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

April 1, 2020 – September 30, 2020

Respectfully Submitted By

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Independent Reviewer
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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's seventeenth 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 and compliance during the seventeenth Review Period, April 1, 2020 – September 30, 2020.

Tragically, the COVID-19 pandemic dominated this Review Period, with its repercussions felt across the entire country. Individuals with IDD, like the elderly, and the essential workers who support them, suffered disproportionately, especially in congregate settings. Overall, Virginia's service providers responded diligently to meet the challenge of ensuring that their essential workers continued to deliver care and supports. In doing so, however, providers could not avoid exposing their most valuable assets – their employees – and their loved ones to life-threatening health risks, even with safety protocols in place. Many of these organizations offered additional services within the Commonwealth without receiving a corresponding financial rate increase.

Virginia's service providers now report being under financial strain. If the Commonwealth is to meet its Agreement obligations, it must supply the resources necessary for providers to retain caring, qualified, trained and experienced direct support professionals, as well as supervisors, nurses, and behavioral specialists. All these workers are especially critical for supporting individuals with complex needs. Serving this population effectively is underscored throughout the Agreement.

During the seventeenth Review Period, Virginia focused intensively on implementing the Agreement's Provisions for a Quality and Risk Management (QRM) system. To be effective, the Parties had agreed that this QRM system would require both external oversight mechanisms and internal self-monitoring mechanisms.

To create such a system in the Commonwealth, Virginia would implement four foundational oversight mechanisms:

1. Frequent and unannounced inspections and investigations by the Department of Behavioral Health and Development (DBHDS)'s Office of Licensing (OL);
2. Frequent in-person observations and assessments by case managers to determine whether services are being appropriately implemented;
3. Annual on-site assessments of the adequacy of services by the OL; and
4. Annual Quality Service Reviews (QSRs) to determine whether individuals' needs are being met.

The Agreement required that the internal self-monitoring mechanisms would be a twofold development, implemented by each of the Commonwealth's forty Community Services Boards (CSBs), as well as all of its licensed service providers. This would involve:

1. A QRM Program, and
2. A Quality Improvement (QI) Program.

During the initial years of the Agreement, Virginia prioritized developing, delivering and monitoring services for individuals who transitioned from institutional to community settings. Since 2012, the OL fulfilled the first external cornerstone by implementing frequent and unannounced inspections and investigations.

DBHDS has continued to this day to expand and strengthen the oversight and quality assurance functions of OL and the Office of Human Rights (OHR). Unfortunately, though, effective development and implementation of the remaining five mechanisms listed above was hampered and delayed, due to two primary reasons:

1. The QSRs implemented by DBHDS in previous Review Periods utilized inadequate tools and processes and were conducted by insufficiently qualified reviewers. This resulted in unreliable findings and conclusions.
2. The development and approval of new regulations was necessary before DBHDS could implement assessments by OL and case managers, as required by the Agreement, and before the Department could require providers to implement QRM and QI Programs.

Creating these new regulations has taken several years. The DBHDS Licensing Rules and Regulations received final approval in August 2020. The new Home and Community-Based Services DD Waiver (Waiver) regulations are still not yet in effect. Because the regulatory process is so lengthy, and in order to make needed progress toward achieving Compliance, the Commonwealth approved emergency Licensing Rules and Regulations in September 2018. Both the emergency and now final licensing regulations require providers to develop QRM and QI Programs. Implementation of these two internal quality assurance mechanisms began in late 2018.

Of the remaining three external oversight mechanisms, OL assessments of adequacy began in January 2020, and the case management assessments and QSRs began in July 2020.

To demonstrate effective implementation of these three mechanisms, DBHDS needed to develop new and improved tools and processes. The Department also needed to document their effectiveness while completing on-site reviews of services based on face-to-face observations of individuals in their home settings and interviews with their caregivers.

Prior to the seventeenth Review Period, without five of the foundational and cornerstone elements of Virginia's QRM system being firmly in place, these monitoring mechanisms could not produce reliable performance and outcome data for analysis, nor could targeted QI initiatives be reliably determined.

Then COVID-19 struck, and required face-to-face observations and interviews had to be replaced with remote processes. DBHDS staff, case managers and its QSR vendor implemented telehealth methodologies to ensure that individuals and their services were still being reviewed. However, the remaining three external oversight mechanisms could not be tested during this Review Period with face-to-face assessments that utilized the new and improved tools and processes.

In the fifteenth Report, dated December 2019, the Independent Reviewer informed the Court that DBHDS did not have sufficient time – i.e., the minimum two years that are typically necessary – to demonstrate that its QSR process could achieve the required outcomes by June 2021. This date represents the end of the Agreement's originally estimated ten-year implementation schedule (i.e., July 1, 2011 – June 30, 2021). Once implementation begins, two years is typically needed because completion of a single cycle necessarily includes sequenced and coordinated performance and evaluation phases. Phases include start-up, operation, review,

correction, demonstration of effective performance, and documentation of the process and outcomes. If, after completion of a cycle, performance has not achieved the agreed to outcomes, the cycle needs to be repeated with QI initiatives.

Once pandemic-related precautions are no longer necessary, DBHDS will complete face-to-face assessments. These should allow for reliable determinations and documentation of system performance to identify needed quality improvement actions.

The Independent Reviewer commends the Commonwealth for maintaining a serious and concerted management focus throughout this challenging seventeenth Review Period. The seventeenth was the first full Review Period since the Indicators were approved, and Virginia sustained Compliance that it had previously achieved, and, for the first time, achieved Compliance with the Provider Training Provision V.H.2. Although it met many of the Indicators required for the remaining Provisions, the Commonwealth did not meet *all* the required Indicators for each Provision, and therefore did not achieve Compliance.

During the eighteenth Review Period, in addition to completing targeted analysis and providing feedback to the Parties, the Independent Reviewer will prioritize studying the status of Virginia's progress toward fulfilling the requirements of the Provisions in the following areas:

- Creation of Waiver Slots;
- Individual and Family Support Program;
- Case Management;
- Crisis Services;
- Peer to peer/family to family programs and guidelines for families;
- Serving individuals in the most integrated setting, including children residing in nursing facilities and the largest ICFs;
- Independent living options;
- Serving individuals with complex medical needs, and
- Quality and Risk Management (V.B. and V.C.1.)

Throughout the seventeenth Review Period, the Commonwealth's staff were once again accessible and forthright. They worked hard to be responsive, providing the Independent Reviewer and his consultants with a dramatically increased number of documents needed for study since the many new Compliance Indicators were established. It was unfortunate, however, that Virginia did not provide DOJ access to the documents that were reviewed by the

Independent Reviewer and his consultants for this Report. As a result, DOJ was not able to evaluate and judge, nor to concur with or object to many of the Independent Reviewer's findings and conclusions. Accordingly, once DOJ receives and reviews these documents, it may supplement the comments it made to the draft Report.

During this Review Period, the Commonwealth's staff and DOJ gathered and shared other information that has 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, as well as any concerns about progress toward shared goals has been critical and productive. The involvement and contributions of the advocates and other stakeholders have helped Virginia make measurable progress.

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.

II. SUMMARY OF COMPLIANCE

In the Summary of Compliance table that follows, the Compliance Rating column shows "Sustained Compliance" if the Independent Reviewer has rated the Commonwealth in Compliance for two consecutive Review Periods. If the Commonwealth has not yet achieved Sustained Compliance, the two most recent ratings are listed.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III	**Serving Individuals with Developmental Disabilities in the Most Integrated Setting**	Ratings prior to the 17th period are not in bold. Ratings for the 17th period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include example(s) to explain the status in relationship to 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.*
III.C.1.a.i.-x.	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 … ix. In State Fiscal Year 2020 35 Waiver slots	Sustained Compliance	*The Commonwealth created sixty Community Living* waiver *slots during FY 2020, twenty-five more than the minimum number required for individuals to transition from Training Centers.*
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) … ix. In State Fiscal Year 2020, 355 waiver slots.	Sustained Compliance	*The Commonwealth created 1017 new* waiver *slots in FY 2020 exceeding the total required for the former ID and IFDDS slots.* *The Parties agreed to consider the effectiveness of the discharge and transition process at NFs and ICFs as an indicator of compliance for III.D.1.*

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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) … ix. In State Fiscal Year 2020, 50 waiver slots."	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 2020 a minimum of 1000 individuals will be supported.	Non Compliance Non Compliance	*The Commonwealth continues to meet the quantitative requirement by providing financial support to more than 3,028 individuals through the first three quarters of Fiscal Year 2020, but has not fulfilled or documented achieving the IFSP compliance indicators.*
III.C.5.a.	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	Sustained Compliance	*153 (100%) of the individuals reviewed in the individual services review studies during the tenth, eleventh, twelfth, thirteenth, fourteenth, fifteenth, and sixteenth 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, there are six paragraphs of Compliance Indicators, one of which has ten required elements. Proper implementation of recommended pandemic precautions precluded achieving the indicators that require face-to-face visits. Without such visits, the data gathered by the case management quality review process were not reliable.

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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**	The Compliance Indicators for III.C.5.b.ii., and the Commonwealth's status of achieving these Indicators, are listed in III.C.5.b.i.
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**	The Compliance Indicators for III.C.5.b.iii., and the Commonwealth's status of achieving these Indicators, are listed in III.C.5.b.i.
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 Non Compliance	*The Commonwealth has not provided sufficient data, analysis and documentation that aligns with compliance indicators and cannot demonstrate that the indicator requirements and the measures have been achieved.*

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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	*This is an overarching provision. Compliance will not be achieved until the Commonwealth is in Compliance with the components of Crisis Services, as specified in the provisions of the Agreement.*
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. REACH hotlines are operated 24 hours per day, 7 days per week, for adults and for 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 five years. The Commonwealth requires that all 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 CSB-ES are not typically dispatching mobile crisis team members to respond to individuals at their homes. Instead the CSB-ES continues the pre-Agreement practice of meeting individuals in crisis at hospitals or at CSB offices. This practice prevents the provision of supports to de-escalate crises.*
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	*See comment immediately above re: III.C.6.b.ii.A. During the fifteenth and sixteenth Review Periods, REACH developed fewer Crisis Education and Prevention Plans, when compared with the substantial increase in individuals in crisis.*

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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 fifteenth and sixteenth Review Periods law enforcement personnel were involved in 45% (1,899 of 4,001) of REACH crisis responses; an additional 828 received training by REACH.*
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 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 provided in-home mobile supports received an average of three days of support. Days of support provided ranged between a low of one and a high of fifteen 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 did not create new teams. It added staff to the existing teams. REACH teams in all five Regions responded within the required average annual response times during the fourteenth Review Period.*
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.*
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	*For adults with IDD who are offered or admitted to the programs, crisis stabilization programs continue to be used as a last resort. Crisis stabilization programs, however, were not yet fully operational for children.*
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	*The Regions' crisis stabilization programs continue to routinely have stays that exceed 30 days, which are not allowed. Transitional and*

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		Non Compliance	*therapeutic homes have been developed but did not yet eliminate stays longer than 30 days.*
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.	Non Compliance Non Compliance	*The Commonwealth does not have sufficient community-based crisis stabilization service capacity to meet the needs of the target population in the Region.*
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 ID/DD.*
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.	Non Compliance Non Compliance	*The Commonwealth determined that it is not necessary to develop additional "crisis stabilization programs" for adults in each Region. It has decided to add two programs statewide to meet the crisis stabilization/transitional home needs of adults who require longer stays. Children's crisis stabilization programs are only partially operational.*
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**	Virginia has not fully achieved the Compliance Indicators 1 – 4 for III.C.7.a. and b. and IV.A. and B.4. Training of case managers is needed with the additional material developed to meet the requirements of Compliance Indicators 1. a.-g. The CSBs report that: • CI 2.b. CSB data shows that employment goals were set for only 30% vs. the standard of 50%.

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			• CI 2.d. CSB data shows that community engagement goals were set for only 38% of the individuals who had ISP meetings vs. the standard of 86%. Note: The consultant's study found no consistently used standards for determining when a CSB case manager should check the box to indicate that a minimally acceptable discussion had occurred. CI 2.c Services began within 60 days of authorization for 59% of the individuals vs. the measure of 86%. CI 2.d The consultant's study of 99 individuals indicated that only 52% of the sample had a meaningful discussion about community engagement vs the standard of 86%. CI 3 Due to the pandemic's impact, the number of employed individuals with IDD who have waiver services declined to 715, which is not within 10% of 1,486 (the Commonwealth's FY 2020 target for Supported Employment.) CI 4 The number of service authorizations show an annual increase of 1.4% vs. the standard of 3.5%.

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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 has reviewed, revised and improved its implementation plans.
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.

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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 fourth 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.7.b.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**	Of the number of individuals who were employed in June 2020, 85% had retained their jobs for 12 months, which met the 85% target set in 2014.

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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**	The RQCs continue to meet each quarter to consult with the DBHDS Employment staff, both members of the SELN (aka EFAG), and to review progress. Meeting frequency slowed during the pandemic.
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**	During FY 2020, the five RQCs all reviewed employment data and targets.
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 provided documentation that it achieved Compliance Indicators 1, 3 and 5. For the remaining three Indicators: 2. Valid information was not provided that 86% received reliable transportation, 4. Findings were not determined, and 6. QSR assessments had not been completed.

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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	Non Compliance Non Compliance	*DBHDS has developed, launched, and provided activity reports re: "My Life, My Community" website with information and guidelines for families. It has not yet distributed the website resource to a list of organizations and entities with likely contact with individuals who may meet the criteria for the Waiver waitlist and their families.*
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 has not provided sufficient data, analysis and documentation that align with Compliance Indicators and cannot demonstrate that indicator requirements and measures have been achieved.* *Infants with complex medical needs are being placed directly into a large institution without the family being offered an informed choice of alternative community-based options.*
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 12/31/19, the Commonwealth had created new options for 1034 individuals who are now living in their own homes. This is 691 more individuals than the 343 individuals who were living in their own homes as of 7/1/15. This accomplishment is 86% of its goal of 1,205 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.*

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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.*
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	*The Commonwealth estimated the number of individuals who would choose independent living options. It established the required baseline, updated and revised the Housing 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 has not provided sufficient data and documentation that align with the three Compliance Indicators and cannot demonstrate that indicator requirements and measures have been achieved.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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**	DBHDS has made progress, but fell short of achieving many of the 13 Compliance Indicators. Examples of not meetings the Indicators include: CI 2 and 4 – case managers have not met the standards for timely submissions. CI 5, 6, and 7 DBHDS has not met the standards for holding CSBs accountable.
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 the performance contracts, developed and provided training to case managers and implemented an ISP form with 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. When case managers submit timely referrals, CRCs and the RSTs continue to fulfill their roles and responsibilities and the Regional Support Teams frequently succeed at their core functions.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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**	DBHDS established the RSTs, which meet monthly. The CRCs continue to refer cases to the RSTs as required.
IV.	**Discharge Planning and Transition**	Ratings prior to the 17th period are not in bold. Ratings for the 17th period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include example(s) to explain the status in relationship to 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.*
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	Sustained Compliance	*The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It has continued to implement improvements in response to concerns identified.*
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.	Non Compliance Non Compliance	*For the one area of Non-Compliance – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve to serve as the measures of compliance for IV.A.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.	Sustained 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.*
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).	Non Compliance Non Compliance	*For the one area of Non-Compliance – lack of integrated day opportunities – the Parties established Indicators for III.C.7.a to serve to 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.	Sustained 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;	Sustained 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;	Sustained Compliance	*See comment re: IV.B.5.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 ;	Sustained Compliance	*See comment re: IV.B.5.*
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;	Sustained 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.	Sustained 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.	Sustained 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.	Sustained 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.	Non Compliance Non Compliance	*For the one area of Non-Compliance, 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.*
	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.	Sustained Compliance	*The Commonwealth's discharge plans indicate that individuals with complex/intense needs can live in integrated settings. Documents reviewed indicate that this process remains in place.*

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.	Sustained Compliance	*The Individual Services Review studies during the fifth, seventh, ninth, twelfth, and fourteenth review periods found that 124 (100%) of individuals and their ARs were provided with information regarding community options and had the opportunity to discuss them with the PST. Documents reviewed indicate that this process remains in place.*
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	Sustained Compliance	*Discharge records included evidence that the Commonwealth had offered a choice of providers. Documents reviewed indicate that this process remains in place.*
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.	Sustained Compliance	*The ninth, twelfth and fourteenth individual services reviews found that 39 of 45 individuals (86.7%) and their ARs did have an opportunity to speak with individuals currently living in their communities and their family members. Documents reviewed indicate that during the sixteenth period this process remains in place. All individuals/ARs received a packet of information with this offer.*
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.	Sustained Compliance	*PSTs and case managers assisted individuals and their Authorized Representative. For 100% of the 72 individuals studied in the ninth, twelfth and fourteenth ISR studies, providers were identified and engaged; provider staff were trained in support plan protocols. Documents reviewed indicate that during the sixteenth period this process remains in place.*

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.	Sustained Compliance	*During the fifth, seventh, ninth, twelfth and fourteenth review periods, the reviews found that 116 of 124 individuals /Authorized Representatives (93.5%) who transitioned from Training Centers were provided with information regarding community options. Documents reviewed indicate that during the sixteenth period this process remains in place.*
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.	Sustained Compliance	*The Independent Reviewer confirmed that training has been provided via regular orientation, monthly and ad hoc events while SWVTC and CVTC remained open.* *Documents reviewed indicate that during the sixteenth period this process remains in place.*
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.	Sustained Compliance	*The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training. All Training Centers had person-centered coaches. While SWVTC and CVTC remained open, there were regularly scheduled opportunities to meet with mentors. Documents reviewed indicate that during the sixteenth period this process remains in place.*

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.	Sustained 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.	Sustained Compliance	*The Independent Reviewer found that for the ninth, twelfth, and fourteenth ISR studies, residential staff for all 72 individuals participated in the pre-move ISP meeting and were trained in the support plan protocols. Documents reviewed indicate that during the sixteenth period this process remains in place.*
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.	Sustained Compliance	*During the fifth, seventh, ninth, twelfth, and fourteenth periods, the Independent Reviewer found that 121 of 124 individuals (97.6%) had moved within 6 weeks, or reasons were documented. Documents reviewed indicate that during the sixteenth period this process remains in place.*

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.	Sustained Compliance	*The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions.* *During the fifth, seventh, ninth, twelfth and fourteenth review periods, the ISR studies found that for 124 (100%) individuals, PMM visits occurred. The monitors had been trained and utilized monitoring checklists.* *Documents reviewed indicate that during the sixteenth period this process remains in place.*
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.	Sustained Compliance	*The Individual Services Review studies during the ninth, twelfth and fourteenth review periods found that:* *For 71 of 72 individuals (98.6%), the Commonwealth updated discharge plans within 30 days prior to discharge.* *Documents reviewed indicate that during the sixteenth period this process remains in place.*
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.	Sustained Compliance	*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.* *Documents reviewed indicate that during the sixteenth period this process remains in place.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.	Sustained Compliance	*The discharge records reviewed in the ninth, twelfth, and fourteenth review periods indicated that all twenty-six individuals (100%) who moved to settings of five or more did so based on their informed choice after receiving options.* *Documents reviewed indicate that during the sixteenth period this process remains in place.*
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.	Sustained 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.* *Documents reviewed indicate that during the sixteenth period this process remains in place.*
IV.D.1.	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	Sustained Compliance	*Community Integration Managers (CIMs) worked at each Training Center, and similar to the other DBHDS discharge and transition planning policies and practices, a CIM position is assigned to SEVTC.* *Documents reviewed indicate that during the sixteenth period this process remains in place.*
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.	Sustained Compliance	*CIMs reviewed PST recommendations for individuals to be transferred to a nursing home or congregate settings of five or more individuals.* *Documents reviewed indicate that during the sixteenth period this process remains in place.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.	Sustained Compliance	*During the twelfth period, there were improvements in the timeliness of referrals to the RST, which is essential to allow sufficient time for the CIM and RST to resolve identified barriers. During the fourteenth period, the ISR study of individuals who moved from Training Centers, found that 11 of 12 (91.3%) were referred timely.* *Documents reviewed indicate that during the sixteenth period this process remains in place.*
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	Sustained Compliance	*The CIMs provide monthly reports and the Commonwealth provides the aggregated information to the Reviewer and DOJ.*
V.	**Quality and Risk Management**	Ratings prior to the 17th period are <u>not</u> in bold. Ratings for the 17th period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include example(s) to explain the status in relationship to 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 <u>italics</u> below are from a prior period when the most recent compliance rating was determined.*

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**	Achieving this provision requires meeting nine Compliance Indicators with 58 sub Indicators, which will be evidence that the QRM system is in compliance. Compliance Indicator 4.b. was not met. QSRs were not available from FY 2020 to complete required evaluations.
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 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.*
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 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.	Compliance **Non-Compliance**	The Commonwealth has made substantial progress. It met six of the eight Indicators and has made significant progress on the other two.

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**	There are 15 Compliance Indicators and 39 sub-indicators. Examples of Indicators that were and were not met include: The MRC met Indicators: (1.a.-h.) charter, (2.a.-g.) membership, (3.a.-d.) training, (4) meeting frequency and attendance, (5.a.-e.) tracking, (6. and 6.c) review of deaths, (7.a. and c.) identifying deaths (8) review within 90 days, (9.a.and b.) documentation, (10) recommendations (11.a.i.-iv.) Annual Report (12, 13 and 14) MRC recommendations. The MRC did not meet Indicators: (7.b.) the completeness of the information to accurately determine type and cause of death is insufficient, (11) analyze data and implement quality initiatives, (11.a.) The MRC Annual Report was not timely, (11.a.v.) determining the proper categorization of some deaths, and (15) disseminated of information re: QI initiatives to stakeholders.
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**	OL achieved the metrics included in the Compliance Indicators 2, 3, and 7. DBHDS reviewed Medicaid claims data and identified serious incidents that may not have been reported as required. DBHDS did

Settlement Agreement Reference	Provision	Compliance Rating	Comments
			document taking further action for providers with recurring deficiencies. Compliance Indicators 1, 4, 5, 6 and 8 were not met. DBHDS did not identify the Training Centers or providers involved with the non-reported serious incidents found in the Medicaid claims data or determine if a corrective action plan was necessary.
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 met Compliance Indicators 1, 2, 3, 4, and 6 , and did not meet 5, 7 and 8. The data review and analysis did not identify trends and patterns. The data definitions and source descriptions are not sufficient to ensure data reliability. "Standard procedures" do not identify the data collection methodology at the source.
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 met Indicator 1, but did not verify the data sources as reliable and valid, which is required to use the data for compliance reporting.
V.D.3.a.-h.	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,	Non Compliance **Non Compliance**	For Provision V.D.3. The Commonwealth met Indicators for 1, 2, and 5, and did not meet 3, 4, and 6. DBHDS did not verify that the data sources were reliable and valid. These data therefore should not be used for compliance reporting (See V.D.2).

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	though any individual type of source need not provide data in every area (as specified):		Without determining that the data sources were reliable, the 16 Indicators for V.D.3.a.-h. are not met.
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**	DBHDS did not verify that the data sources were reliable and valid. These data therefore should not be used for compliance reporting (See V.D.2).
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 met Compliance Indicators 1, 2, and 4. It did not meet 3. DBHDS did not verify that the data sources were reliable and valid. These data therefore should not be used for compliance reporting (See V.D.2).
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 met Indicators 1, 3, 4, 5, and 6. Indicator 2 was not met for the same reason listed above for V.D.5. Indicator 7 was not met because the RQCs are not adequately fulfilling the

Settlement Agreement Reference	Provision	Compliance Rating	Comments
			planning and recommendation requirements of this Indicator.
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 information that has been posted addresses the topics but is primarily from 7/18-6/19 and is outdated.
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 met Indicators 1 and 3. It did not meet 2, 4 and 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 did not meet any of the four Indicators.
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 did not meet either of the two Indicators.
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. DBHDS reported data that some CSBs are below target.*

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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**	The Compliance Indicators for V.F.2. are listed in III.C.5.b.i. DBHDS completed extensive planning and development work and launched it new assessment process in July 2020. However, the pandemic precluded the required face-to-face assessments.
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 ISR studies found that the case managers had completed the required monthly visits for 96 of 100 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 achieved the Indicator for this provision. Achievement depends on the Commonwealth determining that data sources are reliable.

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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**	For the four areas that DBHDS selected (i.e., Choice, Relationships, Change in Status, and ISP Implementation), DBHDS data reports show at least 86% achievement with three areas, but not with Choice. In addition, the 86% related to Change in Status and ISP Implementation was based on the same unreliable SCQR-FY20 data results, which pre-dated the standard definitions and assessment tools.
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 conducts 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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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**	Compliance Indicators 1 and 2 – OL developed a checklist for the seven domains with corresponding regulations. Covid-19 precautions appropriately precluded the use of the checklist for unannounced, onsite, and in-person assessment, which, in turn, precluded DBHDS from demonstrating that the checklist is sufficient to assess adequacy. DBHDS met Indicator 3 by informing providers of its list and assessment expectations. It cannot achieve Indicator 4 until its summary report is based on assessments that are conducted, as required.
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 made considerable efforts and has met Compliance Indicators for 1, 5, 6, 7, 8, 9 , and 13. It has not yet met 2, 3, 4, 10, 11 and 12. Indicator 2 – The Commonwealth has not demonstrated that the DMAS reviews are sufficient to ensure that DSPs meet the core competency requirements. Indicators 3, 10 and 11 – Performance measure data was not provided. Indicator 12 – DBHDS documented that providers had improved to 77.3%, which did not meet the 86% required.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.	Non Compliance **Compliance**	The Commonwealth has achieved this Provision, by making available: • the required supervisory training, which includes all topics specified in Indicator 1, and • the resources specified in Indicator 2. DBHDS has also provide
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**	The Commonwealth did not complete QSRs during Fiscal Year 2020. It's new vendor launched a redesigned and upgraded QSR process in July 2020, which was not completed during this Review Period. The pandemic precluded implementation of face-to-face assessments that are required. Until a complete round of the QSR process is completed, the Independent Reviewer cannot determine that the Commonwealth has achieved the other requirements of the QSR Indicator requirements.
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**	Same as V.I.1. immediately above
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**	Same as V.I.1. immediately above.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
VI.	**Independent Reviewer**	**Rating**	**Comment**
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 the with copies to the parties. The parties will seek a protective order permitting these reports to be …and shared with Intervener's counsel.	**Sustained 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**	**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 has determined that the Commonwealth did not maintain sufficient records to document proper implementation of the provisions, including not determining that its data sources are reliable and valid.

Notes: 1. The Independent Reviewer does not monitor services provided in the Training Centers. The following provisions are related to internal operations of Training Centers and were not monitored: Provisions *III.C..9, IV.B.1., IV.B.2., IV.B.8., IV.B.1.2, IV.B.13., IV.D.2.b.c.d.e.f., and IV.D.3.a.-c.*

III. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

For this seventeenth Review Period (April 1, 2020 through September 30, 2020), the Independent Reviewer prioritized the following areas to monitor the Commonwealth's compliance with the requirements of the Agreement:

- Case Management
- Behavioral Supports and Programming
- Integrated Day Activities and Supported Employment
- Regional Support Teams
- Transportation
- Office of Licensing/Office of Human Rights
- Quality and Risk Management
- Mortality Review
- Provider Training
- Quality Service Reviews

To analyze and assess the Commonwealth's performance across these areas and their associated Compliance Indicators, the Independent Reviewer retained nine 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 in regularly scheduled Parties' meetings and in work sessions with Commonwealth officials;
- Examining and evaluating documentation of supports provided to individuals;
- Interviewing individuals, families, provider staff, and stakeholders; and
- Determining the extent to which the Commonwealth maintains documentation that demonstrates that it meets all Compliance Indicators and achieves Compliance with the Provisions.

The Independent Reviewer focused all seventeenth period reviews on the Compliance Indicators associated with the various Provisions not yet achieved, and for sustaining Compliance for those that had been achieved previously. To ensure that the Independent Reviewer had the facts necessary to determine whether Virginia had met the metrics of the Indicators and achieved Compliance, the Commonwealth was asked to provide documentation that would:

- "Prove its Case" for having achieved all Indicators for the Provisions being studied, and
- Verify the reliability and validity of the Commonwealth's performance data.

To determine any ratings of Compliance for the seventeenth Review Period, the Independent Reviewer considered information provided by the Commonwealth prior to November 16, 2020. 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 Compliance achieved or not, are best understood by reviewing the Comments section in this Report's Summary of Compliance table, 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 included in the respective reports in the Appendix are provided to the Parties and filed under seal with the Court.

For each study, the Commonwealth was asked to provide any additional records that it maintains that document the proper implementation of the provisions being reviewed. Information that was not provided for the studies is not considered in the consultants' reports, nor in the Independent Reviewer's findings and conclusions that result in determinations of Compliance. If the Commonwealth was not able to provide sufficient documentation to demonstrate that the Compliance Indicators had been achieved, then the Independent Reviewer determined a rating of Non-Compliance.

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 seventeenth Report to the Court.

B. Compliance Findings

1. Case Management

Background

The Independent Reviewer's consultant has conducted studies of Virginia's case management system and case management services throughout the length of the Settlement Agreement. His study for the sixteenth review period, in the Spring of 2020, found that DBHDS's Case Management Steering Committee (CMSC) had initiatives already underway to improve specific areas of previously identified inconsistent and inadequate case management performance. Subsequently, in June 2020, the Independent Reviewer determined that the Commonwealth had achieved Sustained Compliance across four of the case management provisions. These require the Commonwealth to ensure that:

- Individuals with HCBS waiver services (Waiver) receive case management services (III.C.5.a.),
- Case managers offer a choice of service providers (III.C.5.), and
- Case managers make face-to-face visits every thirty days (V.F.3.), including at the individual's residence (V.F.1.)

This represented a significant achievement for DBHDS. However, a number of critical case management provisions remain.

In April 2019, the Parties informed the Court of their agreement to measurable Compliance Indicators for all those provisions of the Agreement that the Commonwealth had not yet achieved. For the remaining case management Provisions, the Parties agreed to one set of Indicators that focus on the functioning and monitoring of case management services, as well as service planning and the provision of integrated day activities and supported employment. These indicators are listed at Provision III.C.5.b.i.

With these Indicators established, it is worth reiterating that achieving the necessary measures takes time and involves a complex, multifaceted and sequenced undertaking by DBHDS.

For example, some sets of Indicators for a Provision require significant planning, development and then operation of new or revised systems. Typically, though, newly created systems do not quickly achieve the measures of quality performance standards and outcomes for service

recipients. Before that is possible, an evaluation of the system must be conducted to identify any obstacles to performance. Quality improvement initiatives must then be determined and subsequently implemented. The revised system needs to be operational for a period of time before the impact of the implemented improvement initiatives can be re-evaluated. If obstacles are still not resolved, additional improvement initiatives must be established. Once this cycle of sequenced actions is effectively completed, a new or improved system will be able to achieve and sustain compliance.

Seventeenth Period Study

The Independent Reviewer once again retained the services of the same consultant for this seventeenth Review Period study, which focused on the four sets of Indicators for the remaining Provisions.

The consultant found that the Commonwealth had successfully implemented various initiatives, but that one or more Indicators for each Provision had not yet been met.

It is important to acknowledge that DBHDS has extended considerable and concerted efforts to implement the required improvements and new systems. One example highlights this. In May and June 2020, the agency established the standard definitions for two phrases: change of status in individuals with IDD, and appropriate implementation of services for those individuals. They also developed a new onsite assessment tool that included these definitions and designed a related training program for case managers and their supervisors. In July and August, DBHDS rolled out its new case management external monitoring process required by V.F.2. As part of this rollout, DBHDS trained case managers and their supervisors statewide and communicated their expectations to case managers and their supervisors.

However, due to necessary COVID-19 precautions, an essential component of this process, required by the indicators, could not take place – namely, in-person observations by case managers of individuals with IDD receiving their services, as well as those individuals' at-home environments. These assessments could only be conducted remotely and, therefore, could not provide sufficient information to more accurately determine whether there had been a change of status for the individual, and whether the individual's services were being appropriately implemented.

Only when in-person assessments can take place again, and be completed as required, will Virginia be able to fulfill the numerous additional steps in this external monitoring process. For example, if case managers identify a change in status or a lack of appropriate implementation of services, they must document the issue and convene the service planning team to address it. Following provision of needed service plan changes, the case manager must assess the individual's newly designed services and document that the issue has been resolved. The Commonwealth, in turn, must then collect reliable data and maintain records that demonstrate that each of these required actions has been properly completed.

Because of this lack of critical in-person assessments, and despite DBHDS's substantial progress and accomplishments, the Commonwealth was not able to achieve the Indicators associated with V.F.2. And, given that the current remote assessments are not sufficient, subsequent steps required by the Indicators cannot be effectively fulfilled.

This new case management monitoring process is only one example of the systemic change initiatives required. Although adherence to proper COVID-19 precautions unfortunately contributed to the Commonwealth's inability to fulfill many case management indicators, other long-standing and still-unresolved obstacles contributed as well. One of them is that a few CSBs are not yet making the initial and sustained effort to accomplish performance standards or the outcomes required by the indicators. As well, DMAS waiver regulations were not approved, so the document *Practice Guidelines*, which must be based on the approved regulations, could not be finalized.

As a result, although DBHDS extended significant effort and made some progress in difficult areas during the seventeenth Review Period, the case management study shows that the agency was unable to provide data that align with and demonstrate achievement of the Compliance Indicators. Examples include:

- For the required case management quality review process, now renamed by DBHDS as Support Coordination Quality Review (SCQR), the Department reported progress that 78% of records met nine of the ten required elements listed; this does not meet the 86% required by the Compliance Indicator. However, the performance that was reviewed and reported in the study pre-dated finalization and implementation of the two important standard definitions, referred to above, that are required for case management monitoring (i.e., assessments of appropriate implementation of ISP and for a change of status).

- DBHDS created the required look-behind "Retrospective Review" process to determine if supervisors have properly evaluated their case managers' performance. However, the records reviewed by the agency as part of this look-behind process occurred prior to the creation of the same two standard definitions, and did not include results from the required in-person assessments. The annual DBHDS retrospective review process and its ongoing inter-rater reliability component will mitigate the inherent bias in the qualitative performance determinations reported by CSB case managers and their supervisors.
- For the four V.F.5. areas that DBHDS selected (i.e., Choice, Relationships, Change in Status, and ISP Implementation), their data reports show at least 86% achievement with three areas, but not with Choice. In addition, the 86% related to Change in Status and ISP Implementation was based on the same unreliable *SCQR-FY20* data results, which pre-dated the standard definitions and assessment tools.
- The DMAS draft regulations for the Waiver redesign incorporate the ten required elements. One element is incorporated by reference to existing federal regulatory requirements regarding "strategies on ISP conflicts."
- The CMSC developed and implemented the *Performance Monitoring Spreadsheet* (dated August 6, 2020) as a master tracking log for the required ten elements of the SCQR, RST referral timeliness, and ISP Compliance data. This log will be used to track the Corrective Actions Plans (CAPs) for cited regulatory Non-Compliance required by the provision's indicator. However, DBHDS reported that they would not be issuing CAPs until October 2020. Additionally, the data in the log from the DBHDS record reviews of SCQR must include results from case managers' implementation of the two new definitions and related quality reviews completed by CSB case management supervisors.
- DBHDS made progress by developing *Process Document – Therapeutic Consultation-Behavior Supports* (dated June 23, 2020*)*. However, the planned look-behind process must be based on the approved Waiver and the subsequent publication of *Practice Guidelines*. These are not projected to be completed before the second half of the eighteenth Review Period (i.e., Q3, Fiscal Year 2021).

Conclusion

The consultant's study found that the CMSC's implementation efforts reflected a serious focus on developing and implementing the quality framework needed for case management services to achieve best practice in some areas. It also found that the CMSC's substantial efforts during the seventeenth Review Period made significant progress toward achieving some of the case management Compliance Indicators. However, further progress is hampered. The Commonwealth must first approve its new DD regulations and *Practice Guidelines*, implement new

monitoring systems that address all required elements, and implement a quality improvement process to identify, address and resolve obstacles. Only then will the Commonwealth be able to meet and sustain achievement of the Indicators' performance and outcome measures.

The Commonwealth remains in Non-Compliance with Provisions III.C.5.b.i.-iii.; III.C.5.c.; III.C.5.d.; and V.F.2., 4. and 5.

2. Behavioral Supports and Programming

Background

The Independent Reviewer's behavioral specialist consultant has conducted previous studies of Virginia's behavioral programming for individuals with intense behavioral needs. His 2019 review, during the fifteenth Period, found that the studied individuals demonstrated unsafe behavior that placed them and others at risk and, as reported by their caregivers, negatively impacted their quality of life. The report concluded that individuals with these criteria would likely benefit from formal behavioral programming or other therapeutic supports implemented within their homes. At that time, the Independent Reviewer identified concerns and recommended that the Commonwealth further review behavioral support services and programming to determine whether they were adequate and appropriately implemented.

To meet the requirements of the Compliance Indicators, Virginia had drafted Waiver regulations. However, additional steps still remained in the multiphase regulatory approval process. Once permanent, the Waiver regulations would become the basis for the *Practice Guidelines*. This document will specify for behavior consultants the minimum elements that constitute an adequately designed behavioral program, as well as the use of positive behavior support practices. The permanent Waiver regulations and the *Practice Guidelines* are requirements of the Behavioral Supports Compliance Indicators. They are also foundational to much-needed quality improvement and capacity building efforts to increase the accessibility and quality of the Commonwealth's behavioral services for individuals with IDD.

Seventeenth Period Study

The regulatory approval process for the Waiver regulations remains underway. Virginia currently expects the regulations to become permanent in the first half of 2021. When approved, the *Practice Guidelines* can be finalized and released.

For the latest review, the Independent Reviewer retained the same consultant as previously, plus another, both of whom are Board Certified Behavioral Analysts (Ph.D., BCBA-D), to study the behavioral supports and programming for forty individuals who were randomly selected from a cohort of 134. Everyone in the cohort had intensive behavioral needs meeting level seven of the Support Intensity Scale (SIS), and were also studied in the Person Centered Review portion of DBHDS's 2020 Quality Service Review (QSR) study, which began during the seventeenth Period.

The behavioral services study was designed to verify or refute the QSR study's findings regarding "access to and received treatment services, as necessary" for each of the forty individuals and whether their "needs were met." The comparison would show if these findings by non-clinicians, with clinical consultation available, align with those by licensed clinicians.

The study included a review of provided documents and telephone interviews with caregivers and, in some cases, behavioral specialists or other involved providers. The consultants utilized the same *Monitoring Questionnaire* and standards as in previous studies to compare the behavioral supports and programming that were in place for the individuals studied with generally accepted standards and practice recommendations for effective behavioral programming and supports. These include:

- Level of need (i.e., based on behaviors that are dangerous to self or others, disrupt the environment and negatively impact an individual's quality of life, ability to learn new skills, and gain independence);
- A Functional Behavior Assessment (FBA) that is current;
- A Behavioral Support Plan (BSP) that is developed and overseen by a qualified clinician;
- Behaviors targeted for decrease;
- Functionally equivalent behaviors targeted for increase;
- Care provider and staff training; and
- Ongoing data collection, including regular summary and analysis with revision as necessary.

However, the full purpose of the consultants' study could not be realized, since DBHDS's QSR study was still in process and its findings were not yet available. The QSR evaluations could not be compared with the evaluations of behavioral services by licensed clinicians. This review, therefore, could not verify the overall or individual findings by the non-clinicians who were conducting the QSR evaluations.

In addition, requested documentation for some of the individuals selected for the study was unavailable. Consequently, this current study was unable to fully examine the nature of the behavioral supports and programming that were currently in place for these individuals. As a result, this review's findings are limited and cannot be generalized with high confidence to all of the individuals in the QSR study with SIS level seven needs.

Of the forty individuals studied, though, the majority once again demonstrated unsafe behavior that placed themselves and/or others at risk. Also, most individuals displayed disruptive and/or other behaviors that limited their ability to access diverse community settings as well as their ability to learn new skills.

Overall, although most of the forty individuals in the sample would likely benefit from comprehensive Behavior Support Plans (BSPs), only eleven individuals (28%) had access to and actually were receiving behavioral programming in their homes. Because the Commonwealth could not provide documentation of behavioral services for all forty individuals, the consultants estimated from verbal reports that six other individuals may have had BSPs, in addition to the eleven individuals already identified. If such plans did exist for those six other individuals, they were not provided to the consultants to determine whether they contained the required elements. Also, documentation was not provided that showed the extent to which these BSPs may have been implemented and reviewed, or if they were of any benefit.

Based on informant responses, at least another ten individuals (25%) needed comprehensive behavioral programming, but could not obtain, or had not yet received, such services. Five (12.5%) of the individuals were reported to display minimal maladaptive behaviors and did not require behavioral services support; two others were reported to be successful with minimal school-based strategies and supports in their homes.

Given the majority of individuals who demonstrated a need for formal behavioral programming, and the low number of BSPs implemented, it is evident that not all sampled individuals who needed access to behavioral programming are currently receiving adequate behavioral supports and services to meet their needs.

Of the eleven individuals with BSPs that were provided for review, almost all lacked significant elements of generally accepted practices and recommendations.

Generally accepted practice standards involve the completion of a comprehensive Functional Behavioral Assessment (FBA) in order to identify the potential underlying function(s) of target behaviors and to inform the selection of function-based interventions when developing a BSP. Of the eleven individuals with a BSP, only eight (73%) had an FBA completed. Consequently, not completing an FBA, as evidenced for three (27%) individuals, limits the probability of an effective BSP. In addition, most of the eight FBAs were not considered current, or were not completed in the current setting, or did not utilize direct methods of assessment and identified setting events.

Overall, of the eleven BSPs that were available for review, the prescribed behavioral programming for several missed important elements, and three (27%) appeared inadequate. Between three and seven BSPs lacked target behaviors (for decrease), functionally equivalent replacement behaviors (for increase), skill acquisition strategies, and interventions that appeared to be least restrictive and/or most appropriate.

The Compliance Indicator 3.C) for Provision III.C.6.a.i.-iii. requires "training of family members and providers providing care to the individual." However, evidence that support staff had successfully completed competency-based training was provided for zero (0%) of the eleven individuals with BSPs. The Compliance Indicator 3.D) requires "monitoring of the plan for supports that includes data review." However, evidence that data on all target behaviors (for decrease) and functionally equivalent replacement behaviors (for increase) had been adequately summarized and regularly reviewed was found for only two (18%) of the BSPs.

See Appendix B for the consultants' full report and data summaries.

Conclusion

The findings from this seventeenth Period study, as outlined above, are comparable to those from previous reviews. They strongly indicate that Virginia's community-based service system lacks standards for what constitutes both an adequate behavior program and appropriate implementation and it lacks a sufficient number of behavioral specialists and service providers with the needed level of experience, expertise and available capacity. Furthermore, most of the Commonwealth's current behavioral programming does not meet generally accepted standards and practice recommendations. The limited access to adequate behavioral services, plus the high percentage of services that lack the minimum elements required, need to be addressed.

The Commonwealth has taken some steps to address findings of inadequate behavioral programming. It has incorporated standards for an adequate behavioral support plan into its

draft Waiver regulations, which are now undergoing review in the Governor's office. The Commonwealth reports that its related *Practice Guidelines* and *Case Management Training* have been drafted and will be ready to issue once the Waiver regulations become effective.

Because Virginia has not yet approved revised Waiver regulations and, therefore, has not been able to provide the final *Practice Guidelines*, the Commonwealth has not met the requirements for Provision III.C.6.a.i-iii.'s Compliance Indicator 3, and so remains in Non-Compliance.

3. Integrated Day Activities and Employment Services

Background

The Independent Reviewer's consultant last examined the Compliance Indicators associated with the Provisions for Integrated Day Activities and Employment Services a year ago in the fifteenth Review Period.

At that time, findings of Sustained Compliance were assigned to a number of the Provisions related to planning, regional training, data collection, tenure in employment and the work of the Regional Quality Councils.

Findings of Non-Compliance were assigned to the over-arching Provision III.C.7.a. and key expectations for Provision III.C.7.b., including the obligation to discuss employment opportunities with eligible individuals during the Individual Support Plans (ISP) process and to designate an employment service coordinator.

In Provision III.C.7.a., the Commonwealth is required to provide, to the greatest extent practicable, integrated day opportunities, including supported employment, to individuals in the target population receiving services under the Agreement. Furthermore, in Provision III.C.7.b., Virginia must maintain its membership in the Supported Employment Leadership Network (SELN); establish a state policy on Employment First; include a term in the CSB Performance Contract requiring application of this policy; and have at least one employment service coordinator to monitor implementation of Employment First practices.

Since the last review, the Parties agreed in January 2020 that achieving four Indicators would represent Compliance with the five Provisions related to this subject, i.e., III.C.7.a., III.C.7.b.,

IV.A., IV.B.4., and IV.B.6. All four Indicators are listed under Provision III.C.7.a., but serve to measure Compliance with all five Provisions.

Seventeenth Period Study

For the latest review, the Independent Reviewer retained the same consultant as previously, plus another to assist. Their report covered the period from October 1, 2019 through September 30, 2020, and focused on the four Compliance Indicators included in the five Provisions above. These Indicators address the training of case managers regarding the Employment First policy and the skills needed to work with all individuals, including those with intense medical or behavioral support needs, and their families in order to ensure a timely and goal-directed discussion about employment services and to provide access to such services as authorized in the ISP.

This review built on the expectation that employment is the first option offered to an individual in the target population during the ISP process in which they, their case manager and their team discuss and develop employment goals. The consultants' report examined the Commonwealth's success in meeting its Fiscal Year 2020 targets for the number of individuals who were in supported employment, the progress made in offering community engagement and community coaching to individuals who do not work or as a supplement to work, and the training received by case managers to strengthen their skills in facilitating discussions and setting goals regarding employment and community engagement.

In order to complete this review, the consultants examined relevant documents and interviewed key administrative and quality improvement staff from DBHDS, as well as members of the Employment First Advisory Group (EFAG, and previously SELN). In addition, ninety-nine ISPs were reviewed to validate that each ISP documented the team discussions regarding employment and community engagement.

Based on this evidence, the consultants determined the following accomplishments:

- DBHDS issued an updated project plan for its Employment First outcomes and strategies. These desired outcomes include collaboration between the state agencies that facilitate employment for individuals in the target population; increasing stakeholders' understanding about community-based employment; analysis of relevant data in order to increase employment opportunities; development and implementation of best practices;

and further assuring an active and committed stakeholder group that will help enhance the Employment First initiative.

- The number of individuals in sheltered workshops declined for the third consecutive year. There are currently only thirty-seven Waiver participants in sheltered workshops, and an overall total of 397 individuals in such congregate settings across all employment program sources of funding.
- It is expected in the employment implementation plan (Provision III.7.b.i.) that 85% of individuals will hold their jobs for at least twelve months. Overall, 85% of all individuals employed worked at their job for one year or more.
- DBHDS continues to meet the requirements to maintain the EFAG, has set goals for the CSBs in the performance contracts, and has assigned an Employment Services Coordinator. The department has also engaged the Regional Quality Councils in discussions about employment.
- Stakeholders involved in the Advisory Group remain interested and positive about the Commonwealth's progress and achievements. They report that the work of the Advisory Group will be strengthened by the involvement of the new Employment Services Coordinator, who will be able to assist in the goals to undertake and report trend analyses, address employment barriers, and make continued recommendations to increase employment options for individuals in the target population.

The consultants' report also identified issues and concerns that must be addressed in order to achieve the Indicators for the Agreement's integrated day activities, including supported employment Provisions. These include:

- It was evident from the consultants' review of DBHDS data and the ninety-nine ISPs that case managers are not well educated about Community Engagement services under the Waiver and that the Commonwealth has not developed sufficient capacity for implementation. Between June 18, 2019 and April 3, 2020, the number of providers licensed to deliver Community Engagement services only increased by seven, that is, from 126 to 133 providers. In the same time period, the number of licensed providers for Community Coaching increased only by twelve from 45 to 57. Furthermore, the distribution of these two sets of providers across the Commonwealth is very uneven. Together with residential providers, DBHDS is exploring the possible development of Community Engagement services to increase the number of providers. In its semi-annual *Provider Data Summary* report, the Commonwealth plans to include summaries of

demographic data, successes, barriers and participation. This information is needed and should be expedited as a priority effort.

- **Case Management Training** (Compliance Indicator 1.a.-g.)
  1. As required, the Commonwealth developed and made the online case management training modules and case management manual available for case managers. However, these lacked a number of the required elements, which are described in the consultants' report. (See Appendix C.)
- **Performance Metrics** (Compliance Indicator 2.a.-f.)
  1. The Commonwealth did not achieve this Indicator. DBHDS reported that it had not met the performance percentages required by the metrics at 2.a., 2.c., 2.d. and 2.e. Data were not available for 2.f., and were not verified for 2.b. The data provided for 2.a. and 2.d. were determined to not be reliable. The consultants' report provides detailed information for each of these determinations.
  2. Although DBHDS worked in partnership with DARS to refine its data collection and is now able to report comparative data, the number of individuals reported in Individual Supported Employment (ISE) and General Supported Employment (GSE) declined. This is the first time that there has been an overall decrease in the number of people with IDD employed in ISE and GSE since DBHDS has reported these data. Although this decrease was affected by COVID-19, there was actually a decrease in the number of people employed even prior to the outbreak of the pandemic. It is important to continue to review these data to determine whether this indicates an expected seasonal downturn or an unfortunate overall downward trend, and ultimately if the employment situation for individuals with IDD improves to pre-pandemic levels once COVID-19 comes under control.
- **Employment Targets** (Compliance Indicator 3.)
  1. The data indicate that 715 individuals enrolled in the DD Waivers are employed. This is a decrease from the previous year when 1,078 individuals participating in the DD Waivers were employed. The low number employed does not meet this Indicator – i.e. it is not within 10% of the Commonwealth's target, as required.
  2. If Virginia is to meet its employment targets in future years, DBHDS will need to concentrate on increasing provider capacity. It will also need to ensure that case managers and their supervisors are adequately trained to discuss employment in a meaningful way, and are aware of all resources potentially available to individuals and families. The review of ninety-nine ISPs indicated that families need much more information about employment and its impact on benefits. Additionally, case managers need training to assist individuals with more complex needs to gain

confidence in exploring work as an option. Furthermore, the Commonwealth and its CSBs need to address the barrier of transportation, if the number of employed individuals is to increase in any meaningful way.

- **Annual Increases** (Compliance Indicator 4.)
    1. Insufficient data were provided to evaluate whether Virginia had met this Indicator, which requires an annual increase of 3.5% in the number of Waiver participants being served in the most integrated setting.

Conclusion

The Commonwealth has been implementing positive changes to its employment service array for individuals in the target population since 2012. As discussed above, the Independent Reviewer's consultants identified a number of positive practices now underway. Unfortunately, the efforts to meet targets to increase employment and participation in community engagement have been stymied by the COVID-19 pandemic during this reporting period. As a result, Virginia's progress toward achieving its multi-year employment targets has been reversed. It will require a significant increase in these employment opportunities in Fiscal Year 2021 to meet the Compliance Indicators for employment targets, and for the target for the percentage increase for individuals participating in integrated day activities. A number of recommendations are included in the consultants' report to assist the Commonwealth in reaching its goals and meeting the terms of the Agreement.

The Commonwealth remains in Non-Compliance with the five Provisions III.C.7.a., III.C.7.b., IV.A., IV.B.4., and IV.B.6., but has maintained Sustained Compliance with Provisions III.C.7.b.i., III.C.7.b.i.A., III.C.7.b.i.B.1., III.C.7.b.i.B.1.a.-e., III.C.7.b.i.B.2.a.-d., and III.C.7.c.-d.

4. Transportation

Background

The Independent Reviewer's consultant has conducted several previous reviews of the Commonwealth's community transportation services for Waiver users – i.e., individuals with IDD who receive Waiver-funded services. His review in 2019 found that DMAS had made progress. It had awarded a new contract to LogistiCare that included four transportation recommendations included in a previous Report to the Court. These are to:

- Ensure that more representatives of Waiver users are included on LogistiCare regional Advisory Boards;
- Analyze the LogistiCare databases using the Waiver users as a sub-group for assessment of their differing needs;
- Encourage the use of GPS, tablets and other technologies in matching drivers with users; and,
- Encourage LogistiCare to develop a Network Development Plan to eliminate/reduce gaps in transportation at the community level.

The new LogistiCare contract also included requirements to:

- Conduct statistically valid customer satisfaction surveys from DD Waiver users;
- Implement "trip recovery" technology (i.e., software designed to redirect drivers in real time when another driver is unable to make a ride); and
- Use GPS to facilitate future monitoring of actual on-time pickup and delivery.

The study found that DMAS/LogistiCare had implemented improvements to some aspects of the DMAS transportation system. These included positive action regarding regional Advisory Boards, in-vehicle cameras, GPS in all vehicles, separation of complaint and survey data, increased review of subcontracted providers with high rates of complaints, reduced instances of No Vehicle Available (NVA), and additional options for independence, mileage reimbursement, and availability of a mobile app to track scheduled trips.

However, the 2019 study reported that very few DD Waiver users or their representatives actually filed transportation complaints. Because of this, DMAS/LogistiCare's data show an extremely high rate of "complaint free" trips (99.74), and of those, 99.94% were "on time." In the relatively small number of complaints that were filed (0.26% of all scheduled trips), "provider late" and "no show" were the most frequent problems (75%– 85%) reported.

The Independent Reviewer's analysis from the consultant's 2019 report, as well as from interviews conducted with families and service providers, concluded that the extremely low percentage of filed complaints does not accurately represent the full scale of what is a vexing transportation reliability issue. The number and percentage of "complaint free" trips is not a valid measure of transportation reliability. Instead, the fact that the vast majority of the complaints that were filed involve reliability issues points to this being the primary transportation problem.

The Independent Reviewer determined in his fifteenth Report that the Commonwealth remained in Non-Compliance with Provision III.C.8.a. for the provision of community transportation services. Although improvements had occurred, the Commonwealth's transportation system for Waiver users had not achieved the relevant six Compliance indicators.

Seventeenth Period Study

The same consultant conducted the latest study of the Commonwealth's transportation for individuals with Waivers. This focused on the Commonwealth's progress toward achieving the six indicators of Compliance for III.C.8.a. (See Appendix D for the complete report).

The consultant found that the Commonwealth had documented results of successful initiatives that met the requirements for three of the six indicators. Documentation of progress toward meeting the remaining three indicators was incomplete, however, and either did not fully align with the requirements of the indicator, or was not provided.

Examples of both the successful initiatives and the documentation that was lacking or not provided are:

1. Compliance Indicator 1 – The Commonwealth met this Indicator. It provided documentation showing it had included performance standards and timeliness requirements in the Medicaid Non-Emergency Medical Transportation (NEMT) and Managed Care contracts, including for those services for the Waiver users. DMAS provided documentation that it took actions, i.e., "reduction in payments" and "fines" to contractors, in response to transportation providers not meeting standards.

2. Compliance Indicator 2 – The Commonwealth did not provide valid information that 86% of users of NEMT transportation received reliable transportation, as required by this Indicator. DMAS did provide data that "complaints are filed," but documentation was for less than 1% of NEMT trips. As mentioned above, the lack of a filed complaint is not a valid measure that reliable transportation was provided. However, a valid measure was agreed to by the Parties for the sixth indicator, which is the opinions of users. The DMAS plan to 'install trip encounter billing' may be a vehicle for measuring most accurately " reliable transportation."

3. Compliance Indicator 3 – The Commonwealth provided documents which confirmed that it achieved the requirements in the three sub-provisions:

a. Waiver users' information is separated from other users to allow DMAS/LogistiCare to identify and target quality improvement initiatives to address these users' priority problems (i.e., no-show or late providers);

b. Waiver users or their representatives have opportunities to participate in the regional Advisory Board; and,

c. For a statistically valid sample of Waiver transportation users, surveys are conducted to assess satisfaction and to identify problems on a quarterly basis.

4. Compliance Indicator 4 – DMAS transportation operations decided to conduct four virtual focus groups during a twelve-month period with the Waiver population receiving NEMT and managed care transportation. This Indicator requires that the purpose of the focus groups is to gather input to identify, discuss, and rectify systemic problems. The first meeting was scheduled to occur on September 23, 2020. Documentation of findings and identification of systemic problems were not available for this study.

5. Compliance Indicator 5 – As required by this Indicator, DMAS provided information in its member handbook regarding its processes for filing complaints or appeals. DMAS also provided information for Medicaid recipients on the DMAS transportation website. On August 8, 2020, information regarding the filing of grievances and appeals was added to its Frequently Asked Questions section.

6. Compliance Indicator 6 – The DBHDS Quality Service Reviews (QSRs) vendor included three assessment questions regarding individuals' problems with transportation. However, the QSR process was not completed during the seventeenth Period. It is not apparent from the three questions exactly how the QSR vendor will establish a reliable finding regarding whether the transportation provided facilitates individuals' participation in community activities and Medicaid services.

Conclusion

Since documentation that demonstrates achievement of three of the Indicators is not yet available, the Commonwealth remains in Non-Compliance with Provision III.C.8.a. for the provision of community transportation services for Medicaid recipients with Waiver services.

5. Regional Support Teams

Background

In 2019, the Independent Reviewer's consultant concluded that the Commonwealth's Regional Support Team (RST) system was still a "work in progress." Despite the RST structure and functions being in place for several years, the Compliance Indicators for the remaining RST Provision (III.D.6.) had not been achieved.

That study confirmed that Virginia had maintained Sustained Compliance with the three RST Provisions that it had previously met. These Provisions included requirements regarding the assignment and use of DBHDS's Community Resource Consultants (III.E.1.), their functioning and authority (III.E.2.), and their role in referring specific types of cases to the RST (III.E.3.). Overall, these Provisions include the clearly defined roles and responsibilities for the RST system's three components: case managers, Community Resource Consultants (CRCs), and the five RSTs. The effective functioning of each component is essential to the RST system fulfilling its purposes and meeting the requirements of the Compliance Indicators, which include outcome measures.

All the consultant's earlier studies found that the requirements of the remaining RST Provision could not be accomplished until all CSBs ensured that their case managers contributed effectively. CSB case managers must consistently adhere to the RST referral protocols and submit referrals with sufficient lead time to allow the RSTs to fulfill their purpose and core functions, which are to:

- Identify, address and resolve barriers and ensure placement in the most integrated setting;
- Redirect individuals to more integrated settings prior to placements in nursing homes, intermediate care facilities and other congregate settings of five or more individuals; and
- Promote quality improvements in discharge planning and the development of community-based services.

For the remaining RST Provision, the Parties established thirteen Indicators that measure the RSTs' performance and their achievement of positive outcomes for individuals. These Indicators require DBHDS to:

- Track referrals for adherence to protocol and timeliness standards;
- Conduct quality reviews;

- Provide technical assistance;
- Hold CSBs accountable;
- Address emergency referrals; and
- Include RST data in provider development activities.

By addressing and achieving these indicators, the Parties believe that each component of the RST system will function effectively, and that the Commonwealth will have addressed and resolved the longstanding obstacles to the RSTs achieving acceptable performance. Doing so is a critical component in achieving the Agreement's goal to ensure individuals receive services in the most integrated setting appropriate to their needs.

It is essential to note that meeting all thirteen Indicators and achieving Compliance will require that Virginia conducts its processes effectively over multiple review cycles. For example, to ensure adherence with the process to hold CSBs accountable, a sequence of actions, each with its own timeline, is required. DBHDS must track CSB case managers' adherence to the RST referral protocol and timeline standards. The Department must conduct related quality reviews and determine whether each of the forty CSBs has adhered to protocols and performance standards over two successive quarters, i.e., a six-month period. When DBHDS identifies that a CSB has failed to meet these standards, it must issue a CAP. If the CSB fails to meet the standards over the twelve-month period following implementation of the CAP, DBHDS will provide technical assistance, remediation, and/or sanctions under its Performance Contract until the CSB fulfills the responsibilities that the Commonwealth has delegated.

In addition to this accountability process, the RST Indicators require DBHDS to incorporate RST data into established provider development processes, to provide emergency Waiver slots, and to complete follow-up activities with individuals who moved to settings with five or more individuals.

Seventeenth Period Study

The Independent Reviewer once again retained the services of the same consultant for this seventeenth Period study, which reviewed the status of the Commonwealth's accomplishments related to all thirteen RST Indicators. (See Appendix D.) This included the longstanding foundational obstacle – some CSBs not submitting referrals consistent with the RST protocol and timeline standards – which had previously effectively nullified the RSTs' ability to fulfill their purpose and essential functions.

The consultant found that for the remaining RST Compliance Indicators for Provision III.D.6., DBHDS has made progress, but continued to fall short of achieving many of the Indicators. Examples of the agency's progress and the obligations that have not yet been met include:

- DBHDS implemented RST process changes and subsequently reported improved percentages (73%–80%) of CSB adherence to the protocols and timeline standards for the third and fourth quarters of Fiscal Year 2020. Such improvements are required to achieve the eighth Indicator. However, to meet the second and fourth Indicators, the Commonwealth must achieve 86% adherence statewide.
- Although DBHDS reported overall progress in moving toward the 86% standard during the fourth quarter, three CSBs consistently failed to meet this benchmark. The fifth, sixth and seventh RST Indicators require DBHDS to hold accountable any CSBs that do not meet the benchmark by issuing CAPs in response to such failures. DBHDS reported, however, that it did not begin to issue CAPs during the seventeenth Review Period, but that it intended to begin doing so in October 2020.
- Compliance Indicator 7 can be achieved only after a full year following a CSB's complete implementation of the CAP, at which time DBHDS must verify that the CSB has achieved the required standards.
- The Independent Reviewer cannot determine the extent to which DBHDS has achieved the required metrics for Compliance Indicators 1, 3, 8, 9, 10 and 13 until the Department reports that it has verified the RST data source as reliable and valid, and that these data demonstrate meeting these Indicators for two successive quarters. DBHDS reported that during a six-month period, there were no individuals with IDD who chose a less integrated residential setting due to the absence of a more integrated setting. Given the well documented lack of provider capacity, especially in rural areas and for individuals with complex needs, the validity of this RST data is open to question.

Conclusion

The Commonwealth has maintained Sustained Compliance with Provisions III.E.1.-3. It has made some improvements in the timeliness of case manager referrals; however, as the examples above demonstrate, it has not yet met the set of Indicators for III.D.6, and consequently has not achieved Compliance with this Provision.

6. Office of Licensing/Office of Human Rights

Background

A year ago, the Independent Reviewer's consultant completed his sixth review of the Office of Licensing (OL) and his fifth review of the Office of Human Rights (OHR). The primary purpose of these reviews was to assess the status of the Commonwealth's Compliance with the Agreement's Quality and Risk Management (QRM) Provisions related to licensing and human rights investigations. These entities, OL and OHR, represent the Commonwealth's primary system for ensuring the basic health, safety and wellbeing of individuals receiving services.

The consultant's 2019 review determined that OL had continued to effectively build and significantly strengthen its management structure and upgrade its internal systems. At that time, OL was assessing the regulatory tools available that it could use to force improvements among providers whose services were substandard, and to eliminate any providers who demonstrated a refusal or inability to improve services.

OL had also been planning and developing needed tools for a new external monitoring system – assessments of adequacy of services – to launch in January 2020. This would be a cornerstone of the QRM system required by the Agreement, and was supposed to be implemented back in 2013. However, at that time, DBHDS realized that it could not do so without first having its licensing regulations revised. Such regulatory changes in Virginia typically require a multi-year process. Eventually, the licensing regulations were revised and so OL planned to implement its new system at the start of this year.

In late 2019, OL was searching for additional, more effective tools beyond those of assigning "provisional status" or "heightened scrutiny" to a license. These would allow OL to hold providers more accountable in meeting performance expectations. The existing license status determinations sometimes result in a provider voluntarily relinquishing their license, but not always. For providers who did not voluntarily relinquish their license, and who were still unable to correct unacceptable practices, additional tools were essential.

For OHR, the consultant's 2019 review confirmed that the office had implemented a semiannual look-behind process for a sample of investigations completed internally by providers across all five Regions. To ensure reliability of findings, OHR added an inter-rater reliability assessment component to the ongoing process. The study confirmed that when the look-behind reviews had

identified problems, DBHDS issued and confirmed implementation of required corrective actions.

The Independent Reviewer reported being encouraged by DBHDS's assignment of additional resources and plans to improve the effectiveness of the monitoring processes put in place by both OL and OHR, and by OL plans to implement assessments of adequacy.

Seventeenth Period Study

The Independent Reviewer retained the same consultant for the latest study. He found that OL and OHR continued to fulfill and sustain past accomplishments and to build on them. These positive consequences are, in large part, due to the cumulative impact of improved system oversight by OL and OHR, particularly their planning and implementation of an OL Regional Manager's role, an OL Incident Management Unit, the OHR look-behind process, and most recently, a new OL look-behind process for serious incidents.

It takes significant time to build new systems or substantially revise old ones so that they consistently adhere to standards and upgraded protocols. For OL, this requires establishing a functioning and effective quality improvement feedback loop that identifies obstacles to improved performance, so that initiatives to address and resolve any problems can be implemented. In some instances, it is clear that OL now has systems in place to provide such feedback; thus, it has met some of the relevant Indicators. However, in other instances, the study could not determine whether OL's corrective actions have yet achieved their intended outcomes and the associated Indicators.

During the seventeenth Review Period, the implementation of proper COVID-19 precautions eliminated all but OL's urgent onsite inspections. The lack of unannounced onsite visits prevented OL from conducting face-to-face interviews with individuals and observations of their settings and interviews with their on-duty staff, reviewing the *Medication Administration Record*, and inspecting the individuals' environment, including any adaptive equipment, bedding, cleanliness, telephones, bathrooms, and so on. Without conducting these onsite inspections and related activities, the Commonwealth could not effectively complete the required assessments of adequacy.

After COVID-19 precautions are no longer warranted, the Commonwealth will once again be able to complete and sustain assessments of adequacy. In the meantime, OL can review and implement any needed improvements to elements of this assessment system, such as ensuring that:

- Checklists are sufficient to assess adequacy and address any found weaknesses;
- Data gathering and reporting meets required elements;
- Assessment data are reliable and valid; and
- A quality improvement feedback loop is fully functioning.

One significant aspect that came to light during this review involved data from cross-tabulation. Virginia found that there may have been up to 10% more serious incidents than were reported through its Computerized Human Rights Information System (CHRIS). The Commonwealth discovered this while cross-tabulating, as required by the associated Indicator, with Medicaid claims data regarding emergency room visits and hospitalizations. Of concern, these additional non-reported incidents were not included in Virginia's failure to report data.

The consultant's study found that OL had newly achieved some Compliance Indicators, but that more progress and documentation is needed to demonstrate meeting others.

Examples of both are described below. (See Appendix D for the consultant's full report.)

