Script for Settlement Agreement Compliance Indicators Video for Providers

Intro

You might have heard by now about how Virginia's Settlement Agreement with the Department of Justice contains specific requirements related to providers of supports to those individuals with intellectual and developmental disabilities who receive DD Waiver Services. This agreement has been in place since 2012, and without the efforts of each and every provider, Virginia will not be able to demonstrate quality services and exit the settlement agreement. Today, we are going to discuss the things that you need to know as a provider and what you need to do in order to advance the system in Virginia.

DBHDS has a number of methods for determining compliance with the settlement agreement including internal quality reviews, CHRIS Reports, licensing reviews, HCBS reviews, and reports from WaMS, but do you know exactly what is expected of you?

After each section we will recap what actions providers of DD Waiver Services need to take in order to be in compliance with the settlement agreement.

Provider Development

First, let's talk about how you can be a part of developing more quality services within the Commonwealth.

The My Life My Community Website at mylifemycommunityvirginia.org is the one-stop shop for locating providers throughout the state. Families and Support Coordinators will be directed here to search for services for their loved ones and those for whom they link to services. Powered by Virginia Navigator, the search engine contains self-reported information from providers, so it is essential that you make sure you are registered with up-to-date information so people looking to access DD Waiver services in Virginia can find you. Once registered, you will be able to take surveys to determine whether your agency can be recognized for providing services that meet basic standards for Accessibility, Autism Supports, Behavioral Supports, and/or Complex Health Supports. Once you submit required evidence, you may receive one or all of the badges on your search profile to better assist families and SCs in finding a provider that fits the person's needs.[1]

In order to help you, the provider, know where your services are needed throughout the state, DBHDS will continue to distribute the Provider Data Summary twice a year which identifies gaps in service areas throughout the Commonwealth[2] and offer funding, if available, to expand to these areas of need.[3]

DBHDS will be working with providers to assist with the development of residential providers and permanent homes for individuals with co-occurring conditions. As support staff in these services will need to utilize person-centered practices, trauma informed care, and positive behavioral support approaches, DBHDS can provide resources to locate the training necessary in order to successfully support individuals with co-occurring conditions.[4]

[1] III.C.2.a-f (4) Utilization of the My Life, My Community website.
[2] III.D.1 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] III.D.6 DBHDS will incorporate RST data into established Provider Development processes to evaluate gaps in services statewide on a semiannual basis and encourage provider development in underserved areas through information, data, and, if available, provision of funding designated to support provider expansion.
[4] III.C.6.b.iii.B 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.

DBHDS is determined to enhance and improve services to children and adults with identified significant behavioral support needs, who were assigned a support level of 7, and will study the provision of in home and personal care services they receive at home.[5]

In order to prevent the institutionalization of children due to behavioral or mental health crises, DBHDS will be developing options for children connected to REACH through host home-like services.[6]

To recap:

- Register for the Provider Search on the My Life My Community Website so your services can be located.
- Look out for the semiannual Provider Data Summary to learn where there are opportunities to expand your services.
- DBHDS needs your help to develop residential providers for people with co-occurring conditions and can offer resources for training necessary in order to successfully support that population.
- DBHDS will be studying the provision of in-home and personal assistance services for those assigned a support level of 7.
- DBHDS will be developing options for children connected to REACH through the development of host homes.

Training and Competency

To be able to assure quality services to individuals who receive DD Waiver Services, it is essential that we have a system of competent and proficient Direct Support Professionals throughout Virginia.

So this can be achieved, each and every DSP and DSP Supervisor must meet training and core competency requirements within 180 days of hire, then reviewed and updated annually, including demonstrating competence specific to health and safety,[7] behavioral intervention,[8] and medication administration[9] prior to providing these supports independently. Also, DSPs and DSP Supervisors who have not yet completed training and competency requirements, including passing the knowledge-based test with at least 80% success, must be accompanied and overseen by qualified staff who have already met these requirements.[10]

Be sure to remember that in addition to the DSP Orientation and Competencies, providers need to document that orientation that has covered the objectives and philosophy of the provider, confidentiality, human rights,

