compliance when the Commonwealth is determined to comply with all the requirements of the Provisions and associated Compliance Indicators in Sectoin V. Quality and Risk ManagemenmSystem

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	Non Compliance **Non Compliance**	The Commonwealth met eleven* of the thirty-three Compliance Indicators 29.1-29.33. It met Indicators 29.3, 29.5, 29.6, 29.7, 20.9, 29.11, 29.12, 29.13*, 29.15*, 29.31, and 29.32, but did not meet the remaining 23: 29.1, 29.2, 29.4, 29.8, 29.10, 29.14, 29.16–29.30, and 29.33
V.C.1.	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	Non Compliance **Non Compliance**	The Commonwealth met* seven of the eleven Compliance Indicators 30.1-30.11. It met Indicators 30.1–30.3, 30.5*, 30.6, 30.8, and 30.9, but did not achieve the remaining four: 30.4, 30.7, 30.10 and 30.11.
V.C.2.	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	Sustained Compliance	*DBHDS implemented and maintains a web-based incident reporting system and reporting protocol.*
V.C.3.	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken.	Sustained Compliance	*DBHDS revised its regulations, increased the number of investigators and supervisors, added expert investigation training, created an Investigation Unit, includes double loop corrections in Corrective Action Plans (CAPs) for immediate and sustainable change, and requires 45-day checks to confirm implementation of CAP s re: health and safety.*
V.C.4.	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 32.1, 31.2, 31.5, 31.6, 31.8, and 31.9.* *The Commonwealth has not met Indicators 32.3, 32.4, and 32.7.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.C.5.	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The …mortality review team … shall have at least one member with the clinical experience to conduct mortality re who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death; … (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems … and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 33.1, 33.2, 33.3, 33.4, 33.5, 33.6, 33.7, 33.8, 33.9*, 33.10, 33.11, 33.12, 33.14, 33.16, 33.17, 33.18, 33.19, 33.20, and 33.21.* *The Commonwealth has not met Indicators 33.13 and 33.15.*
V.C.6.	If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider.	Non Compliance Non-Compliance	*The Commonwealth has met Compliance Indicators 34.1, 34.2, 34.3, 34.4*, 34.6*, 34.7, and 34.8*.* *The Commonwealth has not met Indicator 34.5.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.D.1.	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 35.2, 32.4.* *The Commonwealth has not met Indicators 35.1, 32.3, 35.5, 32.6, 35.7, and 32.8.*
V.D.2.a.-d.	The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 36.2* and , 36.7*.* *The Commonwealth has not met Compliance Indicators 36.1, 36.3, 36.4, 36.5, 36.6 and 36.8.*
V.D.3.	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 37.1*, 37.3, 37.4, 37.8, 37.9, 37.10*, 37.11, 37.12*, 37.13, , 37.14*, 37.15, 37.16*, 37.18*, 37.19, 37.20*, 37.21, 37.22*, 37.23and 37.24*.* *The Commonwealth has not met Indicators 37.2, 37.5, 37.6, 37.7, and 37.17.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.D.4.	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	Non Compliance Non Compliance	*The Commonwealth has not met Compliance Indicator 38.1.*
V.D.5.	The Commonwealth shall implement Regional Quality Councils (RQCs) that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 39.1, 39.2, and 39.3.* *The Commonwealth has not met Indicators 39.4, and 39.5.*
V.D.5.a.	The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	Sustained Compliance	*The five Regional Quality Councils include all the required members.*
V.D.5.b.	Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 40.1, 40.2*, 40.3, 40.4, and 40.6.* *The Commonwealth has not met Indicators 40.5 and 40.7.*
V.D.6.	At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability … and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	Non Compliance Non Compliance	*The Commonwealth has not met Indicators 41.1, 41.2, 41.3, 41.4, and 41.5.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.E.1.	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program including root cause analysis that is sufficient to identify and address significant issues.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicator 42.1 and 42.2.* *The Commonwealth has not met Indicators 42.3, 42.4 and 42.5.*
V.E.2.	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program.	Non Compliance Non Compliance	*The Commonwealth has not met Indicators 43.1, 43.2, 43.3 and 43.4.*
V.E.3.	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	Non Compliance Non Compliance	*The Commonwealth has not met Indicators 44.1 and 44.2.*
V.F.1.	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	**Sustained Compliance**	The case management and the ISR study found Compliance with the required frequency of visits, many of which are remote due to COVID precautions. DBHDS reported data that some CSBs are below target.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.F.2.	At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs….	Non Compliance **Non Compliance**	When Virginia achieves the Indicators for III.C.5.b.i., it also achieve compliance for this Provision.
V.F.3.a.-f.	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	**Sustained Compliance**	The ninth, twelfth, fourteenth, and sixteenth and eighteenth ISR studies found that the case managers had completed the required monthly visits for 130 of 134 individuals (96.0%).
V.F.4.	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	Non Compliance **Non Compliance**	The Commonwealth has not met the two Compliance Indicators 46.1 and 46.2, and therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.F.5.	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	Non Compliance **Non Compliance**	The Commonwealth has not met the sole Compliance Indicator 47.01, and therefore remains in Non-Compliance.
V.F.6.	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	**Sustained Compliance**	The statewide CM training modules have been updated and improved and are consistent with the requirements of this provision.
V.G.1.	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	Sustained Compliance	*OLS regularly renewed unannounced inspection of community providers.*
V.G.2.a.-f.	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	Sustained Compliance	*OLS has maintained a licensing inspection process with more frequent inspections.*
V.G.3.	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	Non Compliance Non Compliance	*The Commonwealth met all four Compliance Indicators 48.1, 48.2, 48.3 and 48.4*.* *The Commonwealth remains in Non-Compliance. *See note at the bottom of the Compliance Table.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.H.1.	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 49.1, 49.5, 49.6, 49.7,49.8, 49.9, 49.10, 49.11, and 49.13.* *The Commonwealth has not met Indicators 49.2, 49.3, 49.4, and 49.12.*
V.H.2.	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	Compliance Sustained Compliance	*The Commonwealth met all three Compliance Indicators 50.1, 50.2, and 50.3, and has achieved Compliance for the second consecutive review and therefore has achieved Sustained Compliance.*
V.I.1.a.-b.	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	Non Compliance **Non Compliance**	Of this Provisions five Compliance Indicators, the Commonwealth met one (51.1), but had not met four (51.2-51.5).
V.I.2.	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting..	Non Compliance **Non Compliance**	Of this Provisions six Compliance Indicators, the Commonwealth met four (52.3-52.6), but had not met two (52.1-52.2).
V.I.3.	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.	Non Compliance **Non Compliance**	Of this Provisions four Compliance Indicators, the Commonwealth met one (53.1), but had not met three (53.2-53.4).
V.I.4.	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	**Sustained Compliance**	The Commonwealth's contractor completed the second annual QSR process based on a statistically significant sample of individuals.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
VI.	**Independent Reviewer**	**Rating** **COMPLIANCE*** designates the portions of the Consent Decree achieved by Virginia and relieved by the Court.	**Comments**
VI.D.	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with copies to the parties. The parties will seek a protective order permitting these reports to be …and shared with Intervener's counsel.	COMPLIANCE*	*DBHDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.*
IX.	**Implementation of the Agreement**	**Rating** Ratings prior to the 20th Period are <u>not</u> in bold. Ratings for the 20th Period are in **bold.**	**Comment**
IX.C.	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented …	Non Compliance Non Compliance	*The Independent Reviewer determined that the Commonwealth did not maintain sufficient records to document proper implementation of the Provisions, including not providing completed Process Documents and Attestations determining that its data sets are reliable and valid.*

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

*Compliance**: On March 3, 2021, the Court ordered that it found the Commonwealth in compliance with Sections IV. and Provision VI.D. of the Consent Decree and relieved the Commonwealth of those portions of the Decree.

VI. APPENDICES

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APPENDIX A

Quality and Risk Management

by

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and

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Quality and Risk Management System 20th Review Period Study

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to ensure that all services for individuals receiving services under this Agreement are of good quality, meet individual's needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships), and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system that is consistent with the terms of this section. The related provisions are as follows:

> **Section V.B:** The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.
> **Section V.C.1:** The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.
> **V.I.- V.I.3:** The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice. QSRs shall collect information through: a. Face-to-face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and b. Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers; QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels; and, the Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate. The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.

The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia had not yet been found in sustained compliance. They agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020. For the Report to the Court, due in June 2022, the Independent Reviewer's monitoring priorities again include studying compliance with these agreed-upon compliance indicators.

The Independent Reviewer's 18th Report to the Court, dated June 13, 2021, found the Commonwealth had not met the requirements for compliance at V.B noting that achieving this provision requires meeting

33 Compliance Indicators, which will be evidence that the QRM system is in compliance. It was also noted that Compliance Indicator 29.8 was not met as QSR data were not available from FY 2021 to complete required evaluations. The 16th Report to the Court found that the Commonwealth had not met the requirements for compliance at V.C.1 noting that the Commonwealth does not yet have a functioning risk management process that uses triggers and threshold data to identify individuals at risk or providers that pose risks. \\\

Study Purpose and Methodology:
In April 2019, the Court directed the Commonwealth to develop a library of documents that would show the Court the source of Virginia's authority (i.e., its organizational structure, policies, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, quarterly reports, etc.) needed to demonstrate compliance. Accordingly, this study attempted to identify a minimum set of finalized policies, procedures, instructions, protocols and/or tools that will be needed for the Independent Reviewer to formulate his determinations whether the Compliance Indicators have been met and the Provisions achieved. In addition, the Independent Reviewer asked the consultants to determine the status of Commonwealth's determinations that its data sources provide reliable and valid data, as well as the documents and the method of analysis the Commonwealth is using, or plans to use, to determine whether it is maintaining "sufficient records to document that the requirements of each provision are being properly implemented," as measured by the relevant compliance indicators. This also encompasses required reporting commitments.

The study methodology included document review, DBHDS staff interviews, review of a small sample of annual Office of Licensing inspection reports and evidence packets that it used in determining provider compliance, and review and analysis of any data from sources that DBHDS determined to be valid and reliable as well as other available data. A full list of documents and data reviewed may be found in each section of the Compliance Indicator review table. A full list of individuals interviewed is included in Attachment A. The purpose of the study and the related components of the study methodology were reviewed with DBHDS staff. Following that kick-off meeting, DBHDS was asked to provide all necessary documents and to suggest interviews that provides information that demonstrates proper implementation of the Provision and its associated Compliance Indicator(s).

Summary of Findings:
According to the draft *DBHDS Quality Management Plan SFY2021,* DBHDS is committed to Continuous Quality Improvement (CQI), which the *Plan* describes as "an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes." The *DBHDS Quality Management Plan* further describes quality improvement as a "systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care," and as a "data driven process" that involves analysis of data and performance trends that is used to determine quality improvement priorities.

However, the functionality of the Commonwealth's framework continued to be severely hampered by the lack of valid and reliable data across many components of the system. As previous studies have found, these issues compromise the ability of DBHDS staff to complete meaningful analyses of the various data collected to effectively identify and implement needed improvements. While DBHDS collected considerable data from various sources, significant issues with the reliability and validity of the data existed throughout the system during the 20th period. This an overarching theme that negatively impacts the ability of DBHDS to fully implement its commitment to Continuous Quality Improvement, as described in the draft *Quality Management Plan.*

At the time of the 19th Period review, the study documented a new initiative by the DBHDS Office of Data Quality and Visualization (ODQV) to update the assessments of data source systems and provide actionable recommendations to improve data quality (i.e., validity and reliability). This process saw completion of two such reviews (i.e., for AVATAR and the Comprehensive Employment Spreadsheet) during this Review period. Since that time, DBHDS and USDOJ agreed upon, and the Court approved, a Curative Action for Provision V.D.2.a.-d. Compliance Indicator 36.1 to address validity and reliability of data sets DBHDS uses to report compliance. On 1/21/22 they jointly filed with the Court an agreed-upon curative action that noted that "the Independent Reviewer had identified concerns with the Commonwealth's data reliability and validity specific to particular source systems and that, further, many of the Data Source Systems were outdated compared to the advancements in IT and have planned investments for replacements over the next several years. All parties, the IR, DOJ, and the Commonwealth recognize that bringing source systems in compliance is a multi-year and multimillion dollar process and poses a challenge in exiting the Settlement Agreement in a timely manner."

"DQV will continue to review data sources and update the quality management plan annually as required. DQV will also continue to make recommendations around actionable items with the systems to increase their quality. Additionally, every 3-5 years DQV will do a deep dive into each source system to test and follow the data, from the entering of data into the source system to the reporting of the data from the data set(s). DQV will review and identify concerns related to source systems and will identify threats to the data reliability and validity. DQV provides technical assistance to the SME in collaboration with IT (See "Actionable Steps to Improve Data Validity and Reliability for Target Source Systems," April 23, 2021) to correct threats to data. This improvement will be reviewed with DQV. Assertion of data reliability and validity will be completed by the Chief Data Officer (CDO) once threats have been alleviated."

This was consistent with processes DBHDS described at the time of the 19th Period review. At that time, DBHDS submitted documentation that detailed what appeared to be a well-thought out process for reviewing each primary data source system and for the identification of actionable remedial recommendations DBHDS could take.

For this 20th Period review, the Office of DQV had completed such a review and made recommendations for two data source systems, AVATAR and the Comprehensive Employment Spreadsheet (CES). Of note for the other data source systems that the Office of DQV previously reviewed, however, there remained prior findings of deficiencies that the data set attestation processes needed to address.

The agreed-upon curative action also asserted that "the data that comes from the existing system can still be used to create valid and reliable data sets. The data source system is not what drives the quality and risk management programs, it is the data that comes from these systems and how it is used to make improvements. The Commonwealth uses Data Sets to analyze, report, and make decisions. The use of Data Sets is based on the basic principle: 'What is not defined cannot be measured. What is not measured cannot be improved."

In the curative action, the Commonwealth stated that DBHDS staff had "put together a process that identified all of the data sets that get reported to the Quality Improvement Committee or a subcommittees. If it is part of a report that we use to assert compliance, we are cataloging all of the relevant data sets in a spreadsheet so that we can document the process for collecting each data set, incorporating (a) tool developed by DQV. This data measurement tool (i.e., Process Document) clearly identifies numerators, denominator, methodology, baseline and definitions of different items that we have been collecting." The curative action provided the following details of the Data Set Attestation procedures:

1. Assistant Commissioner/Designee will collect information regarding all data sets reported to the QIC and used to demonstrate compliance. Date of completion: December 31, 2021.
2. Subject Matter Experts (SME) responsible for data productions will conduct the following actions to ensure data validity:
    a. Document the process for collecting the data including the data measurement tool (called the "Process Document").
    b. SME will also identify and document data verification process (for example, a look-behind process, comparison against billing data, external expert consultants, end-user feedback, etc.).
    c. Have the process reviewed and approved by the data project manager.
        i. Review and document for any element of subjectivity
        ii. Ensure all business rules are clearly documented
        iii. Process is easily understandable by non-data staff
    d. Date of completion: January 31, 2022.
3. Subject Matter Experts (SME) responsible for data production will conduct the following actions to ensure data reliability:
    a. Submit process and data to a data analyst to ensure data reliability following the documented process.
    b. Any concerns identified in reliability are shared with the SME and when appropriate IT to resolve the issues.
4. Once all issues are resolved, and data reliability and validity are verified, the Chief Data Officer (CDO) will assert data set quality by signing off on a Data Set Attestation Form for the data set. Date of completion: March 1, 2022 (for all compliance indicators measured in the Independent Reviewer's 20th Report) and June 1, 2022 (for all compliance indicators measured in the Independent Reviewer's 21st Report).

Accompanying the curative action, DBHDS provided a document entitled *Attachment C DOJ SA Process Document - DQV DQ Verification Process*. DBHDS stated the purpose of its *Process Document* is to document the process that will establish traceability of data quality monitoring activities around data quality recommendations. Further, the Commonwealth's *Process Document* identified the input or trigger for the data quality attestation procedures as recommendations generated by the Office of DQV around identified areas of improvement within data source systems and data reporting. In other words, the Commonwealth committed to a clear expectation that a final data set attestation would occur once appropriate DBHDS staff had addressed and resolved the reliability and validity deficiencies identified by the Office of DQV and described in the Process Document. During this 20TH review period, DBHDS also provided a "Data Governance" Process Document to further describe the methodology for the implementation of the data set attestation process. In particular, for purposes of this discussion, this document also indicated that the input or trigger for the undertaking of a data set attestation would include "DQV Data Source System Assessments, New Data Report required for DOJ Settlement Agreement, New Data Report required for reporting purposes, New Data need identified by QIC or subcommittees."

Accordingly, the Independent Reviewer instructed consultants completing studies for this review period to review the relevant Process Document(s) and Data Set Attestation Form(s) for each CI in the relevant studies, to review previous findings by the Office of DQV to determine what, if any, reliability and validity deficiencies (i.e., related to a) the data collection methodology and/or b) the data source system), and to review and analyze the documented facts related to the extent to which the Process Document appears to have sufficiently addressed all previously identified deficiencies/threats related to data reliability and validity.

For Provisions V.B and V.C.1, based on review of the documents DBHDS provided, this study often could not confirm that DBHDS staff completed the required Process Document and/or the applicable Data Set Attestation Forms in a manner that demonstrated the DBHDS staff have identified, isolated and addressed applicable reliability and validity deficiencies in the data source systems. In addition, it appears that the CDO sometimes signed Data Set Attestation Forms without the required Process Document or the information that this document was to include according to the Curative Action.

To begin with, based on the documentation submitted and interviews with DBHDS staff, there was a lack of clarity about what "tool developed by DQV" DBHDS was using to document the data provenance and the mitigation of previously identified deficiencies in the data source systems. it is clear that the Process Document is the "tool developed by DQV" to document … data source systems. Some DBHDS staff suggested that, if a Process Document had not been developed that a PMI could be used instead. In some interviews, DBHDS staff reported that there should be a Process Document in line with the sample provided with the curative action; however, in the case of a Performance Measure Indicator (PMI), the PMI Measure Development Form could suffice as an alternative to the Process Document. Generally speaking, while the Process Document and the PMI Measure Development Form did have areas of overlap, the required Process Document was expected to include all the required information and the PMI was not. In addition, based on interview with the Director of the Office of DQV, the procedures completed for measure development for the PMIs did not constitute the required review of the data source system deficiencies. In other words, the Commonwealth's Curative Action clearly establishes that a Process Document is required for a data set attestation and that PMI documentation does not provide sufficient information to justify a data set attestation.

DBHDS provided a list of compliance indicators being reviewed for this review period, indicating the current status of each with regard to completion of the data set attestation. The table below shows the completion status, as determined by DBHDS, for relevant CIs identified for Provisions V.B and V.C.1.

CI	Data Verification	Attestation Completed	DBHDS Rationale for Non-Completion
29.8	Complete	Signed	
29.13	Cannot Be Done		Incident data is not reliable and valid and cannot assert reliability and validity
29.15	Cannot Be Done		Incident data is not reliable and valid and cannot assert reliability and validity
29.16	Cannot Be Done		Lacks Inter-rater-reliability
29.17	Cannot Be Done		Lacks Inter-rater-reliability
29.18	Cannot Be Done		Incident data is not reliable and valid and cannot assert reliability and validity
29.20	Complete	Signed	
29.21	Cannot Be Done		Data will not be available until 4/22-regulatory
29.22	Cannot Be Done		HCBS Settings - no data available to date
29.23	Cannot Be Done		Incident data is not reliable and valid and cannot assert reliability and validity
29.24	Cannot Be Done		Incident data - is not reliable and valid and cannot assert reliability and validity
29.25	Complete	Signed	
29.26	Complete	Signed	
29.27	Complete	Signed	
29.28	Complete	Signed	

29.29	Complete	Signed	
29.30	Complete	Signed	
29.33	Complete	Signed	
30.4/30.5	Complete	Signed	Not Provided

However, based on the documentation provided for review, in many instances, the Commonwealth was not able to provide a completed *Process Document* which would have the required information that provides the factual basis for the Commonwealth to complete and sign a data set attestations. The curative action did not describe the data set attestation as a stand-alone document because it does not include sufficient information to demonstrate, or to review and verify, how the specific pertinent data source system reliability and validity deficiencies were isolated, addressed, and resolved.

For example, for the Data Set: PMI Data for Physical Exams (i.e., CI 29.20), the documentation indicated that the "Accountable Executive reviewed the process documents to ensure they were thorough and representative of the data that was intended to be collected." Further, a section entitled *Data set and Visualization validation* stated that the Measure Steward made adjustments to the calculations to more accurately calculate the output of the data" and that "calculations of percentages have been adjusted to more appropriately depict the expected result." DBHDS did not provide a Process Document that detailed what adjustments were needed or why, or the specific corresponding actions the Measure Steward took. The following describes similar and additional flaws and/or gaps in the processes.

- For CI 29.8, DBHDS did not submit the required *Process Document.* In addition, the data set attestation only addressed NCI data and did not also address QSR data.
- For CI 29.20, DBHDS did not provide the required *Process Document* to describe how DBHDS staff identified applicable data source system deficiencies and addressed them. The applicable Data Set Attestation Form was not complete. DBHDS provided a PMI for measure development, but it only referenced physical exams, but the CI also requires data to show the compliance percentage related to dental exams for individuals with dental coverage.
- For CI 29.25, DBHDS did not provide the required *Process Document* to describe how DBHDS staff identified applicable data source system deficiencies and how it addressed and resolved them. The signed Data Set Attestation Form and the related PMI for measure development provided conflicting descriptions of the data collection methodologies.
- For 29.28 through 29.30 and 29.33,DBHDS provided a Data Set Attestation, entitled *WaMS ISP Data Repor*t, which indicated the Process Name as "Analysis and reporting of housing choice, housemate choice, daily schedule and plan participation." However, it did not describe the specific action steps that addressed and resolved any data integrity threats which ODQV identified in the WaMS data that was used to produce that report. In addition, DBHDS did not provide a Process Document that identified the specific WaMS data deficiencies pertinent to this CI and the specific steps taken to remediate them. DBHDS did provide a Process Document *Provider Data Summary_VER_001,* but it did not describe the steps for preparing the ISP 3.2 data reports or to ensure that any data source deficiencies were isolated and addressed and that the data reports contained valid and reliable data. In addition, DBHDS did not provide a Data Set Attestation related to the *Provider Data Summary_VER_001 Process Document.* .

In addition to CIs included in the DBHDS list described above, provisions V.B. and V.C.I. include other CIs that require a review of reliable and valid data. For example, the lack of valid and reliable incident data results undermines the quality of trend analyses by the QIC related to 29.7, 29.9, 29.10, 29.11, and by the RMRC related to 29.12, 29.14, 30.11.

V.B.
As described above, the availability of reliable and valid data remained an overarching barrier to the implementation of an environment of Continuous Quality Improvement. Otherwise, DBHDS continued to make progress in the development of a culture of quality and in the maturation of its quality and risk management processes, including the processes for serious incident management, the development of QIIs with measurable goals and the provision of targeted technical assistance.

V.C.1:
In spite of ongoing concerns with data reliability and validity, DBHDS continued to make progress in refining their systems and processes to provide clear expectations, guidance, training, and technical assistance to providers to assist them in developing structured and effective risk management processes. Licensing regulations at *12VAC35-105-520.A-E* continue to require providers to develop and implement a written plan to identify, monitor, reduce, and minimize harms; appoint a staff member to be responsible for the risk management function and assure that staff member has training relevant to effective risk management programs; conduct at least annual systemic risk assessments that incorporate uniform risk triggers and thresholds and include assessment of the environment of care, clinical assessment or reassessment processes, staff competence and adequacy of staffing, use of high-risk procedures including seclusion and restraint, and a review of serious incidents; and conduct and document a safety inspection at least annually for each location they operate and identify and address recommendations for safety improvement.

DBHDS has published on its website guidance documents and reference materials for providers on topics that include development and implementation of a quality improvement program; development and implementation of a risk management program; and development and implementation of a serious incident reporting, follow-up, and analysis system.

The parties have also agreed upon a curative actions to improve performance with regard to provider monitoring of the incidence of risks that are prevalent in individuals with developmental disabilities, In addition DBHDS developed a *Protocol for the Identification and Monitoring of Individuals with Complex Behavioral, Health, and Adaptive Support Needs and the Development of Corrective Action Plans required to Address Instances Where the Management of Needs for These Individuals Falls Below Identified Expectations for the Adequacy of Management and Supports Provided*, which was dated 2/7/22, but with a projected implementation date of 4/1/22.

V.I.1 – V.1.3: Working with the current QSR Contractor, DBHDS continued to complete QSRs for a representative sample of providers and participants on an annual basis. Round 1 was conducted between August 2020 through December 2020. Round 2 (R2 was conducted between February 2021 through June 2021. The Round 2 (R2) QSRs were conducted between February and June 2021 with in-person observations starting April 2021. Round 3 of QSRs reviews began in November 2021 and is scheduled to conclude in June 2022. However, it was too soon to determine if each provider was sampled at least once every two to three years. In the first two Rounds, there were provider refusals to participate. DBHDS notified refusing providers that they must participate in Round 3, but complete data were not yet available.

For this review, DBHDS staff reported that, following the completion of Round 2, they determined that the QSR process and tools needed significant revisions to achieve compliance with the SA and meet the overall intent of the QSR initiative. The DBHDS Assistant Commissioner for Developmental Services led the re-design effort, which was completed in time for implementation with Round 3. However, because Round 3 is ongoing and results are not yet available for review and analysis, many of the compliance determinations for this review are based on results from Round 2. For example, the acknowledged deficiencies related to the Round 2 tools and processes are reflected in Not Met determinations related to

the adequacy of the assessment processes required for CI 51.4, CI 51.5 and CI 52.1, as well as for CI 52.4, which requires the collection of valid and reliable data. In another example, during Round 2, the QSR Contractor was not consistently able to complete the required face-to-face interviews of individual waiver service recipients, family members, or guardians, case managers and service providers, also resulting in a finding that DBHDS did not meet all the requirements for CI 51.2.

For Round 3, this study was able to assess the requirements for a pre-implementation communication plan (i.e., CI 51.3), the policies and outcomes related to QSR Contractor staff identification and reporting of potential abuse, neglect, or exploitation, a potential rights restriction in the absence of an approved plan, or a rights restriction implemented inconsistently with the approved plan (i.e., CI 52.6) and whether QSR staff had training, knowledge, skills, and reviewer qualifications commensurate to what they were expected to review (i.e., CI 53.1), both of which appeared to be met, as well as procedures for inter-rater reliability (i.e., CI 53.3), which did not.

The tables on the following pages illustrate the current compliance status for each Compliance Indicator.

V.B Indicators:	**Status**
29.1 The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. DBHDS Quality Management System shall: a) Identify any areas of needed improvement; b) Develop improvement strategies and associated measures of success; c) Implement the strategies within 3 months of approval of implementation; d) Monitor identified outcomes on at least an annual basis using identified measures; e) Where measures have not been achieved, revise and implement the improvement strategies as needed; f) Identify areas of success to be expanded or replicated; and g) Document reviewed information and corresponding decisions about whether an improvement strategy is needed. The DBHDS Quality Management System is comprised of the following functions: a) Quality Assurance b) Quality Improvement c) Risk Management-	Not Met
29.2 The Offices of Licensing and Human Rights perform quality assurance functions of the Department by determining the extent to which regulatory requirements are met and taking action to remedy specific problems or concerns that arise.	Not Met
29.3 The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations. This includes whether serious incidents required to be reported under the Licensing Regulations are reported within 24 hours of discovery.	Met
29.4 The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process. This includes whether the provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all Level II and Level III serious incidents. The root cause analysis, when required by the Licensing Regulations, includes (a) a detailed description of what happened' (b) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and (c) identified solutions to mitigate its recurrence.	Not Met

V.B Indicators:	Status
29.5 DBHDS monitors compliance with the serious incident reporting requirements of the Licensing Regulations as specified by DBHDS policies during all investigations of serious injuries and deaths and during annual inspections. DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations.	Met
29.6 The DBHDS quality improvement system is led by the Office of Clinical Quality Improvement and structured by organizational committees with the Quality Improvement Committee (QIC) as the highest quality committee for the Department, and all other committees serve as subcommittees, including the: Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, Regional Quality Councils, and the Key Performance Area Workgroups: Health & Wellness, Community Inclusion & Integration, Provider Capacity & Competency.	Met
29.7 The Office of Clinical Quality Improvement leads quality improvement through collaboration and coordination with DBHDS program areas by providing technical assistance and consultation to internal and external state partners and licensed community-based providers, supporting all quality committees in the establishment of quality improvement initiatives, use of data and identification of trends and analysis, and developing training resources for quality improvement.	Met
29.8 The Office of Clinical Quality Improvement oversees and directs contractors who perform quality review processes for DBHDS including the Quality Services Reviews and National Core Indicators. Data collected from these processes are used to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level.	Not Met
29.9 The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas. d. The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures addressing: i. The charge to the committee, ii. The chair of the committee, iii. The membership of the committee, iv. The responsibilities of chair and members, v. The frequency of activities of the committee (e.g., meetings), vi. Committee quorum, vii. Periodic review and analysis of reliable data to identify trends and system-level factors related to committee-specific objectives and reporting to the QIC.	Met
29.10 The QIC sub-committees report to the QIC and identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement. The QIC sub-committees evaluate data at least quarterly, identify at least one CQI project annually, and report to the QIC at least three times per year.	Not Met
29.11 Through the Quality Management Annual Report, the QIC ensures that providers, case managers, and other stakeholders are informed of any quality improvement initiatives approved for implementation as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths.	Met
29.12 DBHDS has a Risk Management Review Committee (RMRC) that has created an overall risk management process for DBHDS that enables DBHDS to identify, and prevent or substantially mitigate, risks of harm.	Met

V.B Indicators:	**Status**
29.13 The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, neglect, and exploitation, at least four times per year by various levels such as by region, by CSB, by provider locations, by individual, or by levels and types of incidents.	Met*
29.14 The RMRC uses the results of data reviewed to identify areas for improvement and monitor trends. The RMRC identifies priorities and determines quality improvement initiatives as needed, including identified strategies and metrics to monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts. The RMRC ensures that each approved quality improvement initiative is implemented and reported to the QIC. The RMRC will recommend at least one quality improvement initiative per year.	Not Met
29.15 The RMRC monitors aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators. When targets are not met the RMRC determines whether quality improvement initiatives are needed, and if so, monitors implementation and outcomes.	Met*
29.16 The RMRC conducts or oversees a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The review will evaluate whether: i. The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols; ii. The provider's documented response ensured the recipient's safety and well-being; iii. Appropriate follow-up from the Office of Licensing incident management team occurred when necessary; iv. Timely, appropriate corrective action plans are implemented by the provider when indicated. v. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation.	Not Met
29.17 The RMRC conducts or oversees a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: i. Comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines; ii. The person conducting the investigation has been trained to conduct investigations; iii. Timely, appropriate corrective action plans are implemented by the provider when indicated. Iv. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation.	Not Met
29.18 At least 86% of the sample of serious incidents reviewed in indicator 5.d meet criteria reviewed in the audit. At least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed in indicator 5.e meet criteria reviewed in the audit.	Not Met
29.19 The Commonwealth shall require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth.	Not Met
29.20 At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam.	Not Met
29.21 At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	Not Met

V.B Indicators:	**Status**
29.22 At least 95% of residential service recipients reside in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings.	Not Met
29.23 At least 95% of individual service recipients are free from neglect and abuse by paid support staff.	Not Met
29.24 At least 95% of individual service recipients are adequately protected from serious injuries in service settings.	Not Met
29.25 For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans.	Not Met
29.26 The Commonwealth ensures that at least 95% of applicants assigned to Priority 1 of the waiting list are not institutionalized while waiting for services unless the recipient chooses otherwise or enters into a nursing facility for medical rehabilitation or for a stay of 90 days or less. Medical rehabilitation is a non-permanent, prescriber-driven regimen that would afford an individual an opportunity to improve function through the professional supervision and direction of physical, occupational, or speech therapies. Medical rehabilitation is self-limiting and is driven by the progress of the individual in relation to the therapy provided. When no further progress can be documented, individual therapy orders must cease.	Not Met
29.27 At least 75% of people with a job in the community chose or had some input in choosing their job.	Not Met
29.28 At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule.	Not Met
29.29 At least 75% of people receiving services who do not live in the family home/their authorized representatives chose or had some input in choosing where they live.	Not Met
29.30 At least 50% of people who do not live in the family home/their authorized representatives chose or had some input in choosing their housemates.	Not Met
29.31 DBHDS implements an incident management process that is responsible for review and follow-up of all reported serious incidents, as defined in the Licensing Regulations.	Met*
29.32 a) DBHDS develops incident management protocols that include triage criteria and a process for follow-up and coordination with licensing specialists, investigators, and human rights advocates as well as referral to other DBHDS offices as appropriate. b) Processes enable DBHDS to identify and, where possible, prevent or mitigate future risks of harm. c) Follow-up on individual incidents, as well as review of patterns and trends, will be documented.	Met
29.33 The Commonwealth ensures that individuals have choice in all aspects of their goals and supports as measured by the following: a. At least 95% of people receiving services/authorized representatives participate in the development of their own service plan.	Not Met

V.C.1 Indicators:	Status
30.1 The licensing regulations require all licensed providers, including CSBs, to implement risk management processes including: a) Identification of a person responsible for the risk management function who has training and expertise in conducting investigations, root cause analysis, and data analysis. b) Implementation of a written plan to identify, monitor, reduce and minimize harms and risks of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability; and c) Conducting annual systemic risk assessment reviews, to identify and respond to practices, situations and policies that could result in harm to individuals receiving services. Risk assessment reviews shall address the environment of care, clinical assessment or reassessment processes, staff competence and adequacy of staffing, the use of high-risk procedures including seclusion and restraint, and review of serious incidents. Risk assessments also incorporate uniform risk triggers and thresholds as defined by DBHDS. See 12VAC-35-105-520.	Met
30.2. The DBHDS Office of Licensing publishes guidance on serious incident and quality improvement requirements. In addition, DBHDS publishes guidance and recommendations on the risk management requirements identified in #1 above, along with recommendations for monitoring, reducing, and minimizing risks associated with chronic diseases, identification of emergency conditions and significant changes in conditions, or behavior presenting a risk to self or others.	Met
30.3. DBHDS publishes on the Department's website information on the use of risk screening/assessment tools and risk triggers and thresholds. Information on risk triggers and thresholds utilizes at least 4 types of uniform risk triggers and thresholds specified by DBHDS for use by residential and day support service providers for individuals with IDD. This information includes expectations on what to do when risk triggers or thresholds are met, including the need to address any identified risks or changes in risk status in the individual's risk management plan. This will be monitored as specified in #7 below.	Met
30.4. At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. Inspections will include an assessment of whether providers use data at the individual and provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations.	Not Met
30.5. On an annual basis, the Commonwealth determines that at least 86% of DBHDS licensed providers of DD services are compliant with the risk management requirements in the Licensing Regulations or have developed and implemented a corrective action plan to address any deficiencies.	Met*
30.6. DBHDS publishes recommendations for best practices in monitoring serious incidents, including patterns and trends which may be used to identify opportunities for improvement. Such recommendations will include the implementation of an Incident Management Review Committee that meets at least quarterly and documents meeting minutes and provider system level recommendations.	Met

V.C.1 Indicators:	Status
30.7. DBHDS monitors that providers appropriately respond to and address risk triggers and thresholds using Quality Service Reviews, or other methodology. Recommendations are issued to providers as needed, and system level findings and recommendations are used to update guidance and disseminated to providers.	Not Met
30.8 DBHDS has Policies or Departmental Instructions that require Training Centers to have risk management programs that: a) reduce or eliminate risks of harm; b) are managed by an individual who is qualified by training and/or experience; c) analyze and report trends across incidents and develop and implement risk reduction plans based upon this analysis; and d) utilize risk triggers and thresholds to identify and address risks of harm.	Met
30.9 With respect to Training Centers, DBHDS has processes to review data and trends and ensure effective implementation of the Policy or Departmental Instruction.	Met
30.10 To enable them to adequately address harms and risks of harm, the Commonwealth requires that provider risk management systems shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such events occur or the risk is otherwise identified. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6.	Not Met
30.11 For each individual identified as high risk pursuant to indicator #6 of V.B, the individual's provider shall develop a risk mitigation plan consistent with the indicators for III.C.5.b.i that includes the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur. The provider shall implement the risk mitigation plan. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6.	Not Met

V.I Indicators:	Status
51.1 The Commonwealth conducts Quality Service Reviews ("QSRs") annually on a sample of providers, with the goal that each provider is sampled at least once every two to three years, comprised of Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs"), to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and preferences	Met

V.I Indicators:	Status
51.2: QSRs utilize information collected from, at a minimum, the following sources for PCRs and PQRs: a. Face-to-face interviews of individual waiver service recipients, family members, or guardians (if involved in the individual's life); case managers; and service providers. b. Record reviews: case management record, the ISP, and the provider's record for selected individuals; the provider's administrative policies and procedures, incident reports, the provider's risk management and quality improvement plans; documents demonstrating compliance with the provider's contractual requirements, as applicable; and the KPA Performance Measure Indicator (PMI) data collected by DBHDS referred to in V.D.2. c. Direct observation of the individual waiver service recipient at each of the provider's service sites (e.g., Residential and/or Day Programs) as applicable for the individuals selected for review.	Not Met
51.3. The DBHDS QSR Contractor will: a. Prior to conducting QSRs, develop a communications plan and orient providers to the QSR process and expectations. b. Ensure interviews of individual waiver service recipients are conducted in private areas where provider staff cannot hear the interview or influence the interview responses, unless the individual needs or requests staff assistance and, where not conducted in private, it will be documented. Interviews with provider staff are conducted in ways that do not permit influence from other staff or supervisors.	Not Met
51.4 Reviews assess on a provider level whether: a. Services are provided in safe and integrated environments in the community; b. Person-centered thinking and planning is applied to all service recipients; c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary; d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols; e. Individuals receiving services are provided opportunities for community inclusion; f. Providers have active quality management and improvement programs, as well as risk management programs.	Not Met
51.5. The Quality Service Reviews assess on a system-wide level whether: a. Services are provided in safe and integrated environments in the community; b. Person-centered thinking and planning is applied to all service recipients; c. Providers keep service recipients safe from harm and access treatment for service recipients as necessary; d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols e. Service recipients are provided opportunities for community inclusion; f. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice.	Not Met

V.I Indicators:	Status
52.1. The QSRs assess on an individual service-recipient level and individual provider level whether: a. Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk. b. Person-centered thinking and planning is applied and people are supported in self-direction consistent with their person-centered plans, and in accordance with CMS Home and Community Based Service planning requirements. Person centered thinking and planning: i. Is timely and occurs at times and locations of convenience to the individual. ii. Includes people chosen by the individual. iii. Reflects cultural considerations of the individual. iv. Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency. v. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. vi. Has strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. vii. Offers informed choices to the individual regarding the services and supports they receive and from whom. viii. Records alternative home and community-based settings that were offered to the individual. ix. Includes a method for the individual to request updates to the plan as needed. c. Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible. d. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice. e. Individuals have opportunities for community engagement and inclusion in all aspects of their lives. f. Any restrictions of individuals' rights are developed in accordance with the DBHDS Human Rights Regulations and implemented consistent with approved plans.	Not Met
52.2 Information from the QSRs is used to improve practice and quality of services through the collection of valid and reliable data that informs the provider and person-centered quality outcome and performance results. DBHDS reviews data from the QSRs, identifies trends, and addresses deficiencies at the provider, CSB, and system wide levels through quality improvement processes.	Not Met
52.3 The summary results of the QSR for each provider (Person-Centered Reviews and Provider Quality Review) will be posted for public review.	Met
52.4 Summary data will be provided by the QSR vendor to the QIC for review on a quarterly basis to inform quality improvement efforts aligned with the eight domains outlined in section V.D.3.a-h. The QIC or other DBHDS entity utilizes this data to identify areas of potential improvement and takes action to improve practice and the quality of services at the provider, CSB, and system-wide levels.	Met
52.5. DBHDS shares information from the QSRs with providers and CSBs in order to improve practice and the quality of services.	Met
52.:6 Whenever a QSR reviewer identifies potential abuse, neglect, or exploitation, a potential rights restriction in the absence of an approved plan, or a rights restriction implemented inconsistently with the approved plan, the reviewer shall make a referral to the DBHDS Office of Human Rights and/or the Department of Social Services adult/child protective services, as applicable	Met
53.1: 100% of reviewers who conduct QSRs are trained and pass written tests and/or demonstrate knowledge and skills prior to conducting a QSR, and reviewer qualifications are commensurate to what they are expected to review.	Met

V.I Indicators:	Status
53.2: Each provider will be reviewed by the QSR at least once every two to three years. Where possible, the QSR samples will target providers that are not subject to other reviews (such as NCI reviews) during the year. Sufficient information is gathered through the samples reviewed to draw valid conclusions for each individual provider reviewed.	Not Met
53.3: To address the requirements of a look-behind, inter-rater reliability has been assessed for each reviewer annually, with 80% or higher target against another established reviewer or a standardized scored review, using either live interviewing and review of records or taped video content. Any reviewer who does not meet the reliability standards is re-trained, shadowed, and retested to ensure that an acceptable level of reliability has been achieved prior to conducting a QSR. The contract with the vendor will include a provision that during reliability testing, the reviewer does not have any access to other reviewers' notes or scores and cannot discuss their rating with other reviewers prior to submission.	Not Met
53.4 QSR reviewers receive and are trained on audit tools and associated written practice guidance that: a. Have well-defined standards including clear expectations for participating providers. b. Include valid methods to ensure inter-rater reliability. c. Consistently identify the methodology that reviewers must use to answer questions. Record review audit tools should identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation). d. Explain how standards for fulfilling requirements, such as "met" or "not met", will be determined. e. Include indicators to comprehensively assess whether services and supports meet individuals' needs and the quality of service provision.	Not Met

V.B. Analysis of 20th Review Period Finding

20th Review Period Findings **V.B The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.**

Compliance Indicator	Facts	Analysis	Conclusion
29.1 The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. DBHDS Quality Management System shall: a. Identify any areas of needed improvement. b. Develop improvement strategies and associated measures of success. c. Implement the strategies within 3 months of approval of implementation. d. Monitor identified outcomes on at least an annual basis using identified measures.	The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. The DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance, b. Quality Improvement and c. Risk Management. The DBHDS Quality Management System specifies responsibilities and has policies and procedures for implementation of a full quality cycle. DBHDS often did not have evidence that they had	For this review period, DBHDS provided a document entitled *DBHDS Quality Management Plan FY2020*, with an effective date of 3/31/21, as well as a draft of the FY2021 version. The plans provided a clear overall conceptualization of the quality improvement structures and functions envisioned, with some updated organizational structure described in the FY2021 draft. In summary, the draft plan describes the DBHDS quality management system as including the following components: • The Division of Developmental Services, which oversees the regulatory, QA, and RM processes, and includes the includes the Offices of Licensing (OL), Human Rights (OHR), and Regulatory Affairs. These offices provide oversight and monitoring of providers to assure individuals' rights and that providers and services meet established standards and requirements. This Division also oversees the DD HCBS Quality Management Plans, including the work of the Quality Review Team (QRT); • The Division of Developmental Services, which includes the Office of Provider Development, the Office of Integrated Health (OIH) and Case Management/Support Coordination; • The Division of Administrative Services which includes the Office of Management Services for Outcomes, Performance Contracts, and Grants; • The Division of Facilities Services which directs, monitors, and strengthens quality improvement in the DBHDS State Facilities; and, • The Division of the Chief Clinical Officer, including the Office of Clinical	18th–Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
e. Where measures have not been achieved, revise and implement the improvement strategies as needed. f. Identify areas of success to be expanded or replicated; g. Document reviewed information and corresponding decisions about whether an improvement strategy is needed. The DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance, b. Quality Improvement, and c. Risk Management	reliable and valid data to enable the steps in the quality cycle (i.e., to identify any areas of needed improvement, devise data-based actions to address those needs, to evaluate and monitor whether those actions are having the desired effect and to make needed revisions when they were not.)	Quality Management, which oversees the quality improvement processes, the Office of Data Quality and Visualization (ODQV), which provides critical support across quality management functions and the Mortality Review Office. In addition, both versions of the Quality Management Plan state that the DBHDS Quality Management System is comprised of the following integrated functions: Quality Assurance (QA), Risk Management (RM) and Quality Improvement (QI). It defines each of these functions, as summarized below: • QA focuses on discovery activities to test compliance with standards, regulations, policies, guidance, contracts, procedures and protocols, and the remediation of individual findings of non-compliance; • RM assesses and identifies the probability and potential consequences of adverse events and develops strategies to prevent and substantially mitigate these events or minimize the effects. • QI is the systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care. The Quality Management Plan description of the DBHDS Quality Management System (QMS) specifies responsibilities and has policies and procedures for implementation of a quality cycle, as specified in a-f of the Compliance Indicator. For example, the Quality Management Plan notes that DBHDS Quality Management Program uses the well-recognized Plan-Do-Study-Act (PDSA) quality improvement model as a guide for implementing the quality cycle. The charters for the QIC and its subcommittees define an expectation that each subcommittee will be responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated, and that the subcommittees will utilize the PDSA Model for such initiatives. As defined in the Quality Improvement Committee (QIC) charter, the PDSA model cites the following expectations for implementation:	

Compliance Indicator	Facts	Analysis	Conclusion
		• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. The Quality Management Plan also acknowledges that QI is a data-driven process. However, as reported at the time of the 18th Period review, the meaningful implementation of the quality improvement cycle requires the use of reliable and valid data to identify any areas of needed improvement, devise data-based actions to address those needs, evaluate and monitor whether those actions are having the desired effect and to make needed revisions when they were not. As described above in the Summary of Findings, for the 20th Period review, although DBHDS was in the process of implementing agreed-upon Curative Actions to address data quality, it did not yet present evidence that valid and reliable data were consistently available to support the quality cycle.	
29.2 The Offices of Licensing and Human Rights perform quality assurance functions of the Department by determining the extent to which regulatory requirements are met and taking action to remedy specific problems or concerns that arise.	The Office of Licensing is the regulatory authority for the DBHDS' licensed service delivery system. The Office of Human Rights is responsible for managing the DBHDS Human Rights dispute resolution program, following up on complaints and allegations of abuse, neglect, and exploitation, monitoring provider reporting and reviewing provider investigations and corrective actions, conducting independent or joint investigations with DBHDS	Both the *DBHDS Quality Management Plan FY2020* and the draft version of the FY 21 plan state that the DBHDS Division of Quality Assurance and Government Relations oversees regulatory, quality assurance, and risk management processes. The division is comprised of the Office of Human Rights and the Office of Licensing. The Office of Licensing (OL) is the regulatory authority for the DBHDS licensed service delivery system. OL implements quality assurance processes including but not limited to initial application reviews, initial site visits, unannounced inspections, review and investigation of serious incidents and complaints, and issuance of licensing reports requiring corrective action plans (CAPs), the OL ensures the mechanisms for the provision of quality service are monitored, enforced, and reported to the DBHDS leadership. The Office of Human Rights (OHR) is responsible for promoting the basic precepts of human dignity, advocating for the rights of persons with disabilities in the DBHDS service delivery systems and managing the DBHDS Human Rights dispute resolution program. Human rights advocates ensure compliance with	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	partners and/or the Virginia Department of Social Services.	human rights regulations by following up on complaints and allegations of abuse, neglect, and exploitation. Advocates respond to and assist in the complaint resolution process by monitoring provider reporting and reviewing provider investigations and corrective actions. Advocates also respond to reports of abuse by conducting independent or joint investigations with DBHDS partners and/or the Virginia Department of Social Services (VDSS), and in cases where there are violations of the Human Rights Regulations, advocates recommend citation through the Office of Licensing. This period's study did not verify that the Office of Licensing adequately determined the extent to which CSB's properly completed root cause analyses. The review of a randomly selected sample of 54 root cause analysis reports from 27 Community Services Boards (CSBs) found that more than half (53.6%) of providers had not met the Licensing Regulations requirements that a root cause analysis is required to included three specific elements. However, the Licensing Specialists' inspection reports determined that for each of the three required elements more than 90% of providers complied.	
29.3 a. The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process. This includes assessing whether: i. Serious incidents required to be reported under the Licensing Regulations are reported within 24 hours of discovery.	The OL continued to have detailed processes and procedures for ongoing review of provider compliance with the serious incident reporting requirements in the Licensing Regulations, including the requirement that the incident be reported within 24 hours of discovery. Based on a review and analysis of a sample of 27 randomly selected licensing inspection reports from a list	As reported previously, DBHDS has established a regulatory requirement at *12VAC35-105-160.D.2* that requires that the provider collect, maintain, and report Level II and Level III serious incidents to DBHDS, that Level II and Level III serious incidents must be reported within 24 hours of discovery, and that the report must include the date, place and circumstances of the serious incident. Similar reporting requirements for serious incidents that involve children contain these same requirements and can be found at *12VAC-35-46-1070.* The Incident Management Unit (IMU) reviews each incident report that is submitted by a provider and evaluates the content of the incident report including whether the incident was reported within the 24-hour timeframe and if late reporting is identified, they notify the provider of non-compliance requiring a corrective action plan. Licensing Specialists also review provider compliance with incident reporting requirements during annual licensing inspections and their review includes review and correlation of the results of the IMU review of incident reports from the provider during the term of the licensing inspection.	18th-Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
	of 275 in the *Inspections Completed 07/01/2021-12/31/2021*, it appeared that the OL was consistently assessing provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process, including assessment of whether the incident is reported within 24 hours of discovery.	The OL continued to have detailed processes and procedures for ongoing review of provider compliance with the serious incident reporting requirements in the Licensing Regulations, including the requirement that the incident be reported within 24 hours of discovery. The following documents describe the processes employed by the Licensing Specialist and by IMU staff: • *Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services* that outlines responsibilities for the IMU, OHR and Licensing Specialists that addresses receipt, review, and follow-up action regarding serious incidents. It also provides information about progressive sanctions for repeat regulatory violations. This document is directed to IDD providers. • *Internal 160 Protocol for DD Providers* that contains the same information as the *Protocol for Assessing Serious Incident Reporting* but also includes specific instructions for DBHDS staff. • *Memo to Providers on late reporting, 6/1/20* that reminds licensed providers of the expectations for reporting serious incidents and the consequences of late reporting. • *OL Annual Checklist Compliance Determination Chart – FY2021* that provides detailed instructions to licensing specialists on how to assess compliance with regulations (including*12VAC35-105-160.D.2*) and how to document identified non-compliance. Based on documentation reviewed and DBHDS staff interview, the IMU continues to review each serious incident report upon receipt from the provider following the processes outlined in the *Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services*. IMU cites the provider if the incident is not reported within 24 hours of discovery, unless the provider notified the IMU during the 24-hour reporting period verbally or via e-mail providing a valid reason for not reporting the incident in the CHRIS system. If cited, the provider must provide a corrective action plan to address the late reporting. Prior to the implementation of the CONNECT system in 11/2021, this process involved entry of specific information about each incident into an Excel tracking document that contained a data field to calculate and identify late reporting. The CONNECT system is linked to the CHRIS system and provides increased automation of this process reducing the impact of human error.	

Compliance Indicator	Facts	Analysis	Conclusion
		DBHDS also tracks incident reporting timeliness through a performance measure "Critical incidents are reported to the Office of Licensing within the required timeframes". The *RMRC Annual Report FY2021* notes that performance for this indicator exceeded the compliance threshold of 86% each quarter of FY20. The *RMRC Measure Tracking Log Jan 2021* records compliance for this indicator as 95% for 2021Q1 and 94% for 2021Q2. To validate these findings, this study included a review and analysis of data and information related to 4,621 incidents that were received and reviewed by the IMU (*DD Providers Incidents June 2021-November 2021.)* The Excel report also included documentation of compliance with the 24-hour reporting timeframe for each incident and whether a corrective action plan was required from the provider for late reporting. Based on that review and analysis, 4,345 (94%) incidents during this period were reported on time. This 94% on time reporting rate is above the 86% threshold set for the relevant performance standard that is documented in the SFY22 RMRC Work Plan as of 1.31.22. Data reported by the IMU to the RMRC in the IMU Report for RMRC–Q2 SFY22 also reflected a 94% on time reporting rate for the two quarters that overlap with the 6-month period for which incident data was reviewed. In addition, per the guidance in the *OL Annual Checklist Compliance Determination Chart*, OL Licensing Specialists continued to verify that serious incidents are reported within 24 hours of discovery through review of a sample of records during each annual licensing inspection to verify timely reporting of serious incidents. If a serious incident is identified in the sample review, it is cross-referenced with a list of incidents that were reported and reviewed by the IMU. If not found on that list, and the provider does not have further proof of timely reporting, the Licensing Specialist cites the provider for late reporting. This study examined data and information in the OL *Inspections Completed 07/01/2021-12/31/2021* report that included information about 275 licensing inspections conducted during this 7-month period and reviewed 27 randomly selected of those licensing inspection reports. Based on findings from review and analysis of information in these documents, It appeared that the OL was	

Compliance Indicator	Facts	Analysis	Conclusion
		consistently assessing provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process, including assessment of whether the incident is reported within 24 hours of discovery. Of note, however, DBHDS has not yet completed a source system assessment with regard to CONNECT. Based on interview with the Director of ODQV, scheduling such an assessment is pending due to the business owners' indication they do not consider the system to be ready for such a review. In addition, as described below with regard to CI 29.13, DBHDS has identified some significant issues with regard to their ability to pull valid and reliable incident data from CONNECT at this time, which are also pending resolution.	
29.4 ii. The provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all level II and level III serious incidents; iii. The root cause analysis, when required by the Licensing Regulations, includes i) a detailed description of what happened; ii) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and iii) identified solutions to mitigate its reoccurrence.	As part of the annual inspection process, the Office of Licensing assessment of provider compliance with the serious incident reporting requirements of the Licensing Regulations includes whether the provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all Level II and Level III serious incidents. The sample reviewed found that licensing specialists consistently reviewed whether there was evidence to determine if the provider conducted quarterly reviews as required in this indicator.	As reported at the time of 18th Period review, DBHDS has established a regulatory requirement at *12VAC35-105-160.C* that requires the provider to collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents as a part of their quality improvement program, and regulatory requirements at *12VAC35-105-160.E.1 and E.2* that require a root cause analysis be conducted within 30 days of discovery of Level II or Level III serious incidents, that includes a detailed description of what happened, an analysis of why it happened and identified solutions to mitigate its reoccurrence and future risk of harm, when applicable. This section also requires the provider to develop and implement a written root cause analysis policy. As part of the annual inspection process, the *OL Annual Checklist Compliance Determination Chart – FY2021* requires that the licensing specialist assessment include whether the provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all Level II and Level III serious incidents. The root cause analysis shall include a detailed description of what happened, an analysis of why it happened and identified solutions to mitigate its recurrence and future risk of harm when applicable. DBHDS has developed guidance documents for providers and departmental staff on the expectations, roles, and responsibilities that each must undertake to achieve and maintain compliance. These include:	18th-Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
		• *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services* that outlines responsibilities for the Incident Management Unit, Office of Human Rights and Licensing Specialists regarding receipt, review, and follow-up action regarding serious incidents. It also provides information about progressive sanctions for repeat regulatory violations. This document is directed to IDD providers. • *OL Annual Checklist Compliance Determination Chart – FY2021* that provides detailed instructions to licensing specialists on how to assess compliance with regulations (including*12VAC35-105-160.C, 12VAC35-105-160.E.1 and 12VAC35-105-160E.2*) and how to document identified non-compliance. During each annual licensing inspection, the licensing specialist reviews provider evidence to determine compliance with each regulation in accordance with the specific instructions contained in the *OL Annual Checklist Compliance Determination Chart – FY2022.* Based on data reported in its Licensing Regulatory Compliance with 12VAC35-105-160 CY2021 report, OL found that 611/694 providers (88%) reviewed during CY2021 met the requirement to conduct a review of all serious incidents, including Level I serious incidents, at least quarterly as a part of their quality improvement program. Based on data reported in its Licensing Regulatory Compliance with 12VAC35-105-160 CY2021 report, the Office of Licensing's Specialists assessed 605 providers for compliance with the root cause analysis content requirements at 12VAC35-105-160.E.1.a-c and found that compliance for each of the relevant sections of the regulation was as follows: • 160.E.1.a – 93.26% • 160.E.1.b – 92.56% • 160.E.1.c – 93.39% However, DBHDS did not provide a Process Document or a signed Attestation Form indicating that the data set that For this 20th Period review, this study included a review of 27 randomly selected sample of licensing inspection reports of the 275 annual inspections conducted	

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>during the period 7/1/21-12/31/21 (Inspections Completed 07/01/2021-12/31/2021). Based on this review, OL Licensing Specialists determined six of 27 licensing inspection reports did not have a serious incident during the review period that required a root cause analysis. Of the remaining 21 reports, 11 of 21 (52%) were found to have fulfilled all requirements at 12VAC35-105-160.E.1.a-c and 10/21(48%) were out of compliance with one or more of these requirements. While not a statistically significant sample, the results of this randomly selected sample review appears to be substantially inconsistent with, and not sufficient to verify, the findings DBHDS staff documented in the Licensing Regulatory Compliance with 12VAC35-105-160 CY2021 report that compliance for each of the relevant sections of the regulation was as follows:
• 160.E.1.a – 93.26%
• 160.E.1.b – 92.56%
• 160.E.1.c – 93.39%

Further, this study also reviewed a randomly selected sample of 54 root cause analysis reports from 27 Community Services Boards (CSBs) that were conducted between 06/01/2021-01/10/2022 to determine whether these sample root cause analysis reports included all the requirements at 12VAC35-105-160.E.1.a-c. Following is a comparison of the consultant's findings from the randomly selected sample of 54 CSB root cause analysis reports and the overall compliance percentages reported by OL for CY2021:

<table>
<tr><th>Licensing Regulation</th><th>OL % Reported</th><th>Study Sample Finding</th></tr>
<tr><td>§160.E.1.a</td><td>93.26%</td><td>79.63%</td></tr>
<tr><td>§160.E.1.b</td><td>93.39%</td><td>51.85%</td></tr>
<tr><td>§160.E.1.c</td><td>92.56%</td><td>66.67%</td></tr>
<tr><td>All 3 Elements</td><td></td><td>46.30%</td></tr>
</table>

These percentages, which were similar to those identified from the review of a randomly selected sample of 27 licensing inspections conducted between 07/01/2021-12/31/2021 referenced above, also failed to verify the CY2021 Licensing Inspection findings.</td><td></td></tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion
		Based on the results of the sample reviews described above, the OL has detailed protocols in place and assesses whether providers are meeting the requirements to conduct at least quarterly review of all Level I serious incidents, and a root cause analysis of all Level II and Level III serious incidents. However, findings from of this study's randomly selected sample review of 27 provider licensing inspections conducted between 07/1/21-12/31/21 and the randomly selected sample of 54 root cause analysis reports completed by CSBs support that a substantial percentage of providers had not consistently met the Licensing Regulations relevant to root cause analysis requirements. Further, this review was not able to verify the 93% compliance percentage that OL reported for requirements at 12VAC35-105-160.E.1.a-c in its 12VAC35-105-160 CY2021 report. Therefore, the percentages reported for §160.E.1.a-c noted above do not appear to be an accurate reflection of the actual extent to which licensed providers comply with 12VAC35-105-160.E.1.a-c based on comparison with the findings from the two randomly selected sample reviews described above.	
29.5 DBHDS monitors compliance with the serious incident reporting requirements of the Licensing Regulations as specified by DBHDS policies during all investigations of serious injuries and deaths and during annual inspections. DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations.	DBHDS has established regulations and related protocols for monitoring compliance with the serious incident reporting requirements of the Licensing Regulations during all investigations of serious injuries and deaths. DBHDS has established regulations and related protocols for monitoring compliance with the serious incident reporting requirements of the Licensing Regulations during annual inspections.	As reports at the time of the 18th Period review, DBHDS had established regulations that require corrective action plans for any violation of serious incident reporting requirements at: • 12VAC35-105-160.C requires that providers shall collect, maintain and review at least quarterly all serious incidents, including Level I serious incidents, as part of the quality improvement program. • 12VAC35-105-160.D.2 requires that the provider collect, maintain, and report Level II and Level III to DBHDS, that Level II and Level III serious incidents must be reported within 24 hours of discovery, and that the report include the date, place, and circumstances of the serious incident • 12VAC35-105-160.E.1 requires that a root cause analysis be conducted by the provider within 30 days of discovery of a Level II or Level III serious incident. • 12VAC35-105-160.E.2 requires the provider develop and implement a root cause analysis policy. DBHDS had also established regulations requiring providers to implement their corrective action plans and monitor the plan implementation and effectiveness at: • 12VAC35-105-170.G requires providers to implement their corrective action	18th-Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations.	plans by the date set in the plan • 12VAC35-105-170.H requires that providers monitor implementation and effectiveness of corrective action plans as a part of their quality improvement program. As described above with regard to CI 29.3, DBHDS Incident Management Unit (IMU) staff and licensing specialists both play key roles in monitoring compliance with the serious incident reporting requirements of the Licensing Regulations and the issuance of CAPs. In summary, the Incident Management Unit (IMU) within OL is responsible for receipt, review, and analysis of all reported incidents. IMU staff monitor compliance during all investigations of serious injuries and deaths, as specified in the *Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services* document. The IMU receives and reviews all reported incidents each business day to determine if the incident was reported within the required timeframe and that the incident report contains all required elements. Prior to the implementation of the CONNECT system in 11/2021, this process involved entry of specific information about each incident into an Excel tracking document that contained information about each element of the IMU review including whether the incident was reported within 24 hours of discovery. At the time of this 20th Period review, the process has been improved with the implementation of the CONNECT system. Under the new system, processes and documentation previously maintained in the Excel report are now automated in CONNECT. Two of the processes that have been automated include the calculation of time lag between incident discovery and reporting and flagging the incident for citation if reported outside the 24-hour timeframe without justification. This automation reduces the risk of human error. Currently, the IMU staff continue to maintain the Excel report to use as a check measure during the early phases of the CONNECT system implementation. In addition, licensing specialists conduct annual licensing inspections or other provider investigations as specified in The *OL Annual Checklist Compliance Determination Chart – FY2021.* This tool provides detailed instructions to licensing specialists regarding determinations of compliance and how non-compliance is to	

Compliance Indicator	Facts	Analysis	Conclusion
		be documented on a CAP. Licensing specialists review data from the incident management system prior to conducting the annual licensing inspection. They compare this information with evidence reviewed during the licensing review. If a serious incident is identified in the sample review, it is cross-referenced with a list of incidents that were reported and reviewed by the IMU. If not found on that list, and the provider does not have further proof of timely reporting, the Licensing Specialist cites the provider for late reporting. Further, the licensing specialist instructs the provider to report the incident, cites the provider for late reporting, and requires the provider to develop and implement a corrective action plan to address the late reporting. This study included a review of OL determinations from 275 licensing inspections conducted during the period 07/1/21-12/31/21 (*Inspections Completed 07/01/2021-12/31/2021*), including a more detailed review of licensing inspection reports for a randomly selected sample of 27 of these inspections. Based on review of this information, it appeared that the OL continued to evaluate compliance with the serious incident reporting requirements of the Licensing Regulations during annual licensing inspections and other investigations as outlined in the OL Annual Checklist Compliance Determination Chart and that any identified area of non-compliance resulted in a CAP from the provider to correct the problem. Of note, during the 18th review period, the data that demonstrated that 100% of providers who are cited for violating the serious incident reporting were required to implement CAPs. However, these data are now drawn from the CONNECT system for which a data integrity assessment has not yet been completed. Based on interview with the Director of ODQV, scheduling such an assessment is pending due to the business owners' indication they do not consider the system to be ready for such a review. In addition, as described below with regard to CI 29.13, DBHDS has identified some significant issues with regard to their ability to pull valid and reliable incident data from CONNECT at this time, which are also pending resolution.	
29.6 The DBHDS quality	The DBHDS quality improvement system is led by	Both the *Quality Management Plan, FY 2020* and the draft version of the FY 2021 plan designate the Office of Clinical Quality Management (OCQM) to lead the	18th-Met 20th-Met

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improvement system is led by the Office of Clinical Quality Improvement and structured by organizational committees with the Quality Improvement Committee (QIC) as the highest quality committee for the Department, and all other committees serve as subcommittees, including the: Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, Regional Quality Councils, and the Key Performance Area Workgroups: Health & Wellness, Community Inclusion & Integration, Provider Capacity & Competency.	the Office of Clinical Quality Improvement and structured by organizational committees with the Quality Improvement Committee (QIC) as the highest quality committee. Other committees serve as subcommittees to the QIC and include the following: Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, Regional Quality Councils, and the Key Performance Area Workgroups: Health & Wellness, Community Inclusion & Integration, Provider Capacity & Competency.	DBHDS quality improvement system. The OCQM provides oversight of quality improvement efforts and responds to trends, by ensuring quality improvement initiatives are developed and corrective actions and regulatory reforms are implemented, if necessary, to address weaknesses and/or service gaps in the system. The OCQM is directed by the Chief Clinical Officer and led by the Senior Director of Clinical Quality Management, who in turn supports the QIC structure. Both Quality Management Plans also describes a hierarchy of interdisciplinary quality committees and workgroups, with specific charters and lines of authority. These include the following: • The Quality Improvement Committee (QIC), which is the highest-level committee and provides oversight of the quality management program as a whole, including prioritization of needs and work areas. • The Risk Management Review Committee (RMRC), whose primary task is to establish goals and performance measure indicators (PMIs) that affect outcomes related to safety and freedom from harm and avoiding crises through establishing uniform risk triggers and thresholds, recommending processes to investigate reports of serious incidents, and identifying remediation steps. • Regional Quality Councils (RQCs), as required by Section V.D.5. of the Settlement Agreement, which are expected to receive and analyze state and regional data to identify trends and make recommendations to the QIC for quality improvement initiatives. • The Mortality Review Committee (MRC), whose purpose is to identify and implement system-wide improvement initiatives to reduce preventable deaths, through analyzing data to identify patterns at the individual service delivery and system levels. • The Case Management Steering Committee is responsible for performance monitoring of case management to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings. • Workgroups for each of the three Key Performance Areas, including Health and Wellness, Community Inclusion/Integrated Settings and Provider	

Compliance Indicator	Facts	Analysis	Conclusion
		Capacity and Competency. Each workgroup recommends goals and performance measures within the respective domain. • The DBHDS/DMAS Quality Review Team (QRT), which is charged with monitoring of data used to measure compliance with the waivers' performance measures. While this team is not a subcommittee to the QIC and does not report to it, its work is an integral component of the overall quality and risk management system. Based on review of four quarters of QIC meeting minutes (i.e., for meetings held on 6/28/21, 9/27/21, 12/31/21 and 3/28/22) and materials, the subcommittees and workgroups described above regularly reported to the QIC.	
29.7 The Office of Clinical Quality Improvement leads quality improvement through collaboration and coordination with DBHDS program areas by providing technical assistance and consultation to internal and external state partners and licensed community-based providers, supporting all quality committees in the establishment of quality improvement initiatives, use of data and identification of trends and analysis, and developing training resources for quality	The Office of Clinical Quality Improvement (OCQI) engages in and or coordinates a variety of technical assistance, consultation and training activities to support the DBHDS quality improvement efforts. DBHDS promulgated a policy and procedure, dated 8/31/21, entitled *Consultation and Technical Assistance (CTA) Framework*. The document stated that he OCQM and the Office of Community Quality Improvement (OCQI) utilize both consultation and technical assistance to further the culture of quality and to assist both internal and external stakeholders in their quality	As reported at the time of the 18th Period review, in addition to providing support to the QIC structure, Office of Clinical Quality Management (OCQM) is responsible for promoting quality improvement through collaboration and coordination with DBHDS program areas. For this review, DBHDS promulgated a policy and procedure, dated 8/31/21, entitled *Consultation and Technical Assistance (CTA) Framework*. The document stated that he OCQM and the Office of Community Quality Improvement (OCQI) utilize both consultation and technical assistance to further the culture of quality and to assist both internal and external stakeholders in their quality management processes and quality improvement efforts upon request. OCQM established a CTA framework that includes responsibilities to assist in the development of TA and materials and resources (including training)and delivery of CTA. The policy noted that the initial identification of CTA or training needs typically comes from analysis of data and identification of trends and the review of provider quality improvement plans. It described consultation as typically focusing on helping a stakeholder plan how to address a specific issue and accomplish goals, while TA activities were specific to an identified issue and focused on program planning and implementation related to improvement plans/compliance issues. The latter might also involve training as part of the TA delivered. The policy also indicated CTA could be provided via phone call, email, written material, on-site consult, webinar, newsletter, or conference (video or in-person), and might be provided during a singular event or as part of a multi-step process.	18th-Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
improvement.	management processes and quality improvement efforts upon request. OCQM also developed a *CTA Tracking Log*, which is used by OCQM and OCQI staff to document CTA requests and provision of CTA.	OCQM also developed a *CTA Tracking Log*, which is used by OCQM and OCQI staff to document CTA requests and provision of CTA. The policy indicates that DBHDS staff will review of the Tracking Log at quarterly, semi-annual and annual intervals to identify emerging trends/patterns across the data collected and be used to enhance the delivery of CTA. Based on review of the documentation submitted for the first two quarters of FY 2022 (i.e., tracking logs and CTA summaries), OCQM and OCQI completed a total of 210 CTA activities (i.e., 166 consultations and 34 TA initiatives.) Some external examples included on-site SCQR reviews and data reviews with CSBs and assistance with facilitating QSR participation, while internally, OCQI continued to assist KPA workgroups with QII development. In addition, one the most significant activities during this review period was a multi-part and systemic CTA pilot project with regard to the implementation of the requirements for providers and CSBs to have quality improvement plans (*Pilot Project Name: 12VAC35-105-620 Technical Assistance (TA) specific to Developmental Disability (DD) providers*.) Through data review, OL had identified *620.C.2*, which mandates that provider quality improvement plans define measurable goals and objectives, as an area of consistent struggle for providers. The goal of the pilot project was to improve provider implementation of approved Corrective Action Plans (CAPs) relative to *620.C.2*, with a related objective to determine if this form of CTA helps providers to improve their implementation of *620.C.2* CAPs. For this project, OCQI collaborated with OL and the Office of Data Quality and Visualization (ODQV). The project period was 12/1/21 through 3/31/22. To kick off the pilot project, OL and OCQI send a joint memo to DD providers with an approved CAP for *620.C.2,* offering the opportunity to self-select for consultation with OCQI. Based on a roster provided for review, the project team worked with ten self-selected providers. Once these providers were identified, OCQI sent the providers a needs assessment to gauge providers' familiarity with QI tools and concepts and assist with guiding the CTA sessions. Each provider received three, one-hour consultation sessions where QI Specialists, based on the approved CAPs and the providers' respective needs assessment, introduced the providers to and	

