Developmental Disabilities Quality Management Plan

Virginia Department of Behavioral Health & Developmental Services

Developmental Disabilities Quality Management Plan
State Fiscal Year 2021

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Table of Contents

APPENDICES

Developmental Disabilities Quality Management Plan

Introduction

This report serves as a comprehensive document describing the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Developmental Disabilities Quality Management Plan (QMP) for State Fiscal Year (SFY) 2021. The DBHDS is committed to continuous quality improvement (CQI), which is an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes. The DBHDS QMP is a detailed in a three-part document. Part 1 contains the Quality Management (QM) Program Description, which describes the current structure and framework for discovery and remediation activities, and existing quality committees for the agency. Part 2 contains the Quality Improvement Committee (QIC) and QIC subcommittee charters of each quality committee and QIC subcommittee work plan, outlining the purpose and aims of the committee and detailing the tracking instrument used to track performance measure indicators (PMIs) and quality improvement initiatives (QIIs). Part 3 includes the Quality Management (QM) Annual Report and Program Evaluation, which summarizes the key accomplishments of the QM Program, work plans, and challenges to meeting stated goals. The DBHDS QMP will be reviewed and updated annually.

> *"DBHDS remains committed to working collaboratively with external stakeholders to improve the quality of our current system and integrated supports for individuals in our communities by promoting recovery, self-determination and wellness in all aspects of life. Our Quality Management System establishes the structure upon which we improve the full continuum of supports and services in our system of care. Through continuous quality improvement, we can ensue enduring improvements to system capacity, high-value care, and continue to grow a culture of collaboration"*

Alison G. Land, FACHE, Commissioner
Virginia Department of Behavioral Health and Developmental Services

Part 1- Quality Management Program Description

Standards for Quality

The DBHDS QMP draws upon multiple quality frameworks to include the Institute of Medicine's six dimensions of quality, the Substance Abuse and Mental Health Services Administration (SAMHSA) quality framework, and the Centers for Medicare & Medicaid Services (CMS) Home and Community Based Services (HCBS) Waivers Quality Framework in the implementation of the DBHDS quality management system (QMS).

The Institute of Medicine identifies six dimensions of quality, which are applicable to all individuals served regardless of whether they access health care in hospitals, rehabilitation facilities, or in the community. These six dimensions[1] are defined and represented in the graphic below:

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes, harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

[1] Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.

Focusing on substance abuse and mental health care, SAMHSA provides the following Quality Framework[2]:
Aims:

- **Better Care:** Improve the overall quality, by making behavioral health care more person-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the behavioral health of the U.S. population by supporting proven interventions to address behavioral, social and environmental determinants of positive behavioral health in addition to delivering higher-quality behavioral health care.
- **Affordable Care:** Increase the value (cost-effectiveness) of behavioral health care for individuals, families, employers, and government.

Priorities:

- Promote the most effective prevention, treatment and recovery practices for behavioral health disorders
- Assure behavioral health care is person- and family-centered
- Encourage effective coordination within behavioral health care, and between behavioral health care and other health care and social support services
- Assist communities to utilize best practices to enable healthy living
- Make behavioral health care safer by reducing harm caused in the delivery of care

[2] SAMHSA. National Framework for Quality Improvement in Behavioral Health Care, June 2011.

- Foster affordable high quality behavioral health care for individuals, families, employers, and governments by developing and advancing new delivery models.

The CMS HCBS Quality Framework[3] identifies similar domains as indicated in the graphic below:

Focus	Desired Outcome
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers, and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

DBHDS Quality Management System

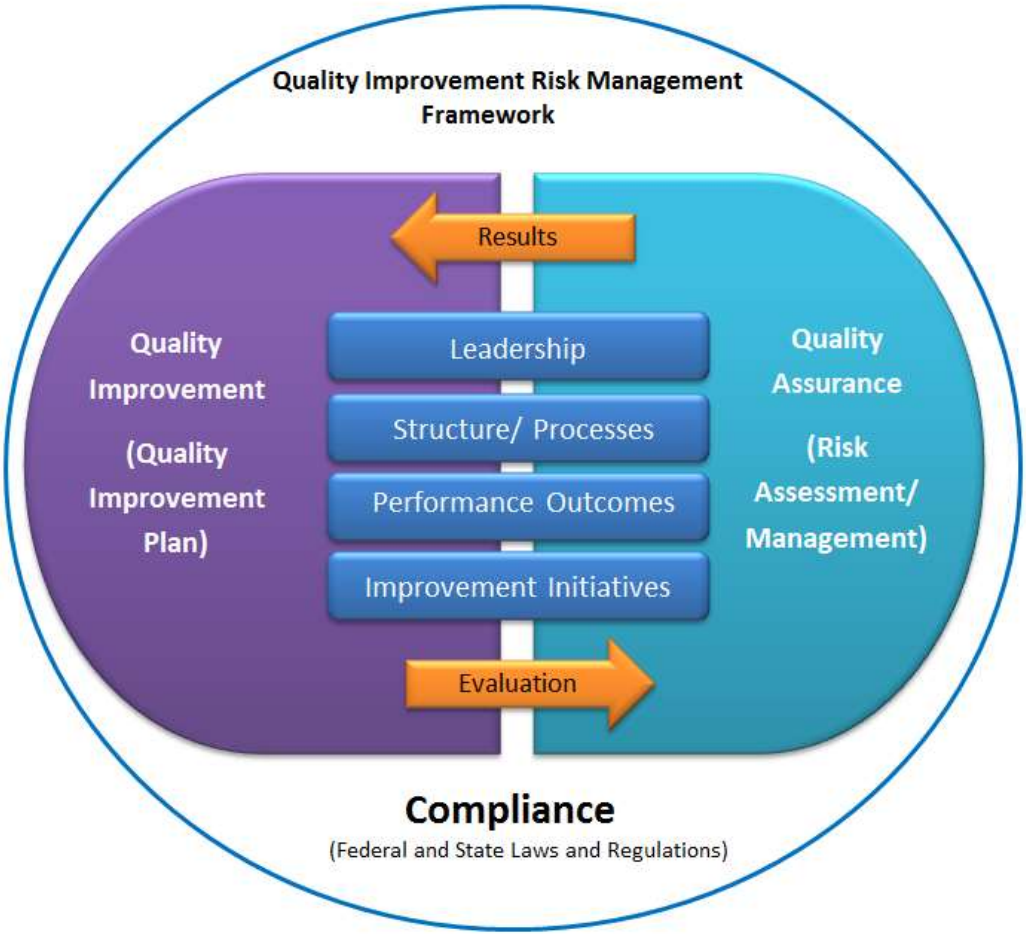
Every organization should implement a quality management system (QMS) that is cross lifespan, appropriate to its size, scope and populations served. The DBHDS QMS is based on the DBHDS vision, mission and strategic plan and incorporates these nationally recognized quality principles. DBHDS developed a multi-faceted approach using these quality frameworks and principles to develop a culture of quality. The system's infrastructure is:

- Supported through the organization's leadership who is:
  - Committed to the success of the QM plan
  - Supportive of the organizational culture of quality improvement

[3] Centers for Medicare and Medicaid Services. HCBS Quality Framework. 2003. Accessed 12/1/20 at: http://www.nasddds.org/uploads/documents/HCBSQualityFramework%28rev06-05%29.pdf

    - Prepared to designate resources for critical support mechanisms
    - Willing to give authority to staff to make changes
- Person and family-centered
- Characterized by employees and providers who are continuously learning and empowered as innovative change agents
- Effective in utilizing data for ongoing quality improvement
- Sustainable and continuous

The graphic below illustrates that while compliance is what we must achieve, the ultimate goal is a system of quality services that allows individuals to direct their own lives and recovery, to access and fully participate in their community and balances risk, health, safety and well-being. An effective quality/risk management (RM) structure includes quality assurance (QA), RM and quality improvement (QI) processes.



