ATTACHMENT A

United States' Noncompliance Contentions

#	Provision	Provision text	Indicator
1	**III.C.2.a-f**	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 2018, a minimum of 1000 individuals will be 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,	The Commonwealth, using its Individual and Family Support Program State Plan for Increasing Support for Virginias with Developmental Disabilities ("IFSP State Plan"), will: 1) examine the standards for prioritizing applicants to receive funding through the ISP to establish criteria for "most at risk for institutionalization" and to determine how the prioritization standards for the waiver waitlist should be applicable to IFSP; 2) establish an on-going communication plan to ensure that all families receive information about the program frequently enough to stay aware of the program and to be knowledgeable about the benefits and the requirements to apply and enroll; 3) establish, based on the emergency regulations that provided case management to individuals on the waiting list, final standards for providing case management services to individuals not in the Medicaid waiver along with guidelines for accessing these services; and 4) establish a set of performance indicators and an annual review cycle to measure: • the performance and outcomes as set by the Commonwealth related to access, comprehensiveness and coordination of individual and family supports, • the impact on the risk of institutionalization, and • individual and family satisfaction.

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		Diagnosis and Treatment ("EPSDT"), or similar programs.)	
2	**III.C.5.b.i.**	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	Portions of the following numbered indicators repeat for multiple provisions associated with case management (**III.C.5.b.i, III.C.5.b.ii**, **III.C.5.b.iii**, **III.C.5.c**, and **V.F.2**). For coherence, they are all listed once here (with the associated provisions identified in parentheses) and repeat for subsequent provisions using the same indicator-numbers. Relevant elements of person-centered planning, as set out in CMS waiver regulations (42 C.F.R. § 441.301(c)), are captured in these indicators. In consultation with the Independent Reviewer, DBHDS shall define and implement in its policies, requirements, and guidelines, "change of status or needs" and the elements of "appropriately implemented services." A statistically valid sample of all CSB entities' individual Service Plans (ISPs) and related records will be audited within six months and thereafter annually to determine: 1. The CSB has offered each person the choice of case manager (**III.C.5.c)** 2. Individuals have been offered choice of providers for each service (**III.C.5.c)** 3. The case manager assesses risk and risk mediation plans are in place as determined by the ISP team **(III.C.5.b.ii; V.F.2)** 4. The case manager assesses whether the person's status or needs for services and supports described in the ISP have changed and the plan has been modified as needed **(III.C.5.b.iii; V.F.2)** 5. The case manager develops ISPs that address all of the individual's risks, identified needs and preferences **(III.C.5.b.ii; V.F.2)** 6. The ISP includes specific and measurable outcomes, including evidence that employment goals have been developed and discussed **(III.C.5.b.i; III.C.7.b)** 7. The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served **(III.C.5.b.i; III.C.5.b.ii)**

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			8. The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary **(III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)** 9. The case manager completes assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their needs **(III.C.5.b.iii; V.F.2)** See V.F.5 for specific domains 10. The CSB has in place, and the case manager uses, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including but not limited to reconvening the planning team (**III.C.5.b.iii; V.F.2)** 100% of the CSBs meet these criteria in at least 86% of the sample individuals Corrective actions plans are imposed on CSBs for any element that has less than 86% compliance, consistent with CMS assessment standards CSB failure to meet the 86% standard over 12 months will result in Virginia imposing contract sanctions.
3	**III.C.5.b.ii**	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP.	A statistically valid sample of all CSB entities' individual Service Plans (ISPs) and related records will be audited within six months and thereafter annually to determine: 3. The case manager assesses risk and risk mediation plans are in place as determined by the ISP team **(V.F.2; III.C.5.b.ii)** 5. The case manager develops ISPs that address all of the individual's risks, identified needs and preferences **(V.F.2; III.C.5.b.ii)** 7. The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary **(III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)**

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			100% of the CSBs meet these criteria in at least 86% of the sample individuals Corrective actions plans are imposed on CSBs for any element that has less than 86% compliance, consistent with CMS assessment standards CSB failure to meet the 86% standard over 12 months will result in Virginia imposing contract sanctions. To address known systemic deficiencies: Nursing: The Commonwealth will adjust nursing reimbursement rates to assure access. The Commonwealth will monitor access to determine the effectiveness of a rate change.
4	**III.C.5.b.iii**	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	A statistically valid sample of all CSB entities' individual Service Plans (ISPs) and related records will be audited within six months and thereafter annually to determine: 4. The case manager assesses whether the person's status or needs for services and supports described in the ISP have changed and the plan has been modified as needed **(V.F.2; III.C.5.b.iii)** 8. The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary **(III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)** 9. The case manager completes assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their needs **(V.F.2; III.C.5.b.iii)** See V.F.5 for specific domains 10. The CSB has in place, and the case manager uses, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including but not limited to reconvening the planning team (**III.C.5.b.iii; V.F.2)**

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			100% of the CSBs meet these criteria in at least 86% of the sample individuals Corrective actions plans are imposed on CSBs for any element that has less than 86% compliance, consistent with CMS assessment standards CSB failure to meet the 86% standard over 12 months will result in Virginia imposing contract sanctions.
5	**III.C.5.c**	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	A statistically valid sample of all CSB entities' individual ISPs and related records will be audited within six months and thereafter annually to determine: 1. The CSB has offered each person the choice of case manager 2. Individuals have been offered choice of providers for each service 100% of the CSBs meet these criteria in at least 86% of the sampled individuals Corrective actions plans are imposed on CSBs for any element that has less than 86% compliance, consistent with CMS assessment standards CSB failure to meet the 86% standard over 12 months will result in Virginia imposing contract sanctions
6	**III.C.5.d**	The Commonwealth shall establish a mechanism to monitor compliance with [case management] performance standards.	By April 1, 2020: a system of Quality Management procedures is in place to measure each CSB's case management services to determine their effectiveness in developing individual service plans, monitoring services and meeting other requirements and also at the aggregate level to determine the CSB's overall effectiveness in achieving outcomes for the population they serve (such as

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			employment, self-direction, independent living, keeping children with families, preventing institutional placements, etc). The QM function will include data from the oversight of the Office of licensing, DMAS Quality Management Reviews, QMD review process, DBHDS Data Dashboard, and CSB CM Supervisors Quarterly Reviews. The QM procedures will provide reports on the ten elements identified in **III.C.5.b.i.** and the domains identified in **V.F.5**. DBHDS will conduct annual statistically sound retrospective reviews of the CSBs' case management supervisory reviews to validate the findings of the CSB supervisory reviews and provide technical assistance to the CSBs on improving the case management function. DBHDS will review case management monitoring data provided by CSBs to identify failures to meet the requirements as outlined in the settlement agreement, direct corrective action and monitor improvement.
7	**III.C.6.a.i-iii**	The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall: i. Provide timely and accessible support to individuals with intellectual and developmental disabilities who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families; ii. Provide services focused on crisis prevention and proactive planning to avoid potential crises; and	**PREVENTION:** **1. Early Identification; and 2. Assessments in Home** By October 1, 2019: DBHDS requires CSBs to screen children and adults for behavioral health needs within 30 days of intake. DBHDS defines the criteria that constitute "risk of hospitalization" for use by CSBs as the basis for making requests for behavioral assessments. DBHDS provides training to CSBs leadership staff and case managers on how to identify children and adults who need assessments and arrange for assessments. To mitigate risk of removal, assessments ordinarily should occur in the child's home. Training will be incorporated as a training

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		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.	requirement for case managers within 6 months of hiring or as a component of orientation. DBHDS will implement a quality review process conducted on a quarterly basis that measures the performance of CSBs arrangement for timely assessments in the home. At least 86% of children and adults will receive the initial assessment at home, the residential setting, or other setting where the crisis occurs (non-hospital/ CSB location). The Commonwealth will provide a directive and training to public psychiatric hospitals to require notification of CSBs and case manager whenever there is a request for an admission and will coordinate with private psychiatric hospitals to encourage their notification of CSBs. The Commonwealth will track new admissions to public psychiatric hospitals and, to the extent Virginia is aware of admissions, to private psychiatric hospitals to determine whether there has been a referral to REACH and will implement improvement strategies to improve performance. At least 95% of children and adults admitted to public psychiatric hospitals, and, to the extent Virginia is aware of admissions, to private psychiatric hospitals will be referred promptly to REACH. **3. Behavioral Supports In Home** By October 2019: i. The Commonwealth reassesses need by conducting a gap analysis and set targets and dates to increase the number of consultants needed to ensure that: • At least 86% of individuals will begin to receive authorized hours of behavioral supports (Therapeutic Consultation) within 30 days from the day it is identified as a need in the individual's ISP; and

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			• At least 86% of individuals will receive no less than 95% of the authorized hours of behavioral supports (Therapeutic Consultation). ii. provides practice guidelines and a training program for behavior consultants on the minimum elements that constitute an adequately (i.e., consistent with practice guidelines of the Behavioral Analyst Certification Board) designed behavioral program, the use of positive behavior support practices, trauma informed care and person-centered practices, as defined in CMS waiver regulations (42 C.F.R. § 441.301(c)(2)). iii. provides the guidelines and a training program for case managers regarding the minimum elements that constitute an adequately designed behavioral program and what can be observed to determine whether the plan is appropriately implemented (i.e., consistent with practice guidelines of the Behavioral Analyst Certification Board). By April 1, 2020, at least 86% of individuals will begin to receive authorized hours of behavioral supports (Therapeutic Consultation) within 30 days from the day these supports are identified as a need in the individual's ISP, and at least 86% of individuals will receive no less than 95% of the all authorized hours of behavioral supports (Therapeutic Consultation). By October 1, 2019, DBHDS will implement a quality review and improvement process that tracks the promptness and on-going delivery of therapeutic consultation services provided by behavioral interventionists and assesses: 1) the length of time between when the services is identified as a need in the ISP and when the service begins; 2) the number of hours individuals are authorized for behavioral interventionist services as compared to the number of hours received; 3) from among hospitalized children and adults, the number who have not received behavioral or crisis services to determine whether more of these individuals could have been diverted if the appropriate community resources, including sufficient CTHs were available;

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			4) for those who received appropriate behavioral services, determine the reason for hospitalization despite the services from REACH; 5) whether behavioral services are adhering to the standards published by DBHDS; 6) whether Case Managers are assessing whether behavioral programming is appropriately implemented. **4. Availability of Direct Support Professionals** By October 1, 2019, DBHDS will implement a quality review and improvement process that tracks authorizations for in-home services provided by direct support professionals and assesses and implements strategies to address: 1) the number of children and adults authorized for in-home services as compared to the number of children and adults receiving the service.
8	**III.C.6.b.ii.A.**	Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.	**MOBILE CRISIS:** DBHDS will, on a semi-annual basis, assess REACH teams for: 1) whether REACH team staff meet DBHDS's qualification and training requirements; 2) whether REACH has developed crisis education and prevention plans (CEPPs) for individuals who screen positive for risk of behavioral crisis, their families and group homes; and 3) whether families and providers are receiving training in the elements of CEPPs. Based on findings, DBHDS will 1) determine the need for training; and 2) when necessary require a quality improvement plan from the CSB managing the REACH unit. Outcomes to be achieved: At least 86% of REACH staff will meet training requirements At least 86% of CEPPs are developed within 45 days of positive screening At least 86% of the parents and providers will receive training in CEPPs

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			Documentation indicates a decreasing trend in the total and percentage of total admissions as compared to population served and lengths of stay of individuals with IDD who enter state psychiatric hospitals and, to the extent Virginia is aware of admissions, to private psychiatric hospitals**.** To monitor lengths of stay in public psychiatric hospitals and, to the extent Virginia is aware of admissions, to private psychiatric hospitals, DBHDS will track the lengths of stay of individuals with developmental disabilities in the following categories: • those previously known to the developmental disability crisis system and those previously unknown; • admissions of adults and children with IDD to psychiatric hospitals as a percentage of total admissions; and • median lengths of stay of adults and children with IDD in psychiatric hospitals.
9	**III.C.6.b.ii.B**	Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting.	Indicators are covered in **III.C.6.a.i-iii** and **III.C.6.b.ii.A.**
10	**III.C.6.b.iii.B**	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another	**CRISIS STABILIZATION:** The Commonwealth will establish and have in operation by June 30, 2019 two Crisis Therapeutic Home (CTH) facilities for children and two transition homes for adults; and will provide training to community residential agencies to enable individuals to return promptly. DBHDS utilizes waiver capacity set aside for emergencies each year to meet the needs of individuals with long term stays in psychiatric hospitals or CTHs.