- **Failure to report** (V.C.6.)
  1. Compliance Indicators 1 and 4 – The tracking framework that DBHDS implemented for reporting serious incidents through its Computerized Human Rights Information System (CHRIS) is an important and needed improvement. The Commonwealth documented that 89.6% of all serious incidents, including a subset of 93% of deaths were reported in a timely manner within 24 hours. Both percentages continue to exceed the required 86% reporting rate. However, the providers involved in the non-reported emergency room visits and hospitalizations mentioned above were not included in Virginia's tracking or calculations.
  2. Compliance Indicators 2 and 3 – The Commonwealth commendably met these Indicators by cross-tabulating the completeness of CHRIS reports with Medicaid claims during the second quarter of Fiscal Year 2020 for individuals on Virginia's three HCBS Waivers. The cross tabulation established 10% non-reporting versus 90% reporting.
  3. Compliance Indicators 5 and 6 – The consultant's review found that OL had documented, as required, the follow-up by Licensing Specialists. The study also confirmed that OL had verified implementation of corrective action plans. However, OL's follow-up did not confirm that the corrective actions achieved their intended outcomes, as is required. In addition, providers involved in the non-reported serious

incidents mentioned above, which were found by cross-tabulating with Medicaid claims, were not cited or did not have corrective action plans developed and reviewed.

4. Compliance Indicator 7 – Of the providers that OL cited for failure to report serious incidents, 100% were required to complete CAPs. Documentation also showed that OL followed up to ensure that CAPs had been implemented within the required 45- or 90-day time frame, and when providers "failed to correct."
5. Compliance Indicator 8 – DBHDS did not determine whether Training Centers were involved in the non-reported serious incidents, or whether corrective actions were implemented as necessary.

- **Adequacy of Supports** (V.G.3.)

1. Compliance Indicators 1 and 2 – OL developed a checklist, as required, to assess adequacy of supports. This included seven of the eight domains listed in V.D.3., however, DBHDS did not provide data regarding the eighth area, Stability, which is required to meet this Indicator. DBHDS plans to add this data from the current round of Quality Service Reviews (QSRs).

   DBHDS did not determine, though, whether the checklist is sufficient to assess the adequacy of an individual's supports and services. Effectively completing such assessments is a complex undertaking. OL should conduct an evaluation of the checklist to demonstrate that DBHDS is properly implementing this requirement.

   The checklist identifies the applicable regulations and the documentation that OL intends to review, but in most cases does not include the questions that the assessment seeks to answer, nor what answers will lead to a determination that services are adequate. It is the Independent Reviewer's considered opinion that the checklist alone does not describe a full assessment process. For example, the checklist does not ask whether all essential services listed in an individual's ISP are in place, nor does it indicate what will be determined if one is not in place.

   The checklist also does not include a specific evaluation of the adequacy of services related to the heightened risks for individuals with complex medical or behavioral needs. For example, it does not ask if these individuals have experienced a symptom of one of the "fatal five" conditions that frequently lead to the premature death of those with IDD.

Due to COVID-19, OL is conducting the required assessments of adequacy remotely, and these are currently based primarily on a review of service documentation. When it is safe to do so, these assessments will once again include the required in-person components. Although necessarily limited, OL has made a concerted and good faith effort to use the checklist during annual inspections and to conduct meaningful reviews. Even though remote assessments cannot meet the unannounced onsite and in-person requirements for these annual inspections, since implementing use of the checklist, OL's rate of identifying services problems has increased the number of providers being assigned "provisional status" than in previous years.

2. Compliance Indicator 3 – DBHDS has met the requirements of this Indicator. OL informed providers of the documents that it intends to review and use as sources of data and shared a copy of the checklist.
3. Compliance Indicator 4 – DBHDS cannot achieve this Indicator until its summary data is a reliable and sufficient measure of the adequacy of services based on assessments that are conducted during annual inspections that are unannounced, on-site and in-person.

Conclusion

OL and OHR continue to strengthen their operations and make important progress. For Provisions V.C.6. and V.G.3., the Commonwealth has achieved some of the Compliance Indicators, but not all, and so remains in Non-Compliance.

7. Mortality Review

Background

The Independent Reviewer's consultant last conducted a study of the Commonwealth's mortality review process a year ago, during the fifteenth Review Period. The findings from that study confirmed that the Mortality Review Committee (MRC) had significantly improved its data collection, data analysis, membership and attendance, and had improved processes and quality of mortality reviews. In addition, a quality improvement (QI) program had been initiated. However, deficiencies were documented in the timeliness for the completion of reviews and in the attendance of certain members.

Seventeenth Period Study

The Independent Reviewer retained the same consultant for this latest study. The review encompassed the period from September 2019 through July 2020, and focused on the fifteen Compliance Indicators agreed to for Provision V.C.5. These require the Commonwealth to

establish standard operating procedures for conducting mortality reviews, including the structure, membership, and responsibilities of the MRC; the reporting requirements for all DBHDS-licensed providers; the investigation of deaths; the collection, analysis and reporting of mortality data and subsequent findings; the issuance of recommendations based on the analysis of mortality data; the development and implementation of QI initiatives, and the evaluation of the impact of the QI initiatives.

Full implementation of the Compliance Indicators is critically important for the Commonwealth, and its MRC, to achieve the Agreement's stated intent of reducing mortality rates to the fullest extent practicable.

In order to reach his conclusions regarding the status of the Commonwealth's progress toward meeting the associated Indicators, the consultant considered documentation submitted by Virginia and interviewed selected staff. Based on this evidence, he determined the following positive findings:

- Compliance Indicator 1.a.-h – The MRC's Charter includes the requisite components and procedures, and so has met these Indicators. The Charter describes the MRC's standard operating procedures as required. The Charter outlines the MRC members' roles and responsibilities, including use of a multidisciplinary approach that addresses relevant factors and quality of service, identifies risk factors and recommends quality improvement strategies to promote safety, freedom from harm and physical, mental and behavioral health and well-being.
- Compliance Indicator 2.a.-g. – The current MRC membership is consistent with requisite expectations of this Indicator. The role of the MRC Coordinator has been integral to the flow of documentation and the timeliness of the many steps in the MRC process.
- Compliance Indicator 3.a.-d. – As required, the MRC provided the required training on March 26, 2020. All twenty-two members (100%) submitted signed confidentiality agreements.
- Compliance Indicator 4 – The MRC is expected to meet at least monthly. During the period of study, meetings were held twice monthly, except for December 2019, when there was one meeting.
- Compliance Indicator 5 – The information management system tracked all MRC recommendations until completion. The QI initiatives approved by the MRC and Quality Improvement Committee (QIC) were also tracked.

- Compliance Indicator 6 – As required, DBHDS tracked whether licensed providers reported deaths in a timely manner (within 24 hours of discovery) through the incident reporting system. From January 1 through August 31, 2020, there were 446 deaths of individuals with IDD. Timely submission of incident reports occurred for 417 deaths (93%).
- Compliance Indicator 6.a.-c. – DBHDS complied with this Indicator's requirements to review all deaths reported, to begin initial review within twenty-four hours or immediately. DBHDS also achieved the statistical requirement that OL's Investigation Team provide available records and information, and the completed investigation report to the MRC, within forty-five business days of the reported date of death, and for at least 86% of the deaths required to be reviewed by the MRC.
- Compliance Indicator 7.a. and c. – For quality assurance purposes, OL queried the incident reporting system monthly, provided information to the Virginia Board of Health, which then identifies names with a death certificate, and OL investigated all unreported deaths and took appropriate actions.
- Compliance Indicator 8 – The backlog of mortality reviews has been resolved. Its *Fiscal Year 2019 Annual Mortality Report* showed that the MRC achieved completion of mortality reviews of deaths reported to DBHDS within ninety days of the death. Since then, between September 12, 2019, and July 23, 2020, mortality reviews for 118 out of 126 deaths (93.7%) were completed within ninety days.
- Compliance Indicator 9.a. and b. – The required information was provided on each *Mortality Review Form*, or documented as unavailable.
- Compliance Indicator 10 – Two types of reports were prepared: quarterly reports for the QIC, of which the DBHDS Commissioner is a member, and the MRC annual report.
- Compliance Indicator 11.a.i.-iv. – The *Annual Mortality Report* contains substantial valuable information, as required. This included the number and causes of deaths, crude mortality rates of individuals with IDD, the number of individuals who had a Waiver and were receiving a DBHDS-licensed service, by residential setting and the demographic factors (i.e., age, gender, and race).
- Compliance Indicators 11.b. – DBHDS released a summary of findings publicly.
- Compliance Indicators 12, 13 and 14 – The MRC documented recommendations for systemic improvement. These were based on previously identified patterns, e.g., failure to adhere to established protocols, an excess number of deaths categorized as of unknown cause, and difficulty acquiring death certificates. The QIC agendas reflected discussions and approval of some recommended QI initiatives, as well as updates on the status and

planned actions related to previous quality initiatives. The MRC's *SFY 2020 June QIC Report* included two recommendations with more specific, measurable and obtainable goals.

However, the consultant's review also indicated the following concerns that must be addressed:

- Compliance Indicator 7.b. – Prior to MRC meetings, the MRC chair or co-chair determines if deaths are included in Tier 1 or Tier 2 status. Although new legislation allows the MRC access to medical documentation, the information received to determine whether a death is expected, unexpected or unexplained is insufficient. There remain significant concerns regarding the lack of information and the ability of the MRC to accurately interpret limited available information for quality assurance purposes, especially in its expected and preventable categories of death.
- Compliance Indicator 11 – The MRC collects and analyzes data. It has identified trends and implemented QI initiatives. The MRC's category and analysis of "potentially preventable" deaths, however, was not sufficient to guide the MRC to develop QI initiatives to reduce preventable deaths. Specifically, the MRC categorized eleven deaths (4%) as potentially preventable in Fiscal Year 2019 – a decrease from fifty-six deaths (21%) in Fiscal Year 2018. This dramatic decrease appears to result primarily from the MRC modifying its interpretation of its definition of "potentially preventable."
- Compliance Indicator 11.a. – The *Fiscal Year 2019 Annual Mortality Report* was not timely. It should have been available publicly as of December 31, 2019, but was not released until May 2020.
- Compliance Indicator 11.a.v. – Although the cause of death is listed in the *Annual Mortality Report*, the analysis of patterns related to many of the "cardiac" deaths and "respiratory" associated deaths needed further information to determine whether these categories of death were indeed correct. Without this information, many of these deaths should have fallen into the "unknown" category, which was already a substantial category for cause of death. Also, the MRC did not always identify the *underlying* causes of death, as should be done, but instead used the *immediate* causes of death. In addition, the current cause of death categories used by the MRC has changed over time, and is not a standardized list.
- Compliance Indicator 15 – Although there were notable recommendations for QI initiatives, documentation was not provided regarding the methods of dissemination to ensure that "providers, case managers, and other stakeholders are informed of any QI initiatives approved for implementation."

See Appendix E for the consultant's full report.

Conclusion

The Commonwealth made many impressive advances toward fulfilling the requirements of the fifteen Compliance Indicators for V.C.5. However, important challenges remain and further progress is still required, especially in addressing unknown causes of death and revising the criteria used to identify all potentially preventable deaths. Identification of potentially preventable deaths is foundational to determining QI initiatives that fulfill the MRC's purpose of reducing mortality rates to the fullest extent practicable.

Although focused efforts resulted in commendable progress in the seventeenth Review Period, based on the evidence in the consultant's report and the findings drawn from the sources provided, the Commonwealth remains in Non-Compliance with Provision V.C.5.

8. Quality and Risk Management

Background

A year ago, the Independent Reviewer's consultant completed a review of the Commonwealth's Quality and Risk Management (QRM) Provisions. These Provisions require Virginia to develop and implement a QRM 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 to ensure continuous quality improvement."

Overall, the 2019 study found that DBHDS had made progress with regard to designing QRM structures. The *DBHDS Quality Management Plan FY 2020* was in draft form, but it offered promise that once all components had been developed as envisioned, this plan should provide a mechanism for DBHDS to demonstrate proper implementation of these Provisions and their associated Compliance Indicators. However, DBHDS had not yet finalized the many other strategies needed to do so, and were keenly aware of the continuing need to make improvements, and were either engaged in or planning improvement initiatives.

The overall functionality of the DBHDS quality management framework continued to be severely hampered by the lack of valid and reliable data across much of the system. A year earlier, in December 2018, the Independent Reviewer had urged DBHDS to create a comprehensive data QI plan, with specific action steps and milestones, to expand and improve

the quantity and quality of data to measure performance and to provide a structure for greater accountability.

Further, these issues hindered DBHDS staff's ability to complete meaningful analyses of the various data collected and to identify needed QI initiatives. Although its *Data Quality Plan* and *CSB Quality Reviews* (issued April 26, 2019) had provided a good foundation, it also identified data validity and reliability issues with regard to various data source systems. To tie its efforts together, DBHDS still needed to develop a comprehensive and specific data QI plan.

Seventeenth Review Period

The Independent Reviewer retained two consultants, one of whom worked on the 2019 QRM review, to conduct the QRM study for the seventeenth Review Period.

Compliance Indicators for V.C.4.

There are eight Indicators approved by the Court that the Commonwealth must meet to achieve Compliance with Provision V.C.4. This latest study examined the progress DBHDS had made toward achieving these Indicators.

A previous section of this Report describes the significant time required to build new systems or substantially revise old ones so they will consistently adhere to the standards and upgraded protocols. This is especially true for QRM systems, which operate both locally and statewide and depend on effective interfaces with the forty CSBs and hundreds of other service providers. Examples of the Commonwealth's progress, achievements and areas that need to be addressed are outlined below. See Appendix F for the consultants' full report.

- Compliance Indicator 1 – The Commonwealth made excellent progress and has now achieved this Indicator. DBHDS placed significant emphasis on enhancing provider training, as well as on other guidance and resources that the Department had made available to proactively identify and address risks of harm, to conduct root cause analyses, and to develop and monitor corrective actions.
- Compliance Indicator 2 – This requires that the Commonwealth make training and topical resources available to providers. Virginia achieved this Indicator by posting the resources identified in Indicator 1 on its website. Whenever it posts new or revised information, DBHDS sends a notice to all subscribers to its Listserv. Being a subscriber is currently voluntary, however DBHDS is exploring options to expand its subscriber base.

- Compliance Indicators 3 and 4 – DBHDS has made substantial progress, but has not yet achieved all the requirements for these Indicators. These require providers, who are determined to be in Non-Compliance due to lack of training or expertise of staff, or failure to use root cause analyses, to demonstrate that they completed necessary training. However, DBHDS has not had sufficient time to assess and determine that providers have demonstrated they have completed the training.
- Compliance Indicator 5 – The Commonwealth met this Indicator by offering written guidance, with specific content, to providers on how to proactively identify and address risks of harm. In June 2020, DBHDS issued a requirement for use of an *Annual Risk Awareness Tool*. Accompanying the requirement, the Department also issued its *Risk Awareness Tool Instruction and Resource Document* and its *Risk Awareness Tool Process and Planning Training*. These tools include guidance on how to use information from the risk assessment during the annual ISP planning process. This guidance also provides support for integrating the information from the risk assessment tool into the ISP.
- Compliance Indicator 6 – DBHDS achieved the initial, first year requirements of this Indicator by publishing detailed guidance about risks common to individuals with DD. The guidance includes considerations for how to appropriately and adequately monitor, assess and address each risk. The Department also used the data and information from these activities, as required. Examples are listed in the consultants' report of the topics identified and providers that specifically needed technical assistance. This Indicator also specifies minimum requirements for DBHDS's use of the data and information from risk management activities, including mortality reviews. To sustain a determination that it has fully met this Indicator, DBHDS must review the content annually and update it as necessary.
- Compliance Indicators 7 and 8 – DBHDS met these Indicators by issuing various guidance and training on conducting root cause analyses and the applicable changes in the *Licensing Rules and Regulations*. The guidance and training included information regarding assessing serious incidents, conducting root cause analysis and the development and use of corrective action plans.

Conclusion for V.C.4.

The Commonwealth remains in Non-Compliance with Provision V.C.4. However, it has met six of the relevant Indicators and has made significant progress on the other two.

Overview of V.D. Provisions

The consultants' study found that DBHDS continued to place a significant and commendable focus on the issues of data collection, validity and reliability, as required by all the V.D. Provisions.

The Office of Data Quality and Visualization (DQV) implemented a study that delved deeply into issues of data reliability and validity across multiple data source systems. Their *Data Quality Plan* indicated the intent to complete a multi-phase structural assessment of twelve such systems. The first two phases of this were accomplished in late 2019 and early 2020. Overall, these source system assessments were thorough and objective, and they found data reliability concerns across the board. (See Appendix F's Section 4.)

A subsequent study of the DBHDS Data Warehouse, conducted by an independent contractor, identified numerous concerns with this system's architecture and other factors impacting data quality. For example, the contractor's assessment noted that the data quality in the Data Warehouse directly reflected the quality or lack of quality of the data received from the source systems.

In addition, the consultants' study found a lack of comprehensive provenance documentation within the Data Warehouse that led to, or could lead to, data quality concerns.

Most recently, in September 2020, DBHDS released its *Data Quality Monitoring Plan*. Its major findings and recommendations remained consistent with those described above, i.e., many factors contributed to the lack of data reliability, especially the extensive manual processes with inadequate quality control. The lack of reliable data results from two primary sources: the data quality concerns related to system architecture and limited data provenance documentation.

In summary, DBHDS had undertaken an impressive body of work with regard to self-assessing its data quality. Moreover, these self-assessments appeared to be fully objective and honest about the source systems and the lack of reliable data that can be retrieved from them. Without documented data provenance, DBHDS cannot yet demonstrate the reliability of the data produced for its own QRM processes, such as the Regional Quality Councils (RQCs), nor demonstrate achievement of the associated Compliance Indicators.

Compliance Indicators for V.D.1.

The consultants' review examined the extent to which DBHDS operated its Waivers in accordance with the CMS-approved Waiver QI plan, including the review of Waiver performance measures in six domains, known as the Waiver Assurances. The findings related to this Provision's eight Compliance Indicators are:

- Compliance Indicator 1 – The Commonwealth has met this Indicator, which requires implementation of the Quality Improvement Plan (QIP) approved by CMS in the operations of its Waivers. The Commonwealth is continuing to expand and improve the structure and functions of the Regional Quality Councils (RQCs), the Quality Review Committee (QRC) and the Quality Improvement Committee (QIC) related to the development of QI initiatives. The structures and process descriptions outlined in the *Quality Management Plan* appear to accurately reflect current operations.
- Compliance Indicator 2 – In its QI program, the Commonwealth outlined the ten elements of this Indicator and met their requirements. These include the evidence-based discovery activities that will be conducted for each of the six major Waiver assurances.
- Compliance Indicator 3 – The Commonwealth met this Indicator's requirements to establish performance measures that are reviewed and approved by CMS. Its Quality Review Team (QRT), a joint DBHDS and DMAS Committee, monitors and evaluates data related to the established performance measures regarding Waiver administration and operations, level of care, qualified providers, service planning, health and welfare, and financial accountability.
- Compliance Indicator 4 – The Commonwealth has met the metrics of this Indicator. Its performance measures can be found in the published Waivers, cms.gov, and on the DBHDS website.
- Compliance Indicator 5 – The Commonwealth has not met the requirements of this Indicator. The structure and framework for data reporting and analysis is in place, but is currently operating at a basic level. The QRT has not yet expanded their data review and analysis process to include identification and analysis of trends and patterns in the data reported. Much of the data currently being reported on the performance measures continues to lack full and complete data definitions and source descriptions, which make it difficult to establish reliability and validity for each of the indicators.
- Compliance Indicator 6 – The Commonwealth has met this Indicator. Based on the information provided, DMAS is following all reporting and oversight requirements set out in the Waivers.

- Compliance Indicator 7 – The Commonwealth has not met this indicator. As required, the QRT year-end report is available on the DBHDS website for review by CSB QI committees. The report details all performance measures, data collected on each, analysis of the data, and recommended remediation where needed. However, Virginia has not determined that the data source is reliable and valid. In an effort to improve this process for Fiscal Year 2021, a more detailed posting, response and action process has been developed and will be implemented with the posting of the next year-end report.
- Compliance Indicator 8 – The Independent Reviewer cannot verify that the Commonwealth has met this Indicator. The consultants' review of the data sources, data collection processes and data verification procedures related to this performance measure found that Virginia had extended considerable effort to ensure the accuracy of its data. DBHDS staff reported that verification of the accuracy, completeness, and reliability of the data for this measure is outlined in standard operating procedures, but the description of these procedures does not identify the specific information, nor the data collection and methodology at the source where the data were collected. (See the Overview of V.D. Provisions above for the Independent Reviewer's concerns about the reliability and validity of the Commonwealth's data.)

Conclusion for V.D.1.

The Commonwealth has provided information that shows it has met five of the eight Compliance Indicators associated with this Provision. However, for the remaining three Indicators (i.e., 5, 7 and 8), the Independent Reviewer cannot verify that the data used for validation were reliable.

Compliance Indicators for V.D.2.

This Review Period's study examined the extent of progress DBHDS had made toward collecting and analyzing reliable and valid data with regard to availability, accessibility and quality of services, as required by Provision V.D.2.

As described above in the Overview of V.D. Provisions, DBHDS created a required *Data Monitoring Plan*. The version provided at the time of the document request for this study was dated Fall 2019. As the study progressed, a number of ensuing associated reports on data quality and reliability were also provided, including the most recent *Data Monitoring Plan* presented to the QIC in September 2020. The consultants' review found that the Commonwealth had taken organized

steps toward achieving the Indicators for V.D.2. They also found areas, though, where the Commonwealth fell short of the metrics of the associated Indicators.

For example, at the time of this review, DBHDS provided documentation indicating it currently had eight output measures and one outcome measure for the Health, Safety and Well Being domain, five outcome measures for Community Inclusion and Integrated Settings and three output measures and four outcome measures for Provider Competency and Capacity. DBHDS also provided the *Technical Guidance for Measure Development* for use by its staff. This document defined the terms "outcome" and "output" measures in a manner aligned with the relevant Indicators. However, it was not clear that staff had applied the document's guidance in a consistent way with the defined terms.

The consultants' report includes a chart that summarizes current efforts related to the domains and measures as well as the findings related to the eight Compliance Indicators associated with Provision V.D.2.

The consultants determined that the Commonwealth made substantial progress toward meeting these Indicators. However, Compliance Indicator 1 requires that "data sources will not be used for compliance reporting until they have been found to be valid and reliable." Overall, based on the documentation reviewed and interviews with DBHDS staff, the Commonwealth's data sources have not yet been determined to produce reliable data.

Overall, the methodology for implementation of the requirement for Compliance Indicator 8 is still a work in progress. Based on the consultants' interviews with key staff, DBHDS were examining opportunities to use case management functions to identify "the needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided." In particular, DBHDS staff were focusing on how to use data from the Risk Assessment Tool (RAT) and a new onsite assessment tool (i.e., used by case managers to document key facets of face-to-face visits) to flesh out this plan. DBHDS anticipated implementing a pilot of the latter tool in the very near future.

Conclusion for V.D.2.

The Commonwealth provided information that showed it met the first of the eight Compliance Indicators associated with this Provision. However, since Virginia did not determine that its data sources were reliable and valid, and therefore cannot be used for compliance reporting, the Commonwealth has not met the remaining seven Indicators.

Compliance Indicators for V.D.3.

This review examined the progress DBHDS had made developing specific measures for the eight domains in Section V.D.3. and for the Key Performance Areas (KPAs) and related data collection methodologies and sources. It is important to note that the data sources used by the Commonwealth to assert achievement of its Performance Measure Indicators (PMIs) are required, by the Compliance Indicators for V.D.2., to first be confirmed as valid and reliable. However, these data sources have not yet been determined to be reliable.

The findings related to this Provision's six Compliance Indicators are:

- Compliance Indicators 1 and 2 – As required, the *Quality Management Plan (QMP) FY 2020* defines the KPAs and includes their assigned domains in each workgroup charter. The QMP also details the quality committees, workgroups, procedures and processes for ensuring that the committees and/or workgroups establish PMIs and QI initiatives in the KPAs on a continuous and sustainable basis. The Commonwealth has therefore met these Indicators.
- Compliance Indicator 3 – As further described in the consultants' report regarding Provision V.D.2., the KPA Workgroups each established at least one PMI. These PMIs included the requirements a.-f. of this Indicator. Based on the KPA Workgroup and QIC meeting minutes provided for review, the KPA Workgroups analyzed data and monitored for trends on an ongoing basis. They also submitted quarterly reports, including recommendations for quality improvement initiatives to the QIC. However, as already noted above, the Commonwealth's data sources have not yet been found to produce reliable data, so this Indicator has not been achieved.
- Compliance Indicator 4 – The consultants' report includes a chart that depicts Section V.D.3.a.-h. and related measures. The chart summarizes the surveillance data collected for the V.D.3.a.-h. Indicators (see below) as well as for this Indicator 4 of V.D.3. It also provides a summary of the related measures for this Indicator. These measures align with the requirements for this Indicator. However, since the data sources have not yet been determined as reliable, this Indicator has not been met.
- Compliance Indicator 5 – As described above in the Overview of V.D. Provisions, and as required by this Indicator, DQV has been integrally involved in the assessment of data reliability, including assessments of data source systems and the reports produced from the Data Warehouse. DQV staff also developed the *Technical Guidance for Measure*

Development. For newly developed measures that will be active for Fiscal Year 2020 or beyond, DQV staff will work with the measure steward during the measure development process and will provide formal recommendations to improve PMI data quality and reliability that will be incorporated into the PMI documentation. The requirements for this Indicator have therefore been met.

- Compliance Indicator 6 – As required by this Indicator, in the fourth quarter of Fiscal Year 2020 DBHDS issued a *Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2019*. This Report described the accomplishments and barriers for each KPA defined in the Indicator. It was positive that the QIC subcommittees regularly reported updated data and other information with regard to PMIs, including actions taken and proposed. However, the documentation submitted did not evidence the use of the QIC Subcommittee Work Plan. In addition, the information and data were out of date, covering Fiscal Year 2019. During interviews for this Review Period, DBHDS staff provided a draft copy of the Fiscal Year 2020 *Annual Report*, which is projected for release following the first quarter of Fiscal Year 2021. Since this *Annual Report* was just a draft and is not final, this Indicator has not yet been met.

Conclusion for V.D.3.

The Commonwealth provided information that shows it met three of the six Compliance Indicators (1, 2 and 5) associated with this Provision. However, Virginia could not provide evidence that it had determined that its data sources were valid and reliable. Therefore, Indicators 3, 4 and 6 could not be achieved.

Compliance Indicators for V.D.3.a.-h.

The consultants' study examined the progress DBHDS had made in the development and implementation of performance measures and associated surveillance data. The related findings are presented in a chart in Appendix F that is organized by the eight V.D.3.a.-h. Provisions.

Overall, the PMI information available did not always specify how the surveillance data categories met all the minimum requirements of the associated Indicators. These minimum requirements included KPAs that involve "safety and freedom from harm" and "access to services." In addition, the measures used for these and other KPAs depended on data that have not yet been determined to be reliable and valid – namely case management and QSRs, two of DBHDS's oversight systems. Using data that have not been determined reliable undermines the efficacy of "downstream" quality system activities. For example, DBHDS was using available

surveillance data that were not determined reliable to complete the required analyses of trends and patterns, to establish goals and to determine quality improvement initiatives. Also, for the initiatives that have been implemented, DBHDS cannot effectively "monitor progress toward achievement" if baselines were determined with unreliable data.

Conclusion for V.D.3.a.-h.

The Commonwealth has not determined the data for reporting progress on these KPAs, and therefore could not achieve any of the sixteen Indicators for this Provision.

Compliance Indicator for V.D.4.

The consultants' review examined the progress DBHDS had made in the areas of collecting and analyzing data from, at a minimum, the set of thirteen sources prescribed for the single Indicator in this Provision.

While it appeared that DBHDS continued to collect data from all of these sources, based on its internal self-assessments, significant questions remain with regard to the reliability of the data. The descriptions in the consultants' report are based on DQV assessments. They provide a summary of the status of each of the data source systems. In particular, these summaries focus on two issues described in the Overview of V.D. Provisions, i.e., the data quality concerns related to system architecture, as identified in the respective source system assessments, and the status of development of data provenance documentation.

For the *Provider Data Summary*, some data provenance documentation existed while others are still needed. For example, much of the data for the *Provider Data Summary* originated from two reports (i.e., the *Residential Settings Report* and the *Baseline Measurement Tool*). DBHDS staff had data provenance documentation for generating the reports, but did not have that documentation for how to transform the *Baseline Measurement Tool* into the metrics and visualizations for the *Provider Data Summary*.

The Waiver Management System (WaMS) presents another example. While the DBHDS source system assessment documented extensive data validation controls and logic checks in place throughout the system, WaMS interfaces with a variety of other provider supported systems, including the various electronic health records at CSBs. The study found that the insufficient data controls in those external systems were also likely to negatively impact the data quality in WaMS.

Conclusion for V.D.4.

Since the data collected from the thirteen sources listed under this Provision's Indicator have not been determined reliable, the Commonwealth cannot utilize these data sources for compliance reporting.

9. Quality Improvement Programs

Background

Provisions V.E.1.-3. are focused on the requirement that all providers (including Training Centers, CSBs, and other community providers) develop and implement a Quality Improvement (QI) program, including root cause analyses, that is sufficient to identify and address significant service issues. At the time of the last review a year ago, DBHDS had issued emergency regulations that required licensed providers to develop and maintain QI programs. These emergency regulations remained effective until August 2020.

In February 2018, CMS issued an evidence report that the Commonwealth did not demonstrate the assurance for Health and Welfare, based on the fact that DBHDS did not collect and/or provide the required data for four related CMS performance measures. In December 2018, after consultants completed a Quality and Risk Management Systems study, the Independent Reviewer urged DBHDS to create a comprehensive data QI plan, with specific action steps and milestones, to expand and improve the quantity and quality of data to measure performance and to provide a structure for greater accountability of effort.

As reported at that time, DBHDS had recently issued a guidance document (OL's *Guidance for a Quality Improvement Program*) to providers. This guidance indicated that DBHDS did not require a specific template for the QI plan, but provided some additional detail with regard to the six subsections of DBHDS's emergency regulations. This guidance also did not specify that the providers must include reviews of serious incidents as part of their QI programs. In January 2020, this became a requirement of Compliance Indicator 2 for Provision V.E.1.

Seventeenth Period Review

The Independent Reviewer retained two consultants to conduct the QSR study for the seventeenth Review Period.

Their study examined the progress DBHDS had made with regard to requirements for all providers to have QI programs. The findings below are organized by the eleven associated Compliance Indicators for the three Provisions V.E.1.-3.

During this Review Period, DBHDS's Licensing Rules and Regulations were finally approved in August of this year, and OL provided an updated draft, dated September 28, 2020, of its *Guidance for a Quality Improvement Program*.

The Commonwealth's status regarding each of the Provisions and associated Indicators are included in Appendix F.

Compliance Indicators for V.E.1.

Highlights of the study's findings regarding the five Compliance Indicators for this Provision are:

- Compliance Indicators 1 and 2 – DBHDS's Licensing Rules and Regulations that were approved this past August include the requirements of these two Indicators; however, the OL guidance document still does not clearly state a requirement for reviewing serious incidents as part of the QI program. The guidance only included a reference to serious injuries as an example of how a provider might word a measurable objective. The Commonwealth met Indicator 1, but has not achieved Indicator 2. The Independent Reviewer notes that Indicator 3 for Provision V.B. requires the Commonwealth to determine the extent to which these regulatory requirements are met.
- Compliance Indicator 3 – DBHDS achieved this Indicator. Its OL staff determined that 96.93% of the providers inspected from January 1, 2020, through June 30, 2020, had fulfilled the requirements specified in the applicable emergency regulations.
- Compliance Indicator 4 – OL reviewed the status of licensed providers in fulfilling their responsibilities to implement and maintain a QI program required by the DBHDS licensing regulations. Licensing Specialists documented that, for the period January 1, 2020 through June 30, 2020, 75.3% of providers had adhered to the applicable regulation. This did not achieve the 86% metric for this Indicator.

- Compliance Indicator 5 – The Commonwealth provided documentation that it has policies or Departmental Instructions that require Training Centers to have QI programs. These instructions address most but not all of the requirements of this Indicator, e.g., the establishment of facility-wide QI initiatives.

Compliance Indicators for V.E.2.

The consultants' review examined the progress DBHDS had made regarding the requirements for provider reporting, including through their risk management/critical incident and QI programs, of key indicators selected from the relevant domains listed in Section V.D.3.

Highlights of the study's findings regarding the four Compliance Indicators for this Provision are:

- Compliance Indicators 1 and 2 – Some of these Indicators' requirements were met through the implementation of the PMIs. However, DBHDS's development of measures for risks, which are prevalent for individuals with IDD, was at an early stage. In June 2020, members of the Risk Management Review Committee (RMRC) agreed to develop measures related to twelve health conditions.

  DBHDS provided *Data Verification Supplemental* as evidence that these Indicators were met. This document, however, does not include verification of the reliability and validity of the data sources, but it does identify reliability concerns (e.g., quality issues and concerns with CHRIS data, despite recent improvements.)
- Compliance Indicator 2 – The RMRC discussed CHRIS-SIR (Serious Incident Report) data being a source for the numerator and WaMS data for the denominator. RMRC acknowledged that it would need to finalize the measure definitions and work with DQV to validate the data collection methodology. Documentation was not provided to the consultants that these measures were developed and implemented for use during the seventeenth Review Period, nor has DBHDS yet described how the providers' QI programs would report data for the selected measures. DBHDS reported that in June 2020 the QIC approved baseline rates for the risk measures required by this Indicator. Data reliability and validity problems result when baselines are established and rates are calculated for a period before the measure is defined and the data collection methodology is validated.

- Compliance Indicators 3 and 4 – Provider QI programs did not report data for the final risk measures for this Review Period. Documentation was not provided that DQV determined that the data sources were valid and that the measures were well defined, as required. The RMRC indicated in June 2020 that it would seek the assistance of DQV for the risk measures under development.

  The QIC monitored and reviewed PMIs on a quarterly basis, but did not yet have provider-reporting measures for all the required domains. It appeared that the QIC had promulgated procedures that would likely be effective for using available data to identify systemic deficiencies or potential gaps, to issue recommendations, to monitor the measures, and to make revisions to quality improvement initiatives as needed.

The Commonwealth has not achieved the four Indicators for V.E.2.

Compliance Indicators for V.E.3.

The consultants' review examined the progress DBHDS had made with regard to the Commonwealth's use of Quality Service Reviews (QSRs) and other mechanisms to assess the adequacy of providers' QI strategies, and to provide technical assistance and other oversight to providers whose QI strategies the Commonwealth determines to be inadequate.

Highlights of the study's findings regarding the two Compliance Indicators for this Provision are:

- Compliance Indicators 1 and 2 – The new QSR vendor's tools and methodologies address each of the requirements described in Indicator 1.a.-c. for assessment of the adequacy of providers' QI programs. But because the contractor had not completed its first cycle of QSRs during the seventeenth Review Period, data or other findings were not yet available for review to assess the adequacy of providers' QI programs. Therefore, the Commonwealth has not met these Indicators.

  DBHDS provided general training and technical assistance to providers related to the implementation of QI programs. However, the Department did not identify how it would offer technical assistance to individual providers who it determined had been unable to demonstrate adequate QI programs. The document *Internal Protocol for Assessing Compliance with 12 VAC 35-105-620* did not describe actions with regard to technical assistance that DBHDS staff would take after a finding of non-compliance.

In addition, as noted above, DBHDS had only recently resumed the QSR process. While the vendor's methodologies addressed assessment of providers' QI programs and the provision of technical assistance as needed, the implementation of the process had not yet reached this stage.

Conclusion

For Provision V.E.1., the Commonwealth met Indicators 1 and 3, but did not meet 2, 4 and 5. For Provision V.E.2., the Commonwealth did not meet any of the four associated Indicators. For Provision V.E.3., the Commonwealth did not meet either of the two associated Indicators.

10. Regional Quality Councils

Background

Provision V.D.5. and V.D.5.b. establish performance expectations for the Regional Quality Councils (RQCs). The RQCs are required to meet on a quarterly basis to share and assess relevant data, identify trends, and recommend regional QI initiatives. Their work is to be directed by a DBHDS Quality Improvement Committee (QIC).

These Provisions were last studied in 2019 during the fifteenth Review Period. At that time, although the RQCs had the requisite membership and met quarterly to discuss certain data, the data provided for review were limited and frequently unreliable. The lack of reliable and valid data sources and the absence of training tools for the members led to determinations of Non-Compliance.

Seventeenth Period Study

There are eleven Compliance Indicators associated with these two Provisions. They are predicated on continued compliance with the RQC membership requirements delineated in Provision 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." The Indicators require a Charter for the RQCs, quarterly meetings with a defined quorum and the exercise of specific responsibilities to review and evaluate data, trends and monitoring efforts. Additionally, the RQCs are to plan and recommend QI initiatives and submit them to the QIC for approval and oversight of implementation.

Information obtained during this Review Period included the Charter, training materials, and meeting minutes for each of the five RQCs. Interviews were conducted with members of the RQCs in order to obtain their perspectives on the functioning and effectiveness of the RQC.

The Independent Reviewer's consultants first confirmed that the RQC Charter, revised and re-published in September 2020, contained all essential elements agreed to by the Parties. It was noted, however, that information about the structure and delivery of required training for RQC members and alternates is not specifically included and would be helpful to ensure consistent adherence to the delivery of training on an ongoing basis. DBHDS does track the training that is provided to members, and as of October 14, 2020, 94% of RQC members and 91% of the alternates have received the required training.

The membership of the RQCs complies with the requirements of Compliance Indicator V.D.5.b. 1.

Each of the five Regions has convened regular quarterly meetings of their appointed RQC. The RQCs serve as subcommittees to the QIC. Meeting minutes are kept and approved by the members. There was only one meeting, out of twenty in the last year, where a quorum was not achieved. Overall, attendance has been consistently good. Compliance Indicator V.D.5.b. 3 was met.

During the meetings, RQC members discuss the data reports presented by DBHDS staff members assigned to the RQC. RQC members reported that the preparation and presentation of data continues to be an evolving process, as a result of ongoing focused improvement efforts to increase the accuracy and validity of the data presented. However, DBHDS could not verify that the data presented or their sources were reliable, so Indicator 3 of VD.5. was not met.

RQC members also cited greater consistency in the content of the QI initiatives submitted by them for review by the QIC. Each RQC submitted one QI initiative with one measurable outcome to the QIC. The QIC did not approve any of these submissions. Instead, the Committee returned each of the proposed initiatives with comments and instructions for improvement. The most commonly identified instruction was the need to narrow the scope of the initiative to allow reasonable assurance that it could be implemented, and that data could be generated to measure its impact and effectiveness.

This critical element – the analysis, planning and recommendation development responsibilities – continues to evolve and remains at this time at an early stage in development. The RQCs are not yet adequately fulfilling this essential element, which is a prerequisite to the development of effective recommendations for regional QI initiatives. The structured approach utilized by the RQCs should yield improved results and more efficient and effective QI initiative development in the future.

See Appendix F for the full report.

Conclusion

Based on the evidence received and studied for this Review Period, the Independent Reviewer has determined that the Commonwealth has fulfilled the structure and functions required of three of the four Compliance Indicators for V.D.5. – namely 1, 2 and 4.

The accuracy of the data presented by DBHDS was reported by RQC members to be improving. However, since DBHDS has not verified the reliability of the data sources, Virginia has not met the requirements for Indicator 3.

For Provision V.D.5.b., the RQCs also fulfilled the structural and functional requirements, so the Commonwealth achieved Indicators 1, 3, 4, 5 and 6.

It is premature, though, to determine that the Commonwealth has achieved Indicators 2 and 7. For Indicator 2, the RQCs do not yet have data from sources that have been determined reliable and valid; it is not sufficient to base QI recommendations on unreliable data. For Indicator 7, the RQCs are in the early stages of QI development work. Although the RQC structure and functions are in place, the processes associated with each have only recently begun to be utilized. As a result, RQCs are not yet adequately performing the planning and recommendation functions that are essential for the development of effective quality improvement initiatives.

11. Public Reporting

Background

Provision V.D.6. requires the Commonwealth, at least annually, to report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service) and quality of supports and services in the community, and any gaps in services. In addition, Virginia is to make recommendations for improvement. This Provision was last studied a year ago, in the fifteenth Review Period, and the Independent Reviewer determined at that time a finding of Non-Compliance, since any plans for reporting this information publicly had not been implemented.

Seventeenth Study Period

There are four Compliance Indicators for this Provision, each specifying in detail the information to be reported publicly by the Commonwealth. This information includes demographics about the individuals with DD who are served, as well as the capacity of services either provided or available to them. Virginia is expected to publish an *Annual Quality Management Report and Evaluation* that includes reports from various Steering Committees and the RQCs' data regarding performance measures, QI initiatives, and systemic challenges. Other reports, including those related to licensing inspections and investigations, QSRs and the National Core Indicators, are also to be released publicly. Information is to be posted and updated at least annually on the Library website or on the DBHDS website.

For this Review Period, the Independent Reviewer's consultants considered all documentation provided by the Commonwealth and interviewed DBHDS staff about the data and information submitted for review. Virginia launched its Library index of documents, which includes many of the documents required by the Indicators associated with this Provision.

In response to Compliance Indicators 1 and 2, DBHDS published the *Provider Data Summary* in May 2020. Although it covered the required topics in detail, the Summary acknowledged that additional work was still needed to ensure the reliability of all reported data.

In response to Compliance Indicator 3, DBHDS issued a *Quality Management Plan: Annual Report and Evaluation, State Fiscal Year 2019*, which covered the period from July 1, 2018, through June 30, 2019. This report included information and data for all of the topics defined in this Indicator, but was almost a year old when it was made publicly available. Outdated information is not sufficient for providing a status report to the public or for developing actionable quality

improvements. DBHDS staff have already recognized these shortcomings and are planning for their next report for Fiscal Year 2020 to be made available much more quickly, after the close of the first quarter of Fiscal Year 2021.

See Appendix F for the full report.

Conclusion

Based on the evidence provided by the Commonwealth, Virginia remains in Non-Compliance with Provision V.D.6.

12. Provider Training

Background

Provisions V.H.1. and V.H.2. focus on the training and supervision of all staff providing services under this Agreement. For the fifteenth Review Period, the Independent Reviewer's consultant evaluated the Commonwealth's efforts last year to establish and implement a statewide core competency-based training curriculum, as well as its actions to ensure that the statewide training program included adequate coaching and supervision of staff trainees. Although Virginia developed and improved the statewide competency-based curriculum and had emergency Waiver regulations in effect from September 2016 – February 2018 that require both direct support professionals (DSPs) and supervisors who provide Waiver-funded services to receive this training, the Independent Reviewer determined that Virginia was in Non-Compliance. The Commonwealth had not effectively monitored or enforced provider adherence to the requirement that all staff complete the requisite core-competency training, and had determined that providers had not achieved the 95% associated Compliance Indicator measure.

Seventeenth Period Study

The details included in the fifteen Compliance Indicators for V.H.1. and V.H.2. emphasize the importance of specific core competencies across the system as a whole. For example, those delineated for direct support staff and their supervisors require knowledge and performance skills related to the characteristics of developmental disabilities, positive behavioral supports, effective communication, the identification of potential health risks and the aspects of community integration and social inclusion. Further, before a finding of Compliance can be achieved, DSPs and supervisory staff system-wide must meet measurable goals for the achievement of these core competencies.

The Independent Reviewer's two consultants reached their conclusions for this Review Period after examining training curricula, training-related websites, numerous documents provided by the Commonwealth, previous Waiver regulations and recent data submitted by DBHDS and DMAS.

Interviews were conducted with Commonwealth staff, as necessary, to confirm facts or obtain additional information. The consultants' report organizes the facts derived from these sources according to the fifteen associated Compliance Indicators for the two Provisions related to Provider Training.

Compliance Indicators for Provision V.H.1.

Highlights of the study's findings regarding the thirteen Compliance Indicators for this Provision are:

- Compliance Indicator 1 – The consultants determined that commendable progress had been made in addressing the availability of an Orientation Training and Competencies Protocol that communicates Waiver requirements for competency training, testing and observation of DSPs and their supervisors.
- Compliance Indicator 2 – The *Protocol*, revised in March 2020, now covers all essential elements agreed to by the Parties. An implementation schedule for the use of the *Protocol* was published on March 27, 2020. However, it permits provider agencies to either use the revised competencies and *Protocol* immediately or delay implementation of the trainings with all required elements until the revised Waiver regulations are in effect. The Commonwealth expects the Waiver regulations to become effective in the second half of Fiscal Year 2021. (These revised regulations mandate competency-based training specific to health and safety within 180 days of hire.) Until the Waiver regulations are in effect, providers effectively implement all elements required, and the DMAS Quality Management Review process is determined to be adequate to ensure the requirements of this Indicator are achieved, the Commonwealth will not meet this Indicator.

  Notably, DBHDS now requires providers to include information about staff competence and the adequacy of staffing in their risk management plans, and to assess compliance with these requirements at least annually. Documentary evidence of completion of the required training and the successful measurement of staff competencies must be

maintained in personnel files. Evaluation of provider performance is expected as part of the DMAS Quality Management Review process.

- Compliance Indicator 3 – The Commonwealth did not provide performance measure data that demonstrated achievement of this Indicator's requirements: that employees or contractors are accompanied and overseen by other qualified staff and are under direct supervision until competence is observed and documented. The Commonwealth reports that its standard competency observation process will document the required demonstrations, once the Waiver regulations are in effect.
- Compliance Indicator 4 – The Commonwealth has not achieved this Indicator's metric that at least 95% of DSPs and their supervisors receive training and competency testing. DBHDS staff indicate there is no current language in the Waiver regulations that require providers to achieve a specific compliance threshold, nor is there a specific sample size or process for the Commonwealth to measure providers' compliance with this requirement. The compliance threshold is currently set at 86% per CMS requirement. In November 2020, DBHDS anticipated that the measure target in the Provider Summary report and internal tracking would be raised to 95% to align with this Indicator.
- Compliance Indicators 5 and 7 – These require that DBHDS provide specific training and other resources to nurses and behavioral interventionists. The Commonwealth has met these requirements by providing a variety of online opportunities and tools. In addition, five RSTs with experience and expertise in serving individuals with DD and complex behavioral and medical needs are available to provide support and coaching for providers.
- Compliance Indicator 6 – The obligations in this Indicator related to the training of transportation providers have been issued as mandatory requirements. Performance is monitored and failure to comply will result in monetary penalties. The most recent report documented that the transportation provider LogistiCare had been penalized $109,500 for failure to meet the expected performance standards.
- Compliance Indicators 8 through 12 – These focus on DBHDS licensed providers and the personnel who perform clinical duties or interventions as specified in an individual's ISP. In their report, the consultants documented that OL, during its annual inspections, reviewed compliance with competency-based training requirements, including those related to orientation, the administration of medication, behavioral interventions and the implementation of ISPs. The Commonwealth reported compliance with these Indicators as follows:

- Compliance Indicator 8 (orientation to job responsibilities within fifteen business days) – The Commonwealth met this Indicator with 93.19% compliance in 2019 and 93.97% compliance in 2020 (through September). However, it should be noted that the compliance measurements in 2019 were completed through onsite inspections while those for 2020 were completed through remote reviews due to COVID-19 restrictions.
- Compliance Indicator 9 – The Commonwealth achieved this Indicator by requiring through its Licensing Regulations that all employees and contractors demonstrate a working knowledge of the objectives and strategies contained in each individual's ISP. DBHDS reported that it determined that 100% met this standard in 2020 (through September). During the seventeenth Review Period, however, the Mortality Review and Behavioral Programming studies found multiple examples of employees who did not meet this standard. The Mortality Review Committee (MRC) determined that nine out of eleven preventable deaths occurred due to failure to follow established protocols. The Independent Reviewer has not reviewed evidence that the Licensing evaluations (V.B.3.) are sufficient to determine that all employees demonstrate compliance with this regulatory requirement or that it takes action to remedy problems that arise.
- Compliance Indicators 10 and 11 – The Commonwealth did not meet Indicator 10 (administration of medication by non-licensed staff) or Indicator 11 (demonstration of competency in skills related to de-escalation and/or behavioral interventions). There were no performance measure data provided from DMAS's Quality Management Reviews or DBHDS's Licensing Inspections regarding the percentage of employees or contractors who successfully demonstrated competency of this set of skills. Also, no data were provided to verify that such demonstrations occurred under direct supervision, or that these staff performed medication administration tasks only with direct supervision. The Commonwealth did report that, once the DD Waiver regulations are in effect, the standard competency observation process will document the required demonstrations.
- Compliance Indicator 12 (training policies required by DBHDS licensed providers) – Compliance must be documented for at least 86% of these providers. The specific training requirements are included in licensing regulations, and Licensing Specialists monitor compliance through the DD Provider Inspections Checklist. Compliance measurements for 2019 were completed during onsite inspections while those for 2020 were obtained through remote reviews of provider documentation. The overall compliance rate for 2019 was reported as

59.95%. The rate for 2020 was 77.33%. These rates indicate progress but they are below the threshold requirement and, therefore, the Commonwealth did not meet this Indicator.

- Compliance Indicator 13 (review and discussion of citations, including those related to staff qualifications and competencies) – The Commonwealth provided documentation that confirmed that information related to the results of DMAS's Quarterly Management Reviews is shared at the quarterly provider roundtable meetings, as required.

Compliance Indicators for Provision V.H.2.

Of the two Compliance Indicator for Provision V.H.2., the first requires adequate coaching and supervision of staff trainees. DSP supervisors bear the responsibility for this, and must demonstrate competency in providing the service that they are coaching and supervising. On the other hand, the Commonwealth is responsible for ensuring that the DSP supervisors in licensed and non-licensed agencies successfully complete training and testing, and document that they have demonstrated competencies, including supervisor-specific competencies and a working knowledge of the individual's ISP.

The consultants reported that supervisory trainings were completed consistently in the period from July 2019 through June 2020 with a well-defined increasing trend and a twelve-month average of forty-four sessions per month. In June 2020, DBHDS expanded the availability of required training for supervisors through the Commonwealth of Virginia Learning Center. All topics specified in this Compliance Indicator are included. Furthermore, following the release of the expanded training, there was a noted increase in the number of supervisory trainings completed in July (107) and in August 2020 (fifty-three).

Of note, neither the Independent Reviewer nor the Commonwealth has evaluated whether the DMAS QMR and the OL quality assurance processes adequately determine the extent to which these regulatory requirements have been achieved, e.g., whether these oversight mechanisms reliably determine and document the percentage of DSP supervisors who under direct observation have demonstrated competency in providing the services they are coaching and supervising of the required. As noted above, DBHDS determined that 100% of DSP supervisors met the standard of demonstrating a working knowledge of the ISPs of the individuals being served, but consultant studies and the MRC's findings identified examples that appeared to conflict with this determination.

The second and final Compliance Indicator for this Provision requires that support and coaching be made available to DBHDS licensed providers upon request and through a variety of sources. The consultants' report summarizes the resources for support and coaching, including additional website options and statewide meetings. Support and coaching can also be obtained through the five RSTs and through the fourteen Community Resource Consultants.

Conclusion

In summary, there is evidence of considerable effort to meet the requirements of the Compliance Indicators related to Provider Training. The Commonwealth is working diligently to ensure that provider staff are trained in the knowledge and performance competencies required for the exercise of their job responsibilities, including protecting the health, safety and wellbeing of the individuals with DD who are reliant on their support.

For Provision V.H.1., the Commonwealth met Indicators 1,5, 6, 7, 8, 9, and 13. However, there was not sufficient evidence to reliably confirm that the metrics for Indicators 2, 3, 4, 10, 11, and 12 were met. Commendably, the Commonwealth has met both Indicators for developing and making available supervisory training and support and coaching resources, and therefore has achieved Compliance with Provision V.H.2. The adequacy of the DMAS QMR and OL DD Provider Inspections Checklist will be determined under Compliance Indicators 3 and 2 for Provisions V.B. and V.H.1., respectively.

13. Quality Service Reviews

Background

At the time of the previous review in 2019, DBHDS had paused the collection of data from Quality Services Reviews (QSRs). Due to the processes used and lack of qualified reviewers, previously completed QSRs had produced unreliable findings and conclusions. These findings could not be used effectively to identify baselines or trends and patterns that could then highlight areas of needed improvement. DBHDS intended to resume annual QSRs following the conclusion of an RFP process and the selection of a new QSR vendor, which occurred in the spring of this year. This meant that DBHDS did not conduct QSRs in Fiscal Year 2020.

Seventeenth Review Period

The Independent Reviewer retained two consultants to conduct the QSR study for the seventeenth Review Period.

With a new QSR contractor engaged, DBHDS expected that the first round of QSRs, which were already underway when the study began, would conclude by the end of November 2020. As a result, the consultants' findings are based on a review and analysis of documentation, rather than on the completed QSRs and the processing and use of their results.

The documentation reviewed included the minimum and actual qualifications and training required for QSR reviewers, the planned QSR methodology, and the assessment tools. The effectiveness of this documentation, as part of the QSR process currently underway, will be determined in a future study.

Compliance with the Agreement's three QSR Provisions will be achieved when the fourteen associated Compliance Indicators are met. The Commonwealth cannot achieve most of these Indicators until a round of QSRs is completed that includes face-to-face interviews and observations, and the results on the individual, provider and system levels are established and analyzed, findings and conclusions are determined, and quality improvement efforts are implemented and evaluated for efficacy.

The QSR Indicators include requirements that range from the design of the QSR evaluations and the hiring of qualified reviewers through to the evaluation and monitoring of the efficacy of QI initiatives implemented to resolve identified individual, provider and systemic problems.

The Commonwealth's status regarding each of the Provisions and Indicators are included in Appendix F.

<u>Compliance Indicators for Provision V.I.1.</u>

Highlights of the study's findings regarding the four Compliance Indicators for this Provision are:

- Compliance Indicator 1 – The new QSR vendor developed a thorough methodology (i.e., *2020 Quality Services Review Methodology* and *Clinical Assessment Plan)* that was consistent with most of the requirements of this Indicator. However, due to the COVID-19 public health emergency, the contractor could only conduct interviews and observations for this current round of QSRs remotely. Some of these could not be completed, though, due to individuals and families not having access to needed technology. The Independent Reviewer has determined that DBHDS cannot meet this Indicator until each provider's

quality of services is evaluated, and each individual's assessment is conducted onsite and face-to-face.

- Compliance Indicator 2 – The QSR vendor developed and implemented a thorough communication plan prior to conducting this round of QSRs that included participation in DBHDS Provider Roundtables, a series of orientation webinars, and posting the QSR tools, methodologies and other related resources on the DBHDS website. The QSR contractor's methodology detailed a process to ensure privacy for individuals, as required. However, as already mentioned, all interviews for this first round were conducted remotely. Although unavoidable, this inherently compromised the ability of the QSR vendor to ensure adequate privacy for many service recipients. Indicator 2.a. is met, however, 2.b. is not met.
- Compliance Indicators 3 and 4 – The QSR documents appeared to be sufficient to address most of the specified requirements, although this won't be verified until they can be fully applied. The most significant exception was whether the QSR process can adequately address the requirement for providers to access treatment for service recipients "as needed." For the most part, the annual planning assessment tool did not include questions that assess whether the ISP accurately or adequately identified the current needs. Instead, the audit tool started with an assumption that what was reflected in the ISP was a correct and complete identification regarding an individual's needs, rather than a tool to determine whether any needed assessments were needed and not available. These Indicators cannot be met until the assessments of the six requirements of each of these Indicators are completed.

Compliance Indicators for Provision V.I.2.

Highlights of the study's findings regarding the six Compliance Indicators for this Provision are:

- Compliance Indicator 1 – The QSR methodology appeared to be sufficient to adequately address person-centered planning, opportunities for community engagement, supports provided in the most integrated setting, and restrictions of individuals' rights being developed and implemented consistent with approved plans. However, the methodology had gaps in the area of assessing whether individuals' needs would be identified and met. If so, this would undermine the ability of reviewers to adequately assess whether services are responsive to changing needs. This Indicator cannot be met until the assessments of its six requirements are completed.

- Compliance Indicators 2, 3, 4, 5 and 6 – DBHDS had not completed this first round of QSRs during this Review Period. Therefore, the Department did not yet have information to review for the purposes of identifying trends and addressing deficiencies at the provider, CSB, and system-wide levels through QI processes. It also did not yet have information to post for public review, did not yet have summary data to provide to the QIC, or to make referrals based on identified concerns. The QSR contractor's methodology and training did address the expectation that QSR auditors would make such referrals, as appropriate. These Indicators cannot be met until the QSR process has been completed.

Compliance Indicators for Provision V.I.3.

Highlights of the study's findings regarding the four Compliance Indicators for this Provision are:

- Compliance Indicator 1 – The Independent Reviewer had previously communicated that reviewers who conduct the QSRs need to have adequate qualifications and training to either make clinical judgments themselves or to know when to seek and have access to clinical consultants, so that a sufficient clinical evaluation can be ensured. The Independent Reviewer had also previously expressed concern with regard to the QSR vendor's current minimum qualifications for "non-clinical" 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. This latest study found that all of the current QSR reviewers had at least two years of experience in the IDD field. The QSR vendor also provided written assurance to DBHDS that each of its current QSR staff have at least one year of IDD experience. However, DBHDS did not provide an update to the QSR methodology to confirm a continuing commitment to this minimum qualification.

  Based on the material made available for the study, the training content did not appear to be sufficiently comprehensive to prepare front-line reviewers to make the required judgments, especially regarding their ability to identify clinical concerns. Therefore, the adequacy of the competency testing cannot be assessed.

  Because of the lack of sufficient training information, the Independent Reviewer cannot determine whether DBHDS has met the requirements of this Indicator.

- Compliance Indicator 2 – The QSR vendor's planned methodology is consistent with the requirements of this Indicator. However, for this current initial round, based on interviews with DQV staff and a QSR contractor representative, the constraints of the COVID-19 pandemic may impact the QSR vendor's ability to attain a sufficient sample to draw valid conclusions for some provider types. For example, the ongoing closure of many congregate day programs had limited their participation in Waiver services. The QSR contractor's representative interviewed was aware of this issue, but did not yet know the extent to which the sampling sufficiency might be impacted. Until the QSRs have been completed, the Independent Reviewer cannot determine whether DBHDS has met the requirements of this Indicator.
- Compliance Indicator 3 – The QSR contractor's planned methodology does not require a minimum level of specific IDD experience. The Independent Reviewer is concerned that a Team Lead, who could conceivably have no IDD experience, would have responsibility for confirming the competency of front-line non-clinical reviewers, who might also have no such experience. This seems a recipe for a potential lack of reliability of the data collected through the QSR process. While it was positive that the current reviewers and Team Leads had specific IDD experience, DBHDS should ensure that the methodology clarifies a minimum level in that regard. The Independent Reviewer cannot determine whether DBHDS has met the requirements of this Indicator until a round of the QSR and inter-rater reliability processes are completed.
- Compliance Indicator 4 – In many respects, the QSR planned methodology met the criteria for this Indicator. The QSR vendor provided the reviewers with the PCR and PQR audit tools, training and written guidance, including the *QSR PCR Abstraction Companion Guide*. In many cases, the tools provided clear and comprehensive guidance about where to find needed documentation and explained the standards for determining whether an indicator was met or not met. However, as discussed above, some issues remained with regard to inter-rater reliability and whether the indicators provided sufficient data to comprehensively assess if services and supports meet individuals' needs, especially in the area of the identification of unmet clinical needs. The Independent Reviewer cannot determine whether DBHDS has met the requirements of this Indicator until this round of QSRs are completed.

Conclusion

Until a complete round of the QSR process is completed, the Independent Reviewer cannot determine whether the Commonwealth has achieved almost all of the QSR Indicator requirements.

IV. CONCLUSION

During the seventeenth Review Period, the Commonwealth, through its lead agencies DBHDS and DMAS, and their sister agencies, maintained Sustain Compliance with the Provisions of the Agreement that it had previously accomplished. It achieved many of the Compliance Indicators and made substantial progress toward meeting others. It met both Indicators and achieved Compliance for the Provider Training Provision V.H.2. It met many, but not all of the Indicators for the remaining Provisions and, therefore, has not achieved additional new ratings of Compliance.

DBHDS has designed, developed and continued to implement a well-organized project management plan to achieve the Compliance Indicators. The efforts of the Commonwealth's senior managers, subject matter experts and support staff are aligned to resolve obstacles to accomplishing needed progress. Virginia plans to continue this well coordinated approach through the eighteenth Review Period and, with effective implementation, will likely achieve additional Indicators.

While it maintains its concerted efforts, the Commonwealth is fully cognizant of the breadth, depth, and complexity of the remaining challenges to achieving all of the Compliance Indicators by June 2021, the end of the ten-year implementation schedule that the Parties estimated in 2011. Nonetheless, the Independent Reviewer's considered opinion continues to be that not enough time remains for the Commonwealth to complete the sequenced phases needed to achieve all the Indicators. There is also not enough time to demonstrate new systems' durability to achieve Compliance for two consecutive periods, thereby achieving Sustained Compliance. In addition, the COVID-19 pandemic, and all its consequences, will slow the pace at which Virginia is able to achieve Compliance.

The Commonwealth deserves commendation. Its leaders have continued to meet regularly, to communicate effectively and positively with the Independent Reviewer and with DOJ, and to collaborate with stakeholders. Virginia continues to express strong commitment to meeting all the Compliance Indicators associated with the Agreement's remaining Provisions and fulfilling its promises to all the citizens of Virginia, especially to those with IDD and their families.

V. RECOMMENDATIONS

The Independent Reviewer recommends that the Commonwealth undertake the fourteen actions listed in the Provision categories below, and provide a report that addresses these recommendations and their status of implementation by March 31, 2021, unless otherwise noted. The Commonwealth should also consider the additional recommendations and suggestions in the consultants' reports, which are included in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the nineteenth review period (April 1, 2021 – September 30, 2021).

Case Management

1. The Commonwealth should incorporate into its DD Waiver regulations the ten elements required by the Compliance Indicator for case management quality reviews.

Behavioral Supports and Programming

2. The Commonwealth should develop and implement a plan to resolve the existing limited access and availability of adequate and appropriately implemented behavioral services. This plan should ensure that behavioral services provided include the minimum elements required.

Integrated Day Activities and Supported Employment

3. The Commonwealth should collect and report quarterly data to help determine and improve the success of its Community Engagement initiative over time. These data should summarize across urban and rural areas the demographics, successes, barriers, and the average hours of participation in Community Engagement and Community Coaching.
4. The Commonwealth should expand the number and capacity of its Community Engagement providers to meet the associated Compliance Indicators. This process should include reviewing and determining if the pay rates for these services are sufficient.

Transportation

5. The Commonwealth should provide a valid data measure regarding the receipt of NEMT reliable transportation for Waiver users. DMAS should complete implementation, ensure consistent reporting and document reliable transportation using "trip encounter billing."

Mortality Review

6. The MRC should intensify its efforts to collect all available information before each death is reviewed.
7. The MRC should categorize each death based on its underlying cause, rather than its immediate cause.
8. The MRC should use standardized categories of causes of death, such as those in the *International Classification of Diseases* (ICD), specifically ICD-10. This will allow the MRC to compare their data with external sources for more reliable benchmarking and interpretation. Standard categories will provide a useful data set for consistent monitoring of trends and for guiding future recommendations as well as in understanding whether QI initiatives have been effective at reducing mortality rates.

Offices of Licensing and Human Rights

9. DBHDS should evaluate whether its licensing inspections of providers' QI programs are sufficient to identify and address significant issues, including their utilization of root cause analysis and that their QI programs include the review and analysis of serious incidents.
10. DBHDS should evaluate whether the OL Checklist is sufficient to assess the adequacy of individualized supports and services. The evaluation should determine the questions that the Checklist seeks to answer, the answers that are necessary to determine that services are adequate, and the reliability of the Checklist's use by Licensing Specialists.

Quality and Risk Management

12. The Commonwealth should review and specifically determine which of its data source systems provide data that are reliable and valid. This should include the provenance (i.e., how and why) of all data used for compliance reporting.

Provider Training

13. The Commonwealth should consider using its Learning Management System to track providers who access and successfully complete its training modules.
14. The Commonwealth should evaluate and determine whether its DMAS Quality Management Review process is sufficient to ensure that all DSPs and DSP supervisors meet the training, testing and observation, as well as the demonstration of competency requirements of the Agreement.

I. APPENDICES

APPENDIX A

CASE MANAGEMENT

TO: Donald Fletcher

FROM: Ric Zaharia, Ph.D.

RE: Period 17 - Compliance Indicators for Case Management

DATE: 10.20.20

The tables below recap the status of the compliance indicators you assigned to me to review. The key is similar to one you used in your last report:

1. Documentation confirmed (i.e., the Commonwealth's documentation aligns with and reports achievement of the indicator);
2. Pending with date (i.e., the Commonwealth's report aligns and will include the facts required by the indicator, but additional progress or documentation to achieve it is expected by the date specified, and must be Confirmed); or
3. Pending (i.e., no report was provided or those that were provided did not align with the facts required to meet the indicator or to substantiate progress).

I have annotated my comments immediately following the itemization of a document in the 'Evidence available' column' and identified them via parenthesis. All documents should be searchable within the DBHDS Box library.

Beginning in March 2020 through the date of this report COVID restrictions under the Governor's Executive authority have altered all face to face case management visits to individuals which resulted in the use of alternate methods.

Noteworthy among the findings are:

III.C.5.b.i (also V.F.2)

- For the SCQR-FY20, DBHDS reported that 78% of CSBs met 9 of 10 elements. However, SCQR-FY20 data pre-dated finalization of two standard definitions for two elements (appropriate implementation of ISP and assessing for change), including the implementation of an assessment tool, associated training, and look-behind monitoring processes.

III.C.5.d

- **The** CMSC (Case Management Steering Committee) appears seriously focused on building the quality framework for best practice case management. Taking into account the SCQR data shortcomings, it may still be of benefit to utilize the data to formulate general improvement plans.

III.C.6.a.i-iii

- CM training on guidelines to assess behavioral program is planned to occur during Q1-2 FY21;

V.F.4

- Technical assistance to CSBs is planned to occur during Q1-2 FY21;

V.F.5

- The four indicators selected by DBHDS include Choice, Relationships, Change in Status, and ISP Implementation. DBHDS initial data reports show at least 86% compliance with all but Choice. However, the data source is SCQR FY20 which predated definitions and tools related to Change in Status and ISP Implementation.

