IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
Richmond Division

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	**CIVIL ACTION NO: 3:12CV59-JAG**
v.	)	
	)	
COMMONWEALTH OF VIRGINIA,	)	
	)	
Defendant.	)	
	)	
and	)	
	)	
PEGGY WOOD, et al.,	)	
	)	
Intervenor-Defendants.	)	
	)	

JOINT FILING OF COMPLETE SET OF AGREED COMPLIANCE INDICATORS

The Commonwealth of Virginia and the United States (collectively referred to as the "Parties"), in accordance with the Court's direction, jointly submit Attachment 1, which contains a complete list of compliance indicators agreed to by the Parties, including those previously filed with the Court, that address all provisions of the Settlement Agreement for which the Commonwealth has yet to be found in compliance.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of January, 2020, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will then send a notification of such filing (NEF) to the following:

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ATTACHMENT 1

Compliance Indicators

#	Provision	Provision text	Indicator
1	**III.C.2.a-f**	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.	The Commonwealth will achieve compliance with this provision of the Settlement Agreement when: 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 2) The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization. 3) The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program. 4) The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including: • The number of individuals on the waiver waitlist who are provided with outreach materials each year • Participant satisfaction with the IFSP funding program • Knowledge of the family and peer mentoring support programs • Utilization of the My Life, My Community website 5) Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter.

#	Provision	Provision text	Indicator
			6) IFSP funding availability announcements are provided to individuals on the waiver waitlist. 7) 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. 8) Documentation continues to indicate that a minimum of 1,000 individuals and/or their families are supported through IFSP funding.
2	**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.	The following indicators to achieve compliance listed in this provision will also achieve compliance with other provisions associated with case management (**III.C.5.b.ii, III.C.5.b.iii, III.C.5.c, and V.F.2**). Relevant elements of person-centered planning, as set out in CMS waiver regulations (42 C.F.R. § 441.301(c)), are captured in these indicators. In consultation with the Independent Reviewer, DBHDS shall define and implement in its policies, requirements, and guidelines, "change of status or needs" and the elements of "appropriately implemented services." DBHDS will perform a quality review of case management services through CSB case management supervisors/QI specialists, who will conduct a Case Management Quality Review that reviews the bulleted elements listed below. DBHDS will pull an annual statistically significant stratified statewide sample of individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB. Each quarter, the CSB case management supervisor and/or QI specialist will complete the number of Case Management Quality Review as determined by DBHDS by reviewing the records of individuals in the sample. The data captured by the Case Management Quality Review will be provided to DBHDS quarterly through a secure software portal that enables analysis of the data in the aggregate. DBHDS analysis of the data submitted will allow for review on a statewide and individual CSB level. The Case Management Quality Review will include review of whether the following ten elements are met:

#	Provision	Provision text	Indicator
			• The CSB has offered each person the choice of case manager. (**III.C.5.c)** • The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team. **(III.C.5.b.ii; V.F.2)** • The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. **(III.C.5.b.iii; V.F.2)** • The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences. **(III.C.5.b.ii; V.F.2)** • The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable. **(III.C.5.b.i; III.C.7.b)** • The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served. **(III.C.5.b.i; III.C.5.b.ii)** • The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary. **(III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)** • Individuals have been offered choice of providers for each service. (**III.C.5.c)** • The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences. **(III.C.5.b.iii; V.F.2)** • The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individuals' needs. (**III.C.5.b.iii; V.F.2)**

#	Provision	Provision text	Indicator
			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. 86% of the records reviewed across the state will be in compliance with a minimum of 9 of the elements assessed in the review. Any individual CSB that has 2 or more records that do not meet 86% compliance with Case Management Quality Review for two consecutive quarters will receive additional technical assistance provided by DBHDS. 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, through the Case Management Steering Committee, will ensure that the CSBs receive their case management performance data semi-annually at a minimum. All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or DBHDS licensing regulations. Corrective actions for cited regulatory non-compliance will be tracked to ensure remediation.
3	**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.	The actions to achieve compliance listed in Section **III.C.5.b.i** will also achieve compliance with this provision of the Settlement Agreement.
4	**III.C.5.b.iii**	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as	The actions to achieve compliance listed in Section **III.C.5.b.i** will also achieve compliance with this provision of the Settlement Agreement.

#	Provision	Provision text	Indicator
		needed.	
5	**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.	The actions to achieve compliance listed in Section **III.C.5.b.i** will also achieve compliance with this provision of the Settlement Agreement.
6	**III.C.5.d**	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	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 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 the information from case management monitoring/oversight processes including: data from the oversight of the Office of Licensing, DMAS Quality Management Reviews, CSB Case Management Supervisors Quarterly Reviews, DBHDS Quality Management Division quality improvement review processes including the Supervisory retrospective review, Quality Service Reviews, and

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			Performance Contract Indicator data. 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. 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 sub-sample of the original sample will be drawn each year for this retrospective review. The sample will be stratified so that each CSB is included in the sample. 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, in addition to providing feedback to the CSB case management supervisors to increase the reliability of future reviews. There will be an ongoing inter-rater reliability process for staff of the DBHDS Quality Improvement Division conducting the retrospective reviews.
7	**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 to individuals with intellectual and developmental disabilities who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families ii. Provide services focused on crisis prevention and proactive planning to	Overall note: There are 3 main components: Prevention, Mobile Crisis, and Crisis Stabilization. **PREVENTION:** Prevention of crisis breaks into 4 sub-components: 1) Early identification 2) Assessment in home 3) Behavior supports in home 4) Availability of direct support professionals **1. Early Identification; and 2. Assessment in Home** 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

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		avoid potential crises; and 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	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. 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. DHBDS will establish criteria for use by CSBs to determine "risk of hospitalization" as the basis for making requests for crisis risk assessments. 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. 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 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. 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 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

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			Diagnosis. 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. 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. 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. 95% of children and adults admitted to state-operated and private psychiatric hospitals who are known to the CSB will be referred promptly (within 72 hours of admission) to REACH. **3. 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. 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. 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

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			determine whether the plan is appropriately implemented. The permanent DD waiver regulations will include expectations for behavioral programming and the structure of behavioral plans. 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. 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. 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

#	Provision	Provision text	Indicator
			5) whether Case Managers are assessing whether behavioral programming is appropriately implemented. **4. Availability of Direct Support Professionals** 1. DBHDS will implement a quality review process for children and adults with identified significant behavior support needs (Support Level 7) 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 the hours identified as needed in ISPs to the hours authorized. 2. Semi-annually, DBHDS will review a statistically significant sample of 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 the families of individuals in the sample to ascertain: a. If the individuals 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. 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.

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8	**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.	**MOBILE CRISIS:** DBHDS will, on a semi-annual basis, 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. Based on findings, DBHDS will 1) determine the need for training related to mobile crisis; and 2) when necessary as determined by DBHDS, require a quality improvement plan through the Performance Contract from the CSB managing the REACH unit. Outcomes to be achieved: 86% of REACH staff will meet training requirements 86% of initial CEPPs are developed within 15 days of the assessment 86% of families and providers will receive training in implementing CEPPs Documentation indicates a decreasing trend in the total and percentage of total admissions as compared to 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**.** For individuals with DD who are admitted to state-operated psychiatric hospitals and those known by DBHDS to have been admitted to private psychiatric hospitals, DBHDS will track the lengths of stay in the following categories: • those previously known to the REACH system and those previously 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 with DD in psychiatric hospitals.

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9	**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.	The findings are redundant and covered in Indicators for **III.C.6.a.i-iii** and **III.C.6.b.ii.A.**
10	**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	**CRISIS STABILIZATION:** 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. DBHDS will utilize waiver capacity set aside for emergencies each year to meet the needs of individuals with long term stays in psychiatric hospitals or CTHs. DBHDS will increase the number of residential providers with the capacity and competencies to support people with co-occurring conditions using a person-centered/trauma-informed/positive behavioral practices approach to 1) prevent crises and hospitalizations, 2) to provide a permanent home to individuals discharged from CTHs and psychiatric hospitals. 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	**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.	86% of individuals with a DD waiver and known to the REACH system admitted to CTH facilities will have a community residence identified within 30 days of admission. This indicator is also in **III.C.6.b.iii.B.**
12	**III.C.6.b.iii.E.**	With the exception of the Pathways	The indicator for this provision is covered in **III.C.6.b.iii.G**.

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		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	
13	**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.	The Commonwealth will establish and have in operation by June 30, 2019 two Crisis Therapeutic Home (CTH) facilities for children. This indicator is also in **III.C.6.b.iii.B.** To address the CTH stays of adults beyond 60 days, DBHDS will establish and operate two transition homes by June 30, 2019. 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 institutionalization of children due to behavioral or mental health crises.
14	**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.	1. All case managers are required to take the on line case management-training modules and review the case management manual. Information contained includes: a. The Employment First Policy with an emphasis on the long term benefits of employment to people and their families and practical knowledge about the relationship of employment to continued Medicaid benefits; b. Skills to work with individuals and families to build their interest and

#	Provision	Provision text	Indicator
			confidence in employment; c. The importance of discussing employment with all individuals, including those with intense medical or behavioral support needs and their families; d. The importance of starting the discussion about employment with individuals and families as early as the age of 14 (when transition begins under IDEA) with goals that lead to employment (*e.g.*, experiences in the community, making purchases, doing chores, volunteering); e. The value of attending a student's IEP meeting starting at age 14 to encourage a path to employment during the school years and to explore how DD services can support the effort; f. Developing goals for individuals utilizing Community Engagement Services that can lead to employment (*e.g.*, volunteer experiences, adult learning). g. Making a determination during their monitoring activities as to whether the person is receiving support as described in the person's plan and that the experience is consistent with the standards for the service. 2. The Commonwealth will achieve compliance with this provision of the Settlement Agreement when: a. At least 86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process. b. At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment. c. At least 86% of individuals who are receiving waiver services and have employment services authorized in their ISP will have a provider and begin services within 60 days.