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		community-based placement that could serve as a short-term placement.	DBHDS will increase the number of residential providers with the capacity and competencies to support people with co-occurring conditions using a person-centered/trauma-informed/positive behavioral practices approach to 1) prevent crises and hospitalizations, 2) to provide a permanent home to individuals discharged from CTHs and psychiatric hospitals. At least 86% of individuals enrolled in CTH facilities and psychiatric hospitals will have a community residence within 30 days of admission in the case of CTHs and by the time of discharge in the case of psychiatric hospitals.
11	**III.C.6.b.iii.D**	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	At least 86% of individuals enrolled in CTH facilities will have a community residence within 30 days of admission. This indicator is also in **III.C.6.b.iii.B.**
12	**III.C.6.b.iii.E**	With the exception of the Pathways 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.	The indicator for this provision is covered in **III.C.6.b.iii.G.**
13	**III.C.6.b.iii.G**	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	The Commonwealth will establish and have in operation by June 30, 2019 two Crisis Therapeutic Home (CTH) facilities for children and two transition homes for adults. This indicator is also in **III.C.6.b.iii.B.**

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			The Commonwealth implements out-of-home crisis therapeutic prevention host-home services for children with statewide access in order to prevent institutionalization of children.
14	**III.C.7.a**	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	The indicator for this provision is covered in **III.C.7.b.**
15	**III.C.7.b**	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disability Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment First policy shall, at a minimum, be based on the following principles: (1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth; (2) the goal of employment services is to support individuals in integrated work settings	All case managers will receive training on: 1) The Employment First Policy with an emphasis on the long term benefits of employment to people and their families and practical knowledge about the relationship of employment to continued Medicaid benefits; 2) Skills to work with individuals and families to build their interest and confidence in employment; 3) The importance of discussing employment with all individuals including those with intense medical or behavioral support needs and their families; 4) The importance of starting the discussion about employment with individuals and families as early as the age of 14 (when transition begins under IDEA) with goals that lead to employment (e.g. experiences in the community, making purchases, doing chores, volunteering); 5) The value of attending a students' IEP meeting starting at age 14 to encourage a path to employment during the school years and to explore how DD services can support the effort; 6) Developing goals for individuals utilizing Community Engagement Services that can lead to employment (e.g. volunteer experiences, adult learning).

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		where they are paid minimum or competitive wages; and (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in ISPs. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.	At least 86% of individuals (age 18-65) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process. At least 50% of ISPs of individuals (age 18-65) who are receiving waiver services include developed goals related to employment. At least 86% of individuals who have employment services authorized in their ISP will have a provider and begin services within 60 days. At least 86% of individuals will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings. At least 86% will have goals for involvement in their community developed in their annual ISP. Establish a quality review and improvement process that measures the performance of each CSB Case management unit, using the data to set improvement targets: • At least 50% of ISPs for individuals age 18-64 that have employment goals and services; • At least 86% of ISPs for individuals age 18-64 that are not receiving employment services with evidence that employment readiness has been discussed; • At least 86% of ISPs for individuals age 14-18 that have goals related to skill building toward employment.
16	**III.C.8.a**	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	DBHDS will conduct a bi-annual quality review using a statistically valid sample from individuals who used Medicaid and Waiver transportation services or data from case management monitoring visits and complaint data to evaluate whether transportation services provided by the Medicaid program and the Waiver program are reliable and safe and make necessary improvements.

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			Outcome: At least 86% of individuals using Medicaid and Waiver transportation services will have reliable transportation (e.g. prompt pick up and drop off times, and safe vehicles). The transportation vendor will adhere to contract requirements to: • Separate out IDD Waiver users in data collection and reporting and in the quality improvement processes to ensure that transportation services are being properly implemented for the members of the target population; • Encourage more users, including IDD Waiver users and/or their representatives, to participate in the Advisory Board process; • Periodically survey a sample of transportation users to assess satisfaction and to identify problems; and • Conduct focus groups with the IDD Waiver population in order to identify problems. The Commonwealth will ensure that the provisions in the contract will continue to apply when the services transition to Managed Care. DBHDS will provide all individuals relying on Medicaid and Waiver transportation with a process to file complaints.
17	**III.C.8.b.**	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.	DBHDS has developed a "My Life, My Community." website to publish information for families seeking developmental disabilities services that inform them how and where to apply for and obtain services. DBHDS will announce the website's availability as a resource to stakeholders and potential referral sources across the state and publish a link to the My Life, My Community website on the DBHDS website. Documentation indicates that the My Life, My Community website resource is distributed to list of organizations and entities that likely have contact with individuals on the waiver waitlist and their families. Documented by reports of activity on the website.

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18	**III.D.1**	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs. (**III.B.2**: The Commonwealth shall not exclude any otherwise qualifying individual from the target population due to the existence of complex behavioral or medical needs or of co-occurring conditions, including but not limited to, mental illness, traumatic brain injuries, or other neurological conditions.)	The Commonwealth will further implement the redesigned waivers (specifics below) and develop additional providers to serve individuals with complex behavioral or medical needs (specifics below). **Expanding Integrated Residential Options for Medically and Behaviorally Complex Individuals:** **Residential Services (additional provider development & implement redesign waivers)** DBHDS will establish a provider recruitment and training program (Network Development Plan) for service providers to meet the needs of people who are medically and behaviorally complex (i.e., those with a SIS score of Level 6 or 7) with a focus on Sponsored Residential services, as determined by the Commonwealth's published gap analysis. Include in the Commonwealth's Jump Start funding expenditures related to making home modifications, adaptive equipment and related supplies, support technology, staff training, cost of transition visits with the person, vehicle purchases or vehicle modifications. Evaluate the impact of the limitations on the Independent Living Supports service in the Building Independence Waiver (no more than 21 hours of support a week) and the Shared Living service in the Community Living Waiver (ADL and IADL supports account for no more than 20% of the companionship time) on the ability of individuals with complex medical and behavioral needs (i.e., those with a SIS score of Level 6 or 7) to live in the most integrated setting appropriate to their needs and modify the hours available in these services to enable this population to live in their own homes. **Support Services for Individuals Living with Families (implement redesign waivers)**

#	Provision	Provision text	Indicator
			To support medically complex individuals living with their family and to support the discharge of children from nursing facilities and ICFs, Virginia will: • Identify and remedy the barriers to providing private duty and skilled nursing services promptly (defined as 30 days from the day it is identified as a need in the ISP) and up to authorized levels; • Establish an ongoing periodic review process for measuring the promptness and on-going delivery of authorized service units for private duty and skilled nursing services in order to identify and remedy patterns of service delivery interruptions; and • Allow respite care to be provided through the Medicaid waiver by a nurse at nursing rates. Outcome measures: At least 86% of individuals will begin to receive authorized units of private duty and skilled nursing services within 30 days from the day it is identified as a need in the ISP. At least 86% of individuals will receive no less than 95% of the authorized units of private duty and skilled nursing services. **Reducing the Number of Children in Nursing Facilities and ICFs (implement redesign waivers & additional provider development)** DBHDS will: Establish a Department policy direction governing children's services that states: All children require Permanency and Attachment - A safe, secure environment with one stable, predictable, comforting, and protective adult who has a long term personal commitment to the child which is necessary for the child to develop a sense of self and well-being, trust in others, emotional stability and to learn and grow. Implement a structure and processes to screen children with IDD prior to admission to a ICF (a single point of entry).

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			Continue to track individuals under 21 who have been through the agency single point of entry (received a PASRR for a nursing facility and a VIDES assessment for an ICF) and have been admitted to nursing facilities and ICFs. Prioritize efforts to discharge individuals 10 years old and younger from ICFs. Assign a family-to-family peer support facilitator to nursing facilities and ICFs with children on long term stays who shall contact families of children on at least a quarterly basis, unless the family refuses contact, and conducts permanency planning for the child (i.e. develop a plan to transition the child home with the family or an alternate family or Sponsored Residential services (including next-of-kin) and to facilitate the transition home and secure community services to support them in the home). (Reference Texas Everychild model) Assign a CSB case manager 180 days prior to discharge to all children on long term stays in nursing facilities and ICFs to plan for discharge with the family. Outcome measures: Case managers will provide at least 86% of all children living in nursing facilities and ICFs, at least semi-annually, with individualized information in a manner that accommodates their cognitive disabilities, addresses past experiences of living in community settings and concerns and preferences about community settings, and includes facilitating visits and direct experiences with the most integrated community settings that can meet the individual's identified needs and preferences. Planning for transition to the most integrated setting appropriate to the individual's needs shall commence within 30 days of the case manager's visit unless the individual or the legal representative affirmatively opposes transition. **Assuring Community Integration (implement redesign waivers)**

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			Using data collected from licensing inspections, DBHDS will analyze the results for provider agencies for compliance with: *12VAC35-105-610. Community Participation. Individuals receiving residential and day support services shall be afforded opportunities to participate in community activities that are based on their personal interests or preferences. The provider shall have written documentation that such opportunities were made available to individuals served.* Failure to meet this standard will result in citations and the requirement to develop a plan to come into compliance. DBHDS will establish standards for community engagement that include: the type of activity; type of location; a definition for most integrated as it relates to interactions with nondisabled peers, and the range of potential outcomes. Train case managers to make a determination during their monitoring activities as to whether the person is receiving support as described in the person's plan and that the experience is consistent with the standards for the service. Waiver employment targets set by the Commonwealth in 2016 for FY 2019 and FY 2020 are met:

Fiscal Year	Total	Indv SE	Group SE	Total % of those on Waiver
2016 baseline	890 (actual)	225	665	(7.7%) 890/11,629
2019	1,661 (target)	830	831	14.2% (1,661/11,629)
2020	2,026 (target)	1,095	931	17.4% (2,026/11,626)

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			Targets will be considered to be met if the actual number of individuals who enroll in supported employment in the year and the number of individuals who remain in integrated work settings at least 12 months after the start of supported employment is within 5% of the targets set for that year.
19	**III.D.5**	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below. (**IV.B.9:** PSTs and the CSB case manager shall coordinate with the specific type of community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their Authorized Representative with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities.)	The Commonwealth, currently through a contract with the VCU Partnership for People with Disabilities, will track and report on outcomes with respect to the number of individuals on the waivers with whom the family-to-family and peer-to-peer supports have contact and the number who receive the service/support. At least 86% of those on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources. At least 95% of individuals being assigned a Community Living Waiver slot will be offered the opportunity to receive Family-to-Family or Peer Mentoring supports.