Compliance Indicator	Facts	Analysis	Conclusion
		demonstrated the use of QI tools and concepts for measurability and monitoring of goals and objectives related to the providers QI plans. A pilot project-specific tracking log provided for review indicated that DBHDS staff provided more than 30 CTA activities in December 2021 and January 2022. Going forward, OCQI and OL intended to evaluate pilot success, challenges, and ability to expand the pilot scope. Presumably, these data and lessons learned will be available after the conclusion of the pilot project, which was just coming to a close at the end of this review period.	
29.8 The Office of Clinical Quality Improvement oversees and directs contractors who perform quality review processes for DBHDS including the Quality Services Reviews and National Core Indicators. Data collected from these processes are used to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level.	*Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities* and the *DBHDS Quality Management Plan* identify the OCQM as the responsible entity to oversee and direct contractors who perform quality review processes for DBHDS including the Quality Services Reviews (QSR) and National Core Indicators (NCI.) Data from the NCI are used to evaluate the sufficiency, accessibility, and quality of services at a systemic level. The QSR is designed to produce data DBHDS will use to evaluate the sufficiency, accessibility, and quality of	*Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities* and the *DBHDS Quality Management Plan*, revised on 4/7/21, identifies the OCQM as the responsible entity to oversees and directs contractors who perform quality review processes for DBHDS including the National Core Indicators (NCI) and the Quality Services Reviews (QSR.) With regard to NCI, DBHDS continued to contract with the NCI vendor and Virginia Commonwealth University (VCU) to complete the NCI survey process and to provide aggregate data. As reported previously, this process is entirely external to DBHDS and has a lengthy track record of consistent implementation and documentation of data provenance. NCI measures have also been approved by CMS for use in HCBS waiver programs. As such, NCI data could be considered reliable for use in evaluating the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. In addition, for this review period, DBHDS provided a Data Set Attestation Form for the NCI Data Set and the NCI Adult Consumer Survey. Because this is an external data source, in lieu of a Process Document, the attestations referenced NCI documentation of data reliability and validity. These included a document entitled *NCI Adult Consumer Survey: Development and Psychometric Properties 09.13.12*, as well as the *NCI Remote Survey Pilot Study Summary Results Dec 2020,* which further attested to the NCI processes undertaken to test and produce reliability and validity of data gathered through a remote survey.	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	services at an individual, service, and systemic level. Meeting minutes showed that the QIC and the QIC's subcommittee and workgroup meeting minutes regularly reviewed and analyzed QSR findings, and responded to QSR recommendations. However, the QSR process has not yet produced sufficient reliable data to be used for this purpose. Based on DBHDS' internal findings following Round 2 of the current vendor's reviews, DBHDS requested significant changes to the review tools and to some of the processes. The vendor began implementing the changes with Round 3 reviews, which started on 11/19/21, but was not expected to conclude until 6/1/22, well after the end of this 20th Period review.	OCQM staff also provided meeting agendas and minutes that demonstrated they met with some regularity with the VCU to coordinate and oversee activities, including monthly meetings between April 2021 through September 2021. VCU also provided written reports of activities for the months of April 2021, June 2021 through August 2021, November 2021 and January 2021. As described further below, DBHDS indicated it uses NCI data as the basis for measuring performance for compliance with CI 29.27 (i.e., at least 75% of people with a job in the community chose or had some input in choosing their job). However, the only data reports provided for this review period did not address this metric. Otherwise, with regard to evidence provided for this review period to show that DBHDS used NCI data to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level, at its meeting on 6/28/21, the QIC reviewed a PowerPoint presentation entitled Using Virginia's NCI Data that provided examples of ways that the NCI could potentially be used for systemic purposes. With regard to QSR data, at the time of the previous review, DBHDS submitted a presentation made by the QSR vendor to the QIC at its March 2021 meeting entitled *2021 Quality Service Review Report to QIC, March 2021*. It featured data from the first round of QSRs and noted that the second round began on 2/26/21. Overall, the presentation noted known data limitations to the QSRs, particularly as those related to COVID circumstances that affected participation. For this 20th Period review, as described further with regard to Provisions V.I.1-V.I.2 below, DBHDS staff reported that, based on DBHDS' internal findings following Round 2 of the current vendor's reviews, DBHDS requested significant changes to the review tools and to some of the processes. The vendor began implementing the changes with Round 3 reviews, which started on 11/19/21, but was not expected to conclude until 6/1/22, well after the end of this 20th Period review. As a result, while the QSR is designed to produce data that DBHDS will use to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level, the process has not yet produced sufficient reliable	

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		data for this purpose. Going forward, based on an agreed upon Curative Action filed with the Court by the parties on 10/29/21, DBHDS also anticipates using QSR data to assess performance with DSP and DSP supervisor competency measures.	
29.9 The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas. The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures addressing: i. The charge to the committee, ii. The chair of the committee, iii. The membership of the committee, iv. The responsibilities of chair and members, v. The frequency of activities of the committee (e.g., meetings), vi. Committee quorum, vii. Periodic review and analysis of reliable data to identify trends and system-level factors related to	The draft version of the *DBHDS Quality Management Plan SFY2021*, DBHDS remains committed to Continuous Quality Improvement (CQI). The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures and responsibilities consistent with the requirements of this Compliance Indicator. Based on review of provided documentation, the QIC and subcommittees met regularly as described in the *DBHDS Quality Management* Plan and consistent with the requirements of their charters. At present, however, as described elsewhere in this report, the functionality of the QIC framework continued to be hampered by the lack of	According to the draft version of the *DBHDS Quality Management Plan SFY2021*, DBHDS remains committed to Continuous Quality Improvement (CQI). The current draft describes quality improvement (QI) as "an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes." The *Quality Management Plan* further describes quality improvement as a "systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care," and as a "data driven process" that involves analysis of data and performance trends that is used to determine quality improvement priorities. Based on review of provided documentation, the QIC and subcommittees met regularly as described in the *DBHDS Quality Management* Plan and consistent with the requirements of their charters. As of 1/31/22, each subcommittee had a current workplan that outlined activities (e.g., review of data and reports and requests for data) and tracked PMIs, development, the implementation, and progress of QIIs across subcommittees/councils/ workgroups, as well as recommendations to and from the QIC. At present, however, as described elsewhere in this report, the functionality of the QIC framework continued to be hampered by the lack of valid and reliable data across much of the system, as well as by limited data-based analysis and data-driven decision making. The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures consistent with the requirements of this Compliance Indicator. The QIC reviews the charters annually and either approves the current version or makes revisions as needed. The status of the	18th-Not Met 20th-Met

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committee-specific objectives and reporting to the QIC.	valid and reliable data across much of the system, as well as by limited data-based analysis and data-driven decision making.	current charters is as follows: • Quality Improvement Committee Charter, QIC Approved September 27, 2021 • Regional Quality Council Charter, QIC Revised QIC Approved September 27, 2021 • Risk Management Review Committee Charter, QIC Approved September 27, 2021 • Mortality Review Committee Charter, QIC Approved September 27, 2021 • Case Management Steering Committee Charter, QIC Approved September 27, 2021 • Health, Safety and Well-being Workgroup Charter, QIC Approved September 27, 2021 • Community Inclusion and Integration Workgroup Charter, QIC Approved September 27, 2021 • Provider Capacity and Competency Workgroup Charter, QIC Approved September 27, 2021 • Quality Review Team Charter, QIC Approved May 2021	
29.10 The QIC sub-committees report to the QIC and identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement. The QIC sub-committees evaluate data at least quarterly,	The QIC sub-committees reported to the QIC four times in the 12-month period concluding with this review period. Each subcommittee has adopted performance measures and Quality Improvement Initiatives (QIIs) that focus on identifying and addressing risks of harm and ensuring the sufficiency, accessibility, and quality of services to meet individuals' needs in	The QIC subcommittee charters call for each to report to the QIC on a quarterly basis. Based on documentation provided, the sub-committees have made reports to the QIC four times in the past twelve months (i.e., on 7/20/21, 9/28/21, 12/13/21 and 3/28/22). The subcommittee reports focus on the respective performance measures and QIIs each has adopted. Each of the subcommittees had adopted at least one QII. The 18th Period study found that the QIC subcommittees often did not construct the QIIs in a manner that could be measured or allow for data collection, which was necessary to facilitate a "data-driven" approach to quality improvement. Many of the QIIs performance measures adopted during the 20th period had similar problems. However, for this 20th Period review, it was positive that DBHDS staff had modified the QII template (i.e., *QII Toolkit Template FY22*, dated 1.10.22 to require the future identification of certain components of measurability. The document instructed users as follows: "The Aim needs to be measurable. An Aim statement is measurable if it	18th-Not Met 20th-Not Met

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identify at least one CQI project annually, and report to the QIC at least three times per year.	integrated settings. The QIC subcommittees identify at least one CQI project annually. DBHDS staff had modified the QII template (i.e., *QII Toolkit Template FY*22, dated 11/10/22 to require identification of certain components of measurability and this appeared to provide sufficient guidance to address the concerns the previous study identified. Using this structure, QIIs reviewed more often had measurable goals, but this was not yet consistent. Based on review of materials for QIC meetings held on 12/13/21 and 3/28/22, it was very positive to see that DBHDS staff consistently presented data and/or narrative information on both the status of action steps and for outcomes for each of the continuing QII projects presented. However, DBHDS staff indicated they had not	has a numeric baseline, a numeric goal, a population, and a target date. It is connected to the Measure described in the next step. Every goal may require multiple smaller tests of change. The Aim should be SMART: Specific, Measurable, Achievable, Realistic/Relevant and Timebound. The problem or issue should be based on baseline data. If available, benchmark data should be used. The target %/rate should be realistic and achievable. The population should be specified. The target date is the date the group would like to achieve the result and complete the QII. Be sure to define key terms that could be interpreted in different ways. If baseline data are not available, explain why; the QII should demonstrate how you plan to obtain it." Overall, this appeared to provide sufficient guidance to address the concerns the previous study identified. Using this structure, in the 20th Period review, QIIs reviewed more often had measurable goals, but this was not yet consistent. Some still did not, as indicated in the table below; The following summarizes progress and concerns noted: • It was positive that all but one of the 16 QIIs included a baseline or otherwise noted why a baseline did not currently exist with a plan to develop one. The exception was for the OSVT QII (i.e., to improve the percent of individuals that have changes in status and appropriately implemented services assessed once quarterly for twelve months for people with DD Waiver). The toolkit indicated the baseline was not applicable because there was not a standard process for this prior to the implementation of the QII. While the QII template appropriately instructed the user that, "if baseline data are not available, explain why; the QII should demonstrate how you plan to obtain it." this QII did not describe a process for setting a baseline. The QII began in July 2020 and by December 2020, DBHDS staff had completed 300 reviews. The toolkit indicated that of these, 95% had an OSVT completed, and 54% had been uploaded into WaMS to evaluate completion of OSVTs quarterly. This was not used to update the baseline or state why it was not useful for the purpose of a baseline.	

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td>verified reliable and valid data sources for all QIIs. In most instances, DBHDS staff reported that the QIIs reviewed relied on existing data sets. Based on documentation submitted, the table below illustrates that only two of 15 (13%) active QIIs that utilized an existing DBHDS data set had both a Process Document and a Data Set Attestation.</td><td>

Several QIIs did not provide a clear definition of terms. For example, the aforementioned RQC 1 goal did not make clear whether increased capacity would be measured by the number of providers, the range of services they provide, the number of people served with Level 6 and 7 needs, the number of IHS provider staff, or some other metric.
The CMSC QII stated the goals as “people with DD Waiver have supports that respond to changes in status through services that are appropriately implemented,” and did not provide a baseline or how to determine the extent of improvement. Written in this manner, objective observers could legitimately disagree whether the goal has been accomplished and to some it would appear to call for confirmation that 100% of individuals to have supports that respond to changes in status.
Multiple Independent Reviewer studies’ findings have concluded that two of the baselines below are invalid: 96% have had documented employment conversations and 92% of individuals have documented community involvement conversations.

<table>
<tr><th>Committee or Workgroup</th><th>Title of QII</th><th>Goal and Baseline Data</th></tr>
<tr><td rowspan="3">MRC</td><td>COVID 19 Mortality</td><td>Decrease COVID-19 mortality rate for individuals on the I/DD waiver to <10% by SFY22 Q2
Baseline: As of 17 May 2021, the MRC had identified 50 (17.5%) COVID-19 related deaths during SFY21.</td></tr>
<tr><td>Frailty</td><td>By Q1 of SFY2023 is to collect baseline data for I/DD individuals in SIS level 6, that can inform if the use of a frailty tool could be used as a predictor of mortality.
Baseline: There is no frailty data available, statewide, as it is currently being utilized in only a minority of DBHDS Offices.</td></tr>
<tr><td>SIS Level</td><td>Reduce the crude mortality rate by 5 per 1000 deaths, each year for the next two years (SFY22 & SFY23) of individuals with SIS level 6.
Baseline: In SFY20, the highest crude mortality</td></tr>
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</td><td></td></tr>
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Compliance Indicator	Facts	Analysis			Conclusion
				rate on the waiver was SIS level 6 (76.2 per 1000 deaths)	
			Opioid Overdose	Increase the percentage of I/DD providers completing REVIVE! Training by SFY22 Q4 to 30%. Baseline: There is no baseline data for the number of providers who have completed REVIVE! Training.	
		RMRC	Falls	Reduce the rate of hospitalizations, emergency room visits, or serious incidents that are caused by a fall, among DD waiver recipients, by 10%. Baseline: 63.2 per 1000 waiver population during 10/1/19-3/31/20.	
		CMSC	On Site Visit Tool (OSVT)	People with DD Waiver have supports that respond to changes in status through services that are appropriately implemented. Baseline: None provided	
			Enhanced Case Management (ECM)	Increase the number and percent of individuals who meet the criteria for Enhanced Case Management (ECM) that receive face to face visits monthly with alternating visits in the home to 86% by June 2022. Baseline: 73%	
			RST Timeliness	There will be a 27% increase in the number of non-emergency referrals meeting timeliness standards by June 30, 2022 Baseline: 59%, 2nd Quarter SFY 2021).	
		HSW KPA Workgroup	Dental	Ensure that 86% of individuals receiving DD waiver services have good oral health through receiving an annual dental exam by June 30, 2022. Baseline: Currently, WaMS ISP data, as of SFY 2021 Q2, shows a rate of 49% of individuals had an annual dental exam	
		CII KPA Workgroup	Employment	Ensure that 86% of individuals, ages 18-64, receiving DD waiver services have meaningful employment conversations resulting in employment goal development (to decrease barriers to employment) by March 31, 2022.	

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				Baseline: Currently, 28% of individuals have employment goals; 96% have had documented employment conversations.	
			Meaningful Conversations	Ensure that 86% of individuals receiving DD waiver services have meaningful conversations regarding Community Involvement, that lead to goal development, resulting in an increased potential/to decrease barriers to Community Involvement by March 31, 2022. Baseline: Currently, 92% of individuals have documented community involvement conversations and 38% have community involvement goals.	
		PCC KPA Workgroup	Transportation	Increase the number of providers of Employment and Community Transportation (ECT) services in each region from 0 to 2 by June 30, 2022 so that individuals receiving DD waiver services have access to reliable transportation. Baseline: The current baseline data is 0 providers as these services are new.	
		RQC1	Increase I-HS	By June 2022, increase provider capacity by 20% in Region 1 to offer In-Home Support (IHS) to allow individuals the opportunity to live in the most integrated setting, appropriate to meet their needs. Baseline: Twenty IHS providers to serve 1815 CL and FIS Waiver enrollees.	
		RQC2	Falls	By June 2022, prevent the rate of falls from returning to pre-COVID levels and "Maintain the Gain". Baseline: For the 6 months pre-COVID (10/1/19-3/31/20) the rate of falls in Region 2 was 67.76 per 1,000 Waiver population and since the beginning of the COVID-19 crisis, it has dropped to 31.78 from 4/1/20- 12/31/2020.	
		RQC3	DSP Competency	By June 2022, improve statewide DSP Competency completion rate by 30% Baseline: 56% in SFY2019	

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RQC5	Employment	By June 2022, Increase by 10% the number of individuals in Region 5 aged 18-64 who reported they have an employment outcome in data reported via CCS3 and/or WaMS for Region 5. Baseline: For Fiscal Year 2020 (July 2019 - June 2020), 25% of ISPs in Region V had employment outcomes.

At the time of the 18th Period review, this study found that the subcommittee and workgroup presentations to the QIC did not present data that showed progress with regard to the action steps, which made it difficult to follow the progress of the implementation of the QIIs. In addition, in many instances, the QII presentations did not include overall outcome data, either.

For this 20th Period review, based on review of materials for QIC meetings held on 12/13/21 and 3/28/22, it was very positive to see that DBHDS staff consistently presented data and/or narrative information on both the status of action steps and for outcomes for each of the continuing QII projects presented. These included the following:

- Falls (RMRC)
- COVID-19 Mortality (MRC)
- SIS Level (MRC)
- OSVT (CMSC)
- Falls (RQC 2)
- Employment (KPA Workgroups)
- Meaningful Conversations (KPA Workgroups)
- Employment (RQC 5)

However, DBHDS staff indicated they had not verified reliable and valid data sources for all QIIs. In most instances, DBHDS staff reported that the QIIs reviewed relied on existing data sets. Based on documentation submitted, the table below illustrates that only two of 15 (13%) active QIIs that utilized an existing DBHDS data set had both a Process Document and a Data Set Attestation. Going forward, DBHDS staff will need to ensure that they consider

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<tr><td></td><td></td><td>the reliability and validity of data sets they use for QII projects, just as they do for other quality improvement efforts.

<table>
<tr><th>Title of QII</th><th>Goal</th><th>Data Set</th><th>Process Document/Attestation</th></tr>
<tr><td>COVID 19 Mortality</td><td>Decrease COVID-19 mortality rate for individuals on the I/DD waiver to <10% by SFY22 Q2</td><td>eMRF</td><td>None provided</td></tr>
<tr><td>Frailty</td><td>By Q1 of SFY2023 is to collect baseline data for I/DD individuals in SIS level 6, that can inform if the use of a frailty tool could be used as a predictor of mortality.</td><td>eMRF</td><td>Not available (Research in progress for tool development)</td></tr>
<tr><td>SIS Level</td><td>Reduce the crude mortality rate by 5 per 1000 deaths, each year for the next two years (SFY22 & SFY23) of individuals with SIS level 6.</td><td>eMRF</td><td>None provided</td></tr>
<tr><td>Opioid Overdose</td><td>Increase the percentage of I/DD providers completing REVIVE! Training by SFY22 Q4 to</td><td>Commonwealth of Virginia Learning Center (COVLC)</td><td>None provided</td></tr>
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Compliance Indicator	Facts	Analysis				Conclusion
				30%.	web-based application	
			Falls	Reduce the rate of hospitalizations, emergency room visits, or serious incidents that are caused by a fall, among DD waiver recipients, by 10%.	CHRIS	Not available
			On Site Visit Tool (OSVT)	People with DD Waiver have supports that respond to changes in status through services that are appropriately implemented.	WaMS Support Coordination Quality Review	*DD Support Coordinator Quality Review Process _VER_001* *Data Set Attestation Form for SCQR*
			Enhanced Case Management (ECM)	Increase the number and percent of individuals who meet the criteria for Enhanced Case Management (ECM) that receive face to face visits monthly with alternating visits in the home to 86% by June 2022.	ECM and TCM Reports	*DD_CMSC DATA REVIEW_VER _002* *Data Set Attestation: CCS ECM Report, CCS TCM Report, Data Quality Support Sample Spreadsheet*
			RST Timeliness	There will be a 27% increase in the number of non-emergency referrals	RST Report	*PD RST VER_001* No Data Set

Compliance Indicator	Facts	Analysis					Conclusion
				meeting timeliness standards by June 30, 2022		Attestation provided	
			Dental	Ensure that 86% of individuals receiving DD waiver services have good oral health through receiving an annual dental exam by June 30, 2022.	WaMS	None provided	
			Employment	Ensure that 86% of individuals, ages 18-64, receiving DD waiver services have meaningful employment conversations resulting in employment goal development (to decrease barriers to employment) by March 31, 2022.	WaMS	None provided	
			Meaningful Conversations	Ensure that 86% of individuals receiving DD waiver services have meaningful conversations regarding Community Involvement, that lead to goal development, resulting in an increased potential/to decrease barriers to Community	WaMS	None provided	

Compliance Indicator	Facts	Analysis				Conclusion
				Involvement by March 31, 2022.		
			Transportation	Increase the number of providers of Employment and Community Transportation (ECT) services in each region from 0 to 2 by June 30, 2022 so that individuals receiving DD waiver services have access to reliable transportation.	Not specified	None provided
			Increase I-HS	By June 2022, increase provider capacity by 20% in Region 1 to offer In-Home Support (IHS) to allow individuals the opportunity to live in the most integrated setting, appropriate to meet their needs.	WaMS/Baseline Measurement Tool	*Provider Data Summary_VER_001* No Data Set Attestation provided
			Falls	By June 2022, prevent the rate of falls from returning to pre-COVID levels and "Maintain the Gain".	CHRIS	Not available
			DSP Competency	By June 2022, improve statewide DSP Competency completion rate by 30%	QRT Quarterly Reports	None provided

Compliance Indicator	Facts	Analysis	Conclusion
		Employment | By June 2022, Increase by 10% the number of individuals in Region 5 aged 18-64 who reported they have an employment outcome in data reported via CCS3 and/or WaMS for Region 5. | Data Warehouse Case Management Reports | *DD CMSC Version 002 document* No Data Set Attestation provided	
29.11 Through the Quality Management Annual Report, the QIC ensures that providers, case managers, and other stakeholders are informed of any quality improvement initiatives approved for implementation as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths.	The QIC last issued a *Quality Management Report* on 3/3/21, covering SFY 2020. That *Quality Management Report* was disseminated to the Provider Listserv, which includes providers, case managers, and other stakeholders, on 4/1/21. The Quality Management Report includes information about quality improvement initiatives approved for implementation as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths. DBHDS developed a *Draft Quality Management Report* for	As reported at the time of the 18th Period review, the QIC issued a *Quality Management Report* on 3/3/21, covering SFY 2020 (i.e., July 1, 2019 - June 30, 2020.) This Report included the quality improvement initiatives approved for implementation. The Report was disseminated to the Provider Listserv, which includes providers, case managers, and other stakeholders, on 4/1/21. At that time, DBHDS staff had made some progress in timely production and distribution of the Report, such that the information was not as dated as for previous periods. However, the 18th Period study recommended that DBHDS needed to consider moving the timeframe for report production further forward, so that stakeholders had access to more recent information. For this 20th Period review, DBHDS had developed a *Draft Quality Management Report* for SFY 2021 (i.e., July 1, 2020 - June 30, 2021), but as of 5/1/22 had not yet been issued it for stakeholders. This represented some regression in timeliness from the progress previously reported. As a result, this review could not verify that an annual report was completed as required and stakeholders did not have access to current information. As discussed in interviews, DBHDS staff might want to consider separating the scheduled publication dates of the *Quality Management Plan* from that of the annual *Quality Management Report*, which, in turn, might allow each to be timelier. The draft of the *Quality Management Report SFY 2021* included information with regard to quality improvement initiatives approved for implementation as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths. The 18th Period	18th-Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
	SFY 2021 (i.e., July 1, 2020 - June 30, 2021), but had not yet issued it for stakeholders. As a result, stakeholders did not have access to current information.	review noted that annual report information was very brief and still did not provide a "data-driven" rationale for why the DBHDS subcommittees and workgroups selected specific topics or provide a clearly stated baseline that would allow stakeholders to understand the scope of the problem or mark progress over time. For this 20th Period review, while some continued improvement was still needed, it was positive to see that the draft version of the *Quality Management Report SFY 2021* more often provided such contextual background. However, because DBHDS had not yet finalized or issued the SFY 2021 annual report, at the time of this review, stakeholders did not have information about many of these more recent (i.e., after June 2020) quality improvement initiatives. In addition, some of the information about "new" initiatives for SFY 2021 was already outdated at the time of this report. The following provides a summary of the QIIs described in the SFY 2021 draft. • The RMRC continued to implement a Falls QII and reported specific data showing a sustained reduction in the rate of falls throughout SFY 2021, below the target goal. The draft also reported that related efforts at training and education had been moderately successful, including the number of participants since 2019 (400) and the percentage of survey respondents (72%) who reported they learned new strategies. • The draft *Quality Management Report SFY 2021* also indicated the RMRC recommended a QII to assist providers in developing tools and resources to better identify medication errors and conduct root cause analysis to identify and address systemic causes. The report indicated the RMRC developed the QII due to "challenges in meeting the target goal for the medication errors PMI." While this provided some context, it was unclear why the report did not quantify those challenges so that stakeholders could conceptualize the scope of the problem. The report further noted the QIC \approved this QII for implementation on 6/28/21. However, based on other documentation provided for this review period, the medication errors QII was abandoned in September, 2021. This was one example of a "new" initiative for SFY 2021 that was already outdated before DBHDS made the report available. • The report identified ongoing MRC QIIs to include the 911 QII, which	

Compliance Indicator	Facts	Analysis	Conclusion
		addressed licensed DBHDS providers' staff failure to contact 911 first in emergencies, a project to address increasing the number of death certificates available for MRC review and two for training related to sepsis. The report described two additional QIIs approved on June 28, 2021, one to decrease the COVID-19 mortality rate and another to reduce the crude mortality rate of individuals with a Supports Intensity Scale (SIS) level 6. It was positive that all of these provided some data-based rationale and/or outcomes. • The report identified three CMSC QIIs. For one (i.e., an ongoing pilot of the *On-Site Visit Tool* (*OSVT*) to address the identification of increasing risks as well as increase the consistency in the application of face-to-face assessments by Support Coordinators), it was positive the report noted an outcome showing that, during the first two quarters of SFY21, consistent application in 75% of reviews. For the remaining two QIIs (i.e., the frequency with which individuals receive ECM visits and the timeliness of RST referrals), DBHDS did not provide any "data-driven" context. • The KPA Workgroups previously identified three QIIs in the areas of independent housing, crisis assessments in the community versus a hospital, and improvements in direct support professional (DSP) competency. The SFY 2021 report stated that the two former QIIs were complete, but that the third would continue. The report did not provide specific outcome data for these QIIs to help explain why DBHDS made these determinations. • The KPA workgroups proposed four additional QIIs, approved for implementation on 6/28/21. These included increasing awareness of the adult Medicaid dental benefit, meaningful employment conversations, meaningful community involvement conversations and increasing the number of providers of Employment and Community Transportation services in each region. Although the draft report stated the KPA Workgroups proposed these QIIs based upon relevant and available data, it did not provide any further context. • The report also listed a QII for each RQC, but none provided a data-based rationale or baseline.	

Compliance Indicator	Facts	Analysis	Conclusion
		Finally, as described throughout this section, during SFY2021 DBHDS often did not yet have valid and reliable data (i.e., based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths) upon which to perform trend analyses to inform the development of these QIIs.	
29.12 DBHDS has a Risk Management Review Committee (RMRC) that has created an overall risk management process for DBHDS that enables DBHDS to identify, and prevent or substantially mitigate, risks of harm.	The Risk Management Review Committee has a charter (*Revised Risk Management Review Committee Charter,* dated 9/27/21*)* that describes its roles and functions as a subcommittee of the DBHDS Quality Council as well as its roles and relationships to other operational areas within DBHDS. The Risk Management Review Committee is integrally involved in the development and operations of the DBHDS risk management processes.	According to the *DBHDS Quality Management Plan,* the "primary task of the RMRC is to establish goals and performance measure indicators that affect outcomes related to safety and freedom from harm and avoiding crises. This is achieved by establishing uniform risk triggers and thresholds, recommending processes to investigate reports of serious incidents, and identifying remediation steps. In addition, the RMRC offers recommendations for guidance and training on proactively identifying and addressing risks of harm, conducting root cause analyses, and developing and monitoring corrective action plans. The RMRC reviews and analyzes trends to determine and recommend quality improvement initiatives to prevent and/or substantially mitigate future risk of harm. The RMRC monitors serious incident reporting, establishes targets, and recommends actions and improvement initiatives when targets are not met." The authorization, roles, functions, and responsibilities of the Risk Management Review Committee are further described in the *Revised Risk Management Review Committee Charter,* dated September 27, 2021. As a subcommittee of the DBHDS QIC, the RMRC is charged to identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends. The *Risk Management Program Description FY21* includes a detailed and thorough description of the RMRC Annual Workplan and describes the Committee's databased approaches to oversight and analysis of the DBHDS Quality Improvement Initiatives, Performance Measures, and other data and information that relate to the DBHDS risk management program and processes. The *RMRC Annual Report FY21* describes the committee's activities which included providing ongoing monitoring of serious incidents and allegations of abuse and neglect; responsibilities related to licensing investigations, analyzing of individual,	18th-Met 20th-Met

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		provider, and system level data to identify trends and patterns and making recommendations to promote health, safety, and well-being of individuals. The *RMRC Annual Report FY21* further documented the activities, accomplishments, findings, and recommendations of the RMRC during SFY 2021. These included focused processes for serious incident reporting, review, and analysis; development and publication of materials specific to risk assessment, risk triggers and thresholds; routine review and analysis data on DBHDS performance indicators relating to safety and freedom from harm; and quality improvement initiatives. While DBHDS staff developed well-thought out and comprehensive documentation of the risk management processes, at the time of this 20th Review Period, DBHDS reported that it cannot attest that the data sets for serious incidents are reliable and valid, which continues to fundamentally compromise the ability of the RMRC and DBHDS to identify, and prevent or substantially mitigate, risks of harm.	
29.13 The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, neglect, and exploitation, at least four times per year by various levels such as by region, by CSB, by provider locations, by individual,	The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, neglect, and exploitation, at least four times per year. The RMRC reviews and identifies trends from aggregated incident data and any other relevant data by various levels such as by	The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, neglect, and not cited td exploitation, at least four times per year, and in a manner consistent with the requirements of this CI: • The *RMRC Charter*, approved on September 27, 2021, requires that the RMRC review data for serious incidents and allegations and substantiations of abuse, neglect, and exploitation at least four times per year. • The *FY21 RMRC Task Calendar and Charter Tasks* is the scheduling tool used by the RMRC to assure that it conducts reviews and analysis of surveillance data specific to abuse/neglect, exploitation, Office of Human Rights look-behind results, serious incidents, the IMU look-behind (triage) process, incident management care concerns, timeliness of reporting and related citations, relevant state facilities data, and performance measures. • The *SFY 22 RMRC QIC Subcommittee Work Plan* is the comprehensive	18th-Met* 20th-Met*

Compliance Indicator	Facts	Analysis	Conclusion
or by levels and types of incidents.	region, by CSB, by provider locations, by individual, or by levels and types of incidents. The RMRC has a structured plan and schedule for review of data and information specific to serious incidents and allegations/substantiations of abuse, neglect, and exploitation. The RMRC meets monthly and reviews/analyzes data and information on performance measures, quality improvement initiatives and data related to reporting and analysis of serious incidents. However, at the time of this 20th Review Period, DBHDS reported that it cannot attest that the incident data sets used by the RMRC provide reliable and valid data for compliance reporting.	tracking and information tool used by the RMRC to document their review and analysis activities. It identifies activities undertaken, data and information reviewed/analyzed, and follow-up activities resulting from the analysis of data and information. It also includes notes about current and proposed Quality Improvement Initiative opportunities and presentation of information to the DBHDS Quality Improvement Council. • A review of RMRC meeting minutes, for meetings held April 2021 through January 2022, provide evidence of that the committee reviews and analyzes various data in an effort to identify trends in each of their monthly meetings. • However, at the time of this 20th Review Period, DBHDS reported that it cannot attest that the data sets for incident data used by the RMRC provide reliable and valid data for compliance reporting. As described further below, based on RMRC meeting minutes provided for review, the RMRC did not review serious incident or ANE data after July 2021 due to newly identified data validity and reliable issues. • In brief, based on RMRC meeting minutes reviewed, including for October 2021 through January 2022, the Data Warehouse (DW) reports DBHDS has historically relied upon for these data cannot definitively isolate DD services from mental health (MH) and/or substance abuse (SA) services. It appeared this fault in the system was recognized when DBHDS began processes to transfer data from CHRIS to the new CONNECT system, although based on the Performance Measure Indicator (PMI) documentation for *Critical incidents are reported to OL within the required timeframe*s, OL had previously expressed concerns in a difference in the counts of serious incidents when comparing CHRIS and the Data Warehouse. DBHDS staff reported they needed a short term fix for cleaning data in CHRIS before its transfer to CONNECT, but this alone would not fix potential issues with the implementation of the business rules for the correct relationship between a service and the population they serve into the architecture of the new system. Of particular note, this would also require DBHDS and the RMRC to consider how, or if, going forward, they would be able to make historical comparisons, which are	

Compliance Indicator	Facts	Analysis	Conclusion
		the basis for the identification of trends. The minutes for the RMRC meeting on 10/18/21 indicated the needed solution was to create a mapping within OLIS and CONNECT. Based on RMRC minutes for 11/19/21, 12/20/21 and 1/24/22, the issues were still pending a resolution and were being referred to the DBHDS Data Forum for consideration. • In addition, DBHDS had paused the look-behind reviews for serious incidents and for review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. In another finding that reflected the problems with incident data, RMRC meeting minutes indicated that, per consultation with ODQV, there did not appear to be a single comprehensive source of information classifying services by diagnosis group and that all of the lookup tables (i.e., OLIS, CHRIS, and the Data Warehouse) lacked complete information related to which program and service codes specialize in supporting individuals with DD. Without such a clear way to group the program and service codes associated with DD services, it was not possible for ODQV to retrieve a valid random sample of Human Rights allegations for DD services. As a result of these circumstances, DBHDS could not provide the requisite Data Set Attestations or Process Documents to show that the RMRC could reliably analyze incident data for trends or make valid recommendations for improvement. *This Met rating is for illustrative purposes only. DBHDS has fulfilled the activities required by this Indicator, and has adequate procedures in place that would support the ability to do this work. The RMRC cannot actually identify trends from analyzing risk management data that is not reliable and valid.	
29.14 The RMRC uses the results of data reviewed to identify areas for improvement and monitor trends. The RMRC identifies	The RMRC uses the results of data reviewed to identify areas for improvement and monitor trends. However, at the time of this 20th Review Period, DBHDS reported that it cannot attest that the	The *SFY 22 RMRC QIC Subcommittee Work Plan* and RMRC meeting minutes demonstrated that the RMRC was reviewing and analyzing data, monitoring apparent trends and patterns in data, and identifying areas of improvement that appeared to be warranted from their review and analysis of data and trends. At the time of the 18th period review, the RMRC was implementing a QII to reduce the number serious incidents that are caused by falls. While the study for	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
priorities and determines quality improvement initiatives as needed, including identified strategies and metrics to monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts. The RMRC ensures that each approved quality improvement initiative is implemented and reported to the QIC. The RMRC will recommend at least one quality improvement initiative per year.	data sets for incident data used by the RMRC provide reliable and valid data for compliance reporting. The RMRC identifies priorities and determines quality improvement initiatives, including identified strategies and metrics to monitor success. The RMRC recommends at least one quality improvement initiative per year.	that period found that there were some good examples of data collection and analysis in graphic form, the RMRC often did not capture or report data to track the implementation of the QII's action steps. As a result, the RMRC could not determine which of the strategies were effective and considered for replication. For this 20th Period review, it was positive to see that RMRC reporting reflected data for both implementation and outcomes. During this review period, the RMRC also initiated a QII related to medication errors. The QIC approved the project on 6/28/21, but the RMRC abandoned it on 9/20/21. Based on review of the QIC meeting minutes and the related RMRC presentations on 9/27/21 and again on 12/13/21, DBHDS did not provide documentation to show that the QIC approved the abandonment of the project. Going forward, the QIC should review and approve not only the initiation of a QII, but also the rationale for abandoning it. However, as described with regard to CI 29.13 above, at the time of this 20th Review Period, DBHDS reported that it cannot attest that the data sets for incident data used by the RMRC provide reliable and valid data for compliance reporting.	
29.15 The RMRC monitors aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators. When targets are not met the RMRC determines whether quality	The RMRC has established processes and schedules for review of aggregated data of provider compliance with serious incident reporting requirements on a quarterly basis. The RMRC monitors and reports on a PMI entitled *Critical incidents are reported to OL within the required timeframes.*	At the time of the 18th Period review, DBHDS staff provided several documents to evidence that the RMRC monitored aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators and, when targets are not met, the RMRC determined whether quality improvement initiatives are needed, and if so, monitors implementation and outcomes. These included the following: • The *RMRC Measure Tracking Log PMI Jan 2021* documented data tracked quarterly by the RMRC related to the measure that reads "Critical Incidents are reported to the Office of Licensing within the required timeframes (24-28 hours)." The target threshold for this indicator was 86%. Data for all four quarters in SFY 2020 reflected compliance well above the 86% threshold. The data were presented to and reviewed by	18th-Met* 20th-Met*

Compliance Indicator	Facts	Analysis	Conclusion
improvement initiatives are needed, and if so, monitors implementation and outcomes.	However, for this review period, the RMRC was not able to consistently adhere to its schedule for review of aggregate data of provider compliance with serious incident reporting requirements, due to the discovery of significant concerns with regard to data validity and reliability (i.e., the inability to definitively isolate DD services from mental health (MH) and/or substance abuse (SA) services.) RMRC minutes provided for review indicate that serious incident data have not been available for review since July 2021. Based on the draft annual *Quality Management Report SFY 2021*, DBHDS reported performance for timeliness at 95%. Based on these findings, the RMRC did not have a basis for recommending a QII. However, DBHDS reported that it cannot attest that the incident data sets used by the RMRC provide reliable and valid data for compliance	the RMRC quarterly. • The process steps, data source, and responsible person(s) for monitoring serious incident report timeliness were outlined in the Process Document 29.3, 29.5, 29.15 Monitoring Serious Injuries, but it was undated. • DBHDS staff also provided a PowerPoint presentation entitled *Incident Management SIR Timelines 9-20-20* that included a comprehensive review of data and information collected and analyzed by the Incident Management Unit and presented to the RMRC on a quarterly basis. The report was comprehensive, and the graphic presentations were easy to read and understand. The report also presented various methods of evaluating data related to late reporting of serious incidents – by region, by type of incident, by provider (with multiple citations). The report reflected identification of system issues with the DBHDS web-based incident reporting portal (CHRIS) and exceptions made for issuance of CAPs for late reports that occurred during these periods when system issues impacted a provider's ability to report incidents within prescribed timeframes. For this this 20th Review Period, the *RMRC Annual Report FY21* indicated that the RMRC continued to track and review aggregate data of provider compliance with serious incident reporting requirements. In particular, the RMRC focuses on timely reporting through a Performance Measure Indicator (PMI) entitled *Critical incidents are reported to OL within the required timeframes*. Based on the draft annual *Quality Management Report SFY 2021*, DBHDS reported performance at 95%. At face value, these data did not indicate a need for quality improvement. However, as described with regard to CI 29.13, based on RMRC meeting minutes provided for review, the RMRC did not review serious incident or ANE data after July 2021 due to newly identified data validity and reliability issues [i.e., the inability to definitively isolate DD services from mental health (MH) and/or substance abuse (SA) services.] While the RMRC did continue to review timeliness of reporting at its meetings in August 2021 and November 2021, it was not clear if reporting on timeliness was impacted by the data validity and reliability issues.	

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	reporting, and did not provide the requisite Data Set Attestation or Process Document to show that the RMRC could reliably analyze for trends or make valid recommendations for improvement.	As a result, DBHDS reported that it cannot attest that the incident data sets used by the RMRC provide reliable and valid data for compliance reporting for this CI. Thus, DBHDS did not provide the requisite Data Set Attestation or Process Document to show that the RMRC could reliably analyze for trends or make valid recommendations for improvement *This Met rating is for illustrative purposes only. DBHDS has fulfilled the activities required by this Indicator, and has adequate procedures in place that would support the ability to do this work. The RMRC cannot yet be confident when analyzing risk management data or reliably identify trends.	
29.16 The RMRC conducts or oversees a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The review will evaluate whether: i. The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols. ii. The provider's documented response ensured the recipient's safety and well-being. iii. Appropriate follow-up from the Office of Licensing incident management team occurred when necessary.	DBHDS discontinued the IMU look behind process prior to April 2021 and began planning to outsource the function. On 03/25/22 DBHDS executed an agreement with the Virginia Commonwealth University (VCU) that details the process that VCU will follow to conduct IMU look behinds consistent with the requirements of this Compliance Indicator. A specific date for implementation of this new process has not yet been established. Due to the discontinuation of the look behind throughout this review period, the RMRC did not have related	The *Incident Management Look Behind Process* document states that the purpose of the process is to validate the reliability of the Incident Management Unit (IMU) triage of incidents, to ensure the IMU reviews incidents consistently, and to confirm that appropriate actions were taken and review protocols were followed. The review process was conducted by DBHDS staff since its inception until a decision to suspend the process was made in Spring 2021. While the structure of the process was noted to be sound, the 18th period review identified three areas of concern with its implementation. • Inter-rater reliability scores were low. • Lack of staffing resources dedicated to the process. • A sampling methodology that produced a statistically valid sample. • A significant delay between the end of the review period and the time when the review was conducted. At that time, there was an approximate 12-month time lag. • Regional managers conducting reviews of cases in their own regions. • Review of cases that had not yet been closed in CHRIS. The *Approved RMRC Minutes 04-19-2021* state that the IMU look behind is on hold and that the agency is considering outsourcing the function. No look behind reviews were conducted after this date. Therefore, the RMRC did not have look-behind data to evaluate for the criteria defined for this CI (i.e., whether incidents were triaged by the OL incident management team appropriately, whether providers' documented responses ensured recipients' safety and well-being,	18th-Not Met 20th-Not Met

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iv. Timely, appropriate corrective action plans are implemented by the provider when indicated. v. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation.	data to review for trends at least quarterly or to recommend quality improvement initiatives when necessary, or to track implementation of initiatives approved for implementation. For this review period, DBHDS also stated that they were unable to attest that data are reliable and valid for this CI due to concerns with inter-rater reliability.	whether there was appropriate follow-up from the Office of Licensing incident management team and whether timely, appropriate corrective action plans were implemented by the provider when indicated), or to review trends and take appropriate actions based on the look-behind results. Based on continued concerns with the previous look behind process, DBHDS began consideration of outsourcing the process in mid-2021 and has recently established an agreement with the Virginia Commonwealth University (VCU) to assume responsibility for conducting the look behind reviews. The terms of the agreement are outlined in the *Fully Executed Contract and Business Associate Agreement dated 03/25/2022*. The agreement states that VCU will assume responsibility for conducting the look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The review will evaluate whether the incident was triaged by the IMU team appropriately according to developed protocols; the provider's documented response ensured the recipient's safety and well-being, appropriate follow-up from the IMU occurred when necessary, and timely and appropriate corrective action plans are implemented by the provider when indicated. Results of the reviews conducted by VCU will be presented to the RMRC quarterly. The RMRC will use this information to inform their trend analyses, recommendations for quality improvement initiatives, and evaluation of process improvement initiatives previously approved for implementation. The agreement also states that VCU will: • Generate a sample of eligible serious injuries • Develop data collection tools and protocols • Hire reviewers • Create training materials and train reviewers • Implement the incident management look-behind process • Complete quality assurance activities addressing inter-rater reliability • Produce reports and presentations quarterly and annually DBHDS is currently working with VCU to restart the IMU look behind process consistent with the terms of the agreement signed on 03/25/22. DBHDS noted they anticipate VCU will be able to implement the process soon after the agreement was executed on 03/25/22, but no specific date for VCU to begin	

Compliance Indicator	Facts	Analysis	Conclusion
		conducting the reviews has been established. DBHDS did not provide a Data Attestation Statement for this Compliance Indicator and stated that data cannot be determined to be reliable and valid at this time due to issues with inter-rater reliability. In addition, DBHDS stated it cannot yet attest to the reliability and validity of the underlying serious incident data. As the development process with VCU moves forward, DBHDS staff will need to develop the minimum set of finalized policies, procedures, instructions, protocols and/or tools, needed to demonstrate compliance, including but not limited to a Process Document and Data Set Attestation.	
29.17 The RMRC conducts or oversees a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines. ii. The person conducting the investigation has been trained to conduct investigations. iii. Timely, appropriate corrective action plans are implemented by the provider when indicated. iv. The RMRC will review trends at least	DBHDS discontinued the existing OHR Community Look Behind Process in September 2021 when the last quarterly data report was presented to the RMRC. Subsequently, DBHDS began plans to restructure the process using the PowerApps data system as a platform for its operation including the review process and the data and information that inform that process. A specific date for implementation of the new system has not yet been established. Due to the discontinuation of the look behind throughout this review period, the RMRC did not have related data to review for trends at	As reported at the time of the 18th Period review, the *Office of Human Rights Community Look-Behind Process, CY 2021*and the *Process Document: Human Rights Look-Behind, 3/1/21* state that the retrospective review of human rights investigations (i.e., the look-behind) was established to ensure that human rights investigations are conducted in compliance with The OHR regulations in the Virginia Administrative Code. The documents further state that the look behind process focuses on assessing the following criteria: • The validity of investigation outcomes (substantiated versus non-substantiated allegations); • The OHR business process by examining certain performance requirements (i.e., comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines; ii. The person conducting the investigation has been trained to conduct investigations; iii. Timely, appropriate corrective action plans are implemented by the provider when indicated); • The data quality between CHRIS and the provider's supporting documentation; and, • Identifying areas where training or follow-up assistance is warranted in order to improve the investigative process and outcomes. Findings in the 18th Period review of the Community Look Behind Process identified three concern areas regarding the process in place at that time: • A significant delay between the end of the review period and the time when the review was conducted. At that time there was an approximate	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation.	least quarterly or to recommend quality improvement initiatives when necessary, or to track implementation of initiatives approved for implementation. DBHDS also stated that they were unable to provide a data attestation statement for this CI due to concerns with interrater reliability.	12-month time lag. • Regional managers conducting reviews of cases in their own regions. • Review of cases that had not yet been closed in CHRIS. For this 20th Period review, the existing process was discontinued in September 2021, when the last data and information was presented to the RMRC. Therefore, the RMRC did not have look-behind data to evaluate for the criteria defined for this CI (i.e., whether comprehensive and non-partial investigations of individual incidents occur within state-prescribed timeline, whether the person conducting the investigation has been trained to conduct investigations, and whether timely, appropriate corrective action plans were implemented by the provider when indicated), or to review trends and take appropriate actions based on the look-behind results. Based on staff interview and information in the *OHR Community Look-Behind Reviews Timeline 2021*, the last data reviewed by the Look-Behind Committee was from the fourth quarter, SFY 2021 (April 2021 through June 2021). Information from this review was presented to the RMRC in September 2021and is documented in the RMRC Minutes, dated 09/20/21. The RMRC did not have subsequent data to review since that time. DBHDS did not provide a Data Attestation Statement for this Compliance Indicator and stated that data cannot be determined to be reliable and valid at this time due to issues with inter-rater reliability. In addition, DBHDS stated it cannot yet attest to the reliability and validity of the underlying serious incident data. Moving forward, based on an agency-wide plan to discontinue the use of Access databases, the source system for the Community Look Behind Process, DBHDS staff indicated they made the decision to shift the platform for this process to PowerApps. The *Community Look Behind PowerApps Process* PowerPoint presentation provided for review describes anticipated system improvements that will come from its implementation. These improvements include automated sample selection, automated approval or replacement of cases in the sample, advanced data validation tools built into the data collection form, online technical assistance with operational questions, and direct access to the review data by the OHR as	

Compliance Indicator	Facts	Analysis	Conclusion
		soon as the reviewer completes the review. Staff were not able, at the time of this review, to identify a specific date when the new system will become operational. Considering the anticipated improvements cited above, the implementation of the PowerApps system should potentially have positive impact on the reliability and validity of the data and improve the accuracy and efficiency of the sample selection, data recording, data querying, and data analysis processes. It could also further improve the timeliness of the reviews and reporting of results to the RMRC. However, DBHDS staff noted during the interview process that due to logistical challenges, reviews will continue to be conducted by managers in the same region where the incident occurred. As the development process moves forward, and DBHDS staff develop the minimum set of finalized policies, procedures, instructions, protocols and/or tools, needed to demonstrate compliance, including but not limited to a Process Document and Data Set Attestation, they should ensure this includes procedures to address any potential impact on data reliability.	
29.18 At least 86% of the sample of serious incidents reviewed in indicator 5.d meet criteria reviewed in the audit. At least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed in indicator 5.e meet criteria reviewed in the audit.	Due to the discontinuation during this 20th Period review of both the serious incident look behind and the ANE look behind processes , DBHDS did not have valid and reliable data to report. At this time, DBHDS indicated that they cannot attest to the validity and reliability of serious incident data overall.	Due to the discontinuation during this 20th Period review of both the serious incident look behind and the ANE look behind processes, as described above with regard to CI 29.16 and CI.29.17, DBHDS did not have valid and reliable data to report. Further, at this time, DBHDS indicated that they cannot attest to the validity and reliability of serious incident data overall.	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
29.19 The Commonwealth shall require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth.	The Commonwealth does not specifically require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth. DBHDS provided a document entitled *Protocol for the Identification and Monitoring of Individuals with Complex Behavioral, Health, and Adaptive Support Needs and the Development of Corrective Action Plans required to Address Instances Where the Management of Needs for These Individuals Falls Below Identified Expectations for the Adequacy of Management and Supports Provided*, which was dated 2/7/22, but with a projected implementation date of 4/1/22. However, for purposes of this CI, the document provided did not describe if providers would be required to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level	At the time of the previous review, DBHDS did not require providers to specifically identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth. Instead, DBHDS staff reported they had developed a Risk Assessment Tool (RAT) to be applied universally for all individuals receiving DD waiver services and required the use of the RAT in the process of developing individual support plans. However, at this time, DBHDS did not have a protocol in place to ensure that providers fulfill their responsibilities to identify and to report the names of individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7. For this review, DBHDS provided a document entitled *Protocol for the Identification and Monitoring of Individuals with Complex Behavioral, Health, and Adaptive Support Needs and the Development of Corrective Action Plans required to Address Instances Where the Management of Needs for These Individuals Falls Below Identified Expectations for the Adequacy of Management and Supports Provided*, which was dated 2/7/22, but with a projected implementation date of 4/1/22. The document stated that DBHDS ODQV would pull a statistically stratified annual sample of individuals with SIS level 6 and 7 support needs order to review the ISP (Parts I-V) and the completion of DBHDS tools, including the Risk Awareness Tool (RAT) and On-site Visit Tool (OSVT), to determine if risks are identified, addressed in the ISP, and reviewed over time. Additional details with regard to this document may be found with regard to CI 30.11. However, for purposes of the requirements of this CI, the document provided did not describe if providers would be required to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 or report that information to DBHDS. It also did not describe a process by which ODQV would collect these data. Going forward, to achieve compliance with this CI, DBHDS will need to develop a related Process Document and provide a Data Set Attestation.	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	6 or 7 or report that information to DBHDS. It also did not describe a process by which ODQV would collect these data or provide a related Process Document or Data Set Attestation.		
29.20 At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam.	Based on the related PMI documentation, it appeared DBHDS planned to utilize data from WaMS to measure performance for this CI. DBHDS provided a Data Set Attestation entitled *OISS DR0021 T2748,* with a process name of *PMI Data for Physical Exams.* However, DBHDS did not provide a Process Document to describe how it collected data for this CI consistent with the agreed-upon Curative Action, which requires both a properly completed Process Document and signed Attestation required for each CI that depends on reported data for a compliance determination. In addition, DBHDS did not provide a Process Document or a Data Set with regard to dental exams.	At the time of the 18th Period review, the DBHDS KPA Workgroup reported it monitored NCI data for the domain of physical, mental and behavioral health and well-being and for this PMI. As described with regard to Compliance Indicator 29.8, it appeared that NCI data could be considered reliable for use in evaluating the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. However, based on a review of the *NCI In-Person Survey (IPS) State Report 2019-20*, as presented at the QIC meeting in 3/22/21, the report did not provide data for this indicator. Instead, the *KPA Workgroups 3rd QTR Report to the QIC SFY2021, March 22, 2021* did provide some data for this PMI using the ISP data in WaMs, but its provenance was not clear. For this 20th Period review, based on the related PMI documentation, it appeared DBHDS planned to utilize data from WaMS to measure performance for this CI. DBHDS provided a Data Set Attestation entitled *OISS DR0021 T2748,* with a process name of *PMI Data for Physical Exams.* However, DBHDS did not provide a Process Document to describe how it collected data for this CI consistent with the agreed-upon Curative Action, which requires both a properly completed Process Document and signed Attestation required for each CI that depends on reported data for a compliance determination. In addition, DBHDS did not provide a Process Document or a Data Set with regard to dental exams.	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
29.21 At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	Based on findings that CI, 7.14, CI 7.18 and CI 7.19 were not met, DBHDS did not achieve compliance with CI 29.21, which requires that at least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	DBHDS did yet have valid and reliable data for whether behavioral support services are adequate or appropriately delivered. At the time of the 18th Period review, DBHDS reported it did not yet have guidelines in place to define the minimum elements required for behavioral support plans to be considered adequate. For this 20th Period review, based on findings elsewhere in this report that CI 7.14, CI 7.18 and CI 7.19 were not met, DBHDS did not achieve compliance with CI 29.21. In addition, DBHDS did not provide a relevant Process Document and Data Set Attestation for CI 29.21, or consistently provide both of those needed documents for CI 7.14, CI 7.18 and CI 7.19, as described below: • CI 7.14 was not met. While DBHDS has increased the number of licensed behavior analysts (LBA)s they have not done a gap analysis or set targets. Of the 3,000 plus LBAs it appears only 200 provide Therapeutic Consultation (TC) and DBHDS could not affirm that this was a sufficient number to meet the needs. Attestation provided. • CI 7.18 was not met. While DBHDS provided a sufficient Process Document and Data Set Attestation, DBHDS reported that in two review cycles only 44 % and 35% of individuals with an authorization for TC had a provider within 30 days. In addition, 50% were not connected to a provider at all within the reporting period. • CI 7.19 was not met. DBHDS only reviewed a sample of 100 behavior support plans (BSPs) and could not report on all individuals receiving TC. In their review they found 80% of the plans included the presence of two of the elements 7.19 requires. The Independent Reviewer's consultants found that only 29% of a randomly sample of 103 included all four required elements. While the BSPARI process was well documented and sufficient, DBHDS did not provide a related Data Set Attestation.	18th-Not Met 20th-Not Met
29.22 At least 95% of residential service recipients reside in a location that is integrated	DBHDS did not provide valid and reliable data to evidence compliance with this Compliance Indicator. Based on a spreadsheet entitled	DBHDS did not provide valid and reliable data to evidence compliance with this Compliance Indicator. Based on a spreadsheet entitled Data Verification Double Check provided for review, DBHDS indicated they did not have HCBS Settings data available to date.	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings.	Data Verification Double Check provided for review, DBHDS indicated they did not have HCBS Settings data available to date. DBHDS did not provide a related Process Document and/or Data Set Attestation.	DBHDS did not provide a related Process Document and/or Data Set Attestation.	
29.23 At least 95% of individual service recipients are free from neglect and abuse by paid support staff.	AN OHR memorandum, dated 2/24/22, reported quarterly data for SFY 2021 and for the first two quarters of SFY 2022, ranging from 98.8% in the first quarter of SFY 2022 to 99.3% in the second quarter of SFY 2021. However, DBHDS indicated that it could not attest to the reliability and validity of the incident data upon which this relied. In addition, DBHDS staff did not submit a current Process Document or Data Set Attestation for this CI. The OHR memorandum provided some description of a process they followed to obtain aggregate data for this measure, it did not meet all the requirements of the Process Document as agreed	For this CI, DBHDS staff did not submit a current Process Document or Data Set Attestation. On 2/24/22, OHR issued a memorandum to the RMRC/KPA Workgroup that provided some description of a process they followed to obtain aggregate data for this measure; however, it did not meet all the requirements of the Process Document as agreed upon in the related Curative Action. The OHR memorandum reported quarterly data for SFY 2021 and for the first two quarters of SFY 2022, ranging from 98.8% in the first quarter of SFY 2022 to 99.3% in the second quarter of SFY 2021. However, as described above with regard to CI 29.13, DBHDS indicated that it could not attest to the reliability and validity of the incident data upon which this relied.	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	upon in the related Curative Action.		
29.24 At least 95% of individual service recipients are adequately protected from serious injuries in service settings.	DBHDS did not have valid and reliable incident data to evidence compliance with this Compliance Indicator. DBHDS did not submit a current Process Document or Data Set Attestation Form.	DBHDS staff reported that they did not have valid and reliable incident data to evidence compliance with this Compliance Indicator. They did not submit a current Process Document or Data Set Attestation Form.	18th-Not Met 20th-Not Met
29.25 For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans.	DBHDS did not have sufficient valid and reliable data to evidence compliance with this Compliance Indicator. DBHDS provided a Data Set Attestation for this CI, but did not provide a Process Document. Based on the PMI documentation, tracking of this CI relies on incident data, and DBHDS reported it could not attest to the validity and reliability of that data set.	DBHDS provided a Data Set Attestation for this CI, but did not provide a related Process Document. Based on the PMI documentation described further below, tracking of this CI relies on incident data, and DBHDS reported it could not attest to the validity and reliability of that data set. The available PMI documentation, last updated on 2/7/22, indicated that, beginning with calendar year 2022, a new methodology was established to utilize a recently updated data warehouse report DW-0070: OHR Community Seclusion. OHR staff reviews these CHRIS reports and uses logic and research in CHRIS to determine whether the seclusion or restraint was used appropriately and whether there was a plan. The numerator (i.e., number of individuals who had an allegation reported in CHRIS that was NOT classified as unauthorized seclusion or restraint) is derived from CHRIS serious incidents via the data warehouse report DW-0070: OHR Community Seclusion. The denominator (i.e., number of individuals enrolled in the DD waivers) is derived from WaMS via the OISS report: "Individuals enrolled in the DD waivers." As DBHDS staff move forward to develop a Process Document, they should give special attention to the potential sources of user error and ensure the process provides clear guidelines. Based on the calculation steps described in the PMI, the Measure Steward will review the narratives in the aforementioned DW report,	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
		eliminate false positives, identify potential unauthorized cases and review the full case within the CHRIS source system for additional verification. If a determination is still unclear, the Measure Steward will collaborate with the assigned OHR Advocate. If the case is verified, the result will be counted in the numerator. If still unclear, the Measure Steward will compare the results to other data or information related to the allegation. Because these steps require a great deal of judgement, the process must provide clear definitions and determination criteria.	
29.26 The Commonwealth ensures that at least 95% of applicants assigned to Priority 1 of the waiting list are not institutionalized while waiting for services unless the recipient chooses otherwise or enters into a nursing facility for medical rehabilitation or for a stay of 90 days or less. Medical rehabilitation is a non-permanent, prescriber-driven regimen that would afford an individual an opportunity to improve function through the professional supervision and direction of physical, occupational, or speech therapies. Medical rehabilitation is	DBHDS provided a Process Document entitled *DD_ Priority 1_VER_002*, dated January 15, 2022. The Process Document noted that the process required review and comparison of numerous data sets, including, but not limited to AVATAR, the REACH Hospitalization Tracker and WaMS. The Process Document also referenced the intersection with another Process Document for hospital admissions and provided it (i.e., *DS_CSS_Hosp Admits and Trends Process_VER_003*, dated 2/1/22) for review. However, *DD_ Priority 1_VER_002* did not reference	For this measure, DBHDS provided a Process Document entitled *DD_ Priority 1_VER_002*, dated January 15, 2022. It noted that the process required review and comparison of numerous data sets. These included, but were not limited to AVATAR, the REACH Hospitalization Tracker and WaMS. The Process Document also referenced the intersection with another Process Document for hospital admissions and provided it (i.e., *DS_CSS_Hosp Admits and Trends Process_VER_003*, dated 2/1/22) for review. *DD_ Priority 1_VER_002* did not reference the intersection with the WaMS waitlist data set. While DBHDS did submit a Process Document and Data Set Attestation related to the WaMS waitlist for the purposes of mailings, this study could not verify that these would be applicable for these purposes. DBHDS also provided a Data Set Attestation Form for the *Data Set: Supplemental Crisis Report*, but did not provide a Data Set Attestation for the *CSS_Hosp Admits and Trends.* From the review, it was also not clear that DBHDS had yet updated the Process Document *DD_ Priority 1_VER_002* to address the eight actionable recommendations in the AVATAR source system review that ODQV completed in December 2021. .	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
self-limiting and is driven by the progress of the individual in relation to the therapy provided. When no further progress can be documented, individual therapy orders must cease.	the intersection with the WaMS waitlist data set. DBHDS provided a Data Set Attestation Form for the *Data Set: Supplemental Crisis Report*, but did not provide a Data Set Attestation for the *CSS_Hosp Admits and Trends.* It was not clear that DBHDS had yet updated the Process Document *DD_ Priority 1_VER_002* to address the eight actionable recommendations in the AVATAR source system review that ODQV completed in December 2021.		
29.27 At least 75% of people with a job in the community chose or had some input in choosing their job.	DBHDS did not provide data to evidence compliance with this Compliance Indicator. Although NCI, the proposed data source, can be considered to produce valid and reliable data, the available Virginia-specific NCI data for SFY 2020 and SFY 2021 with regard to employment did not provide data that clearly reflected the percentage of people with a	As described above with regard to CI 29.8, NCI data may be considered reliable and valid. DBHDS provided a Data Set Attestation Form for the *NCI Adult Consumer Survey* data set that referenced the external documentation that evidenced this. In addition, for the NCI *Adult In-Person Survey,* DBHDS provided a report entitled *Virginia's National Core Indicators (NCI) Project: Comparison of Virginia Data (FY 2020 & 2021) with National Data (FY 2019*), dated February 2022, that attested the findings for these reviews were based on a sample size that could be considered statistically representative of the Commonwealth for both years. This report provided some Virginia-specific data for SFY 2020 and SFY 2021 with regard to employment. However, it did not provide data that clearly reflected the percentage of people with a job in the community who chose or had some input in choosing their job. For example, it included sets of data entitled "Work in Community" and "Choice in Working." The first data set noted that	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	job in the community who chose or had some input in choosing their job. The draft annual *Quality Management Report SFY 2021* provided for review did not report data for this CI. According to the Process Document entitled *Provider Data Summary_VER_001*, while NCI remained the data source for this CI, the *Provider Data Summary* would provide the performance data reporting for this CI. However, DBHDS did not provide a current Provider Data Summary. The last available version covered the period from November 2020 through April 2021.	in SFY 2020, 12% of respondents had a paid community job, while in SFY 2021, that figure was 8%. While this section included other data points for the members of the sample who had jobs, none of these addressed whether they chose or had input in choosing the job. The report section for "Choice in Working" included data points for each of the two years to indicate that for those who were not working, 53% (SFY 2020) and 63% (SFY 2021) wanted to work, but did not otherwise address whether people with community jobs had choice or input with regard to their jobs. The draft annual *Quality Management Report SFY 2021* provided for review did not report data for this CI. According to the Process Document entitled *Provider Data Summary_VER_001*, dated 12/12/22, while NCI remained the data source for this CI, the *Provider Data Summary* would provide the performance data reporting for this CI. However, DBHDS did not provide a current Provider Data Summary. The last available version covered the period from November 2020 through April 2021.	
29.28 At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule.	DBHDS did not provide valid and reliable data to evidence compliance with this Compliance Indicator. Based on the documentation provided for review, the semiannual *Provider Data Summary* should be the source of this reporting. However, DBHDS did not provide a current *Provider Data Summar*y.	DBHDS did not provide sufficient documentation to show it could report valid and reliable data to evidence compliance with this Compliance Indicator. Based on the documentation provided for review, the semiannual Provider Data Summary should be the source of this reporting. However, DBHDS did not provide a current Provider Data Summary. The last available version covered the period from November 2020 through April 2021. With regard to their ability to provide valid and reliable data for this CI, DBHDS provided a Data Set Attestation, entitled *WaMS ISP Data Report,* which indicated it referred to a Process Name s "Analysis and reporting of housing choice, housemate choice, daily schedule and plan participation." The *WaMS ISP Data*	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	The last available version covered the period from November 2020 through April 2021. DBHDS provided a Data Set Attestation, entitled *WaMS ISP Data Report,* which indicated the Process Name as "Analysis and reporting of housing choice, housemate choice, daily schedule and plan participation." However, it did not describe the specific action steps that addressed and resolved any data integrity threats which ODQV identified in the WaMS data source that was used to produce that report. In addition, DBHDS did not provide a Process Document that identified the specific WaMS data deficiencies pertinent to this CI and the specific steps taken to remediate them. DBHDS did provide a Process Document entitled *Provider Data Summary_VER_001*, dated 12/12/22. The latter document specified the	*Report* Data Set Attestation indicated that "data for indicators 29.28, 29.29, 29.30 and 29.33 is contained within the *WaMS ISP Data Report*, which is a MS Excel flat file that contains the row level data and a data worksheet used by DBHDS and CSBs in determining results and monitoring progress. Filtering is used for corresponding columns in determining the numerator and denominator in each report. Video instructions on filtering measures has been provided to CSBs on the methods used to obtain results. The results of analysis are then reported in the Provider Data Summary on a semi-annual basis. The data methods employed for these measures are straight forward. IT will assist with enhancing the visualizations and explore the development of some automated charts that can be built into the report on separate tabs." However, the Data Set Attestation did not describe the specific action steps that addressed and resolved any data integrity threats which ODQV identified in the WaMS data source that was used to produce that report, including identifying and remediating any associated deficiencies. In addition, DBHDS staff did not provide a Process Document for the *WaMS ISP Data Report.* The *WaMS ISP Data Report* Data Set Attestation also indicated that the "(d)ata contained in the data report results from the aforementioned processes and is supported by DQV staff to ensure data validity. These actions are sufficient, no defects were identified." As described in the Introduction to this study, while ODQV staff did identify certain WaMS data source deficiencies during Phase I of the Source System Assessments and provided some updates in described in the 19th Period review, they cannot currently attest to the reliability and validity of the data from WaMS, nor are they involved in the data reliability and validity attestation process. DBHDS did provide a Process Document entitled *Provider Data Summary_VER_001*, dated 12/12/21. The latter document specified the columns to filter on in quarterly ISP 3.2 data reports, but did not describe the steps for preparing the ISP 3.2 data reports to ensure that any data source deficiencies were isolated and addressed and that the data reports contained valid and reliable data. In addition, DBHDS did not provide a Data Set Attestation related to the *Provider Data Summary_VER_001* Process Document.	

Compliance Indicator	Facts	Analysis	Conclusion
	columns to filter on in quarterly ISP 3.2 data reports, but did not describe the steps for preparing the ISP 3.2 data reports to ensure that any data source deficiencies were isolated and addressed and that the data reports contained valid and reliable data. In addition, DBHDS did not provide a Data Set Attestation related to the *Provider Data Summary_VER_001* Process Document.		
29.29 At least 75% of people receiving services who do not live in the family home/their authorized representatives chose or had some input in choosing where they live.	At the time of the 18th Period review, DBHDS reported that NCI data were the source for this PMI. However, for this review, the KPA PMI document, last updated 2/7/22, indicated that DBHDS no longer used NCI as the data source, but instead, in August 2021, transitioned to data taken from the ISP in WaMS. The draft Quality Management Annual Report provided for review reported that data reporting changed with the use of the WaMS	At the time of the 18th Period review, DBHDS reported that NCI data were the source for this PMI. However, for this review, the KPA PMI document, last updated 2/7/22, indicated that DBHDS no longer used NCI as the data source, but instead, in August 2021, transitioned to data taken from the ISP in WaMS. DBHDS provided a Data Set Attestation for this CI, entitled *WaMS ISP Data Report*, which indicated the Process Name as "Analysis and reporting of housing choice, housemate choice, daily schedule and plan participation." However, they did not provide a Process Document that identified the specific WaMS data deficiencies pertinent to this CI and the specific steps taken to remediate them. DBHDS did provide a Process Document entitled *Provider Data Summary_VER_001*, dated 12/12/22. The latter document specified the columns to filter on in quarterly ISP 3.2 data reports, but did not describe the steps for preparing the ISP 3.2 data reports to ensure that any data source deficiencies were isolated and addressed and that the data reports contained valid and reliable data. In addition, DBHDS did not provide a Data Set Attestation related to the *Provider Data Summary_VER_001* Process Document.	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	ISP version 3.2, which launched on May 1, 2021. DBHDS provided a Data Set Attestation, entitled *WaMS ISP Data Report,* which indicated the Process Name as "Analysis and reporting of housing choice, housemate choice, daily schedule and plan participation." However, they did not provide a Process Document that identified the specific WaMS data deficiencies pertinent to this CI and the specific steps taken to remediate them. Instead, DBHDS provided a Process Document entitled *Provider Data Summary_VER_001*, dated 12/12/22, which did not describe the steps for preparing the ISP 3.2 data reports to ensure that any data source deficiencies were isolated and addressed and that the data reports contained valid and reliable data. In addition, DBHDS did not provide a Data Set Attestation related to the	Based on the documentation provided for review, the semiannual Provider Data Summary should be the source of this reporting. However, DBHDS did not provide a current *Provider Data Summary*. The last available version covered the period from November 2020 through April 2021. Therefore, DBHDS did not provide data that were either current or produced after the transition to WaMS as the data source. Of note, however, the draft *Quality Management Annual Report* provided for review indicated the following: "Initially, data for the "choose where you live" measure was derived from the NCI report for Virginia. The SFY19-20 Virginia NCI report indicated that 65% of individuals either chose or had some input into where they lived. Beginning in SFY21, the data source for this measure changed to the Waiver Management System (WaMS) Individual Support Plan (ISP). This enabled DBHDS to review progress at an increased frequency. The overall result for the first three quarters of SFY21 is 100% of individuals receiving DD waiver services confirmed that they had chosen or had input into where they lived, which was above the 86% target. Data reporting changed with the use of the WaMS ISP version 3.2, which launched on May 1, 2021. Results from May 1 to June 30, 2021, showed100% success, which is in line with past reporting. The overall result is100%, which will serve as a new baseline, derived from changes in reporting. DBHDS will continue to monitor this measure." It was unclear if the data cited above were derived from the steps outlined in the *Provider Data Summary_VER_001* Process Document, although it appeared the data source was the same (i.e., the *WaMS ISP version 3.2.)*. In any event, DBHDS did not provide a sufficient Process Document or Data Set Attestation for that underlying data source. It was somewhat more concerning that DBHDS did not provide an analysis of the fairly wide discrepancies documented between the ISP-generated data in their internal reporting and the previously-used NCI data. The latter indicated that for SFY 2019, only 67% of individuals surveyed reported they chose or had some input in choosing where they lived if not living in the family home and only 65% in SFY 2020. This wide variation from one year	

Compliance Indicator	Facts	Analysis	Conclusion
	Provider Data Summary_VER_001 Process Document. Based on the documentation provided for review, the semiannual Provider Data Summary should be the source of this reporting. However, DBHDS did not provide a current *Provider Data Summary*. The last available version covered the period from November 2020 through April 2021. The draft Quality Management Annual Report reported that results from May 1 to June 30, 2021, showed 100% success, but it was not clear how DBHDS staff derived these results in the absence of a *Provider Data Summary*. The *Quality Management Annual Report* stated that the 100% figure was in line with past reporting, but this appeared to be incorrect. The same report showed that, based on previous NCI data for SFY 2019 and SFY 2020, the results showed 67% and 65%	to the next should have led DBHDS staff to have some discussion about the validity of data entered by support coordinators vs. direct responses from individuals. It also appeared, on the face of it, that their conclusion that the 100% result for the period from May 1 to June 30, 2021 was in line with past reporting was incorrect.	