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d. At least 86% of individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process.

e. At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP.

f. At least 86% of individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.

3. New Waiver targets established with the Employment First Advisory Group:

Data Targets:

Fiscal Year	Total	Actual Total	ISE	Actual ISE	GSE	Actual GSE
2016	808	890	211	225	597	665
2017	932	826	301	305	631	521
2018	1297	972	566	422	731	550
2019	1211		661		550	
2020	1486		936		550	
2021*	1685*		1135*		550*	

* FY2021 numbers are included for reference only and are not intended to

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			bind the Commonwealth. Compliance with the Settlement Agreement is attained when the Commonwealth is within 10% of the targets. • The Commonwealth has established an overall target of employment of 25% of the combined total of adults age 18-64 on the DD waivers and waitlist. 4. DBHDS service authorization data continues to demonstrate an increase of 3.5% annually of the DD Waiver population being served in the most integrated settings as defined in the Integrated Employment and Day Services Report (an increase of about 500 individuals each year as counted by unduplicated number recipients).
15	**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 Disability 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	The indicators for III.C.7.a serve to measure III.C.7.b.

#	Provision	Provision text	Indicator
		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 ISPs. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.	
16	**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.	1. The Commonwealth includes performance standards and timeliness requirements in the Medicaid non-emergency medical transportation (NEMT) contracts including those services for the DD waiver recipients. The Commonwealth will take action against Fee for Service NEMT transportation vendors and managed care organizations that fail to meet performance standards or contract requirements, which may include liquidated damages or fines. 2. At least 86% of DD Waiver recipients using Medicaid non-emergency medical transportation (NEMT) will have reliable transportation. 3. The Commonwealth will include in contracts with the Fee for Service (FFS) NEMT for DD Waiver services and managed care transportation vendor(s) (for acute and primary care services) requirements to: a. Separate out DD Waiver users in data collection, reporting, and in the quality improvement processes to ensure that transportation services are being implemented consistent with contractual requirements for the members of the target population; b. Ensure DD Waiver users and/or their representatives have opportunities to participate in the regional Advisory Boards; and

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			c. Through a statistically valid sample of transportation users, surveys are conducted to assess satisfaction and to identify problems on a quarterly basis. 4. DMAS transportation operations will conduct focus groups as needed as determined by DMAS with the DD Waiver population receiving FFS and managed care transportation in order to identify, discuss, and rectify systemic problems. 5. DMAS provides all Medicaid recipients with information on processes for filing complaints or appeals related to their Medicaid services. 6. As part of the person-centered reviews conducted through the Quality Service Review (QSR) process, the vendor will assess if transportation provided by waiver service providers (not to include NEMT) is being provided to facilitate individuals' participation in community activities and Medicaid services per their ISPs. The results of this assessment will be included in the QSR annual report presented to the Quality Improvement Committee (QIC). At least 86% of those reviewed report that they have reliable transportation to participation in community activities and Medicaid services.
17	**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.	The Commonwealth will achieve compliance with this provision of the Settlement Agreement when: 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. 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.

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18	**III.D.1**	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs. (**III.B.2**: The Commonwealth shall not exclude any otherwise qualifying individual from the target population due to the existence of complex behavioral or medical needs or of co-occurring conditions, including but not limited to, mental illness, traumatic brain injuries, or other neurological conditions.)	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. a. Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings b. Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "support needs level" of Levels 6 and 7, since FY 2016 are receiving services in the most integrated setting. 2. DBHDS continues to compile and distribute the Semi-annual Provider Data Summary to identify potential market opportunities for the development of integrated residential service options. The Data Summary indicates an increase in services available by locality over time. 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 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. 4. DBHDS tracks individuals seeking a service consistent with integrated living options as defined in the Integrated Residential Settings Report that is

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			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 (defined as independent living supports, in-home support services, supported living, and sponsored residential) have access to an option that meets their preferences within nine months. 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. 6. DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018 for FY 2018. The utilization rate is defined by whether the hours for the service are identified as a need in an individual's ISP and then whether the hours are delivered. Data will be tracked separately for EPSDT and waiver funded nursing. 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. 7. DBHDS continues to screen children through a VIDES assessment prior to admission to an ICF/IID. During the screening, DBHDS collects information from the family regarding the reason ICF/IID placement is being sought. 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

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			medical rehabilitation, respite or hospice services. 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. 10. DBHDS provides a Community Transition Guide to families of children in nursing facilities and ICFs/IID. For those seeking ICF/IID placement, the Guide is provided when a request for a VIDES assessment is made and every 6 months thereafter. The Guide is designed to provide practical information to children and their families who are preparing to make decisions related to the type of care that best suits their support needs or are preparing to transition from nursing facilities and ICFs/IID to homes in the community. The Guide assists families in preparing to move to a new home through an explanation of resources and services such as DD Waivers, CSBs, and the DBHDS Community Transition Team that can assist the family with the transition process. 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. 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. 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

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			follow-up phone calls. All families are provided with the Community Transition Guide as described in indicator #10 above. Families/Guardians/ARs interested and open to discussion of available community services are contacted not less than semi-annually. All families receive an annual contact unless there is a request for no contact. 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 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. 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. 15. DBHDS ensures that all CSBs are aware of children with DD seeking admission to a nursing facility from their catchment area and of children considering ICF/IID admission or discharge whose families are interested in community-based services through an awareness letter. When a child is identified as being in active discharge status from a nursing facility or ICF/IID, DBHDS sends an action letter to CSBs that enumerates the actions needed from the CSB and ensures funds are available for up to 120 days of Case Management Services for discharge planning. 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. b. DBHDS establishes and implements accountability measures for

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			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.
19	**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.)	The Commonwealth will achieve compliance with this provision of the Settlement Agreement when: 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. 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. 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.

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20	**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).	1. DBHDS tracks on a statewide level whether referrals to RSTs are submitted in accordance with the DBHDS RST Protocol and the timeliness of referrals to the RSTs, as specified in the DBHDS RST Protocol. 2. DBHDS is in compliance with the agreement when 86% of all statewide non-emergency referrals, as such referrals are defined in the DBHDS RST Protocol, meet the timeliness requirements of the DBHDS RST Protocol. 3. DBHDS conducts a quarterly quality assurance review of all new authorizations and any changed authorizations for residential service resulting in individuals residing in homes with 5 beds or more to determine if an RST referral has occurred. 4. DBHDS is in compliance with the agreement when 86% of all statewide situations meeting criteria for referral to the RSTs with respect to home and community-based residential services are referred to the RSTs by the case manager as required by the DBHDS RST Protocol. 5. DBHDS reviews all RST submissions for compliance with both the referral and timeliness standards specified in the DBHDS RST Protocol, by CSB. DBHDS will hold CSBs accountable for submitting 86% of their non-emergency referrals timely in accordance with the DBHDS RST Protocol. 6. DBHDS will require CSBs to submit corrective action plans through the Performance Contract when there is a failure to meet the 86% criteria for 2 consecutive quarters for submitting referrals or timeliness of referrals. 7. Failure of a CSB to improve and meet the 86% criteria over a 12 month period following a corrective action plan will lead to technical assistance, remediation, and/or sanctions under the Performance Contract. 8. DBHDS will conduct data analyses periodically, but not less than on an

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			annual basis, to ensure that the DBHDS revised RST protocol and referral forms are improving the timeliness of referrals to RSTs. 9. DBHDS will ensure the availability of DBHDS Community Resource Consultants to work with case managers to explore community integrated options, including working with providers to attempt to create innovative solutions for individuals with unique or specialized needs, to avoid placements in congregate settings with 5 or more individuals. 10. DBHDS will incorporate RST data into established Provider Development processes to evaluate gaps in services statewide on a semi-annual basis and encourage provider development in underserved areas through information, data, and, if available, provision of funding designated to support provider expansion. 11. DBDHS has a process to review and approve as available requests for emergency waiver slots and other funding supports to address emergency situations when alternate options have been exhausted. 12. DBHDS will add data related to the RST referral process to the Waiver Management Information System (WaMS). Data on RST referrals that were not successfully diverted from congregate settings of 5 or more individuals will be reviewed annually by DBHDS to ensure that integrated options are reviewed and offered annually. 13. DBHDS will identify individuals who chose a less integrated residential setting due to the absence of more integrated options in the desired locality. The names of these individuals will be included in quarterly letters provided to each CSB. On a semi-annual basis, information about new service providers will be provided to CSBs, so that the identified individuals can be made aware of new, more integrated options as they become available. A Community Resource Consultant will contact each of these CSBs at least annually to ensure that any new more integrated options have been offered. DBHDS will report annually the number of people who moved to more integrated settings.

