# REPORT OF THE INDEPENDENT REVIEWER

# ON COMPLIANCE

# WITH THE

# SETTLEMENT AGREEMENT

# UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

October 1, 2020 – March 31, 2021

Respectfully Submitted By

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Independent Reviewer
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# I. EXECUTIVE SUMMARY

This is the Independent Reviewer's eighteenth Report on the status of compliance with the Provisions of the Settlement Agreement (Agreement) between the Parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and the status of its progress during the Eighteenth Review Period, October 1, 2020 – March 31, 2021.

During this Period, as with the Seventeenth, COVID-19's disproportionate impact on individuals with intellectual and developmental disabilities (IDD), their families and service providers sadly continued, at first tragically intensifying before declining as vaccination rates increased.

In addition to the human consequences, the pandemic understandably once again slowed Virginia's progress. When COVID-19 first began to spread in the spring of 2020, the Department of Behavioral Health and Developmental Services (DBHDS) was planning a broad, project-managed drive to achieve all remaining Compliance Indicators by June 30, 2021, the end of the tenth year of the Agreement's estimated implementation schedule.

Since then, the Commonwealth has maintained its focus on meeting the requirements of Compliance Indicators associated with the Provisions that it had not yet achieved, as well as on sustaining its statewide systems' performance that had previously achieved Compliance over consecutive reporting periods.

During the Eighteenth Review Period, Virginia continued to achieve many Agreement requirements. The Independent Reviewer and his consultants confirmed that the Commonwealth achieved three of the seventeen Provisions studied and met seventy-one of the associated 142 Compliance Indicators. Virginia also maintained Sustained Compliance with the Provisions that it had fulfilled previously. Among these accomplishments, the Commonwealth created more waiver slots in Fiscal Year 2021 than the Agreement specified. Virginia continued to expand independent living options and maintained Sustained Compliance at the South Eastern Virginia Training Center. The Commonwealth also established two new crisis stabilization homes for children and transition homes for adults, while also meeting several Indicators associated with the steps required to achieve the Quality and Risk Management

(QRM) Provisions. For the first time, Virginia achieved Compliance with Provisions III.C.6.b.iii.E. and III.C.6.b.iii.G. regarding Crisis Therapeutic Homes (CTHs) for children, and with Provision III.C.8.b. regarding the *My Life, My Community* website.

The Commonwealth also approved its permanent Developmental Disabilities (DD) waiver regulations, a precursor to its ability to fulfill the expectations for future behavioral programming. With the publication of the updated DD waiver manual projected for this summer, DMAS's and DBHDS's expectations will be clearly stated. As a result, providers will be more interested and willing to develop the necessary new services to support individuals who choose to live and receive their services in one of the new independent living options.

During the past year, DBHDS was in various stages of implementing its five new quality monitoring systems required by the QRM Provisions. Although the Department had attempted to implement Quality Service Reviews (QSRs) and assessments of adequacy previously, its methods did not comply with the Agreement's requirements. Some of DBHDS's new systems had been launched in January 2020, while others only began in July 2020, the ninth and tenth years of the Agreement's schedule. To achieve acceptable performance, a system's components typically need to function together over multiple review cycles with improvements and refinements made after each cycle.

These quality monitoring systems are central to achieving a pivotal collection of remaining Provisions, namely:

- Operating a multi-component QRM system that ensures good quality services that meet the needs of all the Commonwealth's individuals in the target population.

Another group of remaining Provisions involve:

- Providing accessible and good quality services that meet the specific needs of those individuals with complex medical and behavioral needs.

When these remaining Provisions are met, the overall service system will reflect the Agreement's core complementary goals: meeting the service needs of individuals with IDD while ensuring that all services provided are of good quality, benefiting both recipients and stakeholders.

Regarding the Eighteenth Period studies, the Independent Reviewer's consultants found progress had been achieved across several areas, while obstacles that have long slowed the Commonwealth's progress continued to do so. These include insufficient staff and provider capacity (especially to meet complex medical and behavioral support needs), challenging and not-yet-finalized policy and process decisions, and Community Services Boards (CSBs) that do not all fulfill the Agreement responsibilities delegated to them by the Commonwealth.

These are familiar and ongoing challenges. However, there are two overarching barriers that are even more far-reaching: they significantly impair Virginia's progress on a whole array of the Agreement's Compliance Indicators. These barriers are:

1. The Commonwealth's data sources have still not been determined by DBHDS to provide reliable and valid data that are approved for compliance reporting, and its various committees and work groups have not been informed of this; and
2. DBHDS's various quality review processes have not yet demonstrated that they function adequately.

The determination of data sources is critical to completing each step of the quality improvement cycles required by the Agreement's QRM Provisions, i.e., work groups interpreting and analyzing reliable and valid data to identify and target areas of needed improvement; implementing data-driven and measurable quality improvement initiatives and action plans; determining the extent of their impact; and, completing the cycle, making data-informed decisions about the need for subsequent improvements.

The second overarching barrier involves Virginia reviewing and determining whether its many quality review processes required by the Agreement are implemented sufficiently. For example, during the Eighteenth Review Period, two studies evaluated the sufficiency of two of DBHDS's quality review processes. Despite the Commonwealth having implemented both of these processes with care, the Independent Reviewer's consultants found substantive discrepancies between the findings of one quality review process and the reviewer's validation, and the other utilized data from a source that had not been determined to provide reliable and valid data.

One study involved DBHDS's 2020 QSR. In this, the Department's QSR vendor's non-clinician auditors found virtually no unmet needs in the study sample of ninety-nine individuals who had complex medical support needs and waiver-funded sponsored or group home services. For a significant randomly selected sample, however, the Independent Reviewer's look-behind study,

conducted by nurses with experience supporting individuals with IDD, found that eighty-five percent had healthcare concerns. One illustration of this is that the QSR found zero percentage had unmet healthcare needs due to lack of dental care, versus fifty percent found by the Independent Reviewer's nurses.

The other study compared findings of DBHDS's 2020 quality review process that determined whether individuals with complex behavioral support needs were authorized to receive the same number of service hours that were specified in their Individual Support Plans (ISPs). The Independent Reviewer's look-behind qualitative reviews found that the WaMS data used in the DBHDS review had not been determined to be reliable and valid or available for compliance reporting.

Statewide service systems' new qualitative review processes often need multiple cycles to address, identify, and correct the problems that contribute to inaccurate and unreliable findings. With the Commonwealth being required to operate many quality review processes, the individuals served, their families and other stakeholders will better trust the basis for any quality improvement initiatives when its quality reviews are conducted by staff qualified to make the required judgements, when the review queries elicit the information needed, and when accurate information is analyzed.

In Fiscal Year 2020, the ninth year of the Agreement's estimated ten-year implementation schedule, the three external of the five quality monitoring systems mentioned above were still under development, with major obstacles remaining at this late stage. These three external systems are:

1. DBHDS Licensing Assessments of Adequacy,
2. Case Managers' Assessments of Appropriate Implementation, and
3. Quality Service Review Assessments.

The Independent Reviewer will prioritize qualitative studies of these three external quality monitoring processes during the Nineteenth and Twentieth Review Periods.

For the Nineteenth Review Period, in addition to completing targeted analyses 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:

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

During this Eighteenth Review Period, the Commonwealth's staff and DOJ gathered and shared other information that helped to facilitate further progress toward effective implementation of the Agreement's Provisions. Overall, the willingness of both Parties to openly and regularly discuss implementation issues, as well as any concerns about progress, has been critical and productive. The involvement and contributions of the advocates and other stakeholders have helped Virginia to formulate policies and processes and 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

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

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **III** | **Serving Individuals with Developmental Disabilities in the Most Integrated Setting** | Ratings prior to the 18th Period are not in bold.<br><br>Ratings for the 18th Period are in **bold.**<br><br>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.<br><br>The Findings Section and attached consultant reports include additional explanatory information regarding the Compliance Indicators.<br><br>*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 … x. | **Sustained Compliance** | The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012-2021. |

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| **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. | **Sustained Compliance** | The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012-2021.<br><br>The Parties agreed to consider the effectiveness of the discharge and transition process at Nursing Facilities (NFs) and ICFs as an indicator of compliance for III.D.1. |
| **III.C.1.c.i.-x.** | The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) … ix. | **Sustained Compliance** | See Comment re: III.C.1.b.i-ix |
| **III.C.2.a.-h.** | The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2021, a minimum of 1,000 individuals will be supported. | Non Compliance<br><br>**Non Compliance** | The Commonwealth has fulfilled the quantitative requirement for the Fiscal Years 2013 through 2020 by providing financial support to more than 1,000 individuals each year. During the 18th period the Commonwealth met the requirements for five of the twelve Compliance Indicators 1.01-1.12. The Commonwealth met Indicators 1.03, 1.05, 1.08, 1.10, and 1.12. It has not met 1.01, 1.02, 1.04, 1.06, 1.07, 1.09, and 1.11, and therefore remains in non-compliance. |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **III.C.5.a.** | The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management. | **Sustained Compliance** | 187(100%) of the individuals reviewed in the Individual Services Review studies during the tenth, eleventh, twelfth, thirteenth, fourteenth, fifteenth, sixteenth and eighteenth periods had case managers and current Individual Support Plans. |
| **III.C.5.b.** | For the purpose of this agreement, case management shall mean: | | |
| **III.C.5.b.i.** | Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs. | Non Compliance **Non Compliance** | For this and four other Provisions, III.C.5.b.ii., III.C.5.b.iii., III.C.5.c. and V.F.2. there are twelve Compliance Indicators 2.01-2.05 and 2.16-2.22. Indicator 2.05 has ten required elements (2.06-2.15). Virginia met four of the Indicators 2.01, 2.04, 2.17 and 2.21, but has not met eight Indicators 2.02, 2.03, 2.05 (includes 2.06 – 2.15), 2.16, 2.18, 2.19, 2.20, and 2.22. |
| **III.C.5.b.ii.** | Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP. | Non Compliance **Non Compliance** | When Virginia achieves the Indicators for III.C.5.b.i., it also achieve compliance for this Provision. |
| **III.C.5.b.iii.** | Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed. | Non Compliance **Non Compliance** | When Virginia achieves the Indicators for III.C.5.b.i., it also achieve compliance for this Provision. |

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| **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<br><br>**Non Compliance** | The Commonwealth met three of the four Compliance Indicators 6.01-6.04. It met 6.01, 6.02, and 6.03., but has not met Indicator 6.04, and therefore remains in Non-Compliance. |
| **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:<br>i. Provide timely and accessible support …<br>ii. Provide services focused on crisis prevention and proactive planning …<br>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<br><br>**Non Compliance** | The Commonwealth met eleven* of the twenty-two Compliance Indicators 7.02-7.23. It met Indicators 7.2, 7.3, 7.4, 7.5*, 7.9*, 7.10, 7.11, 7.12*, 7.13*, 7.17, and 7.23, but has not met Indicators 7.7, 7.7, 7.8, 7.14, 7.15, 7.16, 7.17, 7.18, 7.19, 7.20, 7.21, 7.22, and therefore remains in Non-Compliance. |

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| **III.C.6.b.i.A.** | The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week. | **Sustained Compliance** | CSB Emergency Services are utilized. Regional Education, Assessment, Crisis Services, Habilitation (REACH) hotlines are operated 24 hours per day, 7 days per week, and provide access to information for adults and children with IDD. |
| **III.C.6.b.i.B.** | By June 30, 2012, the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available. | **Sustained Compliance** | REACH trained CSB staff during the past six years. The Commonwealth requires that all Emergency Services (ES) staff and case managers are required to attend training**.** |
| **III.C.6.b.ii.A.** | Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible. | Non Compliance **Non Compliance** | The Commonwealth met five*, of the seven Compliance Indicators 8.01-8.07. It met Indicators 8.01, 8.02, 8.03, 8.05, and 8.07, but has not met 8.04 and[p; 8.06, and therefore remains in Non-Compliance. |
| **III.C.6.b.ii.B.** | Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting. | Non Compliance **Non Compliance** | The Parties agreed that the Indicators for III.C.6.a.i.-iii. and III.C.6.b.ii.A. cover this provision. |
| **III.C.6.b.ii.C.** | Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement. | **Sustained Compliance** | During the seventeenth and eighteenth Review Periods, law enforcement personnel were involved. Mobile crisis team members worked with law enforcement personnel to respond regardless of whether REACH staff responded in person or remotely using telehealth. |

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| **III.C.6.b.ii.D.** | Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises. | **Sustained Compliance** | REACH Mobile crisis teams for children and adults are available around the clock and respond on-site, or remotely due to COVID precautions, at all hours of the day and night. |
| **III.C.6.b.ii.E.** | Mobile crisis teams shall provide local and timely in-home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator | **Sustained Compliance** | In each Region, the individuals are provided in-home mobile supports, or telehealth due to COVID precautions, for up to three days as required. Days of support provided ranged between a low of one and a high of sixteen days. |
| **III.C.6.b.ii.H.** | By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time. | **Sustained Compliance** | The Commonwealth added staff to REACH teams in all five Regions and for five years demonstrated a sufficient number of staff to respond to on-site crises within the required average annual response times. Appropriate COVID precautions temporarily replaced most on-site responses. |
| **III.C.6.b.iii.A.** | Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services. | **Sustained Compliance** | All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults and have two crisis stabilization homes for children. |
| **III.C.6.b.iii.B.** | Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement. | Non Compliance<br><br>**Non Compliance** | The Commonwealth met the four* Compliance Indicators 10.01, 10.2, 10.3*, and -10.04*, however, it remains in Non-Compliance. See *Note at the end of this Table. |

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| **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<br><br>**Non Compliance** | For illustrative purposes only, the Commonwealth met the sole indicator* 11.01, however, it remains in Non-Compliance. See *Note at the end of this Table. |
| **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<br><br>**Compliance** | The Parties agreed that the Indicators for III.C.6.b.iii.G. cover this provision. |
| **III.C.6.b.iii.F.** | By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region. | **Sustained Compliance** | Each Region developed and currently maintains a crisis stabilization program for adults with IDD in each Region and has two programs for children. |
| **III.C.6.b.iii.G.** | By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region. | Non Compliance<br><br>**Compliance** | The Commonwealth met all three Compliance Indicators 13.01, 13.02, and13.03, and therefore has achieved Compliance for the first time. |
| **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<br><br>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.*<br><br>*Training of case managers is needed with the additional material developed to meet the requirements of Compliance Indicators 1. a.-g.*<br><br>*The CSBs report that:*<br><br>• *CI 2.b. CSB data shows that employment goals were set for only 30% vs. the standard of* |

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| | | | *50%.*<br><br>• *CI 2.d. CSB data shows that community engagement goals were met for only 38% of the individuals who had ISP meetings vs. the standard of 86%.*<br><br>*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.*<br><br>*CI 2.c. Services began within 60 days of authorization for 59% of the individuals vs. the measure of 86%.*<br><br>*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%.*<br><br>*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.)*<br><br>*CI 4 The number of service authorizations shows 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<br><br>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.* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
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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<br><br>Non Compliance | *The Commonwealth provided documentation that it achieved Compliance Indicators 1, 3 and 5. For the remaining three Indicators:*<br>*2. Valid information was not provided that 86% received reliable transportation,*<br>*4. Findings were not determined, and*<br>*6. QSR assessments had not been completed.* |
| **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<br><br>**Compliance** | The Commonwealth met the two Compliance Indicators 17.01 and 17.02 and therefore has achieved Compliance for the first time. |

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| **III.D.1.** | The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs. | Non Compliance **Non Compliance** | The Commonwealth met twelve*, of the twenty-three Indicators 18.01-18.23. It met Indicators 18.01*, 18.10, 18.11, 18.12, 18.13, 18.14, 18.15, 18.16, 18.17, 18.18, 18.19*, 18.22, but did it not meet the eleven Indicators 18.02, 18.03, 18.04, 18.05, 18.06, 18.07, 18.08, 18.09, 18.20, 18.21, and 18.23, and therefore remains in Non-Compliance. |
| **III.D.2.** | The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources. | **Sustained Compliance** | As of 3/31/21, the Commonwealth had created new options for 1,562 individuals who are now living in their own homes. This is 1,221 more individuals than the 341 individuals who were living in their own homes as of 7/1/15. This accomplishment is 84% of its goal of 1,886 by 6/30/20. |
| **III.D.3.** | Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments. | **Sustained Compliance** | The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies. |
| **III.D.3.a.** | The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations ... | **Sustained Compliance** | DBHDS has a dedicated housing service coordinator. It has developed and updated its housing plan with these representatives and with others. |

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| **III.D.3.b.i.-ii.** | The plan will establish for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement: Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and recommendations to provide access to these settings during each year of this Agreement. | **Sustained Compliance** | Virginia estimated the number of individuals who would choose independent living options. It established the required baseline, updated and revised the Plan with new strategies and recommendations, and tracks progress toward achieving plan goals. |
| **III.D.4.** | Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing from a one-time fund of $800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii. | **Sustained Compliance** | The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds received permanent rental assistance. |
| **III.D.5.** | Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below. | Non Compliance **Non Compliance** | The Commonwealth met one of the three Compliance Indicators 19.01-19.03. It met Indicator 19.01, but did not meet 19.02 and 19.03, and therefore remains in Non Compliance. |
| **III.D.6.** | No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST). | Non Compliance<br><br>Non Compliance | *DBHDS has made progress, but fell short of achieving many of the 13 Compliance Indicators. Examples of not meetings the Indicators include:*<br>*CI 2 and 4 – case managers have not met the standards for timely submissions.*<br>*CI 5, 6, and 7 DBHDS has not met the standards for holding CSBs accountable.* |

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

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

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

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

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

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

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

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

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

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

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| **V.** | **Quality and Risk Management System** | Ratings prior to the 18th Period are not in bold.<br><br>Ratings for the 18th Period are in **bold.**<br><br>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.<br><br>The Findings Section and attached consultant reports include additional explanatory information regarding the Compliance Indicators.<br><br>*The Comments in italics below are from a prior period when the most recent compliance rating was determined.* |
| **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<br><br>**Non Compliance** | The Commonwealth met twelve* of the thirty-three Compliance Indicators 29.01-29.33 . It met Indicators 29.02, 29.03, 29.04, 29.05, 29.06, 29.07, 29.11, 29.12, 29.13*, 29.15*, 29.31, and 29.32, but did not meet Indicators 29.01, 29.08, 29.09, 29.10, 29.14, 29.16, 29.17, 29.18, 29.19, 29.20, 29.21, 29.12, 29.23, 29.24, 29.25, 29.26, 29.27, 29.28, 29.29, 29.30, and 29.33 and therefore remains in Non-Compliance. |
| **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<br><br>**Non Compliance** | The Commonwealth met five, of the Compliance Indicators 30.01-30.11. It met Indicators 30.01, 30.02, 30.03, 30.04, and 30.06, but did not meet Indicators 30.05, 30.07, 30.08, 30.09, 30.10, and 30.11, and therefore remains in Non-Compliance. |

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| **V.C.2.** | The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol. | Sustained Compliance | *DBHDS implemented and maintains a web-based incident reporting system and reporting protocol.* |
| **V.C.3.** | The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken. | Sustained Compliance | *DBHDS revised its regulations, increased the number of investigators and supervisors, added expert investigation training, created an Investigation Unit, includes double loop corrections in Corrective Action Plans (CAPs) for immediate and sustainable change, and requires 45-day checks to confirm implementation of CAP s re: health and safety.* |
| **V.C.4.** | The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions. | Compliance<br><br>Non Compliance | *The Commonwealth has made substantial progress. It met six of the eight Indicators and has made significant progress on the other two.* |
| **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 | Non Compliance<br><br>Non Compliance | *There are 15 Compliance Indicators and 39 sub-indicators. Examples of Indicators that were and were not met include:*<br><br>*The Mortality Review Committee (MRC) met Indicators:*<br>*(1.a.-h.) charter,*<br>*(2.a.-g.) membership,*<br>*(3.a.-d.) training,*<br>*(4) meeting frequency and attendance,*<br>*(5.a.-e.) tracking,*<br>*(6. and 6.c) review of deaths,*<br>*(7.a. and c.) identifying deaths*<br>*(8) review within 90 days, (9.a.and b.) documentation,*<br>*(10) recommendations*<br>*(11.a.i.-iv.) Annual Report*<br>*(12, 13 and 14) MRC recommendations.*<br><br>*The MRC did not meet Indicators:*<br>*(7.b.) the completeness of the* |

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| | rates to the fullest extent practicable. | | *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<br><br>Non-Compliance | *OL achieved the metrics included in the Compliance Indicators 2, 3, and 7.*<br><br>*DBHDS reviewed Medicaid claims data and identified serious incidents that may not have been reported as required. DBHDS did document taking further action for providers with recurring deficiencies.*<br><br>*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<br><br>Non Compliance | *The Commonwealth met Compliance Indicators 1, 2, 3, 4, and 6 , and did not meet 5, 7 and 8.*<br><br>*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.* |

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| **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<br>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, though any individual type of source need not provide data in every area (as specified): | Non Compliance<br>Non Compliance | *For Provision V.D.3. The Commonwealth met Indicators for 1, 2, and 5, and did not meet 3, 4, and 6.*<br>*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).*<br>*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<br>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<br>Non Compliance | *The Commonwealth met Compliance Indicators 1, 2, and 4. It did not meet 3.*<br>*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).* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
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| **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<br>Non Compliance | *The Commonwealth met Indicators 1, 3, 4, 5, and 6.*<br>*Indicator 2 was not met for the same reason listed above for V.D.5.*<br>*Indicator 7 was not met because the RQCs are not adequately fulfilling the 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<br>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<br>Non Compliance | *The Commonwealth met Indicators 1 and 3.*<br>*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<br>Non Compliance | *The Commonwealth did not meet any of the four Indicators.* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **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<br><br>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 | T*he case management and the ISR study found Compliance with the required frequency of visits. DBHDS reported data that some CSBs are below target.* |
| **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<br><br>**Non Compliance** | When Virginia achieves the Indicators for III.C.5.b.i., it also achieve compliance for this Provision. |
| **V.F.3.a.-f.** | Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria). | Sustained Compliance | *The ninth, twelfth, fourteenth, and sixteenth and eighteenth ISR studies found that the case managers had completed the required monthly visits for 130 of 134 individuals (96.0%).* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **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<br><br>**Non Compliance** | The Commonwealth has not met the two Compliance Indicators 46.01 and 46.02, and therefore remains in Non-Compliance. |
| **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<br><br>**Non Compliance** | The Commonwealth has not met the sole Compliance Indicator 47.01, and therefore remains in Non-Compliance. |
| **V.F.6.** | The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness. | Sustained Compliance | *The statewide CM training modules have been updated and improved and are consistent with the requirements of this provision.* |
| **V.G.1.** | The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement. | Sustained Compliance | *OLS regularly 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<br><br>Non Compliance | *Compliance Indicators 1 and 2 – OL developed a checklist for the seven domains with corresponding regulations.*<br><br>*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.*<br><br>*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<br><br>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.*<br><br>*Indicator 2 – The Commonwealth has not demonstrated that the DMAS reviews are sufficient to ensure that DSPs meet the core competency requirements.*<br><br>*Indicators 3, 10 and 11 – Performance measure data was not provided.*<br><br>*Indicator 12 – DBHDS documented that providers had improved to 77.3%, which did not meet the 86% required.* |
| **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<br><br>Compliance | *The Commonwealth has achieved this Provision, by making available:*<br>• *the required supervisory training, which includes all topics specified in Indicator 1, and*<br>• *the resources specified in Indicator 2.* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **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<br><br>**Non Compliance** | During the first and second quarters of FY 2021, the Commonwealth's QSRs did not meet Indicator 51.04, and therefore remains in Non-Compliance. It's QSRs did not adequately assess whether service recipients were kept safe from harm and whether providers accessed treatment as necessary. |
| **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.<br>. | Non Compliance<br><br>**Non Compliance** | The Commonwealth's QSRs did not meet Indicator 52.01, and therefore remains in Non-Compliance. It's QSRs did not adequately assess whether individuals' healthcare needs were identified and met or that service plans were modified as needed. |
| **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<br>Non Compliance | *The extent to which the Commonwealth achieved the four Compliance Indicators for this provision were studied during the Seventeenth Review Period* |
| **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**<br><br>**COMPLIANCE*** designates the portions of the Consent Decree achieved by Virginia and relieved by the Court. | **Comment** |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **VI.D.** | Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with copies to the parties. The parties will seek a protective order permitting these reports to be …and shared with Intervener's counsel. | **COMPLIANCE*** | DBHDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations. |
| **IX.** | **Implementation of the Agreement** | **Rating**<br><br>Ratings prior to the 18th Period are not in bold.<br><br>Ratings for the 18th Period are in **bold.** | **Comment** |
| **IX.C.** | The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented … | Non Compliance<br><br>**Non Compliance** | The Independent Reviewer 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. |

**Note*: Since DBHDS has not yet determined that the sources of its data provide reliable and valid information available for compliance reporting, "determinations *met" determinations are not yet final, but rather for illustrative purposes only.

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

# III. DISCUSSION OF COMPLIANCE FINDINGS

## A. Methodology

For this Eighteenth Review Period (October 1, 2020 through March 31, 2021), the Independent Reviewer prioritized the following areas to monitor the Commonwealth's compliance with the requirements of the Agreement:

- Waiver Slots
- Case Management
- Crisis Services
- Individual and Family Support Program, Guidelines for Families, and Peer-to-Peer and Family Mentoring
- Community Living Options
- Independent Living Options
- Discharge Planning and Transition from Training Centers
- Quality and Risk Management
- Individuals with Complex Medical Support Needs

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 for 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;
- Verifying the Commonwealth's determinations that its data sources provide reliable and valid data that are available for compliance reporting; 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 Eighteenth Period reviews on the Provisions that the Commonwealth has not yet achieved and their associated Compliance Indicators, and for maintaining Sustained 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 show documentation that would:

- "Prove its Case" for having achieved all Indicators for the Provisions being studied, and
- Demonstrate its determinations that its data sources provide reliable and valid data that are available for compliance reporting.

To determine any ratings of Compliance for the Eighteenth Review Period, the Independent Reviewer considered information provided by the Commonwealth prior to April 28, 2021. The Independent Reviewer considered the findings and conclusions from the consultants' studies, the Commonwealth's planning and progress reports and documents, as well as other sources.

The Independent Reviewer's determinations that Compliance Indicators have or have not been met, and the extent to which Virginia has achieved Compliance, are best understood by reviewing the 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' services included in the respective consultant reports are provided to the Parties under seal.

For each study, the Commonwealth was asked to provide the 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 that Indicators have been met and of Compliance. If the Commonwealth was not able to provide sufficient documentation, the Independent Reviewer determined that it has not demonstrated that it has met the Compliance Indicator. Since DBHDS has not yet determined that the sources of its data provide reliable and valid information available for compliance reporting, the Independent Reviewer's determinations of "met" and "not met" that depend on these data are not yet final, but rather for illustrative purposes only.

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 eighteenth Report to the Court.

## B. Discussion of Compliance Findings

### *1. Waiver Slots*

**Background**

During the first nine years of the Agreement, i.e., Virginia's Fiscal Years 2012–2020, the Independent Reviewer reported to the Court that the Commonwealth had created, and in most years exceeded, the number of Home and Community Based Services (HCBS) waiver slots required by the Agreement. The Independent Reviewer's semi-annual Individual Services Review (ISR) studies have consistently found that waiver slots awarded to individuals and families provide them with critical supports that significantly improve their quality of life and prevent institutionalization.

During the first four years, the Commonwealth created 2,270 waiver slots across its three HCBS waiver programs, 600 more than required by the Agreement. However, during this same period, the number of individuals with IDD on a waitlist increased at a much faster pace, likely driven by the significant increase in the percentage of young children diagnosed with Autism Spectrum Disorders (ASDs). While an annual average of 742 slots were created over those four years, waitlists increased by more than 1,114 per year. As new slots were created and waitlists continued to grow, the Commonwealth redesigned its three waiver programs: Intellectual Disabilities (ID), Day Support (DS), and Individual and Family Developmental Disabilities Support (IFDDS, which was commonly known as the Developmental Disabilities or DD waiver program).

The purpose of the Commonwealth's redesign was to move away from an inflexible and outdated approach that placed participants in a waiver program based on a diagnosis of intellectual disability (ID) or developmental disability (DD) other than ID. These waiver programs had limited service options that incentivized providers to congregate individuals in large day and residential settings. These typically isolated participants from their communities; rarely did their days include integrated experiences.

Each of the Commonwealth's redesigned waiver programs now serves individuals, regardless of whether they are diagnosed with ID or DD. A wider array of services is offered under each program, and many more of these options promote community integration and self-sufficiency. The waiver programs have become more flexible, such as allowing the Commonwealth to reassign individuals to an alternative program, if the individual needs and prefers a different service. Waitlists have also been restructured; rather than being placed on a list based on one's disability diagnosis, the new waitlists are based on the level of the individual's need. The Commonwealth established criteria to ensure consistent determinations of that level of need.

This substantial redesign required the Independent Reviewer to develop new criteria to determine whether Virginia had created the required number of new waiver slots. After gathering input from the Parties, the Independent Reviewer established the following:

- Create more waiver slots with the same funding appropriation;
- Serve more individuals who are on the priority one waitlist;
- Provide the services requested and needed by the individuals who were awarded waiver slots;
- Ensure that needed slots are available to prevent the institutionalization, or continued institutionalization, of individuals in the target population; and
- Achieve the goals of the Agreement more effectively and expeditiously.

**Eighteenth Period Review**

Under the three redesigned waiver programs, the General Assembly created 3,089 waiver slots that met these criteria. This represents 1,389 (81.7%) more slots than the 1,700 required by the Agreement for Fiscal Years 2018–2021. Many of the new slots were created for two of Virginia's newly renamed waivers: Family and Individual Services (FIS, formerly IFDDS) and Building Independence (BI, formerly DS), both of which offer an array of integrated service options. In contrast, the Commonwealth created 346 fewer slots for its Community Living (CL, formerly ID) waiver program that funds congregate residential services.

The impact of the General Assembly's approval of substantially more waiver slots than the Agreement required has had impressive and measurable results. Overall, by the time Fiscal Year 2021 waiver slots are filled, more than 6,500 additional individuals with IDD will be receiving waiver-funded community-based services than in Fiscal Year 2011, before the Agreement began. For example, in Fiscal Year 2017, there were 275 slots for individuals receiving services through the previous DD and DS waiver programs. However, by the end of Fiscal Year 2021, more than

3,000 individuals with either an ID or DD diagnosis will have access to the integrated service models through either the FIS or BI programs.

When the Agreement began, there were 5,783 individuals who were eligible for services, but on waitlists. In each of the first four years of the Agreement (Fiscal Years 2012–2015), despite Virginia creating 2,270 new slots, the waitlists grew by 4,457, i.e., more than 1,100 individuals per year. However, during the final four years of the Agreement's ten-year schedule, the combination of redesigned programs and the creation of more slots resulted in a dramatically slower pace of waitlist growth, down to an annual average of 235. Although the average annual rate of increase slowed from 1,100 to 235, as of November 2020, there were still 13,265 individuals eligible for waiver slots and waiver-funded services on waitlists. Access to waiver-funded services is vitally important to these individuals and their families. The General Assembly should continue to expand the number of waiver slots and Virginia's agency staff should continue to find creative ways to expand services to address this growing need.

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

| **HCBS Waiver Slots<br>Required by the Agreement / Approved by the General Assembly<br>Fiscal Years 2012–2021** | | | | | |
|---|---|---|---|---|---|
| | **Facility Transition** | **Intellectual Disability (ID) / Community Living (CL)** | **Developmental Disability (DD) / Family and Individual Support (FIS)** | **Day Support (DS) / Building Independence (BI)** | **Total** |
| **Required by the Agreement** | 805 | 2915 | 450 | 0 | **4170** |
| **Approved by the General Assembly** | 915 | 2569 | 2995 | 100 | **6579 [+2,409]** |

**Conclusion**

The Commonwealth has maintained Sustained Compliance. It has fulfilled the requirements for the number of waiver slots created and prioritized, pursuant to Provisions III.C.1.a.i- ix., b.i.-x., and c.i-x.

The Independent Reviewer notes that the Compliance Indicators for III.D.1. incorporate his reasons for prior noncompliance findings with Section III.C.1.b. and c. The Parties agreed to address concerns about transitioning individuals with IDD under twenty-two years of age from institutions other than Training Centers (i.e., ICF/IDDs and Nursing Facilities) to the community in the Compliance Indicators for III.D.1.

## *2. Case Management*

**Background**

Recent studies of Virginia's progress toward achieving the Agreement's Case Management Provisions were conducted in April 2019, April 2020 and September 2020. This last review focused on the four sets of related Compliance Indicators with which the Commonwealth had not yet achieved Compliance.

The Commonwealth began planning its system of case management face-to-face assessments system required by Provision V.F.5. in 2019, five years after the 2014 due date, i.e., "within twenty-four months of the date of this Agreement." Case management assessments are essential precursors to the effective functioning of the quality assurance and quality improvement systems required by the Agreement's Quality and Risk Management (QRM) section. To determine what improvements are needed at the individual, provider and systems levels, the Commonwealth's QRM systems depend on reliable data about gaps in services, unaddressed risks, inadequate opportunities for integration, and inappropriate implementation of services. Much of these data come from having a functioning and reliable case management assessment system in place.

The case management assessment system is one of three complementary monitoring mechanisms required by the Agreement. Each of these mechanisms must:

- Be conducted by staff who are from outside the private providers whose services are being assessed;
- Gather data from on-site, in-person interviews with the individuals and their caregivers, as well as from observations of the individual's residential and day program settings; and

- Report data, and if concerns are identified, make determinations, document the issue, and take actions if discrepancies, inadequacies, or inappropriate implementation of services occur.

Case management assessments are required to provide reliable data and valid information regarding various aspects of service delivery: previously unidentified risks, injuries, needs, or other changes in status, the adequacy of services, and whether the services in the individual's support plan are being implemented appropriately and remain appropriate for the individual. The Agreement requires that these case management assessments provide information as inputs to the DBHDS quality assurance systems regarding the positive and negative outcomes for both health and safety and for community integration. Without such reliable data, the Commonwealth cannot effectively determine needed quality improvements on the individual, provider and systems levels.

In 2019, none of these three external monitoring mechanisms, including case management assessments, were operational and providing reliable data.

In 2020, the Independent Reviewer's consultant found that Virginia had extended considerable and concerted efforts to implement case management monitoring and assessment systems. By last July, DBHDS had completed consultation with the Independent Reviewer and established standard definitions for the phrases "change of status or needs" and "appropriate implementation of services," which the Agreement requires be incorporated into its policies, requirements and guidelines. DBHDS had also developed a new on-site case management assessment tool that included these definitions. That summer, the Department communicated its expectations related to case management assessments, and trained case managers and their supervisors on the requirements of the assessment process and on-site assessment tool.

During this same period, however, the Commonwealth's community-based service system had appropriately implemented Virginia's COVID-19 precautions, which did not allow DBHDS and the CSBs the opportunity to implement on-site face-to-face case management assessments or to gather and report reliable data from them. These assessments could only be conducted remotely and, therefore, could not provide sufficient information regarding whether there had been a change of status or needs, services were being appropriately implemented, or adaptive equipment or the individual's setting posed previously unidentified health or safety risks. Case managers cannot adequately complete numerous required post-assessment steps without such information,

especially if concerns cannot be adequately identified, such as reporting and documenting the issue and convening the service planning team to address it.

In each of the 2020 studies, DBHDS provided documentation that showed achievement of four of the nineteen case management Indicators for the four Provisions reviewed. The studies found that the Commonwealth was not able to document achievement of the Indicators associated with the required quality review process, the Support Coordinator Quality Review (SCQR) – Fiscal Year 2020. The SCQR had assessed Calendar Year 2019 records which predated the Commonwealth's establishment of definitions and tools related to "change in status or needs" and "appropriately implemented services." In that SCQR cycle, DBHDS reported that 78% of CSBs achieved nine of the ten required elements (2.06-2.15), which was below the benchmark of 86%. Furthermore, CSBs failed to provide sample reviews for 7% of those requested by DBHDS, which very likely introduced a bias into the final results.

**Eighteenth Period Study**

For the Eighteenth Review Period, the Independent Reviewer retained the same independent consultant to conduct a follow-up study of Virginia's case management system and case management services. This review examined four sets of Indicators: 2.01–2.22 for Provision III.C.5.b.i., 6.01–6.04 for Provision III.C.5.d., 46.01–46.02 for Provision V.F.4., and 47.01 for Provision V.F.5.

In general, DBHDS provided documentation and information for this latest study that showed achievement of ten of nineteen compliance indicators. Although these achievements demonstrated commitment and progress from the prior reviews, nine Indicators could not be met. This was largely due in part to the data source, the SCQR – Fiscal Year 2020, which once again pre-dated finalization of the definitions, tools and implementation related to "change in status or needs" and "appropriately implemented services," and the incomplete response from CSBs. Other than these shortcomings, DBHDS had adequately completed a full annual cycle of their planned SCQR activities, including identifying several quality improvement initiatives.

This latest study found that the SCQR – Fiscal Year 2021 had begun during the first half of Calendar Year 2021 and was assessing case manager activity for the second half of Calendar Year 2020; however, results were not available for this review. DBHDS reported improvements in CSB response rates, which, if sustained, will help ensure the validity of future SCQR results.

Looking to future reviews, because COVID-19 precautions remained in place for this latest Review Period (they were set to be lifted May 1, 2021), this situation will impact the current SCQR cycle and, therefore, the related findings from the consultant's next study. Because case management performance is measured via Indicators that require on-site face-to-face activities, and because the SCQR – Fiscal Year 2021 is still assessing case manager activity from the second half of Calendar Year 2020, this SCQR cycle will not be able to report on the required on-site face-to-face interviews and observations, even though some proportion of records will have followed the finalization of the definitions, tools and implementation mentioned above. SCQRs of case managers' activities, including assessments, that occur without the required agreed-upon definitions of key terms (2.01) and without face-to-face on-site interviews and observations cannot provide reliable data regarding the proper implementation of these requirements or "for review on a statewide and individual CSB level" (2.05).

It may therefore be another two years from now (with a review of SCQR – Fiscal Year 2022) before DBHDS can demonstrate that it has achieved the requirements of the remaining Indicators. However, some of the records sampled between May and December of 2021 will include on-site face-to-face activities, and therefore may be usable. So it may be feasible to make an assessment earlier than in two years' time of case management performance. This would be based on a review of a sample that comprises data from only seven months, rather than a year. This would require DBHDS to accelerate its plans to sample May – December, 2021 records for SCQR –Fiscal Year 2022.

During this current Review Period, the CMSC (Case Management Steering Committee) continued to focus on building the quality framework to measure case management performance. This Committee also continued to regularly inform CSBs of their respective case management performance. Through the CMSC, DBHDS has established a mechanism to monitor CSB compliance with case management standards, although its ability to effect improvements and achieve the associated Indicators has not yet been established.

DBHDS provided no documentation that its Office of Data Quality and Visualization (ODQV) had determined that the case management data sources were reliable and valid, as required by Indicator 37.07 for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2.

The specific facts and analysis for each Compliance Indicator is included in Appendix B.

**Conclusion**

As mentioned above, the Commonwealth met seven of the nineteen Compliance Indicators that comprise the four Case Management Provisions, i.e., III.C.5.b.i., III.C.5.d., V.F.4., and V.F.5. Since it has not yet met the remaining twelve Compliance Indicators, Virginia remains in Non-Compliance. The Indicators to achieve compliance for III.C.5.b.i. will also achieve compliance with the other Provisions associated with case management (III.C.5.b.ii., III.C.5.b.iii., III.C.5.c., and V.F.2.)

Regarding Provision III.C.5.b.i., Virginia met Compliance Indicators 2.01, 2.04, 2.17 and 2.21, but has not met Compliance Indicators 2.02, 2.03, 2.05 (includes 2.06 – 2.15), 2.16, 2.18, 2.19, 2.20, and 2.22. Therefore, Virginia remains in Non-Compliance with *III.C.5.b.i.-iii.; III.C.5.c.; and V.F.2.*

Regarding Provision III.C.5.d, the Commonwealth met Compliance Indicators 6.01, 6.02, and 6.03, but has not met Compliance Indicator 6.04. (DBHDS has successfully completed one cycle of its inter-rater reliability process, but two cycles are required to demonstrate that the process is ongoing, as required by 6.04.) Therefore, Virginia remains in Non-Compliance with III.C.5.d.

Regarding Provision V.F.4., the Commonwealth has not met Compliance Indicators 46.01 and 46.02. Therefore, Virginia remains in Non-Compliance with V.F.4.

Regarding Provision V.F.5., the Commonwealth has not met Compliance Indicator 47.01. Therefore, Virginia remains in Non-Compliance with V.F.5.

## *3. Crisis Services*

**Background**

In his Sixteenth Report to the Court, the Independent Reviewer determined that the Commonwealth remained in Compliance with the Crisis Services Provisions III.C.6.b.i.A. and B.; III.C.6.b.ii.C., D., E., and H.; III.C.6.b.iii.A. and III.C.6.b.iii.F. It remained in Non-compliance with III.C.6.a.i.-iii.; III.C.6.b.ii.A. and B.; III.C.6.b.iii.B., D., E., and G.

The Sixteenth Report also identified significant areas of concern, including the high number of individuals with IDD whose initial crisis assessment occurred at hospitals rather than in the individuals' homes. A high percentage of these individuals continued to be admitted to psychiatric hospitals rather than utilizing in-home supplemental supports or crisis stabilization

services as alternatives to hospitalization. This dynamic resulted in an increase in the number of children and adults with IDD in the Commonwealth who were admitted to psychiatric hospitals.

The Parties recognized the vital role of assessments at home in preventing such unnecessary institutionalization. They established the Compliance Indicator requirement that 86% of this target population should receive the REACH crisis assessment in the home or in other community or non-hospital/Community Services Board (CSB) settings.

**Eighteenth Period Study**

For this current Review Period, the Independent Reviewer retained the same consultants who have examined the Commonwealth's statewide crisis services system for eight previous reports. As in the past, this study includes a review and analysis of facts regarding the status of Virginia's accomplishments in implementing and fulfilling the Agreement's Provisions, as described and measured by the associated Compliance Indicators. Overall, the Crisis Services Provisions require the Commonwealth to:

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

As with all previous studies, prior to the initiation of any work, the Independent Reviewer and his consultants discussed the outline for the review with DBHDS. The Compliance Indicators to be evaluated were identified as: III.C.6.a.i.-iii.; III.C.6.b.ii.A.; as well as III.C.6.b.iii.B., D., and G. (i.e., 7.02 – 7.23, 8.01 – 8.07; 10.01 – 10.04; 11.01; and 13.01 – 13.03, according to Virginia's numbering system.) This study also included a review of the DBHDS standard crisis services reports regarding whether, and the extent to which, the Commonwealth continued to maintain the statewide systems that previously resulted in DBHDS achieving Compliance for two consecutive determinations.

The study identified the following positive accomplishments:

- REACH accepted numerous referrals for both children and adults from a number of sources. REACH continued to offer crisis response twenty-four hours per day, seven days per week, as required, and to report the total number of calls that it receives.
- Virginia, through REACH, continued to train community stakeholders and to work with law enforcement.
- Mobile crisis teams provided local and timely in-home crisis supports in each Region.
- COVID-19 resulted in restrictions on in-person crisis assessments. Therefore, data for this review period cannot be compared to the previous year. However, when face-to-face assessments did occur, 95% were responded to within the required response time for each Region.
- The Commonwealth now has two crisis stabilization programs that exclusively serve children. The Indicators refer to these programs as Crisis Therapeutic Homes (CTHs). Although utilization of the CTHs was impacted by COVID-19 precautions and related staff shortages, Virginia is to be commended that so many more children had this resource during a time of crisis.
- The Commonwealth continued to operate five CTHs for adults. Virginia is to be commended that these programs were also available at the same capacity during COVID-19 as they were prior to the pandemic.
- The availability of Adult Transition Homes had a positive impact by reducing the number of stays in the CTHs that are longer than sixty days.
- The purpose of creating and enhancing the Commonwealth's crisis services system for individuals with IDD and a co-occurring condition is to stabilize these individuals in their existing settings or offer a suitable community service alternative to prevent unnecessary hospitalization. Data reported by DBHDS indicate that, during this reporting period, there was a 19% decrease in hospitalizations for children and an 8% reduction for adults.
- Virginia implemented out-of-home crisis therapeutic prevention host-home like services, which like the two crisis stabilization homes, are available to eligible children statewide. None of the children who have used these short-term out-of-home services were institutionalized.
- The total number of admissions of individuals with IDD to state hospitals decreased to 708 in Fiscal Year 2020, after having increased from 626 to 1,018 between Fiscal Years 2017 and 2019. The positive decreasing trend in the number of total admissions appears to be continuing, with only 298 admissions during the first six months of Fiscal Year 2021. The percentage of admissions of individuals with IDD to state hospitals, compared with the percentage of all admissions, followed a similar trend.

- The value of offering mobile crisis or prevention services continued to be validated. DBHDS reported that the majority of children and adults who received these services retained their settings.

However, the fact-finding for this Review Period also identified concerns that will require additional effort and accomplishments, if Compliance is to be achieved. For example:

- DBHDS acknowledged that it is "most desirable that persons in crisis receive a crisis assessment in the location in which the crisis occurs, as opposed to being removed from their community setting to be assessed in a different location." The Commonwealth, however, continued to fall far short of the Indicator expectation that eighty-six percent of REACH crisis assessments occurred in individuals' own homes or other community settings. During the final three-month period before COVID-19 precautions were implemented (i.e., the third quarter of Fiscal Year 2020, January 1 – March 31, 2020), REACH staff completed forty-six percent of crisis assessments in a home or community location. In the first quarter of Fiscal Year 2021 (July 1 – September 30, 2020), this number was fifty-three percent. During the Eighteenth Period, i.e., the second and third quarters of Fiscal Year 2021, October 1, 2020 – March 31, 2021, this percentage dramatically decreased to thirty-four and thirty-five percent respectively. DBHDS did not provide any analysis as to why so few crisis assessments were conducted in the home or other community setting, nor did it identify its strategic plan to meet this Compliance Indicator.
- As reported previously, individuals with IDD are frequently removed from their homes to receive crisis assessments in hospitals or at the offices of the CSB Emergency Services staff. This approach significantly increases the number of individuals who are hospitalized, while simultaneously decreasing adherence to the Indicator requirement "to provide in-home and crisis services directed at resolving crises and preventing removal from the home." The Commonwealth's *Performance Contract* changes that were issued to CSBs in July 2020 did not address the preferred location for crisis assessments, nor did they set any expectation for CSB ES staff to be part of a community-based assessment. Without this expectation, it is doubtful that the percentage of crisis assessments completed in the community will increase significantly. Virginia hopes to address this long-standing systemic problem with the launch in the fall of 2021 of its plan for a crisis assessment transformation. This new statewide approach will involve an emergency 988 telephone number, triage and team response to the individual's home or other community location.

- Virginia developed Practice Guidelines for behavior consultants, following consultation with the Independent Reviewer and his consultants. DBHDS reported that it would provide these guidelines to behavior consultants during the first quarter of the Fiscal Year 2022. Therefore, DBHDS did not meet Indicator 7.15 during this Review Period, but is poised to do so, if its plans are fully and effectively implemented.
- Certain Indicators (i.e., 7.18 – 7.20) cannot be met and Compliance cannot be determined until after the DD Waiver regulations have been implemented and services delivered in accordance with these regulations.
- DBHDS reports that, for the period September 1, 2020 – February 28, 2021, 271 of the 601 individuals (45%) with a need for therapeutic consultation referral had a service authorization and a provider identified within thirty days.

For the Eighteenth Review Period, a qualitative review was also conducted. This involved children and adults with identified significant behavior support needs and living at home with family, who were to receive either personal care or in-home support services between July 1, 2020 and December 31, 2020. The findings from this review of individuals' records and from interviews with fifty-five percent of their Case Managers are discussed at length in Attachment 2 of the consultants' report in Appendix C. In summary, it concluded that the number of hours of needed services in these individuals' ISPs closely matched the number of hours authorized. However, DBHDS lacked actual data to verify that these services were in fact delivered. Including billing data in its document review could remedy this information gap.

See the consultant's full report in Appendix C.

**Conclusion**

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

Regarding Provision III.C.6.a.i.-iii., Virginia met eleven Compliance Indicators 7.02, 7.03, 7.04, 7.05*, 7.09, 7.10, 7.11, 7.12*, 7.13*, 7.17 and 7.23, but has not met twelve Indicators 7.06, 7.07, 7.08, 7.14, 7.15, 7.16, 7.18 7.19, 7.20, 7.21 and 7.22. Therefore, the Commonwealth remains in Non-Compliance with Provision III.C.6.a.i.-iii.

Regarding Provision III.C.6.b.ii.A., Virginia met five Compliance Indicators 8.01, 8.02, 8.03*, 8.05* and 8.07*, but has not met two Indicators 8.04 and 8.06. Therefore, the Commonwealth remains in Non-Compliance with Provision III.C.6.b.ii.A.

Regarding Provision III.C.6.b.iii.B., Virginia met this Provision's four Compliance Indicators 10.01*, 10.02* 10.03* and 10.04*. However, the Commonwealth remains in Non-Compliance. See **Note* below.

Regarding Provision III.C.6.b.iii.D., Virginia met the sole Compliance Indicator 11.01*. However, the Commonwealth remains in Non-Compliance. See **Note* below.

Regarding Provision III.C.6.b.iii.G., Virginia met the three Compliance Indicators 13.01, 13.02 and 13.03, and therefore the Commonwealth achieved Compliance for the first time.

* *Note*: Since DBHDS has not yet determined that the sources of its data provide reliable and valid information available for compliance reporting, determinations of "met" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

### *4. Individual and Family Support Program, Guidelines for Families, and Peer-to-Peer and Family Mentoring*

**Background**

The Parties agreed that Compliance with these three interrelated Provisions would be determined by meeting seventeen Compliance Indicators. The Individual and Family Support Program (IFSP), Provision III.C.2.a.-h. has twelve Indicators (1.01 –1.12), the Guidelines for Families Provision, III.C.8.b. has two (17.01 – 17.02), and the Peer-to-Peer and Family Mentoring Provision, III.D.5. has three (19.01 – 19.03).

For many years, the Independent Reviewer reported to the Court that the Commonwealth had met and exceeded the pertinent annual quantitative requirements of III.C.2. by providing IFSP monetary grants to at least 1,000 individuals and/or families. Over the same period, the Independent Reviewer also reported that Virginia had not met the qualitative requirements for the IFSP, but noted that it was making steady progress, which had accelerated significantly beginning in 2018, at the time of the twelfth Review Period.

Following development of its IFSP State Plan, DBHDS also developed an IFSP Strategic Plan; created an IFSP Community Coordination Program; organized an IFSP State Council and Regional Councils as forums for informing stakeholders about the IFSP and obtaining their input; continued to develop enhancements to the IFSP Funding Program; and undertook an initiative for a family-to-family and peer-to-peer mentoring program.

A year ago, the sixteenth Review Period study found that DBHDS had continued to make progress across most of the Indicators associated with these three Provisions. Some of DBHDS's IFSP strategic initiatives were still in the preliminary planning or early implementation stages, but had good potential for moving the Commonwealth toward compliance. In some areas, the development and/or implementation of the strategies intended specifically to achieve the Indicators had not yet been finalized, and many elements of the required documentation had not been completed. Although more work, documentation and performance reports were needed to achieve many of the Indicator measures, three major areas continued to need significant progress. These were:

- Identifying the performance and outcomes measures of the IFSP (1.04), including the development of capacity for the collection and the analysis of the needed data;
- Defining who would be considered "most at risk for institutionalization" (1.02) for the purposes of the IFSP; and
- Finalizing the eligibility criteria for case management options (1.09) available to individuals on the waitlist.

These areas of needed progress had also been identified a year prior in the Independent Reviewer's June 2019 Report. Since that time, DBHDS records indicate substantial effort and some progress. However, the Department had not yet finalized significant process and policy decisions.

In other areas, the sixteenth Review Period study found that DBHDS had taken some important steps forward toward implementing the requirements outlined in the Indicators (e.g., providing eligible individuals and families IFSP funding availability announcements), but the documentation of authority and functioning that DBHDS provided were narrative documents without formal provenance. DBHDS still needed to translate these informal narratives into established documents (e.g., policies, procedures, departmental instructions, and reporting) that would demonstrate to the Court the source of its authority and the structure of its IFSP operations. Once finalized, these documents would populate the system of documents, also known as the Library that had been ordered by the Court.

**Eighteenth Period Study**

For the latest study, the Independent Reviewer retained the same independent consultant who, over the past five years, has completed four studies of Virginia's progress toward achieving the Provisions related to the IFSP, the Guidelines for Families, and Peer-to-Peer and Family Mentoring.

The consultant's review included determining the status of the Commonwealth's development of its system of documents, i.e., the Library, that would show the Court the source of Virginia's authority for operating its IFSP (i.e., organizational structure, policies, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, quarterly reports, etc.). The consultant also studied the status of DBHDS's assessments of its IFSP data sources, and its determinations and notifications (Indicator 37.07 for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2.) that these sources provide reliable and valid data that are available for compliance reporting. As with all studies, the Commonwealth was asked to suggest names of those to interview and records to review that document proper implementation of the Provisions being studied.

For each of these three Provisions, this Eighteenth Review Period study found that DBHDS continued to make progress. In some instances, however, the Commonwealth had not finalized or implemented its strategies intended to achieve Compliance. DBHDS's effective implementation of these strategies involves significant process and policy decisions, which it has not yet finalized, nor has it finalized the reporting, determinations of reliable data, and documentation needed to achieve the Indicators.

These policy decisions include:

- Finalizing the definition of who would be considered "most at risk for institutionalization" (1.02) for the purposes of the IFSP;
- Finalizing the eligibility criteria for and informing individuals on the waitlist of the case management options (1.09) available;
- Developing the capacity of the family-to-family support and peer-to-peer and family mentoring programs to ensure they address the specific requirements of the Provisions and their associated Indicators; and

- Identifying measurable indicators (1.04) to assess performance and outcomes of the IFSP, including the development of capacity for the collection and the analysis of reliable and valid data.

DBHDS has taken some important steps toward implementing the requirements outlined in the Indicators for these three Provisions. Going forward, it is important that the Department finalizes and translates its current narrative descriptions of the required policies and practices into formal operational expectations (e.g., policies, procedures, departmental instructions, and reporting capabilities) that are needed to demonstrate the source of its authority and compliance with the IFSP Provisions. As DBHDS makes these four IFSP-related decisions, it will be able to provide documentation of its authority, policies and processes it needs for the Library and for operating its IFSP.

The consultant's study (see Appendix D) includes the facts and analysis related to the Commonwealth's achievement of the Indicators associated with these three Provisions.

**Conclusion**

The Commonwealth met eight of the seventeen Compliance Indicators that comprise the three Provisions, i.e., III.C.2., III.C.8.b., and III.D.5.

Regarding Provision III.C.2., Virginia met Compliance Indicators 1.03, 1.05, 1.08, 1.10, and 1.12 but has not met Compliance Indicators 1.01, 1.02, 1.04, 1.06, 1.07, 1.09 and 1.11. Therefore, the Commonwealth remains in Non-Compliance with Provision III.C.2.

Regarding Provision III.C.8.b., Virginia met both of the Compliance Indicators 17.01 and 17.02. Therefore, the Commonwealth has achieved Compliance with Provision III.C.8.b. for the first time.

Regarding Provision III.D.5., Virginia met Compliance Indicator 19.01, but has not met Compliance Indicators 19.02 and 19.03. Therefore, the Commonwealth remains in Non-Compliance with Provision III.D.5.

## *5. Community Living Options*

**Background**

At the time of the last review in the spring of 2020, DBHDS's documentation demonstrated its concerted effort to promote services in integrated settings and to achieve the Compliance Indicators for Provision III.D.1. The Independent Reviewer's semi-annual Individual Services Review studies had confirmed, and DBHDS's data reports had shown an overall statewide increase in the percentage of individuals receiving services in most integrated settings. The study showed that the Commonwealth had made progress toward achieving many of the associated Indicators by creating reports, assessing and screening children seeking admission to nursing facilities and ICFs, tracking children who were admitted, prioritizing children for transition to community-based settings, and providing information and outreach to families.

One category of concern identified by the consultant who conducted the study was the number of children who continued to be admitted to and remained institutionalized with shift-based care during their critical years of development.

**Eighteenth Period Study**

The Independent Reviewer retained the same consultant to conduct a follow-up study. This review of the Commonwealth's advancements toward achieving the Indicators associated with this Provision confirmed that progress had continued.

However, the Commonwealth had not determined that the data sources for its reports of progress toward compliance provided reliable and valid data. Virginia had agreed to provide data for compliance reporting only after determining it was reliable and valid, consistent with the Compliance Indicators associated with Provision V.D. (Data to Assess and Improve Quality). These Indicators are 37.07 for Provision V.D.3. which must be completed in accordance with Indicators 36.01 and 36.05 for Provision V.D.2. Although DBHDS did not fulfill this essential precursor step, its staff did document its progress toward achieving several Indicators. In fact, some of its progress involved improving data quality. This included developing plans to complete the required annual assessments of its data sources and taking additional steps to remedy known obstacles to its ability to ensure data reliability.

Regarding DBHDS's continued progress, a higher percentage of individuals with waiver-funded services are living in most integrated settings; a focus group was established and it discussed potential barriers limiting the growth of integrated service models for individuals with intense medical and behavioral support needs; and data quality improvements contributed to showing

that the nursing utilization rate had improved during the first six months of Fiscal Year 2020. In addition, DBHDS strengthened its follow through to ensure that CSBs are aware of, report as required, and take actions needed to support children in active discharge status from nursing facilities and ICF/IDDs. DBHDS has also established accountability measures in the CSBs' Community Services Performance Contract for those CSBs not actively involved in a child's discharge planning from a nursing facility or ICF/IID within 30 days of receiving an action letter.

DBHDS initiated efforts to improve data quality in several areas known to have had obstacles to providing reliable data. For example, the quality of the data regarding children in ICFs/IDD and nursing facilities was improved by regular DBHDS contacts with, and on-site visits to these facilities. DBHDS's Office of Integrated Health cross-checked this information with DMAS claims data. DBHDS also reported cross-checking other service information with claims data, which is regularly tested when claims are paid against authorizations and when DMAS conducts post-payment audits.

Despite the Commonwealth's progress in providing a higher percentage of individuals with waiver-funded services in most integrated settings and its efforts to improve data reliability, Virginia has still not made significant progress toward the Agreement's goals for many of its children with IDD, who live in nursing facilities and large ICF/IDDs, to receive community-based services that promote integration and self-sufficiency. Instead, these children continue to spend their developing years living with shift-based care in institutions. For example, twenty-five children from the Commonwealth's March 2016 baseline of fifty children remained residing in a nursing facility as of September 30, 2020. In addition, DBHDS identified another forty-five children with IDD who were not included in the Commonwealth's baseline. Twenty-one of these children also continued to live in a nursing facility as of September 30, 2020.

The Office of Provider Development provided a plan that it had begun to implement to resolve identified concerns and further improve the quality of data reported in its future *Semi-Annual Data Summary Reports*. The Regional Support Teams, which have had difficulty providing reliable data, have moved their data collection process from the back to the front end of the RST process. Looking forward, this is expected to remedy the problem of CSBs failing to notify DBHDS relative to services not being available. The Department reported to the Independent Reviewer that it plans to complete the required annual assessments of several of its data sources in June 2021. These assessments will identify obstacles to the data sources being able to provide reliable

and valid data. These obstacles will then need to be addressed and remedied before these data sources can provide data for compliance reporting.

DBHDS's provider network development tools were also improved: the Department now uses competent marketing and outreach tools to engage service providers interested in expansion. In addition, the DBHDS Provider Data Summaries, Jump Start Funding, and the Jump-Start Calculator are available to complement providers' market research that they previously completed on their own and without this support.

However, DBHDS reports that the pandemic has negatively impacted the availability of providers and slowed the increase in the number of individuals with waiver slots living in the most integrated settings. Properly implementing COVID-19 precautions led to a decline in the number of service authorizations for Community Engagement and Community Coaching. DBHDS expects that suspended or cancelled authorizations for these services will be renewed as COVID-19 precautions are eased. It may take some families many months, though, before they are comfortable allowing family members to attend programs that congregate participants indoors.

The specific facts and analysis related to the Commonwealth's achievement of the twenty-three Compliance Indicators (18.01 – 18.23) associated with the Community Living Options Provision III.D.1., is included in Appendix E.

**Conclusion**

The Commonwealth provided data reports that showed achievement of eleven of Provision III.D.1.'s twenty-three Compliance Indicators: 18.01*, 18.10, 18.11, 18.12, 18.13, 18.14, 18.15, 18.16, 18.17, 18.19* and 18.22, but has not met twelve Indicators: 18.02, 18.03, 18.04, 18.05, 8.06, 18.07, 18.08, 18.09, 18.18, 18.20, 18.21 and 18.23.

* *Note*: Since DBHDS has not yet determined that the sources of its data provide reliable and valid information available for compliance reporting, determinations of "met" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

## *6. Independent Living Options*

**Background**

In November 2013, the Independent Reviewer's consultant completed the first of six reviews of the status of the Commonwealth's progress toward increasing access to independent living options for individuals in the target population. Virginia's Plan to Increase Independent Living Options (Plan) was initially developed, as required, by the assigned housing coordinator at DBHDS and in coordination with representatives from the Commonwealth's sister agencies: the Department of Medical Assistance Services (DMAS), the Virginia Board for People with Disabilities, the Virginia Housing Development Authority (VHDA), the Virginia Department of Housing and Community Development, as well as others determined by DBHDS. Virginia had included the relevant term, as described in Provision III.D.7. in its annual performance contract with the CSBs, as required.

This Plan, which continues to be updated annually, includes as required the estimated number of individuals who would choose the independent living options, as well as recommendations to provide access to these independent housing settings.

The last study from the spring of 2019 reported that 925 individuals in the Agreement's target population were living in their own homes – an increase of 582 individuals since July 2015 – and that 613 new independent housing options had been created. The Commonwealth had been most successful in funding individuals in independent housing using resources through VHDA Vouchers, State rental assistance, and local Public Housing Authorities (PHAs), but had not listed any independent housing options in Low Income Housing Tax Credit (LIHTC) properties. The 2019 review noted that the Plan included a much more aggressive development for Fiscal Years 2020 and 2021. The Independent Reviewer determined that the Commonwealth had maintained Sustained Compliance with Provisions III.D.2, 3, 4 and 7.

**Eighteenth Period Review**

This period, the Independent Reviewer sought to determine whether the Commonwealth had continued to maintain Sustained Compliance with the Independent Living Options Provisions III.D.2, 3, 4 and 7.

Virginia's most recent Plan (dated January 29, 2021) was developed and updated as required, under the supervision of a DBHDS dedicated housing coordinator and in cooperation with the Commonwealth's sister agencies. Representatives from these agencies are the members of

Virginia's Integrated Housing Advisory Committee. The required term continued to be included in the performance contract with the CSBs, and the DBHDS housing coordinator produced quarterly reports of actual outcomes compared with the measurable goals included in the Plan.