[5] III.C.6.a.i-iii Based on results of the quality review process, 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.
[6] III.C.6.b.iii.G The Commonwealth will implement out-of-home crisis therapeutic prevention host-home type 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.
[7] V.H.1 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.
[8] V.H.1 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.
[9] V.H.1 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.
[10] V.H.1 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.

emergency preparedness, infection control practices, other policies and procedures that apply to specific positions and responsibilities, as well as serious incident reporting has been completed within 15 business days of hire.[11]

All providers must have their own training policy and follow it. If providers do not comply with training requirements outlined in regulation, DBHDS will take action in accordance with licensing regulation.[12]

As always, DBHDS in conjunction with DMAS Quality Management Review staff will review citations pertaining to staff qualifications and competencies and will make those results available through quarterly provider roundtable meetings.[13]

For nurses and behavioral interventionists, DBHDS will make available training, online resources, educational newsletters, electronic updates, regional meetings, and technical support that increases their understanding of best practices for people with Developmental Disabilities.[14] Also, providers have access to the Registered Nurse Care Consultants with the Office of Integrated Health, who offer consultation and education specific to serving the DD population, as well as offers resources for ongoing learning and development opportunities to community nurses.[15] To learn more about what the Office of Integrated Health has to offer visit dbhds.virginia.gov/office-of-integrated-health#.

If you are a provider of fee-for-service transportation, you must meet training requirements established by DMAS and managed care contracts. If these providers do not provide transportation according to the contracts, they may face corrective action plans, liquidated damages, or termination of their vendor contracts.[16]

Since DSP Supervisors are responsible for providing adequate coaching and supervision of their staff, DBHDS has developed a DSP Supervisory Training available for all DSP Supervisors that covers basic supervisory skills.[17] This training will be announced through the DBHDS Provider Network Listserv and posted soon in the Commonwealth of Virginia Learning Center. To join the listserv, visit https://tinyurl.com/ProviderNetworkListserv.

---

[11] V.H.1 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.

[12] V.H.1 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] V.H.1 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.

[14] V.H.1 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.

[15] V.H.1 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.

[16] V.H.1 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.

[17] V.H.2 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.

Quarterly, DBHDS holds Provider Roundtable Meetings and Community Nursing meetings to increase the knowledge and skills of staff and supervisors providing waiver services. And don't forget that training, education, support, and coaching is available to DBHDS licensed providers through the Offices of Integrated Health and Provider Development.[18]

To recap:

- All DSPs and DSP Supervisors must meet training and core competency requirements within 180 days of hire and must demonstrate competence in health and safety, behavioral intervention, and medication administration before providing those supports independently.
- Within 15 days of hire, all DSPs and DSP Supervisors must complete Orientation to the organization that covers the areas set forth in the Settlement Agreement.
- All providers must have and follow their own training policy.
- DMAS QMR citations including those regarding staff training and competencies will be shared at the Provider Roundtables.
- DBHDS will make available resources for nurses and behavioral interventionists that detail best practices when working with people with DD.
- Registered Nurse Care Consultants are an available resource on providing nursing care to the DD population.
- Fee-for-service transportation providers must comply with DMAS training requirements.
- DBHDS has developed training for DSP Supervisors covering basic supervisory skills.
- Provider Roundtables and Community Nursing meetings are held quarterly.

Individual Service Plans (ISP)

Here is how providers can participate in and improve the ISP process:

First and foremost, all individuals and their ARs/guardians (if applicable) should be participating in the development of their own ISP, and have choice and input in all aspects of their outcomes and supports. This goes beyond just being present at the meeting, but outcomes and supports should be based around what is important to a person in their own vision of a good life.[19]

Also, in attendance at the ISP meeting should not just be paid supporters like the Support Coordinator and DSPs, but friends and family important to the individual should participate in developing the ISP as well should that person wish. You can assist by helping identify significant others in the person's life and asking if they would like them to be a part of their plan meeting. DBHDS will be able to verify this is occurring through the Part IV Agreements page of the ISP.[20]

[18] V.H.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.

[19] V.B 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.