Compliance Indicator	Facts	Analysis	Conclusion
	respectively. DBHDS staff did not provide any evidence to show they analyzed the reasons for significant discrepancy between NCI results vs. those derived from the ISP and the potential impact on validity.		
29.30 At least 50% of people who do not live in the family home/their authorized representatives chose or had some input in choosing their housemates.	DBHDS did not have valid and reliable data to evidence compliance with this Compliance Indicator. DBHDS provided a Data Set Attestation, entitled *WaMS ISP Data Report,* which indicated the Process Name as "Analysis and reporting of housing choice, housemate choice, daily schedule and plan participation." However, they did not provide a Process Document that identified the specific WaMS data deficiencies pertinent to this CI and the specific steps taken to remediate them.	DBHDS did not provide documentation to review or report valid and reliable data to evidence compliance with this Compliance Indicator. DBHDS reported that the data set for this CI is the *WaMS ISP Data Report.* DBHDS provided a Data Set Attestation for this CI, entitled *WaMS ISP Data Report,* which indicated the Process Name as "Analysis and reporting of housing choice, housemate choice, daily schedule and plan participation." However, they did not provide a Process Document that identified the specific WaMS data deficiencies pertinent to this CI and the specific steps taken to remediate them. DBHDS did provide a Process Document entitled *Provider Data Summary_VER_001*, dated 12/12/22. The latter document specified the columns to filter on in quarterly ISP 3.2 data reports, but did not describe the steps for preparing the ISP 3.2 data reports to ensure that any data source deficiencies were isolated and addressed and that the data reports contained valid and reliable data. In addition, DBHDS did not provide a Data Set Attestation related to the *Provider Data Summary_VER_001* Process Document. Based on the documentation provided for review, the semiannual Provider Data Summary should be the source of this reporting. However, DBHDS did not provide a current Provider Data Summary. The last available version covered the period from November 2020 through April 2021. Therefore, DBHDS did not provide data that were either current or produced after the transition to WaMS as the data source.	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
29.31 DBHDS implements an incident management process that is responsible for review and follow-up of all reported serious incidents, as defined in the Licensing Regulations.	The DBHDS incident management protocols include triage criteria and a process for follow-up and coordination with licensing specialists, investigators, and human rights advocates as well as referral to other DBHDS offices as appropriate. DBHDS has incident management processes in place to identify and, where possible, prevent or mitigate future risks of harm. DBHDS documents follow-up on individual incidents, as well as analysis to identify relevant patterns and trends.	As described at the time of the 18th Period review, the DBHDS incident management processes include specific regulatory requirements, extensive guidance documents and training materials for providers and DBHDS staff involved in the process that are detailed in Sections 29.3, 29.4 and 29.5 above. DBHDS has continued to develop, revise, and expand guidance materials and training curricula for providers and DBHDS staff related to the incident management system, provider expectations, and regulatory requirements. Details of those materials and training curricula are outlined in Sections 29.3, 29.4 and 29.5 above. The following regulations establish expectations of providers regarding how their incident management process includes review and follow-up of all reported serious incidents: • 160.C – the provider shall collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents, as part of the quality improvement program to include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. • 160.E – A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises. • 160.E.1 – The root cause analysis shall include a detailed description of what happened, an analysis of why it happened, and identified solutions to mitigate its reoccurrence and future risk of harm when applicable. • 160.E.2 – The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis should be conducted. • 160.J – The provider shall develop and implement a serious incident management policy, which shall describe the process by which the provider will document, analyze, and report to the department information related to serious incidents. DBHDS has operationalized the incident management system requirements contained at 12VAC35-105-160 through detailed processes and procedures for	18th-Met 20-Met

Compliance Indicator	Facts	Analysis	Conclusion
		review and follow-up of all Level II and Level III serious incidents reported through the CHRIS system. These processes are carried out by staff in the Incident Management Unit (IMU), the Office of Human Rights (OHR), and during annual licensing inspections and other investigations conducted by the Office of Licensing (OL). The *Internal Protocol for DBHDS Incident Management* describes the DBHDS framework, authority, and procedures for implementation of its incident management system to review and follow-up on all reported serious incidents. In addition, the *Protocol for Assessing Serious Incident Reporting by Providers of Developmental Service*s provides detailed information and guidance on the roles and responsibilities of IMU staff, OHR staff, and OL Licensing Specialists to review and follow up on all reported serious incidents consistent with relevant requirements in the Licensing Regulations. In addition to the daily review of reported incidents, the IMU has continued to evaluate serious incident data to determine if there are patterns that meet the threshold criteria as a "care concern." Based on this pattern analysis, the IMU makes the provider aware that a threshold has been met noting that this may be an indication a provider may need to re-evaluate an individual's needs and supports, review the results of their root cause analysis, or consider making other systemic changes. The care concerns and thresholds are defined in the Care Concern Protocol IMU v3 that was revised in August 2021 when, based on data analysis and intent to better identify individuals in need of modification of their plans, five care concern thresholds were consolidated into two with one focusing on unplanned hospital visits and the second on incidents of decubitus ulcers. Prior to the implementation of the CONNECT system, this review process was done manually through queries of the data system, but the CONNECT system automates the process of pattern identification reducing the impact of human error and increasing consistency of pattern identification. Providers are also able to run reports from the CHRIS system to identify which individuals have met care concern thresholds. Copies of care concerns that have been identified are also shared with staff in the OIH and OHR for their review and determination if action on their part is needed. The Office of Human Rights (OHR), following guidance in the Internal Protocol for DBHDS Incident Management and Protocol for Assessing Serious Incident	

Compliance Indicator	Facts	Analysis	Conclusion
		Reporting by Providers of Developmental Services (rev 2/2022), also continues to monitor reporting of abuse/neglect allegations that have been entered into the CHRIS system to confirm that the provider reported the allegation within 24 hours and that each allegation is appropriately investigated. Following guidance in the OL Annual Checklist Compliance Determination Chart, OL Licensing Specialists continue to verify that serious incidents are reported within 24 hours of discovery, that providers take appropriate action in response to serious incidents, and that follow-up corrective actions identified through serious incident investigations are developed and implemented. As describe above with regard to CI 29.4, based on a random sample review of 27 OL licensing inspections conducted during the period 7/1/21-12/31/21, it appeared that OL Licensing Specialists continue to conduct reviews of provider compliance with serious incident reporting requirements, consistent with requirements in the *OL Annual Checklist Compliance Determination Chart*, during annual licensing inspections and investigations. Overall, the framework of the system appears to be comprehensive, multi-faceted and robust. The system includes an electronic portal for incident reporting and an Incident Management Unit responsible for review, triage, tracking and follow-up on reported incidents.	
29.32 a) DBHDS develops incident management protocols that include triage criteria and a process for follow-up and coordination with licensing specialists and investigators, and human rights advocates as well as referral to other DBHDS	OL has developed and continues to revise incident management protocols that govern the incident reporting process for providers and describe processes and procedures for incident triage, follow-up, and coordination between the IMU, OL Licensing Specialists, the Office of Human Rights, and	The OL continues to implement the IMU serious incident review, triage, and follow-up systems, processes, protocols, and documentation procedures for serious incidents reported through the CHRIS system. The *Internal Protocol for DBHDS Incident* Management, last revised in 02/2022, contains detailed procedures to be followed by the Incident Management Unit (IMU) staff to review, triage, and conduct necessary follow-up and coordination activities related to any Level II or Level III serious incident reported through the CHRIS system. This includes follow-up actions with providers, OL Licensing Specialists, the Special Investigations Unit, the Office of Integrated Health, and the Office of Human Rights. These procedures also include supervisory review of	18th-Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
offices as appropriate; b) Processes enable DBHDS to identify and, where possible, prevent or mitigate future risks of harm; and, c) Follow-up on individual incidents, as well as review of patterns and trends, will be documented.	other entities that may be involved in the serious incident reporting, investigation, and follow-up processes. All phases of the incident management process are well-documented with guidance for providers, IMU staff, the OHR, and OL Licensing Specialists. The implementation of the new CONNECT data system in 11/2021 has provided an expanded and more detailed structure for information capture, documentation, review, analysis, and reporting. Based on review of guidance documents and serious incident data and follow-up, the IMU review and analysis of serious incidents, care concern identification, trend and pattern analysis, and follow-up with providers regarding required corrective actions is logically structured, comprehensive, and consistently implemented and documented. The processes	incident closure, tracking and trending of incident data, ongoing audit/review of the IMU incident review process, and training and technical assistance for providers, OL Licensing Specialists, and others. This guidance is reviewed and updated, as needed, to remain responsive to the issues identified and to process improvements as they are implemented. In addition to the daily review of reported incidents, the IMU continues to evaluate serious incident data to determine if there are patterns that meet the threshold criteria as a care concern. The process of identifying care concern patterns helps to identify potential risks of harm and, where possible, prevent or mitigate future risks of harm. From this review, the IMU makes the provider aware that a threshold has been met noting that this may be an indication that the provider may need to re-evaluate an individual's needs and supports, review the results of their root cause analysis, or consider making other systemic changes. The care concerns and thresholds are defined in the *Care Concern Protocol IMU v3* that was revised in 08/2021 when, based on data analysis and intent to better identify individuals in need of modification of their plans, five care concern thresholds were consolidated into two with one focusing on unplanned hospital visits and the second on incidents of decubitus ulcers. Prior to the implementation of the CONNECT system, this review process was done manually through queries of the data system, but the CONNECT system automates the process of pattern identification reducing the impact of human error and increasing consistency of pattern identification. Providers can run reports from the CHRIS system to identify which individuals have met care concern thresholds. IMU provides information about identified care concerns to staff in the OIH and OHR for their review and determination if additional action is needed. The implementation of the new CONNECT data system, which began in November 2021, further automates the IMU processes and procedures and provides more detailed and specific data and information that inform the DBHDS incident management process. As the CONNECT system continues to become fully integrated into the day-to-day operations of the DBHDS incident management system, it will significantly improve the incident analysis and follow-up processes as well as improve and expand data reporting for analysis and quality	

Compliance Indicator	Facts	Analysis	Conclusion
	for IMU coordination with OL Licensing Specialists, the Office of Human Rights, and the Office of Integrated Health are also consistently occurring and are documented.	assurance purposes. For this 20th Period review, the study included an examination and analysis of data and information related to 4,621 incidents that were included in the spreadsheet entitled *DD Providers Incidents June 2021-November 2021*, data and information reported by the IMU to the RMRC related to identified care concerns during SFY 2021, and changes and updates made to the care concern protocol described in the *Care Concern Protocol IMU v3* that was revised in 08/2021. This review verified that the processes outlined in the *Internal Protocol for DBHDS Incident Management,* the *Protocol for Assessing Serious Incident Reporting by Providers of DD Services,* and the *Care Concern Protocol IMU v3* are being implemented and that they identify sources of contributing factors to risk and incident trends and patterns that could benefit from a systemic intervention. Analysis reports are submitted to the Risk Management Review Committee (RMRC), Regional Quality Committee (RQC), and the Quality Improvement Committee (QIC) for further review and follow-up action.	
29.33 The Commonwealth ensures that individuals have choice in all aspects of their goals and supports as measured by the following: a. At least 95% of people receiving services/authorized representatives participate in the development of their own service plan.	DBHDS did not demonstrate they had valid and reliable data to evidence compliance with this Compliance Indicator. DBHDS provided a Data Set Attestation, entitled *WaMS ISP Data Report,* which indicated the Process Name as "Analysis and reporting of housing choice, housemate choice, daily schedule and plan participation." However, DBHDS did not	DBHDS did not provide sufficient documentation to review or report valid and reliable data to show that at least 95% of people receiving services/authorized representatives participate in the development of their own service plan. DBHDS provided a Data Set Attestation for this CI, entitled *WaMS ISP Data Report,* which indicated the Process Name as "Analysis and reporting of housing choice, housemate choice, daily schedule and plan participation." However, they did not provide a Process Document that identified the specific WaMS data deficiencies pertinent to this CI and the specific steps taken to remediate them. DBHDS did provide a Process Document entitled *Provider Data Summary_VER_001*, dated 12/12/22. While it did not include CI 29.33 in the introductory list of indicators impacted, it was included in a list of measures (i.e., measure #7) under *Section III: Reporting.* The Process Document specified the columns to filter on in quarterly ISP 3.2 data reports, but did not describe the steps for preparing the ISP 3.2 data reports to ensure that any data source deficiencies were isolated and addressed and that the data reports contained valid	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	provide a Process Document specifically for the *WaMS ISP Data Report.* They did provide a Process Document entitled *Provider Data Summary_VER_001*, dated 12/12/22. While it did not include CI 29.33 in the introductory list of indicators impacted, it was included in a list of measures (i.e., measure #7) under *Section III: Reporting*. The Process Document specified the columns to filter on in quarterly "ISP 3.2 data reports." Based on the *WaMS ISP Data Set Attestation* provided, dated, 3/4/22, ISP data reports are pulled from WaMS. However, this Process Document did not specify the steps for preparing the quarterly "ISP 3.2 data reports" or address which, if any, underlying data source system deficiencies pertained to this CI, including any steps taken to remediate them. Based on the documentation provided for review, the semiannual Provider Data	and reliable data. In addition, DBHDS did not provide a Data Set Attestation related to the *Provider Data Summary_VER_001* Process Document. Based on the documentation provided for review, the semiannual Provider Data Summary should be the source of this reporting. However, DBHDS did not provide a current Provider Data Summary. The last available version covered the period from November 2020 through April 2021. Therefore, DBHDS did not provide data that were either current or produced the transition to WaMS as the data source. .	

Compliance Indicator	Facts	Analysis	Conclusion
	Summary should be the source of this reporting. However, DBHDS did not provide a current Provider Data Summary. The last available version covered the period from November 2020 through April 2021. Therefore, DBHDS did not provide data that were either current or produced the transition to WaMS as the data source.		

V.C.1 Analysis of 20th Review Period Findings

V.C.1: The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.

Compliance Indicator	Facts	Analysis	Conclusion
30.1: The licensing regulations require all licensed providers, including CSBs, to implement risk management processes including: a) Identification of a person responsible for the risk management function who has	Licensing regulations define requirements for provider risk management programs that that include requirements a) through c) set out in this Compliance Indicator. Licensing protocols require that risk assessment reviews address the environment of care, clinical assessment or	As previously reported, DBHDS has established a set of licensing regulations at *12VAC35-105-520.A-E* that contain requirements for a risk manager to oversee the provider's risk management program; a written plan to identify, monitor, reduce and minimize harms and risks of harm; a requirement for an annual systemic risk assessment that identifies and responds to practices, situations, and policies that could result in the risk of harm to individuals and that incorporate uniform risk triggers and thresholds; and a requirement to conduct a safety inspection, at least annually, of each service location that includes recommendations for safety improvements. OL developed and has continued to implement and update detailed guidelines	18th-Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
training and expertise in conducting investigations, root cause analysis, and data analysis. b) Implementation of a written plan to identify, monitor, reduce and minimize harms and risks of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability; and c) Conducting annual systemic risk assessment reviews, to identify and respond to practices, situations and policies that could result in harm to individuals receiving services. Risk assessment reviews shall address the environment of care, clinical assessment or reassessment processes, staff competence and adequacy of staffing, the use of high-risk	reassessment processes, staff competence and adequacy of staffing, the use of high-risk procedures including seclusion and restraint, and review of serious incidents. DBHDS requires that risk assessments incorporate uniform risk triggers and thresholds as defined by DBHDS.	for licensing specialists to follow in reviewing and making determinations about provider compliance for each of these regulatory requirements. These guidelines are further captured in the *OL Annual Checklist Compliance Determination Chart- 2022,* a tool designed for licensing specialists to use and complete during each licensing visit. With regard to risk triggers and thresholds, for this 20th Period review, The *RMRC Annual Report FY21* provided the following description of DBHDS' current approach: "One of the central components of risk awareness is the recognition of triggers and thresholds. A trigger is a predefined event (indicator) or change in status that indicates an actual or potential risk has occurred or is about to occur. Triggers are events that signify potential risk and they signal the need for review or action to identify the risk and actions that can be taken to reduce the risk and prevent harm. A threshold means that a series of predefined events or changes in status have occurred that indicate that a level of unacceptable risk has been reached. Risk triggers and thresholds may be identified through individual risk screening as well as monitoring patterns of events at the individual or the provider level." "DBHDS has defined event-based triggers to correlate with the care concerns monitored by the IMU. Event-based triggers identify potential risks based on the occurrence of one or more incidents. When a threshold for an event-based trigger is met, it signals the need for a review to determine why these incidents are occurring and whether changes may be necessary to prevent re-occurrence or more serious harm. The activation of an event-based trigger does not mean there is a problem with an individual's care. Rather, it signals a need to review that care, or other circumstances to determine if modifications are necessary to reduce the likelihood of further harm." For this review, DBHDS had made changes to the *Incident Management Unit Care Concern Threshold Joint Protocol Revised/Effective 9/2/2021,* which operationalized the conceptualization described in the *RMRC Annual Report FY21.* It continued to	

Compliance Indicator	Facts	Analysis	Conclusion
procedures including seclusion and restraint, and review of serious incidents. Risk assessments also incorporate uniform risk triggers and thresholds as defined by DBHDS. See 12VAC-35-105-520.		note that if IMU ongoing triage of serious incidents identified that a care concern threshold is met, the provider is notified, and is expected to initiate follow- up actions that include further evaluation of the individual(s) involved and investigation to identify any systemic issues that impact their provision of care. In addition, OL, OHR and the Office of Integrated Health (OIH) are notified when a provider meets a care concern threshold, and each evaluates the situation to determine appropriate follow-up action. The OIH may offer the provider relevant education or technical assistance to evaluate and address the care concern issues. Evaluation of how providers address identified care concerns remained an integral part of the OL annual licensing review.	
30.2: The DBHDS Office of Licensing publishes guidance on serious incident and quality improvement requirements. In addition, DBHDS publishes guidance and recommendations on the risk management requirements identified in #1 above, along with recommendations for monitoring, reducing, and minimizing risks associated with chronic diseases, identification of emergency conditions and significant changes in conditions, or behavior presenting a risk to self or others.	DBHDS continues to provide a variety of resources including reference materials, policy examples, protocols, and informational bulletins that relate to serious incident and quality improvement requirements. The documents reviewed provide evidence of intra-agency coordination between the Office of Licensing , Office of Integrated Health, and the DBHDS Training Department in the development, publication, and revision of these resources. The Office of Licensing published A Crosswalk of Approved Risk Management Training that contains relevant information about	As described below, DBHDS has continued its efforts to develop guidance and training related to serious incident and quality improvement requirements in the licensing regulations: • The OL website contains resources for quality improvement and risk management process development and ongoing refinement. In the *QI-RM-RCA Webinar 12/16/2021*, providers were reminded of these resources and links to them that can be found on the website. The OL has also published a comprehensive list of approved risk training curricula entitled *Risk Management Training for Virginia Licensed Developmental Disability Providers* to help providers identify and access these approved courses. • Examples of recently developed or revised guidance and training resources include *A Crosswalk of Approved Risk Management Training (08/2021), Q&A from Risk Management-Quality Improvement Tips and Tools Training (08/2021), Sample Provider Quality Improvement Plan (06/2021*), *Sample Risk Management Plan (06/2021)*, *Sample Provider Systemic Risk Assessment (06/2021)*, *Assuring Health and Safety for Individuals with DD with a Comprehensive Risk Management Plan (rev 10/2021)*, *OL IMU Care Concern Threshold Joint Protocol (rev 09/2021)*, *DBHDS OL Guidance for Serious Incident Reporting (effective 11/2020)*, and *Sample Root Cause Analysis Policy Template (02/2022)*. Guidance documents published in 2020 are also available as reference tools on the OL webpage. • The Office of Integrated Health (OIH) continues to issue *Health and Safety Alerts* that include recommendations for monitoring, reducing, and	18th-Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
	available training and the specific regulatory requirements that each type of training addresses. It also contains hyperlinks to the training itself. Online training relating to serious incident and quality improvement requirements and other topics is available to providers through the Shriver Online Learning System and through the Center for Developmental Disabilities Evaluation and Research (CDDER).	minimizing risks associated with chronic diseases, identification of emergency conditions, and significant changes in conditions. They issued nine health-related alerts in 2021 and one alert relating to emergency preparedness in 2022. • The OIH also continues to publish the *Health Trends* monthly newsletter that includes updates on relevant health-related topics. The newsletter also includes an article each month relating to behaviors presenting a risk to self or others entitled "ABA Snippets." Examples of topics covered in these articles include Functional Communication Training and Replacement Behaviors, Trauma-Informed Care in Behavioral Services, Acceptance and Commitment Therapy, Therapeutic Consultation Behavioral Services, and Incorporating Elements of Positive Behavior Support in Behavior Planning. DBHDS has also made educational sheets on five common yet serious health conditions available through its training website. These educational sheets address aspiration, bowel obstruction, dehydration, GERD, and seizures. • Providers have access to online training related to risk screening through the Shriver Online Learning System. This training includes eight modules addressing development and implementation of a risk screening system and recommendations for various components to be included in a provider's risk assessment processes and procedures. • Additional training relating to developing and implementing an effective incident management system, a 5-module training course, is available through the Center for Developmental Disabilities Evaluation and Research (CDDER).	
30.3: DBHDS publishes on the Department's website information on the use of risk screening/assessment tools and risk triggers and thresholds. Information on risk triggers and thresholds utilizes at least 4 types of uniform risk	DBHDS has developed and made available to providers a significant amount of information about risk screening and assessment tools and processes. A description and evaluation of the OL monitoring system is described in Section 30.07	DBHDS has continued efforts to develop and refine reference materials, guidance documents and training curricula that relate to provider responsibilities for risk screening and assessment. They developed a Risk Awareness Tool (RAT), *RAT Form Annual Risk Awareness Tool, June 2020,* and published guidance, *Risk Awareness Tool Instruction Document, 06/02/2020,* on how the RAT can be integrated with information from the Support Intensity Scale (SIS) and utilized to increase awareness of a potential for a harmful event to occur. The RAT includes assessments related to pressure injury, aspiration pneumonia, fall with injury, dehydration, bowel obstruction, sepsis, seizure, community safety risks, self-harm, elopement, and lack of safety awareness. Providers were informed on	18th-Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
triggers and thresholds specified by DBHDS for use by residential and day support service providers for individuals with IDD. This information includes expectations on what to do when risk triggers or thresholds are met, including the need to address any identified risks or changes in risk status in the individual's risk management plan.	below where requirements for DBHDS to monitor that providers appropriately respond to and address risk triggers and thresholds is addressed in more detail.	06/12/2021, *RAT Memo Risk Awareness Tool, 06/16/2020* that DBHDS would begin requiring use of the RAT in the process of developing individualized services plans on 07/01/2020. DBHDS published *Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan, 06/2020* to give providers detailed guidance on the purpose, development, and implementation of a comprehensive risk management program for their organization. This document includes definitions and descriptions of risk triggers and thresholds and guidance on their appropriate use in the provider's risk management program. It also includes references to and instructions for use of the Risk Awareness Tool and Support Intensity Scale as risk assessment tools and how these tools can become an essential resource in the development of individualized services plans. The *Quality Improvement Risk Management Training November* 2020 contains guidance to providers that notes that DBHDS defined risk triggers and thresholds as care concerns through review of serious incident reporting conducted by the Incident Management Unit. It also identifies what each of the five care concern thresholds are. The OL IMU reviews each serious incident report upon receipt from the provider. This review entails both a specific review of the incident itself and a review to determine if the provider has reported similar serious incidents that could raise a concern about a provider's ability to ensure the adequacy of supports to one or more individuals they serve. The requirements for DBHDS to monitor that providers appropriately respond to and address risk triggers and thresholds is described in Section 30.7 below.	
30.4: At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations	The annual licensing review includes an assessment of the provider's compliance with regulations relevant to the provider's risk management program. The DBHDS process for assessing compliance with the	As reported at the time of the previous review, DBHDS has established a set of licensing regulations at *12VAC35-105-520.A-E* that contain requirements for a risk manager to oversee the provider's risk management program; a written plan to identify, monitor, reduce and minimize harms and risks of harm; a requirement for an annual systemic risk assessment that identifies and responds to practices, situations, and policies that could result in the risk of harm to individuals and that incorporate uniform risk triggers and thresholds; and a requirement to conduct a safety inspection, at least annually, of each service location that includes recommendations for safety improvements.	18th-Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
during their annual inspections. Inspections will include an assessment of whether providers use data at the individual and provider level, including, at minimum, data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations.	risk management requirements in the Licensing Regulations is documented in significant detail in the OL Annual Checklist Compliance Determination Chart-2022. The DBHDS process for assessing compliance with the risk management requirements in the Licensing Regulations is comprehensive and sufficient to accurately assess a provider's compliance with these regulations. For the period 1/1/21-12/31/21, DBHDS reported that of providers that had annual inspections, OL reviewed approximately 91% of them for compliance with risk management requirements.	DBHDS revised the *OL Annual Checklist Compliance Determination Chart,* in January 2022. This detailed written guidance contains instructions for licensing specialists about how to review evidence, make compliance determinations, and document non-compliance, if identified, on a licensing report (Corrective Action Plan) for each regulation that is evaluated during the annual licensing inspection. The Corrective Action Plan contains the regulatory requirement, compliance determination, description of non-compliance, provider actions to come into compliance, and the projected date for completion of the actions. At the time of the previous review DBHDS had updated the *Internal Protocol for Assessing Compliance with 12VAC35-105-520 and 12VAC35-105-160.E* to provide additional detailed instruction for licensing specialists regarding compliance with specific regulations including *12VAC35-105-520.A-E.* The document stated, "If it is determined during an annual inspection that the provider failed to comply with any component of regulation 12VAC35-105-520.A-E, the Office of Licensing shall issue a licensing report describing the non-compliance and requesting the provider submit a Corrective Action Plan (CAP) for addressing all components of the cited violation." For this review, DBHDS most recently updated the *Internal Protocol for Assessing Compliance with 12VAC35-105-520 and 12VAC35-105-160.E* in February 2022. This version maintained this instruction to OL staff. Based on the document *Summary of Compliance- 30.04-30.05* provided for review, for the reporting period 1/1/21-12/31/21, DBHDS reported that out of 911 providers that had annual inspections, OL assessed 832 (91%) for all risk management requirements. DBHDS provided a Process Document entitled *Provider Risk Management Programs*, dated 1/1/21, that reflected the data source as OLIS, which appeared to be correct for the given date range. However, although DBHDS submitted a listing of signed data set attestations that included CI 30.4, they did not make the documentation available as they updated files throughout the review period. Going forward, DBHDS will also need to update the Process Document to show	

Compliance Indicator	Facts	Analysis	Conclusion
		the data source as CONNECT. DBHDS staff indicated this was underway. The *Summary of Compliance- 30.04-30.05* appeared to indicate the existence of a new Process Document entitled *DOJ Process RM Requirements_VER001,* but DBHDS did not submit this for review. At the time of the 18Th Period review, this study noted that for this indicator to be determined Met in the future, DBHDS would need to show evidence that the Licensing assessment process determines whether it includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. For this 20th Period review, the study included a review of 27 randomly selected sample of licensing inspection reports of the 275 annual inspections conducted during the period 7/1/21-12/31/21 (Inspections Completed 07/01/2021-12/31/2021). Based on review, none of the 27 provided any evidence that OL licensing specialists reviewed for this requirement or provided any relevant citations.	
30.5: On an annual basis, the Commonwealth determines that at least 86% of DBHDS licensed providers of DD services are compliant with the risk management requirements in the Licensing Regulations or have developed and implemented a corrective action plan to address any deficiencies.	During CY21, based on the *Summary of Compliance- 30.04-30.05*, as well as relevant data in the *RM Compliance by Regulation 520 CY21* report, 567/911 providers (62.2%) were assessed and found to compliant with all of the sub-sections of 12VAC35-105-520. In addition, 285 of the providers who were non-compliant developed and implemented an approved corrective action plan to address cited deficiencies. That increased the number of providers who met the requirements of this compliance indicator to 852/911 resulting in a	The 2022 OL Annual Checklist Compliance Determination Chart provides detailed instructions for assessing compliance with each of the five sections under 12VAC35-105-520. The provider is assessed for current compliance and, if the provider was required to implement a corrective action plan for previous non-compliance in the last year, whether that corrective action plan has continued to achieve its desired outcome. The 86% threshold for this compliance indicator requires analysis of data relating to each of these two components. During CY21, based on the *Summary of Compliance- 30.04-30.05*, as well as relevant data in the *RM Compliance by Regulation 520 CY21* report, 567/911 providers (62.2%) were assessed and found to compliant with all of the sub-sections of 12VAC35-105-520. In addition, 285 of the providers who were non-compliant developed and implemented an approved corrective action plan to address cited deficiencies. That increased the number of providers who met the requirements of this compliance indicator to 852/911 resulting in a compliance percentage of 93.5%, above the 86% threshold established in this compliance indicator. The analysis for CI 30.4 identified an inadequate OL inspection process related to determining whether providers identify year-over-year trends and patterns	18th-Not Met 20th-Met*

Compliance Indicator	Facts	Analysis	Conclusion
	compliance percentage of 93.5%, above the 86% threshold established in this compliance indicator.	and the use of baseline data to assess the effectiveness of their risk management systems. This shortcoming does not impact whether OL completed the process of determining whether OL providers were compliant, and, if not, implemented a CAP. Of note, the RMRC continued to voice concern over the relatively low percentages of provider compliance with risk management requirements overall. Members of the RMRC held a QII planning meeting on 2/8/22 and agreed to address raising the percentage of providers who met 100% of the risk management requirements. Specifically, they agree to focus on the regulatory requirements at 520 D (i.e., conducting a systemic risk assessment that includes risk triggers and thresholds), noting that performance had been 75% or lower for two consecutive quarters. This initiative, which was in the early stages of planning, is also addressed in an agreed-upon curative action that the parties submitted to the Court on 4/22/22, as described further below with regard to CI 30.7. With regard to data validity and reliability for this CI, DBHDS submitted a Process Document entitled *Provider Risk Management Programs*, dated 1/1/21, which, as described above with regard to CI 30.4 above, reflected the data source as OLIS, which appeared to be correct for the given date range. It was positive to see that the Process Document included a description of data validation activities that, per the curative action, should be reflected in the documentation. Specifically, it describes a process whereby the OL Regional managers conduct a look-behind review of 10% of completed annual inspections to ensure citations are issued that are consistent with internal protocols and the annual checklist. The QI Specialist then completes a blind look behind on two of the regional manager's look-behinds. Any discrepancies or trends are presented in the staff meeting. While DBHDS acknowledged this was not a formal inter-rater reliability process, it did have potential to address the reliability of data as well as improve related guidance. However, although DBHDS submitted a listing of signed data set attestations that included CI 30.4, they did not make the documentation available to review as they updated files throughout the review period.	

Compliance Indicator	Facts	Analysis	Conclusion
		As also noted for CI 30.4, DBHDS will need to update the Process Document to show the data source as CONNECT. DBHDS staff indicated this was underway. The *Summary of Compliance- 30.04-30.05* appeared to indicate the existence of a new Process Document, entitled *DOJ Process_RM Requirements_VER001,* but DBHDS did not submit this for review. DBHDS did submit a KPA PMI document for this measure, which noted that the Measure Steward reviewed the measure at the Annual KPA PMI Workgroup meeting on 12/14/21, and determined that the source system had changed from OLIS to CONNECT. The Measure Steward updated the PMI methodology and DQV staff reviewed the changes on 2/10/22. While the PMI is not sufficient to serve as a Process Document, it will be helpful to review to ensure there are not inconsistencies between the two documents. *This Met rating is for illustrative purposes only. DBHDS has fulfilled the activities required by this Indicator, and has adequate procedures in place that would support the ability to do this work. However, DBHDS cannot yet be confident when analyzing risk management data or reliably identify trends.	
30.6: DBHDS publishes recommendations for best practices in monitoring serious incidents, including patterns and trends which may be used to identify opportunities for improvement. Such recommendations will include the implementation of an Incident Management Review Committee that meets at least quarterly and documents meeting minutes and provider	DBHDS established specific regulatory requirements at *12VAC35-105-160.C* that require providers to conduct at least quarterly review of serious incidents including analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. *12VAC35-105-160.E* establishes provider requirements related to conducting root cause analyses.	While it does not explicitly reference an "Incident Management Review Committee," the regulation at *12VAC35-105-160.C* establishes a requirement for providers to conduct at least quarterly review of serious incidents that includes analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. In June 2020, the OL developed care concern thresholds that defined specific incident patterns that are monitored by the Incident Management Unit (IMU) and, when identified, are shared with the provider to determine if further analysis and response may be needed. These care concern thresholds, *Care Concern Protocol IMU v3*, were revised in 08/2021 and now include further assessment and action from providers when the following patterns of incidents are identified: (1) multiple [2 or more] unplanned hospital visits for a serious incident (falls, choking, urinary tract infection, aspiration pneumonia, dehydration, or seizures) within a 90-day timeframe for any reason, and (2) any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a	18th-Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
system level recommendations.	DBHDS began to operationalize the identification of patterns of serious incidents by developing criteria for care concerns and related thresholds in 06/2020 and has continued to review and revise these thresholds in response to data and information collected over time. DBHDS continues to publish recommendations for best practices in monitoring serious incident trends and patterns through informational memos, online training opportunities, and periodic provider informational webinars.	bowel obstruction diagnosed by a medical professional. *12VAC35-105-160.E.2.a-d* requires providers to develop and implement specific criteria when a more detailed root cause analysis is necessary based on specific patterns and trends of incidents. These criteria must be specified in the provider's root cause analysis policy. Providers continue to be challenged to meet the requirements relating to the content of a root cause analysis policy. The *Licensing Regulatory Compliance with 12VAC35-105-160 CY2021* report notes that only 70% of providers developed and implemented a root cause analysis policy that met all the requirements at *12VAC35-105-160.E.2.a-d*. In response to these identified challenge areas for providers in CY2021, and to assist providers to meet these requirements, the OL published a *SAMPLE Root Cause Analysis Policy* template in February 2022 that providers may use to assess and improve their root cause analysis policies and procedures and, as a result, more consistently meet the requirements with Licensing Regulations. The content of this document is helpful, but could be further improved with inclusion of more specific examples of minimum expectations for root cause analysis content with a specific focus on those incidents that are not complex in nature. Examples of these types of incidents may include but are not limited to falls, seizures, some types of emergency room visits, and some incidents involving change of condition. *The Root Cause Analysis-The Basics* PowerPoint is an excellent training tool, but consideration of its update to incorporate examples of content requirements that have been identified as insufficient or incomplete through licensing inspections could also be useful to address and a provider's ability to conceptualize and operationalize what an effective root cause analysis process and report looks like in their organization. Other informational materials published by DBHDS include *Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan* (06/2020), *Guidance for a Quality Improvement Program* (11/2020), *Guidance for Risk Management* (08/2020), and *Guidance on Incident Reporting Requirements* (08/2020). Training has also been developed and made available to providers through the DBHDS website, the Center for Developmental Disabilities Evaluation and	

Compliance Indicator	Facts	Analysis	Conclusion
		Research (CDDER), and through the Shriver Online Learning System. OL conducted a provider webinar in 12/2021, *QI-RM-RCA Webinar 12/16/2021*, that included data from OL inspections related to specific regulatory requirements including those at *12VAC35-105-160*. The webinar also included guidance to providers on how to meet these regulations and provided resources for making improvements in their policies, procedures, and practices related to serious incident monitoring more consistently.	
30.7: DBHDS monitors that providers appropriately respond to and address risk triggers and thresholds using Quality Service Reviews, or other methodology. Recommendations are issued to providers as needed, and system level findings and recommendations are used to update guidance and disseminated to providers.	DBHDS did not describe a clear and comprehensive methodology for monitoring that providers appropriately respond to and address risk triggers and thresholds. The *Incident Management Unit Care Concern Joint Protocol* described one approach to DBHDS monitoring that providers appropriately respond to and address risk triggers and thresholds, but it was limited in scope. For this 20th Period review, DBHDS had narrowed, rather than expanded, the scope of care concerns. On 4/22/22, after the conclusion of this review period, the parties jointly filed an agreed upon curative action for CI 30.7, which will again expand these criteria and addresses a more comprehensive set of actions,	As previously reported at the time of the 18th Period review, DBHDS established a requirement for inclusion of risk triggers and thresholds at *12VAC35-105-520.D,* which is stated as follows: "The systemic risk assessment process shall incorporate uniform risk triggers and thresholds as defined by the department." Since that time, as described with regard to CI 30.03, DBHDS has continued a focus on training and offering guidance to providers regarding identifying risks and how providers should use the Risk Awareness Tool to address risk triggers. However, this CI requires that DBHDS also has adequate processes in place to monitor that providers are appropriately responding to and addressing risk triggers and thresholds. At the time of the 18th Period review, this study found that DBHDS needed to develop a clear methodology for monitoring that providers appropriately respond to and address risk triggers and thresholds, and that, while the methodology might be multi-faceted, it would need to be coordinated and comprehensive. Further, the study indicated that to allow for a thorough assessment of compliance with the requirements of this CI, DBHDS would need to implement a cohesive monitoring mechanism to provide sufficient information regarding the extent to which providers appropriately respond to and address risk triggers and thresholds and formulate recommendations that are issued to providers as needed, and system level findings and recommendations are used to update guidance and disseminated to providers. Based on this review, the department did not yet have such adequate processes in place. For example, the previously reviewed version identified five event-based triggers and thresholds that IMU focused upon in the triage and evaluation of serious incidents being reported by providers. These included: • Three or more unplanned medical hospitalizations, ER visits or psychiatric hospitalizations within a 90-day timeframe for any reason.	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	including specific requirements for monitoring, as well as data collection and review.	• Two or more unplanned medical hospitalizations or ER visits for the same condition or reason that occur within a 30-day timeframe. • Any combination of three or more incidents of any type within a 30-day timeframe. • Two or more unplanned hospital admissions or ER visits for any combination of the following serious incidents: falls, choking, bowel obstruction, urinary tract infection, aspiration pneumonia, or dehydration within a 90-day timeframe for any reason. • Any incidents of medically verified decubitus ulcers or bowel obstruction. At the time of the 18th Period review, this study found that what DBHDS staff described as a phased-in approach could hold promise in assisting providers to become more familiar with and to begin successful integration of risk triggers and thresholds into their risk management processes for identification, reporting and follow-up to serious incidents. However, for this 20th Period review, DBHDS had narrowed, rather than expanded the scope of care concerns. Based on review of a document entitled *Care Concern Criteria for State Fiscal Year 2022,* with a date of 3/31/22, this revision grew out of the RMRC's review of SFY 2021 IMU data in August 2021, from which the committee identified a need to re-evaluate the care concern criteria to better identify individuals who might require modification to their plans. The RMRC further recommended that OIH and IMU work together to re-evaluate the care concern criteria, especially as that might align with the ongoing implementation of the RAT. While the document noted that and noted that the revised care concerns now addressed all areas of the RAT, the net effect was a narrowed scope. The current care concerns are limited to the following: • Multiple (2 or more) unplanned hospital visits for a serious incident: falls, choking, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day time-frame for any reason. • Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional.	

Compliance Indicator	Facts	Analysis	Conclusion
		On 4/22/22, after the conclusion of this review period, the parties jointly filed an agreed upon curative action for CI 30.7, which will again expand these criteria. Pursuant to the filing, DBHDS agreed to add, by July 1, 2022, the following care concerns: • Two or more psychiatric hospitalizations per quarter as a risk trigger or threshold for review and follow up (e.g., by REACH, crisis team, licensing, or provider development as indicated and determined appropriate by DBHDS • Any choking event that is reported as a Level II serious incident as a risk trigger or threshold. The curative action further addresses a set of actions that appear to define a comprehensive and coordinated approach as previously recommended, and includes specific requirements for monitoring, as well as data collection and review. Going forward, it will be necessary for DBHDS to develop relevant Process Documents, as well as Data Set Attestations that address all of the agreed upon requirements. For this review, DBHDS provided only the Process Document entitled *Provider Risk Management Programs*, which did not comprehensibly address the components of the current monitoring of risk triggers and thresholds and did not provide a Data Set Attestation.	
30.8: DBHDS has Policies or Departmental Instructions that require Training Centers to have risk management programs that: 1. Reduce or eliminate risks of harm; 2. Are managed by an individual who is qualified by training and/or experience;	The DBHDS DI 401 (RM) 03 sets requirements for risk management programs for DBHDS-operated facilities including the Training Center. Training Center policies and procedures charge various committees with specific key elements of a risk management program to reduce or eliminate risks of	DBHDS Departmental Instruction (DI) 401 (RM) 03 entitled "Risk and Liability Management" applies to all DBHDS-operated facilities including the Training Center. As summarized below, the DI includes most, but not all of the four specified requirements. • It states the purpose of the DI is to "establish a comprehensive and uniform risk management program intended to reduce, eliminate, correct, manage or control risk through the identification, investigation, analysis and treatment of hazards that may result in harm to individuals receiving services" and others and prevent losses to the Commonwealth. • It states that the facility director will be responsible for implementing a risk management program that is "managed by a facility risk manager who is qualified by training and/or experience." It further states that the risk	18th-Not Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
3. Analyze and report trends across incidents and develop and implement risk reduction plans based upon this analysis; and 4. Utilize risk triggers and thresholds to identify and address risks of harm.	harm, to analyze and report trends across incidents and develop and implement risk reduction plans based on the analysis. The Training Center has a facility risk manager whose responsibilities include oversight and operations related to the facility's risk management program. The DI states the facility director will be responsible for implementing a risk management program that is "managed by a facility risk manager who is qualified by training and/or experience" but does not state any minimum criteria related to training and/or experience. The Training Center policies and procedures also do not articulate a minimum set of qualifications. The DI states the facility risk management program must incorporate risk triggers and thresholds,	manager will develop, coordinate and administer an interdisciplinary facility-wide risk management program. However, the DI does not state any minimum criteria for training and/or experience needed to be considered qualified. • It identifies the risk manager's responsibilities relevant to incident reporting and data analysis and for developing and implementing risk reduction plans based on incident analyses. • It states the risk management program must incorporate risk triggers and thresholds and provides definitions. While the definition of a risk trigger (i.e., an event or condition that causes a risk to occur) was essentially consistent with that DBHDS has otherwise defined, the definition of risk threshold (i.e., the amount of risk a facility is willing to accept) did not appear to provide sufficient guidance about how to identify and address risks of harm when implementing the concept of risk thresholds. Training Center staff also provided copies of relevant internal policies, each which contained instruction and expectation with regard to elements of a risk management program. Overall, it appeared that the Training Center had policies that sufficiently described expectations and processes to address the reduction and or eliminate risks of harm, as well as the analysis, reporting and risk reduction planning across many domains. Based on review of the *RMRC Annual Report SFY 2021* as well as RMRC meeting minutes, dated 5/21/21, 8/21/21 and 11/21/21, in SFY 2021, SEVTC shared data with the RMRC that illustrated the Training Center's ongoing efforts to analyze and report trends in serious incidents, abuse/neglect/exploitation allegations and substantiated reports, UTIs, falls and use of restraints. SEVTC also shared information about quality improvement efforts focused on staff turnover, reduction in peer-to-peer incidents, flu vaccines, reducing falls and developing UTI protocols. Overall, it appeared that based on the documents reviewed were sufficient to show that the DBHDS had the policies this CI requires and that they were being implemented.	

Compliance Indicator	Facts	Analysis	Conclusion
30.9: With respect to Training Centers, DBHDS has processes to review data and trends and ensure effective implementation of the Policy or Departmental Instruction.	The 10/07/2019 *SEVTC "Quality Improvement Program and Quality Council Committee"* policy that describes process requirements relevant to this indicator. The *DBHDS Departmental Instruction 401 (RM) 03 Risk and Liability Management* requires that Training Center has a risk manager whose responsibilities include oversight and operations related to the facility's risk management program. The SEVTC Risk Manager is a voting member of the RMRC. The documentation submitted for review provided evidence of how the Training Center actually implemented the use of risk triggers and thresholds.	The RMRC charter outlines roles and responsibilities of the RMRC to review data and trends identified by providers (including the training center). At the time of the previous study, DBHDS had just begun to integrate SEVTC. For this review, DBHDS had taken the following steps to ensure that, with respect to the Training Center, processes were in place to review data and trends and ensure effective implementation of the Policy and Departmental Instruction. • *Departmental Instruction 316 (QM) 20 Quality Improvement* charter was amended to expand upon the requirements for the Training Center with regard to quality and risk management. • The facility's risk manager is also a voting member of the RMRC. • According to the *RMRC Annual Report SFY 2021,* the RMRC is charged to review, analyze and identify trends related to DBHDS facility risk management programs to reduce or eliminate risks of harm, and to monitor the effective implementation of *DI 401 (Risk and Liability Management)* by reviewing facility data and trends, including risk triggers and thresholds to address risks of harm. In SFY 2021, SEVTC began reporting quarterly data to the RMRC, as above with regard to CI 30.8. based on RMRC meeting minutes from 5/21/21, 8/21/21 and 11/21/21 included presentations by the SEVTC risk manager related to the Training Center's risk management program and systems. For each of those meetings, the SEVTC risk manager made presentations regarding specific elements of the SEVTC risk management program. The presentations addressed data collection and analysis procedures SEVTC employs to identify and appropriately assess risks and take actions, where necessary, to address those risks. The documentation submitted for review also provided evidence of how the Training Center actually implemented the use of risk triggers and thresholds. For example, during monthly monitoring, Training Center staff noted that, in August and September of 2021, there was an upward trend of the utilization of PRN bowel medications. They determined through follow up with staff and chart auditing that a lack of documentation not occurring. They then consulted the dietician to review the individuals meeting the established thresholds and made individual adjustments to the diet if indicated. Staff established and tracked a goal for a 60% reduction in the number of prn medications required for	18th-Not Met 20th-Met

Compliance Indicator	Facts	Analysis	Conclusion
		constipation. Of note, RMRC minutes also reflected that other DBHDS staff in attendance found the SEVTC presentations to be cogent, easy to follow and a possible source of templates for community providers.	
30.10: To enable them to adequately address harms and risks of harm, the Commonwealth requires that provider risk management systems shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such events occur, or the risk is otherwise identified. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do	DBHDS regulations at 12VAC35-105-160.D.2 require providers to report incidents of common risk and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) through the Serious Incident Management system. DBHDS regulations at *12VAC35-105-520.C* require providers to "conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services." DBHDS staff reported that, per the regulations at *12VAC35-105-520.C.5*,	As reported at the time of the 18th Period review, DBHDS has defined incidents of common risk and conditions faced by people with IDD that contribute to avoidable deaths as reportable serious incidents. While there is not otherwise a specific licensing regulation that references these common risks and conditions, their being defined as reportable serious incidents is evidence that the requirement to identify these incidents and to take prompt action when they occur is covered at *12VAC35-105-160.D.2*. In addition, *12VAC35-105-520.B* requires providers to "implement a written plan to identify, monitor, reduce, and minimize harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability," and *12VAC35-105-520.C* requires providers to "conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services." As also previously reported, this study found that DBHDS has in place a triage and review system for serious incidents. If a provider is found not to have reported an incident involving one or more of these types of common risks and conditions that contribute to avoidable deaths, a CAP is required for non-compliance. This system is described with regard to CI 29.2 through CI29.5 above As previously noted, this CI requires that provider risk management systems identify the *incidence* of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such events occur, or the risk is otherwise identified. The term "incidence" refers to the rate of occurrence of a disease, injury or condition in a given population. At the time of the 18th Period review, DBHDS had protocols in place that required providers to report *incidents* of common risks and	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
not have the intended effect, DBHDS takes further action pursuant to V.C.6.	*12VAC35-105-160.C* and *12VAC35-105-620* (i.e., requiring that providers review serious incidents as part of their annual systemic risk assessment including an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents), providers that do not comply with these regulations receive citations and are required to develop corrective action plans. DBHDS reported that during calendar year 2021, 88% of providers were found to comply with the requirement to conduct a quarterly review of all serious incidents but only 84% conducted a review of patterns or trends as part of their annual systemic risk review. DBHDS staff reported that it remains difficult to get provider specific aggregate data from CHRIS. As a result, they did not yet really have the tools yet to facilitate the ability of providers to	conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcer), in practice DBHDS did not yet specifically require providers to incorporate incidence tracking of these conditions into their risk management programs. Therefore, while licensing specialists might have cited providers for not reporting individual incidents of these risks and conditions, they did not cite or require corrective action when providers failed to track and address the incidence of these risks and conditions across their entire populations. An effective risk management program, even at the provider level, should do so. At that time, the OL director stated that plans were being formulated to address expectations that providers include this and related process descriptions in their policies and procedures, and anticipated specific guidance to be drafted after OLS completed analysis of all annual licensing reviews for 2021. For this 20th Period review, DBHDS staff reported that, per the regulations at *12VAC35-105-520.C.5*, *12VAC35-105-160.C* and *12VAC35-105-620* (i.e., requiring that providers review serious incidents as part of their annual systemic risk assessment including an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents), providers that do not comply with these regulations receive citations and are required to develop corrective action plans. DBHDS reported that during calendar year 2021, 88% of providers were found to comply with the requirement to conduct a quarterly review of all serious incidents but only 84% conducted a review of patterns or trends as part of their annual systemic risk review. To help providers understand the link between these regulations and the expectation that they track the incidence of risks/serious incidents, OL conducted a webinar on 12/16/21 which instructed providers on the connection between these regulations and the expectation that they track the incidence of these risks (serious incidents) over time, through their quality improvement programs. DBHDS also reported that OL and the RMRC will continue to track provider compliance with these regulations and evaluate the need for and additional training or other system level intervention later in 2022.	

Compliance Indicator	Facts	Analysis	Conclusion
	make an assessment of the incidence of common risks and conditions. In addition, as noted elsewhere throughout this report, serious incident data was not valid and reliable. Therefore, it was not realistic to expect that provider risk management systems could perform as required. On 11/19/21, the parties jointly filed with the Court a related agreed-upon curative action for CI 43.1 and CI 43.2. This agreement calls for DBHDS to gather information from the QSR process with regard to the requirement for provider-reported measures related to risks that are prevalent in individuals with developmental disabilities. Based on interview with DBHDS staff, they are working to develop the specific questions and common provider measures at this time.	However, in interview, DBHDS staff reported that it remains difficult to get provider specific aggregate data from CHRIS. As a result, they did not yet really have the tools yet to facilitate the ability of providers to make an assessment of the incidence of common risks and conditions. In addition, as noted elsewhere throughout this report, serious incident data was not valid and reliable. Therefore, it was not realistic to expect that provider risk management systems could perform as required. On 11/19/21, the parties jointly filed with the Court a related agreed-upon curative action for CI 43.1 and CI 43.2. This agreement calls for DBHDS to gather information from the QSR process with regard to the requirement for provider-reported measures related to risks that are prevalent in individuals with developmental disabilities. Based on interview with DBHDS staff, they are working to develop the specific questions and common provider measures at this time. As they move forward with this related initiative, they will also need to consider the needs for reliable and valid data described above.	
30.11: For each individual identified at high risk	DBHDS did not have a process in place pursuant to Compliance Indicator 29.19	At the time of the 18th Period review, DBHDS did not have a process in place for providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 or to report this	18th-Not Met 20th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
pursuant to Indicator #6 of V.B, the individual's provider shall develop a risk mitigation plan consistent with the indicators for III.C.5.b.1 that includes the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur. The provider shall implement the risk mitigation plan. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6. .	for providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 or to report this information to the Commonwealth. DBHDS did not have a process in place to track that providers for such individuals developed or implemented a risk mitigation plan consistent with the indicators for III.C.5.b.1 that include the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur. DBHDS did not have a process in place for this specific group of individuals to show or ensure that needed corrective action plans were written and implemented for all providers, including CSBs, that do not meet standards, or that, if corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6.	information to the Commonwealth. Without such a process to identify and track such individuals, DBHDS did not have the ability to track the development or implementation of a risk mitigation plan consistent with the indicators for III.C.5.b.1 that include the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur. Similarly, without these protocols in place, for this specific group of individuals, DBHDS did not have the ability to identify when or if corrective action plans were needed, written and effectively implemented by providers, including CSBs. In addition, it appeared that the licensing processes in place at that time might even minimize the level of surveillance for this group of high-risk individuals rather than heighten it. For example, licensing surveys relied on a statistically significant random sample upon which to draw conclusions about a provider's implementation of the regulatory requirements, including risk identification and risk mitigation planning. Because the population of individuals with risk substantial enough to lead to a determination of a SIS level 6 or 7 is a very small percentage of the total population of individuals served in the DD waivers, their representation in licensing survey samples was also likely be too small to generalize findings to confirm that this Indicator has been properly implemented and met. Based on interview with DBHDS staff at that time, they did not employ any methodology to stratify the sampling process to ensure this group of individuals received the warranted heightened surveillance. For this review, DBHDS provided a document entitled *Protocol for the Identification and Monitoring of Individuals with Complex Behavioral, Health, and Adaptive Support Needs and the Development of Corrective Action Plans required to Address Instances Where the Management of Needs for These Individuals Falls Below Identified Expectations for the Adequacy of Management and Supports Provided*, which was dated 2/7/22, but with a projected implementation date of 4/1/22. It further stated the purpose of the protocol was to confirm that risks and complex support needs related to health and behavioral needs identified by the support team are: 1) included in specific outcomes in the ISP; 2) addressed in the Plan for Supports as evidenced in the support activities and/or support instructions; 3) monitored by the Support Coordinator; and	

Compliance Indicator	Facts	Analysis	Conclusion
		4) remediated by DBHDS when deficiencies are found: The document stated that DBHDS ODQV would pull a statistically stratified annual sample of individuals with SIS level 6 and 7 support needs order to review the ISP (Parts I-V) and the completion of DBHDS tools, including the Risk Awareness Tool (RAT) and On-site Visit Tool (OSVT), to determine if risks are identified, addressed in the ISP, and reviewed over time. Further, as a supplement to the review: • The Office of Integrated Health will review the RAT Summary for each individual to confirm it is consistent with the Essential Information (Part II) of the ISP. • The Office of Integrated Health and the Office of Crisis Services (for behavioral support needs) will review the ISP Shared Planning (Part III) and Plan for Supports (Part V) support needs to confirm that outcomes, support activities, and support instructions exist for each identified need. • The Office of Provider Development will request the OSVTs completed for each individual in the sample for the past 12 months with corresponding progress notes and the Office of Integrated Health and the Office of Crisis Services will review to confirm that needs are reviewed at least quarterly. • The Office of Provider Development will issue a request for corrective actions via email to the respective CSB to explain and/or address discrepancies within 30 days when 1) identified needs are not present in the Essential Information, 2) outcomes, support activities, and support instructions do not address identified needs, or 3) quarterly documentation does not confirm that identified needs have been reviewed and addressed where concerns are identified. • The involved DBHDS Offices will confer on the resolution and determine any additional follow-up needed. • The Office Provider Development will assist providers with outcome and plan development to address issues identified and to improve documentation and related supports. • Any health and safety concerns identified in this review will be referred to the appropriate office to include: the Office of Licensing, the Office of	

Compliance Indicator	Facts	Analysis	Conclusion
		Human Rights, and or Department of Medical Assistance Services as necessary. As noted above, DBHDS identified 4/1/22 as the effective date for this protocol, so it was not in effect during the 20th Period review. Thus, the CI was not met. Going forward, DBHDS will also need to 1) expand upon this protocol to identify the entity responsible for monitoring compliance of any corrective action plans through completion and 2) as described with regard to CI 29.11, promulgate a Process Document to describe the collection of reliable and valid data about the individuals who meet the criteria for inclusion, along with a Data Set Attestation.	

Recommendations

1. Overall, DBHDS staff should continue to focus on finalizing the Process Documents required to show data validity and reliability of the data sets used for compliance reporting and quality improvement. DBHDS might consider expanding the level technical assistance that OCQM provides to SMEs in the development of those documents, including a final review before submission to the CDO, with an emphasis on ensuring that Process Documents identify and address all known data source system deficiencies. (All)
2. DBHDS should continue to provide training and technical assistance to providers and licensing specialists regarding the content requirements for root cause analysis reports to include more examples of reports that meet content requirements with specific emphasis on what is to be included in root cause analysis reports for less critical incidents.
3. While progress was made for this Review Period, DBHDS staff should continue to focus on improving the measurability of quality improvement initiatives and corrective action plans and on the rigorous use of reliable and valid data sets in reviewing their impact and in supporting future related decision-making. (29.10)
4. For public reporting requirements (i.e., the annual Quality Management Plan and Report and the Provider Development Summary), DBHDS should focus on improving timeliness. As discussed with DBHDS staff, they might want to consider separating the Quality Management Plan and the Annual Report . A "Plan" is not typically a retrospective, but should be for the current year and describe to stakeholders what the current processes are/will be (and those might not change significantly from one year to the next, mostly tweaking), while the annual report covers a completed year. Writing a plan for SFY 2022 when that it will have come and nearly be gone might not make as much sense, going forward, as writing plan for 2023, due out perhaps in the first quarter and an annual report for 2022, due out later in SFY 2023.

V.I.1 Analysis of 20th Review Period Findings

Section V.I.1 Assess the Commonwealth's Quality Management System capabilities, documentation and outcomes with regard to the following:
The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice. QSRs shall collect information through: a. Face-to-face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and b. Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers.

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
51.1: The Commonwealth conducts Quality Service Reviews ("QSRs") annually on a sample of providers, with the goal that each provider is sampled at least once every two to three years, comprised of Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs"), to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and preferences	Since 2020, DBHDS has completed QSRs with the current QSR Contractor on an annual basis. Round 1 was conducted between August 2020 through December 2020. Round 2 (R2) was conducted between February 2021 through June 2021. The Round 2 (R2) QSRs were conducted with in-person observations starting April 2021. Round 3 of QSRs began in February 2022 and is scheduled to conclude in June 2022. Round 3 has not yet concluded and data	DBHDS selected the current QSR Contactor through a request for proposals (RFP) to conduct quality services reviews (QSRs) to evaluate the quality of home- and community-based services that are provided through Virginia's HCBS DD Waiver program. The QSR includes two components: Provider Quality Reviews (PQRs) and Person-Centered Reviews (PCRs). DBHDS requires all providers and Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs) [hereafter referred to as CSBs] participate in the QSR process. Since 2022, DBHDS has completed QSRs with the current QSR Contractor on an annual basis. Round 1 was conducted between August 2020 through December 2020. Round 2 (R2 was conducted between February 2021 through June 2021. The Round 2 (R2) QSRs were conducted with in-person observations starting April 2021. Round 3 of QSRs which is also utilizing in-person observations began in November 2021 and is scheduled to conclude in June 2022. The sampling procedure is designed to so that each provider would be sampled at least once every two to three years. However, through Round 2, there were providers who declined to participate. For example, based on the *DBHDS Quality Service Review Annual Summary Fiscal Year 2021*, dated September 30, 2021, in Round 1, 65% of providers declined an in-person interview and observation, while in Round 2, 41% of in-person interviews and observations were declined by either the provider and/or individuals. In response, on June 11, 2021, DBHDS Assistant Commissioner, Developmental	Not Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
	were not yet available to demonstrate that the QSR process included 100% of providers over the three year period. DBHDS had taken assertive actions to address provider non-participation that occurred in the first two Rounds. The QSR process is comprised of Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs").	Services issued a memorandum to notify CSB sand licensed DD service providers that QSR participation was required. The memorandum noted that, in FY 21, DBHDS and the Department of Medicaid Assistance Services (DMAS) became aware of provider refusals to allow QSR reviewers entry to conduct associated visits and observations. As of April 1, 2021 observations were expected to be conducted in person with two exceptions; instances where the provider has an active COVID 19 outbreak, in which case, prohibitions to facility access, is allowable) and in the event that the service(s) slated for review were not provided during the QSR look back period. The memorandum further informed recipients that other reasons for refusal to participate would not be honored by DBHDS. On 10/5/21, the Assistant Commissioner issued a third and final letter to providers who continued to refuse QSR participation as notification they were in violation of regulatory requirements. This letter informed providers that Round 3 QSR reviews were scheduled to begin in October of 2021, and would include those providers that had previously not participated in the QSR review process, and that further refusal to participate may result in referral to the DMAS Office of Provider Integrity. While it was positive that DBHDS had taken assertive actions to address provider non-participation, the outcomes were not yet clear. As described in the Introduction, Round 3 has not yet concluded and data were not yet available to demonstrate that the QSR process included 100% of providers over the three year period (i.e., as required in CI 53.1) The process is comprised of Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs") that are intended to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and preferences. The QSR process also includes a review of documents, such as policies and procedures, licensing information, provider records, support coordinator (SC) records including the ISP. The QSR also includes interviews and observations of individuals and interviews with providers, support coordinators, individual family members and/or substitute decision makers. In the future, there may be other specific requirements related to curative actions the partied have agreed upon for DSP/DSP supervisor competencies and provider reporting measures.	

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
51.2: QSRs utilize information collected from, at a minimum, the following sources for PCRs and PQRs: a. Face-to-face interviews of individual waiver service recipients, family members, or guardians (if involved in the individual's life); case managers; and service providers. b. Record reviews: case management record, the ISP, and the provider's record for selected individuals; the provider's administrative policies and procedures, incident reports, the provider's risk management and quality improvement plans; documents demonstrating compliance with the provider's contractual requirements, as applicable; and the KPA Performance Measure Indicator (PMI) data collected by DBHDS referred to in V.D.2. c. Direct observation of the	The Round 2 and Round 3 methodologies for completion of PCR and PQR tools included face-to-face interviews with individual waiver service recipients, family members, or guardians (if involved in the individual's life), case managers, and service providers, as well as direct observations of the individual waiver service recipient at each of the provider's service sites as applicable for the individuals selected for review. However, for the most recent completed round of QSRs (i.e., Round 2), as described above with regard to CI 51.1, the QSR Contractor was not consistently able to complete the required face-to-face interviews of individual waiver service recipients, family	As previously reported, in many respects, the QSR Contractor documented a thorough methodology for both Round 2 (i.e., *2020 Quality Service Review Methodology*) and Round 3 (i.e., *Round 3 Quality Service Review Methodology*), consistent with the requirements of this compliance indicator. The QSR process includes a review of documents, such as policies and procedures, licensing information, provider records, and support coordinator records including the ISP. In addition, the methodology for completion of PCR and PQR tools included face-to-face interviews with individual waiver service recipients, family members, or guardians (if involved in the individual's life), case managers, and service providers, as well as direct observations of the individual waiver service recipient at each of the provider's service sites as applicable for the individuals selected for review. However, for the most recent completed round of QSRs (i.e., Round 2), as described above with regard to CI 51.1, the QSR Contractor was not consistently able to complete the required face-to-face interviews of individual waiver service recipients, family members, or guardians, case managers and service providers, also resulting in a finding that DBHDS was not able to meet all the requirements for CI 51.2. As also described above, DBHDS took assertive action to inform providers of the requirement to allow face-to-face interviews with case managers and service providers in the currently ongoing Round 3, but, of course, could not impose the same requirement on individual waiver service recipients, family members, or guardians.	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
individual waiver service recipient at each of the provider's service sites (e.g., Residential and/or Day Programs) as applicable for the individuals selected for review.	members, or guardians, case managers and service providers, or to visit each of the individual's service sites.		
51.3: The DBHDS QSR Contractor will: a. Prior to conducting QSRs, develop a communications plan and orient providers to the QSR process and expectations. b. Ensure interviews of individual waiver service recipients are conducted in private areas where provider staff cannot hear the interview or influence the interview responses, unless the individual needs or requests staff assistance and, where not conducted in private, it will be documented. Interviews with provider staff are conducted in ways that do not permit influence from other staff or supervisors.	For this CI, this study based findings on the Round 3 communication plan, which was complete and disseminated to providers by the time of this review. The QSR Contractor also posted the QSR tools, methodologies and other related resources on their website. Of note, however, DBHDS had not posted the Round 3 documents on the DBHDS website; instead, the Round 2 documents were still present. This could be confusing to stakeholders. Of note, with regard to the findings below with	For this CI, the study based findings on the Round 3 communication plan, which was completed and disseminated to providers by the time of this review. The QSR Contractor developed and implemented a communication plan, entitled *Quality Service Review Communication Plan*, prior to conducting this round of QSRs. The QSR Contractor also posted the QSR tools, methodologies and other related resources on their site. Of note, however, DBHDS had not posted the Round 3 documents on the DBHDS website; instead, the Round 2 documents were still present. This could be confusing to stakeholders. Of note, with regard to the findings below with regard to the importance of privacy in interviews, it would be important that individuals, family members and provider staff be informed of the expectations for how and why interviews should maintain privacy. The QSR Contractor's Round 3 methodology and communication plan both indicate that interviews with individuals and families would be scheduled with consideration to their privacy, but did not provide any other details with regard to how they would operationalize or implement any such processes. Based on *Attachment A: QSR Training Content* to the *Round 3 Quality Service Reviews Training Program Plan*, it appeared that the training for QSR staff was intended to provide related instruction with regard to process skills and policy, the related policies and the training materials provided for review did not evidence this. A PowerPoint presentation entitled *On-site Observation Review Process Training 11.17.2021,* briefly mentioned interviews, but did not provide any specific instruction or guidance about the specific steps QSR staff should implement to ensure privacy. The *PCR Companion Guide* did not provide guidance in this area. With regard to interviews with provider staff to be conducted in ways that do not permit	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
	regard to the importance of privacy in interviews, it would be important that individuals, family members and provider staff be informed of the expectations for how and why interviews should maintain privacy. The QSR Contractor's Round 3 methodology and communication plan both indicate that interviews with individuals and families would be scheduled with consideration to their privacy, but did not provide any other details with regard to how they would implement any such processes. Based on *Attachment A: QSR Training Content* to the *Round 3 Quality Service Reviews Training Program Plan*, it appeared that the training for QSR staff	influence from other staff or supervisors, the documentation provided for review also did not provide any specific guidance.	

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
	was intended to provide related instruction with regard to process skills and policy, the related policies and the training materials provided for review did not evidence this.		
51.4 The Quality Service Reviews assess on a provider level whether: a. Services are provided in safe and integrated environments in the community; b. Person-centered thinking and planning is applied to all service recipients; c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary; d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks	At the time of the previous review, this study found that the QSR process did not adequately address the requirement for providers to access treatment for service recipients "as needed." The audit tools appear to start with an assumption that what was reflected in the ISP was a correct and complete identification of an individual's needs. The audit tool did not require sufficient data collection to document whether unidentified or inadequately assessed needs might exist. Guidance materials for first- level reviewers	At the time of the previous review, this study found that the QSR process did not adequately address the requirement for providers to access treatment for service recipients "as necessary." The Independent Reviewer raised concerns that PCR and PQR audit tools did not provide a sufficient mechanism to facilitate a thorough review of whether the person-centered planning process identified individuals' needs. For the most part, the questions with regard to the risk assessment and annual planning assessment did not assess whether the ISP accurately or adequately identified the needs, but focused on determining what assessments, including clinical assessments, if any, the Support Coordinator used to develop the risk and annual planning assessments. The audit tool did not require the reviewer to determine if the underlying assessments were clinically adequate or ask the reviewer to determine if any needed assessments were not available. Instead, the items in the tools largely focused on whether the provider or support coordinator ensured the needs identified in the ISP were addressed, but not whether the ISP accurately or adequately identified the needs. In other words, the audit tools appear to start with an assumption that what was reflected in the ISP was a correct and complete identification of an individual's needs. The audit tool did not require sufficient data collection to document whether unidentified or inadequately assessed needs might exist. The Independent Reviewer's and his consultants' studies have repeatedly found that individuals need assessments that were not recommended by the ISP team. The QSR Contractor had developed a Decision Tree Guide, which was intended to support the first-level reviewer's ability to identify such needs, but it did not appear that first-level reviewers had sufficient training and or background to implement the process effectively, especially when an individual's team and health care providers had already not identified the needs. For example, at the time of the previous review, the	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
and individual protocols; e. Individuals receiving services are provided opportunities for community inclusion; f. Providers have active quality management and improvement programs, as well as risk management programs.	seemed to be missing any significant emphasis on reviewing clinical needs having to do with attainment or maintenance of functional skills through direct or consultative occupational therapy, physical therapy or speech therapy, and whether those needs have been identified and/or addressed. DBHDS staff reported that, following the completion of Round 2 QSRs, they determined that the QSR process and tools needed significant revisions to achieve compliance with the SA and meet the overall intent of the QSR initiative to assess whether services and supports are provided in a manner consistent with the CIs. Based on a crosswalk of the specific PCR and PQR elements the	Independent Reviewer provided feedback that the guidance materials for first- level reviewers seemed to be missing any significant emphasis on reviewing clinical needs having to do with attainment or maintenance of functional skills through direct or consultative occupational therapy, physical therapy or speech therapy, and whether those needs have been identified and/or addressed. Based on review of the PCR and PQR tools for Round 3, the PCR tool had been modified to add some questions about whether the ISP incorporated needs identified in any assessments, the Risk Assessment Tool (RAT) or the Supports Intensity Scale (SIS). This was a positive step forward to address the previously-identified deficiencies in the process. However, this did not yet address or resolve the concerns related to the Decision Tree Guide, as updated on 2/3/22, and the lack of any significant emphasis on reviewing clinical needs having to do with attainment or maintenance of functional skills through direct or consultative occupational therapy, physical therapy or speech therapy, and whether those needs have been identified and/or addressed. In addition, DBHDS staff reported that, following the completion of Round 2 QSRs, they determined that the QSR process and tools needed significant revisions to achieve compliance with the SA and meet the overall intent of the QSR initiative to assess whether services and supports are provided in a manner consistent with the CIs. The DBHDS Assistant Commissioner for Developmental Services led the re-design effort, which was completed in time for implementation with Round 3. However, for this review period, because Round 3 is ongoing and results are not yet available for review and analysis, many of the compliance determinations below are based on results from Round 2. Overall, the acknowledged deficiencies related to the Round 2 tools and processes are reflected in Not Met determinations related to the adequacy of the assessment processes required for CI 51.4, as well as for CI 51.5 and CI 52.1. However, this did not yet address or resolve the concerns related to the Decision Tree Guide, as updated on 2/3/22, and the lack of any significant emphasis on reviewing clinical needs having to do with attainment or maintenance of functional skills through direct or consultative occupational therapy, physical therapy or speech therapy, and whether those needs have been identified and/or addressed. Finally, this study requested a crosswalk or listing of the specific PCR and PQR	

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
	QSR Contractor considers in making the required assessments for criteria a.-f. for this CI , input from individuals, in particular, but also families, was used only minimally in the assessment of provider level findings.	elements the QSR Contractor considers in making the required assessments for criteria a.-f. for this CI, and used the information provided to create a crosswalk, found in a supplemental table below. It was concerning that, based on the crosswalk, input from individuals, in particular, but also families, was used only minimally in the assessment of provider level findings.	
51.5: The Quality Service Reviews assess on a system-wide level whether: a. Services are provided in safe and integrated environments in the community; b. Person-centered thinking and planning is applied to all service recipients; c. Providers keep service recipients safe from harm and access treatment for service recipients as necessary; d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to	At the time of the previous review, this study found that the QSR process did not adequately address the requirement for providers to access treatment for service recipients "as needed." The audit tools appear to start with an assumption that what was reflected in the ISP was a correct and complete identification of an individual's needs. The audit tool did not require sufficient data collection to document whether unidentified or inadequately assessed	The findings described above for CI 51.4 with regard to access treatment for service recipients "as necessary." In addition, the DBHDS assessment that the QSR process and tools needed significant revisions to achieve compliance with the SA and meet the overall intent of the QSR initiative (i.e., to assess whether services and supports are provided in a manner consistent with the CIs), also apply to CI 51.5. In addition, although the PCR included approximately 30 questions in the individual interview, the supplemental table crosswalk created for this CI again demonstrated that input from individuals, in particular, was used only minimally in the assessment of system-wide level findings.	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
individuals are knowledgeable about the person and their service plan, including any risks and individual protocols e. Service recipients are provided opportunities for community inclusion; f. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice.	needs might exist. Guidance materials for first- level reviewers seemed to be missing any significant emphasis on reviewing clinical needs having to do with attainment or maintenance of functional skills through direct or consultative occupational therapy, physical therapy or speech therapy, and whether those needs have been identified and/or addressed. DBHDS staff reported that, following the completion of Round 2 QSRs, they determined that the QSR process and tools needed significant revisions to achieve compliance with the SA and meet the overall intent of the QSR initiative to assess whether services and supports are provided in a manner consistent with the CIs.		