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20	**III.D.6**	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	At least 86% of all non-emergency referrals made to RSTs are made in sufficient time to resolve barriers and stabilize the person in the community. At least 86% of all situations meeting criteria for referral to the RST with respect to the residence type of placement are referred to the RST by the case manager as required. DBHDS will conduct a quarterly quality assurance review of each CSB to measure timeliness and to ensure that situations meeting the criteria for referral to the RSTs are being referred; will issue findings to the CSB; and when criteria for 86% timeliness and 86% of situations meeting criteria being referred are not met, DBHDS will require improvements and corrective actions to improve performance. All CSBs will submit corrective action plans when there is a failure to meet the 86% criteria for timely referrals and for referring 86% of the individuals to the RST whose situations meet criteria for referring. Failure to improve and meet criteria over a 12 month period will result in Virginia removing the entity as an authorized provider of case management. DBHDS will conduct data analyses periodically, but not less than on an annual basis, to ensure that DBHDS revised RST protocol and referral forms are improving the timeliness of referrals to RSTs; and that referrals are being made to RSTs in sufficient time for the RSTs to resolve barriers to ensure an informed choice of a more integrated setting to and stabilize the person in the community. DBHDS will develop a quality improvement process and protocol to resolve barriers related to the unavailability of a specific type of program competency/capacity. The protocol will enable RSTs to contact DBHDS managers with authority to resolve barriers.

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			Any case of a failure to remove obstacles which results in the admission of an individual to a nursing facility or congregate setting with five or more individuals, DBHDS will track activity to develop an alternative on a quarterly basis until an appropriate service is provided.
21	**III.E.2**	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	In order to sustain compliance, consistent with the Commonwealth's current practices: RSTs will continue to resolve identified barriers and to report trends of unresolved barriers to DBHDS.
22	**IV.A**	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	Same as IV.B.4
23	**IV.B.4.**	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most	Improve the capacity of the Training Center planning teams to develop person-centered plans that (based on the person's strengths and interests, what is important to them) identify community integration opportunities by: 1) training staff on the array of activities allowed under the waiver community engagement service definition; and

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		integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	2) providing experienced mentors to assist teams to develop and review the plans. All transition plans will contain at least one activity that enables the person to engage with their community.
24	**IV.B.6**	Discharge planning will be done by the individual's PST…Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	Same as IV.B.4
25	**IV.B.15**	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	In order to sustain compliance: At least 86% of all situations meeting criteria for referral to the RST with respect to the residence type of placement are referred to the RST by the Training Center staff as required and barriers to placement in a more integrated setting are identified.
26	**IV.C.5**	The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to	In order to sustain compliance:

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		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 from the Training Center. This determination will be documented. The absence of those services and supports identified as non-essential by the Commonwealth, in consultation with the PST, shall not be a barrier to transition.	At least 95% of all individuals have their essential supports in place at their community placement prior to the individual's discharge from the Training Center.
27	**IV.D.3**	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM. The CIM may consult at any time with the	Same as IV.B.15.

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		Regional Support Teams and will refer cases to the Regional Support Teams when: a. The CIM is unable, within 2 weeks of the PST's referral to the CIM, to document attainable steps that will be taken to resolve any barriers to community placement enumerated in Section IV.D.2 above. b. A PST continues to recommend placement in a Training Center at the second quarterly review following the PST's recommendation that an individual remain in a Training Center (Section IV.D.2.f), and at all subsequent quarterly reviews that maintain the same recommendation. This paragraph shall not take effect until two years after the effective date of this Agreement. c. The CIM believes external review is needed to identify additional steps that can be taken to remove barriers to discharge.	
28	**V.A**	To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-	*To comply with the requirements of V.A, the Commonwealth must be in compliance with all provisions in Section V of the Agreement.*

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		determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships), and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system that is consistent with the terms of this Section.	
29	**V.B**	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	*Also see metrics identified for V.D.3 related to service accessibility and availability.* 1. The Commonwealth has a Risk Management Review Committee (RMRC). The RMRC has a charter or other guiding document that defines the purpose, membership, frequency of meetings responsibilities (e.g., reports/data it should review, follow-up it should undertake, etc.), and the group's relationship to other committees, such as the Quality Improvement Committee (QIC), and Mortality Review Committee (MRC). a. The RMRC meets at least 10 times during the year. 2. The RMRC or other group designated by DBHDS has created overall risk management processes for DBHDS that are current and enable DBHDS to identify, and prevent or substantially mitigate, risks of harm. 3. The RMRC reviews incident data and other identified metrics at least two times per year by various levels including by Region, by CSB, by provider locations, by individual, by levels and types of incidents. Data is also reviewed across time (trends). Descriptive and bivariate statistics are used as appropriate to critically assess observed differences.

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			4. The RMRC uses the results of data reviewed to identify areas for improvement. Either the RMRC drafts quality improvement plans as needed, including identified strategies and metrics to monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts. The RMRC or QIC ensures that each quality improvement plan is implemented. 5. The Quality Improvement Committee (QIC), or designated subgroup, reviews a statistically valid sample of ISPs across CSBs at least annually to monitor the quality of the plans, and specifically whether the plans are person-centered, include goals selected by the person, document choices of service options presented to the person, provide for the person to receive services and supports in the most integrated setting that meets their needs, identify risks and their etiology/cause with measurable, clinically relevant outcomes/goals, include relevant support strategies to address risk, and whether these strategies are implemented, and whether the person signed the final version of the plan. 6. At least 86% of ISPs meet the standards in #5 above in the sample reviewed. 7. The RMRC, or designated subgroup, reviews a statistically valid sample of meeting minutes and recommendations from provider-level Incident Management Committees or the provider entity that fulfills these functions (see metrics for V.C.1) at least annually to monitor: a. The committee reviews all incidents in accordance with CMS expectations as described in the State's approved HCBS waiver application and the State's regulatory and policy requirements for incident management. b. The committee meets as frequently as needed to ensure the timely review of incidents. c. The Committee is composed of appropriate members consistent with CMS expectations as described in the State's approved HCBS waiver application and the State's regulatory and policy requirements.

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			d. The committee reviews incidents and associated investigations such that the committee: i. identifies the facts surrounding incidents as well as the contributing factors associated with incidents; ii. reviews incident investigation reports and discusses their findings and recommendations; iii. considers additionally needed corrective actions and remedies to prevent or reduce the likelihood of future similar incidents; iv. explicitly accepts or rejects the recommended corrective actions in investigations; tracks accepted recommended corrective actions to ensure that they are carried out in a timely manner. v. documents incidents reviewed and an adequate summary of their findings and recommendations and other activities of the committee. vi. identifies system-level themes across providers that may warrant action by DBHDS. 8. The RMRC, or other DBHDS-designated entity, audits a statistically valid sample of incidents reports and corresponding notifications, recommendations and corrective action plans at least annually. The samples should include at minimum: a. all allegations of physical or sexual abuse; b. all allegations of financial exploitation for amounts greater than $250; c. a statistically significant random sample of allegations of neglect; d. a statistically significant random sample of other "serious" incidents (not included above); and e. a statistically significant random sample of "non-serious" incidents. The review conducted during the audit monitors: a. Incident reports for incidents resulting in significant injuries are filed as soon as possible, but in all cases within 24 hours.

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			b. Incident reports provide a clear, complete, and legible description of the incidents. c. Incident reports (or associated documentation) provide a description of the provider's immediate response to the incidents. d. The providers' documented immediate responses to incidents ensure service recipients' safety and well-being. e. Incident reports (or associated documentation) show that law enforcement was notified of incidents that may be associated with possible criminal acts as soon as possible. f. Incident reports (or associated documentation) show that in accordance with State rules and regulations other external parties or other appropriate parties were notified of incidents according to state rules. g. Comprehensive, and nonpartial investigations of individual incidents occur within state prescribed timelines. h. Timely, appropriate corrective actions are implemented by providers in response to individual incidents i. Incident reports (or associated documentation) show that providers ensure a timely review of all incidents by senior management or the provider's Incident Management Committee or both. 9. At least 86% of reported incidents reviewed in indicator #8 meet criteria reviewed in the audit. 10. The Commonwealth informs providers, case managers, and other stakeholders of any systemic interventions required as the result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, critical incidents, and deaths. The Commonwealth informs providers of their responsibility to address such recommendations in a timely manner by implementing them or substantiating that they are unnecessary. 11. The RMRC issues training content and/or guidance as needed to CSBs and the provider agency community to address identified patterns in

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			service planning and implementation related to risk (both health and behavioral), including patterns found in review of provider-level Incident Management Committees, and those from incident reviews, and any related strategies. 12. DBHDS has set performance criteria for incident reporting compliance by individual service providers. DBHDS monitors reporting by provider agencies of incident reports as specified by DBHDS policies during all investigations of serious injuries and deaths and during regular Licensing reviews. At least 95% of providers meet standards. DBHDS requires corrective action plan or other interventions for 100% of providers who do not meet this requirement. 13. DBHDS' Quality Management System uses the processes in V.D.2-3 and considers all resulting findings of these processes to: • Identify any areas of needed improvement; • Develop improvement strategies and associated measures of success; • Implement the strategies within 3 months of identification; • Monitor identified outcomes at least annually using identified measures; • Revise the improvement strategy as needed; and • Identify areas of success to be expanded or replicated. The Quality Management System documents the information reviewed from V.D.2-3 and any corresponding decisions about whether an improvement strategy is needed and if so, each of the six bulleted points above. Through these processes, the Commonwealth ensures the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings.
30	**V.C.1**	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including	1. DBHDS will provide written guidance to Training Centers, CSBs, and providers about the minimum necessary standards of a provider-level risk management system, including minimum standards for the identification of risks, both behavioral and health-related, and corresponding support strategies. Guidance includes:

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		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.	a. Identification of one or more people responsible for risk management. b. Use of written plans to identify, monitor, reduce, and minimize risks associated with personal injury, infectious disease, management of chronic diseases, identification of emergent conditions and significant changes in conditions, behavior presenting risk to self or others. c. Use of structured, clinically valid risk screening/assessment tools. d. System components and associated activities, including data collection, assessment, and management, for provider-level monitoring. e. System components and associated activities, including data collection, assessment, and management, for individual-level monitoring. f. Oversight of the environment of care, clinical assessment and reassessment processes, staff competence in the service elements of each individual served, adequacy of staffing, use of high-risk procedures, including seclusion and restraint, and review of serious incidents. g. Identification by DBHDS, and use by CSBs and providers, of uniform risk triggers and thresholds in a manner enabling them to identify, monitor, reduce and minimize risks of harm. 2. Based on reviews conducted at least every two years for established CSBs/providers and prior to provision of services for new CSBs/providers, at least 86% of CSBs and providers will have risk management systems that meet all specified components, as set out in 1, above. Corrective action plans are written for CSBs/providers that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6. 3. Based on reviews conducted at least every two years, at least 86% of CSBs and providers use data, including at minimum data from incidents and investigations, to identify and address trends and patterns about harm and risk of harm in the events reported, as well as the associated

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			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. 4. CSBs and providers serving 100 or more people for more than 10 hours per week, or 50 or more people in residential services have an Incident Management Review Committee that reviews incident data for trends and patterns, and at least a sample of critical/sentinel incidents at least quarterly and documents meeting minutes and system-level recommendations. CSBs and providers make the documented minutes and recommendations available to the Commonwealth upon request. 5. Based on reviews conducted at least every two years for established CSBs/providers and prior to the provision of services for new CSBs/providers, at least 95% of CSBs and providers use a structured, clinically valid risk screening/assessment tool to identify individuals at high risk. Risks that the tool shall address include, but are not limited to, unplanned hospitalizations or emergency room visits; diagnosis, with recent acute episodes of choking, aspiration pneumonia, bowel obstruction, UTIs, change of mental status, decubitus ulcers; material increase in maladaptive behaviors; threat of residential or day services placement moves; or identification by providers or case managers of a significant deterioration in wellbeing. 6. Based on reviews conducted at least annually for CSBs/providers in compliance with DBHDS standards, and semi-annually for CSBs/providers that are not in compliance with all DBHDS standards, at least 95% of individuals assessed as high risk receive supports and services in a manner that prevents or significantly mitigates the high risk condition. Corrective action plans are written and implemented for all CSBs and providers that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6.

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			7. DBHDS has identified at least 5 types of required incident-based uniform triggers that monitor health, safety, and/or risk of harm, including thresholds for the trigger and requirements for frequency of monitoring. DBHDS has provided written guidance to CSBs and providers on how to use the triggers. 8. DBHDS has a process for CSBs and providers to provide alternative triggers for monitoring for specific individuals or conditions. Plans must be presented to the DBHDS RMRC and approved in order to be accepted for use as alternatives to the DBHDS triggers. 9. At least 86% of CSBs and providers monitor and appropriately respond to triggers (either required triggers, or DBHDS-approved alternatives), based on a statistically valid sample conducted by DBHDS at least annually. Corrective action plans are issued to CSBs and providers as needed and guidance is issued to the field as needed through the RMRC or similar DBHDS committee based on the results of this annual review. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6.
31	**V.C.3**	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken. The Commonwealth shall be required to implement the process for investigation and remediation detailed in the Virginia DBHDS Licensing Regulations (12 VAC 35-105-160 and 12 VAC 35-105-170 in effect on the effective date of this Agreement) and the Virginia Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers	1. The Commonwealth has a written process to investigate reports of suspected or alleged abuse, neglect, critical incidents, and deaths and identify remediation steps taken that adheres to the requirements in Virginia DBHDS Licensing Regulations and the Virginia Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services ("DBHDS Human Rights Regulations"). 2. The Commonwealth has systems to monitor the implementation of this process and documents that the process is consistently implemented as intended across the Commonwealth. 3. The Commonwealth maintains a tracking system for all recommendations for corrective actions emanating from incident reviews and investigations

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		Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services ("DBHDS Human Rights Regulations" (12 VAC 35-115-50(D)(3)) in effect on the effective date of this Agreement, and shall verify the implementation of corrective action plans required under these Rules and Regulations.	that includes each recommendation, the prescribed timeline, the person(s) responsible (including their name and title) and tracks corresponding activities. The Commonwealth utilizes systems to monitor the implementation and adequacy of corrective action plans required under these Rules and Regulations, and conducts ongoing monitoring of this system. 4. At least 86% of corrective action plans are fully implemented within specified timelines (with delays no greater than 30 days) annually. 5. Corrective actions will include double loop corrections, as needed. These include both immediate corrective actions and as well as actions that make the root cause of the problem less likely to occur in the future. 6. The Commonwealth has a process for and informs providers when corrective actions have been found to have been implemented inadequately based on the Commonwealth's review of implementation, or if additional corrective actions are advised through the Commonwealth's other monitoring procedures. 7. The Commonwealth reviews periodically, at least annually, its corrective action tracking systems to evaluate: a. the systems' overall performance in ensuring the timely implementation of accepted recommended corrective actions and b. the effectiveness of implemented corrective actions to achieve the intended outcomes.
32	**V.C.4**	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	1. DHDBDS will develop training material for providers on each of the following topics with an application to disability services, or at minimum to human services: a. proactively identifying and addressing risks of harm b. conducting root cause analysis c. developing and monitoring corrective actions.

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			2. DHDBDS offers written guidance to providers (including residential, day/employment, and case management) on how to proactively identify and address risks of harm. This content will include: a. Guidance on conducting individual-level risk screening b. Either a tool for risk screening selected by DBHDS or example resources for consideration by providers to use when conducting risk screening c. Guidance on how to incorporate the identified risks into service planning and how to adequately address the risks d. For risks common to people with developmental disabilities, guidance on considerations for how to appropriately and adequately monitor, assess, and address each risk. Within one year, the state will develop, with input from relevant professionals, at least 4 topical guidance documents for common risks faced by people with IDD, prioritizing those that contribute to avoidable deaths (e.g., choking, aspiration pneumonia, bowel obstruction, UTIs, change of mental status, decubitus ulcers), and will develop a plan for the development of additional topics as needed across domains such as health/medical, safety, social inclusion, and behavioral supports. 3. DBHDS offers written guidance to providers, and assesses that providers adequately implement training, on how to identify cases for and conduct root cause analysis. 4. DBHDS offers written guidance to providers on how to construct their systems to develop, implement and monitor corrective actions, as well as scenario-based training on best practices for using and implementing corrective actions. DBHDS requires providers to document their plans for corrective actions, as well as their actions taken and any related decisions to deviate from planned actions. 5. Training(s) in each topical area identified in objective 1 will be made available to providers for free on a consistent basis, meaning either

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			through online training resources, or in-person trainings offered at least twice per year in each region of the state. 6. Staff from at least 50% of community-based service providers have been trained in each of the areas in objective 1 by the end of the first year. 7. Within 1 year after the first trainings are offered, at least 50% of community-based service providers have identified staff who are responsible for and trained to identify sentinel (e.g., death, abuse, or preventable accident) or adverse events (e.g., consistent, repeated error; missed opportunity to recognize major change in health condition or service need) for further investigation, lead analyses of contributing systemic factors to these events, and monitor implementation of corrective actions.
33	**V.C.5**	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The Commissioner shall establish the monthly mortality review team, to include the DBHDS Medical Director, the Assistant Commissioner for Quality Improvement, and others as determined by the Department who possess appropriate experience, knowledge, and skills. The team shall have at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and	These objectives are predicated on DBHDS having a critical incident reporting system that collects report of deaths for all service recipients, and that common definitions exist for each of the fields in the system used to report deaths. 1. The Commonwealth has a policy or standard operating procedures for mortality review that governs: a. The charge to the mortality review committee b. The chair of the committee and an executive sponsor within DBHDS c. The membership of the mortality review committee (by role) d. The responsibilities of chair and members e. The frequency of activities of the committee (e.g. meetings) f. Rules about the deaths that must be reviewed (at minimum unexplained or unexpected deaths reported through its incident reporting system(s)), how high priority/urgent reviews (including a rapid review process for unexpected deaths) will be handled, what a complete review must entail (defined below), standards for closing a review, committee

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		nurse's notes, and all incident reports, for the three months preceding the individual's death; (ii) the most recent individualized program plan and physical examination records; (iii) the death certificate and autopsy report; 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.	quorum, recusal from case reviews, confidentiality protections for review, etc. g. Define "unexplained" and "unexpected" deaths h. The expected materials provided to committee members and the review procedures to be employed, which must include a periodic review to identify any system-level factors related to the death or person's service experience prior to death and reporting to the Quality Improvement Committee. 2. The Mortality Review Committee membership includes at minimum (where one person may satisfy up to 2 roles): a. DBHDS Medical Director b. DBHDS Assistant Commissioner for Quality Improvement c. A professional with clinical experience to conduct mortality review who is otherwise independent of the State d. A medical doctor e. A nurse f. DBHDS staff with quality improvement expertise g. DBHDS staff with programmatic/operational expertise 3. DBHDS will ensure that mortality review committee members have the information necessary to be an effective member, including information on how to conduct a systemic mortality review, and formal methods of contributory factor analysis. Mortality review committee members will be trained with these materials before they participate in a mortality review. 4. The Mortality Review Committee membership meets regularly (at least monthly) and at a frequency that enables the Committee to conduct required reviews for deaths. Meetings meet quorum requirements as set forth by policy, which at minimum require the presence of 1) a medical clinician, 2) a member with professional experience in conducting systemic mortality review, 3) a professional with quality improvement expertise, 4) a professional with

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			programmatic/operational expertise (one member may meet one or 2 categories). 5. DBHDS has and utilizes a system to track the screening, referral, and review of deaths, as well as the recommendations of the Mortality Committee and their implementation. 6. At least 95% of all deaths of DBHDS service recipients are screened within 30 days to determine whether a mortality review is needed based on the criteria in the mortality review policy. 7. At least 86% of deaths requiring a mortality review will have a complete review (defined below) by the mortality review committee within 90 days of the date of the death. a. A complete mortality review entails: i. The review of medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death, the person's most recent individualized program plan and physical examination records; the death certificate and autopsy report (if available); and any evidence of maltreatment related to the death; and ii. interviewing, as warranted, any persons having information regarding the individual's care. 8. DBHDS validates that all deaths of service recipients who live in licensed settings and all deaths of other service recipients known or reported to DBHDS have been reported as required through its incident reporting system through comparison with death certificates for DBHDS service recipients received by the VA Department of Health or similar source at least annually. 9. The mortality review committee utilizes procedures determined by their governing policy to prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and

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			recommendations, if any, for at least 86% of reviewed deaths within 90 days of the death. If the mortality review committee elects not to make any recommendations, it must affirmatively state that no recommendations were warranted. 10. The mortality review committee collects and analyzes aggregate mortality data at multiple levels (at minimum, provider, regional and statewide) to identify trends, patterns, and problems for all service recipients at least annually. Data analyzed includes at least the number and rate of deaths, findings from recently substantiated investigations of abuse/neglect, and causes/manner of death related to unexpected, accidental and intentional deaths. 11. The mortality review committee prepares an annual report of aggregate mortality trends and patterns for all DBHDS service recipients within 6 months of the end of the year (the annual interval may be selected by DBHDS as either fiscal or calendar). a. The annual report will, at minimum, include analyses of patterns of mortality by demographic factors (age, gender, race), residential setting or service program, manner of death, cause of death, and by substantiated abuse/neglect and will utilize both counts and rates of deaths (for licensed settings). The report will include the crude mortality rate of individuals served in licensed settings, the total number of deaths (in both licensed and unlicensed settings), and cause of death (in both licensed and unlicensed settings). b. At minimum, as summary of the findings should be released publicly. 12. The Mortality review committee documents recommendations for systemic quality improvement initiatives coming from patterns of individual reviews (on an ongoing basis), or patterns that emerge from any aggregate examination of mortality data (either twice annually or annually as relevant to the review). The Mortality review committee makes at least four recommendations for systemic quality

