REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

SETTLEMENT AGREEMENT

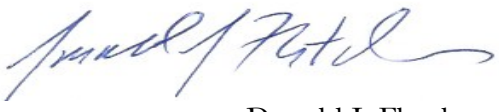
UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

October 1, 2023 – March 31, 2024

Respectfully Submitted By



Donald J. Fletcher
Independent Reviewer
June 13, 2024

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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's Twenty-fourth Report on the status of compliance with the Provisions of the Settlement Agreement (Agreement) between the Parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and progress during the past six months, focusing on the Twenty-fourth Review Period, October 1, 2023 – March 31, 2024.

In 2023, the Parties agreed to target the Independent Reviewer's studies and monitoring for this Report on certain of the Consent Decree's Provisions and 60 of their associated Compliance Indicators. These Indicators represent those that Virginia has not previously met, either at all or twice consecutively, and that have not been removed by the Court. Any Provisions with which the Commonwealth has already achieved Sustained Compliance, as well as any Indicators that Virginia has met twice consecutively were not part of this review.

For these remaining Indicators, the Twenty-fourth Period reviews again found that the Commonwealth has largely addressed and sufficiently resolved previously identified issues regarding the reliability and validity of relevant data sets. However, DBHDS must address any identified threats to this reliability and validity in its methodology for collecting and using the Quality Services Review (QSR) Round 6 data sets, including its inter-rater reliability component.

Leading up to this Report, Virginia had already achieved 29 of the remaining 60 Indicators. This Period's studies concluded that the Commonwealth has now maintained its achievement of 19 of those Indicators over two consecutive reviews, and fulfilled a further four Indicators for the first time. For another 13 Indicators, because Virginia's monitoring cycles since the previous Twenty-third Period studies were still in process, no new data from these cycles were available for review and analysis this time. The Independent Reviewer therefore deferred rating these Indicators until the next Twenty-fifth Period review.

Overall, Virginia has now achieved 32 of the 60 Indicators studied, 19 of them twice consecutively. This brings the Commonwealth into newly Sustained Compliance with eight Provisions of the Consent Decree.

These newly sustained Provisions reflect stable accomplishments across several areas, including the individual and family supports program, crisis education and prevention plans, timely

identification of community residences, mortality reviews, collecting and analyzing data, and maintaining and posting data and documentation publicly. Virginia deserves commendation for implementing durable remedies and sustaining these accomplishments. These achievements, however, primarily involve Indicators that specify structural and functional aspects of the Commonwealth's statewide service system.

This Period's reviews determined that 28 Compliance Indicators remain unmet. Most of these Indicators involve service outcomes for individuals with IDD. Achieving these, though, is proving more difficult than developing the structural and functional aspects. As described in a number of earlier Reports, staffing shortages that had long preceded the pandemic persisted. Inadequate pay rates and the difficulty of the work, compared with jobs with similar qualifications, are most frequently cited as the root causes of Virginia's service providers' challenges to successfully recruit and retain the necessary number of essential staff. The Commonwealth's providers continue to report, and this Period's review confirmed that the ongoing shortage of nurses, crisis services workers and direct support professionals undermines Virginia's ability to provide the core services of the Consent Decree, especially those for people with intense medical and behavioral support needs who live with their families.

For this group of individuals, despite some progress and improvement, the Commonwealth persists in falling short of the Consent Decree's requirements to provide adequate and appropriately delivered behavioral services, conduct initial crisis assessments in individuals' homes or other community settings, deliver needed nursing services, make sure physical and dental exams occur annually, provide participation in integrated day services, and ensure that direct support professionals and their supervisors receive competency-based training.

For the Twenty-fifth Period review, the Parties have agreed that the Independent Reviewer will target his studies and monitoring on 41 remaining Compliance Indicators across 17 Provisions that Virginia has still not met, either at all or twice consecutively. Any Provisions that have achieved Sustained Compliance, any Indicators that have been fulfilled twice consecutively, and any Indicators that have been removed by the Court will not be reviewed.

The following sections of the Agreement cover these remaining 41 Indicators:

- Case Management,
- Crisis and Behavioral Services,
- Integrated Day Activities and Supported Employment,

- Community Living Options,
- Services for Individuals with Complex Medical Support Needs,
- Quality and Risk Management,
- Quality Improvement Programs, and
- Provider Training.

In closing, it is critical to reiterate that the Consent Decree's goals of providing individuals with IDD the opportunities for community integration, self-determination and quality services depend on the Commonwealth consistently meeting these required service outcomes, in addition to completing development of its service system's functions and structures.

II. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

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

- Individual and Family Support Program and Family-to-Family and Peer Programs;
- Case Management;
- Crisis and Behavioral Services;
- Integrated Day Activities and Supported Employment;
- Community Living Options;
- Services for Individuals with Complex Medical Support Needs;
- Quality and Risk Management;
- Provider Training;
- Quality Improvement Programs;
- Mortality Reviews; and
- Public Reporting.

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

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

The Independent Reviewer focused the Twenty-fourth Period studies on any Provisions with which the Commonwealth had not yet achieved Sustained Compliance, and their associated Compliance Indicators that had not already been met twice consecutively. These included Indicators that had been achieved only once or not at all, as determined in the Twenty-third Period Report.

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

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

To determine any ratings of Compliance for the Twenty-fourth Review Period, the Independent Reviewer considered information delivered by Virginia prior to April 19, 2024, and responses to consultant requests for clarifying information up to May 11, 2024. To determine whether the Commonwealth had met the remaining Compliance Indicators and achieved the Provisions studied, the Independent Reviewer considered the findings and conclusions from the consultants' studies, Virginia's planning and progress reports and documents, as well as other sources.

The Independent Reviewer's determinations that Indicators have or have not been met, and the extent to which the Commonwealth has achieved Compliance, are best understood by reviewing the Discussion of Compliance Findings and the consultants' reports, which are included in the

Appendices. To protect individuals' private health information, the summaries from the studies of individuals' services included in the respective consultant reports are submitted to the Parties under seal.

For each study, Virginia was asked to make its records available that document the proper implementation of the Provisions and the associated remaining Compliance Indicators being reviewed. For each Indicator with a function or performance measure that utilized reported data, the Commonwealth must make available its completed *Process Document* and *Attestation*. With these two documents, Virginia asserts that each of its reported data sets has been verified as reliable and valid.

If any of Virginia's monitoring cycles for certain Indicators were still in progress since the previous Twenty-third Period review, the Independent Reviewer determined a "deferred" rating for these relevant Indicators, since new information for this current Period's study was not yet available for review and verification. (If any such Indicators were met in the previous review and the next Twenty-fifth Period study also finds they have been achieved, a determination of met twice consecutively will be made.)

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

Prior to completing a draft of this Twenty-fourth Report to the Court for the Parties to review, the Independent Reviewer distributed copies of the consultants' draft studies to DBHDS, and convened an exit call for each study. These calls provided an opportunity for senior staff from Virginia's relevant departments and their subject matter experts to discuss the contents together with the consultants and the Independent Reviewer. The discussions included the identification of any factual errors and misunderstandings, or needed clarifications. The reports were then modified as appropriate.

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

B. Discussion of Compliance Findings

1. Individual and Family Support Programs and Family-to-Family and Peer Programs

Background

For the Commonwealth's Individual and Family Support Program (IFSP) and Family-to-Family and Peer Programs, the Twenty-third Period study concluded that Virginia had met all 12 Compliance Indicators associated with two remaining Provisions (III.C.2a.-i. and III.D.5.) that had not yet achieved Sustained Compliance.

Regarding Provision III.C.2.a.-i.'s remaining nine Compliance Indicators, namely 1.1–1.4, 1.6, 1.7, and 1.9–1.11, the Commonwealth had met the requirements of eight of them (1.2–1.4, 1.6, 1.7, and 1.9–1.11) twice consecutively. Virginia had also met the additional Indicator (1.1) for the first time, and so had achieved Compliance with this Provision for the first time.

Regarding Provision III.D.5.'s three Compliance Indicators, namely 19.1–19.3, the Commonwealth had met the requirements of one of them (19.1) twice consecutively. Virginia had also met the other two Indicators (19.2 and 19.3) for the first time and so had achieved Compliance with this Provision for the first time as well.

Twenty-fourth Period Study

For the Twenty-fourth Period, the Independent Reviewer retained the same consultant as previously to assess the status of the remaining two IFSP Provisions (III.C.2.a.-i. and III.D.5) not yet in Sustained Compliance. A total of just three associated Indicators were studied – one for Provision III.C.2.a.-i. (namely 1.1) and two for Provision III.D.5. (19.2 and 19.3). All three had been achieved for the first time during the prior Twenty-third Period review.

Key Points

- The Commonwealth again met the requirements of Provision III.C.2.a.-i.'s remaining Indicator 1.1. DBHDS continued to strengthen the foundation of its local community-based supports through its IFSP Regional Councils. The Department made its IFSP regulations permanent, further developed Council work plans and utilized additional resources through Virginia's Community of Practice technical assistance program.

- The latest study verified that the Commonwealth sustained achievement of Provision III.D.5.'s remaining two Indicators, 19.2 and 19.3. DBHDS initiated Individual Supports Plan (ISP) modifications to enable tracking of family-to-family and peer mentoring discussions and service setting outcomes. The Department also enhanced outcome reporting regarding the effectiveness of the peer and family mentoring programs.

See Appendix A for the consultant's full report.

Conclusion

Regarding Provision III.C.2.a.-i.'s sole remaining Compliance Indicator 1.1, Virginia has met its requirements twice consecutively. Therefore, the Commonwealth has achieved Sustained Compliance with this Provision.

Regarding Provision III.D.5.'s two remaining Compliance Indicators, namely 19.2 and 19.3, Virginia has met each of their requirements twice consecutively. Therefore, the Commonwealth has also achieved Sustained Compliance with this Provision.

2. Case Management

Background

As a result of the Twenty-third Period review, the Commonwealth had achieved seven of the nine Compliance Indicators associated with the Agreement's three remaining Case Management Provisions: III.C.5.b.i., V.F.4. and V.F.5.

Regarding Provision III.C.5.b.i.'s six Indicators studied last time, namely 2.2, 2.3, 2.5, 2.16, 2.18 and 2.20, Virginia had met the requirements for two of them (2.2 and 2.5) twice consecutively. The Commonwealth had met an additional three Indicators (2.3, 2.18 and 2.20) for the first time. However, Virginia did not achieve one Indicator (2.16), so therefore had remained in Non-Compliance.

For Indicator 2.16, DBHDS's Case Management Steering Committee (CMSC) had studied the results of the Support Coordinator Quality Review (SCQR) process for Fiscal Year 2023 and had determined that just 64% of records reviewed had achieved a minimum of nine of the ten elements, which was below the 86% benchmark. This represented a continued steady increase over the results from prior studies, and indicated that DBHDS's approach was resulting in

measurable improvements. This SCQR process had identified the element where underperformance had been most resistant to improvement: ensuring that ISPs have specific measurable outcomes, including evidence that employment goals had been developed and discussed.. To resolve this issue and meet this element's 86% performance measure, DBHDS needed to invest in a more concerted and targeted quality improvement initiative.

Regarding Provision V.F.4., the Commonwealth had fully met both Indicators, namely 46.1 and 46.2, and so had achieved Sustained Compliance with this Provision.

For Provision V.F.5., Virginia had not met the sole Indicator 47.1, and therefore remained in Non-Compliance. The Commonwealth had not yet achieved this Indicator's required 86% performance measure for two of its domain elements.

Twenty-fourth Period Study

For this latest review, the Independent Reviewer retained the same two consultants as last time to assess Virginia's status related to its achievement of the two remaining Case Management Provisions (III.C.5.b.i. and V.F.5.) and their five associated Indicators that had not yet been met, either at all or twice consecutively.

For Provision III.C.5.b.i., four remaining Indicators were reviewed, namely 2.3, 2.16, 2.18 and 2.20. Provision V.F.5.'s Indicator 47.1 was also studied.

Key Points

- The Commonwealth met the requirements of Provision III.C.5.b.i.'s Indicator 2.3 for a second consecutive Period. DBHDS again pulled an annual, statistically significant, stratified statewide sample. The Department also revised its guidance tool and wording of goals and outcomes.
- For the remaining four Indicators (Provision III.C.5.b.i.'s three Indicators 2.16, 2.18 and 2.20, as well as Provision V.F.5.'s Indicator 47.1), Virginia did not complete an SCQR monitoring cycle since the last Twenty-third Period review. This meant that no new SCQR monitoring data for this current Period's study were available for analysis and verification. The Independent Reviewer has therefore determined that a rating for these Provisions and each of their four associated Indicators is deferred.

See Appendix B for the consultants' full report.

Conclusion

Regarding Provision III.C.5.b.i.'s four remaining Compliance Indicators, 2.3, 2.16, 2.18 and 2.20, the Commonwealth has now achieved one of them (2.3) twice consecutively. Until Virginia completes a new SCQR cycle, however, a rating for the other three Indicators (2.16, 2.18 and 2.20) is deferred*. Therefore, the Commonwealth remains in Non-Compliance with this Provision until new monitoring data is available for review and verification.

Regarding Provision V.F.5., until Virginia completes a new SCQR cycle, a rating for the sole Indicator 47.1 is deferred*. Therefore, the Commonwealth remains in Non-Compliance with this Provision until new monitoring data is available for review and verification.

* Regarding deferred ratings, if the relevant Indicator was met in the previous review, and the next Twenty-fifth Period study finds it has also been achieved, a determination of met twice consecutively will be made.

3. Crisis and Behavioral Services

Background

The Twenty-third Period study had reviewed five Crisis and Behavioral Services Provisions (III.C.6.a.i.-iii., III.C.6.b.ii.A., III.C.6.b.iii.B., III.C.6.b.iii.D. and III.C.6.b.iii.G.) and their associated nine Compliance Indicators that had not yet been achieved, either at all or twice consecutively.

Regarding Provision III.C.6.a.i.-iii.'s five remaining Indicators, namely 7.8, 7.14 and 7.18–7.20, Virginia had met the requirements of two of them, 7.14 and 7.20, twice consecutively, and had met Indicator 7.19 for the first time. The Commonwealth did not achieve two Indicators, 7.8 and 7.18, and so remained in Non-Compliance.

For Indicator 7.8, the Twenty-third Period review found that a high percentage of individuals with IDD had continued to receive crisis assessments at hospitals or CSB Emergency Departments. This had resulted in a higher percentage of children and adults with IDD being admitted to psychiatric hospitals compared with those who had received crisis assessments in their homes or other community settings where the crises occurred. The percentages of crisis assessments that had taken place in the community had remained nowhere near this Indicator's 86% performance measure, and persistent and substantial variations in the percentages had

occurred between the Department's five Regions. For these reasons, Indicator 7.8 had remained unmet.

Regarding Indicator 7.18, DBHDS had again fallen short of achieving the 86% timeliness benchmark by 15%. Overall, 71% of the children and adults identified for Therapeutic Consultation (i.e., behavioral supports) had been connected to a Therapeutic Consultation provider within 30 days. Two of the Department's Regions had met this timeliness requirement, but DBHDS's other three Regions' performance had remained substandard. The Department had undertaken a root cause analysis and had identified issues to address and resolve the obstacles to fulfilling this Indicator's requirement.

For Provision III.C.6.b.ii.A.'s one remaining Indicator, namely 8.4, Virginia had re-met its requirements and had therefore achieved Compliance with this Provision for the first time.

Regarding Provision III.C.6.b.iii.B.'s one remaining Indicator, namely 10.4, the Commonwealth had not achieved its requirements, and so remained in Non-Compliance. Only one of the five Regions had met or exceeded the 86% expectation that individuals with waivers and known to the REACH system have a community residence identified within 30 days of being admitted to Crisis Therapeutic Homes (CTHs) and psychiatric hospitals.

For Provision III.C.6.b.iii.D.'s sole Compliance Indicator, namely 11.1, the Commonwealth had not achieved its requirements and therefore remained in Non-Compliance. DBHDS had reported that 83% of individuals admitted to CTHs in this Period had had a community residence identified within 30 days. Even though Virginia's performance had improved, the required 86% benchmark had remained unmet.

Regarding Provision III.C.6.b.iii.G.'s one remaining Indicator, namely 13.3, the Commonwealth had not met its requirements and so was in Non-Compliance. During the entire Twenty-third Period, no child was referred to, or accessed the one minimally operational host-home for children experiencing a crisis. Recognizing that the two homes that DBHDS had originally created were not being used, the Department had determined that distance and transportation challenges were significant barriers to family interest. Based on the lack of utilization of this program and the feedback from a focus group, DBHDS had planned to develop alternative prevention supports for children.

Twenty-fourth Period Review

For this latest review, the Independent Reviewer retained the same consultants as previously to assess the status of Virginia's efforts toward achieving the Agreement's remaining five Crisis Services Provisions (III.C.6.a.i.-iii., III.C.6.b.ii.A., III.C.6.b.iii.B., III.C.6.b.iii.D., and III.C.6.b.iii.G.) and their associated seven Indicators that have either not yet been met twice consecutively or not at all.

These include three Indicators (7.8, 7.18 and 7.19) associated with crisis and behavioral services, one Indicator (8.4) for mobile crisis service, and three indicators (10.4, 11.1 and 13.3) related to crisis stabilization.

Key Points

- During the Twenty-fourth Period, the Commonwealth provided fewer than 50% of REACH crisis assessments in individuals' home or other community locations where the crises occurred, and therefore once again failed to make substantial progress toward meeting Indicator 7.8's required 86% performance metric. DBHDS's Region 3 continued to perform much closer to the benchmark, whereas Region 1 only provided crisis assessments in the community to fewer than one out of every five individuals known to the system.
- Regarding Indicator 7.18, Virginia again failed to achieve this Indicator, although its statewide performance improved slightly from 71% to 74%. This is still well below the 86% measure for individuals being referred for behavioral supports within 30 days of the need being identified.
- For Indicator 7.19, DBHDS's monitoring process was effectively implemented and was sufficient to identify whether individuals had received the four required elements within the timeframe required by the DD Waiver regulations. The Department reviewed 92 Behavior Support Plan Adherence Review Instruments (BSPARIs) using established criteria for a minimally adequate behavior program, and found that 93% contained all four elements. The Commonwealth has now achieved this Indicator's 86% performance metric twice consecutively.
- Virginia also achieved the 86% benchmark for Indicator 8.4 for the second consecutive Period. DBHDS completed 87% of the required Crisis Education and Prevention Plans (CEPPs) during the final quarter of Fiscal Year 2023 and the first quarter of Fiscal Year 2024.

- During the current Review Period, of the 335 individuals who were admitted to hospitals and CTHs, only 265 (79%) had a community residence identified within the required 30 days. Once more, this performance did not achieve Indicator 10.4's 86% metric.
- Regarding Indicator 11.1, out of a total of 53 individuals who were admitted to CTHs during this Period, 48 (91%) had a community residence identified within the required 30 days. This represents an improvement for the Commonwealth, and Virginia has now met this Indicator's 86% performance measure for the first time.
- The Commonwealth has still not met the requirements of Indicator 13.3. During the current review Period, no children experiencing a crisis were referred to or accessed the host-home for children. DBHDS requested and reports having received funds to pursue an alternative solution.

See Appendix C for the consultants' full report.

Conclusion

Regarding Provision III.C.6.a.i.-iii.'s remaining three Compliance Indicators, namely 7.8, 7.18 and 7.19, Virginia has met the requirements of one of them (7.19) twice consecutively. However, the Commonwealth did not achieve the other two Indicators, 7.8 and 7.18, and therefore remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.ii.A.'s one remaining Compliance Indicator, namely 8.4, Virginia has again met its requirements. Therefore, the Commonwealth has now achieved Sustained Compliance with this Provision.

Regarding Provision III.C.6.b.iii.B.'s one remaining Compliance Indicator, namely 10.4, Virginia did not achieve its requirements. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.iii.D.'s sole Compliance Indicator, namely 11.1, Virginia has met its requirements for the first time. Therefore, the Commonwealth has achieved Compliance with this Provision for the first time.

Regarding Provision III.C.6.b.iii.G.'s one remaining Compliance Indicator, namely 13.3, Virginia did not meet its requirements. Therefore, the Commonwealth is in Non-Compliance with this Provision.

4. Integrated Day Activities and Supported Employment

Background

The Twenty-third Period study of Virginia's Integrated Day Activities and Supported Employment service system had determined that the Commonwealth had remained in Non-Compliance with the remaining Provision, namely III.C.7.a. None of its three outstanding associated Compliance Indicators (14.8–14.10) had been achieved.

For Indicator 14.8, in Fiscal Year 2022, DBHDS had started to turn around the pandemic-related decline in the number of employed Waiver participants. Even though there were more individuals employed, and despite the Department's reduced numerical targets, Virginia had still not achieved the required 90% of its revised targets. For Fiscal Year 2023, significantly more individuals needed to be employed. However, the Twenty-third Period review found that although the number of employed individuals had increased by 13%, the Commonwealth again did not meet 90% of its annual target.

Regarding the number of adults on the DD Waivers and waitlist, even though Virginia had increased the percentage employed to 23% during the Twenty-third Period, this still fell short of the 25% required by Indicator 14.9, and contrasted with the Commonwealth's pre-pandemic achievement of 24% in 2019.

For Indicator 14.10, with the expected annual growth in the number of individuals receiving Waiver-funded services, and Virginia's attempts to shift its services system to serving more people in integrated, community-based day settings and away from larger segregated settings, the Parties had agreed in January 2020 to a 3.5% increase annually. In 2018, when the Commonwealth had begun maintaining records of the number and percentage of individuals authorized to participate in employment or day services in integrated settings, 25.2% of adults with DD Waiver services had been served in such settings. Although insufficient to achieve Indicator 14.10's required 3.5% increase annually, this percentage had increased to 28.5% by 2020. However, by 2022, the percentage had steadily decreased to 19.7%.

One root cause of this decrease was insufficient provider capacity, with the pandemic being a likely significant contributor. However, the decline in the number of licensed providers and provider locations for Community Engagement had begun well before the pandemic emergency. Between June 2018 and June 2019, the number of licensed provider locations of Community Engagement services had declined from 198 to 171, a decrease of 27 (13.6%). The limited

availability of this integrated service model across all Regions had suggested that funding rates had been inadequate.

The Twenty-third Period study showed the percentage of individuals authorized for these services had increased only slightly to 19.9%, remaining significantly less than the 25.2% baseline established five years prior, and also substantially less than the percentage would have been if the increase of 3.5% annually had been achieved for five years. Again, Virginia did not meet this Indicator's benchmark.

Twenty-fourth Period Study

For this latest review, the Independent Reviewer retained the same consultant as previously to assess the status of the Commonwealth's compliance with the one remaining Integrated Day Activities and Supported Employment Provision, namely III.C.7.a. and its three relevant Indicators, 14.8, 14.9 and 14.10.

Key Points

- DBHDS and its Employment First Advisory Committee reviewed and reduced its numerical targets for employed adults with DD Waiver services from 1,486 in Fiscal Year 2023 to 1,142 in Fiscal Year 2024. The Commonwealth carefully reviewed the impact of the pandemic and the fact that in Fiscal Year 2023 only 986 people with DD Waiver-funded services were actually employed. Although hundreds of additional individuals had begun to receive Waiver-funded services annually, Virginia determined that it would be more realistic to revise its targets based on a projected increase of 15% annually. This approach resulted in substantially reduced Waiver employment targets for Fiscal Years 2024 through 2026. The Commonwealth reported that as of December 31, 2023, there were 914 waiver participants employed, which is 72 individuals fewer than the last reporting period and 80% of the new target. Again, Virginia failed to meet 90% of the target, as required by Indicator 14.8.
- The Commonwealth reported that out of the 21,879 individuals on either the DD Waivers or the waitlists, only 23% were employed. This is below the 25% required by Indicator 14.9 and remains consistent with the percentage of individuals who were employed in the Twenty-third Period.
- DBHDS had reported that as of March 2023, 3,254 (19.5%) out of 16,329 individuals with DD Waiver services had been authorized to participate in integrated day settings. A year later, as of March 2024, 3,762 (21.9%) out of 17,142 were authorized. This

represented a 2.0% increase, remaining less than Indicator 14.10's requirement of a 3.5% annual increase.

See Appendix D for the consultant's full report.

Conclusion

Regarding Provision III.C.7.a.'s remaining three Compliance Indicators, namely 14.8–14.10, Virginia did not achieve any of them. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

5. Community Living Options

Background

For the Twenty-third Period review, six Indicators, namely 18.2–18.6 and 18.9, remained as part of Community Living Options Provision III.D.1. As a result of this previous study, the Commonwealth had met the requirements of three of these Indicators, 18.3–18.5, twice consecutively. Another two Indicators, 18.2 and 18.6, had been newly achieved. Since Virginia did not meet Indicator 18.9, however, the Commonwealth had remained in Non-Compliance.

For Indicator 18.2, DBHDS had continued its multi-year positive trend of increasing the percentage of individuals being served in integrated residential settings by 2.3%, exceeding the required 2% benchmark for the first time.

Regarding Indicator 18.6, DBHDS had already established its Developmental Disability Systems Issues and Resolution Workgroup (DDSIRW) to address issues that impact the development, expansion and maintenance of services, including integrated residential services. With input from the DDSIRW, the Department had finalized its plan to increase more integrated residential service options statewide, and so had met Indicator 18.6 for the first time.

For Indicator 18.9, DBHDS had reported that it had not sustained the required timeliness metric of individuals receiving nursing services within 30 days of the need being identified in their ISPs, nor did the Department achieve this Indicator's nursing utilization benchmark. Instead of the required 70%, only 46% of the individuals whose ISPs had identified the need for nursing services had received the number of hours needed at least 80% of the time for the first six months of Fiscal Year 2023.

The Twenty-third Period Individual Services Review (ISR) study of 36 individuals with complex medical support needs had determined that only 42% received 80% or more of the number of authorized nursing hours. All of the individuals in the cohort had the need for nursing identified in their ISPs. An additional concern from this ISR study was the inconsistency and unreliability of nursing services for 79% of the individuals studied.

For this same Period, the Independent Reviewer had also learned and confirmed that Indicator 18.9's three components of its performance measure included significant flaws, requiring the Department to design and implement an entirely new approach to determining whether individuals with IDD receive 80% of the nursing hours they need.

Additionally, at the start of 2020, Virginia believed that the number of needed hours of nursing services was specified in individuals' ISPs. When DBHDS learned that although the need for nursing services was identified, the number of needed hours was not determined at the time of the annual ISP meeting. Instead, the Department began in July 2020 to use the number of authorized hours to represent the number of needed hours. DBHDS later determined, however that the number of authorized nursing hours is often inflated to cover potential changes in need or unexpected events, and is therefore not an accurate substitute for needed hours to be identified in the ISP.

The Commonwealth had taken steps to expand the availability of nursing services and had significantly increased its reimbursement rates to nursing agencies so that nurses could be paid more. However, these new rates were set at the midrange of the 2020 market rates for nurses. The Commonwealth had hoped nursing utilization rates would improve by the Twenty-fourth Period. The Twenty-third Period Report recommended increasing the reimbursement rates for nursing services.

Twenty-fourth Period Study

For the latest review, the Independent Reviewer retained the same two consultants as previously to assess whether sufficient evidence existed to determine if Virginia has achieved each of Provision III.D.1.'s three remaining Indicators, i.e., 18.2, 18.6 and 18.9.

Key Points

- For Indicator 18.2, DBHDS's data indicated that the percentage of authorizations for individuals with DD Waivers being served in most-integrated residential settings continued to grow as a percentage of all residential settings, i.e., from 79.4% in 2016 to 90% in 2023. For the past seven years, the Commonwealth has consistently achieved a positive annual trend, never below 1.2%. For the year September 2022 through September 2023, Virginia maintained this trend, but was unable to sustain this Indicator's required annual increase of 2%, and so did not meet the necessary performance measure this time, or twice consecutively.
- Regarding Indicator 18.6, DBHDS continued to report on the numbers of individuals with Level 6 or 7 needs receiving services in the five specified service types. The plan that the Department submitted during this reporting Period was sufficient to address the identified prioritized barriers, i.e., limited access to respite services and insufficient provider capacity. The Commonwealth has therefore now met the requirements of this Indicator twice consecutively.
- For Indicator 18.9, in Fiscal Year 2023, DBHDS reported that 104 (77%) of the 135 individuals with new nursing service authorization had these services delivered within 30 days, surpassing the required 70%. However, only 247 (40%) of the overall 616 individuals whose ISPs identified the need for nursing services received at least 80% of the hours that they needed (i.e., the annual utilization rate), falling short of the required 70% benchmark. Once again, Virginia failed to meet the annual nursing utilization rate requirement of this Indicator.

  The methodology used by the Commonwealth to determine these utilization rates continued to produce inaccurate annual results. Interestingly enough, though, as depicted in the table below, the annual utilization trend line generally reflected reality for the five Fiscal Years 2019 through 2023. The increased utilization rates reported for Fiscal Years 2022 and 2023 followed both the return from the pandemic-induced social distancing and the substantial rate increases paid to nursing agencies for the delivery of nursing services.

Fiscal Year	**Utilization Rates***
FY19	48%
FY20	51%
FY21	29%
FY22	34%
FY23	40%

* Annual percentage of individuals who received 80% of authorized hours

Multiple factors contribute to inaccurate annual utilization rates. Virginia continued to use the number of authorized hours to represent the number of needed hours, and the number of nursing hours billed to represent the number of nursing hours delivered. These two factors contribute to lower than actual utilization rates. For example, some individuals receive more authorized hours than they need, in case of potential health challenges or agency scheduling issues, while others receive nursing hours that are not billed to the Commonwealth. Two more factors contribute to annual utilization rates being too high. For example, some individuals who need nursing services do not receive any authorized hours because a nursing agency is not available to deliver them, and other individuals who need nursing do not have the need identified in their ISPs. Virginia has not studied the extent to which each of these factors skews the reported nursing utilization rates.

See Appendix E for the consultants' full report.

Conclusion

Regarding Provision III.D.1.'s three remaining Compliance Indicators, 18.2, 18.6 and 18.9, the Commonwealth did not continue to meet the requirements of Indicator 18.2, which had been achieved for the first time in the prior Period. Virginia has now met the requirements of Indicator 18.6 twice consecutively. However, the Commonwealth has once again failed to achieve Indicator 18.9.

Therefore, Virginia remains in Non-Compliance with this Provision.

6. Services for Individuals with Complex Medical Support Needs

Background

The Twenty-third Period's Individual Services Review (ISR) study had determined that, for the cohort of 36 individuals with IDD reviewed, the Commonwealth had again not met the requirements of Provision III.D.1's Indicator 18.9 or Provision V.B.'s Indicator 29.20. This review's findings were consistent with those of previous ISR studies of individuals with IDD with complex medical support needs.

For Indicator 18.9, of the 24 people in the ISR study's randomly selected sample, only 42% had received at least 80% of the number of authorized hours, falling significantly short of the 70% required by the Indicator. The ISR study had found that the lack of needed in-home nursing care was an obstacle to meeting these individuals' intense healthcare support needs. Of the six people who needed these services but did not receive them, their families and/or sponsors cited the lack of nursing supports as a serious concern.

For Indicator 29.20, only 65% of the cohort with dental coverage had received an annual dental exam, well below this Indicator's 86% benchmark.

Twenty-fourth Period Study

For this latest review, the Independent Reviewer retained the same consultants as previously to conduct another ISR study, designed as a two-phase, year-long review to assess Virginia's status in meeting Provision V.D.2.a.-d.'s Indicator 36.8, which has not yet been achieved. ISR studies, led by highly qualified and experienced nurses and a Team Leader, have now taken place in each of the 24 Periods of the Consent Decree.

The first phase of the latest study was run in conjunction with DBHDS's own review of its pilot Intense Management Needs Review (IMNR) process and had two purposes: the primary one to determine the adequacy of the IMNR, specifically related to individuals with DD Waiver services who have complex health support needs. The secondary purpose was to identify possible positive and/or concerning areas related to the delivery of needed nursing services (Provision III.D.1's Indicator 18.9) and the receipt of annual physical and dental exams (Provision V.B.'s Indicator 29.20).

This Period's ISR study and DBHDS's pilot IMNR review focused attention on individuals with SIS level 6 needs (i.e., complex medical needs), who were involved in annual meetings from April – September 2023 to develop their Individual Supports Plan (ISPs). A stratified sample of 30 individuals with IDD was then randomly selected to include ten people from each of three of the five Regions. Although the intensity and frequency of the specific medical conditions varied among the sample of individuals, they shared many similar diagnoses and mobility impairments.

In several important respects, DBHDS's IMNR review replicated the work of the consultants' ISR study. Each review utilized a Monitoring Questionnaire with written Interpretive Guidelines, conducted on-site interviews with a primary caregiver with knowledge of the relevant

health care services, made observations of the person and their residential setting, and collected and analyzed facts from both the individual's health care records and the site visit itself.

The studies were conducted in parallel to ensure that the newly designed and implemented IMNR process reliably determined the same significant health management concerns as the ISR review.

Both studies' monitoring processes utilized similar tools and methodologies, and were conducted by qualified clinicians overseen by experienced supervisors who collaborated throughout the reviews' timeframes. It was understood, right from the start, that the randomly selected sample was not large enough to generalize findings for any Compliance determinations.

Key Points

- DBHDS's IMNR nurse reviewers and their supervisor were highly experienced, well qualified and performed exceptionally well. The health needs management issues and concerns identified by the two studies were generally aligned, as were the problems that required urgent attention. In such instances, the Department was highly responsive and took appropriate and decisive action.
- The 66.7% nursing utilization rate for the individuals studied was below Indicator 18.9's 70% benchmark. In addition, both the ISR and DBHDS's IMNR studies identified factors that contributed to the calculation of an inaccurate annual nursing utilization rate.
- As well as a low nursing utilization rate, many families, even those who received 80% of authorized hours reported ongoing problems related to the inconsistency and unreliability of nursing services.
- The potentially serious, even grave, consequences of the failure to provide adequate and reliable nursing services cannot be overstated, especially given the responsibilities managed by families as they care for their relative with complex medical support needs.
- DBHDS should make systemic improvements to case managers' use of the Onsite Visit Tool (OSVT). Of the individuals studied, case managers rarely identified significant health issues or took action to improve the management of needs. These relate to previously known risks being adequately addressed and previously unknown risks being identified, including the failure to receive adequate nursing services.
- Progress was evident regarding Indicator 29.20: 97% of the selected sample received an annual physical exam. However, adequate dental care was still lacking as evidenced by 11 (37%) of the 30 individuals not having had an annual dental exam. Once again, two

major obstacles remained: the lack of dentists who accepted Medicaid and/or who provided needed sedation.

- DBHDS identified several needed refinements, including producing more consistent findings in its IMNR Monitoring Questionnaire and Interpretive Guidelines, ensuring the involvement and approval of the individual's guardian/Authorized Representative before implementing any remediation plans for identified issues, and gathering more factual information regarding the interface between the Individual Education Plan (IEP) and the ISP process.
- Case managers need to provide multicultural families with more information and support to navigate the service system.

The second phase of these parallel ISR and IMNR studies will be conducted during the Twenty-Fifth Period and will review a different stratified sample of 30 individuals, including ten from each of the remaining two Regions. They will also review and verify whether the Commonwealth has implemented a systemic process to remedy identified concerns from this current phase by developing corrective actions, tracking the efficacy of these actions and making revisions as necessary to address any deficiencies.

See Appendix F for the consultants' full report.

Conclusion

Overall, as mentioned above, the randomly selected sample was not large enough to generalize findings to determine the extent to which Virginia has achieved or failed to meet the requirements of Provision V.D.2.a.-d.'s Indicator 36.8, Provision III.D.1's Indicator 18.9 and Provision V.B.'s Indicator 29.20.

Regarding Provision V.D.2.a.-d.'s Indicator 36.8, the ISR study verified that the Commonwealth's IMNR process adequately identified health management needs for the sample studied and that when one of those needs required urgent attention, Virginia took immediate action.

DBHDS's IMNR process holds significant promise for the Commonwealth's efforts to collect and analyze data related to individuals with complex medical support needs.

7. Quality and Risk Management

Background

At the time of the previous Twenty-third Period study, seven Provisions, V.B., V.C.1., V.C.4., V.D.1., V.D.2., V.D.3. and V.D.4., and their remaining 59 Compliance Indicators specified the Agreement's requirements for Virginia's Quality and Risk Management (QRM) system.

Provision V.B.

Regarding Provision V.B.'s 23 remaining Compliance Indicators, namely 29.1, 29.2, 29.4, 29.8, 29.10, 29.13, 29.14, 29.16–29.30 and 29.33, the Commonwealth had met the requirements of four of them (29.2, 29.4, 29.19 and 29.27) twice consecutively, and had moved another nine Indicators (29.1, 29.8, 29.10, 29.14, 29.26, 29.28–29.30 and 29.33) from conditionally met to fully met. Virginia had achieved an additional two Indicators, 29.23 and 29.25, for the first time. However, the Commonwealth had not achieved eight Indicators, 29.13, 29.16–29.18, 29.20–29.22 and 29.24, and therefore had remained in Non-Compliance with this Provision.

Virginia had not achieved Indicator 29.13: this previous study had found that DBHDS's Risk Management Review Committee (RMRC) did not review data and identify trends related to allegations of abuse, neglect and exploitation. As required by Indicator 29.16, the RMRC had not fully evaluated whether providers were implementing timely, appropriate Corrective Action Plans (CAPs). The Commonwealth had also not achieved Indicator 29.17: given the newness of its revised process, the RMRC did not yet have sufficient data and information to identify trends at least quarterly. As well, Indicator 29.18's requirements were not met, as Virginia had failed to achieve the 86% threshold.

For Indicators 29.20 and 29.21, DBHDS had not achieved the 86% benchmarks. Annual physical exams had only been completed for 76% of people supported in residential settings. Dental exams had only been completed for 59% of those with coverage, and only 74% of people with identified behavioral support needs had been provided adequate and appropriately delivered services.

Regarding the 95% performance measure for Indicators 29.22 and 29.24, DBHDS did not achieve Indicator 29.22 since the Department did not submit a data report to evidence the required compliance. For Indicator 29.24, DBHDS had failed to meet the 95% benchmark because only 88.7% of individual service recipients were adequately protected from serious injuries in service settings.

DBHDS had achieved Indicators 29.23 and 29.25 for the first time. Respectively, 98% of individual service recipients were free from neglect and abuse by paid support staff, and for 99% of individual service recipients, seclusion or restraints were only utilized after a hierarchy of less restrictive interventions were tried.

Provision V.C.1.

Regarding Provision V.C.1.'s four remaining Compliance Indicators, namely 30.4, 30.7, 30.10 and 30.11, the Commonwealth had met the requirements of two of them, 30.7 and 30.11, twice consecutively. However, Virginia had not achieved the other two Indicators, 30.4 and 30.10, and therefore had remained in Non-Compliance with this Provision.

DBHDS had provided documentation for Indicator 30.4 that showed 98.4% of its licensed providers of DD services had been assessed for their compliance with the Licensing Regulations' risk management requirements during their annual inspections. While this percentage was higher than this Indicator's 86% performance measure, the consultants' review of documentary evidence from a sample of 25 licensed providers had found agreement with only 52% of the sample. Since the Twenty-third Period study could verify the accuracy of only 52% of the Licensing Specialists' determinations, the Commonwealth had once again not met the requirements of this Indicator.

Once again, Virginia had failed to meet the requirements of Indicator 30.10. The same review of sampled provider documents conducted for Indicator 30.4 could not confirm that DBHDS had sufficiently identified the need for CAPs to be written and implemented for all providers, including CSBs, that had not met the requisite standards. This sample review could not verify that providers had used data at the individual and provider level, including from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as in the associated findings and recommendations.

Provision V.C.4.

Regarding Provision V.C.4.'s remaining three Compliance Indicators, namely 32.3, 32.4 and 32.7, the Commonwealth had met the requirements of one of them, 32.3, twice consecutively, and had achieved the other two Indicators, 32.4 and 32.7, for the first time. Therefore, Virginia had achieved Compliance with this Provision for the first time.

DBHDS had met Indicator 32.4 for the first time. The Department had implemented the required processes for providers determined as non-compliant with training and expertise for staff responsible for the risk management function. This previous review of the Commonwealth's documentation had confirmed that 95% of the Office of Licensing (OL) CAPs issued to providers had been completed.

Virginia had also achieved the requirements of Indicator 32.7 for the first time. The Twenty-third Period study had confirmed that the RMRC had used data and information from risk management activities, including mortality reviews, to identify topics for future content. The Committee had reviewed risks identified as potential concerns, and had developed additional educational content to address these concerns. DBHDS had identified providers in need of additional technical assistance or other corrective action, and had continued to post on its website substantial guidance for providers and others related to risk management.

Provision V.D.1.

Regarding Provision V.D.1.'s remaining six Compliance Indicators, namely 35.1, 35.3 and 35.5–35.8, the Commonwealth had met the requirements of one of them, 35.6, twice consecutively. However, Virginia had not achieved the other five Indicators, 35.1, 35.3, 35.5, 35.7 and 35.8, and therefore had remained in Non-Compliance with this Provision.

Regarding Indicators 35.1, 35.3 and 35.5, the Quality Review Team (QRT) did not meet to review quarterly data or to develop and/or monitor needed remediation, as required for each of its DD Waivers. DBHDS had reported that the QRT had undergone a transfer of ownership to DMAS, and therefore no QRT meetings had occurred during the transition.

For Indicator 35.7, the Commonwealth had again not met its requirements. DBHDS had not provided evidence to show that a local level or Community Services Board (CSB) annual review of the Waiver performance measures had occurred. As in previous Reports, the data submitted had been over 14 months old, and therefore had not been adequate or useful for CSB quality improvement committees to establish CSB-specific quality improvement activities.

For Indicator 35.8, the Twenty-third Period review found that only 83% of individuals assigned a Waiver slot were enrolled in a service within five months, per regulations. As a result, Virginia did not achieve this Indicator's 86% performance measure.

Provision V.D.2.

Regarding Provision V.D.2.'s eight Compliance Indicators, namely 36.1–36.8, the Commonwealth had met the requirements of one of them, 36.5, twice consecutively, and had moved another four Indicators (36.2, 36.4, 36.6 and 36.7) from conditionally met to fully met. Virginia had achieved the requirements of an additional two Indicators, 36.1 and 36.3, for the first time. The Commonwealth had not met one remaining Indicator, 36.8, and therefore had remained in Non-Compliance with this Provision.

Regarding Indicator 36.1. DBHDS had issued its *Data Quality Monitoring Plan Source System Report* that included, for 16 source systems, a summary of the improvements the Department had made in the previous year to its data validation controls, key documentation, manual data processing, user interface, and backend structure. Although these improvements had been sufficient to achieve the Indicator's minimum requirements, the study had found some remaining concerns that DBHDS should address, especially the failure of the assessment to address potential inter-rater reliability deficiencies and their impact on data validity and reliability.

DBHDS had fulfilled the requirements of Indicator 36.3 for the first time by putting in place a process to review and analyze results from the National Core Indicators (NCIs) and Quality Service Reviews (QSR) for meaningful quality improvements. The Quality Improvement Committee (QIC) had reviewed NCI and QSR data, discussed quality of services and individual level outcomes, and assigned subcommittees to review recommendations and to report back. The latest review had verified that the groups had each provided specific NCI and QSR feedback.

Once again, Virginia had not fulfilled the requirements of Indicator 36.8. DBHDS had provided relevant data with only one month remaining in the Twenty-third Period, resulting in insufficient time for the consultants and the Independent Reviewer to investigate and verify its quality. The Department had also made several potentially significant modifications to the previously proposed methodology that could impact the validity of the required sample. Additionally,

DBHDS's current methodology did not appear to fulfill this Indicator's corrective action requirements.

Provision V.D.3.

Regarding Provision V.D.3's remaining 14 Compliance Indicators, namely 37.1, 37.2, 37.5–37.7, 37.10, 37.12, 37.14, 37.16–37.18, 37.20, 37.22 and 37.24, the Commonwealth had achieved the requirements of one of them, 37.17, twice consecutively, and had moved another 12

Indicators, 37.1, 37.2, 37.5, 37.6, 37.10, 37.12, 37.14, 37.16, 37.18, 37.20, 37.22 and 37.24, from conditionally met to fully met. Virginia had met an additional Indicator, 37.7, for the first time, and therefore had achieved Compliance with this Provision for the first time.

The Twenty-third Period study had found that the Commonwealth had met the requirements of Indicator 37.7 for the first time. Each Performance Measure Indicator (PMI) had described completely and thoroughly the specific steps used to supply the numerator and denominator for calculation. The PMIs had detailed key elements needed to ensure the data collection methodology produces valid and reliable data.

Provision V.D.4.

Virginia had met Provision V.D.4.'s sole Compliance Indicator 38.1 for the first time, and therefore had achieved Compliance with this Provision for the first time. DBHDS had collected data from each of the sources specified and had also completed a source system review or update for 16 data sources.

Twenty-fourth Period Study

For this latest review, the Independent Reviewer retained the same consultants as previously to assess the status of the Commonwealth's achievement of the seven QRM Provisions and their 24 remaining Indicators which had not yet been achieved, either at all or twice consecutively. These are Provision V.B. (with ten remaining Indicators 29.13, 29.16–29.18 and 29.20–29.25), Provision V.C.1. (with two remaining Indicators 30.4 and 30.10), Provision V.C.4. (with two remaining Indicators 32.4 and 32.7), Provision V.D.1. (with five remaining Indicators 35.1, 35.3, 35.5, 35.7 and 35.8), Provision V.D.2. (with three remaining Indicators 36.1, 36.3 and 36.8), Provision V.D.3. (with one remaining Indicator 37.7) and Provision V.D.4. (also with one remaining Indicator 38.1). None of these Provisions had yet achieved Sustained Compliance.

Key Points for Provision V.B.

- For Indicator 29.13, the RMRC reviewed data and identified trends from allegations and substantiations of abuse, neglect, and exploitation, at least four times per year and met this Indicator's requirements for the first time.
- Regarding Indicator 29.16, DBHDS also met this Indicator's requirements for the first time. The latest study verified that the RMRC continued to oversee the look-behind process into serious incident reviews and follow up processes, including whether providers were implementing timely, appropriate CAPs. The Committee also reviewed trends at

least quarterly, recommended follow-up actions and quality improvement initiatives when necessary, and then tracked their implementation.

- For Indicator 29.17, even though DBHDS's revised look-behind process into reviews of allegations of abuse, neglect and exploitation addressed each of the required outcomes, the RMRC's data analysis was not sufficiently developed and implemented to demonstrate achievement of this Indicator.
- Regarding Indicator 29.18, Virginia has still not achieved its requirements, which involve meeting or exceeding the 86% threshold for all of the review process outcomes required by Indicators 29.16 and 29.17.
- For Indicator 29.20, DBHDS reported that it came close to, but still did not achieve the 86% metric for annual physical exams for people supported in residential settings. The Department reported that only 63%-64% of individuals with dental coverage received annual dental exams. This remains significantly below the required 86% benchmark, and so once again DBHDS failed to meet this Indicator.
- Regarding Indicator 29.21, out of 1,145 of people with identified behavioral support needs, just 729 (64%) received adequate and appropriately delivered services. Even though this latest study found gradual and steady improvement over recent Periods, this percentage still fell below this Indicator's required 86% performance measure.
- For Indicator 29.22, DBHDS reported that only 69% of its residential service recipients lived in a location that supports full access to the greater community. This latest study also found concerns regarding the validity of this measuring process, something that the Department will need to resolve. The Commonwealth did not achieve this Indicator's 95% benchmark.
- Regarding Indicator 29.23, DBHDS reported that more than 98% of individual service recipients were free from abuse, neglect and exploitation, surpassing the 95% performance benchmark for a second consecutive Period.
- For Indicator 29.24, even though DBHDS made significant revisions to its data collection methodology that uses serious incident information from the CHRIS reporting system, new and valid data regarding the percentage of people who were adequately protected from serious injuries in service settings was not available for review and verification. Therefore, Virginia did not meet this Indicator and its 95% threshold.
- Regarding Indicator 29.25, the consultants verified DBHDS's reported performance that for 99.9% of individual service recipients, seclusion or restraints were only utilized after a hierarchy of less restrictive interventions were tried, as outlined in human rights

committee-approved plans. The Commonwealth has now exceeded this Indicator's 95% requirement for a second consecutive Period.

Key Points for Provision V.C.1.

- For Indicator 30.4, the consultants' review of 40 licensing inspections conducted between January 1, 2024 and March 10, 2024 found that 82% complied with this Indicator. This reflected a significant improvement over the 52% found during the Twenty-third Period review, but still remained less than the 86% benchmark. Virginia again did not meet this Indicator.
- Regarding Indicator 30.10, previous studies have confirmed that DBHDS has regulations in place that require providers' risk management systems to report the incidence of common risks and conditions faced by people with IDD. However, based on the findings of a review of 40 licensing inspections of providers, evidence was insufficient that these systems consistently identified such incidences. In addition, there was also insufficient evidence that Licensing Specialists were accurately and consistently identifying when a provider was not meeting these regulatory requirements. Therefore, the Commonwealth once again did not achieve this Indicator.

Key Points for Provision V.C.4.

- For Indicator 32.4, DBHDS consistently implemented the required processes, and so achieved this Indicator for the second consecutive Period. The Department continued to assess providers' compliance in ensuring training and expertise for their staff responsible for the risk management function, i.e., reducing risks for people with IDD. For providers determined by DBHDS as non-compliant, the Department issued the necessary CAPs.
- Regarding Indicator 32.7, this Period's study again verified that the RMRC continued to meet monthly and reviewed relevant data, information and related processes associated with risk management, and so DBHDS met this Indicator for the second consecutive Period.

Key Points for Provision V.D.1.

- For Indicator 35.1, the Quality Review Team (QRT), whose ownership had transferred to DMAS, began to meet again and reviewed quarterly data. However, the Team did not develop and/or monitor remediation plans when Virginia's performance measures regarding systemic factors fell below the 86% threshold required by CMS. The Commonwealth has still not achieved the requirements of this Indicator.

- Regarding Indicator 35.3, Virginia met its requirements for the first time by establishing performance measures as required and approved by CMS for each of the specified areas, including health and safety and quality assurance.
- For Indicator 35.5, even though the Commonwealth collected and reviewed quarterly data reports for performance measures that had fallen below the 86% threshold, Virginia once again did not meet the requirements of this Indicator. DBHDS did not provide evidence that the QRT developed and/or adequately monitored written remediation plans with defined measures to monitor system performance, nor did the Team revise its improvement strategies if remediation actions did not have the required effect.
- Regarding Indicator 35.7, the Commonwealth also failed to meet the requirements of this Indicator. The QRT did not produce a timely report that met its own standard (i.e., within six months of the end of the Fiscal Year). The data continued to be inadequate for CSB quality improvement committees to establish meaningful and timely CSB-specific quality improvement activities. In addition, DBHDS did not provide evidence to show a local level or CSB review, at least annually, of the Waiver performance measures.
- For Indicator 35.8, once again Virginia did not meet its requirements. The most recently reported data showed that only 81% of individuals assigned a Waiver slot were enrolled in a service within five months. This was a decrease from the 83% reported in the previous review, and below the required 86% performance benchmark.

<u>Key Points for Provision V.D.2.</u>

- For Indicator 36.1, until DBHDS completes its next annual *Data Quality Monitoring Plan (DQMP) Source System Assessment*, which requires revision and needs to address previous concerns regarding the validity and reliability of QSR data, the compliance rating for this Indicator has been deferred until the Twenty-fifth Period review. This next DQMP update is scheduled to occur in September 2024.
- Regarding Indicator 36.3, even though DBHDS has a process in place to review and analyze the NCI and QSR results for quality improvement, the Department has not yet adequately reviewed the inter-rater reliability threats for QSR data sets. As well, since data from QSR Round 6 will not be available for validation until the next Twenty-fifth Period, the compliance rating for this Indicator has been deferred until the next review.
- For Indicator 36.8, the Commonwealth has still not met its requirements. DBHDS has not yet analyzed data on at least an annual basis, for a statistically valid sample, regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs. For one of these three groups, i.e., those with complex health/ medical support needs, the Department has developed and implemented a very

promising new annual monitoring process, the Intense Management Needs Review (IMNR). The IMNR, which largely mirrors the Individual Services Review (ISR) process, will be studied again as part of the next Twenty-fifth Period review.

Key Point for Provision V.D.3.

- Regarding Indicator 37.7, since DBHDS has not yet adequately reviewed the inter-rater reliability threats for QSR data sets, and Round 6 QSR data will not be available for validation until the Twenty-fifth Period, the compliance rating for this Indicator has been deferred until the next review.

Key Point for Provision V.D.4.

- For Indicator 38.1, DBHDS continued to collect and analyze data from its source systems, and its source system reviews remained current. The Department therefore achieved this Indicator's requirements for the second consecutive Period.

See Appendix I for the consultants' full report.

Conclusion

Regarding Provision V.B.'s 10 remaining Compliance Indicators, namely 29.13, 29.16–29.18, 29.20–29.25, Virginia has met the requirements of two of them (29.23 and 29.25) twice consecutively, and has achieved an additional two Indicators, 29.13 and 29.16 for the first time. However, the Commonwealth did not meet six Indicators, 29.17, 29.18, 29.20–29.22 and 29.24, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.C.1.'s two remaining Compliance Indicators, namely 30.4 and 30.10, Virginia has not achieved either of them, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.C.4.'s two remaining Compliance Indicators, namely 32.4 and 32.7, the Commonwealth has now met both of them twice consecutively. Therefore, Virginia has achieved Sustained Compliance with this Provision.

Regarding Provision V.D.1's five remaining Compliance Indicators, namely 35.1, 35.3, 35.5, 35.7 and 35.8, the Commonwealth has met the requirements of one of them, 35.3, for the first time. However, Virginia did not achieve the other four Indicators, 35.1, 35.5, 35.7 and 35.8, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.D.2.'s three remaining Compliance Indicators, namely 36.1, 36.3 and 36.8, the Commonwealth has again failed to achieve Indicator 36.8. Until Virginia has completed its next monitoring cycle and provides new data for review and analysis, the Independent Reviewer has deferred* any compliance rating for Indicators 36.1 and 36.3. The Commonwealth therefore remains in Non-Compliance with this Provision.

Regarding Provision V.D.3's one remaining Compliance Indicator 37.7, until Virginia has completed its next monitoring cycle and provides new data for review and analysis, the Independent Reviewer has deferred* any compliance rating for this Indicator or this Provision.

Regarding Provision V.D.4's sole Compliance Indicator 38.1, the Commonwealth has now met its requirements twice consecutively. Therefore, Virginia has achieved Sustained Compliance with this Provision.

* For deferred ratings, if the relevant Indicator was met in the previous review, and the next Twenty-fifth Period study finds it has also been achieved, a determination of met twice consecutively will be made.

8. Provider Training

Background

The Twenty-third Period review had focused on the one remaining Provision related to Provider Training, namely V.H.1., and its four outstanding Compliance Indicators, 49.2–49.4 and 49.12. Of these Indicators, Virginia had met the requirements of two of them, 49.2 and 49.3, for the first time during the Twenty-second Period, and had achieved these same two Indicators twice consecutively for the Twenty-third Period. The Commonwealth had not met the requirements of the other two Indicators, 49.4 and 49.12, and so had remained in Non-Compliance with this Provision.

Regarding Indicator 49.4, Virginia's newly reliable and valid data sets had documented that DBHDS had not met the Indicator's performance measures that at least 95% of Direct Support Professionals (DSPs) and their supervisors receive the required orientation and training, as well as competency training. The Department had reported that its Quality Service Review (QSR)

Round 5 process had determined that 77.8% of providers had met the orientation and training requirements, and that 85.3% had met the competency training requirements.

Likewise for Indicator 49.12, the newly reliable and valid data sets showed that DBHDS had not achieved this Indicator's 86% benchmark. The Department's Office of Licensing's (OL's) annual inspections had determined that for 2022, only 84.2% of providers had complied as required, and for approximately 75% of 2023 inspections completed by the time of the Twenty-third Period study, just 76.3% had complied.

Twenty-fourth Period Study

For this latest review, the Independent Reviewer retained the same consultant as previously to assess whether sufficient evidence existed to determine if the Commonwealth has achieved each of Provision V.H.1.'s two remaining Indicators, 49.4 and 49.12.

Key Points

- For Indicator 49.4, even though QSR Round 6 had begun, it was not scheduled for completion by the conclusion of this Period's review, hence no new data was available for analysis and findings. The Independent Reviewer therefore determined that a rating for this Indicator has been deferred.
- Regarding Indicator 49.12's two applicable regulatory requirements, for calendar year 2023, only 819 (74.1%) out of the 1,105 licensed providers met these requirements during OL's annual licensing inspection. OL also provided data from 427 of its annual licensing inspections that were completed between January 1 and March 10, 2024, which accounted for approximately 25% of the total licensees. Within this group, 301 (just 70.5%) of licensed providers met this Indicator's requirements. Since both these results fell below the 86% performance measure, this Indicator remained unmet.

See Appendix H for the consultant's full report.

Conclusion

Regarding Provision V.H.1's Compliance Indicator 49.4, until Virginia completes its current QSR Round 6 process and provides new data for review and analysis, the Independent Reviewer has deferred its rating. For Compliance Indicator 49.12, the Commonwealth has not met its requirements. Therefore, Virginia remains in Non-Compliance with this Provision.

9. Quality Improvement Programs

Background

As of the Twenty-third Period review, three Provisions, V.E.1.–V.E.3., and their associated eight remaining Indicators specified the Agreement's requirements for Quality Improvement (QI) Programs.

Regarding Provision V.E.1.'s remaining three Compliance Indicators, namely 42.3–42.5, the study showed that Virginia had met one Indicator, 42.3, for the first time. The Commonwealth had also achieved Indicator 42.5's requirements twice consecutively. However, Virginia had still not met Indicator 42.4, and had therefore remained in Non-Compliance with this Provision.

For Indicator 42.3, the review had found that DBHDS had demonstrated that at least 86% of its licensed providers of DD services had been assessed for their compliance with the applicable regulations during their annual inspections. However, the Department had still not achieved Indicator 42.4's 86% benchmark for its licensed providers to comply with these same regulations.

Regarding Provision V.E.2.'s remaining three Compliance Indicators, namely 43.1, 43.3 and 43.4, the Commonwealth had met the requirements of all of them for the first time, and so Virginia had achieved Compliance with this Provision for the first time.

DBHDS had continued to collect and report data for community integration, as well as for 12 surveillance measures related to negative aspects of health and safety that come from provider critical incident reporting. The Department had also notified its DD providers of its expectations regarding provider risk management programs and related reporting measures. In addition, DBHDS had supplied links to appropriate tools that specified the parameters for collecting this data. Overall, the Department's data collection and reporting adequately conformed to the Agreement's requirements.

For Provision V.E.3.'s two Compliance Indicators, namely 44.1 and 44.2, the Commonwealth had met Indicator 44.1's requirements for the first time. However, Virginia had not met Indicator 44.2, and therefore remained in Non-Compliance with this Provision.