Compliance Indicator	Facts	Analysis	Conclusion 17th **20th**
	Based on a crosswalk of the specific PCR and PQR elements the QSR Contractor considers in making the required assessments for criteria a.-f. for this CI, input from individuals, was used only minimally in the assessment of provider level findings. Without written criteria and related training, the data that comes from these inquiries will not provide reliable data.		

Supplemental Table for CI 51.4

CI 51.4 Provider Level Evaluation The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
a. Services are provided in safe and integrated environments in the community;	#91-For individuals with behavioral support plans, were staff addressing behaviors per the BSP? #92-Were staff adhering to medical and behavioral protocols as outlined in the plan? #93-Did staff appear to understand the person's support needs? #94-Did the staff demonstrate competence in supporting the individual? #97-Are specialized staffing support needs being implemented?	#46-Does the provider promote individual participation in what the individual considers to be meaningful work activities? #48- Does the provider encourage individual participation in community outings with people other than those with whom they live?
b. Person-centered thinking and planning is applied to all service recipients;	#86-Were staff engaging with the individual based on the person's preference and interests? #87-Was the person being offered choices throughout the visit? #88-Was the staff utilizing person first language and talk with the individual as opposed to about the individual?	#22-Does the agency have policies around assurance of individual choice and self-determination? #23-Does the agency have policies around dignity of risk? #46-Does the provider promote individual participation in what the individual considers to be meaningful work activities? #47-Does the provider promote individual participation in non-large group activities? #48- Does the provider encourage individual participation in community outings with people other than those with whom they live? #49-Please explain individuals' rights in the program.
c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary;	#71-Is there evidence of completion of an annual physical exam or valid justification for deferral of the annual exam? #72- Is there evidence of completion of an annual dental exam or valid justification for deferral of the annual exam? #73-Did the provider identify any changes to needs or status? #74-If yes, was there evidence that the provider	#28-Is there evidence that the provider ensured health, safety, and well-being of individuals post-incidents? #50-Please explain the agency's process for addressing what to do when someone is having a medical emergency. #51-Please explain the agency's process for individuals' needs when an individual is having a behavioral or

CI 51.4 Provider Level Evaluation The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	implemented actions to address the changing needs and/or status? #75-Describe any inadequately addressed or previously unidentified change in needs or outcomes/support activities, deficiency in support plan or support implementation, discrepancy between support implementations, services provided, and the individual's strengths and preferences, and/or lack of follow up regarding an individual's stated desires.	psychiatric crisis. #52-When you identify concerns with the process, how do you report those? #53-How are they addressed?
d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols;	#86-Were staff engaging with the individual based on the person's preference and interests? #87-Was the person being offered choices throughout the visit? #88-Was the staff utilizing person first language and talk with the individual as opposed to about the individual? #89-Were staff implementing the Part V as written? #90-If No, describe #91-For individuals with behavioral support plans, were staff addressing behaviors per the BSP? #92-Were staff adhering to medical and behavioral protocols as outlined in the plan? #93-Did staff appear to understand the person's support needs? #94-Did the staff demonstrate competence in supporting the individual? #95-Were there new staff supporting the individual? #96-If yes, was there evidence of oversight and monitoring of the new staff? #97-Are specialized staffing support needs being implemented? #98-What types of adaptive equipment does the individual have as part of their plan?	#32-Does the agency have a hiring policy and procedure? #33-Does the policy include requirements around background checks? #34-Does the agency have an orientation training policy for all staff at all levels? #35-Does the agency have a process written for determining staff competence? #37-How many employee records had proof of background checks? #38-List staff without evidence of background checks #39-How many employee records had documentation of provider-based orientation training? #40-List staff without evidence of orientation training #41. How many employee records have proof of competency-based training? #42-List staff without evidence of competency-based training #43. Number of employees reviewed who serve anyone in SIS tier 4? #44-How many employees serving someone in tier 4 have documentation of advanced competency training? #45-List staff without evidence of advanced competency

CI 51.4 Provider Level Evaluation The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	#99-Are staff familiar with adaptive equipment needs? #100-Were staff utilizing adaptive equipment the individual had as part of their plan? #104-Did you identify any support needs not addressed in the person's plan through your observation? #105-Does the person appear to have any unmet health or behavioral support needs? #106-If yes, describe #107-Are staff able to describe things important to and important for the individual? #108-Was staff able to describe the outcomes being worked on in this environment? #109-Could the staff describe the medical support needs of the individuals? #110-Were staff familiar with medical protocols to support the person? #111-What would staff do if the person experienced a medical crisis? #112-Could the staff describe behavioral support needs? #113-Were staff familiar with behavioral protocols to support the person? #114-What would staff do if the person experienced a mental health or behavioral crisis? #115-. Does the staff know what medications the person is taking? #116-Can the staff list the most common side effects of the medications the person is on? #117-Have there been any events related to the individual's high-risk factors (i.e., aspiration, choking, constipation, falls, etc.)? #118-Did these events warrant and result in a modification to the ISP or protocols? #119-What training did you receive when you were hired?	training

CI 51.4 Provider Level Evaluation The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	#120-What ongoing training do you receive? #121-Do you believe you received all of the training you needed to support the individuals you are serving? #122-If no, what training do you feel you need? #6-The Risk Assessment Tool (RAT) was completed timely. #11-The ISP includes RAT elements and documentation of medication side effect review. #20-The ISP indicates the following life area(s): safety & security and health living, have outcomes identified. #24-The ISP includes strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions. #33-The ISP 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.	
e. Individuals receiving services are provided opportunities for community inclusion;	#20-The ISP indicates the following life area(s): employment, integrated community involvement, community living, safety & security, health living, social & spirituality, citizenship & advocacy have outcomes identified. #29-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. #33-The ISP 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	#46-Does the provider promote individual participation in what the individual considers to be meaningful work activities? #47-Does the provider promote individual participation in non-large group activities? #48-Does the provider encourage individual participation in community outings with people other than those with whom they live?

CI 51.4 Provider Level Evaluation The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences.	
f. Providers have active quality management and improvement programs, as well as risk management programs.	#6-The Risk Assessment Tool (RAT) was completed timely. #11-The ISP includes RAT elements and documentation of medication side effect review. #20-The ISP indicates the following life area(s): safety & security and health living, have outcomes identified. #24-The ISP includes strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions. #33-The ISP 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.	#7-Does the agency have a Risk Management Plan? #8-s the plan thorough? #9-Is the plan complete? #10-Providers proactively identify and address risks of harm and develop and monitor corrective actions. #11-The provider implements risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm. #12-Describe any findings of No/opportunities for improvement related to the Risk Management Plan. #13-Does the agency have a QI policy and procedure? #14-Does the agency have a QI plan? #15-Is the plan thorough? #16-Is the plan complete? #17-The quality improvement plan is reviewed annually. #18-Providers have active quality management and improvement programs. #19-Describe any findings of No/opportunities for improvement related to the Quality Improvement Plan. #20-Does the agency have policies and procedures that address HCBS rights? #21-Are those policies and procedures reviewed with the individuals being served? #22-Does the agency have policies around assurance of individual choice and self-determination? #23-Does the agency have policies around dignity of risk? #24-Does the agency have policies around medical and

CI 51.4 Provider Level Evaluation The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
		behavioral health emergencies?

Supplemental Table for CI 51.5

CI 51.5 System-wide Level Evaluation: The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
a. Services are provided in safe and integrated environments in the community;	#20-The ISP indicates the following life area(s): employment, integrated community involvement, community living, safety & security, health living, social & spirituality, citizenship & advocacy have outcomes identified. #29-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. #33-The ISP 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.	#46-Does the provider promote individual participation in what the individual considers to be meaningful work activities? #48- Does the provider encourage individual participation in community outings with people other than those with whom they live?
b. Person-centered thinking and planning is applied to all service recipients	#86-Were staff engaging with the individual based on the person's preference and interests? #87-Was the person being offered choices throughout the visit? #88-Was the staff utilizing person first language and talk with the individual as opposed to about the individual?	#22-Does the agency have policies around assurance of individual choice and self-determination? #23-Does the agency have policies around dignity of risk? #46-Does the provider promote individual participation in what the individual considers to be meaningful work activities? #47-Does the provider promote individual participation in non-large group activities?

CI 51.5 System-wide Level Evaluation: The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
		#48- Does the provider encourage individual participation in community outings with people other than those with whom they live? #49-Please explain individuals' rights in the program.
c. Providers keep service recipients safe from harm and access treatment for service recipients as necessary;	#71-Is there evidence of completion of an annual physical exam or valid justification for deferral of the annual exam? #72-Is there evidence of completion of an annual dental exam or valid justification for deferral of the annual exam? #73-Did the provider identify any changes to needs or status? #74-If yes, was there evidence that the provider implemented actions to address the changing needs and/or status? #75-Describe any inadequately addressed or previously unidentified change in needs or outcomes/support activities, deficiency in support plan or support implementation, discrepancy between support implementations, services provided, and the individual's strengths and preferences, and/or lack of follow up regarding an individual's stated desires.	#28-Is there evidence that the provider ensured health, safety, and #well-being of individuals post-incidents? #50-Please explain the agency's process for addressing what to do when someone is having a medical emergency. #51-Please explain the agency's process for individuals' needs when an individual is having a behavioral or psychiatric crisis. #52-When you identify concerns with the process, how do you report those? #53-How are they addressed?
d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are	#86-Were staff engaging with the individual based on the person's preference and interests? #87-Was the person being offered choices throughout the visit? #88-Was the staff utilizing person first language and talk with the individual as opposed to about the individual? #89-Were staff implementing the Part V as written? #90-If No, describe #91-For individuals with behavioral support plans, were staff addressing behaviors per the BSP? #92-Were staff adhering to medical and behavioral protocols as outlined in the plan?	#32-Does the agency have a hiring policy and procedure? #33-Does the policy include requirements around background checks? #34-Does the agency have an orientation training policy for all staff at all levels? #35-Does the agency have a process written for determining staff competence? #37-How many employee records had proof of background checks? □#38-List staff without evidence of background checks #39-How many employee records had documentation of provider-based orientation training?

CI 51.5 System-wide Level Evaluation: The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
knowledgeable about the person and their service plan, including any risks and individual protocols	#93-Did staff appear to understand the person's support needs? #94-Did the staff demonstrate competence in supporting the individual? #95-Were there new staff supporting the individual? #96-If yes, was there evidence of oversight and monitoring of the new staff? #97- Are specialized staffing support needs being implemented? #98-What types of adaptive equipment does the individual have as part of their plan? #99-Are staff familiar with adaptive equipment needs? #100. Were staff utilizing adaptive equipment the individual had as part of their plan? #104-Did you identify any support needs not addressed in the person's plan through your observation? #105-Does the person appear to have any unmet health or behavioral support needs? #106-If yes, describe #107-Are staff able to describe things important to and important for the individual? #108-Was staff able to describe the outcomes being worked on in this environment? #109-Could the staff describe the medical support needs of the individuals? #110-Were staff familiar with medical protocols to support the person? #111-What would staff do if the person experienced a medical crisis? #112-Could the staff describe behavioral support needs? #113-Were staff familiar with behavioral protocols to support the person? #114-What would staff do if the person experienced a	#40-List staff without evidence of orientation training #41-How many employee records have proof of competency-based training? #42-. List staff without evidence of competency-based training #43-Number of employees reviewed who serve anyone in SIS tier 4? #44-How many employees serving someone in tier 4 have documentation of advanced competency training? #45-List staff without evidence of advanced

CI 51.5 System-wide Level Evaluation: The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	mental health or behavioral crisis? #115-Does the staff know what medications the person is taking? #116. Can the staff list the most common side effects of the medications the person is on? #117-Have there been any events related to the individual's high-risk factors (i.e., aspiration, choking, constipation, falls, etc.)? #118-Did these events warrant and result in a modification to the ISP or protocols? #119-What training did you receive when you were hired? #120-What ongoing training do you receive? #121-Do you believe you received all of the training you needed to support the individuals you are serving? #122-If no, what training do you feel you need? #6-The Risk Assessment Tool (RAT) was completed timely. #11-The ISP includes RAT elements and documentation of medication side effect review. #20-The ISP indicates the following life area(s): safety & security and health living, have outcomes identified. #24-The ISP includes strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions. #33-The ISP 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.	

CI 51.5 System-wide Level Evaluation: The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
e. Service recipients are provided opportunities for community inclusion;	#20-The ISP indicates the following life area(s): employment, integrated community involvement, community living, safety & security, health living, social & spirituality, citizenship & advocacy have outcomes identified. #29-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. #33-The ISP 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.	#46-Does the provider promote individual participation in what the individual considers to be meaningful work activities? #47-Does the provider promote individual participation in non-large group activities? #48-Does the provider encourage individual participation in community outings with people other than those with whom they live?
f. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice.	#3-Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP? #20-The ISP indicates the following life area(s): employment, integrated community involvement, community living, safety & security, health living, social & spirituality, citizenship & advocacy have outcomes identified. #29-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. #30-The ISP includes signatures of the individual (or representative) and all providers responsible for its implementation. #83-Staff were engaging with the individual base on the person's preference and interest.	#22-Does the agency have policies around assurance of individual choice and self-determination? #23-Does the agency have policies around dignity of risk? #46-Does the provider promote individual participation in what the individual considers to be meaningful work activities? #47-Does the provider promote individual participation in non-large group activities? #48- Does the provider encourage individual participation in community outings with people other than those with whom they live? #49-Please explain individuals' rights in the program.

CI 51.5 System-wide Level Evaluation: The Quality Service Reviews assess on a provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	#84-The individual as being offered choices throughout the visit. #137-Do you like living here? #146-Do you like attending this program? #147-Did you get to choose the people you participate in group with? #153-If you want to go somewhere, does your provider take you? #168 & 169-Do you have a job and/or do you want one, if applicable? #193-Do you feel the ISP is representative of the person's needs (SDM/family interview)?	

V.I.2 Analysis of 20th Review Period Findings

Section V.I.2: QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels.

Compliance Indicator	Facts	Analysis	Conclusion
52.1: The QSRs assess on an individual service-recipient level and individual provider level whether: a. Individuals' needs are identified and	DBHDS staff reported that, following the completion of Round 2 QSRs, they determined that the QSR process and	As described with regard to CI 51.4, DBHDS staff reported that, following the completion of Round 2 QSRs and feedback from the Independent Reviewer's studies' findings, they determined that the QSR process and tools needed significant revisions to achieve compliance with the SA and meet the overall intent of the QSR initiative to assess whether services and supports are provided in a manner consistent with the CIs. The DBHDS Assistant Commissioner for Developmental Services led the re-design	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
met, including health and safety consistent with the individual's desires, informed choice and dignity of risk. b. Person-centered thinking and planning is applied and people are supported in self-direction consistent with their person-centered plans, and in accordance with CMS Home and Community Based Service planning requirements. Person centered thinking and planning: i. Is timely and occurs at times and locations of convenience to the individual. ii. Includes people chosen by the individual. iii. Reflects cultural considerations of the individual. iv. Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency. v. Provides necessary information and support to ensure	tools needed significant revisions to achieve compliance with the SA and meet the overall intent of the QSR initiative to assess whether services and supports are provided in a manner consistent with the CIs. Based on a crosswalk of the specific PCR and PQR elements the QSR Contractor considers in making the required assessments for criteria a.-f. for this CI , input from individuals was used only minimally in the assessment of individual service-recipient level and individual provider level findings.	effort, which was completed in time for implementation with Round 3. However, for this review period, because Round 3 is ongoing and results are not yet available for review and analysis, many of the compliance determinations below are based on results from Round 2. The acknowledged deficiencies related to the Round 2 tools and processes are reflected in Not Met determinations related to the adequacy of the assessment processes required for CI 52.1. In addition, based on the crosswalk of the specific PCR and PQR elements the QSR Contractor considers in making the required assessments for criteria a.-f. for this CI, found in a supplemental table below input from individuals, was used only minimally in the assessment of an individual service-recipient level and individual provider level findings. For example, to assess individual service-recipient level and individual provider level with regard to criteria b (i.e., Person-centered thinking and planning is applied and people are supported in self-direction consistent with their person-centered plans, and in accordance with CMS Home and Community Based Service planning requirements), the QSR Contractor indicated that none of the 30 individual interview questions in the current PCR were applicable.	

Compliance Indicator	Facts	Analysis	Conclusion
that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. vi. Has strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. vii. Offers informed choices to the individual regarding the services and supports they receive and from whom. viii. Records alternative home and community-based settings that were offered to the individual. ix. Includes a method for the individual to request updates to the plan as needed. c. Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible. d. Services and supports are provided in the most integrated setting appropriate to			

Compliance Indicator	Facts	Analysis	Conclusion
individuals' needs and consistent with their informed choice. e. Individuals have opportunities for community engagement and inclusion in all aspects of their lives. f. Any restrictions of individuals' rights are developed in accordance with the DBHDS Human Rights Regulations and implemented consistent with approved plans.			
52.2 Information from the QSRs is used to improve practice and quality of services through the collection of valid and reliable data that informs the provider and person-centered quality outcome and performance results. DBHDS reviews data from the QSRs, identifies trends, and addresses deficiencies at the provider, CSB, and system wide levels through quality improvement processes.	DBHDS staff reported that, following the completion of Round 2 QSRs and feedback from the Independent Reviewer's studies' findings, they determined that the QSR process and tools needed significant revisions to achieve compliance with the SA and meet the overall intent of the QSR initiative to assess whether services and supports are provided in a manner consistent with the CIs. In other	As described with regard to CI 52.1, DBHDS staff reported that, following the completion of Round 2 QSRs and feedback from the Independent Reviewer's studies' findings, they determined that the QSR process and tools needed significant revisions to achieve compliance with the SA and meet the overall intent of the QSR initiative to assess whether services and supports are provided in a manner consistent with the CIs. In other words, the QSR process did not collect valid and reliable data in the most recently completed Round 2. The DBHDS Assistant Commissioner for Developmental Services led a re-design effort, which was completed in time for implementation with Round 3. However, for this review period, because Round 3 is ongoing and results are not yet available for review and analysis, many of the compliance determinations below are based on results from Round 2. However, the QIC and its subcommittees routinely reviewed QSR presentations throughout this 20th Period review, and provided responses to QSR recommendations. It was particularly notable that the RMRC closely scrutinized the findings and compared them with OL results, finding both areas of relative agreement as well as areas of disagreement (e.g., with regard to the implementation of risk management and quality improvement programs.). The RMRC also contributed to the redesign effort by analyzing the construction of certain questions and recommending modifications that would allow	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	words, the QSR process did not collect valid and reliable data in the most recently completed Round 2. The QIC and its subcommittees routinely reviewed QSR presentations and provided responses to QSR recommendations throughout this 20th Period review. In particular, the RMRC closely scrutinized the findings and compared them with OL results, finding both areas of relative agreement as well as areas of disagreement (e.g., with regard to the implementation of risk management and quality improvement programs.). The RMRC also contributed to the redesign effort by analyzing the construction of certain questions and recommending modifications that	more discrete responses.	

Compliance Indicator	Facts	Analysis	Conclusion
	would allow more discrete responses.		
52.3: The summary results of the QSR for each provider (Person-Centered Reviews and Provider Quality Review) will be posted for public review.	DBHDS provided a link to the QSR Round 2 Aggregate Report posted on DBHDS website. This report provided provider-specific results. For Round 3, The QSR Contractor had not yet completed interviews and therefore no reports are yet available.	The QSR Contractor had not yet completed Round 3 interviews and therefore no reports are yet available. However, DBHDS provided a link to the QSR Round 2 Aggregate Report posted on DBHDS website. This report provided provider-specific results.	Not Met **Met**
52.4. Summary data will be provided by the QSR vendor to the QIC for review on a quarterly basis to inform quality improvement efforts aligned with the eight domains outlined in section V.D.3.a-h. The QIC or other DBHDS entity utilizes this data to identify areas of potential improvement and takes action to improve practice and the quality of services at the provider, CSB, and		The QSR Contractor provided summary data to the QIC for quarterly review, aligned with the KPA domains. As described above with regard to CI 52.2, the QIC and its subcommittees routinely reviewed QSR presentations throughout this 20th Period review, and also provided responses to QSR recommendations. Overall, as described below with regard to CI 54.5, QSR recommendations to the QIC sometimes tended to be very broad, which made them somewhat difficult to use to inform quality improvement efforts. It is likely that that need for significant revisions to the QSR tools and processes, as well as the resultant lack of valid and reliable data, were factors in the broadness of recommendations. It was also likely that this impacted the ability of the QIC and subcommittees to provide meaningful responses. However, based on review of the QIC meeting minutes and the CMSC and RMRC presentations for 12/13/21, those subcommittees did respond to each of the recommendations. Many of the responses reported on related work already underway, rather than on requests for additional or specific data that might allow the development of a more focused quality improvement effort. One notable exception to	Not Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion
system-wide levels.		the latter was the RMRC response to the QSR recommendation that protocols for physical and behavioral risks are documented and that ISPs are revised to include outcomes and supports for individuals' risks of harm. The RMRC responded that they would like additional information to further understand how to best address this recommendation, noting that a study of the initial implementation of the fall prevention QII found that 74% of individuals with fall risk in RAT had additional supports incorporated into the ISP. The CMSC often noted specific ongoing initiatives and stated they would incorporate recommendations or possible refer the recommendation to a KPA workgroup.	
52.3: DBHDS shares information from the QSRs with providers and CSBs in order to improve practice and the quality of services.	DBHDS provided a link to the QSR Round 2 Aggregate Report posted on DBHDS website. This report provided provider-specific results. The *QSR Round 2 Aggregate Report* provided specific recommendations providers and CSBs in order to improve practice and the quality of services in each of three KPA domains. For Round 3, the QSR Contractor had not yet completed interviews and therefore no reports are yet available.	The QSR Contractor had not yet completed Round 3 interviews and therefore no reports are yet available. However, DBHDS provided a link to the *QSR Round 2 Aggregate Report* posted on DBHDS website. This report provided provider-specific results. The *QSR Round 2 Aggregate Report* provided specific recommendations to providers and CSBs in order to improve practice and the quality of services in each of three KPA domains. For Health, Safety, and Well-Being Elements, recommendations included: • CSBs and providers develop and implement an active quality improvement program sufficient to identify and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. • CSBs and providers develop a process to document annual review of its quality improvement plan. • CSBs and providers develop and implement an active quality improvement program sufficient to identify and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. • Protocols for physical and behavioral risks are documented, and that ISPs are revised to include outcomes and supports for individuals' risks of harm. For Community Integration and Inclusion Elements, recommendations included: • CSBs have a plan to ensure support coordinators' ISP documentation confirms that individuals' assessments are completed annually.	Not Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion
		• CSBs and providers have a plan to ensure that ISP documentation confirms that quarterly review of the ISP is conducted with the individual. • CSBs document the interventions and supports used prior to the modification of ISPs to show all interventions were attempted even and the less intrusive methods of meeting the need of the individual. This will give a more comprehensive overview and show more knowledge of individual preferences/needs. • CSBs ensure support coordinators revise the ISP based on the assessed changing needs and desires of individuals. • CSBs ensure support coordinator understanding of the expectation for documentation of activities and efforts made to address individual risk. CSBs should provide additional clinical-based training to support coordinators that assists with identification of risks, needs, and change in status. For Provider Competency and Capacity Elements, recommendations included: • CSBs retrain the support coordinators on expectations for timely contacts, and/or implementation of audits to identify and address any process improvement needs. • CSBs retrain the support coordinators on expectations for timely contacts. • CSBs and providers develop a process and maintain documentation that demonstrates DSPs receive ISP-specific training. The process must include documentation of training completion • CSBs and providers document how the support staff/sponsor home providers successfully complete and on an on-going bases receive competency-based training related to elements of the individuals support plan.	
52.4: Whenever a QSR reviewer identifies potential abuse, neglect, or exploitation, a potential rights restriction in the absence of an approved plan, or a rights restriction implemented inconsistently with the	For both Round 2 and Round 3, the QSR methodologies required that if during the review process a reviewer identifies potential abuse, neglect, or exploitation of the individual or a potential	For Round 2, the *2020 Quality Service Review Methodology* stated that, if during the review process a reviewer identifies potential abuse, neglect, or exploitation of the individual or a potential rights restriction in the absence of an approved plan, or if the rights restriction is implemented inconsistently with the approved plan, the reviewer will make a referral to DBHDS Human Rights and/or the Department of Social Services Adult/Child Protective Services, as applicable within 24 hours of identification. During Round 2, DBHDS and the QSR Contractor also implemented a laudable Health, Safety and Welfare Alert program. Based on the documentation provided for	Not Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion
approved plan, the reviewer shall make a referral to the DBHDS Office of Human Rights and/or the Department of Social Services adult/child protective services, as applicable.	rights restriction in the absence of an approved plan, or if the rights restriction is implemented inconsistently with the approved plan, the reviewer will make a referral to DBHDS Human Rights and/or the Department of Social Services Adult/Child Protective Services, as applicable within 24 hours of identification. During Round 2, DBHDS and the QSR Contractor also implemented a l Health, Safety and Welfare Alert program and created a reporting template for QSR reviewers to use to report to DBHDS the circumstances of any reportable potential abuse, neglect, or exploitation of the individual or a potential rights restriction.	review, DBHDS created a reporting template for QSR reviewers to use to report to DBHDS the circumstances of any reportable potential abuse, neglect, or exploitation of the individual or a potential rights restriction (*Final Round 2 QSR_ HSW Alert Template 2.3.2021*). DBHDS and the QSR Contractor also developed and provided a video training module to the QSR reviewers with regard to the expectations for reporting and the use if the reporting template. Based on a review of a sample of Alerts QSR reviewers submitted in Round 2, QSR reviewers were providing well-detailed descriptions that allowed DBHDS staff to take important follow-up actions. A designated QSR Review Team monitored the Alerts and their resolutions. The *Round 3 Quality Service Review Methodology* states that, if during the review process a reviewer identifies potential abuse, neglect, or exploitation of the individual or a potential rights restriction in the absence of an approved plan, or if the rights restriction is implemented inconsistently with the approved plan, the reviewer will make a referral to DBHDS Human Rights and/or the Department of Social Services Adult/Child Protective Services, as applicable within 24 hours of identification. Copies of these referrals will be sent to both the DBHDS QSR Coordinator and the back-up designee identified by DBHDS. Presumably the "referrals" are the Alerts, but DBHDS should ensure the QSR Contractor provides a more detailed description of the process and its requirements. Based on a review of the training content and materials provided for review, training the Alert process remained in effect for Round 3.	

Supplemental Table for CI 52.1

CI 52.1 Individual Service Recipient and Individual Provider Level Evaluation: The Quality Service Reviews assess on an individual service-recipient level and individual provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
a. Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk. (Health, Safety and Well-being)	#71- The provider documentation review indicates the completion of an annual physical exam or a valid justification for deferral of the annual exam. #72-The provider documentation review indicates the completion of an annual dental exam or a valid justification for deferral of the annual exam. #4-Were there any medical needs identified in the SIS or any other assessment that were not addressed in the ISP? #5-Were there any behavioral needs identified in the SIS or any other assessment that were not addressed in the ISP? #6-The Risk Assessment Tool (RAT) was completed timely. #11-The ISP includes RAT elements and documentation of medication side effect review. #20-The ISP indicates the following life area(s): safety & security and health living, have outcomes identified. #24-The ISP includes strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions. #33-The ISP 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. #83-Is the individual's environment neat and clean? #84-Was the person's environment accessible? #85- Does the individual appear well kempt?	Not Applicable

CI 52.1 Individual Service Recipient and Individual Provider Level Evaluation: The Quality Service Reviews assess on an individual service-recipient level and individual provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	#101-Was any equipment in need of repair and/or has repair or follow up on repair been occurring? #105-Does the individual have any unmet health or behavioral support needs? #115 and 116- Does staff know what medications the individual is taking and the common side effects of the medication, if applicable? #117-Have there been any events related to the individual's high-risk factors (i.e., aspiration, choking, constipation, falls, etc.)? #170-Do you feel safe here, if not why? #190-Does the individual have any needs or supports that are currently not being met (support decision maker/family interview)?	
a. Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk. (Individual's Desires, Informed Choice and Dignity of Risk)	#3 – Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP? #20-The ISP indicates the following life area(s): employment, integrated community involvement, community living, safety & security, health living, social & spirituality, citizenship & advocacy have outcomes identified. #29-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. #30-The ISP includes signatures of the individual (or representative) and all providers responsible for its implementation. #83-Staff were engaging with the individual base on the person's preference and interest. #84-The individual as being offered choices throughout the visit.	#22-Does the agency have policies around assurance of individual choice and self-determination? #23-Does the agency have policies around dignity of risk? #46-Does the provider promote individual participation in what the individual considers to be meaningful work activities? #47-Does the provider promote individual participation in non-large group activities? #48- Does the provider encourage individual participation in community outings with people other than those with whom they live? #49-Please explain individuals' rights in the program.

CI 52.1 Individual Service Recipient and Individual Provider Level Evaluation: The Quality Service Reviews assess on an individual service-recipient level and individual provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	#137-Do you like living here? #146-Do you like attending this program? #147-Did you get to choose the people you participate in group with? #153-If you want to go somewhere, does your provider take you? #168 & 169-Do you have a job and/or do you want one, if applicable? #193-Do you feel the ISP is representative of the person's needs (SDM/family interview)?	
b. Person-centered thinking and planning is applied and people are supported in self-direction consistent with their person-centered plans, and in accordance with CMS Home and Community Based Service planning requirements. Person centered thinking and planning: i. Is timely and occurs at times and locations of convenience to the individual. ii. Includes people	Not applicable	#20-Does the agency have policies and procedures that address HCBS rights? #21Are those policies and procedures reviewed with the individuals being served?

CI 52.1 Individual Service Recipient and Individual Provider Level Evaluation: The Quality Service Reviews assess on an individual service-recipient level and individual provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
chosen by the individual. iii. Reflects cultural considerations of the individual. iv. Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency. v. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. vi. Has strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all		

CI 52.1 Individual Service Recipient and Individual Provider Level Evaluation: The Quality Service Reviews assess on an individual service-recipient level and individual provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
planning participants. vii. Offers informed choices to the individual regarding the services and supports they receive and from whom. viii. Records alternative home and community-based settings that were offered to the individual. ix. Includes a method for the individual to request updates to the plan as needed.		
c. Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible.	#24-the ISP includes strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions. #33-The ISP 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. #71-Did the provider identify any changes to needs or status?	Not applicable

CI 52.1 Individual Service Recipient and Individual Provider Level Evaluation: The Quality Service Reviews assess on an individual service-recipient level and individual provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	#72-If yes, was there evidence that the provider implemented actions to address the changing needs and/or status?	
d. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice.	#3- Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP? #20-The ISP indicates the following life area(s): employment, integrated community involvement, community living, safety & security, health living, social & spirituality, citizenship & advocacy have outcomes identified. #29-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. #30-The ISP includes signatures of the individual (or representative) and all providers responsible for its implementation. #86-Staff were engaging with the individual base on the person's preference and interest. #87-The individual as being offered choices throughout the visit. #137-Do you like living here? #146-Do you like attending this program? #147-Did you get to choose the people you participate in group with? #153-If you want to go somewhere, does your provider take you? #168 & 169-Do you have a job and/or do you want one, if applicable? #193-Do you feel the ISP is representative of the person's needs (SDM/family interview)?	#46-Does the provider promote individual participation in what the individual considers to be meaningful work activities? #47-Does the provider promote individual participation in non-large group activities? #48-Does the provider encourage individual participation in community outings with people other than those with whom they live? #49-Please explain individuals' rights in the program.
e. Individuals have	#20-The ISP indicates the following life area(s):	#46-Does the provider promote individual

CI 52.1 Individual Service Recipient and Individual Provider Level Evaluation: The Quality Service Reviews assess on an individual service-recipient level and individual provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
opportunities for community engagement and inclusion in all aspects of their lives	employment, integrated community involvement, community living, safety & security, health living, social & spirituality, citizenship & advocacy have outcomes identified. #29-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. #33-The ISP 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.	participation in what the individual considers to be meaningful work activities? #47-Does the provider promote individual participation in non-large group activities? #48-Does the provider encourage individual participation in community outings with people other than those with whom they live?
f. Any restrictions of individuals' rights are developed in accordance with the DBHDS Human Rights Regulations and implemented consistent with approved plans.	#28- The ISP and/or other documentation confirmed review of the ISP was conducted with the individual quarterly or every 90 days. #29-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. #33-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. #34-Describe any inadequately addressed or previously unidentified risk, injury, need, change in status, deficiency in support plan or support implementation, and/or	#14-Does the agency have a QI plan? #17-The quality improvement plan is reviewed annually. #18-Providers have active quality management and improvement programs. #23-Does the agency have policies around dignity of risk? #44-How many employees serving someone in tier 4 have documentation of advanced competency training?

CI 52.1 Individual Service Recipient and Individual Provider Level Evaluation: The Quality Service Reviews assess on an individual service-recipient level and individual provider level whether:		
Requirement	PCR Tool Element	PQR Tool Element
	discrepancy between support implementations, services provided, and the individual's strengths and preferences #51-Was the individual receiving ECM or TCM? How did you make this determination? #73-Did the provider identify any changes to needs or status?	

V.I.3 Analysis of 20th Review Period Findings

Section V.I.3: The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate. The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.

Compliance Indicator	Facts	Analysis	Conclusion
53.1: 100% of reviewers who conduct QSRs are trained and pass written tests and/or demonstrate knowledge and skills prior to conducting a QSR, and reviewer qualifications are commensurate to what they are expected to review.	Based on review of the Round 3 QSR Staffing Plan, dated 11/10/21, the QSR Contractor now requires that all QSR team members have at least three years of ID/DD experience and pass all competency tests.	The Independent Reviewer has previously found that this CI requires reviewers to have adequate training to make clinical judgments themselves, or to have access to clinical consultants to ensure sufficient evaluation. The Independent Reviewer also provided ongoing feedback as to whether the previously submitted QSR Contractor's processes would adequately address issues of clinical adequacy, related to reviewer qualifications commensurate to what they are expected to review and to the training and competency testing proposed. The following describes a summary of findings and concerns the Independent Reviewer has previously communicated to DBHDS with regard to the requirements of this compliance indicator, including any updates provided for this 20th Period review,	Not Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion
	Training materials submitted for this review expanded upon those provided in previous reviews, particularly with regard to knowledge related to licensing, risk management and quality improvement requirements, HCBS settings and DSP competencies.	The Independent Reviewer's feedback expressed concern with regard to the minimum qualifications for "non-clinical" or "first-line" reviewers (i.e., those who would have front-line responsibility for completing the QSR process) and how this could impact their ability to recognize potentially unmet clinical needs and refer them for additional scrutiny. He indicated that minimum qualifications for this role should describe the kinds of experience and knowledge needed by someone (i.e., a QIDP) responsible for the development and oversight of the implementation of an ISP. Because the QSR essentially asks the auditor to assess the development and oversight of the implementation of ISPs, the auditor would need to meet specific minimum criteria regarding their qualifying experience. Further, he indicated that "In order to be adequately prepared to evaluate the development and implementation of an ISP, the auditor should have a minimum number of years (i.e., 3-5 years) completing such work, or closely-related work, including a minimum level of specific experience in the field of developmental disabilities." Based on review of the *Round 3 QSR Staffing Plan*, dated 11/10/21, the QSR Contractor now requires that all QSR team members have at least three years of ID/DD experience and pass all competency tests. It was also positive to see that the training materials submitted for this review expanded upon those provided in previous reviews, particularly with regard to knowledge related to licensing, risk management and quality improvement requirements, HCBS settings and DSP competencies.	
53.2: Each provider will be reviewed by the QSR at least once every two to three years. Where possible, the QSR samples will target providers that are not subject to other reviews (such as NCI reviews) during the year. Sufficient information is gathered through the samples	As described with regard to CI 51.1, DBHDS did not yet have sufficient data to determine that each provider was reviewed by the QSR at least once every two to three years. These data should be available after the conclusion of Round 3.	As described with regard to CI 51.1, DBHDS did not yet have sufficient data to determine that each provider was reviewed by the QSR at least once every two to three years. These data should be available after the conclusion of Round 3.	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
reviewed to draw valid conclusions for each individual provider reviewed.			
53.3: To address the requirements of a look-behind, inter-rater reliability has been assessed for each reviewer annually, with 80% or higher target against another established reviewer or a standardized scored review, using either live interviewing and review of records or taped video content. Any reviewer who does not meet the reliability standards is re-trained, shadowed, and retested to ensure that an acceptable level of reliability has been achieved prior to conducting a QSR. The contract with the vendor will include a provision that during reliability testing, the reviewer does not have any access to other reviewers' notes or scores and cannot discuss their rating with other	This review examined the IRR procedures for both the completed Round 2 and for the ongoing Round 3. Both the Round 2 *2020 Quality Service Review Methodology* and the Round 3 *Interrater Reliability Quality Assurance Policy*, dated 11/1/21, stated that all QSR reviewers are expected to achieve and maintain a confidence level of 95%, based on results of IRR. This was well above the criteria of 80% required by the CI. However, while the current contractors' Round 2 methodology specified the number of tools required to demonstrate a 95% rate IRR for each reviewer, at the time of training, during live reviews and	This review examined the IRR procedures for both the completed Round 2 and for the ongoing Round 3. Many of the procedures remained the same, but some differences did exist, as described below. At the time of the previous review for this CI, the QSR Contractor described an IRR methodology, calling for a "gold reviewer" (a subject matter expert and/or Team Lead) to "over-read" the work of first level reviewers during training and on an ongoing basis thereafter. At the time of the previous review, the study found it was concerning that a Team Lead, who could conceivably have no IDD experience, would have responsibility for confirming the competency of first-level non-clinical reviewers, who might also have no such experience. This seemed a recipe for a potential lack of reliability of the data collected through the QSR process. For Round 2 QSRs, the *2020 Quality Service Review Methodology* remained in effect and included the specifications for the IRR process, including the gold reviewer role. For Round 3, the QSR Contractor provided a separate *Interrater Reliability Quality Assurance Policy*, dated 11/1/21. The Round 3 policy also identified "gold reviewers," who complete an over-read of a QSR reviewer's tools upon completion of a review. However, it was positive to see that for Round 3, the Team Lead job description required a minimum of three years of experience in long term supports and services, developmental disabilities and intellectual disabilities. This should provide an extra layer of reliability in the IRR process. Both the 2020 Round 2 methodology and the Round 3 policy stated that all QSR reviewers are expected to achieve a confidence level of 95%, based on results of IRR. This was well above the criteria of 80% required by the CI. For those QSR reviewers who do not attain the 95 percent rate for these reviews, re-training will be conducted, and IRR will continue on all QSR tools until the QSR reviewer achieves and maintains a 95% level and is then moved to ongoing IRR of five percent of completed reviews. Both documents also note that in some circumstances, removal from the review team might be necessary if the confidence level cannot be reached.	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
reviewers prior to submission.	then on an ongoing basis, the Round 3 policy did not. Both documents identified "gold reviewers," who complete an over-read of a QSR reviewer's tools upon completion of a review. It was positive to see that for Round 3, the Team Lead job description required a minimum of three years of experience in long term supports and services, developmental disabilities and intellectual disabilities. This should provide an extra layer of reliability in the IRR process for the current Round and going forward. The contract with the QSR Contractor provided for review (i.e., the signed 720-4758 Agreement, dated 4/2/20) did not appear to include a provision that during reliability	The *2020 Quality Service Review Methodology* for Round 2 indicated that IRR is completed during training as well as during live QSRs. During training, first level QSR reviewers were required to complete testing environment PQRs and PCRs, using training scenarios that replicate documentation review, interview, and observation elements required during live QSRs. IRR were to be conducted on two PQRs and three PCRs per first level QSR reviewer to determine achievement of the 95 percent confidence level. During live review, IRR were to be conducted on the first two PQRs and first three PCRs for each first level QSR reviewer to determine achievement of the 95 percent confidence level. On an ongoing basis, IRR was to be conducted during each QSR round on five percent of completed reviews for each first level QSR reviewer. The Round 3 policy stated IRR will be conducted on PQRs and PCRs per QSR reviewer to determine achievement of the 95 percent confidence level, but did not specify a minimum number of tools to be reviewed for each reviewer during training, live reviews or on an ongoing basis. The current policy should be clarified to describe the minimum number of IRRs per QSR reviewer to provide a valid and reliable sample. Based on review of the contract with the vendor provided for review (i.e., the signed 720-4758 Agreement, dated 4/2/20) it did not appear to include a provision that during reliability testing, the reviewer does not have any access to other reviewers' notes or scores and cannot discuss their rating with other reviewers prior to submission. In addition, based on review of the Round 2 QSR Methodology and the Round 3 *Interrater Reliability Quality Assurance Policy*, neither specified such a requirement. The contract states that the QSR process will ensure that any reviewer who does not meet the reliability standards has been re-trained, *shadowed*, and retested to ensure acceptable levels of reliability have been achieved prior to conducting QSRs. However, neither the Round 2 QSR Methodology or the Round 3 *Interrater Reliability Quality Assurance Policy* specifically referenced any on-site shadowing of QSR reviewers, either during training or as a part of IRR.	

Compliance Indicator	Facts	Analysis	Conclusion
	testing, the reviewer does not have any access to other reviewers' notes or scores and cannot discuss their rating with other reviewers prior to submission. In addition, based on review of the Round 3 QSR IRR Policy, entitled *Interrater Reliability Quality Assurance Policy*, it did not specify such a requirement. The contract states that the QSR process will ensure that any reviewer who does not meet the reliability standards has been re-trained, *shadowed*, and retested to ensure acceptable levels of reliability have been achieved prior to conducting QSRs. However, the *Interrater Reliability Quality Assurance Policy* did not specifically reference any on-site shadowing of QSR reviewers, either during training as a part of IRR.		

Compliance Indicator	Facts	Analysis	Conclusion
53.4: QSR reviewers receive and are trained on audit tools and associated written practice guidance that: a. Have well-defined standards including clear expectations for participating providers. b. Include valid methods to ensure inter-rater reliability. c. Consistently identify the methodology that reviewers must use to answer questions. Record review audit tools should identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation). d. Explain how standards for fulfilling requirements, such as "met" or "not met", will be determined. e. Include indicators to comprehensively assess whether services and supports meet individuals' needs and the quality of service provision.	For this CI, the study based findings on Round 3 training procedures and tools, all of which were complete at the time of this review. The QSR Contractor provides the reviewers with the PCR and PQR audit tools, training and written guidance, including the *QSR PCR Companion Guide.* Overall, the audit tools and companion guide described the methodology (e.g., interview, record reviews, observations) QST reviewers must use to answer questions, including the identification of the data source (e.g., ISP in WaMS). Tools often explained how standards for fulfilling requirements, such as "met" or "not met", would be	For this CI, the study based findings on Round 3 training procedures and tools, all of which were complete at the time of this review. The QSR Contractor provides the reviewers with the PCR and PQR audit tools, training and written guidance, including the *QSR PCR Companion Guide.* In many cases, the tools provided clear and comprehensive guidance about where to find needed documentation and explained the standards (i.e., for determining whether an indicator was met or not met). Overall, the audit tools and companion guide described the methodology (e.g., interview, record reviews, observations) QST reviewers must use to answer questions, including the identification of the data source (e.g., ISP in WaMS). While in many instances, the tools explained how standards for fulfilling requirements, such as "met" or "not met", would be determined, it was often unclear what criteria the QSR reviewer should apply to determine a "met" or "not met" status with regard to individual participant interviews. Most of the interview questions were posed to elicit a yes/no response, but the tools also offered multiple probes QSR reviewers could employ, presumably to assist in clarifying the question for the interviewee, but also to prompt the reviewer to provide narrative notes. For a number of questions, it was not clear how responses to the probes would impact the yes or no finding. For example, for the yes/no question "Do you feel safe here", the probes included: do you feel safe at this program? Do you feel safe while out in the community with your staff? Do you practice emergency drills? Do you know what to do in an emergency here? It was unclear whether yes responses to the knowledge of emergency needs would be sufficient to result in a yes answer, especially in the absence of responses to the other probes. For a yes/no question "Do you participate in your banking," probes included: Who helps you with your budget? Do you have a rep payee? Who manages your funds? Do you participate in paying bills? If you want to buy something, can you? It also provides guidance that participating by being present for drive-through banking would be included, noting that this element represents the individual's perception of whether or not he/she participates. It was unclear, for example, that being present for drive-through banking would be a sufficient indicator of meaningful participation in banking for many individuals. In addition, as discussed above with regard to CI 53.2, some issues remained with regard to having met the criteria for a reliable and valid IRR process.	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	determined. However, it was often unclear what criteria the QSR reviewer should apply to determine a "met" or "not met" status with regard to individual participant interviews. In addition, as discussed above with regard to CI 53.2, some issues remained with regard to having met the criteria for a reliable and valid IRR process.		

Recommendations:

1. DBHDS should ensure the QSR Contractor's methodologies, policies, procedures and protocols clearly address all of the requirements of each of the CIs (e.g., interview privacy and HSW Alert protocols.)
2. DBHDS should ensure the QSR Contractor develops and implements additional training, tool questions and protocols to address gaps with regard to previously unidentified needs (e.g., the lack of any significant emphasis on reviewing clinical needs having to do with attainment or maintenance of functional skills through direct or consultative occupational therapy, physical therapy or speech therapy, and whether those needs have been identified and/or addressed.)
3. The QSR Contractor's current policies should also be clarified to describe the minimum number of IRRs per QSR reviewer to provide a valid and reliable sample and that policies, procedure and protocols address all the requirements specified in the CI 53.3.
4. In line with the person-centered focus of the PCR, DBHDS should ensure that feedback from individual interviews are incorporated in all individual-level, provider-level and system-wide assessments. DBHDS should ensure the QSR Contractor evaluates and makes needed modifications to the criteria it currently uses, as outlined in the documentation provided for this review, in the evaluation processes.

Attachment A: Interviews

1. Heather Norton, Assistant Commissioner at Department of Behavioral Health and Developmental Services
2. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Government Relations
3. Alexis Aplasca, Chief Clinical Officer
4. Katherine Means, Senior Director of Clinical Quality Management
5. Jae Benz, Director of Licensing;
6. Jenni Schodt, Settlement Agreement Coordinator
7. Stella Stith, IMU Manager
8. Melanie Murphy, SEVTC Facility Risk Manager
9. Jodi Kuhn, Data Quality and Analytics Coordinator
10. Eric Williams, Director of Provider Development;

Attachment B: Documents Reviewed

1. SFY21 Draft DD QM Plan Draft
2. QM Program Assessment Tool for DBHDS 2-2020 updated 6.17.2021
3. Quality Committees Policy & Procedure 2.9.2022
4. PMI Development and Annual Review Processes Final 2 10 22
5. Internal Quality Committee Membership Roster as of 1.31.2022
6. QIC meeting minutes and materials 6/28/21
7. QIC meeting minutes and materials 9/27/21
8. QIC meeting minutes and materials 12/13/21
9. QIC meeting minutes and materials 3/28/21
10. QIC Subcommittee meeting minutes and materials April 2021-January 2022
11. PMI Tracker Inc Annual PMI Review Updated 1.28.22
12. Visio-VAQSR_Org as of 2.9.22
13. Quality Committee Structure 8.30.2019
14. QMP and QSR Public Access Final 8 31 21
15. DI 316 QualityManagement.REVISED.2021.04.07
16. NCI Meeting Agendas 4/27/21-9/14/21
17. NCI Meeting Notes April 2021-November 2021
18. 520 and 160 Protocol Revised February 2022_final
19. List of CSBs Services for Study BOX.xlsx – 01/28/2022
20. 4th Quarter Inspections – CHRIS.xlsx – 01/28/2022
21. CSB Assignment Areas Region.docx – 01/28/2022
22. QI Look Behind Process 4-1-2021 (2).pdf – 01/29/2022
23. QI Look Behind Process 4-1-2021 (2) (1).pdf – 01/29/2022
24. Final DBHDS Org Chart 06092020.pdf (listed for 29.1 & 29.10) – 02/11/2022
25. QM Program Assessment Tool for DBHDS 2-2020 updated 06-17-2021.pdf (listed for
26. DQV Documents List for 20th Review Period.pdf – 02/14/2022
27. Source System Data Quality Roles and Responsibilities – Jan 2022.pdf – 02/14/2022
28. D&D Gentle Touch, LLC – 2480-01-001.pdf – 02/18/2022
29. Providence Healthcare Services, LLC – 3355-01-001.docx – 02/18/2022
30. Richmond Residential Services, Inc. 163-01-001.pdf – 02/18/2022
31. Richmond Residential Services, Inc. 163-01-001.pdf – 02/18/2022
32. Richmond Residential Services, Inc. 163-03-011.pdf – 02/18/2022
33. Good Neighborhood Homes, Inc. 1764-01-001.pdf – 02/18/2022
34. Destin Pathways 2689-02-008.pdf – 02/18/2022
35. Bridges of Virginia 3126-03-011.pdf – 02/18/2022
36. Total Quality Residential Services, Inc. 1223-01-001.pdf – 02/18/2022
37. Life Line Residential Services & OT Consultant Group 672-01-001.docx – 02/18/2022
38. Everyday Angels, LLC 1611-02-008.pdf – 02/18/2022
39. Everyday Angels, LLC 1611-01-001.pdf – 02/18/2022
40. Middle Peninsula-Northern Neck Community Services Board 018-03-001.pdf –02/18/2022
41. Middle Peninsula-Northern Neck Community Services Board 01-01/001.pdf – 02/18/2022
42. Middle Peninsula-Northern Neck Community Services Board 018-16-002.pdf – 02/18/2022
43. Felts Supports for Living 2015-01-001.pdf – 02/18/2022
44. Taylor's Enhanced Living, Inc. 839-02-006.pdf – 02/18/2022
45. Taylor's Enhanced Living, Inc. 839-01-001.pdf – 02/18/2022
46. New Beginning, Inc. 001-01-001.pdf – 02/18/2022
47. New Beginning, Inc. 001-02-006.pdf (no violation) – 02/18/2022
48. Zuriel, LLC 3107-01-001.pdf – 02/18/2022
49. Collaborative Community, LLC 3495-01-001.docs – 02/18/2022
50. Best Hope Community Residential Services 2824-01-001.docs – 02/18/2022

51. A Beautiful Life 1250-01-001.pdf – 02/18/2022
52. St. Vincent's Home 3212-02/006.pdf – 02/18/2022
53. St. Vincent's Home 3212-02-008.pdf – 02/18/2022
54. St. Vincent's Home 3212-03-011.pdf – 02/18/2022
55. Virginia Administrative Code - 12VAC35-105-160. Reviews by the department; requests for information; required reporting
56. Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services.docx – 01/19/2022
57. DD Providers Incidents June 2021-November 2021.xlsx
58. SFY22 RMRC Work Plan as of 1.31.22.pdf – 02/10/2022
59. IMU Report for RMRC–Q2 SFY22 – 03/16/2022
60. OL Annual Checklist Compliance Determination Chart – FY2021.docx – 01/19/2022
61. 2022 OL Annual Checklist Compliance Determination Chart.docx – 02/18/2022
62. 8nspections Completed 07/01/2021-12/31/2021 – 02/09/2022
63. 4th Quarter Inspections-Chris.xlsx – 01/28/2022
64. All Compliance 520, 620, 160 Revised.xlsx – 02/11/2022
65. CHRIS DD DSI Late Report Data 7-1-2021-02-14-2022.xlsx – 02-15-2022
66. Licensing Regulatory Compliance with 12VAC35-105-160 CY2021.xlsx – 03/25/2022
67. NS Citation Template General Regs 2022 CONNECT.docx – 02/18/2022
68. Final 160 Protocol for DD Providers.docx – 02/18/2022
69. Internal 160 Protocol for DD Providers Combined CAP Templates for Serious Incident Reporting II.pdf – 02/18/2022
70. Process Document 29.3, 29.5, 29.15 Monitoring Serious Incidents.docx – 01/19/2022
71. \Memo 12-2-2021 To All Providers Regarding 2022 Inspections (1).pdf – 02/18/2022
72. Memo to Providers and Template DD Inspection 2022.docx – 02/18/2022
73. CHRIS System Training February 2021.pptx – 02/18/2022
74. CHRIS System Training May 2021.pdf – 02/17/2022
75. OL Staff Meeting RM Regs 2-17-2022.pdf – 02/18/2022
76. Virginia Administrative Code - 12VAC35-105-160. Reviews by the department; requests for information; required reporting
60. OL Annual Checklist Compliance Determination Chart – FY2021.docx – 01/19/2022
61. 2022 OL Annual Checklist Compliance Determination Chart.docx – 02/18/2022
62. Licensing Regulatory Compliance with 12VAC35-105-160 CY2021.xlsx – 03/25/2022
63. Sample Root Cause Analysis Policy (February 2022)
64. Inspections Completed 07/01/2021-12/31/2021 – 02/09/2022
65. 4th Quarter Inspections_Chris.xlsx – 01/28/2022
66. CHRIS DD DSI Late Report Data 7-1-2021-02-14-2022.xlsx – 02/15/2022
67. Final 160 Protocol for DD Providers.docx – 02/18/2022
68. Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services.docx – 01/19/2022
69. Process Document – 29.4 Reviewing Root Cause Analyses.docx – 01/19/2022
70. Internal 160 Protocol for DD Providers Combined CAP Templates for Serious Incident Reporting II.pdf – 02/18/2022
71. NS Citation Template General Regs 2022 CONNECT.docx – 02/18/2022
72. CHRIS System Training February 2021.pptx – 02/18/2022
73. CHRIS System Training May 2021.pdf – 02/18/2022
74. OL Staff Meeting RM Regs 2-17-2022.pdf – 02/18/2022
75. Memo 12-2-2021 To All Providers Regarding 2022 Inspections (1).pdf – 02/18/2022
76. Memo to Providers and Template DD Inspection 2022.docx – 02/18/2022
79. Virginia Administrative Code - 12VAC35-105-160. Reviews by the department; requests for information; required reporting

80. Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services.docx – 01/19/2022
81. DD Providers Incidents June 2021-November 2021.xlsx
82. SFY22 RMRC Work Plan as of 1.31.22.pdf – 02/10/2022
83. IMU Report for RMRC – Q2 SFY22 – 03/16/2022
84. OL Annual Checklist Compliance Determination Chart – FY2021.docx – 01/19/2022
85. 2022 OL Annual Checklist Compliance Determination Chart.docx – 02/18/2022
86. Inspections Completed 07/01/2021-12/31/2021 – 02/09/2022
87. 4th Quarter Inspections_Chris.xlsx – 01/28/2022
88. CHRIS DD DSI Late Report Data 7-1-2021-02-14-2022.xlsx – 02/15/2022
89. Licensing Regulatory Compliance with 12VAC35-105-160 CY2021.xlsx – 03/25/2022
90. Corrective Action Protocol.docx – 01/19/2022
91. Final 160 Protocol for DD Providers.docx – 02/18/2022
92. Internal 160 Protocol for DD Providers Combined CAP Templates for Serious Incident Reporting II.pdf – 02/18/2022
93. Process Document 29.3, 29.5, 29.15 Monitoring Serious Incidents.docx – 01/19/2022
94. 02-10-2021 Annual Inspections for Providers of Developmental Services Memo and Checklist – 02/10/2022
95. NS Citation Template General Regs 2022 CONNECT.docx – 02/18/2022
96. 3rd Citation Template 2022 CONNECT.docx – 02/18/2022
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130. OHR Community Look Behind Reviews Timeline 2021.docx – 01/19/2022
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250. RQC2 FY22-Q2 DRAFT Minutes 11.18.2021
251. RQC3 FY22-Q2 DRAFT Minutes 11.30.2021
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284. Round 3 QSR Staffing Plan 11.01.21
285. HSAG VA QSR Provider Training 11.17.2021
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APPENDIX B

Case Management

by

Ric Zaharia Ph.D.

TO: Donald Fletcher

FROM: Ric Zaharia

RE: Case Management Report – 20th Review Period

DATE: May 12, 2022

Introduction

This report constitutes the fourth review of the compliance indicators for Case Management services. In the last review for SCQR-FY20 DBHDS provided documentation that showed achievement of nine (7) of nineteen (19) distinct effort indicators (37%). Although these achievements demonstrated commitment and progress, the outstanding indicators still could not be achieved due to the data source, the SCQR-FY20, which pre-dated finalization of definitions, tools and implementation related to Change in Status and Appropriately Implemented ISP, and the incomplete response rate from CSBs. Other than these shortcomings, DBHDS had adequately completed a full annual cycle of their planned SCQR activities, including identifying several quality improvement initiatives. This included identifying several quality improvement initiatives, although without reliable and complete data, the Commonwealth was not able to effectively determine needed quality improvements on the individual, provider, and systems levels.

For this report the documents reviewed are identified in Attachment A and most can be located in the Box library. A clarifying interview was conducted with Eric Williams, Director of Provider Development/Case Management Steering Committee (CMSC) Chair, in mid-March. In addition, the Independent Reviewer requested an Individual Service Review (ISR) based on 20 individuals with complex medical needs and focused on the use of the On-Site Visit Tool (OSVT), which operationalized two of ten CM elements revised last year. That study is at Attachment B and is summarized below.

Summary of Findings

This 20th Period showed achievement of ten (10) compliance indicators out of the nineteen (19) reviewed (53%). The difficulties around the remaining nine (9) indicators related to CSB effectiveness at achieving expectations for case management performance and establishing data set integrity for data drawn from the WaMS electronic database.

The CMSC has determined that for CY20 records, 86% of the records reviewed do not yet achieve nine of ten elements. In fact, only three CSBs achieved at the 86% level during the SCQR-FY21.

For the last SCQR (FY20) CSB's failed to provide sample reviews for 7% of those requested by DBHDS, which very likely introduced a bias into the results. The CSB response rate for the SCQR-FY21 improved to 100% and, thereby, removed a major threat to data integrity. The level of agreement between CSB supervisors and outside reviewers like OCQI (Office of Community Quality Improvement) is a critical data integrity issue for the SCQR. This second year of OCQI retrospective reviews to establish reliability showed OCQI/CSB agreement ranging from 72% to 98% with 9 of 10 over 75%. These reliability scores are an improvement over the last SCQR and bode well for the tool as a commonly understood vehicle to assess and measure case manager performance in the aggregate.

In addition to direct correspondence and summary reports for CSB's, DBHDS now provides a monthly spreadsheet of achievement statistics on 14 metrics by CSBs, including the ten elements in the SCQR. This represents an extremely valuable tool for CSBs to assess independently their performance of the case management function.

Individual Service Reviews.
As part of this review an Individual Service Review (ISR) was requested by the Independent Reviewer to probe the impact last year of the introduction of the On-Site Visit Tool (OSVT), which was designed to better shape case managers' effectiveness at assessing changes in individual situations and evaluating appropriate implementation of the Individual Service Plan (ISP), two key elements of the ten elements in the indicators of case manager performance. This ISR was completed by examination of at least the ISP and OSVT for a random sample of 20 individuals with complex medical needs (L6 on SIS) by two consultants, one an experienced nurse. This document review was supplemented by telephone interviews, structured by a Monitoring Questionnaire with a residential contact person familiar with the individual's needs and health care services. Case managers were not contacted for this review. The full report is at Attachment B.

The ISR results suggest that CSB case manager turnover is disrupting continuity and adequacy of care for many individuals and, further, that some case managers have not fully adopted the OVST as a tool to assist in their review of caseloads. For four of twenty (20%) individuals residential caregivers expressed concern about turnover; another nine expressed concerns about the contact and involvement of case managers. Twelve of the twenty individuals (60%) had a health issue, change in status or a risk that was not addressed in the documentation provided by the CSB. This latter finding suggests increased oversight (and spot checking) by case manager supervisors is necessary to ensure the effective use of the OSVT tool.

As to case manager stability a VCU report in 2018 (#31) foreshadowed the problems surrounding high turnover (average 28%, range 0-75%), the negative outcomes of caseload size (average 30, range 23-45) and case manager effectiveness. Since that report the complexity and electronic/paper burdens on case managers have increased. If VCU were to repeat its survey of case management in 2022, it would very likely show no improvement or a worsening of the root causes of problems in case management service – turnover and caseload size. DBHDS reports that it recently loosened minimal qualifications for ID case managers to address hiring challenges faced by thirteen CSBs (see # 38). Previously a bachelor's degree had been required (since 2016) to match the minimal requirements for the DD case manager. This action should have alleviated some immediate hiring pressures but will need to be revisited regularly in the future. Furthermore, it may be insufficient to resolve the root causes delaying achievement of these indicators.

Finally, the poor showing of CSBs overall on the SCQR-FY21 compliance indicators of ISP Appropriately Implemented (50%), Change in Status (75%), and ISP Addresses all risks, needs, preferences (69%%) correlate with the findings of this ISR.

Data process and attestation.
Data Process. Documentation for Compliance Indicators 2.2-2.16 (SCQR DQV process documentation, 1.13.22- #40) was reviewed for case management performance on the ten elements in the compliance indicators. That process has now had two complete cycles of implementation and is now showing its value as an outcome measurement for CSB case management effectiveness. It was recommended that the SCQR be folded into the WaMS system (#44) to improve reliability and validity. This reviewer does not believe that recommendation will add to data quality since the major threat with this data is the supervisor halo effect when rating their own employees on the tool, well before data entry and transmission to DBHDS. It may, however, provide administrative efficiencies

Documentation for Compliance Indicator 46.1 (CM Data Quality Process - #16) was reviewed for case management contacts (CCS3 Metrics). DBHDS has established and implemented a Data Quality Framework to review and verify a sample of CSB contact data each quarter and provide follow-up technical assistance. This process includes a Data Quality Tool to assess sources of data error, a Root Cause Analysis format to assist CSBs in addressing data problems, and ECM educational materials. The most recent data re case management contacts for FY22 Q1-2, shows an overall "reliability" (compliance) rate of 76%, with 18 CSBs at or over 86% (see #27).
Documentation for Compliance Indicator 47.1 (CMSC Data Set Process - #14) was reviewed for the Case Management Steering Committee's semi-annual reports on case management performance. These reports are informed by the SCQR, Licensing data, CCS data submissions, QSRs, DMAS quality reviews, WaMS, and other sources. DQV recommends including children in future SCQR sampling, advises discontinuing the use of CCS3 for compliance reporting, urges providing raw data in calculation of numerator and denominator in the SCQR, and suggests incorporation of RST process into WaMS. The Measurement Steward concurred and identified responsive activities to correct all issues identified by DQV.

Data Set Attestation. Documentation for Compliance Indicators 2.2.-4.16 (Data Set Attestation – #25) was reviewed for the SCQR and its sampling. Retrospective reviews and inter-rater reliability checks are implemented to better ensure reliability and validity of the supervisory review, which is the core ingredient to the SCQR. DBHDS's assessment is that seven of ten indicators are reliably reviewed by the supervisors statewide. ISPs with measurable outcomes (CI 2.10), Change in Status (CI 2.18), and ISPs implemented appropriately (CI 2.14) are items that continue to challenge supervisors to evaluate objectively and in agreement with the QI specialists. The Chief Information determined that two indicators lacked sufficient inter-rater reliability between CSB and OCQI (CI 2.10 & 2.14) and therefore cannot be considered valid and reliable for this period. Technical guidance and two indicator questions for SCQR FY22 were revised to improve the inter-rater reliability of these items. DQV partners with DDS (Division of Developmental Services) in the design and implementation of the SCQR

Documentation for Compliance Indicator 46.1 (Data Set Attestation-#41) was reviewed for the CCS3 sourced ECM/TCM reports and the sampling of cases quarterly by DBHDS. Technical assistance and guidance visits to the CSBs is generated from these data. DBHDS conducts cross-tabbing of data from the CCS3 database and the WaMS database to verify that the data are reliable

and valid. However, the DQV has determined (#14) that the CCS3 is not "a valid and reliable data source for Settlement Agreement compliance reporting". This presents a conflict because the Chief Information Officer reviewed and identified no defects in the data collection process.

Documentation for Compliance Indicator 47.1 (PMI Data Set Attestation #41 and SCQR Data Set Attestation #25) for source information for the CMSC reports. The Process Control Document (#14) identifies four main sources: RST data, SCQR data, CCS3 contact data and WaMS data. RST data set attestation (without a control document) was reviewed in a concurrent report on Community Living Options; SCQR data set attestation was provided.

Table 1 recaps the documents provided in response to the reliability and validity expectations of the Settlement Agreement.

Table 1
Data Integrity Documents

CI	Process Control Document	Data Set Attestation
2.2-2.16	SCQR DQV Process	SCQR Data Set Attestation
46.1	CM Contact Data Quality Support Process	CCS ECM/TCM & Sample Attestation
47.1	CMSC Data Set Process Document	PMI Data Set Attestation SCQR Data Set Attestation

Compliance Indicator Achievement.

Table 2 below recaps and summarizes the status of the case management compliance indicators.