The foundation of the framework is compliance with federal and state laws and regulations that focus on individual protections, rights, and liberties and standards to ensure safe consistent quality of care. These include, but are not limited to:

- Americans with Disabilities Act (ADA) and the *Olmstead* decision
- Civil Rights of Institutionalized Persons Act (CRIPA)
- Home and Community Based Services (HCBS) Settings Rule
- The Joint Commission (hospital accreditation)
- Occupational Safety and Health Administration (OSHA)
- Health Insurance Portability and Accountability Act (HIPAA)
- State Board of Behavioral Health and Developmental Services Regulations
- CMS (Department of Medical Assistance Services (DMAS) – Waiver Assurances
- Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services
- Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services

Leadership

Leadership commitment for a culture of quality, structures and data driven processes, established performance outputs/outcomes, and continuous quality improvement are the backbone of the framework. DBHDS' leadership commitment is demonstrated through direction and support of the QMS and CQI. This is consistent with the vision, mission, and strategic plan, to ensure that a culture of quality permeates the agency, through employee engagement at all levels, and through the services provided by our community partners. Leadership values supports and services that are focused on the person and their families with the input of internal and external stakeholders (staff at all levels, individuals, their guardians/authorized representatives, providers, advocates, and others on emerging and ongoing issues).

Leaders encourage staff members to work together to eliminate complacency, promote collective mindfulness, and promote a learning environment (i.e., learning from safety events, including close calls and other system failures that have not yet led to the harm of an individual). In an integrated quality/RM system, these efforts identify opportunities for QI, include assessment of risks, and can result in QIIs, which seek to improve systems and processes to achieve desired outcomes.

DBHDS strives towards a culture of quality, which recognizes that quality is a shared responsibility of all individuals within an organization. While this may require a fundamental shift in perspective, all employees should be empowered to be change agents.

Structure and Processes

QA, RM and QI are integrated processes that are the foundation of the QMS. QA focuses on discovery activities to test compliance with standards, regulations, policies, guidance, contracts, procedures and protocols, and the remediation of individual findings of non-compliance. Regulatory compliance establishes the extent to which basic performance standards are met, which include DBHDS Licensing Regulations, DMAS Developmental Disabilities (DD) HCBS Waiver Regulations, and the assurances built on the statutory requirements of the CMS 1915c Waiver program. Additional performance standards are set forth by the DMAS and DBHDS in support of various program goals.

RM assesses and identifies the probability and potential consequences of adverse events and develops strategies to prevent and substantially mitigate these events or minimize the effects. This is achieved for individuals receiving services using risk screening assessments and responsive care plans. At the systems level, DBHDS monitors critical risk triggers through reported data sources and initiates interventions as appropriate. At the provider level, DBHDS requires service providers to develop RM plans, including the identification of risk triggers and response strategies to mitigate the potential for harm. Comprehensive RM also includes requirements for the reporting of critical incidents, investigation of critical incidents and remediation as indicated through corrective action plans (CAPs). DBHDS also employs a robust complaint system for allegations of abuse, neglect and exploitation.

QI is the systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care.

The DBHDS QMS includes:

- Division of Quality Assurance and Government Relations, which oversees the regulatory, QA, and RM processes
- Division of Developmental Services, which manages discovery, remediation and collaborates with DMAS to implement the DD HCBS Waivers Quality Improvement Strategy, Preadmission Screening and Resident Review (PASRR), and the provision of training and technical assistance
- Division of Administrative Services which includes the Office of Management Services for Outcomes, Performance Contracts, and Grants

- Division of the Chief Clinical Officer, which oversees QMS development and implementation and provides critical support across QM functions.

DBHDS Division of Quality Assurance and Government Relations

Recognizing that QA involves determining the extent to which performance standards/regulations are met and taking action to remedy specific problems or concerns that arise, the DBHDS Division of Quality Assurance and Government Relations includes the Offices of Licensing, Human Rights, and Regulatory Affairs. These offices provide oversight and monitoring of providers to assure individuals' rights and that providers and services meet established standards and requirements.

DBHDS Office of Human Rights

Office of Human Rights (OHR) is responsible for promoting the basic precepts of human dignity, advocating for the rights of persons with disabilities in the DBHDS service delivery systems and managing the DBHDS Human Rights dispute resolution program. Human rights advocates ensure compliance with human rights regulations, following up on complaints and allegations of abuse, neglect, and exploitation. Advocates respond to and assist in the complaint resolution process by monitoring provider reporting and reviewing provider investigations and corrective actions. Advocates also respond to reports of abuse by conducting independent or joint investigations with DBHDS partners and/or external agencies such as the Virginia Department of Social Services (VDSS). In cases where there are violations of the Human Rights Regulations, advocates recommend citation through the Office of Licensing (OL).

OHR uses data to deploy advocates to programs and areas where there are serious concerns. As a proactive protection of rights, advocates visit newly licensed providers within 30 days of service initiation to ensure the basic knowledge of the human rights system, including review of the provider's human rights policies and training on the requirements and process for utilizing the department's web-based reporting application (CHRIS). OHR also provides new waiver provider validation for compliance with HCBS Settings Rule.

OHR has monitoring systems in place to ensure the health and welfare of the individuals served by DBHDS. These systems include:

- Comprehensive Human Rights Information System (CHRIS)
- Local Human Rights Committees (LHRC)
- State Human Rights Committee (SHRC)
- Pre and post move monitoring of individuals discharged from training centers
- Community and Facility provider look behind process
- Shared protocol with VDSS/DARS for Abuse/Neglect reporting

- Central Office Abuse/Neglect Advisory Panel
- Central State Hospital and VCBR Appeals Committees

OHR utilizes data driven decisions, using the Data Warehouse (DW) to deploy advocates to programs and areas where there are emergent issues. OHR has 23 field advocates across the state, responsible for ensuring human rights protections to individuals served in our facilities and services offered through over 1200 DBHDS-licensed community providers. Advocates actively provide guidance, consultation and on-going technical assistance to community providers, facility staff, individuals, and family members via on-site inspections and reviews.

Office of Licensing

Office of Licensing (OL) acts as the regulatory authority for the DBHDS' licensed service delivery system. Through QA processes including but not limited to initial application reviews, initial site visits, unannounced inspections, review and investigation of serious incidents and complaints, and issuance of licensing reports requiring CAPs, OL ensures the mechanisms for the provision of quality service are monitored, enforced and reported to the DBHDS leadership. For example, new regulations require that all providers develop and implement a QI program and a RM plan. OL is responsible for ensuring that DBHDS licensed providers have developed and implemented risk mitigation and QI processes addressing services to individuals with behavioral health and developmental disabilities.

