REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

SETTLEMENT AGREEMENT

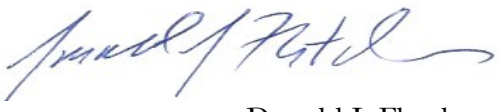
UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

October 1, 2022 – March 31, 2023

Respectfully Submitted By



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Independent Reviewer
June 13, 2023

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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's Twenty-second 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 past year, with a primary focus on the Twenty-second Review Period, October 1, 2022 – March 31, 2023.

Throughout the last year, COVID-19's public health emergency continued. Since 2020, the pandemic disproportionately and negatively impacted individuals with intellectual and developmental disabilities (IDD) and their essential caregivers and support staff. Staffing shortages that had long preceded the pandemic worsened, especially of Virginia's nurses and direct support professionals. The Agreement's ability to conduct required face-to-face on-site assessments and deliver needed support services was curtailed.

However, the Commonwealth continued to make improvements in other areas. Since the Twentieth Period Report a year ago, DBHDS utilized its quality and risk management structure in the development toward a culture of quality, and also in the maturation of its quality and risk management processes. For example, Virginia achieved necessary progress in its processes for serious incident management, the development of quality improvement initiatives with measurable goals, the provision of targeted technical assistance, and the reporting of reliable and valid data.

After establishing standards for acceptable case management and behavioral supports, DBHDS had designed and implemented two monitoring tools and quality review and improvement processes. These resulted in the delivery of direct feedback to CSBs and behavioral services providers regarding the performance of their case managers and behaviorists. These two recurring quality review processes demonstrated their value during the Twenty-second Review Period by documenting measurable progress in the quality of case management and behavioral support services.

This is not to imply that everyone with IDD across the Commonwealth is now receiving adequate and appropriately delivered services – many with complex medical and/or behavioral needs are not. Virginia is to be commended, though, for continuing to refine these two processes: DBHDS's Support Coordinator Quality Review (SCQR) and its *Behavior Support Plan Adherence*

Review Instrument (BSPARI). These two systems each involve an annual quality improvement cycle comprised of four elements: identifying obstacles to achieving acceptable quality standards, implementing improvement initiatives, measuring the extent to which services have improved for the target population as a result of the initiatives, and then prioritizing solutions to resolve any remaining obstacles to be addressed in the next cycle.

This Period's studies confirmed that DBHDS also made significant progress in producing reliable and valid data. This resulted in the Commonwealth newly meeting Indicator requirements across multiple service provision and quality review areas.

In spite of these accomplishments, however, DBHDS still needs to strengthen its efforts to fully achieve the Indicators related to assessing and improving quality, so that the Department can better analyze and effectively identify and implement targeted quality improvements. Specifically, the prior review, for the Twenty-first Period six months ago, had determined that of the 41 Indicators associated with the four relevant Provisions in the Agreement's Data to Assess and Improve Quality section, the Commonwealth had fully met only 15 (37%) of them. Another 18 Indicators were conditionally achieved: even though DBHDS had performed the required functions properly, the Department's data had not been determined to be reliable and valid. Importantly, during the current Twenty-second Period, this resulted in DBHDS conducting its assessment and quality improvement functions without this data having been verified as reliable and valid.

In addition, four of the Indicators that DBHDS did not meet at all in the Twenty-first Period cover the collection and analysis of consistent reliable data, the identification of service gaps, the adequacy of management and supports for individuals with complex needs, and the assessment and communication to workgroups regarding the validity and reliability of data sources. Not achieving these Indicators also resulted in a lack of dependable information – i.e. the critical fuel – that compromised the effective functioning of Virginia's Quality Management System during the Twenty-Second Period. DBHDS therefore remained unable to complete meaningful analyses of various data collected for the purpose of effectively identifying and implementing needed improvements.

In providing services for individuals with intense medical and/or behavioral support needs, Virginia still did not make enough progress to achieve the Agreement's requirements across four service areas vital to these individuals' core interests of health, safety and community integration: being able to live with their families and participate in their communities. These areas encompass

providing in-home nursing services, completing timely referrals to behaviorists, delivering in-home direct support services, and conducting crisis assessments in individuals' homes.

When the Agreement was approved in 2012, a shortage of nurses, direct support professionals and behaviorists was prevalent both nationally and within the Commonwealth. To improve and enhance services for individuals with IDD, the Agreement included requirements related to these shortages. Eight years later, prior to the onset of the pandemic, the Parties further agreed to Compliance Indicators with measurable performance outcomes that, when achieved, would ensure that these four vital services were provided adequately and appropriately. Although the percentage of individuals receiving timely referrals to behaviorists significantly improved during the pandemic, Virginia still did not make substantial progress across the in-home services areas involving nurses, direct support staff and crisis assessments. For individuals with IDD and their families, their interests in the Commonwealth meeting the four Indicators associated with these support services are as critical today as when the Agreement first began 11 years ago. With the pandemic's public health emergency ending on May 11, 2023, it is critical for Virginia to implement new initiatives so that long-overdue progress can finally be made.

Over the past year, the Commonwealth's concerted efforts and progress resulted in newly meeting 32 Indicators. In summary, the Twenty-second Review Period studies determined that Virginia maintained Sustained Compliance with 18 Provisions. The Commonwealth also achieved Sustained Compliance for the first time with one Provision, III.C.5.d., and re-achieved Compliance with Provisions III.C.6.b.iii.G. and III.C.6.b.iii.E. Of the Agreement's 317 Indicators, 142 were reviewed this Period, and Virginia met, either fully (99) or conditionally (12), a total of 111 (78.2%) of them, compared with achieving 79 (55.6%) a year ago. Of the 63 Indicators that the Commonwealth had not met at that time, Virginia fully or conditionally newly achieved 32 of these (50.8%%) this Period. Another 31 Indicators were not met at all. (Note that two Indicators that were achieved fully or conditionally in the Twentieth Period were not met this time.)

The Commonwealth deserves recognition for its ongoing diligence and new initiatives designed to improve its existing services and quality assurance systems. However, Virginia must continue to strengthen its oversight, monitoring and improvement systems to better assess the adequacy and availability of its services, especially for those individuals with intense behavioral and/or medical support needs. To achieve such improvements, the Commonwealth must accurately identify systemic shortcomings in its quality monitoring processes, and also undertake further

well-targeted and measurable quality improvement initiatives, and prioritize addressing and resolving its data integrity issues.

At this late stage of the Agreement, the Parties agreed in March 2023 that, for the next Twenty-third Period Report, the Independent Reviewer will target his studies and monitoring on the remaining 154 Indicators that the Commonwealth has not yet achieved, either at all or twice consecutively, i.e., fully or conditionally met in the Twentieth or Twenty-first Period Reports, and fully met in this Twenty-Second Period Report. Any Provisions that have already achieved Sustained Compliance and any Indicators that have already been met twice consecutively will not be reviewed.

The following sections of the Agreement cover these remaining 154 Indicators:

- Individual and Family Support Program;
- Case Management;
- Crisis Services;
- Integrated Day Activities and Supported Employment;
- Transportation;
- Community Living Options;
- Family-to-Family and Peer Programs;
- Regional Support Teams;
- Quality and Risk Management (Provisions V.B. and V.C.1.);
- Risk Management;
- Mortality Reviews;
- Data to Assess and Improve Quality (Provisions V.D.1.–V.D.4.);
- Regional Quality Councils;
- Public Reporting;
- Quality Improvement;
- Training; and
- Quality Service Reviews.

In closing, it is important once again to reiterate the underlying purpose of the Consent Decree. The Indicators specifying structural and functional aspects of Virginia's system operate in service to other Indicators that measure service outcomes for the individuals with IDD who lie at the heart of the Agreement. It is these service outcomes, rather than the structural inputs, that will ultimately achieve the Agreement's three stated goals of community integration, self-determination and quality services.

II. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

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

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

To analyze and assess Virginia's performance across these areas and their associated Compliance Indicators, the Independent Reviewer retained 13 consultants to assist in:

- Reviewing data and documentation produced by the Commonwealth in response to requests by the Independent Reviewer, his consultants and the Department of Justice;
- Discussing progress and challenges with Virginia officials;
- Examining and evaluating documentation of supports provided to individuals;
- Interviewing caregivers, provider staff, and stakeholders;
- Verifying the Commonwealth's determinations that its data sets provide reliable and valid data that are available for compliance reporting; and
- Determining the extent to which Virginia maintains documentation that demonstrates it meets all Compliance Indicators and achieves Compliance with the Provisions.

The Independent Reviewer focused all Twenty-second Period studies on:

- The respective Provisions that the Commonwealth had not yet achieved and their associated Compliance Indicators, and

- Whether Virginia had maintained Sustained Compliance for the Provisions that it had previously achieved during consecutive reviews.

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

- "Prove its Case" for having achieved all Indicators for the Provisions being studied, and
- Supply its records to document that each of its data sets for the Provisions being studied provide reliable and valid data for compliance reporting.

To determine any ratings of Compliance for the Twenty-second Review Period, the Independent Reviewer considered information delivered by the Commonwealth prior to April 15, 2023, and responses to consultant requests for clarifying information up to May 13, 2023. To determine whether Virginia had met the Compliance Indicators and achieved the Provisions studied, the Independent Reviewer considered the findings and conclusions from the consultants' studies, the Commonwealth's planning and progress reports and documents, as well as other sources.

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

For each study, the Commonwealth was asked to make its records available that document the proper implementation of the Provisions and the associated Compliance Indicators being reviewed. For each Indicator with a function or performance measure that utilized reported data, Virginia must make available its completed *Process Document* and *Attestation*. With these two documents, the Commonwealth asserts that each of its reported data sets has been verified as reliable and valid. If Virginia performs functions using reported data that have not been verified, or if the Commonwealth submits data that show an Indicator's performance measure has been achieved, but either of these two documents was not delivered, was incomplete or otherwise insufficient, then the Independent Reviewer determined that Virginia has "met*" the Indicator. This met* rating is not final and cannot be used for Compliance determinations, but rather is conditional and for illustrative purposes only.

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

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

B. Discussion of Compliance Findings

1. Quality and Risk Management

Background

In the Agreement's Section V., the Commonwealth agreed to develop and implement a statewide Quality and Risk Management (QRM) system to ensure that individuals with IDD are provided with accessible and appropriate services that are of good quality, meet their needs, and help them achieve positive outcomes. The Section V. Provisions require Virginia to develop, implement, and refine multiple quality and improvement processes. When executed effectively, these quality processes identify the service system's most consequential obstacles to achieving these goals and develop, implement, and monitor the impact of its quality improvement initiatives (QIIs). The Parties agreed that all data reported for compliance determinations must be confirmed as reliable and valid. Beyond being required by the Agreement, the on-going collection and analysis of reliable and valid systemwide performance data is critical to the Commonwealth's ability to effectively select and implement all of its QIIs, i.e., the outcome of each quality process required.

A year ago, DBHDS had attested that many of its data sets were reliable and valid. It also reported that it could not attest to the quality of the data for a number of others. Although the consultants' study identified significant shortcomings with some of the Department's signed *Attestations*, DBHDS had accomplished significant progress nevertheless. However, given these shortcomings, data sets were not available to support some of the quality review process cycles required by the QRM Indicators. The consultants found that this lack of valid and reliable data across key parts of the QRM system continued to undermine the functionality of the

Department's Quality Improvement Committee (QIC) framework and its data-driven decision making.

Provision V.B.

The Twentieth Period review confirmed that Virginia's Quality Management System included the CMS-approved waiver quality improvement plan and that this system incorporated the functions required by the applicable Indicator. However, DBHDS often did not have evidence of the reliable and valid data necessary to effectively complete the required quality improvement processes.

Last year's study also established that DBHDS's Offices of Licensing (OL) and Human Rights (OHR) performed required quality assurance functions. For example, as part of its annual inspection process, OL assessed provider compliance with its regulatory requirements to report on conducted reviews and completed root cause analyses of serious incidents. For its annual inspections, OL followed detailed protocols to assess whether providers had met these requirements, and, if violations were identified, to require Corrective Action Plans (CAPs). The consultants' study determined, though, that contrary to OL's findings, a substantial percentage of providers had not implemented the Indicator's root cause analysis requirements. The review confirmed that, overall, OL's Incident Management Unit (IMU) had continued to strengthen-the Department's organizational responses and effectiveness in following up on serious incidents.

DBHDS's Office of Clinical Quality Improvement continued to lead the Department's quality improvement system. Working in collaboration with DBHDS's program areas, this Office led the establishment and use of data for QIIs. It also oversaw and directed the Department's Quality Services Review (QSR) process, which produces data for DBHDS's evaluation of the sufficiency, accessibility and quality of services. However, Round 2 of the QSR process did not produce sufficient reliable data to be used for this purpose. Following an internal review, DBHDS subsequently made significant changes to the QSR review tools and to some of its processes for QSR Round 4 and beyond.

The Twentieth Period study verified that the Commonwealth had attested to the reliability and validity of its data sets for only nine of Provision V.B's 18 Indicators (50%) associated with data-dependent performance measures. Although this represented a significant improvement from previous Periods, the review also found some misunderstanding among DBHDS staff regarding the facts and records required for Virginia to attest to the reliability and validity of its reported data sets. For the remaining nine Indicators, DBHDS appropriately decided that it could not

verify that its data sets were reliable and valid. This continued lack of reliable and valid data remained an overarching barrier to the Commonwealth's effective implementation of the quality improvement processes described in Provision V.B.s' Indicators.

Otherwise, DBHDS again updated its Quality Management Plan, maintained its quality improvement system and continued to make advances in the development and maturation of its QRM processes. This included improved processes for serious incident management, the development of QIIs with measurable goals, and the provision of targeted technical assistance.

The review a year ago confirmed DBHDS's Risk Management Review Committee (RMRC) had completed the functions described in its charter. These included reviewing and analyzing data, monitoring trends and patterns in data, and identifying areas of improvement. However, the RMRC did not review all the data required. In another instance, DBHDS had required case management providers to identify and report on individuals at high risk due to medical or behavioral needs, but did not require such reporting from residential and day/employment service providers.

In addition, DBHDS did not provide a *Process Document* or *Attestation* that might have verified the percentages of service recipients who, for example, resided in an integrated setting or who were free from neglect and abuse by paid support staff. As a result, the Department did not achieve Indicators 29.22–29.26.

Of Provision V.B.'s 33 Indicators (29.1–29.33), Virginia had met 11 of them, one for the first time, but did not meet the remaining 22. The Commonwealth, therefore, remained in Non-Compliance.

Provision V.C.1.

In the Twentieth Period, the consultants' review confirmed again that DBHDS's Licensing Regulations did require providers to implement risk management processes as described in the applicable Indicator. The Department had published guidance on serious incident and quality improvement requirements as well as on the risk management requirements and information about the use of risk assessment and risk triggers and thresholds. DBHDS also published recommendations for best practices in monitoring serious incidents.

As required, OL's annual licensing inspections included assessments of providers' compliance with the regulatory requirements for risk management requirements. The Twentieth Period's

study found that OL's annual inspections had not determined whether providers identified year-over-year trends and patterns or used baseline data to assess the effectiveness of their risk management systems, as Indicator 30.4 requires. OL had determined that the percentage of providers who met its limited requirements increased to 93.5%; however, OL did not inspect and determine whether the providers had met all of DBHDS's regulatory requirements.

When OL determined that providers were non-compliant, it had required them to develop and implement an approved CAP to address cited deficiencies.

DBHDS had established a Departmental Instruction with requirements for risk management programs for DBHDS-operated facilities and had provided sufficient evidence that the Training Center had implemented the use of risk triggers and thresholds. Virginia therefore met Indicators 30.8 and 30.9 for the first time.

The Twentieth Period study established that DBHDS did not have a sufficiently clear and comprehensive methodology or an adequate and functioning process for monitoring whether providers appropriately responded to and addressed risk trigger thresholds. As a result, Virginia did not meet Indicator 30.7.

In spite of ongoing concerns with data reliability and validity, DBHDS continued to improve the refinement of its 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.

Of Provision V.C.1.'s 11 Indicators (30.1–30.11), Virginia either fully or conditionally met seven of them, three for the first time, but did not meet the remaining four. The Commonwealth, therefore, remained in Non-Compliance.

Twenty-second Period Study

For the Twenty-second Period, the Independent Reviewer retained the same two consultants as previously to assess the status of the 44 Indicators associated with the two QRM Provisions, namely V.B. and V.C.1.

This study confirmed that DBHDS made steady progress in developing and implementing an ongoing process of data collection and analysis for the purposes of improving QRM programs, services, and processes. Virginia is to be commended for meeting, either fully or conditionally, a

total of 15 associated Indicators for the first time. Of the two Provisions' 44 associated Indicators, 23 were fully achieved and nine were met conditionally.

With Virginia not yet achieving 12 Indicators, and not having reliable and valid data for another nine, the latest review determined that the Commonwealth's quality framework continued to be hampered. In addition, as previous studies had found, the effectiveness of key components of the QRM system were undermined due to the lack of collection and analysis of consistent reliable data. This data pertains to the identification of service gaps, the adequacy of management and supports for individuals with complex needs, the identification of trends in critical incidents, and the assessment and communication to workgroups regarding the validity and reliability of data sources. Overall, this compromised DBHDS's ability during the Twenty-second Period to complete meaningful analyses of various data collected for the purpose of effectively identifying and implementing needed improvements.

The study also noted DBHDS's improvement in documenting data integrity, but still could not consistently confirm that the Department completed the required *Process Documents* and/or the applicable *Attestations* to demonstrate that DBHDS identified, isolated and addressed applicable reliability and validity deficiencies in the data source systems. The review showed that the Department developed sufficient processes and practices to adequately use valid and reliable data, but did not implement sufficient procedures to ensure that such data exist.

Provision V.B.

DBHDS continued to make advancements in its QRM processes. These included the processes for serious incident management, the development of QIIs with measurable goals and the provision of targeted technical assistance. The Department also developed a well-thought-out strategy for identifying individuals at high risk due to complex medical and/or behavioral needs, which allowed DBHDS to fulfill the requirements for Indicator 29.19 (and 30.11) for the first time.

In the area of training and technical assistance, DBHDS made resources available to providers specific to expectations and processes for conducting thorough root cause analyses (RCAs). This resulted in notable improvements in providers' RCAs. Likewise, the Department's Office of Clinical Quality Management expanded its robust Consultation and Technical Assistance (CTA) Framework, including the very successful CTA practices specific to OL's quality improvement regulations.

In regard to licensing requirements, DBHDS continued refinement of the CONNECT data system. This has been a valuable tool for incident reporting analysis and follow-up as well as a structure for consistent implementation and documentation of annual licensing inspection findings, CAPs, and required follow-up by OL with providers.

The initial implementation of the RMRC look-behind process required by Indicator 29.16 provided OL with significant information about issues and process improvements requiring specific attention. The latest review identified specific areas of focus for process improvement. Once this look-behind process is fully functional in addressing all required elements, it should become a valuable QI tool for DBHDS to evaluate and improve its ability to oversee serious incident reporting, analysis and follow-up. Until then, however, Indicator 29.16 remained unmet.

For this Provision, once again the lack of reliable and valid data sets remained a critical obstacle to compliance determinations. For example, DBHDS did not deliver sufficient evidence of its ability to draw down valid and reliable serious incident data from its CONNECT data system. During the previous review, the Department had provided documentation that delineated both the specific threats and the action steps that would remediate this situation and ensure the reliability and validity of data derived from both the CHRIS and CONNECT data source systems. For this latest Twenty-second Period review, however, DBHDS's *Process Document* did not acknowledge the specific threats the Department had identified, nor did it provide evidence that it had implemented and completed the specific steps outlined in its *Roadmap* document to address and resolve these threats.

In general, a number of Indicators associated with Provision V.B. required a review of reliable and valid serious incident data. The lack of such data also undermined effective trend analyses by the QIC and the RMRC.

In summary, Virginia either fully or conditionally met 23 of Provision V.B.'s 33 Indicators, thirteen of them for the first time. Ten Indicators remain unmet.

Provision V.C.1.

DBHDS made further progress in refining its systems and processes. These are designed to provide clear expectations, guidance, monitoring, training and technical assistance to help providers develop structured and effective risk management processes, and then to assess those processes.

Licensing regulations continued to require providers to develop and implement a written plan that includes the requirements of Indicator 30.1.

OL assessed provider compliance with these regulations and issued CAPs when areas of non-compliance were identified. The Office also delivered training and technical assistance to providers that targeted increased adherence to these regulatory requirements, and provided more specific instructions to Licensing Specialists about how to consistently assess provider compliance.

Specifically, OL continued to annually assess providers' compliance with risk management requirements. Its assessments determined whether providers continued to demonstrate improved compliance with DBHDS's risk management regulatory requirements. OL's inspections found that during Calendar Year 2022, 94% of providers were assessed for these regulations and those found not to comply completed a CAP to address and resolve cited deficiencies.

However, OL's current assessment process is still not sufficient. As found in the Twentieth Period review, it still did not study whether providers used, as required, serious incident and investigation data to identify trends, patterns and baselines. DBHDS targeted a strategy to clarify and address these expectations in a provider training in April 2023. Going forward, OL's updated monitoring approach will assess providers' incorporation of these analyses into their risk management processes. The Office's *Incident Management Unit Care Concern Threshold Joint Protocol* was revised in October 2022 based on its continued analysis of serious incident reports.

DBHDS continued to meet the requirements of Indicators 30.8 and 30.9. It published guidance documents and reference materials for providers on its website. Topics included the development and implementation of a quality improvement program, development and implementation of a risk management program, and development and implementation of a serious incident reporting, follow-up, and analysis system. The Department revised and published several resource and training documents for providers on serious incident requirements.

This Period's study verified that DBHDS continued to have a Departmental Instruction in place to require Training Centers to implement risk management programs. The documentation submitted for this review provided additional evidence of how the Training Center actually implemented the use of risk triggers and thresholds, which included processes to review data and trends.

Although DBHDS did not fulfill the overall requirements of Indicator 30.10, the Department began an initiative during the Twenty-second Period to facilitate provider monitoring of the incidence of risks that are prevalent in individuals with IDD.

In summary, Virginia has now met nine of Provision V.C.1's 11 Indicators, two of them for the first time. Another two Indicators remain unmet.

See Appendix A for the consultants' full report.

Conclusion

Regarding Provision V.B.'s 33 Compliance Indicators, Virginia has either fully or conditionally met the requirements of 23 of them, namely 29.1*, 29.2–29.7, 29.8*, 20.9, 29.10*, 29.11, 29.12, 29.14*, 29.15, 29.19, 29.26*, 29.27, 29.28*, 29.29*, 29.30*, 29.31, 29.32 and 29.33*. The Commonwealth did not achieve the remaining ten Indicators: 29.13, 29.16–29.18 and 29.20–29.25. Therefore, Virginia remains in Non-Compliance with this Provision.

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

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

2. Services for Individuals with Complex Medical Support Needs

Background

For the Twenty-first Review Period, the Independent Reviewer's consultants, including registered nurses, conducted an Individual Services Review (ISR) study. Its purpose was to identify the extent to which significant discrepancies existed between the ISR study's findings and the Commonwealth's Quality Service Reviews (QSR) findings related to serving individuals with IDD who have complex medical support needs. The consultants' ISR study concentrated on the following components of two Compliance Indicators associated with Provisions V.I.1. and V.I.2:

- "Providers keep service recipients safe from harm, and access treatment for service recipients as necessary" (Indicator 51.4 c.);
- "Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk" (Indicator 52.1 a.); 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 52.1 c.).

This ISR study focused on selected individuals with IDD and complex medical support needs (i.e., individuals with Supports Intensity Scale (SIS) scores of level 6). These individuals' services had already been reviewed by DBHDS's Quality Service Reviews (QSRs). The sample selection of 32 individuals allowed the study's findings to be generalized to all individuals with SIS level 6 scores whose services were evaluated during Round 3 of the QSR Person Centered Reviews (PCR).

In analyzing the findings from the ISR Monitoring Questionnaire used by the 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 contrasted with the QSR auditors' findings to determine whether, and the extent to which, there were any health care related discrepancies.

As a result of this comparative analysis, the status of Virginia's achievement of the QSR Indicators referenced above was assessed. The Twenty-first Period's ISR study found that significant discrepancies existed that indicated that the QSR review did not adequately identify individuals who:

- Had an unmet health care need or safety from harm concern;
- Needed assessments or consultations that were not recommended or ordered;
- Needed a support plan modification due to a change in status;
- Lacked access to dental care; and
- Needed lab tests that were not completed.

For the Twenty-first Period, the Commonwealth once again did not meet the requirements of Indicators 51.4 and 52.1.

Twenty-second Period Study

For this latest review, the Independent Reviewer retained the same consultants to again conduct an ISR study to assess Virginia's status in meeting the Agreement's QSR Indicators 51.4 (subsection c.), and 52.1 (subsections a. and c.)

This Period's ISR study continued attention on whether DBHDS's QSR process adequately identified if individuals' complex medical support needs were met, if changes of status led to needed modifications to Individual Support Plans (ISPs) and if providers kept service recipients safe from harm and ensured treatment access as necessary.

The nurse consultants' findings were again compared with the QSR auditors' findings to determine whether, and the extent to which, there were any health and safety related discrepancies. In this respect, this latest study was identical to the ISR studies completed for the Eighteenth and Twenty-first Review Periods. The sample for this study was 17 individuals, all with SIS level 6 needs, whose services were reviewed by the most recent round of QSRs, i.e., Round 4.

In this Period's ISR study, the ISR nurse consultants and the QSR auditors concurred that the records reviewed for three of the 17 individuals (18%) in the study sample raised no health or safety concerns about risk of harm or a lack of needed supports. For the remaining 14 individuals, the ISR consultants identified core concerns that either the QSR auditors did not find, or that the process itself did not review when determining whether these individuals' healthcare and safety needs were met.

The table below provides examples of discrepancies for the 17 individuals:

Individuals' healthcare and safety needs	QSR Findings	ISR Findings
At risk of harm	0 (0%)	4 of 17 (24%)
Needed assessments or consultations	0 (0%)	4 of 17 (24%)
Lacked timely access to dental care	0 (0%)	5 of 17 (29%)
Receipt of less than 80% of in-home nursing services hours identified as needed in the ISP	QSR process does not review	6 of 7 (86%)

Regarding risks of harm, the ISR study found individuals with the following concerns that the QSR review failed to identify: continuous self-injurious behavior, increased risk of choking, severe gingival hyperplasia, and the lack of needed in-home clinical supports. The lack of timely dental care was again cited as a major problem by the ISR nurse consultants, yet the QSR

auditors did not include in their review whether this problem existed for any of the 17 individuals.

The ISR study again determined the lack of needed in-home nursing care as an obstacle to meeting these individuals' intense healthcare support needs. Of the six people who needed these services but did not receive them, their families and/or sponsors cited the lack of nursing supports as a serious concern.

In summary, the findings from the Twenty-second ISR study are consistent with those of previous ISR studies of individuals with complex medical support needs. Significant issues and concerns related to safety and healthcare were not identified during Round 4 of the QSR process.

See Appendix B for the consultants' full report.

Conclusion
Regarding Provision V.I.1.a.-b., Virginia did not achieve Indicator 51.4 (subsection c.).

Regarding Provision V.I.2., the Commonwealth did not achieve Indicator 52.1 (subsections a. and c.).

3. Case Management

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

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

A year ago, the Twentieth Period Case Management review showed that Virginia had met ten of the 19 associated Indicators. The primary obstacles to meeting the requirements of the remaining

nine Indicators were related to CSB effectiveness in achieving expectations for case management performance, and to establishing data integrity for data drawn from the WaMS electronic database.

This same study found that the CSBs had not met the 86% metric of the records reviewed for nine of the ten elements required by Indicator 2.16. and as detailed in Indicators 2.6–2.15. In addition, DBHDS had determined appropriately that two Indicators (2.10 and 2.14) lacked sufficient inter-rater reliability between the CSBs and its Office of Continuous Quality Improvement (OCQI).

The Twentieth Period review also determined that the Commonwealth had achieved the required six Indicators (namely 6.1.a, 6.1.b, and 6.1–6.4) associated with creating a mechanism to monitor compliance with case management performance standards. Virginia's diligent efforts resulted in the Commonwealth achieving Compliance with Provision III.C.5.d. for the first time. DBHDS's Case Management Steering Committee (CMSC) reviewed and analyzed case management performance data and again produced semi-annual reports with recommendations to the Quality Improvement Committee (QIC) for system improvement. The Department's Quality Improvement Division conducted retrospective reviews of a randomly selected sample, and then provided technical assistance as needed.

DBHDS had completed its case management retrospective monitoring process – the Support Coordinator Quality Review (SCQR) – across two successive annual cycles, with each SCQR cycle reviewing records from the previous calendar year. The Twentieth Period study found in the second year of the SCQR that 42% of Support Coordinators'/case managers' records were in compliance with a minimum of nine of the ten elements assessed. This was significantly below Indicator 2.16's required metric of 86%.

The SCQR process utilizes comparisons between CSB case management supervisors' determinations and those of the external reviewers from OCQI. The rate of agreement between the 40 CSB case management supervisors and the OCQI reviewers ranged from 46% to 95%.

Virginia's documentation for case management contact tracking (Indicator 46.1) and for CMSC review of case management contact data (Indicator 46.2) showed that DBHDS had established and implemented a Data Quality Framework, utilized a Data Quality Tool to assess sources of data error, and implemented a Root Cause Analysis format to assist CSBs in addressing data problems. The Department also conducted cross tabulation of data from the CCS3 to the WaMS

database, and the CMSC submitted related recommendations to the QIC and the Commissioner. However, DBHDS's Office of Data Quality and Visualization (DQV) had determined that the data from CCS3 was not valid and reliable for compliance reporting.

DBHDS's documentation for Indicator 47.1 showed that the CMSC established four indicators in the two required areas. The data it reviewed, however, found that the outcome measure of 86% compliance for the four indicators had not been achieved.

The Twentieth Period review of case management services also included an Individual Services Review (ISR) study of a random sample of 20 individuals with complex medical needs (Level 6 on the Support Intensity Scale). The ISR found that the On-Site Visit Tool (OSVT), which is central to accurate case management assessments, was not used effectively by case managers. For example, 12 of the 20 individuals (60%) whose services were reviewed by the registered nurse consultant had a health issue, change in status, or another risk that was not identified or addressed by the assigned case manager in the documentation provided by the CSB. For four of the 20 individuals (20%), their caregivers expressed concern about the high rate of case manager turnover, and another nine caregivers (45%) expressed unease about the adequacy of case manager contact and involvement.

Twenty-second Period Study

For this latest review, the Independent Reviewer retained the same consultant who conducted the Twentieth Period study related to the four Case Management Provisions.

This Twenty-second Period study found that the Commonwealth achieved 14 of the 19 Indicators (74%), compared with meeting ten Indicators a year ago. The four newly met Indicators were 2.2, 2.5, 46.1* and 46.2*, with two of these Indicators being met conditionally, since data integrity could not be established. Similar obstacles to meeting the remaining five Indicators continued. These included overall CSB performance continuing to fall below the required case management metrics specified in the ten elements, 2.6–2.15, despite several CSBs successfully meeting the Agreement's performance measures.

As required, the CMSC established four indicators of health and safety and community integration across its statewide service system for individuals with IDD. Once again, however, DBHDS's case management monitoring process data did not show compliance of 86% adherence to the four indicators.

DBHDS completed its third SCQR, which showed that 53% of Support Coordinators'/case managers' records were in compliance with a minimum of nine of the ten elements assessed. The most important of these elements require that the Individual Supports Plan (ISP) includes specific and measurable outcomes, the case manager assesses risk, completes assessments that the ISP is being implemented appropriately, and also assesses whether the ISP has been modified as needed.

While still significantly below the required 86% compliance metric, the 53% result represented a substantive improvement from the previous 42% a year ago. This year's SCQR additionally determined that six of the 40 CSBs (15%) achieved the 86% performance measure. Again, this was an improvement over three CSBs (7.5%) meeting the 86% level during the previous SCQR annual cycle. This increased adherence to the Department's case management standards is evidence that the SCQR process is resulting in service improvements statewide.

The latest SCQR review also showed that OCQI's assessment agreed with the 40 CSB case manager supervisors' assessments at a rate ranging from 69% to 100%, an improvement over the previous year's low of 46%.

DBHDS plans to implement improvements to the SCQR process in its next cycle in Fiscal Year 2023. Children will be added to the sample, thereby improving the applicability of SCQR results. As well, employment and community integration questions will be revised, employment discussion questions will be added for individuals aged 14–17, and clarifying guidance will be provided for several questions based on user feedback.

DBHDS's most recent data for Enhanced Case Management (ECM) contacts showed that 18 of the 40 CSBs (45%) achieved or exceeded the 86% performance standard. To address problems that result in lower levels of achievement, the Department continued to provide intensive technical assistance to CSBs. It is worth noting that no CSB that received this technical assistance in the previous cycle underperformed in adherence to the SCQR criteria in the following cycle. It is clear that DBHDS's technical assistance, which included cross-tabbing data from the CCS3, WaMS and the CSBs' local electronic records resulted in improved CSB performance.

DBHDS's technical assistance process begins with its Office of Community Quality Improvement (OCQI)'s on-site review of a selected sample of records at each CSB. OCQI evaluates the same records reviewed by the CSB case management supervisor. After completing their review and scoring the SCQR, OCQI reviews the supervisor's SCQR scoring and conducts

informal discussions of congruence and discrepancy with CSB supervisors and staff. This is followed by a more formal debrief between CSB staff and OCQI specialists; this is considered the official technical assistance. The inter-rater agreement between OCQI and CSB supervisors has improved significantly, meaning that supervisors are better equipped to determine whether their case managers' records meet Departmental expectations. The Independent Reviewer has received informal feedback that these face-to-face discussions generate productive conversations that have positively impacted CSB attitudes toward these DBHDS expectations.

For the case management related data that DBHDS reported, the Twenty-second Period study showed that the Department continued to make improvements. Of the threats to data reliability and validity that its own assessments identified, several were addressed sufficiently, but all of the needed fixes have yet to be implemented. The review found that some descriptions of the improvement actions in the *Process Document* were complete and thorough.

This Period's study also reviewed DBHDS's documentation for Indicators 2.16, 6.1.a., 6.1.b. and 47.1. Although the Chief Information Officer found those processes to be thorough and detailed, the Department needed to update the *Attestation* to address issues raised in the 2022 SCQR review from the Twentieth Review Period.

For Indicators 46.1 and 46.2, the Chief Information Officer found DBHDS's data to be reliable and valid regarding case management contact measures. The *Process Document*, however, did not include actions to address the Department's assessment concerns regarding the reliability and validity of CCS3 data. The DBHDS case management monitoring process included providing related technical assistance as required.

See Appendix C for the consultant's full report.

Conclusion

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

Regarding Provision III.C.5.d., the Commonwealth has met all six Indicators: 6.1.a, 6.1.b, 6.1, 6.2, 6.3, and 6.4, and therefore has achieved Sustained Compliance with this Provision for the first time..

Regarding Provision V.F.4., Virginia has met* both Indicators, namely 46.1* and 46.2*, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.F.5., the Commonwealth has not met the sole Indicator 47.1, and therefore remains in Non-Compliance with this Provision.

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

4. Crisis and Behavioral Services

Background

The goals of the Agreement's Crisis Services Provisions are threefold. They aim to:

- Ensure timely community-based support to individuals experiencing crises;
- Focus on preventing future crises; and
- Provide in-home services to resolve crises and prevent individuals' removal from their homes.

Last year's Twentieth Period study reviewed the Commonwealth's 13 Provisions related to Crisis Services: eight Provisions that had previously been determined as being in Sustained Compliance, and five other Provisions that Virginia had not yet accomplished and their 37 associated Compliance Indicators.

For the eight Provisions that the Commonwealth had previously achieved Sustained Compliance, namely III.C.6.b.i.A. and B., III.C.6.b.ii.C.–E. and H., III.C.6.b.iii.A. and F., the Twentieth Period study a year ago confirmed that Virginia's statewide crisis system had continued to serve children and adults and operate 24 hours per day, seven days a week. The Commonwealth's crisis services REACH teams had also continued to operate a Crisis Stabilization Home in each of the five Regions and to train community stakeholders. All eight Provisions were therefore once again determined to be in Sustained Compliance. The review also found, however, that the pandemic had continued to undermine the REACH teams' ability to

recruit and retain needed staff, and to interrupt the mobile teams' ability to respond on-site where the crises occurred.

The Twentieth Period review determined that, for Provision III.C.6.a.i.-iii. and its 22 associated Indicators (7.2–7.23), Virginia had met the requirements of 17 of them, including newly meeting six. Five Indicators had remained unmet. DBHDS had maintained the required terms in its contracts with the 40 CSBs, established criteria for CSBs to determine who is at risk of being hospitalized, and implemented a quality process related to improving services for individuals who are at risk of crises and the required initiatives to minimize the lengths-of-stay for those admitted to psychiatric hospitals.

A year ago, with public health precautions regarding the pandemic still in place, most crisis assessments were not conducted in the homes or other community locations where individuals were experiencing crises. For those who were not provided with crisis assessments in their homes, the Commonwealth could therefore not effectively deliver much of the array of community-based crisis services required by Agreement. Virginia had committed in its Curative Action to address this systemic obstacle through its plan for a crisis assessment transformation (i.e., incorporating newly established 988 Call Centers), which it expected would positively impact crisis assessments at home for all populations, including children and adults with IDD. Completing crisis assessments before individuals are removed from their homes is critical to ensuring the effectiveness of the Commonwealth's community crisis services system for individuals in the target population.

During the Twentieth Period, DBHDS had implemented most of the associated Indicator requirements that the Parties agreed would establish the conditions necessary to significantly improve the behavioral supports provided in individuals' homes. Virginia had established permanent regulatory requirements, increased the number of behaviorists, provided standards in its *Practice Guidelines* and related training, and implemented monitoring and a quality review process. According to the Agreement's requirements, however, the Commonwealth had not yet shown that its implementation of these initiatives had achieved the desired outcomes for the individuals, as measured by the four Indicators, 7.8, 7.14, 7.18, and 7.19, or the quality review process required by Indicator 7.20.

For Provision III.C.6.b.ii.A. regarding Mobile Crisis, DBHDS had achieved all seven Indicators (8.1–8.7); although one had been met conditionally and for illustrative purposes only. These

Indicators include requirements to conduct assessments, implement timely crisis prevention planning and related training, and achieve outcomes for those admitted to psychiatric hospitals.

A year ago, for the eight Indicators associated with Crisis Stabilization Provisions III.C.6.b.iii.B., D. and G., DBHDS had continued to achieve five of them. These five Indicators require Virginia to operate a Crisis Therapeutic Home (CTH) for adults in each Region and two CTHs for children statewide, provide training to caregivers, utilize emergency waivers to reduce lengths of stay in psychiatric hospitals, and increase provider capacity to support individuals with co-occurring conditions in permanent homes. The Commonwealth had not met the remaining three Indicator performance requirements: two to identify a community residence within 30 days for those admitted to psychiatric hospitals and CTHs, and one to implement out-of-home crisis therapeutic host-home like services for children connected to REACH.

For the crisis services data that DBHDS reported during the Twentieth Period, the Department had provided completed *Process Documents* and the study had verified most of the data's reliability and validity. The one exception was the data related to decreasing trends of admissions and lengths of stay at psychiatric hospitals.

As mentioned in the Twentieth Period Report, Virginia had either fully or conditionally met 29 of the associated 37 Indicators; eight remained unmet. Virginia therefore remained in Non-Compliance with these five Crisis Services Provisions.

Twenty-second Period Study

For this latest study, the Independent Reviewer retained the same consultants to once again assess the status of the Commonwealth's compliance with the Agreement's 13 Crisis Services Provisions.

This time, the review also included two supplemental qualitative studies, designed to understand the impact of Virginia's crisis and behavioral services on individuals with IDD who are most at risk of crisis due to behavioral or co-occurring medical conditions.

Of the 13 Crisis Services Provisions, eight had been previously determined to be in Sustained Compliance, namely Provisions III.C.6.b.i.A. and B., III.C.6.b.ii.C.–E. and H., III.C.6.b.iii.A. and F.

The remaining five Provisions include 37 associated Indicators. Provision III.C.6.a.i.-iii. has 22 Indicators (7.2–7.23), Provision III.C.6.b.ii.A. includes seven Indicators (8.1–8.7), Provision III.C.6.b.iii.B. has four Indicators (10.1–10.4); Provision III.C.6.b.iii.D. has a sole Indicator (11.1), and Provision III.C.6.b.iii.G. includes three Indicators (13.1–13.3).

The Twenty-second Period study confirmed that the Commonwealth once again achieved Sustained Compliance with the eight Provisions III.C.6.b.i.A. and B., III.C.6.b.ii.C.–E. and H., III.C.6.b.iii.A. and F. Virginia maintained its statewide crisis service system: in each of its five Regions, DBHDS's REACH programs operated 24/7, provided mobile crisis teams, offered last resort alternatives to hospitalization in Crisis Stabilization Homes, and trained community stakeholders.

For the requirements of the other five Crisis Services Provisions, this Period's study verified that DBHDS newly met three Indicators. The Department completed a gap analysis and set targets and dates to increase the number of behavioral consultants (Indicator 7.14), established a quality review process that tracks and assesses (Indicator 7.20), and implemented out-of-home crisis therapeutic prevention host-home like services for children connected to REACH (Indicator 13.3).

DBHDS also maintained its required contract terms with the CSBs as well as its quality process to improve services for individuals at risk of crisis. Together, the terms and quality process established statewide service system standards, expectations and performance measures for training CSB management and program staff, and screening, identification and referral processes for children and adults at risk of crisis. In addition, the Department maintained its adherence to the hospital admissions and the referral-related requirements and timelines of Indicators 7.9–7.13.

The Commonwealth's crisis system continued to complete crisis assessments. Most of these were not conducted in individuals' homes or other community locations where the crises occur, however, but at hospitals or CSB Emergency Services offices where the assessments are much more likely to result in hospital admissions. In the first two quarter of Fiscal Year 2023, DBHDS reported that only 40% and 41% respectively of crisis assessments occurred in individuals' homes, demonstrating no material change from the results of the Twentieth Period review. For the 60% who were assessed at hospital emergency departments or CSB offices, the REACH mobile crisis teams could not implement the Agreement's crisis services to de-escalate crises in individuals' homes, nor could they provide in-home supplemental supports and, if needed, offer

crisis stabilization services. Therefore, Virginia once again did not meet Indicator 7.8's performance requirement that 86% of children and adults known to the system be assessed where crises occur.

Regarding the 86% performance measure for Indicator 7.18, DBHDS reported that for the period reviewed (March 2022 through January 2023), only 1,020 (68%) of the children and adults who were identified as needing therapeutic consultation (i.e., behavioral supports) were connected to a behaviorist within 30 days. The Department continued fall short of fulfilling the requirements of this Indicator.

Based on the expectations for behavioral programming specified in the Commonwealth's permanent DD Waiver regulations and *Practice Guidelines*, DBHDS created and implemented an effective quality review and improvement process, as required by Indicator 7.20. Through this process, DBHDS monitors the provision of behavioral supports in individuals' homes, utilizing its *Behavior Support Plan Adherence Review Instrument* (BSPARI) tool. During the Twenty-second Period, the Independent Reviewer's consultants conducted two supplemental qualitative studies of the status of this quality process. One was a *Qualitative Study* (see Attachment 2 of Appendix D) of 100 individuals' records. This supplemental study found that the Department's BSPARI tool and monitoring process were sufficient to verify that individuals authorized for Consultation Services had received the four components of behavioral programming (i.e., assessment, plan, training and monitoring) required by Indicator 7.19. DBHDS's quality review and improvement process reported its determination that 76% of the individuals' records reviewed indicated receipt of all four elements. Since this was below the 86% Indicator performance measure, Virginia did not meet Indicator 7.19.

Regarding Indicator 7.20, the second supplemental study, *Individual Services Review Study – Quality of Behavioral Supports* (see Attachment 3 of Appendix D) reviewed the level of agreement between the Independent Reviewer's and DBHDS's Board Certified Behavior Analyst (BCBA) clinicians' findings. The ISR–Behavioral Supports review identified agreement ranging from 60% to 90% with the Department's findings for the 25 sampled individuals.

The two supplemental qualitative reviews found that DBHDS's BSPARI tool and monitoring process were also adequate in determining whether services are adhering to the Department's *Practice Guidelines*. The Twenty-second review verified that DBHDS's quality review and improvement process used its analysis of the five items specified in Indicator 7.20 to provide

useful feedback to the Commonwealth's therapeutic behavioral consultants, and to recommend and implement quality improvements.

DBHDS's quality review process determined, and both qualitative studies verified, that the work of the therapeutic behavioral consultants substantially improved since the previous cycle of BSPARI evaluations and providing feedback. This is vital evidence that Virginia has implemented an adequate quality review and improvement process, and therefore met Indicator 7.20 for the first time.

The reviewers additionally verified that the Commonwealth implemented another quality review process, this time related to the availability of direct support professionals. Their study found that DBHDS's process adhered to, and continued to meet the requirements of Indicators 7.21–7.23. However, the Department reported that during the first two quarters of Fiscal Year 2023, billing data showed that only 14 (5%) of the individuals authorized for in-home supports received 90% or more of their authorized hours, while 81 (28%) received fewer than 30% of their authorized hours. While it remains poignantly unfortunate that children and adults actually receive very few of the direct support hours authorized for them, the requirements of these Indicators were nevertheless achieved.

The Mobile Crisis Provision III.C.6.b.ii.A. and its associated seven Indicators (8.1–8.7) require DBHDS to assess and report on REACH crisis services teams' performance regarding staff qualifications, timely development and training to implement Crisis Education and Prevention Plans (CEPP), and caregiver training. The Department achieved six of these seven Indicators (8.1–8.3 and 8.5–8.7) by conducting and reporting on its semi-annual assessments of these three requirements. DBHDS reported on each Region's performance and provided tailored feedback about areas of strength and those that needed improvement. The Department aggregated the Regional data to show the extent to which Virginia achieved the Indicators statewide. DBHDS's documentation demonstrated that during the Twenty-first and Twenty-second Periods, the Commonwealth fulfilled the performance requirements for these Indicators. The Department itself reported that it did not achieve the performance measure for Indicator 8.4, which it had previously met in the Twentieth Period review. This shortfall was due to only one of its five Regions meeting the requirement that 86% of CEPPs be developed within 15 days of the assessment, and that statewide, only 81% of the CEPPs were completed in a timely manner.

DBHDS also continued to track information, including lengths of stay, of individuals admitted to state-operated psychiatric hospitals and those known to the Department who had been admitted

to private psychiatric hospitals. As well, DBHDS continued to report a decreasing trend of hospital admissions for children and adults with IDD.

The consultants conducted a validation study that verified the processes utilized by the Department to produce its reported data were reliable and valid.

The Agreement's Crisis Stabilization requirements are detailed in Provisions III.C.6.b.iii.B., D. and G. and their eight associated Indicators. The purpose of these three Provisions is to ensure that individuals with IDD are offered a short-term alternative to institutionalization or hospitalization whenever inpatient stabilization services are needed.

Virginia had previously met, twice consecutively, five of these eight Indicators (10.1–10.3, 13.1 and 13.2). DBHDS's two CTHs for children continued to function, waiver slots to reduce long-term stays in hospitals or CTHs were set aside for use in emergencies, the number of residential service providers for individuals with co-occurring behavioral and/or medical conditions were increased, and two transition homes to address CTH stays beyond 60 days continued to be operational. Therefore, for the current Twenty-second Review Period, the Commonwealth again achieved these five Indicators.

Regarding Indicators 10.4 and 11.1, Virginia again did not meet the 86% performance requirement for identifying a community residence within 30 days for those admitted to CTH facilities and psychiatric hospitals.

For Indicator 13.3, DBHDS maintained operation of the out-of-home crisis therapeutic prevention host-home like service for children connected to the REACH system. This service was established to prevent institutionalization of children statewide, and the Department had secured two providers. However, only one was in operation through the third quarter of Fiscal Year 2022. The other provider was unable to open the second home due to staffing shortages.

Although established, the single operating host-home like service was barely functioning and seriously underutilized. Due to the excessive distance from families' homes or families' interests in long-term placements, three Regions did not refer any children, but two Regions did. For this reason, the Commonwealth met the minimum requirement for statewide access and so achieved Indicator 13.3. For the four children in total who were admitted since the previous review, the length of stays ranged from six to 29 days. DBHDS plans to conduct focus groups with families of children using REACH to better assess the causes of underutilization.

The other REACH services were similarly struggling to fulfill their purpose, with ubiquitous staffing shortages being the primary driving force. The CTHs for children remained open and operational, although both were closed for temporary periods over the last year due to staffing shortages, the pandemic and physical plant issues.

Beyond the pandemic's ongoing negative consequences for individuals with IDD who experienced crises, and for the caregivers who supported them, Virginia's statewide crisis system continued to experience significant operational difficulties. For example, REACH teams were challenged to recruit and retain needed staff and their mobile teams had limited ability to respond to crises on-site.

See Appendix D for the consultants' full report and attachments.

Conclusion

Regarding eight of the 13 Crisis Services Provisions, namely Provisions III.C.6.b.i.A. and B., III.C.6.b.ii.C.–E. and H., III.C.6.b.iii.A. and F., the Commonwealth again remained in Sustained Compliance.

Regarding Provision III.C.6.a.i.-iii. and its 22 Indicators, Virginia has met 19, namely 7.2–7.7, 7.9–7.17 and 7.20–7.23. The Commonwealth has not achieved the remaining three Indicators: 7.8, 7.18 and 7.19, and therefore remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.ii.A., Virginia has met six of the seven Indicators, namely 8.1–8.3 and 8.5–8.7. The Commonwealth has not achieved the remaining Indicator 8.4, and therefore remains in Non-Compliance with this Provision.

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

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

Regarding Provision III.C.6.b.iii.G., Virginia has met all three Indicators, namely 13.1–13.3. Therefore, the Commonwealth has re-achieved Compliance with this Provision. (The Parties agreed that Indicators for this Provision also cover Provision III.C.6.b.iii.E.)

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

Background

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

Earlier studies of these obligations documented that Virginia had met the pertinent quantitative requirements by providing IFSP monetary grants to at least 1,000 individuals and/or families, and had made steady progress by developing the IFSP Strategic Plan, creating an IFSP Coordination Program, organizing IFSP State and Regional Councils, continuing to develop enhancements to the IFSP funding program, writing the guidelines for families, and beginning an initiative to develop family-to-family and peer programs.

The Twentieth Period review found that DBHDS had continued to make some gains. The Department finalized and published the eligibility criteria for individuals on the waitlist to receive case management services, reviewed measurable indicators in the IFSP, and was developing a new module to replace its previously implemented application funding online portal.

However, DBHDS also experienced several challenges that had slowed the pace of progress or caused ground to be lost. In most instances, the Department had not finalized development and/or implementation of the strategies needed to achieve the Indicators or formalized its reporting and documentation requirements. In addition, DBHDS was re-thinking the structure and approaches for some areas where its progress had been stalled. For example, its Regional Councils were not meeting and so were largely not functional, the Department had not fully conceptualized an alternative approach to its draft prioritization criteria, and its family-to-family and peer programs were still under development.

For the Twentieth Period, Virginia met five of the 17 Indicators associated with the three Provisions studied.

Twenty-second Period Study

For this latest study, the Independent Reviewer retained the same consultant to review the Commonwealth's progress toward achieving these same three Provisions and their 17 associated Indicators.

DBHDS made significant progress, meeting 14 Indicators, compared with just five during the previous review. The Department developed the required documents to demonstrate the reporting of valid and reliable data. This period's study verified that DBHDS:

- Completed development and launched a new module for the Fiscal Year 2023 funding period;
- Consistently followed the protocols related to annual eligibility determinations and IFSP funding notification processes;
- Implemented the definition of those "most at risk for institutionalization," and utilized funding prioritization criteria based on that definition;
- Updated documents to inform individuals and families about eligibility criteria for individuals on the waitlist to receive case management services;
- Implemented a satisfaction survey; and
- Revised the measurable indicators in the IFSP State Plan.

Once again, however, there were areas where DBHDS's progress was limited, resulting in three unmet Indicators. Although IFSP staff reported they had finalized the selection of membership for the Regional Councils in March 2023, these Councils continued to be largely non-functional. The Department had also not yet taken recommended actions from the Eighteenth and Twentieth Period reports to ensure procedures were in place for the Family-to-Family and Peer Mentoring programs, and so did not fulfill the specific requirements of the two remaining Indicators.

Conclusion

The Twenty-second Period study concluded that the Commonwealth has met 14 of the 17 Compliance Indicators associated with the three IFSP Provisions.

Regarding Provision III.C.2.a.-i.'s 12 Compliance Indicators, Virginia has met the requirements of 11 of them, namely 1.2–1.12. The Commonwealth has not achieved Indicator 1.1. Therefore, Virginia remains in Non-Compliance with this Provision.

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

Regarding Provision III.D.5.'s three Indicators, the Commonwealth has met the requirements of one, namely 19.1. Virginia has not met the remaining two indicators, 19.2 and 19.3, and therefore remains in Non-Compliance with this Provision.

6. Community Living Options

Background

The Settlement's Provision III.D.1. and its 23 associated Compliance Indicators (18.1–18.23) focus on increasing community integration for people with IDD, especially for those with complex medical and/or behavioral needs. Community integration is the first of the three goals that the Agreement specifically intends to achieve.

Since its Agreement, the Commonwealth had established new policies, revised its regulations, created new payment rates and redesigned its DD Waiver programs and services in order to pursue increased community integration across its statewide IDD service system.

The last study, conducted a year ago, reviewed Virginia's achievement of the 23 Indicators associated with Provision III.D.1. The Commonwealth had either fully or conditionally met 17 of them, although for two of these Indicators, Virginia had not yet determined its reported data to be reliable and valid, so these were considered conditionally achieved for illustrative purposes only. Nonetheless, this represented considerable progress from the previous review when just 12 Indicators had been met.

The Twentieth Period study also found that the Commonwealth had increased the percentage of the overall DD Waiver population receiving services in the most integrated settings by 1.5%. This result continued a positive multi-year trend, but fell short of the annual 2% increase requirement. Additionally, Virginia's data continued to show significant gaps in the availability of

services that offer more integrated settings. For example, as of March 31, 2021, five of the 40 CSBs still had 50% or fewer individuals receiving services in such settings, whereas statewide 87.2% lived in integrated settings.

In 2022, DBHDS reported that it had achieved the timeliness benchmark for receipt of some nursing services (i.e., 70% within 30 days), but that it had not achieved the nursing utilization performance requirement (i.e., receipt of the number of hours identified in the ISP 80% of the time). For these figures, the Department utilized data from Fiscal Year 2020, which was an excessively long time-lag for reporting and analysis, but had planned a new approach that would allow it to report data for Fiscal Year 2022 in February 2023.

DBHDS continued to focus on The Every Child Texas model, which concludes that the most compassionate and cost-effective service delivery system for children with IDD is living within a family. To help implement this model, the Commonwealth made its Jump Start funding available to support its sponsored residential services providers who adopted this model. For the first time, Virginia met the Indicator requirement to work with sister agencies and private providers. Their efforts resulted in the development of host-home service model for children.

For the data reported by the Commonwealth during the Twentieth Period, the completeness of the two required documents, the *Process Document* and its *Attestation*, varied considerably. Some were not provided at all, while others were thorough and completed properly.

Twenty-second Period Study

For the latest review, the Independent Reviewer retained the same consultant to once again assess the status of Virginia's achievement of the 23 Indicators for Community Living Options. This study found that the Commonwealth met 20 Indicators, sustaining its previous achievement of 17 Indicators, and meeting an additional three Indicators for the first time.

However, three Indicators remain unmet:

- Annual 2% growth for individuals receiving services in integrated setting;
- Documentation of a workplan to address identified barriers; and
- Receipt of 80% of needed hours of nursing service.

Virginia's data indicated that its various initiatives have driven trends over the last six years toward achieving its community integration goal. DBHDS's HCBS Residential Settings Report

showed that, from September 2016 through September 2022, the Commonwealth continued to achieve a steady annual increase in the percentage of the overall DD Waiver population receiving services in integrated residential settings and an annual decrease in living in non-integrated settings. The increase may have been driven primarily by provider agencies serving those new to the waivers in smaller settings, including in families' homes.

Over this six-year period, the percentage of individuals living in integrated settings increased from 79.4% to 88.9% (from 9,425 to 14,178), representing an average annual 1.6% increase, while those living in non-integrated settings decreased from 20.6% to 11.5% (from 2,446 to 1770), an average annual decrease of 1.5%. While these were positive results, they demonstrated Virginia did not meet the 2% annual increase specified in Indicator 18.2.

DBHDS's most recently available Provider Data Summary showed 95% of all individuals new to the waiver from Fiscal Year 2016 through the first quarter of Fiscal Year 2022 (including individuals with support needs of Levels 6 or 7) live in integrated settings. The Commonwealth therefore achieved Indicator 18.3 for the first time.

DBHDS again completed its Provider Data Summary semi-annually, which showed a significant increase in the availability of integrated service models statewide. For example, in the 18-month period between the spring of 2021 and the fall of 2022, the number of Localities with 100% of individuals on the waiver living in integrated settings increased from 30 to 40, while the number of Localities with 50% or fewer living in integrated settings declined from five to just one. With these increases in integrated residential service options, Virginia met Indicator 18.4 for the first time.

During the Twenty-second Period, following DBHDS's review of stakeholder and focus group feedback and its integrated residential service options data, the Department established a 47-member Developmental Disability Systems Issues and Resolution Workgroup (DDSIRW). DBHDS chartered this workgroup to address issues that impact the development, expansion, and maintenance of services, including integrated residential services (i.e., sponsored residential, in-home, independent, shared and supported living, and respite). By organizing this workgroup, the Department has undertaken the challenge of addressing and resolving the barriers, identified in part by the focus group, to more integrated residential service options statewide. For the first time, the Commonwealth achieved Indicator 18.5.

Once the DDSIRW determines and finalizes its plan, including actionable strategies and timelines for completion with demonstrated actions, Virginia will meet Indicator 18.6.

For its third annual review of nursing services, DBHDS indeed accelerated its data analysis for Fiscal Year 2022. The Department reported that it achieved the timeliness benchmark for the initial delivery of nursing service to DD Waiver recipients, but did not sustain this same accomplishment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service recipients. DBHDS also reported that just 36% of individuals with waiver-funded services and only 18% of children with EPSDT services received the number of hours of needed nursing services identified in their ISP at least 80% of the time. Therefore, the Commonwealth once again did not meet Indicator 18.9.

Virginia continued to meet Indicators 18.10–18.13. These require that children be assessed prior to being admitted to nursing or ICF/IDD facilities, and to limit admissions to nursing facilities to only those who require medical rehabilitation, respite or hospice services. The Indicators also require that the Commonwealth provide a *Community Transition Guide* to assist families in preparing to move their children from these institutions to new community-based homes. Despite having achieved these Indicators, in recent years Virginia has not reduced the overall number of children residing in these facilities. Two years ago, there were 44 children with IDD living in nursing facilities. A year ago, at the end of Fiscal Year 2022, this number increased to 47 children. There was a slight decline in the number of children living in ICF/IDD facilities from 109 at the end of Calendar Year 2021 to 107 as of the end of 2022. Although some children were discharged to integrated community-based settings, many unfortunately continue to grow up in these institutions.

See Appendix F for the consultant's full report.

Conclusion

Regarding Provision III.D.1.'s 23 Indicators, Virginia has met the requirements of 20 of them, namely 18.1, 18.3–18.5, 18.7, 18.8, 18.10–18.23. The Commonwealth has not achieved three Indicators: 18.2, 18.6 and 18.9. Therefore, Virginia remains in Non-Compliance with this Provision.

7. Independent Living Options

Background

Under the terms of the Agreement, the Commonwealth committed to facilitating individuals receiving waivers to live in their own home by developing and implementing a plan to increase access to independent living options.

In June 2022, for the Twentieth Report to the Court, the Independent Reviewer reported that for several years Virginia had consistently fulfilled the Agreement's requirements to increase access to independent living options for these individuals in the target population.

As required by the Agreement's Provision III.D.3.a., the assigned housing coordinator at DBHDS, together with representatives from the Commonwealth's sister agencies on the Interagency Housing Advisory Committee (IHAC), had developed the Plan to Increase Independent Living Options (Plan). The Committee, formed by the Department, is composed of the housing coordinator and representatives from the Office of the Secretary of Health and Human Resources, Virginia Housing (formerly VHDA), the Virginia Department of Housing and Community Development, the Virginia Department of Medical Assistance Services, the Virginia Department for Aging and Rehabilitative Services, and the Virginia Board for People with Disabilities, as well as stakeholder organizations.

DBHDS had also included a term in its annual performance contract with the CSBs to require case managers to offer education at least annually about less restrictive community options. Additionally, DBHDS had developed a form, completed during the Individual Supports Plan (ISP) process, to ensure that this occurs.

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

The last review, conducted in the spring of 2022, found that 1,732 individuals in the Agreement's target population were living in their own homes. This represented an increase of

1,391 since July 2015.

The Independent Reviewer determined in his Twentieth Report to the Court that the Commonwealth had maintained Sustained Compliance with the six Independent Living Options Provisions III.D.2., III.D.3., III.D.3.a., III.D.3.b.i.-ii.., III.D.4. and III.D.7.

Twenty-second Period Review

This latest review confirmed that IHAC had updated the Commonwealth's annual Plan, dated January 19, 2022, under the leadership of DBHDS's dedicated housing coordinator and in cooperation with Virginia's relevant sister agencies.

Throughout the Twenty-first and Twenty-second Review Periods, DBHDS maintained the term in its performance contract with the CSBs that requires case managers to offer annual education about community living options. DBHDS's housing coordinator produced quarterly reports of actual outcomes compared with the measurable goals included in the Plan.

The Commonwealth reported in December 2022 that, at the end of Fiscal Year 2022, 1,872 individuals were living in a home of their own. This represents a 549% increase since DBHDS determined its baseline number of 341 in June 2015.

The table below shows the actual outcomes achieved by the Commonwealth between June 2015 and December 2022, followed by the percentage of the Plan's goal achieved.

Independent Housing Outcomes	
Date	**# in own home* (% of Plan goal achieved)**
June 2015	341 (baseline)
March 2019	925 (116%)
December 2019	1,034 (86%)
December 2020	1,512 (81%)
December 2021	1,732 (92%)
December 2022	1,872 (100%)

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

Conclusion

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

8. Waiver Slots

Background

The Agreement required the Commonwealth to create 4,170 DD Waiver slots, distributed over the ten-year period, Fiscal Years 2012 through 2021. As previously reported to the Court, Virginia had created, and in most years had exceeded, the number of Home- and Community-Based Services (HCBS) DD Waiver slots required. During this same ten-year period, the Commonwealth's General Assembly had approved 6,579 waiver slots, 58% more than required.

To achieve the outcomes of its Agreement, Virginia had redesigned its HCBS DD Waiver programs. Approved in September 2016, these Waiver programs created new models of service that offered increased opportunities to accomplish the Agreement's core goals of community integration and self-determination. These Waiver programs provided more HCBS options as alternatives to services in large congregate residential settings that increase individuals' separation from their families and communities. Since the initial approval of the redesigned Waiver programs, more individuals and families new to the waiver chose service options in smaller more integrated settings, including in families' homes. This shift allowed the Commonwealth to create more waiver slots annually, because the overall average annual cost of services per person is less in these more integrated settings.

Since the beginning of Fiscal Year 2012, Virginia's waitlist for waiver services continued to grow despite hundreds, and eventually thousands, of individuals being awarded the newly created waiver slots and therefore being removed from waitlists. In each of the first four years of the Agreement (Fiscal Years 2012–2015), even though the Commonwealth had created an average of 567 slots per year, waitlists had grown significantly, by an average of 1,114 individuals per year. But since Virginia's redesigned DD Waiver programs were approved in 2016, and more individuals with waiver slots had chosen services in integrated settings, the pace of growth of the waitlist slowed: between 2017 and 2022, the waitlist growth decreased to an annual average of 235.

The significant surge in the waitlists was driven by several factors, the largest being the increased number of eligible children diagnosed with Autism Spectrum Disorders (ASD). The Commonwealth had monitored the growth of its waitlists and had identified two additional contributing factors, both involving more families applying for waiver services earlier to better position their children to receive future services. During the first five years of the Agreement, Virginia awarded certain waiver slots on a first-come, first-served basis, based on established positions on the waitlist. Also, during the first year of the Agreement, the Commonwealth created an Individual and Family Support Program (IFSP) that awarded funds annually to individuals and their families, but only to those on the waitlists. The IFSP's annual fund, which has supported vastly more than the Agreement-required minimum of 1,000 families, awards in most cases $500–$1,000 to assist family members with IDD. The waitlist would likely have grown substantially during Fiscal Years 2012 through 2021, due to the increased number of children with ASD. However, it appears that many families had positioned their eligible family members to have more opportunities to receive services and supports by applying early for waiver-funded services.

Virginia's redesigned waiver program also restructured the waitlists. Rather than being placed on a list based on one's disability diagnosis and the date an individual became eligible, the new waitlists are based on determinations of the individual's level of need. As of March 2022, there were a total of 14,342 on the Commonwealth's three prioritized waitlists, with 3,585 individuals on the Priority 1 waitlist.

As of Fiscal Year 2022, more than 6,500 additional individuals with IDD were receiving waiver-funded community-based services than before the Agreement began in Fiscal Year 2012. Still, as already mentioned above, the waitlists for waiver-funded services had grown to more than 14,000 individuals. A year ago, in its biennium budget for Fiscal Year 2023, Virginia's General Assembly maintained funding for previously approved DD Waiver slots. However, it did not authorize any additional funding for new slots. For the Commonwealth's Fiscal Year 2024, the second year of its biennium budget, the General Assembly approved 600 new DD Waiver slots.

For the Twentieth Review period a year ago, the Independent Reviewer determined that Virginia had maintained Sustained Compliance with the three relevant Provisions III.C.1.a.i.-ix., b.i.-x., and c.i.-x.

Twenty-Second Review Period

For this Period, the Independent Reviewer again sought to confirm whether Virginia continued to maintain Sustained Compliance with these three Provisions.

For its Fiscal Year 2024 budget, the General Assembly had already approved the creation of 600 new DD Waiver slots. It subsequently approved another 500, bringing the total to 1,100. The Commonwealth reported that the Governor plans for this to be the first of three annual increases to address the needs of most of the 3,500+ individuals currently on the Priority 1 DD Waiver waitlist.

Conclusion

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

III. CONCLUSION

During the Twenty-second 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.

Overall, the Commonwealth maintained Sustained Compliance with 18 Provisions. Of the 142 Compliance Indicators studied, Virginia fully or conditionally met 111, with the Commonwealth's data showing 32 Indicators were achieved for the first time. However, for nine of these newly met Indicators, the data reported were not verified as reliable and valid, so these achievements are conditional.

Throughout the Twenty-second Review Period, while the pandemic persisted, Virginia continued to make improvements. DBHDS utilized its quality and risk management structure in the development toward a culture of quality and in the maturation of its quality and risk management processes. By implementing and refining these processes, the Commonwealth demonstrated the value of a quality improvement cycle that implements improvement initiatives to ensure achievement of measurable performance standards.

DBHDS enhanced its production of reliable and valid data across multiple service and quality areas. Yet in other areas, significant shortcomings continued to undermine the functionality of the Department's quality improvement framework. Similarly, while Virginia commendably achieved Indicators for the first time in services and quality processes, the Commonwealth did not make sufficient progress in four direct service areas that are vital to the target population.

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

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

IV. RECOMMENDATIONS

The Independent Reviewer recommends that the Commonwealth undertake the eight actions listed below, and provide a report that addresses these recommendations and their status of implementation by September 30, 2023. Virginia should also consider the additional recommendations and suggestions included in the consultants' reports, which are contained in the Appendices.

Quality and Risk Management

1. DBHDS should ensure its *Attestations* that assert the reliability and validity of its data sets verify that the completed data mitigation processes have resolved all issues identified in the assessments of its data sources. (See Provision V.D.2.a.-d., Indicator 36.1.)

2. DBHDS's Office of Licensing (OL) should issue specific guidance to providers to ensure they use data as required by Indicator 30.4. This guidance should include examples of how providers' use of data can be integrated into their risk management systems. OL should also provide additional guidance and training for Licensing Specialists to ensure they complete consistent assessment and documentation of OL's findings regarding providers' use of data. (See Provision V.C.1.)

Case Management

3. DBHDS should continue its established quality improvement practice (e.g., the SCQR) of providing on-site technical assistance following its review of each CSB's measurable performance compared with the Department's standards. (See Provision III.C.5.d., Indicators 6.2, 6.3 and 6.4.)

Crisis and Behavioral Services

4. DBHDS should evaluate and determine the root causes of the obstacles to completing crisis assessments in individuals' homes or in other community locations where the crises occur, and then develop and implement targeted quality improvement initiatives to achieve Indicator 7.8. (See Provision III.C.6.i.-iii.)

5. DBHDS should revise instructions for completing its monitoring tool, *Behavior Support Plan Adherence Review Instrument* (BSPARI), to simplify scoring options and reduce unscored items. After the new instructions are utilized for a cycle of BSPARI reviews, the Department should evaluate whether the revised instructions have resulted in improved accuracy for individual BSPARI items and enhanced agreement across reviewers. (See Provision III.C.6.i.-iii., Indicators 7.19 and 7.20.)

Individual and Family Support Program (IFSP)

6. DBHDS should document that its IFSP reported data sets have been verified as reliable and valid. The Department should review and provide complete *Process Documents* and current *Attestations* for the data reported. (See Provision III.C.2.a.-f., Indicators 1.5, 1.6, and 1.7.)

Community Living Options

7. The Commonwealth should review the primary obstacles to providing adequate nursing services. Virginia should then enhance existing initiatives, or implement new ones to achieve Indicator 18.9's metric for adequate in-home nursing services, especially for those individuals with intense medical support needs. (See Provision III.D.1.)

Quality Service Reviews (QSRs)

8. The Commonwealth should review each of the discrepancies between the findings of the Twenty-second Period Individual Services Review (ISR) study and DBHDS's Round 4 QSR assessments of the 14 individuals for whom discrepancies were identified. The Department should review and verify whether the ISR nurses' findings are correct. If so, DBHDS should examine the QSR auditors' use of the QSR tools and processes in each of these cases to identify the root causes of the discrepancies and determine steps needed to ensure the adequacy of its QSR assessments. (See Provision V.I.1.a.-b., Indicator 51.4 c., and Provision V.I.2., Indicators 52.1 a. and c.)

V. SUMMARY OF COMPLIANCE

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III	**Serving Individuals with Developmental Disabilities in the Most Integrated Setting**	Ratings prior to the 22nd Period are not in bold. Ratings for the 22nd Period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include the Commonwealth's status with each of the Compliance Indicators associated with the Provision. The Findings Section and attached consultant reports include explanatory information regarding the Compliance Indicators. *The Comments in italics below are from a prior period when the most recent compliance rating was determined.*
III.C.1.a.i.-ix.	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community according to the… schedule (in i-ix).	**Sustained Compliance**	The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012–2021.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.1.b.i.-x.	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community, individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) according to the …schedule (in i.-x.)	**Sustained Compliance**	The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012-2021. The Parties agreed to consider the effectiveness of the discharge and transition process at Nursing Facilities (NFs) and ICFs as an indicator of compliance for III.D.1.
III.C.1.c.i.-x.	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) according to the … schedule (in i-x).	**Sustained Compliance**	See Comment re: III.C.1.b.i-ix.
III.C.2.a.-i.	The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2021, a minimum of 1,000 individuals will be supported.	Non Compliance **Non Compliance**	The Commonwealth has fulfilled the quantitative requirement for the Fiscal Years 2013 through 2020 by providing financial support to more than 1,000 individuals each year. During the 22nd Period, the Commonwealth met the requirements for eleven of the twelve Indicators, 1.1–1.12. The Commonwealth met Indicators 1.2–1.12. It has not met 1.1, and therefore remains in non-compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.5.a.	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	**Sustained Compliance**	207 (100%) of the individuals reviewed in the Individual Services Review studies during the 10th, 11th, 12th, 13th, 14th, 15th, 16th, 18th., and 20th Periods had case managers and current Individual Support Plans.
III.C.5.b.	For the purpose of this agreement, case management shall mean:		
III.C.5.b.i.	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	Non Compliance **Non Compliance**	For this and four other Provisions, III.C.5.b.ii., III.C.5.b.iii.., III.C.5.c. and V.F.2., there are ten Compliance Indicators, 2.1– 2.5 and 2.16-2.20. Indicator 2.16 measures performance regarding the ten required elements (2.6-2.15). Virginia met six of the Indicators 2.1, 2.2, 2.4, 2.5, 2.17 and 2.19, but has not met four Indicators 2.3, 2.16 (includes 2.6 –2.15), 2.18 and 2.20.
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 achieves 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 achieves compliance for this Provision.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.5.c.	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	Sustained Compliance	*The Independent Reviewer and Parties agreed in April 2020 that this provision is in Sustained Compliance.*
III.C.5.d.	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	Compliance **Sustained Compliance**	The Commonwealth has met all six Compliance Indicators, 6.1a, 6.1b, 6.1, 6.2, 6.3, and 6.4. Virginia has achieved Sustained 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: i. Provide timely and accessible support … ii. Provide services focused on crisis prevention and proactive planning … iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current placement whenever practicable.	Non Compliance **Non Compliance**	The Commonwealth met nineteen of the twenty-two Compliance Indicators 7.2–7.23. It met Indicators 7.2-7.7, 7.9–7.17 and 7.20-7.23, but has not met the three Indicators 7.8, 7.18 and 7.19, and therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.i.A.	The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.	**Sustained Compliance**	CSB Emergency Services are utilized. Regional Education, Assessment, Crisis Services, Habilitation (REACH) hotlines are operated 24 hours per day, 7 days per week, and provide access to information for adults and children with IDD.
III.C.6.b.i.B.	By June 30, 2012, the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.	**Sustained Compliance**	REACH trained CSB staff during the past seven years. The Commonwealth requires that all Emergency Services (ES) staff and case managers are required to attend training.
III.C.6.b.ii.A.	Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.	Non Compliance **Non Compliance**	The Commonwealth met six of the seven Compliance Indicators 8.1–8.7. It met Indictors 8.1-8.3, 8.5, 8.6, and 8.7. It did not meet 8.4. 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 19th–22nd Review Periods, law enforcement personnel were involved. Mobile crisis team members worked with law enforcement personnel to respond regardless of whether REACH staff responded in person or remotely using telehealth.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.ii.D.	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	**Sustained Compliance**	REACH Mobile crisis teams for children and adults are available around the clock and respond on-site, or remotely due to COVID precautions, at all hours of the day and night.
III.C.6.b.ii.E.	Mobile crisis teams shall provide local and timely in-home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	**Sustained Compliance**	In each Region, the individuals are provided in-home mobile supports, or telehealth due to COVID precautions, for up to three days as required. Days of support provided ranged between a low of one and a high of sixteen days.
III.C.6.b.ii.H.	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time.	**Sustained Compliance**	The Commonwealth added staff to REACH teams in all five Regions and for five years demonstrated a sufficient number of staff to respond to on-site crises within the required average annual response times. Appropriate COVID precautions temporarily replaced many on-site responses.
III.C.6.b.iii.A.	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services.	**Sustained Compliance**	All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults and have two crisis stabilization homes for children.
III.C.6.b.iii.B.	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.	Non Compliance **Non Compliance**	The Commonwealth met three of the four Indicators 10.1–10.4. It met 10.1–10.3, but did not achieve 10.4. and therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.iii.D.	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	Non Compliance **Non Compliance**	The Commonwealth did not meet the sole indicator 11.1, and therefore remains in Non Compliance.
III.C.6.b.iii.E.	With the exception of the Pathways Program at SWVTC … crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.	Non Compliance **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 **Compliance**	The Commonwealth met all three of Indicators 13.1–13.3, and therefore has re-achieved Compliance.
III.C.7.a.	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	Non Compliance Non Compliance	*The Commonwealth has achieved Compliance Indicator 14.1.* *The Commonwealth has again not met Indicators 14.2 14.3, 14.4, 14.5, 14.6, 14.7. 14.8, 14.9, and 14.10.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.7.b.	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment First policy shall, at a minimum, be based on the following principles: (1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth; (2) the goal of employment services is to support individuals in integrated work settings where they are paid minimum or competitive wages; and (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in the ISP. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.	Non Compliance Non Compliance	*The indicators for III.C.7.a. serve to measure III.C.7.b.*
III.C.7.b.i.	Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First Policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreation opportunities, and other integrated day activities.	Sustained Compliance	*The Commonwealth had previously developed plans for both supported employment and for integrated community activities. Its updated plan includes outcomes and bench marks for FY 21–FY 23*
III.C.7.b.i.A.	Provide regional training on the Employment First policy and strategies through the Commonwealth.	Sustained Compliance	*DBHDS continued to provide regional training.*

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.7.c.	Regional Quality Councils (RQC), described in V.D.5. … shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly … Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	Sustained Compliance	*RQCs did complete a quarterly review of employment data and consultation as required.*
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	*RQCs did complete a quarterly review of employment data but did not document discussions with the RQCs regarding employment targets.*
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	Non Compliance Non Compliance	*The Commonwealth has achieved Compliance Indicators 16.1, 16.3, 16.4, 16.5, 16.6, 16.7 and 16.8.* *The Commonwealth has not met Indicator 16.2.*
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	**Sustained Compliance**	The Commonwealth again met the two Compliance Indicators 17.1 and 17.2 and therefore has Sustained Compliance.
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 twenty of the twenty-three Indicators 18.1–18.23. It met Indicators 18.1, 18.3–18.5, 18.7, 18.8, and 18.10–18.23, but did not meet the three Indicators 18.2, 18.6 and 18.9. Virginia therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.D.2.	The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources.	**Sustained Compliance**	As of 12/31/21, the Commonwealth had created new options for 1,872 individuals who are now living in their own homes. This is 1,531 more individuals than the 341 individuals who were living in their own homes as of 7/1/15.
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.
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.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.D.4.	Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing from a one-time fund of $800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii.	Sustained Compliance	*The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds received permanent rental assistance.*
III.D.5.	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.	Non Compliance **Non Compliance**	The Commonwealth met one of the three Compliance Indicators 19.1-19.3. It met Indicator 19.1, but did not meet 19.2 and 19.3, and therefore remains in Non Compliance.
III.D.6.	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	Non Compliance Non Compliance	*The Commonwealth has met Indicators 20.1, 20.3, 20.5, 20.6, 20.8*, 20.9, 20.10*, 20.11 and 20.13*; but has not achieved Indicators 20.2, 20.4, 20.7 and 20.12. Therefore, Virginia remains in Non-Compliance with this Provision. See *Note below.*
III.D.7.	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home …	Sustained Compliance	*The Commonwealth included this term in its annual performance contract, developed and provided training to case managers and implemented a form for the annual ISP form process regarding education about less restrictive options.*
III.E.1.	The Commonwealth shall utilize Community Resource Consultant ("CRC") positions located in each Region to provide oversight and guidance to CSBs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office…The CRCs shall be a member of the Regional Support Team ...	Sustained Compliance	*Community Resource Consultants (CRCs) are located in each Region, are members of the Regional Support Teams, and are utilized for these functions.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.E.2.	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	Sustained Compliance	*DBHDS has sustained improved RST processes. CRCs and the RSTs continue to fulfill their roles and responsibilities.*
III.E.3.a.-d.	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	Sustained Compliance	*The RSTs, which meet monthly and fulfill their assigned functions when they receive timely referrals.*
IV.	**Discharge Planning and Transition from Training Centers**	**COMPLIANCE*** designates the portions of the Consent Decree achieved by Virginia and relieved by the Court.	Comments explain the Commonwealth's status with each Provision.
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	COMPLIANCE*	*The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. These processes continue at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.11.a.	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	COMPLIANCE*	*The Independent Reviewer confirmed that training has been provided.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.11.b.	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches … will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers.	COMPLIANCE*	*The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
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.*

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.C.4.	The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that for almost all individuals, the Commonwealth updated discharge plans within 30 days prior to discharge.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.C.5.	The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that the Personal Support Teams (PSTs), including the Authorized Representative, had determined and documented, and the CSBs had verified, that essential supports to ensure successful community placement were in place prior to placement.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.C.6.	No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that discharge records for almost all individuals who moved to settings of five or more did so based on their informed choice after receiving options.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.C.7.	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	COMPLIANCE*	*The Independent Reviewer confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.D.1.	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	COMPLIANCE*	*The Independent Reviewer confirmed that the Facility Director job description at SEVTC specifically identifies responsibility for CIM duties and responsibilities.*
IV.D.2.a.	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that CIMs were engaged in addressing barriers to discharge.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.D.3.	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that five RSTs were functioning with the required members and were coordinated by the CIMs.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
V.	**Quality and Risk Management System**	Ratings prior to the 22nd Period are <u>not</u> in bold. Ratings for the 22nd Period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include the Commonwealth's status with each of the Compliance Indicators associated with the provision. The Findings Section and attached consultant reports include additional explanatory information regarding the Compliance Indicators. *The Comments in* <u>italics</u> *below are from a prior period when the most recent compliance rating was determined.*
V.A.	To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships), and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system that is consistent with the terms of this Section.		Provision V.A. will be in Compliance when the Commonwealth is determined to comply with all the requirements of the Provisions and associated Compliance Indicators in Section V. Quality and Risk Management System.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	Non Compliance **Non Compliance**	The Commonwealth met twenty-three* of the thirty-three Compliance Indicators 29.1-29.33. It met Indicators 29.1*, 29.2-29.7, 29.8*, 29.9, 29.10*, 29.11, 29.12, 29.14*, 29.15, 29.19, 29.26*, 29.27, 29.28*, 29.29*, 29.30*, 29.31, 29.32 and 29.33*, but did not meet the remaining 10: 29.13, 29.16–29.18, and 29.20–29.25.
V.C.1.	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	Non Compliance **Non Compliance**	The Commonwealth met nine of the eleven Compliance Indicators 30.1–30.11. It met Indicators 30.1–30.3, 30.5–30.9 and 30.11, but did not achieve the remaining two: 30.4 and 30.10.
V.C.2.	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	Sustained Compliance	*DBHDS implemented and maintains a web-based incident reporting system and reporting protocol.*
V.C.3.	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken.	Sustained Compliance	*DBHDS revised its regulations, increased the number of investigators and supervisors, added expert investigation training, created an Investigation Unit, includes double loop corrections in Corrective Action Plans (CAPs) for immediate and sustainable change, and requires 45-day checks to confirm implementation of CAP s re: health and safety.*
V.C.4.	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 32.1–32.3, 32.5, 32.6, 32.8, and 32.9.* *The Commonwealth has not met Indicators 32.4 and 32.7.*

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.D.1.	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 35.2, , 35.3*, 35.4, 35.6 and 35.8*.* *The Commonwealth has not met Indicators 35.1, 35.5, and 35.7.*
V.D.2.a.-d.	The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 36.2*, 36.4*, 36.5, 36.6* and 36.7*.* *The Commonwealth has not met Compliance Indicators 36.1, 36.3, and 36.8.*
V.D.3.	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 37.1*, 37.2* 37.3, 37.4, 37.5*–37.6* 37.8–37.9, 37.10*, 37.11, 37.12*, 37.13, 37.14*, 37.15, 37.16*, 37.17, 37.18*, 37.19, 37.20*, 37.21, 37.22*, 37.23 and 37.24*.* *The Commonwealth has not met Indicators 37.7.*

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

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.F.2.	At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs….	Non Compliance **Non Compliance**	*When Virginia achieves the Indicators for III.C.5.b.i., it also achieves compliance for this Provision.*
V.F.3.a.-f.	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	Sustained Compliance	*The ninth, twelfth, fourteenth, and sixteenth and eighteenth ISR studies found that the case managers had completed the required monthly visits for 130 of 134 individuals (96.0%).*
V.F.4.	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	Non Compliance **Non Compliance**	The Commonwealth has met* the two Compliance Indicators 46.1* and 46.2*, and therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.F.5.	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	Non Compliance **Non Compliance**	The Commonwealth has not met the sole Compliance Indicator 47.1, and therefore remains in Non-Compliance.
V.F.6.	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	Sustained Compliance	*The statewide CM training modules have been updated and improved and are consistent with the requirements of this provision.*
V.G.1.	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	Sustained Compliance	*OLS regularly renewed unannounced inspection of community providers.*
V.G.2.a.-f.	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	Sustained Compliance	*OLS has maintained a licensing inspection process with more frequent inspections.*
V.G.3.	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	Non Compliance Compliance	*The Commonwealth met all four Compliance Indicators 48.1, 48.2, 48.3 and 48.4.* *The Commonwealth achieved Compliance for the first time.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.H.1.	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	Non Compliance Non Compliance	*The Commonwealth has met Compliance Indicators 49.1, 49.5, 49.6, 49.7,49.8, 49.9, 49.10, 49.11, and 49.13.* *The Commonwealth has not met Indicators 49.2, 49.3, 49.4, and 49.12.*
V.H.2.	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	Sustained Compliance	*The Commonwealth met all three Compliance Indicators 50.1, 50.2, and 50.3, and has achieved Compliance for the third consecutive review and therefore has achieved Sustained Compliance.*
V.I.1.a.-b.	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	Non Compliance Non Compliance	*Of this Provision's five Compliance Indicators, the Commonwealth met one (51.1), but has not met four (51.2–51.5).*
V.I.2.	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting..	Non Compliance Non Compliance	*Of this Provision's seven Compliance Indicators, the Commonwealth met four (52.3–52.6), but has not met two (52.1–52.2).*
V.I.3.	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.	Non Compliance Non Compliance	*Of this Provision's four Compliance Indicators, the Commonwealth met two (53.1–53.2), but has not met two (53.3–53.4).*
V.I.4.	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	Sustained Compliance	*The Commonwealth's contractor completed the annual QSR process based on a statistically significant sample of individuals.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
VI.	**Independent Reviewer**	**Rating** **COMPLIANCE*** Provisions achieved and relieved by the Court.	**Comments**
VI.D.	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with copies to the parties. The parties will seek a protective order permitting these reports to be …and shared with Intervener's counsel.	COMPLIANCE*	*DBHDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.*
IX.	**Implementation of the Agreement**	**Rating** Ratings for the 22nd Period are in **bold.**	**Comment**
IX.C.	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented …	Non Compliance Non Compliance	*The Commonwealth has not met any of this Provision's four Indicators (54.1–54.4) and therefore remains in Non-Compliance.*

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

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

VI. APPENDICES

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APPENDIX A

Quality and Risk Management

by

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Chris Adams, MS

Quality and Risk Management System 22nd 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 2022, the Independent Reviewer's monitoring priorities again include studying compliance with these agreed-upon compliance indicators.