Regarding Indicator 44.2, the Twenty-third Period study could not confirm that any of 15 vendor-issued QI programs that the Quality Service Reviews (QSR) process had reviewed had sufficiently addressed the providers' QI deficiencies, or had identified the needed remediation or

the need for technical assistance. While the consultants' sample size was small, the finding was universal, and had called the QSR data for this Indicator into question. The Independent Reviewer had previously identified concerns regarding the adequacy of DBHDS's QSR inter-rater reliability process, and its potential threat to the validity and reliability of QSR data. The Department was advised to further examine its related *Process Documents* and *Attestations* for this QSR data set to ensure it had adequately identified and addressed these concerns.

Twenty-fourth Period Study

For the latest review, the Independent Reviewer retained the same consultants to assess the status of the Commonwealth's three QI Programs Provisions, V.E.1.–V.E.3., none of which has yet achieved Sustained Compliance. This study focused on a total of seven Indicators (42.3, 42.4, 43.1, 43.3, 43.4, 44.1 and 44.2) that had either remained unmet or had not been achieved twice consecutively.

Key Points for Provision V.E.1.

- DBHDS continued to meet Indicator 42.3. From its Fiscal Year 2023 inspections, the Department's Office of Licensing (OL) assessed 1,077 (96%) of 1,121 providers on all elements of the licensing regulatory requirements related to Quality Improvement, and so surpassed the 86% benchmark for the second consecutive Period.
- For Indicator 42.4, DBHDS again failed to meet the requirement for licensed providers to comply with 86% of the 11 elements of the licensing regulations: the Department reported that providers met only four of these elements. DBHDS did meet the Indicator's requirement that providers be cited for violation of any sub-regulation and that a Corrective Action Plan (CAP) to address the violation be implemented.

Key Points for Provision V.E.2.

- Regarding Indicators 43.1, 43.3 and 43.4, new information was not available since the previous Twenty-third Period review was conducted. In addition, Virginia did not update its *Process Document* and *Attestation*. Until DBHDS completes its next monitoring cycle and provides new data sets for validation purposes, compliance ratings for these three Indicators have been deferred until the Twenty-fifth Period review.

Key Points for Provision V.E.3.

- For Indicators 44.1 and 44.2, new information was not available since the previous Twenty-third Period review was conducted. In addition, the Commonwealth did not update its *Process Document* and *Attestation* to address previously identified inter-rater

reliability concerns. Until DBHDS completes its next monitoring cycle and provides new data sets for validation purposes, compliance ratings for these two Indicators have been deferred until the Twenty-fifth Period review.

See Appendix I for the consultants' full report.

Conclusion

Regarding Provision V.E.1.'s two remaining Compliance Indicators 42.3 and 42.4, Virginia has now met Indicator 42.3's requirements twice consecutively. However, the Commonwealth has still not met Indicator 42.4, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.E.2.'s remaining three Compliance Indicators, namely 43.1, 43.3 and 43.4, until Virginia has completed its next monitoring cycle and provides new data for review and analysis, the Independent Reviewer has deferred* any compliance rating for these Indicators and this Provision.

Regarding Provision V.E.3.'s two Compliance Indicators, namely 44.1 and 44.2, until the Commonwealth has completed its next monitoring cycle and provides new data for review and analysis, the Independent Reviewer has deferred* any compliance rating for these Indicators. Virginia therefore remains in Non-Compliance with this Provision.

* Regarding deferred ratings, if the relevant Indicator was met in the previous review, and the next Twenty-fifth Period study finds it has also been achieved, a determination of met twice consecutively will be made.

10. Mortality Reviews

Background

Regarding Mortality Reviews Provision V.C.5, two Compliance Indicators, namely 33.13 and 33.15, had remained to be studied as part of the previous Twenty-third Period Report. That review had determined that the Commonwealth had achieved Compliance with this Provision for the first time. Virginia had met the requirements of Indicator 33.13 for the Twenty-second Period, and for the last Period, the Commonwealth had again met Indicator 33.13 and had also met Indicator 33.15. Therefore, Virginia had achieved Compliance with this Provision for the first time.

Twenty-fourth Period Study

For the latest review, the Independent Reviewer retained the same consultant to assess the status of the Commonwealth's achievement of Provision V.C.5.'s sole remaining Indicator, 33.15, which had not yet been met twice consecutively, and therefore the Provision had not yet achieved Sustained Compliance.

Key Point

- This study verified that the Mortality Review Committee (MRC) prepared and delivered to the DBHDS Commissioner, as required, a report of deliberations, findings and recommendations, if any, for 92% of deaths necessitating review within 90 days of the death. The Committee also documented any recommendations or whether it elected not to make any recommendations. Virginia therefore achieved Indicator 33.15 again.

See Appendix G for the consultant's full report.

Conclusion

Regarding Provision V.C.5's remaining Compliance Indicator 33.15, the Commonwealth has now met its requirements twice consecutively, and so has achieved Sustained Compliance with this Provision.

11. Public Reporting

Background

Two Public Reporting Provisions, V.D.6. and IX.C., and their associated nine Indicators were studied as part of the Twenty-third Period review.

Provision V.D.6.'s five Compliance Indicators, namely 41.1–41.5, were all fully met, and so the Commonwealth had achieved Compliance with this Provision for the first time. Four of these Indicators, 41.1–41.4, had been conditionally met as a result of the previous Twenty-first Period review, and one Indicator, 41.5 had been achieved for the first time.

Provision IX.C.'s four Compliance Indicators, namely 54.1–54.4, were also all met for the first time, and so Virginia had achieved Compliance with this Provision for the first time as well.

Twenty-fourth Period Study

For the latest study, the Independent Reviewer retained the same consultants as before to assess the current status of the two Public Reporting Provisions, V.D.6. and IX.C. For Provision V.D.6., only Indicator 41.5 remained for review, having been met for the first time as a result of the last study. For Provision IX.C., four Indicators (54.1–54.4) remained, all having been achieved last time.

Key Points

- Regarding Provision V.D.6.'s Indicator 41.5, DBHDS made sufficient required data and reporting available to the public on the Department's website and/or the Settlement Agreement Library website. In response to a previous study's finding that the *Record Index Reference Tool (Record Index)* needed to be more clearly visible, DBHDS also made some enhancements to their processes so that the public could more easily access the information. The Commonwealth met this Indicator's requirements for a second consecutive Period.
- For the four Indicators associated with Provision IX.C, namely 54.1–54.4, this study found that Virginia met all of them for the second consecutive time. The *Record Index* was available on the Library's Record Index page, and DBHDS posted information about the *Record Index* in a prominent area on the Welcome page so that users could be aware of this tool and how to use it immediately on entry to the website. The Department also expanded the *Record Index* to include more than 900 current and archived documents, and specified the required components for each of the current and archived documents listed.

See Appendices I for the consultants' full reports.

Conclusion

Regarding Provision V.D.6.'s sole remaining Compliance Indicator 41.5, Virginia has now met its requirements twice consecutively. Therefore, the Commonwealth has achieved Sustained Compliance with this Provision.

Regarding Provision IX.C.'s four Compliance Indicators, namely 54.1–54.4, Virginia has now met the requirements of all of them twice consecutively. Therefore, the Commonwealth has achieved Sustained Compliance with this Provision.

III. CONCLUSION

During the Twenty-fourth Review Period, Virginia, through its lead agencies DBHDS and DMAS, and their sister agencies, continued its diligent efforts and progress toward fulfilling the requirements of the remaining Provisions of the Agreement.

Of the 60 Compliance Indicators studied this time, the Commonwealth had previously met 29. As a result of the Twenty-fourth Period reviews, Virginia achieved an additional four Indicators for the first time, but did not fulfill one Indicator that had been met before, i.e., 18.2. For another 13 Indicators, since Virginia had not completed various monitoring cycles since the Twenty-third Period studies, the Commonwealth could not provide new data for review and analysis. The Independent Reviewer therefore deferred rating these Indicators until the next Twenty-fifth Period review.

In total, the Commonwealth has now achieved the requirements of 32 of the 60 outstanding Indicators, either for the first time or twice consecutively, resulting in coming into Compliance with eight Provisions for the first time. These newly sustained Provisions primarily reflect stable accomplishments across structural and functional aspects of the Commonwealth's statewide service system.

This Period's reviews determined that 28 Compliance Indicators still remain unmet. Most of these involve service outcomes for individuals with IDD. For this group of people, despite some progress and improvement, the Commonwealth continues to fall short of the Consent Decree's requirements to provide adequate and/or appropriately delivered services.

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

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

IV. RECOMMENDATIONS

The Independent Reviewer recommends that the Commonwealth undertake the 11 actions listed below, and provide a report that addresses these recommendations and their status of implementation by September 30, 2024. Virginia should also consider the additional recommendations and suggestions included in the consultants' reports, which are contained in the Appendices.

Individual and Family Support Program and Family-to-Family and Peer Programs

1. DBHDS should track its outcome data to provide another measure of effectiveness for the peer and family mentoring programs. This data should be analyzed, and findings should be considered for quality improvements to these programs, as described in Indicators 19.2 and 19.3.

Crisis and Behavioral Services

2. DBHDS should conduct a root-cause analysis of the reasons that the Commonwealth has not made substantial progress completing crisis assessments in individuals' homes, as required by Indicator 7.8. This analysis should consider the factors that have led to success in some Regions as well as the challenges that are present in the most underperforming Regions. Virginia should implement a plan to significantly improve entire statewide performance, monitor the efficacy of the plan's strategies and actions, and then make revisions as necessary.

Integrated Day Activities

3. The Commonwealth should incentivize the delivery of integrated Community Engagement (CE) services versus Group Day Support programs. Virginia should increase its reimbursement rate to those agencies that provide CE services and require that the pay rates for direct support staff providing these integrated services be increased. The Commonwealth should also identify and acknowledge the provider agencies that have successfully converted to delivering CE services and the residential agencies that offer these services to their residents, and ensure that these agencies have regular opportunities to share how they have accomplished and are sustaining this transformation.

4. DBHDS should ask its providers what barriers exist that prevent them from providing CE services to more individuals. The Department should then develop and implement a plan to address the most impactful barriers.

Community Living Options

5. The Commonwealth should conduct a root-cause analysis of the adequacy of the nursing services provider rates that were based on the 2020 mid-market rates. This analysis should consider the impact of these current below-market rates on nursing services providers' ability to meet Indicator 18.9's nursing utilization performance measure. Virginia should implement quality improvement initiative(s) that address primary obstacles to achieving this.

Quality and Risk Management/Quality Improvement Programs

6. The Commonwealth should implement a dental care improvement initiative that addresses the lack of dentists who accept Medicaid and the lack of dentists who provide needed sedation.

7. DBHDS's Office of Licensing should continue to encourage providers to utilize the Excel-based incident tracking tool template that was made available in 2023. It was designed to more fully structure incidence data analysis specific to the common risks and conditions faced by people with IDD that contribute to avoidable deaths, as required by Indicator 30.10.

8. For Compliance Indicators 35.1 and 35.5, the Commonwealth's Quality Review Team (QRT) should work with DBHDS to obtain and review relevant data to ensure the adequate development of written remediation plans that focus on systemic factors. The plans should include specific strategies to be employed, as well as the defined measures that will be utilized to monitor performance. If, based on the QRT's assessment, the Department's proposed plans do not sufficiently address the remedial needs, the QRT should either develop their own plans and/or request appropriate modifications to DBHDS's plans.

9. For Compliance Indicator 36.1, DBHDS should address the continuing concerns regarding the validity and reliability of Quality Services Review (QSR) data, including potential inter-rater reliability deficiencies impacting all QSR data sets. This recommendation also applies to other Indicators that rely on QSR data sets, i.e., residential compliance (Indicator 29.22), use of QSR data for analysis and quality improvement (Indicator 36.3), Performance Measure Indicator (PMI) data quality (Indicator 37.7), provider reporting measures (Indicators 43.1. 43.3 and 43.4), and provider quality improvement programs (Indicators 44.1 and 44.2).

Public Reporting

10. To make its Library of documents more accessible to the public, DBHDS should follow a consistent naming or organizational protocol in the *Record Index* to allow listed documents to be more easily located. The Department should also consider posting the Virginia-specific National Core Indicator (NCI) reports on the Library itself, rather than simply providing a link to the NCI website.

11. To make critically important data regarding individuals with IDD more easily understandable, the Library should include graphics that show simple trends over time for outcome measures. These include Indicators 7.8 (crisis assessments), 7.18 (behavioral referral within 30 days), 10.4 (placement after crisis stabilization), 14.10 (integrated day activities), 18.9 (nursing), 29.20 (annual dental exam), 29.21 (adequate behavioral services), and 35.8 (Waiver service within five months).

V. SUMMARY OF COMPLIANCE

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III	**Serving Individuals with Developmental Disabilities in the Most Integrated Setting**	Ratings prior to the 24th Period are not in bold. Ratings for the 24th Period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include the Commonwealth's status with each of the Compliance Indicators associated with the Provision. The Findings Section and attached consultant reports include explanatory information regarding the Compliance Indicators. *The Comments in italics below are from a prior period when the most recent compliance rating was determined.*
III.C.1.a.i.-ix.	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community according to the… schedule (in i-ix).	Sustained Compliance	*The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012–2021.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.1.b.i.-x.	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community, individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) according to the …schedule (in i.-x.)	Sustained Compliance	*The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012-2021.* *The Parties agreed to consider the effectiveness of the discharge and transition process at Nursing Facilities (NFs) and ICFs as an indicator of compliance for III.D.1.*
III.C.1.c.i.-x.	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) according to the … schedule (in i-x).	Sustained Compliance	*See Comment re: III.C.1.b.i-ix.*
III.C.2.a.-i.	The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2021, a minimum of 1,000 individuals will be supported.	Compliance **Sustained Compliance**	The Commonwealth again met the one remaining Indicator 1.1, achieving Sustained Compliance for the first time.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.5.a.	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	Sustained Compliance	*207 (100%) of the individuals reviewed in the Individual Services Review studies during the 10th, 11th, 12th, 13th, 14th, 15th, 16th, 18th., and 20th Periods had case managers and current Individual Support Plans.*
III.C.5.b.	For the purpose of this agreement, case management shall mean:		
III.C.5.b.i.	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	Non Compliance **Deferred ***	Of the four remaining Indicators studied this Period, Virginia met one, namely, 2.3. The rating determination for 2.16, 2.18 and 2.20 is deferred., therefore the Commonwealth remains in Non-Compliance.
III.C.5.b.ii.	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP.	Non Compliance Non Compliance	*When Virginia achieves the Indicators for III.C.5.b.i., it also achieves compliance for this Provision.*
III.C.5.b.iii.	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	Non Compliance Non Compliance	*When Virginia achieves the Indicators for III.C.5.b.i., it also achieves compliance for this Provision.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.5.c.	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	Sustained Compliance	*The Independent Reviewer and Parties agreed in April 2020 that this provision is in Sustained Compliance.*
III.C.5.d.	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	Compliance Sustained Compliance	*The Commonwealth has met all six Compliance Indicators, 6.1a, 6.1b, 6.1, 6.2, 6.3, and 6.4. Virginia has achieved Sustained Compliance.*
III.C.6.a.i.-iii.	The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall: i. Provide timely and accessible support … ii. Provide services focused on crisis prevention and proactive planning … iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current placement whenever practicable.	Non Compliance **Non Compliance**	Of the remaining three Compliance Indicators, the Commonwealth met one of them 7.19, but did not meet 7.8 and 7.18 and therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.i.A.	The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.	Sustained Compliance	*CSB Emergency Services are utilized. Regional Education, Assessment, Crisis Services, Habilitation (REACH) hotlines are operated 24 hours per day, 7 days per week, and provide access to information for adults and children with IDD.*
III.C.6.b.i.B.	By June 30, 2012, the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.	Sustained Compliance	*REACH trained CSB staff during the past seven years. The Commonwealth requires that all Emergency Services (ES) staff and case managers are required to attend training.*
III.C.6.b.ii.A.	Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.	Compliance **Sustained Compliance**	Of the remaining one Compliance Indicator, the Commonwealth again met Indicator 8.4 and achieved Sustained Compliance for the first time.
III.C.6.b.ii.B.	Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting.	Non Compliance Non Compliance	*The Parties agreed that the Indicators for III.C.6.a.i.-iii. and III.C.6.b.ii.A. cover this provision.*
III.C.6.b.ii.C.	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement.	Sustained Compliance	*During the 19th–22nd Review Periods, law enforcement personnel were involved. Mobile crisis team members worked with law enforcement personnel to respond regardless of whether REACH staff responded in person or remotely using telehealth.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.ii.D.	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	Sustained Compliance	*REACH Mobile crisis teams for children and adults are available around the clock and respond on-site, or remotely due to COVID precautions, at all hours of the day and night.*
III.C.6.b.ii.E.	Mobile crisis teams shall provide local and timely in-home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	Sustained Compliance	*In each Region, the individuals are provided in-home mobile supports, or telehealth due to COVID precautions, for up to three days as required. Days of support provided ranged between a low of one and a high of sixteen days.*
III.C.6.b.ii.H.	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time.	Sustained Compliance	*The Commonwealth added staff to REACH teams in all five Regions and for five years demonstrated a sufficient number of staff to respond to on-site crises within the required average annual response times. Appropriate COVID precautions temporarily replaced many on-site responses.*
III.C.6.b.iii.A.	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services.	Sustained Compliance	*All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults and have two crisis stabilization homes for children.*
III.C.6.b.iii.B.	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.	Non Compliance **Non Compliance**	Of the remaining one Compliance Indicator, the Commonwealth did not achieve 10.4. and therefore remains in Non-Compliance.
III.C.6.b.iii.D.	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	Non Compliance **Compliance**	The Commonwealth achieved sole Indicator 11.1, and therefore has achieved Compliance for the first time.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.iii.E.	With the exception of the Pathways Program at SWVTC … crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.	Compliance **Non Compliance**	The Parties agreed that the Indicators for III.C.6.b.iii.G. cover this Provision.
III.C.6.b.iii.F.	By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.	Sustained Compliance	*Each Region developed and currently maintains a crisis stabilization program for adults with IDD in each Region and has two programs for children.*
III.C.6.b.iii.G.	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	Compliance **Non Compliance**	Of the remaining one Indicator, the Commonwealth did not achieve 13.3 and therefore is in Non Compliance.
III.C.7.a.	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	Non Compliance **Non Compliance**	Of the remaining three Compliance Indicators, the Commonwealth did not achieve 14.8–14.10 and therefore remains in Non-Compliance. The Court removed Indicators 14.2-14.7**

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

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.7.c.	Regional Quality Councils (RQC), described in V.D.5. … shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly … Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	Sustained Compliance	*RQCs did complete a quarterly review of employment data and consultation as required.*
III.C.7.d.	The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.	Sustained Compliance	*RQCs did complete a quarterly review of employment data but did not document discussions with the RQCs regarding employment targets.*
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	Sustained Compliance	*Of the remaining two Compliance Indicators, the Commonwealth met both 16.2 and 16.8 in both the 22nd and 23rd Periods and therefore has achieved Sustained Compliance for the first time.*
III.C.8.b.	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access	Sustained Compliance	*The Commonwealth again met the two Compliance Indicators 17.1 and 17.2 and therefore has Sustained Compliance.*
III.D.1.	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	Non Compliance **Non Compliance**	Of the remaining six Compliance Indicators, the Commonwealth met five of them, 18.2–18.6, but did not meet Indicator 18.9 and therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.D.2.	The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources.	Sustained Compliance	*As of 12/31/21, the Commonwealth had created new options for 1,872 individuals who are now living in their own homes. This is 1,531 more individuals than the 341 individuals who were living in their own homes as of 7/1/15.*
III.D.3.	Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments.	Sustained Compliance	*The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies.*
III.D.3.a.	The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations ...	Sustained Compliance	*DBHDS has a dedicated housing service coordinator. It has developed and updated its housing plan with these representatives and with others.*
III.D.3.b.i.-ii.	The plan will establish for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement: Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and recommendations to provide access to these settings during each year of this Agreement.	Sustained Compliance	*Virginia estimated the number of individuals who would choose independent living options. It established the required baseline, updated and revised the Plan with new strategies and recommendations, and tracks progress toward achieving plan goals.*

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

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.A.	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	COMPLIANCE*	*For the one area of Non-Compliance previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for IV.A.*
IV.B.3.	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans reviewed were well organized and well documented.*
IV.B.4.	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	COMPLIANCE*	*For the one area of Non-Compliance previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for IV.B.4.*
IV.B.5.	The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan will be developed within 30 days prior to discharge.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision and its sub provisions a.-e., e.i. and e.ii. The discharge plans are well documented.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.5.a.	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes.	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.c.	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.d.	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes.	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	COMPLIANCE*	*See comment re: IV.B.5.*
IV.B.5.e.ii.	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	COMPLIANCE*	*See comment re: IV.B.5.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.6.	Discharge planning will be done by the individual's PST…Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	COMPLIANCE*	*For the one area of Non-Compliance previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for IV.B.6.*
IV.B.7.	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	COMPLIANCE*	*The Commonwealth's discharge plans indicate that individuals with complex/intense needs can live in integrated settings. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.9.	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	COMPLIANCE*	*The Individual Services Review studies determined that individuals and their authorized representatives, were provided with information regarding community options and had the opportunity to discuss them with the PST. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that Commonwealth had offered a choice of providers. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.9.b.	PSTs and the CSB case manager shall coordinate with the … community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	COMPLIANCE*	*The Individual Services Review studies determined that individuals and their authorized representatives did have an opportunity to speak with individuals currently living in their communities and their family members. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.9.c.	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	COMPLIANCE*	*The Individual Services Review studies determined that PSTs and case managers assisted individuals and their Authorized Representative. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.11.	The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	COMPLIANCE*	*The Individual Services Review studies determined that individuals /Authorized Representatives who transitioned from Training Centers were provided with information regarding community options. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.11.a.	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	COMPLIANCE*	*The Independent Reviewer confirmed that training has been provided.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.11.b.	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches … will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers.	COMPLIANCE*	*The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.B.15.	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	COMPLIANCE*	*See Comment for IV.D.3.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.C.1.	Once a specific provider is selected by an individual, the Commonwealth shall invite and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that provider staff participated in the pre-move ISP meeting and were trained in the support plan protocols. Interviews and documents reviewed indicate that this process remains in place at South Eastern Virginia Training Center (SEVTC).*
IV.C.2.	Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for discharge will be developed by the PST.	COMPLIANCE*	*The Independent Reviewer's Individual Services Review studies found that almost all individuals had moved within 6 weeks, or reasons were documented. Interviews and documents reviewed indicate that this process remains in place at SEVTC.*
IV.C.3.	The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring (PMM) Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.	COMPLIANCE*	*The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions.* *The Independent Reviewer's Individual Services Review studies found that PMM visits occurred. The monitors had been trained and utilized monitoring checklists.* *Interviews and documents reviewed indicate that this process remains in place at SEVTC.*

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

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	COMPLIANCE*	*The CIM provides monthly reports and DBHDS provides the aggregated weekly and. monthly information to the Reviewer and DOJ.*
V.	**Quality and Risk Management System**	Ratings prior to the 24th Period are not in bold. Ratings for the 24th Period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include the Commonwealth's status with each of the Compliance Indicators associated with the provision. The Findings Section and attached consultant reports include additional explanatory information regarding the Compliance Indicators. *The Comments in italics below are from a prior period when the most recent compliance rating was determined.*
V.A.	To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships), and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system that is consistent with the terms of this Section.		*Provision V.A. will be in Compliance when the Commonwealth is determined to comply with all the requirements of the Provisions and associated Compliance Indicators in Section V. Quality and Risk Management System.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	Non Compliance **Non Compliance**	Of the remaining ten Compliance Indicators, the Commonwealth met four (29.13, 29.16, 29.23, and 29.25), but did not meet six (29.17, 29.18, 29.20–29.22 and 29.24).
V.C.1.	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	Non Compliance **Non Compliance**	Of the remaining two Compliance Indicators, the Commonwealth did not meet either (30.4 and 30.10) and remains in Non-Compliance.
V.C.2.	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	Sustained Compliance	*DBHDS implemented and maintains a web-based incident reporting system and reporting protocol.*
V.C.3.	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken.	Sustained Compliance	*DBHDS revised its regulations, increased the number of investigators and supervisors, added expert investigation training, created an Investigation Unit, includes double loop corrections in Corrective Action Plans (CAPs) for immediate and sustainable change, and requires 45-day checks to confirm implementation of CAP s re: health and safety.*
V.C.4.	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	Compliance **Sustained Compliance**	Of the remaining two Compliance Indicators, the Commonwealth again met both (32.4, and 32.7) and achieved Sustained Compliance for the first time.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.C.5.	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The …mortality review team … shall have at least one member with the clinical experience to conduct mortality re who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death; … (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems … and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.	Compliance **Sustained Compliance**	Of the remaining one Compliance Indicator, the Commonwealth again met 33.15 and achieved Sustained Compliance for the first time.
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.	Sustained Compliance	*The Commonwealth has met all eight Compliance Indicators 34.1–34.8 and has achieved Sustained Compliance for the first time.*
V.D.1.	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	Non Compliance **Non Compliance**	Of the remaining five Compliance Indicators, the Commonwealth has met one (35.3), but has not met four (35.1, 35.5, 35.7 and 35.8) and therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.	Non Compliance **Non Compliance**	Of the remaining three Compliance Indicators, the ratings for two (36.1 and 36.3) were deferred*. The Commonwealth has not met one (36.8) and therefore remains in Non-Compliance.
V.D.3.	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	Compliance **Deferred***	Of the remaining one Compliance Indicator (37.7), the rating was deferred*. If the Commonwealth meets this indicator in the 25th Period it will have met all Indicators twice consecutively and will achieved Sustained Compliance.
V.D.4.	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	Compliance **Sustained Compliance**	The Commonwealth has again met the sole Compliance Indicator 38.1 and achieved Sustained Compliance for the first time.
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.	Sustained Compliance	*Of the remaining two Compliance Indicators, the Commonwealth again met both of them (39.4-39.5) and achieved Sustained Compliance for the first time.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.D.5.a.	The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	Sustained Compliance	*The five Regional Quality Councils include all the required members.*
V.D.5.b.	Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.	Sustained Compliance	Of the remaining three Compliance Indicators, the Commonwealth has again met all of them (40.2, 40.5 and 40.7) and has achieved Sustained Compliance.
V.D.6.	At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability … and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	**Sustained Compliance**	The Commonwealth has again met the sole Compliance Indicator 41.5 and achieved Sustained Compliance for the first time.
V.E.1.	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program including root cause analysis that is sufficient to identify and address significant issues.	Non Compliance **Non Compliance**	Of the remaining two Compliance Indicators, 42.3 and 42.4, the Commonwealth again met 42.3. Virginia has not met Indicator 42.4. and remains in Non-Compliance.
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.	Compliance **Deferred***	For the remaining three Compliance Indicators (43.1, 43.3 and 43.4), the rating is deferred*. If the Commonwealth meets this indicator in the 25th Period it will have met all Indicators twice consecutively and will achieved Sustained Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.E.3.	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	Non Compliance **Deferred***	Of the remaining two Compliance Indicator (44.1 and 44.2), the rating is deferred. The Commonwealth had previously met Indicator 44.1, but had not met 44.2. Therefore, Virginia remains in Non-Compliance.
V.F.1.	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	Sustained Compliance	*The case management and the ISR study found Compliance with the required frequency of visits, many of which are remote due to COVID precautions. DBHDS reported data that some CSBs are below target.*
V.F.2.	At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs….	Non Compliance Non Compliance	*When Virginia achieves the Indicators for III.C.5.b.i., it also achieves compliance for this Provision.*
V.F.3.a.-f.	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	Sustained Compliance	*The ninth, twelfth, fourteenth, and sixteenth and eighteenth ISR studies found that the case managers had completed the required monthly visits for 130 of 134 individuals (96.0%).*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.F.4.	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	Sustained Compliance	*The Commonwealth has again met both Compliance Indicators 46.1 and 46.2, and therefore achieved Sustained Compliance for the first time.*
V.F.5.	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	Non Compliance **Deferred***	For the sole Compliance Indicator 47.1, the rating has been deferred and therefore remains in Non-Compliance.
V.F.6.	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	Sustained Compliance	*The statewide CM training modules have been updated and improved and are consistent with the requirements of this provision.*
V.G.1.	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	Sustained Compliance	*OLS regularly renewed unannounced inspection of community providers.*
V.G.2.a.-f.	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	Sustained Compliance	*OLS has maintained a licensing inspection process with more frequent inspections.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.G.3.	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	Sustained Compliance	*The Commonwealth again met all four Compliance Indicators 48.1, 48.2, 48.3 and 48.4 and achieved Sustained Compliance for the first time.*
V.H.1.	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	Non Compliance **Non Compliance**	Of the remaining two Compliance Indicators, the Commonwealth has not met Indicators 49.4 and 49.12. Therefore, Virginia remains in Non-Compliance.
V.H.2.	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	Sustained Compliance	*The Commonwealth met all three Compliance Indicators 50.1, 50.2, and 50.3, and has achieved Compliance for the third consecutive review and therefore has achieved Sustained Compliance.*
V.I.1.a.-b.	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	Non Compliance Removed**	*The Court removed Indicators 51.1–51.5***
V.I.2.	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting..	Non Compliance Removed**	*The Court removed Indicators 51.1–51.5***

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.I.3.	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.	Non Compliance Removed**	*The Court removed Indicators 53.1–53.4***
V.I.4.	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	Sustained Compliance	*The Commonwealth's contractor completed the annual QSR process based on a statistically significant sample of individuals.*
VI.	**Independent Reviewer**	**Rating** **COMPLIANCE*** Provisions achieved and relieved by the Court.	**Comments**
VI.D.	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with copies to the parties. The parties will seek a protective order permitting these reports to be …and shared with Intervener's counsel.	COMPLIANCE*	*DBHDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IX.	**Implementation of the Agreement**	**Rating** Ratings for the 24th Period are in **bold.**	**Comment**
IX.C.	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented …	Compliance **Sustained Compliance**	The Commonwealth has again met all four Compliance Indicators (54.1–54.4), and therefore achieved Sustained Compliance for the first time.

Notes:

* Until new monitoring data is available for review and verification, the Independent Reviewer has determined a Deferred rating for this Provision. (If the relevant Indicator was met in the previous review and the next Twenty-fifth Period study also finds it has been achieved, a determination of met twice consecutively will be made.)

** The Parties recommended and the Court removed these Indicators from the Consent Decree on July 27, 2023.

COMPLIANCE*: On March 3, 2021, the Court ordered that it found the Commonwealth in compliance with Sections IV. and Provision VI.D. of the Consent Decree and relieved the Commonwealth of those portions of the Decree. For the one area of Non-Compliance in Section IV previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for three Provisions, namely IV.A, IV.B.4, and IV.B.6.

VI. APPENDICES

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APPENDIX A

Individual and Family Support Program
and
Family-to-Family and Peer Programs

by

Rebecca Wright, MSW, LICSW

Individual and Family Support Program 24th Period Study

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

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

The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) have jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia had not yet been found in compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020.

As of the conclusion of the 23rd Period Report, the Commonwealth had met all CIs at least once and only had three remaining CIs that had not yet been met twice consecutively.

- For CI 1.1, DBHDS achieved compliance for the first time, as a result of actions to substantially revitalize the foundation for a meaningful re-implementation of local community-based support through the IFSP Regional Councils.
- DBHDS had also taken actions to enhance procedures for the Family-to-Family and Peer Mentoring programs to address the specific requirements of CI 19.2 and CI 19.3. These included improvement to the Virginia Informed Choice Form and Protocol and additional data tracking and trending capabilities. The Commonwealth met these two indicators for the first time. Of note, the 23rd Period study recommended that for CI 19.3, DBHDS and the contracted family and peer mentoring program providers should consider how they might further expand options for tracking outcomes related to individuals and families who are considering sponsored homes or congregate residential settings

For this 24th Period review, the Parties agreed to target the Compliance Indicators that have not been Met twice consecutively in the two most recent reviews. The reviews of these CIs, which were studied in the recently completed 23rd Period, include only the 24th Period (10/1/23-3/30/24), and are intended to confirm whether the Commonwealth sustained the compliance achieved during the 23rd Period. The following summarizes, as of the time of the 23rd Period Report, the compliance status of the Provisions and Compliance Indicators under review for this Period:

Twenty-fourth Period Studies		
Compliance Indicator	**Corresponding Provision**	**22nd/23rd Status**
1.1	II.C.2.a-i	NM/M
19.2	III.D.5	NM/M
19.3	III.D.5	NM/M

24th Period Study Purpose and Methodology

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

The Independent Reviewer has also instructed consultants completing studies to review any applicable Process Document and Data Set Attestation Form for CIs which require the reporting of valid and reliable data, to review previous findings by DBHDS data analysts (i.e. the Office of Data Quality and Validity or its successors) to determine what, if any, reliability and validity deficiencies (i.e., related to the data collection methodology and/or the data source system) exist, and to review and analyze the documented facts related to the extent to which the Process Document appears to have sufficiently addressed all previously identified deficiencies/threats related to data reliability and validity.

The study methodology included document review, review and analysis of available data and written follow-up interviews with DBHDS staff. The purpose of the study and the related components of the study methodology were reviewed with DBHDS staff. Following that kick-off meeting, DBHDS was asked to provide all necessary documents and to suggest interviews that provide information that demonstrates proper implementation of the Provisions and their associated Compliance Indicator(s). A full list of individuals interviewed is included in Attachment A. The full list of documents and data reviewed may be found in Attachment B. IFSP staff again provided summary documents for the CIs under study that clearly laid out the program activities and were extremely helpful in ensuring a comprehensive understanding of compliance status.

Summary of Findings

This 24th Period study found that DBHDS continued to meet the requirements for each of the three remaining indicators under study. Many of the previous findings continued as described at the time of the 23rd Period review. In addition, DBHDS reported some modifications, all of which served to enhance the program. These included the following:

- For CI 1.1, DBHDS had developed a new Departmental Instruction (DI), effective 11/13/23 that superseded the previous version. DBHDS was also engaged in a public comment process to make permanent the existing IFSP emergency amendments to the regulations at *12VAC35-230*. Work continued to develop Regional Council workplans, with additional resources tapped through Virginia's Community of Practice (CoP) technical assistance.
- For CI 19.2, DBHDS reported it had initiated work to make changes to the ISP to separate the annual discussion of the more integrated services section into two elements, to isolate integrated residential from other types of integrated options. The intent of this modification is to enable DBHDS to confirm 1) that the specific residential discussion occurred and 2) which settings are being considered, at what frequency, and where. DBHDS also expected this would enable it to track the specific discussions with people who went through the Regional Support Team (RST) process and chose a less integrated setting.
- For CI 19.3, DBHDS was working to enhance outcome reporting to include data that would track percentages of individuals in sponsored and other congregate settings who chose to move to more, or less, integrated settings. While this CI did not require reporting on such outcomes, tracking these data would potentially give DBHDS another measure of the effectiveness of the peer and family mentoring programs and would lend themselves to overall quality improvement in this area.

The table below illustrates the final compliance status for each CI. Note: Shaded CIs represent CIs previously Met twice consecutively and therefore not reviewed during this 24th Period.

III.C.2.a-f (II.D): Indicators	**Status 24th Period**
1.1 The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following: • Funding resources • A family and peer mentoring program • Local community-based support through the IFSP Regional Councils	**Met**
1.2 The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization.	Met
1.3 The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program.	Met
1.4 The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including:	Met
1.6 Participant satisfaction with the IFSP funding program	Met
1.7 Knowledge of the family and peer mentoring support programs	Met
1.9 Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter.	Met
1.10 IFSP funding availability announcements are provided to individuals on the waiver waitlist.	Met
1.11 Eligibility guidelines for IFSP resources and other supports and services, such as case	Met

management for individuals on the waiver waitlist, are published on the My Life, My Community website.	
III.D.5 (IV.B.9.b.): Indicators	**Status**
19.1 At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources.	Met
19.2 The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested.	**Met**
19.3 The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to-family and the peer-to-peer supports have contact and the number who receive the service.	**Met**

Analysis of 23rd Review Period Findings

23rd Review Period
Findings

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

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

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
1.1 The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following: • Funding resources • A family and peer mentoring program	Overall, DBHDS met the criteria for this CI. The *Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities (IFSP State Plan)* developed by the IFSP State Council includes the essential components of a comprehensive and coordinated set of strategies, including funding resources, a family	Overall, DBHDS met the criteria for this CI. As previously reported, DBHDS issued the current *Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities (IFSP State Plan)* in 2019 and continued to make annual updates. The most recent (i.e., *FY 23 State Plan Update and Progress Report*) was completed on 8/28/23, and posted to the DOJ Library. It was also shared with the IFSP State Council at the September 2023 meeting. Previously, DBHDS had issued a Departmental Instruction (DI) with regard to the IFSP (i.e., *DI 113 (TX) 20: Facilitation of Access to Resources and Supports to Enhance Community Inclusion and Engagement*). For this 24th Period, a more current document, entitled *Individual and Family Support Program, Policy Number CS.01*, dated 11/13/23, superseded that DI. This new policy continued to call for the development of procedures to comply with the requirements, as outlined in the previous	23rd - Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
• Local community-based support through the IFSP Regional Councils	and peer mentoring program and local community-based support through IFSP Regional Councils. During the 24th Period, DBHDS issued a new IFSP policy, entitled *Individual and Family Support Program, Policy Number CS.01*, dated 11/13/23. It superseded the previous *DI 113*. Overall, this policy did not make substantive changes to the previous DI that would affect overall compliance, but it did expand on details of program components. In addition, on 2/26/24, DBHDS notified stakeholders through the Constant Contact list-serv of proposed regulatory action to make permanent the existing (i.e., effective since 1/19/23) emergency regulations to the Individual and Family Support Program [*12VAC35-230*]. The email provided an access link to a	document: • Processes and procedures to support the implementation of the State Plan and the state and regional council structure to build the local infrastructure to promote person-centered and family-centered resources, supports, services, and other assistance; • A process for providing family and peer mentoring to provide one on one support and information to individuals and families; • A process to establish criteria for identifying applicants most at risk for institutionalization; and, • A process to maintain accessible, user-friendly information including information on eligibility for IFSP-Funding, case management, and other DD resources and services through a website and other mechanisms that shall be shared with individuals upon their placement on the DD Waiver Waiting List. Overall, this policy did not make substantive changes to the previous DI that would affect overall compliance, but it did expand on details of program components. In addition, during this 24th Period, on 2/26/24, DBHDS notified stakeholders through the Constant Contact list-serv of proposed regulatory action to make permanent the existing emergency amendments to *12VAC35-230* that had been in effect since 1/19/23, and are set to expire on 7/18/24 unless a six month extension is granted. The email provided an access link to a 60-day public comment forum which opened on 7/18/24 and which would remain open through 4/26/24. The email noted this comment period was the second of three stages to make the amendments permanent, with a third and final stage to occur before the amendments become permanently effective. The comment forum included the regulatory	

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
	60-day public comment forum from 2/26/24 through 4/26/24. The IFSP Funding Program has been in continuous operation since 2013 and DBHDS continued to provide funding resources annually. The most recent Funding Period opened on 10/16/23 closed on 11/14/23. For the FY24 Funding period, DBHDS submitted a document entitled *FY 2024 IFSP-Funding Summary, February 16, 2024.* It indicated IFSP received 4,872 applications for funding and funded 3,765 (77.38%), with the total amount of funding disbursed at $2,499,339. As reported previously, IFSP staff issued, and updated as needed, eligibility and prioritization criteria, formal guidelines, policies and procedures sufficient to implement the	text, as well as an *Agency Background Document* that provided detailed background information. As of 4/14/24, the forum listed 17 comments. This CI requires implementation of the strategies in the IFSP State Plan, specifically "offering information and referrals through an infrastructure" that includes funding resources, family and peer mentoring programs and local community-based support through the IFSP Regional Councils. The following paragraphs describe the status of each of these components. **Funding Resources:** For this review, DBHDS continued to provide funding resources annually, again utilizing the WaMS Funding Portal. As reported at the time of the 23rd Period, on 10/16/23, DBHDS opened the FY24 Funding Program, which remains the most current funding period for this 24th Period review. The funding period closed on 11/14/23. The prioritization criteria for receipt of funding described at the time of the 23rd Period remained unchanged. DBHDS also continued to maintain an extensive library of formalized policies and procedures, which they had consistently updated over time to address any programmatic changes. The 23rd Period study described various tools available at the time of the FY24 Funding Program to support users in accessing and using the portal. These included the *DBHDS IFSP Funding Guidelines*, updated 1/9/23, which remained current; the *IFSP Portal User Guide (Apply for Funds Using the DBHDS Waitlist and IFSP Portal)* dated 10/13/23; *IFSP-Funding Application Quick Tips Fall Version Date: 10/13/2023;* and *IFSP Funding Application Training Video (FY24)*. For the FY24 Funding period, DBHDS submitted a document entitled *FY 2024 IFSP-Funding Summary, February 16, 2024.* It indicated IFSP received 4,872 applications for funding and funded 3,765 (77.38%), with the total amount of funding disbursed at $2,499,339.	

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
	program. DBHDS also continued to employ a robust methodology for providing all individuals on the waitlist with time-sensitive notifications of funding availability. At the time of the 23rd Period review, DBHDS provided a Process Document entitled *IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation *entitled IFSP Annual Funding Award*, dated 10/2/23 which met the requirements for the *Curative Action for Data Validity and Reliability*. These documents remained current for this 24th Period. DBHDS provides for both a family and a peer mentoring program, as evidenced by vendor contract and quarterly reports. For the 24th Period, to show continuation of the family-to-family program,	For this period, DBHDS continued to employ a robust methodology for providing all individuals on the waitlist with time-sensitive notifications of funding availability. At the time of the 23rd Period review, DBHDS provided the following documentation, which met the requirements for the *Curative Action for Data Validity and Reliability* and remain current for this 24th Period: • A Process Document entitled *IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation entitled *IFSP Annual Funding Award*, dated 10/2/23. These described the methodology and attested to its validity and reliability. • A document entitled *IFSP Annual Notification for Individuals on WWL: FY 2024 Update and Quantity Detail*, dated September 27, 2023 to show the notifications procedures were followed. **A Family and Peer Mentoring Program:** The Settlement Agreement requires the Commonwealth to develop family-to-family and peer mentoring programs as a part of a comprehensive and coordinated set of person-centered and family-centered strategies, but also specifically to facilitate opportunities for families and individuals considering congregate care to receive information about options for community placements, services, and supports. Overall, DBHDS had met the requirements for implementing family and peer mentoring programs for this CI: • **Family Mentoring Program**: As reported previously, at this time, DBHDS continues to contract with the Virginia Commonwealth University Center for Family Involvement (CFI) Partnership for People with Disabilities to engage with individuals and families on behalf of DBHDS across a platform of programs. These efforts include the implementation of a family-to-family network to provide one-to-one emotional, informational and systems navigational support to families. Through the program, Family Navigators provide support and information, and discuss options with	

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
	DBHDS provided the most recent updated contract modification to the original Memorandum of Agreement (MOA) with Virginia Commonwealth University Center for Family Involvement (CFI) Partnership for People with Disabilities, for the period between 1/1/24 through 7/31/24. For the peer mentoring program, DBHDS previously submitted the most recent contract modification with The Arc of Virginia, which was effective 6/4/23 through 6/3/24 and therefore remained current for the 24th Period. With regard to the requirement for local community-based support through Regional Councils, as previously described, each of five Regional Councils continued to be operational. This was evidenced by minutes from meetings from the IFSP All-Council Annual	families so they can make the best choices for their family member with a disability. This program had been in existence for more than 15 years and is well-established. For the 24th Period, DBHDS provided the most recent updated contract modification to the original Memorandum of Agreement (MOA), dated 6/16/23, to show continuation of the family-to-family program for the period between 1/1/24 through 7/31/24. • **Peer Mentoring Program:** As reported previously, for this 23rd Period review, the primary DBHDS vehicle for the implementation of peer-to-peer supports continued to be a statewide peer mentoring system operated by The Arc of Virginia (The Arc). The original contract, dated 5/26/20, described a scope of work to develop the necessary infrastructure to successfully implement a Statewide Peer Support Program, which included multiple tasks pertinent to this CI, primarily related to the development and implementation of a peer mentoring curriculum and network. The performance period for the most recent renewal was 6/4/23 through 6/3/24 and therefore remained current for the 24th Period. Both CFI and The Arc submitted ongoing quarterly reports of activities and outcomes. For this 24th Period, the quarterly reports covered the second and third quarters of SFY 24. **Local community-based support through the IFSP Regional Councils:** As previously reported, based on the existing 2019 *IFSP State Plan*, the Community Coordination program serves as the hub for family engagement and the primary vehicles for that engagement were the IFSP State and Regional Councils. While the purpose of the State Council is to provide guidance to DBHDS reflecting the needs and desires of individuals and families across	

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
	Meeting on 1/19/24 and two reports of *IFSP 2024 State and Regional Council Summary of Activities*, one for the period September 2023-January 2024 and one for the period February 2024-March 2024. Based on review of the document entitled *IFSP Summary of Activities October 1, 2023 – January 31, 2024*, in November 2023, DBHDS hired an IFSP Support Specialist, in part to support IFSP State and Regional Councils. In the continued work to develop Regional Council workplans, IFSP staff also solicited assistance from Virginia's Community of Practice (CoP) technical assistance facilitator. At the IFSP All-Council Annual Meeting on 1/19/24, IFSP staff and CoP facilitator introduced a brainstorming tool, and, during February through March 2024, each Regional Council held	Virginia, the five IFSP Regional Councils are envisioned as the primary means of providing local community-based support (e.g., identifying and/or developing local resources and sharing those with their communities.) At the time of the 20th and 22nd Period reviews, the Regional Councils were largely non-functional due to the pandemic as well as IFSP staffing turnover. However, during the 23rd Period, DBHDS re-vitalized the Regional Councils, which began their work together in June 2023 with planning meetings. At the time of the 23rd Period review, the Regional Councils did not yet have finalized work plans, but the planning effort was underway. For this 24th Period, the Regional Councils continued to be operational, based on review of minutes from meetings from the IFSP All-Council Annual Meeting on 1/19/24 and of two reports of *IFSP 2024 State and Regional Council Summary of Activities*, one for the period September 2023-January 2024 and one for the period February 2024-March 2024. Throughout these periods, the aforementioned effort to develop regional workplans continued. IFSP staff solicited the assistance from Virginia's Community of Practice (CoP) technical assistance facilitator to develop a brainstorming tool the Councils could use to identify resource, service, and knowledge gaps. At the IFSP All-Council Annual Meeting on 1/19/24, IFSP staff and CoP facilitator introduced the brainstorming tool. During February 2024 and March 2024, each Regional Council held workshop meetings, facilitated by the CoP TA facilitator, to use the tool results to develop a regional workplan structure, goals, and strategies. In addition, based on review of the document entitled *IFSP Summary of Activities October 1, 2023 – January 31, 2024*, in November 2023, DBHDS hired an IFSP Support Specialist, in part to support IFSP	

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
	workshop meetings, facilitated by the CoP TA facilitator, to use the tool results to further develop a regional workplan structure, goals, and strategies.	State and Regional Councils. This staff member is supervised by the IFSP Community Coordination Supervisor.	

23rd Review Period
Findings

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

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

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
19.2 The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability	DBHDS met the criteria for this CI. For this 24th Period review, DBHDS reported it had made	For this 24th Period review, DBHDS met the criteria for this CI. DBHDS reported it had made no modifications to the *Virginia Informed Choice Form and Protocol: FY23 Update,* dated 8/29/23. Based on the findings of the 23rd Period study, this protocol met the requirements for this CI. As reported at that time, the protocol achieved the following:	23rd - Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
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.	no modifications to the *Virginia Informed Choice Form and Protocol: FY23 Update,* dated 8/29/23. The protocol clearly specified that the *Virginia Informed Choice Form* must be completed whenever new services are requested, when the individual wants to move to a new location, when there is a request for a change in waiver provider(s), when the individual is dissatisfied with the current provider and when making a Regional Support Team (RST) referral for an individual with a DD Waiver. The protocol also strengthened the guidance to Support Coordinators to ensure individuals were receiving an adequate explanation of the purpose of the family and peer mentoring and the specific referral processes to follow. The form includes references and contact information for both the family and peer mentoring resources. It also collects needed information regarding whether the	• The revised *Virginia Informed Choice Form* collected needed information (i.e., whether the individual was considering a sponsored home or congregate residential setting, as well as whether the individual requested a referral for a to be connected to the family and/or peer mentoring support). • The form included references and contact information for both the family and peer mentoring resources. • The revision to the accompanying *Virginia Informed Choice Form* included a section that required the Support Coordinator to document confirmation of discussion of all applicable waiver service options by checking the options listed, including all residential options (i.e., including but not limited to sponsored residential, group home residential four beds or less and group home residential five beds or more). • The protocol clearly specified that the *Virginia Informed Choice Form* must be completed whenever new services are requested, when the individual wants to move to a new location, when there is a request for a change in waiver provider(s), when the individual is dissatisfied with the current provider and when making a Regional Support Team (RST) referral for an individual with a DD Waiver. • DBHDS updated accompanying guidance for Support Coordinators related to the implementation of the revised process to ensure individuals were receiving an adequate explanation of the purpose of the resources. At the time of the 23rd Period, DBHDS staff reported they had partially integrated the revised *Virginia Informed Choice Form* into WaMS. For this 24th Period, DBHDS staff reported that no further integration was planned. However, DBHDS submitted a document entitled *19.2 ISP Update*, dated 3/1/24, that stated DBHDS planned to make changes to the ISP in WaMS in the coming months, to separate the annual discussion of more integrated services section into two elements to isolate integrated residential from other types of integrated options. The stated intent of this modification is to	

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
	individual was considering a sponsored home or congregate residential setting, as well as whether the individual requested a referral for a to be connected to the family and/or peer mentoring support. At the time of the 23rd Period, DBHDS staff reported they had partially integrated the revised *Virginia Informed Choice Form* into WaMS. For this 24th Period, DBHDS staff reported that no further integration was planned. However, for the 24th Period, a document entitled *19.2 ISP Update*, dated 3/1/24, stated that DBHDS planned to make changes to the ISP to separate the annual discussion of more integrated services section into two elements to isolate integrated residential from other types of integrated options. The intent of this modification is to enable DBHDS to confirm 1) that the specific residential discussion occurred and 2) which settings are being considered, at what frequency, and where. The document also indicated this will enable tracking the specific	enable DBHDS to confirm 1) that the specific residential discussion occurred and 2) which settings are being considered, at what frequency, and where. The documents also indicated this will enable tracking the specific residential discussions with people who went through the RST process and chose a less integrated setting.	

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
	residential discussions with people who went through the RST process and chose a less integrated setting.		
19.3 The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to-family and the peer-to-peer supports have contact and the number who receive the service.	DBHDS met the requirements for this CI. At the time of the 23rd Period, DBHDS demonstrated it met the requirements and, for this 24th Period, DBHDS reported no substantive changes to the previous findings. Based on review of the second and third quarterly reports for SFY 24 from both CFI and The Arc, (i.e., which operate the about family and peer mentoring programs respectively), those programs continued to provide waiver-specific data for individuals receiving family-to-family and peer mentoring supports. This included reporting on referral source and waiver/waiver waitlist status. As previously provided, for reporting these data, DBHDS had in place both a Process Document, entitled	DBHDS met the requirements for this CI. At the time of the 23rd Period review, CFI and The Arc, (i.e., which operate the family and peer mentoring programs respectively) provided waiver-specific data for individuals receiving family-to-family and peer mentoring supports. Effective 1/1/23, CFI updated its reporting to begin providing a report of the number of individuals who currently were on the Waiver, on the WWL or not on the WWL/was unsure of WWL status. Based on review of CFI quarterly program reports for the second and third quarters of SFY 24, the reporting continued to provide these data. Similarly, based on review of quarterly program reports for the second and third quarters of SFY 24 from The Arc, that organization also continued to report referral source and waiver/waiver waitlist status. As previously provided, for reporting these data, DBHDS had in place both a Process Document, entitled *DD_IFSP_F2F P2P_VER_003*, dated 10/10/23, and Data Set Attestation, dated 10/16/22, that met the requirements of the *Curative Action for Data Validity and Reliability*. At the time of the 23rd Period review, the study recommended that DBHDS and the contracted family and peer mentoring program providers should consider how they might further expand these outcome tracking opportunities. For this 24th Period, DBHDS reported it was also continuing to collect and report on data related to individuals transitioning from one residential provider to another. To that end, DBHDS provided a document, entitled *Residential Service Provider Change Spreadsheet and Summary,* dated 3/1/24. It included a data report indicating that between 7/1/23 and 12/31/23:	23rd - Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion 23rd Period **24th Period**
	DD_IFSP_F2F P2P_VER_003, dated 10/10/23, and Data Set Attestation, dated 10/16/22, that met the requirements of the *Curative Action for Data Validity and Reliability*. With the implementation of the revised *Virginia Informed Choice Form and Protocol*, DBHDS had enhanced capability to track whether individuals considering group homes of five beds or more access family or peer mentoring. With regard to other related outcomes, for this 24th Period, DBHDS reported it was continuing to collect and report on data related to individuals transitioning from one residential provider to another. DBHDS did not yet have a completed formal Process Document for this data collection, as required by the *Curative Action for Data Validity and Reliability* for all data reporting. However, in order to be Met, this CI does not require reporting on such outcomes.	• Of the 58 people who transitioned from a group setting of five or more, 42 (72%) moved to a group setting of four or fewer and seven (12%) moved to a sponsored residential setting. Only nine (16%) chose a new provider setting that was also in the category of group setting of five or more. • Of the 196 who transitioned from a group setting of four or fewer, 159 (81%) chose a new provider setting in the same category and 30 (15%) moved to a sponsored residential setting. Only seven individuals (less than 4%) chose a group setting of five or more. • Of the 121 people who transitioned to a new provider from a sponsored residential setting, 90 (74%) remained in that category in their new setting. The others moved to either a group setting of four or fewer (28 or 23%) or a group setting of five or more (three or 2%). Going forward, tracking these data will potentially give DBHDS another measure of effectiveness for the peer and family mentoring programs and would lend themselves to quality improvement in this area. DBHDS did not yet have a completed formal Process Document for this data collection, as required by the *Curative Action for Data Validity and Reliability* for all data reporting. However, in order to be Met, this CI does not require reporting on such outcomes.	

Attachment A: Written Interviews

1. Heather Norton, Assistant Commissioner, Developmental Services
2. Heather Hines, IFSP Program Director

Attachment B: Documents Reviewed:

1. FY 23 State Plan Update and Progress Report
2. DI 113 (TX) 20: Facilitation of Access to Resources and Supports to Enhance Community Inclusion and Engagement
3. Individual and Family Support Program, Policy Number CS.01
4. Agency Background Document
5. FY 2024 IFSP-Funding Summary, February 16, 2024
6. Curative Action for Data Validity and Reliability
7. IFSP Outreach Materials VER002, dated 8/18/23
8. IFSP Annual Funding Award
9. IFSP Annual Notification for Individuals on WWL: FY 2024 Update and Quantity Detail
10. Updated contract modification to the original Memorandum of Agreement (MOA) with VCU
11. IFSP 2024 State and Regional Council Summary of Activities, one for the period September 2023-January 2024 and one for the period February 2024-March 2024.
12. IFSP Summary of Activities October 1, 2023 – January 31, 2024
13. Virginia Informed Choice Form and Protocol: FY23 Update
14. 19.2 ISP Update
15. DD_IFSP_F2F P2P_VER_003
16. Residential Service Provider Change Spreadsheet and Summary
17. IFSP FY24 State Council Roster_2.28.2024
18. IFSP Regional Council Member Description_10.31.2023
19. SC Annual Minutes Jan. 2024_01.19.2024
20. 10.2023-12.2023 PM Quarterly Program Report
21. F2F_Data_Quarterly_Report_10.2023-12.2023
22. VCU_F2F_Quarterly_Program_Report_10.23-12.23
23. Quarter2_Report_P2P_F2F1.31.24
24. Residential_Settings__Attachment_B_3.04.2024
25. ResProviderSQL

APPENDIX B

Case Management

By

Kathryn du Pree, MPS
Joseph Marafito, MS

Case Management
24th Review Period
Study Report

Introduction

This report constitutes the seventh review of the Compliance Indicators (CIs) for Case Management services. This review will take place during the twenty-fourth review period. The focus of the review is to determine if the Commonwealth has achieved the five case management Compliance Indicators (CIs) that have not been met or sustained in the previous two consecutive reviews. The Parties have agreed upon the indicators to determine compliance with Case Management Provisions that remain out of sustained compliance. These include CIs that relate to Provisions III.C.5.b.i. and V.F.5. These CIs address the Commonwealth's responsibilities to review and monitor the quality of service coordination and the delivery of waiver services to analyze the findings of the quality review related to CSB Case Management performance across ten elements (*CI 2.16);* to specifically analyze and monitor the achievement of four key indictors related to health and safety and community integration (*CI 47.1*); and to require and track the effectiveness of corrective actions undertaken by CSBs that underperform meeting the performance expectations for the service indicators (*CI 2.18 and 2.20*).

The chart below lists the CIs and their two most recent ratings. For this subset of CIs associated with these Provisions, progress toward achieving the agreed upon CI metrics will be reviewed and reported. This review will include an analysis and reporting of Virginia's status implementing only the CI requirements associated with Case Management that have not been met twice consecutively (see Table below). This includes *CIs 2.3, 2.16 (including elements 2.6-2.15), 2.18, 2.20, and 47.1.*

For this report the documents reviewed are identified in Attachment A. This reviewer conducted an interview with Eric Williams, Director of Provider Development/Case Management Steering Committee (CMSC) Chair in March and appreciates the information he provided during the interview and in subsequent written responses to any outstanding questions.

Summary of Findings for the 24th Period

In this reporting period the Commonwealth sustained its achievement for one of the five indicators reviewed. CIs *2.3* is now met for the second consecutive review period. As noted in this report the Commonwealth continues to demonstrate progress meeting the requirements of CIs 2.18 and 2.20 but these will need to be reviewed for compliance in the 25th reporting period. Determinations for *CIs 2.16, and 47.1* , which were not met in the 23rd review period, are also deferred because there

are no new data to review since the 23rd period's review. The data used to rate these two CIs are derived from the Support Coordinator Quality Review (SCQR). The last summary of a completed SCQR was available during the 23rd review period. DBHDS has implemented the SCQR process for FY24 but the CSBs have until July to complete the samples for which they are responsible. After July the DBHDS Office of Community Quality Improvement (OCQI) staff (1, 2) will conduct and summarize findings from its look-behind process. Therefore, the data produced by the FY24 SCQR process will not be available for me to review and analyze until the 25th review period.

As reported in the 23rd review period study, the CMSC reviewed the results of the SCQR-FY23 and determined for CY22 records that 64% (307/479) achieved a minimum of nine of the ten indicators, which is below the benchmark of 86%. This represented a continuing steady improvement over the 42% achievement found in the CY20 records and the 53% achievement found in the CY21 records. Across the records reviewed, five of the ten indicators were above 86%; four were very close; and only one was well below. The indicator, which was significantly below the 86% benchmark was at 54%, requires that ISPs have specific measurable outcomes.
Across CSBs, ten (25%) of the forty CSBs achieved at the 86% benchmark level or better. These results indicate improvement in that four (10%) CSBs met the benchmark for CY21 records versus three (7.5%) meeting the benchmark for CY20 records. However, these findings continue to highlight the large number and percentage of CSBs that are not in compliance (1).