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

| **Independent Housing Outcomes** | | |
|---|---|---|
| **Date** | **# in own home* (% of goal achieved)** | **# of rental resources** (% of goal achieved)** |
| June 2015 | 341 (baseline) | |
| March 2019 | 925 (116%) | 613 |
| December 2019 | 1,034 (86%) | 798 (117%) |
| June 2020 | 1,376 (114%) | 833 (122%) |
| December 2020 | 1,512 (81%) | 993 (117%) |
| **March 2021** | **1,642 (88%)** | **993 (117%)** |

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

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

DBHDS formalized the development of its Office of Community Housing, under the leadership of its housing coordinator, and devoted increased resources to create Regional Implementation Teams in each of its five Regions to coordinate independent housing options.

The Commonwealth had previously set an aggressive goal to double the number of individuals living in their own home from 925 in March 2019 to 1,860 in March 2021. It is notable, and a strong sign of the number of initiatives underway, that the Commonwealth was able to increase this number over this two-year period to 1,642 – a growth of 637 (+77.5%). This increase is especially impressive given the disproportionate impact of the pandemic on individuals with disabilities, their caregivers and provider agencies that ensure caregivers are available, trained, and supervised.

As of April 1, 2021, the Commonwealth finally promulgated its permanent DD waiver regulations for its HCBS waiver programs that were redesigned four years ago. By advancing its regulatory framework, Virginia is conveying to the provider community its commitment to developing, delivering and sustaining more integrated residential service models. With DMAS's and DBHDS's future expectations now clear, providers will be less reluctant to develop the necessary new services to support individuals who choose to live, and receive their support services, in one of the new independent living options.

The DD waiver regulations also permit rate structures for supported living services to be combined with units that are leased by the individual. DBHDS conducted a Housing Exploration series in March 2021 that walked individuals in congregate settings through the steps of imagining and understanding independent living. The individuals who participated heard directly from their peers who described their own experiences transitioning to independent living options. The series was well received and another is planned for summer 2021. DBHDS reports being in the initial stages of working on a learning collaborative to promote changes with service providers to increase individuals' opportunities for independent living with combined support packages and rental subsidies.

**Conclusion**

The Commonwealth has maintained Sustained Compliance with Provisions III.D., III.D.3., 3a,.3bi-ii., and III.D.4.

## *7. Discharge Planning and Transition from Training Centers*

**Background**

The Agreement's Section IV is large and broad, including nearly fifty Training Center Discharge Planning and Transition Provisions. These were established to ensure fulfillment of the Commonwealth's "long-standing goal and policy" to transition individual facility residents from an institutional model of care to a community-based system that is designed to meet the needs of all individuals with ID/DD, including those with the most complex needs. The Court recognized when it approved the Agreement that the decision whether the Commonwealth would cease residential operations at any Training Center lies not with DBHDS, a negotiated Settlement, or the Federal Court, but with the Commonwealth's General Assembly.

To achieve this long-standing goal, the Commonwealth committed to an annual schedule of creating a total minimum of 805 waiver slots over ten years. These would enable individuals living in Training Centers to transition to a waiver-funded community-based services system.

Since July 1, 2011, the beginning of the Agreement's ten-year schedule, the Commonwealth implemented new policies and procedures to benefit those who were living in Training Centers. These spell out how Virginia ensures that individuals transition to and are served in the integrated community-based settings appropriate to their needs and informed choice. Specifically, the Commonwealth has developed and implemented a range of processes at all Training Centers that include:

- Discharge and transition plans for all residents;
- Active transition planning participation for the individuals and their authorized representatives;
- 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;
- Personalized goals that promote the individual's growth, well-being and independence;
- Individualized support plans to transition into the most integrated setting consistent with informed individual choice and needs;
- Choice among services providers that can provide the needed supports;
- Community Integration Managers at all Centers to provide oversight, guidance, and technical assistance to address or overcome barriers to discharge;
- Regional Support Teams, each coordinated by the Community Integration Manager (CIM), to identify and address obstacles to transition to a most integrated setting of four or fewer individuals;
- Family-to-family and peer-to-peer programs to facilitate conversations and meetings with individuals currently living in the community and their families;
- Restrictions on transfers to a congregate settings with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options;
- Active transition participation of the selected provider;
- Essential supports in place at the individual's community placement prior to discharge; and
- Post Move Monitoring in each Region to proactively identify and address gaps in care.

By developing and implementing these policies and processes, DBHDS created an effective organizational structure and process to facilitate the transition and discharge of Training Center residents. By the spring of 2020, during the Sixteenth Review Period, the Commonwealth had ceased residential operations at the fourth of the five Training Centers that it was operating when the Agreement began. At that time, the Independent Reviewer confirmed that the remaining facility, the South Eastern Virginia Training Center (SEVTC), had maintained the discharge and transition policies and processes required by the Agreement.

As shown in the table below, Virginia's Training Center census declined steadily from 1,084 on June 30, 2011, to 73 on May 3, 2021.

**Virginia Training Center Census**
**June 30, 2011 – May 3, 2021**

| **Training Center** | June 30, 2011 | June 30, 2012 | June 30, 2013 | June 30, 2014 | June 30, 2015 | June 30, 2016 | June 30, 2017 | June 30, 2018 | June 30, 2019 | June 30, 2020 | May 3, 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **SVTC** | **242** | 197 | 114 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **CVTC** | **381** | 342 | 301 | 288 | 233 | 192 | 144 | 86 | 45 | 0 | **0** |
| **NVTC** | **157** | 153 | 135 | 106 | 57 | 0 | 0 | 0 | 0 | 0 | **0** |
| **SEVTC** | **123** | 104 | 84 | 75 | 69 | 65 | 72 | 73 | 71 | 78 | **73** |
| **SWVTC** | **181** | 173 | 156 | 144 | 124 | 98 | 70 | 17 | 0 | 0 | **0** |
| **TOTALS** | **1084** | **969** | **790** | **613** | **483** | **355** | **286** | **176** | **116** | **78** | **73** |

In January 2020, the Parties informed the Court they had agreed, with minor exceptions, that the Commonwealth had achieved Compliance with all but three of the Training Center discharge planning and transition Provisions. The Parties agreed that a future determination of Compliance for these three Provisions, which all have a single area of non-compliance, i.e., the lack of integrated day opportunities and supported employment, would occur when compliance is achieved with the Compliance Indicators for Provision III.C.7., Integrated Day Opportunities and Supported Employment.

**Eighteenth Period Review**

During this Eighteenth Review Period, the Independent Reviewer interviewed Commonwealth officials, reviewed DBHDS and SEVTC records, and verified that SEVTC has continued to operate consistent with the policies and processes required by the Agreement. The DBHDS commitment to sustain Compliance is reflected in its careful attention to modifying the SEVTC structure and management processes to incorporate the policies and procedures required by the Agreement into the roles and practices at a smaller facility. For example, the Facility Director's job description at SEVTC includes multiple responsibilities required by the Agreement, such as functioning as the SEVTC CIM, conducting Post-Move Monitoring visits, ensuring the completion of mandated training, co-facilitating discharge planning and status meetings, and facilitating quality improvement activities.

**Conclusion**

The Commonwealth has maintained Sustained Compliance with Sections IV.; IV.A., IV.B.3,5.a-e.ii.,6,7; B.9.a.-c., B.11.a.-b., and B.15; IV.C.1.-7.; IV.D.1.-4, and VI.D..

## *8. Individuals with Complex Medical Support Needs*

**Background**

For each of his Reports to the Court, the Independent Reviewer has examined the supports provided to a cohort of individuals with IDD. To conduct these examinations, the Independent Reviewer developed an Individual Services Review (ISR) methodology and Monitoring Questionnaire. The cohorts for these ISR studies were selected to provide information regarding the extent to which the Commonwealth's community-based service system identified and met the needs of individuals in various subgroups of the Agreement's target population.

In the Agreement, Virginia committed to develop and implement several quality review processes to ensure that its programs are of good quality, are protecting people from harm and are meeting the needs of the individuals served. One of these processes is annual Quality Service Reviews (QSRs), which are required to collect information from face-to-face interviews with the individual, relevant professional staff and others involved in the person's life, as well as from face-to-face assessments and from on-site direct observations of an individual's program settings. The QSR evaluation must be conducted consistent with a variety of Indicator requirements. These requirements include that the reviewers who conduct the QSRs have qualifications commensurate to what they are expected to review (53.01). The QSR reviewers determine whether providers have identified and met individuals' needs, including healthcare needs. The

Agreement also requires that the information collected from the QSRs be used to improve practice and the quality of services on the provider, CSB, and system-wide levels.

DBHDS began planning a QSR process in 2012. In 2013, the Independent Reviewer studied the Commonwealth's plans and determined that they did not address many of the Agreement's requirements. In 2014, DBHDS contracted with a private vendor to conduct the required QSRs. In 2015, the Independent Reviewer studied the vendor's tools and planned evaluation processes and informed DBHDS that they were seriously flawed. Without substantially addressing these flaws, the vendor conducted QSRs in Fiscal Years 2016, 2017 and 2018. In December 2017, the Independent Reviewer reported these ongoing inadequacies – primarily a lack of standards and definitions of terms for the review methodology and for determining whether needs are met. In addition, the QSR auditors were insufficiently qualified to make judgments related to the QSR's clinically driven inquiries and indicators. DBHDS tried to make the needed improvements in 2018, but being largely unsuccessful, the Department decided to seek a different vendor. The subsequent lengthy process to select and retain a new vendor resulted in DBHDS cancelling the 2019 round of QSRs.

Then in January 2020, when the Parties agreed to a set of Compliance Indicators for all Provisions that the Commonwealth had not yet achieved, fifteen Indicators for the required QSRs were included.

DBHDS selected a new vendor in the spring of 2020. In May and June of that year, to solicit review and feedback, DBHDS shared the vendor's draft tools and proposed QSR methodology with the Independent Reviewer. Although the tools and methodology were much improved, and the vendor made some suggested upgrades, the Independent Reviewer continued to point out several fundamental concerns. Primary among these was the long-standing concern that the vendor's minimum qualifications for its QSR auditors, as well as for its planned oversight and training, were insufficient. The vendor's non-clinician QSR evaluators were unlikely to have the knowledge and insight to discern whether individuals' needs were identified and met, as necessary. These kinds of judgments require the QSR evaluators to have the minimum qualifications, experience and training necessary to have sufficient awareness of healthcare and other clinical issues, so they can identify and pursue any initial indications that might suggest that the provider is not meeting an individual's clinical and healthcare needs.

**Eighteenth Period Study**

The Independent Reviewer prioritized an Individual Services Review (ISR) study that utilized the ISR Monitoring Questionnaire to determine whether an individual's complex medical support needs were being met. This study, however, differed from previous ISR studies in an important aspect: the cohort was selected from a list of individuals whose services had already been evaluated as part of DBHDS's 2020 QSR process.

This latest ISR study focused primarily on evaluating whether the Commonwealth's QSR auditors, tools and processes were sufficient to meet certain requirements of Provisions V.I.1. and V.I.2. Of the associated fifteen QSR Compliance Indicators, the Independent Reviewer selected the following three for review:

- V.I.1. The QSRs assess on a provider level whether "Providers keep service recipients safe from harm, and access treatment for service recipients as necessary" (Indicator 51.04 c.); and
- V.I.2. The QSRs assess on an individual service recipient-level and individual provider-level whether "Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk" (Indicator 52.01a.), and "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." (Indicator 52.01c.)

The cohort for this ISR study was the ninety-nine individuals who were living in HCBS waiver-funded sponsored or group home residential services, whose Supports Intensity Scale (SIS) evaluation results placed them in level six and whose services were evaluated during the Person-Centered Review (PCR) portion of DBHDS's 2020 QSR study. From the study's cohort, a sample of thirty-four individuals was randomly selected, which allows this study's findings to be generalized to this cohort with a 90% confidence level. In order to ensure geographic representation, the proportional random sample was stratified by Region.

In analyzing the findings from the ISR Monitoring Questionnaire, which were completed by the Independent Reviewer's nurse consultants, comparisons were made with the findings from DBHDS's 2020 QSR evaluations of the same individuals and for the same period. To determine any discrepancies, the ISR registered nurses' findings were compared with the QSR evaluators' findings. As a result of this comparative analysis, the status of the Commonwealth's achievement with the QSR Indicators that are referenced above could be assessed.

As the Independent Reviewer previously indicated, for a DBHDS QSR study to achieve the associated Indicators, the reviews must be conducted in accordance with these Indicator requirements for collecting sufficient information. The Indicators require that the QSR evaluation collect information utilizing face-to-face on-site interviews and assessments and direct observations of the individual's program settings. Neither the 2020 QSR evaluations, nor the Eighteenth Period's ISR process were able to achieve these requirements due to the appropriate implementation of Virginia's COVID-19 precautions. Instead, both of these reviews were conducted remotely.

Following the finalization of the ISR Monitoring Questionnaires, the nurse consultants compared their findings with the responses documented in the individual summaries from the PCRs conducted by the QSR auditors. The QSR summaries were primarily "Yes" or "No" responses to the elements contained in the PCR Tool which were administered to the same thirty-four individuals reviewed in the ISR study. All of the questions found in the completed QSR tools were reviewed and compared to the ISR Monitoring Questionnaire responses. The differences identified are summarized in the two Comparison Charts included as Attachment A.

Several constraints were identified throughout the course of this ISR study. First, the documentation provided by DBHDS was not consistent for all individuals reviewed. The ISR reviewers may not have had all the documents actually reviewed by the QSR auditors. Therefore, it is possible that certain identified discrepancies in the respective findings were not actual discrepancies but were instead the result of reflected inconsistent sources of information. Second, unlike previous ISR studies, the interviews for this study were focused on past rather than current facts or circumstances. Although most of the individuals' residential contacts who were interviewed were knowledgeable about the individual and their health-related supports, some contacts had difficulty answering questions about the past with accuracy or sufficient detail. Third, key documents usually examined during site visits to the residence were simply not available for review.

DBHDS's QSR vendor's documentation of the 2020 QSR evaluations showed that the Commonwealth's service providers had met virtually all of the healthcare needs of a significant sample of all individuals with complex medical needs and waiver-funded sponsor or group home residential services. Based on the documents provided for review, however, this ISR study found that DBHDS's 2020 QSR evaluations failed to identify the vast majority of unmet healthcare needs for the individuals studied. (A random selection of thirty-four from a cohort of ninety-nine

individuals allows the ISR study's findings to be generalized to the cohort of individuals with complex healthcare needs.) For example:

- The ISR reviews identified nine of the thirty-four individuals (26.5%) who were not protected from potential risk of harm; whereas the QSR reviewers identified zero of thirty-four individuals (0%) was at potential risk of harm.
- The ISR reviews determined that nineteen of the thirty-four individuals (55.9%) needed assessments or consultations that were not recommended or ordered; whereas the QSR reviewers identified one of thirty-four individuals (0.03%) needed such assessments.
- The ISR reviews determined that fifteen of the thirty-four individuals (44.1%) lacked access to dental care; whereas the QSR reviewers identified zero of thirty-four individuals (0.0%) needed dental care.
- The ISR reviews did not find evidence that necessary lab tests were completed for seven of the thirty-four individuals (20.6%); whereas the QSR reviewers identified the lack of evidence of necessary lab tests for zero of thirty-four individuals (0.0%).
- The ISR reviews identified four of the thirty-four individuals (11.8%) whose ISPs required but were not modified; whereas the QSR consultants identified zero of thirty-four individuals' (0.0%) ISPs that were not modified as needed. Both reviews found the ISP for one individual had been modified as required.

As demonstrated by these points, the 2020 QSR PCR assessments erroneously determined that the Commonwealth's providers met virtually all the healthcare needs of the individuals studied. As a result, these inaccurate findings severely compromised the Commonwealth's ability to fulfill the Indicator requirements and the fundamental purpose of the QSR study. For example, the 2020 QSR study failed to identify that a significant percentage of individuals lacked dental care or that the lack of such care reflected an unmet healthcare need. This failure occurred despite previous ISR studies having identified the lack of dental care as a significant gap in healthcare services, which this period's ISR study again verified. In addition, the residential providers interviewed for this ISR study expressed serious concerns about this lack of access to dental care, appreciating what a significant obstacle it is to meeting the healthcare needs of these individuals.

It is not possible to determine definitively whether the root cause of this erroneous finding of DBHDS's 2020 QSR assessments was the QSR interview tools, the remote assessments, another aspect of the QSR process, or the QSR auditors' lack of clinical awareness. It is certain, however, that the 2020 QSR study did not identify the lack of dental care as an unmet healthcare of individuals with complex medical needs. As a result, this significant concern was not included in

the QSR Summary data for the Quality Improvement Council (QIC) to consider as a potential Quality Improvement Initiative to improve practice and the quality of services on the individual, provider, CSB or system-wide level.

Another discrepancy between the findings of the ISR and QSR studies raises additional concerns. DBHDS's 2020 QSR study's PCR interview tool asks questions on health risks related to eight serious health conditions that DBHDS has identified as frequently associated with potentially preventable deaths of individuals with IDD. The ISR study found that most of the reviewed individuals experienced symptoms related to these eight conditions, including problems with constipation, seizures and choking precautions, whereas the non-clinician QSR auditors usually did not identify these concerns.

**Conclusion**

The Commonwealth has not met the three QSR Compliance Indicators 51.04 c., 52.01 a. and 52.01 c. which were the focus of this latest ISR study and therefor remains in Non-Compliance.

Regarding Provision V.I.1., Virginia has not met Indicator 51.04 c.

Regarding Provision V.I.2., Virginia has not met Indicators 52.01a. and c.

## *9. Quality and Risk Management*

**Background**

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

In January 2020, during the ninth year of the Agreement's ten-year implementation schedule, the Parties jointly submitted to the Federal Court a complete set of Compliance Indicators for all Provisions with which the Commonwealth had not yet been determined to have Sustained Compliance. Virginia then created a numbering system that listed 193 Indicators for the twenty-four Provisions in the QRM System that had not yet been achieved. Provisions V.B. (Indicators

29.01 – 29.33) and V.C.1. (Indicators 30.01 – 30.11) comprise forty-four of the 193 Section V Indicators.

Over the past year, the Independent Reviewer determined that the Commonwealth had not met some of the Indicator requirements for both V.B. and V.C.1. Regarding V.B., the Independent Reviewer determined in his Seventeenth Report to the Court (December 2020) that the Commonwealth had not met the Indicator studied (29.08) because findings from its Fiscal Year 2020 Quality Service Reviews were not yet available. Six months earlier, in his Sixteenth Report (June 2020), the Independent Reviewer determined that the Commonwealth had not met the V.C.1. requirement to have a functioning risk management process that uses triggers and threshold data to identify individuals at risk or providers that pose risks.

The last study, conducted in the fall of 2020, documented that DBHDS's Office of Data Quality and Visualization (ODQV) had implemented a multi-phase initiative that delved deeply into issues of data reliability and validity across multiple systems. The initial phases, which involved a preliminary assessment of many of the data source systems, was followed by a vendor-developed "maturity matrix" that DBHDS used to guide production of its *Data Quality Plan Source Systems Assessments: Findings and Recommendations December 2019*. During the Sixteenth and Seventeenth Periods, ODQV completed assessments of DBHDS's Data Warehouse and eleven of its data source systems; and in September 2020, the DBHDS *Data Quality Monitoring Plan: Major Findings and Recommendations from the First Year of Implementation* was presented to the DBHDS Quality Improvement Committee (QIC). It detailed the factors contributing to ongoing concerns with the reliability and validity of reported data, including for compliance determinations. In recognition of the inherent flaws in the source systems, and to improve data quality, DBHDS staff developed manual solutions for reviewing and adjusting data from some source systems to eliminate known data problems. Many data source systems require manual processes to ensure reliable data. However, the manual processes were not documented and were therefore subject to interpretation and human error. Without documented data provenance, DBHDS could not demonstrate that its data were reliable.

The functionality of the data across Virginia's quality and risk management systems continued to be severely hampered by the lack of valid and reliable data. This impeded DBHDS staff's ability to complete meaningful analyses of the various data collected to effectively identify and implement needed improvements. The implications of data quality problems continued to be an over-arching theme that negatively impacted DBHDS's ability to fully implement its

commitment to the continuous quality improvement goals of its *Quality Management Plan* and the related Indicator requirements.

**Eighteenth Period Study**

For this latest study related to Provisions V.B. and V.C.1, the Independent Reviewer retained the same consultants as previously, and requested that DBHDS provide its records that document proper implementation of these Provisions and their associated Indicators.

This review found that, overall, the Commonwealth had continued to make progress in the development of a culture of quality and in the maturation of its quality and risk management processes. Virginia reported making progress toward meeting many of the forty-four Indicators in Provisions V.B. and V.C.1, and the study confirmed the Commonwealth had achieved seventeen of them. However, although DBHDS provided data intended to document its progress, it did not provide the required determinations that these data actually met the Agreement's standards for compliance reporting.

For example, DBHDS did not provide the requested dates of its determinations that the data provided were reliable and valid. It also did not provide a QIC directive or workplan to address the recommendations from the *Data Quality Plan* or an IT strategic plan to remedy the problems identified in the Department's data quality assessments. DBHDS did provide documentation that indicated its data source systems continued to present barriers to the collection and production of reliable and valid data. It also reported that the required annual reliability and validity assessments of many of its data sources would not occur until June 2021.

V.B.

Overall, the Commonwealth reported progress in implementing the *DBHDS Quality Management Plan FY2020,* which emphasizes DBHDS's commitment to continuous quality improvement. Its progress included meeting the Indicators related to: establishing the leadership and internal organizational committee structure needed to implement its quality improvement system; its Offices of Licensing and Human Rights performing quality assurance functions; its Offices of Licensing assessing and monitoring provider compliance with the serious incident reporting requirements in the Licensing Regulations; and implementing an incident management process and related protocols.

This Period's study also concluded that, while the lack of assured data quality remains an overarching barrier to the implementation of a continuous quality improvement environment, the lack of the measurability of quality improvement initiatives and corrective action plans also remained an issue that must be addressed. When initiatives and plans cannot be adequately measured, their impact cannot be reliably determined. Being able to reliably determine whether its quality improvement initiatives and corrective action plans achieve sufficient impact is essential for the Department's determinations regarding the need for further actions. This in turn is an essential component of an effective and continuous quality improvement process.

V.C.1.

Despite ongoing concerns with data reliability and validity, DBHDS continued to make progress in refining its systems and processes to provide clear expectations, guidance, training, and technical assistance, especially to service providers who in turn must develop structured and effective risk management processes.

DBHDS's licensing regulations require service providers to develop an organizational structure and implement a written plan to build and utilize the elements of an internal risk management system. Overall, the regulations require providers to identify, monitor, reduce, and minimize harms. To achieve these required actions and desired outcomes, each provider must appoint a staff member to be responsible for the risk management function and to assure the staff member has training relevant to effective risk management programs. At least annually, the providers must conduct systemic risk assessments that incorporate uniform risk triggers and thresholds and include assessment of the environment of care, clinical assessment or reassessment processes, staff competence and adequacy of staffing, use of high-risk procedures including seclusion and restraint, and a review of serious incidents. Providers must also conduct and document, at least annually, a safety inspection for each location they operate to identify and address recommendations for safety improvement.

To support providers' efforts to comply with its regulatory requirements, DBHDS published and provided access to guidance documents and reference materials on topics that include development and implementation of a quality improvement program, a risk management program, and serious incident reporting. DBHDS also developed a Risk Awareness Tool and now requires providers to utilize it in the development and revision of individualized services plans.

DBHDS significantly improved consistency in its processes and procedures to assess provider compliance with licensure regulations. The Department expanded and enhanced the roles and responsibilities of staff in its Office of Licensing's Incident Management Unit (IMU). This unit reviews and triages each serious incident report submitted by licensed providers and conducts follow-up on issues identified from these reviews. They also track and initiate corrective actions for any late reporting of serious incidents.

In addition, DBHDS established care concern thresholds for five high-risk issues. The IMU staff review each serious incident report and the provider's history of similar serious incidents to determine if one or more of these thresholds is met. Continued progress is needed to ensure consistency in documentation of findings, especially relating to those regulations where compliance could not be determined because the provider did not have a serious incident or care concern identified during the evaluation period.

**Conclusion**

The Commonwealth met seventeen of the forty-four Compliance Indicators that comprise the two QRM System Provisions V.B. and V.C.1. The extent of the Commonwealth's achievement of these Indicators is detailed in the consultants' full report – see Appendix G.

Regarding Provision V.B., Virginia met twelve Compliance Indicators 29.02, 29.03, 29.04, 29.05, 29.06, 29.07, 29.11, 29.12, 29.13*, 29.15*, 29.31, and 29.32, but has not met twenty-one Indicators 29.01, 29.08, 29.09, 29.10, 29.14, 29.16, 29.17, 29.18, 29.19, 29.20, 29.21 29.22, 29.23, 29.24, 29.25, 29.26, 29.27, 29.28, 29.29, 29.30, and 29.33. Therefore, the Commonwealth remains in Non-Compliance with Provision V.B.

Regarding Provision V.C.1., Virginia met five Compliance Indicators 30.01, 30.02, 30.03, 30.04, and 30.06, but has not met six Indicators 30.05, 30.07, 30.08, 30.09, 30.10, and 30.11. Therefore, the Commonwealth remains in Non-Compliance with Provision V.C.1.

* *Note*: Since DBHDS has not yet determined that the sources of its data provide reliable and valid information available for compliance reporting, determinations of "met" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

# IV. CONCLUSION

During the Eighteenth Review Period, Virginia, through its lead agencies DBHDS and DMAS, and their sister agencies, continued its diligent efforts and progress toward fulfilling the requirements of the remaining Provisions of the Agreement. The Commonwealth achieved this progress while continuing to respond to the pandemic's impact, particularly its service disruptions and disproportionate negative consequences for the target population and their essential care givers. The Independent Reviewer determined that Virginia newly achieved Compliance with three of the Agreement's Provisions and met many of the Compliance Indicators that it had not previously achieved. However, considerable work remains: much of it in areas where progress has been limited and hampered by long-standing barriers.

In March 2021, as the end of the Settlement Agreement's anticipated ten-year implementation schedule approached, the Court found that the Commonwealth had maintained Sustained Compliance with the Provisions of Section IV (Discharge Planning and Transition from Training Centers) and the related Provision VI.D. The Court also ordered that the anticipated end of the Agreement be extended to July 1, 2022. This extension provides Virginia time to accomplish the remaining Provisions, notably those in the Agreement's Section III (Enhancement of Community Services) and in Section V (Quality and Risk Management).

Achieving these will require the Commonwealth to address and resolve many familiar obstacles, two of which significantly impair Virginia's progress toward achieving an array of the Agreement's Compliance Indicators. These two barriers are:

- The Commonwealth's data sources have still not been determined by DBHDS to provide reliable and valid data that are approved for compliance reporting, and its various committees and work groups have not been informed of this; and
- DBHDS's various quality review processes have not yet demonstrated that they function adequately.

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

# V. RECOMMENDATIONS

The Independent Reviewer recommends that the Commonwealth undertake the thirteen actions listed in the Provision categories below, and provide a report that addresses these recommendations and their status of implementation by September 30, 2021. Virginia should also consider the additional recommendations and suggestions included in the consultants' reports, which are contained in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the Twentieth Review Period (October 1, 2021 – March 31, 2022).

***Case Management***

1. Now that relevant precautions due to the pandemic have been lifted, DBHDS should determine if and how it can accelerate the completion of its review of the *Support Coordinator Quarterly Reviews – Fiscal Year 2022*. The Department's review must be based on a majority of face-to-face visits and assessments having occurred per quarter, as required.

***Crisis Services***

2. DBHDS should evaluate the primary factors that contribute to the significant variance among the Regional REACH programs' achievement of the associated Compliance Indicator performance measures. Based on this evaluation, the Department should then determine needed systemic improvements.

***Behavioral Programming***

3. DBHDS's "quality review and improvement process" (Compliance Indicator 7.20), should include a sufficient and randomly selected sample. Doing this will ensure that findings are generalizable, e.g., to determine the extent to which "behavioral services are adhering to" the *Practice Guidelines*.
4. DBHDS should continue to work with the two professional organizations, Positive Support Behavior Facilitators (PSBFs) and Board Certified Behavior Analysts (BCBAs), to identify barriers and other factors that inhibit behavioral professionals from becoming qualified to serve as behavioral consultants for individuals with IDD.

***Community Living Options***

5. The Commonwealth should create statewide opportunities for individuals with IDD to choose to live together in independent living arrangements by "combining" their supports and rent subsidy budgets.
6. DBHDS should work collaboratively with residential providers to increase their desire, capacity and know-how to deliver services that would facilitate more independent living arrangements, including for individuals that these providers currently support in congregate settings.
7. Virginia should create funding rates that incentivize these residential providers to develop the support services needed for individuals with IDD in independent living arrangements.

***Data to Assess and Improve Quality***

8. DBDHS should clarify its timelines, methodology and processes to assess its data quality. This evaluation of its various data sources should be conducted "at least annually, and includes a review of, at minimum, data validation processes, data origination, and data uniqueness." The Department should then remedy significant barriers to its data quality, determine that its data sources now produce reliable and valid data, and inform its workgroups and committees that the data can be used for compliance reporting.
9. DBHDS should conduct periodic claims checks with DMAS to ensure the quality of its various data source reporting.

***Quality and Risk Management***

10. DBHDS should improve the measurability of its formal initiatives (e.g., quality improvement initiatives and CAPs). This will allow for a more rigorous use of data in reviewing these initiatives' impact, and in supporting future decision-making related to further needed improvements.
11. DBHDS should provide additional guidance to service providers to ensure their effective implementation of the requirements for utilization of risk triggers and thresholds. The Department should also train providers to address the required elements of an annual systemic risk assessment, including specific examples of how the provider is to incorporate the uniform risk triggers and thresholds, as defined by DBHDS.

12. DBHDS should implement a monitoring mechanism that provides sufficient information regarding the extent to which an individual provider appropriately responds to and addresses risk triggers and thresholds. This mechanism must produce recommendations, as needed, for these individual providers to implement. The mechanism must also provide system-level findings and recommendations that DBHDS can then use to update its guidance for providers and disseminate to them.

***Quality Service Reviews***

13. DBHDS should review each of the discrepancies between the findings of the Individual Services Review study and those of the PCR portion of its 2020 QSR study. The Department should then determine whether the ISR findings of healthcare needs not being met are correct. If the ISR nurses' findings are verified, DBHDS should review the root cause(s) of the QSR auditors' failure to identify these healthcare service inadequacies, and take needed corrective actions.
14. DBHDS should modify the QSR assessment processes to ensure that the accurate evaluation of individuals' needs is predicated on the completion of all requisite clinical assessments. In addition, these assessments should be clinically adequate for determining whether individuals' needs, including for healthcare and behavioral services, are identified and met. To achieve this, the Department should address gaps in the adequacy of its vendor's PCR and PQR audit tools.
15. DBHDS should establish minimum qualifications and extended orientation/specialized training for QSR auditors to ensure they are sufficiently aware of the health conditions that disproportionately impact individuals with IDD.

# VI. APPENDICES

# APPENDIX A

## WAIVER SLOTS

UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia
Civil Action No. 3:12 CV 059

## WAIVER SLOTS: REQUIRED VERSUS CREATED
## FISCAL YEARS 2012 - 2021

| **Fiscal Year** | **Facility Transition** | | **ID/CL** | | **DD/FIS** | | **DS/BI** | | **Total** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Required | GA* approved | Required | GA approved | Required | GA approved | Required | GA approved | Required | GA approved |
| FY 2012 | 60 | 90 | 275 | 495 | 150 | 180 | - | - | 485 | 765 |
| FY 2013 | 160 | 160 | 225 | 300 | 25 | 50 | - | - | 410 | 510 |
| FY 2014 | 160 | 160 | 225 | 575 | 25 | 130 | - | - | 410 | 865 |
| FY 2015 | 90 | 90 | 250 | 25 | 25 | 15 | - | - | 365 | 130 |
| FY 2016 | 85 | 85 | 275 | 325 | 25 | 40 | - | - | 385 | 450 |
| FY 2017 | 90 | 90 | 300 | 315 | 25 | 365 | - | - | 415 | 770 |
| FY 2018 | 90 | 100 | 325 | 80 | 25 | 344 | - | 60 | 440 | 584 |
| FY 2019 | 35 | 60 | 325 | 154 | 25 | 414 | - | - | 385 | 628 |
| FY 2020 | 35 | 60 | 355 | 160 | 50 | 807 | - | 40 | 440 | 1067 |
| FY 2021 | - | 20 | 360 | 140 | 75 | 650 | - | - | 435 | 810 |
| **Total** | **805** | **915** | **2915** | **2569** | **450** | **2995** | | **100** | **4170** | **6579** |

*General Assembly (GA)

# APPENDIX B

## CASE MANAGEMENT

**by**

**Ric Zaharia Ph.D.**

Consortium on Innovative Practices

TO: Donald Fletcher

FROM: Ric Zaharia, Ph.D.

RE: Period 18 - Compliance Indicators for Case Management

DATE: April 30, 2021

Introduction

This report constitutes my third review of the compliance indicators for Case Management services. In the two reviews during 2020 DBHDS provided documentation that showed achievement of four indicators out of nineteen indicators included in this review. Most indicators were outstanding because activity could not be adequately considered due to the data source, the SCQR-FY20 (Support Coordinator Quality Reviews). It had assessed CY19 records which predated establishment of definitions and tools related to "change in status or needs" and "appropriately implemented services". In that SCQR cycle DBHDS reported that 78% of CSBs achieved nine of the ten required elements (CI-2.06-2.15), which was below the benchmark of 86%. Furthermore, CSB's failed to provide sample reviews for 7% of those requested by DBHDS, which very likely introduced a bias into the final results.

For this report the documents I reviewed are identified in Attachment A and can be located in the Box library. Clarifying interviews were conducted with Eric Williams, Director of Provider Development, in mid-March.

Summary of Findings

In general, DBHDS provided documentation and information for the 18th Period that showed achievement of nine of twenty-one distinct compliance measures (using Virginia's numbering system). Although these achievements demonstrated commitment and progress, the outstanding indicators still could not be achieved due to the data source, the SCQR-FY20, which pre-dated finalization of definitions, tools and implementation related to "change in status or needs" and "appropriately implemented services", and the incomplete response from CSBs. Other than these shortcomings, DBHDS had adequately completed a full annual cycle of their planned SCQR activities, including identifying several quality improvement initiatives.

This 18th Period study found that the SCQR-FY21 is currently underway (i.e., during Q3-4, FY21) and is assessing case manager activity for CY20. Results are not available at the time of this review. DBHDS reports improvements in CSB response rates, which, if sustained, will help ensure the validity of future SCQR results. However, COVID precautions implemented in March 2020 remain in place and are set to expire May 1, 2021. Since case management performance is measured via

compliance indicators that require face to face on-site activities and since the SCQR-FY21 is assessing case manager activity from CY20, this cycle will review some proportion of records following finalization of definitions, tools and implementation related to "change in status or needs" and "appropriately implemented services", but they will not be usable for this purpose because of remote implementation (i.e. no face to face). Therefore, it may be a review of SCQR-FY22 before DBHDS can demonstrate that it has achieved the requirements of the compliance indicators. Records sampled between May and December of 2021 will be usable. It may be feasible to make an earlier assessment of case management performance based on a partial sample review, if DBHDS can accelerate its plans to sample May-December, 2021 records for SCQR-FY22.

The timeline for the SCQR over the next few years is laid out below. Understanding the timing and complexity of the process, is important to forecasting the earliest opportunity for compliance.

| | | | | |
|---|---|---|---|---|
| **CY19 records** | | | | |
| → | **Q3-4 FY 20 review, SCQR-FY20** | | | |
| | **CY20 records** | | | |
| | → | **Q3-4 FY 21 review, SCQR-FY21** | | |
| | | **CY21 records** | | |
| | | → | **Q3-4 FY 22 review, SCQR-FY22** | |
| | **1.1.20** | **1.1.21** | **1.1.22** | **1.1.23** |

The DBHDS *Case Management Data Plan, 1.29.21* is basic but competently designed. As a baseline all CSBs are being surveyed as to the reliability and validity of their data collection processes. By May 2021 a process is planned to directly sample CSB case management data quarterly. Although the CMSC is actively involved with statisticians from ODQV, it was not clear from interviews that the ODQV has or will determine that the case management data sources provide reliable and valid data for compliance reporting (per CI-37.07for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2.).

The table below recaps the status of the compliance indicators you assigned to me to review. All documents should be searchable within the DBHDS Box library.

**Table I**
**Case Management Status**

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| ***SA Provision- III.C.5.i:*** *Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs* | | | | |
| 2.01 | **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<br><br>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." | **Email correspondence between DF and EW dated 6.19.20 memorializes Independent Reviewer's input and agreement regarding the definitions of "change of status or needs" and the elements of "appropriately implemented services."** | **DBHDS has incorporated these definitions into its assessment tools, training, policies, and contract expectations. (see Attachment A)** | **MET** |
| 2.02 | 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. | **SCQR-FY 20 was completed for a CY 19 sample before the two required changes described above were implemented.** | **SCQR surveys are planned for implementation during Q3-4, FY21, which will cover CY20. Therefore, this task has not been achieved.** | **NOT MET** |
| 2.03 | DBHDS will pull an annual statistically significant stratified statewide sample of individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB. | **Although drawn as a statistically significant, stratified sample (*SCQR Methodology & Supporting Processes, 2.23.21*), the CSB response** | **This indicator has not yet been achieved.** | **NOT MET** |

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| | | **rate missed the DBHDS target (374 responding vs 401 sampled) per the *SCQR Annual Report, 9.8.20*.** | | |
| 2.04 | 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. | **SCQR-FY 20 was completed for a CY 19 sample in the required manner (see *SCQR Annual Report, 9.8.20* and *CMSC Semi-Annual Reports, FY19-FY20*.) CSBs provided data to DBHDS quarterly as required.** | **The SCQR-FY21 is being implemented Q3-4, FY21, in this manner (see *SCQR Methodology & Supporting Processes, 2.23.21).* This indicator is being achieved.** | **MET** |
| 2.05<br>2.06<br>2.07<br>2.08<br>2.09<br>2.10<br>2.11 | 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:<br>•The CSB has offered each person the choice of case manager. (**III.C.5.c)**<br>• 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)**<br>• 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)**<br>• 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)**<br>• 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)**<br>• 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. | **DBHDS completed analysis of the data at a statewide and CSB level for the review of ten elements. However, SCQR-FY20 was completed for a CY19 sample before the two required changes (2.09 & 2.14) were finalized.** | **SCQR-FY21 surveys are being implemented during Q3-4, FY21, which will cover CY20, so about half this sample should include these changes. Otherwise, the elements now include the required definitions for change in status and appropriate implementation of services, and data have been analyzed regularly in the aggregate (see *Annual Report, 9.8.20* and *CMSC Semi-Annual Reports, FY19-FY20*.) However, these indicators have not yet been fully accomplished.** | **NOT MET** |

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| 2.12.<br><br><br><br><br><br><br><br><br><br>2.13<br><br>2.14<br><br><br><br><br><br><br>2.15 | **(III.C.5.b.i; III.C.5.b.ii)**<br>• The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary. **(III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)**<br>• Individuals have been offered choice of providers for each service. (**III.C.5.c)**<br>• 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)**<br>• 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)** | | | |

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| 2.16 | The Case Management Steering Committee will analyze the Case Management Quality Review data submitted to DBHDS that reports on CSB case management performance each quarter.<br><br>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. | **See *CMSC Monthly Minutes, 4.18.19 to 1.5.21* for a record of the Committee's analysis of the data.**<br><br>**DBHDS analysis of the SCQR-FY20 indicated that for the CY19 sample 78% rather than the required 86% of CSBs met 9 of 10 elements (see *SCQR Annual Report, 9.8.20*). However, SCQR-FY20 pre-dated implementation of the two required definitions and the sample may have had a bias due to the non-responding CSBs, in addition to the self-reporting bias of supervisor ratings. Although drawn as a statistically significant, stratified sample (*SCQR Methodology & Supporting Processes, 2.23.21)*, the CSB response rate missed the DBHDS target (374 responding out of 401 sampled) per the *SCQR Annual Report, 9.8.20.*** | **DBHDS continues to achieve the requirement to analyze case management data submitted by the CSBs quarterly.**<br><br>**This metric has not been achieved.** | **NOT MET** |
| 2.17 | In this analysis any individual CSB that has 2 or more records that do not meet 86% compliance with Case Management Quality Review for two consecutive quarters will receive additional technical assistance provided by DBHDS. | **DBHDS implemented technical assistance for the ten elements in the CY19 sample for the eleven CSBs with 2 or more records that did not meet 86% (see *CRC CSB TA Summary, 10.1.20; CSB Case Management DQI Improvement Reviews- Operational*** | **This task has been achieved for SCQR-20.** | **MET** |

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| | | ***Process, 9.3.20*).** | | |
| *2.18* | If, after receiving technical assistance, a CSB does not demonstrate improvement, the Case Management Steering Committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract and licensing regulations. | **The CMSC made recommendations to the Commissioner re CSB performance and enforcement actions (see *CMSC Recommendations Letter, 11.13.20*). No enforcement recommendations were provided, although CAPs have been required of four underperforming CSBs. On interview, DBHDS reported that Section 9.d. of the CSB *FY19 & FY20 Community Services Performance Contract, undated,* would be followed for CSB non-performance. DBHDS reports that it has only needed to use non-"dispute resolution" contractual processes (notification, clarification, follow-up, CAPs, etc.) to ensure CSB compliance and it has not needed to implement further accountability measures, as all CSBs have been responsive."** | **The referenced section when combined with Exhibit M, give DBHDS sufficient enforcement authority, including financial penalties and termination. Because no CSB is in this position to date, enforcement actions cannot be assessed. Therefore, this indicator is not yet Met.** | **NOT MET** |
| *2.19* | DBHDS, through the Case Management Steering Committee, will ensure that the CSBs receive their case management performance data semi-annually at a minimum. | **DBHDS transmitted their first round of performance data for SCQR-FY20 via *Letters* (10.21.20); these included requests for Corrective Action Plans where appropriate.** | **DBHDS should be sending out a second round for preliminary data on SCQR-FY21 this spring, but until that is accomplished, the indicator measure "semi-annual at a minimum" is Not Met.** | **NOT MET** |
| *2.20* | All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or | **The Independent Reviewer has accepted** | **After 5.1.21 CMSC will need to add CAPs** | **NOT MET** |

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| | DBHDS licensing regulations. Corrective actions for cited regulatory non-compliance will be tracked to ensure remediation. | **the Commonwealth's incorporation of all ten elements. Waiver Regulations were adopted 4.21.21 and are to be enforced beginning 5.1.21. CAPs are tracked on a CMSC *Watch List* (4.6.21).** | **required by Licensing due to citations relating to the ten elements and will need to demonstrate that the required corrective actions were sufficient to ensure remediation. Therefore, this action has not been fully accomplished.** | |
| *2.21* | The Case Management Steering Committee will review and analyze the Case Management data submitted to DBHDS and report on CSB case management performance related to the ten elements and also at the aggregate level to determine the CSB's overall effectiveness in achieving outcomes for the population they serve (such as employment, self-direction, independent living, keeping children with families). | **The CMSC has issued five (5) semi-annual reports since FY19 (see Attachment A). These reports include reviews and analysis of the a) SCQR process and implementation (i.e., ten elements), b) RST timeliness data, c) nineteen (19) key performance indicators from CSBs, d) case manager training, e) WaMS data integrity, and f) Licensing data.** | **This activity is being accomplished.** | **MET** |
| *2.22* | The Case Management Steering Committee will produce a semi-annual report to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. | **The CMSC has issued five (5) semi-annual reports over three fiscal years. The CMSC's most recent *Semi-annual Report* (Q1-2, FY21, 3.19.21) recommended the use of the Tableau graphing interface to improve ease of interpretation of data by the data consumers and proposed an amendment to the *Performance Contract* for CSBs requiring acceptance of technical assistance.** | **The CMSC is producing the required semi-annual reports, which include recommendations for improvement.** | **NOT MET** |

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| | 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. | **The most recent *Semi-annual Report* (Q1-2, FY21, 3.19.21) includes a review and analysis of data from Licensing, Performance Contracts, SCQR, QID/OCQI, case manager training, and WaMS.** | **The semi-annual report does not yet include data from two required sources: DMAS–QMR and QSR data. Therefore this indicator is not yet accomplished.** | |
| ***SA Provision – III.C.5.d:*** *The Commonwealth shall establish a mechanism to monitor compliance with performance standards* | | | | |
| *6.01* | 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. | **The CMSC transmitted a *Recommendations Letter (11.13.20)* to the Commissioner reporting CSB performance with recommended enforcement actions. Documentation details the tracking, CAP and TA processes for CSB performance issues, including the creation of a Watch List of underperforming CSBs. DBHDS reported that generally Section 9.d. of the CSB *FY19 & FY20 Community Services Performance Contract, undated,* would be followed for any CSB non-performance.** | **CMSC is making recommendations to the Commissioner, as required. Draft processes provide for "advanced and intensive monitoring" of underperforming CSBs. This activity is being accomplished.** | **MET** |
| *6.02* | 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 | **QID/OCQI conducted these reviews subsequent to the SCQR-FY20 cycle, including the use of a stratified random sample of completed SCQRs drawn by DQV (see *OCQI Preliminary Report to CMSC, Follow Up*** | **The reviews were conducted to validate findings and technical assistance was provided. This indicator is met. Pending recommendations from the Data Management Committee, the next review for the** | **MET** |

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| | sample will be drawn each year for this retrospective review…. | ***Retrospective Reviews, 11.9.20*). Depending on the item, inter-rater agreement with CSB assessments ranged from 58% to 94% with 6 of 10 over 75%, which is a generally accepted inter-rater threshold. Technical Assistance was provided.** | **SCQR-FY21 cycle should be conducted during Q1 FY22. Inter-rater agreement improvements in measurable outcomes, ISP participants, and plan implementation need to be accomplished, but the process is in place.** | |
| *6.03* | The DBHDS central office Quality Improvement Division's reviewers will visit each CSB in person and review case management records for the individuals in the sub-sample. They will then complete an electronic form so that agreement between the CSB Case Management Quality Review and the DBHDS Quality Improvement Division record reviews can be measured quantitatively. | **QID/OCQI completed these visits during Q1 FY21, completed reviews of the sample, and then the required form. QID staff reported/explained quantitative reliability discrepancies (see *OCQI Preliminary Report to CMSC, Follow Up Retrospective Reviews, 11.9.20*). Pending recommendations from the Data Management Committee, the next visits for the SCQR-FY21 cycle should be conducted during Q1 FY22.** | **The DBHDS achieved this indicator. The reviewers completed visits, reviewed records and completed the form and quantitative measurements. were reviewed as required Therefore, this activity is being accomplished.** | **MET** |
| *6.04* | There will be an ongoing inter-rater reliability process for staff of the DBHDS Quality Improvement Division conducting the retrospective reviews. | **QID/OCQI completed these inter- rater reliability reviews for one cycle. The second cycle of CY20 cases is scheduled for Q1 FY22 following recommendations from the Data Management Committee. This activity is critical to the integrity of the SCQR process, because of the intrinsic bias of self-evaluation by supervisors.** | **Whether the inter-rater reliability process is on-going remains to be determined, therefore, this activity is not being accomplished.** | **NOT MET** |
| ***SA Provision- V.F.4:*** *Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number,* | | | | |

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| *type, and frequency of case manager contacts with the individual* | | | | |
| 46.01 | 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. | **CMSC's *CM Data Quality Plan, 2.3.21*, identifies the timeline to establish process steps and schedules the initial implementation of quarterly reviews in May 2021. In addition, OCQI surveyed all forty (40) CSBs during Q3 FY21 to clarify agency data collection and utilization practices (see *OCQI CM Data CSB Follow-up Meetings Report to CMSC, 2.25.21*).** | **Quarterly reviews have not begun; therefore, this indicator has not been fully accomplished.** | **NOT MET** |
| 46.02 | The data regarding the number, type, and frequency of case management contacts will be included in the Case Management Steering Committee data review. Recommendations to address non-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. | **This indicator is accomplished through CMSC semi-annual reports to the QIC and Commissioner for review of contract performance issues (see e.g., *QIC Minutes, 9.20 & 12.14.20* and *CMSC Recommendation Letter, 11.13.20*). Five semiannual reports since FY19 include the required information to address non-compliance issues.** | **Systemic improvements could not be adequately considered because the data source (SCQR-FY20) predated establishment of definitions and tools related to assessments of "change in status or needs" and "appropriately implemented services". Therefore, this action has not been fully accomplished.** | **NOT MET** |
| ***SA Provision- V.F.5:*** *Within 24 months from the date of this Agreement, key indicators from the case manager's face to face visits with the individual and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data….* | | | | |
| 47.01 | The Case Management Steering Committee will establish two indicators in each of the areas of health & safety and community integration associated with selected domains in V.D.3 and based on a review of the data submitted from case management monitoring processes. Data indicates 86% compliance with the four indicators. | **The four indicators selected by DBHDS, which are from the two required areas, include Choice, Relationships, Change in Status, and ISP Implementation; CY19 data reports showed 86% compliance with all but** | **This indicator has not yet been achieved. The data source is SCQR FY20 which predated the definitions and tools related to Change in Status and ISP. Data indicates that one of the four indicators did not show** | **NOT MET** |

| VA# | Compliance Indicator: | Facts | Analysis | Status |
|---|---|---|---|---|
| | | **Choice.** | **86% compliance with the Choice indicator.** | |

**Recommendations:**
Accelerate SCQR-FY22 reviews for late CY21 once face to face visits by case managers occur following lifting of pandemic restrictions.

DBDHS should clarify the timelines, methodology and process by which ODQV determines and informs workgroups of data source reliability and validity per CI-37.07 for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2.

**Attachment A**
**Case Management Documents**

| VA# | # | S.A. Section | Documents |
|---|---|---|---|
| 2.01 | 1 | ***III.C.5.b.i (also for V.F.2)*** | *-Defining Change in Status and ISP Implemented Appropriately, 6.9.20*<br>*-On-Site Visit Tool, 7.9.20, 10.30.20*<br>*-On-Site Visit Tool Reference Chart, 6.9.20*<br>*-On-Site Visit Tool Q&A, 7.6.20, 10.30.20*<br>*-Understanding and Assessing 'Change in Status' and 'ISP implemented appropriately, 8.6.20,10.30.20*<br>*-DDS correspondence to CSBs (Heather Norton) re Upcoming Training and Activities, 6.8.20*)<br>*-Proposed Quality Improvement Initiative for CMSC, 8.6.20*<br>---<br>*-Email Correspondence, 6.19.20, DF-EW*<br>*-Exhibit M, 7.1.20*<br>*-WaMS Data and Reporting Form, 2.19.21;* |
| 2.02-2.15 | 2 | " | *-CMSC Performance Monitoring Spreadsheet, 8.6.20*<br>*-SCQR Annual Report-FY20, undated*, (9.8.20)<br>*-SCQR Retrospective Reviews, and Inter-rater Reviews, 11.15.19,*<br>*-SCQR Survey Instrument & Technical Guidance-FY20, undated*,<br>---<br>*-SCQR Survey Instrument & Technical Guidance-FY21, 12.28.20;*<br>*-SCQR: Methodology & Supporting Processes, 2.23.21;* |
| 2.16 | *3* | " | *-CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20;*<br>*-CMSC Semi-Annual Reports, Q1-2 FY19, Q3-4 FY19. Q1-2 FY20, Q3-4 FY20;*<br>---<br>*--CMSC Semi-Annual Reports, Q1-2 FY21*<br>*-CMSC Monthly Meeting Minutes, 10.620 to 1.5.21;* |
| | *4* | " | *SCQR Annual Report-FY20, final undated*; |
| 2.17 | *5* | " | *-CSB Case Management DQI Improvement Reviews-Operational Process, 9.3.20,*<br>*-FY20 Full SCQR Reports by CSB, 8.14.20;*<br>---<br>*- Provider Development SCQR TA Process, 6.3.20*<br>*-CRC CSB TA Summary, 10.1.20* |
| *2.18* | *6* | " | *-CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20; 10.620 to 1.5.21;*<br>---<br>*-CMSC Recommendations Letter, 11.13.20;*<br>*-FY19 & FY20 Community Services Performance Contract, undated.* |
| *2.19* | *7* | " | *-FY20 Full SCQR Reports by CSB, 8.14.20, 10.21.20;* |

| VA# | # | S.A. Section | Documents |
|---|---|---|---|
| | | | ------<br>*-CSB CMSC Performance Letters FY20, 10.21.20* |
| *2.20* | *8* | " | *-CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20; 10.620 to 1.5.21;*<br>*-Final Licensing Regulations, 12 VAC 35-105-10 to 1410, 8.1.20;*<br>*-Three Waiver Redesign- Draft Regulations, 12 VAC 30-120,10.8.20;*<br>*-CMSC Performance Monitoring Spreadsheet, 8.6.20;*<br>----<br>*-CSB Performance Tracking, 10.1.20;*<br>*-Draft CMSC Watch List, 4.6.21;*<br>*-CSB CMSC Performance Letters FY20, 10.21.20;*<br>*-Provider Network Listserv email, 3.22.21;* |
| *2.21* | *9* | " | *-CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20; 10.620 to 1.5.21;*<br><br>*-CMSC Semi-Annual Reports, Q1-2 FY19, Q3-4 FY19. Q1-2 FY20, Q3-4 FY20*<br>*-SCQR Annual Report-FY20, undated*, (9.8.20);<br>-----<br>*-CMSC Semi-Annual Reports, Q1-2 FY21*<br>*-CMSC Monthly Meeting Minutes, 10.620 to 1.5.21;* |
| *2.22* | *10* | " | *- CMSC Semi-Annual Reports, Q1-2 FY19, Q3-4 FY19. Q1-2 FY20, Q3-4FY20, Q1-2 FY21;* |
| | *11* | " | *-CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20; 10.620 to 1.5.21;*<br>*-SCQR Annual Report-FY20, final, undated*;<br>------<br>*-CMSC Semi-Annual Reports, Q1-2 FY21*<br>*-CMSC Monthly Meeting Minutes, 10.6.20 to 1.5.21;* |
| *6.01* | *12* | ***III.C.5.d*** | *-CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20; 10.620 to 1.5.21;*<br>*-SCQR Annual Report-FY20, final, undated*;<br>-------<br>*-Draft CMSC CAP Flowchart, 4.6.21;*<br>*-Draft CMSC Watch List, 4.6.21;*<br>*-CSB Performance Tracking, 4.6.21;*<br>*-CMSC Semi-Annual Reports, Q1-2 FY21;*<br>*-CMSC Recommendations Letter, 11.13.20;*<br>*-CSB CMSC Performance Letters FY20, 10.21.20;*<br>*-SCQR Retrospective Review Protocol, 6.30.20;* |
| *6.02* | *13* | " | *-CSB Case Management DQI Improvement Reviews-Operational Process, 9.3.20;*<br>*-SCQR Retrospective Reviews, and Inter-rater Reviews, 11.15.19;*<br>*-FY20 Full SCQR Reports by CSB, 8.14.20;*<br>------ |

| VA# | # | S.A. Section | Documents |
|---|---|---|---|
| | | | -*SCQR Retrospective Review Protocol (OCQI), 6.30.20;*<br>*-Look Behind Tables, 10.23.20;*<br>*-OCQI Preliminary Report to CMSC, Follow up Retrospective Reviews, 11.9.20;* |
| *6.03* | *14* | . " | *-CSB Case Management DQI Improvement Reviews-Operational Process, 9.3.20,*<br>*-SCQR Retrospective Reviews, and Inter-rater Reviews, 11.15.19;*<br>*-FY20 Full SCQR Reports by CSB, -8.14.20* |
| *6.04* | *15* | " | *-SCQR Retrospective Reviews, and Inter-rater Reviews, 11.15.19,*<br>*-Results from Team [QI] Practice-SCQR, 3.2.20,;* |
| 46.01<br><br><br><br><br><br><br><br><br><br>46.02 | 16 | ***V.F.4*** | *-CSB Case Management DQI Improvement Reviews-Operational Process, 9.3.20;*<br>*-SCQR Retrospective Reviews, and Inter-rater Reviews, 11.15.19;*<br>*-CMSC Monthly Meeting Minutes, 4.18.19 to 9.1.20; 10.620 to 1.5.21;*<br>*-CMSC Semi-Annual Report, Q1-2 FY19, Q3-4 FY19. Q1-2 FY20, Q3-4 FY20, Q1-2,FY21;*<br>---<br>*-Case Management Data Quality Plan, 1.29.21;*<br>*-CCS3 Data Quality Survey, undated;*<br>*-OCQI CM Data CSB Follow-up Meetings Report to CMSC, 2.25.21*;<br><br>*-CCS3 Metrics, F2F & in-home visits/CSB, Nov. 2020;*<br>*--CCS3 Metrics, F2F & in-home visits, 7/19-11/20, Nov. 2020;*<br>*--CCS3 Metrics, F2F & in-home visits/Region-CSB Quarterly, FY19-FY21, Nov. 2020;*<br>*-QIC Minutes, 9.21.20, 12.14.20;*<br>*-CMSC Recommendations Letter, 11.13.20;* |
| 47.01 | 17 | . ***V.F.5*** | *-Developmental Disabilities Quality Management Plan FY20, 3.31.21;*<br>*-KPA Workgroup Reports, 12.14.20, 3.22.21* |

# APPENDIX C

## CRISIS SERVICES

**by**

**Kathryn du Pree MSP**

**and**

**Joseph Marafito MS**

## Review of Crisis Services Through the Eighteenth Review Period

### I. Introduction and Overview

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

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

The status of the Commonwealth's progress will be studied for all of the requirements of the Compliance Indicators that are detailed for Provisions III.C.6.a-b. of the Settlement Agreement. For a subset of these Provisions, progress toward achieving the agreed upon compliance indicator (CI) metrics will be reviewed and reported. The Parties have agreed upon a number of indicators to determine compliance with crisis services Provisions that remain out of compliance. This subset includes: III.C.6. a. i-iii; III.C.6.b.ii.A and B; as well as III.C.6.b.iii.B. D. E. and G. Virginia's has numbered these CIs *7.1-7.23; 8.1-8.7; 10.1-10.4; 11.1; and 13.1-13.3.*

The Independent Reviewer and Expert Reviewer presented the outline for the review to be conducted this spring of the seventeenth and eighteenth review periods, which is referred to as Year 6 throughout this report. This review includes an analysis and reporting of Virginia's status implementing all of the Compliance Indicator (CI) requirements associated with the Commonwealth's statewide crisis services system. These include the main components identified as Prevention, Mobile Crisis and Crisis Stabilization. Prevention is identified by CI #7.1 as early identification; assessment in the home; behavior supports in the home; and the availability of direct support professionals,

The Independent Reviewer continues to be deeply concerned about the high number of individuals with DD whose initial crisis assessment occurs at hospitals rather than in the individuals' homes. A high percentage of these individuals continue to be admitted to psychiatric hospitals rather than utilizing in-home supplemental supports or crisis stabilization

services as alternatives to hospitalization. This dynamic results in an increase in the number of children and adults with DD who are admitted to psychiatric hospitals in Virginia. The Parties recognized the vital role of assessments at home in preventing unnecessary institutionalization by establishing the CI requirement that 86% of this population will receive the REACH crisis assessment in the home or other community (non-hospital/CSB) setting.

The Expert Reviewer will review the Quarterly REACH reports to determine the status of the Commonwealth's implementation of the systemic changes needed to resolve the obstacles that have previously slowed progress toward achieving the required measures of compliance, but both the Expert and Independent Reviewers understand that the protocol that was properly put in place during COVID to assure individual's safety and lessen the spread of COVID results in fewer in-person crisis assessments being conducted during the seventeenth and eighteenth review periods.

The study also includes a review of the DBHDS standard crisis services reports regarding whether, and the extent to which, the Commonwealth continued to maintain the systems that previously resulted in DBHDS achieving compliance for two consecutive determinations. This will include the staff capacity of the REACH programs to both respond to crises as well as to provide follow-up crisis services in an appropriate and timely way. DBHDS continues to produce quarterly reports summarizing the progress of the REACH programs to meet the requirements of the SA as they relate to developing and sustaining a statewide crisis support system for children and adults with DD. DBHDS is also engaging in quarterly qualitative reviews of each Region's crisis services implementation for both children and adults. The quarterly reports from each Region's quality review with DBHDS will be reviewed for both children and adult crisis services. This is proposed with the understanding that these semiannual qualitative reviews inform DBHDS of the quality of existing REACH services and contribute to DBHDS' understanding of the REACH teams' success meeting training requirements for staff; completing CEPPS; and training caregivers on the elements of the CEPP.

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

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

The Independent Reviewer reported on the Commonwealth's success in complying with the provisions of the Settlement Agreement (SA) in the fifteenth and sixteenth review periods. He found the Commonwealth was in compliance with the provisions listed below. In this Overview Section I will summarize the Commonwealth's continued compliance with these Provisions of the SA. All reported data are for the seventeenth and eighteenth reporting periods, which includes data from FY20 Q4, FY21 Q1, FY21 Q2, and FY21 Q3. This is the sixth year this data has been compiled to compare data across years. Given the Commonwealths' continued compliance with the following provisions, and the focus in this review period of reviewing and analyzing data that demonstrates progress towards the agreed upon Compliance Indicators (CIs) I will summarize briefly relevant data for Year 6 related to those Provisions which the Independent Reviewer has previously determined to be in compliance in two successive review periods. This will be reported in initial part of this report. The second section of the report will provide information regarding the Commonwealth's progress towards meeting the requirements of the agreed upon CIs.

The completion of this study required us to review numerous documents and to conduct several interviews. We conducted four separate meetings with DBHDS staff. The first was the kickoff meeting with Heather Norton, Assistant Commissioner; Jenni Schodt, Settlement Agreement Director; and four of the Regional Crisis Systems Managers: Nathan Habel, Sharon Bonaventura, Bill Howard, and Denise Hall. We also interviewed Denise Hall and Sharon Bonaventura to discuss CIs *7.21, 7.22 and 7.23;* interviewed Heather Norton, Jenni Schodt, Nathan Habel, Sharon Bonaventura and Denise Hall to discuss questions regarding the REACH reports; and interviewed Nathan Habel and Sharon Bonaventura to review the components of the REACH Data Store used to produce data for four of the CIs. We greatly appreciate the staff's willingness to schedule these interviews and more importantly to provide a wealth of data to guide us in our review and analysis. Significantly more documentation has been requested in this review period. All of our requests for data have been responded to graciously and timely. The entire list of documents is included as Appendix 1.

## II. Provisions Previously in Sustained Compliance

DBHDS has maintained compliance for the following provisions: III.C.6. b.i.A., III.C.6.b.i.B., III.C.6.b.ii.C, III.C.6.b.ii.D, III.C.6.b.ii.E., III.C.6.b.ii.H., III.C.6.b.iii.A., and III.C.6.b.iii.F. A short summary of the data relevant to each of these Provisions with a comparison to findings from Year 5 follows.

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

***Children's Services***-REACH continues to accept numerous referrals for both children and adults. There were 1505 referrals for children in this period of which 612 (41%) were crisis referrals. This is a decrease in referrals compared to Year 5 when REACH received 1,644 referrals for children. Referrals continue to be made by a number of referral sources. During this review period families and Case Managers (CM) referred 879 (58%) of the children and 505 (34%) were referred by hospitals or CSB Emergency Services (ES). REACH continues to offer crisis response 24 hours a day, 7 days a week as required. Two hundred seven (207) referrals were made on weekends or holidays, which is 14% of the referrals. More than half of all the referrals (756) were made between 3PM and 7AM.

REACH also reports the total number of calls it receives which is more than the number of referrals. There were a total of 9,656 calls to the REACH children's programs, of which 1,013 (10%) were crisis calls. This is an increase over the 8,493 calls received by REACH in Year 5 of which 1,349 (16%) were crisis calls. The number and percentage of crisis calls was less in Year 6 then it was in Year 5.