Providers are required to report human rights complaints, allegations of abuse, neglect and exploitation, and serious incidents as defined in licensing and Human Rights regulations into the CHRIS. These reports are monitored and may result in onsite visits by the OHR and/or investigation by OL.

OL plays an integral, vital role in assessing the applicants to become providers and their potential in meeting the needs of individuals in safe, secure, and less restricted environments. OL ensures the mechanisms for quality service provision are enforced, monitored and reported back to DBHDS leadership via data and other measures. In addition, OL is responsible for:

- Coordination with other agencies - DMAS, Managed Care Organizations (MCOs), Department of Social Services (DSS), State and local law enforcement, Office of the Attorney General (OAG), Department of Health Professions (DHP)
- Coordination with other departments within DBHDS – Office of Human Rights, Division of Developmental Services, Division of Community Behavioral Health, and Division of Compliance, Risk Management and Audit,
- Utilization of a performance management system to ensure that CAPs, Inspections, and Investigations are done in accordance with office protocol and regulations.

OL includes an incident management unit (IMU) and a special investigations unit (SIU). IMU is responsible for the daily review, triage, and follow-up on all reported serious incidents to identify and, where possible, prevent future risks of harm. Follow-up on incidents may include phone contact with the provider and/or individual to ensure immediate protections and health and safety follow-up has occurred and desk review of records relevant to the incident and reports. IMU works closely with SIU, licensing specialists, Office of Integrated Health (OIH) and human rights advocates to assure adequate follow-up.

Serious incidents include any event or circumstance (including injuries or deaths) that causes, or could cause harm to the health, safety, or well-being of an individual. Providers are required to report serious incidents to DBHDS through CHRIS within 24 hours of their identifying or being notified of the incident. IMU cites any provider who does not have a valid reason for entering a report into CHRIS within required timeframe. Upon review of a serious incident, IMU determines whether further follow-up is needed. Any incidents that give rise to concerns that the individual or others are at imminent risk are referred for immediate investigation, and all deaths of individuals with developmental disabilities are referred to the SIU. Other concerns are forwarded to the provider's licensing specialist for follow-up. IMU also reviews and triages all laboratory confirmed positive COVID-19 cases. IMU calls the provider, checks the status of the individual(s), and asks pertinent questions based on a specially designed COVID-19 review form, which is shared with OIH and OHR.

IMU reviews data to identify trends, including providers that have a high volume of incidents or several incidents of the same type (e.g., falls or medication errors), and identifies patterns of incidents with the same individual that may indicate the need for a change in services or the need for additional resources. Through this review, IMU identifies areas, based on serious incidents, where there is potential risk for more serious future outcomes. A review of a serious incident may raise concern about a provider's ability to ensure the adequacy of supports to one or more individuals receiving their licensed service. As a result, a provider may need to re-evaluate an individual's needs and supports, review the results of root cause analysis, and make systemic changes or updates to their RM or QI plan. IMU has identified these situations as Care Concerns. Incidents of individuals or providers who meet Care Concern criteria will trigger follow-up by IMU or other offices once notified by the IMU. OIH and OHR then follow-up and provide technical assistance to/for providers who have identified care concerns.

IMU also reports on trends across the system, such as total incidents and frequency of different types of incidents by provider, service, and for individuals. Trend reports are reviewed with the Risk Management Review Committee (RMRC) to determine when system level QI activities may be necessary.

SIU is responsible for the investigation of deaths of individuals with developmental disabilities (DD) and for complaints of providers licensed to provide services to individuals with DD in accordance with office protocols and review criteria. As additional resources are added to the unit, they will expand to include all investigations involving individuals with DD, and eventually to all investigations regardless of disability type.

Investigators are responsible for contacting providers, requesting and reviewing records, conducting on-site inspections, interviewing provider staff and individuals, coordinating with other agencies and law enforcement, identifying any regulatory violations, writing investigation reports, and following up with providers to ensure implementation of their CAPs.

DBHDS Division of Developmental Services

DD HCBS Quality Management Plans

DMAS, the DBHDS DDS Waiver Operations Unit and the DBHDS Provider Development Unit, with support from the DBHDS Office of Integrated Services and Supports (OISS), collaboratively manage implementation of the DD HCBS Waivers Quality Improvement Strategy. The DD HCBS Waivers contain CMS DD performance measures (PM) approved by CMS. The DD Waivers Quality Review Team (QRT) meets on a quarterly basis to report on, review the results of the discovery and remediation activities for each performance measure, and establish individual and/or systemic remediation strategies for those measures that fall below an 86% performance threshold. The joint DBHDS-DMAS DD Waivers QRT prepares an annual report for the DBHDS QIC for its review and consideration as part of the DD system QI process.

Office of Provider Development

Office of Provider Development (OPD) focuses on developing and sustaining a qualified community of providers in Virginia so that people who have DD and their families have choice and access to options that meet their needs. Work is organized across three capacity-building teams at the individual, provider, and system levels that is carried out through Community Resource Consultants (CRCs) who offer technical assistance to community stakeholders through a variety of methods such as regional meetings, virtual and on-site training, and ongoing communications. OPD has established a comprehensive approach to program development. This approach includes Regional Support Teams (RST) that bolster informed choice in Virginia's system by ensuring the consideration of more integrated support options. Also included, a Provider Data Summary process that evaluates and shares gaps in integrated services with the provider community, maintains an online provider database that includes a Provider Designation process for the identification and promotion of provider expertise. The remaining approaches include access to Jump-Start funding to develop integrated service options where needs exist; and, monitoring and improving the

performance of Support Coordinators through the provision of materials and technical assistance deigned to support success with Settlement Agreement (SA) requirements. In addition, OPD seeks to promote best practices through implementation of the HCBS settings rule, a Direct Support Professional (DSP) and DSP Supervisor training and competencies process, the development and use of a Person-Centered Individual Support Plan (ISP), and access to a variety of person-centered practices training opportunities.

Case Management/Support Coordination

Case Management/Support Coordination is the core service that Virginians with DD and behavioral health disorders use to help navigate and access needed and desired services, while building on the individuals' strengths and natural supports systems. This essential QA role includes coordinating the development of a person-centered plan, assessing and monitoring to ensure the plan is implemented appropriately and updated when a change in status occurs, linking individuals with services, identifying and balancing health and safety needs with dignity of risks, while also strengthening and supporting each person's right to determine the life they want. Often referred to as the linchpin that holds the elements of a complicated structure together, the case manager/support coordinator (CM/SC) is of critical importance in helping individuals achieve positive outcomes, avoid harm, maintain stable community living, and increase integration, independence and self-determination in all life domains.

CM/SCs facilitate the development of the ISP to assist and support individuals in determining what is important to and for them including proactively identifying risks and developing mitigating strategies while recognizing and supporting the individual in making informed choices. Additional assessments were added to the ISP process to assist the CM/SC in identifying risks. These include a crisis risk assessment to identify potential risks for crisis and a proactive referral process to crisis support services as well as a risk awareness assessment to identify risks commonly associated with individuals with DD. CM/SC monitor implementation of the ISP. This monitoring process now includes a standardized on-site visit assessment tool (OSVT) to assist in determining if the ISP is implemented appropriately and identifying if there has been a change in status, which will initiate an update to the ISP.