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 did not yet have a functioning risk management process that uses triggers and threshold data to identify individuals at risk or providers that pose risks. The Independent Reviewer's 18th Report to the Court, dated June 13, 2021, found the Commonwealth had not met the requirements for compliance at V.B noting that achieving this provision requires meeting 33 Compliance Indicators, which will be evidence that the QRM system is in compliance. It was also noted that Compliance Indicator 29.8 was not met as QSR data were not available from FY 2021 to complete required evaluations. For the 20th Report to the Court, dated June 13, 2022, the Commonwealth had not yet achieved 24 CIs for Provision V.B (29.1, 29.2, 29.4, 29.8, 29.10, 29.14, 29.16– 29.30, and 29.33) and some (29.13*, 29.15*, 29.32*) were only conditionally met due to a lack of valid and reliable data. Similarly, for Provision V.C.1, the Commonwealth had not met the following CIs: 30.4, 30.07, 30.10 and 30.11, and had only conditionally met 30.5*.

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 primary focus for this study was on those CIs that the Commonwealth has not previously provided sufficient evidence that the requirements of the Indicator were met, including those previously denoted as "Met*" for illustrative purposes pending data reliability and validity determinations. Secondary focus was on the Compliance Indicators where evidence was sufficient to demonstrate that the Commonwealth met the requirements in the indicator for the first time during the 20th period study, which included CIs 29.9, 30.8 and 30.9. The study also sought to confirm that the Commonwealth has maintained sustained compliance for the following CIs: 29.3. 29.5. 29.6, 29.11, 29.12, 29.32, 30.1, 30.2, 30.3 and 30.6.

The study methodology included document review, DBHDS staff interviews, review of a sample of relevant records from 50 randomly selected licensed providers and Community Services Boards (CSBs) across the Commonwealth, review of data and information regarding the 11,268 Level II and Level III incidents reported by providers during CY 2022, annual Office of Licensing (OL) inspection reports, and evidence packets that OL used in assessing regulatory compliance during the CY 2022 annual licensing inspection 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 each Provision and its associated CIs.

Summary of Findings:
According to the *Developmental Disabilities Quality Management Plan State Fiscal Year 2023*, dated October 14, 2022, DBHDS is committed to Continuous Quality Improvement (CQI), which the *Plan* describes as "an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes." The *DBHDS Quality Management Plan* further describes quality improvement (QI) 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."

This study found that DBHDS continued to make steady progress in these areas, but the functionality of the Commonwealth's framework continued to be hampered by a lack of valid and reliable data across some key components of the system. As previous studies have found, these issues compromise the ability of DBHDS staff to complete meaningful analyses of the various data collected to effectively identify and implement needed improvements. This an overarching theme that continues to negatively impact the ability of DBHDS to fully implement its commitment to Continuous Quality Improvement, as described in the *DBHDS Quality Management Plan.*

During the 20th Period review, DBHDS had begun to implement procedures documented in an agreed-upon Curative Action for Data Validity and Reliability that was jointly filed by the parties on 1/21/22. It stated that "DQV will continue to review data sources and update the quality management plan annually as required. DQV will also continue to make recommendations around actionable items with the systems to increase their quality. Additionally, every 3-5 years DQV will do a deep dive into each source system to test and follow the data, from the entering of data into the source system to the reporting of the data from the data set(s). DQV will review and identify concerns related to source systems and will identify threats to

the data reliability and validity. DQV provides technical assistance to the SME in collaboration with IT (to correct threats to data. This improvement will be reviewed with DQV. Assertion of data reliability and validity will be completed by the Chief Data Officer (CDO) once threats have been alleviated."

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

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

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

Accompanying the curative action, DBHDS provided a document entitled *Attachment C DOJ SA Process Document - DQV DQ Verification Process*. DBHDS stated the purpose of its *Process Document* is to document the process that will establish traceability of data quality monitoring activities around data quality recommendations. Further, the Commonwealth's *Process Document* identified the input or trigger for the data quality attestation procedures as recommendations generated by the Office of DQV around identified areas of improvement within data source systems and data reporting. In other words, the Commonwealth committed to a clear expectation that a final data set attestation would occur once appropriate DBHDS staff had addressed and resolved the reliability and validity deficiencies identified by the Office of DQV and described in the Process Document. During the 20th review period, DBHDS also

provided a "Data Governance" Process Document to further describe the methodology for the implementation of the data set attestation process. In particular, for purposes of this discussion, this document also indicated that the input or trigger for the undertaking of a data set attestation would include "DQV Data Source System Assessments, New Data Report required for DOJ Settlement Agreement, New Data Report required for reporting purposes, New Data need identified by QIC or subcommittees."

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

Based on the findings of this study and others in this 22nd Period review, DBHDS has made continued strides in this area, but some challenges persist. For Provision V.B in particular, based on review of the documents DBHDS provided, this study noted progress, but still could not consistently confirm that DBHDS staff completed the required Process Document and/or the applicable Data Set Attestation Forms in a manner that demonstrated the DBHDS staff have identified, isolated and addressed applicable reliability and validity deficiencies in the data source systems. The study revealed the following progress as well as ongoing concerns:

- For most CIs that require the reporting of metrics, DBHDS staff have developed Process Documents that describe the methodologies where data are stored and how to aggregate the data for reporting. This has been an area of notable progress, although there are still methodologies that have deficiencies impacting data validity and/or reliability. Many of these are described in Sections V.B and V.C.1 below.
- In particular, while Process Documents more often documented the previously identified (i.e., by EHA) threats to data validity and reliability, they only inconsistently identify clear mitigation steps that will ameliorate the identified threats. One very good example of identifying and comprehensively addressing the threats is the *Provider Data Summary 004*, described below for a number of CIs. On the other hand, the *Process Document for Serious Incident Reports by Type _Surveillance Rates* did not acknowledge the threats identified in a February 2022 document entitled *RMRC Data Reporting Roadmap: A Path to Improved Data Quality in Routine Data Reporting*. As follow-up, the consultant requested some narrative to document the assertion that staff had addressed all of these, but the narrative provided only minimal evidence.
- The Curative Action for Data Validity and Reliability requires that for each Process Document, the DBHDS the Chief Data Officer (CDO) will assert data set quality by signing off on a Data Set Attestation Form for the data set. Although DBHDS consistently provided these Data Set Attestations, the documents typically did not meet the requirements of the Curative Action for Data Validity and Reliability overall. They attested to how to pull data from the data set, but did not attest they had considered the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. In other words, the Data Set Attestations typically did not attest *all* issues were resolved. While it would not be necessary for Data Set Attestations to repeat all the language in the relevant Process Document(s) to this effect, it would require attestations that all resolutions were reviewed and found to be sufficient.

Of note for this 22nd Period Review, the *Developmental Disabilities Quality Management Plan* also describes the role and responsibilities of the Office of Epidemiology and Health Analytics (EHA), formerly the Office of Data Quality and Visualization (DQV). It states, among other functions, that the EHA supports the

identification, evaluation, refinement, and documentation of processes that already exist in their respective areas and assists in determining where improvements can be made. EHA also utilized this model of quality monitoring and improvement in its development of a comprehensive Data Quality Monitoring Plan (DQMP). The DQMP was designed to be an objective assessment of the quality of the major data source systems used for agency reporting. The results of this plan will be used to guide the improvement of key data sources, monitor progress over time, and ensure that the Department is able to collect and analyze consistent, reliable data. Based on interview with DBHDS staff for this 22nd Period review, the EHA office no longer exists, although the functions will remain but be dispersed in other parts of the organizational structure. At this time of this study, DBHDS had not yet developed any documentation that clearly describes this realignment of staff and function, but in interview indicated a plan to do so. Going forward, this will be a critical need. It is particularly relevant to the ongoing discussion and evaluation of data validity and reliability challenges that have been identified as a primary barrier to compliance in numerous Reports to the Court by the Independent Reviewer.

It bears repeating that DBHDS defines QI as the "systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care." The need for data that are valid and reliable undergirds the QI process, described in CI 29.1. Despite a robust set of policies, procedures and practices for QI, as well as for QA and RM, described throughout the CIs for V.B and V.C.1, the lack of valid and reliable data continues to be the primary challenge to a finding of full compliance. This is illustrated in a number of Met* Conclusions below, which signify that DBHDS has developed sufficient processes and practices to adequately use valid and reliable data, they have not yet implemented procedures that ensure such data exist.

Additional specific findings for each of this study's provisions are detailed below.

V.B.

As described above, the availability of reliable and valid data remained an overarching barrier to the implementation of an environment of Continuous Quality Improvement. Otherwise, DBHDS continued to make progress in the development of a culture of quality and in the maturation of its quality and risk management processes, including the processes for serious incident management, the development of QIIs with measurable goals and the provision of targeted technical assistance. For example, DBHDS developed some new processes that held promise One notable example was an initiative to facilitate provider monitoring of the incidence of risks that are prevalent in individuals with developmental disabilities, which was just underway. Another example was a well thought out strategy for identifying individuals with high risks, which allowed DBHDS to achieve compliance with CI 29.19 and CI 30.11 for the first time.

In the area of the training and technical assistance, DBHDS made resources available to providers specific to expectations for and processes to conduct thorough root cause analyses (RCAs) that has proven to be effective. This study's sample of 90 RCAs completed by providers during CY 2022 noted recognizable improvement in the quality and utility of these analysis processes compared to a similar review during the 20th period study. Likewise, the Office of Clinical Quality Management was expanding its robust Consultation and Technical Assistance (CTA) Framework, including the very successful CTA practices specific to Office of Licensing (OL) quality improvement regulations.

Also with regard to licensing requirements, DBHDS has continued refinement of its use of the CONNECT data system which has proven to be a valuable tool for incident reporting analysis and follow-up as well as structure for consistent implementation and documentation of annual licensing inspection findings, CAPs, and required follow-up by OL with providers. The initial implementation of

the VCU IMU look-behind process required at CI 29.16 has been positive to date, providing OL with significant information about issues/process improvements requiring specific attention. Initial review results have identified specific focus areas for OL/IMU process improvement and once the system is fully functional addressing all required elements, it should become a valuable tool for DBHDS to evaluate and improve its ability to oversee its responsibilities for serious incident reporting, analysis, and follow-up. It is hoped that as the revised OHR look-behind process is implemented over the next few months, similar positive results identified from the IMU look-behind initial implementation will be replicated for OHR.

However, as referenced above in this Summary of Findings, DBHDS did not yet provide sufficient evidence to its ability to utilize CONNECT to draw down valid and reliable serious incident data. During the 21st Period review, DBHDS provided a document developed by the RMRC's Data Workgroup, entitled RMRC *Data Reporting Roadmap: A Path to Improved Data Quality in Routine Data Reporting (Roadmap)*, dated 2/4/22, that spelled out a series of specific threats to the reliability and validity of data derived from the CHRIS data source system, as well as specific steps to achieve needed remediation. For this 22nd Period review, the aforementioned Process Document provided for review contained minimal evidence of the actual completion of the specific steps outlined in the *Roadmap* document other than to provide written statements that the steps were completed. It did not acknowledge the specific threats identified in the *Roadmap*. Provision V.B. includes a number of CIs that require a review of serious incident reliable and valid data. For example, the lack of valid and reliable incident data results undermines full compliance determinations for indicators that require trend analyses by the QIC and the RMRC . Therefore, the incident review data cannot be used for compliance reporting for those CIs.

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

DBHDS has published on its website guidance documents and reference materials for providers on topics that include development and implementation of a quality improvement program; development and implementation of a risk management program; and development and implementation of a serious incident reporting, follow-up, and analysis system. The I*ncident Management Unit Care Concern Threshold Joint Protocol* was revised on 01/01/2023 based on continued analysis of serious incident reports. This revision included the addition of two new care concern (risk trigger/threshold) categories relating to choking incidents and unplanned psychiatric hospital admissions.

DBHDS revised and published several guidance documents for providers including the Internal Protocol for DBHDS Incident Management (rev 01/01/2023), the *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services* (rev January 2023), and the *OL New Hire Staff Orientation: 12VAC35-105-620.A-E* PowerPoint. The Office of Integrated Health (OIH) continues to publish periodic Health and Safety Alerts and the Health Trends Monthly Newsletter.

Providers continue to demonstrate improved compliance with the risk management requirements in the Licensing Regulations at *12VAC35-105-520.A-E.* During CY 2022, 94% of providers were assessed for compliance with these regulations as required by CI 30.4 and 97% of those assessed complied with these regulations or completed a corrective action plan addressing cited deficiencies as required by CI 30.5. However, the current assessment process still does not sufficiently evaluate all of the requirements at CI 30.4. The review of sample provider documents did not demonstrate that providers are using data at the individual and provider level, including 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. To clarify provider expectations and more consistently assess providers' incorporation of these analyses into the risk management program, DBHDS has targeted a strategy to address these expectations in the provider training entitled *Minimizing Risk* that is being delivered in April 2023.

The tables below illustrate the current compliance status for each Compliance Indicator.

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

V.B Indicators:	Status
29.5 DBHDS monitors compliance with the serious incident reporting requirements of the Licensing Regulations as specified by DBHDS policies during all investigations of serious injuries and deaths and during annual inspections. DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations.	Met
29.6 The DBHDS quality improvement system is led by the Office of Clinical Quality Improvement and structured by organizational committees with the Quality Improvement Committee (QIC) as the highest quality committee for the Department, and all other committees serve as subcommittees, including the: Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, Regional Quality Councils, and the Key Performance Area Workgroups: Health & Wellness, Community Inclusion & Integration, Provider Capacity & Competency.	Met
29.7 The Office of Clinical Quality Improvement leads quality improvement through collaboration and coordination with DBHDS program areas by providing technical assistance and consultation to internal and external state partners and licensed community-based providers, supporting all quality committees in the establishment of quality improvement initiatives, use of data and identification of trends and analysis, and developing training resources for quality improvement.	Met
29.8 The Office of Clinical Quality Improvement oversees and directs contractors who perform quality review processes for DBHDS including the Quality Services Reviews and National Core Indicators. Data collected from these processes are used to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level.	Met*
29.9 The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas. d. The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures addressing: i. The charge to the committee, ii. The chair of the committee, iii. The membership of the committee, iv. The responsibilities of chair and members, v. The frequency of activities of the committee (e.g., meetings), vi. Committee quorum, vii. Periodic review and analysis of reliable data to identify trends and system-level factors related to committee-specific objectives and reporting to the QIC.	Met
29.10 The QIC sub-committees report to the QIC and identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement. The QIC sub-committees evaluate data at least quarterly, identify at least one CQI project annually, and report to the QIC at least three times per year.	Met*
29.11 Through the Quality Management Annual Report, the QIC ensures that providers, case managers, and other stakeholders are informed of any quality improvement initiatives approved for implementation as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths.	Met
29.12 DBHDS has a Risk Management Review Committee (RMRC) that has created an overall risk management process for DBHDS that enables DBHDS to identify, and prevent or substantially mitigate, risks of harm.	Met

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

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

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

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

V.B. Analysis of 22nd Review Period Finding

22nd Review Period Findings **V.B The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.**

Compliance Indicator	Facts	Analysis	Conclusion
29.1 The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. DBHDS Quality Management System shall: a. Identify any areas of needed improvement. b. Develop improvement strategies and associated measures of success. c. Implement the strategies within 3 months of approval of implementation. d. Monitor identified outcomes on at least an annual basis using identified measures.	The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. The DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance, b. Quality Improvement and c. Risk Management. The DBHDS Quality Management System specifies responsibilities and has policies and procedures for implementation of a full quality cycle. DBHDS often did not have evidence that they had reliable	For this review period, DBHDS provided a document entitled *Developmental Disabilities Quality Management Plan State Fiscal Year 2023*, dated October 14, 2022. Part 1: The Quality Management (QM) Program Description describes the current structure and framework for discovery and remediation activities and provides a path forward for improvement activities, while Part 2: The Quality Improvement Committees describes the organization of all the quality improvement committees comprised within the quality management system, the accountability structure, charter requirements, and describes the work plan used by each of the QIC Subcommittees to track the progress of performance measure indicators (PMI) and quality improvement initiatives (QII). Similarly to the findings of previous reviews, the plan provided a clear overall conceptualization of the quality improvement structures and functions envisioned. The plan asserts that quality assurance (QA), risk management (RM) and quality improvement (QI) are integrated processes that are the foundation of the DBHDS quality management system (QMS) overall. It further states the following: • "QA focuses on discovery activities to evaluate compliance with standards, regulations, policies, guidance, contracts, procedures and protocols, and the remediation of individual findings of non-compliance. Regulatory compliance establishes the extent to which basic performance standards are met, which include DBHDS Licensing and Human Rights Regulations, DMAS Developmental Disabilities (DD) HCBS Waiver Regulations, and the assurances built on the statutory	20th-Not Met **22nd- Met***

Compliance Indicator	Facts	Analysis	Conclusion
e. Where measures have not been achieved, revise and implement the improvement strategies as needed. f. Identify areas of success to be expanded or replicated; g. Document reviewed information and corresponding decisions about whether an improvement strategy is needed. The DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance, b. Quality Improvement, and c. Risk Management	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.)	requirements of the CMS 1915c Waiver program." • "RM assesses and identifies the probability and potential consequences of adverse events and develops strategies to prevent and substantially mitigate these events or minimize the effects. This is achieved for individuals receiving services using risk screening assessments and responsive care plans. At the systems level, DBHDS monitors critical risk triggers through reported data sources and initiates interventions as appropriate. At the provider level, DBHDS requires service providers to develop RM plans, including the identification of risk triggers and response strategies to mitigate the potential for harm. Comprehensive RM also includes requirements for the reporting, investigating and remediation pf critical incidents as indicated using corrective action plans (CAPs). DBHDS also employs a robust complaint system for allegations of abuse, neglect, and exploitation." • "QI is the systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care. At the provider level, DBHDS requires service providers to develop RM plans, including the identification of risk triggers and response strategies to mitigate the potential for harm." The description of the DBHDS QMS also continues to specify responsibilities and policies and procedures for implementation of a quality cycle, as specified in a-f of the Compliance Indicator, including the use of the well-recognized Plan-Do-Study-Act (PDSA) quality improvement model as a guide for implementing the quality cycle. The charters for the QIC and its subcommittees again defined an expectation that each subcommittee will be responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated, and that the subcommittees will utilize the PDSA Model for such initiatives. As reported previously, this continued to be well evidenced in the QII documents reviewed for this current study period.	

Compliance Indicator	Facts	Analysis	Conclusion
		The plan describes the DBHDS QMS as including the following components: • The DBHDS Division of Provider Management, which provides a quality assurance function for the agency, establishing basic requirements for provider organizations through regulation, determining the extent to which these standards/regulations are met and taking action to remedy specific problems or concerns that arise. The DBHDS Division of Provider Management includes the Offices of Licensing, Human Rights, and Regulatory Affairs. These offices provide oversight and monitoring of providers to assure individuals' rights and that providers and services meet established standards and requirements. • The Division of Quality Assurance and Government Relations, which oversees the regulatory, QA, and RM processes, and includes the includes the Offices of Licensing (OL), Human Rights (OHR), and Regulatory Affairs. These offices provide oversight and monitoring of providers to assure individuals' rights and that providers and services meet established standards and requirements. This Division also oversees the DD HCBS Quality Management Plans, including the work of the Quality Review Team (QRT); • The Division of Developmental Services, which includes the Office of Provider Development, the Office of Integrated Health (OIH) and Case Management/Support Coordination; • The Division of Administrative Services provides the support and infrastructure of the operationalization of all program areas of DBHDS. The Division includes the Offices of Finance, Procurement, Human Resources, Internal Audit, Information Technology, and Information Security • The Division of Facilities Services which directs, monitors, and strengthens quality improvement in the DBHDS State Facilities; and, • The Division of Clinical and Quality Management, is comprised of the following offices: Pharmacy Services, Epidemiology and Health Analytics, Mortality Review, Clinical Quality Management, Community Quality Improvement, and Compliance Management. Of note for this 22nd Period Review, the plan also describes the role and	

Compliance Indicator	Facts	Analysis	Conclusion
		responsibilities of the Office of Epidemiology and Health Analytics (EHA), formerly the Office of Data Quality and Visualization (DQV). It states, among other functions, that the EHA supports the identification, evaluation, refinement, and documentation of processes that already exist in their respective areas and assists in determining where improvements can be made. EHA also utilized this model of quality monitoring and improvement in its development of a comprehensive Data Quality Monitoring Plan (DQMP). The DQMP was designed to be an objective assessment of the quality of the major data source systems used for agency reporting. The results of this plan will be used to guide the improvement of key data sources, monitor progress over time, and ensure that the Department is able to collect and analyze consistent, reliable data. Based on interviews with DBHDS staff for this 22nd Period review, the EHA office no longer exists, although the functions will remain but be dispersed in other parts of the organizational structure. At this time of this study, DBHDS had not yet developed any documentation that clearly describes this realignment of staff and function, but in interview indicated a plan to do so. Going forward, this will be a critical need. It is particularly relevant to the ongoing discussion and evaluation of data validity and reliability challenges that have been identified as a major barrier to compliance in numerous *Reports to the Court* by the Independent Reviewer. Previous studies completed during the 18th and 20th Period reviews noted that the meaningful implementation of the quality improvement cycle requires the use of reliable and valid data to identify any areas of needed improvement, devise data-based actions to address those needs, evaluate and monitor whether those actions are having the desired effect and to make needed revisions, but that DBHDS did not present evidence that valid and reliable data were consistently available to support the quality cycle. During the 20th Period review, DBHDS had begun to implement procedures pursuant to an agreed-upon Curative Action for Data Validity and Reliability, jointly filed with the Court by the parties on 1/21/22, but considerable work remained at that time. Based on the findings of this study and others in this 22nd Period review, DBHDS has made continued strides in this area, but some challenges persist, including the following examples:	

Compliance Indicator	Facts	Analysis	Conclusion
		• For most CIs that require the reporting of metrics, DBHDS staff have developed Process Documents that describe the methodologies where data are stored and how to aggregate the data for reporting. This has been an area of notable progress, although there are still methodologies that have significant deficiencies impacting data validity and/or reliability. Many of these are described in Sections V.B and V.C.1 below. • In particular, while Process Documents more often documented the previously identified (i.e., by EHA) threats to data validity and reliability, they only inconsistently identify clear mitigation steps that will ameliorate the threats. One very good example of identifying and comprehensively addressing the threats is the *Provider Data Summary 004,* which addresses several CIs and is described further below. On the other hand, the Process Document for *Serious Incident Reports by Type _Surveillance Rates* did not acknowledge the threats identified in a February 2022 document entitled *RMRC Data Reporting Roadmap: A Path to Improved Data Quality in Routine Data Reporting.* As follow-up, the consultant requested some narrative to document the assertion that staff had addressed all of these, but the narrative provided only minimal evidence. • The Curative Action for Data Validity and Reliability requires that for each Process Document, the DBHDS the Chief Data Officer (CDO) will assert data set quality by signing off on a Data Set Attestation Form for the data set. Although DBHDS consistently provides these Data Set Attestations, the documents did not meet the requirements of the Curative Action for Data Validity and Reliability overall. They attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. It bears repeating that DBHDS defines QI as the systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment,	

Compliance Indicator	Facts	Analysis	Conclusion
		which occurs in a continuous feedback loop to inform the system of care. The need for data that are valid and reliable undergirds the QI process, described in criteria a. through f. of this CI. Despite a robust set of policies, procedures and practices for QI, as well as for QA and RM, described throughout the CIs for V.B and V.C.1, the lack of valid and reliable data continues to be the primary challenge to a finding of full compliance. This is illustrated in a number of Met* Conclusions below, which signify that DBHDS has developed sufficient process es and practices to adequately use valid and reliable data, they have not yet implemented procedures that ensure such data exist.	
29.2 The Offices of Licensing and Human Rights perform quality assurance functions of the Department by determining the extent to which regulatory requirements are met and taking action to remedy specific problems or concerns that arise.	The Office of Licensing (OL) is the regulatory authority for the DBHDS licensed service delivery system. Through quality assurance processes, the OL determines the extent to which regulatory requirements are met and takes action to remedy specific problems or concerns as they are identified. The Office of Human Rights (OHR) ensures compliance with human rights regulations; follows up on complaints and allegations of abuse, neglect, and exploitation; conducts independent or joint investigations with OL or other DBHDS partners and/or the Virginia Department of Social Services.	The *DBHDS Quality Management Plan SFY 2023* states that the DBHDS Division of Quality Assurance and Government Relations includes the Offices of Licensing (OL), Human Rights (OHR), and Regulatory Affairs. As described in the two paragraphs below, these offices provide oversight and monitoring of providers to assure individuals' rights are protected and promoted and that providers and services meet established standards and requirements. The 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), OL ensures the mechanisms for the provision of quality service are monitored, enforced, and reported to DBHDS leadership. OL is responsible for ensuring that DBHDS licensed providers have developed and implemented risk mitigation and quality improvement (QI) processes including a QI program and a risk management plan and assessing delivery of services for individuals with behavioral health and developmental disabilities. The OL includes an Incident Management Unit (IMU) and a Special Investigations Unit (SIU). IMU is responsible for the daily review, triage, and follow-up on all reported serious incidents to identify and, where possible, prevent future risks of harm. Follow-up on incidents may include phone contact with the provider and/or individual to assure immediate protections and health and safety follow-up has occurred and desk review of records relevant to the incident and related report documentation. The IMU	20th-Not Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
		works closely with the SIU, Licensing Specialists, the Office of Integrated Health (OIH) and staff in the OHR to ensure adequate follow-up on reported incidents. The OHR is responsible for promoting the basic precepts of human dignity, advocating for the rights of persons with disabilities in the DBHDS service delivery system, and managing the Human Rights Complaint Process. OHR Advocates ensure compliance with human rights regulations, following up on complaints and allegations of abuse, neglect, and exploitation and respond to and assist in the complaint resolution process by monitoring provider reporting and reviewing provider investigations and corrective actions. OHR Advocates also respond to reports of abuse by conducting independent or joint investigations with DBHDS partners and/or external agencies such as the Virginia Department of Social Services. In cases where there are violations of the Human Rights Regulations, Advocates recommend citation through the OL. Providers are required to report human rights complaints; allegations of abuse, neglect, and exploitation; and serious incidents as defined in Licensing and Human Rights regulations through the DBHDS online incident management reporting system (CHRIS). OHR monitors these reports and coordinates address with OL. The various processes that relate to the requirements in this Compliance Indicator are described in detail in the *29.3-29.5 34.4-34.7 Licensing Assessment Incident Report Process Document VER 003*. The determination from the 20th period study that DBHDS did not meet the requirements of this Compliance Indicator were based on review and comparative analysis of sample Root Cause Analysis (RCA) reports and findings from annual licensing inspections from a sample of Community Services Boards (CSBs). The results of that sample review did not verify that the OL adequately determined the extent to which providers properly completed RCAs. The consultant conducted a similar review and analysis for this 22nd period study. The 22nd period analysis included review of 90 RCAs and annual systemic risk assessment reports, risk management plans, and relevant provider policies from a randomly selected sample of 50 licensed providers. Analysis included comparison of the consultant's compliance determinations with those of the Licensing	

Compliance Indicator	Facts	Analysis	Conclusion
		Specialist documented on the sample provider's CY 2022 annual licensing inspection CAP report. From review of these RCAs from the sample providers and comparison of results with findings from the sample provider's annual licensing inspection, the consultant determined that the quality of the RCAs themselves were significantly improved compared to those reviewed in the 20th period study. Additionally, the consultant's agreement with the findings of the Licensing Specialist during the provider's CY 2022 annual inspection increased significantly. Comparing the percentage agreement from the 20th period study and the results of this study: • Regarding whether the RCA included a detailed description of what happened, the percentage agreement increased from 79.6% to 91%. • Regarding whether the RCA included an analysis of why the incident happened and related underlying causes under the control of the provider, the percentage agreement increased from 51.8% to 91%. • Regarding whether the RCA included identified solutions to mitigate reoccurrence of the incident and reduce future risk of harm, the percentage agreement increased from 66.7% to 87%. Additional details about this analysis are summarized at CI 29.4 below. Of note, Curative Action #5 requires that in addition to the oversight processes of the OL and OHR, DBHDS will utilize the Quality Services Review (QSR) processes to assess provider compliance with regulatory requirements related to staff training and competency assessment identified in CI's 49.2, 49.3, 49.9, and 50.1. Those processes were initially evaluated in the 21st period study.	
29.3 a. The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process. This	*12VAC35-105-160.D.2 (effective 08/01/20)* requires that Level II and Level III serious incidents be reported within 24 hours of discovery. The *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services*	This 22nd Period review verified again that OL continues to assess provider compliance with 12VAC-35-105-160.D.2 (effective 08/01/2020) that require Level II and Level III serious incidents be reported via the Department's web-based reporting application (CHRIS) within 24 hours of discovery. The assessment processes are outlined in the OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (rev January 2023). This protocol includes specific responsibilities of the IMU, the OHR, and Licensing Specialists (during their annual inspections and investigations). The primary assessment process for assuring timely reporting (within 24 hours of	20th-Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
includes assessing whether: i. Serious incidents required to be reported under the Licensing Regulations are reported within 24 hours of discovery.	*(revised January 2023)* contains detailed procedures for assessing compliance with the serious incident reporting requirements in the Licensing Regulations. Based on the consultant's review of data and information provided for the 11,268 incidents reported between 01/2022-12/31/2022 and review of CAPs for an randomly selected sample of 50 licensed providers who had inspections during CY2022, IMU staff and Licensing Specialists continue to follow protocol requirements to assess whether providers are meeting the serious incident reporting requirements in the Licensing Regulations including the requirement that incidents be reported within 24 hours of discovery.	discovery) of deaths and serious injuries is the responsibility of the IMU. Data from the CHRIS system is imported into the CONNECT data system and IMU staff run daily reports that identify all Level II or Level III serious incidents or deaths that were reported more than 24 hours after the date of discovery. On each business day, the IMU CAP Specialist reviews the content of this data report and issues a licensing report to the provider citing late reporting unless the provider had a valid reason (acceptable reasons are specified in in Section D of the Protocol) for not reporting the serious injury or death within the 24-hour timeframe. The licensing report requires the provider to develop and implement a CAP addressing remediation of the late reporting. Documentation of each of the steps in this process, including issuance and approval of the CAP, is recorded in the CONNECT data system. This process is described in detail in the *29.3-29.5 34.4-34.7 Licensing Assessment Incident Report Process Document VER 003*. A Performance Measure Indicator (PMI) (*CI36.5 and CI29.3 KPA PMI Critical incidents are reported on time – Updated 8.19.2022*) relating to the 24-hour reporting timeframe set a target that 86% of critical incidents be reported to the OL within 24 hours. Previously, there were concerns that the data used to measure this timeframe was not sufficiently specific to accurately assess whether the report was made within the required 24-hour period. DBHDS made improvements to address this concern include making the "date of discovery" field a mandatory field for data entry and incorporating a field to capture time of discovery that is also used in the calculation. The *DBHDS Developmental Disabilities Annual Report and Evaluation SFY 2022* noted SFY 2022 results for this PMI at 96%. OL provided a report detailing information about each of the 11,268 Level II and Level III serious incidents or deaths reported by providers during CY 2022 (OL Regulatory Compliance with 12VAC35-105-160.D.2 Data Report). Adjusting for the 378 reports that were reported late for excused reasons, 10,454/10,890 (96.0%) incidents were reported within the prescribed 24-hour period. This data is consistent with the percentage compliance noted in the Annual Report referenced above. Following guidance in the *OL Annual Compliance Determination Chart (revised annually),* during annual licensing inspections Licensing Specialists review a	

Compliance Indicator	Facts	Analysis	Conclusion
		sample of records to verify that serious incidents are reported within 24 hours of discovery. If a serious incident is identified in the sample review, OL cross-references it with a list of incidents that were reported and reviewed by the IMU. If not found on that list, and the provider does not have further proof of timely reporting, the Licensing Specialist cites the provider for late reporting.	
29.4 ii. The provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all level II and level III serious incidents; iii. The root cause analysis, when required by the Licensing Regulations, includes i) a detailed description of what happened; ii) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and iii) identified solutions to mitigate its reoccurrence.	As part of the annual inspection process, the OL assessment of provider compliance with the serious incident reporting requirements of the Licensing Regulations includes whether the provider has conducted at least quarterly review of all Level I serious incidents, completion of an RCA for all Level II and Level III serious incidents, and that each RCA include (1) a detailed description of what happened; (2) 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 (3) identified solutions to mitigate its reoccurrence. Based on results of the sample review, Licensing Specialists are assessing provider compliance with the	DBHDS regulations at *12VAC35-105-160.C* require providers to collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents, as a part of their quality improvement program. The review must include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. DBHDS Regulations at *12VAC35-105-160.E.1.a-c* require providers to conduct an RCA for any Level II or Level III serious incidents and prescribe that each RCA must include (1) a detailed description of what happened; (2) 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 (3) identified solutions to mitigate its reoccurrence. The *OL Annual Compliance Determination Chart (revised annually)* prescribes the methodology used by Licensing Specialists to assess provider compliance with each of these requirements. This process is described in detail in the *29.3-29.5 34.4-34.7 Licensing Assessment Incident Report Process Document VER 003*. The *OL Regulatory Compliance with 12VAC35-105-160.C Data Report* documented compliance determinations for each of the elements of 160.C for all annual licensing inspections conducted during CY 2022 noting that 83% of providers (828/1003) reviewed complied with the requirement to conduct at least quarterly review of Level I serious incidents and 162 providers were not able to be assessed as they did not have Level I serious incidents to review during the period. Within the sample of 50 licensed providers reviewed by the consultant, the percentage of providers that complied with this requirement was similar to that DBHDS reported for all providers assessed during CY 2022. The results of this comparative sample review support that the OL is consistently assessing provider compliance with the requirement to conduct at least quarterly review of all Level I serious incidents as part of their quality improvement program.	20th-Not Met **22nd - Met**

Compliance Indicator	Facts	Analysis	Conclusion
	requirements relevant to this Compliance Indicator following the protocols outlined in the *OL Annual Compliance Determination Chart (revised annually)*. Based on the results of the sample review, Licensing Specialists have significantly increased the accuracy and consistency of their assessment of the licensing requirements relevant to this Compliance Indicator compared to findings from the 20th period.	The *OL Regulatory Compliance with 12VAC35-105-160.E Data Report* documented compliance determinations for each of the elements of 160.E for all annual licensing inspections conducted during CY 2022 noting the following: • Regarding compliance with the requirement that the RCA include a detailed description of what happened (§E.1.a), 831/909 providers (91%) complied, and 263 providers could not be assessed as they did not have serious incidents requiring a root cause analysis to be completed. Comparing results and supporting documentation for the sample of 90 RCAs completed by 50 providers, the consultant agreed with 92% (83/90) of the Licensing Specialist determinations. Providers completed CAPs for all regulations where non-compliance was identified in the sample. • Regarding compliance with the requirement that the RCA include an analysis of why the incident happened including identification of all identifiable underlying causes of the incident that were under control of the provider (§E.1.b), 832/907 providers (92%) complied, and 263 providers could not be assessed as they did not have serious incidents requiring a root cause analysis to be completed. Comparing results and supporting documentation for the sample of 90 RCAs completed by 50 providers, the consultant agreed with 91% (82/90) of the Licensing Specialist determinations. Providers completed CAPs for all regulations where non-compliance was identified in the sample. • Regarding compliance with the requirement that the RCA include identified solutions to mitigate its reoccurrence and future risk of harm when applicable (§E.1.c), 830/904 providers (92%) complied, and 263 providers could not be assessed as they did not have serious incidents requiring a root cause analysis to be completed. Comparing results and supporting documentation for the sample of 90 RCAs completed by 50 providers, the consultant agreed with 88% (79/90) of the Licensing Specialist determinations. Providers completed CAPs for all regulations where OL identified non-compliance in the sample. From the sample review results related to compliance determinations for §160.E.1.a-c summarized above, there was a significant increase in agreement with Licensing Specialist determinations compared to results from the 20th period study. For §160.E.1.a, the percentage agreement increased from 79.6% to 91%; for §160.E.1.b, from 51.8% to 91%; and for §160.E.1.c, from 66.7% to 87%.	

Compliance Indicator	Facts	Analysis	Conclusion
		Also noted during this sample review, there were six of the RCAs that the Licensing Specialist rated "compliant" when the rating should have been "not determined" as the Specialist noted there were no RCAs required during the review period. OL has improved this consistency through revised protocols, increased look-behind reviews, and additional training for Licensing Specialists to improve accuracy and thoroughness of their regulatory determinations, particularly for regulations at §160.C and §160.E.1. Based on results from the consultant's sample reviews and the data analyses provided by the Department, there is sufficient evidence to support that the OL is continuing to refine and improve its processes to consistently assess provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process.	
29.5 DBHDS monitors compliance with the serious incident reporting requirements of the Licensing Regulations as specified by DBHDS policies during all investigations of serious injuries and deaths and during annual inspections. DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations.	DBHDS has established regulations and related protocols for monitoring compliance with the serious incident reporting requirements of the Licensing Regulations during all investigations of serious injuries and deaths and during annual licensing inspections. DBHDS requires CAPs for all regulations found out of compliance. Based on review of data regarding the results of IMU assessments of serious incident reports, data from annual licensing inspections, and detailed review of CAPs for a	*12VAC35-105-160.D* establishes requirements, procedures, and timeframes for providers to report allegations of abuse or neglect, Level II and Level III serious incidents and deaths to DBHDS. *12VAC35-105.170.G-H* establishes requirements for providers to implement CAPs for all regulations found not to be in compliance. These regulations serve as a framework for DBHDS to monitor provider compliance with the serious incident reporting requirements during investigations of serious injuries and deaths and during annual licensing inspections. DBHDS IMU staff play key roles in monitoring compliance with the serious incident reporting requirements and the issuance of CAPs. The *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services* (revised January 2023*)* provides detailed descriptions for and guidance to the IMU staff related to these roles and responsibilities. This process is described in detail in the *29.3-29.5 34.4-34.7 Licensing Assessment Incident Report Process Document VER 003*. This study included a review of data regarding IMU assessment of serious incident reports by providers and data regarding the results of annual licensing inspections for all licensed providers specific to the regulations referenced above, the results of which are maintained in the CONNECT data system. This study	20th-Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
	sample of 50 licensed providers, OL has in place and follows regulatory protocols to monitor compliance with the serious incident reporting requirements in the Licensing Regulations and consistently requires providers to develop and implement CAPs for all regulations found out of compliance.	also included a detailed review of background documents, licensing inspection reports, and related CAPs from a randomly selected sample of annual licensing inspections for 50 licensed providers conducted during CY 2022. Regarding compliance with *12VAC35-105-160.D*, OL provided a report detailing information about each of the 11,268 Level II and Level III serious incidents or deaths reported by providers during CY2022 (*OL Regulatory Compliance with 12VAC35-105-160.D.2 Data Report*). Adjusting for the 378 reports that were reported late for excused reasons, 10,454/10,890 incidents (96%) were reported within the prescribed 24-hour period. CAPs were required for each of the 436 unexcused late reports. The results of the VCU IMU Look-Behind validation process (discussed in detail at Compliance Indicator 29.16 below), as it becomes fully operational addressing all four required elements, will provide further data and information to guide the OL's continued efforts to refine and improve the IMU's monitoring of provider compliance with the serious incident reporting process. DBHDS has also continued to update and revise its *OL Annual Compliance Determination Chart (*revised annually*)* to provide detailed inspection protocols and compliance determination instructions for Licensing Specialists. This document is revised prior to the commencement of annual inspections each year and includes specific, detailed guidance for all regulations that are assessed including those that relate to serious incident reporting (§160.D) and those requiring providers to implement and monitor implementation of corrective action plans as part of their quality improvement plan (§170.G-H). The consultant reviewed relevant documents provided by DBHDS regarding its monitoring of compliance with the serious incident reporting requirements of the Licensing Regulations, focusing specifically on the roles and responsibilities of IMU staff and Licensing Specialists to investigate serious incidents and deaths. Findings from this review support that DBHDS has developed, implemented, and continues to refine and improve its requirements and training for providers and its protocols, procedures, and training for IMU staff and Licensing Specialists relating to serious incident reporting requirements in the licensing regulations. Additionally, the consultant's review of background documents, licensing inspection reports, and CAPs for a randomly selected sample of 50	

Compliance Indicator	Facts	Analysis	Conclusion
		licensed providers provided further evidence of consistent adherence to the review protocols relevant to serious incident reporting outlined in the *OL Annual Compliance Determination Chart (revised annually)*.	
29.6 The DBHDS quality improvement system is led by the Office of Clinical Quality Improvement and structured by organizational committees with the Quality Improvement Committee (QIC) as the highest quality committee for the Department, and all other committees serve as subcommittees, including the: Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, Regional Quality Councils, and the Key Performance Area Workgroups: Health & Wellness, Community Inclusion & Integration, Provider Capacity & Competency.	The *Quality Management Plan, State Fiscal Year 2023,* dated October 14, 2022 indicates that the Office of Clinical Quality Management (OCQM) supports the development and expansion of an agency-wide quality management plan. Under the oversight of the Director of the OCQM, the Office of Community Quality Improvement (OCQI) exists to analyze data to identify trends and patterns, provide technical assistance, training and consultation to external and internal partners and providers, in areas such as case management, quality improvement and risk management. OCQM staff also support the structured by organizational committees with the Quality Improvement Committee (QIC) as the highest quality committee.	The *Quality Management Plan, State Fiscal Year 2023,* dated October 14, 2022 indicates that the Office of Clinical Quality Management (OCQM) supports the development and expansion of an agency-wide quality management plan. 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 also oversees and directs community-based quality review activities for DBHDS through both internal agency activities and using contracted vendors, including the Quality Services Review (QSR) and National Core Indicators (NCI) efforts, to conduct quality related activities. The *Quality Management Plan* states that the Office of Community Quality Improvement (OCQI), which functions under the oversight of the Director of the OCQM, analyzes a variety of data for the identification of trends and patterns to inform data-driven decisions aimed at improving the quality of services at both the provider and system levels; provides technical assistance and consultation, to internal and external state partners and community-based licensed providers, related to developing, implementing, and monitoring QI programs; develops and/or offers resources for evidence-based best practice guidance and training related to QI and RM; conducts case management data reviews at least semi-annually and provides related assistance to the CSBs. The *Quality Management Plan* also describes a hierarchy of interdisciplinary quality committees and workgroups. As defined in the specific charters, these include the following: • The Quality Improvement Committee (QIC), which is the designated oversight body for the Quality Management System and ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas.	20th-Met **22nd Met**

Compliance Indicator	Facts	Analysis	Conclusion
	Other committees serve as subcommittees to the QIC and include the following: Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, Regional Quality Councils, and the Key Performance Area Workgroups: Health & Wellness, Community Inclusion & Integration, Provider Capacity & Competency. Based on review of four quarters of QIC meeting minutes (i.e., for meetings held on 3/28/22, 6/27/22, 9/21/22 and 12/12/22) and materials, the subcommittees and workgroups regularly reported to the QIC.	• The Risk Management Review Committee (RMRC), which provides ongoing monitoring of serious incidents and allegations of abuse and neglect; and 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. The RMRC identifies and addresses risks of harm; ensures the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collects and evaluates data to identify and respond to trends to ensure continuous quality improvement. • Regional Quality Councils (RQCs), as required by Section V.D.5. of the Settlement Agreement, which are expected identify and address risks of harm and ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings. RQCs review and evaluate state and available regional data related to PMIs and monitoring efforts to identify trends and recommend responsive actions in their respective regions. • The Mortality Review Committee (MRC), whose purpose is to conduct mortality reviews of individuals diagnosed with an intellectual disability and/or developmental disability (I/DD) who were receiving a DBHDS licensed service at the time of death and to utilize an information management system to track the referral and review of these individual deaths. • The Case Management Steering Committee, which is responsible for identifying and addressing risks of harm, ensuring the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings, and evaluating data to identify and respond to trends to ensure continuous quality improvement. • 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. • The DBHDS/DMAS Quality Review Team (QRT), which is responsible for oversight and improvement of the quality of services delivered under the Commonwealth's Developmental Disabilities(DD) waivers as described in the approved waivers' performance measures. While not a formal subcommittee to the QIC and does not report to it, its work is an integral	

Compliance Indicator	Facts	Analysis	Conclusion
		component of the overall quality and risk management system. Based on review of four quarters of QIC meeting minutes (i.e., for meetings held on 3/28/22, 6/27/22, 9/21/22 and 12/12/22) and materials, the subcommittees and workgroups described above regularly reported to the QIC.	
29.7 The Office of Clinical Quality Improvement leads quality improvement through collaboration and coordination with DBHDS program areas by providing technical assistance and consultation to internal and external state partners and licensed community-based providers, supporting all quality committees in the establishment of quality improvement initiatives, use of data and identification of trends and analysis, and developing training resources for quality improvement.	The Office of Clinical Quality Improvement (OCQI) engages in and or coordinates a variety of technical assistance, consultation and training activities to support the DBHDS quality improvement efforts. On 8/31/21, DBHDS promulgated a policy and procedure entitled *Consultation and Technical Assistance (CTA) Framework*, which continued to be in effect for this review period. The document stated that the OCQM and the Office of Community Quality Improvement (OCQI) utilize both consultation and technical assistance to further the culture of quality and to assist both internal and external stakeholders in their quality management processes and quality improvement efforts upon request. OCQM also continued to	As reported at the time of the 18th and 20th Period reviews, in addition to providing support to the QIC structure, Office of Clinical Quality Management (OCQM) is responsible for promoting quality improvement through collaboration and coordination with DBHDS program areas. At the time of the 20th Period review, DBHDS had promulgated a policy and procedure, dated 8/31/21, entitled *Consultation and Technical Assistance (CTA) Framework Practices*, which remained in effect for the 22nd Period review. The document states that the OCQM and the Office of Community Quality Improvement (OCQI) utilize both consultation and technical assistance to further the culture of quality and to assist both internal and external stakeholders in their quality management processes and quality improvement efforts upon request. OCQM established a CTA framework that includes responsibilities to assist in the development of TA and materials and resources (including training)and delivery of CTA. The policy noted that the initial identification of CTA or training needs typically comes from analysis of data and identification of trends and the review of provider quality improvement plans. It described consultation as typically focusing on helping a stakeholder plan how to address a specific issue and accomplish goals, while TA activities were specific to an identified issue and focused on program planning and implementation related to improvement plans/compliance issues. The latter might also involve training as part of the TA delivered. The policy also indicated CTA could be provided via phone call, email, written material, on-site consult, webinar, newsletter, or conference (video or in-person), and might be provided during a singular event or as part of a multi-step process. OCQM also continued to use a *CTA Tracking Log*, by which OCQM and OCQI staff document CTA requests and provision of CTA. The policy indicates that DBHDS staff will review of the Tracking Log at quarterly, semi-annual and	20th-Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
	utilize a *CTA Tracking Log*, to document CTA requests and provision of CTA. External examples of CTA included on-site SCQR reviews and data reviews with CSBs and assistance with facilitating QSR participation, while internally, OCQI continued to assist KPA workgroups with QII development. In another example, after successful completion and evaluation of a pilot project to assist DD licensed providers improve provider implementation of approved Corrective Action Plans (CAPs) relative to *620.C.2*, OCQM and OCQI expanded this initiative at the time of the 22nd Period.	annual intervals to identify emerging trends/patterns across the data collected and be used to enhance the delivery of CTA. Based on review of the documentation submitted for the last two quarters of FY 22 and the first two quarters of FY 23 (i.e., tracking logs and CTA summaries), OCQM and OCQI completed a total of 210 CTA activities (i.e., 166 consultations and 34 TA initiatives.) Some external examples included on-site SCQR reviews and data reviews with CSBs and assistance with facilitating QSR participation, while internally, OCQM and OCQI continued to assist KPA workgroups and RQCs with QII development. In addition, as reported at the time of the 20th Period review, OCQM and OCQI had implemented a multi-part and systemic CTA project with regard to the implementation of the requirements for providers and CSBs to have quality improvement plans (*Pilot Project Name: 12VAC35-105-620 Technical Assistance (TA) specific to Developmental Disability (DD) providers.*) Through data review, OL had identified *620.C.2*, which mandates that provider quality improvement plans define measurable goals and objectives, as an area of consistent struggle for providers. The goal of the pilot project was to improve provider implementation of approved Corrective Action Plans (CAPs) relative to *620.C.2*, with a related objective to determine if this form of CTA helps providers to improve their implementation of *620.C.2* CAPs. The initial pilot project period continued from 12/1/21 through 3/31/22. The project team worked with ten self-selected providers. Following an individualized needs assessment, each provider received three, one-hour consultation sessions, during which QI Specialists, based on the approved CAPs and the providers' respective needs assessment, OCQM and OCQI. For this 22nd Period review, OCQM/OCQI had completed a *Consultation/Technical Assistance Pilot Project Report*, dated 8/25/22. The report documented that all participating providers reported new learning they would use in their work, in the areas regarding writing measurable goals and objectives using the SMART definition and SMART worksheet, distinguishing between QA and QI, and using cause and effect tools. Based on documentation submitted, all participants were found to be in compliance with *620.C.2* at the	

Compliance Indicator	Facts	Analysis	Conclusion
		time of their next licensing review. In light of these results, OCQM/OCQI was continuing and expanding this initiative at the time of the 22nd Period. In January 2023, providers received an invitation to apply for participation in *620.C.2* CTA, with sessions to be offered in the first, second and fourth quarters of FY 23. During each quarter, CTA sessions were to be offered for up to five DD licensed providers in each region that received a non-compliant licensing citation for *620.C.2* at any time during calendar year 2022 and had an approved CAP. On 1/25/23, OCQM also promulgated an additional policy memorializing these practices, entitled *CTA Practices Specific To Office Of Licensing Quality Improvement Regulations.*	
29.8 The Office of Clinical Quality Improvement oversees and directs contractors who perform quality review processes for DBHDS including the Quality Services Reviews and National Core Indicators. Data collected from these processes are used to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level.	*Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities* and the *DBHDS Quality Management Plan* identify the OCQM as the responsible entity to oversee and direct contractors who perform quality review processes for DBHDS including the Quality Services Reviews (QSR) and National Core Indicators (NCI.) DBHDS also provided additional OCQM policy and procedure to operationalize these responsibilities, including *the Quality Service Reviews (QSRs) and National Core Indicators (NCI) Policy & Procedur*e and *National Core Indicators (NCI) Practices*,	As reported at the time of the 20th Period review, for this 22nd Period, the *Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities* remains in effect. It identifies the OCQM as the responsible entity to oversees and directs contractors who perform quality review processes for DBHDS including the National Core Indicators (NCI) and the Quality Services Reviews (QSR). For this 22nd Period review, DBHDS also provided additional OCQM policy and procedure to operationalize these responsibilities, including *the Quality Service Reviews (QSRs) and National Core Indicators (NCI) Policy & Procedur*e and *National Core Indicators (NCI) Practices*, both last revised on 2/1/23. With regard to NCI, DBHDS continued to contract with Virginia Commonwealth University (VCU) to complete the NCI survey process and to provide aggregate data. DBHDS provided a contract renewal for the period between 10/15/22 through 10/14/23. As reported previously, the NCI survey process is entirely external to DBHDS and has a lengthy track record of consistent implementation and documentation of data provenance. NCI measures have also been approved by CMS for use in HCBS waiver programs. As such, NCI data could be considered reliable for use in evaluating the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. In addition, for the previous review period, DBHDS provided a *Data Set Attestation Form for the NCI Data Set and the NCI Adult Consumer Surv*ey that is still applicable for this 22nd Period. Because the NCI Survey is an external data	20th- Not Met **22nd - Met***

Compliance Indicator	Facts	Analysis	Conclusion
	both last revised on 2/1/23. Data from the NCI are used to evaluate the sufficiency, accessibility, and quality of services at a systemic level. for the previous review period, DBHDS provided a *Data Set Attestation Form for the NCI Data Set and the NCI Adult Consumer Survey* that is still applicable for this 22nd Period. Because the NCI Survey is an external data source, in lieu of a Process Document, the attestations referenced NCI documentation of data reliability and validity. These included a document entitled *NCI Adult Consumer Survey: Development and Psychometric Properties 09.13.12*, as well as the *NCI Remote Survey Pilot Study Summary Results Dec 2020,* which further attested to the NCI processes undertaken to test and produce reliability and validity of data gathered through a remote survey. DBHDS designed the QSR to produce data to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and	source, in lieu of a Process Document, the attestations referenced NCI documentation of data reliability and validity. These included a document entitled *NCI Adult Consumer Survey: Development and Psychometric Properties 09.13.12*, as well as the *NCI Remote Survey Pilot Study Summary Results Dec 2020,* which further attested to the NCI processes undertaken to test and produce reliability and validity of data gathered through a remote survey. OCQM staff also provided meeting agendas and minutes that demonstrated they continued to meet with some regularity with the VCU to coordinate and oversee activities, including frequent meetings between January 2022- through September 2021. VCU also provided written reports of activities for five months in FY22 Q3 and Q4, and for the three months in FY23 Q1. For the 22nd Period review, the QIC, subcommittees and workgroups continued to review NCI data and recommendations. The QIC Review Schedules for both FY22 and FY 23 included a NCI report for the first and fourth quarterly agendas. DBHDS indicated it continues to use NCI data as the basis for measuring performance for compliance with CI 29.27 (i.e., at least 75% of people with a job in the community chose or had some input in choosing their job). In addition, for FY 23, the KPA Workgroups initiated a QII for improving annual dental exams, based in part on NCI data that showed a need for improvement. The NCI data will be used a s a baseline and to track progress for this QII. DBHDS designed the QSR to produce data to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. With regard to QSR data, for the 22nd Period review, the QIC, subcommittees and workgroups continued to review QSR data and recommendations. The QIC Review Schedules for both FY22 and FY 23 included a QSR report for each of the quarterly agendas. DBHDS indicated it continues to use QSR data as the basis for measuring performance with several PMIs and DOJ CIs. However, questions remained with regard to QSR data validity and reliability. At the time of the 20th Period review, this study found that while the QSR was designed to produce data that DBHDS will use to evaluate the sufficiency,	

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	systemic level. DBHDS indicated it continues to use QSR data as the basis for measuring performance with several PMIs and DOJ CIs. Meeting minutes showed that the QIC and the QIC's subcommittee and workgroup meeting minutes regularly reviewed and analyzed QSR findings, and responded to QSR recommendations. Based on the findings of the Independent Reviewer's 21st Period review, the QSR process has not yet produced sufficient reliable data to be used for this purpose. For this 22nd Period review, DBHDS provided some additional documentation, including and *OCQM Dataset and External Data Source Validation Checklist, version 2*, updated 2/17/23, which was again described as a checklist and attestation for the quality of datasets and external data vendors. DBHDS also submitted a document entitled *OCQM Dataset and External Data Source Validation Checklist_Process*	accessibility, and quality of services at an individual, service, and systemic level, DBHDS had not yet established that the QSR process produced sufficient reliable data for this purpose. At the time of the 21st Period review, the Independent Reviewer's report found that, based on the evaluation of CI 36.1, DBHDs did not have a plan in place to evaluate the QSR as a data source system and had not otherwise completed an Attestation for the QSR-derived data. Instead, DBHDS and QSR Contractor staff completed an *External Data Validation Checklist*. However, this could not take the place of a source system assessment, as required by the Curative Action. The document noted that, among the limitations of the checklist is the fact that there is currently no way to validate whether the checklist is an objective measure of the validity and reliability of external data sources. None of the items were independently validated using objective standards and EHA had yet to devise a scoring system for the checklist, and therefore does not have a way to determine whether every item on the checklist applicable to the vendor should be marked "Yes" in order to confirm the validity and reliability of the data source. Given that QSR is the basis for measuring compliance not only for many provisions, but also for several Curative Actions, the 21st Period report found that using only a tool that cannot assure it is an objective measure of validity and reliability was not sufficient. For this 22nd Period review, DBHDS submitted a *OCQM Dataset and External Data Source Validation Checklis*t, version 2, updated 2/17/23, which was again described as a checklist and attestation for the quality of datasets and external data vendors. The document indicated that the checklist will be used to help assure the validity and reliability of data provided by dataset and data source business owners and external data vendors. The stated outcome of this process is to determine if the processes employed and documentation provided by the external data vendor or dataset business owners indicate that the dataset or external data source system produces valid and reliable data. The structure of the revised checklist separates checklist items into seven categories: data purpose and scope, data collection, data processing and management, data storage, data analysis and reporting, and vendor services.	

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	in progress. With regard to an attestation of data validity and reliability, it indicated the following: "(t)here are no conclusions as to data validity and reliability asserted here; as such assertions will be made as part of the DBHDS data attestation process. This outcome of this assessment is to guide the development of those assertions." This document reflected the current status of the use of the Checklist to assess the current QSR vendor, but was not yet finalized. Based on its current status, this version contained more robust content than the previous Checklist applied to the QSR vendor. However, DBHDS staff had not yet submitted it for attestation that it was a valid tool for determining the reliability and validity of QSR data. Based on interview with DBHDS staff, the attestation remained pending.	DBHDS also submitted a document entitled *OCQM Dataset and External Data Source Validation Checklist_Process in progress*. With regard to an attestation of data validity and reliability, it indicated the following: "(t)here are no conclusions as to data validity and reliability asserted here; as such assertions will be made as part of the DBHDS data attestation process. Theis outcome of this assessment is to guide the development of those assertions." This document reflected some additional modifications to the process pertinent to this review: • "At the time that the agency is considering a business owner dataset or external data vendor to fulfill a data or reporting requirement or at the time of external data vendor contract renewal, the agency representative shall convene with representatives from the business area or the external data vendor to review the contents of the "OCQM Dataset and External Data Sources Validation Checklist," before the vendor completes it and provides supporting documentation. Following this review, the business owner dataset or external data vendor will be directed, by OCQM, to self-assess their dataset or external data source data collection tools and repository for storing data, processes and training for its use and data entry and extraction, staff credentials for persons supporting system maintenance and system, reporting tools, processes for ensuring data integrity and security, and process oversight otherwise. Once the form is completed, the vendor shall provide a completed copy of the document, and all supporting documentation listed, by the business owner dataset or external data vendor, therein." • "OCQM personnel shall then review the checklist and supporting documentation, to assess the reasonableness of respondent answers and to ensure each element of the question has been adequately addressed. OCQM will then schedule a meeting to walk through the checklist with the business owner dataset or external data vendor, to reach a mutual agreement, as to whether the business owner or external data vendor has provided documentation that supports their assertions…." • From this meeting, a final "OCQM Dataset and external Data Source Validation Checklist" will be produced and signed by the OCQM	

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		representative and a representative from the business owner or external data vendor participating in this process. By signing the document, signatories acknowledge deficiencies, proposed remediation, and ownership of completion of any assignments (items or actions that are required in order to consider the dataset or external data source reliable and the data it produces valid and reliable." • "Following acquisition of signatures, the completed document shall be forwarded to the applicable department Assistant Commissioner and to the Office of Information Technology for the development of an attestation." At the time of this 22nd Period review, the *OCQM Dataset and External Data Source Validation Checklist_Process in progress* for QSR, as indicated in the title of the document, was not yet completed and signed, and had not been submitted for attestation that it was a valid tool for determining the reliability and validity of QSR data. Based on interview with DBHDS staff, the attestation remained pending. As compared to the initial QSR *External Validation Checklist* DBHDS staff completed at the time of the 21st Period review, it was positive to see a more robust approach to evidence collection for this Period. However, as DBHDS staff continue along this path, they should take into consideration the following: • In interview, DBHDS staff stated that a source system evaluation was pending completion. Based on the document DBHDS submitted entitled *Source System Roles and Responsibilities*, dated August 2022, indicated that an Information Technology (IT) expert must be the accountable party for certain source system assessment criteria; if not, this would constitute a threat to data quality. Therefore, DBHDS must ensure that an IT expert is responsible for each of the designated assessment criteria. • Based on a review of the partially completed *OCQM Dataset and External Data Source Validation Checklist_Process in progress,* there appeared to be some errors in scoring. For example, the document provided scoring guidance that indicates that a "Yes" answer indicates both the agency	

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		representative and the business area or the external data can attest that the materials and documentation support the conclusion that the checklist requirement has been met. The document also states that a "Partially Met" score indicates that supporting documentation provided to the OCQM reviewer is lacking some information needed to respond "Yes." For several items, the OCQM reviewer noted that additional documentation was required and further scored the sufficiency of evidence submitted as "Partially Met." However, the item was still scored as "Yes" overall. • For several items documented as being "Partially Met," the OCQM reviewer commented that it did not appear to "significantly impact data validity and reliability of QSR data," primarily because the QSR vendor staff could provide an adequate verbal description. DBHDS staff should consider the potential for these impacts to be cumulative and/or to create threats over time as QSR vendor staff change.	
29.9 The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas. The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures addressing: i. The charge to the committee, ii. The chair of the committee, iii. The membership of the	Based on the *Developmental Disabilities Quality Management Plan State Fiscal Year 2023,* dated October 14, 2022, DBHDS remains committed to Continuous Quality Improvement (CQI). The QIC maintains a charter and ensures that all sub-committees have a charter describing standard operating procedures and responsibilities consistent with the requirements of this Compliance Indicator. Based on review of provided documentation, the QIC and	According to the *Developmental Disabilities Quality Management Plan State Fiscal Year 2023*, DBHDS remains committed to Continuous Quality Improvement (CQI). The current plan describes quality improvement (QI) as "an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes." The Quality Management Plan further describes quality improvement as a "systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care," and as a "data driven process" that involves analysis of data and performance trends that is used to determine quality improvement priorities. Based on review of provided documentation, the QIC and subcommittees met regularly as described in the *Quality Management Plan* and consistent with the requirements of their charters. Documentation submitted included subcommittee workplans that outlined activities (e.g., review of data and reports and requests for data) and tracked PMIs, development, the implementation, and	20th-Met **22nd -Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	subcommittees met regularly as described in the *DBHDS Quality Management* Plan and consistent with the requirements of their charters. At present, while this CI was found to be met overall however, as described elsewhere in this report, the functionality of the QIC framework continued to be hampered by the lack of valid and reliable data across much of the system, as well as by limited data-based analysis and data-driven decision making.	progress of QIIs across subcommittees/councils/ workgroups, as well as recommendations to and from the QIC. These included completed workplans for each subcommittee ending with the last quarter of FY 22 (i.e., 6/30/22), although some had documentation of dates in the early months of the first quarter of FY 23. Each subcommittee also had workplans labelled as "in progress" for FY 23, along with regular updates (most recent dated 12/19/22-1/31/23.) 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. Based on the documentation provided for review, all of the following current charters were last updated and approved by the QIC on 9/21/22: • Quality Improvement Committee Charter • Regional Quality Council Charter • Risk Management Review Committee Charter • Mortality Review Committee Charter • Case Management Steering Committee Charter • Health, Safety and Well-being Workgroup Charter • Community Inclusion and Integration Workgroup Charter • Provider Capacity and Competency Workgroup Charter • Quality Review Team Charter While this CI was found to be met overall, as described elsewhere in this report, the functionality of the QIC framework continued to be somewhat hampered, although to a lesser degree than in the past, by the lack of valid and reliable data for parts of the system.	

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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.	The QIC sub-committees reported to the QIC four times in the period between 3/28/22 through 12/12/22. 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. The QIC subcommittees identify at least one CQI project annually. DBHDS staff had previously modified the QII template to require identification of certain components of measurability and this appeared to provide sufficient guidance to address the concerns the previous study identified. For this 22nd period review, the study found that QIIs were generally measurable, included baselines and provided a clear definition of terms. For this 22nd Period review,	The QIC subcommittee charters call for each to report to the QIC on a quarterly basis. Based on documentation provided, the sub-committees have made reports to the QIC four times in the past twelve months (i.e., on 3/28/22, 6/27/22, 9/21/22 and 12/12/22). The subcommittee reports focus on the respective performance measures and QIIs each has adopted. Each of the subcommittees had adopted at least one QII. The 19 current QIIs were a mix of projects continued from previous FY periods and new projects identified for FY23. The following describes the status and progress DBHDS staff achieved with regard to previously identified deficiencies: • The 18th Period study found that the QIC subcommittees often did not construct the QIIs in a manner that could be measured or allow for data collection, which was necessary to facilitate a "data-driven" approach to quality improvement. During the 20th Period review, it was positive that DBHDS staff had modified the QII template to require the future identification of certain components of measurability and that QIIs reviewed more often had measurable goals. However, this was not yet consistent. For this 22nd period review, the study found that QIIs were generally measurable, included baselines and provided a clear definition of terms. • At the time of the 18th Period review, this study found that the subcommittee and workgroup presentations to the QIC did not present data that showed progress with regard to the action steps, which made it difficult to follow the progress of the implementation of the QIIs. In addition, in many instances, the QII presentations did not include overall outcome data, either. For the 20th Period review, DBHDS staff consistently presented data and/or narrative information on both the status of action steps and for outcomes for each of the continuing QII projects presented. For this 22nd Period review, DBHDS staff consistently presented data and/or narrative information on the status of action steps and on outcomes. However, subcommittee reporting should make additional effort to ensure the tracking of outcome data whenever feasible.	20th-Not Met **22nd- Met***

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS staff consistently presented data and/or narrative information on the status of action steps and on outcomes. However, subcommittee reporting should make additional effort to ensure the tracking of outcome data whenever feasible. For this 22nd Period review, DBHDS staff had made a consistent effort to identify and track the data sets they use for QII projects. As indicated in the document *QII Dataset Process and Attestation Tracker*, DBHDS staff had identified a Process Document and a Data Set Attestation for17 of 19 current QIIs. The remaining two QIIs were newly developed and pending the identification of the needed data sets. However, as noted throughout this report, questions remain about the adequacy of some of the Process Documents and accompanying Data Set Attestations relied upon for some QIIs (e.g., Process Documents for *Serious Incident Reports by Type - Surveillance*	• At the time of the 20th Period review, DBHDS staff indicated they had not verified reliable and valid data sources for all QIIs. For example, only two of 15 (13%) active QIIs that utilized an existing DBHDS data set had both a Process Document and a Data Set Attestation. For this 22nd Period review, DBHDS staff had made a consistent effort to identify and track the data sets they use for QII projects. As indicated in the document *QII Dataset Process and Attestation Tracker*, DBHDS staff had identified a Process Document and a Data Set Attestation for17 of 19 current QIIs. The remaining two QIIs were newly developed and pending the identification of the needed data sets. Overall, DBHDS had made significant progress and has fulfilled the activities required by this Indicator, with has adequate procedures in place that would support the ability to do this work. However, as noted throughout this report, questions remain about the adequacy of some of the Process Documents and accompanying Data Set Attestations relied upon for some QIIs (e.g., Process Documents for *Serious Incident Reports by Type - Surveillance Rates*) as described with regard to CI 29.13 Therefore, this Met* rating is for illustrative purposes only.	

Compliance Indicator	Facts	Analysis	Conclusion
	Rates) as described with regard to CI 29.13.		
29.11 Through the Quality Management Annual Report, the QIC ensures that providers, case managers, and other stakeholders are informed of any quality improvement initiatives approved for implementation as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths.	The *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022,* dated 2/17/23, was made available on the DBHDS website on 2/21/23. The report includes information about quality improvement initiatives approved for implementation, including several in the category of serious incidents and deaths. DBHDS has fulfilled the reporting activities required by this Indicator, and has adequate procedures in place that would continue to support the ability to do so. However, during 2022, DBHDS staff did not have data available to complete trend analyses based on valid and reliable information from investigations of reports of	For the 20th Period review, DBHDS had developed a *Draft Quality Management Report* for FY 2021 (i.e., July 1, 2020 - June 30, 2021), but as of 5/1/22 had not yet been issued it for stakeholders. This represented some regression in timeliness from the progress previously reported. As a result, that review could not verify that an annual report was completed as required and stakeholders did not have access to current information. For this review, DBHDS provided evidence they issued the FY 21 report on 5/17/22. For this 22nd Period review, in accordance with a strategy previously discussed in interviews with DBHDS staff, they separated the scheduled publication dates of the *Quality Management Plan* from that of the annual *Quality Management Report*, to improve timeliness. This was a positive step that allowed stakeholders to have timely information about quality improvement initiatives. On 2/21/23, DBHDS posted on its website the *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022*, dated 2/17/23. The report included a summary detailing the QIIs implemented during SFY22 along with the QIIs proposed during SFY22, including several that focused on data related to serious incidents and deaths. These include a proposed MRC QII that would have focused on decreasing choking as a cause of death, based on data indicating steady increases since SFY18 in choking as a cause of death. The QIC did not approve this QII for implementation due to identified capacity issues impacting the department's ability to implement the QII, at the time of the QII proposal. In addition, the RMRC and RQC 5 were implementing QIIs related to falls, while RQC 4 proposed a QII focused on reducing the rate of urinary tract infections in that region. The QIC did not approve this latter QII due to data validity and reliability concerns. The falls QIIs were impacted by data validity and reliability, as well.	20th-Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
	suspected or alleged abuse, neglect, serious incidents, and deaths. Serious incident data only became available for review in February 2022, and the look behind of investigations of serious incidents was both newly implemented in FY 23 and was as of yet incomplete (i.e., addresses only three of the five required elements). DBHDS also reported the OHR look-behind process related to investigations of reports of suspected or alleged abuse and neglect has not been operational since September 2021.	DBHDS has fulfilled the reporting activities required by this Indicator, and has adequate procedures in place that would continue to support the ability to do so. However, of note, as described above and elsewhere in this report, during FY22 DBHDS did not yet have valid and reliable data based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents, and deaths upon which to perform trend analyses to inform the development of QIIs. For this 22nd Period review, serious incident data only became available for review in February 2022, and the look behind of investigations of serious incidents was both newly implemented in FY 23 and was as of yet incomplete (i.e., addresses only three of the five required elements). DBHDS also reported the OHR look-behind process related to investigations of reports of suspected or alleged abuse and neglect has not been operational since September 2021. In addition, as noted throughout this report, questions remain about the adequacy of the Process Documents for *Serious Incident Reports by Type - Surveillance Rates* as described with regard to CI 29.13.	
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.	DBHDS has an appropriately constituted Risk Management Review Committee (RMRC). The RMRC has a charter, dated 9/21/22, that describes its roles and functions as a subcommittee of the DBHDS Quality Council as well as its roles and relationships to other operational areas within DBHDS. The Risk Management Review Committee is	According to the *Risk Management Review Committee Annual Report,* dated July 1, 2021– June 30, 2022, "The purpose of the RMRC is to provide ongoing monitoring of serious incidents and allegations of abuse and neglect; and 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. RMRC is charged with systematically reviewing and analyzing data related to serious incident reports (SIRs); deaths; abuse, neglect and exploitation (ANE) allegations; findings from licensing inspections and investigations; and other related data. RMRC also reviews related data collected from community service providers and the training center and data and information related to DBHDS program activities. As a subcommittee of the DBHDS QIC, the RMRC identifies and addresses risks of harm; ensures the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collects and evaluates data to identify and respond to trends to ensure continuous quality	20th-Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
	integrally involved in the development and operations of the DBHDS risk management processes, as described in the *Risk Management Review Committee Annual Report* and the *Risk Management Program Description SFY23*. DBHDS had sufficient policies and procedures in place to effectively address the requirements of this CI. However, DBHDS did not yet provide sufficient evidence to demonstrate that the data sets for serious incidents are reliable and valid, which continues to fundamentally compromise the ability of the RMRC and DBHDS to identify, and prevent or substantially mitigate, risks of harm. This is discussed in more detail in CI 29.13 below.	improvement." The authorization, roles, functions, and responsibilities of the Risk Management Review Committee are further described in the *SFY2023 Risk Management Review Committee Charter,* dated 9/21/22. As a subcommittee of the DBHDS QIC, the RMRC is charged to is to "provide ongoing monitoring of serious incidents and allegations of abuse and neglect; and 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." In addition, the "RMRC will identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluates data to identify and respond to trends to ensure continuous quality improvement." The *Risk Management Program Description SFY23* 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. The *RMRC Annual Report FY22* describes the committee's activities which included providing ongoing monitoring of serious incidents and allegations of abuse and neglect; responsibilities related to licensing investigations, analyzing of individual, provider, and system level data to identify trends and patterns and making recommendations to promote health, safety, and well-being of individuals. The *RMRC Annual Report FY22* further documented the activities, accomplishments, findings, and recommendations of the RMRC during that timeframe. These included focused processes for serious incident reporting, review, and analysis; development and publication of materials specific to risk assessment, risk triggers and thresholds; routine review and analysis data on DBHDS performance indicators relating to safety and freedom from harm; and quality improvement initiatives.	

Compliance Indicator	Facts	Analysis	Conclusion
		While DBHDS staff developed well-thought out and comprehensive documentation of the risk management processes, at the time of this 22nd Period review, DBHDS did not yet provide sufficient evidence to demonstrate that the data sets for serious incidents are reliable and valid, which continues to fundamentally compromise the ability of the RMRC and DBHDS to identify, and prevent or substantially mitigate, risks of harm. This is discussed in more detail in CI 29.13 below.	
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.	In the months between January 2022 through March 2023, the RMRC met monthly and reviewed/analyzed data and information on performance measures, quality improvement initiatives and certain other data sources. While the RMRC *FY22* and *FY23 RMRC Task Calendar and Charter Tasks* provide a structured plan and schedule for review of data and information specific to serious incidents and allegations/substantiations of abuse, neglect, and exploitation, the RMRC has been unable to adhere to it during this period. While for the 20th Period, the RMRC documented a review of aggregated incident data, including allegations and substantiations of abuse,	For this 22nd Period review, the RMRC did not review and identify 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, and in a manner consistent with the requirements of this CI. There continued to be written processes that laid out an adequate framework for completing these responsibilities, as described in the bulleted paragraphs below, but the RMRC could not access the needed data to do so. • The *RMRC Charter*, approved on 9/21/22, requires that the RMRC review data for serious incidents and allegations and substantiations of abuse, neglect, and exploitation at least four times per year. • The *FY22* and *FY23 RMRC Task Calendar and Charter Tasks* documents are the scheduling tool used by the RMRC to assure that it conducts reviews and analysis of surveillance data specific to abuse/neglect, exploitation, Office of Human Rights look-behind results, serious incidents, the IMU look-behind (triage) process, incident management care concerns, timeliness of reporting and related citations, relevant state facilities data, and performance measures. • The *SFY 22 RMRC QIC Subcommittee Work Plan* is the comprehensive 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 QII opportunities and presentation of information to the DBHDS Quality Improvement Council. • A review of RMRC meeting minutes for meetings held from January 2022 through March 2023 provided evidence that the committee	20th-Met* **22nd-Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	neglect, and exploitation, at least four times per year, in the months between January 2022 through March 2023, the RMRC had only been able to review and identify trends from aggregated incident data including allegations and substantiations of abuse, neglect, and exploitation, one time. The only documented review for the 22nd Period occurred on 2/27/23 and included a presentation of data from the first quarter of FY 21 through the second quarter of FY 23 and a preliminary review of trends. At the time of 20th and 21st Period reviews, the Independent Reviewer's report documented that DBHDS could not attest to having valid and reliable serious incident data. During the 21st Period review, DBHDS provided a document developed by the RMRC's Data Workgroup, entitled *RMRC Data Reporting Roadmap: A Path to Improved Data Quality in Routine Data Reporting* (*Roadmap*), dated 2/4/22, that spelled out a series of specific threats to the reliability and	reviews and analyzes various data in an effort to identify trends in each of their monthly meetings. However, this did not extend to serious incident data. Based on the RMRC meeting minutes, the RMRC only reviewed serious incident data once during this period, due to unresolved data validity and reliable issues. The single review of serious incident data took place at the February RMRC meeting held on 2/27/23. This meeting included a presentation of data from the first quarter of FY 21 through the second quarter of FY 23 and a preliminary review of trends. • As described with regard to CI 29.16 and CI 29.17 below, for most of this review period, DBHDS had paused the look-behind reviews for serious incidents and for review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. At the time of 20th and 21st Period reviews, the Independent Reviewer's report documented that DBHDS could not attest to having valid and reliable serious incident data. During the 21st Period review, DBHDS provided a document developed by the RMRC's Data Workgroup, entitled *RMRC Data Reporting Roadmap: A Path to Improved Data Quality in Routine Data Reporting* (*Roadmap*), dated 2/4/22, that spelled out a series of specific threats to the reliability and validity of data derived from the CHRIS and CONNECT data source systems, as well as specific steps to achieve needed remediation. At the time of this 22nd Period review, DBHDS submitted a Process Document entitled *Serious Incident Reports by Type _Surveillance Rates,* dated 3/3/2023 and a Data Set Attestation for the RMRC SIR Data set, dated 3/17/2023. These documents indicated DBHDS could attest that the serious incident data sets used by the RMRC provide reliable and valid data for compliance reporting. However, as submitted, the Process Document provided minimal evidence of the actual completion of the specific steps outlined in the aforementioned *Roadmap* document other than to provide written statements that the steps were complete. It did not acknowledge the specific threats identified in the *Roadmap.* As follow-up, the consultant requested some narrative to document the assertion that staff had addressed all of these requirements. However, the narrative provided largely reiterated that DBHDS had completed the required steps, but with only	

Compliance Indicator	Facts	Analysis	Conclusion
	validity of data derived from the CHRIS and CONNECT data source systems, as well as specific steps to achieve needed remediation. At the time of this 22nd Period review, DBHDS submitted a Process Document entitled – *Serious Incident Reports by Type _Surveillance Rates*, dated 3/3/2023 and a Data Set Attestation for the RMRC SIR Data set, dated 3/17/2023. These documents indicated DBHDS could attest that the serious incident data sets used by the RMRC provide reliable and valid data for compliance reporting. However, as submitted the Process Document provided minimal evidence of the actual completion of the specific steps outlined in the aforementioned *Roadmap* document other than to provide written statements that the steps were complete. It did not acknowledge the specific threats identified in the *Roadmap*. As follow-up, the consultant requested DBHDS provide some narrative to document	minimal factual evidence. This was insufficient to demonstrate compliance. DBHDS was able to show it had commissioned a project in partnership with the IT Department, a "90 Day Data CONNECT/OLIS Item Identification and Planning" effort, with staff from IT project management, application developers, OL and OHR, to focus on identified issues, develop solutions, and track progress. In lieu of other factual evidence, the consultant requested that DBHDS make available the minutes of these proceedings that could document the identified issues, proposed solutions, and the ongoing tracking of progress to completion. During the timeframe of this review period, DBHDS was not able to provide such documentation, with the exception of one set of slides describing the intent of the 90-day effort and one email that reflected DBHDS held an initial meeting. In addition, the Data Set Attestation provided did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of needed mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.	