***Adult Services***- There were 2,189 referrals for adults in this period of which 823 (38%) were crisis referrals. This is a decrease from Year 5 in the total number of referrals when there were 2,424 referrals, of which 1,420 (59%) were crisis referrals. Referrals continue to be made by a number of referral sources. During this review period families, residential providers and Case Managers (CM) referred 1,048 (49%) of the adults and 902 (41%) were referred by hospitals or CSB Emergency Services (ES). REACH continues to offer crisis response 24 hours a day, 7 days a week as required. Three hundred thirty-nine 339 referrals were made on weekends or holidays, which is 15% of the referrals. Half (1086) of all the referrals were made between 3PM and 7AM.

REACH also reports the total number of calls it receives which is more than the number of referrals. There were a total of 20,575 calls to the REACH adult programs, of which 1997 were crisis calls. The number of total calls in Year 6 was greater than in Year 5 when REACH received 18,876 total calls. There were 2,663 crisis calls in Year 5 which was a greater number of crisis calls than in Year 6.

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

REACH continues to train community stakeholders including CMs and CSB ES staff. Overall, REACH staff trained 636 CMs and 244 ES staff in Year 6. In Year 5 REACH programs trained 1,377 CMs and 338 ES staff. It is not possible to draw any conclusions in the differences because the number of new staff needing to be trained is unknown.

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

DBHDS reports on the involvement of law enforcement personnel in Year 6 for all crises involving the police regardless of whether REACH staff responded in person or remotely using telehealth.

***Children's Services***- REACH staff continue to work with law enforcement personnel to respond to individuals with DD who are in crisis. As reported above there were 1,013 crisis calls involving children. Law Enforcement was involved responding with REACH staff to 323 (32%) children.

***Adult Services***- REACH staff continue to work with law enforcement personnel to respond to individuals with DD who are in crisis. As reported above there were 1,997 crisis calls involving adults. Law Enforcement was involved responding with REACH staff to 736 (37%) adults.

Overall, the REACH programs trained 453 police officers. This compares to Year 5 when REACH programs trained 828 police officers.

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

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

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

DBHDS reports that during Year 6 the data for in-home crisis supports includes a mix of in-person and telehealth services. Services may be mixed for an individual or some individuals may have received only telehealth services. DBHDS is unable to report more specifically as to how often each type of support (in person or remote) was used.

***Children's Services***- In each Region, REACH provided individuals with in-home mobile support. The range was 1-15 days, and the average number of days ranged from 2-13.5 for children. In Year 6 there were only three instances when the average days per case was fewer than three. This occurred twice in Region I and once in Region V over four quarters. Region III consistently provides the most average days per case, ranging from 10-14. A total of 336 children received crisis mobile supports in Year 6. This included 313 children who were new referrals to REACH. More children received mobile supports in Year 6 compared to Year 5 when 289 children received mobile supports. New referrals to REACH included 265 children in Year 5. This indicates new referrals who are individuals not previously served by REACH, continue to increase.

***Adult Services***- In each Region, REACH provided individuals with in-home mobile support. The range was 1-16 days, and the average number of days ranged from 3-12 for adults. In Year 6 there were no instances when the average days per case was lower than three days. Region III consistently provides the most average days per case, ranging from 9-12. A total of 627 adults received crisis mobile supports in Year 6. This included 559 adults who were new referrals to REACH. More adults received mobile supports in Year 6 compared to Year 5 when 584 adults participated in mobile supports. New referrals to REACH included 511 adults in Year 5. This indicates new referrals who are individuals not previously served by REACH, continue to increase.

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

REACH was not able to respond to all crisis calls in person as a result of the COVID pandemic. DBHDS provides the data for the response times for only the crises that were responded to in-person. DBHDS does report on the location of all crisis assessments, whether they were responded to in person or using telehealth.

***Children's Services-*** REACH staff responded to 246 of the 612 (38%) crisis referrals in person. Of these face-to-face assessments, 234 (95%) were responded to within the required response time set for each Region. Region III was able to conduct face-to-face assessment for the most individuals experiencing a crisis. Region III responded in person to 138 (56%) of the total number of crisis referrals that were responded to face-to-face across all five Regions. These data cannot be compared to Year 5 when there was no restriction to conduct in-person crisis assessments.

DBHDS also reports on the location of the crisis assessments. The report derives its data from the location of the individual who was assessed for a crisis. This total is 1002 children. Only 401 (40%) were conducted in a community location and 583 (58%) were conducted at the hospital or CSB ES. There were more crisis assessments in Year 5. The total was 1,344, of which 460

(34%) were conducted in a community location. This number results in a higher percentage of assessments being conducted in community locations in Year 6 (40%) compared to Year 5 (34%). This data is not used to determine the Commonwealth's progress towards meeting *CI 7.8* that requires 86% of crisis assessments be conducted in community settings for individuals known to REACH. This particular data reported in the Quarterly REACH reports includes crisis assessments done for all children and adults whether they are already known to REACH or a new referral.

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

***Adult Services***- REACH staff responded to 522 (26%) of the crisis referrals in person. Of these face-to-face assessments, 494 (95%) were responded to within the required response time set for each Region. Region III was able to conduct face-to-face assessment for the most individuals experiencing a crisis. Region III responded in person to 277 (53%) of the total number of crisis referrals that were responded to face-to-face across all five Regions. These data cannot be compared to Year 5 when there was no restriction to conduct in-person crisis assessments.

DBHDS also reports on the location of the crisis assessments. The report derives its data from the location of the individual who was assessed for a crisis, not on the number of crises REACH staff responded to in person. This total is 1944 adults. Only 657 (34%) were conducted in a community location and 1217 (63%) were conducted at the hospital or CSB ES. There were more crisis assessments in Year 5. The total was 2,655, of which 895 were conducted in a community location. This number results in the same percentage (34%) of assessments being conducted in community locations in both Years 5 and 6.

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

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

***Children's Services-*** The Commonwealth now has two CTHs serving children. One is located in Region II and serves children in Region I and II. It was licensed for only four beds throughout Year 6, but has just been licensed for a total of six beds on April 28, 2021. The second home is located in Region IV and serves Regions III, IV and V. Neither CTH was able to operate at full capacity during this reporting period either because of the licensing issue or because of staffing shortages in the Region IV home. A total of 108 children used the 2 CTHs in Year 6: 68 (63%) for stabilization; 17(16%) for prevention; 13 (12%) for stepdown; and 10 (9%) who were readmitted. In comparison only seventeen children used the CTH program in Year 5. The

average Lengths of Stay (LOS) were under ten days for all types of admission. The utilization of the CTH beds was only 20% for the Region II program and 21% for the Region IV program. It is likely that utilization was impacted by COVID restrictions and related staffing shortages. The Commonwealth is to be commended that so many more children had this resource to assist them in a time of crisis in Year 6.

***Adult Services***- The Commonwealth continues to operate five CTHs for adults with co-occurring conditions. All were in operation during Year 6 and served a total of 252 adults. This includes 108 (43%) for stabilization; 24 (10%) for prevention; 102 (40%) for stepdown; and 18 (7%) who were readmitted. The average Lengths of Stay (LOS) were under thirty days for all types of admission and averaged between 3 and 26 days. The utilization of the CTH beds averaged 59% across the five CTHs and ranged from 47% to 81%. Region III had the highest utilization and Region IV served the most individuals. In comparison 256 adults used the CTH programs in Year 5. The Commonwealth is to be commended that they were able to make the CTH program available at the same capacity during COVID as they were prior to COVID.

The average LOS across the four quarters ranges from 13-23 days. The actual LOS for some individuals are longer than the expected thirty days. DBHDS reports in detail about the LOS for individuals whose stay continues from one quarter to the next. There were ten individuals in FY20 Q4; eight in FY21 Q1; eight in FY21 Q2; and eight in FY21 Q3 in this category. Ten of the thirty-four individuals who stayed longer than thirty days and stayed across quarters were discharged in fewer than sixty days. It seems that the availability of the Adult Transition Homes is having a positive impact on the LOS in the CTH. The availability of this alternative should allow the CTHs to accept more referrals as beds are more readily available.

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

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

## III. Hospitalizations

The purpose of creating and enhancing the statewide crisis services system in the Commonwealth for individuals with DD and a co-occurring condition is to be able to stabilize these individuals in their existing settings or offer a suitable community service alternative to prevent unnecessary hospitalization. Therefore, it is important to share the Year 6 data as it relates to these hospitalizations.

***Children:*** DBHDS reports the total number of children who were hospitalized during this reporting period. The total was 369 of whom 245 (66%) are considered new referrals and 124 (34%) are children who are active with REACH. Fewer children were hospitalized in Year 6 (369)

compared to Year 5 when 454 children were admitted to a psychiatric hospital. This decline is a 19% decrease in hospitalizations for children.

DBHDS also reports on the number of children who were hospitalized as an outcome of the crisis assessment which is a portion of the total number of children hospitalized (369). This number is 324 which represents 32% of the children who had a crisis assessment in Year 6. This number compares favorably to the number of children hospitalized as the outcome of a crisis assessment in Year 5 when 467 (35%) of the 1,344 children who had a crisis assessment were hospitalized.

***Adults:*** DBHDS reports the total number of adults who were hospitalized during this reporting period. The total was 842 of whom 441 (52 %) are considered new referrals and 401 (48%) are adults who are active with REACH. The number of hospitalizations decreased in Year 6 compared to Year 5 when 918 adults were hospitalized. This is an 8% reduction in hospitalizations for adults.

DBHDS also reports on the number of adults who were hospitalized as an outcome of the crisis assessment which is a portion of the total number of adults hospitalized (842). This number is 620 which represents 32%% of the adults who had a crisis assessment in Year 6. This number compares favorably to the number of adults hospitalized as the outcome of the crisis assessment in Year 5 when 885 (33%) of the 2655 adults who had a crisis assessment. However, the percentage of individuals hospitalized after the crisis assessment is similar.

DBHDS concludes that the REACH program has more success diverting individuals from being hospitalized when the person is active with REACH rather than being a new referral. However, this is somewhat misleading because the new referral category includes individuals who were previously served by REACH but whose case has been closed. Since REACH is a temporary crisis support, there will be many children and adults whose cases will be closed. As an example, the data from FY21 Q3 includes thirty-two adults and eleven children as new referrals who previously received crisis support from REACH. These numbers represent 33% and 17% respectively of the referrals.

The value of offering crisis services continues to be validated. DBHDS reports on the dispositions for individuals who received either mobile crisis or prevention services and what their dispositions were after receiving these supports. These supports were provided to a total of 2329 children in Year 6. Only 81 (3%) of children who received mobile supports were hospitalized after these mobile supports ended. The vast majority of these children retained their setting: 2183 (94%) children remained home. DBHDS reports that of the 112 children who used the CTH, only 6 (5%) were hospitalized after being discharged from the CTH and 90 (80%) retained their setting while a new community residence was found for 5 (4%) of the children. Only 17 children used the CTH in Year 5 so there is not sufficient use to compare these data points in Years 5 and 6.

These services were provided to 4,450 adults. Only 214 (5%) of these adults who received mobile, or prevention services were hospitalized after receiving these supports. The vast majority of these adults retained their setting: 4127 (91%) remained in their existing residence. DBHDS reports that of the 306 adults who used the CTH program, only 26 (8%) were hospitalized after leaving the CTH. Many adults retain their setting, 128 (42%) or transition to a new community residence, 66 (22%). In Year 5, 45 (13%) of individual using CTHs were subsequently hospitalized and 177 (5%) of adults using mobile crisis or prevention services were hospitalized. More adults using mobile, or prevention services retained their settings in Year 6, (91%) compared to 2809 (79%) in Year 5. More adults using the CTH in Year 6 retained their setting or transitioned to a new community residential setting compared to Year 5 when 36% retained their setting and 23% transitioned to a new community residence.

## IV. Compliance Indicators Related to Crisis Services

The focus of this review period is to gather facts, analyze and determine the Commonwealth's progress towards achieving the Compliance Indicators related to the provision of crisis services. These indicators relate to SA Provisions: III.C.6. a. i-iii, III.C.b.ii.A.; III.C.6.b.ii.B.; III.C.6.b.iii.B., III.C.6.b.iii.D., III.C.6.b.iii.E. and III.C.6.b.iii.G. The report is organized by Compliance Indicator (CI), which are sometimes grouped together because of the relationship of one or more to each other. Each CI is listed. Our review of these CIs is summarized by facts, analyses, conclusions and recommendations. **Facts** include a summary of the DBHDS report of the documents and data used to determine the status of achieving the expected outcomes and requirements. Facts also note the report DBHDS produce to report progress. The **Analysis** section provides a summary of findings related to the review of the process statements, documents, and actual outcome data. The **Conclusion** section poses my determination of whether the CI is met or not met based on the analysis of the data and performance metrics submitted by DBHDS. However, Virginia cannot be found to be in full compliance with the Crisis Services Provisions during the eighteenth review period because DBHDs has not determined that its data sources provide reliable and valid data for compliance reporting. The 2020 assessment by its Office of Data Quality and Visualization (DQV) identified several barriers to data reliability and validity concerns. DQV has not determined, or informed the crisis services workgroups, that the data from these sources are available for compliance reporting. DBHDS informed the Independent Reviewer on April 28, 2021 that it projects that the annual assessments of the AVATAR and REACH data sources will be completed in June 2021. **Recommendations** are offered when appropriate for consideration by DBHDS but are not necessary to meet the requirements of the CIs.

The following CIs are found to be met based on an analysis of the facts reported by the Commonwealth and verified. *7.2, 7.3, 7.4, 7.10, 7.11, 7.17, 7.23, 8.1, 8.2, 13.1, 13.2, and 13.3.*

The Commonwealth provided data that showed that it had achieved additional indicators. However, these indicators cannot be validated as met until the data sources are reviewed and determined to be reliable and valid and available for compliance reporting, as required by 37.07 for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2. These CIs include: *7.5, 7.9, 7.12, 7.13, 8.3, 8.5, 8.7, 10.1, 10.2, 10.3, 10.4, and 11.1.*

The Commonwealth was found not to have met CIs *7.6, 7.7, 7.8, 7.14, 7.15, 7.16, 7.18, 7.19, 7.20, 7.21, 7.22, 8.4, and 8.6.*

**Review and Analysis of the Compliance Indicators**

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

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

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

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

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

**Facts:** DBHDS submitted its Performance Contracts with three CSBs (i.e., Cumberland Mountain, Eastern Shores and Alexandria CSBs) as examples that include the revisions required by these compliance indicators. These changes were effective July 2020. DBHDS developed Exhibit M: Department of Justice Agreement Requirements and both referenced Exhibit M in the revised contract with the CSB and attached it to the contracts. Exhibit M addresses the following *CIs: 7.2, 7.3, 7.5 and 7.6.* They are explicitly defined in the Exhibit as numbers 12, 13 and 14. The CSB Performance Contract changes address *CIs 7.2, 7.3, 7.5 and CI 7.6.*

DBHDS has a process for *CI 7.5* detailing how DBHDS will identify and monitor the number of staff who take the training. The training is available through the Commonwealth of Virginia

Learning Management Center (COVLC) to all CSB staff. The process ensures that DBHDS can verify the CMs; DD and Executive Directors that are trained. The written information reviewed does not indicate that CM Supervisors or Intake Workers were trained but DBHDS confirmed during the interview that the Supervisors and Intake Workers are included under case management personnel. DBHDS incorporated a quality improvement process step that involves follow-up by the Assistant Commissioner with CSB leadership when a training deficit is noted. This crisis risk assessment tool (CAT), which includes criteria for CSBs to use as the basis for making requests for crisis risk assessments to determine "risk of hospitalization, addresses *CI 7.4.*

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

**Analysis:** We reviewed the training outline for crisis assessment and the crisis assessment tool during the 16th review period and gave feedback, which DBHDS subsequently incorporated in the training. The Crisis Assessment Tool is a useful guide for CMs to determine the need to refer someone to REACH for crisis assessment. It includes a scoring guide and instructions to ensure it is an objective process and is consistently applied to address situations that may lead to a crisis and hospitalization. The training is comprehensive and provides sufficient resources for CMs and Intake Coordinators. Trainees must pass a quiz after training and pass with a score of at least 80%.

DBHDS reports 2,552 staff were trained in FY20Q4. As of April 4, 2021, 3,020 individuals had completed this training through COVLC. DBHDS reports that 2850 were CSB/BHA staff and the additional 170 staff were from Virginia's private case management organizations or its public sector employees. DBHDS determines that everyone needing training has been trained based on its identification of the numbers of staff in the following professions: CSB/BHA Case Managers (1972); CSB/BHA Executive Directors (40) and Developmental Disability Directors (40). This totals 2,052 employees. This is 500 fewer than the number trained which DBHDS uses to account for turnover in these positions. DBHDS does not maintain records that document the actual numbers on staff turnover or data on whether new intake workers and CMs are trained within six months or of hire, as required by 7.6.

**Conclusion:** DBHDS has accomplished significant training on risk identification and assessment with thousands of staff being trained in the past year. DBHDS has used the CSB Performance Contract to set the requirements of *CIs 7.2, 7.3, 7.4 and 7.6.* It has met the full requirements of *CIs 7.2, 7.3 and 7.4.* It has set the requirement for CSBs to train all CMs and intake workers. It has met *CI 7.5.* It has not met *CI 7.6* because DBHDS does not document and cannot ensure that newly hired CMs and intake workers are trained within six months of hire.

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

**Facts:** The data sources for *CI 7.7* are WaMS; AVATAR; and completed Crisis Assessment Tools (CATs). DBHDS reported on the implementation of this quality review process in FY21Q1 in the Supplemental DOJ Quarterly Crisis Report and will report again in the nineteenth review period. DBHDS provides a summary of the purpose of this process which is to: select a statistically significant sample; obtain the CATs from CSBs; review the CATs for scoring and referral integrity; and deliver quality review feedback to CSBs on scoring and referral integrity. They report a DBHDS statistician has determined the sample. The review methodology is specific and clear and establishes multiple internal checks as the process is operationalized. DBHDS indicates that "someone already opened in REACH" (i.e., enrolled) should not be included in the quality review process, but does not indicate if a substitution will be made through a random selection. This process depends on reliable and valid data from WaMS and Avatar. DBHDS leadership reports that the annual assessments of the WaMS and Avatar data sources will be updated in June 2021 (See Attachment 1 #43)

**Analysis:** FY21Q1 sample of 300 achieved 93% scoring integrity and 98% referral integrity. However, the CI process describes a sample size of 600 which has not been achieved. DBHDS explained in the interview that the sample of 600 is for the annual review. DBHDS conducted a six-month review initially and reviewed 300 completed CATs in July 2020. Their plan is to complete 300 every six months to achieve an annual sample of 600. DBHDS has had a statistician verify what constitutes a significant sample size corresponding to the population number. The sample for January 2021 was not shared. DBHDS reports the sample was randomly selected; all individuals in the sample were qualified to be included; training was provided to the staff who collected the data, but not to those who analyzed the data. The staff who analyzed the data were master's level or board certified. The sample was qualified by the DBHDS Statistician Methodologist in September 2020.

**Conclusion**: DBHDs has implemented a quality review process. To date DBHDS has only conducted one review of 300 CATs. *CI 7.7* is not met as a result.

**Recommendation:** DBHDS should more clearly define when it is applicable to involve REACH leadership (Step 6 of the QI process).

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

**Facts:** DBHDS has outlined a process for REACH Crisis Managers to collect this data. Terms are defined. DBHDS reports that data verification and methodologies were most recently reviewed with all REACH programs in FY20Q4 as part of the quarterly qualitative review, but has not been reviewed by DQV.

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

**Analysis:** DBHDS uses data from the REACH Data Store to address this CI and three other CIs. We were able to review the REACH Data Store with two of the DBHDS Crisis Managers. It is a great repository of data. The core of the system is the document titled Entry Sheet. This document is a very well thought out and designed as the basic component of this data collection system. It includes data that is required and needed without making the critical error of collecting extraneous data. All the data collected has a built-in process for verification that is reliable and sufficient.

DBHDS uses the data on the Entry Sheet to develop all of the spreadsheets needed to track all of the information related to compliance issues for the corresponding CIs. We were able to review the data store's tracking abilities and DBHDS' protocols for data utilization and follow up during their demonstration. Based on this review we offer the following conclusions:

- The success of the data collection protocol is the entering of data correctly on the Entry Sheet. DBHDS has designed a system check that flags incorrect data entry to the source. They have the capability to follow up to initiate the correction. They can track error trends that trigger retraining or a corrective action plan. An error that will lead or has led to a barrier meeting an outcome is flagged, as a "Severe Error," and initiates an immediate response from DBHDS to the REACH program.
- The system is checked monthly. DBHDS indicated that checks also occur more frequently especially for Regions that have shown or are showing negative trends.
- A corrective action plan was issued as recently as last month for a Region that was trending negatively meeting training timelines.
- The spreadsheet design allows the user to pull critical data subsets for tracking and follow up. This function reduces or eliminates delay in services or training.
- Reporting on tracking of success or lack thereof is a dynamic process given the design and practices used as described.

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

DBHDS acknowledges that it is "most desirable that persons in crisis receive a crisis assessment in the location in which the crisis occur, as opposed to being removed from their community setting to be assessed in a different location" in the Supplemental Crisis Report. The Commonwealth continues to fall far short of this expectation. While 53% of individuals received REACH crisis assessments in a community location in FY21 Q1, this percentage dramatically

decreased to 34% in FY21 Q2 and 35% in FY21 Q3. There is a variance across the five Regions in the percentage of crisis assessments conducted in a community setting. As an example, the range in FY21 Q3 is from 18% in Region I to 61% in Region III. Region III consistently completed the highest percentage of its assessments in community locations, and Region V completes the second most in three of the four quarters. Region III has consistently assessed more than 60% of its individuals in crisis throughout the reporting period, despite the outbreak of COVID. Regions I and II have the lowest percentages consistently across all four quarters.

DBHDS does not provide any analysis of why so few crisis assessments are conducted in the home, residential setting or community; nor does it identify its strategic plan to meet this CI. It does not discern whether there are any reasons for significant variation across the Regions or whether an analysis of those reasons might lead to insights regarding achieving this outcome across the Commonwealth.

Of interest is that the CI requires that 86% of individuals should receive the ***REACH crisis assessment*** in one of these community settings. The original purpose of the REACH program regarding the REACH's staff involvement in crisis assessments was twofold. First was to team the REACH staff with the CSB ES or hospital staff in completing these assessments. Secondly was to have the individuals benefit from the inclusion of a professional who has IDD experience in addressing and hopefully stabilizing the crisis situation without psychiatric hospitalization. This CI is requiring the crisis assessment performed by REACH to be done in the community setting but fails to refer to the full crisis assessment that involves CSB ES staff. There is nothing in the Performance Contract changes that were issued to CSBs in July 2020 that address the location of the crisis assessment or sets any expectation for CSB ES staff to be part of a community-based assessment. Without this expectation it is doubtful that the percentage of crisis assessments completed in the community will increase significantly. REACH staff have always been able to respond to an individual in their family home, residence or day program and stabilized a percentage of these crises without the individual having to be taken to the CSB ES or hospital. This CI is being interpreted in a way that separates the REACH involvement in a crisis assessment from the original team approach to crisis assessment.

The Commonwealth hopes to address this systemic problem through its plan for a crisis assessment transformation that will positively impact crisis assessments for all populations, not just individuals with DD. DBHDS reported in the interview that the Commonwealth hopes to address this in the fall of 2021 as it launches a new Call Center. There will be an emergency 988 telephone number for anyone in crisis to call. Staff at the Call Center will triage these calls and address as many as possible telephonically. DBHDS reports that national research indicates as many as 85% of crises can be successfully addressed by professionals talking to the individual and family via the telephone. The staff will then triage those calls that need an in-person response and a crisis team will be dispatched to the person's location. This is a very positive initiative as It is unlikely without this involvement that the Commonwealth will see a significant decline in hospitalizations of individuals with IDD who experience a crisis or the commensurate increase in individuals being stabilized where they live.

**Conclusion:** The metric for *CI 7.8* is not met as the Commonwealth has not been able to conduct crisis assessments in community settings for 85% of the individuals assessed. It has not been met during any quarter of the review period and was 35% in the last quarter of the eighteenth period. DBHDS first presented and analyzed data related to this metric in its FY20 Q3 Supplemental Crisis Report. This includes data on the location of assessments for the time period January 1-March 31,2020. The REACH teams would have been responding in person for the majority of this quarter as it was prior to COVID restrictions being in place. REACH staff completed 46% of crisis assessments in community locations during FY20 Q3. The range across the Regions was 22% in Region I to 57% in Region V.

**Recommendations:** It seems beneficial to determine if there are reasons for the variance among the Regions in achieving this metric and if that analysis points to any systemic changes that could be made to increase the number of assessments completed in a community setting across the Commonwealth. DBHDS can analyze the correlation with increase or decrease in the number of assessments completed in the community and the increase or decrease in hospitalizations and determine what else needs to be addressed if hospitalizations do not decrease for individuals with DD.

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

**Facts:** DBHDS provided several documents to demonstrate compliance with this CI. There is a dated directive (6/21/16) from previous DBHDS Commissioner Jack Barber related to requirements for state hospitals to notify REACH during pre-screenings and requirements for CSBs to report to DBHDS if REACH is not notified of the evaluation for an involuntary admission. Exhibit K was submitted from the larger performance contract with CSBs. It does not include the state hospitals' responsibilities related to admission but does clarify the CSBs responsibilities. Section 4: Individuals with Developmental Disabilities details these responsibilities. The CSB is responsible for reporting back to the state hospital information within two days but only for individuals with a moderate, severe, or profound level of ID.

There are Collaborative Discharge Protocols for CSBs and State Hospital for both Adults and Children. These protocols require the state hospital to notify the CSB of an admission of an individual with DD within one day of the admission. These protocols also clarify the CSB CM's role in discharge planning including arranging for needed community services and waiver application. DBHDS provided samples of training/competency documents for hospital clinical social workers.

DBHDS also provided documentation of training provided to staff of the state hospitals.

**Analysis:** Some of the evidence provided did not directly address the requirement of *CI 7.9* as the directives indicated referrals to REACH rather than to CSBs; and CSB responsibilities for individuals after they were hospitalized so discharges could be effectively planned. There were examples of two hospitals' performance evaluation forms for Clinical Social Workers that did address informing CSBs of an admission of an individual with DD. One state hospital also requires REACH to be involved but the other state hospital did not. The identification of the expected competencies for clinical social workers related to serving individuals with DD are inconsistent and do not provide evidence that state hospital staff have been trained regarding the notification to the CSBs that DBHDS expects, and the CI requires.

The DBHDS Collaborative Discharge Protocols do require state hospital personnel to notify CSBs of the admission of an individual with DD. DBHDS provided two training sessions pertinent to this CI. The training, *Hospital Discharge Planning 101,* was offered on two occasions: 9/15/20 and 10/23/20. It was offered to state hospital employees and CSB employees. Staff from Catawba, Central State, Northern Virginia MHI, Piedmont Geriatric, Southern Virginia MHI, Southwestern Virginia MHI, and Western State Hospital attended. DBHDS furnished the lists of staff who attended.

**Conclusion:** *CI 7.9* is met. The Commonwealth provided a directive and offered training to state-operated psychiatric hospitals to require notification of CSBs and case managers during pre-screenings prior to the admission of a person with a DD Diagnosis.

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

**Facts:** These three CIs are related and they rely on the same documents for information related to achieving compliance. These documents include the Standardized DBHDS Consolidated Morning Report (CMR) and the REACH Hospital Tracker. DBHDS reports on the data related to these CIs in the Quarterly Supplemental Crisis Report. The CMR document (see Attachment 1 #16) showed that the Director of Community Support Services or designee consistently notified the REACH Director or designee of admission for follow up, as required. The CMR is a report provided by the state hospital using hospital data that is also entered into AVATAR. The REACH Hospital Tracker (see Attachment 1 #18) provided an example of individuals who were admitted to state psychiatric hospitals with DD during FY21 and provides data regarding referrals made within 72 hours. The DBHDS provided documentation in its Process Document on hospitalization documentation (See Attachment 1 #42) that it has implemented a review process, including that the process has identified needed quality improvements.

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

**Analysis:** From the information provided, DBHDS documents how it is meeting CI 7.12 and 7.13. DBHDS uses the REACH Hospitalization Tracker, and the CMR which provides data directly from the hospitals to determine if all individuals with a DD who were admitted were referred to REACH. There is no documentation that the methodology used by DBHDS to make these determinations provides reliable and valid data. The documents provided are sufficient to indicate that REACH and DBHDS are aware that all hospital admissions of individuals with DD were referred.

Although the required annual assessments have not occurred and the REACH data source has not yet been determined to provide reliable and valid data, the Hospitalization Tracking Guide/Definitions document is a well-organized and succinct. It includes a clear set of definitions and provides unambiguous guiding statements. It is cross-referenced with the AVATAR data, which is directly reported by state hospitals, retrospectively on a quarterly basis to confirm that all of the individuals who the state hospitals reported as having a DD were confirmed by REACH to have such a diagnosis.

The AVATAR spreadsheet is a very good collection of useful data and avoids the common mistake of including extraneous data. The data being collected on the REACH Hospital Tracker and the AVATAR are consistent, but AVATAR is not used to validate the REACH data entries. We have recommendations regarding the data each form includes.

- *Column J Definition Titled Discharge Date*- A clarifying statement in the definition states, "If the person has not discharged at the end of the quarter, type in "still hospitalized". It would be useful in the definition or process statement to indicate what action is prompted by someone remaining in the hospital, who is responsible for follow up, and what is the timeline.
- *Column K Titled Date REACH Notified of Admission*- Is the email by named individual, designee or entity qualifying as validation that REACH was notified?
- *Column L Titled Individual Discharged from Residential Provide During Hospitalization*- Include a column titled Reason for Discharge and provide guidance in the Guide/Definition section. This may be helpful to determine capacity issues regarding the type of service and/or provider per CSB. Such data would be helpful for efficient recruitment of specialized providers as well as training improvements for existing providers. It would be helpful to identify the timelines DBHDS expects for REACH staff to address any irregularities.

DBHDS does report the following percentages of all individuals who were known to the CSB and who were hospitalized were referred promptly to REACH:

The outcomes for this review period were:

- 93% in FY20 Q4
- 97% in FY21Q1.
- 94% in FY21Q2; and
- 98% in FY21Q3.

The average over four quarters is 95%. The DBHDS reports show that the referral rate for children was above 95% for all four quarters, including both quarters of the eighteenth review period. The referral rate for adults was reported below 95% in FY20 Q4 (91%) and FY21 Q2 (93%) but averages 94.5% overall for the four quarters.

**Conclusion**: *CI 7.10* is met. The Director of Community Support Services or designee consistently notifies the REACH Director or designee of admission for follow up.
*CI 7.12* is met because the data submitted in the CMR is entered directly by the hospitals. *CI 7.13* is met as the data demonstrates that the overall average for children and adults referred to REACH within 72 hours of admission to the state hospital has been achieved in the seventeenth and eighteenth review periods.

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

**Facts:** DBHDS sent letters to the Virginia Hospital and Healthcare Association (VHHA) on 6/5/2020 and 2/13/2021 outlining this request and encouragement to notify the ES staff of the CSBs. The letters specified *requests for admissions and admissions of individuals with a DD diagnosis.*

**Conclusion:** *CI 7.11* is met. DBHDS has encouraged private psychiatric hospitals to notify ES staff of any admissions of individuals with DD (see Attachment #1 17).

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

**Facts:** DBHDS reported on this CI in its semiannual Behavioral Supports Report. Two such reports were submitted for this study period; a final report for FY21 Q1 and a draft report for FY21 Q3. DBHDS uses data from the state department that licenses Behavior Analysts and Associate Behavioral Analysts. The specific data sources are the VA Department of Health Professionals LBA/LaBA active licensees and the PBSF provider organization. DBHDS' process relies on Waiver Management System (WaMS) and Service Authorization data to determine if individuals in need of behavior support are referred to an identified provider within 30 days.

DBHDS began tracking the number of individuals identified during the ISP planning process as being in need of therapeutic consultation in July, 2020. DBHDS also tracks data to determine the percentage of those persons who have a therapeutic consultation provider within thirty days of that need being identified. As part of this data DBHDS also reports the number of individuals who have a provider identified outside of the thirty days; and the number of individuals who do not have a provider identified, but for whom the need for therapeutic consultation was indicated during the ISP meeting. The data reported for this study reflects the results of ISP meetings that were conducted during the six months between 9/1/20-2/28/21. The data source is the WaMS. The data reported in the Behavior Supports Report: FY21 Q3 is detailed by Region and totaled for the Commonwealth.

**Analysis:** DBHDS has surpassed the expectation of increasing the number of behaviorists by 30% over the baseline in 7/2015 of behaviorists. DBHDS reported its baseline of 821 behaviorists (i.e., PBSFs, BCBAs, and BCaBAs) at the beginning of FY16. DBHDS reported that, as of FY17, there were a total of 1,055 behaviorists; 1,113 at the end of FY18; 1,352 behaviorists at the end of FY19; and 1,493 behaviorists at the end of FY 20. As of FY21 through Q3 there were 1,891 behaviorists (See Attachment 1 #19 & 20.) The increase between FY16 and FY21 is 130% over baseline. The increase is 105% if BCaBAs are excluded.

DBHDS reports that, for the period 9/1/20-2/28/21, 271(45%) of the 601 individuals with a need for therapeutic consultation referral had a service authorization and a provider identified within thirty days (See Attachment 1 #20). DBHDS reports that an additional 62 (10%) of individuals had a provider identified in more than thirty days. DBHDS does report that each of these individuals had a service authorization in place with the provider. In this period from 9/1/20-2/28/21, 601 individuals were identified with the need for therapeutic consultation, of whom 268 (45%) continued to be without a therapeutic consultation provider. DBHDS has taken action to increase the number of behaviorists who become therapeutic consultants. The Commonwealth reported that as of 3/4/21, based on billing data, there are 57 provider groups who provide behavioral services (therapeutic consultation) to the IDD population.
DBHDS Community Resource Consultants assist behaviorists to enroll with DMAS to become therapeutic consultants.

DBHDS has developed draft Practice Guidelines for Behavior Support Plans. The final version of these Guidelines will be based on the DD Waiver Regulations, which were approved in April 2021 and, govern therapeutic consultation behavioral services. The Guidelines are scheduled to be finalized and disseminated in FY21Q4. To ensure that its draft Practice Guidelines sufficiently

specify the minimum elements that constitute an adequately designed behavioral program, the Commonwealth sought and received input from the Independent Reviewer and his crisis services and behavioral consultants.

DBHDS is assisting CSBs to locate behaviorists in their Regions. However, the Commonwealth has not provided documentation that it completed the required gap analysis and setting targets and dates has been done, to increase the number of consultants needed so that 86% of individuals whose Individualized Services Plan identify Therapeutic Consultation (behavioral support) service as a need are referred for the service (and a provider is identified) within 30 days that the need is identified. It is heartening that there are so many more PBSFs and BCBAs in Virginia who have the potential to become therapeutic consultants and serve individuals with DD whose ISPs indicate they need this service. However, the significant increase in the numbers of PBSFs and BCBAs is not resulting in a similar increase in the number and percentage of individuals with DD who can access these professionals. DBHDS did report that it has worked with the Virginia Association of Behavioral Analysts (VABA) to discuss the barriers for behaviorists to pursue qualification to provide therapeutic consultation. VABA sent a survey to its members to identify barriers and shared concerns about the process of becoming qualified with DBHDS. DBHDS was able to qualify three behaviorists after DBHDS staff addressed their specific concerns. DBHDS staff have also participated in a community chat room offered by VABA to reach out to the members of VABA and discuss therapeutic consultation.

**Conclusion**: The CI metric to increase the number of PBSFs and LBAs is met and surpassed. The metric to assure 86% of individuals who need therapeutic consultation are referred and have a provider within 30 days is not met. The Commonwealth has not provided records that document the required gap analysis or an examination of why the increased number of behaviorists has not resulted in documentation of a substantial increase in the percentage of individuals with an identified need for therapeutic consultation who are referred to an identified provider within thirty days. As a result, the Commonwealth has not met the requirements of *CI 7.14*.

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

**Facts:** The Behavior Practice Guidelines were completed by DBHDS and have been reviewed by two Expert Reviewers and the Independent Reviewer. DBHDS incorporated their feedback to ensure that the Guidelines included the minimum elements and the use of the other practices.

**Analysis:** An analysis of the sufficiency of the Guidelines and recommendations have been provided to DBHDS staff prior to this report.

**Conclusion:** The Commonwealth has developed the Practice Guidelines. DBHDS reports that it will provide these guidelines to behavior consultants during FY21 Q4. DBHDS did not meet *CI*

*7.15* during the eighteenth review period. However, it is poised to do so during the next review period when it plans to launch the guidelines and train behaviorists and case managers in their application.

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

**Facts:** DBHDS has developed training for Case Managers regarding the minimum elements that constitute an adequately designed behavioral program. It is entitled: ***Therapeutic Consultation Behavioral Services Service Coordinator Training.***

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

**Conclusion:** *CI 7.16* is not yet met. DBHDS has developed the required training program, but has not yet been provided it to case managers.

**Recommendation:** DBHDs notes in its training curriculum that a behavioral plan is not the same as a crisis plan. DBHDS should provide an explanation of the differences between these plans since many CMs deal with both types.

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

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

**Analysis:** At the core of its DD waiver regulations is the criteria qualifying individuals for behavioral services. Receiving the services is based on an identified need, which is to be

expressed in the ISP. The regulations state: **"**Documented need shall indicate that the ISP cannot be implemented effectively and efficiently without such consultation as provided by this covered service and approved through service authorization. The need for this service shall be based on the individual's ISP and shall be provided to an individual for whom specialized consultation is clinically necessary".

The regulations define the service description; the specific professionals, licenses and certifications required for said professionals; and what waivers (FIS and CL) cover such services. The definition of the support plan is clear and includes all of the following: criteria and allowable activities; what allowable activities must include (i.e. interviewing specific individuals for identifying the intended purpose and desired outcomes); observation; assessment of current interventions and support strategies; assistive devices if in use or if needed; development of data collection mechanisms and collection of baseline data appropriate for the type of consultation being considered; the specific design components of the support plan or therapeutic consult; the requirement for demonstrating and training in the delivery of the plan by the consultant; adherence to HIPPA for in-person, phone and video interactions. The regulations define service units and associated billing parameters. Authorization specifically describes the initial request of 180 maximum days and what is required for submission of subsequent authorizations (E.g., a BSP; baseline data for initial request post assessment; and annual summary of quarterly data).

Components of the required BSP are detailed and comprehensive. Documentation is required for who was trained in the BSP as well as a plan for ongoing training. The regulations provide specificity of format and the expected details of progress notes; and requirements for submission of quarterly reviews to the to the support coordinator/case manager when service exceeds three months that must be. In addition, the review process is detailed for services exceeding one year including a plan revision and submission to the support coordinator for authorization. Quarterly reviews must include graphed or tabled data covering trending during the three-month period.

The report to terminate the plan must include strategies utilized; objectives met; unresolved issues; and consultant recommendations. The report must be submitted to the support coordinator within thirty days of service completion.

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

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

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

**Conclusion:** *CI 7.18* is not, and cannot, be met until April 1, 2022, one year from the effective date of the DD Waiver regulations.

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

**Facts:** This CI for behavioral services can be achieved only after the DD Waiver regulations for Therapeutic Consultation Services are fully implemented and the authorized services occurr within the timeframes in these regulations and include the components described in 7.19 A-D. DBHDS provided a process document that noted this process is in draft. It has drafted Business Rules for the process, but these have not yet been shared.

**Conclusion:** *CI 7.19* is not met, and compliance cannot be determined until after the DD Waiver Regulations are implemented and the services are delivered in accordance with these regulations.

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

**Facts**: The Commonwealth can achieve this CI only after the DD Waiver regulations for Therapeutic Consultation Services are fully implemented, the authorized services are provided, and a quality review and improvement process assesses the status of the services that are delivered. DBHDS provided a draft document regarding the review and improvement process.

**Conclusion:** *CI 7.20* is not met. Achievement of this CI cannot be determined until after the quality review assessments and improvement process are completed.

**Recommendations:** The quality review process includes a review of a statistically significant number of BSPs. The sampling and data quality methodology should be reviewed and verified by DQV before it is finalized or implemented.

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

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

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

**Facts:** DBHDS has a detailed description for this quality review process. While it was not clear in the process description, we confirmed during an interview with a DBHDS staff that the draft process will include a review of the ISP and a comparison of the services requested/needed to the behaviors identified and other issues that may pose safety risks for the individual. This ISP review is critical. It informs the reviewer of potential areas of safety concerns to be prepared to interview families as to whether the safety concerns are all being met. DBHDS uses the WaMS system as its source of data. The WaMS system includes access to the ISP including the Part V that is completed by the provider; the provider's schedule of when support will be delivered;

and authorization information. The outcome data and results and recommendations of the QI process are reported in the Supplement Crisis Reports.

**Analysis:** We determined in reviewing DBHDS' process of record review and conducting our qualitative study that DBHDS cannot actually verify that all services authorized were delivered except through its interviews with families. Only fifty-three (31%) of the 168 families responded to the request to be interviewed in October. The DBHDS review for the July 2020-December 2020 time period included 252 individuals who received in-home or personal care services. DBHDS interviewers were able to interview 102 (40%) of the 252 families who received either in-home or personal care services. DBHDS has not indicated if either of these represent a statistically significant number of respondents. Families who are interviewed are self-reporting. Especially during the pandemic many of the families receiving personal care were using the consumer-directed option. In many cases it was a parent or grandparent who is the paid caregiver. DBHDS is using only the family interview to verify that all services that were authorized were delivered. This information would be more consistent and reliable if DBHDS uses or cross checks the information with billing claims information when it completes its semiannual reviews. DBHDS reported that it plans to use the billing data in its next semiannual review,

DBHDS completed a baseline review of information in October 2020 to determine concerns identified and completed its second review in April 2021.

During this review period, we conducted a quality review of the implementation of the processes to achieve these CIs. Our findings and conclusions are discussed in greater detail in Attachment 2. Our study validated the process DBHDS uses in terms of its record review and interviews to determine qualitative improvements. We interviewed Case Managers instead of families as we believed from previous studies, we would have greater success reaching the CMs. DBHDS may want to consider the CMs as a data source for future quality reviews.

DBHDS cannot provide documentation that it has actually confirmed that services were delivered as authorized. The DBHDS record review confirms that needs are assessed and needed services are specified and requested. The WaMS system data review verifies that service were authorized but does not verify these services were actually delivered. As an example, we had two individuals in our sample who had services authorized in WaMS for the entire review period but we learned in our interviews with CMs that both had been placed into a new residential setting during this same time. DBHDS has access to billing information from providers of personal care and in-home supports that would allow them to more accurately verify whether services that were authorized were actually delivered and to more readily identify gaps in service delivery.

DBHDS reports that of its reviews of 168 individuals with the need for personal care or in-home services reflected in their ISPs between January and June 2020, 91% received services; 99% had approved authorizations that matched hours requested. Of the 53 families who were

interviewed 100% received some services; 57% received all services; and 13% had safety concerns.

DBHDS reports that two hundred sixty (260) individuals had an identified need for in-home or personal care services in their ISPs between July and December 2020. Of these individuals DBHDS reported that 252 were receiving these services. The additional eight individuals moved or the waiver slot was released or placed on hold. (The report does not explain why waiver slots were released or placed on hold.) Families of 102 (40%) of the 252 individuals with services were interviewed. Of those who were interviewed 100% received some services; 61% received all services; and 8% reported safety concerns. However, DBHDS is only able to verify the delivery of services for 102 individuals whose families participated in an interview. This conclusion is based totally on interviews with the family informant.

As required by *CI 7.23* DBHDS made determinations to enhance and improve service delivery to children and adults with identified significant behavior support needs (Support Level 7) in need of in-home and personal care services, as a result of its quality review process completed in April 2021. The recommended improvements are that DBHDS will develop information for providers to develop more complete schedules for personal care and in-home services; work with the provider community to ensure personal assistants and in-home workers will be aware of proactive strategies to address behaviors; and will use billing data in the future to compare authorized services to billed services.

**Conclusion:** *CI 7.21* and *7.22* are not met. The DBHDS review process is not sufficient. DBHDS is not using data that can verify the number of children and adults in Support Level 7 receiving the in-home or personal care services identified in their ISPs as required in *CI7.21 b*.; or authorized services were delivered as required in *CI 7.22 a.* The proposed change to review billing data will address this in the next review period. DQV has not yet determined that the data generated by the review process is reliable and valid and can be used for compliance reporting

*CI 7.23* is met. DBHDS reviewed the results of its review process and made recommendations to enhance and improve service delivery to children and adults with identified significant behavior support needs (Support Level 7) who are in need of in-home and personal care services.

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

**Facts:** DBHDS most recently completed the assessment (See Attachment 1 #23-28) of the three issues in FY21 Q2 and FY21 Q3. These reviews are conducted individually with each Region during the quarter. The Commonwealth's performance related to these three issues are addressed in the associated indicators 8.2 ,8.3, 8.4, and 8.5. Staff training and staff qualifications are assessed semiannually during the Performance Contract Review which occurs

in Q2 and Q4 of each year. REACH program standards including CEPP development and related training of providers is assessed semiannually during the Program Standards Review which occurs in Q1 and Q3 of each year. Two of the quarterly quality reviews of REACH focus on performance contract expectations and two of the quarterly reviews concentrate on REACH program standards.

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

**Conclusion**: *CI 8.1* is met because DBHDS completed the required assessment.

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

**Facts:** DBHDS documented its assessment findings (See Attachment 1 #23-28) and its determinations related to the need for training related to mobile services. During the seventeenth and eighteenth review periods, DBHDS determined that it was necessary to require a quality improvement initiative in two of the Regions. DBHDS utilized employee personnel files and the REACH Performance Contract Review Summaries as the sources of data for its determinations.

**Analysis:** DBHDS reports that it used the assessment results to determine if there is a need for further training based on performance within each Region. DBHDS also uses data from the REACH Quarterly Qualitative Review Performance Contract Review to determine the need for training related to mobile crisis. DBHDS does not report that this contract review process or the data collection methodology has been determined to provide reliable and valid data for compliance reporting. I reviewed the REACH Quarterly Qualitative Review for the four quarters of the seventeenth and eighteenth review periods. Semiannually DBHDS reviews each REACH program for fiscal, administrative, and training requirements. These reviews include each REACH program's performance related to referral, intake and assessment procedures; community crisis response; crisis prevention; and staff qualifications. At each quarterly review, DBHDS staff determine the need for training based on a review a total of four clinical records of two children and two adults who had been served by REACH in the quarter.

DBHDS shared two corrective action plans that it determined were necessary based on the findings of its quarterly qualitative review process from FY21Q2 which categorized as "partially meeting standards". The Corrective Action Plans (CAP) detail the content area needing improvement; the specific improvement that is needed to meet the REACH standard; the program's plan to address the required improvement area; and measurable benchmarks against which the REACH program will be evaluated. Note, some areas of the CAP are still in progress based on dates of achievement for associated benchmarks being in the future. The

existing CAPs are examples of the required quality improvement plans that DBHDS determined were necessary; and they are sufficient to fulfill this CI requirement.

For several years, DBHDS has done a good job conducting quarterly quality reviews of REACH programs. DBHDS has defined expectations and reviewed the performance of its regional REACH programs using a standard approach. These quality reviews are comprehensive reviews of the REACH programs' performance related to the DBHDS' defined standards. The process only includes a review of four clinical records.

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

**Recommendations:** Given the number of REACH staff employed each quarter this number should be increased, and the number should be determined by a statistician to make sure it is representative of the population REACH serves.

***8.3: 86% of REACH staff will meet training requirements***

**Facts:** DBHDS uses the Master Training Data Spreadsheet (See Attachment 1 #30) as its data source for determining the percentage of REACH staff who meet the training requirements. DBHDS reports on staff training in the Supplemental Crisis Reports. DBHDS require REACH staff to complete initial employee training sequence within six months of hire. Subsequently, all REACH staff must complete annually a minimum of twelve hours of continuing education topics pertinent to their professional development. DBHDS reports that during the seventeenth and eighteenth review periods 99% or more of REACH staff were trained.

**Analysis:** DBHDS reports in the REACH Master Staff Training Data Sheet that there were a total of 304 staff whose training status was reviewed in FY21 Q1. This includes veteran staff and new hires. Approximately sixty-five were newly hired in this reporting period. The Master training sheet lists all REACH staff and designates if they have completed training; are on track to complete training; or will not complete training in the required timeframe. DBHDS reports the percentage of all REACH staff who are in compliance with REACH training requirements. The outcomes for *CI 8.3* this reporting period are:

- 8.3 FY20Q4: 99%
- 8.3 FY21Q1: 99%
- 8.3 FY21 9/1/20-3/1/20: 99.7% (this overlaps FY21 and does not include the last month of FY21Q3)

There is no evidence in the review process that DBHDS rechecks the records of staff who are expected to complete on time to verify completion of the required training as planned. However, DBHDS staff were able to report that upon receipt of the REACH Master Staff Training

Data spreadsheet, there is a brief cross check of the current submission of the spreadsheet to the previous submission to confirm that anyone who did not complete the training requirements in the previous period has now completed the training. Thus far, DBHDS has found that the REACH staff who were not on track to complete, or did not complete, the required trainings have separated from the program by the next review period. DBHDS will add this double-check component into its review process document.

DBHDS audits the employee files of eight employees per REACH program during each semiannual review, which includes a review of the competencies of REACH staff. DBHDS selects the training records of two veteran staff and two newly hired staff from each Region. Therefore, a total of twenty employees are reviewed semiannually from REACH programs, for a total of forty employees annually. DBHDS pulls twenty records of new hires and twenty records annually of veterans although there are far more veteran staff. During the other two quarterly reviews DBHDS staff review 10% of staff personnel records to confirm that REACH staff meet the required qualification standards. DBHDS did not report the exact number of REACH staff but there were approximately 300 positions in REACH programs during this reporting period.

DBHDS has not provided documentation that DQV has determined that a review of forty staff records annually provides reliable and valid data.

**Conclusion**: *CI 8.3* is met as the data has been confirmed from the Master Training Data Spreadsheet regarding staff who were in process of completing the required training.

**Recommendation:** DBHDS should establish a sufficient sample of training records for REACH employees during semiannual quality reviews that allows findings to be generalized to the cohort of all REACH staff.

***8.4: 86% of initial CEPPs are developed within fifteen days of the assessment***

**Facts:**
DBHDS reported that seventy-eight to eighty-one percent of CEPPs were completed during the seventeenth and eighteenth periods.

DBHDS cited the REACH Data Store as its data source for *CI 8.4*. DBHDS staff reviewed the REACH Data Store information with us. The outcomes related to 8.4 are reported on in the Supplemental Crisis Report.

**Analysis:** DBHDS staff reviewed the REACH Data Store information with us. The outcomes are reported on in the Supplemental Crisis Report. There is no documentation that explains how the REACH Data Store is used. The process does not explain who submits the data into the REACH Data Store or how these submissions are reviewed for accuracy.
The statewide outcomes reported by DBHDS for *CI 8.4* during the seventeenth and eighteenth reporting periods are:

- 8.4 FY20Q4: 78%
- 8.4 FY21Q1: 78%
- 8.4 FY21 Q2-Q3: 81%

There is significant variation across the Regions meeting the expectation of *CI 8.4.* During FY21 Q2 and Q3, Regions I and IV achieved 90% and 95% respectively, which exceeded the requirement of 86%. The other three Regions underperformed by achieving between 69% to 76%.

**Conclusion:** *CI 8.4* is not met. The 86% benchmark for the percentage of CEPPs completed within 15 days was not achieved.

**Recommendation:** DBHDS should undertake a quality improvement review to determine the root causes for the underperformance by three Regions and how to address and resolve the obstacles to acceptable performance.

***8.5: 86% of providers will receive training in implementing CEPPs***

**Facts:** DBHDS reports that during the seventeenth and eighteenth periods, 899 of 1,002 providers (89.7%) received training in implementing CEPPs (See Attachment 1 #31, 32, 33). DBHDS has not yet determined, as required by CI 37.07 for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2., that the REACH data source provide reliable and valid data for compliance reporting. DBHDS reports that it has scheduled for June 2021 the required annual assessment of the REACH data source, which is a required preliminary step to remedying identified data quality issues and then determining that the source provides reliable and valid data.

**Analysis:** Of the 1,002 CEPPs that REACH completed, 313 were for children and 689 for adults. REACH programs provided training to 616 providers supporting adults and to 283 providers supporting children for a total of 899 providers. REACH trained 90% of its providers in implementing CEPPs. Regions III, IV and V trained 100% of their providers.

**Conclusion:** *CI 8.5* would be met if the data reported that shows that the Commonwealth has exceeded this CI 86% performance measure had been determined to be reliable and valid.

***8.6 Documentation indicates a decreasing trend in the total and percentage of total admissions as compared to the population served and lengths of stay of individuals with DD who are admitted to state-operated and known by DBHDS to have been admitted to private psychiatric hospitals.***

***8.7 for individuals who are admitted to state-operated psychiatric hospitals known by DBHDS to have been admitted to private psychiatric hospitals, DBHDS will track the length of stay in the following categories:***

- ***Those previously known to the REACH system and those previously unknown;***
- ***Admission of adults and children with DD to psychiatric hospitals as a percentage of total admissions; and***
- ***Median lengths of stay of adults and children with DD in psychiatric hospitals***

**Facts:** DBHDS reports a decrease in the number of admissions in FY20 from a peak in FY19. Admissions to state hospitals decreased from a high of 1018 in FY19 to 708 in FY 2020. This represents a 30% percentage decrease in admissions between FY19 and FY20. This was after admissions reached a peak of 1018 in FY19 which was a 40% increase compared to the 727 admissions to state hospitals in FY18. DBHDS also reports the percentage of individuals with DD admitted to state hospitals as a portion of all admissions to state hospitals. The percentage of admissions of children with DD to state hospitals decreased between FY17 to FY20 from 31% to 23% of all admissions.

DBHDS has a combined process to address *CIs 8.6 and 8.7.* It includes a glossary of terms and process steps. It does not provide direction as to when the data is pulled for the report. The data sources are AVATAR, the REACH Hospitalization Tracker and the
State Hospital IDD Hospitalizations: Total Executed TDOs and State Hospital Admissions Report. DBHDS reports its data in the Supplemental Crisis Report. DBHDS has not determined, as required by 37.07 for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2. that the data from these sources are reliable and valid for compliance reporting. DBHDS has scheduled for June 2021 an updated assessment of the AVATAR and REACH data sources. The first two quarters of FY21 also show a decrease from 708 for the full FY20 to 298 for half of FY21

**Analysis:** DBHDS reports trends in the number of individuals with DD admitted to state hospitals from FY17 through FY20. Total admissions in state hospitals increased from 626 in FY17 to 1018 in FY19, with a decrease in admissions in FY20 to 708. Adults follow this same trend reaching the highest number of admissions in FY19 of 701 and decreasing to 478 in FY20 which is still more admissions than in FY17 (396). The admissions for children had leveled in FY20 to be comparable to admissions in FY17 after two years of increases in FY18 and FY19. The percentages of admissions of all individuals with DD decreased overall between FY17 to FY20 from 31% to 23% of all admissions. DBHDS' data for FY21 includes only Q1 and Q2, when 298 individuals were hospitalized, including 92 children and 205 adults, (missing one person to total 298).

DBHDS also reports the percentage of individuals with IDD admitted to state psychiatric hospitals as a percentage of the entire sum of individuals admitted in FY17 through FY20. This is a separate data report from the report referenced above which reports total number of individuals with DD admitted not comparing that number to total admissions to state hospitals. The percentages of admissions of all individuals with DD peaked in FY19 to 13% of all admissions over the baseline of 9% of all admissions if FY17. The percentage of all admissions decreased back to 9% in FY20, and was trending to 8% in FY21 for the first two quarters. Over

these four years the percentage of children with DD dropped from 31% in FY17 to 23% in FY20. Adults represented 6% of all admissions in FY17 and 7% in FY20.

The total number of both children and adults with DD as a percentage of the total admissions was 9% in both FY17 and FY20, after an increase to 13% of total admissions in FY19. The data for FY21 is only for the first two quarters and does not differ by more than a percentage point compared to FY17.

Although the Commonwealth reports that there were substantial increases in the actual number of admissions of individuals with IDD to state hospitals from FY 17 to FY 19, when these CIs were approved, there has been a decrease in the number of admissions for individuals with DD from FY 19 through FY 20. This trend appear to be continuing for FY21 as evidenced by the data through FY21 Q2 with only 298 admissions of individuals with DD. While the percentage of admissions for individuals with DD peaked in FY19, it was back to its baseline of FY17 at the end of FY20 when individuals with DD represented 9% of all admissions. It was 8% through the first two quarters of FY21. The average Length of Stay (LOS) has shown a steady decrease for adult from a high of 61 days in FY17 to an average LOS of 30 days in FY20, and 29 days in FY21 through Q2. Children experienced an average LOS of 12 days in FY17 and 11 days in FY20. The average LOS for children has increased to 18 days in FY21 through Q2. Children are not yet experiencing a decrease in the average LOS.

DBHDS began reporting this data for admission to private psychiatric hospitals in FY21 Q1. Individuals with IDD accounted for 4% of all admissions to private hospitals in FY21 Q1 and Q2.

Related to *CI 8.7,* DBHDS reports on the average and median lengths of staff for children and adults in state psychiatric hospitals from FY17-FY20. The average LOS has decreased dramatically for adults from 61 in FY17 to 30 days in FY20 and to 29 days during the first two quarters of FY21. The average length of stay for children has been relatively unchanged from 12 to 11 days from FY17-FY20 but has increased to 18 days in FY21 (through Q2). The median LOS for both children and adults dropped between FY17 and FY20. For children the decrease was 10 to 7 days, and it was 23 to 14 days for adults. Adults are experiencing an increase in median LOS so far in FY21 to 18 days from 14 at the end of FY20. Children's median LOS is less varied: 10 days in FY17 and 7 days in FY20 with an increase to 9 days through Q2 in FY21. DBHDS has started to report this data for private hospitals in FY21 Q3.

DBHDS can now report on the average and median LOS comparing individuals known and unknown to REACH. Through FY21 Q2 there are not significant differences whether an individual is known to REACH or not for admissions to state hospitals. DBHDS reports on these data for admissions to private hospitals for only FY21 Q3. The only significant difference is for adults in their average LOS. Those adults known to REACH stayed 8 days on average compared to 15 days on average for adults who were unknown to REACH.

**Conclusion:** *CI 8.6* is not met. There has been a decrease in the number and percentage of admissions and lengths of stay for individuals with IDD from FY 19 through FY 20, which show

that the CI 8.6 metrics for state hospitals have been met. However, there are insufficient data on admissions to private hospitals to determine whether a trend exists.

*CI 8.7* is met as DBHDS is tracking the data for admissions to state hospitals and the admissions of individuals known by DBHDS to have been admitted to private psychiatric hospitals.

***10.1: The Commonwealth will establish and have in operation by June 30, 2019 two Crisis Therapeutic Home (CTH) facilities for children and will provide training to those supporting the child to assist the child in returning to their placement as soon as possible.***

**Facts:** The two CTHs for children became operational in FY19 Q3 and have continued to operate through the eighteenth review period. DBHDS refers to the processes related to *8.3 and 8.5* for training of CTH staff and providers to implement CEPPs as evidence of training to those supporting the child. The data sources are REACH Quarterly Report Data; Summary Operational Definitions/ Data Submission Form (*8.5)*; Master Staff Training Data Spreadsheet; and the REACH Data Store (8.3). DBHDS reports the implementation and its progress toward achieving *CI 10.1* in the Quarterly REACH Child Data Summary Reports. DBHDS has not determined that these data sources provide reliable and valid data and has not informed the workgroups that these data can be used for compliance reporting.

**Analysis:** DBHDs provides a breakdown of the providers trained in CEPPs by service type in its REACH Quarterly Reports. These include CTH Crisis Stabilization; Crisis Step Down; and Crisis Prevention. Over the four quarters there were 100 children in CTHs who received a CEPP. There were 84 children's providers who were trained for a total of 84% of the providers. Region IV consistently trains 100% of the providers but Region II trains fewer which affects the overall accomplishment significantly. The variance in Region II across the four quarters is from a low of 78% in FY21 Q3 to a high of 86% on FY21 Q2.

DBHDs uses the Master Staff Training Data Spreadsheet as its source for data to report the number of REACH employees working in the Children's' CTHs who are trained. There is not separate training information related to the employees who work in the children's CTH programs to verify that they received training specific to their job responsibilities, but DBHDS reports that this information is included in the summary training data.

DBHDS reports that the two CTHs did not operate at full capacity throughout the review period. There were never more than seven of the twelve beds available in this reporting period. There were licensing issues and staffing issues.

**Conclusion:** *CI 10.1* is met. Both CTHs are open, although they are not operating at capacity. DBHDS demonstrates that CTH staff are trained. DBHDS reported that 84% of providers have been trained in the CEPPs. Since no numerical metric was set for *CI 10.1,* it is met.

***10.2 DBHDS will utilize waiver capacity set aside for emergencies each year to meet the need of individuals with long term stays in psychiatric hospitals or CTH's.***

**Facts:** To meet the needs of individuals in these facilities, DBHDS reports that during FY 20, 27 waiver slots were used for emergencies and 16 waiver slots were used in the first three quarters of FY 21. To report its progress toward achieving this CI DBHDS uses data from three sources: WaMS; Complex Case Consult for Emergency Access to Waiver form; and the Emergency Slot Spreadsheet. DBHDS reports on the progress towards meeting this CI in its Supplemental Crisis Report. DBHDS reports on the total number of individuals in this population receiving a waiver slot and also reports on the individual outcome for each, i.e., placement in a 4-person group home.

**Analysis:** The glossary does not include individuals with long term stays in CTHs and hospitals as one of the criteria for receiving an emergency waiver slot under the uses for Emergency Waiver Slots. The process does not describe what follow up is expected by DBHDS for individuals who are granted an emergency slot, but do not receive services in the quarter. The process only requires the Regional Crisis Manager to maintain the name and to check each quarter until services can be reported.
The outcomes for this reporting period are:

- FY20- 27 of 68 of waiver slots were used for this population (40%)
- FY21Q1- Q3: 16 of 52 waiver slots were used for this population (31%)

There is not a separate report for FY20 Q4. DBHDS is using these waiver slots for individuals leaving CTHs or psychiatric hospitals as required by the CI and also includes individuals leaving the Adult Transition Homes.

**Conclusion:** The *CI 10.2* is met. DBHDS is consistently using waiver capacity to address the needs of individuals with long stays in CTHs and hospitals.

**Recommendations:** The Glossary of Terms should clarify that individuals with long-term stays in psychiatric hospitals or CTHs meet the criteria for an emergency waiver slot. The process for ensuring waiver slots are used for this population should address what follow up is expected of Regional Crisis Managers when individuals who are granted an emergency slot do not receive the slot in the quarter. Since the goal is to execute a timely transition for individuals who are ready for discharge, there should there be a more active, timely responsibility for CSB reporting to the Crisis Manager regarding the progress to support the individual when it has not occurred within the quarter.