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21	**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.	No indicators submitted. The Independent Reviewer found the Commonwealth in sustained compliance in December 2019.
22	**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.	For the one area of noncompliance – lack of integrated day opportunities – the indicators for III.C.7.a serve to measure IV.A.
23	**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,	For the one area of noncompliance – lack of integrated day opportunities – the indicators for III.C.7.a serve to measure IV.B.4.

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		employment, education, recreation, healthcare, and relationships).	
24	**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.	For the one area of noncompliance – lack of integrated day opportunities – the indicators for III.C.7.a serve to measure IV.B.6.
25	**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.	No indicators submitted. The Independent Reviewer found the Commonwealth in sustained compliance in June 2019.
26	**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	No indicators submitted. The Independent Reviewer found the Commonwealth in sustained compliance in June 2019.

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		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 nd placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge from the Training Center. This determination will be documented. The absence of those services and supports identified as non-essential by the Commonwealth, in consultation with the PST, shall not be a barrier to transition.	
27	**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. The CIM may consult at any time with the	No indicators submitted. The Independent Reviewer found the Commonwealth in sustained compliance in June 2019.

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		Regional Support Teams and will refer cases to the Regional Support Teams when: a. The CIM is unable, within 2 weeks of the PST's referral to the CIM, to document attainable steps that will be taken to resolve any barriers to community placement enumerated in Section IV.D.2 above. b. A PST continues to recommend placement in a Training Center at the second quarterly review following the PST's recommendation that an individual remain in a Training Center (Section IV.D.2.f), and at all subsequent quarterly reviews that maintain the same recommendation. This paragraph shall not take effect until two years after the effective date of this Agreement. c. The CIM believes external review is needed to identify additional steps that can be taken to remove barriers to discharge.	
28	**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	No indicators submitted. The Parties have agreed no indicators are needed for V.A.

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		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.	
29	**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.	The Commonwealth's Quality Management System includes the CMS-approved waiver quality improvement plan and the DBHDS Quality Management System. 1. 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. 2. The DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance b. Quality Improvement c. Risk Management

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			3. The Offices of Licensing and Human Rights perform quality assurance functions of the Department by determining the extent to which regulatory requirements are met and taking action to remedy specific problems or concerns that arise. a. The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process. This includes assessing whether: i. Serious incidents required to be reported under the Licensing Regulations are reported within 24 hours of discovery. 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. b. DBHDS monitors compliance with the serious incident reporting requirements of the Licensing Regulations as specified by DBHDS policies during all investigations of serious injuries and deaths and during annual inspections. DBHDS requires corrective action plans for 100% of providers who are cited for violating the serious incident reporting requirements of the Licensing Regulations. 4. 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 sub-committees, 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.

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			a. 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. b. 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. c. 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. e. 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. f. Through the Quality Management Annual Report, the QIC ensures

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			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. 5. 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. a. 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. b. 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. c. 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. d. 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;

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			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. e. 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. f. 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. 6. 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. 7. The Commonwealth shall meet the following: a. 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. b. At least 86% of people with identified behavioral support needs

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			are provided adequate and appropriately delivered behavioral support services. c. 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. d. At least 95% of individual service recipients are free from neglect and abuse by paid support staff. e. At least 95% of individual service recipients are adequately protected from serious injuries in service settings. f. 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. g. 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. 8. 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. b. At least 75% of people with a job in the community chose or had some input in choosing their job.

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			c. At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule. d. 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. e. 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. 9. 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. 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. c. Follow-up on individual incidents, as well as review of patterns and trends, will be documented.
30	**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.	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 assessments reviews shall address: the environment of care; clinical assessment or reassessment

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			processes; staff competence and adequacy of staffing; the use of high-risk procedures, including seclusion and restraint; and a review of serious incidents. Risk assessments also incorporate uniform risk triggers and thresholds as defined by DBHDS. See 12 VAC 35-105-520 found at http://register.dls.virginia.gov/details.aspx?id=6997. 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 emergent conditions and significant changes in conditions, or behavior presenting a risk to self or others. 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. 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

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			recommendations. 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. 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. 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. 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. 9. With respect to Training Centers, DBHDS has processes to review data and trends and ensure effective implementation of the Policy or Departmental Instruction.

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			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. 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.
31	**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. The Commonwealth shall be required to implement the process for investigation and remediation detailed in the Virginia DBHDS Licensing Regulations (12 VAC 35-105-160 and 12 VAC 35-105-170 in effect on the effective date of this Agreement) and the Virginia Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers	No indicators submitted. The Independent Reviewer found the Commonwealth in sustained compliance in December 2019.

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		Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services ("DBHDS Human Rights Regulations" (12 VAC 35-115-50(D)(3)) in effect on the effective date of this Agreement, and shall verify the implementation of corrective action plans required under these Rules and Regulations.	
32	**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.	1. DBHDS will make training and topical resources available to providers on each of the following topics with an application to disability services, or at minimum to human services: a. proactively identifying and addressing risks of harm b. conducting root cause analysis c. developing and monitoring corrective actions. 2. Training(s) or educational resources in each topical area identified in Indicator 1 will be made available to providers through the DBHDS website, or other on-line systems. 3. Providers that have been determined to be non-compliant with risk management requirements (as outlined in V.C.1, indicator #4) for reasons that are related to a lack of knowledge, will be required to demonstrate that they complete training offered by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan. 4. Providers that have been determined to be non-compliant with requirements about training and expertise for staff responsible for the risk management function (as outlined in V.C.1, indicator #1.a) and providers that have been determined to be non-compliant with requirements about conducting root cause analyses as required by 12 VAC 35-105-160(E) will be required to demonstrate that they complete training offered by the

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			Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan process. 5. DBHDS offers written guidance to providers (including residential, day/employment, and case management) on how to proactively identify and address risks of harm. This content will include: a. Guidance on conducting individual-level risk screening b. Either a tool for risk screening selected by DBHDS or example resources for consideration by providers to use when conducting risk screening c. Guidance on how to incorporate identified risks for individual service recipients into service planning and how to adequately address the risks. 6. DBHDS publishes detailed guidance, with input from relevant professionals, about risks common to people with developmental disabilities, which include considerations for how to appropriately and adequately monitor, assess, and address each risk. DBHDS will review its content annually and revise as necessary to ensure current guidance is sufficient and is included in each alert. a. DBHDS will use data and information from risk management activities, including mortality reviews to identify topics for future content; make determinations as to when existing content needs to be revised; and identify providers that are in need of additional technical assistance or other corrective action. Content will be posted on the DBHDS website and the DBHDS provider listserv. Guidance will be disseminated widely to providers of services in both licensed and unlicensed settings, and to family members and guardians. 7. DBHDS offers written guidance to providers on conducting root cause analysis, and assesses that providers adequately (in accordance with DBHDS's own guidance) identify cases for and conduct root cause analysis.

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			8. DBHDS offers written guidance to providers, including example scenarios, on developing, implementing, and monitoring corrective actions they identify as necessary, as well as identified solutions to mitigate the re-occurrence of serious incidents. This guidance will instruct providers to document their plans for corrective actions resulting from regulatory citations, root cause analyses, or other risk management or quality improvement activities; as well as their actions taken and any related decisions to deviate from planned actions.
33	**V.C.5**	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The Commissioner shall establish the monthly mortality review team, to include the DBHDS Medical Director, the Assistant Commissioner for Quality Improvement, and others as determined by the Department who possess appropriate experience, knowledge, and skills. The team shall have at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death; (ii) the most recent individualized program plan and physical examination records; (iii) the death certificate and autopsy report;	1. The Commonwealth has a charter describing standard operating procedures for conducting mortality reviews that addresses: a. The charge to the Mortality Review Committee ("MRC") b. The chair of the committee and an executive sponsor within DBHDS c. The membership of the mortality review committee (by role) d. The responsibilities of chair and members e. The frequency of activities of the committee (*e.g.*, meetings) f. Review of unexplained and unexpected deaths reported through the DBHDS incident reporting system, what a complete mortality review must entail, standards for closing a review, committee quorum, recusal from case reviews, and confidentiality protections for reviews. g. The definitions of "unexplained" and "unexpected" deaths h. The requirements for periodic review and analysis of mortality data to identify trends, patterns and problems at the individual service delivery and systemic-level factors related to deaths; the development and implementation of quality improvement initiatives to reduce mortality rates to the fullest extent practicable; and the reporting of quality improvement initiatives to the DBHDS Quality Improvement Committee. 2. The MRC membership includes at minimum (one member may satisfy up to 2 roles): a. DBHDS Chief Clinical Officer (former title Medical Director) b. DBHDS Senior Director of Clinical Quality Management (former equivalent position Assistant Commissioner for Quality Improvement)

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		and (iv) any evidence of maltreatment related to the death; (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems at the individual service-delivery and systemic levels and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.	c. A member with clinical experience to conduct mortality reviews who is otherwise independent of the State d. A medical doctor e. A nurse f. DBHDS staff with quality improvement expertise g. DBHDS staff with programmatic/operational expertise 3. MRC members will receive training that includes: a. orientation to the MRC charter to educate the member on the scope, mission, vision, charge, and function of the MRC b. review of the policies, processes, and procedures of the MRC; c. education on the role/responsibility of the member(s); and d. training on continuous quality improvement principles. 4. The MRC meets regularly (at least monthly) and at a frequency that enables the Committee to conduct required reviews of deaths. Meetings meet quorum requirements as set forth by the MRC charter, which at minimum require the presence of: a. a medical clinician (medical doctor, nurse practitioner, or physician assistant); b. a member with clinical experience to conduct mortality reviews; c. a professional with quality improvement expertise; and d. a professional with programmatic/operational expertise. e. One member may satisfy up to two roles. 5. DBHDS utilizes an information management system to track the referral and review of individual deaths, as well as the recommendations of the MRC at the provider level and the quality improvement initiatives that have been approved by the MRC chair for implementation. 6. DBHDS requires all DBHDS-licensed providers to report deaths through the incident reporting system within 24 hours of discovery. The DBHDS Licensing Investigations Team reviews all deaths of individuals with a developmental disability reported to DBHDS through its incident reporting system.