Compliance Indicator	Facts	Analysis	Conclusion
	the assertion that staff had addressed all of these requirements. However, the narrative provided largely reiterated that DBHDS had completed the required steps, but with only minimal factual evidence. It was insufficient to demonstrate compliance. DBHDS was able to show it had commissioned a project in partnership with the IT Department, a "90 Day Data CONNECT/OLIS Item Identification and Planning" effort, with staff from IT project management, application developers, OL and OHR to focus on identified issues, develop solutions, and track progress. In lieu of other factual evidence, the consultant requested that DBHDS make available the minutes of these proceedings that could document the identified issues, proposed solutions, and the ongoing tracking of progress to completion. During the timeframe of this review period, DBHDS was not able to provide such		

Compliance Indicator	Facts	Analysis	Conclusion
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Compliance Indicator	Facts	Analysis	Conclusion
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.	The *SFY 22 RMRC QIC Subcommittee Work Plan* , *SFY 3 RMRC QIC Subcommittee Work Plan* and RMRC meeting minutes demonstrated that the RMRC was reviewing and analyzing data, monitoring apparent trends and patterns in certain data, and identifying areas of improvement that appeared to be warranted from their review and analysis of data and trends to the extent possible. The RMRC identifies priorities and determines quality improvement initiatives, including identified strategies and metrics to monitor success. The RMRC recommends at least one quality improvement initiative per year. At the time of this review, the RMRC was engaged in two QIIs. One was a newly implemented joint effort with the Region 5 Regional Quality Council to increase provider compliance with two QI licensing regulations. The second was a continuing QII to reduce the number serious incidents	For this 22nd Period review, the *SFY 22 RMRC QIC Subcommittee Work Plan*, *SFY23 RMRC QIC Subcommittee Work Plan* and RMRC meeting minutes demonstrated that the RMRC was reviewing and analyzing data, monitoring apparent trends and patterns in certain data, and identifying areas of improvement that appeared to be warranted from their review and analysis of data and trends to the extent possible. In addition, the RMRC recommended QIIs to the QIC based on their review and analysis of the available data. At the time of this review, the RMRC was engaged in two QIIs. One was a newly implemented joint effort with the Region 5 Regional Quality Council to increase provider compliance with two key risk management licensing regulations. The other was a continuing QII to reduce the number serious incidents caused by falls. However, the data limitations described above for CI 29.13 had effectively prevented the RMRC from reviewing or identifying trends related to serious incident data. This, in turn, limited the ability to identify priorities and determine quality improvement initiatives as needed in the scope needed to adequately mitigate risk. For example, for more than a year, the RMRC members could not review data to show the extent of progress, or lack thereof, toward the Falls QII outcome. As described with regard to 29.13 above, this occurred because DBHDS could not yet provide sufficient evidence to show it had taken all the necessary steps to substantiate its attestation that the that the data sets for serious incident data used by the RMRC provided reliable and valid data for compliance reporting. This, in turn, limited the ability to identify priorities and determine quality improvement initiatives as needed in the scope needed to adequately mitigate risk.	20th-Not Met **22nd-Met***

Compliance Indicator	Facts	Analysis	Conclusion
	caused by falls. However, for more than a year, the RMRC members could not review data to show the extent of progress, or lack thereof, toward the Falls QII outcome. As described with regard to 29.13 above, this occurred because DBHDS could not yet provide sufficient evidence to show it had taken all the necessary steps to substantiate its attestation that the that the data sets for serious incident data used by the RMRC provided reliable and valid data for compliance reporting. This, in turn, limited the ability to identify priorities and determine quality improvement initiatives as needed in the scope needed to adequately mitigate risk.		
29.15 The RMRC monitors aggregate data of provider compliance with serious incident reporting requirements and establishes targets for	The RMRC has established processes and schedules for review of aggregated data of provider compliance with serious incident reporting requirements on a quarterly basis.	At the time of the 20th Period review, DBHDS staff provided several documents to evidence that the RMRC monitored aggregate data of provider compliance with serious incident reporting requirements and established targets for performance measurement indicators. When targets were not met, the RMRC determined whether quality improvement initiatives were needed, and if so, monitored implementation and outcomes. However, at that time, DBHDS reported it could not attest that incident data sets used by the RMRC provided	20th- Met* **22nd- Met**

Compliance Indicator	Facts	Analysis	Conclusion
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 and reports on a PMI entitled *Critical incidents are reported to OL within the required timeframes.* Based on a review of RMRC minutes from January 2022 through January 2023, the RMRC continued to track and review aggregate data of provider compliance with timely reporting requirements. With regard to other aspects of provider compliance with serious incident reporting requirements, the RMRC regularly reviewed data on licensing citations related to serious incident reporting requirements. Overall, this appeared to substantively address the requirements, but, going forward, the RMRC should consider requesting additional data resulting from monitoring compliance with the serious incident reporting requirements of the Licensing Regulations during all investigations of serious injuries and deaths. DBHDS provided a Process	reliable and valid data for compliance reporting for this CI. DBHDS did not provide the requisite Data Set Attestation or Process Document to show that the RMRC could reliably analyze for trends or make valid recommendations for improvement. As context for the findings below, CI 29.3, CI 29.4 and CI 29.5 above describe the requirements for DBHDS to monitor provider compliance with serious incident reporting requirements in the following areas: incidents required to be reported under the Licensing Regulations are reported within 24 hours of discovery; 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; and iii. the root cause analysis, when required by the Licensing Regulations, includes a detailed description of what happened, 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 identified solutions to mitigate its reoccurrence. In addition to the daily incident monitoring work of the IMU, DBHDS is expected to monitor compliance with the serious incident reporting requirements of the Licensing Regulations during all investigations of serious injuries and deaths and during annual inspections, and to require corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations. DBHDS provided the following documentation to evidence that the RMRC monitors aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators: • The *RMRC Annual Report FY22* indicated that the RMRC is responsible for monitoring aggregate data of provider compliance with serious incident reporting requirements and establishing targets for PMIs. To achieve this, the IMU identifies late, or unreported serious incidents, and issues citations and corrective action plans (CAPS) when applicable and reports these data to RMRC quarterly. The report also stated that on a quarterly basis, the IMU provides data to the RMRC about late incident reporting and the status of the work of the IMU. • The *Risk Management Program Description SFY23* states that the RMRC	

Compliance Indicator	Facts	Analysis	Conclusion
	Document entitled *Licensing Assessment Incident Report Process Document VER 003*, dated 2/21/23, which describes the key roles in monitoring compliance with the serious incident reporting requirements and the issuance of CAPs, and also included steps to address identified threats to data validity and reliability. Along with the *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services*, revised January 2023, and the *OL Annual Compliance Determination Chart*, which is revised annually, these appeared to be sufficient to provide valid and reliable data. DBHDS also provided a Data Set Attestation for the data set entitled *Death and Serious Incidents by Type*. It did not appear this data set alone was sufficient to address all the purposes of this Process Document related to licensing requirements. In addition, it did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the	monitors aggregate data of provider compliance with serious incident reporting requirements and establishes targets for PMIs. When targets are not met the RMRC determines whether quality improvement initiatives are needed, and if so, monitors implementation and outcomes. DBHDS staff should consider some additional detail about how it accomplishes this in the *Process for Reviewing Data* section. • Based on a review of RMRC minutes from January 2022 through January 2023, the RMRC continued to track and review aggregate data of provider compliance with timely reporting requirements. • Based on the *RMRC Annual Report FY22*, DBHDS reported timely reporting performance at 96%. This exceeded the expectation of the PMI entitled *KPA PMI Critical incidents are reported on time*, updated 8/19/22 which set a target that 86% of critical incidents be reported to the OL within 24 hours. Therefore, the data did not indicate a need for quality improvement. • As described above for CI 29.3 and CI 29.5, DBHDS provided a Process Document entitled *29.3, 29.5, 29.15 Licensing Assessment Incident Report Process Document VER 003* that outlined the process steps, data source, and responsible person(s) for monitoring serious incident report timeliness. Previously, there were concerns that the data used to measure this timeframe was not sufficiently specific to accurately assess whether the report was made within the required 24-hour period. Based on this review, DBHDS made improvements to address this concern include making the "date of discovery" field a mandatory field for data entry and incorporating a field to capture time of discovery that is also used in the calculation. This appeared to be sufficient to ensure data quality for timely reporting overall. • With regard to other aspects of provider compliance with serious incident reporting requirements, the RMRC regularly reviewed data on licensing citations related to serious incident reporting requirements. Overall, this appeared to substantively address the requirements, but, going forward, the RMRC should consider requesting additional data resulting from monitoring compliance with the serious incident reporting requirements of the Licensing Regulations during all investigations of	

Compliance Indicator	Facts	Analysis	Conclusion
	sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. . .	serious injuries and deaths. • The Process Document entitled *Licensing Assessment Incident Report Process Document VER 003*, dated 2/21/23, which describes the key roles in monitoring compliance with the serious incident reporting requirements and the issuance of CAPs, also included steps to address identified threats to data validity and reliability. Along with the *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services*, revised January 2023, and the *OL Annual Compliance Determination Chart,* which is revised annually, these appeared to be sufficient to provide valid and reliable data. • DBHDS a provided a Data Set Attestation for the data set entitled *Death and Serious Incidents by Type*. It did not appear this data set alone was sufficient to address all the purposes of this Process Document related to licensing requirements. In addition, it did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.	
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	DBHDS has established an agreement with the Virginia Commonwealth University (VCU) to conduct look-behind reviews of a statistically valid, random sample of DBHDS serious incident reviews and follow-up processes. The VCU process includes interrater reliability procedures that are described in the *Incident Management IRR Recommendations* document. The VCU process addresses	DBHDS established an agreement with the Virginia Commonwealth University (VCU) on 03/25/2022 to assume responsibility for conducting look-behind reviews of a statistically valid, random sample of DBHDS serious incident reviews and follow-up processes. The reviews are being conducted on a quarterly schedule. VCU issued its first report on 01/26/2023 addressing a sample of incidents reported in April, May, and June 2022 (*VCU IMU 2nd Quarter 2022 Report final 1.26.23*) and its second report on 03/15/2023 addressing a sample of incidents reported in July, August, and September 2022. A process document (*29.16, 29.18 DOJ Process IMU Look-Behind VER001*) provides a detailed description of data collection and analysis associated with the requirements for the IMU Look-Behind process. It describes specific roles and responsibilities for the IMU Manager, the VCU Project Manager, and the RMRC related to data associated in these processes. An attestation statement	20th-Not Met **22nd-Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	only three of the four elements required in this Compliance Indicator; it does not currently include assessment of timely, appropriate corrective action plans implemented by the provider. VCU issued its first quarterly report on 01/26/2023 evaluating incidents reported in April, May, and June 2022. The RMRC received and completed an initial review of the VCU Quarterly Report but given the newness of the process, sufficient data and information is not yet available for the RMRC to identify trends that could inform potential quality improvement initiatives. Within one month of receipt, the OL developed and implemented substantive process improvement initiatives based on findings from the initial VCU quarterly look-behind report that are summarized in the *Q2 2022 VCU IMU Look Behind DBHDS Response 01/31/2023*.	(*29.16, 19.18 IMU Look Behind Attachment B*) dated 03/17/2023 was also provided attesting to the reliability and validity of the data used in the IMU Look-Behind process. The look-behind review process appears well-structured, is based on information derived from a randomly generated sample of 100 incidents reported during the quarter and includes a process for inter-rater reliability determination described in the *Incident Management IRR Recommendations* document. The review currently assesses three outcomes: (1) the incident was triaged appropriately by the IMU according to developed protocols; (2) the provider's documented response addresses ways to mitigate future occurrences; and (3) appropriate action from the IMU occurred. The audit does not currently include determination of whether there were timely, appropriate corrective action plans implemented by the provider when indicated. DBHDS noted that this element has not yet been formally added to the VCU assessment process and plans are underway to add it within the next three months. The *2/27/2023 RMRC Meeting Minutes* noted review of this first VCU quarterly report and some discussion about the results; however, a representative from VCU was not able to attend the meeting. Results of this first review were as follows: • Outcome #1 (the incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols) was noted by VCU to be present in 59% of the incident reviews; • For Outcome #2 (the provider's documented response ensured the recipient's safety and well-being), it was positive to note from VCU's findings that this outcome that is specifically related to ensuring the recipient's safety and well-being was present in 86% of the incident reviews, the highest of the three assessment scores; and • Outcome #3 (appropriate follow-up from the Office of Licensing incident management team occurred when necessary) was noted to be present in 71% of the incident reviews. As this is a new process and was the first review conducted by VCU and reviewed by the RMRC, there was insufficient data available to the RMRC to	

Compliance Indicator	Facts	Analysis	Conclusion
		identify trends or support recommendations for quality improvement initiatives. The OL has initiated follow-up address of concerns noted in the *VCU IMU 2nd Quarter 2022 Report final 1.26.23*. Responses to cited areas of concern are summarized in the *Q2 2022 VCU IMU Look Behind DBHDS Response 01/31/2023* and include: • Revision of the *IMU Triage Training Form (revised 02/23/2023)*. This template is a training tool that includes prompts that are to be addressed in each triage activity. It is being used as a guide in training IMU staff. • Implementation of several quality assurance processes that include activities during the daily triage review process, a self-audit process that is completed weekly, and a look-behind process completed by the Incident Management Unit Manager. These processes were implemented in 02/2023 and are described in the *Incident and Discover Date Triage and Audit (02/2023)* document. • Implementation of a monthly Incident Reportability Look-Behind process in 02/2023. This process is described in the *Incident Reportability Look Behind (02/2023)* document. It includes review of a 10% sample of incidents categorized as "Other" to determine if they are correctly categorized. Results are compiled and reviewed with the Incident Management Unit Manager to determine appropriate follow-up which could include process changes or additional training for IMU reviewers. These actions appropriately address the major areas of concern identified in the initial VCU look-behind audit report and are evidence of timely and substantive IMU triage and review process improvement efforts initiated by OL. They further evidence the utility of the VCU look-behind process to identify targeted areas of process improvement necessary for the IMU triage and review process to achieve its intended purposes. The results of the 2nd quarterly review were received on 03/15/2023, and DBHDS has not yet had the opportunity to analyze those results and determine appropriate follow-up actions. A preliminary review noted: • 78% of the sample cases met Outcome #1, an increase from 59% in the 2nd quarter.	

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		• 77% of the sample cases met Outcome #2, a decrease from 86% in the 2nd quarter. • 72% of the sample cases met Outcome #3, a slight increase from 71% in the 2nd quarter. Based on evidence provided, this review verified that DBHDS through its contract with VCU, has established a structured look-behind review process of a statistically valid, random sample of serious incident reviews and follow-up processes. The VCU review addresses three of the five required elements in this Compliance Indicator but does not address determination of whether there were timely, appropriate corrective action plans implemented by the provider when indicated. Regarding the final element of the RMRC review, there has not been sufficient time nor evidence generated from the VCU review process for the RMRC to identify trends and recommend quality improvement initiatives when necessary. Considering these findings, additional time and efforts are needed for DBHDS to successfully address all five of the requirements of this Compliance Indicator.	
29.17 The RMRC conducts or oversees a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines. ii. The person conducting the investigation has been trained to conduct	DBHDS discontinued the previous OHR Community Look Behind Process in September 2021. Data from April, May, and June 2020 was presented to the RMRC on 03/21/2022. No additional data reports have been presented to the RMRC regarding the OHR look-behind process since that date. Data used in the OHR look-behind process was to be transitioned to the PowerApps platform to address issues with data quality referenced in the	The 20th Period study referenced that the *OHR Community Look-Behind RMRC Report 03/21/2022*_stated that DBHDS discontinued the OHR Community Look-Behind process in September 2021 "due to data quality issues preventing sampling." This document provides an overview of the processes associated with the OHR Look-Behind process as it was implemented prior to September 2021, identifies a number of concerns and issues with information related to the process, and provides some description of remediation efforts to address these concerns. It concludes with a detailed description of data issues that, as referenced above, resulted in the discontinuation of the look-behind process as it was structured prior to September 2021. These issues are also detailed in the *OHR Community Look-Behind – DQV Processes and Procedures* document. DBHDS reported that there was no Look-Behind RMRC Report completed to date in 2023 as the look-behind process has not been operational since September 2021. The *2023 OHR Community Look-Behind Timeline (revised)* provides a schedule for the look-behind reviews for 2023 and 2024. DBHDS stated that current efforts are focusing on completion of the look-behind tool and related processes and that	20th-Not Met **22nd-Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	*OHR Community Look-Behind RMRC Report 03/21/2022.* Information regarding the status of this transition was not provided for this study. The *2023 OHR Community Look-Behind Timeline* states that a review of cases in October, November, and December 2022 was to be conducted in March-April 2023. DBHDS did not provide a status update on this review.	they anticipate beginning the revised look-behind process with a projected completion date of the tool by mid-April. DBHDS did not provide a process document or description of the revised look-behind process for this review; however, they provided information that the revised schedule will sample investigations that were closed in the previous month, significantly reducing the time lag for findings to be identified, analyzed, and acted upon. Look-Behind reviews are projected to begin in early May. The first review will evaluate cases closed in April. The first quarterly report of findings from the look-behind review of cases closed in April-June is projected to be submitted to the RMRC for review and analysis during their August 2023 meeting. As the revised process has not yet been initiated and details of the tools and procedures to be utilized have not yet been finalized, it was not possible to assess whether the revised process addresses all required elements in this Compliance Indicator.	
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.	Regarding the look-behind process requirement at Compliance Indicator 29.16 above, this review process which is being conducted by VCU has begun and the first quarterly report evaluating a sample of 100 incidents reported in April, May, and June 2022 has been completed and received by the RMRC. Of the four outcomes required to meet the 86% threshold score for the IMU Look-Behind process, only Outcome 2 met this threshold. Outcome 1 was at 59%, Outcome 3 was at 73%, and the process to	Regarding the look-behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process required at CI 29.16, The Partnership for People with Disabilities at the Virginia Commonwealth University (VCU), the contracted audit entity, issued its first quarterly report on 1/26/2023 addressing incidents reported in April, May, and June 2022. Results from this first review addressed three of the four elements required by Compliance Indicator 29.16. Those results are as follows: Outcome 1 – Incident was triaged appropriately by the IMU according to developed protocols – the audit found this to be true in 59% of the sample cases reviewed. Outcome 2 – The provider's documented response addresses ways to mitigate future occurrences – the audit found this to be true in 86% of the sample cases reviewed. Outcome 3 – Appropriate action from the IMU occurred – the audit found this to be true in 73% of the sample cases reviewed. Outcome 4 - Timely, appropriate corrective action plans are implemented by the provider when indicated – this element has not yet been incorporated into the VCU review process.	20th-Not Met **22nd-Not Met**

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	assess Outcome 4 has not yet been implemented. No data or information from the OHR Community Look-Behind required at Compliance Indicator 29.17 was made available for this 22nd period study.	Based on these results, only one of the four outcomes achieved the 86% required threshold score. A process document (*29.16, 29.18 DOJ Process IMU Look-Behind VER001*) provides a detailed description of the data management process associated with the requirements for the IMU Look-Behind described at Compliance Indicator 29.16 above. It describes specific roles and responsibilities for the IMU Manager, the VCU Project Manager, and the RMRC related to data associated with the IMU Look-Behind process. This document does not address data management processes for the Abuse, Neglect, and Exploitation (ANE) Look-Behind described at Compliance Indicator 29.17 above. An attestation statement (*29.16, 19.18 IMU Look Behind Attachment B*) dated 03/17/2023 was also provided attesting to the reliability and validity of the data used in the IMU Look-Behind process. Regarding the look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation (the OHR Community Look-Behind), the revised process has not yet been fully implemented and no look-behind data has been presented to the RMRC for review since 03/21/2022 (data from April, May, June 2020).	
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.	DBHDS provided a set of documents that describe a quality assurance/improvement methodology for ensuring that the RAT is complete, appropriately identifies any new potential risk or new diagnosis associated with a potential risk; that the new potential risk or diagnosis is identified and documented in the ISP; and whether the potential risk was or was not referred to a qualified health	At the time of the 20th Period review, DBHDS did not have a process in place for providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 or to report this information to the Commonwealth. However, DBHDS did provide a provided a proposed *Protocol for the Identification and Monitoring of Individuals with Complex Behavioral, Health, and Adaptive Support Needs and the Development of Corrective Action Plans required to Address Instances Where the Management of Needs for These Individuals Falls Below Identified Expectations for the Adequacy of Management and Supports Provided*, which was dated 2/7/22, but with a projected implementation date of 4/1/22. This protocol stated that DBHDS Office of DQV would pull a statistically stratified annual sample of individuals with SIS level 6 and 7 support needs order to review the ISP (Parts I-V) and the completion of DBHDS tools, including the Risk Awareness Tool (RAT) and On-site Visit Tool (OSVT), to determine if risks are identified, addressed in the ISP, and reviewed over time. It also identified supplemental roles for OIH, the Office of Crisis Services and the Office of Provider Development. However, for purposes of the requirements of this CI, the	20th-Not Met **22nd-Met**

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	professional. These include a conceptual document entitled 29.19 Summary, which stated that there are two ways that Virginia DD Providers 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. One is through the Risk Awareness Tool (RAT) process and the other is when a Request for a Reassessment of the individual's SIS secondary to the observation of a change in status. A Process Document entitled *Risk Awareness Tool Review and High Need Review*, with a creation date of 9/20/21 and the most recent revision date of 2/17/23 described a series of steps by which an OIH Specialist would complete a biannual review a statistically significant sample of RATs completed during the preceding six month period, and then to provide audit	document provided did not describe if providers would be required to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 or report that information to DBHDS. For this 22nd Period review, DBHDS had abandoned that proposed protocol in favor of another, but with some similarities. DBHDS staff provided the following documents: • **A conceptual document entitled *29.19 Summary*:** This document stated that there are two ways that Virginia DD Providers 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. o One is through the Risk Awareness Tool (RAT) process and the other is when a Request for a Reassessment of the individual's SIS secondary to the observation of a change in status. The document noted that DD Providers are required to complete the RAT with the development of each Individual Service Plan (ISP) and that the RAT was designed to increase awareness of the potential for a harmful event (e.g., accident, choking, dehydration, aspiration pneumonia, seizure, pressure injury, bowel obstruction, sepsis, fall with injury, self-harm, elopement, etc.). In the RAT, if one trigger is present the threshold is met, and the findings indicate a potential risk. These harmful events are those that are most frequently result in an adverse event or finding that could result in an individual with a SIS score of level 2,3,4,5 seeing an increase in their SIS level to 6 or 7 upon the next assessment. o The *Request for Reassessment of the SIS* process is based in Virginia Code12VAC30-122-190. The Support Intensity Scale (SIS) is utilized to determine the individual's assigned level and tier and needs to be updated as needs change. Reassessment Requests are to be submitted by the individual's Support Coordinator "when the individual's support needs have been deemed to have changed significantly for a sustained period of at least six	

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	feedback to CSBs and related technical assistance and/or training, as needed, to Support Coordination teams. The RAT is completed by the interdisciplinary team at the time of the ISP and is uploaded to DBHDS. A RAT Summary Page, which is a part of the upload, includes check boxes to identify whether, based on the RAT review, the individual has no potential risk or a potential risk for a changing SIS level (i.e., potential for Level 1,2 or 3; potential for Level 4 or 5; potential for Level 6 or 7). While the process described in the *29.19 Summary* conceptual document currently allows DBHDS staff to complete a sample review, based on documentation provided, they expect the RAT, including the Summary, to be fully integrated in WaMS by FY 25. At that point, DBHDS should be able to run a report that identifies all individuals with risk factors that have the potential to lead to a Level 6 or 7.	months." The request for reassessment notifies DBHDS that individuals may have emergent high risk medical or behavioral health needs and / or other factors that might lead to a SIS Level 6 or 7. The SIS staff evaluates documentation submitted to identify the needed supports that are not already captured in the current SIS and confirm that they are in fact needed and expected to be on-going. • **A Process Document entitled *Risk Awareness Tool Review and High Need Review*, with a creation date of 9/20/21 and the most recent revision date of 2/17/23.** The Process Document described a series of steps by which an OIH Specialist would complete a biannual review of a statistically significant sample of RATs completed during the preceding six month period, and then to provide audit feedback to CSBs and related technical assistance and/or training, as needed, to Support Coordination teams. • **A *Data Set Attestation for CSB RAT Scorecards*, based on the Process Document for the *Risk Awareness Tool Assessment Version 007*, dated 3/10/23.** • **A Process Document for the *Request for Reassessment of the SIS,* with an effective date of 7/7/20.** It described the steps to complete the referenced process. • **A *Risk Mitigation Framework,* dated 8.19.21**. This document was a flow chart of risk identification and plan development as well as processes for verification, data collection, reporting, an possible actions for noncompliance. In general, this set of documents describe a quality assurance/improvement methodology for ensuring that the RAT is complete, appropriately identifies any new potential risk or new diagnosis associated with a potential risk; that the new potential risk or diagnosis is identified and documented in the ISP; and whether the potential risk was or was not referred to a qualified health professional. The RAT is completed by the interdisciplinary team at the time of the ISP and is uploaded to DBHDS. A RAT Summary Page, which is a part of the upload, includes check boxes to identify whether, based on the RAT review, the	

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	DBHDS also indicated they reviewed data from the process for requesting a reassessment of an individual's SIS level. Using the *SIS Reassessments Spreadsheet*, the reviewer pulls data for the total number of reassessment requests and the numbers of requests that were approved, denied and rejected. DBHDS staff provided a Process Document for this process, dated 6/6/20, and indicated that the SIS QM and Waiver Operations Director review this process and its annual results. It was not clear in the materials provided how DBHDS uses these quantitative data, but presumably there is an opportunity to cross reference the reassessment data with changes to SIS levels for individuals. Overall, it appeared DBHDS met the intent of this CI. Going forward, the process can become even more robust when the RAT is fully integrated into WaMS. DBHDS might also want to consider how Care Concerns	individual has no potential risk or a potential risk for a changing SIS level (i.e., potential for Level 1,2 or 3; potential for Level 4 or 5; potential for Level 6 or 7). While the process described in the *29.19 Summary* conceptual document currently allows DBHDS staff to complete a sample review, based on documentation provided, they expect the RAT, including the Summary, to be fully integrated in WaMS by FY 25. At that point, DBHDS should be able to run a report that identifies all individuals with risk factors that have the potential to lead to a Level 6 or 7. In the *29.19 Summary* conceptual document referenced above, DBHDS provided an analysis of the data from the first review process completed. This analysis focused on the percentages of individuals in various Tiers and Levels who had an identified potential risk that could result in an adverse event and therefore an increase in support needs that might result in a SIS score placing them at a SIS Level 6 or 7. In particular, the data showed that individuals in Tier 3, Levels 1-5 had a higher percentage of the risk of moving to Level 6 or 7. The summary document also included recommendations for additional review elements in the future, such as considering if there are common characteristics of the Tier 3, Levels 1-5 group that could inform training opportunities focused on preventative and proactive risk reduction. DBHDS also indicated they reviewed data from the process for requesting a reassessment of an individual's SIS level. Using the *SIS Reassessments Spreadsheet*, the reviewer pulls data for the total number of reassessment requests and the numbers of requests that were approved, denied and rejected. DBHDS staff provided a Process Document for this process, dated 6/6/20, and indicated that the SIS QM and Waiver Operations Director review this process and its annual results. It was not clear in the materials provided how DBHDS uses these quantitative data, but presumably there is an opportunity to cross reference the reassessment data with changes to SIS levels for individuals. Overall, it appeared DBHDS met the intent of this CI. Going forward, the process can become even more robust when the RAT is fully integrated into WaMS. DBHDS might also want to consider how Care Concerns identification might be incorporated into the identification of individuals with these noted risk	

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	identification might be incorporated into the identification of individuals with these noted risk factors.	factors.	
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.	DBHDS reported in the *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022*, dated February 17, 2023, that in FY 2022, for the relevant PMI, 74% of individuals in residential settings on the DD waivers had documented annual physical exam date. DBHDS also provided a document labelled *Annual Physical Exams FY 2023,* dated 2/7/23, which also indicated 74% for the two most recently reported quarters (i.e., Q4, FY22 and Q1 FY 23). Therefore, this aspect of the CI was not met. The *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022* did not provide a percentage of those individuals who had a documented annual dental exam date. However, the *Annual Physical Exams FY 2023* indicated the percentage of individuals with annual dental exams ranged from 50% in Q1	For this 22nd Period review, DBHDS reported in the *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022*, dated February 17, 2023, that in FY 2022, for the relevant PMI, 74% of individuals in residential settings on the DD waivers had documented annual physical exam date. This was consistent with another document labelled *Annual Physical Exams FY 2023,* dated 2/7/23, which also indicated 74% for the two most recently reported quarters (i.e., Q4, FY22 and Q1 FY 23). Therefore, this aspect of the CI was not met The *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022* did not provide a percentage of those individuals who had a documented annual dental exam date. However, the *Annual Physical Exams FY 2023* indicated the percentage of individuals with annual dental exams ranged from 50% in Q1 of FY 22 to 56% in Q1 of FY 23. Therefore, this aspect of the CI was not met. However, it was positive to see the steady incremental growth in this area. DBHDS staff reported that 100% of all DD waiver participants have dental coverage at this time, to which some of this growth could be attributed. In addition, it was positive that DBHDS was taking steps to further improve this performance, through a series of Office of Integrated Health (OIH) education and outreach materials, as well as a newly implemented KPA Workgroups QII for SFY 23. The QII goal is to improve the percentage of individuals enrolled in DD waivers who receive an annual dental exam to 86 %. At the time of the 20th Period review, based on the related PMI documentation, it appeared DBHDS planned to utilize data from WaMS to measure performance for this CI. However, DBHDS did not provide a properly completed Process Document or signed Attestation for either an annual physical exam or an annual dental exam. The following paragraphs describe progress made since then and remaining concerns with regard to data validity and reliability for future consideration.	20th-Not Met **22nd-Not Met**

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	of FY 22 to 56% in Q1 of FY 23. Therefore, this aspect of the CI was not met. DBHDS provided two Process Documents (*Annual Physical Exams*, *Version 002*, last revised on 1/13/23, and *Annual Dental Exams*, also last revised on 1/13/23) and a single Data Set Attestation entitled *Physical and Dental Exams*, dated 2/17/23. The Process Document defined the steps in the data collection methodology and addressed previously identified threats to data validity and reliability with mitigation strategies. While several of the strategies were still pending and not fully in place for the data collected during the 22nd Period review, they appeared to sufficiently address the identified threats. Going forward, DBHDS will need to update the Process Document as they finalize the implementation of the mitigation steps. The Data Set Attestation did not meet the requirements of	For this 22nd Period review, DBHDS provided two Process Documents (*Annual Physical Exams*, *Version 002*, last revised on 1/13/23, and *Annual Dental Exams*, also last revised on 1/13/23) and a single Data Set Attestation entitled *Physical and Dental Exams*, dated 2/17/23. Both Process Documents indicated that OISS pulls the raw data from the WaMS ISP according to the business rules for OISS DR0002. Based on the process steps, both sets of data are derived from pivot tables that pull from the "Person ID" column and the "Most Recent Physical Categorized" or the "Most Recent Dental Categorized" columns, as applicable. The Process Document addressed previously identified threats to data validity and reliability with the following mitigation strategies: • **Last Exam Dates, Date of last complete Physical/Dental Exam: does not define what a "complete" exam is.** The proposed mitigation was to ensure that guidance provides more specific information regarding the use and expectation for this section and that appropriate slides would be updated in FY23 to clarify. o For the *Annual Physical Exams*, the Process Document stated the numerator as the number of individual who have an annual physical date recorded in their annual ISP and the denominator as the number of individuals living in DBHDS licensed settings. It also defined the Annual Physical Date as a date of an annual physical that occurs within the year proceeding the Annual ISP date. The document provides the applicable definition for complete physical exam as follows: "A physical examination is a routine test a primary care provider (PCP) performs to check an individual's overall health. A PCP may be a doctor, a nurse practitioner, or a physician assistant. Also known as a wellness visit, an annual physical exam includes a review of preventative screenings. The physical exam can be a good time to ask the PCP questions, discuss any concerns, changes or problems that have been observed. There are different tests that can be performed during a physical examination depending on the	

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	the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. In addition to addressing the remaining concerns, the KPA PMI Measure "Individuals in residential settings on the DD waivers will have a documented physical exam date," dated 2/7/22 will need to be updated to be consistent with or incorporate the related Process Document.	individual's age or medical or family history." o For the Annual Dental Exams, the Process Document stated the identical numerator and denominator and the following applicable definition of a complete dental exam: "A physical examination is a routine test a dentist performs to check an individual's overall oral health. The annual dental exam can be a good time to ask the dentist and/or dental hygienist questions, discuss any concerns, changes or problems that have been observed. There are different tests that can be performed during a dental examination depending on the individual's age or medical or family history." Although the numerator was consistent with the definition of the annual dental exam as a "physical examination," using the identical numerator for both measures could potentially lead to error. DBHDS should consider modifying the numerator for this measure to clearly state it is a dental physical examination to differentiate it from the annual physical exam numerator. o DBHDS provided a set of slides, entitled *WaMS Clarifications*, dated 4/12/23. The set included a slide that showed the WaMS entry fields for the last "complete" annual physical and dental exams. The guidance on this slide indicated that the entered date should be, by individual/family/provider report, the last medical/dental appointment that included discussion of preventative screenings and the person's overall health/oral health. It was not immediately clear if this guidance was integrated into WaMS or was a stand-alone presentation. If the guidance is not readily available at the time of data entry, it remains a potential source of user entry error. Based on written responses, DBHDS staff indicated the slideshow was distributed through the listserv to 5,056 stakeholders on 4/12/23, and described a couple of elements that were modified in the current ISP module (i.e. version 3.4) in response to the recommendations. Other slides speak to the issues collected from users during the DQV interviews. Term definitions were provided in the slideshow as well to address the planning terms	

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		guidance that was needed. Confusion stems from the definitions of outcome, key steps, support activities, measures, and support instructions. These slides will be posted online for user reference. These slides were provided to the Assistant Commissioner for review and approval. Provider Development will work with OISS to incorporate content into the WaMS User guide by 7/1/23. While these mitigations will not be finalized until that date, it appeared they would address the identified threats at that time. • **Living Situation on Waiver, Start Date: users did not know which start date this refers to.** The proposed mitigation was that in FY23, DBHDS would work with the WaMS Vendor to modify the WaMS element from "start date" to "begin date" to draw a distinction between what's being requested and the typical association of the word "start" when referring to the effective date of services or the ISP year. Based on the 4/12/23 *WaMS Clarification* slides cited above, the following resolution was in place and appeared to be sufficient: "The WaMS User Interface has two tables under the Person's Information Overview section to enter the start date for a person's living situation on Waiver and Start Date for a person's living situation when they are on the waitlist. As described in the WaMS CSB User Manual, the Start Date refers to the start or begin date of the living situation being reported. For example, if a person moved into a sponsored residential home on August 1, 2022, this is the date that is entered for this living situation. When a new living situation is added in WaMS, the previous living situation is automatically ended on the preceding day." • **Ensure that ISPs are completed by their effective date**. The proposed mitigation was for DBHDS to modify the quarterly ISP Compliance report format to include the number and percent of ISPs not placed into a proper status prior to the effective date of the current, related ISP year. This element would be considered in issuing corrective action plan requests and providing technical assistance beginning in	

Compliance Indicator	Facts	Analysis	Conclusion
		FY23. Based on the 4/12/23 *WaMS Clarification* slides cited above, "DBHDS does not have the ability to implement a system edit that ensures SCs complete their steps in planning on time. DBHDS does have an established process of monitoring CSB performance and working with CSBs to track and improve data quality related to ISP entry. Currently (sic) the Case Management Steering Committee provides CSBs with a quarterly ISP Compliance report and related row level data for internal monitoring, which can be modified to incorporate the number and percent of ISPs not completed by the effective date. This would introduce the element into the established corrective action plan and related support processes. DBHDS has requested that the quarterly ISP Compliance report format to include the number and percent of ISPs not placed into a proper status prior to the effective date of the current, related ISP year. This element will be considered in issuing corrective action plan requests and providing technical assistance beginning in FY24." At the time of the publication of the *Assessment of WaMS Completion Criteria* in November 2022, the Office of EHA indicated that a similar proposed resolution did not provide sufficient detail such as a timeframe and did not list any specific staff responsibilities, and that it required further workgroup discussion between IT and the business area, with project management and EHA staff facilitation as needed. While this current version of the proposed resolution did provide a target date of FY24, some additional detail will need to be spelled out in an update to the Process Document when that full resolution takes effect. The mitigation was not in place for the most recently reported data. • **Ensure duplicate individuals are not being counted.** The proposed mitigation was to ensure to utilize "Distinct Count" in Pivot Tables to count unique individuals. The Process Document included this instruction. Based on written response from DBHDS staff, the Distinct Count Function was in place at the time of the most recently reported data. The unique identifier exists in WAMS as the person's ID. The challenge with unique identifiers arises most frequently when a metric crosses over with systems such as the incident reporting system.	

Compliance Indicator	Facts	Analysis	Conclusion
		This indicator metric only utilizes WaMS as a data source. This appeared to be a sufficient mitigation for the identified threat. With regard to the Data Set Attestation entitled *Physical and Dental Exams*, dated 2/17/23, it did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. In addition to addressing the remaining concerns above, the KPA PMI Measure "Individuals in residential settings on the DD waivers will have a documented physical exam date," dated 2/7/22 will need to be updated to be consistent with or incorporate the related Process Document.	
29.21 At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	Based on findings that CI 7.18 and CI 7.19 were not met for this 22nd Period, DBHDS did not achieve compliance with CI 29.21, which requires that at least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services. DBHDS did make progress, though, as CI 7.14 and CI 7.20 were found to be met for this first time.	At the time of the 20th Period review, DBHDS did not achieve compliance with CI 7.14, CI 7.18 and CI 7.19; as a result, CI 29.21 was not met. In addition, DBHDS did not provide a relevant Process Document and Data Set Attestation for CI 29.21, or consistently provide both of those needed documents for CI 7.14, CI 7.18 and CI 7.19. For this 22nd Period review, based on findings elsewhere in this report that CI 7.18 and CI 7.19 were not met for this 22nd Period, DBHDS did not yet achieve compliance with CI 29.21. DBHDS did make progress, though, as CI 7.14 and CI 7.20 were found to be met for this first time. The following summarizes these results: • CI 7.14 was met. This CI metric to increase the number of PBSFs and LBAs was met and surpassed. The Commonwealth also completed the required gap analysis and undertaken actions to the increase the number of behaviorists to increase the number of individuals with an identified need for therapeutic consultation who are referred to an identified provider within thirty days. • CI 7.18, which requires that 86% of individuals identified for TC will have a provider identified within thirty days of the service being authorized, was not met. During this review cycle, 1,020 (68%) of the	20th-Not Met **22nd-Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
		1,509 individuals identified as needing behavioral services (TC) were connected to a TC provider within thirty days. • CI 7.19 was not met. The Commonwealth had not achieved comprehensive TC service implementation for 86% of the individuals who are authorized to receive these services. However, DBHDS had developed a sufficient methodology to verify that the Functional Behavior Analyses (FBAs) and behavior Support Plans (BSPs) are adequate to meet the requirements for behavior programs. The Process Document for this CI was modified and improved from the last review period. Enhancements/workarounds were made in order to validate data before prior to calculations. DBHDS provided an attestation on 2/17/23 that found no defects. • CI 7.20, which addresses the implementation of a related quality improvement process, was met. Given that a thorough data set review and visualization was performed and attested, the study found the process to be reliable and valid.	
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.	For this 22nd review, DBHDS did not provide a written data report, but reported verbally that of 4,059 provider settings, they had completed 1,786 reviews for compliance with the HCBS Settings Rule. Of these, eight were deemed as being unable to come into compliance. Of the remaining settings, 1,573 (88%) were found to be in compliance, with another 205 in the process of remediation. However, these were only partial data and are not sufficient to evidence the status	For the 20th Period review, DBHDS indicated they did not have HCBS Settings data available to date and did not provide a related Process Document and/or Data Set Attestation. For this 22nd review, DBHDS did not provide a written data report, but reported verbally that of 4,059 provider settings, they had completed 1,786 reviews for compliance with the HCBS Settings Rule. Of these, eight were deemed as being unable to come into compliance. Of the remaining settings, 1,573 (88%) were found to be in compliance with another 205 were in the process of remediation. However, these were only partial data and are not sufficient to evidence the status of compliance overall. In addition to a lack of data for 2,273 settings, DBHDS did not currently report the relevant number and percentage of actual residential service recipients living in complaint settings. Therefore, this CI is not yet met. Based on staff interview and the related Process Document, dated 1/1/23, going forward the data to be reported will include both the number and percentage of	20th-Not Met **22nd-Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	of compliance overall. In addition to a lack of data for 2,273 settings, DBHDS did not currently report the relevant number and percentage of actual residential service recipients living in complaint settings. Therefore, this CI is not yet met. DBHDS did submit a Process Document, dated 1/1/23, but did not submit an Attestation. Of note, the Process Document seeks to incorporate QSR findings, based on HCBS questions that have been added back for Round 5. It indicates that settings that receive a full QSR review during a reporting period will be considered compliant "since the provider will have to implement their quality plan." DBHDS will need to re-consider this process. A plan to achieve compliance does not equate to compliance and therefore would invalidate this measure.	compliant settings and the number and percentage of people living in compliant settings. The timeframe for completion of the initial compliance determinations is as yet unknown, but is anticipated by June, 2025, based on an HCBS Corrective Action Plan submitted to CMS. However, DBHDS also reports an effort to fast-track these determinations, which are being performed by seven dedicated reviewers, including both DBHDS and DMAS staff. The Process Document states that DBHDS intends to rely on data from WaMS, CONNECT and the HCBS Master Tracking Spreadsheet maintained by DMAS to confirm compliance. The WaMS report will provide the number of individuals authorized by residential service type by provider, CONNECT data will provide the number of licensed provider locations by residential services type and the number served in each location and the HCBS Master Tracking Spreadsheet will provide the names of provider locations that have been found to be in compliance (i.e., have received a compliance letter) with the Settings Rule. The Process Document also seeks to incorporate QSR findings, based on HCBS questions that have been added back for Round 5. It states that the HCBS Master Tracking Spreadsheet will be cross-referenced with a pending and yet unnamed QSR report that will be filtered to identify any setting that received a full QSR review for the period in question. In that event, the Process Document indicates that those settings will be considered compliant "since the provider will have to implement their quality plan." DBHDS will need to re-consider this portion of the methodology. A plan to achieve compliance does not equate to compliance and therefore would invalidate this measure. At best, these settings would have to be considered as in remediation until such time successful completion of that remediation can be confirmed.	

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29.23 At least 95% of individual service recipients are free from neglect and abuse by paid support staff.	For this 22nd Period review, in a memorandum dated 7/21/22, OHR reported quarterly data for all four quarters of FY 22 that resulted in an aggregate finding of 89.1% of individual service recipients who were free from neglect and abuse by paid support staff. Therefore, this CI was not met. DBHDS also submitted a Process Document entitled *HR Process Document 29.3 Version 002*, last revised on 1/13/23, and a Data Set Attestation dated 3/10/23. The methodology in the Process Document was not sufficient to determine the validity and reliability of the data: • The validity of the measure could be at risk because the Process Document does not clearly state the numerator as the number of individuals who had a complaint reported in CHRIS substantiated as abuse/neglect *by paid support staff*.	At the time of the 20th Period review, OHR reported quarterly data to the RMRC for FY 21 and the first two quarters of FY 22 that were consistently at 98.8% or above. However, DBHDS staff did not submit a Process Document or Data Set Attestation. OHR had issued a memorandum to the RMRC/KPA Workgroup that provided some description of a process they followed to obtain aggregate data for this measure; however, it did not meet all the requirements of the Process Document as agreed upon in the related Curative Action. For this 22nd Period review, in a memorandum dated 7/21/22, OHR reported quarterly data for all four quarters of FY 22 that resulted in a finding of 89.1% of individual service recipients who were free from neglect and abuse by paid support staff. Therefore, this CI was not met. DBHDS also submitted a Process Document entitled *HR Process Document 29.3 Version 002*, last revised on 1/13/23. It stated the numerator is the number of individuals who had a complaint reported in CHRIS substantiated as abuse/neglect, while the denominator is the number of individual enrolled in the DD waivers. The validity of this measure could potentially be at risk because the Process Document does not clearly state the numerator as the number of individuals who had a complaint reported in CHRIS substantiated as abuse/neglect *by paid support staff*. DBHDS staff should clarify. As described, the process to derive the data for the numerator and denominator relies on data from CHRIS and related reports from CONNECT, as well as population data from WaMS, as reported by OISS. Going forward, to ensure valid and reliable data for reporting this CI, DBHDS staff will need to ensure that the underlying data from each of these each of these processes also meet the requirements of the Curative Action for Data Validity and Reliability. With regard to the identification and mitigation of threats to data quality, the Process Document identified the following issues: • Advanced business rules and data validation controls should be added such that duplicate records cannot be created for individuals or reports. To give each record a distinct ID, create a system-generated unique ID	20th-Not Met **22nd -Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	• As described, the process to derive the data for the numerator and denominator relies on data from CHRIS and related reports from CONNECT, as well as population data from WaMS, as reported by OISS. DBHDS staff will need to ensure that the underlying data from each of these each of these processes also meet the requirements of the Curative Action for Data Validity and Reliability. • Overall, the mitigation section did not comprehensively address the threats to data validity and reliability identified in the Process Document. • The Process Document included steps to review two Data Warehouse reports (i.e., one for CSB data and one for licensed provider data) which then must be added together to determine the total number of substantiated cases of abuse and neglect. In interview, DBHDS staff acknowledged this could	that is truly unique across the platform. • Add controls to individual fields (such as location) to prevent erroneous data from being entered. • Seek to improve usability (the User Experience) of the source system to streamline the data collection process by making enhancements to the interface such as renaming fields, rearranging fields, and adding instructions to the interface if necessary. • To ensure accurate use of the system, end users should be trained on the entire system (not just Human Rights) as part of their "onboarding" process. • Other improvements can be made by building and documenting processes that support use of the system (internal and external). Examples of processes could include: getting user access/removing permissions, end user training, systems administration, system updates and communications, communicating changes to data structures with the data warehouse. The Process Document indicated the mitigation and timeline as follows: • DBHDS is issuing an RFP to replace the CHRIS System- the RFP is currently under review. • New training was developed for Abuse/Neglect reporting in CHRIS. • To assure there are no duplicates in the data, the human rights advocates reviews all data real time to ensure there is not multiple entries for the same issue. Overall, this mitigation section did not comprehensively address the threats to data validity and reliability identified. It was positive that DBHDS provided a memorandum dated February 2023 describing training enhancements and revisions to OHR training for FY 22, but the Process Document did not describe these or tie them to the mitigation of the specific data entry threats. It was also positive that the "human rights advocates reviews all data real time to ensure there is not multiple entries for the same issue." However, this expectation and the steps in that process still needed to be detailed in the Process Document.	

Compliance Indicator	Facts	Analysis	Conclusion
	lead to overcounting. However, the Process Document needed to reflect this threat and how it was to be addressed, but did not. The Data Set Attestation provided did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set to derive the numerator and denominator, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.	As an example, in addition to the previously identified concerns with regard to the lack of a unique identifier for each individual served, the Process Document itself included steps to review two Data Warehouse reports (i.e., one for CSB data and one for licensed provider data) which then must be added together to determine the total number of substantiated cases of abuse and neglect. In interview, DBHDS staff acknowledged this could lead to overcounting. The Process Document needed to reflect this threat and how it was to be addressed, but did not. DBHDS also provided a Data Set Attestation for this Process Document, dated 3/10/23. It did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set to derive the numerator and denominator, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.	
29.24 At least 95% of individual service recipients are adequately protected from serious injuries in service settings.	Based on documentation provided and interviews, DBHDS staff intends to use the Support Coordination Quality Review (SCQR) process, Indicator 7 as the method for measuring this C.I. 29.24. The Indicator evaluates whether or not an individual had a RAT completed, and whether risks identified on the RAT were	At the time of the 20th Period review, DBHDS staff reported that they did not have valid and reliable incident data to evidence compliance with this CI. They did not submit a Process Document or Data Set Attestation Form. For this 22nd Period review, based on RMRC meeting minutes spanning a period from January 2022 through February 2023, the body's Data Workgroup reported ongoing work to identify an appropriate data source that focused not on the percentage of individual service recipients who did not experience serious injuries in service settings, but on the adequacy of the risk mitigation planning and implementation. The rationale for this is based on a recognition that even with the best of planning and implementation, some serious injuries will still occur. While this is likely to be true to a degree, it is unclear how or if DBHDS	20th-Not Met **22nd-Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	incorporated into the ISP. DBHDS did not include any reference to the percentage of *actual* serious injuries (i.e., the outcome for people served) to the determination of adequacy. DBHDS provided a Process Document entitled *Individuals Protected from Injury, version 001*, dated 3/27/23 and a Data Set Attestation for the SCQR, dated 3/9/22. The documentation indicated this proposed methodology for this CI had both obvious and potential flaws: • The most current version of the *Support Coordination Quality Review Process Documentation*, including updates to the methodology, was dated January 19, 2023, so this attestation was not currently applicable. In addition, the 3/9/22 attestation referenced weak inter-rater reliability agreement with regard to one of the two questions	would factor in a percentage of *actual* serious injuries (i.e., the outcome for people served) to the determination of adequacy. In other words, would there be a floor that, if reached, should trigger an analysis of the adequacy of the risk planning and implementation processes, in spite of data that might show those processes stood at 95% compliance? At the time of the October 2023 meeting, the Data Workgroup indicated they supported using a QSR measure as the basis for reporting on the adequacy of risk planning and implementation. This measure read "The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation." The workgroup invited other members to propose an alternative method if not on agreement. At the time of the January 2023 RMRC meeting, the minutes and presentations indicated that the Data Workgroup met with the QSR vendor on January 20, 2023 to learn more about the measure and learned that QSR measure under consideration was a composite of 30 indicators; if any one of the indicators was missed, the measure was failed. The minutes noted that the QSR vendor would be providing us information about the topics of the 30 indicators, to be discussed further at next Data Workgroup meeting. The draft RMRC minutes for February 2023 indicated that the meeting did not include a report or discussion of the Data Workgroup, but that members should review the presentations available in Teams. The consultant requested the meeting presentations, but the Data Workgroup presentation was not included with the other presentations provided. Based on interview with DBHDS staff, the 30 indicators in the QSR measure were not limited to risk planning and implementation, but also included factors such as employment and community integration that would potentially skew the results for the purposes of CI 29.24. The draft RMRC minutes for March reflected that, instead, the Data Workgroup proposed Support Coordination Quality Review (SCQR) process, Indicator 7 as the method for measuring this C.I. 29.24. The rationale was that the Indicator evaluates whether or not an individual had a RAT completed, and whether risks identified on the RAT were	

Compliance Indicator	Facts	Analysis	Conclusion
	that made up Measure 7 and indicated the process would be updated in 2022. In other words, there was known potential for a need to update the attestation as well. It also did not reference the use of the data set for this reporting purpose related to CI 29.24. • Upon request for any updated Attestation, DBHDS provided a document entitled SCQR Data Quality Statement April 2023. It provided a description of the ways in which DBHDS promotes the validity and reliability of the SCQR, but it did not include an attestation from the Chief Data Officer and was not consistent with the requirements of the Curative Action for Data Validity and Reliability overall. • The Process Document did not address how DBHDS would factor in the *actual* percentage of serious injuries (i.e., the	incorporated into the ISP. The discussion noted that although the inter-rater reliability among DBHDS reviewers was strong, the agreement between CSB and DBHDS reviewers was weak. The minutes reflected further discussion that although the low agreement between the CSB and DBHDS reviewers calls into question the reliability of this data, the fact that there is strong reliability between DBHDS reviewers indicates that the measure itself is sound, but that there needs to be improvement in the scoring of this measure by CSB reviewers. The committee agreed that the method was appropriate, given their own focus on developing and implementing the RAT as a way of identifying and addressing risks. DBHDS provided a Process Document entitled *Individuals Protected from Injury*, *version 001* and dated 3/27/23. Based on review of this document, DBHDS planned to use Indicator 7 of the Support Coordination Quality Review (SCQR) tool. This measure read "The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team." It consists of two questions: "Does the PC ISP Essential Information indicate that the SC assessed for risk?" and "Did the ISP team develop a risk mediation plan?" To attest to the underlying validity and data reliability of Indicator 7, DBHDS staff presented an Attestation for the SCQR data set, dated 3/9/22. However, the most current version of the *Support Coordination Quality Review Process Documentation*, was updated January 19, 2023, so it is unclear that this Attestation was currently applicable. Based on review of the 3/9/22 attestation, it referenced weak inter-rater reliability agreement with regard to one of the two questions that made up the measure and indicated the process would be updated in 2022. In other words, there was known potential for a need to update the attestation as well. It also did not reference the use of the data set for this reporting purpose. Upon request for any updated Attestation, DBHDS provided a document entitled *SCQR Data Quality Statement April 2023*. It provided a description of the ways in which DBHDS promotes the validity and reliability of the SCQR, but it did not include an attestation from the Chief Data Officer and was not consistent with the requirements of the Curative Action for Data Validity and Reliability overall.	

Compliance Indicator	Facts	Analysis	Conclusion
	outcome for people served) to the determination of adequacy. • The SCQR documentation provided showed that although the inter-rater reliability among DBHDS reviewers was strong, the agreement between CSB and DBHDS reviewers was weak. CSB reviewers, who were reviewing their own internal work, often found performance to be higher than DBHDS reviewers. Although DBHDS staff reported the agreement between CSB and DBHDS reviewers was improving, the SCQR Data Quality Statement April 2023 indicated that for Indicator 7, the rate of agreement had fallen from 75% in FY 21 to 72% in FY 22. • Under the current SCQR framework, the sample size for this would not be sufficient to be used as a valid application to the population as a whole, which the methodology for	Overall, the SCQR documentation provided showed that although the inter-rater reliability among DBHDS reviewers was strong, the agreement between CSB and DBHDS reviewers was weak. CSB reviewers, who were reviewing their own internal work, often found performance to be higher than DBHDS reviewers. Although DBHDS staff reported the agreement between CSB and DBHDS reviewers was improving, the *SCQR Data Quality Statement April 2023* indicated that for Indicator 7, the rate of agreement had fallen from 75% in FY 21 to 72% in FY 22. DBHDS might be able to make a case to rely on their own external evaluation of CSB performance as reliable data, but under the current framework, the sample size for this would not be sufficient to be used as a valid application to the population as a whole. While the 400 reviews completed by CSBs would reach the 95% confidence level needed to do so (i.e., if the data could otherwise be considered reliable), the sampling methodology for the DBHDS look behind called for only a total of 100 retrospective reviews (i.e., a minimum of two records per CSB to be sampled, with twenty additional reviews distributed by waiver population). This was not a statistically significant sample for application to the population as a whole.	

Compliance Indicator	Facts	Analysis	Conclusion
	measuring this CI must be able to accomplish. While the 400 reviews completed by CSBs would reach the 95% confidence level needed to do so, if the data could otherwise be considered reliable, the sampling methodology for the DBHDS look behind called for a total of 100 retrospective reviews (i.e., a minimum of two records per CSB to be sampled, with twenty additional reviews distributed by waiver population). This was not a statistically significant sample for application to the population as a whole.		
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-	The *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022* reported performance at 99% for 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.	At the time of the 20th Period review, DBHDS provided a Data Set Attestation for this CI, but did not provide a related Process Document. Based on the PMI documentation described further below, tracking of this CI relied on incident data, and DBHDS reported it could not attest to the validity and reliability of that data set. Based on the calculation steps described in the PMI at that time, which required a great deal of judgement, the process needed to provide clear definitions and determination criteria. For this 22nd Period review, the *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022* reported performance at 99% for 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.	20th- Not Met **22nd-Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
approved plans.	This exceeded the requirements of this CI. DBHDS submitted a Process Document entitled *HR Process Document 29.5 Version 002*, last revised on 4/19/22 and a related Data Set Attestation, dated 3/10/23. The Process Document substantively modified the data collection methodology from the previous process, but it was not yet sufficient to determine the validity and reliability of the data: • The validity of the measure could be at risk because the Process Document does not define how "substantiated complaints alleging the unauthorized use of seclusion or restraint" (i.e., as used to calculate the numerator) was fully reflective of the criteria for this CI, including that "seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where	This exceeded the requirements of this CI. DBHDS submitted a Process Document entitled *HR Process Document 29.5 Version 002*, last revised on 4/19/22. That revision described a substantively modified data collection methodology, as follows: "Previously, the methodology and calculation steps assessed the (N) number of individuals with an LHRC approved behavioral plan in which less restrictive alternative are utilized prior to seclusion or restraint compared to (D) the number of behavioral treatment plans that include seclusion or restraint, reviewed by the LHRC. These came from the OHR LHRC Tracker. This previous methodology rendered a baseline of 98.7% for SFY21; however, this process was limited to a very small subset of individuals (often less than 30). To meet the indicator, beginning with calendar year 2022, a new methodology was established to utilize the logic of recently updated data warehouse report DW-0070: OHR Community Seclusion as a cross-reference when OHR staff utilize existing data warehouse reports: DW-0033a and DW-0038a to review and research the identified CHRIS reports to determine the (N) number of individuals who had a substantiated complaint alleging the unauthorized use of seclusion or restraint. OISS staff supply a report related to the (D) number of unique individuals who have an active waiver service in the given quarter). ….OHR will continue to collect and review data specific to the number of behavioral plans utilizing restraint (and/or timeout) reviewed and approved by the LHRC where less restrictive interventions were utilized. The data is maintained in the LHRC Tracker and reviewed as surveillance data." Going forward, the Measure Steward will need to address the following concerns that could impact data validity and reliability: • The validity of the measure could be at risk. The Process Document did not include a Definitions section, but should have, to clarify how "substantiated complaints alleging the unauthorized use of seclusion or restraint" was fully reflective of the criteria for this CI, including that	

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	necessary to protect from an immediate risk to physical safety)," and "as outlined in human rights committee-approved plans." • The current calculation steps would not result in a numerator that showed the number of people who did not have unauthorized restraint or seclusion, but rather the inverse (i.e., the number who did have unauthorized restraint or seclusion). The process steps needed to include a step for subtracting the number of people who had unauthorized restraint or seclusion from the total in the denominator to arrive at the numerator for this who did not. • Overall, the mitigation section did not comprehensively address the threats to data validity and reliability identified in the Process Document. • The Process Document included steps to review two Data Warehouse reports (i.e., one for CSB	"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." Providing the CHRIS definitions for unauthorized seclusion and unauthorized restraint might resolve this concern. • The current calculation steps would not result in a numerator that showed the number of people who did not have unauthorized restraint or seclusion, but rather the inverse (i.e., the number who did have unauthorized restraint or seclusion). The process steps needed to include a step for subtracting the number of people who had unauthorized restraint or seclusion from the total in the denominator to arrive at the numerator for this who did not. It appeared likely that DBHDS did report the data correctly, so the Process Document just needed to be revised to reflect that step. • As described with regard to CI 29.3 above, this Process Document also required the review two Data Warehouse reports (i.e., one for CSB data and one for licensed provider data) which then must be added together to determine the total number of substantiated cases of unauthorized seclusion and restraint. In interview, DBHDS staff acknowledged this could lead to overcounting. However, the Process Document needed to reflect this threat and how it was to be addressed, but should be . • The findings for the Mitigation Timelines described for CI 29.3 also apply here. Overall, this mitigation section did not comprehensively address the threats to data validity and reliability identified. DBHDS also provided a Data Set Attestation for this Process Document, dated 3/10/23. This was prior to the substantively modified process on 4/19/22 and would therefore not be applicable. It also did not otherwise meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for	

Compliance Indicator	Facts	Analysis	Conclusion
	data and one for licensed provider data) which then must be added together to determine the total number of substantiated cases of abuse and neglect. In interview, DBHDS staff acknowledged this could lead to overcounting. However, the Process Document needed to reflect this threat and how it was to be addressed, but did not. The Data Set Attestation, dated 3/10/23, was completed prior to the substantively modified Process Document on 4/19/22 and was therefore not applicable.	addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. The Data Set Attestation indicated that "the ISP data were imported and formatted to PowerBi" for reading and described the functions used to obtain the numerator and denominator.	
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	Based on three quarterly reports of the Supplemental Crisis Report, DBHDS was achieving this measure. The *Supplemental Crisis Report: Quarter IV-FY22*, dated 7/15/22, reported that 99.8% of people on the Priority 1 waiting list were not institutionalized during Q3 of FY 22. The *Supplemental Crisis Report: Quarter I-FY23*, dated 10/15/22, reported that during the Q4 of FY22, 99.5% of the people on	Based on three quarterly reports of the *Supplemental Crisis Report*, DBHDS was achieving this measure. The *Supplemental Crisis Report: Quarter IV-FY22*, dated 7/15/22, reported that 99.8% of people on the Priority 1 waiting list were not institutionalized during Q3 of FY 22. The *Supplemental Crisis Report: Quarter I-FY23*, dated 10/15/22, reported that during the Q4 of FY22, 99.5% of the people on the Priority 1 waiting list were not institutionalized, Finally, the *Supplemental Crisis Report: Quarter II-FY23* reported the data showed 99.7% of people on the Priority 1 waiting list were not institutionalized. This exceeded the requirement for this CI for each of the quarters reported. At the time of the 20th Period review, DBHDS provided a Process Document entitled *DD_ Priority 1_VER_002*, dated January 15, 2022. It noted that the process required review and comparison of numerous data sets. These included, but were not limited to AVATAR, the REACH Hospitalization Tracker and	20th-Not Met **22nd- Met***

Compliance Indicator	Facts	Analysis	Conclusion
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.	the Priority 1 waiting list were not institutionalized, Finally, the *Supplemental Crisis Report: Quarter II-FY23* reported the data showed 99.7% of people on the Priority 1 waiting list were not institutionalized. This exceeded the requirement for this CI for each of the quarters reported. DBHDS provided a Process Document entitled *DD_ Priority 1_VER_004*, dated 1/10/23. The Process Document noted that the process required review and comparison of numerous data sets, including, but not limited to AVATAR, the REACH Hospitalization Tracker and WaMS. DBHDS staff will still need to ensure that the underlying data from each of these each of these processes also meet the requirements of the Curative Action for Data Validity and Reliability. Of note, the Process Document also referenced the intersection with another Process Document for hospital admissions (i.e., *DS_CSS_Hosp Admits and Trends Process_VER_001),* but did not	WaMS. The Process Document also referenced the intersection with another Process Document for hospital admissions and provided it (i.e., *DS_CSS_Hosp Admits and Trends Process_VER_003*, dated 2/1/22) for review. DBHDS provided a Data Set Attestation Form for the *Data Set: Supplemental Crisis Report*, but did not provide a Data Set Attestation for the *CSS_Hosp Admits and Trends.* It was also not clear that DBHDS had yet updated the Process Document *DD_ Priority 1_VER_002* to address the eight actionable recommendations in the AVATAR source system review completed in December 2021. For this 22nd Period review, DBHDS provided a Process Document entitled *DD_ Priority 1_VER_004*, dated 1/10/23. Based on review, the methodology continues to rely on various other data sets to derive the data for the numerator and denominator, including: *SH-IDDD Hospitalizations* with data from AVATAR; *REACH Hospital Tracker Private Hospitalizations*; *ICF-IDD Admissions Data* from the Family Resource Consultant; *PASS-R Data* from nursing facilities admission data and the *Priority 1 Waitlist by CSB Data* from WaMS. DBHDS staff will need to ensure that the underlying data from each of these processes also meet the requirements of the Curative Action for Data Validity and Reliability. For example, in order to fully evaluate the validity and reliability of data for this CI, it would be necessary to ensure that the data reported from the other data sets sufficiently took into account through definitions and/or process steps whether recipient chose institutionalization, entered into a nursing facility for medical rehabilitation or for a stay of 90 days or less or was receiving medical rehabilitation. The methodology for this Process Document did note that AVATAR data for the state hospital admissions are validated in a process described in another Process Document entitled *DS_CSS_St Hosp DD Verification Process_VER_001*, but did not provide it, or a related Data Set Attestation, for review. Otherwise, this Process Document provided a detailed and carefully constructed methodology for how to pull and organize the data reports from the other sources to derive the numerator and denominator for this CI. This included the identification of previously identified threats to validity and reliability for WaMS and AVATAR data that were applicable to this measure, accompanied by an explanation of the mitigating strategies in place.	

Compliance Indicator	Facts	Analysis	Conclusion
	provide the documentation for review. Otherwise, the Process Document provided a detailed and carefully constructed methodology for how to pull and organize the data reports from the other sources to derive the numerator and denominator for this CI. This included the identification of previously identified threats to validity and reliability for WaMS and AVATAR data that were applicable to this measure, accompanied by an explanation of the mitigating strategies in place. DBHDS also provided a Data Set Attestation entitled Data Set Attestation for the *Supplemental Crisis Report Data Set* as it related to this referenced Process Document, dated 2/17/23. It did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the spreadsheet, but did not attest to the sufficiency of the Process Document mitigation steps for	For this 22nd Period review, DBHDS also provided a Data Set Attestation entitled Data Set Attestation for the *Supplemental Crisis Report Data Set* as it related to this referenced Process Document, dated 2/17/23. It did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. .	

Compliance Indicator	Facts	Analysis	Conclusion
	addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.		
29.27 At least 75% of people with a job in the community chose or had some input in choosing their job.	According to the Process Document entitled *Provider Data Summary_VER_001*, dated 3/13/23, the NCI remained the data source for this CI, but the *Provider Data Summary* includes the performance data reporting for this CI. Based on the *Provider Data Summary State Fiscal Year 2022-23*, dated November 1, 2022, the results from the *National Core Indicators In-Person Survey (IPS) State Report 2020-21 Virginia Report* indicate that a combined 92% (n=52) either chose or had some input on choosing their job. The *Provider Data Summary* noted this was a positive increase of 2% when compared to the previous 2019-2020 report. NCI data may be considered reliable and valid and the full NCI *2020-21 In-Person Survey (IPS)*, found on the NCI website (accessed on 4/17/23)	As described above with regard to CI 29.8, NCI data may be considered reliable and valid. DBHDS previously provided a Data Set Attestation Form for the *NCI Adult Consumer Survey* data set that referenced the external documentation that evidenced this. In addition, for the full NCI *2020-21 In-Person Survey (IPS)*, found on the NCI website (accessed on 4/17/23) attested to the methodology for ensuring a sample size that could be considered statistically representative of the Commonwealth for both years. For the 22nd Period review, according to the Process Document entitled *Provider Data Summary_VER_001*, dated 3/13/23, the NCI remained the data source for this CI, but the *Provider Data Summary* includes the performance data reporting for this CI. Based on the *Provider Data Summary State Fiscal Year 2022- 23*, dated November 1, 2022, the results from the *National Core Indicators In-Person Survey (IPS) State Report 2020-21 Virginia Report* indicate that a combined 92% (n=52) either chose or had some input on choosing their job. The *Provider Data Summary* noted this was a positive increase of 2% when compared to the previous 2019-2020 report. Based on this, the *Provider Data Summary* concluded the measure was met.	20th-Not Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
	attested to the methodology for ensuring a sample size that could be considered statistically representative of the Commonwealth for both years. Based on these facts, the measure was met.		
29.28 At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule.	The *Provider Data Summary State Fiscal Year 2022- 23,* dated November 1, 2022, reported the data for this measure as follows: 100% for Q4 FY22 and Q1 FY23. This exceeded the requirement for this CI. DBHDS provided a Process Document entitled *Provider Data Summary, Version 004* with a revision date of 3/3/23, and Data Set Attestation entitled *WaMS Individual Service Plan (ISP), Daily Choice Input*, dated 8/9/22. The Measure Steward provided extensive and thorough detail with regard to strategies implemented or in development to mitigate nine specific threats to data validity and reliability identified in the *Assessment of Completion Criteria WaMS,* dated November 2022.	The *Provider Data Summary State Fiscal Year 2022- 23,* dated November 1, 2022, indicated that the data for this measure was derived from *WaMS ISP Quarterly Aggregate Reports* by combining the numerators and then the denominators for FY22 Quarters 2 and 3 in each instance. It reported the data for this measure as follows: 100% for Q4 FY22 and Q1 FY23. This exceeded the requirement for this CI. DBHDS provided a Process Document entitled *Provider Data Summary, Version 004*, with a revision date of 3/3/23. In the section of the Process Document labelled *DOJ Documentation*, the Measure Steward provided extensive and thorough detail with regard to strategies implemented or in development to mitigate nine specific threats to data validity and reliability identified in the *Assessment of Completion Criteria WaMS,* dated November 2022. While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure. DBHDS needed to make the following improvements to the Process Document: • The Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report,* documenting only that the result was derived from the two quarterly ISP 3.2 Data reports covering the two most recent quarters prior to report completion. DBHDS also did not provide an alternative Process Document for that report outlining the process steps for that derivation. Either one would be	20th-Not Met **22nd-Met***

Compliance Indicator	Facts	Analysis	Conclusion
	While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure. However, DBHDS will still need to make the following improvements to the Process Document: • The Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report,* documenting only that the result was derived from the two quarterly ISP 3.2 Data reports covering the two most recent quarters prior to report completion. DBHDS also did not provide an alternative Process Document for that report outlining the process steps for that derivation. Either one would be acceptable as a vehicle for doing so.	acceptable as a vehicle for doing so. • The Process Document did not reference this measure among those to which it was applicable, but this appeared to be an easily corrected oversight. • For this measure, the Process Document did not state the numerator and denominator, but should do so. • Going forward, DBHDS staff should update the Process Document as they finalize the mitigation strategies. For this 22nd Period review, DBHDS provided a Data Set Attestation entitled *WaMS Individual Service Plan (ISP), Daily Choice Input*, dated 8/9/22. It did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. The Data Set Attestation indicated that the ISP data were imported and formatted to PowerBi for reading and described the functions used to obtain the numerator and denominator. However, there was not a Process Document outlining these steps as those subject to the attestation process, nor did the Data Set Attestation state the numerator and denominator.	

Compliance Indicator	Facts	Analysis	Conclusion
	• The Process Document did not reference this measure among those to which it was applicable, but this appeared to be an easily corrected oversight. • For this measure, the Process Document did not state the numerator and denominator, but should do so. • Going forward, DBHDS staff should update the Process Document as they finalize the mitigation strategies. The Data Set Attestation did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.		

Compliance Indicator	Facts	Analysis	Conclusion
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.	The *Provider Data Summary State Fiscal Year 2022- 23,* dated November 1, 2022, reported the data for this measure as follows: 99.9% for both Q4 FY22 and Q1 FY23. This exceeded the requirement for this CI. DBHDS provided a Process Document entitled *Provider Data Summary, Version 004* and a Data Set Attestation *entitled WaMS Individual Service Plan (ISP), Daily Choice Input,* dated 8/9/22. In the section of the Process Document labelled *DOJ Documentation*, the Measure Steward provided extensive and thorough detail with regard to strategies implemented or in development to mitigate nine specific threats to data validity and reliability identified in the *Assessment of Completion Criteria WaMS,* dated November 2022. While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented,	The *Provider Data Summary State Fiscal Year 2022- 23,* dated November 1, 2022, indicated that the data for this measure was derived from *WaMS ISP Quarterly Aggregate Reports* by combining the numerators and then the denominators for FY22 Quarters 2 and 3 in each instance. It reported the data for this measure as follows: 99.9% for both Q4 FY22 and Q1 FY23. This exceeded the requirement for this CI. DBHDS also provided a Process Document entitled *Provider Data Summary, Version 004,* with a revision date of 3/3/23. The Process Document indicated the numerator was defined as "Number of "yes" responses to the ISP question "Have I chosen or had input into where I live?" The denominator was defined as "Number of responses to the ISP question "Have I chosen or had input into where I live?" In the section of the Process Document labelled *DOJ Documentation*, the Measure Steward provided extensive and thorough detail with regard to strategies implemented or in development to mitigate nine specific threats to data validity and reliability identified in the *Assessment of Completion Criteria WaMS,* dated November 2022. While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure. DBHDS needed to make the following improvements to the Process Document: • The Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report,* documenting only that the result was derived from the two quarterly ISP 3.2 Data reports covering the two most recent quarters prior to report completion. DBHDS also did not provide an alternative Process Document for that report outlining the process steps for that derivation. Either one would be acceptable as a vehicle for doing so. • Going forward, DBHDS staff should update the Process Document as they finalize the mitigation strategies.	20th-Not Met **22nd-Met***

Compliance Indicator	Facts	Analysis	Conclusion
	but were in planning or pending status, it appeared they would be sufficient for this measure. However, DBHDS will still needed to make the following improvements to the Process Document: • The Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report*, documenting only that the result was derived from the two quarterly ISP 3.2 Data reports covering the two most recent quarters prior to report completion. DBHDS also did not provide an alternative Process Document for that report outlining the process steps for that derivation. Either one would be acceptable as a vehicle for doing so. • Going forward, DBHDS staff should update the Process Document as they finalize the mitigation strategies.	For this 22nd Period review, DBHDS provided a Data Set Attestation entitled *WaMS Individual Service Plan (ISP), Daily Choice Input*, dated 8/9/22. It did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. DBHDS also submitted a KPA PMI measure, dated 2/7/22 with identical measure language. The definitions of the numerator and denominator were also identical to those of the *Provider Data Summary* Process Document measure. However, the PMI methodology indicated the data source as OISS Report *DR0021 T2748*, which provided quarterly data that showed results for individuals who had an ISP review in the previous quarter where the following question was asked: "Have I chosen or had input into where I live?" The methodology indicated that counts excluded individuals whose WaMS living situation was "Living with family, "Living independently" or "Building Independence." It was unclear if DBHDS intended to track this measure from two different sources to provide a basis for a data reliability check or if DBHDS needed to update the KPA PMI methodology. At the time of the 20th Period review, the Independent Reviewer's report pointed out there was fairly wide discrepancy documented between the ISP-generated data in their internal reporting and the previously used NCI data. The latter indicated that for SFY 2019, only 67% of individuals surveyed reported they chose or had some input in choosing where they lived if not living in the family home and only 65% in SFY 2020. The *National Core Indicators In-Person Survey (IPS) State Report 2020-21 Virginia Report*, the current report for this reporting period again reported a much smaller percentage (at 72%) for an NCI indicator, which read "Chose or had some input in choosing their housemates if not living in the family home." As recommended previously, this repeated discrepancy should lead DBHDS to complete some analysis of why such differences occur, especially as that might call the validity of their measure and/or the reliability of the reported data into question.	

Compliance Indicator	Facts	Analysis	Conclusion
	The Data Set Attestation did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.		
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.	The *Provider Data Summary State Fiscal Year 2022- 23,* dated November 1, 2022, reported the data for this measure as follows: 99.9% for Q4 FY22 and 99.8% for Q1 FY23. This exceeded the requirement for this CI. DBHDS provided a Process Document entitled *Provider Data Summary, Version 004,* with a revision date of 3/3/23, and Data Set Attestation entitled *WaMS Individual Service Plan (ISP), Individual Housemate Choice*, dated 8/9/22. In the section of the Process Document labelled *DOJ Documentation*, the Measure	The *Provider Data Summary State Fiscal Year 2022- 23,* dated November 1, 2022, indicated that the data for this measure was derived from *WaMS ISP Quarterly Aggregate Reports* by combining the numerators and then the denominators for FY22 Quarters 2 and 3 in each instance. It reported the data for this measure as follows: 99.9% for Q4 FY22 and 99.8% for Q1 FY23. This exceeded the requirement for this CI. DBHDS provided a Process Document entitled *Provider Data Summary, Version 004,* with a revision date of 3/3/23. In the section of the Process Document labelled *DOJ Documentation*, the Measure Steward provided extensive and thorough detail with regard to strategies implemented or in development to mitigate nine specific threats to data validity and reliability identified in the *Assessment of Completion Criteria WaMS,* dated November 2022. While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure. DBHDS will still need to make the following improvements to the Process Document:	20th-Not Met **22nd-Met***

Compliance Indicator	Facts	Analysis	Conclusion
	Steward provided extensive and thorough detail with regard to strategies implemented or in development to mitigate nine specific threats to data validity and reliability identified in the *Assessment of Completion Criteria WaMS*, dated November 2022. While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure. However, DBHDS will still need to make the following improvements to the Process Document: • The Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report*, documenting only that the result was derived from the two quarterly ISP 3.2 Data reports covering the two most recent	• The Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report*, documenting only that the result was derived from the two quarterly ISP 3.2 Data reports covering the two most recent quarters prior to report completion. DBHDS also did not provide an alternative Process Document for that report outlining the process steps for that derivation. Either one would be acceptable as a vehicle for doing so. • Going forward, DBHDS staff should update the Process Document as they finalize the mitigation strategies. For this 22nd Period review, DBHDS also provided a Data Set Attestation entitled *WaMS Individual Service Plan (ISP), Individual Housemate Choice*, dated 8/9/22. It did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.	

Compliance Indicator	Facts	Analysis	Conclusion
	quarters prior to report completion. DBHDS also did not provide an alternative Process Document for that report outlining the process steps for that derivation. Either one would be acceptable as a vehicle for doing so. • Going forward, DBHDS staff should updated Process Document as they finalize the mitigation strategies. The Data Set Attestation did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.		
29.31 DBHDS implements an incident management process that is responsible for review and follow-up	The *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (revised January 2023)* and the *Internal Protocol for DBHDS*	Regulations at *12VAC35-105-160.C, 160.E.1-2. and 160.J* establish expectations of providers regarding how their incident management processes must include review and follow-up of all reported serious incidents. Details of the implementation of the DBHDS incident management processes and validation of their consistent implementation are described in Sections 29.3, 29.4 and 29.5	20th-Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
of all reported serious incidents, as defined in the Licensing Regulations.	*Incident Management (revised 01/01/2023)* describe the elements of the DBHDS incident management processes that are responsible for review and follow-up of Level II and Level III serious incidents and deaths required by the Licensing Regulations. DBHDS has continued efforts to refine and improve incident management processes that include regulatory requirements, extensive guidance documents for providers and staff, and training for providers and staff involved in these processes. The initial implementation of the external validation process described at Compliance Indicator 29.16 above conducted by VCU on a quarterly basis, while not yet fully implemented, is beginning to provide objective, external validation of whether specific required outcomes of the IMU incident review process are being met.	above. Examples of the ongoing process improvement efforts during this past year include: • Provider training on incident reporting requirements and timeframes in 04/2022. Content of this training is detailed in the *Individual and Systemic Risk-How to Report and Respond to Incidents PowerPoint dated 04/28/2022.* • At least annual review comparing incident reports with claims data to identify potentially missing incident reports. Specific details of the results of this review and follow-up action by OL are found in the *IMU Annual Medicaid Claims Review PowerPoint dated 11/29/2022.* • Revision of care concern thresholds in 01/2023 based on analysis of incident and care concern data in 2022. Two additional care concerns were added addressing choking incidents requiring physical aid by another person and multiple unplanned psychiatric admissions within a 90-day timeframe. These revisions are outlined in the *Incident Management Unit Care Concern Threshold Joint Protocol revised 01/01/2023*, the *Risk Triggers and Thresholds Handout dated 01/01/2023* and related provider training outlined in the *IMU Care Concern PowerPoint Training Effective 01/01/2023*. OL notified providers of changes to the care concerns protocol in a memo entitled *Operational Changes Related to Care Concerns dated 02/14/2023*. • Additional guidance to providers regarding expectations for tracking Level I serious incidents and what evidence of the provider's internal tracking procedures is required to be reviewed during the provider's annual licensing inspection. Additionally, this guidance addressed how to establish behavioral baselines that define when a behavioral incident would be considered a Level I serious incident. The guidance is outlined in the *Tracking of Level I Serious Incidents vs. Baseline Behaviors Memo dated 02/14/2023*. The *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (revised January 2023)* and the *Internal Protocol for DBHDS Incident Management (revised 01/01/2023)* describe the DBHDS framework, authority, and procedures for implementation of its incident management system to review and follow up on all reported serious incidents. The system is implemented through the daily review of incidents, identification of care concerns, and evaluation of serious incident data by the IMU with periodic reports to the RMRC.	

