Exhibit M

Department of Justice Settlement Agreement Requirements

The CSB and the Department agrees to comply with the following requirements in the Settlement Agreement for Civil Action No: 3:12cv00059-JAG between the U.S. Department of Justice (DOJ) and the Commonwealth of Virginia, entered in the U. S. District Court for the Eastern District of Virginia on August 23, 2012 [section IX.A, p. 36], and in compliance indicators agreed to by the parties and filed with the Court on January 14, 2020.

Sections identified in text or brackets refer to sections in the agreement requirements apply to the target population defined in section III.B of the Agreement: individuals with developmental disabilities who currently reside in training centers, (ii) meet criteria for the DD Waiver waiting list, including those currently receiving DD Waiver services, or (iii) reside in a nursing home or an intermediate care facility (ICF).

1.) Case Managers or Support Coordinators shall provide anyone interested in accessing DD Waiver Services with a DBHDS provided resource guide that contains information including but not limited t case management eligibility and services, family supports including the IFSP Funding Program, family and peer supports, information on how to access REACH services, and information on where to access general information. [section III.C.2. a-f, p. 1].

2.) Case management services, defined in section III.C.5.b, shall be provided to all individuals receiving Medicaid Home and Community-Based Waiver services under the Agreement by case managers or support coordinators who are not directly providing or supervising the provision of Waiver services to those individuals [section III.C.5.c, p. 8].

3.) For individuals receiving case management services pursuant to the Agreement, the individual's case manager or support coordinator shall meet with the individual face-to- face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs [section V.F.1, page 26].
   a. At these face-to-face meetings, the case manager or support coordinator 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 changes in status; assess whether the individual's individual support plan (ISP) is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.
   b. The case manager or support coordinator shall document in the ISP the performance of these observations and assessments and any findings, including any changes in status or significant events that have occurred since the last face-to-face meeting.
   c. 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 or support coordinator shall report and document the issue in accordance with Department policies and regulations, convene the individual's service planning team to address it, and document its resolution.

4.) DBHDS shall develop and make available training for CSB case managers and leadership staff on how to assess change in status and that ISPs are implemented appropriately. DBHDS shall provide a tool with elements for the case managers to utilize during face-to-face visits to assure that changes in status as well as ISP are implemented appropriately and documented.
   a. CSB shall ensure that all case managers and case management leadership complete the training that helps to explain how to identify change in status and that elements of the ISP are implemented appropriately. The CSB shall deliver the contents of the DBHDS training through support coordinator

supervisors or designated trainers to ensure case managers understand the definitions of a change in status or needs and the elements of appropriately implemented services, as well as how to apply and document observations and needed actions.

b. CSB shall ensure that all case managers use the DBHDS On-Site Visit Tool during one face-to-face visit each quarter to assess at whether or not each person receiving targeted case management under the waiver experienced a change in status and to assess whether or not the ISP was implemented appropriately.

5.) Using the process developed jointly by the Department and Virginia Association of Community Services Boards (VACSB) Data Management Committee (DMC), the CSB shall report the number, type, and frequency of case manager or support coordinator contacts with individuals receiving case management services [section V.F.4, p. 27].

6.) The CSB shall report key indicators, selected from relevant domains in section V.D.3 on page 24, from the case manager's or support coordinator's face-to-face visits and observations and assessments [section V.F.5, p 27]. Reporting in WaMS shall include the provision of data and actions related to DBHDS defined elements regarding a change in status or needs and the elements of appropriately implemented services in a format, frequency, and method determined by DBHDS [section III.C.5.b.i.].

7.) The individual's case manager or support coordinator shall meet with the individual face-to-face at least every 30 days (including a 10 day grace period but no more than 40 days between visits), and at least one such visit every two month must be in the individual's place of residence, for any individuals who [section V.F.3, pages 26 and 27]:

a. Receive services from providers having conditional or provisional licenses;
b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale category representing the highest level of risk to individuals
c. Have an interruption of service greater than 30 days;
d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;
e. Have transitioned from a training center within the previous 12 months; or
f. Reside in congregate settings of five or more individuals. Refer to Enhanced Case Management Criteria Instructions and Guidance issued by the Department.

8.) Case managers or support coordinators shall give individuals a choice of service providers from which they may receive approved DD Waiver services, present all options of service providers based on the preferences of the individuals, including CSB and non-CSB providers, and document this using the Virginia Informed Choice Form in the waiver management system (WaMS) application. [section III.C.5.c, p. 8].