***10.3: DBHDS will increase the number of residential providers with the capacity and competencies to support people with co-occurring conditions using a person-centered/trauma-informed/positive behavioral practices approach to:***
***1. prevent crisis and hospitalizations, and***

***2. to provide a permanent home to individuals discharged from CTHs and psychiatric hospitals.***

**Facts:** DBHDS used an RFP process to select providers and award these providers a set number of homes/beds to develop to serve this population. Each quarter the providers report on utilization by the identified target groups: individuals discharged from CTHs, ATHs, or psychiatric hospitals. The provider also reports on unused beds and beds being used by individuals not in the target groups. A Continuous Quality Improvement (CQI)process is defined to ensure beds are used appropriately and discharges are not based on "lack of clinical acumen."

To report on this CI, DBHDS uses the data for compliance reporting from the Adult High Behavior Homes Bed Tracking Report. The form is completed by the providers quarterly. This report included data on admission and discharge dates; the reasons for discharge; and where the person was post admission including psychiatric hospital; CTH or CSU admissions; or medical treatment. DBHDS follows up on all individuals who were hospitalized to determine their outcome and if they return to the residential provider. DBHDS reports on its progress to implement *CI 10.3* in the Supplemental Crisis Report.

As of the most recent Supplemental Crisis Report issued in April 2021, the six homes chosen through the original RFP process have all opened and are operational. These homes offers a total of thirty beds to serve this population. Additionally, two more homes have also opened to specifically serve individuals with co-occurring conditions bringing the total number of beds available to thirty-seven. A ninth home is in the process of being licensed which will bring the total capacity to forty-one beds. There are now one or more homes in each Region. At the end of FY21 Q3, thirty-four of the thirty-seven beds were occupied. Of the thirty-four individuals residing in these homes, thirty-two have co-occurring conditions and meet the eligibility criteria of CI *10.3.* DBHDS is involved in a new RFP process in FY21 Q3 seeking providers to develop additional homes to support individuals with high behavior needs.

**Analysis:** There is evidence that DBHDS ensures these providers use a trauma- informed person-centered approach and positive behavioral practices. Providers were required to respond to these expectations in their responses to the RFP. DBHDS confirmed the approach each provider used to provide behavioral supports before making the contract award. Positive behavioral supports are a requirement of the state regulations. Licensing reviews these requirements during regular inspections of these residential settings. Providers do not report how long individuals stay in these homes to determine if these settings address permanency. DBHDS in its CQI process notes Regional Crisis Managers inquire about discharges but there is no evidence of continuous data being provided about this and linked to how long an individual resides in these settings or whether the providers' services prevent crises and hospitalizations. Records were not provided that document that the requirements of CI are met.

**Conclusion:** *CI 10.3* is met. DBHDS reports that residential provider homes have been developed and, as of FY21 Q3, are supporting thirty-two individuals who have co-occurring

conditions. These providers demonstrated that they used positive behavioral practices including trauma-informed care in their responses to the Commonwealth's RFP and this is checked for continued compliance during licensing reviews. Providers must have a BCBA or other licensed behaviorists on staff.

***10.4: 86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities and psychiatric hospitals will have a community residence identified within 30 days of admission.***
***11.1: 86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities will have a community residence identified within 30 days of admission.***

**Facts:** DBHDS reports that, during three of the four quarters during the seventeenth and eighteenth review periods, 86% or more of the individuals known to the REACH system had a community residence identified within 30 days of admission.

These are similar CIs except *11.1* addresses only CTH admissions and *10.4* includes both CTH and psychiatric hospital admissions. The staff who enter the data are instructed to only include individuals with active waiver status who were admitted to CTHs. But all individuals are included who were hospitalized whether they are enrolled in a waiver or not. This is to track the outcomes for the many children admitted to hospitals who are not yet waiver participants. DBHDS has a CQI process to address issues with regions that do not achieve the CI of 86% to determine and correct systemic problems. The Commonwealth's data sources are the REACH Hospital Tracker and REACH No Dispositions/ Over 30 Days Tracker. The data are reported in the Supplemental Crisis Report. The Commonwealth has not determined that these sources provide data that can be used for compliance reporting.

**Analysis:** The DBHDS records do not document a clear process to determine that the REACH Hospital Tracker includes all admissions to psychiatric hospitals. There is no evidence of cross referencing with AVATAR, the data source that tracks all hospital admissions.

DBHDS reports the following data to calculate the percentage of all individuals admitted to a CTH who have a DD waiver, and all individuals admitted to a psychiatric hospital who accepted REACH services who have a community residence identified within 30 days of their admissions. The reported outcomes for all individuals *with a DD waiver and known to the REACH system who are admitted to CTH facilities and psychiatric hospitals or* the seventeenth and eighteenth reporting periods are:

- FY20Q4- 92%
- FY21Q1- 86%
- FY21Q3- 80%
- FY21Q4- 86%

**Conclusion:** The Commonwealth reported that its data shows that it met the 86% metric in three of the four quarters in the seventeenth and eighteenth reporting period. Using just the percentages (the actual numbers of individuals was not reported) the Commonwealth reported that it averaged 86% over the entire reporting period. These data sources however have not been determined to provide reliable and valid data.
The *CIs 10.4 and 11.1* would be met if the Commonwealth's data were complete (i.e., included the numbers of individuals along with the percentages), were determined to provide reliable and valid data, and the data were verified.

***13.1: The Commonwealth will establish and have in operation by June 30, 2019 two Crisis Therapeutic Home (CTH) facilities for children.***

**Facts**: This CI is similar to *CI 10.1* but only requires that the Commonwealth establish two CTHs for children. DBHDS has fulfilled the requirements of this CI. The REACH CTH utilization data is and will continue to be included in the REACH Children's Data Summary Report.

**Analysis:** DBHDS reports that the two CTHs operated throughout the review period, but not yet at full capacity. Of the twelve beds available, there were never more than seven beds occupied in this reporting period. The DBHDS monitoring processes were in place and they had identified licensing and staffing issues for the providers to address.

**Conclusion:** *CI 13.1* is met. Both of the required CTHs for children are operational.

***13.2: To address the CTH stays of adults beyond 60 days, DBHDS will establish and operate two transition homes by June 30, 2019.***

**Facts:** DBHDS established these homes in FY20. They have been fully operational since FY20 Q2.

One home (Culpeper) serves individuals with DD in Regions I and II. The second home (Chester) serves individuals with DD in Regions III, IV, and V. DBHDS provided a report for utilization for FY20 Q2 through FY21 Q3. DBHDS reports that the expected LOS is targeted between three to four months. Each home has the capacity to serve six individuals.

**Analysis:** DBHDS provided a separate report on utilization of the Adult Transition Homes (ATH) during this review period. The report covered FY20 Q2 though FY21 Q3. For this review period, the two homes ranged in utilization from 39% to 71% for the Culpeper ATH, and from 31% to 74% for the Chester ATH. No explanation was provided regarding the low utilization. It is very likely that the low utilization of the ATHs was, at least in part, caused by COVID restrictions and related staffing concerns.

DBHDS provide additional data in an Addendum Report: *ATH Utilization and Disposition* to aid our understanding of the utilization of these settings regarding the actual and average LOS is

for each home and information on where individuals transition after staying at the ATH. The goal of creating these two homes is "to address the CTH stays of adults beyond 60 days." Twenty-three adults were admitted to these two ATHs during Year 6. One individual was admitted from a psychiatric hospital and the remaining twenty-two were transferred from the adult CTHs. The number of days individuals stay ranges from 30 to 36 days at Culpeper and from 30 to 53 days at Chester. These data indicate the operation of these homes has positively impacted the number of CTH stays greater than sixty days. DBHDS reported the dispositions of adults who transitioned from the ATHs in FY20 Q2 and Q3. One person was admitted to a psychiatric hospital and one person was jailed. Everyone else was transitioned to a community setting. Two individuals returned to live with their families; three went to sponsored residential settings and thirteen transitioned to group homes.

DBHDS reports in detail about the LOS for individuals whose stay continues from one quarter to the next. There were ten such individuals in FY20 Q4; eight in FY21 Q1; eight in FY21 Q2; and eight in FY21 Q3. Ten of the thirty-four individuals who stayed longer than thirty days and stayed across quarters were discharged in fewer than sixty days. Although, the ATHs are not yet operating at full capacity, they have had a positive impact on the LOS in the CTH. The increased availability of this alternative should allow the CTHs to accept more referrals as beds are more readily available.

**Conclusion**: *CI 13.2* is met. The homes are operational and are addressing CTH stays of adults beyond 60 days.

***13.3 The Commonwealth will implement out-of-home crisis therapeutic prevention host homes like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service through statewide access in order to prevent institutionalization of children due to behavioral or mental health crises.***

**Facts:** DBHDS has implemented the "out-of-home crisis therapeutic prevention host homes like services for children connected to the REACH system". This service is a short term out-of-home alternative that offers a break from the current family home environment to mitigate a larger crisis situation and avoid the need for longer term out-of-home placement. Referrals of eligible children come directly from the Commonwealth's Regional REACH programs statewide, A family that enrolls their child receives therapeutic services towards the youth's individual support plan, along with collaboration and support from the REACH crisis program.

**DBHDS** has secured two providers, one of which was in operation through FY21 Q3.

DBHDS provided documentation that shows that it monitors, tracks and reports on the number of children who use ***out-of-home crisis therapeutic prevention host homes***. DBHDS also tracks and reports on the number of referrals; number of admissions; lengths of stay; and outcomes of the stay. The outcomes include data for those hospitalized versus those who retained their

home setting or transitioned to a new community setting. The outcome data is used by the Regional Crisis Managers to determine if action for improvement is warranted. The source of data is the Out of Home Prevention Services Operational Data Definitions Sheet. DBHDS reports on the utilization of these host homes in the Quarterly REACH Children's Reports.

**Analysis: DBHDS** has secured two providers but only one is in operation through FY21 Q3. The other is working to become licensed. REACH makes referrals to these settings. They are operated in Regions IV and V but are available to all children in Virginia who need to access them. Since FY21 Q1 thirteen children were referred and five received services. DBHDS reported that the families of the eight children who were referred but not served did not accept the services. Lengths of stay were 6 to 29 days. All but one child returned to their homes. This child transitioned to a new community setting. None of the children were institutionalized.

Conclusion: *CI 13.3* is met. The Commonwealth has developed out-of-home crisis therapeutic prevention host homes like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis in order to prevent institutionalization of children due to behavioral or mental health crises.

Submitted By:

Kathryn du Pree, MPS
Expert Reviewer

Joseph Marafito, MS
Expert Reviewer
May 10, 2021

## ATTACHMENT 1 DOCUMENT LIST

| NUMBER | DOCUMENT | TIME PERIOD OR DATE | RELATED COMPLIANCE INDICATOR OR PROVISION |
|---|---|---|---|
| 1 | CSB Performance Contract Examples | 7.20 | CIs 7.2, 7.3, 7.6 |
| 2 | Crisis Risk Assessment Tool (CAT) | 7.9.20 | CIs 7.4, 7.6 |
| 3 | CAT Quality Review Feedback Form | Not Dated | CIs 7.4, 7.6 |
| 4 | CAT Completed Examples | Not Dated | CIs 7.4, 7.6 |
| 5 | Supplemental DOJ Quarterly Crisis Report | FY20Q4-FY21Q3 | CIs 7.5, 7.8, 7.13, 7.21, 7.22, 7.23, 8.1, 8.3, 8.4. 8.6, 8.7, 10.2, 10.3, 10.4, 11.1 |
| 6 | Monitoring Questionnaire | 3.21 | CIs 7.5,7.7, 7.8, 7.13, 7.14,7.21, 7.22,8.3, 8.4, 8.5, 8.6, 8.7, 10.2, 10.3, 10.4, 11.1 |
| 7 | Valley Crisis Risk Assessment Tool Feedback Form | 12.20 | CI 7.7 |
| 8 | Region Ten Risk Assessment Tool Feedback Form | 12.20 | CI 7.7 |
| 9 | New River Valley Risk Assessment Tool Feedback Form | 12.20 | CI 7.7 |
| 10 | Crisis Assessments Examples | Not Dated | CI 7.7 |
| 11 | REACH Data Store | Not Dated | CI 7.8, 8.4, 8.7 |
| 12 | Exhibit K | Not Dated | CI 7.9 |
| 13 | Commissioner Letter to CSBs | 6.21.16 | CI 7.9 |
| 14 | MHI Competency Checklists | Not Dated | CI 7.9 |

| | | | |
|---|---|---|---|
| 15 | Collaborative D/C Protocols: CSB & SH | Not Dated | CI 7.9 |
| 16 | DBHDS Consolidated Morning Report | Not Dated | CIs 7.10 and 7.12 |
| 17 | DBHDS Letter to Private Hospitals | 6.5.20<br>2.13.20 | CI 7.11 |
| 18 | REACH Hospitalization Tracker | 11.19.20 | CIs 7.12, 8.6, 8.7, 10.4, 11.1 |
| 19 | Behavioral Supports Report DRAFT | FY21Q1-FY21Q3<br>3.08.21 | CI 7.14 |
| 20 | Behavioral Supports Report FINAL | FY21Q1<br>4.15.21 | CI 7.14 |
| 21 | Practice Guidelines for Behavior Support Plans DRAFT | FYQ1<br>2.2021 | CI 7.15 |
| 22 | Behavioral Services Case Management Training Curriculum | Not Dated | CI 7.16 |
| 23 | REACH Region I Quarterly Quality Reviews Adults | FY20Q4-FY21Q3 | CIs 8.1,8.2,8.3 |
| 24 | REACH Region I Quarterly Quality Reviews Children | FY20Q4-FY21Q3 | CIs 8.1, 8.2, 8.3 |
| 25 | REACH Region II Quarterly Quality Reviews | FY20Q4-FY21Q3 | CIs 8.1, 8.2, 8.3 |
| 26 | REACH Region III Quarterly Quality Reviews | FY20Q4-FY21Q3 | CIs 8.1, 8.2, 8.3 |
| 27 | REACH Region IV Quarterly Quality Reviews | FY20Q4-FY21Q3 | CIs 8.1, 8.2, 8.3 |
| 28 | REACH Region V Quarterly Quality Reviews | FY20Q4-FY21Q3 | CIs 8.1, 8.2, 8.3 |
| 29 | REACH Quarterly Qualitative Correction Plans Examples Regions III & V | FY21Q2 | CIs 8.1, 8.2, 8.3 |
| 30 | REACH Master Staff Training Data | 9.1.20 | CI 8.3 |

| | | | |
|---|---|---|---|
| 31 | REACH Summary Operational Definitions | Not Dated | CI 8.5 |
| 32 | REACH Quarterly Reports Adults | FY20Q4-FY21Q3 | CI 8.5 and all Provisions in compliance |
| 33 | REACH Quarterly Reports Children | FY20Q4-FY21Q3 | CIs 8.5,13.3 and all Provisions in compliance |
| 34 | AVATAR | Not Dated | CIs 8.6, 8.7 |
| 35 | State Hospital SH-IDDD Report | Not Dated | CIs 8.6, 8.7 |
| 36 | Emergency Slot Spreadsheet | Not Dated | CI 10.2 |
| 37 | Bed Tracking Adult High Behavior Homes | 7.29.20 | CI 10.3 |
| 38 | REACH Data Dictionary | Update 9.15.20 | CIs 10.4, 11.1 |
| 39 | Adult Transition Home Utilization Report | 4.16.21 | CI 13.2 |
| 40 | ATH Addendum | 4.29.21 | CI 13.2 |
| 41 | Data Reliability and Validity Cover Letter | 4.28.21 | All CIs |
| 42 | Process Documents | 3.21 | All CIs |
| 43 | DBHDS memo and table re: Data Reliability and Validity | 4.28.21 | All CIs that require data |
| 44 | Exhibit M DOJ SA Requirements | 7.1.20 | All CIs |

**Attachment 2: Qualitative Study of the Delivery of Personal Care and In-Home Services between July 1, 2020 and December 31, 2021**

**Introduction and Overview**

For the eighteenth period review, we conducted a qualitative review of 110 of the 252 children and adults with identified significant behavior support needs (Support Level 7) living at home with family who were to receive either personal care or in-home support services between July 1, 2020 and December 31, 2020. The purpose of the study was to determine if individuals with level 7 needs are receiving the services that are authorized for them; to determine the reasons authorized services were not delivered; and if there are any unmet needs that are leading to safety risks. This study will parallel the review that DBHDS conducts to implement *CIs 7.21, 7.22 and 7.23* to determine the reliability and sufficiency of their review methodology.

This qualitative study includes a review of the available records of forty-seven children and sixty-three adults. DBHDS provided the list of all children and adults who received these services in this time period. We randomly selected forty-seven children and four alternates; and sixty-three adults and seven alternates from the DBHDS database of all individuals who received these services in the July 2020- December 2020 review period. For selected sample of individuals lived in all five of the Regions. Twenty-five reside in Region I; thirty-six in Region II; seventeen in Region III; sixteen in Region IV; and sixteen in Region V. The number and methodology applied for sample selection yielded a statistically significant sample that will allow generalization of the findings to the cohort with a 90% confidence level.

DBHDS shared its methodology for reviewing the data to determine if authorized services were received; the reasons when authorized services were not received, and if the individuals have unmet needs that are leading to safety risks. We used this same methodology to make these determinations, although our questions varied slightly. DBHDS interviewed families as part of its inquiry. Whereas, we interviewed Case Managers (CM) and expected them to represent the individuals' and families' interests and needs. In past reviews, we have had greater success contacting and speaking with a much larger sample of CMs versus family members. Additionally, CMs have proven to be more informed on specific provider issues and have the ability to access relevant information from WaMS which assists us to more accurately complete the interview items.

DBHDS produced the following documentation for each of the selected individuals:

- Individual Service Plans (ISP) including Sections I-IV, and Sections V from the in-home service provider
- Names and contact information (phone and email address) of the Case Managers

In some cases, the documentation provided was incomplete. For example, the ISP that was provided did not cover the time period fully; an entire Part V was missing; or a Part V schedule was not included.

**Methodology**
The methodology we planned included both a record review and an interview with the individual's CM as a reliable informant. We also reviewed DBHDS' methodology and interviewed Denise Hall, the DBHDS Regional Crisis Manager, who conducted the DBHDS review to implement CIs 7.*21, 7.22* and *7.23.*

**Record Review**
The record review for this study was completed separately by two reviewers. To ensure a consistent approach to the review of the ISP and the WaMS data, we developed and followed a written protocol, which was shared by DBHDS .

The review of the ISP included a review of its Overview section; the listing of providers; the Health section; the behavioral section; the social and developmental history; the Part III to verify goals for personal care and in-home supports; the Part V and the Part V Schedule to verify hours of personal care or in-home support services that were needed and scheduled.

The review of the WaMS data included a review of the types of services authorized for each individual; the authorized start and ending dates for the service; and the MMIS units that were authorized. We then compared the information in the ISP and the authorizations and approved units listed in WaMS to determine if the needed services were approved and if the services were approved for the level of need indicated in the ISP.

**Interviews with Case Managers**
We contacted all CMs for whom we were given an email address and attempted to call CMs for whom only a telephone number was provided. We were only able to interview CMs for thirty of the forty-seven (64%) children and thirty-one of the sixty-three (49%) adults in the study. Overall, we were able to interview sixty-one of the 110 (55%) individuals' CMs. Some CMs had more than one individual in the sample. A total of twenty-four CMs did not respond to either emails or telephone calls requesting an interview. This included twelve CMs for children, twelve CMs for adults, and two CMs who had both children and adults in the study sample. These twenty-four CMs provided services for a total of forty-nine individuals of the 110 (45%) individuals randomly selected for the study.

We asked each CM the following questions:

1. How did the team determine the amount and frequency of the personal care and in-home supports services the individual needs?
2. Does the authorization for these services match the individual's need for the services?
3. If not, why not?
4. Did the person receive all of the services authorized between 7/1/20- 12/31/20?
5. If not, why not?
6. If there were gaps in services has this been rectified and how was it rectified?

7. Ask if there was a change in provider and not addressed by the previous questions:
   We note there was a change in service provider. What was the reason for this change?
8. Do you or the family believe there are any unmet needs that may lead to a safety risk for the individual?

**Findings**

***Assessments to determine need:*** We asked one question which was not asked by DBHDS in its study. This was, how did the team determine the amount and frequency of the personal care and in-home supports services the individual needs? We asked this to gain more insight about how need is determined for individuals in Virginia. The CMs answers were quite consistent. The CMs reported that they rely on data from the VIDES, SIS and crisis assessments; however of equal or greater importance are the input of family members and the assessments completed by the chosen provider. CMs reported that the system of authorization is very responsive to changing needs as identified by families, providers and the CMs. They believe this strengthens the utility of in-home and personal care services to assist families to maintain their family member safety at home.

***Alignment of the ISP and Service Authorization Dates:*** From the record review, we found that the dates and type of services of the ISP and the WaMS service authorization aligned for forty-five (96%) of the forty-seven children and for sixty-one (97%) of the sixty-three adults. One child had services listed in the ISP but the services were not listed as approved by WaMS. We were provided this child's ISP, but not the Part V for the in-home services being studied. DBHDS did not provide us with the ISPs for two adults that covered the entire time period of July 2020-December 2020. Overall, 106 (96%) of the dates of the ISP and the service authorizations matched.

***Alignment of the ISP hours needed and the WaMS hours approved***: We found that the hours identified as needed in the ISP aligned with the authorizations for forty-four (94%) of the forty-seven children and for fifty-six (89%) of the sixty-three adults. One child had in-home supports in the ISP, but not in the WaMS authorization. The other two children had more hours authorized than were documented in the ISP. Six adults had authorized hours that differed from those documented in the ISP; three had more hours in the WaMS authorizations and three had fewer hours. One individual did not have a Part V schedule to review so we could not compare the hours. We were not able to interview the CMs for these individuals and it may be that hours were adjusted upwards as a result of day program closures that occurred during COVID-19. CMs reported during interviews that in some cases authorized hours had been increased for some of the children who were homebound during the pandemic. Overall, the ISP hours and the service hours authorized matched for 100 of the 110 (91%) individuals in the study sample.

***Service Delivery:*** The CMs were able to tell us to the best of their knowledge whether services were delivered to individuals between July 2020 and December 2020 and if there were any gaps in services. Their information about whether services were delivered was based on information the CMs receive from families during monthly or quarterly calls or visits. Many CMs reported they also receive quarterly reports from the providers of these services. CMs reported

that twenty-three (77%) of thirty children who were authorized to receive personal care or in-home services consistently received such services throughout the six-month period. Overall, the CMs who we were able to interview reported that fifty-two (85%) of the sixty-one individuals received services consistently throughout the reporting period. This included twenty-nine (91%) of the thirty-one adults and twenty-three (77%) of the thirty children While only two of the thirty-one adults did not receive services for some of the review period, another three had brief gaps. We consider there to be a gap if the CM reported the individual was without the service for at least two weeks. The gaps in services for both children and adults were the result of: a change in the service being provided to one that was not listed in the ISP, a change in the provider of the in-home services that were listed in the ISP, or a provider having staff available to consistently provide the personal care or in-home service. For example, two children in the selected sample had been placed in residential treatment for the entire six-month period; however, neither their ISPs nor the related WaMS authorization data had been adjusted to reflect this major change in the services they received. This is an example of the fallacy that WaMS authorizations for a service is a reliable and valid data source for a service actually being delivered.

Many of the families used consumer-directed personal care services during the pandemic. The Commonwealth was able to offer families the consumer-directed option to provide them the flexibility of hiring family members, including parents or grandparents, as the personal care provider. Families found this very helpful during the pandemic when many were uncomfortable allowing agency staff into their homes. CMs seem to be very prompt in informing families of the option to use consumer-directed personal assistance services. Many CMs reported that the consumer-directed option helped families to minimize gaps in service delivery. CMs also reported that it was easy to adjust hours upwards or for different parts of the day or week to allow families to receive the support they needed as programs closed or re-opened during the pandemic.

***Safety Issues:*** We asked if the services in place addressed the individual's safety needs or if there were unmet service needs that lead to a safety risk. CMs reported that six (20%) of the thirty children had unmet needs and a related a safety risk. Two of the children need fencing to prevent elopement, which was an identified need in their ISPs; one needs ABA and in-home support in addition to the personal care (which the CM is seeking); and four need more consistent staff than the family is able to enlist to ensure consistent service delivery. These were all known service needs during these individuals' annual ISP meetings. CMs report that the long-standing shortage of staff willing to provide in-home services for the low wages offered, especially for working with individuals with level 7 needs, has been exacerbated by COVID-19. CMs reported unmet needs related to known safety risks for five (16%) of the thirty-one adults. Two adults have had provider agencies refuse to serve them; one cannot be in the community without being accompanied by two people; one is in need of a residential placement, which was delayed because of COVID; and the fifth individual has not started a needed behavior program because the guardian has not yet approved it. Overall, CMs reported safety concerns related to unmet needs for eleven (18%) of the sixty-one individuals they support.

***Comparison to the DBHDS review*:** Addressing *CI 7.21*, DBHDS determined that based on a comparison of services identified in their ISPs and the authorization data in WaMS system 252 of the 260 (97%) were "receiving" the services in their ISPs. Yet DBHDS reports 249 (99%) of the persons reviewed had approved authorizations and that the authorized hours matched the hours in the ISP. In our study, we determined that the data from WaMS that lists the approved number of MMIS units (i.e., hours of in-home and personal services) is not evidence that services were actually provided. WaMS authorization data is a reliable source for the number of hours authorized, but is not provide reliable data for the hours of services that were actually provided.

In our sample, we found that 106 (96%) of 110 individuals of the ISPs matched the WaMS for the dates and type of service authorized; and that for 100 (91%) out of 110 individuals the hours listed in the ISP matched the number of authorized hours in WaMS. We were not always provided the actual schedule of services that is part of the Part V ISP document which may account for some of the variance. Of the 91% with the same hours and schedule listed, we were not able to determine how many hours of service were actually delivered.

Addressing *CI 7.22,* DBHDS was able to interview 102 families (39%) of the 260 identified with a need; and (40%) of the 252 individuals found to be receiving services. All families interviewed indicated COVID has impacted their lives. In our study we were able to interview CMs who served 60% of the 110 individuals in our sample.

DBHDS reports that forty (39%) of the families cited barriers to receiving the number of authorized service hours and, therefore, gaps in service delivery. The two most frequently reported barriers were a lack of staff and insufficiently trained staff. Ten (10%) families reported that technology and documentation requirements created barriers to being able to pay staff in a timely manner. Families reported to DBHDS that low wages for personal care services is a significant impediment to being able to hire qualified staff. In our study CMs reported that twelve (20%) of the families had experienced some gap in service delivery. CMs reported the same concerns about staffing barriers and discussed the significant impact COVID has had on all of these families. We did not elicit any information about payment barriers in our interviews with CMs.

Eight families (8%) reported to the DBHDS interviewer safety concerns related to service needs that were not being addressed. In our study CMs reported safety concerns for eleven (18%) of the sixty-one individuals they represented.

***Table 1: A Comparison of Findings of the DBHDS and Expert Review Studies*** below summarizes the findings of each review completed of *CI 7.21 and 7.2*

**Table 1: A Comparison of Findings of the DBHDS and Expert Reviewer Studies**

| Issue | DBHDS Findings | Independent Study Findings | Comments |
|---|---|---|---|
| ISP/MMIS Dates Match for same type of service | 97% (252 of 260) | 96% (*106 of 110)* | *DBHDS notes 8 of the 260 didn't receive services that were identified as needed in their ISPs yet does not count those 8 in further calculations* |
| ISP service needs and WaMS authorized Hours Match | 99% (*249 of 252)* | 91% (*100 of 110)* | |
| Individual reported* to have Received Services: 7/1-12/31/20 | 61% (*62 of 102)* | 85% (*52 of 61)* | |
| Individual Experienced Gaps in Service delivery: 7/1-12/31/20 | 39% (*40 of 102)* | 13% (*8 of 61)* | |
| Individual has safety concerns and unmet needs | 8% (*8 of 102*) | 18% (*11 of 61)* | |
| Number of Informants | 40% (*102 of 252)* | 54% (*59 of 110)* | *DBHDS did not interview the 8 individuals who did not receive services, some of whom had their waiver slot released or placed on hold to determine the reason* |

*The expert reviewer's finding were based on reports by the individuals' case managers. The Commonwealth's findings were based on reports by the individuals' families. Both the Case Managers' and families' reports are more reliable indicators of services actually received, but memory recall by those involved in planning or arranging for services to be delivered may be influenced by a cognitive bias, such as choice-supportive or confirmation bias.

**Conclusion:** The findings of the DBHDS review and of the Expert Reviewer had similar findings for the areas of inquiry that were dependent on the ISP and WaMS service authorization data. However, our study's findings were dissimilar for the areas of inquiry (i.e., services actually delivered) that were dependent upon the willingness of families or case managers to be interviewed, their recall ability, and their respective potential for cognitive bias. Neither study cross checked the services delivered information with billing data. Our review that was based on information reported by case managers indicated a higher percentage of individuals received services in the period and fewer experienced gaps when compared with the DBHDS review findings. More of the individuals in our sample were reported to have safety concerns related to gaps in the service delivered. However, an increase in gaps in service delivery was expected during COVID-19 era when it was more difficult to recruit staff and some families were reluctant to have staff in their homes. Wages of personal care staff are reported as an on-going barrier to the consistent delivery of services by sufficiently trained staff.

We were able to interview more informants than DBHDS as a result of contacting CMs. The percentage of individuals interviewed for both studies may account for some of the differences in the findings, but neither studies' findings can be generalized with confidence to the cohort. However, our findings seem to validate the conclusion and recommendation in the eighteenth period Crisis Services Report that DBHDS should review actual billing data to determine the extent individuals received the services that were authorized. Both of our studies relied on one informant group, either families or CMs. CMs are reliant on the families reporting accurately to them during monthly or quarterly contact. DBHDS can only report on actual service delivery using a reliable and valid data source, such as provider billing information. This information would allow the DBHDS reviewers to be more specific in their interviews with either CMs or families to better ascertain reasons for specific periods of time when services were not delivered. DBHDS has not determined that WaMS authorization data provides reliable and valid data for compliance reporting, as required by CI 37.07 for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2..

We were extremely impressed with the knowledge and responsiveness of all of the CMs we were able to interview. We appreciate their time as they contributed to our understanding of the provision of personal care and in-home supports in the Commonwealth. They were remarkably knowledgeable of the individuals on their caseloads and the needs of their families. They are strong advocates and have worked diligently during the pandemic to make sure the service delivery system is responding to the needs of these individuals. DBHDS is to be complimented for its efforts to increase the flexibility and responsiveness of the service delivery system. Families have appreciated that family members could be approved as the personal care provider. This option allowed some parents to leave a job to care for a child whose program had closed. Many CMs reported that it was simple to request the additional hours a family needed or to rearrange hours, so the schedule responded to needs that changed as a result of program closures and re-openings.

Our review of the methodology used by DBHDS to complete the review of data related to CIs 7.21, 7.22, and 7.23 demonstrates that the methodology of record review and informant interview is well constructed and provides useful data. The interview process might be strengthened by including CMs if it is easier to complete interviews with a greater number of them then family members. DBHDS lacks actual data to verify that services were delivered, but including billing data in its document review could verify this essential data point.

Submitted By:

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May 11, 2021

# APPENDIX D

## INDIVIDUAL AND FAMILY SUPPORT PROGRAM, GUIDELINES FOR FAMILIES, PEER TO PEER

**By**

**Rebecca Wright LCSW**

# IFSP 18th Review Period Study

**Introduction/Overview**

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to create an Individual and Family Support program (hereinafter IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. The related provisions are as follows:

> **Section II.D:** Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and family-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C. The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.
> **Section III.C.2**: The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization...
> **Section III.C.8.b:** The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.
> **Section III.D.5.** Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.
> **Section IV.B.9.b.** ...The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities.

The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) have jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia has not yet been found in compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020. For the next Report to the Court, due in June 2021, the Independent Reviewer's monitoring priorities again include studying compliance with the these agreed-upon compliance indicators.

The Independent Reviewer's previous reports (i.e., 6th, 8th, 12th, 14th and 16th Reports to the Court, dated June 6, 2015, and June 6, 2016, June 13, 2018, June 13, 2019 and June 6, 2020, respectively) found the Commonwealth had met the pertinent quantitative requirements by providing IFSP monetary grants to at least 1,000 individuals and/or families. These same Reports to the Court further found that the Commonwealth had not met the qualitative requirements for the IFSP, but noted steady progress, which had accelerated significantly beginning at the time of the12th review period, following the development of the IFSP State Plan. In addition to developing an IFSP Strategic Plan, DBHDS had created an IFSP Community Coordination Program; organized a IFSP State Council and Regional Councils as forums for informing stakeholders about the IFSP and obtaining their input; continued to develop enhancements to the IFSP Funding Program; and undertook an initiative for a family-to-family and peer-to-peer mentoring program. At the time of the last Report to the Court on this topic (i.e., the 16th Report), some of these

efforts were still in the preliminary planning or early implementation stages, but had good potential for moving the Commonwealth toward compliance.

**Study Purpose and Methodology**

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

The study methodology included document review, DBHDS staff interviews, stakeholder interviews, and review and analysis of available data. The purpose of the study and the related components of the study methodology were reviewed with DBHDS staff. Following that kick-off meeting, DBHDS was asked to provide all necessary documents and to suggest interviews that provide information that demonstrates proper implementation of the Provision and its associated Compliance Indicator(s). A full list of individuals interviewed is included in Attachment A. full list of documents and data reviewed may be found in Attachment B.

**Summary of Findings**

For each provision cited above, this 18th period study again found DBHDS continued to make progress, but in some instances had not yet finalized development and/or implementation of the strategies intended to achieve the compliance indicators and/or formalized the reporting and documentation requirements. DBHDS still needed to focus additional attention on several areas, including the following: finalizing the definition of who would be considered "most at risk for institutionalization" for the purposes of the individual and family support program (hereinafter "prioritization criteria); finalizing the eligibility criteria for and informing individuals on the waitlist of the case management options available; developing the capacity of the family-to-family support and peer-to-peer mentoring programs to ensure they address the specific requirements of the provisions and Compliance Indicators, and identifying measurable indicators to assess performance and outcomes of the IFSP, including the development of capacity for the collection and the analysis of reliable and valid data.

As reported at the time of the last study, in some instances, such as defining the prioritization criteria, DBHDS had taken some important steps forward toward implementing the requirements outlined in the compliance indicators, but sometimes provided only narrative and/or draft documents that did not have any formal provenance. DBHDS did develop a Departmental Instruction (DI) 113 (TX) 20, entitled *Facilitation of Access to Resources and Supports to Enhance Community Inclusion and Engagement, which indicates its purpose is to outline the supportive policies within the IFSP as they relate to the administration of peer-to-peer mentoring, family to family mentoring, information and referral, and the IFSP community coordination efforts. The DI provides extensive definitions of terms, but specific guidance is both broad and limited in scope. Instead, the DI defers to the DBHDS Central Office to "ensure that procedures are developed to comply with this DI."* DBHDS still needed to translate the processes described in the various narrative documents into the formal operational expectations (e.g., policies, procedures, departmental instructions, reporting capabilities) that are needed to demonstrate the source of its authority.

The table on the following page illustrates the current compliance status for each Compliance Indicator.

| **III.C.2.a-f (II.D): Indicators** | | **Status** |
|---|---|---|
| 1.01 | The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following:<br>• Funding resources<br>• A family and peer mentoring program<br>• Local community-based support through the IFSP Regional Councils | Not Met |
| 1.02 | The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization. | Not Met |
| 1.03 | The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program. | Met |
| 1.04 | The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including: | Not Met |
| 1.05 | The number of individuals on the waiver waitlist who are provided with outreach materials each year | Met |
| 1.06 | Participant satisfaction with the IFSP funding program | Not Met |
| 1.07 | Knowledge of the family and peer mentoring support programs | Not Met |
| 1.08 | Utilization of the My Life, My Community website | Met |
| 1.09 | Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter. | Not Met |
| 1.10 | IFSP funding availability announcements are provided to individuals on the waiver waitlist. | Met |
| 1.11 | Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website | Not Met |
| 1.12 | Documentation continues to indicate that a minimum of 1,000 individuals and/or their families are supported through IFSP funding. | Met |
| **III.C.8.b: Indicators** | | **Status** |
| 17.01 | DBHDS has developed and launched the "My Life, My Community" website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. This will be documented by reports of activity on the website. | Met |
| 17.02 | Documentation indicates that the My Life, My Community website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families. | Met |
| **III.D.5 (IV.B.9.b.): Indicators** | | **Status** |
| 19.01 | At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources. | Met |
| 19.02 | The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested. | Not Met |
| 19.03 | The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to- family and the peer-to-peer supports have contact and the number who receive the service. | Not Met |

# Analysis of 18th Review Period Findings

**18th Review Period**
**Findings**

**III.C.2.a-f (II.D)**
**The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization……. In State Fiscal Year 2019, a minimum of 1000 individuals supported.**

**(II.D: Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and family-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C above. The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.)**

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 1.01<br>The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following:<br>• Funding resources<br>• A family and peer mentoring program | The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council includes the essential components of a comprehensive and coordinated set of strategies, including funding resources, a family and peer mentoring | For this review, DBHDS had developed a Departmental Instruction (DI) with regard to the IFSP. *DI 113 (TX) 20: Facilitation of Access to Resources and Supports to Enhance Community Inclusion and Engagement* states its purpose is to outline the supportive policies within the IFSP, as they relate to the administration of peer-to-peer mentoring, family-to-family mentoring, information and referral, and the IFSP community coordination efforts. The DI provides extensive definitions of terms, but specific guidance tends to be both broad and limited in scope. Instead, it defers to the DBHDS Central Office to "ensure that procedures are developed to comply with this DI." Specifically, the DI indicates that the procedures to be developed shall include:<br>• Processes and procedures to support the implementation of the State Plan and the state and regional council structure to build the local infrastructure to promote person-centered and family-centered resources, supports, services, and other | Not Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| • Local community-based support through the IFSP Regional Councils | program and local community-based support through the IFSP Regional Councils. *Virginia's Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities, Version Date: October 3, 2020; Departmental Instruction 113 (TX) 20)*<br><br>The IFSP Funding Program continued to evolve, but has been in continuous operation since 2013. In addition, IFSP staff have issued, and updated as needed, formal guidelines, policies and procedures sufficient to implement the program. *(IFSP Funding Program Summary 2013-2020; Individual & Family Support Program Application Portal User Guide FY 2020, the Individual and Family Support Program Guidelines, updated February 2020, and a document entitled Maximizing Your IFSP Funds: A detailed guide of allowable items, low to no-cost resources for commonly* | assistance;<br>• A process for providing family and peer mentoring to provide one on one support and information to individuals and families;<br>• A process to establish criteria for identifying applicants most at risk for institutionalization; and,<br>• A process to maintain accessible, user-friendly information including information on eligibility for IFSP-Funding, case management, and other DD resources and services through a website and other mechanisms that shall be shared with individuals upon their placement on the DD Waiver Waiting List.<br><br>This Compliance Indicator requires implementation of the strategies in the IFSP State Plan, specifically "offering information and referrals through an infrastructure" that includes funding resources, Family and Peer Mentoring program and local community-based support through the IFSP Regional Councils. Implementation requires a foundation of a minimum set of clear, written finalized policies, procedures, instructions, protocols and/or tools. With regard to funding resources and local community-based support through the IFSP Regional Councils, DBHDS had developed and published a clear set of such documents, but had not yet fully done so for the Family and Peer Mentoring programs. The following paragraphs describe the relative presence and/or absence of the needed documents and/or processes.<br><br>**Funding Resources:** As found during the 16th Review Period, for this review, DBHDS continued to implement and refine its IFSP Funding Program infrastructure. Briefly, for implementation, this infrastructure relies on the Individual & Family Support Program Application Portal, which is currently hosted on the DBHDS website. It can also be accessed via a link on the MLMC website. IFSP staff have developed various tools to support users in accessing and using | |

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| | *requested items and other possible services or supports available in the community, Ver. 12.10.19.*<br><br>The Family-to Family Mentoring program infrastructure was well-developed overall, but DBHDS had not yet developed a clear and comprehensive referral process.<br>*(Appendix C Family to Family Supports, Family-to-Family-Network-of-VA-Brochure-2018; Appendix C Family to Family Supports- DBHDS F2F and P2P Report July 2019 to June 2020; MLMC System Integration Goals (VCU Partnership for People with Disabilities MOA), 5.8.20)*<br><br>DBHDS was working with the Arc of Virginia to develop a Peer Mentoring program infrastructure, but it remained in the formative stages. In addition, DBHDS had not yet developed a clear and comprehensive referral process.<br>*(Statewide Peer Mentoring* | the portal, including the *Individual & Family Support Program Application Portal User Guide FY 2020*, the *Individual and Family Support Program Guidelines*, updated February 2020, and a document entitled *Maximizing Your IFSP Funds: A detailed guide of allowable items, low to no-cost resources for commonly requested items and other possible services or supports available in the community, Ver. 12.10.19.*<br><br>As described above, for this review period, DBHDS had developed *DI 113 (TX) 20* with regard to the IFSP. While the DI defined the IFSP Funding Program in the following manner: subject to the availability of funds, the IFSP Funding available in accordance with *12 VAC 35-230* assists individuals on Virginia's DD Waiting List and their families with accessing resources, supports and services. While the DI did not otherwise detail guidance with the regard to the operation of the funding program, IFSP staff had developed an extensive library of formalized policies and procedures, which they had consistently updated over time to address any programmatic changes. In addition, as described further below for Compliance Indicator 3 of this provision, IFSP staff had worked with other DBHDS staff to develop a robust capacity for providing all individuals on the waitlist with time-sensitive notifications of funding availability.<br><br>Additional details with regard to proposed prioritization criteria for funding, and potential related modifications to the overall Funding Program infrastructure, are provided below under compliance indicator 2 in this section. However, DBHDS staff did not anticipate implementing the new prioritization criteria in the FY21 funding cycle.<br><br>**A Family and Peer Mentoring Program:** The Settlement Agreement requires the Commonwealth to develop family-to-family and peer mentoring programs as a part of a comprehensive and coordinated set of person-centered and family-centered strategies, but also specifically to facilitate opportunities for families and individuals | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | *System Proposal; Arc of Virginia Proposed Work Plan FY2022; Peer Mentoring Quarterly Program Report,12.30.20; Post Training Info 12.2020, 12.20)*<br><br>The IFSP Regional Council infrastructure was well-developed. *(FY 2020 Council Narrative: Council Activities and Reference Documents June 2020; FY 2020 Regional Council Activities Timeline; IFSP Council Charter 2.24.2021; FY 2020 Council Narrative: Council Activities and Reference Documents June 2020)* | considering congregate care receive information about options for community placements, services, and supports.<br><br>As reported previously, DBHDS continues to contract with the Virginia Commonwealth University (VCU) Partnership for People with Disabilities (Partnership) to engage with individuals and families on behalf of the Department across a platform of programs. These efforts included the implementation of a family-to-family network to provide one-to-one emotional, informational and systems navigational support to families. For this Review Period, DBHDS provided an updated addendum to the Memorandum of Agreement (MOA) with dated 5/8/20, to show continuation of the family-to-family program. It indicated the purpose of the collaboration was to 1) provide direct family to family support to families of children and adults with ID/DD to assist with navigating community-based services and resources; 2) support the structure and success of regional Individual and Family Support Councils; and 3) participate in DBHDS efforts to develop a statewide program that offers a continuum of peer-to-peer supports for individuals with ID/DD.<br><br>The brochure for the Family-to-Family Network of Virginia states its intent is to support families of children and adults with disabilities and special healthcare needs. Through the program, Family Navigators provide support and information, and discuss options with families so they can make the best choices for their family member with a disability. Family Navigators are a parent or primary caregiver who is or has supported a child or adult family member with disabilities or special healthcare needs, who has been trained to support other families in accessing supports and services for their child and family and are knowledgeable about local and state resources and disability service systems. This program had been in existence for more than 15 years and is well-established. However, while the infrastructure was in place for providing Family-to-Family mentoring supports, DBHDS had not yet developed a clear and | |

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| | | comprehensive referral protocol for accessing those services, as described further below with regard to Compliance Indicator 19.02.<br><br>With regard to the Peer Mentoring program, it was notable that, while the 6/10/19 MOA with the Partnership called for that organization to "develop programs that offer a continuum of peer-to-peer supports for people with ID/DD," the current contract required simply that they participate in DBHDS efforts to develop a statewide program to offer a continuum of peer-to-peer supports. Instead, as reported at the time of the 16th Review Period, IFSP staff continued to work with the Arc of Virginia (the Arc) to create the capacity to provide Peer Mentoring supports throughout the State. Since the previous report, DBHDS had funded a collaboration with the Arc to develop a statewide Peer Mentor system intended to 1) increase Virginia's capacity to provide peer support by developing a pipeline of individuals who will provide peer supports; 2) provide leadership by supporting DBHDS' vision of more fully incorporating the voice of engagement of self-advocates across multiple DBDHS' initiatives including IFSP, Family-to-Family and the broad My Life My Community (MLMC) initiative; and, 3) ensure access to peer supports for individuals on Virginia DD Waiver Waiting List. This contract period runs from 5/26/20-5/25/21.<br><br>Based on review of the *Peer Mentor Quarterly Report*, for the period October through December 2020, the Arc had made good strides toward developing peer mentoring capacity through the formation of a statewide Alliance of Self-Advocacy and through recruiting, training and developing leadership skills among Peer Mentors. However, the program was not yet providing individual Peer Mentoring to any significant extent.<br><br>Overall, DBHDS also still needed to continue to work towards defining the parameters of the Peer Mentoring program and provide the documentation to show the authority, policies, etc. needed to demonstrate compliance and to inform the Independent Reviewer's | |

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| | | future determinations as well as to populate the Library. In addition, DBHDS had not yet developed a clear referral protocol for accessing those services, as described further below with regard to Compliance Indicator 19.02.<br><br>**Local community-based support through the IFSP Regional Councils:** As reported previously, the Community Coordination program serves as the hub for family engagement. The primary vehicle for that engagement is the IFSP State and Regional Councils. These Councils are comprised primarily of comprised of families of individuals on the waitlist, but it was good to see that the IFSP had been successful in recruiting an energetic and accomplished self-advocate to serve on the State Council.<br><br>While the purpose of the State Council was to provide guidance to DBHDS reflecting the needs and desires of individuals and families across Virginia, the five IFSP Regional Councils were envisioned as the primary means of providing local community-based support (e.g., identifying and/or developing local resources and sharing those with their communities.) DBHDS provided a charter that described these responsibilities in detail.<br><br>Overall coordination for the IFSP was provided by the Individual and Family Support Program Manager. DBHDS also continued to utilize VCU's Regional Navigator Coordinators (RNCs,) through the MOA cited above, to provide overall guidance, coordination and support to the Regional Councils. Based on the workplan attached to the 5/8/20 MOA, the agreement called for VCU's Center for Family Involvement (CFI) to support the IFSP Regional Councils, including assistance with developing and executing regional meetings, events and activities (e.g., facilitating IFSP Regional Council meetings, assisting IFSP Regional Councils with developing an agenda and guiding the meeting process, supporting administrative tasks associated with IFSP Regional Council events, supporting | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | publicity of IFSP Regional Council meetings and events, facilitating connections with local stakeholders and partners) and recruitment of parents, family members and people with disabilities to serve on IFSP State and Regional Councils (e.g., assisting IFSP staff with application development and dissemination, interviewing potential IFSP Regional Council members, etc.) Overall, Regional Council members interviewed for this study continued to find this assistance to be invaluable, particularly as they continued to struggle with sustaining membership.<br><br>In addition to increased support from RNCs, IFSP staff reported hiring a new Community Coordination Specialist in February 2020, who assisted with the day-to-day operations of the IFSP Regional Council through administrative support, supporting the distribution of funds via the mini- grant program, and leading regional strategic planning. DBHDS also hired two part-time staff members to support the regional council models in the Western and Northern regions. Going forward, they will also provide support to those who present with emergency assistance requests (i.e., once the new prioritization model is implemented.)<br><br>In the past year, implemented a virtual annual planning process for the Regional Councils, resulting in a work plan for each Council. They also adopted a new model for virtual Regional Council meetings that integrated a statewide presentation with regional breakout rooms that served as regional business meetings. Regional Council members will also invite "regional experts" to participate in a facilitated conversation about the main topic at a more localized level in the breakout.<br><br>Overall, the Regional Council system was well-organized and efficient, and Council members interviewed indicated they appreciated the support they received. At the same time, IFSP staff might want to give some thought to accepting a certain degree of incertitude and untidiness in the process in order to nourish the | |

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| | | uniqueness of the Council members' voices and sustain the opportunities for facilitating their input. For example, based on the Regional Council Charter, dated February 24, 2021, the Regional Council Leadership Board is charged with "leading" local activities established in the annual regional work plans and coalition. Similarly, the State Council Charter indicates its members should collaborate with the Regional Council and local coalitions to advise the Department on creating a robust family support program that increases the number of resources for families and individuals and promotes community engagement and coordination with other stakeholders. At times, an underlying theme in conversations with Council members was that it appeared state and contracted staff were largely leading and managing the Councils' activities to the extent that the members' decision-making roles were increasingly limited. | |
| 1.02<br>The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization. | DBHDS staff drafted a set of criteria for determining applicants most at risk for institutionalization. (*Individual and Family Support Program (IFSP) Prioritization Model Version Date: 2/22/2021, IFSP-Funding FY 2021 Prioritization Proposal September 2020)*<br><br>DBHDS obtained stakeholder feedback on the draft criteria through the IFSP State Council and a series of virtual Town Hall meetings. (*IFSP-Funding FY 2021 Prioritization Proposal September 2020)* | Previous reviews have consistently recommended that DBHDS should finalize and formalize the definition of "most at risk for institutionalization" as it impacts eligibility requirements and program structure for the IFSP Funding Program, beyond the existing first-come, first-served approach. Further, the previous reviews recommended that this process should be undertaken in a fully transparent communication process with stakeholders. At the time of the 16th Review Period, DBHDS had not yet adopted a set of prioritization criteria for determining applicants most at risk for institutionalization, but had developed a draft and proposed the following timeline for finalization and implementation:<br>• By June 2020, IFSP staff would present the IFSP State Council with FY21 Funding Program priorities and timelines.<br>• By Summer 2020, IFSP staff would develop and formalize partnerships needed to execute the design, finalize the programming needed to support the new model and work with the Regional Councils to share information on the program design. | Not Met |

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| | DBHDS has not yet formalized the prioritization criteria in a Departmental Instruction, the IFSP State Plan or in IFSP Guidelines. | • By Late Fall/ Early Winter 2020, IFSP staff would implement the changes into the FY21 Funding Program structure and work with partners to assess their capacity to assist with and evaluate the model.<br><br>Since the 16th Review Period, IFSP staff have continued to move forward to implement that set of action steps. In order to create a framework for identifying and supporting those most-at- risk of institutionalization, IFSP staff reported taking several steps. The early feedback from the State and Regional Councils evolved into a guiding principle that priority categories should consider both the individual circumstances of the applicant and their family and the type of request. The State Council advised staff to find a way to consider both in establishing priorities, and especially in cases of emergencies.<br><br>Additional steps included consulting with other DBHDS offices and departments (e.g., DD Services Leadership, Crisis Services, Waiver Services, Office of Integrated Health, Provider Development, and Housing to discuss and review various assessment tools (i.e., Crisis Risk Assessment Tool, Annual Risk Assessment Tool and DBHDS Housing Resource Referral & Assessment) and how they might be integrated into the prioritization framework. In addition, they reviewed past IFSP-Funding outcome data to understand what needs are typically requested and how changes to the program may impact assistance for those needs. Based on the review of tools, data, records, and feedback from DBHDS staff, IFSP developed a program design that uses existing measurement tools to standardize the assessment of individual circumstances and seeks to leverage coordination among DD Services and IFSP supports to meet as many needs as possible.<br><br>IFSP staff also reported holding a series of stakeholder input sessions, beginning with soliciting feedback at the IFSP State Council meeting | |

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| | | in May 2020, and culminating with a series of Town Hall meetings in August through October 2020.<br><br>The resulting prioritization framework included three funding streams, as described below:<br>• Emergency Needs: This new emergency assistance fund will serve individuals who, without emergency assistance, are at high risk of a crisis that would require services in an institutional setting because care cannot be adequately provided in a community setting or in a family home. It will allow individuals and families to apply for assistance at any time during the calendar year, but only once per fiscal year. Applicants funded in this pool will also not be considered for other IFSP Funding assistance pools after an award is made. Funds will be available and dispersed throughout the year as they are available. The maximum funding amount will be $3,000. Twenty-five percent of the total annual finding will be allocated to this category.<br>• Prevention Supports Needs: This new funding pool to provide assistance to people who have a demonstrated complex service coordination needs as demonstrated by receiving or are eligible for Targeted Case Management, CCC-Plus, and/or who have a Priority One Waiver Waitlist Status. The assumption for this set of criteria is that failure to meet their prevention support needs might result in a need for institutional care. This application pool will open only once in FY 21, but IFSP staff anticipating a twice-yearly funding opportunity thereafter. Applicants funded in this pool may apply only once a year and will not be considered for general IFSP Funding, as described below, after an award is made. However, recipients in this pool may apply for Emergency Assistance if additional needs arise after the initial funding. The award amount is $1000 per application. Fifty percent of the total annual funding will be allocated to | |

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| | | this category.<br>• The IFSP will continue to maintain a funding pool for general assistance requests, and the general assistance funding pool will operate much like the past IFSP Funding program (i.e., available one time each year and reviewed on a first come first served basis.) Individuals and families on the DD Waiver Waiting List who have not received funds from any other IFSP Funding Assistance Pool may apply for General Assistance. General Assistance will be the last of the funding pools opened during a fiscal year, so that any funds unspent in the Prevention Assistance Pool can be diverted to the General Assistance Pool if need is low. Applicants can request a minimum of $200 and a maximum of $500. Twenty-five percent of the total annual finding will be allocated to this category.<br>• In addition to funding, applicants will also be referred to the following resources: MLMC, Family and Peer Mentoring, and IFSP Regional Councils. For applicants applying for Emergency Assistance, IFSP staff will also facilitate the following referrals, as appropriate: Family-to-Family Mentoring through a targeted and monitored referral process; a warm hand-off to the IFSP Regional Council through outreach conducted by CFI Regional Navigators, and a warm hand-off to the DBHDS Housing Team for screening and assessment for rental, mortgage, and utility assistance.<br><br>Based on this review, it appeared that DBHDS had developed a thoughtful and methodical set of prioritization criteria, that leveraged and expanded on existing resources and integrated stakeholder input. The only remaining issue to be resolved is to clarify the circumstances under which an individual might be eligible for case management, but not receiving it due to a lack of availability. This is discussed further with regard to Compliance Indicator 1.09 below. | |

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| | | Once DBHDS finalizes the prioritization criteria along these lines and formalizes the requisite documentation to show the Court the source of Virginia's authority (i.e., its organizational structure, policies, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, quarterly reports, etc.) needed to demonstrate compliance, the Commonwealth should be able to meet compliance. | |
| 1.03<br>The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program. | The IFSP State Plan includes a goal to "create a comprehensive communication plan that establishes communication priorities and strategies to address the needs of communities and organizations," as well as four short term objectives for developing partnerships and resources to implement goal. *(State Plan Annual Update Combined with all Appendices 10.3.20)*<br><br>Appendix B of the IFSP State Plan describes an ongoing and multi-faceted communication plan to ensure that all families receive information about the program *(IFSP Communication Plan FY* | The IFSP State Plan includes a goal to "create a comprehensive communication plan that establishes communication priorities and strategies to address the needs of communities and organizations," as well as four short term objectives for developing partnerships and resources to implement the goal. In addition, Appendix B of the IFSP State Plan describes an ongoing and multi-faceted communication plan to ensure that all families receive information about the program. This plan encompasses a large number of documents and communication activities, categorized by type (i.e., general information and referral, funding program, communications policies, MLMC, information to key stakeholders, state plan, and council recruitment.) For each document or activity, the plan cites the target audience, purpose and objective, timing and frequency and description and venue. The plan notes that it will be updated as needed. Overall DBHDS appears to have met the requirements of this Compliance Indicator.<br><br>IFSP staff use the annual waiver waitlist attestation process and an annual mailer campaign as the primary vehicles for ensuring that individuals and families on the waiver waitlist receive needed communications about the IFSP Funding Program, Family and Peer Mentoring supports, case management eligibility and the MLMC website. In the process of establishing this capacity, they have | Met |

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| | *2021Effective February 23, 2021)*<br><br>IFSP staff developed and implemented a sufficiently robust set of strategies to ensure that all families receive information about the program. *(IFSP Communication Plan FY 2021, 2.23.2; Annual Attestation Cover Letter, English and Spanish; DBHDS WL Annual Contact Guidance 1.15.21; Notification Letter-FINAL, 7-31-20; FINAL Report-FY21 Annual Notification for Individuals on WWL Quantity Details, 2.22.21; Annual Mailer File Creation Requirements 2.17.20; IFSP FIRST STEPS 2.17.21; First Steps Methodology, 2.22.21; Notification Letter- FINAL, 7-31-20; FINAL Report-FY21 Annual Notification for Individuals on WWL Quantity Details, 2.22.21; Annual Mailer File Creation Requirements 2.17.20; IFSP FIRST STEPS 2.17.21; First Steps Methodology, 2.22.21)*<br><br>IFSP staff continued to | documented a detailed step-by-step methodology for ensuring that, to the extent possible, everyone on the waiver waitlist receives these notifications. The *Annual Mailer File Creation Requirements* details creates a set of system requirements (e.g., date to perform the data extract, format for the data extract, required data elements and data source, etc.) that describes all of the data elements that are needed to create a data set for all individuals who are active on the waiver waitlist. It also describes a set of queries that flag exceptions that require additional handling to ensure all waitlist members are contacted. For example, the logic generates a data file of wait list members who will require mailing of a hard copy instead of the usual email methodology, and/or direct contact by the responsible CSB. The methodology also includes follow-up processes for continuing to update the waitlist.<br><br>It was also positive to see that IFSP staff continued to develop new and creative communication and marketing strategies, such as the *IFSP: First Steps* initiative. In November 2020, DBHDS published *First Steps*, which is intended to guide families through a basic overview of the IFSP program at DBHDS, Virginia's Developmental Disability (DD) system, and the resources that are available for people who are waiting for a DD Waiver. *First Steps* also integrates several other documents and messaging needs, including the IFSP flyer; the Family Guide to Case Management Guidance; the Annual Notification for Individuals on the Waiver Waiting List; Navigating the Waiver Simplification; and My Life, My Community website updates. In December 2020, IFSP staff sent an IFSP Funding Program update to individuals, families and providers listservs that included the *First Steps* document and also featured it in that month's issue of the monthly IFSP Digest. Going forward, *First Steps* is intended to replace the annual IFSP program brochure, with annual updates. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | update the Communication Plan as needed. *(IFSP: First Steps)* | | |
| 1.04<br>The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including… | The IFSP State Plan includes a set of program outcomes. *(Virginia's Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities Version Date: October 3, 2020)*<br><br>DBHDS did not provide evidence that DQV assisted IFSP staff to evaluate the measurability of the outcomes or the validity and reliability of the data. | The *IFSP State Plan* included a set of program outcomes, for which DBHDS issued an annual report with regard to progress toward the specified program outcomes. However, overall, many program outcomes were not currently measurable because DBHDS had not yet developed a measurement methodology. Examples of this issue are provided below in the analysis for Compliance Indicators 1.05 and 1.07. As a result, overall, DBHDS could not demonstrate that the Commonwealth met the requirements of this Compliance Indicator. However, in one instance (i.e., the number of individuals on the waiver waitlist who are provided with outreach materials each year), it appeared DBHDS provided sufficient evidence that it had taken necessary steps to produce reliable and valid data. | Not Met |
| 1.05<br>The number of individuals on the waiver waitlist who are provided with outreach materials each year | The annual report provided data reports for the number of individuals on the waiver waitlist who are provided with outreach materials each year *(IFSP Communication Plan FY 2021, 2.23.2; IFSP State Plan Update, 6/26/20; Annual Attestation Cover Letter, English and Spanish; DBHDS WL Annual Contact Guidance 1.15.21; Notification Letter-* | The *IFSP State Plan* set a target outcome that 80% of individuals on the waiver waitlist and have a Priority One designation would be outreached for IFSP assistance. In the *IFSP State Plan Update,* staff reported they achieved this outcome August 2019 by sending out the annual electronic and postal notification for all individuals on the DD waiver waitlist.<br><br>For this measure, as described above for Compliance Indicator 1.03, DBHDS staff had developed a detailed and robust methodology for ensuring that all individuals on the waiver waitlist received outreach materials. Based on review of those procedures, it appeared IFSP staff could reliably determine the number of individuals for whom it provided outreach materials each year. | Met |

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| | *FINAL, 7-31-20; FINAL Report-FY21 Annual Notification for Individuals on WWL Quantity Details, 2.22.21; Annual Mailer File Creation Requirements 2.17.20; IFSP FIRST STEPS 2.17.21; First Steps Methodology, 2.22.21; Notification Letter- FINAL, 7-31-20; FINAL Report-FY21 Annual Notification for Individuals on WWL Quantity Details, 2.22.21; Annual Mailer File Creation Requirements 2.17.20; IFSP FIRST STEPS 2.17.21; First Steps Methodology, 2.22.21)* | Of note, a related outcome target called for 90% of people on the DD waiver waitlist to indicate awareness of IFSP supports. However, the annual *IFSP State Plan update* indicated they did not yet have a data collection tool or methodology to assess this outcome measure (i.e., to measure effectiveness of the outreach activities.) | |
| 1.06<br>Participant satisfaction with the IFSP funding program | DBHDS issued an annual report with regard to progress toward program outcomes for:<br>• Participant satisfaction with the IFSP funding program<br>*((IFSP State Plan Update, 6/26/20; IFSP Annual Satisfaction Survey and Data Overview Methodology 2.4.21; Satisfaction Survey FY20 Calculation Formula 2.18.2; FY 20 Combined Satisfaction Survey Results for FY20 2.18.21)* | With regard to measurability, the *IFSP State Plan* set one outcome target for participant satisfaction that called for 80% of people who complete an IFSP satisfaction survey to indicate high satisfaction with funding, as well as another outcome target for a 20% response rate with over 85% of respondents would indicate satisfaction with the funding program. DBHDS collected data for these measures through issuance of an annual satisfaction survey for the IFSP funding program, for which IFSP staff had documented a methodology.<br><br>For this 18th Review Period, for FY 20, IFSP staff reported issuing the satisfaction survey to all funding recipients and receiving 480 responses (i.e., a 19.8% response rate) in return. Overall, as in previous years, respondents reported favorable experiences across a number of indicators. Based on the responses received, recipients reported they were either very satisfied (67.01%) or satisfied (26.7%) with the IFSP funding program. As a result, the IFSP annual update reported the designated outcome target as met. | Not Met |

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| | | However, as reported at the time of the 16th Period Review, this approach to measuring satisfaction is not adequate, in that it only measured the satisfaction of those who were awarded funding (i.e., were successful in getting their applications in before the funds were exhausted.) In other words, this would provide an inadequate picture of the satisfaction of all participants whose applications were not approved. Instead, the survey focused only on those who would be highly likely to report satisfaction (which more than 93% did) with the process and the IFSP Funding Program as a whole. Measuring the satisfaction of this latter group as a subset might provide some valuable data with regard to how the receipt of funding impacted individual outcomes. However, for purposes of program improvement, it would also be essential to survey those whose applications were not approved to identify and understand the problems or challenges those applicants experienced.<br><br>Given that the survey was the only avenue for measuring participant satisfaction, it had other limitations in addition to its previously described limited scope (i.e., measuring only the satisfaction of successful applicants.) For example, as the methodology described, the survey was voluntary and therefore the respondents self-selected. This also limited the utility of the data. As previously recommended, DBHDS should be cautious about reporting the current dataset to the public as the information cannot adequately represent overall funding program satisfaction without significant caveats. | |