Office of Integrated Health

Office of Integrated Health (OIH) ensures DBHDS meets the federal requirements for PASRR, pre-admission screening of individuals with DD referred for nursing home level of care. In addition to ensuring individuals with DD meet the required level of care for admission, the OIH ensures that any specialized needs are addressed and a connection between the community services board/behavioral health authority hereafter referred to as CSB and nursing facilities are made to aid in discharge facilitation. When nursing home placement is determined to be appropriate, the PASRR team follows the individual to ensure they are receiving the supports

and specialized services needed as identified by their person-centered plan. This includes the use of OBRA funding to support the services needed that are outside the usual scope of the nursing homes. Through the resident review process, the PASRR team continues to evaluate whether nursing home placement remains appropriate; these reviews occur at least every 180 days.

OIH developed a transitions team directed at helping to move children currently living in nursing facilities to the community. DBHDS Community Transitions Nurse, in conjunction with the interdisciplinary teams at each of the two largest nursing facilities that serve children in the Commonwealth, identifies barriers and possibilities for community placement. OIH staff also participate in investigations as requested, develop training and educational materials in support of QI recommendations and provide on-going training and technical assistance to community providers.

DBHDS Division of Facilities Services

The DBHDS Division of Facilities Services directs, monitors, and strengthens the QI in the DBHDS State Facilities. The Division of Facilities Services ensures the coordination and integration of QI activities aimed toward the delivery of safe, high-quality care in state facilities. The goal is to maintain a systematic agency-wide approach to safety and performance improvement across three overlapping areas of focus: accreditation and regulatory compliance; incident management and risk reduction; and systematic and sustainable performance improvement.

DBHDS Division of the Chief Clinical Officer

DBHDS Office of Clinical Quality Management

QI is a data driven process and involves analysis of data and performance trends captured in the QA processes described above as well as through CSB reporting, Waiver Management System (WaMS) and other data sources. This data analysis is used to determine QI priorities. Office of Clinical Quality Management (OCQM) provides oversight of QI efforts and responds to trends, by ensuring QIIs are developed, and corrective actions and regulatory reforms are implemented, if necessary, to address weaknesses/service gaps in the system.

OCQM supports the development and expansion of an agency-wide QM Plan by ensuring high quality service delivery focused on prevention, early intervention, effective treatment, and recovery and rehabilitation. OCQM works with interdisciplinary teams to achieve system wide community inclusion, safety and well-being, recovery and self-empowerment outcomes (related to behavioral health and developmental service provision) across all service setting areas, including community and hospital-based care. The office facilitates inter-departmental, inter-

agency, and cross-sectoral alignment of QIIs for DBHDS, and works to ensure compliance with the QM requirements as outlined in the SA with the United States Department of Justice DOJ).

The office staff supports the QIC structure, which provides system-wide oversight of the QM Program. In addition, the office partners with and facilitates efforts within DBHDS divisions to ensure that QI activities, including best practices and evidence-based outcomes, are coordinated and integrated into the primary functions of the organization. DBHDS is delegated the authority by DMAS to oversee the state's waivers program and the DD HCBS Waivers Quality Improvement Strategy through the QRT. Although this oversight responsibility lies with the QRT, the follow-through remediation activities are led by the individual subject matter experts (SME's) from each office/state department on the team having purview over those activities, including DMAS. QRT relies on the departmental units represented on the QRT to complete the remediation (individual and systemic) to achieve performance improvement.

In addition, OCQM oversees and directs community-based quality review processes for DBHDS. DBHDS implements quality service reviews (QSRs) through a contracted vendor. QSRs are completed on a sample of individuals receiving services and include desk reviews, on-site visits, face-to-face interviews, in-person service observations, retrospective record reviews, and/or surveys of individuals receiving services. QSRs are completed to gain information about the quality of services provided and/or to obtain individual and family input on services provided for the purpose of making improvements in the service experience, and to determine how to improve the array of services provided. QSRs include provider quality reviews, person-centered reviews, individual and family interviews and/ or surveys, Community Service Board Quality Record Reviews, and other DBHDS quality service reviews. Data collected from these processes is used in the evaluation of service quality at the individual, service, and systemic levels and to identify and implement QIIs.

DBHDS contracts with an external certified quality improvement organization (QIO) to complete QSRs, which include provider quality reviews (PQRs) and person-centered reviews (PCRs). These QSRs evaluate:

- The quality of services at an individual, provider (i.e., CSB and private providers), and system-wide level; and
- The extent to which services are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice.

QSRs also provide an assessment of whether or not individuals' needs are being identified and met through person-centered planning and thinking, 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 given opportunities for community integration in all aspects of their lives. Additionally, QSRs assess the quality and adequacy of providers' services, QI and

RM strategies, and provide recommendations to providers for improvement. Results of the QSRs are used to improve individual provider and system practice and service quality.

The National Core Indicators (NCI) Project is a collaboration between the National Association of State Directors of Developmental Disabilities Services (NASDDDS), the Human Services Research Institute (HRSI) and voluntary state participants, including Virginia. The core indicators are standard measures used across states to learn about the outcomes of supports and services provided to individuals and families. Indicators address important elements of person-centered planning, including employment, rights, service planning, community inclusion, choice, health and safety and satisfaction. Individuals (and their families) who use services through the DD Waivers are randomly selected to participate in the interview surveys. Virginia has participated in the NCI project since 2013. DBHDS contracts with The Partnership for People with Disabilities who conducts the surveys required for NCI participation. These surveys provide valuable insight concerning the outcomes of supports and services from the individual's and family's perspective and are used to identify areas needing improvement. The Staff Stability Survey is conducted with focus on stability and quality of DSP workforce (state and national level). Standardized measures and calculations to monitor priority data points: wages, turnover, vacancies, and employee benefits/environment. The standardized performance measures facilitate tracking outcomes over time, are used to compare outcomes across states, and inform where system improvements may be made.

Office of Community Quality Improvement (OCQI), under the oversite of the Director of the Office Community Quality Management, directs, mentors, and strengthens the QI processes in community-based service providers. Through the development of outcome measures and analysis of trends, data driven decisions are made to improve the quality of services at systems, provider, and individual levels. This includes providing technical assistance and consultation to internal and external state partners and community-based licensed providers related to developing, implementing, and monitoring QI programs. OCQI develops and/or offers resources for evidence-based best practice guidance and training related to QI and RM for use by community-based providers.

Support Coordination Quality Reviews (SCQRs) are conducted at each CSB as part of the comprehensive QI program. CSB CM/SC supervisors/QI specialists complete these quality reviews. DBHDS identifies a statistically significant stratified statewide sample of individuals receiving HCBS waiver services and provides each CSB with the names of individuals to be reviewed. CSB supervisors/QI specialists complete a portion of the reviews each quarter. These reviews include an assessment of core CM requirements. Data from the reviews is used by the CSB and the DBHDS Case Management Steering Committee (CMSC) to analyze implementation of CM processes and to develop QIIs to strengthen areas of weakness. In order to ensure the integrity of the CSB quality reviews, OCQI staff complete a retrospective review of

a sample of records reviewed by each of the CSBs at least once per year using the same review process in order to measure agreement quantitatively. DBHDS provides technical assistance to SC supervisors/QI specialists to increase reliability of the results in future reviews and to identify any CSB specific improvements needed. CMSC analyzes data throughout the process to determine systemic areas in need of improvement, including, as needed, recommendations for enforcement actions pursuant to the CSB Performance Contract and licensing regulations.