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			improvement initiatives based on aggregate patterns or trends annually. Recommendations will, at minimum, be submitted to the DBHDS Commissioner. 13. DBHDS develops and implements quality improvement initiatives, either locally (e.g. regionally) or statewide as determined by data patterns and trends and the significance of the underlying issue, to reduce mortality rates as recommended by the committee or documents why the recommendation was not implemented. The state broadly disseminates to service providers and to service recipients and their representatives relevant information about alerts, new resources/tools, etc. 14. Decisions regarding the implementation of each recommended quality improvement initiative made by the Mortality Review Committee are reported to the Committee by DBHDS on a regular basis, and at least quarterly, to enable the Committee to track implementation.
34	**V.C.6**	If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider pursuant to the DBHDS Human Rights Regulations (12 VAC 35-115-240), the DBHDS Licensing Regulations (12 VAC 35-105-170), Virginia Code § 37.2-419 in effect on the effective date of this Agreement, and other requirements in this Agreement.	1. The Commonwealth has processes to track whether Training Centers, CSBs, or other community providers fail to report harms and implement corrective actions. A report will be produced semi-annually with a list of providers that have failed more than once during the six month period of the report. 2. Service providers identified as having recurring deficiencies in the timely implementation of accepted recommended corrected actions shall be subject to actions by the Commonwealth, including fines, suspension of permission to enroll new participants, waiver contract termination, and/or decertification. The Commonwealth shall demonstrate that it is able to execute these allowed sanctions when and as needed. 3. The Commonwealth takes action with the provider (e.g., provides retraining, issues corrective action plans, or imposes sanctions) in accordance with current DBHDS Human Rights Regulations, the DBHDS Licensing Regulations, and Virginia Code § 37.2-419 for at

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			least 95% of Training Centers, CSBs, and other community providers demonstrating one or more failures within the year to report harms or implement corrective actions.
35	**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 DMAS/DBHDS, respectively.	<u>Data Collection and Analysis</u> 1. DBHDS has a written guidance document for an overall quality management and improvement structure and process, including: a. Identification of persons responsible for overall management of the QM function(s). b. Processes to oversee and monitor all processes related to the QM Strategy c. Identification of performance measures that will be assessed. d. Processes to review performance trends, patterns, and outcomes to establish quality improvement priorities. e. Processes to recommend changes to policies, procedures and practices, waivers, and regulation as informed through ongoing review of data. f. Processes to develop, review and approve QM Plans. g. Processes to ensure remediation activities are completed and to evaluate their effectiveness. h. Processes to report progress and recommendations to the QIC i. Processes to ensure QM information is communicated internally and externally. 2. DBHDS has a comprehensive inventory of performance measures, and has selected performance measures that will be assessed in alignment with measures identified in CMS-approved waivers. In addition to other metrics, DBHDS utilizes metrics specifically to assess whether the needs of individuals enrolled in a waiver are met, whether individuals have choice in all aspects of their selection of goals and supports, and whether there are effective processes in place to monitor individuals' health and safety. 3. DBHDS has critically evaluated the data sources used to measure system performance for completeness, reliability and validity, and re-

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			evaluates a data source when its reporting mechanisms change. DBHDS implements improvement strategies for data sources with deficiencies within 3 months of identifying a deficiency. Improvement strategies include the specific steps to be employed and defined measures for use in monitoring performance of the improvement strategy. Performance of the improvement strategy is monitored at least every 6 months. If such improvement strategies do not have the intended effect, a revised strategy is implemented and monitored. 4. DBHDS has a quality management and improvement plan that identifies practices to be adopted, modified, or eliminated; and associated measures to monitor effectiveness. Measures are monitored and plans are modified as needed based on results, and reviewed at least annually. <u>Needs of individuals enrolled in a waiver</u> 5. The Commonwealth ensures that the needed level of service as determined by the DBHDS service assessment (SIS or equivalent) is provided to all individuals enrolled in a waiver. 6. The Commonwealth ensures that at least 86% of individuals whose waiver application is approved are enrolled within three months of submission of the application. <u>Effective processes in place to monitor health and safety</u> 7. The Commonwealth has a process to track the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., choking, aspiration pneumonia, bowel obstruction, UTIs, change of mental status, decubitus ulcers) and to take prompt action when such events occur. *See III.C.5.b.i for metric regarding monitoring of case managers regular contacts with people receiving services to ensure monitoring of health and safety needs.*

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			DBHDS Plan components 8. DBHDS shall assess the development and monitoring of individual service plans; the assurance of qualified providers; and the identification, response and prevention of occurrences of abuse, neglect and exploitation at a minimum by utilizing the Quality Service Reviews. 9. DBHDS has written plans for the oversight of identification, response and prevention of abuse, neglect and exploitation. *See V.C.3 for other indicators related to this system.* 10. The Commonwealth has in place adequate administrative oversight functions as described in its HCBS waivers approved by CMS. The Commonwealth reviews adherence to these program specifications at least annually and is in compliance. 11. Providers of HCBS waiver-funded services for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, do not provide case management or lead the development of the ISP unless CMS has granted an exception to this requirement. If CMS has granted an exception, the Commonwealth has conflict of interest protections in place including separation of entity and provider functions within provider entities, which are approved by CMS. Individuals are provided with a clear and accessible alternative dispute resolution process under this CMS exception. 12. The Commonwealth has in place a financial audit program that ensures the integrity of provider billings for Medicaid payment of waiver services, consistent with the methods, scope and frequency of audits approved by CMS. The Commonwealth reviews adherence to these program specifications at least annually and is in compliance. 13. Metrics for section V.D.1 listed above are reviewed at local and state levels including by Community Service Boards (CSB) and the

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			Department of Medical Assistance Services (DMAS)/DBHDS at least annually. Metrics must be monitored for each CSB at least once every two years in good standing with the licensure review process, and at least annually for CSBs that perform below Virginia's prescribed levels of performance from licensure reviews or other disciplinary-related standing (e.g., placement holds, substantial corrective action). 14. Improvement recommendations will be written by DBHDS for any indicator that does not meet required levels, with a focus on systemic factors where present. Improvement recommendations include the specific strategy to be employed and defined measures that will be used to monitor performance. Improvement strategies are implemented within 3 months and are monitored at least every 6 months. If such improvement strategies actions do not have the intended effect, a revised strategy is implemented and monitored.
36	**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,	*In addition to the indicators identified for provisions V.D.1 and V.B:* 14. The Commonwealth assesses data quality, including the validity and reliability of data, and remediates any issues. 15. At least 95% of all incidents of deaths and serious injuries (Levels 2 and 3 per VA incident level definitions) are reported within 24 hours of occurrence in the DBHDS Computerized Human Rights Information System (CHRIS). 16. To validate that medical-related incidents are reported, the Commonwealth conducts a Medicaid Data Correlation Audit at least annually focused on waiver service recipients whose care and supports are largely the responsibility of paid service providers, including: • individuals in residential services, • individuals who receive in-home paid staff supports at least 40 hours a week, and

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		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.	• individuals who receive day services at least 20 hours a week. Medicaid services data screened includes services associated with: a. Allegations of abuse, neglect and/or exploitation; b. hospital emergency room visits; c. unplanned hospitalizations; d. ambulance services; e. urgent care center visits caused by accidental injuries. At a minimum, one quarter of Medicaid services data is reviewed per calendar year for each active HCBS waiver under the direction of DBHDS. 17. DBHDS uses its *Incident Management Report* or equivalent tool to monitor incident and investigation data at least biennially to identify trends, patterns, strengths, and problems at the individual, service-delivery, and systemic levels. Findings are reported to the RMRC or equivalent DBHDS committee that identifies and implements any additional corrective actions that are needed including needed state-wide and regional remedies as well as needed remedies for select groups of service recipients and providers. 18. DBHDS tracks and documents the efficacy of at least 95% of preventative, corrective, and improvement measures. 19. DBHDS demonstrates annually at least 3 ways in which it has utilized findings from aggregate data review or systemic factor review (such as root cause analysis) to enhance outreach, education, and training. DBHDS tracks the number of activities for outreach, education and training as well as at minimum satisfaction data from education/training activities directly provided to learners. 20. DBHDS will develop preventative, corrective, and improvement measures to address at least 98% of identified problems. 21. DBHDS has and utilizes a system for tracking the efficacy of preventative, corrective, and improvement measures. DBHDS uses this

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			information with its QIC or other similar interdisciplinary committee to identify systemic weaknesses or deficiencies and make and implement recommendations to address them. 22. DBHDS reviews at least annually data from the Quality Service Reviews and *National Core* Indicator data 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 and implemented as needed from this review by DBHDS. 23. 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. 24. DBHDS collects and analyzes data collected as part of the discharge and transition planning process at least annually to identify any quality issues with these processes based on provisions in Section IV. DBHDS develops corrective action(s) based on its analysis, tracks the efficacy of that action, and revises as necessary to ensure that the action addresses the deficiency.
37	**V.D.3.a.-h**	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case	1. For each of the subsections of V.D.3, the following activities will be expected of DBHDS: • Finalize measures to inform each area of focus (subsections a through h, infra) • Identify data sources for the area of focus • Measure and document validity and reliability of measures. Demonstrate acceptable levels of validity and reliability for the sources used

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		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:	• Set levels of performance for each area of focus • Measure performance across each area of performance. *Specific requirements have been added within areas of focus to ensure alignment of metric.* 2. DBHDS will document each of the foregoing steps by area of focus to facilitate independent review. 3. Data developed pursuant to these steps will be shared at minimum with the QIC and RMRC, as well as the Commissioner.
	V.D.3.a	Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);	1. Finalize measures for "safety and freedom from harm," at minimum including a. Individual service recipients are free from neglect and abuse b. Individual service recipients are adequately protected from serious injuries c. Seclusion or restraints are utilized only 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 d. Corrective action plans are effective e. Individuals receiving residential services feel safe in their homes (informed by NCI) 2. Identify data sources for "safety and freedom from harm" at minimum addressing: a. neglect and abuse, b. injuries, c. use of seclusion or restraints, d. deaths, e. effectiveness of corrective actions, f. licensing violations 3. Measure and document validity and reliability of measures. Demonstrate acceptable levels of validity and reliability for the sources used