Compliance Indicator	Facts	Analysis	Conclusion
		The OHR, also following guidance in the *Internal Protocol for DBHDS Incident Management (revised 01/01/2023)* and *Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (rev January 2023)*, monitors reporting of abuse/neglect allegations that have been entered into the CHRIS system to confirm that the provider reported the allegation within 24 hours and that each allegation is appropriately investigated. Following guidance in the *OL Annual Checklist Compliance Determination Chart (revised annually)*, during annual licensing inspections, OL Licensing Specialists conduct additional verification that serious incidents are reported within 24 hours of discovery, that providers take appropriate action in response to serious incidents, and that follow-up corrective actions identified through serious incident investigations are developed and implemented. The various processes described above are also detailed in the *29.3-29.5 34.4-34.7 Licensing Assessment Incident Report Process Document VER 003*. Based on review of the processes and documents described above, RCA reports, annual licensing inspection reports and CAPs for a sample of 50 randomly selected licensed providers, and review of data and information for the 11,268 Level II and Level III incidents reported by providers during CY 2022, the consultant verified that DBHDS has developed and implemented comprehensive and multi-faceted incident management processes to review and follow up on all reported serious incidents, as defined in the Licensing Regulations. Further, from review of the licensing inspection reports for the sample of 50 randomly selected providers, the consultant verified that the Licensing Specialist did not identify any unreported incidents from the sample review. The external validation process completed quarterly by VCU described at CI 29.16 above is beginning to provide objective, external validation of whether specific required outcomes of the IMU incident review process are being met. While the VCU look-behind process is not yet fully implemented, the initial quarterly report (*VCU IMU 2nd Quarter 2022 Report final 1.26.23*) identified specific areas of needed improvement related to two of the four defined outcomes. This is evidence that information from the validation process will inform DBHDS' targeted process improvement	

Compliance Indicator	Facts	Analysis	Conclusion
		initiatives to further enhance its incident management processes for review and follow-up of all reported serious incidents. It is expected that, once fully implemented, the internal validation process described at CI 29.17 will also provide similar validation evidence that can be used to enhance the incident management processes.	
29.32 a) DBHDS develops incident management protocols that include triage criteria and a process for follow-up and coordination with licensing specialists and investigators, and human rights advocates as well as referral to other DBHDS offices as appropriate; b) Processes enable DBHDS to identify and, where possible, prevent or mitigate future risks of harm; and, c) Follow-up on individual incidents, as well as review of patterns and trends, will be documented.	DBHDS has developed and implemented incident management protocols that include daily review and triage of incidents, identification of care concerns, and evaluation of serious incident data by the IMU. It also includes follow-up actions with providers, OL Licensing Specialists and Investigators, the Office of Integrated Health, and the Office of Human Rights. The *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (revised annually)* provides documentary descriptions of each element of the incident management process and protocols. Documentation of various elements of the evaluation and follow-up on reported Level II and Level III serious incidents and deaths is maintained in the CONNECT data system. Based on review of guidance documents and serious	DBHDS has documented incident management protocols that have been implemented and revised as necessary including: • The *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (revised annually)* which describes the DBHDS framework, authority, and procedures for implementation of the incident management system. This review verified that the OL protocol system is implemented through the daily review and triage of incidents, identification of care concerns, and evaluation of serious incident data by the IMU. It also includes follow-up actions with providers, OL Licensing Specialists/Investigators, the Office of Integrated Health, and the Office of Human Rights. • In addition to the daily review of reported incidents, the IMU continues to evaluate serious incident data to determine if there are patterns that meet threshold criteria as a care concern. The most recent revisions to the care concern thresholds are documented in the *Care Concern Protocol IMU (revised 01/01/2023)*. The process of identifying care concern patterns/thresholds helps to identify potential risks of harm and, where possible, prevent or mitigate future risks of harm. If a threshold is met, the IMU makes the provider aware that, based on the identified care concern, the provider may need to re-evaluate an individual's needs and supports, review the results of relevant root cause analyses, and/or consider making other systemic changes. • The OHR monitors reporting of abuse/neglect allegations that have been entered into the CHRIS system to confirm that the provider reported the allegation within 24 hours and that each allegation is appropriately investigated. The elements of that process are also documented in the *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (revised January 2023)*. • Following guidance in the *OL Annual Compliance Determination Chart (revised annually)*, OL Licensing Specialists, during annual licensing inspections,	20th-Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
	incident data and follow-up, the IMU review and analysis of serious incidents, care concern identification, trend and pattern analysis, and follow-up with providers regarding required corrective actions is logically structured, comprehensive, and consistently implemented and documented. The processes for IMU coordination with OL Licensing Specialists, the Office of Human Rights, and the Office of Integrated Health are also consistently occurring and are documented.	conduct additional verification that serious incidents are reported within 24 hours of discovery, that providers take appropriate action in response to serious incidents, and that follow-up corrective actions identified through serious incident investigations are developed and implemented. All steps in the IMU review and follow-up process are documented in the CONNECT system. • The incident review process also includes supervisory review of incident closure, tracking and trending of incident data, quarterly audit/review of the IMU incident review process conducted by VCU (described in detail at Compliance Indicator 29.16 above), and training and technical assistance for providers, OL Licensing Specialists, and others. This guidance is reviewed and updated, as needed, to remain responsive to the issues and needed improvements as they are identified. For this 22nd Period review, the consultant examined and analyzed data and information related to 11,268 Level II, Level III incidents and deaths that were reported by providers to the IMU through the CHRIS system during CY2022 (*OL Regulatory Compliance with 12VAC35-105-160.D.2 Data Report*), serious incident data reported to the RMRC by the IMU (*Serious Incident Data PowerPoint (02/27/2023)*, the *Internal Protocol for DBHDS Incident Management (revised 01/01/2023)*, the *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (revised January 2023)*, the *OL Annual Compliance Determination Chart (revised annually)*, and changes and updates made to the care concern protocol described in the *Care Concern Protocol IMU (revised 01/01/2023)*. Based on findings from this review, the consultant verified that the processes outlined in these documents are being implemented, that they identify sources of contributing factors to risk and incident trends and patterns that could benefit from a systemic intervention, and that follow-up on individual incidents and identification of patterns and trends is being documented in the CONNECT system. The VCU IMU Look-Behind process, while not yet fully implemented, has begun to identify elements of the incident management process and related protocols that need further evaluation and revision, as necessary, to ensure	

Compliance Indicator	Facts	Analysis	Conclusion
		consistency of process implementation and related documentation.	
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.	The *Provider Data Summary State Fiscal Year 2022- 23,* dated November 1, 2022, reported the data for this measure as follows: 99.9% for Q4 FY22 and 100% for Q1 FY23. This exceeded the requirement for this CI. DBHDS provided a Process Document entitled *Provider Data Summary, Version 004*, with a revision date of 3/3/23, and Data Set Attestation entitled *WaMS Individual Service Plan (ISP), Individual Planning Participation*, dated 8/9/22. In the section of the Process Document labelled DOJ Documentation, the Measure Steward provided extensive and thorough detail with regard to strategies implemented or in development to mitigate nine specific threats to data validity and reliability identified in the *Assessment of Completion Criteria WaMS,* dated November 2022. While some of the mitigation strategies were only recently	The *Provider Data Summary State Fiscal Year 2022- 23,* dated November 1, 2022, indicated that the data for this measure was derived from *WaMS ISP Quarterly Aggregate Reports* by combining the numerators and then the denominators for FY22 Quarters 2 and 3 in each instance. It reported the data for this measure as follows: 99.9% for Q4 FY22 and 100% for Q1 FY23. This exceeded the requirement for this CI. DBHDS provided a Process Document entitled *Provider Data Summary_VER_004*, with a revision date of 3/3/23. The Process Document indicated the numerator was defined as "Number of "yes" responses to the ISP question related to participation in the development of their own plan." The denominator was defined as "Number of responses to the ISP question related to participation in the development of their own plan. In the section of the Process Document labelled *DOJ Documentation*, the Measure Steward provided extensive and thorough detail with regard to strategies implemented or in development to mitigate nine specific threats to data validity and reliability identified in the *Assessment of Completion Criteria WaMS,* dated November 2022. While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure. DBHDS will still need to make the following improvements to the Process Document: • The Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report*, documenting only that the result was derived from the two quarterly *ISP 3.2 Data* reports covering the two most recent quarters prior to report completion. DBHDS also did not provide an alternative Process Document for that report outlining the process steps for that derivation. Either one would be acceptable as a vehicle for doing so.	20th-Not Met **22nd-Met***

Compliance Indicator	Facts	Analysis	Conclusion
	implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure. DBHDS will still need to make the following improvements to the Process Document: • The Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report*, documenting only that the result was derived from the two quarterly *ISP 3.2 Data* reports covering the two most recent quarters prior to report completion. DBHDS also did not provide an alternative Process Document for that report outlining the process steps for that derivation. Either one would be acceptable as a vehicle for doing so. • The Process Document did not include CI 29.33 in the introductory list of	• The Process Document did not include CI 29.33 in the introductory list of indicators impacted, although it was included in a list of measures (i.e., measure #7) under *Section III: Reporting*. • Going forward, DBHDS staff should update the Process Document as they finalize the mitigation strategies. DBHDS also provided a Data Set Attestation entitled *WaMS Individual Service Plan (ISP), Individual Planning Participation*, dated 8/9/22. It did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.	

Compliance Indicator	Facts	Analysis	Conclusion
	indicators impacted, although it was included in a list of measures (i.e., measure #7) under *Section III: Reporting*. • Going forward, DBHDS staff should update the Process Document as they finalize the mitigation strategies The Data Set Attestation did not meet the requirements of the Curative Action for Data Validity and Reliability overall. It attested to how to pull data from the data set, but did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.		

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

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

Compliance Indicator	Facts	Analysis	Conclusion
30.1: The licensing regulations require all licensed providers, including CSBs, to implement risk management processes including: Identification of a person responsible for the risk management function who has training and expertise in conducting investigations, root cause analysis, and data analysis. 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 Conducting annual systemic risk assessment reviews, to identify and respond to practices, situations and policies	Licensing regulations at *12VAC35-105-520.A-E* define requirements for provider risk management programs addressing all requirements set out in this Compliance Indicator. DBHDS requires that risk assessments incorporate uniform risk triggers and thresholds as defined by DBHDS. Care Concern Thresholds were revised in January 2023 adding any choking incident that requires physical aid by another person and multiple (2 or more) unplanned psychiatric admissions within a ninety (90) day timeframe for any reason.	DBHDS licensing regulations at *12VAC35-105-520.A-E* require all licensed providers, including CSBs, to identify a risk manager to oversee their risk management program (§520.A); to develop and implement a written plan to identify, monitor, reduce, and minimize harms and risks of harm (§520.B); to conduct 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 (§520.C.1-5 and §520.D); and to conduct a safety inspection, at least annually, of each service location that includes recommendations for safety improvements (§520.E). §520.C of the regulations requires that the provider's annual systemic risk assessment shall address at least the following elements: the environment of care (§520.C.1); clinical assessment or reassessment processes (§520.C.2); staff competence and adequacy of staffing (§520.C.3), use of high-risk procedures, including seclusion and restraint (§520.C.4); and review of serious incidents (§520.C.5). §520.D of the regulations requires the systemic risk assessment process to incorporate uniform risk triggers and thresholds as defined by the department. DBHDS defined uniform risk triggers and thresholds as care concerns. The care concern thresholds are reviewed annually by the DBHDS Risk Management Review Committee (RMRC). Based on feedback from the Committee and other sources, the list of care concerns may be modified. Resulting from analysis of incident and care concern data in 2022 and input from the RMRC, the care concern thresholds were revised in January 2023 and the revisions are described in the *Incident Management Unit Care Concern Threshold Joint Protocol revised 01/01/2023*, the *Risk Triggers and Thresholds Handout dated 01/01/2023* and related provider training outlined in the *IMU Care Concern PowerPoint Training*	20th-Met **22nd-Met**

Compliance Indicator	Facts	Analysis	Conclusion
that could result in harm to individuals receiving services. Risk assessment reviews shall address the environment of care, clinical assessment or reassessment processes, staff competence and adequacy of staffing, the use of high-risk procedures including seclusion and restraint, and review of serious incidents. Risk assessments also incorporate uniform risk triggers and thresholds as defined by DBHDS. See 12VAC-35-105-520.		*Effective 01/01/2023*. OL notified providers of changes to the care concerns protocol in a memo entitled *Operational Changes Related to Care Concerns dated 02/14/2023*. The revised care concerns included two new ones relating to choking incidents and unplanned psychiatric hospital admissions. The full list includes: • Multiple (2 or more) unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day timeframe for any reason. • Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction by a medical professional. • Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR. • Multiple (2 or more) unplanned psychiatric admissions within a ninety (90) day timeframe for any reason. OL developed and has continued to implement and update detailed guidelines for Licensing Specialists to determine provider compliance for each of these regulatory requirements. These guidelines are documented in the *OL Annual Compliance Determination Chart (revised annually)*. The consultant conducted a review of the results of annual licensing inspections in CY2022 (detailed data in the *OL Regulatory Compliance with 12VAC35-105-520 Data Report* and summary data in the *RM Compliance by Regulation 520 CY2022 Report*) and a more detailed review of provider documents and licensing inspection reports for a random sample of 50 licensed providers. Based on information gathered from these two sources, providers are meeting requirements for content of their annual systemic risk assessments. The provider training entitled "Minimizing Risk: Helping Providers Meet Licensing Requirements related to Risk – 160.C, 520.C, 520.D and Beyond" (*DRAFT Minimizing Risk PowerPoint*) scheduled for April 2023 includes additional	

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		guidance and examples that are intended to increase consistency in how providers incorporate uniform risk triggers and thresholds into their risk assessment processes.	
30.2: The DBHDS Office of Licensing publishes guidance on serious incident and quality improvement requirements. In addition, DBHDS publishes guidance and recommendations on the risk management requirements identified in #1 above, along with recommendations for monitoring, reducing, and minimizing risks associated with chronic diseases, identification of emergency conditions and significant changes in conditions, or behavior presenting a risk to self or others.	DBHDS continues to publish a variety of resources including reference materials, policy examples, protocols, and informational bulletins that relate to serious incident and quality improvement requirements. The Office of Licensing website provides an organized repository of reference materials, forms, training materials for DBHDS staff and providers, and links to various publications including the monthly *Health* Trends newsletter and *Health and Safety Alerts* issued by the Office of Integrated Health. Online training relating to serious incident and quality improvement requirements and other topics is available to providers through the Shriver Online Learning System and through the Center for Developmental Disabilities Evaluation and Research (CDDER).	DBHDS has continued efforts to develop and revise guidance and training related to serious incident and quality improvement requirements in the licensing regulations. Most recently, OL published several documents to inform providers of changes to the Care Concern Thresholds that became effective 01/01/2023 and to provide a comprehensive overview of the changes in PowerPoint format. These documents included *Tracking Level I Serious Incidents vs. Baseline Behaviors (02/14/2023), Operational Changes Related to Care Concerns dated 02/14/2023, Risk Triggers and Thresholds Handout (01/01/2023), and Risk Triggers and Thresholds/Care Concern Thresholds PowerPoint (January 2023).* Documents published or updated that are specific to roles and responsibilities of OL staff include the *Internal Protocol for DBHDS Incident Management (rev 01/01/2023)*, the *OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (rev January 2023)*, and the *OL New Hire Staff Orientation: 12VAC35-105-620.A-E PowerPoint.* The OL website contains a significant amount of information for providers including links to important correspondence; links to regulations; guidance documents related to quality improvement, risk management, incident reporting, and serving individuals with high risk health conditions; information about and links to provider training including training by the Center for Developmental Disabilities Evaluation & Research (CDDER) addressing risk management and quality improvement strategies; links to forms and formats relating to specific provider requirements; a Frequently Asked Questions document; and contact information for OL staff at the state and regional levels. The Office of Integrated Health (OIH) continues to issue *Health and Safety Alerts* that include recommendations for monitoring, reducing, and minimizing risks associated with chronic diseases, identification of emergency conditions, and significant changes in conditions. The OIH also continues to publish the *Health Trends Monthly Newsletter* that includes updates on relevant health-related topics. Additionally, there is a collection of guides, toolkits, and training resources to	20th-Met **22nd-Met**

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		help build quality improvement knowledge and skills posted on the DBHDS Office Clinical Quality Management webpage.	
30.3: DBHDS publishes on the Department's website information on the use of risk screening/assessment tools and risk triggers and thresholds. Information on risk triggers and thresholds utilizes at least 4 types of uniform risk triggers and thresholds specified by DBHDS for use by residential and day support service providers for individuals with IDD. This information includes expectations on what to do when risk triggers or thresholds are met, including the need to address any identified risks or changes in risk status in the individual's risk management plan.	DBHDS has continued efforts to develop and refine tools, reference materials, guidance documents, and training curricula that relate to provider responsibilities for risk screening and assessment and to make these available for providers on the Department's website. The latest revision of the *Incident Management Unit Care Concern Threshold Joint Protocol revised 01/01/2023*, includes definitions and descriptions for four types of risk triggers/thresholds (care concerns) that are monitored by the IMU with required follow-up from the provider each time a threshold is met. A description and evaluation of the OL monitoring system is described in Section 30.7 below where requirements for DBHDS to monitor that providers appropriately respond to, and address risk triggers and thresholds is addressed in more detail.	The following are examples of instructional documents, reference materials and training relating to risk screening and risk assessment that are currently available on the DBHDS website. Examples of documents and trainings addressing risk screening and risk assessment that are currently available via link on the DBHDS OL website include *Individuals with Developmental Disabilities with High-Risk Health Conditions*, *Guidance for Risk Management*, *Sample Provider Systemic Risk Assessment*, and *Risk Management and Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation and Research (CDDER)*. Examples of documents and reference materials relating to risk screening and risk assessment that are available via link on the DBHDS OIH website include various *Health and Safety Alerts* (11 were published in 2022 and three to date in 2023), *Fall Prevention Resources*, *Choking Resources*, *Risk Awareness Tools* addressing various conditions and health risks, *Guidance on Understanding the Risk Awareness Tool and Use with the WAMS ISP*, and *Urinary Tract Infection Resources*. DBHDS has defined uniform risk triggers and thresholds as care concerns. The care concern thresholds are reviewed annually by the RMRC. Based on analysis of incident and care concern data in 2022 and input from the RMRC, the Care Concern Thresholds were revised in January 2023 and the revisions are described in the *Incident Management Unit Care Concern Threshold Joint Protocol revised 01/01/2023*, the *Risk Triggers and Thresholds Handout dated 01/01/2023* and related provider training outlined in the *IMU Care Concern PowerPoint Training Effective 01/01/2023*. OL notified providers of changes to the care concerns protocol in a memo entitled *Operational Changes Related to Care Concerns dated 02/14/2023*. The revised care concerns included two new ones relating to choking incidents and unplanned psychiatric hospital admissions. The full list includes: • Multiple (2 or more) unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day timeframe for any	20th-Met **22nd-Met**

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		reason. • Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional. • Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR. • Multiple (2 or more) unplanned psychiatric admissions within a ninety (90) day timeframe for any reason. Content in the *Memorandum: Operational Changes Related to Care Concerns* reinforces previously described expectations for providers regarding their response to identified care concerns and suggestions for effective provider processes to evaluate serious incident patterns within their ongoing operations and the need to assess/reassess individuals' needs and services relating to these identified incident patterns. The requirements for DBHDS to monitor that providers appropriately respond to, and address risk triggers and thresholds are also referenced with regard to CI 30.7 below.	
30.4: At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. Inspections will include an assessment of whether	The annual licensing inspection includes an assessment of whether the provider's risk management program complies with relevant requirements in the Licensing Regulations but does not include assessment of whether providers use data at the individual and provider level to identify and address trends and patterns of harm and risk of harm in the events reported as well as the	The *OL Annual Compliance Determination Chart (revised annually)* provides detailed instructions for assessing compliance with each of the five sections under 12VAC35-105-520. The provider is assessed for current compliance and, if the provider was required to implement a corrective action plan for previous non-compliance in the last year, whether that corrective action plan has continued to achieve its desired outcome. The 86% threshold for this compliance indicator requires analysis of data relating to each of these two components. DBHDS provided a *Process Document: (30.4, 30.5, 30.7 DOJ Process RM Requirements VER002)* and Attestation Statement *(30.4, 30.5, 30.7 Attachment B)* addressing the data used to inform calculation of the threshold percentage requirement in this Compliance Indicator. The Process Document provides a detailed description of the Licensing Specialist's compliance determination following requirements in the *OL Annual Compliance Determination Chart (revised*	20th-Not Met **22nd-Not Met**

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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.	associated findings and recommendations. The DBHDS protocol for assessing compliance with the risk management requirements in the Licensing Regulations is documented in significant detail in the *OL Annual Compliance Determination Chart (updated annually)*. Additional guidance was added to this protocol on 02/08/2023 to include requirements for assessment of whether providers use data at the individual and provider level 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. The data from licensing inspections conducted during CY2022 reflects that 94% of providers (1151/1222) were assessed for compliance with the risk management requirements in the Licensing Regulations. This exceeds the 86% threshold, but the current assessment process does not include all required elements specified in this	*annually)*, the data entry of the results into the CONNECT system, the query criteria to obtain the numeric data used to calculate the numerator and denominator, descriptions of the numerator and denominator for the equation, and the reporting processes to the RMRC on a quarterly and annual basis. It also includes a brief description of the look-behind process conducted by the Regional Manager (2 reviews per week) to ensure regulations are reviewed appropriately and the look-behind process conducted by the Quality Improvement Specialist (2 per week) focusing on regulations §520, §620, and §160.E and follow-up provided to Licensing Specialists and Regional Managers regarding remedial action needed. The Attestation Statement verifies that the data is correctly queried from the CONNECT system, that the calculations are done in Excel using Excel functions for all calculations including calculated functions, formulas, and visualizations to do the statistical checks and that sum, count, and values were checked for compliance data, cross-checked, and confirmed to be statistically correct. The document entitled *30.04 30.05 Summary of Compliance* defines the sources for data in the numerator and denominator for this measure to be: Numerator (N) – Total providers (licensed services) that were assessed for 100% of the 9 risk management regulations during the reporting period. Denominator (D) – Total number of providers (licensed services) that had annual inspections during the reporting period. The reporting period is January 1, 2022-December 31, 2022, and the specific data for the equation is as follows: N = 1151 providers assessed for all RM requirements D = 1222 providers that had annual inspections 94% of providers (1151/1222) were assessed for compliance with the risk management requirements. The consultant reviewed documentary evidence from a sample of 50 randomly selected providers relevant to the requirements at §520A-E and the CAPs	

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	Compliance Indicator. Specific instructions for Licensing Specialists about how to assess whether "providers use data at the individual and provider level 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" were incorporated into the *OL Annual Compliance Determination Chart* on 02/09/2023 and providers will be informed of these expectations in training entitled "Minimizing Risk: Helping Providers Meet Licensing Requirements related to Risk – 160.C, 520.C, 520.D and Beyond" (*DRAFT Minimizing Risk PowerPoint*) to be delivered in three parts in April 2023.	resulting from each of these providers' 2022 annual licensing inspection. Based on these reviews, the consultant agreed with 90% of the findings of the Licensing Specialists for the providers in this sample. The reports from the 18th and 20th period studies identified concerns about the Licensing Inspection process not including 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 and identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. These previous study reports stated that, to meet the requirements of this Compliance Indicator, this element must be incorporated into the annual Licensing Inspection process. For this 22nd period study, the consultant conducted a review of systemic risk assessments for a sample of 46/50 randomly selected licensed providers and found evidence that the provider's systemic risk assessment addressed these expectations in only 7/46 (15%) of these assessment documents. Four of the providers in the sample did not provide evidence of a systemic risk assessment during the annual licensing inspection or for this sample review and each was appropriately cited by the Licensing Specialist regarding this area of non-compliance during their annual inspection. To address these previously noted concerns, the OL Director stated that the *OL Annual Compliance Determination Chart (revised annually)* was revised on 02/09/2023 to incorporate additional instructions for assessment of compliance with §520.C.5 as follows: "The provider will be cited if their review of serious incidents does not include evidence that the provider completed an analysis of trends from their quarterly review of serious incidents, identified potential systemic issues or causes, indicated remediation and planned/implemented steps taken to mitigate the potential for future incidents. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems." This additional provider expectation will be included in an upcoming training program for providers and Licensing Specialists *entitled Minimizing Risk: Helping Providers Meet Licensing Requirements related to Risk – 160.C, 520.C, 520.D and Beyond* (*DRAFT Minimizing*	

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		Risk PowerPoint) to be delivered in three parts in April 2023. Plans are to also include this topic in a communication to providers regarding expectations about their processes to monitor incidents. It is anticipated that these recent efforts will inform providers and Licensing Specialists of the added expectations and that, as a result, these requirements will be addressed more consistently in providers' systemic risk assessment processes in the future.	
30.5: On an annual basis, the Commonwealth determines that at least 86% of DBHDS licensed providers of DD services are compliant with the risk management requirements in the Licensing Regulations or have developed and implemented a corrective action plan to address any deficiencies.	The annual licensing inspection includes an assessment of whether the provider's risk management program complies with relevant requirements in the Licensing Regulations. The DBHDS protocol for assessing compliance with the risk management requirements in the Licensing Regulations is documented in significant detail in the *OL Annual Compliance Determination Chart*. The data from licensing inspections conducted during CY2022 reflects that 99.7% of providers (1,147/1,151) were found to be compliant with all risk management requirements or had an approved corrective action plan, exceeding the 86% threshold required by this Compliance Indicator.	The *OL Annual Compliance Determination Chart (revised annually)* provides detailed instructions for assessing compliance with each of the five sections under 12VAC35-105-520. The provider is assessed for current compliance and, if the provider was required to implement a corrective action plan for previous non-compliance in the last year, whether that corrective action plan has continued to achieve its desired outcome. The 86% threshold for this compliance indicator requires analysis of data relating to each of these two components. The *CI36.5 and CI30.5 KPA PMI Compliance with RM Regulations updated 2.10.22* document provides a detailed description of how the data queries are completed in the CONNECT system to obtain the data used in the compliance measurement. DQV staff reviewed the content of the PMI on 07/07/2021. 09/14/2021, 02/10/2022 and did not identify any concerns with the PMI during each of these reviews. DBHDS provided a *Process Document: (30.4, 30.5, 30.7 DOJ Process RM Requirements VER002)* and *Attestation Statement: (30.4, 30.5, 30.7 Attachment B)* addressing the data used to inform calculation of the threshold percentage requirement in this Compliance Indicator. The Process Document provides a detailed description of the Licensing Specialist's compliance determination following requirements in the *OL Annual Compliance Determination Chart (revised annually)*, the data entry of the results into the CONNECT system, the query criteria to obtain the numeric data used to calculate the numerator and denominator, descriptions of the numerator and denominator for the equation, and the reporting processes to the RMRC on a quarterly and annual basis. It also includes a brief description of the look-behind process conducted by the Regional Manager (2 reviews per week) to ensure regulations are reviewed appropriately and the look-behind process conducted by the Quality Improvement Specialist (2 per week) focusing on regulations 520, 620, and	20th-Met* **22nd-Met**

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		160.E and follow-up provided to Licensing Specialists and Regional Managers regarding remedial action needed. The Attestation Statement verifies that the data is correctly queried from the CONNECT system, that the calculations are done in Excel using Excel functions for all calculations including calculated functions, formulas, and visualizations to do the statistical checks and that sum, count, and values were checked for compliance data, cross-checked, and confirmed to be statistically correct. The *30.04 30.05 Summary of Compliance* document defines the sources for data in the numerator and denominator for this measure to be: Numerator – Total number of providers (licensed services) that were compliant with 100% of the risk management regulations (for which they could be assessed) during the reporting period plus the number of providers (licensed services) who were not compliant, who had an approved corrective action plan to address any deficiencies. Denominator – The total number of providers (licensed services) that had all RM regulations reviewed during the annual inspections of their compliance with the risk management regulations during the reporting period. The reporting period is January 1, 2022-December 31, 2022, and the specific data for the equation is as follows: N = 649 providers (56%) compliant with 100% of RM requirements + 498 providers who were not compliant but had an approved corrective action plan = 1,147 providers who were compliant with 100% of RM regulations OR developed an approved corrective action plan. D = 1151 providers had annual inspections of their compliance with risk management regulations. DBHDS found that 99.7% of providers (1,147/1,151) were compliant with all risk management requirements or had an approved corrective action plan.	

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		The consultant reviewed documentary evidence from a sample of 50 randomly selected providers relevant to the requirements at §520A-E, the CAPs resulting from each of these providers' 2022 annual licensing inspection, and OL Compliance Data for 12VAC35-105-520.A-E. Based on a spot-check review of this information and comparison to the data described above, the consultant verified that the Commonwealth provided reliable and valid data and achieved this Indicators compliance percentage.	
30.6: DBHDS publishes recommendations for best practices in monitoring serious incidents, including patterns and trends which may be used to identify opportunities for improvement. Such recommendations will include the implementation of an Incident Management Review Committee that meets at least quarterly and documents meeting minutes and provider system level recommendations.	Regulations at *12VAC35-105-160.C* establish requirements for providers to conduct at least quarterly analysis of serious incidents. DBHDS updated the *Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan* reference document in September 2022. This document serves as a comprehensive overview of provider risk management requirements, recommendations, and resource descriptions. DBHDS operationalized requirements for identification of patterns of serious incidents by developing criteria for risk triggers and thresholds (care concerns) and related thresholds in 06/2020. These thresholds have been revised two times since their initiation. The most recent	DBHDS established specific regulatory requirements at *12VAC35-105-160.C* that require providers to conduct at least quarterly review of serious incidents including analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. To assist providers to refine and improve their incident management systems and processes, DBHDS has continued to publish new or revised reference documents and training materials relating to best practices in monitoring serious incidents, including patterns and trends, that providers can utilize or reference for refinement of their relevant policies, procedures, and practices. These materials include address of the requirements for incident review and analysis as a part of the provider's Quality Improvement program, requirements for tracking and trending incident data, the roles and responsibilities of an Incident Management Review Committee for analyzing incident data, and specific information about updated threshold criteria for risk triggers and thresholds (care concerns). Examples of these publications include: • *Tools for Developing a Quality Improvement Program (February 2022)* including requirements for at least quarterly review of all serious incidents as a part of the provider's Quality Improvement Program • *Sample Root Cause Analysis Policy (February 2022)* • *Sample Provider Systemic Risk Assessment (February 2022)* • *Flow-Chart Incident Reviews (April 2022)* including reference to requirements for quarterly reviews and an annual systemic review • *Individual and Systemic Risk – How to Report and Respond to Incidents Recorded Training (April 2022)* • *Quality Improvement Q&A's (Updated June 2022)* including numerous	20th-Met **22nd-Met**

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	revision was published in the *2023 Care Concern Threshold Criteria Memo (February 2023)*. DBHDS continues to publish recommendations for best practices in monitoring serious incident trends and patterns through informational memos, online training opportunities, and periodic provider informational webinars.	references to incident management policies, procedures, and practices • *Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan (revised September 2022)* addressing use of the Risk Assessment Tool, incident review and analysis as an essential element of the provider's quality assurance program, and the relationship between risk management regulations and incident reporting • *2023 Care Concern Threshold Criteria Memo (February 2023)* • *IMU Care Concern PowerPoint Training (February 2023)* • *Risk Triggers and Thresholds Handout (February 2023)* • *Tracking of Level I Serious Incidents vs. Baseline Behaviors (February 2023)*	
30.7: DBHDS monitors that providers appropriately respond to and address risk triggers and thresholds using Quality Service Reviews, or other methodology. Recommendations are issued to providers as needed, and system level findings and recommendations are used to update guidance and disseminated to providers.	DBHDS has established a requirement for inclusion of risk triggers and thresholds at *12VAC35-105-520.D.* On 4/22/22, after the conclusion of the 20th Period review, the parties jointly filed an agreed upon Curative Action for CI 30.7. Pursuant to the filing, DBHDS agreed to add, by July 1, 2022, the following care concerns: • Two or more psychiatric hospitalizations per quarter as a risk trigger or threshold for review and follow up (e.g., by REACH, crisis team, licensing, or provider development as indicated and determined	As previously reported, DBHDS has established a requirement for inclusion of risk triggers and thresholds at *12VAC35-105-520.D*, which is stated as follows: "The systemic risk assessment process shall incorporate uniform risk triggers and thresholds as defined by the department." Since that time, as described with regard to CI 30.03, DBHDS has continued a focus on training and offering guidance to providers regarding identifying risks and how providers should use the RAT to address risk triggers. This CI also requires that DBHDS has adequate processes in place to monitor that providers are appropriately responding to and addressing risk triggers and thresholds. At the time of the 20th Period review, DBHDS did not yet have such adequate processes in place. For example, the previously reviewed version identified five event-based triggers and thresholds that IMU focused upon in the triage and evaluation of serious incidents being reported by providers. Previously, a study found that what DBHDS staff described as a phased-in approach could hold promise in assisting providers to become more familiar with and to begin successful integration of risk triggers and thresholds into their risk management processes for identification, reporting and follow-up to serious incidents. However, for the 20th Period review, DBHDS had narrowed, rather than expanded the scope of care concerns. On 4/22/22, after the conclusion of the 20th Period review, the parties jointly	20th-Not Met **22nd- Met**

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	appropriate by DBHDS • Any choking event that is reported as a Level II serious incident as a risk trigger or threshold. As described with regard to CI 30.3, DBHDS has defined uniform risk triggers and thresholds as care concerns. These thresholds are reviewed annually by the RMRC. Based on analysis of incident and care concern data in 2022 and input from the RMRC, the *Care Concern Thresholds* were revised in January 2023, at which time the care concerns expanded to include the two defined in the Curative Action. The narrative in CI 30.3 also describes the thorough training and notifications provided by DBHDS in the first two months of 2023. The Curative Action further addresses a set of actions that appear to define a comprehensive and coordinated approach as previously recommended, and includes specific requirements for monitoring,	filed an agreed upon Curative Action for CI 30.7, which again expand these criteria. Pursuant to the filing, DBHDS agreed to add, by July 1, 2022, the following care concerns: • Two or more psychiatric hospitalizations per quarter as a risk trigger or threshold for review and follow up (e.g., by REACH, crisis team, licensing, or provider development as indicated and determined appropriate by DBHDS • Any choking event that is reported as a Level II serious incident as a risk trigger or threshold. For this 22nd Period review, as described with regard to CI 30.3, DBHDS has defined uniform risk triggers and thresholds as care concerns. These thresholds are reviewed annually by the RMRC. Based on analysis of incident and care concern data in 2022 and input from the RMRC, the *Care Concern Thresholds* were revised in January 2023, at which time the care concerns expanded to include the two defined in the Curative Action. The narrative in CI 30.3 also describes the thorough training and notifications provided by DBHDS in the first two months of 2023. The Curative Action further addresses a set of actions that appear to define a comprehensive and coordinated approach as previously recommended, and includes specific requirements for monitoring, as well as data collection and review. For this 22nd Period review, DBHDS had taken steps to address these requirements, including the following: • As described with regard to CI 30.6 above, DBHDS updated the OIH document entitled *Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan* document to identify examples of typical risks experienced by individuals with developmental disabilities and events that may precede a risk trigger or threshold that indicate that this risk should be reviewed to determine if the individual's ISP or the provider risk mitigation plans need to be updated to further mitigate this risk. This was completed by September, 2022. • As described with regard to CI 29.31 and CI 29.32, serious incidents	

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	as well as data collection and review. DBHDS had taken steps to address these requirements, including the following: • DBHDS updated the OIH document entitled Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan by September, 2022. • As described with regard to CI 29.31 and CI 29.32, serious incidents are monitored each business day by the DBHDS Incident Management Unit (IMU) to identify and respond to care concerns. OHR will follow up on any risk triggers/care concerns that appear to involve abuse or neglect, while OIH will reach out to providers on risk triggers/care concerns that present health and safety concerns to offer technical assistance on managing risks for that individual and provider	are monitored each business day by the DBHDS Incident Management Unit (IMU). When a reported incident meets the threshold for a risk trigger, the IMU reviewer will flag the incident as a risk trigger/care concern in CONNECT and notify the Office of Integrated Health (OIH) and the Office of Human Rights (OHR). The OHR will follow up on any risk triggers/care concerns that appear to involve abuse or neglect; the OIH will reach out to providers on risk triggers/care concerns that present health and safety concerns to offer technical assistance on managing risks for that individual and provider. Providers are also able to determine when the IMU has identified a risk trigger/care concern through the CHRIS portal. • As described with regard to CI 30.4 and CI 30.5, DBHDS has processes in place to implement the expectation that providers monitor incidents that occur to identify when risk triggers/care concerns, or other risks, are present. When the threshold for a risk trigger/care concern has been met, providers are expected to review the incidents that have occurred to determine whether the individual's service plan needs to be revised to mitigate the risk of future harm. Providers are also advised that they should review for potential systemic issues that may impact other individuals; this may involve a root cause analysis of the incidents and may also include the quarterly review of serious incidents conducted pursuant to *12VAC35-105-160(C)* and the annual systemic risk assessment that is conducted pursuant to *12VAC35-105-520(D)*. Licensing specialists monitor compliance during annual inspections. Prior to conducting an inspection, the specialist uses CONNECT to determine whether any incidents met the threshold for a risk trigger/care concern. The specialist will then determine whether the provider's systemic risk assessment included a review of risk triggers (care concerns) that were met and whether and how they were addressed. Licensing specialists monitor compliance during annual inspections. Prior to conducting an inspection, the specialist uses CONNECT to determine whether any incidents met the threshold for a risk trigger/care concern. The specialist will then determine whether the provider's systemic risk assessment included a review of risk triggers (care concerns) that were met and whether and how they were	

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	• As described with regard to CI 30.4 and CI 30.5, DBHDS has processes in place to implement, and monitor through licensing, the expectation that providers monitor incidents that occur to identify when risk triggers/care concerns, or other risks, are present. • As reported with regard to CI 30.4 and CI 30.5, DBHDS also reports annually on the number and percentage of providers that have been determined to be appropriately responding to and addressing the management regulations, including risk triggers and thresholds. • As described with regard to CI 30.3 above, DBHDS has expanded provider training that focuses on the systemic risk assessment and risk triggers and thresholds. the RMRC and the Region 5 Regional Quality Council had joined forces during FY23 to implement a QII to	addressed. Individual providers that are found to have not met the requirements to review risk triggers (care concerns) are issued a citation by their licensing specialist and required to develop a corrective action plan to address the issue. • As reported with regard to CI 30.4 and CI 30.5, DBHDS also reports annually on the number and percentage of providers that have been determined to be appropriately responding to and addressing the management regulations, including risk triggers and thresholds. • The Curative Action for CI 30.7 notes that the RMRC previously established a work group to develop interventions to address a lower level compliance with *§520.D* of the regulations, which requires the systemic risk assessment process to incorporate uniform risk triggers and thresholds as defined by the department. As described with regard to CI 30.3 above, DBHDS has expanded provider training that focuses on the systemic risk assessment and risk triggers and thresholds. In addition, the RMRC and the Region 5 Regional Quality Council had joined forces during FY23 to implement a QII to address *§520.D* performance, which continued to be below the goal of 86%, despite efforts from the Office of Licensing to provide generalized training and tools. • As reported previously in the Curative Action for CI 30.7, the QSR vendor findings related to the RAT are provided to each service provider, including any indications that identified risks have not been addressed in the ISP. As reported at the time of the 20th Period review, the Health and Safety Alerts is the process by which QSR reviewers contact Adult Protective Services and DBHDS to report such risks that present an imminent threat. These Alerts continued to be tracked and monitored for resolution by an internal DBHDS team.	

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	address *§520.D* performance, which continued to be below the goal of 86%, despite efforts from the Office of Licensing to provide generalized training and tools. • As reported at the time of the 20th Period review, he Health and Safety Alerts process, by which QSR reviewers contact Adult Protective Services and DBHDS to report such risks that present an imminent threat. These Alerts continued to be tracked and monitored for resolution by an internal DBHDS team.		
30.8: DBHDS has Policies or Departmental Instructions that require Training Centers to have risk management programs that: 1. Reduce or eliminate risks of harm; 2. Are managed by an individual who is qualified by training and/or experience; 3. Analyze and report	The *DBHDS DI 401 (RM) 03* sets requirements for risk management programs for DBHDS-operated facilities including the Training Center. Training Center policies and procedures charge various committees with specific key elements of a risk management program to reduce or eliminate risks of harm, to analyze and report	As previously reported at the time of the 20th Period review, the *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 and remains in effect for this 22nd Period review. • It states the purpose of the DI is to "establish a comprehensive and uniform risk management program intended to reduce, eliminate, correct, manage or control risk through the identification, investigation, analysis and treatment of hazards that may result in harm to individuals receiving services" and others and prevent losses to the Commonwealth. • It states that the facility director will be responsible for implementing a risk management program that is "managed by a facility risk manager who is qualified by training and/or experience." It further states that the risk manager will develop, coordinate and administer an interdisciplinary	20th-Met **22nd-Met**

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trends across incidents and develop and implement risk reduction plans based upon this analysis; and 4. Utilize risk triggers and thresholds to identify and address risks of harm.	trends across incidents and develop and implement risk reduction plans based on the analysis. The Training Center has a facility risk manager whose responsibilities include oversight and operations related to the facility's risk management program. The DI states the facility director will be responsible for implementing a risk management program that is "managed by a facility risk manager who is qualified by training and/or experience" but does not state any minimum criteria related to training and/or experience. The Training Center policies and procedures also do not articulate a minimum set of qualifications. The DI states the facility risk management program must incorporate risk triggers and thresholds, Based on DBHDS staff report, all previously reported procedures remained in effect	facility-wide risk management program. However, the DI does not state any minimum criteria for training and/or experience needed to be considered qualified. • It identifies the risk manager's responsibilities relevant to incident reporting and data analysis and for developing and implementing risk reduction plans based on incident analyses. • It states the risk management program must incorporate risk triggers and thresholds and provides definitions. While the definition of a risk trigger (i.e., an event or condition that causes a risk to occur) was essentially consistent with that DBHDS has otherwise defined, the definition of risk threshold (i.e., the amount of risk a facility is willing to accept) did not appear to provide sufficient guidance about how to identify and address risks of harm when implementing the concept of risk thresholds. In addition, at the time of the 20th Period review, Training Center staff 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. DBHDS staff confirmed that all of these internal policies remain in effect for the 22nd Period and are unchanged since the previous period. Based on review of the *RMRC Annual Report SFY 2021* as well as RMRC meeting minutes for February 2022, June 2022, August 2022 and February 2023, SEVTC staff shared data with the RMRC that illustrated the Training Center's ongoing efforts to analyze and report trends in serious incidents, abuse/neglect/exploitation allegations and substantiated reports, UTIs, falls and use of restraints. SEVTC also shared information about quality improvement efforts focused on staff turnover, reduction in peer-to-peer incidents, flu vaccines, reducing falls and developing UTI protocols. Overall, the documents reviewed were sufficient to show that the DBHDS had the policies this CI requires and that they were being implemented. Based on DBHDS staff report, all previously reported procedures remained in effect for	

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	for this reporting period.	this reporting period.	
30.9: With respect to Training Centers, DBHDS has processes to review data and trends and ensure effective implementation of the Policy or Departmental Instruction.	The 10/07/2019 *SEVTC "Quality Improvement Program and Quality Council Committee"* policy described process requirements relevant to this indicator. The *DBHDS Departmental Instruction 401 (RM) 03 Risk and Liability Management* requires that Training Center has a risk manager whose responsibilities include oversight and operations related to the facility's risk management program. The SEVTC Risk Manager is a voting member of the RMRC. The documentation submitted for review provided evidence of how the Training Center actually implemented the use of risk triggers and thresholds.	The RMRC charter outlines roles and responsibilities of the RMRC to review data and trends identified by providers (including the training center). For this review, DBHDS continued to have in place specific processes to review Training Center data and trends and ensure effective implementation of the Policy and Departmental Instruction. • *Departmental Instruction 316 (QM) 20 Quality Improvement* charter was amended to expand upon the requirements for the Training Center with regard to quality and risk management. • The facility's risk manager is also a voting member of the RMRC. • The RMRC is charged to review, analyze and identify trends related to DBHDS facility risk management programs to reduce or eliminate risks of harm, and to monitor the effective implementation of *DI 401 (Risk and Liability Management)* by reviewing facility data and trends, including risk triggers and thresholds to address risks of harm. For this review period, SEVTC consistently reported data to the RMRC. RMRC 2022 meeting minutes from February, June and August 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. As reported for the previous review, the documentation for the 22nd Period review continued to evidence the implementation of the use of risk triggers and thresholds. RMRC minutes continued to reflect that the committee membership in attendance found the SEVTC presentations to be cogent, thorough and easy to follow.	20th-Met **22nd-Met**

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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.	DBHDS regulations at *12VAC35-105-160.D.2* require providers to report incidents of common risk and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) through the Serious Incident Management system. DBHDS regulations at *12VAC35-105-520.C* require providers to "conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services." Per the regulations at *12VAC35-105-520.C.5*, *12VAC35-105-160.C* and *12VAC35-105-620* (i.e., requiring that providers review serious incidents as part of their annual systemic risk assessment including an analysis of trends, potential	Previous reports confirmed that DBHDS has regulations in place that require provider risk management systems 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 ulcers) and that providers take prompt action when such events occur, or the risk is otherwise identified. The care concerns processes, as described above with regard to CI 29.32, CI 30.1, CI 30.3 and CI 30.7, also address reporting and heightened monitoring of individual incidents of these common risks and conditions. This study also continues to confirm that DBHDS has in place a triage and review system for serious incidents. If a provider is found not to have reported an incident involving one or more of these types of common risks and conditions that may contribute to avoidable deaths, a CAP is required for non-compliance. This system is described with regard to CI 29.2 through CI 29.5 above. However, as previously noted, this CI requires that provider risk management systems identify the *incidence* of common risks and conditions faced by people with IDD that contribute to avoidable deaths (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. In the past, while licensing specialists might have cited providers for not reporting individual incidents of these risks and conditions, they did not cite or require corrective action when providers failed to track and address the incidence of these risks and conditions across their entire populations. An effective risk management program, even at the provider level, should do so. As reported at the time of the 20th Period review, per the regulations at *12VAC35-105-520.C.5*, *12VAC35-105-160.C* and *12VAC35-105-620* (i.e., requiring that providers review serious incidents as part of their annual systemic risk assessment including an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents), providers that do not comply with these regulations receive citations and are required to develop corrective action plans. However, DBHDS staff have previously reported that it was difficult to get provider-specific aggregate data from CHRIS. As a result, they did not really	20th-Not Met **22nd-Not Met**

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	systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents), providers that do not comply with these regulations receive citations and are required to develop corrective action plans. However, as reported with regard to CI 30.4 above, the existing licensing assessment process did not previously include all required elements related to the provider's use of data at the individual and provider level 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. On 2/09/23, these were incorporated into the OL Annual Compliance Determination Chart. Going forward, to clarify expectations for providers and facilitate the ability of DBHDS to assess these aspects of provider risk management programs more consistently, DBHDS	have the tools yet to facilitate the ability of providers to make an assessment of the incidence of common risks and conditions. Therefore, it was not realistic to expect that provider risk management systems could perform as required. For this 22nd Period review, DBHDS provided a document entitled *Monitoring Serious Incidents Draft.* This document made the case that the existing multiple regulations should be seen as a single process designed to identify: 1) potential risk to a single individual; 2) potential risk across programs or services that may impact many individuals; and 3) opportunities to improve the overall quality of services delivered to all individuals. The document noted that regardless of the category of serious incident (i.e., Level I, II or III), the provider must document information about the event for inclusion in the quarterly review of serious incidents. While only Level II or Level III incidents that occur during the provision of a service or on the provider's premises require a root cause analysis, providers should still review Level I incidents to determine whether additional actions are needed to prevent the risk of future harm. The document further explained that, regardless of the incident level, providers should track the number and the types of events that occur, such as by type of event and/or by individual, to help identify systemic risks which can be addressed to prevent more serious harm in the future; to provide insight into the types of risks that are most prevalent in their services; and whether there are any changes in these risks that need to be addressed. As described with regard to CI 30.4, above, the review of sample provider documents did not demonstrate that providers were currently using data at the individual and provider level, including 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. As a part of this initiative, DBHDS developed a template spreadsheet to assist providers to track categories of incidents that have been identified as having the potential to cause serious harm. Using the template to record individual incidents as they occur and aggregate these incidents by type would assist with	

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	developed a provider training entitled "Minimizing Risk." The three part series is being delivered in April 2023. The series will include a roll-out of incident tracking tools that providers can use to document, track and analyze the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths. The aggregated data would be readily available to providers and can be used by them to calculate incidence over time (i.e., trends) within their service delivery systems, as well as to facilitate analysis and development of a meaningful and timely plan of action. DBHDS staff noted that providers are not required to use these specific tools, but must have such a functional process in place to meet the licensing requirements identified above. It appears that, once fully implemented, these modifications would be sufficient for the	the quarterly review of serious incidents that is required in accordance with *12VAC35-105-160.C.* (i.e., the quarterly review shall include an analysis of trends, identification of any systemic issues, indicated remediation, and documentation of any steps taken to minimize the potential risk of future incidents) and the annual systemic risk assessment as it relates to *12VAC35-105-520.C.5* (i.e., to review the previous year's serious incidents and identify areas that may present risks to individuals in the future and take steps to reduce the likelihood that those risks will reoccur, or if they do reoccur, to reduce the likelihood they will result in serious harm.) Of particular note for the purposes of this CI, the tracking tools provided allowed for the tracking and aggregating of incident data in a manner that can be used to 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). By tracking the types of incidents on an ongoing basis, the aggregated data is readily available and can be used to calculate incidence over time (i.e., trends) within a provider's service delivery system and to facilitate analysis and development of a meaningful and timely plan of action. DBHDS staff noted that providers are not required to use these specific tools, but must have such a functional process in place to meet the licensing requirements identified above. As described above with regard to CI 30.4, the existing licensing assessment process did not previously include all required elements related to the provider's use of data at the individual and provider level 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. On 2/09/23, these were incorporated into the *OL Annual Compliance Determination Chart*. Going forward, to clarify expectations for providers and to facilitate the ability of DBHDS to assess these aspects of provider risk management programs more consistently, DBHDS developed a provider training entitled "Minimizing Risk." This training is being delivered in April 2023. Based on documentation DBHDS staff provided following the initial session of the three-part series, provider feedback consisting of 511 responses indicated that : • While only 5 said they would definitely not use the new template for the	

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	Commonwealth to achieve compliance with this CI. However, they were not fully implemented during the review period.	Annual Systemic Risk Assessment Review, 377 said they would plan to do so. • As a result of the training, 441 reported feeling more capable of meeting the requirements of *12VAC35-105-520.C-D.* It appears that, once fully implemented, these modifications would be sufficient for the Commonwealth to achieve compliance with this CI. However, they were not fully implemented during the review period.	
30.11: For each individual identified at 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.1 that includes the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur. The provider shall implement the risk mitigation plan. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do	DBHDS had developed a protocol to address the identification of high risk individuals, as described in detail with regard to CI 29.19 above. As described, it is a sample-based quality assurance methodology that allows DBHDS to measure whether reporting mechanisms are working appropriately (i.e., are RATs completed, are the Summary pages uploaded, do ISPs document new diagnoses and other potential risks that could lead to a SIS Level 6 or 7?) As described with regard to CI 30.4 and CI 30.5 above, DBHDS has demonstrated it has effective licensing processes in place to monitor provider development and implementation of risk mitigation plans through the	At the time of the 20th Period review, DBHDS did not have a process in place for providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 or to report this information to the Commonwealth. However, DBHDS did provide a proposed *Protocol for the Identification and Monitoring of Individuals with Complex Behavioral, Health, and Adaptive Support Needs and the Development of Corrective Action Plans required to Address Instances Where the Management of Needs for These Individuals Falls Below Identified Expectations for the Adequacy of Management and Supports Provided*, which was dated 2/7/22, but with a projected implementation date of 4/1/22. This protocol stated that DBHDS Office of DQV would pull a statistically stratified annual sample of individuals with SIS level 6 and 7 support needs order to review the ISP (Parts I-V) and the completion of DBHDS tools, including the Risk Awareness Tool (RAT) and On-site Visit Tool (OSVT), to determine if risks are identified, addressed in the ISP, and reviewed over time. It also identified supplemental roles for OIH, the Office of Crisis Services and the Office of Provider Development. For this 22nd Period review, DBHDS had abandoned that proposed protocol in favor of another, but with some similarities. This is described in detail with regard to CI 29.19 above. As described, it is a sample-based quality assurance methodology that allows DBHDS to measure whether reporting mechanisms are working appropriately (i.e., are RATs completed, are the Summary pages uploaded, do ISPs document new diagnoses and other potential risks that could lead to a SIS Level 6 or 7?) As described with regard to CI 30.4 and CI 30.5 above, DBHDS has demonstrated it has effective licensing processes in place to monitor provider	20th-Met **22nd-Met**

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not have the intended effect, DBHDS takes further action pursuant to V.C.6. .	licensing sample, and to issue and track implementation of related CAPs. As a result of the methodology described with regard to 29.19, DBHDS has also been able to extrapolate some findings to make population-level recommendations, which indicate that s that individuals in Tier 3, Levels 1-5 had a higher percentage of the risk of moving to Level 6 or 7. Since the group with the highest risk is likely to be substantially larger than the existing Level 6 or 7 population, this helped to alleviate previously reported concerns that the licensing process might under-sample the at-risk population. The licensing review processes are also bolstered by supplemental monitoring efforts. For example, as noted above with regard to CI 30.7, the QSR process also evaluates the development and implementation of risk mitigation plans for a	development and implementation of risk mitigation plans through the licensing sample, and to issue and track implementation of related CAPs. As a result of the methodology described with regard to 29.19, DBHDS has also been able to extrapolate some findings to make population-level recommendations, which indicate that individuals in Tier 3, Levels 1-5 had a higher percentage of the risk of moving to Level 6 or 7. Since the group with the highest risk is likely to be substantially larger than the existing Level 6 or 7 population, this helped to alleviate previously reported concerns that the licensing process might under-sample the at-risk population. The licensing review processes are also bolstered by supplemental monitoring efforts. For example, as noted above with regard to CI 30.7, the QSR process also evaluates the development and implementation of risk mitigation plans for a statistically significant sample of the overall population, and may issue Quality Improvement Plans if noncompliance is found. In addition, as described with regard to CI 30.1 through CI 30.3, the care concerns processes address monitoring, tracking and remediation of related risk identification and risk planning requirements for individuals on the DD waivers.	

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	statistically significant sample of the overall population, and may issue Quality Improvement Plans if noncompliance is found. In addition, as described with regard to CI 30.1 through CI 30.3, the care concerns processes address monitoring, tracking and remediation of related risk identification and risk planning requirements for individuals on the DD waivers.		

Recommendations:

1. For CI 29.1, DBHDS should
   - Developed documentation that clearly describes the realignment of staff and function for the Office of EHA (formerly DQV.
   - Ensure the adequacy of the process for implementing the requirements of the Curative Action for Data Validity and Reliability.

2. For CI 29.4, related to some inconsistency in the use of the "Not Determined" finding code, the Office of Licensing should continue to emphasize, in training for Licensing Specialists, the correct use of the "Not Determined" coding consistent with the instructions found in the OL Annual Compliance Determination Chart (revised annually).

3. For CI 29.8, related to assuring valid and reliable data from QSR:
   - When completing a Source System Assessment, including for QSR data, DBHDS must ensure that an IT expert is responsible for each of the designated assessment criteria, as stated in the document entitled *Source System Roles and Responsibilities*, dated August 2022, which indicated that not to do so would constitute a threat to data quality.
   - DBHDS should review the *OCQM Dataset and External Data Source Validation Checklist_Process in progress* to ensure fidelity in implementation of the scoring guidance.
   - DBHDS staff should consider the potential cumulative impacts of multiple instances for which partially met scoring was deemed to not "significantly impact data validity and reliability of QSR data." This might also create threats over time as QSR vendor staff change.

4. For CI 29.10, for QIIs, QIC subcommittee staff should make additional effort to ensure the tracking of outcome data whenever feasible.

5. For CI 29.13 and other indicators that rely on reporting of serious incident data, DBHDS should provide sufficient factual evidence to show it addressed all previously identified specific threats to the reliability and validity of data derived from the CHRIS and CONNECT data source systems, as well as specific steps to achieve needed remediation , including but not limited to those found in the DBHDS document entitled *RMRC Data Reporting Roadmap: A Path to Improved Data Quality in Routine Data Reporting*, dated 2/4/22.

6. For CI 29.15, the RMRC should:
   - Consider requesting additional data resulting from monitoring compliance with the serious incident reporting requirements of the Licensing Regulations during all investigations of serious injuries and deaths.
   - Consider providing additional detail in the "Process for Reviewing Data" section of the *Risk Management Program Description SFY23* about how it accomplishes certain requirements (i.e. monitoring of aggregate data of provider compliance with serious incident reporting requirements and establishment of targets for PMIs and, when targets are not met, the determination of whether quality improvement initiatives are needed, and monitoring the implementation and outcome of those initiatives).

7. For CI 29.16, DBHDS should:
   - Ensure incorporation of the requirement that "timely, appropriate corrective action plans are implemented by the provider when indicated" into the VCU Look-Behind Process.
   - In collaboration with VCU, continue to reduce the lag time between the end of the evaluation period and submission of the VCU Look-Behind analysis reports.

8. For CI 29.17, DBHDS should fully implement the OIH Look-Behind process required as soon as possible and ensure that the entirety of the process is documented in a process document.

9. For CI 29.19, going forward, DBHDS might also want to consider how Care Concerns identification might be incorporated into the identification 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 and to report this information to the Commonwealth.

10. For the measurement methodology for CI 29.20 (i.e., 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) DBHDS should:
    - Consider modifying the numerator in the Process Document entitled *Annual Dental Exams*, last revised on 1/13/23, to clearly state it is a dental physical examination to differentiate it from the annual physical exam numerator.
    - Review and consider updating the KPA PMI Measure "Individuals in residential settings on the DD waivers will have a documented physical exam date," dated 2/7/22, to be consistent with or incorporate the related Process Document for 29.20.
    - Update both relevant Process Documents as DBHDS staff finalize pending mitigation strategies

11. For the measurement methodology for CI 29.22, DBHDS will need to re-consider the portion of the methodology that seeks to incorporate QSR findings, based on HCBS questions that have been added back for Round 5. A plan to achieve compliance does not equate to compliance and therefore would invalidate this measure. At best, these settings would have to be considered as in remediation until such time successful completion of that remediation can be confirmed.

12. For the measurement methodology for CI 29.23 (i.e., at least 95% of individual service recipients are free from neglect and abuse by paid support staff), DBHDS staff should:

- Modify the *HR Process Document 29.3 Version 002*, last revised on 1/13/23 to ensure the validity of the measure, which could potentially be at risk because the Process Document does not clearly state the numerator as the number of individuals who had a complaint reported in CHRIS substantiated as abuse/neglect by paid support staff. DBHDS staff should clarify.
- Update the Process Document to reflect and address the threat of potential overcounting related to the steps that require the review two Data Warehouse reports (i.e., one for CSB data and one for licensed provider data) which then must be added together to determine the total number of substantiated cases of unauthorized seclusion and restraint.
- Ensure the mitigation section comprehensively address the threats to data validity and reliability identified in the Process Document.
- Ensure the process to derive the data for the numerator and denominator, which relies on data from CHRIS and related reports from CONNECT, as well as population data from WaMS, as reported by OISS, documents that the underlying data from each of these each of these processes also meet the requirements of the Curative Action for Data Validity and Reliability

13. For the measurement methodology for CI 29.24 (i.e., at least 95% of individual service recipients are adequately protected from serious injuries in service settings, DBHDS should describe modifications to the Process Document *Individuals Protected from Injury, version 001* to accomplish the following:
    - Describe how the methodology will be revised to report data that does not rely solely on the findings of CSB reviewers, who are reviewing their own internal work. The ongoing weak

agreement between CSB and DBHDS reviewers was insufficient to establish the reliability and validity of the CSB data as a stand-alone data source.

- Describe how the revision will ensure a statistically significant sample that can be applied to the population as a whole.
- Describe how it will factor in the percentage of *actual* serious injuries (i.e., the outcome for people served) to the overall determination of the adequacy of protection.

14. For the measurement methodology for CI 29.25 [i.e., 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 should make the following modifications to the Process Document entitled, *HR Process Document 29.5 Version 002*, last revised on 4/19/22:
    - To address risk to the validity of the measure , the Process Document should define how "substantiated complaints alleging the unauthorized use of seclusion or restraint" was fully reflective of the criteria for this CI, including that "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." Providing the CHRIS definitions for unauthorized seclusion and unauthorized restraint might resolve this concern.
    - To provide a correct numerator for reporting, DBHDS should revise the current calculation steps to reflect the number of people who did not have unauthorized restraint or seclusion, rather than the inverse (i.e., the number who did have unauthorized restraint or seclusion).
    - DBHDS staff should update the Process Document to reflect and address the threat of potential overcounting related to the steps that require the review two Data Warehouse reports (i.e., one for CSB data and one for licensed provider data) which then must be added together to determine the total number of substantiated cases of unauthorized seclusion and restraint.
    - Ensure the mitigation section comprehensively address the threats to data validity and reliability identified in the Process Document.

15. For the measurement methodology for CI 29.26 (i.e., 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), DBHDS should ensure the Process Document entitled *DD_ Priority 1_VER_004*, dated 1/10/23, adequately reflects that underlying data from each of the required data sets, including, but not limited to AVATAR, the REACH Hospitalization Tracker and WaMS, also meet the requirements of the Curative Action for Data Validity and Reliability.

16. For the measurement methodologies for CI 29.28, CI, 29.9, CI 29.30 and CI, 29.33, DBHDS needed to revise the Process Document to address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report* or provide an alternative Process Document for that report outlining the process steps for that derivation. Either one would be acceptable as a vehicle for doing so.

17. For the measurement methodologies for CI 29.28, CI, 29.9, CI 29.30 and CI, 29.33, going forward, DBHDS staff should update the *Provider Data Summary* Process Document as they finalize pending mitigation strategies.

18. In addition to the above, for the measurement methodology for CI 29.28: DBHDS should modify the *Provider Data Summary* Process Document to:
    - Reference this measure among those to which the mitigation timelines are applicable
    - State the numerator and denominator.

19. In addition to the above, for CI 29.29 (i.e., 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 should complete some analysis of why ISP-derived data vary significantly and on repeated occasions from the NCI IPS State Report 2020-21 Virginia Report.

20. In addition to the above, for the measurement methodology for CI 29.33 (i.e., 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 should update the *Provider Data Summary* Process Document to include CI 29.33 in the introductory list of indicators impacted.

21. As required by CI 30.4, the OL should provide additional guidance to providers to ensure that, 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 and identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems and provide examples of how this can be integrated into their risk management systems.

22. The OL should provide additional guidance and training for Licensing Specialists to ensure they complete consistent assessment and documentation of findings regarding 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 and identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems and that these data are incorporated into the compliance calculation required at CI 30.4.

Attachment A: Interviews

1. Heather Norton, Assistant Commissioner, Developmental Services
2. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Governmental Relations
3. Katherine Means, Senior Director of Clinical Quality Management
4. Susan Moon, Director, Office of Integrated Health
5. Eric Williams, Director, Office of Provider Development
6. Jae Benz, Director, Office of Licensing
7. Taneika Goldman, Director, Office of Human Rights
8. Mackenzie Glassco, Associate Director of Quality and Compliance
9. Gayle Jones, DOJ Settlement Agreement Coordinator

Attachment B: Documents Reviewed

1. SFY22 DBHDS Quality Management Plan Parts 1 & 2
2. SFY23 DBHDS Quality Management Plan Parts 1 & 2
3. SFY21 DBHDS Quality Management Plan Part 3
4. SFY22 DBHDS Quality Management Plan Part 3
5. Link to posting of SY21 DD QMP
6. Link to posting of SFY22 & SFY23 DD QMP Parts 1 & 2
7. DI 316 QualityManagement.REVISED.2021.04.07
8. 30.8_DI401
9. Link to annual QRT Report
10. QMP and QSR Public Access Policy
11. Link to QSR posting on DBHDS website
12. QIC meeting Minutes and Materials, SFY22
13. QIC meeting Minutes and Materials, SFY23
14. QIC Review Schedule SFY22
15. QIC Review Schedule SFY23
16. QIC Subcommittee meeting minutes and materials
17. QIC Subcommittee SFY22 Completed Work Plans
18. QIC Subcommittee SFY23 In Progress Work Plans
19. Source System Data Quality Roles and Responsibilities AUG2022
20. External Data Validation Checklist Process 11FEB2022
21. External Data Validation Checklist v.1.2.4_HSAG 8.22.22
22. Follow-up_Process AUG2022
23. DQMPAU Process v.2.0 08AUG2022
24. 37.7_DQMP Annual_Update June_2022
25. Avatar Follow-up 19AUG202
26. Actionable Recommendations Process 15AUG2022
27. WaMS Follow-up 29NOV2022
28. DQMP Recommendations Progress as of 8.26.22
29. KPA PMI forms
30. Quality Committees Policy & Procedures
31. Quality Committee Structure
32. QIC and Subcommittee Charters FY23
33. Curative Action on Data Validity and Reliability
34. 18.2, 18.3, 18.4, 18.7, 20.10, 29.27, 29.28, 29.29, 29.30, 29.33, 41.2, 41.3, 49.4 DD Provider Data Summary_VER_004.pdf
35. 25.29_DR0071 SQL.txt
36. 29.13_29.15_RMRC Review Processes.pdf
37. 29.13_Process Documents Serious Incident Reports by Type _Surveillance Rates.docx
38. 29.16, 29.18 DOJ Process IMU Look-behind_VER001.docx
39. 29.19 Risk Awareness Tool Assessment 3.1.23v2docx (1).docx
40. 29.20 Annual Dental Process VER 002.docx
41. 29.20 Annual Physical Process VER 002.docx
42. 29.22_HCBS Setting Process Document.docx
43. 29.23_HR_Process Document _VER_002.docx
44. 29.24_Process Document Individuals Protected from Injury_March2023.pdf

45. 29.25_HR_ProcessDocument_VER_003.docx
46. 29.26_DD_PRIORITY 1_VER_004.docx
47. 29.3- 29.5_34.4-34.7LIC_Asmt_Incident_Reprt_Prov_DS_VER_003.docx
48. 30.4, 30.5, 30.7 DOJ Process RM Requirements_VER002.pdf
49. 51.1, 53.1, 53.2, 53.3_OCQM_QSR Methodology_Ver_003.pdf
50. 7.14 7.18 7.19 7.20 29.21_DD_Therapeutic Consultation_BS_Ver_004.pdf
51. OCQM Dataset and External Data Source Validation Checklist Process in progress .docx
52. OCQM Dataset and External Data Source Validation Checklist ver 2.0 2.17.23
53. SIS Reassessment Request Process Document FINAL_6-4-21 (1).docx2.2_2.16_6.2_6.4_47.1_SCQR_Data Set Attestation Form
54. 29.13_Serious_Incident_Data_Attachment_B.
55. 29.16_29.18__IMU_Look_Behind_Attachment_B.
56. 29.19_Risk_Awareness_Attachment_B.
57. 29.20__Physical_Dental_Attachment_B.
58. 29.21_Attachment_B_Data_Set_Attestation_
59. 29.23_Abuse_Neglect_Attachment_B.
60. 29.25_Seclusion_Restraint_Attachment_B.
61. 29.26_Attestation_Attachment_B.
62. 29.27_Attachment_B_Data_Set_Attestation
63. 29.28_Attachment_B_Data_Set_Attestation
64. 29.29_Attachment_B_Data_Set_Attestation
65. 29.30_Attachment_B_Data_Set_Attestation
66. 29.3-29.5,_34.4-34.7_Late_Reporting_Attachment
67. 29.33_Attachment_B_Data_Set_Attestation
68. 30.4_30.5_30.7_Attachment_B.
69. 29.19.Summary
70. OTP queries
71. QII Toolkits
72. QII Process Document
73. Abandoned - Completed QIIs
74. Current in Progress QIIs
75. Proposed not Approved QIIs
76. QII Tracker
77. QII Dataset Process Documents and Attestations
78. CTA Policy & Procedure
79. CTA Practices
80. CTA Practices Specific to OL QI Regulations
81. CTA Pilot Final Report
82. CTA Log SFY22
83. CTA Log SFY23 through 2.2.23
84. CTA Log Templates
85. OL QI Regs CTA Training
86. Email on communication to providers regarding CTA Opportunity
87. CTA Pilot Project Report
88. QSR Contract
89. NCI Contract SIGNED -720-4919, Renewal 1 of 6, Modification 01 10.14.22
90. NCI Monthly Reports

91. NCI Meeting Agendas-Notes
92. NCI links FY21 Reports
93. QSR & NCI Policy & Procedure
94. NCI Practices
95. QSR & NCI Policy & Procedure
96. QSR Practices
97. QSR data presentations to the QIC & subcommittee responses
98. RMRC Program Description SFY2023
99. RMRC Review Processes.pdf
100. Risk Awareness Tool Assessment 3.1.23v2docx (1).doc
101. RMRC Task Calendar
102. Completed RMRC Work Plan ending 6.30.22
103. SFY23 RMRC Work Plan Revised 12.19.22 Through 1.31.23
104. RMRC SFY2022 Minutes and Materials
105. RMRC SFY2023 Minutes and Materials
106. RMRC Minutes 02.27.23 Draft
107. RMRC Data Reporting Roadmap
108. RMRC 02.27.23 Meeting Materials

a. OIH Choking mitigating strategy
b. RMRC Serious Incident Data
c. RMRC_Abuse, Neglect, and Exploitation Data_23.02.27_final
d. OLIMU_2.27.2023

109. Licensed Provider Statewide Training Schedule
110. Community ANE Training_FINAL draft
111. Reporting in CHRIS_9.2022 (1)
112. Restrictions, BTPs, Restraints_2022
113. 29.23 29.25_The Human Rights Regulations - An Overview_2022 – NEW
114. Memo re OHR 2022 Training Enhancements
115. FY21_Q1_Q2FY22
116. Report to RMRC FY22
117. Provider Documents for 50 Sample Providers – Root Cause Analysis reports, Root Cause Analysis policies, Risk Management/Quality Assurance policies, Risk Management Plans, Annual Systemic Risk Assessments, and CAP reports from 2022 Annual Licensing Inspections
118. DBHDS Data Reports – OL Regulatory Compliance with 12VAC35-105-160.C Data Report, OL Regulatory Compliance with 12VAC35-105-160.D.2 Data Report, OL Regulatory Compliance with 12VAC35-105-160.E Data Report, OL Regulatory Compliance with 12VAC35-105-170.G-H Report, OL Regulatory Compliance with 12VAC35-105-520 Data Report, RM Compliance by Regulation 520 CY2022
119. OL Annual Compliance Determination Chart (2022 & 2023 versions)
120. IMU Process Overview 1.1.2023
121. Curative Action #5
122. 12VAC35-105-160.D.2 (effective 08/01/2020)
123. OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (rev 01/2023)
124. CI36.5 and CI29.3 KPA PMI Critical incidents are reported on time – Updated 8.19.2022)
125. OL Regulatory Compliance with 12VAC35-105-160.D.2 Data Report

126. 12VAC35-105-160.C and 160.E.1.a-c
127. Tracking of Level I Serious Incidents vs. Baseline Behaviors
128. OL Regulatory Compliance with 12VAC35-105-160.C Data Report
129. OL Regulatory Compliance with 12VAC35-105-160.E Data Report
130. 12VAC35-105-160.D and 170.G-H
131. OL Regulatory Compliance with 12VAC35-105-160.D.2 Data Report
132. VCU IMU 2nd Quarter 2022 Report final 1.26.23
133. VCU IMU 3rd Quarter 2022 Report final 3.15.23
134. Incident Management IRR Recommendations
135. 02/27/2023 RMRC Meeting Minutes
136. Q2 2022 VCU IMU Look Behind DBHDS Response 01/31/2023
137. IMU Triage Training Form (revised 02/23/2023
138. Incident and Discover Date Triage and Audit (02/2023)
139. Incident Reportability Look Behind (02/2023)
140. OHR Community Look-Behind RMRC Report 03/21/2022
141. OHR Community Look-Behind – DQV Processes and Procedures
142. 2023 OHR Community Look-Behind Timeline (revised)
143. Transitioning the OHR Look-Behinds to PowerApps
144. 12VAC35-105-160.C, 160.E.1-2. and 160.J
145. Individual and Systemic Risk-How to Report and Respond to Incidents PowerPoint dated 04/28/2022
146. IMU Annual Medicaid Claims Review PowerPoint dated 11/29/2022
147. Incident Management Unit Care Concern Threshold Joint Protocol revised 01/01/2023
148. Risk Triggers and Thresholds Handout dated 01/01/2023
149. IMU Care Concern PowerPoint Training Effective 01/01/2023.
150. Operational Changes Related to Care Concerns dated 02/14/2023
151. 2023 Care Concern Threshold Criteria Memo (February 2023)
152. Memorandum: Operational Changes Related to Care Concerns
153. Tracking of Level I Serious Incidents vs. Baseline Behaviors Memo dated 02/14/2023
154. Internal Protocol for DBHDS Incident Management (revised 01/01/2023)
155. OL Annual Compliance Determination Chart (revised annually)
156. VCU IMU 2nd Quarter 2022 Report final 1.26.23
157. Care Concern Protocol IMU (revised 01/01/2023)
158. OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (revised January 2023)
159. OL Regulatory Compliance with 12VAC35-105-160.D.2 Data Report
160. Serious Incident Data PowerPoint (02/27/2023)
161. Internal Protocol for DBHDS Incident Management (revised 01/01/20230
162. 12VAC35-105-520.A-E
163. Risk Triggers and Thresholds Handout dated 01/01/2023
164. OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (revised annually)
165. Tracking Level I Serious Incidents vs. Baseline Behaviors (02/14/2023)
166. Risk Triggers and Thresholds Handout (01/01/2023)
167. Risk Triggers and Thresholds/Care Concern Thresholds PowerPoint (January 2023)
168. Internal Protocol for DBHDS Incident Management (rev 01/01/2023)
169. OL New Hire Staff Orientation: 12VAC35-105-620.A-E PowerPoint

170. Health and Safety Alerts
171. Health Trends Monthly Newsletter
172. Individuals with Developmental Disabilities with High-Risk Health Conditions
173. Guidance for Risk Management,
174. Sample Provider Systemic Risk Assessment
175. Risk Management and Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation and Research (CDDER)
176. Health and Safety Alerts
177. Fall Prevention Resources
178. Choking Resources
179. Risk Awareness Tools
180. Guidance on Understanding the Risk Awareness Tool and Use with the WAMS ISP
181. Urinary Tract Infection Resources
182. 30.04 30.05 Summary of Compliance
183. DBHDS Data Reports – OL Regulatory Compliance with 12VAC35-105-520 Data Report
184. Draft Minimizing Risk Power Point – "Helping Providers Meet Licensing Requirements related to Risk – 160.C, 520.C, 520..D and Beyond"
185. 30.10_Flow-Chart_Incident-Review_April-2022.
186. 30.10_Monitoring Serious Incidents_Draft
187. 30.10_Risk Tracking Tool_INDIVID LOG vFeb2023
188. 30.10_Risk Tracking Tool_MONTHLY vFeb2023
189. 30.10_Risky Business Training Outline DRAFT_Version by OL
190. Instruction Video_Risk Tracking Tool.mp4
191. Minimizing Risk flyer.pdf
192. Training Day 1 Survey Results.pdf
193. CI36.5 and CI30.5 KPA PMI Compliance with RM Regulations updated 2.10.22
194. OL Annual Compliance Determination Chart (revised annually)
195. 30.04 30.05 Summary of Compliance
196. DBHDS Data Reports – OL Regulatory Compliance with 12VAC35-105-520 Data Report
197. 12VAC35-105-160.C
198. Tools for Developing a Quality Improvement Program (February 2022)
199. Sample Root Cause Analysis Policy (February 2022)
200. Sample Provider Systemic Risk Assessment (February 2022)
201. Flow-Chart Incident Reviews (April 2022)
202. Individual and Systemic Risk – How to Report and Respond to Incidents Recorded Training (April 2022)
203. Quality Improvement Q&A's (Updated June 2022)
204. Assuring Health and Safety for Individuals with Developmental Disabilities with a Comprehensive Risk Management Plan (revised September 2022)
205. Tracking of Level I Serious Incidents vs. Baseline Behaviors (February 2023)

APPENDIX B

Services for Individuals with Complex Medical Support Needs

by

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Marisa C. Brown, MSN, RN
Barbara Pilarcik, RN
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Michael West, Ph.D.

TWENTY-SECOND PERIOD INDIVIDUAL SERVICES REVIEW STUDY:

Individuals with Complex Medical Needs

Submitted By:

Marisa C. Brown, MSN, RN
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April 24, 2023

Introduction/Overview

The Individual Services Review (ISR) Study conducted during this twenty-second review period continues the Independent Reviewer's attention to individuals with complex medical needs. The ISR Studies are relevant to an assessment of compliance with the terms of the Settlement Agreement for at least two reasons: first, they provide specific current examples of the effectiveness of the Commonwealth's system of supports for people who are at higher risk and, second, they underscore the safeguards that must be implemented and sustained to ensure that individuals, and their families, can rely on the Commonwealth's expressed commitment to meet its obligations now and in the future.

As part of its obligations under the Settlement Agreement, the Commonwealth agreed to meet the requirements of Provision **V.I.1.** Compliance Indicator 51.4 c. and Provision **V.I.2.** Compliance Indicator 52.1 a. and c. These Compliance Indicators require that:

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

51.4 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:

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

52.1 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.

From July through December 2022, the Department of Behavioral Health and Disability Services (DBHDS) completed Quality Service Reviews (QSRs) of seventeen people who scored a level 6 on their Supports Intensity Scale (SIS) evaluation. This QSR Round 4 review period relied on documents and interviews regarding health-related needs and events experienced by the seventeen people between July 1, 2021 through April 30, 2022. The QSR process is, therefore, a retrospective review.

The current ISR Study is designed to determine, at least in part, whether the QSR process, as implemented in Round 4, satisfies the requirements of the Compliance Indicators referenced above. The findings of the Independent Reviewer's nurse consultants are compared with the QSR auditors' findings to determine whether, and the extent to which, there are any discrepancies. The current ISR Study is, therefore, a discrepancy analysis. In that respect, it is identical to the ISR Studies completed for the eighteenth and twenty-first review periods.

The discrepancy findings from the twenty-first review period included the QSR auditors' failure to identify eleven of the fifteen individuals (73%) who lacked dental care, six of the seven individuals (86%) who needed clinical assessments or consultations, the two individuals who

needed ISP modifications, and four of the six individuals (67%) who received less than 80% of their authorized service hours.

As discussed below, the current ISR Study identifies similar concerns: five individuals (29%) in the sample lacked adequate dental care; four individuals (24%) lacked clinical assessments, and four individuals (24%) were determined to be at risk of harm. Once again, the QSR auditors did not identify any of these deficits in care and treatment.

The methodology for the ISR Study was discussed with key staff from DBHDS. There was agreement to provide access to the same documents examined by the QSR auditors and to their findings. In addition, the questions in the respective monitoring questionnaires were matched to ensure greater consistency and accuracy in the comparison of responses. DBHDS staff were very responsive to all requests made by the Team Leader. The documents provided for review were timely and complete. The DBHDS calls to the providers included in the sample were thorough in their explanation. As a result, all site visits were scheduled without difficulty and the reception to the site visits was courteous. The diligent and collegial efforts made by DBHDS to assist with the preparation for this Study are greatly appreciated by the Independent Reviewer and his entire team of consultants.

Between February 27 and March 16, 2023, each of the seventeen individuals from Round 4 were reviewed in their residences by the Independent Reviewer's nurse consultants.

The demographics for the seventeen individuals in the study are attached. The ISR Monitoring Questionnaires completed by the nurse consultants will be provided to the Parties. Key findings are described in the narrative below. By September 30, 2023, DBHDS is scheduled to report to the Independent Reviewer the actions and resolutions of any individual concerns/issues identified on the Issues Page in each Monitoring Questionnaire.

Summary of Findings

The findings from this discrepancy study are recorded as follows:

The Independent Reviewer's nurse consultants and the QSR auditors concurred that there were three people (Individual # 4, #7, # 9) in the sample (18%) who raised no concerns about risk of harm or a lack of needed services/supports. The residential circumstances for Individual #4, an elderly woman, were highly commended by the ISR nurse consultant.

Of the remaining fourteen individuals (82%), the QSR auditors did not identify the same concern as the ISR nurse for any (0%) of the four individuals (24%) assessed to be at risk of harm. The potential harm included the risks from continuous self-injurious behavior in one immune compromised individual; an increased risk of choking in an individual with Prader-Willi Syndrome; the presence of severe gingival hyperplasia with bleeding that was clearly noticeable in another individual; and the lack of in-home clinical supports for a young man with a high level of medical acuity who lives with his family.

As in previous ISR Studies, the lack of timely dental care was again cited as a major problem by the ISR nurse consultants. There were five people (29%) in the sample who lacked timely treatment. The QSR auditors did not identify this problem for any of the five individuals. The QSR auditor did identify the lack of timely dental care for an additional person, but this could not be confirmed based on the information available during the site visit.

22nd Review Period Findings			
V.I. 1 The QSRs assess on a provider level whether: **51.4 c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary**	**Unmet health care need or safety from harm concern identified in ISR study (# of individuals)**	**Did the QSR auditors identify this healthcare need or safety concern?**	**Conclusion:**
	The ISR reviews identified 4 individuals (24%) who were not protected from potential risk of harm (Individuals # 3, #5, #10, #17).	The QSR auditors identified none of individuals (0%) who were at risk of harm.	Based on the documents available for review, the QSR auditor failed to identify: the extent of self-injurious behavior and the resulting risk of infection (#3), increased risk of choking (#5), the presence of severe gingival hyperplasia with bleeding (# 10) and the insufficient support for a high level of medical acuity (#17).