OCQI also conducts CM data reviews at least semi-annually. Quality Improvement Specialists (QIS) review CM data and provide technical assistance to the CSBs relative to CM data.

Office of Data Quality and Visualization

Office of Data Quality and Visualization (DQV) within the Division of the Chief Clinical Officer was established to support efforts for DBHDS to become an insight-driven organization and to align resources with the increasing demand for data analytics. The mission of DQV is to advance the use of quality data through collaboration and empowerment. The team promotes analytics as a key component in quality monitoring and decision-making throughout the agency by assisting SMEs and QIC subcommittees with the creation of specialized deliverables or services, including:

- Analytic consultation
- Data collection, restructuring, and reconciliation
- Ad-hoc data reporting and visualization
- Methodological development and reporting logic
- Documentation of data processes and cleaning procedures
- Survey development
- Sampling methodology
- Retrospective studies
- Queries for ad-hoc analysis
- Process mapping for data flow
- Advanced statistical analyses

DQV also supports the identification, evaluation, refinement, and documentation of processes that already exist in their respective areas and assists in determining where improvements can be made. Understanding the process from which data originate is a necessary component to deciding what data should be collected, analyzed, and reported. Therefore, it is essential that DQV team members gain a foundational understanding of business processes in order to assist SMEs with the development of effective data questions and analyses.

To support the mission of DQV, team members also work to assess data, measures, and source system integrity for data quality issues. Established profiling criteria are used in these assessments, including:

- Completeness
- Validity
- Reliability
- Accuracy
- Consistency
- Availability
- Timeliness
- Usefulness
- Uniqueness
- Relevance
- Format

When data quality issues have been identified using these criteria, DQV team members alert the QIC subcommittees in a variety of ways. First, they hold a seat at the table in order to see and understand the committee processes and participate from the bottom up, including different aspects of data entry, measure development, monitoring, visualization, reporting, improvement strategies, and future planning. As support staff or as voting members, this valuable position ensures they have an opportunity to ask questions, raise concerns, and provide education on specific issues. DQV team members identify and verbally address most issues during the course of QIC subcommittee meetings; however, if data quality concerns are more pervasive, DQV team members may communicate the issue through specially designated meetings or formalized reports and presentations.

In addition to identifying and communicating data quality concerns, DQV team members are in the trenches with SMEs and QIC subcommittees as they work to brainstorm solutions, utilize data collection tools, streamline procedures, and standardize documentation. DQV team members then work to educate SMEs, senior level staff, and other relevant stakeholders on the creation of new processes and workflows in order to implement these solutions and improvement strategies based on available agency resources. Team members may also advise on potential future resources, where appropriate.

DQV collaborates one-on-one with SMEs to document the details associated with each QIC-approved PMI, including a comprehensive methodology and set of calculation steps. After working with a SME to complete a measure development form, DQV conducts an assessment to identify potential threats to validity and reliability associated with each specific performance measure and documents them within each form.

There are several procedures inherent in how DQV functions. These procedures are conducted to continuously monitor, measure, and improve data quality. In an effort to exercise the versatility of the process and establish models for ongoing quality monitoring, DQV regularly applies a process established by Avedis Donabedian to the development of their quality monitoring efforts. General steps in this model of quality monitoring and improvement include:

1. Determining what to monitor
2. Determining priorities in monitoring
3. Selecting an assessment approach
4. Formulating criteria and standards

5. Obtaining the necessary information
6. Choosing when and how to monitor
7. Constructing a monitoring system
8. Bringing about behavior change

DQV utilized this approach to the development of a comprehensive Data Quality Monitoring Plan (DQMP). The DQMP was designed to be an objective assessment of the quality of the major data source systems used for DOJ SA reporting. The results of this plan will be used to guide the improvement of key data sources, monitor progress over time, and ensure that the Department is able to collect and analyze consistent, reliable data.

Mortality Review Office

The purpose of the Mortality Review Office (MRO) is to focus on system-wide QI by conducting mortality reviews of deaths of all individuals with an intellectual and/or developmental disability (I/DD) diagnosis who received services in the community from a DBHDS-licensed provider. MRO also provides oversight for all state operated facility deaths. On a daily basis, MRO performs activities necessary for the Mortality Review Committees (MRC) to complete their responsibilities. MRC provides ongoing monitoring and data analysis, identification of trends and patterns, and makes recommendations to promote the health, safety and well-being of said individuals, to reduce mortality rates to the fullest extent practicable.

As a commitment to the Commonwealth of Virginia, MRO contributes to the system of care improvements through integration of clinical evidence, data driven determinations, and evidenced based QI principles. Review, identification and analysis of trends, patterns, and issues related to the deaths of these individuals, can indicate opportunities for system improvement (to reduce risks to all individuals receiving behavioral health or developmental services). On an ongoing basis, DBHDS seeks to prevent instances of abuse, neglect, exploitation, and unexplained death by identifying and addressing relevant factors during mortality reviews.

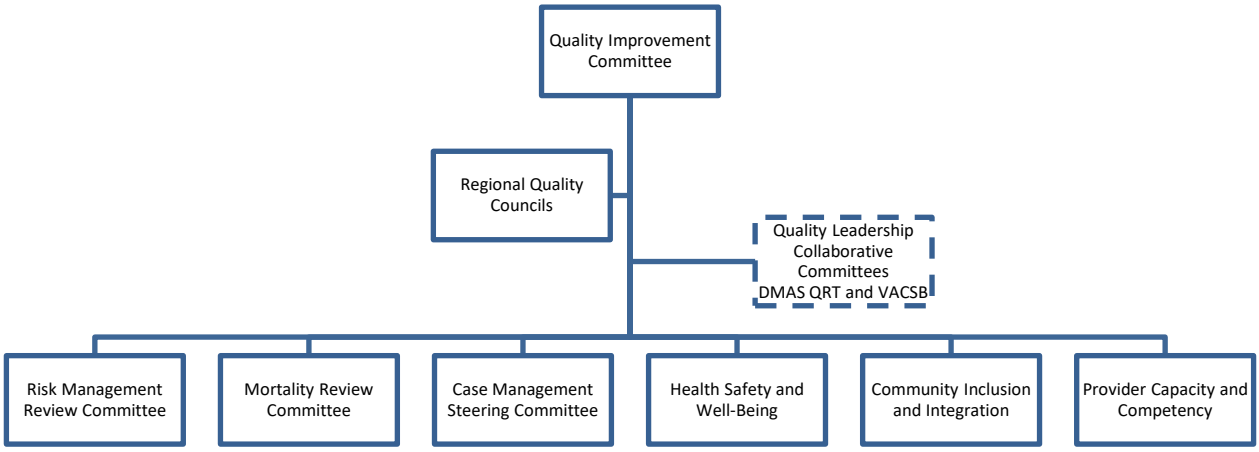
MRO is responsible for:

- Assuring receipt of documents from the OL (with respect to deaths that occur in the community) and state facilities within 45 business days of date of death
- Reviewing the documentation from service providers and facilities and assessing for risk mitigation, health, safety, and freedom from harm concerns noted therein
- Compiling relevant information into a succinct clinical summary for the MRC to review, within 90 calendar days of the date of death
- Classifying cases according to Tier category or reclassifying state facility determinations, when circumstances warrant
- Requesting additional information as needed
- Interviewing any persons having information regarding the individual's care

- Collecting, tracking, analyzing and reporting facility and I/DD mortality data to identify trends, patterns, and issues at the individual, service delivery and systemic levels
- Documenting MRC determinations (including recommendations), and monitoring assigned actions for completion

Organizational Quality Improvement Committee Structure

The current structure of the QM Program includes collection and analysis of data by various interdisciplinary quality committees. The chart below illustrates the DBHDS quality committee structure. In it, you see that the QIC subcommittees report up to the QIC.