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			4. Set levels of performance, at a minimum 86%, for "safety and freedom from harm" 5. Measure performance across "safety and freedom from harm" measures.
	V.D.3.b	Physical, mental, and behavioral health and well being (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status));	1. Finalize measures to inform "Physical, mental, and behavioral health and well being" and ensure alignment with metrics to inform "Effective processes in place to monitor health and safety" for provision V.D.1. 2. Identify data sources for "Physical, mental, and behavioral health and well being"; ensure alignment with data sources to inform "Effective processes in place to monitor health and safety" for provision V.D.1. 3. Measure and document validity and reliability of measures. Demonstrate acceptable levels of validity and reliability for the sources used 4. Set levels of performance for "Physical, mental, and behavioral health and well being"' in alignment with those specified for metrics informing "Effective processes in place to monitor health and safety" for provision V.D.1. 5. Measure performance across "Physical, mental, and behavioral health and well being" measures.
	V.D.3.c	Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);	1. Finalize measures to inform "Avoiding crises" 2. Identify data sources for "Avoiding crises". At minimum address: a. Number and demographics of people using crisis services b. admissions to emergency rooms or hospitals, c. admissions to Training Centers or other congregate settings, d. contact with criminal justice system, including at least interactions with the police, arrests, and incarceration 3. Measure and document validity and reliability of measures. Demonstrate acceptable levels of validity and reliability for the sources used 4. Set levels of performance for "Avoiding crises" 5. Measure performance across "Avoiding crises" measures.
	V.D.3.d	Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);	1. Finalize measures to inform "stability." At minimum include a. The number of times service recipients change from their chosen living arrangement

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			b. The number of times service recipients change from their chosen providers c. The number of times service recipients change from their chosen work or day program 2. Identify data sources for "stability". 3. Measure and document validity and reliability of measures. Demonstrate acceptable levels of validity and reliability for the sources used 4. Set levels of performance for "stability" 5. Measure performance across "stability" measures.
	V.D.3.e	Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);	1. Finalize measures to inform each "Choice and self-determination." At minimum, include metrics identified for provision V.D.1 2. Identify data sources for "Choice and self-determination". At minimum, include data sources identified for provision V.D.1 3. Measure and document validity and reliability of measures. Demonstrate acceptable levels of validity and reliability for the sources used 4. Set levels of performance for "Choice and self-determination"' 5. Measure performance across "Choice and self-determination" measures.
	V.D.3.f	Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);	1. Finalize measures to inform "Community inclusion." At minimum include: a. Percent of service recipients who report being able to go out and do the things they like to do, by service type b. Percent of service recipients who report being able to go out and do the things they like to do as frequently as they would like, by service type c. Percent of service recipients who report that they have enough things to do at home, by service type d. Percent of service recipients who attend school or participate in other educational opportunities, by service type e. Percent of service recipients who participate in community groups, including average frequency and duration of activity. f. Percent of residential service recipients who went on errands in the past month, including average frequency and duration of activity

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			g. Percent of residential service recipients who went on vacation in the past year, including average frequency and duration of activity h. Percent of residential service recipients who went out to eat in the past month, including average frequency and duration of activity i. Percent of residential service recipients who went out to entertainment in the past month, including average frequency and duration of activity j. Percent of residential service recipients who went shopping in the past month, including average frequency and duration of activity k. Percent of residential service recipients who went to a religious service or spiritual practice in the past month, including average frequency and duration of activity l. Percent of residential service recipients who participated in activities with non-paid individuals who did not have IDD, including average frequency and duration of activity. 2. Identify data sources for "Community inclusion", at minimum include National Core Indicator data and QSR reviews. 3. Measure and document validity and reliability of measures. Demonstrate acceptable levels of validity and reliability for the sources used 4. Set levels of performance for "Community inclusion". For any measures informed by National Core Indicators, the performance level is at or above the national average performance for the most recent NCI reported data. 5. Measure performance across "Community inclusion" measures.
	V.D.3.g	Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and	1. Finalize measures to inform "Access to services." At minimum, include: a. The Commonwealth ensures that the needed level of service as determined by the DBHDS assessment is provided to at least 86% of applicants assigned to Priority 1 of the waiting list within 1 year. b. The Commonwealth ensures that the needed level of service as determined by the DBHDS assessment is provided to at least 86% of applicants assigned to Priority 2 of the waiting list within 5 years.

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			c. Proportion of service recipients who reported they are always able to get rides for recreational activities d. Proportion of service recipients who reported they are always able to get rides for work or appointments e. Proportion of people who receive the adaptive equipment for identified needs in assessments and other service planning materials. f. Services provided meet service recipients' identified needs for cultural and linguistic competencies g. Services are available in all geographic areas of the Commonwealth. 2. Identify data sources for "Access to services". At minimum, include: a. waitlists, b. documentation of outreach efforts, identified barriers, service gaps and delays, c. a statistically valid sample of risk assessments and ISPs at minimum to inform needs for adaptive equipment, transportation, and cultural and linguistic competency 3. Measure and document validity and reliability of measures. Demonstrate acceptable levels of validity and reliability for the sources used 4. Set levels of performance for "Access to services. For any measures informed by National Core Indicators, the performance level is at or above the national average performance for the most recent NCI reported data. 5. Measure performance across "Access to services" measures, including across state regions.
	V.D.3.h	Provider capacity (e.g., caseloads, training, staff turnover, provider competency).	1. Finalize measures to inform "Provider capacity," at minimum: a. Direct support staff turnover by provider b. Provider staff vacancy rates c. Percentage of staff that have received competency-based training d. percentage of staff that have demonstrated competency, in both core competencies and in elements of service for the individuals they serve 2. Identify data sources for "Provider capacity", at minimum:

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			a. Caseloads across providers b. Office of Licensing Services (OLS) and Department of Medical Assistance Services (DMAS) citations, c. completion of Service Coordinator/Case Manager training and competencies by provider, and d. direct support professional and supervisor completion of training and competencies by provider 3. Measure and document validity and reliability of measures. Demonstrate acceptable levels of validity and reliability for the sources used 4. Set levels of performance for "Provider capacity"'. Staff stability measures should use National Core Indicator national averages as benchmarks. 5. Measure performance across "Provider capacity" measures.
38	**V.D.4**	The Commonwealth shall collect and analyze data from available sources, including, the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g., providers, case managers, Quality Service Reviews, and licensing), Quality Management Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	1. The Commonwealth collects and analyzes, using valid analytic procedures, data from, at minimum: a. risk management system described in V.C. above, b. Measures identified in metrics related to V.D.3.a-h, c. Provider's performance on their identified goals and objectives identified in quality improvement plans, d. Provider data reported to the Commonwealth related to service provision, incidents, and individual-level outcomes, e. Provider reports on root cause analysis findings and strategies as well as their implementation status, f. Corrective actions issued and related steps performed, g. a statistically valid sample of risk assessments and ISPs, h. National Core Indicators, i. Quality Service Reviews, j. licensing, k. Quality Management Reviews, l. the crisis system, m. service and discharge plans from the Training Centers, n. service plans for individuals receiving waiver services, o. Regional Support Teams, p. CIMs,

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			q. Waitlists
39	**V.D.5**	The Commonwealth shall implement Regional Quality Councils that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	The metrics listed for all portions of V.D.5 are predicated on the continued compliance of V.D.5.a for each RQC: "The councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders." 1. DBHDS has a guiding document (e.g., policy, practice guidelines, etc.) for Regional Quality Councils that dictates at minimum the charge/purpose, membership (by role), leadership and responsibilities, meeting frequency, structure and quorum, process for recruiting/approval of new members, and other activities to be conducted by the councils. DBHDS orients at least 86% of RQC members based on this guiding document and on quality improvement, data analysis and related practices. 2. Each DHDBS Region has convened a RQC. 3. Each RQC identifies at least two topics of quality initiatives (for example, choice in services, or employment outcomes) and establishes quality indicators to guide monitoring and discussion per year. 4. Relevant and reliable data is prepared and presented to the RQCs for at least 86% of their identified quality indicator topic areas annually. Data presentations include comparing with other internal or external data that provide context and meaning of the relative performance of measures, as well as multiple years of data (as it becomes available). 5. DBHDS staff in the Office of Data Quality & Visualization and Offices of Quality Improvement review the preparation of data for presentation to the RQCs for at least 86% of presentations. 6. Each RQC reviews and assesses (i.e. critically considers) the data that is presented to identify: a) possible trends, b) questions about the data and c)

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			any areas in need of quality improvement initiatives. The RQC identifies themes across each of these areas and records them in meeting minutes.
40	**V.D.5.b**	Each council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.	1. Each RQC meets, with a quorum, at least 3 of the 4 quarters with membership as outlined in the RQC guiding policy. A quorum is defined as at least 60% of members and must include representation from the following groups: the DBHDS Quality Improvement Committee (QIC), an individual experienced in data analysis, a DD service provider, and at least two individuals receiving services or a family member of a service recipient. 2. The meeting agenda for each meeting includes at minimum: a. at least 1 data presentation, or continued discussion about the data presentation from a prior meeting that relates to one of the identified quality indicators for that year; and b. Feedback from DBHDS about RQC recommendations or questions from prior meetings where relevant. 3. DBHDS shares data with members at least two days prior to the meeting. Lay summaries of data presentations are provided to RQC members at or before meetings. DBHDS offers support and pre-meeting time to review meeting materials in advance to individuals receiving services who participate as RQC members. 4. Each RQC maintains meeting minutes for 100% of meetings. Meeting minutes must include key discussion points brought up by RQC members, and decisions and recommendations of the RQC. a. The RQC chair(s) review 100% of meeting minutes and either recommend revisions, or sign-off on RQC minutes as an accurate reflection of the relevant discussion and recommendations resulting from the meetings. 5. For each priority area identified by the RQC, the RQC either a) determines that no quality improvement initiative is necessary in the area, b) more information/data is needed for the topic area, or c) forms at least

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			one recommendation related to quality improvement initiatives for the Region and/or for DBHDS. 6. For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC for each quality indicator. 7. 100% recommendations agreed upon by the RQC are captured in meeting minutes. 8. 100% of RQC recommendations are presented to the DBHDS QIC. 9. DBHDS QIC reports back to the RQC on its consideration and any related progress on each outstanding recommendation at least annually.
41	**V.D.6**	At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	1. DBHDS publishes information, updated at least annually, on DBHDS service programs including the home and community-based service (HCBS) waiver, crisis services, employment services and any other service program operated by DBHDS for people with developmental disabilities, including: • Number of people currently receiving services under each waiver, reported at minimum by: o Type of service o Geographic region o Support level • Number of individuals residing at training centers by training center. • Number of individuals currently residing in a nursing home or Intermediate Care Facility by region. • Analysis of quality of services and service gaps experienced by current service recipients (for example within specific regions, across types of services, related to choices of services, etc.) and projected for future service recipients (e.g., those on the priority one waiting list). • Benchmarks for comparison