9.) The CSB shall complete the Support Coordinator Quality Review process for a statistically significant sample size as outlined in the Support Coordinator Quality Review Process.

a. DBHDS shall annually pull a statistically significant stratified sample of individuals receiving HCBBS
waiver services and send this to the CSB to be utilized to complete the review.
b. Each quarter, the CSB shall complete the number of Support Coordinator Quality Reviews and provide data to DBHDS as outlined by the process.
c. DBHDS shall analyze the data submitted to determine the following elements are met:
    i. The CSB offered each person the choice of case manager/provider
    ii. The case manager assesses risk, and risk mitigation plans are in place

iii. The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.
iv. The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences.
v. The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable.
vi. 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.
vii. 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.
viii. Individuals have been offered choice of providers for each service.
ix. The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences.
x. The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individuals' needs.

d. DBHDS shall review the data submitted and complete a semi-annual report that includes a review of data from the Support Coordinator Quality Reviews and provide this information to the CSB. To assure consistency between reviewers, DBHDS shall complete an inter-rater reliability process.
e. If 2 or more records do not meet 86% compliance for two consecutive quarters, the CSB shall receive technical assistance provided by DBHDS.
f. The CSB shall cooperate with DBHDS and facilitate its completion of on-site annual retrospective reviews at the CSB to validate findings of the CSB Support Coordinator Quality Review to provide technical assistance for any areas needing improvement.

10.) Case managers or support coordinators shall offer education about integrated community options to any individuals living outside of their own or their families' homes and, if relevant, to their authorized representatives or guardians [section III.D.7, p. 14]. Case managers shall offer this education at least annually and at the following times:
   a. At enrollment in a DD Waiver
   b. When there is a request for a change in Waiver service provider(s)
   c. When an individual is dissatisfied with a current Waiver service provider,
   d. When a new service is requested
   e. When an individual wants to move to a new location, or
   f. When a regional support team referral is made as required by the Virginia Informed Choice Form

11.) For individuals receiving case management services identified to have co-occurring mental health conditions or engage in intense behaviors, the individual's case manager or support coordinator shall assure that effective community based behavioral health and/or behavioral supports and services are identified and accessed where appropriate and available.
   a. If the case manager or support coordinator incurs capacity issues related to accessing needed behavioral support services in their designated Region, every attempt to secure supports should be made to include adding the individual to several provider waitlists (e.g. based upon individualized needs, this may be inclusive of psychotherapy, psychiatry, counseling, applied behavior analysis/positive behavior support providers, etc.) and following up with these providers quarterly to determine waitlist status.

12.) The CSB shall identify children and adults who are at risk for crisis through the standardized crisis screening tool or through the utilization of the elements contained in the tool at intake, and if the individual is identified as at risk for crisis or hospitalization, shall refer the individual to REACH. [SA. Provision: III.C.6.a.i-iii Filing reference: 7.2]

13.) For individuals that receive enhanced case management, the case manager or support coordinator shall utilize the standardized crisis screening tool during monthly visits; for individuals that receive targeted case management, the case manager or support coordinator shall use the standardized crisis screening tool during quarterly visits. Any individual that is identified as at risk for crisis shall be referred to REACH. [S.A. Provision: III.C.6.a.i-iii Filing reference: 7.3]

14.) The CSB shall ensure that CSB Executive Directors, Developmental Disability Directors, case management or support coordination supervisors, case managers or support coordinators, and intake workers participate in training on how to identify children and adults who are at risk for going into crisis.
   a. CSBs shall ensure that training on identifying risk of crisis for intake workers and case managers (or support coordinators) shall occur within 6 months of hire. [S.A. Provision: III.C.6.a.i-iii Filing reference: 7.5]

15.) The CSB shall provide data on implementation of the crisis screening tool as requested by DBHDS when it is determined that an individual with a developmental disability has been hospitalized and has not been referred to the REACH program.
   a. The CSB shall provide to DBHDS a "statistically significant" number of the times the CSB utilizedof the crisis screening tools, or documentation of utilization of the elements contained within the tool during a crisis screening, completed during the 1st six months and annually thereafter for the Department to review to ensure the tool is being implemented as designed and is appropriately identifying people at risk of crisis. [S.A. Provision: III.C.6.a.i-iii Filing reference: 7.6]
   b. DBHDS shall develop the risk of crisis/hospitalization elements and tool in partnership with the VACSB.
   c. DBHDS shall develop a training on assessing risk of crisis/hospitalization for the CSB to utilize to train staff. The CSB shall utilize this training to train staff.
   d. DBHDS shall initiate a quality review process monthly to include requesting documentation for anyone hospitalized who was not referred to the REACH program and either actively receiving case manager during the time frame or for whom an intake was completed prior to hospitalization. The CSB shall promptly, but within no more than 5 business days, provide the information requested.