Table 2
Case Management Findings

SA Provision- III.C.5.i: Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**18th**	**20th**
2.0	**III.C.5.b.i (also for V.F.2)** The following indicators to achieve implementation listed in this provision will also achieve implementation with other provisions associated with case management (**III.C.5.b.ii, III.C.5.b.iii, III.C.5.c, and V.F.2**). Relevant elements of			**NA**	**NA**

	person-centered planning, as set out in CMS waiver regulations (42 C.F.R. § 441.301(c)), are captured in these indicators.				
2.1	In consultation with the Independent Reviewer, DBHDS shall define and implement in its policies, requirements, and guidelines, "change of status or needs" and the elements of "appropriately implemented services."	Efforts to improve continue, including quality reviews, a revised OSVT, its incorporation into the SC Manual, and formalization as a Quality Improvement Initiative project. See #'s 1, 2, 3, 34, 35.	Sustained effort**.**	**M**	**M**
2.2	DBHDS will perform a quality review of case management services through CSB case management supervisors/QI specialists, who will conduct a Case Management Quality Review that reviews the bulleted elements listed below.	2.2 The SCQR-FY21 reviewed records from CY20, so the two changes referenced above are partially represented in these surveys; the use of face-to-face visits returned in May 2021. The FY21 SCQR Final Report (#5) and the FY22 Semi-annual Report (#15) summarize the findings regarding the ten bullets below**.**	2.2 This task has not been fully achieved. (SCQR Data Control and Attestation documents are addressed below at 2.16.)	**NM**	**NM**
2.3	DBHDS will pull an annual statistically significant stratified statewide sample of individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB.	2.3 The FY21 SCQR Final Report (#5) achieved a 100% response rate from CSBs for a statistically significant statewide sample of **adults**. The omission of almost a thousand children from the SCQR is significant (see #14).	2.3 Although this sample was statistically significant for adults in the waiver, its omission of children leaves a large growing population unsampled. This task has not been fully achieved. 2.4 Sustained effort.	**NM**	**NM**
2.4	Each quarter, the CSB case management supervisor and/or QI specialist will complete the number of Case Management Quality Review as determined by DBHDS by reviewing the records of individuals in the sample. The data captured by the Case Management Quality Review will be provided to	2.4 Technical Guidance was revised and CSB response rate improved to 100%. (See #4, 5).		**M**	**M**

2.5	DBHDS quarterly through a secure software portal that enables analysis of the data in the aggregate. DBHDS analysis of the data submitted will allow for review on a statewide and individual CSB level. The Case Management Quality Review will include review of whether the following ten elements are met: 2.6 •The CSB has offered each person the choice of case manager. 2.7 • The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team.	2.5 SCQR-FY21 reviewed records from CY20, so the two changes referenced above are partially represented in this report (#5); the use of face-to-face visits returned May 2021. The SCQR-FY21 Report (#5) reported mixed results as to CSB improvements in this area in CY21 records: 2.6 CI compliance reported at 77% (see #5, data quality reported below at 2.16) 2.7 CI compliance reported at 92% across CSBs (see #5, data quality reported below at 2.16)	2.5 Improvements in agreement between CSB raters and OCQI raters lays the foundation for CSB improvements in case manager performance in future SCQR reviews**.** CSBs are most challenged by 2.6, 2.8, 2.9, 2.10, and 2.14. This task has not been fully achieved. ↓ 2.7 The 92% reported could not be verified. The Findings of the ISR study (see Attachment B) identified significant discrepancies regarding the validity of the data DBHDS reported for this CI as well as for CIs 2.8, 2.9, 2.10, 2.12, and 2.14. The ISR study found that twelve of the twenty individuals (60%) had a health issue, change in status or a risk that was not addressed in the CM documentation provided. See comments above.	**NM** ↓	**NM** ↓

	2.8 • The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.	2.8 CI compliance reported at 74% across CSBs (See #5, data quality reported below at 2.16)	See comments above.		
	2.9 • The case manager assists in developing the person's ISP that addresses all the individual's risks, identified needs and preferences.	2.9 CI compliance reported at 69% across CSBs (See #5, data quality reported below at 2.16)	See comments above.		
	2.10 • The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable.	2.10 CI compliance reported at 82% across CSBs. OCQI-CSB inter-rater reliability reported as weak. (See #5, data quality reported below at 2.16)			
	2.11 • The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served	2.11 CI compliance reported at 85% across CSBs (See #5, data quality reported below at 2.16)	See comments above.		
	2.12. • The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary.	2.12 CI compliance reported at 93% across CSBs (See #5, data quality reported below at 2.16)			
	2.13 • Individuals have been		See comments above.		

	offered choice of providers for each service. 2.14 • The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences. 2.15 • The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individuals' needs.	2.13 CI compliance reported at 77% across CSBs (See #5, data quality reported below at 2.16) 2.14 CI compliance reported at 50% across CSBs. OCQI-CSB inter-rater reliability reported as weak (See #5, data quality reported below at 2.16) 2.15 CI compliance reported at 99% across CSBs (See #5, data quality reported below at 2.16)			
2.16	The Case Management Steering Committee will analyze the Case Management Quality Review data submitted to DBHDS that reports on CSB case management performance each quarter. In this analysis 86% of the records reviewed across the state will be in implementation with a minimum of 9 of the elements assessed in the review.	The CMSC has determined that for CY20 86% of the records reviewed do not yet achieve nine of ten elements. Only three CSBs achieved at the 86% level. (See #5, 8, 9). The SCQR Process Control Document (#40) was reviewed. It identifies sample selection, CSB supervisor and OCQI look behinds. Data is entered into Qualtrics, which DQV staff monitor. OCQI staff are deployed and run parallel	This task has not been fully achieved. SCQR data set and sample selection attestations have been reviewed (#25, #42) and R/V threats are being actively addressed. However, the Chief Information Officer determined that two indicators lacked sufficient inter-rater reliability between CSB and OCQI (CI 2.10 & 2.14) and therefore cannot be considered valid and reliable for this period.	**NM**	**NM**

		mini samples in order to reconcile and provide technical assistance to CSBs.			
2.17	In this analysis any individual CSB that has 2 or more records that do not meet 86% implementation with Case Management Quality Review for two consecutive quarters will receive additional technical assistance provided by DBHDS.	DBHDS has continued to provide Technical Assistance. to CSBs. See #11.	Sustained effort	**M**	**M**
2.18	If, after receiving technical assistance, a CSB does not demonstrate improvement, the Case Management Steering Committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract and licensing regulations.	DBHDS has continued to provide Technical Assistance. No CSB has been identified that did not demonstrate improvement warranting enforcement action pursuant to the CSB Performance Contract. (See #12).	CSBs have responded positively to DBHDS's technical assistance and expectations, however, this CI will be achieved when technical assistance is provided, when enforcement actions are implemented as needed, and when all CSBs achieve 86% compliance.	**NM**	**NM**
2.19	DBHDS, through the Case Management Steering Committee, will ensure that the CSBs receive their case management performance data semi-annually at a minimum.	In addition to direct correspondence and summary reports, DBHDS now provides a monthly spreadsheet of case management performance stats on 14 metrics by CSB, including the ten elements. (See #'s 5, 6, 13, 15, 21)	DBHDS has provided more than sufficient, timely and actionable feedback on case management performance. This indicator has been achieved**.**	**NM**	**M**
2.20	All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or DBHDS licensing regulations. Corrective actions for cited regulatory non-implementation will be tracked to ensure remediation.	In the 18th period the Independent Reviewer accepted the Commonwealths incorporation of all ten elements into Waiver Regulations which were adopted 4.21.21. CMSC tracks some CAPs on a *Watch List* (See #18, 22). Documentation was provided to show OL tracking on CAPs for	The DBHDS plan to address this indicator is not clear. A crosswalk is needed between the ten elements and the regulations/waiver; then either the CMSC or OL should track specific CAPs to the ten elements. Therefore, this indicator has not been fully accomplished.	**NM**	**NM**

		citations under the Adequacy of Supports domains and in the Health & Safety category; there is only a partial overlap with the 10 elements of case management (see #15, 26, 30, 32, 33). DBHDS has considered this issue and is engaged in further exploration between the CMSC and Licensing.			
SA Provision – III.C.5.d: The Commonwealth shall establish a mechanism to monitor effort with performance standards					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**18th**	**20th**
6.1.a (formerly 2.21)	The Case Management Steering Committee will review and analyze the Case Management data submitted to DBHDS and report on CSB case management performance related to the ten elements and also at the aggregate level to determine the CSB's overall effectiveness in achieving outcomes for the population they serve (such as employment, self-direction, independent living, keeping children with families).	The second full cycle of SCQR was completed and analyzed. (See # 5, 11, 15, 20, 23).	Sustained effort	**M**	**M**
6.1.b (formerly 2.22)	The Case Management Steering Committee will produce a semi-annual report to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. The Case Management Steering Committee's report will include an analysis of findings and recommendations based on review of … data from the oversight of the Office of Licensing, DMAS Quality Management Reviews, CSB Case Management Supervisors Quarterly Reviews, DBHDS Quality Management Division quality improvement review processes including the	The CMSC has issued six semi-annual reports to the QIC over the past three fiscal years (see #5, 15, 20, 23). Based on its review of data from Licensing, DMAS-QMR, SCQR, OCQI, QSRs, and Performance Contracts, the most recent CMSC report (#15) recommended five new improvement initiatives, in addition to its five existing recommended initiatives.	This indicator has been achieved.	**NM**	**M**

	Supervisory retrospective review, Quality Service Reviews, and Performance Contract Indicator data.				
6.1	The Case Management Steering Committee will also make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings.	Ten CSBs identified as non-compliant on 9 of 10 CI's. TA provided in April, no further recommendations to Commissioner. (See #12, 18).	CMSC has previously made recommendations for enforcement actions. These actions were implemented and resulted in improvements. DBHDS has determined that the previous recommendations are sufficient to achieve this indicator – even though ten CSBs are identified as still non-compliant. Sustained effort	**M**	**M**
6.2	Members of the DBHDS central office Quality Improvement Division will conduct annual retrospective reviews to validate the findings of the CSB case management supervisory reviews and to provide technical assistance to the case managers and supervisors for any needed improvements. A random subsample of the original sample will be drawn each year for this retrospective review….	DBHDS conducted OCQI retrospective reviews for a random sample drawn for CY21. DBHDS provided technical assistance and improvements occurred. OCQI/CSB agreement ranged from 46% to 95% with 7 of 10 over 75% (see #5).	Agreement between OCQI/CSB shows improvement over last year's SCQR. Sustained effort.	**M**	**M**
6.3	The DBHDS central office Quality Improvement Division's reviewers will visit each CSB in person and review case management records for the individuals in the sub-sample. They will then complete an electronic form so that agreement between the CSB Case Management Quality Review and the DBHDS Quality Improvement Division record reviews can be measured quantitatively.	This was the second year of OCQI retrospective reviews with technical assistance (see #'s 5, 15, 10) and visits to all CSBs. DBHDS's assessment is that seven of ten indicators are reliably reviewed by the supervisors statewide; ISPs with measurable outcomes and employment discussions (CI 2.10), Change in Status (CI 2.18), and ISPs implemented appropriately (CI 2.14) are requirements that	Sustained effort	**M**	**M**

		continue to challenge supervisors to evaluate objectively and in agreement with the QI specialists. Technical guidance for SCQR FY22 was revised to improve the reliability of these items.			
6.4	There will be an ongoing inter-rater reliability process for staff of the DBHDS Quality Improvement Division conducting the retrospective reviews.	The inter-rater reliability process has been maintained and agreement improved for SCQR FY22 over FY20 on nine of ten indicators - the tenth element, Change in Status, did not improve. The range of agreement was 72% to 98% (see #5).	Over the past two years inter-rater reliability has improved, showing effectiveness of the process. Therefore, this indicator has been achieved.	**NM**	**M**
SA Provision- V.F.4: Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**18th**	**20th**
46.1	The Commonwealth tracks the number, type, and frequency of case management contacts. DBHDS will establish a process to review a sample of data each quarter to determine reliability and provide technical assistance to CSBs as needed.	DBHDS has continued to track case management contacts. It has also established and implemented a Data Quality Framework and process to review a sample of CSB contact data each quarter and provide follow-up technical assistance (# 16). This is proposed as the Process Control Document for CM contact data quality and includes a Data Quality Tool to assess sources of data error, a Root Cause Analysis format to assist	This review confirmed that the Commonwealth tracks CM contacts. It has established and implemented a process to review a sample of data each quarter and provides technical assistance as needed. However, the Data Quality Framework is not organized in the format of a Data Process Control Document and DQV has disqualified the use of CCS3 database to inform this compliance indicator (#14). Therefore this indicator is not yet achieved.	**NM**	**NM**

		CSBs in addressing data problems, and ECM educational materials (see #16, 17, 24, 36). The CM contact data set quality control process (#16) has been reviewed and R/V threats are being actively addressed.			
46.2	The data regarding the number, type, and frequency of case management contacts will be included in the Case Management Steering Committee data review. Recommendations to address non-implementation issues with respect to case manager contacts will be provided to the Quality Improvement Committee for consideration of appropriate systemic improvements and to the Commissioner for review of contract performance issues	This indicator is accomplished through the Data Quality Framework (#16), its CM contact data analysis (see #27, 28, 29), and CMSC semi-annual reports to the QIC and Commissioner for review of appropriate systemic improvements and contract performance issues (see #15, 20, 23). The most recent CCS3 data re case management contacts for FY22 Q1-2, shows an overall "reliability" (compliance) rate of 76%, with 18 CSBs at or over 86% (see #27). Although 14 CSBs have significantly under-performed their case management contacts obligation, improvements are noted (#27). Six semiannual reports since FY19 include the required information to address non-compliance issues. No contract performance issues have been identified. DBHDS is pursuing an automated worksheet for application of the ECM status (see #15) and continued technical assistance (#37).	„ Contact data shows that 89% of CM contacts have now returned to face-to-face (#29). Additionally, DBHDS conducts fine grained tracking of CM contact data to provide feedback to CSBs through the Data Quality Framework. However, this overlooks the DQV assessment (#14) that the CCS3 is not "a valid and reliable data source for Settlement Agreement compliance reporting". Therefore, this indicator has not yet been achieved.	**NM**	**NM**

SA Provision-V.F.5: *Within 24 months from the date of this Agreement, key indicators from the case manager's face to face visits with the individual and the case manager's observation and assessment, shall be reported to the Commonwealth for its review and assessment of data….*					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**18th**	**20th**
47.1	The Case Management Steering Committee will establish two indicators in each of the areas of health & safety and community integration associated with selected domains in V.D.3 and based on a review of the data submitted from case management monitoring processes. Data indicates 86% implementation with the four indicators.	The four indicators selected by DBHDS, which are from the two required areas, include Choice, Relationships, Change in Status, and ISP Implementation. - CY19 data reports showed 86% compliance with all but Choice. -CY20 data showed <u>none</u> of the four indicators reaching 86% (see #15, 20). The involvement of OCQI and technical assistance has been the source of these changes.	The CMSC and SCQR data process documents have been reviewed (#14, 40) and R/V threats are being actively addressed. However, the benchmark for this indicator has not been achieved.	**NM**	**NM**

<u>Suggestions for DBHDS Consideration:</u>

1. Incorporate children into the sampling for future SCQRs, in order to include what is likely to be the fastest growing segment of the Waiver population.
2. Develop a plan to address CM turnover, retention, and caseload size, in order to enhance CM stability.
1. Crosswalk ten CM elements with Licensing regulations, waiver regulations and corrective actions, in order establish tracking responsibility.
2. Incorporate the OSVT review process completed in May 2021 (#15) into the SCQR process <u>for selected items,</u> in order to positively impact supervisory reviews of the OSVT.

Attachment A
Documents Reviewed
Case Management – Title or BOX Filename

1. OSVT Survey Q1-Q2, Q3-Q4 (2021)
2. dd-sc-handbook-12202021-rev-2-final
3. CMSC Q11 OSVT PDSA 1.31.22
4. 2022 SCQR Technical Guidance
5. FY2021 SCQR final report, 11.19.21
6. SCQR FY21 with names, (40 CSBs)
7. SC Quality Review Sample, FY21, FY22
8. CMSC Minutes, 7/21-12/21
9. CMSC Work Group Updates, 2/21 to 3/22
10. OCQI Report to CMSC, 9.20.21, 11.10.21
11. CRC TA Summary April 21
12. CMSC Recommendation Letter 8.2.21 and 12.20.21
13. CMSC Performance Letters, 40 CSBs, 11.30.21 and 4.30.21
14. CMSC Data Set – Process Document, 10.15.21
15. CMSC Report FY21 (Q3 & 4), 10.29.21; FY22 (Q1&Q2), 3.30.22
16. Case Management Data Quality Support Process, 11.19.21
17. Data RCA Template 10.29.21
18. CMSC CAP Watchlist, 2.3.22
19. CCS3 Metrics, Q1-4, FY21
20. QIC Minutes & Attachments, 6.2.21, 9.27.21, 12.13.21, 3.28.22
21. WaMS ISP Data Report Walkthrough Final 2.25.22 (training video)
22. Draft DD Waiver Regulations (Final), 2.24.21.
23. CMSC Semi-annual Report, FY21 Q3-4. 11.18.21
24. ECM Questions & Answers, 8.9.21
25. SCQR Data Set Attestation Form, 3.4.22
26. OL Annual Checklist Compliance Determination Chart, 9.10.21
27. CM Contact Data, 3.11.22
28. ECM Report, Dec 2021
29. Targeted Case Management, FY22 Q2
30. Adequacy of Supports Q1 9-2021 QIC notes
31. PPWD VCU CM Report, May 2018
32. OL Health & Safety CAPs, 9.7.21
33. Regulatory Crosswalk for the DD Waivers/OL/Perf. Contracts, 2.25.18
34. OVST Q3 Q4 2021
35. On site visit tool Q3 Q4 2021 (PowerPoint)
36. ECM Video Shared with CSBs
37. DQS Notes 3.8.22
38. Memo, EW to DD Directors, 2.28.22
39. DR0032 Annual ISP as of endFY22Q1 & FY22Q2.
40. SCQR DQV process documentation, 1.13.22

41. PMI Data Set Attestation (CCS ECM/TCM, DQ Sample), 3.4.2022
42. PMI Data Attestation (SCQR Sample), 3.4.2022
43. DQS notes, 3.8.22, 4.5.22 (CM contact TA notes)
44. 220215 CI Data RV Sources & Crosswalk-19th Period (IR-rw)

Attachment B

TWENTIETH REVIEW PERIOD

INDIVIDUAL SERVICES REVIEW STUDY:

INDIVIDUALS WITH COMPLEX MEDICAL NEEDS

Submitted By: Elizabeth Jones, Team Leader
Julene Hollenbach, RN, BSN, NE-BC

May 11, 2022

Introduction/Overview

In this reporting period, the Independent Reviewer again focused attention on a cohort of individuals with a developmental disability (DD) and complex medical needs. A random sample of twenty individuals, nineteen adults and one teenager, was selected for review to determine whether their health needs were identified and addressed by their Case Managers during their periodic site visits. The sample included individuals from all Regions: three individuals from Region I; four from Region II; five from Region III; three from Region IV; and five from Region V. Eighteen of the forty (45%) Community Services Boards (CSBs) were represented in the random sample. All individuals in this sample were scored at a level six on the Supports Intensity Scale (SIS).

The framework for this Individual Services Review (ISR) study was intentionally designed to evaluate an initiative introduced by the Commonwealth to ensure that Case Management practices are uniformly implemented as required by Provision V.F.2. and the associated Compliance Indicators.

In June 2020, the Commonwealth developed a process, in consultation with the Independent Reviewer, to address the requirements of Provision V.F.2. of the Settlement Agreement. This Provision specifies the observations to be made and the actions to be taken by Case Managers during and after their face-to-face meetings with the individuals assigned to them.

Provision V.F.2 had been identified as a significant area of concern by the Independent Reviewer, which, if not addressed properly, could prevent the Commonwealth from achieving compliance with one of the Agreement's primary external service monitoring mechanisms.[1]

In order to help achieve compliance, an On-Site Visit Monitoring Tool (OSVT) was developed, by DBHDS, for use by the Case Managers (See Attachment 1) Online training on the OSVT was offered, on June 26, 2020, to Support Coordination/Case Managers' supervisors to convey the contents of the tool, expectations for its use, and a process for collecting feedback during the first three months of implementation. The OSVT was intended to ensure that consistency is applied when assessing for any "change in status" and to confirm that the ISP is "implemented appropriately."

There are five Compliance Indicators related to this period's study of individuals with complex medical needs. They are the primary foci of the comparisons between the ISR and OSVT findings and conclusions:

> 2.7 The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team.
>
> 2.8 The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.

[1] See Memorandum from the Assistant Commissioner, Developmental Services, to CSB Executive Directors/CEOs, staff and Providers, June 8, 2020.

2.10 The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable.[2]

2.12 The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary.[3]

2.14 The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences.[4]

As with all prior studies, the draft methodology for this ISR study was shared with and discussed with key staff from the Commonwealth's Department of Behavioral Health and Disability Services (DBHDS). The Commonwealth provided the list of individuals from which the sample was drawn, the contact information for each selected individual and documents relevant to the study. The Monitoring Questionnaire used by the Independent Reviewer's consultants was adapted for this period's study. (See Attachment 2.)

There were several constraints experienced during this review. The information that the Commonwealth provided from WaMS was not correct for certain individuals and delays were experienced in addressing this problem, especially in identifying the appropriate residential contact person. Although the ISP and at least one OSVT were provided for each individual, the other documents submitted by the CSBs differed in quantity and type. As a result, it is possible that certain identified discrepancies in the findings were not actually discrepancies in fact but were the result of the inconsistent sources of information provided for the study. Finally, since the interviews were conducted only by telephone, key documents usually examined during site visits to the residences were simply not available for review. For example, informed consent forms for psychotropic medications, the Medication Administration Record (MAR), clinical consultation reports, laboratory test results, and records of hospitalizations or Emergency Room visits were not included in most of the documentation provided for review. The Commonwealth was not able to provide Case Manager notes for most of the individuals in the sample.

Copies of the completed ISR Monitoring Questionnaires, which include personal health information, for the twenty people in the sample will be provided to the Parties under seal. The Independent Reviewer expects any identified Issues to be reported on by DBHDS no later than September 30, 2021.

[2] NOTE: Employment goals were not studied as part of this review.
[3] NOTE: Education, transportation, and housing were not studied as part of this review.
[4] NOTE: integration preferences were not studied as part of this review.

Discussion of Findings

Reliance on Case Managers

At the onset, it is important to distinguish between the residential settings for the individuals in the sample. There are eight individuals (40%) who live with their families. Two of these family homes are credentialed as Sponsor Homes. The remaining twelve individuals either live in a group home (11) or a sponsored home with a non-relative (1).

Family caregivers expressed more reliance on Case Managers, often because their supports were more limited in scope, and they were not familiar with the methods for accessing services and other supports. In several instances, the family members expressed disappointment and frustration that they were only given listings of potential resources, such as dentists, and were expected to make all the inquiries on their own without direct assistance from the Case Manager. One parent has been seeking guardianship for many years but has never been helped in contacting the lawyers on the lists provided by the Case Manager. During the interview, the high level of stress expressed by one parent regarding her inability to obtain nursing services resulted in an immediate report to the Independent Reviewer and his notification to DBHDS.

The turnover of Case Managers was reported by families as a disruption in four reviews (20%). One parent related that she was not able to obtain a Case Manager after moving, eighteen months ago, to a new city. She was informed that "they were not accepting new clients." (Fortunately, the previous Case Manager continues to support this family, despite a four-hour drive.) In nine interviews with either a family member or residential provider, there were complaints about the lack of involvement of the Case Manager, including the infrequency of home visits.

On-Site Visit Tools

The documents requested for this study included Case Manager progress notes from January 21, 2021 to January 21, 2022 and the last two OSVTs completed by the Case Manager. The documentation received did not include Case Manager progress notes for each individual in the sample. One person had only one OSVT submitted; all others had at least two OSVTs provided for review.

The OSVT is a set of questions and descriptions of expected responses with checkboxes (Yes, No, N/A). There is a column for any comments or actions needed. The OSVTs provided for the individuals in the sample were examined prior to the interviews with the designated residential informant.

Given the findings from this ISR, it is problematic that the Case Managers' responses to the questions in the OSVT consist primarily of a checked box. Virtually all the OSVTs indicated that there were no concerns or deficiencies. No specific information was included to support any such finding. In fact, there was only one individual whose OSVT documented an unaddressed or inadequately addressed health risk, injury, need or change in status. In that instance, the Case Manager for Individual # 3 identified an increase in seizure activity. As a result, his medical care has been closely monitored.

Identification of Risks

Although the findings from the Monitoring Questionnaires are instructive, the primary purpose of this specific ISR study was to evaluate the use of the OSVT and its reliability in the consistent identification of any unmet needs or a change in status, potentially creating risks to the health and safety of the person, and the appropriate implementation of the ISP.

Based on the information obtained through interviews and document review, seven of the individuals (35%) in the sample (Individuals # 2, 4, 6,7, 8, 9, 16) did not have any unidentified or inadequately addressed health risks, injuries, needs or change in status.

As cited above, the change in seizure activity for Individual # 3 (5%) was identified in the OSVT and appropriate enhanced monitoring of his medical care is being implemented.

Individual Findings from 20th ISR Study

Individual #	Unidentified or inadequately addressed health risks, injuries, needs or change in status
1	The ISP completed in March 2021 identified the need for a PT assessment. This was not completed at the time of the ISR interview. The Case Manager did not identify the lack of timely assessment and receipt of an adapted wheelchair. Additionally, the Case Manager did not identify the lack of a communication device or the absence of a current oral examination, ophthalmological evaluation and endocrinology evaluation.
5	He is taking eight medications related to behavior, which creates a potential polypharmacy issue. There is no indication that a medical reason has been ruled out for the behaviors. There was no information provided regarding any monitoring for tardive dyskinesia. This increased health risk was not identified by the Case Manager. The ISP states that there is no BSP but the provider states there is.
10	Although he has diabetes and an annual eye exam is, therefore, highly recommended to detect diabetic retinopathy, Individual #10 has not had an ophthalmological exam since 2020. In his completed OSVT assessments, the Case Manager did not identify that risk.
11	The OSVT assessments completed by the Case Manager did not identify the significant change in his health, including loss of use of arms and legs, no longer able to stand, use cup, etc. The Case Manager did not identify or recommend further evaluation to identify the cause and how to best meet his health needs. He has not had a dental exam since June 1, 2014. The Case Manager has given a list of dentists to his mother but has not assisted in contacting dentists to find one that would be able to care for his dental needs. The lack of dental care was not identified as a health risk in the OSVT assessments,
12	The need for a travel seat was included in the ISP but still has not been obtained for over a year. In the OSVT assessments, the Case Manager did not identify: the risk of skin breakdown without the needed wheelchair repair and bean bags for positioning; the risk of deteriorating health due to low weight, which could indicate a lack of adequate nutrition and result in organ damage; and the lack of a lift to assist her into and out of the bathtub.
13	Immediately following the interview with the parent regarding the lack of appropriate nursing and other supports for her son, these circumstances were referred to the Independent Reviewer, who then contacted DBHDS for assistance. DBHDS promptly contacted the parent. In the OSVT assessments, the Case Manager has not identified/adequately addressed the risks related to: the continued lack of nursing services; the lack of appropriate implementation of dental care since June 3, 2019; the need for a Speech and Language Assessment related to the decrease in verbal skills and the need for an effective communication plan; the need for a nutritional plan; and the need for behavioral support.
14	The Case Manager did not identify the lack of dental care as an unaddressed service need since November 2018; the inability of his provider to weigh him due to the absence of a

	scale; the lack of a current nutritional assessment to ensure the best diet to meet his needs; and the need to evaluate his day to ensure that there are mental and physical stimulatory activities to promote total wellness.
15	After interview and review of documentation provided, a psychiatric diagnosis related to receiving two psychotropic medications could not be identified. Although he is taking a medication for "drooling," there was no information provided regarding the use of AIMS or any standardized tool used to test for tardive dyskinesia. The Case Manager notes state that routine CAT testing has been completed and indicates no need for behavioral services. However, it is reported by the residential informant that behavioral episodes occur daily and there is no behavior support plan. This apparent disagreement should be reviewed and addressed.
17	The Case Manager had not identified the following concerns: 1) adaptive equipment was identified by the Case Manager as a need in May 2021 but it has not yet been obtained; 2) he has had multiple falls but a Physical Therapy evaluation has not been considered; 3) he exhibits self-abusive behavior but there has not been an Occupational Therapy Assessment to determine possible sensory stimulation that might decrease the self-abuse; 4) his mother stated that she would like him to gain weight but no nutritional evaluation has been considered.
18	Residential staff requested a nutritional assessment in June 2021, but the request was not addressed until February 2022 when ordered by the PCP. On-site visit tools do not identify any health issues or the risks associated with the lack of a timely nutritional assessment.
19	There is a potential risk of diminished mental health/emotional well-being. According to his mother, her son has a strong desire to have friends and companionship. The CM had not identified this emotional health-related risk and, therefore, no actions have been recommended by the ISP team to address this need.
20	She has a risk of aspiration, is significantly underweight at 62 pounds, has a poor appetite, and was prescribed an atypical antidepressant as an appetite stimulant but those risks did not result in the ISP team's consideration of a nutritional assessment and mealtime assessment. Her ISP identified that she has constipation, a major risk for individuals with DD, but the home does not track her fluid intake, which is crucial in addressing that health risk, and the ISP did not identify that as a need.

The OSVT requires a response to these two questions:

1. Question 14: "Was a change in status identified?" The Case Managers responded NO for the twenty individuals reviewed. The ISR study identified seven individuals (35%) with a change in status, including individuals 5, 11, 13,14,15,16 and 20.
2. Question 15: "Is the ISP implemented appropriately?" The Case Managers responded YES for all twenty individuals. The ISR study responded NO for 11 individuals (55%), including individuals 1,5,10,11,12,13,14,15,17,18 and 20.

In addition to the identification of unidentified or inadequately addressed risks, injuries, needs, or changes in status, the ISR study examined the ISPs to determine whether they were current and whether they included specific and measurable objectives/outcomes.

All ISPs were current. None of the ISPs were modified since written. (It was noted that Individual #3's increased seizures had been referenced in the ISP when it was written in December 2021 so that further modification was not necessary.)

Only four (20%) of the ISPs had specific and measurable objectives/outcomes. The remaining sixteen ISPs (80%) had tasks for staff to implement directly or activities to be conducted to structure the individual's day.

Summary

Between February 21 and March 17, 2022, interviews were completed with the residential contact person for each of the twenty individuals in the sample. Information obtained from the interviews was entered onto the Monitoring Questionnaire and reviewed against the information provided by DBHDS for each individual.

The ISR study identified the following:

- Seven individuals (35%) did not have any unidentified or inadequately addressed health risks, injuries, needs or change in status. This finding is consistent with the Case Managers' assessments that were documented in the OSVTs provided for these seven people.
- One individual (#3) had increased seizure activity that required enhanced monitoring and medical oversight. The current ISP included this health risk, and the Case Manager documented this concern in the Service Note of March 22, 2021, following the completion of the OSVT on the same date.
- Twelve individuals (60%) had unidentified or inadequately addressed risks or needs that were not identified by their Case Managers' completed OSVT assessment. These include: lack of dental care (3); lack of adaptive equipment or lack of adaptive equipment in good repair (3); lack of emotional or behavioral supports or assessments (5); concerns about the monitoring of psychotropic medications (2); lack of clinical assessments related to nutrition, physical or occupational therapy, speech/language, and ophthalmology (9) and lack of nursing services (1).

Based on the discrepancies identified in the individual service reviews and the fact that the Commonwealth's WaMS data source has not yet been determined to provide reliable and valid information, the information documented in the OSVTs for the twelve individuals discussed above cannot be verified as complete and accurate and, therefore, and cannot be used to support a finding of compliance with Compliance Indicators 2.7, 2.8, 2.10, 2.12, and 2.14.

Finally, the work for this report depended on considerable assistance from DBHDS staff and detailed information from the residential contacts. Their assistance is greatly appreciated.

Recommendations

The Commonwealth should review each of the discrepancies between the findings of the ISR study and the OSVTs completed for the twelve individuals listed above. DBHDS should review and determine whether the ISR findings are correct. As mentioned previously, any oversights or inconsistencies in study documentation related to the ISRs can be brought forward in the DBHDS responses to the findings presented here. If the ISR nurse's findings are verified, then DBHDS should examine the use of the OSVT in each of those cases and should review the adequacy of supervision for the assigned Case Managers. The inadequate or delayed services/supports identified for each of the twelve individuals on the Issues page in their Monitoring Questionnaire should be remedied.

In addition, DBHDS should require that supporting facts are included in the "Comments/Actions Needed" column on the OSVT form, regardless of whether a "Yes" or "No" response is checked for the question. There should be information documented for any finding by the Case Manager.

ATTACHMENT 1

Instructions: Complete this tool during each quarterly face-to-face visit. It is a means to ensure that consistency is applied when assessing for any "change in status" and to confirm that the ISP is "implemented appropriately." Based on observation and report, include specific, detailed notes about the findings and any actions that will be taken (including the need for any additional assessments or root cause analysis, such as behavioral and/or medical reviews, to understand and address identified concerns). **If the person has lost a service as a result of behavioral or medical issues or a provider's perception of increased needs, additional assessment is necessary.**

On-Site Visit Tool

Individual's Name:

Location of visit: ☐ **home** ☐ **community** ☐ **work** ☐ **day support** ☐ **Other:** _____

Date of visit:

	Focus Area Questions:	Check:	Comments/Actions Needed:
Change in Status			
1	**Is the environment clean, safe and appropriate to the person's needs?** (i.e., no evidence of infestation or unpleasant odor, no observable concerns with the environment such as torn carpets, unsafe throw rugs, a lack of toilet paper, food, soap or other needed supplies, and that the setting is physically is accessible to the individual with no barriers noted, etc.)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
2	**Are environmental modifications or assistive technologies needed to increase independence or prevent institutionalization?** (i.e., there is an appropriate integration of setting and supports available to promote the individual's independence and/or access to the greater community, wheelchair, walker, communication device, etc.)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
4	**Does the person appear healthy/safe?** (e.g, is there a new diagnosis from the past 90 days that could increase risk, such as going to the emergency room for an accident, injuring oneself and without effective behavioral services, signs of inadequate care like skin breakdown or choking that could have been avoided, or other changes in physical appearance: hygiene, weight, physical marks, etc.)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
5	**Have there been any changes observed or reported in health since the last visit?** (e.g., changes that create a new risk such as a new medical diagnosis, having remaining teeth removed for a person on a special diet, has lost five pounds in 90 days or has not been weighed properly when weight has been of concern, or other changes in medical, behavioral, and/or mental health)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**yes**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
6	**Does the person have meals that match his needs and preferences?** (i.e., physician's order, equipment, individual choice is observed with menu selections and/or cultural or religious preferences are honored, no policies indicating food restrictions, set mealtimes, etc. Any modifications are supported, justified and documented in the person-centered plan.)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
7	**Have there been any significant life changes that impact services?** (e.g., the loss of a day, residential, or behavioral service provider, change in financial status, benefits, eligibility for services, or a change in waiver status, etc.)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**yes**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*

ISP Implemented Appropriately			
8	**Does the person express satisfaction with current supports?** (i.e., the type, amount, who provides, interest in other services or supports, does the setting ensure individual privacy, dignity and freedom from coercion and restraints, optimize individual autonomy and independence in the setting, etc.)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
9	**Does the person express satisfaction with the progress being made?** (e.g., increased abilities, opportunities for inclusion, having more independence, etc.)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
10	**Are the paid supporters qualified to provide the services?** (e.g., do the DSPs know the individual's needs and understand their role in providing support?)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
11	**Are service, including specialized services such as nursing and/or behavioral consultation, occurring as needed, and as authorized?** (i.e., number of days and hours authorized)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
11a	**If no to question 11 for behavioral services, confirm the following:** • An onsite assessment was completed? ☐Yes ☐ No • A behavioral plan designed to decrease negative behavioral and increase functional replacement behaviors? ☐Yes ☐ No • Presence of data collection/reviews to improve supports? ☐Yes ☐ No • Changes were made to the behavioral plan as needed? ☐Yes ☐ No • Caregivers are trained to implement the behavior plan? ☐Yes ☐ No		
11b	**If no to question 11 for nursing services, confirm the following:** • Services were provided consistently for past 90 days? ☐Yes ☐ No • The hours provided are sufficient to ensure health and safety? ☐Yes ☐ No • The services provided meet the person's identified needs? ☐Yes ☐ No		
12	**Do the services include skill-building if required?** (i.e., progress is occurring as expected, data is collected and reviewed by the provider; this is a required element in certain services to focus on increasing independence based on the ISP)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
13	**Does community involvement occur as described in the ISP?** (i.e., person has natural supports, are they being provided, do individual activity schedules and reports confirm that the individual is going out to places they choose and like as indicated in the ISP, he/she has access to reliable transportation, and any modifications are supported, justified and documented in the person-centered plan.)	☐ **Yes** ☐ **No** ☐ **N/A**	*[Answering "**no**" indicates the need for additional assessment and action as necessary to resolve concerns. Document details and actions needed here.]*
Additional Comments:			

Determination (To be completed following questions 1 through 13)		
14. Was a **change in status** identified? "Change in status" refers to changes related to a person's mental, physical, or behavioral condition and/or changes in one's circumstances to include representation, financial status, living arrangements, service providers, eligibility for services, and type of services or waiver.	☐ **Yes** ☐ **No**	*[if yes, describe actions that will be taken]*
15. Is the **ISP implemented appropriately**? "ISP implemented appropriately" means that services identified in the ISP are delivered consistent within generally accepted practices and have demonstrated progress toward expected outcomes, and if not, have been reviewed and modified.	☐ **Yes** ☐ **No**	*[if no, describe actions that will be taken]*
16. Does the person (and substitute decision-maker if applicable) understand that he has a **choice** of providers and/or support coordination agency/support coordinator? (i.e., does documentation shows that the setting was selected by the individual and SDM, if applicable?)	☐ **Yes** ☐ **No**	*[if no, describe actions that will be taken]*
17. Do any concerns observed or reported require **reporting** to DBHDS or other state agency or your supervisor? (i.e., safety concerns, does a scan of the physical setting indicate compliance with HCBS requirements: privacy in sleeping unit, lockable entrances with individual possessing keys, freedom to furnish and decorate living unit, choice of roommate, no restrictions on visitation, etc.)	☐ **Yes** ☐ **No**	*[if yes, describe actions that will be taken]*

Printed name:_____

Signature :_____ Date:_____

ATTACHMENT 2

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

CIVIL ACTION NO. 3:12cv59-JAG

INDIVIDUAL SERVICES REVIEW: 20th REVIEW PERIOD

SECTION 1: DEMOGRAPHICS / OBSERVATION

1. **Individual's Name**: **Region:** ☐I ☐II ☐III ☐IV ☐V
2. **Gender**: ☐ Male ☐ Female
3. **Date of Birth:**
4. **Age Range**:

   ☐ Under 21 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80 ☐ 81-90 ☐ 91+

5. **Mobility Status**:

   ☐Walks without support ☐Walks with support ☐Total assistance with walking
   ☐Uses wheelchair ☐Confined to bed

6. **Authorized Representative (Name and Relationship):**

   a. Does the Individual have an Authorized Representative? ☐ Yes☐ No

   b. If Yes, is the Authorized Representative a legal Guardian? ☐ Yes ☐ No ☐ NA

   c. Name:

   d. Relationship: ☐ Parent ☐ Sibling ☐ Other relative
   ☐ Other, e.g. friend ☐ Public guardian

9. **Current Supports in Residence**:

   a. Provider and Contact Person:

   b. Residential Address:

   c. Telephone Number:

10. **Type of Residence**:

    ☐ Own/family home ☐ Sponsored home ☐ Supported Apartment
    ☐ Psychiatric facility ☐ Group home ☐ ICF- ID
    ☐ Nursing facility ☐ Rehabilitation facility

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

SECTION 3: INDIVIDUAL'S SUPPORT PLANS/PLAN OF CARE*

*Sources of information: Refer to documents (for example, Discharge Plan or ISP) submitted by the provider agency or DBHDS. Note the title and date of any document used as supporting evidence.

34.	a. Is the Individual's Support Plan current?	☐Yes ☐No
35.	Has the Individual's Support Plan been modified as necessary in response to a major health-related event for the person, if one has occurred? If No, describe the major event: (A major event is one that significantly changes the circumstances related to the individual's health goals or high-risk factors.)	☐Yes ☐No ☐NA
39.	Does the Individual's Support Plan have specific and measurable outcomes and support activities?	☐Yes ☐No
45.	Does the individual require adaptive equipment? List: a. If Yes, is the equipment reported as available? b. If No, has it reportedly been ordered? c. If available, is the equipment reportedly in good repair and functioning properly? If No, list any equipment in need of repair: d. If No, has the equipment reportedly been in need of repair more than 30 days? e. If No, has anyone reportedly acted upon the need for repair?	☐Yes ☐No ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA

48.	Is the individual receiving supports identified in his/her Individual Support Plan? Supports: a. Residential/In-Home b. Medical (physician and medical specialists) c. Dental d. Health (nursing and other health supports) g. Mental Health: 1. Psychiatry i. Communication/assistive technology, if needed j. Is the individual refusing any of the above services? k. If yes, is the team addressing this issue? Note: If individual is declining a service, note on Issues Page.	 ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA

Reviewer's Name / Title:

Date(s) of Review:

MONITORING QUESTIONNAIRE

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SECTION 6: HEALTH CARE

Sources of Information:

Informants:

Primary Care Physician:

Psychiatrist (if applicable):

Neurologist (if applicable):

Psychologist (if applicable):

Other specialists (if applicable):

Health Indicator Checklist (Check all that apply)

☐ Significant Change in Health / Behavior in past year
☐ Choking Precautions
☐ 2 or more Medical Hospitalizations in the past year
☐ Suction Required (type:)
☐ Tube Feeding (type:)
☐ Bowel Elimination Problems- colostomy, ileostomy
☐ Bowel Elimination Problems- diarrhea or constipation
☐ Bladder Elimination Problems- recurrent UTI (3 or more a year)
☐ PICA
☐ Communicable Disease- TB/Hepatitis A, B or C, STD, MRSA
☐ Pressure Ulcer/Skin Breakdown
☐ Major Seizure Disorder (date of most recent seizure:)
☐ Dialysis
☐ Injuries
☐ Falls (2 or more a month)
☐ Diabetes
☐ Difficulty Maintaining or Losing Weight (not within BMI range)
☐ Mobility
☐ Recurrent (3 or more a year) respiratory infections
☐ Chronic Pain
☐ Hypertension
☐ Psychotropic Medications (total number:)
List:
☐ Anti-convulsant Medications (total number:)
List:
☐ PRN Medications (total number:)
List:
Are there individualized written instructions and protocols? ☐Yes ☐No
☐ ER visits

96.	Were appointments with medical practitioners for essential supports scheduled for and did they occur within 30 days of discharge?	☐Yes ☐No ☐NA

97.	If ordered by a physician, was there a current physical therapy assessment? Date:	☐Yes ☐No ☐NA
98.	If ordered by a physician, was there a current occupational therapy assessment? Date:	☐Yes ☐No ☐NA
99.	If ordered by a physician, was there a current psychological assessment? Date:	☐Yes ☐No ☐NA
100.	If ordered by a physician, was there a current speech and language assessment? Date:	☐Yes ☐No ☐NA
101.	If ordered by a physician, was there a current nutritional assessment? Date:	☐Yes ☐No ☐NA
102.	Were any other relevant medical/clinical evaluations or assessments recommended? If Yes, list with date:	☐Yes ☐No
103.	Are there needed assessments that were not recommended? If Yes, list and explain on Issues Page:	☐Yes ☐No
104.	Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments? a. OT b. PT c. S/L d. Psychology e. Nutrition f. Other	 ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA
105.	Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	☐Yes ☐No
106.	Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist? Date of last exam: If No, explain:	☐Yes ☐No ☐NA
107.	Were the dentist's recommendations implemented within the time frame recommended by the dentist?	☐Yes ☐No ☐NA
108.	Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	☐Yes ☐No ☐NA

	If No, explain:	
109.	Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist? If No, explain:	☐Yes ☐No ☐NA
110.	Is lab work completed as ordered by the physician?	☐Yes ☐No ☐NA
111.	List any significant lab work not completed:	
112.	Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	☐Yes ☐No ☐NA
113.	List any significant consults not completed:	
114.	Is there monitoring of fluid intake, if applicable per the physician's orders?	☐Yes ☐No ☐NA
115.	Is there monitoring of food intake, if applicable per the physician's orders?	☐Yes ☐No ☐NA
116.	Is there monitoring of tube feedings, if applicable per the physician's orders?	☐Yes ☐No ☐NA
117.	Is there monitoring of seizures, if applicable per the physician's orders?	☐Yes ☐No ☐NA
118.	Is there monitoring of weight fluctuations, if applicable per the physician's orders?	☐Yes ☐No ☐NA
119.	Is there monitoring of positioning protocols, if applicable per the physician's orders?	☐Yes ☐No ☐NA
130.	Does this individual receive psychotropic medication?	☐Yes ☐No
131.	If Yes, list DSM diagnosis documented in the record: Axis I:	
133.	If Yes, is there documentation that the individual and/or a legal guardian has given informed consent for the use of psychotropic medication(s)? List relationship of person who gave consent**:**	☐Yes ☐No ☐NA
134.	Does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic medications, using a standardized tool (e.g. AIMS) at baseline and at least every 6 months thereafter)?	☐Yes ☐No ☐NA ☐CND
135.	Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.?	☐Yes ☐No ☐NA ☐CND
136.	Is there any evidence of administering excessive or unnecessary medication(s), including psychotropic medications? If "Yes" or "CND" response, explain on the Issues Page.	☐Yes ☐No ☐CND

MONITORING QUESTIONNAIRE

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SECTION 7: SUMMARY QUESTIONS

137.	Based on documentation reviewed and interview (s) conducted, is there any evidence of actual or potential harm, including neglect? If Yes, cite:	☐Yes ☐No ☐CND
138.	In your professional judgment, does this individual's health care require further review? If Yes, identify the issue here and explain further on the Issues Page:	☐Yes ☐No ☐CND

Reviewer's Name / Title:

Date(s) of Review:

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SECTION 8: SUPPLEMENTAL QUESTIONS

Since January 1, 2021:

For each of the following answered "Yes," did all necessary and timely reporting occur through CHRIS?

What does the staff do when they become aware of an injury, suspected abuse or neglect?

141.	Has there been a psychiatric hospitalization? If Yes, list the date he/she was hospitalized and the length of stay:	☐Yes ☐No
142.	Have there been any events related to the individual's high risk health factors (i.e. aspiration, choking, constipation, falls, etc.) a. If Yes, list the date and describe: b. If Yes, are those who support the individual aware of any DBHDS alert about the risk factor(s)? c. If Yes, have any protocols or procedures been created or modified as a result?	☐Yes ☐No ☐Yes ☐No ☐NA ☐Yes ☐No ☐NA
143.	Has there been an emergency room visit or unexpected medical hospitalization? If Yes, list the date(s) and the reason(s):	☐Yes ☐No
147.	Has there been the use of physical, chemical, or mechanical restraint? If Yes, list the date and reason:	☐Yes ☐No
152.	a. Did the Case Manager identify an unidentified or inadequately addressed health-related risk, injury, need, or change in status? If Yes or No, list the risk, etc.: b. If Yes or No, did they document, report and convene the ISP team?	☐Yes ☐No ☐NA ☐Yes ☐No ☐NA

Reviewer's Name / Title:

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ISSUES PAGE

(Use only for issues related to the individual reviewed that require follow-up or for issues that were resolved, and commendation is warranted.)

Reviewer's Name / Title:

Date(s) of Review:

APPENDIX C

Crisis Services

by

Kathryn du Pree MPS

and

Joseph Marafito MS

Review of Crisis Services Through the Twentieth Review Period

I. Introduction and Overview

This is the twentieth review period which is the tenth annual study of the Commonwealth's statewide crisis services system. It is the seventh year comparing the data and reporting on trends in the Commonwealth's provision of a statewide system of crisis services. As in the past, this study included a review and analysis of facts regarding the status of the Commonwealth's accomplishments in implementing and fulfilling the Agreement's provisions as described and measured by the associated compliance indicators. This is the third study in which I evaluated the status of documentation that DBHDS maintains to demonstrate its progress toward achieving the Agreement's twenty-one crisis services provisions and their twenty-nine associated compliance indicators. Overall, the crisis services provisions require the Commonwealth to:

- Develop and maintain a statewide crisis system for individuals with DD.
- Provide timely and accessible supports to individuals who are experiencing a crisis.
- Provide services focused on crisis prevention and proactive planning to avoid crises.
- Provide mobile response, in-home and community-based crisis services to resolve crises and to prevent the individual's removal from his or her home, whenever practical; and
- Provide out-of-home crisis stabilization services for children and avoid out-of-home placement

The eighteenth review period study of Virginia's crisis service system found that Virginia could not be found to be in full compliance with the Crisis Services Provisions during the eighteenth review period because DBHDS had not determined that its data sources provide reliable and valid data for compliance reporting. DBHDS had also not met all the outcomes of the Crisis Services Provisions as detailed in the Compliance Indicators most notably the expectation that crisis assessments would occur in community settings (*CI 7.8).* Other CIs that were not met based on a lack of outcome achievement included *CI 7.14* because DBHDS did not complete a gap analysis to identify how many licensed behaviorists are needed; and *CI 8.04* because initial CEPPs were not developed within fifteen days of the assessment,

For this twentieth period review, the status of the Commonwealth's progress will be studied for all the requirements of the Compliance Indicators that are detailed for Provisions III.C.6.a-b. of the Settlement Agreement. For a subset of these Provisions, progress toward achieving the agreed upon compliance indicator (CI) metrics will be reviewed and reported. The Parties have agreed upon several indicators to determine compliance with crisis services Provisions that were determined to be out of compliance in 2020. Some CIs have been determined to be Met since then and others were found to be Not Met in the eighteenth review period. This subset includes: III.C.6. a. i-iii (i.e., 7.1 – 7.23 according to Virginia's numbering system); III.C.6.b.ii.A and B (i.e., 8.1 – 8.7); as well as III.C.6.b.iii.B. D, E (i.e., 10.1 – 10.4) and G (i.e., 13.1 – 13.3)

The Independent Reviewer and Expert Reviewer presented to the Commonwealth the draft plan for the review to be conducted this spring of the nineteenth and twentieth review periods, which is referred to as Year 7 throughout this report. This review includes an analysis and reporting of Virginia's status implementing all the Compliance Indicator (CI) requirements associated with the Commonwealth's statewide crisis services system. These include the main components identified as Prevention, Mobile Crisis and Crisis Stabilization. Prevention is identified by *CI 7.1* as early identification; assessment in the home; behavior supports in the home; and the availability of direct support professionals.

The Independent Reviewer continues to be deeply concerned about the high number of individuals with DD whose initial crisis assessment occurs at hospitals rather than in the individuals' homes. In its Settlement Agreement Virginia promised that its mobile crisis teams "shall respond to individuals at their homes" and offer services "to de-escalate crises without removing individuals from their current placement whenever practicable." However, the standard practice of CSB Emergency Services prior to the Settlement Agreement of individuals being routinely removed from their homes to receive an assessment at a CSB office or at a hospital remains. While there has been a welcome decrease in the number and percentage of individuals hospitalized in this reporting period, the number of individuals hospitalized is still a significant concern. The data is not specific to the outcome of crisis assessments by the location in which the assessment is conducted, but we remain concerned that many individuals assessed at CSB offices or hospitals continue to be admitted to psychiatric hospitals rather than utilizing in-home supplemental supports or crisis stabilization services as alternatives to hospitalization. Although there are other factors, this dynamic contributes to an increase in the number of children and adults with DD who are admitted to psychiatric hospitals in Virginia. During Year 7 28% of adults and 22% of children who were assessed for a crisis were hospitalized. In the Settlement Agreement, the Parties recognized the vital role of assessments at home in preventing unnecessary institutionalization. In 2019, having made little progress, the Parties established the compliance indicator requirement expressed in *CI 7.8* that 86% of this population will receive the REACH crisis assessment in the home or other community (non-hospital/CSB) setting.

For this 20th period study, the Expert Reviewer will review the Quarterly REACH reports to determine the status of the Commonwealth's implementation of the systemic changes needed to resolve the obstacles that have previously slowed progress toward achieving the required outcome measures of compliance. Both the Expert and Independent Reviewers understand that the protocol that was properly put in place during COVID to assure individual's safety and lessen the spread of COVID may have continued to result in fewer in-person crisis assessments at the individuals' homes in this review period. We hope to see an increase of in-person work during this review period.

This period's study also includes a review of the DBHDS standard crisis services reports regarding whether, and the extent to which, the Commonwealth continued to maintain the systems that previously resulted in DBHDS achieved and sustained compliance for two consecutive determinations. This review will include the staff capacity of the REACH programs

to both respond to crises as well as to provide follow-up crisis services in an appropriate and timely way. DBHDS continues to produce quarterly reports summarizing the progress of the REACH programs to meet the requirements of the SA as they relate to developing and sustaining a statewide crisis support system for children and adults with DD. DBHDS is also engaging in a quarterly qualitative review of each Region's crisis services implementation for both children and adults. The quarterly reports from each Region's quality review with DBHDS will be reviewed for both children and adult crisis services. This is planned with the understanding that these quarterly qualitative reviews inform DBHDS of the quality of existing REACH services and contribute to DBHDS' understanding of the REACH teams' success meeting training requirements for staff; completing CEPPS; and training caregivers on the elements of the CEPP.

This consultant will review the DBHDS actions, and sufficiency of these actions, to achieve the metrics and purpose of the indicators of compliance to learn what progress has been accomplished. These include the changes to the CSB contracts to address Case Manager (CM) training; crisis screening and referral to REACH; the implementation and sufficiency of assessment for risk for crisis needs including the identification of risk for hospitalization; timely referrals from psychiatric hospitals to REACH; increase in behavioral consultant capacity and timely referral to and services by behavior specialists, the availability of in-home supports; the availability and utilization of the REACH CTH programs for adults and children; the ability of CSB ES and REACH staff to respond to crises in the individual's home or day program; and planning, implementation and sufficiency of the quality review and improvement process led by DBHDS. These areas of review are detailed in the list below which identifies specific reports that were expected to be provided related to the CIs for crisis services.

During the sixteenth review period, DBHDS began to produce expanded and/or additional reports or documents to address the agreed upon indicators of compliance regarding crisis services. The Parties agreed and the Court approved (IX.C) that the Commonwealth would maintain records that document proper implementation of the Settlement Agreement's (SA) Provisions and associated CIs. Therefore, the Commonwealth's reports are expected to provide sufficient information to determine whether each of the indicator metrics has been achieved.

The Independent Reviewer reported on the Commonwealth's success in complying with the provisions of the Settlement Agreement (SA) in the seventeenth and eighteenth review periods. He found the Commonwealth was in compliance with the provisions listed below. In this Overview Section I will summarize the Commonwealth's continued compliance with these Provisions of the SA. All reported data are for the nineteenth and twentieth reporting periods, which includes data from FY21 Q4, FY22 Q1, FY22 Q2, and FY22 Q3. This is the seventh year this data has been compiled to compare data across years. Given the Commonwealths' continued compliance with the following provisions, and the focus in this review period of reviewing and analyzing data that demonstrates progress towards the agreed upon Compliance Indicators (CIs) I will summarize relevant data for Year 7 related to those Provisions which the Independent Reviewer has previously determined that Virginia has achieved and sustained compliance during at least two successive review periods. These findings will be reported in the

initial part of this report. The second section of the report will provide information regarding the Commonwealth's progress towards meeting the requirements of the agreed upon CIs.

The completion of this study required us to review numerous documents and to conduct several interviews. We conducted five separate meetings with DBHDS staff. The first was the kickoff meeting with Heather Norton, Assistant Commissioner; Jenni Schodt, Settlement Agreement Director; and two of the Regional Crisis Systems Managers: Nathan Habel and Sharon Bonaventura. We also interviewed Nathan Habel and Sharon Bonaventura to discuss *CIs 7.19 and 7.20* and conducted a second interview to discuss the process to spot check several CIs which are discussed later in this report. We interviewed Heather Norton, Nathan Habel, and Sharon Bonaventura near the end of the review to clarify any questions we had about the information and data in various reports. We greatly appreciate the staff's willingness to schedule these interviews and more importantly to provide a wealth of data to guide us in our review and analysis. Significantly more documentation has been requested in this review period. All our requests for data have been responded to graciously and timely. The entire list of documents is included as Appendix 1.

II. Summary of Provisions

DBHDS has sustained compliance for the following provisions: III.C.6. b.i.A., III.C.6. b.i.B., III.C.6.b.ii.C, III.C.6.b.ii.D, III.C.6.b.ii.E., III.C.6.b.ii.H., III.C.6.b.iii.A., and III.C.6.b.iii.F. A short summary of the data relevant to each of these Provisions with a comparison to findings from Year 6 follows.

III.C.6.b.i.A. *The Commonwealth shall utilize existing CSB Emergency Services including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, seven days per week.*

Children's Services-REACH continues to accept numerous referrals for both children and adults. There were 1,476 referrals for children in this period of which 625 (42%) were crisis referrals. This is a slight decrease in referrals compared to Year 6 when REACH received 1,505 referrals for children of which 41% were crisis referrals. Referrals continue to be made by several referral sources. During this review period families and Case Managers (CM) referred 808 (55%) of the children and 530 (36%) were referred by hospitals, CSB Emergency Services (ES), or law enforcement. REACH continues to offer crisis response 24 hours a day, 7 days a week as required. One hundred fifty-five (155) referrals were made on weekends or holidays, which is 10% of the referrals. Almost half of all the referrals (720) were made between 3PM and 7AM.

REACH also reports the total number of calls it receives which is more than the number of referrals. There was a total of 6,219 calls to the REACH children's programs, of which 1,089 (17%) were crisis calls. This is a significant decrease from the 9,656 total calls received by REACH in Year 6 of which 1,013 (10%) were crisis calls. However, the number and percentage of crisis calls was greater in Year 7 then it was in Year 6.

Adult Services- There were 1,971 referrals for adults in this period of which 793 (40%) were crisis referrals. This is a decrease from Year 6 in the total number of referrals when there were 2,189 referrals, of which 823 (38%) were crisis referrals. Referrals continue to be made by several referral sources. During this review period families, residential providers and CMs referred 1,024 (52%) of the adults and 879 (45%) were referred by hospitals, CSB Emergency Services (ES) and law enforcement. REACH continues to offer crisis response 24 hours a day, 7 days a week as required. Two hundred eighty (280) referrals were made on weekends or holidays, which is 14% of the referrals. Approximately half,1,000, (51%) of all the referrals were made between 3PM and 7AM.

REACH also reports the total number of calls it receives which is more than the number of referrals. There was a total of 15,515 calls to the REACH adult programs, of which 2,067 (13%) were crisis calls. The number of total calls in Year 7 was less than in Year 6 when REACH received 20,575 total calls of which 2,663 (13%) crisis calls. Fewer crisis calls were received in Year 7 than were received in Year 6.

III.C.6.b.i.B. *By June 30,2012 the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals; and the resources that are available.*

REACH continues to train community stakeholders including CMs and CSB ES staff. Overall, REACH staff trained 833 CMs and 168 ES staff in Year 7. In Year 6 REACH programs trained 636 CMs and 244 ES staff. It is not possible to draw any conclusions in the differences because the number of new staff needing to be trained is unknown.

III.C.6.b.ii.C *Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement.*

DBHDS reports on the involvement of law enforcement personnel in Year 7 for all crises involving the police regardless of whether REACH staff responded in person or remotely using telehealth.

Children's Services- REACH staff continue to work with law enforcement personnel to respond to individuals with DD who are in crisis. As reported above there were 1089 crisis calls involving children. Law Enforcement was involved responding with REACH staff to 310 (28%) children. This compares to Year 6 when law enforcement was involved with (32%) of the crisis calls.

Adult Services- REACH staff continue to work with law enforcement personnel to respond to individuals with DD who are in crisis. As reported above there were 2067 crisis calls involving adults. Law Enforcement was involved responding with REACH staff to 743 (36%) adults. This is similar to Year 6 when law enforcement was involved in 37% of the crisis calls.

Overall, the REACH programs trained 839 police officers in Year 7. This compares to Year 6 when REACH programs trained 453 police officers.

III.C.6.b.ii.D. *Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.*

See data reported under III.C.6.b.i.A.

III.C.6.b.ii.E. *Mobile crisis teams shall provide local and timely in-home crisis supports for up to three days, with the possibility of an additional period of up to three days upon review by the Region Mobile Crisis Team Coordinator.*

DBHDS reports that during Year 7 the data for in-home crisis supports includes a mix of in-person and telehealth services. Services may be mixed for an individual or some individuals may have received only telehealth services. DBHDS is unable to report more specifically as to how often each type of support (in person or remote) was used.

Children's Services- In each Region, REACH provided individuals with in-home mobile support. The total number of children who received mobile support during Year 7 was 322, of which only 20 were children who were re-admitted. The range of mobile support was 1-16 days, and the average number of days ranged from 2-15 for children. In Year 7 there were only four instances when the average days per case was fewer than three. This occurred twice in Region I and twice in Region IV over four quarters. Region III and Region V consistently provides the most average days per case. A total of 336 children received crisis mobile supports in Year 6. Fewer children received mobile supports in Year 7 compared to Year 6 when 322 children received mobile supports.

Of concern is that Region I did not provide mobile supports to any children in FY22Q3 and to only one child in FY22 Q2. DBHDS explains that this is because the management of the program moved to Region Ten CSB effective January 1,2022, and all but one staff position had to be refilled. In the first two quarters of Year 7, Region I provided mobile supports to a total of thirty-four children, so it is likely that several families went without needed crisis mobile supports for the last six months of the reporting period. It does not appear that children in Region I experienced more hospitalizations during these two quarters when 21 (18%) of the 118 children who were hospitalized across the state were from Region I.

Adult Services- In each Region, REACH provided individuals with in-home mobile support. A total of 466 adults received crisis mobile supports in Year 7. The range was 1-15 days, and the average number of days ranged from 2.6-12.6 for adults. In Year 7 there were only two instances when the average days per case was lower than three days, both in Region IV that averaged 2.7 days in FY21 Q4 and 2.7 days in FY22 Q3. Region III consistently provides the most average days per case, ranging from 8-12. The total number of adults who received mobile supports included 428 adults who were new referrals to REACH. Fewer adults received mobile supports in Year 7 compared to Year 6 when 627 adults participated in mobile supports. Later in this report I include a summary of staff vacancies in the REACH programs. The decline in the number of adults receiving mobile supports may be attributed to staff shortages. Data from DBHDS verifies that the staff vacancies in March 2022 ranged from 25%-65% across the five regions.

III.C.6.b.ii.H. *By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site crises as follows: in urban areas within one hour, in rural areas within two hours, as measures by the average annual response time.*

REACH continued to be unable to respond to all crisis calls in person as a result of the COVID pandemic in Year 7. DBHDS provides the data for the response times for only the crises that were responded to in-person. DBHDS does report on the location of all crisis assessments, whether they were responded to in person or using telehealth.

Children's Services- REACH staff responded to 420 of the 1089 (39%) crisis referrals in person. Of these face-to-face assessments, 404 (96%) were responded to within the required response time set for each Region. Once again Region III was able to conduct face-to-face assessment for the most individuals experiencing a crisis. Region III responded in person to 186 (46%) of the total number of crisis referrals that were responded to face-to-face across all five Regions. Region IV responded to 131 (32%) of the crises responded to face-to-face. There is no explanation for the variation across the regions in the number that has been responded to in-person versus telephonically.

DBHDS also reports on the location of the crisis assessments. The report derives its data from the location of the individual who was assessed for a crisis. This total is 1089 children. Only 393 (36%) were conducted in a community location and 678 (62%) were conducted at the hospital or CSB ES. A lower percentage of assessments were conducted in community locations in Year 7 (36%) compared to Year 6 (40%). This data is not used to determine the Commonwealth's progress towards meeting *CI 7.8* that requires 86% of crisis assessments be conducted in community settings for individuals known to REACH. These data reported in the Quarterly REACH reports, includes crisis assessments done for all children and adults whether they are already known to REACH or a new referral. *CI 7.8* only requires community- based assessments for those individuals known to the system.

For the reporting purposes of responding to *CI 7.8* that requires 86% of crisis assessments to be performed in community locations for individuals known to REACH, DBHDS reports in its Supplemental Crisis Report. These data are reported and discussed in a later section of this report.

Adult Services- REACH staff responded to 887 (43%) of the 2067 crisis referrals in person in Year 7. Of these in-person assessments, 851 (96%) were responded to within the required response time set for each Region. As was true in Year 6, Region III completed the most in-person assessments of any region. Region III alone completed 401 (45%) of the 887 crisis assessments conducted in-person throughout the five Regions in Year 7. REACH staff responded to 522 (26%) of the crisis referrals in person in person in Year 6. Of these in-person assessments, 494 (95%) were responded to within the required response time set for each Region. Prior to Year 6 the expectation was that the crisis assessment would be conducted face-to-face.

It is troubling that COVID restrictions in hospitals or by family preference has resulted in the REACH program responding to the majority of its crises by telephone. This is contrary to the Settlement Agreement requirement that "crisis teams shall respond to individuals at their homes". DBHDS does not even report how many crisis assessments were responded to by telephone, or by video phone but rather only reports the total number of crisis calls and the number responded to in-person. The Commonwealth does not report how many REACH staff are present for the assessment conducted at the hospital or in community settings. More crisis assessments were completed in-person in Year 7 compared to Year 6 but the in-person assessments were still done for fewer than 50% of the individuals who needed them. DBHDS reports that REACH clinicians always respond in person if a Temporary Detention Order (TDO) is considered. However, some Regions did not respond in-person to all the crisis assessments that occurred in hospitals. Region I did not respond to any in-person assessments at hospitals in either FY22 Q2 or Q3 for either adults or children. Region III, as mentioned consistently, conducts the highest percentage of in-person assessments. There is no explanation of the wide variation across the Regions of the number and percentages of assessments completed onsite versus telephonically. This provision contains the expectation that crisis assessments are conducted onsite rather than telephonically. DBHDS staff report that they have researched the success of telephonic responses to crises in establishing the 988 crisis call centers. However, in-person onsite assessments have been required since the beginning of the Agreement in 2012 and individuals with DD in the Commonwealth are still experiencing high rates of hospitalizations after crisis assessments. The significant decrease in onsite responses to complete the crisis assessment may indicate the Commonwealth is no longer complying with this Provision. Telephonic responses to crisis calls are contrary to Virginia's commitments to Virginians with DD and their families and will not sustain compliance in future reviews.

DBHDS also reports on the location of the crisis assessments. The report derives its data from the location of the individual who was assessed for a crisis, not on the number of crises REACH staff responded to in person. This total is 2,067 adults. In Year 7 only 645 (31%) of the crisis assessments were conducted in a community location. Alternatively, 1,365 (66%) were conducted at the hospital (1,212) or the CSB ES (153). A few were conducted at police stations

(17) and a few at other locations (36). In Year 6 only 657 (34%) were conducted in a community location and 1217 (63%) were conducted at the hospital or CSB ES. There was a comparable percentage of assessments completed in community locations in Year 5.

The Commonwealth has developed its 988-crisis response system and data was provided on the number of calls received. To date, these calls are not separated for different populations, including individuals with DD. The Commonwealth's decision to change its crisis response system, does not change the requirements of the Settlement Agreement and the associated compliance indicators. The 988-crisis system will not be fully operationalized until FY23 as was originally intended. DBHDS decided to pilot it starting in December 2021. Beginning in FY23 Virginia's call center will dispatch trained licensed crisis response staff to address crises that cannot be resolved directly by the call center. There will be crisis staff specifically trained to respond to children; adults with mental health concerns; and individuals with DD. REACH staff will continue to respond to the latter group. DBHDS has conducted research on the use of similar call centers and based on national best practices and data anticipates that 80% of the crises can be resolved by the call center. DBHDS has contracted with two providers. PSR, Inc. service Regions I, II, IV and V. Frontier Behavioral Health supports Region III. Both providers are certified by the National Suicide Prevention Lifeline. The Commonwealth has received $2.5 million in federal funds from the Substance Abuse and Mental Health Services Administration (SAMSHA) to support the capacity of the 988-crisis response.

There has not been an increase toward meeting the goal of 86% of crisis assessments being conducted in community settings. For the reporting purposes of responding to CI 7.8 that requires 86% of crisis assessments to be performed in community locations, DBHDS reports in its Supplemental Crisis Report. These data are reported in a later section of this report.

III.C.6.b.iii.A. *Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services.*

Children's Services- The Commonwealth now has two CTHs serving children. One home is located in Region I and operated by Region II and serves children in Region I and II. The second home is in Region IV and serves Regions III, IV and V. Neither CTH was able to operate at full capacity during this reporting period. A total of 143 children used the 2 CTHs in Year 7: 72 (50%) for stabilization; 37 (26%) for prevention; 28 (20%) for stepdown; and 6 (4%) who were readmitted. The average Lengths of Stay (LOS) were under twelve days for all types of admission. A larger percentage of children used a CTH for step down in Year 7 compared to the 12% who used it for this purpose n Year 6. The utilization of the CTH beds was only 34% for the Region II program and 27% for the Region IV program. It is likely that utilization was impacted by COVID restrictions and related staffing shortages. The Commonwealth is to be commended that so many more children had this resource to assist them in a time of crisis in Year 7 than in Year 6 when 108 children used the CTH programs.

However, it is concerning that the CTHs are used very infrequently by Regions I, III and V. As examples, of statewide referrals to CTHs, children from Regions II and IV accounted for 78% of the referrals in FY22 Q2 and 93% of the referrals in FY22 Q3. DBHDS should determine if the goal to provide access to and serve all children in the Commonwealth by operating only two CTHs is being met. During these two quarters the three Regions in which the CTHs are not physically located, hospitalized eighty-five children (72%) of the 118 children who were hospitalized from all five Regions during FY22 Q2 and Q3.

Adult Services- The Commonwealth continues to operate five CTHs for adults with co-occurring conditions. All were in operation during Year 7 and served a total of 233 adults compared to Year 6 when 252 adults were served. This includes 118 (51%) for stabilization; 35 (15%) for prevention; 72 (31%) for stepdown; and 8 (3%) who were readmitted. The average Lengths of Stay (LOS) were under thirty -five days for all types of admission and averaged between 5 and 34 days. The utilization of the CTH beds averaged 39% across the five CTHs and ranged from 31-49%. Region IV had the highest utilization and served the most individuals. It is concerning that fewer adults were served in the year past the start of the COVID pandemic but again this may be attributable to staffing shortages and the continuation of COVID outbreaks in Virginia. In Year 6 CTH utilization ranged from 47%-81% which was a substantially higher utilization rate than in the current year, Year 7.

The average LOS across the four quarters of year 7 ranges from 16-27 days. The actual LOS for some individuals is longer than the expected thirty days. DBHDS reports in detail about the LOS for individuals whose stay continues from one quarter to the next. There were fifteen individuals in FY20 Q4; eighteen in FY21 Q1; twenty in FY21 Q2; and fifteen in FY21 Q3 in this category. Of all these adults whose stays crossed over from one quarter to the next, thirty-three stayed at the CTH longer than thirty days. Twelve of the thirty-three individuals who stayed longer than thirty days and stayed across quarters were discharged in fewer than sixty days. Seven had stays of more than 100 days. It seems that the availability of the Adult Transition Homes is having a positive impact on the LOS in the CTH. The availability of this alternative should allow the CTHs to accept more referrals as beds are more readily available.

III.C.6.b.iii.F. *By June 30,2012 the Commonwealth shall develop one crisis stabilization in each Region.*

It is noted above that the Commonwealth has opened its CTHs for children. Historically Provision III.C.b.iii.F has been determined in compliance because each Region has a CTH for adults. The data for the use of the CTHs are included under III.C.b.iii. A.

Hospitalizations

The purpose of creating and enhancing the statewide crisis services system in the Commonwealth for individuals with DD and a co-occurring condition is to be able to stabilize these individuals in their existing settings or offer a suitable community service alternative to

prevent unnecessary hospitalization. Therefore, it is important to share the Year 7 data as it relates to these hospitalizations.

Children: DBHDS reports the total number of children who were hospitalized during this reporting period. The total was 299 of whom 196 (66%) are considered new referrals and 103 (34%) are children who are active with REACH. Fewer children were hospitalized in Year 6 (299) compared to Year 6 when 369 children were admitted to a psychiatric hospital. This decline is a 19% decrease in hospitalizations for children. There was also a decline in hospitalizations of 19% between Years 5 and 6 which is a positive trend.

DBHDS also reports on the number of children who were hospitalized as an outcome of the crisis assessment which is a portion of the total number of children hospitalized (299). This number is 240 which represents 22% of the children who had a crisis assessment in Year 7. This number compares favorably to the number of children hospitalized as the outcome of a crisis assessment in Year 6 when 324 (32%) and Year 5 when 467 (35%) of children who had a crisis assessment were hospitalized.

Adults: DBHDS reports the total number of adults who were hospitalized during this reporting period. The total was 689 of whom 341 (49%) are individuals known to REACH and 348 (51%) who were individuals who were newly referred. In Year 6 the total was 842 of whom 441 (52 %) were new referrals and 401 (48%) were adults who are active with REACH. The number of hospitalizations decreased in Year 6 compared to Year 5 when 918 adults were hospitalized. This is an 18% reduction in hospitalizations for adults. There was an 8% reduction in hospitalizations for adults in Year 6 compared to Year 5. The continued trend of decreased hospitalizations is positive.

DBHDS also reports on the number of adults who were hospitalized as an outcome of the crisis assessment which is a portion of the total number of adults hospitalized (689). This number is 584 which represents 28% of the individuals who had a crisis assessment. This number compares favorably to both Year 6 and Year 5 when 620 (32%) and 885 (33%) of the adults who had a crisis assessment were hospitalized respectively. The overall decrease in hospital admissions for adults is mirrored for the adults who were assessed for a crisis.

The value of offering crisis services continues to be validated. DBHDS reports on the dispositions for individuals who received either mobile crisis or prevention services and their dispositions after receiving these supports. These supports were provided to a total of 2166 children in Year 7. Only 43 (2%) of children who received mobile supports were hospitalized after these mobile supports ended. Most of these children retained their setting: 2064 (95%) children remained home. DBHDS reports that of the 154 children who used the CTH, only 9 (6%) were hospitalized after being discharged from the CTH and 123 (80%) retained their setting while a new community residence was found for 6 (4%) of the children. This number differs from the total number of children who are reported as using the CTH which was 143 but the 143 does not include children who had a continued stay over a quarter.