DBHDS made further improvements to its SCQR-FY24 process to enhance the applicability of the SCQR by adding children to the initial sample of 400 waiver participants rather than including children as an add on to the sample; clarifying the scoring methodology for children; revising questions for greater clarity and to provide greater opportunity for comment; enhancing the Technical Guidance document; and clarifying the wording for goals and objectives. There were no changes to the indicators and no substantive changes for the FY24 SCQR (3).

The Case Management Steering Committee (CMSC) continued to monitor the CSBs for the Performance Indicators (PMI) relevant to CI 2.16 and additional indicators, addressing employment and community engagement discussions and goals; Regional Support Team (RST) timeliness, and dental and physical examinations. The minutes of the monthly CMSC meetings that occurred between August and December 2023 provide evidence of both regular and meaningful involvement of the CMSC in the oversight of the CSBs Case Management services and DBHDS' implementation of quality review, analysis, technical assistance, training, and communication with CSBs (4). The CMSC spent significant time during the past several months reviewing RST data to identify trends. DBHDS created a data dashboard to compare the results of the SCQR sample with Electronic Health Record (EHR) data and another dashboard to display RST performance. CSBs were required to address RST and ISP performance in their Improvement Plans, specifically addressing the retention of Support Coordinators and the timeliness of referrals to the RSTs. Five CSBs were required to address issues related to RST referrals and one of the five had an accepted Improvement Plan (IP). Five other CSBs improved their performance in this area and the CMSC recommended their IPs be closed and removed (4).

Six CSBs had open IPs related to underperformance for ISP indicators**.** The CMSC had recommended closing and removing the IPs for twelve other CSBs. One CSB had only achieved 50% compliance with three of the ten indicators**.** The CMSC sent a letter to the Commissioner in January summarizing the Committee's activities and findings, recommending the Commissioner send letters noting high achievement to the CSBs that meet overall performance expectations consistently (4).

The CMSC also added the performance expectations for Targeted Case Management (TCM) and Enhanced Case Management (ECM) to the Watch List process. DBHDS set a threshold of three consecutive quarters below 90% to trigger the Watch List process for these case management responsibilities (4).

The CMSC continued to oversee the partnership between DBHDS and DMAS to issue and follow Case Management related Corrective Action Plans (CAPs) required of CSBs. Between January and June 2023, DMAS accepted seven such CAPs. Technical Assistance was offered to each of these CSBs and was accepted by one (4).

Data Process and Attestation

All data processes which have been reviewed previously and verified to be reliable and valid remain in place. All attestations are completed and current.

Compliance Indicator Achievement

Table 1 below summarizes the status of the case management compliance indicators.

Table 1
Case Management Findings

#	Indicator	Facts	Analysis/Conclusions	23rd	24th
2.3	DBHDS will pull an annual statistically significant stratified statewide sample of individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB.	2.3 The FY24 SCQR process included revised guidance to score the tool for children; revisions to questions for greater clarity; and revisions to the wording of goals and outcomes. There were no changes to the indicators and no revisions to the substance of the questions. These changes were incorporated	2.3 The FY24 sample included 400 individuals in the sample including children. The sample was distributed to the CSBs in January 2024. The first half of the sample is to be completed by March 30, 2024. The second half is to be completed by June 15, 2024 but can be completed at the same time as the first half	**M**	**M**

		into the Technical Guidance document and shared with the CSBs (3,4) This year children were added directly to the sample rather than included as an add on as was done in the last reporting period. Except for employment questions, the questions for children are the same as for adults. DBHDS concluded that the total number of individuals in the sample needed to be statistically significant, but subgroups did not.	of the sample. DBHDS will have some data to report and analyze by April 30th, but it will not include the full sample or the results of the look behind conducted by DBHDS Office of Community Quality Improvement (OCQI), as this review begins in July. The statewide results are analyzed and shared in October. DBHDS pulls a statistically significant sample; ensures consistent review of the sample across the CSBs; and conducts a look-behind review that is performed by DBHDS quality monitors. DBHDS continues to meet the requirements of this CI.		
2.6	2.6 • The CSB has offered each person the choice of case manager.	2.6 Compliance reported for the FY23 SCQR at 83%. This is compared to 78% in the FY22 SCQR. This is below the benchmark of 86%.	2.6 See CI 2.16.		
2.7	2.7 • The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team.	2.7 Compliance reported at 88.5%, compared to 84% in SCQR-FY22. This is above the benchmark of 86%.	2.7 See CI 2.16.		
2.8	2.8 • The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.	2.8 Compliance reported at 84%. This is the same performance as in SCQR-FY22. This is slightly below the benchmark of 86%.	2.8 See CI 2.16.		
2.9	2.9 • The case manager assists in developing the person's ISP that addresses all the individual's risks, identified needs and preferences.	2.9 Compliance reported at 84% which is a slight decrease from SCQR FY22. This is slightly below the benchmark of 86%	2.9 See CI 2.16.		

2.10	2.10 • The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable.	2.10 Compliance reported at 54%. This is a significant increase from SCQR-FY22 but remained substantially below the benchmark of 86%.	2.10 See CI 2.16.		
2.11	2.11 • The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served.	2.11 Compliance reported at 88%. This is an increase from SCQR-FY22. This is above the benchmark of 86%.	2.11 See CI 2.16.		
2.12	2.12. • The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary.	2.12 Compliance reported at 98.5%. This is a slight improvement over SCQR-FY22. This is above the benchmark of 86%.	2.12 See CI 2.16.		
2.13	2.13 • Individuals have been offered choice of providers for each service.	2.13 Compliance reported at 93%. This is a slight improvement over SCQR-FY22. This is above benchmark of 86%.	2.13 See CI 2.16.		
2.14	2.14 • The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences.	2.14 Compliance reported at 84%. This is comparable to the performance on SCQR-FY22. This is slightly below the benchmark of 86%.	2.14 See CI 2.16.		

2.15	2.15 • The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in individual needs, including, but not limited to, reconvening the planning team as necessary to meet individual needs.	2.15 Compliance reported at 100%. This is the same as SCQR-FY22. This is above the benchmark of 86%. (Data source for 2.6-2.15 is Attachment 1)	2.15 See CI 2.16.		
2.16	The Case Management Steering Committee will analyze the Case Management Quality Review data submitted to DBHDS that reports on CSB case management performance each quarter. In this analysis 86% of the records reviewed across the state will be in implementation with a minimum of 9 of the elements assessed in the review.	As reported in the 23rd reporting period, the CMSC has reviewed the results of the SCQR FY23 (1) and determined for CY22 records that 64% of the records achieved at a minimum nine of the ten indicators, which is below the benchmark of 86%. This is an improvement on the 53% metric for the previous reporting period. There was a decrease in compliance for Indicators 1,2,3, and 7. There was an increase in compliance for Indicators 4,6,8,9, and 10. There continued to be 100% compliance for Indicator 5. The DD CMSC data review process document (3) and the SCQR Process Documentation were reviewed for case management performance on the ten elements in the compliance indicators and the Look Behind sub-sample review. The FY 2023 SCQR Final Report (1) provides the results on the 10 indicators, the look behind and	As reported in the 23rd reporting period, these results indicate improvement, e.g., ten CSBs met the benchmark in CY22 compared to six CSBs met the benchmark for CY21 records, and three CSBs met the benchmark for CY20 records; 64% of 479 records compared to 53% of 400 records achieved at 86%, and 42% in CY20. However, they also highlight the large amount of CSB underperformance to be corrected. As noted under *CI 2.6* the results of the SCQR conducted during FY24 are not available and cannot be analyzed until the 25th reporting period. DBHDS did provide related data to demonstrate the role the CMSC is taking to review the quality and performance of the CSBs (1,5,6). The CMSC tracked the CSBs performance on fifteen performance measures. This indicator align with CI 2.6-2.15 but do measure performance related to discussions and goal setting for employment, community engagement and community relationships; choice of living arrangement, housemates	**NM**	**deferred**

		OCQI Interrater performance. The Maxwell RE coefficient is used for scoring. Moderate agreement ranges from .40 to .59 and Substantial Agreement ranges from .60 to 1. Within the Indicator, area 7 of 10 were within the substantial range and 1 of those in the moderate range. Within the Interrater area, 9 of 10 were in the substantial range and one in the moderate range. The SCQR Process is now in its fifth cycle of implementation and has shown its value as a measurement for CSB case management effectiveness and an effective improvement process.	and routine; and physical and dental examinations. The performance is measured using data for all individuals on the waiver who have had an ISP meeting during the review period. Except for the PMIs for individuals to have goals in employment (24%) and participate in integrated services (60%); adolescents having employment discussions (62%); individuals having a physical examination within 14 months of the ISP (85.5%) and individuals having an annual dental examination (64%), the remaining measures range in achievement from 91%-100%. These data are based on self-reporting by Case Managers. The CMSC uses this data to determine Quality Improvement initiatives (QII) that are recommended to DBHDS for implementation (5,6) The Commonwealth has not yet achieved this indicator because only 64% of the records reviewed achieved the benchmark as of the last reporting period for which SCQR data was available for the CMSC to analyze. As a result, CI 2.16 remains not met and a new rating determination is deferred (i.e., DD). This CI can be evaluated in the 25th reporting period.		

2.18	If, after receiving technical assistance, a CSB does not demonstrate improvement, the Case Management Steering Committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract and licensing regulations.	As reported in the FY23 reporting period, DBHDS continues to provide targeted technical assistance to CSBs who underperform on three or more of the ten indicators following look-behinds. Ten (25%) CSBs had only 1 indicator below 86%. Eight CSBs had less than 50% of their records with nine of ten indicators meeting the metric of 86%; and 3 or more indicators below 50%. These CSBs received targeted TA. (8) Across FY23, DBHDS requested a total of thirty-two IPs. These included eighteen for ISP timeliness, thirteen for RST timeliness and one for SCQR results. Sixteen CSBs were removed from the Watch List for achieving above target performance. The CMSC prepared a letter to the Commissioner during the 24th reporting period (7). This letter summarized the concerns of the CMSC regarding ISP data entry and the timeliness of referrals to the RSTs. It also recommended a letter be sent to the one CSB that had three indicators under 50% performance as documented in the SCQR.	DBHDS through the CMSC, performs analysis and provides technical assistance (TA) to CSBs to improve performance and quality. The CMSC continues to inform the Commissioner of DBHDS of the performance of the CSBs in key areas and makes recommendations for the Commissioner's action as is warranted. This indicator remains met and a new rating determination is deferred. This CI can be re-evaluated in the 25th review period when new data will be available.	**M**	**deferred**
2.20	All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or DBHDS licensing regulations. Corrective actions for cited regulatory non-implementation will be tracked to ensure remediation.	DBHDS meets quarterly with the Department of Medical Assistance (DMAS) QMR to share and track citations relating to the SCQR elements (6). They have cross-walked and tracked actions jointly since 1/23. The ten CM elements assessed pursuant to the requirements of CI 2.16 are	DBHDS and DMAS have instituted joint tracking of CAPs. This process is in its third year. This indicator remains met and a new rating determination is deferred. This CI can be re-evaluated in the 25th	**M**	**deferred**

		addressed by DMAS through its quality reviews. The elements have been incorporated into the DMAS Waiver or DBHDS licensing regulations. The action plans to address corrective actions are shared with DBHDS. The Department is currently tracking six CSB Corrective Action Plans (CAP). One CSB has an approved CAP. The other five do not have an accepted CAP as of 3/27/24.	review period when new data will be available.		
47.1	The Case Management Steering Committee will establish two indicators in each of the areas of health & safety and community integration associated with selected domains in V.D.3 and based on a review of the data submitted from case management monitoring processes. Data indicates 86% implementation with the four indicators.	CMSC has continued to review twenty performance measure indicators including the seven indicators (PMIs) selected by DBHDS (3). The SCQR, completed in FY23 Q3 and Q4 addressed the review for CY22 records. The implementation rates from the SCQR-FY23 were: Change in Status (PMI-16 at 84%) ISP Implementation (PMI-17 at 84%) Relationships (PMI-18 at 90%) p Choice (PMI-19 based on Indicator 1: 83% and Indicator 2: 93%) The CMSC also tracks two additional PMIs:	VA is tracking two indicators in the areas of health and safety: ISP implementation and Change in Status, and two in the area of community integration: Relationships and Choice. Based on the SCQR FY23 data, the two indicators related to health and safety were each performing at 84% which is below the benchmark of 86%. The two indicators related to community integration are performing at 90% and 93% respectively. Since VA has four indicators in the areas of health and safety and community integration and is below the 86% benchmark on two of them, this indicator is not yet met. This indicator remains not met and a new rating determination is deferred. This CI can be re-evaluated in the 25th review period when new	**NM**	**deferred**

		Employment Goals (PMI-2 at 27%) Employment discussion with 14–17-year-old (PMI-3 at 59%) CMSC has engaged in crosswalks and discussion about congruence between PMIs, QSR results, and QMR-DMAS audits (3) The CMSC continued to meet regularly in this reporting period and was engaged in monitoring the delivery of case management services by the CSBs and reviewed the direct review, monitoring, technical assistance, training and policy direction issued by DBHDS (4). The CMSC uses data DBHDS collects from CSBs in each quarter for a number of indicators. These data are derived from WaMS data from the ISPs that are convened in each quarter.	data will be available.		

Attachment A
Documents Reviewed

1. SCQR Final Report FY23
2. CSB SCQR Sample for First Half Year Reviews
3. CMSC Semiannual Report FY24 1st and 2nd Quarters
4. CMSC Meeting Minutes: 8.1.23, 9.5.23, 10.17.23, 11.14.23, 12.5.23
5. Which QII Should We Choose Tool
6. DR0093 ISP Measures Quality Report through FY24 Q2
7. CMSC Recommendations Letter Draft
8. CSB Indicators QMR Data Tracking
9. RST Report FY24 Q1
10. RST Report FY24 Q2

Submitted:
Kathryn du Pree MPS
Joseph Marafito MS
May 16, 2024

APPENDIX C

Crisis and Behavioral Services

by

Kathryn du Pree, MPS
Joseph Marafito, MS

Review of Crisis Services for the Independent Reviewer
Twenty Fourth Review Period

Crisis Services, Mobile Crisis, and Crisis Stabilization Review

This review was conducted during the twenty-fourth review period. The focus of the review was to determine if the Commonwealth achieved compliance with Compliance Indicators (CIs) that have not been met for two consecutive review periods to date. The Parties have agreed upon a number of indicators to determine compliance with crisis services Provisions that remain out of compliance. These include CIs that relate to Provisions III.C.6.i.-iii for Crisis Services; III.C.6.i.i.A. for Mobile Crisis; and III.C.6i.i.i.B., III.C.6.i.i.i.D; and III.c.6.i.i.i.G for Crisis Stabilization. These CIs, which have not been met or sustained, include: *7.8, 7.18, 7.19, 8.4, 10.4, 11.1 and 13.3.* These CIs are associated with each of crisis services' main components identified as Prevention, Mobile Crisis and Crisis Stabilization. Prevention is identified in the CIs to include assessment in the home; behavior supports in the home; and the availability of direct support professionals. For this subset of these Provisions, progress toward achieving the agreed upon CI metrics will be reviewed and reported.

In the 23rd review period *CIs 7.19 and 8.4* were met for the first time. Respectively these relate to individuals receiving all elements of therapeutic consultation services within 180 days of the service authorization and that the Comprehensive Educational Prevention Plans (CEPPs) are developed within fifteen days of the behavioral assessment being completed. In the 23rd review period *CIs 7.8, 7.18, 10.4, 11.1 and 13.3* had not been met for two consecutive periods. CI 7.8 was not met because only 42% of children and adults received a crisis assessment at home or in another community location where the crisis occurred. *CI 7.18* was not met because only 71% of the individuals identified as needing therapeutic consultation (behavioral supports) were referred to a provider within thirty days of the need being identified. *CI 10.4 and 11.*1 were not met because only 79% and 83% respectively of the individuals who were known to REACH and admitted to a CTH, or psychiatric hospital had a community residence identified within thirty days if their admissions. *CI 13.3* was not met because no children were referred to the host homes during the 23rd review period.

DBHDS provided the documents and files that were requested. Attachment A lists the documents that were reviewed for the purposes of determining compliance with the CIs reviewed for study of the 24th period. Where applicable, this report cites the document number as listed in Attachment A. In addition to reviewing all relevant documents, I interviewed Nathan Habel, Project Manager; Sharon Bonaventura and Denise Hall, Regional Crisis Systems Managers; April Dovel, Director of Crisis Services; and Heather Norton Assistant Commissioner, Developmental Services. I appreciate the time these subject matter experts gave to both answering questions and providing all needed documentation and follow-up.

The Independent Reviewer continues to be deeply concerned about the high number of individuals with I/DD whose initial crisis assessment occurs at hospitals rather than in the individuals' homes as expected in *CI 7.8*. A high percentage of these individuals continue to be admitted to psychiatric hospitals compared to those who have assessments at home and who more frequently utilize in-home supplemental supports or crisis stabilization services as alternatives to hospitalization. This dynamic results in an increased number of children and adults with I/DD who are admitted to psychiatric hospitals in Virginia rather than receiving the mobile crisis service and crisis stabilization services required by the Agreement.

This concern continues to be borne out reviewing the data submitted by DBHDS for FY24 Q2 and FY24 Q3. During this time period only 48% of crisis assessments took place in the home or other community locations in FY24 Q2, and 52% in FY24 Q3. Since the Parties agreed to CI 7.8, including before, throughout and after the end of the pandemic, the percentage of individuals each quarter who received crisis assessments at the location where the crisis occurred has not shown significant improvement. Table 1 includes the percentages of crisis assessments performed in a community setting since FY 20 Q3.

Table 1: The % of individuals who received their initial crisis assessment at home, residential setting, or community setting (non-hospital/CSB location).

Date	Percentage
FY 2020 Q3	46%
FY 2020 Q4	41%
FY 2021 Q1	53%
FY 2021 Q2	34%
FY 2021 Q3	35%
FY 2021 Q4	42%
FY 2022 Q1	51%
FY 2022 Q2	36%
FY 2022 Q3	40%
FY 2022 Q4	36%
FY 2023 Q1	44%
FY 2023 Q2	49%
FY 2023 Q3	37%
FY 2023 Q4	40%
FY 2024 Q1	46%
FY 2024 Q2	48%
FY 2024 Q3	52%

Since Compliance Indicator 7.8 was established in FY 2020 Q3, the quarterly percentage of children and adults who received crisis assessments at home or other community location has ranged from 34% - 53%. Furthermore, there have been significant variances, of up to 19%, between successive quarters. These variances have reflected the results of the crisis assessment practices within the Commonwealth's five Regions and do not indicate either a significant positive or negative systemic change. Data from the most recent four quarters have been consistently nearer the top of the 34% - 53% range and there have been smaller % changes between quarters. This may indicate the beginning of a sustainable positive trend.

As of the 24th Period, far too many children and adults continue to be assessed for a crisis at CSB Emergency Departments or hospitals which leads to the predictable increased rate of hospitalizations compared to the rate for individuals who receive a crisis assessment in a community setting. This finding aligns with the results of previous studies. The results of these assessments strongly support the Independent Reviewer's and Expert Reviewer's contention that it is essential to provide these assessments in the community including the individual's home setting because it is far more likely that the individual will retain this setting and not be hospitalized if the assessment occurs in the community. It is important to note that there are persistent and substantial variations in the percentages between Regions. For example, Region I had as few as 14% in the second quarter of FY 24, whereas Region III had 64% of crisis assessments conducted in the community during this same quarter. Region I was equally low providing assessments in community locations in the previous reporting period.

Table 2: Crisis Assessments Conducted In Community Settings for Individuals Known to REACH

Date	Average % assessed in community setting	Range	
FY 24 Q2	42%	Region 1 14%	Region 3 64%
FY 24 Q3	50%	Region 1 22%	Region 3 66%

During FY24 Q2 and FY24 Q3 the outcomes for individuals who received a crisis assessment in the community and retained their home setting were 65% and 89% respectively. This compares to 60% and 61% when the crisis assessment occurred in a hospital, or CSB ED (Emergency Department). These data are depicted in Tables 3 and 4 below. These data are derived from the total number of crisis assessments including those conducted for children and adults with DD who were both known and not known to REACH. This included 862 children and 863 adults for a total of 1,725 individuals who were assessed for a crisis in the 24th reporting period (#4,5,6,7 and 9). DBHDS does not report data regarding the number of individuals who are known to the system who receive a crisis assessment at home or in another community location where the crisis occurs, as required by this CI.

Table 3: Results of Crisis Assessments Conducted in Community Locations

Time	Remain Home	CTH/CSU	Other	Hospitalized
FY24 Q2	65%	4%	3%	28%
FY24 Q3	89%	5%	1%	5%

Table 4: Results of Crisis Assessments Conducted in Hospitals and CSB ES

Time	Remain Home	CTH/CSU	Other	Hospitalized
FY24 Q2	60%	5%	4%	31%
FY24 Q3	61%	5%	3%	31%

In Table 2 above, DBHDS provides data regarding the children and adults who were known to REACH and had a crisis assessment in the Supplemental Crisis Reports (#2,3) to and adults with DD who receive a crisis assessment in the REACH Quarterly Reports (#4,5,6,7). Comparing the numbers of crisis assessments conducted during the reporting period for individuals known to REACH and those not known to REACH allows me to reflect on the success of the REACH program. In this review period, 1,725 children and adults with DD were assessed for a crisis. However, only 641 (37%) of the 1,725 individuals with a crisis assessment were known to REACH and 1,084 (63%) were children and adults with DD who were not known to REACH. This is not an analysis I have performed in the past, so I am unable to report if these data indicate a trend. If there is consistently a much lower percentage of children and adults known to REACH who experience a crisis and are assessed, this smaller number of individuals known to REACH versus those individuals not known to REACH appears to indicate the success of REACH interventions to avert future crises.

The Expert Reviewer reviewed the Quarterly REACH reports (#4,5,6,7) to determine the status of the Commonwealth's implementation of the systemic changes needed to resolve the obstacles that have previously slowed progress toward achieving this indicator's measure of compliance. DBHDS continues to report and track all aspects of crisis assessment and services performed by the regional REACH programs. Regions continue to meet the overall expectations for timely response to crises.

All REACH programs continue to use telehealth to some extent and do not respond to all crisis calls in person. Regions vary in the percentage of responses that are onsite response with Regions III and V conducting more onsite assessments (81%-96% of the time) during FY24 Q2 and Q3 compared to the other regions. Region I conducted 25%-31%, Region II 74-81%, and Region IV conducted approximately 50% of its crisis assessment onsite. DBHDS explained that it has set an expectation that REACH staff will no longer perform crisis assessments via telehealth but are expected to attend all crisis assessments onsite. However, the Code of Virginia governing hospital screenings allow for these assessments to be conducted by ES and hospital staff using telehealth. The Commonwealth will only have REACH staff participate in an onsite assessment if Virginia's CSB ES or hospital staff are performing the assessment onsite

and include the REACH staff. DBHDS reports the ES and ED staff are using telehealth more frequently in certain parts of the state and some families prefer and request a telehealth assessment. DBHDS also reported that there is not any significant difference in the rate of hospitalizations as a result of an assessment conducted onsite versus using telehealth. No data were provided to confirm this but as reported previously in this report, significantly more individuals whose crisis was assessed in the community retain their setting at the completion of the assessment.

The Children's and Adult CTH programs were underutilized during both quarters primarily because of staffing shortages. There were no Regions that reported a waiting list. However, a high number of individuals are still hospitalized after a crisis assessment who might have been able to be stabilized at a CTH if the program was fully available.

During the interview with the subject matter experts, I discussed the low utilization of the CTHs and the continued hospitalization of individuals with DD after a crisis assessment. DBHDS staff report CTH referrals have decreased, and REACH programs find the individuals who are referred have a higher acuity level. Individuals who are admitted with a higher acuity level need more staff to support them. Others may have an acuity level that precludes their admission to the CTH program because the program is not structured or staffed to support individuals with more intense needs and/or are only willing to be supported in an acute facility. Prevention and mobile crisis services continue to be provided and the outcome is that almost all recipients of these services retain their residential setting after participating in other prevention or mobile crisis services. Although it did not provide evidence, DBHDS posits that the increase in these prevention and mobile community crisis services post pandemic, are having a positive impact on children and adults, either averting crises or being able to manage than with support services that allow the individual with DD to stay home.

Virginia has expanded its statewide crisis response by investing in Crisis Receiving Centers (CRCs). These settings provide the opportunity for an adult or child experiencing a crisis to stay for up to 23 hours. The CRCs are available to anyone experiencing a mental health crisis and is not limited to individuals with DD. The CRCs do link individuals with DD to REACH when this is an appropriate referral. These CRC's currently serve adults with eight out of nineteen of the planned CRCs being open in Regions II, III, IV and V. Children are served in two out of four planned CRCs which are open in Regions II and IV. The Commonwealth is to be commended for expanding crisis services that support individuals with DD as well as those with mental health diagnoses. The availability of this service is expected to have a positive impact on decreasing hospitalizations.

The Commonwealth is seeing a decrease in hospitalizations for individuals with DD in this reporting period, which follows a trend of fewer hospitalizations over the past few years. The Commonwealth reports separately for hospitalizations in state psychiatric facilities and private psychiatric hospitals (#11). In state psychiatric facilities the Commonwealth reports back several years. Although REACH services were in place, the number of hospitalizations peaked in FY19 when a total of 1,018 children and adults with DD were admitted to these facilities for a

behavioral crisis. This number has steadily dropped since FY21, the first full year of the pandemic, when 588 individuals with DD were admitted to FY23 when 345 individuals were admitted. The data for FY24, which is through Q2, indicates that a similar number may be hospitalized in FY24 compared to FY23.

The Commonwealth began reporting admissions to private psychiatric hospitals in FY21 when 735 children and adults with DD were admitted to these facilities. The number of admissions to the private hospitals has always been higher than those to the public hospitals. Private hospital admissions have decreased from 735 in FY21 to 561 in FY23. The Commonwealth reported on these admissions through Q3 in FY24. Projecting from this number with only one more quarter to report, admissions to private psychiatric hospitals may continue to decrease to approximately 375 in FY24.

DBHDS provided the following response regarding the status of the 988-crisis response line. Virginia continues its partnership with 988 within the Commonwealth to provide more robust access to crisis services. Virginia's 988 can now dispatch Mobile Crisis Response teams when an individual is identified as needing an in-person response. DBHDS reports that the 988 system allows for expanded access to REACH services throughout the state. The Commonwealth originally expected that using 988 would lead to an increase in the number of crisis assessments that occurred in community settings. The percentage of crisis assessments being conducted in community settings has gradually increased in each quarter of FY24 as depicted in Table 1. The most recent quarters have averaged near the top of the 34%-53% range that all quarters have been within for the past four years. Furthermore, they remain well below the expected outcome that 86% of these assessments will be conducted in community locations where the crisis occurs. Table 1 above shows why this increase must be sustained and continue for the next year before it can be cited as a trend that may eventually lead to a significant increase in the number of assessments completed in the community that achieves the benchmark of 86%.

DBHDS reported on the use of the out-of-home crisis therapeutic prevention host-home like services for children (#4,5). These settings were expected to provide an alternative support to families and therefore reduce hospitalizations for children and be accessible statewide. Three years ago, the Commonwealth awarded contracts to two providers to serve these children but only one provider is staffed and has residential settings to support children with DD in crises. The other provider does not, and has not, had sufficient staff to open homes. In addition, the Commonwealth's crisis services system has not made any referrals in the 22nd, 23rd, or 24th reporting periods to the provider that DBHDS reports has the potential to be operational. As explained in Table 7 below, DBHDS is working with the Regions to develop Children's CTHs where none currently exist as an alternative to the host-home model. This will offer families out-of-home alternatives within their region but may not address the concerns families have to be able to have their children continue to attend school when they are psychiatrically stable but have not returned home.

DBHDS continues to conduct quarterly reviews of the REACH programs (#10,11). These reviews include data review; review of compliance standards and program performance; clinical chart review of selected program participants; review of any previous corrective actions and an in-person interview to discuss clinical improvement. During the most recent quarterly reviews, most of the Regions met all or the majority of the REACH standards. DBHDS reviewers provide feedback on areas that are partially met and expect improvement. Region I submitted an Action Plan to increase REACH responsiveness and access in the region as a result of qualitative reviews and underperformance during the 23rd reporting period. DBHDS reports that the leadership has changed, and this Region's performance is slowly improving. However, the quarterly reviews for FY24 Q2 and Q3 still note areas of underperformance in Region I. Much of the corrective action addressed the impact of the staffing shortage the Region has continued to experience.

The REACH programs continue to experience significant staffing shortages statewide. Vacancies in the community programs range during the 24th review Period from 18% for supervisory/clinical positions to 43% for mobile crisis support workers. The Children and Adult CTH programs experience vacancies as well. The Adult CTH programs overall have 35% of their positions vacant. The Children's CTH and the Adult Transition Homes have fewer vacancies, 16% in each program. With the exception of statewide mobile support services where the vacancy rate decreased slightly from 47% to 43%, all other components of REACH programs have a higher percentage of vacancies in this reporting period overall compared to FY23.

The DBHDS REACH Quarterly Reports note that the CTH program is not being fully utilized in any Region. DBHDS attributes this to staffing shortages, serving individuals with higher acuity who need more intense staffing, and periods of time CTH beds are offline due to damages caused by CTH visitors.

The following Tables depicts the data regarding staffing as of FY24 Q3.

Table 5: FY24 Annual REACH Staffing Data for REACH Crisis Teams

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Supervisory/clinical filled	7	12	15	16	8	**58**
Supervisory/clinical vacant	1	0	5	1	6	**13**
Total	8	12	20	17	14	**71**
Percent Vacant	12%	0%	25%	6%	43%	**18%**
Coordinator filled	6	17	3	13	0	**39**
Coordinator vacant	10	7	9	3	0	**29**
Total	16	24	12	16	0	**68**
Percent Vacant	60%	29%	75%	19%	N/A	**43%**
Mobile filled*	0	8	6	11	21	**46**
Mobile vacant	0	0	21	6	8	**35**
Total	0	8	27	17	29	**81**
Percent Vacant	N/A	0%	78%	35%	33%	**43%**
Hospital Liaison	1	1	1	2	1	

- R1 added one clinical position and one coordinator and has coordinators providing mobile support
- R3 added one clinical position
- R4 added one clinician
- R5 decreased one mobile staff

Table 6: FY23 Annual REACH Staffing Analysis for REACH CTH and ATH Settings

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Adult CTH filled	11	21	22	21	9	**84**
Adult CTH vacant	12	4	5	4	20	**45**
Total	23	25	27	25	29	**129**
Percent Vacant	50%	16%	18%	16%	67%	**35%**
Children's CTH filled		14		22		**36**
Children's CTH vacant		5		2		**7**
Total		19		24		**43**
Percent Vacant		26%		8%		**16%**
ATH Filled		18		23		**41**
ATH Vacant		4		4		**8**
Total		22		27		**49**
Percentage Vacant		18%		4%		**16%**

- R3 decreased 2 Adult CTH staff
- R4 decreased 3 Adult CTH staff and increased ATH by 4 staff
- R5 increased its vacancies in the Adult CTH from 45% to 67% in the 24th period

The DBHDS Office of Crisis Services announced budget approval from the State General Funds for a one-time allocation of $10,000,000. This funding is earmarked for a $2,00,000 contract with a recruitment firm; subscriptions to Indeed for job postings; and almost $8,000,000 for the Regions to use to fund strategies to improve recruitment and retention. These strategies include vehicles for mobile crisis response, electronic equipment and cell phones, on-call and shift differential payments, relocation fees, bonuses, student loan repayment, professional development and support for maximizing billing activities. DBHDS staff are optimistic that this infusion of resources will have a positive impact on both staff recruitment and retention in the REACH programs. This is a significant financial investment by the Commonwealth to address continued staffing shortages that have not diminished since the COVID pandemic began in 2020.

DBHDS continues to use the Behavioral Support Program Adherence Review Instrument (BSPARI) to determine the quality of the behavior programs developed by behaviorists and provided to individuals with therapeutic consultation. DBHDS is to be commended for developing this comprehensive review process that has achieved high inter-rater reliability. The DBHDS BCBAs who conduct these reviews provide feedback and offer assistance to behaviorists to help improve the quality of plans and therefore services that individuals with I/DD receive to address problematic behaviors and increase positive behaviors. This is a clear example of the focus DBHDS places on continuous quality improvement in providing services to individuals with behavioral needs. DBHDS staff, Nathan Habel and Sharon Bonaventura co-authored an article, *The Development of a Behavioral Plan Quality Assurance Instrument in a Publicly Funded System of Care*, that was published in the Behavior Analysis in Practice Journal in January 2024. It is highly commendable of DBHDS and its subject matter experts that the BSPARI tool and review process are considered noteworthy in a nationally recognized journal in the field of behavior analysis.

Summary of Findings

Seven CIs were reviewed in the 24th period. The Commonwealth met three of these CIs, including *7.19 and 8.4* which are now met for two consecutive periods. CIs *11.1* is now initially met. Virginia has not met CIs *7.8, 7.18, 10.4 or 13.3.* Table 7 summarizes the facts and conclusions for the review of these CIs. All processes and attestations have been verified in previous studies and no substantive changes have been made.

Table 7 below summarizes the status of the Commonwealth's efforts to meet the Crisis Services CIs.

Table 7: Crisis Services Compliance Indicator Achievements

SA Provision- III.C.6.a.i-iii: The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall: i. Provide timely and accessible support; ii. Provide services focused on crisis prevention and proactive planning; iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the induvial from his or her current placement whenever practicable.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**23**	**24**
7.8	86% of children and adults who are known to the system will receive REACH crisis assessments at home, the residential setting, or other community setting (non-hospital/CSB location)	DBHDS reported (#2,3) for the percentages of individuals who had a crisis assessment conducted in community settings: FY24 Q2 42% Range: 14% R1 to 64% R3 DBHDS reported for this quarter the numbers of assessments completed as well as the percentages. A total of 273 assessments were completed of which 115 were conducted in community locations. FY24Q3: 50% Range: 22% R1 to 66% R3 DBHDS reported for this quarter the numbers of assessments completed as well as the percentages. A total of 368 assessments were completed of which 183 were conducted in community locations.	A total of 641 children and adults were assessed for a crisis in this reporting period (FY24 Q2 and Q3). Of these children and adults known to REACH, 298 (46%) received their crisis assessment in the home or community setting to de-escalate the crisis where it occurred. This percentage aligns with the average annual percentage since FY 2020 and remains far below the performance metric of 86%. Since a higher percentage of individuals are hospitalized when the assessment occurs at either the CSB-ES office or hospital this remains a significant concern. These data are described in the report. Virginia has not met this CI's 86% benchmark and remains far below the expected performance metric.	**NM**	**NM**
7.18	Within one year of the effective date of the permanent DD Waiver regulations, 86% of those identified as in need of the Therapeutic Consultation service (behavioral supports) are referred for the service (and a provider is identified) within 30 days.	1,307 individuals needed TC (behavioral supports) between 7.23 and 1.24 (#1). Of these individuals 962 (74%) were connected to a behaviorist within 30 days, compared to 608 (71%) of the individuals connected within 30 days in the previous reporting period. Three of the regions, central, western and northern met the benchmark of 86% at least once during the reporting	Overall, only 962 (74%) of the 1,307 children and adults who were identified for TC were connected to a TC provider within 30 days. This is a sizeable increase of individuals authorized compared to the previous reporting period when 854 individuals were authorized. The number of children and adults who were connected within 30 days to a provider increased by 354	**NM**	**NM**

		period. The Northern Region met or exceeded the benchmark three times in the period and has the most individuals needing therapeutic consultation. The average number of days for people connected beyond thirty days was 59 (July), 68 (August), 75 (September), 64 days (October), 68 days (both November and December), and 52 days (January). Overall, at the time of the FY24 Q3 report between July and January, only 1,057 (81%) of individuals who needed a behaviorist were connected to one at all, which is an increase over the total percentage of individuals who were connected in the 23rd period which was 78%.	individuals from 608 to 962 individuals since the 23rd reporting period. DBHDS has undertaken a root cause analysis using the Performance Diagnostic Checklist to identify the business problems and identify related solutions. This analysis was conducted by a DBHDS BCBA with subject matter expertise. Potential variables that DBHDS identified as contributing to the Commonwealth's underperformance include Support Coordinator's (SC's) awareness of the behavioral resources available to individuals in need of therapeutic consultation and the Settlement Agreement requirements; unique CSB business practices; and supervisory support for SCs in this area of performance. DBHDS is providing training, communication and follow up with CSBs regarding expectations and service provider availability and has done so monthly since July 2023 with CSB leadership. DBHDS also informs CSBs of new providers in their regions and has made a search engine available for timely access by CSB Service Coordinators. DBHDS also notes that providers may include more than one behaviorist. DBHDS has worked to increase the number of providers available in regions following up on last year's gap analysis. A total of 11 providers were added as of 1/24 which brings the total number of providers to 94 which is an increase of 13% in this reporting period compared to		

			the number of providers reported in the 23rd reporting period. Virginia has continued to not meet this indicator because only 74% of the individuals who need TC are connected to a provider within 30 days.		
7.19	86% of individuals authorized for Therapeutic Consultation Services (behavioral supports) receive, in accordance with the time frames set forth in the DD Waiver Regulations, A) a functional behavior assessment; B) a plan for supports; C) training of family members and providers providing care to the individual in implementing the plan for supports; and D) monitoring of the plan for supports that includes data review and plan revision as necessary until the Personal Support Team determines that the Therapeutic Consultation Service is no longer needed.	DBHDS established its Behavioral Support Program Adherence Review Instrument (BSPARI) to determine whether the four elements of behavioral supports were received (#1). DBHDS reported in the Behavior Supplemental report for FY24 Q2 and Q3 that 92 behavior plans, and related documentation were reviewed for individuals with annual authorizations for FY24 Q2-FY24 Q3. Eighty-six (93%) contained all four components of the CI 7.19 requirements, compared to 88 (88%) reported in the 23rd period.	The DBHDS Program Manager and the Expert Reviewers agreed to the minimum elements of the BSPARI that needed to be present for a determination that all four requirements of 7.19 were met. This review determined that the DBHDS monitoring process was effectively implemented and was sufficient to identify whether individuals received the four required elements. DBHDS reviewed 92 BSPARIs using acceptable criteria for a minimally adequate behavior program and found that 93% contained all four elements. Additionally, DBHDS has reviewed a total of 590 behavior programs. Of these 575 (97%) have been completed prior to or within 180 days of the service authorization. This CI is now achieved for the second consecutive review period.	**M**	**M**

SA Provision- III.C.6.ii.A: Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**23**	**24**
8.4	86% of initial CEPPs are developed within fifteen days of the assessment.	DBHDS reported (#3) CEPPs completed for FY23 Q4-FY24 Q1 combined. This was not reported for FY23 Q2 and Q3. Overall, 87% were completed on time, which is consistent with the performance in the previous reporting period. This ranged from 50% in R1 to 100% in R5.	The Commonwealth has now achieved this CI's benchmark for the second consecutive period.	**M**	**M**

SA Provision- III.C.6.b.iii.B.: Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**23**	**24**
10.4	86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities and psychiatric hospitals will have a community residence identified within 30 days of admission.	DBHDS reports separately on those admitted to a CTH and those admitted to a psychiatric hospital (#13). The following data combines these data to evaluate compliance with CI 10.4. The data are for individuals with a DD waiver and known to REACH, not a report of everyone with DD who was hospitalized or admitted to a CTH. In FY24 Q2 a total of 176 individuals were hospitalized or admitted to REACH. A total of 130 (74%) had a community residence identified within 30 days. In FY24 Q3 a total of 159 individuals were hospitalized or admitted to REACH. A total of 135 (85%) had a community residence identified within 30 days.	In FY24 Q2 and FY24 Q3 only one of the five Regions met or exceeded the 86% expectation. Over both quarters in the 24th period, 335 individuals were admitted to hospitals and CTHs of which 265 (79%) had a community residence identified in 30 days. The Commonwealth has not met the requirements of this Indicator.	**NM**	**NM**

SA Provision- III.C.6.b.iii.D.: Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**23**	**24**
11.1	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 CI is also in III.C.b.iii.B.	DBHDS reports (#13) that in FY24 Q2 28 individuals were admitted to the CTH who were known to REACH and on a waiver. Of these 26 (93%) had a community residence identified within 30 days of the admission to the CTH. DBHDS reports (#13) that in FY24 Q3 25 individuals were admitted to the CTH who were known to REACH and on a waiver. Of these 22 (88%) had a community residence identified within 30 days of the admission to the CTH.	A total of 53 individuals were admitted to CTHs in this reporting period. Of these individuals 48 (91%) had a community residence identified within 30 days. The Commonwealth's performance has improved. It has now not only met but exceeded the 86% benchmark for the first time.	**NM**	**M**

SA Provision- III.C.6.b.iii.G.: By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.					
#	**Indicator**	**Facts**	**Analysis/Conclusions**	**23**	**24**
13.3	The Commonwealth will implement out-of-home crisis therapeutic prevention host-home like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service through statewide access in order to prevent institutionalization of children due to behavioral or mental health crises.	The Commonwealth had selected two agencies to provide this support, only one of which is operational as was true in the last reporting period. The home in Region 4 is not operational. DBHDS considers the home in Region 5 as being operational. No children were served however during the entire 24th review period nor were there any referrals during the 24th or the previous 23rd Reporting Period. While the existing host home did not serve any children, DBHDS reports that the Children's CTH operated in Region II served 3 children in FY24 Q2 and 4 children in FY24 Q3 to provide out-of-home crisis therapeutic	The Commonwealth has not met the requirements of this indicator. There were no referrals to either of the two programs that were created to serve children who would benefit. No individuals have accessed this service during the 24th Period. DBHDS reviewed and reported in the 23rd period that it was unsure of the interest among families of children in this model. DBHDS reported that the distance and transportation challenges for families were significant barriers. The DBHDS has acted on the results of the focus group activities they organized in the 23rd reporting period. The feedback from	**NM**	**NM**

		prevention.	stakeholders including parents of children needing crisis services affirmed their conclusions of why these host homes were not being used. DBHDS has met with the three Regions that do not have a CTH for children. Regions III and V have decided to develop CTHs to serve six children. Funds are available and have been approved by DBHDS but are awaiting approval from the Governor's Office. Once this funding is approved, DBHDS estimates the CTHs will be operational in eighteen months. Region I is still analyzing its needs. The Children's CTH operated by Region II is actually physically located in Region I and may meet the needs of children in crisis living in this part of the state. The use of this CTH for therapeutic crisis prevention for 7 children is an example of DBHDS' plans to provide out-of-home crisis prevention services throughout the state by operating a children's CTH in every Region.		

Attachment A

Document List

1. Behavior Supports Report FY24 Q3
2. Supplemental Crisis Report FY24 Q2
3. Supplemental Crisis Report FY24 Q3
4. REACH Data Summary Report-Children: FY24 Q2
5. REACH Data Summary Report- Children FY24 Q3
6. REACH Data Summary Report- Adults: FY24 Q2
7. REACH Data Summary Report- Adults: FY24 Q3
8. REACH Staffing Reports for FY24Q3: All Regions
9. Email from Sharon Bonaventura 4.19.24
10. FY24 Q2 REACH Quarterly Qualitative Reviews: All Regions
11. FY24 Q3 REACH Quarterly Qualitative Reviews: All Regions

Submitted by:
Kathryn du Pree MPS
Joseph Marafito MS
May 16, 2024

APPENDIX D

Integrated Day Activities and Supported Employment

by

Kathryn du Pree, MPS

Integrated Day Activities Including Supported Employment for the Independent Reviewer
Twenty Fourth Review Period

The purpose of this study is to review the Commonwealth of Virginia's progress achieving the Settlement Agreement's (SA) Compliance Indicators (CIs) for Integrated Day Activities including Supported Employment (Section III.C.7.a. and b.) during the 24th review period. This study will review evidence to determine if the Commonwealth has met CIs *14.8, 14.9* and *14.10*. The Commonwealth has not yet achieved the benchmarks for these three CIs for the first time, and, therefore, the focus of this review is to analyze the Commonwealth's related performance during the twenty-fourth period.

Integrated Day Activities was last studied in the 23rd review period. In that period the Commonwealth did not meet any of these indicators. The 23rd study found that although more individuals with DD were employed, Virginia did not meet 90% of its revised targets set by *CI 14.8*. Regarding *CI 14.9*, 23% of individuals with DD were employed through the Department of Aging and Rehabilitation Services (DARS) or the waivers administered by DBHDS, which did not meet the measure that 25% of all individuals with DD either on a waiver or on the waiver waiting list are employed. *CI 14.10* requires the Commonwealth to increase the percentage of individuals with DD in an integrated day service including employment by 3.5%. The 23rd review period found that the percentage of these individuals increased by .2%.

Facts were gathered regarding the Commonwealth's progress related to the performance measures for the three remaining Compliance Indicators associated with the SA provisions III.C.7.a. The focus of this period's review, therefore, will be to review the Commonwealth's progress toward achieving the employment targets for all individuals with DD on the waivers or the waiver waiting list; increased employment specifically within waiver service options for individuals enrolled in a DD waiver; and an increased percentage of waiver recipients who are participating in the most integrated settings for their employment and day services.

Settlement Agreement Provisions
Provision III.C.7.a. requires that: 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.

The three CIs associated with Provisions III.C.7.a. that Virginia has not met twice consecutively, or that were not relieved by the Court, include:

CI 14.8 New Waiver Targets established by DBHDS's Employment First Advisory Group. The data target for FY20 is 936 individuals in Individual Supported Employment (ISE) and 550 individuals in Group Supported Employment (GSE) for a total of 1486 in supported employment.

Compliance with the Settlement Agreement is attained when the Commonwealth is within 10% of the targets.

CI 14.9 The Commonwealth has established an overall target of employment of 25% of the combined total of adults ages18-64 on the DD waivers and waitlist.

CI 14.10 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).

Methodology

This review focused on the Commonwealth's progress toward achieving the indicators for increasing the number of individuals who are engaged in supported employment or who are competitively employed, and those who are receiving Community Engagement (CE) and other integrated day services. I engaged in the following activities to review and analyze the DBHDS' progress toward meeting the CIs for integrated day activities.

Interviews: I interviewed members of the Employment First Advisory Group (E1AG). The E1AG meets bi-monthly and met regularly in the 24th review periods (# 6). The E1AG returned to meeting in person in July 2023. The E1AG members who were interviewed continue to be pleased about the direction of the E1AG.The return to in-person meetings and scheduling the sub-committee and E1AG meetings to occur on the same day has increased participation. The E1AG renewed its focus on reviewing data. Members believe the data is accurate and has provided the basis for the decision for DBHDS to again significantly reduce their employment targets related to *CI 14.8*.

The Chair of the Data Committee is very complimentary of the work of the DBHDS data analyst. The analyst's expertise and contributions have resulted in reliable and accurate data for the committee to use to make projections and set targets that the committee members believe are challenging but achievable. Committee members were very positive about the inclusion of staff from Department for Aging and Rehabilitation Services (DARS who are leading employment projects to increase customized employment, transition students from school to employment, and address the transition of providers who no longer operate sheltered employment operations that pay individuals less than minimum wage.

E1AG members remain concerned with the challenges to meeting the employment targets. While more individuals with DD were employed as of December 2023, E1AG members report that the workforce shortage is an obstacle that impacts the providers' abilities to have sufficient job coach capacity to assist all individuals seeking employment in a timely way. The data committee analyzed the employment data and supported a further reduction in the employment targets for waiver

participants during the 24th review period. This reduction is described in greater detail in the Summary of Findings and Table 1. Members also express concern that the E1AG should increase its focus on the needs of individuals with behavioral health and substance use disorders to reflect the inclusion of these groups in the mission of the E1AG.

I also interviewed Heather Norton Assistant Commissioner, Developmental Services, DBHDS.

Documents: I reviewed the Semiannual Report on Employment; the Provider Data Summary for the State FY2023; the meeting minutes for the Employment First Advisory Group (E1AG) and the Community Engagement Advisory Committee (CEAG); the Community Engagement Strategic Plan; and the Employment Services Strategic Plan.

Summary of Findings for the 24th Period

The purpose of this review is to determine the Commonwealth's progress meeting the following Compliance Indicators: *14.8, 14.9 and 14.10*. None of these were met in previous studies. It is important to note that the data used to make the 24th Period determinations reflect a six-month period from July 1, 2023, to December 31, 2023. The data used in all previous studies reflected twelve-month periods commensurate with Virginia's fiscal years.

CI 14.8 It is the responsibility of the E1AG to work with DBHDS to set and review the targets. The E1AG has a data committee which reviews the employment data at least annually and completes trend analyses. The Commonwealth made progress towards achieving its employment targets though 2019. DBHDS achieved the highest percentage towards meeting its overall employment target in 2019 when it reached 89% of the target it set (1,078 employed compared to the target of 1,211).

An expected decline in the number of employed waiver participants occurred during the pandemic. The decline was dramatic between June 2019 and June 2020 (from 1,078 to 715 employed waiver participants). This decline began to turn around in FY22 when 764 individuals on the waiver were employed. The Commonwealth did not meet its target for FY23 of 1,486 waiver participants employed but did achieve employment for 986 of these individuals which was a 29% increase in employment in one year. This was reported in the 23rd reporting period.

As reported in the 23rd Study Report, during the pandemic, DBHDS revised its waiver employment targets for 2022, reducing the target to 1,211 which was the pre-pandemic target for 2019. The E1AG met in April 2022 to revise the employment targets. This decision was made after a review and analysis of the impact of the COVID pandemic on employment outcomes for individuals with I/DD in Virginia. The decision was to return to the targets of 2019 for 2022 and those of 2020 for 2023. Virginia achieved the highest percentage of its target since 2019 (pre-pandemic) when the Commonwealth reached 89% of its target as noted above.

As of the prior study, which was conducted in the fall of 2023, DBHDS planned to return to its pre-existing targets for the out years through 2026. However, during this current review period DBHDS and the E1AG undertook a more rigorous analysis of the employment data. DBHDS and the E1AG Data Committee members reviewed the historic approach to setting employment targets. Percentage increases year to year were not consistently set by the Commonwealth. The E1AG committee's review found that originally, there was no apparent methodology or review of actual and projected performance to set the targets. As an example, between 2016 and 2017 the expected increase in employment was 15% yet it was 28% between 2017 and 2018. The E1AG reviewed the last few years' performance including the declining enrollment in GSE. This decrease in the reliance of GSE has been anticipated and promoted as Virginia views ISE as the more integrated employment opportunity. As a result of its data analysis, the E1AG Data Committee recommended reducing future employment targets based on what they consider a more realistic annual increase of 15% in employment for waiver participants.

This new approach results in the following targets based on the actual achievement in FY23:

- FY24 1,142
- FY25 1,310
- FY26 1,512

For the 24th review period study, there is only six months of data to review. DBHDS' target for FY24 is 1,142. As of December 31, 2023, there were 914 waiver participants employed. This number represents 80% of the target of 1,142 for this fiscal year. Whether Virginia will meet this target cannot be determined until the end of the fiscal year.

CI 14.9 The data reported is derived from data submitted by the Commonwealth's Employment Service Organizations (ESO) and Department for Aging and Rehabilitative Services (DARS). The data are analyzed by DBHDS and the E1AG. There were 21,879 individuals receiving or on the wait list for waiver services as of 6.30.23. Of these individuals a total of 4,959 (4,373 in ISE and 586 in GSE) were employed. This represents 23% of the waiver population. This is an increase of 186 individuals who are employed compared to the number employed in the 23rd period but *CI 14.9* is not yet achieved as Virginia did not meet the outcome that 25% of the waiver participants and individuals on the waiting list for waiver services were in integrated day services. These data are described in Table 1 below.

CI 14.10 The Commonwealth established 25.2% (3,279/13,014) as the baseline number and percentage for this indicator in March 2018 when there were service authorizations (SA) for 3,279 individuals with DD being served in the most integrated employment and day service settings and 13,014 individuals in the DD waivers. For this reporting period the comparison is from 9.30.22 to 9.30.23. In September 2022, there were 3,157 (19.5%) individuals with DD who received waiver services and participated in integrated employment or day services of 16,197 in the DD Waiver population. In September 2023, a year later, 3,450 (21%) of 16,454 individuals in the DD Waiver population participated in the most integrated settings for employment and day services. While the number of waiver participants in integrated day services increased by 293 individuals, the

percentage of waiver participants with SAs for integrated day services increased by only 1.5% percent. The Commonwealth has not yet returned to or surpassed the number of individuals participating in integrated day settings in 3/31/20 which was 4,171. This was the largest number of participants in the most integrated employment and day service settings since the baseline was set in March 2018.

These data are only reported through March 2023, which was the end of the 22nd review period. The reporting period does not match fiscal year or the time of the 24th study period (10.1.23-3.31.24). While there is some overlap in the data from the 23rd study which reported data from 3.22-3.23 with the 24th review period which reports data from 9.22-9.23, it should be noted that in the 23rd review period the participation of waiver participants increased by only .2%, whereas in the 24th period the percentage of the DD Waiver population that participated in integrated day services increased by 1.5%. The Commonwealth did not meet the *CI 14.10* requirement of an annual increase of 3.5% of waiver participants.

Compliance Indicator Achievement

Table 1 below summarizes the status of the compliance indicators. For integrated day services.

Table 1
Integrated Day Services Findings

#	Indicator	Facts	Analysis/Conclusions	23rd	24th
14.8	New Waiver Targets established by the Employment First Advisory Group. The data target for FY20 is 936 individuals in ISE and 550 individuals in GSE for a total of 1486 in supported employment. Compliance with the Settlement Agreement is attained when the Commonwealth is within 10% of its targets.	The E1AG met in the 24th period to revise the employment targets (# 6). The E1AG made the decision to lower the targets after it reviewed and analyzed the previous methodology for setting the targets; the decrease in the use of GSE and post-pandemic systems issues including a shortage of employees for employment supports. The targets for 2024 are 1,142 individuals employed overall including 842 in ISE and 300 in GSE. During the 24th period as reported in the Semiannual Employment Report through December 2023, the number of individuals who were employed was 914 of whom 635 were in ISE and 279 were in GSE (#1). This data only reflects employment for the first six months of the fiscal year. However, DBHDS does not set specific targets in six month increments but rather sets the target annually. The data reported are derived from data submitted by the Employment Service Organizations (ESO) and DARS. The data are analyzed by DBHDS and the E1AG (#1,2).	The Commonwealth has decreased the number of individuals with waiver-funded services who are employed by 72 since the last reporting period when 986 individuals were employed. The decreases are in both ISE (67 fewer individuals) and SE (5 fewer individuals). It is understandable that the Commonwealth wanted to set reasonable and achievable targets and want the targets to reflect the commitment to increasing ISE rather than GSE. However, it is very concerning that there are decreases in ISE to date in FY24 with 635 individuals in employed through ISE after DBHDS achieved a marked increase in 2023 when 702 individuals were in ISE compared to 2022 when only 530 individuals were in ISE as the impact of the pandemic lessened. The target is set to be achieved in June 2024. It is not possible to determine if this indicator will be achieved at this point in the year, having only six months of data to analyze.	**NM**	**NM**

14.9	The Commonwealth has established an overall target of employment of 25% of the combined total of adults ages 18-64 on the DD waivers and waitlist.	DBHDS reports that there were 21,879 individuals on either the waivers or the waiver waiting list as of 6.30.23. Therefore, the goal is to have 5,470 individuals employed by 12.31.23 to achieve the 25% metric. DBHDS reports in the Semi-annual Employment Services report of 12.31.23 that 4,959 individuals are employed. This is 23% of the number of individuals on waivers or the waiver waiting list. There has been an increase of 186 individuals employed since the 23rd reporting period when 4,773 individuals with DD were employed. The increase in the number of individuals employed in ISE is 149. This is the 18th semiannual employment report produced by DBHDS. Data were submitted by 100% of the Employment Service Organizations (ESO) and by DARS. The individuals employed primarily participate in the Extended Employment Services (EES); Long-term Employment Support Services (LTESS); and HCBS waiver programs. The E1AG conducts trend analyses for the data in the semiannual employment reports and used this analysis to make recommendations to DBHDS which are contained in the semiannual reports.	The Settlement Agreement establishes a target of 25% employment for the adults on the I/DD waivers or wait lists. In this reporting period only 23% of this population was employed in ISE or GSE offered by DBHDS or DARS. The Commonwealth has achieved 23% in both the 23rd and 24th reporting period. DBHDS reports that of the 4,959 individuals with DD who are employed, 4373 (88%) are employed through ISE. This is consistent with the percentage of individuals with DD who were employed in the 23rd reporting period. This indicator has not been achieved but the metrics are consistently positive since the low point of the pandemic.	**NM**	**NM**
14.10	DBHDS service authorizations 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	The baseline for this indicator was established in 2016 when there were service authorizations for 1,120 individuals with I/DD being served in the most integrated employment and day service	Comparing the achievement of the number of service authorizations in September of 2022 to September 2023, there is an increase from 19.5% to 21%, which is a 1.5% increase. This is a	**NM**	**NM**

	Day Services Report (an increase of about 500 individuals each year as counted by unduplicated number recipients). .	setting. For this reporting DBHDS reported that in March 2023, 3,254 out of 16,329 (19.5%) individuals with DD Waiver services were authorized to participate in integrated day settings. A year later, March 2024 3,762 out of 17,142 (21.9%) were authorized. This represented a 2.0% increase. This outcome remains less than Indicator 14.10's requirement to demonstrate an increase of 3.5% annually.	positive achievement compared to the .2% increase in the number of individuals with DD in integrated settings in the 23rd reporting period. Comparing March 2023 to March 2024, there is a 2.0% increase. Recommendation: The Commonwealth should incentivize the delivery of integrated Community Engagement (CE) services versus group day support programs. Virginia should increase its reimbursement rate to those agencies that provide CE services as well as the pay rates for direct support staff who provide these integrated services. It should also identify and acknowledge the provider agencies that have successfully converted less integrated day services to delivering Community Engagement services in Virginia and the residential agencies that have offered Community Engagement services to their residents, and should ensure that these agencies have regular opportunities to share with the broader provider community how they accomplished and have sustained this transformation and the benefits of doing so. DBHDS should ask its providers what barriers exist to providing Community Engagement to more individuals and develop and implement a plan to address the most impactful barriers. The Commonwealth has not achieved the requirements of this indicator.		

Attachment A
Documents Review
Integrated Day Services- Title or File Name

1. Semiannual Report on Employment December 2023 Data: Issued March 2023
2. Provider Data Summary Report FY2023 Final: Issued February 2024
3. Community Engagement Work Plan FY24-26
4. CEAG Meeting Minutes 2.16.24
5. E1AG Plan for FY24-26 with Quarterly Updates
6. E1AG Meeting Agendas and Minutes: 10.18.23,12.20.23,2.21.24
7. Regional Quality Council Meeting Minutes FY24 Q1 and FY24 Q2

Submitted by:
Kathryn du Pree MPS
June 8, 2024

APPENDIX E

Community Living Options

by

Kathryn du Pree, MPS
Joseph Marafito, MS

Community Living Options Report
24th Review Period
Prepared for the Independent Reviewer

Introduction

This report constitutes the sixth review of the compliance indicators for Community Living Options (Integrated Settings - Section III.D.1). In the Independent Reviewer's 22nd Report to the Court, the Commonwealth provided documentation that twenty (20) of twenty-three (23) Compliance Indicators (CI) had been achieved, of which seventeen (17) were met for two consecutive study periods. In the 23rd review period six CIs were reviewed of which three CIs, *18.3, 18.4 and 18.5* had been met once before, and three CIs, *18.2, 18.6 and 18.9* had not been met previously. The study conducted during the 23rd period concluded that CIs *18.3, 18.4, and 18.5* were met for a second consecutive review, and *18.2* and *18.6* were met for the first time. *CI 18.9* remained not met.