16.) CSB Case manager shall work with the REACH program to identify a community residence within 30 days of admission to the program including making a referral to RST when the system has been challenged unable to find an appropriate provider within this timeframe.

17.) CSB emergency services shall be available 24 hours per day and seven days per week, staffed with clinical professionals who shall be able to assess crises by phone, assist callers in identifying and connecting with local services, and, where necessary, dispatch at least one mobile crisis team member adequately trained to address the crisis for individuals with developmental disabilities [section III.C.6.b.i.A, p. 9].
   a. The mobile crisis team shall be dispatched from the Regional Education Assessment Crisis Services Habilitation (REACH) program that is staffed 24 hours per day and seven days per week by qualified persons able to assess and assist individuals and their families during crisis situations and has mobile crisis teams to address crisis situations and offer services and support on site to

individuals and their families within one hour in urban areas and two hours in rural areas as measured by the average annual response time [section III.C.6.b.ii, pages 9 and 10].

b. All Emergency services staff and their supervisors shall complete the REACH training, created and made available by DBHDS, that is part of the emergency services training curriculum.
c. DBHDS shall create and update a REACH training for emergency staff and make available through the agency training website.
d. CSB emergency services shall notify the REACH program of any individual suspected of having a developmental disability who is experiencing a crisis and seeking emergency services as soon as possible, preferably prior to the initiation of a preadmission screening evaluation.
e. Early notification would allow REACH and emergency services to appropriately divert the individual from admission to psychiatric inpatient services when possible.
f. If the CSB has an individual receiving services in the REACH Crisis Therapeutic Home (CTH) program with no plan for placement and a length of stay that shall soon exceed 30 concurrent days, the CSB Executive Director or his or her designee shall provide a weekly update describing efforts to achieve an appropriate discharge for the individual to the Director of Community Support Services in the Department's Division of Developmental Services or his/her designee.
g. DBHDS shall notify the CSB executive director when it is aware of a person at the REACH CTH who is nearing a 30-day concurrent stay.

18.) Comply with State Board Policy 1044 (SYS) 12-1 Employment First [section III.C.7.b, p. 11]. This policy supports identifying community-based employment in integrated work settings as the first and priority service option offered by case managers or support coordinators to individuals receiving day support or employment services.

a. CSB case managers shall take the on line case management training modules and review the case management manual.
b. CSB case managers shall initiate meaningful employment conversations with individuals starting at the age of 14 until the age of retirement 65.
c. CSB case managers shall discuss employment with all individuals, including those with intense medical or behavioral support needs, as part of their ISP planning processes.
d. CSB case managers shall document goals for or toward employment for all individuals 18-64 or the specific reasons that employment is not being pursued or considered.
e. DBHDS shall create training and tools for case managers around meaningful conversation around employment including for people with complex medical and behavioral support needs. The CSB shall utilize this training with its staff and document its completion.

19.) CSB case managers or support coordinators shall liaise with the Department's regional community resource consultants in their regions [section III.E.1, p. 14].

20.) Case managers or support coordinators shall participate in discharge planning with individuals' personal support teams (PSTs) for individuals in training centers for whom the CSB is the case management CSB, pursuant to § 37.2-505 and § 37.2-837 of the Code that requires the CSB to develop discharge plans in collaboration with training centers [section IV.B.6, p. 16].

21.) In developing discharge plans, CSB case managers or support coordinators, in collaboration with facility PSTs, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan and the opportunity to discuss and meaningfully consider these options [section IV.B.9, p. 17].

22.) CSB case managers or support coordinators and PSTs shall coordinate with specific types of community providers identified in discharge to provide individuals, their families, and, where applicable,

their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families before being asked to make choices regarding options [section IV.B.9.b, p. 17].

23.) CSB case managers or support coordinators and PSTs shall assist individuals and, where applicable, their authorized representatives in choosing providers after providing the opportunities described in subsection 13 above and ensure that providers are timely identified and engaged in preparing for individuals' transitions [section IV.B.9.c, p.17].