These services were provided to 3,924 adults, which is 526 fewer adults than the number who received these crisis supports in Year 6 (4,450). Only 287 (7%) of these adults who received mobile, or prevention services were hospitalized after receiving these supports. Most of these adults retained their setting: 3,359 (86%) remained in their existing residence. DBHDS reports that of the 292 adults who used the CTH program, only 23 (8%) were hospitalized after leaving the CTH. Many adults retain their setting, 119 (41%) or transition to a new community residence, 59 (20%). Fewer adults using mobile, or prevention services retained their settings in Year 7: (86%) compared to 4127 (91%) in Year 6. A similar number and percentage of adults using the CTH in Year 7 retained their setting or transitioned to a new community residential setting compared to Year 6 when 42% retained their setting and 22% transitioned to a new community residence.

The Parties have agreed to the importance of conducting crisis assessments in the individual's home or other community location. A Compliance Indicator has been developed that sets the expectation that 86% of individuals who experience a crisis will be assessed for that crisis in the community setting in which the crisis occurs. The belief is that this will result in fewer hospitalizations as a result of the needed community supports being immediately identified and provided to stabilize the crisis for the individual. DBHDS does not provide data that connects the location of the assessment, either hospital or CBS ES; or a community setting to the outcome of hospitalization. This more detailed outcome data may assist the Expert Reviewer, Independent Reviewer and Parties to determine how consequential the location of the assessment is to whether the individual can remain in the community safely. Since REACH staff are now completing many crisis assessment telephonically it will also be useful to have data that reflects the outcome of these assessments compared to those assessments that are conducted by the REACH staff in person.

REACH STAFFING

The accomplishments of the REACH teams must be reviewed within the context of staff capacity and availability. Nationally providers of services to support individuals with DD have struggled to retain and recruit staff since the beginning of the COVID pandemic. The REACH program has experienced similar difficulties maintaining its workforce. DBHDS reported on the filled and vacant positions for all five of the REACH programs in March 2022. Staff vacancies statewide for REACH community services ranges from 16% for supervisory and clinical positions to 44% for staff who provide mobile crisis response. Region V has the highest percentage of vacancies for supervisory/clinical and coordinator positions, while Region III has the highest percentage of vacancies for its mobile crisis staff. The Children's CTH programs and the ATH programs have fewer vacancies, compared to the Adult CTH program. The CTH Program for Adults is experiencing 37% vacancy rate statewide with Region III the most significantly impacted with 67% of its positions vacant.

The following Tables depicts the data.

Table 1: FY22 Annual REACH Staffing Data for REACH Crisis Teams

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Supervisory/ clinical filled	9	20	12	23	7	**71**
Supervisory/clinical vacant	3	1	4	2	4	**14**
Total	12	21	16	25	11	**85**
Percent Vacant	25%	4%	25%	8%	36%	**16%**
Coordinator filled	9	14	6	11	6	**46**
Coordinator vacant	7	2	4	5	9	**27**
Total	16	16	10	16	15	**73**
Percent Vacant	44%	12%	40%	31%	60%	**37%**
Mobile filled	4	6	7	11	5	**33**
Mobile vacant	3	2	13	4	4	**26**
Total	7	8	20	15	9	**59**
Percent Vacant	43%	25%	65%	27%	44%	**44%**

Table 2: FY22 Annual REACH Staffing Analysis for REACH CTH and ATH Settings

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Adult CTH filled	9	10	6	10	12	**47**
Adult CTH vacant	4	2	12	2	7	**27**
Total	13	12	18	12	19	**74**
Percent Vacant	31%	17%	67%	17%	37%	**36%**
Children's CTH filled		14		12		**26**
Children's CTH vacant		1		1		**2**
Total		15		13		**28**
Percent Vacant		7%		8%		**7%**
ATH Filled		11		12		**23**
ATH Vacant		0		2		**2**
Total		11		14		**25**
Percentage Vacant		0%		14%		**8%**

III. Compliance Indicators Related to Crisis Services

The focus of this review period is to gather facts, analyze and determine the Commonwealth's progress towards achieving the Compliance Indicators related to the provision of crisis services. These indicators relate to SA Provisions: III.C.6. a. i-iii, III.C.b.ii. ii. A; III.C.6.b.ii.B; III.C.6.b.iii.B., III.C.6.b.iii.D., III.C.6.b.iii.E.and III.C.6.b.iii.G. The report is organized by Compliance Indicator (CI), which are sometimes grouped together because of the relationship of one or more to each other. Each CI is listed. Our review of these CIs is summarized by facts, attestations, analyses, conclusions. **Facts i**nclude a summary of the DBHDs report of the documents and data used to determine the status of achieving the expected outcomes and requirements. Facts also note the report DBHDS produces to report progress. The **Attestation** section addresses DBHDS' reporting of whether it has determined its data sources to be reliable and valid. Virginia could not be found to be in full compliance with the Crisis Services Provisions during the eighteenth review period because DBHDS had not determined that its data sources provide reliable and valid data for compliance reporting. The Attestations which were shared in March 2022 address many of these issues making it possible for these CIs to be met in the twentieth review period if the outcomes are also achieved, DBHDS produced Attestations for most CIs that relied upon data sources that would need to be verified for validity and reliability. The **Analysis** section provides a summary of findings related to the review of the outcome data. This section also addressed all Process Documents in the last review period. DBHDS Process Documents (PD) for Crisis Services were for the most part extremely comprehensive. We previously made some recommendations in the Year 6 report which were considered by DBHDS and generally used. Therefore we do not reanalyze the processes unless there was a significant issue to note. DBHDS has produced a Process Document for every CI for crisis services that requires a process to review and validate the data. Each PD includes the following elements: Purpose, Scope, Document Management, Roles and Responsibilities of staff who enter or analyze data; inputs and outputs; dates and descriptions of any changes and the author; data sources; process steps; DQV recommendations (if any); data source verification; CQI, and a Glossary of Terms. We find that the process steps are clearly written and thoroughly describe the steps to be taken to review and confirm data related to the achievement of the CIs.

We conclude that the processes that have been designed for the Crisis Services CIs, except for those that rely significantly on Avatar data, most notable *CIs 8.6 and 8.7,* include sufficient cross checks and methods for inter-rater reliability to adjust for any problems in data sources. This determination was supported by the validation study which used the exact same processes used by DBHDS staff.

The **Conclusion** section poses my determination of whether the CI is met or not met based on the analysis of the data and performance metrics submitted by DBHDS.

Validation Study: The Independent Reviewer asked us to conduct a validation study for a selection of CIs responsive to crisis services. We selected the following CIs to validate: *7.7; 7.8;*

7.10/7.12/7.13; 8.6/8.7; and 10.4/11.1. The purpose of the validations study was to spot check the implementation of several of the processes DBHDS uses to determine if the outcomes of the CIs are met. This study included a review of each step of the associated processes replicating DBHDS' methodology and activities. When possible, I provided an additional inter-rater reliability check using the sample provided by DBHDS. All the sources I used for the random sample selections are the specific sources cited in each associated CI. I followed the same methodology to validate each process.

The methodology used for the study is as follows:

Methodology

1) Select a random sample of at least thirty individuals or defined events from the population provided for each CI.
2) Eliminate those that went through the inter-rater process by DBHDS from the random sample.
3) Complete an additional inter-rater test on each random sample.
4) Follow the process described by the process documents and addressed in the processes training by DBHDS' Subject Matter Experts (SME).

Anticipated Conclusion/Hypothesis If DBHDS followed process correctly and inter-rater reliability was done correctly, the independent process and findings would either uncover weaknesses or validate DBHDS' process and its determinations of its inter-rater reliability.

We report on the process review and conclusion of the validation study under each CI in the study.

Summary of Findings for all Crisis Services CIs the following CIs were found to be met based on an analysis of the facts reported by the Commonwealth and verified in Year 6: 7.2, 7.3, 7.4, *7.9, 7.10, 7.11, 7.15, 7.16, 7.23, 8.2, 10.2, 10.4*, 11.1*, 13.1,13.2, and 13.3*. Those noted with an asterisk were met in Year 6 but are not met in Year 7.*

The following CIs were found to be met in Year 7: *7.5, 7.6, 7.7, 7.12, 7.13, 7.17,7.21, 7.22, 8.1, 8.3, 8.4, 8.5, 8.6**, 8.7**10.1, 10.3. Those noted with two asterisks need further data verification*

The Commonwealth was found not to have met CIs in Year 7: 7*.8, 7.14, 7.18, 7.19, 7.20, 10.4, 11.1 or 13.3*

DBHDS has met the requirements of twenty-nine CIs by the end of Year 7; however, two need further data verification. Eight CIs remain not met.

Review and Analysis of the Compliance Indicators

7.2: DBHDS will add a provision to the CSB Performance Contract requiring CSBs to identify children and adults who are at risk for crisis through a screening at intake, and if the individual is identified as at risk for crisis needs, refer the individual to REACH to ensure that when needed the initial crisis assessments are conducted in the home.

7.3: DBHDS will add a provision to the CSB Performance Contract requiring, for individuals who receive ongoing case management, the CSB case manager to assess an individual's risk for crisis during face-to-face visits and refer to REACH when a need is identified.

7.4 DBHDS will establish criteria for use by the CSBs to determine "risk of hospitalization" as the basis for making requests for crisis risk assessments.

7.5: DBHDS will ensure that all CSB Executive Directors, Developmental Disability Directors, case management supervisors, and case managers receive training on how to identify children and adults receiving active case management who are at risk for going into crisis. Training will also be made available to intake workers at CSBs on how to identify children and adults presenting for intake who are at risk for going into crisis and how to arrange for crisis risk assessments to occur in the home or link them to REACH crisis services.

7.6: DBHDS will add a provision to the CSB Performance Contract requiring training on identifying risk of crisis for case managers and intake workers within 6 months of hire.

Facts: The CSB Performance Contract requirements were determined during the eighteenth review period to address *CIs 7.2, 7.3, 7.5 and CI 7.6*.

This review found that DBHDS has a process for *CI 7.5* detailing how DBHDS will identify and monitor the number of staff who take the training. The training is available through the Commonwealth of Virginia Learning Management Center (COVLC) to all CSB staff. The process ensures that DBHDS can verify the CMs; DD and Executive Directors that are trained. DBHDS incorporates a quality improvement process step that involves follow-up by the Assistant Commissioner with CSB leadership when a training deficit is noted. This crisis risk assessment tool (CAT), which includes criteria for CSBs to use as the basis for making requests for crisis risk assessments to determine "risk of hospitalization, addresses *CI 7.4.*

DBHDS uses the Commonwealth of Virginia's Learning Center (COVLC) data and information in the Data Warehouse to identify the number of individuals who are trained on identifying risk of crisis as required in *CI 7.5.*

Analysis: The CAT is a useful guide for CMs to determine the need to refer someone to REACH for crisis assessment. It includes a scoring guide and instructions to ensure it is an objective process and is consistently applied to address situations that may lead to a crisis and hospitalization. The training is comprehensive and provides sufficient resources for CMs and Intake Coordinators. Trainees must pass a quiz after training and pass with a score of at least 80%.

DBHDS reported in April 2021 that 3020 CSB/BHA staff had completed this training through COVLC. DBHDS reports that a total of 3.431 CSB/BHA staff were trained by February 2022 to identify risks and to arrange for risk assessments to occur in the home. DBHDS determined in the 18th review period that everyone needing training has been trained based on its identification of the numbers of staff in the following professions: CSB/BHA Case Managers (1972); CSB/BHA Executive Directors (40) and Developmental Disability Directors (40). This totals 2052 employees. This is 500 fewer than the number trained which DBHDS uses to account for turnover in these positions. At that time, we found this CI to be not met because DBHDS did not maintain records that document that new intake workers and CMs are trained within six months or of hire, as required by *CI 7.6.* DBHDS has required new CMs and intake workers to be trained in risk assessment within six months of hire. In the twentieth reporting period. DBHDS was able to verify that 75% of the newly hired staff took this training. This was reported in the FY22 Q3 Supplemental DOJ Quarterly Crisis Report. DBHDS made this determination by comparing the hiring date of these new CSB employees with the training dates documented by COVLC. DBHDS provided feedback to the CSBs about the newly hired employees who were not trained in risk identification within six months of hire.

Conclusion: DBHDS has accomplished significant training on risk identification and assessment with thousands of staff being trained. DBHDS has used the CSB Performance Contract to set the requirements of *CIs 7.2, 7.3, 7.4 and 7.6.* It has met the full requirements of *CIs 7.2, 7.3 and 7.4.* It has set the requirement for CSBs to train all CMs and intake workers. It has met *CI 7.5.* It has now also met *CI 7.6* because DBHDS can report the dates of newly hired CMs and intake workers and the dates they are trained within six months of hire. DBHDS plans follow up by the CSBs for any newly hired staff who have not met this requirement.

7.7 DBHDS will implement a quality review process conducted initially at six months, and annually thereafter, that measures the performance of CSBs in identifying individuals who are at risk of crisis and in referring to REACH where indicated.

Facts: The data sources for *CI 7.7* are WaMS; AVATAR; and completed Crisis Assessment Tools (CATs). DBHDS reported on the implementation of this quality review process in FY21Q4 and FY22 Q3 in the Supplemental DOJ Quarterly Crisis Report. DBHDS provides a summary of the purpose of this process which is to: select a statistically significant sample; obtain the CATs from CSBs; review the CATs for scoring and referral integrity; and deliver quality review feedback to CSBs on scoring and referral integrity. They report a DBHDS statistician has determined the sample. The review methodology is specific, clear and establishes multiple internal checks as the process is operationalized. DBHDS indicates that "someone already opened in REACH"

(enrolled) should not be included in the quality review process but does not indicate if a substitution will be made through a random selection. This process depends on reliable and valid data from WaMS and Avatar. DBHDS reports that it updated the CQI section of its Process Document in January 2022 to focus the quality improvement efforts for CSBs using the trend and error analysis included in the process.

Attestation: DBHDS submitted the attestation form for CI 7.7 on March 4, 2022. The CIO performed a data set validation of the excel document. He created a sample data set in the application and recreated all visualizations. This analysis included a comparison of the data in the Supplemental Crisis Report. No defects were identified. The CIO concludes that the data is representative, the processes were followed, and the data and processes are reliable and valid. However, this CI relies on data from WaMS and AVATAR in addition to the completed CATS. There is no attestation to the reliability and validity of Avatar or WaMS. However, the Process that is used by the subject matter experts addresses any possible weaknesses in these two data sources.

Analysis: DBHDS reported on two samples, each of 300 individuals, that were drawn in Year 7. In FY21Q4 a sample of 300 achieved 98% scoring integrity and 100% referral integrity. In FY22Q2 a sample of 300 also achieved 98% scoring integrity and 100% referral integrity. The CI process describes a sample size of 600 which has now been achieved. DBHDS reports the sample was randomly selected; all individuals in the sample were qualified to be included; training was provided to the staff who collected the data, but not to those who analyzed the data. The staff who analyzed the data were master's level or board certified. The sample was qualified by the DBHDS Statistician Methodologist.

CI 7.7 was one of the CIs included in the validation study.
Process Review: DBHDS supplied a population of over 300 names. I removed the thirty names they had used for their inter-rater reliability check from the population of 300 and completed an inter-rater reliability check on these thirty in their sample. I then randomly selected an additional thirty names from the remaining 270 names for my further review. I followed the exact process described and used by DBHDS.

Conclusion of the Validation Study: The inter-rater check resulted in 100% reliability for both our sample and the DBHDS sample. The crosscheck of the DBHDS process appears to accommodate for any weaknesses that may be present in the WaMS system for this process and CI. Therefore, the study indicates that the process is both reliable and valid.

Conclusion: DBHDs has implemented a quality review process. To date DBHDS has conducted three reviews of 300 CATs, for a total of 900 reviews. Six hundred of these reviews occurred in Year 7. *CI 7.7* is met as a result.

7.8 86% of children and adults who are known to the system will receive REACH crisis assessments at home, the residential setting, or other community setting (non-hospital/CSB location)

Facts: DBHDS has provided a Process Document that outlines a process for REACH Crisis Managers to collect this data. Terms are defined. DBHDS reports that data verification and methodologies have been reviewed with all REACH programs as part of the quarterly qualitative review.

The data are derived from the REACH Data Store. REACH Crisis Managers review the data quarterly to compare and double check the data in the Data Store to the REACH Quarterly Data Summary/Data Submission Form. DBHDS reports on this CI in its Quarterly Supplemental Crisis Report.

Attestation: DBHDS submitted a signed attestation form for the Supplement Crisis Report which is the data set used to determine compliance with this CI. Data is maintained in the REACH Data Store. This was reviewed by Robert Hobbelman, the Chief Information Officer and attested to on March 4, 2022. Data set validation was performed by analyzing the combined data contained in the Excel document. A sample data set was uploaded in the application and all visualizations were recreated. The CIO did not identify any defects in the data.

Analysis: DBHDS uses data from the REACH Data Store to address this CI and three other CIs. We reviewed and commented on the adequacy of the data collection process in the reports for Year 6. The core of the REACH Data Store system is the document titled Entry Sheet. This document is a very well thought out and designed as the basic component of this data collection system. It includes data that is required and needed without making the critical error collecting extraneous data. All the data collected has a built-in process for verification that is reliable and sufficient.

Overall, the REACH Data Store is a very good data collection source and includes a QA mechanism in its design which is regularly employed by DBHDS. We find it to be sufficient and reliable for the intended purposes.

DBHDS acknowledges that it is “most desirable that persons in crisis receive a crisis assessment in the location in which the crisis occur, as opposed to being removed from their community setting to be assessed in a different location” in the Supplemental Crisis Report. The Commonwealth continues to fall far short of this expectation. It has not been met during any quarter of the review period and was: 42% FY21 Q4; 51% FY22 Q1; 36% FY22 Q2; and 40% FY22 Q3, compared to 35% in the last quarter of the eighteenth period.

The range across the Regions are as follows:
FY21 Q4: R1 22%- R3 53%
FY22 Q1: R1 11%- R2 76%
FY22 Q2: R1 0%- R5 50%
FY22 Q3: R1 8%- R3 51%

DBHDS does not provide any analysis of why so few crisis assessments are conducted in the home, residential setting or community. It does not discern whether there are any reasons for significant variation across the Regions or whether an analysis of those reasons might lead to insights regarding achieving this outcome across the Commonwealth.

Of interest is that the CI requires that 86% of individuals should receive the ***REACH crisis assessment*** in one of these community settings. The original purpose of the REACH program regarding the REACH's staff involvement in crisis assessments was twofold. First was to team the REACH staff with the CSB ES or hospital staff in completing these assessments. Secondly was to have the individuals benefit from the inclusion of a professional who has IDD experience in addressing and hopefully stabilizing the crisis without psychiatric hospitalization. This CI is requiring the crisis assessment performed by REACH to be done in the community setting but fails to refer to the full crisis assessment that involves CSB ES staff. Without this expectation, CSBs have not modified their pre-Settlement Agreement practice of completing assessments at the hospital of CSB office. Without CSBs making this change, it is doubtful that the percentage of crisis assessments completed in the community will increase significantly. REACH staff have always been able to respond to an individual in their family home, residence or day program and stabilized a percentage of these crises without the individual having to be removed from the setting and taken to the CSB ES or hospital. It is the considered opinion of this reviewer that DBHDS will continue not to make substantial progress toward achieving this the CI if its service system continues to separate the REACH involvement in a crisis assessment from the original team approach to crisis assessment.

The Commonwealth hopes to address this systemic problem through its plan for a crisis assessment transformation that will positively impact crisis assessments for all populations, not just individuals with DD. DBHDS reported in the 18th period that the Commonwealth planned to address this in the fall of 2021 as it launches a new statewide Call Center. DBHDS established regional call centers tied to the national suicide prevention lifeline. Two providers are under contract to provide the 988-call response. Staff at the Call Center will triage these calls and address as many as possible telephonically. DBHDS reports that national research indicates as many as 85% of crises can be successfully addressed by professionals talking to the individual and family via the telephone. The staff will then triage those calls that need an in-person response, and a crisis team will be dispatched to the person's location. While this appears to be a very positive initiative to decrease the number of crisis assessments performed in hospitals and CSB emergency departments, the data does not support that a significant change has occurred yet. Individuals with DD who experience a behavioral crisis still do not usually experience the crisis assessment in their home or other community setting. The DBHDS did not report any specific data on the outcomes of the 988-system implementation or how this new

system will fulfill Virginia's Settlement Agreement commitments. This will not be fully implemented until July 2022 as the national 988 initiative does not launch until then. The contractual material the Commonwealth shared did include Virginia's Settlement Agreement performance expectations for these two new providers, including to respond to crises to avert the need for hospital-based assessments.

CI 7.8 was one of the CIs included in the validation study.

Process Review: DBHDS supplied a spreadsheet of 231 calls, that followed the process document for developing the population to be reviewed. I separated the spreadsheet into regions and attempted to pull a minimum sample of thirty calls per region based on qualifying factors specified in the process document. I was unable to achieve the number per region but was still able to develop a sample size of 128. I followed the exact process described and used by DBHDS.

Conclusion of the Validity Study: My inter-rater reliability check of this process showed that the methodology used by DBHDS provides accurate findings on the data pulled from the specified sources. I found that 100% of the calls were tracked properly. The use of the REACH Data Dictionary Tool as a cross check and the total number of calls in combination, is the factor that allows for a correction of the weakness of timely updating of the REACH Data Store. The results of the validation study for this CI indicate that the process is both reliable and valid.

Conclusion: The process for *CI 7.8* is found to be comprehensive and successfully implemented. The data sources have been verified as reliable and valid. The Process Document includes a cross-check of all data submitted in the REACH Data Tool (element #10) with the actual crisis calls to make sure the two data sources match precisely. The metric for *CI 7.8* is not met as the Commonwealth has not been able to conduct crisis assessments in community settings for 86% of the individuals assessed.

Recommendations: This CI is critical to ensuring the success of the Commonwealth's community crisis services system. To make needed progress toward achieving this CI, DBHDS should determine if there are reasons for the variance among the Regions in achieving this metric and if that analysis points to any Regional or statewide systemic changes that could be made to increase the number of assessments completed in a community setting across the Commonwealth. The overall small percentage of assessments being completed at home may be in part attributable to staff vacancies among REACH Coordinators which is 40-60% in Regions I, III and V. Region 1 consistently performed the fewest crisis assessments in the person's home. However, Region 3 performed the highest percentage of assessments in the home for two quarters and Region 5 accomplished this for one quarter.

DBHDS can analyze the correlation with increase or decrease in the number of assessments completed in the community and the increase or decrease in hospitalizations and determine what else needs to be addressed if hospitalizations do not decrease for individuals with DD.

7.9: The Commonwealth will provide a directive and training to state-operated psychiatric hospitals to require notification of CSBs and case managers whenever there is a request for an admission for a person with a DD Diagnosis.

Facts: DBHDS provided several documents to demonstrate compliance with this CI in the eighteenth review period.

Conclusion: *CI 7.9* continues to be met. The Commonwealth provided a directive and offered training to state-operated psychiatric hospitals to require notification of CSBs and case managers whenever there is a request for an admission for a person with a DD Diagnosis. DBHDS has provided data in its Supplemental DOJ Quarterly Crisis Reports that indicate CSBs are being appropriately notified of hospitalizations of individuals with DD.

7.10: Via the morning reporting process, the Director of Community Support Services or designee will notify the REACH Director or designee of admission for follow up.
7.12: The Commonwealth will track admissions to state-operated psychiatric hospitals and those to private hospitals as it is made aware, to determine whether there has been a referral to REACH and will implement a review process to determine if improvement strategies are indicated.
7.13 95% of children and adults admitted to state-operated hospitals who are known to the CSB will be referred promptly (within 72 hours of admission) to REACH.

Facts: These three CIs are related, and they rely on the same documents for information related to achieving compliance. These documents include the Standardized DBHDS Consolidated Morning Report (CMR) and the REACH Hospital Tracker. DBHDS reports on the data related to these CIs in the Quarterly DOJ Supplemental Crisis Report. The CMR document showed that the Director of Community Support Services or designee consistently notified the REACH Director or designee of admission for follow up, as required. The DBHDS provided documentation in its Process Document on hospitalization documentation in Year 6 that it has implemented a review process, including that the process has identified needed quality improvements.

DBHDS provided these documents and the Hospitalization Tracking Guide/Definitions. The definitions provide staff with specific guidance regarding the data to enter for each data field.

Attestation: DBHDS submitted the signed attestation form for the Supplement Crisis Report which is the data set used to determine compliance with this CI. Data is maintained in the REACH Data Store. This was reviewed by Robert Hobbelman, the Chief Information Officer and attested to on March 4, 2022. The data set validation was performed by analyzing the combined data contained in the MS Excel document. The data contained in the MS Excel document contains PHI and is therefore password encrypted and only accessible to the Regional Crisis Managers to protect the identity of individuals included in the report. A sample

data set was uploaded into the application and all visualizations were recreated. Included in the data set analysis was a comparative analysis of the data included in the Supplemental DOJ Quarterly Crisis Report. The process did not identify defects in the data, including images, derived from the analysis.

Analysis: DBHDS does document how it is meeting *CI 7.12 and 7.13.* DBHDS uses the REACH Hospitalization Tracker. The Hospitalization Tracking Guide/Definitions document is a well-organized and succinct. It includes a clear set of definitions and provides unambiguous guiding statements. However, it is cross-referenced with the Avatar data, which is directly reported by state hospitals, retrospectively on a quarterly basis.

DBHDS does report the following percentages of all individuals who were known to the CSB and who were hospitalized were referred promptly to REACH:
The outcomes for this review period were:

- 95.3% in FY21Q4
- 95% in FY22Q1
- 92% in FY22Q2; and
- 96% in FY21Q3.

In Year 7, the average over four quarters is 94.6%, which is a slight reduction from 95% in Year 6. The DBHDS reports show that the referral rate for children was above 95% for all four quarters, including both quarters of the twentieth review period. The referral rate for adults was reported below 95% in FY22 Q1 (94%) and FY22 Q2 (91%).

CI 7.10, 7.12, 7.13 were included in the validation study.

Process Review: Using the spreadsheets DBHDS supplied that were from all sources outlined in the Process Document, I attempted to pull a sample size of thirty individuals per region based on the qualifying criteria. However, given the low regional totals only a sample size of ninety-two was possible. I followed the exact process described and used by DBHDS.

Conclusion of the Validation Study: My inter-rater check resulted in 91% reliability. My inter-rater check of this process showed that the methodology used by DBHDS provides accurate findings using the data they pull from the specified sources. The results of the validation study for this CI I indicate that the process is both reliable and valid.

Conclusion: *CI 7.10* was met in Year 6 and continues to be met. The Director of Community Support Services or designee consistently notifies the REACH Director or designee of admission for follow up.
CI 7.12 is now met because DBHDS has verified and attested that the data source is reliable and valid.

CI 7.13 is met because the expectation that 95% of children and adults who were hospitalized are referred to REACH within 72 hours is met when rounding 94.6% to 95% for the average of the four quarters in Year 7.

7.11: DBHDS will request and encourage private psychiatric hospitals to notify the emergency services staff of the CSB serving the jurisdiction where the individual resides of requests for admissions and admissions of individuals with a DD diagnosis.

Facts: DBHDS provided this documentation of its request and encouragement during the eighteenth review period.

Conclusion: *CI 7.11* is met. DBHDS has encouraged private psychiatric hospitals to notify ES staff of any admissions of individuals with DD.

7.14: Behavior Supports In Home- By June 2019, DBHDS will increase the number of Positive Behavior Support Facilitators and Licensed Behavior Analysts by 30% over the July 2015 baseline and reassess need by conducting a gap analysis and setting targets and dates to increase the number of consultants needed so that 86% of individuals whose Individualized Services Plan identify Therapeutic Consultation (behavioral support) service as a need are referred for the service (and a provider is identified) within 30 days that the need is identified.

Facts: DBHDS reported on this CI in its semiannual Behavioral Supports Report. Two such reports were submitted for this study period; a final report for FY22 Q1 and a draft report for FY22 Q3. DBHDS uses data from the state department that licenses Behavior Analysts and Associate Behavioral Analysts. The specific data sources are the VA Department of Health Professionals LBA/LaBA active licensees and the PBSF provider organization. DBHDS' process relies on Waiver Management System (WaMS) and Service Authorization data to determine if individuals in need of behavior support are referred to an identified provider within thirty days.

DBHDS began tracking the number of individuals identified during the ISP planning process as needing therapeutic consultation in July 2020. DBHDS also tracks data to determine the percentage of those persons who have a therapeutic consultation provider within thirty days of that need being identified. As part of this data DBHDS also reports the number of individuals who have a provider identified outside of the thirty days; and the number of individuals who do not have a provider identified, but for whom the need for therapeutic consultation was indicated during the ISP meeting. The data reported for this study reflects the results of ISP meetings that were conducted during the six months between 3/1/21 and 8/31/21, and the subsequent five-month period between 9/1/21 and 1/31/22. The data source is the WaMS. The data reported in the Behavior Supports Reports for FY22 Q1 and FY22Q3 is detailed by Region and totaled for the Commonwealth.

Attestation: DBHDS submitted the attestation form on March 4, 2022. The CIO determined that this CI is reliant upon data from the Crisis Behavioral Supports Report and Therapeutic Consultation Data and Service Authorizations. His analysis was based on service authorization data from 3/1/21-8/31/21 and the FY22 Q1 Behavioral Supports Report. He determined the results were the same and no defects were identified. He determined the data collected and the processes are reliable and valid. No changes were made to the Process Document for CI *7.14.* The PD did not indicate that any adjustments were needed

Analysis: DBHDS had already surpassed the expectation of increasing the number of behaviorists by 30% over the baseline in 7/2015 of behaviorists. DBHDS reported its baseline of 821 behaviorists (i.e., PBSFs, BCBAs, and BCaBAs) at the beginning of FY16. DBHDS reported that, as of FY22 Q3 there were a total of 2,275 licensed behaviorists including 1,982 LBAs; 212 LABAs; and 81 PBSFs. The increase between FY16 and FY22 is 177% over baseline. The increase is 151% if BCaBAs are excluded.

DBHDS reports that, for the period 3/1/21-8/31/21 222 of the 639 (35%) individuals with a need for therapeutic consultation referral had a service authorization and a provider identified within thirty days. This is a decrease from the previous reporting period when 45% of the individuals with a service authorization for TC had a provider identified within 30 days of the authorization. DBHDS reports that 100 (16%) of individuals had a provider identified in more than thirty days.

In the period from 9/1/21-1/31/22 387 individuals were identified with the need for therapeutic consultation, of whom 231 (60%) had a TC provider identified within thirty days. For this second period, DBHDS does not report whether any of the individuals who did not have a provider identified within thirty days, did have one identified in more than thirty days. The Commonwealth was only able to identify a provider within thirty days for 44% of the 1026 individuals in the two periods that comprise most of Year 7

DBHDS has taken action to increase the number of behaviorists who become therapeutic consultants. DBHDS reports that this number of TCs recently increased by ten, which is a 19% increase. There are now sixty providers of TC. Some of these providers may employ more than one licensed behaviorist but DBHDS cannot report on that. This indicates that of all the licensed behaviorists in the Commonwealth only a small percentage provide therapeutic consultation. DBHDS notes in its FY22 Q3 Behavioral Supports Report that it is assigning one of the Regional Crisis Managers to focus on developing the capacity of TCs. DBHDS will also begin reviewing authorization data monthly rather than quarterly and will identify those CSBs that may need technical assistance or help building provider capacity. DBHDS also included information about resources to locate behaviorists in the training for CMs. DBHDS provided examples of reports it is now producing specific to each CSB. These reports analyze by month the percentage of individuals who are connected to a TC provider within thirty days. DBHDS staff follow up with the CSB to try to connect the CSB to providers of TC within their geographic area.

However, the Commonwealth has not provided documentation that it completed the required gap analysis and setting targets and dates, to increase the number of consultants needed so

that 86% of individuals whose Individualized Services Plan identify Therapeutic Consultation (behavioral support) service as a need are referred for the service (and a provider is identified) within 30 days that the need is identified. There is no indication by area how many TC providers are available; what capacity each provider has to respond to the need for TC; what the overall level of need for TC exists in each CSB; and how these gaps will be remedied. The fact that there has actually been a decrease in the percentage of individuals who need TC who were connected to a provider within thirty days from Year 6 to Year 7 indicates that current efforts are not sufficient. It is heartening that there are so many more PBSFs and BCBAs in Virginia who have the potential to become therapeutic consultants and serve individuals with DD whose ISPs indicate they need this service. However, the significant increase in the numbers of PBSFs and BCBAs is not resulting in a similar increase in the number and percentage of individuals with DD who can access these professionals. This concern was also expressed in the eighteenth review period report.

Conclusion: The CI metric to increase the number of PBSFs and LBAs is met and surpassed. The metric to assure 86% of individuals who need therapeutic consultation are referred and have a provider within 30 days is not met. Other than identifying CSB specific problems with connections to existing BCBAs the Commonwealth has not provided records that document the required gap analysis that includes setting targets and dates to increase the number of consultants needed where gaps have been identified. For example, there is no indication by area how many TC providers are available, what capacity each provider has to respond to the need for TC, what the overall level of need exists in each CSB area, or how these gaps will be remedied. As a result, the Commonwealth has not met the requirements of *CI 7.14*.

7.15: The Commonwealth will provide practice guidelines for behavior consultants on the minimum elements that constitute an adequately designed behavioral program, the use of positive behavior support practices, trauma informed care, and person-centered practices.

Facts: The Behavior Practice Guidelines were completed by DBHDS and have been reviewed by two Expert Reviewers and the Independent Reviewer. DBHDS incorporated their feedback to ensure that the Guidelines included the minimum elements and the use of the other practices. DBHDS issued these Guidelines at the end of FY21 and expected behaviorists to follow the guidelines effective July 1, 2021.

Conclusion: The Commonwealth has developed the Practice Guidelines. DBHDS provided these guidelines to behavior consultants during FY21 Q4 as promised. The Guidelines have also been shared with CMs. DBHDS has met *CI 7.15.*

7.16: The Commonwealth will provide the practice guidelines and a training program for case managers regarding the minimum elements that constitute an adequately designed behavioral program and what can be observed to determine whether the plan is appropriately implemented.

Facts: DBHDS has developed training for Case Managers regarding the minimum elements that constitute an adequately designed behavioral program. It is entitled: ***Therapeutic Consultation Behavioral Services Service Coordinator Training.*** The training is accessible to all CMs through the Commonwealth of Virginia's Learning Center. DBHDS reports that 755 CSB staff took the training as of the February data available in the CVA Learning Management Center. DBHDS reports that there are 681 DD CMs working in the CSBs.

Analysis: The training curriculum sets learning goals and provides tests of concepts throughout the training. The training curriculum defines key requirements of a behavioral program; demonstrates appropriate data collection methods; provides indicators of good implementation of a behavioral plan; distinguishes the role and responsibilities of the behaviorist versus the CM who is to ensure appropriate implementation; provides guidance for follow up if problems with implementation are noted; and provides additional resources for CMs. The training curriculum is sufficient to provide CMs with an understanding of the minimum elements that constitute an adequately designed behavior program.

Conclusion: *CI 7.16* is met. DBHDS has developed the required training program and has made it available to case managers.

7.17: The permanent DD waiver regulations will include expectations for behavioral programming and the structure of behavioral plans.

Facts: The DD waiver regulations, *12 VA C30-122-550 Therapeutic Consultation Service,* which were approved and became part of Virginia's Administrative Code on April 1, 2021, specifies Virginia's expectations for behavioral programming and the structure of behavioral plans. DBHDS has developed the Practice Guidelines to articulate the specific minimum elements for behavioral support plans.

Conclusion: *CI 7.17* remains met. The DD Waiver regulations were approved April 1, 2021.

7.18: Within one year of the effective date of the permanent DD Waiver regulations, 86% of those identified as in need of the Therapeutic Consultation service (behavioral supports) are referred for the service (and a provider is identified) within 30 days.

Facts: DBHDS is currently gathering information regarding the number and percentage of individuals with this identified need who are referred within 30 days, as described related to *CI 7.14.* Beginning April 1, 2022, one year from the effective date of the DD Waiver Regulations, Virginia can determine the extent to which it has achieved *CI 7.18.*

DBHDS reports that, for the period 3/1/21-8/31/21 222 of the 639 (35%) individuals with a need for therapeutic consultation referral had a service authorization and a provider identified within thirty days. This is a decrease from the previous reporting period when 45% of the individuals with a service authorization for TC had a provider identified within 30 days of the authorization.

DBHDS reports that 100 (15%) of individuals had a provider identified in more than thirty days. This means that 317 (50%) individuals had no provider identified.

In the period from 9/1/21-1/31/22, 387 individuals were identified with the need for therapeutic consultation, of whom 231 (60%) had a TC provider identified within thirty days. For this second period, DBHDS does not report whether any of the individuals who did not have a provider identified within thirty days, did have one identified in more than thirty days. The Commonwealth was only able to identify a provider within thirty days for 44% of the 1026 individuals in the two periods that comprise most of Year 7.

Attestation: DBHDS submitted the attestation form on March 4, 2022. The CIO determined that this CI is reliant upon data from the Crisis Behavioral Supports Report and Therapeutic Consultation Data and Service Authorizations. His analysis was based on service authorization data from 3/1/21-8/31/21 and the FY22 Q1 Behavioral Supports Report. He determined the results were the same and no defects were identified. He determined the data collected and the processes are reliable and valid.

Conclusion: *CI 7.18* is not met as DBHDS has not met the expectation that 86% of individuals identified for TC will have a provider identified within thirty days of the service being authorized.

7.19: 86% of individuals authorized for Therapeutic Consultation Services (behavioral supports) receive, in accordance with the time frames set forth in the DD Waiver Regulations, A) a functional behavior assessment; B) a plan for supports; C) training of family members and providers providing care to the individual in implementing the plan for supports; and D) monitoring of the plan for supports that includes data review and plan revision as necessary until the Personal Support Team determines that the Therapeutic Consultation Service is no longer needed.

Facts: This CI for behavioral services can be achieved only after the DD Waiver regulations for Therapeutic Consultation Services are fully implemented and the authorized services occurred within the timeframes in these regulations and include the components described in 7.19 A-D.

Analysis: DBHDS has selected a small, randomized sample and has not reported on all the individuals who had TC authorized for them in Year 7. For its sample, DBHDS reported that only 80% had all the elements in the BPS and related documents that are required under *CI 7.19.* DBHDS plans to always select a randomized statistically significant sample to analyze compliance with this CI due to the amount of data that must be reviewed and determined present. DBHDS reports that it will be sufficient to determine if the four elements are present to determine if the minimum elements expected in the FBAs and BSPs are completed. This does not meet the expectation of *CI 7.19* since DBHDS has determined what is minimally necessary in both the FBA and the BSP, yet it is finding that these documents are in compliance though they do not include the minimum elements that the Commonwealth requires.

We conducted a qualitative study of *CI 7.19* which is detailed in Attachment 2 of this report. We found that all the elements were present in the records of thirty (29%) of the 103 individuals in our randomized sample. Our methodology is described in the Qualitative Study Report. While we found that most FBAs and BSPs were completed on time, we found that 71% of the FBAs met the minimum expectations of DBHDS and only 42% of the BSPs met these minimum expectations. DBHDS expects a completed Part V of the IP to detail the measurable goals and the training plan. Of the Part Vs we reviewed 69% had both elements. There was evidence of training being offered to caregivers in 61% of the records. Behaviorists documented their review of the implementation of the BSPs for 76% of the individuals who had TC services, and the CM used the face-to-face visit to accurately review the presence of behavioral programming for 79% of the individuals.

Conclusion: *CI 7.19* is not met as the Commonwealth has not achieved comprehensive TC service implementation for 86% of the individuals who are authorized to receive these services. DBHDS cannot legitimately credit the presence of FBAs and BSPs that do not include the Commonwealth's minimum required elements and are clearly inadequate. Nor has DBHDS attested to the reliability and validity of its data sources.

7.20: DBHDS will implement a quality review and improvement process that tracks authorization for therapeutic consultation services provided by behavior consultants and assesses: (1) the number of children and adults with an identified need for Therapeutic Consultation (behavioral supports) in the ISP assessments as compared to the number of children and adults receiving the service; (2) from among known hospitalized children and adults, the number who have not received services to determine whether more of these individuals could have been diverted if the appropriate community resources, including sufficient CTHs were available; (3) for those who received appropriate behavioral services and are also connected to REACH, determine the reason for hospitalization despite the services; (4) whether behavioral services are adhering to the practice guidelines issued by DBHDS; and (5) whether Case Managers are assessing whether behavioral programming is appropriately implemented.

Facts: The Commonwealth's needed the DD Waiver regulations for Therapeutic Consultation Services fully implemented which has occurred with the passage of the regulations in April 2021 and a full year for services to be authorized under these regulations. DBHD has designed and implemented a quality review and improvement process to assess the status of the services that are delivered 7.20 (4). DBHDS developed the Behavior Support Plan Adherence Review Instrument (BSPARI) to review the FBAs and BSPs completed by licensed behaviorists to design the TC services needed by individuals with an assessed need for behavioral supports. The BSPARI was reviewed and approved by the Expert Reviewer for Behavioral Services in the nineteenth review period. It uses a weighted scoring system to determine if the minimum requirements of the FBA and BSP are met for each plan. A total of forty points can be awarded for a completed FBA and BSP. DBHDS licensed behaviorists review the plans and consider a score of 34 (85%) to meet the minimum expectations adequately. Feedback is provided to any behaviorist whose plan scored below 34 points. This review and feedback comprise the quality

improvement process. DBHDS has not attested to the validity and reliability of the process it is using. DBHDS also reports on the data related to 7.20 (2), (3), and (5) in the Behavioral Supports Report.

DBHDS reports the number of children and adults who have an identified need for TC compared to the number of individuals who are receiving these services. These data are presented in the semiannual Behavioral Support Reports. DBHDS uses the data that identifies the number of individuals who need TC and how many are connected to a provider for TC within thirty days as required by *CI 7.18.* DBHDS reports the following Table.

Table 3: Number of Children and Adults Needing Therapeutic Consultation Compared to Those Receiving Therapeutic Consultation

Time Period	Total in Need	Provider in 30 days	Provider after 30 days	No provider	% With TC
3/1-8/31/21	639	222	100	317	50%
9/1/21-2/28/22	387	231	N/A	156	60%
TOTAL	1,026	453	100	473	54%

Analysis: The data presented by DBHDS as portrayed in ***Table 3*** does not sufficiently address the requirement of *CI 7.20 (1).* The data includes the total number of individuals who need TC but doesn't report how many are receiving it, only how many have been connected to a provider. As we have found and report later in this report under the data analysis for *CI 7.21,* the billing data does not match the authorization data. It is not possible to confirm the number of individuals receiving TC using the data DBHDS is presenting.

DBHDS reviewed 100 randomly selected records to determine 7.20 (4) the number of plans being implemented between FY22 Q1 and FY22 Q3. Thirteen (13%) met all expectations for the four required elements. (This compares to our qualitative study finding of thirty plans (29%) that included all required elements.) The median score on the BSPARI was 28 (70%) of the records reviewed. DBHDS notes in its report that 89% of the BSPs were written before DBHDS offered training to the behaviorists in the BSP Guidelines. The areas of weakness in the plans included: incomplete analysis of replacement behaviors and strategies to promote acquisition; lack of training plans; lack of measurable benchmarks; lack of a risk/benefit statement; and weak methods to conduct the FBAs. DBHDS also included the review of the BSP implementation by the CMs 7.20 (5) which was determined by reviewing the completed Onsite Visitation Tools (OSVT) for the sample. DBHDS determined that 76% of the CMS scored these correctly. This compares to our finding in the qualitative study that 79% of the CMs accurately reviewed the implementation of the BSP.

DBHDS reports separately on sixty annual plans in their sample that were written after 7/1/21 when the guidelines were in place and behaviorists were trained in the minimum expectations for the FBA and the BSP. DBHDS found that 48 (80%) of the 60 plans met all four requirements of *CI 7.19.* Again, DBHDS does not verify that the FBA and BSP are actually minimally acceptable (i.e., include the minimum elements required), but only that these documents are submitted and present in the individual's file.

DBHDS reports on the number of individuals who were hospitalized who did or did not have TC services at the time of the hospitalization and how many could have been diverted to a CTH but who were not. In FY22 Q2 DBHDS reports that 82 individuals known to REACH did not have TC at the time of the hospitalization and twenty individuals did have TC implemented. Three individuals could have been diverted to a CTH, but the CTH was not available at the time of the hospital admission. For the individuals who did have TC but were still hospitalized DBHDS also reports the reason for the hospitalizations. These reasons are as follows: suicidal ideation (7); homicidal ideation (1); Court mandated (2); TDO by police (1); voluntary admission (1); and medication adjustment (2). Two other individuals were offered REACH support but declined; and one adult was sent from the ATH to the hospital due to aggression. The remaining three individuals were hospitalized because their group home staff could not handle their behaviors and refused to allow them to return to their homes.

Conclusion: *CI 7.20* is not met because 7.20 (1) is not met. The data reported indicates that all the other required outcomes are met, however, DBHDS has not yet attested to the validity and reliability of its data sources.

7.21 Availability of Direct Support Professionals: DBHDS will implement a quality review process for children and adults with identified significant behavior support needs (Support Level7) living at home with family that tracks the need for in-home and personal care services in their homes. DBHDS will track the following in its waiver management system (WaMS):
a. The number of children and adults in Support Level 7 identified through their ISPs in need of in-home or personal care services.
b. The number of children and adults in Support Level 7 receiving the in-home or personal care services identified in their ISPs; and
c. A comparison of hours identified as needed in the ISPs to the hours authorized.

7.22 Semi-annually, DBHDS will review a statistically significant sample and those children and adults with identified significant behavior support needs (Support Level 7) living at home with family. DBHDS will review the data collected in 1.a-c. and directly contact families in the sample to ascertain:
a. if the individual received the services authorized.
b. What reasons authorized services were not delivered: and
c. If there are any unmet needs that are leading to safety risks

7.23: Based on results of this review, DBHDS will make determinations to enhance and improve service delivery to children and adults with identified significant behavior support needs (Support Level 7) in need of in-home and personal care services.

Facts: DBHDS has a detailed description for this quality review process. DBHDS uses the WaMS system as its source of data. The WaMS system includes access to the ISP including the Part V that is completed by the provider; the provider's schedule of when support will be delivered; and service authorization information. DBHDS reports its outcome data and results and recommendations of the QI process in its Supplement Crisis Reports.

DBHDS conducted these reviews semiannually as required. The semiannual review submitted for this reporting period covered the time period July 1-December 31, 2021. DBHDS did do a review of the billing data as was recommended in the Year 6 report. This was done for FY20 Q3 and Q4; and FY21 Q1 and Q2.

Attestation: DBHDS submitted the attestation form on March 3, 2022. The CIO indicated the data set is contained in an Excel spreadsheet that is a "conglomerate of data from varied source systems". He performed the data set validation by analyzing the combined data in the Excel document. He then uploaded a sample data set and recreated all visualizations. He conducted a comparative analysis of the data included in the Supplemental DOJ Quarterly Crisis Report and found no defects. He attests that the data collected, and processes are reliable and valid. DQV has reviewed the source system documents. The processes address the reliability and validity concerns. No issues were identified by DQV related to the process used to implement *CI7.23.*DBHDS reports that the DQV concerns about *CIs 7.21 and 7.22* have been addressed by the processes that have been developed which takes into account any limitations of the source system, During Year 7 DBHDS built into the PD the review of the billing data available from DMAS claims data to actually verify the delivery of these in-home support services. This was based on the recommendation made in the eighteenth review period report.

Analysis: DBHDS reports in the FY22 Q1 Supplemental DOJ Quarterly Crisis Report on the data for the provision of in-home support services for the period 1/1/21- 6/30/21. During this period 326 (98%) of the 333 individuals with a Support Level Need of 7 received the in-home supports identified in their IP. The authorized hours matched the hours needed as expressed in the IP for 315 individuals which is 97% of those who received the in-home services and 95% of those who needed in-home support services. DBHDS interviews families to determine if services were delivered. One hundred and six (106) families responded to DBHDS' request for an interview. Of these families:

- 100% report receiving some level of service
- 36 (34%) report a service gap
- 70 (66%) report consistent service delivery, and
- None report a safety concern

DBHDS reports in the FY22 Q3 Supplemental DOJ Quarterly Crisis Report on the data for the provision of in-home support services for the period 7/1/21- 12/31/21. DBHDS reported that during this period 307 (99%) of the 308 individuals with a Support Level Need of 7 received the in-home supports identified in their IP. The authorized hours matched the hours needed as expressed in the IP for 307 which is 100% of those who received the in-home services and 99% of those who needed in-home support services. DBHDS interviews families to determine if services were delivered. Forty-nine responded to DBHDS' request for an interview. Of these families:

- 100% report receiving some level of service
- 22 (45%) report a service gap
- 27 (55% report consistent service delivery, and
- None report a safety concern

DBHDS reported that it selected a statistically significant sample, but that its review was not able to directly contact all of them. Families who are interviewed are self-reporting. Especially during the pandemic many of the families receiving personal care were using the consumer-directed option. Most of the families responded that the option to hire family members as allowed under Appendix K of the HCBS Waiver was critically necessary to have support in the home. The reasons for services not being delivered included: the continued impact of COVID on securing staff: a lack of trained staff to hire (a concern of all of those who reported a service gap); delays in processing documents; and an insufficient rate of pay. The latter barrier was reported by all the families who responded to DBHDS.

We had noted in our last report that this information would be more consistent and reliable if DBHDS used or cross checked the information with billing claims information when it completes its semiannual reviews. DBHDS did perform this analysis for both semiannual reviews. The data are informative and alarming. Whereas, DBHDS's FY22 Q1 and Q3 Supplemental DOJ Quarterly Crisis Report stated that 95 and 99% respectively of the individuals studied with a Support Level Need of 7 received the in-home supports identified in their IP, the individuals' families reported service gaps for 36% and 45%. The effort to verify that the needed services were actually delivered found that a vast majority of individuals in both semiannual review periods appear to have received very few services. DBHDS reviewed the delivery of Personal Assistance, Respite and In-Home Support Services.

Personal Assistance Services- 93% and 94% of individuals billed for 10% or less of their authorized hours in FY21 Q3 and Q4, and FY22 Q1 and Q2 respectively

Respite- no authorization was billed for more than 7% and 10 % of the authorized level of hours in FY21 Q3 and Q4, and FY22 Q1 and Q2 respectively

In- Home Supports- 58% and 57% of individuals billed for less than 10% of their authorized hours in FY21 Q3 and Q4, and FY22 Q1 and Q2 respectively

As required by *CI 7.23* DBHDS is to make determinations to enhance and improve service delivery to children and adults with identified significant behavior support needs (Support Level 7) in need of in-home and personal care services. In Year 6 DBHDS made the following recommendations: DBHDS will develop information for providers to develop more complete schedules for personal care and in-home services; work with the provider community to ensure personal assistants and in-home workers will be aware of proactive strategies to address behaviors; and will use billing data in the future to compare authorized services to billed services. DBHDS reported on its quality review for *CI 7.23* in the Supplemental DOJ Quarterly Reports for Year 7. DBHDS did review billing data, and it has taken steps with providers to address the documentation errors with the schedules of supports which was follow up to the recommendations the SME made in the review completed in Year 6. Minimum wage has been increased in the Commonwealth and there was a 12.5% increase to the rates for in-home and personal care services during the pandemic. The budget proposed for FY23 includes a more permanent increase for the rates. There is no evidence that DBHDS worked with providers to increase staff's proactive skills to address behaviors.

Conclusion: *CI 7.21* and *7.22* are met. The DBHDS review process has been implemented and tracks the need for in home and personal care services. The review process is now sufficient as it includes a review of the billing data that offers more information as to whether these services are actually delivered. DQV determined in the eighteenth period that the data generated by the review process is reliable and valid and can be used for compliance reporting. It appears that a very low percentage of services are actually being delivered based on the billing data for this review period, but CI 7,21 and 7.22 do not require a metric be met for actual service delivery.

CI 7.23 is met. Based on the results from its review process, DBHDS has made some recommendations to enhance and improve service delivery to children and adults with identified significant behavior support needs (Support Level 7) who need in-home and personal care services and it implemented some of the recommendations made in Year 6. The previous recommendations resulted in DBHDS cross-tabbing authorization and billing data which resulted in a more accurate understanding of the current status which increases the likelihood that future recommendations to enhance and improve will be effective. In light of the extremely low percentage of these in-home and personal care services being billed for, which indicates very low actual utilization, it is essential that DBHDS track whether the increase in minimum wage and the implementation of the rate increases, if passed in next year's budget has any significant positive impact of the rate at which these essential services are actually received by those in need. If not, further improvement strategies must be developed and implemented. While the requirements of the CIs are met it is extremely concerning that so few individuals who are authorized to receive these services are actually receiving more than a small portion of services that they desperately need to assist them and their families to address their behavioral needs with ancillary supports.

***8.1: Mobile Crisis: DBHDS will semiannually assess REACH teams for: 1) whether REACH team staff meet qualification and training requirements; 2) whether REACH has developed Crisis Education and Prevention Plans (CEPPs) for individuals, families, and group homes; and 3) whether families and providers are receiving training on implementing CEPPs*.**

Facts: DBHDS most recently completed the assessment of the three requirements of *CI 8.1* in FY22 Q2 and FY22 Q3. These reviews are conducted individually with each Region during the quarter. The Commonwealth's performance related to these three issues are addressed in the associated indicators 8.2*,8.3, 8.4, and 8.5.* Staff training and staff qualifications are assessed by DBHDS semiannually during the Performance Contract Review which occurs in Q2 and Q4 of each year. REACH program standards including CEPP development and related training of providers is assessed semiannually during the Program Standards Review which occurs in Q1 and Q3 of each year. Two of the quarterly quality reviews of REACH focus on performance contract expectations and two of the quarterly reviews concentrate on REACH program standards.

Analysis: DBHDS does assess REACH teams and reviews staff qualification and training requirements; CEPP development; and CEPP training. These specific requirements are analyzed in the following CIs.

Conclusion: *CI 8.1* continues to be met because DBHDS completed the required assessment.

8.2: Based on findings, DBHDS will 1) determine the need for training related to mobile crisis; and 2) when necessary, as determined by DBHDS, require a quality improvement plan through the Performance Contract from the CSB managing the REACH unit.

Facts: DBHDS documented its semi-annual assessment findings and its determinations related to the need for training related to mobile crisis support. DBHDS utilized employee personnel files and the REACH Performance Contract Review Summaries as the sources of data for its determinations.

Analysis: DBHDS reports that it used the assessment results to determine if there is a need for further training based on performance within each Region. DBHDS also uses data from the REACH Quarterly Qualitative Review Performance Contract Review to determine the need for training related to mobile crisis. I reviewed the REACH Quarterly Qualitative Review for the four quarters of the nineteenth and twentieth review periods. Semiannually DBHDS reviews each REACH program for fiscal, administrative, and training requirements. These reviews include each REACH program's performance related to referral, intake and assessment procedures; community crisis response; crisis prevention; and staff qualifications. At each semiannual review, DBHDS staff determine the need for training based on a review a total of four clinical records of two children and two adults who had been served by REACH in the quarter.

For several years, DBHDS has done a good job conducting quarterly quality reviews of REACH programs. DBHDS has defined expectations and reviewed the performance of its regional REACH programs using a standard approach. Our annual independent studies have found that REACH has implemented quality improvement plans as a result of findings from the quarterly quality reviews. In Year 7 DBHDS found that the REACH programs for the most part met all expectations. No program was found to have a requirement not met. This is an indication that previous quality improvement plans have proven effective. In the past these quality recommendations have focused on improvement to training, crisis stabilization plans, and CEPPs. Although there were no areas of deficiency in Year 7 quality reviews, DBHDS provided feedback to regions that were having trouble recruiting and retaining staff. The DBHDS review in FY22 Q3 included discussions of the involvement of law enforcement responding to crises. DBHDS and the REACH teams discussed communication; interaction between law enforcement and REACH staff; and the reason law enforcement was needed to respond.

These quality reviews are comprehensive reviews of the REACH programs' performance related to the DBHDS' defined standards.

Conclusion: *CI 8.2* continues to be met. DBHDS determines the need for training related to mobile crisis; and 2) requires a quality improvement plan through the Performance Contract from the CSB managing the REACH unit.

8.3: 86% of REACH staff will meet training requirements

Facts: DBHDS uses the Master Training Data Spreadsheet as its data source for determining the percentage of REACH staff who meet the training requirements. DBHDS reports on staff training in the Supplemental Crisis Reports. DBHDS require REACH staff to complete initial employee training sequence within six months of hire. Subsequently, all REACH staff must complete annually a minimum of twelve hours of continuing education topics pertinent to their professional development. DBHDS reports that during the nineteenth and twentieth review periods 99% of REACH staff were trained.

Analysis: DBHDS reports in the REACH Master Staff Training Data Sheet training completed. This includes veteran staff and new hires. DBHDS reports the percentage of all REACH staff who are following REACH training requirements. The outcomes for *CI 8.3* this reporting period are:

- FY22Q1 report: 99% of REACH staff met training requirements
- FY22Q3 report 99% of REACH staff met training requirements

Attestation: DBHDS submitted the attestation form on March 4, 2022. The CIO reviewed the data in an excel document that is "a conglomerate of data from varied Source systems". He also uploaded a sample data set and recreated all visualizations. He found no defects and attests that the data is representative, and the processes are followed concluding that the data is reliable and valid. However, there is no reference that the Master Training Data Spreadsheet is

the data source that was reviewed and is being attested as valid and reliable, or that the various source documents referenced were individually reviewed. When I followed up with DBHDS I was told: "REACH employee information is contained in the data set received by Regional Crisis Managers but is not included in the reporting as the data is aggregated and reported as metrics in the Supplemental DOJ Quarterly Report." DBHDS reports that the data received by the Regional Crisis Managers is the Master Training Data Spreadsheet.

Conclusion: *CI 8.3* is met as the data has been confirmed from the Master Training Data Spreadsheet regarding staff who were in process of completing the required training. The Commonwealth has previously Met and significantly exceeded the requirements of this Indicator. DBHDS has consistently reported that more that 95% and now 99% of REACH staff have met training requirements. DBHDS has consistently reported over multiple review periods that the Commonwealth has significantly and consistently exceeded the 86% requirement. Multiple DBHDS reviews and independent studies have not identified REACH staff who have not met training requirements.

8.4: 86% of initial CEPPs are developed within fifteen days of the assessment

Facts: DBHDS reported that, or year 7,87% of initial CEPPs were develop within fifteen days. The breakdown during the nineteenth and twentieth periods was that 91% and 83% of CEPPs, respectively, were completed within the required fifteen days..

DBHDS cited the REACH Data Store as its data source for *CI 8.4* is. DBHDS staff reviewed the REACH Data Store information with us. The outcomes related to 8.4 are reported on in the Quarterly DOJ Supplemental Crisis Report. DBHDS provided a Process Document related to the determination that the data reported were reliable and valid in the eighteenth period. DBHDS subsequently reported that staff updated the process steps related to CI 8.04 to address guidance from DQV in August 2021.

Attestation: DBHDs submitted the attestation form on March 4, 2022. The CIO reviewed the Excel document that is a "conglomerate of data from varied source systems". Data set validation was performed by analyzing the combined data in the Excel document and reviewing a sample data set recreating all visualizations. The dataset analysis also included a comparative analysis of the data in the Supplemental DOJ Quarterly Crisis Report. No defects were identified. The CIO determined that the data is representative, and the processes followed are reliable and valid.

Analysis: There is less variation across the Regions meeting the expectation of *CI 8.4* in Year 7 than was seen in Year 6. In FY21 Q4 and FY22 Q1 the Regions ranged from 81% in Region 3 to 100% in Region 4. In FY 22 Q2 and Q3 the range was 76% in Region 2 to 91% in Region 5.

Conclusion: *CI 8.4* is met. The 86% benchmark for the percentage of CEPPs completed within 15 days was achieved.

8.5: 86% of providers will receive training in implementing CEPPs

Facts: DBHDS reports that during the nineteenth and twentieth periods, 899 of 1,008 providers (89 %) received training in implementing CEPPs. DBHDS has determined, as required by CI 37.07, that the REACH data source provide reliable and valid data for compliance reporting. There have been concerns about the data accuracy of the REACH Data Store. The PD includes processes to address any weaknesses in the data. The data is reviewed quarterly by a DBHDS Regional Crisis Manager (RCM) who reviews the data for quality. A cross check is performed by another RCM for adherence to the data rules. If any training is not completed within the quarter, the RCM notes this and follows up with the appropriate REACH program in the next quarter to confirm the training was delivered.

Attestation: The attestation form was submitted on March 4, 2022. The CIO reviewed the data received from REACH Program Directors using an Excel table. Data collection is through a manual process, with three phases of validation as described above. The CIO attests that the data and processes are reliable and valid.

Analysis: Of the 1,008 CEPPs that REACH completed, 404 were for children and 604 for adults. REACH programs provided training to 368 providers supporting children and 531 providers supporting adults for a total of 899 providers. REACH trained 89% of its providers in implementing CEPPs. Regions IV trained 100% of its providers. Regions III and V trained over 90% of their providers.

Conclusion: *CI 8.5* is met as the Commonwealth has exceeded this CI 86% performance measure.

8.6 Documentations indicates a decreasing trend in the total and percentage of total admissions as compared to the population served and lengths of stay of individuals with DD who are admitted to state-operated and known by DBHDS to have been admitted to private psychiatric hospitals.

8.7 for individuals who are admitted to state-operated psychiatric hospitals known by DBHDS to have been admitted to private psychiatric hospitals, DBHDS will track the length of stay in the following categories:

- ***Those previously known to the REACH system and those previously unknown;***
- ***Admission of adults and children with DD to psychiatric hospitals as a percentage of total admissions; and***
- ***Median lengths of stay of adults and children with DD in psychiatric hospitals***

Facts: DBHDS reports a continued decrease in the number of admissions in FY22 from a peak in FY19. FY22 data includes reporting through FY22 Q2. Admissions to state hospitals decreased from a high of 1018 in FY19 to 180 in the first two quarter of FY 22, including 95 admissions in

FY22 Q1 and 85 admissions n FY22 Q2. This includes 131 adults and 49 children. It is illustrative to also consider the data from FY21 to support this decreasing trend analysis. In FY21 there was a total of 588 admissions including 387 adults and 201 children. This represents a 42% percentage decrease in admissions between FY19 and FY21. The data for FY22 only includes two quarters but indicates a continued decrease in the number of hospital admissions.

DBHDS also reports the percentage of individuals with DD admitted to state hospitals as a portion of all admissions to state hospitals. The percentage of admissions of individuals with DD to state hospitals decreased between FY17 to FY21 from 31% to 7% of all admissions. Admissions of individuals with DD to state hospitals represents 7% of all admissions for the first two quarters of FY22: the percentage of adults stayed the same as it was in FY21 but the percentage of admissions for children decreased by 7%, from 27% of all admissions in FY21 to 20% to date in FY22.

DBHDS has a combined process document to address *CIs 8.6 and 8.7.* It includes a glossary of terms and process steps. The data sources are AVATAR, the REACH Hospitalization Tracker and the State Hospital IDD Hospitalizations: Total Executed TDOs and State Hospital Admissions Report. DBHDS reports its data in the Supplemental Crisis Report.

Attestation: DBHDS submitted the attestation form on March3, 2022. The CIO reviewed the data set in an Excel document that is a "conglomerate of data from varied source systems". He analyzed the combined data to validate the data set. A sample data set was uploaded, and all visualizations were recreated. No defects were identified, and he determined the data was reliable and valid. However, these CIs rely on data from the Avatar, REACH Hospitalization Tracker and the State Hospital Admissions Report. These were not independently verified to be valid and reliable.

Analysis: As noted under the fact section, the trend in admissions to public psychiatric hospital continues to decrease. DBHDS also reports on admissions to private hospitals while acknowledging these are not complete data but represent the information about the admissions to private psychiatric hospitals known to DBHDS. Those individuals known to have been admitted to private hospitals totaled 735 in FY21 and total 450 through the third quarter in FY22. The 450 admissions include 342 adults and 108 children This compares to 535 adults and 200 children being admitted over the course of FY21.The percentage of these admissions compared to all individuals admitted is reported for FY22 Q1, and FY22 Q2. Admissions for individuals with DD represent 7% of all admissions in the first two quarters of FY22 Q2.

Related to *CI 8.7,* DBHDS reports on the average and median lengths of stay (LOS) for children and adults in state psychiatric hospitals from FY17-FY22. The median (LOS) has shown a steady decrease for adult from a high of 23 days in FY17 to a median LOS of 20 days in FY22 through Q2. Children experienced a median LOS of 10 days in FY17 and 7 days in FY22 through Q2.

DBHDS began reporting this data for admission to private psychiatric hospitals in FY21. Individuals with IDD accounted for 4% of all admissions to private hospitals in FY21 and 2% in FY22 through the second quarter.

DBHDS can now report on the average and median LOS comparing individuals known and unknown to REACH. Through FY22 Q2 there are differences whether an individual is known to REACH or is not known to REACH for admissions to state hospitals. Adults known to REACH averaged a 27-day LOS while those not known to REACH averaged a 24-day LOS. Children experienced a more significant difference in the average LOS between the groups known to REACH (8 days) and the group not known to REACH (14 days)

Conclusion: *CI 8.6* is met*. There has been a decrease in the number and percentage of admissions and lengths of stay for individuals with DD since FY17 which show that the CI *8.6* metrics for state hospitals have been met. There are now sufficient data on admissions to private hospitals to begin to analyze the trend in these settings. *CI 8.6* will not be fully met until corrections are made to Avatar as the primary source for these data.

CI 8.7 is met as DBHDS is tracking the data for admissions to state hospitals and the admissions of individuals known by DBHDS to have been admitted to private psychiatric hospitals.

CIs 8.6 and 8.7 were included in the validation study.

Process Review: I was able to use the entire population provided for the check of this process. I did not find any errors in the tracking process used by DBHDS.

Conclusion of the Validity Study: This process and the methodology used by DBHDS rely very heavily on Avatar as the data source in nine of the ten steps outlined in the Process Document. Given the acknowledged weaknesses of Avatar I propose that this specific process have another validation study done in the next Review Period. Because of the acknowledged weaknesses in Avatar, I could not determine that this process can sufficiently demonstrate reliability or validity at this time.

10.1: The Commonwealth will establish and have in operation by June 30, 2019 two Crisis Therapeutic Home (CTH) facilities for children and will provide training to those supporting the child to assist the child in returning to their placement as soon as possible.

Facts: The two CTHs for children became operational in FY19 Q3 and have continued to operate through the twentieth review period. DBHDS refers to the processes related to *8.3 and 8.5* for training of CTH staff and providers to implement CEPPs as evidence of training to those supporting the child. The data sources are REACH Quarterly Report Data; Summary Operational Definitions/ Data Submission Form (*8.5)*; Master Staff Training Data Spreadsheet; and the REACH Data Store (*8.3).* DBHDS reports the implementation and its progress toward achieving *CI 10.1* in the Quarterly REACH Child Data Summary Reports. DBHDS provided a Process

Document that addresses the training portion of this requirement under *CI 8.3 and 8.5*,DBHDS has attested that the data sources provide reliable and valid data as described under *Ci 8.3 and 8.5,*

Analysis: DBHDs provides a breakdown of the providers trained in CEPPs by service type in its REACH Quarterly Reports. These include CTH Crisis Stabilization; Crisis Step Down; and Crisis Prevention. Over the four quarters there were twenty-three children in CTHs who received a CEPP. There were twenty-one children's providers who were trained for a total of 91% of the providers. Region IV consistently trains 100% of the providers.

DBHDs uses the Master Staff Training Data Spreadsheet as its source for data to report the number of REACH employees working in the Children's CTHs who are trained. There is not separate training information related to the employees who work in the children's CTH programs to verify that they received training specific to their job responsibilities, but DBHDS reports that this information is included in the summary training data.

DBHDS reports that the two CTHs did not operate at full capacity throughout the review period. The numbers served and utilization are discussed under *CI 13.1*

Conclusion: *CI 10.1* is met. Both CTHs are open, although they are not operating at capacity. DBHDS demonstrates that CTH staff are trained and reported that 91% of the involved children's providers have been trained in the CEPPs.

10.2 DBHDS will utilize waiver capacity set aside for emergencies each year to meet the need of individuals with long term stays in psychiatric hospitals or CTH's.

Facts: To meet the needs of individuals in these facilities, DBHDS reports that during Year 7, 29 (38%) of the 76 waiver slots allocated for emergencies were used to support individuals who left CTHs, ATHs or psychiatric hospitals. To report its progress toward achieving this CI DBHDS uses data from three sources: WaMS; Complex Case Consult for Emergency Access to Waiver form; and the Emergency Slot Spreadsheet. DBHDS reports on the progress towards meeting this CI in its Supplemental Crisis Report. DBHDS reports on the total number of individuals in this population receiving a waiver slot and reports on the individual outcome for each, i.e., placement in a 4-person group home.

Attestation: DBHDS submitted the attestation form on March 4, 2022. The CIO analyzed the data set in an Excel document to validate the data set and uploaded a sample set of data in which the visualizations were recreated. He completed a comparative analysis of the data included in the Supplemental DOJ Quarterly Crisis Report. He found no defects and determined the data is representative of the data intended to be collected and is therefore reliable and valid.

Analysis: The outcomes for this reporting period are:

- FY21 Q4 9 of 19 of waiver slots were used for this population (47%)
- FY22Q1- Q3: 20 of 57 waiver slots were used for this population (35%)

DBHDS reports each quarter on the status of the individuals who received these emergency waiver slots. For those individuals who do not have a service initiated yet, DBHDS continues to report on their status in future quarterly reports until a service is in place. Overall, during Year 7 of the 29 individuals allocated a waiver slot:

- 17 went to a group home
- 4 went to a sponsor home
- 1 was hospitalized
- 7 do not have services initiated

Conclusion: The *CI 10.2* is met. DBHDS is consistently using waiver capacity to address the needs of individuals with long stays in CTHs and hospitals.

10.3: DBHDS will increase the number of residential providers with the capacity and competencies to support people with co-occurring conditions using a person-centered/trauma-informed/positive behavioral practices approach to:
1. prevent crisis and hospitalizations, and
2. to provide a permanent home to individuals discharged from CTHs and psychiatric hospitals.

Facts: DBHDS used an RFP process to select providers and award these providers a set number of homes/beds to develop to serve this population. Each quarter the providers report on utilization by the identified target groups: individuals discharged from CTHs, ATHs, or psychiatric hospitals. The providers also report on unused beds and beds being used by individuals not in the target groups. A Continuous Quality Improvement (CQI) process is defined to ensure beds are used appropriately and discharges are not based on "lack of clinical acumen."

To report on this CI, DBHDS uses the data for compliance reporting from the Adult High Behavior Homes Bed Tracking Report. The form is completed by the providers quarterly. This report included data on admission and discharge dates; the reasons for discharge; and where the person was living post admission including psychiatric hospital; CTH or CSU admissions; or medical treatment. DBHDS reports on its progress to implement *CI 10.3* in the Quarterly DOJ Supplemental Crisis Report.