The 23rd review found that the Commonwealth had not achieved the performance metric for CI 18.9. During the first six-months of FY23, only 46% of the 540 individuals with authorized nursing services received the hours allotted to them 80% of the time, which was significantly less than the 70% of individuals required.

This sixth review being conducted during the 24th view period is to determine if the Commonwealth has achieved compliance with the CIs that have not been met for two consecutive review periods. This includes the following CIs which were met for the first time in the 23rd review period: *CIs 18.2 and 18.6* to determine if achievement has been sustained; and the CI which had not been met in any review period since the Indicators were established in FY 2020: *CI 18.9.*

For this review the facts gathered are identified and analyzed for each indicator in the Findings Table below. The documents which include these facts are listed by reference in Attachment A and most are found in the Commonwealth's library of documents. Clarifying interviews were conducted with Eric Williams, Director of the Office of Provider Network Supports; Susan Moon, Director, Health Support Network; Brian Nevetral, OIH Project Manager; and Heather Norton, Assistant Commissioner, Developmental Services.

Summary of Findings for the 24th Review Period

This review found that one of the three indicators reviewed was sustained through continuing effort. *CIs 18.2 and 18.6* were achieved for the first time in the 23rd review period. *CI 18.6* is met in the 24th period, having been sustained for two consecutive reporting periods. *CI 18.2* was found to be not met in this reporting period for reasons described below. The third indicator *CI 18.9*, which addresses the delivery of nursing services to both children and adults, remains not met.

Regarding *CI 18.2,* DBHDS data showed that the number and percentage of authorizations for individuals being served in most-integrated residential settings (i.e. fewer than four individuals with DD) has continued to grow as a percentage of all residential settings, i.e., from 79.4% in 2016 to 90% in 2023. Data showed a 2.3% annual increase between 3.31.22 and 3.31.23, which exceeded the 2% benchmark for the first time as reported in the 23rd study. For seven years, Virginia consistently achieved a positive annual trend (never below 1.2%). For the year 9.30.22 through 9.30.23, the Commonwealth maintained this trend, but was unable to sustain an annual increase of 2% and therefore did not meet this CI during the 24th period.

The number and percentage of individuals residing in less-integrated residential settings have decreased during the same seven-year period. In 2016 the baseline was 2,446 individuals in less-integrated settings, compared to 1,770 individuals in September 2022, and 1,566 individuals in September 2023. There was a decrease of 204 individuals between September 2022 and 2023, decreasing the percentage from 11.1% to 9.5% of the DD waiver population which results in a percentage decrease of 1.6% for individuals living in less-integrated settings.

Over 90% of Virginia's waiver participants now reside in integrated residential settings. The actual numerical increase of 755 individuals in integrated settings between September 2022 and September 2023, is a 5% increase numerically comparing this reporting period to the previous reporting period as described in Table 4 below. Because of the increased number of waiver recipients, the denominator changes each year. Therefore, the change in percentage is determined by comparing the percentage totals from year to year, not the numerical increase. Having maintained a positive seven-year trend and achieving over 90% of individuals living in most-integrated settings, it becomes increasingly difficult for Virginia to achieve an annual 2% increase. It is the considered opinion of this reviewer that this CI's current 2% annual increase performance metric may be an appropriate performance measure for a small set number of years under the Settlement Agreement, but is not a viable long-term metric especially when the percentage remaining in less-integrated homes becomes increasingly small. A more useful performance metric would require Virginia to continue a positive multi-year trend in the percentage of individuals living in most-integrated settings as well as a corresponding multi-year decrease in the percentage living in less-integrated settings.

Table 1 recaps these changes between 2022 and 2023. The point in time the data is extracted for this report is different (November) than the reporting time to respond to the *CI 18.2* (September). While the total number of individuals by locality in most-integrated settings has increased, as has the number of localities with 100% of the individuals in such settings, the number and percentage of individuals in localities with at least 86% of DD waiver participants in most-integrated residential settings has decreased from 127 to 108 localities. DBHDS staff were not able to explain the reason for the decrease but will include the analysis in a future deep dive.

Table 1
Integrated Settings per WaMS

	Spring 2022, Provider Data Summary	Spring 2023, Provider Data Summary	Fall 2023, Provider Data Summary
Person locality by integrated setting	88% (13,527/15,428)	90% (14,562/16,167)	92% (15,287/16,658)
Localities with 100% persons in integrated settings i.e., zero (0) persons in NON-integrated settings	40	48	55
Localities with 86%+ persons in integrated setting	73% 99/135	94% 127/135	80% 108/135
Localities with 50% or fewer persons in integrated settings	1	0	2

In its review of nursing services, DBHDS provided the data analysis for all of FY23 in the Nursing Services Data Report issued in February 2024 to determine compliance with *CI 18.9*. The DBHDS report used to determine compliance during the 23rd reporting period relied on data for the first six months of FY23.

CI 18.9 requires both timeliness (i.e. within 30 days) to initiate newly authorized nursing services and consistent utilization of authorized nursing hours. DBHDS reports that it has achieved the timeliness benchmark for the initial delivery of nursing services to both EPSDT and Waiver service recipients (135 individuals). The Commonwealth previously achieved this performance for Waiver recipients, and for individuals receiving nursing services under EPSDT. Table 2 below depicts the achievements over the past three years regarding the timeliness of initiating newly authorized nursing services. It also indicates that DBHDS has not yet achieved the nursing utilization benchmark (i.e., receipt of the number of hours identified in the ISP 80% of the time) for 70% of individuals in the DD waivers or receiving services under EPSDT.

The Office of Integrated Health (OIH) performed the review of the FY23 data for nursing services authorized and delivered from 7.1.22- 06.30.23. There were 616 unique individuals with 2,050 authorizations. Services were newly authorized for 135 unique individuals. Authorizations were effected within thirty days for 75% of EPSDT recipients and for 78% of DD Waiver participants. The overall timeliness for the initiation of nursing services for those with new authorizations was for 104 (77%) of the 135 individuals.

Virginia did not achieve the performance level of nursing hours utilization performance expected. Only 247 (40%) of the 616 unique individuals with service authorizations receiving 80% of the hours allotted. The Commonwealth explains that it has learned that the number or authorized hours in Part V of the ISP for an individual who needs for nursing services may be inflated to cover either RN or LPN services. These duplicate authorizations can both be requested and approved due to likely scheduling challenges for the nursing services provider agencies that do not know in advance which staff will be available. Hours beyond the expected weekly schedule may also be authorized to address unexpected health events/emergencies. Therefore, the number of authorized hours in Part V of an individual's ISP may not be accurate. Table 2 depicts the summary of utilization for EPSDT and Waiver individuals for all nursing services that were authorized.

Table 2
Nursing Services

	FY21	FY22	FY23
EPSDT Timeliness	71%	55%	75%
Waiver Timeliness	83%	83%	78%
EPSDT Utilization	22%	18%	26%
Waiver Utilization	30%	36%	42.5%

**Note: the nursing utilization percentages are determined by dividing the number of billed hours by the number of authorized hours.*

The Nursing Utilization Report includes a specific breakdown of the utilization of both Private Duty Nursing (PDN) and Skilled Nursing, both by RN and LPN level nurses. The report indicates a more significant increase in the utilization of PDN compared to Skilled Nursing. Between FY22 and FY23 the utilization of 80% of authorized hours of PDN by an RN increased from 43% to 65% and from 44% to 49% of PDN by an LPN. The utilization of 80% of one's authorized hours for skilled nursing both by RNs and LPNs increased by less than 1% for RNs and 3.5% for LPNs comparing FY23 to FY22 utilization. Because of the episodic and difficult to predict nature of home healthcare (health need spikes, emergencies, etc.) and the presence of multiple service authorizations (SA) for both the RN and LPN levels of nursing, the system has continued its tendency to over authorize nursing hours (#3). This suggests that the reported aggregate utilization rates will regularly fall below the actual service authorization amount because this number is inflated for some individuals for the reasons stated.
The Commonwealth has not yet determined the extent of excess authorizations.

The benchmark for this CI is that 70% of individuals receive 80% of the number of needed hours of nursing services. DBHDS also reports the number of individuals who receive 50% or more of their authorized hours. This amount of utilization increased by 10% for skilled nursing by LPNs; 16.5% for PDN by RNs; and 6% for PDN provided by LPNs in FY23 compared to FY22. Whereas utilization of skilled nursing by RNs decreased by 7% in FY23 compared to FY22.

The Commonwealth has expanded the provider stimulant Jump Start Funding to include nursing services. The Provider Data Summary published in November 2023 indicated DBHDS awarded $59,512.10 in funding during this reporting period. These funds are available to nursing service providers to expand integrated services including Skilled Nursing and Private Duty Nursing. Virginia has not yet determined the extent to which the nursing rate increases provided in July 2022 contributed to the reported nursing utilization rate increases in PDN during FY23.The Commonwealth has increased the rates for PDN and skilled nursing services twice since the start of the pandemic. The first increase was effective in FY22, increasing the rate by $4 per hour, and the second increase of $7 per hour was effective in FY23. The methodology to determine these rate increases is to use the midpoint of the Bureau of Labor Statistics (BLS) rate for the hourly wages of nurses while also factoring costs related to benefits, mileage, time off and productivity to compute an hourly rate. The new rate that became effective in FY22 was based on the BLS midpoint for nursing wages set in FY20. The General Assembly is considering a 3% rate increase for skilled and private duty nursing services, which if approved would take effect in July 2024.

Table 3 depicts the total number of individuals including both those using EPSDT and those enrolled in a DD waiver who needed and received nursing services from FY19 through FY23. DBHDS reported that the total number of individuals needing nursing services decreased significantly (28%) between FY21 when 860 individuals needed nursing services to 616 in FY23, a period that included hundreds of new waiver participants. Although, DBHDS speculated on the root causes, it could not explain the factors behind this dramatic decrease. DBHDS reports some providers with nurses on staff choose to provide the service without requesting specific service authorization because of the extra documentation and administrative burden associated with the authorization process.

This data provides a longitudinal perspective regarding the utilization of nursing services pre and post pandemic and pre and post the nursing agency pay rate increase which took effect July 2022. In FY19, 311 (48%) of individuals needing nursing services receive 80% or more of their allotted nursing hours. Whereas, in FY23 only 247 (40%) received 80%. The Commonwealth has not yet returned to the level of nursing services utilization reported in the years prior to the pandemic. The rate at which individuals received in-home nursing services plummeted, like most types of services, in FY 21. Since this low point, the utilization rate has increased from 29% to 40%, although the number of recipients remains significantly below pre-pandemic levels. It has not yet been determined the extent to which this increase since FY 21 is due to a gradual recovery from the pandemic and/or the impact of the significant FY22 and FY23 nursing pay rate increases.

Table 3
Nursing Services

Fiscal Year	Percentage receiving 80% of hours	Number of individuals receiving 80% or more	Total number of individuals needing nursing services
FY19	48%	311	648
FY20	51%	372	736
FY21	29%	247	860
FY22	34%	208	613
FY23	40%	247	616

**Note: the nursing utilization percentages are determined by dividing the number of billed hours by the number of authorized hours.*

It is impressive that DBHDS completes a "Deep Dive" to ascertain the reasons for late starts for nursing services and to determine barriers to utilization. DBHDS nurses contacted representatives for 363 of the 616 individuals with SAs for nursing services. Nursing shortage was the barrier most mentioned related to the workforce challenges to address the needs of children and adults with DD. Representatives also reported an insufficient number of nursing service provider agencies for skilled nursing or to allow for individual choice; too few nurses in rural areas; and no shift differential to make evening and weekend hours more attractive to work. Other barriers included the lack of physician understanding of waiver services and process requirements, service authorization complexity, and Medicaid billing barriers. DBHDS also reviews all nursing services authorizations which totaled 2,129 for FY23. Only fifteen requested authorizations were denied and thirty-six were rejected. All were explained and some were the result of a duplicate authorization or a lack of pre-authorization. Authorizations are generally denied because they do not meet eligibility criteria or a justification is not provided after having been previously pended. Authorizations are rejected due to an error including a duplicate request.

The Department also provided a further breakdown of the utilization data by living situation. The percentage of individuals by living situation who receive at least 80% of the nursing hours allotted is as follows demonstrating an individual living in a group home is more likely to receive his authorized hours:

- Sponsored Home- 3/28 (11%)
- Group Home- 152/318 (48%)
- Living with Family- 88/249 (35%)
- Living Independently- 4/11 (36%)

DBHDS also reported the percentage of utilization that met the 80% benchmark by Regions. There is significant difference in the percentages across the five regions as follows:

- Region 1- 24%
- Region 2- 65%
- Region 3- 17%
- Region 4- 31%
- Region 5- 34%

DBHDS compares each Regions' performance against the metric for FY21, FY22 and FY23. Region 3 has experienced an insignificant increase toward meeting the metric; Region 1 has increased from 10.5% to 24%; Regions 4 and 5 have remained relatively the same meeting the metric for almost one third of their participants; and Region 2 has increased from 39% to 65% of their individuals receiving 80% of their allocated hours. In all likelihood Regions 1 and 3 have fewer nurses given the rural nature of these parts of the Commonwealth. It is not surprising that Region 2 achieves the highest percentage of utilization since it comprises an area that has more health professionals.

The data reported by DBHDS that compares the percentage of hours delivered to authorized hours by SIS Level indicates that the majority of the 616 individuals authorized for nursing services are Level 4 (121) and Level 6 (378). During FY23, 33% of individuals with a Level 4 and 44% of individuals with a Level 6 received 80% of their authorized nursing services. The only level receiving a higher percentage of authorized hours are individuals with a Level 7 (21) who received 48% of the Service Authorization.

DBHDS continues to refine nursing training and to convene stakeholders to identify unresolved barriers to the consistent and timely delivery of skilled and private duty nursing (PDN). While the recommendations address many of the barriers, the workforce shortage is not addressed directly in the recommendations.

In the 23rd review period DBHDS shared a draft of a proposed Intense Management Needs Review (IMNR) process to assess and monitor the adequacy of management and supports provided to all individuals whose SIS evaluation results placed them in tier four level six (intense management needs) to meet their needs. The purpose of the IMNR is to ensure the documentation properly reflects the continuity of care across services is addressing the individual's medical management needs. The review mirrors the Individual Service Review (ISR) study's process conducted by the Independent Reviewer. The sample for the 24th study period will include a randomly selected sample from a cohort of individuals with SIS Level 6 needs. The process includes interviews, record reviews and on-site observations completed by Registered Nurse Care Consultants (RNCC). The RNCC will note clinical and non-clinical issues in the findings and conclusions. The DBHDS IMNR process is designed to include Remediation Plans that will define the expected corrective action to be taken by Providers and Case Managers. A Quality Assurance Team will verify all facts and that the reviewers' clinical judgments were made consistent with their training and expertise. DBHDS plans to track the efficacy of the corrective action(s) and make future revisions as necessary to ensure that the action(s) address the deficiency. DBHDS plans to produce IMNR reports semi-annually to align with the ISR studies.

The first IMNR was conducted during the 24th reporting period. It included a sample of thirty individuals with complex support needs (i.e., SIS level 6). In this sample, eleven (37%) of the individuals needed nursing services of whom eight were authorized for nursing services. Six (75%) of the eight individuals who were authorized to receive nursing services received 80% of their authorized hours. Of the nine whose ISPs identified that nursing services were needed, the six who

received 80% of their authorized hours confirms that 67% received the benchmark percentage of the authorized hours.

Two Processes Documents were submitted for review in the 24th review period due to changes made in those processes. Attestation Documents that aligned with said processes were also submitted for review. These Process Documents addressed Nursing Services Utilization of Hours and Timeliness (Version 003 with Last Revision date of 6.9.23) and for Provider Data Summary (Version 013 with last Revision Date of 9.15.23). These original documents are specific to the CIs under review and the calculation methodologies utilized and have been verified in previous reporting periods. All changes that were made to the processes improved the level of reliability and validity. However, the extent of the validity that the authorized hours equal the number of hours needed has not been established.

Compliance Indicator Achievement

Table 4 below summarizes the status of the Compliance Indicators this study reviewed.

Table 4
Community Living Options Findings

#	Indicator	Facts	Analysis and Conclusions	23rd	24th
18.2	*a. Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings*	Data showed a 1.4% increase in individuals receiving services in most-integrated settings between 9.30.22 and 9.30.23. The number of these individuals increased by a total of 755 individuals from 14,178 to 14,933. Last year there was a 2.3% increase for the time period of 3.31.22 to 3.31.23. In this same time period, the number of individuals with DD Waiver services living in less-integrated situations decreased from 1770 to 1566 (1.6%).	This indicator had consistently trended in a positive direction through the 23rd reporting period but did not demonstrate a continued increase of 2% in this reporting period. The baseline was established in 2016. At that time 79.4% of people with DD Waiver services lived in integrated settings. The total percentage living in integrated settings as of 9.30.23 is 90.3%. While the increase of 755 individuals is 5% of the 14,178 individuals receiving waiver services in the previous reporting period, the calculation is computed by comparing the percentages from year to year because the denominator varies. This	**M**	**NM**

			methodology results in an annual increase of 1.4%. Therefore, this CI is not met.		
18.6	*DBHDS will report on how many individuals who are medically and behaviorally complex (i.e., those with a "support needs level" of Level 6 or 7) are using the following DD Waiver services, by category: sponsored residential, supported living residential, shared living, in-home supports, and respite services. Using this data and the focus groups, DBHDS will prepare a plan to prioritize and address barriers within the scope of its authority and establish timelines for completion with demonstrated actions.*	DBHDS reported on the numbers of individuals with Level 6-7 needs receiving services in the five areas (#5). The report is for individuals enrolled in a waiver 7.1.2016-4.30.2023 who are currently active with a SIS Level 6 or 7 who do not have an approved authorization for a less-integrated service from 5.1.23-10.31.23. Of 1,020 individuals with a Level 6 or 7, 976 (95.7%) are using an integrated waiver service. For the services listed below where any utilization is reported there is an increase in use compared to the use reported in the 23rd reporting period: Type L-6 L-7 SR 305 330 SLR 0 5 ShL 0 0 InHS 89 100 Resp 480 306 DBHDS provided a summary and plan to address the barriers to respite services. The budget considerations include increase funding for transportation services to access respite; create a scholarship for non-waiver participants to access respite; increase the respite rate; and use Jump Start funding to incentivize provider development, all of which are consistent with the previous reporting period. DBHDS provided an update to its plan to improve access to Respite Services. Licensing issues regarding modifications for respite bed licensing requirements have been explored and rate	The Provider Data Summary Report of November 2023 indicates the Measure is for at least 90% of individuals new to waivers since FY16, including those individuals with a SIS Level 6 or 7 are receiving services in the most integrated setting. DBHDS has surpassed this measure, achieving almost 96% of individuals with a SIS Level 6 or 7. The Plan DBHDS submitted during this reporting period is sufficient to address the barriers to accessing respite services and building capacity. This CI continues to be met.	**M**	**M**

		recommendations have been made. Other plan activities remain ongoing.			
18.9	*6. DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018, for FY 2018. The utilization rate is defined by whether the hours for the service are identified a need in an individual 's ISP and then whether the hours are delivered. Data will be tracked separately for EPSDT and waiver funded nursing. Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.*	DBHDS issued its Nursing Services Data Report: Nursing Hours Utilization III.D.I Full Year Review of FY23 (#3). In this reporting period there was a total of 616 unique individuals and an additional 135 unique individuals with ID/D with a new service authorization that began in FY23. **Timeliness**: Of these 135 individuals, 104 (77%) started services within 30 days. These numbers include 36 children receiving EPSDT and 99 adults receiving waiver services. 27 (75%) of the 36 children; and 77 (78%) of the 99 adults with waiver services received nursing services within 30 days. **Utilization:** 616 individuals utilized EPSDT or waiver nursing services. Only 247 (40%) received 80% of the hours that were allotted to them. This includes 23 (26%) of the 89 children receiving nursing through EPSDT, and 224 (42.5%) of the 527 adults receiving DD waiver services. The recently completed IMNR offer additional data regarding the need for nursing service among individuals with complex medical support needs and the utilization of authorized hours by these individuals. The 24th Period's Individual Services Review Study, which is included in the Appendix, found that of 11 individuals who needed nursing services 6 of 8 (75%) individuals received	This indicator has not yet been fully achieved. It will be achieved when both the timeliness and utilization performance metrics are reached. The indicator requires that the percentage of hours delivered versus needed be determined. The Commonwealth reports that the Parties believed when this Indicator was agreed upon the number of hours of needed nursing hours was included in the ISP. However, DBHDS reported that the authorizations requests made by providers on the CMS 485 Form for waiver participants and Form 62 for children using EPSDT may not reflect the number of hours needed. DBHDS reports this is because some providers may be unsure if they will be able to provide the services through an RN or LPN, so some providers request more hours than are needed. Providers also want to have sufficient hours authorized to address emergency needs for additional nursing. The Commonwealth has learned that, as explained above, the number of authorized hours may not always be an accurate portrayal of needed nursing hours. When the data are	**NM**	**NM**

		80% or more of their authorized nursing hours. Of the 9 whose ISPs identified that nursing services were needed 6 (67%) received 80% of their authorized hours. It also found that 3 (27%) of the total of 11 individuals who needed nursing services, were not considered in the nursing utilization rate reported. This lack of complete reporting occurred because either an individual could not find a nursing agency to request authorized hours, or the ISP expected the individual's group home provider to deliver the needed nursing services. These factors contribute to the Commonwealth reporting nursing utilization rates that are not accurate.	compared to timeliness and utilization in FY22 the following differences emerge. The timeliness of starting services for children using EPSDT improved from 54.5% to 75% of individuals beginning to receive services within 30 days. However, it decreased from 83% to 78% for adults on the DD waivers. While the percentage of adults using waiver services decreased, the actual number of adults whose nursing service commenced within 30 days increased from 52 adults in FY22 to 99 adults in FY23. The Commonwealth still exceeded the expectation of 70% so this requirement of timeliness is achieved again. The Commonwealth has also committed to 70% of individuals needing nursing services receiving the number of hours in their ISP 80% of the time. This requirement has not been achieved since overall, only 247 (40%) of the 616 individuals with authorized nursing services received the hours allotted to them 80% of the time. DBHDS reported its utilization data for FY 19 through FY 23**.** It is important to note that the Commonwealth reports having used the same nursing rate methodology since 2019. Therefore, the trend line of the utilization rates reported for the past five years very likely reflects reality. However,		

			multiple factors contribute to individual utilization rates that are either too low or too high. The Commonwealth has not completed a study to determine the extent to which these different factors skew the reported utilization rates. These annual utilization rates, which were all determined using the same methodology, showed that utilization rates declined from FY20 (51%) to FY21 (29%) at the peak impact of the pandemic. Since that low point, the percentages have steadily increased for adults. Since FY21, 12.5% more adults receive 80% of the allotted nursing hours to meet their needs. The percentage increased from 30% in FY21, to 36% in FY22 and to 42.5% in FY23**.** There has also been an increase in the percentage for children which reached a low point of 18% in FY22 climbing to 26% during FY23. The utilization increases in FY23 occurred after the Commonwealth significantly increased its nursing agency pay rates. Virginia has not yet determined the extent to which the pay rate increases versus the diminishing impact of the pandemic caused the increases. DBHDS reported that it cannot replicate the methodology that it used to establish the FY 18 utilization of nursing		

			services baseline included in this CI. Without being able to use the same calculation methodology, DBHDS cannot report and, this reviewer cannot determine or verify whether the utilization rate reported for FY 23 was higher or lower than the actual CI baseline in FY18. Regardless of its relationship to the baseline, this CI has not been achieved.		

Attachment A

Documents Reviewed

Title or Filename

1. CLO 23rd Study Period Document Tracker
2. Provider Data Summary FY23 November 2023 Final: Issued 1.25.24
3. DBHDS Nursing Services Data Report FY23: Issued January 2024
4. DDSIRW Workgroup Report: Barriers to Respite Workgroup Summary and Plan 3.1.24
5. DBHDS Individuals by Service Type Services Active 5.1.23-10.31.23

Submitted by:
Kathryn du Pree MPS
Joseph Marafito MS
Expert Reviewers
May 16, 2024

APPENDIX F

Services for Individuals with Complex Medical Support Needs

by

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

TWENTY-FOURTH PERIOD INDIVIDUAL SERVICES REVIEW STUDY:

Individuals with Complex Medical Needs

Submitted By:

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

May 10, 2024

Introduction/Overview

Since the inception of the Individual Services Review (ISR) Studies, there has been an unrelenting emphasis on identifying the strengths of and the barriers to the adequacy and continuity of comprehensive healthcare strategies, resources, and outcomes for people with complex medical needs. As the Parties continue to weigh the requirements and outcomes from the implementation of actions mandated by the Settlement Agreement and by the Court, it has been important to clearly focus on the adequacy of the Commonwealth's monitoring systems that are intended to evaluate the services for individuals with complex medical needs. During the 22nd and 23rd review periods, the ISR Studies focused on DBHDS's Quality Service Reviews (QSRs) which evaluated the quality of services for individuals with complex medical support needs.

The focus of the 24th review period's ISR Study relates to determining the adequacy of the Commonwealth's pilot initiative related to Compliance Indicator 36.8. Overall, this indicator requires DBHDS to collect and analyze data regarding the management of supports for individuals with complex medical, behavioral, and adaptive support needs. During the 24th review period, DBHDS created and implemented its Intense Management Needs Review (IMNR) process by studying the health care supports for a randomly selected group of individuals with complex medical needs. In several important respects, the IMNR process replicates the work of the ISRs completed under the supervision of the Independent Reviewer. It utilizes a Monitoring Questionnaire, conducts on-site interviews of a primary caregiver with knowledge of the health care services, makes observations of the person and the residential setting, and collects and analyzes facts from both the individual's health care records and the site visit itself.

In an effort to mirror the ISR Study process and identification of issues that require remediation, DBHDS and the ISR Team Leader and their respective nurse reviewers conducted collaborative planning and field work that was supported by the Independent Reviewer and the Assistant Commissioner of DBHDS.

The Independent Reviewer established that an IMNR study of 60 randomly selected individuals with complex medical support needs, that utilizes the ISR framework with 30 individuals during two successive review periods, would serve as a sufficient sample for collecting and analyzing data regarding the care management of individuals with identified complex medical support needs.

Individuals with complex medical support needs is one of the three subgroups that DBHDS is required to review by Compliance Indicator 36.8. During this current review period, the ISR nurse reviewer will collaborate with and complete half of the reviews with the IMNR nurses. The other half of the ISR/IMNR reviews will involve on-site visits, observations, and interviews together, while the review of documents and the recording of facts and judgements in the Monitoring Questionnaires will be done separately.

The ISR Team Leader and the Director of the Office of Integrated Health (OIH) worked together in a similar manner. As the supervisors of their respective teams of nurses, they reviewed the findings of the jointly completed site visits and shared the information documented from those visits.

They were responsible for ensuring that the Interpretive Guidelines for the respective Monitoring Questionnaires (MQ) were followed as written and that any identified issues or concerns were limited to the scope of this Study. In addition, they convened periodic online meetings of the nurse reviewers in order to clarify directions and to respond to any questions about the process.

This collaboration is a substantial part of the foundation for this report.

Methodology

The decision to collaborate required several preliminary and ongoing steps. First, the monitoring process and the respective questionnaires/guidelines used for reviewing the health care of the people included in the randomly selected sample were shared and discussed prior to developing an overall timetable for the work and the schedule for the site visits. Revisions to the Commonwealth's questionnaire were suggested for consideration and the Independent Reviewer's questionnaire was modified as appropriate in order to enhance consistency in the interviews. Both monitoring questionnaires included questions requiring a factual response while a small set of questions called for clinical judgements based on the documented facts. Second, the nurses assigned to each team were identified and introduced in online discussions that explained the process, the tools, and the framework for the site visits. Third, the site visit process includes a consistent approach to interviews with caregivers familiar with the individual's health care services, review of the individual's medical and medication administration records, and related contemporaneous staff notes. Fourth, each of the site visits was conducted with two experienced nurses, one working for DBHDS and the other for the Independent Reviewer. Fifth, any potentially serious concerns identified in the site visits were immediately reported to the Team Leaders. The Director of OIH is the Team Leader for DBHDS and she took responsibility for responding to any concern brought to her attention. Sixth, the findings from the reviews were discussed by the Team Leaders and additional immediate actions were taken as appropriate.

The Independent Reviewer randomly selected 30 individuals with SIS level 6 needs (i.e. complex medical) who had ISP meetings in the six-month period between April 1 and September 30, 2023. It was agreed that the random selection would be stratified with ten individuals randomly selected from each of three Regions (II, IV, and V).

This sample is not sufficient to generalize either its findings or any identified themes to all individuals with complex medical support needs. As noted above, since this is not a statistically valid sample, the Independent Reviewer has determined that the requirements of V.D. 2.a-d Compliance Indicator 36.8 will be met for the group of people with complex medical needs by repeating a review of 30 randomly selected individuals in two successive periods, if the review includes on-site observations, review of the individual's medical records and contemporaneous notes (such as staff notes between shifts and Medication Administration Records), interviews with primary caregivers, verification of the facts stated by those interviewed, and a small set of clinical judgement determinations based on the facts. To produce reliable and replicable findings, it continues to be essential that facts are reported and verified rather than relying on opinions.

Characteristics of the Sample

The sample for this ISR study includes 30 individuals with SIS level 6 needs (i.e., complex medical) who had ISP meetings between April 1 and September 30, 2023.

Seventeen males and thirteen females are included in the sample. Ages range from 11 years old to 74 years old with the majority of the adults reviewed in the 21 to 30 years age group.

Three of the individuals are ambulatory and can walk without any assistance. Two people walk with support. One person is confined to her bed. Twenty-four individuals use wheelchairs.

Fourteen people live in their family home and twelve people live in group homes. Four of the individual's family homes are categorized as sponsor homes.

A Demographic Table is included in Attachment A.

Discussion of Major Themes and Initial Findings

Although numerous health-related issues, including risks of harm, are carefully reviewed during the administration of the monitoring questionnaire, there are three critical requirements related to the Compliance Indicators agreed to by the Parties and ordered by the Court. These requirements focus on whether individuals receive annual physical and dental examinations and whether individuals whose ISPs indicate that they need nursing services have those services identified, authorized, and delivered. The actions specified in Compliance Indicator 36.8 assist DBHDS in examining and addressing the management of health support needs, including these three important sets of requirements.

The themes related to Compliance Indicator 36.8 are summarized below:

Since this is the first time that the IMNR is being implemented, the 24th period review provided the opportunity for the Department to study and adjust the details of its process to be used in future reviews. DBHDS determined that it will make changes that will help provide additional facts to improve its analysis as required by Compliance Indicator 36.8. For example, certain questions in the monitoring questionnaire developed by DBHDS require more precise wording to be consistently accurate. A separate set of the questions that are applicable to children and young adults who are still in school will be added to its monitoring questionnaire. This change will provide more information about the interface between consultations and services recommended in the Individual Education Plan (IEP) and the ISP. Families from multi-cultural backgrounds may require more comprehensive information and assistance as they attempt to navigate bureaucratic systems. DBHDS's intent to develop remediation plans in order to address concerns identified in the site visit is commendable but there needs to be involvement and approval by the individual and the family or Guardian/Authorized Representative before initiating any corrective actions. In addition, as discovered during the reviews conducted by the nurses, the On-Site Visit Tool (OSVT)

is not effective in documenting the issues and concerns that require attention and remediation. Case Managers require more training and supervision about the purpose of these forms if they are to be accurate and useful in identifying and resolving deficits in care.

DBHDS is knowledgeable about the need to make these discrete adjustments; the work is already underway and is being supervised by the Director of OIH.

The themes related to Compliance Indicator 18.9 are summarized below:

Theme: The reliability and consistency of sufficient nursing supports is absolutely critical to the continuity of the individual's health care and for the stabilization of the household as a whole.

> Each of these individuals requires close supervision and careful physical care. Their caregivers must be competent in the monitoring of serious health conditions, including major seizures (six people), tube feeding (eight people), ventilator use (one person), and tracheostomy care (one person.) Since each of these people requires multiple pieces of adaptive equipment, including Hoyer lifts, caregivers must be knowledgeable about the maintenance and use of this essential equipment. Furthermore, this is especially essential for the family settings where there are multiple demands on the family caregivers and resources may be limited or already stressed.

Theme: The currently reported nursing utilization percentages reported by the Commonwealth are inaccurate.

> As described in the report for the 23rd Study, DBHDS continued to provide information about the actions required to obtain authorized nursing service hours for people who have the need for nursing services identified in their ISPs. Each of these requisite steps was examined as part of the current Study's process. For example, the number of nursing hours to be authorized were to be identified in Part V of the ISP and in the CMS 485 forms. DBHDS prepared a spreadsheet documenting the number of authorized and billed nursing hours for each applicable individual during the timeframe for the Study. Finally, the scope and reliability of nursing services was discussed with each caregiver during the on-site visit to the residential setting.
>
> In this sample, nine people, 30% of the sample, have a need for nursing services documented in their ISP or, in the case of #30 discussed below, confirmed by the Support Coordinator after the ISP was issued. (This ISP was not modified, as it should have been, but the facts were verified with DBHDS.) Individual #30 was not authorized for nursing services because an agency could not be identified to provide the nursing service hours. In his case, a CMS 485 form was not completed or authorized. The remaining eight people received the authorization of nursing services in accordance with the number of prescribed nursing hours. Six of these eight individuals are determined to receive at least 80% of their authorized hours. Two individuals (#10, #12) did not receive at least 80% of their

authorized hours. Therefore, three of the nine people who require nursing services did not receive them.

Finally, it was determined during the site visits and the review of records that of the 11 individuals who needed nursing services, two individuals (#4 and #8) (18%) did not have a need for nursing hours identified in their ISPs. Both of these individuals live in group homes where there is oversight of health care needs by the staff assigned to everyone living in the residence. Neither group home provider requested that additional nursing hours be authorized for either Individual #4 or Individual #8. The ISR nurse reviewer documented six health-related concerns about Individual #4 on the Issues Page of his monitoring questionnaire. In particular, she cited multiple hospitalizations and the failure to individualize healthcare protocols related to falls and sepsis. She also could not determine whether he was receiving excessive or unnecessary medications and recommended further review. Individual #8's review raised concerns about a pressure sore and the lack of individualized protocols for wound care and positioning. The lack of psychotropic medication oversight by a psychiatrist or psychiatric nurse practitioner was also cited as questionable, despite the individual's refusal to see a therapist. Since these two individuals did not have additional nursing authorizations in their ISPs, they are not included in the Summary of Individual Findings provided below. Nonetheless, it is recommended that there be further inquiry into the health care status of these two individuals as well as examination of the thoroughness of their case management oversight.

Theme: Of the nine individuals with nursing needs identified in their ISP, three (33%) of them did not receive adequate nursing services.

Individual #10 is authorized to receive 56 hours of nursing per week. Between June 1, 2023 and September 11, 2023, the last reported billing period, she received 57% of the authorized hours. Her family reported that there have been three different nurses in the last eleven months, each working for a short period of time. The parents also report that when the nursing hours are not filled, there is no plan or back up nursing services provided. They are dissatisfied with the nursing services in general.

Individual #12 received only 46% of his authorized nursing hours between June 28 and September 30, 2023, the last billing period reported for him by DBHDS.

Individual #30 lives with his family. They are his primary caregivers. However, as reported during the site visit interview with his mother and later confirmed by DBHDS, his need for nursing support had been identified in August or September 2023; he was approved for 40 hours per week. His ISP, dated June 15, 2023, does not identify the need for nursing hours and should have been modified. At the time of the site visit interview on March 29, 2024, he had not yet received any private duty nursing support.

Further inquiry with DBHDS provided the information that a CMS 485 had not been completed because a nursing agency had not been located to provide the nursing support.

> The DBHDS Nurse Care Coordinator present for the interview provided information about a nursing agency that might have a nurse available to provide services for #30. This information was also provided to the Support Coordinator, who had documented the problems in obtaining nursing care since September 2023, although the ISP itself had not been modified.

Theme: Even when 80% or more of the authorized nursing hours were delivered, families reported ongoing problems related to the inconsistency and unreliability of nursing services.

> Individual #14 has extremely complex care needs. Her parents report that the assigned nursing staff require significant supervision by them. They report having to train all nursing staff; one nurse reported for duty who had never given anyone a bed bath. They also report that 50% of the assigned nurses refuse to use the Hoyer lift. It was not clear if their refusal was due to their lack of familiarity with the use of the lift. As a result, her brother must lift her into her chair. Although the assigned nursing hours have been provided, there were disruptions in the continuity of care because the hours are covered by multiple nurses who may have different ways of doing the required work and/or communicating with the family.
>
> Individual #19's mother reported that, although her daughter needed staff to be awake during their overnight shifts, the nursing staff were frequently sleeping, regardless of the nursing agency assigned to her daughter's care.

Theme: Case Managers rarely documented on the OSVT the significant issues, including health care risks or the failure to receive adequate nursing services, experienced by the individuals studied.

> One of the safeguards initiated by DBHDS is the individual's Case Manager's completion of an On-Site Visit Tool (OSVT) following a monthly or quarterly site visit, depending on the level of support. The completed OSVTs were provided for each person in this sample. It is notable that the Case Manager rarely documented on the OSVT the significant issues, including health care risks, that the nurse consultants described on the Issues Pages in the individual's monitoring questionnaire. In fact, only two Case Managers used these forms to describe any issues/concerns at all. The Case Managers for Individual # 19 cited the problems with transportation and the lack of a nurse for Individual #30 was documented.

The potentially serious, even grave, consequences of the failure to provide adequate and reliable nursing services cannot be overstated, especially given the responsibilities managed by families as they care for their relative with complex medical support needs. In addition to the implementation of the IMNR responsibilities, additional remedial actions must continue to be designed, implemented, and monitored on both individual and systemic levels in order to ensure that the risk of harm is removed to the greatest extent practicable so that people with complex needs can continue to live and thrive in their own homes and their own communities.

The themes related to Compliance Indicator 29.20 are summarized below:

Theme: Among the small sample reviewed, progress is evident in the provision of an annual physical exam.

> The ISR nurse reviewers confirmed that 97% of the people in the sample had an annual physical. There was one person who lacked an annual physical exam:
>
> Individual #19 has not seen her PCP in over a year because of the difficulty in obtaining transportation by ambulance. This individual's mother insists that her daughter be transported by ambulance due to problems with her cervical spine, although the nurse reviewer thought that the customized wheelchair provided adequate cervical support. An appointment for March 12, 2024 was not kept because the transportation company sent the wrong vehicle. (Additional problems with transportation were also cited in this review.)

Theme: Among the small sample reviewed, the progress in providing annual dental exams remains insufficient to meet the 86% performance benchmark for this Compliance Indicator.

> Only 19 (63%) of the individuals received an annual dental exam. Eleven (37%) people were not provided adequate dental care via an annual exam. The lack of dentists who accept Medicaid and that provide sedation were two of the primary reasons for not receiving an annual dental exam. For two of the eleven individuals, transportation was an obstacle.
>
> Individual #1 has not had a dental visit since 2022. To date, his mother has not been satisfied with the dentists available but she has now identified a dentist and is scheduling an appointment.
>
> Individual # 5 requires sedation for treatment. It has not been possible to find a dentist in the area who will provide sedation. Individual #22 requires sedation and is waiting for an appointment at VCU's dental clinic. Individual # 27 requires sedation but her group home staff have not been able to find a dentist who provides sedation and will accept Medicaid. Individual #29 is not cooperative at the dentist's office and requires sedation. His group home staff reported that they have had difficulty finding a dentist who provides sedation and accepts Medicaid. They stated that VCU provides this care but it is very difficult to get an appointment there as they "are not very responsive when called." The staff person is now planning to travel to VCU to schedule an appointment.
>
> Individual #8 cannot find a dentist that takes Medicaid. Individual #10's parents have now identified a dentist and will make an appointment.
>
> Individual #9 was eventually transitioned to a dentist for adults from pediatric dental care but the last two appointments were cancelled by the new dentist.
>
> Individual # 14's health conditions confine her to bed. She cannot be transported to and treated in a dental office.

Individual #19 must be transported by ambulance. Her mother has had considerable difficulty obtaining transportation and, as a result, there has not been a dental consult since 1991.

Individual #20 will not have a dental exam until August 2024. No explanation was provided by the family.

Using the information described above, the following chart summarizes the results of the Study on an individual-by-individual basis. The details underlying these determinations are included in the monitoring questionnaires provided to the Parties.

Summary of Individual Findings

ID#	Family home or Group home	Nursing Services Needed	ISP Indicated Nursing Hours Needed	Received Some Authorized Nursing Hours	80% of Authorized Nursing Hours Were Received	Annual Physical Exam	Annual Dental Exam
01	Family	No	No	NA	NA	Yes	No
02	Family	No	No	NA	NA	Yes	Yes
03	Family	No	No	NA	NA	Yes	Yes
04	Group	Yes	No	NA	NA	Yes	Yes
05	Sponsor/ Family	No	No	NA	NA	Yes	No
06	Family	No	No	NA	NA	Yes	Yes
07	Family	No	No	NA	NA	Yes	Yes
08	Group	Yes	No	NA	NA	Yes	No
09	Group	No	No	NA	NA	Yes	No
10	Family	Yes	Yes	Yes (57%)	No	Yes	No
11	Group	No	No	NA	NA	Yes	Yes
12	Family	Yes	Yes	Yes (46%)	No	Yes	Yes
13	Sponsor/ Family	No	No	NA	NA	Yes	Yes
14	Family	Yes	Yes	Yes	Yes	Yes	No
15	Group	Yes	Yes	Yes	Yes	Yes	Yes
16	Group	No	No	NA	NA	Yes	Yes
17	Family	Yes	Yes	Yes	Yes	Yes	Yes
18	Group	Yes	Yes	Yes	Yes	Yes	Yes
19	Family	Yes	Yes	Yes	Yes	No	No
20	Family	No	No	NA	NA	Yes	No
21	Family	No	No	NA	NA	Yes	Yes
22	Family	No	No	NA	NA	Yes	No
23	Group	Yes	Yes	Yes	Yes	Yes	Yes

24	Group	No	No	NA	NA	Yes	Yes
25	Family	No	No	NA	NA	Yes	Yes
26	Group	No	No	NA	NA	Yes	Yes
27	Group	No	No	NA	NA	Yes	No
28	Sponsor/ Family	No	No	NA	NA	Yes	Yes
29	Group	No	No	NA	NA	Yes	No
30	Sponsor/ Family	Yes	Yes- Verbal agreement	None	No	Yes	Yes
%		**(11/30) 37% Needed Nursing**	**(9/30) 30% Needed Nursing hrs.**	**(8/9) 89% Received Authorized hrs.**	**(6/9) 67% Received 80% of hrs.**	**(29/30) 97% Received physical**	**(19/30) 63% Received dental**

Concluding Comments

The collaborative fieldwork with the nursing team from DBHDS was very positive and productive overall. Discussions about individual cases were insightful and led, in certain instances, to prompt DBHDS to complete remedial investigations, planned actions, and interventions to address the identified problems. DBHDS is to be commended for this work.

All reviewers benefitted by the thorough and timely work done in preparation for the selection of the sample, the production of documents, the logistical assistance and the carefully prepared spreadsheet summary of the authorization and utilization of nursing hours. DBHDS is to be commended for this assistance and its responsiveness in answering the many questions and requests that a study of this nature inevitably requires once underway.

The work completed for this Study leads to several recommendations for expediting the review of nursing hours and addressing potential problems. First, DBHDS should consider adding a checkbox to the ISP form to indicate whether it would be good for the individual to receive nursing supports. Second, DBHDS might consider developing a specific form to summarize the discrete facts underlying the determination for and the implementation of nursing support hours. It would be helpful for the reviewers if DBHDS were to organize the information about the number of hours authorized by CMS 485 and specified in Part V of the ISP on the same form. This information can then be confirmed during the site visits. Third, as in the case of Individual #30, DBHDS should implement a mechanism to ensure that it is notified of any delays in authorizing nursing hours. This should be both documented and consistently reviewed for corrective action at OIH. The failure to locate a nursing agency should not remove the immediate responsibility to oversee and prevent the potentially negative consequences for an individual and his/her family. Fourth, the process for completing the On-Site Visit Tools (OSVTs) should be reviewed at a higher supervisory level in

order to emphasize the attention required to assessing and addressing the inadequacy of nursing supports as well as any other gaps/deficiencies in clinical or programmatic resources, including dental care. This study found a clear theme that the OSVTs are not adequately completed related to the risks of harm linked to the lack of needed nursing services. Enhanced training and supervision of the Case Managers/Support Coordinators appears to be warranted if this external monitoring safeguard is to be effective in preventing or ameliorating harm.

In summary, the findings from this 24th Review Period are not generalizable. However, they have documented that 97% of the individuals in the sample have had an annual physical and 63% have had an annual dental exam as required by Compliance Indicator 29.20. As required by Compliance Indicator 18.9, 80% of the nursing hours were authorized and received by 67% of the people identified to require them in their ISPs. The next Study in the 25th Review Period will be important to clarifying the adequacy of such supports in the more rural areas of the Commonwealth with its incidence of poverty and other barriers to healthcare. Generally, Regions II, IV, and V are considered to have more dental and nursing resources than Region I and III.

Once again, it is important to recognize and strongly commend the unwavering support that is provided by the families who are the primary caregivers for their children and adult sons and daughters with complex medical needs. The nurse reviewers' interviews with family members underscored the skills they have developed and are diligently practicing so that their family members can remain at home. It was noted in certain site visits that families from diverse cultural backgrounds may not fully understand the healthcare resources potentially available to them or the methods for accessing them in our bureaucratic systems. This appears to result from inadequacies of the current case management system. It is recommended that this issue be explored more fully in order to plan and implement effective strategies to assist caregivers from multi-cultural backgrounds.

Finally, the Independent Reviewer and the ISR Team express their appreciation to DBHDS for the unwavering cooperation that is always extended to us. We look forward to our next Study and hope that our findings will contribute to strengthening the Commonwealth's community-based system for people with complex medical needs.

ATTACHMENT A

Demographic Tables

Region		
II	10	33.3%
IV	10	33.3%
V	10	33.3%

Sex		
Male	17	56.7%
Female	13	43.3%

Age Group		
Under 21	3	10.0%
21-30	12	40.0%
31-40	5	16.7%
41-50	6	20.0%
51-60	0	0.0%
61-70	2	6.7%
71-80	2	6.7%
81-90	0	0.0%
Over 90	0	0.0%

Mobility Status		
Walks without support	3	10.0%
Walks with support	2	6.7%
Uses wheelchair	24	80.0%
Confined to bed	1	3.3%

Residence Type		
Group home	12	40.0%
Own/family home	14	46.7%
Sponsored home	4	13.3%

INDIVIDUAL'S SUPPORT PLANS/PLAN OF CARE

		Yes	No	NA	CND
34.	a. Is the Individual's Support Plan current?	30			
35.	Has the Individual's Support Plan been modified as necessary in response to a major health-related event for the person, if one has occurred?		1	29	
39.	Does the Individual's Support Plan have specific and measurable outcomes and support activities?	8	22		
45.	Does the individual require adaptive equipment?	30			
	a. If Yes, is the equipment reported as available?	30			
	b. If No, has it reportedly been ordered?			30	
	c. If available, is the equipment reportedly in good repair and functioning properly? If No, list any equipment in need of repair:	25	5		
	d. If No, has the equipment reportedly been in need of repair more than 30 days?	2	2	26	
	e. If No, has anyone reportedly acted upon the need for repair?	3	1	26	
46.	Is staff/family member knowledgeable and able to assist the individual to use the equipment?	30			
47.	Is staff/family member assisting the individual to use the equipment as prescribed?	30			
48.	Is the individual receiving supports identified in his/her Individual Support Plan?				
	Supports:				
	a. Residential/In-Home	30			
	b. Medical (physician and medical specialists)	30			
	c. Dental	19	11		
	d. Health (nursing and other health supports)	27	3		
	1. Based on the health and safety needs identified in the ISP, and after consulting with a qualified health professional, did the provider/family identify that nursing supports were required?	9	21		
	2. If so, after the assessment by a qualified health professional, did the need for nursing services result in the completion of a Health Care Plan (CMS 485)?	8	5	17	
	3. If so, did the schedule of activities and/or Part 5 specify the number of nursing hours identified on	8	5	17	

	the CMS 485 to be provided? g. Mental Health: 1. Psychiatry i. Communication/assisted technology, if needed.	 5 3 2	 1 1 1	 24 26 27	
		Yes	**No**	**NA**	**CND**
56.	Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	20		10	

HEALTH CARE

		Yes	**No**	**NA**	**CND**
97.	If ordered by a physician, was there a current physical therapy assessment?	7	2	21	
98.	If ordered by a physician, was there a current occupational therapy assessment?	6	1	23	
99.	If ordered by a physician, was there a current psychological assessment?	3		27	
100.	If ordered by a physician, was there a current speech and language assessment?	5	9	16	
101.	If ordered by a physician, was there a current nutritional assessment?	6	1	23	
102.	Were any other relevant medical/clinical evaluations or assessments recommended?	16	14		
103.	Are there needed assessments that were not recommended?	8	22		
104.	Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments? a. OT b. PT c. S/L d. Psychology e. Nutrition f. Other	 5 8 4 4 11	 1 1 2 1	 24 21 24 26 18 30	

105.	Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	29	1		
106a.	Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	19	11		
106b.	Does the individual have coverage for dental services?	30			
107.	Were the dentist's recommendations implemented within the time frame recommended by the dentist?	13	7	10	
108.	Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	23	3	4	
		Yes	**No**	**NA**	**CND**
109.	Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	21	1	8	
110.	Is lab work completed as ordered by the physician?	26	1	2	1
112.	Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	17	2	11	
114.	Is there monitoring of fluid intake, if applicable per the physician's orders?	18		12	
115.	Is there monitoring of food intake, if applicable per the physician's orders?	6		24	
116.	Is there monitoring of tube feedings, if applicable per the physician's orders?	12		18	
117.	Is there monitoring of seizures, if applicable per the physician's orders?	15		15	
118.	Is there monitoring of weight fluctuations, if applicable per the physician's orders?	17	4	9	
119.	Is there monitoring of positioning protocols, if applicable per the physician's orders?	9	1	20	
130.	Does this individual receive psychotropic medication?	9	21		
133.	If Yes, is there documentation that the individual and/or a legal	5	4	21	

	guardian has given informed consent for the use of psychotropic medication(s)?				
134.	Does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic medications, using a standardized tool (e.g. AIMS) at baseline and at least every 6 months thereafter)?	1	1	24	4
135.	Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.?	3		24	3
136.	Is there any evidence of administering excessive or unnecessary medication(s), including psychotropic medications?		26		4

SUMMARY QUESTIONS

		Yes	No	NA	CND
94.	Is the residence free of any safety issues or needed repairs? If no, check concerns: a. Carpet edge poses a fall hazard b. Loose railings c. Broken furniture/windows d. No first aid supplies e. Slanted/unsteady stairs	28	2		
137.	Based on documentation reviewed and interview (s) conducted, is there any evidence of actual or potential harm, including neglect? If Yes, cite: a. Was a Risk Assessment Tool completed for the annual ISP meeting? b. Did it cite any evidence of actual or potential harm, including neglect?	2	27 2 2		1
138.	In your professional judgment, does this individual's health care require further review?	10	20		

APPENDIX G

Mortality Reviews

by

Wayne Zwick, MD

24th Review Period Study Proposal and Report - V.C.5

Wayne Zwick MD
04/30/24

Introduction/Background

This reviewer's 23rd Period study determined that DBHDS had achieved all Compliance indicators for the mortality review Provision V.C.5. CI 33.15, was met, but had not yet been met twice consecutively. This one outstanding CI is the focus of this 24th period review.

As background information, the Independent Reviewer's 21st period Report to the Court (December 2022) included validation of the reliability and validity of the MRC reviewed data, which was confirmed by DBHDS and found to be consistent with the findings during the study review. The MRC continued to have access to medical records from several sources, which included assistance of the Specialized Investigations Unit - Office of Licensing. Based on more complete medical information, more accurate causes of death, demographic information, and other parameters resulted in the Mortality Review Committee's continued ability to track reliable quality data. The MRC continued to track the implementation of action steps recommended by the MRC, and continued to follow them to closure. DBHDS was found to have an effective system in place to minimize unreported deaths. With more complete medical information, the number of cases with an unknown cause of death was reduced, and there was increased accuracy in categorizing deaths as potentially preventable or not potentially preventable. Curative action definitions were incorporated into the MRC process beginning January 2022.

The 21st period study found that the Commonwealth had not met the requirement of Indicator 33.13 (86% of unexplained/unexpected deaths reported through DBHDS incident report system have a completed MRC review within 90 days of death) or the related indicator 33.15 (i.e. MRC report delivered to the DBHDS Commissioner of deliberations, findings, and recommendations for 86% of deaths requiring review within 90 days of death). Historically, these two indicators were determined conditionally Met* during the 17th review period and were found not to have been achieved, i.e. performance had declined, during the 19th and 21st period reviews. The Commonwealth anticipated that this area of compliance would be resolved and the 21st period's review would be able to make this determination following the gathering and analyzing of ample evidence from the requested documentation. However, this was not able to be achieved by DBHDS at the time of the 21st period's review, although there was progress in achieving completed MRC review within 90 days of death.

The 21st period's review found that the Commonwealth had met the requirements of the other nineteen Mortality Review compliance indicators (CIs 33.1-33.12, 33.14, and 33.16-33.21) and verified that the data reported were reliable and valid.

The Independent Reviewer's 23rd period Report to the Court (December 2023) included a review of unexpected deaths and applicable quarterly Reports to the Commissioner. The 23rd period review found that the Commonwealth had met the requirements of CI 33.13 for both the 22nd and 23rd periods and therefore had achieved sustained compliance for two consecutive review periods, The Commonwealth also achieved CI 33.15 in the 23rd Period, but had not yet met this indicator's requirements in two successive review periods.

Methodology
The findings and conclusions of this review are based on the following document submitted for review during this time period:
MRC Quarterly Report to the Commissioner FY24 Q1

Settlement Agreement Provision:
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 monthly mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurses notes, and all incident reports, for the three months preceding the individual's death; (ii) the most recent individualized program plan and physical examination records; (iii) the death certificate and autopsy report; and (iv) any evidence of maltreatment related to the death; (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, 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.*

Compliance Indicator 33.15:
The 24th review focused on determination of whether DBHDS had sustained compliance with this remaining specific requirement of the Settlement Agreement:

33.15. 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 affirm this in each report.

Ci#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status: Met	Status: Not Met	Factual verification and analysis
33.15	MRC report prepared and delivered to DBHDS Commissioner of deliberations, findings, and recommendations for 86% of deaths requiring review within 90 days of death. If the MRC elects not to make any recommendations, it must affirmatively state that no recommendations were warranted."	The Mortality Review Committee Charter Draft – FY22 states "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." See Attachment 4 for content review of the MRC Quarterly Reports to the Commissioner.	23rd X 24th X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.15. This study included the review of the MRC Quarterly Report to the Commissioner FY 24, Q1 which reviewed deaths that occurred from July 1, 2023 through September 30,2023. This MRC Quarterly Report to the Commissioner documented that the MRC had reviewed 92% of unexpected IDD deaths within 90 days of death. The prior MRC Quarterly Report to the Commissioner FY 23Q4, also documented that the 86% requirement for the MRC to review unexpected IDD deaths within 90 days had been met. As this verified two consecutive

					Commissioner's Reports confirming that this indicator had been met, compliance for this indicator has again been met.
33.15	The Mortality Review Committee Charter Draft – FY22 states "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." See Attachment 4 for content review of the MRC Quarterly Reports to the Commissioner.	The Mortality Review Committee Charter Draft revised FY22 states: "If the MRC elected not to make any recommendations, documentation will affirmatively state that no recommendations were warranted."	23rd X 24th X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.15. For each MRC meeting, a 'DBHDS MRC Meeting Notes Summary' report documented whether a recommendation was made or not made/not considered applicable for each case reviewed. The MRC committee minutes documented whether a recommendation or not was made for consecutive review periods in the past. This was the background information provided in the MRC Quarterly Report to the Commissioner. A summary of all MRC recommendations was documented in the MRC's Report to the Commissioner. If there were no

					MRC recommendations from an MRC meeting, this was stated in the MRC Quarterly Reports to the Commissioner also for FY23Q4, FY23Q3, and FY23Q2. As several successive MRC Quarterly Reports to the Commissioner have included this information, compliance has been met for this indicator.

APPENDIX H

Provider Training

by

Chris Adams, MS

TO: Donald Fletcher, Independent Reviewer

FROM: Chris Adams, Consultant

RE: 24th Study Report: Provider Training

DATE: May 11, 2024

Introduction

Prior to initiation of the 24th study of the requirements at Provision V.H.1, the Commonwealth was found to have achieved and sustained achievement of the requirements in the following eleven Compliance Indicators (CIs):

- 49.1 – DBHDS makes available an Orientation Training and Competencies Protocol that communicates DD Waiver requirements for competency training, testing, and observation of DSPs and DSP Supervisors.
- 49.2 – 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 training must include seven specific components enumerated in the Compliance Indicator.
- 49.3 – DSPs and DSP Supervisors who have not yet completed training and competency requirements 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.
- 49.5 – DBHDS make 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.
- 49.6 – 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.
- 49.7 – 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 developmental opportunities.
- 49.8 – DBHDS licensing regulations require DBHDS licensed providers, their new employees, contractors, volunteers, and students to be oriented commensurate with their function or job-specific responsibilities with commensurate documentation by the provider. The orientation must address nine specific requirements enumerated in the Compliance Indicator.
- 49.9 – The Commonwealth requires through the DBHDS Licensing Regulations 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 the ISP, including an individual's detailed health and safety protocols.

- **49.10** – The Commonwealth requires all employees and contractors without a clinical license who are responsible for medication administration to demonstrate competency of this set of skills under direct observation prior to performing the task without direct supervision.
- **49.11** – The Commonwealth requires all employees or contractors 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 the tasks with any individual service recipient.
- **49.13** – Consistent with CMS assurances, DBHDS in conjunction with DMAS QMR staff, reviews citations and makes results available to providers through quarterly provider roundtables.