[20] III.C.5.b.i (6) 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)

At the annual plan meeting, outcomes are not developed by just the Support Coordinator. You should come to the meeting prepared to participate in developing measurable outcomes as part of a team, including employment outcomes, if desired, as well as when outcomes are added during revisions of the Part V Plan for Support.[21]

When Planning the ISP, providers should be involved in the discussion and development of outcomes and activities that support a person with working towards employment or to stay employed, to be involved and engage in their community, and to be supported with work readiness after graduation. All adults who have a DD Waiver should have these opportunities discussed at their ISP meetings.[22]

During the ISP meeting, the Support Coordinator, providers, and other support partners should discuss and verify that all of the individual's risks, identified needs, and preferences are addressed in the ISP.[23] If risk is identified in the ISP, Providers should assure that they develop a risk mitigation plan as part of their Part V Plan for Supports[24] and need to identify and report to DBHDS individuals who are high risk due to medical needs, behavioral needs, or other factors that lead to the assignment of a SIS Level 6 or 7.[25] Providers must also be sure to revise their Plan for Supports as the person's needs and preferences change throughout the year.[26]

The Commonwealth strives for 86% of people who are supported in residential settings will receive an annual physical and 86% of people who have dental coverage will receive an annual dental exam, which will help identify health risks to be addressed in the plan.[27] So be sure to schedule routine physicals and dental appointments for people supported in residential settings.

Remember, all provider's employees or contractors who are responsible for implementing a person's ISP must demonstrate a working knowledge of the Support Activities and Support Instructions contained in each person's current ISP, including any detailed health and safety protocols.[28]

To recap:

- All individuals and their ARs or Guardians (if applicable) should attend their ISP meeting and have choice and input in all aspects of their plan.
- Each individual has the option to involve friends, family, and significant others in their life as part of their planning process.
- Outcomes are developed by the entire team, not just the Support Coordinator, and should be meaningful to the person, measurable, address risk, and address employment, if desired.
- All providers should have a risk mitigation plan for all risks identified in the ISP.
- Be sure to revise the Part V Plan for Support whenever a person's needs or preferences change.

---

[21] III.C.5.b.i (5) 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)

[22] III.C.7.a The Commonwealth will achieve compliance with this provision of the Settlement Agreement when: 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.

[23] III.C.5.b.i (4) 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)

[24] III.C.5.b.i (2) 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)

[25] V.B 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.

[26] III.C.5.b.i (3) 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)

[27] V.B 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.

[28] V.H.1 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 current ISP, including an individual's detailed health and safety protocols.

- If you are a residential provider, make sure everyone you support has an annual physical and dental exam (for those with dental coverage).
- Don't forget, everyone tasked with implementing a person's ISP must demonstrate that they have a working knowledge of the Support Activities and Support Instructions in that plan.

REACH/ Crisis

The Department of Justice expects everyone in the Commonwealth who has identified behavioral support needs to receive adequate and appropriately delivered behavioral support services. In order to meet this goal, providers need to work collaboratively with REACH and Behavioral Consultation providers to implement behavioral supports to those who need them.[29]

DBHDS will be monitoring authorizations for Therapeutic Consultation Services and the appropriate implementation of behavioral plans based on practice guidelines for behavioral services.[30]

The goal is for 86% of children and adults who are known to the REACH system to receive REACH Crisis Assessments at home, the residential setting, or other community setting. In order to achieve this, providers should work with REACH to support the crisis assessment process. REACH has two Crisis Therapeutic Homes for children and two Adult Transition Homes for adults who need crisis supports longer than 60 days.[31]

For every individual supported by REACH, individuals, families, and Group Home providers should receive training on Crisis Education and Prevention Plans (CEPP) from REACH staff.[32]

Also, your services may be needed for individuals who have been admitted to REACH Crisis Therapeutic Homes. You may be contacted by Support Coordinators or REACH, as community residences for individuals in the CTHs must have a community residence identified within 30 days of admission.[33] Obtaining a Provider Designation Badge in Behavioral Support on the My Life My Community provider search may help your program to be identified.

To recap:

- Work collaboratively with REACH and Behavioral Consultants in the assessment process and to implement behavioral supports.
- REACH staff will train individuals, families, and residential staff on Crisis Education and Prevention Plans (CEPP).

[29] V.B At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.