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| 1.07<br>Knowledge of the family and peer mentoring support programs | DBHDS issued an annual report with regard to progress toward program outcomes for:<br>• Knowledge of the family and peer mentoring support programs<br>*IFSP State Plan Update, 6/26/20)* | The *IFSP State Plan* included outcome targets for this measure that read "In each region, at least 30% of Satisfaction Survey respondents have visited either Facebook, connected with SeniorNavigator, visited the DBHDS IFSP webpage, connected with VCU F2F Network, or attended a VCU F2F Network event," and "Of event attendees: at least 30% indicate having visited Facebook, SeniorNavigator, IFSP, or F2F Network." However, IFSP staff reported they did not yet have the ability to collect data for all of these requirements. The *IFSP State Plan Update*, dated 6/26/20, did not provide any relevant data to report annually. In addition, neither the *IFSP State Plan* nor the *IFSP State Plan Update* provided a description or an annual report of progress related to a target outcome for Peer Mentoring. The only data available at the time of the *IFSP State Plan Update* indicated that the Arc of Virginia had not yet provided any. | Not Met |
| 1.08<br>Utilization of the My Life, My Community website: | DBHDS issued an annual report with regard to progress toward program outcomes for:<br>• Utilization of the My Life, My Community website<br>*(IFSP State Plan Update, dated 6/26/20)* | For utilization of the MLMC website, the IFSP State Plan referenced outcome targets included in the *IFSP State Plan Update* and did provide some limited data with regard to the growth in the number of sessions (398%), users (408%) and page views (661%) from the first quarter of calendar year 2019 as compared to the first quarter of calendar year 2020. IFSP staff should further consider the targeted outcomes it wishes to achieve and develop appropriate measurement methodologies. | Met |
| 1.09<br>Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter. | DBHDS informs individuals of their eligibility for IFSP funding upon being placed on the waiver waitlist and annually thereafter.<br>*(IFSP Communication Plan FY 2021, 2.23.2; Town Hall FY 21 postcard, 7.31.20; Notification Letter- FINAL, 7-31-20; FINAL Report-FY21* | **Eligibility for IFSP Funding:** As described above, DBHDS had implemented an annual waiver waitlist eligibility attestation process in which every individual on the waitlist received a letter on or around the anniversary date of the initial determination. Among other information, this letter included the following statement:<br><br>"Individuals on the DD Waiver Waiting List are eligible for supports offered through the Individual and Family Support Program (IFSP). To learn more about IFSP and related resources/supports that may be available to you, go to My Life My Community on the web at | Not Met |

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| | *Annual Notification for Individuals on WWL Quantity Details, 2.22.21; Annual Mailer File Creation Requirements 2.17.20; IFSP FIRST STEPS 2.17.21; First Steps Methodology, 2.22.21; Email Memo to DD Directors 6.25.20;*<br><br>DBHDS informs individuals of their eligibility for case management upon being placed on the waiver waitlist and annually thereafter *(IFSP Communication Plan FY 2021, 2.23.2; SC Manual, Ch 5 Case management and wait list eligibility flowchart; SC Manual Letter 4.12.19; Annual Attestation Cover Letter, English and Spanish; DBHDS WL Annual Contact Guidance 1.15.21; Support Coordination: Questions and Answers for People with DD and their Families, 6.2.20; Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019; 12VAC30-50-490. Support* | http://www.mylifemycommunityvirginia.org/ or call 844-603-9248 to speak with a live operator by phone."<br><br>In addition, the annual waiver waitlist eligibility attestation packet included an insert that described various supports for which individuals on the waiting list might be eligible. This included a notification that individuals might be able to access financial assistance through the IFSP and provided a link to obtain further information.<br><br>**Eligibility for case management:** DBHDS indicated it informs individuals of their eligibility for case management upon being placed on the waiver waitlist and annually thereafter as a part of the annual waiver waitlist eligibility attestation process. However, as previous studies have found, DBHDS protocols do not yet provide clear guidance with regard to individuals' eligibility to receive case management (or support coordination, as it is also known) while on the waiver waitlist.<br><br>Various regulatory and guidance documents (e.g., the 2016 Medicaid State Plan Amendment for targeted case management and Virginia administrative code, *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019, Development Disabilities Support Coordination Manual*, etc.) indicate that individuals with developmental disabilities "may" receive time-limited case management when a "special service need" existed. However, none of the documents provided any criteria for what could constitute a "special service need." The language continued to be vague and open to various interpretations from one CSB to another; indeed, from one case manager to another. For example, many individuals on the waitlist might be expected to have needs that required linkage to supports and services to address an individual's mental health, behavioral, or medical needs, so it was not clear what might make such a need "special." The language was also | |

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| | *coordination/case management for individuals with developmental disabilities; Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist, 4.22.20)* | somewhat circular in nature with regard to that determination, indicating that, on the one hand, the "special service need" is one that is identified in an ISP, but on the other, that the case management agency would develop an ISP if a "special service need" was identified.<br><br>Overall, for this review, DBHDS had not addressed the issues described above. Continuing issues included the following:<br>• The relevant regulatory language found at *12VAC30-50-455. Support coordination/case management for individuals with developmental disabilities (DD),* defines the Target Group as follows: "Individuals who have a developmental disability as defined in state law (§ 37.2-100 of the Code of Virginia) shall be eligible for support coordination/case management." It further states that "when an individual applies for the DD Waivers and is found to meet the criteria as defined in 12VAC30-122-50, but there is no available slot, the individual will be placed on a waitlist until a slot is available. Individuals on the waitlist shall not receive developmental disability support coordination/case management services unless a special service need … is identified, in which case an ISP shall be developed to address the special service need. Support coordinators/case managers shall make face-to-face contact with the individual at least every 90 calendar days to monitor the special service need, and documentation is required to support such contact. The support coordinator/case manager shall assure the ISP addresses the current special service needs of the individual and shall coordinate with the Department of Medical Assistance Services designee to assure actual enrollment into the waiver upon slot availability." The regulation goes on to define a special service need as one "that requires linkage to and temporary monitoring of those supports and services identified in the ISP to address an individual's mental health, | |

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| | | behavioral, and medical needs or provide assistance related to an acute need that coincides with the allowable activities …of this section. If an activity related to the special service need is provided in a given month, then the support coordinator/case manager would be eligible for reimbursement. Once the special service need is addressed related to the specific activity identified, billing for the service shall not continue until a special service need presents again." This did not provide any additional clarity with regard to definition of a special service need found in previous guidance beyond that which previously existed.<br>• DBHDS had not updated the *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019* or the web-based *Development Disabilities Support Coordination Manual* to provide additional clarification.<br>• DBHDS did submit a document entitled *Support Coordination: Questions and Answers for People with DD and their Families,* dated 6.2.20, but it did not expand upon or further clarify the definition of a "special service need."<br>• DBHDS should also clarify for individuals, families and CSBs the differing circumstances with regard to eligibility for case management for individuals on the waiver waiting list, depending on whether those individuals are Medicaid-eligible. Based on interview with DBHDS staff, individuals who are Medicaid eligible and are determined to have a need for case management should be enrolled in TCM in a timely manner. However, individuals determined to have a need for case management, but who are not Medicaid eligible, might not receive the services or might not receive them immediately, due to a lack of sufficient resources at a CSB. It will be important for individuals and families to be informed of these distinctions. | |

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| | | However, in interview, the DBHDS Director of Provider Development indicated an understanding of the issue and could draft additional language to further clarify the expectations. He subsequently shared the draft document for review. It offered additional guidance by providing examples of special service needs for people with DD who are waiting for waiver services, as follows:<br>• A child with autism on the waiting list needs to access behavioral services;<br>• An adult experiences the loss of a family caregiver and needs to look for alternate housing;<br>• Following a stroke, an adult needs to locate specialized medical services to transition back home;<br>• A young person is transitioning out of school and needs to access vocational rehabilitation or employment services;<br>• A young woman who has limited contact with family begins experiencing seizures and needs support to locate a neurologist;<br>• New neighbors move into a person's neighborhood resulting in escalating conflict between the person with DD and the neighbors;<br>• A family member reports a child on the waiting list has experienced changes in his health status and needs to explore options to avoid placement in an institutional setting.<br><br>These appeared to be excellent examples indicative of a need for at least short-term case management. However, it was not clear that this set of examples would be sufficient, on their own, to provide clarity about eligibility determinations for waitlist case management for individuals and families or for case management providers. DBHDS still needed to issue the following:<br>• A clear policy or Departmental Instruction on case management options for individuals on the waitlist, including TCM for Medicaid eligible-individuals and other options for non-Medicaid eligible individuals. | |

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| | | • A clear policy/instruction defining "DD or ID active support coordination/case management service criteria" and "special service need" and any associated protocol to be used by CSBs, both for making determinations of eligibility and for terminating services. The DBHDS Performance Contract should also be revised as needed.<br>• Updated and expanded Guidelines for individuals on the waitlist and families regarding case management options and how to apply for them.<br>• A clear policy/instruction regarding the requirements for TCM to be provided to all individuals who demonstrate eligibility under the State Plan Amendment, without regard to a waitlist, as well as the duty to inform individuals of these requirements.<br>• Appropriate revisions *to Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners* and the *Development Disabilities Support Coordination Manual.* | |
| 1.10<br>IFSP funding availability announcements are provided to individuals on the waiver waitlist. | DBHDS had a clear, written process for providing IFSP funding availability announcements are provided to individuals on the waiver waitlist. *(IFSP FY 2021 Annual Notification for Individuals on WWL Quantity Details v2.22; Annual Notification for Individuals on WWL Quantity Details, 2.22.21; Annual Mailer File Creation Requirements 2.17.20)* | At the time of the 16th Review Period, IFSP staff had undertaken an initiative to ensure that every individual on the waitlist would receive a timely notification about the upcoming IFSP funding period, either by email or by postal service. This required an intensive effort by multiple staff to ensure complete coverage. IFSP staff provided a document describing the steps they had taken to achieve this goal, which also included sending funding period announcements out through various listservs. This was a robust and thorough process. The notification also provided information about some other services for which individuals and families of the waitlist might be eligible, such as IFSP Regional Councils, CSBs, the VCU Family-to-Family program.<br><br>The previous study recommended that, for purposes of identifying the basis for programmatic authority and continuity, DBHDS staff needed to develop a formal expectation (e.g., a policy, procedure, departmental instruction, etc.) that, going forward, all individuals on | Met |

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| | DBHDS documented providing IFSP funding availability announcements to individuals on the waiver waitlist during the funding cycle that occurred during this Review Period. (*IFSP FY 2021 Annual Notification for Individuals on WWL Quantity Details v2.22.21)* | the waitlist will receive direct timely notifications from DBHDS of upcoming funding periods. For this review, as described above, DBHDS had developed DI 113 (TX) 20 with regard to the IFSP. While the DI defined the IFSP Funding Program (i.e., subject to the availability of funds, the IFSP Funding available in accordance with 12 VAC 35-230 assists individuals on Virginia's DD Waiting List), it provided little guidance with regard to these expectations. DBHDS might consider expanding on the level of detail in the DI. However, as described above with regard to Compliance Indicators 1.03 and 1.05, IFSP staff had developed a detailed and robust methodology for providing IFSP funding availability announcements to individuals on the waiver waitlist.<br><br>For the funding period that occurred during this review period, the Funding Notification was sent via Constant Contact on August 25, 2020. It was sent to the *Funding Announcement FY21* listserv as well as to the Provider listserv, to a total of 15,104 email addresses. In addition, DBHDS mailed 4,770 hard copy announcements on August 24, 2020. On December 17, 2020, IFSP used Constant Contact to send an IFSP-Funding Program update to IFSP's families and providers listservs. | |
| 1.11<br>Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website | The MLMC website was operational and DBHDS had posted to it various eligibility guidelines for IFSP resources and other supports and services. However, the information provided with regard to eligibility criteria ("most at risk") and case management criteria ("special service need") was incomplete and pending | The MLMC website was operational and DBHDS had posted to it various eligibility guidelines for IFSP resources and other supports and services. In that regard, DBHDS had an effective mechanism for posting eligibility guidelines for IFSP resources and other supports and services for easy access on the internet. However, as reported at the time of the 16th Review Period, information provided with regard to eligibility criteria ("most at risk") and case management criteria ("special service need") was incomplete and pending final resolution. This is described in more detail with regard to Compliance Indicators 2 and 5 above.<br><br>Consistent with previous findings, the following provides examples of key documents and information found on the MLMC website in | Not Met |

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| | final resolution. *(Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019; Individual and Family Support Program Guidelines, updated February 2020; Support Coordination: Questions and Answers for People with DD and their Families, 6.2.20; Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist, 4.22.20)* | April 2021 and May 2021, which highlight some continuing issues with regard to their adequacy and utility. These concerns are also discussed elsewhere throughout this report:<br>• As the Independent Reviewer has previously reported, the Individual and Family Support Program Guidelines, updated February 2020, were mostly thorough and clearly written, and served as a valuable resource for individual and families seeking funding assistance through the IFSP. However, they did not yet provide a clear description of how the program would serve those who were "most at risk for institutionalization."<br>• The *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019*, was also a valuable resource, but will require updating to reflect a clear and consistent description of case management options for individuals on the waitlist.<br>• To provide information on case management options for individuals on the DD waitlist, the MLMC website posted the *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist*, dated 4/22/20, and the *Support Coordination: Questions and Answers for People with DD and their Families*, dated 6.2.20. However, as described above, this document did not provide clear guidelines for individuals and families with regard to the types of needs that would be considered as a "special service need" or describe the expectations for CSBs to apply those consistently. | |
| 1.12<br>Documentation continues to indicate that a minimum of 1,000 individuals and/or their families are supported through IFSP funding. | In FY 20, DBHDS reported approving 2,531 IFSP applications, for a total of $2,500,226.03. *(FY 2020 IFSP Funding Summary, Version Date 2/18/21; IFSP Funding Program Summary 2013-2020)* | DBHDS continued annual distribution of IFSP funding to eligible individuals and families. An *IFSP Funding Program Summary 2013-2020* documented that DBHDS had regularly exceeded the minimum requirement for serving 1,000 people for every year beginning in 2014. For the last full Fiscal Year, (FY20), the number of individuals served again exceeded the required 1,000, with a distribution of $2,500,226.03 to 2,531 individuals and families. | Met |

**18th Review Period**
**Findings**

**III.C.8.b. The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.**

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| 17.01<br>DBHDS has developed and launched the "My Life, My Community" website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. This will be documented by reports of activity on the website. | As of August 2019, DBHDS launched the "My Life, My Community" (MLMC) website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. The MLMC website continued to be operational since that time.<br>*(*https://www.mylifemycommunityvirginia.org*;)*<br><br>The MLMC website published various forms of information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services.<br>*(Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019; Individual and Family Support Program Guidelines,* | In August 2019, DBHDS and its contractor, Senior Navigator, formally launched the MLMC website. The MLMC website has continued to be operational since that time.<br><br>The MLMC website publishes various forms of information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. In addition to DBHDS guidance documents (i.e., *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019; Individual and Family Support Program Guidelines, updated February 2020; First Steps,* etc.*),* the website features links to other service and advocacy organizations and has a searchable database of local services. It also has key pages devoted to the IFSP, providing information about the work of the Councils as well serving as a hub for the Funding Program. MLMC staff operate a call center to serve individuals and families who might need additional assistance.<br><br>Senior Navigator continued to make regular quarterly reports to DBHDS about activity on the website including, but not limited to, data for the number of sessions, number of users, number of pageviews, number of returning and new visitors and average duration users spend on the site. In addition, they reported on the volume of calls to their call center seeking technical assistance or | Met |

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| | *updated February 2020; Support Coordination: Questions and Answers for People with DD and their Families, 6.2.20; Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist, 4.22.20; IFSP FIRST STEPS 2.17.21)*<br><br>The operational contractor (i.e., Senior Navigator) provided quarterly reports of activity on the website. *(MyLifeMyCommunity Virginia Stats 1.1.20-3.31.2; MyLifeMyCommunity Virginia Stats Quarterly Report 10.1.2020_12.31.2020; MyLifeMyCommunity Virginia Stats 1.1.20-3.31.20; MyLifeMyCommunity Virginia Stats Quarterly Report 7.1.2020_9.30.2020)* | additional information and included data about frequently asked questions and topics. Finally, the reports provided narrative updates about new materials and functionalities added since the previous report. It appeared that the number of site visits had begun to stabilize and were no longer growing at the pace that followed the site launch in 2019. This was probably to be expected; however, it might provide some opportunity to continue to brainstorm the expansion of marketing venues. | |
| 17.02<br>Documentation indicates that the My Life, My Community website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families. | DBHDS distributed materials (i.e., the IFSP Digest, the Annual WWL Attestation letter/mailer) that informed recipients about the My Life, My Community website resource. Based on interview, dissemination of the documents occurred using a Constant Contact database which has over 19,000 email addresses. Of these, over 4,000 were for providers, CSBs and case managers. *(IFSP Communication Plan FY 2021, 2.23.2; Notification Letter- FINAL, 7-31-20; FINAL Report-FY21 Annual* | Overall, for this purpose, IFSP staff relied upon the IFSP Communication Plan, described above with regard to Provision III.C.2.a-f, Compliance Indicator 3. To support the implementation of the Communication Plan, IFSP staff had developed a detailed methodology for collecting, managing and using contact data to facilitate dissemination of various types of information that would be useful to individuals, families, providers and other stakeholders. In addition to communicating with individuals on the waitlist and their families, IFSP staff made use of the existing Provider Listserv (i.e., that DBHDS maintains for the purpose of updating providers and stakeholders on policy changes, trainings, meetings, and other important information) to communicate the same types of information to provider organizations. Via the Constant Contact database, IFSP staff sent an email message to the Provider Listserv, including a Flyer | Met |

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| | *Notification for Individuals on WWL Quantity Details, 2.22.21; Annual Mailer File Creation Requirements 2.17.20; Annual Attestation Cover Letter, English and Spanish; DBHDS WL Annual Contact Guidance 1.15.21; Messaging Providers about Waiting List Resource & My Life, My Community Notification Protocol Update 6/4/2020)*<br><br>DBHDS also initiated two targeted marketing initiatives to inform developmental pediatricians and Early Intervention Coordinators. *(IFSP FIRST STEPS 2.17.21; First Steps Methodology 02.22.21)* | created by IFSP staff, and information about IFSP Funding, family-to-family and peer mentoring supports, case management information and information about how to access MLMC.<br><br>In addition, for this review period, DBHDS also undertook two other targeted marketing initiatives to raise awareness among developmental pediatricians and Early Intervention Coordinators. These were appropriate target groups because they often encounter individuals with developmental disabilities early in life. IFSP staff worked with internal and external partners to identify contact information for the two target group and, on November 30, 2020, mailed a total of 510 "First Steps" documents to 51 medical professionals via postal mail. These contacts and mailing addresses were those identified at 40 local EI lead agencies, and the 11 pediatric offices in DBHDS's Eastern service region. Each contact received 1 cover letter and 10 "First Steps" documents for immediate distribution to clients and families.<br><br>These were positive initiatives. Going forward IFSP staff might also want to develop an initiative around schools. In interviews, IFSP Regional and State Council members frequently mentioned raising awareness in schools as an area that needed focus. | |

**18th Review Period**
**Findings**

**III.D.5 Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.**

**(IV.B.9.b: PSTs and the CSB case manager shall coordinate with the specific type of community providers identified in the discharge plan as providing appropriate community- based services for the individual, to provide individuals, their families, and, where applicable, their Authorized Representative with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family- to-family and peer programs to facilitate these opportunities.)**

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| 19.01<br>At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources. | The annual waiver waitlist attestation packet provides information on accessing Family-to-Family and Peer Mentoring resources to all individuals on the waiver waitlist. The process is sufficiently robust to ensure that at least 86% of individuals on the waitlist at the time of the annual attestation process receive the information. *(IFSP Communication Plan FY 2021, 2.23.2; Annual Attestation Cover Letter, English and Spanish; DBHDS WL Annual Contact Guidance 1.15.21; Notification Letter- FINAL, 7-31-20; FINAL* | DBHDS uses notifications provided as a part of the annual waiver waitlist attestation process to inform individuals on the waitlist about Family-to-Family and Peer Mentoring resources.<br><br>As described above with regard to Compliance Indicator 1.03, the attestation process appeared to be sufficiently robust to ensure that at least 86% of individuals on the waiver waitlist have received this information. | Met |

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| | *Report-FY21 Annual Notification for Individuals on WWL Quantity Details, 2.22.21; Annual Mailer File Creation Requirements 2.17.20)* | | |
| 19.02<br>The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested. | DBHDS Guidance for the Virginia Informed Choice Form indicates when it must be completed, including upon enrollment in a Developmental Disability waiver. The guidance also indicates the form must be completed annually but does not stipulate that the form must be completed as a part of the annual ISP process. *(Virginia Informed Choice protocol 6.17.20)*<br><br>The form includes references and contact information for both the Family-to-Family Program and Peer Mentoring resources. (*Virginia Informed Choice Form Example 6.17.20)*<br><br>DBHDS did not have a clear referral process to facilitate and ensure that referrals were being made and/or that relevant data could be tracked. *(Updated Virginia Informed Choice protocol 4.27.21 DRAFT)* | The guidance for the Virginia Informed Choice Form, as provided for review, indicated when it must be completed, including upon enrollment in a Developmental Disability waiver. The guidance also indicates the form must be completed annually but does not stipulate that the form must be completed as a part of the annual ISP process.<br><br>As reported at the time of the previous report, the Virginia Informed Choice Form also includes a section for the Support Coordinator to check whether or not he or she provided the individual opportunities to speak with other individuals receiving waiver services who live and work successfully in the community. In another section, the form also included references to and contact information for both the VCU CFI Family-to-Family network and the Virginia Arc Peer Mentoring program. However, it was not clear that, by signing the Informed Choice Form, individuals were acknowledging that they had received an adequate explanation of the purpose of the resources (i.e., as that related to the requirements of this provision), nor an established referral process for connecting individuals or families with the desired supports.<br><br>The previous IFSP report recommended that DBHDS provide a clear protocol for the use of the Informed Choice Form, including explicit expectations that Support Coordinators will inform individuals of the various resources. At the time of this review, DBHDS staff had not made all the needed revisions to the accompanying instructions or otherwise developed policies, procedures or protocols needed to facilitate and ensure that referrals were being made, as they relate to the specific requirements of this provision and the related Compliance Indicators.<br><br>However, in interview, the DBHDS Director of Provider Development indicated he could draft additional language to further clarify the | Not Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | expectations, and subsequently shared it for review. The draft language read, *"The Support Coordinator also reviews and offers to link the individual and/or substitute decision-maker (SDM) with VCU's Center for Family Involvement if they would like to talk with others who have waiver services and The Arc of Virginia if they have questions related to Peer Mentoring. Some individuals and/or the SDM may choose to make the contacts themselves, if so, the SC would ensure that the contact information is provided. The Support Coordinator documents these linkages in a progress note or other location in the person's record. Making and encouraging these linkages connects families with others who have lived experience and supports informed decisions."*<br><br>This was an improvement, but it appeared to require additional fleshing out to effectuate the likelihood that referrals would occur. In other words, it seemed that while Support Coordinators did need to be instructed with regard to the requirement to offer the opportunities, DBHDS also needed to provide clear expectations with regard to the specific referral process to follow. Based on the documentation submitted, VCU-CFI protocols include a referral form (i.e., *Family-to-Family Network Referral Form 2021*) that DBHDS staff could incorporate into a clear referral process. As described further below, DBHDS should also craft the referral process to ensure that data specific to the purposes of this provision and related Compliance Indicators can occur. DBHDS should construct a similar referral process and data collection methodology for the Peer Mentoring program at the Virginia Arc. It was positive that IFSP staff reported they were developing FY22 workplans with the two partnering organizations that would include such processes. | |
| 19.03<br>The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to- family and the peer-to-peer supports have contact and the number who receive the | VCU-CFI provides some data for individuals receiving family-to- family supports, but does not provide data that adequately show the purpose and outcomes of the contacts. *(Center for Family Involvement @ Partnership for People with Disabilities @ VCU Data Report for the Period 10/1/2020 –* | In the absence of an established referral process, the current procedures do not allow DBHDS to track outcomes related to the Settlement Agreement provision requiring that DBHDS facilitate conversations and meetings with individuals currently living in the community and their families. As described above, DBHDS needed to develop a referral process to facilitate this purpose. Of note, DBHDS has established a referral and data tracking process with VCU-CFI for families with children living in an ICF or a nursing facility that could serve as a starting place.<br><br>For purposes of tracking and reporting on outcomes with respect to the | Not Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| service. | *12/31/2020; Center for Family Involvement @ Partnership for People with Disabilities @ VCU Data Report for the Period 1/1/2020 – 3/31/2020; Center for Family Involvement @ Partnership for People with Disabilities @ VCU Data Report for the Period 4/1/2020-6/22/2020)*<br><br>Reporting does not include specific data with regard to peer-to-peer supports, as that relates to this provision. | number of individuals with whom family-to- family and the peer-to-peer supports have contact, DBHDS should ensure that, in the event a family or individual chooses to make the contact with the Family-to-Family or Peer Mentoring resources directly, the organizations' intake processes include a specific question or set of questions to try to capture whether the contact is related to the specific purposes that are required by this provision and its associated Compliance Indicators. Once DBHDS staff can establish and confirm consistent application of the expectations, this would presumably allow them to reliably use the aggregate data from the intake forms to show that this indicator has been achieved. | |

**Recommendations**

1. With regard to the definition of "most at risk for institutionalization," DBHDS still needed to issue the following:
   - A clear policy or Departmental Instruction on case management options for individuals on the waitlist, including TCM for Medicaid eligible-individuals and other options for non-Medicaid eligible individuals.
   - A clear policy/instruction defining "DD or ID active support coordination/case management service criteria" and "special service need" and any associated protocol to be used by CSBs, both for making determinations of eligibility and for terminating services. The DBHDS Performance Contract should also be revised as needed.
   - Updated and expanded Guidelines for individuals on the waitlist and families regarding case management options and how to apply for them.
   - A clear policy/instruction regarding the requirements for TCM to be provided to all individuals who demonstrate eligibility under the State Plan Amendment, without regard to a waitlist, as well as the duty to inform individuals of these requirements.
   - Appropriate revisions *to Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners* and the *Development Disabilities Support Coordination Manual.*

2. IFSP staff should request technical assistance from DQV to ensure the measurability of the program outcome measures and develop methodologies for collection of reliable and valid data, as well as to consider additional methodologies for defining and measuring participant satisfaction with the IFSP Funding Program.

3. As reported previously, going forward, DBHDS will also want to consider additional program outcome measures to assess impact on risk of institutionalization, the comprehensiveness of the IFSP, as it reflects the expressed needs of those it is designed to serve, and the degree and adequacy of coordination, both on a systemic and individual basis. This should include a measure to assess the evenness and consistency of the implementation of waitlist case management. DBHDS will also need to consider how it will integrate key IFSP measures into its overall departmental Quality Improvement/Risk Management Framework.

4. DBHDS should provide clear expectations with regard to the specific referral process to follow for the Family and Peer Mentoring programs. The referral processes should also ensure that data specific to the purposes of this provision and related Compliance Indicators can occur.

Attachment A: Interviews

1. Beverly Rollins, Director of DBHDS Administrative and Community Operations
2. Erika Jones-Haskins, DBHDS IFSP Community Coordinator
3. Jenni Schodt, DBHDS Settlement Agreement Coordinator
4. Eric Williams, DBHDS Director of Provider Development
5. Benita Holland, DBHDS MFP Resource Consultant
6. Susan Moon, Director, DBHDS Office of Integrated Health
7. Lisa Rogers, DBHDS Office of Integrated Health
8. Dana Yarbrough, Director, Center for Family Involvement, Virginia Commonwealth University Partnership for People with Disabilities
9. Ann Bevan, Director, DMAS Division of High Needs Supports
10. Erika Bischoff, IFSP Council Member
11. Sean Campbell, IFSP Council Member
12. Dana Koenig, IFSP Council Member
13. Jennifer Rockwell, IFSP Council Member
14. Jan Rychtar, IFSP Council Member
15. Nichole Pangle, IFSP Council Member
16. Tina Long, IFSP Council Member
17. Mary Claire Miller, IFSP Council Member
18. Bernadette Miller, Parent of IFSP Council Member
19. Maria Worth, IFSP Council Member

Attachment B: Documents Reviewed

1. State Plan Annual Update Combined with all Appendices 10.3.20
2. Appendix A Funding Program
3. Appendix A Funding Program IFSP PowerPoint FY2020 - Trainer Training PowerPoint
4. IFSP-Funding Program Summary 2013 – 2020
5. FY 2018 Audit Summary
6. FY 2020 IFSP Funding Data, rev. 6/11/2020
7. Appendix B Communications IFSP Communication Plan FY 2021
8. Appendix B Communications IFSP Flyer
9. Appendix B Communications Maximizing your IFSP Funds 12.2019 Edit
10. Appendix B Communications-Annual Attestation Cover Letter, English and Spanish.
11. Appendix B Communications Notification of DD Waitlist Eligibility- FINAL-7-31-19.
12. Appendix C Family to Family Supports, Family-to-Family-Network-of-VA-Brochure-2018
13. Appendix C Family to Family Supports- DBHDS F2F and P2P Report July 2019 to June 2020
14. Appendix D Programmatic Overview Community of Practice Virginia Application
15. Appendix D Programmatic Overview DI113
16. Appendix D Programmatic Overview Peer to Peer Contract
17. Appendix E Senior Navigator- Stats 1.1.20-3.31.20 Website and Call Center
18. Appendix E Senior Navigator- Stats 10.1.19 - 12.31.19 Website and Call Center
19. FY 2020 Council Narrative: Council Activities and Reference Documents June 2020: FY 2020 Regional Council Activities Timeline
20. IFSP Council Charter 2.24.2021.
21. Annual State Council Meeting Notes January 2021, 1.29.21
22. IFSP Prioritization Model Public Presentation, 9.30.20.
23. Individual and Family Support Program (IFSP) Prioritization Model Version Date: 2/22/2021
24. IFSP Communication Plan FY 2021, 2.23.2
25. Town Hall FY 21 postcard, 7.31.20.
26. Notification Letter- FINAL, 7-31-20
27. FINAL Report-FY21 Annual Notification for Individuals on WWL Quantity Details, 2.22.21
28. Annual Mailer File Creation Requirements, 2.17.20
29. IFSP FIRST STEPS, 2.17.21
30. First Steps Methodology, 02.22.21
31. Email Memo to DD Directors, 6.25.20
32. SC Manual- Ch 5 Case management and wait list eligibility flowchart
33. Support Coordination: Questions and Answers for People with DD and their Families, 6.2.20
34. SC Manual Letter 4.12.19
35. Annual Attestation Cover Letter, English and Spanish
36. DBHDS WL Annual Contact Guidance, 1.15.21
37. Overall Methodology for Required Annual Contact for Individuals on the WWL Version Date: 2/17/21
38. IFSP Annual WWL Notification Mailer File Creation Requirements
39. IFSP Annual Satisfaction Survey and Data Overview Methodology, 2.4.21.
40. Satisfaction Survey FY20 Calculation Formulas, 2.18.21
41. FY 20 Combined Satisfaction Survey Results for FY20, 2.18.21
42. CFI Referral Process and Form
43. IFSP Annual Satisfaction Survey and Data Overview Methodology, 2.4.21
44. MLMC System Integration Goals (VCU Partnership for People with Disabilities MOA), 6.10.19
45. MLMC System Integration Goals (VCU Partnership for People with Disabilities MOA), 5.8.20
46. CFI Data Report for the Period 7/1/19-6/22/20
47. VCU Proposed Work Plan FY2020

48. DBHDS F2F and P2P Report April 2020 to June 2020, 6.22.20
49. DBHDS F2F and P2P Report Jan 2020 to March 2020, 3.31.20
50. DBHDS F2F and P2P Report July 2020 to Sept 2020, 9.30.20
51. DBHDS F2F and P2P Report Oct 2020 to Dec 2020, 12.31.20
52. Center for Family Involvement @ Partnership for People with Disabilities @ VCU Data Report for the Period 10/1/2020 – 12/31/2020
53. Center for Family Involvement @ Partnership for People with Disabilities @ VCU Data Report for the
54. 1/1/2020 – 3/31/2020
55. Center for Family Involvement @ Partnership for People with Disabilities @ VCU Data Report for the Period 4/1/2020-6/22/2020
56. Statewide Peer Mentoring System Proposal
57. Arc of Virginia Proposed Work Plan FY2022
58. Peer Mentoring Quarterly Program Report,12.30.20
59. Post Training Info 12.2020, 12.20
60. MyLifeMyCommunityVirginia Stats, 1.1.20-3.31.20
61. MyLifeMyCommunityVirginia Stats Quarterly Report, 10.1.20 -12.31.20
62. MyLifeMyCommunityVirginia Stats ,1.1.20-3.31.20
63. MyLifeMyCommunityVirginia Stats Quarterly Report, 7.1.20-9.30.20
64. Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Sixth Edition Updated June 2019
65. 12VAC30-50-490: Support coordination/case management for individuals with developmental disabilities
66. Virginia Informed Choice protocol 6.17.20
67. Updated Virginia Informed Choice protocol 4.27.21 DRAFT

# APPENDIX E

## COMMUNITY LIVING OPTIONS

**by**

**Ric Zaharia Ph.D.**

Consortium on Innovative Practices

TO: Donald Fletcher

FROM: Ric Zaharia, Ph.D.

RE: Period 18 - Compliance Indicators for Community Living Options

DATE: May 5, 2021

Introduction

This report constitutes my second review of the compliance indicators for Community Living Options (III.D.1**).** In the 2020 review, for the Independent Reviewer's 16th Report to the Court, the Commonwealth provided documentation that showed achievement of seven (7) of fifteen (15) general compliance indicators. At that time the Commonwealth provided reports that included information that aligned with seventeen (17) of the twenty-nine (29) distinct measures for the fifteen (15) compliance indicators. That review did not include an independent verification of the data reported by the Commonwealth.

The most complicated issue in that review was the correct interpretation of the nursing service indicators. The parties and the Independent Reviewer agreed to discuss and finalize 'formulas' that would operationalize the narrative language of the indicators. Also, of interest among the indicators was the development and implementation of accountability mechanisms addressing CSB involvement in discharge planning for ICF/IID or nursing facilities.

For this report the facts gathered are identified at each indicator in the Findings Table below. The documents, which include these facts are listed by reference in Attachment A and can be located in the Commonwealth's Box library. Clarifying interviews were conducted with DBHDS officials (See Attachment B), including those who DBHDS identified as being most familiar with the Commonwealth's progress toward achieving the compliance indicators associated with the Integrated Settings Provision III.D.1.

Summary of 18th Review Period Findings

This review of Integrated Settings found that of twenty-three (23) compliance indicators (based on DBHDS numbering system: 18.01-18.23), the Commonwealth provided documentation and reports that showed achievement of twelve (12) indicators; eleven (11) compliance indicators were Not Met. These focused on increases in integrated settings, on the outcomes of a work group focused on barriers to increasing integrated settings, on improvements in the delivery of nursing services, and on CSB follow through.

DBHDS has initiated data quality efforts in several areas. ICFs/IID and Nursing Facilities reporting is enhanced by regular and weekly contacts by responsible DBHDS staff, including on-site visits. In

addition, OIH (Office of Integrated Health) annually runs the names they are tracking against DMAS claims data, which constitutes a prudent data quality check. For WaMS authorizations-claims data quality is regularly tested when claims are paid against authorizations and when DMAS conducts post-payment audits; that is, reporting based on claims data is regularly tested at payment and post-payment which results in a self-correcting database. DBHDS staff described Nursing Services data quality in a Monitoring Questionnaire. And the Office of Provider Development provided a plan that it has begun to implement to address data quality issues in their future Semi-Annual Reports in collaboration with statisticians in the Office of Integrated Support Services and the Office of Data Quality & Visualization (ODQV). However, the Commonwealth did not provide documentation of the assessments or the required ODQV determinations that the data sources provide reliable and valid data for compliance reporting, as required by Compliance Indicator 37.07 for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2.

Provider network development has matured and is now using competent marketing and outreach tools to entities interested in expansion. Provider Data Summaries, Jump Start Funding, the Jump-Start Calculator, etc., serve as an 'opportunity roadmap' for interested providers and complement whatever market research providers need to complete. For instance, the Jump Start Calculator allows an interested provider to enter a specific city/county name and a particular service, in order to get a real time report of persons by waiver, number of available providers, and a sufficiency statement about provider capacity. However, DBHDS reports that the pandemic environment has negatively impacted the availability of providers and the percentage of people being served in the most integrated settings. The number of authorizations for Community Engagement and Community Coaching has declined, but suspended or cancelled authorizations for these services are expected to return as pandemic restraints are eased.

The Provider Data Summary shows provider network development has increased service availability, but availability is uneven statewide. For instance, four (4) cities/counties support only 50% of their residents with intellectual or developmental disabilities in integrated settings through the Waivers, whereas two thirds of cities/counties support over 86% of their residents in integrated settings. Families still face a scarcity of integrated settings in some parts of the Commonwealth.

Regarding the tracking of individuals who request integrated settings and receive those services within nine months, DBHDS was not able to provide reliable data for this indicator in the last review period. It has since changed its data collection from the back end of the RST (Regional Support Team) process to the front end for FY21. CSBs were failing to notify DBHDS of cases resolved or unresolved relative to 'services not available'. DBHDS reports that tracking from the front end now enables it to follow-up on any individual coming in with 'services not available'.

At this reviewer's recommendation DBHDS conducted a six-month analysis (7.1.19-12.31.19) for FY20 'nursing hours' and applied the utilization rate formulas that the Parties agreed to in June 2020. This six-month analysis provides a clean look at the status of nursing services, without the problem of unpaid, late submitted claims. However, DBHDS has not yet provided full year nursing data for FY 20. After the 16th review period and agreements reached in June of 2020, DBHDS made adjustments to the data to address authorizations that were not utilized (e.g. individuals who had passed away or were hospitalized during the period). DBHDS has improved the quality of its utilization data by adding a filter to confirm eligibility for the EPSDT benefit. Nonetheless, DBHDS continues to report that it has fallen short of the utilization (80%) benchmark.

The tables below recap the status of the compliance indicators this study reviewed.

**18th Review Period**
**Findings – Community Living Options**

| VA # | Compliance Indicator | Facts | Analysis/Conclusion | Status |
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| ***S.A. Provision - III.D.1:*** *The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs. (**III.B.2**: The Commonwealth shall not exclude any otherwise qualifying individual from the target population due to the existence of complex behavioral or medical needs or of co-occurring conditions, including but not limited to, mental illness, traumatic brain injuries, or other neurological conditions.)* | | | | |
| 18.01 | *1. DBHDS service authorization data will continue to demonstrate an increase in the percentage of the DD Waiver population being served in the most integrated settings as defined in the Integrated Residential Settings Report.* | Market share of authorizations for individuals being served in integrated residential has grown at least 1-2% annually over the past 3 years and 6.3% over 2016 baseline. | In the WaMs data source, the reliability of claims data is tested against authorizations when claims are paid and periodically thereafter when DMAS conducts post-payment audits.<br><br>The authorization data demonstrates a continued increase. | **MET*** |
| *18.02* | *a. Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings* | Data shows a 1.2% increase between 9.30.19 and 9.30.20, (11,781/13,935 to 12,617/14,719). This increase (1.2%) in annual 'market share' is less than the 2% benchmark and the previous 12 month period increase (2.3%). | The drop in 'market share' increase (1.2% from 2.3%) was likely due to fewer transitions between settings and slowed growth in integrated settings in 2020 due to COVID precautions. | **NOT MET** |
| *18.03* | *3*<br>*b. Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "support needs level" of Levels 6 and 7, since FY 2016 are receiving services in the most integrated setting.* | For the 5.1.20 to 10.31.20 period data shows 78% (468/598) of all individuals new to the DD Waivers and; and 48% (46/96) of individuals in L6-7 new to the waivers received services in integrated settings (*Provider Data Summary, PowerPoint, 3.16.21).* However, this indicator uses a denominator of 'new since 2016', which was reported in 2019 as 93.6% for L6-7 (2556/2731) in *Provider Data Summary, Semi-Annual Report, November 2019;* | When DBHDS reports the data for 'all since 2016', if over 90%, this benchmark will have been achieved and therefore this indicator will be MET.. | **NOT MET** |

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| *18.04* | *2. DBHDS continues to compile and distribute the Semi-annual Provider Data Summary …. The Data Summary indicates an increase in services available by locality over time.* | The Office of Provider Development distributed a final draft of the *Semi-annual Provider Data Summary, 5.1.20 to 10.31.20 on 2.26.21.* The Data Summary shows provider growth in integrated services over baseline: statewide 78 at baseline, loss of 15, and growth of 40 resulting in a net growth of 25 providers of integrated settings.<br><br>Provider growth by locality has been variable. Of 20 regional subareas six have seven or fewer providers of integrated services to support the area. Moreover, while almost two thirds (62%) of the cities/counties in VA are achieving integrated settings for 86% of individuals, some cities/counties (4) have only 50% of individuals living in integrated settings. Region 1 appears to have the lowest percentage of individuals served in integrated settings. | The Office of Provider Development is implementing a plan to improve data quality issues in the Semi-Annual Report in collaboration with statisticians in the Office of Integrated Support Services and the Office of Data Quality & Visualization.<br><br>Relative to individuals accessing integrated services, the numbers have increased over 2018. However, during most of 2020 (April to October) there was no increased access for individuals to the following services: benefits planning, shared living, supported living, community coaching, community engagement, electronic home services.<br><br>. | **NOT MET** |
| *18.05* | *3. DBHDS will establish a focus group with family members, individuals, and providers to identify potential barriers limiting the growth of sponsored residential, supported living, shared living, in-home supports, and respite for individuals with a "support needs level" of Level 6 or 7.* | A focus group was established on 10.9.19. The members of the group included family members, and providers. | The focus group minutes (see Attachment A) recorded the discussions of barriers to implementing new services for individuals with Level 6 or 7 support needs. However, the focus group did not include individuals, as required. | **NOT MET** |
| *18.06* | *DBHDS will report on how many individuals who are medically and behaviorally complex (i.e., those with a "support needs level" of Level 6 or 7) are using the following DD Waiver services, by category: sponsored residential, supported living residential, shared living, in-home supports, and respite services.*<br><br>*Using this data and the focus groups, DBHDS will prepare a plan to prioritize* | DBHDS reported (*HCBS (Residential Settings Level 6 and 7, 10.3.19)* the number of individuals with level 6 or 7 needs. The Residential Settings Report, 9.3020 included the data regarding residential services (i.e. in-home, sponsored, shared and supported living). The | This review could not determine whether actions are planned, prioritized, or implemented to address barriers. Timelines for completion were not provided. | **NOT MET** |

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| | *and address barriers within the scope of its authority and establish timelines for completion with demonstrated actions.* | report, however, did not include the number served in respite services.<br><br>Planning discussions flowed from the data from the "focus group" (which met 10.19), between DBHDS and DMAS. A plan was not provided for review. | | |
| *18.07* | *4. DBHDS tracks individuals seeking a service consistent with integrated living options as defined in the Integrated Residential Settings Report that is not available at the time of expressed interest as described in indicator # 13 of III.D.6. 86% of people with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option …have access to an option that meets their preferences within nine months.* | DBHDS reported that two individuals (3.5.01, 2.12.65) requested integrated services that were not immediately available 7.1.19-9.30.19 (Q1FY20) and were accommodated within 90 days.<br><br>Reporting by CSBs was revised to better ensure that DBHDS can track cases to closure. | There are insufficient data to determine that this indicator has been achieved or that performance has been sustained. The ODQV has not determined that the data source provides reliable and valid data. | **NOT MET** |
| *18.08* | *5. DBHDS establishes an ongoing periodic review process for measuring the promptness and on-going delivery of authorized service units for private duty and skilled nursing services, including those provided under the EPSDT benefit, in order to identify and remedy patterns of service delivery interruptions.* | DBHDS established the required ongoing process (see *Nursing Services Work Group Survey Analysis, 2/2; -Nursing Utilization-Process Document, 12.1.20; -Nursing Auth. Timeliness-Process Document, 12.1.20;*<br>*-Nursing Workgroup Survey-Process Document, 12.1.20)* | The DBHDS processes for 18.08-09 are described well and are detailed. However, there are insufficient data to determine patterns of service delivery interruptions to identify, remedy the problems.<br><br>DBHDS described nursing services data quality assessment in the *Monitoring Questionnaire for Data Verification, 3.1.21.* However, there is no assessment or determination of nursing utilization data quality from ODQV, as required. | **NOT MET** |

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| *18.09* | *6. DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018 for FY 2018. The utilization rate is defined by whether the hours for the service are identified as a need in an individual 's ISP and then whether the hours are delivered . Data will be tracked separately for EPSDT and waiver funded nursing.*<br><br>*Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.* | DBHDS established the baseline in 2018. DBHDS has provided reports that track data separately.<br><br>DBHDS reports that EPSDT data was 'cleaned up' with improved filtering of those who are eligible.<br><br>DBHDS survey and analysis suggest about half of the providers reported reasons for not achieving benchmarks are under provider control; the remainder are individual situations (person died, switched to private insurance, lost Medicaid eligibility, etc.) not under provider control.<br><br>The six month interval of this report was based on a 12.31.20 cutoff, suggesting that the actual utilization rate may be slightly higher due to lagging claims data. This should be cleared up in an annual report. | Current DBHDS reports (*Nursing Services Data Report, Six Month Review of FY20, 2/21)* show timeliness, 'within 30 days', at 86%, which is over the benchmark of 70% (ISP date is defined as the official, annual 'ISP Start Date'). In addition, of the 643 unique individuals with nursing services as a need in their ISPs, 425 (66.1%) received 80% or more of the hours in their ISPs, which is below the 70% benchmark | **NOT MET** |
| *18.10* | *7. DBHDS continues to screen children through a VIDES assessment prior to admission to an ICF/IID. During the screening, DBHDS collects information from the family regarding the reason ICF/IID placement is being sought.* | DBHDS continues to screen children through a VIDES assessment prior to admission (see *SOP-Community Transition Support for Individuals in ICFs, 2.19.21;*<br>*Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20;*<br>*SOP-Screening for Admission into an ICF, 10.14.20).*<br><br>The census of ICF/IIDs has increased over the past four years (108 in 2017, 114 in 2021). There was one diversion in Q2 FY21. | DBHDS continues to screen children, as required and collects information about families' reasons for seeking ICF/IID placement (see *Family Contact Sheets, CY20*). | **MET** |

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| *18.11* | *8. DBHDS continues to do Level II Preadmission Screening and Resident Reviews ("PASRR") on all children who have an indicator of a developmental disability diagnosis and are seeking nursing home services.*<br><br>*All children who enter nursing facilities are limited to those who require medical rehabilitation, respite or hospice services.* | DBHDS continues to do Level II PASRR on all children (see -*Children Identified in NF, 12.31.20;*<br>-*Children referred for NF Placement through PASRR, 12.31.20*). In CY20 5 of 15 admission requests were diverted.<br><br>DBHDS ensures children who enter nursing facilities are limited to those who require these services per the PASRR by annually cross-tabbing with DMAS nursing facility claims. | DBHDS continues to use PASRR, as required, and to actively divert inappropriate NF admission requests. | **MET** |
| *18.12* | *9. DBHDS tracks individuals under 22 who have received a PASRR screening for nursing facility entry or a VIDES assessment for ICF/IID entry and have been admitted. Children in ICFs receive annual Level of Care reviews and children in nursing facilities receive required resident reviews every 180 days at a minimum.* | DBHDS continues to track NF admissions: ten (10) NF residents received PASRR review during Q2FY21 (see *Children referred for NF Placement through PASRR, 12.31.20*)<br><br>DBHDS continues to track ICF/IID admissions: 1 of 5 admission requests to ICF/IIDs Q2FY21 was diverted: thirty-five (35) ICF/IID residents received LOC reviews during Q2FY21 (see *Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20*) | DBHDS tracks admissions. Children residing in these facilities who receive Level of Care and resident reviews, as required. | **MET** |
| *18.13* | *10. DBHDS provides a Community Transition Guide to families of children in nursing facilities and ICFs/IID. For those seeking ICF/IID placement, the Guide is provided when a request for a VIDES assessment is made and every 6 months thereafter.*<br><br>*The Guide is designed to provide practical information to children and their families who are preparing to make decisions related to the type of care that best suits their support needs or are preparing to transition from nursing facilities and ICFs/IID to homes in the community. The Guide assists families in preparing to move to a new home through an explanation of resources and services such as DD Waivers, CSBs, and the DBHDS Community Transition Team that can assist the family with the transition process.* | DBHDS provides Community Transition Guides (CTG) guides to families of children admitted to nursing facilities (21 during Q2FY21; see *Children referred for NF Placement through PASRR, 12.31.20*)<br><br>CTG guides were distributed to ICF/IID admissions (4 during Q2FY21; see *Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20*. This documentation also confirmed that the Guide is provided every 6 months after admission (each | DBHDS provides Community Transition Guides (CTG) guides to families of children who live in nursing facilities and ICFs. The Guides provide practical information and explain resources to assist families. | **MET** |

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| | | January and June).<br><br>The Guide (*Community Transition Guide, 8/19*) provides practical information, such as providing the required explanations about resources that can assist the family with the transition. However, language and presentation could be made more user friendly. | | |
| *18.14* | *11. Information with respect to services and supports for children with DD is available to families on the My Life My Community website.*<br><br>*This information is disseminated consistent with the indicators in III.C.8.b.* | The required information is available on the My Life My Community website. (see http://mylifemycommunityvirginia.org/)<br><br>This information has received wide distribution and is cited as a source on the DBHDS website, in the Community Transition Guide, and in on the DBHDS Listserv. Website activity is reported at - *MyLifeMyCommunityVirginia.org; Webpage and Call Center Status Report, Q1 F19.* | The required information is available on the My Life My Community website and has been widely distributed to organizations and entities likely to have contact with individuals eligible for waiver services. | **MET** |
| *18.15* | *12. DBHDS includes children aged 10 years and under as a priority group for discharge from ICF/IID settings per the ICF Community Transition Protocol, including prioritizing waiver slots to facilitate their discharge.* | DBHDS has established a process that prioritizes five slots annually (ten slots per biennium) for children under 10 (see *Waiver Slot Distribution-Process Document, 12.1.20).* | DBHDS has established as a priority group children aged 10 and under. | **MET** |
| *18.16* | *13. DBHDS implements a Family Outreach Plan that provides an avenue of communication with families/guardians/ARs of individuals with DD under 22 years of age receiving long term care services in nursing facilities and ICF/IIDs. Contact with parents/guardians/ARs is initially made by mail with follow-up phone calls. All families are provided with the Community Transition Guide as described in indicator #10 above.Contact with parents/guardians/ARs is initially made by mail with follow up phone calls. All families are provided with the Community Transition Guide as described in indicator #10 above.* | The Family Outreach Plan is defined by DBHDS as an individualized set of approaches and strategies for the family, guardian, AR**.** However, it does not include a "Next Steps" or "Plan" section (see *SOP-Community Transition Support for Individuals in ICFs, 2.19.2).*<br><br>Families are provided with the Community Transition Guides twice annually (see *SOP-Community Transition Support for* | Although the Family Outreach Plan and Family Contact Sheets taken together present a fairly complete picture of where the case is and where it is going, next steps for DBHDS staff and/or families are often not clear. | **MET** |

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| | | *Individuals in ICFs, 2.19.21)*<br><br>The review of Outreach Plans for twenty-seven (27) families and the accompanying Family Contact Sheet for this study confirmed that DBHDS is contacting families at least annually. Not all families respond or participate, but when families engage, it is via phone, email, mail, personal contact, or indirectly through facility social workers or CSB case managers. | | |
| *18.17* | *Families/Guardians/ARs interested and open to discussion of available community services are contacted not less than semi-annually. All families receive an annual contact unless there is a request for no contact.* | As verified in the 16th and again during the 18th period, DBHDS has collected this information. Unless families indicated otherwise, during Q1-2 FY21, twenty-one (21) annual contacts were made and twenty-two (22) semi-annual contacts were made with families who have children under age 10 (see *Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20.*) | DBHDS staff are implementing these annual contacts with families. | **MET** |
| *18.18* | *Contact through the Family Outreach Plan will also involve individualized information in a manner that accommodates their cognitive disabilities, addresses past experiences of living in community settings and concerns and preferences about community settings, and includes facilitating visits and direct experiences with the most integrated community settings that can meet the individual's identified needs and preferences.* | When families respond, the Family Outreach Plan interview includes past experiences living in the community, concerns about community living, interest in site visits to community settings, and interest in peer support (see *Family Outreach Plans, CY20).* | The contacts through the Family Outreach plan involved, as required. | **MET** |
| *18.19* | *DBHDS facilitates with families a contact by a family-to-family peer support facilitator who shall contact families of children on at least a semi-annual basis for children aged 10 years and under, and on an annual basis for children aged 11 to 21 years, unless the family refuses contact.* | DBHDS has established a process that delegates to VCU its responsibility to assign family-to-family peer support facilitators to families. During | The DBHDS reported data that families of children aged ten years and under were contacted semi-annually and that the families for all children were | **MET*** |

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| | | Q1 FY21 eight (8) families were referred to VCU. The VCU peer support facilitator contacted 8 families, only 1 of whom was interested; this family was linked 10.14.20. (see *SOP-Community Transition Support for Individuals in ICFs, 2.19.21; see Email, 3.17.21, Holland to Zaharia)*<br><br>Sections III.C.i and III.C.iv of *SOP-Community Transition Support for Individuals in ICFs, 2.19.21* prescribe that all families are contacted quarterly for children 10 and under and annually for children over 10 in ICF/IIDs. | contacted at least annually. | |
| *18.20* | *14. DBHDS will collaborate with sister agencies and private providers to explore augmenting current Medicaid funded host home service models for children that incorporate core elements of the Every Child Texas model focusing on children coming out of institutional settings.* | The DBHDS policy expects the Family Resource Consultant (FRC) toc collaborate with other DBHDS departments to develop and implement measures for augmenting current Medicaid funded host home service models for children that incorporate elements of the Every Child Texas model (see *SOP-Community Transition Support for Individuals in ICFs, 2.19.2) for discharging from ICF/IDDs.*<br><br>A DBHDS PowerPoint (*Virginia DD Services & Every Child Texas Model, PowerPoint, undated*) includes next steps planning for implementation of model approaches with children, including an inter-agency/provider focus group in Q4 FY21. Therefore the compliance indicator has not yet been accomplished. | DBHDS has not yet provided documentation that it collaborated with its sister agencies, private providers, etc., to explore augmenting current host home service models for children. | **NOT MET** |

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| *18.21* | *15. DBHDS ensures that all CSBs are aware of children with DD seeking admission to a nursing facility from their catchment area and of children considering ICF/IID admission or discharge whose families are interested in community-based services through an awareness letter.*<br><br>*When a child is identified as being in active discharge status from a nursing facility or ICF/IID, DBHDS sends an action letter to CSBs that enumerates the actions needed from the CSB and ensures funds are available for up to 120 days of Case Management Services for discharge planning.* | DBHDS provided documentation that CSBs are routinely informed of children with DD seeking admission or discharge (see *NF Awareness Letters Log, 2/20-1/21; ICF/IID Data Spreadsheet, 2.16.21*)<br><br>DBHDS provided documentation that it sends the required action letters to CSBs. This documentation confirmed that they identify the actions needed (see *NF Action Letters Log, 2/20-1/21; ICF/IID Data Spreadsheet, 2.16.21*)<br><br>Action letters do not always appear to clarify per individual that funds are available for case management 120 days for discharge planning.<br><br>CSB eagerness to become involved in discharge planning is dependent on support of those activities, which are not always funded/supported in the normal course of CSB budgeting. Therefore the consistent 'marketing" of the availability of funding through action letters may ensure CSB participation**.** | DBHDS documented that CSBs are routinely informed to ensure awareness and that it sends CSBs the letter in which the needed actions are identified. Often, however, the action letters were not sufficient as they did not indicate that funding was ensured. | **NOT MET** |
| *18.22* | *a. 90% of those children known to be in active discharge status at a nursing facility or ICF/IID have an action letter sent to their home CSB.* | DBHDS sent seven nursing facilities action letters (see *NF Action Letters Log, 2/20-1/21*) to all those known to be in active discharge status during this 12 month period.<br><br>DBHDS sent five ICF/IID action letters to all those known to be in active discharge status during Q1FY21 (*ICF/IID Data Spreadsheet, 2.16.21*). | DBHDS sent action letters for 100% of those children known to be in active discharge status. | **MET** |

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| *18.23* | *b. DBHDS establishes and implements accountability measures for those CSBs not actively involved in a child's discharge planning from a nursing facility or ICF/IID within 30 days of receiving an action letter.* | DBHDS reports that it has accountability measures established in the CSBs' *Community Services Performance Contract.* (see specifically Section 9.d of the *Contract* in Attachment A). The document, *SOP-Community Transition Support for Individuals in ICFs, 2.19.2,* also specifically states this.<br><br>DBHDS reports that it has not implemented the use of measures beyond notification and discussions and has not needed to implement further accountability measures as all CSBs have been actively involved within 30 days of receiving an action letter. | This indicator requires that accountability measures be established and implemented. Achievement will be determined when DBHDS implements these accountability measures. | **NOT MET** |

*Note: Two of the twelve Met determinations were based on data that the Commonwealth has not determined to be reliable and valid and available for compliance reporting, as required by CI 37.07 for V.D.3. which must be completed in accordance with 36.01 and 36.05 for Provision V.D.2.

**Recommendations:**

DBHDS should create rates for integrated services that incentivize these services (i.e., above and beyond true and actual cost) to aid in building out the provider community.

DBHDS should conduct annual ICF/IID claims check with DMAS to ensure quality of facility reporting.

DBHDS should add a "Next Steps" or "Plan" section to the Family Outreach Plan.

**Suggestions for DBHDS Consideration**

DBHDS should consider freezing admissions to group homes larger than six.

DBHDS should consider asking the Nursing Services Workgroup to follow, without intervention, a cohort of 20+ individuals who have these services newly identified in their ISPs to better identify the circumstances leading to failures to utilize full authorization amounts.

DBHDS should consider directly encouraging and supporting Children's Hospital Kings Daughters efforts to support families who wish to return their child home.

DBHDS should consider convening a users group to give feedback at the next update of the *Community Transition Guide* and to make needed modifications to address concerns regarding accessibility and user-friendly issues (REPEAT).

**Attachment A**
**Community Living Options Documents**

| VA# | Documents |
|---|---|
| 18.01 | *-HCBS Residential Settings Report, 9.30.20;*<br>*-Provider Data Summary, Semi-Annual Report, 2.26.21;*<br>*- Provider Data Summary, PowerPoint, 3.16.21* |
| *18.02* | *-Provider Data Summary, Semi-Annual Report, 2.26.21;*<br>*- Provider Data Summary, PowerPoint, 3.16.21*<br>*-HCBS Residential Settings Report, 9.30.20;* |
| *18.03* | *-Provider Data Summary, Semi-Annual Report, November 2019;*<br>*-Provider Data Summary, Semi-Annual Report, 2.26.21;*<br>*- Provider Data Summary, PowerPoint, 3.16.21*<br>*-HCBS Residential Settings Report, 9.30.20;* |
| *18.04* | *-Provider Data Summary, Semi-Annual Report, 2.26.21;*<br>*-PowerPoint, 3.16.21;*<br>*-Webinar, presentation, 3.16.21;*<br>*-Jump-Start Calculator 20201031;*<br>*-Data Quality Plan Phase III;*<br>*-Provider Data Summary, FY20. undated* |
| | *-Provider Data Summary, Semi—Annual Report, 2.26.21;*<br>*- Provider Data Summary, PowerPoint, 3.16.21*<br>*Baseline Measurement Tool Master, 20201031*<br>*-FY21Q1 Integrated Residential by Locality, 3.5.21* |
| *18.05* | *-Barriers to Implementing New Services – Minutes, 10.9.19; 11.12.20, 11.20.20, 12.2.20* |
| *18.06* | *-Barriers to Implementing New Services – Minutes, 10.9.19; 11.12.20, 11.20.20, 12.2.20*<br>*-Residential Settings Level 6 and 7, 10.3.19;*<br>*-HCBS Residential Settings Report, 9.30.20;* |
| | *-Barriers to Implementing New Services – Minutes, 10.9.19; 11.12.20, 11.20.20, 12.2.20* |
| *18.07* | *-Provider Data Summary, Semi-Annual Report, 2.26.21* |
| *18.08* | *-Nursing Services Data Report, Six Month Review of FY20, 2/21;*<br>*- Nursing Services Work Group Survey Analysis, 2/2;*<br>*-Nursing Utilization-Process Document, 12.1.20;*<br>*-Nursing Auth. Timeliness-Process Document, 12.1.20;*<br>*-Nursing Workgroup Survey-Process Document, 12.1.20;*<br>*-Monitoring Questionnaire for Data Verification, 3.1.21;* |
| *18.09* | *-Nursing Services Data Report, Six Month Review of FY20, 2/2;*<br>*-Nursing Services Work Group Survey Analysis, 2/21* |
| | *-Nursing Services Data Report, Six Month Review of FY20, 2/21* |
| | *Nursing Services Data Report, Six Month Review of FY20, 2/21;*<br>*-Memorandum, DF to BC & K, memorialized formulas to be used, 6.24.20;* |
| *18.10* | *-SOP-Community Transition Support for Individuals in ICFs, 2.19.21;*<br>*-Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20;*<br>*-SOP-Screening for Admission into an ICF, 10.14.20*<br>*-- Family Outreach Plans, CY20; ICF Family Contact Sheets, CY20* |
| *18.11* | *-Children Identified in NF, 12.31.20;* |

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| | *-Children referred for NF Placement through PASRR, 12.31.20;*<br>*-Children in Nursing Facility Transition Protocol/Process, 8.5.19* |
| | *-Baseline Children in NF, 12.31.20;*<br>*-Children Identified in NF, 12.31.20* |
| *18.12* | *-Children referred for NF Placement through PASRR, 12.31.20;*<br>*-Baseline Children in NF, 12.31.20;*<br>*-Children Identified in NF, 12.31.20;*<br>*-Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20;* |
| *18.13* | *-NF Family Outreach Log, 11-12/20;*<br>*-Community Transition Guide, 8/19;*<br>*--SOP-Community Transition Support for Individuals in ICFs, 2.19.21;*<br>*Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20;*<br>*-ICF/IID Data Spreadsheet, 2.16.21* |
| | *-Community Transition Guide, 8/19;* |
| *18.14* | http://mylifemycommunityvirginia.org/ |
| | *-MyLifeMyCommunityVirginia.org; Webpage and Call Center Status Report, Q1 F19;*<br>*-NF Family Outreach Log, 11-12/20;*<br>*-Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20;*<br>*-ICF/IID Data Spreadsheet, 2.16.21* |
| *18.15* | *-Waiver Slot Distribution-Process Document, 12.1.20;*<br>*--SOP-Community Transition Support for Individuals in ICFs, 2.19.21;* |
| *18.16*<br>*To*<br>*18.19* | *- Family Outreach Plans, CY20;*<br>*- NF Family Outreach Log, 11-12/20;*<br>*--SOP-Community Transition Support for Individuals in ICFs, 2.19.21;*<br>*-ICF/IID Data Spreadsheet, 2.16.21*<br>*-Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20*<br>*-Email, 3.17.21, Holland to Zaharia, Families referred to Family to Family Program;* |
| *18.20* | *--SOP-Community Transition Support for Individuals in ICFs, 2.19.2;*<br>*-Virginia DD Services & EveryChild Texas Model, PowerPoint, undated;* |
| *18.21* | *-NF Awareness Letters Log, 2/20-1/21;*<br>*-ICF/IID Data Spreadsheet, 2.16.21* |
| | *-NF Action Letters Log, 2/20-1/21;*<br>*-ICF/IID Data Spreadsheet, 2.16.21;*<br>*- CSB Action Letters, 2.21.20,3.2.20, 3.17.20;* |
| *18.22* | -NF *Action Letters Log, 2/20-1/21;*<br>*-Children's ICF/IID Cumulative & Q2FY21 Report Log, 12.31.20;* |
| *18.23* | *-Children's ICF/IID Cumulative &* Q2FY21 Report Log, 12.31.20;<br>*-FY19 & FY20 Community Services Performance Contract, undated.* |

Attachment B
Interviews

Benita Holland, Family Resource Consultant, DDS

Susan Moon, Nurse Care Consultant, OIH

Brian Nevetral, Program Specialist, OIH

Heather Norton, Assistant Commissioner, DDS

Lisa Rogers, Community Transition Nurse, OIH

Jenni Schodt, DOJ Settlement Agreement Advisor

Eric Williams, Director of Provider Development, DDS

# APPENDIX F

## INDIVIDUALS WITH COMPLEX MEDICAL SUPPORT NEEDS

by

**Elizabeth Jones, Team Leader**
**Marisa C. Brown, MSN, RN**
**Julene Hollenbach, RN, BSN, NE-BC**
**Barbara Pilarcik, RN**

# EIGHTEENTH REVIEW PERIOD
# INDIVIDUAL SERVICES REVIEW STUDY:

# INDIVIDUALS WITH COMPLEX MEDICAL SUPPORT NEEDS

**Submitted By:** **Elizabeth Jones, Team Leader**
**Marisa C. Brown, MSN, RN**
**Julene Hollenbach, RN, BSN, NE-BC**
**Barbara Pilarcik, RN**

**May 17, 2021**

**Introduction/Overview**

For each of his reports to the Court, the Independent Reviewer has examined the supports provided to a cohort of individuals with a development disability (DD) and complex medical support needs. For the last review period, the seventeenth, individuals with challenging behaviors were selected for study. For this current reporting period, a statistically significant random sample of 34 individuals was reviewed by a team of nurses experienced in the provision of healthcare to individuals with DD.