Description of Quality Committee Structure

Quality Improvement Committee

The QIC is the highest-level quality committee for the agency and provides overall oversight of the QM Program. All other quality committees report to the QIC. The QIC ensures a process of CQI and maintains responsibility for prioritization of needs and work areas and resource allocation to achieve intended outcomes for the agency and the Commonwealth. The QIC identifies systemic issues or potential gaps within the semi-annual review of provider reporting measures and issues recommendations, including revisions to QIIs as needed.

Regional Quality Councils

The DBHDS Commissioner established Regional Quality Councils (RQCs) for DD in each of the five DBHDS regions in Virginia. RQCs review and evaluate state and available regional data related to performance measure indicators (PMIs) and monitoring efforts to identify trends and recommend responsive actions. RQCs recommend QIIs to the QIC and implement QIIs as the QIC directs.

Risk Management Review Committee

RMRC seeks to improve quality and safety by learning from past performance, errors, and near misses, and to gain awareness of areas of vulnerability in practice and to improve these areas, thereby creating a safer environment for the delivery of services. Risk assessment and management is a key dimension of managing quality overall. Risk assessment and management involves identification and mitigation through incident reporting, investigation, and response to serious incidents to protect an individual's safety and well-being and to mitigate reoccurrence in both the facilities and in community-based services.

The primary task of the RMRC is to establish goals and PMIs that affect outcomes related to safety and freedom from harm and avoiding crises. Establishing uniform risk triggers and thresholds, recommending processes to investigate reports of serious incidents, and identifying remediation steps, achieve this. In addition, RMRC offers recommendations for guidance and training on proactively identifying and addressing risks of harm, conducting root cause analyses, and developing and monitoring CAPs. RMRC reviews and analyzes trends to determine and recommend QIIs to prevent and or substantially mitigate future risk of harm. RMRC monitors serious incident reporting, establishes targets, and recommends actions and improvement initiatives when targets are not met.

Mortality Review Committee

Mortality Review Committee (MRC) reviews and collects mortality data for intellectual and developmentally disabled (DD) individuals who received services from a DBHDS licensed provider at the time of their death. The committee's purpose is to identify and implement system wide QIIs to reduce the mortality rates for this targeted population to the fullest extent practicable. MRC conducts a trend analysis of mortality data to identify patterns at the individual service-delivery and system levels. The mortality review process enhances quality by providing information that triggers corrective action to reduce future risk and affords a retrospective examination regarding process, service level performance, and adherence to standards, to inform CQI.

Case Management Steering Committee

CMSC is responsible for monitoring CM performance across responsible entities to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings. There is a core committee and two sub-committees – one focused on data and one on the SCQR process. CMSC evaluates data to identify and respond to trends to ensure CQI and is responsible for reviewing data to determine progress toward meeting established CM/SC targets. Based on this data review and system analysis, the committee recommends systemic QIIs to the QIC, provides technical assistance, and makes recommendations for action under the Performance Contract when targets are not met.

Health, Safety, and Wellbeing Key Performance Area (KPA) Workgroup

The DD Health, Safety and Wellbeing KPA Workgroup is responsible for the collection and analysis of data as it relates to helping individuals achieve positive health outcomes. The workgroup is tasked with establishing goals and PMIs related to physical, mental, and behavioral health and well-being, safety and freedom from harm and avoiding crises. Data related to prevention strategies, wellness trends, and clinical outcomes are monitored. The workgroup provides technical assistance and oversight for clinical QI strategies for these measures. The workgroup recommends at least one QII per year.

Community Inclusion and Integration Key Performance Area (KPA) Workgroup

The DD Community Inclusion and Integration KPA Workgroup is charged with promoting service provisions in the most integrated settings and ensuring full access and participation in community life. The workgroup establishes goals and PMIs to ensure the most integrated settings appropriate to the individuals' needs, community stability, individual choice and self-determination and community inclusion. The workgroup recommends at least one QII per year.

Provider Capacity and Competency Key Performance Area (KPA) Workgroup

The DD Provider Capacity and Competency KPA Workgroup is charged with improving availability of and access to DBHDS services across the Commonwealth and facilitating provider training, competency and quality service provision. The workgroup establishes goals and PMIs related to access to services and provider competency. The workgroup recommends at least one QII per year.

Quality Leadership Collaborative

DBHDS Quality Leadership Collaborative provides an opportunity for enhanced collaboration and coordination of quality at a cross-agency or cross-sectoral level. The aim of the Quality Leadership Collaborative is to align shared missions and visions and provide a forum to enhance communication and data sharing through a single process. The work of the Quality Leadership Collaborative may inform the work of the DBHDS QIC but is not considered to be a sub-committee of the DBHDS QIC. The current Quality Leadership Collaborative in which DBHDS participates includes the DBHDS/DMAS Quality Review Team.

HCBS Quality Management: DBHDS/DMAS Quality Review Team

The Division of Developmental Services (DDS), as the administrative entity for the Commonwealth's DD Waivers, has delegated authority over the quality of services delivered under the waivers. DMAS, as the state Medicaid agency, retains overall state level authority over the DD HCBS Waivers' Quality Improvement Strategy outlined in the waiver applications. DMAS and the DDS Waiver Operations Unit collaboratively oversee implementation of these plans using data derived from both DMAS and DBHDS designated offices with data, administrative and technical support from both agencies.

All HCBS waiver programs must operate in accordance with the CMS required waiver assurances. States develop CMS DD PMs under each assurance, which serve as the indicators of performance. Specific details regarding the frequency of review, sample size, methods of discovery and remediation, and responsible parties are detailed in the state's HCBS 1915c Waivers Applications.

Ongoing compliance with the assurances is necessary to maintain Virginia's DD Waivers program.

The assurances include the following:

1. Administrative Authority-The State Medicaid agency is responsible for the oversight of the waiver and is ultimately responsible for all facets of the program.
2. Evaluation/Reevaluation of Level of Care - Individuals enrolled in the waiver have needs consistent with an institutional level of care.
3. Person-Centered Planning and Service Delivery-Service Plan-Participants have a service plan that is appropriate to their needs, and services/supports specified in the plan are received.
4. Qualified Providers-Waiver providers are qualified to deliver services/supports.
5. Health and Welfare-Participants' health and welfare are safeguarded and monitored.
6. Financial Accountability-Claims for waiver services are paid according to state payment methodologies.