[30] III.C.6.a.i-iii DBHDS will implement a quality review and improvement process that tracks authorization for therapeutic consultation services provided by behavior consultants and assesses: (1) the number of children and adults with an identified need for Therapeutic Consultation (behavioral supports) in the ISP assessments as compared to the number of children and adults receiving the service; (2) from among known hospitalized children and adults, the number who have not received services to determine whether more of these individuals could have been diverted if the appropriate community resources, including sufficient CTHs were available; (3) for those who received appropriate behavioral services and are also connected to REACH, determine the reason for hospitalization despite the services; (4) whether behavioral services are adhering to the practice guidelines issued by DBHDS; and (5) whether Case Managers are assessing whether behavioral programming is appropriately implemented.

[31] III.C.6.a.i-iii 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).

[32] III.C.6.b.ii.A 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.

[33] III.C.6.b.iii.B 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.

- Be prepared to be contacted about supporting individuals who have been admitted to REACH and will need supports once they leave the program.

Integrated Settings

Since there is a focus on increasing the number of persons being served in the most integrated settings, and DBHDS is tracking this information through Service Authorization data, people served in the most integrated settings is planned to increase by at least 2% annually. A 3.5% annual increase is expected for people served in the most integrated employment and day service.[34]

For individuals new to the DD Waiver, including those with an assigned supports needs level of 6 and 7 due to extensive support with health and behavioral needs, the expectation is that 90% will be supported in most integrated settings.[35]

It is expected that all residential locations are fully integrated into the community and are fully compliant with CMS rules on Home and Community Based Settings.[36] The Home and Community Based Services Toolkit can be accessed at http://www.dmas.virginia.gov/#/hcbs.

Also, individuals with jobs in the community are expected to have chosen their job themselves or had some input in choosing their job.[37] And all people receiving services and their AR or Guardian, if applicable, should have chosen or had input in their daily schedule.[38] Beginning July 2020, a question will be in the Agreements section of the ISP to collect this information.

It is also expected that people receiving services who do not live in the family home have chosen or had input on where they live[39] and input on choosing their housemates,[40] as well.

Annually, or when there is a change in services, setting, or provider, the Support Coordinator will offer choice of providers and document on the Virginia Informed Choice Form. As a provider, if you intend to have an individual add another service you provide or move to another program you operate, the SC must be informed so they can offer choice of providers to that person.[41]

DBHDS will review new and/or changed service authorizations each quarter for residential services that have 5 or more beds to determine that the Support Coordinator did, in fact, provide informed choice.[42]

To ensure success of individuals with skilled and private duty nursing services and their ability to live in the most integrated settings, DBHDS will be reviewing the provision of these services to make sure they are started within 30 days from identified need and are delivered as written in the ISP for 70% of approved people at least 80% of the

---

[35] III.D.1 Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings.

[36] V.B 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.

[37] V.B b. At least 75% of people with a job in the community chose or had some input in choosing their job.

[38] V.B c. At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule.

[39] V.B 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.

[40] V.B 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.

[41] III.C.5.b.i(8) Individuals have been offered choice of providers for each service. (III.C.5.c)

[42] III.D.6 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.

time. DBHDS will work to identify and remedy patterns of service disruption.[43] If a person moves into a less integrated setting, yet wants a more integrated setting, the Support Coordinator will refer the issue to the Regional Support Team, and DBHDS will assist with locating a provider with that person. The goal is that 86% of people with DD Waiver who desire more integrated services will have access to options that meet their preferences within nine months.[44]

To recap:

- The goal is for people to reside in the most integrated setting, including people assigned level 6 or 7.
- All residential settings must meet CMS requirements for Home and Community Based Settings.
- People get to choose their own homes, their own housemates, their own schedules, and their own jobs.
- Choice must be offered by the SC. Do not make any changes in services or location without involving the Support Coordinator, and DBHDS will be reviewing that informed choice was, in fact, provided for people moving to homes with 5 or more beds.
- DBHDS will be reviewing whether skilled and private duty nursing services were provided as written in the ISP.
- If someone wants to live in a more integrated setting, but one is not available, DBHDS will assist with finding a more integrated service for that person.