Table I
Case Management Status 10/20

	Compliance Indicator:	Evidence available to substantiate:
1	**III.C.5.b.i (also for V.F.2)** The following indicators to achieve compliance listed in this provision will also achieve compliance 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 person-centered planning, as set out in CMS waiver regulations (42 C.F.R. § 441.301(c)), are captured in these indicators 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."	**Documentation confirmed:** *Defining Change in Status and ISP Implemented Appropriately, 6.9.20 – (*follows communications between IR and DBHDS) *On-Site Visit Tool, 7.9.20 –* (formalizes CM monthly/quarterly ftf (face-to-face) visits and assessment of change of status/ISP appropriately implemented; (follows dialogue between IR and DBHDS). *On-Site Visit Tool Reference Chart, 6.9.20 –* (provides examples and suggested actions by the CM for change of status or ISP implemented appropriately issues.) *On-Site Visit Tool Q&A, 7.6.20 –* (frequently asked questions about the Tool). *Understanding and Assessing 'Change in Status' and 'ISP implemented appropriately, 8.6.20' –* (power point slides for CM training) *DDS correspondence to CSBs (Heather Norton) re Upcoming Training and Activities, 6.8.20 –* *(*advises CSBs of rationale and training registration for CM On-Site Visit Tool, change in status/ISP implemented) *Proposed Quality Improvement Initiative for CMSC, 8.6.20 –* *(*lays out the plan for successful rollout and implementation of On-Site Review Tool, training and compliance tracking)
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. DBHDS will pull an annual statistically significant stratified statewide sample of	**Documentation confirmed:** *CMSC Performance Monitoring Spreadsheet, 8.6.20 – (*Master tracking log for SCQR ten, RST timeliness, ISP Compliance data) *SCQR Annual Report-FY20, undated*, (9.8.20) *SCQR Retrospective Reviews, and Inter-rater*

	Compliance Indicator:	Evidence available to substantiate:
	individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB. 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 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: •The CSB has offered each person the choice of case manager. (**III.C.5.c**) • The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team. (**III.C.5.b.ii; V.F.2**) • 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. (**III.C.5.b.iii; V.F.2**) • The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences. (**III.C.5.b.ii; V.F.2**) • The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable. (**III.C.5.b.i; III.C.7.b**) • 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. (**III.C.5.b.i; III.C.5.b.ii**) • The ISP includes the necessary services	*Reviews, 11.15.19, (*survey completed in Qualtrics with Transport Layer Security [TLS] encryption-HTTPS; links provided via secure email –Virtu) *SCQR Survey Instrument & Technical Guidance-FY20,undated*,

	Compliance Indicator:	Evidence available to substantiate:
	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. (**III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2**) • Individuals have been offered choice of providers for each service. (**III.C.5.c**) • 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. (**III.C.5.b.iii; V.F.2**) • 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. (**III.C.5.b.iii; V.F.2**)	
3	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.	**Pending 2020-21 CMSC reporting:** *CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20;* *CMSC Semi-Annual Reports, Q1-2 FY19, Q3-4 FY19. Q1-2 FY20, Q3-4 FY20*
4	In this analysis 86% of the records reviewed across the state will be in compliance with a minimum of 9 of the elements assessed in the review.	**Pending 2021 SCQR data:** *SCQR Annual Report-FY20, undated, -* (9.8.20; 78% of CSBs met 9 of 10 elements; however, SCQR-FY20 pre-dated implementation of the two standard definitions, assessment tool, associated training, and look-behind process; sample may have response bias due to the non-responding CSBs and self-reporting bias).
5	In this analysis any individual CSB that has 2 or more records that do not meet 86% compliance with Case Management Quality	**Pending 2020-21 QID technical assistance reporting:** *CSB Case Management DQI Improvement*

	Compliance Indicator:	Evidence available to substantiate:
	Review for two consecutive quarters will receive additional technical assistance provided by DBHDS.	*Reviews-Operational Process, 9.3.20, (*implementation scheduled for Q2, FY21*)* *FY20 Full SCQR Reports by CSB, 8.14.20*
6	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.	**Pending 2020-21 CMSC reporting:** *CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20;*
7	DBHDS, through the Case Management Steering Committee, will ensure that the CSBs receive their case management performance data semi-annually at a minimum.	**Confirmed documentation:** *FY20 Full SCQR Reports by CSB, 8.14.20*
8	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-compliance will be tracked to ensure remediation.	**Pending 2021 corrective actions and incorporation of elements into Regulations:** *CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20;* *Final Licensing Regulations, 12 VAC 35-105-10 to 1410, 8.1.20;* *Three Waiver Redesign- Draft Regulations, 12 VAC 30-120,10.8.20;* *(*one element appears to be missing from these revised regulations: 'strategies on ISP conflicts'; DBHDS/DMAS cite federal regulation (§441.725) which requires state to have a plan for resolving ISP conflicts; suggest all ten be incorporated into *Regulations* as SCQR contents). *CMSC Performance Monitoring Spreadsheet, 8.6.20 –* *(*Master tracking log for SCQR ten, RST timeliness, ISP Compliance data; DBHDS reports that CAPs will not be required until October 2020)
9	**III.C.5.d** The Case Management Steering Committee will review and analyze the Case Management data submitted to	**Pending 2021 SCQR data:** *CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20;*

	Compliance Indicator:	Evidence available to substantiate:
	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).	*CMSC Semi-Annual Reports, Q1-2 FY19, Q3-4 FY19. Q1-2 FY20, Q3-4 FY20* *SCQR Annual Report-FY20, undated*, (9.8.20)
10	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.	**Confirmed documentation:** *CMSC Semi-Annual Report, Q1-2 FY19, Q3-4 FY19. Q1-2 FY20, Q3-4 FY20*
11	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 Supervisory retrospective review, Quality Service Reviews, and Performance Contract Indicator data.	**Pending 2021 CMSC reporting:** *CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20;* *SCQR Annual Report-FY20, undated*, (9.8.20)
12	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.	**Pending 2020-21 CMSC reporting:** *CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20;* *SCQR Annual Report-FY20, undated*, (9.8.20)
13	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….	**Pending QID implementation data and actions 2021:** *CSB Case Management DQI Improvement Reviews-Operational Process, 9.3.20,* (implementation scheduled for Q2, FY21) *SCQR Retrospective Reviews, and Inter-rater Reviews, 11.15.19;* *FY20 Full SCQR Reports by CSB, 8.14.20*
14	The DBHDS central office Quality	**Pending QID 2020-21 reporting:**

	Compliance Indicator:	Evidence available to substantiate:
	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.	*CSB Case Management DQI Improvement Reviews-Operational Process, 9.3.20, (*implementation of visits, completion of electronic form, and measurement are scheduled for Q2, FY21*)* *SCQR Retrospective Reviews, and Inter-rater Reviews, 11.15.19;* *FY20 Full SCQR Reports by CSB, 8.14.20*
15	There will be an ongoing inter-rater reliability process for staff of the DBHDS Quality Improvement Division conducting the retrospective reviews.	**Pending 2020-21 data:** *SCQR Retrospective Reviews, and Inter-rater Reviews, 11.15.19,* *Results from Team [QI] Practice-SCQR, 3.2.20, -* (Inter-rater reliability data within QIC, FY 20)
16	**III.C.6.a.i-iii** 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…..	**Pending 2021 documentation of "practice guidelines" training to CMs:** *Draft Therapeutic Consultation Behavioral Services: Support Coordinator Training, undated – (*8.6.20 power point version includes suggested Minimal Elements and suggestions/examples of what CMs can look for.)
17	DBHDS will implement a quality review and improvement process that tracks authorization for therapeutic consultation services provided by behavior consultants and assesses:….. 5) whether Case Managers are assessing whether behavioral programming is appropriately implemented	**Pending 2021 implementation and improvement data:** *Process Document- Therapeutic Consultation-Behavior Supports, 6.23.20,* (describes a planned look behind process for CMs that includes phone or email queries; requires approval of DD regulations and publication of Practice Guidelines.)
18	**V.F.4** 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. The data regarding the number, type, and frequency of case management contacts will be included in the Case Management	**Pending 2020-21 reporting and plan for ongoing quarterly data review:** *CSB Case Management DQI Improvement Reviews-Operational Process, 9.3.20, -(*implementation scheduled for Q2, FY21; will require assess-ment of adequacy/sufficiency of DQI technical assistance; plan for continuing quarterly sampling of contact data is not clear *)*

	Compliance Indicator:	Evidence available to substantiate:
	Steering Committee data review. Recommendations to address non-compliance 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.	*SCQR Retrospective Reviews, and Inter-rater Reviews, 11.15.19,* *CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20;* *CMSC Semi-Annual Report, Q1-2 FY19, Q3-4 FY19. Q1-2 FY20, Q3-4 FY20*
19	**V.F.5** The Case Management Steering Committee will establish two indicators in each of the areas of health and safety and community integration associated with selected domains in V.D.3 and based on its review of the data submitted from case management monitoring processes. Data indicates 86% compliance with the four indicators.	**Pending CMSC data on four SCQR-FY21 indicators:** *PMI –implemented appropriately, 6.15.20, (*Q3, FY20=95%) *PMI -change in status, 6.15.20, (*Q3 FY20=96%) *PMI - choice, 6.15.20,* (Q3, FY20=82%) *PMI -relationships, 6.15.20, (*Q3, FY20=88%) (These metrics are based on the SCQR-FY20 data, which pre-dated finalization of the standard definitions for 'ISP implemented appropriately' and 'change of status'.

APPENDIX B

BEHAVIORAL SUPPORTS AND PROGRAMMING

By

Patrick F. Heick, Ph.D., BCBA-D, LABA,

To: Donald J. Fletcher

From: Patrick F. Heick, Ph.D., BCBA-D, LABA, Manager, PFHConsulting, LLC

RE: UNITED STATES v. VIRGINIA, CIVIL ACTION NO. 3:12cv59-JAG

Date: November 12, 2020

Introduction

The current report, including the following *Summary* and *Addendum,* was prepared and submitted in response to the Independent Reviewer's request for a study, as part of the seventeenth Review Period, to examine the Commonwealth of Virginia's implementation of the Settlement Agreement (SA) as it pertains to the behavior supports in the home. The study was designed to specifically examine two Compliance Indicators (CI) under provision III.C.a.i-iii – these included:

- *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.**
- *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.*

* NOTE: The current study was not designed to examine the first indicator (listed above) in its entirety. More specifically, elements relative to 'trauma informed care' and 'person-centered practices' were not specifically examined.

Overall, the study examined the behavioral programming currently in place for a sample of individuals who were randomly selected from the 134 individuals with Service Eligibility Assessment level 7 needs who were included in the Person Centered Review (PCR) portion of the Commonwealth of Virginia's Department of Behavioral Health and Developmental Services (DBHDS) Quality Service Review (QSR) study. These individuals have been identified as those who were at significant risk (i.e., "Support level 7") due to the nature of their challenging behavior. As noted above, the current study examined whether or not the above Compliance Indicators were being met within this selected sample. As detailed below, the current study utilized specific methodology, including a Monitoring Questionnaire, to review the provision of needed behavioral support services. In addition, the current study aimed to examine its findings compared to findings of the larger QSR study of individuals with similar needs in order to

confirm the adequacy of the clinical judgments of non-clinical QSR auditors. Ultimately, the study aimed to determine whether or not the sampled individuals had access to behavioral programming as necessary, had behavioral programming services modified as necessary, and had behavioral needs met as necessary.

Methodology

The following Summary, including findings and related data summaries, is based upon the reviews of the behavioral services for 40 individuals (13 females and 27 males), including 11 individuals under 22 years of age. These reviews compared the behavioral programming and supports that are currently reported to be in place with generally accepted standards and practice recommendations with regard to components of effective behavioral programming and supports – these components included: level of need; Functional Behavior Assessment (FBA); Behavioral Support Plan (BSP) including targeted behaviors for decrease and functionally equivalent behaviors for increase; care provider and/or staff training; ongoing data collection, including regular summary and analysis; and, revision of programming, as necessary. It should be noted that the Reviewer does not intend to offer these components as reflective of an exhaustive listing of essential elements of behavioral programming and supports. Furthermore, these reviews were based on the understanding that all existing documents were provided in response to the Independent Reviewer's initial and/or subsequent request.

This Summary is submitted in addition to the Demographic and Behavioral Sections of the Individual Services Review Monitoring Questionnaires (Attachment 2) that were completed for each of the individuals sampled as well as Data Summaries (Attachment 1). The ISR Monitoring Questionnaires were submitted separately and under seal as they contain private health information. It should be noted that the following Summary and Data Summaries within the Addenda are based upon the ISR study's Monitoring Questionnaires which were completed using provided information during off-site reviews, including review of available documentation provided in response to the Independent Reviewer's document request (Attachment 3) as well as one or more phone calls with care providers and others, as available, as identified on the contact information request (Attachment 4). It should be noted that questions on the MQ referencing

whether or not an item (e.g., FBA, BSP) was completed was only endorsed (i.e., 'Yes' or '1') if the actual document was provided for review. It should also be noted that questions on the MQ examining elements of the FBA and BSP were answered only using content within the FBA and/or BSP, as provided.

Summary

Findings

1. Based on a review of the completed individuals' service records and other provided documentation as well as the completed ISR Monitoring Questionnaire, nearly all of the individuals sampled demonstrated maladaptive behaviors that had unsafe and/or disruptive consequences to themselves and their households, including negative impacts on their ability to access their communities, to learn new skills, to become more independent and/or the quality of their lives. Meeting these criteria is a strong indication that these individuals would likely benefit from formal behavioral programming (or other therapeutic supports) implemented within their homes or residential programs. More specifically, of those sampled, 37 (93%) engaged in behaviors that could result in injury to self or others, 34 (85%) engaged in behaviors that disrupt the environment, and 31(78%) engaged in behaviors that impeded his or her ability to access a wide range of environments (see Figure 1). In addition, of those sampled, 28 (70%) engaged in behaviors that impeded their ability to learn new skills or generalize already learned skills. Overall, 35 (88%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence. Consequently, it appeared that the majority of the individuals sampled would likely benefit from behavioral programming or other therapeutic supports.

2. Although it was found that the majority of sampled individuals would likely benefit from behavioral programming or other therapeutic supports given their identified needs, of those sampled, only 11 (28%) individuals were receiving behavioral programming through the implementation of comprehensive Behavior Support Plans (BSPs) in their homes. Note: this total was determined using receipt of the BSP. This finding underestimates the actual number of BSPs currently implemented as several BSPs were not provided for review and, consequently, were not included in the current data analysis. More specifically, based on verbal reports and/or other available documentation, it appeared that six (15%) additional individuals likely had BSPs

currently implemented at home (see Figure 2). Nonetheless, the estimated 17 (43%) BSPs currently in place likely does not reflect an adequate provision of behavioral support given the level of need reported for a majority of sampled individuals as evidenced by scores on items in Section 2 of the MQ (see Figure 1). In addition to these scores, informant reports and additional information further supported the need for behavioral services for those without BSPs. For example, behavioral services were recently requested or initiated for four individuals (i.e., Individuals #18, #33, #38, & #40) and informants for two others (i.e., Individuals #19 & #39) expressed interest in pursuing behavioral support. And, given the nature of the behavior displayed and/or interventions currently in place, the reviewer believed additional support was needed for at least four more of those sampled (i.e., Individuals #2, #6, #20 & #23). It should be noted that three individuals (i.e., Individuals #12, #28, & #30) reportedly displayed minimal maladaptive behaviors not requiring behavioral support and two others (i.e., Individuals #1 & #36) appeared successful with minimal school-based strategies and supports in their homes. Overall, in addition to the estimated 17 (43%) individuals with BSPs currently in place, it was also estimated that at least another 10 (25%) individuals within the current sample needed comprehensive behavioral programming.

3. As noted above, of the 40 individuals sampled, 11 (28%) individuals had BSPs. Of these 11, only seven (64%) individuals had a BSP that was considered current (i.e., implemented or updated within the last 12 months). In addition, only five (45%) individuals had a BSP that was currently overseen by the author or other similarly qualified clinician. Lastly, of the 11 BSPs, eight (73%) were developed by a Board Certified Behavior Analyst (BCBA) or Positive Behavior Support Facilitator (see Figure 3). The BCBA is the nationally accepted certification for practitioners of applied behavior analysis. This certification is granted by the Behavior Analyst Certification Board (BACB), a nonprofit corporation established to develop, promote, and implement a national and international certification program for behavior analyst practitioners. In Virginia, the PBSF is an endorsement given to practitioners who have completed DBHDS/VCU sponsored training in positive behavior support.

4. As noted above, of the 40 individuals sampled, 11 (28%) individuals had BSPs that were included in the current study. Of these 11, eight (73%) had a Functional Behavior Assessment (FBA) completed (See Figure 4). Generally accepted practice involves the completion of a comprehensive FBA in order to identify potential underlying function(s) of target behaviors and inform the selection of function-based interventions when developing a BSP. Consequently, not

completing an FBA to inform the development of a BSP, as evidenced for three (27%) individuals, likely limits the probability of developing an effective BSP.

5. Of the eight individuals with FBAs, only four (50%) had an FBA that was considered current (i.e., completed or updated within the last 12 months) and only six (75%) were completed in the current setting (see Figure 5). In addition, of the eight FBAs, only six (75%) were conducted by a BCBA or Positive Behavior Support Facilitator. Although nearly all of FBAs included the identification of antecedents and consequences as well as a proposed a hypothesis of underlying function(s) of behavior, only six (75%) utilized direct methods of assessment and identified setting events. It should be noted that the provided description of FBA methods (noted within the BSP) was so limited that several elements of the MQ could not be scored for one individual.

6. Upon closer examination of the BSPs, it was noted that prescribed behavioral programming appeared inadequate for the majority of reviewed BSPs (see MQs for specific details). For example, target behaviors (for decrease) and functionally equivalent replacement behaviors (for increase) were only adequately identified and defined in six (55%) and four (36%) BSPs, respectively (see Figure 6). And, although all (100%) and nearly all (91%) of the BSPs identified antecedent- and consequence-based strategies, respectively, only eight (73%) included skill acquisition strategies aimed at promoting functionally equivalent or alternative behaviors. The prescribed adequate provision of positive reinforcement as well as interventions that appeared to be least restrictive and/or most appropriate were identified in six (55%) and seven (64%) BSPs, respectively. Lastly, BSPs only specified data collection and review expectations as well as prescribed evidence-based staff training methods in two (18%) and two (18%), respectively, of those reviewed. Overall, only three (27%) BSPs had all (i.e., Individual #31) or nearly all (i.e., Individuals #13 & #22) of the typical elements of generally accepted practice targeted by the MQ. It should be noted that staff from DBHDS pointed out that some of the elements noted above were described in documentation (e.g., Part V Plan for Supports) other than the BSP for Individual #22 and Individual #16. As detailed previously, only the BSP was used when scoring MQ items noted above.

7. Evidence that support staff had successfully completed competency-based training (on the BSP) was provided for zero (0%) of the 11 individuals with BSPs (see Figure 7). In addition, evidence that data on all target behaviors (for decrease) and functionally equivalent replacement behaviors

(for increase) had been adequately summarized and regularly reviewed was found for only two (18%) of the BSPs.

8. Based on verbal report from the Independent Reviewer, the Practice Guidelines (i.e., on the minimum elements that constitute an adequately designed behavioral program and use of positive behavior support practices), based on the approved DD waiver regulations, had not yet been developed and disseminated by the Commonwealth at the time of the current study. In addition, summarized results and findings of the QSR study had similarly not been completed and disseminated. Consequently, requested Practice Guidelines, summarized results of the QSR study for sampled individuals, and notes completed by QSR reviewers were not received and available for inclusion in the current study. Consequently, the current study was not able to make anticipated comparisons to the findings of the QSR study as initially planned.

9. As previously noted, in addition to the 11 BSPs reviewed above, six additional BSPs were likely implemented in the homes of sampled individuals; however, these plans were not available for review and, consequently, not examined within the current study. It should be noted that many of the BSPs that were received were provided following a second request. The absence of these plans as well as other requested documentation was concerning to the reviewers. That is, in addition to the missing documentation already reviewed, other requested documentation was either not provided or appeared outdated. The inadequate provision of current Individual Support Plans (ISPs) is a primary example. More specifically, although current ISPs were requested for all sampled individuals, ISPs were provided for 38 (95%) individuals and, of these, only 15 (39%) were current at the time of the study (see Figure 8).

Conclusions – Primary Areas of Concern:

1. Due to the unavailability of requested documentation, the current study was unable to fully examine the nature of the behavioral supports and services that were currently in place for a number of individuals sampled. Consequently, the findings of the current study are limited and incomplete. Learning from the study and generalizing its findings with a high level of confidence to all of the individuals within the cohort is limited as well.

2. The majority of individuals sampled demonstrated unsafe behavior that placed themselves and/or others at risk. In addition, most individuals displayed disruptive and/or other behaviors that limited their ability to access diverse community settings and their ability to learn new skills. Overall, the majority of individuals engaged in behaviors that negatively impacted their quality of life and greater independence.

3. Overall, the majority of BSPs were found to be inadequate. That is, only three had all or nearly all of the requisite elements identified within the MQ. Indeed, four of the BSPs examined had adequately included less than half of the requisite elements. As noted above, the Reviewer found, for example, that four were outdated and six were currently implemented without the oversight of the author or similarly qualified clinician. In addition, most BSPs did not adequately identify and define functionally equivalent replacement behaviors and prescribe related data collection and review procedures. Finally, evidence of adequate staff training of the BSP and data collection was provided for none and two of the BSPs, respectively.

4. Three BSPs appeared to be developed without the completion of an FBA. Of the FBAs examined, only three had all or nearly all of the elements examined. It should be noted that the provided description of FBA methods (i.e., as noted within the corresponding BSP) was so limited that several elements of the MQ could not be scored for one individual.

5. Behavioral programming did not meet standards of generally accepted practice for the majority of sampled individuals with BSPs currently implemented within their homes.

6. Given that the majority of individuals who demonstrated a need for formal behavioral programming and the number of BSPs currently implemented, it was evident that not all sampled

individuals who needed access to behavioral programming were currently receiving necessary behavioral supports and services.

7. The current study was not able to make anticipated comparisons to the findings of the QSR study in order to confirm the adequacy of the clinical judgments of non-clinical QSR auditors regarding whether these same individuals behavioral needs were met.

Respectfully submitted by,

Patrick F. Heick, Ph.D., BCBA-D, LABA
Manager, PFHConsulting, LLC

Attachment 1

Data Summaries:

Figure 1

Name	item 1	item 2	item 3	item 4	item 5
38	1	1	1	1	1
33	1	1	1	1	1
9	1	1	1	1	1
24	1	1	0	0	1
37	1	0	1	0	1
14	1	1	1	1	1
22	1	1	1	1	1
16	1	1	1	1	1
34	1	1	1	1	1
7	1	1	1	1	1
25	1	1	1	1	1
17	1	1	1	1	1
6	1	1	1	0	1
11	1	1	0	1	1
31	1	1	1	0	1
27	1	1	1	1	1
1	1	1	1	1	1
39	1	1	1	0	1
35	1	0	1	1	1
20	1	1	1	1	1
10	1	1	1	1	1
28	0	0	0	0	0
4	1	1	0	0	0
8	1	1	1	1	1
15	1	0	0	0	0
26	0	1	1	0	1
30	1	0	0	0	0
23	1	1	1	1	1
12	0	0	0	0	0
18	1	1	1	0	1
29	1	1	0	1	1
40	1	1	1	1	1
2	1	1	1	1	1

21	1	1	1	1	1
13	1	1	1	1	1
32	1	1	0	1	1
5	1	1	1	1	1
36	1	1	1	1	1
3	1	1	1	1	1
19	1	1	1	1	1
total (N=40)	37	34	31	28	35
percentage	93%	85%	78%	70%	88%

Figure 2

	BSP	***Receipt***	
Name	***in place?***	***yes***	***no***
38	0	0	0
33	0	0	0
9	0	0	0
24	0	0	0
37	1	1	0
14	0	0	0
22	1	1	0
16	1	1	0
34	1	1	0
7	1	0	1
25	1	0	1
17	1	0	1
6	0	0	0
11	1	1	0
31	1	1	0
27	1	0	1
1	0	0	0
39	0	0	0
35	0	0	0
20	0	0	0
10	0	0	0
28	0	0	0
4	1	0	1
8	1	1	0

15	1	0	1
26	0	0	0
30	0	0	0
23	0	0	0
12	0	0	0
18	0	0	0
29	0	0	0
40	0	0	0
2	0	0	0
21	1	1	0
13	1	1	0
32	0	0	0
5	1	1	0
36	0	0	0
3	1	1	0
19	0	0	0
total (N=40)	17	11	6
percentage	43%	28%	15%

Figure 3

	BSP	***Current***	***Setting***	***BCBA or PBSF***	***Overseen by Clinician***
name	**item 7**	**item 7a**	**item 7b**	**item 7c**	**item 7d**
37	1	1	1	1	0
22	1	1	1	1	1
16	1	1	1	1	1
34	1	0	1	0	0
11	1	1	1	1	0
31	1	1	1	1	1
8	1	0	1	1	0
21	1	1	1	0	0
13	1	0	1	1	1
5	1	1	1	0	1
3	1	0	1	1	0
total (N=11)	11	7	11	8	5
percentage	100%	64%	100%	73%	45%

Figure 4	**BSP**	**FBA**
name	**item 7**	**item 6**
37	1	0
22	1	0
16	1	1
34	1	0
11	1	1
31	1	1
8	1	1
21	1	1
13	1	1
5	1	1
3	1	1
total (N=11)	11	8
percentage	100%	73%

Figure 5

	FBA	*Current*	*Setting*	*BCBA or PBSF*	*Direct Methods*	*Setting Events*	*As*	*Cs*	*hypoth*
name	**item 6**	**item 6a**	**item 6b**	**item 6c**	**item 6d**	**item 6e**	**item 6f**	**item 6g**	**item 6h**
16	1	1	1	1	1	1	1	1	1
11	1	1	1	1	1	1	1	1	1
31	1	0	0	1	1	1	1	1	1
8	1	0	1	1	1	1	1	1	1
21	1	1	1	0	1	1	1	1	1
13	1	0	1	1	0	1	1	1	1
5	1	1	1	0	1	0	1	1	0
3	1	0	cnd	1	0	cnd	cnd	cnd	1
total (N=8)	8	4	6	6	6	6	7	7	7
percentage	100%	50%	75%	75%	75%	75%	88%	88%	88%

Figure 6

	target behavior	*FERB*	*As*	*Cs*	*skill acq strategy*	*SR+*	*least*	*data*	*training*
name	***item 7e***	***item 7f***	***item 7g***	***item 7h***	***item 7i***	***item 7j***	***item 7k***	***item 7l***	***item 7m***
37	0	0	1	0	0	0	1	0	0
22	1	1	1	1	1	1	1	0	0
16	0	0	1	1	1	1	1	0	0
34	0	0	1	1	0	0	0	0	0
11	0	0	1	1	1	0	0	0	0
31	1	1	1	1	1	1	1	1	1
8	1	0	1	1	1	1	1	0	0
21	1	0	1	1	1	1	0	0	0
13	1	1	1	1	1	1	1	0	1
5	0	0	1	1	0	0	0	1	0
3	1	1	1	1	1	0	1	0	0
total (N=11)	6	4	11	10	8	6	7	2	2
percentage	55%	36%	100%	91%	73%	55%	64%	18%	18%

Figure 7

	training	*data*
name	***item 8***	***item 10***
37	0	0
22	0	1
16	0	0
34	0	0
11	0	0
31	0	1
8	0	0
21	0	0
13	0	0
5	0	0
3	0	0
total (N=11)	0	2
percentage	0%	18%

Figure 8

	ISP	
Name	***Received***	***Current***
38	1	1
33	1	1
9	1	1
24	1	0
37	0	0
14	1	1
22	1	1
16	1	0
34	1	1
7	1	1
25	1	0
17	1	1
6	1	0
11	1	0

31	1	0
27	1	1
1	1	0
39	1	1
35	1	0
20	1	0
10	1	0
28	1	1
4	1	1
8	1	0
15	1	0
26	1	1
30	1	0
23	0	0
12	1	0
18	1	0
29	1	0
40	1	0
2	1	1
21	1	0
13	1	0
32	1	0
5	1	0
36	1	1
3	1	0
19	1	0
total (N=40)	38	15
percentage	95%	38%

Attachment 2

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

SECTION 1: DEMOGRAPHICS

1. **Individual's Name**:

2. **Age Range**:

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

3. **Gender**: ☐ Male ☐ Female

4. **Residential Provider**:

5. **Address**:

6. **Telephone Number**:

7. **Type of Residence**:

   ☐ Family/Own Home
   ☐ Sponsor Home
   ☐ Supported Apartment
   ☐ Group Home
   ☐ ICF
   ☐ Other (please specify):

8. **Documents Reviewed**:

9. **Phone Interviews Conducted**:

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

SECTION 2: Need for Behavioral Support

1.	Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
2.	Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
3.	Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
4.	Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
5.	Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No

SECTION 3: Nature of Behavioral Support

6.	Was there evidence that an FBA was completed?	☐Yes ☐No
	If yes:	
	a. Was the FBA developed or updated within the last 12 months?	☐Yes ☐No
	b. Was the FBA completed in the current setting?	☐Yes ☐No
	c. Was the FBA completed by a Licensed Behavior Analyst or a Positive Behavior Support Facilitator?	☐Yes ☐No
	d. Were direct methods of assessment utilized when conducting the FBA?	☐Yes ☐No
	e. Were potential setting events identified?	☐Yes ☐No
	f. Were potential antecedents identified?	☐Yes ☐No
	g. Were potential consequences identified?	☐Yes ☐No
	h. Was the proposed hypothesis of function(s) of behavior identified?	☐Yes ☐No

7.	Was there evidence that a BSP was completed and implemented?	☐Yes ☐No
	If yes:	
	a. Was the BSP developed (or updated) within the last 12 months?	☐Yes ☐No
	b. Was the BSP developed for the current setting?	☐Yes ☐No
	c. Was the BSP developed by a Licensed Behavior Analyst or a Positive Behavior Support Facilitator?	☐Yes ☐No
	d. Is the BSP currently overseen by the author or similarly trained clinician?	☐Yes ☐No
	e. Were all target behaviors for decrease adequately identified and defined?	☐Yes ☐No
	f. Were all the target behaviors (i.e., functionally equivalent replacement behaviors or adaptive alternative behaviors) for increase adequately identified and defined?	☐Yes ☐No
	g. Were preventative, proactive and/or antecedent-based strategies identified?	☐Yes ☐No
	h. Were consequence-based strategies identified?	

	i. Were strategies to promote skill acquisition of functionally equivalent replacement or alternative adaptive behaviors identified?	☐Yes ☐No ☐Yes ☐No
	j. Was there adequate provision of positive reinforcement?	☐Yes ☐No
	k. Do interventions appear to be least intrusive/restrictive and/or most appropriate?	☐Yes ☐No
	l. Does the plan specify the data (for targets for increase and decrease) to be collected as well as prescribe when data will be summarized, displayed, and reviewed?	☐Yes ☐No
	m. Was there a description of prescribed staff training, including the identification of evidence-based methods (e.g., behavior skills training).	☐Yes ☐No

SECTION 4: Training & Monitoring

8.	Was there evidence (documentation) that staff or family members who support the individual successfully completed competency-based training on the current BSP within the last year?	☐Yes ☐No ☐NA
9.	Did verbal reports from family or care providers indicate that the Behavior Support Plan was implemented with a high degree of fidelity?	☐Yes ☐No ☐NA
10.	Was there evidence (documentation) that data on all target behaviors for increase and decrease had been adequately collected, summarized, and regularly reviewed (at least monthly) by a clinician?	☐Yes ☐No ☐NA
11.	Were necessary changes made to the BSP, as appropriate?	☐Yes ☐No ☐NA

REVIEWER'S NOTES

ISSUES

Reviewer's Name / Title:

Date(s) of Review:

Attachment 3

Document Request

The following documents will be obtained, organized and made electronically accessible to the current study's author and other reviewer(s):

- Practice Guidelines developed by the Commonwealth (on the minimum elements that constitute an adequately designed behavioral program and use of positive behavior support practices)
- Summarized results and findings for the selected individual and documentation related to the QSR study

For each selected individual:

- The Service Eligibility Assessment (e.g., SIS) which placed the individual in level 7 for the QSRs.
- Current Individual Support Plan (ISP) (including Section V for any provider involved with participating in the delivery of behavioral supports)
- Current Functional Behavior Assessment (FBA)
- Current Plan for Supports (aka Behavior Support Plan, Behavior Intervention Plan, Positive Behavior Support Plan, or similar)
- Behavior related training documentation relative to the current plan for supports (i.e., to evidence training provided to family members or providers, and their supervisors who are providing behavior programming)
- Copy of a current blank data sheet (i.e., used to track behaviors targeted in the plan for supports)
- Data for target behavior (behavior to decrease) and replacement behavior (behavior to increase) for the last three months
- Data summaries (e.g., monthly) and/or graphed data and analysis (from the last three months) reflective of ongoing data review
- Any documentation of the case managers' assessments of the appropriate implementation of behavioral supports and any related changes of status, as applicable.
- Any documentation reflective of revisions or amendments to the Plan for Supports (or the need thereof)
- Notes completed by QSR reviewers

Attachment 4

Contact Information Request

The name, position, and contact information (phone number and email address) for QSR study lead trainers as well as reviewers of the selected individuals.

The name and contact information (phone number and email address), as applicable, for the following key stakeholders for each sampled individual:

1. Author(s) of the BSP & FBA
2. Current clinician overseeing behavioral programming (if different from #1)
3. Case Manager or Service Coordinator
4. House manager (if placed in residential setting)
5. Parent, Guardian or Authorized Representative
6. Nominated direct care staff with experience working with identified individual

APPENDIX C

INTEGRATED DAY ACTIVITIES AND SUPPORTED EMPLOYMENT

By
Kathryn du Pree

and

Joseph Marafito

2020 REVIEW OF THE INTEGRATED DAY AND EMPLOYMENT SERVICES REQUIREMENTS OF THE US v COMMONWEALTH OF VIRGINIA'S SETTLEMENT AGREEEMENT

REVIEW PERIOD: OCTOBER 1, 2019– SEPTEMBER 30, 2020

SUBMITTED TO DONALD FLETCHER

INDEPENDENT REVIEWER

BY:

KATHRYN DU PREE, MPS AND JOSEPH MARAFITO, MS

EXPERT REVIEWERS

November 12, 2020

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I. Overview of Requirements

Donald Fletcher, the Independent Reviewer, has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the employment services requirements of the Settlement Agreement for the time period 10/01/19 – 9/30/20. The purpose of the review is to determine the Commonwealth's progress implementing plans to comply with the requirements of the Settlement Agreement (SA) focused on integrated day opportunities, including supported employment. (III.C.7.a.1; III.C.7.a.2; and III.C.7.b). The report of integrated day services will review evidence that the Commonwealth has completed a legitimate process that verifies the accuracy of the Commonwealth's data and documentation of its efforts to achieve compliance with these indicators.

Virginia has been implementing progressive changes to its employment service array for individuals with intellectual and developmental disabilities (I/DD) since 2012. This is the third review that covers a twelve-month period of time. The Independent Reviewer determined it is more useful to review the relevant data over a twelve-month, rather than a six-month, period to provide a greater understanding of the advances that are being made and to provide a longitudinal view of the Commonwealth's efforts to address challenges and implement policy and funding changes.

Facts were gathered regarding the Commonwealth's progress related to the provisions of the Settlement Agreement in Sections III.C.7.a. and b. and the focus for the provisions studied will be to review the Commonwealth's progress toward achieving the compliance indicators associated with these sections. The review will include the progress of its CSBs to address employment and community engagement in the individual planning process discussing and developing employment and community engagement goals for individuals at least annually and including these related goals in the ISP.

Settlement Agreement Provisions

The report from this period will include data and findings of the Commonwealth of Virginia's progress toward achieving the following requirements:

> 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.*
>
> III.C.*7.b. The Commonwealth shall maintain its membership in the State Employment Leadership Network (SELN) established by NASDDDS; establish state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy; [use] the principles of employment first include offering employment as the first and priority service option; providing integrated work settings that pay individuals minimum wage; discussing and developing employment options with individuals through the person-centered planning process at least annually; and employ at least one employment services coordinator to monitor the implementation of employment first practices.*

7.b.i. Within 180 days, the Commonwealth shall develop an employment implementation plan to increase integrated day opportunities for individuals in the target population including supported employment, community volunteer activities, and other integrated day activities. The plan shall:

A. *Provide regional training on the Employment First policy and strategies throughout the Commonwealth; and*
B. *Establish, for individuals receiving services through the HCBS waivers:*
    1. *Annual baseline information regarding:*
        a. *The number of individuals receiving supported employment;*
        b. *The length of time people maintain employment in integrated work settings;*
        c. *The amount of earnings from supported employment;*
        d. *The number of individuals in pre-vocational services as defined in 12 VAC 30-120-211 in effect on the effective date of this Agreement; and*
        e. *The lengths of time individuals remain in pre-vocational services*
    2. *Targets to meaningfully increase:*
        a. *The number of individuals who enroll in supported employment in each year; and*
        b. *The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment*

III.C.7.c. Regional Quality Councils, described in Section V.D.5 below, 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 to the Regional Quality Councils and the Quality Management system by the providers. Regional Quality Councils shall consult with those providers and the SELN regarding the need to take additional measures to further enhance these services.

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.

Compliance Indicators

The Parties have jointly agreed to several compliance indicators (CI) for provisions of the SA for which the Commonwealth has not met or sustained compliance. The CIs that are relevant for the employment provisions of the SA are detailed below. This review focuses on determining if the Commonwealth has reliable data to demonstrate compliance and if the expected levels of compliance have been achieved.

III.C.7.a. and b.:

1. All case managers are required to take online case management training modules and review the case management manual. Information contained includes:
    a. The Employment First Policy with an emphasis on the long-term benefits of employment to people and their families and practical knowledge about the relationship of employment to continued Medicaid benefits;
    b. Skills to work with individuals and families to build their interest and confidence in employment;
    c. The importance of discussing employment with all individuals, including those with intense medical and behavioral support needs and their families;

d. The importance of starting the discussion about employment with individuals and families as early as the age of 14 with goals that lead to employment (e.g., experiences in the community, making purchases, doing chores, volunteering);
e. The value of attending a student's IEP meeting starting at age 14 to encourage a path to employment during school years and to explore how DD services can support the effort;
f. Developing goals for individuals utilizing Community Engagement Services that can lead to employment (e.g., volunteer experiences, adult learning);
g. Making a determination during their monitoring activities as to whether the person is receiving support as described in the person's plan and that the experience is consistent with the standards of the service.

2. The Commonwealth will achieve compliance with this provision of the Settlement Agreement when:
    a. At least 86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of the ISP planning process;
    b. At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment;
    c. At least 86% of individuals who are receiving waiver services and have employment services authorized in their ISPs will have a provider and begin services within 60 days;
    d. At least 86% of individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process;
    e. At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP;
    f. At least 86% of individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.

3. New Waiver Targets established by the Employment First Advisory Group.
The data target for FY20 is 936 individuals in ISE; 550 individuals in GSE for a total of 1486 in supported employment. Compliance with the Settlement Agreement is attained when the Commonwealth is within 10% of the targets. The Commonwealth has established an overall target of employment of 25% of the combined total of adults age 18-64 on the DD waivers and waitlist.

4. DBHDS service authorization data continues to demonstrate an increase of 3.5% annually of the DD Waiver population being served in the most integrated settings as defined in the Integrated Employment and Day Services Report (an increase of about 500 individuals each year as counted by unduplicated number recipients).

II. Purpose of the Review

This review will build off the review completed last fall by the Expert Reviewer for the review period 10/01/18 through 10/30/19 and the related recommendations the Independent Reviewer made in his last Report to the Court. The focus of this review is to determine Virginia's progress toward achieving compliance with the indicators noted above where compliance has not been previously achieved but will also briefly address all areas of compliance related to employment services to make sure that the Commonwealth has sustained compliance in areas achieved during previous reporting periods. The focus of this review will be on:

- The expectation that individuals in the target population are offered employment as the first option by Case Managers and their teams during the individual planning process in which they discuss and develop employment goals
- The Commonwealth's success meeting the FY 2020 targets it set for the number of people, members of the target population, who are in supported employment
- The Commonwealth's progress to offer community engagement and community coaching to individuals who do not work or as a supplement to employment
- The training CMs have received regarding employment and community engagement options for individuals with I/DD and facilitating discussions and setting goals regarding employment and community engagement with these individuals

III. Methodology and Review Process

To complete this review and determine compliance with the requirements of the Settlement Agreement, I reviewed relevant documents and interviewed key administrative and quality improvement staff of DBHDS, and members of the Employment First Advisory Group (E1AG), previously known as the SELN-Virginia. In July 2020, prior to initiating this review, a kickoff meeting was held with the Independent Reviewer, the Expert Reviewer, Heather Norton, and Jenni Schodt to review the process and to clarify any components of the review and the qualitative study. The Commonwealth was also asked to provide any additional documents that it maintains to demonstrate that it is properly implementing the Settlement Agreement's provisions related to integrated day and employment services.

I engaged in the following activities to review and analyze the DBHDS' progress to meet the Compliance Indicators for integrated day activities to increase the number of individuals who are engaged in supported employment or who are competitively employed, and those who are receiving Community Engagement. I will review the methodology that DBHDS is using to verify that its documents and reports include reliable data only; that the data align fully with all CIs for integrated day activities and supported employment; and that the specific steps that it used to make its calculations and determinations of compliance are valid and statistically significant. The methodology included a review of documents that are listed below and interviews with DBHDS staff and community stakeholders.

In addition, I reviewed the 100 ISPs that have been reviewed in the retrospective review to validate whether the information in each ISP documents the team discussions regarding employment and community engagement and goal setting for both service types as a check on the DBHDS review process. The SA expects these conversations will occur. The Commonwealth has set the targets for both a discussion about employment and setting employment goals. Case

Managers (CMs) are expected to have discussions with 86% of the adults who have an Individual Service Plan (ISP), and to set employment goals for 50% of the adults. CMs are also expected to have discussions with 86% of the individuals they support to explore involvement in the community through the use of Community Engagement (CE) and Community Coaching (CC) services and set a goal in the area of community engagement for 86% of the individuals. The study is further detailed, and the findings are presented in a separate report to the Independent Reviewer.

Document Review: Documents reviewed include:

1. VA DBHDS Employment First Plan: FY2020-2023 Update
2. DBHDS Semiannual report on Employment (through 12/31/19)
3. DBHDS Semiannual report on Employment (draft through 06/30/20)
4. DBHDS Report on Employment Service Authorizations and Service Start Dates
5. Regional Quality Council (RQC) meeting minutes and recommendations for implementing Employment First
6. Case Management Training Module 11: Employment
7. Case Management Training: Employment Options Discussion
8. Case Management Employment Training Quiz
9. Support Coordinator Quality Reviews Methodology and Supporting Processes
10. The State of the State Report May 2020
11. Jump Start Initiative Description
12. Employment Data Reporting Process and Glossary of Terms

I also requested summaries of the CSB CM Supervisors Support Coordination Quality Reviews SCQR, and the summary of the retrospective review completed by the Office of Community Quality Improvement (CQI) staff. DBHDS was unable to provide these reports.

Interviews: The Expert Reviewer interviewed members of the E1AG; Heather Norton, Assistant Commissioner, Developmental Services, DBHDS; Challis Smith, Director of the Office of Quality Improvement, DBHDS; Christi Lambert, QI Reviewer; Cathy Starling, QI Reviewer; Debra Vought, QI Reviewer; and Britton Welch, QI Reviewer for DBHDS.

I appreciate everyone's willingness to participate in interviews and for the work of DBHDS staff to share numerous individual plans and reports. All of the interviews provide information that contribute to a more robust report. The graphs in this report are taken from DBHDS' Semiannual Employment Report through June 2020.

IV. The Employment Implementation Plan

7. b.i. Within 180 days the Commonwealth shall develop an employment implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer and recreational activities, and other integrated day activities.

Review of the Division of Developmental Services: Employment First Project Plan- FY 2021-2023

DBHDS shared its updated project plan for its Employment First outcomes and strategies. The plan includes the intended outcomes and benchmarks for FY21- FY23. It then lists the activities it plans to engage in to achieve the desired outcomes. The DBHDS did not include a status report of any progress towards implementing the activities or meeting the benchmarks. Below is a summary of the Project Plan.

Desired Outcomes, Benchmarks and Activities for the Employment First Project

Outcome 1: Maintain collaboration between state agencies that facilitate employment for individuals with intellectual and developmental disabilities (I/DD), Serious Mental Illness (SMI), & Substance Use Disorder (SUD).

Benchmarks for Success: Individual Agency policy differences do not impede provision of services to individuals; Memorandums of Understanding exist that include commitment to efforts to collaborate and resolve differences and inconsistencies; alignment of state regulation and administrative policy with Employment First policies and values.

Activities: DBHDS collaborates with the other relevant state agencies including DARS, DMAS, DOE and Workforce for technical assistance, undertakes policy review and development to develop policies that do not impede employment services for the target population; reviews and revises interagency Memorandums of Understanding (MOU's) to resolve issues and inconsistencies; and maintains interagency collaborations.

Outcome 2: Consistent understanding of community-based employment by stakeholders throughout Commonwealth to support Virginia's Employment First Initiative.

Benchmarks for Success: Tools and trainings that help stakeholders to have meaningful conversations that lead to employment; increase capacity and competence of employment providers (school, CSB, ESO, etc.)

Activities: Revise Case Management training modules to align with new expectations and compliance indicators; develop resource materials for educators, CM's, and families to increase community engagement and employment opportunities; identify the target audiences and their role in transition activities towards employment; develop reference and access guides and fact sheets

Outcome 3: Track and analyze existing and new data to increase employment opportunities for the targeted population.

Benchmarks for Success: Increased number of individuals are employed in competitive integrated employment

Activities: Complete trend data report; develop baseline data for individuals, by age group, who received new waiver slots by 07/2018 who were employed by 12/2019; revise data survey to improve information collected; assess capacity; and develop and implement a plan to address areas needing additional provider capacity

Outcome 4: Development and implementation of best practices evidenced informed Individual Placement Supports Pilot Program for the state of Virginia.

Benchmark for Success: Policy recommendations that lead to increased employment; best practice implementation guides; communication materials for stakeholders

Activities: Develop best practices framework for supported employment; high needs supported employment; customized employment sustainability; and peer recovery supported employment

Outcome 5: Assure an active and committed membership that will help advance the Employment First Initiative for all.

Benchmark for Success: Active member participation; Membership representative of all stakeholders

Activities: Review E1AG membership guidelines; convene membership group as needed; and review and insure active E1AG participation

Conclusion and Recommendations

Based on interviews and a review of the training materials it is evident that both DBHDS and the E1AG continue to be involved in the activities of the Employment First Project Plan. There continues to be involvement of other state agencies on the E1AG and DBHDS has developed a comprehensive curriculum for CMs and well as training materials and FAQ's for families, including videos that depict individuals with various disAbilities successfully working. The E1AG has a data sub-committee that continues to analyze employment data which is presented for analysis and recommendation to the full E1AG. Membership or the E1AG has been re-structured in the past year to reconfirm membership and to add members who can represent individual with mental health and substance use conditions.

7.b.i.B.1.a-e: The Commonwealth is to develop an employment implementation plan to increase integrated day opportunities for individuals in the target population including supported employment, community volunteer activities, and other integrated day activities. The plan shall establish, for individuals receiving services through the HCBS waivers:

Annual baseline information regarding:

a. The number of individuals receiving supported employment;

b. The length of time individuals maintain employment in integrated work settings;

c. The amount of earning from supported employment;

d. The number of individuals in pre-vocational services; and

e. The lengths of time individuals remain in pre-vocational services.

DBHDS has worked in partnership with the DARS to refine its data collection since October 2014. DBHDS had a response rate of 100% from ESOs for several review periods. The DBHDS submitted two semiannual reports on employment. One summarizes December 2019 data and the other summarizes June 2020 data. The DBHDS Semiannual Report on Employment dated 10/04/20, is the ninth semiannual reporting period in which responses were received from 100% of the ESOs.

DBHDS continues to gather data from a second source for its employment reports. DBHDS used its data sharing agreement with DARS to gather data regarding individuals with developmental disAbilities who receive employment support from DARS funded services including Extended Employment Services (EES) and Long-Term Employment Support Services (LTESS). The consistency of data reporting from both DARS and the ESOs make it possible to make comparisons between reporting periods.

Statewide Employment Data Analysis-This report compares the achievements in June 2019 to the achievements in employment in June 2020 to provide comparison over a full year. The data in ***Table 1*** below compares the employment data for individuals funded by DARS or an HCBS Waiver in June 2019 and June 2020.

Table 1: Comparison of the Number of Individuals in ISE and GSE in June 2019 and June 2020

Funding Source	ISE Participant 0619	ISE Participant 0620	**ISE Change**	GSE Participants 0619	GSE Participants 0620	**GSE Change**	**Total Change of ISE and GSE**
Waiver	555	480	**-75**	523	235	**-288**	**-363**
EES	39	32	**-7**	28	25	**-3**	**-10**
LTESS	1701	1865	**+164**	31	45	**+14**	**+178**
Other	547	334	**-213**	500	250	**-250**	**-463**
DARS	405	249	**-156**	2	2	**0**	**-156**
TOTAL	3247	2960	**-287**	1084	557	**-527**	**-814**

The data indicates that there were decreases in the number of individuals were in Individual Supported Employment (ISE) services and in Group Supported Employment (GSE) services in June 2020 compared to June 2019. A total of 3,517 individuals were employed as of June 2020 compared to 4,331 who were employed twelve months earlier. This is a decrease of 814 individuals (19%) who were employed across ISE and GSE. The decrease of 287 ISE participants is a 9% decrease while participation in GSE decreased by 49%. While there are decreases in both ISE and GSE overall, the participation in both employment programs funded by LTESS increased over the twelve-month period under review by 164 individuals in ISE and 14 individuals in GSE. The most significant decreases by both number and percentage were seen for those funded by DARS and those who had other funding sources.

As of June 2020, the numbers of individuals in these two situations changed when compared to June 2019, as follows:

- 287 fewer individuals were employed in ISE
- 527 fewer individuals were employed in GSE

These numbers reflect the total number reported as employed across all employment programs including the programs offered by DARS as well as the HCBS waiver employment services. This is the first time there has been an overall decrease in the number of individuals with I/DD employed in ISE and GSE since DBHDS has reported these data. In all likelihood this was caused by the outbreak of the COVID 19 pandemic in Virginia and the nation which caused both short and long-term unemployment for many workers including those with disAbilities. However, DBHDS reports that in December 2019 there were 3,188 individuals in ISE and 1,042 individuals in GSE for a total of 4,320 employed individuals. This data is for a time period before the outbreak of COVID and a retrenchment of employment options. The number of ISE participants decreased by 59 and the number of GSE participants decreased by 42 comparing December 2019 to June 2019 data.

It will be important to review the data in both of the next two semiannual reports which analyze data for December 2020 and June 2021 to determine if this becomes an unfortunate downward trend or if individual in Virginia with disabilities recover or replace their jobs as the effects of the pandemic on employment lessen.

Overall, 3,517 people are employed with supports from ISE and GSE as reported in June 2020. The target set by the E1AG in 2015 was that 4,655 individuals would be employed representing 25% of the 18,621 individuals on the waiting list as of 6/30/20. The number actually employed, 3,517, represents 19% of the number of individuals either on a HCBS waiver or the waiver waiting list who are between the ages of 18 and 64. As noted above there were 4,320 individuals in ISE and GSE combined in December 2019 which represents 23% of the total waiver and waiver list number of 18,621.

The data indicates that 715 individuals on the waivers are employed representing (5%) of the 14,563 individuals who are waiver participants. This is a decrease from the previous year when 1,078 individuals on the waiver were employed, representing (8%) of all 13,955 individuals on the waiver as of June 2019. Of the 715 individuals who were employed as of June 2020, 480 (67%) are employed through ISE and 235 (33%) are employed through GSE.

DBHDS has been able to sustain the accuracy and comprehensiveness of the employment data in terms of the overall number of individuals with disabilities who were employed. Once again, and for the ninth consecutive semi-annual period, 100% of the ESOs reported on the number of individuals employed who were waiver participants. The information submitted includes data that reflects quantitative information that continues to reflect improvements or changes, and not qualitative judgements.

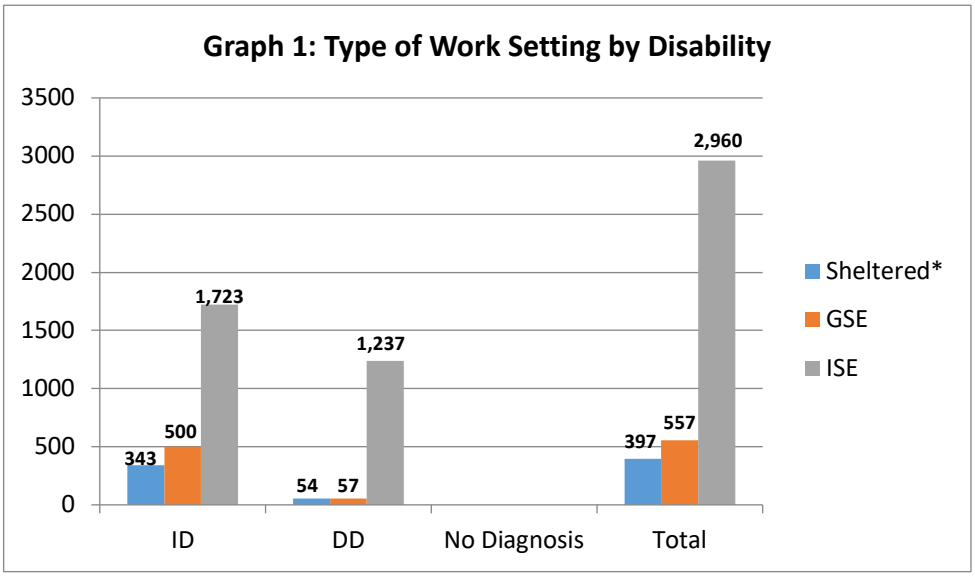
DBHDS continues, as it should, to report on the number of individuals employed in ISE and the number in GSE. The long-term goal of the SA, however, is to have individuals employed through ISE and eventually competitively employed. Overall, of the individuals in supported employment in June 2020, in either ISE or GSE, 84% were employed in ISE, compared to 75% in June 2019 and 73% in June 2018. This is positive but may be skewed by the significant decrease in work for individuals in GSE during the height of the COVID in Virginia.

Again, the DARS LTESS program funds the majority of individuals in ISE accounting for 1,865 (63%) of the 2,960 individuals in ISE. Of the total number of individuals in ISE, 16%, compared to17% in June 2019 and 14% in June 2018 are participating in the HCBS waiver-funded employment services as of June 2020. Of the individuals in HCBS waiver funded ISE, the number decreased by 75 individuals between June 2019 and June 2020. There have been increases in the number of ISE waiver participants since Fiscal Year 2016. During this most recent period, the number of individuals in HCBS waiver funded GSE decreased by 288 individuals which is a significantly higher decrease than previous years. The decrease in the number of GSE participants continues an overall trend, although the pandemic was a new and significant contributing factor in FY 20 Q4.

The number of individuals in the sheltered workshops (SW) is not counted by DBHDS towards the employment target goals. However, it is important to track the changes in utilization of the congregate settings. Fewer individual should be in SWs as a result of the changes DBHDS made in the waiver service definitions. The Commonwealth did not plan to have SWs in the waiver at all by July 2019 to make sure Virginia was fully compliant with the federal Workforce Innovation and Opportunity Act (WIOA). It is heartening to see a third year of decrease in the number of individuals in sheltered workshops overall and in the waiver program specifically. There are only thirty-seven waiver participants in sheltered workshops, and overall a total of 397 in sheltered work across all employment program funding sources.

Employment of individuals by disability group- Overall there are decreases in the numbers of individuals employed with either ID or DD between June 2019 and June 2020 which is reflective of previous data presented in this report. This decrease results largely from the loss of jobs for individuals with disAbilities during the COVID 19 pandemic. There were 815 fewer individuals with I/DD employed. This number includes 659 individuals with ID and 156 individuals with DD. This represents an 11% decrease in employment for individuals with DD, and a 23% decrease in the employment of individuals with ID. The percentage of individuals with DD compared to the percentage of individuals with ID who are employed shifted slightly between June 2019 and June 2020. In June 2019 33% of those with disAbilities who were employed had DD and 67% had ID. In June 2020 these percentages changed to 37% and 63% respectively.

Graph 1 below shows the employment involvement of individuals by disAbility group: individuals with Intellectual DisAbilities (ID) and those with Developmental DisAbilities (DD), other than ID as of June 2020.

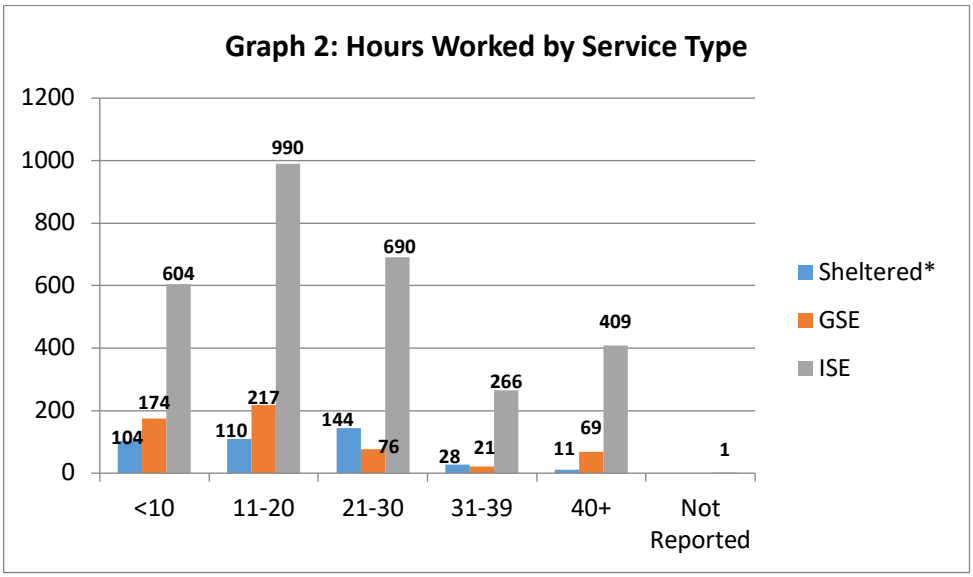


Average hours worked- The Commonwealth no longer reports on these data by ID and DD target groups or by Region. Previously individuals with DD worked more hours on average than did their counterparts with ID. Comparisons of both data sets have been useful in the past as they provide more detailed information about potential areas of underemployment and geographic disparities. This information could also help identify needed quality improvement initiatives that could address identified disparities. **Graph 2** below details hours worked by service type in the DBHDS Semiannual Employment Report as of June 2020.

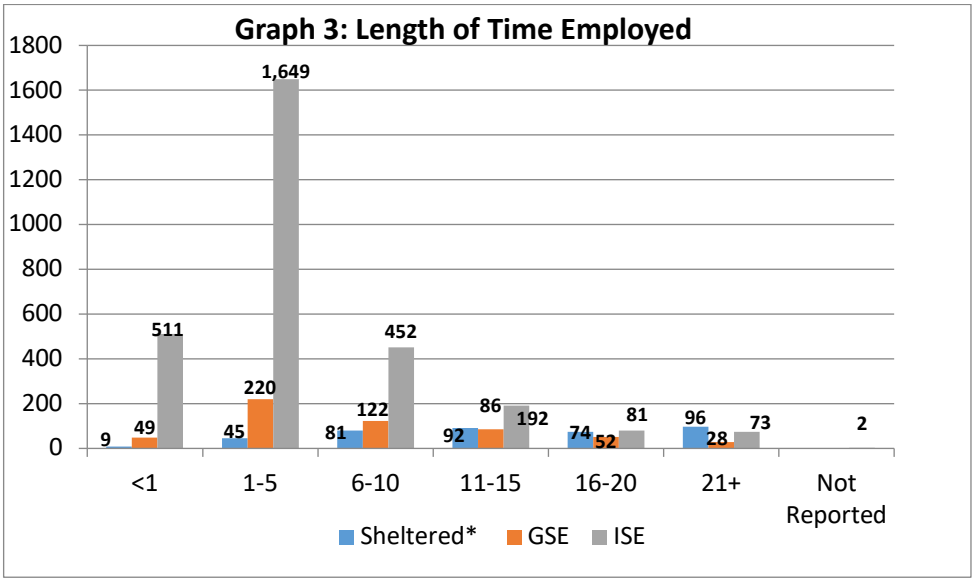
There has been a decrease in the number of individuals who receive employment support whose wages are reported. The percentage of individuals who work twenty hours or less per week comparing the data from June 2020 to the data from June 2019 remains at 56% of the total number of individuals working. However, the percentage of individuals in GSE working twenty or fewer hours decreased from 77% to 70% of the total number of individuals with I/DD working in GSE, while the percentage for individuals in ISE decreased slightly from 56 to 54% of all individuals with I/DD working in ISE.

The percentage of individuals reporting working more than thirty hours per week in ISE increased from 22% to 25% of the total number working in ISE and increased from 7% to 16% in GSE between June 2019 and June 2020. However, the number of individuals in ISE working either 31-39 or forty or more hours per week actually decreased by nineteen individuals during FY20 Q3 and FY 20 Q4, the first half of the seventeenth reporting period. DBHDS still does not report on whether individuals are working the number of hours they want to be employed. Many of the individuals may be underemployed. This is determined based on the fact that 56% (1,985 of 3,517 individuals) are working no more than twenty hours per week. This overall percentage

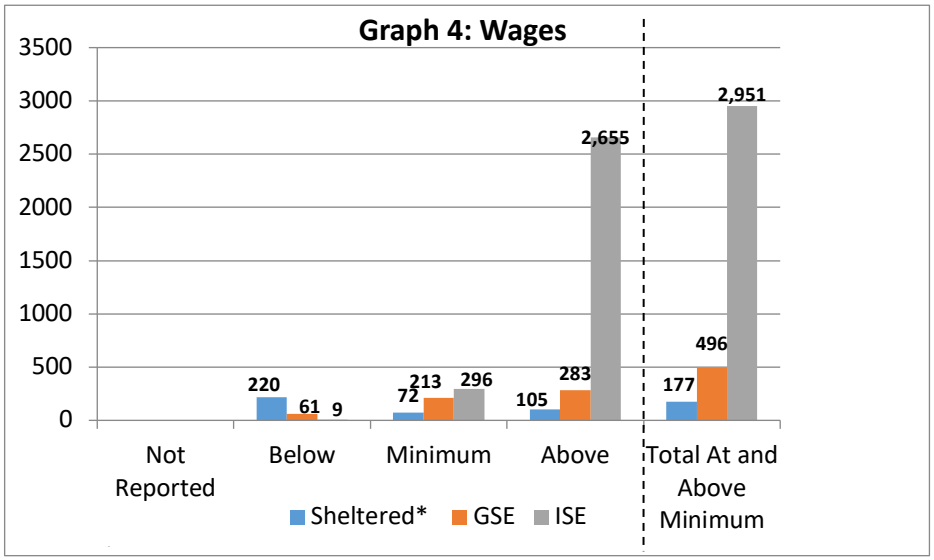
remains consistent with the data from previous reporting periods. The data below depicts the hours worked by service type as of June 2020.



Average length of time at current job- these data are no longer specific to disability group, and, therefore, reviewers cannot compare the length of time individuals with ID versus DD maintain a job. The expectation is that 85% of individuals will hold their jobs for at least twelve months. ***Graph 3:*** *Length of Time Employed* below depicts the data as of June 2020. Overall, 85% of all individual employed worked at their job for one year or more. This is reflective that 83% of individuals in ISE held their jobs for twelve months or more compared to 77% in June 2019; and 93% of individuals in GSE in June 2020, compared to 90% of individuals in GSE in June 2019 who were employed in their job for more than twelve months. This Compliance Indicator is Met.



Earnings from supported employment- DBHDS collected information regarding wages and earnings. **Graph 4** *Wages* below depict the number of individuals that earn above or below minimum wage by employment program type for June 2020. All but nine individuals in ISE earn at least minimum wage as of June 2020 compared to ten earning less than minimum wage in June 2019. The number of individuals in GSE, earning less than minimum wage has decreased from 250 in June 2019 to 61 in June 2020. Overall, 98% of individuals working in either ISE or GSE make at least minimum wage, compared to 94% on June 2019. Currently there are 70 (2%) people employed who are earning below minimum wage. DBHDS reports this data may be skewed in GSE as a result of jobs lost during the pandemic. The wages paid to individuals in ISE range from $5.25 (plus tips) to $60.00. In GSE the range of wages paid in $0.32-$24.09.



Conclusion and Recommendations: The DBHDS is meeting the expectations set forth in *7.b.i.B.1.a, b, c, d, and e.* Its data reflects information from 100% of all providers including the providers who offer HCBS waiver funded services and all employment related data from DARS relevant to the I/DD population. These data should be considered reliable and valid. These providers (100%) have submitted these data for nine consecutive semi-annual periods. The previous period 92% of ESO providers responded. The data submitted have been studied, issues have been identified, quality improvement initiatives implemented, and fixes confirmed. Semi-Annual Reports based on these data have been published.

V. Setting Employment Targets

Sections 7.i.B.2.a and b. require the Commonwealth to set targets to meaningfully increase the number of individuals who enroll in supported employment in each year and the number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.

DBHDS has set employment targets at two levels. A target was set on December 30, 2015 for 25% of the total number of individuals with I/DD 18-64 years old on the waivers or the waiting list (16,871), to be employed, in both ISE and GSE, by June 30, 2019, for a total of 4,218 individuals. This target was revised to reflect the total number of individuals with DD on the waivers or waiver waiting list as of 6/30/19, which was 17,964. The number of individuals on the waiver or waiting lists has increased to 18,621 as of June 2020. Therefore, the Commonwealth commits to a total of 4,655 being employed as of June 30, 2020. There were 4,331 individuals employed in either GSE or ISE as of June 30, 2019 which represented 24% of the waiver and waiting list number. There were 3,517 individuals employed through ISE and GSE combined as of June 2020, representing 19% of the waiver and waiver list number of individuals.

The second goal is to increase the number of individuals who are employed through waiver programs. DBHDS set employment targets for this goal several years ago. These targets are depicted in ***Table 2*** below. DBHDS has reversed its progress toward the employment targets it has adopted for increases in employment for individuals in the HCBS waiver in this reporting period, in large measure as a result of individuals losing employment during COVID 19.

Table 3 depicts the overall employment changes in waiver programs from FY16- FY20. In the past four years an additional 255 individuals are employed in ISE programs, negatively impacting the gains made in previous years. There is an overall decrease in the number of individuals employed in waiver programs of 175 because of a significant decrease in the number of individuals employed through GSE. The target (depicted in ***Table 2*** for FY20 was to have 1486 individuals employed including 936 in ISE and 550 in GSE. Instead there are only 715 individuals employed through HCBS waiver employment programs including 480 individuals in ISE and 235 individuals in GSE.

A total of 363 fewer waiver recipients were employed as of June 2020 compared to waiver recipients who were employed as of June 2019. This decrease includes 75 individuals in ISE and 288 in GSE. DBHDS has been set back during this reporting period reaching only 48% of the target it set for the end of FY20.

Table 2 illustrates and compares the original targets to the revised targets set in 2019 and reflected in the June 2020 report as the continued targets set by the Commonwealth.

Table 2: Employment Targets for the HCBS Waiver Programs FY16-21						
End of FY	**ISE**	**ISE (new)**	**GSE**	**GSE (new)**	**Total**	**Total (new)**
16	211		597		808	
17	301		631		932	
18	566		731		1297	
19	830	**661**	831	**550**	1661	**1211**
20	1095	**936**	931	**550**	2026	**1486**
21	NP	**1135**	NP	**550**	NP	**1685**
Total Increase '16-'21	*884*	***924***	*334*	***(-47)***	*1218*	***877***

Table 3 below depicts that actual change in the number of individuals employed in the HCBS waiver programs from FY16 to FY20.

Table 3: Number of Individuals Employed in the HCBS Waiver Programs FY16-20			
End of FY	**ISE**	**GSE**	**Total**
16	225	665	890
17	305	521	826
18	422	550	972
19	555	523	1078
20	480	235	715
Total Change '16-'19	***255***	***(-430)***	***(-175)***

Comparison of the Targets- As of June 2020 neither of the targets set for employment have been met. There have been significant reductions as a result of COVID, but the Commonwealth had not met it targets in FY19 either. As of June 2019, Virginia was much closer to achieving its overall employment goal of 25% of all waiver participants and waiting list individuals being employed when it achieved employment for 24% of this group. In June 2020 this percentage dropped to 19% of individuals on HCBS waivers or waiting lists.