22nd Review Period Findings			
V.I. 2 The QSRs assess on an individual service recipient-level and individual provider-level whether: **52.1 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 auditors identify this Issue?**	**Conclusion:**
	The ISR reviews determined that 4 of the 17 individuals (24%) needed assessments or consultations that were not recommended or ordered (Individuals # 3, # 5, #6, #11).	The QSR auditors did not identify any of these needed assessments.	Based on the documents available for review, the QSR auditors failed to identify needed assessments or consultations for all of these individuals (100%).
	The ISR reviews determined that 5 individuals (29%) lacked timely access to dental care (Individuals # 1, 6, 8, 15, 17).	The QSR auditors identified none (0%) of these 5 individuals who needed dental care.	Based on the documents available for review, the QSR auditors failed to identify needed dental care for 5 individuals. The auditor did cite delayed dental care

	The ISR reviews found that necessary lab tests were completed timely for <u>all</u> relevant individuals with documentation provided.	The QSR auditors' findings also did not cite any delayed lab work.	for Individual #12 but that could not be confirmed by the ISR nurse.

22nd Review Period Findings			
V.I.2 The QSRs assess on an individual service recipient-level and individual provider-level whether: **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.**	**Issue identified in ISR study (# of individuals):** The ISR reviews identified that there was no need to modify the ISP for 13 individuals (76%). The ISP for one individual (6%) required modification (Individual # 15) due to a change in status. This ISP was modified (100%). The ISP for Individual #10 was not modified after he fractured his tibia, but modification was not necessarily required because he already had a hospital bed and wheelchair.	**Did the QSR auditors identify whether a change in needs occurred or whether a modified plan was needed?** The QSR auditor did not identify the need to modify the ISP for Individual #15.	**Conclusion:** The QSR auditor did not identify the need to modify the ISP for Individual #15 (0%). However, a single example is not sufficient to draw a conclusion.

As in the last ISR Study, the number of nursing hours assigned and provided for certain individuals in the sample was reviewed. There were seven people, as noted below, authorized to need and receive nursing hours during the timeframe for this review. DBHDS was requested to provide these data and they responded very promptly.

Except for Individual #6, DBHDS provided data for two distinct time intervals that overlapped with the timeframe for this Study. The beginning date for each time interval is included below.

Nursing Hours Utilized			
ID#	**Authorization End Date**	**Percent Utilized**	**Meets 80% Utilization**
06	6/30/22	71.43%	No
07	2/1/21; 2/1/22	14.86%; 11.55%	No
12	11/1/21; 5/1/21	100%; 100%	Yes
13	9/23/20; 9/27/21	15.59%; 57.84%	No
15	2/6/21; 12/7/21	49.42%; 39.3%	No
16	11/30/20;11/30/21	49.94%; 52.76%	No
17	6/27/21; 12/27/21	41.07%; 63.94%	No

These findings are reported because Provision **III.D.1**., Compliance Indicator 18. 9 requires that "seventy percent of the individuals who have these services identified in their ISP…must have these services delivered…eighty percent of the time." In the current sample, that standard was met for only one person (#12). The lack of nursing supports was cited as a serious concern by the families and sponsors who lacked these resources, which are essential to meeting the individual's needs. Individual #17's parent said she welcomed inclusion in the ISR study so that her need for nursing support could be reported and, hopefully, addressed. Individual #17 has high medical acuity and is identified by the ISR nurse as someone who is at risk without sufficient clinical supports. The provider for Individual #13 stated that not all nursing hours were billed but the services were provided. Because there could not be confirmation of this statement, the data provided by DBHDS were relied upon for this finding. The provider for Individual # 15 is at risk if the Director of his program, an RN, does not get some relief from working every day. In addition to the problem of inadequate nursing staff to be billed, this program has a severe lack of adequate staffing overall. The Director stated that she has not had a day off in over a year due to the lack of staffing. This work schedule is not sustainable.

Concluding Comments

The findings from this ISR Study, conducted by registered nurses, indicated the following discrepancies:

- The ISR nurses and the QSR auditors agreed that there were no unaddressed health care issues identified for three of the people (18%) included in the Study. These were individuals #4, #7 and #9.
- The Independent Reviewer's nurse consultants identified four individuals (24%) in the sample (#3, #5, #10, #17) who were at risk of harm. The QSR auditors did not identify any individuals (0%).
- There was agreement between the ISR nurse and the QSR auditors that all seventeen individuals (100%) had current ISPs. One individual (#15) required modifications due to new or changed service needs. This ISPs was modified by the case manager as expected. It was unclear whether the ISP required modification for #10's fractured tibia since he already had a wheelchair and hospital bed at his home.

- The nurse consultants identified four individuals (#3, #5, #6, #11), 24% of the sample, who needed clinical assessments or consultations. These assessments/consultations are referenced on the Issues Pages. They include psychiatric, behavioral, nutritional and gender identity assessments/consultations. The QSR auditors did not recommend these assessments.
- Although the nurse consultants identified five individuals (29%) who lacked adequate dental care (#1, #6, #8, #15, #17), the QSR auditors did not identify any of these five individuals (0%). The QSR auditor identified one other individual (#12). However, the dental care for that individual could not be identified as a concern by the ISR nurse. The lack of dentists who would complete treatment under sedation was highlighted as a concern. In addition, the lack of funding, including insurance, was described as a barrier to treatment. Providers stated that they would pay "out-of-pocket" to access needed dental care. The QSR did not identify these obstacles to meeting individuals' dental needs.
- Of the seven people who needed and were authorized to receive nursing services, only one (14%) received 80% or more of the hours that were authorized. The QSR auditors did not identify the six individuals as not having their needs met, despite these individuals' ISP teams determining such services were needed and despite the Commonwealth authorizing the nursing services to meet their identified needs. With Virginia's available reimbursement rates, the inability to recruit and retain nursing personnel was described repeatedly as a serious impediment to meeting the individuals' health and safety needs.
- Several providers mentioned turnover in Service Coordinators as a significant constraint in providing continuity of care and in obtaining necessary supports. For example, it was reported that Individual # 1's most recent Service Coordinator lasted one month. Prior to this, she reportedly averaged two Service Coordinators per year. The seven-year tenure of Individual #16's Service Coordinator was a notable exception.
- All but one person in the sample (#6) required adaptive equipment. All adaptive equipment was available and in good repair. However, three problems were documented in the ISR Study. First, the Service Coordinator for Individual #6 conscientiously tracked the armrest repair needed for the wheelchair. This repair was significantly delayed. Individual #6 has dystonia and cannot walk. However, she enjoys swimming, and the exercise is important for her. Although the family does have a swimming pool, the pool lift has been denied as durable medical equipment. Individual # 3 requires a highly specialized bed. The bed now has been provided but his parent reports that it was very difficult to obtain.
- Individual #3's parent speaks Spanish. Although DBHDS promptly ensured that a translator was available for the telephone scheduling call as well as for the site visit, this parent received her son's REACH assessment in English. She would not sign the document because she could not read it. The QSR auditor did not identify this problem.

In summary, the findings from the twenty-second ISR Study are consistent with those of previous Studies of individuals with complex medical needs. Significant issues/concerns related to health care are not identified in the QSR process. As the Commonwealth continues to refine and implement its QSR process and protocol, it is hoped that the findings from this ISR Study are useful to those efforts. It is clear from the site visits that the monitoring of services and supports for individuals with complex medical needs is of critical importance.

ATTACHMENTS

CHART ONE

Name	Compliance Question: Do providers keep service recipients safe from harm?	Response
#1	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#2	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#3	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There is continuous self-injurious behavior that creates a risk of infection in this immune compromised individual.	Yes ☒ No ☐ Yes ☐ No ☒
#4	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☐ No ☒
#5	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: Prader-Willi Syndrome presents significant challenges. There is an increased risk of choking due to the rapid pace with which he eats his food.	Yes ☒ No ☐ Yes ☐ No ☒
#6	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#7	QSR Auditor answered	Yes ☒ No ☐

	ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐
#8	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#9	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#10	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The presence of gross gingival hyperplasia with bleeding is a serious risk.	Yes ☒ No ☐ Yes ☐ No ☒
#11	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#12	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#13	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#14	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No:	Yes ☒ No ☐ Yes ☒ No ☐

	There were no issues identified.	
#15	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#16	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#17	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There is insufficient support available for a high level of medical acuity.	Yes ☒ No ☐ Yes ☐ No ☒

CHART TWO

Name	Compliance Question: Are individuals' needs identified and met?	Response
#1	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There has been at least four years since dental care was provided.	Yes ☒ No ☐ Yes ☐ No ☒
#2	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: NOTE: The QSR auditor's concerns regarding inadequately addressed or unidentified needs could not be identified or confirmed.	Yes ☐ No ☒ Yes ☒ No ☐
#3	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The behavioral assessment does not adequately address, with an appropriate plan, the self-injury experienced by this individual.	Yes ☒ No ☐ Yes ☐ No ☒
#4	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There was no issue of concern noted.	Yes ☒ No ☐ Yes ☒ No ☐
#5	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There is no monitoring of seizures. Risks related to Prader-Willi Syndrome and other serious medical conditions were not identified as requiring follow-up.	Yes ☒ No ☐ Yes ☐ No ☒
#6	QSR Auditor answered ISR Nurse answered	Yes ☒ No ☐ Yes ☐ No ☒

	Issue identified, if ISR nurse answered No: Dental care has not been provided for almost four years. Service Coordinator continues to try to obtain lift for swimming pool so that swimming can be used for exercise. Lift was denied as durable medical equipment.	
#7	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#8	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The lack of dental and physical exams was not noted.	Yes ☒ No ☐ Yes ☐ No ☒
#9	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#10	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: Severe gingival hyperplasia with bleeding was not documented or treated.	Yes ☒ No ☐ Yes ☐ No ☒
#11	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: Gender affirming treatment/therapy was not addressed.	Yes ☒ No ☐ Yes ☐ No ☒
#12	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The out-of-date dental exam cited by the QSR auditor had been resolved.	Yes ☐ No ☒ Yes ☒ No ☐
#13	QSR Auditor answered ISR Nurse answered	Yes ☒ No ☐ Yes ☐ No ☒

	Issue identified, if ISR nurse answered No: All authorized nursing hours were not billed. As a result, he does not receive authorized health and nursing supports.	
#14	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The required residential/in-home services are not provided due to 1) frequent staff call-outs with no back-up and 2) uncovered hours from the agency.	Yes ☒ No ☐ Yes ☐ No ☒
#15	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: No dental visit since January 2, 2020, due to the inability to locate a dentist with sedation capability and the structural condition of #15's palate. All authorized nursing hours were not billed due to the lack of available nurses. This situation is not sustainable over the long term unless adequate staffing is obtained.	Yes ☒ No ☐ Yes ☐ No ☒
#16	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: Since the office closed, mental health services through a psychiatrist have not been received. A new psychiatrist has not been identified. All authorized nursing hours were not billed.	Yes ☒ No ☐ Yes ☐ No ☒
#17	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: Lacks timely dental care/treatment. There are periods without nursing support, despite high medical acuity, due to the lack of availability of nurses.	Yes ☒ No ☐ Yes ☐ No ☒

DEMOGRAPHICS

Region		
I	2	11.8%
II	2	11.8%
III	3	17.6%
IV	5	29.4%
V	5	29.4%

Sex		
Male	11	64.7%
Female	6	35.3%

Age Group		
Under 21	2	11.8%
21-30	6	35.3%
31-40	4	23.5%
41-50	3	17.6%
51-60	1	5.9%
61-70	0	0.0%
71-80	0	0.0%
81-90	1	5.9%
Over 90	0	0.0%

Mobility Status		
Walks without support	3	17.6%
Walks with support	3	17.6%
Uses wheelchair	11	64.7%
Confined to bed	0	0.0%

Residence Type		
Group home	6	35.3%
Own/family home	6	35.3%
Sponsored home	5	29.4%

APPENDIX C

Case Management

by

Ric Zaharia, Ph.D.

TO: Donald Fletcher

FROM: Ric Zaharia

RE: Case Management Report – 22nd Review Period

DATE: May 1, 2023

Introduction

This report constitutes the fifth review of the compliance indicators for Case Management services. In the last review for SCQR-FY21, DBHDS provided documentation that showed achievement of ten (10) of nineteen (19) compliance indicators (53%). Although these achievements demonstrated progress, the outstanding indicators could not be accomplished due primarily to most CSBs failure to achieve the 86% benchmark on the SCQR (Support Coordinator Quality Review).

The second year of OCQI (Office of Community Quality Improvement) retrospective reviews to establish reliability showed OCQI/CSB agreement at over 75% for nine of ten indicators. This was a major boost to data integrity and the congruence of CSB supervisor ratings of their own staff with the external ratings of OCQI staff.

For this report the documents reviewed are identified in Attachment A and most can be located in the DBHDS Team library. A clarifying interview was conducted with Eric Williams, Director of Provider Development/Case Management Steering Committee (CMSC) Chair, in mid-March.

Summary of Findings for the 22nd Period

This 22nd Period study showed the achievement of fourteen (14) compliance indicators out of the nineteen (19) reviewed (74%). The difficulties around the remaining five (5) indicators still relate to CSB effectiveness at achieving expectations for case management performance on ten elements of the SCQR and DBHDS's ability to achieve the indicator metrics statewide. DBHDS has completed three full annual cycles of the planned SCQR activities, including records from CY-19, CY-20, and CY-21. It has established the usefulness of the SCQR in monitoring case

management performance. In the most recent SCQR process, OCQI/CSB agreement has improved to a median of 85% for nine of ten indicators.

The CMSC reviewed the results of the SCQR-FY22 and determined for CY21 records that 53% (213/400) achieved a minimum of nine of the ten indicators, which is below the benchmark of 86%. However, it is a significant improvement over the 42% found in the CY20 records. Across records four of the ten indicators were above 86%, four were very close, and two were well below. Finally, this SCQR incorporated the presence of an On-site Visit Tool (OVST) as part of the assessment and reported compliance for its presence in the last four visits was 86%.

Across CSBs, six of the forty CSBs (15%) achieved at the 86% benchmark or better. These results indicate improvement in that six CSBs met the benchmark for CY21 records versus three CSBs (7.5
%) meeting the benchmark for CY20 records. However, these findings also highlight the large amount of CSB compliance still to be achieved.

The CSB response rate for the SCQR-FY22 was again 100% thereby assuring data integrity in sample size. The level of agreement between CSB supervisors and outside reviewers like OCQI (Office of Community Quality Improvement) is a critical data integrity issue for the SCQR. This third year of OCQI retrospective reviews to establish reliability showed OCQI/CSB agreement ranging from 69% to 100%, with a median agreement level of 85%. These reliability scores, as well as the inter-rater reliability checks, are an improvement over the last SCQR and continue to endorse the tool and processes as a common mechanism to evaluate and measure case manager performance.

For the next SCQR-FY23, improvements to the process include adding children to the sample (thereby improving the applicability of the SCQR results), revising employment and community integration questions, adding employment discussion questions for ages 14-17, and clarifying guidance for several questions based on user feedback.

The most recent data for Enhanced Case Management (ECM) contacts for FY22 Q1-2 showed an overall "reliability" (compliance) rate of 76%, with 18 CSBs (45%) at or over 86%. DBHDS's provision of intensive technical assistance with CSBs continues through cross-tabbing of the CCS3, WaMS and the local electronic individual record.

Finally, no CSBs in this cycle underperformed at DBHDS criteria following SCQR technical assistance. Therefore, no enforcement actions were required. However, the CMSC recommended one CSB to the Commissioner for a CAP under their Performance Contract for failing to meet targets under other compliance indicators (RST referrals). This represents a first for Provider Development and perhaps a first for DDS in recommending the use of contract level actions to enforce expectations on CSBs.

Data Process and Attestation.
Data Process. Table 1 below recaps data integrity documents for Process Control Documents.

Documentation for Compliance Indicators 2.16, 6.1a, 6.2, and 47.1 (DD CMSC DATA REVIEW process document- #29 and the SCQR Process Documentation- #30) was reviewed for case management performance on the ten elements in the compliance indicators and the Look Behind sub-sample review. The CMSC process document is considered the governing control document for the SCQR, which has its own "process document", although it is not in the format of a process document and is more of a methodology description, i.e. it may be mislabeled as a process document. Moreover, the CMSC process document covers the SCQR in substantial detail.

The CMSC process document identifies the process steps needed to effect the SCQR (Technical Guide, Survey Blanks, Sample selections, report generation), as well as the transmission of the findings to CSBs, QIC, Commissioner, etc. and the translation of mathematical results into PMI's and compliance indicators. DQV review suggested 8 recommendations for the SCQR, all of which were accepted or plans implemented to mitigate.

The SCQR methodology (i.e., process document) has now had three complete cycles of implementation and has shown its value as a measurement for CSB case management effectiveness. Although not all fixes have been implemented, it is complete and thorough, including tabular layouts, detailed process to be followed when client names don't match on the merger of the CSB supervisor version with the OCQI version, and a 'script' to be followed when duplicate supervisor responses appear.

Documentation for Compliance Indicator 6.1.b (DD CMSC DATA REVIEW, #29) was reviewed for the Case Management Steering Committee's semi-annual reports on case management performance. These reports are informed by the SCQR, Licensing data, CCS data submissions, QSRs, DMAS quality reviews, WaMS, and other sources. DQV recommends including children in future SCQR sampling, advises discontinuing the use of CCS3 for compliance reporting, urges providing raw data in calculation of numerator and denominator in the SCQR, and suggests incorporation of RST process into WaMS. The DBHDS Measurement Steward concurred and identified responsive activities to mitigate all issues identified by DQV.

Documentation for Compliance Indicator 46.1-2 (DD CMSC DATA REVIEW, #29) was reviewed for case management contacts (CCS3 Metrics, Look Behinds, WaMS). For two review periods DBHDS has implemented a Data Quality Framework to review and verify a sample of CSB contact data each quarter and provide follow-up technical assistance. This process includes a Data Quality Tool to assess sources of data error, a Root Cause Analysis format to assist CSBs in addressing data problems, and ECM educational materials. DQV continues to deem CCS3 data 'not valid and reliable' (#29, p.20), so the technical assistance cross-tabbing of CCS3, WaMS, and local individual records continues as an ongoing quality improvement measure.

Data Set Attestation. Table 1 below recaps data integrity documents for Data Set Attestation.

Documentation for Compliance Indicators 2.16, 6.1.a-b, and 47.1 was reviewed from the 20th Review Period for the SCQR component (#31). The Chief Information Officer found those processes to be thorough and detailed.

Data Set Attestations for Compliance Indicator 6.1.b) were reviewed. The Chief Information Officer found those processes to be thorough and detailed.

Data Set Attestations (#35-36) for Compliance Indicator 46.1-2 were reviewed. The Chief Information Officer found both targeted and enhanced case management contact measures to be reliable and valid, but it is not clear that he resolved the DQV data concerns re the reliability and validity of CCS3 data with all the technical assistance DBHDS has provided CSBs (#29, p.20).

Table 1
Data Integrity Documents

CI	Process Control Document	Data Set Attestation
2.16, 6.1.a, 6.2, 47.1	DD CMSC DATA REVIEW (process control document- #29) (SCQR Process Documentation (#30), i.e., Methodology)	SCQR Data Set Attestation (#31)
6.1.b	DD CMSC DATA REVIEW (process control document- #29)	Attachment B (CMSC - #33) SCQR Data Set Attestation (#31)
46.1-2	DD CMSC DATA REVIEW (process control document- #29)	Attachment B (Provider Data Summary - #35 & 36)

Compliance Indicator Achievement.

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

Table 2
Case Management Findings

#	Indicator	Facts	Analysis/Conclusions	20th	22nd
2.0	**III.C.5.b.i (also for V.F.2)** The following indicators to achieve implementation listed in this provision will also achieve implementation with other provisions associated with case management (**III.C.5.b.ii, III.C.5.b.iii, III.C.5.c, and V.F.2**). Relevant elements of person-centered planning, as set out in CMS waiver regulations (42 C.F.R. § 441.301(c)), are captured in these indicators.			**NA**	**NA**
2.1	In consultation with the Independent Reviewer, DBHDS shall define and implement in its policies, requirements, and guidelines, "change of status or needs" and the elements of "appropriately implemented services."	DBHDS has continued use of the definitions and the training of case managers in "change of status or needs" and "appropriately implemented services (see #5-6).	Sustained achievement	**M**	**M**

2.2	DBHDS will perform a quality review of case management services through CSB case management supervisors/QI specialists, who will conduct a Case Management Quality Review that reviews the bulleted elements listed below.	2.2 SCQR-FY22 reviewed records from CY21 (see #1, 8, 22). This is the third year of case management record review using the SCQR and CSB supervisors/QI specialists. The FY22 SCQR process included the revised OSVT which was incorporated into the SC Manual.	This is the third year of case management record review using the SCQR process. With DBHDS including the revised OSVT incorporated into the SC Manual for FY-22, this indicator is achieved. Reliability and validity are qualified for the SCQR report – see below at 2.16.	**NM**	**M**
2.3	DBHDS will pull an annual statistically significant stratified statewide sample of individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB.	2.3 For SCQR-FY22 the CSB response rate was again 100% (400/400) for a statistically significant statewide sample of adults (children are to be included in SCQR-FY23). See #1, 17, 19-22.	2.3 Although the FY22 sample was statistically significant for adults in the waiver, its omission of children leaves a large growing population unsampled. This task has not been fully achieved.	**NM**	**NM**
2.4	Each quarter, the CSB case management supervisor and/or QI specialist will complete the number of Case Management Quality Review as determined by DBHDS by reviewing the records of individuals in the sample. The data captured by the Case Management Quality Review will be provided to DBHDS quarterly through a secure software portal that enables analysis of the data in the aggregate.	2.4 This is the third round of DBHDS completing SCQR reviews of the number determined by DBHDS. The CSB response rate was again 100% (400/400) for a statistically significant statewide sample. The data captured was provided as required.	2.4 Sustained achievement	**M**	**M**
2.5	DBHDS analysis of the data submitted will allow for review on a statewide and individual CSB level. The	2.5 SCQR-FY22 reviewed records from CY21, so the two changes at 2.1 are fully	2.5 This is the third year of DBHDS's statewide and individual case management record	**NM**	**M**

	Case Management Quality Review will include review of whether the following ten elements are met:	incorporated in the results. CMSC conducts both statewide and CSB level analysis. This is the third year of case management record review using the SCQR, including the ten elements below (see #8).	review of the ten elements using the SCQR. The data submitted allow for review on a statewide and individual CSB level.		
	2.6 • The CSB has offered each person the choice of case manager.	2.6 Compliance reported at 78% (see #8). This is the same as SCQR-FY21. This is below the benchmark of 86%.	2.6 See CI 2.16.		
	2.7 • The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team.	2.7 Compliance reported at 84% (see #8). This is a drop from SCQR-FY21. This is slightly below the benchmark of 86%.	2.7 See CI 2.16.		
	2.8 • The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.	2.8 Compliance reported at 84% (see #8). This is an improvement over SCQR-FY21. This is slightly below the benchmark of 86%.	2.8 See CI 2.16.		
	2.9 • The case manager assists in developing the person's ISP that addresses all the individual's risks, identified needs and preferences.	2.9 Compliance reported at 87% (see #8). This is an improvement over SCQR-FY21 and is above the benchmark of 86%	2.9 See CI 2.16.		
	2.10 • The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable.	2.10 Compliance reported at 40% (see #8). This is a drop from SCQR-FY21 This is below the benchmark of 86%.	2.10 See CI 2.16. 2.11 See CI 2.16.		

	2.11 • The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served.	2.11 Compliance reported at 82% (see #8). This is a slight drop from SCQR-FY21. This is below the benchmark of 86%.			
	2.12. • The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary.	2.12 Compliance reported at 98% (see #8). This is a slight improvement over SCQR-FY21. This is above the benchmark of 86%.	2.12 See CI 2.16.		
	2.13 • Individuals have been offered choice of providers for each service.	2.13 Compliance reported at 92% (see #8). This is a slight improvement over SCQR-FY21. This is above benchmark of 86%.	2.13 See CI 2.16.		
	2.14 • The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences.	2.14 Compliance reported at 85% (see #8). This is an improvement on SCQR-FY21. This is slightly below the benchmark of 86%.	2.14 See CI 2.16.		
	2.15 • The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and	2.15 Compliance reported at 100% (see #8). This is the same as SCQR-FY21. This is above the benchmark of 86%.	2.15 See CI 2.16.		

	addressing changes in individual needs, including, but not limited to, reconvening the planning team as necessary to meet individual needs.				
2.16	The Case Management Steering Committee will analyze the Case Management Quality Review data submitted to DBHDS that reports on CSB case management performance each quarter. In this analysis 86% of the records reviewed across the state will be in compliance with a minimum of 9 of the elements assessed in the review.	The CMSC has reviewed the results of the SCQR-FY22 (#1, 7-8, 22) and determined for CY21 records that 53% (213/400) of the records achieved at a minimum of nine of the ten indicators, which is below the benchmark of 86%. Six of the forty CSBs achieved at the 86% benchmark or better (see #1, 7-8). The DD CMSC DATA REVIEW process document (see #29) and the SCQR Process Documentation (see #30) were reviewed for case management performance on the ten elements in the compliance indicators and the Look Behind sub-sample review. The CMSC process document is considered the governing control document for the SCQR, which has its own "process document", although it is not in the format of a process document and is more of a methodology description, i.e. it may be mislabeled as a process document. Moreover, the	These results indicate improvement, e.g., six CSBs meeting the benchmark for CY21 records vs three CSBs meeting the benchmark for CY20 records; 53% of 400 records achieving at 86% vs 42% in CY20. However, they also highlight the large amount of CSB underperformance to be corrected. This indicator is not yet achieved.	**NM**	**NM**

		CMSC process document covers the SCQR in substantial detail. The CMSC process document identifies the process steps needed to effect the SCQR (Technical Guide, Survey Blanks, Sample selections, report generation), as well as the transmission of the findings to CSBs, QIC, Commissioner, etc. and the translation of mathematical results into PMI's and compliance indicators. DQV review suggested 8 recommendations for the SCQR, all of which were accepted or plans implemented to mitigate. The SCQR Process Documentation (methodology) has now had three complete cycles of implementation and has shown its value as a measurement for CSB case management effectiveness. Although not all fixes have yet been implemented, the document is complete and thorough, including tabular layouts, detailed process to be followed when client names don't match on the merger of the CSB supervisor version with the OCQI version, and a 'script' to be followed when			

		duplicate supervisor responses appear. Data Attestations from the 20th Review Period for the SCQR component (#31) were reviewed. The Chief Information Officer found those processes to be thorough and detailed.			
2.17	In this analysis any individual CSB that has 2 or more records that do not meet 86% implementation with Case Management Quality Review for two consecutive quarters will receive additional technical assistance provided by DBHDS.	DBHDS continues to track CSB achievement of 86% on ten indicators (see #3, 4, 11).	Sustained achievement	**M**	**M**
2.18	If, after receiving technical assistance, a CSB does not demonstrate improvement, the Case Management Steering Committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract and licensing regulations.	DBHDS continues to provide targeted technical assistance to CSBs who underperform on three or more of the ten indicators following look-behinds. Six of 40 CSBs achieved the 86% benchmark. No CSBs in this cycle underperformed following technical assistance, so no enforcement actions were required (see #2, 4, 11).	Congruence between DBHDS reviewers and CSB supervisors is improving, so it is likely that the coaching and training of case managers in these expectations is also improving. This indicator will be met when all records in the sample achieve the 86% metric at CI 2.16, so this indicator is not yet achieved.	**NM**	**NM**
2.19	DBHDS, through the Case Management Steering Committee, will ensure that the CSBs receive their case management performance data semi-annually at a minimum.	DBHDS continues to provide each CSB with their case management performance data (#10, 11).	Sustained achievement	**M**	**M**
2.20	All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or DBHDS licensing regulations. Corrective actions for cited regulatory non-implementation will be	DBHDS meets quarterly with DMAS-QMR to share and track citations relating to the SCQR elements (see #32). Corrective actions have been cross-walked and tracked jointly since	This indicator will be met in the next review when the joint tracking of CAPs will be in its second year and completed to ensure remediation for a full review period, so this indicator is not yet	**NM**	**NM**

	tracked to ensure remediation.	1/23.	achieved.		
#	**Indicator**			**20th**	**22nd**
6.1.a (formerly 2.21)	The Case Management Steering Committee will review and analyze the Case Management data submitted to DBHDS and report on CSB case management performance related to the ten elements and also at the aggregate level to determine the CSB's overall effectiveness in achieving outcomes for the population they serve (such as employment, self-direction, independent living, keeping children with families).	The CMSC has reviewed and analyzed case management record performance on the ten elements for 3 review cycles (see #1, 8, 22). The DD CMSC DATA REVIEW process document (see #29) and the SCQR Process Documentation (see #30) were reviewed for case management performance on the ten elements in the compliance indicators and the Look Behind sub-sample review. See above at 2.16 for a fuller discussion. Data Attestations from the 20th Review Period for the SCQR component (#31) were reviewed. The Chief Information Officer found those processes to be thorough and detailed	Sustained achievement	**M**	**M**
6.1.b (formerly 2.22)	The Case Management Steering Committee will produce a semi-annual report to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. The Case Management Steering Committee's report will include an analysis of findings and recommendations based on review of … data from the oversight of the Office of Licensing, DMAS Quality Management Reviews, CSB Case Management Supervisors	CMSC has issued semi-annual reports since April 2019. The most recent Semi-Annual Report (#22) included SCQR-FY22 records from CY21 and considered data from Licensing, DMAS-QMR, OCQI, data integrity processes, performance contract indicators and the QSR. The CMSC	Sustained achievement	**M**	**M**

	Quarterly Reviews, DBHDS Quality Management Division quality improvement review processes including the Supervisory retrospective review, Quality Service Reviews, and Performance Contract Indicator data.	has generated fourteen recommendations it is pursuing or has implemented (see Semi-Annual Reports, #1, 22). The DD CMSC DATA REVIEW process document (see #29) and the SCQR Process Documentation (see #30) were reviewed for case management performance on the ten elements in the compliance indicators and the Look Behind sub-sample review. See above at 2.16 for a fuller discussion. Data Set Attestations for Compliance Indicator 6.1.b) were reviewed. The Chief Information Officer found those processes to be thorough and detailed.			
6.1	The Case Management Steering Committee will also make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings.	DBHDS continues to make recommendations to the Commissioner. Although 6 of 40 CSBs achieved the 86% benchmark, no CSBs in this cycle underperformed at DBHDS criteria following technical assistance. Therefore, no enforcement actions were required (see #2). One CSB was recommended for a CAP under their Performance Contract but it was for failing to meet targets under other	Sustained achievement	**M**	**M**

		compliance indicators (see #34).			
6.2	Members of the DBHDS central office Quality Improvement Division will conduct annual retrospective reviews to validate the findings of the CSB case management supervisory reviews and to provide technical assistance to the case managers and supervisors for any needed improvements. A random subsample of the original sample will be drawn each year for this retrospective review….	OCQI look-behinds continue on a random subsample of 100 from the annual sample of 400 (see #3, 9, 27, 8). The DD CMSC DATA REVIEW process document (see #29) and the SCQR Process Documentation (see #30) were reviewed for case management performance on the ten elements in the compliance indicators and the Look Behind sub-sample review. See above at 2.16 for a fuller discussion. Data Attestations from the 20th Review Period for the SCQR component (#31) were reviewed. The Chief Information Officer found those processes to be thorough and detailed.	Sustained achievement	**M**	**M**
6.3	The DBHDS central office Quality Improvement Division's reviewers will visit each CSB in person and review case management records for the individuals in the sub-sample. They will then complete an electronic form so that agreement between the CSB Case Management Quality Review and the DBHDS Quality Improvement Division record reviews can be measured quantitatively.	OCQI look-behinds with visits to each CSB and review of case management records continue as do completion of the electronic form (see #3, 9, 18, 8).	Sustained achievement	**M**	**M**

6.4	There will be an ongoing inter-rater reliability process for staff of the DBHDS Quality Improvement Division conducting retrospective reviews.	OCQI specialists annually utilize a 50-person sub-sample out of the 100-person look behind sample to compare their own level of inter-rater agreement (see #3, 9,17, 8).	Sustained achievement	**M**	**M**
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**20th**	**22nd**
46.1	The Commonwealth tracks the number, type, and frequency of case management contacts. DBHDS will establish a process to review a sample of data each quarter to determine reliability and provide technical assistance to CSBs as needed.	For the last two review cycles DBHDS has been reviewing and analyzing case management data quarter to quarter (see #15-16) pursuant to a Data Quality Support process (#23-24) that details sample selection, data to be entered, and verification steps. The end goal is a collaborative root cause analysis/TA with CSB staff to resolve data reporting issues by cross-tabbing the CCS3-WaMS-EHR data (see #25). DD CMSC DATA REVIEW (see #29) was reviewed for case management contacts (CCS3 Metrics, Look Behinds, WaMS). DBHDS has implemented a Data Quality Framework to review and verify a sample of CSB contact data each quarter and provide follow-up technical assistance. This process includes a Data Quality Tool to assess sources of data error, a Root Cause Analysis format to assist CSBs in addressing	DBHDS has implemented this process for two review periods. Since the 20th Review Period all 40 CSBs were reviewed to identify barriers to accurate coding and develop quality improvement plans to ensure case management data are reported accurately. This was followed up with visits at CSBs between DBHDS IT staff and CSB staff to examine 3 records per CSB for accuracy in case management data. Because this process will continue in the future, this indicator has been achieved. Data reliability and validity issues still exist pending the resolution of the use of CCS3 data (#29, p.20)	**NM**	**M***

		data problems, and ECM educational materials. DQV continues to deem CCS3 data 'not valid', so the technical assistance cross-tabbing of CCS3, WaMS, and local individual records continues as an ongoing quality improvement measure. Data Set Attestations (#35-36) for Compliance Indicator 46.1-2 were reviewed. The Chief Information Officer found both targeted and enhanced case management contact measures to be reliable and valid, but it is not clear that he resolved the CCS3 data reliability or validity concerns of DQV (#29, p.20).			
46.2	The data regarding the number, type, and frequency of case management contacts will be included in the Case Management Steering Committee data review. Recommendations to address non-implementation issues with respect to case manager contacts will be provided to the Quality Improvement Committee for consideration of appropriate systemic improvements and to the Commissioner for review of contract performance issues.	DBHDS has an ongoing, established CMSC workgroup (QII) to address the issue of improved face to face contacts (see #12-13). The CM contact data was included in the CMSC review. The data shows ECM contacts systemwide have not met their internal 90% benchmark; the annual, average FY23 contact rate was 72% (see #22). However, the annual average FY23 contact rate for targeted case management (non-ECM) was over 90% (see #22). In reviewing and analyzing case	DBHDS has implemented this data collection and distribution process for two review periods under the Data Quality Framework. See 46.1 above for more discussion of Framework activities. CMSC has continued regular reporting to QIC (see#26, 28), which has included recommended improvement initiatives. Since these processes are planned to continue in the future, this indicator has been achieved. Data reliability and validity issues still exist	**NM**	**M***

		management data quarter to quarter (see #15-16), the CMSC has identified 13 coding problems in their CCS3 data common to many CSBs (only 6 CSBs had no data quality issues -see #24). Corrections at the CSB and DBHDS level were recommended (see #24). DBHDS implemented a Data Quality initiative in CY22 that sampled records jointly with CSBs and DBHDS via cross-tabbing contact information in the CCS3 with the EHR and WaMS, in order to support CSBs with improved data reporting (see #22, 24). CMSC has continued regular reporting to QIC (see#26, 28), which has included recommended improvement initiatives to update the 2017 guidance tool for the CCS3 and to retain case managers. The revised guidance tool was effective 1.27.23. See 46.1 above for a discussion of reliability and validity issues.	pending the resolution of the use of CCS3 data (#29, p.20).		
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**20th**	**22nd**
47.1	The Case Management Steering Committee will establish two indicators in each of the areas of health & safety and community integration associated with	CMSC has continued to review 19 performance measure indicators (see #1, 22) including the four indicators (PMIs) selected by DBHDS. For	Since three of the four indicators are below the 86% benchmark, this indicator is not yet Met. With data indicating that	**NM**	**NM**

	selected domains in V.D.3 and based on a review of the data submitted from case management monitoring processes. Data indicates 86% implementation with the four indicators.	CY21 records implementation rates from the SCQR were: Change in Status (PMI-16 at 84%) ISP Implementation (PMI-17 at 84%) Relationships (PMI-18 at 90%) Choice (PMI-19 at 78%) CMSC has engaged in crosswalks and discussion about congruence between PMIs, QSR results, and QMR-DMAS audits (see #14). The DD CMSC DATA REVIEW process document (see #29) and the SCQR Process Documentation (see #30) were reviewed for case management performance on the ten elements in the compliance indicators and the Look Behind sub-sample review. See above at 2.16 for a fuller discussion. Data Attestations from the 20th Review Period for the SCQR component (#31) were reviewed. The Chief Information Officer found those processes to be thorough and detailed	only one of the indicators is significantly below the benchmark, the CMSC should be able to fully achieve PMI-16, 17, and 19 in the next review.		

<u>*Data reliability and validity issues</u>

Suggestions for DBHDS Consideration:

1. DBHDS should continue its technical assistance efforts with face-to-face contact reporting with CSBs until all meet Departmental targets. This contact reporting is the heart of the case management function and represents the *quid pro quo* for case management reimbursement.
2. CMSC should consider requesting Commissioner or Assistant Commissioner transmit certificates acknowledging CSB accomplishment of the 86% benchmark on the SCQR.
3. DBHDS should adopt the CMSC proposal for a QII on Case Manager/SC Retention, in particular the establishment of an SC retention baseline and ongoing measurement.

Attachment A
Documents Reviewed
Case Management – Title or Filename

1. CMSC Report FY22 3rd and 4th Qtr. final, 1st, and 2nd Qtr. final
2. CMSC Recommendations Letter (1.30.23, m, 6.3.22)
3. OCQI Report to CMSC-SCQR (12.6.22)
4. CRC TA Summary CSB Performance Tracking2022
5. OSVT Definitions…6.9.20
6. OSVT training slides…10.30.20
7. CMSC Minutes – (monthly, Jan.-Oct. 2022)
8. FY2022 SCQR Final Report
9. SCQR FY2022 Look Behinds--, (40 CSBs)
10. FY2022 (SCQR Data Report), --(40 CSBs)
11. --, CMSC Performance Letter, FY22 (40 CSBs), 2.6.23
12. CMSC Work Group Updates, (7/22 to 2/23)
13. QII Updates, 11.1.22
14. Surveillance data review draft, undated.
15. ECM Report SFY22 complete (face to face contacts)
16. Targeted Case Management SFY22 complete (face to face)
17. SCQR Processes updated Jan 2022 final
18. SCQR 2023 Link and Information
19. SCQR 2023… (Technical guidance), 1.6.23
20. SCQR 2023 Multi-record form, undated
21. SCQR 2023 Changes, 12.16.22
22. CMSC Report FY 23 1st and 2nd Qtr. (3.1.23)
23. Case Management Data Quality Support Operational Process, 11.19.21
24. Data Quality Support Process and Recommendations, 8.6.22
25. Data RCA Template (2) 10.29.21
26. CMSC Report to the QIC (6.27.33, 3.28.22, 12.13.21)
27. Look Behind sample FY2022.
28. QIC Minutes, 6.27.22, 9.21.22, 12.12.22
29. DD CMSC DATA REVIEW VER 006, 2.13.23
30. SCQR process documentation (1.19.23)
31. SCQR Data Set Attestation Form, 3.4.22
32. CSB Data Indicator Tracking Process, Feb 2023
33. Attachment B (CMSC) 3.17.23
34. HNNCSB CAP….3.13.23
35. Case Management Attachment B (Provider Data Summary), 4.10.23
36. Enhanced Case Management Attachment B (Provider Data Summary), 4.14.23
37. Community Consumer Submission (CCS) Extract Specifications, Version 8.2, 1.27.23

Attachment B

Interviews

Nathan Habel, Project Manager, 3.17.23

Eric Williams, Director, Provider Development, 3.17.23

APPENDIX D

Crisis and Behavioral Services

by

Katherine du Pree, MPS
Joseph Marafito, MS

includes
Individual Services Review: Quality of Behavioral Supports

by

Patrick Heick, Ph.D., BCBA-D, LABA, Team Leader
Alan Harchik, Ph.D., BCBA-D, LABA
Caroline Sherpa, MA, BCBA, LABA

Review of Crisis Services Through the Twenty-Second Review Period

I. Introduction and Overview

This is the twenty-second review period which is the eleventh annual study of the Commonwealth's statewide crisis services system. It is the eighth 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 fourth study in which I evaluated the status of documentation that DBHDS maintains to demonstrate its progress toward achieving the Agreement's twenty-one crisis services provisions and their twenty-nine associated compliance indicators. Overall, the crisis services provisions require the Commonwealth to:

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

The twentieth review period study of Virginia's crisis service system determined that Virginia could not be found to be in full compliance with the Crisis Services Provisions during the twentieth review period. DBHDS had not met all the outcomes of the Crisis Services Provisions as detailed in the Compliance Indicators (CI) most notably the expectation that crisis assessments would occur in community settings (*CI 7.8).* Other CIs that were not met based on a lack of outcome achievement included *CI 7.14* because DBHDS did not complete a gap analysis to identify how many licensed behaviorists are needed; *CI 7.18, 7.19, 7.20, 10.4/11.1, and 13.3.* DBHDS completed and submitted the process documents and the attestations confirming that the processes were reliable and valid. The processes for *7.5, 7.19, 8.6, and 8.7* were to be reviewed and verified in the twenty-second period. A summary of the status of the Process Documents and Attestations is portrayed in Table 3.

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

The Independent Reviewer and Expert Reviewer presented to the Commonwealth the draft plan for the review to be conducted this spring of the twenty-first and twenty-second review periods,

which is referred to as Year 8 throughout this report. This review includes an analysis and reporting of Virginia's status implementing all the 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 plan also includes two separate sub-studies that review the behavioral services provided for individuals with Support Intensity Scale (SIS) level 7 needs. These are the Qualitative Study of the Delivery of Therapeutic Consult Services and the Individual Services Review Study: Quality of Behavioral Supports.

The Independent Reviewer continues to be deeply concerned about the high number of individuals with DD whose initial crisis assessment occurs at hospitals rather than in the individuals' homes. In its Settlement Agreement Virginia promised that its mobile crisis teams "shall respond to individuals at their homes" and offer services "to de-escalate crises without removing individuals from their current placement whenever practicable." However, the standard practice of CSB Emergency Services prior to the Settlement Agreement of individuals being routinely removed from their homes to receive an assessment at a CSB office or at a hospital remains. While there has been a welcome decrease in the number and percentage of individuals hospitalized in this and the previous two reporting periods, during the pandemic, the number of individuals hospitalized is still a significant concern. At our recommendation during the twentieth period, the data are now specific to the outcome of crisis assessments by the location in which the assessment is conducted. We recommended these data be provided because we remained concerned that many individuals assessed at CSB Emergency Services (ES) offices or hospitals continue to be admitted to psychiatric hospitals rather than having their crisis de-escalated in their homes and being offered in-home supplemental supports or crisis stabilization services as alternatives to hospitalization and that a higher percentage of individuals assessed at a hospital or CSB would be hospitalized compared to individuals who were assessed for a crisis in the community.

DBHDS reported in the first quarter of Fiscal Year 2023 (FY23 Q1) that 60% of crisis assessments were conducted in hospitals or CSB Emergency Services (ES) settings and 40% of the assessments were conducted in the home or other community setting. The community crisis assessments resulted in 89% of the individuals retaining their setting; 5% served at a CTH; and only 5% hospitalized. Out of the 60% of the crisis assessments completed in the ED/ES setting only 54% of the individuals retained their setting, 3% were admitted to a CTH, and 37% were hospitalized. Completing assessments in the home and utilizing the other services required by the Settlement Agreement has clear and compelling benefits for the members of the target population. It continues to be is significant and troubling that most members of the target population are assessed at a hospital or CSB office, are hospitalized at a much higher rate, and are not provided the community crisis services required by the SA at the time of the crisis.

DBHDS reported in FY23 Q2 that 59% of crisis assessments were conducted in hospitals or CSB ES settings and 41% percent of these assessments were conducted in the home or other community setting. The community crisis assessments resulted in 93% of the individuals retaining their setting; 1% using a CTH; and only 5% hospitalized. Out of the 59% of the crisis assessments completed in the ED/ES setting only 58% of the individuals retained their setting; 3% were admitted to a CTH; and 33% were hospitalized. Although there are other factors, this

dynamic contributes to an increase in the number of children and adults with DD who are admitted to psychiatric hospitals in Virginia. During Year 8 27% of adults and 18% of children who were assessed for a crisis were hospitalized. In the Settlement Agreement, the Parties recognized the vital role of assessments at home in preventing unnecessary institutionalization. In 2019, having made little progress increasing the percentage of crisis assessments in individuals' homes, the Parties established the compliance indicator requirement expressed in *CI 7.8* that 86% of this population will receive the REACH crisis assessment in the home or other community (non-hospital/CSB) setting and be offered the other crisis support services in the Commonwealth's statewide crisis service system.

For this twenty-second period study, the Expert Reviewer reviewed the Quarterly REACH reports to determine the status of the Commonwealth's implementation of the required crisis support services and systemic changes needed to resolve the obstacles that have previously slowed progress toward achieving the required outcome measures of compliance. Both the Expert and Independent Reviewers understand that the protocol that was properly put in place during COVID to assure individual's safety and lessen the spread of COVID may have continued to result in fewer in-person crisis assessments at the individuals' homes in this review period. We hoped to see an increase of in-person work during this review period. The data described throughout this report confirms that Virginia is still relying heavily on telehealth for both crisis assessments and mobile crisis supports. The expert reviewer is not aware of any initiatives prioritized and implemented by the Commonwealth that has significantly increased the number and percentage of crisis assessments including the CSB ES workers in the individuals' homes.

This period's study also includes a review of the DBHDS standard crisis services reports regarding whether, and the extent to which, the Commonwealth continued to maintain the services in its statewide crisis services system that previously resulted in DBHDS achieving and sustaining compliance for two consecutive determinations. This review also included an analysis of the staff capacity of the REACH programs to both respond to crises and, when given the opportunity, to provide follow-up community-based 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 also engages in a quarterly qualitative review of each Region's crisis services implementation for both children and adults. The quarterly reports from each Region's quality review with DBHDS was reviewed for both children and adult crisis services. This is planned with the understanding that these quarterly qualitative reviews inform DBHDS of the quality of existing REACH services and contribute to DBHDS' understanding of the REACH teams' success meeting training requirements for staff; completing CEPPS; and training caregivers on the elements of the CEPP.

This consultant reviewed 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 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 sections below which identifies specific reports that were expected to be provided related to the CIs for crisis services.

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

The Independent Reviewer reported on the Commonwealth's success in complying with the provisions of the Settlement Agreement (SA) in the nineteenth and twentieth 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 twenty first and twenty second reporting periods, which includes data from FY22 Q4, FY23 Q1, FY23 Q2, and FY23 Q3. This is the eighth year this data has been compiled to compare data across years. Given the Commonwealth's continued compliance with the following provisions, and the focus in this review period of reviewing and analyzing data that demonstrates progress towards the agreed upon Compliance Indicators (CIs), I will summarize relevant data for Year 8 related to those Provisions which the Independent Reviewer has previously determined that Virginia has achieved and sustained compliance during at least two successive review periods. These findings will be reported in the initial part of this report. The second section of the report will provide information regarding the Commonwealth's progress towards meeting the requirements of the agreed upon CIs. Table 4: Crisis Services Compliance Indicator Achievements, provides a summary of the Commonwealth's achievement of CIs since the twentieth review period, and the status for this review period.

The completion of this study required us to review numerous documents and to conduct several interviews. We conducted five separate meetings with DBHDS staff. The first was the kickoff meeting with Heather Norton, Assistant Commissioner of Behavioral Health Services; Curt Gleeson, Assistant Commissioner of Crisis Services; William Howard, Director of Crisis Services; Nathan Habel, Project Manager, Eric Williams, Director of Professional Development; and two of the Regional Crisis Systems Managers: Denise Hall and Sharon Bonaventura. We attended two meetings with Nathan Habel to review the scoring of the BSPARI. We also interviewed Nathan Habel and Sharon Bonaventura to discuss *CIs 7.20* and conducted a second interview to discuss the process to spot check several CIs which are discussed later in this report. We interviewed Brandon Rodgers, Region V Crises Services Director to discuss the Commonwealth's 988 system. We interviewed Heather Norton and Sharon Bonaventura near the end of the review to clarify any questions we had about the information and data in various reports. We greatly appreciate the staff's willingness to schedule these interviews and more importantly to provide a wealth of data to guide us in our review and analysis. Significantly more documentation has been provided in this review period. All our requests for data have been responded to graciously and timely. The entire list of documents is included as Appendix 1.

II. Summary of Provisions

DBHDS has sustained compliance for the following provisions: III.C.6. b.i.A., III.C.6. b.i.B., III.C.6.b.ii.C, III.C.6.b.ii.D, III.C.6.b.ii.E., III.C.6.b.ii.H., III.C.6.b.iii.A., and III.C.6.b.iii.F. A short summary of the data relevant to each of these Provisions with a comparison to findings from Year 7 follows.

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

Children's Services-REACH continues to accept numerous referrals for both children and adults. There were 1,287 referrals for children in this period of which 478 (37%) were crisis referrals. This is a significant decrease (-13%) in referrals compared to Year 7 when REACH received 1,476 referrals for children of which 42% were crisis referrals. Referrals continue to be made by several referral sources. During this review period families and Case Managers (CM) referred 594 (46%) of the children and 530 (31%) 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. One hundred sixty-four (164) referrals were made on weekends or holidays, which is 13% of the referrals. Almost half of all the referrals (618) were made between 3PM and 7AM.

REACH also reports the total number of calls it receives which is more than the number of referrals. There was a total of 4,651 calls to the REACH children's programs, of which 1,034 (22%) were crisis calls. This is a significant decrease (-25%) from the 6,219 total calls received by REACH in Year 7 of which 1,089 (17%) were crisis calls.

Adult Services- There were 1,972 referrals for adults in this period of which 893 (45%) were crisis referrals. This is a consistent with Year 7 in the total number of referrals when there were 1971 referrals, and a slight increase in crisis calls of which 793 (40%) were crisis referrals in Year 7. Referrals continue to be made by several referral sources. During this review period families, residential providers and CMs referred 989 (50%) of the adults and 826 (42%) were referred by hospitals, CSB Emergency Services (ES) and law enforcement. REACH continues to offer crisis response 24 hours a day, 7 days a week as required. Three hundred four (304) referrals were made on weekends or holidays, which is 15% of the referrals. Half, 988, (50%) of all the referrals were made between 3PM and 7AM.

REACH also reports the total number of calls it receives which is more than the number of referrals. There was a total of 11,501 calls to the REACH adult programs, of which 1,785 (15%) were crisis calls. The number of total calls in Year 8 was less than in Year 7 when REACH received 15,515 total calls of which 2,067 (13%) crisis calls. Fewer crisis calls were received in Year 8 than were received in Year 7. Year 7 had far fewer overall calls then Year 6 (20,575) with 2663 (13%) crisis calls. The number of calls and the number of crisis calls continues to decrease, but the percentage of crisis calls has increased slightly.

The Commonwealth utilizes the nationally available 988 crisis call centers for all crisis referrals including from individuals and families who are eligible for REACH services. Each Region contracts with a 988 vendor and calls are directed to the CSB in each Region that operates the REACH program. DBHDS estimates that 10% of the crisis calls for individuals with DD are first received by 988 responders and dispatched to the REACH programs. DBHDS does not report the data separately but includes it in the quarterly reports regarding referrals to REACH for crisis assessment and response.

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 814 CMs and 338 ES staff in Year 8. In Year 7 REACH programs trained 833 CMs and 168 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. However, it is noteworthy that the number of ES staff trained more than doubled in Year 8.

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 8 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 1034 crisis calls involving children. Law Enforcement was involved responding with REACH staff to 248 (24%) children. This compares to Year 7 when law enforcement was involved with (28%) of the crisis calls.

Adult Services- REACH staff continue to work with law enforcement personnel to respond to individuals with DD who are in crisis. As reported above there were 1785 crisis calls involving adults. Law Enforcement was involved responding with REACH staff to 445 (25%) adults. This is a decrease in the percentage of crises in which law enforcement was involved in Year 7 when law enforcement was involved in 36% of the crisis calls.

Overall, the REACH programs trained 939 police officers in Year 8. This compares to Year 7 when REACH programs trained 839 police officers.

A significant number of adults who were in crisis were able to retain their home setting after the initial crisis response. Seven hundred ninety (790) or 44% did so without further assistance and another 394 (22%) retained their setting with REACH services, for a total of 1184 (66%) retaining their setting. The number of adults who were hospitalized after the crisis response was 475 (27%).

There were similar outcomes for children after the initial crisis response when 422 (41%) retained their home without further assistance and another 350 (34%) retained their setting with REACH services, for a total of 772 (74%) retained their setting. The number of children who were hospitalized after the crisis response was 187 (18%).

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 8 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 for mobile supports but does distinguish for preventative services.

Children's Services- In each Region, REACH provided individuals with in-home mobile support. The total number of children who received mobile support during Year 8 was 326, of which only 33 were children who were re-admitted. The range of mobile support was 0-15 days, and the average number of days ranged from 0-9 for children. In Year 8 there were four instances when the average days per case was fewer than three. This occurred consistently in Region I that only provided mobile supports in FY22Q2. The Region did not provide any mobile supports in the other three quarters for children. Region I also failed to provide mobile supports consistently in Year 7. A similar number of children statewide received mobile supports in Year 8 compared to Year 7 when 322 children received crisis mobile supports.

It is likely that several families went without needed crisis mobile supports in Region I because Region I did not provide any mobile crisis support for three of four quarters.. Although Region I children did not experience more hospitalizations during Year 8, the Region did have the most children who were new referrals who were hospitalized, which was 52 compared to the range in the other Regions of 14-46 for newly referred children.

Adult Services- In each Region, REACH provided individuals with in-home mobile support. A total of 435 adults received crisis mobile supports in Year 8. The range was 1-15 days, and the average number of days ranged from 2.5-11.4 for adults. In Year 8 there was only one instance when the average days per case was lower than three days which was in Region IV that averaged 2.5 days in FY22 Q4. Region III consistently provides the most average days per case, ranging from 6-11 days. The total number of adults who received mobile supports included 386 adults who were new referrals to REACH. Fewer adults received mobile supports in Year 8 compared to Year 7 when 466 adults participated in mobile supports. It is very concerning that Region I consistently provides mobile supports to the fewest number of adults in this reporting period. Until FY22 Q3, Region I provided mobile supports to only three or fewer adults in each of the

previous three quarters. While Region I did provide prevention services, the number of adults receiving this REACH service was the lowest of all Regions.

Later in this report I include a summary of staff vacancies in the REACH programs. The decline in the number of adults receiving mobile supports may be attributed to staff shortages. Data from DBHDS verifies that the staff vacancies for mobile workers totaled 26 (44%) in March 2023 in Regions II-V. Region I has no mobile workers but has their Coordinators provide mobile support. There is a 37% vacancy rate among Coordinator positions where 27 of 73 are unfilled. Region I has the highest vacancy rate for Coordinators with 13(76%) of 17 Coordinator positions vacant.

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

REACH continued to be unable to respond to all crisis referrals in person in Year 8. 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. Telephonic response continued to be used through FY23 Q3. There was no specific explanation given but it may be attributed staffing shortages and continued concerns about COVID exposure.

Children's Services- REACH staff responded to 601 of the 1034 (58%) crisis referrals in person. Only 39% of the crisis assessments were in-person in Year 7 so this notes an improvement. Of these face-to-face assessments, 547 (91%) were responded to within the required response time set for each Region. Once again Region III was able to conduct face-to-face assessment for the most individuals experiencing a crisis. Region III responded in person to 240 (40%) of the total number of crisis referrals that were responded to face-to-face across all five Regions. Region V responded to 153 (25%) of the crises responded to face-to-face and responded to all crises in person starting in FY23 Q3. There is no explanation for the variation across the regions in the number that has been responded to in-person versus telephonically.

DBHDS also reports on the location of the crisis assessments. The report derives its data from the location of the individual who was assessed for a crisis including all individual assessed for a crisis regardless of whether the response was in-person of telephonic. This total is 1034 children. Only 462 (45%) were conducted in a community location and 554 (54%) were conducted at the hospital or CSB ES. A higher percentage of assessments were conducted in community locations in Year 8 (45%) compared to Year 7 (36%). This data is not used to determine the Commonwealth's progress towards meeting *CI 7.8* that requires 86% of crisis assessments be conducted in community settings for individuals known to REACH. These data reported in the Quarterly REACH reports, includes crisis assessments done for all children and adults whether they are already known to REACH or a new referral. *CI 7.8* only requires community- based assessments for those individuals known to the system.

For the reporting purposes of responding to *CI 7.8* that requires 86% of crisis assessments to be performed in community locations for individuals known to REACH, DBHDS reports in its

Supplemental Crisis Report. These data are reported and discussed in a later section of this report.

Adult Services- REACH staff responded to 911 (51%) of the 1785 crisis referrals in-person in Year 8. Of these in-person assessments, 833 (91%) were responded to within the required response time set for each Region. As was true in Year 7, Region III completed the most in-person assessments of any region. Region III alone completed 363 (40%) of the 911 crisis assessments conducted in-person throughout the five Regions in Year 8. REACH staff responded to 887 (43%) of the crisis referrals in person in person in Year 7 so more responses were in person in Year 8. The timeliness of the in-person assessment response time, 833 (91%) is less than the 96% of crisis assessments responded to on time in Year 7. Prior to Year 6 the expectation was that the crisis assessment would be conducted in-person.

It is troubling that the combination of COVID restrictions in hospitals, family preference and staff vacancies continues to result in the REACH program responding to 49% of adults and 42% of children's' crises by telephone. This is contrary to the Settlement Agreement requirement that "crisis teams shall respond to individuals at their homes". DBHDS does not directly report how many crisis assessments were responded to by telephone, or by video phone but rather only reports the total number of crisis calls and the number responded to in-person. The Commonwealth does not report how many REACH staff are present for the assessment conducted at the hospital or in community settings. More crisis assessments were completed in-person in Year 8 compared to Year 7. It seems the in-person response would have increased more significantly in Year 8 since COVID is less of a health concern. DBHDS reports that REACH clinicians always respond in person if a Temporary Detention Order (TDO) is considered. However, some Regions did not respond in-person to all the crisis assessments that occurred in hospitals. Region I did not respond to any in-person assessments at hospitals in either FY22 Q1 for adults, or in FY22 Q4, FY23 Q1 or Q3 for children. Region III, as mentioned, consistently conducts the highest percentage of in-person assessments. Region V responded to all crisis in -person by FY23 Q3 for both children and adults. The Commonwealth did not explain the wide variation across the Regions of the number and percentages of assessments completed onsite versus telephonically.

This provision contains the expectation that crisis assessments are conducted onsite rather than telephonically. DBHDS staff report that they have researched the success of telephonic responses to crises in establishing the 988 crisis call centers. As noted above this accounts for only 10% of referrals to REACH and it is still the REACH staff who respond. However, in-person onsite assessments have been required since the beginning of the Agreement in 2012 and individuals with DD in the Commonwealth are still experiencing high rates of hospitalizations after crisis assessments. The significant decrease onsite responses to complete the crisis assessment may indicate the Commonwealth is no longer complying with this Provision. Telephonic responses to crisis calls are contrary to the Commonwealth's commitments to Virginians with DD and their families. As soon as Virginia's declared Public Health Emergency ends, which is currently scheduled for May 11, 2023, only in-person on-site responses will comply with the requirements of the Settlement Agreement. The extent of the Commonwealth's adherence to in-person on-site responses should be studied during the 23rd Period

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. The total number of adults assessed is 1,785. In Year 8 only 581 (32%) of the crisis assessments were conducted in a community location. Most of the crisis assessments were conducted at the hospital (1033), CSB ES (130) and police stations (31), resulting in 67% of the crisis assessments being performed in other than community locations. In Year 7 only 645 (31%) of the crisis assessments were conducted in a community location. Alternatively, 1,365 (66%) were conducted at the hospital (1,212) or the CSB ES (153). There was a comparable percentage of assessments completed in community locations in Year 6.

The Commonwealth has developed its 988-crisis response system and provided data on the number of calls received. To date, these calls are not separated for different populations, including individuals with DD. The Commonwealth's decision to change its crisis response system, does not change the requirements of the Settlement Agreement and the associated compliance indicators. REACH staff will continue to respond to individuals with DD. DBHDS has conducted research on the use of similar call centers and based on national best practices and data anticipates that 80% of the crises can be resolved by the call center. DBHDS has contracted with two providers. PRS, Inc. service Regions I, II, IV and V. Frontier Behavioral Health supports Region III. Both providers are certified by the National Suicide Prevention Lifeline. No data has been provided to support the contention that crises for individuals with DD will be successfully resolved telephonically.

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

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

Children's Services- The Commonwealth now has two Crisis Therapeutic Homes (CTHs) serving children. One home is operated by Region II and serves children in Region I and II. The second home is in Region IV and serves Regions III, IV and V. Neither CTH was able to operate at full capacity during this reporting period. The Region II CTH closed twice briefly due to COVID and physical plant issues and the Region IV CTH closed at various times because of staffing shortages and once because of COVID. A total of 89 children used the two CTHs in Year 8 compared to 143 children who used the two CTHs in Year 7. In Year 8 these admissions included 46 (52%) for stabilization; 27 (30%) for prevention; 12 (13%) for stepdown; and 4 children (5%) who were readmitted. The average Lengths of Stay (LOS) were under twelve days for all types of admission. The utilization of the CTH beds was only 23%, compared to 34% in Year 7 for the Region II program and 13%, compared to 27% in Year 7 for the Region IV program. Utilization was impacted by COVID restrictions during both years. The decline in utilizations during Year 8 was primarily due to staffing shortages. This is the fewest number of children who have had access to the CTH program since Year 5. In Year 6, the first year of the COVID pandemic, 108 children used the CTH programs.

It was noted in Year 7 that the CTHs were used very infrequently by Regions I, III and V. In that period children from Regions II and IV accounted for 78% of the referrals in FY22 Q2 and 93% of the referrals in FY22 Q3. In Year 8 DBHDS reports sixteen children from Regions I, III, of V using the CTHs. Yet, a total of ninety-one children from these three Regions were hospitalized during Year 8. DBHDS should determine if the goal to provide viable access to and provide all children in the Commonwealth an alternative to being hospitalized by operating only two CTHs is being met.

Adult Services- The Commonwealth continues to operate five CTHs for adults with co-occurring conditions. All were in operation during Year 8 and served a total of 164 adults compared to Year 7 when 233 adults were served. The purposes for these admissions include 82 (50%) for stabilization; 27 (17%) for prevention; 52 (33%) for stepdown; and 3 (2%) who were readmitted. The average Lengths of Stay (LOS) were under 23 days for all types of admission (compared to 35 days in Year 7) and averaged between 4 and 22.5 days. The utilization of the CTH beds averaged 21% across the five CTHs and ranged from 3-35%. Region IV had the highest utilization and served the most individuals as was true in Year 7. It is concerning that fewer adults were served more than two years past the start of the COVID pandemic. In Year 7 CTH utilization averaged 39% which declined to 21% in the current year, Year 8. This very significant 46% utilization decline (i.e., from 39 to 21%) appears to be attributable to staffing shortages. This is not surprising given the 33 (25%) staff vacancies among the 130 positions assigned to the CTHs in the Adult REACH programs. The 25% staff vacancy rate and the resulting 46% decline in utilization of the CTH's has reduced the number of adults with IDD who were able to utilize the CTH programs across Virginia.

The average LOS across the four quarters of Year 8 ranges from 4-22.5 days. The actual LOS for some individuals is longer than the expected thirty days. DBHDS reports in detail about the LOS for individuals whose stay continues from one quarter to the next. There were nine individuals in FY22 Q4; ten in FY23 Q1; five in FY22 Q2; and eight in FY21 Q3 in this category, for a total of thirty-two adults whose length of stay was more than thirty days. Of all these adults whose stays crossed over from one quarter to the next, eighteen stayed at the CTH longer than sixty days. We conjectured in Year 7 that the availability of the Adult Transition Homes is having a positive impact by reducing the number of excessive LOS in the CTHs, and that the availability of this alternative should allow the CTHs to accept more referrals as beds are more readily available. However, given low utilization and staff vacancies resulting in fewer adults using the CTHs, and the fewer remaining more than thirty days may be attributable to less availability and reduced staffing capacity of the CTH programs.

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

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

Hospitalizations

The Commonwealth's purpose in creating and enhancing the statewide crisis services system 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 8 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 288 of whom 177 (61%) are considered new referrals and 111 (3%) are children who are active with REACH. Fewer children were hospitalized in Year 8 (288) compared to Year 7 when 299 children were admitted to a psychiatric hospital. This decline is a 4% decrease in hospitalizations for children. There was also a decline in hospitalizations of 19% between Years 6 and 7 which is a positive trend.

DBHDS also reports on the number of children who were hospitalized as an outcome of the crisis assessment which is a portion of the total number of children hospitalized (288). This number is 187 which represents 18% of the children who had a crisis assessment in Year 8. This number compares favorably to the number of children hospitalized as the outcome of a crisis assessment in Year 7 when 240 (22%) of children who had a crisis assessment were hospitalized.

Adults: DBHDS reports the total number of adults who were hospitalized during this reporting period. The total was 603 of whom 278 (46%) are individuals known to REACH and 328 (54%) who were individuals who were newly referred. In Year 7 the total was 689 of whom 348 (51 %) were new referrals and 341 (49%) were adults who are active with REACH. The number of hospitalizations decreased in Year 8 compared to Year 7. Year 7 saw a reduction in hospitalizations from Years 5 and 6. The continued trend in fewer hospitalizations in Year 8 is positive, especially considering the reduced capacity of the CTHs for adults and less mobile support being offered.

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 (603). This number is 475 which represents 27% of the individuals who had a crisis assessment. This number compares favorably to Year 7 when 584 (28%) of individuals assessed for a crisis were hospitalized. The overall decrease in hospital admissions for adults is correlates with the number of adults who were assessed for a crisis.

The value of offering home and community-based crisis services that are designed for individuals with IDD continues to be validated. DBHDS reports on the dispositions for individuals who received either mobile crisis or prevention services and their dispositions after receiving these supports. These supports were provided to a total of 2433 children in Year 8 compared to 2166 children in Year 7, which is a 12% increase. Only 51 (2%) of children who received mobile supports were hospitalized after these mobile supports ended. Most of these children retained their setting: 2174 (89%) children remained home. DBHDS reports that of the 92 children in Year 8 compared to the 154 children who used the CTH in Year 7. Of the 89 children whose stays did not continue over a quarter, only 4 (4%) were hospitalized after being discharged from the CTH and 62 (67%) retained their setting while a new community residence was found for 20 (22%) of the children.

In year 8, crisis services were provided to 3,331 adults, which is 593 fewer adults than the number who received these crisis supports in Year 7 (3,924). Only 163 (5%) of these adults who

received mobile, or prevention services were hospitalized after receiving home and community-based crisis supports. Most of these adults retained their setting: 2,662 (80%) remained in their existing residence compared to 3,359 (86%) in Year 7. DBHDS reports that of the 197 adults who used the CTH program, only 16 (8%) were hospitalized after leaving the CTH. This number differs from the total number of adults who are reported as using the CTH which was 164 but the 164 does not include adults who had a continued stay over a quarter. Many adults retain their setting, 80 (40%) or transition to a community residence, 46 (23%).

Fewer adults using mobile, or prevention services retained their settings in Year 8 when 80% retained their setting compared to 86% in Year 7. A similar number and percentage of adults using the CTH in Year 8 retained their setting or transitioned to a new community residential setting compared to Year 7 when 41% retained their setting and 22% transitioned to a new community residence. These outcomes are more favorable than the outcomes for adults who were hospitalized. DBHDS reports dispositions for 688 adults hospitalized (a larger number then the 603 reported as hospitalized). For this cohort, only 42% retained their setting; 20% retained their setting with REACH but 25% remained hospitalized.

The Parties have agreed to the importance of conducting crisis assessments in the individual's home or other community location. A Compliance Indicator has been developed that sets the expectation that 86% of individuals who experience a crisis will be assessed for that crisis in the community setting in which the crisis occurs. The parties agreed to this requirement with the expectation that fewer individuals will be hospitalized when crisis assessments occur in the home and needed community supports are immediately identified and provided to stabilize the crisis for the individual. The data reported earlier supports this contention. This more detailed outcome data may assist the Expert Reviewer, Independent Reviewer and Parties to determine how consequential the location of the assessment is to whether the individual can remain in the community safely. Since REACH staff are now completing many crisis assessment by video feed, it will also be useful to gather and analyze data that reflects the outcome of these assessments compared to those assessments that are conducted by the REACH staff in person.

REACH STAFFING

The accomplishments of the REACH teams must be reviewed within the context of staff capacity and availability. Nationally providers of services to support individuals with DD have struggled to retain and recruit staff, especially since the beginning of the COVID pandemic. The REACH program has experienced similar difficulties maintaining its workforce. DBHDS reported on the filled and vacant positions for all five of the REACH programs in March 2023 to reflect the status of the REACH positions during FY23 Q2. Staff vacancies statewide for REACH community services ranges from 16% for supervisory and clinical positions to 44% for staff who provide mobile crisis response. Region V has the highest percentage of vacancies for supervisory/clinical and coordinator positions, while Region III has the highest percentage of vacancies for its mobile crisis staff. The Children's CTH programs and the ATH programs have fewer staff vacancies, compared to the Adult CTH program. The CTH Program for Adults is experiencing a 25% vacancy rate statewide with Region III the most significantly impacted with 32% of its positions vacant.

It is deeply concerning that Region I has no Mobile Crisis staff, but rather use Coordinators to provide mobile crisis support. As there are significant vacancies in Region I for Coordinators, the capacity to offer mobile crisis supports to Region I families is severely limited.

The following Tables depicts the data.

Table 1: FY23 Annual REACH Staffing Data for REACH Crisis Teams

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Supervisory/clinical filled	7	12	16	29	12	**71**
Supervisory/clinical vacant	0	0	5	2	1	**14**
Total	7	12	21	31	13	**85**
Percent Vacant	0%	0%	24%	6%	8%	**16%**
er						
Coordinator filled	4	13	6	12	0	**46**
Coordinator vacant	13	7	6	2	0	**27**
Total	17	20	12	14	0	**73**
Percent Vacant	76%	35%	50%	14%		**37%**
Mobile filled	0	6	9	4	15	**33**
Mobile vacant	0	2	18	2	11	**26**
Total	0	8	27	6	26	**59**
Percent Vacant		25%	67%	33%	42%	**44%**

- R1 eliminated 5 supervisory positions since FY22
- RII eliminated 9 supervisory positions since FY22
- R3 added 5 supervisory/clinical, 2 Coordinators and 7 mobile staff
- R4 added 6 clinicians and 2 coordinators and lost 9 mobile staff
- R5 added 2 clinicians and 17 mobile staff

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

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Adult CTH filled	9	23	21	23	21	**97**
Adult CTH vacant	9	5	10	3	6	**33**
Total	18	28	31	26	27	**130**
Percent Vacant	50%	18%	32%	12%	22%	**25%**
Children's CTH filled		13		25		**38**
Children's CTH vacant		4		4		**8**
Total		17		29		**46**
Percent Vacant		24%		8%		**17%**
ATH Filled		12		23		**35**

ATH Vacant		3		5		**8**
Total		15		28		**43**
Percentage Vacant		20%		18%		**19%**

- R1 has the same number of CTH staff that it had in FY22
- R2 added 2 Adult CTH staff since FY22
- R3 added 11 Adult CTH staff since FY22
- R4 added 14 Adult CTH staff, 16 Children CTH staff and 14 ATH staff since FY22
- R5 added 8 CTH staff since FY22

III. Compliance Indicators Related to Crisis Services

The focus of this review period is to gather facts, analyze and determine the Commonwealth's progress towards achieving the Compliance Indicators related to the provision of crisis services. These indicators relate to SA Provisions: III.C.6.a.i-iii, III.C.6.b.i.A-B; III.C.6.b.ii.A-H, III.C.6.b.iii.A-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 in Table 2: Crisis Services Compliance Indicator Achievements. Our review of these CIs is summarized by facts, analyses, and conclusions. **Facts i**nclude a summary of the DBHDs report of the documents and data used to determine the status of achieving the expected outcomes and requirements. The **Analysis** section provides a summary of findings related to the review of the 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.

DBHDS produces many reports to address the metrics and outcomes for each CI. The reports that address the CIs are as follows:

1. REACH Crisis Services Quarterly Reports address *CIs 8.5, 10.1, 13.1, and 13.3.*
2. REACH Quarterly Qualitative Reviews address *CI 8.2.*
3. Performance Contracts between DBHDS and the CSBs address *CIs 7.2, 7.3 and 7.9.*
4. The Supplemental Crisis Report (quarterly) addresses *CIs 7.4, 7.5, 7.6, 7.7, 7.8, 7.10, 7.11, 7.12, 7.13, 7.21, 7.22, 7.23, 8.3, 8.4, 8.6, 8.7, 10.2, 10.3, 10.4, 11.1.*
5. The Behavioral Supports Report (semiannual) addresses *CIs 7.14, 7.15, 7.16, 7.17, 7.18, 7.19, 7,20.*
6. The ATH Utilization and Disposition Report 22nd Period addresses *CI 13.2.*

The determination of the reliability and validity of the data sources is summarized in Table 3: Crisis Services Data Integrity Documents. The majority of the data sources were validated in the eighteenth and twentieth review periods. We reviewed the process documents and data validity and reliability for the following CIs in the twenty-second review period: CIs *7.5, 7.19, 8.6 and 8.7.* The Attestations which were shared in March 2023 and revisions to some processes address the issues of concern that we noted in the twentieth period report. DBHDS Process Documents (PD) for Crisis Services were for the most part extremely comprehensive in Year 7. We previously made some recommendations in the Year 6 report which were considered by DBHDS and

generally used. Therefore, we do not reanalyze the processes already confirmed as comprehensive unless there was a significant issue to note.

DBHDS has produced a PD for every CI for crisis services that requires a process to review and validate the data. Each PD includes the following elements: Purpose, Scope, Document Management, Roles, and Responsibilities of staff who enter or analyze data; inputs and outputs; dates and descriptions of any changes and the author; data sources; process steps; DQV recommendations (if any); data source verification; CQI, and a Glossary of Terms. We find that the process steps are clearly written and thoroughly describe the steps to be taken to review and confirm data related to the achievement of the CIs.

We conclude that all the processes that have been designed for the Crisis Services CIs, now include sufficient cross checks and methods for inter-rater reliability to adjust for any problems in data sources. This determination was supported by the Expert Reviewers' validation study completed in this review period which used the exact same processes used by DBHDS staff. During this review period we reviewed the DBHDS processes for *CIs 7.5,7.19, 8.6,* and *8.7.* We also reviewed the attestation for *CI 7.20* which was not available in the twentieth review period. We report on the process review and conclusion for *CI 7.5 and CI 7.19***,** the attestation for *CI 7.20 and the results of the Validation Study for CIs 8.6 and 8.7* under the summary for those CIs below.

Table 3
Crisis Services Data Integrity Documents

CI	Process Control Document	Data Set Attestation
7.1	N/A	N/A
7.2	N/A	N/A
7.3	N/A	N/A
7.4	N/A	N/A
7.5	YES*	YES
7.6	N/A	N/A
7.7	YES	YES
7.8	YES	YES
7.9	N/A	N/A
7.10	YES	YES
7.11	N/A	N/A
7.12	YES	YES
7.13	YES	YES
7.14	YES	YES
7.15	N/A	N/A
7.16	N/A	N/A
7.17	N/A	N/A
7.18	YES	YES
7.19	YES*	YES
7.20	YES	YES
7.21	YES	YES
7.22	YES	YES
7.23	YES	YES

8.1	N/A	N/A
8.2	N/A	N/A
8.3	YES	YES
8.4	YES	YES
8.5	YES	YES
8.6	YES*	YES*
8.7	YES*	YES*
10.1	N/A	N/A
10.2	YES	YES
10.3	YES	YES
10.4/11/1	YES	YES
13.1	N/A	N/A
13.2	N/A	N/A
13.3	N/A	N/A

*Data Validation in 22nd Period

Summary of Findings for all Crisis Services CIs

The following seventeen CIs were found to be met consecutively in Years 6, 7 and 8: *7.2, 7.3, 7.4, 7.9, 7.10, 7.11, 7.16, 7.17, 7.23, 8.2, 8.6, 8.7, 10.1, 10.2, 10.3, 13.1, and 13.2.*

The following eleven CIs were for the first time met consecutively in Years 7 and 8: *7.5, 7.6, 7.7, 7.12, 7.13, 7.15, 7.21, 7.22, 8.1, 8.3, and 8.5.*

The following three CIs were met in Year 8: *7.14, 7.20 and 13.3.*

The Commonwealth was found not to have met six CIs in Year 8: *7.8, 7.18, 7.19,, 8.4, 10.4, or 11.1.Only 8.4 was met previously.*

DBHDS has met the requirements of thirty-one CIs in Year 8, compared to twenty-nine CIs in Year 7. Six CIs remain not met in Year 8 compared to eight CIs in Year 7.

The facts, analysis and conclusions are summarized in Table 4: Crisis Services Compliance Indicator Achievements below. Following Table 4, I include more detail about specific CIs to provide the reader with a greater understanding of some of the more complex Indicators.