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			a. Each case is assigned to an investigator on the Licensing Investigations Team who conducts an initial review of available information within 24 hours after the death is reported to DBHDS or the next business day. b. Any deaths that appear to be related to abuse or neglect or that pose an imminent and substantial threat to the health, safety, or welfare of other individuals served by that provider have an investigation initiated by the DBHDS Licensing Investigations Team immediately, with actions taken, as appropriate, in accordance with licensing protocols. c. The Licensing Investigations Team provides available records and information it obtains and the completed investigation report to the MRC within 45 business days of the date the death was reported on at least 86% of deaths required to be reviewed by the MRC. 7. For quality assurance purposes in identifying deaths subject to MRC review: a. The incident reporting system is queried monthly to extract reports of all deaths of individuals, including unexplained or unexpected deaths of all individuals with an ID/DD diagnosis, receiving a licensed ID/DD service, and/or residing in a training center. Such reports will be included in the data tracking log for MRC review. b. The MRC clinical reviewers review the information received for those individuals on the data tracking log and determine if a death is unexplained or unexpected and requires review by the MRC. c. DBHDS provides the identifying information of individuals in the Waiver Management System (WaMS) who receive DBHDS-licensed services on a monthly basis to the Virginia Department of Health, which will identify the names for which a death certificate is on file. The results are provided to DBHDS and used by DBHDS to attempt to identify deaths that were not reported through the incident reporting system. The DBHDS Office of Licensing will investigate all unreported deaths identified by this process and take appropriate action in accordance with DBHDS licensing regulations and protocols.

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			8. 86% or greater of unexplained or unexpected ID/DD deaths as reported through the DBHDS incident reporting system have a complete review by the MRC within 90 days of the date of the death. 9. A complete mortality review includes: a. the review, or documentation of the unavailability of, medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death; the most recent individualized program plan and physical examination records; the death certificate and autopsy report; and any evidence of maltreatment related to the death; and b. interviewing, as warranted, any persons having information regarding the individual's care. 10. The MRC prepares and delivers to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any, for 86% of deaths requiring review within 90 days of the death. If the MRC elects not to make any recommendations, it must affirmatively state that no recommendations were warranted. 11. The MRC shall collect and analyze mortality data to identify trends, patterns, and problems at the individual service-delivery and systemic levels and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable. a. The MRC prepares an annual report of aggregate mortality trends and patterns for all individuals reviewed by the MRC, as described in Indicator 7 for V.C.5, within six months of the end of the year (the annual interval may be selected by DBHDS as either fiscal or calendar). The annual report will, at minimum, include: i. the total number of deaths and cause of death in DBHDS-licensed residential settings; ii. crude mortality rate of individuals on a DD HCBS waiver and receiving a DBHDS licensed service; iii. crude mortality rate of individuals by residential setting in

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			aggregate known to DBHDS; iv. crude mortality rate of individuals by age, gender, and race; and v. analyses of patterns of mortality by age, gender, and race; residential settings and DBHDS facilities; service program; and cause of death. b. A summary of the findings will be released publicly. 12. The MRC documents recommendations for systemic quality improvement initiatives coming from patterns of individual reviews (on an ongoing basis), or patterns that emerge from any aggregate examination of mortality data (either twice annually or annually as relevant to the review). 13. The MRC makes four recommendations for systemic quality improvement initiatives based on aggregate patterns or trends annually and reports these recommendations to the QIC and the DBHDS Commissioner. 14. DBHDS develops and implements quality improvement initiatives, either regionally or statewide, as recommended by the MRC and approved by the DBHDS Commissioner. On a quarterly basis, DBHDS staff assigned to implement quality improvement initiatives will report data related to the quality improvement initiatives to the MRC to enable it to track implementation. 15. DBHDS disseminates to stakeholders the Quality Management Annual Report, which contains information related to quality improvement initiatives, including any alerts or identified resources that promote quality improvement consistent with indicator V.B.4.f.
34	**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	1. DBHDS identifies providers, including CSBs, that have failed to report serious incidents, deaths, or allegations of abuse or neglect as required by the Licensing Regulations. Identification occurs through: a. Licensing inspections and investigations;

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		pursuant to the DBHDS Human Rights Regulations (12 VAC 35-115-240), the DBHDS Licensing Regulations (12 VAC 35-105-170), Virginia Code § 37.2-419 in effect on the effective date of this Agreement, and other requirements in this Agreement.	b. DBHDS receipt of information from external agencies, such as the protection and advocacy agency, or other agencies such as the Department of Health or local adult protective services agencies; c. Any other information that DBHDS may receive from individuals, other providers, family members, or others; d. Reports of deaths from the Virginia Department of Health as described in Indicator 7.c of V.C.5. 2. To validate that medical-related incidents are reported as required, at least annually, the Commonwealth conducts a review of Medicaid claims data and how it correlates to serious incidents reported to DBHDS. This review will be done of individuals enrolled in the DD waivers who receive one of the following waiver services: group home residential, sponsored residential, and supported living. Data related to Medicaid claims screened includes services associated with reporting requirements for: i. emergency room visits; and ii. hospitalizations. 3. One quarter of data related to Medicaid claims is reviewed per calendar year for each of the following DD waivers under the direction of DBHDS: i. Building Independence ii. Community Living iii. Family and Individual Supports 4. At least 86% of reportable serious incidents are reported within the timelines set out by DBHDS policy. 5. Providers, including CSBs, that fail to report serious incidents, deaths, or allegations of abuse or neglect as required by the Licensing Regulations receive citations and are required to develop and implement DBHDS-approved corrective action plans. 6. DBHDS reviews and approves corrective action plans that are in response to serious incidents, abuse, neglect, or death in accordance with the Licensing and Human Rights Regulations. DBHDS follows-up on approved corrective action plans to ensure that they have been implemented and are achieving their intended

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			outcomes as follows: a. For serious injuries and deaths that result from substantiated abuse, neglect, or health and safety violations, the Office of Licensing verifies that corrective action plans have been implemented within 45 days of their start date. b. In cases of substantiated abuse or neglect that do not involve serious injury or death, the Office of Human Rights verifies that corrective action plans have been implemented within 90 days of their start date. c. On an annual basis, at least 86% of corrective action plans related to substantiated abuse or neglect, serious incidents, or deaths are fully implemented as specified in this indicator or, if not implemented as specified, DBHDS takes appropriate action as determined by the Commissioner in accordance with the Licensing Regulations. 7. Providers, including CSBs, that have recurring deficiencies in the timely implementation of DBHDS-approved corrective action plans related to the reporting of serious incidents, deaths, or allegations of abuse or neglect will be subject to further action as appropriate under the Licensing Regulations and approved by the DBHDS Commissioner. 8. DBHDS has Policies or Departmental Instructions that specify requirements for Training Centers to report serious incidents, including, deaths, or allegations of abuse or neglect and to implement and monitor corrective actions. a. DBHDS has a process to monitor the implementation of corrective actions. b. When DBHDS identifies that harms have not been reported in accordance with policies or Departmental Instructions, an analysis is conducted to identify root causes; DBHDS implements corrective action as necessary to address identified causes.
35	**V.D.1**	The Commonwealth's HCBS waivers shall operate in accordance with the	1. The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers.