More significantly the Commonwealth has not met the target for employment for individuals with waiver-funded services as its population of individuals with I/DD has experienced reductions in employment.

There is a table in the Semiannual Employment Report that captures the number of unique individuals who have a service authorization for each day service in the waiver including ISE and GSE. This information is included in this report in ***Table 4*** on Page 21 of this report and is more fully discussed later in this report regarding community engagement.

The number of individuals *authorized* for ISE and GSE differ from the number of individuals *participating* in ISE and GSE. In June 2019, 789 ISE and 555 GSE authorizations were awarded versus 555 ISE and 523 GSE actual participants. The number of authorizations versus the number of actual participants in 2020 follows a similar pattern: 953 ISE authorizations versus 480 participants, and 519 GSE authorizations versus 235 GSE participants. Both authorization numbers are higher than the number reported as actually employed through waiver ISE and GSE services, which is understandable as many individuals may still be assisted finding a job, and the availability of jobs has decreased during the pandemic. It is noteworthy that Virginia continues to make a significant financial commitment to employment for individuals on the HCBS waivers. The increase in authorizations for ISE was 164 between June 2019 and June 2020. The ISE and GSE authorizations more closely match the waiver employment targets for the first time. The ISE target for FY20 was 936 and there are 953 authorizations. The GSE authorization of 519 is slightly less than the target of 550 set for FY20.

In order for the Commonwealth to reach its employment targets in future fiscal years, especially in ISE for individuals in the HCBS waivers, the DBHDS will need to concentrate on increasing provider capacity and ensure CMs and their supervisors are adequately trained to discuss employment in a meaningful way and are aware of all of the resources to make available to individuals and families. Virginia's plan to provide training and technical assistance to providers to offer employment support to individuals with more significant disabilities should prove helpful to increase the number of waiver participants who are employed. Later in this report I will discuss the themes from the qualitative study in which 99 individuals' ISPs were reviewed to determine if Case Managers held meaningful employment discussions and set employment goals for individuals interested in employment. As a result of reviewing these ISPs and interviewing case managers it is evident that families need much more information about employment and particularly its impact on individuals' benefits; case managers need training to assist individuals with behavioral, medical or physical needs to feel more confident exploring employment; and DBHDS and CSBs need to address the barrier of transportation if the number of individuals employed is to increase in any significant way. These are similar themes to those discussed in the last Expert Reviewer's report.

Conclusions and Recommendations: The Commonwealth has not met the target it set for the percentage of individuals with I/DD who would be employed by 2020 across all of the DARS and DBHDS waiver employment programs which responds to Section *7.b.i.B.2.a. (Compliance Indicator #1-4 for 7.a.1-4)* The Commonwealth reduced its targets to meaningfully increase the number of individuals receiving services through the waivers in 2019. These revised targets have not been achieved as of June 2020.

DBHDS did not include recommendations in the Semiannual Employment Report draft based on June 2020 data. However, many of the recommendations made in June 2019 remain relevant to achieving these targets. Continued efforts to fully implement these recommendations would further DBHDS's efforts to achieve its employment goals. Recommendations include:

1. *DBHDS needs to continue collaborating with CSBs to ensure that accurate information about the different employment options is discussed with individuals in the target population and that these discussions are documented.*
    a. *Work with the SELN to develop a video that shows the conversation between a case manager and individual and their family to show how to have a better conversation. (not done)*
2. *Increase the capacity of the Commonwealth's provider community to provide Individual Supported Employment services to persons with intellectual and developmental disabilities by providing technical assistance and training to existing and potential new providers.*
    a. *Report the number of waiver providers offering Individual Supported Employment and Group Supported Employment*
    b. *Training for providers to support people with more significant disabilities.*
    c. *Competency development*
    d. *Find out from ESO's additional services offered/subcontracted to identify potential combination of services that would help providers be better able to support people with specialized needs.*
3. *Increase capacity in parts of the Commonwealth that have less providers and employment options. Create a map of the service providers in each of the Regions and the services provided so we can track increase in capacity.*
4. *Do a comparison in future reports of employment discussions and employment goals to evaluate the impact on the percent of people employed per region.*
    a. *DBHDS will follow up with the CSBs who have data reporting concerns around the discussion of employment and goals to address barriers to employment.*
5. *Create data tables around the waiver data according to old slots, new slots, and training center slots.*
6. *Implement recommendations from the Regional Quality Councils.*
    a. *Develop tools/training for individuals and families by using the trend reports for targeted training (Update: Listening sessions all conducted throughout VA spring of 2019 and recommendations shared with DBHDS and the E1AG.)*
    b. *Gather transportation data (Update: survey summarized and shared with stakeholders.)*
    c. *Improve communication with DOE around transition age youth and employment services and supports. (No update.)*
7. *Monitor the number of transition age youth entering non-integrated work settings to determine potential future intervention.*

I continue to recommend that the Commonwealth further refine these targets by indicating the number of individuals it hopes to provide ISE to from the following groups: individuals currently participating in GSE or pre-vocational programs; individuals in the target population who are leaving the Training Centers; and individuals newly enrolled in the waivers during the implementation of the Settlement Agreement. I am pleased that the E1AG has also made this recommendation. However, it did so over two years ago and the Commonwealth has not yet undertaken the recommendation.

Creating these sub-groups with specific goals for increased employment for each will assist DBHDS to set measurable and achievable goals within the overall target and make the undertaking more manageable and strategic. Realistic and successful marketing and training approaches to target these specific groups can be developed through discussions between the

DBHDS and the E1AG. A collaborative outreach effort to families, case managers, CSBs, Training Center staff, and ESOs will assist the DBHDS to make additional needed progress and achieve its overall targets in the next fiscal year.

VI. The Plan for Increasing Opportunities for Integrated Day Activities

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.

Integrated Day Activity Plan: The Settlement Agreement requires that: *To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under the Agreement with integrated day opportunities, including supported employment.*

Since the Commonwealth of Virginia entered into the Settlement Agreement with the US DOJ, DBHDS focused its work and activities on increasing employment opportunities for individuals with ID and DD. The Independent Reviewer directed DBHDS to develop a plan by March 31, 2014 to describe its approach to create integrated day activity capacity throughout its provider community and ensure that individuals in the target population can participate in these integrated activities as the foundation of their day programs. During the previous review period, DBHDS submitted the revised Community Engagement Plan FY2016-FY2018, which includes updates through FY19 Q4. The foundation for community engagement is included in the HCBS waiver as redesigned to offer community engagement, community coaching, and related services with reasonable rates.

DBHDS, with the input of the CEAG, drafted a comprehensive Community Inclusion Policy in 2016. This policy sets the direction and clarifies the values of community inclusion for all individuals with intellectual and developmental disabilities, regardless of the severity. The policy requires the involvement of both the DBHDS and the CSBs:

- to establish outcomes with specific percentage goals;
- to identify strategies to address barriers;
- to expand capacity of providers;
- to collaborate with the State Department of Education (and schools to promote transition planning; and
- to conduct a statewide education campaign about Community Engagement.

Implementation requires DBHDS to provide training and consultation; to work with DMAS to incorporate these services in the waivers; to continue the role of the CEAG; to develop an implementation plan; and to maintain membership in the national SELN. The CEAG has been disbanded as the work of this group was considered completed by DBHDS. The Community Engagement Plan had six goals that are considered to be completed so there was no reporting for the review period. However, the Commonwealth has committed to achieving compliance with indicators that require discussions of community engagement services and goal setting for community involvement. It is apparent from the CSB's self-reporting (reviewed later in this report) and the IDA study I completed for this review period, that these indicators are not being met. It is evident from the IDA study that CMs are not well educated about CE and the Commonwealth has not developed sufficient capacity. It would be useful to reconvene the CEAG to assist DBHDS to address these areas.

Individuals Participating in Day Service Options

DBHDS has provided data, which is depicted in **Table 4** below that allows for comparison and growth of Community Engagement (CE), Community Coaching (CC), and Workplace Assistance (WA) from 6/30/16 through 6/30/20. This information reflects the number of individuals authorized for each service type.

Table 4: Number of Day Services Authorizations 6/30/19-6/30/20							
Date	**Group* Day**	**CC****	**CE****	**ISE****	**GSE****	**WA****	**Total**
06/30/19	**6545**	**283**	**2650**	**789**	**552**	**69**	**10,888**
12/31/19	**6669**	**317**	**2768**	**975**	**562**	**69**	**11.360**
06/30/20	**6511**	**295**	**2572**	**953**	**513**	**72**	**10,916**
Change	**(-34)**	**(+12)**	**(-78)**	**(+164)**	**(-39)**	**(+3)**	**(+28)**

** congregate settings*
*** integrated settings*

In the twelve-month period, 6/30/19 and 6/30/20, there was an increase of 12 individuals authorized for CC, compared to 44 and 119 respectively in the previous twelve-month period. The authorization for individuals in CE decreased by 78 individuals compared to an increase 275 in the previous twelve months and 787 authorizations as of June 2018. Group day services also experienced a reduction in its authorizations from 6545 in June 2018 to 6511 in June 2019. Authorizations for ISE as reported previously increased dramatically in June 2020 from 789 in June 2019 to 953 in June 2020. This continues to indicate greater preference for, and choice of day services that are more focused on employment or community engagement options, although the decrease in CE authorizations is discouraging.

These employment and day support programs had 10,916 individuals authorized as of 6/30/20 compared to 10,888 as of 6/30/19. This is a very minimal increase but primarily the result of increases to ISE authorizations. The percentage of individuals authorized for integrated day service options, CC, CS, GSE and ISE, remained 40% of the individuals authorized for some type of day support service in June 2020 as was true in June 2019. However, in this review period, there was a reduction in CE authorizations but an increase in ISE authorizations compared to a slight decrease (34) in Group Day authorizations.

While DBHDS produces data that allows for a comparison of individuals actually participating in GSE and ISE to the numbers authorized for ISE and GSE (see Table 3), similar data are not provided for CC and CE. DBHDS does not report on the actual number of individuals enrolled in a CC or CE service. This would be particularly valuable data to have and analyze particularly because it appears from the two qualitative studies completed by the Expert Reviewer in 2019 and 2020 that there is insufficient capacity of CE providers.

The Virginia State of the State Report issued in May 2020 addresses provider capacity. The number of providers licensed to deliver CE services has only increased by seven between 6/18/19 and 4/3/20, from 126 to 133 providers. The five Regions have between a low of 1and a high of 27 providers, with only two regions having more than 13. Some sub-areas have only one or two CE providers. The providers for Community Coaching (CC) have increased by twelve over the same time period, from 45 to 57. However, eleven of the twenty sub-areas of the Regions have 0-2 providers of CC. Coaching is a critical service for individuals who initially need individual supervision and support from staff to meaningfully engage in community activities that are inclusive.

Conclusion and Recommendations*:* The DBHDS and the CEAG have developed a robust definition of Integrated Day Activities, which it now calls Community Engagement. These services have been approved by CMS and offered to waiver participants since September 2016. There is a total of 10,916 individuals authorized for waiver day services including center-based day services. In comparison to the number of authorizations for Group Day in congregate settings, the percentage of authorized services for integrated day settings is not increasing, as the Commonwealth had planned and expected, The integrated day options still represent only 4,405 of all day service authorizations.

As of June 2020, 2,867 of these individuals are authorized for CE and Community Coaching (CC) compared to 2,933 in June 2019.This is 66 fewer individuals who have these authorizations. The percentage of participants compared to the percentage in center-based day settings has not grown in the past year. It is evident from the independent IDA study of 99 individuals during this reporting period that there is not a sufficient number of CE providers in all parts of the Commonwealth. DBHDs reports there are concerns among providers about the viability of providing CE within the current rate structure. DBHDS plans to introduce the need for increased rates for CC and CE in the upcoming agency budget preparation for FY22.

DBHDS is exploring with residential providers their development of CE services. These providers typically know the individuals well and may be more suited to match individual interests and to support their meaningful participation in integrated community-based activities, especially after work and on weekends, when more typical adults are also involved in community activities.

DBHDS planned to produce quarterly reports summarizing demographic data, successes, barriers and the average hours of participation in CE and community coaching by urban and rural areas this year. These reports were expected to provide information to help DBHDS analyze and determine quality improvement initiatives to increase participation in CE and to encourage more providers to offer CE. This information is needed, and I recommend that DBHDS initiate its data collection and the production of these quarterly reports during the next reporting period. Having specific data will help to determine and improve the success of this initiative longitudinally.

During this review period DBHDS decreased the number of authorizations of community engagement services for the first time. In addition, it does not appear from the qualitative studies that were conducted in 2019 and 2020 that CMs are well prepared to discuss CE options with individuals and families, nor are there sufficient providers to offer CE. This is unfortunate because many individuals now in Group Day settings may switch from congregate based day

programs to CE, as DBHDS originally planned, if it was available reasonably nearby and if the benefits were well explained and understood.

There appears to be a clear need to further education of Case Managers to explain CE to individuals and families and to help them address any barriers to the participation of the individual. DBHDS also needs to assure there is adequate funding and support to develop a sufficient number of providers in all regions, so families do not find the travel time to be a deterrent to the participation of their sons or daughters in CE. I support the DBHDS plan to further engage residential providers in offering CE and CC. I again suggest the Commonwealth develops targets for CE as it does for employment; articulate its expectations for hours of participation; and monitor the provision of these services to assure they are meaningful for the individuals.

Compliance Indicator III.C.7.a. 4. Addresses DBHDS' continued demonstration of an increase of 3.5% annually of the DD Waiver population being served in the most integrated settings as defined in the Integrated Employment and Day Services Report (an increase of about 500 individuals each year as counted by the unduplicated number of recipients).

Table 5 extracts data from the DBHDS Semiannual Report on Employment (June 2020 Data) produced 10/4/20 for only those day services that are considered integrated day service options. This excludes Group Day. It indicates that the increase in the number of service authorizations for participants in the programs considered Integrated Employment and Day Services is sixty-two individuals. These services include: Community Coaching (CC) which increased by 12; Community Engagement (CE) which decreased by 78; ISE which increased by 164; GSE which decreased by 39; and Workplace Assistance (WA) which increased by 3 individuals. While these are increases in service authorizations it does not actually indicate how many of these individuals have initiated these services and are actually receiving them. The data provided in a different section of the DBHDS Semiannual Report on Employment (June 2020 Data) indicates that of the 953 individuals authorized for HCBS waiver ISE, only 480 are receiving this service. Similarly, fewer individuals authorized for GSE are yet to receive GSE: 513 are authorized but only 235 were receiving it as of June 2020.

DBHDS does not report on the number of individuals receiving WA, CC or CE, just the number who have authorizations for these services. Without this data compliance with this indicator cannot be determined. However, since there were reductions in authorizations in two of the categories, and the overall change in service authorizations between June 2019 and June 2020 was an increase of only 62 or 1.4% of the 4,343 who had authorizations in June 2019 compared to the 4,405 who had authorizations for an integrated day setting in June 2020, the Commonwealth does not appear to be compliance as of this reporting period. DBHDS will need to report on the actual numbers of individuals receiving CE, CC and WA in future reporting periods for this indicator to be thoroughly analyzed.

Table 5: Service Authorizations or Integrated Day Service Options 6/30/19-6/30/20						
Date	**CC**	**CE**	**ISE**	**GSE**	**WA**	**Total**
06/30/19	**283**	**2650**	**789**	**552**	**69**	**4,343**
12/31/19	**317**	**2768**	**975**	**562**	**69**	**4,691**
06/30/20	**295**	**2572**	**953**	**513**	**72**	**4,405**
Change	**(+12)**	**(-78)**	**(+164)**	**(-39)**	**(+3)**	**(+62)**

VII. Review of the SELN and the Inclusion of Employment in the Person-Centered ISP Planning Process

III.C.7.b. The Commonwealth shall:

- ✓ *Maintain its membership in the SELN established by NASDDDS.*
- ✓ *Establish a state policy on Employment First (EF) for this target population and include a term in the CSB Performance Contract requiring application of this policy.*
- ✓ *The principles of the Employment First Policy include offering employment as the first and priority service option; providing integrated work settings that pay individuals minimum wage; discussing employment options with individuals through the person-centered planning process at least annually.*
- ✓ *Employ at least one Employment Services Coordinator to monitor the implementation of the employment first practices.*

Virginia has maintained its membership in the SELN and issued a policy on Employment First. DBHDS hired an Employment Services Coordinator in the late fall of 2019 after this position was vacant since February 2019.

The Settlement Agreement requires the Commonwealth to ensure that individuals in the target population are offered employment as the first day service option. DBHDS included this requirement expectation in its Performance Contracts with the CSBs starting in FY15.

The CSB Performance Contract requires the CSBs to monitor and collect data and report on these performance measures:

I.C. The number of employment aged adults receiving case management services from the CSB whose case manager discussed integrated, community-based employment with them during their annual ISP meeting, and

I.D. The percentage of employment-aged adults in the DOJ Settlement Agreement population whose ISP included employment-related or employment-readiness goals.

The Commonwealth had previously expected that 100% of individuals with I/DD with a case manager will have "employment services and goals developed and discussed at least annually" by 12/30/15, and that 35% of these individuals will have an employment or employment-related goal in the Individual Service Plan (ISP). During this past year the Parties agreed to specific Compliance Indicators in this area. The indicators III.C.7.a. CI #1-4 include requirements that employment discussions are held with 86% of individuals in waiver programs and that employment goals are set for 50% of these same individuals who are age18-64.

Employment Discussion with Individuals- DBHDS reports that a total of 9.805 adults' case managers conducted annual ISP meetings or updates between July 1, 2019 and June,2020. However, there are 13,070 individuals between the ages of 18-64 on a HCBS waiver who have a CM and an annual ISP meeting. The DBHDS report from the CSBs reflects data from ISP meeting for 75% of the total number of adults on one of the HCBS waivers. Of these 9,805 individuals, their case managers checked a box that indicated that a total of 9,215 individuals had discussed integrated, community-based employment during their annual ISP meetings. This indicates that 94% of the individuals who had an ISP meeting conducted discussed employment at some level, compared to 93% as of the previous report, based on CSB reporting.

Eight (20%) of the CSBs report CMs had employment conversations with all of their waiver participants, which is an increase achieving 100% compared to the previous reporting periods. The number of CSBs reporting these employment conversations with at least 90% of individuals increased from twenty-eight in June 2019 to thirty-one for a total of 78% of all CSBs.

It is important to look at the data specific to each of the forty CSBs. The following table, ***Table 6***, provides a breakdown of the percentage of individuals by CSB who were engaged in an employment discussion.

Table 6: A Comparison of Employment Conversations 2018-2020

Number of CSBs June 2018	Number of CSBs June 2019	Number of CSBs June 2020	% of Employment Discussion
6	6	8	100%
27	22	23	90-99%
3	7	5	80-89%
1	1	2	70-79%
1	2	0	60-69%
0	1	1	50-59%
0	0	0	40-49%
0	0	0	30-39%
2	0	1	20-29%
0	1	0	10-19%
0	0	0	0%

The twenty-one CSBs that reported having discussed employment with 95% or more of individuals having ISP meetings are: Alexandria, Alleghany, Blue Ridge, Chesapeake, Colonial, Chesterfield, Cumberland Mountain, Eastern Shore, Fairfax-Falls Church, Goochland-Powhatan, Hanover, Harrisonburg-Rockingham, Henrico, Highlands, Horizon, Loudon, Mount Rogers, New River Valley, Norfolk, Northwestern, Piedmont, Prince William, Region 10, Richmond, Rockbridge, Southside, Virginia Beach and Valley. All but six of the CSBs recorded employment discussions for at least 86% of the adults who had an ISP meeting in the review period.

A total of 2,937 of the 9,805 individuals in June 2020 compared to 2,825 of the 8,828 individuals in June 2019, have employment or employment related goals in their ISP. This results in a statewide average of 30% of individuals who had an annual ISP review in this reporting period who have an employment or an employment-related goal in their ISP, which falls short of the 50% required to meet compliance indicator #2.b.. This compares to 32% in June 2019. Only one CSB, Alexandria met the target of setting employment goals for at least 50% of adult on the HCBS waivers met the expectation to have employment goals for at least 50% of their consumers and this CSB is Alexandria. Six CSBs record goals set for at least 40% of the adults on their caseloads who had ISP meeting in the review period. One CSB reported that no one on its caseload had an employment goal included in their ISP.

The full DBHDS report of the CSB effort to meet these two target goals is detailed in Attachment 1.

The DBHDS has focused on improving the accuracy of the reporting. During this reporting period DBHDs also established a record review process to monitor if the employment discussions occur, and employment goals are established for individuals in their individual service plans. This was done through its Service Coordinator Quality Review (SCQR) process in which CSB supervisors reviewed 401 records and DBHDS Quality Improvement staff review 99 records of those 401 records that were randomly selected. Definitions of what DBHDs expects to see in a record to document if a discussion occurred were developed and shared with reviewers. A process of inter-rater reliability was designed for the reviews conducted by the DBHDS QI reviewers. I interviewed Challis Smith Director of the DBHDS Office of Quality Improvement, and the QI review staff. The process they followed is quite thorough. Unfortunately, DBHDS cannot share the results of either the CSB supervisory quality reviews or the DBHDS QI reviews. Therefore, DBHDS and I are unable to attest to whether the SCQR data are reliable, valid or accurate. Later in this report I summarize the findings and conclusions from the Integrated Day Activity (IDA) Study I undertook using the same 99 records that were part of the CSB and DBHDS monitoring initiative. The findings from this independent study did not confirm that meaningful discussions occur at the rate the CSBs report or that there is consistent follow up by the Case Managers and teams to educate individuals and families about employment and address barriers.

DBHDS continues to report that it has worked with the Case Management Coordinator and Performance Contracting staff to retrain all CSB case managers on these data elements. The E1AG and DBHDS have worked together to develop both written materials and a video for case managers to build their competencies to conduct employment discussions and develop meaningful employment goals for individuals. Materials and FAQ's are also completed for families. I have summarized how well the training curriculum and related materials address the CIs addressing employment training expectations for CMs.

There is also considerable variation in the individual levels of compliance across the forty CSBs. The range in the number of annual ISPs convened ranges from 47-92%. The percentage of employment discussions held ranges from 54-100%; and the percentage of ISPs that include employment goals ranges from 0-59%. The CSB reports a high percentage of employment discussions occur as Virginia seeks to fully and effectively implement its Employment First policy. The CSBs self-report that they are not meeting the requirement of the SA to include an

employment goal in 50% of the ISPs developed for adult waiver participants. This is more concerning when reviewing the findings of the independent IDA Study conducted in this review period, which included 99 individuals served by all forty CSBs. There is a lack of evidence in the plans that meaningful discussions actually take place at all ISP annual meetings. Rather than a discussion, it is more typical that the question is asked if the individual or guardian wants employment considered. There is no evidence that the benefits of employment, the person's interests, skills and challenges are discussed or that the plans developed address these issues, or that the CM provides ongoing opportunity for the individual and family to learn more about employment or how providers or staff could help address barriers. It was not even apparent that all CMs actually discuss the specific employment options offered by DARS and the HCBS waivers. DBHDS has still not demonstrated that it has the ability through its performance contract to ensure that CSBs take effective corrective actions that address and resolve repeated performance below acceptable standards.

Community Engagement Discussion with Individuals- CSB CMs are also expected to have conversations with individuals on their caseloads about community engagement services. DBHDS reports that a total of 11,406 adults' case managers conducted annual ISP meetings or updates between July 1, 2019 and December 31, 2019. However, there are 14,695 individuals on a HCBS waiver who have a CM and an annual ISP meeting. This number is greater than the number reported earlier in this report for the number of individuals who had ISP meetings in which the CM was expected to lead an employment discussion. This is because the employment discussion, unlike the discussion about CE is limited to 18-64-year-old adults. The DBHDS report from the CSBs reflects data from ISP meeting for 78% of the total number of adults on one of the HCBS waivers. Case Managers checked a box that indicated a total of 10,352 individuals had discussed integrated, community-based engagement during their annual ISP meetings. This reported number indicates that 91% of the individuals who had an ISP meeting conducted discussed CE at some level as reported by the CSBs.

Only one of the CSBs had CE conversations with all of their waiver participants. The number of CSBs reporting these conversations with at least 86% of individuals was thirty-two. The Parties agreed to an indicator of compliance for community engagement discussions which set the expectation for 86% of all waiver participants to have these discussions.

The Parties also agreed to a Compliance Indicator for the percentage of individuals on the waiver who would have a community engagement goal. This CI #2.e. requires that 86% of all waiver participants have this type of goal in their ISPs. As reported by the CSBs this expectation has not been realized. The state average for setting CE goals is only 38%. There were not any CSBs who set goals for 86% of their waiver participants. One CSB reported setting CE goals for 81% if its waiver participants. It is important to look at the data specific to each of the forty CSBs. The following table, ***Table 7*** provides a breakdown of the percentage of individuals by CSB who were engaged in a discussion about CE and those who had a goal set for CE.

Table 7: Community Engagement Discussions and Goals June 2020		
Number of CSBs Holding CE Discussion	**Number of CSBs Setting CE Goals**	**% of CSBs with Discussions and Goals Set**
1	0	100%
24	0	90-99%
10	1	80-89%
3	0	70-79%
0	9	60-69%
2	4	50-59%
0	3	40-49%
0	11	30-39%
0	7	20-29%
0	5	10-19%
0	0	0%

This reviewer cannot determine whether the Commonwealth has met CI 2.d. The CSBs report 91% of individuals had CE discussions and 38% had goals set for CE. However, ISPs were held for only 78% of the waiver population. Also, there has been no verification or validation of the CSB reporting through any standardized monitoring review process. The results of the SCQR process conducted by CSB Supervisors and the retrospective review by DBHDS QI staff were not available to analyze for this review period.

The Engagement of the SELN - The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan, to set the targets for the number of individuals in the target population who will be employed, and to provide ongoing assistance to implement the plan and the Employment First Policy. The SELN Advisory Group was renamed the Employment First Advisory Group. Its members are appointed for two-year terms. The E1AG expanded during this reporting period to include members representing behavioral health and substance disorders. It includes self-advocates, family members, advocacy organization representatives, CSB staff, educators, employment providers, and representatives of the following state agencies: DBHDS, DMAS, DARS, and VDOE.

This Advisory Group has several sub-committees: membership, training and education, policy, and data. Normally I review the E1AG meeting minutes for meetings that occurred during the review year. These minutes were not made available for this reporting period. I interviewed five members of the E1AG for this reporting period to gain perspective on the work of the advisory group and the progress the Commonwealth is making to meet the SA and the associated compliance indicator requirements for employment. From the information they provided it is apparent that the E1AG and its sub-committees remain active, although sub-committees have met less frequently this year in part due to the COVID pandemic.

1.***The operation of the SELN and the opportunity afforded its members to have input into the planning process -*** most of the members who I interviewed continue to report that the E1AG is active and has a diverse and effective membership. Members are positive about the inclusion of new members who represent mental health and substance use needs in the Commonwealth. The new membership has been energizing to the Group. Members report that they have opportunity for meaningful input. They appreciate the structure of the sub-committees for policy, training and data. However, there were fewer meetings of the subgroups in this reporting period, which was also reported during the previous reporting period. The structure is for the full E1AG to meet bimonthly and for both sub-committees to meet during alternate months. There have been fewer meetings in general and have been conducted virtually because of COVID. The members believe that it will be helpful to have the Employment Services Coordinator to coordinate the work of the E1AG and the sub-committees now that the position has been refilled. The Training Committee has stayed active creating a user-friendly guide to help individual success services and have developed flow charts for families to help explain the system of employment services.

Members are pleased that decisions are more data driven but there is some concern that this year the E1AG is more the recipient of data from DBHDS and is not always engaged in meaningful and substantive review of the data. The data sub-committee is becoming re-engaged and undertaking trend analysis. To date data has not been included for mental health or substance use. Data for the past several months is also skewed as a result of so many individuals losing their employment during the pandemic.

The data sub-committee is developing a trend analysis of the key data elements to compare progress over the past few years. The sub-committee was working this fall to continue its trend analysis of employment data related to wages, length of time employed, and employment by disAbility groups. The data committee did not receive the data until recently.

Some members would like the E1AG's agendas and work to be driven more by the committee members with DBHDS responding to requests for data and providing progress reports on implementation of recommendations made by the E1AG.

2. ***Review of the Employment Targets***- Members appreciate the continued progress to increase the number of individuals overall who are employed, both overall and in the waiver programs through December 2019, while acknowledging that the waiver targets are not being met. The June 2020 Semiannual Employment Report was recently shared with the E1AG but had not been discussed at a full meeting. There was disappointment that there was progress towards meeting the targets reflected in the December 2019 data and then significant losses of jobs as a result of COVID. Members think the date to achieve the target will need to be revised as a result of changes to the employment environment as a result of COVID which may have longer lasting impact on jobs.

3. ***Review of CSB Targets-*** E1AG meetings have not focused on the review of these targets. The majority of the members I interviewed think that CMs will benefit from continued training on employment to fully embrace the principles, intent, and policy direction, and that case managers need a greater understanding of their role in the ISP planning to assist families and individuals to seriously consider employment as the first and priority option. The E1AG has been involved in the past with DBHDS to develop training material for the CSB CMs which include

employment scripts, answers to frequently asked questions, and employment discussion videos. There continues to be concern expressed that the workload of CMs limits their ability to meet the minimum standards for effective work with families to meaningfully consider employment for their children with I/DD or to be able to facilitate productive discussions to identify and address barriers to employment. Members also concerned that most CMs are not sufficiently trained or prepared to discuss the impact of employment on benefits. With a history of very low levels of employment for people with significant disabilities in their communities, some members are concerned whether CMs can help families whose children have significant disabilities to understand the possibilities of the important value of work for their family member.

4. Review of the RQC Recommendations- The recommendations of the five RQCs are shared with the E1AG. Members report that similar concerns are expressed by the various RQC's and from one reporting period to the next. The members agree with the general RQC concerns and feel the E1AG and DBHDS are working to address the issues of ensuring sufficient training, capacity, waiver service access, and transportation. This feedback was similar to last year's interviews. DBHDS worked with the Center for Family Involvement at VCU to provide training to all of the RCQ members during the past year. One hundred RQC members participated in the training session. They were taught how to undertake data analysis in a more meaningful way and use it for decision making. Some of the members of the E1AG hope that the training will result in more specific recommendations being made by the RQCs and shared with the E1AG for discussion and analysis that leads to the design and implementation of needed quality improvement initiatives.

5. Interagency Initiatives- the members of the E1AG who I interviewed continue to be positive about the interagency cooperation between DBHDS and DARS. They reported reinvolvement with both the Department of Education (DOE) and Department of Medicaid Assistance Services (DMAS). DARS allowed providers to assist individuals who had lost their jobs to apply for unemployment. DARS has been focusing attention on pre-employment planning with students 14-17. DARs is also working to increase opportunities for Customized Employment. DARS, DBHDS, and DOE are collaborating to expand best practices. Part of this effort is to address the needs of the MH and SU populations and to include Peer Connections and Recovery Support. DARS has re-opened its LTESS program for those individuals in the most severe category of need as of January 2020. There is now greater acceptance that individuals with severe disabilities benefit from DARS assistance.

6. Transportation- The E1AG has done a survey on barriers related to transportation and availability of ESO support and jobs in rural areas. Members fully support adding non-medical transportation as a waiver service and see it as essential to addressing a critical barrier for many individuals to be able to work. Provider members report varying opinions regarding the impact of not providing financial support for individuals' transportation unless they are accompanied by staff.

Conclusion and Recommendation: The DBHDS continues to meet the Settlement Agreement requirements to maintain the SELN, has set goals for the CSBs in the performance contracts, but has not fully met the compliance indicators for the provisions of *III.C.7.b.* as highlighted earlier in this report. The CSBs have not consistently offered employment as the first and priority option or developed and discussed employment service goals annually, a target that was anticipated to be achieved by June 2015. The data currently submitted for Employment

Discussions do not appear to a reliable indication that a discussion occurred that met basic requirements. DBHDS has an Employment Services Coordinator. The interagency work and training provided for the RQC members were highlights of this period.

VIII. Regional Advisory Councils

III.C.7.c. Regional Quality Councils, [described in Section V.D.5 below,] 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 to the Regional Quality Councils and the Quality Management system by the providers. Regional Quality Councils shall consult with those providers and the SELN regarding the need to take additional measures to further enhance these services.

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.

RQC Regional Meetings

The minutes for the Regional Quality Councils (RQC) were shared for all five Councils. These meetings occurred for each RQC in FY20 Q2, FY20 Q3, and FY20 Q4. Minutes for RQC meetings held during FY21 Q1 were not available for review. Heather Norton or other DBHDS staff discussed employment targets with each RQC, highlighting the data in the Semiannual Employment Report of December 2019, and analysis done by the department and by the E1AG data committee. During this reporting period the data from the June 2020 report was not available for these discussions.

DBHDS staff provided updates on employment for each Council meeting. Various Councils had more in-depth discussions and made recommendations. These discussions focused on: clarification of DARS reporting expectations; the adequacy of employment rates for providers; the continued barriers of transportation and the lack of employment providers in rural areas of Virginia. One Region suggested that DBHDS undertake a survey of providers barriers and recommended the funding rates be re-evaluated. These recommendations and concerns were all shared with the E1AG. They are areas of consistent discussion and recommendation by all RQCs.

The RQCs' meeting minutes reflect that DBHDS consistently made presentations about employment. It does not appear that DBHDS has discussed the reductions it made in the employment targets for the waiver with any of the RQCs in this review period. These were not discussed in the previous review period.

Most of the Councils had members attend the meetings who represented individuals, families and employment providers than was noted in the last employment report.

The Commonwealth is responding to the requirement of involving the RQCs because the meetings were held, and employment was at least presented. Targets are expected to be reviewed on an annual basis and were reviewed during this reporting period, but not yet for the June 2020 Semiannual Employment Report

Conclusions and Recommendations: DBHDS continues to meet the requirements of Section III.C.7.d. The employment target for sustaining employment for twelve months was reviewed by the five RQCs in the reporting period. DBHDS did not complete a quarterly review of employment data in FY21 Q1. All five Regions held meetings in the other three quarters that comprise this annual review period. The RQCs had evidence of more meaningful discussions. I continue to recommend the role of the RQCs to review employment data be changed to semiannually to align with the availability of the Semiannual Employment Report and that each RQC make recommendations for consideration by the E1AG so all parts of the state have the opportunity for input that may lead to policy change.

IX. A Review of the Compliance Indicators Agreed to by the Parties and Virginia's Progress Towards Achieving Compliance

Compliance Indicator III.C.7.a: 1.a.-g. The first compliance indicator for employment training for all Case Managers (CM) has not been achieved. DBHDS provided a copy of the DBHDS Support Coordination/Case Management Employment Training Module. DBHDS has included employment training for CMs in the CM orientation since 2015. A CI of the Settlement Agreement for III.C.7.a. requires all CMs to take the online training and review the CM Manual. The information must include seven components which are reviewed and evaluated here.

1.a. The Employment First Policy with an emphasis on the long-term benefits of employment to people and their families and practical knowledge about the relationship of employment to continued Medicaid benefits. The training includes information about the general value to all individuals including those with disAbilities of work; its contribution to one's self-esteem; connection to the larger community; the development of friendships; providing a sense of meaning; and financial benefits. The training explains the Employment First Policy in Virginia. It offers links to resources for benefits planning that can help families and individuals understand the impact of earning wages on Medicaid benefits. The CM is to consider how the person's benefits may be impacted by working when leading team discussions that focus on employment planning. The training notes that a common barrier to employment is misconceptions about benefits. The training includes a vignette about the impact of employment on benefits for one individual to offer an example for CMs and recommends the CM direct the family to a benefits planner. An overview of benefits planning is offered in a section of the training. However, the training does not include anything specific that will provide a CM with "practical knowledge about the relationship of employment to continued employment benefits" as required in the CI.

Conclusion: The training fully addresses the Employment First Policy and provides the CM with information as to the long-term benefits of employment. While the training includes information that benefits may be affected by employment for an individual with a disAbility and points to external resources for families to explore and understand these impacts, the training does not give the CM practical knowledge about the relationship of employment to continued Medicaid benefits.

1.b. Skills to work with individuals and families to build their interest and confidence in employment. The training includes information on the variety of benefits a person with a disAbility will accrue through employment. The various types of support individuals can receive, and the variety of employment models are discussed. The CM is trained to make the discussion of employment a person-centered process that starts by identifying the individuals interests and skills and how these relate to different employment opportunities. The availability of experienced employment staff through Employment Service Organizations (ESO) and the availability of funding through DARs and DBHDS waivers are discussed. The CM is expected to work with the person to encourage career exploration. The training educates the CM about a number of resources that can be offered to individuals and families to build their interest and over time their confidence in working. The training prepares the CM to discuss and help the team address barriers to employment which is important to build interest and confidence in the planning process and the eventual connection with an employment service provider. DBHDs offers videos of individuals with various disAbilities working which can contribute to the confidence of individuals contemplating if employment is right for them.

Conclusion: The training addresses this CI.

1.c. The importance of discussing employment with all individuals, including those with intense medical or behavioral needs and their families. Virginia supports the Employment First Policy developed and issued by the Association of People Supporting Employment First (APSE). This policy states that "employment is the first and preferred outcome in the provision of publicly funded services for *all working age citizens, regardless of disAbility."* This statement is included and discussed in the CM Employment Training. A section of the training titled, "Myths, Misconceptions, or Realities" addresses the needs of individuals with medical or behavioral complexities through the use of vignettes of individuals who have these issues and who are employed. The training encourages work for these individuals an cites research of the benefits of working on behavioral, mental and physical health.

Conclusion: Virginia supports employment for all individuals regardless of the level, severity of type of disAbility. The training reinforces that employment should be discussed with all individuals and their families. The videos of individual employment situations are useful to help CMs facilitate meaningful discussion. The training does not equip the CM to address questions or concerns families or individuals may have regarding complex disAbilities. There is no information about behavioral or medical supports that may be available to individuals with these needs. There is no reference to how a Behavior Support Professional or the development of a behavioral plan may prepare an individual with behavioral complexity to eventually work. This material regarding employment for individuals with medical or behavioral complexities was added to the CM online training that is being made available during the 18th review period beginning in October 2020. However, the additional training was sent to all CSBs by DBHDS in June 2020 and the CSBs were instructed to provide the training to CMs who had already completed the existing online training and to insure it was offered to all newly hired CMs. Once completion of the training including the additional material by all CMs, the Commonwealth will have achieved this indicator.

1.d. The importance of starting the discussion about employment with individuals and families as early as the age of 14 with goals that lead to employment (e.g., experiences in the community, making purchases, doing chores, volunteering).

The training addresses the need and expectation for CMs to initiate employment-related discussions with adolescents starting at age fourteen. It includes information regarding the Virginia Department of Education's (VDOE) standards of accreditation in this area including the expectation for middle school students to begin work exploration and develop a portfolio. It gives the CMs resources in this area and educates the CM as to what is available through DARS for pre-employment transition. The training includes questions to use to guide a discussion of employment exploration and preparation with this age group and highlights the value of volunteering and other skill building activities.

Conclusion: The revised Employment training for CMs addresses this CI. It was shared with CSBs in written form as is noted above regarding the additional materials about employment for individual with behavioral and medical complexity.

1.e. The value of attending a student's IEP meeting starting at age 14 to encourage a path to employment during school years and to explore how DD services can support the effort. The training module recommends that the CM ask the family to request the school to invite the CM to the students IEP and explains the importance of the CM being part of this meeting and planning process to discuss transition supports to lead to employment. The training includes suggested questions the CM can ask during planning meeting for adolescents to direct the development of transition plans.

Conclusion: The Employment training for CMs addresses this CI. It was shared with CSBs in written form in June 2020, as is noted above regarding the additional materials about employment for individual with behavioral and medical complexity.

1.f Developing goals for individuals utilizing Community Engagement Services that can lead to employment (e.g., volunteer experiences, adult learning). The value of community engagement and coaching services are included in the section regarding planning for 14-17-year-old students. A section on Link to Resources includes community colleges and other post-secondary educational opportunities to enhance skills for learning opportunities and adult learning classes. However, there is no information or training about the value or availability of community engagement services to lead to employment for other age groups.

Conclusion: The Employment training for CMs does not meet this CI as it does not include any relevant information about community engagement except for students 14-17. The information for this age group has been added to the revised training materials but was not addressed at all in the previous version of the employment training module. DBHDS reports that training regarding the value of Community Engagement (CE) and Community Coaching (CC) has been provided through direct presentation by DBHDS staff to regional groups of CMs. While this training includes information about both CE and CC for individuals with I/DD of all ages and is comprehensive, it has not necessarily been taken by all CMs, nor is there any testing or demonstration of competency. This training was given in person by DBHDS staff over the past few years. There is no documentation to indicate that CMs who have been hired since the training was offered have been similarly trained.

1.g. Making a determination during their monitoring activities as to whether the person is receiving support as described in the person's plan and that the experience is consistent with the standards of the service. The Employment training includes a module on monitoring progress that emphasizes the responsibility of the CM to monitor the services in the plan for either preparing a person for work and addressing barriers to employment, or making sure if a person is employed it is in a job they want and asking if they would prefer other options. The training does not reference the standards of the service the individual is using or how to assess or ensure that these standards are being met. There is no instruction as to how this monitoring may occur during visits, how it should be documented, or what is the expectation for the CM's follow up if the support is not being received, and individuals' needs or program standards are not being met.

Conclusion: The Employment training for CMs does not meet the CI as it does not address monitoring the standards of employment or employment readiness services. Also, the monitoring section of the Employment Training for CMs is included in the new version of the training but is not include in the previous version. It was shared with CSBs in written form as is noted above regarding the additional materials about employment for individual with behavioral and medical complexity.

The Commonwealth is to ensure all CMs take the online training modules and review the CM manual. To date the data has been maintained by Virginia Commonwealth University (VCU). VCU also requires each CM to take a test after completing the online training. The CM must pass the test with a score of at least 80% for the training to be confirmed as completed. Starting this fall, DBHDS will maintain the data in its own online training database.

DBHDS indicates it reviews the data VCU has for each CSB compared to the number of CM FTEs in each CSB to determine if all CMs have been trained. The department does not have data to confirm names but reports it has confidence that all CMs have been trained because the numbers reported by VCU are greater than the number of FTEs which DBHDS reports accounts for turnover of case managers. However, no actual data were produced for this review regarding the number of CMs trained, and DBHDS does not have an entirely accurate methodology to verify that every CM has completed the online training.

Conclusion: Virginia has not fully achieved the compliance indicators for III.C.7.a. & b. regarding employment and community engagement training for its CMs.

The second CI regarding employment expectations of the SA focus on the discussions of employment and community engagement; the goal setting for employment and CE services; and the initiation of employment services. Below is a summary of the Commonwealth's status supplying verified data and meeting the CI measures.

III.C.7.a & b. CI 2.a. At least 86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of the ISP planning process. The DBHDS cannot produce reliable, valid, verified data regarding this CI. The SCQR was designed to provide this data but as I reference earlier in this report DB HDS was unable to share the findings of the SCQR as it relates to employment and CE discussions and goals for this review period. The CSBs report that discussions are held with 94% of the

individuals who had ISP meetings between June 2019 and June 2020, but the CSB methodology for collecting this data has not been verified. The independent IDA Study conducted this period found no consistently used standards for determining when a CM should check the box to indicate that a minimally acceptable discussion had occurred. This IDA Study, which are presented in a separate report to the Independent Reviewer, found that only 72% of the sample reviewed had a meaningful discussion about employment.

III.C.7.a.& b. CI 2.b. At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment. The DBHDS cannot produce reliable, valid, verified data regarding this CI. The SCQR was designed to provide this data but has been referenced earlier in this report DBHDS was unable to share the findings of the SCQR as it relates to employment and CE discussions and goals. The planned Retrospective Review by the DBHDS QI staff was also not available. The CSBs report that employment goals were set for 30% of the individuals who had ISP meetings between June 2019 and June 2020 but the CSB methodology for collecting this data has not been verified.

III.C.7.a.& b. CI 2.c. At least 86% of individuals who are receiving waiver services and have employment services authorized in their ISPs will have a provider and begin services within 60 days. DBHDS produced a report for this CI. DBHDS completed a Monitoring Questionnaire for data verification. It is based on reliable information from the WaMS system and from ESOs. DBHDs reported on individuals who had new employment service authorizations between January 1, 2020 and June 30, 2020. There were 110 individuals with authorizations for employment services in this time period. Of these, sixty-five had start dates. All of these sixty-five individuals began employment services within 60 days. Thirty-nine of them started the day of the authorization; twenty-three started between 1-48 days of the authorization; and three started 60 days after the service authorization. Of these individuals, fifty-four (83%) started their services prior to April 1, 2020 when more businesses started closing and furloughing employees because of COVID. However, there were fifty-five individuals with no start dates for employment services. This CI is not met since only 59% of the individuals with service authorizations between January and June 2020 had services begin within 60 days of the authorization. DBHDS did not provide data for service authorizations that began July 2019 through December 2019.

III.C.7.a.& b. CI 2.d. At least 86% of individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process. The SCQR was designed to provide this data but has been referenced earlier in this report DBHDS was unable to share the findings of the SCQR as it relates to employment and CE discussions and goals. The CSBs report that discussions are held with 91% of the individuals who had ISP meetings between June 2019 and June 2020 but the CSB methodology for collecting this data has not been verified. Also, the findings of the Employment Study which are presented in a separate report to the Independent Reviewer indicate that only 52% of the sample had a meaningful discussion about community engagement.

III.C.7. a.& b. CI 2.e. At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. The SCQR was designed to provide this data but has been referenced earlier in this report DBHDS was unable to share the findings of the SCQR as it relates to employment and CE discussions and goals. The CSBs report that CE goals were set for 38% of the individuals who had ISP meetings between June 2019 and June 2020 but the CSB methodology for collecting this data has not been verified.

III.C.7.a.& b. CI. 2.f. At least 86% of individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP. DBHDS does not yet have the data to report this information and has not met this CI.

III.C.7. a.& b. CI 3. New Waiver Targets established by the Employment First Advisory Group. The data target for FY20 is 936 individuals in ISE; 550 individuals in GSE for a total of 1486 in supported employment. Compliance with the Settlement Agreement is attained when the Commonwealth is within 10% of the targets. The Commonwealth has established an overall target of employment of 25% of the combined total of adults age 18-64 on the DD waivers and waitlist. DBHDS produced a report for this CI. DBHDS completed a Monitoring Questionnaire for data verification. It is based on reliable information from the WaMS system and from ESOs. The information is reported in the Semiannual Employment Report that has been issued by the DBHDS for the past eleven reporting periods. As has been noted earlier in this report the employment targets were not met as of June 2020 when only 715 individuals were employed through waiver services: 480 in ISE and 235 in GSE.

III.C.7.a.& b. CI. 4.DBHDS service authorization data continues to demonstrate an increase of 3.5% annually of the DD Waiver population being served in the most integrated settings as defined in the Integrated Employment and Day Services Report (an increase of about 500 individuals each year as counted by unduplicated number recipients). DBHDS produced a report for this CI. DBHDS completed a Monitoring Questionnaire for data verification. The DBHDS report is based on reliable information from the WaMS system and from ESOs. The information is reported in the Semiannual Employment Report that has been issued by the DBHDS for the past eleven reporting periods. Integrated Day Services include CC, CE, ISE, GSE and WA. The changes in the number of individuals authorized is displayed in ***Table 5*** in this report. The overall increase in the number of service authorizations between June 2019 and June 2020 was sixty-two individuals which is a 1.4% increase over the 4,343 individuals who had these service authorizations effective June 2019. This target was not met during the review period.

X. Summary

DBHDS' previous trend of making gains to increase employment and in its efforts to implement and increase participation in community engagement have been stymied by the COVID pandemic during this reporting period. As a result, its progress toward achieving its multi-year employment targets is reversed this year. It will require a significant increase in these employment opportunities in FY21 to meet the CIs for employment targets and the target for the percentage increase for individuals participating in integrated day activities. The percentage of meeting its overall target for employment dropped from 24% to 19%, versus the expectation that 25% of all individuals on the waivers or the waiting lists will be employed. The number of individuals employed through HCBS waiver services declined dramatically during the COVID pandemic, which is not unexpected and reflects national trends in the I/DD field. One hopes that many of these individuals are being rehired and employment will improve over the next several months. Service authorizations for CE decreased during this reporting period. It is also concerning that there still does not seem to be sufficient provider capacity to offer available CE services in all parts of Virginia.
The Commonwealth cannot confirm that it has achieved its targets set for the CSBs for employment and CE discussions or for employment and CE goal setting in the ISPs of waiver participants.

The Stakeholders who are part of the E1AG remain interested and positive about the Commonwealth's progress and achievements. They report that the work of the E1AG will be strengthened by including representatives from mental health and substance use. DBHDS has hired a new Employment Services Coordinator who can devote time to assisting the E1AG to achieve its goals to undertake and report trend analyses; address employment barriers; and make continued recommendations to increase employment options for individuals with I/DD.

Attachment 1 (DBHDS Report October 2020)

Tracking Employment First Conversations:

DBHDS has worked to develop new measures as part of the CSB performance contract, which specifically collects data on:

1. discussing employment with individuals receiving case management services, and
2. developing individual employment related and/or readiness goals.

The results of the data collection are presented below for the first half of the fiscal year of FY2020 (7/1/19-6/30/2020).

Report #1 ISP Reviews Jul 1, 2019 – June 30, 2020	Active Waiver	F2F ISP	% with F2F ISP	Employ Discussion	% Employ Discussion	Employ Outcomes Present	% Outcomes
Chesterfield	989	560	63%	532	95%	193	**34%**
Crossroads	198	178	93%	167	94%	50	**28%**
District 19	308	204	72%	167	82%	40	**20%**
Goochland-Powhatan	67	55	85%	55	100%	18	**33%**
Hanover	184	127	68%	123	97%	43	**34%**
Henrico Area	542	445	81%	434	98%	172	**39%**
Richmond	434	395	90%	388	98%	149	**38%**
Southside	193	169	88%	169	100%	49	**29%**
Central region	**2,915**	**2,133**	**77%**	**2,035**	**95%**	**714**	**33%**
Chesapeake	304	206	69%	206	100%	55	**27%**
Colonial	165	146	90%	145	99%	33	**23%**
Eastern Shore	112	71	70%	70	99%	12	**17%**
Hampton-Newport News	560	456	81%	407	89%	117	**26%**
Middle Peninsula-Northern Neck	248	189	77%	172	91%	37	**20%**
Norfolk	488	415	87%	393	95%	104	**25%**
Portsmouth	228	154	71%	117	76%	32	**21%**
Virginia Beach	734	516	70%	511	99%	140	**27%**
Western Tidewater	269	240	91%	193	80%	63	**26%**
Eastern region	**3,108**	**2,393**	**78%**	**2,214**	**93%**	**593**	**25%**
Alexandria	98	74	83%	73	99%	44	**59%**
Arlington	166	141	88%	120	85%	47	**33%**
Fairfax-Falls Church	1,149	880	78%	861	98%	251	**29%**
Loudoun County	262	215	80%	212	99%	97	**45%**
Northwestern	405	260	73%	256	98%	94	**36%**

Report #1 ISP Reviews Jul 1, 2019 – June 30, 2020	Active Waiver	F2F ISP	% with F2F ISP	Employ Discussion	% Employ Discussion	Employ Outcomes Present	**% Outcomes**
Prince William	508	318	64%	318	100%	90	**28%**
Rappahannock Area	552	364	64%	313	86%	150	**41%**
Rappahannock-Rapidan	266	222	84%	201	91%	93	**42%**
Northern region	**3,406**	**2,470**	**75%**	**2,350**	**95%**	**865**	**35%**
Blue Ridge	439	294	66%	286	97%	64	**22%**
Cumberland Mountain	162	142	92%	141	99%	66	**46%**
Danville-Pittsylvania	341	253	76%	136	54%	41	**16%**
Dickenson	21	17	81%	4	24%	-	**0%**
Highlands	132	61	47%	61	100%	18	**30%**
Mount Rogers	314	188	60%	183	97%	30	**16%**
New River Valley	240	220	87%	219	100%	71	**32%**
Piedmont	281	237	86%	229	97%	38	**16%**
Planning District I	160	131	82%	104	79%	9	**7%**
Southwestern region	**2,090**	**1,543**	**75%**	**1,363**	**88%**	**337**	**22%**
Alleghany-Highlands	53	39	70%	39	100%	18	**46%**
Harrisonburg-Rockingham	200	131	66%	130	99%	60	**46%**
Horizon	606	513	84%	509	99%	188	**37%**
Region Ten	351	307	88%	299	97%	82	**27%**
Rockbridge Area	59	41	65%	40	98%	14	**34%**
Valley	274	237	84%	236	100%	66	**28%**
Western region	**1,543**	**1,268**	**81%**	**1,253**	**99%**	**428**	**34%**
Statewide	**13,070**	**9,805**	**77%**	**9,215**	**94%**	**2,937**	**30%**

Attachment 2 (Community Engagement Discussion and Goals)

Report #3 Community Engagement Jul 1, 2019 - Jun 30, 2020	Ind with DD	Ind with DD who had "CCS3 recorded" ISP	% Ind with DD who had "CCS3"	Ind CE discussion	% Individuals CE discussion	Ind CE goals at ISP	% Ind CE goals at ISP
Chesterfield	985	622	63%	548	88%	121	**19%**
Crossroads	217	200	92%	184	92%	162	**81%**
District 19	332	239	72%	197	82%	138	**58%**
Goochland-Powhatan	76	66	87%	62	94%	13	**20%**
Hanover	224	146	65%	142	97%	47	**32%**
Henrico Area	640	515	80%	499	97%	177	**34%**
Richmond	504	456	90%	446	98%	97	**21%**
Southside	222	196	88%	190	97%	53	**27%**
Central region	3,161	2,440	77%	2,268	93%	808	**33%**
Chesapeake	333	227	68%	226	100%	135	**59%**
Colonial	185	167	90%	161	96%	21	**13%**
Eastern Shore	122	84	69%	71	85%	53	**63%**
Hampton-Newport New	620	507	82%	432	85%	70	**14%**
Middle Peninsula-North	285	222	78%	200	90%	60	**27%**
Norfolk	543	480	88%	451	94%	140	**29%**
Portsmouth	238	170	71%	165	97%	107	**63%**
Virginia Beach	820	575	70%	568	99%	88	**15%**
Western Tidewater	291	266	91%	236	89%	150	**56%**
Western region	3,418	2,698	79%	2,510	93%	824	**31%**
Alexandria	108	88	81%	84	95%	32	**36%**
Arlington	176	155	88%	120	77%	59	**38%**
Fairfax-Falls Church	1,314	1,001	76%	970	97%	202	**20%**
Loudoun County	316	247	78%	238	96%	147	**60%**
Northwestern	391	292	75%	263	90%	173	**59%**
Prince William	554	349	63%	343	98%	239	**68%**
Rappahannock Area	673	442	66%	394	89%	282	**64%**
Rappahannock-Rapidan	297	252	85%	221	88%	151	**60%**
Northern region	3,785	2,822	75%	2,630	93%	1,284	**45%**
Blue Ridge	519	345	66%	299	87%	169	**49%**
Cumberland Mountain	183	172	94%	164	95%	71	**41%**
Danville-Pittsylvania	367	277	75%	145	52%	100	**36%**
Dickenson	35	31	89%	23	74%	10	**32%**
Highlands	154	71	46%	68	96%	47	**66%**
Mount Rogers	427	272	64%	213	78%	98	**36%**
New River Valley	332	288	87%	278	97%	178	**62%**

Piedmont	324	276	85%	246	89%	108	**39%**
Planning District I	205	163	80%	93	57%	32	**20%**
Report #3 Community Engagement Jul 1, 2019 - Jun 30, 2020	Ind with DD	Ind with DD who had "CCS3 recorded" ISP	% Ind with DD who had "CCS3"	Ind CE discussion	% Individuals CE discussion	Ind CE goals at ISP	**% Ind CE goals at ISP**
Southwestern region	2,521	1,895	75%	1,529	81%	813	**43%**
Alleghany-Highlands	69	51	74%	49	96%	7	**14%**
Harrisonburg-Rockingham	243	160	66%	152	95%	75	**47%**
Horizon	769	643	84%	564	88%	232	**36%**
Region Ten	406	361	89%	334	93%	125	**35%**
Rockbridge Area	84	53	63%	52	98%	33	**62%**
Valley	346	285	82%	264	93%	96	**34%**
Western Region	**1,912**	**1,553**	**81%**	**1,415**	**91%**	**568**	**37%**
Statewide	**14,695**	**11,406**	**78%**	**10,352**	**91%**	**4,297**	**38%**

ATTACHMENT 3

Integrated Day Activities Including Supported Employment Study 17th Review Period

Introduction and Study Methodology

At the request of the Independent Reviewer, a record review of employment and community engagement (CE) was undertaken in this review period to provide added information to the data reports provided by DBHDS which summarizes statewide data for various aspects of employment and community engagement for individual with I/DD. The purpose of the review was to determine if there were meaningful discussions about employment interests and options and about increasing opportunities for engaging in community-based activities on a regular basis; and whether an individual employment or employment readiness goal and/or community engagement goal were established for the individuals. DBHDS had its QI staff randomly select 99 records for its data review and verification of SCQR reviews of 430 records reviewed by CSB supervisors. We reviewed the same 99 records that were reviewed by the DBHDS QI staff.

The study included a review of the written plans and any other documentation related to employment and Community Engagement (CE) discussions during the face-to-face ISP meetings. DBHDS shared ISPs; Provider Part V sections detailing service implementation plans; the CM quarterly reviews of each ISP; the CM progress notes; the SIS and the VA Informed Choice forms.

Ninety-nine adults were selected as the sample for this review of employment and CE, the two primary waiver-funded services in Virginia that comprise integrated day activities. The sample included all forty CSBs and 99 of the individuals whose ISP annual meetings were convened in the year prior to July 2020. Each CSB had 2-4 individuals in the sample. Individuals were affiliated with the following regions:

- Eastern Region 22
- Central Region 19
- North Region 21
- Western Region 16
- Southwestern Region 21

The reviewers reviewed all the documents to determine:

- Did the individual's planning team meaningfully discuss employment with the individual at the annual ISP meeting?
- Did the team identify and address any barriers to employment?
- Did the team with the participation of the individual and authorized representative (AR), set an employment goal or employment readiness goal for the individual?
- If the individual or AR was not interested in employment at this time did the team develop strategies to educate the individual and family about the benefits of employment?
- Did the individual's planning team meaningfully discuss community engagement with the individual at the annual ISP meeting?
- Did the team identify and address any barriers to community engagement?
- Did the team with the participation of the individual and AR, set a community engagement goal for the individual?
- If the individual or AR was not interested in community engagement at this time did the team develop strategies to educate the individual and family about the benefits of community engagement?

In order to make these determinations we considered the following issues:

1. Is there documentation of the employment and community engagement discussions?
2. Were the individual's and/or AR's opinions, desires, and concerns included in the discussions?
3. Did the discussions include determining what the individual's interests and skills are?
4. Did the discussions include any challenges or barriers to employment that the individual is experiencing?
5. Did the discussions include an explanation of the employment options that are available to the individual?
6. Did the team review the impact of employment on the individual's benefits if the individual was interested in working?
7. If the individual is interested in working did the team recommend related assessments if not already done?
8. Was an employment or employment readiness goal created?

9. Does the goal reflect the employment discussion (strengths, preferences, needs and barriers)?
10. Is the goal/outcome measurable?
11. Does the plan include goals, objectives, and activities to promote the individual's participation in integrated day activities?
12. Do these integrated day activities reflect the strengths, preferences and needs of the individual?
13. Do these integrated day activities promote active participation for the individual in the community?

Medical and Behavioral Concerns

Pursuant to the Commonwealth's Employment First policy and its Employment Plan, DBHDS is committed to providing supports to both employment and CE for individuals who may have medical or behavioral concerns that must be addressed for the individuals to successfully work or engage in the community interacting with typical peers in a meaningful way. There are 99 individuals in the sample for this study. Of these individuals, forty-one have medical conditions that the team would need to address, and thirty-seven have behavioral concerns that may be a barrier to employment or community inclusion. Only five individuals of the forty-one with medical concerns have such a significant health concerns that they may preclude work. These concerns include individuals who have quadriplegia; are frequently suctioned and use a ventilator; or whose medical fragility preclude them from being out of their home settings because of fear of infection or lack stamina to engage in activities. We made these determinations based on our review of the Risk Assessment; the Service Intensity Scale (SIS); and the need for and presence of a behavior support plan for each individual in the sample.

DBHDS expects teams will work to address individuals' medical and behavioral concerns if there are barriers to employment and community engagement. There was evidence in the records reviewed that teams were addressing the behavior issues for twenty-one (57%) of the thirty-seven individuals with behavioral needs. The majority of these individuals had a Behavior Support Professional (BSP) and/or a behavioral plan. There were thirty-six individuals in the Employment Study who had medical conditions that needed to be addressed. This does not include the five individuals identified above whose medical or physical conditions are so significant that work is precluded. Of these thirty-six individuals there was evidence in the records reviewed that teams were addressing these medical concerns as they might impact employment and CE for twenty-two (61%) of them.

Findings

ISP document review - DBHDS provided the ISPs for the individuals and included the Part V section completed by the CMs and providers. The section of the ISP that addresses employment and CE is comprised of check off boxes for each service related to the discussion by the team; the individual's interest; whether the person is deciding to retire; a listing of barriers; and whether there is a plan to further educate the individual and family about employment and CE. There is no area in the ISP that provides an opportunity for the CM to enter information that would document what comprised these discussions; or what was being planned to address the barriers. There is a section for the CM to document how the CM and team planned to provide further education and information about employment or CE for individuals who were not interested at the time of the meeting. However, this was rarely completed.

The Section V of the ISPs that were shared were the Part V's completed by the CM, and the CE, SE or Group Day provider, as well as the residential provider. Overall, this study found that the goal statements in the Section V's were weak, very general and for the most part reflected basic rights and life expectations. For example, few of the outcomes/goals include measurable objectivities that would allow the CM to be aware of real progress or the need to possibly modify an ISP because of a lack of progress. Also, goals that are not measurable, cannot be objectively determined and, therefore inherently contribute to unreliable data that are provided by CMs and verified by their supervisors.

Employment Discussions and Goal Setting

Table 1 below summarizes by CSB the findings for the CMs fulfilling the Commonwealth's employment policy and case management expectations. This Table includes "Yes" answers when the documentation reviewed provided evidence of: discussing employment; determining the individual's interest; identifying and addressing barriers to employment; setting employment goals and planning to further educate individuals who are not currently interested in employment. The Table compiles and displays information for each Region's sample and an aggregate total of compliance for each element for each Region and for the entire sample.

TABLE 1: EMPLOYMENT SUMMARY							
	Employment Discussion	**Interest**	**Plan to Educate**	**Plan Implement.**	**Goals Set**	**Identified Barriers**	**Addressed Barriers**
EASTERN REGION							
ER1***	YES	NO	NO	NO	N/A	NO	NO
ER2	YES	YES	N/A	N/A	YES	YES	YES
ER3	NO	NO	NO	NO	N/A	YES	N/A
ER4	YES	NO	NO	NO	N/A	YES	N/A
ER5	YES	YES	N/A	N/A	YES	YES	N/A
ER6	NO	NO	NO	NO	N/A	YES	NO
ER7	YES	NO	YES	YES	N/A	YES	NO
ER8	YES	YES	N/A	N/A	NO	YES	N/A
ER9	NO	NO	NO	NO	N/A	YES	NO
ER10	NO	NO	NO	NO	N/A	YES	NO
ER11	NO	NO	NO	NO	N/A	NO	NO
ER12	YES	YES	N/A	N/A	YES	YES	YES
ER13	YES	YES	N/A	N/A	YES	YES	YES
ER14	NO	NO	NO	NO	N/A	YES	NO
ER15	NO	NO	NO	NO	N/A	YES	NO
ER16**	YES	NO	NO	NO	N/A	YES	NO
ER17	YES	YES	N/A	N/A	NO	NO	NO
ER18	NO	NO	NO	NO	N/A	NO	NO
ER19	NO	NO	NO	NO	N/A	NO	NO
ER20	YES	NO	YES	YES	N/A	YES	N/A
ER21	NO	NO	NO	NO	N/A	YES	NO
ER22	YES	YES	N/A	N/A	YES	YES	N/A
REGION COMPLIANCE PERCENTAGE	**12/ 22 = 55%**	**7/22 = 32%**	**2/14 = 14%**	**2/14 = 14%**	**5/7= 71%**	**17/22 = 77%**	**3/16= 19%**

	Employment Discussion	Interest	Plan to Educate	Plan Implement	Goals Set	Identified Barriers	Addressed Barriers
CENTRAL REGION							
CR1	YES	YES	N/A	N/A	YES	YES	YES
CR2	YES	YES	N/A	N/A	YES	YES	NO
CR3	YES	YES	N/A	N/A	YES	YES	YES
CR4	YES	YES	N/A	N/A	YES	YES	N/A
CR5	NO	NO	NO	NO	N/A	YES	NO
CR6	NO	NO	NO	NO	N/A	YES	NO
CR7	NO	NO	NO	NO	N/A	YES	N/A
CR8	YES	YES	N/A	N/A	YES	YES	N/A
CR9	YES	YES	N/A	N/A	YES	YES	N/A
CR10	NO	NO	NO	NO	N/A	YES	NO
CR11	YES	NO	YES	NO	YES	NO	NO
CR12	YES	NO	NO	NO	N/A	YES	NO
CR13	YES	NO	NO	NO	N/A	YES	NO
CR14	YES	NO	NO	NO	N/A	YES	NO
CR15***	YES	YES	N/A	N/A	N/A*	YES	YES
CR16	YES	NO	YES	YES	N/A	NO	NO
CR17	NO	NO	NO	NO	N/A	YES	NO
CR18	NO	NO	NO	NO	N/A	YES	NO
CR19	NO	NO	NO	NO	N/A	YES	NO
REGION COMPLIANCE PERCENTAGE	**12/19 = 63%**	**7/19 = 37%**	**2/12 = 17 %**	**1/12 = 8%**	**7/7 = 100%**	**17/19 = 89%**	**3/15 = 20%**

	Employment Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
NORTHERN REGION							
NR1	YES	YES	N/A	N/A	YES	YES	YES
NR2	YES	YES	N/A	N/A	YES	YES	YES
NR3**	YES	NO	NO	NO	N/A	YES	N/A
NR4	NO	NO	NO	NO	N/A	YES	NO
NR5	NO	NO	NO	NO	N/A	YES	NO
NR6*	YES	NO	N/A	N/A	N/A	N/A	N/A
NR7*	YES	NO	N/A	N/A	N/A	N/A	N/A
NR8	NO	NO	NO	NO	N/A	NO	NO
NR9	YES	NO	NO	NO	N/A	YES	NO
NR10**	YES	NO	YES	YES	N/A	YES	YES
NR11** & ***	YES	NO	N/A	N/A	N/A	N/A	N/A
NR12	YES	YES	N/A	N/A	YES	YES	YES
NR13**	YES	NO	YES	YES	N/A	YES	YES
NR14	YES	YES	N/A	N/A	NO	YES	YES
NR15	YES	NO	YES	NO	N/A	YES	YES
NR16**	YES	NO	NO	NO	N/A	NO	NO
NR17** & ***	YES	NO	N/A	N/A	N/A	N/A	N/A
NR18	YES	NO	YES	YES	N/A	YES	YES
NR19	YES	NO	NO	NO	N/A	NO	NO
NR20*	YES	NO	N/A	N/A	N/A	N/A	N/A
NR21	YES	YES	N/A	N/A	YES	YES	YES
REGION COMPLIANCE PERCENTAGE	**18/21 = 86%**	**5/21 = 24%**	**4/11 = 36%**	**3/11 = 27%**	**4/5 = 80%**	**13/16 = 81%**	**9/15= 60%**

	Employment Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
WESTERN REGION							
WR1	YES	YES	N/A	N/A	YES	YES	YES
WR2	NO	NO	NO	NO	N/A	YES	NO
WR3*	YES	NO	N/A	N/A	N/A	N/A	N/A
WR4	NO	NO	NO	NO	N/A	YES	NO
WR5	YES	NO	YES	YES	N/A	YES	YES
WR6*	YES	NO	N/A	N/A	N/A	N/A	N/A
WR7	YES	NO	NO	NO	N/A	YES	YES
WR8	YES	YES	N/A	N/A	YES	YES	YES
WR9*	YES	NO	N/A	N/A	N/A	N/A	N/A
WR10	YES	NO	NO	NO	N/A	YES	NO
WR11	YES	NO	NO	NO	N/A	NO	NO
WR12	YES	NO	NO	NO	N/A	NO	NO
WR13*	YES	NO	N/A	N/A	N/A	N/A	N/A
WR14	NO	NO	NO	NO	N/A	NO	NO
WR15	YES	YES	N/A	N/A	YES	YES	YES
WR16	YES	YES	N/A	N/A	YES	YES	YES
REGION COMPLIANCE PERCENTAGE	**13/16 = 81%**	**4/16 = 25%**	**1/8 = 13 %**	**1/8= 13%**	**4/4 = 100%**	**9/12 = 75%**	**6/12 = 50%**

	Employment Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
SOUTHWEST REGION							
SW1	NO	NO	NO	NO	N/A	NO	NO
SW2	NO	NO	NO	NO	N/A	NO	NO
SW3**	YES	NO	NO	NO	N/A	YES	YES
SW4**& ***	YES	NO	N/A	N/A	N/A	YES	N/A
SW5	YES	NO	NO	NO	N/A	YES	YES
SW6	YES	NO	NO	NO	N/A	YES	YES
SW7*	YES	NO	N/A	N/A	N/A	YES	YES
SW8	YES	NO	NO	NO	N/A	NO	NO
SW9*	YES	NO	N/A	N/A	N/A	N/A	N/A
SW10	YES	NO	NO	NO	N/A	YES	YES
SW11	YES	NO	NO	NO	N/A	YES	YES
SW12** & ***	YES	NO	N/A	N/A	N/A	YES	YES
SW13	YES	YES	N/A	N/A	NO	NO	NO
SW14	NO	NO	NO	NO	N/A	NO	NO
SW15	YES	NO	NO	NO	N/A	YES	YES
SW16	YES	YES	N/A	N/A	YES	YES	YES
SW17	YES	NO	YES	YES	N/A	YES	NO
SW18	NO	NO	YES	YES	N/A	YES	YES
SW19	YES	NO	NO	NO	N/A	NO	NO
SW20	YES	YES	N/A	N/A	NO	YES	NO
SW21	NO	NO	NO	NO	N/A	NO	NO
REGION COMPLIANCE PERCENTAGE	**16/21 = 76%**	**3/21 = 14%**	**2/14 = 14%**	**2/14 = 14%**	**1/3 = 33%**	**13/20 = 65%**	**10/19 = 53%**

TOTAL COMPLIANCE PERCENTAGE	**71/99 = 72%**	**26/99 = 26%**	**11/59 = 17%**	**9/59= 15%**	**21/26 = 81%**	**69/89 = 78%**	**31/77 = 40%**

KEY:
* Retired due to age or health
** Parent/Authorized Representative does not want employment
*** Physically or medically unable to participate

Employment Discussion- DBHDS expects that CSB CMs will have employment discussions with 100% of the individuals on their caseloads (between the ages of 18-64) at the ISP annual meeting. The Parties have agreed that compliance with this indicator will be reached when these discussions occur with 86% of adults between the ages of 18-64 who are on a HCBS waiver. DBHDS reported in its Semiannual Employment Report that these discussions were held for 94% of all individuals during FY20 for whom an ISP was held. During the twelve-month period, ISPs were held for 77% of the 99 waiver participants.