Table 4
Crisis Services Compliance Indicator Achievements

SA Provision- III.C.6.a.i-iii: The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall: i. Provide timely and accessible support; ii. Provide services focused on crisis prevention and proactive planning; iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the induvial from his or her current placement whenever practicable.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**20**	**22**
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.	The CSB performance contracts continue to require the CSBs to identify children and adults who are at risk for crisis and refer the individuals screened to be at risk to REACH. This was evidenced in the FY22-23 Performance Contract, Exhibit M.	This CI continues to be Met and will not need further review.	**Met**	**Met**
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.	The CSB performance contracts continue to require the CSBs to identify children and adults who are at risk for crisis and refer the individuals screened to be at risk to REACH. This was evidenced in the FY22-23 Performance Contract, Exhibit M.	This CI continues to be Met and will not need further review.	**Met**	**Met**
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.	Met in the 18th review period and has maintained the criteria through the 22nd period.	This CI continues to be Met. The CSBs continue to use the required criteria.	**Met**	**Met**
7.5	DBHDS will ensure that all CSB Executive	DBHDS reports that through FY23 Q1 4,108	This CI has now been Met for two consecutive	**Met**	**Met**

	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.	CSB/BHA staff completed the training, which is an increase of 538 staff trained since the last report. This number increased to 4,434 CSB/BHA staff who completed the training as of 3/31/23.	reporting periods.		
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.	The CSB performance contracts continue to require the CSBs to train newly hired CMs within six months of hire. This was evidenced in the FY22-23 Performance Contract, Exhibit M. 78% of the staff completed the training within 182 days of hire since 7/1/20 through FY22 Q3 and 88% of all staff completed the training regardless of how long it took to complete it.	DBHDS has consistently reported on the number of staff trained. In this reporting period they revised the process to collect and report the number of newly hired CMs and intake workers to ensure accurate reporting for the time period in which newly hired staff are trained. This CI has now been met for two consecutive review periods.	**Met**	**Met**
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.	DBHDS continues to conduct a quality review process annually as reported in the Supplemental Crisis Report. The scoring integrity was 99% and the referral integrity was 100% for all reports through FY23 Q2. This report is completed	This CI has again been Met and for two first time, been met in two consecutive review periods.	**Met**	**Met**

		annually			
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).	The following was reported for the percentages of individuals who had a crisis assessment conducted in community settings: FY22 Q4: 37% Range: 20% R1 to 55% R3 FY23 Q1: 44% Range: 0% R1 to 57% R3 FY23 Q2: 49% Range: 21% R1 to 62% R5 FY23 Q4 37% Range: 19% R1 to 50% R3	This is discussed in greater detail in the body of the report but only 42% of all children and adults known to REACH received their crisis assessment in the home or community setting to de-escalate the crisis where it occurred. While the percentage was slightly increasing from FY22 Q4 to FY23 Q2, it then dropped again in FY23 Q3. Since a higher percentage of individuals are hospitalized when the assessment occurs at either the CSB-ES office or hospital this remains a significant concern. These data are described in the report.	**Not Met**	**Not Met**
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.	DBHDS continues to meet this CI. DBHDS issued a policy 7/22 to update this requirement titled: Collaborative Discharge Requirements for CSBs and State Hospitals for Adult and Geriatric Services and one for Child and Adolescent Services. Training is required in the CSB performance contracts and continues to be provided to the Social Workers at the hospitals.	This CI has continued to provide this directive and training and has again Met this indicator.	**Met**	**Met**
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	The Directors of Community Support Services consistently notified the REACH Director or designee of admissions for follow up.	DBHDS has continued to meet the requirements of this CI.	**Met**	**Met**

	follow up.				
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.	DBHDS Assistant Commissioner of Crisis Services sent a letter to the VA Hospital and Healthcare Association (VHHA) on 3/3/23 requiring direct notification to REACH when a CSB is not directly involved with the individual.	DBHDS has continued to request and encourage private psychiatric hospitals as required and CI continues to meet this indicator.	**Met**	**Met**
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.	The Commonwealth tracks admissions to state-operated and private psychiatric hospitals to determine if a referral has been made to REACH.	The Commonwealth is tracking admissions and referrals which did not meet the requirements of the CI for two of the four quarters. DBHDS has implemented improvement strategies to confirm the hospitals responsibilities to make these referrals in a timely way.	**Met**	**Met**
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.	DBHDS reports the following percentages of children and adults who were hospitalized and referred to REACH within 72 Hours: FY22 Q4 95% FY23 Q1 92% FY23 Q2 92% FY23 Q3 96%	Overall DBHDS achieved this indicator for the most recent quarter and for two of the previous four quarters. It has maintained the processes to ensure that state-operated hospitals nearly always refer promptly.	**Met**	**Met**
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	DBHDS continues to exceed the goals and measures to increase the number of PBSFs and LBAs in the 22nd period. The baseline in FY16 was 821 qualified behaviorists, either PBSFs, LBAs, or LABAs. In Fy22 DBHDS reported 2275 behaviorists. This number	The gap analysis identifies the percentage of individuals who are not connected to a behaviorist by Region as follows: Region 1: 17-20% Region 2: 18-29% Region 3: 5-14% Region 4: 18-34% Region 5: 16-27%	**Not Met**	**Met**

	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.	increased to 2604 by FY23 Q1 which is a 217% increase over the baseline. The increase by FY23 Q3 was 198 for a total of 2802. DBHDS completed a thorough gap analysis this review period.	The focus of its future development will be for Regions 2,4, and 5. A summary is contained in the narrative of this report.		
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.	Met in the 20th review period. The practice guidelines provided and are being used by behavioral consultants to design programs	This CI continues to be Met and has been Met for consecutive review periods.	**Met**	**Met**
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.	Training is offered and documented through the Commonwealth of Virginia's Learning Management System. During the 20th review period 755 CMs and Supervisors were trained through 2/22. As of 9/22 a total of 901 CMs and Supervisors have been trained. This increased to 979 as of March 2023.	DBHDS has met this indicator for three consecutive review periods.	**Met**	**Met**
7.17	The permanent DD waiver regulations will include expectations for behavioral programming and the structure of behavioral plans.	Met in the 18th period. No further review is necessary.	This CI continues to be Met.	**Met**	**Met**
7.18	Within one year of the effective date of the permanent DD Waiver	543 individuals were authorized for TC (behavioral supports)	Overall, only 1,020 (68%) of the children and adults who were	**Not Met**	**Not Met**

	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.	between 4/-7/22. Of these individuals 358 (66%) were connected to a behaviorist within 30 days. The average number of days for this connection was 68 (April), 59 (May), 71 (June), and 59 (July). DBHDS reported in the FY22 Q3 report that 69% of individuals were connected to a behaviorist within 30 days. The total number of individuals connected within 30 days was 662 of 966. The range across the Regions was 55% in Region 2 to 81% in Region 3 within 30 days. Overall, at the time of the FY23 Q3 report, only 75% of individuals who needed a behaviorist were connected to one at all.	identified for TC were connected to a TC provider within 30 days.		
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	DBHDS established its Behavioral Support Program Adherence Review Instrument (BSPARI) to determine whether the four elements of behavioral supports were received. DBHDS reported in the Behavior Supplemental report for FY23 Q3 that 178 behavior plans, and related documentation were reviewed for individuals with annual authorizations since mid FY22 Q3. Of these, 136 (76%) contained all four components of the CI 7.19 requirements.	The DBHDS Program Manager and the Expert Reviewers agreed to the minimum elements of the BSPARI that needed to be present for a determination that all four requirements of 7.19 were met. This review determined that the DBHDS monitoring process was effectively implemented and was sufficient to identify that individuals received the four required elements. DBHDS reviewed 178 BSPARIs using acceptable criteria for a minimally adequate	**Not Met**	**Not Met**

	Team determines that the Therapeutic Consultation Service is no longer needed.		behavior program and only found that 76% contained all four elements.		
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	DBHDS reported on its quality review and improvement (QI) process for FY22 in the Behavior Supplemental Report. The QI process tracks the authorizations for the number of children and adults needing behavioral services and the number of children and adults receiving behavioral services. 1) DBHDS reports that 1075 children and adults had an identified need for TC, of whom 624 (58%) received TC during Year 7. (note: this number is slightly different from the number reported under &.18 because the reporting timeframes are not aligned.) DBHDS has designed a variety of strategies to increase the number of individuals connected to a provider within 30 days. 2) For FY23 Q1 DBHDS reported that 154 individuals were hospitalized and did not have TC accepted REACH services. Nine of these individuals could have been diverted from the hospitalization if the CTH was available; however, seven refused	This review verified that DBHDS has implemented a QI process that tracks and assesses for the five items listed and has Met this indicator. a 1) DBHDS compares the number needing the service to the number receiving the service (not just those authorized). For all of the reporting period 624 (58%) of the 1,075 received the TC services that were authorized for them, and 451 (42%) did not receive the authorized services. This requirement is achieved because DBHD compared authorizations to services received. 2) DBHDS tracks , determines and reports the number of children and adults who could have been diverted. In Year 8, those who could have been, but were not, diverted were primarily due to staffing shortage at the CTH although many families refused the CTH option. 3) DBHDS provides a confidential addendum of the reasons for	**Not Met**	**Met**

	implemented.	the CTH option had it been available. Thirteen individuals who had TC and who were hospitalized accepted REACH services. For FY23 Q2, DBHDS reported that 138 individuals who were hospitalized and did not have TC accepted REACH. Four of these individuals could have been diverted from the hospitalization if the CTH was available; however, all refused the CTH option had it been available. Thirteen individuals in FY23 Q1 and seventeen in FY23 Q2 who had TC and who were hospitalized accepted REACH services. 3) DBHDS reports on the reasons the 21 individuals with TC and REACH services were still hospitalized. The reasons include suicidality, severe aggression and property destruction, police involvement because of uncontrolled aggression, serious self-injurious behavior, and voluntary admission. 4) DBHDS implements the BSPARI review which determines if behaviorists are adhering to expected practice.	hospitalization and gives a justification for each of the individuals who were hospitalized. These explanations indicate the need for hospitalization despite the availability of REACH services. DBHDS achieved this requirement. 4) DBHDS's review through FY23 Q1 summarizes its review of 150 BSPARIs. The total score for an approved BSPARI is 40 points when all of the practice guidelines are met. DBHDS expects 75% will score at least 30 points and 85% will score at least 34 points. In this period 61% achieved at least 30 points (91 of 150) and 39% achieved 34 of 40 points (59 of 150)/ The percentage of BSPARIs that reflect the DBHDS expectations increased by 13% from mid FY22 Q3 through FY23 Q1. DBHDS reviewed and reported on an additional 94 BSPARIs in FY23 Q3. In this period 72% achieved at least 30 points (68 of 94) and 47% (44 of 94) scored at least 34 points. DBHDS conducted a total of 244 BSPARI reviews from mid FY22 Q3 through FY23 Q3.		

		The Individual Services Review Study: Quality of Behavioral Supports (see Attachment 3 for full study) examined the DBHDS BSPARI tool and its monitoring and feedback process to determine whether these components of the quality review and improvement process were sufficient. 5) DBHDS determined that 61% of the 150 behavior programs that it reviewed from FY22 Q3-FY23 Q1 were scored correctly by the CM completing the OSVT. Of the 94 BSPARI reviews that it conducted in FY23 Q2 and Q3, 64 % were scored correctly.	The Individual Services Review Study: Quality of Behavioral Supports (ISR-Behavioral Supports) found that the overall percentage agreement across the 25 sampled individuals ranged from 60% to 90%, with a mean of 77%, median of 75%, and mode of 81%. The DBHDS reviewers have provided direct feedback to 90% of the providers since the review process started which includes 344 reviews and feedback to 310 providers. The ISR Behavioral Supports study verified that the quality of FBAs and BSPs provided by behavioral consultants has improved since DBHDS revised its BSPARI assessment and feedback process. The DBHDS monitoring and feedback process demonstrate that it has achieved the requirement to assess whether behavioral services are adhering to the practice guidelines and that it has utilized its findings for performance improvement. 5) DBHDS also assessed whether CMs were properly implementing		

			the On-Site Visit Tool in their reviews of appropriate behavior services. DBHDS found that the OSVTs were scored correctly by the CM for 62% of the total 244 BSPARI reviews during the entire review period. This differs from the findings of the qualitative study for *CI 7.19 and 7.20 (5)* which found the OSVT to be scored correctly for 82% of the 100 individuals in the its sample. However, the sample for our study may have not reflected the cohort. Our sample included OSVTs for all 100 individuals, whereas DBHDS reports they did not have OSVTs for all of the 244 BSPARIs they reviewed. DBHDS has achieved this indicators requirement to review the OSVTs and provide feedback to the CSBs when an OSVT is done incorrectly or not submitted.		
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	DBHDS's quality review process reports semiannually on these elements. In the first report for the 22nd review period but covering FY22 Q3 and Q4, the report included the following: a) 305 children and adults need in-home services. b) 305 have these services identified in their ISP and are authorized to receive these services	This study verified that DBHDS implements a quality review process that tracks the data required by this CI. While it is very unfortunate that children and adults actually receive few of the hours authorized, the requirements of this CI are Met.	**Met**	**Met**

	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.	c) 305 (100%) had approved authorizations. The second report includes data from FY23 Q1 and Q2: a) 319 children and adult need in home service b) 319 receive at least some level of services identified in the ISP. c) 313 (98%) had approved authorizations.			
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	DBHDS reported that of 170 families contacted only 49 responded to a telephone inquiry for FY22 Q3/ Q4. Of the 178 families contacted during FY23 Q1/Q2, 72 (40%) responded and reported: • received some level of service (100%) • experienced staffing turnover and inadequate training of staff 51%/37% • were satisfied 22%/63% • that there were no safety concerns or risks	DBHDS received feedback from only 121 families who responded to the telephone inquiry 120% of the families who were authorized for these services (618 for Year 8). Families report concerns with rate of pay, hiring and onboarding staff. DBHDS did report on the review of billing data for FYQ1/Q2 which would confirm the number of authorized hours that were received. Overall, only 14 (5%) individuals received more than 90% of their authorized hours; 52 (18%) individuals received 83-90% of their authorized hours; and 81 (28%) received fewer than 30% of their authorized hours	**Met**	**Met**

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.	DBHDS did report their analysis of the staffing concerns families brought to their attention and the actions they have taken to address these concerns including rate increases and access to online rather than in-person training,	DBHDS did analyze the utilization data or utilize family feedback to make determinations of enhancements to improve the service delivery system.	**Met**	**Met**

SA Provision- III.C.6.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.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**20**	**22**
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.	DBHDS produces its assessments in reports that analyze the REACH data submitted by the Regions. All three requirements are monitored by DBHDS.	DBHDS has achieved this indicator by conducting and reporting on its semi annual assessments of the three requirements CIs 8.2 and 8.3 are Met. CI 8.4 is Not Met in terms of the 15-day requirement for the development of CEPPs CI 8.5 is Met. Only 81% of the CEPPs in Year 7 were completed within 15 days.	**Met**	**Met**
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	DBHDS shared the summaries of the REACH Quarterly Qualitative Reviews for all of the reporting period. Each region had semiannual reviews that addressed performance contract expectations which includes training.	DBHDS has met the requirements of this indicator. All Regions consistently achieved the expectations for training. DBHDS selects a topic to focus on with REACH teams for each	**Met**	**Met**

	managing the REACH unit.	The focus of the FY23 Q2 quality review was on the training standards including onboarding and continuing education.	quarter and holds individual meetings with each Region four times a year. FY22 Q4 focused on the integration of the REACH crisis response system with the Virginia's crisis response changes; FY22 Q1 reviews stressed the expectation that REACH teams would return to face-to-face crisis assessments, and discussed the use of telehealth as part of mobile support. FY22 Q2 reviews focused on the training standards and the focus of the FY22 Q3 reviews was a review of each Region's QA/QI processes to identify best practices for replication. DBHDS continues to meet the requirements of this indicator.		
8.3	86% of REACH staff will meet training requirements.	DBHDS reported training compliance for FY22 Q4 and FY23 Q1 combined. 99% of all REACH staff met the training requirements. During FY23 Q2 and Q3 99% of all REACH staff were trained as required.	DBHDS continues to meet the requirements of this indicator.	**Met**	**Met**
8.4	86% of initial CEPPs are developed within fifteen days of the assessment.	DBHDS reported CEPPs completed for FY22 Q4-FY23 Q1 combined. Overall, 81% were completed on time. This ranged from 68% in R3 to 100% in R1. During	Four of the five Regions did not achieve the 86% metric from this indicator. Only R5 met or exceeded the 86% requirement in FY23 Q2/Q3.	**Met**	**Not Met**

		FY23 Q2 and Q3, 80% of the CEPPs were completed on time. This ranged from 46% in R1 to 90% in R5			
8.5	86% of families and providers will receive training implementing CEPPs	The DBHDS REACH Quarterly Reports include these data. For mobile crisis services, DBHDS reports that at least 88% of all families and providers were trained for children ranging from 88% FY23 Q2 to 94% FY23 Q3. The REACH adult services teams trained at least 94% of families and providers, ranging from 94% in FY23 Q3 to 99% in FY23 Q1. The adult CTH program trained 99% of families and providers. The children CTH providers trained 94% of families and providers.	The data reported by DBHDS are somewhat difficult to analyze and confirm because of the reporting format that footnotes a combination of acceptable reasons training didn't occur, (i.e., hospitalized, still at the CTH) with other reasons that subtract from the desired metric. The DBHDS SME confirmed the % reported here in a telephone interview.	**Met**	**Met**
8.6	Documentation indicates a decreasing trend in the total and percentages of total admissions to state-operated and known by DBHDS to have been admitted to private psychiatric hospitals.	The DBHDS DOJ Supplemental Report compares the totals for FY21 and FY22 which demonstrates a decline in the number of admissions for children, adults and overall resulting in the fewest admissions since DBHDS has reported these data. Data for FY23 through Q2 evidences a continued decline in admissions but is only reported for half of the FY.	For FY22, admissions to state psychiatric hospitals for children decreased from 201 to 103 (49%); adults decreased from 387 to 270 (30%); and from 588 to 373 (37%) in total. For Q1 and Q2 of FY23 the number of admissions demonstrates a continued decrease. The percentages of admissions decreased for children in FY22 and was consistent for adults. Although not yet a full year, through Q2 of FY 23, a decreasing trend continued overall. Admissions for adults	**Met***	**Met**

			decreased by 7%). Admissions for children slightly increases from 23% to 25%. The trend of known admissions to private psychiatric hospitals also declined in FY22 compared to FY21 102 fewer adults and 46 fewer children were admitted. This trend continues through FY22 Q3. The processes were reviewed and verified as described in the narrative of this report. DBHDS continues to meet the requirements of this indicator.		
8.7	For individuals with DD who are admitted to state-operated hospitals and those known to DBHDS to have been admitted to private psychiatric hospitals, DBHDS will track the lengths of stay in the following categories: those previously known to REACH systema and those unknown; admissions of adults and children with DD to psychiatric hospitals as a percentage of total admissions; and median lengths of stay of adults and children in psychiatric hospitals.	The DBHDS DOJ Supplemental Report compares the average and median lengths of stay for adults and children in state and private psychiatric hospitals. Trends since FY17 are reported for state hospital admissions which shows an increase in the average lengths of stay for both children and adults through FY22. A decrease is reported for FY23 through Q3 for adults and an increase for children DBHDs' report for private hospitals is only for FY23 Q2 when children averaged 8-day	The average LOS for adults increased from 32 days in FY21 to 45 days in FY22, and from 18 days to 24 days for children between FY21 and 22. FY23 Q3 shows a decrease of 7 days (45 to 38) days for adults and an increase of 2 days (15 to 17) for children. In private hospitals the average LOS generally differ for FY23 Q1 and Q3 noted below as Q1/Q3: Children known to REACH: 8/9 Children unknown to REACH: 9/18 Adults known to	**Met**	**Met**

		and adults averaged 10-day admissions. The average and median LOS of stay for individuals known and unknown to REACH is reported. In private hospitals for FY23 Q2 LOS is similar for both children and adults known to REACH but is lower in state hospitals and significantly lower for children.	REACH: 11/11 Adults unknown to REACH: 10/11 In state hospitals the average LOS are: Children known to REACH: 15/15 Children unknown to REACH: 23/20 Adults known to REACH: 27/32 Adults unknown to REACH: 30/33 Hospital stays for both children and adults with DD are significantly longer in private psychiatric hospitals. The Commonwealth has met the requirements of this CI for three consecutive periods.		

SA Provision- 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.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**20**	**22**
10.1	The Commonwealth will establish and have operational by June 30, 2019 two 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.	The CTHs for children remain open and operational although both were closed for temporary periods in Year 7 due to COVID, staffing, and physical plant issues. Utilization is lower than previous years. Training does occur as required.	The number of children served, and the utilization continues to decrease in great part because of staff vacancies. These are discussed in the report. DBHDS reports training for each category of admission: stabilization, prevention, and step down. In all categories families and caregiver are trained, achieving an overall percentage of 94%, for 63 of 67 children. There was utilization by a total of 16 children living in Regions I (10), III (2) and V (4) in this reporting period. This should continue to be reviewed as a result and because utilization continues to decline because of staffing shortages.	**Met**	**Met**
10.2	DBHDS will utilize waiver capacity set aside for emergencies to meet the needs of individuals with long term stays in psychiatric hospitals or CTHs.	DBHDS reports that the following number of waiver slots were used by individuals with long term hospital or CTH stays: FY22 Q4 5 FY23 through Q3 4 (15%) of 26 emergency slots awarded to individuals with long term stays	DBHDS continues to use a portion of the waiver slots for individuals who experience long-term stays. DBHDS continues to meet the requirements of this indicator.	**Met**	**Met**

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 1)to prevent crises and hospitalizations, 2) to provide a permanent home to individuals discharged from CTHs and psychiatric hospitals	DBHDS reports for both FY22 Q4 and FY23 Q1 that 26 of the 29 beds were occupied. In FY23 Q2 DBHDS reports that 27 of 29 beds are filled. In FY23 Q3 24 of 29 beds are filled. Other providers offer 7 additional beds which were fully utilized both quarters. DBHDS has issued another RFP to increase the number of providers. They have many responses and will make awards soon,	DBHDS continues to meet the requirements of this indicator.	**Met**	**Met**
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.	DBHDS reports the following percentages of individuals who were admitted to a CTH or a psychiatric hospital had a community residence identified within 30 days: FY22 Q4: 86% Range: 79% R3- 92% R4 FY23 Q1: 81% Range: 70% R1-88% R4 FY23 Q2: 75% Range: 62% R3-93% R4 FY23 Q3: 80% Range: 56% R1-95% R4. DBHDS does not report separately on those admitted to a CTH and those admitted to a psychiatric hospital.	Region 4 is consistently effective at connecting individuals in the CTH to a community provider. In FY23 Q2 and Q3 only one of the five Regions met or exceeded the 86% expectation. Overall, only 80% of individuals were connected to a community provider within 30 days.	**Not Met**	**Not Met**

SA Provision- 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.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**20**	**22**
11.1	86% of individuals with a DD waiver and known to the REACH system admitted to CTH facilities	See CI 10.4 Facts and analysis.		**Not Met**	**Not Met**

	will have a community residence identified within 30 days of admission. This CI is also in III.C.b.iii.B.				

SA Provision- 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.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**20**	**22**
13.1	The Commonwealth will establish and have in operation by June 30, 2019 two CTH facilities for children. This indicator is also in III.C.6.b.iii.B.	See *CI 10.1*	See *CI 10.1*	**Met**	**Met**
13.2	To address the CTH stays of adult beyond 60 days, DBHDS will establish two transition homes by June 30, 2019.	DBHDS operates two transition homes in Culpepper and Chester which can be accessed statewide. Each has six beds. Neither was fully utilized in this review period. Culpepper served a total of three individuals through FY23 Q2 all from CTHs. Chester served a total of six individuals, five from CTHs and one who stepped down from a hospital.	Culpepper had no more than one person in any one quarter. Chester had two residents in FY22 Q4; one in FY23 Q1; and three in FY22 Q2. The homes are established but are not operating at full capacity.	**Met**	**Met**
13.3	The Commonwealth will implement out-of-home crisis therapeutic prevention host-home like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service through statewide access in order to prevent	The Commonwealth has selected two agencies to provide this support, only one of which is operational. DBHDS has established admission criteria, initiated marketing and established related communication with REACH programs. Of the seven referrals in Year 8 (none in FY23 Q3)	Staffing appears problematic and a hurricane in Q1 precluded any children being admitted. While any Region can make a referral the setting is most accessible to families in Regions IV and V. The provider in the southwest area of VA has not yet opened its services.	**Not Met**	**Met**

	institutionalization of children due to behavioral or mental health crises.	four of the seven children were admitted. Three retained their settings and one transitioned to a new permanent residence. DBHDS does not request or have data regarding the outcomes for the children who were not admitted.	However, in Year 8 all but one referral came from Region IV. DBHDS is unsure of the interest among families of children. They plan to conduct focus groups to ascertain family interest and concerns.		

IV. Review and Analysis of Select Compliance Indicators

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.

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.*

Conclusion: DBHDS has accomplished significant training on risk identification and assessment with thousands of staff being trained. DBHDS has used the CSB Performance Contract to set the requirements of *CIs 7.2, 7.3, 7.4 and 7.6.* It has continued to meet 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.

In the twentieth review period, we found that DBHDS had met *CI 7.5* but did not have a process to ensure that it could verify all newly hired CMs and those who were trained within six months. It has now also met *CI 7.6* twice consecutively because DBHDS can report the dates of hire for CMs and intake workers and the dates they are trained. DBHDS follows up with the CSBs for any newly hired staff who have not met this requirement. DBHDS informed us in our initial interview for the twenty-second review period that they had accomplished this task and had also created a new version of the Process Document to encompass these changes. In order to validate the process, we completed a comparison review of Version 002 and the new Version 003. We also conducted interviews with the author and the co-author of the document. The interviews consisted of validating the Roles and Responsibilities in the Process, the Purpose, Scope, and Document Management. In addition, sample of individuals was chosen in which we reviewed

each step outlined in the process and how errors and omissions were corrected. The validation process verified that the Process is reliable and valid in that it now encompasses the ability to identify all trainees on a quarterly basis, the date of training, and the CSB they are associated with encompassing all newly hired CMs. The process culminates with a clean count of those that have completed training.

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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)

DBHDS acknowledges that it is "most desirable that persons in crisis receive a crisis assessment in the location in which the crisis occur, as opposed to being removed from their community setting to be assessed in a different location" in the Supplemental Crisis Report. The Commonwealth continues to fall far short of this expectation. It has not been met during any quarter of the review period and was: 37% in FY22 Q4; 44% in FY23Q1; 49% in FY23 Q2; and 37% in FY23 Q3. With the exception of FY23 Q2, the percentages of crisis assessments completed in a community setting was approximately 7% less than the percentages in the same quarters in FY22. This lackluster performance is occurring when the COVID pandemic has been more controlled though vaccinations and treatment, and after the 988-crisis response service has been implemented in Virginia. The Commonwealth has not provided any data to explain if there has been any significant impact from the availability of 988.

DBHDS continues not to provide any analysis of why so few crisis assessments are conducted in the home, residential setting or community. The Expert Reviewers are not aware of a quality initiative that DBHDS has implemented or any plans to address and resolve this systemic obstacle to proper implementation of the fundamentally important Settlement Agreement requirement. DBHDS has not determined or documented whether there are any reasons for significant variations across the Regions or whether an analysis of those reasons might lead to insights regarding achieving this outcome across the Commonwealth. Region III consistently conducts more than 50% of the crisis assessments in community settings, and Region V conducted 62% of these assessments in community settings in FY23 Q2. When the Commonwealth's crisis service system assesses individuals in their homes, it is more common for its trained REACH staff to be able to successfully offer other REACH crisis support services, to de-escalate crises without removing individuals from their homes. Whereas the individuals who are assessed for a crisis in the hospital or CSB ES are much more likely to be hospitalized.

While these data are not reported specifically for this CI regarding those individuals known to the CSB who are assessed for a crisis, the REACH quarterly reports contain information about the number of in-person assessments versus video feed crisis assessments. These data are reported earlier in the report. The Commonwealth has not conducted an analysis of the impact of telephonic assessments for crises on the outcome of hospitalization.

As I have reported in earlier reviews, this CI is requiring the crisis assessment performed by REACH to be done in the community setting but the CI and therefore DBHDS' expectation, fails to refer to the full crisis assessment that involves CSB ES staff. Without this expectation, CSBs have not modified their pre-Settlement Agreement practice of completing assessments at

the hospital or CSB ES office. Although the Commonwealth agreed to have 86% of crisis assessments in the home or other community setting, it is doubtful that without implementing an initiative bring about this important change, the percentage of crisis assessments completed in the community will increase significantly, especially if CSBs are not required to have ES staff respond in a community setting. It is the considered opinion of this reviewer that DBHDS will continue not to make substantial progress toward achieving this CI if its service system continues to separate the REACH involvement in a crisis assessment from the mobile team approach to which it committed in the Settlement Agreement.

Recommendations: This CI is critical to ensuring the success of the Commonwealth's community crisis services system. To make needed progress toward achieving this CI, DBHDS should determine the root causes for the current obstacles. For example, DBHDS should review and determine if there are reasons for the variance among the Regions in achieving this metric and whether there are any Regional or statewide systemic changes that could be made to increase the number of assessments completed in a community setting across the Commonwealth. The overall small percentage of assessments being completed in-person in the community may be in part attributable to staff vacancies among REACH Coordinators which is between 35 and 76% in Regions I, II, and III. Region 1 consistently performed the fewest crisis assessments in the person's home and has a 76% vacancy rate for staff positions that are responsible for crisis response.

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

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

In Year 8, the average is 94% compared to 95% In Years 6 and 7. The DBHDS reports show that the referral rate for children ranged from 87%-98% and ranged from 92%-96% for adults for all four quarters. The reporting for adults met the requirement of 95% for three of the four quarters. For children the reporting was exceeded in two quarters.

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 uses data from the state department that licenses Behavior Analysts and Associate Behavioral Analysts. The specific data sources are the VA Department of Health Professionals LBA/LaBA active licensees and the PBSF provider organization. DBHDS' process relies on Waiver Management System (WaMS) and Service Authorization data to determine if individuals in need of behavior support are referred to an identified provider within thirty days or beyond thirty days.

DBHDS began tracking the number of individuals identified during the ISP planning process as needing therapeutic consultation (TC) in July 2020. DBHDS also tracks data to determine the percentage of those persons who have a TC (behavioral) provider within thirty days of that need being identified. As part of these data, DBHDS also reports the number of individuals who have a provider identified in excess 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 five months between 4/1/22 and 8/31/22, and the subsequent five-month period between 9/1/21 and 1/31/23. The data are reported in the Behavior Supports Reports for FY22 Q1 and FY22 Q3 and are detailed by Region and totaled for the Commonwealth. The data points do not align with the quarterly reporting periods. The data is analyzed under *CI 7.18*.

DBHDS reported that as of FY23 Q3, there was a total of 2,802 Behaviorists, which is an increase of 198 during Year 7. Most (97%) of the PBSFs are Licensed Behavioral or Assistant Behavioral Analysts (LBA of LaBA).

During FY23 Q1 DBHDS reported on the conclusions of its gap analysis the staff conducted. The analysis was done by DBHDS to determine the numbers of, and locations where PBSFs/LBAs were needed to provide TC to children and adults with DD.

Analysis: DBHDS had already surpassed the expectation of increasing the number of behaviorists by 30% over the baseline in 7/2015 of behaviorists and continues to increase the number of them. There are 2,802 PBSFs/LBAs as of FY23 Q3.

DBHDS reviews authorization data monthly and identifies those CSBs that may need technical assistance or help building provider capacity. DBHDS also included information about resources to locate behaviorists in the training for CMs. DBHDS staff follow up with the CSB to try to connect the CSB to providers of TC within their geographic area.

The Commonwealth has provided documentation that it completed the required gap analysis and is setting targets and dates to increase the number of behaviorists needed so that 86% of individuals whose Individualized Service Plan identify TC (behavioral support) service as a need, are referred for the service (and a provider is identified) within 30 days of the need being identified. The analysis was completed by reviewing the need for and availability of PBSFs/LBAs by Region. At the time of its analysis, the Regions ranged from 5% in Region III to 34% in Region IV of individuals with a need for TC who were not connected to a provider. DBHDS proposes that a reasonable caseload size is between 10-15 individuals. The SMEs will use the results of the BSPARI reviews to confirm reasonable caseload sizes. DBHDS projects needing between one and three additional Behavioral Providers in each Region. Based on the DBHDS analysis the focus for securing more TC providers will be in Regions II, IV and V.

DBHDS is taking other steps to increase the availability of TC. The Commonwealth's reimbursement rates were increased by 22-31%; a directory of TC providers is being developed for CMs to locate providers more easily in their area; monthly outreach to the CMs is occurring to help the CMs connect to TC providers in their area; and the Community Resource Consultants are reaching out to behaviorists to encourage their involvement in waiver services as TC providers.

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. As noted in the analysis of *CI 7.18*, Virginia is beginning to see a steady increase in the TC (behavioral capacity) for individuals with DD.

Conclusion: The CI metric to increase the number of PBSFs and LBAs is met and surpassed. The Commonwealth completed the required gap analysis and undertaken actions to increase the number of behaviorists to increase the number of individuals with an identified need for therapeutic consultation who will be referred to an identified provider within thirty days. Once the Commonwealth implements these system improvements, a higher percentage of individuals in need will be referred within thirty days. The Commonwealth has met the requirements of *CI 7.14*.

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 more up to date information regarding the number and percentage of individuals with this identified need who are referred within 30 days, as described under *CI 7.14*.

DBHDS reports that statewide, for the period 4/1/22-7/31/22 358 (66%) of the 543 individuals needing TC were connected to a provider within thirty days. This compares favorably to the results in Year 7 when 222 of the 639 (35%) individuals and in Year 6 when 45% of the individuals with a need for therapeutic consultation had a service authorization and a provider identified within thirty days. DBHDS reports that an additional 34 individuals were connected to a provider beyond thirty days for a total of 72% of the individuals needing TC being connected to a TC provider between April and July 2022.

DBHDS reports that, for the period 8/1/22-1/31/23 662 (69%) of the 966 individuals needing TC were connected to a provider within thirty days. This compares favorably to the 387 individuals were identified with the need for therapeutic consultation, of whom 231 (60%) had a TC provider identified within thirty days in the second period of Year 7. In this same time period of Year 8 an additional 63 individuals were connected to a TC provider beyond thirty days. This brings the total of individuals connected with a TC provider to 725 (75%) in Year 8. DBHDS did not report whether any of the individuals who did not have a provider identified within thirty days, did have one identified in more than thirty days in Year 7 so this cannot be compared between years. In Year 8 1,020 (68%) of the 1,509 individuals identified as needing behavioral services (TC) were connected to a TC provider within thirty days. The capacity of behavioral (TC) providers continues to increase and more importantly be available to children and adults with developmental disabilities. Table 5 under *CI 7.20* depicts these data.

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

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

Facts: DBHDS reports in FY23 Q3 that 136 (76%) of 178 behavior plans with Annual Authorizations contained all four elements that are required for behavioral programs: a Functional Behavior Analysis (FBA); a Behavior Support Plan (BSP); training of caregivers; and evidence that the PBSF/LBA is monitoring the implementation of the plan.

DBHDS reviewed 344 behavior programs since the inception of the program using the Behavior Support Plan Adherence Review Instrument (BSPARI) discussed under *CI 7.20,* of which 329 (96%) were completed within 180 days of the initial authorization of services.

Analysis: In Year 7, we did not agree with DBHDS' methodology to review the elements of the behavior programs to determine if all four elements were present. This was because DBHDS found the FBA and BSP to be adequate by presence alone regardless of their content. During

this review period DBHDS and the Expert Reviewers agreed to the discrete expected components in the BSPARI tool that would be sufficient to determine if the four elements are adequate for the requirements of behavioral programs under *CI 7.19*. This methodology is explained in Attachment 2 which details our qualitative study. DBHDS's updated review methodology now meets the expectation of *CI 7.19* since DBHDS has determined what minimally necessary content for the FBA, BSP, caregiver training and plan monitoring. Using this methodology DBHDS did not find that 86% of the behavior program were adequate.

We conducted a qualitative study of *CI 7.19* that verified the adequacy of DBHDS's updated review methodology. Our verification review found that all the elements were present in the records of eighty-seven (87%) of the 100 individuals in our stratified sample.

Conclusion: *CI 7.19* is not met as the Commonwealth has not achieved the 86% requirement that individuals who are authorized to receive the four elements of behavioral support services. DBHDS has developed a methodology to verify that the FBAs and BSPs are adequate to meet the requirements for behavior programs to be considered sufficient. The Process Document for this CI was modified and improved from the last review period. Enhancements/workarounds were made in order to validate data prior to calculations. The Chief Information Officer on 2/17/23 signed an attestation. The CIO found no defects.

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

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

whose plan scored below 34 points. This review and feedback are important components of the quality improvement process.

Attestation: DBHDS had not attested to the validity and reliability of the process it uses during the twentieth period. DBHDS submitted the attestation form on February 17, 2023. The CIO determined that these data are representative of the data to be collected and the processes that were followed were thorough and detailed. Therefore, the CIO determined the process is reliable and valid for the identification of quality improvements and risk mitigation. Our qualitative review verified the reliability and validity of data reported from DBHDS scoring of the BSPARI. Given our verification and that DBHDS performed a thorough data set review and visualization, we determine this process is reliable and valid.

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

Table 5: Number of Children and Adults Needing Therapeutic Consultation Compared to Those Receiving Therapeutic Consultation

Time Period	Total in Need	Provider in 30 days	Provider after 30 days	No provider	% with TC in 30 days	% with TC
3/1-8/31/22	543	358	34	151	66%	72%
9/1/22-1/31/23	966	662	63	241	68.5%	75%
TOTAL	1,509	1.020	97	392	68%	74%

Analysis: The data presented by DBHDS as portrayed in ***Table 5*** includes the total number of individuals who need TC but doesn't include how many are receiving it, only how many have been connected to a provider. However, DBHDS does report separately on the number of individuals receiving TC who were authorized in FY22 to provide some data of relevance but not congruous with the reporting period displayed in Table 5. These data indicate 58% of individuals with an authorization received the TC services.

DBHDS reviewed 244 BSPARIs and reported in its FY23 Q1 and FY23 Q3's Behavior Support Reports to address CI *7.20 (4)*. The median scores on the BSPARI are reported in Table 2. The BSPARI tool and its scoring algorithms have been determined to be a very effective methodology and process to review the minimum expectations and quality of the behavioral programs. DBHDS continues to enhance the BSPARI. This year DBHDS automated the scoring to increase its reliability; provided tabs with links to regulations; and links to professional literature for professional development.

DBHDS also included the review of the BSP implementation by the CMs 7.20 (5) which was determined by reviewing the completed Onsite Visitation Tools (OSVT) for the sample. DBHDS determined that 62% of the CMs scored these correctly.

Conclusion: *CI 7.20* is now Met. DBHDS has attested to the validity and reliability of its data sources.

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

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

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

Facts: DBHDS has a detailed description for this quality review process.

DBHDS conducted these reviews semi-annually as required. The semi-annual review submitted for this reporting period covered the time period July 1-December 31, 2022. DBHDS did do a review of the billing data for FY23Q1 and Q2. These data indicate that only 14 (5%) of the individuals authorized for in-home supports received 90% or more of the authorized hours and 81 (28%) received fewer than 30% of their authorized hours.

Analysis: DBHDS reports in the FY23 Q3 Supplemental DOJ Quarterly Crisis Report on the data for the provision of in-home support services for the period 7/1/22- 12/31/22. During this period 319 (100%) of the 319 individuals with a Support Level Need of 7 received at least some of the in-home supports identified in their IP. The authorized hours matched the hours needed as expressed in the IP for 313 individuals which is 98% of those who needed and received the in-home services. DBHDS interviews families to determine if services were delivered. DBHDS

reports contacting 178 families during FY22 Q1 and Q2, of whom 72 (40%) responded. Of these families:

- 100% report receiving some level of service
- 51% (Q1) and 37% (Q2) report staffing problems
- 22% (Q1) and 63% (Q2) were satisfied, and
- None report a safety concern

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. Most of the families responded that the option to hire family members as allowed under Appendix K of the HCBS Waiver was critically necessary to have support in the home. The reasons for services not being delivered included: the continued impact of COVID on securing staff: a lack of trained staff to hire; and an insufficient rate of pay.

We had noted Year 6 that this information would be more consistent and reliable if DBHDS used or cross checked the information with billing claims information when it completes its semiannual reviews. DBHDS did perform this analysis beginning in Year 7. The data are informative and alarming, as was true in Year 7. Whereas DBHDS's FY23 Q3 Supplemental DOJ Quarterly Crisis Report stated that 100% of the individuals studied with a Support Level Need of 7 received the in-home supports identified in their IP, the billing data described above indicates very few receive close to their authorized hours.

As required by *CI 7.23,* DBHDS is to make determinations to enhance and improve service delivery to children and adults with identified significant behavior support needs (Support Level 7) in need of in-home and personal care services. DBHDS did not report on its quality review for *CI 7.23* in the Supplemental DOJ Report, but did tell me of their improvement strategies during an interview with Heather Norton and Sharon Bonaventura. Payment rates have been raised for respite and personal care services and the Governor has proposed an additional 5% increase to these rates for FY24. The rates for in-home supports have been increased substantially by approximately 35%. Telehealth was offered as an option under Appendix K of the waivers during the pandemic and is now being addressed as a service delivery option in the three DD waivers that include these in-home services. Social media is being used more effectively to make training more widely available to families and caregivers. DBHDS reports easing the required documentation to approve family members living in the home as caregivers.

Conclusion: *CI 7.21*, *7.22 and 7.23* continue to be met. The DBHDS review process has been implemented and tracks the need for in-home and personal care services. The review process is now sufficient as it includes a review of the billing data that offers more information as to whether these services are actually delivered. It appears that a very low percentage of services are actually being delivered based on the billing data for this review period, but *CI 7.21 and 7.22* do not require that a metric be met for actual service delivery.

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 assessments of the three requirements of *CI 8.1* in FY22 Q2 and FY22 Q3. These reviews are conducted individually with each Region during the quarter. The Commonwealth's performance related to these three issues are addressed in the associated indicators 8.2,*8.3, 8.4, and 8.5.* Staff training and staff qualifications are assessed by DBHDS semi-annually 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 semi-annually during the Program Standards Review which occurs in Q1 and Q3 of each year. Two of the quarterly quality reviews of REACH focus on performance contract expectations and two of the quarterly reviews concentrate on REACH program standards.

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

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

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

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

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

Facts:

DBHDS has a combined process document to address *CIs 8.6 and 8.7.* It includes a glossary of terms and process steps. The data sources are AVATAR, the REACH Hospitalization Tracker and the State Hospital IDD Hospitalizations: Total Executed TDOs and State Hospital Admissions Report. DBHDS reports its data in the Supplemental Crisis Report. The Independent Reviewer asked us to conduct a validation study of *CIs 8.6 and 8.7* because of the weaknesses discovered in the AVATAR data source during previous studies.

Validation Study: The purpose of the validations study was to spot check the implementation of the processes DBHDS uses to determine if the outcomes of CI *8.6 and 8.7* are met. This study included a review of each step of the associated processes replicating DBHDS' methodology and activities. All the sources we used for the random sample selections are the specific sources cited in each associated CI. We followed the same methodology to validate each process. This process and the methodology used by DBHDS in the 20th Review Period relied very heavily on Avatar as the data source in nine of the ten steps outlined in the Process Document. Given the acknowledged weaknesses of Avatar we proposed that this specific process have another validation study done in the next Review Period.

A spot check using the same methodology as DBHDS was used in this review period. We reviewed the new version of the Process Document and conducted interviews with the Author of the improvements to the Process Document to address any questions. All weaknesses related to how Avatar was relied on have been removed in the Process. Therefore, I have found the Process to be reliable and valid.

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

Facts: The two CTHs for children became operational in FY19 Q3 and have continued to operate through the twentieth review period. DBHDS refers to the processes related to *8.3 and 8.5* for training of CTH staff and providers to implement CEPPs as evidence of training to those supporting the child. The data sources are REACH Quarterly Report Data; Summary Operational Definitions/ Data Submission Form *(8.5)*; Master Staff Training Data Spreadsheet; and the REACH Data Store *(8.3)*. DBHDS reports the implementation and its progress toward achieving *CI 10.1* in the Quarterly REACH Child Data Summary Reports. DBHDS provided a Process Document that addresses the training portion of this requirement under *CI 8.3 and 8.5*, DBHDS has attested that the data sources provide reliable and valid data as described under *Ci 8.3 and 8.5,*

Analysis: DBHDs provides a breakdown of the providers trained in CEPPs by service type in its REACH Quarterly Reports. These include CTH Crisis Stabilization; Crisis Step Down; and Crisis Prevention. Over the four quarters there were twenty-three children in CTHs who received a CEPP. There were twenty-one children's providers who were trained for a total of 91% of the providers. Region IV consistently trains 100% of the providers.

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

DBHDS reports that the two CTHs did not operate at full capacity throughout the review period. The numbers served and utilization are discussed under *CI 13.1*

Conclusion: *CI 10.1* is met. Both CTHs are open, although they are not operating at capacity. DBHDS demonstrates that CTH staff are trained and reported that 91% of the involved children's providers have been trained in the CEPPs.

10.4: 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 only one of the four quarters of Year 8 did the individuals known to the REACH system have a community residence identified within 30 days of admission. This was during FY22 Q4. During the other three quarters only 75% to 81% of these individuals had a community residence identified within thirty days of admission.

Conclusion: The *CIs 10.4 and 11.1* are not met because the Commonwealth did not achieve the requirement that 86% of the individuals who were known to REACH and who were hospitalized or placed in a CTH would have a residential provider identified within thirty days.

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

Facts: DBHDS has implemented the "out-of-home crisis therapeutic prevention host homes like services for children connected to the REACH system". DBHDS has secured two providers, only one of which was in operation through FY22 Q3. The second provider remains unable to open the second home due to staffing shortages.

DBHDS provided documentation that shows that it monitors, tracks and reports on the number of children who use out-of-home crisis therapeutic prevention host homes. DBHDS also tracks and reports on the number of referrals; number of admissions; lengths of stay; and outcomes of the stay. The outcomes include data for those hospitalized versus those who retained their home setting or transitioned to a new community setting. The outcome data is used by the Regional Crisis Managers to determine if action(s) for improvement is warranted.

Analysis: DBHDS reported through FY22 Q3 that only four children were served of seven referrals. Two returned home and one transitioned to a new residence. Lengths of stay were 6 to 29 days. It is concerning that only one host home is opened and only four children were able to take advantage of the setting. It is also troubling that the home is not better utilized when so

many children are still being hospitalized, and that the other home has never opened. This is meant to be a statewide program, but six of the seven referrals made in Year 8 were from Region IV, where the program is located. Region I made one referral in Year 8. However, DBHDS staff report that many families do not wish to use these settings either because of the distance from their family home or because they may be seeking a more permanent alternative residence. DBHDS will conduct focus groups with families of children using REACH to better assess the causes of underutilization.

Conclusion: *CI 13.3* is Met. The Commonwealth has implemented out-of-home crisis therapeutic prevention host home like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis in order to prevent institutionalization of children due to behavioral or mental health crises. While only one home has been implemented and the service is underutilized, there does not appear to be a level of interest that is not being met.

Submitted By:

Kathryn du Pree, MPS
Expert Reviewer

Joseph Marafito, MS
Expert Reviewer
May 1, 2023

ATTACHMENT 1 DOCUMENT LIST

NUMBER	DOCUMENT	TIME PERIOD OR DATE	RELATED COMPLIANCE INDICATOR OR PROVISION
1	CSB Performance Contract Examples	7.22	CIs 7.2, 7.3, 7.6
2	Supplemental DOJ Quarterly Crisis Report	FY22Q4-FY23Q3	CIs 7.5, 7.8, 7.13, 7.21, 7.22, 7.23, 8.1, 8.3, 8.4. 8.6, 8.7, 10.2, 10.3, 10.4, 11.1
3	Attestations	3.23	CIs 7.5,7.7, 7.8,7.14,7.18, 7.21, 7.22,8.3, 8.4, 8.5, 8.6, 8.7, 10.3, 10.4, 11.1
4	Process Documents	3.23	CI 7.8, 8.4, 8.7
5	Behavioral Supports Report	FY23Q1-FY23Q3 3.23	CI 7.14
6	Practice Guidelines for Behavior Support Plans	7.23	CI 7.15
7	BSPARI	3.23	7.15
8	REACH Region I Quarterly Quality Reviews Adults	FY22Q4-FY23Q3	CIs 8.1,8.2,8.3
9	REACH Region I Quarterly Quality Reviews Children	FY22Q4-FY23Q3	CIs 8.1, 8.2, 8.3
10	REACH Region II Quarterly Quality Reviews	FY22Q4-FY23Q3	CIs 8.1, 8.2, 8.3
11	REACH Region III Quarterly Quality Reviews	FY22Q4-FY23Q3	CIs 8.1, 8.2, 8.3
12	REACH Region IV Quarterly Quality Reviews	FY22Q4-FY23Q3	CIs 8.1, 8.2, 8.3
13	REACH Region V	FY22Q4-	CIs 8.1, 8.2, 8.3

	Quarterly Quality Reviews	FY23Q3	
14	REACH Quarterly Reports Adults	FY22Q4-FY23Q3	CI 8.5 and all Provisions in compliance
15	REACH Quarterly Reports Children	FY22Q4-FY23Q3	CIs 8.5,13.3 and all Provisions in compliance
16	Bed Tracking Adult High Behavior Homes	3.23	CI 10.3
17	Adult Transition Home Utilization Report	4.23	CI 13.2
18	Process Documents	3.23	All CIs
19	Exhibit M DOJ SA Requirements	7.23	All CIs
20	Curative Actions	7.22	CI 8.5
21	988 Documents	3.23	CI 8.6
22	REACH Staffing Report	3.23	All provisions
23	100 Records for BSP, FBA, OSVT, Training and Monitoring Documentation	2.23	CI 7.19
24	BSPARI Training Materials	3.23	CI 7.19 and 7.20

Attachment 2: Qualitative Study of the Delivery of Therapeutic Consult Services between April 1, 2022, and January 31, 2023

Introduction and Overview

For the twenty second period, we conducted a qualitative review of 100 of the 224 children and adults who received an annual authorization to receive therapeutic consultation (behavioral supports) and whose plans were reviewed by DBHDS between April 1, 2022, and January 31, 2023. The purpose of the study was to determine if individuals who are identified as needing therapeutic consultation (TC) are receiving the services that are authorized for them. These services are described in CI 7.19 which states:

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

This study will parallel the review that DBHDS conducts to implement *CI 7.19* to determine the reliability and sufficiency of their review methodology, and to determine the success of the Commonwealth meeting the expectations of *CI 7.19.*

We also reviewed *CI 7.20 (5*) to determine if the Case Managers (CM) are fulfilling their responsibility to monitor the delivery of behavioral programs to individuals on their caseloads.CI7.20 (5) requires a determination of: ***whether Case Managers are assessing whether behavioral programming is appropriately implemented.***

This qualitative study includes a review of the available records of 100 individuals. DBHDS provided the list of all children and adults who were reviewed for these services between 4/1/22 and 1/31/23 who had an Annual Authorization. From this original list of 224 children and adults, we selected 100 names of individuals who had been reviewed by the DBHDS staff who determined if the records demonstrated that the requirements of *CI 7.19* were met. All the 100 individuals had Annual Authorizations.

We randomly selected 100 individuals from the DBHDS database of all individuals who were authorized to these services. We stratified the selected sample of individuals to include people who lived in all five of the DBHDS Regions' and reflect the overall number and percentages per Region of the total number of individuals authorized for Therapeutic Consultation in the review period. Eighteen reside in Region 1; thirty-five in Region 2; thirteen in Region 3; twenty-three in Region 4; and eleven in Region 5. The number and methodology applied for sample selection yielded a statistically significant sample that will allow generalization of the findings to the cohort with a 90% confidence level.

DBHDS provided us with the DBHDS document "Minimum BSP Content Areas and Elements." This document provides guidance for BCBAs and other Licensed Behavioral Support

Professionals which include Positive Behavioral Services Facilitators (PBSF), to develop Functional Behavior Assessments (FBAs) and Behavior Support Plans (BSPs). These guidelines describe what should be included in the BSP and FBA for the following content areas: demographic information; history and rationale; person centered information; hypothesized functions of behavior; behaviors targeted for decrease; behaviors targeted for increase; antecedent interventions; consequence interventions; safety and crisis guidelines; plan for training; and appropriate signatures, which include the signature of the individual or the legal representative.

DBHDS shared its methodology for reviewing the data to determine if authorized services received include the FBA; the BSP; caregiver education; and monitoring the implementation of TC. Our methodology determined whether the required documents included the minimum required elements for what constitutes receipt of minimally adequate behavioral programming. In the 20th Review Period, the DBHDS methodology only determined that the required documents were present and did not determine if these documents met the minimum requirements.

We worked with the DBHDS Subject Matter Expert (SME), Nathan Habel, Project Manager, to determine for this review period what would constitute a minimally acceptable FBA, BSP, monitoring verification, and evidence that caregivers were trained to implement the BSP and record relevant data. The SME proposed a rationale and methodology to determine which of the elements that are included in the Behavioral Support Plan Adherence Review (BSPARI) reflect what must be present for the four requirements, listed above, of *CI 7.19* to be considered met. The methodology included the most fundamental, basic elements of an acceptable FBA and BSP; what is required to demonstrate the behavioral support professional is monitoring the implementation of the plan and revising if necessary; and the needed documentation to verify caregivers were trained.

An adequate FBA must include information that it was completed in the location where services occur and hypothesize the functions of the behaviors the individual exhibits. An adequate BSP must be developed for the individual's current setting; identify preventative, proactive and/or antecedent-based strategies; and identify consequence-based strategies. DBHDS expects the behaviorist to monitor the BSP and make revisions as needed to ensure effective monitoring is occurring. Targeted behaviors must be visually displayed and include indicators demonstrating that decision making and/or analysis was performed by the behaviorist. Training records detailing topics, dates and trainees must be present.

For our review, DBHDS produced the following documentation for each of the selected individuals if it was available:

- Individual Service Plan (ISP) including Sections I-IV
- ISP Section V from the TC provider
- FBA
- BSP
- Quarterly Monitoring Reports
- Training Documentation
- OSVT and CM Progress Notes

We reviewed the same documentation that the DBHDS SMEs reviewed to report on *CI 7.19* so that we could validate their process.

Methodology

The methodology we used for this Qualitative Study was a review of all the relevant documents which are listed above. As noted, we also reviewed DBHDS' methodology and interviewed Nathan Habel, the DBHDS Project Manager who conducted the DBHDS review to implement CI 7.*19.* We reviewed the FBA, BSP, Part V, training documentation and monitoring reports using the BSPARI elements that we agreed determined adequacy, as explained above. We reviewed these documents to determine if they met the minimum expected requirements set forth by DBHDS. It should be noted that DBHDS uses the complete BSPARI with a weighted scoring system to provide feedback to the licensed behaviorists and have shared with us their summary findings, which are detailed in the section of the Crisis Services Report for the 22nd Reporting Period to address the requirements of *CI 7.20.*

We did review the content of each document: the FBA, BSP, Part V and the monitoring summaries for each individual in the sample. We reviewed the content to ensure that the minimum expectations as required by DBHDS, and the applicable compliance indicator were addressed. We did not try to determine the clinical quality of the sections of the FBA or the BSP or determine if adequate progress was being made implementing the behavioral plan as reflected in the quarterly monitoring summaries. We also did not judge the adequacy of the training that was provided to caregivers, just the evidence that training was provided as outlined in the BSP. These clinical determinations must be made by a licensed behaviorist and is being conducted as another study for the Independent Reviewer to address the requirements of *CI 7.20 (4).* A clinical review was not the purpose of this qualitative study.

Record Review

The record review for this study was completed separately by two reviewers. To ensure a consistent approach to the review of the data, we developed and followed a written protocol and we each reviewed the same two records and compared our determinations to assure inter-rater reliability. We also participated in training offered by the DBHDS Project Manager for the implementation of this qualitative study and the study conducted for *CI 7.20.* We participated in an interrater reliability process with the Expert Reviewers conducting this latter study.

The review of the ISP included a review of its Overview section; the behavioral section, the Part III and the Part V. We reviewed the Part V to determine if it included the minimum requirements: measurable benchmarks for the behavioral targets and a description of the training to be provided to family members and other caregivers. The FBA and BSP were reviewed to determine if they included the minimum elements required.

The review of the WaMS data included a review of the authorized start and end dates for the service; the provider; the dates each of the FBAs and BSPs were completed; the presence of the training plan and the OSVTs for the review period. DBHDS provided these data for all 100 individuals in the sample. We reviewed records for 100 individuals. When we compare our findings to those of DBHDS, our percentages are based on 100 individuals and DBHDS's review is based on 224 individuals. This comparison is detailed in the 22nd Review Period report.

Findings

Functional Behavioral Assessment- We reviewed the content of the FBAs to determine if each conformed with the minimum expectations of DBHDS as expressed in its Practice Guidelines and Minimum BSP Content Areas and Elements.

In terms of the content of the FBAs, our finding is that 95 (95%) of the FBAs were adequate. The percentage ranged from 89% in Region 2 to 100% in Regions 3, 4 and 5. We cannot compare this year's findings to last year's findings because the criteria were different.

Behavioral Support Plan- We reviewed the content of the BSPs to determine if each conformed with the minimum expectations of DBHDS as expressed in the Minimum BSP Content Areas and Elements.

In terms of the content of the BSPs, our finding is that 100 (100%) of the BSPs included the elements for each content area that DBHDS has determined is minimally adequate. We cannot compare this year's findings to last year's findings because the criteria were different.

Caregiver Education- DBHDS expects that caregivers including family members and paid staff will be trained to effectively implement the BSP. Caregiver training is required for Annual Authorizations of BSPs. We found evidence that training was provided to caregivers for 92 (92%) of the individuals in the sample. This finding can be compared to the findings of the last review because the criteria was the same. This is a significant increase compared to Review Period 20 when we found only 61% of individuals' caregivers received training. This percentage ranged from 82% in Region 5 to 97% in Region 2. We reviewed actual training sheets that listed who was trained and the dates of training. We also accepted a reference to training in the quality monitoring summaries completed by the behaviorist as evidence that training did occur. We did not evaluate the quality or adequacy of the training.

Monitoring the Implementation of the BSP- *CI 7.19* includes the expectation that the BSP will be monitored for effective implementation and to determine if changes are needed over the course of implementation to improve the outcomes for the individual. The DBHDS expects that the behaviorist will monitor the plan and submit a summary at least quarterly. We found evidence that this monitoring did occur for 95 of 100 (95%) individuals in the sample. This percentage ranged from 89% in Region 1 to 100% in Region 3. We made this determination by reviewing the summaries submitted to us by DBHDS for review. This finding can be compared to the findings of the last review as the criteria was the same. This compares favorably to the findings in the 20th Review Period when we found evidence of monitoring for only 76% of the sample.

Review by the Case Managers- Case Managers are expected to make onsite visits to review and determine the appropriate implementation of service delivery for individuals on their caseloads. These visits are either monthly for individuals on Enhanced CM or quarterly. DBHDS has developed an Onsite Visitation Tool (OSVT) for CMs to record the results of their in-person assessments. DBHDS provided training for all CMs regarding how to properly complete the OSVT. The CMs are required to determine and note if a BSP is being

implemented as authorized. If it is not implemented as authorized, they must answer additional questions to document if the FBA and BSP have been done, if the plan is monitored and if caregivers are trained. While the case manager's review is not a specific requirement of *CI 7.19*, it is a requirement of *CI 7.20 (5)*. We include it in this qualitative study review to assure that Case Managers are fulfilling their responsibilities to monitor service implementation of the behavior programs and determine the satisfaction of individuals and their authorized representatives with the services they receive.

We reviewed each OSVT that was submitted and determined if the answers of the CM matched the information we had from reviewing the FBA, BSP, Part V, training documentation and the monitoring summaries. The CMs correctly completed all OSVT forms for 82 of the 100 (82%) individuals in the sample, compared to 79% in the last review period. This percentage ranged from 82% in Region 5 to 86% in Region 2. We found that in some of the 100 completed OSVTs, the CMs marked N/A as the answer to the question about behavioral services despite evidence that a BSP was being implemented. Other CMs marked this question as a Yes even when there was no documentation of training. We did not expect that the CM would be determining the quality of the FBA or BSP so the reader will note that we found the OSVT to be completed accurately on occasions where we did not find the FBA or BSP met the requirements to be determined adequate for the purposes of this study.

Table 1 summarizes the findings of this study for each of the components of behavioral support service that DBHDS has agreed to provide under *CI 7.19*. We report whether the FBA and BSP include the minimum elements that DBHDS includes in its guidelines for behavioral services. The sample we selected for this qualitative study was not the same sample that DBHDS used for its review as required in *CI 7. 19*. DBHDS did submit the results of its own qualitative review of its selected records for individuals who have service authorizations for TC. These results are discussed in the main body of this report.

Table 1: A Summary of the Findings of the Expert Review Study below summarizes the findings of the review completed of *CI 7.19*

Table 1: A Summary of the Findings of the Expert Reviewer Study

Required Elements of CI 7.19	**Independent Study Findings**
FBA	95% (95 of 100)
BSP	100% (100 of 100)
Caregivers Educated	92% (92 of 100)
Behaviorist Monitors	95% (95 of 100)
All elements present	87% (87 of 100)
OSVT (*CI 7.20 requirement*)	84% (84 of 100)

Table 2 which is below details our determination for each of the requirements of *CI 7.19* as to whether they are met or not met. A Yes indicates that we determined the expectations were fully met. For the individuals in the sample, we have created a version of Table 2 that includes our comments supporting our determinations of not met and have separately submitted this individual information to DBHDS under seal.

Summary- We found that a very high percentage of FBAs (95%) and BSPs (100%) were completed for Therapeutic Consultation service (behavioral supports) in accordance with the requirements of the DD Waiver Regulations expectations and Practice Guidelines. Overall, 87% of the individuals in the sample are receiving an adequate behavioral program. These programs include a functional behavioral assessment; a plan for supports; training for those providing care; and monitoring of the plan including data review and plan revisions as necessary. The achievement ranged from 83% in Region 1 to 92% in Region 3.

We found many examples of excellent FBAs and BSPs and comprehensive monitoring. In this sample studied, we found that the Commonwealth's behavioral programming is consistently meeting the minimum expectations for what constitutes adequate behavioral programming. We reported in the 20th review period that DBHDS designed and implemented an extremely thorough qualitative review process to determine the clinical quality of all the aspects of the behavioral program as defined in *CI 7.19* and required to be reviewed by *CI 7.20*.

The strengths of the BSPARI are evident in the review of this sample. The DBHDS Subject Matter Experts provide a comprehensive review of the FBAs and BSPs in their annual sample; identify both the strengths and weaknesses of the assessments and plans; and provide constructive feedback to the Behaviorists who have conducted the FBAs and completed the BSPs. This process is a sound approach to review plans and address quality improvement. It is helping to ensure that the FBAs and BSPs meet the expectations DBHDS has set for behavioral assessments and plans.

Table 2: Determination of Whether the Requirements of CI 7.19 Are Met for the Individuals in the Qualitative Study

REGION / INDIVIDUAL	FBA PRESENT	BSP	MONITORING	TRAINING	RESULT (MET/NOT MET)	OSVT
REGION 1						
1	YES	YES	NO	NO	NOT MET	NO
2	YES	YES	YES	NO	NOT MET	NO
3	YES	YES	YES	YES	MET	YES
4	YES	YES	YES	YES	MET	YES
5	YES	YES	YES	YES	MET	YES
6	YES	YES	YES	YES	MRT	YES
7	YES	YES	YES	YES	MET	YES
8	YES	YES	YES	YES	MET	YES
9	YES	YES	YES	YES	MET	YES
10	YES	YES	YES	YES	MET	YES
11	YES	YES	YES	YES	MET	YES
12	YES	YES	YES	YES	MET	YES
13	YES	YES	YES	YES	MET	YES
14	YES	YES	YES	YES	MET	YES

15	NO	YES	NO	YES	NOT MET	NO
16	YES	YES	YES	YES	MET	YES
17	YES	YES	YES	YES	MET	YES
18	YES	YES	YES	YES	MET	YES
Region Total	17/18	18/18	16/18	16/18	15/18	15/18
Region %	94%	100%	89%	89%	83%	83%
REGION / INDIVIDUAL	**FBA PRESENT**	**BSP**	**MONITORING**	**TRAINING**	**RESULT (MET/NOT MET)**	**OSVT**
REGION 2						
1	YES	YES	YES	YES	MET	YES
2	YES	YES	YES	YES	MET	YES
3	YES	YES	YES	YES	MET	YES
4	YES	YES	YES	YES	MET	YES
5	YES	YES	YES	YES	MET	YES
6	YES	YES	YES	YES	MET	NO
7	YES	YES	YES	YES	MET	YES
8	YES	YES	YES	YES	MET	YES
9	YES	YES	YES	YES	MET	YES
10	YES	YES	YES	YES	MET	YES
11	YES	YES	YES	YES	MET	YES
12	YES	YES	NO	YES	NOT MET	NO
13	YES	YES	YES	YES	MET	YES
14	YES	YES	YES	YES	MET	YES
15	NO	YES	YES	YES	NOT MET	YES
16	YES	YES	YES	YES	MET	YES
17	YES	YES	YES	YES	MET	YES
18	YES	YES	YES	YES	MET	NO
19	YES	YES	YES	YES	MET	YES
20	YES	YES	YES	YES	MET	YES
21	NO	YES	YES	YES	NOT MET	YES
22	YES	YES	YES	YES	MET	NO
23	NO	YES	YES	NO	NOT MET	NO
24	YES	YES	YES	YES	MET	YES
25	YES	YES	YES	YES	MET	YES
26	YES	YES	YES	YES	MET	YES
27	YES	YES	YES	YES	MET	YES
28	YES	YES	YES	YES	MET	YES
29	YES	YES	YES	YES	MET	YES
30	YES	YES	YES	YES	MET	YES
31	YES	YES	YES	YES	MET	YES
32	NO	YES	NO	YES	NOT MET	YES
33	YES	YES	YES	YES	MET	YES
34	YES	YES	YES	YES	MET	YES
35	YES	YES	YES	YES	MET	YES
Region Total	31/35	35/35	33/35	34/35	30/35	30/35
Region %	89%	100%	94%	97%	86%	86%
REGION / INDIVIDUAL	**FBA PRESENT**	**BSP**	**MONITORING**	**TRAINING**	**RESULT (MET/NOT MET)**	**OSVT**
REGION 3						
1	YES	YES	YES	YES	MET	YES
2	YES	YES	YES	YES	MET	YES
3	YES	YES	YES	YES	MET	NO
4	YES	YES	YES	YES	MET	YES
5	YES	YES	YES	YES	MET	YES
6	YES	YES	YES	NO	NOT MET	NO
7	YES	YES	YES	YES	MET	YES
8	YES	YES	YES	YES	MET	YES
9	YES	YES	YES	YES	MET	YES
10	YES	YES	YES	YES	MET	YES
11	YES	YES	YES	YES	MET	YES
12	YES	YES	YES	YES	MET	YES
13	YES	YES	YES	YES	MET	YES
Region Total	13/13	13/13	13/13	12/13	12/13	11/13
Region %	100%	100%	!00%	92%	92%	85%
REGION /	**FBA**	**BSP**	**MONITORING**	**TRAINING**	**RESULT (MET/NOT**	**OSVT**

INDIVIDUAL	PRESENT				MET)	
REGION 4						
1	YES	YES	NO	NO	NOT MET	YES
2	YES	YES	YES	YES	MET	YES
3	YES	YES	YES	YES	MET	YES
4	YES	YES	YES	YES	MET	NO
5	YES	YES	YES	YES	MET	YES
6	YES	YES	YES	YES	MET	YES
7	YES	YES	YES	YES	MET	YES
8	YES	YES	YES	YES	MET	NO
9	YES	YES	YES	YES	MET	YES
10	YES	YES	YES	YES	MET	YES
11	YES	YES	YES	YES	MET	YES
12	YES	YES	YES	YES	MET	YES
13	YES	YES	YES	YES	MET	YES
14	YES	YES	YES	YES	MET	YES
15	YES	YES	YES	YES	MET	NO
16	YES	YES	YES	YES	MET	YES
17	YES	YES	YES	YES	MET	YES
18	YES	YES	YES	NO	NOT MET	YES
19	YES	YES	YES	YES	MET	YES
20	YES	YES	YES	YES	MET	NO
21	YES	YES	YES	YES	MET	YES
22	YES	YES	YES	YES	MET	YES
23	YES	YES	YES	YES	MET	YES
Region Total	23 /23	23 /23	22/23	21/23	21/23	19/23
Region %	100%	100%	96%	91%	91%	83%
REGION / INDIVIDUAL	**FBA PRESENT**	**BSP**	**MONITORING**	**TRAINING**	**RESULT (MET/NOT MET)**	**OSVT**
REGION 5						
1	YES	YES	YES	NO	NOT MET	YES
2	YES	YES	YES	NO	NOT MET	NO
3	YES	YES	YES	YES	MET	YES
4	YES	YES	YES	YES	MET	YES
5	YES	YES	YES	YES	MET	YES
6	YES	YES	YES	YES	MET	YES
7	YES	YES	YES	YES	MET	YES
8	YES	YES	YES	YES	MET	NO
9	YES	YES	YES	YES	MET	YES
10	YES	YES	YES	YES	MET	YES
11	YES	YES	YES	YES	MET	YES
Region Total	11/11	11/11	11/11	9/11	9/11	9/11
Region %	100%	100%	100%	82%	82%	82%
Totals	**95/100**	**100/100**	**95/100**	**92/100**	**87/100**	**84/100**
Percentage Met	**95%**	**100%**	**95%**	**92%**	**87%**	**84%**

Attachment 2

Practice Guidelines for Behavior Support Plans

The following resource provides basic guidelines on the minimum elements that constitute an adequately designed behavior support plan for individuals receiving therapeutic consultation behavioral services under the Family and Independence Supports (FIS) and Community Living (CL) Developmental Disability Medicaid waivers in Virginia (note: the term 'behavior support plan,' or abbreviation 'BSP,' is synonymous with "behavior treatment plan" in sections 12VAC35-115-105 and 12VAC35-115-110 of the Department of Behavioral Health and Developmental Services ("DBHDS") Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services ("Human Rights Regulations"). Additionally, there is supplemental information included subsequent to these guidelines on the use of the least restrictive and most effective treatment philosophy and positive behavior supports, utilizing person-centered thinking and planning, and incorporating a trauma informed approach as it relates to behavior support planning. Further, following the literature review, there is an associated visual that provides a summary of the authorization types, associated timelines for each authorization, and required documentation. Behaviorists should reference the permanent DD waiver regulations for this service to review the entirety of regulatory requirements, available here: 12 VAC 30-122-550.

Practitioners that are billing therapeutic consultation behavioral services have already demonstrated a particular level of competency by obtaining appropriate licensure, credentialing, or endorsement in the field. As with any human service provider that obtained a credential or license through a certification, licensing, or endorsing board, there are rigorous ongoing requirements that must be adhered to in order to maintain their professional status. It must be noted, it is not the intention of the information below to supplant codes of ethics or standards of practice for a behaviorist; practitioners must always practice within the limits of their professional training and in adherence with their governing code of ethics and standards of or scope of practice. Instead, what is indicated in the table which follows are: 1) minimum required BSP content areas; and 2) minimum elements, notes/additional information for each of the required BSP content areas. DBHDS suggests that authors of behavior support plans be mindful of the audience of and those implementing behavior support plans as it relates to the use of extensive technical jargon.

Minimum BSP Content Areas and Elements

Minimum required BSP	**Minimum elements and notes/additional information**
Demographic information	*Minimum elements:* *Individual's name, DOB, gender identification, medical /behavioral health diagnostic information, medications if known, current living situation, Medicaid ID, legal status, date of initial plan and revisions (and nature of revisions), authoring clinician's name/credentials/contact information, and the individual's location related to where the BSP is going to be implemented.* *Note: Include as much pertinent information as possible in this area; it is understood that the behaviorist may not have comprehensive records of all medications or the entirety of diagnostic information. Include known influences of medical/behavioral healthcare conditions and treatment on behavior presentation*
History and rationale	*Minimum elements:* *Current and/or relevant historical information about this person and their life, the reason and rationale that the behavior support plan is being implemented/necessity for formalized intervention as it relates to challenging behaviors, and any known history of previous services and the impact of these services on both challenging and desired behaviors. If there is clear information on a history of trauma, it must be included in this area (note: when indicated, trauma informed considerations must be included in other appropriate content areas of the BSP; see related section in these Practice Guidelines on "Trauma informed care in behavior support planning"). Describe any dangerous behavior to include topographies, intensities, and associated risks and/or negative outcomes. Include risk and benefit information related to prescribed behavioral programming; this includes potential risks of physical and psychological harm or other potential negative outcomes as well as the benefits of prescribed*
Person centered information	*Minimum elements:* *This area must include the individual's communication modality, preference assessment information/results, cultural/heritage considerations (if known), routines/current schedule, individual's strengths and positive contributions, and particular aversions/dislikes. Information must be incorporated from the larger ISP as needed as it relates to behavior planning and updated with the annual shared planning meeting, which includes individual and guardian's participation. As part of the identification of preferences, identify who in the individual's life is especially preferred and what activities are enjoyed and sought by the individual.* *Note: There are numerous person-centered planning tools, indirect reinforcer surveys, and empirical preference assessment procedures that can be accessed through publicly available resources in behavior analysis, person centered planning, and positive behavior supports. Several resources are located in the section labeled "Person Centered Practices in Behavior Support*

Functional Behavior Assessment	*Minimum elements:* *Include information as to 1) when/where the FBA was conducted, 2) the FBA methods used (e.g. interviews with caregivers, ABC recording techniques, behavior checklists/rating scales, functional analysis, etc.) and 3) the associated results and analyses (e.g. setting events/motivation operations, antecedents, and consequences associated with the target behavior). Include data results and/or graphical displays of findings from the FBA as appropriate. If there are any known non-operant conditions that influence behavior, include such information in this section. In conjunction with the preparation for the shared planning meeting, the behaviorist must review the FBA and treatment data and make a determination if the functions are still valid or if the FBA must be revised and updated. A reassessment of the functions of behavior is required when data suggest treatment expectations are not being met or there has been a significant change in status of the individual that is negatively effecting the treatment outcomes. The review of the continued validity of the FBA, or the reassessment results from the FBA, must be documented in the FBA section of the BSP annually.* *Note: Basing the behavior support plan solely on the results of indirect FBA methods (e.g. interviews, rating scales) is not adequate. Such methods may be useful in formulating hypothesis to inform the FBA process, but overall indirect FBA methods have significant reliability and validity limitations. At a minimum, descriptive assessment that analyzes the relationship between antecedents and consequences surrounding challenging behavior must be conducted. The FBA should be conducted in the setting in which behavioral treatment is to occur. There is also a BSP content area on hypothesized functions of behavior, which can be incorporated into the FBA area. Include information on setting events if this is apparent based on the FBA process. Functional analysis (e.g. experimental functional analysis procedures) has the highest degree of validity amongst all FBA methodologies and is the "gold standard" in the research literature; however, functional analysis also requires a high level of training and experience to design, conduct, and interpret results. Only licensed practitioners with the appropriate level of competence should conduct functional analysis and the risks, benefits, and resources available must be carefully considering and described to those consenting*
Hypothesized functions of behavior	*Minimum elements:* *This section must include a description and situations of occurrence for each challenging behavior that will be targeted for decrease in this BSP along with the hypothesized function(s) of each behavior. This may be incorporated directly into the section on FBA as opposed to utilizing a separate section in the BSP.* *Note: A hypothesis statement may be used to outline the function(s) of behavior(s). Hypothesized function(s) of behavior must correspond with what are generally accepted functions of operant behavior (attention, escape, tangible, and automatic).*

Behaviors targeted for decrease	*Minimum elements:* *Include 1) each behavior that is targeted for decrease, 2) an objective operational definition for each behavior including examples and non-examples, and 3) the method(s) of measurement that will be used to track each behavior.* *Note: Subsequent to completion of the FBA and launching the BSP, data analysis ugh an*
Behaviors targeted for increase (e.g. replacement and/or alternative and adaptive behaviors)	*Minimum elements:* *This section must include 1) each functionally equivalent replacement behavior(s) that will be targeted for acquisition,* *2) an objective operational definition for each replacement behavior/behavior targeted for increase including examples and non-examples, and 3) the method(s) of measurement that will be used to track each.* *Note: Behaviors targeted for decrease should have a functionally equivalent replacement behavior (i.e. replacement behaviors corresponds to the hypothesized function(s) of behavior(s) it is to replace, though it is understood that it may not be possible to identify functionally equivalent replacement behaviors for all behaviors targeted for decrease at all times. Subsequent to completion of the FBA, data analysis through an appropriate graphical display is required for behaviors targeted for increase (e.g. replacement behaviors).* *There may be other behaviors that are targeted for increase as a part of the BSP that are not necessarily functionally equivalent replacement behaviors (e.g. alternative or adaptive behaviors such*
Antecedent interventions	*Minimum elements:* *This section must be inclusive of individualized, evidence-based procedures and tactics that minimize the likelihood that challenging behavior occurs and promotes an environment in which the acquisition of the functionally equivalent replacement behaviors is more likely to occur. For example, tactics that modify or minimize setting events or motivating operations that are correlated with behavior, as well as tactics or procedures that directly addresses immediate antecedents or precursors. Include preventative strategies that describe environmental stimuli that should or should not be present and any de-*
Consequence interventions	*Minimum elements:* *This area must be inclusive of individualized, detailed information as to how those that are implementing this plan will respond to behaviors targeted for decrease and behaviors targeted for increase when they occur. This area contains procedures and tactics that are 1) evidence-based and clinically indicated in regard to the hypothesized function(s) of behavior(s) to minimize reinforcement of challenging behavior(s), 2) emphasize the least restrictive, most effective treatment model based on the person's needs, learning history, and level of severity/intensity of behaviors targeted for decrease and 3) promote the acquisition of replacement behaviors and behaviors targeted for increase via appropriate provision of reinforcement (e.g. consideration of the matching law, schedule of reinforcement, inclusion of preferences/known reinforcers to increase desired behavior(s), and expectations of learning environment and associated learning materials or teaching conditions)*

Consequence interventions	*Note: There must be clear justification for the use of any procedures in this area which would constitute a limit imposed on an assured right or "Restrictions on Freedoms of Everyday Life" and such procedures must be approved in accordance with Virginia Administrative Code 12VAC35-115-50 and 12VAC35-115-100. Restrictive components of a behavior support plan, such as restraint or time out, to address challenging behaviors that are an immediate danger may be utilized only after a licensed professional or licensed behavior analyst has conducted a detailed and systematic assessment, see 12VAC35-115-105. Behavioral Treatment Plans.*
Safety and Crisis Guidelines	*Minimum elements:* *This section is required only if severe or dangerous behavior requires the prescription of the use of restrictive components as denoted in the Human Right's Regulations such as restraint or time out, or if there is specialized safety equipment needed for an individual receiving or persons providing services (e.g. armguards to prevent injury from biting). If so, then this area must be included to include information as to any safety gear to be available when working with the individual, specific crisis protocols and/or indications as to where to obtain these protocols and/or any other safety precautions to promote both the safety of the individual and the safety of others in the environment. This section should also reference all known contraindications to the use of rime out or any form of restraint, including medical contraindications, see 12VAC35-115-110. Use of Seclusion, Restraint and Time Out. Additionally, describe objectively any topographies, intensities, and/or related negative outcomes of severe and dangerous behavior and the supports necessary to ensure the safety of the individual and others. Any prescription of emergency safety procedures (e.g. restraint or time out) must adhere to Human Rights guidelines (see below) and of the policy and procedures of the provider including continuous monitoring of the individual while in restraint or time out, criteria for release of the restraint or time out, and debriefing procedures. For intrusive or restrictive components, a monthly review of data (or more frequently, as needed) is required.* *Note: There must be clear justification for the use of any procedures in this area which would constitute a limit imposed on an assured right or "Restrictions on Freedoms of Everyday Life" and such procedures must be approved in accordance with Virginia Administrative Code 12VAC35-115-50 and 12VAC35-115-100. Restrictive components of a behavior support plan, such as restraint or time out, to address challenging behaviors that are an immediate danger may be utilized only after a licensed professional or licensed behavior analyst has conducted a detailed and systematic assessment, see 12VAC35-115-105. Behavioral Treatment Plans. The documentation of approval and related signatures of the behavior treatment plan (behavior support plan) are required to be available for review by DBHDS Office of Licensing, Human Rights and any other quality review by DBHDS.*

Plan for training	*Minimum elements:* *The BSP must include the proposed plan to train staff or others that will be implementing the BSP. Quality training consists of delivering information on staff expectations per the plan and data collection once it is developed, as well as providing opportunities for staff to practice skills that are to be performed when providing support to an individual (e.g. using a behavioral skills training model for staff training). Plan for training must include how often data will be obtained and reviewed by the behaviorist. The BSP will outline specifics on the plan of training to include how planning will be provided to key stakeholders, both initially and ongoing. When delivering training, the behaviorist must keep a record of those that have been trained on the BSP by the behaviorist. Training records will need to be submitted in WaMS for any annual authorization requests.*
Appropriate signatures	*Minimum elements:* *Informed consent must be obtained prior to the initiation of behavioral services, assessment and launch of the behavior plan, and when significant treatment updates occur. Consent must include individual and/or guardian's signature and contact information (guardian or Authorized Representative, where applicable). Signatures and associated dates are to be included on the behavior plan when it is initiated. Consent must be obtained prior to treatment procedures/protocols changes that involve the addition of a restrictive component.* *Note: There must be clear justification for the use of any procedures in this area which would constitute a limit imposed on an assured right or "Restrictions on Freedoms of Everyday Life" and such procedures must be approved in accordance with Virginia Administrative Code 12VAC35-115-50 and 12VAC35-115-100. Restrictive components of a behavior support plan, such as restraint or time out, to address challenging behaviors that are an immediate danger may be utilized only after a licensed professional or licensed behavior analyst has conducted a detailed and systematic assessment, see 12VAC35-115-105. Behavioral Treatment Plans. The documentation of approval and related signatures of the behavior treatment plan (behavior support plan) are required to be available for review by DBHDS Office of Licensing, Human Rights and any other quality review by DBHDS.*

Utilizing elements of positive behavior support in behavior support plans

While there are differing definitions on the term "positive behavior support"(PBS) in the extensive literature on the topic, the Association of Positive Behavior Support (n.d.) offers a definition of PBS as a set of research based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment. Seminal works on PBS indicate its origins to be a synthesis of applied behavior analysis (ABA), the normalization and inclusion movement, and person-centered values (Carr, Dunlap, Horner, Koegel, Turnbull, Sailor, Anderson, Albin, Koegel, & Fox, 2002). One key researcher in the PBS movement has described PBS as "an approach that blends values about the rights of people with disabilities with a practical science about how learning and behavior change occur" (Horner, 2000, p. 97). A focus in many streams of quality PBS applications is the utilization of the science of ABA to modify environments to make problem behavior irrelevant, inefficient, and ineffective (Horner, 2000). As Horner (2000) notes, the PBS movement is deeply rooted in the science of behavior analysis, which offers thousands of research studies in the professional literature on the natural laws that govern behavior. Espousing the use of non-aversive behavior change techniques is an important component of early PBS works and should be incorporated into behavior support planning by all behaviorists (Horner, Dunlap, Koegel, Carr, Sailor, Anderson, Albin, & O'Neill, 1990). For historical context, prior to the full formalization of the larger PBS movement, the right to effective behavioral treatment had been well articulated in the behavioral literature, with these rights outlined as follows: treatment in a therapeutic environment, services with an overriding goal of personal welfare, behavioral treatment provided by professionals with appropriate education and experience, programming that teaches functional skills, treatment driven by assessment and ongoing evaluation, and utilization of the most effective and scientifically validated treatments available (Van Houten, Axelrod, Bailey, Favell, Foxx, Iwata, & Lovaas, 1988). This information is outlined to highlight for both newly minted behavioral providers (as well as those that have been practicing for many years) that the concepts of using the least restrictive treatment approach, avoiding unnecessary aversive interventions and/or restrictive procedures and instead promoting reinforcement based strategies that focus on establishing functionally equivalent replacement behaviors, and considering what is important to the individual in working towards increasing the quality of one's life are long established expectations for behavioral services. As it relates to incorporating positive behavior support concepts into behavior treatment plans, it is suggested that behavior support plans always address or include the following fundamental elements (at a minimum): 1) utilization of functional behavior assessment procedures to determine functions and conditions in which functions occur; 2) focus on promoting an environment in which the acquisition of functionally equivalent (replacement), or other desirable behaviors, can occur; 3) incorporation of interventions which correspond to the outcomes of functional assessment procedures (e.g. function based treatment) and consider needs, resources, and the individual's preferences; and 4) applying principles of behavior not only to address the individual's challenging behavior, but simultaneously to bolster the larger system of support for the individual and to improve quality of life in accordance with the individual's values (Carr et. al, 2002; Heineman, 2015). The two primary credential and license (Board Certified Behavior Analyst®/BCBA® and Licensed Behavior Analyst) or endorsement (Positive Behavior Supports Facilitator/PBSF) that are providing therapeutic consultation behavioral services in Virginia have comprehensive standards of or scopes of practice and ethical codes, and though semantics may differ slightly across these, each aligns with the concepts noted above. As such, in behavior support planning for individuals receiving therapeutic consultation behavioral services through the DD waiver, it is expected that practitioners will be delivering services to Virginians that are congruent with their own practice standards, ethical codes, and regulations that govern their endorsement, credential, or license. This information can be found at the following websites:

https://www.bacb.com

https://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm

http://www.personcenteredpractices.org/launch_vpbs.html

In addition, providers must be aware of and comply with the DBHDS Human Rights Regulations:

http://law.lis.virginia.gov/admincode/title12/agency35/chapter115/

Resources and References:

Association for Positive Behavior Support. (n.d.). *What is positive behavior support?* https://www.apbs.org/

Carr, E.G., Dunlap, G., Horner, R.H., Koegel, R.L., Turnbull, A.P., Sailor, W., Anderson, J.L., Albin, R.W., Koegel, L.K., & Fox, L. (2002). Positive behavior support: evolution of an applied science. *Journal of Positive Behavior Interventions, 4(1), 1-20.*

Heineman, M. (2015). Positive behavior support for individuals with behavior challenges.