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		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; identification, response and prevention of occurrences of abuse, neglect and exploitation; administrative oversight of all waiver functions including contracting; and financial accountability. Review of data shall occur at the local and state levels by the CSBs and DBHDS/DMAS, respectively.	2. The CMS-approved Quality Improvement Plan in the DD HCBS waivers outlines: a. Inclusion of the evidence based discovery activities that will be conducted for each of the six major waiver assurances. b. The remediation activities followed to correct individual problems identified in the implementation of each of the assurances. c. Identification of the Department and Division responsible for overall management of the respective QM function(s). DMAS, as the Single State Medicaid Agency, retains overall authority for the operation of the DD HCBS waivers in their entirety. d. Processes to oversee and monitor all components related to the QM Strategy. e. Identification of performance measures that will be assessed. f. Processes to review performance trends, patterns, and outcomes to establish quality improvement priorities. g. Processes to recommend changes to policies, procedures and practices, waivers, and regulation as informed through ongoing review of data. h. Processes to ensure remediation activities are completed and to evaluate their effectiveness. i. Processes to report progress and recommendations to the QIC. 3. The Commonwealth has established performance measures, reviewed quarterly by DMAS and DBHDS, as required and approved by CMS in the areas of: a. health and safety and participant safeguards, b. assessment of level of care, c. development and monitoring of individual service plans, including choice of services and of providers, d. assurance of qualified providers, e. whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR, f. identification, response to incidents, and verification of required corrective action in response to substantiated cases of

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			abuse/neglect/exploitation (prevention is contained in corrective action plans). 4. The performance measures are found in the published DD HCBS waivers and found at cms.gov and are posted on the DBHDS website. 5. Quarterly data is collected on each of the above measures and reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans are written and remediation actions are implemented as necessary for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86% compliance. Quality Improvement remediation plans will focus on systemic factors where present and will include the specific strategy to be employed and defined measures that will be used to monitor performance. Remediation plans are monitored at least every 6 months. If such remediation actions do not have the intended effect, a revised strategy is implemented and monitored. 6. DMAS provides administrative oversight for the DD Waivers in compliance with its CMS-approved waiver plans, coordinates reporting to CMS, and conducts financial auditing consistent with the methods, scope and frequency of audits approved by CMS. 7. The DMAS-DBHDS Quality Review Team will provide an annual report on the status of the performance measures included in the DD HCBS Waivers Quality Improvement Strategy with recommendations to the DBHDS Quality Improvement Committee. The report will be available on the DBHDS website for CSBs' Quality Improvement committees to review. Documentation of these reviews and resultant CSB-specific quality improvement activities will be reported to DBHDS. The above measures are reviewed at local level including by Community Service Boards (CSB) at least annually. 8. The Commonwealth ensures that at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations.

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36	**V.D.2**	The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement. The Commonwealth shall use data to: a. identify trends, patterns, strengths, and problems at the individual, service-delivery, and systemic levels, including, but not limited to, quality of services, service gaps, accessibility of services, serving individuals with complex needs, and the discharge and transition planning process; b. develop preventative, corrective, and improvement measures to address identified problems; c. track the efficacy of preventative, corrective, and improvement measures; and d. enhance outreach, education, and training.	1. DBHDS develops a Data Quality Monitoring Plan to ensure that it is collecting and analyzing consistent reliable data. Under the Data Quality Monitoring Plan, DBHDS assesses data quality, including the validity and reliability of data and makes recommendations to the Commissioner on how data quality issues may be remediated. Data sources will not be used for compliance reporting until they have been found to be valid and reliable. This evaluation occurs at least annually and includes a review of, at minimum, data validation processes, data origination, and data uniqueness. 2. DBHDS analyzes the data collected under V.D.3.a-h to identify trends, patterns, and strengths at the individual, service delivery, and system level in accordance with its Quality Improvement Plan. The data is used to identify opportunities for improvement, track the efficacy of interventions, and enhance outreach and information. 3. At least annually, DBHDS reviews data from the Quality Service Reviews and National Core Indicators related to the quality of services and individual level outcomes to identify potential service gaps or issues with the accessibility of services. Strategic improvement recommendations are identified by the Quality Improvement Committee (QIC) and implemented as approved by the DBHDS Commissioner. 4. DBHDS quality committees and workgroups, including Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, and Key Performance Area (KPA) workgroups, establish goals and monitor progress towards achievement through the creation of specific KPA Performance Measure Indicators (PMI). These PMIs are organized according to the domains, as outlined in the Settlement Agreement in V.D.3.a-h. PMIs are also categorized as either outcomes or outputs: a. Outcome PMIs focus on what individuals achieve as a result of services and supports they receive (*e.g.*, they are free from restraint, they are free from abuse, and they have jobs). b. Output PMIs focus on what a system provides or the products (*e.g.,*

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			ISPs that meet certain requirements, annual medical exams, timely and complete investigations of allegations of abuse). 5. Each KPA PMI contains the following: a. Baseline or benchmark data as available. b. The target that represents where the results should fall at or above. c. The date by which the target will be met. d. Definition of terms included in the PMI and a description of the population. e. Data sources (the origins for both the numerator and the denominator) f. Calculation (clear formulas for calculating the PMI, utilizing a numerator and denominator). g. Methodology for collecting reliable data (a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation). h. The subject matter expert (SME) assigned to report and enter data for each PMI. i. A Yes/No indicator to show whether the PMI can provide regional breakdowns. 6. DBHDS in accordance with the Quality Management Plan utilizes a system for tracking PMIs and the efficacy of preventative, corrective, and improvement measures, and develops and implements preventative, corrective, and improvement measures where PMIs indicate health and safety concerns. DBHDS uses this information with its QIC or other similar interdisciplinary committee to identify areas of needed improvement at a systemic level and makes and implements recommendations to address them. 7. DBHDS demonstrates annually at least 3 ways in which it has utilized data collection and analysis to enhance outreach, education, or training. 8. DBHDS collects and analyzes data (at minimum a statistically valid sample) at least annually regarding the management of needs of

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			individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS develops corrective action(s) based on its analysis, tracks the efficacy of that action, and revises as necessary to ensure that the action addresses the deficiency.
37	**V.D.3**	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area:	DBHDS has established three Key Performance Areas (KPAs) that address the eight domains listed in V.D.3.a-h. DBHDS quality committees and workgroups, including Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee and KPA workgroups, establish performance measure indicators (PMIs) that are in alignment with the eight domains that are reviewed by the DBHDS Quality Improvement Committee (QIC). The components of each PMI are set out in indicator #5 of V.D.2. The DBHDS quality committees and workgroups monitor progress towards achievement of PMI targets to assess whether the needs of individuals enrolled in a waiver are met, whether individuals have choice in all aspects of their selection of their services and supports, and whether there are effective processes in place to monitor individuals' health and safety. DBHDS uses these PMIs to recommend and prioritize quality improvement initiatives to address identified issues. The assigned committees or workgroups report to the QIC on identified PMIs, outcomes, and quality initiatives. PMIs are reviewed at least annually consistent with the processes outlined in the compliance indicators for V.D.2. Based on the review and analysis of the data, PMIs may be added, deleted, and/or revised in keeping with continuous quality improvement practices. 1. The KPA workgroups and assigned domains (V.D.3.a-h) are: A. Health, Safety and Well Being KPA workgroup encompasses the domains of: *a) Safety and Freedom from Harm* *b) Physical, Mental, and Behavioral Health and Well being* c) *Avoiding Crises* B. Community Integration and Inclusion KPA workgroup encompasses the

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			domains of: *a) Community Inclusion* *b) Choice and Self-Determination* *c) Stability* C. Provider Competency and Capacity KPA workgroup encompasses the domains of: *a) Provider Capacity* *b) Access to Services* 2. The DBHDS Quality Management Plan details the quality committees, workgroups, procedures and processes for ensuring that the committees and/or workgroups establish PMIs and quality improvement initiatives in the KPAs on a continuous and sustainable basis. 3. Each KPA workgroup will: a) Establish at least one PMI for each assigned domain b) Consider a variety of data sources for collecting data and identify the data sources to be used c) Include baseline data, if available and applicable, when establishing performance measures d) Define measures and the methodology for collecting data e) Establish a target and timeline for achievement f) Measure performance across each domain g) Analyze data and monitor for trends h) Recommend quality improvement initiatives i) Report to DBHDS QIC for oversight and system-level monitoring 4. DBHDS collects and analyzes data from each domain listed in V.D.3.a-h. Within each domain, DBHDS collects data regarding multiple areas. Surveillance data is collected from a variety of data sources as described in the Commonwealth's indicators for V.D.3.a-h. This data may be used for ongoing, systemic collection, analysis, interpretation, and dissemination and also serves as a source for establishing PMIs and/or quality improvement initiatives.

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			5. The Office of Data Quality and Visualization will assess data quality and inform the committee and workgroups regarding the validity and reliability of the data sources used in accordance with V.D.2 indicators 1 and 5. 6. The Quality Management Annual Report will describe the accomplishments and barriers for each KPA.
	V.D.3.a	Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);	1. The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for "safety and freedom from harm," at minimum including: a. Neglect and abuse b. Injuries c. Use of seclusion or restraints d. Effectiveness of corrective action e. Licensing violations f. Deaths 2. The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: • Abuse, neglect and exploitation • Serious incidents and injuries (SIR) • Seclusion or restraint • Incident Management • National Core Indicators – (*i.e.* Health, Welfare and Rights) • DMAS Quality Management Reviews (QMRs)
	V.D.3.b	Physical, mental, and behavioral health and well being (e.g., access to medical care (including preventative care), timeliness and adequacy of	1. The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for "Physical, mental, and behavioral health and well being."

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		interventions (particularly in response to changes in status));	2. The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: • SIR • Enhanced Case Management (ECM) • National Core Indicators - (*i.e.* Health, Welfare and Rights) • Individual and Provider Quality Service Reviews (QSRs) • QMRs
	V.D.3.c	Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);	1. The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for "avoiding crises," at minimum including: a. Number of people using crisis services b. Age and gender of people using crisis services c. Known admissions to emergency rooms or hospitals d. Admissions to Training Centers or other congregate settings e. Contact with criminal justice system during crisis 2. The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: • Crisis Data • QMRs • QSRs • Waiver Management System (WaMS) • CHRIS
	V.D.3.d	Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program	1. The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "stability," at minimum including data related to living arrangement, providers, and

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		stability);	participation in chosen work or day programs. 2. The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: • Employment • Housing • NCI – (*i.e.,* Individual Outcomes) • QSRs • WaMS
	V.D.3.e	Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);	1. The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "Choice and self-determination." 2. The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: • Employment • Community Engagement/Inclusion • QSRs • NCI – (*i.e.,* Individual Outcomes) • WaMS
	V.D.3.f	Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);	1. The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "community inclusion," at minimum including data related to participation in groups and community activities, such as shopping, entertainment, going out to eat, or religious activity.