In contrast with the number of employment self-reported by CMs, our study found that sufficient discussions were held for 72% of the selected sample overall, compared to 73% in the IDA Study completed in 2019. The percentage of individuals with whom discussions were held across the five Regions in the study ranged from 55-86%. The Eastern Region achieved 55% and the Northern Region achieved 86%.

Almost all the ISPs included a checkmark that an employment conversation occurred. In making our determinations we expected to see evidence that a meaningful discussion occurred including a discussion of the person's interests and history of employment; their skills related to employment; the employment services available through DARs and HCBS waivers; and the barriers that they or their family felt existed to successful employment. We confirmed an employment discussion occurred if the there was any documentation in the ISP, Quarterly Reviews or progress notes that explained or summarized an actual discussion. Again, it appears that self-reported checked boxes do not reliably verify that a required action has in fact occurred.

Setting an Employment Goal- The Parties have agreed to a CI for setting employment goals and including the goal(s) in the ISP(s). With recognition that some individuals are not able or interested in working, the parties agreed, and the Court approved a CI that sets the expectation that 50% of all adults between the ages of 18-64 who are on a HCBS waiver will have an employment goal. -Using the agreed upon methodology which does not subtract the individuals who do not express an interest in or have conditions that preclude employment, the percentage of individuals with an employment goal included in their ISPs is only 30% in the CSB report dated June 2020 and the percentage of individuals with an employment goal is 21% of the sample for this study.

Interest in Employment and Plans to Educate Individuals and Families **-** The interest of the individual or family is noted only by a checked off box on the ISP. Often it is noted if it is the family who objects. We noted eight families who have strong objections to either employment and/or CE. (These individuals are noted in the Tables with two asterisks.) Of these eight families, four had children who had significant medical or physical conditions that would preclude employment. Of the individuals who were not interested, nine had chosen to retire and six have medical or physical conditions that may preclude work.

Overall, only 26% (26) of the individuals expressed an interest in employment and 74% (73) expressed that they did not have interest at this time. These are the same percentages reported in these reviewers' 2019 IDA Study. The Commonwealth's and CSB policy require employment to be the first and priority service option for individuals' day service option. To be the priority service option, this study expects that, at a minimum, educational plans would be developed for those individuals who are not interested in employment, unless an educational plan was unnecessary. We determined that an educational plan was unnecessary for individuals who had previously worked or volunteered and wanted to retire, and for those individuals who had significant medical and/or physical challenges that affected their interest and seemed a legitimate reason for them to not want to consider employment. Overall, nine individuals had retired and six have significant health and/or physical issues that preclude them from working.

Of the remaining individuals who were not interested in employment, only 18% (11 of 62) individuals have a plan to further educate them about employment, compared to 25% who had a plan in 2019. Upon further review of the records, CMs had only implemented the plans to educate individuals and families for nine of these eleven individuals who were not interested. We did not consider a plan implemented if the only way the CM followed up was to ask the family if they were interested about employment at the next annual ISP meeting and if there was nothing specifically identified to help that family or individual become more knowledgeable of employment options.

Identifying and Addressing Barriers – For the individuals in the sample studied, CMs did a good job of identifying barriers to employment for individuals on their caseload. Overall, 78% of the individuals had barriers identified in their ISPs, compared to 77% in 2019. The only individuals excluded from needing barriers identified were those who have retired or those whose medical conditions that precluded work. The range with barriers identified was 65% in the Southwestern Region to 89% in the Central Region. However, there is only

evidence that barriers are being addressed for 40% of the remaining individuals in the sample, compared to 45% in last year's sample. We did not include individuals in rating this category who are retired; whose teams identified that they did not have any barriers to employment; or who are currently uninterested in employment and have a significant health or physical consideration that makes employment difficult.

It is critical that teams become proficient in both identifying barriers and in developing specific strategies to address and overcome barriers if more individuals are going to build confidence and become interested in pursuing paths to employment. Many of the individuals in this sample participate in group day programs in congregate settings and have some work activities. These are individuals who may have fewer barriers to individualized employment and whose teams could concentrate on assisting them to understand the benefits of integrated employment and to address whatever barriers or hesitancies may exist that is keeping them from actively pursuing employment opportunities.

Community Engagement Discussions and Goal Setting

Table 2 summarizes by CSB the findings for the Community Engagement expectations. This includes discussing CE; determining the individual's interest; identifying and addressing barriers to community engagement; setting community engagement goals and planning to further educate individuals who are not currently interested in CE about its benefits. The Table compiles and displays information for each Region's sample and an aggregate total of compliance for each element for each Region, and for the entire sample.

TABLE 2 COMMUNITY ENGAGEMENT SUMMARY							
	CE Discussion	**Interest**	**Plan to Educate**	**Plan Implement.**	**Goals Set**	**Identified Barriers**	**Addressed Barriers**
EASTERN REGION							
ER1	YES	YES	N/A	N/A	YES	YES	N/A
ER2	YES	YES	N/A	N/A	NO	YES	N/A
ER3	NO	NO	NO	NO	N/A	NO	NO
ER4	YES	YES	N/A	N/A	YES	YES	YES
ER5	YES	YES	N/A	N/A	YES	YES	YES
ER6	NO	NO	NO	NO	N/A	YES	NO
ER7	NO	NO	NO	NO	N/A	YES	N/A
ER8	NO	NO	NO	NO	N/A	YES	N/A
ER9	YES	YES	N/A	N/A	YES	YES	N/A
ER10	YES	YES	N/A	N/A	YES	YES	YES
ER11	YES	YES	N/A	N/A	YES	YES	N/A
ER12	YES	YES	N/A	N/A	YES	YES	YES
ER13	NO	NO	NO	NO	N/A	YES	YES
ER14	NO	NO	NO	NO	N/A	YES	NO
ER15	NO	NO	NO	NO	N/A	YES	N/A
ER16	NO	NO	NO	NO	N/A	YES	N/A
ER17	YES	YES	N/A	N/A	YES	YES	N/A
ER18	NO	YES	N/A	N/A	NO	YES	NO
ER19	NO	NO	NO	NO	N/A	NO	NO
ER20	NO	NO	NO	NO	N/A	NO	NO
ER21	NO	NO	NO	NO	N/A	YES	NO
ER22	NO	NO	NO	NO	N/A	NO	NO
REGION COMPLIANCE PERCENTAGE	**9/22 = 41%**	**10/22 = 45%**	**0/12 = 0%**	**0/12 = 0%**	**8/10 = 80%**	**18/22 = 82%**	**5/13 = 38%**

	CE Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
CENTRAL REGION							
CR1	YES	YES	N/A	N/A	YES	YES	YES
CR2	NO	NO	NO	NO	N/A	NO	NO
CR3	NO	YES	N/A	N/A	NO	NO	NO
CR4	NO	NO	NO	NO	N/A	YES	N/A
CR5	NO	YES	N/A	N/A	NO	YES	NO
CR6	NO	NO	NO	NO	N/A	YES	NO
CR7	NO	NO	NO	NO	N/A	NO	NO
CR8	NO	NO	NO	NO	N/A	YES	N/A
CR9	NO	NO	NO	NO	N/A	NO	NO
CR10	NO	NO	NO	NO	N/A	YES	NO
CR11	NO	NO	NO	NO	N/A	NO	NO
CR12	YES	NO	NO	NO	N/A	YES	NO
CR13	NO	NO	NO	NO	N/A	YES	NO
CR14	YES	NO	NO	NO	N/A	YES	NO
CR15	YES	YES	N/A	N/A	YES	YES	N/A
CR16	YES	YES	N/A	N/A	NO	YES	YES
CR17	NO	NO	NO	NO	N/A	YES	NO
CR18	NO	NO	NO	NO	N/A	YES	NO
CR19	NO	NO	NO	NO	N/A	YES	N/A
REGION COMPLIANCE PERCENTAGE	**5/19 = 26%**	**5/19 = 26%**	**0/14 = 0%**	**0/14 = 0%**	**2/5 = 40%**	**14/19 = 74%**	**2/15 = 13%**

	CE Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
NORTHERN REGION							
NR1	YES	YES	N/A	N/A	YES	YES	YES
NR2	YES	YES	N/A	N/A	YES	YES	YES
NR3	YES	YES	N/A	N/A	YES	YES	NO
NR4	NO	NO	NO	NO	N/A	YES	NO
NR5	NO	NO	NO	NO	N/A	YES	NO
NR6	YES	YES	N/A	N/A	YES	YES	YES
NR7	YES	NO	NO	NO	N/A	NO	NO
NR8	YES	YES	N/A	N/A	YES	YES	YES
NR9	YES	YES	N/A	N/A	NO	YES	NO
NR10	YES	NO	YES	YES	N/A	YES	YES
NR11	YES	NO	NO	NO	N/A	NO	NO
NR12	YES	YES	N/A	N/A	NO	YES	YES
NR13	YES	NO	NO	NO	N/A	NO	NO
NR14	YES	YES	N/A	N/A	YES	YES	YES
NR15	YES	NO	NO	NO	N/A	YES	YES
NR16	YES	NO	NO	NO	NO	NO	NO
NR17	YES	NO	NO	NO	N/A	YES	NO
NR18	YES	YES	N/A	N/A	YES	YES	YES
NR19	YES	YES	N/A	N/A	NO	NO	NO
NR20** & ***	YES	NO	NO	NO	N/A	YES	NO
NR21	YES	YES	N/A	N/A	YES	YES	YES
REGION COMPLIANCE PERCENTAGE	**19/21 = 90%**	**11/21 = 52%**	**1/10 = 10%**	**1/10 = 10%**	**8/11 = 73%**	**16/21 = 76%**	**10/21 = 48%**

	CE Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
WESTERN REGION							
WR1	YES	YES	N/A	N/A	YES	YES	YES
WR2	NO	NO	NO	NO	N/A	YES	NO
WR3	NO	NO	NO	NO	N/A	YES	YES
WR4	NO	NO	NO	NO	N/A	YES	NO
WR5	YES	YES	N/A	N/A	YES	YES	YES
WR6	YES	YES	N/A	N/A	YES	YES	YES
WR7	NO	NO	NO	NO	N/A	NO	NO
WR8	YES	YES	N/A	N/A	YES	YES	YES
WR9	YES	YES	N/A	N/A	NO	NO	NO
WR10	YES	YES	N/A	N/A	NO	YES	YES
WR11	NO	NO	NO	NO	N/A	NO	NO
WR12	NO	NO	NO	NO	N/A	NO	NO
WR13	NO	NO	NO	NO	N/A	NO	NO
WR14	NO	NO	NO	NO	N/A	NO	NO
WR15	NO	NO	NO	NO	N/A	NO	NO
WR16	NO	NO	NO	NO	N/A	YES	YES
REGION COMPLIANCE PERCENTAGE	**6/16 = 38%**	**6/16 = 38 %**	**0/10 = 0%**	**0/10 = 0%**	**4/6 = 67%**	**9/16 = 56%**	**7/16 = 44%**

	CE Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
SOUTHWEST REGION							
SW1	NO	NO	NO	NO	N/A	NO	NO
SW2	NO	NO	NO	NO	N/A	NO	NO
SW3	YES	NO	YES	YES	N/A	YES	YES
SW4	YES	YES	N/A	N/A	NO	YES	YES
SW5	NO	NO	NO	NO	N/A	NO	NO
SW6	NO	NO	NO	NO	N/A	NO	NO
SW7	YES	YES	N/A	N/A	NO	NO	NO
SW8	YES	YES	N/A	N/A	NO	NO	NO
SW9	YES	YES	N/A	N/A	NO	NO	NO
SW10	YES	YES	N/A	N/A	NO	YES	NO
SW11	YES	YES	N/A	N/A	NO	YES	NO
SW12	YES	YES	N/A	N/A	YES	YES	YES
SW13	YES	YES	N/A	N/A	NO	YES	NO
SW14	NO	NO	NO	NO	N/A	NO	NO
SW15	NO	NO	NO	NO	N/A	YES	NO
SW16	NO	NO	NO	NO	N/A	NO	NO
SW17	YES	NO	NO	NO	N/A	YES	NO
SW18	YES	YES	N/A	N/A	NO	NO	NO
SW19	YES	YES	N/A	N/A	NO	YES	YES
SW20	NO	NO	NO	NO	N/A	YES	YES
SW21	NO	NO	NO	NO	N/A	NO	NO
REGION COMPLIANCE PERCENTAGE	**12/21 = 57%**	**10/21 = 48%**	**1/11 = 9%**	**1/11 = 9%**	**1/10 = 10%**	**10/21 = 48%**	**5/21 = 24%**

TOTAL COMPLIANCE PERCENTAGE	**51/99 = 52%**	**42/99 = 42%**	**2/57 = 4%**	**2/57 = 4%**	**23/42 = 55%**	**67/99 = 68%**	**29/86 = 34%**

KEY:
* Retired due to age or health
** Parent/Guardian does not want employment
*** Physically or medically unable to participate

Community Engagement Discussion - DBHDS set a goal in the Outcome-Timeline submitted to the Court in January 2016 that 100% of individuals would have an annual discussion about CE. More recently the Parties agreed that 86% of all individuals in the HCBS waivers would have an annual discussion about CE. The reduction to 86% allowed that not all obstacles to including discussions for some individuals will be resolved. Our study found that sufficient discussions were held for 52% of the sample. In our 2019 Study sample, we found that 74% of the individuals had such discussions. The percentage of compliance across the five Regions ranged from 26% in the Central Region to 90% in the Northern Region. As was true for employment we expected to find evidence of meaningful discussions that at a minimum included discussing the services available, the individual's skills, interests, challenges and barriers in order to find that a sufficient discussion occurred.

Setting a CE Goal – It appears when comparing the interest in CE between the samples in our 2019 and 2020, that a higher percentage did not express interest in CE 2020. It is surprising that so many individuals in the 2020 sample were uninterested in CE. This could be the result of so few discussions to adequately explain CE; the lack of CE capacity and availability in parts of the state; and a seeming lack of some CM's understanding of the definition of CE. This observation is based on the overall outcome of and specifics found in the record review. Many CMs report that the very limited involvement individuals have in group activities offered by the center-based group day providers equate to community engagement. These activities are typically offered to more than three individuals in one group, which is the maximum number of individuals to be in inclusive activities in the community when using CE, and do not include significant or meaningful interaction with typical community members.

Using this methodology, 55% of the individuals who expressed an interest also have a CE goal (23 of 42 individuals). This compares to 69% of the sample who had goals in the 2019 IDA Study. Regions ranged from 10% in the Southwestern Region to 80% in the Eastern Region in the number of individuals who have a CE goal. Using the same methodology DBHDS and CSBs use to calculate this percentage for determining the percentage of individuals with a CE goal, the percentage of individuals with a CE goal is only 38% as of June 2020. If we applied the same methodology DBHDS uses, the percentage of individuals with a CE goal in the sample would be reduced to 23%.

Interest in CE and Plans to Educate Individuals and Families - The interest of the individual, family or Authorized Representative (AR) is noted by a check off box on the ISP. Overall, 42% of the individuals expressed an interest in CE, compared to 26% expressing an interest in employment, and 58% of the individuals expressed having no interest in CE at this time. These are similar findings to those concluded in the 2019 IDA Study. DBHDS expects progress towards achieving the agreed upon compliance indicator measure by developing educational plans to address the obstacles to individuals interested in CE. The lack of development of such plans and identification of obstacles has clearly hindered progress. For example, of the fifty-seven individuals in the 2020 sample who were not interested in CE, only 4% (2) of the individuals have a plan to further educate them about CE. There was evidence that these two plans were being implemented. However, this is a decline since the 2019 study which found that 10% of the sample had a plan to educate the individuals/ARs further about the benefits of CE.

Many CMs record that their plan was merely to simply ask each year whether the individuals, family or AR were interested in CE. Whereas, we determined that there was an acceptable education plan in place and implemented when the CM documented specific strategies they would use to further the individual 's and family's interest and comfort with and understanding of CE. CMs may achieve a higher percentage of individuals who express interest by utilizing a strategy to explore the individual's or family's interests as they relate to participating in community groups, functions and activities including volunteering. Many of these individuals are attending congregate group day programs. They may already volunteer, but on a limited basis and in large groups. The volunteer work is not individualized to their interests. CMs report that group day programs offer limited weekly community outings, but few give the individuals the opportunity to substantively interact, or develop relationships, with others in their communities, make contributions, learn new skills or pursue interests outside of shopping, dining out and attending sporting events or concerts. The ISP teams could use this level of activity and community presence to assist individuals to transition to CE.

Identifying and Addressing Barriers - CMs identified barriers to participation in CE for 68% (67) of the individuals on their caseloads who are in the sample, compared to 76% in the 2019 IDA Study sample. The range was from 48% in the Southwestern Region to 82% in the Eastern Region. However, there is only evidence that barriers are being addressed for 34% (29) of the individuals in the sample, compared to 43% of last year's sample. We excluded from these percent calculations individuals whose teams identified that the individual did not have any

barriers to CE, or those who are currently uninterested in CE and have a significant health or physical consideration that makes meaningful CE difficult.

To achieve the compliance measures associated with CE, it is critical that ISP teams become proficient in both identifying barriers and developing specific strategies to address and overcome barriers if more individuals are going to be interested in transitioning from their day programs in congregate settings to become more meaningfully engaged in their communities. Many of the individuals in this sample participate in center-based group day programs which often include some community-based activities as discussed earlier. These are individuals who may have fewer barriers to participating in CE and whose teams could concentrate on assisting them to understand the benefits of CE and addressing whatever barriers or hesitancies may exist that is keeping them from becoming engaged in community life and developing relationships with typical peers.

Last year, CMs who were interviewed talked about the lack of a sufficient number of CE providers to meet the needs and interests of individuals on their caseloads in less populated areas of Virginia. It was evident from our review of records in this year's study that remains a barrier to participation. This is a systemic barrier that the Commonwealth must address for its IDA initiative to be successful. The State of the State Report issued in May 2020 supports this sentiment among CMs and the documentation found in the record review. The findings related to this are summarized in the Expert Reviewer's Report to the Independent Reviewer. CMs cannot be asked to present CE as an available service when it is not accessible in reasonable proximity to where individuals reside.

DBHDS indicates providers have reported that the pay rates for CE are not adequate, and even before the pandemic, some providers had closed their CE programs and moved individuals back to a congregate center-based program. The financial viability for a provider to effectively offer a type of service is a precursor to increasing the availability of that service.

Conclusions and Recommendations

The findings of this study do not conclude that the targets DBHDS set for both IDA discussions and IDA goals are being met. Only seventy-one (72%) individuals had a meaningful employment discussion and fifty-one (52%) individuals had a sufficient discussion of CE. The discussions of employment are similar to those that occurred for the 2019 IDA Study sample but decreased dramatically for CE discussions from 76% to 52%. Many CMs do not discuss employment but rather only ask if there is an existing interest. In these cases, there is no evidence that the CM engaged in a discussion about available employment or CE services, interests, skills and what individuals and ARs may perceive are barriers.

The interest in employment and CE is surprisingly low with only 26% of individuals and ARs expressing an interest in employment and 42% of individuals and ARs expressing an interest in CE. This is consistent with our findings in the 2019 IDA Study. Many ARs do not want employment opportunities explored for their family member; and some also do not want to explore CE. These ARs often represent individuals who do not have a significant health or physical reason why employment cannot be pursued. After decades of experiences when employment and other integrated day activities were not offered or available, especially for individuals with complex needs, these ARs need much more information about employment and integration opportunities that are actually available in order to more seriously consider it as the first and priority option for their family members. To view these integrated service options as a viable and beneficial for their adult children, families may need opportunities to observe other individuals with similar characteristics in these programs.

The findings of this study also indicate that CMs need to be more prepared to have initial discussions about the impact of wages on existing Medicaid and other benefits, so families are more comfortable seeking more information about this critical issue rather than dismissing employment as even an option at the ISP meeting. These are consistent with the findings from the 2019 IDA Study. The fact that there is little evidence that CMs have the practical knowledge and information to discuss the impact of employment on benefits is concerning. Families have legitimate concerns and questions about benefits. CMs can refer these families to Benefit Counselors. However, this entails creating an extra responsibility for families who are already expressing a lack of interest in employment for their children with I/DD. CMs should be educated to answer the basic questions about the impact of employment on benefits. These answers will give the families a greater sense of comfort that benefits may not be negatively impacted or that the

combination of wages and reduced benefits will provide greater financial security for their loved ones.

CSBs are not training or expecting the CMs to develop strategies to educate individuals who are not yet interested in employment or CE to learn more about these services. CMs have educational plans in place for only 18% and 4% respectively for individuals who are not currently interested in employment or CE. CMs need training to be able to both educate these ARs and individuals and develop more concrete plans to address the barriers to employment and CE that are identified if individuals are to select IDA rather than congregate day programs that offer limited opportunities for community integration and inclusion.

DBHDS has developed a number of training modules regarding the IDA initiative for CMs which is discussed in the Expert Reviewer's Report to the Independent Reviewer. DBHDS reports that all CMs take the online employment training and that regional in-person trainings were held to educate CMs about CE. It is apparent from a review of the 99 records in this sample that many CMs do not grasp what options should be offered through CE. Many CMs report that individuals in Group Day settings enjoy community inclusion or are receiving community engagement because the provider takes them to community activities. However, these outings are not typically individualized; are often done with several other program participants; and do not offer opportunities to regularly engage with typical peers or to develop relationships with people without disAbilities.

Supervisors are most likely the key to advancing cultural change via a more consistent training process and setting clear expectations especially for CE for new CMs. Supervisors need to continue mentoring existing CMs in this area. DBHDS may want to work with the CSBs that are more proficient at achieving the discussion and goal targets to identify best practices for CM training and supervision. Training should include detailed technical training, and shadowing by supervisors for monthly visits and annual ISP meetings to offer timely technical assistance. CMs who demonstrate these competencies over time may be paired with newly hired CMs. This is especially important because there is turnover in these positions. CMs need more training to make goals more specific and to develop measurable objectives to be able to reliably determine progress.

To make substantive progress, the lack of provider capacity to offer CE must be addressed and resolved. There is not a sufficient number of these providers in many geographic areas of Virginia, and DBHDS has indicated existing providers report that the rates paid to deliver CE services is not adequate. The combination

of these factors may contribute to the reduced rate of availability and enrollment in these programs, as reported in the June 2020 Semiannual Employment Report. CMs cannot reasonably be expected to offer CE when it is not available in proximity to where individuals reside. The lack of providers may also result in CMs avoiding discussions about interest with individuals and ARs.

The Parties negotiated and the Court has approved compliance indicators with precise measures for employment and CE discussions and goal setting. The SCQR process now includes a review of employment and CE expectations for discussion and goal setting. We discussed the criteria the DBHDS QI reviewers were using to make these determinations. In this study, as noted earlier in this report, we highlighted the importance for individuals who expressed not being interested in employment or CE that education plans developed and implemented. This criteria for what should be a sufficient discussion results in a much different and lower percentage of individuals who have had "discussions' and have "goals" included in their ISPs, than the current check box methodology that does not include documentation that demonstrates that a meaningful discussion occurred, which is what CSBs report and what DBHDS includes in its semiannual employment report and the ad hoc CE report DBHDS provided, which just compares the number of individuals with goals compared to the number of individuals who had a discussion about employment and CE.

It is very positive that DBHDS is using a two phase SCQR process to assure an internal CSB supervisory review followed by an external review to ensure that the CSB CMs understand how to have, and actually do have, sufficient discussions, which lead to identifying obstacles, creating goals, and developing education strategies about IDA for individuals who express not having a current interest in these services. The DBHDS was not able to share the results of the summaries, findings, conclusions and recommendations from these reviews in the time period available to complete the Expert Review.

CSBSs and CMs may benefit if minor changes are made to the forms used for the ISP and Quarterly Reviews. First, not all of the CSBs use the newest ISP form. Second, there is no space on the form or a requirement that the CM summarize what they actually discussed about employment and CE services. Barriers are noted through a check off section, but the CM does not need to note how they are being addressed. Many CMs note a family does not want employment as a barrier without seemingly exploring with the family what brings them to the conclusion that they do not want to pursue employment for their child. Effective implementation of the Commonwealth's Employment First policy requires that the

team determines the cause of their reluctance so a plan can be developed to actually address the factual and perceived barriers. The Quarterly Reviews expect the CM to note if community inclusion goals and employment goals are on track, but a simple Yes/No format is used. Therefore, the CM does not provide any actual quantitative data or qualitative information to support their determinations.

The newest ISP form includes a section after Employment titled: *Alternatives to Work*. The questions asked in this section are solely about volunteering. There is no section that pertains directly to community engagement other than for the CM to check the boxes that it was discussed and whether the individual is interested. Because of the focus on volunteering it cannot be determined if CMs discuss other aspects of CE services. This confirms the need for greater education about CE for Case Managers, individuals and families.

APPENDIX D.

TRANSPORTATION, REGIONAL SUPPORT TEAMS, AND OFFICES OF LICENSING AND HUMAN RIGHTS

By
Ric Zaharia Ph.D.

Consortium on Innovative Practices

TO: Donald Fletcher

FROM: Ric Zaharia, Ph.D.

RE: Period 17 - Compliance Indicators (RST/OL/OHR/TRANS)

DATE: 11.13.20

The tables below recap the status of the compliance indicators you assigned to me to review. The key is similar to one you used in your last report:

1. Documentation and facts (i.e., the Commonwealth's documentation aligns with and reports achievement of the indicator);
2. Pending with date (i.e., the Commonwealth's reports align with and will include the facts required by the indicator, but additional progress or documentation to achieve it is expected by the date specified, and must be verified); or
3. Pending (i.e., no report was provided or reports that were provided did not align with the facts required to meet the indicator or to substantiate progress).

In this recap I have annotated my comments and cited reported facts immediately following the itemization of a document in the 'Evidence available' column and identified them via parentheses. This reviewer's explanatory 'Notes' are also included. All documents should be searchable within the DBHDS Library.

Beginning in March 2020 through the date of this report COVID restrictions under the Governor's Executive guidelines have altered all face to face onsite visits to providers or families and revamped them to remote inspections. Subsequent protocols have limited exceptions for the Office of Licensing to those where there is an "imminent risk of harm to an individual receiving services".

Noteworthy among the findings of this review are:

III.C.8.a – Transportation:

- CI (compliance indicator) #4 - DMAS has scheduled four focus groups during FY21; however, none were convened soon enough to be reviewed 17th review period for the identification and discussion of systemic problems The earliest was scheduled for 9.23.20.

- CI #6 - The Commonwealth's contractor HSAG's (Health Services Advisory Group's) QSR (Quality Service Review) tool includes three specific questions regarding transportation during the individual interviews of the Person Centered Review. However, the revamped QSR process was not completed during the 17th.

III.D.6 – RST (Regional Support Team):

- CI #2 - DBHDS reports for Q4 FY20 show 80% system compliance in RST referrals; although 3 CSBs consistently failed to meet the benchmark. Adherence to this indicator showed improvement over earlier quarters in FY20.
- CI #5, 6 and 7 - DBHDS reports that CAPs will not be required of CSBs until October 2020, the first month of the next (18th) review period. CI #7 cannot be met until 12 months after a CAP is implemented and reviews determine that all RST referrals were submitted timely (at the 86% level).

V.C.6 – Failure to report:

- CI # 1 - Tracking framework for reporting serious incidents is an important and needed improvement and looks sound.
- CI # 1, 4 - The Commonwealth reports that serious incidents are submitted at 89.6% and deaths (subset) are submitted timely at 93%. These percentages do not include the 10% non- reporting described immediately below.
- CI #2, 3 - DMAS claims cross-tab with CHRIS reports for individuals on the three HCBS Waivers, establishes 10% non-reporting versus 90% reporting.
- CI #5, 6 a., b. and c. - OL follow-up shows that 100% of providers were required to complete CAPs when cited for failing to report (i.e., does not include 10% non-reporting per DMAS claims study). Documentation showed that OLS followed up appropriately (i.e., ensure that CAPs have been implemented by 45 or 90 days) and when providers fail to correct.

V.G.3 – Adequacy of Supports:

- CI #1, 2 - The OL checklist for assessing adequacy of supports includes seven of the eight areas. Due to COVID-19 precautions, the OL checklist is currently being applied remotely during the annual visit cycle and is evaluated primarily on the availability of documentation from the provider. Remote data collection by OL will have to be evaluated for effectiveness, although the rate of provisional status assignment continues at higher than previous rates in prior years.
- CI #1 No data were provided regarding the eighth area, Stability.

Item #	III.c.8.a - Transportation	Evidence available to substantiate:
1	1. The Commonwealth includes performance standards and timeliness requirements in the Medicaid non-emergency medical transportation (NEMT) contracts including those services for the DD waiver recipients.	**Documentation confirmed:** *RFP 2018-01 NEMT Brokerage Services, 9.25.17 –* (Constitutes contract by reference); *Contract Modification #1 Nbr. 10041 – Medicaid Expansion Requirements, 12.11.18;* (Contract revision) *Contract Modification #2, Nbr. 10041 – Rate Adjustment, 3.15.19;* (Contract revision)
2	The Commonwealth will take action against Fee for Service NEMT transportation vendors and managed care organizations that fail to meet performance standards or contract requirements, which may include liquidated damages or fines.	**Documentation confirmed** (Note: documentation includes information regarding both NEMT and managed care organizations) *DMAS SLAs Deducted from LogistiCare Payments, Q2 FY20 -* (documents $109,500 in payment reductions to NEMT contractor); *LogistiCare Liquidated Damages & Sanctions, Jan-May 2019,-* (documents $82,330 in fines to sub-contractors) *DMAS Current Contract Section VIII, Quality Review & Performance Standards & Penalties-Service Level Agreements,* (Itemizes penalties to be levied on Logisticare) *LogistiCare Transportation Provider Agreement, 2/18* *(*Contract which Logisticare employs with transporters)
3	2. At least 86% of DD Waiver recipients using Medicaid non-emergency medical transportation (NEMT) will have reliable transportation.	**Pending more accurate measure of reliable transportation:** (Note: the DMAS complaint data is not a valid measure of the provision of reliable transportation.) *Complaint Report Summary of NEMT (IDD)-Q2& Q3, FY20* (Tracking logs of Logisticare complaints) *Email Bevan to Schodt, 9.3.20 –* (DMAS considers reliable transportation as 'complaint free', i.e. on time and no reported issues; for the period Oct. 2019-Mar 2020, there were 1,520,000 trips by IDD users – 1,515,991 occurred without complaint (99.74%); 1,519,103 were on time (99.94%)
NA	3. The Commonwealth will include in contracts with the Fee for Service (FFS) NEMT for DD	NA

Item #	III.c.8.a - Transportation	Evidence available to substantiate:
	Waiver services and managed care transportation vendor(s) (for acute and primary care services) requirements to:	
4	a. Separate out DD Waiver users in data collection, reporting, and in the quality improvement processes to ensure that transportation services are being implemented consistent with contractual requirements for the members of the target population;	**Documentation Confirmed:** *NEMT Brokerage Services, 9.25.17- (*constitutes contract by reference); *Contract Modification #1 Nbr. 10041 – Medicaid Expansion Requirements, 12.11.18;* *Contract Modification #2, Nbr. 10041 – Rate Adjustment, 3.15.19;*
5	b. Ensure DD Waiver users and/or their representatives have opportunities to participate in the regional Advisory Board; and	**Documentation Confirmed:** *RFP 2018-01 NEMT Brokerage Services, 9.25.17 – (*constitutes contract by reference; opportunities to participate confirmed previously);
6	c. Through a statistically valid sample of transportation users, surveys are conducted to assess satisfaction and to identify problems on a quarterly basis.	**Documentation confirmed:** *LogistiCare Satisfaction Surveys – Post Call/Post Trip Survey, undated* - (9.30.20. Describes LogistiCare survey methodology, including achieving statistically valid sample size; see below) *DMAS-IDD DD Waiver Customer Satisfaction Survey, Q4 FY20* - (9.30.20. Monthly surveys by LogistiCare, 212 IDD/DD users surveyed for the period out of 5,000+ unduplicated IDD/DD riders) (Note: per Logisticare/DMAS, Great Blue ensures "we are getting an adequate number of completed surveys per plan, we use a common statistical formula to calculate the lowest number of completed surveys required to allow us to generalize the results of those surveyed to the plan overall, based on the plan's call volume. We use an 80% confidence level and 5% margin of error in our calculations, which means 8 out of 10 times, if we surveyed a random sample of members from the plan, the overall satisfaction for the plan would be within 5 percentage points of the sample estimate. Inviting members to take the survey based on the plan's call volume helps us ensure we are getting a fair number of completed surveys per plan, regardless of plan call volume/size and allows us to generalize the satisfaction reported by those surveyed to the plan overall. The equation used is written out below:

Item #	III.c.8.a - Transportation	Evidence available to substantiate:
		Where: n = sample size X2 = Chi-square for the specified confidence level at 1 degree of freedom (our confidence level is 80%) N = population size (this varies depending on the call volume per plan) P = population proportion ME = desired Margin of Error (for our purposes, 5%) Source: LogistiCare Surveys Manual_051818
7	4. DMAS transportation operations will conduct focus groups as needed as determined by DMAS with the DD Waiver population receiving FFS and managed care transportation in order to identify, discuss, and rectify systemic problems.	**Pending documentation of Focus Group findings and system improvements** *DMAS Response to 9.11.20 Status, 9.14.20 –* (Note: four virtual Focus Groups scheduled over next 12 months, the first of which was scheduled for 9.23.20*)*
8	5. DMAS provides all Medicaid recipients with information on processes for filing complaints or appeals related to their Medicaid services.	**Documentation confirmed:** *LogistiCare Member Handbook for Riding NEMT, 4/18,- (*available on DMAS website, not on LogistiCare website*)* *DMAS Response to 9.11.20 Status, 9.14.20 – (*includes a discussion of handbook location) *Virginia Medicaid Appeal Request Form, 6.19 (www.dmas.virginia.gov);* *WeCare Form*, LogistiCare website 6.8.20; *Member FAQs*, https:/transportation.dmas.virginia.gov/ (revised 8.20.20 to include grievance and appeals)
9	6. As part of the person-centered reviews conducted through the Quality Service Review (QSR) process, the vendor will assess if transportation provided by waiver service providers (not to include NEMT) is being provided to facilitate individuals' participation in community activities and Medicaid services per their ISPs.	**Pending documentation** regarding DBHDS QSR findings *HSAG- DBHDS PCR Tool, undated,* 7.15.20- (Includes 3 questions specific to transportation to be asked of individual—'who is your transportation provider?' 'do you have problems w transportation?', and 'what kinds of transportation problems do you have?'. Other queries may be needed. During this 17th review period, the Commonwealth's vendor will not complete the revamped QSR process or the required assessment.)
10	The results of this assessment will be included in the QSR annual report presented to the Quality Improvement Committee (QIC). At least 86% of those reviewed	**Pending documentation regarding DBHDS QSR findings and annual report:** (*HSAG- DBHDS PCR Tool, undated,* 7.15.20 – (Same comments as immediately above.)

Item #	III.c.8.a - Transportation	Evidence available to substantiate:
	report that they have reliable transportation to participation in community activities and Medicaid services.	

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Item #	III.D.6 - RST	Evidence available to substantiate:
1	1. DBHDS tracks on a statewide level whether referrals to RSTs are submitted in accordance with the DBHDS RST Protocol and the timeliness of referrals to the RSTs, as specified in the DBHDS RST Protocol.	**Documentation confirmed:** *RST Internal Process Guide, 6.30.20*; (Describes RST process and roles.) *Q2-3, FY 20, RST Referral Info Letters to CSBs*; (RST performance feedback to CSBs) *CMSC Performance Monitoring Spreadsheet, 8.6.20 –* *(*Master tracking log for SCQR ten elements, RST referral timeliness, and ISP Compliance data)
2	2. DBHDS is in compliance with the agreement when 86% of all statewide non-emergency referrals, as such referrals are defined in the DBHDS RST Protocol, meet the timeliness requirements of the DBHDS RST Protocol.	**Pending documentation regarding achievement of 86%:** *CM Report, 4Q Regional Support Teams final – RST Data Results, 9.16.20* *(*FY19 final report of RST referral data) *CSB-RST Referrals FY20 4Q Percentages, 8.28.20* (DBHDS reported percentages of system compliance for the four FY20 quarters was 60%, 48%, 73%, and 80%) *Referral Info Letters to CSBs,5.28.20* (RST performance feedback of CSBs) *RST Internal Process Guide, 6.30.20*; (Describes RST process and roles.) (Note: When considering the number of CSBs that successfully met 86% of their referrals for individuals choosing less integrated settings, 80% [or 32 out of 40 CSBs] achieved the target in the 4th quarter FY20. This result is based on the number of CSBs meeting 86%, including for reason A for lateness, and excluding B, 'CM sent but individual moved before RST review', and C, 'provider did not notify CM')
3	3. DBHDS conducts a quarterly quality assurance review of all new authorizations and any changed authorizations for residential service resulting in individuals residing in homes with	**Documentation confirmed:** (Note: The RST Q2 FY20 Report was responsive to this Indicator. DBHDS reports that WaMS authorizations were reviewed for RST outliers for this report.)

Item #	III.D.6 - RST	Evidence available to substantiate:
	5 beds or more to determine if an RST referral has occurred.	
4	4. DBHDS is in compliance with the agreement when 86% of all statewide situations meeting criteria for referral to the RSTs with respect to home and community-based residential services are referred to the RSTs by the case manager as required by the DBHDS RST Protocol.	**Pending documentation of FY21 data:** *CM Report, 4Q Regional Support Teams final – RST Data Results, 9.16.20* *(*FY19 final report of RST referral data) *CSB-RST Referrals FY20 4Q Percentages, 8.28.20* (DBHDS reported percentages of system compliance for the four FY20 quarters was 60%, 48%, 73%, and 80%) *RST Referral Info Letters to CSBs*; (RST performance feedback to CSBs) *CMSC Performance Monitoring Spreadsheet, 8.6.20 –* *(*Master tracking log for SCQR ten, RST timeliness, ISP Compliance data) (Note: When considering the number of CSBs that successfully met 86% of their referrals for individuals choosing less integrated settings, 80% [or 32 out of 40 CSBs] achieved the target in the 4th quarter FY20. This result is based on the number of CSBs meeting 86% for reason A for lateness, and excludes B, 'CM sent but individual moved before RST review', and C, 'provider did not notify CM')
5	5. DBHDS reviews all RST submissions for compliance with both the referral and timeliness standards specified in the DBHDS RST Protocol, by CSB. DBHDS will hold CSBs accountable for submitting 86% of their non-emergency referrals timely in accordance with the DBHDS RST Protocol.	**Pending documentation of FY21 data:** *CM Report, 4Q Regional Support Teams final, RST Data Results, 9.16.20* *(*FY19 final report of RST referral data) *CSB-RST Referrals FY20 4Q Percentages, 8.28.20* (DBHDS reported percentages of system compliance for the four FY20 quarters was 60%, 48%, 73%, and 80%) *CMSC Performance Monitoring Spreadsheet, 8.6.20 –* *(*Master tracking log for SCQR ten elements, RST timeliness, ISP Compliance data) (Note: When considering the number of CSBs that successfully met 86% of their referrals for individuals choosing less integrated settings, 80% [or 32 out of 40 CSBs] achieved the target in the 4th quarter FY20. This result is based on the number of CSBs meeting 86% for reason A for lateness.

Item #	III.D.6 - RST	Evidence available to substantiate:
6	6. DBHDS will require CSBs to submit corrective action plans through the Performance Contract when there is a failure to meet the 86% criteria for 2 consecutive quarters for submitting referrals or timeliness of referrals.	**Pending documentation of FY21 CAPs and follow-up:** *CMSC-CSB Performance Data Review, Spreadsheet/Workbook, Q1-4 FY20. 8.4.20 –* *(*Master CMSC tracking log for SCQR, RST timeliness, and ISP Compliance data) (DBHDS reports that CAPs will begin to be required in October 2020 due to CSB contract changes)
7	7. Failure of a CSB to improve and meet the 86% criteria over a 12 month period following a corrective action plan will lead to technical assistance, remediation, and/or sanctions under the Performance Contract.	**Pending documentation of FY21 CAPs and follow-up:** (*CMSC Performance Monitoring Spreadsheet, 8.6.20 –* *(*Master tracking log for SCQR ten elements, RST timeliness, ISP Compliance data) (DBHDS reports that CAPs will begin to be required in October 2020 due to CSB contract changes)
8	8. DBHDS will conduct data analyses periodically, but not less than on an annual basis, to ensure that the DBHDS revised RST protocol and referral forms are improving the timeliness of referrals to RSTs.	**Documentation confirmed:** *RST Member Annual Survey, 5/20* *(*Annual survey required in the RST Policy) *RST Internal Process Guide, Revised , 6.30.20*; (Describes RST process and roles.) *Virginia Informed Choice Form, Revised, 6.17.20* *(*Revised via RST/Provider Development process*)* *CRC Contacts by Capacity Building Focus Area, 1.31.20* *(*Produced by Provider Development*)* (Note: DBHDS reported percentages of system compliance for Q3-4 FY20 73%- 80%, so system improvements may be attributed to process changes made to RST)
9	9. DBHDS will ensure the availability of DBHDS Community Resource Consultants to work with case managers to explore community integrated options, including working with providers to attempt to create innovative solutions for individuals with unique or specialized needs, to avoid placements in congregate settings with 5 or more individuals.	**Documentation confirmed for examples provided:** *RST Examples, 7.31.20 –* (This reviewer reviewed 10 examples provided by DBHDS from FY20)

Item #	III.D.6 - RST	Evidence available to substantiate:
10	10. DBHDS will incorporate RST data into established Provider Development processes to evaluate gaps in services statewide on a semiannual basis and encourage provider development in underserved areas through information, data, and, if available, provision of funding designated to support provider expansion.	**Documentation confirmed:** *Provider Data Summary, 11/20 & 5/20* *(*Data reflects service utilization by types throughout the system, including to local areas. This is an ongoing semi-annual Provider Development report series; next report should be issued in November 2020. These reports have documented increases in people served in integrated settings, the introduction of the Charting Lifecourse planning, Provider Innovation Collaboration, the introduction of Community Guide Services and Electronic Home-Based Services) *Provider Data Summary, State of the State, 7.23.20* – (Public presentation of Data Summary information; power point)

11	11. DBDHS has a process to review and approve as available requests for emergency waiver slots and other funding supports to address emergency situations when alternate options have been exhausted.	**Pending revised/update policy:** *Emergency Slot Request Process, 7.17.17* – (Describes the process for emergency waiver slot request, when other funding supports are exhausted; utilizes C3T Committee to screen and recommend allocation; DBHDS previously advised - 2017- that the C3T was defunct and emergency funds were handled by DD Crisis System Administrators. DBHDS advises Assistant Directors compose the committee. New policy draft needed.)
12	12. DBHDS will add data related to the RST referral process to the Waiver Management Information System (WaMS). Data on RST referrals that were not successfully diverted from congregate settings of 5 or more individuals will be reviewed annually by DBHDS to ensure that integrated options are reviewed and offered annually.	**Pending Q4, FY20; Q1, FY21 data :** *Q2-3, FY 20 RST Referral Info Letters to CSBs*, - (identifies individuals not diverted due to "Needed Services not Available in Desired Location"; DBHDS reports that for Q2-3, FY20 no individual met the criteria of having chosen more restrictive setting due to "Needed Services not Available in Desired Location"-6.5.20)
13	13. DBHDS will identify individuals who chose a less integrated residential setting due to the absence of more integrated options in the desired locality. The names of these	**Documentation confirmed** *Q2-3, FY 20 RST Referral Info Letters to CSBs*, (identifies individuals not diverted due to "Needed Services not Available in Desired Location"; in Q2-3, FY20 no individual met the criteria of having chosen more restrictive

	individuals will be included in quarterly letters provided to each CSB.	setting due to "Needed Services not Available in Desired Location)
14	On a semi-annual basis, information about new service providers will be provided to CSBs, so that the identified individuals can be made aware of new, more integrated options as they become available	**Pending November 2020 Provider Data Summary:** *Provider Data Summary, 11/19 & 5/20;* (Data reflecting service utilization by types throughout the system, including to local areas) *Provider Data Summary, State of the State, 7.23.20* (Public presentation of Data Summary information) *Provider Network Listserv distribution;* *DDS Semi-Annual PDS webinar, Baseline Measurement Tool, 5/20.* *OL Licensed Provider Search Tool,* http://www.dbhds.virginia.gov/quality-management/Licensed-Provider-Location-Search *Consumer Search Tool,* http://www.mylifemycommunityvirginia.org/ *(*DBHDS reports that there is no distinct notification to CSBs of the availability of new service providers, however, DBHDS advises that information is continuously available through the two search functions listed above; during Q2-3, FY20, no individual met the criteria of having chosen more restrictive setting due to "Needed Services not Available in Desired Location no individuals identified Location"-6.5.20)
15	A Community Resource Consultant will contact each of these CSBs at least annually to ensure that any new more integrated options have been offered.	**Pending Q4,FY20 & Q1,FY21 letters:** *Q2-3, FY 20, RST Referral Info Letters to CSBs*;
16	DBHDS will report annually the number of people who moved to more integrated settings.	**Documentation confirmed:** RST Report, Q4,FY20 and Annual Report, 11.5.20. (Note: Two individuals through Q4 indicated "Needed Services not Available in Desired Location"-
Item #	V.B. CI #3 OL/OHR - SIR reporting	Evidence available to substantiate:
1	3. 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	Cross Reference to V.C.6 but in general the positive, cumulative impact of developing a) a OL Regional Manager's role, b) an OL Incident Management Unit, c) the OHR Look Behind Process, and, most recently, d) the OL Incident Look Behind Process, is evidence of improved system oversight.

	taking action to remedy specific problems or concerns that arise. 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.	
2	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;	**Pending reliable data that achieve the indicator:** *Data Warehouse (DW97), 160C, 1.1.20-7.31.20, -* (Review was conducted through the CHRIS/OLIS system to the Data Warehouse, OL reports that RCA compliance in 967 reviews was 81% for Levels 1, 2, 3 for this period.) *160C compliance tracking spreadsheet, 1.1.20-7.31.20;* *(*Spreadsheet by agency of compliance with Reg 160C) (No documentation was specifically requested or provided regarding whether incidents reviewed included those reported by non-provider sources (as required by V.C.6. CI#1 a.-d.) were included,
3	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.	**Pending documentation of the reliability of CHRIS/OLIS data and that RCAs were completed for serious and non-reported incidents** *Data Warehouse (DW97), 160E, 1.1.20-7.31.20, -* *(*CHRIS/OLIS data via Data Warehouse report shows that RCA <u>content</u> compliance in 968 reviews was 78%) (Note: From this reviewer's analysis of 10 Sample RCAs across 5 Regions, 1.1.20-6.20.20, only 5 of 10 included i-iii. The others are simply detailed incident reports.) *160E compliance tracking spreadsheet, 1.1.20-7.31.20,* *(*OL data report from annual inspections for Reg 160.E)
4	b. 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.	**Pending reports categorizing non-provider reports (Health, anonymous, Law Enforcement, etc):** *Health & Safety CAP Tracking Spreadsheet, 12-18.19-7.24.20,* (The current report includes violations cited by DBHDS. However, documentation did not demonstrate that all providers were cited for violating the serious incident reporting requirements for violations such as those surfaced in the DMAS claims study cited below in V.C.6; incidents

	DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations.	reported by sources other than the provider should be separately tracked and documented.)
Item #	V.C.6 – OL/OHR - Failure to report	Evidence available to substantiate:
1	1. DBHDS identifies providers, including CSBs, that have failed to report serious incidents, deaths, or allegations of abuse or neglect as required by the Licensing Regulations. Identification occurs through a. Licensing inspections and investigations b. DBHDS receipt of information from external agencies, such as the protection and advocacy agency, or other agencies such as the Department of Health or local adult protective services agencies; c. Any other information that DBHDS may receive from individuals, other providers, family members, or others d. Reports of deaths from the Virginia Department of Health as described in Indicator 7.c of V.C.5	**Pending reports identifying/categorizing non-provider reports (Health, anonymous, Law Enforcement, etc.** *RMRC Annual Report, FY 19, undated;* - (Recap of RMRC activities and findings FY19) *RMRC Meeting Minutes, 3.12.19-615.20;* - (Record of RMRC discussions, recommendations,) *RMRC CLB Trend Analysis, FY19, 4.20.20* (OHR Look Behind data for abuse and neglect reports, FY19) *DW80- Reporting Delay Tracking Log, 3.31.20-7.1.20.* (Spreadsheet displays 'incident time to time to report' during this period) *V.C.6.4 Power point Slide, 8.5.19 - 6.30.20, undated*, - (Licensed providers reporting timely during this period was 89.6%) *DW-Incident Management Report, Deaths 12.25.19 to 8.29.20, undated/not numbered,* - (446 deaths, 417 reported timely -93%; subset of H&S CAP tracking spreadsheet) (Note: the RMRC utilizes data from the Data Warehouse, which is enterprise software that integrates data from the CHRIS/OLIS system, CHRIS, OL, OHR, WaMS, etc.; for example, DMAS claims/CHRIS reports study suggest 10% missing reports are not included, cited, or corrected).
2	2. To validate that medical-related incidents are reported as required, at least annually, the Commonwealth conducts a review of Medicaid claims data and how it correlates to serious incidents reported to DBHDS. This review will be done of individuals enrolled in the DD waivers who receive one of the following waiver services: group	**Documentation confirmed**: *DBHDS Memo Re: DOJ Metric-Inpatient and ED visits, 9.16.20, Q2 FY20, Newsome to Nair.* (from DMAS hospital billing claims data cross-tabbed to DBHDS CHRIS data: "2260 inpatient/ER (Emergency Room/Department) visits, 845 individuals receiving residential, 231 of the visits had no CHRIS report on file for these individual or 10%)

	home residential, sponsored residential, and supported living. Data related to Medicaid claims screened includes services associated with reporting requirements for: i. emergency room visits; and ii. hospitalizations	
3	3. One quarter of data related to Medicaid claims is reviewed per calendar year for each of the following DD waivers under the direction of DBHDS: i. Building Independence, ii. Community Living, iii. Family and Individual Supports	**Pending documentation of corrective action follow-up:** *DBHDS Memo Re: DOJ Metric-Inpatient and ED visits, 9.16.20, Q2 FY20 , Newsome to Nair*, - (2260 inpatient/ER visits, 845 individuals receiving residential, 231 of the visits had no CHRIS report on file for these individual or 10%)
4	4. At least 86% of reportable serious incidents are reported within the timelines set out by DBHDS policy.	**Pending documentation of corrective action follow-up to non-provider reports :** *DW80- Reporting Delay Tracking Log, 3.31.20-7.1.20.* *V.C.6.4 Power point Slide, 8.5.19 - 6.30.20, undated –* (Licensed providers reporting within 24 hours was 89.6%)
5	5. Providers, including CSBs, that fail to report serious incidents, deaths, or allegations of abuse or neglect as required by the Licensing Regulations receive citations and are required to develop and implement DBHDS-approved corrective action plans.	**Pending documentation of corrective action follow-up to non-provider reports:** *Health & Safety CAP Tracking Spreadsheet, 12-18.19-7.24.20,* *DW80- Reporting Delay Tracking Log, 3.31.20-7.1.20.* *V.C.6.4 Power point Slide, 8.5.19 - 6.30.20, undated –* (Licensed providers reporting within 24 hours was 89.6%) *DW-Incident Management Report, Deaths 12.25.19 to 8.29.20, undated/not numbered –* (446 deaths, 417 reported timely -93%; subset of H&S CAP tracking spreadsheet*)* (Note: these data and calculations did not include the 10% of DMAS claims not reported via CHRIS)
6	6. DBHDS reviews and approves corrective action plans that are in response to serious incidents, abuse, neglect, or death in accordance with the Licensing and Human Rights Regulations. DBHDS follows-up on approved corrective action plans to ensure that they have been	**Pending documentation of corrective action follow-up to non-provider reports** *Health & Safety CAP Tracking Spreadsheet, 12-18.19-7.24.20 -* (During this period 47 active CAPs were open and being monitored; six CAPs were reviewed) *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services, undated*, (10.8.20- details contents and disposition of CAPs)

	implemented and are achieving their intended outcomes as follows:	*OL Guidance on Corrective Action Plans, 8.22.20-* (OL guidance requires that the root causes be identified in developing CAPs with providers but it places the onus for determining effectiveness on the provider. Guidance appears to suggest the OL role is to assess whether actions were taken as pledged and not whether they actions achieved intended outcomes. *Memo, H&S CAP Process Revisions/Clarification- Benz, 4.23.20* (outlines CAP process) *Memo, Guidance on Incident Reporting Requirements-Benz, 8.22.20* (Establishes minimum OL criteria for a CAP and subsequent actions for failure to correct, including invoking statutory sanctions.)
7	a. For serious injuries and deaths that result from substantiated abuse, neglect, or health and safety violations, the Office of Licensing verifies that corrective action plans have been implemented within 45 days of their start date. .	**Documentation confirmed:** *OL Look Behind Process – Annual Inspections, 5.26.20* (quality review of citations and CAPs) *Health & Safety CAP Tracking Spreadsheet, 12-18.19-8.11.20,* (Note: This reviewer reviewed OL tracking of 30 incidents regarding 45-day follow-ups; and verified that OL tracked and confirmed CAP implementation occurred as required.)
8	b. In cases of substantiated abuse or neglect that do not involve serious injury or death, the Office of Human Rights verifies that corrective action plans have been implemented within 90 days of their start date.	**Pending:** (Note: OL/OHR look behind analysis FY20) *RMRC Annual Report, FY 19, undated; -* (93% reported verified as implemented within 90 days in Q4, FY19) *RMRC CLB Trend Analysis, FY19, 4.20.20* (93% reported verified as implemented within 90 days in Q4, FY19) *RMRC Meeting Minutes, 4.20.20 –* (93% reported verified as implemented within 90 days in Q4, FY19) *OHR Look Behind Analysis, FY19, undated; -* (93% reported verified as implemented within 90 days in Q4, FY19)
9	c. On an annual basis, at least 86% of corrective action plans related to substantiated abuse or neglect, serious incidents, or deaths are fully implemented as specified in this indicator or, if	**Pending retrospective analysis FY 20 citations/CAPs, including identification of non-provider reports :** *RMRC CLB Trend Analysis, FY19, 4.20.20* (93% reported verified as implemented within 90 days in Q4 FY19)

	not implemented as specified, DBHDS takes appropriate action as determined by the Commissioner in accordance with the Licensing Regulations	*OHR Look Behind Analysis, FY19, undated* – (93% reported verified as implemented within 90 days in Q4, FY19) *Retrospective Analysis of Health & Safety CAPs, 12/19 - 8/20, undated* – (51 H&S CAPs during this period, 100% followed up within 30 days, 33/35 CAPs that were due were successfully implemented - 96%; Provider 34 received second CAP for failure to respond and then voluntarily agreed to surrender license; Provider 35 received second CAP and was then placed on provisional status.)
10	7. Providers, including CSBs, that have recurring deficiencies in the timely implementation of DBHDS-approved corrective action plans related to the reporting of serious incidents, deaths, or allegations of abuse or neglect will be subject to further action as appropriate under the Licensing Regulations and approved by the DBHDS Commissioner.	**Pending:** (Note: retrospective analysis of next cycle of data on H&S CAPs (recurring providers) *Retrospective Analysis of Health & Safety CAPs, 12/19 - 8/20, undated* – (51 H&S CAPs during this period, 100% followed up within 30 days, and 33/35 CAPs that were due were successfully implemented - 96%. Provider 34 received second CAP for failure to respond and then voluntarily agreed to surrender license; Provider 35 received second CAP and was then placed on provisional status.)
11	8. DBHDS has Policies or Departmental Instructions that specify requirements for Training Centers to report serious incidents, including, deaths, or allegations of abuse or neglect and to implement and monitor corrective actions. a. DBHDS has a process to monitor the implementation of corrective actions. b. When DBHDS identifies that harms have not been reported in accordance with policies or Departmental Instructions, an analysis is conducted to identify root causes; DBHDS implements corrective action as necessary to address identified causes.	**Pending documentation of non-provider reports and any RCAs:** *Data Warehouse Incidents Report, CVTV & SEVTC, 7.1.19-6.30.20* – *(*tracking sheet of SIRs at TCs) *RMRC CLB Trend Analysis, FY19, 4.20.20* (93% verified as implemented within 90 days in Q4, FY19) *RMRC Annual Report, FY 19, undated* – (93% reported verified as implemented within 90 days in Q4, FY19) *RMRC Meeting Minutes, 4.17.20* – (93% reported verified as implemented within 90 days in Q4, FY19) *OHR Look Behind Analysis, FY19, undated* – (93% reported verified as implemented within 90 days in Q4, FY19) *Health & Safety CAP Tracking Spreadsheet, 12-18.19-8.11.20*

		(Tracking of H&S CAPSs) *OL Look Behind Process – Annual Inspections, 5.26.20* (quality review of citations and CAPs) OHR *Protocol No. 145: Human Rights Violation Notice for State Operated Facilities, 5.20;* (monitoring process description) *OHR Memo – Notification of Human Rights Violations in State Operated Facilities, 6.5.20;* (monitoring process description) *Health & Safety CAPs process Revisions Memo, 4.23.20;* (monitoring process description) *Guidance on Incident Reporting Requirements Memo, 8.22.20;* (monitoring process description) *Guidance on Corrective Action Plan (CAPs) Memo, 8.22.20;* (monitoring process description) (Note: this review found that 30 incidents and CAP follow-up during this period are documented; includes TCs and OHR violations)

Item #	V.G.3 – OL - Adequacy of Supports	Evidence available to substantiate:
1	1. The DBHDS Office of Licensing (OL) develops a checklist to assess the adequacy of individualized supports and services (including supports and services for individuals with intensive medical and behavioral needs) in each of the domains listed in Section V.D.3 for which it has corresponding regulations. Data from this checklist will be augmented at least annually by data from other sources that assess the adequacy of individual supports and services in those domains not covered by the OL checklist.	**Pending Stability data for domain #8:** *Stability measure, Business Definition, undated*, (8.25.20) **Documentation confirmed:** (Note: limited to domains #1-7) *Correspondence to Providers, Benz, 3.14.20* (Note: The checklist to assess adequacy appears sufficient. For example, for community inclusion, two queries – is there documentation the individual is accessing community supports consistent with goals? And are there barriers to individual accessing integrated supports? If yes, is there a plan in place to address barrier *Memo to Providers, OL Remote Inspection Protocol, 5.15.20, Attachment B, V.G.3 Checklist for all annual visits –* (Note: includes 7 of 8 domains listed in V.D.3., is a criterion referenced assessment relying on relevant regulations and specific documentation to be supplied by the provider. Case Management is assessed separately from regular services.

Item #	V.G.3 – OL - Adequacy of Supports	Evidence available to substantiate:
		For the Stability domain, DBHDS plans to use information from the QSR process, supplemented with statewide crisis services and hospitalization data.)
2	2. The DBHDS Office of Licensing uses the checklist during all annual unannounced inspections of DBHDS-licensed DD service providers, and relevant items on the checklist are reviewed during investigations as appropriate. Reviews are conducted for providers at least annually pursuant to 12VAC35-105-70	**Pending resumption of on-site unannounced inspections:** *Data Warehouse Report, OL Adequacy of Supports, 1.1.20-6.30.20* – (OL documented that 13,387 out of 16,448 reported citations (81%) for this six month period were compliant) *Data Warehouse Report, OL Adequacy of Supports, 1.1.20-6.30.20* – (Avoiding Crisis Domain reports 59% compliance, Freedom from Harm shows 77%) (Note: DBHDS assumes that the remote assessments are a good faith effort to meet the indicator requirements; alternatively, DBHDS views Q3-4 FY20 as a pilot of the checklist. OL began remote inspections 3.14.20. Data reports did not separate January-March onsite inspections; no information was provided on the utilization of Adequacy checklist during investigations.)
3	3. DBHDS informs providers of how it assesses the adequacy of individualized supports and services by posting information on the review tool and how it is assessed on the DBHDS website or in guidance to providers. DBHDS has informed CSBs and providers of its expectations regarding individualized supports and services, as well as the sources of data that it utilizes to capture this information. e	**Documentation confirmed:** *Correspondence to Providers, Benz, 3.14.20* *Memo to Providers, OL Remote Inspection Protocol, 5.15.20, Attachment B, V.G.3 Checklist for all annual visits* - (This memo informs providers about remote inspections, and, as required, Adequacy of Supports review tool. The memo includes information regarding 7 of 8 domains, except Stability, which will be assessed through QSR, supplemented with REACH and hospitalization data.)
4	4. The DBHDS Office of Licensing produces a summary report from the data obtained from the checklist. On a semi-annual basis, this data is shared with the Case Management Steering Committee and relevant Key Performance Area workgroups. These groups	**Pending Annual Report to QIC covering CY20:** *Semi-annual Report (OL to CMSC/KPA, 8.1.20* – (First V.G.3 summary report; 1.1.20 – 6.30.20: Providers- Avoiding Crisis domain shows 60% compliance, Choice reports 82% compliance, Well-being shows 81%; Case Managers- all above 91%. No recommendations for areas to target for improvement were identified, although Avoiding Crisis is an obvious target despite being tied to only one regulation)

Item #	V.G.3 – OL - Adequacy of Supports	Evidence available to substantiate:
	evaluate the licensure data along with other data sources, including those referred to in indicator #1, to determine whether quality improvement initiatives are needed. A trend report also will be produced annually for review by the QIC to ensure that any deficiencies are addressed. If improvement initiatives are needed, they will be recommended, approved, and implemented in accordance with indicators 4-6 of V.D.2.	*Data Warehouse Report, OL Adequacy of Supports, 1.1.20-6.30.20* – (Note: Data for *Semi-annual Report*, Adequacy of Supports for providers and CM, assessed during Q4 FY 20 without required unannounced inspections and on-site face-to-face assessments. No annual report has been completed. No improvement initiatives were proposed.)

Item #	Miscellaneous Sections, previously reviewed	Evidence available to substantiate:
1	III.E.1 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 provide on-site, electronic, written, and telephonic technical assistance to CSB case managers and private providers regarding person-centered planning, the Supports Intensity Scale, and requirements of case management and HCBS Waivers. The CRC shall also provide ongoing technical assistance to CSBs and community providers during an individual's placement. The CRCs shall be a member of the Regional Support Team	*RST Internal Process Guide, 5.8.20*; (Note: The revised Guide continues to describe the assignment and use of CRC's in each Region consistent with this provision. IR found the Commonwealth in sustained compliance 12.13.19.)