This eighteenth period Individual Services Review (ISR) study, however, differs from previous studies in an important aspect. The cohort for this ISR study was selected from a list of individuals whose services were evaluated during the 2020 Quality Services Reviews (QSR) process. This ISR study focused specifically on evaluating whether the Commonwealth's QSR consultants and process were sufficient to meet the requirements of Provision V.I.1. Compliance Indicator 51.04 c. and Provision V.I.2, Compliance Indicator 52.01 a. and c. These Compliance Indicators require that:

V.I. 1 The QSRs assess on a provider level whether:

51.04 c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary;

V.I. 2 The QSRs assess on an individual service recipient-level and individual provider-level whether:

52.01 a. Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk.

52.01 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.

The actual sample of individuals to review was drawn from the cohort of 99 individuals, with HCBS waiver-funded sponsored or group home residential services, whose Supports Intensity Scale (SIS) evaluation results placed them in level six and whose services were reviewed during the PCR portion of the 2020 QSR study.

For this review, a sample size of 34 individuals was determined adequate for the study findings to be generalized to this cohort with a 90% confidence level. In order to ensure geographic representation, a proportional random sample stratified by Region was selected, with replacements if needed. (Only one replacement was required, due to an individual's death.) The final sample consisted of ten individuals from Region I; five from Region II; six from Regions III and IV; and seven from Region V.

In analyzing the findings from the ISR Monitoring Questionnaire used by the Independent Reviewer's nurse consultants, comparisons were made with the findings from the QSR evaluations of the same individuals and for the same period. The ISR findings were compared with the QSR consultants' findings to determine whether, and the extent to which, there were

any discrepancies. As a result of this comparative analysis, the status of the Commonwealth's achievement with the QSR Compliance Indicators referenced above could be assessed, at least in part. As the Independent Reviewer has previously indicated, in order to determine whether an indicator has been met for the Person Centered Review (PCR) portion of the 2020 QSR study, those reviews must be conducted in accordance with the QSR Indicator requirements for collecting sufficient information. That is, the QSR evaluation process requires that the collection of information utilize face-to-face on-site interviews and direct observations of the individuals' program settings. The 2020 QSR round was not able to fulfill these requirements for collecting sufficient information due to the appropriate implementation of Virginia's COVID-19 precautions.

As with all prior studies, the draft methodology for this ISR study was shared with and discussed with key staff from the Commonwealth's Department of Behavioral Health and Disability Services (DBHDS). The Commonwealth was asked to identify both the individuals to interview and the documents to review to ensure the ISR study gathered the information needed to complete the study. The Commonwealth was asked to provide all the contact information for the individuals selected for the ISR study, these individuals' documents that were reviewed during the 2020 QSR process and any other QSR records that the Commonwealth maintains that document the proper implementation of the Compliance Indicators being studied.

Due to the continuing restrictions on visitation and travel, all interviews for this ISR study were conducted via telephone. Two nurses and the Team Leader participated in each interview with the designated residential contact person in order to complete the ISR Monitoring Questionnaire inquiries developed and utilized by the Independent Reviewer in this and previous ISR studies. The interviews were completed between March 2 and April 6, 2021.

Copies of the completed ISR Monitoring Questionnaires for the 34 individuals in the sample will be provided to the Parties when the Independent Reviewer submits his eighteenth Report to the Court in June 2021. The Independent Reviewer expects any identified Issues to be reported on by DBHDS no later than September 30, 2021.

Following the finalization of the ISR Monitoring Questionnaires, the nurse consultants compared their findings with the responses documented in the individual summaries from the PCRs conducted by the Commonwealth's QSR consultants. The QSR summaries were primarily "Yes" or "No" responses to the elements contained in the PCR Tool administered to the same 34 individuals reviewed in the ISR study. All of the questions found in the completed QSR tools were reviewed and compared to the ISR Monitoring Questionnaire responses. Any differences identified are summarized in the Comparison Charts included as Attachment A.

Several constraints were identified throughout the course of this ISR study. First, as the study progressed, it became clear that the documentation provided by DBHDS was not consistent for all individuals reviewed. It is not certain to the ISR reviewers whether all documents actually reviewed by the QSR consultants were provided for review by the Independent Reviewer's nurse consultants. Therefore, it is possible that certain identified discrepancies in the respective findings were not actually discrepancies in fact but were the result of inconsistent sources of information. Second, unlike previous ISR studies, the interviews for this study were focused on past rather than current facts or circumstances. Although most residential contacts interviewed were

knowledgeable about the individual and their health-related supports, especially when it was a family member as Sponsor, some contacts had difficulty answering questions with accuracy or sufficient detail. Third, key documents usually examined during site visits to the residence were simply not available for review. For example, informed consent forms for psychotropic medications, Medication Administration Records (MARS), clinical consultation reports, records of hospitalizations or Emergency Room visits, laboratory test results and nursing care plans were not included in most of the documentation provided for review.

A list of the specific documents reviewed for each of the 34 individuals included in the sample can be found in his/her ISR Monitoring Questionnaire as well as the name of the residential contact(s) interviewed.

**Summary of Findings**

First, acknowledgement must be made of the generous and capable assistance received from DBHDS staff. Numerous requests were made, especially at the onset of the study, and were responded to in a timely and thoughtful manner. All of the consultants who worked on this ISR study wish to express their strong appreciation for the support provided by DBHDS staff.

Second, it is recognized that the Commonwealth initiated and completed this first round of the PCR portion of the 2020 QSR study and that there is now information about medically complex individuals with DD and their residential providers that can be utilized to assess the strengths and vulnerabilities of the community system. It is hoped that the findings from the current ISR study can be instrumental in identifying areas for remedial actions and/or enhanced attention. For example, the 2020 QSR study did not identify that a significant percentage of individuals lacked dental care or that the lack of such care reflected an unmet healthcare need. Instead, the PCR assessments erroneously determined that all of these individuals' healthcare needs had been met. Previous ISR studies identified the lack of dental care as gaps in service. Again during this ISR study, residential providers interviewed continued to express serious concerns that the lack of access to dental care was a significant obstacle to meeting individuals' healthcare needs. The 2020 QSR's PCR assessments by non-clinicians did not always identify the lack of dental care for any of these individuals. Without specific QSR findings that the lack of dental care constitutes an unmet healthcare need, especially for individuals who need sedation or specialized interventions, the 2020 QSR study could not determine that the lack of dental care was a system wide obstacle to meeting individuals' healthcare needs. Without these findings, the lack of dental care was not identified as an unmet healthcare need by the QSR study or included in the QSR Summary data for the QIC to consider as a potential Quality Improvement Initiative on the individual, provider, CSB or system-wide level.

Additionally, a review of the issues described on the Issues Page in the ISR Monitoring Questionnaires may be useful in highlighting aspects of the PCR tool and/or the clinical qualifications of the QSR auditors that should be supplemented or examined more closely for improvements. For example, the PCR tool contains two specific questions (#7 and #36) on health risks and asks for information related to eight serious health conditions (that are frequently associated with potentially preventable deaths of individuals with DD) identified by DBHDS. Despite most of the reviewed individuals experiencing problems with constipation, seizures and choking precautions, the non-clinician QSR auditors usually did not identify these concerns. \

Although the findings from the Monitoring Questionnaires are instructive, the primary stated purpose of this specific ISR study was to determine whether the QSR studies conducted by the Commonwealth's consultants were sufficient and met the specific requirements of the Compliance Indicators discussed further below. Based on the discrepancies identified in the table below, on the lack of on-site face-to-face interviews and observations in the QSR 2020 round, and the fact that the Commonwealth's data sources have not yet been determined to provide reliable and valid information, a finding of compliance with Compliance Indicators V.I.1.-51.04c, V.I.2.-52.01a. and c. cannot be recommended at this time.

**Analysis of Findings**

The Independent Reviewer's nurse consultants identified physical wellbeing and healthcare concerns for 29 of the 34 (85%) of the medically complex individuals in the ISR sample[1]. As indicated below, the QSR-PCR assessments identified only one of these concerns for one of the 29 individuals. (There were no such issues/concerns identified by either the QSR or the ISR evaluations for five individuals--#2, 7, 14, 15 and 29.) Attachment A contains a complete discussion of the findings for each individual as related to the Compliance Indicators referenced in this ISR study. A summary chart for each Compliance Indicator is provided below.

| **18th Review Period Findings** | | | |
|---|---|---|---|
| **V.I. 1 The QSRs assess on a provider level whether:**<br><br>**51.04 c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary.** | **Unmet healthcare need or safety from harm concern identified in ISR study (# of individuals)** | **Did the QSR consultants identify this healthcare need or safety concern?** | **Conclusion:** |
| | The ISR reviews identified individuals 9 of the 34 individuals (26.5%) who were not protected from potential risk of harm (Individuals #1, 3, 8, 13, 22, 23, 27, 31, 34). | The QSR reviewers identified 0 of 34 individuals (0%) who were at risk of harm. | Based on the documents available for review, the QSR consultants failed to identify these critical issues. |

[1] A list of the 34 individuals' names that correspond to these numbers was provided under seal to the Parties.

| 18th Review Period Findings | | | |
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| **V.I. 2 The QSRs assess on an individual service recipient-level and individual provider-level whether:**<br><br>**52.01 a. Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk.** | **Issue identified in ISR study (# of individuals):** | **Did the QSR consultants identify this Issue?** | **Conclusion:** |
| | The ISR reviews determined that 20 of the 34 individuals (58.8%) needed assessments or consultations that were not recommended or ordered (Individuals #3, 4, 5, 6, 8, 9, 11, 12, 13, 16, 17, 19, 21, 22, 24, 25, 31, 32, 33, 34). | The QSR reviewers identified 1 individual (#8) of 34 individuals (0.03%) who needed assessments. | Based on the documents available for review, the QSR consultants failed to identify all needed assessments or consultations. |
| | The ISR reviews determined that 15 of the 34 individuals (44.1%) lacked access to dental care (Individuals #3, 5, 6, 9, 10, 11, 13, 18, 22, 26, 28, 30, 31, 32, 34). | The QSR reviewers identified 0 of 34 individuals (0.0%) who needed access to dental care. | Based on the documents available for review, the QSR consultants failed to identify needed dental care. |

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| | The ISR reviews determined that there was no evidence that necessary lab tests were completed for 7 of the 34 individuals (20.6%) (Individuals #9, 17, 20, 21, 24, 27, 34). | The QSR reviewers identified the lack of evidence of necessary lab tests for 0 of 34 individuals (0.0%). | Based on the documents available for review, the QSR consultants failed to identify evidence that necessary lab tests were completed. |

| **18th Review Period Findings** | | | |
|---|---|---|---|
| **V.I.2 The QSRs assess on an individual service recipient-level and individual provider-level whether:** | **Issue identified in ISR study (# of individuals):** | **Did the QSR consultants identify this Issue?** | **Conclusion:** |
| **1.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.** | The ISR reviews identified that the ISPs for 4 out of the 34 individuals (11.8%) required modification but were not modified (Individuals #3, 8, 13, 23). Only one ISP was found to have been modified (Individual #14) as needed. | The QSR consultants identified the need for ISP modification for 0 of 34 individuals (0%). The QSR auditor recognized that the ISP had been modified for Individual #14. | Based on the documents available for review, the QSR consultants failed to identify that ISPs required modification. |

**Conclusions**

Based on the documents provided for review, this ISR study found that DBHDS's 2020 QSR evaluations failed to identify the vast majority of unmet healthcare needs for individuals with complex medical support needs.

The following findings show healthcare needs that were unmet, as identified by the ISR registered nurses:

- 26.5% versus 0.0% were not protected from potential risk of harm;
- 58.8% versus 0.03% needed assessments or consultations that were not recommended or ordered;
- 44.1% versus 0.0% lacked access to dental care;
- 20.6% versus 0.0% did not receive necessary lab tests; and
- 11.8% versus 0.0% of ISPs were not modified when needed.

**Recommendations**

The Commonwealth should review each of the discrepancies between the findings of the ISR study and those of the PCR portion of its 2020 QSR study. DBHDS should review and determine whether the ISR findings of healthcare needs not being met are correct. If the ISR nurses' findings are verified, then DBHDS should review the root cause of the QSR auditor's failure to identify these healthcare service inadequacies and take needed corrective actions. The Commonwealth should determine whether the QSR auditors were qualified and sufficiently trained to identify potential clinical concerns and to determine whether these individuals' healthcare needs were met.

In addition, DBHDS should review and determine whether any of the questions/probes included in the PCR tool should be modified or supplemented in order to elicit additional information relevant to the need for assessment and treatment of individuals with complex medical needs. The Issues cited on the Issues Pages of the 34 Monitoring Questionnaires should be helpful in analyzing the need for further revision of the QSR tool and for identifying systemic or programmatic gaps that permit health-related harm or risk of harm for medically complex individuals.

**ATTACHMENT A**
**CHART ONE**

| **Name** | **Compliance Question: Do providers keep service recipients safe from harm?** | **Response** |
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| #1 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>Potential adverse medication event: The use of Paroxetine in combination with Tramadol can increase the risk of serotonin syndrome. Furthermore, the use of paroxetine together with Quetiapine, while effective in managing depressive and anxiety symptoms, may increase side effects such as dizziness, drowsiness, confusion and difficulty concentrating. Some people, particularly the elderly, may also experience impairment in thinking, judgment and motor coordination. Note: #1 did have an incident in August 2020 where it is reported that he fell because he lost track of where he was in relation to his wheelchair. If the prescribing clinician believes the current therapy to be the best course of treatment, the following needs to occur: 1) Inclusion of the potential for drug-drug interactions on the written psychotropic medication consent; 2) Justification for the course of treatment in the medical record; and 3) Protocol for staff to follow to monitor for adverse signs/symptoms. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #2 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |
| #3 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#3 utilizes a protective arm sleeve to prevent her from biting | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

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| | her arms, which is a physical restraint. There was no review/approval by the Human Rights Committee and there was no Behavioral Support Plan.<br><br>#3's ISP stated that she was diagnosed with multiple myeloma. Her actual diagnosis is monoclonal gammopathy and anemia which requires ongoing monitoring. The hematologist/oncologist had ordered follow-up laboratory work, but it had not been done.<br>The concerns are: 1) The provider's nursing staff were not aware of the diagnosis; therefore, were not providing ongoing monitoring for potential symptoms related to development of myeloma or lymphoma; 2) Laboratory tests were ordered but not completed; 3) Routine laboratory tests related to monoclonal gammopathy were not occurring. | |
| #4 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #5 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #6 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #7 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No: | Yes ☒ No ☐<br>Yes ☒ No ☐ |

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| | There were no issues identified. | |
| #8 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>The ISP dated October 27, 2020 - October 28, 2021 stated that #8 could "consume solid foods as long as they are soft or smashed." #8 had a gastric tube placed in November 2019 and a subsequent swallow study in September 2020 that determined that she cannot safely take oral nutrition. Consuming food or liquids orally could result in aspiration. The ISP needs to be corrected to document the food texture that can be consumed without risk.<br><br>#8 was removed from her grandmother's home due to severe malnutrition requiring a gastric tube, sexual abuse with vaginal scarring and not receiving her anti-epileptic medication. There was no documentation indicating that emotional support was provided through this transition. The provider stated that to this day #8 has spontaneous periods of crying which may indicate that she suffers from emotional harm. | Yes ☒ No ☐<br>Yes ☐ No ☒ |
| #9 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #10 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #11 | QSR Auditor answered<br>ISR Nurses answered | Yes ☒ No ☐<br>Yes ☒ No ☐ |

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| | Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | |
| #12 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |
| #13 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#13 had a pressure ulcer in November 2019, March 2020 and June 2020. The PCP requested that he receive skilled nursing care to ensure proper skin care and referred the issue of the pressure ulcers to Adult Protective Services. His medical needs resulted in his move to a new Group Home on February 8, 2021 that has sixteen hours of skilled nursing care available. There is no indication that his ISP was modified because of the recurrent pressure ulcers. However, there was documentation in the Multiservice Progress Notes of the ISP Team meeting several times regarding #13's pressure ulcers and need for skilled nursing care. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #14 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |
| #15 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |

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| #16 | QSR Auditor answered<br>ISR Nurses answered<br>Issue identified, if ISR nurses answered No:<br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #17 | QSR Auditor answered<br>ISR Nurses answered<br>Issue identified, if ISR nurses answered No:<br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #18 | QSR Auditor answered<br>ISR Nurses answered<br>Issue identified, if ISR nurses answered No:<br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #19 | QSR Auditor answered<br>ISR Nurses answered<br>Issue identified, if ISR nurses answered No:<br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #20 | QSR Auditor answered<br>ISR Nurses answered<br>Issue identified, if ISR nurses answered No:<br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #21 | QSR Auditor answered<br>ISR Nurses answered<br>Issue identified, if ISR nurses answered No: | Yes ☒ No ☐<br>Yes ☒ No ☐ |

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| | There were no issues identified. | |
| #22 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#22 is receiving two psychotropic medications: 1) Fluvoxamine - used to treat obsessive-compulsive disorder and social anxiety disorder; and 2) Quetiapine - used to treat bipolar disorder, depression and schizophrenia. #22's ISP does not identify any of these diagnoses. He is monitored routinely by the psychiatrist and those medical records may identify an applicable diagnosis, but the records were not available for review. #22 also does not have a Behavior Support Plan. Therefore, it could not be determined if #22 was receiving any "unnecessary" medications. | Yes ☒ No ☐<br>Yes ☐ No ☒ |
| #23 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#23 is receiving multiple psychotropic medications daily and has seven different psychiatric diagnoses. #23 also receives an anti-convulsant for his psychiatric diagnoses. There is a history of multiple psychiatric hospitalizations beginning about 2015 and continuing through 2020. Reportedly, he sees the psychiatrist monthly and is actively followed by REACH. However, eight medications fit within the definition of polypharmacy and need to be evaluated. | Yes ☒ No ☐<br>Yes ☐ No ☒ |
| #24 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #25 | QSR Auditor answered<br>ISR Nurses answered | Yes ☒ No ☐<br>Yes ☒ No ☐ |

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| | Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | |
| #26 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |
| #27 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#27 is prescribed several psychotropic and one anticonvulsant medication (to treat bi-polar disorder). However, there are several medications to which a psychiatric diagnosis cannot be tracked. He does not have a formal Behavior Support Plan. He may be at risk of over-medication. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #28 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |
| #29 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |
| #30 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No: | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |

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| | There were no issues identified. | |
| #31 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>On December 23, 2019, #31 incurred a fractured ankle while at home with her mother. The cause of the injury was not communicated to the residential staff but could have been related to #31's fall risk. | Yes ☒ No ☐<br>Yes ☐ No ☒ |
| #32 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #33 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #34 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#34 receives an enema every Monday, Wednesday, and Friday, unless he has had a stool. Long term, regular use of enemas can lead to electrolyte imbalance, a lack of natural flora in the intestine and weakening of the muscles of the intestine. The routine use of enemas must be monitored closely by the physician. | Yes ☒ No ☐<br>Yes ☐ No ☒ |

**ATTACHMENT A**
**CHART TWO**

| Name | Compliance Question: Are individuals' needs identified and met? | Response |
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| #1 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #2 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #3 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#3's ISP stated that it "would be beneficial for a professional evaluation related to adaptive equipment, assistive technology or other modifications." There was no documentation of completion.<br><br>#3 is taking Paxil, an anti-depressant, daily and Atarax for anxiety PRN. The PCP prescribed the medications. There has been no evaluation by a psychiatrist. #3 has received Atarax PRN almost daily during this review period. If a medication intended to be used PRN to reduce anxiety is being used daily, a reevaluation of the treatment plan is needed. The ISP Team should determine if there are behavioral interventions that can be used to minimize the use of the Atarax PRN and obtain a psychiatric consultation to determine if there needs to be a change in #3's daily medication.<br><br>#3 is underweight and receives Benecalorie twice daily and Boost pudding three times daily. She has a history of skin | Yes ☒ No ☐<br>Yes ☐ No ☒ |

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| | breakdown and chronic constipation that resulted in her receiving a colostomy in July 2019. From September 1, 2019 through September 30, 2020, #3 was hospitalized twice due to constipation issues. Due to her being underweight, having a history of skin breakdown and the continued hospitalizations due to constipation, #3 should have a nutritional assessment to establish a plan to minimize her constipation, promote good nutrition and help her to achieve a normal BMI range.<br><br>#3's last dental examination was in July 2017. She is in need of a dental examination with sedation. It is difficult to obtain dental care for individuals that require sedation. There was no indication that the SC identified or documented the lack of dental care as a concern or convened the team to determine whether the ISP should be modified or otherwise attempted to obtain dental care. | |
| #4 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#4 has a gait tracker available for transferring but her mother is unable to properly place her into it, rendering it unusable. A physical therapy consult is needed to address this issue. Her mother stated that it can take up to six months to get new equipment or get equipment repaired.<br><br>There were no records provided that document that the neurologist performs any standardized Tardive Dyskinesia Screening. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #5 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#5 engages in minimal voluntary movement and there does not appear to be routine range of motion exercises occurring. Range of motion exercises are done to maintain flexibility and mobility of the joints. Since #5 has minimal movement, passive range of motion exercises would likely be beneficial. She would benefit from a Physical Therapist to evaluate her and train the staff in proper implementation of passive range of motion exercises. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

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| | #5 is not receiving routine dental examinations and cleanings. It was reported that dental care would be obtained for #5 if she showed any signs of dental issues, such as bleeding gums, pain, etc. Dentistry is considered to be "essential healthcare." Individuals with feeding tubes are at increased risk of tartar build-up and could develop a significant dental problem such as an abscessed tooth gum disease, oral cancer, etc. before staff would be aware of a problem. | |
| #6 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#6 receives all nutrition and hydration via a gastrostomy tube. Her BMI is borderline for being "overweight" and she is prone to skin breakdown. A nutritional assessment would be beneficial to ensure #6's nutritional support needs are being met.<br><br>#6 requires sedation for a dental examination and cleaning. It has been at least 3-4 years since she has had sedation for dental care and #6 is not totally cooperative with toothbrushing. Since #6 does not eat or drink orally, she has a greater chance of building up more tartar and harboring bacteria that leads to infection, especially chest infections. Due to her health risks, #6 should have routine dental cleanings. | Yes ☒ No ☐<br>Yes ☐ No ☒ |
| #7 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | Yes ☒ No ☐<br>Yes ☒ No ☐ |
| #8 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#8 receives a bed bath because there has been no assessment to determine whether she can benefit from a shower chair and any needed environmental modifications to the home to provide her an opportunity for a shower. | Yes ☐ No ☒<br>Yes ☐ No ☒ |

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| | #8 was very underweight when she was hospitalized in October/November 2019. She required a feeding tube placement and has gained weight, but the home does not have an appropriate scale to check her weights at least monthly to identify any changes that could indicate a health issue. | |
| #9 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>The ISP stated that a "professional evaluation related to adaptive equipment, assistive technology and/or modifications would be beneficial." There was no indication if an assessment occurred.<br><br>#9 has not seen a dentist since August 9, 2018. (At that time, he was taken to a dentist who does not accept Medicaid and as a result, #9 has an outstanding bill of $1500 and cannot continue with this practice.)<br><br>Phenobarbital lab levels should be drawn annually. There is no evidence that this is being done. | Yes ☒ No ☐<br>Yes ☐ No ☒ |
| #10 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There is no record or staff report of any oral examination since his teeth were pulled in 2008. There is no record or staff report that his oral structures, including gums, are examined at any time, by any medical personnel. Although #10 is edentulous, his oral structures should be examined for any oral disease. | Yes ☒ No ☐<br>Yes ☐ No ☒ |
| #11 | QSR Auditor answered<br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#11 has limited mobility and there does not appear to be routine range of motion exercises done. She would benefit from an evaluation from a Physical Therapist to determine what | Yes ☒ No ☐<br>Yes ☐ No ☒ |

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| | physical therapy regimen, including passive range of motion, would enable her to maintain flexibility and strength.<br><br>#11 does not have routine dental examinations and cleanings. It was reported that dental care would be obtained for #11 if she showed any signs of dental issues, such as bleeding gums, pain, etc. Dentistry is considered to be "essential healthcare." Individuals with feeding tubes are at increased risk of tartar build-up and could develop a significant dental problem, such as an abscessed tooth, gum disease, oral cancer, etc. before staff would be aware of a problem. In addition, #11 takes Phenobarbital, which has a common side effect of gingival overgrowth. | |
| #12 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#12 was prescribed two psychotropic medications – Abilify and Zoloft - and has hydronephrosis. He has not been evaluated by a psychiatrist since 2018. He would benefit from a psychiatrist conducting laboratory studies and reviewing his medications. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #13 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#13 has not had a dental visit since November 16, 2018. The Case Manager asked the program about dental services in December 2019 and the program reports that he goes to Grove Dental Services but has not been since 2018. No reason was given and the Case Manager requests that dental services are obtained. There is nothing in the record that indicates that he saw a dentist.<br><br>In December 2019, due to #13's recurrent pressure areas, the ISP Team determined that #13 needed a Physical Therapy Assessment for a new wheelchair. The PCP was uncooperative and delayed writing a referral. There was no documentation regarding the assessment, but the ISP stated that he should be receiving a new wheelchair in December 2020.<br><br>The Multiservice Progress Notes dated September 19, 2019 and | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

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| | ISP (November 1, 2019 to October 31, 2020) stated that the ISP Team was requesting a Speech and Language Assessment to determine if #13 would benefit from an augmentative communication device. The February 21, 2020 Case Manager Notes stated that #13 needed a Speech Assessment and possible swallow study. However, the PCP was not cooperative and would not complete a referral. According to the ISP dated November 1, 2020 to October 31, 2021, the Speech Assessment had not been completed and was still needed.<br><br>In November 2019, the PCP recommended that #13 receive skilled nursing care due to the recurrence of a pressure ulcer. Even though the Case Manager was making every effort to obtain the services, she had not been successful. #13 did not receive skilled nursing care until he moved to the new Group Home on February 8, 2021.<br><br>The ISP dated November 1, 2019 to October 31, 2020 stated that the "SC asked all providers who are administering psychotropic medications if evidence of consent for use has been obtained." However, the Group Home does not have an informed consent form.<br><br>During the review period, #13 had health issues which included: a pressure ulcer in November 2019, March 2020 and June 2020; a request for a Speech Assessment to determine if an augmentative communication device would be beneficial; the lack of a dental assessment and cleaning since November 16, 2018; a report of being underweight and a deterioration in his overall health. On February 8, 2021, he moved to a new Group Home which has sixteen hours of skilled nursing care daily and has a new PCP. It would be beneficial to reassess his health status after these changes to determine if his health is improving and not continuing to deteriorate. | |
| #14 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>There are no issues identified. | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |
| #15 | QSR Auditor answered<br><br>ISR Nurses answered | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |

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| | Issue identified, if ISR nurses answered No:<br><br>There are no issues identified. | |
| #16 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#!6 has diabetes and is overweight with her weight steadily increasing. It would be beneficial to have a Nutritional Assessment to assist the home with implementing meal plans that would meet her health needs. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #17 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#17 has Mobias Syndrome, a rare neurological disorder characterized by weakness or paralysis of multiple cranial nerves. The Sponsor reports that he has been diagnosed with Parkinson's Disease and his health is declining. The ISP did not indicate a Parkinson's diagnosis but stated that he has Tourette's Syndrome (with which the Sponsor disagreed). With #17's reported declining health, it would be beneficial for him to have a neurological evaluation to determine a definitive diagnosis from which a treatment plan could be developed that would help him to achieve the best health possible.<br><br>#17 is prescribed Divalproex. This medication requires routine serum level monitoring (every three to six months) for liver function and blood counts. Given the lack of records, it could not be determined if these routine laboratory tests were being monitored.<br><br>There were no records provided that document whether periodic screening for tardive dyskinesia was taking place. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #18 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No: | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

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| | Sponsor/Guardian reports that #18 could benefit from a smaller overhead lift that fits into her bedroom; there is some controversy as to whether someone in a Sponsored home is eligible for that specific lift. Lifts are important so that caregivers can safely transfer people with complex motor needs (as is present in Rhett's syndrome) and to preserve the health of the primary care provider for continuity of care and support.<br><br>#18 has not seen a dentist since 2017. Her Sponsor/Guardian reports that the pre-approval process required for the last time she had dental work under sedation was extremely difficult. It took a long time for the dentist who did the work to be paid. They now only seek dental care when there is a problem. The Sponsor/Guardian has tried to find a new dentist but one who can meet her needs for sedation is not available. The Sponsor considers this her biggest unmet need. | |
| #19 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#19 transitioned to the community in 2019. At the time she reportedly displayed significant behavioral outbursts that were treated with PRN Valium. Given her history of self-injurious behavior and Pica, she could benefit from a functional behavioral assessment (none were available in the records reviewed) to determine if a behavior support plan could be of benefit. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #20 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#20 is taking Divalproex, an anti-epileptic, that should have serum levels, liver function and blood counts checked every three to six months. The Sponsor stated that serum levels were monitored but did not know the specific testing. Laboratory tests were not provided for review.<br><br>There were no records provided that document that periodic screening for tardive dyskinesia was occurring. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

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| #21 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#21 prefers a tub bath, but there is none in the home and the informant is not aware if this environmental modification is being addressed.<br><br>#21 has not had her routine laboratory work completed because the skilled nurse assigned to her has not been able to access her veins.<br><br>#21 has had at least two medical hospitalizations in October to December 2019 and, according to the ISP, three instances of paralytic ileus. Paralytic ileus is a serious condition and must be promptly treated. In addition to the paralytic ileus, she developed a serious decubitus that was described as open, weeping and bleeding. The staff person stated that the physicians treating her were not in agreement concerning the treatment protocols, and she continued to have "flares" of her decubiti. She has a g-tube and is immobile, both conditions contributing to the complexity of her medical needs. Further review of Ms. Dickerson's healthcare is recommended. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #22 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#22's BMI is 36.6 which is considered to be obese. He has been diagnosed with hypertension and requires two medications for treatment. He has arthritis in his knees and hands, which causes him chronic pain. #22's obesity contributes to his hypertension and his arthritic pain. #22 is also diagnosed with Chronic Obstructive Pulmonary Disease (COPD). Excess weight increases the work of breathing which is already impaired with COPD. It would be beneficial for #22's overall health to have a nutritional assessment and, in conjunction with the nutritionist, develop and implement a weight loss plan.<br><br>#22 is edentulous. He does not see a dentist and has not for quite some time. It is not clear that anyone is checking his oral cavity and structures for any signs of disease. He should have a dental assessment to determine any treatment or to order no | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

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| | further assessments. | |
| #23 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#23 is actively exploring a change in his gender identity. He has multiple, chronic, and serious health related issues. There are at least fourteen different specialists following him and there are multiple physician visits monthly. He has had several serious health related events in the past year. The ISP does not mention the gender identity issue, so it is not clear if the team is working collaboratively with him, his physicians and Sponsor on this life-changing issue. As he determines his future, he must have the active support of all his team members and providers. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #24 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#24 has osteoarthritis, a degenerative joint disease. She is followed by rheumatology, but there is no evidence that she has been assessed for the benefit of formal physical therapy. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #25 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>In December 2019, the SC, QDDP and Nurse Manager identified the need for #25 to have a cardiology consult due to a diagnosis of diastolic heart failure. The cardiology evaluation had not occurred.<br><br>QDDP note dated November 7, 2019, stated that PT and OT services would be provided to #25 in her home. Group Home staff provided low impact range of motion exercises but ongoing OT and PT services from consulting therapists had not occurred.<br><br>There were no records provided that document that periodic Tardive dyskinesia screenings were occurring. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

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| #26 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#26 has not seen a dentist since December 26, 2018 due to his challenges and insurance coverage.<br><br>#26 is authorized to receive fifty-six hours of nursing weekly but is only receiving thirty-two hours weekly due to difficulty in hiring. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #27 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#27 is prescribed several medications (Aripiprazole, Atorvastatin and Valproic Acid) that require routine laboratory monitoring. There is no evidence in the record that all these tests are being completed.<br><br>Weights are not being monitored because the home scale is broken.<br><br>There were no records provided that document that tardive dyskinesia monitoring was being completed by the prescribing physician; and the provider's staff are not aware of signs of TD. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #28 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#28's last dental examination was in 2018. Her gums bleed when brushing which could indicate gum disease. There is a lack of dentists that can perform assessments and cleaning under sedation. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #29 | QSR Auditor answered<br><br>ISR Nurses answered | Yes ☒ No ☐<br><br>Yes ☒ No ☐ |

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| | Issue identified, if ISR nurses answered No:<br><br>There were no issues identified. | |
| #30 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#30's last dental examination was July 2019. #30 requires sedation for a dental assessment and cleaning. The ISP goal was an annual examination; however, the Sponsor indicated it was difficult to find a dentist that can provide dental services under sedation. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #31 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#31 has not seen a dentist since 2018 because there is no dentist available that can provide the sedation she requires in order to have dental work. She would benefit from a dental evaluation.<br><br>As of February 2020, #31's BMI score was 30.3 which is considered in the obese range. The provider has recommended that #31 obtain a nutritional evaluation but her legal guardian has refused. This places her at greater risk for chronic health conditions, such as cancer, diabetes and heart attacks. She also requires medication for constipation. It would be beneficial for #31 to have a nutritional evaluation to determine the best diet that would maximize her health.<br><br>The ISP dated March 13, 2019 to March 12, 2020 stated that #31 would "benefit from a professional evaluation related to "sensory and communication abilities" and "adaptive equipment, assistive technology and other modifications." However, the ISP dated March 14, 2020 to March 13, 2021 does not identify those same needs. It does not appear that Occupational Therapy/Physical Therapy/Speech Therapy evaluations occurred and the reason for the change could not be determined.<br><br>#31's health concerns are: 1) Her BMI is within the obese range | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

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| | which places her at greater risk of chronic health issues; 2) She has not had a dental examination and prophylaxis since June 2018; 3) She takes four anti-epileptic medications but continues to have seizures monthly; 4) She has behavioral health challenges but has not had an assessment to determine a plan to promote her behavioral health; and 5) She suffers from constipation that may be exacerbated by the seizure medications and/or her diet. For these reasons, it would be beneficial for her healthcare to be reviewed. | |
| #32 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#32 experiences multiple health risk factors including high BMI, skin integrity vulnerability, nutrition via gastrostomy tube and constipation. #32 could benefit from a nutritional assessment to identify a healthy dietary plan that would meet her nutritional needs, assist with her constipation, and promote weight loss.<br><br>#32 has not had a dental examination since December 20, 2014. Her team has not been able to find a dentist who is willing to provide dental care with sedation, which she requires. #32 is on a waiting list for dental care at Southeast Virginia Training Center.<br><br>#32 is overweight according to her BMI score and receives all nutrition via a gastrostomy tube, yet she only has access to a scale to weigh her once a year at her physician's office. Accurate weight assessment is an essential indicator to monitor her health status. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |
| #33 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#33 needs a Speech and Language Assessment to determine the most effective assistive technology to optimize her communication abilities.<br><br>The ISP stated that a "professional evaluation related to adaptive equipment, assistive technology would be beneficial" | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

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| | but it had not occurred.<br><br>The ISP stated that #33 is in the "severe range" of intellectual disability. However, after a review of records and interview with staff, it appears that her cognitive abilities may be higher. A more accurate picture of her cognitive abilities is important as it helps set other people's expectations for her. #33 should have a psychological assessment to determine her cognitive abilities. | |
| #34 | QSR Auditor answered<br><br>ISR Nurses answered<br><br>Issue identified, if ISR nurses answered No:<br><br>#34 receives two anti-epileptic medications, Divalproex and Lamotrigine. There had been a recommendation for a neurological assessment but it had not occurred.<br><br>#34 has not had a dental examination since 2015. There have been no attempts to schedule an appointment.<br><br>Since #34 receives Divalproex and Lamotrigine, Divalproex serum levels, liver function tests and complete blood counts must be routinely monitored. Documentation was not provided to indicate what and when laboratory tests were completed. | Yes ☒ No ☐<br><br>Yes ☐ No ☒ |

# APPENDIX G

## QUALITY AND RISK MANAGEMENT

**by**

**Rebecca Wright LCSW**

**and**

**Chris Adams MS**

# Quality and Risk Management System 18th Review Period Study

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

> **Section V.B:** The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.
> **Section V.C.1:** The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.

The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia had not yet been found in sustained compliance. They agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020. For the Report to the Court, due in June 2021, the Independent Reviewer's monitoring priorities again include studying compliance with these agreed-upon compliance indicators.

The Independent Reviewer's previous report, his 17th Report to the Court, dated December 15, 2020, found the Commonwealth had not met the requirements for compliance at V.B noting that achieving this provision requires meeting nine Compliance Indicators with 58 sub-indicators, which will be evidence that the QRM system is in compliance. It was also noted that Compliance Indicator 4.b. (29.08 with Virginia's numbering system) was not met as QSRs were not available from FY 2020 to complete required evaluations. The 16th Report to the Court found that the Commonwealth had not met the requirements for compliance at V.C.1 noting that the Commonwealth does not yet have a functioning risk management process that uses triggers and threshold data to identify individuals at risk or providers that pose risks.

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

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

**Summary of Findings:**
According to the *DBHDS Quality Management Plan FY2020,* DBHDS is committed to Continuous Quality Improvement (CQI), which the *Plan* describes "an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes." The *DBHDS Quality Management Plan* further describes quality improvement as a "systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care," and as a "data driven process" that involves analysis of data and performance trends that is used to determine quality improvement priorities.

As described at the time of the previous study, however, the functionality of the Commonwealth's framework is severely hampered by the lack of valid and reliable data across much of the system. Previous studies have found that issues of data validity and reliability have hampered the ability of DBHDS staff to complete meaningful analyses of the various data collected to effectively identify and implement needed improvements. While DBHDS collected considerable data from various sources, significant issues with the reliability and validity of the data existed throughout the system. This an overarching theme that negatively impacts the ability of DBHDS to fully implement its commitment to Continuous Quality Improvement, as described in the *Quality Management Plan.*

At the time of the last review, the study documented that the Office of Data Quality and Visualization (ODQV) had implemented a multi-phase initiative that delved deeply into issues of data reliability and validity across multiple systems. These included:

- Phase 0 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 ODQV identified data quality issues.
- In Phase 1, ODQV 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). 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.
- 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, ODQV made a presentation to the QIC, entitled *DBHDS Data Quality Monitoring Plan: Major Findings and Recommendations from the First Year of Implementation*. Overall, with regard to the source systems, these included, but were not limited to, 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 require extensive manual processes, with inadequate quality control. In addition, despite some improvements, supporting documentation continued to be lacking in many areas.
- 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.

For this review period, the Independent Reviewer requested that DBHDS provide documentation to show that the ODQV completed the required annual reliability and validity assessments of data sources, and determined that the data sources provided reliable and valid data for compliance reporting. The DBHDS response indicated that the annual reliability and validity assessments of data sources would not take place until June 2021. In addition, other documentation submitted for this review indicated that data source systems continued to present barriers to the collection of reliable and valid data. For example, ODQV issued two technical assistance documents in January 2021 (i.e., *Validity and Reliability: Assessment of Key Performance Area Performance Indicators*, dated 1/4/21 and *Validity and Reliability Assessment of Key Performance Area Performance Indicators KPA Teams Meeting*, dated 1/28/21.). Both of these documents noted that ODQV's role was to help synthesize the results from the *Data Quality Monitoring Plan* with the performance measure indicators (PMIs), but with the recognition that a PMI might draw data from a source system

that was known to have weak validity or reliability. Further, the documents indicated it would become essential to prioritize recommendations from the *Data Quality Monitoring Plan* and align these results with IT strategic plans and noted that until that occurred, source systems might continue to have limitations that affect their ability to produce consistent, reliable data. DBHDS did not respond to a request for any specific QIC workplan to address the recommendations from the *Data Quality Plan* or any relevant IT strategic planning documents related to existing data source systems and/or the recommendations from the various data quality reports.

**V.B.**

Overall, DBHDS continued to make progress in the development of a culture of quality and in the maturation of its quality and risk management processes, including the processes for serious incident management. DBHDS had also continued to make progress in the utilization of risk triggers and thresholds as risk management tools, although much more work needed to be done, especially for their application in a more systemic fashion. While the availability of reliable and valid data remained an overarching barrier to the implementation of an environment of Continuous Quality Improvement, DBHDS staff should also focus on improving the measurability of quality improvement initiatives and corrective action plans and on the rigorous use of data in reviewing their impact and in supporting future related decision-making.

**V.C.1:**

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

DBHDS has published on its website guidance documents and reference materials for providers on topics that include development and implementation of a quality improvement program; development and implementation of a risk management program; and development and implementation of a serious incident reporting, follow-up, and analysis system. DBHDS has developed a Risk Awareness Tool and now requires its use by providers in the development and revision of individualized services plans.

DBHDS has focused considerable attention on improving consistency in its processes and procedures to assess provider compliance with licensure regulations. DBHDS has expanded and enhanced the roles and responsibilities of staff in their Office of Licensing Incident Management Unit (IMU). This unit reviews and triages each serious incident report submitted by licensed providers and conducts follow-up on issues identified from that review. They also track and initiate corrective action for any late reporting of serious incidents. DBHDS has established care concern thresholds for five high-risk issues and IMU staff review each serious incident report and the provider's history of similar serious incidents to determine if one or more of these thresholds is met. Continued work is needed, though, to ensure consistency in documentation of findings, especially relating to those regulations where compliance could not be determined as the provider did not have a serious incident or care concern identified during the evaluation period.

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

| **V.B Indicators:** | **Status** |
|---|---|
| 29.01 The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. DBHDS Quality Management System shall:<br>a) Identify any areas of needed improvement;<br>b) Develop improvement strategies and associated measures of success;<br>c) Implement the strategies within 3 months of approval of implementation;<br>d) Monitor identified outcomes on at least an annual basis using identified measures;<br>e) Where measures have not been achieved, revise and implement the improvement strategies as needed;<br>f) Identify areas of success to be expanded or replicated; and<br>g) Document reviewed information and corresponding decisions about whether an improvement strategy is needed.<br>The DBHDS Quality Management System is comprised of the following functions:<br>a) Quality Assurance<br>b) Quality Improvement<br>c) Risk Management- | Not Met |
| 29.02 The ul functions of the Department by determining the extent to which regulatory requirements are met and taking action to remedy specific problems or concerns that arise. | Met |
| 29.03 The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations. This includes whether serious incidents required to be reported under the Licensing Regulations are reported within 24 hours of discovery. | Met |
| 29.04 The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process. This includes whether the provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all Level II and Level III serious incidents. The root cause analysis, when required by the Licensing Regulations, includes (a) a detailed description of what happened' (b) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and (c) identified solutions to mitigate its recurrence. | Met |
| 29.05 DBHDS monitors compliance with the serious incident reporting requirements of the Licensing Regulations as specified by DBHDS policies during all investigations of serious injuries and deaths and during annual inspections. DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations. | Met |
| 29.06 The DBHDS quality improvement system is led by the Office of Clinical Quality Improvement and structured by organizational committees with the Quality Improvement Committee (QIC) as the highest quality committee for the Department, and all other committees serve as subcommittees, including the: Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, Regional Quality Councils, and the Key Performance Area Workgroups: Health & Wellness, Community Inclusion & Integration, Provider Capacity & Competency. | Met |

| **V.B Indicators:** | **Status** |
|---|---|
| 29.07 The Office of Clinical Quality Improvement leads quality improvement through collaboration and coordination with DBHDS program areas by providing technical assistance and consultation to internal and external state partners and licensed community-based providers, supporting all quality committees in the establishment of quality improvement initiatives, use of data and identification of trends and analysis, and developing training resources for quality improvement. | Met |
| 29.08 The Office of Clinical Quality Improvement oversees and directs contractors who perform quality review processes for DBHDS including the Quality Services Reviews and National Core Indicators. Data collected from these processes are used to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. | Not Met |
| 29.09 The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas. d. The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures addressing: i. The charge to the committee, ii. The chair of the committee, iii. The membership of the committee, iv. The responsibilities of chair and members, v. The frequency of activities of the committee (e.g., meetings), vi. Committee quorum, vii. Periodic review and analysis of reliable data to identify trends and system-level factors related to committee-specific objectives and reporting to the QIC. | Not Met |
| 29.10 The QIC sub-committees report to the QIC and identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement. The QIC sub-committees evaluate data at least quarterly, identify at least one CQI project annually, and report to the QIC at least three times per year. | Not Met |
| 29.11 Through the Quality Management Annual Report, the QIC ensures that providers, case managers, and other stakeholders are informed of any quality improvement initiatives approved for implementation as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths. | Met |
| 29.12 DBHDS has a Risk Management Review Committee (RMRC) that has created an overall risk management process for DBHDS that enables DBHDS to identify, and prevent or substantially mitigate, risks of harm. | Met |
| 29.13 The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, neglect, and exploitation, at least four times per year by various levels such as by region, by CSB, by provider locations, by individual, or by levels and types of incidents. | Met* |
| 29.14 The RMRC uses the results of data reviewed to identify areas for improvement and monitor trends. The RMRC identifies priorities and determines quality improvement initiatives as needed, including identified strategies and metrics to monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts. The RMRC ensures that each approved quality improvement initiative is implemented and reported to the QIC. The RMRC will recommend at least one quality improvement initiative per year. | Not Met |

| **V.B Indicators:** | **Status** |
|---|---|
| 29.15 The RMRC monitors aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators. When targets are not met the RMRC determines whether quality improvement initiatives are needed, and if so, monitors implementation and outcomes. | Met* |
| 29.16 The RMRC conducts or oversees a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The review will evaluate whether: i. The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols; ii. The provider's documented response ensured the recipient's safety and well-being; iii. Appropriate follow-up from the Office of Licensing incident management team occurred when necessary; iv. Timely, appropriate corrective action plans are implemented by the provider when indicated. v. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation. | Not Met |
| 29.17 The RMRC conducts or oversees a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: i. Comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines; ii. The person conducting the investigation has been trained to conduct investigations; iii. Timely, appropriate corrective action plans are implemented by the provider when indicated. Iv. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation. | Not Met |
| 29.18 At least 86% of the sample of serious incidents reviewed in indicator 5.d meet criteria reviewed in the audit. At least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed in indicator 5.e meet criteria reviewed in the audit. | Not Met |
| 29.19 The Commonwealth shall require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth. | Not Met |
| 29.20 At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam. | Not Met |
| 29.21 At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services. | Not Met |
| 29.22 At least 95% of residential service recipients reside in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings. | Not Met |
| 29.23 At least 95% of individual service recipients are free from neglect and abuse by paid support staff. | Not Met |
| 29.24 At least 95% of individual service recipients are adequately protected from serious injuries in service settings. | Not Met |
| 29.25 For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans. | Not Met |

| **V.B Indicators:** | **Status** |
|---|---|
| 29.26 The Commonwealth ensures that at least 95% of applicants assigned to Priority 1 of the waiting list are not institutionalized while waiting for services unless the recipient chooses otherwise or enters into a nursing facility for medical rehabilitation or for a stay of 90 days or less. Medical rehabilitation is a non-permanent, prescriber-driven regimen that would afford an individual an opportunity to improve function through the professional supervision and direction of physical, occupational, or speech therapies. Medical rehabilitation is self-limiting and is driven by the progress of the individual in relation to the therapy provided. When no further progress can be documented, individual therapy orders must cease. | Not Met |
| 29.27 At least 75% of people with a job in the community chose or had some input in choosing their job. | Not Met |
| 29.28 At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule. | Not Met |
| 29.29 At least 75% of people receiving services who do not live in the family home/their authorized representatives chose or had some input in choosing where they live. | Not Met |
| 29.30 At least 50% of people who do not live in the family home/their authorized representatives chose or had some input in choosing their housemates. | Not Met |
| 29.31 DBHDS implements an incident management process that is responsible for review and follow-up of all reported serious incidents, as defined in the Licensing Regulations. | Met |
| 29.32 a) DBHDS develops incident management protocols that include triage criteria and a process for follow-up and coordination with licensing specialists, investigators, and human rights advocates as well as referral to other DBHDS offices as appropriate.<br>b) Processes enable DBHDS to identify and, where possible, prevent or mitigate future risks of harm.<br>c) Follow-up on individual incidents, as well as review of patterns and trends, will be documented. | Met |
| 29.33 The Commonwealth ensures that individuals have choice in all aspects of their goals and supports as measured by the following: a. At least 95% of people receiving services/authorized representatives participate in the development of their own service plan. | Not Met |

| **V.C.1 Indicators:** | Status |
|---|---|
| 30.01 The licensing regulations require all licensed providers, including CSBs, to implement risk management processes including:<br>a) Identification of a person responsible for the risk management function who has training and expertise in conducting investigations, root cause analysis, and data analysis.<br>b) Implementation of a written plan to identify, monitor, reduce and minimize harms and risks of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability; and<br>c) Conducting annual systemic risk assessment reviews, to identify and respond to practices, situations and policies that could result in harm to individuals receiving services.<br>Risk assessment reviews shall address the environment of care, clinical assessment or reassessment processes, staff competence and adequacy of staffing, the use of high-risk procedures including seclusion and restraint, and review of serious incidents. Risk assessments also incorporate uniform risk triggers and thresholds as defined by DBHDS. See 12VAC-35-105-520. | Met |
| 30.02. The DBHDS Office of Licensing publishes guidance on serious incident and quality improvement requirements. In addition, DBHDS publishes guidance and recommendations on the risk management requirements identified in #1 above, along with recommendations for monitoring, reducing, and minimizing risks associated with chronic diseases, identification of emergency conditions and significant changes in conditions, or behavior presenting a risk to self or others. | Met |
| 30.03. DBHDS publishes on the Department's website information on the use of risk screening/assessment tools and risk triggers and thresholds. Information on risk triggers and thresholds utilizes at least 4 types of uniform risk triggers and thresholds specified by DBHDS for use by residential and day support service providers for individuals with IDD. This information includes expectations on what to do when risk triggers or thresholds are met, including the need to address any identified risks or changes in risk status in the individual's risk management plan. This will be monitored as specified in #7 below. | Met |
| 30.04. At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. Inspections will include an assessment of whether providers use data at the individual and provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations. | Met* |
| 30.05. On an annual basis, the Commonwealth determines that at least 86% of DBHDS licensed providers of DD services are compliant with the risk management requirements in the Licensing Regulations or have developed and implemented a corrective action plan to address any deficiencies. | Not Met |
| 30.06. DBHDS publishes recommendations for best practices in monitoring serious incidents, including patterns and trends which may be used to identify opportunities for improvement. Such recommendations will include the implementation of an Incident Management Review Committee that meets at least quarterly and documents meeting minutes and provider system level recommendations. | Met |

| **V.C.1 Indicators:** | Status |
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| 30.07. DBHDS monitors that providers appropriately respond to and address risk triggers and thresholds using Quality Service Reviews, or other methodology. Recommendations are issued to providers as needed, and system level findings and recommendations are used to update guidance and disseminated to providers. | Not Met |
| 30.08 DBHDS has Policies or Departmental Instructions that require Training Centers to have risk management programs that:<br>a) reduce or eliminate risks of harm;<br>b) are managed by an individual who is qualified by training and/or experience;<br>c) analyze and report trends across incidents and develop and implement risk reduction plans based upon this analysis; and<br>d) utilize risk triggers and thresholds to identify and address risks of harm. | Not Met |
| 30.09 With respect to Training Centers, DBHDS has processes to review data and trends and ensure effective implementation of the Policy or Departmental Instruction. | Not Met |
| 30.10 To enable them to adequately address harms and risks of harm, the Commonwealth requires that provider risk management systems shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such events occur or the risk is otherwise identified. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6. | Not Met |
| 30.11 For each individual identified as high risk pursuant to indicator #6 of V.B, the individual's provider shall develop a risk mitigation plan consistent with the indicators for III.C.5.b.i that includes the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur. The provider shall implement the risk mitigation plan. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6. | Not Met |

## V.B. Analysis of 18th Review Period Finding

| 18th Review Period |
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| **V.B The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| **29.01**<br>The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. DBHDS Quality Management System shall:<br>a. Identify any areas of needed improvement.<br>b. Develop improvement strategies and associated measures of success.<br>c. Implement the strategies within 3 months of approval of implementation.<br>d. Monitor identified outcomes on at least an annual basis using identified measures. | The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System.<br><br>The DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance, b. Quality Improvement and c. Risk Management.<br><br>The DBHDS Quality Management System specifies responsibilities and has policies and procedures for implementation of a full quality cycle.<br><br>DBHDS often did not have evidence that they had | For this review period, DBHDS provided a document entitled *DBHDS Quality Management Plan FY2020*, with an effective date of 3/31/21. The document provided a clear overall conceptualization of the quality improvement structures and functions envisioned. In summary, the Quality Management Plan described the DBHDS quality management system as including the following components:<br>• The Division of Compliance, Legislative and Regulatory Affairs which oversees the regulatory, quality assurance and risk management processes and includes the Office of Human Rights (OHR) and Office of Licensing (OL);<br>• The Division of Developmental Services, which collaboratively implements the DD HCBS Waivers Quality Management Plans in conjunction with the Virginia Department of Medical Assistance Services (DMAS), administers the Office of Integrated Health (OIH) and is responsible for tracking many settlement agreement compliance measures;<br>• The Division of the Chief Clinical Officer, including the Office of Clinical Quality Management, which oversees the quality improvement processes, and the Office of Data Quality and Visualization (ODQV), which provides critical support across quality management functions.<br><br>In addition, the Quality Management Plan stated that the DBHDS Quality Management System is comprised of the following functions: Quality Assurance, Quality Improvement and Risk Management.<br><br>The DBHDS Quality Management System specifies responsibilities and has policies and procedures for implementation of a quality cycle, as specified in a-f of | Not Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| e. Where measures have not been achieved, revise and implement the improvement strategies as needed.<br>f. Identify areas of success to be expanded or replicated; g. Document reviewed information and corresponding decisions about whether an improvement strategy is needed.<br>The DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance, b. Quality Improvement, and c. Risk Management | reliable and valid data to enable the steps in the quality cycle (i.e., to identify any areas of needed improvement, devise data-based actions to address those needs, to evaluate and monitor whether those actions are having the desired effect and to make needed revisions when they were not.)<br><br>*Documents Reviewed: Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities; DBHDS Quality Management Plan, FY2020* | the Compliance Indicator. However, the meaningful implementation of the quality improvement cycle requires the use of reliable and valid data to identify any areas of needed improvement, devise data-based actions to address those needs, to evaluate and monitor whether those actions are having the desired effect and to make needed revisions when they were not. As described above in the Summary of Findings, DBHDS did not yet present evidence that valid and reliable data were available to support the quality cycle. In addition, as described below with regard to Compliance Indicators 29.10 and 29.14, quality improvement initiatives were often not constructed with sufficient measurability to support the quality cycle and, as also described below with regard to Compliance Indicators 29.16 and 29.18, data were sometimes too old to be useful for quality improvement purposes. | |
| **29.02**<br>The Offices of Licensing and Human Rights perform quality assurance functions of the Department by determining the extent to which regulatory requirements are met and taking action to remedy specific problems or concerns that arise. | The Office of Licensing is the regulatory authority for the DBHDS' licensed service delivery system.<br><br>The Office of Human Rights is responsible for managing the DBHDS Human Rights dispute resolution program, following up on complaints and allegations of abuse, neglect, and exploitation, | The *DBHDS Quality Management Plan FY2020* states that the DBHDS Division of Quality Assurance and Government Relations oversees regulatory, quality assurance, and risk management processes. The division is comprised of the Office of Human Rights and the Office of Licensing.<br><br>The Office of Licensing (OL) is the regulatory authority for the DBHDS licensed service delivery system. Through quality assurance processes including but not limited to initial application reviews, initial site visits, unannounced inspections, review and investigation of serious incidents and complaints, and issuance of licensing reports requiring corrective action plans (CAPs), the OL performs functions to ensure that the mechanisms for the provision of quality service are monitored, enforced, and reported to the DBHDS leadership. | Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | monitoring provider reporting and reviewing provider investigations and corrective actions, conducting independent or joint investigations with DBHDS partners and/or the Virginia Department of Social Services.<br><br>Data related to allegations and confirmations of abuse, neglect, and exploitation as well as care concerns identified by the Incident Management Unit that are reported to the RMRC detail the activity and results of the work of the IMU and OHR as well as the analysis and follow-through by the RMRC on this information.<br><br>*Documents Reviewed: DBHDS Quality Management Plan FY2020; OL Annual Checklist Compliance Determination Chart-FY2021; RMRC Annual Report-FY2020; Internal Protocol for Department of Behavioral Health and Developmental Services Incident* | This review verified that OL developed and implemented a detailed protocol for completing annual licensing inspections, the OL Annual Checklist Compliance Determination Chart-FY2021. Document reviews, interviews and a review of evidence packets for 12 2021 annual licensing inspections confirmed that licensing specialists are implementing the OL protocol by completing evaluations of providers' compliance with regulatory requirements, citing evidence of non-compliance and requiring corrective action plans to address each regulation found not in compliance consistent with the requirements set out in this Annual Checklist Compliance Determination Chart.<br><br>The Office of Human Rights (OHR) is responsible for promoting the basic precepts of human dignity, advocating for the rights of persons with disabilities in the DBHDS service delivery systems and managing the DBHDS Human Rights dispute resolution program. Human rights advocates ensure compliance with human rights regulations, following up on complaints and allegations of abuse, neglect, and exploitation. Advocates respond to and assist in the complaint resolution process by monitoring provider reporting and reviewing provider investigations and corrective actions. Advocates also respond to reports of abuse by conducting independent or joint investigations with DBHDS partners and/or the Virginia Department of Social Services (VDSS), and in cases where there are violations of the Human Rights Regulations, advocates recommend citation through the Office of Licensing. This review verified that the IMU confirms that OHR is notified of each human rights complaint or allegation of ANE. The OHR and IMU work in coordination to report data periodically to the RMRC on allegations of abuse, neglect or exploitation and the number of these allegations that are substantiated. DBHDS reports and documentation reviewed confirmed that the IMC notifies the OHR and OIH regarding identified care concern, which allows them to determine if follow-up or technical assistance is needed.<br><br>The RMRC review IMC and ANE Look-behind data on a quarterly basis. Per the schedule in the FY21 RMRC Task Calendar and Charter Tasks document, the RMRC reviews IMC and ANE Look-behind data in September, December, March and June. They review serious incident data in August, November, February and May. A review of RMRC minutes confirmed that they reviewed ANE data in | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | *Management_05.29.20; FY21 RMRC Task Calendar and Charter Tasks; Evidence packets for 12 annual licensing reviews conducted in 2021* | 09/2020, 11/2020 and 12/2020. They also reviewed IMC data in 09/2020 and 12/2020. These reviews and recommendations are documented in RMRC minutes. Data related to these allegations and substantiations are included in the RMRC annual report along with a description of their analysis, findings and recommendations. While the IMU and ANE look-behind processes required at Compliance Indicators 29.16 and 29.17 appear to be well-organized, concerns with their implementation are detailed in the analysis and conclusions for these indicators above. The OL Protocol requires, and interviews and the review of twelve packets confirmed, that prior to initiating their annual licensing inspection, OL licensing specialists obtain data regarding any corrective action plans issued by the IMC for late reporting of incidents and any care concerns identified by the IMC that were sent to the provider. The licensing specialist uses this data to verify information obtained from the provider and to assure that follow-through on any corrective actions has been completed. If issues are identified that support non-compliance with a regulatory requirement, the licensing specialist will issue a CAP to describe and address that non-compliance.<br><br>A review of evidence packets for 12 annual licensing reviews conducted in 2021 included evidence that this process is being followed by licensing specialists as they conduct their annual licensing reviews and that if they identify evidence of non-compliance, they cite the violation and require a corrective action plan. | |
| **29.03**<br>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 | As part of the annual inspection process, the Office of Licensing assessment of provider compliance with the serious incident reporting requirements of the Licensing Regulations<br>includes an assessment of whether serious incidents required to be reported under the Licensing Regulations are reported within 24 hours of discovery. | DBHDS has established a regulatory requirement at *12VAC35-105-160.D.2* that requires that the provider collect, maintain, and report Level II and Level III serious incidents to DBHDS, that Level II and Level III serious incidents must be reported within 24 hours of discovery, and that the report must include the date, place and circumstances of the serious incident. Similar reporting requirements for serious incidents that involve children contain these same requirements and can be found at *12VAC-35-46-1070.* The Incident Management Unit (IMU) is charged with the responsibility for initial determination of incident reporting within the 24-hour timeframe and if late reporting is identified, they notify the provider of non-compliance requiring a corrective action plan.<br><br>DBHDS has developed extensive guidance documents and training for providers and departmental staff on the expectations, roles, and responsibilities that each | Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| Licensing Regulations are reported within 24 hours of discovery. | Documents Reviewed: *Regulations at 12VAC35-105-160.D.2 and 12VAC-35-46-1070; Internal 160 Protocol for DD Providers; DBHDS Incident Management, 5/29/20; Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services; OL Annual Checklist Compliance Determination Chart – FY2021; Memo to Providers on late reporting, 6/1/20; RMRC Annual Report FY2020; RMRC Measure Tracking Log Jan 2021; Evidence packets for 12 annual licensing reviews conducted in 2021; MQ for Data Verification29.3.* | must undertake to achieve and maintain compliance. DBHDS has developed policies, guidance documents and memos, protocols, and training materials for providers and DBHDS staff that structure the process for determination of compliance with regulations relevant to serious incident reporting requirements. These include:<br>• *Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services* that outlines responsibilities for the IMU, OHR and Licensing Specialists that addresses receipt, review, and follow-up action regarding serious incidents. It also provides information about progressive sanctions for repeat regulatory violations. This document is directed to IDD providers.<br>• *Internal 160 Protocol for DD Providers* that contains the same information as the *Protocol for Assessing Serious Incident Reporting* but also includes specific instructions for DBHDS staff.<br>• *Memo to Providers on late reporting, 6/1/20* that reminds licensed providers of the expectations for reporting serious incidents and the consequences of late reporting.<br>• *OL Annual Checklist Compliance Determination Chart – FY2021* that provides detailed instructions to licensing specialists on how to assess compliance with regulations (including*12VAC35-105-160.D.2*) and how to document identified non-compliance.<br><br>DBHDS tracks incident reporting timeliness through a performance measure "Critical incidents are reported to the Office of Licensing within the required timeframes". The *RMRC Annual Report FY2020* notes that performance for this indicator exceeded the compliance threshold of 86% each quarter of FY20. The *RMRC Measure Tracking Log Jan 2021* records compliance for this indicator as 95% for 2021Q1 and 94% for 2021Q2.<br><br>This study also included a review of the annual licensing inspections for 12 providers to sample performance of the licensing specialists in several key areas. This review indicated that licensing specialists assessed provider compliance with the serious incident reporting requirements in all instances. They identified that 10/12 (83%) had evidence that they were reporting serious incidents within the 24-hour reporting requirement. As described above, this was not a statistically | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | significant sample of provider performance; however, it did indicate consistent performance by the licensing specialists. | |
| **29.04**<br>ii. The provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all level II and level III serious incidents; iii. The root cause analysis, when required by the Licensing Regulations, includes i) a detailed description of what happened; ii) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and iii) identified solutions to mitigate its reoccurrence. | The OL Annual Checklist Compliance Determination Chart-FY2021 describes the procedure that its licensing specialist are expected to follow when assessing provider compliance with the serious incident reporting requirements of the Licensing Regulations. This includes determining whether the provider has conducted at least quarterly review of all Level I serious incidents (12VAC35-105-160.C), and a root cause analysis of all Level II and Level III serious incidents (12VAC35-105-160.E).<br><br>In each of the 12 sample packets reviewed, the consultant verified that the licensing specialist reviewed whether there was evidence to determine if the provider conducted quarterly reviews as required in this indicator | DBHDS has established a regulatory requirement at *12VAC35-105-160.C* that requires the provider to collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents as a part of their quality improvement program, and regulatory requirements at *12VAC35-105-160.E.1 and E.2* that require a root cause analysis be conducted within 30 days of discovery of Level II or Level III serious incidents, that includes a detailed description of what happened, an analysis of why it happened and identified solutions to mitigate its reoccurrence and future risk of harm, when applicable. This section also requires the provider to develop and implement a written root cause analysis policy.<br><br>As part of the annual inspection process, the *OL Annual Checklist Compliance Determination Chart – FY2021* requires that the licensing specialist assessment include whether the provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all Level II and Level III serious incidents. The root cause analysis shall include a detailed description of what happened, an analysis of why it happened and identified solutions to mitigate its recurrence and future risk of harm when applicable.<br><br>DBHDS has developed guidance documents for providers and departmental staff on the expectations, roles, and responsibilities that each must undertake to achieve and maintain compliance. These include:<br>• *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services* that outlines responsibilities for the Incident Management Unit, Office of Human Rights and Licensing Specialists regarding receipt, review, and follow-up action regarding serious incidents. It also provides information about progressive sanctions for repeat regulatory violations. This document is directed to IDD providers.<br>• *OL Annual Checklist Compliance Determination Chart – FY2021* that provides | Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | and correctly cited the provider if sufficient evidence of compliance was not identified. The consultant agreed with the licensing specialist's determination in 11 of 12 packets reviewed.<br><br>*Documents Reviewed: Regulations at 12VAC35-105-160.C, 12VAC35-105-160.E.1 and 12VAC35-105-160.E.2; OL Annual Checklist Compliance Determination Chart – FY2021; OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services; Evidence packets for 12 annual licensing reviews conducted in 2021.* | detailed instructions to licensing specialists on how to assess compliance with regulations (including*12VAC35-105-160.C, 12VAC35-105-160.E.1 and 12VAC35-105-160E.2*) and how to document identified non-compliance.<br><br>During each annual licensing inspection, the licensing specialist is expected to review provider evidence to determine compliance with each regulation in accordance with the specific instructions contained in the *OL Annual Checklist Compliance Determination Chart – FY2021.*<br><br>A review of evidence packets for 12 annual licensing reviews conducted in 2021 determined that licensing specialists consistently fulfilled the expectations described in the OL protocol. The licensing specialist reviewed whether there was evidence to determine if the provider conducted quarterly reviews as required in this indicator. The only exception noted was for one provider in the sample who did have documented serious incidents but did not conduct a quarterly review and the licensing specialist failed to identify it. For each of the remaining 11 licensing reviews in the sample, when compared to the instructions for compliance determination in the *OL Annual Checklist Compliance Determination Chart* – FY2021, f, these three regulatory requirements appeared to have been cited correctly.<br><br>Of note, based on this review, it is recommended that DBHDS continue to provide guidance to providers on the requirement to have a written root cause analysis policy that describes the criteria for and methods by which they will complete root cause analyses consistent with the requirements at 12VAC35-105-160. E. This recommendation is based on the following findings for the 12 sample licensing packets:<br>• 75% of providers had evidence that they were completing quarterly reviews of all serious incidents.<br>• 92% of providers had evidence of completing a root cause analysis for each Level II or Level III serious incident that occurred within the review period.<br>• 58% of providers had evidence of a policy that described when a more detailed root cause analysis must be conducted. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| **29.05**<br>DBHDS monitors compliance with the serious incident reporting requirements of the Licensing Regulations as specified by DBHDS policies during all investigations of serious injuries and deaths and during annual inspections. DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations. | DBHDS has established regulations and related protocols for monitoring compliance with the serious incident reporting requirements of the Licensing Regulations during all investigations of serious injuries and deaths.<br><br>DBHDS has established regulations and related protocols for monitoring compliance with the serious incident reporting requirements of the Licensing Regulations during annual inspections.<br><br>DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations.<br><br>*Documents Reviewed:*<br>*Regulations at 12VAC35-105-170.G and 12VAC35-105-170.H;*<br>*Internal Protocol for DBHDS Incident Management, 5/29/20;*<br>*OL Annual Checklist Compliance Determination Chart – FY2021;*<br>*OL Protocol for Assessing Serious* | DBHDS has established regulations that require corrective action plans for any violation of serious incident reporting requirements at:<br>• 12VAC35-105-160.C requires that providers shall collect, maintain and review at least quarterly all serious incidents, including Level I serious incidents, as part of the quality improvement program.<br>• 12VAC35-105-160.D.2 requires that the provider collect, maintain, and report Level II and Level III to DBHDS, that Level II and Level III serious incidents must be reported within 24 hours of discovery, and that the report include the date, place, and circumstances of the serious incident<br>• 12VAC35-105-160.E.1 requires that a root cause analysis be conducted by the provider within 30 days of discovery of a Level II or Level III serious incident.<br>• 12VAC35-105-160.E.2 requires the provider develop and implement a root cause analysis policy.<br><br>DBHDS has also established regulations requiring providers to implement their corrective action plans and monitor the plan implementation and effectiveness at:<br>• 12VAC35-105-170.G requires providers to implement their corrective action plans by the date set in the plan<br>• 12VAC35-105-170.H requires that providers monitor implementation and effectiveness of corrective action plans as a part of their quality improvement program.<br><br>In brief, DBHDS Incident Management Unit (IMU) staff and licensing specialists both play key roles in monitoring compliance with the serious incident reporting requirements of the Licensing Regulations and the issuance of CAPs, as described below:<br>• The department has established an Incident Management Unit (IMU) within OL responsible for receipt, review, and analysis of all reported incidents. IMU staff monitor compliance during all investigations of serious injuries and deaths, as specified in the *Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services* document. The Incident Management Unit receives and reviews all reported incidents each business day to determine if the incident was reported within the required timeframe and that the incident | Met |