The focus of this 24th study is on the following CIs. The requirements for each of these had not been achieved at the beginning of the 24th period study:

- **49.4** – At least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180. At the time of the 23rd period study, DBHDS was not able to achieve the 95% threshold requirement at this CI. Using the validated calculation methodology, neither of the two elements measured for this indicator achieved the 95% threshold in QSR Rounds 3, 4, or 5 and the percentage scores regressed for each measure over these three QSR rounds. For Requirement 1, the percentages were R3-90.4%, R4-85% and R5-77.8%. For Requirement 2, the percentages were R3-92.3%, R4-92.8% and R5-85.3%. **49.12** – 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 action in accordance with Licensing Regulations if providers fail to comply with training requirements required by regulation. At the time of the 23rd period study, DBHDS was not able to achieve the 86% threshold requirement at this CI. During CY2022, 84.2% of licensed providers (978/1156) met the requirement during their annual inspection. During the first six months of CY2023, 76.3% of licensed providers (648/849) met the requirement during their annual inspection.

Summary of Findings 24th Study

DSP and DSP Supervisor training and core competency requirements are codified at 12 VAC 30-122-180 which became effective 03/31/2021. In November 2021, recognizing concerns regarding the adequacy of the DMAS provider review process specific to assessment of providers meeting these training and core competency requirements, the parties agreed to modifications in the process to utilize data and information from Quality Service Reviews (QSRs) to measure achievement of the requirements of CIs 49.2, 49.3 and 49.4. Results from the 21st and 23rd period studies confirmed that these process changes address each of the requirements of CIs 49.2 and 49.3 and Curative Action #10 and provide objective data to measure the training threshold requirements at CI 49.4.

This current study assessed whether there is evidence to determine if valid and reliable data sufficient to meet the 95% threshold required at CI 49.4 has been achieved. For the 23rd period study, DBHDS provided a detailed description of the process to obtain data and information related to CIs 49.2, 49.3, and 49.4 and a description of the verification, validation and testing processes completed by the data analyst on 09/12/2023.

There were minor modifications made to the process in 03/2024 to include addition of a drop-down menu of licensed agency names to reduce the likelihood of incorrect provider names occurring. These process changes are being utilized in QSR Round 6.

The measurement criteria established by DBHDS requires achievement of the 95% threshold for two measures: (1) percentage of provider agency staff meeting provider orientation and training requirements, and (2) percentage of provider agency DSPs meeting competency training requirements. Both have to be at or above 95% to achieve the threshold. This threshold was not achieved in QSR Round 3, 4, or 5 and no additional data was available for review for this 24th period study. Round 6 has begun but was not yet completed by the conclusion of this study, so no additional data was available but will be available for review in the 25th study. Since no new information for this current Period's study was available for review and verification a new rating has been deferred until the 25th period review.

The findings of the 21st and 23rd period studies verified that DBHDS has a licensing requirement at 12VAC35-105-450 that contains the training policy requirements in CI 49.12. Additionally, licensing requirements at 12VAC35-105-50, 100, 110, and 115 prescribe negative actions and sanctions that can be taken with providers with significant or re-occurring citations. There have been no changes to these requirements since their effective date.

DBHDS has not yet achieved the 86% threshold requirement at CI 49.12.

- During CY2022, 973/1156 licensed providers (84.17%) met these requirements during their annual licensing inspection.
- During CY2023, 819/1105 licensed providers (74.12%) met these requirements during their annual licensing inspection.
- OL provided data from 427 annual licensing inspections completed between 01/01/2024-03/10/2024 (approximately 25% of the total licensees). Within that group, 301/427 (70.49%) met the requirements at 12VAC35-105-450.

Utilizing results from analysis of data from the CY2023 annual licensing inspection cycle, OL modified its compliance determination criteria to provide a more accurate measurement of provider compliance with the specific requirements at §450 and this CI. Details of that modification are described in the §49.12 CI section of the table below. Further analysis of data and information by OL at the conclusion of the CY2024 licensing inspection cycle will more accurately assess whether this change results in improvement in the percentage score.

Methodology

Procedures employed in this Consultant's previous studies were continued for the current study. These included a review of documents and records provided by DBHDS that describe efforts taken to improve the accuracy and consistency of Licensing Specialist determinations of whether providers comply with the applicable licensing requirements. The evidence also included content and participation levels for training for providers and for Licensing Specialists relevant to the requirements at CI 30.4 and 30.12.

To verify and validate the Licensing Specialist determinations specific to compliance with 12VAC35-105-450 and CI 49.12, the Consultant reviewed licensing inspection results for, and relevant evidentiary documents from a sample of 40 providers across the Commonwealth that had their annual licensing inspection completed between 01/01-03/10/2024. The Consultant concurred with the compliance determinations made by Licensing Specialists determination of whether the provider included all required training elements in their policy. For

those who did not meet these requirements, appropriate action was taken consistent with DBHDS licensing inspection protocols and procedures.

This period's study also included review of Process Documents and Attestation Statements relevant to the data associated with CI 49.4 and CI 49.12. This review continued to verify that these processes are well-documented and that the steps in each of the processes were tested by a data analyst who determined that the processes were accurately described and that the data resulting from the processes were reliable and valid.

Compliance Indicator Achievement

The Commonwealth has not yet achieved the requirements for CI 49.4 and CI 49.12 as the threshold requirements in each of these CIs have not yet been achieved. The process descriptions provided specific to these CIs are well-documented and the resulting data has been determined to be valid and reliable.

The table below details the facts, analysis, and conclusions drawn from the review of the Commonwealth's efforts to achieve and sustain the requirements of Provision V.H.1, CIs 49.4 and 49.12.

Compliance Indicator Table

The table below details the facts, analysis, and conclusions drawn from the 24th period review of the Commonwealth's efforts to meet and sustain the requirements of Provision V.H.1, Compliance Indicators 49.4 and 49.12.

24th Period Study Findings
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.

CI	Facts	Analysis	Conclusion(s)
49.4: At least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180.	***12VAC30-122-180*** contains the regulatory requirements relevant to this Compliance Indicator and ***Curative Action #10***. Beginning with the 3rd round of QSR reviews in 11/2021, assessment of this measure was shifted from the DMAS Quality Management Review process to the QSR process conducted by the Health Services Advisory Group (QSR vendor). The ***DSP Comp Ver 005 Process Document*** dated 08/28/2023 and related ***Attestation Statement 49.2-49.4 DSP Competencies Attachment B 9.9.23*** dated 09/09/2023 provide a detailed description of the data collection	***12VAC30-122-180*** requires that DSPs and DSP Supervisors providing services to individuals with developmental disabilities receive or have received training on specified knowledge, skills, and abilities; that DSPs and DSP Supervisors pass or have passed, with a minimum score of 80%, a DMAS approved objective, standardized test of required knowledge, skills and abilities; and that DSPs and DSP Supervisors complete competency observations and verification and document this verification on the competency checklist within 180 days from date of hire. The Commonwealth modified methodology to measure percentage compliance with this indicator, as stipulated in ***Curative Action #10*** approved by the parties on 11/19/2021, using data regarding the number of Health, Safety, and Wellbeing (HSW) alerts issued in response to three relevant questions in the Provider Quality Review (PQR) tool and twelve relevant questions in the Person-Centered Review (PCR) tool. The Commonwealth documented the data definitions and data collection/reporting procedures in a ***Process Document DSP***	23rd - Not Met 24th – Deferred

CI	Facts	Analysis	Conclusion(s)
	and analysis processes and verification of their validity. The ***Process Document DSP Comp Ver 006*** was revised again on 03/22/2024 to include reference to process modifications to ensure accurate data entry of provider identification, an issue identified at the conclusion of QSR Round 5. This reviewer confirmed that the revisions made were validated by the data analyst and this revision is being utilized in QSR Round 6. DBHDS has not yet completed QSR Round 6. Updated information regarding whether the 95% threshold score is met for either of the two defined outcomes being measured is not yet available. Round 6 data will be available for review during the 25th study period.	***Comp Ver 005*** dated 08/28/2023 that was reviewed and determined to be comprehensive and detailed during the 23rd study. The ***Attestation Statement 49.2-49.4 DSP Competencies Attachment B 9.9.23*** dated 09/09/2023 validated the accuracy of the process. The process changes outlined in this Process Document are being utilized in QSR Round 6 (see note below regarding a subsequent revision that also is being utilized in QSR Round 6). The Process Document references two elements that are assessed to determine if the requirements of CI 49.4 are met. These elements are (1) percentage of provider agency staff meeting provider orientation and training requirements, and (2) percentage of provider agency DSPs meeting competency training requirements. The Process Document stipulates that both elements must be at the 95% threshold or higher for the requirements of this CI to be met. Subsequent to completion of QSR Round 5, the Commonwealth identified that the ***QSR Tracker*** allowed for multiple entries of the same provider with slightly different naming which required subsequent manual reconciliation to accurately review and analyze the Round 5 data. The ***QSR Tracker*** was modified beginning with QSR Round 6 to utilize a pre-populated drop-down menu of licensed agency names to avoid this variance in data entry. This review verified that ***Process Document (DSP Comp Ver 006)*** was updated on 03/22/2024 to include process improvements that address the remediation of the above-described issue. The process changes outlined in this latest revision are being utilized in QSR Round 6. These changes were reviewed and validated by the Data	

<table>
<tr><th>CI</th><th>Facts</th><th>Analysis</th><th>Conclusion(s)</th></tr>
<tr><td></td><td></td><td>Analyst.

DBHDS has begun its QSR Round 6, but the process was not yet completed by the conclusion of the 24th period study so no additional data was available subsequent to what was reviewed during the 23rd study. Therefore, a determination whether the requirements of this CI to achieve a 95% score on each of the two identified requirements will be deferred until QSR Round 6 data will be available for review during the 25th study.

The table below from the 23rd study provides a summary of scoring for Requirements 1 and 2 for QSR Round 3, 4, and 5. The QSR Round 5 data was included in the Provider Data Summary Report November 2023.

<table>
<tr><th></th><th>QSR R3*</th><th>QSR R4*</th><th>QSR R5</th></tr>
<tr><td>Req 1</td><td>511/565
90.4%</td><td>272/320
85.00%</td><td>235/302
77.81%</td></tr>
<tr><td>Req 2</td><td>1092/1133
92.3%</td><td>653/719
92.82%</td><td>492/577
85.27%</td></tr>
<tr><td colspan="4">*Note: QSR data from Rounds 3 and 4 were not verified as reliable and valid.</td></tr>
</table>
</td><td></td></tr>
<tr><td>49.12:
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</td><td>DBHDS has regulatory requirements at 12VAC35-105-450 and 12VAC35-105-50, 100, 110 and 115 that address the requirements of this CI.

The DBHDS Office of Licensing's Annual Compliance Determination Chart-2024 provides detailed guidance to licensing specialists on how to assess compliance with</td><td>DBHDS has a licensing requirement at 12VAC35-105-450 that contains the training policy requirements in this CI. Additionally, licensing requirements at 12VAC35-105-50, 100, 110, and 115 prescribe negative actions and sanctions that can be taken with providers with significant or re-occurring citations.

The Office of Licensing (OL) has provided detailed instructions to providers regarding the required content of their staff training policy. It also provided detailed instructions to Licensing Specialists in the Annual Compliance Determination Chart-2024 regarding the methodologies they are to employ to determine if the provider's staff training policy contains all of the elements</td><td>23rd – Not Met

24th – Not Met</td></tr>
</table>

<table>
<tr><th>CI</th><th>Facts</th><th>Analysis</th><th>Conclusion(s)</th></tr>
<tr>
<td>them to support the individuals receiving services and to carry out their job responsibilities. These required training policies will address the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department.

DBHDS will take appropriate action in accordance with Licensing Regulations if providers fail to comply with training requirements required by regulation.</td>
<td>these regulations.

DBHDS did not make any changes in the process document related to this CI subsequent to its review for the 23rd study. The validation of the data that was completed for the 23rd review remains current and accurate.

The Consultant reviewed documentary evidence and licensing specialist determinations specific to the requirements at §450 and this Compliance Indicator in a sample of 40 licensed providers. From this review, the Consultant concurred with the compliance determinations made by Licensing Specialists regarding the provider including all required training elements in their policy. For these 40 sample providers, licensing specialists determined that 22/40 (55%) met the requirements at §450.

During CY2023, the percentage of licensed providers receiving an annual inspection that have a training policy meeting established</td>
<td>required at §450 and this CI.

During DBHDS's 2024 Annual DD Inspections Kickoff Training conducted in January 2024, providers were again reminded of the requirements for staff training policy content at §450 and what documents are required for review by the Licensing Specialist including the training policy itself and signed training attestation statements for any employees requested by the Licensing Specialist.
For the 23rd study, DBHDS provided a Process Document (49.12 DOJ Process Provider Training Policy Requirements VER002 – revised 8.23.23) and the Attestation Statement 49.12 Provider Training Attachment B 8.31.23 that includes detailed information about the data used to calculate the percentage required by this CI. No changes to this document have been made since it was reviewed during the 23rd study.

The following comparative data table summarizes the results of annual licensing inspections specific to the licensing requirements at 12VAC35-105-450 conducted in CY2022, CY2023, and CY2024 to date and documented in CONNECT data reports for each period provided by OL. The 86% threshold requirement of this CI was not met in CY2022 or CY2023 and continues not to be met in the portion of inspections completed to date in CY2024.

<table>
<tr><th colspan="7">Comparative Compliance Data for CI 49.12</th></tr>
<tr><th></th><th colspan="2">CY22</th><th colspan="2">CY23</th><th colspan="2">CY24 To Date</th></tr>
<tr><td>Total Inspections</td><td>1,156</td><td></td><td>1,105</td><td></td><td>427</td><td></td></tr>
<tr><td>Compliant</td><td>973</td><td>84.17%</td><td>819</td><td>74.12%</td><td>301</td><td>70.49%</td></tr>
<tr><td>Non-Compliant</td><td>148</td><td>12.80%</td><td>233</td><td>21.09%</td><td>100</td><td>23.42%</td></tr>
</table>
</td>
<td></td>
</tr>
</table>

CI	Facts	Analysis	Conclusion(s)
	DBHDS requirements for staff training (*12VAC35-105-450*) again fell below the 86% threshold requirement in this CI. The OL had not completed a sufficient number of inspections during the CY 2024 licensing inspection cycle, and therefore this study found that there is insufficient data to date to determine if the 86% threshold will be met this year.		

Non-Compliant Systemic	27	2.34%	53	4.80%	26	6.09%
Non-Determined	8	0.69%	-	-	-	-

The Consultant reviewed documents relevant to this Compliance Indicator for 40 sampled providers and concurred with the compliance determinations made by Licensing Specialists regarding the provider including all required training elements in their policy. Of the 40 providers in the sample, the licensing specialist determined that 22/40 (55%) met the requirements at §450.

Using data available from the CONNECT licensing database, the OL conducted a detailed data analysis of CY2023 licensing inspection results to identify factors that may have contributed to the decrease in percentage compliance with *12VAC35-105-450*. This increase appears to be continuing during the initial phase of licensing inspections conducted in CY2024. From that analysis, OL determined that a significant contributing factor to the lower percentage scores in CY2023 was the result of adding an instruction to the Licensing Specialist to find the provider non-compliant if employees in the sample did not pass the competency assessment test with a score at or above 80%. Since the 80% threshold is not a specific requirement in §450 (this DMAS requirement is assessed in the QSR sample review process as described in the Analysis section of CI 49.4 above), OL determined that removing it would provide a more accurate measurement of provider compliance with the specific requirements at §450 and this CI. The reviewer concurs with the findings of this analysis and remedial action. The DBHDS OL revised its *Annual Compliance Determination Chart-2024* on

CI	Facts	Analysis	Conclusion(s)
		03/20/2024 to remove the instruction to consider the score at or above 80% as an element in determining compliance with §450. Further analysis of data and information by OL at the conclusion of the CY2024 licensing inspection cycle will more accurately assess whether this change results in improvement in the percentage score. While OL continues to focus significant efforts on improving provider compliance with the licensing requirements in §450 and this CI, and while OL requires a CAP in response to any determination that the requirements of §450 are not met, the Commonwealth has not yet achieved the 86% threshold requirement and continues not to meet the requirements of this CI.	

RECOMMENDATIONS:
There are no recommendations related to Provision V.H.1, Compliance Indicators 49.4 and 49.12.

INTERVIEWS CONDUCTED:
The following individuals were interviewed virtually or provided clarifying information via email or through TEAMS to inform these study analyses.

1. Heather Norton, Assistant Commissioner, Developmental Services
2. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Governmental Relations
3. Eric Williams, Director, Office of Provider Development
4. Jae Benz, Director, Office of Licensing
5. Mackenzie Glassco, Associate Director of Quality and Compliance

DOCUMENTS REVIEWED:
The following documents were reviewed during the course of this study:
1. 12VAC30-122-180
2. 12VAC35-105-50, 100, 110, and 115
3. 12VAC35-105-450
4. Curative Action #10
5. Process Document DSP Comp Ver 005
6. 49.2-49.4 DSP Competencies Attachment B 9.9.23 Attestation Statement
7. QSR Tracker
8. Process Document DSP Com Ver 006
9. Provider Data Summary Report, November 2023
10. Annual Compliance Determination Chart-2024
11. 2024 Annual DD Inspections Kickoff Training
12. 49.12 DOJ Process Provider Training Policy Requirements VER002 – Revised 8.23.23
13. 49.12 Provider Training Attachment B 8.31.23
14. Training policies and related documents from 40 sampled providers whose annual Licensing Inspection was completed between 01/01-03/10/2024.

APPENDIX I

Public Reporting

By

Rebecca Wright, MSW, LICSW

Public Reporting 24th Period Study

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to make available information on the availability and quality of services in the community and to maintain sufficient records to document that the requirements of this Agreement are being properly implemented. The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) jointly submitted to the Federal Court a complete set of compliance indicators (CIs) for all provisions with which Virginia had not yet been found in sustained compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020. The following CIs incorporate Public Reporting requirements:

Section 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.
Section IX.C: the Commonwealth will 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.

Study Methodology

This study served as a follow-up to previous studies that have been competed annually since 2017 regarding the status of the Commonwealth's achievements regarding these requirements. For this 24th Period review, the Parties agreed to target only the CIs that had not been Met twice consecutively. The table below illustrates the compliance status for each of the applicable CIs to be studied during this 24th Period:

Twenty-fourth Period Studies		
Compliance Indicator	**Corresponding Provision**	**22nd/23rd Status**
41.5	V.D.6	NM/M
54.1	IX.C	NM/M
54.2	IX.C	NM/M
54.3	IX.C	NM/M
54.4	IX.C	NM/M

This study sought to gather and investigate facts and verify data and documentation provided by the Commonwealth to assess the sufficiency of the Commonwealth's actions to achieve and sustain achievement with each of the CIs described above. The methodology included a review of the documents that Virginia maintains to demonstrate that it has properly implemented and fulfilled the Agreement's requirements, interviews with state officials, subject matter experts, and stakeholders, and verification that Virginia's relevant Process Documents and Attestations are complete. Evidence gathering included a review of the information available at the Settlement Agreement Library Site and the DBHDS website anad of documentation DBHDS provided to describe the improvements they made since the 23rd Period.

Summary of Findings

V.D.6: By making most required data and reporting available to the public on the DBHDS website and/or the Settlement Agreement Library website, and because those data were sufficiently valid and reliable, for the second consecutive period, the Commonwealth met the overall requirements for the single remaining CI (i.e., CI 41.5) for this Provision. In response to a previous study's finding that the *Record Index Reference Tool (Record Index)* needed to be more clearly visible, DBHDS also made some enhancements

to their processes so that the public could more easily access the information. As described with regard to CI. 54.1-54.3, DBHDS expanded the *Record Index* to include many additional documents and updated the Library website "Welcome Page" to provide prominent instructions for access to and use of the *Record Index*. Utilizing the links in the *Record Index*, which was available on the Library Record Index page during this review, the consultant was again able to locate most of the specific information required by this CI.

IX.C: This study found that the Commonwealth met all of the relevant CIs for the second consecutive time. The *Record Index* was available on the Library Record Index page. DBHDS posted information about the *Record Index* in a prominent area on the Welcome Page so that users could be aware of this tool and how to use it immediately upon entry to the website. Based on review of the website, it was visible and available on several web browsers (i.e., Safari, Edge, Chrome.) DBHDS expanded the *Record Index* to include more than 900 current and archived documents and all tested links worked as required. The *Record Index* specified the required components for each of the current and archived documents listed. The exception was the process to monitor/audit record completion; however, that process is described in the Process Document. These enhancements significantly improved the ease of document access from the previous period, but DBHDS should continue to evaluate opportunities for additional improvement. In particular, the *Record Index* did not use a consistent naming protocol. This sometimes made it difficult to use the alphabetical protocol in an effective manner. However, it was notable that using the search function generally provided the location of the needed documents. DBHDS should follow a consistent naming or organizational protocol in the *Record Index* by which documents listed could be more easily located. This would make the *Record Index* a more effective tool.

DBHDS reported the Process Document entitled *Settlement Agreement Library Protocol VER 002*, dated 6/27/23, remained in place. This document provides a glossary of terms and describes roles and responsibilities for ensuring that the *Record Index Reference Tool* and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the Settlement Agreement) are updated at least semiannually and that the various reports are updated according to their due dates. It also specifies the retention schedule for documents on the Settlement Agreement Library (i.e., 10 years.)

The table below summarizes the findings for each of the applicable CIs. Note: Shaded CIs represent CIs previously Met twice consecutively and therefore not reviewed during this 24th Period.

V.D.6 Compliance Indicators	Status
41.1: 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.	Met
41.2: Demographics – Individuals 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, 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 (to the extent known) h. Number of individuals with DD (waiver and non-waiver) receiving Supported Employment 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.	Met

V.D.6 Compliance Indicators	Status
41.3: Demographics – 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 providers of Supported Employment and Therapeutic Consultation for Behavioral Support Services Number of providers of non-licensed services (e.g., supported employment, crisis) c. Number of ICF/IID non-state operated beds d. Number of independent housing options created	Met
41.4: 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, Risk Management Review Committee Report e. Annual Mortality Review Report, including Quality Improvement Initiatives stemming from mortality reviews f. Quality Management Program Evaluation g. Planned quality improvement initiatives metrics h. Quality Improvement initiatives metrics employed i. Key Accomplishments of the Quality Management Program j. QI Committee, workgroup and council challenges, including positive and negative outcomes and/or performance measure indicators outcomes that differ materially from expectations. Challenges, 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	Met
41.5: 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 Report.	**Met**

IX.C Indicators:	Status
54.1 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").	**Met**
54.2 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; 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.	**Met**
54.3 The Record Index and all associated documents are timely available to the Independent Reviewer upon request.	**Met**
54.4 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.	**Met**

V.D.6 Analysis of 23rd Review Period Findings

Section V.D.6: At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvements.

Compliance Indicator	Facts	Analysis	Conclusion
41.5: 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	Overall, DBHDS fulfilled the requirements of this Indicator. For this 24th Period, DBHDS continued to make improvements, as described in detail with regard to Provision IX.C below. Utilizing the links in the *Record Index Reference Tool* (*Record Index*), which was available on the Library Record Index page during this review, the consultant was able to locate the specific information required by this CI. As described further with regard to CI. 54.1-54.3 below, DBHDS had expanded the *Record Index* to include many additional documents and updated the Library website "Welcome Page" to provide prominent instructions for access to and use of the *Record Index*.	At the time of the 23rd Period review, DBHDS had undertaken a multi-phase project to assess the Library and make improvements. As a result, searches often produced most of the specific information required by this CI, with a few exceptions (i.e., the *Integrated Residential Services Report* and the most current version of the *Provider Data Summary*). While DBHDS provided a document with links to most of the reports and information, without the benefit of that document, it remained difficult at times to locate pertinent documents. Therefore, at the time of the 23rd Period, this study found that DBHDS continued to need to make enhancements so that the public could more easily access information. For this 24th Period, DBHDS continued to make improvements, as described in detail with regard to Provision IX.C below. Utilizing the links in the *Record Index Reference Tool* (*Record Index*), which was available on the Library Record Index page during this review, the consultant was again able to locate most of the specific information required by this CI. Of note, at the time of the 23rd Period, this study found that Library did not provide easy access to the *National Core Indicators (NCI) Annual Report and Bi-Annual National Report.* For this 24th Period review, DBHDS provided somewhat clearer instruction about how to access the survey on the NCI site. However, for ease of use by stakeholders, DBHDS should consider posting the Virginia-specific reports on the Library itself. As described further with regard to CI. 54.1-54.3 below, DBHDS had expanded the *Record Index* to include many additional documents and updated the Library website "Welcome Page" to provide prominent instructions for access to and use of the *Record Index*. The Welcome Page identified the *Record Index* as a resource for Library visitors to supplement the Library search engine. Visitors could also search for documents by clicking on one of the three tabs	23rd – Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion
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 Report.	With regard to data validity and reliability of the data reported in the required documents, as described for CI 36.1, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. At the time of this 24th Period, only one of the twelve reporting requirements (i.e. QSR) continued to have some remaining data concerns, as these related to IRR.	(i.e., Integrated Settings, Providers and Quality & Risk Management) at the top of the Library Record Index page and then on any of the various related topics. With regard to data validity and reliability, as described for CI 36.1, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. At the time of this 24th Period, only one of the twelve reporting requirements (i.e. QSR) continued to have some remaining data concerns, as these related to IRR.	

Section IX.C. The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being implemented properly

Compliance Indicator	Facts	Analysis	Conclusion
54.1: 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").	Overall, DBHDS fulfilled the requirements of this Indicator. For this 24th Period, the *Record Index* continued to be available on the Library Record Index page. At the time of the 23rd Period, DBHDS developed a Process Document entitled *Settlement Agreement Library Protocol VER 002*, dated 6/27/23. This document provided a glossary of terms and describes roles and responsibilities for ensuring that the *Record Index* and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the Settlement Agreement) were updated at least semiannually and that the	Previous reports found that DBHDS developed two documents that described the protocols for maintenance of the Library Record Index. These included the *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol*, both of which were effective on June 30, 2020. As reported previously, based on the *Settlement Agreement Library Record Index*, the purpose of the Library Record Index is to identify the records sufficient to document that the requirements of the Settlement Agreement are implemented, as well as the entities responsible for monitoring. Consistent with the requirements of CI 54.1, the *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol* indicated the Library Record Index will catalogue all documents posted to the Library (http://dojsettlementagreement.virginia.gov/) and will specify the business owner or Subject Matter Expert (SME) responsible for the origination and update of the record. The *Settlement Agreement Library Record Index* also stated that the business owner of the Library overall is the DBHDS Settlement Agreement Coordinator. At the time of the 23rd Period, DBHDS also developed a Process Document entitled *Settlement Agreement Library Protocol VER 002*, dated 6/27/23. This document provided a glossary of terms and describes roles and responsibilities for ensuring that the *Record Index* and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the Settlement Agreement) were updated at least semiannually and that the various reports are updated according to their due dates. For this 24th Period, DBHDS reported that there have not been any changes to this Process Document or to the project management structure (e.g. Kanban board, frequent meetings with SMEs to review progress, etc.) that were described in the 23rd study period.	23rd – Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion
	various reports are updated according to their due dates. For this 24th Period, DBHDS reported that there have not been any changes to this Process Document or to the project management structure that were described in the 23rd study period. DBHDS most recently updated the *Record Index* on 2/29/24.	For this 24th Period, the *Record Index* continues to be available on the Library Record Index page. DBHDS most recently updated the *Record Index* on 2/29/24.	
54.2 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 • 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.	Overall, DBHDS fulfilled the requirements of this Indicator. For this 24th Period review, the *Settlement Agreement Library Protocol VER 002* remained in place. This Process Document describes roles and responsibilities for ensuring that the *Record Index* and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the	At the time of the 23rd Period, the *Record Index* was available on the Library Record Index page and, for more than 900 distinct reports, it specified the parent page, the frequency and the due date for when each report would be due to be posted to the Library. In addition, the Process Document entitled *Settlement Agreement Library Protocol VER 002*, described roles and responsibilities for ensuring that the *Record Index Reference Tool* and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the Settlement Agreement) were updated at least semiannually and that the various reports are updated according to their due dates. It also described the processes to monitor/audit record completion. For this 24th Period review, the *Settlement Agreement Library Protocol VER 002*, remained in place. The *Record Index* is available on the Library Record Index page of the Library website. For each listed record, the *Record Index* specified the required components for the more than 900 current and archived documents listed. The exception was the process to monitor/audit record completion; however, that process is described in the Process Document.	23rd – Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion
	Settlement Agreement) are updated at least semiannually and that the various reports are updated according to their due dates. The *Settlement Agreement Library Protocol VER 002* also described the processes to monitor/audit record completion. The *Record Index* is available on the Library Record Index page of the Library website. For each listed record, the *Record Index* specified the required components for the more than 900 current and archived documents listed. The exception was the process to monitor/audit record completion; however, that process is described in the Process Document.		
54.3 The Record Index and all associated documents are timely available to the Independent Reviewer upon request.	Overall, DBHDS fulfilled the requirements of this Indicator. For this 24th Period, the *Record Index* was available on the Library Record	At the time of the 23rd Period, the *Record Index* was available on the Library Record Index page. Most documents were timely and could be accessed on the Library Site. However, the study found that the site was not intuitive and often required the viewer to have a level of prior knowledge about a report to access it with ease. In addition, accessibility to the *Record Index* was limited and DBHDS needed to consider making this tool more clearly visible.	23rd – Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion
	Index page. In addition, DBHDS posted information about the *Record Index* in a prominent area on the Welcome Page so that users can be aware of this tool and how to use it immediately upon entry to the website. Based on review of the website, it was visible and available on several web browsers (i.e., Safari, Edge, Chrome.) DBHDS had expanded the *Record Index* to include more than 900 current and archived documents. All tested links worked as required. Each of these enhancements significantly improved the ease of document access from the previous period. However, DBHDS should continue to evaluate additional opportunities for improvement. In particular, the *Record Index* did not follow a consistent naming or organizational protocol, which sometimes made it difficult to use the	For this 24th Period, the *Record Index* was available on the Library Record Index page. In addition, DBHDS posted information about the *Record Index* in a prominent area on the Welcome Page so that users can be aware of this tool and how to use it immediately upon entry to the website. Based on review of the website, it was visible and available on several web browsers (i.e., Safari, Edge, Chrome.) As described above for CI 54.2, DBHDS had expanded the *Record Index* to include more than 900 current and archived documents. All tested links worked as required. These enhancements significantly improved the ease of document access from the previous period. However, DBHDS should continue to evaluate opportunities for additional improvement. In particular, the *Record Index* did not use a consistent naming protocol. For example, although the Record Index listed the documents alphabetically, a user seeking to find Quality Review Team (QRT) documents could not immediately find all of the pertinent materials by scrolling to the Q section. Instead, QRT documents were sometimes listed by a title beginning with *SFY*, and sometimes beginning with *QRT*. Similarly, REACH documents were sometimes listed by various titles beginning with *FY*, *DOJ* or *REACH*. This sometimes made it difficult to use the alphabetical protocol in an effective manner. It was notable that using the search function generally provided the location of the needed documents, but DBHDS should follow a consistent naming or organizational protocol by which documents could be more easily located. This would make the *Record Index* a more efficient tool.	

Compliance Indicator	Facts	Analysis	Conclusion
	alphabetical protocol in an effective manner.		
54.4: 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.	For the 24th Period, the Commonwealth continued to meet the requirements for this CI. As reported previously, DBHDS has in place a Process Document entitled *Settlement Agreement Library Protocol VER 002*. The Glossary of Terms/Roles and Responsibilities clearly stated that "Under Code of Virginia § 42.1-85, the Library of Virginia (LVA) has the authority to issue regulations governing the retention and disposition of state and local public records. In keeping with the Code's mandate, LVA has developed records retention and disposition schedules outlining the disposition of public records. The retention schedule for documents on the Settlement Agreement Library is 10 years."	At the time of the 23rd Period review, the Commonwealth met the criteria for this CI. The *Settlement Agreement Library Protocol VER 002* Glossary of Terms/Roles and Responsibilities clearly stated that "Under Code of Virginia § 42.1-85, the Library of Virginia (LVA) has the authority to issue regulations governing the retention and disposition of state and local public records. In keeping with the Code's mandate, LVA has developed records retention and disposition schedules outlining the disposition of public records. The retention schedule for documents on the Settlement Agreement Library is 10 years." For this 24th Period, the *Settlement Agreement Library Protocol VER 002* remained in place.	23rd – Met **24th - Met**

Recommendations:

1. For ease of use by stakeholders, DBHDS should consider posting the Virginia-specific NCI reports on the Library itself, rather than simply linking to the NCI website.
2. DBHDS should follow a consistent naming or organizational protocol in the *Record Index* by which documents listed could be more easily located. This would make the *Record Index* a more efficient tool.
3.

Documents Reviewed:

1. Settlement Agreement Library Protocol VER 002
2. Record Index Reference Tool dated 2/29/24
3. 41.1-41.5 Report Links
4. Public Reporting Improvement Activities 2.2024

Websites Accessed:

1. Official Site of the Commonwealth of Virginia – DOJ Settlement Agreement (https://dojsettlementagreement.virginia.gov) on 4/14/24 and 4/15/24 to confirm presence of documents and currency of:
    a. Results of licensing findings resulting from inspections and investigations

    b. Data Quality Management Plan

    c. Annual Quality Service Review (QSR) documents for Round 5

    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

2. NCI-IDD (https://idd.nationalcoreindicators.org) to confirm access to National Core Indicators Annual Report and Bi-Annual National Report. (4/14/24)

APPENDIX J

Quality and Risk Management
and
Quality Improvement Programs

By

Rebecca Wright, MSW, LICSW
Chris Adams, MS

Quality and Risk Management System 24th Period Study

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

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

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

Section 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.

Section V.D.1: The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers; 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.

Section V.D.2 a-d: The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement. 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.

Section 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: Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations); Physical, mental, and behavioral health and well-being (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status); 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); Stability (e.g., maintenance of chosen providers, work/other day program stability); 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);Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals); 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 Provider capacity (e.g., caseloads, training, staff turnover, provider competency).

Section 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.

Section V.D.5, 5.a and 5.b: 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…..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.

Section V.E.I: 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.

Section 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.

Section 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.

The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) jointly submitted to the Federal Court a complete set of compliance indicators (CIs) for all provisions with which Virginia had not yet been found in sustained compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020.

For this 24th Period review, the study served as a follow-up to previous studies that have been competed annually since 2017 regarding the status of the Commonwealth's achievements regarding these selected Quality and Risk Management System requirements and systems. For the 24th Period reviews, the Parties have agreed to target the CIs that have not been Met twice consecutively in the two most recent reviews.

The following summarizes the compliance status of the Provisions and Compliance Indicators under review as of the time this 24th Period Report began:

Compliance Indicator	Corresponding Provision	22nd/23rd Status
29.13	V.B	NM/NM
29.16	V.B	NM/NM
29.17	V.B	NM/NM
29.18	V.B	NM/NM
29.20	V.B	NM/NM
29.21	V.B	NM/NM
29.22	V.B	NM/NM
29.23	V.B	NM/M
29.24	V.B	NM/NM
29.25	V.B	NM/M
30.4	V.C.1	NM/NM
30.10	V.C.1	NM/NM
32.4	V.C.4	NM/M
32.7	V.C.4	NM/M
35.1	V.D.1	NM/NM
35.3	V.D.1	M*/NM
35.5	V.D.1	NM/NM
35.7	V.D.1	NM/NM
35.8	V.D.1	M*/NM
36.1	V.D.2.a-d	NM/M
36.3	V.D.2.a-d	NM/M
36.8	V.D.2.a-d	NM/NM
37.7	V.D.3	NM/M
38.1	V.D.4	NM/M
42.3	V.E.1	NM/M
42.4	V.E.1	NM/NM
43.1	V.E.2	NM/M
43.3	V.E.2	NM/M
43.4	V.E.2	NM/M
44.1	V.E.3	NM/M
44.2	V.E.3	M*/NM

Study Methodology:
This study sought to gather and investigate facts and verify data and documentation provided by the Commonwealth to assess the sufficiency of the Commonwealth's actions to achieve and sustain achievement with each of the CIs described in the previous section. The methodology included a review of the documents that Virginia maintains to demonstrate that it has properly implemented and fulfilled the Agreement's requirements, interviews with state officials, subject matter experts, and stakeholders, and verification that Virginia's relevant Process Documents and Attestations are complete.

Evidence gathering included:

- Review of documentary evidence provided by the Commonwealth specific to the requirements set out in each Indicator.
- A review of a sample of relevant records from 40 randomly selected licensed providers and Community Services Boards (CSBs) across each of the five regions in the Commonwealth, annual Office of Licensing (OL) inspection reports, and evidence packets that OL used in assessing regulatory compliance during the CY 2023 and the first two months of CY2024 annual licensing inspection and review and analysis of any data from sources that DBHDS determined to be valid and reliable as well as other available data from the QSR process.
- Review of any changes that have been made to policies, procedures, and/or practices relating to the requirements in the applicable Compliance Indicators listed above.
- For CIs that rely on data to demonstrate compliance, the data validation process included review and analysis of documents described above for each CI focusing on:
    a. Threats to data integrity previously identified by DBHDS assessments.
    b. Actions taken by DBHDS that resolved these problems including completion dates for those activities.
    c. Review of the verification process that DBHDS completed that confirmed that the data reported is reliable and valid.
    d. The date when the Commonwealth's Attestation that the Process Document was properly completed, that the threats were sufficiently mitigated, and that the data reported are reliable and valid.
- Where the Parties had agreed to Curative Actions relevant to any of these Compliance Indicators as of the date of this proposal, the study also reviewed the current status of implementation.
- Interviews with key DBHDS staff.

Study Findings:

The bullets below summarize the results of the 24th Period study, followed by a more detailed summary of each section.

- DBHDS achieved a fully Met status for the second consecutive time for the following CIs: 29.3, 29.25, 32.4, 32.7, 38.1, and 42.3.
- DBHDS also achieved a fully Met status for the first time for the following CIs: 29.13, 29.16, and 35.3.
- DBHDS did not meet the requirements for the following CIs: 29.17, 29.18, 29.20, 29.21, 29.22, 29.24, 30.4, 30.10, 35.1, 35.5, 35.7, 35.8, 36.8 and 42.4.
- Determinations were deferred until the 25th Period for the following CIs: 36.1, 36.3, 37.7, 43.1, 43.2, 43.4, 44.1 and 44.2.

Section V.B.

Previous reports have stressed that having valid and reliable data was a crucial pre-requisite to a functional QMS and frequently documented deficiencies in this area. As described in previous reports, on 1/21/22, the Parties jointly filed with the Court an agreed-upon *Curative Action for Data Validity and Reliability*. It stated that DBHDS would continue to review data sources and update the quality management plan annually as required, including recommendations around actionable items for the systems to increase their quality and a deep dive into each source system every 3-5 years to test and follow the data and to review and identify source system threats to data reliability and validity.

The *Curative Action for Data Validity and Reliability* includes two elements: The first requires DBHDS to continue to complete periodic assessments of its data source systems, including the identification of threats to data validity and reliability and actions taken to mitigate those threats. The second

entails confirming the validity and reliability of specific data sets and their use in producing data for compliance reporting. While the confirmation process itself is outside the provenance of OCQM, that office is responsible for identifying the threats to data validity and reliability in the data collection methodologies. The *Curative Action for Data Validity and Reliability* describes creation of a Process Document that, among other things, for each applicable purpose must describe the data set to be used, a methodology for addressing any threats to validity and reliability of the data available in the data set, and a methodology for addressing any threats to validity and reliability in the process of pulling the data from the data set. Once this is complete, the office of the Chief Data Office (CDO) completes a review and attests that the process will produce valid and reliable data. This is known as the Data Set Attestation.

For the 23rd Period, despite some remaining needs for enhancements, DBHDS efforts for CI 29.23 and CI 29.25 continued to sufficiently demonstrate they met the requirements for data validity and reliability described in the *Curative Action for Data Validity and Reliability*. As a result of these overall efforts, the Commonwealth met CI 29.23 and CI 29.25 for the second consecutive period.

At the time of the 23rd Period, some deficiencies remained related to RMRC review of abuse, neglect, and exploitation (ANE) data (i.e., CI 29.13) and look behind-reviews for both serious incident and ANE processes (i.e., CI 29.16 - CI 29.18). For the 24th Period, DBHDS made progress and met CI 29.13 and 29.16, each for the first time. However, the requirement to complete look-behind reviews of reported allegations of abuse, neglect, and exploitation required at CI 29.17 was implemented in Q3 FY23 and results from four quarterly reviews have been presented to the RMRC. The data and trend analysis processes associated with this CI continue to be in their infancy; however, the process continues to demonstrate improvement. The process does not yet have an inter-rater reliability component and the automation of aspects of the process in the PowerApps platform has not yet been fully implemented. These facts also negatively impacted CI 29.18, which remained not met.

At the time of the 23rd Period, DBHDS did not meet reporting requirements for several V.B metrics, including CI 29.20 (i.e., annual physical and dental exams), CI 29.21 (i.e., adequacy of behavioral services), CI 29.22 (i.e., residential settings compliant with HCBS community integration requirements), and CI 29.24 (i.e., individual protection from serious injury). For this 24th Period, DBHDS again did not meet any of these requirements. This study noted some progress, but also some remaining concerns:

- For CI 29.20, DBHDS data again indicated that the Commonwealth did not yet achieve 86% for annual physical exams for people supported in residential settings or 86% for annual dental exams for individuals who have coverage for dental services. For annual physical exams, DBHDS reported data at or just below the threshold during three recent quarters, but data for annual dental exams continued to be well below the threshold. It is important to note the apparent improvement for annual physical exams is likely the result of changes to the data collection methodology, which DBHDS modified during SFY23 to allow for the exam to occur within a 14 month period ahead of the ISP anniversary date, instead of 12 months. It was positive that DBHDS continued to implement a number of systemic efforts to increase resources for annual physical and dental exams.
- For CI 29.21, DBHDS again did not yet achieve compliance with these requirements, reporting that 64% of people with identified behavioral support needs received adequate services and 36% received inadequate or no services. At the behest of the Independent Reviewer, DBHDS used a corrected calculation methodology that was in line with the *Agreed-Upon Curative Action for Compliance Indicator 29.21*, filed with the Court on 7/11/22. This revised methodology is designed to ensure that the measure denominator accurately reflects the entire cohort of people with identified behavioral support needs. Of note, due to the change in the calculation methodology, the currently reported percentage cannot be compared to previously reported data for the purpose of determining trends.

- For CI 29.22, the Commonwealth did not meet the requirements of this CI. DBHDS reported that only 69% of the applicable settings were compliant with HCBS community integration requirements vs. the required 95%. DBHDS and DMAS continued to work to complete validation of settings, but had not yet completed all reviews. In addition, at the time of the 23rd Period, this study found that the proposed methodology was not a valid indicator of the total percentage of residential service recipients residing in compliant settings because it counted individuals who lived in settings for which the QSR vendor found noncompliance and issued a quality improvement plan, but without any evidence that the noncompliance had been successfully remediated. For this 24th Period, a modification to the relevant Process Document indicated that DBHDS staff would follow-up with the provider regarding the quality improvement plan, but did not include the actual steps staff would take or the criteria they would apply. Overall, DBHDS did not provide a clear description of the QSR protocol for determining HCBS compliance that outlined and incorporated all of the validation processes in the approved Statewide Transition Plan (STP) or the requirements of the HCBS Settings Rule and related CMS guidance. In addition, the Round 6 PCR and PQR tools contained many elements that addressed key HCBS requirements for integration in and access to the greater community that were that were not included in the designated list of questions used to calculate compliance, nor did they always provide sufficient guidance for making a reliable determination.
- For CI 29. 24, at the time of the 23rd Period, DBHDS still needed to ensure the measure methodology would produce valid and reliable data and that DBHDS had sufficient data capabilities to allow for an adequate evaluation of serious injury data. For this 24th Period, DBHDS made significant revisions to the data collection methodology, which used serious incident data from the CHRIS incident reporting system, and provided a revised Process Document. It defined individuals who were not protected from serious injury as those for whom a licensing investigation revealed a licensing violation that required a corrective action plan (CAP). This was a novel application of the IMU and Investigation processes that, with some revisions, could potentially provide valid and reliable data. However, the current proposed methodology reflected a funneling effect that appeared to significantly limit the serious injuries that could possibly reach the investigation stage. Of the approximately 2,400 serious injuries reported during the past 12 months, DBHDS investigated just over 4% of them. DBHDS staff reported they were considering opportunities to enhance these processes.

In the area of the training and technical assistance, DBHDS made resources available to providers specific to expectations for and processes to conduct thorough root cause analyses (RCAs) that have proven to be effective. This study's sample of 42 RCAs completed by providers during CYs 2022-2023 noted continued improvement in the quality and utility of these analysis processes compared to a similar review during the 22nd period study. Likewise, the Office of Clinical Quality Management was expanding its robust Consultation and Technical Assistance (CTA) Framework, including the very successful CTA practices specific to Office of Licensing (OL) quality improvement regulations.

Section V.C.1

During CY23, the Office of Licensing conducted licensing inspections and assessed all applicable licensing requirements at *12VAC35-105-520a-e* in 96.8% of the inspections. This was a 2.6% increase over the percentage assessed in CY22. However, the current assessment process still does not sufficiently evaluate all of the requirements at CI 30.4. This also prevented DBHDS from meeting the requirements for CI 30.10. From review of a sample of 40 annual licensing inspections completed to date in CY24 specific to the requirements at CI 30.4, the Consultant agreed with the licensing specialist findings in 82% of the sample providers. This represents a significant improvement from a similar sample review for the 23rd period study where the Consultant agreed with the licensing specialist findings specific to CI 30.4 for only 52% of the sampled providers. However, because the Office of Licensing had only completed approximately 25% of the total number of licensing inspections that will be conducted in 2024, the sample

was determined insufficient to validate the process for CY24. The Office of Licensing has continued to provide training and technical assistance to providers and to licensing specialists regarding these requirements and should continue these efforts to improve the accuracy and consistency of the licensing specialist assessments of compliance with the requirements at CI 30.4 and CI 30.10. The Consultant shared the results of the sample reviews with the Office of Licensing at the conclusion of the review to provide additional detail regarding targeted areas of improvement necessary to continue the improvements in accuracy and consistency noted to date in CY24.

Section V.C.4: DBHDS met the requirements for CI 32.4 for the second consecutive period, as described in the previous study. This CI requires providers to demonstrate that they complete training as part of their corrective action plan process when inspections determined they were non-compliant with requirements about training and expertise for staff responsible for the risk management function and and/or requirements about conducting root cause analyses. To show they met the requirements for CI 32.7 and used risk management data to identify and implement needed training in these areas, DBHDS provided documentation of the implementation of RMRC procedures to review of surveillance data, PMIs, case reviews, or other information that is brought to the committee to either implement improvement activities and/or develop or revise informational content that is disseminated to providers. DBHDS provided RMRC meeting minutes that reflected related agenda items, discussions, presentations and action items. In addition, DBHDS continued to subsequently develop and post substantial guidance for providers and others on its website related to risk management (e.g., the OIH and OL webpages).

Section V.D.1: For the 24th Period, DBHDS for the first time, met the requirements for CI 35.3 related to data validity and reliability, providing sufficient Process Documents and applicable Data Set Attestations for each Waiver Performance Measure and a quarterly review of data. However, despite reviewing data on a quarterly basis, DBHDS again did not meet the requirements for CI 35.1 or CI 35.5, because they did not develop and/or monitor needed remediation, as required in the Quality Improvement Systems (QIS) outlined in Appendix H for each of the HCBS Waivers. It was positive that, in interview, the DBHDS Assistant Commissioner could describe a current or proposed remediation plan, including some pending QIIs, for each of the measures that did not meet the threshold in the *SFY23 Quality Review Team End Of Year Report* (*EOY Report*). Going forward, the Quality Review Team (QRT) will need to work with DBHDS to obtain and review any such proposed remediation plans in writing and ensure that those plans focus on systemic factors, where present, and include the specific strategy to be employed and the defined measures that will be used to monitor performance. The Commonwealth did not meet the requirements for CI 35.7 because, as reported at the time of the 23rd Period, DBHDS did not show a local level or Community Service Boards (CSB) review, at least annually, of the Waiver Performance Measures. However, this was pending. DBHDS also again did not meet CI 35.8 (i.e., at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months), because the most recently reported data showed performance at only 81%, a decrease from 83% reported at the time of the 23rd Period. As has been previously recommended, during this 24th Period, DBHDS did begin more frequent data collection for CI 35.8 to facilitate timely remediation.

Section V.D.2 a-d: At the time of the 23rd Period, DBHDS met CI 36.1 and CI 36.3 for the first time. For this Period, a determination is deferred until the 25th Period, as described below. If the Commonwealth meets the requirements of these CIs during the 25th Period, it will have met this indicator in two consecutive reviews.

Since the 23rd Period, DBHDS had not yet completed the next annual *Data Quality Monitoring Plan (DQMP) Source System Assessment*, which for this 24th Period, required revision to address some potential breakdown in the quality and thoroughness of the source system assessment process, as evidenced by errors in the annual updates to the assessments for CHRIS-SIR and CHRIS-HR. In interview, DBHDS

staff indicated they would undertake additional monitoring of the process through the office of the Assistant Commissioner to ensure such breakdowns would not occur in the future.

In addition, with regard to the QSR data source system, while the 23rd Period study determined DBHDS at least minimally met the requirements of the *Curative Action for Data Validity and Reliability*, the study found the assessment failed to address potential inter-rater reliability (IRR) deficiencies and their impact on data validity and reliability. Previous Reports to the Court had repeatedly identified these concerns and provided multiple examples of discrepancies between the data findings of the QSR reviewers and those of the Independent Reviewer's consultants. As a result, the 23rd Period found that the Commonwealth minimally met the requirements of CI 36.1, but only with the caveat that DBHDS needed to further examine the Process Documents and Data Set Attestations for any QSR data set to ensure they adequately identified and addressed the IRR threats. For this 24th Period, DBHDS did not report completing any further examination for IRR threats to validity and reliability in Process Documents and Data Set Attestations that use QSR data sets. Also of note, documentation indicated that as compared to Round 5, the Round 6 QSR IRR Policy now requires only two cases per reviewer, instead of three, and does not require the live video observation. The materials did not state the rationale for this change, which had the effect of reducing the overall IRR effort for the upcoming Round 6, and potentially the outcomes. However, Round 6 data will not be available for validation until the 25th Period. For this QRM study, that impacts the following CIs that rely on QSR data sets: HCBS residential compliance (i.e., CI 29.22), use of QSR data for analysis and quality improvement (CI 36.3), PMI data quality (CI 37.7), provider reporting measures (i.e., CI 43.1. 43.3 and CI 43.4), and provider quality improvement programs (i.e., CI 44.1 and CI 44.2).

At the time of the 23rd Period, the Commonwealth did not meet the requirements of CI 36.8 because DBHDS made several potentially significant modifications to the previously proposed methodology that not only could impact the validity of the sample, but also did not appear to fulfill the corrective action requirements of the CI. DBHDS made this information available with only one month remaining in the 23rd Period, so there was not sufficient time for the Independent Reviewer to investigate and verify the data quality. For this 24th Period, DBHDS reported the development of a new *Intense Management Needs Review Process* to assess and monitor the adequacy of supports provided to individuals with identified complex medical needs, which closely mirrored the Individual Services Review (ISR) study's process conducted by the Independent Reviewer. While this CI requires at a minimum a statistically significant sample on an annual basis, Independent Reviewer approved an exception for the subgroup of individuals with complex medical needs, allowing for review of 60 randomly selected individuals in an annual period (i.e., 30 each during two successive periods). Of note, this exception did not apply to the other subgroups of individuals (i.e., individuals with complex adaptive and behavioral support needs) and the evidence submitted did not demonstrate that this was a statistically significant sample. In addition, the *IMNR* process did not address behavioral needs, so it was insufficient to assess and monitor the adequacy of supports provided to those individuals.

The *IMNR* provided extensive detail to define corrective actions that providers and support coordinators would need to take, based on triggers defined in a Remediation Plan Guide. It also provided for timeframes and follow-up to ensure loop closure to address specific individual findings. This was a positive finding. However, based on review of the *Intense Management Needs Review Report Twenty-Fourth Review Period*, dated April 2024, DBHDS did not yet provide a clear methodology for analyzing aggregate data from the reviews to monitor the overall adequacy of management of the needs of individuals with identified complex behavioral, health and adaptive support needs and the supports provided or to develop related systemic corrective actions pursuant to such data analysis.

Section V.D.3: The sole remaining requirement, CI 37.7, requires the OCQM (i.e., the successor to the Office of Data Quality and Visualization) to assess data quality and inform the committee and

workgroups regarding the validity and reliability of the data sources used for Performance Measure Indicators (PMIs). Pursuant to the findings for CI 36.1, this determination is deferred until the 25th Period.

Section V.D.4: For the 24th Period, DBHDS continued to collect and utilize data from all the identified source systems identified in this Provision's single CI 38.1. In addition, as described at the time of the 23rd Period, DBHDS achieved substantial improvement with regard to ensuring data validity and reliability, including at least minimally adequate source system assessments. These assessments remained current for this 24th Period. As a result, the Commonwealth met the requirements of this CI for the second consecutive time.

Section V.E.I: For CI 42.3, DBHDS continued to demonstrate that 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. However, DBHDS did not meet CI 42.4, which requires that at least 86% of DBHDS-licensed providers of DD services are compliant with *12 VAC 35-105-620*. DBHDS is now measuring comparative compliance with each sub-regulation across a calendar year. In CY22, only 3/11 sub-regulations met or exceeded the 86% threshold, and this increased slightly to 4/11 in CY23. One sub-regulation which requires that the provider's quality improvement plan include and report on statewide performance measures, if applicable, *(§620.C.3)* was not measured in either CY as providers were not sufficiently informed of the requirements to complete this. Providers have now been advised of their responsibilities and data should be available at the conclusion of CY2024. DBHDS provided a Process Document and Data Set Attestation for the 23rd study specific to these requirements and made a slight modification in that process document for CY24 in response to a recommendation from the 23rd review that now requires that the denominator must always be of sufficient size to reach a 95% confidence level for all providers who had an annual unannounced inspection during the year. In CY23, 99% (473/478) of providers who received a citation for any requirement at *§620* were required to develop and implement a CAP to address the citation. Each of these CAPs were reviewed and approved by the Office of Licensing.

Section V.E.2: At the time of the 23rd Period, the Commonwealth met the requirements for the remaining three CIs for this Provision (i.e., CI 43.1, CI 43.3 and CI 43.4), each for the first time. Overall, the data collection and reporting at least minimally conformed with the requirements of the *Curative Action for Data Validity and Reliability*. However, this finding included a caveat that DBHDS needed to further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats have been adequately identified and addressed.

For this 24th Period, while the Commonwealth continued to implement the other requirements of these CIs (i.e., collect and report data for 12 surveillance measures related to negative aspects of health and safety that come from provider critical incident reporting, and to collect and report data for community integration utilizing specific QSR questions, DBHDS did not complete any additional examination of the related Process Documents and Data Set Attestations for this QSR data. In addition, Round 6 QSR data will not be available for validation until the 25th Period. As a result, this study could not make a final determination that DBHDS met the requirements for this CI due to pending actions by DBHDS related to QSR data quality, and will defer additional consideration until the 25th Period. If the Commonwealth meets the requirements of these CIs during the 25th Period, it will have met each of them in two consecutive reviews.

Section V.E.3: The 23rd Period review determined that the Commonwealth met the requirements for CI 44.1 (i.e., to use the QSR to assess provider quality improvement programs) for the first time, but did not meet CI 44.2 because the study could not confirm that any of 15 vendor-issued QIPs sufficiently addressed the quality improvement deficiencies or identified the needed remediation or need for technical

assistance. While this sample size was still small, the finding was universal. This finding called the QSR data for this CI into question. This was consistent with the overall 23rd Period caveat that DBHDS needed to further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats have been adequately identified and addressed.

For this 24th Period, this study could not fully evaluate the Commonwealth's performance and will defer a finding until the 25th Period. This was due several factors, including 1) the scheduling of Round 6 provider reviews and the resulting inability to completed needed sampling 2), the DBHDS timeframes for submission of documents for review for Round 6 QSR, resulting in inadequate time to review significant revisions in the processes for evaluation provider quality improvement programs, and 3) the need for DBHDS to complete a review of IRR concerns with regard to data validity and reliability of QSR data sets. If Commonwealth meets the requirements of CI 44.1 during the 25th Period, it will have met this indicator in two consecutive reviews.