Item #	Miscellaneous Sections, previously reviewed	Evidence available to substantiate:
	in the appropriate Region.	
2	III.E.2 The CRC may consult at any time with the Regional Support Team. Upon referral to it, the Regional Support Team 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 Regional Support Team shall have the authority to recommend additional steps by the PST and/or CRC.	*RST Internal Process Guide, 5.8.20*; (Note: The revised Guide continues to describe the assignment and use of CRC's in each Region consistent with this provision. IR found the Commonwealth in sustained compliance 12.13.19.)
3	III.E.3 The CRC shall refer cases to the Regional Support Teams for review, assistance in resolving barriers, or recommendations whenever: a. The PST is having difficulty identifying or locating a particular community placement, services and supports for an individual within 3 months of the individual's receipt of HCBS waiver services. b. The PST recommends and, upon his/her review, the CRC also recommends that an individual residing in his or her own home his or her family's home, or a sponsored residence be placed in a congregate setting with five or more individuals. c. The PST recommends and, upon his/her review, the CRC also recommends an	*RST Internal Process Guide, 5.8.20*; (Note: The revised Guide continues to describe the assignment and use of CRC's in each Region consistent with this provision. IR found the Commonwealth in sustained compliance 12.13.19.)

Item #	Miscellaneous Sections, previously reviewed	Evidence available to substantiate:
	individual residing in any setting be placed in a nursing home or ICF. d. There is a pattern of an individual repeatedly being removed from his or her current placement.	
4	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 analyses, that is sufficient to identify and address significant service issues and is consistent with the requirements of the DBHDS Licensing Regulations at 12 VAC 35-105-620 in effect on the effective date of this Agreement and the provisions of the Agreement.	**Pending Q2-4,FY20 data:** *Memo to Providers, OL Remote Inspection Protocol, 5.15.20, Attachment B, V.G.3 Checklist for all annual visits –* (includes 7 of 8 domains, except Stability – QSR, REACH) *DBHDS Licensing Regulations at 12 VAC 35-105-620. 8.2.20* (Note: Documentation was not provided to show that the outcomes of QI programs have been determined to be sufficient "to identify and address".)
5	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.	**Documentation confirmed:** https://sccmtraining.partnership.vcu.edu/sccmtrainingmodules/ - (support coordinator training modules, 3.29.19) (Note: The statewide CM training modules have been updated and improved. They are consistent with the requirements of this provision.)

APPENDIX E

MORTALITY REVIEW

By
Wayne Zwick MD

To: Donald Fletcher, Independent Reviewer

From: Wayne Zwick, MD
Re: Mortality Review
Date: 10/25/20
Re: Review of the Mortality Review requirements in the Settlement Agreement, U.S. vs. Commonwealth of Virginia

This is the report of the 17th review period to assess the status of the Commonwealth's planning, development, and implementation of the mortality review committee membership, process, documentation, reports, and quality improvement initiatives and evaluation to comply with the mortality review provisions of the Settlement Agreement. The review encompasses nearly a full year of progress and change (September 2019 through July 2020). Focus is on the status of Virginia's achievement of the compliance indicators that were agreed upon by the Department of Justice and the Commonwealth of Virginia and approved by the Federal Court.

Methodology
The findings and conclusions of this review are based on the documents provided and information obtained during interviews with administration and staff from DBHDS: Alexis Aplaska, MD, FAAP, Chief Clinical Officer; Patricia Cafaro, DNP, FNP-BC, Co-Chair of MRC, Mortality Review Clinical Manager; Robert Rigdon, RN MRC Reviewer; and Whitney Queen, MRC Coordinator.

Additionally, the following documents were submitted for review during this review period: Mortality Review Meeting Minutes: 09/12/19, 09/26/19, 10/10/19, 10/24/19, 11/07/19, 11/21/19, 12/12/19, 01/09/20, 01/23/20, 02/13/20, 02/27/20, 03/12/20, 03/26/20, 04/09/20, 04/23/20, 05/14/20, 05/28/20, 06/11/20. 06/25/20, 07/09/20, and 07/23/20.

For the above listed meetings, the documents reviewed included the MRC Agenda, MRC minutes (including attendance documentation), "The DBHDS MRC Meeting Minutes Attachment" and the completed "DBHDS Mortality Review Form" for each individual discussed by the MRC.

"MRC Master Document Posting Schedules (MDPS)" for each month from September 2019 - July 2020.
"Mortality Review Office Procedures" Draft June 2020
"Mortality Review Office Procedures" Draft July 2020
"Investigations: Appendix C: DD Death Investigations Revised for Indicators 4/1/2020"
"Mortality Review Form": Blank copy
"Office of Licensing Protocols Investigations, Revised For Indicators 4/1/20"
"Mortality Review Committee Charter" September 2019, final Draft FY21 09082020
"Potential Unreported Deaths Log" for each month: July 2019- June 2020
"MRC Data Report Q3 2020 Final Draft: MRC Quarterly Data Review FY 2020 Q3, June 11, 2020",

"MRC Data Report Q4 2020 Final Draft: MRC Quarterly Data Review FY 2020 Q4 August 27, 2020"
"Final Draft MRC Charter FY21 09082020: Mortality Review Committee Charter July 2021"
"Mortality Review Committee Charter September 2019"
"FY 20 eMRF Database Spreadsheet Column Titles"
"MRC Action Tracking Log 09.01.10 through 7.23.20"
"MRC Quarterly Report to the Commissioner: A Report On Deliberations And Findings During Quarters 3 & 4 of State Fiscal Year 2020"
Mortality Review Committee SFY 2020 June QIC Report/ "Annual Mortality Review Report SFY 2019"
"Mortality Review Committee Member Orientation March 26, 2020"
MRC member orientation: "Quality Improvement: Putting the Pieces Together" March 26, 2020
Copy of "DBHDS MRC Confidentiality Agreement" signed (by each of 16 members)
"Attendance MRC Orientation " roster 3/26/20
"DBHDS Departmental Instruction 315 (QM)13: Reporting and Reviewing Deaths"
"DBHDS MRC Response to V.C.5 – August 2020""MRC Title 37.2 Code of VA: DBGDS Chapter 851
Office of Licensing – DBHD: "Mortality Review Submission Checklist for Required Records"
DW-0080a " Incident Management Reports" 9/1/19-10/4/19, 10/1/19-11/5/19, 11/1/19-11/30/19, 12/1/19/12/31/19, 1/1/20-2/5/20, 2/1/20-3/2/20, 3/1/20-3/31/20, 4/1/20-4/30/20, 5/1/20-5/31/20, 6/1/20-6/30/20, 7/1/20-7/31/20
"DW-0080a – Incident Management Report Sample.xls"
"DW—0080a- Incident Management Report 1.1.20-8.31.20"
"DD Deaths.late.docx" (Jan1, 2020- Aug 31,2020)
"A Guidance Document for Department of Behavioral Health and Developmental Services Incident Management" (Revised 5/22/20)
"DBHDS Memorandum to DBHDS Licensed Providers: "Guidance on Incident Reporting Requirements" 8/22/20
"DD Death SIU Tracking Spreadsheet 1.1.20-8.31.20.xlsx"
QIC meeting information: "9-5-2019 Approved QIC Minutes", "QIC Meeting September 2019 Agenda", "QIC Meeting December 2019 Agenda", "Dec2019 MRC QIC Report FY19", "12-5-2019 Approved QIC Minutes", Mortality Review Committee (MRC) QIC Report Final March 2020, Mortality Review Committee (MRC) March 5, 2020", "QIC Meeting March 2020 Agenda", "3-5-2020 Approved QIC Minutes", "Draft 6-30-2020 QIC Minutes", "QIC Meeting June 2020 Agenda", "June 2020 DBHDS MRC Report to QIC"
"Quality Management Plan Annual Report and Evaluation State Fiscal Year 2019. May 2020"

Settlement Agreement Requirement
V. Quality and Risk Management System, C. Risk Management

5. The Commonwealth shall ***conduct monthly mortality reviews for unexplained or unexpected deaths*** *reported through its incident reporting system. The Commissioner shall establish the monthly mortality review team, to include the DBHDS Medical Director, the Assistant Commissioner for Quality Improvement, and others as determined by the Department who possess appropriate experience, knowledge, and skills. The team shall have* ***at least one member with the clinical experience to conduct mortality reviews*** *who is otherwise* ***independent of the State***

. ***Within ninety days of a death,*** *the monthly 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;

(ii) the most recent individualized program plan and physical examination records;

(iii) the death certificate and autopsy report; and

(iv) any evidence of maltreatment related to the 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, i****f any.*

The team also shall ***collect and analyze mortality data to identify trends, patterns, and problems at the individual service-delivery and systemic levels and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.***

Compliance Indicators

The following compliance indicator table has been developed to track DOJ requirements of the MRC structure and process. Several indicators have been subdivided, as they often had several components. Evidence was then used to determine compliance with each subpart. Evidence was based on submitted documentation as well as with interviews with selected staff. The following indicators were found to have MET or NOT MET the compliance indicator metric.

MRC charter components and procedures	Evidence in submitted documentation	MET	NOT MET	Document Comments
1.a. The charge to MRC	From the 'Final Draft MRC Charter FY21 09082020'" the following was recorded: "Focus on system wide quality improvement by conducting mortality reviews of individuals who were receiving a service licensed by DBHDS at the time of death and diagnosed with an intellectual disability and or developmental disability."	X		Final Draft MRC Charter FY21 09082020: Draft: "Mortality Review Committee Charter July 2021"
1.b.Chair identified	Chief Clinical Officer, or Mortality Review Clinical Manager "shall serve as committee chair"	X		Final Draft MRC Charter FY21 09082020: Draft: "Mortality Review Committee Charter July 2021"
1.b.Executive sponsor within DBHDS	"The committee is authorized by the DBHDS Quality Improvement Committee (QIC)	X		Final Draft MRC Charter FY21 09082020: Draft: "Mortality Review Committee Charter July 2021"
1.c..Membership of MRC by role	Membership includes: 'Required MRC members' totaling 15 by role or department represented, and 'Advisory	X		Final Draft MRC Charter FY21 09082020: Draft:

	(non-voting members) nominated by the Commissioner or Chair of the MRC' totaling 6 members			"Mortality Review Committee Charter July 2021"
1.d.Responsibilities of chair and members	"The Chief Clinical Officer or Mortality Review Clinical Manager, shall serve as committee chair and shall be responsible for ensuring the committee performs its functions, the quality improvement activities, and core monitoring metrics."	X		Final Draft MRC Charter FY21 09082020: Draft: "Mortality Review Committee Charter July 2021"
1.e. Frequency of meetings	MRC meets at minimum on a monthly basis.	X		Final Draft MRC Charter FY21 09082020: Draft: "Mortality Review Committee Charter July 2021"
1.f.Review of unexplained and unexpected deaths	These terms are defined as part of clarification of Tier 1 and Tier 2 classification of deaths.	X		Final Draft MRC Charter FY21 09082020: Draft: "Mortality Review Committee Charter July 2021"
1.f. Components of a complete mortality review	""Within 90 calendar days of a death, the Mortality Review Team (MRT) compiles a review summary of the death. This includes development of a succinct clinical case summary by reviewing and documenting the availability or unavailability of: medical records including health care provider and nursing notes for three months preceding death, incident reports for three months preceding death, most recent individualized service program plan, medical and physical examination records, death certificate and autopsy report (if applicable), any evidence of maltreatment related to the death. Interview, as warranted, any persons having information regarding the individual's care. The Clinical Reviewer(s) documents all relevant information onto the Mortality Review Form and the Chief Clinical Officer/Clinical Manager completes a preliminary review of all case summaries prior to an MRC meeting. During the preliminary review, a case is identified as	X		Final Draft MRC Charter FY21 09082020: Draft: "Mortality Review Committee Charter July 2021"

	Tier 1 or Tier 2 … At each meeting the MRC members, perform comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors and quality of service, evaluate the quality of the decedents' licensed services related to disease, disability, health status, service use, and access to care, to ensure provision of a reliable, person centered approach identify risk factors and gaps in service, recommends quality improvement strategies to promote safety, freedom from harm, and physical, mental and behavioral health and well-being, review Office of Licensing CAPs related to required recommendations to ensure no further action is required and for inclusion in meeting minutes, and refer any required recommendations not included in the initial CAP to the Office of Licensing for further investigation. And or other divisions represented by members, when appropriate, assign recommendations and /or actions to MRC members as appropriate, review and track the status of previously assigned recommended actions to ensure completion. "			
1.f. Standards for closing a review	"After the case review, the MRC seeks to identify: the cause of death, if the death was expected, whether the death was potentially preventable, any relevant factors impacting the individual's death, any other findings that could affect the health, safety, and welfare of these individuals and communication regarding risk, alerts, and opportunities for education, if any actions are identified based on the case review, the MRC will then make and document relevant recommendations and /or interventions; documentation of all the above is then made in the meeting minutes and on the electronic Mortality Review Form. The MRC will make recommendations in order to reduce mortality rates to the	X		Final Draft MRC Charter FY21 09082020: Draft: "Mortality Review Committee Charter July 2021'

	fullest extent practicable. The case may be closed or pended. If all determinations are made, the case is closed by the committee. If additional information is needed in order to make a determination, the case is pended until the next meeting. Cases that are pended have been reviewed within 90 days of the individual's death; the case is pended until the next meeting. Cases that are pended have been reviewed within 90 days of the individual's death based on the beginning review date. A pended case remains open until the following meeting, when the designated committee member provides an update or specific information as requested, IF all determinations are made, the pended case is closed by the committee."			
1.f. Standards for Committee quorum	"A quorum is 50% of the voting membership plus one, with attendance of at least (one member may satisfy two roles): a medical clinician, a member with clinical experience to conduct mortality reviews, a professional with QI expertise, and a professional with programmatic /operational expertise. "	X		Draft: "Mortality Review Committee Charter July 2021"
1.f Standards for Recusal from case reviews	"Members must recuse themselves from MRC proceedings if a conflict of interest arises, in order to maintain neutrality (prevent bias) and credibility of the MRC mortality review process. Conflict of interest exists when an MRC member has a financial, professional or personal interest that could directly influence MRC determinations, findings, or recommendations…." Examples given	X		Draft: "Mortality Review Committee Charter July 2021"
1.f. standards for Confidentiality protections for reviews	"To ensure confidentiality and adhere to mandated privacy regulations and guidelines, case reviews are provided to MRC members during the meeting only….all MRC members and other persons who attend closed meetings of the MRC are required to sign a confidentiality agreement form. Members shall notify the MRC Co-Chair and /or MRO Program Coordinator prior to having a guest	X		Draft: "Mortality Review Committee Charter July 2021"

	attend a meeting so that arrangements may be made for the guest to sign the confidentiality agreement form before (s)he is permitted to attend. Member confidentiality forms are valid for the entire term of MRC membership, and guest confidentiality forms are valid for repeat attendance at MRC meetings."			
1.g.Definition of unexplained deaths	"an unexplained death also is considered an unexpected death" (See next entry).	X		Draft: "Mortality Review Committee Charter July 2021"
1.g. Definition of unexpected deaths	"denotes a death that occurred as a result of an acute medical event that was not expected in advance, not based on a person's known medical conditions. Examples might include suicide, homicide, accident, acute medical event, a new medical condition, or sudden and unexpected consequences of a known medical condition. An unexplained death is also considered an unexpected death. "	X		Draft: "Mortality Review Committee Charter July 2021"
1.h.Requirements for periodic review and analysis at individual service level	This is part of Standard operating procedures: "within 90 days of a death, the Mortality Review Team develops a succinct case summary by reviewing and documenting the availability /unavailability of medical records (including health care provider and nursing notes for 3 months preceding death), previous 3 months incident reports, most recent individualized service program plan, medical and physical examination records, death certificate and autopsy report (if applicable), any evidence of maltreatment related to the death. The Clinical reviewer documents all relevant information on the Mortality Review Form and the Chief Clinical Officer /Clinical Manager completes a preliminary review of all case summaries prior to an MRC meeting. During the preliminary review, a case is identified as Tier 1 (requires a detailed comprehensive review of multiple factors and areas of focus by the MRC), or Tier 2 (does not require a detailed comprehensive review	X		A. Draft: "Mortality Review Committee Charter July 2021" B. "Mortality Review Office Procedures"/ "9/12/13 MRC Procedures Draft June 2020"

	as the preliminary review was sufficient). The MRC then performs comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors and quality of service. Evaluate the quality of the decedent's licensed services related to disease, disability, health status, service use, and access to care, to ensure provision to reliable person centered approach, identifies risk factors and gaps in service and recommends quality improvement strategies to promote safety, freedom from harm, and physical, mental and behavioral health and well being. Reviews Office of Licensing corrective action plans (CAPs) related to required recommendations, to ensure no further action is required and for inclusion in meeting minutes. Refers any required recommendations not included in the initial CAP to the Office of Licensing for further investigation. To its best ability, the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable. The MRC will make recommendations in order to reduce mortality rates to the fullest extent practicable. "(A), See also 'Mortality Review Office Procedures' which includes more detailed steps concerning procedures for the following areas entitled : 'Notification and Validation of Deaths', 'Clinical Summary, MRC Meeting', 'Recommended Actions', 'Death Certificates', 'Discrepancy Log', 'Potential Unreported Deaths', 'MRC Charter,' 'Member Orientation and Confidentiality Forms', 'Attendance/Quorum Monitoring' (B)			
1.h.Requirements for periodic review and analysis for system level factors	"The MRC documents recommendations for systemic quality improvement initiatives coming from patterns of individual reviews on an ongoing basis, and analyzes patterns that emerge from any aggregate examination of mortality data. From this analysis the	X		A. Draft: "Mortality Review Committee Charter July 2021" B. "Mortality Review Office Procedures"/ "9/12/13 MRC Procedures Draft June

	MRC makes one recommendation per quarter for systemic quality improvement initiatives and reports these recommendation to the QIC (quarterly) and the DBHDS Commissioner (annually). On a quarterly basis, the MRC also prepares and delivers to the QIC a report specific to the committee's findings. Within ninety days of a death, the MRC will prepare and deliver to the Commissioner of DBHDS, a report specific to the committee's deliberation, findings, and recommendations. If the MRC elected not to make any recommendations, documentation will affirmatively state that no recommendations were warranted. The MRC prepares an annual report of aggregate mortality trends and patterns for all individuals reviewed by the MRC within six months of the end of the year. A summary of the findings is released publicly."(A) See also 'Mortality Review Office Procedures', which includes more detailed steps concerning procedures for the following area entitled: "Recommendations and Quality Improvement Initiatives" and "Annual Report to the Commissioner" (B).			2020"
1.h. Develop and implement QI initiatives to reduce mortality rates.	"On a quarterly basis DBHDS staff assigned to implement quality improvement initiatives will report data related to the quality improvement initiative to the MRC to enable the committee to track implementation. Through mortality reviews, data collection, and analysis of data including trends, patterns, and problems at individual service delivery and system levels, the MRC identifies area for development of quality improvement initiatives...Additionally, the MRC establishes performance measure indicators (PMIs) that align with the eight domains when applicable. Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are	X		Draft: "Mortality Review Committee Charter July 2021"

	designed to raise the performance. Assess PMIs annually and based upon analysis, PMIs may be added, revised or returned in keeping with continuous quality improvement practices, implements approved Quality Improvement Initiatives (QII) within 90 days of the date of approval. Monitors progress of approved QIIs assigned and addressed concerns/barriers as needed. Evaluates the effectiveness of the approved QII for its intended purpose. Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training, utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures. Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns. "			
1.h. Reporting of QI initiatives to the QIC	"On a quarterly basis, the MRC also prepares and delivers to the QIC , a report specific to the committee's findings" …. "The MRC documents recommendations for systemic Quality Improvement Initiatives (QII) coming from patterns of individual reviews on an ongoing basis, and analyzes patterns that emerge from any aggregate examination of mortality data. From this analysis , the MRC makes one recommendation per quarter (4 recommendations/year) for systemic quality improvement initiatives, and reports the recommendation to the QIC (Quarterly) and the DBHDS Commissioner (annually)."	X		Draft: "Mortality Review Committee Charter July 2021"

Current MRC membership	Evidence in submitted documentation	MET	NOT MET	Document Comments
2.a. DBHDS Chief Clinical Officer (former title Medical Director)	Listed under membership section as : "Chief Clinical Officer (MD, and staff member with QI and programmatic/operational (P/O) expertise)"	X		Draft: "Mortality Review Committee Charter July 2021"

2.b. DBHDS Senior Director of Clinical Quality Management (former Asst. Comm. for QI)	Listed under membership section as "Senior Director of Quality Improvement (staff member with QI and P/O expertise"	X		Draft: "Mortality Review Committee Charter July 2021"
2.c.Independent practitioner	Listed as "a member with clinical experience to conduct mortality reviews who is otherwise independent of the State (medical doctor, nurse practitioner, or physician assistant, is an external member with P/O expertise"	X		Draft: "Mortality Review Committee Charter July 2021"
2.d.Medical doctor	Both Chief Clinical Officer and independent medical doctor	X		Draft: "Mortality Review Committee Charter July 2021"
2.e. Nurse	Includes 'Director of Community Quality improvement Services or designee (RN), Mortality Review Office Clinical Manager Co Chair (NP), MRO Clinical Reviewer (RN)	X		Draft: "Mortality Review Committee Charter July 2021"
2.f. QI staff	Includes Chief Clinical Officer, Deputy Commissioner of Developmental Services or designee, Senior Director of Quality Improvement or designee, Director of Office of Human Rights, Director of Office of Integrated Health, Mortality Review Officer Clinical Manager, Office of Pharmacy Services Manager, MRO Clinical Reviewer, MRO program Coordinator	X		Draft: "Mortality Review Committee Charter July 2021"
2.g. Programmatic/ operational staff	Includes Chief Clinical Officer, Deputy Commissioner of Developmental Services or designee, Senior Director of Quality Improvement, Director of Community Quality Improvement, Director of Office of Human Rights, Director of Office of Integrated Health, Mortality Review Office Clinical Manager, Office of Licensing Manager (both for Incident Team and investigation team), Office of Pharmacy Services Manager, MRO clinical reviewer, MRO Program Coordinator, independent clinician.	X		Draft: "Mortality Review Committee Charter July 2021"

The MRC charter fulfills the compliance indicators focusing on this area.

MRC member training topics to	Evidence in submitted documentation	MET	NOT MET	Document Comments

members				
3.a. Orientation to MRC Charter scope, mission, vision, charge, and function of the MRC	In 'Mortality Review Office (MRO) Procedures' section IX. Member Orientation and Confidentiality Forms: states: "A. Documents involved. MRC Orientation PowerPoint, QI Orientation PowerPoint, Confidentiality Agreement. B. processes involved: A member of the MRO provides the MRC member orientation. All MRC members must attend Member Orientation within 30 days of joining the committee. Member Orientation will include orientation to the MRC Charter to educate the members on the scope, mission, vision, charge, and function of the MRC. Review of the policies, processes, and procedures of the MRC. Education on the role/responsibility of the members, and training on continuous quality improvement principles. The MRC requires that members and guests must sign a confidentiality agreement prior to attending a meeting. Member confidentiality forms are valid for the entire term of MRC membership, and guest confidentiality forms are valid for repeat attendance at MRC meetings." (A) 22 of 22 (100%) MRC members submitted confidentiality agreements forms of MRC members submitted. (B) 22 of 22 (100%) MRC members attended the orientation in service. (C) A Mortality Review Committee Member Orientation was held 3/26/20. A copy of the training material /power-point was provided. This included the purpose, mission, and vision of the MRC.(D), (E)	X		A. "Mortality Review Office (MRO) Procedures" section IX. Member Orientation and Confidentiality Forms B."DBHDS Mortality Review Committee Confidentiality Agreement". C. " Attendance MRC Orientation March 26, 2020" D."MRC Member Orientation 03.26.20" E. "QI Putting the pieces Together MRC 3.26.20"
Prior to participation after 3/3.b. Review policies, processes, and procedures of the MRC	A Mortality Review Committee Member Orientation was held 3/26/20. Training included the following: meeting requirements Quorum requirements, voting membership, advisory membership, role of the Mortality Review Team, MRC Confidentiality Procedures, tasks of the MRC, data analysis, MRC recommendations for systemic quality	X		"MRC Member Orientation 03.26.20"

	improvement initiatives, quarterly report to QIC, annual report to Commissioner			
3.c Education on the Role/responsibilities of members	A Mortality Review Committee Member Orientation was held 3/26/20. Training included membership requirements. Role of the MRC members, signing an agreement to maintain confidentiality, meeting etiquette	X		"MRC Member Orientation 03.26.20"
3.d training on continuous QI principles	A Mortality Review Committee Member Orientation was held 3/26/20. This include a presentation "Quality Improvement: Putting the pieces Together"	X		"QI Putting the pieces Together MRC 3.26.20"

This section did not fulfill the relevant compliance indicators.

MRC functional requirements	Evidence based on submitted documentation	MET	NOT MET	Document Comment
4. Frequency: meets at least monthly	For September 2019 through July 2020, meetings were held twice monthly, except for December 2019, when there was one meeting.	X		"Mortality Review Meeting Minutes": 09/12/19, 09/26/19, 10/10/19, 10/24/19, 11/07/19, 11/21/19, 12/12/19, 01/09/20, 01/23/20, 02/13/20, 02/27/20, 03/12/20, 03/26/20, 04/09/20, 04/23/20, 05/14/20, 05/28/20, 06/11/20. 06/25/20, 07/09/20, 07/23/20
4. Quorum met for each monthly meeting	There was at least one monthly meeting fulfilling definition of quorum.	X		Same documents listed immediately above
4.a. Medical clinician (medical doctor, nurse practitioner, or physician assistant) required for quorum	There were only two meetings in which the independent clinician was not present. In both instances, another MD (chair) or NP (Co-chair) was present.	X		Same documents listed immediately above
4.b. Clinician with experience in mortality review	The chair and/or co-chair were present for all meetings.	X		Same documents listed immediately above

required for quorum				
4.c. QI professional/staff required for quorum	There was representation by professional/staff with QI experience at each meeting	X		Same documents listed immediately above
4.d. Programmatic/ operational professional/staff required for quorum	There was representation by programmatic/operational professionals/staff at each meeting.	X		Same documents listed immediately above
4.e. one member may satisfy up to two roles	This allowed each meeting to meet requirements of a quorum. Attendance varied from 9 to 16 with an average attendance of 14. Attendance was considered robust.	X		Same documents listed immediately above

The frequency and membership of the MRC fulfilled the requirements of the compliance indicators.

DBHDS information management system	Evidence based on submitted documentation	MET	NOT MET	Document Comment
5. Track referral and review of individual deaths	The MRC tracked all MRC recommendations until completion.	X		'MRC Action Tracking Log 09/01/19 thru 07/31/20
5. Track recommendations of the MRC at provider level	Submitted 'MRC Action Tracking Log 09/01/19 thru 07.31.20 tracked all MRC recommendations until completion. These recommendations were focused on provider care.	X		Same document listed immediately above
5. Track QI initiatives approved by MRC chair for implementation	See CI #13 below for a list of Quality Improvement Initiatives approved by the MRC and QIC for implementation. As an example, the Mortality Review Committee SFY 2020 June QIC Report recorded two recommendations with follow-up data per quarter: 1".Determine the factor causing 'unknown' as a classification for both expected and cause of death. 2. Identify the responsible established protocol that was not execute and develop QII to increase adherence to that	X		"Mortality Review Committee (MRC) SFY 2020 June QIC Report"

	protocol." Also listed were the results of several Performance Measure Indicator (PMI) activities that were tracked and results. "Domain: Safety and Freedom from Harm: Unexpected deaths where the cause of death or a factor in the death, was potentially preventable and some intervention to remediate was taken. Target 86%, results: FY19 annual results, FY20 1st QTR 100%, 2nd QTR 100%, 3rd QTR 100% correct. Domain: Safety and Freedom from Harm - Goal: reduce the number of IDD deaths where nonadherence to 911 protocol was identified to <75% of total reviewed IDD deaths. Target <75%, FY19 not tracked, FY20 1QTR 100%, FY20 2QTR 75%, FY20 3QTR 67%. Domain: Safety and Freedom from Harm - Goal: increase the number of mortality review cases in which 911 protocol was followed. Target >60%. " Not tracked as this is a new goal.			

Licensing responsibility with death reviews	Evidence based on submitted documentation	MET	NOT MET	Document Comment
6. DBHDS licensed providers report deaths through incident reporting system within 24 hours of discovery	This is tracked by DBHDS. From January 1 through August 31, 2020, there were 446 deaths of individuals with IDD. 33 incident reports were filed late, of which 4 were excused. 93% (417 of 442) of incident reports of deaths were provided in a timely manner.	X		"DD Deaths late"
6. DBHDS Licensing Investigations Team reviews all deaths of individuals with a developmental disability reported to DBHDS incident reporting system	The Office of Licensing tracks investigations of deaths reported through the Incident Management System.	X		DW-0080a Incident Management Reports (monthly spreadsheets) and cumulative spreadsheet 1/1/20-8/31/20

6.a. Initial review within 24hrs of death reported to DBHDS or next business day	Same as immediately above	X		Same as immediately above
6.b.Immediate licensing investigation if concern of abuse/neglect or concern of imminent and substantial threat to health, safety and welfare of other individuals, with action steps as appropriate	The Special Investigations Unit of the Office of Licensing also tracks IDD deaths via a tracking spreadsheet 1/1/20 through 8/31/20, including this requirement.	X		The Special Investigations Unit tracking spreadsheet 1/1/20 through 8/31/20. "DD Death SIU Tracking Spreadsheet 1.1.20 thru 8.31.20" updated 9/14/20
6.c. Licensing provides available record and information it obtains and the completed investigation report to the MRC within 45 business days of date death reported on at least 86% of deaths required to be reviewed by MRC	The Office of Licensing tracks the dates when the available records and the final investigation are provided to the MRC or the completion dates of death investigations. The Commonwealth submitted documentation that Licensing provided available records and final investigations to the MRC within 45 business days of date of death reported on 220 out of 221 (99.5%) of deaths reviewed by MRC".	X		"MRC Master Documents Posting Schedule" for September 2019, October 2019, Nov 2019, December 2019, January 2020, February 2020, March 2020, April 2020, May 2020, June 2020, July 2020.

MRC process in identifying deaths subject to review	Evidence based on submitted documentation	MET	NOT MET	Document Comment
7.a incident reporting system queried monthly to extract reports of all deaths with an ID/DD dx	The Office of Licensing tracks monthly queries of the incident reporting system	X		"DW-0080a Incident Management Reports" (monthly spreadsheets) and cumulative spreadsheet 1/1/20-8/31/20.

receiving licensed ID/DD service and /or residing in training center				
7.a. extracted reports included in data tracking log for MRC review	Same as immediately above	X		Same as immediately above
7.b. MRC clinical reviewers review information on data tracking log and determine if death is unexplained or unexpected and requires review by MRC	The MRC chair or co-chair determines if deaths are included in Tier 1 or 2 status prior to the MRC meeting. However, the information received to determine whether a death is unexpected or expected or unexplained is insufficient. The MRC's categorization was often based on incomplete information. The MRC is implementing new initiatives in which death certificates were able to be received (according to the "MRC SFY 2020 QIC Report). Additionally, there was new legislation allowing the MRC access to medical documentation. The additional information will allow for improved quality reviews of deaths. There remain significant concerns regarding the adequacy of reviews due to the lack of information and the ability of the MRC to accurately interpret limited available information, especially in the MRC's categories of expected and preventable deaths. At times it was difficult for this reviewer to understand the rationale for the MRCs determination of category of death as noted in the MRC minutes. See Attachment B (submitted under seal) for individual examples.		X	"MRC Action Tracking Log 09/01/19 thru 07/31/20" "June 2020 DBHDS MRC Report to QIC: Mortality Review Committee (MRC) SFY 2020 June QIC Report"
7.c. DBHDS data crosslinked with DOH to determine if death certificate on file results provided to DBHDS to attempt to identify deaths	Process: "DBHDS provides the identifying information of individuals in the Waiver Management System (WaMS) who receive DBHDS licensed on a monthly basis to the Virginia Department of Health (VDH), which will identify the names of individual receiving waiver-funded services for which a death certificate is on file. The results are being provided to and used by DBHDS to attempt to identify deaths that were not	X		"MRC Procedures Draft July 2020 Mortality Review Office Procedures" "Potential Unreported Deaths Log FY 20" This includes the following documents:

not reported through incident report system.	reported through the incident reporting system ... The DBHDS Office of Licensing investigates all unreported deaths identified by this process and takes appropriate action in accordance with DBHDS licensing regulations and protocols." This log indicates that the Office of Licensing reviewed the names provided by VDH and determined the following: July 2019 - 1 individual was on the wait list, but not receiving DBHDS services listed at time of death in WaMS. August 2019 - 1 individual was on wait list, but was deactivated 5/16/19 and was not receiving licensed services at time of death. September 2019 - 1 individual was on the wait list, but was deactivated on 9/13/18, and was not receiving licensed services at time of death. October 2019 - 4 individuals, three were not receiving DBHDS licensed services at time of death, 1 individual was receiving DBHDS licensed services. The OLS Specialized Incident Unit (SIU) Investigation Team confirmed on 4/22/20 that the required reporting had not occurred. OLS issued on 4/23/20. The MRC reviewed this death on 5/14/20. November 2019 - 2 individuals were not receiving DBHDS licensed services at time of death. December 2019 - 5 individuals not receiving DBHDS licensed services at time of death. January 2020 - 9 individuals listed - 4 did not receive DBHDS licensed services at time of death, 1 individual was not an IDD individual, 4 listed as NA, but names listed on Master Document Posting Schedule (MDPS) February 2020 - 7 individuals, 6 were not receiving DBHDS services at time of death, one listed on MDPS March 2020 - 6 individuals, 2 were not receiving licensed services at time of death. 4 were listed on MDPS April 2020 - 6 individuals, 4 individuals were not receiving DBHDS services at time of death, 1 individual was receiving DBHDS			"Definitions Process (for Provision V.C.5)", "Potential Unreported Deaths - July 2019", "Potential Unreported Deaths - August 2019", "Potential Unreported Deaths - September 2019", "Potential Unreported Deaths – October 2019", "Potential Unreported Deaths - November 2019," "Potential Unreported Deaths – December 2019", "Potential Unreported Deaths- January 2020", "Potential Unreported Deaths - February 2020", "Potential Unreported Deaths – March 2020", "Potential Unreported Deaths – April 2020", "Potential Unreported Deaths" – May 2020", "Potential Unreported Deaths – June 2020"

	services at time of death. This death was referred to OL for initial investigation. 1 individual was on MDPS. May 2020 - 9 individuals, 4 individuals not receiving DBHDS licensed services at time of death. 5 were listed on MDPS (2 to be presented at future MRC meetings) June 2020 - 1 individual listed on MDPS (1 to be presented at a future MRC meeting) DBHDS has made a significant attempt to identify individual deaths that were not reported to DBHDS.			
7.c. DBHDS Office of Licensing investigates all unreported deaths identified by this process	As above, detailed process provides evidence all names not reported are matched to Department of Health database. It appears that all individuals benefiting from licensed services monitored through the Office of Licensing are investigated.	X		Same as the document above.
7.c DBHDS Office of Licensing takes appropriate action.	OLS has followed-up and required Corrective Action Plans for providers who did not report the incident as required.	X		Same as the documents above, and "'DW-0080a-Incident Management Report"

MRC process consistent with charter	Evidence in submitted documentation	MET	NOT MET	Document Comment
8. 86% of unexplained/ unexpected deaths reported through DBHDS Incident reporting system have a completed MRC review within 90 days of date of death	95.1% of unexpected deaths reviewed at the 9/12/19 – 7/23/20 MRC meetings were completed within the 90-day timeline. (This reviewer calculated 118/126 (93.7%)	X		MRC minutes for the 9/12/19 – 7/23/20 meetings, also "MRC DOJ Indicators Aug 2020: DBHDS MRC Response to V.C.5 - August 2020"
9.a Availability of specific key documents or documentation of unavailability	This information was provided on each Mortality Review Form. Key documents were listed in a table in the Mortality Review Form completed by the clinical reviewers. If not available, then this was documented as	X		Mortality Review Form for MRC meetings for 9/12/19 – 7/23/20.

of medical records	such.			
9.a. Availability of physician case notes, nurses notes, incidents reports for 3 months preceding death	This information was provided on each Mortality Review Form.	X		Same as the document above.
9.a Availability or not of most recent individualized program plan	This information was provided on each Mortality Review Form (MRF)	X		Same as the document above.
9.a. Availability of physical exam records.	This information was provided on each Mortality Review Form	X		Same as the document above.
9.a Availability of death certificate and autopsy report(if applicable)	This information was provided on each Mortality Review Form	X		Same as the document above.
9.a. Any evidence of maltreatment related to death	This evidence is recorded in the Mortality Review Form under "Was there evidence of maltreatment/OHR violation?	X		Same as the document above.
9.b. Interviews as warranted for any person(s) having information regarding individual's care	According to the Chair of the Committee, interviews have been occurring, but not documented as such in the MRF. There is a recent revision to the MRF in which this area will be specifically noted. However, interviews are reported as being completed as warranted to complete an MRC review.	X		No document was available for the period reviewed.
10. MRC report prepared and delivered to DBHDS Commissioner of deliberations, findings, and recommendations for 86% of deaths requiring review	There are two types of reports prepared for the DBHDS Commissioner that include deliberations, findings, and recommendations. One is the quarterly report provided by the MRC to the QIC, which includes the DBHDS Commissioner as a member. The other report is the MRC Annual Report for each fiscal year. The MRC Annual Report was completed as of May 2020. Examples of the most recent MRC quarterly	X		"MRC Quarterly Data Review FY 2020" Q3, June 11, 2020 and Q4 August 27, 2020. "MRC Annual Report FY 2019"

within 90 days of death.	report include the following: "MRC Quarterly Data Review FY 2020 Q3, June 11, 2020' Initiative #1: revised Dec. 2019 goal from: reduce potentially preventable identified deaths to <15% of total reviewed I/DD deaths," to: reduce the number of potentially preventable deaths in which there was a failure to adhere to 911 protocols." "After three quarters worth of data collected (Q1-Q3), the MRT identified that the numerator and denominator neither reflects the goal, nor demonstrates progress made toward decreasing the overall number of deaths in which the improper use of 911 protocols was a factor." Initiative #2 "Aim: establish a target of <10% of deaths reviewed to be classified as 'unknown'. Measure: 13.5% of deaths reviewed in SFY19 were classified as unknown Cause of death. and the goal was to decrease the 'unknown' as cause of death to <10%, Plan: The MRC has identified that obtaining additional medical information through relevant documentation is a major obstacle in identifying cause of death and other relevant determinations." Plan includes "obtain documentation from VDH (death certificates) and medical records from healthcare facilities and providers, when needed to establish sequence of events and the cause of death." Two steps included: 1."work with VDH Office of Vital Records and DBHDS Information Technology (IT) to establish a process of obtaining Death Certificates." "Develop a process for implementation of legislation S42." 2."Collaborate with other Offices within DBHDS to implement approved legislation allowing MRC to obtain additional medical records for implementation July 1, 2020. Three steps for this area includes revise Departmental Instruction (DI) 315 and submit through DBHDS approval process. Develop DBHDS memo and obtain required signatures. Work with SLIT/OL to utilize memo when requesting additional medical records. Do:			

	monitor implementation, gather data, document barriers, study ongoing data analysis performed, compare data to predictions, monitor effectiveness, if ineffective after Study of data and related to predictions, re-evaluate plan and actions.". 'MRC Quarterly Data Review FY 2020 Q4 August 27, 2020' which documented "MRC QIC Proposal September 2020: Plan: Provide awareness and prevention education or training of infections that may contribute to sepsis development, to >50% of providers. Do: compile mortality review data for deaths related to sepsis for the past 3 years, Study: identify the top two sources of infection leading to sepsis (e.g., pneumonia, pressure injuries, or other). Act: develop infection awareness and prevention education or training for Providers, with tracking capability, and monitor Provider participation. Note: the impact of infection awareness and prevention education or training on sepsis deaths over a 12 month period." Data for FY 2020 Q3 and Q4: The "MRC Data Report Q4 2020 Final Draft" includes the following data: MRC review of case with in 90 days of death: Q1 92.3%, Q2 98.8%, Q3 98.7%, Q4 91.9%			
10. When MRC makes no recommendations, this is stated, that no recommendations were warranted.	Example "March 12,2020 and March 26, 2020. The MRC did not make any recommendations." Located in '	X		"MRC Quarterly Report to the Commissioner SFY 2020, Quarters 3 and 4."

The MRC process in these areas follows their charter.

MRC Annual Report content	Evidence from submitted documentation	MET	NOT MET	Document Comment

11. The MRC shall collect and analyze mortality data to identify trends, patterns and problems at the individual service-delivery and systemic levels and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent possible.	The MRC FY 2019 Annual Report documents the required analysis of the mortality data, identification of trends and implementation of quality improvement initiatives. The MRC's category and analysis of "potentially preventable" deaths was not sufficient to guide the MRC to develop related quality improvement initiatives to reduce mortality rates. Specifically, the MRC categorized 11 deaths (4%) as potentially preventable in FY 2019 – a decrease from 56 deaths (21%) in Fiscal Year 2018. The dramatic decrease in the number of deaths that the MRC categorized as potentially preventable in FY 2019 appears to result primarily from the MRC modifying its interpretation of its definition of "potentially preventable" and not from quality improvement initiatives.		X	"MRC Annual Report FY 2019"
11.a.Completed within 6 month of fiscal or calendar year	In 'Mortality Review Office Procedures' "XI. The MRC prepares an annual report of aggregate mortality trends and patterns for all individuals reviewed by the MRC and within 6 months of the end of the fiscal year". (state fiscal year ends June 30). The SFY 2019 Annual Mortality Report was presented by the DBHDS Mortality Review Committee May 2020.		X	Draft: "Mortality Review Office Procedures July 2020"' This report was overdue, as the fiscal year ends June 30, 2019, the SFY 19 should have been finalized/publicly available as of 12/31/19.
	The annual report will, at a minimum include:			
11.a.i. number and cause of deaths	The total number of deaths and cause of deaths in DBHDS licensed residential settings. This information is based on the data available to the MRC and MRO. Table 1 includes total number of deaths - 312 and various causes. There were 21 categories of causes listed. Tables 4-7 include the number of deaths	X		"SFY 2019 Annual Mortality Report May 2020"
11.a.ii. Crude mortality rate	Crude mortality rate of individuals on a DD HCBS waiver and receiving a DBHDS licensed service is included in Tables 9a and 9b	X		Same as immediately above

11.a.iii. Crude mortality by residential settings	Crude mortality rate of individuals by residential setting in aggregate known to DBHDS. Tables 9a and 9b.	X		Same as for 11.a.i.
11.a.iv. Crude mortality rate by age	Crude mortality rate of individuals by age. Table 4 and Figure 2	X		Same as for 11.a.i.
11.a.iv. Crude mortality by gender	Crude mortality rate of individuals by gender. Table 5 and Figure 3.	X		Same as for 11.a.i.
11.a.iv. Crude mortality by race	Crude mortality rate of individuals by race. Table 6 and Figure 4	X		Same as for 11.a.i.
11.a.v. analysis of patterns of mortality:	Analysis of patterns of mortality: is documented in the narrative section following the tables/graphs. This information is based on the data available to the MRC and MRO.	X		Same as for 11.a.i.
11.a.v. by age	By Age	X		Same as for 11.a.i.
11.a.v. by gender	By gender	X		Same as for 11.a.i.
11.a.v. race	By race	X		Same as for 11.a.i.
11.a.v. residential settings and DBHDS facilities	By licensed residential facility and DBHDS facilities.	X		Same as for 11.a.i.
11.a.v. service program	By service program. The definition of 'service program' was clarified by DBHDS. For this indicator, it is reflected in the mortality rate per SIS (Supports Intensity Scale) level. Crude mortality rate was calculated for each of 7 levels.	X		Same as for 11.a.i.
11.a.v. cause of death	By cause of death. Although the cause of death is listed, the analysis of patterns did not address the many 'cardiac' deaths and 'respiratory' associated deaths that needed further information. Many of these should otherwise have fallen into the 'unknown' category, which was already a substantial category for cause of death.		X	Same as for 11.a.i.
11.b. summary of findings released publicly	A summary of findings was publicly released in May 2020.	X		"SFY 2019 Annual Mortality Report May 2020"

Areas not meeting the applicable compliance indicators include an overall crude mortality rate, and the need to ensure appropriate categorization of death, with many causes of death remaining unknown.

MRC recommendations	Evidence and analysis based on submitted documentation	MET	NOT MET	Document Comment
12. Documents recommendations for systemic QI initiatives from patterns of individual reviews or patterns that emerge from any aggregate examination of mortality data. annually or twice annually	In the "Mortality Review Office Procedures' section XII, describes procedures and responsibilities of the MRO and the MRC. "The MRO shall collect and analyze mortality data to identify trends, patterns, and problems at the individual service delivery and systemic levels and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable. The MRC makes one recommendation per quarter (4 recommendations per year) for systemic quality improvement initiatives and reports these recommendation to the QIC quarterly and the DBHDS Commissioner annually. On a quarterly basis, the MRC prepares and delivers to the QIC, a report specific to the committee's findings." This review confirmed that the MRC was part of the agenda of the QIC at all quarterly QIC meetings. Recommendations were made for the most recent 3 QIC meetings, but not the meeting in September 2019.	X		"Mortality Review Office Procedures" QIC Agendas for 9/5/19, 12/5/19, 3/5/20, and 6/4/20 (meeting minutes dated 6/30/20).
13. MRC makes 4 recommendations for systemic QI initiatives based on aggregate patterns or trends annually	"To the fullest extent practicable. From the analysis, the MRC makes one recommendation per quarter (4 recommendations per year) for systemic quality improvement initiatives and reports these recommendation to the QIC quarterly and the DBHDS Commissioner annually." There were 4 systemic recommendations in the FY19 MRC Annual report.	X		A. "Mortality Review Office Procedures" B. "FY19 MRC Annual Report"
13. MRC reports these recommendations to the QIC and the DBHDS Commissioner	"The MRC makes one recommendation per quarter (4 recommendations per year) for systemic quality improvement initiatives and reports these recommendation to the QIC quarterly and the DBHDS Commissioner annually. On a quarterly basis, the MRC prepares and delivers to the QIC, a report specific to the committee's findings. " The QIC met on 9/5/19, 12/5/19,	X		A. "Mortality Review Office Procedures" "December 2019 MRC QIC Report FY 2019". "MRC QIC Report – Final March 2020: Mortality Review Committee (MRC)

	3/5/20, and 6/30/20. Submitted: There were no quality initiatives submitted to the QIC at the 9/5/19 meeting. "December 2019 MRC QIC Report FY 2019. Two quality initiatives were listed. A Performance measure indicator was listed as "unexpected deaths were the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken. A target of 86% was not achieved (partially met at 78%) A quality initiative was listed as 'achieving compliance for mortality reviews within a 90-day timeframe with a target of 86%. This was only partially met, with 72% of reviews meeting this target. A second quality initiative that the MRC recommended to QIC identified a concern that the number of potentially preventable deaths may be related to a delay in calling 911 (failure to adhere to established protocol). An MRC QIC report of March 2020 indicated the prior initiative related to unexpected deaths where the cause of death or a factor in the death was potentially preventable indicated some intervention to remediate was taken in 100% of cases. Documentation included the ongoing quality initiative to focus on execution of established protocols in relation to 911. This initiative was approved at the 3/5/10 QIC meeting. A second quality initiative that the MRC recommended to QIC would attempt to reduce the number of unknown causes of death. The plan was to pursue avenues to obtain additional medical information through relevant documentation. This included collaboration with other Offices within DBHDS to draft legislation allowing the MRC to obtain this information. This initiative was placed on hold by the QIC until additional details could be provided to the committee on the data to be collected. At the June QIC meeting, an update on the 911 quality initiative was provided. Minutes documented the plan needed revisions. The revised 911 quality initiative was approved			March 5, 2020" "June 2020 DBHDS MRC Report to QIC: Mortality Review Committee (MC) SFY 2020 June QIC Report" "MRC Quarterly Report to the Commissioner: A Report on Deliberations and Findings During Quarters 3&4 of State Fiscal Year 2020"

	by the QIC. The quality improvement initiative to improve the availability of death certificates was approved. "MRC Quarterly report to the Commissioner: A report on deliberations and findings during quarter 3&4 of state fiscal year 2020" listed the following number of MRC recommendations with focus on both provider and systemic findings: January 9, 202 two recommendations January 23, 2020 2 recommendations. February 13, 2020 3 recommendations February 27, 2020 2 recommendations 3/12/2020 no recommendations 3/26/2020 no recommendations 4/9/2020 1 recommendation 4/23/2020 4 recommendations 5/14/2020 1 recommendation 5/28/2020 3 recommendations 6/11/2020 no recommendation 6/25/2020 2 recommendations There was 1 recommendation to QIC during June 2020 QIC meeting (recorded in July 2020 MRC Quarterly Report to Commissioner): This goal was to increase the number of IDD death certificates available for mortality review to >90%. (with Plan, DO , Study, Act action steps)			
14. DBHDS develops and implements QI initiatives, either regionally or statewide, as recommended by MRC and approved by DBHDS Commissioner	The Mortality Review Committee SFY 2020 June QIC Report recorded two recommendations: 1.Determine the factor causing 'unknown' as a classification for both expected and cause of death. 2. Identify the responsible established protocol that was not executed and develop Quality Improvement Initiatives to increase adherence to that protocol. Also listed were the results of several Performance Measurement Indicator activities that were tracked; summary results were included. Unexpected deaths where the cause of death or a factor in the death, was potentially preventable and some intervention to remediate was taken included the following trend data: Target 86%, results: FY19 annual results, FY20 1st QTR 100%, 2nd	X		"The Mortality Review Committee SFY 2020 June QIC Report"

	QTR 100%, 3rd Q 100%. Goal: reduce the number of IDD deaths where nonadherence to 911 protocol was identified to <75% of total reviewed IS/DD deaths. Target <75%, FY19 not tracked, FY20 1QTR 100%, FY20 2QTR 75%, FY20 3QTR 67%. Goal: increase the number of mortality review cases in which 911 protocol was followed. Target >60%. There was no tracking data as this was a new goal. This review found that the MRC's recommended Quality Improvement Initiatives are presented to and some are approved by the QIC. The DBHDS Commissioner is a member of the QIC.			
14. DBHDS staff on quarterly basis report data related to the QI initiatives, to the MRC	The DBHDS MRC/MRO reports developed quarterly and an Annual data report for fiscal year and quarterly data reports for the most recent quarters. The MRC minutes included an agenda item for 'MRC Recommendations update'.	X		"December 2019 MRC QIC Report FY 2019: Mortality Review Committee (MRC)". "MRC QIC Report – Final March 2020: Mortality Review Committee (MRC) March 5, 2020" "June 2020 DBHDS MRC Report to QIC: Mortality Review Committee (MC) SFY 2020 June QIC Report" "MRC Quarterly Report to the Commissioner: A Report on Deliberations and Findings During Quarter 3&4 of State Fiscal Year 2020" "MRC Quarterly Data Review FY 2020 Q3" "MRC Quarterly Data Review FY 2020 Q4." MRC minutes dated 12/5/19, 3/5/20,

				6/30/20 "The MRC Action Tracking Log 09.01.19 thru 07.31.20 " recorded updates for MRC recommendations Actions taken / outcome. Date completed
14. MRC tracks implementation of QI initiatives	The Mortality Review Committee SFY 2020 June QIC Report recorded two recommendations and tracking of implemented initiatives: 1.Determine the factor causing 'unknown' as a classification for both expected and cause of death. 2. Identify the responsible established protocol that was not executed and develop QII to increase adherence to that protocol. Also listed were the results of several Performance Measurement Indicator activities that were tracked. The following is an example of the data collected during tracking: Unexpected deaths where the cause of death or a factor in the death, was potentially preventable and some intervention to remediate was taken. Target 86%, results: FY19 annual results, FY20 1st QTR 100%, 2nd QTR 100%, 3rd Q 100%. Goal: reduce the number of IDD deaths where nonadherence to 911 protocol was identified to <75% of total reviewed I/DD deaths. Target <75%, FY19 not tracked, FY20 1QTR 100%, FY20 2QTR 75%, FY20 3QTR 67%. Goal: increase the number of mortality review cases in which 911 protocol was followed. Target >60%. Not tracked as this is a new goal.	X		"Mortality Review Committee SFY 2020 June QIC Report"
15. DBHDS disseminates the Quality Management Annual Report	The "Quality Management Annual Report" included in its narrative a copy of the "Annual Mortality Report SFY 2019." As the Annual Mortality Report was not available for distribution to stakeholders until		X	"Quality Management Plan Annual Report and Evaluation State Fiscal Year 2019, May 2020"

to stakeholders.	May 2020, the release date to the public of the "Quality Management Annual Report" was not clearly identified. Documentation was not provided regarding methods of access/dissemination were available to this annual report (web site, mailings, etc.)			
15. Quality Management Annual Report contains information related to QI initiatives, including any alerts or identified resources that promote QI consistent with indicator V.B.4.f ("Through the Quality Management Annual Report, the QIC ensures that providers, case managers, and other stakeholders are informed of any QI initiatives approved for implementation as the result of trend analyses based on information from investigations of …deaths")	Located within the "Quality Management Annual Report", the SFY 2019 Annual Mortality Report (May 2020) reviewed the recommendations of the MRC for SFY 2019. These included: "Recommendation 1: DBHDS should maintain an established target of less than 10% of deaths reviewed to be classified as "unknown" for the cause of death and continue to utilize the process improvement plan that better identifies causes of death through the mortality review process. DBHDS did not meet this target for FY19, and further process improvements are needed to achieve this, specifically for individuals living in private residences." "Recommendation 2: DBHDS should maintain an established target that potentially preventable deaths make up less than 15% of the total DD deaths per year. DBHDS determined that less than 4% of deaths in FY 19 were potentially preventable and of those, failure to adhere to established protocols was determined to be the reason in 82% of cases. The data indicated that this recommendation should be renewed and that additional quality improvement initiatives are needed to specifically address this." Recommendation 3: For FY19 11 deaths were classified as potentially preventable, and each different cause of death was only represented by one or two individual cases (i.e. One was due to pneumonia, one due to motor vehicle accident, two due to cardiac arrest). Targeting one of these causes of death for a quality improvement initiative based on the FY19 data would not be reflective of the known causes of death common for individuals with developmental disabilities as was reported in previous years. Thus, based on cumulative past data related		X	

	to causes of death in its potentially preventable category, DBHDS should establish quality improvement initiatives specifically targeted at decreasing the rate of potentially preventable deaths related to aspiration and bowel obstruction. "Recommendation 4: DBHDS should evaluate the contributory factors leading to the increased crude mortality rates of individuals on the waiver with respect to SIS level." Of concern: The 4% of individuals categorized with a potentially preventable death was problematic. A large category of deaths were listed under unknown cause. There were other categories needing refinement – sudden cardiac death and respiratory failure. There were reviews in which Office of Licensing required a corrective action plan for clinical concerns, and for whom a preventive category would have been appropriate, but were not categorized as such by the MRC. The MRO is working on improving its access to medical records and has made recent strides in this area. This should assist the MRC in determining whether a death is potentially preventable, but for the SFY19, this was problematic. Usually there is a significant number of preventable deaths which can demonstrate a need for priority investigation, data tracking and analysis, and quality improvement initiatives but this important guidance was not available due to the low, and significantly reduced numbers of death categorized as potentially preventable in SFY 19. Identification of preventable deaths is essential to determining quality improvement initiatives to reduce mortality rates to the fullest extent practicable. See Attachment B (under seal) for deaths which may have been preventable. Of concern: documentation was not provided regarding the methods of dissemination to ensure "that providers, case managers, and other stakeholders are informed of any QI initiatives approved for implementation."			

Summary: The MRC has made many and impressive advances toward fulfilling the requirements of the fifteen compliance indicators and thirty-nine-in sub-indicators for V.C.5. However, further progress is needed. The MRC Annual Report for SFY 2019 did not meet the timeline of publication requirement. Data indicated the need to address unknown cause of deaths. The MRC category of death 'potentially preventable' was unable to guide the MRC to develop related quality improvement initiative. The MRC had to depend on prior year data to determine these initiatives. The MRC's new interpretations of definition/criteria that were used in FY 2019 to identify potentially preventable did not result in the sufficient identification of many such deaths (See Attachment A for examples). This reviewer's conclusion is that these criteria and the MRC's cause of death designations need to be revised/revamped in order to be a useful data set in guiding future recommendations and initiatives for the MRC to be able to achieve its purpose of reducing mortality rates to the fullest extent practicable.

Summary Bullets

Advances

- MRC occurs monthly or more often as needed.
- Names of attendees with titles and department/ institution affiliation continue to be documented as part of the MRC minutes.
- Attendance at MRC meetings reflects a robust multidisciplinary approach.
- Data accuracy, consistency, and integrity continues to be reviewed by data analysts.
- A list of documents that providers are required to submit to DBHDS licensing specialists continues to be utilized. Tracking included when the documents were received by MRC administrative staff. Timely inventory of received documents at periodic intervals continues to be part of the tracking process by an MRC Coordinator.
- The role of the MRC coordinator has been integral to the flow of documentation and timeliness of the many steps in the MRC process.
- A standardized format for mortality reviews continues to be utilized in providing essential information during MRC meetings.
- The MRC has been expanded to include other departments/agencies which contribute expertise to the mortality review process.
- Both Chair and Co-Chair of the MRC have clinical backgrounds.
- Deaths are reviewed and assigned to one of two tiers. A death review with no concerns, and clear diagnosis and was not considered preventable does not undergo full review. Deaths with concerns undergo a full review. This process has allowed the MRC to resolve the backlog of deaths to be reviewed. For the year, they have achieved completion of mortality reviews of all deaths reported to DBHDS within 90-days of death.
- An independent practitioner continues to participate in the MRC.
- When sufficient documentation is received, the quality of the clinical reviews brought to the MRC is generally complete and of sufficient quality to allow the MRC to complete its duties.
- The MRC protocol continues to ensure a formal mortality review process.
- The current process of database management in populating the Mortality Tracker spreadsheets has improved the integrity of the data for known deaths.
- The MRC's tracking system follows progress of recommendation implementation/data collection until closure.
- The Office of Licensing has created a team (Special Investigations Unit) to respond to urgent clinical concerns.
- Recently, the MRC has been allowed accessibility to death certificates for individuals under the Commonwealth's jurisdiction. Recently, Virginia legislation was passed allowing the MRC to obtain medical records from various additional sources

Challenges

- Obtaining complete information as to deaths of individuals benefiting from the various 'service program' remains to be resolved.
- The MRC Annual Report needs to be available to stakeholders within 6 months of the end of the fiscal year.
- Reducing the number of unknown causes of deaths continues to be a challenge.
- The MRC needs to review its definition or types of cases for which its category 'potentially preventable' would be appropriate. The current criteria and/or interpretations do not produce valid results, which are, therefore not useful in prioritizing improvement initiatives to reduce avoidable deaths.

Attachment A

Documents submitted during prior review periods as reference/background information for this review:

Mortality Review Committee meeting minutes 2015: 2/11/15, 2/24/15, 3/11/15, 4/15/15, 4/17/15(2), 5/27/15, 6/10/15, 6/29/15, 7/10/15, 7/22/15, 10/14/15, 11/23/15, 12/2/15, 12/9/15, and 12/29/15.

2016: 1/27/16, 2/10/16, 3/9/16, 3/28/16, 6/8/16, 6/22/16, 6/30/16, 7/7/16, 7/13/16, 8/10/16, 8/24/16, 9/14/16, 9/21/16, 10/12/16, 11/9/16, 12/5/16, 12/9/16, 12/14/16, and 12/21/16.

2017: 1/11/17, 1/18/17, 2/15/17, 3/8/17. 3/22/17, 4/18/17, 4/26/17, 5/10/17, 5/24/17, 6/7/17, 6/14/17, 6/28/17, 7/19/17, 7/26/17, 8/9/17, 8/17/17, 8/23/17, 9/13/17, and 9/27/17, 10/25/17, 11/08/17, 11/27/17, 12/13/17, 12/27/17.

2018: (01/08/18), 01/10/18, 01/24/18, 02/01/18, 02/14/18, 02/22/18, 03/01/18, 03/08/18, 03/15/18, 03/29/18, 04/12/18, 04/26/18, 05/03/18, 05/10/18. 05/17/18, 05/24/18, 05/31/18, 06/07/18, 06/21/18, 06/28/18, 07/19/18, 07/26/18, 08/02/18, 08/09/18, 08/16/18, 08/23/18, and 08/30/18. 10/18/18, 10/25/18, 11/15/18, 11/29/18, 12/13/18.

2019: 01/03/19, 01/17/19, 01/31/19, 02/14/19, 02/28/19, 03/14/19, 03/28/19, 04/04/19, 04/18/19, 05/02/19, 05/23/19, 06/13/19, 06/27/19, 07/11/19, 07/25/19, 08/08/19, 08/22/19.

For the above listed meeting minutes, the MRPF reviews (Mortality Review Presentation Forms) for individuals discussed at these meetings.

2016 Mortality Tracker

2017 SFY Mortality Tracker (as of October 2017)

Draft Community DD Mortality Review Worksheet

'Mortality Among Individuals with a Developmental Disability: DBHDS Annual Mortality Report for January 1, 2015 –June 30, 2016'

Departmental Instruction 315 (QM)13 Reporting and Reviewing Deaths (draft)

Mortality Review Committee Operating Procedures 2017

Responses to Recommendations from the Independent Reviewer Report to the Court 12-23-16

Mortality Review Committee Membership/Participation (undated)

Numbered Recommendation Status Tracker

Mortality Review Committee tracking 3/15/17

Mortality Review Committee Interventions to Address Concerns

Form letter to Office of Vital Records for copy of death certificate (draft)

Form letter to provider organization requesting specific documents for review (draft)

DBHDS ID/DD Mortality 2013 Annual Report (May 2014 Draft)

DBHDS 2014 Annual Mortality Report (August 2015 draft): 'Mortality Among Individuals with an Intellectual Disability'

DBHDS Mortality Review Letter to Medical Practitioners (October 2015): "Reminding Medical Practitioners of High Risk Conditions"

Mortality Review Committee data tracking documents: 2014 Mortality Tracker, 2015 Mortality Tracker, and 2016 Mortality Tracker (to 6/30/16)

Action Tracking Report FY 18 (in testing): Mortality Review Committee Action Tracking Report July-Sept 2017

DBHDS Instruction (July 2016 Draft): Mortality Review

Mortality Review Committee: Master Document Posting Process (undated)
Copy of Master Schedule July 2017 (in testing): MRC Master Document Posting Schedule (MDPS) Posting Period July 2017; Date Master Schedule Posted August 2017
Mortality Review Presentation Form (Final) Form MRC #001, 08/11/17
MRC Master Document Posting Schedule (MDPS) with drop downs
DI (Department Instruction) 315 Reporting and Reviewing Deaths. Draft. Field Review 10/3/17: DI 315 (QM) 13 Attachment B: (Name of Facility) Mortality Review Worksheet
MRC Meeting Minutes Shell 10/16/17
Office of Licensing DBHDS: ID/DD Death Mortality Review Committee Required documents/reviews
Safety and Quality Alerts of the Office of Integrated Health Services: Recognizing Constipation, Type II Diabetes, Type I Diabetes, Sepsis Awareness, Scalding, Preventing Falls, Breast Cancer Screening, Aspiration Pneumonia – Critical Risk, 5/19/17 Drug Recall Alert
Mortality Review Committee: Quality Improvement Plan: CY 2017
Recommendations Status 3/14/17
Quality Improvement Committee Meeting Minutes 7/6/17
2017 Progress Report: Office of Integrated health
Training Data (Skin Integrity Training)
MRC: Action tracking Log: Sept 2017 - Dec 2018 Plus Outstanding Recommendations from Previous Tracker
Excerpt from the Office of Integrative Health Annual Report: Data ending April 30, 2017 report published June 2017
Virginia DBHDS Annual Mortality Report SFY 2017: Mortality Among Individuals with a Developmental Disability
Power Point Presentation: Death Certificates: Quarterly Data Presentation "Incorporating VDH Death Certificates Onto the MRC Tracker" August 2018, Virginia DBHDS
Standard Operating Procedures for the DBHDS DD Mortality Review Committee (prepared 6/12/18)
FY 2017 Mortality Discrepancy file
2018 SFY Mortality Discrepancy file
Mortality Review Tracking Tool FY18
Mortality Review Tracking Tool Oct 2017-Feb 2018
Mortality Review Presentation Form
MRC Samples of Data Warehouse Reports: DW-0064 Incidents, DW-0055 Mortality Report Detail, DW-0025 Death and Serious Injury reporting Time Detail
Action Tracking Log Sept 2017- Dec 2018 Plus Outstanding Recommendations from Previous Tracker
Action Tracking Log Oct 2017 – present.
13th Review MRC Health Alerts Developed as a Result of MRC Recommendations: Sickle Cell, Aspiration pneumonia, congestive heart failure, stroke,
Health Alerts Developed as a Result of MRC Recommendations (Alerts from Oct 2017 – 8/8/18)
Health Alerts Developed as a Result of MRC Recommendations (Newsletter Topics from Oct 2017 – present [September 2018]}
Newsletter (Virginia DBHDS) "Health Trends" for the following months with featured health alert/focused topics:
October 2017: Bowels: Constipation, C-diff, and Obstruction
November 2017: Diabetes management

December 2017: Aspiration
January 2018: Sickle Cell Anemia, Winter and Extreme Cold Preparation
February 2018: Seizures
March 2018: Congestive Heart Failure, Depression and Suicide, Medication Management
April 2018: Urinary Tract Infections, Safety for Individuals with Autism
May 2018: Stroke, Transportation Safety for individuals in Wheelchairs
June 2018: Choking, Behavioral Changes and Underlying Medical Issues
September 2018: Pica
Power Point Presentation: Tracking Health and Safety Alert Views: Mortality Review Committee, August 30, 2018, Virginia DBHDS

Attachment B (submitted under seal)

Attachment B (submitted under seal)

Attachment B (submitted under seal)

APPENDIX F

QUALITY AND RISK MANAGEMENT, QUALITY IMPROVEMENT PROGRAMS, REGIONAL QUALITY COUNCILS, PROVIDER TRAINING AND QUALITY SERVICE REVIEWS

By
Rebecca Wright
and
Chris Adams

Section V.C.4

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.

V.C.4: The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analyses, and developing and monitoring corrective actions

This review examined the progress DBHDS had made in offering training and guidance to providers on proactively identifying risks of harm, conducting root cause analyses and developing and monitoring corrective actions. The findings below are organized by the seven associated compliance indicators.