As of the Supplemental Crisis Report issued in FY21 Q4, the seven homes chosen through the original RFP process were all operational. These homes offer a total of thirty-four beds to serve this population. Additionally, two more homes have opened to specifically serve individuals with co-occurring conditions bringing the total number of beds available to forty-one. There are

one or more homes in each Region. At the end of FY22 Q3, thirty of the thirty-four beds were occupied. Of the thirty individuals residing in these homes, twenty-nine have co-occurring conditions and meet the eligibility criteria of *CI 10.3.* DBHDS has issued another RFP recently seeking providers to develop additional homes to support individuals with high behavior needs.

Conclusion: *CI 10.3* is met. DBHDS reports that residential provider homes have been developed and, as of FY22 Q3, are supporting twenty-nine individuals who have co-occurring conditions. DBHDS has clarified that the RFPs required the providers to demonstrate their ability to provide trauma informed care and were only selected if their proposal adequately addressed this requirement.

10.4: 86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities and psychiatric hospitals will have a community residence identified within 30 days of admission.
11.1: 86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities will have a community residence identified within 30 days of admission.

Facts: DBHDS reports that, during two of the four quarters during the nineteenth and twentieth review periods, 86% or more of the individuals known to the REACH system had a community residence identified within 30 days of admission.

These are similar CIs except *11.1* addresses only CTH admissions and *10.4* includes both CTH and psychiatric hospital admissions. The staff who enter the data are instructed to only include individuals with active waiver status who were admitted to CTHs. But all individuals are included who were hospitalized whether they are enrolled in a waiver or not. This is to track the outcomes for the many children admitted to hospitals who are not yet waiver participants. DBHDS has a CQI process to address issues with regions that do not achieve the CI of 86% to determine and correct systemic problems. The Commonwealth's data sources are the REACH Hospital Tracker and REACH No Dispositions/ Over 30 Days Tracker. The data is reported in the Quarterly DOJ Supplemental Crisis Report.

Attestation: DBHDS submitted the attestation form on March 4, 2022. The DBHDS Process Document addresses concerns with the REACH Data Store that were expressed by DQV. These are noted as resolved by updating the language to more accurately depict the overall system. These changes were made to the Process Document in July 2021.The verification process of cross walking data from the REACH data store and the Excel spreadsheet validated the data set. The CIO reports that no defects were identified. He attests that the data is reliable and valid.

Analysis: DBHDS reports the following data to calculate the percentage of all individuals admitted to a CTH who have a DD waiver, and all individuals admitted to a psychiatric hospital who accepted REACH services who have a community residence identified within 30 days of their admissions. The reported outcomes for all individuals with a DD waiver and known to the

REACH system who are admitted to CTH facilities and psychiatric hospitals during the nineteenth and twentieth reporting periods are:

- FY21Q4- 80%
- FY22Q1- 86%
- FY22Q4- 79%
- FY22Q3- 86%

CIs 10.4/11.1 were included in the validation study.

Process Review: I reviewed each step of the associated processes with DBHDS methodology and provide an additional inter-rater reliability check on the sample used by DBHDS.

The methodology used for the study is as follows:

1. Methodology for this study varied slightly from the other validation studies as a random sample was not possible given the methodology used to collect the original population sample.
2. Given information provided in Number 1, an additional Inter-rater reliability check on the entire sample was accomplished using the exact process outlined by the process document and explained by DBHDS staff responsible for conducting the initial process and the inter-rater reliability function.
3. DBHDS supplied a spreadsheet with multiple tabs that were associated with 182 names and accompanying information as prescribed by the Process Document.
4. The 182 names were divided among the five regions allowing for regional comparisons. I conducted an inter-rater reliability process for each region and made comparisons with conclusion tables that were provided by DBHDS staff that conducted their inter-rater reliability test.

My additional inter-rater check resulted in 98% reliability on the sample provided and used by DBHDS staff for this reporting period. It is worth noting that the 2% margin of error resulted in a slightly higher percentage of success than was reported by DBHDS in the submitted tables.

Conclusion of the Validation Study: Given the results of the validation study for this CI I propose that this process is both reliable and valid.

Conclusion: The Commonwealth reported that its data shows 83% achievement over the entire reporting period. The Commonwealth reports that it achieved 86% metric in two of the four quarters in the nineteenth and twentieth reporting period. The Commonwealth only reported the quarterly percentages. Actual numbers of individuals were not reported. Based on the Process Document and signed Attestation, these data sources have now been determined by DBHDS to provide reliable and valid data.

The *CIs 10.4 and 11.1* are not met because the Commonwealth did not achieve the requirement that 86% of the individuals who were known to REACH and who were hospitalized or placed in a CTH would have a residential provider identified within thirty days.

13.1: The Commonwealth will establish and have in operation by June 30, 2019, two Crisis Therapeutic Home (CTH) facilities for children.

Facts: This CI is similar to *CI 10.1* but only requires that the Commonwealth establish two CTHs for children. DBHDS has fulfilled the requirements of this CI. The REACH CTH utilization data is and will continue to be included in the REACH Children's Quarterly Reports.

Analysis: DBHDS reports that the two CTHs operated throughout the review period but were never at full capacity. The Region II CTH served seventy-six children this year with its bed utilization at 34%. Region IV served sixty-seven children this year with its bed utilization at 27%. Utilization is extremely low at a time when children still are being hospitalized for crises The DBHDS monitoring processes were in place and they had identified staffing issues for the providers to address. However, neither home experienced significant staff vacancies during the reporting period as evidenced by the DBHDs report issued in March 2022,

Conclusion: *CI 13.1* is met. Both required CTHs for children continue to be operational.

13.2: To address the CTH stays of adults beyond 60 days, DBHDS will establish and operate two transition homes by June 30, 2019.

Facts: DBHDS established these homes in FY20. They have been fully operational since FY20 Q2.

One home (Culpeper) serves individuals with DD in Regions I and II. The second home (Chester) serves individuals with DD in Regions III, IV, and V. DBHDS provided a report for utilization for FY21Q4 through FY22 Q2. DBHDS reports that the average LOS is targeted between three to four months. Each home has the capacity to serve six individuals.

Analysis: DBHDS provided a separate report on utilization of the Adult Transition Homes (ATH) during this review period. The report covered FY21Q2 though FY22Q3. For this review period, the two homes ranged in utilization from 60-83% (compared to 39% to 71% in Year 6) for the Culpeper ATH, and from 53-81% (compared to 31% to 74% in Year 6) for the Chester ATH. It was noted that utilization was impacted by COVID restrictions. Only two staff vacancies were reported at the Chester ATH.

DBHDS provided additional data in an Addendum Report: *ATH Utilization and Disposition* to aid our understanding of the utilization of these settings regarding the actual and average LOS is for each home and information on the settings to which individuals transition after staying at the ATH. The goal of creating these two homes is "to address the CTH stays of adults beyond 60

days." Sixteen adults were admitted to these two ATHs during Year 7, compared to twenty-three adults admitted in Year 6. All the individuals admitted were transferred from the adult CTHs. The average number of days individuals stay ranges from 19 to 70 days (compared to 30 to 36 days in Year 6) at Culpeper and from 32 to 39 (compared to 30 to 53 days in Year 6) at Chester. These data indicate the operation of these homes has positively impacted the number of CTH stays greater than sixty days.

DBHDS reported the dispositions of adults who transitioned from the ATHs in these three quarters. One person was admitted to a psychiatric hospital; six people transitioned to new group homes, and three peoples transitioned to sponsor homes. Twenty-three remained in the ATH in various quarters. This compares to Year 6 when eighteen individuals went to a community setting.

DBHDS reports in detail about the LOS for individuals whose stays continue from one quarter to the next. Twenty-three individuals were at the ATH across at least two quarters. Although, the ATHs continue to not operate at full capacity, they have had a positive impact on the LOS in the CTHs. The utilization of the ATHs is higher in Year 7 than in Year 6. The increased availability of this alternative should allow the CTHs to accept more referrals as beds are more readily available.

Conclusion: *CI 13.2* is met. The homes are operational and are addressing CTH stays of adults beyond 60 days.

13.3 The Commonwealth will implement out-of-home crisis therapeutic prevention host homes like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service through statewide access in order to prevent institutionalization of children due to behavioral or mental health crises.

Facts: DBHDS has implemented the "out-of-home crisis therapeutic prevention host homes like services for children connected to the REACH system". DBHDS has secured two providers, one of which was in operation through FY21 Q3. Only one remains in operation one year later. The provider was not able to open the second home due to staffing shortages.

DBHDS provided documentation that shows that it monitors, tracks and reports on the number of children who use out-of-home crisis therapeutic prevention host homes. DBHDS also tracks and reports on the number of referrals; number of admissions; lengths of stay; and outcomes of the stay. The outcomes include data for those hospitalized versus those who retained their home setting or transitioned to a new community setting. The outcome data is used by the Regional Crisis Managers to determine if action(s) for improvement is warranted. The source of data is the Out of Home Prevention Services Operational Data Definitions Sheet. DBHDS reports on the utilization of these host homes in the Quarterly REACH Children's Reports. DBHDS has secured two providers but only one is in operation as of FY22 Q3. REACH makes referrals to

these settings, which are operated in Regions IV and V but are available to all children who need them.

Analysis: DBHDS reported through FY22 Q3 that only three children were served, all were from Region IV and the children had stays of two, seven and ten days. Two returned home and one transitioned to a new residence. Lengths of stay were 6 to 29 days. Three additional children were referred in FY21 Q1 and two in FY22 Q3 but none of them were served. One was inappropriate and needed residential treatment. The other three were referred too late in the quarter to be served. They were not re-referred in the subsequent quarter. It is concerning that only one host home is opened and only three children were able to take advantage of the setting. It is also troubling that the home is not better utilized when so many children are still being hospitalized, and that the other home has never opened. It is also apparent from the data that none of the other regions are making referrals as all three children reside in Region IV.

Conclusion: *CI 13.3* is not met. The Commonwealth has implemented out-of-home crisis therapeutic prevention host home like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis in order to prevent institutionalization of children due to behavioral or mental health crises. Yet only one home has been implemented; statewide access to prevent institutionalization of children is not being achieved; and the service is underutilized.

Submitted By:

Kathryn du Pree, MPS
Expert Reviewer

Joseph Marafito, MS
Expert Reviewer
May 21, 2022

ATTACHMENT 1 DOCUMENT LIST

NUMBER	DOCUMENT	TIME PERIOD OR DATE	RELATED COMPLIANCE INDICATOR OR PROVISION
1	CSB Performance Contract Examples	7.21	CIs 7.2, 7.3, 7.6
2	Supplemental DOJ Quarterly Crisis Report	FY21Q4-FY22Q3	CIs 7.5, 7.8, 7.13, 7.21, 7.22, 7.23, 8.1, 8.3, 8.4. 8.6, 8.7, 10.2, 10.3, 10.4, 11.1
3	Attestations	3.22	CIs 7.5,7.7, 7.8,7.14,7.18, 7.21, 7.22,8.3, 8.4, 8.5, 8.6, 8.7, 10.3, 10.4, 11.1
4	REACH Data Store	Not Dated	CI 7.8, 8.4, 8.7
5	DBHDS Consolidated Morning Report	Not Dated	CIs 7.10 and 7.12
6	REACH Hospitalization Tracker	11.19.20	CIs 7.12, 8.6, 8.7, 10.4, 11.1
7	Behavioral Supports Report DRAFT	FY22Q1-FY22Q3 3.22	CI 7.14
8	Practice Guidelines for Behavior Support Plans	7.21	CI 7.15
9	BSPARI	7.22	7.15
10	Behavioral Services Case Management Training Curriculum	6.21	CI 7.16
11	REACH Region I Quarterly Quality Reviews Adults	FY21Q4-FY22Q3	CIs 8.1,8.2,8.3
12	REACH Region I Quarterly Quality Reviews Children	FY21Q4-FY22Q3	CIs 8.1, 8.2, 8.3
13	REACH Region II Quarterly Quality Reviews	FY21Q4-FY22Q3	CIs 8.1, 8.2, 8.3
14	REACH Region III Quarterly Quality Reviews	FY21Q4-FY22Q3	CIs 8.1, 8.2, 8.3

15	REACH Region IV Quarterly Quality Reviews	FY21Q4-FY22Q3	CIs 8.1, 8.2, 8.3
16	REACH Region V Quarterly Quality Reviews	FY21Q4-FY22Q3	CIs 8.1, 8.2, 8.3
17	REACH Master Staff Training Data	9.1.21	CI 8.3
18	REACH Summary Operational Definitions	Not Dated	CI 8.5
19	REACH Quarterly Reports Adults	FY21Q4-FY22Q3	CI 8.5 and all Provisions in compliance
20	REACH Quarterly Reports Children	FY21Q4-FY22Q3	CIs 8.5,13.3 and all Provisions in compliance
21	AVATAR	Not Dated	CIs 8.6, 8.7
22	State Hospital SH-IDDD Report	Not Dated	CIs 8.6, 8.7
23	Emergency Slot Spreadsheet	Not Dated	CI 10.2
24	Bed Tracking Adult High Behavior Homes	7.29.20	CI 10.3
25	REACH Data Dictionary	Update 9.15.20	CIs 10.4, 11.1
26	Adult Transition Home Utilization Report	4.22	CI 13.2
27	Process Documents	3.22	All CIs
28	Exhibit M DOJ SA Requirements	7.20	All CIs
29	Curative Actions	7.21	CI 8.5
30	988 Documents	4.22	CI 8.6
31	REACH Staffing Report	3.22	All provisions
32	OSVT Training	7.21	CI 7.20

Attachment 2: Qualitative Study of the Delivery of Therapeutic Consult Services between July 1, 2021, and February 28, 2022

Introduction and Overview

For the twentieth period review, we conducted a qualitative review of 103 of the 638 children and adults who were authorized to receive therapeutic consultation (behavioral supports) between July 1, 2021, and February 28, 2022. The purpose of the study was to determine if individuals who are identified as needing therapeutic consultation (TC) are receiving the services that are authorized for them. These services are described in CI 7.19 which states: ***86% of individuals authorized for Therapeutic Consultation Services (behavioral supports) receive, in accordance with the timeframes set forth in the DD Waiver Regulations, A) a functional behavior assessment; B) a plan for supports: C) training of family members and providers providing care to the individual in implementing the plan for supports; and D) monitoring of the plan for the supports that include data review and plan revision as necessary until the Personal Support Team determines that the Therapeutic Consultation Service is no longer needed .*** This study will parallel the review that DBHDS conducts to implement *CI 7.19* and *7.20* to determine the reliability and sufficiency of their review methodology, and to determine the success of the Commonwealth meeting the expectations of *CI 7.19.*

This qualitative study includes a review of the available records of 103 individuals. DBHDS provided the list of all children and adults who were authorized for these services as of July 1, 2020. From this original list of 638 children and adults, we selected 140 names to include alternates if they were needed. Of these 240 individuals, thirty-three had only the initial authorization; forty-six had secondary authorizations; and sixty-one had annual authorizations. We decided to make our selection from the individuals who were authorized for either Secondary or Annual Authorizations starting in July 2021.We excluded those individuals with only an Initial Authorization. Our reasoning was that, at the time of our review, these individuals would not have all the required elements of *CI 7.19* in place yet.

We randomly selected 103 individuals and another 4 alternates from the DBHDS database of all individuals who received these services between July 2021- February 2022. The selected sample of individuals included people who lived in all five of the DBHDS-DDS Regions. Eleven reside in Region 1; thirty-six in Region 2; twenty-two in Region 3; twenty-five in Region 4; and nine in Region 5. The number and methodology applied for sample selection yielded a statistically significant sample that will allow generalization of the findings to the cohort with a 90% confidence level.

DBHDS shared its methodology for reviewing the data to determine if authorized services were received to include the Functional behavioral assessment (FBA); the Behavioral Services Plan (BSP); caregiver education; and monitoring the implementation of TC. Our methodology included a determination of whether the required documents included the minimum required elements for what constitutes receipt of minimally adequate behavioral programming.

Whereas the DBHDS methodology only determined that the required documents were present and did not determine if these documents met the minimum requirements.

DBHDS provided us with the DBHDS document "Minimum BSP Content Areas and Elements." This document provides guidance for BCBAs and other Licensed Behavioral Support Professionals which include Positive Behavioral Services Facilitators (PBSF) to develop FBAs and BSPs. These guidelines describe what should be included in the BSP and FBA for the following content areas: demographic information; history and rationale; person centered information; hypothesized functions of behavior; behaviors targeted for decrease; behaviors targeted for increase; antecedent interventions; consequence interventions; safety and crisis guidelines; plan for training; and appropriate signatures, which include the signature of the individual or the legal representative. This guidance is included in this report as Attachment 1.

DBHDS also shared the: Timelines and required documentation for therapeutic consultation behavioral services authorizations. Authorizations for TC include three types: Initial Authorization, Secondary Authorization, and Annual Renewal. DBHDS establishes a timeframe and details the required documentation for each type of authorization. In addition to the FBA and the BSP, documents required for Secondary and Annual Renewal Authorizations include the ISP Part V for TC and graphic displays of data with a written summary covering at least the current review period. This document is included in this report in Attachment 1.

We reviewed the guidance provided by DBHDS and met with Sharon Bonaventura and Nathan Habel to discuss the criteria. We clarified definitional issues regarding the expectation for the behaviorist to monitor the implementation of the BSP, and for the Case Managers (CMs) to be noting the presence or absence of TC using the Onsite Visitation Tool (OSVT). DBHDS explained its review process and educated us regarding the use of the Behavior Support Plan Adherence Review Instrument (BSPARI). The Guidelines for developing the FBA and BSP have been provided to Licensed Behaviorists and to CMs. DBHDS staff have provided training to both groups on the implementation of *CI 7.19.* DBHDS also shared the training curriculum which we reviewed and determined to be very thorough. We became aware during the conversation that our Methodology differed to some degree as is described below in the Methodology Section,

For our review, DBHDS produced the following documentation for each of the selected individuals:

- Individual Service Plans (ISP) including Sections I-IV
- ISP Sections V from the TC provider
- FBA
- BSP
- Quarterly Monitoring Reports
- OSVT and CM Progress Notes

In some cases, the documentation provided was incomplete. For the most part, DBHDS was able to locate and share the missing documents.

Methodology

The methodology we used for this Qualitative Study was a review of all the relevant documents which are listed above. As noted, we also reviewed DBHDS' methodology and interviewed Nathan Habel and Sharon Bonaventura, the DBHDS Regional Crisis Managers who conducted the DBHDS review to implement CI 7*.19.* We reviewed the FBA, BSP, Part V, and monitoring reports using the two guides issued by DBHDS which are explained above. We reviewed these documents to determine if they met the minimum expected requirements set forth by DBHDS, and if the FBA and BSP were submitted within the expected timeframes. We learned from our conversation with the DBHDS Regional Crisis Managers, that while they provided feedback to the Behaviorist regarding minimum elements that were missing, they determined that the FBA, BSP and Part V were complete not because they included all the minimum elements that DBHDS and the applicable compliance indicators require, but by virtue of the assessment, plan and Part V being submitted on time. However, they use the BSPARI with a weighted scoring system to provide feedback to the incensed behaviorists and have shared with us their summary findings, which are detailed in the section of this report that addresses the Commonwealths compliance with the CIs. We determined that the requirements of *CI 7.19* were met only if there was evidence that the minimum elements required by *7.15* and *7.19* were addressed. Therefore, our findings differ somewhat from the findings of DBHDS.

We did review the content of each document: the FBA, BSP, Part V and the monitoring summaries for each individual in the sample. We reviewed the content to ensure that the minimum expectations as required by DBHDS and the applicable compliance indicators were addressed. We did not try to determine the clinical quality of the sections of the FBA or the BSP or determine if adequate progress was being made implementing the behavioral plan as reflected in the quarterly monitoring summaries. We also did not judge the adequacy of the training that was provided to caregivers, just the evidence that training was provided as outlined in the BSP. We believe that these clinical determinations would need to be made by a licensed behaviorist and a clinical review was not the purpose of this qualitative study.

Record Review

The record review for this study was completed separately by two reviewers. To ensure a consistent approach to the review of the data, we developed and followed a written protocol and we each reviewed the same two records and compared our determinations to assure inter-rater reliability. We identified one comprehensive FBA that included all the minimum required elements and used it to guide our review of all FBAs.

The review of the ISP included a review of its Overview section; the behavioral section, the Part III and the Part V. We reviewed the Part V to determine if it included the minimum requirements: measurable benchmarks for the behavioral targets and a description of the training to be provided to family members and other caregivers. The FBA and BSP were reviewed to determine if they included the minimum elements required. After our conversation with the Regional Crisis Managers, we reviewed the minimum required elements and determined those that seemed most essential to the behavioral services received by the

individual. As examples, if the demographic data did not include every demographic listed i.e. Medicaid number or gender identification, we did not rate that element as not met. Also, we were informed that we may not see all signatures on the documents shared with us because not all behaviorists have electronic health records, so we did not allow the lack of signatures to lead to a determination that the BSP was not fully completed. It should be noted that very few of the 103 BSPs reviewed included the signatures of the individual or legal representative.

The review of the WaMS data included a review of the authorized start and end dates for the service; the provider; the dates each of the FBAs and BSPs were completed; the presence of the training plan and the OSVTs for the review period. This data was provided for all 107 individuals in the sample including our alternates. We reviewed records for 103 individuals. When we compare our findings to those of DBHDS, our percentages are based on 103 individuals and DBHDS's review is based on 107 individuals.

Findings

Functional Behavioral Assessment- We reviewed the FBAs to determine if they were submitted on time using the timelines established by DBHDS and reviewed the content of the FBAs to determine if each conformed with the minimum expectations of DBHDS as expressed in the Practice Guidelines and Minimum BSP Content Areas and Elements. We found that 98 (95%) of the FBAs were submitted within the expected timeframe. The percentage ranged from 95% in Region 4 to 100% in Regions 1, 3, and 5. DBHDS determined that FBAs were submitted for 95% of the individuals.

In terms of the content of the FBAs, our finding is that only 73 (71%) of the FBAs were adequate, that is, only these FBAs included all the elements for each content area that DBHDS requires. The percentage ranged from 47% in Region 2 to 91% in Region 3. DBHDS expects that the FBA will include information as to where and when the FBA was conducted; the methods used; and the associated results and analyses of motivation operations, antecedents, and consequences associated with the target behavior. Generally, we found a lack of this expected analysis in the FBAs that we determined did not meet the DBHDS expectations. DBHDS did not make a determination of whether all of the elements expected in an FBA were present. Rather DBHDS judged an FBA as acceptable if the assessment was present without determining the presence and quality of all the minimum requirements.

Behavioral Support Plan- We reviewed the BSPs to determine if they were submitted on time using the timelines established by DBHDS and reviewed the content of the BSPs to determine if each conformed with the minimum expectations of DBHDS as expressed in the Minimum BSP Content Areas and Elements. We found that 98 of the 101 (for two of the individuals this was N/A) individuals in the sample (97%) had BSPs that were submitted within the expected timeframe. This percentage ranged from 92% in Region 4 to 100% in Regions 1,2 and 3. DBHDS determined that BSPs were submitted for 92% of the individuals.

In terms of the content of the BSPs, our finding is that only 42 of 101 (42%) of the BSPs included all of the elements for each content area that DBHDS requires. The percentage ranged from 11% in Region 5 to 76% in Region 4. These content areas include demographic information; history and rationale; person centered information; hypothesized functions of behavior; behaviors targeted for decrease and for increase; antecedent interventions; consequence interventions; safety and crisis guidelines; a training plan; and authorized signatures. Generally, the BSPs that we determined did not include all the required elements, were missing the following: replacement behaviors; measurements of the target behavior expectations; training plans; and information on the person's strengths and interests. DBHDS did not make a determination of whether all of the elements expected in a BSP were present. Rather, DBHDS judged a BSP as acceptable if the plan was present without determining the presence and quality of all the minimum requirements.

ISP Part V- DBHDS describes its requirements for the Part V for therapeutic consultation behavioral services in its Timelines and required documentation for TC authorizations summary table (Attachment 2). It must include measurable benchmarks for behaviors targeted for increase or decrease and a request for or description of the training for caregivers. We found the Part Vs were complete for only 70 of 102 (69%) individuals in the sample. (The Part V was N/A in one case.) This percentage ranged from 51% in Region 2 to 91% in Region 3. DBHDS, which reported that 100% of the individuals in the sample had Part Vs submitted in WaMS but did not review and determine that the content of the Part V documents included all required elements. We found that many of the Part Vs did not include measurable benchmarks for the behaviors targeted for decrease or increase.

Caregiver Education- DBHDS expects that caregivers including family members and paid staff will be trained to effectively implement the BSP. Caregiver training is required for Annual Authorizations of BSPs but not of Secondary Authorizations. We found evidence of caregiver training in many of the plans implemented during a secondary authorization so included these data for DBHDS' information and review. Twenty-nine of the thirty-eight secondary authorizations (76%) in which there was sufficient time to provide training to caregivers had implemented this training. We found evidence that training was provided to caregivers for only 59 of 96 (61%) of the individuals in the sample. (Education was N/A for seven of the individuals in the sample because of timing of creating the plan.) This percentage ranged from 33% in Region 2 to 100% in Region 1. We reviewed actual training sheets that listed who was trained and the dates of training. We also accepted a reference to training in the quality monitoring summaries as evidence that training did occur. We did not evaluate the adequacy of the training. DBHDS determined that the caregivers of 93 of the 107 (87%) individuals in the sample were trained. We cannot explain the substantial discrepancy of our finding compared to DBHDS' finding related to caregiver training.

Monitoring the Implementation of the BSP- *Ci 7.19* includes the expectation that the BSP will be monitored for effective implementation and to determine if changes are needed over the course of implementation to improve the outcomes for the individual. The DBHDS expects the behaviorist will monitor the plan and submit a summary at least quarterly. We found evidence

that this monitoring did occur for 76 of 100 (76%) individuals in the sample. (This was N/A for three of the individuals in the sample because of timing of crating the plan.) This percentage ranged from 48% in Region 3 to 100% in Region 5. We made this determination by reviewing the summaries submitted to us by DBHDS for review. DBHDS determined that monitoring occurred for 99 of the 107 (92%) individuals in the sample. We cannot explain the discrepancy of our finding compared to DBHDS' finding related to monitoring of the BSP.

Review by the Case Managers- Case Managers are expected to make onsite visits to review service delivery for individuals on their caseloads. These visits are either monthly for individuals on Enhanced CM or quarterly. DBHDS has developed an Onsite Visitation Tool (OSVT) for CMs to record the results of their in-person assessments. DBHDS provided training for all CMs regarding how to properly complete the OSVT. The CMs are required to determine and note if a BSP is being implemented as authorized. If it is not implemented as authorized, they must answer additional questions to document if the FBA and BSP have been done, and if caregivers are trained. We reviewed each OSVT that was submitted and determined if the answers of the CM matched the information we had from reviewing the BSP, Part V and the monitoring summaries. The CMs correctly completed all OSVT forms for 81 of the 103 (79%) individuals in the sample. This percentage ranged from 64% in Region 1 to 95% in Region 3. We found that some CMs did not complete all of the OSVTs related to the questions about behavioral services or may have marked the answer to the question as N/A despite evidence that a BSP was being implemented. We cannot compare our findings to that of DBHDS. DBDS noted whether every OSVT was submitted either monthly or quarterly but did not indicate if they had been reviewed regarding the appropriate delivery of TC.

Table 1 summarizes the findings of this study by each of the components of service that DBHDS has agreed to provide under *CI 7.19.* We report for the FBA and the BSP both if they were completed and submitted on time, and separately whether the FBA and BSP include the minimum elements that DBHDS includes in its guidelines for behavioral services. The sample we selected for this qualitative study was not the same sample that DBHDS used for its qualitative review as required in CI 7.20. DBHDS did submit the results of its own qualitative review of 100 randomly selected records for individuals who have service authorizations for TC. These results are discussed in the main body of this report.

Table 1: A Summary of the Findings of the Expert Review Study below summarizes the findings of the review completed of *CI 7.19*

Required Element of CI 7.19	Independent Study Findings
FBA	71% (73 of 103)
FBA Timely	95% (98 of 103)
BSP	42% (42 of 101)
BSP Timely	97% (98 of 101)
Part V Completed	69% (70 of 102)
Caregivers Educated	61% (59 of 96)
Behaviorist Monitors	76% (76 of 100)
OSVT Completed	79% (81 of 103)

Table 2 which is below details our determination for each of the requirements of *CI 7.19* as to whether they are met or not met. A Yes indicates that we determined the expectations were fully met. For the individuals in the sample, we have created a version of Table 2 that includes our comments supporting our determinations of not met and have separately submitted this to DBHDS under seal.

Summary- We found that a very high percentage of FBAs (95%) and BSPs (97%) were completed on time based on the date of the service authorization and the expected timelines of DBHDS. However, the Commonwealth is not assuring the 86% of individuals identified as needing Therapeutic Consultation service (behavioral supports) are receiving all the required elements in accordance with the requirements of the DD Waiver Regulations expectations and Practice Guidelines for what constitutes an adequate behavioral program. These include a functional behavioral assessment; a plan for supports; training for those providing care; and monitoring of the plan including data review and plan revisions as necessary. At least one Region achieves more than 86% of the elements comprising *CI 7.19,* except for the BSP. In many cases Regions have one or more individuals in the sample for whom all of the required elements were present and met. Of the individuals in the sample a total of thirty had all of the elements for TC as required by CI 15 and CI 19: four in Region 2; eleven in Region 3; fourteen in Region 4; and one in Region 5. We found many examples of excellent FBAs and BSPs and comprehensive monitoring. However, we found in this sample studied that the Commonwealth's behavioral programming is not consistently meeting the minimum expectations for what constitutes adequate behavioral programming. DBHDS has designed and implemented an extremely thorough qualitative review process using a randomized sample. The strengths of the BSPARI are discussed in the main body of this report. The DBHDS Subject Matter Experts provide a comprehensive review of the FBAs and BSPs in their annual sample; identify both the strengths and weaknesses of the assessments and plans; and provide constructive feedback to the Behaviorists who have conducted the FBAs and completed the BSPs. This process is a sound approach to review and quality improvement. Over time it should

help ensure that the FBAs and BSPs meet the expectations DBHDS has set for behavioral assessments and plans.

Table 2: Determination of Whether the Requirements of CI 7.19 Are Met for the Individuals in the Qualitative Study

REGION	CSB	AUTH TYPE	FBA	FBA TIMELY	BSP	BSP TIMELY	PART V MEETS REQ	FAM/CG EDUCATED	BEH MONITORS	OSVT
REGION 1 (WESTERN)										
WR-1	REGION 10	ANNUAL	YES	YES	NO	YES	NO	YES	YES	YES
WR-2	REGION 10	ANNUAL	YES	YES	YES	YES	YES	YES	NO	YES
WR-3	REGION 10	ANNUAL	NO	YES	NO	YES	NO	YES	YES	YES
WR-4	REGION 10	SECONDARY	NO	YES	NO	YES	YES	YES	YES	YES
WR-5	REGION 10	SECONDARY	YES	YES	NO	YES	NO	YES	YES	YES
WR-6	REGION 10	SECONDARY	YES	YES	NO	YES	NO	YES	YES	NO
WR-7	Rappahannock	ANNUAL	YES	YES	NO	YES	YES	YES	NO	YES
WR-8	Rappahannock	ANNUAL	YES	YES	NO	YES	YES	YES	YES	NO
WR-9	Rappahannock	ANNUAL	NO	YES	NO	YES	YES	N/A	YES	YES
WR-10	Rappahannock	SECONDARY	YES	YES	NO	YES	YES	YES	YES	NO
WR-11	Rappahannock	SECONDARY	YES	YES	NO	YES	YES	N/A	YES	NO
Region Total			8 of 11	11 of 11	1 of 11	11 of 11	7 of 11	9 of 9	9 of 11	7 of 11
Region %			67%	100%	9%	100%	64%	100%	82%	64%
REGION	**CSB**	**AUTH TYPE**	**FBA**	**FBA TIMELY**	**BSP**	**BSP TIMELY**	**PART V MEETS REQ**	**FAM/CG EDUCATED**	**BEH MONITORS**	**OSVT**
REGION 2 (NORTHERN)										
NR-1	ARLINGTON	ANNUAL	YES	YES	NO	YES	NO	NO	YES	YES
NR-2	FAIRFAX	ANNUAL	NO	NO	YES	YES	YES	NO	NO	NO
NR-3	FAIRFAX	ANNUAL	NO	NO	NO	YES	NO	NO	YES	YES
NR-4	FAIRFAX	ANNUAL	YES	YES	YES	YES	NO	YES	YES	YES
NR-5	FAIRFAX	ANNUAL	NO	YES	NO	YES	NO	NO	YES	NO
NR-6	FAIRFAX	ANNUAL	NO	NO	NO	YES	YES	NO	N/A	YES
NR-7	FAIRFAX	ANNUAL	NO	YES	YES	YES	NO	NO	NO	NO
NR--8	FAIRFAX	ANNUAL	NO	YES	NO	YES	YES	YES	YES	NO
NR-9	FAIRFAX	ANNUAL	NO	YES	NO	YES	YES	NO	NO	NO
NR-10	FAIRFAX	ANNUAL	NO	YES	NO	YES	NO	NO	YES	YES
NR-11	FAIRFAX	ANNUAL	YES	YES	NO	YES	YES	YES	NO	YES
NR-12	FAIRFAX	SECONDARY	YES	YES	NO	YES	NO	NO	NO	YES
NR-13	FAIRFAX	SECONDARY	YES	YES	YES	YES	YES	N/A	YES	YES
NR-14	FAIRFAX	SECONDARY	YES	YES	YES	YES	NO	NO	YES	YES
NR-15	FAIRFAX	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
NR-16	FAIRFAX	SECONDARY	YES	YES	N/A	N/A	N/A	N/A	N/A	YES
NR-17	FAIRFAX	SECONDARY	YES	YES	NO	YES	YES	YES	NO	YES
NR-18	FAIRFAX	SECONDARY	YES	YES	N/A	N/A	NO	N/A	N/A	NO
NR-19	FAIRFAX	SECONDARY	YES	YES	NO	YES	YES	YES	YES	YES
NR-20	FAIRFAX	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
NR-21	LOUDON	ANNUAL	YES	YES	NO	YES	NO	NO	YES	YES
NR-22	PRINCE WILLIAM	ANNUAL	NO	YES	NO	YES	NO	YES	YES	YES
NR-23	PRINCE WILLIAM	ANNUAL	YES	YES	NO	YES	NO	YES	YES	NO
NR-24	PRINCE WILLIAM	ANNUAL	NO	YES	NO	YES	NO	YES	YES	YES
NR-25	PRINCE	ANNUAL	YES	YES	NO	YES	YES	NO	NO	YES

	WILLIAM									
REGION	**CSB**	**AUTH TYPE**	**FBA**	**FBA TIMELY**	**BSP**	**BSP TIMELY**	**PART V MEETS REQ**	**FAM/CG EDUCATED**	**BEH MONITORS**	**OSVT**
REGION 2 (NORTHERN)										
NR-26	PRINCE WILLIAM	ANNUAL	NO	YES	NO	YES	YES	NO	NO	YES
NR-27	PRINCE WILLIAM	ANNUAL	YES	YES	NO	YES	NO	NO	YES	YES
NR-28	PRINCE WILLIAM	ANNUAL	NO	YES	NO	YES	NO	NO	NO	YES
NR-29	Northwestern	ANNUAL	NO	YES	NO	YES	YES	NO	NO	YES
NR-30	Northwestern	ANNUAL	NO	YES	NO	YES	NO	NO	NO	YES
NR-31	Northwestern	ANNUAL	NO	YES	NO	YES	YES	NO	NO	YES
NR-32	Northwestern	ANNUAL	NO	YES	NO	YES	NO	YES	NO	YES
NR-33	Northwestern	ANNUAL	NO	YES	NO	YES	YES	NO	NO	YES
NR-34	Northwestern	ANNUAL	NO	YES	NO	YES	YES	NO	NO	YES
NR-35	Northwestern	ANNUAL	NO	YES	NO	YES	YES	NO	NO	YES
NR-36	Northwestern	SECONDARY	YES	YES	NO	YES	YES	NO	NO	NO
Region Total			17 of 36	33 of 36	7 of 34	34 of 34	18 of 35	11of 33	16 of 33	28 of 36
Region %			47%	92%	21%	100%	51%	33%	48%	78%
REGION	**CSB**	**AUTH TYPE**	**FBA**	**FBA TIMELY**	**BSP**	**BSP TIMELY**	**PART V MEETS REQ**	**FAM/CG EDUCATED**	**BEH MONITORS**	**OSVT**
REGION 3 (SOUTHWEST)										
SW-1	BLUE RIDGE	ANNUAL	YES	YES	NO	YES	YES	YES	YES	YES
SW-2	BLUE RIDGE	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
SW-3	BLUE RIDGE	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
SW-4	BLUE RIDGE	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
SW-5	BLUE RIDGE	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
SW-6	CUMBERLAND	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
SW-7	HIGHLANDS	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
SW-8	MT. ROGERS	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
SW-9	MT. ROGERS	SECONDARY	YES	YES	NO	NO	YES	NO	YES	NO
SW-10	MT. ROGERS	SECONDARY	YES	YES	YES	YES	YES	NO	YES	YES
SW-11	NEW RIVER	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
SW-12	NEW RIVER	ANNUAL	YES	YES	NO	YES	YES	YES	YES	YES
SW-13	NEW RIVER	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
SW-14	PIEDMONT	ANNUAL	YES	YES	NO	YES	YES	YES	YES	YES
SW-15	PIEDMONT	ANNUAL	YES	YES	NO	YES	YES	YES	YES	YES
SW-16	PIEDMONT	SECONDARY	YES	YES	NO	YES	YES	YES	YES	YES
SW-17	PIEDMONT	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
SW-18	PLANNING DISTRICT	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
SW-19	RBHA	ANNUAL	NO	YES	NO	YES	NO	NO	NO	YES
SW-20	RBHA	ANNUAL	NO	YES	NO	YES	NO	NO	NO	YES
SW-21	VALLEY	ANNUAL	YES	YES	YES	YES	YES	NO	YES	YES
SW-22	VALLEY	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
Region Total			20 OF 22	22 OF 22	14 of 22	21of 22	20 of 22	17 OF 22	20 OF 22	21 OF 22
Region %			91%	100%	64%	95%	91%	77%	91%	95%

REGION	CSB	AUTH TYPE	FBA	FBA TIMELY	BSP	BSP TIMELY	PART V MEETS REQ	FAM/CG EDUCATED	BEH MONITORS	OSVT
REGION 4 (CENTRAL)										
CR-1	CHESTERFIELD	ANNUAL	YES	YES	YES	YES	YES	NO	YES	NO
CR-2	CHESTERFIELD	ANNUAL	YES	YES	YES	YES	NO	YES	YES	YES
CR-3	CHESTERFIELD	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
CR-4	CHESTERFIELD	ANNUAL	NO	NO	NO	YES	NO	NO	NO	NO
CR-5	CHESTERFIELD	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
CR-6	CHESTERFIELD	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
CR-7	CHESTERFIELD	ANNUAL	YES	YES	YES	YES	NO	YES	YES	YES
CR-8	CHESTERFIELD	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
CCR-9	CHESTERFIELD	SECONDARY	YES	YES	NO	NO	NO	YES	YES	YES
CR-10	CHESTERFIELD	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
CR-11	CHESTERFIELD	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
CR-12	CHESTERFIELD	SECONDARY	YES	YES	NO	YES	YES	NO	YES	NO
CR-13	CHESTERFIELD	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
CR-14	CHESTERFIELD	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
CR-15	CHESTERFIELD	SECONDARY	NO	NO	NO	NO	YES	NO	NO	NO
CR-16	CHESTERFIELD	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
CR-17	CHESTERFIELD	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
CR-18	CROSSROADS	SECONDARY	NO	YES	NO	YES	YES	YES	YES	YES
CR-19	DISRTICT 19	SECONDARY	YES	YES	YES	YES	YES	YES	YES	NO
CR-20	GOOCHLAND	SECONDARY	YES	YES	YES	YES	YES	NO	YES	NO
CR-21	HANOVER	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
CR-22	HANOVER	ANNUAL	YES	YES	YES	YES	YES	YES	YES	YES
CR-23	HENRICO	ANNUAL	NO	YES	NO	YES	YES	NO	NO	YES
CR-24	HENRICO	SECONDARY	YES	YES	YES	YES	YES	NO	YES	YES
CR-25	HENRICO	SECONDARY	YES	YES	YES	YES	YES	YES	YES	YES
Region Total			21 of 25	23 of 25	19 of 25	23 of 25	21 of 25	18 of 25	22 of 25	19 of 25
Region %			84%	92%	76%	92%	84%	72%	88%	76%

REGION	CSB	AUTH TYPE	FBA	FBA TIMELY	BSP	BSP TIMELY	PART V MEETS REQ	FAM/CG EDUCATED	BEH MONITORS	OSVT
REGION 5 (EASTERN)										
ER-1	COLONIAL	ANNUAL	YES	YES	NO	YES	NO	YES	YES	NO
ER-2	EASTERN SHORE	SECONDARY	YES	YES	NO	YES	YES	N/A	YES	YES
ER-3	NORFOLK	ANNUAL	NO	YES	NO	YES	NO	YES	YES	YES
ER-4	NORFOLK	SECONDARY	YES	YES	YES	YES	YES	N/A	YES	YES
ER-5	NORFOLK	SECONDARY	YES	YES	NO	YES	YES	NO	YES	NO
ER-6	PORTSMOUTH	SECONDARY	YES	YES	NO	YES	NO	NO	YES	YES
ER-7	VIRGINIA BEACH	ANNUAL	YES	YES	NO	YES	NO	YES	YES	YES
ER-8	VIRGINIA BEACH	ANNUAL	NO	YES	NO	YES	NO	NO	YES	YES
ER-9	WESTERN TIDEWATER	SECONDARY	YES	YES	NO	YES	YES	YES	YES	NO
REGION	**CSB**	**AUTH TYPE**	**FBA**	**FBA TIMELY**	**BSP**	**BSP TIMELY**	**PART V MEETS REQ**	**FAM/CG EDUCATED**	**BEH MONITORS**	**OSVT**
Region Total			7 of 9	9 of 9	1 of 9	9 of 9	4 of 9	4 of 7	9 of 9	6 of 9
Region %			78%	100%	11%	100%	44%	57%	100%	67%
Statewide Total			73 of 103	98 of 103	42 of 101	98 of 101	70 of 102	59 of 96	76 of 100	81 of 103
Statewide % Met			71%	95%	42%	97%	69%	61%	76%	79%

Timelines and required documentation for therapeutic consultation behavioral services authorizations

Note: The table below provides a summary visual. Please see the full text of the regulations that govern this service at: 12 VAC 30-122-550

Authorization Type	*Timeframe*	*Required documentation for authorization*
Initial Authorization	Up to 180 days	• Part V must outline the following: ○ that a Functional Behavioral Assessment (FBA) will be conducted ○ that a BSP will be created ○ the plan for data collection during this period
Second authorization	Post 180 days of the initial authorization period until the ISP annual date	• Behavior Support Plan • FBA (the FBA may be within the BSP or a separate document). • Any baseline data or treatment data collected used in formulating the plan • Part V must outline the following: ○ Request for or description of training for stakeholders must be included and parallel what is included in the training section of the BSP. ○ Measurable benchmarks for behaviors targeted for increase and decrease in the BSP, which must be included in the " I no longer want (or)/need supports when..." area of the Part V
ISP Update (Annual renewal or when needed)	Annual ISP date to annual ISP date	• Graphical displays with progress summary covering at least the current review period. • Current BSP • Current FBA (FBA can be incorporated into the BSP or on a separate document) ○ In preparation for the shared planning meeting, the most recent FBA and treatment data must be reviewed by the behaviorist. A reference of this review and the behaviorist's determination of the continued validity or need for re-assessment must be included in the FBA. See Part V requirements below if re-assessment is determined. • Documentation of any training completed within the timeframe of the most recent review period • Part V must outline the following: ○ Request for or description of training for stakeholders must be included and parallel what is included in the training section of the BSP. ○ *If the behaviorist determines re-assessment is needed, request re-assessment in Part V. If behaviorist determines previous FBA is still valid, re-assessment does not need to be include in the Part V.*

APPENDIX D

Individual and Family Support Program, Guidelines for Families, and Family-To-Family And Peer Programs

by

Rebecca Wright MSW LCSW

Introduction/Overview

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to create an Individual and Family Support program (hereinafter IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. The related provisions are as follows:

Section II.D: Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and family-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C. The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.

Section III.C.2: The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization...

Section III.C.8.b: The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.

Section III.D.5. Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.

Section IV.B.9.b. ...The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities.

The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) have jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia has not yet been found in compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020. For the next Report to the Court, due in June 2021, the Independent Reviewer's monitoring priorities again include studying compliance with the these agreed-upon compliance indicators.

The Independent Reviewer's previous reports (i.e., 6th, 8th, 12th, 14th, 16th and 18th Reports to the Court, dated June 6, 2015, and June 6, 2016, June 13, 2018, June 13, 2019, June 6, 2020, and June 13, 2021 respectively) found the Commonwealth had met the pertinent quantitative requirements by providing IFSP monetary grants to at least 1,000 individuals and/or families. These same Reports to the Court further found that the Commonwealth had not met the qualitative requirements for the IFSP, but noted steady progress, which had accelerated significantly beginning at the time of the12th review period, following the development of the IFSP State Plan. In addition to developing an IFSP Strategic Plan, DBHDS had created an IFSP Community Coordination Program; organized a IFSP State Council and Regional Councils as forums for informing stakeholders about the IFSP and obtaining their input; continued to develop enhancements to the IFSP Funding Program; and undertook an initiative for a family-to-family and peer-to-peer mentoring program.

At the time of the last Report to the Court on this topic (i.e., the 18th Report), some of these efforts continued to be in the preliminary planning or early implementation stages, but had good potential for moving the Commonwealth toward compliance. The Commonwealth had met Compliance Indicators 1.3, 1.5,1.8, 1.10, and 1.12. However, it remained in Non-Compliance because it had not Met Indicators 1.1, 1.2, 1.4, 1.6, 1.7, 1.9, and 1.11.

20th Period Study Purpose and Methodology

In April 2019, the Court directed the Commonwealth to develop a library of documents that would show the Court the source of Virginia's authority (i.e., its organizational structure, policies, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, quarterly reports, etc.) needed to demonstrate compliance. Accordingly, this study attempted to identify a minimum set of finalized policies, procedures, instructions, protocols and/or tools that will be needed for the Independent Reviewer to formulate future compliance recommendations. In addition, the Independent Reviewer asked the consultant to analyze the Commonwealth's reliable and valid data, as well as the documents and the method of analysis the Commonwealth is using, or plans to use, to determine whether it is maintaining "sufficient records to document that the requirements of each provision are being properly implemented," as measured by the relevant compliance indicators. This also encompasses required reporting commitments.

The study methodology included document review, DBHDS staff interviews, stakeholder interviews, and review and analysis of available data. The purpose of the study and the related components of the study methodology were reviewed with DBHDS staff. Following that kick-off meeting, DBHDS was asked to provide all necessary documents and to suggest interviews that provide information that demonstrates proper implementation of the Provision and its associated Compliance Indicator(s). A full list of individuals interviewed is included in Attachment A. full list of documents and data reviewed may be found in Attachment B.

Summary of Findings

For each provision cited above, this 20th period study again found DBHDS continued to make some progress, but the IFSP initiatives experienced significant staff turnover at the state level. In addition, for the second consecutive annual funding period, an application portal breakdown had resulted in a breach of privacy data for some applicants and required DBHDS to shut down the process prematurely. Combined with challenges related to the COVID-19 pandemic, progress from the previous reporting period had slowed and, in some cases, lost ground. Still, while in most instances DBHDS had not yet finalized development and/or implementation of the strategies intended, and needed, to achieve the compliance indicators and/or formalized the reporting and documentation requirements, they had made some forward progress in key areas. For example:

- DHBDS had finalized the eligibility criteria for individuals on the waitlist to receive case management and published it in the updated Waiver Manual, but still needed to update various documents to inform individuals and families about these options;
- DBHDS staff had begun to review the measurable indicators in the IFSP State Plan intended to assess performance and outcomes of the IFSP, including the development of capacity for the collection and the analysis of reliable and valid data, but this was in a very preliminary stage; and,
- In response to the data breaches that occurred in the past two funding cycles, DBHDS was in the process of developing a new module in the Waiver Management System (WaMS) to replace the previously-implemented application funding on-line portal. IFSP and DBHDS IT staff reported they expect the new module to be available during FY 23.

There also continued to be some areas for which progress had stalled and/or DBHDS staff were re-thinking the structure and approaches:

- There had been some significant changes to the operations of the Regional Councils, and they were largely non-functional at the time of this report. In addition to challenges resulting from COVID-19 pandemic restrictions, this appeared to be due at least in part to the departures of key DBHDS staff at the state and regional levels as well as other changes in the availability of operational supports. DBHDS staff also reported they were beginning to consider whether, and how, those roles and responsibilities might need to look different in the future, and planned to convene the State Council in April 2022 to discuss and devise a workplan for reconstituting the Regional Councils.
- DBHDS staff reported that, given IFSP staffing resources and other factors, the draft prioritization criteria described at the time of 18th Period Review did not appear to be feasible, or even represent the best use of DBHDS resources overall. They had not yet fully conceptualized an alternative approach;
- DBHDS staff had not consistently followed the protocols they indicated were applicable to annual eligibility and/or IFSP funding notification processes;
- DBHDS had not taken actions, as recommended in the 18th Period report, to develop the capacity of the family-to-family support and peer-to-peer mentoring programs to ensure they address the specific requirements of the relevant provisions and Compliance Indicators; and,
- As a consequence of the disruptions in the IFSP Funding Program, DBHDS staff had not been able to disseminate a satisfaction survey. This might provide an opportunity to further consider feedback the Independent Reviewer has provided in past reports with regard to the efficacy of the previous methodology.

The table on the following page illustrates the most recent and the current compliance status for each Compliance Indicator.

III.C.2.a-f (II.D): Indicators	**Status** 18th Period **20th Period**
1.1 The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following: • Funding resources • A family and peer mentoring program • Local community-based support through the IFSP Regional Councils •	Not Met **Not Met**
1.2 The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization.	Not Met **Not Met**
1.3 The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program.	Met **Not Met**
1.4 The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including:	Not Met **Not Met**
1.5 The number of individuals on the waiver waitlist who are provided with outreach materials each year	Met **Met**

1.6 Participant satisfaction with the IFSP funding program	Not Met **Not Met**
1.7 Knowledge of the family and peer mentoring support programs	Not Met **Not Met**
1.8 Utilization of the My Life, My Community website	Met **Met**
1.9 Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter.	Not Met **Not Met**
1.10 IFSP funding availability announcements are provided to individuals on the waiver waitlist.	Met **Not Met**
1.11 Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website	Not Met **Not Met**
1.12 Documentation continues to indicate that a minimum of 1,000 individuals and/or their families are supported through IFSP funding.	Met **Met**
III.C.8.b: Indicators	**Status**
17.1 DBHDS has developed and launched the "My Life, My Community" website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. This will be documented by reports of activity on the website.	Met **Met**
17.2 Documentation indicates that the My Life, My Community website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families.	Met **Met**
III.D.5 (IV.B.9.b.): Indicators	**Status**
19.1 At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources.	Met **Not Met**
19.2 The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested.	Not Met **Not Met**
19.3 The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to-family and the peer-to-peer supports have contact and the number who receive the service.	Not Met **Not Met**

Analysis of 18th Review Period Findings

18th Review Period
Findings

III.C.2.a-f (II.D)
The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization……. In State Fiscal Year 2019, a minimum of 1000 individuals supported.

(II.D: Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and family-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C above. The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.)