The tables below summarize the status of each CI studied for this report:

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

V.B Indicators:	Status
29.22 At least 95% of residential service recipients reside in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings.	Not Met
29.23 At least 95% of individual service recipients are free from neglect and abuse by paid support staff.	**Met**
29.24 At least 95% of individual service recipients are adequately protected from serious injuries in service settings.	Not Met
29.25 For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans.	**Met**

V.C.1 Indicators:	Status
30.4. At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. Inspections will include an assessment of whether providers use data at the individual and provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations.	Not Met
30.10 To enable them to adequately address harms and risks of harm, the Commonwealth requires that provider risk management systems shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such events occur or the risk is otherwise identified. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6.	Not Met

V.C.4 Compliance Indicators	Status
32.4: 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.	**Met**
32.7: 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.	**Met**

V.D.1. Compliance Indicators	Status
35.1: The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers.	Not Met
35.3 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 abuse/neglect/exploitation (prevention is contained in corrective action plans).	**Met**
35.5: 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	Not Met
35.7: 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.	Not Met
35.8: 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	Not Met

V.D.2 Compliance Indicators	Status
36.1: 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.	Deferred
36.3 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	Deferred

V.D.2 Compliance Indicators	Status
Committee (QIC) and implemented as approved by the DBHDS Commissioner.	
36.8: DBHDS collects and analyzes data (at minimum a statistically valid sample) at least annually regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS develops corrective action(s) based on its analysis, tracks the efficacy of that action, and revises as necessary to ensure that the action addresses the deficiency.	Not Met

V.D.3 Compliance Indicators	Status
37.7: 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.	Deferred

V.D.4 Compliance Indicators	Status
38.1: 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 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	**Met**

V.E.1 Compliance Indicators	Status
42.3 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.	**Met**
42.4: 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.	Not Met

V.E.2 Compliance Indicators	Status
43.1: 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	Deferred

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	
43.3: 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.	Deferred
43.4 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.	Deferred

V.E.3 Compliance Indicators	**Status**
44.1: 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.	Deferred
44.2: 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.	Deferred

V.B. Analysis of 23rd Review Period Finding

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

Compliance Indicator	Facts	Analysis	Conclusion
29.13 The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, neglect, and exploitation, at least four times per year by various levels such as by region, by CSB, by provider locations, by individual, or by levels and types of incidents.	Overall, for this 24th Period review, DBHDS met the requirements for this CI. The 23rd Period review confirmed that DBHDS had established written processes that laid out an adequate framework for completing these responsibilities. For the 24th Period, these tools and processes continued to be in place. RMRC meeting minutes evidenced that the RMRC reviewed some type of aggregate data related to serious incidents (i.e., either the IMU Data Review or the Serious Incident Data Review) on at least five occasions Thus far during SFY 24. These presentations addressed	At the time of the 23rd Period review, this CI was not met because the RMRC did not review data and identify trends from allegations and substantiations of abuse, neglect, and exploitation, at least four times per year. For this 24th Period review, DBHDS met the overall requirements for this CI, as described below. The 23rd Period review confirmed that DBHDS had established written processes that laid out an adequate framework for completing these responsibilities. For the 24th Period, these tools and processes continued to be in place. These included the *RMRC Charter*, which required that the RMRC review data for serious incidents and allegations and substantiations of abuse, neglect, and exploitation at least four times per year; the *RMRC Task Calendar and Charter Tasks* which are the scheduling tool used by the RMRC to ensure that it conducts reviews and analysis of surveillance data specific to abuse/neglect, exploitation, Office of Human Rights look-behind results, serious incidents, the IMU look-behind (triage) process, incident management care concerns, timeliness of reporting and related citations, relevant state facilities data, and performance measures; and, the *RMRC QIC Subcommittee Work Plan,* which is the comprehensive tracking and information tool used by the RMRC to document their review and analysis activities, including the activities undertaken, data and information reviewed/analyzed, and follow-up activities resulting from the analysis of data and information. At the time of the 23rd Period, the RMRC had reviewed aggregate data related to serious incidents (i.e., either the *IMU Data Review* or the *Serious Incident Data Review*) on four occasions during calendar year 2023. This included two meetings that took place during SFY24: • In July 2023, the RMRC meeting included a *Serious Incident Data Review*	23rd - Not Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion
	data for serious incidents, including allegations and substantiations of abuse, neglect, and exploitation (ANE). For 23rd Period review, DBHDS submitted sufficient factual evidence to show it addressed all previously identified specific threats to the reliability and validity of data derived from the CHRIS and CONNECT data source systems, as well as specific steps to achieve needed remediation, including a Process Document entitled *SIR by Type Surveillance Rates ANE VER004,* dated 8/22/2023, a Data Set Attestation for the Process Document and the related data reports. DBHDS also submitted a Process Document entitled *HR Process Document Free From ANE 29.23, Ver 005*, dated 10/12/23 and a Data Set Attestation, dated 8/30/23.	presentation. • In August 2023, the RMRC reviewed a presentations for the *IMU Data Review*. For this 24th Period review, RMRC meeting minutes for September 2023 through February 2024 evidenced that the RMRC reviewed some type of aggregate data related to serious incidents on another three occasions during SFY24: • In November 2023, the RMRC meeting included a *Serious Incident Data Review* presentation, also with surveillance rates, and an *IMU Data Review.* • In January 2024, the RMRC meeting included a *Serious Incident Data Review* presentation, also with surveillance rates. • In February 2024, the RMRC meeting included an *IMU Data Review.* At the time of the 23rd Period, RMRC quarterly presentations did not always address allegations and substantiations of abuse, neglect, and exploitation (ANE) as required, and whether the data reviewed are from the most recent quarter to allow timely corrective actions by DBHDS. However, the 24th Period, RMRC meeting minutes for September 2023 through February 2024 evidenced that the RMRC reviewed aggregate data related to ANE documentation on three occasions, including October 2023, December 2023 and February 2024. Therefore, the RMRC was on track to complete four quarterly reviews for SFY24. In addition, these presentations referenced sufficiently timely data. At the time of the 23rd Period review, DBHDS staff provided numerous documents to demonstrate the efforts made to ensure the serious incident data were valid and reliable and could be used for compliance reporting. These documents were sufficient to demonstrate DBHDS met the data validity and reliability requirements. These included: • A Process Document entitled *SIR by Type Surveillance Rates ANE VER004*, dated 8/22/2023, which remained unchanged for this 24th Period review. • A Data Set Attestation for the Process Document and the related data reports (i.e., *DW-0123-CHRIS Incident Report*, *DW-003a-OHR_CONNECT CSB*	

Compliance Indicator	Facts	Analysis	Conclusion
	The 23rd Period report also noted that, going forward, DBHDS should revise the materials as needed to reflect new recommendations from the August 2023 assessments of CHRIS-SIR and CHRIS-HR completed by OCQM as a part of the annual source system assessment processes. At the time of the 24th Period review, DBHDS had not yet reviewed the SIR Process Document and Data Set Attestation, but were able to provide evidence to show that they had previously implemented remedial strategies to address the specific concerns and recommendations in the CHRIS-SIR and CHRIS-HR updates. This also applied to the current *HR Process Document Free From ANE 29.23, Ver 005*, dated 10/12/23, and the Data Set Attestation updated	*Incidents*, *DW-0038a-OHR_Connect Provider Incidents)*, dated 8/29/23. • With regard to ANE data validity and reliability, DBHDS submitted a Process Document (i.e., *HR Process Document Free From ANE 29.23, Ver 005*, dated 10/12/2023) and Data Set Attestation, dated 8/30/23 for this Period. A revision to the current Data Set Attestation, was pending for the most recent revisions, but it did not substantially impact compliance for the purpose of this CI. As described with regard to CI 29.23, these documents were sufficient to demonstrate DBHDS met the data validity and reliability requirements for this Period. However, the 23rd Period report also noted that, going forward, DBHDS should revise these materials as needed to reflect new information. Of note, as part of the *DQMP* annual evaluation, in August 2023, OCQM completed assessments of CHRIS-SIR and CHRIS-HR and identified data threats not addressed in the previous source system assessments. As a result, the related Process Document and Data Set Attestations needed to be updated to incorporate these findings. At the time of the 24th Period review, DBHDS had not yet reviewed the SIR Process Document and Data Set Attestation, but were able to provide evidence to show that they had previously implemented remedial strategies to address the specific concerns and recommendations in the CHRIS-SIR and CHRIS-HR updates. This also applied to the current *HR Process Document Free From ANE 29.23, Ver 005*, dated 10/12/23, and the Data Set Attestation updated on 3/6/24. In interview, DBHDS staff stated that it was likely that the CHRIS-SIR and CHRIS-HR updated assessments missed some of the completed remediation due to the readying of the *RMRC Roadmap Progress V4,* and the numerous planning and technical specification documents that accompanied it, within the same timeframe that OCQM was completing the source system assessments. Going forward, in order to ensure accuracy and timeliness, DBHDS staff stated an intent to enhance the pre-publication review of the source system documents to ensure accuracy as well as to ensure that any time a source system assessment or update identifies threats to data validity and reliability or recommendations, the Process Document owner will document a review and response and request any Data Set Attestation update that might be required as a	

Compliance Indicator	Facts	Analysis	Conclusion
	on 3/6/24. DBHDS staff stated an intent to enhance the pre-publication review of the source system documents to ensure accuracy and to ensure that any time a source system assessment or update identifies threats to data validity and reliability or recommendations, the Process Document owner will document a review and response and request any Data Set Attestation update that might be required as a result.	result. In addition, DBHDS staff will need to ensure that any time a source system assessment or update identifies threats to data validity and reliability or recommendations, the Process Document owner will document a review and response and request any Data Set Attestation update that might be require as a result.	
29.16 The RMRC conducts or oversees a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The review will evaluate whether: i. The incident was triaged by the Office of Licensing incident management team appropriately according	In 2022, DBHDS implemented a look-behind review of a statistically valid, random sample of serious incident reviews and follow-up processes conducted by VCU and with subsequent improvements and expansions of the process, it now includes review of each of the four outcomes required by this CI.	The Virginia Commonwealth University (VCU) has continued to conduct and report findings from the look-behind review of a statistically valid, random sample of serious incident reviews and follow-up processes for five quarters (04/01-06/30/22, 07/01-09/30/22, 01/01-03/31/23, 04/01-06/30/23, and 07/01-09/30-23). Each of these reviews consistently evaluated sample data specific to Outcomes 1, 2, and 3. VCU developed a process to evaluate Outcome 4 and implemented its use in the two most recent quarterly reviews. The three most recent reviews also included a rater reliability process with a threshold score of 88% established by VCU. The comparative data table below details percentage scores for each of the outcomes across the five quarterly look-behind reviews completed to date and the rater reliability scores for the three most recent quarters as well. Percentage scores below the 86% threshold for Outcomes 1-4 are in red in the table:	23rd - Not Met **24th - Met**

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr>
<td>to developed protocols.
ii. The provider's documented response ensured the recipient's safety and well-being.
iii. Appropriate follow-up from the Office of Licensing incident management team occurred when necessary.
iv. Timely, appropriate corrective action plans are implemented by the provider when indicated.
v. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation.</td>
<td>The 24th Period review verified that the RMRC continues to oversee the look-behind process, review trends at least quarterly, recommend follow-up actions and quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation.

DBHDS has developed and is now consistently utilizing a comprehensive tabular tracking report for all recommendations, process improvements, and remedial or corrective actions taken in response to findings from the VCU report and recommendations from the RMRC.

Data across the five quarters reviewed by VCU demonstrate consistent percentage improvement in each of the four outcomes. The scores for each of the</td>
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<table>
<tr><td>Quarter:</td><td>Q2 CY2022</td><td>Q3 CY2022</td><td>Q1 CY2023</td><td>Q2 CY2023</td><td>Q3 CY2023</td></tr>
<tr><td>Dates:</td><td>4/22-6/22</td><td>7/22-9/22</td><td>1/23-3/23</td><td>4/23-6/23</td><td>7/23-9/23</td></tr>
<tr><td>Rpt Date:</td><td>2/26/23</td><td>5/22/23</td><td>8/29/23</td><td>1/15/24</td><td>2/26/24</td></tr>
<tr><td>RMRC Review:</td><td>5/22/23</td><td>5/22/23</td><td>9/11/23</td><td>1/22/24</td><td>2/26/24</td></tr>
<tr><td>Outcome 1:</td><td>59%</td><td>78%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Outcome 2:</td><td>86%</td><td>77%</td><td>90%</td><td>93%</td><td>100%</td></tr>
<tr><td>Outcome 3:</td><td>73%</td><td>72%</td><td>82%</td><td>91%</td><td>96%</td></tr>
<tr><td>Outcome 4:</td><td>Not Assessed</td><td>Not Assessed</td><td>Not Assessed</td><td>86%</td><td>100%</td></tr>
<tr><td>Rater Reliability:</td><td>Not Assessed</td><td>Not Assessed</td><td>93.0%</td><td>98.0%</td><td>99.5%</td></tr>
<tr><td colspan="6">NOTES: There was no review completed for Q4 CY22
Rater Reliability Threshold: 88.0%</td></tr>
</table>

The Quarter 3 2023 VCU Report includes findings of the 07/2023-09/2023 Incident Management Unit (IMU) look-behind and the Incident Management Look Behind RMRC Monthly Meeting 2023 Quarter 3 Data PowerPoint presentation dated 02/26/2024 summarized these findings to the RMRC. The comparative data table above reflects results from these reviews for each of the four quarters and notably reflects results above the 86% threshold for each of the four outcomes in each of the two most recent quarterly reviews. Rater reliability over the three most recent quarters has been consistently high. The RMRC Minutes 02-26-24 document the information presented, deliberations, and areas where the RMRC will focus its follow-up.

The OL has initiated corrective and improvement actions to address findings and recommendations from each of the quarterly look-behind reviews completed to date. OL summarized and submitted a report (Q3 2023 VCU IMU Look Behind DBHDS Response) to the RMRC for review and approval. These follow-up actions include process changes, training, and other remedial actions. Both the OL and the RMRC track implementation of each of the actions.

Based on this consultant's review and analysis of information relevant to this CI, the RMRC continues to conduct/oversee a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up processes that</td>
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Compliance Indicator	Facts	Analysis	Conclusion
	outcomes have met or exceeded the 86% threshold in each of the most recent two quarterly reviews. The validity of these scores is further evidenced by a rater reliability scoring process that was utilized over the three most recent quarters with results exceeding the 88.0% threshold established by VCU in each of these quarters.	address each of the four outcomes referenced in the CI. The process also includes a rater reliability component. Further, the RMRC is now reviewing trends at least quarterly, recommending follow-up actions and quality improvement initiatives when necessary, and tracking implementation of initiatives approved for implementation as documented in the RMRC meeting minutes. These processes meet each of the requirements of this CI.	
29.17 The RMRC conducts or oversees a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: i. comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines. ii. The person conducting the investigation has been trained to conduct investigations. iii. Timely, appropriate	DBHDS implemented a revised Community Look-Behind review process in 06/2023 that addresses each of the outcomes required by this CI. OHR Regional Managers evaluate a sample of 75 cases each quarter utilizing a comprehensive review tool. To date, the OHR analyzed, summarized, and reported four quarters of data to the RMRC for review. The revised process is	The Community Look-Behind (CLB) is a DBHDS review of abuse reports among individuals receiving DD services in licensed community provider settings conducted by the DBHDS Office of Human Rights (OHR). The OHR case reviews completed by OHR Regional Managers include evaluation of three targeted outcomes required by this Compliance Indicator: • Outcome 1 – Comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines. • Outcome 2 – The person conducting the investigation has been trained to conduct investigations. • Outcome 3 – Timely, appropriate corrective action plans are implemented by the provider when indicated. In addition to the three required outcomes, DBHDS has expanded the CLB process to include three additional targeted outcomes: • Outcome 4 – Facts of the provider investigation support the director's determination regarding whether the allegation was substantiated. • Outcome 5 – Involved staff were interviewed during the provider investigation. • Outcome 6 – Involved individuals were interviewed.	23rd - Not Met **24th - Not Met**

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.

well-organized and includes the three outcomes required by this CI and three additional outcomes established by OHR and the RMRC for inclusion in the process. There is no inter-rater reliability component yet developed for the system to further validate reported data.

Process automation using the PowerApps platform has been under development during each of the past two review periods but is not yet fully operational. DBHDS reports that it is currently targeted for full implementation by 08/2024.

Data analysis by OHR and by the RMRC is in its infancy but there is evidence that with continued quarterly analysis of data, this process will evolve into a robust oversight system. As these analysis requirements of the CI have not yet been fully

After a two-year hiatus that resulted from data integrity issues, DBHDS implemented a revised CLB review process in June 2023. The *Provider CLB Memo November 2023* describes the process which includes a sample size of 25 cases/month (projected 300 reviews/year). OHR conducts reviews, on average, 30 days or less after case closure. Eventually, the review process will be automated using a PowerApps automation solution. There has been a delay in full implementation of the PowerApps system due to technical issues and OHR currently projects full implementation by 08/2024. The OHR Director stated that the five Regional Managers who conduct the look-behind reviews have been engaged in development, training, and testing of the new PowerApps system and should be proficient in its use by the projected implementation date.

The *Community Look-Behind Format in the CHRIS System* utilized by the OHR Regional Managers to document their review findings is comprehensive and the *CLB Review Form and Process Technical Guidance* provides detailed guidance for completion of each of the sections in the review. The *OHR Role in the Corrective Action Plan (CAP) Process [Protocol No. 316]* provides detailed written guidance for the reviewers for each element of the CAP process which relates specifically to the information utilized to measure Outcome 3.
The table below summarizes the results from each of the four quarterly reviews conducted since re-implementation of the CLB process. The OHR uses an 86% threshold to measure achievement of each outcome as indicated by reviewer responses to discrete questions in the *CLB Review Form*. Percentage scores below the 86% threshold are in red in the table:

	Q3 SFY23 Results Jan-Mar	Q4 SFY23 Results Apr-Jun	Q1 SFY24 Results Jul-Sep	Q2 SFY24 Results Oct-Dec
Report Date:	8/28/23	8/28/23	12/18/23	2/26/24
RMRC Review:	8/28/23	8/28/23	12/19/23	2/26/24
Sample Size:	75	75	75	75
Outcome 1:	83%	81%	81%	88%
Outcome 2:	64%	60%	65%	59%
Outcome 3:	89%	87%	75%	80%

	developed and implemented, there is insufficient evidence to demonstrate that the components of this CI are being fully met at this time.	The following three outcomes are not specifically required by this Compliance Indicator but were added to the CLB review process to provide additional data to the OHR and RMRC regarding consistency of process implementation and identification of process improvement initiatives. **Outcome 4:** 87% 93% 97% 95% **Outcome 5:** 71% 76% 84% 84% **Outcome 6:** 48% 35% 53% 56% Assuring that comprehensive, non-partial investigations are completed within specific timeframes (Outcome 1) showed improvement in the most recent quarter. Assuring that trained investigators conduct investigations (Outcome 2) showed regression and has remained consistently below the 86% threshold score. Implementation of timely appropriate corrective action plans (Outcome 3) showed improvement from Q1 to Q2 but continues to be below the 86% threshold. OHR has developed and implemented corrective actions to address each of these, but documentation provided for review did not reflect specific identification of objective measurement criteria for each of these actions. Currently, data and trend analysis continue to be in their infancy; however, as a result of continued focus on Outcome 2, staff have identified potential changes in the question used to inform this measure which may prove to have positive impact. Should those changes be determined appropriate by the RMRC, OHR will need to update scores over the previous quarters to provide comparable data across each quarter since the CLB was re-implemented for Q3 SFY 23. As subsequent quarterly data are available, having additional comparative data should help increase the scope and breadth of the data analysis; however, the Consultant believes more detailed analysis of available and relevant data will be necessary to effect positive, lasting achievement of the 86% target levels. For example, in the *RMRC Minutes 02/26/24*, the RMRC Chair asked about factors contributing to the lower scores related to timely appropriate implementation of corrective action plans (Outcome 3) in quarters 1 and 2. The OHR Director identified one contributing factor to be the increase in the number of new providers and that providers were "still learning how to implement human rights requirements." There was no specific data referenced to support the increased number of providers or any cross-referencing within the sample itself to measure the length of operation for the lower scoring providers contrasted with that of those with higher scores.	

		At this time, the case review process does not include an inter-rater reliability component pending full implementation of the data automation process. OHR has not yet drafted a protocol for conducting this reliability evaluation, but the OHR Director stated that she expects the draft protocol will be complete by 05/2024. OHR should give priority focus to the development and full implementation of this validation process. Additionally, the Consultant noted some minor discrepancies when comparing data presented in the narrative explanations in the *12/18/2023 OHR Community Look-Behind Report* for Outcomes 1, 2 and 3 and the data presented to the RMRC in the PowerPoint presentation. The OHR Director stated that these minor variances, none of which impacted the determination of meeting threshold scoring requirements for any of the outcomes, were the result of human error. It is critically important that the RMRC receives accurate, reliable, and valid data for review, analysis, and follow-up. To address this as a potential risk, additional review of data presentations in the *Quarterly CLB Report to the RMRC* to double-check accuracy may be advisable. Based on review of the CLB system development to date and the oversight review of the RMRC, DBHDS continues to experience challenges to fully implementing the CLB system to achieve its desired purpose of informing the RMRC oversight of a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. DBHDS continues to evolve this look-behind process resulting in improvement in the scores for Outcome 1 in the most recent quarterly evaluation. The RMRC's analysis of data is in its infancy but is showing progress in the most recent quarter. There continue to be process improvements that are underway including full implementation of the PowerApps automation platform and the addition of an inter-rater reliability component. DBHDS's continued improvements with these additional elements as well as its further development of more in-depth data analysis should positively contribute to the full implementation of the CLB process and the provision of accurate and valid data to the RMRC for their review, analysis, and remediation/process improvement recommendations. Based on consideration of each of these factors, there is insufficient evidence to demonstrate that the requirements of this CI are being met at this time.	
29.18 At least 86% of the sample of serious	The Commonwealth has met the 86% threshold for all four of the outcome	Details regarding the implementation of the review processes required at CIs 29.16 and 29.17 are described in the previous two sections of this report.	23rd - Not Met **24th - Not Met**

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.	requirements related to the RMRC conducting or overseeing a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up processes (CI 29.16) for two consecutive quarters. The Commonwealth has met the 86% threshold for only one of three outcome requirements related to the RMRC conducting a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation (CI 29.17) and the Commonwealth met this for the first time in Q2 SFY 24. The other two outcomes have not yet achieved the 86% threshold. The Commonwealth has not yet met the requirements of CI 29.18 as it requires meeting or exceeding the 86% threshold for all of the outcomes required by both CIs 29.16 and 29.17.	<u>Regarding the requirements that relate to CI 29.16:</u> In review of evidence presented in the *Incident Management Look-Behind RMRC Monthly Meeting 2023 Quarter 3 Data Report,* the *Q3 2023 VCU Report,* and similar reports submitted by VCU to the RMRC over the previous four quarters, the following comparative data table summarizes the VCU look-behind results over five quarters of completed evaluations. Percentage scores below the 86% threshold are in red in the table: **Data for CI 29.16** **Quarter:** / **Q2 CY2022** / **Q3 CY2022** / **Q1 CY2023** / **Q2 CY2023** / **Q3 CY2023** 4/22-6/22 / 7/22-9/22 / 1/23-3/23 / 4/23-6/23 / 7/23-9/23 **Rpt Date:** / 2/26/23 / 5/22/23 / 8/29/23 / 1/15/24 / 2/26/24 **RMRC Review:** / 5/22/23 / 5/22/23 / 9/11/23 / 1/22/24 / 2/26/24 **Outcome 1:** / 59% / 78% / 100% / 100% / 100% **Outcome 2:** / 86% / 77% / 90% / 93% / 100% **Outcome 3:** / 73% / 72% / 82% / 91% / 96% **Outcome 4:** / Not Assessed / Not Assessed / Not Assessed / 86% / 100% **Rater Reliability:** / Not Assessed / Not Assessed / 93.0% / 98.0% / 99.5% **NOTES:** There was no review completed for Q4 CY22 Rater Reliability Threshold: 88.0% There has been consistent improvement in the data for CI 29.16 Outcomes 1-3 over the most recent four quarters in which VCU conducted look-behind reviews. Data for Outcome 4, measured only over the two most recent quarters, showed a dramatic improvement from Q2 to Q3 with both quarterly scores achieving or exceeding the 86% threshold. Rater reliability, which has a threshold score of 88.0% set by VCU, has remained consistently high in measurements over each of the three most recent quarters. Specific to the four outcome requirements, the Commonwealth has met the requirements for Outcomes 1, 2, 3, and 4 at or above the 86% threshold for two consecutive quarters.	

<u>Regarding the requirements that relate to CI 29.17:</u>

In review of evidence related to the Community Look-Behind (CLB) required at CI 29.17, DBHDS has fully implemented the revised process to conduct these reviews, but the automation component of the process is not yet operational, and the data analysis functions at the OHR level and at the RMRC level remain in their infancy. To date, the OHR has provided data to the RMRC for four quarters for review, evaluation, and recommendation of needed follow-up actions. The table below summarizes results for these four quarters specific to the three required outcomes in CI 29.17 and the three additional outcomes that DBHDS has added to the process to further its evaluation of functions. Percentage scores below the 86% threshold are in red in the table:

Data for CI 29.17				
	Q3 SFY23 Results Jan-Mar	Q4 SFY23 Results Apr-Jun	Q1 SFY24 Results Jul-Sep	Q2 SFY24 Results Oct-Dec
Report Date:	8/28/23	8/28/23	12/18/23	2/26/24
RMRC Review:	8/28/23	8/28/23	12/19/23	2/26/24
Sample Size:	75	75	75	75
Outcome 1:	83%	81%	81%	88%
Outcome 2:	64%	60%	65%	59%
Outcome 3:	89%	87%	75%	80%
The following three outcomes are not specifically required by this Compliance Indicator but were added to the CLB review process to provide additional data to the OHR and RMRC regarding consistency of process implementation and identification of process improvement initiatives.				
Outcome 4:	87%	93%	97%	95%
Outcome 5:	71%	76%	84%	84%
Outcome 6:	48%	35%	53%	56%

Assuring that comprehensive, non-partial investigations are completed within specified timeframes (Outcome 1) showed improvement in the most recent quarter and exceeded the 86% threshold for the first time. Assuring that trained investigators are conducting investigations (Outcome 2) showed regression and continues to remain

		below the 86% threshold. Implementation of timely appropriate corrective action plans (Outcome 3) showed improvement from Q1 to Q2 but continues to remain below the 86% targeted threshold. Based on review and analysis of these results, the Commonwealth is not meeting the three outcomes specific to the RMRC conducting or overseeing a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation required by CI 29.17. CI 29.18 requires that the Commonwealth meet or exceed the 86% threshold for all of the outcomes required by CIs 29.16 and 29.17. Based on evidence reviewed for this study, the Commonwealth is not meeting the requirements of CI 29.18 at or above the 86% threshold.	
29.20 At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam.	This CI was not met because DBHDS data indicated that the Commonwealth did not yet achieve 86% for annual physical exams for people supported in residential settings or 86% for annual dental exams for individuals who have coverage for dental services. For this 24th Period, the *Developmental Disabilities Annual Report and Evaluation, State Fiscal Year 2023, Published Date February 27, 2024* reported slow yet steady progress for physical exams during 2023 and the previous two fiscal years. DBHDS provided another document entitled *Annual Physicals*	At the time of the 23rd Period review, this CI was not met because DBHDS data indicated that the Commonwealth did not achieve 86% for annual physical exams for people supported in residential settings or 86% for annual dental exams for individuals who have coverage for dental services. ` For this 24th Period, this remained true. However, as described further below, for annual physical exams, DBHDS reported data at or just below the threshold during three recent quarters. However, data for annual dental exams continued to be well below the threshold. **Annual Physical Exam Data**: At the time of the 23rd Period review, despite not achieving the required 86% threshold, DBHDS reported steady incremental growth for completion of annual physical exams. For this 24th Period, the *Developmental Disabilities Annual Report and Evaluation, State Fiscal Year 2023, Published Date February 27, 2024* again reported slow yet steady progress for physical exams during 2023 and the previous two fiscal years. DBHDS noted that, when looking at the third quarter of each of the past three years, year over year, there was a consistent increase in the number of individuals receiving annual exams. For SFY23, there was a 2% increase overall from Q1 at 74% to Q4 at 76%. Based on review of the report, there were a variety of reasons why the 86% target was not achieved. The reasons cited included difficulty locating a primary care physician, accessibility of the medical office, anxiety and fear of medical encounters, transportation, and for some, a support person/advocate to accompany them during the process. DBHDS provided another document entitled *Annual Physicals 29.20 24th Review*, dated	23rd - Not Met **24th - Not Met**

	29.20 24th Review, dated 2/20/24, reporting data for three recent quarters, as follows: SFY23 Q4 at 86%, SFY24 Q1 at 85% and SFY24 Q2 at 85%. DBHDS also provided a document entitled *Annual Dental 29.20 24th Review*, dated 2/1/24. It reported annual dental exam data for three recent quarters, as follows: SFY23 Q4 at 63%, SFY24 Q1 at 63% and SFY24 Q2 at 64%. At the time of the 23rd Period review, DBHDS provided updated Process Documents (i.e., *Annual Dental Exams Ver 005* and *Annual Physical Exams Ver 005*), both dated 8/24/23, and a single Data Set Attestation, dated 8/4/23. Of note, the data collection methodology for annual exams was similarly modified in both Process Document to allow for an annual exam to occur within a 14 month period ahead of the ISP anniversary date,	2/20/24, reporting data for three recent quarters, as follows: SFY23 Q4 at 86%, SFY24 Q1 at 85% and SFY24 Q2 at 85%. Although these data do not cover a full annual period, they reflected what would appear to be a significantly improved trend over SFY 23 as a whole. However, it is important to note this apparent improvement is likely the result of changes to the data collection methodology. Based on review of the *Developmental Disabilities Annual Report and Evaluation, State Fiscal Year 2023,* during SFY23, DBHDS reported discovering a data calculation issue that they believed resulted in an undercounting of individuals who received annual physical exams. As a result, the PMI methodology was revised to add in time (i.e., from 12 months to 14 months) for administrative purposes to ensure documentation in the ISP. In other words, since an ISP must be completed no later than 12 months after the previous, this typically requires that the data collection and documentation begin in the months prior to the ISP anniversary. Therefore, a look-behind period to document the most recent annual physical must take that into account. Data reporting using the revised methodology began for FY23 Q4. The Process Document (i.e., *Annual Physical Exams Ver 005)* reflected these changes. **Annual Dental Exam Data:** For this 24th Period, DBHDS provided a document entitled *Annual Dental 29.20 24th Review*, dated 2/1/24. It reported data for this CI for three recent quarters, as follows: SFY23 Q4 at 63%, SFY24 Q1 at 63% and SFY24 Q2 at 64%. Of note, the data collection methodology for dental exams was similarly modified in the relevant Process Document (i.e., *Annual Dental Exams Ver 005*) to allow for the exam to occur within a 14 month period ahead of the ISP anniversary date, in order to ensure documentation in the ISP. Since the 23rd Period, DBHDS has continued to implement a number of systemic efforts to increase resources for annual physical and dental exams. For example, for annual physical exams, the *Annual Physicals 29.20 24th Review* referenced the Annual Health Care Visit Toolkit that could be found on the DBHDS website. It is intended to help caregivers gather and organize important information before the annual healthcare visit (e.g., a 4-page document intended to serve as a communication and advocacy tool to relay the unique needs of individuals with DD to healthcare professionals and others that can be used during the annual healthcare visit, a preventative screening tracker, etc.) and for actions needed post-visit. As an example of an initiative to improve performance for annual dental exams, a 2/14/24 report to Court noted that the Commonwealth identified one-time funds to purchase two additional dental vehicles and additional funds to increase the number of staff and	

	rather than the previous 12 month period, in order to ensure documentation in the ISP. For this 24th Period, the previously-reviewed documents remained current. DBHDS did not update the Data Set Attestation as recommended at the time of the 23rd Period to clearly reference the adequacy of mitigation strategies for ensuring that ISPs are completed by their effective date. DBHDS did not update the Data Set Attestation as recommended, and still needed to do so. In addition, the Scope section of both Process Documents also required clarification. They still indicated that the date of an annual exam, either physical or dental, must occur within the year proceeding the Annual ISP date (i.e. rather than within 14 months.)	community dentists supporting the dental program. This report indicated the Commonwealth believed this would allow for the provision of annual dental exams to more individuals in the target population and would lead to compliance with this portion of the CI. For example, the report noted that over the most recent 3 quarters (i.e., SFY23 Q4, SFY24 Q1 and SFY24 Q2), only three CSBs had met the 86% threshold. One of these (i.e. Eastern Shore CSB) met the threshold in the last two reporting quarters, and the report posited that this may be because the CSB hosts the OIHSN Mobile Dental Program on a quarterly basis. . With regard to data validity and reliability, at the time of the 23rd Period review, DBHDS provided updated Process Documents (i.e., *Annual Dental Exams Ver 005* and *Annual Physical Exams Ver 005*), both dated 8/24/23, and a single Data Set Attestation, dated 8/4/23. Of note, DBHDS had issued a *DQMP* document entitled *WaMS Recommendations: Data Source System Enhancement Progress*, with a completion date of 8/4/23. This document indicated that with regard to ensuring that ISPs are completed by their effective date, that DBHDS was still making changes to the quarterly ISP Compliance report format to include the number and percentage of ISPs not placed in the proper status before the effective date of the related ISP year and that this modification will be considered when issuing corrective action plan requests and providing technical assistance starting in FY24. At the time of the 23rd Period, the study noted the Data Set Attestation did not clearly reference the adequacy of mitigation strategies for ensuring that ISPs are completed by their effective date. For this 24th Period, the previously-reviewed documents remained current. DBHDS did not update the Data Set Attestation as recommended, but should do so. Going forward, in addition to ensuring the Attestation confirms the adequacy of the remediation strategy for ensuring that ISPs are completed by their effective date, DBHDS should review and clarify the Scope section of both Process Documents, which still appear to indicate that the date of an annual exam, either physical or dental, must occur within the year proceeding the Annual ISP date (i.e. rather than within 14 months.)	

29.21 At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	For this 24th Period review, DBHDS did not yet achieve compliance with CI 29. 21. During this review cycle, DBHDS reported that, overall, 64% of people with identified behavioral support needs (729/1145) received adequate services and 36% (416/1145) received inadequate or no services. At the time of the 23rd Period, the data for determining the Commonwealth's level of compliance was the percentage of behavioral plans reviewed using the BSPARI tool that achieve 34 of 40 points indicating that the plan meets 85% of the criteria for adequacy and appropriateness. However, for this 24th period, at the behest of the Independent Reviewer, DBHDS used a corrected calculation methodology, to be in line with the *Agreed-Upon Curative Action for Compliance Indicator 29.21*,	For this 24th Period review, DBHDS did not yet achieve compliance with CI 29. 21. During this review cycle, DBHDS reported that, overall, 64% of people with identified behavioral support needs (729/1145) received adequate services and 36% (416/1145) received inadequate or no services. At the time of the 23rd Period, the data reported for determining the Commonwealth's level of compliance was the percentage of behavioral plans reviewed using the BSPARI tool that achieved 34 of 40 points (i.e., indicating that the plan meets 85% of the criteria for adequacy and appropriateness). However, for this 24th period, at the behest of the Independent Reviewer, DBHDS used a corrected calculation methodology, to be in line with the *Agreed-Upon Curative Action for Compliance Indicator 29.21*, filed with the Court on 7/11/22. This revised methodology is designed to ensure that the measure's denominator accurately reflects the entire cohort of people with identified behavioral support needs. It requires DBHDS staff to perform a series of calculations, as described in a document entitled *Behavioral Supports Report: Q3/FY24 Addendum for CI 29.21*: • The first curative action measure for CI 29.21 includes the following: "Out of the individuals identified as needing Therapeutic Consultation (behavioral supports) in the ISP assessments, how many received the service." DBHDS reported that 1145 people needed this service from July-December 2023. Of the total, 923 received the service (81%). Of the total, 222 did not receive the service (19%). • The second curative action measure for CI 29.21 includes the following: "Out of the individuals who received Therapeutic Consultation behavioral services as part of the statistically significant sample, how many received services that were "adequate and appropriately delivered" as determined by the BSPARI." DBHDS reported completion of 126 BSPARI reviews during the most recent reporting period included in the FY24Q3 Behavioral Supports Report. There were 100 BSPARIs that scored at least 30 out of 40 points (79%). There were 26 BSPARIs that scored less than 30 points (21%). • DBHDS then generalized the BSPARI results to the 923 people that received the service, as follows: 729 (923 x .79) people would have received 30 points or above on the BSPARI, while 194 people (923 x .21) would not have received 30 points or above on the BSPARI. • To combine the generalized BSPARI results further with those that needed	23rd - Not Met **24th - Not Met**

	filed with the Court on 7/11/22. This revised methodology is designed to ensure that the measure denominator accurately reflects the entire cohort of people with identified behavioral support needs. It requires DBHDS staff to perform a series of calculations, as described in a document provided entitled *Behavioral Supports Report: Q3/FY24 Addendum for CI 29.21*. Due to the change in calculation methodology, the currently reported percentage cannot be compared to previously reported data for the purpose of determining trends. Going forward, because this methodology uses multiple data sets to complete a calculation unique for CI 29.21, DBHDS will need to develop a specific Process Document for reporting this metric, and obtain a Data Set Attestation for data validity and	services and did not receive them, this would translate to a total of 416 people (194 generalized + 222 actual) who received inadequate or no services. Therefore, of the 1145 people with identified behavioral support needs, 416 (36%) individuals received inadequate or no services, while the remaining 729 (64%) received adequate services. Due to the change in calculation methodology, the currently reported percentage cannot be compared to previously reported data for the purpose of determining trends. In addition, because this methodology uses multiple data sets to complete a calculation unique for CI 29.21, DBHDS will need to develop a specific Process Document for reporting this metric, and obtain a Data Set Attestation for data validity and reliability.	

	reliability.		
29.22 At least 95% of residential service recipients reside in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings.	The Commonwealth did not meet the requirements of this CI because it submitted a data report that indicated it had confirmed compliance for only 69% of the applicable settings. While this did not yet clearly address the percentage of recipients who resided in an HCBS Settings Rule, and DBHDS was currently simply extrapolating the number of settings to the number of individuals, the current Process Document did include a step for calculating the actual number/percentage of individuals living in compliant settings. This study previously reported that based on the methodology documented in *HCBS Settings (Version 002)*, updated 8/17/23 the measure was not a valid indicator of the total	For the 23rd Period review, the Commonwealth did not meet the requirements of this CI because it did not submit a data report to evidence compliance. For this 24th Period review, on 3/26/24, DBHDS provided a narrative summary for this CI that included the following data points: • The total number of settings to be reviewed is 3,286. Of those, 2,275 (69%) settings have been deemed compliant, based on a review by DBHDS, DMAS or as part of the QSR process. • There are 282 settings under remediation plans. • There are 10 settings that have been deemed non-compliant and letters of intent have been submitted. • There are 203 reviews that are in process, meaning they are actively assigned and being worked on by one of the three entities (i.e., DBHDS, DMAS or as part of the QSR process.) • There are 132 setting that have not yet been assigned and the process has not been initiated. At the time of the 23rd Period review, the Commonwealth's approved *Home and Community-Based Services Settings Regulations Corrective Action Plan* indicated the Commonwealth does not expect to complete validation of the QSR residential settings findings with regard to HCBS compliance until 6/30/25. The 23rd Period report noted that, for the purpose of achieving compliance within the SA timeline, the Commonwealth needed to re-evaluate this timeline and devote additional resources to the validation process. For this 24th Period, on 2/14/24, DBHDS reported to the Court that to support compliance with this CI, DBHDS identified one-time funding to hire additional staff on a short-term basis to expedite reviews of provider settings to ensure their compliance with the CMS Home and Community-based Services Settings Rule. Based on the narrative summary DBHDS provided on 3/26/24, DBHDS received permission to hire ten additional reviewers to help with these reviews. By 4/1/21, DBHDS had completed hiring for three new staff, with interviews continuing for the remaining reviewers. However, DBHDS did not provide a timeline revision and, as of 4/24/24, the CMS website continues to reflect the previous *Home and Community-Based Services Settings Regulations Corrective Action Plan* remains effective at this time.	23rd - Not Met **24th - Not Met**

	percentage of residential service recipients residing 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 Setting. It counted individuals who lived in settings for which the QSR vendor found noncompliance and issued a quality improvement plan, but without any evidence that the noncompliance had been successfully remediated. For this 24th Period, DBHDS provided a revised Process Document, dated 4/19/24. This version added a requirement for DBHDS staff to contact the provider to determine and validate implementation of any HCBS quality improvement plan prior to inclusion in the *HCBS Master Tracking Spreadsheet* as a compliant setting. While this broadly	The 23rd Period report also found that the Process Document entitled *HCBS Settings (Version 002),* updated 8/17/23, did not provide a valid measure of the total percentage of residential service recipients residing 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 Setting. It counted individuals who lived in settings for which the QSR vendor found noncompliance and issued a quality improvement plan, but without any evidence required to show that the noncompliance had been successfully remediated. For this 24th Period, DBHDS provided a revised *HCBS Settings* Process Document, updated 4/19/24. This version added a requirement for DBHDS staff to contact the provider to determine and validate implementation of any HCBS quality improvement plan prior to inclusion in the *HCBS Master Tracking Spreadsheet* as a compliant setting. While this broadly addressed the previous question concerning validity of the measure, it did not provide any specific detail with regard to the methodology and criteria DBHDS staff would apply to the determination and validation of the successful implementation of the quality improvement plan. In addition, this 24th Period study found other concerns with regard to the validity of the measure that DBHDS will need to resolve, examples of which are described in the paragraphs below. As this 24th study period was concluding, DBHDS made available the Round 6 PCR and PQR tools and, upon request, a list of the questions used to calculate this measure. Based on the Process Document, the Assistant Commissioner of Developmental Services will review the designated questions to determine if all questions are answered in the affirmative. Based on review of this list, and an initial comparison to the totality of questions in the two tools, many key HCBS requirements with regard to integration in and access to the greater community were not included in the list of questions used in the calculation, did not provide sufficient guidance for determining a Yes or No response, and/or were text field responses that did not provide a Yes or No response. For context, the federal regulation at *CMS-2249-F/CMS-2296-F* requires that the "setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and	

	addressed the previous question concerning validity of the measure, it did not provide any specific detail with regard to the methodology and criteria DBHDS staff would apply to the determination and validation of the successful implementation of the quality improvement plan. DBHDS also made available the Round 6 PCR and PQR tools and, upon request, a list of the questions used to calculate this measure. Based on the Process Document, the Assistant Commissioner of Developmental Services will review the designated questions to determine if all questions are answered in the affirmative. However, based on review of the list of HCBS-designated questions, and an initial comparison to the totality of questions in the two tools, many key HCBS requirements with regard to integration in and	work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS." Examples of concerns in the PCR tool included: • A Yes answer to Question 31 requires that the ISP and/or other individual record documentation demonstrates that annual education was provided about less restrictive community options to any individuals living outside their own home or family's home, and specifically a non-disability specific settings and an option for a private unit in a residential setting. This is a key HCBS requirement, but is not included in the PCR questions used to determine compliance. Similarly, Question 146 (i.e., Did you choose the people you live with?) is included in the HCBS-designated list, but Question 145 (i.e., Would you like to live somewhere else?) is not. • Question 170 (i.e., Do you want to attend a church/synagogue/mosque or other religious activity of your choice?) is included in the calculation list, but Questions 171 and 172 probe whether an individual who wants to attend a religious service or activity actually gets to engage in that activity and if not, why not. These latter questions go to the heart of the HCBS Settings Rule, which is the actual experience of the person in the setting. • Question 176 (i.e., Do you participate in your banking?) is the only designated question related to the key HCBS requirement for control of personal resources. The probes and guidance include the following: "Who helps you with your budget? Do you have a rep payee? Who manages your funds? Do you participate in paying bills? If you want to buy something, can you? Participating by being present for drive-through banking would be included. This element represents the individual's perception of whether or not he/she participates." It is unclear if the QSR reviewer is required to use all the probes or how the responses should be documented. In addition, the PCR tool does not provide clear criteria to apply to probe responses when making a Yes/No determination. • None of the PCR questions related to employment are included in the HCBS-designated list for calculating compliance.	

	access to the greater community were not included in the list of questions used in the calculation, did not provide sufficient guidance for determining a Yes or No response, and/or were text field responses that did not have a Yes or No response. Also for this 24th Period, DBHDS provided the *QSR Methodology* for Round 6. Based on review of this document, the PCR and PQR tools, and the Process Document, none of these provide a clear description of the QSR protocol for determining HCBS compliance that outlines the incorporates all of the validation processes in the approved Statewide Transition Plan (STP) and the requirements of the HCBS Settings Rule and related CMS guidance. As described with regard to CI 36.1 above, DBHDS must also ensure	DBHDS should also review the PQR tool to ensure guidance is sufficient. This tool includes only three questions designated for inclusion in the calculation for compliance. These include: • Question 31: Does the agency have policies and procedures that address HCBS rights? • Question 32: Are those policies and procedures reviewed with the individuals being served? • Question 52: Does provider documentation show that the setting has implemented annual HCBS specific training with all staff? The guidance for Question 31 and Question 52 do not provide sufficient criteria. For example, for Question 31, the guidance indicates only that the QSR reviewer should determine a Yes or No response based on provider evidence that it has policies and procedures that address HCBS rights. For Question 52, the guidance indicates only that the QSR reviewer should determine a Yes or No response based on whether provider documentation demonstrates that the list of attendees for the most recent annual HCBS-specific training held by the provider includes all employees listed on the staff roster submitted by the provider unless the staff has been hired within the last 180 days and have not completed full training to date. Neither provide criteria required for the QSR reviewer to evaluate if the policy, procedure and/or training are adequate. Also for this 24th Period, DBHDS provided the QSR Methodology for Round 6. Based on review of this document, the PCR and PQR tools, and the Process Document, none of these provide a clear description of the QSR protocol for determining HCBS compliance. DBHDS should develop a formal written protocol that outlines the process from start to finish. Of note, as discussed in interview with DBHDS staff, the protocol should also incorporate all of the validation processes in the approved Statewide Transition Plan (STP) and the requirements of the HCBS Settings Rule and related CMS guidance. In particular, DBHDS should ensure that the protocol documents how it takes the following into account: • Per CMS guidance, the validation of settings compliance must be setting-specific. This means that the finding of compliance for one provider setting cannot be used to attest to compliance for the provider's additional settings. • Per the Commonwealth's *Addendum to the Commonwealth of Virginia's Statewide Transition Plan February 2019*, for onsite reviews to validate remediation, a	

	that the Process Document and Data Set Attestation address potential threats to data reliability related to potential IRR deficiencies. The current revision of the Process Document described above does not include an examination of potential IRR concerns for the use if the QSR data set. As indicated above, the Round 6 PCR and PQR evidence opportunities for IRR deficiencies to occur. DBHDS did not provide a Data Set Attestation for this measure. As reported previously, going forward, DBHD will also need to ensure that Process Documents and Attestations are in place for this specific use of the data from WaMS, CONNECT and the HCBS Master Tracking Spreadsheet maintained by DMAS.	"minimum of 25% of individuals receiving services in a setting will be interviewed and no less than 2 individuals for smaller settings of 2 or more persons receiving services." As described with regard to CI 36.1 above, DBHDS must also ensure that the Process Document and Data Set Attestation address potential threats to data reliability related to potential IRR deficiencies. The current revision of the Process Document described above does not include an examination of potential IRR concerns for the use of the QSR data set. As indicated above, the Round 6 PCR and PQR tools evidence opportunities for IRR deficiencies to occur. DBHDS did not provide a Data Set Attestation for this measure. As reported previously, going forward, DBHD will also need to ensure that Process Documents and Attestations are in place for this specific use of the data from WaMS, CONNECT and the *HCBS Master Tracking Spreadsheet* maintained by DMAS.	
29.23 At least 95% of individual service recipients are free from neglect and abuse by paid support staff.	For the 24th Period review, DBHDS provided ANE data for the last two quarters of SFY23 and the first two quarters of	At the time of the 23rd Period review, DBHDS provided the following ANE data for the last two quarters of SFY23: Q3: 15,741-212/15,741=98.6% Q4: 15,826-225/15,826=98.5%	23rd - Met **24th - Met**

	SFY24. These showed DBHDS exceeded 98% for each quarter. Based on these data, DBHDS met the requirements of this CI. For this 24th Period review, DBHDS again submitted the previously-reviewed Process Document entitled *HR Process Document Free From ANE 29.23 VER005*, dated 10/12/23. This version had added clarifying language to Steps 4 and 5 regarding the process used to identify substantiated reports; added actions to Step 7 to correct against potential overcounting due to duplication across *DW-0033a* and *DW-0038a*; clarified exploitation is defined as a type of abuse and clarified the operational definition of the term "paid support staff." These modifications addressed the previously identified deficiencies. DBHDS also provided an updated Data Set	For the 24th Period, DBHDS provided the following ANE data for the first two quarters of SFY24: Q1: 15,998-234/15,444 =98.5% Q2: 16,228-211/16,228=98.6% Based on these data, DBHDS met the requirements of this CI. At the time of the 23rd Period review, DBHDS submitted a revised Process Document entitled *HR Process Document Free From ANE 29.23 VER005*, dated 10/12/23. This version added clarifying language to Steps 4 and 5 regarding the process used to identify substantiated reports; added actions to Step 7 to correct against potential overcounting due to duplication across *DW-0033a* and *DW-0038a*; clarified exploitation is defined as a type of abuse and clarified the operational definition of the term "paid support staff." These modifications addressed previously identified deficiencies. For this 24th period, this remained current. At the time of the 23rd Period review, DBHDS provided a Data Set Attestation for this Process Document, dated 8/30/23. The report found that the CDO should review the recent modifications to the methodology and re-attest to reliability and validity. For this 24th Period review, DBHDS provided an updated Data Set Attestation for this Process Document, dated 3/6/24. It documented a review of the above modifications and updated the attestation. While, overall, this met the requirements of the *Curative Action for Data Validity and Reliability*, going forward DBHDS will need to ensure that these current documents reflect the remedial strategies in place for the threats identified in the most recent CHRIS-HR source system update (i.e., as described with regard to CI 29.13.)	

	Attestation for this Process Document, dated 3/6/24 and included a review of the modifications described above. Overall, DBHDS met the requirements of the *Curative Action for Data Validity and Reliability* overall.		
29.24 At least 95% of individual service recipients are adequately protected from serious injuries in service settings.	For this 24th Period review, DBHDS had made significant revisions to the data collection methodology that used serious incident data from the CHRIS incident reporting system, and provided a revised Process Document entitled *Individuals Protected from Serious Injury*, dated 2/21/24. However, this new methodology did not produce valid data. To determine if individuals are protected from serious injury, serious incident reports are linked with Incident Management Unit (IMU) referrals for a licensing investigation to determine whether any licensing violations were found related to the incident,	At the time of the 23rd Period review, DBHDS reported that 88.7% of individual service recipients were adequately protected from serious injuries in service settings. This did not meet the requirement of this CI. Moreover, DBHDS still needed to ensure the measure methodology would produce valid and reliable data. Concerns identified at the time of the 23rd Period review included the following: • The adequacy of the processes DBHDS implements to protect individual service recipients from serious injuries in service settings could not be fully evaluated without some measure of the rate at which those individuals experience serious injuries. DBHDS did not provide evidence they considered whether the outcome for people served (i.e., the rate at which individuals experience serious injuries) was included in the overall definition of adequacy. • In addition to not addressing how DBHDS would factor in the actual percentage of serious injuries (i.e., the outcome for people served) to the determination of adequacy, the Process Document entitled *Individuals Protected from Injury Ver 002*, dated 8/24/23, and a related Data Set Attestation, dated 10/16/23, indicated the measure still largely relied on the SCQR process, Indicator 7, as the method for measuring this CI, which did not yet appear to yield reliable data. • It was not clear that DBHDS had sufficient data capabilities to allow for an adequate evaluation of serious injury data, based on a large number of documented ER visits and unplanned hospitalizations for which the cause was not defined. In interview, DBHDS staff acknowledged that this could include an unknown number of serious injuries. For this 24th Period review, DBHDS had made significant revisions to the data collection methodology and provided a revised Process Document entitled *Individuals Protected from Serious Injury*, dated 2/21/24. It noted that individuals may experience an	23rd - Not Met **24th - Not Met**

	and whether a corrective action plan (CAP) was issued. Only individuals for whom a licensing investigation of the serious injury found a licensing violation requiring a CAP are considered to have not been protected. The Process Document further indicated that the measure documentation would include reporting of the percentage of individuals who did not experience a serious injury, with a target of 95% or greater, as well as the percentage of individuals protected from injury, with the same target. This novel application of the IMU and Investigation processes potentially could, with some revisions, provide valid and reliable data. The current proposed methodology reflected a funneling effect that appeared to significantly limit the serious injuries that could possibly reach	injury despite appropriate identification of risks and implementation of an individual's service plan and further defined individuals considered to have *not* been protected from serious injury as those who experienced an injury that was related to a licensing violation. To determine if individuals are protected from serious injury, serious incident reports are linked with referrals for an investigation by licensing to determine whether any licensing violations were found related to the incident and whether a corrective action plan (CAP) was issued. Only individuals for whom a licensing investigation of the serious injury found a licensing violation requiring a CAP are considered to have not been protected. The Process Document described a series of steps using serious injury data reported by providers in the CHRIS-SIR portal: • Providers are required to submit reports of serious incidents within 24 hours of their discovery and that these include serious injuries as defined in *12VAC35-105-20* (i.e., an injury that results in bodily hurt, damage, harm, or loss that requires medical attention by a licensed practitioner.) • The serious injuries are reviewed by an incident management unit (IMU) specialist within one business day, who performs a triage of all level II and level III incidents. This includes a review of all incidents that meet care concern criteria. • Incidents that meet the Care Concern Thresholds criteria trigger the IMU referral and notification process in accordance with the *Incident Management Unit Care Concern Threshold Joint Protocol*. • Once the referral and notification process is triggered, IMU staff complete a desk review of the incident and may refer the incident for further review to the Licensing Specialist (LS)/Investigator if the review reveals concerns with the provider's management of the incident. • The LS Investigator is then responsible for reviewing the incident and making a determination if an investigation is warranted based on the licensing investigation protocol. Criteria for investigation include; incidents resulting in significant injuries/risks and/or a repeated pattern of similar serious incidents within 30 days for the same individual; the provider has a history of failing to address and resolve serious issues affecting care and treatment; a provider's internal investigation fails to identify and resolve issues of noncompliance; a decubitus ulcer; similar injuries to the same individual within 30 days. • If the LS Investigator determines an investigation is warranted, the incident	

	the investigation stage. Based on the Process Document, the IMU Care Concerns Threshold criteria would serve as the trigger for the initiation of the referral and notification process. These criteria would screen out many, if not most, serious injuries right at the beginning of the process. If IMU does make a referral, the Licensing Investigator applies another set of criteria to determine whether to undertake an investigation. These criteria include incidents resulting in significant injuries/risks and/or a repeated pattern of similar serious incidents within 30 days for the same individual; the provider has a history of failing to address and resolve serious issues affecting care and treatment; a provider's internal investigation fails to identify and resolve	will be tied to the CHRIS incident within the CONNECT system. • Investigations are initiated within three business days of the incident referral and are completed within 45 business days. If a violation is identified a citation is issued and the provider is responsible for developing a corrective action plan (CAP). CAPs that do not adequately address the violation are returned to the provider to address; investigations remain open until an acceptable plan of correction is received. The Process Document further indicated that the measure documentation would include reporting of the percentage of individuals who did not experience a serious injury, with a target of 95% or greater, as well as the percentage of individuals protected from injury, with the same target. The latter data point is captured in a report entitled *Individuals Protected from Injury* culled from CHRIS Data Warehouse and CHRIS / CONNECT. Overall, this appeared to be an approach to measuring this CI that could, with some revisions, provide valid and reliable data. Over the past several reporting Periods, this study has documented the thoroughness of the work products and protocols of the IMU, as those applied to serious incident and Care Concern review. However, this is a novel application of the IMU and Investigation processes and will require additional modifications in order to provide valid and reliable data. The paragraphs below describe in detail the concerns The most pressing concern is the very small percentage of serious injuries that DBHDS investigates. DBHDS staff provided two sets of data DBHDS staff for review, as detailed below. Overall, these data indicate a need to continue to evaluate this methodology before it can be considered to be a valid measure for this CI. • The first set of data included four quarterly *Individuals Protected from Injury* reports, covering the period between 4/1/23 through 3/31/24. Added together, these four reports showed 2,457 serious injuries, 2,118 unique individuals with serious injuries, 94 referrals from the IMU to the LS Investigator and 13 CAPs. The report did not provide data to show how many of the referrals the LS Investigator determined to require an investigation. • The second set of data provided by DBHDS staff covered the same period, but provided somewhat different numbers. This report indicated a total of	

	issues of noncompliance; a decubitus ulcer; similar injuries to the same individual within 30 days. In particular, the 30 day criteria would not be expansive enough to sufficiently capture repeated serious injuries as a reason to open an investigation. Using this process, DBHDS staff provided two sets of data for the period 4/1/23 through 3/31/24. While there were some variations between the two sets of data, the percentage of injuries IMU referred for investigation ranged from less than 4% to just over 11%. Of the approximately 2,400 serious injuries reported during this time frame, DBHDS investigated just over 4% of them. In interview, DBHDS staff also provided some background information about variations from the Process Document regarding the day-to-day	2,468 serious injuries occurred during this period and that this reflected 1,734 unique individuals. o The apparent discrepancy for unique individuals was likely due to some individuals having serious injuries in more than one quarter over the annual period. o This second report indicated referrals to the LS Investigator for 360 incidents impacting 275 individuals. This resulted in 104 investigations that involved 95 unique individuals. DBHDS staff reported that the reason for the discrepancy between the first and second data sets with regard to the number of referrals was a reporting error that mis-identified the number of investigations as the number of referrals, and that the second set of data they provided corrected for this. Of note, DBHDS staff reported that the small discrepancy between the number of referrals in the first set of data and the number of investigations in the second was due to a reporting lag related to the different data run dates of the two sets. Depending on the set of data reviewed, it appears that the percentage of injuries referred for investigation ranges from less than 4% to just over 11%. Based on the second set of data, which provides the percentage of serious injuries actually investigated, this figure was 4%. The biggest concern is to understand why such a small percentage of serious injuries are referred for investigation, since only that number could therefore result in a CAP. As described below, the proposed methodology reflected a funneling effect that appeared to significantly limit the serious injuries that could possibly reach the investigation stage. This began with the IMU Care Concerns Threshold criteria as the trigger for the initiation of the referral and notification process. These criteria, as listed below, would screen out many, if not most, serious injuries right at the beginning: i. Multiple (Two or more) unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day time-frame for any reason. ii. Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional. iii. Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or	

	implementation of these processes, which could also potentially skew the reported data. In interview, DBHDS staff indicated an understanding of these concerns and the need to continue to consider them in order to produce valid and reliable data. They indicated they planned to consider having DBHDS nursing staff review a sample of the cases referred for investigation to determine if they agreed that appropriate services were in place to protect individuals from injury when no citations/corrective actions were implemented. This would be an appropriate step for validating the investigation outcomes. However, it would not fully address the facts that IMU refers only a small percentage of serious injuries for investigation and that the licensing investigator completed investigations for only a	CPR. iv. Multiple (Two or more) unplanned psychiatric admissions within a ninety (90) day time-frame for any reason. If the IMU does make a referral, based on the data provided above, the LS Investigator often does not find an investigation is needed after applying the criteria (i.e., incidents resulting in significant injuries/risks and/or a repeated pattern of similar serious incidents within 30 days for the same individual; the provider has a history of failing to address and resolve serious issues affecting care and treatment; a provider's internal investigation fails to identify and resolve issues of noncompliance; a decubitus ulcer; similar injuries to the same individual within 30 days). In particular, the 30 day criteria would not be expansive enough to sufficiently capture repeated serious injuries as a reason to open an investigation. The available data indicated that there was at least some concern about repeated injuries, since 1,734 people had 2,468 serious injuries during the year. However, based on the criteria for investigation, hypothetically someone could have four serious injuries in a year without meeting the investigation criteria. Of note, in interview, DBHDS staff provided some background information about the day-to-day implementation of these processes. For example, for those serious injuries that did meet the Care Concerns Threshold, IMU staff indicated that as they completed the desk reviews, they tried to resolve as many as possible to reduce the number of investigations needed, and that this might at times result in referrals for technical assistance (e.g., to OIH). If they are able to resolve concerns they found, they do not refer for an investigation. This would not be reflected in the data. In addition, DBHDS staff indicated that the LS Investigator might take some actions, such as contacting the provider for additional information, leading to a determination that it was not necessary to open a full formal investigation. This would also not be reflected in the data. DBHDS staff also provided a walk-through of the CHRIS-SIR system for reporting serious incidents. This demonstration indicated that CHRIS-SIR has functionality that addresses the previously noted concern about ER visits and unplanned hospitalizations, in that it forces reporting of the cause for those, incidents including whether an injury occurred. In addition, CHRIS-SIR contains the full history of reported incidents for the individual by type, which would allow for IMU and LS Investigation staff to easily review beyond the 30-day criteria for repeated injuries.	

	small percentage of those referrals. For the 24th Period, DBHDS reported that, for each of the past six quarters (i.e., SFY23 Q1 through SFY24 Q2), over 99% of individuals were adequately protected from serious injury. In interview, DBHDS acknowledged that this percentage would be better reported as an annualized rate and provided that updated figure as part of the second set of data described above. That report indicated that the investigation resulted in 18 individuals with CAPs. DBHDS indicated that per WaMS data, 16,454 individuals were served during this annual period and that this resulted in 99.89% of individuals protected from serious injury. However, as described in detail above, this was based on a methodology with significant flaws that continued to screen out most serious injuries and	In interview, DBHDS staff indicated an understanding of these concerns and the need to continue to consider them in order to produce valid and reliable data. They indicated they planned to consider having DBHDS nursing staff review a sample of the cases referred for investigation to determine if they agreed that appropriate services were in place to protect individuals from injury when no citations/corrective actions were implemented. This would be an appropriate step for validating the investigation outcomes. However, it would not fully address the facts that IMU refers only a small percentage of serious injuries for investigation and that the licensing investigator completed investigations for only a small percentage of those referrals. To meet the requirements of this CI, DBHDS will need to revise the proposed processes to address these concerns. This should include the Care Concerns criteria for referral, as well as the investigatory criteria, including but not limited to, the 30-day look behind for repeated injuries; a more thorough methodology for identification and tracking of individuals with repeated injuries (i.e. since there were 734 more serious injuries than there were individuals who sustained them); and re-visiting whether a formal CAP sufficiently captures the various actions IMU and investigator staff take that are remedial in nature. For the 24th Period, DBHDS reported that, for each of the past six quarters (i.e., SFY23 Q1 through SFY24 Q2), over 99% of individuals were adequately protected from serious injury. However, in interview, DBHDS acknowledged that this percentage would be better reported as an annualized rate and provided that updated figure as part of the second set of data described above. That report indicated that the investigation resulted in 18 individuals with CAPs. DBHDS indicated that per WaMS data, 16,454 individuals were served during this annual period and that this resulted in 99.89% of individuals protected from serious injury. However, as described in detail above, this was based on a methodology with significant flaws that continued to screen out most serious injuries and was not yet a valid measure.	

	was not yet a valid measure.		
29.25 For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans.	Overall, DBHDS fulfilled the requirements of this Indicator. The *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2023* reported performance at 99% of individual service recipients for whom seclusion or restraints were 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. In addition, DBHDS submitted data reports (i.e., *KPA Q1/Q2 FY24 Hierarchy Data Reports*) for the first and second quarters of SFY24, both of which also exceeded 99%. These data evidenced that DBHDS exceeded the requirements of this CI.	The *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2023* reported performance at 99% of individual service recipients for whom seclusion or restraints were 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. This exceeded the requirements of this CI. DBHDS also submitted data reports (i.e., *KPA Q1/Q2 FY24 Hierarchy Data Reports*) for the first and second quarters of SFY24, as follows: • Q1: 15988 – 3/ 15988 = 99.9% • Q2: 16234 – 3/ 16234 = 99.9% At the time of the 23rd Period review, DBHDS submitted a Process Document entitled *HR Process Document 29.25 VER005,* dated 6/20/23. This version updated the mitigation section to address threats of data validity and reliability, clarified the calculation of the numerator to include subtraction of total number unauthorized seclusion/restraint from total number of individuals on waiver, addressed the threat of potential overcounting, and added definitions for seclusion and restraint. These modifications addressed the previously identified deficiencies from the 22nd Period review. DBHDS also provided a Data Set Attestation for this Process Document, dated 9/1/23. These met the requirements of the Curative Action for Data Validity and Reliability overall and remained current for the 24th Period.	23rd - Met **24th - Met**

	For the 23rd Period review, DBHDS submitted a revised Process Document entitled *HR Process Document 29.25 VER005,* dated 6/20/23. This version updated the mitigation section to address threats of data validity and reliability, clarified the calculation of the numerator to include subtraction of total number unauthorized seclusion/restraint from total number of individuals on waiver, addressed the threat of potential overcounting, and added definitions for seclusion and restraint. These modifications addressed the previously identified deficiencies. DBHDS also provided a Data Set Attestation for this Process Document, dated 9/1/23. These documents remained current for the 24th Period and met the requirements of the *Curative Action for Data Validity and Reliability* overall.		