24.) Case managers or support coordinators shall provide information to the Department about barriers to discharge for aggregation and analysis by the Department for ongoing quality improvement, discharge planning, and development of community-based services [IV.B.14, p. 19].

25.) In coordination with the Department's Post Move Monitor, the CSB shall conduct post- move monitoring visits within 30, 60, and 90 days following an individual's movement from a training center to a community setting [section IV.C.3, p.19]. The CSB shall provide information obtained in these post move monitoring visits to the Department within seven business days after the visit.

26.) If a CSB provides day support or residential services to individuals in the target population, the CSB shall implement risk management and quality improvement processes, including establishment of uniform risk triggers and thresholds that enable it to adequately address harms and risks of harms, including any physical injury, whether caused by abuse, neglect, or accidental causes [section V.C.1, p. 22].

27.) Using the protocol and the real-time, web-based incident reporting system implemented by the Department, the CSB shall report any suspected or alleged incidents of abuse or neglect as defined in § 37.2-100 of the Code, serious injuries as defined in 12 VAC 35- 115-30 of the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services* or deaths to the Department within 24 hours of becoming aware of them [section V.C.2, p. 22].

28.) Participate with the Department to collect and analyze reliable data about individuals receiving services under this Agreement from each of the following areas:

a. safety and freedom from harm
b. physical, mental, and behavioral
c. avoiding crises
d. choice and self-determination
e. community inclusion, health and well-being
f. access to services
g. provider capacity
h. stability, [section V.D.3, pgs. 24 & 25]

29.) Participate in the regional quality council established by the Department that is responsible for assessing relevant data, identifying trends, and recommending responsive actions in its region [section V.D.5.a, p. 25].

30.) Provide access and assist the Independent Reviewer to assess compliance with this Agreement. The Independent Reviewer shall exercise his access in a manner that is reasonable and not unduly burdensome to the operation of the CSB and that has minimal impact on programs or services being provided to individuals receiving services under the Agreement [section VI.H, p. 30 and 31].

31.) Participate with the Department and any third party vendors in the implementation of the National Core

Indicators (NCI) Surveys and Quality Service Reviews (QSRs) for selected individuals receiving services under the Agreement. This includes informing individuals and authorized representatives about their selection for participation in the NCI individual surveys or QSRs; providing the access and information requested by the vendor, including health records, in a timely manner; assisting with any individual specific follow up activities; and completing NCI surveys [section V.I, p. 28].

a. During FY 21, the QSR process will be accelerated and will require the CSB to fully participate in the completion of QSR implementation twice during a nine-month period. This will ensure that the Commonwealth can show a complete improvement cycle intended by the QSR process by June 30, 2021. The attached GANTT details the schedule for the QSR reviews of 100% of providers, including support coordinators, for two review cycles.

32.) The CSB shall notify the community resource consultant (CRC) and regional support team (RST) in the following circumstances to enable the RST to monitor, track, and trend community integration and challenges that require further system development:

a. within five calendar days of an individual being presented with any of the following residential options: an ICF, a nursing facility, a training center, or a group home/congregate setting with a licensed capacity of five beds or more;
b. if the CSB is having difficulty finding services within 30 calendar days after the individual's enrollment in the waiver; or
c. immediately when an individual is displaced from his or her residential placement for a second time [sections III.D.6 and III.E, p. 14].

33.) DBHDS shall provide data to CSBs on their compliance with the RST referral and implementation process.

a. DBHDS shall provide information quarterly to the CSB on individuals who chose less integrated options due to the absence of something more integrated at the time of the RST review and semi-annually
b. DBHDS shall notify CSBs of new providers of more integrated services so that individuals who had to choose less integrated options can be made aware of these new services and supports.
c. CSBs shall offer more integrated options when identified by the CSB or provided by DBHDS.
d. CSBs shall accept technical assistance from DBHDS if the CSB is not meeting expectations.

34.) Case managers or support coordinators shall collaborate with the CRC to ensure that person-centered planning and placement in the most integrated setting appropriate to the individual's needs and consistent with his or her informed choice occur [section III.E.1- 3, p. 14].

a. CSBs shall collaborate with DBHDS CRCs to explore community integrated options including working with providers to create innovative solutions for people.

The Department encourages the CSB to provide the Independent Reviewer with access to its services and records and to individuals receiving services from the CSB; however, access shall be given at the sole discretion of the CSB [section VI.G, p. 31].