Behavior Analysis in Practice 8(1), 101-108. Horner, R. H. (2000). Positive behavior supports.

Focus on Autism and Other Developmental Disabilities, 15(2), 97-105.

Horner, R. H., Dunlap, G., Koegel, R. L., Carr, E. G., Sailor, W., Andeson, J., Albin, R.W., & O'Neill, R.E. (1990). Toward a technology of "nonaversive" behavior support. *Journal of the Association for Persons with Severe Handicaps, 15, 125–132.*

Positive Behavioral Interventions and Supports: https://www.pbis.org/

Van Houten, R., Axelrod, S., Bailey, J.S., Favell, J.E., Foxx, R.M., Iwata, B.A., & Lovaas, O.I. (1988). The right to effective behavioral treatment. *The Behavior Analyst, 11(2), 11-114.*

Person centered practices in behavior support plans

Person centered thinking has been described as a set of value-based skills that result in getting to know a person and then acting on what is learned (Center for Person Centered Practices, n.d.). Person centered thinking and values must be integrated into behavior support planning as the individualized preferences, needs, and strengths of the person receiving behavioral services are critical in learning about both what is important for the individual and to the individual in developing plans that will promote sustained behavior change and improved quality of life. It has been well established in the professional literature that behavior change tactics which take into consideration not only what is important for the person (e.g. decreasing challenging behavior), but also what is important to the person (e.g. acquiring new skills to express their desires) not only decreases problem behavior but can increase and maintain new ways of responding and promote habilitation (Durand & Carr, 1991).

Behaviorists utilize evidence and function-based interventions that are selected based upon functional behavior assessment (FBA) results to decrease challenging behaviors while simultaneously increasing desirable behaviors that promote habilitation and independence (Newcomb & Hagopian, 2018). Thorough FBA procedures can be considered inherently person centered in nature as the goal of FBA is to determine "why" the person is communicating with challenging behavior. Subsequently, function-based treatment can be considered person centered in nature in that it uses the results of FBA to minimize reinforcement of problem behavior and to strengthen appropriate alternative behavior such that the individual is less likely to engage in challenging behavior as they have learned new skills that get their wants and needs met. Though the "behavior modification" techniques of old were effective in reducing challenging behavior, such tactics relied on incorporating reinforcers or punishers to change behavior without a thorough understanding of the function of the target behavior(s) (Hanley, 2012). Relying on evidence- based FBA processes "dignifies the treatment development process by essentially 'asking' the person why he or she is in engaging in problem behavior prior to developing a treatment" (Hanley, 2012, p. 55). It is now established best practice in applied behavioral service delivery that those who are responsible for assessing challenging behavior and designing behavioral treatment packages should be utilizing empirically supported functional behavior assessment and function based treatment practices (Newcomb & Hagopian, 2018; Ala'i-Rosales, Cihon, Currier, Ferguson, Leaf, Leaf, McEachin, & Weinkauf, 2019).

There are a variety of person-centered planning tools which are freely available on the internet and can be used as a part of initial assessment and treatment planning. Person-centered planning is also a requirement for individuals receiving waiver services as a part of the Individual Supports Plan (ISP) process and behaviorists that are billing therapeutic consultation behavioral services may request the individual's person-centered plan from the individual's support coordinator. There are a plethora of interview-based and empirically validated preference or reinforcement assessment tools that are also freely available via a web search. Several examples are the Reinforcer Assessment for Individuals with Severe Disability (RAISD), single stimulus preference assessments, paired stimulus preference assessments, and multiple stimulus preference assessments without replacement, to name a few. In the context of determining what is most important to an individual, research suggests the importance of empirically evaluating reported preferences from person centered plans (Green, Middleton, & Reid, 2000); validated empirical

preference assessments are tools which behaviorists should utilize to learn more about what is important to an individual in behavior support planning. Resources on person centered planning and preference or reinforcer assessment tools are available in the resources and references area below.

Resources and References:

Ala'i-Rosales, S., Cihon, J.H., Currier, T.D.R, Ferguson, J.L., Leaf, J.B., Leaf, R, McEachin, J., & Weinkauf, S.M. (2019). The Big Four: Functional Assessment Research Informs Preventative Behavior Analysis. *Behavior Analysis in Practice, 12(1), 222-234.*

Cornell University ILR School Employment and Disability Institute: http://www.personcenteredplanning.org/

Durand, V. M., & Carr, E. G. (1991). Functional communication training to reduce challenging behavior: Maintenance and application in new settings. *Journal of Applied Behavior Analysis, 24, 251-264.*

Hanley, G.P. (2012). Functional assessment of problem behavior: dispelling myths, overcoming implementation obstacles, and developing new lore. *Behavior Analysis in Practice, 5(1), 54-72.*

Green, C.W., Middleton, S. G., Reid, D.H. (2000). Embedded evaluation of preferences sampled from person-centered plans for people with profound multiple disabilities. *Journal of Applied Behavior Analysis, 33*(4), 639-642.

Kennedy Krieger Institute, Neurobehavioral Unit: Resources for Practitioners https://www.kennedykrieger.org/patient-care/centers-and- programs/neurobehavioral-unit-nbu

Newcomb, E.T. & Hagopian, L.P. (2018) Treatment of severe problem behavior in children with autism spectrum disorder and intellectual disabilities, *International Review of Psychiatry, 30*(1), 96-109, DOI: 10.1080/09540261.2018.1435513

The Learning Community for Person Centered Practices: https://tlcpcp.com/

Virginia Commonwealth University Center for Person Centered Practices (n.d.) *Person centered thinking.* http://www.personcenteredpractices.org/launch_pct.html

Trauma Informed Care in Behavior Support Planning

The concept of "trauma informed care" has become well known in education, health, and human services fields. One conceptualization suggests that trauma informed care is a recognition among service providers that there is the possibility for trauma related presentations with persons served and that an overall commitment is taken to reducing the likelihood that persons are re-traumatized through treatment (Keesler, 2014).

The Substance Abuse and Mental Health Services Administration further offers a trauma informed conceptualization as follows: "[a] program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist retraumatization." (SAMSHA, 2014, p. 9). Sadly, the DD population remains at a much higher likelihood than the general population for experiencing traumatic experiences of abuse, neglect, or exploitation. A 2012 Spectrum Institute study indicated that 70 percent of individuals with I/DD interviewed indicated they had been sexually, physically, or financially abused, and 90 percent of those individuals indicated that this abuse was ongoing (Baladerian, Coleman, & Stream, 2013). It is important for behavioral providers to be aware of such statistics when providing services to a vulnerable population, in particular one in which many individuals possess limited communicative skills. Such statistics suggest that it is more likely than not that those individuals that are receiving therapeutic consultation behavioral services have contacted traumatic experiences over the course of their lives, which may manifest in their overt behavioral repertoire. In children, repeated exposure to trauma can alter the child's psychobiological development and influence overt behavior; the neurological processes of children that experience complex trauma may be significantly impaired and result in changes in emotional self-regulation and responses to environmental stimuli (Ko, Ford, Kassam-Adams, Berkowitz, Wilson, Wong, Brymer, Layne, 2008). Regardless of one's age, significant or repeated exposure to traumatic events become a part of an individual's learning history and can shape an individual's behavioral patterns. Co-occurring symptoms or formal diagnoses of post-traumatic stress disorder or other mental health disorders are not uncommon among persons that have experienced trauma (Keesler, 2014). It is critical to thoroughly examine an individual's learning history, including their known trauma history, when completing an FBA. Subsequently, incorporating informed interventions in an individualized behavior support plan is a necessity.

At this time, there is unfortunately scant peer reviewed, empirical literature on trauma informed care practices specific to behavior support planning derived from FBA processes. Notably, however, the Center on Positive Behavior Supports and Interventions (PBIS) has provided practice guidelines on integrating a trauma informed approach within a PBIS framework in educational settings (*Note: PBIS is a three tiered model utilized in schools to achieve academic and social success which is rooted in behavioral research;* see Horner, Sugai, & Lewis, 2020).

Though PBIS operates at a school or district-wide educational level (and also includes a tier for individualized support for the most at risk students), the indications in recent PBIS practice guidelines on trauma informed care draws parallels between approaches, the following of which can be certainly applied

at an individual behavior support planning level in non-educational settings: predictable, safe, and positive environments promote healing and acquisition of new skills (Eber, Barrett, Scheel, Flammini, & Pohlman, 2020). With such a conceptualization in mind, there are some general suggestions offered as it relates to adopting a trauma informed care approach in functional behavior assessment, behavior support planning, and the delivery of behavioral services. As a part of the initial functional assessment process, behaviorists pay close attention to details about a person's physiological and psychiatric conditions, medication regimens, the aspect of the environment in which the person lives and interactions with others, as well as their learning history; this is part and parcel of a robust ecological assessment in the FBA process and can provide very useful information in beginning to formulate hypotheses as to what variables are contributing to and maintaining behavioral challenges. As a part of this assessment process, it is suggested that behaviorists also pay close attention to any apparent trauma history, and when appropriate ask follow up questions to learn about past or current events that may be impactful to the way the individual interacts with their world. If such information is garnered during the FBA process, it must be incorporated into the body of the behavior support plan both via individualized interventions that are designed specifically for the needs of the individual, as well as such that persons working to support the individual have clear awareness of traumatic experiences the individual has encountered. Such information should also be outlined in trainings presented as a part of ongoing psycho-education for families and staff members. When it is learned that there is a trauma history, some behaviorists may find it useful to conceptualize trauma in behavioral terms, such as conceptualizing trauma as an aversive event and to assume that there is a strong likelihood that the stimuli associated with traumatic experiences have become conditioned punishers for the individual. Behaviorists are trained to understand the naturally occurring patterns of behavior evoked surrounding known punishers, in particular escape or avoidance behavior, and are aware that in some situations these behavioral patterns may present with challenging behavior in the form of emotional or aggressive reactions (Cooper, Heron, & Heward, 2007). As it is important to consider the immediate consequence of challenging behavior, it is also important to consider the entirety of learning history as the sum of one's past experiences can influence behaviors that are used later in life (Kolu, N.D.). By learning about traumatic experiences in the functional assessment process, behaviorists can adopt trauma informed practices into behavior support plans and associated stakeholder training. As it relates to trauma informed practices in behavior support planning, a few basic examples may be as follows: providing as many opportunities as possible to contact positive reinforcers on a non-contingent basis, incorporating proactive teaching strategies for replacement behaviors, utilizing strategies that do not replicate a known traumatic experience (including in crisis or safety related strategies), and utilizing antecedent modification tactics to reduce the presence of discriminative stimuli in the environment which are associated with highly traumatic experiences. Again, it cannot be overemphasized that selected behavior change tactics should be clinically indicated based upon the specific needs of the person and function(s) of behavior(s) as determined through robust FBA procedures. In non-behavioral terms, and in particular as it relates to staff and key stakeholder training on behavior support plans, it is important to build in as much opportunity for choice as possible, provide freedom to encounter experiences that are positive and valued to the person without strings attached, to train staff to work as a partner as opposed to an authority figure, to be aware of the known "triggers" surrounding traumatic events and the known trauma history, to provide information on how staff can build rapport with an individual, to proactively plan for therapeutic safety and crisis interventions that are as non-restrictive and non-aversive as possible, to include information on known traumatic experiences in the content of the plan and tailor interventions that are mindful of these experiences, and of course to treat all individuals with the utmost dignity and respect at all times.

References and resources:

Adverse Childhood Experiences Study information:
https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html

American Psychological Association Division 56, Trauma Psychology. https://www.apatraumadivision.org/

Baladerian, N.J., Coleman, T.F., & Stream, J. (2013). Abuse of people with disabilities: victims and their families speak out. *Spectrum Institute Disability and Abuse Project.* Retrieved from: http://disability-abuse.com/survey/survey-report.pdf

Cooper, J., Heron, T. & Heward, W., 2007. *Applied Behavior Analysis*. 2nd ed. Upper Saddle River, NJ: Pearson.

Eber, L, Barrett, S., Scheel, N., Flammini, A. & Pohlman, K. Integrating a trauma-informed approach within a PBIS framework. *Center on PBIS.*
Retrieved from: https://www.pbis.org/resource/integrating-a-trauma-informed-approach-within-a-pbis-framework

Horner, R.H., Sugai, G., & Lewis, T. (2020). Is school wide positive behavioral interventions and supports (PBIS) an evidence based practice?
Center on PBIS. Retrieved from: https://www.pbis.org/resource/is-school-wide-positive-behavior-support-an-evidence-based-practice

Keesler, J.M. (2014). Trauma through the lens of service coordinators: exploring their awareness of adverse life events among adults with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities, 8(3), 151-164.*

Ko, S.J., Ford, J.D., Kassam-Adams, N., Berkowitz, S.J., Wilson, C., Wong, M. Brymer, M.J., & Layne, C.M. (2008). Creating trauma informed systems: child welfare, education, first responders, health care, and juvenile justice. *Professional Psychology: Research and Practice, 39(4), 396- 404.*

Kolu, C. (n.d.) *Interview with Camille Kolu: trauma informed behavior analysis helps trusted teams make informed care decisions*; *Awake Labs.*
https://awakelabs.com/trauma-informed-behavior-analysis-autism/

Sciaraffa, M. A., Zeanah, P. D., & Zeanah, C. H. (2018). Understanding and promoting resilience in the context of adverse childhood experiences. Early Childhood Education Journal, 46(3), 343-353.

Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and guidance for a trauma- informed approach (HHS Publication No. 14-4884). Retrieved from https://store.samhsa.gov/system/files/ sma14- 4884.pdf.

In addition, providers must be aware of and comply with the DBHDS Human Rights Regulations:

https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/section175/

https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/section230/

ATTACHMENT 3

Twenty-Second Review Period

Individual Services Review Study:

Quality of Behavioral Supports

Submitted By:

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Introduction

This report, including the following *Summary* and *Addendum,* was prepared, and submitted in response to the Independent Reviewer's request for a study, as part of the 22nd Review Period, to examine the Commonwealth of Virginia's implementation of the Settlement Agreement (SA) as it pertains to the Department of Behavioral Health and Disabilities Services (DBHDS) quality review and improvement process that examines and monitors the therapeutic consultation services provided by behavioral consultants. More specifically, the current Individual Services Review (ISR) study will specifically examine one Compliance Indicator (CI) under provision III.C.6.a.i-iii – this included 7.20 #4:

4) *Whether behavioral services are adhering to the practice guidelines issued by DBHDS.*

The purpose of the current ISR study was to identify whether or not DBHDS's quality review process was sufficiently implemented to establish whether or not supported individuals had behavioral services that adhered to DBHDS Practice Guidelines. In addition, the current ISR study aimed to compare data collected during the 19th Review Period with data collected during the current review period to evaluate progress in improving behavioral programming that more closely adhered to the Practice Guidelines. The three reviewers on the current ISR team were licensed Board Certified Behavior Analysts (BCBA) with extensive experience in the provision of behavioral services to individuals with significant challenging behaviors in community-based settings.

Methodology

The following Summary, including findings and related data summaries, is based upon the review of 25 individuals (8 females and 17 males). This sample was randomly selected from a larger population of individuals previously reviewed by DBHDS during their Quality Review and Improvement Process between 7/1/22 and 9/30/22. The behavioral services provided to these individuals was previously examined by DBHDS to determine the degree to which they adhered to its practice guidelines. This previous review included examination of available documentation and subsequent scoring of the DBHDS *Behavior Support Plan Adherence Review Instrument* (BSPARI). The BSPARI examines the minimal requirements of behavioral programming prescribed within the Practice Guidelines. The findings of this prior DBHDS review are described below. In an effort to examine the quality of this review

process, the current ISR team used the same methodology and reviewed the same documentation – that is, previously utilized by DBHDS – to determine if the above Compliance Indicator was being sufficiently met. More specifically, the same documents – for example, Behavior Support Plans (BSPs), Functional Behavior Assessments (FBA), training documentation, etc. – for each of the randomly selected individuals were reviewed and the BSPARI was scored to assess adherence to the practice guidelines. The findings from the current ISR study were also compared to previous findings of the prior DBHDS review, including an examination of agreement of total and item scores between review teams. Ultimately, the current study aimed to determine if DBHDS's quality review process was sufficiently implemented to establish whether the sampled individuals had behavioral services that adhered to the Practice Guidelines issued by DBHDS. Lastly, the current ISR study aimed to compare finding reported during the 19th Review Period with data collected during the current review period to evaluate progress in improving behavioral programming. More specifically, BSPARI total scores previously reported during the 19th Review Period were compared to scores reported in the current ISR study. This comparison was undertaken to examine the nature of progress over time in behavioral services adhering to the Practice Guidelines.

The following Summary is submitted in addition to BSPARI rubrics that were completed for each individual sampled as well as overall Data Summaries (Attachment 1).

Summary

Findings

1. The DBHDS BCBA clinicians overseeing its quality review and improvement process have identified and implemented needed improvements since this reviewer's previous study during the 19th review period in Fiscal Year 2022. The current 22nd Period study found that DBHDS has utilized the results of its BSPARI quality review assessments to identify needed improvements and to provide technical assistance feedback to TC (behavioral) consultants. Evidence found also indicates that the quality of FBAs and BSPs, as measured by the BSPARI, provided by behavioral consultants has improved since DBHDS revised and implemented its BSPARI assessment process.

2. The current study examined the findings of the prior DBHDS quality review by examining total scores of BSPARIs completed for the 25 sampled individuals. It was noted that two DBHDS professionals completed the reviews of all 25 sampled individuals – this included the three (12%) reviews completed by Sharon Bonaventura and 22 (88%) reviews completed by Nathan Habel. Based on the previous DBHDS quality review, of the 25 sampled individuals, DBHDS determined that only 15 (60%) individuals had behavioral programming with a total BSPARI score of 34 or higher (see Figure 1). Note: a score of 34 (85% of total points) or higher was the predetermined criterion identified by DBHDS as the score reflecting the minimal adherence to the practice guidelines. Consequently, based on the review completed by DBHDS, 15 (60%) of the sampled individuals (i.e., Individuals # 2, 3, 4, 5, 6, 7, 8, 9, 11, 14, 15, 17, 19, 22, & 23) were found to have behavioral programming that met (or exceeded) minimal adherence to the practice guidelines. Conversely, of the 25 sampled individuals, 10 (40%) individuals had behavioral programming with a total BSPARI score of 33 or less. Consequently, based on the review completed by DBHDS, 10 (40%) of the sampled individuals (i.e., Individuals #1, 10, 12, 13, 16, 18, 20, 21, 24, & 25) had behavioral programming that did not meet sufficient adherence to the practice guidelines.

3. In an effort to independently determine if behavioral services were sufficiently adhering to the practice guidelines, the current ISR study also examined the same behavioral programming previously assessed by DBHDS. This examination was accomplished by scoring BSPARIs using the same methodology and documentation previously used by DBHDS for the same 25 sampled individuals. Based on this review by the ISR team, it was determined that, of the 25 sampled

individuals, only three (12%) individuals had behavioral programming with a total BSPARI score of 34 or higher (see Figure 2). Note: a score of 34 (85% of total points) or higher was the predetermined criterion identified by DBHDS as the score reflecting the minimal adherence to the practice guidelines. Consequently, only three individuals (i.e., Individuals #4, #11, & #22) were found to have behavioral programming that met (or exceeded) minimal adherence to the practice guidelines. Conversely, of the 25 sampled individuals, 22 (88%) had behavioral programming with a total BSPARI score of 33 or less and, as a result, were identified as not meeting sufficient adherence to the practice guidelines. Consequently, based on the current ISR study, 22 (88%) of the sampled individuals were determined to have behavioral programming that did not meet sufficient adherence to the practice guidelines.

4. The current ISR team examined the level of agreement between the previous DBHDS review and the current review in determining the quality of behavioral programming as evidenced by scoring of the BSPARI. That is, the nature of agreement in determining which behavioral programs met minimal standards (i.e., a BSPARI score of 34 or higher) or did not meet minimal standards (i.e., a BSPARI score of less than 34) between reviews from DBHDS and the current ISR team was examined. The overall agreement between the DBHDS and current ISR teams was 52% (see Figure 3). More specifically, the reviewers agreed that three individuals (i.e., Individuals #4, #11, & #22) had behavioral programming that minimal adhered to the Practice Guidelines (i.e., BSPARI score of 34 or more). In addition, reviewers agreed that 10 individuals (i.e., Individuals #1, #10, #12, #13, #16, #18, #20, #21, #24, & #25) had behavioral programming that did not met minimal adherence to the practice guidelines (i.e., BSPAIR score of less than 34). The two review teams disagreed with regard to the quality of the behavioral programming and its adherence to the Practice Guidelines for 12 (48%) individuals – this included Individuals #2, #3, #5, #6, #7, #8, #9, #14, #15, #17, #19, & #23).

5. Given the variability in agreement observed between review teams (as noted above), the current ISR study more closely examined the overall agreement on individual line-item scores on the BSPARI as recorded by the prior DBHDS quality review study and the current ISR study. More specifically, this analysis included determining agreement and disagreement for each scored BSPARI item as well as overall percentage agreement (i.e., agreement / (disagreements + agreements)) for each of the 25 sampled individual. The range of scores as well as measures of

central tendency, including the mean, median, and mode, were calculated to facilitate interpretation of the data set. As shown in Figure 4, the overall percentage agreement across the 25 sampled individuals ranged from 60% to 90%, with a mean of 77%, median of 75%, and mode of 81%.

6. Given the variability in agreement between the two review teams when scoring items on the BSPARI (as noted above), the current ISR study further examined scored items in an effort to identify those items with the highest number of disagreements. Initial exploration revealed that several items had a high number (e.g., 10 or more) of disagreements. Consequently, the ISR team identified a criterion of '10 or more' and worked to identify relevant items that met that criterion. The ISR team readily noted that most of these items contained three possible score responses (e.g., X, ✓, N/A; X, ✓, UNK; or, X, ✓, ✓✓) compared to items with the two typical responses (i.e., X, ✓). As a result, the ISR team identified and examined items with 10 or more disagreements and/or three possible score responses – these are illustrated in Figure 5. Of the 11 items with more than 10 disagreements, nine (82%) were items with three possible score responses – this included Items #29, #40, #51, #61, #65, #82, #83, #84, #86, #102, & #103. It was noted that the items with the highest number of disagreements were Items #40 and #51. Four of the six items within the *Safety and Crisis Guidelines* section were noted to have high numbers of disagreement (Items #82, 83, 84, & 85) as well as all of the items in the *Graphical Displays and Analysis* section (with Items #102 & #103 meeting the criterion and Items #101 & #105 nearly meeting the criterion). Overall, one commonality found to most of the items with the highest number of disagreements is the increased number of possible response options.

7. In an effort to understand the nature of the high level of disagreement more fully, the current study more closely examined the responses recorded by the DBHDS review team for several of the items identified above, including Items #29, #40, #51, #61 & #65 (see Figure 6). This that, in addition to scoring 'Yes' (✓) or 'No' (X), items were also scored 'Not Applicable' (NA) or 'Unknown' (UNK). In addition, it was discovered that many items were often not scored at all. For example, across the 25 sampled individuals, items were left unscored four times for Item #29, 11 times for Item #40, and 13 times for Item #51. Overall, cells were left unscored 28 times which represented 37% of the total response opportunities for the current sample on these three items. Taken together with the frequent use of 'NA' or 'UNK', these findings are likely to explain some of the highest numbers

of disagreements observed in the sample. That is, these findings suggest that the high number of disagreements for some items can likely be explained by the increased variability due to increased response options as well as a significant number of unscored items (i.e., for these reviewed items). It should be noted that DBHDS readily shared that reviewers intentionally left some answers blank as they worked to refine better selections and explained that leaving items #29, #40, and #51 blank ultimately did not change the scoring. The ISR Team recognized the efforts to improve scoring but nonetheless, enountered descrepancies given that the ISR Team followed more current guidance when scoring these items. It should also be noted that, due to time constraints, further illustration of scores for additional items (e.g., Items #82, 83, & 84) was not included here. However, brief review revealed that the high level of disagreement was likely due to difficulty in determining when to use 'NA'. Similarly, lack of agreement on Items #101 - #105 was likely due to difficulty determining when to use '✓' or '✓✓' or other response choice. It was clear, however, that a similar explanation (i.e., for the high number of disagreements) would not be possible for Items #61 and #65. That is, the lack of agreement for these items was likely due to insufficient instructions/guidance, differences in judged presence and/or adequacy of content between reviewers, or a combination of both.

8. There were three exceptions noted with regard to items with three possible response options with a high number of disagreements – these included Item #86, Item #87, & Item #98 (see Figure 5). More specifically, these three items had a relatively low number of disagreements compared to items with similar possible response options. The current study hypothesized that these items targeted conspicuous and infrequently utilized interventions (e.g., restraint, timeout, or other restrictive component) thus reducing the number of scoring opportunities and the inherent potential variability when scoring.

9. Given the above findings highlighting the considerable variability in scoring resulting in high number of disagreements for specific items, the current ISR study completed a second agreement analysis. This second analysis, however, was completed only after removing several items with the highest number of disagreements from the analysis– this primarily included the removal of items with three possible responses. Overall, 14 items were removed prior to conducting this 'modified analysis' – these included Items #29, #40, #51, #82, #83, #84, #85, #86, #87, #98, #101, #102, #103, and #105. As previously done, the range of scores as well as measures of central tendency,

including the mean, median, and mode, were calculated to facilitate interpretation of the data set. As shown in Figure 7, the overall percentage agreement – for the initial analysis – ranged from 60-90%, with a mean of 77%, median of 75%, and mode of 81%. Following the removal of 'problematic items' (i.e., items with a high number of disagreements), the overall percentage agreement – for the modified analysis – ranged from 64-96%, with a mean of 83%, median of 83%, and mode of 84%. Overall, removal of problematic items improved agreement between the two review teams. The ISR team expects that revision of these items, including the nature of their scoring, would provide additional clarity to expected content as well as scoring procedures and ultimately improve agreement across reviewers. Lastly, as noted by DBHDS and acknowledged by the ISR Team, some discrepancies may have likely been further mitigated through additional reviewer training.

10. During the current study, it was noted by each ISR reviewer that some authors adhered closely to the structure of the BSPARI when writing their BSPs. That is, the sequence of content areas and elements within the BSP closely corresponded to that of the structure of the BSPARI. Reviewers noted, for example, that the BSPs for Individuals #4, #5, #9, #16 and #22 closely corresponded to the BSPARI format. When authors develop BSPs that closely correspond to the structure of the BSPARI, the outcome will likely be a more robust BSP that more closely adheres to the Practice Guidelines as well as provides a more efficient format for reviewers to score. Indeed, it appears that authors of BSPs who adhere to the BSPARI template were more likely to include the minimal content areas and related minimum elements. For example, for the five individuals identified above, all five had BSPs with scores above the mean ($\bar{x} = 24$) for the sample, and two of the BSPs (Individual #4 & #22) met or exceeded the minimal standard (i.e., total score of 34 or higher) of adequacy. This finding is consistent with previous verbal reports from DBHDS contacts that indicated that materials had been provided to providers and clinicians to assist in adherence to the BSPARI format as well as with verbal reports of feedback sessions facilitated by DBHDS with clinicians in an effort to better promote adherence to the BSPARI and the Practice Guidelines. It should be noted that the current ISR team found it difficult and time consuming to search across multiple documents for required content. Feedback from the current ISR reviewers indicated that inadvertent errors in scoring (and higher levels of disagreement across reviewers) was more likely given that required content could be documented across multiple documents (i.e., potentially missed by reviewers).

11. Summary data previously reported by the ISR team during the 19th Review Period was identified and compared to data currently collected to estimate the nature of progress over time relative to changes in the quality of behavioral programming. More specifically, total BSPARI scores reported during the 19th ISR study were compared to BSPARI scores collected during the current ISR study. This comparison was undertaken to determine whether or not progress was being made in improving behavioral programming as evidenced by higher BSPARI scores. As previously noted, the BSPARI was created to promote and monitor adherence to the Practice Guidelines and higher scores reflect stronger adherence. Based on DBHDS guidance, a BSP is determined adequate in its adherence to the inclusion of minimal content areas and related minimal elements if its score is at least 34 out of 40 total points. During the 19th review period, the ISR study reviewed BSPs for 27 individuals using the BSPARI. At that time, only one (4%) of the 27 BSPs was found to be adequate (see Figure 8). Currently, of the 25 BSPs reviewed, the ISR study found three (12%) was found to be adequate. Indeed, although these findings reflect a small increase in the number of BSPs that meet the minimal standard of adequacy, the current ISR study found improvement overtime. Overall, findings across the two review periods provide evidence of improvement in the quality of behavioral services and adherence to the Practice Guidelines.

12. In an effort to more closely examine and fully interpret the distribution of BSPARI scores reported during the 19th ISR study and the current ISR study, the range of scores as well as measures of central tendency, including the mean, median, and mode were calculated. For the 27 sampled individuals reviewed during the 19th ISR study, BSPARI total scores ranged from 3 to 34 and included a mean of 18, a median of 18, and mode of 13 & 23 (i.e., three BSPs had a score of 13 and three BSPs had a score of 23). For the sampled 25 individuals within the current ISR study, BSPARI total scores ranged from 10 to 36 and included a mean of 24, a median of 25, and mode of 26 (see Figure 9). When comparing the ranges and calculated measures of central tendency, it was evident that total BSPARI scores increased across these two review periods. More specifically, the distribution of total BSPARI scores for the current sample evidenced higher scores when compared to the previous sample. Evidence of this improvement over time is evident when visual analysis as well (see Figure 10). As illustrated, the distribution of scores reported within the current sample reflect higher values compared to scores reported within the sample from the previous ISR study. Indeed, 17 (68%) compared to 12 (44%) of BSPs had a total BSPARI score of 20 or more within the current sample compared to the prior ISR study, respectively. Lastly, many more BSPs

appeared to nearly meet the minimal criterion (of 34 points) within the current sample compared to the previous sample. More specifically, 4 (16%) and 13 (52%) BSPs with BSPAIR total scores that were within 5 and 10 points, respectively, of meeting the minimal criterion within the current sample. These findings are compared to the prior ISR study were only 1 (3%) and 4 (15%) BSPs had total BSPARI scores that were within 5 and 10 points, respectively, of meeting the minimal criterion within the previous sample. Overall, the distribution of scores of the current sample reflects higher values – compared to scores from the prior sample – and reflects improvement over time.

Conclusions:

1. Evidence indicates that DBHDS has a process to effectively monitor and review behavioral programming to promote and ensure that behavioral services are adhering to the Practice Standards. This process includes the use of the BSPARI by DBHDS reviewers who actively examine programming and provide feedback and technical assistance to clinicians. Indeed, two DBHDs reviewers completed reviews of individuals in the current sample and, according to verbal report, a third reviewer was recently hired and was being trained to similarly review behavioral programming.

2. Evidence indicated that some clinicians are using the BSPARI format to structure their BSPs. Following the BSPARI format appeared to enhance inclusion of minimal content areas and required elements leading to higher scores and closer adherence to the Practice Standards. If not already in place, it is recommended that DBHDS require BSPs to follow a standardized template based on the BSPARI.

3. Prior evidence provided by the DBHDS review team as well as current findings of the current ISR team indicates that some behavioral programming meet minimal adequacy criterion set by DBHDS. The ISR team recognizes that the BSPARI and related review process has only been implemented for a relatively short time and are encouraged by evidence of its initial success.

4. The current ISR team acknowledges the utility of the BSPARI in monitoring the nature of behavioral services, but also recognizes that further improvement is still needed. Levels of agreement across items on the BSPARI were found to be quite variable. Indeed, agreement on

several items was poor. However, agreement scores improved when selected items were omitted. Consequently, the ISR team recommends that DBHDS revise its instructions and/or the provision of more robust, supplemental guidance for several items, including processes for scoring (e.g., simplifying scoring options, reducing unscored items), to promote improved accuracy for individual items as well as to enhance agreement across reviewers. The ISR team also recognized that the number of documents involved in the review process likely contributed to the lower agreement on some items. Overall, DBHDS's current BSPARI assessment, scoring and feedback process provides an effective foundation for future refinement and quality improvement.

Lastly, data collected during the previous 19th and current 22nd review periods evidenced improvement in the quality of behavioral programming and adherence to the Practice Standards overtime.

Respectfully submitted by,

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Attachment 1

Data Summaries, including Figure 1-10 below:

Figure 1

ID #	DBHDS Review	34 pts or more
1	33	0
2	36	1
3	35	1
4	38	1
5	34	1
6	37	1
7	34	1
8	34	1
9	35	1
10	32	0
11	35	1
12	26	0
13	31	0
14	34	1
15	35	1
16	32	0
17	38	1
18	22	0
19	36	1
20	28	0
21	22	0
22	34	1
23	34	1
24	30	0
25	28	0
Total (N=25)		15
percentage		60%
Key: 0 = No; 1 = Yes		

Figure 2

ID #	ISR Review	34 pts or more
1	28	0
2	31	0
3	24	0
4	36	1
5	25	0
6	13	0
7	27	0
8	26	0
9	26	0
10	16	0
11	34	1
12	10	0
13	29	0
14	30	0
15	26	0
16	27	0
17	19	0
18	17	0
19	33	0
20	15	0
21	12	0
22	34	1
23	24	0
24	20	0
25	10	0
total (N=25)		3
percentage		12%
Key: 0 = No; 1 = Yes		

Figure 3

ID #	DBHDS Review	ISR Review	Agreement
1	33	28	1
2	36	31	0
3	35	24	0
4	38	36	1
5	34	25	0
6	37	13	0
7	34	27	0
8	34	26	0
9	35	26	0
10	32	16	1
11	35	34	1
12	26	10	1
13	31	29	1
14	34	30	0
15	35	26	0
16	32	27	1
17	38	19	0
18	22	17	1
19	36	33	0
20	28	15	1
21	22	12	1
22	34	34	1
23	34	24	0
24	30	20	1
25	28	10	1
total (N=25)			13
percentage			52%
Key: 0 = No; 1 = Yes			

Figure 4

ID #	Line-Item Agreement
1	87%
2	87%
3	76%
4	90%
5	70%
6	61%
7	74%
8	79%
9	79%
10	60%
11	86%
12	66%
13	79%
14	87%
15	81%
16	81%
17	76%
18	66%
19	86%
20	70%
21	74%
22	86%
23	81%
24	81%
25	67%
range =	60-90%
mean =	77%
median =	75%
mode =	81%

Figure

5

Item #	Item Description	# of Disagreements	Possible Responses
29	*Trauma history*	10	X, ✓, N/A
40	*Cultural/heritage considerations*	22	X, ✓, UNK
51	*Non-operant conditions*	21	X, ✓, N/A
61	*inclusion examples/non-examples*	12	X, ✓
65	*operational definition*	14	X, ✓
82	*Safety gear outlined*	15	X, ✓, N/A
83	*Crisis protocol*	13	X, ✓, N/A
84	*Supports needed to ensure safety*	12	X, ✓, N/A
85	*Topographies, intensities, etc*	11	X, ✓, N/A
86	*Restraint/time out debriefing*	3	X, ✓, N/A
87	*Restraint/time out criterion*	3	X, ✓, N/A
98	*Consent for restrictive component*	3	X, ✓, N/A
101	*Visual display for each behavior*	8	X, ✓, ✓✓
102	*Summary statement for each graph*	14	X, ✓, ✓✓
103	*Indicators on graphs*	14	X, ✓, ✓✓
105	*Data review reflected on graph*	9	X, ✓, N/A

Figure 6

ID #	Item 29	Item 40	Item 51	Item 61	Item 65
1	✓	✓	✓	✓	✓
2	✓	NS	✓	✓	✓
3	NS	NS	NS	✓	✓
4	✓	✓	✓	✓	✓
5	NA	✓	NA	✓	X
6	✓	UNK	NA	✓	✓
7	NS	NS	NS	✓	✓
8	NA	NS	NS	✓	✓
9	NA	✓	NS	✓	✓
10	✓	NS	NS	✓	✓
11	✓	UNK	✓	✓	✓
12	X	UNK	✓	X	✓
13	NA	UNK	NS	✓	X
14	✓	NS	NS	✓	✓
15	✓	UNK	NA	✓	✓
16	✓	✓	NS	✓	X
17	NS	NS	✓	✓	✓
18	NA	NS	NS	X	✓
19	✓	NS	✓	✓	✓
20	NS	NS	NS	✓	✓
21	X	UNK	NS	✓	✓
22	✓	NS	NA	✓	X
23	✓	✓	NA	✓	✓
24	✓	✓	NS	✓	X
25	✓	✓	NS	✓	X

Key: 1 = Yes; 0 = No; NA = Not Applicable; NS = Not Scored; UNK = Unknown

Figure 7

ID #	Initial Agreement Analysis	Modified Agreement Analysis
1	87%	89%
2	87%	95%
3	76%	86%
4	90%	96%
5	70%	82%
6	61%	64%
7	74%	84%
8	79%	86%
9	79%	84%
10	60%	64%
11	86%	93%
12	66%	71%
13	79%	84%
14	87%	93%
15	81%	86%
16	81%	88%
17	76%	79%
18	66%	68%
19	86%	91%
20	70%	75%
21	74%	77%
22	86%	91%
23	81%	84%
24	81%	84%
25	67%	73%
range =	60-90%	64-96%
mean =	77%	83%
median =	75%	83%
mode =	81%	84%

Figure 8

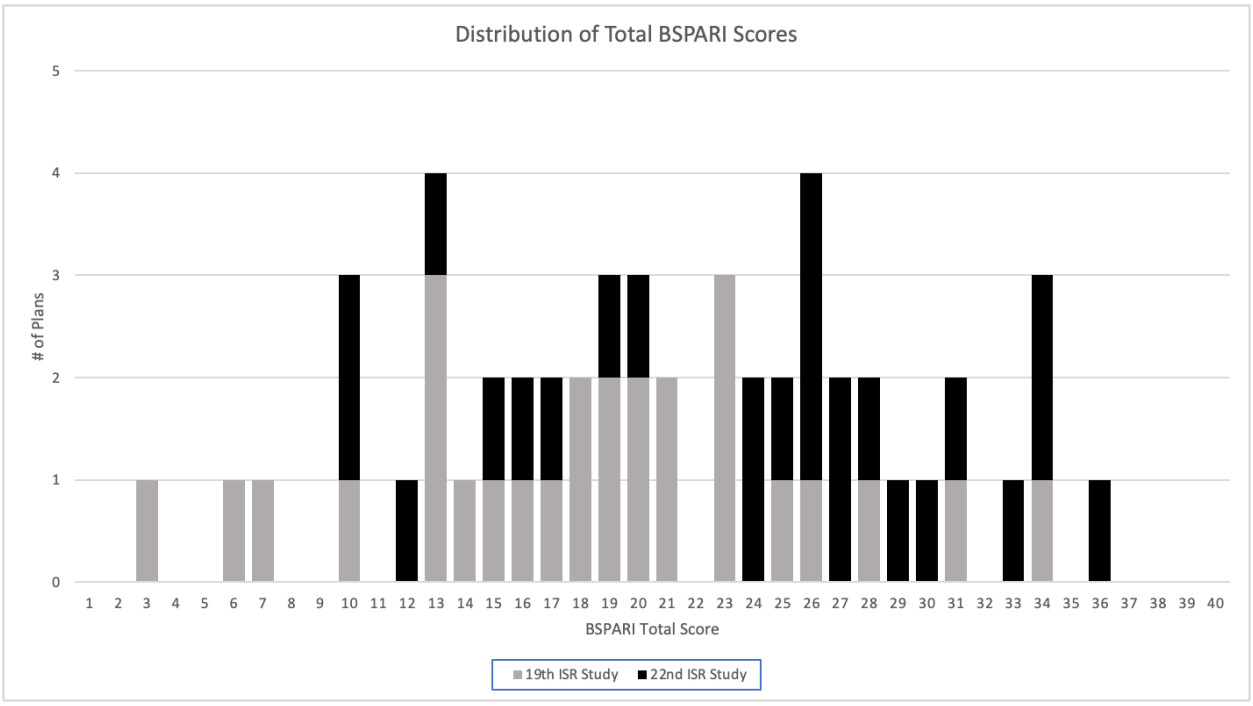
19th ISR Study		
ID #	**BSPARI Score**	**34 pts or more**
#8	13	0
#15	19	0
#32	18	0
#35	16	0
#7	17	0
#11	34	1
#17	20	0
#18	21	0
#21	19	0
#22	26	0
#26	23	0
#29	28	0
#6	7	0
#1	14	0
#2	18	0
#4	15	0
#9	23	0
#19	13	0
#24	6	0
#33	23	0
#39	13	0
#5	21	0
#10	3	0
#25	10	0
#27	25	0
#30	31	0
#40	20	0
total (N=27)		1
percentage		4%
Key: 0 = No; 1 = Yes		

22nd ISR Study		
ID #	**BSPARI Score**	**34 pts or more**
1	28	0
2	31	0
3	24	0
4	36	1
5	25	0
6	13	0
7	27	0
8	26	0
9	26	0
10	16	0
11	34	1
12	10	0
13	29	0
14	30	0
15	26	0
16	27	0
17	19	0
18	17	0
19	33	0
20	15	0
21	12	0
22	34	1
23	24	0
24	20	0
25	10	0
total (N=25)		3
percentage		12%
Key: 0 = No; 1 = Yes		

FIGURE 9

	19th ISR Study	22nd ISR Study
ID # 19th & 22nd	**BSPARI Score**	**BSPARI Score**
8 &1	13	28
15 &2	19	31
32 & 3	18	24
35 & 4	16	36
7 & 5	17	25
11 & 6	34	13
17 & 7	20	27
18 & 8	21	26
21 & 9	19	26
22 & 10	26	16
26 & 11	23	34
29 & 12	28	10
6 & 13	7	29
1 & 14	14	30
2 & 15	18	26
4 & 16	15	27
9 & 17	23	19
19 & 18	13	17
24 & 19	6	33
33 & 20	23	15
39 & 21	13	12
5 & 22	21	34
10 & 23	3	24
25 & 24	10	20
27 &25	25	10
30	31	
40	20	
total N =	27	25
range =	3 to 34	10 to 36
mean =	18	24
median =	18	25
mode =	13 & 23	26

Figure 10


Distribution of Total BSPARI Scores
# of Plans
0
1
2
3
4
5
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BSPARI Total Score
19th ISR Study
22nd ISR Study

Timelines and required documentation for therapeutic consultation behavioral services authorizations

Note: The table below provides a summary visual. Please see the full text of the regulations that govern this service at: 12 VAC 30-122-550

Authorization Type	*Timeframe*	*Required documentation for authorization*
Initial Authorization	Up to 180 days	• Part V must outline the following: ○ that a Functional Behavioral Assessment (FBA) will be conducted ○ that a BSP will be created ○ the plan for data collection during this period
Second authorization	Post 180 days of the initial authorization period until the ISP annual date	• Behavior Support Plan • FBA (the FBA may be within the BSP or a separate document). • Any baseline data or treatment data collected used in formulating the plan • Part V must outline the following: ○ Request for or description of training for stakeholders must be included and parallel what is included in the training section of the BSP. ○ Measurable benchmarks for behaviors targeted for increase and decrease in the BSP, which must be included in the " I no longer want (or)/need supports when..." area of the Part V
ISP Update (Annual renewal or when needed)	Annual ISP date to annual ISP date	• Graphical displays with progress summary covering at least the current review period. • Current BSP • Current FBA (FBA can be incorporated into the BSP or on a separate document) ○ In preparation for the shared planning meeting, the most recent FBA and treatment data must be reviewed by the behaviorist. A reference of this review and the behaviorist's determination of the continued validity or need for re-assessment must be included in the FBA. See Part V requirements below if re-assessment is determined. • Documentation of any training completed within the timeframe of the most recent review period • Part V must outline the following: ○ Request for or description of training for stakeholders must be included and parallel what is included in the training section of the BSP. ○ *If the behaviorist determines re-assessment is needed, request re-assessment in Part V. If behaviorist determines previous FBA is still valid, re-assessment does not need to be include in the Part V.*

APPENDIX E

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

by

Rebecca Wright, MSW, LICSW

Individual and Family Support Program 22nd Period Study

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 2023, the Independent Reviewer's monitoring priorities again include studying compliance with these agreed-upon compliance indicators.

The Independent Reviewer's previous reports (i.e., 6th, 8th, 12th, 14th, 16th, 18th and 20th Reports to the Court, dated June 6, 2015, and June 6, 2016, June 13, 2018, June 13, 2019, June 6, 2020, June 13, 2021 and June 13, 2022, 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 met some but not all of the qualitative requirements for the IFSP. For the 20th Report to the Court, dated June 13, 2022, the following summarizes the compliance status of the Provisions and Compliance Indicators (CIs) under review as of the time of the 20th Report:

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

- Regarding Provision III.C.8.b.'s two Indicators, the Commonwealth had met both of them: 17.1 and 17.2.
- Regarding Provision III.D.5.'s three Indicators, the Commonwealth did not meet any of them: 19.1–19.3. (This represented a decrease from the Eighteenth Period, when one Indicator was met.)

22nd Period Study Purpose and Methodology

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

In addition, the Independent Reviewer has also instructed consultants completing studies to review any applicable Process Document and Data Set Attestation Form for CIs which require the reporting of valid and reliable data, to review previous findings by the Office of DQV (now the Office of EHA) to determine what, if any, reliability and validity deficiencies (i.e., related to the data collection methodology and/or the data source system) exist, and to review and analyze the documented facts related to the extent to which the Process Document appears to have sufficiently addressed all previously identified deficiencies/threats related to data reliability and validity.

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. The full list of documents and data reviewed may be found in Attachment B. Of note, IFSP staff provided summary documents for most CIs that clearly laid out the program activities and specific progress achieved. These were extremely helpful in ensuring a comprehensive understanding of compliance status, and much appreciated by the reviewer.

Summary of Findings

For each provision cited above, this 22nd period study again found DBHDS continued to make progress and ongoing staff vacancies at the state level were continuing to stabilize. At the time of this report, the Commonwealth had met 14 of 17 CIs. DBHDS had provided, as applicable, Process Documents and related documents that described methodologies for reporting valid and reliable data of key CIs. The following bullets describe additional progress noted:

- In response to the data breaches that occurred in the previous two funding cycles, DBHDS completed development of a new module in the Waiver Management System (WaMS) to replace the application funding on-line portal, and it was successfully launched for the FY 23 funding period.
- DBHDS staff had consistently followed the protocols they indicated were applicable to annual eligibility and/or IFSP funding notification processes;

- DBHDS finalized the definition of those "most at risk for institutionalization" and the funding prioritization criteria based on that definition. These were in place during the FY 23 funding period that concluded in March 2023.
- DBHDS had updated various documents to inform individuals and families about eligibility criteria for individuals on the waitlist to receive case management.
- DBHDS staff had designed and disseminated a satisfaction survey that addressed the feedback the Independent Reviewer has provided in past reports with regard to the efficacy of the previous methodology.
- With the assistance of the Office of Epidemiology and Health Analytics (EHA), IFSP staff had reviewed and revised the measurable indicators in the IFSP State Plan intended to assess performance and outcomes of the IFSP, and had made substantial progress with regard to the measurability of program goals and outcomes. While some data methodologies were not fully fleshed out and could benefit from some additional work, for the three outcomes specifically required (i.e., as defined in CI 1.5 through CI 1.7), a review of the measurement methodologies did not reveal any significant deficiencies.

There also continued to be some areas for which progress was more limited, resulting in three Not Met findings:

- While DBHDS made substantial progress for CI 1.1 overall, it was not met because it requires , the offering of information and referrals through an infrastructure that provides local community-based support through the IFSP Regional Councils. These Regional Councils continued to be largely non-functional for the period covered by this report. However, IFSP staff reported they had finalized Regional Council membership selection in March 2023, with an initial orientation meeting scheduled for April 2023. In preparation for that meeting, DBHDS staff provided the membership with an updated draft charter and other material for their review. It appeared the work DBHDS has completed and has planned for the months ahead formed a foundation for a meaningful re-implementation of local community-based support through the IFSP Regional Councils.
- DBHDS had not yet taken recommended actions from the 18th and 20th Period reports to ensure procedures for the Family-to-Family and Peer Mentoring programs to address the specific requirements of the Provision III.D.5 and CIs 19.2 and 19.3

The table below illustrates the most recent and the current compliance status for each Compliance Indicator.

III.C.2.a-f (II.D): Indicators	**Status 22nd Period**
1.1 The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following: • Funding resources • A family and peer mentoring program • Local community-based support through the IFSP Regional Councils	**Not Met**
1.2 The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization.	**Met**
1.3 The IFSP State Plan establishes a requirement for an on-going communication plan to	**Met**

ensure that all families receive information about the program.	
1.4 The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including:	**Met**
1.5 The number of individuals on the waiver waitlist who are provided with outreach materials each year	**Met**
1.6 Participant satisfaction with the IFSP funding program	**Met**
1.7 Knowledge of the family and peer mentoring support programs	**Met**
1.8 Utilization of the My Life, My Community website	**Met**
1.9 Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter.	**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	**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**
17.1 DBHDS has developed and launched the "My Life, My Community" website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. This will be documented by reports of activity on the website.	**Met**
17.2 Documentation indicates that the My Life, My Community website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families.	**Met**
III.D.5 (IV.B.9.b.): Indicators	**Status**
19.1 At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources.	**Met**
19.2 The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested.	**Not Met**
19.3 The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to-family and the peer-to-peer supports have contact and the number who receive the service.	**Not Met**

Analysis of 22nd Review Period Findings

22nd 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 20th Period **22nd Period**
1.1 The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following: • Funding resources • A family and peer mentoring	The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council includes the essential components of a comprehensive and coordinated set of strategies, including funding resources, a family	DBHDS issued the current IFSP State Plan in 2019, as well as the most recent *IFSP State Plan Update* in February, 2023. As reported during the 20th Period review, the February 2022 version indicated that DBHDS IFSP staff would collaborate with IFSP State Council to conduct a more extensive review of the IFSP State Plan prior to the installation of a new State Council in January 2023. Based on interview with IFSP staff during this review period, they completed a review of the plan and updated goals and objectives with the assistance of the Office of Epidemiology and Health Analytics (EHA) and reviewed these with the State Council. The State Council minutes dated 1/20/23 reflected this review. However, IFSP staff reported they anticipated undertaking a previously planned more extensive review after the new State Council is seated in April 2023.	20th - Not Met **22nd - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
program • Local community-based support through the IFSP Regional Councils	and peer mentoring program and local community-based support through the IFSP Regional Councils. The IFSP Funding Program has been in continuous operation since 2013 and DBHDS continued to provide funding resources annually. In addition, IFSP staff have issued, and updated as needed, formal guidelines, policies and procedures sufficient to implement the program. For this 22nd Period review, funding period opened on 1/23/23 and closed on 2/24/23. This funding period relied on a newly designed set of prioritization criteria as well as a new funding portal integrated into WaMS. DBHDS created and disseminated a clear and complete set of written finalized policies, procedures, instructions, protocols and/or tools and	Previously, DBHDS had developed a Departmental Instruction (DI) with regard to the IFSP (i.e., *DI 113 (TX) 20: Facilitation of Access to Resources and Supports to Enhance Community Inclusion and Engagement*). The DI, dated 9/4/20, remains current for this 22nd Period review. The document states its purpose as to outline the supportive policies within the IFSP, as they relate to the administration of peer-to-peer mentoring, family-to- family mentoring, information and referral, and the IFSP community coordination efforts. DBHDS staff reported no changes to the DI for this 20th Period Review. As previously noted, this DI provides extensive definitions of terms, but guidance tends to be broad, non-specific and/or limited in scope. Instead, it defers to the DBHDS Central Office to "ensure that procedures are developed to comply with this DI." Specifically, the DI indicates that the procedures to be developed shall include: • Processes and procedures to support the implementation of the State Plan and the state and regional council structure to build the local infrastructure to promote person-centered and family-centered resources, supports, services, and other assistance; • A process for providing family and peer mentoring to provide one on one support and information to individuals and families; • A process to establish criteria for identifying applicants most at risk for institutionalization; and, • A process to maintain accessible, user-friendly information including information on eligibility for IFSP-Funding, case management, and other DD resources and services through a website and other mechanisms that shall be shared with individuals upon their placement on the DD Waiver Waiting List. This Compliance Indicator requires implementation of the strategies	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
	held informative online trainings with stakeholders DBHDS provides for both a family and a peer mentoring program, as evidenced by vendor contract and quarterly reports. DBHDS provided an updated contract modification, dated 4/12/22, to the original Memorandum of Agreement (MOA) with the Virginia Commonwealth University Center for Family Involvement (CFI) Partnership for People with Disabilities to show continuation of the family-to-family program for the period between 7/1/22 through 6/30/23. DBHDS continued to work with the Arc of Virginia to implement a peer mentoring program and associated infrastructure. On 4/14/22, DBHDS	in the IFSP State Plan, specifically "offering information and referrals through an infrastructure" that includes funding resources, family and peer mentoring programs and local community-based support through the IFSP Regional Councils. As the DI indicates, DBHDS staff acknowledge that such implementation requires a foundation of a minimum set of clear, written finalized policies, procedures, instructions, protocols and/or tools. At the time of the 20th Period review, with regard to funding resources, DBHDS had developed and published a clear set of most such documents, but had not yet fully done so for the family and peer mentoring programs. The most recent funding period at that time occurred in October 2021, at which time DBHDS continued to provide funding resources, a clear set of written finalized policies, procedures, instructions, protocols and/or tools. For this 22nd Period review, funding period opened on 1/23/23 and closed on 2/24/23. This funding period relied on a newly designed set of prioritization criteria as well as a new funding portal integrated into WaMS. DBHDS created and disseminated a clear and complete set of written finalized policies, procedures, instructions, protocols and/or tools and held informative online trainings with stakeholders. The details are described further below in this section and with regard to CI 1.2. At the time of the 20th Period review, due to pandemic-related challenges and staffing turnover, the Regional Councils were not operational. Further, DBHDS staff indicated they intended to make structural changes to the Regional Councils, and expected to meet with IFSP State Council in the near future to begin to envision the future of the regional structure, roles and responsibilities. Therefore, the existing charters and other documents describing the role of the Regional Councils were not a current set of finalized policies,	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
	executed the most recent contract renewal with the Arc. For this review period, there had been some significant changes to the operations of the Regional Councils, and they were largely non-functional at the time of this report and none had current members appointed. DBHDS staff also reported they were beginning to consider whether, and how, those roles and responsibilities might need to look different in the future. As a result of these circumstances, the existing Regional Council charter, dated 2/24/21, was not sufficient to describe a yet-to-be-determined local infrastructure and will need to be reviewed and modified as appropriate. For this 22nd Period, with the exception of DBHDS updating notices on the	procedures, instructions, protocols and/or tools, nor did they reflect the DBHDS plan and commitment for future practices. This remained true for most of the current 22nd Period review. While the State IFSP Council continued to meet throughout the past year, DBHDS had just selected new Regional Council members in March 2023 and held a first meeting in April 2023. IFSP State Council meeting minutes for April 2022 and June 2022 indicated that DBHDS continued to defer the previously proposed re-visioning of the Regional Councils' structure, roles and responsibilities. By the time of this review, IFSP staff reported that, during the upcoming year, DBHDS instead intended to retain the existing structure to allow time for a more thorough examination and subsequent decision-making. The January 2023 IFSP State Council minutes reflected a related discussion. The following paragraphs describe the relative presence and/or absence of other needed documents and/or processes. **Funding Resources:** For this review, DBHDS continued to provide funding resources annually. The previous funding period occurred in October 2021 and distributed funds from both FY 2021 and FY 2022. For that funding period, the process relied on the Individual & Family Support Program Application Portal, which could be accessed via a link on the My Life My Community (MLMC) website. As described in previous reports, malfunctions of this IFSP-Funding Portal in both 2019 and 2021 caused breaches of some individuals' private information. DBHDS reported concluding that rather than attempting to repair the Portal again, they would seek a completely new solution. As a result, at the time of the 20th Period review, DBHDS was in the midst of making potentially fundamental changes	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
	Regional Council Facebook pages, the Regional Councils continued to be on hold throughout most of the year since the last review. IFSP staff reported they had finalized membership selection in March 2023, with an initial orientation meeting scheduled for April 2023. In preparation for that meeting, DBHDS staff provided the membership with an updated draft charter and other material for their review. However, the Regional Councils were not in place during this review period	to its IFSP Funding Program infrastructure and was working to integrate a new Funding Portal module into the Waiver Management System (WaMS). For this 22nd Period review, the WaMS Funding Portal was operational for the FY23 funding period that took place in in January 2023 through February 2023. It worked successfully, with no significant issues. Additional details with regard to funds distributed for FY23 are provided below under CI 1.12. For this review period, DBHDS staff implemented a new set of prioritization criteria following a determination that previously described prioritization criteria were not feasible or practical within existing resources. DBHDS staff presented the revised criteria to the IFSP State Council at the 4/22/22 meeting and received their feedback and agreement to move forward. Additional details with regard to the prioritization criteria for the January 2023 funding period are provided below under CI 1.2. The aforementioned DI defined the IFSP Funding Program in the following manner: subject to the availability of funds, the IFSP Funding available in accordance with 12 VAC 35-230 assists individuals on Virginia's DD Waiting List and their families with accessing resources, supports and services. While the DI did not otherwise detail guidance with regard to the operation of the funding program, DBHDS continued to maintain an extensive library of formalized policies and procedures, which they had consistently updated over time to address any programmatic changes. IFSP staff disseminated various tools to support users in accessing and using the portal, including the *IFSP Portal User Guide* dated 1/17/23, the *DBHDS IFSP Funding Guidelines*, updated 1/9/23, and a document entitled *IFSP-Funding Application Quick Tips, Version Date: 1/26/2023*. IFSP staff also created an *IFSP Funding Application Training Video (FY23)*, which was delivered live on 1/18/23 and then posted to YouTube for ongoing access. In addition, as described further below	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
		for CI 1.3 of this provision, IFSP staff worked with other DBHDS staff to develop a robust capacity for providing all individuals on the waitlist with time-sensitive notifications of funding availability. For this 22nd Period review, DBHDS provided documentation to show the notifications procedures were followed. **A Family and Peer Mentoring Program:** The Settlement Agreement requires the Commonwealth to develop family-to-family and peer mentoring programs as a part of a comprehensive and coordinated set of person-centered and family-centered strategies, but also specifically to facilitate opportunities for families and individuals considering congregate care receive information about options for community placements, services, and supports. As reported previously, at this time, DBHDS continues to contract with the Virginia Commonwealth University Center for Family Involvement (CFI) Partnership for People with Disabilities to engage with individuals and families on behalf of DBHDS across a platform of programs. These efforts include the implementation of a family-to-family network to provide one-to-one emotional, informational and systems navigational support to families. For this 22nd Period, DBHDS provided an updated contract modification to the original Memorandum of Agreement (MOA), dated 4/12/22, to show continuation of the family-to-family program for the period between 7/1/22 through 6/30/23. As described at the time of the previous study, the brochure for the Family-to-Family Network of Virginia states the intent is to support families of children and adults with disabilities and special health care needs. Through the program, Family Navigators provide support and information, and discuss options with families so they can make the best choices for their family member with a disability. Family Navigators are a parent or primary caregiver who have supported a	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
		child or adult family member with disabilities or special health care needs, who has been trained to support other families in accessing supports and services for their child and family and are knowledgeable about local and state resources and disability service systems. This program had been in existence for more than 15 years and is well-established. As reported previously, for this 22nd Period review, the primary DBHDS vehicle for the implementation of peer-to-peer supports continued to be a statewide peer mentoring system operated by The Arc of Virginia (The Arc). On 4/14/22, DBHDS executed the most recent contract renewal, which renewed the original agreement that was dated 5/26/20. The original contract described a "Phase One" and "Phase Two" scope of work to develop the necessary infrastructure to successfully implement a Statewide Peer Support Program, and included the following peer mentoring activities: 1) develop a Statewide Alliance of self-advocacy groups; 2) assist DBHDS with increasing the participation and input of self-advocates across multiple program initiatives; 3) provide statewide leadership on peer supports by supporting DBHDS' vision of more fully incorporating the voice and engagement of self-advocates across multiple DBHDS initiatives; 4) collaborate with the IFSP to promote the peer mentor program, recruit and prepare both mentors and mentees, and ensure access for individuals not receiving waiver services; and provide quarterly and semi-annual reports. The third activity included multiple tasks pertinent to this CI, primarily related to the development and implementation of a peer mentoring curriculum and network. Of note, a contract modification, dated 5/3/20, also specifically required the ARC to expand trainings to include supporting people on the DD Waiver Waiting list (WWL) that were not eligible for Peer-to-Peer Waiver Services. Based on review of the *Peer Mentor Quarterly Report*, for the period October through December 2022, the Arc had a total of 11 trained	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
		Peer Mentors across Virginia. Both CFI and The Arc submitted ongoing quarterly reports of activities and outcomes. Overall, DBHDS had met the requirements for implementing family and peer mentoring programs for this CI. However, DBHDS had not yet implemented a clear referral protocol for accessing either the family-to-family or peer mentoring services for the purposes of Provision III.D.5, as described further below with regard to CI 19.2. **Local community-based support through the IFSP Regional Councils:** At the time of the 18th Review Period, the review found that Regional Council system was well-organized and efficient. The Community Coordination program served as the hub for family engagement and the primary vehicles for that engagement were the IFSP State and Regional Councils. While the purpose of the State Council was to provide guidance to DBHDS reflecting the needs and desires of individuals and families across Virginia, based on the current IFSP State Plan, the five IFSP Regional Councils were envisioned as the primary means of providing local community-based support (e.g., identifying and/or developing local resources and sharing those with their communities.) However, at the time of the 20th Period review, the Regional Councils were largely non-functional. In addition to challenges resulting from the COVID-19 pandemic restrictions, this appeared to be due at least in part to the departures of key DBHDS staff at the state and regional levels as well as other changes in the availability of operational supports from VCU. Unexpected staff departures of both peer support specialists, the Community Coordinator, and the Program Manager, led to a hold on Regional Council activities since October 2021. At the time of the 20th Period review, none of the Regional Councils had been constituted, although DBHDS had	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
		surveyed previous members about their future interest in continuing membership. Further, at that time, there was a lack of clarity about the future roles of the Regional Councils. DBHDS staff reported they were beginning to consider whether, and how, those roles and responsibilities might need to look different in the future. The *IFSP State Plan Update*, dated 2/15/22, noted that DBHDS staff was seeking to explore the most sustainable way to facilitate community support groups in the future, while relying on local partners to move the vision of the State Plan and Regional Councils forward. DBHDS staff stated a continuing commitment to supporting Regional Councils, but there were no firm parameters. For this 22nd Period, with the exception of DBHDS updating notices on the Regional Council Facebook pages, the Regional Councils continued to be on hold throughout most of the year since the last review. Again, this was due largely to continuing staff vacancies and the focus of existing staff on ensuring the availability of funding during this period. IFSP State Council meeting minutes for April and June 2022 continued to indicate that DBHDS deferred the proposed revisioning of the Regional Councils' structure, roles and responsibilities. At the time of this review, IFSP staff reported that DBHDS intended to retain the existing structure to allow time for a more thorough examination and subsequent decision-making. The January 2023 IFSP State Council minutes reflected a related discussion. In interview, IFSP staff reported they had finalized membership selection in March 2023, with an initial orientation meeting scheduled for April 2023. In preparation for that meeting, DBHDS staff provided the membership with an updated draft charter and other material for their review. IFSP staff also provided a document	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
		entitled *IFSP Council Application and Appointment Process: FY 2023 Update*, dated 4/12/23, with additional details about this process. Based on review of this material and interviews with IFSP staff stakeholders, it appeared the work DBHDS has completed and has planned for the months ahead formed a foundation for a meaningful re-implementation of local community-based support through the IFSP Regional Councils. However, this was not in place during this review period. In addition, the following updated *IFSP State Plan* outcome remained unmet: "Each of the 5 Regional Councils will develop a work plan and establish annual goals that include a regional gap analysis and plan for increasing support got Virginians with Development Disabilities." Similarly, several other updated outcomes require input from the Regional Councils.	
1.2 The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization.	DBHDS formalized prioritization criteria for determining applicants most at risk for institutionalization. It provided for two categories for fund distribution based on Priority designation on the WWL. Based on the IFSP State Council meeting minutes, dated 4/22/22, IFSP staff presented the proposed Funding Program update and sought the members' input.	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. Over the course of the 18th and 20th Period reviews, DBHDS proposed varied strategies for prioritization criteria for determining applicants most at risk for institutionalization. When the 20th Review Period commenced, as of February 2022, DBHDS staff reported they had begun drafting new regulations to enact a Prioritization Model proposed during the 18th Period, with an expectation those regulations would be approved in FY 2023. DBHDS also reported that it was given authority to promulgate emergency regulations for the 2022 General Assembly session, with budget language expected	20th - Not Met **22nd - Met**

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	The Commonwealth took the following additional steps to operationalize the prioritization criteria: • Issued a document entitled IFSP Funding Categories– Revised Plan Proposal, dated 5/6/22, which described the prioritization criteria as well the plans for, functions and benefits of the new Funding Portal being incorporated in WaMS. • In August 2022, issued an Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document, describing the proposed amendments to *12 VAC35-230* to establish criteria and annual funding priorities through the Annual Funding Program	to be approved in April 2022 once the session ended. However, as the 20th Period was concluding, DBHDS staff reported back that, upon further examination, they believed the draft prioritization criteria described above did not appear to be feasible, given IFSP staffing resources, or even represent the best use of DBHDS resources overall. DBHDS did describe an intent to continue an annual funding resource. However, it was still not clear how DBHDS staff would determine which individuals on the waitlist (WWL) were "most at-risk for institutionalization," although they indicated they would likely consider the WWL priority categorizations in some manner. Therefore, DBHDS staff did not have a policy, DI of other protocol to further describe the implementation of these processes and expected outcomes. It also remained unclear how individuals on the WWL would become aware of how to access the Critical Needs Summary processes and other resources, particularly if they were not in the Priority One designation or receiving Support Coordination. For this 22nd Period review, DBHDS provided thorough documentation to show it had met this CI. Based on the IFSP State Council meeting minutes, dated 4/22/22, IFSP staff presented a proposed Funding Program update and sought the members' input. The presentation noted that DBHDS was in the process of creating a new portal for future funding cycles and that, to achieve compliance with the Settlement Agreement requirements, it must incorporate a prioritization model. Based on previous stakeholder input and the goals of the IFSP State Plan, the presented model described both funding categories and criteria that would help address different types of needs and move away from exclusively a "first-come, first-served" process. IFSP staff noted these prioritization categories would be different than those previously proposed. Instead, the revised proposal streamlined the prioritization of funding categories, based on the WWL Prioritization criteria (i.e., as defined in the *DD Waiver Chapter 4*, dated 11/1/22.) The proposal provided for two categories	

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	Guidelines and to ensure public input. • On 11/23/22, issued an *IFSP-Funding Regulatory Action and Public Comment Forum*, noticing individuals on the waitlist of the upcoming regulatory changes and how they could review and comment on the language in the draft guidance document entitled I*FSP Funding Guidelines (FY2023)*. • On 12/5/22, issued a monthly *IFSP Digest*, again notifying individuals on the waitlist of proposed upcoming regulatory changes to the IFSP-Funding Program and how to make public comment. • Issued the *IFSP State Plan Update*, dated 2/7/23, which integrated these criteria into the outcomes and	for fund distribution: • Fifty percent (50%) of ISFP annual funding would be devoted to applicants in Priority 1, with approval based on the application and the individual's scores for the *Critical Needs Summary,* specifically to question 7a and 7b which consider behavioral and medical support needs. Each approved recipient would receive $1,000. • The remaining 50% of the annual funding amount would be used to fund applications from individuals in Priorities 2 and 3, with $500 per approved recipient. To avoid the potential or perceived inequities in the former "first-come, first-served" methodology, eligible applications would be funded based on a randomized selection. Of note, to further expand the reach of the funding to the larger population, Priority 2 and 3 applicants approved in one funding cycle would not be eligible to apply for the next two funding cycles. IFSP staff indicated they will need data to determine whether 2 funding cycles will be sufficient enough to ensure that funds are distributed to new and different people over the course of 3 years. • If funds remained available after disbursement to all approved applicants are disbursed in a funding period, an additional application period would be offered, following the same process described above. In the months that followed, the Commonwealth took the following additional steps to operationalize the prioritization criteria: • DBHDS issued a document entitled *IFSP Funding Categories–Revised Plan Proposal*, dated 5/6/22, which described the prioritization criteria as well the plans for and functions and benefits of the new Funding Portal incorporated in WaMS. • In August 2022, the Commonwealth issued an *Emergency*	

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	activities. • Implemented the prioritization criteria for the FY23 funding period.	*Regulation and Notice of Intended Regulatory Action (NOIRA)Agency Background Document,* describing the proposed amendments to *12 VAC35-230* to establish criteria and annual funding priorities through the annual funding program guidelines, and to ensure public input. • 11/23/22, DBHDS issued an *IFSP-Funding Regulatory Action and Public Comment Forum*, noticing individuals on the waitlist of the upcoming regulatory changes and how they could review and comment on the language in the draft guidance document entitled *IFSP Funding Guidelines (FY2023).* • On 12/5/22, IFSP staff issued a monthly *IFSP Digest,* which reminded individuals on the waitlist of proposed upcoming regulatory changes to the IFSP-Funding Program and informed them that the Virginia Town Hall website was now open for public comment regarding the proposed *IFSP Funding* guidelines. The *IFSP Digest* provided the link to review the message, including how individuals could review and comment. • DBHDS staff issued the *IFSP State Plan Update*, dated 2/7/23, which integrated these criteria into the outcomes and activities. • DBHDS implemented the prioritization criteria for the FY23 funding period.	
1.3 The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program.	The *IFSP State Plan Update*, dated 2/7/23, includes a goal that reads to "DBHDS develops a comprehensive communication plan that provides information to individuals and families as	The *IFSP State Plan Update*, dated 2/7/23, includes a goal that reads to "DBHDS develops a comprehensive communication plan that provides information to individuals and families as well as stakeholders who support them at least annually," 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.	20th – Not Met **22nd - Met**

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	well as stakeholders who support them at least annually," 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. The *IFSP Communications Plan FY 2023,* updated 2/10/23, 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	Consistent with previous reports, the current version of the communication plan (i.e., *IFSP Communications Plan FY 2023* updated 2/10/23) 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. IFSP staff continued to use, and update, the *IFSP: First Steps (First Steps)* as the annual IFSP program brochure. First published in November 2020, *First Steps,* is intended to guide families through a basic overview of the IFSP program at DBHDS, Virginia's Developmental Disability (DD) system, and the resources that are available for people who are waiting for a DD Waiver Slot. To enhance content for FY 2023, IFSP staff reported they updated the FY 2022 version of *First Steps* to add the following: • A link to the updated version of DBHDS Provider Development's *Case Management Eligibility Options* document, which was revised to include language reflecting specific special service needs related to case management. This study could not confirm this link was available in the December 2022 version of *First Steps*. Based on review of the document, there was not a specific link with that document referenced, and the link provided to "Contact your local CSB/BHA to ask about support coordination" was not operational. The document did provide a link for *Resources for Families* on the MLMC website which, in turn, includes a link to a document	

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	objective, timing and frequency and description and venue. The plan notes that it will be updated as needed. IFSP staff continued to use, and update, the *IFSP: First Steps* as the annual IFSP program brochure. IFSP staff updated the FY 2022 version of *First Steps* with enhanced content. IFSP staff continued to use the annual WWL attestation process and an annual mailer campaign as the primary vehicles for ensuring that individuals and families on the waiver waitlist receive needed communications about their eligibility for the IFSP Funding Program, family and peer mentoring supports, case management options and the MLMC website. IFSP staff provided the *First Steps* document, updated in December 2022, in the annual WWL attestation	entitled *Information on Case Management Eligibility for Individuals on the DD Waiver Waitlist.* However, it was not operational on 3/14/23 or on 4/30/23. Going forward, IFSP should consider a more direct link to this document is available in First Steps and also ensure that link is working. • A link to the updated version of DBHDS Provider Development's *Navigating the DD Waivers Guidebook*, which was also updated to include language reflecting specific special service needs related to case management. • Updated link to the DBHDS Office of Integrated Health's Mobile Rehab Engineering (MRE) team's Durable Medical Equipment maintenance and repair, assistive technology and physical therapy consultations. In addition, based on documentation provided for this review, DBHDS appeared to have implemented this plan and cured the dissemination deficiencies present at the time of the 20th Period review. As previously reported at that time, while IFSP staff had a robust process in place for utilizing the annual Waiver Waitlist (WWL) attestation mailing to meet the requirements of this CI, the 20th Period review found that DBHDS could not demonstrate it continued to implement the steps in the Process Document, which was necessary to maintain compliance with the requirement to ensure that all families receive information about the program. For this 22nd Period review, IFSP staff continued to use the annual WWL attestation process and an annual mailer campaign as the primary vehicles for ensuring that individuals and families on the waiver waitlist receive needed communications about their eligibility for the IFSP Funding Program, family and peer mentoring supports, case management options and the MLMC website. IFSP staff provided the *First Steps* document, updated in December 2022, in the	

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	mailing that occurred in that same month. DBHDS also provided documentation to show the dissemination process and outcomes, as described further with regard to CI 1.5 below.	annual WWL attestation mailing, which also occurred during that month. DBHDS also provided documentation to show the dissemination process and outcomes, as described further with regard to CI 1.5 below.	
1.4 The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including…	The *IFSP State Plan Update* dated 2/7/23, includes a set of updated program outcomes. DBHDS provided evidence that the Office of EHA assisted IFSP staff to evaluate the measurability of the outcomes or the validity and reliability of the data. Some data methodologies were not fully fleshed out and could benefit from some additional work. However, for the three outcomes specifically required for this CI (i.e., as defined in CI 1.5, CI 1.6 and CI 1.7 below), a review of the measurement methodologies did not	The 20th Period study found that *IFSP State Plan* included a set of program outcomes, for which DBHDS issued an annual report with regard to progress toward the specified program outcomes. However, several of the outcomes were not measurable and DBHDS staff determined that some of the program outcomes, and that some of the current measures are not valid and/or reliable. For this 22nd Period review, as described with regard to CI 1.1 above, DBHDS issued an *IFSP State Plan Update* in February, 2023. Based on interview with IFSP staff during this review period, they had completed this review of the plan and updated the goals and objectives with the assistance of the Office EHA. The updated *IFSP State Plan Update* also included a report of progress for FY22. For this review, it appeared that IFSP staff had made substantial progress with regard to the measurability of program goals and outcomes, although some data methodologies were not fully fleshed out and could benefit from some additional work. However, for the three outcomes specifically required for this CI (i.e., as defined in CI 1.5, CI 1.6 and CI 1.7 below), a review of the measurement methodologies did not reveal any significant deficiencies. As a result, overall, DBHDS demonstrated that the Commonwealth met the requirements of this CI.	20th - Not Met **22nd - Met**

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	reveal any significant deficiencies. The *IFSP State Plan Update*, dated 2/7/23, included a report of progress for FY22.		
1.5 The number of individuals on the waiver waitlist who are provided with outreach materials each year.	The *IFSP State Plan Update FY2022*, dated 2/7/23, provided data for the number of individuals on the waiver waitlist who are provided with outreach materials for FY22. DBHDS met the intent of this CI to report on this outcome. For the 22nd Period, IFSP staff also provided data for the number of individuals on the waiver waitlist who are provided with outreach materials for FY23, which they will presumably capture in the *FY23 IFSP State Plan.* Based on review of a document *entitled IFSP Annual Notification for Individuals on WWL: FY*	For the 20th Period review, DBHDS provided a clear measurement methodology for reporting data on the number of individuals on the waiver waitlist who are provided with outreach materials each year, including a Process Document and a Data Set attestation to support the data reported at that time. However, that study could not confirm that IFSP staff followed the methodology. As a result, at that time, it was not clear that DBHDS could reliably report the number on the waiver waitlist who are provided with outreach materials that year. The *IFSP State Plan Update FY2022*, dated 2/7/23, reported DBHDS achieved this outcome for FY22 by sending out the annual electronic and postal notification for all individuals on the DD waiver waitlist (i.e., regardless of Priority One designation). The data provided in the update were consistent with the following study findings at the time of the 20th Period review: • DBHDS provided promotional materials electronically to all individuals on the Waiver Waiting List with a valid email address in either the WaMS database (WaMS), or from a past IFSP-Funding application request. Emails were sent to 7,727 individuals on the Waiver Waiting List. • In the case that IFSP did not identify an email address in WaMS, IFSP mailed hardcopies of the materials to physical addresses as provided in WaMS. On September 29, 2021,	20th - Met **22nd - Met**

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	2023 Update and Quantity Detail, dated 4/13/23, IFSP released the electronic version of the Annual Notification message via Constant Contact on 12/23/22. It was sent to 19,514 email addresses on the Funding announcement and families mailing list. This list included 10,904 email addresses for people on the FY 2023 WWL, which as of 1/1/22 totaled 11,348 individuals. The email message was also distributed to the Provider list. In addition to email dissemination, IFSP sent mailings to individuals with no available email address provided in WaMS, but with one or more physical mailing addresses. From 1/6/23 to 1/9/23, IFSP staff sent the outreach material via postal mail to 4,052 addresses. representing an additional 2,890 people on the WWL.	promotional materials were sent via postal mail to 6,329 people with physical addresses as of August 28, 2021. Of note, however, for the 20th Period review, DBHDS did provide a clear measurement methodology for the reported data, including a Process Document and a Data Set attestation to support the data reported at that time, but the study could not confirm that IFSP staff followed the methodology. As a result, at that time, it was not clear that DBHDS could reliably report the number on the waiver waitlist who are provided with outreach materials that year. The *IFSP State Plan Update FY2022*, dated 2/7/23, did not reference this deficiency. While DBHDS met the intent of this CI to report on this outcome, going forward, IFSP staff should strive to be transparent about any possible deficiencies in the reliability of the data they make available. To address the process methodology to obtain valid and reliable data related to the annual WWL attestation mailing, DBHDS provided two versions of a Process Document entitled *IFSP Outreach and Notifications Version 001*and dated 3/13/23. However, they were otherwise not identical. For purposes of this analysis, it appeared that one was more complete and included steps related to the creation of the *First Steps* document. This version also addressed CI 1.5, CI1.9 and CI 19.1, while the other indicated it only addressed the latter two. Overall, this version included several steps that were not thoroughly documented as written, but DBHDS provided additional sufficient documentation to evidence the details of the process were in place. Going forward, the Process Document should be formulated in such a manner that it can stand on its own, with sufficient detail for it to be implemented correctly. For example, two steps indicated that IFSP staff should request email addresses for all individuals on the WWL from WaMS, as well as mailing addresses for all individuals for whom	

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	DBHDS also provided a Process Document entitled *IFSP Outreach and Notifications,* dated 3/13/23, and Data Set Attestation for the Data Set entitled *IFSP Annual Funding.* Overall, the Process Document included several steps that were not thoroughly documented as written. In addition, the Data Set Attestation for the Data Set did not indicate validation of the accuracy of needed queries or the efficacy of the documented mitigation. However, DBHDS provided additional sufficient documentation to evidence the details of the process were in place.	there is no email address. It further indicated that IFSP staff/OISS staff would perform the steps, but did not provide any detail with regard to the process to obtain the needed information. However, DBHDS staff provided the queries upon request, which was sufficient to evidence the process. In addition, the Process Document indicated that the only previously identified threat to reliability and data could be mitigated by the implementation of an effective process to prevent duplicate individual records from being created. The Mitigation Timeline indicated that IFSP staff had a process in place to review and deduplicate the data, but did not provide any detail about the steps by which the process implemented. Again, DBHDS staff provided documentation in the form of a written process entitled *WaMS Merge Record Form*, dated 3/27/23. In each of these instances, DBHDS should update the Process Document, by either attaching the applicable queries and procedures or identifying them by name and current effective date. This will make it possible to ensure the data are collected in the appropriate manner each time the process is completed. Of note, the methodology provided for the 20th Period review (i.e., the *Annual Mailer File Creation Requirements)* was much more complete as a stand-alone document. It documented a detailed step-by-step methodology for ensuring that, to the extent possible, everyone on the waiver waitlist receives these notifications. This methodology created 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 described all of the data elements that are needed to create a data set for all individuals who are active on the waiver waitlist and described set of queries needed to flag exceptions that required additional handling to ensure all waitlist members are contacted. IFSP staff should review the level of detail provided in that earlier document, even if some of the specific details had changed.	