V.C.1 Analysis of 23rd Review Period Findings

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

Compliance Indicator	Facts	Analysis	Conclusion
30.4: 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	The DBHDS annual licensing inspection continues to include an assessment of whether the provider's risk management program complies with relevant requirements in the Licensing Regulations at *§520.A-D* and the additional requirements in this Compliance Indicator that providers use data at the individual and provider level to identify and address trends and patterns of harm and risk of harm in the events reported as well as the associated findings and recommendations. DBHDS continues to review and revise the *OL Annual Compliance Determination Chart* to refine instructions for	The *OL Annual Compliance Determination Chart*, updated each year prior to the initiation of the annual licensing inspection reviews, contains specific instructions to the Licensing Specialist to assess whether the providers are using data at the individual and provide 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. Since the conclusion of the 2023 annual licensing inspection cycle, the OL has again expanded and refined its guidance and training to assist providers to understand what their responsibilities are and to assist Licensing Specialists to assess provider compliance consistently and accurately. These process changes, made at the beginning of each new licensing inspection cycle to address the specific areas of concern from the sample analyses, continue to have a positive impact on the percentage improvements noted here. The *OL Annual Compliance Determination Chart-2024* contains more detailed and specific guidance for providers and Licensing Specialists related to these requirements and, based on the 40-provider sample reviewed in this study, are continuing to result in increasingly consistent inspection processes and findings specific to this CI. The revised instruction for Licensing Specialists for §520.C requires that provider documentation relevant to this regulatory requirement "must address a review of serious incidents including consideration of harms and risks identified and lessons learned from the provider's quarterly reviews of all serious incidents conducted pursuant to 12VAC35-105-160.C, including an analysis of trends, from incidents and investigations, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. Documentation that the provider is tracking data is necessary to evaluate trends and patterns over time. After a year of tracking data, the provider should use this baseline data to assess the effectiveness of their Risk Management System."	23rd - Not Met **24th - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations.	Licensing Specialists to increase the consistency of their assessment of compliance with these and other licensing requirements. The Consultant reviewed the Process Document and Attestation Statement relevant to this CI in the 23rd study and determined it to be complete and accurate. There have been no changes made to these documents since that review. Data from licensing inspections conducted between 01/01/2023-12/31/2023 reflect that OL assessed 96.8% of providers on all nine requirements under *§520.a-d.* A full complement of data for the CY2024 licensing inspection cycle will not be available until later in the fall. The Consultant conducted a sample review of documentation	In addition, the Office of Licensing developed and has implemented the *160 & 520 Rubric for OL Staff dated January 2024)* to guide the Licensing Specialist to accurately assess compliance with regulatory requirements at 12VAC35-105-520.C.1-5 and 520.D, each of which has specific relationship to the requirements of this Compliance Indicator. The content of this rubric is clear, detailed, and provides extensive guidance to the Licensing Specialist to assess compliance consistently and accurately. For the 23rd period study, DBHDS supplied a *Process Document: (30.4, 30.5, 30.7 DOJ Process RM Requirements VER005)* and *Attestation Statement: (30.4, 30.5, 30.7 RM Requirements Attachment B – 8.30.2023)* that defined the data that it used to inform calculation of the threshold percentage requirement in this CI and the processes used to collect and report this data. That review determined that the methodology accurately described the numerator and denominator for this measure. There have been no changes to these documents for the 24th period study. In CY2022, OL assessed 94.2% of licensed providers for regulatory compliance with risk management requirements in the Licensing Regulations (12VAC35-105-520) during their annual inspections. This percentage, reported in the data report *RM Compliance Total CY2023* increased to 96.8% in CY2023. While these percentages exceed the 86% threshold required by this CI, the consultant's previous reviews of the regulatory findings for a sample of 50 licensed providers in the 22nd study and 25 licensed providers in the 23rd study did not reflect agreement that the Licensing Specialist correctly assessed compliance with licensing requirements relevant to this CI. A comparable percentage from the 2024 licensing inspection cycle will not be complete until later in 2024; however a sample of 40 licensed providers was drawn from the 295 inspections that had been completed between 01/01-03/10/2024 to evaluate whether the agreement percentage improvement noted from the 23rd review was continuing. The agreement level in the 22nd review was only 15%. This level increased to 52% in the 23rd study and increased again in this 24th study to 82%. The percentage increases have continued to demonstrate effective process changes by the OL to improve consistent assessment of whether providers are meeting the licensing requirements specific to CI 30.4. A full and complete assessment cannot be made from the small number of providers that had licensing inspections completed in time for this sample study; however, the improvements to	

Compliance Indicator	Facts	Analysis	Conclusion
	from 40 licensing inspections conducted between 01/01-03/10/2024 and comparing the Licensing Specialist findings regarding compliance with the requirements at *§520.a-d* with those of the Consultant, the agreement percentage increased from 52% in the 23rd study to 82% in this 24th study; however, because only approximately 25% of providers had been inspected at the time the sample was drawn, it is insufficient to generalize to the full cohort of licensed providers.	date indicate that the percentage agreement may increase to an acceptable level by the conclusion of the 2024 annual licensing inspection cycle with these findings assessed during the 25th review. Based on assessment of the evidence summarized above, there continues to be insufficient evidence to demonstrate that the Commonwealth has met the requirements of this CI.	
30.10: To enable them to adequately address harms and risks of harm, the Commonwealth requires that provider risk management systems shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable	Previous studies have confirmed that DBHDS has regulations in place that require provider risk management systems to report incidents of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia,	As has been confirmed in previous studies, DBHDS has regulations and associated processes that require providers to report serious incidents which include "incidents of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., aspiration pneumonia, bowel obstructions, UTIs, choking incidents, etc.)" and that providers take prompt action when such events occur, or the risk is otherwise identified. The care concerns processes also address reporting and heightened monitoring of individual incidents of these common risks and conditions. If OL finds that a provider did not report an incident involving one or more of these types of common risks and conditions, OL will issue a CAP for non-compliance. DBHDS has continued to expand and refine its training and training tools for providers and Licensing Specialists focusing on the specific requirements for risk	23rd - Not Met **24th - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	bowel obstruction, UTIs, decubitus ulcers) and that providers take prompt action when such events occur, or the risk is otherwise identified. The care concerns process also addresses reporting and heightened monitoring of individual incidents of these common risks and conditions. The findings from this study continue to confirm that these regulations and processes are in place and operational and include a triage and review system for serious incidents conducted by the Incident Management Unit (IMU). If a provider is found not to have reported an incident involving one or more of these types of common risks and conditions that may contribute to avoidable deaths, a CAP is required for non-compliance. DBHDS continues to provide information and training to providers and	assessments including individual, monthly, quarterly, and annual reviews/assessments of risks. Those trainings and training tools highlight the necessity of provider focus on common risks and conditions faced by people with IDD that contribute to avoidable deaths. While not mandated for use, DBHDS has developed an Excel-based risk tracking tool template and has provided instruction on its use via a pre-recorded YouTube video, made available to providers in May 2023, that includes instructions on how the tool can be used effectively to record and track risk areas, including those risks associated with common risks and conditions faced by people with IDD that contribute to avoidable deaths. Use of the tool produces monthly, quarterly, and annual reporting and trend graphs that inform the provider's mandatory quarterly serious incident reviews and annual systemic risk assessment. It also provides monthly data frequencies sufficient to calculate "incidence" rates for each of these common risks and conditions. DBHDS issued an *Expectations of Provider Risk Management Programs* provider memo and further reinforced its content in the *2024 DD Inspections Kickoff Training* . This training was provided in November/December 2023 with over 40 Licensing Specialist attendees and in January 2024 with approximately 1100 provider attendees. DBHDS also developed and implemented the *160 & 520 Rubric for OL Staff dated January 2024*) to guide the Licensing Specialist to accurately assess compliance with regulatory requirements at 12VAC35-105-520.C.1-5 and 520.**D.** This CI requires that provider risk management systems identify the "incidence" of common risks and conditions faced by people with IDD that contribute to avoidable deaths and take prompt action when such events occur, or if the provider identifies the risk in another manner. Applicable licensing regulations at *12VAC35-105-520* require that the provider's risk management plans contain a description of how they identify the incidence of these common risks and conditions, a description of how they use data to assess and evaluate the incidence of these common risks and conditions, and the requirement for implementation of corrective action to address issues related to these common risks and conditions. Despite providing the example Excel-based tracking tool template as a method to meet this requirement and providing training for providers and Licensing Specialists regarding these requirements to include calculation of incidence rates over time, within the sample of 40 providers from a total of 295 annual inspections completed	

Compliance Indicator	Facts	Analysis	Conclusion
	Licensing Specialists regarding these licensing regulations and processes, has developed the *160 & 520 Rubric for OL Staff dated January 2024*) to guide the Licensing Specialist to accurately assess compliance with regulatory requirements at *12VAC35-105-520.C.1-5* and *520.D*, and continues to encourage providers to utilize the Excel-based tracking tool template to assist them in meeting these licensing requirements and to provide a framework for tracking and aggregating incident data in a manner that can be used to identify the incidence rates of common risks and conditions faced by people with IDD that contribute to avoidable deaths and disseminated the tools to all providers. A review of documentary evidence from 40 sample providers who had an annual licensing	between 01/01-03/10/2024, Licensing Specialists determined that only 58% of the providers in the sample met the applicable requirements. The Consultant reviewed documentary evidence from the same 40 sample providers and found that only 25% provided sufficient evidence that they were meeting these requirements. The variance between these percentages continues to raise concern regarding providers understanding of what they must do to meet these licensing requirements and Licensing Specialists accurate determination of whether the provider's evidence is sufficient to demonstrate they are meeting these requirements. Of note, Licensing Specialists found that each of the providers in the sample that were utilizing the DBHDS developed Excel-based tracking tool template were complying with the applicable regulations and the Consultant agreed with each of these determinations. Based on the findings of this sample review, there is insufficient evidence that provider risk management systems consistently identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths and take prompt action when such events occur, or the provider identified the risk in another manner. There is also insufficient evidence that Licensing Specialists are accurately and consistently identifying when a provider is not meeting these licensing requirements.	

Compliance Indicator	Facts	Analysis	Conclusion
	inspection between 01/01/2024-03/10/2024 did not demonstrate that the sample providers were currently using data at the individual and provider level, including data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. The sample review also identified that Licensing Specialists are not accurately and consistently identifying when a provider is not meeting these licensing requirements.		

V.C.4 Analysis of 23rd Review Period Findings

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

Compliance Indicator	Facts	Analysis	Conclusion
32.4: 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.	DBHDS has continued to consistently implement the processes that address the requirements of this CI with no changes made since the conclusion of the 23rd review. Based on review of data for 61 provider organizations that had annual licensing inspections conducted between 01/01-03/10/2024, 308 citations were issued specific to the requirements in this CI. CAP reports were issued for each of these citations and providers submitted CAPs for 84 of these to date. OL has approved each of the CAPs submitted to date.	DBHDS has continued the processes that were evaluated and determined to be meeting the requirements of this CI during the 23rd study. There have been no process changes made since the previous review was concluded. DBHDS provided a data report that detailed information about 61 provider organizations that were determined 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 (12VAC35-105-160.E). Within those 61 provider organizations, there were 308 individual citations issued and of those 308 citations, CAPs had been received and approved by DBHDS for 84 (28%) by the time the data report was run. This percentage of approved CAPs is understandable given that it is still early in the CY2024 annual inspection cycle. Within the sample of 40 provider licensing inspections that were completed between 01/01-03/10/2024, nine received citations specific to these indicators. Six of those nine had submitted CAPs and each was approved. The information from this sample review was correlated with the information in the CONNECT data report and the data report accurately reflected information for all of these sample providers. Based on this review of the processes associated with this CI, DBHDS continues to consistently assess compliance with requirements about training and expertise for staff responsible for the risk management function (as outlined in V.C.1, Indicator #1.a), providers that have been determined to be non-compliant with requirements about conducting root cause analyses (12VAC35-105-160.E), and by doing so continues to fulfill each of the requirements of this CI.	23rd - Met **24th - Met**
32.7: DBHDS will use data and information from risk management	RMRC used data and information from risk management activities,	For the past two review periods, the study found that the RMRC met monthly and reviewed relevant data, information and related processes associated with risk management. This continued to be true for this 24th Period. As previously reported,	23rd - Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	including mortality reviews to identify topics for future content. The *Risk Management Program Description, FY24*, for the period from 7/1/23 through 6/30/24, states that, as part of the RMRC's task calendar, the RMRC reviews risks that have been identified as potential concerns and discusses the need to develop additional educational content to address these concerns. Based on review of the *Risk Management Program Description, FY24*, the RMRC procedures include review of surveillance data, PMIs, case reviews, care concerns or other information that is brought to the committee to either implement improvement activities and/or develop or revise informational content that is disseminated to providers.	the *Risk Management Program Description, FY24*, for the period from 7/1/23 through 6/30/24, states that, as part of the RMRC's task calendar, the RMRC reviews risks that have been identified as potential concerns and discusses the need to develop additional educational content to address these concerns. In addition, for the past two review periods, the RMRC reviews included serious incident data, as required by CI 29.13. As also reported at the time of the 23rd Period review, based on review of the *Risk Management Program Description, FY*24, the RMRC procedures include review of surveillance data, PMIs, case reviews, or other information that is brought to the committee to either implement improvement activities and/or develop or revise informational content that is disseminated to providers. The document, which remained in effect for the 24th Period, states that if the RMRC determines that new or additional educational or informational material is needed, members make recommendations for the type of information that may be needed. If similar information is already available, members discuss and reach consensus as to whether additional content is needed. If the determination is made to pursue additional content, the committee makes a request to the appropriate Office (i.e., whose subject matter expertise most closely aligns with the topic area). If new content development or content revision is undertaken, the designated Office is expected to report back to the RMRC at least quarterly on progress. As also reported at the time of the 23rd Period, with regard to the third criterion (i.e., identify providers that are in need of additional technical assistance or other corrective action), the *Risk Management Program Description FY24* stated that the RMRC uses data and information to identify providers in need of additional technical assistance or other corrective action. As detailed in the 23rd Period report, the current *Risk Management Program Description, FY24,* indicated DBHDS used risk management data and information for this purpose in multiple ways. In brief, these included information presented to the RMRC, as well as from day-day activities occurring within program units; ongoing data reporting to identify providers in need of assistance as part of an improvement activity; forming a workgroup to conduct further analysis with regard to specific measures not meeting target and targeting intervention on specific providers who are contributing to the performance issue; care concern data and information on specific providers transmitted by the IMU to	

Compliance Indicator	Facts	Analysis	Conclusion
	The *Risk Management Program Description, FY*24 also provided a description and examples of how DBHDS used risk management data and information to identify providers that are in need of additional technical assistance or other corrective action. For this 24th Period review, DBHDS provided RMRC meeting minutes that again demonstrated the implementation of these processes. Specifically, for this 24th Period, in addition to the presentation on 9/11/23 of the flow chart/methodology for review, RMRC meeting minutes, dated 10/23/23 and 12/19/23 reflected related agenda items, discussions, presentations and action items. In addition, as described in previous reviews, DBHDS continued to post substantial guidance	OIH; OL findings of deficiencies related to health and safety and corrective action follow-up; Office of Human Rights (OHR) review of allegations of abuse and neglect, monitoring the provider's investigation, and offering technical assistance as necessary. This description of the process continued to be sufficient and appropriate for the criteria for this CI. In addition, for the 24th Period review, to further document the process it takes to identify providers that are in need of additional technical assistance or other corrective action, DBHDS developed a flow chart summarizing key components of the methodology. On 9/11/23, the RMRC reviewed and approved the flow chart. It identifies the following components: • The RMRC reviews the following reports to determine if they indicate a need of additional technical assistance or other corrective action: o The quarterly IMU report of the number of care concerns by criteria as well as the IMU Look-behind report. o Quarterly OIH report: Number of care concerns by primary and secondary risk; type of support offered and provided. o OL report, including a biannual report of the number of Health & Safety CAPs issued and results of subsequent steps in the process and a quarterly report of the percent of providers that comply with RM regulations. o The quarterly OHR Report with regard to the verification that CAPs have been implemented within 90 days of start date, as well as the OHR Look-behind report. The latter includes TA and system-wide improvement opportunities. • In addition, the process includes review of data from the Mortality Review Office reviews, for which participants include representatives from OIH, OL and OHR. This can include any additional inquiries that may be made regarding concerns and/or actions in the 90 days prior to date of death. For this 24th Period review, DBHDS provided RMRC meeting minutes that again demonstrated the implementation of these processes. Specifically, for this 24th Period, in addition to the presentation on 9/11/23 of the flow chart/methodology for review, RMRC meeting minutes, dated 10/23/23 and 12/19/23 reflected related agenda items, discussions, presentations and action items. In addition, as	

Compliance Indicator	Facts	Analysis	Conclusion
	for providers and others on its website related to risk management (e.g., the OIH and OL webpages). At the time of the 23rd Period, DBHDS had at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. As described with regard to CI 36.1 and 38.1, this remained true for the 24th Period.	described in previous reviews, DBHDS continued to post substantial guidance for providers and others on its website related to risk management (e.g., the OIH and OL webpages). As reported at the time of the 23rd Period, overall, for this 24th Period DBHDS had again at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*, as further documented below for CI 36.1 and for CI 38.1 with regard to data quality for the source systems.	

V.D.1 Analysis of 23rd Review Period Findings

Section V.D.1: The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers; 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.

Compliance Indicator	Facts	Analysis	Conclusion
35.1: The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers.	For this 24th Period review, this CI continued to be Not Met. While the Quality Review Team (QRT) met during the period to review quarterly data, it did not develop and/or monitor specific needed remediation plans for performance measures that fell below the 86% threshold, as required in the Quality Improvement Systems (QIS) outlined in Appendix H for each of the HCBS Waivers. Otherwise, there have been no changes or revisions to the QIP since the last review period. DBHDS and DMAS also continued to sufficiently address data validity and	For this 24th Period, there have been no changes or revisions to the waiver QIPs since the last review period. However it is noteworthy that, for the upcoming renewal on July 1, 2024 that Community Living Waiver Renewal Application has been put out for public comment by the Department of Medical Assistance Services (DMAS). The public comment period began on 2/1/2024 and ended on 3/2/2024. At the time of the 23rd Period review, DBHDS and DMAS had sufficiently addressed previously identified data validity and reliability deficiencies, as evidenced by findings for CI 361. This continued to be evidenced for this 24th Period. The 23rd Period review found that this CI was not met because the Quality Review Team (QRT) had not met during that period to review quarterly data or to develop and/or develop and monitor needed remediation. This requirement is outlined in the Quality Improvement Systems (QIS) outlined in Appendix H for each of the HCBS Waivers, which makes the following statement: "Following the end of each quarter, the QRT reviews data related to the waiver assurances. Representatives from various DBHDS and DMAS divisions and departments work collaboratively on the QRT to provide data, discuss barriers to compliance, and present remediation strategies to correct areas of deficiency." For this 24th Period, the QRT held two quarterly meetings to review and discuss data, but, as described more fully with regard to CI 35.5 below, the Commonwealth often did not develop and/or monitor specific needed remediation plans for performance measures that fell below the 86% threshold, as required. Therefore, the	23rd - Not Met **24th - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	reliability.	requirements of this CI were not yet fully met.	
35.3 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 abuse/neglect/exploitation (prevention is contained in corrective action plans).	Overall, for the 24th Period, the Commonwealth met the requirements of this CI. The Commonwealth has established performance measures as required and approved by CMS for each of the areas defined in CI 35.3, sub-indicators a. through f. During this review period, the QRT met twice, on 11/9/23 and on 2/21/24 to review the performance measure data. During the first meeting, the QRT caught up on reviewing the first three quarters of data from SFY23. During the second meeting, the QRT meeting reviewed data from the fourth quarter of SFY23. At the time 23rd Period, with regard to data quality for the source systems, overall, DBHDS	At the time of the 23rd Period review, this CI was Not Met because the DMAS and DBHDS did not meet to review quarterly performance measure data. At that time, DBHDS reported that the QRT had undergone a transfer of ownership from DBHDS to DMAS and therefore no QRT meetings had occurred during this period of transition. The documentation further indicated the QRT planned to catch up on reviewing three quarters of data at a meeting scheduled for November 2023. For this 24th Period, as described in the bullets below, the Commonwealth met the criteria for this CI: • The Commonwealth has established Performance Measures as required and approved by CMS for each of the areas defined in CI 35.3 (i.e., sub-indicators a. through f.) • As described in more detail with regard to CI 35.5 below, the QRT met twice, on 11/9/23 and on 2/21/24, to review performance measure data. During the first meeting, the QRT caught up on reviewing the first three quarters of data from SFY23. During the second meeting, the QRT meeting reviewed data from the fourth quarter of SFY23. While it remained a quality management concern that the data review lagged many months behind, the Commonwealth met the requirement of this CI to review data quarterly. • At the time 23rd Period, with regard to data quality for the source systems, overall, DBHDS had at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. DBHDS provided a Process Document and applicable Data Set Attestation for each measures that relied on data collected by either DBHDS or DMAS. This continued to be true for the 24th Period, as DBHDS reported there have been no changes or revisions to the established performance measures in terms of the processes and attestations of validity and reliability. The only significant related change was that DMAS will not be utilizing the QRT PowerApp to access the quarterly data reports from DBHDS. Rather, going forward, the DBHDS Subject Matter Experts (SMEs) will upload data to a DMAS SharePoint website where it can be retrieved by DMAS staff for review. DBHDS provided an	23rd - Not Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion
	had at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. DBHDS provided a Process Document and applicable Data Set Attestation for each measures that relied on data collected by either DBHDS or DMAS. This continued to be true for the 24th Period, as DBHDS reported there have been no changes or revisions to the established performance measures in terms of the processes and attestations of validity and reliability.	updated Process Document entitled *QRT DMAS_QRT_VER_004* and indicated it did not change any of the processes for collecting the data, but only for how the data is posted for DMAS review.	
35.5: 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	This CI was not met because DBHDS did not provide evidence that QRT members developed and/or monitored remediation plans as required. For this 24th Period, DBHDS reported that the QRT met twice, on 11/9/23 and on 2/21/24	At the time of the 23rd Period review, DBHDS did not provide evidence of QRT meetings which the members reviewed quarterly data, or developed and/or monitored remediation plans. Documentation indicated that the QRT had undergone a transfer of ownership from DBHDS to DMAS and therefore no QRT meetings had occurred during this period of transition. The documentation further indicated the QRT planned to catch up on reviewing three quarters of data at a meeting scheduled for November 2023. For this 24th Period, DBHDS reported that the QRT met twice, on 11/9/23 and on 2/21/24 to review quarterly data. This met the requirement for the QRT to review data on a quarterly basis. • On 11/9/23, the QRT reviewed data for the first three quarters of SFY23,	23rd - Not Met **24th - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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	to review quarterly data. For both meetings, DBHDS provided for review a PowerPoint presentation entitled *DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration*. These evidenced that the QRT members reviewed data reports for performance measures that fell below the 86% threshold. However, based on the available documentation, the QRT members discussed some specific remedial actions for some measures, but not for others. Even when members did discuss specific actions, these were not in the form of written remediation plans and did not reference the measures the QRT would use to monitor the implementation of the plans. On 3/1/24, DBHDS also provided the *SFY23 EOY*	as evidenced by a PowerPoint presentation entitled *DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration SFY 23 Quarters 1-3*. The presentation indicated the objectives for the meeting were to present data for the DD HCBS Waiver, collaborate to address barriers, develop solutions and increase remediation efforts, optimize services for waiver participants, and prioritize & plan for improvement with monitoring the overall success of each stakeholder impacted by the DD HCBS Waiver. It focused on data reports for performance measures that fell below the 86% threshold and generally provided a brief synopsis of common findings that resulted in the lower scores. However, it did not provide information about the development or monitoring of specific needed remediation. • Similarly, for the meeting on 2/21/24, DBHDS provided for review a PowerPoint presentation entitled *DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration* for Q4 SFY23. It also presented data for measures that fell below the threshold, but did not include the common findings of deficiencies. It also did not provide any information about the development or monitoring of specific needed remediation. Overall, the QRT did not yet meet the remaining requirements for this CI. Upon request for minutes of the two meetings to reflect the QRT members' discussion, DBHDS provide a transcript of the video meeting held on 2/21/24, but not for the meeting on 11/9/23. Based on the available transcript, the QRT members discussed some specific remedial actions for some measures, but not for others. Even when members did discuss specific actions, these were not in the form of written remediation plans and did not reference the measures the QRT would use to monitor the implementation of the plans. Given that a number of the measures have fallen below the threshold for multiple quarters, and sometimes multiple years, the lack of written plans, and ongoing and specific reporting on the implementation of the plans at least every six months, rendered the intended monitoring ineffective for the purpose of revising remedial strategies that did not have the intended outcome. While it was positive that the QRT had returned to regular quarterly meetings, the next step should be to formalize the remediation planning and monitoring protocols. This is consistent with previous findings that there continued to be a need to develop improvement and remediation plans that evidenced a focus on systemic remediation,	

Compliance Indicator	Facts	Analysis	Conclusion
	Report. While the report generally noted when systemic remediation and improvement were needed, in most instances it did not provide a specific remedial or improvement strategy with defined measures to monitor performance. On a positive note, in interview, the DBHDS Assistant Commissioner was able to describe a current or proposed remediation plan, including some pending QIIs, for each of the measures that did not meet the threshold in the *SFY23 EOY Report*. However, the QRT had not reviewed these plans in writing, did not have measures to monitor performance of these plans and did not have evidence of any formal monitoring every six months.	both in QRT proceedings as well as in the *QRT End of Year (EOY) Reports*. Previously reviewed *EOY Reports* provided summaries for some measures that referenced possible systemic remediation, but these were often not sufficient. The report narrative often did not include the specific strategy to be employed or define measures that would be used to monitor performance. In addition, it was impractical to use data that old for any comparative purposes to current year activities. This continued to be true for this 24th Period review. On 3/1/24, DBHDS provided the *SFY23 EOY Report*. While the report generally noted when systemic remediation and improvement were needed, in most instances it did not provide a specific remedial or improvement strategy with defined measures to facilitate the monitoring of performance. On a positive note, in interview, the DBHDS Assistant Commissioner was able to describe a current or proposed remediation plan, including some pending QIIs, for each of the measures that did not meet the threshold in the *SFY23 EOY Report*. However, the QRT had not reviewed these plans in writing, did not have measures to monitor performance of these plans and did not have evidence of any formal monitoring every six months. Going forward, the QRT will need to work with DBHDS to obtain and review any such proposed remediation plans in writing and ensure that those plans focus on systemic factors, where present, and include the specific strategy to be employed and the defined measures that will be used to monitor performance. When the remediation plan is in the form of a QII, the QRT may find it useful to review and adopt those strategies and measures, since to QII Toolkit addresses those components in some detail. If, based on QRT assessment, proposed DBHDS remediation plans do not address the remedial needs or do not do so sufficiently, the QRT can either develop their own written plans and/or request appropriate modifications to the DBHDS plans.	
35.7: The DMAS-DBHDS Quality Review Team will provide an annual report	For the 24th Period, the Commonwealth did not meet the requirements of	Previous reports found that performance measure data for one SFY were not available to providers and CSBs until nearly the end of the following SFY, and then only in draft, with the final report coming sometime after the conclusion of the	23rd - Not Met **24th - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	this CI because DBHDS did not provide evidence to show a local level or Community Service Boards (CSB) review, at least annually, of the Waiver Performance Measures. DBHDS reported that issues with the Survey Monkey survey account led to the account and survey being deleted, and that DBHDS was therefore unable to send out a survey the SFY22 *EOY* report. As a result, they did not have information to report regarding CSB-specific QI activities for that timeframe. DBHDS reported it was working to recreate the survey in time to distribute to CSBs following the completion of the SFY23 *EOY* report. For the 23rd Period, DBHDS provided an *EOY Report*, revised as of 9/20/23 and covering the period 7/1/21 through 6/30/22 (i.e.,	following SFY. Reports with data that are 14 months old are not adequate or useful for CSB quality improvement committees to establish CSB-specific quality improvement activities and therefore were not sufficient to fulfill the requirements of this indicator. The SFY23 QRT charter added a requirement that, going forward, the QRT would produce the *EOY Report* for the public review within no more than six months of the end of the preceding fiscal year. For this 24th Period review, the final SFY24 QRT charter continued to include the requirement for the production of the *EOY Report* within no more than six months of the end of the preceding fiscal year. DBHDS reported that DMAS has taken over the lead responsibility for completing the annual *EOY Report*, consistent with the other changes in responsibility for QRT leadership. On 3/31/24, DBHDS made available the *SFY23 EOY Report*. This was within one year of the previous *SFY22 EOY Report*, which was issued on 9/20/23, and therefore met the annual requirement. However, DMAS did not provide the report within six months of the end of the preceding fiscal year, which conclude on 6/30/23 and the data continued to be too old to be useful for meaningful quality improvement. It was therefore positive that DBHDS provided a written plan (i.e., *V.D.1 Supplemental Updates 2/27/2024*) to remedy this concern. The plan indicated that the QRT has a tentative schedule which will allow for the completion of the *SFY24 EOY Report* by 11/1/24, and rightly noted that this would be the first time that the annual report has been completed in such a timely manner following the completion of a fiscal year. Of particular note, the plan would ensure that by April, 2024, the ongoing quarterly QRT data reviews will be for the most recently completed quarter. This improvement in data timeliness, combined with a formalized approach to remediation plans as discussed with regard to CI 35.5 above, would allow the QRT to address quality performance in a much more meaningful manner. The remaining requirements for CI 35.7 focus on local level and CSB reviews of EOY reports, at least annually. Previous reports described a process whereby DBHDS submitted the annual *EOY Report* to CSBs for review using a targeted *Survey Monkey* questionnaire. At the time of the 23rd Period review, DBHDS did not provide any evidence to show the CSB reviews occurred for the most recent *EOY Report* (i.e.	

Compliance Indicator	Facts	Analysis	Conclusion
	SFY22.) On 3/31/24, DBHDS made available the *SFY23 EOY Report.* This was within one year of the previous report and therefore met the annual requirement. However, the FY 2024 QRT charter included a requirement that, going forward, the QRT shall produce the *EOY Report* for the public review within no more than 6 months of end of the preceding fiscal year (i.e., by the end of the ensuing December.) While there was improvement in the timeliness of the report year-over-year, the QRT did not meet its own standard. As a result, the data continued to be inadequate for CSB quality improvement committees to establish meaningful and timely CSB-specific quality improvement activities.	the SFY22 version). For this 24th Period, DBHDS reported that issues with the Survey Monkey survey account led to the account and survey being deleted, and that DBHDS was therefore unable to send out a survey the *SFY22 EOY Report*. As a result, they did not have information to report regarding CSB-specific QI activities. DBHDS reported it was working to recreate the survey in time to distribute to CSBs following the completion of the *SFY23 EOY Report.* On 4/11/24, to solicit CSB feedback, DBHDS distributed the *SFY23 EOY Report* to those organizations by email, which also included a link to the survey. The email also stated the due date as 4/30/24. For this version of the report, it again seemed unlikely that the survey will be meaningful, given the staleness of the data upon which it is based. However, going forward with improved timeliness as described above, it should have potential to yield useful results.	

Compliance Indicator	Facts	Analysis	Conclusion
	It was therefore positive that DBHDS provided a written plan (i.e., *V.D.1 Supplemental Updates 2/27/2024*) to remedy this concern. The plan indicated that the QRT has a tentative schedule which will allow for the completion of the *SFY24 EOY Report* by 11/1/24, and rightly noted that this would be the first time that the annual report has been completed in such a timely manner following the completion of a fiscal year. Of particular note, the plan would ensure that by April, 2024, the quarterly QRT data reviews will be for the most recently completed quarter.		
35.8: 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.	For the 24th Period, the Commonwealth did not meet this CI because the most recently reported data, as found in the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2024 1st and 2nd Quarters*,	For the 23rd Period review, DBHDS provided the *Case Management Steering Committee Semi-Annual Reports State Fiscal Year 2023 3rd and 4th Quarters*, dated 9/8/23. The report indicated that, in FY22, performance dropped to 83%, below the target. For the 24th Period, the Commonwealth also did not meet this CI because the most recently reported data showed performance for SFY23 did not meet the 86% threshold. DBHDS submitted for review the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2024 1st and 2nd Quarters*, dated 3/1/24. The report indicated that, in FY23, performance dropped to 81%, a decrease of two percentage	23rd - Not Met **24th - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	dated 3/1/24, showed performance at only 81% for SFY23, which was a decrease of two percentage points from SFY22. As reported at the time of the 23rd Period, the above-referenced report again stated that joint efforts with DMAS occurred in FY23 to initiate services with individuals following the national public health emergency ends, but did not provide and specificity with regard to the nature of the efforts. For this 24th Period review, DBHDS reported in its 2/14/23 report to the Court that it would be transitioning to quarterly tracking of these data in Q3 SFY24 and that the data would be available once the 150-day post-period occurs each quarter and reported in the next semi-annual report. In addition, DBHDS staff reported in	points from SFY22. This version of the report again noted that joint efforts with DMAS occurred in FY23 to initiate services with individuals following the end of the national public health emergency, but did not provide any specificity with regard to the nature of the efforts. This study had previously recommended that, in order to identify potentially concerning performance trends and take remedial actions on a timelier basis, DBHDS, DMAS and the Case Management Steering Committee (CMSC) should consider completing quarterly tracking of this measure, similarly to the other waiver performance measures, particularly in light of the decreasing performance over time. For this 24th Period review, DBHDS reported in its 2/14/23 report to the Court that it would collect this data quarterly. Specifically, DBHDS stated that the data for this measure would transitioning to quarterly tracking in Q3 SFY24 and it would be available once the 150-day post-period occurs each quarter and reported in the next semi-annual report. The *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2024 1st and 2nd Quarters* also confirmed this plan. In addition, DBHDS staff reported in interview that the CMSC would review the data on a quarterly basis and recommend needed action, including, but not limited to, follow-up with individual participants who had not received services within the 150-day timeframe. At the time of the 23rd Period, DBHDS submitted an applicable Process Document, entitled *DD CMSC VER 016*, dated 8/29/23, and an applicable Data Set Attestation, dated 8/30/23. These met the requirements for the *Curative Action for Data Validity and Reliability*. For this 24th Period review, DBHDS reported these documents remained current.	

Compliance Indicator	Facts	Analysis	Conclusion
	interview that the CMSC would review the data on a quarterly basis and recommend needed action, including, but not limited to, follow-up with individual participants who had not received services within the 150-day timeframe. DBHDS submitted an applicable Process Document, entitled *DD CMSC VER 016*, dated 8/29/23, and an applicable Data Set Attestation, dated 8/30/23. These met the requirements for the *Curative Action for Data Validity and Reliability*. For this 24th Period review, DBHDS reported these documents remained current.		

V.D.2 Analysis of 23rd Review Period Findings

Section 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.**

Compliance Indicator	Facts	Analysis	Conclusion
36.1: 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,	A determination is deferred until the 25th Period because, since the 23rd Period, DBHDS had not yet completed the next annual *Data Quality Monitoring Plan (DQMP) Source System Assessment*, which required revision, or addressed the previous caveat regarding validity and reliability of QSR data. For this 24th Period, DBHDS had previously issued a *Data Quality Monitoring Plan Source System Report,* dated 9/28/23, and it remained the most current version available . This is the	Previous studies have documented the steps DBHDS has taken to address this CI. Overall, these documents described what appeared to be a sound process by which a designated office within DBHDS would complete an annual update for each of the data sources systems, and a process by which DBHDS would phase in broader re-assessments for each of the sources systems included in the original *Data Quality Monitoring Plan*. As an output of this process, staff from the designated office would identify up to twelve actionable recommendations for each system, that, if completed, would result in the greatest improvement to data validity and reliability. As described at the time of the 20th Period review, on 1/21/22 the Parties jointly filed with the Court an agreed-upon Curative Action regarding data reliability and validity that memorialized this process as a set of actions DBHDS would implement going forward. This Curative Action (i.e., *Curative Action for Data Validity and Reliability*) is also summarized in the Summary of this report above. It includes two elements: 1) internal periodic assessments of data source systems (i.e., the Source System Assessment), including the identification of threats to data validity and reliability and actions taken to mitigate those threats; and 2) a process for confirming the validity and reliability of specific data sets and their use in producing data for compliance reporting, including a Process Document and a Data Set Attestation. The Process Document must describe the data set to be used for the applicable indicator, a methodology for addressing any threats to validity and reliability	23rd - Met **24th - Deferred**

Compliance Indicator	Facts	Analysis	Conclusion
data origination, and data uniqueness.	annual update produced using the methodology described in the *Data Quality Monitoring Plan: Annual Update Process*, dated April 2021. At the time of the 23rd Period review, DBHDS had made significant strides in implementation of the requirements of Curative Action for Data Validity and Reliability and consistently provided more comprehensive Process Documents and Data Set Attestations that addressed identified threats to validity and reliability and the adequacy of mitigation strategies. Most of these documents remained current for this 24th Period review. This 24th Period study identified some potential breakdown in the quality and thoroughness of the source system assessment process, as evidenced by errors in the annual updates to the	of the data available in the data set, and a methodology for addressing any threats to validity and reliability in the process of pulling the data from the data set. Once this is complete, the office of the Chief Data Office (CDO) will complete a review and attests that the process will produce valid and reliable data. **Source System Assessment:** At the time of the 23rd Period, DBHDS issued the *Data Quality Monitoring Plan Source System Report,* dated 9/28/23, and this remains the most current version. This annual update was produced using the methodology described in the *Data Quality Monitoring Plan: Annual Update Process*, described above and it remains current for this 24th Period. In addition to a chart of source systems, it included, for 16 source systems, a narrative description of the improvements DBHDS indicated staff had made in the following categories: Data Validation Controls, Key Documentation, Manual Data Processing, User Interface, and Backend Structure. As previously reported, the source systems reviewed during the period include the following: 1. Avatar 2. Children in Nursing Facilities Spreadsheet 3. CHRIS- Serious Incident Report (SIR) 4. CHRIS-Human Rights (HR) 5. Community Consumer Submission 3 (CCS3) 6. CONNECT 7. Consolidated Employment Spreadsheet 8. Protection and Advocacy Incident Reporting System (PAIRS) 9. Quality Service Review (QSR) 10. Regional Educational Assessment Crisis Habilitation (REACH) 11. Support Coordination Quality Review (SCQR) 12. Waiver Management System (WaMS) Individual Support Plan (ISP) Proper 13. WaMS Customized Rate Module 14. WaMS Individual and Family Support Program (IFSP) Module 15. WaMS Regional Support Team (RST) Module 16. WaMS Waitlist Module This 23rd Period version of the *Data Quality Monitoring Plan Source System Report* also	

Compliance Indicator	Facts	Analysis	Conclusion
	assessments for CHRIS-SIR and CHRIS-HR. These serve as source systems for a number of PMIs and for reporting compliance with the CIs. These updated assessments failed to identify previously documented remedial strategies. In addition, the process evidenced the lack of an adequate review of the draft assessments by the SME/process owner. While it appeared these breakdowns might have been limited in nature, in interview, DBHDS staff indicated they would undertake additional monitoring of the process through the office of the Assistant Commissioner to ensure such breakdowns would not occur in the future or become more widespread. DBHDS should revise the overall DQMP process to formalize the specific monitoring steps.	summarized areas of improvement identified during the previous year. Of note, several systems continued to be slated for replacement, including AVATAR, CHRIS-SIR, CHRIS-HR, CCC-3 and PAIRS. The report also indicated DBHDS planned to replace these three systems with a unified Incident Management system, but had not yet released a Request for Proposals (RFP) for that system. The 24th Period review identified the following updates for this CI: • For this 24th Period, upon request, on 4/17/24, DBHDS staff responded with a document entitled *CI29.13-Data concerns Summary*, which included an RFP update related to the planned CHRIS replacement. It stated that DBHDS issued the RFP on 6/30/23 and it closed on 9/25/23. As of the date of the DBHDS response, the evaluation team has narrowed the proposals down to two vendors who have both presented demonstrations of their proposed solutions. The evaluation team is planning to follow-up with additional questions before making a selection. Once a candidate has been identified, contracts will need to be reviewed by the Office of the Attorney General (OAG) and the Virginia IT Agency (VITA) before a selection is finalized. DBHDS reported that a target date for the final contract approval is 2/24/25. • As described with regard to 29.13 above, this 24th Period study identified some potential breakdown in the quality and thoroughness of the source system assessment process, as evidenced by errors in the annual updates to the assessments for CHRIS-SIR and CHRIS-HR. These serve as source systems for a number of PMIs and for reporting compliance with the CIs. These updated assessments failed to identify previously documented remedial strategies. In addition, the process evidenced the lack of an adequate review of the draft assessments by the SME/process owner. While it appeared these breakdowns might have been limited in nature, in interview, DBHDS staff indicated they would undertake additional monitoring of the process through the office of the Assistant Commissioner to ensure such breakdowns would not occur in the future or become more widespread. DBHDS should revise the overall DQMP process to formalize the specific monitoring steps. • With regard to QSR data, at the time of the 23rd Period, DBHDS finalized the most recent version of the *External Data Validation Checklist* on 3/1/23. At that time, the study found the validation document did not fully address the previously identified concerns, but determined that, in its finished state, the	

Compliance Indicator	Facts	Analysis	Conclusion
	However, with regard to the QSR data source system, the 23rd Period study found some remaining concerns, concurrent with Round 5, that DBHDS still needed to address going forward. Chief among these was the failure of the assessment to address potential IRR deficiencies and their impact on data validity and reliability. Previous Reports to the Court have repeatedly identified these concerns and provided multiple examples of discrepancies between the data findings of the QSR reviewers and those of the Independent Reviewer's consultants. As a result, the 23rd Period study issued the following caveat to the finding that DBHDS minimally met the requirements for this CI; that is, that DBHDS needed to further examine the specific Process Documents and	document at least minimally met the requirements of the *Curative Action for Data Validity and Reliability*. However, the 23rd Period study found some remaining concerns that DBHDS needed to address going forward. Chief among these was the failure of the assessment to address potential IRR deficiencies (including multiple examples of discrepancies between the data findings of the QSR reviewers and those of the Independent Reviewer's consultants) repeatedly identified in previous Reports to the Court and their impact on data validity and reliability. For this 24th Period, DBHDS submitted an updated *External Data Validation Checklist* document entitled *OCQM Third Party Data Source System Validation Checklist with vendor and OCQM Scoring HSAG Final*, dated 3/6/24, and a *OCQM Third Party Data Source System Validation Checklist Scoring Sheet QSR 2024*, dated 3/5/24. For the most part, this review was based on the previous QSR Round 5 policies, procedures and methodologies. QSR Round 6 methodologies, including the *Round 6 IRR Policy*, only became available for review with few days remaining in this 24th Period review, so it was not possible to fully determine if this set of Round 5 source system documents will be fully applicable to QSR Round 6 results. However, based on an initial scan of those latter documents, Round 6 documents appear to largely replicate those from Round 5. However, in the documents listed as the basis for the validation scoring, DBHDS did reference a document that was completed after Round 5 and after the issuance of the 23d Period Report to the Court. This document, entitled *IRR Process Summary*, and dated 1/19/24, indicated that the QSR vendor approached building IRR through a combination of efforts, including 1) abstraction tool guides with clear scoring criteria and operational definitions, 2) training curriculum with knowledge and competency checks, 3) reliability reviews of live cases, 4) clinical re-reviews of cases, and 5) quality assurance reviews of all cases. This document did not appear to indicate any new processes and therefore did not address the failure of the previous assessment of this source system to address potential IRR deficiencies. **Data Set Validity and Reliability:** As described above, the second element of the *Curative Action for Data Validity and Reliability* entails confirming the validity and reliability of specific data sets and their use in producing data for compliance	

Compliance Indicator	Facts	Analysis	Conclusion
	Data Set Attestations for QSR data sets to ensure those documents adequately identified and addressed IRR threats. For this 24th Period, DBHDS did not report completing any further examination of Process Documents and Data Set Attestations that use QSR data sets for IRR threats to validity and reliability. In addition, for this 24th Period, DBHDS finalized a more recent version of the *External Data Validation Checklist* on 3/6/24. It again did not fully address the previously identified concerns with regard to IRR. For the most part, this review was based on the previous QSR Round 5 policies, procedures and methodologies. QSR Round 6 methodologies only became available for review with few days remaining in this 24th Period review, but based	reporting. At the time of the 23rd Period review, DBHDS had made significant strides in implementation of the requirements of *Curative Action for Data Validity and Reliability* and consistently provided more comprehensive Process Documents and Data Set Attestations that addressed identified threats to validity and reliability and the adequacy of mitigation strategies. Most of these documents remained current for this 24th Period review. However, similarly to, and in light of, the findings for the QSR source system assessment, the 23rd Period study indicated that DBHDS should further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats had been adequately identified and addressed. It appeared that DBHDS had at least minimally met this element for the 23rd Period, but only with that caveat. For this 24th Period, DBHDS did not report completing any further examination for IRR threats to validity and reliability in Process Documents and Data Set Attestations that use QSR data sets. Also of note, the *IRR Process Summary* indicated that, as described in the Round 5 QSR IRR Policy, the reliability reviews of live cases included three cases minimum per reviewer are reviewed, including one (1) PCR, one (1) PQR, and one (1) live video observation. However, the *QSR IRR Policy* DBHDS provided for Round 6, requires only two cases per reviewer and does not mention a live video observation. The materials did not state the rationale for this change, which had the effect of reducing the overall IRR effort. Overall, DBHDS failed to further address potential IRR deficiencies as needed given the discrepancies between the data findings of the QSR reviewers and those of the Independent Reviewer's consultants cited during the 23rd Period, as well as multiple examples of such discrepancies repeatedly identified in previous Reports. For this QRM study, the lack of action to review Process Documents and Attestations that rely on QSR data impacted the following CIs: HCBS residential compliance (i.e., CI 29.22), use of QSR data for analysis and quality improvement (CI 36.3), PMI data quality (CI 37.7), provider reporting measures (i.e., CI 43.1. 43.3 and CI 43.4), and provider quality improvement programs (i.e., CI 44.1 and CI 44.2). Therefore, the caveat for these eight measures remained. Until such time as DBHDS completes this examination of the pertinent Process Documents and Data Set Attestations, this study cannot confirm that DBHDS has fully met the	

Compliance Indicator	Facts	Analysis	Conclusion
	on an initial scan they appeared to largely replicate those from Round 5. DBHDS provided an additional document, entitled *IRR Process Summary,* dated 1/19/24, which was completed after Round 5 and the issuance of the 23d Period Report to the Court. It described the QSR vendor's approach to building IRR through a combination of efforts, but did not indicate any new processes and therefore did not address the failure of the previous assessment of this source system to address potential IRR deficiencies. In addition, while the *IRR Process Summary* indicated that the reliability reviews of live cases included three cases minimum per reviewer are reviewed, including one (1) PCR, one (1) PQR, and one (1) live video observation	requirements of those specific CIs and will defer determinations until the 25th Period. In addition, an overall determination for CI 36.1 is also deferred until the 25th Period because, since the 23rd Period, DBHDS had not addressed the previous caveat regarding validity and reliability of QSR data, but also had not yet completed the next annual *Data Quality Monitoring Plan (DQMP) Source System Assessment*, which required revision. If the Commonwealth meets the requirements of this CI during the 25th Period, it will have met this indicator in two consecutive reviews.	

Compliance Indicator	Facts	Analysis	Conclusion
	(i.e., the policy in place during Round 5 and at the time of the 23rd Period review.) However, the *Round 6 QSR IRR Policy* requires only two cases per reviewer and does not mention a live video observation. The materials did not state the rationale for this change which would reduce IRR efforts.		
36.3 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.	Overall, DBHDS had a process in place to review and analyze the NCI and QSR results for quality improvement. However, as described with regard to CI 36.1 above, during the 23rd Period, and now during the 24th Period, DBHDS has not yet adequately reviewed the IRR threats for QSR data sets and Round 6 QSR data will not be available for validation until the 25th Period. As a result, confirmation of continued compliance is deferred until that time. For the 24th Period	At the time of the 23rd Period review, DBHDS had a process in place to review and analyze the NCI and QSR results for quality improvement. This remained true for the 24th Period. The *QIC Review Schedule SFY22 - SFY24* indicated the QIC review NCI data would occur in the third quarter, while reviews of QSR data would take place on a quarterly basis. **NCI:** At the time of the 23rd Period review, DBHDS and VCU staff met monthly to discuss sampling procedures and other logistical concerns, but did not otherwise review specific data related to the quality of services and individual level outcomes to identify potential service gaps or issues with the accessibility of services. For this 24th Period review, DBHDS indicated no changes to these processes. For the 24th Period review, based on a review of QIC meeting minutes for three quarters (i.e., SFY24 Q1, Q2 and Q3), the QIC reviewed 2022-2023 NCI In-Person Survey (IPS) data and recommendations on 3/25/24, and assigned subcommittees to review recommendations and determine opportunities for quality improvement initiatives. The recommendations called for further exploration of the following: 1) the relationship between residential environment and outcomes, 2) community employment goals, 3) Continued understanding and mitigation of falls and 4) supporting friendships and social inclusion.	23rd - Met **24th - Deferred**

Compliance Indicator	Facts	Analysis	Conclusion
	review, based on a review of QIC meeting minutes for three quarters (i.e., SFY24 Q1, Q2 and Q3), the QIC reviewed 2022-2023 NCI In-Person Survey (IPS) data and recommendations on 3/25/24, and assigned subcommittees to review recommendations and determine opportunities for quality improvement initiatives. For this 24th Period, QIC meeting minutes for SFY24 Q1 and Q2 reflected ongoing discussion and activity about NCI data relating to mental health medications. For the 24th Period review, the QIC minutes cited above showed that the QIC reviewed and discussed QSR data for all four quarters, as indicated in the *QIC Review Schedule SFY22 - SFY24*.	As previously reported, during the SFY 23 Q4 QIC meeting, held on 6/26/23, the minutes reflected that RQC 2 and RQC5 both recommended that DBHDS create a focus group involving OIH, OHR, VCU and other interested parties to perform a deeper dive into the Virginia NCI data relating to mental health medications. For this 24th Period, QIC meeting minutes for SFY24 Q1 and Q2 included ongoing discussion in this area. **QSR:** For the 24th Period review, the QIC minutes cited above showed that the QIC reviewed and discussed QSR data for all four quarters, as indicated in the *QIC Review Schedule SFY22 - SFY24*. At the time of the SFY24 Q1 QIC meeting, the minutes indicated that the QIC directed the subcommittees to review the presentation and Round 5 aggregate report to identify opportunities for possible quality improvement activities or those the subcommittees had underway. At the time of the SFY24 Q2 QIC meeting, the minutes reflected that the CMSC, RMRC, KPA Workgroups and RQCs provided a summary of their feedback, including recommendations for improvement in the PCR and PQR tool criteria. At the time of the SFY24 Q3 QIC meeting, the minutes indicated that the QSR vendor reported on elements of the upcoming Round 6 QSR process, including data regarding the number of provider and person-centered reviews. As described above for CI 36.1 with regard to data quality for the source systems and the use of the pertinent data sets, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability* for NCI data. However, as also described with regard to CI 36.1 above, DBHDS has not yet adequately reviewed the IRR threats for QSR data sets and Round 6 QSR data will not be available for validation until the 25th Period. As a result, confirmation of continued compliance is deferred until that time.	