Quality and Risk Management

DBHDS has set up a Quality Management System that is tasked with Quality Assurance, Quality Improvement, and Risk Management.[45]

It is very important for providers to report serious incidents to the Office of Licensing within 24 hours of discovery. Any provider who does not do so will be cited and will have to complete a Corrective Action Plan.[46] The Office of Licensing Investigation Team will review all deaths for people DD reported through CHRIS,[47] and DBHDS will identify providers, including CSBs that have failed to report serious incidents, deaths, or allegations of abuse or neglect as required by the Licensing Regulations[48] with the expectation that 86% of reportable serious incidents are reported within the 24 hour timeline.[49] Also, Providers with recurring deficiencies in the timely implementation

[43] III.D.1 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.

[44] III.D.1 DBHDS tracks individuals seeking a service consistent with integrated living options as defined in the Integrated Residential Settings Report that is not available at the time of expressed interest as described in indicator # 13 of III.D.6. 86% of people with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (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.

[45] V.B The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. DBHDS Quality Management System shall: a. Identify any areas of needed improvement; b. Develop improvement strategies and associated measures of success; c. Implement the strategies within 3 months of approval of implementation; d. Monitor identified outcomes on at least an annual basis using identified measures; e. Where measures have not been achieved, revise and implement the improvement strategies as needed; f. Identify areas of success to be expanded or replicated; and g. Document reviewed information and corresponding decisions about whether an improvement strategy is needed. The DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance b. Quality Improvement c. Risk Management;

[46] V.B 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.

[47] V.C.5 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.

[48] V.C.6 DBHDS identifies providers, including CSBs that have failed to report serious incidents, deaths, or allegations of abuse or neglect as required by the Licensing Regulations. Identification occurs through: a. Licensing inspections and investigations; b. DBHDS receipt of information from external agencies, such as the protection and advocacy agency, or other agencies such as the Department of Health or local adult protective services agencies; c. Any other information that DBHDS may receive from individuals, other providers, family members, or others; d. Reports of deaths from the Virginia Department of Health as described in Indicator 7.c of V.C.5.

[49] V.C.6 At least 86% of reportable serious incidents are reported within the timelines set out by DBHDS policy.

of approved CAPs will be subject to further action as appropriate under the Licensing Regulations and approved by the DBHDS Commissioner.[50]

All providers must conduct quarterly reviews of all level I serious incidents and a root cause analysis of all level II and level III serious incidents in order to mitigate reoccurrence.[51]

DBHDS will verify that people who receive services are free from abuse and neglect by paid staff and are adequately protected from serious injuries in service settings,[52] and that providers adhere to regulations and requirements when restrictive measures are used.[53]

Licensing Regulations require that all licensed providers implement risk management processes that address the environment of care, clinical assessment or reassessment processes, staff competence and the adequacy of staffing, the use of high-risk procedures, including seclusion and restraint, as well as a review of serious incidents.[54]

There will be information on the DBHDS website for residential and day support providers on the use of risk screening and assessment tools as well as information on uniform risk triggers and thresholds, including the need to address any identified risks or changes in risk status in the person's risk management plan.[55] DBHDS will be monitoring that providers appropriately respond to and address risk triggers and thresholds using Quality Service Reviews, otherwise known as QSRs, or other methodology.[56]

Providers are expected to develop a risk mitigation plan for each individual identified as high risk, which includes the risk and actions to take to mitigate the risk. Providers that do not meet these standards will face corrective action.[57]

---

[50] V.C.6 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.

[51] V.B 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.

[52] V.B At least 95% of individual service recipients are free from neglect and abuse by paid support staff and is adequately protected from serious injuries in service settings.

[53] V.B 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.

[54] V.C.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 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

[55] V.C.1 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 DD. 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.

[56] V.C.1 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.