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
1.1 The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following: • Funding resources • A family and peer mentoring	The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council includes the essential components of a comprehensive and coordinated set of strategies, including funding resources, a family	DBHDS issued the current IFSP State Plan in 2019, as well as the most recent *IFSP State Plan Update* in February, 2022. This most recent version indicated that DBHDS IFSP staff would collaborate with IFSP State Council to conduct a more extensive review of the IFSP State Plan prior to the installation of a new State Council in January 2023. Previously, DBHDS had developed a Departmental Instruction (DI) with regard to the IFSP. DI 113 (TX) 20: Facilitation of Access to Resources and Supports to Enhance Community Inclusion and Engagement. The DI, dated 9/4/20, states its purpose as to outline the supportive policies within the IFSP, as they relate to the administration of peer-to-peer mentoring, family-to- family mentoring, information and referral, and the IFSP community	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
program • Local community-based support through the IFSP Regional Councils	and peer mentoring program and local community-based support through the IFSP Regional Councils. The IFSP Funding Program has been in continuous operation since 2013. In addition, IFSP staff have issued, and updated as needed, formal guidelines, policies and procedures sufficient to implement the program. For this review, DBHDS continued to provide funding resources annually, with the last funding period occurring in October 2021. After repeated privacy breaches of applicant data in the last two funding periods, DBHDS was currently in the midst of making potentially fundamental changes to its IFSP Funding Program infrastructure and was currently working to integrate a new Funding Portal module into the Waiver Management	coordination efforts. DBHDS staff reported no changes to the DI for this 20th Period Review. As previously noted, this DI provides extensive definitions of terms, but guidance tends to be both too broad, non-specific and/or limited in scope. Instead, it defers to the DBHDS Central Office to "ensure that procedures are developed to comply with this DI." Specifically, the DI indicates that the procedures to be developed shall include: • Processes and procedures to support the implementation of the State Plan and the state and regional council structure to build the local infrastructure to promote person-centered and family-centered resources, supports, services, and other assistance; • A process for providing family and peer mentoring to provide one on one support and information to individuals and families; • A process to establish criteria for identifying applicants most at risk for institutionalization; and, • A process to maintain accessible, user-friendly information including information on eligibility for IFSP-Funding, case management, and other DD resources and services through a website and other mechanisms that shall be shared with individuals upon their placement on the DD Waiver Waiting List. This Compliance Indicator requires implementation of the strategies in the IFSP State Plan, specifically "offering information and referrals through an infrastructure" that includes funding resources, Family and Peer Mentoring program and local community-based support through the IFSP Regional Councils. As the DI indicates, DBHDS staff acknowledge that such implementation requires a foundation of a minimum set of clear, written finalized policies, procedures, instructions, protocols and/or tools.	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
	System (WaMS). The Family-to Family Mentoring program infrastructure was well-developed overall, but DBHDS had not yet developed a clear and comprehensive referral process. DBHDS continued to work with the Arc of Virginia to implement a Peer Mentoring program and associated infrastructure. However, DBHDS had not yet developed a clear and comprehensive referral process. For this review period, there had been some significant changes to the operations of the Regional Councils, and they were largely non-functional at the time of this report and none had current members appointed. DBHDS staff also reported they were beginning to consider whether, and how, those	At the time of the 18th Period review, with regard to funding resources, DBHDS had developed and published a clear set of such documents, but had not yet fully done so for the Family and Peer Mentoring programs. For the last funding period occurring in October 2021, DBHDS continued to provide funding resources, and provided a clear set of written finalized policies, procedures, instructions, protocols and/or tools. Of note, due to repeated data privacy breaches and the resulting need to develop a new IT solution, as well as pending changes to the prioritization criteria, written finalized policies, procedures, instructions, protocols and/or tools were not yet available for the upcoming funding period. The details of these issues are described further below in this section and with regard to CI 1.2. In addition, due to pandemic-related challenges and staffing turnover, the Regional Councils were not currently operative. Further, DBHDS staff indicated they would be making structural changes to the Regional Councils, and expected to meet with IFSP State Council in the near future to begin to envision the future of the regional structure, roles and responsibilities. Therefore, the existing charters and other documents describing the role of the Regional Councils were not a current set of finalized policies, procedures, instructions, protocols and/or tools, nor did they reflect the DBHDS plan and commitment for future practices. The following paragraphs describe the relative presence and/or absence of other needed documents and/or processes. **Funding Resources:** For this review, DBHDS continued to provide funding resources annually, with the last funding period occurring in October 2021. For that funding period, the process relied on the Individual & Family Support Program Application Portal, which was hosted on the DBHDS website and could be accessed via a link on the My Life My Community (MLMC) website.	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
	roles and responsibilities might need to look different in the future. As a result of these circumstances, the existing Regional Council charter, dated 2/24/21, was not sufficient to describe a yet-to-be-determined local infrastructure and will need to be reviewed and modified as appropriate.	The aforementioned DI defined the IFSP Funding Program in the following manner: subject to the availability of funds, the IFSP Funding available in accordance with 12 VAC 35-230 assists individuals on Virginia's DD Waiting List and their families with accessing resources, supports and services. While the DI did not otherwise detail guidance with regard to the operation of the funding program, DBHDS had an extensive library of formalized policies and procedures, which they had consistently updated over time to address any programmatic changes. IFSP staff disseminated various tools to support users in accessing and using the portal, including the *Individual & Family Support Program Application Portal User Guide Revised 9/7/21,* the *Individual and Family Support Program Guidelines and FAQs*, updated 9*/14/21*, and a document entitled *Beyond IFSP-Funding, Revised December 2021.* In addition, as described further below for Compliance Indicator 1.3 of this provision, IFSP staff had previously worked with other DBHDS staff to develop a robust capacity for providing all individuals on the waitlist with time-sensitive notifications of funding availability. However, based on interview with DBHDS staff, for this 20th Period review, they did not follow the protocol completely. They used the WWL waitlist contact information to send electronic notifications by email, but did not complete mailing notifications to individuals and families who did not have email addresses in WaMS. Of note, and as described further with regard to CI 1.12 below, no funds were distributed in FY 21, due to the malfunction of the IFSP-Funding Portal, causing a breach of some individuals' private information. In addition, as a result of the aforementioned breach, the Funding Portal was closed for extensive review and testing. In September 2021, the Funding Portal re-opened, but experienced another breach and was shut down within 6 minutes of opening. The 2021 breach appeared to be similar to the breach from 2019, again resulting in the potential that some applicants' personal information may have been seen by other applicants. DBHDS reported	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		concluding that rather than attempting to repair the Portal again, they would seek a completely new solution. As a result, at the time of this 20th Period review, DBHDS was in the midst of making potentially fundamental changes to its IFSP Funding Program infrastructure and was currently working to integrate a new Funding Portal module into the Waiver Management System (WaMS). In the interim, to ensure that individuals and families had continuing access to IFSP funding, in October of 2021 (i.e., in the second quarter of FY 22), DBHDS distributed funds from both FY 21 and FY 22. Specific funding details are described with regard to CI 1.12. Additional details with regard to the pending proposal for prioritization criteria for funding are provided below under CI 1.2. As further described in that section, DBHDS staff had not implemented the prioritization criteria proposed at the time of the 18th Period review, but initially reported they planned to do so with the implementation of the new Funding Portal in WaMS projected for the FY 23 funding cycle. However, by the time this 20th review period concluded, DBHDS staff determined that those prioritization criteria were not feasible within existing resources and were planning to review a revised solution with the IFSP State Council at the next meeting. **A Family and Peer Mentoring Program:** The Settlement Agreement requires the Commonwealth to develop family-to-family and peer mentoring programs as a part of a comprehensive and coordinated set of person-centered and family-centered strategies, but also specifically to facilitate opportunities for families and individuals considering congregate care receive information about options for community placements, services, and supports. At the time of the 18th Period review, DBHDS had not yet fully developed and published a clear set of such operational documents for the Family and Peer Mentoring programs.	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		As reported previously, at this time, DBHDS continues to contract with the Virginia Commonwealth University (VCU) Center for Family Involvement (CFI) Partnership for People with Disabilities to engage with individuals and families on behalf of the Department across a platform of programs. These efforts include the implementation of a family-to-family network to provide one-to-one emotional, informational and systems navigational support to families. For this Review Period, DBHDS provided an updated contract modification to the original Memorandum of Agreement (MOA), dated 5/10/21, to show continuation of the family-to-family program. It continued to indicate the purpose of the collaboration was to 1) provide direct family to family support to families of children and adults with ID/DD to assist with navigating community-based services and resources; 2) support the structure and success of regional Individual and Family Support Councils; and 3) participate in DBHDS efforts to develop a statewide program that offers a continuum of peer-to-peer supports for individuals with ID/DD. As described at the time of the previous study, the brochure for the Family-to-Family Network of Virginia states the intent is to support families of children and adults with disabilities and special health care needs. Through the program, Family Navigators provide support and information, and discuss options with families so they can make the best choices for their family member with a disability. Family Navigators are a parent or primary caregiver who is or has supported a child or adult family member with disabilities or special health care needs, who has been trained to support other families in accessing supports and services for their child and family and are knowledgeable about local and state resources and disability service systems. This program had been in existence for more than 15 years and is well-established. However, as also reported at the time of the 18th Period study, while the infrastructure was in place for providing Family-to-Family mentoring supports, DBHDS had not yet	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		developed a clear and comprehensive referral protocol for accessing those services, as described further below with regard to Compliance Indicator 19.2. With regard to the Peer Mentoring program, the contract modification with the Partnership continued to require that they participate in DBHDS efforts to develop a statewide program to offer a continuum of peer-to-peer supports. However, as reported previously, the primary DBHDS vehicle for the implementation of peer-to-peer supports continued to be a statewide Peer Mentor system operated by the Arc of Virginia (the Arc). Based on the contractual documentation provided for review, the Arc and DBHDS agreed to a "Phase One" scope of work to develop the necessary infrastructure to successfully implement a Statewide Peer Support Program, and a "Phase Two" scope of work, which included the following peer mentoring activities: 1) develop a Statewide Alliance of self-advocacy groups; 2) assist DBHDS with increasing the participation and input of self-advocates across multiple program initiatives; 3) provide statewide leadership on peer supports by supporting DBHDS' vision of more fully incorporating the voice and engagement of self-advocates across multiple DBHDS initiatives; 4) collaborate with the IFSP to promote the Peer Mentor Program, recruit and prepare both mentors and mentees, and ensure access for individuals not receiving waiver services; and provide quarterly and semi-annual reports. The third activity included multiple tasks pertinent to this CI, primarily related to the development and implementation of a peer mentoring curriculum and network. Of note, a contract modification, dated 5/3/20, also specifically required the ARC to expand trainings to include supporting people on the DD Waiver Waiting list that were not eligible for Peer-to-Peer Waiver Services. The current contract period runs from 6/4/21 through 6/3/22. Based on review of the *Peer Mentor Quarterly Report*, for the period October through December 2021, the Arc had a total of 9 trained Peer Mentors across Virginia	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		and five had been matched with Mentees. Overall, as reported previously, DBHDS still needed to continue to work towards documenting the proper implementation of defined parameters of the Peer Mentoring program, as that applies to IFSP requirements, and provide the documentation to show the authority, policies, etc. needed to demonstrate compliance and to inform the Independent Reviewer's future determinations as well as to populate the Library. In addition, DBHDS had not yet developed a clear referral protocol for accessing either the family-to-family or peer mentoring services, as described further below with regard to Compliance Indicator 19.02. **Local community-based support through the IFSP Regional Councils:** At the time of the 18th Review Period, based on the Regional Council Charter, dated February 24, 2021, the Regional Council Leadership Board was charged with leading local activities established in the annual regional work plans and coalition. The State Council Charter, dated 10/1/21, indicated its members should collaborate with the Regional Council and local coalitions to advise the Department on creating a robust family support program that increases the number of resources for families and individuals and promotes community engagement and coordination with other stakeholders. Overall, the 18th Period review found that Regional Council system was well-organized and efficient. The Community Coordination program served as the hub for family engagement and the primary vehicles for that engagement were the IFSP State and Regional Councils. These Councils were comprised primarily of comprised of families of individuals on the waitlist, but DBHDS had also recruited some self-advocates to serve on the State Council. While the purpose of the State Council was to provide guidance to DBHDS reflecting the needs and desires of individuals and families across Virginia, based on the current IFSP State Plan, the five IFSP Regional Councils were envisioned as the primary	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		means of providing local community-based support (e.g., identifying and/or developing local resources and sharing those with their communities.) At the time of the 18th Period review, overall coordination for the IFSP continued to be provided by the Individual and Family Support Program Manager. DBHDS also utilized VCU's Regional Navigator Coordinators (RNCs,) through the MOA cited above, to provide overall guidance, coordination and support to the Regional Councils. In addition to support from RNCs, in February 2020, DBHDS had hired a Community Coordination Specialist who assisted with the day-to-day operations of the IFSP Regional Council through administrative support and other activities. DBHDS also hired two part-time staff members to support the regional council models in the Western and Northern regions. Finally, IFSP staff had implemented a virtual annual planning process for the Regional Councils, resulting in a work plan for each Council, as well as new model for virtual Regional Council meetings that integrated a statewide presentation with regional breakout rooms that served as regional business meetings. However, for this review period, there had been some significant changes to the operations of the Regional Councils, and they were largely non-functional at the time of this report. In addition to challenges resulting from the COVID-19 pandemic restrictions, this appeared to be due at least in part to the departures of key DBHDS staff at the state and regional levels as well as other changes in the availability of operational supports from VCU. Unexpected staff departures of both peer support specialists, the Community Coordinator, and the Program Manager, led to a hold on Regional Council activities since October 2021. In addition, based on *2021 Regional Council Activities Summary v. 2/12/2022*, DBHDS decided not to move forward at that time with any appointments or re-appointments to the Regional Councils. At the time of this review,	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		none of the Regional Councils had been constituted, although DBHDS had surveyed previous members about their future interest in continuing membership. Further, based on a review of the *2021 Regional Council Activities Summary,* as well as interviews with both DBHDS staff and State Council members, there was a current lack of clarity about the future roles of the Regional Councils. DBHDS staff reported they were beginning to consider whether, and how, those roles and responsibilities might need to look different in the future. The *IFSP State Plan Update*, dated 2/15/22, noted that DBHDS staff was seeking to explore the most sustainable way to facilitate community support groups in the future, while relying on local partners to move the vision of the State Plan and Regional Councils forward. DBHDS staff stated a continuing commitment to supporting Regional Councils, but there were no firm parameters at the time of this review. With the onboarding of a new IFSP Program Manager in February 2022, DBHDS planned to convene the State Council in April 2022 to discuss and devise a workplan for reconstituting the Regional Councils. As a result of these circumstances, the existing Regional Council charter, dated 2/24/21, was not sufficient to describe a yet-to-be-determined local infrastructure and will need to be reviewed and modified as appropriate. In addition, the following *IFSP State Plan* outcomes remained unmet: • 100% of all IFSP Regional Councils have a local plan to address needs in their community and provide a progress updates every 2 months • All 5 Councils will establish annual goals per their regional Work-Plans for addressing a locally identified gap that aligns with Virginia's Individual and Family Support State Plan for Increasing Support for Virginians with Developmental Disabilities and achieve 50% of their goals on an annual basis.	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
1.2 The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization.	DBHDS has not yet formalized prioritization criteria in a Departmental Instruction, the IFSP State Plan or in IFSP Guidelines. DBHDS staff previously drafted a set of criteria for determining applicants most at risk for institutionalization, but recently concluded that, as written, implementation was not feasible with current resources. They were currently considering other options, but did not yet have a draft available for review.	Previous reviews have consistently recommended that DBHDS should finalize and formalize the definition of "most at risk for institutionalization" as it impacts eligibility requirements and program structure for the IFSP Funding Program, beyond the existing first-come, first-served approach. Further, the previous reviews recommended that this process should be undertaken in a fully transparent communication process with stakeholders. At the time of the 18th Review Period, DBHDS had not yet adopted a set of prioritization criteria for determining applicants most at risk for institutionalization, but had developed a draft and proposed a timeline for finalization, culminating with implementation by late fall/early winter 2020. These criteria, as described below, were based on feedback from the State and Regional Councils, which evolved into a guiding principle that priority categories should consider both the individual circumstances of the applicant and their family and the type of request. The State Council advised staff to find a way to consider both in establishing priorities, and especially in cases of emergencies. Based on a review of tools, data, records, and feedback from DBHDS staff, IFSP developed a program design that proposed to use existing measurement tools to standardize the assessment of individual circumstances, as well as seek to leverage coordination among DD Services and IFSP supports to meet as many needs as possible. IFSP staff also reported holding a series of stakeholder input sessions, beginning with soliciting feedback at the IFSP State Council meeting in May 2020, and culminating with a series of Town Hall meetings in August through October 2020. The resulting prioritization framework included three funding streams, as described below: • Emergency Needs: This new emergency assistance fund would serve individuals who, without emergency assistance, are at high risk of a crisis that would require services in an institutional setting because care could not be adequately	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		provided in a community setting or in a family home. It would allow individuals and families to apply for assistance at any time during the calendar year, but only once per fiscal year. Applicants funded in this pool would also not be considered for other IFSP Funding assistance pools after an award is made. Funds would be available and dispersed throughout the year as they were available. The maximum funding amount would be $3,000. Twenty-five percent of the total annual finding would be allocated to this category. • Prevention Supports Needs: This new funding pool would provide assistance to people who have a demonstrated complex service coordination needs as demonstrated by receiving or were eligible for Targeted Case Management, CCC-Plus, and/or who had a Priority One Waiver Waitlist Status. The assumption for this set of criteria was that failure to meet their prevention support needs might result in a need for institutional care. This application pool would open only once in FY 21, but IFSP staff anticipated a twice-yearly funding opportunity thereafter. Applicants funded in this pool could apply only once a year and would not be considered for general IFSP Funding, as described below, after an award was made. However, recipients in this pool could apply for Emergency Assistance if additional needs arose after the initial funding. The award amount would be $1000 per application. Fifty percent of the total annual funding would be allocated to this category. • The IFSP would continue to maintain a funding pool for general assistance requests, and the general assistance funding pool would operate much like the past IFSP Funding program (i.e., available one time each year and reviewed on a first come first served basis.) Individuals and families on the DD Waiver Waiting List who had not received funds from any other IFSP Funding Assistance Pool could apply for	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		General Assistance. General Assistance would be the last of the funding pools opened during a fiscal year, so that any funds unspent in the Prevention Assistance Pool could be diverted to the General Assistance Pool if need was low. Applicants could request a minimum of $200 and a maximum of $500. Twenty-five percent of the total annual finding would be allocated to this category. • In addition to funding, applicants would also be referred to the following resources: MLMC, Family and Peer Mentoring, and IFSP Regional Councils. For applicants applying for Emergency Assistance, IFSP staff would also facilitate the following referrals, as appropriate: Family-to-Family Mentoring through a targeted and monitored referral process; a warm hand-off to the IFSP Regional Council through outreach conducted by CFI Regional Navigators, and a warm hand-off to the DBHDS Housing Team for screening and assessment for rental, mortgage, and utility assistance. At the time of the 18th Review Period, the study noted that it appeared that DBHDS had developed a thoughtful and methodical set of prioritization criteria, that leveraged and expanded on existing resources and integrated stakeholder input. Further, the study found that the Commonwealth should be able to meet compliance once DBHDS finalized the prioritization criteria along these lines and formalized the requisite documentation (i.e., records to document … proper implementation of this Indicator) to include in the system of documents in the Library as ordered by the Court: the source of Virginia's authority (i.e., its organizational structure, policies, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, quarterly reports, etc.) needed to demonstrate compliance,	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		When this 20th Review Period commenced, as of February 2022, DBHDS staff reported they had begun drafting new regulations to enact this Prioritization Model, with an expectation those regulations would be approved in FY 2023. DBHDS also reported that it was given authority to promulgate emergency regulations for the 2022 General Assembly session, with budget language expected to be approved in April 2022 once the session ended. However, as the Review Period was concluding, DBHDS staff reported back that, upon further examination, they believed the draft prioritization criteria described above did not appear to be feasible, given IFSP staffing resources, or even represent the best use of DBHDS resources overall. While DBHDS staff had not yet developed a written alternative plan, they did describe an intent to continue an annual funding resource. As an example of a possible alternative to the "first-come, first served approach," they were considering a model that would provide $1,000 stipends made to individuals and families randomly selected from the entire pool of applicants for each funding period. It was not yet clear how DBHDS staff would determine which individuals on the waitlist (WWL) were "most at-risk for institutionalization," although they indicated they would likely consider the WWL priority categorizations in some manner. As DBHDS staff move forward with fleshing out this model, they will need to clarify this definition. In addition, they noted that DBHDS already had multiple resources and methodologies in place to address crisis and prevention needs they did not wish to duplicate by having IFSP staff complete what could be viewed as a secondary evaluation of an individual's need for those resources. Overall, they indicated they believed that the current processes were adequate to address the crisis and prevention needs if individuals on the WWL. For example, they referred to an Emergency Slot request process implemented across all CSBs to address crises, and provided the applicable form, as well as a Critical	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		Needs Summary that Support Coordinators also proactively completed for everyone designated as Priority One on the WWL. This latter process evaluated 13 weighted criteria (e.g., availability of a primary caregiver, risk of abuse, neglect, exploitation of the individual, homelessness, an individual's behavioral risk, level of physical care needs or medical needs, the lack of opportunities for a meaningful day activity, etc.). However, DBHDS staff did not provide a policy, DI of other protocol to further describe the implementation of these processes and expected outcomes. It also remained unclear how individuals on the WWL currently became aware of how to access the Critical Needs Summary processes and other resources, particularly if they were not in the Priority One designation or receiving Support Coordination. While it seems feasible and appropriate to continue to seek to leverage existing processes, DBHDS will need to consider how to coordinate, publicize and measure the effectiveness of these as IFSP supports. Most importantly, DBHDS will need to re-engage stakeholders for their feedback about the proposed changes to the prioritization criteria and whether all individuals should be considered most at risk for institutionalization by virtue of their placement on the WWL. Also CI 1.2 requires that they will also need to re-visit the *IFSP State Plan*, which states a goals of ensuring that IFSP Funding serves individuals with developmental disabilities and their families by braiding and blending resources to focus on the needs of the whole person with emphasis on prioritizing those with the greatest needs and most at risk of institutionalization, enhancing the IFSP Funding Program so that those with complex circumstances and with the greatest support needs are prioritized and developing a data-driven process for shifting away from providing funds on a first-come-first-served basis to providing funds based on individual circumstances as defined by common assessment tools while factoring in the criticality of the request. Based on the description DBHDS staff most recently provided, all individuals on the WWL would be	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		considered most at risk of institutionalization by virtue of their inclusion on the WWL.	
1.3 The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program.	The IFSP State Plan includes a goal to "create a comprehensive communication plan that establishes communication priorities and strategies to address the needs of communities and organizations," as well as four short term objectives for developing partnerships and resources to implement goal. Appendix B of the IFSP State Plan describes an ongoing and multi-faceted communication plan to ensure that all families receive information about the program. IFSP staff developed a Process Document that described a robust set of strategies to ensure that all families receive information about the	The IFSP State Plan includes a goal to "create a comprehensive communication plan that establishes communication priorities and strategies to address the needs of communities and organizations," as well as four short term objectives for developing partnerships and resources to implement the goal. In addition, Appendix B of the IFSP State Plan describes an ongoing and multi-faceted communication plan to ensure that all families receive information about the program. Consistent with the previous report, the current version of the communication plan (i.e., *IFSP Communications Plan FY 2022 Updated 1/4/22*) encompasses a large number of documents and communication activities, categorized by type (i.e., general information and referral, funding program, communications policies, MLMC, information to key stakeholders, state plan, and council recruitment.) For each document or activity, the plan cites the target audience, purpose and objective, timing and frequency and description and venue. The plan notes that it will be updated as needed. Overall DBHDS's written plan appears to have met the requirements of this Compliance Indicator. However, as described in the paragraphs below, DBHDS did not adequately implement its plan and did not actually "ensure that all families receive information about the program. As reported at the time of the 18th Period review, IFSP staff continued to use, and update, the *IFSP: First Steps* as the annual IFSP program brochure. First published in November 2020, *First Steps,* is intended to guide families through a basic overview of the IFSP program at DBHDS, Virginia's Developmental Disability (DD) system, and the resources that are available for people who are	Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
	program, but could not provide evidence to show they implemented all of these strategies in a consistent manner.	waiting for a DD Waiver Slot. *First Steps* also integrates several other documents and messaging needs, including the IFSP flyer; the Family Guide to Case Management Guidance; the Annual Notification for Individuals on the Waiver Waiting List; Navigating the Waiver Simplification; and My Life, My Community website updates. In September 2021, IFSP staff included the *First Steps* document, updated in September 2021, in the annual waitlist attestation mailing, as described further with regard to CI 1.5 below. As previously reported, for this 20th Period review, IFSP staff continued to use the annual waiver waitlist attestation process and an annual mailer campaign as the primary vehicles for ensuring that individuals and families on the waiver waitlist receive needed communications about their eligibility for the IFSP Funding Program, Family and Peer Mentoring supports, case management options and about the MLMC website. In the process of establishing this capacity, they had documented a detailed step-by-step methodology for ensuring that, to the extent possible, everyone on the waiver waitlist receives these notifications. The *Annual Mailer File Creation Requirements* details creates a set of system requirements (e.g., date to perform the data extract, format for the data extract, required data elements and data source, etc.) that describes all of the data elements that are needed to create a data set for all individuals who are active on the waiver waitlist. It also describes a set of queries that flag exceptions that require additional handling to ensure all waitlist members are contacted. For example, the logic generates a data file of wait list members who will require mailing of a hard copy instead of the usual email methodology, and/or direct contact by the responsible CSB. The methodology also includes follow-up processes for continuing to update the waitlist. DBHDS provided a Process Document entitled *Annual Notification of People on Waiver Waiting List*, dated 3/12/21, that commemorated these requirements. DBHDS also provided a Data Set Attestation	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		entitled *Data Set: WaMS Data Report* with a Process Name indicating it addresses the *Analysis of waiver waitlist and mailers.* It stated that the "data are contained within a WaMS Data Report, which is a MS Excel flat file that contains the row level data and a data worksheet. Tables are joined through the use of Power Query. The process looks for individuals on the waitlist and their contact information. Using the data, a mailing list is created through the use of query. If no email is provided, they are added to the mail list. The data also counts how many mailings are to be sent." As written, these documents appeared to describe a robust process that considered potential errors related to contact information and corrected for them. The written process also appeared to address the requirements, as they related to the IFSP piggybacking the WWL annual mailer process to disseminate information about the program. However, for this 20th Period review, the study found that DBHDS could not demonstrate it continued to implement the steps in the Process Document, which was necessary to maintain compliance with the requirement to ensure that all families receive information about the program: • First and foremost, for the WWL attestation process that took place in August through September, 2021 DBHDS staff could not demonstrate they followed the required process steps as described in the aforementioned Process Document or as referenced in the Data Set Attestation. For example, the Process Document requires the completion of several summary reports at various points in the process, as well as *Returned Mail Tracker*, and DBHDS staff are supposed to use to update the WWL. DBHDS could not provide most of these documents for review. • Second, During the 18th Period review, the IFSP Funding notification also took place as a part of the WWL annual mailers and therefore appeared to satisfy the requirement to share this	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		information with families and individuals eligible for the funding. For this 20th Period review, as described further below with regard to CI 1.10, for the September 2021 funding period, the Funding Notification (i.e., one of the critical pieces of program information) was not included with the annual WWL attestation. It went out as a separate electronic notification, but did not include a hard copy mailing to those without an email address. Of note, as further described with regard to CI.1.5 below, the WWL attestation mailing included hardcopy mailings to physical addresses for 6,329 people, so it is likely that many of those individuals did not receive the Funding Notification from DBHDS.	
1.4 The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including…	The IFSP State Plan includes a set of program outcomes, including for the topics identified in CI 1.5 through CI 1.8. DBHDS did not provide evidence that ODQV assisted IFSP staff to evaluate the measurability of the outcomes or the validity and reliability of the data. As described for previous reports, overall, many program outcomes remained unmeasurable because DBHDS had not yet developed a measurement methodology and/or had determined,	The *IFSP State Plan* included a set of program outcomes, for which DBHDS issued an annual report with regard to progress toward the specified program outcomes. However, several of the outcomes are not measurable and DBHDS staff determined that some of the program outcomes, and that some of the current measures are not valid and/or reliable. The *IFSP State Plan Update,* dated 2/15/22 provided a summary update, for the period from 7/1/20 through 6/30/21, on the program indicators and outcomes adopted by the IFSP State Council in June 2020. Overall, DBHDS staff reported their review the program outcomes for validity (i.e., whether they actually measured what they purported to measure) as well as for a reliable data collection methodology determined that the current measures were not valid and/or reliable, and would need to be revised. The *IFSP State Plan Update* further indicated that in partnership with the State Council, IFSP would provide annual update addenda to the State Plan to reflect changing program priorities and needs when and if needed. As described for previous reports, overall, many program outcomes remained unmeasurable because DBHDS had not yet developed a measurement methodology. Examples of outcomes that are not measurable are provided below in the analysis for Compliance	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
	upon review, that the measures were not valid/required revisions.	Indicators 1.05 and 1.07. As a result, overall, DBHDS could not demonstrate that the Commonwealth met the requirements of this Compliance Indicator. At the time of the 18th Period review, this study found that for the number of individuals on the waiver waitlist who are provided with outreach materials each year, it appeared DBHDS continued to provide sufficient evidence that it had taken necessary steps to produce reliable and valid data.	
1.5 The number of individuals on the waiver waitlist who are provided with outreach materials each year.	The *IFSP State Plan Update*, dated 2/15/22, provided data reports for the number of individuals on the waiver waitlist who are provided with outreach materials each year. DBHDS staff provided a clear measurement methodology, including a Process Document and a Data Set attestation.	The *IFSP State Plan* set a target outcome that 80% of individuals on the waiver waitlist and have a Priority One designation would be outreached for IFSP assistance. In the *IFSP State Plan Update,* staff reported they achieved this outcome August 2019 by sending out the annual electronic and postal notification for all individuals on the DD waiver waitlist (i.e., regardless of Priority One designation). For this measure, as described above for CI 1.3, DBHDS staff had previously developed a detailed and robust methodology for ensuring that all individuals on the waiver waitlist received outreach materials. Based on review of those procedures, it appeared that, if followed as written, IFSP staff would be able to reliably determine the number of individuals for whom it provided outreach materials each year. A document entitled *IFSP Annual Notification for Individuals on WWL: FY 2022 Update and Quantity Details*, dated 2/14/22 described dissemination outcomes as follows: • DBHDS provided promotional materials electronically to all individuals on the Waiver Waiting List with a valid email address in either the WaMS database (WaMS), or from a past IFSP-Funding application request. Emails were sent to 7,727 individuals on the Waiver Waiting List. • In the case that IFSP did not identify an email address in WaMS, IFSP mailed hardcopies of the materials to physical addresses as provided in WaMS. On September 29, 2021, promotional materials were sent via postal mail to 6,329 people with physical addresses as of August 28, 2021.	Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		• IFSP sent the electronic version of the Annual Notification message via Constant Contact on September 10, 2021. It was sent to the Funding announcement mailing list for families, the mailing list of people on the FY 22 Waiver Waiting List, and to the Provider mailing list, at a total of 21,058 email addresses. As described above with regard to CI 1.3, for this 20th Period review, the study found DBHDS could not demonstrate it implemented all of the steps described in the Process Document intended to ensure that all individuals on the WWL received outreach materials, but it did appear that IFSP staff could reliably report the number who were contacted, if not a number of those who did not receive notification. A related outcome target called for 90% of people on the DD waiver waitlist to indicate awareness of IFSP supports. However, the annual *IFSP State Plan Update* indicated they did not yet have a data collection tool or methodology to assess this outcome measure (i.e., to measure effectiveness of the outreach activities.)	
1.6 Participant satisfaction with the IFSP funding program	According to the *IFSP State Plan Update*, dated 2/15/22, following the most recent funding period's privacy breach, DBHDS did not conduct an Annual Satisfaction Survey and therefore did not have data as required for this CI.	With regard to measurability, the *IFSP State Plan* set one outcome target for participant satisfaction that called for 80% of people who completed an IFSP satisfaction survey to indicate high satisfaction with funding, as well as another outcome target for a 20% response rate with over 85% of respondents indicating satisfaction with the funding program. In the past, DBHDS collected data for these measures through issuance of an annual satisfaction survey for the IFSP funding program, for which IFSP staff had documented a methodology. However, for this 20th Review Period, per the *IFSP State Plan Update Prepared: February 15, 2022*, because no funds were distributed in FY 2021, IFSP could not conduct the Annual Satisfaction Survey. Instead, a Survey of Needs was developed and distributed as part of the FY22 Annual Notification Message to People on the Waiver Wait List to the entire population of individuals on the WWL. However,	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		because only 147 respondents completed the survey, IFSP recognized that the results were of limited utility as a meaningful representation of people on the WWL. In addition, as reported during the 16th and 18th Period Reviews, the overall approach to measuring satisfaction had not been adequate. As previously recommended, as DBHDS staff continue to examine how to measure participant satisfaction in the future, they should ensure they address these issues: • The survey only measured the satisfaction of those who were awarded funding (i.e., were successful in getting their applications in before the funds were exhausted.) In other words, this would provide an inadequate picture of the satisfaction of all participants, including those whose applications were not approved. Instead, the survey focused only on those who would be highly likely to report satisfaction with the process and the IFSP Funding Program as a whole. Measuring the satisfaction of this latter group as a subset might provide some valuable data with regard to how the receipt of funding impacted individual outcomes. However, for purposes of program improvement, it would also be essential to survey those whose applications were not approved to identify and understand the problems or challenges those applicants experienced. • Given that the survey was the only avenue for measuring participant satisfaction, it had other limitations in addition to its previously described limited scope (i.e., measuring only the satisfaction of successful applicants.) For example, as the methodology described, the survey was voluntary and therefore the respondents self-selected. This also potentially limited the utility of the data.	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
1.7 Knowledge of the family and peer mentoring support program.	IFSP staff reported they did not yet have a valid and reliable methodology to collect data for knowledge of the family and peer mentoring support programs. Therefore, DBHDS did not have data to report as required by this CI.	The *IFSP State Plan* included outcome targets for this measure that read "In each region, at least 30% of Satisfaction Survey respondents have visited either Facebook, connected with SeniorNavigator, visited the DBHDS IFSP webpage, connected with VCU F2F Network, or attended a VCU F2F Network event," and "Of event attendees: at least 30% indicate having visited Facebook, SeniorNavigator, IFSP, or F2F Network." The *IFSP State Plan Update*, dated 2/15/22, did not provide any relevant data and DBHDS staff reported they did not yet have the ability to collect data for all of these requirements.	Not Met **Not Met**
1.8 Utilization of the My Life, My Community website:	DBHDS issued an annual report that included Appendix E: SeniorNavigator Quarterly Reporting. Appendix E provided four quarterly reports detailing the utilization of the My Life, My Community website. While the reported utilization data did not appear to address measurable outcomes identified in the I*FSP State Plan*, it did appear to meet the intent of this CI.	For utilization of the MLMC website, the *IFSP State Plan Update* included Appendix E: SeniorNavigator Quarterly Reporting. Appendix E provided four quarterly reports detailing the utilization of the My Life, My Community website, including data with regard to the number of sessions, users (both new and returning), page views and the number of calls to the call center, as further described below with regard to CI 17.1. These data provided an overview of utilization, but did not address any of the related measurable outcomes in the *IFSP State Plan.* The relevant short-term goal appeared to be "Explore building an interactive web-based portal for families and individuals with information on existing local/regional/state organizations/agency resources." However, based on review of the *IFSP State Plan* the outcomes that accompanied the goal included the following: 1) in each region, at least 30% of Satisfaction Survey respondents have visited either Facebook, connected with SeniorNavigator, visited the DBHDS IFSP webpage, connected with VCU F2F Network, or attended a VCU F2F Network event, 2) of event attendees: at least 30% indicate having visited Facebook, SeniorNavigator, IFSP, or F2F Network and 3) at least 50% of F2F Network Satisfaction Survey respondents indicate Center for Family Involvement F2F Network	Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		information is helpful. The data reports provided in its Appendix E did not address these outcomes. While it appeared the data reporting on MLMC utilization substantially met the intent of this CI, as previously recommended, IFSP staff should further consider the targeted outcomes it wishes to achieve with regard to utilization and develop appropriate measurement methodologies.	
1.9 Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter.	DBHDS informs individuals of their eligibility for IFSP funding upon being placed on the waiver waitlist and annually thereafter. DBHDS had updated *Chapter IV Covered Services and Limitations* in the *Developmental Disabilities Waivers (BI,FIS,CL)Services Manual* to clarify eligibility for WWL case management, but had not yet informed individuals with regard to this information or updated related documents.	**Eligibility for IFSP Funding:** As described above with regard to CI 1.3, DBHDS had implemented an annual waiver waitlist eligibility attestation process in which every individual on the waitlist received a letter on an annual basis. For this Review Period, the annual notification occurred during the period of August 2021 through September 2021. The annual waiver waitlist eligibility attestation packet included an insert that described various supports for which individuals on the waiting list might be eligible. This included a notification that individuals might be able to access financial assistance through the IFSP and provided a link to obtain further information. Since the previous review, DBHDS had added a new improvement to the IFSP Funding process. The new function checked applicants' eligibility against Waiver Waiting List data and instantly let applicants and responsible parties know if they were eligible for IFSP Funding. After successfully meeting the eligibility criteria, eligible applicants would re-directed to the remaining application sections to ask about need. If applicants felt that the system had incorrectly identified the applicant as ineligible, the Portal provided instructions for additional steps they could take to confirm. **Eligibility for case management:** DBHDS indicated it informs individuals of their eligibility for case management upon being placed on the waiver waitlist and annually thereafter as a part of the annual	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		waiver waitlist eligibility attestation process. Previous studies have found that DBHDS protocols did not provide clear guidance with regard to individuals' eligibility to receive case management (or support coordination, as it is also known) while on the waiver waitlist. Various regulatory and guidance documents (e.g., the 2016 Medicaid State Plan Amendment for targeted case management and Virginia administrative code, *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019*, *Development Disabilities Support Coordination Manual*, etc.) indicated that individuals with developmental disabilities "may" receive time-limited case management when a "special service need" existed. However, none of the documents provided any criteria for what could constitute a "special service need." The language continued to be vague and open to various interpretations from one CSB to another; indeed, from one case manager to another. For example, many individuals on the waitlist might be expected to have needs that required linkage to supports and services to address an individual's mental health, behavioral, or medical needs, so it was not clear what might make such a need "special." The language was also somewhat circular in nature with regard to that determination, indicating that, on the one hand, the "special service need" is one that is identified in an ISP, but on the other, that the case management agency would develop an ISP if a "special service need" was identified. For this review, DBHDS had made some progress in this area. Final language included in *Chapter IV Covered Services and Limitations* in the *Developmental Disabilities Waivers (BI,FIS,CL)Services Manual*, with an effective date of 2/15/22, described the following: *"Individuals are eligible for DD support coordination if they are Medicaid eligible, have a developmental disability as defined in § 37.2-100 of the Code of Virginia below and are enrolled in one of the DD waivers or are on*	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		the DD waiver waiting list and have a "special service need." *"If a special service need is identified for an individual on the DD waiver waiting list, an ISP must be developed to address that need. A special service need is one that requires linkage to and temporary monitoring of those supports and services identified in the ISP to address an individual's mental health, behavioral, and medical needs or provide assistance related to an acute need that coincides with support coordination allowable activities (see below). Support coordinators must make face-to-face contact with the individual at least every 90 calendar days to monitor the special service need, and documentation is required to support such contact. If an activity related to the special service need is provided in a given month, then the support coordinator would be eligible for reimbursement. Once the special service need is addressed related to the specific activity identified, billing for the service may not continue until a special service need presents again."* *"Examples of special service needs for people with DD who are waiting for waiver services could include:* • *A child with autism on the waiting list needs to access behavioral services;* • *An adult experiences the loss of a family caregiver and needs to look for alternate housing;* • *Following a stroke an adult needs to locate specialized medical services to transition back to their home;* • *A family member reports a child on the waiting list has experienced changes in his health, status and needs to explore options to avoid placement in an institutional setting;* • *A young person is transitioning out of school and needs to access vocational rehabilitation or employment services;* • *A young woman who has limited contact with family begins experiencing seizures and needs to support to locate a neurologist;* • *New neighbors move into a person's neighborhood resulting in escalating conflict between the person with DD and the*	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		neighbors." DBHDS still needed to update various materials to ensure that individuals and families are informed of these options, as described below: • DBHDS had not updated the current *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Seventh Edition Updated July 2021* or the web-based *Development Disabilities Support Coordination Manual* to reflect the information in *Chapter IV Covered Services and Limitations* in the *Developmental Disabilities Waivers (BI,FIS,CL)Services Manual.* • At the time of the previous review, DBHDS submitted a document entitled *Support Coordination: Questions and Answers for People with DD and their Families,* dated 6.3.20, but it had not yet been updated and was still posted on the MLMC website. • Per the minutes of the IFSP Communications Advisory Group, dated 12/17/21, a finalized version of a *Family Guide to Case Management* was expected to be upcoming. However, based on interview with the DBHDS Director of Provider Development, this was in error. Instead, DBHDS was planning to publish a guide to ISP planning for individuals and families. This remained in outline form at the time of this 20th Period. Upon review of the outline, it referenced the *IFSP First Steps* as the resource for describing the role of support coordinators. However, the current version of that document did not include the expectations described in *Chapter IV Covered Services and Limitations* in the *Developmental Disabilities Waivers (BI,FIS,CL)Services Manual.* Instead, it referred individuals and families to the CSBs for assessment. Going forward, it will be important to ensure that individuals and families have access to first-hand knowledge with regard to their potential eligibility for case management services.	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		Of note, it was very positive that DBHDS staff had begun to collect and review relevant data about the number of individuals on the waitlist who were receiving case management.	
1.10 IFSP funding availability announcements are provided to individuals on the waiver waitlist.	For the funding period that opened in September 2021, the full Funding Notification was not included with the annual WWL notification, as in previous periods. Instead, it was a separate notification that was only completed electronically to individuals with email addresses, with no hard copy mailings. As described with regard to CI 1.5 above, data for the WWL attestation mailing indicated hardcopy mailings to physical addresses were needed for 6,329 people, so it is likely those individuals did not receive the Funding Notification from DBHDS. As a result, DBHDS could not demonstrate that they	For the 16th and 18th Review Periods, IFSP staff had implemented an initiative to ensure that every individual on the waitlist would receive a timely notification about the upcoming IFSP funding period, either by email or by postal service. IFSP staff provided a document describing the steps they had taken to achieve this goal, which also included sending funding period announcements out through various listservs. This was a robust and thorough process. The notification also provided information about some other services for which individuals and families of the waitlist might be eligible, such as IFSP Regional Councils, CSBs, the VCU Family-to-Family program. The previous study recommended that, for purposes of identifying the basis for programmatic authority and continuity, DBHDS staff needed to develop a formal expectation (e.g., a policy, procedure, departmental instruction, etc.) that, going forward, all individuals on the waitlist will receive direct timely notifications from DBHDS of upcoming funding periods. For this review, as described above, DBHDS had developed DI 113 (TX) 20 with regard to the IFSP. While the DI defined the IFSP Funding Program (i.e., subject to the availability of funds, the IFSP Funding available in accordance with 12 VAC 35-230 assists individuals on Virginia's DD Waiting List), it provided little guidance with regard to these expectations. DBHDS might consider expanding on the level of detail in the DI. As described above with regard to Compliance Indicators 1.3 and 1.5, IFSP staff had developed a detailed and robust methodology for providing IFSP funding availability announcements to individuals on	Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
	provided Funding Notification to individuals who did not have email addresses.	the waiver waitlist. The Process Document entitled *Annual Notification of People on Waiver Waiting List,* dated 3/12/21, formalized these requirements. In addition, DBHDS completed a related Data Set Attestation for the WaMS data set used for this process. It appeared the Process Document addressed any known potential deficiencies in the data source system. However, for the funding period that opened in September 2021, the full Funding Notification was not included with the annual WWL notification. Instead, it was released electronically shortly after the electronic annual WWL notification message went out, on 9/7/21, with a follow-up email on the day the Funding Portal opened on 9/14/21. DBHDS did not provide requested documentation to show they followed the same protocols established in the Process Document for the WWL annual notification. For example, DBHDS staff reported they did not mail any hard copy Funding Notifications, as had been the practice in the past. As a result, DBHDS could not demonstrate that they provided Funding Notification to individuals who did not have email addresses. As described with regard to CI 1.5 above, data for the WWL attestation mailing showed hardcopy mailings to physical addresses were required for 6,329 people, so it is likely those individuals did not receive the Funding Notification from DBHDS.	
1.11 Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website	The MLMC website was operational and DBHDS had posted to it various eligibility guidelines for IFSP resources and other supports and services. However, the information provided with regard to eligibility criteria ("most at risk") and case	The MLMC website continued to be operational and DBHDS had posted to it various eligibility guidelines for IFSP resources and other supports and services. In that regard, DBHDS had an effective mechanism for posting eligibility guidelines for IFSP resources and other supports and services for easy access on the internet. However, information provided with regard to eligibility criteria ("most at risk") and case management criteria ("special service need") continued to be incomplete and was pending final resolution. This is described in more detail with regard to CI 1.2 and CI 1.5 above.	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
	management criteria ("special service need") was incomplete, pending final resolution, and not published on the website	Consistent with previous findings, the following provides examples of key documents and information found on the MLMC website in March-April 2022, which highlight some continuing issues with regard to their adequacy and utility. These concerns are also discussed elsewhere throughout this report: • The *Individual and Family Support Program Guidelines and FAQs, updated 9/14/21* continued to be thorough and clearly written, and served as a valuable resource for individual and families seeking funding assistance through the IFSP. However, they did not yet provide a clear description of how the program would serve those who were "most at risk for institutionalization," as described with regard to CI 1.2 • The *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Seventh Edition, Updated July 2021* also continued be a valuable resource, but still required updating to reflect a clear and consistent description of case management options for individuals on the waitlist. • As previously reported at the time of the 18th Period Review, to provide information on case management options for individuals on the DD waitlist, the MLMC website had posted the *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist*, dated 4/22/20, and the *Support Coordination: Questions and Answers for People with DD and their Families*, dated 6.3.20. However, as described above, the documents did not provide clear guidelines for individuals and families with regard to the types of needs that would be considered as a "special service need" or describe the expectations for CSBs to apply those consistently. As of this review, and as described with regard to CI 1.9, while it was positive that DBHDS had clarified these guidelines and published them in *Chapter IV Covered Services and Limitations in the Developmental Disabilities Waivers (BI,FIS,CL)Services Manual* on 2/15/22, the documents on the MLMC website had not	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		yet been updated to reflect this information.	
1.12 Documentation continues to indicate that a minimum of 1,000 individuals and/or their families are supported through IFSP funding.	In October 2021, after a data breach required the shut-down of the IFSP Funding Portal, DBHDS staff reported they chose to approve all of the IFSP application drafts that were saved as of 10/4/21, with each applicant being awarded $1,000. This utilized funds from both FY 2020 and FY 2021. In all, DBHDS awarded $4,036,000 during this most recent funding period.	DBHDS continued annual distribution of IFSP funding to eligible individuals and families, although for this review, as described above with regard to CI 1.1, the funding processes were complicated by the failure of the IFSP Funding Portal. When the Funding Portal opened in September 2021 (i.e., during FY22) for a "Save a Draft" period leading up to the opening of the application period, the IFSP program received over 4,000 requests for assistance. Following the shut-down of the Portal when the data breach occurred, and given the large number of applications saved, DBHDS staff reported they chose to approve all of the IFSP application drafts that were saved as of October 4, 2021, with each applicant being awarded $1,000. This utilized funds from both FY 2021 and FY 2022. In all, DBHDS awarded $4,036,000 during this most recent funding period.	Met **Met**

20th Review Period
Findings

III.C.8.b. The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.

Compliance Indicator	**Facts**	**Analysis**	**Conclusion** 18th Period **20th Period**
17.1 DBHDS has developed and launched the "My Life, My Community" website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. This will be documented by reports of activity on the website.	As of August 2019, DBHDS launched the "My Life, My Community" (MLMC) website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. The MLMC website continued to be operational since that time. *(*https://www.mylifemycommunityvirginia.org*;)* The MLMC website published various forms of information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. The operational contractor (i.e., Senior Navigator) provided quarterly reports of activity on the website.	In August 2019, DBHDS and its contractor, Senior Navigator, formally launched the MLMC website. The MLMC website has continued to be operational since that time. The MLMC website continued to publish various forms of information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. In addition to DBHDS guidance documents (i.e., *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Seventh Edition, Updated July 2021; Individual and Family Support Program Guidelines and FAQs, updated 9/14/21; First Steps, Beyond IFSP-Funding, Revised December 2021* etc.*),* the website features links to other service and advocacy organizations and has a searchable database of local services. It also has key pages devoted to the IFSP, providing information about the work of the Councils as well serving as a hub for the Funding Program. MLMC staff continued to operate a call center to serve individuals and families who might need additional assistance. Senior Navigator continued to make regular quarterly reports to DBHDS about activity on the website including, but not limited to, data for the number of sessions, number of users, number of pageviews, number of returning and new visitors and average duration users spend on the site. In addition, they reported on the volume of calls to their call center seeking technical assistance or	Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		additional information and included data about frequently asked questions and topics. Finally, the reports provided narrative updates about new materials and functionalities added since the previous report. Data for the last two quarters of FY21 and the first two quarters of FY22 indicated that both the number of website users and the number of callers varied considerably and appeared to be much higher during IFSP funding periods. With regard to the data reports, DBHDS created a Process Document entitled *My Life, My Community Website Analytics Quarterly Report,* dated 3/12/21, but did not provide a companion Data Set Attestation. However, it did not appear this CI required this level of documentation in order to show compliance.	
17.2 Documentation indicates that the My Life, My Community website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families.	In August, 2021, DBHDS distributed materials that included information about the MLMC website to the Provider Listserv. DBHDS also mailed a total of 1,160 "First Steps" documents, including MLMC information, to 58 medical professionals 42 local EI lead agencies, and 16 pediatric offices in DBHDS's Eastern, Southwest, and Central service regions.	Overall, for this purpose, IFSP staff relied upon the IFSP Communication Plan, described above with regard to CI 1.3. As previously reported, to support the implementation of the Communication Plan, IFSP staff had developed a detailed methodology for collecting, managing and using contact data to facilitate dissemination of various types of information that would be useful to individuals, families, providers and other stakeholders. In addition to communicating with individuals on the waitlist and their families, IFSP staff made use of the existing Provider Listserv (i.e., that DBHDS maintains for the purpose of updating providers and stakeholders on policy changes, trainings, meetings, and other important information) to communicate the same types of information to provider organizations. As described above with regard to CI 1.9, via the Constant Contact database and as a part of the annual waitlist attestation process, IFSP staff sent an email message to the Provider Listserv, including a Flyer created by IFSP staff, and information about IFSP Funding, family-to-family and peer mentoring supports, case management information and information about how to access MLMC.	Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		In November, 2021, IFSP also mailed a total of 1,160 "First Steps" documents to 58 medical professionals via postal mail. These contacts and mailing addresses were those identified at 42 local EI lead agencies, and the 16 pediatric offices in DBHDS's Eastern, Southwest, and Central service regions. DBHDS reported that each contact received one cover letter and 20 *First Steps* documents for immediate distribution to clients and families. As reported previously, going forward IFSP staff might also want to develop an initiative an awareness and marketing initiative directed toward schools. In interviews for both the 18th and 20th Period reviews, IFSP State Council members frequently mentioned raising awareness in schools as an area that needed focus.	

20th Review Period
Findings

III.D.5 Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.

(IV.B.9.b: PSTs and the CSB case manager shall coordinate with the specific type of community providers identified in the discharge plan as providing appropriate community- based services for the individual, to provide individuals, their families, and, where applicable, their Authorized Representative with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family- to-family and peer programs to facilitate these opportunities.)

Compliance Indicator	**Facts**	**Analysis**	**Conclusion** 18th Period **20th Period**
19.01 At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources.	The annual waiver waitlist attestation packet provides information on accessing Family-to-Family and Peer Mentoring resources to individuals on the waiver waitlist. The process, as described in the Process Document entitled *Annual Notification of People on Waiver Waiting List*, dated 3/12/21, is sufficiently robust, as written, to ensure that at least 86% of individuals on the waitlist at the time of the annual attestation process receive the information.	DBHDS uses notifications provided as a part of the annual waiver waitlist attestation process to inform individuals on the waitlist about Family-to-Family and Peer Mentoring resources. For this review, DBHDS staff provided for review a copy of the *Annual Notification Message for People on Virginia's DD Waiver Waiting List*, dated September 2021, which included links to the VCU-CFI Family to Family (F2F) Program and to the Arc of Virginia's Peer Mentoring Program. As described above with regard to Compliance Indicator 1.3, the attestation process, as described in the Process Document entitled *Annual Notification of People on Waiver Waiting List*, dated 3/12/21, appeared to be sufficiently robust to ensure that at least 86% of individuals on the waiver waitlist have received this information. This was consistent with the findings of the 18th Period review. However, as also described above, for this 20th Period review, DBHDS staff could not provide documentation to evidence that they followed all the steps of the process. However, based on the number of mailings and notifications completed and	Met **Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
	For this 20th Period review, DBHDS staff could not provide documentation to evidence that they followed all the steps of the process. However, based on the number of mailings and notifications completed and as described with regard to CI 1.5 above (i.e., more than 27,000) , it appeared this was sufficient to show contact with at least 86% of the individuals on the WWL.	as described with regard to CI 1.5 above (i.e., more than 27,000) , it appeared this was sufficient to show contact with at least 86% of the individuals on the WWL. Going forward, however, DBHDS should maintain the documentation as defined in the relevant Process Document.	
19.02 The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested.	DBHDS Guidance for the Virginia Informed Choice Form indicates when it must be completed, including upon enrollment in a Developmental Disability waiver. The guidance also indicates the form must be completed annually but does not stipulate that the form must be completed as a part of the annual ISP process. The form includes references and contact information for both the Family-to-Family Program and Peer Mentoring resources.	As reported previously, the guidance for the Virginia Informed Choice Form indicated when it must be completed, including upon enrollment in a Developmental Disability waiver. The guidance also indicates the form must be completed annually, but does not stipulate that the form must be completed as a part of the annual ISP process. As reported at the time of the previous report, the Virginia Informed Choice Form includes a section for the Support Coordinator to check whether or not he or she provided the individual opportunities to speak with other individuals receiving waiver services who live and work successfully in the community. In another section, the form also included references to and contact information for both the VCU CFI Family-to-Family network and the Virginia Arc Peer Mentoring program. However, it was not clear that, by signing the Informed Choice Form, individuals were acknowledging that they had received an adequate explanation of the purpose of the resources (i.e., as that related to the requirements of this provision), nor did DBHDS have in place an established referral process for connecting individuals or families with the desired supports.	Not Met

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
	For this review, for both the Family-to-Family and Peer Mentoring programs, DBHDS staff reported they had not yet completed a referral process or a data collection methodology specific to the intent of these provisions (i.e., to facilitate opportunities for individuals considering a sponsored home or any congregate setting to have conversations and meetings with individuals currently living in the community and their families regarding options for community placements, services, and supports before being asked to make choices), or to the requirements of this CI (i.e., so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested).	The previous two IFSP reports (i.e., the 16th and 18th Period reviews) recommended that DBHDS provide a clear protocol for the use of the Informed Choice Form, including explicit expectations that Support Coordinators will inform individuals of the various resources. For this review, DBHDS staff had not made all the needed revisions to the accompanying instructions or otherwise developed policies, procedures or protocols needed to facilitate and ensure that referrals were being made, as they relate to the specific requirements of this provision and the related Compliance Indicators. At the time of the 18th Period review, in interview, the DBHDS Director of Provider Development indicated he could draft additional language to further clarify the expectations, and subsequently shared it for review. The draft language read, *"The Support Coordinator also reviews and offers to link the individual and/or substitute decision-maker (SDM) with VCU's Center for Family Involvement if they would like to talk with others who have waiver services and The Arc of Virginia if they have questions related to Peer Mentoring. Some individuals and/or the SDM may choose to make the contacts themselves, if so, the SC would ensure that the contact information is provided. The Support Coordinator documents these linkages in a progress note or other location in the person's record. Making and encouraging these linkages connects families with others who have lived experience and supports informed decisions."* This still appeared to require additional fleshing out to effectuate the likelihood that referrals would occur. In other words, it seemed that while Support Coordinators did need to be instructed with regard to the requirement to offer the opportunities, DBHDS also needed to provide clear expectations with regard to the specific referral process to follow. Based on the documentation submitted previously , VCU-CFI protocols include a referral form (i.e., *Family-to-Family Network Referral Form 2021*) that DBHDS staff could incorporate into a clear referral process. DBHDS also needed to craft the referral process to ensure that data specific to the purposes of this provision and related Compliance Indicators could occur.	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		DBHDS should construct a similar referral process and data collection methodology for the Peer Mentoring program at the Virginia Arc. For this review, for both the Family-to-Family and Peer Mentoring programs, DBHDS staff reported they had not yet completed a referral process or a data collection methodology specific to the intent of these provisions (i.e., to facilitate opportunities for individuals considering a sponsored home or any congregate setting to have conversations and meetings with individuals currently living in the community and their families regarding options for community placements, services, and supports before being asked to make choices), or to the requirements of this CI (i.e., so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested).	
19.03 The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to-family and the peer-to-peer supports have contact and the number who receive the service.	VCU-CFI and the Arc of Virginia, respectively, provide some data for individuals receiving family-to-family and peer mentoring supports, but do not provide data that adequately show outcomes (or the purpose) of the contacts, as they relate to this provision. Reporting does not include specific data with regard to family-to-family and peer-to-peer supports, as that relates to this provision.	As reported at the time of the 18th Period Review, in the absence of an established referral process, current procedures do not allow DBHDS to track outcomes related to the Settlement Agreement provision requiring that DBHDS facilitate conversations and meetings with individuals currently living in the community and their families. As described above, DBHDS needed to further develop referral processes to facilitate this purpose. Of note, DBHDS has established a referral and data tracking process with VCU-CFI for families with children living in an ICF or a nursing facility and modified the existing MOA to include those expectations, which could serve as a model for this purpose. At the time of the 18th Period Review, the Independent Reviewer recommended that, for purposes of tracking and reporting on outcomes with respect to the number of individuals with whom family-to-family and the peer-to-peer supports have contact, DBHDS should ensure that, in the event a family or individual chooses to make the contact with the Family-to-Family or Peer Mentoring resources directly, the organizations' intake processes include a specific question or set of questions to try to capture whether the contact is related to the specific purposes that are required by this provision and its associated Compliance Indicators. Once DBHDS staff can establish and confirm consistent application of the expectations,	Not Met **Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		this would presumably allow them to reliably use the aggregate data from the intake forms to show that this indicator has been achieved. For this review, DBHDS did not provide evidence to show it had developed or otherwise addressed a capacity to track and report these data. However, both the DBHDS Director of Provider Development and the Director of VCU-CFI indicated they were willing to work on such an effort. DBHDS should ensure to undertake a similar collaborative effort with the Arc of Virginia with regard to the Peer Mentoring program.	

Recommendations

1. With regard to the definition of "most at risk for institutionalization," DBHDS needed to re-enga stakeholders to consider alternative prioritization criteria following their determination that the previously publicly-vetted criteria could not be implemented.

2. With regard to required annual notifications of IFSP eligibility and IFSP Funding Periods, DBHD staff should adhere to the full protocol described in the associated Process Document for the annua WWL attestation or, if they decide to no longer utilize the attestation process for such notifications they should develop an applicable Process Document and obtain an attestation of data validity and reliability.

3. With regard to the requirement that individuals are informed of their eligibility for case managem upon being placed on the waiver waitlist and annually thereafter, DBHDS still needed to issue the following:
   - Updated and expanded Guidelines for individuals on the waitlist and families regarding case management options and how to apply for them.
   - Appropriate revisions *to Navigating the Developmental Disability Waivers, Seventh Edition: A Guide for Individuals, Families and Support Partners*, *First Steps* and the *Development Disabilities Support Coordinati Manual.*
   - A DBHDS Performance Contract revision defining "DD or ID active support coordination/c management service criteria" and "special service need" and any associated protocol to be use by CSBs, both for making determinations of eligibility and for terminating services.

4. IFSP staff should request technical assistance from DQV to ensure the measurability of the progra outcome measures and develop methodologies for collection of reliable and valid data, as well as t consider additional methodologies for defining and measuring participant satisfaction with the IFS Funding Program.

5. As reported previously, going forward, DBHDS should consider additional program outcome measures to assess impact on risk of institutionalization, the comprehensiveness of the IFSP, as it reflects the expressed needs of those it is designed to serve, and the degree and adequacy of coordination, both on a systemic and individual basis. This should include a measure to assess the consistency of the implementation of waitlist case management across CSBs. DBHDS will also nee to consider how it will integrate key IFSP measures into its overall departmental Quality Improvement/Risk Management Framework.

6. DBHDS should provide clear expectations with regard to the specific referral process to follow for Family-to-Family and Peer Mentoring programs. The referral processes should also ensure that d specific to the purposes of this provision and related Compliance Indicators can occur.

Attachment A: Interviews

1. Heather Norton, Assistant Commissioner at Department of Behavioral Health and Developmental Services
2. Beverly Rollins, Director of DBHDS Administrative and Community Operations
3. Stephanie Mote, DBHDS IFSP Community Coordinator
4. Jenni Schodt, DBHDS Settlement Agreement Coordinator
5. Eric Williams, DBHDS Director of Provider Development
6. Dana Yarbrough, Director, Center for Family Involvement, Virginia Commonwealth University Partnership for People with Disabilities
7. Jennifer Rockwell, IFSP State Council Member
8. Jan Rychtar, IFSP Council Member
9. Jonothan Meador, IFSP Council Member
10. Stephanie Thull, IFSP State Council Member
11. Angela Lello, IFSP Council Member

APPENDIX E

Community Living Options

by

Ric Zaharia Ph.D.

Consortium on Innovative Practices

TO: Donald Fletcher

FROM: Ric Zaharia

RE: Community Living Options – 20th Review Period

DATE: May 10, 2022

Introduction

This report constitutes the third review of the compliance indicators for the Community Living Options (Integrated Settings) Section III.D.1. In the Independent Reviewer's 18th Report to the Court, the Commonwealth provided documentation for twenty-three (23) compliance indicators (18.01-18.23). This documentation showed achievement of twelve (12) indicators (52%). Note that two (2) of these indicators were considered Met for illustrative purposes only. Eleven (11) compliance indicators (48%) were not yet achieved and focused on increases in integrated settings, on the outcomes of a work group focused on barriers to increasing integrated settings, on improvements in the delivery of nursing services, and on CSB follow through. DBHDS reported that the pandemic environment had negatively impacted the availability of its providers and the percentage of people being served in the most integrated settings. For example, the number of authorizations for Community Engagement and Community Coaching had declined, but the Commonwealth expected that suspended or cancelled authorizations for these services will return as pandemic restraints are eased.

The 18th Period review did not include an independent verification of the data reported by the Commonwealth. In addition, the Commonwealth did not provide documentation of the assessments or the required ODQV determinations that the data sources provide reliable and valid data for compliance reporting.

For this review, the 20th Report, the facts gathered are identified at each indicator in the Findings Table below. The documents which include these facts are listed by reference in Attachment A and most can be located in the Commonwealth's Box library. Clarifying interviews were conducted with DBHDS officials (see Attachment B), including those who DBHDS identified as being most familiar with the Commonwealth's progress toward achieving the compliance indicators associated with Section III.D.1.

Summary of Findings for 20th Review Period

This review found that seventeen (17) of twenty-three (23) indicators (74%) had been achieved or had been sustained through continuing effort.

The Provider Data Summary shows provider network development continued to be relatively flat during FY21, the heart of the pandemic. This may be a positive in light of a national contraction in the availability of HCBS providers in most states during the pandemic (see #34). Integrated services development, where it has occurred, may be following the clientele, i.e., substantial growth in number of new people served attracts providers to offer the newer, more integrated services. There continues to be significant variability statewide, the most recent available data again showed that 2/3s of counties/cities match or exceed the statewide average of 86.7% (as of 3.31.21) living in integrated settings. However, five (5) counties/cities still have 50% or less of the individuals served in integrated settings.

Regarding the tracking of individuals who request integrated settings and receive those services within nine months, DBHDS tracked and reports that only two individuals who requested integrated services that were not immediately available in FY21 Q2; and that both were accommodated within 9 months. DBHDS reports that there have been no individuals who requested integrated services that were not available during FY21 Q3.

DBHDS reports that it has achieved the timeliness benchmark for receipt of some nursing services (i.e., 70% within 30 days) but that it has not achieved the nursing utilization benchmark (i.e., receipt of the number of hours identified in the ISP 80% of the time). DBHDS reports indicate that a substantial number of authorized nursing hours do not get delivered and that shortages of personnel are the root cause of most of the issues in nursing utilization. In addition, DBHDS reports that it has taken steps to address secondary causes of nurse utilization problems by:

- Rolling out an educational training in March on 'authorizations' to nursing agencies to improve their use of that process and reduce the number of authorized, but unused hours.
- Evaluating nurse retention programs in future review periods to identify any viable strategies to impact nurse turnover, e.g., OIH has begun providing free CEU units to its administrative region meetings.
- Collaborating with DMAS and other partners to develop new certification tracks for Certified Nursing Assistants (CNAs) pending legislative approval

For the Commonwealth's workgroup leading this initiative, the past year has been characterized by a change in leadership, it's initiation of direct consultation from The Every Child Texas program, the production of a statement of actionable strategies that emphasizes the principles of permanency planning for children with developmental disabilities and making Jump Start funding available for Sponsored Residential providers. Jump Start should have the most immediate impact in this and the next fiscal year, and the other strategies should be operationalized in future review periods.

Data process and attestation.
The process document for the Provider Data Summary (#29) was reviewed and is thorough. This semi-annual report is informed by the Residential Settings Report, WaMS, RST data, the Baseline Measurement Tool (BMT), and other reports. No potential threats were identified by DQV, except in the BMT; in response, additional calculation procedures were outlined by the Measurement Steward.

The process document for the RST (Regional Support Teams) reports (#30) was reviewed. The following facts indicate that the RST process is thorough. The RST reports are informed by the aggregation of manually completed Referrals. This manual entry is the major threat to data integrity identified by DQV, so the Measurement Steward intends to incorporate the referral form into WaMS, so that it will become an electronic entry..

Process documents for Nursing Utilization and Timeliness (#19, 20) were reviewed and are methodologically sound. The DBHDS verification of the reliability and validity of the data includes crosstabs of data conducted between the Medicaid paid claims system and WaMS authorization database and data pull precision is achieved through pro-rata authorizations, 12-month lag in data pulls, and templates for data analysis. DBHDS did not provide a signed Attestation form for Nursing Utilization and Timeliness data.

The DBHDS signed Data Set Attestations were provided and reviewed for: the Residential Settings Report (#16). Data integrity for these sets is verified by the Chief Information Officer, who identified no defects in the reports. However, no Process Control Document was provided for the Residential Settings Report.

Data Set Attestations were provided by DBHDS and reviewed for: the Children's ICF Data Sheet, and the Family Outreach Tracking Log-NF (#17). Data integrity for these sets is verified by the Chief Data Officer (CDO), who identified no defects in the reports. However, no Process Documents were provided. A properly completed Process Document is necessary for the CDO to attest to the reliability and validity of the data reported.

Data Set Attestations were provided by DBHDS and reviewed for the RST workbook (#18). Data integrity for these sets is verified by the Chief Data Officer, who recommended incorporation into WaMS, as an electronic entry versus a manual entry. However, no Process Documents were provided. A properly completed Process Document is necessary for the CDO to attest to the reliability and validity of the data reported.

Given its emerging role as the centerpiece of the electronic tracking system for case management, the absence of WaMS control documents and data attestations weakens its data integrity. DQV has identified several reliability and validity issues around the WaMS processes (#33).

Table 1 below recaps the documents provided and identifies those outstanding.

Table 1
Data Integrity Documents

CI	Process Control Document	Data Set Attestation
18.1-18.3	Provider Data Summary Process Res. Settings Report Process- none provided	Provider Data Summary- none provided Res. Settings Report Attestation
18.7	RST Process	RST Tracking Data Set Attestation
18.9	Nursing Auth Timeliness/Utilization Process	None provided
18.19	None provided	Children's ICF Data, Family Outreach Tracking Log- Data Set Attestation

Compliance Indicator Achievement.

The Table 2 below recaps the status of the compliance indicators this study reviewed.

Table 2
Community Living Options Findings

SA III.D.1 The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs…					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**18th**	**20th**
18.1	*DBHDS service authorization data will continue to demonstrate an increase in the percentage of the DD Waiver population being served in the most integrated settings as defined in the Integrated Residential Settings Report.*	Integrated Residential Settings Report updated to 9.30.21 shows that market share of authorizations for individuals being served in integrated residential has continued to grow as a percentage of all residential settings. See # 15. In the 18th Report, the number of individuals served in the most integrated settings had increased by 6.3% since the baseline was established in 2016 to 9/20 (9,425 / 11,871 to 12,617 / 14,719) (79.4 % to 85.7%) As of 9.30.21: the number of individuals living had increased to 13,458 out of 15,427 (87.2%) total	The absence of a Process Document that shows how threats to data reliability and validity in the data set that includes information from WaMS were addressed and resolved prevents a determination that this indicator is achieved without a qualification. The absence of an up-to-date PDS, undermines unqualified achievement of this indicator.	**M***	**M***

		individuals on the wavier were living in most integrated settings.) (see #13, 15) PDS Reports are based on multiple data sources (see #29), including the stand-alone Residential Settings report. The Process Control Document (#29) identifies WaMS enrollment counts as the data source for this indicator. However, the PDS Process Document does not show how the reliability and validity threats for the information from WaMS was addressed and resolved. Data Set Attestation forms (#16) were provided to establish data integrity for the Residential Settings report.			
18.2	*a. Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings*	Data shows a 1.5% increase between 9.30.20 and 9.30.21. This increase is more than the previous 12-month increase, but short of the 2% benchmark. PDS Reports are based on multiple data sources (see #29), including the stand-alone Residential Settings report. The PDS Process Control Document (#29) identifies WaMS enrollment counts as the data source for this indicator. However, the Process Document does not show how the reliability and validity threats for the information from WaMS was addressed and resolved. Data Set Attestation forms (#16) were provided to establish data integrity for the Residential Settings report.	The absence of a Process Document that shows how threats to data reliability and validity in the data set that includes information from WaMS were addressed and resolved prevents a determination that this indicator is achieved. The absence of an up-to-date PDS undermines achievement of this indicator. This indicator has not yet been achieved.	**NM**	**NM**
18.3	*b. Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "support needs level" of Levels*	The most recent available PDS (#21) shows 87% of all people new to the waiver in FY20 (including Levels 6 & 7) live in integrated settings.	The absence of a WaMS Process Control Document and Attestation weakens the data integrity of this indicator.	**NM**	**NM**

	6 and 7, since FY 2016 are receiving services in the most integrated setting.	Reanalysis of these figures for the cumulative period FY16 to FY20 is pending. PDS Reports are based on multiple data sources (see #29), including the stand-alone Residential Settings report. The PDS Process Control Document (#29) identifies WaMS enrollment counts as the data source for this indicator. Data Set Attestation forms (#16) were provided to establish data integrity for the Residential Settings report.	The absence of an up-to-date PDS and reanalysis of the figures for the cumulative period FY16 to FY20, undermines achievement of this indicator.		
18.4	*2. DBHDS continues to compile and distribute the Semi-annual Provider Data Summary …. The Data Summary indicates an increase in services available by locality over time.*	The most recent available PDS (#21) showed that 2/3s of counties/cities match or exceed the statewide average of 86.7% living in integrated settings (as of 3.31.21). Finer grained analysis using the DBHDS Baseline Measurement Tool (#27) on a sample of CSBs (rural: small-medium-large budget; urban: small - medium/large/very large) suggests increases in integrated services are partially tied to increases in people served. Finally, DBHDS reports (#21) that growth in integrated services/providers statewide has been a net of only one during the past year. PDS Reports are based on multiple data sources (see #29), including the stand-alone Residential Settings report.	Integrated services development may be following the clientele, e.g., over three years Fairfax Falls with a substantial growth of individuals served (+331) developed two new integrated services/providers compared to Horizon with modest growth (+40) developed no new services/provider during the same three years. Because some of the lack of substantial growth in integrated services/providers during FY21 may be attributed to the pandemic, growth statewide should return to higher levels in subsequent reviews. Therefore, this indicator is not yet fully achieved.	**NM**	**NM**
18.5	*3. DBHDS will establish a focus group with family members, individuals, and providers to identify potential barriers limiting the growth of sponsored residential, supported living, shared living,*	DBHDS established a focus group. However, the role of family member, individual and provider on the focus group was not provided**.**	The review was not able to verify that the required roles were properly fulfilled, therefore, this indicator has not yet been achieved.	**NM**	**NM**

	in-home supports, and respite for individuals with a "support needs level" of Level 6 or 7.				
18.6	*DBHDS will report on how many individuals who are medically and behaviorally complex (i.e., those with a "support needs level" of Level 6 or 7) are using the following DD Waiver services, by category: sponsored residential, supported living residential, shared living, in-home supports, and respite services. Using this data and the focus groups, DBHDS will prepare a plan to prioritize and address barriers within the scope of its authority and establish timelines for completion with demonstrated actions.*	The Plan resulting from the focus group was not provided.	This indicator has not yet been achieved.	**NM**	**NM**
18.7	*4. DBHDS tracks individuals seeking a service consistent with integrated living options as defined in the Integrated Residential Settings Report that is not available at the time of expressed interest as described in indicator # 13 of III.D.6. 86% of people with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option …have access to an option that meets their preferences within nine months.*	DBHDS reports that in FY21 Q2 RST tracking two individuals requested integrated services that were not immediately available; both were accommodated within 9 months (see #21). DBHDS reports that there have been no new individuals who requested integrated services that were not available during the period FY21 Q3. RST Reports are based on CM referrals to CRC and then to RSTs which manage through a Recommendation Tracker (see #30); timeliness is ensured by cross-checks with a) WaMS authorizations, b) ICF enrollment, and c) NF enrollments. The RST Process Control Document (#30) identifies a series of spreadsheet workbooks to manage the referral data. Data Set Attestation for RST was reviewed (see #18).	Because only two individuals requested integrated services that were not available and that both had access within nine months, the threat to RST data integrity is not applicable. This is the second year of data reported on the tracking of 'individuals whose request for integrated services was not immediately available'. This indicator has been achieved**.**	**NM**	**M**
18.8	*5. DBHDS establishes an*	Data Process Documents for	Twenty-four months of data	**NM**	**M**

	ongoing periodic review process for measuring the promptness and on-going delivery of authorized service units for private duty and skilled nursing services, including those provided under the EPSDT benefit, in order to identify and remedy patterns of service delivery interruptions.	Nursing Utilization and Timeliness were reviewed and are described well and are detailed (see #19, 20). Crosstabs of data are conducted between the Medicaid paid claims system and WaMS authorization database, and data pull precision is achieved through pro-rata authorizations, 12-month lag in data pulls, and templates for data analysis. Attestation forms were not provided.	have been analyzed and are now available for actionable strategies (see #7, 8, 9). There are now sufficient data to determine patterns of service delivery interruptions, and to identify and remedy the problems. Shortages of personnel are the root cause of most of the issues in nursing utilization. Remediation lies in improved payment systems and retention-recruitment efforts, that will make this type of nursing attractive. This indicator has been achieved.		
18.9	*6. DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018 for FY 2018. The utilization rate is defined by whether the hours for the service are identified a need in an individual 's ISP and then whether the hours are delivered. Data will be tracked separately for EPSDT and waiver funded nursing. Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.*	The most recent full year review (FY20 -see#7) shows these rates: **<u>Timeliness (70% in 30 days)</u>** **EPSDT-87%** **Waiver-89%** **<u>Utilization</u>** **EPSDT-51% (77/150) got 80%** **Waiver – 52% (295/579) got 80%** Data Process documents for Nursing Utilization and Timeliness were reviewed and are described well and are detailed (#19, 20). Crosstabs of data are conducted between the Medicaid paid claims system and WaMS authorization database, and data pull precision is achieved through pro-rata authorizations, 12-month lag in data pulls, and templates for data analysis. Attestation forms were not provided.	Twenty-four months of data (two six-month periods and one full fiscal year) have been analyzed and are now available for actionable strategies (see #7, 8, 9). This indicator has not been achieved.	**NM**	**NM**
18.10	*7. DBHDS continues to screen children through a VIDES*	DBHDS continues to screen via VIDES prior to	Sustained effort.	**M**	**M**

	assessment prior to admission to an ICF/IID. During the screening, DBHDS collects information from the family regarding the reason ICF/IID placement is being sought.	admission and collect information from families regarding the reason/s placement is sought. See #14, 10) Youth census of ICF/IIDs was 109 at the end of CY21 compared to 111 at the end of CY19. There was one diversion in Q1 FY22. ICF Data Set Attestation forms (#17) were provided to establish data integrity.			
18.11	*8. DBHDS continues to do Level II Preadmission Screening and Resident Reviews ("PASRR") on all children who have an indicator of a developmental disability diagnosis and are seeking nursing home services. All children who enter nursing facilities are limited to those who require medical rehabilitation, respite or hospice services.*	DBHDS continues to do PASRR reviews on all children seeking NF placement. Four were diverted in CY21 (see #3). Overall, the number of children being followed in NFs has reduced to 43 at the end of CY21, compared to 44 at the end of CY20."	Sustained effort.	**M**	**M**
18.12	*9. DBHDS tracks individuals under 22 who have received a PASRR screening for nursing facility entry or a VIDES assessment for ICF/IID entry and have been admitted. Children in ICFs receive annual Level of Care reviews and children in nursing facilities receive required resident reviews every 180 days at a minimum.*	DBHDS continues to track NF admissions and conduct reviews every 180 days (see # 1). DBHDS continues to track ICF/IID admissions and conduct Level of Care Reviews every 180 days (see #14)	Sustained effort.	**M**	**M**
18.13	*10. DBHDS provides a Community Transition Guide to families of children in nursing facilities and ICFs/IID. For those seeking ICF/IID placement, the Guide is provided when a request for a VIDES assessment is made and every 6 months thereafter. The Guide is designed to provide practical information to children and their families who are preparing to make decisions related to the type of care that best suits their support needs or are preparing to transition from nursing facilities and ICFs/IID to homes in the community. The Guide assists families in preparing to move to a new home through an explanation of resources and services*	DBHDS provides the *Community Transition Guides* (CTG) to families of children in nursing facilities (23 during Q2FY22). See #4. CTGs were also distributed to four ICF/IID admissions during Q1 FY2. See #14. This documentation also confirmed that the Guide is provided every 6 months after admission. The *Community Transition Guide,* provides practical	Sustained effort.	**M**	**M**

	such as DD Waivers, CSBs, and the DBHDS Community Transition Team that can assist the family with the transition process.	information.			
18.14	*11. Information with respect to services and supports for children with DD is available to families on the My Life My Community website. This information is disseminated consistent with the indicators in III.C.8.b.*	The required information is available on the My Life My Community website. (http://mylifemycommunityvirginia.org/) This information has been widely distributed to organizations and entities likely to have contact with individuals eligible for waiver services.	Sustained effort.	**M**	**M**
18.15	*12. DBHDS includes children aged 10 years and under as a priority group for discharge from ICF/IID settings per the ICF Community Transition Protocol, including prioritizing waiver slots to facilitate their discharge.*	DBHDS utilizes a *Waiver Slot Distribution-Process* that prioritizes five slots annually for children under 10 in ICFs or NFs (see #32).	Sustained effort.	**M**	**M**
18.16	*13. DBHDS implements a Family Outreach Plan that provides an avenue of communication with families/guardians/ARs of individuals with DD under 22 years of age receiving long term care services in nursing facilities and ICF/IIDs. Contact with parents/guardians/ARs is initially made by mail with follow up phone calls. All families are provided with the Community Transition Guide as described in indicator #10 above.*	DBHDS continues to develop Family Outreach Plans (see #10)	Sustained effort.	**M**	**M**
18.17	*Families/Guardians/ARs interested and open to discussion of available community services are contacted not less than semi-annually. All families receive an annual contact unless there is a request for no contact.*	DBHDS continues to implement these annual and semi-annual contacts with families (see #10, 12)	These activities have occurred over 3 review cycles, therefore this indicator has been achieved.	**M**	**M**
18.18	*Contact through the Family Outreach Plan will also involve individualized information in a manner that accommodates their cognitive disabilities, addresses past experiences of living in community settings and concerns and preferences about community settings, and includes facilitating visits and direct experiences with the most integrated community settings that can meet the individual's identified needs and preferences.*	DBHDS continues to implement these annual contacts with families, including past experiences, concerns, and preferences (see #10, 12).	Sustained effort.	**M**	**M**
18.19	*DBHDS facilitates with families a contact by a family-to-family peer support facilitator who shall contact families of children on at least a semi-annual basis for children aged 10 years and under, and on an annual basis for children aged 11 to 21 years,*	DBHDS continues to facilitate family-to-family peer mentors when interested (see #11, #14).	Sustained effort.	**M***	**M***

	unless the family refuses contact.	DBHDS did not provide a Process Document that delineates the process for collecting the data and for identifying and documenting the verification process for the Family Outreach Tracking Log Data Set. Attestation forms (#17) were provided to establish data integrity.			
18.20	*14. DBHDS will collaborate with sister agencies and private providers to explore augmenting current Medicaid funded host home service models for children that incorporate core elements of the Every Child Texas model focusing on children coming out of institutional settings.*	For the DBHDS workgroup overseeing this collaboration, the past year has been characterized by a change in leadership, direct consultation from The Every Child Texas program and convening a larger workgroup of external and internal stakeholders (see # 22, 23, 24), who have recommended: -making Jump Start funding available for Sponsored Residential providers (accomplished); - formation of a sub-workgroup of private providers interested in serving children; - identifying other structural barriers to expanded children's services; - re-evaluating the role of CMs in serving children with a primary focus of permanency planning (see #28). The major challenges for development appear to be recruitment of additional children-capable providers into Sponsored Residential services (i.e. there were only 7 providers serving 18 children statewide in May-October 2020), reorienting the practices and philosophies of serving young children, and	DBHDS has laid a good foundation for further development of a family-centered system. The actionable strategies with sister agencies and private providers are appropriately focused. Making Jump-start funds available to providers is a concrete first step. Therefore, this indicator is achieved.	**NM**	**M**

		educational materials targeted for adult providers interested in services for children.			
18.21	*15. DBHDS ensures that all CSBs are aware of children with DD seeking admission to a nursing facility from their catchment area and of children considering ICF/IID admission or discharge whose families are interested in community-based services through an awareness letter. When a child is identified as being in active discharge status from a nursing facility or ICF/IID, DBHDS sends an action letter to CSBs that enumerates the actions needed from the CSB and ensures funds are available for up to 120 days of Case Management Services for discharge planning.*	DBHDS provided documentation that CSBs are routinely informed of children with DD seeking admission or discharge (see #5, 12). DBHDS action letters now contain the notification that funding is available for 120 days of pre-discharge case management (five during FY21 Q2 - see #25). DBHDS reports CSB responsiveness has improved in this area. .	These activities have occurred over 3 review cycles, therefore this indicator has been achieved. The action letters now indicate that funding was available for up to 120 days.	**NM**	**M**
18.22	*a. 90% of those children known to be in active discharge status at a nursing facility or ICF/IID have an action letter sent to their home CSB.*	DBHDS sent action letters for 100% of those children known to be in active discharge status (see # 5, 26)	Sustained effort	**M**	**M**
18.23	*b. DBHDS establishes and implements accountability measures for those CSBs not actively involved in a child's discharge planning from a nursing facility or ICF/IID within 30 days of receiving an action letter.*	DBHDS reports that it has established notification and discussions and that CSB responsiveness has greatly improved. The establishment of additional accountability measures have not been warranted as all CSBs have been actively involved within 30 days of receiving an action letter.	For the second consecutive year, DBHDS reports CSB responsiveness has greatly improved, so the outcome expected by this indicator has been achieved.	**NM**	**M**

*Note: Data R/V

Attachment A
Documents Reviewed
CLO – Title or BOX Filename

1. Baseline Children in NF, 12/21
2. Children Identified in NF, 12/21
3. Children Referred for NF Placement through PASRR, 12/21
4. Family Outreach – November/December 2021
5. Action Letters Sent February 2021-January 2022
6. Awareness Letters Sent February 2021-January 2022
7. Nursing Hours Utilization III.D.I Yearly Review of SFY2020 October 2021
8. Nursing Hours Utilization III.D.I Six Month Review of FY20 February 2021
9. Nursing Hours Utilization III.D.I, FY19, 10.16.20
10. DBHDS Family Outreach Plan (S-, J-, L-)
11. Family to Family Network Referral Form (E-, J-, L-)
12. Awareness Letters (S-, J-, L-, C-)
13. Dr 0055 Residential Settings, FY22 Q1
14. Level of Care Reviews (FY21 Q3, FY22 Q1-2)
15. HCBS Residential Settings Report, FY21Q1
16. HCBS Residential Settings Report -Data Set Attestation Form, 3.4.22
17. Children's ICF Data Sheet, Family Outreach Tracking Log - Data Set Attestation Form, 3.4.22
18. RST Workbook - Data Set Attestation Form, 3.7.22
19. Nursing Auth Utilization Process, 1.14.22
20. Nursing Auth Timeliness of Service Process, 1.14.22
21. Provider Data Summary Report, 8.4.21
22. Every Child, Texas Model, 3.20.20
23. VA Framework/Every Child TX
24. Virginia DD Services & Every Child Texas Model, (PowerPoint)
25. CSB Notification of Active Discharge (A, B, M, S, W)
26. ew/bmt+ejw.docx (email 3.18.22)
27. Baseline Measurement Tool Master_10.31.20
28. Focus Group Recommendations, 1.26.22
29. DD Provider Data Summary, 3.22.22
30. DD PD RST, 1.7.21
31. 220215 CI Data RV Sources & Crosswalk-19th Period (IR-rw)
32. Waiver Slot Distribution Process, 1.21.22
33. Email 4.28.21, Land et al to Fletcher
34. https://www.kff.org/coronavirus-covid-19/issue-brief/state-medicaid-home-community-based-services-hcbs-programs-respond-to-covid-19-early-findings-from-a-50-state-survey/

Attachment B
CLO Interviews

Benita Holland, Family Resource Consultant, DDS, 3.16.22

Susan Moon, Nurse Care Consultant, OIH, 3.16.22

Brian Nevetral, Program Specialist, OIH, 3.16.22

Lisa Rogers, Community Transition Nurse, OIH, 3.16.22

Jenni Schodt, DOJ Settlement Agreement Advisor, 3.16.22

Eric Williams, Director of Provider Development, DDS, 3.15.22

APPENDIX F

List of Acronyms

ADL	Activities of Daily Living
APS	Adult Protective Services
ADA	Americans with Disabilities Act
AR	Authorized Representative
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Professional
CAP	Corrective Action Plan
CAT	Crisis Assessment Tool
CEPP	Crisis Education and Prevention Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Manager
CI	Compliance Indicator
CIT	Crisis Intervention Training
CL	Community Living (HCBS Waiver)
CLO	Community Living Options
CM	Case Manager
CMS	Center for Medicaid and Medicare Services
COVLC	Commonwealth of Virginia Learning Center
CPS	Child Protective Services
CRC	Community Resource Consultant
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTH	Crisis Therapeutic Home
CTT	Community Transition Team
CVTC	Central Virginia Training Center
DARS	Department of Rehabilitation and Aging Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disabilities
DDS	Division of Developmental Services, DBHDS
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice, United States
DS	Day Support Services
DSP	Direct Support Professional
DSS	Department of Social Services
DW	Data Warehouse
ECM	Enhanced Case Management
EDCD	Elderly or Disabled with Consumer Directed Services
EFAG	Employment First Advisory Group

EPSDT	Early and Periodic Screening Diagnosis and Treatment
ES	Emergency Services (at the CSBs)
ESO	Employment Service Organization
FRC	Family Resource Consultant
GH	Group Home
GSE	Group Supported Employment
HCBS	Home- and Community-Based Services
HPR	Health Planning Region
HR/OHR	Office of Human Rights
HSN	Health Services Network
IADL	Individual Activities of Daily Living
ICF	Intermediate Care Facility
ID	Intellectual Disabilities
IDD	Intellectual Disabilities/Developmental Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports ("DD" waiver)
IFSP	Individual and Family Support Program
IR	Independent Reviewer
ISE	Individual Supported Employment
ISP	Individual Supports Plan
ISR	Individual Services Review
KPA	Key Performance Areas
LIHTC	Low Income Housing Tax Credit
MLMC	My Life My Community (website)
MOU	Memorandum of Understanding
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
OCQI	Office of Continuous Quality Improvement
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
OSIG	Office of the State Inspector General
PASSR	Preadmission Screening and Resident Review
PCR	Person Centered Review
PCP	Primary Care Physician
PHA	Public Housing Authority
POC	Plan of Care
PMI	Performance Measure Indicator
PMM	Post-Move Monitoring
PST	Personal Support Team
QAR	Quality Assurance Review
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QMD	Quality Management Division

QMR	Quality Management Review
QRT	Quality Review Team
QSR	Quality Service Reviews
RAC	Regional Advisory Council for REACH
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RFP	Request For Proposals
RNCC	RN Care Consultants
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group
SEVTC	Southeastern Virginia Training Center
SIR	Serious Incident Report
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home
START	Systemic Therapeutic Assessment Respite and Treatment
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
VCU	Virginia Commonwealth University
VHDA	Virginia Housing and Development Agency
WaMS	Waiver Management System