Compliance Indicator	Facts	Analysis	Conclusion
36.8: DBHDS collects and analyzes data (at minimum a statistically valid sample) at least annually regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS develops corrective action(s) based on its analysis, tracks the efficacy of that action, and revises as necessary to ensure that the action addresses the deficiency	The Commonwealth did not meet the requirements of CI 36.8 because they had not yet analyzed data for a statistically valid sample regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs on at least an annual basis. In addition, the described process did not include a clear methodology for using the analysis of the data to monitor the adequacy of management of the needs and supports provided, or to develop, track and revise as needed corrective actions based on the overall analysis For this 24th Period review, DBHDS reported the development of a new *Intense Management Needs Review Process*, dated 1/25/24, to assess and monitor the adequacy of supports provided to individuals with identified	At the time of the 23rd Period review, in late August 2023, DBHDS had made several potentially significant modifications to the previously proposed methodology. These modifications had 1) potential to impact the validity of the sample and 2) did not appear to fully address the corrective action requirements of the CI. Due to the timing of the DBHDS submission of those modifications, the Independent Reviewer did not have sufficient time for to investigate and verify the data quality. The 23rd Period Report found that DBHDS needed to implement a review to determine whether its new methodology was sufficient to achieve the requirements of CI 36.8. At that time, the study identified several outstanding concerns that required resolution, including the adequacy of processes to obtain a statistically significant sample, clear requirements for the development, tracking and revision of corrective actions, and the review methodology, particularly with regard to individuals with identified complex behavioral needs. For this 24th Period review, DBHDS reported it developed a new *Intense Management Needs Review Process* to assess and monitor the adequacy of supports provided to individuals with identified complex medical needs. During this 24th Period, DBHDS submitted this process to the Independent Reviewer for review and began coordination of this review process with his Nurse Consultants. Going forward, DBHDS indicated it planned to incorporate the learning and feedback into additional process improvements. The *Intense Management Needs Review Process* document, dated 1/25/24, focused on individuals with complex medical/health needs. It indicated the intent was to "ensure the documentation properly reflects the continuity of care across services is addressing the individual's medical management needs," and that it closely mirrored the Individual Services Review (ISR) study's process conducted by the Independent Reviewer. The process, to be completed by DBHDS Registered Nurse Care Consultants (RNCC,) required an on-site review of the selected sample, including an interview, an assessment of all relevant documentation and observation of health-related safety and accessibility aspects of the environment, adaptive equipment and technology, and the staff/family member's proper use of these supports. The on-site review process utilized a standard data entry tool and guidelines (i.e., *IMNR Questionnaire 24th Review Final* and the *IMNR Questionnaire*	23rd - Not Met **24th - Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	complex medical needs. It closely mirrored the Individual Services Review (ISR) study's process conducted by the Independent Reviewer and was to be completed by DBHDS Registered Nurse Care Consultants (RNCC). It required an on-site review, including observation and interview, and review of relevant documentation. It utilized a standard data entry tool and guidelines (i.e., *IMNR Questionnaire 24th Review Final* and the *IMNR Questionnaire Guidelines Draft*) For the initial implementation of this process during this 24th Period, DBHDS conducted 30 on-site reviews, in conjunction with the Independent Reviewer nurses. In addition, the *Intense Management Needs Review Report Twenty-Fourth Review Period*, dated April 2024, indicated that, DBHDS	*Guidelines Draft*) to capture all responses to each question. For the initial implementation of this process during the 24th Period, DBHDS conducted 30 on-site reviews, in conjunction with the Independent Reviewer nurses. On 4/18/24, DBHDS staff provided a report entitled *Intense Management Needs Review Report Twenty-Fourth Review Period*, dated April 2024. This report indicated that, in addition to the on-site reviews described in the *Intense Management Needs Review Process*, DBHDS nursing staff completed desk audits of another 30 individuals with complex adaptive support needs and/or behavioral health needs. The documentation utilized to conduct these reviews included all available information within the WaMS to include but not limited to the ISP, the Health Care Plan, and the authorization form (*CMS 485*) for nursing services. Supplemental documentation, such as medical consults and medication administration records as well as additional documentation, were not available for this review. During the review, DBHDS RNCCs completed the same paper questionnaire utilized in the *IMNR* process. Some questions on the questionnaire had to be omitted as it was difficult to respond to certain questions without being onsite. Therefore, it did not appear this desk audit process addressed complex adaptive support needs to the extent the *IMNR* process addressed complex health needs, and, what's more, only addressed the health needs of people with complex behavioral health needs. This CI requires at a minimum a statistically significant sample on an annual basis. For this 24th Period, the Independent Reviewer approved an exception for the subgroup of individuals with complex medical needs, allowing for review of 60 randomly selected individuals in an annual period (i.e., 30 each during two successive periods), as long as those reviews included on-site observations, review of the individual's medical records and contemporaneous notes (such as staff notes between shifts and MARs), interviews with primary caregivers, and verification of the facts (stated by those interviewed. DBHDS operationalized the definition of individuals with complex medical needs as those in the Supports Intensity Scale (SIS) level 6 (intense medical needs). DBHDS indicated the total number of individuals in this subgroup was 754. However, this exception did not apply to the other subgroups of individuals. DBHDS operationalized the definition of individuals with complex adaptive support	

Compliance Indicator	Facts	Analysis	Conclusion
	nursing staff also completed desk audits of another 30 individuals with complex adaptive support needs and/or behavioral health needs. This CI requires at a minimum a statistically significant sample on an annual basis. For this 24th Period, the Independent Reviewer approved an exception for the subgroup of individuals with complex medical needs, allowing for review of 60 randomly selected individuals in an annual period (i.e., 30 each during two successive periods). However, this exception did not apply to the other subgroups of individuals (i.e., individuals with complex adaptive and behavioral support needs). DBHDS did not provide the total number of individuals in these subgroups. Therefore, it was not possible to assess whether reviews of 60	needs as those in in SIS tier four, level five (Maximum Support Needs) and of individuals with complex behavioral support needs as those in SIS tier four, level seven (Intensive Behavioral Support Needs), but did not provide the total number of individuals in these subgroups. Therefore, it was not possible to assess whether reviews of 60 individuals across the two subgroups on an annual basis would constitute a statistically significant sample. However, it seemed unlikely. Going forward, DBHDS will need to further define the sampling procedure for obtaining an adequate sample size. Of note, the ability to meaningfully analyze aggregate results from this process for monitoring and systemic corrective action relies on having a statistically significant sample size that allows for generalization. This CI also requires that DBHDS use this process to monitor the adequacy of management and supports provided and to analyze the resulting data to develop corrective action(s), track the efficacy of that action, and revise those actions as necessary to ensure that they address the deficiency. At the time of the 23rd Period review, the follow-up methodology fell short of what is required for a corrective action: a corrective action includes action step(s) to be completed to achieve a verifiable outcome(s) by a specific date(s). For this 24th Period review, the *Intense Management Needs Review Process* required the development of Remediation Plans to define corrective actions that providers and support coordinators would need to take, based on triggers defined in the *Remediation Plan Guide*. Based on review of the latter document, these triggers and Remediation Plans address specific individual findings. It also provided for timeframes and follow-up to ensure loop closure. While this was a thorough process for individual concerns and a positive finding overall, the process did not yet provide a clear methodology for analyzing aggregate data from the reviews of individuals with complex medical needs, or those with complex adaptive or behavioral support needs, to monitor the overall adequacy of management and supports or to develop corrective actions pursuant to such data analysis. Based on review, the *Intense Management Needs Review Report Twenty-Fourth Review Period* included a presentation of some aggregate data from this initial review, (e.g., the	

Compliance Indicator	Facts	Analysis	Conclusion
	individuals across the two subgroups on an annual basis would constitute a statistically significant sample. The CI requires that DBHDS develop corrective action(s) based on its analysis, track the efficacy of that action, and revise as necessary to ensure that the action addresses the deficiency. For this 24th Period review, the *Intense Management Needs Review Process* required the development of Remediation Plans to define corrective actions that providers and support coordinators would need to take, based on triggers defined in the *Remediation Plan Guide*. Based on review of the latter document, these triggers and Remediation Plans address specific individual findings. It also provided for timeframes and follow-up to ensure loop closure.	numbers of individuals reviewed who had annual physical and annual dental exams), but at this point in this very new process, there was limited discussion about how these aggregate data would be used to develop systemic corrective action plans for the target population. Broadly, the report indicated that at the conclusion of the study period, the DBHDS RNCCs, Independent Nurse Consultants, Director of the Office of Integrated Health Supports Network and Independent Nurse Lead will be meeting to collaborate and discuss lessons learned from the reviews conducted during this study period, and that they would use the lessons learned to update the Skilled Nursing/Private Duty Nursing training for SFY25. Going forward, and as more data become available, DBHDS will need to further consider how to use this process as an effective tool for monitoring and meeting the needs of the target population in more specific systemic ways. As stated above, having a statistically significant sample size that allows for generalization will be critical to achieving this. For the 24th Period, DBHDS did not provide a relevant Process Document or a Data Set Attestation for this new process. Per interview with DBHDS staff, these remained pending based on the outcomes of the initial review.	

Compliance Indicator	Facts	Analysis	Conclusion
	The process did not yet provide a clear methodology for analyzing aggregate data from the reviews to monitor the overall adequacy of management of the needs of individuals with identified complex behavioral, health and adaptive support needs and the supports provided or to develop related systemic corrective actions pursuant to such data analysis. Of note, having a statistically significant sample size that allows for generalization will be critical to meaningful analysis and corrective action planning for the target population as a whole.		

V.D.3 Analysis of 23rd Review Period Findings

Section V.D.3: The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area:

- **a. Safety and freedom from harm(e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);**
- **b. Physical, mental, and behavioral health and wellbeing (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status);**
- **c. Avoiding crises(e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);**
- **d. Stability(e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);**
- **e. Choice and self-determination(e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);**
- **f. Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);**
- **g. Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and,**
- **h. Provider capacity (e.g., caseloads, training, staff turnover, provider competency)**

Compliance Indicator	Facts	Analysis	Conclusion
37.7: 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.	For this 24th Period, DBHDS had not yet adequately reviewed the IRR threats for QSR data sets and Round 6 QSR data will not be available for validation until the 25th Period. Therefore, this 24th Period study will defer a determination until that time. If the Commonwealth meets the requirements of this	V.D.2 indicator 5 (i.e., CI 36.5) requires that each KPA PMI describes key elements needed to ensure the data collection methodology produces valid and reliable data (e.g., definitions of key terms, data sources set targets, etc.). It also requires that each PMI describe a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation. As described at the time of the 23rd Period review, DBHDS had met these requirements for two consecutive periods and achieved compliance. As described with regard to CI 36.1 above, part of the *Curative Action for Data Validity and Reliability* previously re-defined responsibilities and methodologies for the assessment of data reliability and validity of the data sets for the PMIs. These require an adequately completed Process Document (i.e., which replaced the PMI Methodology) and a Data Set Attestation. The designated Subject Matter Expert (SME) completes relevant Process Document(s) while the CDO issues the Data Set	23rd - Met **24th - Deferred**

Compliance Indicator	Facts	Analysis	Conclusion
	CI during the 25th Period, it will have met this indicator in two consecutive reviews. At the time of the 23rd Period, this study found that DBHDS still needed to further examine Process Documents and Data Set Attestations using QSR data sets, as those related to IRR deficiencies identified in Independent Reviewer reports. For this 24th Period, DBHDS had not yet examined those Process Documents and Data Set Attestations. For the remaining requirements of this CI, and as described with regard to CI 29.1 and CI 36.1 above, the *Curative Action for Data Validity and Reliability* has defined responsibilities and methodologies for the assessment of data reliability and validity of the data sets for the PMIs described in V.D.2, indicators 1 and 5.	Attestation. V.D.2 indicator 1 (i.e., CI 36.1) requires that 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. It also requires that this evaluation occurs at least annually and includes a review of, at minimum, data validation processes, data origination, and data uniqueness. Further, it specifies that data sources will not be used for compliance reporting until they have been found to be valid and reliable. As described above for CI 36.1, for this 24th Period review, DBHDS continued to meet these requirements for most reporting purposes, with the exception of those using QSR data sets. At the time of the 23rd Period, this study found that DBHDS still needed to further examine Process Documents and Data Set Attestations using QSR data sets, as those related to IRR deficiencies identified in Independent Reviewer reports. For this 24th Period, DBHDS had not yet adequately reviewed the IRR threats for QSR data sets and Round 6 QSR data will not be available for validation until the 25th Period. Therefore, this 24th Period study will defer a determination until that time. If the Commonwealth meets the requirements of this CI during the 25th Period, it will have met this indicator in two consecutive reviews. Of note, as described with regard to CI 36.1, this 24th Period study also identified some potential breakdown in the quality and thoroughness of the process to assess data quality, as evidenced by errors in the annual updates to the assessments for CHRIS-SIR and CHRIS-OHR, which serve as source systems for a number of PMIs, as well as the failure to complete recommended reviews of Process Documents that rely on QSR data sets and the SIR Process Document (i.e., as described with regard to CI 29.13. In interview, DBHDS staff indicated they would undertake additional monitoring of the process through the office of the Assistant Commissioner to ensure such breakdowns would not occur in the future. DBHDS should revise the overall DQMP process to formalize the specific monitoring steps, including assigning responsibility for ensuring that SMEs complete all Process Document reviews and	

Compliance Indicator	Facts	Analysis	Conclusion
	V.D.2 indicator 1 (i.e., CI 36.1) requires an adequately completed Process Document (i.e., which replaced the PMI Methodology) and a Data Set Attestation. The designated Subject Matter Expert (SME) completes relevant Process Document(s) while the CDO issues the Data Set Attestation. V.D.2 indicator 5 (i.e., CI 36.5) requires that each KPA PMI describes key elements needed to ensure the data collection methodology produces valid and reliable data. As previously documented, DBHDS had achieved substantial compliance with these requirements.	updates in a timely manner.	

V.D.4 Analysis of 23rd Review Period Findings

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.

Compliance Indicator	Facts	Analysis	Conclusion
38.1: 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 individuals on the waivers, waitlist, and service authorizations. F. Case	For the 24th Period, DBHDS continued to collect data from each of these sources or, in some instances, their replacements (i.e., CONNECT). At the time of the 23rd Period review, DBHDS provided the *Data Quality Monitoring Plan Source System Report*, dated 9/28/23. DBHDS also completed a source system review or update (i.e., review of completion criteria for previous *Actionable Recommendations*) for 16 data sources. These remained current for the 24th Period review.	The single compliance indicator for this provision requires the Commonwealth to collect and analyze data from 13 source systems, at a minimum. Previous studies review examined the progress DBHDS had made in the areas of collecting and analyzing data from a set of prescribed sources. For this 24th Period review, DBHDS continued to collect data from each of these sources or, in some instances, their replacements (i.e., CONNECT). At the time of the 23rd Period review, as described further with regard to 36.1 above, DBHDS provided a *Data Quality Monitoring Plan Source System Report*, dated 9/28/23 and had completed a source system review or update (i.e., review of completion criteria for previous *Actionable Recommendations*) for the following data sources: 1. Avatar 2. Children in Nursing Facilities Spreadsheet 3. CHRIS- Serious Incident Report (SIR) 4. CHRIS-Human Rights (HR) 5. Community Consumer Submission 3 (CCS3) 6. CONNECT 7. Consolidated Employment Spreadsheet 8. Protection and Advocacy Incident Reporting System (PAIRS) 9. Quality Service Review (QSR) 10. Regional Educational Assessment Crisis Habilitation (REACH) 11. Support Coordination Quality Review (SCQR) 12. Waiver Management System (WaMS) Individual Support Plan (ISP) Proper 13. WaMS Customized Rate Module	23rd - Met **24th - Met**

Compliance Indicator	Facts	Analysis	Conclusion
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		14. WaMS Individual and Family Support Program (IFSP) Module 15. WaMS Regional Support Team (RST) Module 16. WaMS Waitlist Module For this 24th Period, these remained current.	

V.E.1 Analysis of 23rd Review Period Findings

Section V.E.1: The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program, including root cause analyses, that is sufficient to identify and address significant service issues and is consistent with the requirements of the DBHDS Licensing

Compliance Indicator	Facts	Analysis	Conclusion
42.3: 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.	DBHDS continues to fulfill the requirements of this CI. During CY2022, 93% of all providers were assessed on the requirements at 12VAC35-105-620. This percentage increased to 96% in CY2023. With regard to data reliability and validity, DBHDS revised the Process Document submitted for the 23rd review; however, none of the revisions were relevant to CI 42.3. The Data Set Attestation provided for the 23rd review did not require any updates. These documents continue to meet the requirements of the *Curative Action for Data Validity and Reliability*.	As reported in the 23rd period study, during the last half of CY22, the Office of Licensing (OL) assessed 95% of providers on all elements of the QI regulations at 12VAC35-105-620. Information in the *42.3 42.4 QI Compliance Total CY2023* and *42.3 42.4 Summary of Compliance* found that through all four quarters of CY2023, OL assessed 96% of providers (1077/1121) on all elements of the QI regulations at 12VAC35-105-620. This data for the four quarters of CY2023 demonstrate that the Commonwealth continues to meet the requirements of this CI. Beginning in CY2024, the RMRC will evaluate compliance for this CI on a calendar year basis to ensure that their assessment includes a full complement of comparable data for each calendar year. For this review, with regard to data reliability and validity, DBHDS provided a revised Process Document entitled *42.3 42.4 DOJ Process QI Requirements VER005*. This document included revisions as explained in the narrative for CI42.4 below; however, none of the revisions were relevant to the requirements of CI 42.3. The content of this document continues to meet the requirements of the Curative Action for Data Validity and Reliability.	23rd – Met **24th - Met**

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>42.4: 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.</td><td>For the 24th Period, based on self-reported data, the requirement of this CI that 86% of DBHDS licensed providers of DD services are compliant with each of the sub-regulations at 12VAC35-105-620 continues not to be met. In CY2022, 3/11 requirements met or exceeded the 86% threshold. In CY2023, this number increased to 4/11.

In response to a recommendation made in the 23rd review, DBHDS modified their process document for this CI to require that the denominator must always be of sufficient size to reach a 95% confidence level for all providers who had an annual unannounced inspection during the year. This</td><td>At the time of the 21st Period review, through a Curative Action the Parties filed with the Court on 4/2/22, the Commonwealth agreed to calculate the measure by determining whether 86% of the providers were compliant with each and every one of the 11 sub-regulations at 12VAC35-105-620.A-E and including an evaluation of whether the provider was implementing its QI plan.

Using data and information included in documents 42.3 42.4 Compliance by Reg 620 CY2022 and 42.3 42.4 QI Compliance Total CY2023, the table below provides a comparison of sub-regulation specific scores for CY2022 and CY2023. The consultant independently validated each of these percentages through review of the data reports referenced above.

<table>
<tr><th>Regulation</th><th>CY2022</th><th>CY2023</th></tr>
<tr><td>620A</td><td>93.73%</td><td>93.11%</td></tr>
<tr><td>620B</td><td>92.07%</td><td>89.28%</td></tr>
<tr><td>620C1</td><td>85.93%</td><td>84.77%</td></tr>
<tr><td>620C2</td><td>83.27%</td><td>81.69%</td></tr>
<tr><td>620C3</td><td>Not Measured*</td><td>Not Measured*</td></tr>
<tr><td>620C4</td><td>77.76%</td><td>74.50%</td></tr>
<tr><td>620C5</td><td>80.83%</td><td>79.85%</td></tr>
<tr><td>620D1</td><td>84.91%</td><td>83.38%</td></tr>
<tr><td>620D2</td><td>87.56%</td><td>87.76%</td></tr>
<tr><td>620D3</td><td>77.77%</td><td>76.50%</td></tr>
<tr><td>620E</td><td>82.94%</td><td>87.72%</td></tr>
</table>
*It was determined in CY2023 that, in relation to the requirements at 620.C.3, DBHDS had not sufficiently informed providers of their responsibility to include and report on statewide performance measures in their quality improvement plan. To ensure providers are fully aware of this licensing requirement, on 11/21/2023 DBHDS sent a provider memorandum entitled Expectations Regarding Provider Reporting Measures for Residential and Day Support Providers which provided a detailed explanation of</td><td>23rd - Not Met

24th - Not Met</td></tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion
	modification was incorporated into their data reporting and analysis reviewed for this 24th study. DBHDS provided evidence of consistently meeting the requirement that providers cited for violation of any sub-regulation of 12VAC35-105-620 develop and implement a Corrective Action Plan (CAP) to address the violation. Based on review of provider-specific data for CY2023, 473/478 (99%) of providers cited for a violation developed and implemented a CAP to address the cited violation.	these requirements and the provider's responsibilities to meet those requirements. The Office of Licensing also addressed these requirements in their *2024 DD Inspections Kickoff Training* for Licensing Specialists in December 2023 and for providers in January 2024. Beginning with licensing inspections conducted during the CY2024 cycle, OL is assessing providers' compliance with this licensing requirement in accordance with the information outlined in the Provider Memorandum. The full calendar year's data for each sub-regulation including 620.C.3 should be available for assessment during the 25th study period. Regarding the requirement that providers that are not compliant have implemented a Corrective Action Plan (CAP) to address the violation, the DBHDS report *42.4 620 CAP Status CY2023* includes a list of all providers OL cited for non-compliance with any element of 12VAC35-105-620. There were 478 providers who received a citation and OL required that 473 (99%) develop a CAP in response to the citation(s). The report also includes information that OL reviewed and approved that the provider implemented the CAP. Based on the data and explanations outlined above, the Commonwealth continues not to meet the requirements of this Compliance Indicator and the requirements set out in the Curative Action. The percentage of providers meeting 100% of the quality improvement regulations at 12VAC35-105-620 in CY2023 remained at 56% as it was in CY2022, significantly below the required 86% threshold. Additionally, only 4/10 sub-regulations exceeded the 86% threshold and OL did not assess the 11th sub-regulation (620.C.3) as explained above. The 23rd study report noted a recommendation that DBHDS modify the Process Document to require that the denominator must always be of sufficient size to reach a 95% confidence level for all providers who had an annual unannounced inspection during the year. The *42.3 42.4 DOJ Process QI Requirements VER005* process document provided for this study included additional language in the "Outputs/Measure of Success" describing how this requirement has been integrated into the data reporting/analysis to ensure the validity of reported results requiring that the denominator for measures #2 and	

Compliance Indicator	Facts	Analysis	Conclusion
		#3 must be of sufficient size to reach a confidence interval of 95% for all providers that had an annual unannounced inspection. DBHDS incorporated the data resulting from this additional requirement into the *42.4 Compliance by Regulation 620 CY23* report. This report reflects sub-regulation specific percentages ranging from 97.33% to 98.75%. Including this information in each subsequent data report will ensure sufficient reporting and tracking to verify that the data is sufficiently representative of the universe of providers that received an unannounced inspection.	

V.E.2 Analysis of 23rd Review Period Findings

Section 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.

Compliance Indicator	Facts	Analysis	Conclusion
43.1 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	DBHDS fulfilled most of the requirements of this Indicator. However, for this 24th Period, DBHDS did not submit an update to this Process Document and Data Set Attestation, as needed. In addition, since the 23rd period, DBHDS had not yet implemented the next Round of the QSR and has not yet obtained a new QSR data set for validation purposes. Therefore, the 24th Period rating is deferred. On 11/9/21, the Parties agreed upon a Curative Action, and filed it with the Court. The Curative Action required DBHDS	On 11/9/21, the Parties filed with the Court an agreed-upon Curative Action for this CI. In addition to the ongoing provider reporting of 12 surveillance measures representing risks that are prevalent in individuals with developmental disabilities (e.g., aspiration, bowel obstruction, sepsis, etc.), which are collected through the incident management system and tracked by the RMRC, this Curative Action required DBHDS to develop and track provider reporting measures that assess both positive and negative aspects of health and safety and of community integration through the QSR process. These latter measures utilize data from three PQR questions to evaluate the following provider reporting measure: 86% of providers demonstrate a commitment to community inclusion by demonstrating actions that lead to participation in community integration activities. This measure was intended to define the demonstration of commitment to community inclusion based on the extent to which providers demonstrate the following: a. N: The number of providers who promote meaningful work/ D: Number of providers reviewed b. N: The number of providers who promote individual participation in non-large group activities/D: Number of providers reviewed c. N: The number of providers who encourage participation in community outings with people other than those with whom they live/D: Number of providers reviewed	23rd - Met **24th - Deferred**

Compliance Indicator	Facts	Analysis	Conclusion
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.	to gather information from the Quality Services Review (QSR) process during Round 3, utilizing specific questions on the Person-Centered Review (PCR) Tool to be identified as provider reporting measures. DBHDS determined that instead of using questions from the PCR, it would use data from three PQR questions to evaluate the following provider reporting measure for promotion of community integration. The Curative Action states it will not be considered operational until DBHDS finds that the QSR data related to this data set for V.E.2 provides reliable and valid data for compliance reporting and the Independent Reviewer reviews and determines that DBHDS utilized a sufficient methodology to reach its findings. The 23rd Period found	For this 24th Period, the specific requirements, as italicized, and the current status of each, of the Curative Action are described below for this CI and for CI 43.2 below: • *The QSR vendor will present individual data gathered from QSR process to providers and individual and aggregate data to DBHDS. As part of the QSR quality improvement process, providers will be expected to incorporate their individual results into their QI programs and track and address them as measurable goals and objectives*: For this 24th Period, *12VAC35-105-620.C.3* continues to require the following: "The quality improvement plan shall: Include and report on statewide performance measures, if applicable, as required by DBHDS." As described in the bullets below, DBHDS has provided guidance to providers outlining the expectations for establishing and tracking measurable goals and objectives related to the provider reporting measures. As reported previously, for Round 4 and Round 5, the QSR vendor presented data to providers and to DBHDS. Round 6 had not yet begun. • *DBHDS will track and address overall statewide results through its QI committees, and providers will be expected to track and address their individual results through their QI programs. DBHDS will report overall state-wide results to providers to assist them in setting goals for their programs:* Based on QIC and subcommittee minutes and materials, DBHDS tracked and addressed overall statewide results. o Data on the 12 surveillance measures are reported and reviewed by the RMRC, as detailed with regard to CI 29.13 above. In addition, the data for these measures are traditionally reported in the annual *Developmental Disabilities Annual Report and Evaluation*. The current *Developmental Disabilities Annual Report and Evaluation, State Fiscal Year 2023, Published Date February 27, 2024* is posted on the DBHDS Settlement Agreement Library Site and includes this reporting. o As reported previously QSR reports for Round 4 and Round 5 included performance for the community integration provider reporting measures. These are also posted on the DBHDS website and on the Library Site. The QSR vendor made presentations to the QIC that included a review of data for these measures on 9/20/23 and 12/11/23. o As described in the next bullet, on 11/21/23, DBHDS sent a	

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS needed to further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats have been adequately identified and addressed. For this 24th Period, DBHDS did not submit an update to this Process Document and Data Set Attestation, or any evidence of further examination. The Curative Action also required DBHDS to continue to collect and report data for these 12 surveillance measures related to negative aspects of health and safety that come from provider critical incident reporting. For these measures, for which data are collected through CHRIS-SIR, DBHDS informed providers of these requirements through regulations at *12VAC35-105-160*, as well as through various training and guidance documents.	memorandum to providers of developmental disability services describing the expectations to track and address their individual results through their QI programs. • *To ensure reliability and validity, DBHDS will ensure that appropriate tools that specify the parameters for collecting this data are made available to providers. Significant deviations between data collected through the QSR process and data collected by a provider will be reviewed, assessed and corrected. The FY23 round of QSRs will begin approximately in October 2022, and this is when providers will begin to collect and report this data to DBHDS.* As reported at the time of the 23rd Period review, for Round 4 and Round 5 of QSRs, DBHDS had used that process to collect data with regard to the community integration provider reporting measure described above. For this 24th Period, Round 6 QSR had not yet begun. During the 23rd Period, on 8/27/23, DBHDS sent a memorandum to providers of developmental disability services describing expectations regarding provider risk management programs and provider reporting measures. The memorandum stated that DBHDS uses provider reporting data from critical incidents, the Risk Awareness tool and the ISP to report on positive and negative aspects of health and safety, and data from Quality Service Reviews, Semi-Annual Employment Report, NCI, and ISPs for provider reporting measures of positive and negative aspect of community integration. Further, the memorandum stated that each provider should have in their Quality Improvement Plan a specific measure that addresses the promotion/participation in community integration as defined by meaningful work activities, non-large group activities (community engagement) and individual participation in community outings. The document gave examples and also defined "meaningful work" and "meaningful community inclusion." For this 24th Period, on 11/21/23, DBHDS again sent a memorandum to providers of developmental disability services describing these expectations, but with additional updated language and information. In particular, it expanded upon the requirements for providers to track community integration as statewide performance measures through their QIPs,	

Compliance Indicator	Facts	Analysis	Conclusion
	In addition, on 8/27/23, DBHDS sent a memorandum to providers of developmental disability services describing expectations regarding provider risk management programs and provider reporting measures. The Curative Action requires that DBHDS must ensure that appropriate tools that specify the parameters for collecting this data are made available to providers (i.e., a function of notification to providers). DBHDS provided this information to providers in the aforementioned 8/27/23 memorandum.	consistent with the regulatory requirements, and noted that the QIPs must include a measurable goal for either meaningful work or meaningful community inclusion. The memorandum also expanded on the examples of measurable goals and objectives in these two areas. The document stated that beginning with the 2024 annual licensing inspections, OL would be reviewing QIPs for adherence to this requirement and, for any identified non-compliance, providing a rating of Non-Determined and providing technical assistance. On 12/19/23, OL sent another memo entitled *2024 Annual Inspections for Providers of Developmental Services* as a reminder of these requirements, along with a checklist that also outlined the regulatory expectations. Finally, on 12/18/23, OL provided training for providers that included this information. • *Additionally, DBHDS will continue collecting the negative aspects of health and safety that come from provider critical incident reporting (provider risk measures). Documentation of the process for calculating and reporting these rates is described in the document "Risk Incident Monitoring Rates." Providers are required to report all serious incidents within 24 hours of identification. The RMRC developed 12 measures from the critical incidents reported by providers. These measures are closely tied with the risks that are reviewed with the Risk Awareness Tool (RAT), and report the incidence rate for the 12 conditions as a proportion of the number of individuals on the DD waivers. The 12 rates measured are: aspiration pneumonia, bowel obstruction, sepsis, decubitus ulcer, fall, dehydration, seizure, urinary tract infection, choking, self-injury, sexual assault, and suicide attempt. The "Surveillance Measures" report is reported quarterly to the RMRC. These measures were reported beginning in FY2021.* The RMRC continues to collect data for these 12 surveillance measures related to negative aspects of health and safety. Based on review of applicable meeting minutes during the 24th Period, the RMRC reviewed the data on two quarterly occasions during this six month period (i.e., 11/27/23 and 1/22/24). As previously reported, for the measures for which data are collected through CHRIS-SIR, DBHDS informs providers of these requirements through regulations at *12VAC35-105-160*, as well as through various provider trainings and guidance documents. These include the requirement to report all serious incidents within 24 hours of identification.	

Compliance Indicator	Facts	Analysis	Conclusion
		• *Information collected by DBHDS through the process laid out above will be selected from the following domains listed Section V.D.3: a. Safety and freedom from harm (e.g., neglect and abuse, use of seclusion or restraints); b. Physical, mental, and behavioral health and well being (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions, particularly in response to changes in status); 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); and f. Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals).* As further described above, the provider reporting measures include both physical health and community inclusion. • *This curative action will not be considered operational until DBHDS finds that the QSR data related to this data set for V.E.2 provides reliable and valid data for compliance reporting and the Independent Reviewer reviews and determines that DBHDS utilized a sufficient methodology to reach its findings:* At the time of the 23rd Period, as reported with regard to CI 36.1, while some concerns remained with regard to the adequacy of IRR, and its potential impact on data validity and reliability, DBHDs at least minimally met the requirements to evaluate the QSR as a data source system and to provide a Process Document (i.e., entitled *QSR Quality Improvement Findings*, dated 8/1/23) and a Data Set Attestation (i.e., dated 9/9/23). However, the 23rd Period study issued a caveat stating that, going forward, DBHDS should further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats have been adequately identified and addressed. For this 24th Period, DBHDS did not submit an update to this Process Document and Data Set Attestation. The previously reviewed documents did not address IRR as a potential threat to data validity and reliability, but should have. Instead, the Data Set Attestation described IRR as a factor that contributed to remediation of any threats to validity and reliability. The same findings are true for most recent version of the Process Document *Provider Reporting Measures*, dated 9/7/23, and the relevant Data Set Attestation, 9/27/23. DBHDS did not update them during this 24th Period.	

Compliance Indicator	Facts	Analysis	Conclusion
		As indicated with regard to CI 36.1 above, this lack of action and the fact that Round 6 of the QSR has not been completed or generated data for validation impact the ability for this study to confirm the overall methodology is sufficient for this data set. That determination will be deferred until DBHDS documents completion of the needed examination. If the Commonwealth meets the requirements of this CI during the 25th Period, it will have met this indicator in two consecutive reviews.	
43.3: 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.	Previous reports have documented that the Office of Data Quality and Visualization assisted with analysis of the 12 surveillance provider reporting measures. In addition, as reported at the time of the 23rd Period review, OCQM staff reported the provider measures were included in the annual PMI review on 6/9/23. This annual review process remained current at the time of this 24th Period. The 23rd Period study also reported that OCQM had contemporaneously issued an annual update for the CHRIS-SIR source system	Previous reports have documented that the Office of Data Quality and Visualization assisted with analysis of the 12 surveillance provider reporting measures. In addition, at the time of the 23rd Period review, the findings for CI 37.2 indicated that OCQM staff reported the provider measures above were included in the most recent annual PMI review and that the process was consistent with a thorough process described in a document entitled *PMI Development and Annual Review Processes*, revised 6/29/23. DBHDS tracked the findings of the most recent annual review, including the decisions to add, abandon or revise PMIs, in the *SFY23 PMI Tracker with Annual PMI Review Updated Spring 2023*. This annual review process remained current at the time of this 24th Period. As described above with regard to CI 29.13, the 23rd Period study found that DBHDS demonstrated completion of a robust effort to develop remediation strategies for data collection for the 12 surveillance provider reporting measures. However, the 23rd Period study also noted that OCQM had contemporaneously issued an annual update for the CHRIS-SIR source system recommendations that identified continuing threats to data validity and reliability, and that these were not yet specifically addressed in the relevant Process Document (i.e., *SIR by Type Surveillance Rates ANE VER004*, dated 8/22/23). Further, the study indicated that DBHDS would need to review the recommendations and ensure the Process Document and Data Set Attestation reflected those updated recommendations. For this 24th Period, DBHDS had not modified the Process Document and/or Data Set Attestation. However, as also described above with regard to CI 29.13, DBHDS staff were able to provide evidence that they had previously	23rd - Met **24th - Deferred**

Compliance Indicator	Facts	Analysis	Conclusion
	recommendations that identified continuing threats to data validity and reliability, and that these were not yet specifically addressed in the relevant Process Document (i.e., *SIR by Type Surveillance Rates ANE VER004*, dated 8/22/23). Further, the study indicated that DBHDS would need to review the recommendations and ensure the Process Document and Data Set Attestation reflected those updated recommendations. For this 24th Period, DBHDS had not modified the Process Document and/or Data Set Attestation. However, as also described above with regard to CI 29.13, DBHDS staff were able to provide evidence that they had previously addressed the specific concerns identified in the CHRIS-SIR source system annual update.	addressed the specific concerns identified in the CHRIS-SIR source system annual update. DBHDS staff further indicated they would update the Process Document and Data Set Attestation with the appropriate details. As described in detail with regard to CI 36.1 and CI 44.1 above, for this 24th Period, DBHDS did not complete a needed review of the Process Documents that rely on QSR data sets and still need to complete these evaluations. This included *QSR Quality Improvement Findings*, dated 8/1/23, and *Provider Reporting Measures*, dated 9/7/23, as well as the related Data Set Attestations. As indicated with regard to CI 36.1 above, this lack of action impacts the ability for this study to confirm the overall methodology is sufficient for this CI. In addition, Since the 23rd period, DBHDS has not yet implemented the next Round of the QSR and has not yet obtained a new QSR data set. The determination of the status of this CI will be deferred until DBHDS documents completion of the needed examination. If the Commonwealth meets the requirements of this CI during the 25th Period, it will have met this indicator in two consecutive reviews.	

Compliance Indicator	Facts	Analysis	Conclusion
	They also indicated they would update Process Document and Data Set Attestation with the appropriate details.		
43.4: 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.	For this 24th Period, the study could not make a final determination that DBHDS met the requirements for this CI due to DBHDS pending actions related to QSR data quality, and will defer additional consideration until the 25th Period. The 23rd Period found that for the QSR-derived data, DBHDS at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. However, this finding included a caveat that DBHDS needed to further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats have been adequately	At the time of the 22nd Period review, per the applicable Curative Action described above, DBHDS had defined provider reporting measures in all required domains. For this 24th Period, these continued in effect. In addition, the QIC monitored and reviewed the provider measures at least semi-annually with input from Regional Quality Councils. At the time 23rd Period, as described with regard to CI 29.13, DBHDS had met the requirements to review valid and reliable data for the 12 surveillance measures four times during the past year. This continued to be true for the 24th Period review. At the time of the 23rd Period, this study found that for the QSR-derived data, as described with regard to CI 36.1 above, DBHDS at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. However, this finding included a caveat that DBHDS needed to further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats had been adequately identified and addressed. For this 24th Period, DBHDS did not report they had yet completed any further examination of Process Documents and Data Set Attestations that use QSR data sets for IRR threats to validity and reliability. In addition, while DBHDS updated the underlying source system assessment documents (i.e., *OCQM Third Party Data Source System Validation Checklist with vendor and OCQM Scoring HSAG Final*, dated 3/6/24, and a *OCQM Third Party Data Source System Validation Checklist Scoring Sheet QSR 2024*, dated 3/5/24), those did not document any significant updates to IRR procedures that DBHDS or the QSR vendor	23rd - Met **24th - Deferred**

Compliance Indicator	Facts	Analysis	Conclusion
	identified and addressed. For this 24th Period, DBHDS did not report they had yet completed any further examination of Process Documents and Data Set Attestations that use QSR data sets for IRR threats to validity and reliability, including for the provider reporting measures. In addition, Round 6 data will not be available for validation until the 25th Period. Otherwise, the study found DBHDS had defined provider reporting measures in all required domains. In addition, the QIC monitored and reviewed the provider measures at least semi-annually with input from Regional Quality Councils. In addition, for this 24th Period, as described with regard to CI 29.13, DBHDS had met the requirements to review valid and reliable data for	implemented to address previously identified IRR deficiencies. Since the 23rd Period a subsequent round of QSR evaluations has not been completed and a new QSR data set has not been produced for validation purposes. As a result, the study could not make a final determination that DBHDS met the requirements for this CI due to DBHDS pending actions related to QSR data quality, and will defer additional consideration until the 25th Period. DBHDS should document a thorough review of the Process Document and Data Set Attestation for the provider reporting measures.	

Compliance Indicator	Facts	Analysis	Conclusion
	the 12 surveillance measures four times during the past year.		

V.E.3 Analysis of 23rd Review Period Findings

Section 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.

Compliance Indicator	Facts	Analysis	Conclusion
44.1: 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	For this 24th Period, this study could not fully evaluate the Commonwealth's performance and will defer a finding until the 25th Period. As summarized below, this is due several factors, including 1) the scheduling of Round 6 provider reviews and the resulting inability to completed needed sampling 2), the DBHDS timeframes for submission of documents for review for Round 6 QSR, and 3) the need for DBHDS to complete a review of	For the 23rd Period, this study found that DBHDS had significantly enhanced the guidance, questions, evaluation criteria and additional guidelines in the QSR PQR tool overall and that it provided a clear procedure for addressing each of the specific criteria defined in the CI as necessary to the assessment and determination of the adequacy of providers' quality improvement program. The PQR tool included six elements relevant to the determination of the adequacy of providers' quality improvement programs: • Does the agency have a QI program policy and procedure? • Does the agency have a QI plan? • Is the QI plan thorough? • Is the QI plan complete? • The quality improvement plan is reviewed annually. • Providers have active risk management and quality improvement programs. The PQR tool also included a seventh element that called for a narrative to list any "No" findings and describe any opportunities for improvement related to the provider Quality Improvement Plan. At the time of the 23rd Period, DBHDS and the vendor had also refined the guidance and evaluation criteria for use by reviewers when making determinations.	23rd - Met **24th - Deferred**

Compliance Indicator	Facts	Analysis	Conclusion
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.	IRR concerns with regard to data validity and reliability of QSR data sets. Pursuant to 23rd Period findings of Round 5 discrepancies between the QSR reviewers' findings and the results of a sample review, this study required additional planned sampling of QSR provider results. However, due to the Round 6 timetable, this sampling must be deferred until the 25th Period, at which time Round 6 results will be available. For this 24th Period, DBHDS also indicated that it was making some changes to the Round 6 PQR tool as that related to the assessment and determination of the adequacy of providers' quality improvement program. However, these only became available as this study neared completion, which did	For this 24th Period, DBHDS indicated that, for Round 6, it was making some changes to the PQR tool as that related to the assessment and determination of the adequacy of providers' quality improvement program. However, these only became available as this study neared completion and, due to time constraints, will be subject to a thorough evaluation during the 25th Period review. On initial review, it appeared DBHDS and the QSR vendor made substantial changes to the protocols that it had used for evaluating provider quality improvement programs during Round 5. With regard to data validity and reliability, at the time of the 23rd Period review, DBHDS provided a Process Document entitled *DOJ Process QSR Quality Improvement Program Findings VER001,* dated 8/1/23, and a Data Set Attestation, dated 9/9/23. The 23rd Period study found that these documents met minimum requirements of the *Curative Action for Data Validity and Reliability*, but issued a caveat stating that, due to continuing IRR concerns, DBHDS should review this Process Document and Attestation, as well as all other Process Documents and related Attestations for measures that relied on QSR data sets. At that time, it remained concerning that neither of the documents acknowledged or addressed the IRR deficiencies that multiple Reports to the Court have previously identified. Of note, the 23rd Period study found similar concerns related to the source system assessment OCQM completed for QSR. None of the documentation provided at that time indicated the steps DBHDS had taken since the previous review to improve the IRR process, especially to the point that it could be considered a rationale for attesting to data validity and reliability rather than an identified deficiency. As a result, the 23rd Period study issued a caveat stating that, going forward, DBHDS should further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats have been adequately identified and addressed. For this 24th Period, DBHDS did not submit an updated Process Document or Data Set Attestation or otherwise provide evidence they completed an examination of IRR as it related to the specific QSR questions and evaluation criteria for provider quality improvement programs. In addition, for this 24th	

Compliance Indicator	Facts	Analysis	Conclusion
	not allow sufficient time for a thorough evaluation. On initial review, it appeared DBHDS and the QSR vendor made substantial changes to the protocols used for evaluating provider quality improvement programs during Round 5. At the time of the 23rd Period review, DBHDS provided a Process Document entitled *DOJ Process QSR Quality Improvement Program Findings VER001,* dated 8/1/23, and a Data Set Attestation, dated 9/9/23. The study found that these documents met minimum requirements of the *Curative Action for Data Validity and Reliability*, but issued a caveat that stated, due to continuing IRR concerns, DBHDS should review this Process Document and Attestation. At that time, it remained concerning	Period, DBHDS staff acknowledged that the substantial changes in the Round 6 protocols for evaluating such programs will potentially require revisions to the Process Document and the Data Set Attestation. The 23rd Period study reviewed a sample of documents from a set of Round 5 provider findings to test the validity of the QSR sample for this CI. The sample turned out not to be large enough to generalize the results, but there were some clear discrepancies between the QSR reviewers' findings and the results of the sample review. For this 24th Period review, Round 6 was just beginning as this study concluded, so data were not yet available for review. This will be further evaluated through a sampling procedure during the 25th Period review. Due to the pending review of the Process Document and Attestation, pursuant to Round 6 IRR changes, and to the inability to complete a sample with generalizable results during this 24th Period, this study will defer a finding of the compliance status until the 25th Period review. At that time, Round 6 will be complete and available to sample. In addition, DBHDS will have had an opportunity to update the Process Document and Attestation to reflect the updated Round 6 protocols, as well as a thorough evaluation of possible IRR threats to data validity and reliability.	

Compliance Indicator	Facts	Analysis	Conclusion
	that neither of the documents acknowledged or addressed the IRR deficiencies that multiple Reports to the Court have previously identified. For this 24th Period, DBHDS did not submit an updated Process Document and Data Set Attestation or otherwise provide evidence they completed an examination of IRR as it related to the specific QSR questions and evaluation criteria for provider quality improvement programs. In addition, for this 24th Period, DBHDS staff acknowledged that the substantial changes in the Round 6 protocols for evaluating such programs will potentially require revisions to the Process Document and the Data Set Attestation.		

Compliance Indicator	Facts	Analysis	Conclusion
44.2: 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.	For this 24th Period, due to DBHDS timeframes the scheduling of Round 6 provider reviews, this study could not fully evaluate the Commonwealth's performance and will defer a finding until the 25th Period. At the time of the 23rd period, this CI was not met because the study could not confirm that any of 15 vendor-issued QIPs sufficiently addressed the quality improvement deficiencies and identified the needed remediation or need for technical assistance. While this sample size was small, the finding was universal. This called the QSR data for this CI into question. Otherwise, for this 24th Period, DBHDS continued to use data collected from licensing reviews to identify providers in need of technical assistance.	As described with regard to CI 32.7, to identify providers for targeted technical assistance in this area, DBHDS uses data collected from licensing reviews. Specifically, a flow chart (i.e., *Flow Chart_Identify providers needing TA*, dated 9/8/23) documented the use of the OL report, including a biannual report of the number of Health & Safety CAPs issued and results of subsequent steps in the process and a quarterly report of the percent of providers that comply with RM regulations. Of note, in a report to the Court on 2/20/24 DBHDS indicated it had identified funding to hire additional quality improvement specialists to provide technical assistance to providers to help them develop quality improvement plans and training plans that comply with the DBHDS Licensing Regulations. DBHDS also provided a document entitled *HSAG QIP CTA*, describing a process for notifying providers and CSBs, via email that their QSR reports were available in the SAFE portal. The email also notified the provider or CSB if a QIP is required. This included the provider or CSB QSR report overview, as applicable. In addition, DBHDS uploads into SAFE several documents for the provider or CSB to use when developing their QIP response, including the *QIP Template*, the *PCR Actionable Recommendations* and the *PQR Actionable Recommendations*. DBHDS reported that 76 providers or CSBs received technical assistance and modification of QIP responses and 54 providers and CSBs who received technical assistance through second notifications. As reported at the time of the 23rd Period review, for Round 5 QSRs, Item 7 of the PQR required the QSR reviewers to document any areas of opportunities for quality improvement elements and that for such elements that were scored "no" the QSR reviewers needed to provide corresponding information to inform the provider about opportunities for improvement and to identify providers in need of technical assistance. The Round 5 sample review of provider and QSR documentation described above for CI 44.1 could not confirm that QSR reviewers were adequately identifying these opportunities for improvement. While the sample size was small, the finding was universal. Therefore, at the time of the 23rd Period, this CI was not met because the study could not confirm that any of 15 vendor-issued QIPs sufficiently addressed the	23rd - Not Met **24th - Deferred**

Compliance Indicator	Facts	Analysis	Conclusion
	Specifically, a flow chart (i.e., *Flow Chart_Identify providers needing TA*, dated 9/8/23) documented the use of the OL report, including a biannual report of the number of Health & Safety CAPs issued and results of subsequent steps in the process and a quarterly report of the percent of providers that comply with RM regulations.	quality improvement deficiencies and identified the needed remediation or need for technical assistance. The study recommended that DBHDS implement training for QSR reviewers to ensure, and a supervisor methodology to confirm, that all vendor-issued QIPs sufficiently address the quality improvement deficiencies and identifies the needed remediation or need for technical assistance. This was consistent with other recommendations in this study that DBHDS should further evaluate IRR for the QSR process. Due to the timing for Round 6, which was just underway at the conclusion of the 24th Period review, the current study could not complete any additional sampling to determine if vendor-issued QIPs sufficiently addressed the quality improvement deficiencies and identified the needed remediation or need for technical assistance. The 25th Period study will therefore include a sample of Round 6 findings to further evaluate DBHDS performance with regard to the requirements if this CI. Further evaluation is deferred until that time.	

Recommendations:

1. As a standard practice, OHR should expand its corrective actions to address the requirements at CI 29.17 and 29.18 to include specific identification of objective measurement criteria for each corrective action.
2. If changes proposed by OHR are approved by the RMRC specific to modifications in the methodology for calculating percentage measurement of CI 29.17 Outcome 2, OHR must update scores over the previous quarters utilizing the modified methodology to provide comparable data across each quarter since the CLB was re-implemented for Q3 SFY 23.
3. As described in the Analysis section for CI 29.17, the OHR should develop and implement a more robust and detailed analysis of available and relevant data that will be necessary to effect positive, lasting achievement of the 86% target levels.
4. As described in the Analysis section for CI 29.17, the OHR should increase its review of data presentations in the Quarterly CLB Report to the RMRC to ensure the accuracy of each data element presented.
5. DBHDS should assure the full implementation of the PowerApps automation platform to support the full implementation of the revised CLB process.
6. DBHDS should expedite the finalization and implementation of the inter-rater reliability component of the CLB process.
7. For CI 29.20, DBHDS still needed to update the Data Set Attestation to clearly reference the adequacy of mitigation strategies for ensuring that ISPs are completed by their effective date.
   and clarify the Scope section of both the annual physical and annual dental Process Documents, which still appear to indicate that the date of an annual exam, either physical or dental, must occur within the year proceeding the Annual ISP date (i.e. rather than within 14 months.)
8. For CI 29.21, because the methodology uses multiple data sets to complete a calculation unique for CI 29.21, DBHDS will need to develop a specific Process Document for reporting this metric, and obtain a Data Set Attestation for data validity and reliability.
9. For CI 29.22, DBHDS should develop a formal written protocol that outlines the QSR HCBS compliance process from start to finish, which should incorporate all of the validation processes in the approved Statewide Transition Plan (STP) and the requirements of the HCBS Settings Rule and related CMS guidance.
10. Also for CI 29.22, DBHDS should ensure that the compliance calculation incorporates all of the PCR and PQR elements that address HCBS requirements with regard to integration in and access to the greater community and that each of compliance element with a Yes or No response provides sufficient guidance for making that determination. In addition, the compliance calculation must define how to incorporate elements with text field responses.
11. To meet the requirements of CI 29.24, DBHDS should revise the proposed processes to address identified concerns. These include the Care Concerns criteria for referral, as well as the investigatory criteria, including but not limited to, the 30-day look behind for repeated injuries; a more thorough methodology for identification and tracking of individuals with repeated injuries (i.e. since there were 734 more serious injuries than there were individuals who sustained them); and re-visiting whether a formal CAP sufficiently captures the various actions IMU and investigator staff take that are remedial in nature.
12. For CI 35.1 and CI 35.5, the QRT should work with DBHDS to obtain and review any such proposed remediation plans in writing and ensure that those plans focus on systemic factors, where present, and include the specific strategy to be employed and the defined measures that will be used to monitor performance. If, based on QRT assessment, proposed DBHDS remediation plans do not address the remedial needs or do not do so sufficiently, the QRT can either develop their own written plans and/or request appropriate modifications to the DBHDS plans.

13. For CI 36.1, DBHDS should address the continuing concerns regarding validity and reliability of QSR data, including the need to examine potential IRR deficiencies in all QSR data sets. This recommendation also applies to the following CIs that rely on QSR data sets: HCBS residential compliance (i.e., CI 29.22), use of QSR data for analysis and quality improvement (CI 36.3), PMI data quality (CI 37.7), provider reporting measures (i.e., CI 43.1. 43.3 and CI 43.4), and provider quality improvement programs (i.e., CI 44.1 and CI 44.2).
14. Also for CI 36.1, DBHDS should revise the overall DQMP process to formalize specific monitoring steps to ensure the adequacy and currency of all source system assessments.
15. For CI, 37.7, DBHDS should ensure the revision of the overall DQMP process to formalize that the specific monitoring steps include assigning responsibility to ensure that SMEs complete all Process Document reviews and updates in a timely manner.
16. The Office of Licensing should continue to encourage providers to utilize the Excel-based incident tracking tool template that was initially made available to providers in 2023 to more fully structure incident data analysis and specific inclusion of analysis of data specific to the common risks and conditions faced by people with IDD that contribute to avoidable deaths.

Attachment A: Interviews

6. Heather Norton, Assistant Commissioner, Developmental Services
7. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Governmental Relations
8. Katherine Means, Senior Director of Clinical Quality Management
9. Eric Williams, Director, Office of Provider Development
10. Jae Benz, Director, Office of Licensing
11. Taneika Goldman, Director, Office of Human Rights
12. Mackenzie Glassco, Associate Director of Quality and Compliance
13. Michelle Laird
14. Angelica Howard

Attachment B: Documents Reviewed

1. Abuse, Neglect, and Exploitation Q2 FY24 DataRMRC2.26.24
2. Abuse, Neglect, and Exploitation Q1 FY24 Data RMRC 12.19.23
3. Abuse, Neglect, and Exploitation Q4 FY23 Data RMRC 10.23.23
4. Incident Management Unit RMRC Data Review11.27.2023.
5. Incident Management Unit RMRC Data Review2.26.2024
6. List of data reviewed with RMRC-updated 02.26.24.
7. RMRC Minutes 02.26.24 draft.
8. RMRC Minutes 10.23.2023 Approved
9. RMRC Minutes 11.27.23 Approved
10. RMRC Minutes 12.19.23 Approved
11. Serious Incident Data - 11272023.
12. 29.13_Data Concern #3_IT email on correction
13. CI29.13- Data concerns Summary
14. RMRC QIC Subcommittee Work Plan
15. RMRC Task Calendar and Charter Tasks
16. *SIR by Type Surveillance Rates ANE VER004*, dated 8/22/2023, and Attestation
17. *HR Process Document Free From ANE 29.23, Ver 005*, dated 10/12/23 and Attestation, 3/6/24
18. *Data Quality Monitoring Plan Source System Report* for CHRIS-SIR and CHRIS-HR
19. 12VAC35-105-160
20. 12VAC35-105-450
21. 12VAC35-105-520
22. 12VAC35-105-620
23. Quarter 3 2023 VCU Report
24. Incident Management Look-Behind RMRC Monthly Meeting 2023 Quarter 3 Data Report and PowerPoint Presentation
25. RMRC Minutes 02-26-24
26. Q3 2023 VCU IMU Look-Behind DBHDS Response
27. Provider CLB Memo November 2023
28. Community Look-Behind Format in the CHRIS System
29. CLB Review Form and Process Technical Guidance
30. OHR Role in the Corrective Action Plan (CAP) Process [Protocol No. 316]
31. CLB Review Form
32. 12/18/2023 OHR Community Look-Behind Report
33. Quarterly CLB Report to the RMRC
34. *Developmental Disabilities Annual Report and Evaluation, State Fiscal Year 2023*, Published Date February 27, 2024
35. Annual Physicals 29.20 24th Review, dated 2/20/24
36. Annual Dental 29.20 24th Review, dated 2/1/24.
37. *Annual Physical Exams Ver 005*, dated 8/24/23 and Attestation
38. *Annual Dental Exams Ver 005*, dated 8/24/23 and Attestation
39. WaMS Recommendations: Data Source System Enhancement Progress, dated 8/4/23
40. Agreed-Upon Curative Action for Compliance Indicator 29.21, filed with the Court on 7/11/22
41. Behavioral Supports Report: Q3/FY24 Addendum for CI 29.21
42. DBHDS narrative summary for CI 29.22, dated 3/26/24
43. *HCBS Settings* Process Document, updated 4/19/24 and Attestation
44. Home and Community-Based Services Settings Regulations Corrective Action Plan

45. QSR Methodology for Round 6
46. QSR PCR and PQR tools for Round 6
47. Addendum to the Commonwealth of Virginia's Statewide Transition Plan February 2019
48. HR Process Document Free From ANE 29.23 VER005, dated 10/12/23
49. *Individuals Protected from Serious Injury*, dated 2/21/24 and Attestation dated 3/6/24
50. Incident Management Unit Care Concern Threshold Joint Protocol
51. Four quarterly Individuals Protected from Injury reports, covering the period between 4/1/23 through 3/31/24
52. DBHDS *Individuals Protected from Serious Injury* data summary email, provided 4/23/24
53. DBHDS *Individuals Protected from Serious Injury* updated data summary email, provided 5/17/24
54. KPA Q1/Q2 FY24 Hierarchy Data Reports for the first and second quarters of SFY24
55. *HR Process Document 29.25 VER005*, dated 6/20/23 and Attestation, dated 9/1/23
56. Risk Management Program Description, FY24
57. Flow Chart Identify providers needing TA, dated 9/8/23
58. QIC Meeting minutes, dated9/20/23, 12/11/23 and 3/25/24
59. KPA Workgroups Schedule with S Data Requirements SFY23 Updated 12.13.22
60. OL Compliance Determination Chart-2024
61. 160 & 520 Rubric for OL Staff dated January 2024
62. Process Document - 30.4, 30.5, 30.7 *DOJ Process RM Requirements VER005*
63. Attestation Statement - 30.4, 30.5, 30.7 *RM Requirements Attachment B* – 8.30.2023
64. RM Compliance Total CY2023 Data Report
65. Expectations of Provider Risk Management Programs
66. 2024 DD Inspections Kickoff Training
67. QI Compliance Total CY2023 Data Report
68. 42.3 42.4 Summary of Compliance Data Report
69. Curative Action for Data Validity and Reliability
70. Compliance by Reg 620 CY2022 Data Report
71. QI Compliance Total CY2023 Data Report
72. Expectations Regarding Provider Reporting Measures for Residential and Day Support Providers
73. CAP Status CY2023 Data Report
74. Compliance by Regulation 620 CY23 Data Report
75. The following documents provided by 40 sample providers to inform the sample review for this study:
    a. Risk Management Policy/Plan
    b. Incident Reporting and Review Policy
    c. Annual Systemic Risk Assessment
    d. Minutes of Incident Review Meetings over the past six months and related data review/analysis reports
    e. Risk Management Training Attestation Statement for Risk Manager
    f. Employee Training Policy
74. Provision VD1 Progress & Revisions Summary
75. QRT DMAS_QRT_VER_004
76. DD CMSC VER 016, dated 8/29/23, and Attestation, dated 8/30/23
77. DMAS/DBHDS Quality Review Team (QRT) Quarterly Collaboration for Q4 SFY23
78. SFY23 EOY Report
79. SFY22 QRT EOY Presentation to QIC (9-2022)
80. SFY24 QRT Charter (FINAL)
81. V.D.1 Supplemental Updates, dated 2/27/2024

82. Case Management Steering Committee Semi-Annual Report State Fiscal Year 2024 1st and 2nd Quarters, dated 3/1/24
83. Process Document and applicable Data Set Attestation for each QRT measure that relied on data collected by either DBHDS or DMAS.
84. Data Quality Monitoring Plan Source System Report, dated 9/28/23
85. OCQM Third Party Data Source System Validation Checklist with vendor, dated 3/6/24
86. OCQM Scoring HSAG Final, dated 3/6/24
87. OCQM Third Party Data Source System Validation Checklist Scoring Sheet QSR 2024, dated 3/5/24
88. Round 6 IRR Policy
89. IRR Process Summary, dated 1/19/24
90. QIC Review Schedule SFY22 - SFY24
91. QIC meeting minutes for SFY24 Q1, Q2 and Q3
92. Intense Management Needs Review Process document, dated 1/25/24
93. IMNR Questionnaire 24th Review Final
94. IMNR Questionnaire Guidelines Draft
95. Intense Management Needs Review Report Twenty-Fourth Review Period, dated April 2024
96. Data Quality Monitoring Plan Source System Report, dated 9/28/23
97. 2024 Annual Inspections for Providers of Developmental Services, dated 12/19/23
98. *QSR Quality Improvement Findings*, dated 8/1/23 and Attestation dated 9/9/23
99. *Provider Reporting Measures*, dated 9/7/23, and Attestation, dated 9/27/23
100. Expectations regarding provider reporting measures for residential and day support providers of developmental services
101. *DOJ Process QSR Quality Improvement Program Findings VER001*, dated 8/1/23, and Attestation, dated 9/9/23.
102. HSAG QIP CTA
103. QSR QIP Template
104. PCR Actionable Recommendations and the PQR Actionable Recommendations

APPENDIX K

List of Acronyms

ADL	Activities of Daily Living
APS	Adult Protective Services
ADA	Americans with Disabilities Act
AR	Authorized Representative
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Plan
BSPARI	Behavior Support Plan Adherence Review Instrument
CAP	Corrective Action Plan
CAT	Crisis Assessment Tool
CEPP	Crisis Education and Prevention Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Manager
CI	Compliance Indicator
CIT	Crisis Intervention Training
CL	Community Living (HCBS Waiver)
CLO	Community Living Options
CM	Case Manager
CMS	Center for Medicaid and Medicare Services
COVLC	Commonwealth of Virginia Learning Center
CQI	Community Quality Improvement
CPS	Child Protective Services
CRC	Community Resource Consultant
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTA	Consultation and Technical Assistance
CTH	Crisis Therapeutic Home
CTT	Community Transition Team
CVTC	Central Virginia Training Center
DARS	Department of Aging and Rehabilitative Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disabilities
DDS	Division of Developmental Services, DBHDS
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice, United States
DS	Day Support Services
DSP	Direct Support Professional
DSS	Department of Social Services
DW	Data Warehouse

ECM	Enhanced Case Management
EDCD	Elderly or Disabled with Consumer Directed Services
EHA	Office of Epidemiology and Health Analytics (formerly DQV)
E1AG	Employment First Advisory Group
EPSDT	Early and Periodic Screening Diagnosis and Treatment
ES	Emergency Services (at the CSBs)
ESO	Employment Service Organization
FRC	Family Resource Consultant
GH	Group Home
GSE	Group Supported Employment
HCBS	Home- and Community-Based Services
HPR	Health Planning Region
HSN	Health Services Network
ICF	Intermediate Care Facility
ID	Intellectual Disabilities
IDD	Intellectual Disabilities/Developmental Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports ("DD" waiver)
IFSP	Individual and Family Support Program
IR	Independent Reviewer
IRR	Inter-rater Reliability
ISE	Individual Supported Employment
ISP	Individual Supports Plan
ISR	Individual Services Review
KPA	Key Performance Areas
LIHTC	Low Income Housing Tax Credit
MLMC	My Life My Community (website)
MOU	Memorandum of Understanding
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
OCQI	Office of Continuous Quality Improvement
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
OSIG	Office of the State Inspector General
OSVT	On-Site Visit Tool
PASSR	Preadmission Screening and Resident Review
PCR	Person Centered Review
PCP	Primary Care Physician
PHA	Public Housing Authority
PMI	Performance Measure Indicator
PMM	Post-Move Monitoring
POC	Plan of Care
PST	Personal Support Team
QAR	Quality Assurance Review

QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QMD	Quality Management Division
QMR	Quality Management Review
QRT	Quality Review Team
QSR	Quality Service Reviews
RAC	Regional Advisory Council for REACH
RAT	Risk Assessment Tool
RCA	Root Cause Analysis
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RFP	Request For Proposals
RNCC	RN Care Consultants
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group
SEVTC	Southeastern Virginia Training Center
SIR	Serious Incident Report
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
VCU	Virginia Commonwealth University
VHDA	Virginia Housing and Development Agency
WaMS	Waiver Management System