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			2. The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: • Employment • Community Engagement/Inclusion • QSRs • Housing • Regional Support Teams • Home and Community-Based Settings • NCI – (*i.e.,* Individual Outcomes) • WaMS
	V.D.3.g	Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and	1. The Provider Competency and Capacity KPA workgroup will finalize surveillance data to be collected for "access to services," at minimum including: a. For individuals on the waitlist, length of time on the waitlist and priority level, as well as whether crisis services, Individual and Family Support Program funding, or a housing voucher have been received b. Ability to access transportation c. Provision of adaptive equipment for individuals with an identified need d. Service availability across geographic areas e. Cultural and linguistic competency 2. The Provider Competency and Capacity KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: • NCI – (*i.e.,* System Performance) • WaMS • Individual and Family Support Program (IFSP)

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			• Provider Data Summary • QSRs
	V.D.3.h	Provider capacity (e.g., caseloads, training, staff turnover, provider competency).	1. The Provider Competency and Capacity KPA workgroup will finalize surveillance data to be collected for "Provider capacity," at minimum including: a. Staff receipt of competency-based training b. Demonstration of competency in core competencies c. Demonstration of competency in elements of service for the individuals they serve 2. The Provider Competency and Capacity KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: • Staff competencies • Staff training • QSRs • Provider Data Summary • QMRs • Licensing Citations
38	**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 Management Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals	The Commonwealth collects and analyzes data from the following sources: a. Computerized Human Rights Information System (CHRIS): Serious Incidents – *Data related to serious incidents and deaths.* b. CHRIS: Human Rights – *Data related to abuse and neglect allegations.* c. Office of Licensing Information System (OLIS) – *Data related to DBHDS-licensed providers, including data collected pursuant to V.G.3, corrective actions, and provider quality improvement plans.* d. Mortality Review e. Waiver Management System (WaMS) – *Data related to*

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		receiving waiver services, Regional Support Teams, and CIMs.	*individuals on the waivers, waitlist, and service authorizations.* f. Case Management Quality Record Review – *Data related to service plans for individuals receiving waiver services, including data collected pursuant to V.F.4 on the number, type, and frequency of case manager contacts.* g. Regional Education Assessment Crisis Services Habilitation (REACH) – *Data related to the crisis system.* h. Quality Service Reviews (QSRs) i. Regional Support Teams j. Post Move Monitoring Look Behind Data k. Provider-reported data about their risk management systems and QI programs, including data collected pursuant to V.E.2 l. National Core Indicators m. Training Center reports of allegations of abuse, neglect, and serious incidents
39	**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.	The metrics listed for all portions of V.D.5 are predicated on the continued compliance of V.D.5.a for each RQC: "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." 1. DBHDS has a charter for Regional Quality Councils ("RQCs") that describes the standard operating procedures as described in indicator V.B.4.d. DBHDS orients at least 86% of RQC members based on the charter and on quality improvement, data analysis, and related practices. 2. Each DBHDS Region has convened a RQC that serves as a subcommittee to the QIC as described in indicator V.B.4. 3. DBHDS prepares and presents relevant and reliable data to the RQCs which include comparisons with other internal or external data, as appropriate, as well as multiple years of data (as it becomes available). 4. Each RQC reviews and assesses (i.e., critically considers) the data that is

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			presented to identify: a) possible trends; b) questions about the data; and c) any areas in need of quality improvement initiatives, and identifies and records themes in meeting minutes. RQCs may request data that may inform quality improvement initiatives and DBHDS will provide the data if available. If requested data is unavailable, RQCs may make recommendations for data collection to the QIC.
40	**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.	1. Each RQC meets quarterly with a quorum at least 3 of the 4 quarters with membership as outlined in the RQC charter. A quorum is defined as at least 60% of members or their alternates as defined in the RQC charter and must include representation from the following groups: the DBHDS QIC; an individual experienced in data analysis; a Developmental Disabilities (DD) service provider; and an individual receiving services or on the DD Waiver waitlist or a family member of an individual receiving services or on the DD Waiver waitlist. 2. During meetings, conducted in accordance with its charter, the RQC reviews and evaluates data, trends, and monitoring efforts. Based on the topics and data reviewed, the RQC recommends at least one quality improvement initiative to the QIC annually. 3. Each RQC maintains meeting minutes for 100% of meetings. Meeting minutes are reviewed and approved by the membership of the RQC to ensure accurate reflection of discussion and evaluation of data and recommendations of the RQC. 4. For each topic area identified by the RQC, the RQC a) decides whether more information/data is needed for the topic area, b) prioritizes a quality improvement initiative for the Region and/or recommends a quality improvement initiative to DBHDS, or c) determines that no action will be taken in that area. 5. For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC.

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			6. 100% of recommendations agreed upon by the RQCs are presented to the DBHDS QIC. 7. The DBHDS QIC reviews the recommendations reported by the RQCs and directs the implementation of any quality improvement initiatives upon approval by the QIC and the Commissioner. Relevant Department staff may be assigned to statewide quality improvement initiatives to facilitate implementation. The QIC directs the RQC to monitor the regional status of any statewide quality improvement initiatives implemented and report annually to the DBHDS QIC on the current status. The DBHDS QIC reports back to each RQC at least once per year on any decisions and related implementation of RQC recommendations. If the QIC declines to support a quality improvement initiative recommended by a RQC, the QIC shall document why.
41	**V.D.6**	At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	The Commonwealth posts reports, updated at least annually, on the Library Website or the DBHDS website on the availability and quality of services in the community and gaps in services and makes recommendations for improvement. Reports shall include annual performance and trend data as well as strategies to address identified gaps in services and recommendations for improvement strategies as needed and the implementation of any such strategies. 1. Demographics – Individuals with DD served a. Number of individuals by waiver type b. Number of individuals by service type c. Number of individuals by region d. Number of individuals in each training center e. Number of children and adults with DD who were admitted to, or residing in, state operated psychiatric facilities f. Number of children residing in NFs and ICFs/IIDs g. Number of adults residing in ICFs/IIDs and NFs whose services are paid for by the Commonwealth h. Number of individuals with DD (waiver and non-waiver) receiving Supported Employment

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			i. Number of individuals with DD receiving crisis services by type, by region and disposition j. Number of individuals on the DD waiver waiting list by priority level, geographic region, age, and amount of time that individuals have been on the waiting list. k. Number of individuals in independent housing 2. Demographics – DD Service capacity a. Number of licensed DD providers i. Residential setting by size and type as defined by the Integrated Residential Services Report ii. Day services by type as defined by the Integrated Day Services Report b. Number of provider agencies that have provided services to DD waiver recipients during the previous fiscal year (provided separately by service): Personal Care, Companion, Respite, Supported Employment, Therapeutic Consultation Services (specifically for Behavioral Support), Crisis, Benefits Planning, Community Guide, and Peer Mentoring c. Number of ICF/IID non-state operated beds d. Number of independent housing options created 3. The DBHDS Annual Quality Management Report and Evaluation includes the following information: a. An analysis of Data Reports, including performance measure indicators employed, an assessment of positive and negative outcomes, and performance that differs materially from expectations b. Key Performance Areas performance measures with set targets: 1. Health, Safety, and Well Being 2. Community Inclusion–Integrated Settings 3. Provider Capacity and Competency c. Case Management Steering Committee Report d. Risk Management Review Committee Report e. Annual Mortality Review Report f. Quality Management Program Evaluation

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			g. Planned quality improvement initiatives and any metrics established for those initiatives h. Quality improvement initiatives and any metrics established for those initiatives i. Key Accomplishments of the Quality Management Program j. System challenges identified through the work of the QIC, its workgroups, or the RQCs, including positive and negative outcomes and/or indications that performance is below expectations. k. Committee Performance l. A summary of areas reviewed by the Regional Quality Councils, along with recommendations and any strategies employed for quality improvement m. A summary of areas reviewed by the DBHDS Quality Improvement Committee (QIC), along with gaps identified, recommendations, and any strategies employed for quality improvement n. Recommendations and strategies for related improvement 4. Additional information, including areas reviewed, and where available, gaps identified, recommendations, and strategies employed for quality improvement, and reports available: a. Results of licensing findings resulting from inspections and investigations b. Data Quality Plan c. Annual Quality Service Review d. Annual REACH Report on crisis system e. Semi-Annual Supported Employment Report f. RST Annual Report, including barriers to integrated services g. Semi-annual Provider Data Summary Report: provides information on geographic and population based disparities in service availability as well as barriers to services by region h. IFSP outcomes report and updates to IFSP Plan i. Integrated Residential Services Report j. Integrated Day Services Report k. DBHDS Annual Report l. National Core Indicators Annual Report and Bi-Annual National