1. *DBHDS will make training and topical resources available to providers on each of the following topics with an application to disability service or, at a minimum, to human services: a) Proactively identifying and addressing risks of harm; b) Conducting root cause analyses; and, 3) Developing and monitoring corrective actions.*

DBHDS has provided extensive training and topical resources to providers through virtual training and through training content outlines and information presentations maintained on the DBHDS website. Specific to this indicator, the following resources and descriptions are currently available:

- Proactively identifying and addressing risks of harm:
    - "Office of Licensing Emergency Regulation Changes Training" PowerPoint (dated 10/2018) which includes:
        - Definitions of Levels 1, 2 & 3 Serious Incidents
        - Requirements for reporting and review of serious incidents on a periodic basis to identify trends, systemic issues or causes
        - Comprehensive information about risk management including the scope of risk management in a provider system and structural/procedural requirements for establishing an effective risk management program
        - Links to additional relevant department website resources
    - "Office of Licensing Guidance for Risk Management" dated 08/22/2020 that includes specific requirements for identification and addressing risks of harm and requirements for inclusion of this information in the provider's annual risk assessment.
    - "Assuring Health and Safety for Individuals with DD" which was posted on the DBHDS website under "Health Risks" in 10/2020.
    -
- Conducting Root Cause Analysis:
    - "Root Cause Analysis (RCA): The Basics" PowerPoint (dated 2019)
    - "Office of Licensing Emergency Regulation Changes Training" PowerPoint (dated 10/2018) that includes:
        - A section on RCA definitions and required processes
        - Describes how RCA will be evaluated during licensing inspections

        - Links to additional relevant department website resources
    - "Office of Licensing Guidance for a Quality Improvement Program" dated 09/28/2020 (a revision from a 2018 document) that contains specific requirements for and guidance in conducting root cause analyses as a part of the provider's Quality Improvement Program.
    - Root Cause Analysis (RCA) Training PowerPoint dated 10/2020 and presented in early 11/2020 that includes all relevant information about the requirements for, purpose, process and desired outcomes of RCA.
- Developing and monitoring corrective actions:
    - "Office of Licensing Emergency Regulation Changes Training" PowerPoint (dated 10/2018) which includes information on:
        - Identification of indicated remediation and how to document steps taken to mitigate the potential for future incidents
        - A Quality Improvement Program section that addresses corrective actions and how they are to be follow up on
        - Links to additional relevant department website resources
    - "Guidance on Corrective Action Plans issued 08/22/2020 by the DBHDS Office of Licensing
    - "Office of Licensing Guidance for a Quality Improvement Program" dated 09/28/2020 (a revision from 2018 document) that includes specific requirements for content and guidance related to developing corrective plans.
    - "Quality Improvement-Risk Management Training" PowerPoint (dated10/2020) that includes information on developing and monitoring implementation and effectiveness of corrective action plans.

The department has placed significant emphasis on enhancing provider training as the above-noted examples reflect. The department has also recently contracted with the Shriver Center to make risk management training available to providers including on-line risk management modules in four areas: (1) Risk Screening, (2) Root Cause Analysis, (3) Incident Management, and (2) Data Analysis for Quality Improvement. The date for initiation of this training has not yet been established.

Interviews with provider and CSB staff also confirm the significant increase in training being made available to them. While provider and CSB staff note that they are reaching "information overload" of late, they also shared positive comments about the training content and the department's commitment to support the overall quality improvement program throughout the Commonwealth.

2. *Training(s) or educational resources in each topical area identified in Indicator 1 will be made available to providers through the DBHDS website, or other on-line systems.*

Training and topical resource reference materials are in the Commonwealth of Virginia's Learning Center (COVLC) and on the DBHDS Office of Integrated Health website. When new or revised information is available on the web, a notice is sent to all subscribers to the DBHDS Listserv. Since current subscription to the Listserv is voluntary, the Department is exploring

other options to be able to expand the Listserv subscriptions to assure that all providers of services are included. DBHDS is working with DMAS to identify additional sources of provider identification that may be contained in the DMAS data system.

A project has been initiated to place training modules into the department's Learning Management System, but this process is in its infancy. The Learning Management System has the capability to track providers that access and successfully complete the training – a significant advantage for longitudinal analysis of the effectiveness of the training.

3. *Providers that have been determined to be non-compliant with risk management requirements (as outlined in V.C.1, Indicator #4) for reasons that are related to a lack of knowledge, will be required to demonstrate that they complete training offered by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan.*

The Office of Licensing recently developed and implemented an "Internal Protocol for Assessing Compliance with 12VAC35-105-520" that provides specific instructions to licensing specialists about how to identify and cite providers found not to be compliant with the risk management requirements due to lack of knowledge. The instructions state "The Provider shall demonstrate that they completed training offered by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan." It is anticipated that this guidance to licensing specialists will increase consistency in their compliance assessments and assurance that corrective action plans contain assuring completion of required training as an element of the correction. DBHDS has not had sufficient time to assess and determine that providers have demonstrated that they have completed the training.

4. *Providers that have been determined to be non-compliant with requirements about training and expertise for staff responsible for the risk management function (as outlined in V.C.1, Indicator #1.a) and providers that have been determined to be non-compliant with requirements about conducting root cause analyses as required by 12VAC 35-105-160(e) will be required to demonstrate that they completed training offered by the Commonwealth or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan.*

The Office of Licensing recently developed and implemented an "Internal Protocol for Assessing Compliance with 12VAC35-105-520" that provides specific instructions to licensing specialists about how to identify and cite providers found not to be compliant with the requirement to conduct a Root Cause Analysis for any Level 2 or Level 3 incidents. This guidance requires that any corrective action plan for a citation for violation of 12VAC35-105-160.E (RCA for Level 2 or Level 3 incidents) must include "completion of training offered by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan,. Department-approved training will be posted on the Office of Licensing webpage." It is anticipated that this guidance to licensing specialists will increase consistency in their compliance assessments and assurance that corrective action plans contain the requirement to complete required training as an element of the correction.
DBHDS has not had sufficient time to assess and determine that providers have demonstrated that they have completed the training

5. *DBHDS offers written guidance to providers (including residential, day/employment, and case management) on how to proactively identify and address risks of harm. This content will include: 1)Guidance on conducting individual-level risk screening; 2) Either a tool for risk screening selected by DBHDS or example resources for consideration by providers to use when conducting risk screening; 3) Guidance on how to incorporate identified risks for individual service recipients into service planning and how to adequately address the risks.*

The Department issued a requirement for use of an Annual Risk Awareness Tool in June 2020. The tool contains seven medical risk awareness sections (pressure injury, aspiration pneumonia, falls with injury, dehydration, bowel obstruction, sepsis & seizures) and four behavioral risk awareness sections (law enforcement involvement, self-harm, elopement & lack of safety awareness). Accompanying the requirement, the Department also issued a "Risk Awareness Tool Instruction and Resource Document" dated 06/02/2020 and "Risk Awareness Tool Process and Planning Training" dated 06/2020. Both include guidance to use information from the Risk Assessment during the annual ISP planning process to support integration of the information from the Risk Assessment Tool into the ISP.

The department has also developed risk training PowerPoint presentations on topics including Seizures, Sepsis, Pressure Injury, Falls, Dehydration, Constipation and Bowel Obstructions & Aspiration Pneumonia and made these presentations available on the Department website.

6. *DBHDS publishes detailed guidance, with input from relevant professionals, about risks common to people with developmental disabilities, which include considerations for how to appropriately and adequately monitor, assess and address each risk. DBHDS will review its content annually and revise as necessary to ensure current guidance is sufficient and is included in each alert.*

DBHDS will use data and information from risk management activities, including mortality reviews, to: Identify topics for future content; Make determinations as to when existing content needs to be revised, and, Identify providers that are in need of additional technical assistance or other corrective action.
Content will be posted on the DBHDS website and the DBHDS provider listserv. Guidance will be disseminated widely to providers of service in other licensed and unlicensed settings, and to family members and guardians.

The department has developed risk training PowerPoint presentations on topics including Seizures, Sepsis, Pressure Injury, Falls, Dehydration, Constipation and Bowel Obstructions & Aspiration Pneumonia and made these presentations available on the Department website.

The Department issued a requirement for use of an Annual Risk Awareness Tool in June 2020. The tool contains seven medical risk awareness sections (pressure injury, aspiration pneumonia, falls with injury, dehydration, bowel obstruction, sepsis & seizures) and four behavioral risk awareness sections (law enforcement involvement, self-harm, elopement & lack of safety awareness). Accompanying the requirement, the Department also issued a "Risk Awareness Tool Instruction and Resource Document" dated 06/02/2020 and "Risk Awareness Tool Process and Planning Training" dated 06/2020. Both include guidance to use information from the Risk Assessment during the annual ISP planning process to support integration of the information from the Risk Assessment Tool into the ISP.

The Risk Management Review Committee (RMRC) meets monthly and reviews relevant data, information and related processes associated with risk management. Some examples include:

- Identified falls as a significant issue resulting in development and deployment of an additional training module that focuses on fall prevention.
- Identified provider failure to immediately contact 911 resulted in potentially preventable deaths (also identified by the Mortality Review Committee). A Health & Safety Alert entitled "Contacting 911 Emergency Services" was published in 12/2019. The Office of Licensing published a PowerPoint training entitled "Importance of Calling 911" which highlighted the importance of providers having specific guidance in policy about contacting 911 immediately in case of an emergency. A document entitled "Importance of Calling 911" was published on the Office of Integrated Health webpage and the Office of Licensing webpage in 02/2020.
- The Office of Integrated Health conducted a review of all Health & Safety Alerts posted on the website dating back to 2014 and presented its findings and recommendations to the RMRC in their 06/15/2020 meeting. Based on information from this review, the RMRC recommended making updates to a letter to clinicians from Dr. Barber that had been removed from the website. Based on information that the content was still needed but in revised format, it was revised and reposted to the website. Another review and results will be presented to the RMRC in their 12/2020 meeting.

The Mortality Review Committee also identifies specific risks and issues and recommends follow-up action with specific providers and providers in general. Several examples beyond the 911 notification issue identified above were identified through review of MRC minutes dated 11/07/2019, 05/28/2020 and 09/10/2020. Follow-up actions were verified through notations in the Mortality Review Committee Quarterly Report to the Commissioner for Q1/FY2021.

7. *DBHDS offers written guidance to providers on conducting root cause analyses and assesses that providers adequately (in accordance with DBHDS's own guidance) identify cases for and conduct root cause analyses.*

The Department has issued the following guidance on conducting root cause analyses:

- "Root Cause Analysis (RCA): The Basics" PowerPoint (dated 2019)
- "Office of Licensing Emergency Regulation Changes Training" PowerPoint (dated 10/2018) that includes:
    - A section on RCA definitions and required processes
    - Describes how RCA will be evaluated during licensing inspections
    - Links to additional relevant department website resources
- "Licensing Regulations Final DOJ Regulations PowerPoint" dated 10/2020 that included full review of the content of final regulations and identification of changes related to the requirements for conducting root cause analyses including examples of specific implementation.

- "Office of Licensing Guidance for a Quality Improvement Program" dated 09/28/2020 (a revision from a 2018 document) that contains specific requirements for and guidance in conducting root cause analyses as a part of the provider's Quality Improvement Program.
- Root Cause Analysis (RCA) Training PowerPoint dated 10/2020 that includes all relevant information about the requirements for, purpose, process, and desired outcomes of RCA.

The Department of Licensing assesses that providers adequately identify cases for and conduct root cause analyses as a part of the annual licensing inspection. The Department issued guidance to licensing specialists entitled "Office of Licensing Internal Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services" on 10/01/2020 regarding this assessment process. This guidance includes protocols for review and determination of compliance with requirements to conduct root cause analyses as specified in 12VAC35-105-160E. The guidance also includes a requirement for a Corrective Action Plan (CAP) for any cited violations including those related to conducting root cause analyses.

Section V.D: Overview

Inasmuch as each of the provisions for Section V.D. focus on various aspects of the collection and analysis of reliable and valid data, it will be helpful as context to provide an overview of the status of data reliability concerns at the outset.

At the time of the previous review, this study found that, while DBHDS collected considerable data from various sources, significant issues with the reliability and validity of the data existed throughout the system. Further, those issues hampered the ability of DBHDS staff to complete meaningful analyses of the various data the collected and/or implement needed improvements. The study also documented DBHDS' development of a draft *Data Quality Plan.* This plan identified data validity and reliability issues with regard to the CHRIS serious incident and death reporting system, the CHRIS human rights reporting system, the OLIS, Regional Support Team data and the PAIRS system for facility injuries and deaths. At that time, DBHDS staff were keenly aware of the need to make improvements in this area, and were either engaged in improvement initiatives or planning efforts to make improvements. However, the study found they still needed to develop a comprehensive and specific data quality improvement plan, with specific action steps and milestones, to expand and improve the quantity and quality of data to measure performance and to provide a structure for greater accountability of effort.

Based on documentation submitted and interviews completed for this review period, since the previous review, DBHDS had continued to place a significant and commendable focus on the issues of data collection, validity and reliability. The Office of Data Quality and Visualization (DQV) implemented a multi-phase initiative that delved deeply into issues of data reliability and validity across multiple systems. That Office issued a Data Quality Plan, dated Fall 2019, indicating an intent to complete a structural assessment of twelve data source systems.

This plan was predicated on some actions DBHDS staff had taken earlier in 2019. Known cumulatively as "Phase 0," these steps included the production of an undated Data Quality

Inventory and a May 2019 Data Quality Plan. The Data Quality Inventory was characterized as an "informal pre-assessment of the different source systems used for DOJ reporting." The Data Quality Inventory addressed nine source systems, including the following: the Computerized Human Rights Information System (CHRIS): Serious Incidents, the CHRIS: Human Rights, Children in Nursing Facilities, PAIRs (facility injuries and deaths), Individual and Family Support Program, Office of Licensing Information System (OLIS*)*, Regional Support Team (RST) data, independent housing data, Waiver Management System (WaMS) and WaMS Individual Service Plan (ISP). For each of these source systems, the Office of DQV identified

The three phases are described below:

- In Phase 1, DQV contracted with a vendor to develop a "maturity matrix." DQV staff used this tool to guide production of a document *Data Quality Plan Source Systems Assessments: Findings and Recommendations December 2019.* A follow-up Phase 1 report was entitled *Data Quality Plan Source Systems Assessments: Findings and Recommendations from an agency perspective, January 2020.* Between June 2019-August 2019, this phase also produced a separate source system assessment and an At-a-Glance overview for each of 12 DBHDS data systems: CHRIS – SIR; Employment; IFSP, MRC Form; OLIS; PAIRS REACH; RST; and, WaMS. Overall, these source system assessments were thorough and objective and found data reliability concerns across the board. (See Section V.D.4 for system-specific summaries.) Of note, the Phase 1 report specifically excluded two data sources: 1) Post-Move Monitoring because DBHDS was no longer planning to use the existing spreadsheet and 2) CCS3 because it was is not a true source system, but rather extracts of health records provided by Community Services Boards (CSBs). For this review, DBHDS did not provide any additional documentation with regard to the data reliability of these two data collection processes.

- Phase 2 was a similar assessment of the Data Warehouse (DW) processes, with reports issued in January and February of 2020. DBHDS engaged a third-party vendor to assist in this assessment process. The assessment identified numerous concerns with the system architecture and other factors impacting data quality. For example, the assessment noted that data quality in the DW was "a direct reflection of the quality of the data it receives from the source systems." The DW does not contribute any additional layers of data quality to source system data. Therefore, bad, missing and erroneous data from the source systems is reflected in the DW. Late and untimely data from the sources systems also adversely affects the quality and trust of data in the DW." At the time of this review, the Chief Information Officer noted that key staffing issues within the DW had resulted in a pause in addressing the issues and recommendations in the 2020 assessments, but that he hoped to be able to hire needed staff in the near future. In the meantime, he was taking the opportunity to meet with CSBs and others to explore ways to improve data quality in a systemic manner (e.g., a universal identifier.)

- In May 2020, Phase 3 produced an assessment of eleven reporting mechanisms including an assessment of the reliability of data upon which the reports relied. These included reports for CHRIS: SIR; RST; QRT; Employment; QSR; Provider Data; Integrated Day; REACH; Substantiated Cases (ANE); Case Management; and Unauthorized Seclusion. In addition to the data quality concerns identified in Phase 1 for the source system data used to produce the reports, these assessments often identified issues within the DW and the lack of comprehensive provenance documentation that led, or could lead, to data quality concerns.

In September 2020, the Office of DQV made a presentation to the QIC, entitled *DBHDS Data Quality Monitoring Plan: Major Findings and Recommendations from the First Year of Implementation*. Overall, the findings remained consistent with the those described above. With regard to the source systems, these included, but were not limited, a lack of advanced controls, confusing user interfaces, limited key documentation, duplication and redundancies, requirements for manual linking across systems and a need to improve/create/maintain documentation of all the processes required to produce the data (i.e., data provenance.) All of these factors contribute to concerns for data reliability. With regard to the Data Warehouse extract- transform-load (ETL) processes used to blend data from the multiple source systems, the presentation further identified data quality concerns (e.g., master data management no longer functioning, outdated architecture and manual procedures, lack of tracking or remediation of quality issues, absence of meta-data). Similarly, with regard to business area analytics and reporting of programmatic data, the presentation noted that the reporting processes requires extensive manual processes, with inadequate quality control. In addition, despite some improvements, supporting documentation continued to be lacking in many areas.

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In summary, over this last year, DBHDS had undertaken an impressive body of work with regard to self-assessing data quality. Moreover, the self-assessments appeared to be fully objective and honest about the source systems and the lack of reliability of the data DBHDS could retrieve from them. In recognition of the inherent flaws in the source systems, DBHDS staff had been endeavoring to develop various "work-arounds" to enhance the reliability of the data. However, many of those work-around processes were not documented and therefore subject to interpretation and human error. Without that documented data provenance, DBHDS could not yet demonstrate that data were reliable.

Consistent with the Office of DQV's overall findings with regard to inadequate data provenance, the September 2020 presentation reiterated the need to formalize documentation to enable the determination of data reliability. In a related vein, for this 17th Review Period, the Independent Reviewer developed a Monitoring Questionnaire For Data Verification (MQ). The MQ was comprised of 12 questions with regard to the data provenance, and supporting documentation, for all the applicable compliance indicators (CI) associated with the provisions being studied. An "applicable" CI is one that requires tracking, using statistical samples, achieving numerical or percentage measures, documenting trends and achieving increases, or documenting similar measurable outcomes. In many instances, DBHDS staff returned MQs that did not have all the requested information, further affirming the issue of establishing data provenance as an essential next step that will enable DBHDS to demonstrate data reliability. Among other things, DBHDS staff should give particular attention to formalizing the documentation with regard to the data collection methodology, the documentation of the data verification approach used to determine the reliability and validity of the data at the point of data collection, and the documentation of how DBHDS/DMAS has verified the accuracy, completeness and reliability of the data from the data source. In many instances, DBHDS staff cited "established" or "standard" procedures in response to these questions, but it will be essential that they provide, or develop, the specific steps of those procedures.

DBHDS should also continue to consider the other recommendations made in the Office of DQV's September 2020 presentation including, but not limited to, improving or sunsetting outdated data sources, transitioning to automated solutions, choosing enterprise solutions for new

or replacement systems, and perhaps procuring an overall enterprise data collection system. In the absence of new enterprise data collection systems, formalizing the documentation of data provenance, including standard procedures and ad-hoc "work-around" processes will be especially critical to establishing data reliability.

Section V.D.1

V.D.1: The Commonwealth's HCBS [Home and Community-Based Services] waivers shall operate in accordance with the Commonwealth's CMS [Centers for Medicare and Medicaid Services]-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; identification, response and prevention of occurrences of abuse, neglect and exploitation; administrative oversight of all waiver functions including contracting; and financial accountability. Review of data shall occur at the local and state levels by the CBSs and DBHDS/DMAS, respectively.

This review examined the extent to which DBHDS operated its HCBS waivers in accordance with the CMS approved waiver quality improvement plan, including the review of waiver performance measures in six domains (i.e., the waiver Assurances.) The findings below are organized by the eight compliance indicators.

1. *The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS waivers.*

The most recent annual revision of the Commonwealth's Quality Management Plan is for FY2020. Departmental Instruction 316 entitled "Quality Improvement, Quality Assurance, and Risk Management for Individuals with Developmental Disabilities," dated 06/03/2020, outlines the structure and implementation of the Quality Management Plan. Major elements of this Department Instruction include:

- Description of the framework for the quality management system.
- Roles and responsibilities of the Chief Clinical Officer who is responsible for oversight of the implementation of the elements outlined in the Departmental Instruction including chairing the Quality Improvement Committee.
- The structure, functions and responsibilities of the Quality Improvement Committee and its subcommittees including the (1) Mortality Review Committee (MRC), (2) Risk Management Review Committee (RMRC); (3) Case Management Steering Committee (CMSC); (4) Five Regional Quality Councils (RQCs); and (5) Three Key Performance Area (KPA) Workgroups that focus on (1) Health, Safety and Wellbeing, (2) Community Inclusion and Integration, and (3) Provider Capacity and Competency.
- Data are collected and organized into eight domains including (1) Safety and Freedom from Harm; (2) Physical, Mental and Behavioral Health and Well-Being; (3) Avoiding Crises; (4)

Stability; (5) Choice and Self-Determination; (6) Community Inclusion; (7) Access to Services and (8) Provider Capacity.

Through review of the functions of the Regional Quality Councils, Quality Review Committee and Quality Improvement Council, the Commonwealth is continuing to expand and improve the structure and functions of its quality improvement initiatives. The structures and process descriptions outlined in the Quality Management Plan appear to be an accurate reflection of the structure and functions that are operational within DMAS and DBHDS relating to the services and supports provided through the DD waivers and the oversight and management of the Commonwealth's DD services and supports system.

2. *The CMS-approved Quality Improvement Plan in the DD HCBS waivers outlines: a) Inclusion of the evidence-based discovery activities that will be conducted for each of the six major waiver assurances; b) The remediation activities followed to correct individual problems identified in the implementation of each of the assurances; c) Identification of the department and division responsible for overall management of the respective QM function(s); d) DMAS, as the Single State Medicaid Agency, retains overall authority for the operation of the DD HCBS waivers in their entirety; e) Processes to oversee and monitor all components related to the QM Strategy; f) Identification of performance measures that will be assessed; g) Processes to review performance trends, patterns, and outcomes to establish quality improvement priorities; h) Processes to recommend changes to policies, procedures, and practices, waivers, and regulation as informed through ongoing review of data; i) Processes to ensure remediation activities are completed and to evaluate their effectiveness, and, k) Processes to report progress and recommendations to the QIC.*

The Commonwealth's Quality Management Plan includes:

- Evidence-based discovery activities (KPAs, Domains and Performance Measure Indicators) in eight Quality of Life and Provider Service domains that incorporate data and information related to each of the six major waiver assurances - (1) Level of care, (2) Service planning and delivery, (3) Qualified providers, (4) Health and safety, (5) Fiscal accountability, and (6) Quality improvement.
- Outline of the process for remediation of individual problems in the implementation of each of the discovery activities
- Assignments of responsibility for each of the performance measures including data collection, analysis, and reporting
- Description of the oversight processes for each of these areas including reporting requirements culminating in final review each quarter by the Waiver Quality Review Team.
- Identification of specific performance measures for each identified KPA and Domain area.
- Responsibilities of the individual departments and various committees and councils to collect, analyze and report relevant data and information to the QRT to review results (trends, patterns and outcomes) of data collected and analyzed for each performance measure.
- Responsibilities of the QRT to recommend policy and/or procedural changes related to identified concerns from the quarterly review and analysis of the data, trends, patterns and outcomes.

- Responsibilities of the QRT to review and assure successful completion of remediation activities and/or to identify new or additional remediation needed.

3. *The Commonwealth has established performance measures, reviewed quarterly by DMAS and DBHDS, as required and approved by CMS in the areas of: a. Health and safety and participant safeguards; b. Assessment of level of care; c. Development and monitoring of individuals' service plans, including choice of services and provider; d. .Assurance of qualified providers; e. Whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR; f. Identification of and response to incidents and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation (prevention is contained in corrective action plans).*

The QRT, a joint DBHDS and DMAS committee, monitors and evaluates data related to the following CMS assurances and sub-assurances outlined in the DD waivers. The quarterly reports reflect data presentation with indicators assigned to each of these assurance areas:

- Waiver administration and operations
- Level of care
- Qualified providers
- Service planning
- Health and welfare
- Financial accountability

Minutes of the quarterly QRT meetings reflect their review activities and reporting of the data related to each of the performance indicators. Data reports for the most recent three quarters reflect data is being received and reviewed for all of the performance indicators except the few that have annual reporting only.

4. *The performance measures are found in the published DD HCBS waivers and found at cms.gov and are posted on the DBHDS website.*

Performance measures are identified and defined in the Commonwealth's DD waivers that are available for review on the CMS website (cms.gov) and on the DBHDS website in various forms but most specifically in the Quality Management Plan Annual Report and Evaluation for State Fiscal Year 2019 published in 05/2020.

5. *Quarterly data is collected on each of the above measures and reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans are written, and remediation actions are implemented as necessary for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86% compliance. Quality Improvement remediation plans will focus on systemic factors where present and will include the specific strategy to be employed and defined measures that will be used to monitor performance. Remediation plans are monitored at least every 6 months. If such remediation actions do not have the intended effect, a revised strategy is implemented and monitored.*

The charter for the Quality Review Team (QRT) describes it as a joint DBHDS and DMAS committee responsible for oversight and improvement of the quality of services delivered under

the Commonwealth's Developmental Disabilities (DD) waivers as described in the waivers' performance measures. The Quality Review Team (QRT) is co-led by DMAS and DBHDS and includes staff from DMAS QMR and the DBHDS Division of Developmental Services (DDS), Office of Human Rights (OHR), Office of Licensing (OL), and Division of Quality Management and Development (QMD). The QRT is responsible for:

- Receipt and tracking of performance measure data from specifically assigned sources. The data provided is specific to a defined numerator and denominator and a brief summary of explanations and recommended remediation if the indicator is below the required threshold. No trending data or data analysis beyond the basic report is provided to the QRT for review.
- Quarterly review of data provided and development of systemic remediation strategies for those measures that fall below an 86% performance threshold when required.
- Production of an annual report to the DBHDS Quality Improvement Committee as a summary review of the measurement data across the four quarters of the fiscal year.

The QRT collects, reports, analyzes and reports data that is organized within the waiver assurances and sub-assurances and categorized as follows: (1) waiver administration and operations, (2) level of care, (3) qualified providers, (4) service planning, (5) health and welfare, and (6) financial accountability.

The structure and functions of the QRT and its reporting responsibilities to the QIC are well organized and appear to be functioning consistently as outlined in its charter. Under current processes, data is reported to the QRT numerically – a numerator and denominator for each measurement. Significant efforts have been undertaken and have shown improvement in more specifically identifying and defining the numerator and denominator for each of the measures. Given the limited amount of data provided to the QRT, they have not yet expanded their data review and analysis processes to include identification and analysis of trends and patterns in the data reported. The QRT chair reports that resources have been allocated for staff to develop data mining capabilities that would expand the ability of the QRT to analyze performance measure data more fully in the future.

The report generated from the QRT each quarter presents relevant information about each performance measure in an understandable and easy-to-read format. For each performance measure, the report details the numerator and denominator, the associated waiver, the agency responsible for data reporting, the data source, quarterly data measurements, fiscal year total data measurements and remediation activities where required.

Remediation was noted for each of the indicators falling below the 86% threshold and progressive remediation was noted for those who fell below the threshold for more than one quarter. Some remediation plans reflect a systemic focus but this is an area that needs continued effort to expand the scope and improve the impact of the remediation being implemented.

A shortcoming of the current report content is the lack of specificity for the data source information. In most cases, if information is noted in this column, it is very generically described. For example, a number of the measurements are derived from evidence collected in DMAS

QMR process. For those indicators, the description notes only "QMR" and the staff member responsible for reporting. No information is provided to describe the data source more specifically.

DBHDS has developed and maintains a data quality monitoring plan to ensure that it is collecting and analyzing consistent, reliable data. The DBHDS Office of Data Quality and Visualization (DQV) has conducted reviews of the validity and reliability of data used to measure each of the performance indicators and has worked closely with staff responsible for data collection and reporting to refine the data identification, collection and reporting processes. While data definitions and source descriptions are being refined on an ongoing basis and improvements have been noted in some elements of the performance measurement system over the past year, much of the data currently being reported on the performance measures continues to lack full and complete data definitions and source descriptions making it difficult to establish its validity and reliability for each of the indicators.

The use of data to measure performance has been incorporated into the quality improvement structures that are currently operational. The structure and framework for data reporting and analysis is in place but is currently operating at a basic level. There appears to be recognition that considerable work remains to assure the validity and reliability of the data being used for performance measurement and to support the effectiveness of the work of the QRT.

6. *DMAS provides administrative oversight for the DD waivers in compliance with its CMS-approved waiver plans, coordinates reporting to CMS and conducts financial auditing consistent with the methods, scope and frequency of audits approved by CMS.*

The following is a description of the structure of administrative oversight for the Commonwealth's DD waivers:

- 12VAC30-120-1005(c) establishes DMAS as the single state agency authority pursuant to 42 CFR 431.10. It also establishes DBHDS as responsible for the daily administrative supervision of the DD waivers in accordance with the interagency agreement between DMAS and DBHDS.
- 12VAC30-120-990(A) authorizes DMAS to perform quality management reviews for the purpose of assuring high quality of service delivery for individuals enrolled in the Commonwealth's waivers.
- The approved waiver applications identify DMAS as the agency responsible for all required reporting requirements set out in the waiver.
- DMAS conducts onsite and desk audit quality management reviews (QMRs) and contractor evaluations. Information collected through the DMAS QMR process is the source for much of the data that is aggregated and reported for each of the performance measures.

Each of the Commonwealth's three DD waivers is current with no pending amendments. All reporting and communication with CMS regarding the waiver operations is coordinated by DMAS working closely with staff at DBHDS. Data and information are being collected for performance measures as outlined in the approved waivers with no identified exceptions. No

data reports to CMS on performance measures are currently due or pending submission. Based on information reviewed for this section, DMAS is following all reporting and oversight requirements set out in the waivers.

7. *The DMAS-DBHDS Quality Review Team will provide an annual report on the status of the performance measures included in the DD HCBS Waivers Quality Improvement Strategy with recommendations to the DBHDS Quality Improvement Committee. The report will be available on the DBHDS website for CSBs' Quality Improvement Committees to review. Documentation of these reviews and resultant CSB-specific quality improvement activities will be reported to DBHDS. The above measures are reviewed at local levels including by Community Services Boards (CSBs) at least annually.*

The QRT's most recent approved Year-End Report covers the period from 07/01/2018-06/30/2019. The report details all performance measures, data collected on each, analysis of the data and recommended remediation where needed. There were two recommendations to the QIC from the FY2019 QRT year-end report. These included:

- Consider new regulatory language to make it mandatory for providers who receive multiple citations within a specified time period and in specific key areas to submit to mandatory provider training and technical assistance.
- Consider development of a new integrated tool for capturing all of the data used in QRT reviews.

The QRT year-end report is available on the DBHDS website for review by CSB Quality Improvement Committees. CSBs and providers were given opportunity to review and provide feedback on the information contained in the FY2019 report and those responses were reviewed, and a determination was made regarding action on each. In an effort to improve this process for FY2021, a more detailed posting, response and action process was developed and will be implemented with the posting of the next year-end report. The revised process includes an expanded notice process to CSBs and providers about the report's availability, a longer period of time for this review to be completed, and a more detailed description of the process for receipt, review, and action on each of the responses. This modification is evidence of the continued efforts of the Commonwealth to assure that data being used for performance evaluation is an accurate reflection of the service delivery system effectiveness and that stakeholders at all levels of the service delivery system are given opportunity and encouraged to be engaged in quality improvement for the system.

7. *The Commonwealth ensures that at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations.*

A review of the data sources, data collection processes and data verification procedures related to this performance measure reflect considerable effort to ensure its accuracy. Staff report that verification of the accuracy, completeness, and reliability of the data for this measure is outlined in standard operating procedures but the description did not identify the specific information contained in those procedures. Data for this indicator is reported as a Key Performance Measure for DBHDS and is summarized in the "Provider Data Summary" dated 07/23/2020.

The 07/23/2020 Provider Data Summary reflects a 91.5% compliance level with details of the data.

The data for this indicator was reported for the first time in the recently developed Provider Data Summary. Staff report that historical data is not available for this indicator at this time.

Section V.D.2

V.D.2: 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. The Commonwealth shall use data to:

a. *Identify trends, patterns, strengths, and problems at the individual, service-delivery, and systemic levels, including, but not limited to, quality of services, service gaps, accessibility of services, serving individuals with complex needs, and the discharge and transition planning process;*
b. *Develop preventative, corrective, and improvement measures to address identified problems;*
c. *Track the efficacy of preventative, corrective, and improvement measures; and,*
d. *Enhance outreach, education, and training.*

This review examined the progress DBHDS had made toward the ability to collect and analyze reliable and valid data with regard to availability, accessibility and quality of services to people in the target population. The findings below are organized by the associated eight compliance indicators:

1. *DBHDS develops a Data Quality Monitoring Plan to ensure that it is collecting and analyzing consistent reliable data. Under the Data Quality Monitoring Plan, DBHDS assesses data quality, including the validity and reliability of data and makes recommendations to the Commissioner on how data quality issues may be remediated. Data sources will not be used for compliance reporting until they have been found to be valid and reliable. This evaluation occurs at least annually and includes a review of, at minimum, data validation processes, data origination, and data uniqueness.*

As described above in the Overview for Section V.D, DBHDS has created a Data Monitoring Plan. The version provided for review at the time of the document request was dated Fall 2019, with a number of ensuing associated reports on data quality and reliability, including the most recent update to the QIC on September 2020. All of these are also described above in the Overview. Overall, based on the documentation reviewed and interviews with DBHDS staff, the data sources had not yet been found to produce reliable data and so cannot yet be used for compliance reporting

2. *DBHDS analyzes the data collected under V.D.3.a-h to identify trends, patterns, and strengths at the individual, service delivery, and system level in accordance with its Quality Improvement Plan. The data is used to identify opportunities for improvement, track the efficacy of interventions, and enhance outreach and information.*

Based on review of documentation submitted, including meeting minutes from the QIC and the KPA Workgroups, DBHDS was using available surveillance data collected pursuant to V.D.3.a-h to complete analyses with regard to trends and patterns. However, as described above in the Section V.D Overview, and in Section V.D.4 below with regard to data quality for the source systems, DBHDS had not yet ensured the data used for analysis was reliable.

3. *At least annually, DBHDS reviews data from the Quality Service Reviews and National Core Indicators related to the quality of services and individual level outcomes to identify potential service gaps or issues with the accessibility of services. Strategic improvement recommendations are identified by the Quality Improvement Committee (QIC) and implemented as approved by the DBHDS Commissioner.*

During this review period, DBHDS staff continued to provide National Core Indicators (NCI) data to the QIC for review. For the QIC meeting on 6/30/20, members received two documents, the *In- Person Survey (IPS) State Report 2018-19* and a PowerPoint presentation entitled *2018-2019 National Core Indicators (NCI) Annual Report June 30, 2020*. The IPS was a compilation of the survey results overall, while the presentation pulled out several notable findings for consideration. For example, these cited potentially concerning findings with regard to behavioral medications (e.g., individuals taking behavioral (10%) and mental health medications (15%) with no corresponding diagnoses; roughly 20% of individuals with mental health conditions and no behavioral conditions taking behavioral medication and 47% of individuals with a behavior diagnosis and no mental health conditions taking mental health medication; and 22% of people taking behavior medication but do not have a behavior plan.) Similarly, the presentation cited findings with regard to cancer screenings that indicated case managers often did not have knowledge as to the status of colon cancer screenings for the applicable individuals served, and that other cancer screening information was not readily found in individuals' records. Both sets of findings merited discussion and consideration for quality improvement strategies. However, it was unclear that the QIC actually reviewed the data provided. Based on the QIC minutes provided for review, due to time constraints, the NCI Annual Report was not verbally reviewed. Instead, members were provided with an email contact for a designated staff should they have any questions regarding the report.

At the time of the previous review, DBHDS had paused the collection of data from Quality Services Reviews (QSRs), intending to resume following the conclusion of an RFP process and selection of a new vendor. For this 17th Review Period, DBHDS had engaged a new vendor which at the time of this report, was just wrapping up their initial set of reviews. No data were yet available for review. Further information with regard to this process can be found in Section V.I.

3. *DBHDS quality committees and workgroups, including Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, and Key Performance Area (KPA) workgroups, establish goals and monitor progress towards achievement through the creation of specific KPA Performance Measure Indicators (PMI). These PMIs are organized according to the domains, as outlined in the Settlement Agreement in V.D.3.a-h. P MIs are also categorized as either outcomes or outputs: a. Outcome PMIs focus on what individuals achieve as a result of services and supports they receive (e.g., they are free from restraint, they are free from abuse, and they have jobs) and b. Output PMIs focus on what a system*

provides or the products (e.g., ISPs that meet certain requirements, annual medical exams, timely and complete investigations of allegations of abuse).

As described in Section V.B. above, at the time of the previous review, DBHDS had developed the *DBHDS Quality Management Plan FY2020,* effective 9/13/19 which chartered three KPA workgroups (i.e., one for each domain) and charged them with the proposal and development of measures, which would be reviewed and approved by the QIC. For this review, DBHDS had also promulgated *Departmental Instruction 316 (QM) 20, Quality Improvement, Quality Assurance, and Risk Management for Individuals with Developmental Disabilities.* That document defined three broad categories aimed at addressing the availability, accessibility, and quality of services, those being Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity. According to the DI 316, the charge of each KPA workgroup was as follows:

- "The Health, Safety, and Wellbeing Workgroup is responsible for the collection and analysis of data as it relates to helping individuals achieve positive health outcomes, remain safe from harm, and avoid crises. The workgroup establishes goals and performance measures related to physical, mental, and behavioral health well-being. Data related to prevention strategies, wellness trends, and clinical outcomes are monitored."
- "The Community Inclusion and Integrated Settings Workgroup is charged with promoting stable service provision in the most integrated settings appropriate to each individual's needs and consistent with the individual's informed choice and ensuring full access and participation in community life. The workgroup establishes goals and performance measures to help ensure the most integrated settings appropriate to the individuals' needs, community stability, individual choice, and self-determination, and community inclusion."
- "The Provider Capacity and Competency Workgroup is charged with improving availability of and access to services across the Commonwealth and facilitating provider training, competency, and quality service provision. The workgroup establishes goals and performance measures related to provider capacity, access to services, and provider competency."

At the time of this review, DBHDS provided documentation indicating it currently had eight output measures and one outcome measure for the Health, Safety and Well-being domain, five outcome measures for Community Inclusion and Integrated Settings and three output measures and four outcome measures for Provider Competency and Capacity. The chart below summarizes the surveillance data collected for the indicators for V.D.3.a-h as this responds to the compliance requirement for those indicators as well as for indicator V.D.3. 4 above. It also provides a summary of the related measures for V.D.3.a-h. While it appeared that DBHDS collected and analyzed data regarding multiple areas in each domain listed in V.D.3.a-h, and from a variety of data sources, many of those data sources did not yet produce reliable data. This fundamentally compromised the ability of DBHDS staff to conduct meaningful analysis. As discussed further in the next section, while DBHDS was making efforts to ensure reliable data for the KPAs, some of these efforts were as of yet incomplete.

KPA Domain	Measure
Health, Safety and Well Being	Output: Critical incidents are reported to the Office of Licensing within the required timeframes.
	Output: Licensed DD Provider that administer medications are NOT cited for failure to review medication errors at least quarterly
	Output: Unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken.
	Output: Corrective actions for substantiated cases of ANE are verified by DBHDS as being implemented (DBHDS verifies that providers' corrective actions for substantiated case of ANE are implemented)
	Output: State policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed.
	Output: State policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed.
	Outcome: 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.
	Output: Individuals on the DD waivers will have a documented annual physical exam date
	Output: Individuals with an active waiver status and a documented annual physical exam date in their ISP in WaMS will have an actual annual physical exam date recorded.
Community Integration and Integrated Settings	Outcome: Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds.
	Outcome: Individuals live in independent housing.
	Outcome: Individuals participate in a discussion with their Support Coordinator about relationships and interactions with people other than paid program staff.
	Outcome: Individuals are given choice among providers, including choice of support coordinator
	Outcome: Individuals on the DD waiver and waitlist (aged 18-64) are working and receiving ISE and GSE.
Provider Competency and Capacity	Output: Provider investigations of abuse and neglect allegations are conducted in accordance with regulations of the Office of Human Rights.
	Output: Licensed providers implement quality improvement (QI) plans.
	Output: Licensed providers implement risk management (RM) provisions of regulations.
	Outcome: Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained Medicaid DD Waiver Community Engagement/or Community Coaching services goals.

KPA Domain	Measure
	Outcome: Adults (age 18-64) with a DD Waiver receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contains employment outcomes, including outcomes that address barriers to employment.
	Outcome: Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "supports need level" of 6 or 7, since FY16 are receiving services in the most integrated setting.
	Output: DBHDS continues to compile and distribute the Semi-annual Provider Data Summary to identify potential market opportunities for the development of integrated residential service options. The Data Summary indicates an increase in services available by locality over time.

Figure 1

As described further below, the Office of DQV created a *Technical Guidance for Measure Development* for use by DBHDS staff. It defined the terms "outcome" and "output" measures in a manner consistent with this indicator. However, it was not clear that DBHDS staff had applied the guidance in a manner that was also consistent with the compliance indicators. For example, while DBHDS staff correctly identified certain measures as outcomes (e.g., individuals live in independent housing, individuals on the DD waiver and waitlist (aged 18-64) are working and receiving ISE and GSE), in other instances they incorrectly identified measures as outcomes when they were output measures. Examples included "individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained Medicaid DD Waiver Community Engagement/or Community Coaching services goals," and "individuals participate in a discussion with their Support Coordinator about relationships and interactions with people other than paid program staff.." These measures reflected expectations for ISP requirements rather than outcomes for individuals (e.g., individuals are engaged and included in their communities or individuals have relationships with people in the community other than paid program staff.) DBHDS should revisit the designation of measures as output vs. outcome.

4. *Each KPA PMI contains the following: a. Baseline or benchmark data as available.; b. The target that represents where the results should fall at or above; c. The date by which the target will be met; d. Definition of terms included in the PMI and a description of the population; e. Data sources (the origins for both the numerator and the denominator); f. Calculation (clear formulas for calculating the PMI, utilizing a numerator and denominator); g; Methodology for collecting reliable data (a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation); h. The subject matter expert (SME) assigned to report and enter data for each PMI. i. Yes/No indicator to show whether the PMI can provide regional breakdowns.*

The Office of DQV provided the aforementioned *Technical Guidance for Measure Development* for use by DBHDS staff for measure development, accompanied by a *Measure Development Template.* The guidance addressed each of the requirements, as listed below:

- Measure Steward: Each PMI has a measure steward. This is the team member responsible for the measure details provided in this document. They are also responsible for reporting data and monitoring progress towards the goal.
- Approval Date and Implementation: The Quality Improvement Committee (QIC) approval date will appear here and a confirmation of the state fiscal year of data collection that this measure is considered 'active.' If the measure is 'retired,' the final state fiscal year of data collection would be indicated here as well. If the measure was changed, a reference to the sister measure may be included here.
- Data Source: The source(s) where the original data is maintained (e.g. a specific database, a data warehouse report, the name of a specific spreadsheet). If someone other than the measure steward is responsible for maintaining or reporting out this data, it may be described here.
- Methodology: Description of the data reporting details (e.g., inclusion codes). This section may also include calculation steps, including details regarding how and when the data will be collected.
- Regional Breakdown: Indicates whether the measure can provide regional data breakdowns.
- Population: A description of the population, or subpopulation (e.g., percentage of the population), included in the measure. This could be individuals or providers.
- Goal & Timeline: The goal for where the results should fall at or above, and the date by which it will be met.
- Baseline: The current baseline data or most recent data.
- Business Definitions & Processes: Definition of terms included in the measure/indicator for any terms that could be interpreted in more than one way. Other information related to specific business knowledge required to understand the importance and use of the measure in determining programmatic goals would be included here. This section may also include additional notes, ideas, issues or concerns that may be addressed at a later time by the KPA Workgroup.
- DQV Recommendations: The Office of Community Quality Improvement implemented a new process for newly developed measures that will be active for SFY20 or after. The measure steward first meets with the Senior Director of Clinical Quality Management to draft essential quality improvement elements of the PMI. The measure steward then meets with the Data Reporting Specialist in the Office of Data Quality and Visualization to provide details on the essential data elements. After the PMI is finalized, DQV completes the recommendation section to offer recommendations that the measure steward may choose to implement in order to improve PMI data quality and reliability.

With regard to the collection of valid and reliable data, the guidance related to the methodology was limited. It indicated that the methodology should include the details regarding how and when the data would be collected. However, based on the lack of data provenance documentation as discussed in the Section V.D. Overview above, it appeared DBHDS staff could benefit from expanded guidance in this area. For example, the Independent Reviewer reports have previously stated that the methodology should specifically describe how the data

will be collected (e.g., through a monitoring tool, through review of records, through review of the implementation of individuals' ISPs, etc.) and by whom, when and how often the data will be pulled/aggregated (e.g., monthly, quarterly, end of month, within first five days of month for preceding month, etc.), and the process and schedule for assessing data reliability, including who will be responsible for it. For further guidance about data provenance expectations, DBHDS staff should also refer to the MQ template the Independent Reviewer provided for this review period.

5. *DBHDS in accordance with the Quality Management Plan utilizes a system for tracking PMIs and the efficacy of preventative, corrective, and improvement measures, and develops and implements preventative, corrective, and improvement measures where PMIs indicate health and safety concerns. DBHDS uses this information with its QIC or other similar interdisciplinary committee to identify areas of needed improvement at a systemic level and makes and implements recommendations to address them.*

The *Quality Management Plan, FY 2020* incorporated a QIC Subcommittee Work Plan which included a log of PMI status and related notes. The Quality Management Plan stated that the Work Plan was the system for tracking PMIs and development, implementation, and progress of QIIs across committees/councils/workgroups consistently. In addition, the QI Committee's Work Plan was expected to assist the committee in completing its annual committee performance evaluation and committee report. Based on QIC minutes and materials reviewed (i.e., for 12/5/19, 3/5/20 and 6/30/20), it was not clear how or if the QIC was using this system. It was positive the QIC subcommittees regularly reported updated data and other information with regard to PMIs, including actions taken and proposed. However, the documentation submitted did not evidence the use of the QIC Subcommittee Work Plan to track the efficacy of improvement initiatives or use of the efficacy determinations.

6. *DBHDS demonstrates annually at least 3 ways in which it has utilized data collection and analysis to enhance outreach, education, or training.*

At the QIC meeting on 6/30/20, DBHDS staff offered a PowerPoint presentation entitled *Key Performance Area Workgroups: Health, Safety and Well-Being Community Inclusion and Integration Provider Capacity and Competency SFY 2020 (June 30 2020).* For each KPA Workgroup, the presentation documented three examples for which DBHDS used KPA data to provide outreach, education or training during the prior twelve months. Additional detail for some of the efforts cited and examples of related provider outreach, education, or training may be found in various sections of this report (e.g., V.C.4, V.D.5, V.H.1 and V.H.2.)

For Health, Safety and Well-Being, the initiatives described included:

- Office Of Integrated Health: The Importance of Calling 911 Feb 2020;
- The REACH programs offered numerous training programs during the third quarter which enabled 1191 community partners to receive this training; and,
- RMRC offered HR Access training and regional provider training to promote provider literacy.

For Community Inclusion and Integrated Settings, the presentation listed the following efforts:

- An April 2020 training for approximately 75 providers on implementing Community Engagement
- DBHDS selected 30 providers interested in the Home and Community-Based Services (HCBS) Business Acumen Business Development Learning Collaborative, as a part of a technical assistance opportunity.
- CMS-contracted consultants presented to approximately 50 providers on the "Support Packages" developed to adequately support individuals in the community

For Provider Competency and Capacity, DBHDS reported the following projects:

- Provider self-assessments were reviewed by DBHDS and this information has been delivered to DMAS. DMAS will be contacting providers, within the next Quarter, who have been found to be non-compliant with HCBS organizational policies
- The My Life My Community Provider Database and Provider Designation Process were launched on November 15, 2019
- Provider Roundtables and Regional Support Coordination Meetings were held in all regions in October 2019. A total of 307 provider representatives attended the Roundtable and 151 Support Coordination representatives attended the Support Coordination meetings.

7. *DBHDS collects and analyzes data (at minimum a statistically valid sample) at least annually regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS develops corrective action(s) based on its analysis, tracks the efficacy of that action, and revises as necessary to ensure that the action addresses the deficiency.*

Overall, the methodology for implementation of this requirement appeared to be a work in progress. Based on interview with key staff, DBHDS were examining opportunities to use case management functions to identify the needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided. In particular, DBHDS staff were focusing on how to use data from the Risk Assessment Tool (RAT) and a new On-Site Tool (i.e., used by Support Coordinators to document key facets of the face-to-face visits), to flesh out this plan. DBHDS anticipated implementing a pilot of the latter tool in the very new future.

Section V.D.3

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 is 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:

a. *Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);*
b. *Physical, mental, and behavioral health and wellbeing (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status);*
c. *Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);*
d. *Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);*
e. *Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);*
f. *Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);*
g. *Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and,*
h. *Provider capacity (e.g., caseloads, training, staff turnover, provider competency)*

This review examined the progress DBHDS had made toward the development of specific measures in the eight domains specified in Section V.D.3. (i.e., safety and freedom from harm; physical, mental, and behavioral health and wellbeing; avoiding crises; stability; choice and self-determination; community inclusion; access to services; and, provider capacity), and for the key performance areas (KPAs) and related data collection methodologies and sources. The findings below are organized by the six associated compliance indicators for V.D.3, as well as the specific indicators for each KPA area (i.e., V.D.3 a-h.), which describe in more detail how the Commonwealth is addressing each of the requirements.

DBHDS has established three Key Performance Areas (KPAs) that address the eight domains listed in V.D.3.a-h. DBHDS quality committees and workgroups, including Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee and KPA workgroups, establish performance measure indicators (PMIs) that are in alignment with the eight domains that are reviewed by the DBHDS Quality Improvement Committee (QIC). The components of each PMI are set out in indicator #5 of V.D.2. The DBHDS quality committees and workgroups monitor progress towards achievement of PMI targets to assess whether the needs of individuals enrolled in a waiver are met, whether individuals have choice in all aspects of their selection of their services and supports, and whether there are effective processes in place to monitor individuals' health and safety. DBHDS uses these PMIs to recommend and prioritize quality improvement initiatives to address identified issues.

The assigned committees or workgroups report to the QIC on identified PMIs, outcomes, and quality initiatives. PMIs are reviewed at least annually consistent with the processes outlined in the compliance indicators for V.D.2. Based on the review and analysis of the data, PMIs may be added, deleted, and/or revised in keeping with continuous quality improvement practices.

1. *The KPA workgroups and assigned domains (V.D.3.a-h) are: A. Health, Safety and Well Being KPA workgroup encompasses the domains of: a)Safety and Freedom from Harm, b) Physical, Mental, and Behavioral Health and Well being, c) Avoiding Crises; B. Community Integration and Inclusion KPA workgroup encompasses the domains of: a) Community Inclusion, b) Choice and Self-Determination, c) Stability; C. Provider Competency and Capacity KPA workgroup encompasses the domains of: a) Provider Capacity, b) Access to Services.*

As described above in Section V.B, the Quality Management Plan FY 2020 defines the KPA Workgroups and includes their assigned domains in each workgroup charter, consistent with the requirement of this compliance indicator.

2. *The DBHDS Quality Management Plan details the quality committees, workgroups, procedures and processes for ensuring that the committees and/or workgroups establish PMIs and quality improvement initiatives in the KPAs on a continuous and sustainable basis,*

As also described above in Section V.B, the Quality Management Plan FY 2020 details the quality committees, workgroups, procedures and processes for ensuring that the committees and/or workgroups establish PMIs and quality improvement initiatives in the KPAs on a continuous and sustainable basis.

3. *Each KPA workgroup will: a) Establish at least one PMI for each assigned domain; b) Consider a variety of data sources for collecting data and identify the data sources to be used; c) Include baseline data, if available and applicable, when establishing performance measures; d) Define measures and the methodology for collecting data; e) Establish a target and timeline for achievement; f) Measure performance across each domain; g) Analyze data and monitor for trends; h) Recommend quality improvement initiatives; i) Report to DBHDS QIC for oversight and system-level monitoring*

As further described with regard to V.D.2, the KPA Workgroups had each established at least one PMI for each assigned. These PMIs included the requirements a.- f of this compliance indicator. Based on the KPA Workgroup and QIC meeting minutes provided for review, the KPA Workgroups analyzed data and monitored for trend on an ongoing basis and made quarterly reports, including recommendations for quality improvement initiatives to the QIC.

4. *DBHDS collects and analyzes data from each domain listed in V.D.3.a-h. Within each domain, DBHDS collects data regarding multiple areas. Surveillance data is collected from a variety of data sources as described in the Commonwealth's indicators for V.D.3.a-h. This data may be used for ongoing, systemic collection, analysis, interpretation, and dissemination and also serves as a source for establishing PMIs and/or quality improvement initiatives.*

The chart below summarizes the surveillance data collected for the indicators for V.D.3.a-h as this responds to the compliance requirement for those indicators as well as for indicator V.D.3.4 above It also provides a summary of the related measures for V.D.3. a-h.

5. *The Office of Data Quality and Visualization will assess data quality and inform the committee and workgroups regarding the validity and reliability of the data sources used in accordance with V.D.2 indicators 1 and 5.*

As described above with regard to the Section V.D. Overview and further in Section V.D.2.5, the Office of DQV has been integrally involved in the assessment of data reliability, including assessments of data source systems and the reports produced from the DW. DQV staff also developed the Technical Guidance for Measure Development. For newly developed measures that will be active for SFY20 or after, staff from the Office of DQV will work with the measure steward during the measure development process and will provide formal recommendations to improve PMI data quality and reliability that will be incorporated into the PMI documentation.

6. *The Quality Management Annual Report will describe the accomplishments and barriers for each KPA.*

As described above with regard to Section V.B, in May 2020, DBHDS issued a *Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2019.* It described the accomplishments and barriers for each KPA defined in the compliance indicator. However, as also described above, the information and data were dated, covering a period between 7/1/18-6/30/19. During interviews for this review period, DBHDS staff had were in the process of adjusting the schedule for the production of the report. They provided for review a draft copy of the SFY 2020 version, which they expected to release following the first quarter of SFY 2021.

Sections V.D.3. a-h

This review examined the progress DBHDS had made in the development and implementation of performance measures and associated surveillance data. The findings below are presented in a chart organized by the eight associated compliance indicators. Overall, based on the PMI information available, did not always clearly specify how the surveillance data categories met all the minimum requirements of the compliance indicators. As a result, the chart attempts make those categorizations based on the wording of each measure.

V.D.3.a: Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);	
Indicator	*Measures and Specified Surveillance Data*
1. *The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for "safety and freedom from harm," at minimum including: a) Neglect and abuse; b) Injuries; c) Use of seclusion or restraints; d) Effectiveness of corrective action; e) Licensing violations; and f) Deaths* 2. *The Health, Safety and Well Being KPA workgroup*	Critical incidents are reported to the Office of Licensing within the required timeframes (CHRIS - SIR) Licensed DD Provider that administer medications are NOT cited for failure to review medication errors

will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Abuse, neglect and exploitation; Serious incidents and injuries (SIR); Seclusion or restraint; Incident Management; National Core Indicators – (i.e. Health, Welfare and Rights); and DMAS Quality Management Reviews (QMRs)	at least quarterly (CHRIS/OLIS-Licensing Violations) Unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken. (Action Tracking -Deaths) Corrective actions for substantiated cases of ANE are verified by DBHDS as being implemented (DBHDS verifies that providers' corrective actions for substantiated case of ANE are implemented) (CHRIS-OHR, Effectiveness of corrective action) State policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed. (CHRIS-SIR, CHRIS-OHR Use of seclusion or restraints)
V.D.3.b: Physical, mental, and behavioral health and well-being (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status));	
Indicator	*Measures and Specified Surveillance Data*
1. *The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for "Physical, mental, and behavioral health and well being."* 2. *The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: SIR; Enhanced Case Management (ECM); National Core Indicators - (i.e. Health, Welfare and Rights); Individual and Provider Quality Service Reviews (QSRs); QMRs*	Individuals on the DD waivers will have a documented annual physical exam date (WaMS) Individuals with an active waiver status and a documented annual physical exam date in their ISP in WaMS will have an actual annual physical exam date recorded. (WaMS)
V.D.3.c: Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);	
Indicator	*Measures and Specified Surveillance Data*
1. *The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for "avoiding crises," at minimum including: Number of people using crisis services; a) Age and gender of people using crisis services; b) Known admissions to emergency rooms or hospitals; c) Admissions to Training Centers or other congregate settings; d) Contact with criminal justice system during crisis.* 2. *The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Crisis Data; QMRs; QSRs; Waiver Management System*	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 (REACH Datastore - Known admissions to emergency rooms or hospitals)

(WaMS); CHRIS.	
V.D.3.d: Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program	
Indicator	*Measures and Specified Surveillance Data*
1. *The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "stability," at minimum including data related to living arrangement, providers, and participation in chosen work or day programs.* 2. *The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Housing; NCI – (i.e., Individual Outcomes); QSRs; WaMS*	Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds. (RST spreadsheet – Living arrangements) Individuals live in independent housing. (DDS Housing Outcomes and WaMS - – Living arrangements) Individuals on the DD waiver and waitlist (aged 18-64) are working and receiving ISE and GSE. (DARS report and WaMS – participation in chose work.)
V.D.3.e: Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);	
Indicator	*Measures and Specified Surveillance Data*
1. *The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "Choice and self- determination."* 2. *The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Community Engagement/Inclusion; QSRs; NCI – (i.e., Individual Outcomes); WaMS*	Individuals are given choice among providers, including choice of support coordinator. (SCQR - choice and self-determination)
V.D.3.f: Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);	
Indicator	*Measures and Specified Surveillance Data*
1. *The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "community inclusion," at minimum including data related to participation in groups and community activities, such as shopping, entertainment, going out to eat, or religious activity.* 2. *The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Community Engagement/Inclusion; QSRs; Housing; Regional Support Teams; Home and Community-Based Settings;*	Individuals participate in a discussion with their Support Coordinator about relationships and interactions with people other than paid program staff. (SCQR -community participation)

NCI – (i.e., Individual Outcomes); WaMS	
V.D.3.g: Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and	
Indicator	*Measures and Specified Surveillance Data*
1. *The Provider Competency and Capacity KPA workgroup will finalize surveillance data to be collected for "access to services," at minimum including: a) For individuals on the waitlist, length of time on the waitlist and priority level, as well as whether crisis services, Individual and Family Support Program funding, or a housing voucher have been received; b) Ability to access transportation; c) Provision of adaptive equipment for individuals with an identified need; d) Service availability across geographic areas; and e) Cultural and linguistic competency* 2. *The Provider Competency and Capacity KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: NCI – (i.e., System Performance); WaMS; Individual and Family Support Program (IFSP); Provider Data Summary; QSRs*	Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained Medicaid DD Waiver Community Engagement/or Community Coaching services goals. (CCS3) Adults (age 18-64) with a DD Waiver receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contains employment outcomes, including outcomes that address barriers to employment.(CCS3) Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "supports need level" of 6 or 7, since FY16 are receiving services in the most integrated setting. (WaMS Residential Settings Report) DBHDS continues to compile and distribute the Semi-annual Provider Data Summary to identify potential market opportunities for the development of integrated residential service options. The Data Summary indicates an increase in services available by locality over time. (WaMS Baseline Measurement Tool- Service availability across geographic areas)
V.D.3.h: Provider capacity (e.g., caseloads, training, staff turnover, provider competency).	
Indicator	*Measures and Specified Surveillance Data*
1. *The Provider Competency and Capacity KPA workgroup will finalize surveillance data to be collected for "Provider capacity," at minimum including: a) Staff receipt of competency-based training; b) Demonstration of competency in core competencies; and, c) Demonstration of competency in elements of service for the individuals they serve* 2. *The Provider Competency and Capacity KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Staff competencies; Staff training; QSRs; Provider Data Summary; QMRs; Licensing Citations*	Provider investigations of abuse and neglect allegations are conducted in accordance with regulations of the Office of Human Rights (Community Look-Behind spreadsheet - Demonstration of competency in core competencies) Licensed providers implement quality improvement (QI) plans (OLIS - Demonstration of competency in core competencies) Licensed providers implement risk management (RM) provisions of regulations. (OLIS - Demonstration of competency in core competencies)

Figure 2

Section V.D.4

V.D.4: The Commonwealth shall collect and analyze data from available sources, including, the risk management system described in Section 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 Management Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.

This review examined the progress DBHDS had made in the areas of collecting and analyzing data from a set of prescribed sources. The single compliance indicator for this provision requires the Commonwealth to collect and analyze data from 13 source systems, at a minimum. While it appeared that DBHDS continued to collect data from all of these sources, based on its own internal self-assessments, questions with regard to the reliability of the data remained. The descriptions below are based on the Office of DQV assessments, as previously referenced in the overview to Section V.D.1., and provide a summary of the status of each of the source systems. In particular, these summaries focus on two issues described in the V.D.1 Overview: 1) the data quality concerns related to system architecture, as identified in the respective source system assessments, and 2) the status of development of data provenance documentation.

a. *Computerized Human Rights Information System (CHRIS): Serious Incidents – Data related to serious incidents and deaths:* As described in the previous study, limitations with regard to the CHRIS architecture and processes continued to need to be addressed before DBHDS could extract and analyze meaningful data to identify patterns and trends or monitor the impact of corrective actions and quality improvement strategies. DBHDS had taken actions to correct some of the identified issues. For example, DBHDS had clarified definitions for reportable incidents. On the other hand, some of limitations remained the same as previously reported:
   - System design concerns that prevented DBHDS staff from using the data to identify systemic needs for preventative, remedial or improvement interventions. For example, a confusing and incomplete protocol of checkboxes with regard to type of incident had resulted in the majority of incidents being coded as "other." There had been some improvement with regard to the percentage of incidents being coded as "other," but additional work continued to be needed.
   - In addition, information about how and why incidents occurred was still sometimes recorded in free-text boxes, which did not make aggregation for analysis feasible.
   - A provider address drop-down menu could include thousands of locations, including closed locations, and these options are not listed in alphabetical or numeric order. As a result, addresses were often incorrect;
   - When an injury occurs as the result of abuse, the CHRIS architecture requires providers to enter a report twice, once in the licensing database and once in the OHR side of the system. This increased the likelihood of error and conflicting information. In addition, the reporter must enter the number of the abuse report on the injury incident report; otherwise, the system cannot link the two; and,
   - Individuals served do not have a unique identifier in the system, making it difficult to match records within CHRIS and externally for identifying potential individual trends.

b. *CHRIS: Human Rights – Data related to abuse and neglect allegations:* The Office of DQV completed a review of this system for the Phase 0 Data Quality Inventory, a source system assessment in July 2019 and assessment of two reports (i.e., Substantiated Cases and Unauthorized Seclusion) in May 2020. According to the source system assessment, numerous data quality issues existed within the architecture and it lacked advanced business rule to prevent erroneous data entry. Of note, as reported previously, the system allows for the creation of multiple profiles for the same person and multiple records for the same incident. The assessment found that it was positive, though, that the Office of Human Rights (OHR) had thorough process in place for reviewing data for accuracy and resolving data quality issues closest to the point of entry and that OHR provided new provider and ongoing quarterly provider training on the data entry procedures.

c. *Office of Licensing Information System (OLIS) – Data related to DBHDS-licensed providers, including data collected pursuant to V.G.3, corrective actions, and provider quality improvement plans:* The Office of DQV completed a Phase 1 Source System Assessment of OLIS in June 2019. This assessment detailed numerous concerns with the architecture and functionality of the system. For example, the assessment documented system instability and cumbersome user interfaces that at times caused users to rely on manual and informal strategies. Further, the processes used to monitor compliance with regulations appeared to vary substantially among licensing specialists. The Office of DQV also completed a Phase III Assessment of *Incident Management Reports DW-0080 and DW-0080a, May 2020.* Based on that assessment, data reliability issues continued to exist in the reporting processes. For example, the DW-0080 and DW-0080a displayed differing numbers of SIRs when run with the same date parameters, and neither of these record counts was equal to the number of SIRs in CHRIS-SIR for the same timeframe. It was positive to note that the Office of Licensing reported it was preparing to implement a process for assessing data reliability. Beginning in October, two Regional Managers were to be assigned to validate the various DW reports by the 5th of each month for the previous month by running the reports choosing two records in each region from DW report and comparing it to data in OLIS. If any discrepancies are noted, the manager will investigate to determine if it is an issue on the side of OLIS or DW. The results will be written up formally with detailed description and either fixed in OLIS or issue sent to DW to determine the cause of error. If error is on the side of the OLIS or the specialist, this will be discussed in staff meetings and used as training opportunity. It was unclear that how the Office of Licensing determined the sample size and whether that would be sufficient. Things to think about are the total number of providers/individuals reviewed each month, the frequency with which certain types of error may have been occurring during the validation process and whether the sampling will test for the types of errors identified in the OLIS Source System Assessment.

d. *Mortality Review:* The Office of DQV completed a source system assessment of the Mortality Review Committee Form in June 2019. According to that study, this Microsoft Access database had some good data validation features, but these were limited. Some of the more significant data quality concerns included the loading of data from various external data sources, unlocked fields that could be overwritten with no audit trail to show who made the changes or when they occurred. This also presented opportunities for conflicting data to exist between the Mortality Review Form and the original source system.

e. *Waiver Management System (WaMS) – Data related to individuals on the waivers, waitlist, and service authorizations:* The Office of DQV completed a review of WaMS for the Data Quality Inventory, a source system assessment in August 2019 and an assessment of the Provider Data Summary in May 2020. Findings for the source system documented extensive data validation controls and logic checks in place throughout the system, which was positive. However, given that WaMS interfaces with a variety of other vendor supported systems, including the various electronic health records at CSBs, the study found that the insufficient data controls in those external systems were also likely to impact data quality in WaMS. The study also recommended that assessing the data validation controls on that imported data should be a next priority. For the Provider Data Summary, some data provenance documentation existed, but some was still needed. For example, much of the data for the Provider Data Summary originated from two reports (i.e., the Residential Settings report and the Baseline Measurement Tool.) DBHDS staff had data provenance documentation for generating the reports, but did not have that documentation for how to transform the baseline Measurement Tool into the metrics and visualizations for the Provider Data Summary.

f. *Case Management Quality Record Review – Data related to service plans for individuals receiving waiver services, including data collected pursuant to V.F.4 on the number, type, and frequency of case manager contacts.* Based on interview with DBHDS staff, most of the data collection functionality for case management is in the process of migrating to WaMS, with the integration of the ISP into that system. As described above, although DBHDS continues to make strides in using the WaMS source system to produce reliable data, some data quality concerns persist. Other issues with regard to reliability of this data source included the following:

- Elsewhere in the Independent Reviewer's report, he concluded that the data for this review FY19 and FY19 cannot be considered reliable because, during that period, DBHDS did not have a standard definition of terms (i.e., for what constituted a change in status, for services that no longer remained appropriate or services not being implemented appropriately.)
- In addition, based on interview with DBHDS Provider Development staff, the Commonwealth will continue to use CCS3 to collect data with regard to case manager face-to-face visits. As described in the V.D.1 overview section, the Office of DQV did not complete a source system assessment for CCS3. However, this consultant's previous study documented data reliability issues within CCS3, as well extensive technical assistance Community Quality and Risk Management (CQRIM) staff provided to the CSBs to identify and resolve issues with quality data. This appeared to have been a well-planned and well-organized effort. However, for this review period, this process had been discontinued. If DBHDS staff plan to continue use CCS3 as an ongoing source of data for the Case Management Quality Record Review, they will need to address the data reliability issues.

g. *Regional Education Assessment Crisis Services Habilitation (REACH) – Data related to the crisis system:* The Office of DQV completed a REACH Source System Assessment in August 2019 and an assessment of the REACH Quarterly Data Report in May 2020. While the assessment of the source system documented some advanced business rules, mechanisms for data validation and ample technical documentation, the biggest potential draw-back was a lack of test-user access to anyone in the DBHDS Central Office, including the designated business owner. As a result, DBHDS staff could not independently conduct reliability checks. With regard to the reporting mechanism, data quality concerns included a lack of data validation features and manual quality controls and field calculations (e.g., bed utilization) that increased the risk of human error. In addition, at that time, REACH data loaded into the Data Warehouse did not meet business requirements related to timeliness and validity.

h. *Quality Service Reviews (QSRs):* At the time of the previous review, DBHDS had paused the collection of data from Quality Services Reviews (QSRs), intending to resume following the conclusion of an RFP process and selection of a new vendor. For this 17th Review Period, DBHDS had engaged a new vendor which at the time of this report, was just completing their initial set of reviews. No data were yet available for review. While the Director of the Office of DQV reported working closely with the vendor to develop data collection methodologies that would produce reliable data, which was positive, her Office had not completed a related source system assessment. Over the course of the past six months, the Independent Reviewer has provided substantial feedback about potential concerns with regard to data reliability. DBHDS and vendor staff have been responsive, but the Independent Reviewer's most recent memorandum on the subject noted continuing concerns. On November 16, 2020, DBHDS provided some additional documents that might address some of those concerns; however, this did not leave sufficient time during this review period to thoroughly review them and assess how well they address the concerns. The COVID-19 pandemic also had the potential to impact data reliability. Related issues included the inability of vendor staff to complete face-to-face observations, as required by the compliance indicators, and the potential that the sample would not be adequately representative by service type, due to individuals and families declining to participate. Please refer to Section V.I for additional information about the QSR data collection process.

i. *Regional Support Teams:* Overall, the reliability of data collection and data reporting for this source system stem from the significant manual work. The Office of DQV completed an assessment of the RST report in May 2020, and noted that automation was required for achievement of compliance with the related Provision III.D.6, and that, further, DBHDS planned to achieve this through integration into WaMS. However, at the time of the assessment, there was not a targeted completion date for this to occur. Based on interview, there were no new updates at the time of this review.

j. *Post Move Monitoring Look Behind Data:* Based on the Data Monitoring Plan documentation, DBHDS had not completed any analysis of the reliability of data collected with regard to Post-Move Monitoring. As described above in the V.D Overview, the Phase 1 report specifically excluded this data source Post-Move Monitoring because DBHDS was no longer planning to use the existing spreadsheet. However, the only information DBHDS provided

for this data source was dated 12/8/15, so it was unclear whether staff had updated the data collection methodology.

k. *Provider-reported data about their risk management systems and QI programs, including data collected pursuant to V.E.2: Provider-reported data about their risk management systems and QI programs, including data collected pursuant to V.E.2:* Based on the documentation provided (e.g., KPA measure methodologies), it appeared that, for the PMIs and for the pending risk measures, DBHDS staff pull and report aggregate data from various sources, including some for which the Office of DQV has documented data quality concerns (e.g. CHRIS, WaMs, CCS3 etc.) DBHDS did not provide evidence of a process whereby providers would report their own data specific to their risk management and quality management programs.

l. *National Core Indicators:* DBHDS continued to contract with the NCI vendor and Virginia Commonwealth University to complete the NCI survey process and to provide aggregate data. 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 recently approved by CMS for use in HCBS waiver programs. It would appear these data could be considered reliable

m. *Training Center reports of allegations of abuse, neglect, and serious incidents:* Training Center staff use the CHRIS-HR system to report allegations of abuse and neglect. Based on the documentation provided (i.e., Phase 0 Data Quality Inventory and Phase 1 Source System Assessment), DBHDS uses the PAIRS system for reporting of injuries and deaths, but it does not collect some other serious incident data such as emergency room visits. Some of the reported data quality issues included a lack of advanced validation or business rules to prevent erroneous data from being entered, a lack of updated and comprehensive systems documentation, including no comprehensive user manual from DBHDS Central Office, leaving each facility to interpret procedures and definitions in its own way and a lack of training for all staff entering the data in the system. At the time of the Phase 1 report, the PAIRS system was being revamped and built into a web-based platform. Recommendations included the production of comprehensive documentation for users, a data dictionary and data definitions for the documentation library.