DBHDS and DMAS have primary responsibility for monitoring performance under the waiver assurances through the DD Waiver Quality Review Team (QRT). QRT meets on a quarterly

basis to report on and review the results of the discovery and remediation activities for each performance measure and establish systemic remediation strategies for those measures that fall below the CMS-established 86% standard in a waiver year. The work of the QRT is accomplished by accessing data across a broad range of monitoring activities, including DBHDS licensing and human rights investigations and inspections; DMAS QM reviews (QMR); serious incident reporting; CM data reporting; QSRs; mortality reviews; and DBHDS level of care evaluations performed by CSBs.

QRT identifies barriers to performance and the steps needed to address them. These remediation steps are in addition to state agency required provider or individual-level remediation. First level systemic remediation includes statewide or regional provider training and targeted technical assistance conducted by DDS Provider Development and/or OIH. Remediation strategies may include, but are not limited to, targeted communication to the provider community, changes in protocols or processes designed to ensure the health and safety of individuals, IT system enhancements for collecting and reporting data, changes to state standards (regulations and policy manual), payment retractions, change in licensing status, targeted QMRs by DMAS, and ceasing referrals to providers.

A requirement for participation in the Medicaid HCBS Waiver program is multi-year evidence reporting to CMS during the third year of each waiver's five-year approval cycle. The purpose of the reporting is to ensure that the waivers are being implemented as intended through review of waiver program data and QI activities. States are required to report performance regarding the state's specific CMS DD PMs related to the six required CMS assurances. States must demonstrate a certain level of compliance (currently set by CMS at 86%) for each performance measure.

DBHDS Quality Management System Quality Improvement Process Description:

In accordance with this structure, the creation and/or discontinuation of a DBHDS quality committee/workgroup shall be approved by the QIC. Basic standard operating procedures apply to all quality committees and include:

- Development and annual review and update of the committee charter
- Committees are expected to meet regularly to ensure continuity of purpose
- Committees are expected to maintain reports and/or meeting minutes as necessary and pertinent to the committee's function
- Quality improvement initiatives in each committee follow the Plan, Do, Study, Act Model

The following standard definitions apply to all quality committees:

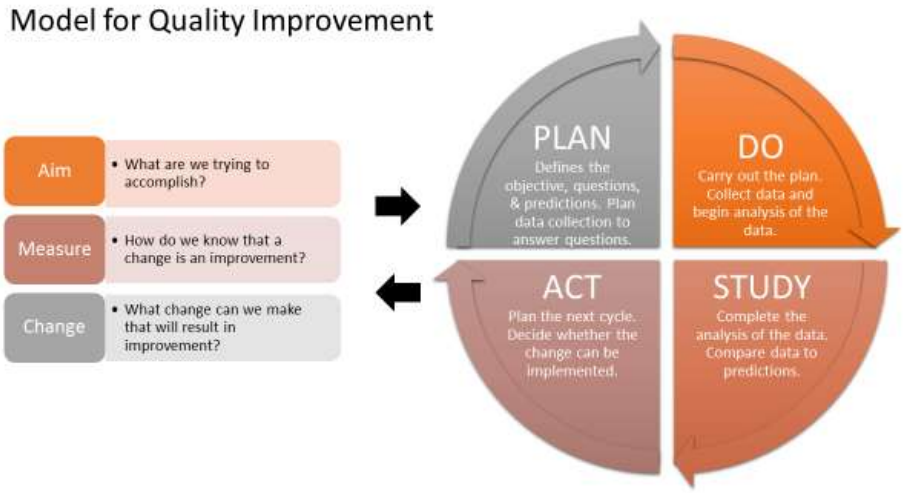
- Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval.
- Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations
- Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues.
- Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity.
- Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver.
- Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Wellbeing; Community Inclusion and Integration; and Provider Capacity and Competency.
- Key Performance Area Workgroups - DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains.
- N - Sample size
- National Core Indicators - Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety
- Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review.
- Quality Committees - The QIC and QIC Subcommittees collectively
- Quality Improvement Committee (QIC) Subcommittee/Quality Committee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality

Review Committee, Regional Quality Councils, and the Risk Management Review Committee).

- Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees
- Quality Improvement Initiative (QII) - Addresses systemic quality issues identified through the work of the QIC subcommittees.
- Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS.
- Quality Service Review (QSRs) - Review conducted for evaluation of services at individual, provider, and system-wide levels to determine whether individuals' needs are being identified and met through person-centered planning and thinking, whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals have opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, QI and RM strategies, and provide recommendations to providers for improvement.
- Quorum - Number of voting members required for decision-making.
- Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions.
- State Fiscal Year (SFY) - July 1 to June 30
- Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval.
- Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

The DBHDS Quality Management program utilizes the Plan-Do-Study-Act[4] quality improvement model depicted below.

[4] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.



Performance Outcomes and Improvement Initiatives

Quality remains a continuous process, rather than a one-time activity, and connects with the agency's mission, vision and strategic plan. This process involves:

- Development of quality outputs and outcomes
- Data collection
- Data analysis
- Evaluating the effectiveness of the overall system
- Determining findings and conclusions
- Identifying trends that need to be addressed
- Identifying corrective actions, remedies, or quality improvement initiatives as needed
- Implementing quality improvement initiatives, corrective actions or remedies; and
- Evaluating the effectiveness of implemented corrective actions, remedies, and or quality improvement initiatives.

Regardless of an organization's chosen quality model, leadership commitment, engagement of employees, defined structures and processes, defined performance measures, data driven quality initiatives, and customer focus are all essential elements of any quality management framework. This framework sets the stage for our QM work plan (Part 2) which includes committee charters and a template of the QIC subcommittees' work plan.

Part 2 Quality Improvement Committee (QIC) and QIC Subcommittee Charters and Work Plan

QIC and QIC Subcommittee Charters

Quality Improvement Committee Charter
QIC Approved September 27, 2021

Committee / Workgroup	Quality Improvement Committee
Statement of Purpose	The Quality Improvement Committee (QIC) is the designated oversight body for the Quality Management System of the Department of Behavioral Health and Developmental Services (DBHDS). The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas.
Authorization/Scope of Authority	The Executive Sponsor of the QIC is the Commissioner of DBHDS and the Commissioner maintains executive authority over the actions taken by the QIC. In keeping with DBHDS's mission, vision and values, the QIC is the highest-level quality committee with all other quality subcommittees reporting to the QIC.
Charter Review	The QIC charter will be reviewed and/or revised on an annual basis or as deemed necessary by the committee.
DBHDS Quality Improvement Standards	**DBHDS is committed to a Culture of Quality that is characterized as:** • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS subcommittees assigned to implement QIIs will report data related to the QIIs to the QIC to enable the QIC to track implementation. Through data reviews and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the QIC identifies areas for development of QIIs.