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			Report
42	**V.E.1**	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program, including root cause analyses, that is sufficient to identify and address significant issues and is consistent with the requirements of the DBHDS Licensing Regulations at 12 VAC 35-105-620 in effect on the effective date of this Agreement and the provisions of this Agreement.	1. DBHDS, through its regulations, requires DBHDS-licensed providers, including CSBs, to have a quality improvement (QI) program that: a. Is sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis; b. Uses standard QI tools, including root cause analysis; c. Includes a QI plan that: i. is reviewed and updated annually, ii. defines measurable goals and objectives; iii. includes and reports on statewide performance measures, if applicable, as required by DBHDS; iv. monitors implementation and effectiveness of approved corrective action plans; and v. includes ongoing monitoring and evaluation of progress toward meeting established goals and objectives. 2. DBHDS has published written guidance for providers on developing and implementing the requirements of 12 VAC 35-105-620 consistent with the regulation as in effect on October 1, 2019, including reviewing serious incidents as part of the quality improvement program, and will update and revise this guidance as necessary as determined by DBHDS. 3. On an annual basis at least 86% of DBHDS licensed providers of DD services have been assessed for their compliance with 12 VAC 35-105-620 during their annual inspections. 4. On an annual basis, at least 86% of DBHDS-licensed providers of DD services are compliant with 12 VAC 35-105-620. Providers that are not compliant have implemented a Corrective Action Plan to address the violation. 5. DBHDS has policies or Departmental Instructions that require Training Centers to have quality improvement programs that: a. Are reviewed and updated annually;

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			b. Has processes to monitor and evaluate quality and effectiveness on a systematic and ongoing basis; c. Use standard quality improvement tools, including root cause analysis; d. Establish facility-wide quality improvement initiatives; and e. Monitor implementation and effectiveness of quality improvement initiatives.
43	**V.E.2**	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3. above. The measures will be monitored and reviewed by the DBHDS quality improvement committee, with input from Regional Quality Councils, described in Section V.D.5 above. The DBHDS quality improvement committee will assess the validity of each measure at least annually and update measures accordingly.	1. DBHDS has developed measures that DBHDS-licensed DD providers, including CSBs, are required to report to DBHDS on a regular basis, and DBHDS has informed such providers of these requirements. The sources of data for reporting shall be such providers' risk management/critical incident reporting and their QI program. Provider reporting measures must: a. Assess both positive and negative aspects of health and safety and of community integration; b. Be selected from the relevant domains listed in Section V.D.3 above; and c. Include measures representing risks that are prevalent in individuals with developmental disabilities (*e.g.*, aspiration, bowel obstruction, sepsis) that are reviewed at least quarterly by the designated sub-committee as defined by the Quality Management Plan. 2. DBHDS requires regular reporting, at least annually, of each provider reporting measure from DBHDS-licensed DD providers. Measures referenced in indicators #1.c are reported quarterly. 86% of such providers report the measure as required. 3. The DBHDS Office of Data Quality and Visualization assists with analysis of each provider reporting measure to ensure that the data sources are valid, identify what the potential threats to validity are, and ensure that the provider reporting measures are well-defined and measure what they purport to measure. The QIC or designated subgroup will review and assess each provider reporting measure annually and update accordingly.

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			4. Provider reporting measures are monitored and reviewed by the DBHDS Quality Improvement Committee ("QIC") at least semi-annually, with input from Regional Quality Councils, described in Section V.D.5. Based on the semi-annual review, the QIC identifies systemic deficiencies or potential gaps, issues recommendations, monitors the measures, and makes revisions to quality improvement initiatives as needed, in accordance with DBHDS's Quality Management System as described in the indicators for V.B.
44	**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.	1. In addition to monitoring provider compliance with the DBHDS Licensing Regulations governing quality improvement programs (see indicators for V.E.1), the Commonwealth assesses and makes a determination of the adequacy of providers' quality improvement programs through the findings from Quality Service Reviews, which will assess the adequacy of providers' quality improvement programs to include: a. Development and monitoring of goals and objectives, including review of performance data. b. Effectiveness in either meeting goals and objectives or development of improvement plans when goals are not met. c. Use of root cause analysis and other QI tools and implementation of improvement plans. 2. Using information collected from licensing reviews and Quality Service Reviews, the Commonwealth identifies providers that have been unable to demonstrate adequate quality improvement programs and offers technical assistance as necessary. Technical assistance may include informing the provider of the specific areas in which their quality improvement program is not adequate and offering resources (e.g., links to on-line training material) and other assistance to assist the provider in improving its performance.
45	**V.F.2**	At these face-to-face meetings, the case manager shall: observe the individual	The actions to achieve compliance listed in Section **III.C.5.b.i** will also achieve compliance with this provision of the Settlement Agreement.

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		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. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.	
46	**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	The Commonwealth tracks the number, type and frequency of case management contacts. DBHDS will establish a process to review a sample of data each quarter to determine reliability and provide technical assistance to CSBs as needed. The data regarding the number, type, and frequency of case management

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		manager contacts with the individual.	contacts will be included in the Case Management Steering Committee data review. Recommendations to address non-compliance issues with respect to case manager contacts will be provided to the Quality Improvement Committee for consideration of appropriate systemic improvements and to the Commissioner for review of contract performance issues.
47	**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.	The Case Management Steering Committee will establish two indicators in each of the areas of health and safety and community integration associated with selected domains in V.D.3 and based on its review of the data submitted from case management monitoring processes. Data indicates 86% compliance with the four indicators.
48	**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.	1. The DBHDS Office of Licensing (OL) develops a checklist to assess the adequacy of individualized supports and services (including supports and services for individuals with intensive medical and behavioral needs) in each of the domains listed in Section V.D.3 for which it has corresponding regulations. Data from this checklist will be augmented at least annually by data from other sources that assess the adequacy of individual supports and services in those domains not covered by the OL checklist. 2. The DBHDS Office of Licensing uses the checklist during all annual unannounced inspections of DBHDS-licensed DD service providers, and relevant items on the checklist are reviewed during investigations as appropriate. Reviews are conducted for providers at least annually pursuant to 12VAC35-105-70.

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			3. DBHDS informs providers of how it assesses the adequacy of individualized supports and services by posting information on the review tool and how it is assessed on the DBHDS website or in guidance to providers. DBHDS has informed CSBs and providers of its expectations regarding individualized supports and services, as well as the sources of data that it utilizes to capture this information. 4. The DBHDS Office of Licensing produces a summary report from the data obtained from the checklist. On a semi-annual basis, this data is shared with the Case Management Steering Committee and relevant Key Performance Area workgroups. These groups evaluate the licensure data along with other data sources, including those referred to in indicator #1, to determine whether quality improvement initiatives are needed. A trend report also will be produced annually for review by the QIC to ensure that any deficiencies are addressed. If improvement initiatives are needed, they will be recommended, approved, and implemented in accordance with indicators 4-6 of V.D.2.
49	**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.	1. DBHDS makes available an Orientation Training and Competencies Protocol that communicates DD Waiver requirements for competency training, testing, and observation of Direct Support Professionals (DSPs) and DSP supervisors. 2. The Commonwealth requires DSPs and DSP Supervisors, including contracted staff, providing direct services to meet the training and core competency requirements contained in DMAS regulation 12VAC30-122-180, including demonstration of competencies specific to health and safety within 180 days of hire. The core competencies include: a. the characteristics of developmental disabilities and Virginia's DD Waivers; b. person-centeredness (and related practices such as dignity of risk and self-determination in alignment with CMS definitions); c. positive behavioral supports; d. effective communication; e. at a minimum, the following identified potential health risks of individuals with developmental disabilities and appropriate

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			interventions: choking, skin care (pressure sores, skin breakdown), aspiration pneumonia, falls, urinary tract infections, dehydration, constipation and bowel obstruction, change of mental status, sepsis, seizures, and early warning signs of such risks, and how to avoid such risks; f. community integration and social inclusion (*e.g.*, community integration, building and maintaining positive relationships, being active and productive in society, empowerment, advocacy, rights and choice, safety in the home and community); and g. DSP Supervisor-specific competencies that relate to the supervisor's role in modeling and coaching DSPs in providing person-centered supports, ensuring health and wellness, accurate documentation, respectful communication, and identifying and responding to changes in an individual's status. 3. DSPs and DSP Supervisors who have not yet completed training and competency requirements per DMAS regulation 12VAC30-122-180, including passing a knowledge-based test with at least 80% success, are accompanied and overseen by other qualified staff who have passed the core competency requirements for the provision of any direct services. Any health-and-safety-related direct support skills will only be performed under direct supervision, including observation and guidance, of qualified staff until competence is observed and documented. 4. At least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180. 5. DBHDS makes available for nurses and behavioral interventionists training, online resources, educational newsletters, electronic updates, regional meetings, and technical support that increases their understanding of best practices for people with developmental disabilities, common DD-specific health and behavioral issues and methods to adapt support to address those issues, and the requirements of developmental disability services in Virginia, including development and implementation of individualized service plans.