Section V.D.5

V.D.5: The Commonwealth shall implement Regional Quality Councils that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.

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; and,*
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.*

This review examined the progress DBHDS had made in its efforts to implement Regional Quality Councils. The findings below are organized by the seven associated compliance indicators:

1. *DBHDS has a charter for Regional Quality Councils ("RQCs") that describes the standard operating procedures as described in Indicator V.B.4.d. DBHDS orients at least 86% of RQC members based on the charter and on quality improvement, data analysis, and related practices.*

The Regional Quality Council Charter was revised and re-published in September 2020. The Charter contains all elements outlined in Indicator V.B.4.d including:

- The charge to the committee (Statement of Purpose)
- The chair of the committee (Leadership and Responsibilities)
- The membership of the committee (Membership)
- The responsibilities of the chair and members (Leadership and Responsibilities)
- The frequency of activities of the committee (Meeting Frequency)
- Committee quorum (Quorum)
- Periodic review and analysis of reliable data to identify trends and system-level factors related to committee-specific objectives and reporting to the Quality Improvement Committee (Leadership and Responsibilities)

The Charter does not contain information about the structure and delivery of required training for RQC members and alternates. It would appear this would be helpful to ensure consistent adherence to the structure for delivery of this training on an ongoing basis.

Orientation and training of new and incumbent RQC members and alternates is provided through online video training that covers all required information about the RQC purpose, operations, and member responsibilities. Each member/alternate who completes the online training module is required to sign an attestation statement indicating participation in and completion of the training. Additionally, members are provided extensive training through the annual Quality Improvement Tools and Methods Training which was first held in August 2019 and again (virtually) in August 2020. The most recent virtual training conference included the following topic focus areas: (1) general overview of the roles and responsibilities of the five RQCs; (2) detailed presentation by Val Bradley on the roles and responsibilities of regional quality councils in general and specifically in Virginia; and (3) the specific responsibilities of the RQCs relating to identification, development, implementation and monitoring of Quality Improvement Initiatives (QIIs). Participants in the annual training indicated that the training topics and materials were very useful and served to better equip them for their roles and responsibilities as RQC members, especially relating to the use of data to measure performance and improve services and supports for individuals with intellectual/developmental disabilities served by the Commonwealth.

Training provided to RQC members is recorded and tracked through a comprehensive Excel spreadsheet. As of 10/14/2020, 61/65 (94%) RQC members have received required training and 58/64 (91%) alternate members have received required training.

2. *Each DBHDS Region has convened an RQC that serves as a subcommittee to the QIC as described in Indicator V.B.4.*

Each of the five regions within the Commonwealth has convened regular quarterly meetings of their appointed RQC. Minutes were provided for quarterly meetings for the past four quarters.

3. *DBHDS prepares and presents relevant and reliable data to the RQCs which include comparisons with other internal and external data, as appropriate, as well as multiple years of data (as it becomes available).*

The DBHDS staff members who are standing members of each RQC organize the agenda and presentation of relevant data reports for review by the RQC members. This process assures consistent presentation of data to each of the five RQCs and has, as reported by RQC members, resulted in improved content presentation and discussion in each of the meetings. The preparation of data reports and presentation of data continues to be an evolving process with ongoing focused improvement efforts to increase the accuracy and validity of the data being presented. RQC members interviewed believed that the data presentations and discussions surrounding them have continued to improve in both quantity and quality. Members also described active engagement of RQC members in discussions about the data.

4. *Each RQC reviews and assesses (i.e., critically considers) the data that is presented to identify: (a) possible trends, (b) questions about data, and (c) any areas in need of quality improvement initiatives, and identifies and records themes in meeting minutes. RQCs may request data that may inform quality improvement initiatives and DBHDS will provide the data, if available. If requested data is unavailable, RQCs may make recommendations for data collection to the QIC.*

Minutes reflect review and discussion of data presented about relevant service delivery processes, operational requirements, etc. The standardized format for the minutes of each meeting presents clear descriptions of the data presentations, the deliberations of the RQC members, any requests for additional or clarified data, etc. RQC members indicated that as this process has developed, members have become more familiar with specifically available data resulting in less need for data requests and more time and focus on the data provided in advance of and reviewed during each quarterly meeting.

Section V.D 5.b

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.

This review examined the quarterly activities of the Regional Quality Councils. The findings below are organized by the associated compliance indicators.

1. *Each RQC meets quarterly with a quorum at least 3 of the 4 quarters with membership as outlined in the RQC charter. A quorum is defined as at least 60% of members or their alternates as defined in the RQC charter and must include representation from the following groups: the DBHDS QIC; an individual experienced in data analysis; a Developmental Disabilities (DD) service provider; and an individual receiving services or on the DD Waiver waitlist or a family member of an individual receiving services or on the DD Waiver waitlist.*

The RQC charter describes the required membership representing the following stakeholder groups:

- Residential Services Provider
- Employment Services Provider
- Day Services Provider
- Community Services Board [CSB] Developmental Services Director
- Support Coordinator/Case Manager
- CSB Quality Assurance/Improvement staff
- Provider Quality Assurance/Improvement staff
- Crisis Services Provider
- An individual receiving services or on the Developmental Disability Waiver waitlist [self-advocate] and/or a family member of an individual receiving services or on the waitlist.

To ensure representation and participation from each membership group, an alternate is appointed for each member, receives the same training as members and is eligible to attend meetings as a proxy when the incumbent is not able to attend. Additionally, three DBHDS staff members are standing members of each RQC. These staff members include the:

- Director of Community Quality Improvement
- Regional Quality Improvement Specialist
- Community Resources Consultant

Minutes reviewed and interviews with RQC members reflect very few vacancies within the designated membership categories and reflect consistent and active participation by the appointed members/alternates in each of the meetings. Region 2 has not had an individual receiving services as a member for the past year and has experienced some challenge in recruiting for this representative. A family member representative was present in each of these meetings. State office and regional participants described continued efforts to recruit an individual to serve in this capacity.

The minutes of each quarterly meeting provide a roster of members/alternates participating and reflect whether their participation was in person or by telephone. The minutes also specifically state whether a quorum was achieved. During the last four quarterly RQC meetings in each of the five regions (20 meetings), there was only one instance where a quorum was not achieved. Attendance was consistently good throughout the past four quarters. Members interviewed noted that a factor contributing to this was the increasing value that RQC members place in their participation in each of the meetings, through data review and comment and through efforts to identify and develop quality improvement initiatives to benefit the service delivery systems in their respective regions and across the Commonwealth.

2. *During meetings, conducted in accordance with its charter, the RQC reviews and evaluates data, trends, and monitoring efforts. Based on the topics and data reviewed, the RQC recommends at least one quality improvement initiative to the QIC annually.*

Each set of minutes of the RQC meetings reflect review of data, trends and monitoring efforts. They also include recommendations and follow-up from previous recommendations. Minutes reflect at least one recommendation made to the QIC during the four quarters reviewed. DBHDS implemented a structure to guide the identification and development of a quality improvement initiative from each RQC beginning in Spring 2020. This process included specific training on the structure and methods to develop the initiative, a format for small-group review of data within each RQC, the selection of the topic area for the initiative, and the formulation of the content of the initiative to be submitted to the QIC for review and approval/disapproval.

This structure was reported to have been a positive learning experience for RQC members interviewed and resulted in greater consistency in the content of the initiatives submitted for QIC review. The QIC returned each of the proposed initiatives with comments and instructions for improvement. The most commonly identified concern was the need to narrow the scope of the initiative to allow reasonable assurance that it could be implemented, and that data could be generated to measure its impact/effectiveness. While some concerns were noted that each of the submitted initiatives required further work, the RQC members interviewed each indicated they viewed the process favorably and that the feedback they received was useful to refine the initiative to increase the likelihood that the initiative would have a successful impact on the focused topic.

This critical element of the responsibilities of the RQCs continues to be evolving and remains at a very early stage in development at this point in time. However, the structured approach utilized this year should result in improved results and more efficient and effective initiative development in the future.

3. *Each RQC maintains meeting minutes for 100% of meetings. Meeting minutes are reviewed and approved by the membership of the RQC to ensure accurate reflection of discussion and evaluation of data and recommendations of the RQC.*

Minutes of RQC meetings for the past four quarters for each of the five RQCs were reviewed. The format of the minutes is consistent and very easy to follow. At the beginning of each quarterly meeting, the RQC reviews the content of the meeting minutes for the previous meeting and approves it as submitted or identifies needed revisions to accurately reflect the meeting discussions, requests and recommendations. Documentation of review and approval is noted in the minutes.

4. *For each topic area identified by the RQC, the RQC: a. Decides whether more information/data is needed for the topic area; b. Prioritizes a quality improvement initiative for the Region and/or recommends a quality improvement initiative to DBHDS; or c. Determines that no action will be taken in that area.*

Minutes of each of the meetings reflect compliance with these requirements. Details of the compliance elements are reflected in Section V.D.5.b.2 above.

5. *For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC.*

The consistent structured approach utilized for development of quality improvement initiatives by each RQC during 2020 ensured the development of at least one measurement outcome and specification of data to be used in measurement of that outcome. As noted in Section V.D.5.b.2 above, the QIC reviewed and provided response to each RQC with suggestions for improvement/revision. The most commonly identified concern was the need to narrow the scope of the initiative to allow reasonable assurance that it could be implemented, and that data could be generated to measure its impact/effectiveness.

6. *100% of recommendations agreed upon by the RQCs are presented to the DBHDS QIC.*

The consistent structured approach utilized for development of quality improvement initiatives by each RQC during 2020 focused attention on development of one initiative. As this process was new to most RQC members, at least in the context of region-wide initiative development, focusing on the process for development of an effective initiative was a well-advised approach. It also allowed for more focused review and feedback from the QIC and should serve as a solid foundation for continued refinement and implementation of initiatives in the future.

7. *The DBHDS QIC reviews the recommendations reported by the RQCs and directs the implementation of any quality improvement initiatives upon approval by the QIC and the Commissioner. Relevant Department staff may be assigned to statewide quality improvement initiatives to facilitate implementation. The QIC directs the RQC to monitor the regional status of any statewide quality improvement initiatives implemented and report annually to the DHBDS QIC on the current status. The DBHDS QIC reports back to each RQC at least once per year on any decisions and related implementation of the RQC recommendations. If the QIC declines to support a quality improvement initiative recommended by an RQC, the QIC shall document why.*

As noted above, the process for quality improvement initiative development by the RQCs is in its initial development. To date, each of the RQCs has drafted an initiative and submitted it to the QIC for review. The QIC did not approve any of the initial submissions and returned each to the respective RQC with comments and suggestions for further work. Based on the positive

comments noted from RQC members interviewed about this process, the deliberate structured approach being used for this initial quality improvement initiative development process appears to be positive both in providing RQC members experience in initiative development and in increasing the likelihood that the initiatives being developed will be successful in achieving their stated purpose(s).

Section V.D.6

> *V.D.6: At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvements.*

This review examined the progress DBHDS had made toward public reporting with regard to the availability and quality of supports and services. The findings below are organized by the associated compliance indicators.

The Commonwealth posts reports, updated at least annually, on the Library Website or the DBHDS website on the availability and quality of services in the community and gaps in services and makes recommendations for improvement. Reports shall include annual performance and trend data as well as strategies to address identified gaps in services and recommendations for improvement strategies as needed and the implementation of any such strategies.

1. *Demographics – Individuals with DD served: a. Number of individuals by waiver type; b. Number of individuals by service type; c. Number of individuals by region; d. Number of individuals in each training center; e. Number of children and adults with DD who were admitted to, or residing in, state operated psychiatric facilities; f. Number of children residing in NFs and ICFs/IIDs; e. Number of adults residing in ICFs/IIDs and NFs whose services are paid for by the Commonwealth; f. Number of individuals with DD (waiver and non-waiver) receiving Supported Employment; g. region and disposition; h. Number of individuals on the DD waiver waiting list by priority level, geographic region, age, and amount of time that individuals have been on the waiting list; i. Number of individuals in independent housing*

2. *Demographics – DD Service capacity: a. Number of licensed DD providers, i. Residential setting by size and type as defined by the Integrated Residential Services Report, ii. Day services by type as defined by the Integrated Day Services Report; b. Number of provider agencies that have provided services to DD waiver recipients during the previous fiscal year (provided separately by service): Personal Care, Companion, Respite, Supported Employment, Therapeutic Consultation Services (specifically for Behavioral Support), Crisis, Benefits Planning, Community Guide, and Peer Mentoring; c. Number of ICF/IID non-state operated beds, d. Number of independent housing options created*

With regard to compliance indicators 1 and 2, DBHDS published the Provider Data Summary in May 2020. It covered in detail the required topics. Based on the assessment the Office of DQV completed in Phase 3 of its Data Monitoring Plan, additional work is needed to ensure all the data reported are reliable.

3. *The DBHDS Annual Quality Management Report and Evaluation includes the following information: a. An analysis of Data Reports, including performance measure indicators employed, an assessment of positive and negative outcomes, and performance that differs materially from expectations; b. Key Performance Areas performance measures with set targets: Health, Safety, and Well Being Community Inclusion–Integrated Settings Provider Capacity and Competency; c. Case Management Steering Committee Report; d. Risk Management Review Committee Report e. Annual Mortality Review Report Quality Management Program Evaluation*

As described in Section V.B above, in May 2020, DBHDS issued a *Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2019.* It included information for all the topics defined in the compliance indicator. However, as also described above, the information and data were dated, covering a period between 7/1/18-6/30/19. Data and information that are nearly a year old are not particularly useful in providing the public with a status report. In addition, year-old data does not lend itself to actionable quality improvement. During interviews for this review period, it was positive that DBHDS staff had already recognized these concerns and were in the process of adjusting the schedule for the production of the report. They provided for review a draft copy of the SFY 2020 version, which they expected to release after the close of the first quarter of SFY 2021.

Section V.E.1

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 analyses, that is sufficient to identify and address significant service issues and is consistent with the requirements of the DBHDS Licensing Regulations at 12 VAC 35-105-620 in effect on the effective date of this Agreement and the provisions of this Agreement.

This review examined the progress DBHDS had made with regard to requirements for all providers to have quality improvement programs. The findings below are organized by the five associated compliance indicators.

1. *DBHDS, through its regulations, requires DBHDS-licensed providers, including CSBs, to have a quality improvement (QI) program that: a) Is sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis; b) Uses standard QI tools, including root cause analysis; c) Includes a QI plan that: i) is reviewed and updated annually, ii) defines measurable goals and objectives, ii) includes and reports on statewide performance measures, if applicable, as required by DBHDS; iv) monitors implementation and effectiveness of approved corrective action plans; and v) includes ongoing monitoring and evaluation of progress toward meeting established goals and objectives.*

At the time of the previous review, the Commonwealth had issued emergency regulations to require licensed providers to develop and maintain quality improvement programs, which remained effective during this review period. The regulation at 12 VAC 35-105-620 states the following:

The provider shall develop and implement a quality improvement program sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. The program shall: (i) include a quality improvement plan that is reviewed and updated at least annually; (ii) establish measurable goals and objectives; (iii) include and report on statewide performance measures, if applicable, as required by DBHDS; (iv) utilize standard quality improvement tools, including root cause analysis; (v) implement a process to regularly evaluate progress toward meeting established goals and objectives; and (vi) incorporate any corrective action plans pursuant to 12VAC35-105-170. Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality improvement plan. The provider shall implement improvements, when indicated.

2. *DBHDS has published written guidance for providers on developing and implementing the requirements of 12 VAC 35-105-620 consistent with the regulation as in effect on October 1, 2019, including reviewing serious incidents as part of the quality improvement program, and will update and revise this guidance as necessary as determined by DBHDS.*

As reported at the time of the previous review, in November 2018, DBHDS issued a guidance document (Office of Licensing Guidance for a Quality Improvement Program) to providers regarding these requirements. This guidance indicated that DBHDS did not require a specific template for the quality improvement plan, but provided some additional detail with regard to the six subsections of the regulation (i.e., quality improvement plan reviewed and updated at least annually; measurable goals and objectives; include and report on statewide performance measures; utilize standard quality improvement tools; regularly evaluate progress; and incorporate any corrective action plans.) For this review period, DBHDS provided an updated draft "Office of Licensing Guidance for a Quality Improvement Program" dated 09/28/2020. Neither of these guidance documents clearly stated a requirement for reviewing serious incidents as part of the quality improvement program. The documents only included a reference to serious injuries as an example of how a provider might word a measurable objective.

3. *On an annual basis at least 86% of DBHDS licensed providers of DD services have been assessed for their compliance with 12 VAC 35-105- 620 during their annual inspections.*

For the period 1/1/20-6/30/20, DBHDS provided documentation to show DBHDS Licensing staff assessed 96.93% of the providers inspected during that timeframe for compliance with the applicable regulations.

4. *On an annual basis, at least 86% of DBHDS-licensed providers of DD services are compliant with 12 VAC 35-105-620. Providers that are not compliant have implemented a Corrective Action Plan to address the violation.*

For the period 1/1/20-6/30/20, DBHDS provided documentation to show that DBHDS Licensing staff found that 75.30% of providers were compliant with the applicable regulation. Of note, based on review of other documentation (e.g., source system assessment for OLIS), the Office of DQV found that processes used to monitor compliance with regulations appeared to vary substantially among licensing specialists, raising some concern about the reliability of the data regarding compliance assessments.

5. *DBHDS has policies or Departmental Instructions that require Training Centers to have quality improvement programs that: a) Are reviewed and updated annually; b) Has processes to monitor and evaluate quality and effectiveness on a systematic and ongoing basis; c) Use standard quality improvement tools, including root cause analysis; d) Establish facility-wide quality improvement initiatives; and e) Monitor implementation and effectiveness of quality improvement initiatives.*

DBHDS did not provide evidence to show it has policies or Departmental Instructions that require Training Centers to have quality improvement programs that meet all of the criteria for this compliance indicator. DBHDS provided Departmental Instruction 316 (QM) 20, Quality Improvement, Quality Assurance, and Risk Management for Individuals with Developmental Disabilities (DI 316), which states the following:

"All training centers are required to develop and implement a quality improvement program, including root cause analysis, which identifies and addresses significant issues and is in compliance with DI 301 and DI 401. The training centers must maintain CMS certification and must maintain a quality improvement program in accordance with 42 CFR § 422.152. Staff shall assess the adequacy of individualized supports and services provided to individuals receiving services in each of the eight domains, as relevant. The [facility] director shall ensure that required data and assessments are reported to DBHDS Central Office as required."

However, this compliance indicator requires that the quality improvement programs a) Are reviewed and updated annually; b) Has processes to monitor and evaluate quality and effectiveness on a systematic and ongoing basis; c) Use standard quality improvement tools, including root cause analysis; d) Establish facility-wide quality improvement initiatives; and e) Monitor implementation and effectiveness of quality improvement initiatives. DI 316 only broadly states the requirement and expectations for the establishment of a quality improvement program and does not require, for example, that the programs be reviewed and updated annually, the use of standard quality improvement tools or the establishment and monitoring of facility-wide quality improvement initiatives. DBHDS also provided DI 301, dated 7/01/99, and DI 401 updated 9/4/20, which address Training Center requirements for implementation of quality improvement and risk management programs, respectively. Taken collectively, they address most of the requirements. However, it was unclear that the requirement for the use of root cause analysis in the risk management program therefore applied to the quality improvement program. DBHDS should update DI 301 to reflect all of the requirements, including the applicability of root cause analysis to quality improvement functions. In addition, DBHDS should not rely on the citation of a federal regulation (i.e., 42 CFR § 422.152) to describe its expectations, but should spell them out. In any event, while it was unclear which section(s) of 42 CFR § 422.152 DBHDS considered to be applicable, overall, it did not explicitly address all of the requirements of the compliance indicator (e.g., establishment of facility-wide quality improvement initiatives.)

Section V.E.2

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. 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 Section V.D.3. above. The measures will be monitored and reviewed by the DBHDS quality improvement committee, with input from Regional Quality Councils, described in Section V.D.5 above. The DBHDS quality improvement committee will assess the validity of each measure at least annually and update measures accordingly.

This review examined the progress DBHDS had made with regard to requirements for provider reporting of key indicators selected from the relevant domains in Section V.D.3. The findings below are organized by the four associated compliance indicators.

1. *DBHDS has developed measures that DBHDS-licensed DD providers, including CSBs, are required to report to DBHDS on a regular basis, and DBHDS has informed such providers of these requirements. The sources of data for reporting shall be such providers' risk management/critical incident reporting and their QI program. Provider reporting measures must: a) Assess both positive and negative aspects of health and safety and of community integration; b) Be selected from the relevant domains listed in Section V.D.3 above; and c) Include measures representing risks that are prevalent in individuals with developmental disabilities (e.g., aspiration, bowel obstruction, sepsis) that are reviewed at least quarterly by the designated sub- committee as defined by the Quality Management Plan.*

Based on the documentation reviewed, DBHDS had not yet fully implemented the requirements for this compliance indicator. Some of the requirements appeared to have been met through the implementation of the PMIs, as describe above in Section V.D.3 (i.e., selected from those domains and addressing positive and negative aspects of health and safety and of community integration.) With regard to developing measures for risks that are prevalent for the population of individuals with developmental disabilities, work was at an early stage. At the RMRC meeting held on 6/15/20, the minutes indicated the members discussed the need to develop these measures and agreed to develop measures related to 12 health conditions (i.e., aspiration pneumonia, bowel obstruction, sepsis, choking, decubitus ulcer fall or trip, dehydration, seizures, urinary tract infection, self-injury, sexual assault, and suicide attempt.) The minutes further indicated the data source for the numerator would be CHRIS-SIR and WaMS for the denominator, and that RMRC would need to finalize the measure definitions and work with the Office of DQV to validate the data collection methodology. DBHDS provided an additional document (i.e., *Performance Measure Indicator documentation for the twelve risk incident monitoring rates*, last updated June 26, 2020) that indicated DQV continued to identify data quality issues. These included:

> "The CHRIS incident reporting system focuses on incidents reported by various providers in the community and does not efficiently associate at the individual level. While efforts in the past have attempted to de-duplicate reports at the individual level, this method requires extensive manual effort and human

decisions. The data warehouse teams and the DQV teams have worked consistently to improve record linking between CHRIS and WaMS; however, several quality issues still hinder this effort.

Another potential concern regarding these rates is due to the fact that, despite recent improvements to provider reporting and the CHRIS reporting systems, the most popular checkbox on CHRIS reports continues to be "Other." The measure steward should interpret these rates with the understanding that there may be other uncategorized conditions occurring at higher rates, or that there may be cases reported as "other" that are actually better categorized as one of these risk incidents. In an effort to address several issues related to provider reporting, the Office of Licensing created the Incident Management Unit (IMU). As of June 2020, the IMU was working in three of the five regions to triage daily incidents, determine appropriate follow up actions and investigations, and consider how providers reported these incidents. As the IMU expands, there is a potential for overall improvements in the quality of reports."

In addition to the need to develop and implement these measures, it did not appear that DBHDS met the full intent of this compliance indicator because it did not describe how any of the measures addressed provider reporting from their QI programs.

2. *DBHDS requires regular reporting, at least annually, of each provider reporting measure from DBHDS-licensed DD providers. Measures referenced in indicators #1.c are reported quarterly. 86% of such providers report the measure as required.*

As described above in V.D.3, DBHDS had a process in place for regular reporting of PMI data. However, DBHDS staff had not yet fully developed the measures referenced in indicator 1.c, so no data were available for those. In addition, it appeared that, for the PMIs and for the pending risk measures, DBHDS pulled and reported aggregate data from various source systems, rather than requiring providers to report their own data.

3. *The DBHDS Office of Data Quality and Visualization assists with analysis of each provider reporting measure to ensure that the data sources are valid, identify what the potential threats to validity are, and ensure that the provider reporting measures are well-defined and measure what they purport to measure. The QIC or designated subgroup will review and assess each provider reporting measure annually and update accordingly.*

As described above with regard to Sections V.D.2 and V.D.3, beginning for measures active for SFY20 or after, the Office of DQV will assist with the analysis of each PMI to ensure that the data sources are valid, identify what the potential threats to validity are, and ensure that the provider reporting measures are well-defined and measure what they purport to measure. Based on review of the measure templates for the PMIs ….. In addition, the RMRC minutes from 6/15/20 indicated members would seek the assistance of the Office of DQV for the risk measures under development.

4. *Provider reporting measures are monitored and reviewed by the DBHDS Quality Improvement Committee ("QIC") at least semi-annually, with input from Regional Quality Councils, described in Section V.D.5. Based on the semi-annual review, the QIC identifies systemic deficiencies or potential gaps, issues recommendations, monitors the measures, and makes revisions to quality improvement initiatives as needed, in accordance with DBHDS's Quality Management System as described in the indicators for V.B.*

Based on review of the QIC and KPA Workgroup minutes submitted for review, the QIC monitored and reviewed PMIs on a quarterly basis, but did not yet have provider reporting measures for all required domains (i.e., for risks that are prevalent for the population of individuals with developmental disabilities.) It appeared that the QIC had promulgated procedures that would likely be effective for using available data to identify systemic deficiencies or potential gaps, to issue recommendations, to monitor the measures, and to make revisions to quality improvement initiatives as needed.

Section V.E.3

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.

This review examined the progress DBHDS had made with regard to the Commonwealth's processes to assess the adequacy of providers' quality improvement strategies and to provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate. The findings below are organized by the two associated compliance indicators.

1. *In addition to monitoring provider compliance with the DBHDS Licensing Regulations governing quality improvement programs (see indicators for V.E.1), the Commonwealth assesses and makes a determination of the adequacy of providers' quality improvement programs through the findings from Quality Service Reviews, which will assess the adequacy of providers' quality improvement programs to include: a) Development and monitoring of goals and objectives, including review of performance data; b) Effectiveness in either meeting goals and objectives or development of improvement plans when goals are not met, and c) Use of root cause analysis and other QI tools and implementation of improvement plans.*

As described above with regard to Section V.D.4, at the time of the previous review, DBHDS had paused the collection of data from Quality Services Reviews (QSRs), intending to resume following the conclusion of an RFP process and selection of a new vendor. For this 17th Review Period, DBHDS had engaged a new vendor, as further described with regard to Section V.I below. Based on review of the vendor's tools and methodologies, they address each of the requirements at a) through c) for assessment of the adequacy of providers' quality improvement programs. However, at the time of this report, the vendor was just finishing their initial set of reviews, with an expected completion date at the end of November 2020. They did not have data or other findings yet available for review to assess the adequacy of providers' quality improvement programs (i.e., development and monitoring of goals and objectives, including review of performance data; effectiveness in either meeting goals and objectives or development of improvement plans when goals are not met, or use of root cause analysis and other QI tools

and implementation of improvement plans.)

2. *Using information collected from licensing reviews and Quality Service Reviews, the Commonwealth identifies providers that have been unable to demonstrate adequate quality improvement programs and offers technical assistance as necessary. Technical assistance may include informing the provider of the specific areas in which their quality improvement program is not adequate and offering resources (e.g., links to on-line training material) and other assistance to assist the provider in improving its performance.*

As described with regard to Section V.C.4 above, DBHDS provided general training and technical assistance to providers related to the implementation of quality improvement programs. However, DBHDS did not identify how it would offer technical assistance to individual providers who it determined, through licensing reviews pursuant to Section V.E.1, had been unable to demonstrate adequate quality improvement programs. The document entitled *Internal Protocol for assessing Compliance with 12 VAC 35-105-620* did not describe actions DBHDS staff would take if those protocols resulted in a finding of noncompliance.

In addition, as noted above for Section V.E.3, compliance indicator 1, DBHDS had only recently resumed the QSR process. While the vendor's methodologies addressed assessment of providers' quality improvement plans and the provision of technical assistance as needed, the implementation of the process had not yet reached this stage. As further discussed with regard to Section V.1.3, the vendor had not yet fully demonstrated that its reviewers had the necessary experience and/or training to provide this technical assistance.

Section V.H.1

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.

This review examined the progress DBHDS had made with regard to a statewide core-competency training for all staff. The findings below are organized by the 13 associated compliance indicators.

1. *DBHDS makes available an Orientation Training and Competencies Protocol that communicates DD waiver requirements for competency training, testing, and observation of Direct Support Professionals (DSPs) and DPS Supervisors.*

All DSPs and DSP Supervisors providing services to individuals with developmental disabilities must receive training that includes:

- The characteristic of developmental disabilities and Virginia's DD waivers
- Person-centeredness, positive behavior supports, and effective communication
- Identified potential health risks of individuals with developmental disabilities and the appropriate interventions
- Best practices in the support of individuals with developmental disabilities

DBHDS revised the Orientation Training and Competencies in March 2020. The Orientation Manual is divided into six sections:

- The Values that Support Life in the Community
- Introduction to Developmental Disabilities
- Waivers for People with Developmental Disabilities
- Communication
- Positive Behavior Support
- Health and Safety

Content in these six sections addresses all required elements listed above including person-centered practices and community integration and self-determination awareness.

A draft copy of the revised "DSP and DSP Supervisor Orientation Competencies, Protocol and Checklists" was shared with providers and CSBs to solicit their feedback. The Department reviewed all comments submitted and a compilation of these comments and DBHDS responses was completed on 03/27/2020 prior to the finalization of the latest revision of the Orientation and Competencies Protocol. The revised DSP and DSP Supervisor DD Waiver Orientation and Competencies Protocol covers all required elements set out in Section V.H.1 of the agreement.

On 03/27/2020, DBHDS published an implementation schedule for the revised and streamlined Orientation Competencies, Protocol and Checklists. Providers were notified they could begin using the revised competencies and protocol effective immediately or delay implementation until the revised DD waiver regulations become effective (current anticipated effective date is 02/01/2021).

The Department also placed all relevant information about the revised Orientation Training and Competencies on the newly developed DBHDS Centralized Training Website and an announcement of the new website that includes links to all required DSP and DSP Supervisor Orientation Competencies, Protocol and Checklists was posted on the Listserv on 06/30/2020. Supervisor-specific training requirements, content and competency testing is accessed through the Virginia Learning Center (VLC) online portal. Linked resources are maintained online at: http://www.dbhds.virginia.gov/developmental-services/provider-development.

The Department added an additional requirement that providers must include information about staff competence and adequacy of staffing in their risk management plans and to assess compliance with these requirements at least annually as a part of their systemic risk assessment.

2. *The Commonwealth requires DSPs and DSP Supervisors, including contracted staff, providing direct services to meet the training and core competency requirements contained in DMAS regulation 12VAC 30-122-180, including demonstration of competencies specific to health and safety, within 180 days of hire. The core competencies include: a) The characteristic of developmental disabilities and Virginia's DD waivers; b) Person-centeredness (and related practices such as dignity of risk and self-determination in alignment with CMS definitions); c) Positive behavioral supports; d) Effective communication; e) At a minimum, the following identified potential health risks of individuals with developmental disabilities and appropriate interventions:*

choking, skin care (pressure sores, skin breakdown), aspiration pneumonia, falls, urinary tract infections, dehydration, constipation and bowel obstruction, change of mental status, sepsis, seizures, and early warning signs of such risks, and how to avoid such risks; f) Community integration and social inclusion (e.g., community integration, building and maintaining positive relationships, being active and productive in society, empowerment, advocacy, rights and choice, safety in the home and community); g) DSP Supervisor-specific competencies that relate to the supervisor's role in modeling and coaching DSPs in providing person-centered supports, ensuring health and wellness, accurate documentation, respectful communication, and identifying and responding to changes in an individual's status

The DMAS Medicaid Memo 9.1.16 established an emergency regulation entitled "Updated Orientation and Competency Requirements for Direct Support Professionals and their Supervisors/Trainers". The emergency regulations expired in August 2018 and requirements have been continued based on specific references to these requirements in the Commonwealth's approved DD waiver applications.

The requirements are now contained in proposed waiver regulations at 12VAC30-122-180. Sec. B of the proposed regulations includes language relating to the required completion of the "competency observation and the competency checklist" within 180 days from date of hire. Sec. D establishes structure and content for provision of additional core competency requirements and related competency-based training for DSPs and DSP supervisors supporting individuals having the most intensive needs in the areas of health, behavioral needs, autism or all three , as determined by assignment to Supports Intensity Scale (SIS) Tier 4. Documentation of this training specific to the identified individual(s) needs is entered on DMAS Forms P240a, P244a and/or P201.

The DD Orientation and Competency Requirements for DBHDS-Licensed Providers effective 09/01/2016 provide a description of the required competencies and required documentation relating to training and achievement of these competencies by DSPs and DSP Supervisors. The content of the "Orientation Manual for Direct Support Professionals and Supervisors" includes:

- Section 1 - The Values That Support Life in the Community includes information related to the principals that stand behind successful community integration and social inclusion and the roles and responsibilities of Direct Support Professionals to support individuals to achieve successful community integration and social inclusion.
- Section 6 - Health and Safety includes specific references to nine of the ten required areas to be addressed. Choking is not addressed in this manual.
- Useful details, forms and instructions about the training competencies and related information can be found in the online at

https://partnership.vcu.edu/DSP_orientation/Competencies-Assurances-Tests.html

The "Developmental Disabilities DSP and Supervisor Competencies Checklist" includes the following content relating to the required supervisor role in modeling and coaching DSPs:

- Provides Person-Centered Supports – Competency 1 (all sections)
- Ensuring Health and Wellness – Competency 3 (all sections)
- Accurate Documentation – Competencies 2.3. 2.6 & 3.8
- Respectful Communication – Competency 1.9
- Identifying and Responding to Changes in an Individual's Status – Competencies 3.6,

3. *DSPs and DSP Supervisors who have not yet completed training and competency requirements per DMAS regulation 12VAC 30-122-180, including passing a knowledge-based test with at least 80% success, are accompanied and overseen by other qualified staff who have passed the core competency requirements for the provision of any direct services. Any health-and-safety-related direct support skills will only be performed under direct supervision, including observation and guidance, of qualified staff until competence is observed and documented.*

   As noted above, the DMAS Medicaid Memo 9.1.16 established an emergency regulation entitled "Updated Orientation and Competency Requirements for Direct Support Professionals and their Supervisors/Trainers". The emergency regulation expired in August 2018 and requirements have been continued based on specific references to these requirements in the Commonwealth's approved DD waiver applications.

   The current proposed revision of 12VAC30-122-180 includes specific requirements related to oversight of DSPs and DSP Supervisors who have not yet completed training and competency requirements if they are providing services to individuals. Sections A.2 (requirements for DBHDS-licensed providers) and B.2 (requirements for non-DBHDS licensed providers) include specific language relating to this requirement. That language states in both sections "Other qualified staff who have passed the knowledge-based test shall work alongside any DSP or supervisor who has not yet passed the test."

4. *At least 95% of DSPS and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180.*

   Assessment of provider compliance with these requirements for all DSPs and DSP Supervisors providing services to individuals with developmental disabilities is measured through the annual DMAS Quality Management Review (QMR) process. Providers are required to maintain documentary evidence of completion of the required training and successful measurement of competency in their personnel files. The QMR sample selection is based on a review of the records and identification of all DSPs and DSP Supervisors who have provided services to individuals including both provider-employed staff and contractor-employed staff. Contractor-employed staff are not uniquely identified in the sample selection; however, since the sample is identified from DSPs and DSP Supervisors who actually provided service, this should be sufficient to ensure inclusion of provider-employed and contractor-employed staff.
   Compliance with these requirements is measured through two performance indicators under the waiver sub-assurance requiring the State to "implement its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver."
   - Performance Measure C.8 measures the "Number and percent of provider agency staff meeting provider orientation training requirements." Compliance scores for the first three quarters of FY2020 reflect improving compliance. Through three quarters, 402/474 (84.8%) of sampled DSP and DSP Supervisor employment records were found to be in compliance.
   - Performance Measure C.9 measures the "Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements." Compliance

scores for the first three quarters of FY2020 reflect continued challenges to meet training requirements. Through three quarters, 237/429 (55.2%) of sampled DSP and DSP Supervisor employment records were found to be in compliance.

DBHDS staff indicate there is no current language in regulation establishing a specific compliance threshold nor is there a specific sample size or process for measuring the compliance requirement. The compliance threshold for each of these measures is currently set at 86% per CMS requirement. The compliance threshold for each is slated to be revised in 11/2020 to 95% to comply with the threshold requirement in this Indicator.

Remediation efforts to improve compliance have been varied and include required corrective action plans and systemic approaches to provide additional training to increase awareness for provision of this training and related documentary evidence. To date, a primary contributing factor to the lower percentage compliance for Performance Measure C.9 has been noted confusion on the part of providers that they must retain separate records of provision of training and measurement of competency in the employee records. Often records of the training provision are found but no corresponding record for competency measurement.

The Commonwealth continues to place significant emphasis on compliance challenges related to training and competency measurement. In a joint DMAS/DBHDS provider memo entitled "DD Waivers Performance Measures Improvement Efforts" dated 05/15/2020, providers were made aware of compliance challenges for Performance Measures C.8 and C.9. The memo provided information to providers about the competency requirements and links to guidance and checklists designed to assist the provider to achieve compliance with both measures.

5. *DBHDS makes available for nurses and behavioral interventionists training, online resources, educational newsletters, electronic updates, regional meetings, and technical support that increases their understanding of best practices for people with developmental disabilities, common DD-specific health and behavioral issues and methods to adapt support to address those issues, and the requirements of developmental disability services in Virginia, including development and implementation of individualized service plans.*

Online resources are found in the Commonwealth of Virginia's Learning Center (COVLC), the DBHDS Office of Integrated Health website and other DBHDS websites. Examples of these resources include:

- Office of Integrated Health provides information through a monthly "Health Trends" newsletter that highlights specific health-related topics in each edition.
- Office of Integrated Health training and information sharing opportunities through monthly regional nursing meetings and annual statewide nursing meetings. Minutes of these meetings document this activity.
- Office of Integrated Health provides a Health Support Network focusing primarily on provision of community nursing.
- "Office of Licensing Guidance for Risk Management" dated 08/22/2020 includes specific requirements related to identification and addressing risks of harm and requirements for inclusion of this information in the provider's annual risk assessment.
- The Department issued a requirement for use of an Annual Risk Awareness Tool in June 2020. The tool contains seven medical risk awareness sections (pressure injury, aspiration

pneumonia, falls with injury, dehydration, bowel obstruction, sepsis & seizures) and four behavioral risk awareness sections (law enforcement involvement, self-harm, elopement & lack of safety awareness). Accompanying the requirement, the Department also issued a "Risk Awareness Tool Instruction and Resource Document" dated 06/02/2020 and "Risk Awareness Tool Process and Planning Training" dated 06/2020. Both include guidance to use information from the Risk Assessment during the annual ISP planning process to support integration of the information from the Risk Assessment Tool into the ISP.

- The department has also developed risk training PowerPoint presentations on topics including Seizures, Sepsis, Pressure Injury, Falls, Dehydration, Constipation and Bowel Obstructions & Aspiration Pneumonia and made these presentations available on the Department website.

Five Regional Support Teams (RSTs) comprised of professionals with experience and expertise in serving individuals with developmental disabilities and complex behavioral and medical needs are available to provide support and coaching for providers through participation in regional meetings and through request for individual provider support.

6. *Employers and contractors responsible for providing transportation will meet the training requirements established in the DMAS transportation fee-for-service and managed care contracts. Failure to provide transportation in accordance with the contracts may result in liquidated damages, corrective action plans, or termination of the vendor contracts.*

LogistiCare is the DMAS-contracted provider to manage non-emergency transport services for DMAS programs. Section 4.2.2 of the Virginia Transportation Provider Agreement dated 2018 requires that all transportation services meet requirements set out in the Virginia LogistiCare Transportation Provider Manual. The manual includes requirements for orientation training for all transportation providers outlined in the Transportation Provider Agreement. The Agreement further requires that all transportation services must meet the requirements set out in the agreement and that non-compliance could result in punitive action including liquidated damages, corrective action plans or termination of the vendor contract.

The DMAS SFY2019 Transportation Management Services Year-End Report dated 10/18/2020 references "continued reporting to DOJ on ID/D waivered transportation services that monitor quality, safety, timeliness of providers' performance." Compliance monitoring is overseen by the Transportation Unit Field Monitoring Team. This team evaluates contracted transportation providers to ensure proper credentialing of drivers which includes training requirements. The report also references training-related non-compliance including drivers found not to have received required training.

Quarterly reports are generated to summarize Service-Level Agreement (SLA) payment reductions relating to LogistiCare, the contracted transportation provider, relating to non-compliance findings. During the most recent reported quarter, a total of $109,500 was reduced from the SLA vendor payment relating to non-compliance issues.

7. *The DBHDS Office of Integrated Health provides consultation and education specific to serving the DD population to community nurses, including resources for ongoing learning and development opportunities.*

The Office of Integrated Health provides consultation and online educational resources for community nurses including:

- A monthly "Health Trends" newsletter that highlights specific health-related topics in each edition.
- Training and information sharing opportunities through monthly regional nursing meetings and annual statewide nursing meetings. Minutes of these meetings document this activity.
- A Health Support Network that focuses primarily on provision of community nursing.
- Online training related to health risk topics including Seizures, Sepsis, Pressure Injury, Falls, Dehydration, Constipation and Bowel Obstructions & Aspiration Pneumonia.

8. *Per DBHDS Licensing Regulations, DBHDS licensed providers, their new employees, contractors, volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within 15 business days. The provider shall document that the orientation covers each of the following policies, procedures, and practices: 1) Objectives and philosophy of the provider; 2) Practices of confidentiality including access, duplication, and dissemination of any portion of an individual's record; 3) Practices that assure an individual's rights including orientation to human rights regulations; 4) Applicable personnel policies; 5) Emergency preparedness procedures; and, 6) Person-centeredness.*
   (1) Infection control practices and measures
   (2) Other policies and procedures that apply to specific positions and specific duties and responsibilities
   (3) Serious incident reporting, including when, how, and under what circumstances a serious incident report must be submitted and the consequences of failing to report a serious incident to the Department in accordance with the Licensing regulations

12VACS35-105-450 "Employee Training and Development" (effective 12/07/2011) establishes a requirement that "The provider shall develop a training policy that addresses the frequency of retraining on medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department."

12VAC35-105-440 "Orientation of New Employees, Contractors, Volunteers and Students" (effective 08/01/2020) establishes requirements that include all required elements for the orientation training and requires that orientation must be provided within 15 days of employment including the addition of requirements related to serious incident reporting which were not included in the emergency regulations. Compliance with this requirement is measured by the Office of Licensing during annual provider inspections. The Office of Licensing developed the "DD Provider Inspections Checklist" (dated 05/08/2020) that includes a requirement for review and determination of compliance with 12VAC35-105-440, Sec. 1-9 (the required elements).

The Office of Licensing Review Results Comparison for CY2019 and CY2020 Report notes overall provider compliance to be 93.19% in CY2019 and 93.97% in CY2020. It should be noted that compliance measurements for CY2019 were completed during onsite inspections and compliance measurements for CY2020 were completed through desk reviews of

compliance-related documentation due to limitations on onsite inspections related to COVID-19 statewide restrictions.

9. *The Commonwealth requires through the DBHDS Licensing Regulations specific to licensed providers that all employees or contractors who are responsible for implementing an individual's ISP demonstrate a working knowledge of the objectives and strategies contained in each individual's current ISP, including an individual's detailed health and safety protocols.*

   The regulation at 12VAC35-105-665 (dated 09/01/2018) includes two sections relevant to this indicator:

   - Sec. A.2 requires that the comprehensive ISP shall include: "Services and supports and frequency of services required to accomplish the goals including relevant psychological, mental health, substance abuse, behavioral, medical, rehabilitation, training, and nursing needs and supports;"
   - Sec. D requires "Employees or contractors who are responsible for implementing the ISP shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP."

   Compliance is measured through annual inspections completed by the Office of Licensing. The DD Provider Inspections Checklist" (dated 05/08/2020) requires the Licensing Specialist to determine compliance with this section for each of the individual's records reviewed in the sample.

   Compliance measurement for CY2020 reflects 100% compliance. It should be noted that compliance measurements for CY2020 were completed through desk reviews of compliance-related documentation due to limitations on onsite inspections related to COVID-19 statewide restrictions.

10. *The Commonwealth requires all employees or contractors without clinical licenses who will be responsible for medication administration to demonstrate competency of this set of skills under direct observation prior to performing this task without direct supervision.*

    There are several regulatory requirements that are relevant to this indicator:

    - The regulation found at 12VAC35-105-770 outlines all provider requirements for Medication Management Services. Within that section, two specific requirements pertain to persons who are authorized to administer medications:
      - Sec. A.4 – The provider shall implement written policies addressing employees or contractors who are authorized to administer medication and training required for administration.
      - Section B – Medications shall be administered only by persons who are authorized to do so by state law.
    - If a program provider requires staff members to administer medications, those staff members must have met the Virginia Board of Nursing requirements for certification as a medication aide. Board of Nursing regulations relevant to this indicator are found at 18VAC-90-21-40 dated 06/23/2020 and require that program providers require each student to pass a written and practical examination at the conclusion of training that measures minimum competency in medication administration.

- The regulation found at 12VAC35-105-450 requires all providers to develop a training policy that addresses the frequency of retraining on, among other topics, medication administration. It further requires employee participation in training and development opportunities to be documented and accessible to DBHDS/DMAS.
- A relevant competency measurement requirement is included in the DSP/Supervisor Competencies: Competency 3.2 states "Conveys an understanding of the steps needed to ensure medications are provided as prescribed to include providing medications or contacting qualified staff who can provide medications."

Compliance with relevant licensing standards is measured through annual licensing inspections focusing on the regulations found at 12VAC35-105-450 (provider training policy) and 12VAC35-105-770 (qualifications for persons authorized to administer medications).

Compliance with the competency requirement (Competency 3, Sec. 3.2) is measured through the DMAS Quality Management Annual Reviews.

11. *The Commonwealth requires all employees or contractors of DBHDS-licensed providers who will be responsible for performing de-escalation and/or behavioral interventions to demonstrate competency of this set of skills under direct observation prior to performing these tasks with any individual service recipient.*

Two specific regulatory requirements are relevant to this indicator:

- The regulation found at 12VAC35-105-450 requires all providers to develop a training policy that addresses the frequency of retraining, among other topics, behavior intervention. This topic is inclusive of "de-escalation-related interventions". It further requires that employee participation in training and development opportunities shall be documented and accessible to the DBHDS/DMAS.
- The DSP Competencies Checklist contains two specific competencies related this item:
    - Competency 3.6 which states that the employee must be able to explain the process for observing and reporting changes in behavioral or health status to include (a) how to monitor and document changes; (b) When to call a supervisor; (c) When to call REACH/Emergency services; and (d) When to call 911 (medical or police).
    - Competency 3.9 which states that the employee must be able to implement health and behavioral plans as written.

Compliance is measured through annual licensing inspections focusing on the regulation found at 12VAC35-105-450 which requires the provider to have a training policy (that includes, among other requirements, behavior intervention) and that documentation exists to support that the required training occurred.

Compliance with the competency requirement (Competency 3, Sec. 3.2) is measured through the DMAS Quality Management Annual Reviews.

11. *At least 86% of DBHDS licensed providers receiving an annual inspection have a training policy meeting established DBHDS requirements for staff training, including development opportunities for employees to enable them to support the individuals receiving services and to carry out their job responsibilities. These required training policies will address the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department. DBHDS will take appropriate action in accordance with Licensing regulations if providers fail to comply with training requirements required by regulation.*

    The regulation at 12VAC35-105-450 Employee Training and Development" (effective 08/01/2020) states "The provider shall develop a training policy that addresses the frequency of retraining on medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department." The DD Provider Inspections Checklist requires the Licensing Specialist to review and determine compliance with the requirements in this regulation.

    The Office of Licensing Review Results Comparison for CY2019 and CY2020 Report notes overall provider compliance to be 59.95% in CY2019 and 77.33% in CY2020. It should be noted that compliance measurements for CY2019 were completed during onsite inspections and compliance measurements for CY2020 were completed through desk reviews of compliance-related documentation due to limitations on onsite inspections related to COVID-19 statewide restrictions.

12. *Consistent with CMS assurances, DBHDS, in conjunction with DMAS QMR staff, reviews citations (including those related to staff qualifications and competencies) and makes results available to providers through quarterly provider roundtables.*

    The review of DMAS QMR reports is a standing item on the agenda for each quarterly provider roundtable meeting. A review of minutes of the Quarterly Provider Roundtable meetings on 04/2020 and 07/2020 reflect presentation and discussion of information from the DMAS Quality Management Review Reports. Included in the 04/2020 presentation was information about missing documentation related to required DSP and DSP Supervisor training, Additionally, information was shared with participants about changes in the Competencies Checklist and the allowance for providers to choose whether to begin using it immediately or wait until the waiver regulations are approved. Included in the 07/2020 presentation was additional information about missing documentation related to DSP and DSP Supervisor training and discussion of the new rollout of the Commonwealth of Virginia Learning Center website on 07/01/2020 to serve as a single source for all requirements and documentation related to competency training.

Section V.H.2

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.

1. *DSP Supervisors are responsible for adequate coaching and supervision of their staff trainees. As part of its training program, DBHDS will develop and make available a supervisory training for all DSP supervisors who are required to complete DSP training and testing per DMAS waiver regulations in DHBDS-licensed agencies as described in DMAS waiver regulations. At a minimum, this training shall include the following topics: Skills needed to be a successful supervisor; Organizing work activities; The supervisor's role in delegation; Common motivators and preventive management; Qualities of effective coaches; Employee management and engagement; Stress Management; Conflict Management; The Supervisor's role in minimizing risk (e.g., health-related, interpersonal, and environmental); Mandated reporting,; and, CMS-defined requirements for the planning process and the resulting plan.*

   Data on Supervisor Trainings Completed 07/2019-06/2020 reflect a consistent number of supervisory trainings each month ranging from 33-64 with a well-defined increasing trend and a 12-month average of 44/month.

   In June 2020, DBHDS announced expanded DSP Supervisor required training on the Commonwealth of Virginia Learning Center (COVLC) effective 07/01/2020. The revised training contains all the topics specified in this indicator including:
   - Skills needed to be a successful supervisor
   - Organizing work activities
   - The supervisor's role in delegation
   - Common motivators and preventive management
   - Qualities of effective coaches
   - Employee management and engagement
   - Stress management
   - Conflict management
   - The supervisor's role in minimizing risk
   - Mandated reporting
   - CMS-defined requirements for the program planning process and the resulting program plan

   There was a noted increase in the number of supervisory trainings completed in 07/2020 upon release of the expanded training. 107 trainings were completed in 07/2020 and 53 in 08/2020. Data beyond that point is not yet reliably available.

2. *In addition to training and education, support and coaching is made available to DBHDS-licensed providers through the DBHDS Offices of Integrated Health and Provider Development upon request and through community nursing meetings, provider roundtables, and quarterly support coordinator meetings to increase the knowledge and skills of staff and supervisors providing waiver services. DBHDS will compile available support and coaching resources that have been reviewed and approved for placement online and ensure that DBHDS-licensed providers are aware of these resources and how to access them.*

On 06/30/2020, DBHDS announced the rollout of a new Centralized Training for Providers section on the DBHDS website.

- The website includes sections entitled "Required Training", "Recommended Training", "Resources for Training" and "Peer Mentoring".
- The "Resources for Training" section is the repository for information related to this indicator. Topics there are limited at present, but plans are underway to expand this section to serve as the central repository for provider support and coaching materials.
- While this section has not yet been significantly populated, it provides a centrally accessible resource for providers to seek written guidance and its content will be expanding over time.

Additional resources for support and coaching include:

- Information on the Provider Development webpage which includes links to information about trainings and other provider support resources.
- Support resources are provided through the Statewide Provider Roundtable meetings including information about additional support and coaching resources that are needed by providers.
- There are 14 positions for Community Resource Consultants who provide hands-on support to providers seeking support and coaching resources.
- Five Regional Support Teams (RSTs) comprised of professionals with experience and expertise in serving individuals with developmental disabilities and complex behavioral and medical needs are available to provide support and coaching for providers. Activities of the RSTs are reported and tracked through quarterly reports that include both data and descriptions of the support activities they provide within each region.

DBHDS provides quarterly summaries of activities related to provision of support and coaching for licensed providers to DMAS.

Recommendation

DBHDS should also continue to consider and document its decisions related to the recommendations made in the Office of DQV's September 2020 presentation including, but not limited to, improving or sunsetting outdated data sources, transitioning to automated solutions, choosing enterprise solutions for new or replacement systems, and perhaps procuring an overall enterprise data collection system.

Section V.I.1

V.I.1. 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.

This review examined the progress DBHDS had made in its efforts to implement QSRs and use them to evaluate the quality of services. The findings below are organized by the four associated compliance indicators.

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. 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: and 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.*

At the time of the previous review, DBHDS had paused the collection of data from Quality Services Reviews (QSRs), intending to resume following the conclusion of an RFP process and selection of a new vendor. DBHDS did not conduct QSRs in SFY20. For this 17th Review Period, DBHDS had engaged a new QSR Contractor. At the time of this review, the first round of QSRs was underway and expected to conclude by the end of November 2020.

In many respects, the QSR Contractor developed a thorough methodology (i.e., *2020 Quality Services Review Methodology* and *Clinical Assessment Plan)* consistent with the requirements of this compliance indicator. They had developed extensive Person-Centered Reviews (PCRs) and Provider Quality Reviews (PQRs). In addition to addressing the requirements for record reviews, the methodology for completion of these two 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, due to the COVID-19 public health emergency, for this current round of QSRs, the QSR Contractor had only completed interviews and observations remotely. Whenever possible, QSR Contractor reviewers completed interviews with individuals and families through a virtual platform, but some could not be completed even in that manner due to individuals and families not having access to needed technology.

2. *The DBHDS QSR Contractor will: a) Prior to conducting QSRs, develop a communications plan and orient providers to the QSR process and expectations; and, 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.*

The QSR Contractor developed and implemented a thorough communication plan prior to conducting this round of QSRs. This included participation in DBHDS Provider Roundtables and a series of orientation webinars, which were recorded and remain available on the QSR Contractor's SharePoint site. The QSR Contractor also posted the QSR tools, methodologies and other related resources on their site, which may also be found on the DBHDS website.

The QSR Contractor's methodology laid out processes to ensure privacy for individuals and the ability of staff to speak freely. Training for QSR staff included related instruction. As described above, however, all interviews for this first round have been conducted remotely and this could have inherently compromised the ability of the QSR Contractor to ensure adequate privacy.

3. *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; recipients; e; Sufficient staffing is provided as required by individual service plans; f) Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols; g) Individuals receiving services are provided opportunities for community inclusion; and h) Providers have active quality management and improvement programs, as well as risk management programs.*

With regard to compliance indicator 3 above, the QSRs appeared to address most of the specified requirements. The most significant exception was with regard to whether the QSR process adequately addressed the requirement for providers to access treatment for service recipients "as needed." The Independent Reviewer has 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.

For example, element #67 required the first-level reviewer to judge whether 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. Element #68 also required the first-level reviewer to describe any inadequately addressed or previously unidentified risk, injury, need, change in status, deficiency in support plan or support implementation, and/or discrepancy between support implementations, services provided, and the individual's strengths and preferences. However, the audit tool did not require sufficient data collection to document whether unidentified or inadequately assessed needs might exist. 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 processes effectively.

In addition, 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.

4. *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; and f) Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice.*

The issues identified above for indicator 3 (i.e., whether the QSR methodology adequately assesses whether providers access treatment for service recipients "as necessary" are also applicable for this indicator.

Section V.I.2

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.

This review examined the progress DBHDS had made in its efforts to implement QSRs and use them to evaluate the quality of services. The findings below are organized by the six associated compliance indicators.

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; and, f) Any restrictions of individuals' rights are developed in accordance with the DBHDS Human Rights Regulations and implemented consistent with approved plans.*

The QSR methodology appeared to adequately address person-centered thinking and planning, opportunities for community engagement and inclusion, services and supports provided in the most integrated setting, and restrictions of individuals' rights being developed in accordance with the DBHDS Human Rights Regulations and implemented consistent with approved plans. However, consistent with the findings for V.1, indicators 3 and 4 above, the methodology had gaps in the area of assessing whether individuals' needs were identified and met. In turn, this impacted the ability of reviewers to adequately assess if services were responsive to changing needs.

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.*

As described above, DBHDS had not fully completed a round of QSRs during this review period and therefore did not yet have information to review for the purposes of identifying trends, and addressing deficiencies at the provider, CSB, and system wide levels through quality improvement processes. The QSR Contractor anticipated completing the first round of QSR data collection by the end of November 2020 and projected that they would make results available sometime after January 1, 2021.

3. *The summary results of the QSR for each provider (Person-Centered Reviews and Provider Quality Review) will be posted for public review.*

DBHDS had not fully completed a round of QSRs during this review period and therefore did not yet have information to post for public review. The QSR Contractor anticipated completing the first round of QSR data collection by the end of November 2020 and projected that they would make results available sometime after January 1, 2021.

4. *Summary data will be provided by the QSR Contractor 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.*

The QSR Contractor had not fully completed a round of QSRs during this review period and therefore did not yet have summary data to provide for the QIC. The QSR Contractor anticipated completing the first round of QSR data collection by the end of November 2020 and projected that they would make results available sometime after January 1, 2021.

5. *DBHDS shares information from the QSRs with providers and CSBs in order to improve practice and the quality of services.*

As described above, DBHDS had not fully completed a round of QSRs during this review period and therefore did not yet have information to share with providers and CSB. The QSR Contractor anticipated completing the first round of QSR data collection by the end of November 2020 and projected that they would make results available sometime after January 1, 2021.

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.*

The QSR Contractor's methodology and training addressed these expectations.

Section V.I.3

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.

This review examined the progress DBHDS had made in its efforts ensure that 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 findings below are organized by the four associated compliance indicators.

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.*

The Independent Reviewer has previously found that indicators for V.I.1 require reviewers to have adequate training to make clinical judgments themselves, or to have access to clinical consultants to ensure sufficient evaluation. Over the course of the past six months, the Independent Reviewer has also provided ongoing feedback as to whether the current 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.

- The Independent Reviewer's feedback expressed concern with regard to the minimum qualifications for "non-clinical" 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 revised documents submitted on July 28, 2020, and July 31, 2020, the QSR Vendor made a change to the qualifications for the first level reviewers, to state: "A minimum of three years' experience in a human-service related field such as long-term services and supports or developmental and intellectual disabilities." This phrasing did not address the lack of a requirement for any specific developmental and intellectual disabilities (IDD) experience. Based on review of a document entitled *VA QSR Reviewer*

Qualifications August 14, 2020, all of the current reviewers had at least two years of experience in the I/DD field. For the current round of QSRs, it is very positive that the vendor provided a written commitment that all QSR staff would have IDD experience. However, DBHDS did not provide updates to memorialize this commitment, either contractually or in its QSR Methodology.

- The training materials submitted for this review did not show that first-line reviewers received sufficient training to prepare them to identify possible unmet needs in clinical areas. DBHDS provided eleven PowerPoint presentations on various topics for our review. Some of the presentations (e.g., Rights Restrictions) included considerable content, while others did not. Most of the presentations also referenced external content that DBHDS did not make available for review, so we were unable to see the full scope of what might have been covered with the trainees. Based only on the material made available for review, the training content did not appear to be sufficiently comprehensive to prepare first-level reviewers to make the required judgements, especially with regard to their ability to identify clinical concerns. As this review period was concluding, DBHDS provided some additional training materials, but there was not sufficient time to review them in detail.
- With regard to competency demonstration, DBHDS submitted a *QSR Reviewer Training Competency Tracking* document that appeared to be a tracking log showing individual trainees' competency status in certain categories. These topics included QSR Basics, ISP, HCBS Settings Rule, Quality, Crisis, PQR and PCR Entry, Fatal 8, Clinical Decision Tree, Interview and PCR and PQR inter-rater reliability (IRR). The document indicated that, in addition to IRR, competency demonstration would include the following:
    - CT: Competency Test –Competency testing is utilized to determine retention and application of information relative to QSR topic areas. Competency training is considered the final assessment of topic competency based on all activities and training provided to trainees. Trainees who do not pass are provided retraining, exercises, etc. and allowed re-takes to determine if competency can be achieved.
    - KC: Knowledge Check –Knowledge checks are utilized by the training team to determine retention of information to inform decisions for refinement of training in real-time. Results are reviewed with trainees and supplemental information or retraining is provided.
    - ST: Scenario Test –Scenario testing is a component utilized by the training team to determine application of information based on mock scenarios provided. Results are reviewed with trainees and supplemental information or retraining is provided.

  DBHDS did not provide any other content (e.g., the actual scenario test or any other competency test samples) to show how the QSR Contractor would make determinations of competency. Therefore, the adequacy of the competency testing cannot be assessed.

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.

The QSR Contractor's methodology is consistent with these requirements. However, for this current initial round, based on interview with staff from the Office of DQV and a QSR Contractor representative, the constraints of the COVID-19 pandemic may impact the QSR Contractor's ability to attain a sufficient sample to draw valid conclusion for some provider types. For example, the ongoing closure of many congregate day programs had limited participation in waiver services. The QSR Contractor representative interviewed was aware of this issue, but did not yet know the extent to which sampling sufficiency might be impacted.

2. *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.*

The QSR Contractor described a methodology that, on its face, appeared consistent with these requirements. Based on a review of the *VA 2020 QSR Methodology*, dated July 27, 2020,.the QSR Contractor has described what appears to be a robust IRR process, 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. According to the *QSR Training Plan,* during the training phase, the QSR Contractor will require that IRR will be conducted on two PQRs and three PCRs per first level reviewer to determine achievement of a 95 percent confidence level. This would determine whether the first level reviewer was eligible to move to live review, or required additional training. During live review, IRR would also be conducted on the first two PQRs and first three PCRs for each first level reviewer, to again determine achievement of the 95 percent confidence level. All first level reviewers would be required to establish and maintain a 95 percent IRR rate in order to complete independent QSRs. The QSR Contractor further indicated that the ongoing IRR requirement would be five percent of a first-level reviewer's completed reviews.

However, because the methodology does not require a minimum level of specific I/DD experience, it remains 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 seems a recipe for a potential lack of reliability of the data collected through the QSR process. While it was positive that the current slate of reviewers and Team Leads had specific I/DD experience, DBHDS should ensure that the methodology clarifies a minimum level in that regard.

3. *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; and, e) Include indicators to comprehensively assess whether services and supports meet individuals' needs and the quality of service provision.

Again, in many respects, the QSR methodology met the criteria for this indicator. The QSR Contractor provided the reviewers with the PCR and PQR audit tools, training and written guidance, including the *QSR PCR Abstraction 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). However, as discussed above, some issues remained with regard to IRR and whether the indicators provided sufficient data to comprehensively assess if services and supports meet individuals' needs, especially in the area of the identification of unmet clinical needs.

APPENDIX G

LIST OF ACRONYMS

ADL	Activities of Daily Living
APS	Adult Protective Services
AR	Authorized Representative
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Professional
CAP	Corrective Action Plan
CEPP	Crisis Education and Prevention Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Manager
CIT	Crisis Intervention Training
CL	Community Living (HCBS Waiver)
CM	Case Manager
CMS	Center for Medicaid and Medicare Services
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
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
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
PMM	Post-Move Monitoring
PST	Personal Support Team
QAR	Quality Assurance Review
QI	Quality Improvement
QIC	Quality Improvement Committee
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