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| | *Incident Reporting by Providers of Developmental Services; Office of Licensing Incident Management Unit (IMU) PowerPoint, May 2021; CAP Templates for Serious Incident Reporting; IMU RMRC Review of Patterns and Trends, 1/25/21;*<br>*Evidence packets for 12 annual licensing reviews conducted in 2021.* | report contains all required elements. A licensing report (CAP) is issued by the IMU to a provider found non-compliant due to late reporting of an incident. The consultant determined, based on interviews with the IMU manager and OL Director and review of data presented in the IMU RMRC Review of Patterns and Trends 1/25/21, that the IMU is operating consistent with the requirements in the OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services.<br>• Licensing specialists conduct annual licensing inspections or other provider investigations as specified in The *OL Annual Checklist Compliance Determination Chart – FY2021.* This tool provides detailed instructions to licensing specialists regarding determinations of compliance and how non-compliance is to be documented on a CAP. Licensing specialists review data from the incident management system prior to conducting the annual licensing inspection. They compare this information with evidence reviewed during the licensing review and if an incident is identified that was not reported, the licensing specialist instructs the provider to report the incident, cites the provider for late reporting, and requires a corrective action plan. Based on the sample of annual licensing inspections for 12 providers reviewed for this study, licensing specialists followed protocols for monitoring compliance with the serious incident reporting requirements of the Licensing Regulations during annual inspections, identified the need for corrective action plans for all regulatory non-compliance determinations, and cited providers who were found not to be in compliance with these regulatory requirements.. | |
| **29.06**<br>The DBHDS quality improvement system is led by the Office of Clinical Quality Improvement and structured by organizational committees with the Quality Improvement Committee (QIC) as the | The DBHDS quality improvement system is led by the Office of Clinical Quality Improvement and structured by organizational committees with the Quality Improvement Committee (QIC) as the highest quality committee.<br><br>Other committees serve as | The *Quality Management Plan, FY 2020* designates the Office of Clinical Quality Management (OCQM) to lead the DBHDS quality improvement system. The OCQM) provides oversight of quality improvement efforts and responds to trends, by ensuring quality improvement initiatives are developed and corrective actions and regulatory reforms are implemented, if necessary, to address weaknesses and/or service gaps in the system. The OCQM is directed by the Chief Clinical Officer and led by the Senior Director of Clinical Quality Management, who in turn supports the QIC structure.<br><br>The *Quality Management Plan* also describes a hierarchy of interdisciplinary quality committees and workgroups, with specific charters and lines of authority. These | Met |

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| highest quality committee for the Department, and all other committees serve as subcommittees, including the: Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, Regional Quality Councils, and the Key Performance Area Workgroups: Health & Wellness, Community Inclusion & Integration, Provider Capacity & Competency. | subcommittees to the QIC and include the following: Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, Regional Quality Councils, and the Key Performance Area Workgroups: Health & Wellness, Community Inclusion & Integration, Provider Capacity & Competency.<br><br>*Documents Reviewed: Developmental Disabilities Quality Management Plan FY 2020, March 31, 2021; Developmental Disabilities Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020, October 2020; Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities* | include the following:<br>• The Quality Improvement Committee (QIC), which is the highest-level committee and provides oversight of the quality management program as a whole, including prioritization of needs and work areas. The QIC is also charged to produce an annual report that addresses the availability and quality of supports and services, gaps in those areas and recommendations for improvement.<br>• The Risk Management Review Committee (RMRC), which monitors system-wide data to develop actions to prevent and ameliorate risks of harm. These actions may include setting performance goals and performance measures; establishing risk triggers and thresholds; identifying remedial, mitigation and improvement processes and actions; and, offering guidance and training for providers (e.g., root-cause analysis, corrective action planning, etc.)<br>• Regional Quality Councils (RQCs), as required by Section V.D.5. of the Settlement Agreement, which are expected to receive and analyze state and regional data to identify trends and make recommendations to the QIC for quality improvement initiatives.<br>• The Mortality Review Committee (MRC), whose purpose is to identify and implement system-wide improvement initiatives to reduce preventable deaths, through analyzing data to identify patterns at the individual service delivery and system levels.<br>• The Case Management Steering Committee, responsible for performance monitoring of case management, including review and analysis of relevant data sets to identify trends and progress toward meeting established Support Coordination/Case Management targets.<br>• Workgroups for each of the three Key Performance Areas, including Health and Wellness, Community Inclusion/Integrated Settings and Provider Capacity and Competency. Each workgroup recommends goals and performance measures within the respective domain.<br>• The DBHDS/DMAS Quality Review Team (QRT), which is charged with monitoring of data used to measure compliance with the waivers' performance measures. While this team is not a subcommittee to the QIC and does not report to it, its work is an integral component of the overall quality and risk management system. | |

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| **29.07**<br>The Office of Clinical Quality Improvement leads quality improvement through collaboration and coordination with DBHDS program areas by providing technical assistance and consultation to internal and external state partners and licensed community-based providers, supporting all quality committees in the establishment of quality improvement initiatives, use of data and identification of trends and analysis, and developing training resources for quality improvement. | The Office of Clinical Quality Improvement (OCQM) engages in and or coordinates a variety of technical assistance, consultation and training activities to support the DBHDS quality improvement efforts.<br><br>Documents Reviewed: *Process for PMI Development, dated 5/13/20; Guidance for Measure Development, dated 5/20/20; DQV TA KPA PMI Validity and Reliability Assessment1/4/21; Process for PMI Development, dated 5/13/20; the Guidance for Measure Development, 5/20/20; Validity and Reliability Assessment of Key Performance Area Performance Measure Indicators, 1/28/21; Quality Improvement & Facilitation Using Data to Set Priorities 8/10/20; SFY21 KPA Workgroups Data Feedback.* | In addition to providing support to the QIC structure, OCQM is responsible for promoting quality improvement through collaboration and coordination with DBHDS program areas. For example, during previous reviews, OCQM coordinated with ODQV to publish two technical assistance documents to support performance measure development, the *Process for PMI Development*, dated 5/13/20 and the *Guidance for Measure Development*, dated 5/20/20.<br><br>In addition to publishing those documents, examples of work the OCQM has undertaken and/or coordinated during this review period include the following:<br>• Providing technical assistance and consultation to internal and external state partners and licensed community-based providers: OCQM coordinated technical assistance to various workgroups and subcommittees with regard to performance measures. These included the KPA Workgroups, Provider Development and the RMRC, among others.<br>• Supporting all quality committees in the establishment of quality improvement initiatives: OCQM developed a QII Toolkit for use by all the QIC subcommittees and provided staff support to each subcommittee as they considered and developed QIIs. OC<br>• Developing training resources for quality improvement: OCQM coordinated the development of a training for the KPA Teams Meeting 1/28/21 on *Validity and Reliability Assessment of Key Performance Area Performance Measure Indicators*<br>• Use of data and identification of trends and analysis: OCQM coordinated training to RQCs on *Quality Improvement & Facilitation: Using Data to Set Priorities* and provided ongoing feedback on the use of data to the QIC subcommittees through a series of one-page *KPA Workgroups Data Feedback.* | Met |
| **29.08**<br>The Office of Clinical Quality Improvement oversees and directs | *Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with* | *Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities* and the *DBHDS Quality Management Plan* identify the OCQM as the responsible entity to oversees and directs contractors who perform quality review processes for DBHDS including | Not Met |

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| contractors who perform quality review processes for DBHDS including the Quality Services Reviews and National Core Indicators. Data collected from these processes are used to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. | *Developmental Disabilities* and the *DBHDS Quality Management Plan* identify the OCQM as the responsible entity to oversee and direct contractors who perform quality review processes for DBHDS including the Quality Services Reviews (QSR) and National Core Indicators (NCI.)<br><br>Data from the NCI are used to evaluate the sufficiency, accessibility, and quality of services at a systemic level.<br><br>The QSR is designed to produce data DBHDS will use to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. However, the QSR process has not yet produced sufficient reliable data to be used for this purpose.<br><br>*Documents Reviewed: Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities; DBHDS Quality Management* | the National Core Indicators (NCI) and the Quality Services Reviews (QSR.)<br><br>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 approved by CMS for use in HCBS waiver programs. As such, NCI data could be considered reliable for use in evaluating the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. As described further below, DBHDS does use some NCI data as the basis for certain performance measures.<br><br>At the time of the previous review, DBHDS had engaged a new vendor which was just wrapping up its initial set, the 2020 QSRs. For this review, DBHDS submitted a presentation made by the QSR vendor to the QIC at its March 2021 meeting entitled *2021 Quality Service Review Report to QIC, March 2021*. It featured data from the first round of QSRs and noted that the second round began on 2/26/21. Overall, the presentation noted known data limitations to the QSRs, particularly as those related to COVID circumstances that affected participation. For example, the QSR vendor reported that 65% of providers declined an in-person interview and observation and 66% of individuals interviewed declined an in-person interview and observation. In addition, at the time of the 17th review period, the Report to the Court found some continuing concerns with regard to inter-rater reliability (IRR) and whether the QSR 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. As a result, while the QSR is designed to produce data that DBHDS will use to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level, the process has not yet produced sufficient reliable data for this purpose. | |

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| | *Plan, FY2020*; *NCI In-Person Survey (IPS) State Report 2019-2020* | | |
| **29.09**<br>The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas.<br><br>The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures addressing: i. The charge to the committee, ii. The chair of the committee, iii. The membership of the committee, iv. The responsibilities of chair and members, v. The frequency of activities of the committee (e.g., meetings), vi. Committee quorum, vii. Periodic review and analysis of reliable data to identify trends and system-level factors related to committee-specific objectives and reporting | The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures consistent with the requirements of this Compliance Indicator.<br><br>Documents Reviewed: *Developmental Disabilities Quality Management Plan FY 2020, March 31, 2021; Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities; SFY21 Quality Improvement Committee Charter 9/21/20; SFY21 Case Management Steering Committee Charter 9/21/20*; *SFY21 Provider Capacity and Competency Workgroup Charter 9/21/20 SFY21 Risk Management Review Committee Charter 9/21/20 SFY21 Health Safety and Wellbeing Workgroup Charter 9/21/20; SFY21 Mortality Review Committee Charter* | According to the *DBHDS Quality Management Plan FY2020,* DBHDS is committed to Continuous Quality Improvement (CQI), which the *Quality Management Plan* describes as "an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes." The *Quality Management Plan* further describes quality improvement as a systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care," and as a "data driven process" that involves analysis of data and performance trends that is used to determine quality improvement priorities.<br><br>At present, however, as described in the Summary of Findings above, the functionality of the QIC framework is severely hampered by the lack of valid and reliable data across much of the system, as well as by limited data-based analysis and data-driven decision making (e.g., as described with regard to Compliance Indicators 29.10 and 29.14.)<br><br>The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures consistent with the requirements of this Compliance Indicator. The QIC reviews the charters annually and either approves the current version or makes revisions as needed. The status of the current charters is as follows:<br>• Quality Improvement Committee Charter, QIC Approved September 21, 2020<br>• Regional Quality Council Charter, QIC Revised QIC Approved December 8, 2020<br>• Risk Management Review Committee Charter Revised, QIC Approved December 14, 2020<br>• Mortality Review Committee Charter, Revised QIC Approved November 16, 2020 | Not Met |

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| to the QIC. | *11/16/20; SFY21 Regional Quality Council Charter 12/8/20; SFY21 Community Inclusion and Integration Charter 9/21/20*<br><br>*Documents Reviewed: Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities; DBHDS Quality Management Plan, FY2020* | • Case Management Steering Committee Charter, QIC Approved September 21, 2020<br>• Health, Safety and Well-being Workgroup Charter, QIC Approved September 21, 2020<br>• Community Inclusion and Integration Workgroup Charter, QIC Approved September 21, 2020<br>• Provider Capacity and Competency Workgroup Charter, QIC Approved September 21, 2020<br>• Quality Review Team Charter, QIC Approved September 2019 | |
| **29.10**<br>The QIC sub-committees report to the QIC and identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement. The QIC sub-committees evaluate data at least quarterly, identify at least one CQI project annually, and report to the QIC at least three times per year. | The QIC sub-committees report to the QIC at least three times per year.<br><br>Each subcommittee has adopted performance measures and Quality Improvement Initiatives (QIIs) that focus on identifying and addressing risks of harm and ensuring the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings.<br><br>The QIC subcommittees identify at least one CQI project annually.<br><br>The QIC sub-committees | The QIC subcommittee charters call for them to report to the QIC on a quarterly basis. Based on documentation provided, the sub-committees have made reports to the QIC twice in the past six months, in December 2020 and March 2021.<br><br>The subcommittee reports focus on the respective performance measures and QIIs each has adopted. Each of the subcommittees had adopted at least one QII. As of the 2/22/21 QIC meeting, these included:<br>• Health, Safety and Well Being KPA: Crisis Assessments (Increase the percent of crisis assessments that occur in the community to individuals known to the system (CSB);<br>• Community Inclusion/Integrated Settings KPA: Independent Housing (Increase the number of adults with developmental disabilities on a DD Waiver or waitlist who live in independent housing);<br>• Provider Capacity and Competency KPA: DSP Competency (People with DD Waiver are supported by trained, competent Direct Support Professionals);<br>• RMRC: Falls (Reduce the number of serious incident reports among individuals with DD who receive DD waiver services that were caused by a fall);<br>• MRC: 911 (failure to execute established protocol number of mortality review | Not Met |

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| | collect and evaluate data at least quarterly, but do not consistently collect and evaluate data to effect the sufficient identification and response to trends required to ensure continuous quality improvement.<br><br>Documents Reviewed:<br>*Developmental Disabilities Quality Management Plan FY 2020, March 31, 2021; Developmental Disabilities Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020, October 2020* | cases in which 911 protocol was followed); No death certificates available for review within 90 days of date of death (decrease the number of unknown cause of death due to increased number of death certificates available for review); and a decrease in the number of I/DD sepsis deaths by at least 1% as reported annually in the MRC annual report;<br>• CMSC: Supports respond to change in status with appropriately implemented services (People with DD Waiver have supports that respond to changes in status through services that are appropriately implemented;<br><br>Overall, the QIC subcommittees did not construct the QIIs in a manner that was sufficient for the measurement and data collection necessary to identify and respond to trends to ensure continuous quality improvement.. In other words, the QIIs were often not measurable and therefore were not adequate to facilitate the collection and evaluation of data to allow trends to be adequately identified. The lack of measurability prevents a "data-driven" approach to quality improvement. DBHDS should consider the following steps to designing the QIIs – or any corrective action plan:<br><br>• First, the expected outcome should be stated as a measurable goal and should include a clear definition of terms. Most of the QIIs were not stated in measurable terms. For example, most of the QII goals described above stated an intent to reduce or increase the occurrence of certain events or outcomes (e.g., crisis assessments, DSP competency; serious incidents resulting from falls), but did not state a baseline and/or the extent of the reduction or increase that would signal achievement of the goal. In addition, some of the QII goals described above incorporated terms that required further definition. For example, in order to measure whether people with DD are supported by trained, competent Direct Support Professionals, it is necessary to have clear definitions of what constitutes "trained" and "competent."<br>• A QII should move the objective forward from where it stands at the beginning of the process (i.e., a clearly stated baseline) through achievement of the final goal. In many instances, the QIIs did not state the baseline. This is also a basic requirement for establishing a measurable goal and for identifying trends. | |

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| | | • As with any planning document, some preliminary work is needed to determine the scope and potential causes of the problem, and then to develop a set of targeted and measurable interventions. These interventions, or action steps should form a methodical path that begins at the baseline and ends with achievement of the goal, with clear mechanisms for measuring progress along the way. This often requires some additional preliminary work before embarking on the design and implementation of the QII action steps.<br>• To lend itself to ongoing measurement and evaluation, the QII should define an anticipated outcome of each action step. In general, the anticipated outcome of each action step should allow DBHDS staff to assess the interim success of that step on the path toward the overall goal of the QII. It is also important to clearly state the anticipated outcome of each action step in a measurable way. In order to develop a measurable interim outcome for an action step, it is necessary to have conceptualized and defined why one thinks the action step will make a difference, and therefore, help to achieve the overall goal.<br>• The QII should include a time frame in which each action step must occur: Each of the action steps should reference both expected implementation/initiation and completion dates. The reasons for providing a timeline are not only to project implementation and achievement dates, but also to serve as a benchmark for review and modification when implementation or achievement are not reached as planned. In other words, the timelines, among other aspects of the CAP, should be monitored and revised as needed, based on the results (i.e., relevant data).<br><br>In the absence of this structure, most QIIs reviewed did not present data that showed progress with regard to the action steps. In many instances, the QII presentations also did not include overall outcome data. Importantly, without clearly stated measurable goals, even when outcome data were presented, it was not clear whether an overall goal had been reached. | |

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| **29.11**<br>Through the Quality Management Annual Report, the QIC ensures that providers, case managers, and other stakeholders are informed of any quality improvement initiatives approved for implementation as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths. | The QIC issued a Quality Management Report on 3/3/21, covering SFY 2020.<br><br>The Quality Management Report was disseminated to the Provider Listserv, which includes providers, case managers, and other stakeholders, on 4/1/21.<br><br>The Quality Management Report informed stakeholders of quality improvement initiatives approved for implementation as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths.<br><br>Documents Reviewed:<br>*Developmental Disabilities Quality Management Plan FY 2020, March 31, 2021; Developmental Disabilities Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020, October 2020* | The QIC issued a *Quality Management Report* on 3/3/21, covering SFY 2020 (i.e., July 1, 2019 - June 30, 2020.) This Report included the quality improvement initiatives approved for implementation. The Report was disseminated to the Provider Listserv, which includes providers, case managers, and other stakeholders, on 4/1/21. It was positive to see that DBHDS staff had accelerated the timeframe for production and distribution of the Report to nine months after the period from approximately 12 months for the previous Report, such that the information was not as dated as for previous periods. However, they still needed to consider moving the timeframe for report production further forward, such that stakeholders received more recent information.<br><br>This edition of the *Quality Management Report* informed stakeholders of quality improvement initiatives approved for implementation. These included the following:<br>• The RMRC identified the rate of falls as a quality issue, recommended initiating a QII aimed at reducing the rate of falls and noted that preliminary data indicated a decreasing trend in the rate of falls.<br>• The MRC proposed four QIIs during SFY20, including proposing legislation to allow the MRC to obtain documents from agencies and facilities related to case reviews when/as needed, reducing the number of Potentially Preventable deaths to less than 15% of total DD deaths reviewed; and decrease the number of causes of death coded as "unknown."<br>• The CMSC implemented a QII for piloting an *On-Site Visit Tool* (*OSVT*) to address the identification of increasing risks as well as increase the consistency in the application of face-to-face assessments by Support Coordinators.<br>• The KPA Workgroups identified three QIIs in the areas of independent housing, crisis assessments in the community versus a hospital, and improvements in direct support professional (DSP) competency.<br><br>It appeared that DBHDS met the overall intent of this Compliance Indicator. However, the information was very brief and did not provide a "data-driven" rationale for why the DBHDS subcommittees and workgroups selected these | Met |

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| | | specific topics or provide a clearly stated baseline that would allow stakeholders to understand the scope of the problem or mark progress over time. As DBHDS continues to seek to establish a culture of quality that relies on utilizing data to monitor trends and outcomes in a continuous feedback loop to inform the system of care (i.e., as described in the *DBHDS Quality Management Plan*), this is another opportunity to expand that culture throughout the system. | |
| **29.12**<br>DBHDS has a Risk Management Review Committee (RMRC) that has created an overall risk management process for DBHDS that enables DBHDS to identify, and prevent or substantially mitigate, risks of harm. | The Risk Management Review Committee has a charter (*Revised Risk Management Review Committee Charter Dec 2020)* that describes its roles and functions as a subcommittee of the DBHDS Quality Council as well as its roles and relationships to other operational areas within DBHDS.<br><br>The Risk Management Review Committee is integrally involved in the development and operations of the DBHDS risk management processes.<br><br>Documents Reviewed: *Revised Risk Management Review Committee Charter Dec 2020; Risk Management Program Description FY21; RMRC Annual Report FY20; RMRC Minutes 09/21/20, 10/19/20, 11/16/20 and* | According to the *DBHDS Quality Management Plan,* the "primary task of the RMRC is to establish goals and performance measure indicators that affect outcomes related to safety and freedom from harm and avoiding crises. This is achieved by establishing uniform risk triggers and thresholds, recommending processes to investigate reports of serious incidents, and identifying remediation steps. In addition, the RMRC offers recommendations for guidance and training on proactively identifying and addressing risks of harm, conducting root cause analyses, and developing and monitoring corrective action plans. The RMRC reviews and analyzes trends to determine and recommend quality improvement initiatives to prevent and/or substantially mitigate future risk of harm. The RMRC monitors serious incident reporting, establishes targets, and recommends actions and improvement initiatives when targets are not met."<br><br>The authorization, roles, functions, and responsibilities of the Risk Management Review Committee are further described in the *Revised Risk Management Review Committee Charter Dec 2020.* As a subcommittee of the DBHDS QIC, the RMRC is charged to identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends. The *RMRC Annual Report FY20* describes the committee's activities which included providing ongoing monitoring of serious incidents and allegations of abuse and neglect; analysis of individual, provider, and system level data to identify trends and patterns and make recommendations to promote health, safety, and well-being of individuals.<br><br>The *RMRC Annual Report FY20* further documented the activities, accomplishments, findings, and recommendations of the RMRC during SFY 2020. These included focused processes for serious incident reporting, review, | Met |

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| | *01/25/21; QIC Subcommittee Workplan; RMRC Task Calendar and Charter Tasks; RMRC Measure Tracking Log.* | and analysis; development and publication of materials specific to risk assessment, risk triggers and thresholds; and routine review and analysis of data on DBHDS performance indicators relating to safety and freedom from harm. A review of RMRC meeting minutes, their Task Calendar and Measure Tracking Log provided evidence of continued efforts by the RMRC to carry out the functions described in the RMRC Annual Report FY20.<br><br>The *Risk Management Program Description FY21* includes a description of the RMRC Annual Workplan and describes the Committee's databased approaches to oversight and analysis of the DBHDS Quality Improvement Initiatives, Performance Measures, and other data and information that relate to the DBHDS risk management program and processes. | |
| **29.13**<br>The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, neglect, and exploitation, at least four times per year by various levels such as by region, by CSB, by provider locations, by individual, or by levels and types of incidents. | The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, neglect, and exploitation, at least four times per year.<br><br>The RMRC reviews and identifies trends from aggregated incident data and any other relevant data by various levels such as by region, by CSB, by provider locations, by individual, or by levels and types of incidents.<br><br>The RMRC has a structured plan and schedule for review of data and information | The *FY21 RMRC Task Calendar and Charter Tasks* is the scheduling tool used by the RMRC to assure that it conducts reviews and analysis of surveillance data specific to abuse/neglect, exploitation, Office of Human Rights look-behind results, serious incidents, the IMU look-behind (triage) process, incident management care concerns, timeliness of reporting and related citations, relevant state facilities data, and performance measures.<br><br>The *SFY 21 RMRC QIC Subcommittee Work Plan* is the comprehensive tracking and information tool used by the RMRC to document their review and analysis activities. It identifies activities undertaken, data and information reviewed/analyzed, and follow-up activities resulting from the analysis of data and information. It also includes notes about current and proposed Quality Improvement Initiative opportunities and presentation of information to the DBHDS Quality Improvement Council.<br><br>A review of three sets of RMRC meeting minutes (i.e., *RMRC Minutes 11.16.2020, RMRC Minutes 12.21.2020, and RMRC Minutes 01.25.2021)* provide evidence of that the committee reviews and analyzes data and identifies trends in each of their monthly meetings. The reviews contained in the referenced sets of minutes include examples of various data analyses by type of incident, by region, by gender, by age, by quarter and by provider type. Also, in review of care concerns based on the specific criteria DBHDS developed for identification of a care | Met* |

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| | specific to serious incidents and allegations/substantiations of abuse, neglect, and exploitation.<br><br>The RMRC meets monthly and reviews/analyzes data and information on performance measures, quality improvement initiatives and data related to reporting and analysis of serious incidents.<br><br>Documents Reviewed: *FY21 RMRC Task Calendar and Charter Tasks; SFY 21 RMRC QIC Subcommittee Work Plan; RMRC Annual Report FY20; RMRC Minutes 11.16.2020; RMRC Minutes 12.21.2020; RMRC Minutes 01.25.2021* | concern, some analyses included identification by individual.<br><br>DBHDS has not determined that the data sources used by the RMRC provides reliable and valid data for compliance reporting.<br><br>*This Met rating is for illustrative purposes only. DBHDS has fulfilled the activities required by this Indicator, and has adequate procedures in place that would support the ability to do this work. The RMRC cannot yet be confident when analyzing risk management data or reliably identify trends. | |
| **29.14**<br>The RMRC uses the results of data reviewed to identify areas for improvement and monitor trends. The RMRC identifies priorities and determines quality improvement initiatives as needed, including identified strategies and metrics to | The RMRC uses the results of data reviewed to identify areas for improvement and monitor trends.<br><br>The RMRC identifies priorities and determines quality improvement initiatives as needed, including identified strategies and metrics to monitor success, or refers these areas | The *SFY 21 RMRC QIC Subcommittee Work Plan* contains evidence that the RMRC is reviewing and analyzing data, monitoring trends and patterns in data, and identifying areas of improvement that appear to be warranted from their review and analysis of data and trends.<br><br>The RMRC reviewed and approved a tool to assist in prioritizing and choosing potential areas for improvement. The *QII Tool, February 2021* outlines and documents a structured and data-driven approach to identify and prioritize potential areas being considered as quality improvement initiatives. The factors considered in the analysis include prevalence, risk, cost, relevance, responsiveness, feasibility, and continuity. The tool appears useful in forcing consideration of an array of relevant factors that help to ensure that resources are directed to those | Not Met |

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| monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts. The RMRC ensures that each approved quality improvement initiative is implemented and reported to the QIC. The RMRC will recommend at least one quality improvement initiative per year. | to the QIC for consideration for targeted quality improvement efforts.<br><br>The RMRC recommends at least one quality improvement initiative per year.<br><br>The RMRC implemented the approved falls quality improvement initiative and made reports to the QIC. However, the updates provided to the QIC did not include data on five specific areas that were identified to be monitored. Without this data, there was insufficient evidence, in this QII, to demonstrate that the RMRC was using the results of data reviewed to identify areas for improvement and monitor trends.<br><br>*Documents Reviewed: SFY 21 RMRC QIC Subcommittee Work Plan; QII Initiative – Falls with Injury June 2020; RMRC Fall QII to QIC Dec2020; QII Tool February 2021; RMRC Annual Report FY20; DBHDS Quality Management Plan FY2020;* | initiatives that have the greatest potential to positively impact improved safety and health of persons served in DBHDS programs.<br><br>The RMRC proposed a quality improvement initiative to reduce the number serious incidents that are caused by falls. The *QII Initiative – Falls with Injury June 2020* provides details of the proposal, desired outcomes, data to be collected and analyzed, and monitoring and evaluation processes. The proposal also included prior actions that are relevant to the desired outcome of this QII. Those prior actions and frequency data on falls were presented in graphic form in the RMRC presentation to the QIC in December 2020. The graph contained data from 08/2019 through 09/2020 and highlighted the implementation of several strategies and other intervening events (e.g., the COVID-19 pandemic) that might have impacted the rate of falls during the review period.<br><br>The *Falls Quality Improvement Initiative-2020.10.19* PowerPoint includes information about the QII and data analysis of the overall biweekly frequency of reported falls over time for waiver recipients. It also breaks down the fall data by age, gender, and race. These are good examples of data collection and analysis in graphic form. However, the *RMRC – QII Initiative – Falls with Injury*, dated June 2020 identified five separate activities that are to be monitored with data including (1) % of completed ISPs incorporating RAT; (2) # of providers meeting risk triggers for falls; # who receive follow-up; (3) # of providers accessing and completing training materials through COVLC; (4) Track downloads and access to resources (newsletters, health alters) on new website; and (5) Track % of provider receiving invitations who participated in training. Data was not presented related to any of these five activities. Without the data outlined above, there was insufficient evidence for this QII to demonstrate that the RMRC was meeting the requirements of this compliance indicator to "use the results of data reviewed to identify areas for improvement and monitor trends." Without these data, the RMRC could not determine which of the strategies were effective and considered for replication.<br>It was positive that the members of the RMRC QII workgroup had begun to have some conversations about how to measure these factors, but had not yet developed those mechanisms. | |

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| | *Annual Summary of Approved and Implemented QIIs* | . | |
| **29.15**<br>The RMRC monitors aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators. When targets are not met the RMRC determines whether quality improvement initiatives are needed, and if so, monitors implementation and outcomes. | The RMRC monitors aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators.<br><br>When targets are not met the RMRC determines whether quality improvement initiatives are needed, and if so, monitors implementation and outcomes.<br><br>The RMRC has established processes and schedules for review of aggregated data of provider compliance with serious incident reporting requirements.<br><br>The RMRC has established a performance threshold for timely reporting (86%) and collects and analyzes data quarterly to measure whether this target is met. Data reviewed reflected that percentage of serious incidents that are reported | The *RMRC Measure Tracking Log PMI Jan 2021* documents data tracked quarterly by the RMRC related to the measure that reads "Critical Incidents are reported to the Office of Licensing within the required timeframes (24-28 hours)." The target threshold for this indicator is 86%. The percentage of serious incident reports submitted within required timeframes for the four quarters in SFY2020 are as follows: Q1-94%, Q2-93%, Q3-89%; Q4-95%. Data for all four quarters in SFY 2020 reflected compliance well above the 86% threshold. This data is presented to and reviewed by the RMRC quarterly.<br><br>The process steps, data source, and responsible person(s) for monitoring serious incident report timeliness are outlined in the Process Document 29.3, 29.5, 29.15 Monitoring Serious Injuries.<br><br>The *Incident Management SIR Timelines 9-20-20* presentation includes a comprehensive review of data and information collected and analyzed by the Incident Management Unit and presented to the RMRC on a quarterly basis. The report is comprehensive, and the graphic presentations are easy to read and understand. The report presents various methods of evaluating data related to late reporting of serious incidents – by region, by type of incident, by provider (with multiple citations). The report reflects identification of system issues with the DBHDS web-based incident reporting portal (CHRIS) and exceptions made for issuance of CAPs for late reports that occurred during these periods when system issues impacted a provider's ability to report incidents within prescribed timeframes.<br><br>The *RMRC Annual Report FY20* also documents the data review and analysis functions of the RMRC relating to timeliness of incident reporting. This report also references issuance of citations for late reporting. For SFY 2020, there were 611 late reports, and 376 providers were issued citations for late reporting, each requiring a corrective action plan. Additional guidance, *Guidance for Serious Incidents*, 11/28/20 was sent to providers by the Office of Licensing on November | Met* |

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| | within specified timeframes well exceeds the established threshold.<br><br>Because targets are being exceeded consistently, there has not been a need for development of a quality improvement initiative addressing this issue.<br><br>Documents Reviewed: *Process Document 29.3, 29.5, 29.15 Monitoring Serious Injuries; MQ for Data Verification 29.15; RMRC Measure Tracking Log PMI Jan 2021; Incident Management SIR Timelines 9-20-20; RMRC Annual Report FY20; 30.06 Guidance for Serious Incidents 11282020* | 28, 2020 outlining the types of serious incidents and providing clarifying guidance on incident reporting timelines. | |
| **29.16**<br>The RMRC conducts or oversees a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The review will evaluate whether: i. The incident was triaged by the Office of Licensing incident management team appropriately according to developed | The RMRC oversees a look behind review of a random sample of DBHDS serious incident reviews and follow-up process.<br><br>DBHDS did not provide evidence to show that the random sampling methodology and process for the serious incident look-behind was statistically significant. | The *Incident Management Look Behind Process* states the purposes of the serious incident look-behind are to validate the reliability of the IMU's triaging of incidents, to ensure the IMU review incidents consistently, to confirm appropriate actions were reviewed, to ensure protocols were followed; and to assist the IMU to improve the quality of the triage process. The documents further state that the look behind process focuses on assessing the following criteria:<br>• The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols;<br>• The provider's documented response ensured the recipient's safety and well-being;<br>• Appropriate action from the Office of Licensing Incident Management Unit occurred when necessary; and<br>• Timely, appropriate corrective action plans are implemented by the provider | Not Met |

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| protocols.<br>ii. The provider's documented response ensured the recipient's safety and well-being.<br>iii. Appropriate follow-up from the Office of Licensing incident management team occurred when necessary.<br>iv. Timely, appropriate corrective action plans are implemented by the provider when indicated.<br>v. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation. | The look behind review addressed each of the required elements.<br><br>The RMRC reviewed the trends identified in the serious incident look behind at least quarterly.<br><br>Based on the data reviewed, the RMRC did not see a need to implement quality improvement initiatives.<br><br>Documents Reviewed:<br>*Draft Incident Management Look Behind Process; IMU Look Behind Report FY21Q1; IMU Look Behind Committee Description; IMU Lookbehind Reviewer Sheet; IMU LB Data Collection Tool FY20Q4; IMU Triage Review Form; IMU LB Scoring Guide Draft; OL IMU LB Sample Calendar; Instructions for reviewing Incidents in CHRIS, 3/9/20; RMRC Minutes excerpt_10.19.2020.* | when indicated.<br><br>Overall, the look-behind process was well-organized and had many structural components in place to produce reliable and valid data, including the following tools and protocols:<br>• *IMU Look Behind Committee Description;*<br>• *IMU Lookbehind Reviewer Sheet;*<br>• *IMU LB Data Collection Tool FY20Q4;*<br>• *IMU Triage Review Form;*<br>• *IMU LB Scoring Guide Draft; OL IMU LB Sample Calendar;*<br>• *Instructions for reviewing Incidents in CHRIS, 3/9/20*<br><br>However, the process continued to have significant limitations. It was positive that DBHDS had self-identified some of these limitations and planned to consider methodological revisions to address them in the future. For example, DBHDS staff did indicate during the interview that they recognized some limitations in their current processes and were anticipating the likelihood of contracting out the completion of this look-behind in order to have a more robust process. The following describes examples of concerns noted in the current process:<br>• Based on documentation provided for review, inter-rater agreement had been low thus far. For example, the RMRC Minutes, dated 10/19/20 stated that, after two quarters of implementation, there was low agreement among reviewers on 10 of 14 fields. The four fields that exceeded 80% agreement included the following: Which incident level is selected in the report's check boxes; Which incident level did the Incident Management Unit (IMU) specialist assign to this incident; The incident report is for an individual who is under the age of 18 years; and, the IMU specialist assessed for imminent danger in accordance with IMU protocols. For the remaining ten items, the percentage of agreement ranged. As a result of these very low IRR scores, much of the data presented in the reports could not be considered reliable (i.e., the data collection methodology does not consistently produce the same results.)<br>• One of the inherent limitations DBHDS staff identified was the lack of staffing resources dedicated to the effort. Instead, the process relied upon an IMU | |

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| | | Look Behind Committee comprised of professionals from various offices within the agency, including OHI, Provider Development, and OIH, all of whom had other job descriptions.<br>• DBHDS did not provide evidence to show the sampling methodology produced a statistically valid sample. According to the *IMU LB Scoring Guide Draft*, the sampling design indicated the annual look behind sample size would be calculated based on the projected annual population of eligible serious injury. The Look Behind Review of Incident Management Unit Triage Process FY2021 Q1 (i.e., the most recent data provided for review), indicated that the annual sample size was calculated using a projected annual population of 14,800 eligible incident reports and, further, that the IMU Look Behind Committee would review one-quarter of the sample (i.e., 47 reports each quarter or a total of 188 per year.). In interview, the consultant requested DBHDS provide further information to explain the level of statistical significance from that sample size, but did not receive any additional explanation. | |
| **29.17**<br>The RMRC conducts or oversees a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines.<br>ii. The person conducting the investigation has been trained to conduct | The RMRC conducts or oversees a look-behind review of a random sample of reported allegations of abuse, neglect, and exploitation.<br><br>The look-behind review sample of reported allegations of abuse, neglect, and exploitation appeared to be statistically valid, with 90% confidence interval,<br><br>The look-behind review evaluated all of the required components of this Compliance Indicator. | The *Office of Human Rights Community Look-Behind Process, CY 2021*and the *Process Document: Human Rights Look-Behind, 3/1/21* state that the retrospective review of human rights investigations (i.e., the look-behind) was established to ensure that human rights investigations are conducted in compliance with The OHR regulations in the Virginia Administrative Code. The documents further state that the look behind process focuses on assessing the following criteria:<br>• The validity of investigation outcomes (substantiated versus non-substantiated allegations);<br>• The OHR business process by examining certain performance requirements (i.e., comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines; ii. The person conducting the investigation has been trained to conduct investigations; iii. Timely, appropriate corrective action plans are implemented by the provider when indicated);<br>• The data quality between CHRIS and the provider's supporting documentation; and,<br>• Identifying areas where training or follow-up assistance is warranted in order | Not Met |

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| investigations.<br>iii. Timely, appropriate corrective action plans are implemented by the provider when indicated.<br>iv. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation. | The RMRC reviewed the trends identified in the ANE look behind at least quarterly, but the data being reviewed was approximately a year old and therefore not particularly useful for the purpose of quality improvement.<br><br>*Documents Reviewed:*<br>*Office of Human Rights Community Look-Behind Process, CY 2021;*<br>*Process Document: Human Rights Look-Behind, 3/1/21; CY2021 Reviews CLB Form technical guidance; CLB Reviews Timeline 2021; CLB COVID remote review process; MQ for Data Verification 29.17;*<br>*RMRC Q3 CLB, 9.21.20;*<br>*RMRC Q4 CLB, 12.22.20;*<br>*RMRC Minutes excerpt, 9.21.2020; RMRC Minutes excerpt, 12.21.* | to improve the investigative process and outcomes.<br><br>Overall, the look-behind process was well-organized and had many structural components in place to produce reliable and valid data, as described below:<br>• The *CY2021 Reviews CLB Form* technical guidance provides a step-by-step process for completing the review forms/tool. Due to the COVID-19 pandemic, the OHR regional managers will complete the retrospective reviews and inter-rater reviews via a new remote review process that requires providers to email their documentation and complete the assessment over video conference.<br>• The sampling process appeared to be statistically valid. The process assumes that a random sample of 300 cases over the course of one year will allow results to be generalized across the entire population (i.e., "all closed human rights investigations for individuals receiving DD services"). For this past year, OHR reported 2,287 eligible cases, resulting in a confidence interval exceeding 90%, with a +-% margin of error.<br>• The reliability of the look behind outcomes was further enhanced by an inter-rater reliability process to quantify the degree of agreement of the independent assessments made by the reviewers. The Office of Data Quality & Visualization (ODQV) selected sixty cases (20%) to be randomly distributed to a second manager for review and comparison, with careful firewalls to minimize bias.<br><br>On the other hand, this process also continued to have significant limitations. It was positive that DBHDS had self-identified some of these limitations and planned to consider methodological revisions to address them in future years. These included the following:<br>• As described with regard to the serious incident look behind process, perhaps the most significant limitation to the current process stemmed from the delays that occurred in the processes during the COVID pandemic. As a result, it appeared that in the in fourth quarter of 2020, the look behind was reviewing data for the fourth quarter of CY 2019. For the purposes of quality improvement, data this stale are not particularly actionable, since they reflect practices that were occurring a year in the past. As a result, while the RMRC | |

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| | | reviewed the trends identified in the ANE look behind at least quarterly, these data were too old to be useful in identification of the need for quality improvement initiatives. DBHDS staff might want to consider whether there is relative value in trying to "catch-up" older reviews or to focus their efforts on more recent investigations.<br>• The random sample of cases within each region is assigned to the manager in that region. To eliminate the possibility of regional bias, ideally the reviews would be randomly assigned to a manager. This continues to not be feasible based on resource allocation. An inter-rater reliability process has been established to identify any inconsistencies between reviewers and potentially aid in the identification of bias.<br>• The sampling frame requires cases to have a status of "closed" within CHRIS. However, there might be some cases that have not closed due to needed extensions. This might result in some bias, but OHR anticipates this to be a small subgroup. | |
| **29.18**<br>At least 86% of the sample of serious incidents reviewed in indicator 5.d meet criteria reviewed in the audit. At least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed in indicator 5.e meet criteria reviewed in the audit. | For the most recent sample of reviews in the serious incident look-behind, DBHDS reported that compliance scores met or exceeded 86% for only one of the three criteria. In addition, the sample was not of a sufficient size to be statistically significant; therefore, it could not be used to extrapolate with any confidence that 86% of serious incidents would meet criteria for triage, appropriate and timely actions or corrective action implementation.<br><br>For the most recent sample | DBHDS reported that it did not achieve compliance with this Compliance Indicator for either the serious incident look behind or the ANE look behind.<br><br>For the serious incident look behind, DBHDS reported that it achieved the 86% measure for one of three criteria.<br>• 94% for "the incident was triaged appropriately by the IMU according to developed protocols."<br>• 53% for "the provider's documented response addressed ways to mitigate future occurrences of the incident."<br>• 40% for "appropriate action from the IMU occurred."<br><br>In addition, DBHDS did not provide evidence to show the sample was of a sufficient size to be statistically significant; therefore, it could not be used to extrapolate with any confidence that 86% of serious incidents would meet criteria for triage, appropriate and timely actions or corrective action implementation.<br><br>For the ANE look behind, DBHDS reported that it achieved the 86% measure for two of three criteria. The scores reported were:<br>• 89% for "comprehensive, and non-partial investigations of individual | Not Met |

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| | reviewed in the ANE look-behind, DBHDS reported that compliance scores met or exceeded 86% for two of the three criteria, but was at 83% for the third. | incidents occur within state prescribed timelines."<br>• 88% for "the person conducting the investigation has been trained to conduct investigations."<br>• 83% for "timely, appropriate corrective action plans are implemented by the provider when indicated and the case closed within 60 days."<br><br>In addition, for the ANE look-behind, the data were 9 - to 12 - months old and too stale to be of meaningful use for quality improvement. | |
| **29.19**<br>The Commonwealth shall require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth. | The Commonwealth does not specifically require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth.<br><br>*Documents Reviewed:*<br>*Risk Awareness Tool Instruction and Resource Document v.5.20* | Based on interview with DBHDS staff and documentation provided for review, DBHDS does not require providers to specifically identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth.<br><br>Instead, DBHDS has developed a Risk Assessment Tool (RAT) to be applied universally for all individuals receiving DD waiver services. Through a memo to providers dated 06/16/2020, DBHDS established a requirement for using the Risk Assessment Tool (RAT) in the process of developing individual support plans. They also published a guidance document entitled *Risk Awareness Tool Instruction and Resource Document v.5.20 t*hat gives providers detailed information on use of the Risk Assessment Tool. However, at this time, DBHDS does not have a protocol to require providers to identify or to report the names of individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7. DBHDS has access to the RAT for each individual, but does not currently plan to on using the RAT data to fulfill these requirements. | Not Met |
| **29.20**<br>At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who | Based on NCI data reported for 2018-2019, 82% of people receiving services had a physical exam in the past 12 months. For 2019-2020, the NCI data were unavailable and the ISP data did not appear to be valid or reliable. | The DBHDS KPA Workgroup monitors NCI data for the domain of physical, mental and behavioral health and well-being and for this PMI. As described with regard to Compliance Indicator 29.08, it appeared that NCI data could be considered reliable for use in evaluating the sufficiency, accessibility, and quality of services at an individual, service, and systemic level.<br><br>The *Developmental Disabilities Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020* reported that NCI data for 2018-2019 showed that 82% of people receiving services had a physical exam in the past 12 months. Based on a | Not Met |

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| have coverage for dental services will receive an annual dental exam. | NCI data for 2018-2019 showed that 65% of people receiving services had a dental exam in the past year. The most recent NCI In-Person Survey (IPS) State Report 2019-20, as presented at the QIC meeting in 3/22/21, indicated the percentage for this most recent period was 61%.<br><br>For both measures, concerns for data validity were evident.<br><br>*Documents Reviewed: Developmental Disabilities Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020; NCI In-Person Survey (IPS) State Report 2019-20; KPA Workgroups 3rd QTR Report to the QIC SFY2021 March 22, 2021* | review of the *NCI In-Person Survey (IPS) State Report 2019-20*, as presented at the QIC meeting in 3/22/21, the report did not provide data for this indicator. The *KPA Workgroups 3rd QTR Report to the QIC SFY2021, March 22, 2021* did provide some data for this PMI using the ISP data in WaMs, but its provenance was not clear. For example, the presentation indicated that for SFY21 Q2, 71% of individuals on the DD waivers had a documented annual physical exam date in their ISPs, but only 54% of those individuals had an actual annual physical exam date. It was unclear how the ISP could document an annual physical exam date if an individual had not had an actual physical exam. DDHDS should take, and document, any steps necessary to ensure the WaMS data are valid and reliable.<br><br>With regard to validity, it was not clear that the NCI data previously relied upon captured whether the physical exam included a review of preventative screenings and/or whether the survey cohort included individuals in all service settings, rather than just residential. DBHDS staff will need to clarify. In addition, DBHDS will need to define "receiving an annual" physical exam. The NCI percentage reports the percentage of individuals who had had a physical exam in the past twelve months. It does not report the number of individuals who receive a physical exam annually.<br><br>The *Developmental Disabilities Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020* that NCI data for 2018-2019 showed that 65% of people receiving services had a dental exam in the past year. The most recent NCI In-Person Survey (IPS) State Report 2019-20, as presented at the QIC meeting in 3/22/21, indicated the percentage for this most recent period was 61%. While it was not clear whether COVID restrictions impacted this decline, it seemed likely.<br><br>Going forward, DBHDS will also need to consider measure validity concerns for dental exams. For example, it was not clear whether or not the NCI data reflected only individuals who had dental coverage. Similar to the measure for physical exams, DBHDS will also need to define receiving an "annual" dental exam. | |

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| **29.21**<br>At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services. | DBHDS is finalizing its Practice Guidelines which will include the minimum elements required for behavioral support plans to be considered adequate. DBHDS has not yet gathered data to evidence compliance with this Compliance Indicator. | DBHDS does not yet have valid and reliable data for whether behavioral support services are adequate or appropriately delivered. | Not Met |
| **29.22**<br>At least 95% of residential service recipients reside in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings. | DBHDS did not provide valid and reliable data to evidence compliance with this Compliance Indicator. | DBHDS did not provide documentation to review or report valid and reliable data to evidence compliance with this Compliance Indicator. | Not Met |
| **29.23**<br>At least 95% of individual service recipients are free from neglect and abuse by paid support staff. | DBHDS did not yet have valid and reliable data to evidence compliance with this Compliance Indicator.<br><br>*Documents Reviewed:*<br>*Process Document: Abuse and Neglect Prevalence, 5/18/2020;*<br>*2019-2020 Data Quality Monitoring Assessment; DBHDS Memorandum: DOJ Compliance Indicator V.B.7.d (29.23), 5/18/20;* | Based on a *DBHDS Memorandum: DOJ Compliance Indicator V.B.7.d (29.23)*, dated 5/18/20, DBHDS reported that they achieved a compliance score of 98.75% in Quarter 1 and 98.70% in Quarter 2.<br><br>However, DBHDS derives data for this measure from CHRIS and WaMS. Based on the 2019-2020 *Data Quality Monitoring Assessment*, both CHRIS and WaMS are known to have significant data limitations. Although DBHDS staff had documented some interim steps to address these concerns, they had not completed an annual review of the *Data Quality Monitoring Assessment* for these source systems. They expected to do so in June 2021. At the RMRC meeting held on 12/22/20, OHR recommended that the RMRC consider facilitating a study through the Data Workgroup to further review the methods used to gather | Not Met |

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| | *DOJ SA - IR Determination Table Final, 04.28.21v2* | this data, including threats to data validity and identifying a process for de-duplicating CHRIS data. | |
| **29.24**<br>At least 95% of individual service recipients are adequately protected from serious injuries in service settings. | DBHDS did not have sufficient valid and reliable data to evidence compliance with this Compliance Indicator.<br><br>*Documents Reviewed:*<br>*Risk Management Review Committee (RMRC) Meeting Minutes, 6/22/20; RMRC Minutes, 6/15/20* | Based on review of RMRC minutes of meetings held on 6/15/20 and 6/22/20, DBHDS intends to derive data for this measure from the QSR, item #333 of the Person-Centered Review (PCR) tool. This item probes whether providers proactively identify and address risks of harm and develop and monitor corrective actions. In making this choice of data source, the RMRC considered feedback from the Court that this measure should be looking at whether or not providers are acting to protect individuals from injury and not necessarily whether or not individuals are injured. The RMRC considered other options (e.g., Support Coordinator Quality Review), but ultimately determined PCR assessment as to whether the ISP confirms that risks of harm were identified and addressed would be a valid measure of whether the provider is taking appropriate actions to protect individuals from serious injury.<br><br>As described with regard to Compliance Indicator 29.08 above, at the time of this review, the QSR process had not yet produced sufficient reliable data for this measure. | Not Met |
| **29.25**<br>For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans. | DBHDS did not have sufficient valid and reliable data to evidence compliance with this Compliance Indicator.<br><br>*Documents Reviewed:*<br>*Process Document, Seclusion & Restraint, 5/18/20; OHR LHRC Review; Tracker MQ for Data Verification 29.25; Protocol No. 141; Provider LHRC Review Requests; Technical Notes for OHR Advocate Activities Tracker;* | Based on review of the documentation submitted for this Compliance Indicator, DBHDS last documented compliance data in a Memorandum DOJ Compliance Indicator V.B.7.d (29.25), dated 5/18/20. The memorandum provided data for the third quarter of SFY2020 indicating compliance of 96%. The memorandum further noted that, due to COVID, there were no meetings in March through May of 2020. DBHDS did not provide any additional updated data since that time.<br><br>Going forward, DBHDS staff should further verify and document that the data collection methodology can produce valid and reliable data. The data source is a spreadsheet entitled staff *OHR LHRC Review Tracker*, which is completed by OHR staff as described in the *Process Document, Seclusion & Restraint*. However, the DBHDS *MQ for Data Verification 29.25* did not provide any documentation of how DBHDS had verified the accuracy, completeness and reliability of the data from | Not Met |

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| | *DBHDS Memorandum DOJ Compliance Indicator V.B.7.d (29.25), 5/18/20.* | the data source. | |
| **29.26**<br>The Commonwealth ensures that at least 95% of applicants assigned to Priority 1 of the waiting list are not institutionalized while waiting for services unless the recipient chooses otherwise or enters into a nursing facility for medical rehabilitation or for a stay of 90 days or less. Medical rehabilitation is a non-permanent, prescriber-driven regimen that would afford an individual an opportunity to improve function through the professional supervision and direction of physical, occupational, or speech therapies. Medical rehabilitation is self-limiting and is driven by the progress of the individual in relation to the therapy provided. When no further progress | DBHDS did not have sufficient valid and reliable data to evidence compliance with this Compliance Indicator. | For this study period, DBHDS did not provide documentation with regard to how it ensures the collection of valid and reliable data. At the time of the previous study, DBHDS staff submitted an *MQ for Data Verification 29.25*, dated 10/12/20, which stated that the data were derived from several sources, including WaMS, the REACH hospital tracker, PASRR data, and the ICF IID process. The document further indicated that DBHDS did not have documentation of how DBHDS had verified the accuracy, completeness, and reliability of the data from the data source or provide a description of the data verification approaches used to determine the reliability and validity of the data at the point of data collection. | Not Met |

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| can be documented, individual therapy orders must cease. | | | |
| **29.27**<br>At least 75% of people with a job in the community chose or had some input in choosing their job. | DBHDS did not provide valid and reliable data to evidence compliance with this Compliance Indicator. | DBHDS did not provide documentation to review or report valid and reliable data to evidence compliance with this Compliance Indicator. | Not Met |
| **29.28**<br>At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule. | DBHDS did not provide valid and reliable data to evidence compliance with this Compliance Indicator. | DBHDS did not provide documentation to review or report valid and reliable data to evidence compliance with this Compliance Indicator. | Not Met |
| **29.29**<br>At least 75% of people receiving services who do not live in the family home/their authorized representatives chose or had some input in choosing where they live. | DBHDS reported NCI data for 2018-2019 showed that 67% of people receiving services who do not live in the family home, their authorized representatives chose or had some input in choosing where they live.<br><br>The most recent *NCI In-Person Survey (IPS) State Report 2019-20,* as presented at the QIC meeting on 3/22/21, indicated the percentage for this most recent period was 65%. | The KPA Workgroup monitors NCI data for the domain of choice and self-determination and for this PMI. As described with regard to Compliance Indicator 29.08, for 2018-2019, overall, NCI data could be considered reliable for use in evaluating the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. However, due to the limitations associated with the COVID data for 2019-2020, the NCI noted that these most recent data should not be used to compare to previous years and is provided only as a reference point.<br><br>The *Developmental Disabilities Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020* reported that NCI data for 2018-2019 showed that 67% of people receiving services who do not live in the family home/their authorized representatives chose or had some input in choosing where they live. The report further noted that there was no change in that percentage from the previous year. Based on a review of the *NCI In-Person Survey (IPS) State Report 2019-20,* as presented at the QIC meeting on 3/22/21, the percentage for this most recent | Not Met |

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| | *Documents Reviewed: Developmental Disabilities Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020, October 2020;* | period appeared to be 65% (i.e., 20% of respondents indicated that the person made the choice, while 45% indicated the person had some input). It was unclear whether COVID limitations impacted this slight decline. | |
| **29.30**<br>At least 50% of people who do not live in the family home/their authorized representatives chose or had some input in choosing their housemates. | DBHDS did not have valid and reliable data to evidence compliance with this Compliance Indicator. | DBHDS did not provide documentation to review or report valid and reliable data to evidence compliance with this Compliance Indicator. | Not Met |
| **29.31**<br>DBHDS implements an incident management process that is responsible for review and follow-up of all reported serious incidents, as defined in the Licensing Regulations. | The DBHDS incident management protocols include triage criteria and a process for follow-up and coordination with licensing specialists, investigators, and human rights advocates as well as referral to other DBHDS offices as appropriate.<br><br>DBHDS has incident management processes in place to identify and, where possible, prevent or mitigate future risks of harm.<br><br>DBHDS documents follow-up on individual incidents, as well as analysis to identify | The DBHDS incident management process has continued to evolve and be refined over several years. The process includes specific regulatory requirements, extensive guidance documents and training materials for providers and DBHDS staff involved in the process that are detailed in Sections 29.03, 29.04 and 29.05 above.<br><br>DBHDS has continued to develop, revise, and expand guidance materials and training curricula for providers and DBHDS staff related to the incident management system, provider expectations, and regulatory requirements. Details of those materials and training curricula are outlined in Sections 29.03, 29.04 and 29.05 above.<br><br>The following regulations establish expectations of providers regarding how their incident management process includes review and follow-up of all reported serious incidents:<br>• 160.C – the provider shall collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents, as part of the quality improvement program to include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to | Met |