35.) Developmental Case Management Services

a. Case managers or support coordinators employed or contracted by the CSB shall meet the knowledge, skills, and abilities qualifications in the Case Management Licensing Regulations, 12 VAC 35-105-1250. During its inspections, the Department's Licensing Office may verify compliance as it reviews personnel records.
b. Reviews of the individual support plan (ISP), including necessary assessment updates, shall be conducted with the individual quarterly or every 90 days and include modifications in the ISP when the individual's status or needs and desires change.

c. During its inspections, the Department's Licensing Office may verify this as it reviews the ISPs including those from a sample identified by the CSB of individuals who discontinued case management services.
d. The CSB shall ensure that all information about each individual, including the ISP and VIDES, is imported from the CSB's electronic health record (EHR) to the Department within five (5) business days through an electronic exchange mechanism mutually agreed upon by the CSB and the Department into the electronic waiver management system (WaMS).
e. If the CSB is unable to submit via the data exchange process, it shall enter this data directly through WaMS, when the individual is entered the first time for services, or when his or her living situation changes, her or his ISP is reviewed annually, or whenever changes occur, including information about the individual's:

i.	full name	iv.	level of care information
ii.	social security number	v.	change in status
iii.	Medicaid number	vi.	terminations
vii.	CSB unique identifier	viii.	transfers
ix.	current physical residence address	x.	waiting list information
xi.	living situation (e.g., group home	xii.	bed capacity of the group home if that is chosen
xiii.	family home, or own home)		

f. Case managers or support coordinators and other CSB staff shall comply with the SIS® Administration Process and any changes in the process within 30 calendar days of notification of the changes.
g. Case managers or support coordinators shall notify the Department's service authorization staff that an individual has been terminated from all DD waiver services within 10 business days of termination.
h. Case managers or support coordinators shall assist with initiating services within 30 calendar days of waiver enrollment and shall submit Request to Retain Slot forms as required by the Department. All written denial notifications to the individual, and family/caregiver, as appropriate, shall be accompanied by the standard appeal rights (12VAC30-110).
i. Case managers or support coordinators shall complete the level of care tool for individuals requesting DD Waiver services within 60 calendar days of application for individuals expected to present for services within one year.
j. Case managers or support coordinators shall comply with the DD waitlist process and slot assignment process and implement any changes in the processes within 30 calendar days of written notice from the Department.

Exhibit M

Department of Justice Settlement Agreement Requirements

PLAN TO MEET COMPLIANCE BY JUNE 30, 2021					PERIODS												
	MILESTONES	PLAN START	PLAN DURATION	COMPLETE DATE	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Phase 1	Vendor Contract	4/1/2020	1 Month	4/27/2020														
	Tools/Definitions/ Methodology Refined and Delivered to	5/1/2020	1 Month	5/22/2020														
	IR/Consultant Review and Approval	5/22/2020	2 Weeks	6/5/2020														
	Finalize Tools and Train Reviewers	6/5/2020	4 Weeks	6/30/2020														
	Group 1 Reviews Begin (290)	7/1/2020	45 Days	8/15/2020														
	Group 2 Reviews (290)	8/15/2020	45 Days	9/30/2020														
Phase 2	Group 1 Data Analysis and Reports Developed and Delivered	8/16/2020	1 Month	9/15/2020														
	Group 1 Technical Assistance Developed and Delivered	7/1/2020	1 Month/ Ongoing	9/15/2020														
	Group 2 Data Analysis and Reports Developed and Delivered	10/1/2020	1 Month	10/31/2020														
	Group 2 Technical Assistance Developed and Delivered	9/16/2020	45 Days/ Ongoing	10/31/2020														
Phase 3	Group 1 Improvements Implemented	9/16/2020	2 Months	11/15/2020														
	Group 2 Improvements Implemented	11/1/2020	2 Months	12/31/2020														
Phase 4	Group 1 Re-Review	11/15/2020	45 Days	12/31/2020														
	Goup 2 Re-Review	1/1/2021	45 Days	2/15/2021														
	Group 1 Data Analysis and Report Generation to Evaluate Impact	1/1/2021	1 Month	1/31/2021														
	Group 2 Data Analysis and Report Generation to Evaluate Impact	2/16/2021	1 Month	3/15/2021														
	Group 1 Report Delivered to IR	2/1/2021	N/A	2/1/2021														
	Group 2 Report Delivered to IR	3/16/2021	N/A	3/16/2021														

Specific Activity

Ongoing Activity