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		Overall, when taken together, these documents appeared to describe a sufficient process. DBHDS also provided a Data Set Attestation for the Data Set entitled *IFSP Annual Funding,* but it did not indicate validation of the accuracy of the queries or the efficacy of the mitigation. For the 22nd Period, IFSP staff also provided data for the number of individuals on the waiver waitlist who are provided with outreach materials for FY23, which they will presumably capture in the *FY23 IFSP State Plan.* Based on review of a document *entitled IFSP Annual Notification for Individuals on WWL: FY 2023 Update and Quantity Detail*, dated 4/13/23, IFSP released the electronic version of the Annual Notification message via Constant Contact on 12/23/22. It was sent to 19,514 email addresses on the Funding announcement and families mailing list, and included 10,904 email addresses for people on the FY 2023 Waiver Waiting List (which as of 11/1/22 totaled 11,348 individuals) The email message was also distributed to the Provider list, for a total of 24,357 email addresses. In addition to email dissemination, IFSP sent mailings to individuals with no available email address provided in WaMS, but with one or more physical mailing addresses. From 1/6/23 to 1/9/23, IFSP staff sent the outreach material via postal mail to 4,052 addresses representing an additional 2,890 people.	
1.6 Participant satisfaction with the IFSP funding program	The *IFSP State Plan Update FY2022*, dated 2/7/23, provided a progress report on participant satisfaction with the IFSP funding program, as previously described at the time of the 20th Period review.	For the 20th Review Period, because no funds were distributed in FY 2021, IFSP could not conduct the Annual Satisfaction Survey. Instead, a Survey of Needs was developed and distributed as part of the FY22 Annual Notification Message to People on the Waiver Wait List to the entire population of individuals on the WWL. However, because only 147 respondents completed the survey, IFSP recognized that the results were of limited utility as a meaningful representation of people on the WWL. For this 22nd Period review, the *IFSP State Plan Update FY2022*, dated 2/7/23, provided a progress report on	20th - Not Met **22nd - Met**

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	The *IFSP State Plan Update FY2022* reported that because no funds were distributed in FY 2021, IFSP could not conduct the Annual Satisfaction Survey. Instead, a Survey of Needs was developed and distributed as part of the FY22 Annual Notification Message to People on the Waiver Wait List to the entire population of individuals on the WWL. However, because only 147 respondents completed the survey, IFSP recognized that the results were of limited utility as a meaningful representation of people on the WWL. For this 22nd Period review, IFSP staff worked with the Office of EHA to create an enhanced methodology that addressed previously identified concerns. This revised approach was utilized in FY22 and FY23 satisfaction surveys.	participant satisfaction with the IFSP funding program, which reflected this previously reported information. Previous reviews also found the overall approach to measuring satisfaction had not been adequate. For this 22nd Period review, IFSP staff worked with the Office of EHA to create an enhanced methodology that addressed these concerns. DBHDS submitted two documents that described the revised processes. These included a report entitled *IFSP FY 2022 Annual Satisfaction Survey Report* and an *IFSP Annual Satisfaction Survey Summary: FY23 Update March 28, 2023*. The following bullets provide a summary of the information in these documents: • In previous periods, the survey process only measured the satisfaction of those who were awarded funding (i.e., were successful in getting their applications in before the funds were exhausted), a methodology that would provide an inadequate picture of the satisfaction of all participants, including those whose applications were not approved. 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. For this 22nd Period, for both FY 22 and FY 23, the survey was provided via email link to all individuals on the WWL with an email address in WaMS. The FY 22 *Annual Satisfaction Survey* link was primarily disseminated as part of IFSP's *FY 23 Annual Notification* message through both electronic and postal mail to all individuals on the WWL. This link was also included in the December 2022 and January 2023 *IFSP Digests*, and was shared on the IFSP Facebook page. For FY 23, the survey was also shared in a separate Constant Contact campaign to the mailing list of IFSP Funding recipients in FY 22. • Survey development began in September 2022, when IFSP	

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	DBHDS submitted two documents that described the revised processes. These included a report entitled *IFSP FY 2022 Annual Satisfaction Survey Repor*t and an *IFSP Annual Satisfaction Survey Summary: FY23 Update March 28, 2023*. DBHDS also submitted a Process Document entitled *DD IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 001*, last updated on 1/15/23, and a related Data Set Attestation, dated 4/10/23. Both of these documents required some revision. However, the overall processes were, for the purposes of validity and reliability, sufficiently reflected in the two documents that described the revised processes.	began consulting with DQV. In addition, the survey questions were presented to the IFSP State Council, and Councilmembers were invited to share their feedback with IFSP. IFSP then shared this feedback with the Office of EHA, who incorporated the appropriate changes. • The survey included questions to gather expanded information about individuals' level of satisfaction with the funding program, and knowledge and utilization of other IFSP resources, including family and peer mentoring, My Life, My Community, and IFSP marketing efforts. • Respondents completed the survey via URL weblink to the Qualtrics survey platform and EHA staff extracted the raw data file from Qualtrics and used it to calculate the data for percentages. In addition to using this data file to conduct a quantitative analysis for IFSP, the DQV team assisted IFSP in the qualitative analysis process. Overall, the documentation described above appeared sufficient to meet the requirements of this CI and that of CI 1.4. DBHDS submitted a Process Document entitled *DD IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 001,* last updated on 1/15/23, but it included several steps that were not thoroughly documented; however, DBHDS provided additional sufficient documentation. Going forward, the Process Document should be formulated in such a manner that it can stand on its own, with sufficient detail for it to be implemented correctly. For example, one step stated, "Perform query to extract the email addresses for all individuals on the waitlist," but did not provide any additional detail about how to perform or even how to obtain the query. DBHDS staff provided the query upon request, which was sufficient to evidence the process, but should update the Process Document, by either attaching the query or identifying it by name and current effective date. This will make it	

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		possible to ensure the data are collected in the appropriate manner each time the process is completed. Similarly, the Process Document should provide sufficient detail about how to extract the raw data file from Qualtrics and use it to calculate the data for percentages. DBHDS also provided a related Data Set Attestation, dated 4/10/23. While it found no deficiencies, it did not address the missing information described in the previous bullet.	
1.7 Knowledge of the family and peer mentoring support program.	The *IFSP State Plan Update*, dated 2/7/23, provided a summary of activities and included Appendix C: Family and Peer Supports. The *IFSP State Plan Update*, dated 2/7/23, provided a summary of activities and included Appendix C: Family and Peer Supports. Th plan included a goal that read, "Goal 4: The IFSP Program will connect individuals to appropriate supports and services while waiting on the waiting list through My Life My Community, Family to Family, Peer Supports and/or the Regional Council Structure." It did not include a specific outcome target related to	At the time of the 20th Period review, IFSP staff reported they did not yet have a valid and reliable methodology to collect data for knowledge of the family and peer mentoring support programs. Therefore, DBHDS did not have data to report as required by this CI. The *IFSP State Plan* in place at that time included outcome targets for this measure that read "In each region, at least 30% of Satisfaction Survey respondents have visited either Facebook, connected with SeniorNavigator, visited the DBHDS IFSP webpage, connected with VCU F2F Network, or attended a VCU F2F Network event," and "Of event attendees: at least 30% indicate having visited Facebook, SeniorNavigator, IFSP, or F2F Network." The *IFSP State Plan Update*, dated 2/7/23, provided a summary of activities and included Appendix C: Family and Peer Supports. The plan included a goal that read, "Goal 4: The IFSP Program will connect individuals to appropriate supports and services while waiting on the waiting list through My Life My Community, Family to Family, Peer Supports and/or the Regional Council Structure." It did not include a specific outcome target related to knowledge of the family and peer mentoring support programs. However, as described above with regard to CI 1.6 above, IFSP and Office of EHA staff included measures for this CI as a part of the *Annual Satisfaction Survey* process.	20th - Not Met **22nd - Met**

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	knowledge of the family and peer mentoring support programs. However, as described above with regard to CO 1.6 above, IFSP and Office of EHA staff included measures for this CI as a part of the *Annual Satisfaction Survey* process. The Process Document entitled *DD_IFSP_ANNUAL STSFCTN SRVY DATA VRFCTN_VER_001* indicated one of its intentions was to determine the percent of survey respondents familiar with family and peer mentoring support programs. It further documented two measures, defined by two sets of numerators and denominators. It was not clear that as written, the framing would provide for a valid measure, due primarily to including two variables (i.e., do not know vs have	The Process Document entitled *DD_IFSP_ANNUAL STSFCTN SRVY DATA VRFCTN_VER_001* indicated one of its intentions was to determine the percent of survey respondents familiar with family and peer mentoring support programs. It further documented two measures, defined by the following two sets of numerators and denominators: • Numerator: Number of people who had some knowledge of family mentoring (CFI) – answered "very useful" or "somewhat useful" on question "How would you rate the usefulness of Family Mentoring in the last 12 months?"/Denominator: Number of people who responded to survey. • Numerator: Number of people who had some knowledge of Peer Mentoring (Arc of Virginia) – answered "very useful" or "somewhat useful" on question "How would you rate the usefulness of Peer Mentoring in the last 12 months?"/Denominator: Number of people who responded to survey. It was not clear that this framed the measures correctly. The Process Document noted that EHA staff had previously reported that, to obtain valid and reliable data, IFSP staff would need to include an option for respondents to answer, "I do not know or have not used it." Based on the *IFSP FY 2022 Annual Satisfaction Survey Repor*t, the survey included this response option. However, it might have been more useful to be able to separately capture the response to these two variables (i.e., do not know vs have not used), because "have not used" is not necessarily an indicator of lack of knowledge. This construction could result in an artificially suppressing the percentage of respondents who had "knowledge." If	

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	not used) as a single response. This construction could result in an artificially suppressing the percentage of respondents who had "knowledge." The *IFSP FY 2022 Annual Satisfaction Survey Repor*t did not report a percentage of knowledge of family mentoring of Peer Mentoring. Instead, for 12 resources, including family mentoring and peer mentoring it provided a table showing the number of responses categorized as "I don't know what this is or I have not used it." For family mentoring, it reported that 492 respondents selected that option, while for peer mentoring the number of respondents selecting that option was 454. It was not clear how many respondents rated each of the questions about resources, so it was not possible to determine a	the survey could isolate the number of respondents who specifically "did not know," one could more likely obtain a valid measure of actual knowledge in the following manner: Numerator: Number of people who did not report they had no knowledge of family mentoring (CFI)"/Denominator: Number of people who responded to survey. Numerator: Number of people who did not report they had no knowledge of family mentoring of Peer Mentoring (Arc of Virginia) /Denominator: Number of people who responded to survey The *IFSP FY 2022 Annual Satisfaction Survey Repor*t did not report a percentage of knowledge of family mentoring of Peer Mentoring. Instead, for 12 resources, including family mentoring and Peer Mentoring it provided a table showing the number of responses categorized as "I don't know what this is or I have not used it." For family mentoring, it reported that 492 respondents selected that option, while for peer mentoring the number of respondents selecting that option was 454. It was not clear how many respondents rated each of the questions about resources, so it was not possible to determine a percentage. Overall, though, with some modifications to the methodology, the annual satisfaction survey would be a sufficient vehicle for measuring this CI.	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
	percentage. Overall, though, with some modifications to the methodology, the annual satisfaction survey would be sufficient for measuring this CI.		
1.8 Utilization of the My Life, My Community website:	DBHDS issued an annual report that included a narrative summary of the utilization of the MLMC website and an Appendix E: SeniorNavigator Quarterly Reporting. Appendix E provided six quarterly reports detailing the utilization of the My Life, My Community website. Appendix E provided six quarterly reports, for all of FY22 and the first two quarters of FY23, detailing the utilization of the My Life, My Community website, including data with regard to the number of sessions, users (both new and returning), page views and the number	For utilization of the MLMC website, The *IFSP State Plan Update* stated the following pertinent goal, "The IFSP Program will connect individuals to appropriate supports and services while waiting on the waiting list through My Life My Community, Family to Family, Peer Supports and/or the Regional Council Structure." It also stated a related outcome: "At least 50% of people who access the My Life My Community website annually will be new users." The *IFSP State Plan Update* included Appendix E: SeniorNavigator Quarterly Reporting. Appendix E provided six quarterly reports, for all of FY22 and the first two quarters of FY23, detailing the utilization of the My Life, My Community website, including data with regard to the number of sessions, users (both new and returning), page views and the number of calls to the call center, as further described below with regard to CI 17.1.	20th - Met **22nd - Met**

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
	of calls to the call center, as further described below with regard to CI 17.1.		
1.9 Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter.	DBHDS informs individuals of their eligibility for IFSP funding upon being placed on the waiver waitlist and annually thereafter. DBHDS had updated multiple documents as needed to clarify eligibility for WWL case management, and made outreach information available on MLMC and as a part the annual WWL mailing. While the First Steps document did not specifically describe the options, it did provide a link for Resources for Families on the MLMC website which, in turn, included a link to a document entitled *Information on Case Management Eligibility for Individuals on the DD Waiver Waitlist*. Going forward,	**Eligibility for IFSP Funding:** As described above with regard to CI 1.3, DBHDS had implemented an annual waiver waitlist eligibility attestation process in which every individual on the waitlist received a letter on an annual basis. For this Review Period, the annual notification occurred during December 2022. The annual waiver waitlist eligibility attestation packet included an insert (i.e., *First Steps*) that described various supports for which individuals on the waiting list might be eligible. It also included a notification that individuals might be able to access financial assistance through the IFSP and provided a link to obtain further information. **Eligibility for case management:** DBHDS indicated it informs individuals of their eligibility for case management upon being placed on the WWL and annually thereafter as a part of the annual waiver waitlist eligibility attestation process. At the time of the 20th Period review, DBHDS had updated final language in *Chapter IV Covered Services and Limitations* in the *Developmental Disabilities Waivers (BI,FIS,CL)Services Manual*, with an effective date of 2/15/22, that appeared to adequately define the circumstances under which individuals with developmental disabilities "may" receive time-limited case management when a "special service need" existed. For this 22nd Period review, DBHDS had again updated *Chapter IV Covered Services and Limitation* on 11/2/22. It still included the needed definition. At the time of the 20th Period review, DBHDS still needed to update various materials to ensure that individuals and families were	20th - Not Met **22nd - Met**

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
	IFSP should consider a more direct link to this document is available in *First Steps* and also ensure that link remains operational.	informed of these options. For this 22nd Period review, DBHDS had updated the following documents as needed: • *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Seventh Edition Updated January 2023*. • *Support Coordination: A Handbook For Developmental Disabilities Waiver Support Coordination*, dated 2/27/23, reflected the information in *Chapter IV Covered Services and Limitations* in the *Developmental Disabilities Waivers (BI,FIS,CL)Services Manual*. • *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist,* which also incorporated *Support Coordination: Questions and Answers for People with DD and their Families,* updated 10/31/22. • *First Steps,* dated December 2022, informed individuals and families that they can contact their local CSB/BHA to ask about support coordination. While it did not specifically describe the options, it did provide a link for Resources for Families on the MLMC website which, in turn, included a link to a document entitled *Information on Case Management Eligibility for Individuals on the DD Waiver Waitlist*. Going forward, IFSP should consider a more direct link to this document is available in *First Steps* and also ensure that link is working.	
1.10 IFSP funding availability announcements are provided to individuals on the waiver waitlist.	As described above with regard to CI 1.5, IFSP staff implemented procedures to ensure that every individual on the waitlist would receive a timely	For this 22nd Period review, IFSP staff had implemented procedures 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. As described above with regard to CI 1.5, IFSP staff had developed a sufficiently robust methodology for providing IFSP funding availability announcements to individuals on the waiver	20th – Not Met **22nd - Met**

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
	notification about the upcoming IFSP funding period, either by email or by postal service. The Process Document entitled *IFSP Outreach and Notifications Version 001,* dated 3/13/23, and related documents formalized these requirements and appeared to address any known potential deficiencies in the data source system. This process, as implemented during the annual WWL notification, ensured notifications to 19,514 email addresses on the Funding announcement and families mailing list. This list included 10,904 email addresses for people on the FY23 WWL, which as of 1/1/22, totaled 11,348 individuals. The email message was also distributed to the Provider list, for a total of 24,357	waitlist. The Process Document entitled *IFSP Outreach and Notifications Version 001,* dated 3/13/23, and related documents formalized these requirements and appeared to address any known potential deficiencies in the data source system. In addition, CI 1.5 documents the outcomes showing that the process, as implemented, ensured notifications to 19,514 email addresses on the Funding announcement and families mailing list. This list included 10,904 email addresses for people on the FY 2023 WWL, which as of 1/1/22, totaled 11,348 individuals. The email message was also distributed to the Provider list, for a total of 24,357 email addresses. In addition to email dissemination, for individuals who did not have an email address in WaMS, but did have one or more physical mailing addresses, over a period from 1/6/23 to 1/9/23, IFSP staff sent the outreach material via postal mail to 4,052 addresses representing an additional 2,890 people on the WWL. DBHDS also provided a Process Document entitled *IFSP Outreach and Notifications,* dated 3/13/23. This is discussed in detail with regard to CI 1.3 and was sufficient to demonstrate the process overall. The previous study recommended that, for purposes of identifying the basis for programmatic authority and continuity, DBHDS staff needed to develop a formal expectation (e.g., a policy, procedure, departmental instruction, etc.) that, going forward, all individuals on the waitlist will receive direct timely notifications from DBHDS of upcoming funding periods. For this review, as described above, DBHDS had developed *DI 113 (TX) 20* with regard to the IFSP. While the DI defined the IFSP Funding Program (i.e., subject to the availability of funds, the IFSP Funding available in accordance with *12 VAC 35-230* assists individuals on Virginia's DD Waiting List), it provided little guidance with regard to these expectations. DBHDS might consider expanding on the level of detail in the DI.	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
	email addresses. In addition to email dissemination, for individuals who did not have an email address in WaMS, but did have one or more physical mailing addresses, over a period from 1/6/23 to 1/9/23, IFSP staff sent the outreach material via postal mail to 4,052 addresses representing an additional 2,890 people on the WWL.	.	
1.11 Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website	The MLMC website was operational and DBHDS had posted to it various eligibility guidelines for IFSP resources and other supports and services. However, the information provided with regard to eligibility criteria ("most at risk") and case management criteria ("special service need") was incomplete, pending final resolution, and not published on the website	The MLMC website continued to be operational and DBHDS had posted to it various eligibility guidelines for IFSP resources and other supports and services. In that regard, DBHDS had an effective mechanism for posting eligibility guidelines for IFSP resources and other supports and services for easy access on the internet. At the time of the 20th Period review, information provided with regard to eligibility criteria ("most at risk") and case management criteria ("special service need") continued to be incomplete and was pending final resolution. For this review, as described with regard to CI 1.9 above, DBHDS had updated documents to provide this information, and these key documents and information were available on the MLMC website in March 2023, as described below: • The *Individual and Family Support Program Guidelines and FAQs*, updated 1/9/23 continued to be thorough and clearly	20th - Not Met **22nd - Met**

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
		written, and served as a valuable resource for individual and families seeking funding assistance through the IFSP. These updated documents provided a clear description of how the program would serve those who were "most at risk for institutionalization," as described with regard to CI 1.2 • DBHDS updated the *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Seventh Edition*, updated January 2023, to include a clear and consistent description of case management options for individuals on the waitlist. • As previously reported at the time of the 18th Period Review, to provide information on case management options for individuals on the DD waitlist, the MLMC website had posted the *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist*, dated 10/3/22. It provided clear guidelines for individuals and families with regard to the types of needs that would be considered as a "special service need." It was positive to see that IFSP staff ensured that this information was referenced in the *Resources for Families* webpage as well as the *General Information* webpage. • As of the 20th Period review, and as described with regard to CI 1.9, DBHDS had clarified the guidelines with regard to the availability of support coordination of individual on the WWL and published them in *Chapter IV Covered Services and Limitations in the Developmental Disabilities Waivers (BI,FIS,CL)Services Manual* on 2/15/22. This described the expectations for CSBs to apply those consistently. In addition, the documents on the MLMC website had been updated to reflect this information. DBHDS updated this document on 11/1/22 and it continued to include the above information.	

Compliance Indicator	Facts	Analysis	Conclusion 20th Period **22nd Period**
1.12 Documentation continues to indicate that a minimum of 1,000 individuals and/or their families are supported through IFSP funding.	For the funding period that took place during the 22nd Period review, DBHDS approved 3,770 applications, with applicants being awarded varying amounts depending on the applicable Prioritization Criteria and requested amount. In all, DBHDS awarded $2,499,620.20 during this funding period.	DBHDS continued annual distribution of IFSP funding to eligible individuals and families, as described above with regard to CI 1.1. At the time of the 20th Period review, DBHDS received 4,000 requests for assistance that were saved as of October 4, 2021. Each applicant was awarded $1,000. This utilized funds from both FY 2021 and FY 2022. In all, DBHDS awarded $4,036,000 during this funding period. For the funding period that took place during the 22nd Period review, DBHDS approved 3,770 applications, with applicants being awarded varying amounts depending on the applicable Prioritization Criteria and requested amount. As reported in a document entitled *FY 2023 IFSP-Funding Summary,* dated 4/11/23, DBHDS awarded $2,499,620.20 during this funding period. Of note, the document included a chart entitled *IFSP-Funding Program Summary FY 2013 – 2023* that demonstrated DBHDS had provided a total of $28,480,862.20 in IFSP funding over that period.	20th - Met **22nd - 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.

Compliance Indicator	**Facts**	**Analysis**	**Conclusion** 18th Period **20th Period**
17.1 DBHDS has developed and launched the "My Life, My Community" website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. This will be documented by reports of activity on the website.	As of August 2019, DBHDS launched the "My Life, My Community" (MLMC) website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. The MLMC website continued to be operational since that time. *(*https://www.mylifemycommunityvirginia.org*;)* The MLMC website publishes various forms of information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. The operational contractor (i.e., Senior Navigator) provided quarterly reports of activity on the website.	In August 2019, DBHDS and its contractor, Senior Navigator, formally launched the MLMC website. The MLMC website has continued to be operational since that time. For this 22nd Period review, the MLMC website continued to publish various forms of information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. In addition to DBHDS guidance documents (i.e., *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Seventh Edition,* updated January 2023*; Individual and Family Support Program Guidelines,* updated 9/14/21*; First Steps,* revised December 2022 and *Beyond IFSP-Funding,* revised December 2021, etc.*),* the website features links to other service and advocacy organizations and has a searchable database of local services. The website also has key pages devoted to the IFSP, providing information about the work of the Councils as well providing information about the Funding Program, including a link to the Funding Portal. Of note, however, the links to some IFSP documents (e.g., the *Individual and Family Support State Plan*) were not operational on 3/14/23 and should be updated. MLMC staff also continued to operate a call center to serve individuals and families who might need additional assistance	20th - Met **22nd - Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		The *IFSP State Plan Update* stated the following pertinent goal, "The IFSP Program will connect individuals to appropriate supports and services while waiting on the waiting list through My Life My Community, Family to Family, Peer Supports and/or the Regional Council Structure." It also stated a related outcome: "At least 50% of people who access the My Life My Community website annually will be new users." 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 additional information and included data about frequently asked questions and topics. Finally, the reports provided narrative updates about new materials and functionalities added since the previous report. Data for the last two quarters of FY22 and the first two quarters of FY23 indicated that both the number of website users and the number of callers continued to be much higher during IFSP funding periods. In the second quarter of FY23, data indicated the highest level of usage to date since the website rolled out. The data reporting on MLMC utilization substantially met the intent of this CI. With regard to the validity and reliability of data reports, DBHDS provided a Process Document entitled *DD IFSP My Life, My Community Version 001,* updated 1/9/23. It noted that the data for the quarterly reports of activity on the website were generated by Google Analytics, while the call volume data was generated by the Fusion Connect application. DBHDS did not provide a companion Data Set Attestation. However, it did not appear this CI required this level of	

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
		documentation in order to show compliance.	
17.2 Documentation indicates that the My Life, My Community website resource is distributed to a list of organizations and entities that likely have contact with individuals who may meet the criteria for the waiver waitlist and their families.	In December 2022, as a part of the annual WWL notification, DBHDS distributed materials that included information about the MLMC website to the Provider Listserv. At the time of the 20th Period review, DBHDS also mailed a total of 1,160 *First Steps* including MLMC information, to 58 medical professionals 42 local EI lead agencies, and 16 pediatric offices in DBHDS's Eastern, Southwest, and Central service regions. For this 22nd Period review, IFSP staff provided a document entitled *IFSP: First Steps Document: Annual Update for FY 2023*, dated 4/19/23. The document indicated that in May 2023, IFSP intends to mail a total of 1,400 "First Steps" documents to 70 medical professionals via postal mail. The annual update document also stated that in FY23, per the Independent Reviewer's findings from previous studies and IFSP State Council member input, IFSP plans to replicate the process for expanding *First Steps* outreach to	Overall, for this purpose, IFSP staff relied upon the IFSP Communication Plan, described above with regard to CI 1.3. As previously reported, to support the implementation of the Communication Plan, IFSP staff had developed a detailed methodology for collecting, managing and using contact data to facilitate dissemination of various types of information that would be useful to individuals, families, providers and other stakeholders. In addition to communicating with individuals on the waitlist and their families, IFSP staff continued to use the existing Provider Listserv (i.e., that DBHDS maintains for the purpose of updating providers and stakeholders on policy changes, trainings, meetings, and other important information) to communicate the same types of information to provider organizations. As described above with regard to CI 1.9, via the Constant Contact database and as a part of the annual waitlist attestation process, IFSP staff sent an email message to the Provider Listserv, including a Flyer created by IFSP staff, and information about IFSP Funding, family-to-family and peer mentoring supports, case management information and information about how to access MLMC. This occurred in December 2022. At the time of the 20th Period review, IFSP staff had also mailed a total of 1,160 *First Steps* documents (i.e., which include information about MLMC) to 58 medical professionals via postal mail. These contacts and mailing addresses were those identified at 42 local EI lead agencies, and the 16 pediatric offices in DBHDS's Eastern, Southwest, and Central service regions. DBHDS reported that each contact received one cover letter and 20 *First Steps* documents	20th - Met **22nd - Met**

Compliance Indicator	Facts	Analysis	Conclusion 18th Period **20th Period**
	include schools, as staff capacity allows.	for immediate distribution to clients and families. For this 22nd Period review, IFSP staff provided a document entitled *IFSP: First Steps Document: Annual Update for FY 2023*, dated 4/19/23. The document indicated that in May 2023, IFSP intends to mail a total of 1,400 "First Steps" documents to 70 medical professionals via postal mail. These contacts and mailing addresses were those identified at 41 local EI lead agencies, and the 29 pediatric offices in all five of DBHDS CSB service regions. Again, each contact will receive 1 cover letter and 20 *First Steps* documents for immediate distribution to clients and families. The annual update document also stated that in FY23, per the Independent Reviewer's findings from previous studies and IFSP State Council member input, IFSP plans to replicate the process for expanding *First Steps* outreach to include schools, as staff capacity allows.	

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.)

Compliance Indicator	Facts	Analysis	Conclusion
19.1 At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources.	The annual WWL attestation packet provides information on accessing about family and peer mentoring resources to individuals on the WWL. As described above with regard to Compliance Indicator 1.5, the Process Document entitled *IFSP Outreach and Notifications Version 001,* dated 3/13/23, and related documents, is sufficiently robust, as written, to ensure that at least 86% of individuals on the WWL at the time of the annual attestation process received the information.	DBHDS uses notifications provided as a part of the annual WWL attestation process to inform individuals on the waitlist about family and peer mentoring resources. As described with regard to CI 1.3 the *First Steps* documentation distributed as a part of the annual WWL attestation process included links to the VCU-CFI Family to Family (F2F) Program and to The Arc of Virginia's Peer Mentoring Program. As described above with regard to Compliance Indicator 1.5, the annual WWL process, (i.e., as described in the Process Document entitled *IFSP Outreach and Notifications Version 001,* dated 3/13/23, and related documents) was sufficiently robust to ensure that at least 86% of individuals on the waiver waitlist have received this information. DBHDS also provided documentation to show they followed the process and were able to report valid and reliable data. Based on the number of mailings and notifications completed and as described with regard to CI 1.5 above, it appeared this was sufficient to show with at least 86% of the individuals on the WWL received information about family and peer mentoring	20th – Not Met **22nd - Met**

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS also provided documentation to show they followed the process and were able to report valid and reliable data. Based on the number of mailings and notifications completed and as described with regard to CI 1.5 above, this was sufficient to with at least 86% of the individuals on the WWL.		
19.2 The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested.	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. The form includes references and contact information for both the family and peer mentoring resources. For this review, for both the family and peer mentoring programs, DBHDS staff reported they had not yet completed a referral process or a data collection methodology specific to the intent of these provisions (i.e., to facilitate	As reported previously, the guidance for the *Virginia Informed Choice Form* indicated when it must be completed, including upon enrollment in a Developmental Disability waiver. The guidance also indicates the form must be completed annually. The *Virginia Informed Choice Form* also included a section for the Support Coordinator to check whether or not he or she provided the individual opportunities to speak with other individuals receiving waiver services who live and work successfully in the community. In another section, the form also included references to and contact information for both the VCU CFI Family-to-Family network and the Virginia Arc Peer Mentoring program. However, it was not clear that, by signing the Informed Choice Form, individuals were acknowledging that they had received an adequate explanation of the purpose of the resources (i.e., as that related to the requirements of this provision), nor did DBHDS have in place an established referral process for connecting individuals or families with the desired supports. Three previous IFSP reports (i.e., the 16th, 18th and 20th Period reviews) found that for the family and peer mentoring programs, DBHDS did not provide a referral process or a data collection methodology specific to the intent of these provisions (i.e., to facilitate opportunities for individuals considering a sponsored home or any congregate setting to have conversations and meetings with individuals currently living in the	20th - Not Met **22nd - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	opportunities for individuals considering a sponsored home or any congregate setting to have conversations and meetings with individuals currently living in the community and their families regarding options for community placements, services, and supports before being asked to make choices), or to the requirements of this CI (i.e., so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested).	community and their families regarding options for community placements, services, and supports before being asked to make choices), and to the requirements of this CI (i.e., so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested). At the time of the 20th Period review, the study also found that the methodology with regard to the requirements of Provision III.D.5 and CI 19.02 needed additional fleshing out to effectuate the likelihood that referrals would occur. DBHDS staff had also not made all the needed revisions to the accompanying instructions to the *Virginia Informed Choice Form* 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. In other words, in addition to Support Coordinators being instructed with regard to the requirement to offer the opportunities, DBHDS also needed to provide clear expectations with regard to the specific referral process to follow. Based on the documentation submitted previously, CFI protocols include a referral form that DBHDS staff could incorporate into a clear referral process for family-to-family opportunities, as well as use that as a model for parallel process for peer-to-peer opportunities. DBHDS also needed to craft the referral process to ensure that data specific to the purposes of this provision and related Compliance Indicators could occur. For this 22nd Period review, DBHDS provided a document entitled *Virginia Informed Choice Form: FY23 Update*, dated 2/28/23. As background, it indicated that this was responsive to Provision III.D.5 and CI 19.02. The update provided a sample revised *Virginia Informed Choice Form* as it appears in WaMS. As indicated in the summary the sample form showed two questions related to an individual/families desire for support connecting to the CFI and/or The Arc. The summary stated that the Office of Provider Development will incorporate these two questions into the paper version of the form for completion with people who do not go through the RST process. The summary further stated that the additions were currently being made to the form, but will need to go through fiscal analysis and public	

Compliance Indicator	Facts	Analysis	Conclusion
		comment processes before they can be required. It projected this version of the *Virginia Informed Choice Form* would be available for use prior to FY24. Based on review of the sample *Virginia Informed Choice Form*, it appeared it would have the capacity, with some minor revisions, to collect sufficient information to enable DBHDS to meet the requirements outlined in Provision III.D.5 and CI 19.02. • For both CFI and The Arc, the form asked if the Support Coordinator provided the individual and family with the contact information. • For each of the two entities, a question then posed, "if yes," whether the individual/family would like assistance with "this referral." Based on review of the form, it appeared the "yes" response alluded to whether the Support Coordinator had provided contact information, not to whether a referral was desired. It was not clear what expectation there might be for the Support Coordinator to document 1) explaining the purpose of family to family and/or peer to peer (especially with regard to the requirements of Provision III.D.5) or 2) specifically inquiring if the individual and/or family would like a referrals for this purpose. DBHDS should consider adding documentation of the completion of each of these steps. • The form also requires that the Support Coordinator choose the primary reason for referral from a list provided, and indicates that if residential DD waiver options is selected, the Support Coordinator should check all the options discussed. Once DBHDS makes the recommended changes and the revised *Virginia Informed Choice Form* is fully integrated into WaMS, this would presumably allow for the data pertinent to Provision III.D.5 and CI 19.2 (i.e., identification of individuals considering sponsored homes or congregate residential settings; documentation to show they were offered opportunities to speak to individuals currently living in the community and their families, before being asked to make a choice regarding options; and an indication of	

Compliance Indicator	Facts	Analysis	Conclusion
		those that chose a referral to be connected to the family and peer mentoring support) to be aggregated directly from that source system. Combined with appropriate policies and procedures for SCs related to documenting the provision of information and referrals, and a clear Process Document outlining all the required steps for collecting and aggregating the data, this would allow DBHDS and entities providing about family and peer mentoring to readily identify and track the outcomes as required by CI 19.3 below.	
19.3 The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to-family and the peer-to-peer supports have contact and the number who receive the service.	CFI and the Arc of Virginia, respectively, provide data for individuals receiving family-to-family and peer mentoring supports, but do not provide data that adequately track and report on outcomes as they relate to this provision. CFI has updated its reporting, effective 1/1/23, to begin providing a report of the number of individuals who currently were on the Waiver, on the WWL or not on the WWL/was unsure of WWL status. However, reporting does not include specific data with regard to family-to-family and peer-to-peer supports that are offered to individuals and families pursuant to their consideration related to sponsored homes or any	For this 22nd Period review, CFI and The Arc, (i.e., which operate the about family and peer mentoring programs respectively) provide applicable data for individuals receiving family-to-family and peer mentoring supports, but do not provide data that adequately track and report on outcomes as they relate to this provision. CFI has updated its reporting, effective 1/1/23, to begin providing a report of the number of individuals who currently were on the Waiver, on the WWL or not on the WWL/was unsure of WWL status. However, as reported at the time of the previous two review Periods, DBHDS did not have an established referral process for the entire target population that met the requirements of Provision III.D.5 (i.e. which ensures that that 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 and that DBHDS facilitates those conversations and meetings with individuals currently living in the community and their families through the development of about family and peer mentoring programs.) DBHDS needed to further develop referral processes to facilitate this purpose. The 18th and 20th Independent Reviewer's reports recommended that, for purposes of tracking and reporting on outcomes with respect to the number of individuals with whom family-to-family and the peer-to-peer supports	20th - Not Met **22nd - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	congregate setting. As described above for CI 19.2, DBHDS provided a sample *Virginia Informed Choice Form,* which appeared to have the potential, with some minor revisions, to collect sufficient information to enable DBHDS to meet the requirements outlined in Provision III.D.5 and CI 19.02. That is, DBHDS would be able to identify individuals considering sponsored homes or congregate residential settings; document that they were offered opportunities to speak to individuals currently living in the community and their families, before being asked to make a choice regarding options; and document those individuals who chose a referral to be connected to the family and/or peer mentoring support. It would then also be possible for CFI and The Arc to develop a relatively simple process track whether those specific individuals received the support. In the longer run, this would also enable DBHDS and the contracted family and peer	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. For this 22nd Period review, as described above for CI 19.2, DBHDS provided a sample *Virginia Informed Choice Form*, which appeared to have the potential, with some minor revisions, to collect sufficient information to enable DBHDS to meet the requirements outlined in Provision III.D.5 and CI 19.02. That is, DBHDS would be able to identify individuals considering sponsored homes or congregate residential settings; document that they were offered opportunities to speak to individuals currently living in the community and their families, before being asked to make a choice regarding options; and document those individuals who chose a referral to be connected to the family and/or peer mentoring support. With such a record, it could then be feasible to inform CFI and The Arc of individuals and families who desired the support , as well as which were considering sponsored homes or congregate residential settings. With that information provided in advance, it would not be necessary for CFI and The Arc to modify their intake processes to discern it. It would then also be possible for CFI and The Arc to develop a relatively simple process to track whether those specific individuals received the support. In the longer run, this would also enable DBHDS and the contracted family and peer mentoring program providers to evaluate the outcomes of these supports and their impact on individuals' choices of sponsored homes or congregate residential settings.	

Compliance Indicator	Facts	Analysis	Conclusion
	mentoring program providers to evaluate the outcomes of these supports and their impact on individuals' choices of sponsored homes or congregate residential settings.		

Recommendations:

1. For CI 1.3 and CI 1.9, IFSP staff should evaluate how to ensure that *First Steps* includes a more direct link to *Information on Case Management Eligibility for Individuals on the DD Waiver Waitlist* and also ensure that link is working.

2. For CI 1.5, DBHDS should formulate the Process Document entitled *IFSP Outreach and Notifications Version 001*, dated 3/13/23, in such a manner that it can stand on its own, with sufficient detail for it to be implemented correctly.

3. For CI 1.6, DBHDS should update the Process Document entitled *DD IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 001*, by either attaching the query or identifying it by name and current effective date and by providing sufficient detail about how to extract the raw data file from Qualtrics and use it to calculate the data for percentages.

4. For CI1.7, to obtain a valid measure, DBHDS should more accurately and clearly define the numerator and denominator and revise the survey to separately capture the response to two variables (i.e., do not know vs have not used),

5. For CI 17.1, DBHDS should work with MLMC to ensure that links to all IFSP documents (e.g., the Individual and Family Support State Plan) remain operational.

6. For CI 19.2 and CI 19.3, DBHDS should make the recommended changes in order to capture the requisite data to meet the intent and requirements of Provision III.D.5

7. For CI 19.3, DBHDS should ensure that CFI and The Arc develop a process to track whether all individuals identified in Provision III.D.5 receive family and/or peer mentoring supports as they desire.

Attachment A: Interviews

1. Heather Norton, Assistant Commissioner, Developmental Services
2. Gayle Jones, DOJ Settlement Agreement Coordinator
3. Heather Hines, IFSP Program Director
4. Rachel Vamenta, IFSP Communications and Program Coordinator

Attachment B: Documents Reviewed

1. 1.01, 1.04 FY22 IFSP State Plan Update 2.7.23.
2. 1.01, 1.04 IFSP State Plan Feb 2023
3. 1.01, 1.04 2023 IFSP Council Process Summary 4.12.2023
4. 1.01, 1.04 2023 IFSP Council Self-Paced Orientation4.14.2023
5. 1.01, 1.04 IFSP FY22 State Council Roster_1.6.2023.pdf
6. 1.01, 1.04_IFSP SC Recording April 2023_4.20.2023.mp4
7. 1.01, 1.04 Beyond IFSP-Funding 12.2021
8. 1.01, 1.04 IFSP Regulations and Funding Guidelines 2.2.2023
9. 1.01, 1.04 IFSP-Funding Announcement Archives 2.17.2023
10. 1.01, 1.04 IFSP-Funding Portal User Guide 1.17.2023
11. 1.01, 1.04 IFSP-Funding Program Guidelines and FAQs 1.9.2023
12. 1.01, 1.04 IFSP-Funding Quick Tips 1.26.2023.
13. 1.01, 1.04 IFSP-Funding Timeline1.10.2023
14. 1.01, 1.04 IFSP Funding - Steps for Card File Creation (4.9.23)
15. 1.01, 1.04 IFSP Communications Plan FY23 2.10.23
16. 1.01, 1.04 Information Access Summit Notes 2.3.23
17. 1.01, 1.04 IFSP SC Annual Minutes Jan 2022 1.7.22
18. 1.01, 1.04 IFSP SC Annual Minutes Jan 2023 1.20.23
19. 1.01, 1.04 IFSP SC Minutes April 2022_4.22.22
20. 1.01, 1.04 IFSP SC Minutes June 2022_6.29.22
21. 1.01, 1.04 EWP IFSP Communications and Program Coordinator.
22. 1.01, 1.04 EWP IFSP Program Manager
23. 1.01, 1.04 EWP IFSP Support Specialist
24. 1.01, 1.04 IFSP Organizational Chart 2.1.2023
25. 1.01, 1.04, 1.05, 1.09, 1.10, 17.02 IFSP: First Steps Revised Dec. 2022
26. 1.02 DD Waiver Chapter 4 11.1.22
27. 1.02 IFSP Digest Nov. 2022 12.5.2022
28. 1.02 IFSP Regulations and Funding Guidelines 2.2.2023
29. 1.02 IFSP-Funding Categories DRAFT 5.2022
30. 1.02 Stakeholder Message IFSP-Funding Regulations Update11.23.2022
31. 1.02 State Council Minutes 4.22.22
32. 1.02 TH05 Emergency NOIRA 11.23.2022.
33. 1.03 IFSP Communications Plan FY23 2.10.23.pdf
34. 1.05, 1.09, 1.10 FY23 Accessing the WWL Forms Quick Tips 12.22.22.
35. 1.05, 1.09, 1.10 FY23 Annual Notification Msg Electronic Providers 12.22.22
36. 1.05, 1.09, 1.10 FY23 Annual Notification Msg Electronic Public12.23.22
37. 1.05, 1.09, 1.10 FY23 Cover Letter12.16.22
38. 1.05, 1.09, 1.10 FY23 IFSP First Steps 12.22
39. 1.05, 1.09, 1.10 FY23 WWL Forms and Survey Postcard 12.22.22
40. 1.05, 1.09, 1.10 Case Management Options for Individuals on the DD Waiver Waitlist 0.31.22
41. 1.05, 1.09, 1.10 Count of Individuals on Waitlist 9.7.22.
42. 1.05, 1.09, 1.10 DD Waiver Chapter 4 Special Service Needs 11.01.22
43. 1.05, 1.09, 1.10 IFSP First Steps 12.22.
44. 1.05, 1.09, 1.10 Navigating the DD Waivers January 2023

45. 1.05, 1.09, 1.10 Annual Notification for Individuals on WWL FY23 Update and Quantity Details 4.13.2023
46. 1.05, 1.09, 1.10 FY23 Accessing the WWL Forms Quick Tips 12.22.22
47. 1.05, 1.09, 1.10 FY23 Annual Notification Msg Electronic Providers 12.22.22.
48. 1.05, 1.09, 1.10 FY23 Annual Notification Msg Electronic Public 12.23.22.
49. 1.05, 1.09, 1.10 FY23 Cover Letter12.16.22
50. 1.05, 1.09, 1.10 FY23 WWL Forms and Survey Postcard 12.22.22
51. 1.05,1.09, 1.10, 19.1 IFSP Funding Attachment_B
52. 1.05, 1.09, 19.1 IFSP Outreach Materials 001Final
53. 1.05, 1.09, 19.1DR0115 IFSP Application query
54. 1.05, 1.09, 19.1DR0025_SQL_query for email addresses and mailing addresses
55. 1.06, 1.07_DS_IFSP_ANNUAL STSFCTN SRVY DATA VRFCTN_VER_001_3.28.23.docx
56. 1.06 1.07_IFSP_ANNUAL STSFCTN SRVY DATA VRFCTN_VER_002.docx
57. 1.08 17.01_ DS_IFSP_MLMC UTLZN_VER_002.docx
58. 1.09 1.10_IFSP Outreach Materials_001_Finaldocx.docx
59. 1.12 DS_IFSP_FUNDING SUPPORT_VER_001_final.docx
60. 19.03_ DS_IFSP_F2F P2P_VER_002.docx
61. 1.6,1.7 IFSP_Satisfaction_Survey__Attachment_B.docx.pdf
62. 1.06 1.07 IFSP_ANNUAL STSFCTN SRVY DATA VRFCTN_VER_002
63. 1.06, 1.07 IFSP Annual Satisfaction Survey Summary FY23 Update 3.28.2023
64. 1.06, 1.07 IFSP FY 2022 Annual Satisfaction Survey Report 3.28.2023.pdf
65. 1.06, 1.07 IFSP FY 2022 Satisfaction Survey Flowchart 11.11.2022
66. 1.06, 1.12 FY 2023 IFSP-Funding Summary 4.11.2023
67. 1.07, 19.03 Peer Mentor Report April-June 2022 6.30.2022.
68. 1.07, 19.03 Peer Mentor Report Jan-March 2022 3.31.2022
69. 1.07, 19.03 Peer Mentor Report July-Sept 2022 9.30.2022
70. 1.07, 19.03 Peer Mentor Report Oct-Dec 2022 12.31.2022
71. 1.07, 19.03 720-4798 Contract Administration Designation 10.28.2021
72. 1.07, 19.03 720-4798 Contract Administration Designation 4.15.2022
73. 1.07, 19.03 720-4798 Contract Modification 01 3.3.2021
74. 1.07, 19.03 720-4798 Contract Renewal 1 of 3 Modification 02_4.27.2021
75. 1.07, 19.03 720-4798 Contract Renewal 2 of 3 Modification 03_4.14.2022
76. 1.07, 19.03 720-4798 Contract 5.26.2020
77. 1.07, 19.03 720-4671 Contract Administration Designation 10.28.2021
78. 1.07, 19.03 720-4671 Contract Administration Designation 6.17.2022
79. 1.07, 19.03 720-4671 Contract Modification (No Cost Extension) 2.6.2019
80. 1.07, 19.03 720-4671 Contract Modification 01 6.7.2019
81. 1.07, 19.03 720-4671 Contract Modification 02 12.31.2019
82. 1.07, 19.03 720-4671 Contract Modification 03 6.5.2020
83. 1.07, 19.03 720-4671 Contract Modification 04 1.4.2021
84. 1.07, 19.03 720-4671 Contract Renewal 1 of 4 6.28.2019
85. 1.07, 19.03 720-4671 Contract Renewal 2 of 4 6.4.2020
86. 1.07, 19.03 720-4671 Contract Renewal 3 of 4 5.10.2021
87. 1.07, 19.03 720-4671 Contract Renewal 4 of 4 Modification 05 4.12.2022
88. 1.07, 19.03 720-4671 MOA 5.31.2018
89. 1.07, 19.03 F2F and P2P Report April-June 2022 6.30.2022
90. 1.07, 19.03 F2F and P2P Report Jan-March 2022 3.31.2022

91. 1.07, 19.03 F2F and P2P Report July-Sept 2022 9.30.2022
92. 1.07, 19.03 F2F and P2P Report Oct-Dec 202212.31.2022
93. 1.07, 19.03 F2F Data Report April-June 2022 6.30.2022
94. 1.07, 19.03 F2F Data Report Jan-March 2022_3.31.2022
95. 1.07, 19.03 F2F Data Report July-Sept 2022_9.30.2022
96. 1.07, 19.03 F2F Data Report Oct-Dec 2022_12.31.2022
97. 1.08, 17.01 MyLifeMyCommunity Stats Quarterly Report FY22Q1
98. 1.08, 17.01 MyLifeMyCommunity Stats Quarterly Report FY22Q2
99. 1.08, 17.01 MyLifeMyCommunity Stats Quarterly Report FY22Q3
100. 1.08, 17.01 MyLifeMyCommunity Stats Quarterly Report FY22Q4
101. 1.08, 17.01 720-4632 Contract Extension Modification 08 8.31.2022
102. 1.08, 17.01 720-4632 Contract Modification 02_6.24.2019
103. 1.08, 17.01 720-4632 Contract Modification 03_6.24.2020
104. 1.08, 17.01 720-4632 Contract Modification 06_10.26.2021
105. 1.08, 17.01 720-4632 Contract Renewal 1 of 4_9.13.2018
106. 1.08, 17.01 720-4632 Contract Renewal 2 of 4_8.13.2019
107. 1.08, 17.01 720-4632 Contract Renewal 3 of 4 Modification 04 9.24.2020
108. 1.08, 17.01 720-4632 Contract Renewal 4 of 4 Modification 05 9.23.2021
109. 1.08, 17.01 720-4632 Senior Navigator Contract 9.25.2017
110. 1.08, 17.01 720-4632 Sole Source signed by Commissioner 9.12.2017
111. 1.08 17.01 DS_IFSP_MLMC UTLZN_VER 002
112. 1.11, 19.01, 19.02 VIC Form Update and WaMS Sample 2.28.2023
113. 19.03 DS IFSP F2F P2P VER 002

APPENDIX F

Community Living Options

by

Ric Zaharia, Ph.D.

Consortium on Innovative Practices

TO: Donald Fletcher

FROM: Ric Zaharia

RE: Community Living Options – 22nd Review Period

DATE: April 30, 2023

Introduction

This report constitutes the fourth review of the compliance indicators for Community Living Options (Integrated Settings - Section III.D.1). In the Independent Reviewer's 20th Report to the Court, the Commonwealth provided documentation that seventeen (17) of twenty-three (23) indicators (74%) had been achieved or had been sustained through continuing effort. Although the value of the different indicators varies substantially for the members of the Agreement's target population, this represented progress from the previous review during Period 18 of 52%.

DBHDS data for FY21 showed that provider network development remained relatively flat during the pandemic. The data showed that 2/3 of counties/cities match or exceed the statewide average of 86.7% living in integrated settings, but five (5) counties/cities had less than 50% of the individuals served in integrated settings. The 20th Period review of residential data integrity included process control documents for some reports but did not include an independent verification through data attestation for all reports.

DBHDS data for FY20 indicated that it had achieved the timeliness benchmark for initial receipt of nursing services (i.e., 70% within 30 days) but that it had not achieved the nursing utilization benchmark (i.e., receipt of the number of hours identified in the ISP 80% of the time). DBHDS reports indicate that a substantial number of authorized nursing hours do not get delivered. The 20th Period review of nursing services included process control documents but did not include an independent verification through data attestation.

For the Commonwealth's workgroup leading the Every Child Texas model initiative, FY22 was characterized by a change in leadership, the initiation of direct consultation from The Every Child Texas program, the production of a statement of actionable strategies that emphasized the

principles of permanency planning for children with developmental disabilities, and making Jump Start funding available for Sponsored Residential providers.

For this review for the 22nd Report, the facts gathered are identified and analyzed at each indicator in the Findings Table below. The documents which include these facts are listed by reference in Attachment A and most can be located in the Commonwealth's Team library. Clarifying interviews were conducted with DBHDS officials (see Attachment B), including those who DBHDS identified as being most familiar with the Commonwealth's progress toward achieving the compliance indicators associated with Section III.D.1.

Summary of Findings for the 22nd Review Period

This review found that twenty (20) of twenty-three (23) indicators (87%) had been achieved or had been sustained through continuing effort. The remaining indicators relate to a) achieving the growth benchmark for integrated services, b) the documentation of a barriers workplan, and c) achieving nursing service delivery metrics.

DBHDS data showed that market share of authorizations for individuals being served in integrated residential settings has continued to grow as a percentage of all residential settings, i.e., 79.4% in 2016 to 88.9% in 2022. Data showed a 1.7% increase between 9.30.21 and 9.30.22, which is better than the previous year's 1.5% but does not achieve the 2% benchmark. This compliance indicator metric has consistently trended in a positive direction (never below 1.2%). Moreover, DBHDS has averaged a 1.5% increase annually over the last six years.

Also significant is the increased availability of integrated services statewide after the flat national and local experience of the pandemic. Table 1 recaps these changes over the past eighteen months.

Table 1
Integrated Settings per WaMS

	Spring 2021, Provider Data Summary (#64)	Fall 2022, Provider Data Summary (#60)
Person locality by integrated setting	87% (13,292/15,336)	90% (14,334/16,002)
Localities with 100% persons in integrated settings i.e., zero (0) persons in NON-integrated settings	30	40
Localities with 86%+ persons in integrated setting	59% 79/135	73% 99/135

Localities with 50% or fewer persons in integrated settings	5	1

One reason for this positive trend is that since the Commonwealth restructured its Home- and Community-based Services (HCBS) waiver program in Fiscal Year 2017, the vast majority of Virginia's new waiver slots include waiver services in most integrated settings, but not services in congregate residential settings. In addition, specific efforts by DBHDS to actively promote integrated settings are noted in its recent establishment of the Behavioral Services Search Engine to improve staff and family ability to locate therapeutic behavioral consultation and statewide email blasts to the Provider List Serv soliciting for more Sponsored Residential Providers in a specific CSB area.

DBHDS established during the review period a 47-member Developmental Disability Systems Issues and Resolution Workgroup (DDSIRW). This group was chartered to include stakeholders and to address issues that impact the development, expansion, and maintenance of developmental disability services, including integrated residential services. Workgroups are divided into 5 focused areas (Information Access, Workforce Growth, Community Options, Streamlining, System Transformation) plus a cross area Respite Workgroup. This larger, more broadly chartered workgroup reflects DBHDS's recognition that the barriers to more integrated services (sponsored residential, in-home, independent, shared, and supported living, and respite) are barriers to improving all services that the Division offers. Once the DDSIRW concludes actionable strategies and timelines, the required plan in these compliance indicators will have been achieved.

In its third annual review of nursing services DBHDS was able to accelerate the data analysis for the most recent fiscal year (FY22), as well as complete its FY21 review. Although some late claims will be missed, this is significant in that a more contemporaneous assessment of nursing services can be conducted. For FY22 DBHDS reports that it has achieved the timeliness benchmark for the initial delivery of nursing to Waiver service recipients (52 individuals) but that it has not sustained this same accomplishment for EPSDT service recipients (11 individuals). Table 2 below recaps the achievements over the past three years. It also indicates DBHDS has not yet achieved the nursing utilization benchmark (i.e., receipt of the number of hours identified in the ISP 80% of the time) for 613 individuals. FY23 data should show the impacts of the 7.1.22 nursing rate increases.

Table 2
Nursing Services

	FY20	FY21	FY22
Timeliness (70%)			
EPSDT	83%	71%	55%
Waiver	91%	83%	83%

Utilization (% of individuals who received 80%)*			
EPSDT	51%	22%	18%
Waiver	51%	30%	36%

*Note: the utilization percentages are based on the number of authorized hours which often varies from the number of hours identified in the ISP

The Commonwealth has expanded the provider stimulant Jump Start Funding to include nursing services. However, the nursing service utilization problem may be resistant to improvement efforts. The Independent Reviewer's Individual Services Review studies consistently identified these problems during the first several years of the Settlement Agreement. These findings existed when the Parties' agreed to the compliance indicator metrics in 2020. Second, there continues to be a national shortage of nursing personnel (see #34) that will require concerted state and federal human resource development efforts to fully resolve local and state shortages. Virginia is not only below the national average for nurses per capita population, but it is well below the nurses per capita among its four adjacent states. And finally, because of the episodic and difficult to predict nature of home healthcare (health need spikes, emergencies, etc.) and the presence of multiple service authorizations, the system has continued its tendency to over authorize nursing hours; this suggests that utilization will regularly fall below full utilization by some measurable amount. Based on Virginia's determination that its reimbursement rates for nursing services were substantially below market rates, the Commonwealth substantially increased these rates effective 7.1.22 to levels, although still below, are much closer to, market rates.

As to noteworthy activities that have been sustained, DBHDS tracked and reported that one individual requested integrated services that were not immediately available in CY22. Within nine months an integrated option that met the preferences of the legal guardian had been identified as available and was offered.

Finally, DBHDS has noted an increase in families with children in nursing facilities who are requesting more information on community placement into more integrated settings. DBHDS also reports successful efforts to divert three children from a specialized acute-chronic care hospital in CY22. While not reflecting on any specific compliance indicator, this is a very positive step and is in the spirit of shifting the system toward integrated settings, particularly for very young children. Similarly, the number of IDD adults in nursing facilities has dropped to a low of 210 at the end of CY22.

Data process and attestation.
Table 3 below recaps the data integrity documents reviewed for these indicators.

The process document for the Provider Data Summary (#40) was reviewed during the last Period. This semi-annual report is informed by the Residential Settings Report, WaMS, RST data, the Baseline Measurement Tool (BMT), and other reports. No potential threats were

identified by DQV, except in the BMT; in response, additional calculation procedures were outlined by the Measurement Steward. Updated Attestation Forms were completed by the Chief Information Officer, who verified that this is an "automated data pull" from WaMS and validated independently that the program was pulling the data intended to be pulled and that processes were in place to "deduplicate" data if duplicates occurred. He affirmed that the data was representative of the data to be collected, the processes that were used were thorough and detailed, and the data was, therefore, reliable and valid. (#39).

The process document for the RST (Regional Support Teams) reports (#41) from Period 20 was reviewed. Manual entry is the major threat to data integrity identified by DQV. The Measurement Steward planned to incorporate the referral form into WaMS, so that it will become an electronic entry. That conversion has occurred, but the process document and data set attestation both need to be updated to include the RST.

A consolidated and updated process document for Nursing Utilization and Timeliness (#51) was reviewed and continues to be clear and sound. The indicator metrics require that there be a cross-tab of Medicaid paid claims and WaMS authorizations semi-annually. Analytic steps are clearly identified. The Attestation Form (#53) was completed by the Chief Information Officer, who found processes to be thorough and detailed. He verified each count and checked all values in a raw data report, He identified no defects in data or analyses.

The Process Document for Outreach Logs (#52) was reviewed and is based on semi-annual data pulls from the PASRR central record. These data pulls trigger transmittal of the CTG to families, phone contacts with all families, and the provision of more information if requested. DQV recommendations included reduction in manual entries, clarifying process to establish "unique identifiers, etc. Mitigation strategies have been implemented for all DQV recommendations. An updated Attestation Form for Outreach Logs (#56) was completed by the Chief Information Officer, who found the process to be thorough and detailed through a matched analysis of the PASRR record. He concluded that the data processes were reliable and valid.

Process Documents for PASRR-Awareness/Action Letters was reviewed (#50). It is a process built on notification of DBHDS by a contractor that an admission PASRR has been completed, which then results in an entry on a central PASRR record that is used to trigger Awareness letters to home CSBs. Notifications by nursing facilities or others of discharge planning triggers an Action letter to the individual's home CSB and subsequent monitoring of CSB response. DQV recommendations included reducing manual entries, clarifying process to establish "unique identifiers", etc. Mitigation strategies have been implemented for all DQV recommendations. The Attestation Form for PASRR- Awareness/Action letters (#54) was completed by the Chief Information Officer, who found the processes utilized thorough and detailed. He verified each count and checked all values in a raw data report. He identified no defects in data or analyses.

Table 3 recaps the documents provided.

Table 3
Data Integrity Documents

CI	**Process Control Document**	**Data Set Attestation**
18.1-18.3, 18.6	Provider Data Summary Process (#40)	Provider Data Summary Attestation (#39)
18.7	RST Process (#41) [does not include RST move to WaMS]	RST Tracking Data Set Attestation (#42) [does not include RST move to WaMS]
18.9	Nursing Auth Timeliness/Utilization Process (#43-44, 51)	Nursing Utilization Attestation (#53)
18.19	Outreach Log Process (#52) [described processes are similar to those followed by ICF/IIDs but only nursing facilities are mentioned]	Outreach Log Attestation (#56) [described reviews are similar to those followed by ICF/IIDs but only nursing facilities are mentioned]
18.22	PASRR Awareness/Action Letter Process (#50)	PASRR Letter Attestation (#54)

Compliance Indicator Achievement.

Table 4 below recaps the status of the compliance indicators this study reviewed.

Table 4
Community Living Options Findings

#	Indicator	Facts	Analysis/ Conclusions	20th	22nd
18.1	*DBHDS service authorization data will continue to demonstrate an increase in the percentage of the DD Waiver population being served in the most integrated settings as defined in the Integrated Residential Settings Report.*	Data showed that market share of authorizations for individuals being served in integrated residential settings has continued to grow as a percentage of all residential settings, i.e., 79.4% in 2016 to 88.9% in 2022 (see # 27, 60). The process document for the Provider Data Summary (#40) was reviewed during the last Period. This semi-annual report is informed by the Residential Settings Report, WaMS, RST data, the Baseline Measurement Tool (BMT), and other reports. No potential threats were identified by DQV, except in the BMT; in response additional calculation procedures were outlined by the Measurement Steward. Updated Attestation Forms were completed by the Chief Information Officer, who verified that this is an "automated data pull" from WaMS and validated	Sustained achievement.	**M***	**M**

		independently that the program was pulling the data intended to be pulled and that processes were in place to "deduplicate" data if duplicates occurred. He affirmed that the data was representative of the data to be collected, the processes that were used were thorough and detailed, and the data was, therefore, reliable and valid. (#39).			
18.2	*a. Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings*	Data showed a 1.7% increase in individuals receiving services in integrated settings between 9.30.21 and 9.30.22, which is better than the previous year's 1.5% but does not achieve the 2% benchmark (see #27, 60). The Data Process document and Attestation for the Provider Data Summary were reviewed (see #39-40). See above at 18.1.	This indicator has consistently trended in a positive direction (never below 1.2%). Moreover, DBHDS has <u>averaged</u> a 1.5% increase annually over the last six years. However, despite these efforts, the 2% benchmark has not yet been achieved.	**NM**	**NM**
18.3	*b. Data continues to indicate that at least 90% of individuals new to the waivers, including individuals with a "support needs level" of Levels 6 and 7, since FY 2016 are receiving services in the most integrated setting.*	The most recent available PDS (#60) showed 95% of all people new to the waiver FY16 to FY22-Q1 (including Levels 6 & 7) live in integrated settings. This analysis is based on the cumulative enrollee count since FY16 (see #17, 60).	This indicator has very likely been achieved previously, and this analysis confirms substantial achievement for the period.	**NM**	**M**

		The Data Process document and Attestation for the Provider Data Summary were reviewed (see #39-40). See above at 18.1.			
18.4	*2. DBHDS continues to compile and distribute the Semi-annual Provider Data Summary …. The Data Summary indicates an increase in services available by locality over time.*	The PDS reports (see #17, 60, 64) are archived on the DBHDS website (see #19) and various portions are reviewed at its Provider Roundtables and webinars (see #18). When the most recent semi-annual report (#60, 11.1.22) was analyzed by city/county, integrated residential services are used in 90% of Virginia localities as of Fall 2022, a 3% improvement over Spring 2021. Moreover, 40 of 135 cities/counties have <u>no one</u> living in non-integrated settings and there is only <u>one</u> city/county where less than 50% individuals live in non-integrated settings, a four locality improvement over Spring of 2021; 73% of cities/counties have 86% or more individuals living in integrated settings, a 14% improvement over Spring 2021 (see #64, 60). Efforts by DBHDS to assertively promote integrated settings are noted in the establishment	There is evidence that availability by locality over time is improving, due to more integrated services being offered and available in more locations. Because of the development of systems and infrastructure in more and more localities, DBHDS reports 334 more licensed DD providers during the last year, so it is not likely that this local service availability will diminish, save another pandemic. This improvement should become more pronounced in the next review period. Therefore, this indicator has been achieved.	**NM**	**M**

		of a Behavioral Services Search Engine to improve staff and family ability to locate therapeutic behavioral consultation (see #58), statewide email blasts to the Provider List Serv soliciting for more Sponsored Residential Providers in a specific CSB area (see #59), and Jump Start Funding expansion to nursing services (see #60).			
18.5	*3. DBHDS will establish a focus group with family members, individuals, and providers to identify potential barriers limiting the growth of sponsored residential, supported living, shared living, in-home supports, and respite for individuals with a "support needs level" of Level 6 or 7.*	DBHDS established a focus group on these barriers in 2019 (see #61). However, the role of family members, individuals, and providers in that focus group was unclear. The 2019 work of the Barriers Focus Group included recommendations for a potential workplan (see #61). DBHDS has now convened a larger ongoing Issues Resolution Workgroup (DDSIRW- see #63), which includes a cross-section of Self-Advocates and Family members and which has continued and expanded on the 2019 work of the Barriers Focus Group. One of the purposes of the DDSIRW is to identify barriers to the integrated service models, with level	DBHDS established and convened the focus group in 2019 and documented the potential barriers the group identified. The roles of the group's members were not documented. This indicator is now Met. DBHDS has undertaken the challenge of addressing the barriers, identified in part by the focus group. It has established and launched a continuing and broader workgroup that includes a range of stakeholders to pursue the growth of integrated service models, including for individuals with SIS Level 6 or 7 support needs.	**NM**	**M**

		6 or 7 support needs.			
18.6	*DBHDS will report on how many individuals who are medically and behaviorally complex (i.e., those with a "support needs level" of Level 6 or 7) are using the following DD Waiver services, by category: sponsored residential, supported living residential, shared living, in-home supports, and respite services. Using this data and the focus groups, DBHDS will prepare a plan to prioritize and address barriers within the scope of its authority and establish timelines for completion with demonstrated actions.*	DBHDS reported on the numbers of Level 6-7 individuals receiving services in the five areas (see #29): Type L-6 L-7 SR 291 297 SLR 1 5 ShL 0 0 InHS 91 89 Resp 477 293 DBHDS provided a DDSIRW 'draft' working paper for addressing barriers to respite (see #62). The Data Process document and Attestation for the Provider Data Summary were reviewed (see #39-40). See above at 18.1.	When the Plan referenced in this Indicator is documented (including the original issues identified by the Barrier Focus Group and barriers to all five service types), this indicator will be achieved. The DDSIRW "Barriers to Respite" working paper (#62) is a good start and does address the most frequently used integrated service, but it does not include timelines, and actions to be taken or barriers to the other four specified service types). Therefore, this indicator is not yet achieved.	**NM**	**NM**
18.7	*4. DBHDS tracks individuals seeking a service consistent with integrated living options as defined in the Integrated Residential Settings Report that is not available at the time of expressed interest as described in indicator # 13 of III.D.6. 86% of people with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option …have access to an option that meets their preferences within nine months.*	DBHDS reports that in CY22 RST tracked one individual who requested integrated services that were not immediately available (see #37-38). Within nine months an integrated option meeting the preferences of the legal guardian had been identified and offered to the individual's guardian (see #55). RST Data Process documents and Data Set	Sustained achievement.	**M**	**M**

		Attestations from Period 20 (#41-42) were reviewed and verified. They do not yet incorporate the move of RST into WaMS, but the process changes that are needed to implement this were completed (see #46-48).			
18.8	*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 has completed full reviews for the last 3 fiscal years. Patterns of service delivery interruptions and root causes are emerging and should help the Commonwealth to identify and remedy the problems. A consolidated and updated process document for Nursing Utilization and Timeliness (#51) was reviewed and continues to be clear and sound. The indicator metrics require that there be a cross-tab of Medicaid paid claims and WaMS authorizations semi-annually. Analytic steps are clearly identified. The Attestation Form (#53) was completed by the Chief Information Officer, who found processes to be thorough and detailed. He verified each count and checked all values in a raw data report, He identified no defects in data or analyses. He did not address the use	Shortage of personnel remains the most suggested reason for undelivered services but the complexity of the billing process and over-authorizations are areas which need more evaluation. Multiple service authorizations also appear to be a significant factor in the overlapping prescription of hours. DBHDS has established and maintained an ongoing review process, and therefore has sustained its achievement.	**M**	**M**

		of authorized hours versus hours in the ISP.			
18.9	*6. DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018, for FY 2018. The utilization rate is defined by whether the hours for the service are identified a need in an individual 's ISP and then whether the hours are delivered. Data will be tracked separately for EPSDT and waiver funded nursing. Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.*	The Commonwealth's three most recent full year reviews (see #31-33) - showed these rates for FY20-FY21-FY22: **<u>Timeliness</u> (70% in 30 days)** **EPSDT*-83%-71%-55%** **Waiver*-91%-83%-83%** **<u>Utilization (rec'd 80%)</u>** **EPSDT**-51%-22%-18%** **Waiver** – 51%-30%-36%.** ***Individuals, not authorizations** **** Authorizations, not hours identified in ISPs** Data Process Documents for Nursing Utilization and Timeliness, as well as the associated Data Set Attestation, were reviewed (see #51, 53). **See above at 18.8.**	This indicator has not yet been fully achieved. It will be achieved when the metrics are reached. The indicator requires that the percentage of hours delivered be determined. The Commonwealth reports that the number of hours in the ISP is often not identified, so it instead uses the number of authorized hours. The Commonwealth explains that it has learned that the number of authorized hours for nursing services is often inflated to cover potential changes in need or unexpected events/emergencies and therefore is not an accurate replacement for "hours in the ISP".	**NM**	**NM**
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*	DBHDS continues to screen via VIDES prior to admission and collect information from families regarding the reason/s placement is sought. See #6-7. Out of 24	Sustained achievement.	**M**	**M**

	being sought.	admissions, 4 were diverted in CY22 (see #8).			
18.11	*8. DBHDS continues to do Level II Preadmission Screening and Resident Reviews ("PASRR") on all children who have an indicator of a developmental disability diagnosis and are seeking nursing home services. All children who enter nursing facilities are limited to those who require medical rehabilitation, respite or hospice services.*	DBHDS continues to do PASRR reviews on all children seeking NF placement (see #20-21). Seven children were diverted in FY22 (see #22).	Sustained achievement.	**M**	**M**
18.12	*9. DBHDS tracks individuals under 22 who have received a PASRR screening for nursing facility entry or a VIDES assessment for ICF/IID entry and have been admitted. Children in ICFs receive annual Level of Care reviews and children in nursing facilities receive required resident reviews every 180 days at a minimum.*	DBHDS continues to track NF admissions and conduct reviews every 180 days (see #20-22). DBHDS continues to track ICF/IID admissions and conduct Level of Care Reviews every 180 days (see #2).	Sustained achievement.	**M**	**M**
18.13	*10. DBHDS provides a Community Transition Guide to families of children in nursing facilities and ICFs/IID. For those seeking ICF/IID placement, the Guide is provided when a request for a VIDES assessment is made and every 6 months thereafter. The Guide is designed to provide practical information to children and their families who are preparing to make decisions related to the type of care that best suits their support needs or are preparing to transition from nursing facilities and ICFs/IID to homes in the community. The Guide assists families in preparing to move to a*	DBHDS provides the *Community Transition Guides* (CTG) to families of children in ICF/IID and nursing facilities at admission and every 6 months after admission (see #3-4, 7, 23). DBHDS notes an increase of families requesting information for community placement. The current version of the *Community Transition Guide* provides practical information but in a bureaucratic style.	Sustained achievement.	**M**	**M**

	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.				
18.14	*11. Information with respect to services and supports for children with DD is available to families on the My Life My Community website. This information is disseminated consistent with the indicators in III.C.8.b.*	The required information continues to be available on the My Life My Community website. (http://mylifemycommunityvirginia.org/) This information has also been widely distributed to organizations and entities likely to have contact with individuals eligible for waiver services.	Sustained achievement.	**M**	**M**
18.15	*12. DBHDS includes children aged 10 years and under as a priority group for discharge from ICF/IID settings per the ICF Community Transition Protocol, including prioritizing waiver slots to facilitate their discharge.*	DBHDS continues to utilize a *Waiver Slot Distribution-Process* that prioritizes and tracks five slots annually for children under 10 in ICFs or NFs (see #26).	Sustained achievement.	**M**	**M**
18.16	*13. DBHDS implements a Family Outreach Plan that provides an avenue of communication with families/guardians/ARs of individuals with DD under 22 years of age receiving long term care services in nursing facilities and ICF/IIDs. Contact with parents/guardians/ARs is initially made by mail with follow up phone calls. All families are provided with the Community Transition Guide as described in indicator #10 above.*	DBHDS continues to develop Family Outreach Plans (see #5, 9-10, 23). All families are provided with the Community Transition Guide.	Sustained achievement.	**M**	**M**
18.17	*Families/Guardians/ARs interested and open to discussion of available*	DBHDS continues to implement these annual and semi-annual contacts	Sustained achievement.	**M**	**M**

	community services are contacted not less than semi-annually. All families receive an annual contact unless there is a request for no contact.	with families (see #5, 27, 30). These activities have occurred over five review cycles.			
18.18	*Contact through the Family Outreach Plan will also involve individualized information in a manner that accommodates their cognitive disabilities, addresses past experiences of living in community settings and concerns and preferences about community settings, and includes facilitating visits and direct experiences with the most integrated community settings that can meet the individual's identified needs and preferences.*	DBHDS continues to implement these annual contacts with families, including past experiences, concerns, and preferences (see #5, 23, 30).	Sustained achievement.	**M**	**M**
18.19	*DBHDS facilitates with families a contact by a family-to-family peer support facilitator who shall contact families of children on at least a semi-annual basis for children aged 10 years and under, and on an annual basis for children aged 11 to 21 years, unless the family refuses contact.*	DBHDS continues to facilitate family-to-family peer mentors when interested (see # 11-12, 23, 30). The Process Document for Outreach Logs (#52) was reviewed and is based on semi-annual data pulls from the PASRR central record. These data pulls trigger transmittal of the CTG to families, phone contacts with all families, and the provision of more information if requested. DQV recommendations included reduction in manual entries, clarifying process to establish "unique identifiers, etc. Mitigation strategies have been implemented for all	Sustained achievement.	**M***	**M**

		DQV recommendations. An updated Attestation Form for Outreach Logs (#56) was completed by the Chief Information Officer, who found the process to be thorough and detailed through a matched analysis of the PASRR record. He concluded that the data processes were reliable and valid.			
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.*	DBHDS has continued its Focus Group efforts with sister agencies and private providers to develop a family-centered system of care for children. DBHDS has explored the shared parenting model, the support family model, and the host home model in collaboration with Every Child Texas management. In addition, they are evaluating customized special rates for Sponsored Residential providers for children in light of the additional workload for children (support coordination duties, court testimony, permanency planning, etc.) See #57.	Sustained achievement.	**M**	**M**
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*	Over four review cycles DBHDS has provided documentation that CSBs are informed of children with IDD seeking admission or discharge to	Sustained achievement.	**M**	**M**

	admission or discharge whose families are interested in community-based services through an awareness letter. When a child is identified as being in active discharge status from a nursing facility or ICF/IID, DBHDS sends an action letter to CSBs that enumerates the actions needed from the CSB and ensures funds are available for up to 120 days of Case Management Services for discharge planning.	an ICF/IID or a nursing facility (see #13-16, 24-25). DBHDS reports two instances of CSBs utilizing the 120 days of case management funding for pre-discharge planning at nursing facilities but no uses of the funding for discharge planning at ICF/IIDs			
18.22	*a. 90% of those children known to be in active discharge status at a nursing facility or ICF/IID have an action letter sent to their home CSB.*	DBHDS sent action letters for 100% of those children known to be in active discharge status at an ICF/IID or nursing facility (see #15-16, 24, 49). Process Documents for PASRR-Awareness/Action Letters was reviewed (#50). It is a process built on notification of DBHDS by a contractor that an admission PASRR has been completed, which then results in an entry on a central PASRR record that is used to trigger Awareness letters to home CSBs. Notifications by nursing facilities or others of discharge planning triggers an Action letter to the individual's home CSB and subsequent monitoring of CSB response. DQV recommendations	Sustained achievement.	**M**	**M**

		included reducing manual entries, clarifying process to establish "unique identifiers", etc. Mitigation strategies have been implemented for all DQV recommendations. The Attestation Form for PASRR-Awareness/Action letters (#54) was completed by the Chief Information Officer, who found the processes utilized as thorough and detailed. He verified each count and checked all values in a raw data report. He identified no defects in data or analyses.			
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.*	CSBs have been actively involved within 30 days of receiving an action letter for ICF/IID or nursing facility discharges (see #15-16, 24).	Sustained achievement.	**M**	**M**

*Data reliability and validity issues

Suggestions for DBHDS consideration

1. Convene a group of consumers/family members to edit the Community Transition Guide into a more user-friendly version; for example, eliminate or minimize all use of acronyms, reorganize text/Table of Contents so it attracts family perspectives, add an index for family reference, move historical and background information into attachments or appendices, etc.
2. The Nursing Services Workgroup should conduct:
    a. A task analysis of the nursing billing process from authorization to delivery to billing and, especially, to claim denials, in order to identify any mechanisms or changes that may help simplify the process and expedite billing for nursing providers.

b. A focused assessment of the 20 providers (out of the 112) who were able to deliver 80% of their authorized hours in FY22, in order to identify practices or patterns that support fulfilment of the 80% metric.
c. A repeat of the study of multiple service authorizations, in order to confirm and quantify an over authorization factor for this metric and to establish determinants of the 'nursing needs met' conclusion.
d. An evaluation of whether establishing a nursing service claims *cutoff date* will motivate late billing agencies to submit more timely claims.

Attachment A
Documents Reviewed
CLO – Title or Filename

1. CLO 22nd Study Period Document Tracker 2.2.23
2. --, LOC Review Findings Letter, 20 individuals, CY22
3. --, CTG Letter, 20 individuals, CY22
4. DBHDS Community Transition Guide (Spanish and English), 1/22
5. --, Community ICF/IID Family Contact Sheet, 10 individuals (>1), CY22
6. --, Completed VIDES, 10 individuals, CY22
7. --, Community ICF /IID Family Contact Sheet, 10 individuals, CY22
8. VIDES Summary (CY22)
9. --, Family Outreach Plan, 9 individuals, ongoing
10. Family Outreach Plan Summary, 3.10.20 to 12.7.22
11. --, Family to Family Referral, 9 individuals, CY22
12. Family to Family Referral Network Summary, CY22
13. --, CSB Admission Awareness Letters, 9 individuals, CY22
14. Summary of CSB Admission Awareness Letters, CY22
15. --, CSB Notification of Active Discharge, 7 individuals, CY22
16. Summary of Discharges for CY22
17. Provider Data Summary, 5.1.22
18. Provider Roundtable-Jan. 25, 2023
19. https://dbhds.virginia.gov/developmental-services/provider-development/
20. Baseline 4th Quarter FY22
21. Found 4th Quarter FY22
22. Preadmission 4th Quarter
23. Family Outreach Results Winter 2022
24. Action Letters (NF) FY22
25. Awareness Letters (NF) FY22
26. Waiver Slot Distribution Process, 1.21.22
27. DR0055 Residential Settings Report…09302022
28. Dr0022 Residential Settings 10252022 (locality)
29. DR0052 Counts by Service Type…(5/22-10/22)
30. Family Outreach individual update, 2.17.23
31. Nursing Service Data Report FY21
32. Nursing Service Data Report FY22
33. Nursing Hours Utilization…FY20
34. The U.S. Nursing Shortage: A State-by-State Breakdown | NurseJournal (9.29.22)
35. Timeline…Region Ten (2.16.23)
36. Mail CRC Outlook (email Cramer to Williams, 2.17.23)
37. CRC R1 2441 VIC Region Ten, 6.15.22
38. CRC R1 2441 Region Ten, 6,15.22

39. Attachment B (PDS – 3.1.23 & 3.10.23 & 4.14.23)
40. DD Provider Data Summary, 3.22.22
41. DD PD RST, 1.7.21
42. RST Workbook, 3.7.22
43. Nursing Authorization Timeliness…, 1.14.22
44. Nursing Authorization Utilization…, 1.14.22
45. Data Set Attestation (ICF data & Family Outreach), 3.4.22
46. WaMS Data and Reporting Request Form…1.5.23
47. WaMSCR-153 RST Module Edits…
48. WaMS CR RST Module Edits…1.5.23
49. --, Notification of Active Discharge, (10 letters)
50. Indicator Process PASRR Awareness Action
51. Nursing Authorization and Timeliness…2.22.23
52. Indicator Process – Outreach
53. Nursing Utilization Attachment B
54. PASRR Attachment B
55. RST Update 3.14.23 (2441)
56. Family Outreach Attachment B
57. Every Child Texas Model v Virginia DD Services, 3/23
58. Email blast, "Behavioral Services Search Engine now available", Provider List Serv, 4.3.23
59. Email blast "Sponsored Residential Providers Needed in the Charlottesville Are", Provider List Serv, 3.31.23
60. Provider Data Summary Report, 11.1.22
61. Barrier Meeting (Implementing Integrated Services), 10.9.19, 11.12.19, 11.20.19, 12.2.19
62. Barriers to Respite, undated.
63. Developmental Disability Services Issue Resolution Workgroup, 3.20.23 (includes agendas, minutes, charter, 5 subcommittees, issue statements)
64. Provider Data Summary Report, 5.21.21
65. Email blast, "DD System Issues Resolution Workgroup for Individuals and Families-(4.28.23, 1 pm)", Provider List Serv, 4.19.23

Attachment B
CLO Interviews

Benita Holland, Family Resource Consultant Manager, DDS, 3.13.23

Susan Moon, Director, Office of Integrated Health, DDS, 3.15.23

Brian Nevetral, Project Manager, OIH, 3.15.23

Heather Norton, Assistant Commissioner, Developmental Services, 3.15.23

Lisa Rogers, RN Community Integration Consultant, OIH, 3.15.23

Eric Williams, Director, Provider Development, DDS. 3.17.23

APPENDIX G

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 Plan
BSPARI	Behavior Support Plan Adherence Review Instrument
CAP	Corrective Action Plan
CAT	Crisis Assessment Tool
CEPP	Crisis Education and Prevention Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Manager
CI	Compliance Indicator
CIT	Crisis Intervention Training
CL	Community Living (HCBS Waiver)
CLO	Community Living Options
CM	Case Manager
CMS	Center for Medicaid and Medicare Services
COVLC	Commonwealth of Virginia Learning Center
CQI	Community Quality Improvement
CPS	Child Protective Services
CRC	Community Resource Consultant
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTA	Consultation and Technical Assistance
CTH	Crisis Therapeutic Home
CTT	Community Transition Team
CVTC	Central Virginia Training Center
DARS	Department of Aging and Rehabilitative 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
EHA	Office of Epidemiology and Health Analytics (formerly DQV)
E1AG	Employment First Advisory Group
EPSDT	Early and Periodic Screening Diagnosis and Treatment
ES	Emergency Services (at the CSBs)
ESO	Employment Service Organization
FRC	Family Resource Consultant
GH	Group Home
GSE	Group Supported Employment
HCBS	Home- and Community-Based Services
HPR	Health Planning Region
HSN	Health Services Network
ICF	Intermediate Care Facility
ID	Intellectual Disabilities
IDD	Intellectual Disabilities/Developmental Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports ("DD" waiver)
IFSP	Individual and Family Support Program
IR	Independent Reviewer
ISE	Individual Supported Employment
ISP	Individual Supports Plan
ISR	Individual Services Review
KPA	Key Performance Areas
LIHTC	Low Income Housing Tax Credit
MLMC	My Life My Community (website)
MOU	Memorandum of Understanding
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
OCQI	Office of Continuous Quality Improvement
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
OSIG	Office of the State Inspector General
OSVT	On-Site Visit Tool
PASSR	Preadmission Screening and Resident Review
PCR	Person Centered Review

PCP	Primary Care Physician
PHA	Public Housing Authority
POC	Plan of Care
PMI	Performance Measure Indicator
PMM	Post-Move Monitoring
PST	Personal Support Team
QAR	Quality Assurance Review
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QMD	Quality Management Division
QMR	Quality Management Review
QRT	Quality Review Team
QSR	Quality Service Reviews
RAC	Regional Advisory Council for REACH
RAT	Risk Assessment Tool
RCA	Root Cause Analysis
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
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