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			6. Employers and contractors responsible for providing transportation will meet the training requirements established in the DMAS transportation fee for service and managed care contracts. Failure to provide transportation in accordance with the contracts may result in liquidated damages, corrective action plans, or termination of the vendor contracts. 7. The DBHDS Office of Integrated Health provides consultation and education specific to serving the DD population to community nurses, including resources for ongoing learning and development opportunities. 8. Per DBHDS Licensing Regulations, DBHDS licensed providers, their new employees, contractors, volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within 15 business days. The provider shall document that the orientation covers each of the following policies, procedures, and practices: a. Objectives and philosophy of the provider; b. Practices of confidentiality including access, duplication, and dissemination of any portion of an individual's record; c. Practices that assure an individual's rights including orientation to human rights regulations; d. Applicable personnel policies; e. Emergency preparedness procedures; f. Person-centeredness; g. Infection control practices and measures; h. Other policies and procedures that apply to specific positions and specific duties and responsibilities; and i. Serious incident reporting, including when, how, and under what circumstances a serious incident report must be submitted and the consequences of failing to report a serious incident to the department in accordance with the Licensing Regulations. 9. The Commonwealth requires through the DBHDS Licensing Regulations specific to DBHDS-licensed providers that all employees or contractors who are responsible for implementing an individual's ISP demonstrate a working knowledge of the objectives and strategies contained in each individual's

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			current ISP, including an individual's detailed health and safety protocols. 10. The Commonwealth requires all employees or contractors without clinical licenses who will be responsible for medication administration to demonstrate competency of this set of skills under direct observation prior to performing this task without direct supervision. 11. The Commonwealth requires all employees or contractors of DBHDS-licensed providers who will be responsible for performing de-escalation and/or behavioral interventions to demonstrate competency of this set of skills under direct observation prior to performing these tasks with any individual service recipient. 12. At least 86% of DBHDS licensed providers receiving an annual inspection have a training policy meeting established DBHDS requirements for staff training, including development opportunities for employees to enable them to support the individuals receiving services and to carry out their job responsibilities. These required training policies will address the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department. DBHDS will take appropriate in action in accordance with Licensing Regulations if providers fail to comply with training requirements required by regulation. 13. Consistent with CMS assurances, DBHDS, in conjunction with DMAS QMR staff, reviews citations (including those related to staff qualifications and competencies) and makes results available to providers through quarterly provider roundtables.
50	**V.H.2**	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors	1. DSP Supervisors are responsible for adequate coaching and supervision of their staff trainees. As part of its training program, DBHDS will develop and make available a supervisory training for all DSP supervisors who are required to complete DSP training and testing per DMAS Waiver

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		must have demonstrated competency in providing the service they are coaching and supervising.	Regulations in DBHDS-licensed and non-DBHDS-licensed agencies as described in DMAS Waiver Regulations. At a minimum, this training shall include the following topics: a. skills needed to be a successful supervisor; b. organizing work activities; c. the supervisor's role in delegation; d. common motivators and preventive management; e. qualities of effective coaches; f. employee management and engagement; g. stress management; h. conflict management ; i. the supervisor's role in minimizing risk (*e.g.*, health-related, interpersonal, and environmental); j. mandated reporting; and k. CMS-defined requirements for the planning process and the resulting plan. 2. In addition to training and education, support and coaching is made available to DBHDS-licensed providers through the DBHDS Offices of Integrated Health and Provider Development upon request and through community nursing meetings, provider roundtables, and quarterly support coordinator meetings to increase the knowledge and skills of staff and supervisors providing waiver services. DBHDS will compile available support and coaching resources that have been reviewed and approved for placement online and ensure that DBHDS-licensed providers are aware of these resources and how to access them.
51	**V.I.1**	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and	1. The Commonwealth conducts Quality Service Reviews ("QSRs") annually on a sample of providers, with the goal that each provider is sampled at least once every two to three years, comprised of Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs"), to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and preferences.

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		choice. QSRs shall collect information through: a. Face-to-face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and b. Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers.	QSRs utilize information collected from, at a minimum, the following sources for PCRs and PQRs: a. Face-to-face interviews of individual waiver service recipients, family members, or guardians (if involved in the individual's life); case managers; and service providers. b. Record reviews: case management record, the ISP, and the provider's record for selected individuals; the provider's administrative policies and procedures, incident reports, the provider's risk management and quality improvement plans; documents demonstrating compliance with the provider's contractual requirements, as applicable; and the KPA Performance Measure Indicator (PMI) data collected by DBHDS referred to in V.D.2. c. Direct observation of the individual waiver service recipient at each of the provider's service sites (e.g., Residential and/or Day Programs) as applicable for the individuals selected for review. 2. The DBHDS QSR Contractor will: a. Prior to conducting QSRs, develop a communications plan and orient providers to the QSR process and expectations. b. Ensure interviews of individual waiver service recipients are conducted in private areas where provider staff cannot hear the interview or influence the interview responses, unless the individual needs or requests staff assistance and, where not conducted in private, it will be documented. Interviews with provider staff are conducted in ways that do not permit influence from other staff or supervisors. 3. The Quality Service Reviews assess on a provider level whether: a. Services are provided in safe and integrated environments in the community. b. Person-centered thinking and planning is applied to all service recipients. c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary. d. Qualified and trained staff provide services to individual service

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			recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols. e. Individuals receiving services are provided opportunities for community inclusion. f. Providers have active quality management and improvement programs, as well as risk management programs. 4. The Quality Service Reviews assess on a system-wide level whether: a. Services are provided in safe and integrated environments in the community. b. Person-centered thinking and planning is applied to all service recipients. c. Providers keep service recipients safe from harm and access treatment for service recipients as necessary. d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols. e. Service recipients are provided opportunities for community inclusion. f. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice.
52	**V.I.2**	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the	1. The QSRs assess on an individual service-recipient level and individual provider level whether: a. Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk. b. Person-centered thinking and planning is applied and people are supported in self-direction consistent with their person-centered plans, and in accordance with CMS Home and Community Based

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		individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels.	Service planning requirements. Person centered thinking and planning: i. Is timely and occurs at times and locations of convenience to the individual. ii. Includes people chosen by the individual. iii. Reflects cultural considerations of the individual. iv. Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency. v. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. vi. Has strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. vii. Offers informed choices to the individual regarding the services and supports they receive and from whom. viii. Records alternative home and community-based settings that were offered to the individual. ix. Includes a method for the individual to request updates to the plan as needed. c. Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible. d. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice. e. Individuals have opportunities for community engagement and inclusion in all aspects of their lives. f. Any restrictions of individuals' rights are developed in accordance with the DBHDS Human Rights Regulations and implemented consistent with approved plans. 2. Information from the QSRs is used to improve practice and quality of services through the collection of valid and reliable data that informs the

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			provider and person-centered quality outcome and performance results. DBHDS reviews data from the QSRs, identifies trends, and addresses deficiencies at the provider, CSB, and system wide levels through quality improvement processes. 3. The summary results of the QSR for each provider (Person-Centered Reviews and Provider Quality Review) will be posted for public review. 4. Summary data will be provided by the QSR vendor to the QIC for review on a quarterly basis to inform quality improvement efforts aligned with the eight domains outlined in section V.D.3.a-h. The QIC or other DBHDS entity utilizes this data to identify areas of potential improvement and takes action to improve practice and the quality of services at the provider, CSB, and system-wide levels. *5.* DBHDS shares information from the QSRs with providers and CSBs in order to improve practice and the quality of services. 6. Whenever a QSR reviewer identifies potential abuse, neglect, or exploitation, a potential rights restriction in the absence of an approved plan, or a rights restriction implemented inconsistently with the approved plan, the reviewer shall make a referral to the DBHDS Office of Human Rights and/or the Department of Social Services adult/child protective services, as applicable.
53	**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.	1. 100% of reviewers who conduct QSRs are trained and pass written tests and/or demonstrate knowledge and skills prior to conducting a QSR, and reviewer qualifications are commensurate to what they are expected to review. 2. Each provider will be reviewed by the QSR at least once every two to three years. Where possible, the QSR samples will target providers that are not subject to other reviews (such as NCI reviews) during the year. Sufficient information is gathered through the samples reviewed to draw valid conclusions for each individual provider reviewed.

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			3. To address the requirements of a look-behind, inter-rater reliability has been assessed for each reviewer annually, with 80% or higher target against another established reviewer or a standardized scored review, using either live interviewing and review of records or taped video content. Any reviewer who does not meet the reliability standards is re-trained, shadowed, and retested to ensure that an acceptable level of reliability has been achieved prior to conducting a QSR. The contract with the vendor will include a provision that during reliability testing, the reviewer does not have any access to other reviewers' notes or scores and cannot discuss their rating with other reviewers prior to submission. 4. QSR reviewers receive and are trained on audit tools and associated written practice guidance that: a. Have well-defined standards including clear expectations for participating providers. b. Include valid methods to ensure inter-rater reliability. c. Consistently identify the methodology that reviewers must use to answer questions. Record review audit tools should identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation). d. Explain how standards for fulfilling requirements, such as "met" or "not met", will be determined. e. Include indicators to comprehensively assess whether services and supports meet individuals' needs and the quality of service provision.
54	**IX.C**	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to the Independent Reviewer for inspection and copying upon request and on a reasonable basis.	The Commonwealth maintains a written index that identifies the records sufficient to document that the requirements of the Settlement Agreement are being implemented and the entities responsible for monitoring and ensuring that the records are made available ("Record Index"). The Record Index specifies the following components for each record: • Identification and documentation of record locations • Timeframe for collecting and updating records as specified in the Settlement Agreement or as determined by DBHDS

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			• Identification of a custodian of the records who is responsible for oversight of the collection, storage, and updates • A process to monitor/audit record completion. The Record Index and all associated documents are timely available to the Independent Reviewer upon request. Records will be maintained in accordance with applicable Library of Virginia Records Retention and Disposition Schedules or longer, as necessary to demonstrate compliance with the Settlement Agreement.