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			2. DBHDS shall provide quarterly updates to information about the number of people waiting for services: • Number of people waiting for services, at minimum by geographic region, and including priority levels. • Number of people admitted from the waitlist by priority area • Analysis of service gaps informed by waiting list members, including metrics related to the amount of time that people have been on the waiting list by priority level. (For example, the percent of people who have been waiting 0-6 months, 7-12 months and >1 year, 1-5 years, >5 years.) • Benchmarks for comparison • Discussion of current waitlist management strategies • Recommendations for addressing service gaps. 3. The Commonwealth makes information about the licensure of service providers, inspection or investigation reports, and associated quality service reviews available to the public for all licensed providers within 60 days of the end of a licensure review and/or QSR process. Information is reported by provider in a manner on the DBHDS website that enables visitors to review information by provider. 4. DBHDS publishes an annual Quality Management Plan report online. The report should contain information about the quality of supports and services in the community and gaps in services, and shall make recommendations for improvement in the following areas, at minimum: • Facility-based Quality measures and related strategies employed for quality improvement • Case Management Quality measures and related strategies employed for quality improvement • Quality Service Reviews (QSR) • National Core Indicators (NCI) – a summary of relevant findings from NCI data (or bi-annually if data is not collected annually) • Quality improvement initiatives stemming from mortality reviews

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			• A summary of areas reviewed by the DBHDS Quality Improvement Committee (QIC) and RQCs, along with recommendations and any strategies employed for quality improvement. • Outcomes related to DBHDS's identified quality measures for developmental services, with analysis and associated recommendations if not already covered by above areas. 5. DBHDS publishes its Annual Report online. The annual report is directly responsive to areas contained within the DBHDS Comprehensive State Plan, and within the Settlement Agreement. It includes information about the people served, waitlists and other gaps in services, metrics that measure quality of services and any related recommendations or initiatives to improve quality.
42	**V.E.1**	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program, including root cause analyses, that is sufficient to identify and address significant issues and is consistent with the requirements of the DBHDS Licensing Regulations at 12 VAC 35-105-620 in effect on the effective date of this Agreement and the provisions of this Agreement.	1. DBHDS will provide written guidance to Training Centers, CSBs and providers about the minimum necessary standards of a quality management and improvement system. Guidance includes requirements for: a. A quality improvement plan that is reviewed and updated at least annually. b. Establishment of measurable goals and objectives, including any measures required for monitoring by DBHDS, including those required pursuant to V.E.2. c. Regular review of data related to service provision, incidents, and individual-level outcomes, including the use of Virginia's Incident Management Report or equivalent report. d. Identification, monitoring, and evaluation of clinical and service quality and effectiveness on a systematic and ongoing basis. e. Utilization of standard quality improvement tools, including root cause analysis. f. Implementation of a process to regularly evaluate progress toward meeting established goals and objectives. g. Implementation and monitoring of any corrective action plans, and revision of such corrective action plans when necessary.

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			2. The Commonwealth requires (through contract, regulation, instruction, or otherwise) that all CSBs and providers have documented quality improvement programs that accurately measure evidence-based indicators, that comprehensively monitor the CSB's or provider's provision of services and resulting individual outcomes, and that provide information about deficiencies and areas for improvement. This includes the prioritization of quality improvement initiatives and the gathering and review of data regarding initiatives' implementation and efficacy. 3. At least 86% of providers and 100% of CSBs have, and implement, quality improvement programs that meet all specified components in #1 above. Compliance assessments occur at least every 2 years for all CSBs and established providers, and prior to provision of services for new providers. Corrective action plans are written for providers that do not meet standards. 4. At least 86% of all providers, and 100% of all Training Centers (with 15 or more DBHDS service recipients at the Training Center) and CSBs will conduct root cause analyses in response to each major negative event within their services or trends of multiple negative incidents to identify and address significant issues. As part of the root cause analysis, Training Centers, CSBs, and providers will keep written documentation of major contributory factors, identified prevention strategies, their decisional analyses, and related progress on each strategy's implementation.
43	**V.E.2**	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting	1. DBHDS has developed measures that CSBs and other community providers are required to report to DBHDS on a regular basis, and DBHDS has informed CSBs and other community providers of these requirements. The sources of data for reporting shall be CSBs' and other community providers' risk management/critical incident reporting or their QI program. Measures must:

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		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.	a. Assess both positive and negative aspects of health and safety and of community integration; and b. Be selected from the relevant domains listed in Section V.D.3 above. 2. DBHDS requires regular reporting, at least once per quarter, of each measure from all providers and CSBs. 100% of CSBs and at least 95% of community providers report the measures as required. 3. At least one measure is monitored and reviewed by the DBHDS Quality Improvement Committee each quarter, with input from Regional Quality Councils, described in Section V.D.5. The QIC identifies systemic deficiencies or potential gaps, issues recommendations and specific action steps based on its review, and monitors implementation of those recommendations and action steps. 4. The DBHDS Quality Improvement Committee assesses the validity of each measure selected for monitoring at least annually. Translational validity (face and content validity) has been determined by review by two or more experts in the field as to whether the measure fit the conceptual definition of the construct. Criterion validity has been assessed via correlation with other criterion considered highly representative of the construct and/or predictive of the measure, with a target correlation coefficient of at least 0.5. a. Any measures that do not meet commonly accepted levels of validity are revised to improve the validity. Validity should be reassessed for any revised measures, with revisions continuing as needed until accepted levels of validity are achieved.
44	**V.E.3**	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and	In addition to the metrics for V.I.1: 1. The Commonwealth assesses and makes a determination of the adequacy of providers' management and improvement system in the first year of

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		other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	operation and annually thereafter for providers who met standards, and semi-annually for those that did not, through, at minimum, review of: a. The provider's written quality improvement plan; b. The provider's performance on goals and objectives identified in the quality improvement plan, as well as strategies employed to achieve the goals and objectives; c. Findings from Quality Service Reviews; d. Review of the provider's performance data, including data reported to the Commonwealth related to service provision, incidents, and individual-level outcomes; e. Provider reports on root cause analysis findings and strategies as well as their implementation status; and f. Corrective actions issued and related steps performed. 2. The Commonwealth provides technical assistance to, and/or other documented oversight of, providers whose quality management and improvement system the Commonwealth determines to be inadequate. The Commonwealth continues to provide this assistance and/or oversight until the Commonwealth determines that provider has demonstrated that it has effectively implemented an adequate quality management and improvement system.
45	**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	In consultation with the Independent Reviewer, DBHDS shall define and implement in its policies, requirements, and guidelines, "change of status or needs" and the elements of "appropriately implemented services." A statistically valid sample of all CSB entities' individual Service Plans (ISPs) and related records will be audited within six months and thereafter annually to determine: 3. The case manager assesses risk and risk mediation plans are in place as determined by the ISP team **(V.F.2; III.C.5.b.ii)** 4. The case manager assesses whether the person's status or needs for services and supports described in the ISP have changed and the plan has been modified as needed **(V.F.2; III.C.5.b.iii)**

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		the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.	5. The case manager develops ISPs that address all of the individual's risks, identified needs and preferences **(V.F.2; III.C.5.b.ii)** 8. The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary **(III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)** 9. The case manager completes assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their needs **(V.F.2; III.C.5.b.iii)** See V.F.5 for specific domains 10. The CSB has in place, and the case manager uses, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including but not limited to reconvening the planning team (**III.C.5.b.iii; V.F.2)** 100% of the CSBs meet these criteria in at least 86% of the sample individuals Corrective actions plans are imposed on CSBs for any element that has less than 86% compliance, consistent with CMS assessment standards CSB failure to meet the 86% standard over 12 months will result in Virginia imposing contract sanctions. The Commonwealth tracks and analyzes data from reviews annually to determine the presence of systemic obstacles to meeting individuals needs that are either at the local level or statewide level in order to institute broader remedies to improve performance.
46	**V.F.4**	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from	A data collection system that produces reliable and routine reports on the number, type and frequency of case manager contacts with individuals on a monthly basis is established. See **III.C.5.d** for a for description of quality

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		the case managers on the number, type, and frequency of case manager contacts with the individual.	management requirements, **III.C.5.b.i.** and **V.F.5** for the data elements that should be collected.
47	**V.F.5**	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	By meeting **III.C.5.b.i.** (which contains the elements to measure whether the service plan is implemented and is meeting the person's needs) and **V.D.3** (which delineates the domains for data collection related to "positive and negative outcomes for both health and safety and community integration") this provision will be met.
48	**V.G.3**	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	1. DBHDS has a process to review the qualifications of providers and utilizes this process with 100% of new providers and conducts reviews of 100% of providers needing re-licensure. 2. The Commonwealth has a process to measure the adequacy of supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3. This process shall also measure the adequacy of behavioral services and supports provided to people with identified behavioral support needs in their service plans, including in settings that are licensed by DBHDS. 3. DBHDS has informed CSBs and providers of its expectations regarding individualized supports and services, as well as the sources of data that it utilizes to capture this information. 4. The Commonwealth ensures that CSBs and service providers have systems to monitor health and safety. CSBs assess that services remain

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			appropriate and are being appropriately delivered during face to face visits, as provided in V.F.2.
49	**V.H.1**	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	1. DBHDS provides requirements of core competencies for any staff providing direct support services, including but not limited to direct support professionals (DSPs) and their supervisors in programs licensed by DBHDS, that are measurable and at minimum include competencies in: a. The characteristics of developmental disabilities and Virginia's DD waivers; b. Person-centeredness and related practices (in alignment with CMS definitions) and self-determination awareness; c. Crisis Prevention and Intervention including positive behavioral supports, effective communication; d. Evaluation and Observation; e. Good Health: Appropriate Health Care and Wellness, medication administration, DBHDS-identified health risks and the appropriate interventions; f. Common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., choking, aspiration pneumonia, bowel obstruction, UTIs, change of mental status, decubitus ulcers), early warning signs of such risks, and how to avoid such risks; g. Abuse/neglect reporting requirements; h. Safety: safe home environments, safe operation of equipment and strategies to keep people safe in the home and in the community, emergency preparedness; i. Community Integration & Social Inclusion: building and maintaining positive relationships & being active and productive in society; j. Service Requirements: understanding of protocols and documentation, professionalism, and ethics; k. Empowerment & Advocacy including rights and choice; l. Cultural Competence; m. Safe transportation (for staff involved in transportation).