[57] V.C.1 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

DBHDS will make training and topical resources available through DBHDS website to providers including, proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.[58] Providers that have been determined to be non-compliant with risk management requirements for reasons related to a lack of knowledge will demonstrate that they have completed training as part of their corrective action plan,[59] and providers that have been determined to be non-compliant with training and expertise for staff responsible for the risk management and in conducting root cause analyses will also demonstrate that they completed training as part of their corrective action plan process.[60] DBHDS will use data and information from risk management activities, including mortality reviews to identify future topics and determinations when content needs to be revised. In addition, providers will be identified that are in need of additional technical assistance or other corrective action. Guidance will be disseminated widely to providers of services in both licensed and unlicensed settings and to family members and guardians.[61]

The Commonwealth posts reports, updated at least annually, on the availability and quality of services in the community, gaps in services, and makes recommendations for improvement.[62]

DBHDS-licensed providers are required to have a quality improvement (QI) programs that are sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis.[63] Information collected from licensing reviews and Quality Service Reviews allows the Commonwealth to identify providers that have been unable to demonstrate adequate quality improvement programs and offers technical assistance as necessary.[64]

DBHDS requires regular reporting, at least annually, of each provider reporting measure from DBHDS-licensed DD providers, and at least quarterly, measures representing risks that are prevalent in individuals with developmental

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.

[58] V.C.4 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

[59] V.C.4 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.

[60] V.C.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 Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan process.

[61] V.C.4 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.

[62] V.D.6 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.

[63] V.E.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. iii. includes and reports on statewide performance measures, if applicable, as required by DBHDS.

[64] V.E.3 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.

disabilities (for example, aspiration, bowel obstruction, or sepsis). DBHDS is working on a solution for collecting this information.[65]

DBHDS will inform 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.[66]

The Commonwealth conducts Quality Service Reviews (QSRs) annually on a sample of providers, comprised of Person-Centered Reviews (or "PCRs") and Provider Quality Reviews (or "PQRs"), to evaluate the quality of services at an individual, provider, and system-wide level.[67]

The Quality Service Reviews assess on a provider level whether: services are provided in safe and integrated environments in the community; person-centered thinking and planning is applied to all service recipients; providers keep individuals safe from harm, and access treatment for individuals as necessary; qualified and trained staff provide services to individuals, sufficient staffing is provided as required by individual service plans, and staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols; individuals receiving services are provided opportunities for community inclusion; and providers have active quality management and improvement programs, as well as risk management programs.[68]

The summary results of the QSR for each provider will be available for public review. The information from the QSRs will be shared with providers and CSBs in order to improve practice and the quality of services.[69] Each provider will be reviewed by the QSR at least once every two to three years.[70]

Be aware that one thing that the QSR will verify is if transportation provided by waiver service providers is happening, which supports people to participate in community activities and Medicaid services per their ISPs. The goal is that 86% of those reviewed report that they have reliable transportation to participation in community activities and Medicaid services.[71]

---

[65] V.E.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.

[66] V.G.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.

[67] V.I.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

[68] V.I.1 The Quality Service Reviews assess on a provider level whether: a. Services are provided in safe and integrated environments in the community. b. Person-centered thinking and planning is applied to all service recipients. c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary. d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks 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.

[69] V.I.2 DBHDS shares information from the QSRs with providers and CSBs in order to improve practice and the quality of services.

[70] V.I.3 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.

[71] III.C.8.a 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.

The Commonwealth will maintain a written "Record Index" in an online library format 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.[72]

To recap:

- Report serious incidents, including death, within 24 hours of discovery.
- Conduct Quarterly Reviews of all level I serious incidents and root cause analysis for all level II and III serious incidents.
- All people with DD Waiver should be free from neglect and abuse; and providers adhere to requirements when restrictions are used.
- All licensed providers must implement a risk management process and are required to have a Quality Improvement program.
- There will be information on the DBHDS website regarding the use of risk screening and assessment tools as well as information on uniform risk triggers and thresholds.
- All people with identified risks must have a risk mitigation plan.
- The DBHDS website will host information about proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.
- Reports will be posted by DBHDS and updated at least annually on the availability and quality of services in the community, gaps in services, and making recommendations for improvement.
- DBHDS requires reporting of risks that are prevalent in individuals with developmental disabilities.
- Quality Services Reviews (QSRs) are conducted annually on a sample of providers, and the summary results from those reviews will be available publicly. Providers can expect to be reviewed once every 2-3 years.
- The Commonwealth will maintain a "Record Index" to document that the requirements of the Settlement Agreement are being implemented.

Remember, DBHDS, CSBs, and providers must all work together in order to meet these indicators. With your help, we can advance the DD system in the Commonwealth of Virginia and assure that everyone with Developmental Disabilities can have the lives they want.

[72] IX.C 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").