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| | relevant patterns and trends.<br><br>*Documents Reviewed: IMU Triage Review Form, 2/12/21; OL Incident Management Unit Care Concern Threshold Joint Protocol, 1/19/21; Incident Management Unit 5 Business Days Protocol, 03/30/2020; Internal Protocol for DBHDS Incident Management, 5/29/20; Serious Incident Data Update, 11/16/20; IMU RMRC Review of Patterns and Trends, 1/25/21.* | mitigate the potential for future incidents.<br>• 160.E – A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises.<br>  ○ 160.E.1 – The root cause analysis shall include a detailed description of what happened, an analysis of why it happened, and identified solutions to mitigate its reoccurrence and future risk of harm when applicable.<br>  ○ 160.E.2 – The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis should be conducted.<br>• 160.J – The provider shall develop and implement a serious incident management policy, which shall describe the process by which the provider will document, analyze, and report to the department information related to serious incidents.<br><br>DBHDS has operationalized their process for assessing compliance with these regulations though detailed instructions to licensing specialists in the *OL Annual Checklist Compliance Determination Chart – FY2021*<br><br>Overall, the framework of the system appears to be comprehensive, multi-faceted and robust. The system includes an electronic portal for incident reporting and an Incident Management Unit responsible for review, triage, tracking and follow-up on reported incidents.<br><br>Data are being obtained from currently available data systems and are being used in evaluating both provider performance and performance of the DBHDS incident management program. As described in previous reports and summarized the Introduction section of this study, there remained some continuing concerns with the reliability and validity of the data derived from the source systems.<br><br>DBHDS continues to expand and improve data analysis approaches that focus on measurement of performance over time. For example, the *Risk Management Review Committee Annual Report, FY2020* contains numerous charts and graphs that present | |

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| | | data longitudinally. This longitudinal approach allows for measurement of operations or impacts of corrective actions over time rather than by viewing data as a snapshot in time. The department is encouraged to continue the expansion of the data-based approaches they have initiated to evaluate the operation and effectiveness of the incident management system more objectively and consistently.<br><br>DBHDS has worked diligently to assure that providers are aware of the requirements for policies and implementation plans for the required elements of their incident management systems. Evidence of a provider training curricula is referenced in Section 29.05 above. The department's approach to provider training and technical assistance is incremental which appears to be the most appropriate method of bringing providers into full compliance with the program's expectations and compliance with regulations even though that may take some time. | |
| **29.32**<br>a) DBHDS develops incident management protocols that include triage criteria and a process for follow-up and coordination with licensing specialists and investigators, and human rights advocates as well as referral to other DBHDS offices as appropriate;<br>b) Processes enable DBHDS to identify and, where possible, prevent or mitigate future risks of harm; and,<br>c) Follow-up on individual incidents, as | The DBHDS incident management protocols include triage criteria and a process for follow-up and coordination with licensing specialists, investigators, and human rights advocates as well as referral to other DBHDS offices as appropriate.<br><br>DBHDS has incident management processes in place to identify and, where possible, prevent or mitigate future risks of harm.<br><br>DBHDS documents follow-up on individual incidents, as | Procedures and expectations for coordination between the Office of Licensing's Incident Management Unit and Licensing Specialists, and the Offices of Human Rights and Integrated Health are in place, as described below:<br>• The *Internal Protocol for DBHDS Incident Management, 05/29/20* provides a comprehensive overview of the structure, responsibilities, and inter-relationships of the various components of the DBHDS incident management system including the Office of Licensing (OL) as a whole, the IMU, the Office of Human Rights and the Office of Integrated Health.<br>• The *Internal Protocol for DBHDS Incident Management, 05/29/20* describes the Incident Management Unit triage protocol in detail and describes the various levels of review that the IMU undertakes for the incident specifically and secondarily for determination of whether this incident, along with relevant provider incident history, meets a care concern threshold criterion. The IMU also handles interoffice communication about reported serious incidents assuring notifications to the Office of Human Rights, Office of Integrated Health, or, in the case of a death, to the Special Investigations Unit (SIU), as appropriate. The SIU processes the death investigation information through the SIU process.<br>• The *Internal Protocol for DBHDS Incident Management, 05/29/2020* describes the | Met |

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| well as review of patterns and trends, will be documented. | well as analysis to identify relevant patterns and trends.<br><br>*Documents Reviewed: IMU Triage Review Form, 2/12/21; OL Incident Management Unit Care Concern Threshold Joint Protocol, 1/19/21; Incident Management Unit 5 Business Days Protocol, 03/30/2020; Internal Protocol for DBHDS Incident Management, 5/29/20; Serious Incident Data Update,11/16/20; IMU RMRC Review of Patterns and Trends, 1/25/21.* | incident reporting interface with the Office of Human Rights (OHR), which has responsibility for monitoring abuse and neglect allegations to confirm that providers are reporting incidents within prescribed regulatory and procedural guidelines. The OHR assesses the need for follow-up and triages incidents that meet regulatory requirements for reporting/provider investigation to the appropriate regional advocate. OHR's primary focus is on ensuring rights protections for individuals receiving services from licensing providers, specifically that they are free from abuse and neglect and that incidents of abuse/neglect are appropriately investigated and mitigated according to the human rights regulations.<br>• The Office of Integrated Health (OIH) assesses the need for follow-up and triages incidents that present with a need for education or technical assistance. Their focus is on ensuring that providers receive education and resources to provide supports around health and safety that reflect best practices. Providers with identified care concerns are made aware of the availability of technical assistance from OIH.<br>• The *Internal Protocol for DBHDS Incident Management, 05/29/2020* also describes the training and technical assistance functions carried out by the Office of Licensing.<br>• The *OL Incident Management Unit Care Concern Threshold Joint Protocol, 1/19/21* includes clear descriptions of the specific roles and responsibilities for staff in the Incident Management Unit and Licensing Specialists who conduct annual and periodic licensing inspections of providers.<br><br>The *Internal Protocol for DBHDS Incident Management, 5/29/20* also describes the IMU responsibilities for trending and tracking incident and issue data to discover patterns, identify trends for individuals and providers and to inform DBHDS Serious Management of patterns and trends. The data used for this analysis is obtained from the DBHDS reporting systems (CHRIS and OneSource). The IMU prepares data reports, conducts analysis of data, prepares summary reports and submits these summary reports quarterly and year-end to the Risk Management Review Committee, the Regional Quality Committee, and the Quality Improvement Committee. | |

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| **29.33**<br>The Commonwealth ensures that individuals have choice in all aspects of their goals and supports as measured by the following: a. At least 95% of people receiving services/authorized representatives participate in the development of their own service plan. | DBHDS did not have valid and reliable data to evidence compliance with this Compliance Indicator. | DBHDS did not provide documentation to review or report valid and reliable data to evidence compliance with this Compliance Indicator. The CMSC did provide some data to show that they track whether individuals are given a choice of providers and support coordinators, for which they reported compliance of 80%. However, DBHDS did not provide data or other documentation to show that at least 95% of people receiving services/authorized representatives participate in the development of their own service plan. | Not Met |

## V.C.1 Analysis of 18th Review Period Findings

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

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| **30.01:**<br>The licensing regulations require all licensed providers, including CSBs, to implement risk management processes including:<br>a) Identification of a | Licensing regulations define requirements for provider risk management programs that that include all of the requirements set out in this Compliance Indicator.<br><br>Risk assessment reviews | DBHDS has established a set of licensing regulations at *12VAC35-105-520.A-E* that contain requirements for a risk manager to oversee the provider's risk management program; a written plan to identify, monitor, reduce and minimize harms and risks of harm; a requirement for an annual systemic risk assessment that identifies and responds to practices, situations, and policies that could result in the risk of harm to individuals and that incorporate uniform risk triggers and thresholds; and a requirement to conduct a safety inspection, at least annually, of each service location that includes recommendations for safety improvements. | Met |

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| person responsible for the risk management function who has training and expertise in conducting investigations, root cause analysis, and data analysis.<br>b) Implementation of a written plan to identify, monitor, reduce and minimize harms and risks of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability; and<br>c) Conducting annual systemic risk assessment reviews, to identify and respond to practices, situations and policies that could result in harm to individuals receiving services.<br><br>Risk assessment reviews shall address the environment of care, clinical assessment or | address the environment of care, clinical assessment or reassessment processes, staff competence and adequacy of staffing, the use of high-risk procedures including seclusion and restraint, and review of serious incidents.<br><br>DBHDS requires that risk assessments incorporate uniform risk triggers and thresholds as defined by DBHDS.<br><br>Documents Reviewed:<br>*Regulations-12VAC35-105-520.A-D;*<br>*External Memo to all DD Providers_2021_Final 2.12.21;*<br>*Internal Protocol for Assessing Compliance with 12VAC35-105-520 and 12VAC35-105-160.E, 01/25/2021;*<br>*OL Memo to Providers 02/24/2021;*<br>*OL Annual Checklist Compliance Determination Chart-FY2021;*<br>*OL instructions to licensing specialists for writing non-compliance citations at 12VAC85-105-520; 10/2020 PowerPoint training entitled "Quality Improvement and Risk Management"; OL Guidance for a* | OL developed and implemented detailed guidelines for licensing specialists to follow in reviewing and making determinations about provider compliance for each of these regulatory requirements. Citing feedback from licensing specialists that provider policies frequently quoted regulations rather than describing how they would be implemented, OL staff developed expanded instructions to licensing specialists regarding acceptable content of the annual systemic risk assessment. These guidelines are further captured in the *OL Annual Checklist Compliance Determination Chart-FY2021,* a tool designed for licensing specialists to use and complete during each licensing visit.<br><br>With regard to risk triggers and thresholds, the *Incident Management Unit (IMU) Care Concern Threshold* identifies five event/based triggers and thresholds that are currently being focused upon in the triage and evaluation of serious incidents being reported by providers. These include:<br>• Three or more unplanned medical hospitalizations, ER visits or psychiatric hospitalizations within a 90-day timeframe for any reason.<br>• Two or more unplanned medical hospitalizations or ER visits for the same condition or reason that occur within a 30-day timeframe.<br>• Any combination of three or more incidents of any type within a 30-day timeframe.<br>• Two or more unplanned hospital admissions or ER visits for any combination of the following serious incidents: falls, choking, bowel obstruction, urinary tract infection, aspiration pneumonia, or dehydration within a 90-day timeframe for any reason.<br>• Any incidents of medically verified decubitus ulcers or bowel obstruction.<br><br>If a care concern threshold is met, the provider is notified, and is expected to initiate follow- up actions that include further evaluation of the individual(s) involved and investigation to identify any systemic issues that impact their provision of care. OL, OHR and the Office of Integrated Health (OIH) are also notified when a provider meets a care concern threshold, and each evaluates the situation to determine appropriate follow-up action. The OIH may offer the provider relevant education or technical assistance to evaluate and address the | |

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| reassessment processes, staff competence and adequacy of staffing, the use of high-risk procedures including seclusion and restraint, and review of serious incidents.<br><br>Risk assessments also incorporate uniform risk triggers and thresholds as defined by DBHDS. See 12VAC-35-105-520. | *Quality Improvement Program, 11/28/2020; Updates from Quality Improvement Look Behind, dated 04/01/2021; and Evidence packets for 12 annual licensing reviews conducted in 2021.* | care concern issues. Evaluation of the provider's address of identified care concerns is an integral part of the OL annual licensing review. This approach appeared to hold promise in assisting providers to become more familiar with and to begin successful integration of risk triggers and thresholds into their risk management processes for identification, reporting and follow-up to serious incidents.<br><br>As a part of this review, the consultants selected a sample of 12 FY2021 evidence packets and corrective action plans, across all five DBHDS regions. A review of the sample revealed that OL staff evaluated providers' compliance with each of these regulations during annual licensing reviews. The consultant's validation assessment was consistent with those of the Licensing Specialists in a range from 88%-100% across the five assessment areas.<br><br>The consultant also completed an analysis of the sample findings. While it is important to acknowledge that these data cannot be considered representative of provider performance overall, the following provides a snapshot of licensing findings in the first months of this SFY:<br>• Providers are appointing risk managers but not all have completed or documented required training.<br>• Provider risk management plans are not consistently including all required elements.<br>• Provider annual systemic risk assessments are being conducted but frequently do not contain all required elements. Only 33% of the sampled providers' assessments included assessment of all required elements. The most frequently omitted risk areas were "clinical assessment or reassessment processes" and "use of high-risk procedures."<br>• Risk triggers and thresholds were referenced in 67% of the provider assessments in the sample but evidence of risk triggers and thresholds being utilized effectively in the risk assessment and management process was not consistently observed. For example, a provider policy may state it "… monitors all risks identified through the Proactive Risk Assessment process and reviews the impact of the risk reduction strategies on a quarterly basis. The (provider) additionally monitors all Risk Triggers and Thresholds | |

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| | | identified by DBHDS." But the provider demonstrated no evidence of identifying risk triggers and thresholds for identified risk areas or using them in their risk monitoring processes. | |
| **30.02:** The DBHDS Office of Licensing publishes guidance on serious incident and quality improvement requirements.<br><br>In addition, DBHDS publishes guidance and recommendations on the risk management requirements identified in #1 above, along with recommendations for monitoring, reducing, and minimizing risks associated with chronic diseases, identification of emergency conditions and significant changes in conditions, or behavior presenting a risk to self or others. | DBHDS has published numerous information and/or guidance documents guidance on serious incident and quality improvement requirements.<br><br>DBHDS has published guidance and recommendations on the risk management requirements, along with recommendations for monitoring, reducing, and minimizing risks associated with chronic diseases, identification of emergency conditions and significant changes in conditions, or behavior presenting a risk to self or others.<br><br>Documents Reviewed: *OIH Health Safety Alerts 2020-2021; OL Guidance for a Quality Improvement Program, 11/28/2020; OL Memo to Providers, 05/28/2020; OL Guidance for Risk Management 08/27/2020; OL Guidance for Serious Incident Reporting, 11/28/2020; DBHDS "Memo* | DBHDS published detailed guidance for providers to utilize in developing and implementing their policies and practices that address serious incidents and quality improvement programs. Guidance documents included the following: *"Individuals with Developmental disabilities with High-Risk Health Conditions" 05/28/2020, "Guidance for a Quality Improvement Program", 11/28/2020; "Guidance for Risk Management", 08/27/2020; and "Guidance for Serious Injury Reporting", 11/28/2020.* These guidance documents include recommendations on the required content of a Quality Improvement Plan, the importance of adequately supporting individuals with high-risk health conditions, the components of a provider risk management program, and detailed definitions and instructions for reporting of serious incidents. The trainings focused on methods for identifying risk and developing successful risk mitigation efforts, and the critical benefits of having comprehensive and effective risk management and quality improvement strategies.<br><br>DBHDS also provided training opportunities for providers to become more familiar with these requirements, and resources that are available to assist them in their serious incident management processes and quality assurance program development and implementation. Trainings included *"PC ISP Module 3 – Identifying Risk"* and *"Risk Management and Quality Improvement Strategies", 12/10/2020.*<br><br>The *OIH Health Safety Alerts 2020-2021* summary document identifies guidance published by the Office of Integrated Health (OHI) on high-risk health conditions along with recommendations for monitoring, reducing, and minimizing risks associated with chronic diseases, identification of emergency conditions and significant changes in conditions, or behavior presenting a risk to self or others. Some examples of publications in 2020 include safety alerts on diabetes management, choking, pneumococcal vaccine, influenza, dehydration, care considerations for epilepsy and seizure disorders. In 2021, safety alerts were published on psychotropic medications and sepsis. | Met |

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| | *to Providers, 06/16/2020: Incident Management Unit Care Concern Threshold Joint Protocol, 01/19/2021; DBHDS PowerPoint training Identifying Risk; "Risk Management and Quality Improvement Strategies", 12/10/2020.* | | |
| **30.03:** DBHDS publishes on the Department's website information on the use of risk screening/assessment tools and risk triggers and thresholds. Information on risk triggers and thresholds utilizes at least 4 types of uniform risk triggers and thresholds specified by DBHDS for use by residential and day support service providers for individuals with IDD. This information includes expectations on what to do when risk triggers or thresholds are met, including the need to address any identified risks or changes in risk status in the individual's risk management plan. | DBHDS has developed and made available to providers a significant amount of information about risk screening and assessment tools and processes.<br><br>A description and evaluation of the OL monitoring system is described in Section 30.07 below where requirements for DBHDS to monitor that providers appropriately respond to and address risk triggers and thresholds is addressed in more detail.<br><br>Documents Reviewed: *RAT Form Annual Risk Awareness Tool, June 2020; RAT Memo Risk Awareness Tool, 06/16/2020; Risk Awareness Tool Instruction Document, 06/02/2020; Quality Improvement Risk Management Training November 2020;* | DBHDS has continued efforts to develop and refine reference materials, guidance documents and training curricula that relate to provider responsibilities for risk screening and assessment. They developed a *Risk Awareness Tool (RAT), RAT Form Annual Risk Awareness Tool, June 2020,* and published guidance, *Risk Awareness Tool Instruction Document, 06/02/2020,* on how the RAT can be integrated with information from the Support Intensity Scale (SIS) and utilized to increase awareness of a potential for a harmful event to occur. The RAT includes assessments related to pressure injury, aspiration pneumonia, fall with injury, dehydration, bowel obstruction, sepsis, seizure, community safety risks, self-harm, elopement, and lack of safety awareness. Providers were informed on 06/12/2021, *RAT Memo Risk Awareness Tool, 06/16/2020* that DBHDS would begin requiring use of the RAT in the process of developing individualized services plans on 07/01/2020.<br><br>DBHDS published *Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan, 06/2020* to give providers detailed guidance on the purpose, development, and implementation of a comprehensive risk management program for their organization. This document includes definitions and descriptions of risk triggers and thresholds and guidance on their appropriate use in the provider's risk management program. If a care concern is identified indicating a threshold for an event-based trigger is met, it signals the need for a review to determine why these incidents are occurring and whether changes may be necessary to prevent re-occurrence of more serious harm. Examples are included for the provider to follow demonstrating how to approach the additional analysis through "a review or a root cause analysis to understand the causes … Examining these questions and | Met |

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| | *Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan, 06/2020.* | others can help to determine whether modifications to an individual's care plan or environment may be necessary to mitigate the risk." The document includes references to and instructions for use of the Risk Awareness Tool and Support Intensity Scale as risk assessment tools and how these tools can become an essential resource in the development of individualized services plans.<br><br>The *Quality Improvement Risk Management Training November* 2020 contains guidance to providers that notes that DBHDS defined risk triggers and thresholds as care concerns through review of serious incident reporting conducted by the Incident Management Unit. It also identifies what each of the five care concern thresholds are. The OL IMU reviews each serious incident report upon receipt from the provider. This review entails both a specific review of the incident itself and a review to determine if the provider has reported similar serious incidents that could raise a concern about a provider's ability to ensure the adequacy of supports to one or more individuals they serve.<br><br>The requirements for DBHDS to monitor that providers appropriately respond to and address risk triggers and thresholds is described in Section 30.07 below. | |
| **30.04:**<br>At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections.<br><br>Inspections will include an assessment of whether providers use data at the | The annual licensing review includes an assessment of the provider's compliance with regulations relevant to the provider's risk management program.<br><br>The DBHDS process for assessing compliance with the risk management requirements in the Licensing Regulations is documented in significant detail in the OL Annual Checklist Compliance Determination Chart- | DBHDS has established a set of licensing regulations at *12VAC35-105-520.A-E* that contain requirements for a risk manager to oversee the provider's risk management program; a written plan to identify, monitor, reduce and minimize harms and risks of harm; a requirement for an annual systemic risk assessment that identifies and responds to practices, situations, and policies that could result in the risk of harm to individuals and that incorporate uniform risk triggers and thresholds; and a requirement to conduct a safety inspection, at least annually, of each service location that includes recommendations for safety improvements.<br><br>DBHDS revised the *OL Annual Checklist Compliance Determination Chart, 02/24/2021.* This detailed written guidance contains instructions for licensing specialists about how to review evidence, make compliance determinations, and document non-compliance, if identified, on a licensing report (Corrective Action Plan) for each regulation that is evaluated during the annual licensing inspection. The Corrective Action Plan contains the regulatory requirement, compliance | Met * |

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| individual and provider level, including, at minimum, data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems.<br><br>The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations. | FY2021.<br><br>The DBHDS process for assessing compliance with the risk management requirements in the Licensing Regulations is comprehensive and sufficient to accurately assess a provider's compliance with these regulations.<br><br>OL reviewed approximately 97% of providers for compliance with risk management requirements in 2020 licensing inspections.<br><br>2021 annual licensing inspections began in 02/2021 and are ongoing at this time. OL reported 94 inspections had been completed when the 12 sample packets were selected.<br><br>D*ocuments Reviewed: Regulations-12VAC35-105-520.A-E; Report DW-0097- Jan-June 30, 2020, 08/25/2020; Internal Protocol for Assessing Compliance with 12VAC35-105-520 and 12VAC35-105-160.E – 2021; OL Annual Checklist Compliance Determination Chart,* | determination, description of non-compliance, provider actions to come into compliance, and the projected date for completion of the actions.<br><br>DBHDS developed the *Internal Protocol for Assessing Compliance with 12VAC35-105-520 and 12VAC35-105-160.E – 2021* to provide additional detailed instruction for licensing specialists regarding compliance with specific regulations including *12VAC35-105-520.A-E.* The document states "If it is determined during an annual inspection that the provider failed to comply with any component of regulation 12VAC35-105-520.A-E, the Office of Licensing shall issue a licensing report describing the non-compliance and requesting the provider submit a Corrective Action Plan (CAP) for addressing all components of the cited violation."<br><br>A review of a sample of 12 licensing evidence packets completed in 2021 indicated that licensing specialists were consistently evaluating providers' compliance with regulatory requirements as 12VAC35-105-520.A-E.<br><br>The Licensing Regulation Compliance Report, *Report DW-0097-Jan-June 30, 2020* for the period 01/01/2020-06/30/2020 documented that licensing reviews made regulatory compliance determinations for 97% of providers regarding their compliance with requirements 520.A-520D and 96% of providers at 520.E. Based on this data, DBHDS exceeded the threshold requirement to assess at least 86% of licensed providers for their compliance with risk management requirements in the licensing regulations during their annual inspections in SFY 2020. A complete set of compliance data for licensing inspections conducted in SFY 2021 will not be available until after the 18th Review Period is completed.<br><br>The Commonwealth completed the required assessments of providers. Based on review of 12 annual licensing review evidence packets for SFY21, reviews are comprehensive and sufficient to accurately assess a provider's compliance with these regulations, they included citations for areas found out of compliance and recommendations for further action by the provider, as necessary. The Commonwealth will continue to meet the requirements of this compliance indicator by completing annual assessments of at least 86% of providers | |

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| | *02/24/2021; Performance Measure Indicator documentation for provider compliance with risk management regulations, updated 09/18/2020; MQ for Data Verification 30.4, 09/10/2020; Verification 30.4, 09/10/2020; DBHDS Quality Management Plan FY2020; Evidence packets for 12 annual licensing reviews conducted in 2021.* | regarding their compliance with risk management requirements in the licensing regulations and that those inspections continue to include each of the elements identified in the compliance indicator.<br><br>For this indicator to be determined Met in the future, the Licensing assessment process will determine whether year over year trends his Indicator, a second year of data is required to identify over-year trends and patterns and the use of baseline data to assess | |
| **30.05:** On an annual basis, the Commonwealth determines that at least 86% of DBHDS licensed providers of DD services are compliant with the risk management requirements in the Licensing Regulations or have developed and implemented a corrective action plan to address any deficiencies. | The *Report DW-0097-Jan-June 30, 2020*, for the period 01/01/2020-06/30/2020 (SFY2020) documents the percentage of providers compliant with each of the five licensing regulations as follows: 520.A-89.42%, 520.B-92.19%, 520.C-79.88%, 520.D-87.94% and 520.E-86.21%.<br><br>The *Risk Management Review Committee Annual Report, 07/01/2019-06/30/2020 documents the same individual percentage compliance data noted in the previous paragraph. It also reports a total compliance figure of 82%.*<br><br>The *Developmental Disabilities* | Based on data collected through the implementation of the licensing processes related to risk management programs described with regard to 30.01 above, DBHDS reported they did not achieve compliance with this Compliance Indicator.<br><br>The source documents *Report DW-0097-Jan-June 30, 2020*, and the *Risk Management Review Committee Annual Report, 07/01/2019-06/30/2020* identify compliance with four of five individuals' risk management requirements in the Licensing Regulations. For the fifth requirement, 520.C relating to completion of an annual systemic risk assessment, DBHDS reported that only 79.88% of providers fulfilled this requirement.<br><br>It was unclear how 82% of the licensed providers was determined to be compliant in the *Risk Management Review Committee Annual Report* and in the *Developmental Disabilities Quality Management Plan Annual Report and Evaluation – State Fiscal Year 2020 Completed: October 2020*; however, this figure was not considered in the conclusion for this compliance indicator. Compliance will be met when the 86% of licensed providers are compliant with the five individual requirements relating to risk management in the Licensing Regulations. | Not Met |

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| | *Quality Management Plan Annual Report and Evaluation – State Fiscal Year 2020 Completed: October 2020* reported that 82% of licensed providers met regulatory requirements for risk management programs but did not contain an explanation of how this compliance percentage was calculated.<br><br>The *Risk Management Review Committee Annual Report, 07/01/2019-06/30/2020* and the *Developmental Disabilities Quality Management Plan Annual Report and Evaluation – State Fiscal Year 2020 Completed: October 2020* each reported that 82% of licensed providers met regulatory requirements for risk management programs. This percentage falls below the 86% threshold established in this Compliance Indicator.<br><br>For this monitoring period, DBHDS has not yet completed sufficient reviews to determine compliance with this Compliance Indicator.<br><br>*Documents Reviewed:* | | |

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| | *Regulations-12VAC35-105-520.A-E; Report DW-0097-Jan-June 30, 2020, 08/25/2020; Risk Management Review Committee Annual Report, 07/01/2019-06/30/2020; Developmental Disabilities Quality Management Plan Annual Report and Evaluation – State Fiscal Year 2020 Completed: October 2020; Performance Measure Indicator Documentation for Provider Compliance with Risk Management Regulations 09/18/2020; MQ for Data Verification 30.4_30.5, 9/10/20; RMRC minutes 9/21/20 and 11/16/20; Evidence packets for 12 annual licensing reviews conducted in 2021.* | | |
| **30.06:** DBHDS publishes recommendations for best practices in monitoring serious incidents, including patterns and trends which may be used to identify opportunities for improvement. Such recommendations will include the implementation of an Incident Management | DBHDS established a regulation at *12VAC35-105-160.C* that requires providers to collect, maintain and review at least quarterly all serious incidents as part of their quality improvement program.<br><br>DBHDS published guidance and information documents relevant to this indicator including *OL Guidance for* | The regulation at *12VAC35-105-160.C* establishes a requirement for providers to conduct at least quarterly review of serious incidents. While the regulatory requirement does not specify that this process must be structured and carried out by a Risk Management Review Committee, the process description, guidance documents, and provider training appear to meet the requirements of this indicator.<br><br>DBHDS published guidance documents and provided training that included information related to best practices in monitoring serious incidents including:<br>• *Guidance for Serious Incident Reporting, 11/28/2020* that contains definitions of reportable serious incidents, procedures for reporting serious incidents, requirements to have a root cause analysis policy and guidance on when a root cause analysis is required, and requirements for a serious incident | Met |

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| Review Committee that meets at least quarterly and documents meeting minutes and provider system level recommendations. | *Serious Incident Reporting, 11/28/2020* and *Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan, 06/30/2020.*<br><br>DBHDS provided comprehensive training relevant to this indicator including *Final Licensing Regulations PowerPoint Training, 10/2020, Quality Improvement Risk Management Training, November 2020*, and *Risk Management and Quality Improvement Strategies Webinar, 12/10/2020*<br><br>*Documents Reviewed:*<br>*OL Guidance for Serious Incident Reporting, 11/28/2020; Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan, 06/30/2020; Final Licensing Regulations PowerPoint Training, 10/2020; Questions and Answers from QI-RM-RCA Training November 2020; 11/2020; Quality Improvement Risk Management Training, November 2020; Risk Management and Quality Improvement Strategies* | management policy.<br>• *Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan, 06/30/2020* that provides guidance to providers to develop and implement a comprehensive risk management program that includes reporting and analysis of serious incidents.<br>• *Final Licensing Regulations PowerPoint Training, 10/2020,* that included information on what a provider must do to comply with the regulatory requirements in 12VAC35-105-160.<br>• *Quality Improvement Risk Management Training, November 2020* that included requirements for a serious incident policy, a root cause analysis policy, a documented risk management program, the purpose, structure and content of a systemic risk assessment, uniform risk triggers and thresholds and serious incident review and analysis.<br>• *Risk Management and Quality Improvement Strategies Webinar, 12/10/2020* that addressed required components of both a comprehensive risk management and quality improvement program and the use of data to measure and analyze operations and identify and reduce risks. | |

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| | *Webinar, 12/10/2020.* | | |
| **30.07:** DBHDS monitors that providers appropriately respond to and address risk triggers and thresholds using Quality Service Reviews, or other methodology. Recommendations are issued to providers as needed, and system level findings and recommendations are used to update guidance and disseminated to providers. | The *Incident Management Unit Care Concern Joint Protocol* described one approach to DBHDS monitoring that providers appropriately respond to and address risk triggers and thresholds, but it was limited in scope.<br><br>Other examples that DBHDS cited as current or potential methodologies for monitoring that providers appropriately respond to and address risk triggers included: *Incident Management Unit Care Concern Joint Protocol; Risk Assessment Tool* (RAT); *On-Site Visit Tool (OSVT)*; and *DBHDS QSR PCR Tool (Items 329-332)*<br><br>DBHDS reports that some of these latter monitoring methodologies are in the early stages of planning and/or implementation and do not yet produce sufficient reliable and valid data to meet the requirements of this Compliance Indicator. | DBHDS established a requirement for inclusion of risk triggers and thresholds at *12VAC35-105-520.D,* which is stated as follows: "The systemic risk assessment process shall incorporate uniform risk triggers and thresholds as defined by the department." As described with regard to Compliance Indicator 30.03, DBHDS is focusing on the development and implementation of several processes to inform and train providers on these requirements, some of which include guidance regarding identifying risks and how providers should use the Risk Awareness Tool to address risk triggers.<br><br>However, this Compliance Indicator requires that DBHDS also has adequate processes in place to monitor that providers are appropriately responding to and addressing risk triggers and thresholds. Based on documentation reviewed and interviews with DBHDS staff, the department did not yet have such adequate processes in place. One effort along this line was the implementation of the *Incident Management Unit Care Concern Joint Protocol*, as described in detail with regard to Compliance Indicator 30.01, but, standing alone, it did not constitute a sufficiently comprehensive monitoring approach due to its limited scope.<br><br>DBHDS should take steps to develop a clear methodology for monitoring that providers appropriately respond to and address risk triggers and thresholds. The methodology may be multi-faceted, but will need to be coordinated and comprehensive. The following provides a summary of other activities and strategies DBHDS is implementing, or is planning to, that might be relevant, with modifications, to the development and coordination of an adequate monitoring methodology in the future:<br>• The Quality Service Review PCR Tool includes assessment of several specific elements (i.e., Indicators 329-332), including, 1) evidence that the RAT was completed with the annual ISP, 2) whether the RAT summary of actions to develop a plan to mitigate potential risk was uploaded into WaMS, 3) Evidence that the provider completed the follow-up actions summarized by the Risk Awareness Tool , and 4) evidence that recommendations provided by the qualified professional(s) or therapeutic consultant in behavior management were implemented. These four | Not Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | *Documents Reviewed: 12VAC35-105-520.D; 11/28/2020 'Guidance for Serious Incident Reporting 06/2020;PowerPoint training, Final Licensing Regulations October 2020 10/2020; DBHDS FAQs during the 11/05/2020 and 11/12/2020 Risk Management and Root Cause Analysis training; Risk Awareness Tool Instruction and Resource Document" v.5.20. Risk Awareness Tool (RAT) and Associated Training, 06/16/2020; DBHDS QSR PCR Tool (Items 329-332)* | inquiries (Indicators 329-332) do not refer to the uniform risk triggers and thresholds and appear insufficient as a monitoring methodology to for determining whether providers appropriately respond to and address risk triggers and thresholds<br>• DBHDS staff reported the imminent implementation of a look behind process for the RAT to sample the accuracy and quality of implementation. DBHDS was not yet prepared to share additional details about how and whether this methodology would fulfill the requirement to determine whether providers appropriately respond to and address risk triggers and thresholds.<br>• In June 2020, DBHDS rolled out an On-Site Visit Tool (OSVT). This is as assessment tool for support coordinators/case managers to determine whether an individual has had a change in status or needs and whether services are being implemented appropriately and remain appropriate. The tool includes two questions that potentially address risks for the individual who is being assessed, but the OSVT is not designed for the support coordinator to monitor or determine whether providers appropriately respond to and address risk triggers and thresholds.<br>• The Risk Management Review Committee routinely monitors results from licensing reviews and other relevant sources to identify trends/patterns of results. The information the RMRC gathers is used as a reference when the department is developing or revising guidance to providers. However, it does not implement a monitoring methodology of providers' use of triggers and thresholds.<br><br>In summary, DBHDS has conceptualized a multifaceted framework for informing and training providers to identify and respond to risk triggers and thresholds for individuals. The processes described in the documents reviewed and interviews, however, did not include a comprehensive DBHDS monitoring methodology to determine whether providers appropriately respond to and address risk triggers and thresholds. With the exception of the Care Concerns process, which was limited in scope, the processes described also did not specify how a DBHDS monitoring methodology would lead to DBHDS issuing recommendations. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | The existing and planned monitoring mechanisms described by DBHDS regarding the use of risk triggers and thresholds in provider risk management programs have not yet provided findings and recommendations. A more thorough assessment of compliance with the requirements of this indicator can be made when DBHDS implements a monitoring mechanism that provides sufficient information regarding the extent to which providers appropriately respond to and address risk triggers and thresholds and formulate recommendations that are issued to providers as needed, and system level findings and recommendations are used to update guidance and disseminated to providers. | |
| **30.08:** DBHDS has Policies or Departmental Instructions that require Training Centers to have risk management programs that:<br>1. Reduce or eliminate risks of harm;<br>2. Are managed by an individual who is qualified by training and/or experience;<br>3. Analyze and report trends across incidents and develop and implement risk reduction plans based upon this analysis; and<br>4. Utilize risk triggers and thresholds to | The DBHDS DI 401 (RM) 03 sets requirements for risk management programs for DBHDS-operated facilities including the Training Center.<br><br>Training Center policies and procedures charge various committees with specific key elements of a risk management program to reduce or eliminate risks of harm, to analyze and report trends across incidents and develop and implement risk reduction plans based on the analysis.<br><br>The Training Center has a facility risk manager whose responsibilities include | DBHDS Departmental Instruction (DI) 401 (RM) 03 entitled "Risk and Liability Management" applies to all DBHDS-operated facilities including the Training Center. As summarized below, the DI includes most, but not all of the four specified requirements.<br>• It states the purpose of the DI is to "establish a comprehensive and uniform risk management program intended to reduce, eliminate, correct, manage or control risk through the identification, investigation, analysis and treatment of hazards that may result in harm to individuals receiving services" and others and prevent losses to the Commonwealth.<br>• It states that the facility director will be responsible for implementing a risk management program that is "managed by a facility risk manager who is qualified by training and/or experience." It further states that the risk manager will develop, coordinate and administer an interdisciplinary facility-wide risk management program. However, the DI does not state any minimum criteria for training and/or experience needed to be considered qualified.<br>• It identifies the risk manager's responsibilities relevant to incident reporting and data analysis and for developing and implementing risk reduction plans based on incident analyses.<br>• It states the risk management program must incorporate risk triggers and thresholds and provides definitions. While the definition of a risk trigger (i.e., an event or condition that causes a risk to occur) was essentially consistent | Not Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| identify and address risks of harm. | oversight and operations related to the facility's risk management program.<br><br>The DI states the facility director will be responsible for implementing a risk management program that is "managed by a facility risk manager who is qualified by training and/or experience" but does not state any minimum criteria related to training and/or experience. The Training Center policies and procedures also do not articulate a minimum set of qualifications.<br><br>The DI states the facility risk management program must incorporate risk triggers and thresholds, but did not appear to provide sufficient guidance about how to implement the concept of risk thresholds. The Training Center had relevant internal policies that contained instruction and expectation with regard to some elements of a risk management program, but they did not address the minimum qualifications | with that DBHDS has otherwise defined, the definition of risk threshold (i.e., the amount of risk a facility is willing to accept) did not appear to provide sufficient guidance about how to identify and address risks of harm when implementing the concept of risk thresholds.<br><br>Training Center staff also provided copies of relevant internal policies, each which contained instruction and expectation with regard to elements of a risk management program. Overall, it appeared that the Training Center had policies that sufficiently described expectations and processes to address the reduction and or eliminate risks of harm, as well as the analysis, reporting and risk reduction planning across many domains. However, these policies did not address the minimum requirements for qualifications (i.e., training and or experience of the facility risk manager.) In addition, the documentation provided for review also did not clearly evidence the Training Center policies regarding the utilization of risk triggers and thresholds to identify and address risks of harm.<br><br>The SEVTC chart entitled SEVTC Triggers/Thresholds, November 2020 listed various triggers and thresholds, but did not differentiate between them or clearly indicate in all instances when a trigger or threshold might be activated. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | requirements for the facility risk manager or clearly evidence the Training Center policies regarding the utilization of risk triggers and thresholds to identify and address risks of harm.<br><br>DBHDS also provided a chart entitled SEVTC Triggers/Thresholds, November 2020. that listed various triggers and thresholds, but did not differentiate between them or clearly indicate in all instances when a threshold might be might.<br><br>*Documents Reviewed: DBHDS Departmental Instruction 401 (RM) 03 Risk and Liability Management; Risk Management Review Committee (RMRC) minutes dated 10/19/2020, 11/16/2020, and 01/25/2021; SEVTC Instruction Number 2002, Risk Management Program 7/9/19; Risk Management Plan, undated; SEVTC Instruction Number 8015, 2/28/19; SEVTC Instruction Number 9090, 10/7/19; SEVTC Instruction Number 8000 Infection Prevention* | | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | *and Control Program, Continuous Quality Improvement/Risk Management Plan, 2020-202* | | |
| **30.09:** With respect to Training Centers, DBHDS has processes to review data and trends and ensure effective implementation of the Policy or Departmental Instruction. | The 10/07/2019 *SEVTC "Quality Improvement Program and Quality Council Committee"* policy that describes process requirements relevant to this indicator.<br><br>The *DBHDS Departmental Instruction 401 (RM) 03 Risk and Liability Management* requires that Training Center has a risk manager whose responsibilities include oversight and operations related to the facility's risk management program. The SEVTC Risk Manager is a voting member of the RMRC.<br><br>*Documents Reviewed: DBHDS Departmental Instruction 401 (RM) 03 Risk and Liability Management; Risk Management Review Committee charter; SEVTC Quality Improvement Program and Quality Council Committee policy, RMRC minutes* | The RMRC charter outlines roles and responsibilities of the RMRC to review data and trends identified by providers (including the training center). At the time of the previous study, DBHDS had just begun to integrate SEVTC. For this review, DBHDS had taken the following steps to ensure that, with respect to the Training Center, processes were in place to review data and trends and ensure effective implementation of the Policy and Departmental Instruction.<br>• *Departmental Instruction 316 (QM) 20 Quality Improvement* charter was amended to expand upon the requirements for the Training Center with regard to quality and risk management.<br>• The facility's risk manager is also a voting member of the RMRC.<br>• RMRC meeting minutes from 10/19/2020, 11/16/2020, and 01/25/2021 included presentations by the SEVTC risk manager related to the Training Center's risk management program and systems. For each of those meetings, the SEVTC risk manager made presentations regarding specific elements of the SEVTC risk management program. The presentations addressed data collection and analysis procedures SEVTC employs to identify and appropriately assess risks and take actions, where necessary, to address those risks.<br><br>However, as described above with regard to Compliance Indicator 30.08, the *DBHDS Departmental Instruction 401 (RM) 03 Risk and Liability Management* requires utilization of risk triggers and thresholds, but provides insufficient guidance to ensure effective implementation of the requirements for utilization of risk triggers and thresholds. In addition, none of the documentation submitted for review provided evidence of how the Training Center actually implemented the use of risk triggers and thresholds. | Not Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | *10/07/2019; 10/19/2020, 11/16/2020, and 01/25/2021.* | | |
| **30.10:** To enable them to adequately address harms and risks of harm, the Commonwealth requires that provider risk management systems shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such events occur, or the risk is otherwise identified.<br><br>Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards.<br><br>If corrective actions do not have the intended effect, DBHDS takes | Virginia's Administrative Code at 12VAC35-105-160.D.2 require providers to report *incidents* of common risk and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) through the Serious Incident Management system.<br><br>Virginia's Administrative Code at *12VAC35-105-520.C* require providers to "conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services." However, neither these regulations or any other documents provided, specify that the provider risk management systems shall identify the *incidence* of common risks and | DBHDS has defined incidents of common risk and conditions faced by people with IDD that contribute to avoidable deaths as reportable serious incidents. While there is not otherwise a specific licensing regulation that references these common risks and conditions, their being defined as reportable serious incidents is evidence that the requirement to identify these incidents and to take prompt action when they occur is covered by Virginia's Administrative Code at 12VAC35-105-160.D.2. In addition, *12VAC35-105-520.B* requires all providers to "implement a written plan to identify, monitor, reduce, and minimize harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability," and at *12VAC35-105-520.C* requires providers to "conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services."<br><br>As described with regard to Compliance Indicators 29.02-29.05 of this report, for reportable incidents, DBHDS has in place a triage and review system. If a provider is found not to have reported an incident involving one or more of these types of common risks and conditions that contribute to avoidable deaths, a CAP is required for non-compliance.<br><br>This was positive. However, this Compliance Indicator requires that provider risk management systems identify the *incidence* of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such events occur, or the risk is otherwise identified. The term "incidence" refers to the rate of occurrence of a disease, injury or condition in a given population. While DBHDS does have protocols in place that require providers to report *incidents* of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcer), in practice it does not appear that DBHDS specifically requires providers | Not Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| further action pursuant to V.C.6. | conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers.<br><br>*Documents Reviewed: 12VAC35-105-160.D.2, 12VAC35-105-520.B, 12VAC35-105-520.C, 12VAC35-105-170.G and 12VAC35-105-170.H; DBHDS OL Guidance for Serious Incident Reporting, 11/28/2020; Risk Awareness Tool Instruction and Resource Document" v.5.20; OL Incident Management Unit Care Concern Threshold Joint Protocol, 01/19/2021; OL Guidance on Corrective Action Plans (CAPs),08/22/2020; Evidence packets for 12 annual licensing reviews conducted in 2021.* | to incorporate incidence tracking of these conditions into their risk management programs. Therefore, while licensing specialists might cite providers for not reporting individual incidents of these risks and conditions, they do not cite or require corrective action when providers fail to track and address the incidence of these risks and conditions across the entire populations they serve. An effective risk management program, even at the provider level, should do so.<br><br>Of note, only one of twelve providers in the consultant's study sample included a reference to or description of the provider's policy and procedures for addressing common risks and conditions faced by people with IDD that contribute to avoidable deaths in their risk management or quality improvement policies/plans. The OL director stated that plans are being formulated to address expectations that providers include this and related process descriptions in their policies and procedures. This guidance will be drafted once OLS completes analysis of all annual licensing reviews for 2021.<br><br>This CI also requires that DBHDS document that corrective actions have the intended effect, which in turn requires DBHDS to confirm that not only were the actions required by the CAP implemented, but that the outcome was achieved. That said, because DBHDS does not currently cite or require corrective action when providers fail to track and address the incidence of these risks and conditions across the entire population they serve, and have not yet issued clear guidance in this area, this study cannot yet evaluate the requirement that DBHDS takes further action pursuant to V.C.6. when corrective actions do not have the intended effect. | |
| **30.11:** For each individual identified at high risk pursuant to Indicator #6 of V.B, the individual's provider shall develop a | DBHDS did not have a process in place pursuant to Compliance Indicator 29.19 for providers to identify individuals who are at high risk due to medical or | As described above with regard to Compliance Indicators 29.19 and 30.07, DBHDS had developed several new methodologies to assess and monitor risk and implementation of risk mitigation plans (i.e., the RAT, OSVT, Crisis Assessment and the QSR.) In addition, as described above with regard to Compliance Indicators 29.02 and 30.04, DBHDS has licensing regulations and protocols in place for assessment of provider compliance with the regulatory | Not Met |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| risk mitigation plan consistent with the indicators for III.C.5.b.1 that includes the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur.<br><br>The provider shall implement the risk mitigation plan.<br><br>Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards.<br><br>If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6.<br><br>. | behavioral needs or other factors that lead to a SIS level 6 or 7 or to report this information to the Commonwealth.<br><br>DBHDS did not have a process in place to track that providers for such individuals developed or implemented a risk mitigation plan consistent with the indicators for III.C.5.b.1 that include the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur.<br><br>DBHDS did not have a process in place for this specific group of individuals to show or ensure that needed corrective action plans were written and implemented for all providers, including CSBs, that do not meet standards, or that, if corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6.<br><br>*Documents Reviewed:*<br>*Regulatory requirements at 12VAC35-105-665;* | requirements for risk management, including identifying the need for corrective action and ensuring implementation of corrective action plans.<br><br>However, as also described above with regard to Compliance Indicator 29.19, DBHDS did not have a process in place for providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 or to report this information to the Commonwealth. Without such to identify and track such individuals, DBHDS did not have the ability to track the development or implementation of a risk mitigation plan consistent with the indicators for III.C.5.b.1 that include the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur. Similarly, without these protocols in place, for this specific group of individuals, DBHDS did not have the ability to identify when or if corrective action plans were needed, written and effectively implemented by providers, including CSBs.<br><br>What's more, it appeared that the current licensing processes might even minimize the level of surveillance for this group of high-risk individuals rather than heighten it. For example, licensing surveys rely on a statistically significant random sample upon which to draw conclusions about a provider's implementation of the regulatory requirements, including risk identification and risk mitigation planning. Because the population of individuals with risk substantial enough to lead to a determination of a SIS level 6 or 7 is a very small percentage of the total population of individuals served in the DD waivers, their representation in licensing survey samples will also likely be too small to generalize findings to confirm that this Indicator has been properly implemented and met. Based on interview with DBHDS staff, they did not currently employ any methodology to stratify the sampling process to ensure this group of individuals received the warranted heightened surveillance. However, DBHDS staff agreed that this required further examination and indicated they intended to take some time to develop a comprehensive methodology that integrated the various risk assessment and risk assessment approaches. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | *Risk Awareness Tool Process and Planning PowerPoint training, 06/2020; Guidance on Corrective Action Plans (CAPs) 08/22/2020.*<br>*Risk Awareness Tool Instruction and Resource Document v.5.20.*<br>*Memo on Risk Awareness Tool (RAT) and Associated Training memo, 6/16/2020* | | |

## Recommendations

1. DBHDS should continue to provide guidance to providers on the requirement to have a written root cause analysis policy that describes the criteria for and methodology by which they will complete root cause analyses consistent with the requirements at 12VAC35-105-160.E. (29.04)

2. DBHDS staff should focus on improving the measurability of quality improvement initiatives and corrective action plans and on the rigorous use of data in reviewing their impact and in supporting future related decision-making. (29.10)

3. DBHDS should encourage the use of longitudinal analysis of data similar to that shown in the run chart graph detailing the frequency of falls and trips on page 9 of the RMRC Annual Report. This longitudinal approach allows for measurement of operations or impacts of corrective actions over time rather than by viewing data as a snapshot in time. (29.31)

4. DBHDS should consider additional provider training to address the required elements of an annual systemic risk assessment with specific examples of how the provider is to incorporate uniform risk triggers and thresholds defined by the department into this assessment process. The training should differentiate these expectations from the established process for providers to address care concerns identified by the DBHDS Incident Management Unit. Guidance should then be developed for licensing specialists to identify what evidence they should consider in determining whether the provider is complying with the requirement to incorporate uniform risk triggers and thresholds into their annual systemic risk assessment process. (30.01)

5. DBHDS should report the percentage of the licensed providers that are compliant with the five requirements at 12VAC35-105-520.

6. DBHDS should implement a monitoring mechanism that provides sufficient information regarding the extent to which a provider appropriately responds to and addresses risk triggers and thresholds and formulate recommendations that are issued to providers, as need, and system level findings and recommendations are used to update guidance and disseminated to providers. (30.07)

7. DBHDS should provide additional guidance to the Training Center to ensure effective implementation of the requirements for utilization of risk triggers and thresholds. This could be done through revision of the DBHDS Departmental Instruction 401 (RM) 08 Risk and Liability Management or through a separate document. (30.10)

**Attachment A: Interviews**

1. Heather Norton, Assistant Commissioner at Department of Behavioral Health and Developmental Services
2. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Government Relations
3. Jenni Schodt, Settlement Agreement Coordinator
4. Jae Benz, Director of Licensing
5. Stella Stith, IMU Manager
6. Melanie Murphy, SEVTC Facility Risk Manager
7. Taneika Goldman, State Human Rights Director

**Attachment B: Documents Reviewed**

1. RQC 1st QTR FY21 Report to the QIC
2. 2020 Quality Service Review Report to QIC DRAFT
3. 2020 Quality Service Review Report to QIC Final
4. Abuse, Neglect, and Exploitation Data - 2020.12.21
5. Abuse, Neglect, and Exploitation FY20
6. Annual Risk Awareness Tool June 2020
7. Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan
8. Case Management Steering Committee 2nd QTR Report to the QIC SFY2021
9. Case Management Steering Committee 3rd QTR Report to the QIC SFY2021
10. Case Management Steering Committee SFY2020 3rd and 4th Quarters Semi-Annual Report
11. Case Management Steering Committee SFY2021 1st and 2nd Quarters Semi-Annual Report
12. Change Request Form: Waiver management System (WaMS)
13. CMSC 1st QTR FY21 Report to RQC 11.20.2020
14. CMSC 3rd QTR Report to Region I RQC SFY2023
15. CMSC 3rd QTR Report to Region III RQC SFY2023
16. CMSC 3rd QTR Report to Region V RQC SFY2021
17. Corrective Action Protocol
18. CY2021 Reviews OHR Community Look-Behind Form Technical Guidance
19. DBHDS Departmental Instruction 316 (QM) 4.07.2021
20. DBHDS Departmental Instruction 316 (QM) 20 Review Summary 4.07.2021
21. DBHDS Developmental Disabilities Quality Management Plan Provider Listserv Notification 4.21.21
22. DBHDS QSR PCR Tool 10.22.2020
23. DBHDS Quality Management Plan FY2020 3.31.2021
24. Departmental Instruction 401 (RM) 03 Risk and Liability Management 9.4. 2020
25. Document Name
26. DRAFT_ Regional Quality Council Agenda FY21, 3rd Quarter
27. Email Confirmation on Posting of SY19 QM Plan 8-14-2020
28. Email Request on Posting of SFY19 QM Plan 8-14-2020
29. EMPLOYMENT 1st QTR FY21 Report to the RQC 112020
30. External Memo Contacting 911 Emergency Services
31. Falls Quality Improvement Initiative - 2020.10.19 Update
32. FY21 1st quarter- SE-ID -Draft Summer2020 Semi Annual Employment Report 10.4.2020
33. FY21 Revised Risk Management Review Committee Charter December 2020
34. FY21 RMRC Task Calendar and Charter Tasks
35. Guidance for Risk Management 8.27.2020
36. Guidance for Serious Incident Reporting 11.28.2020
37. Incident Management Unit Care Concern Joint Protocol 6.3.2020
38. Incident Management Unit Look-Behind Committee Description
39. Incident Management Unit Look-Behind Data Collection Tool FY20Q4
40. Incident Management Unit Look-Behind FY20Q4
41. Incident Management Unit Look-Behind Process
42. Incident Management Unit Look-Behind Process April 2 2020 Final
43. Incident Management Unit Look-Behind Report FY21Q1
44. Incident Management Unit Look-Behind Reviewer Sheet
45. Incident Management Unit Look-Behind Sample Calendar
46. Incident Management Unit Look-Behind Scoring Guide Draft
47. Incident Management Unit Triage Review Form 2-12-21
48. Individuals with Developmental Disabilities with High Risk Health Conditions Memo 5.28.2020
49. Instructions for reviewing Incidents in CHRIS 030920

50. Key Performance Area Workgroups 2nd QTR Report to the QIC SFY 2021
51. KPA 1st QTR FY21 Report to the RQC 112020
52. KPA Workgroups: Health, Safety and Wellbeing Community Inclusion and Integration Provider Capacity and Competency Report to the RQCs- 3rd QTR FY2021
53. Licensing Protocol No. 141 Revised 5.14.20
54. Local Human Rights Committee Behavior Treatment Plan Review Request Form
55. Meeting Minutes Quality Improvement Committee December 14, 2020_DRAFT
56. Meeting Minutes Quality Improvement Committee September 21, 2020
57. Memo OSVT Change of Status and ISP Implemented Appropriately 6.20.2020
58. Memo to RMRC 5.18.2020
59. Mortality Review Committee (MRC) 3rd QTR Report to the RQCs SFY2021
60. Mortality Review Committee 2nd QTR Report to the QIC SFY2021
61. Mortality Review Committee 3rd QTR Report to the QIC SFY2021
62. MQ for Data Verification 29.17
63. MQ for Data Verification 29.23
64. MQ for Data Verification 29.25
65. MRC_RQCReport_Nov2020
66. National Core Indicators 2019-20 In-Person Survey (IPS) reporting
67. National Core Indicators In-Person Survey (IPS) State Report 2019-2020 Virginia (VA) Report
68. OCQI-OCQM Quality Improvement & Facilitation Using Data to Set Priorities for their Regions
69. Office of Licensing Guidance on Corrective Action Plans (CAPS) 8.21.2020
70. Office of Licensing Internal Memo Health and Safety CAP Process Revisions/Clarification
71. Office of Licensing Regulations 12VAC35-105-520
72. OHR Community Look-Behind COVID remote review process
73. OHR Community Look-Behind Methodology
74. OHR Community Look-Behind Methodology CY2018
75. OHR Community Look-Behind Reviews Timeline 2021
76. OL 2020 Incident Reporting Guidance 8.22.21
77. OL Annual Checklist compliance determination chart
78. On-Site Visit Tool (OSVT) 6.20.2020
79. PC ISP Module 3 Identifying Risk
80. Performance Measure Indicator documentation for provider compliance with risk management regulations
81. Process Document - 29.17 OHR Community Look-Behind
82. Process Document - 29.23 Abuse and Neglect Prevalence
83. Process Document - 29.25 Seclusion and Restraint
84. Process Document Provider Risk Management Programs 1.1.2021
85. Protocol for Assessing Compliance with 12VAC35-105-520 and 12VAC35-105-160.E
86. Protocol NO 146 OHR Triage Process 5.08.2019
87. QIC Member Orientation Nov 2020
88. QIC update to RQCs 8-10-20
89. QII Tool February 2021
90. Quality Improvement & Facilitation Using Data to Set Priorities 8-10-20
91. Quality Improvement Committee Agenda December 15, 2020
92. Quality Improvement Committee Agenda March 22, 2021
93. Quality Improvement Risk Management Provider Training November 2020
94. Quality Improvement Risk Management Training November 2020
95. Quality Review Team Meeting Summary 11.17.2020
96. Quality Review Team Meeting Summary 2.17.2021
97. Region I RQC Approved Minutes 8.10.2020
98. Region I RQC FY21-Q2 DRAFT Minutes
99. Region II RQC Approved Minutes 11.05.2020

100. Region II RQC Approved Minutes 8.10.2020
101. Region III RQC Approved Minutes 8.10.2020
102. Region III RQC FY21-Q2 DRAFT Minutes
103. Region IV RQC Approved Minutes 11.05.2020
104. Region IV RQC Approved Minutes 8.10.2020
105. Region V RQC Approved Minutes 8.10.2020
106. Regional Quality Council 2nd QTR Report to the QIC SFY2021
107. Regional Quality Council 3rd QTR Report to the QIC SFY2021
108. Regional Quality Councils 3rd Quarter FY21 Review of Independent Reviewer Report and Recommendations
109. Risk Awareness Tool Instruction and Resource Document 6.2.2020
110. Risk Awareness Tool Memo June 2020
111. Risk Awareness Tool Presentation June 2020
112. Risk Awareness Tool Process and Planning Presentation June 2020
113. Risk Management Program Description FY21
114. Risk Management Review Committee (RMRC) 2nd QTR Report to the QIC SFY2021
115. Risk Management Review Committee 3rd QTR Report to the QIC SFY2021
116. Risk Management Review Committee (RMRC) 3rd QTR Report to the RMRC SFY2021
117. Risk Management Webinar 12.10.2020
118. RMRC - QII Initiative - Falls with Injury June2020
119. RMRC 2020 Q3 OHR Community Look-Behind 9.21.20
120. RMRC 2020 Q4 OHR Community Look Behind 12.22.20
121. RMRC 2nd QTR Report to the RQC
122. RMRC Annual Report FY20
123. RMRC Fall QII report to QIC Dec2020
124. RMRC Measure Tracking Log PMI January 2021
125. RMRC Meeting Minutes 1.25.2021
126. RMRC Meeting Minutes 10.19.2020
127. RMRC Minutes 11.16.2020 Approved
128. RMRC Minutes 9.21.20
129. RMRC Minutes ad hoc June 22 2020
130. RMRC Minutes excerpt 12.21.2020
131. RMRC Minutes excerpt 10.19.202
132. RMRC Minutes excerpt 9.21.2020
133. RMRC Minutes excerpt June 15 2020
134. RMRC Presentation Training Center Triggers and Thresholds 11.16.2020
135. RMRC Surveillance Measures Q1 SFY 2021
136. RMRC Work Group Update 11.16.20
137. RMRC Task Calendar and Charter Tasks
138. RQC Training Quality Improvement & Facilitation Using Data to Set Priorities 8.10.20
139. RQC Training Using RCA & Related Methods for Quality and Safety 8-10-20
140. Serious Incident Data Update
141. Serious Incident Data Update - 2020.11.16
142. Serious Incident Data Updates for Q1 SFY 2021
143. Serious Incidents and Office of Licensing Guidance Sept.23.2020
144. SEVTC Data on Restraints Falls and UTI January 2021
145. SEVTC Triggers and Thresholds November 2020
146. SFY20 CMSC QIC Subcommittee Work Plan
147. SFY20 KPA Workgroup QIC Subcommittee Work Plan
148. SFY20 MRC QIC Subcommittee Work Plan
149. SFY20 RMRC QIC Subcommittee Work Plan
150. SFY20 RQCs QIC Subcommittee Work Plan

151. SFY2020 Annual Mortality Report
152. SFY2020 RQC Summit Trainings with Mission Analytics and HSRI Chat Messages 8.10.20
153. SFY21 Case Management Steering Committee Charter 9.21.2020
154. SFY21 CMSC QIC Subcommittee Work Plan as of 2.2.21
155. SFY21 Community Inclusion and Integration Workgroup Charter 9.21.2020
156. SFY21 Health Safety and Wellbeing Workgroup Charter 9.21.2020
157. SFY21 KPA Workgroup QIC Subcommittee Work Plan as of 2.24.21
158. SFY21 Mortality Review Committee Charter 11.16.2020
159. SFY21 MRC QIC Subcommittee Work Plan as of 2.11.2021
160. SFY21 Provider Capacity and Competency Workgroup Charter 9.21.2020
161. SFY21 Quality Improvement Committee Charter 9.21.2020
162. SFY21 Regional Quality Council Charter 12.8.2020
163. SFY21 Risk Management Review Committee Charter 9.21.2020
164. SFY21 RMRC QIC Subcommittee Work Plan
165. SFY21 RMRC QIC Subcommittee Work Plan as of 1.25.21
166. SFY21 RQCs QIC Subcommittee Work Plan as of 2.24.21
167. SIR - Surveillance Data Review - 20200817
168. SIR Measures Quarterly 9.02.2021
169. Surveillance Measures Update - 2020.11.16
170. Surveillance Measures Update - 2021.02.22
171. Technical Notes for OHR Advocate Activities Tracking
172. Training Center Quality Improvement and Risk Management Structure and Plan
173. V.C.1 Description of Compliance_30.10
174. V.C.1 Description of Compliance_30.11
175. VA DBHDS Risk Management Webinar Final Handout 12.11.20
176. VA2020 QSR PCR Item333 10.22.2020

# APPENDIX H

## LIST OF ACRONYMS

| | |
|---|---|
| ADL | Activities of Daily Living |
| APS | Adult Protective Services |
| ADA | Americans with Disabilities Act |
| AR | Authorized Representative |
| AT | Assistive Technology |
| BCBA | Board Certified Behavior Analyst |
| BSP | Behavior Support Professional |
| CAP | Corrective Action Plan |
| CAT | Crisis Assessment Tool |
| CEPP | Crisis Education and Prevention Plan |
| CHRIS | Computerized Human Rights Information System |
| CIL | Center for Independent Living |
| CIM | Community Integration Manager |
| CI | Compliance Indicator |
| CIT | Crisis Intervention Training |
| CL | Community Living (HCBS Waiver) |
| CM | Case Manager |
| CMS | Center for Medicaid and Medicare Services |
| COVLC | Commonwealth of Virginia Learning Center |
| CPS | Child Protective Services |
| CRC | Community Resource Consultant |
| CSB | Community Services Board |
| CSB ES | Community Services Board Emergency Services |
| CTH | Crisis Therapeutic Home |
| CTT | Community Transition Team |
| CVTC | Central Virginia Training Center |
| DARS | Department of Rehabilitation and Aging Services |
| DBHDS | Department of Behavioral Health and Developmental Services |
| DD | Developmental Disabilities |
| DDS | Division of Developmental Services, DBHDS |
| DMAS | Department of Medical Assistance Services |
| DOJ | Department of Justice, United States |
| DS | Day Support Services |
| DSP | Direct Support Professional |
| DSS | Department of Social Services |
| DW | Data Warehouse |
| ECM | Enhanced Case Management |
| EDCD | Elderly or Disabled with Consumer Directed Services |
| EFAG | Employment First Advisory Group |
| EPSDT | Early and Periodic Screening Diagnosis and Treatment |
| ES | Emergency Services (at the CSBs) |

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|---|---|
| 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 |
| QII | Quality Improvement Initiative |
| QMD | Quality Management Division |
| QMR | Quality Management Review |
| QRT | Quality Review Team |
| QSR | Quality Service Reviews |
| RAC | Regional Advisory Council for REACH |
| REACH | Regional Education, Assessment, Crisis Services, Habilitation |
| RFP | Request For Proposals |

| | |
|---|---|
| RNCC | RN Care Consultants |
| RST | Regional Support Team |
| RQC | Regional Quality Council |
| SA | Settlement Agreement US v. VA 3:12 CV 059 |
| SC | Support Coordinator |
| SELN AG | Supported Employment Leadership Network, Advisory Group |
| SEVTC | Southeastern Virginia Training Center |
| SIR | Serious Incident Report |
| SIS | Supports Intensity Scale |
| SW | Sheltered Work |
| SRH | Sponsored Residential Home |
| START | Systemic Therapeutic Assessment Respite and Treatment |
| SVTC | Southside Virginia Training Center |
| SWVTC | Southwestern Virginia Training Center |
| TC | Training Center |
| VCU | Virginia Commonwealth University |
| VHDA | Virginia Housing and Development Agency |
| WaMS | Waiver Management System |