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			2. DBHDS provides requirements that any staff providing direct support services, including but not limited to direct support professionals (DSPs) and their supervisors in programs licensed by DBHDS, receive training on the individualized service plan and related needs of each individual ("elements of service"), including individual behavioral, health, and safety protocols, prior to providing direct supports to the person, and that this training and demonstration of the competency is documented. 3. DBHDS provides requirements of competencies specifically for supervisors of programs licensed by DBHDS that are measurable and at minimum include competencies in: a. DBHDS provider reporting requirements (e.g., CHRIS.) b. Person-centered planning and support plan development, including CMS-defined requirements for planning process and the resulting plan c. Risk assessment d. Management of safe service environments (i.e. infection control, oversight of medication administration, etc.) e. Facilitating access to medical care for service recipients f. Service management and quality assurance g. Best practices in supervision, promoting professional relations and teamwork, staff recruitment, selection, hiring and development 4. At least 90% of all residential managers have completed supervisory training and have demonstrated acceptable levels of competencies within 30 days of hire. 5. DBHDS provides requirements to service providers for: a. Requirements for staff training prior to service delivery b. Guidance on the frequency of in-service training c. Staff (roles) required to be trained d. Documentation requirements for evidence of staff training regarding job expectations and demonstration of the skills learned and associated record retention requirements

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			e. Criteria for acceptable evidence of skill and knowledge gain f. Consequences for providers for failure to adhere to requirements 6. DBHDS notifies providers of requirements within 30 days for new providers and on an annual basis for current providers. 7. At least 86% of all DSPs and DSP supervisors have been trained in and demonstrate acceptable levels of core competencies within 90 days of hire as assessed via in person observation and written competency assessments. 100% of DSPs who have not yet demonstrated the core competencies are accompanied and overseen by other qualified staff who have passed the core competency requirements in the provision of any direct services. 8. At least 86% of all staff providing direct services (including DSPs and DSP supervisors) have been trained and demonstrated competency in each individual's service plan protocols prior to providing direct services to the person.
50	**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.	*In addition to items identified in V.H.1:* 1. DBHDS has in a written guiding document: a. A definition of coaches and supervisors and their intended role, and of trainees b. Criteria for the competencies that must be demonstrated by coaches and supervisors in providing the service they are coaching and supervising c. A defined process for assessing competency and who should have the authority to observe and determine competency. d. Guidelines on expectations for how coaches and supervisors should interact with trainees, and the training they should provide. e. A process for how trainees will be identified and connected with coaches/supervisor. f. Specifications for how the process components of the program and associated outcomes of the statewide training program will be

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			tracked. Measures are sufficient in order to assess the adequacy of the coaching/supervision. 2. The Commonwealth has competent coaches and supervisors identified and available to trainees. 3. Trainees have been identified. At least 86% of trainees have been connected with a coach or supervisor within 3 months of identification/request. 4. At least 86% of trainee coaching/supervision in the program have been determined to be adequate.
51	**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. QSRs shall collect information through: a. Face-to-face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and b. Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers.	1. Quality Service Reviews are conducted annually on statistically valid samples of people receiving services. Each individual served has a chance to be included in the survey. 2. Quality Service Reviews utilize information collected from the following sources for individual service-recipient level reviews, at minimum: • Interviews of Individual waiver service recipients, Family or Guardians (if involved in the person's life), case managers, and service providers. • Records are reviewed from the case manager, the Individual Support Plan, the Provider Record, provider Policies and Procedures, incident reports • Direct observation of the individual waiver service recipient occurs at each of their service sites (e.g. Residential and/or Day Programs) 3. Interviews of Individual waiver service recipients are conducted in private areas where provider staff cannot hear the interview or influence the interview responses. Interviews with provider staff are conducted in ways that do not permit influence from other staff or supervisors. 4. The Quality Service Reviews assess on an individual service-recipient level whether:

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			• Individuals' needs are identified and met, including health and safety. • Person-centered thinking and planning is applied and people are supported in self-direction, in accordance with their person-centered plan. • Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs. • Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice. • Individuals have opportunities for community engagement and inclusion in all aspects of their lives. • Any restrictions on individual's rights are in approved plans and constitute the minimum necessary restrictions to ensure safety of the person and others. 5. Quality Service Reviews utilize information collected from the following sources for provider level reviews, at minimum: • All materials and results from individual service-recipient level QSRs • Interviews of multiple levels of service provider staff including direct support workers and managers. • Review of data across the organization including incident reports, all key performance data tracked by the provider, the provider contract and/or license and documentation of required activities, provider policies and procedures, any documentation pertaining to requirements under the Settlement agreement of providers. • Direct observation of service provision at site(s) of service during hours when people are receiving services. 6. The Quality Service Reviews assess on a provider level whether: • Services are provided in safe and integrated environments in the community.

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			• Person-centered thinking and planning is applied to all service recipients. • Providers keep service recipients safe from harm, and access treatment for service recipients as necessary. • Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols. • People receiving services are provided opportunities for community inclusion. • Providers have active quality management and improvement programs, as well as risk management programs. • Providers are in compliance with contracts and/or licensing requirements. • Providers are in compliance with requirements pertaining to providers in the Settlement Agreement. 7. The Quality Service Reviews assess on a system-wide level whether: • Services are provided in safe and integrated environments in the community. • Person-centered thinking and planning is applied to all service recipients. • Providers keep service recipients safe from harm, and access treatment for service recipients as necessary. • Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols. • Service recipients are provided opportunities for community inclusion.

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			• Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice.
52	**V.I.2**	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels.	1. DBHDS has a formal assessment process (SIS or equivalent) that is consistently applied across applicants for evaluating and assigning the level of care for the individual. The level of care must be related to the level of need determined by the evaluation. The assessment process for level of care is not based on the current availability of services and supports. 2. 100% of applicants for services receive an assessment and level of care determination within 90 days of application. 3. DBHDS has a structured person-centered planning process (in alignment with CMS definitions) in place for the development of individual service plans that builds 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. The planning process includes the following components, as measured by the QSR: a. Is timely and occur at times and locations of convenience to the individual. b. Only includes people chosen by the individual c. Reflects cultural considerations of the individual. d. Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency e. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. f. Has strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. g. Offers informed choices to the individual regarding the services and supports they receive and from whom. h. Records alternative home and community-based settings that were offered to the individual. i. Includes a method for the individual to request updates to the plan as needed.

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			4. At least 86% of individual service plans are found to be appropriate (as defined below), as assessed by the QSR. Appropriate service plans meet the following criteria: a. Includes the individual's strengths and preferences. b. Identifies risks, clinical and support needs identified from the SIS and any other assessment performed. c. Identifies goals and desired outcomes specifically for and identified by the individual. d. Includes services and supports (paid and unpaid, including natural supports) necessary for the individual to meet the needs identified in their SIS assessment, as well as what is important to the individual with regard to preferences for the delivery of such services and support. e. Includes measures in place to minimize risk factors, including individualized back-up plans and strategies when needed. f. The setting in which the individual will reside is chosen by the individual/authorized representative, and is integrated in, and supports full access to the greater community. g. Includes those services, the purpose or control of which the individual elects to self-direct. h. Identifies the individual and/or entity responsible for monitoring the plan. i. Is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. 5. Employment service goals are developed and discussed in at least 86% of plans of people ages 18 to 64, inclusive. 6. For those people who are not currently employed, possible goals are developed and discussed to help the individual/AR understand possible paths toward achieving employment in at least 86% of plans of people ages 18 to 64, inclusive. 7. At least 86% of the people supported in residential settings will receive an annual physical and dental exam, including review of preventive screenings.

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			8. At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services. *In addition to indicators measured under III.D:* 9. The Commonwealth ensures that individuals have choice in all aspects of their goals and supports as measured by the following: a. At least 95% of people receiving services/authorized representatives participate in the development of their own service plan b. At least 86% of service plans have goals that reflect the person's/authorized representative's choices, preferences, and needs c. At least 86% of people receiving services/authorized representatives report they could choose their service provider for services, including residential, day, and case management services d. At least 86% of people receiving services/authorized representatives report they chose or were aware they could request to change their case manager/service coordinator. e. At least 86% of people receiving services/authorized representatives sign the ISP report, confirming that choices have been presented in writing and have been discussed in the planning process. f. At least 75% of people with a job in the community report they chose or had some input in choosing their job g. At least 86% of people receiving services/their authorized representatives report they choose or help decide how to spend their free time h. At least 75% of people receiving services report two or more out of home activities per week involving people who are not paid staff and do not have IDD. i. At least 86% of people receiving services in residential services/their authorized representatives report they choose or help decide their daily schedule j. At least 75% of people receiving services who do not live in the family home/their authorized representatives report they chose or had some input in choosing where they live

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			k. At least 50% of people who do not live in the family home/their authorized representatives report they chose or had some input in choosing their housemates 10. 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. 11. At least 86% of people receiving services feel safe in their homes, work and relationships. 12. At least 86% of ISPs are modified in response to major life events (such as diagnosis of serious medical condition, onset of a major injury, significant change in the individual's condition or circumstances that may require a new or modified service, death or serious illness of a parent or caregiver, loss of other major source of care or housing, experience of other potentially traumatic event or event that substantially changes the support needs of the person), within 90 days of the case manager and/or DBHDS learning of life event. 13. At least 86% of ISPs are reviewed every 12 months and modified in response to an individual's changing service needs or at the request of the individual/authorized representative. 14. The QSRs contain measures determined by the gathering of individual-level information (interviews or other means) that correspond with V.D.3. 15. DBHDS shares information from the QSRs with providers and CSBs in order to improve practice and the quality of services. 16. The QIC or other DBHDS entity utilizes information from the QSRs to identify areas of potential improvement, and takes action to improve practice and the quality of services on the provider, CSB, and system-wide levels.
53	**V.I.3**	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to	1. 100% of auditors who conducting QSRs are trained and pass written and/or demonstrated knowledge and skill prior to conducting a QSR. 2. 100% of auditors who assess clinically driven indicators (e.g. behavior support plans, adequate nursing care, sufficient medical supports, etc.)

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		validate the reliability of the QSR process.	have the appropriate clinical qualifications to make such determinations specific to the indicator being assessed (e.g. a behavioral clinician assesses behavior support plans, a nurse assesses adequate nursing care, etc.) 3. 100% of samples drawn for QSRs are conducted using valid statistical sampling techniques and sample sizes. Sufficient information is gathered through the actual samples reviewed to draw valid conclusions for each individual provider reviewed. 4. Inter-rater reliability has been assessed for each reviewer, with 85% or higher target against another established reviewer or a standardized scored review, using either live interviewing and review of records, or taped video content. During reliability testing, the reviewer does not have any access to other reviewer's notes or scores and cannot discuss their rating with other reviewers prior to submission. Any reviewer who does not meet the reliability standards has been re-trained, shadowed, and retested to ensure acceptable levels of reliability have been achieved prior to work on the QSR. 5. QSR reviewers receive and are trained on audit tools and associated written practice guidance that: a. have well-defined standards including clear expectations for participating providers b. include valid methods to ensure inter-rater reliability. c. consistently identify the methodology that auditors must use to answer questions. Record review audit tools should identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation). d. Explain how standards for fulfilling requirements, such as "met" or "not met", will be determined. e. Include indicators to comprehensively assess whether services and supports meet individuals' needs, including the quality of both clinical assessments and service provision.

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			6. DBHDS or its delegate conducts an independent review of a sample of the QSR to validate the reliability of the QSR process.
54	**IX.C**	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to the Independent Reviewer for inspection and copying upon request and on a reasonable basis.	1. The Commonwealth has a written record-keeping plan that identifies the records sufficient to document whether the requirements of each provision of the Agreement are implemented, and the entity or entities responsible for monitoring and ensuring that the plan is implemented. The plan has the following components specified for each record source: o Identify and document record locations o Process for collecting and updating records as specified in the agreement or determined by DBHDS o Identify a custodian of the records responsible for oversight of the collection, storage, updates and quality of the data. The plan also specifies: o a process to monitor/audit record completion and quality o a record retention and destruction schedule developed in coordination with the Independent Reviewer. 2. The Commonwealth conducts monitoring/auditing as specified in the process document. 3. The Commonwealth achieves 86% or greater compliance with their documentation plan as evidenced by their monitoring/auditing.