	To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the QIC: • Approves new, revised or retired PMIs that are based in data analysis and in keeping with continuous quality improvement practices • Analyzes data and monitors for trends to identify areas for systemic improvement • Reviews annual reports and determines recommendations to be addressed through quality subcommittees; ensures that deficiencies have been addressed • Develops strategic recommendations regarding any gaps or issues with availability of services identified through data reviews from Quality Service Reviews (QSRs) and National Core Indicators (NCI) related to the quality of services and individual level outcomes • Gathers stakeholder input to inform recommended actions • Approves proposed QIIs whose design follows the Model for Quality Improvement, addresses identified systemic area of concern, aligns with agency priorities, and agency resources permit implementation of the QII as written • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed
Structure of Committee / Workgroup:	
Membership	The QIC is composed of internal and external stakeholders who have clinical training and experience in quality improvement, quality management, resource management, intellectual disabilities/developmental disabilities, behavioral health, compliance, behavioral analysis, provider services, and data analytics. **<u>Voting Members:</u>** • DBHDS Commissioner (Executive Sponsor) • Chief Deputy Commissioner, Community Services • Chief Clinical Officer • Senior Director of Clinical Quality Management

	• Chief Administrative Officer • Deputy Commissioner for Facilities • Deputy Commissioner for Quality Assurance and Government Relations • Assistant Commissioner for Developmental Disability Services **<u>Advisory Members (non-voting):</u>** • Assistant Commissioner of Quality Assurance and Government Relations • Assistant Commissioner for Facilities • Director, Community Quality Management • Pharmacy Manager • Behavioral Health Facility Director • Training Center Director • Representative, Department of Medical Assistance Services • Liaisons, Regional Quality Councils • Quality Improvement Director, Community Services Board • Representative, Service Provider • Representatives, Associations as determined by the committee
Meeting Frequency	The QIC shall meet at a minimum four times a year. Meetings can occur in the absence of quorum; however, no action, where approval of the QIC is required, could be taken in this instance. In such instances, approval may be sought via email.
Quorum	A quorum shall be defined as 50% plus one of voting membership. These actions require quorum: approval of minutes, approval/denial of QIIs, PMIs (new, revised, ending), and charter revisions.
Leadership and Responsibilities	The Chief Clinical Officer and Senior Director of Clinical Quality Management shall serve as committee chair and co-chair and shall be responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics. <u>Standard Operating Procedures include</u>: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the committee's function • Analysis of PMIs to measure performance across the key performance areas, to determine if a PMI needs to be revised or retired, at least on an annual basis • Prioritizes needs and work areas • Directs the work of the QIC subcommittees

	The QIC: • Ensures a process of continuous quality improvement • Approves the creation/discontinuation of quality improvement subcommittees/workgroups • Approves all quality committees' charters • Monitors quality subcommittees/workgroups • Holds QIC subcommittees accountable for QIIs • Reviews the progress of performance measure indicators (PMIs) across all eight domains • Approves and prioritizes QIIs resources • Reviews/monitors provider reporting measures semi-annually with input from the RQCs, identifies systemic deficiencies or potential gaps, issues recommendations, monitors measures, and makes revisions to QIIs as needed • Annually, assesses the validity of provider reporting measures • Reviews the recommendations reported by the RQCs and directs the implementation of any QII to the relevant DBHDS staff after approval by the QIC and the Commissioner • Directs the work of the Regional Quality Councils (RQCs) and reviews reports and/or recommendations presented by the RQCs; reports to the RQCs on any decisions and related implementation of RQC recommendations • Reports publicly on an annual basis regarding the availability and quality of supports and services, gaps in supports and services, and provides recommendations for improvement • Informs stakeholders of QIIs approved for implementation including those that result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents or deaths Membership Approval: The DBHDS Commissioner shall approve the committee membership. The DBHDS Commissioner appoints advisory members. Internal members are appointed by role. Member Responsibilities: **Voting Members**: • Have decision making capability and voting status. • Attend 75% of meetings per year; may send a proxy to one meeting per year • Review data and reports for meeting discussion

	• A designated proxy has the authority that the voting member maintains and therefore should be in a position reflective of that authority, including awareness of the organization or system impact of actions taken by the QIC **Advisory Members**: • Perform in an advisory role for the QIC whose various perspectives provide insight on QIC performance goals, outcomes PMIs and recommended actions • Inform the committee by identifying issues and concerns to assist the QIC in voting and prioritizing meaningful QI initiatives • Attend 75% of meetings per year and may send a proxy to one meeting per year if the proxy represents the same advisory role (i.e. representing same subject matter, discipline, or DBHDS office) • Advisory members, save RQC liaisons, have no term limits. RQC liaisons can serve up to two consecutive terms (one term is three years). All members receive orientation and training, both as new to the committee and on an annual basis. Members shall be trained on the Quality Management System, QIC charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members- Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions- DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan- Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include

	Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups-DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N -Sample size • National Core Indicators- Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety. • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees- The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative (QII) - Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan- Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review- Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate whether individuals' needs are being identified and met through person-centered planning and thinking, 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. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum- Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions.

	• State Fiscal Year (SFY)- July 1 to June 30 • Voting Members- Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS)-The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Regional Quality Council Charter
QIC Approved September 27, 2021

Committee / Workgroup	Regional Quality Councils
Statement of Purpose	As a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), the Regional Quality Councils (RQCs) are to identify and address risks of harm and ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings. RQCs review and evaluate state and available regional data related to performance measure indicators (PMIs) and monitoring efforts to identify trends and recommend responsive actions in their respective regions to ensure continuous quality improvement.
Authorization / Scope of Authority	The RQCs are part of the DBHDS quality oversight structure and represent each of the five DBHDS regions in Virginia. DBHDS provides the RQCs with relevant and reliable data to include comparisons with other internal or external data, as appropriate, as well as multiple years of data (as it becomes available). The PMIs guide the RQC's discussion and monitoring. The QIC directs the work of the RQCs. RQCs may request data that may inform quality improvement initiatives (QIIs) and if requested data is unavailable, RQCs may make recommendations for data collection to the QIC.
Charter Review	The RQC charter is reviewed/revised on an annual basis or as needed and submitted to the QIC for approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and QIIs as indicated
Model for Quality Improvement	With the approval of regional QIIs implemented at the direction of the QIC, each RQC QII work group will report to the respective RQC regarding the status of the QII being implemented. This report, including associated data, will help the RQCs track implementation of the regional QII. The RQCs use the presented data (including trends and patterns), along with their analysis, to identify areas for development of QIIs at the individual, service-delivery, or systemic levels. To that end, the committee determines the: • Aim: What are we trying to accomplish?

	• Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the RQC: • Reviews and evaluates data, trends, and monitoring efforts • Based on topics and data reviewed, recommends at least one QII to the QIC annually • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the RQC Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Committee / Workgroup:	
Membership	An interdisciplinary team approach will be achieved through representation from the following stakeholder groups: • Residential Services Providers • Employment Services Providers • Day Services Providers • Community Services Board (CSB) Developmental Services Directors • Support Coordinators/Case Managers • CSB Quality Assurance/Improvement staff • Provider Quality Assurance/Improvement staff • Crisis Services Providers • Individuals receiving services or on the Developmental Disability Waiver waitlist (self-advocate) • Family members of an individual previously or currently receiving services or on the *waitlist (Previously is defined as within the past 3 years, either the individual having passed or lost services for whatever reason.)* Membership will include one person from each of these stakeholder groups with an additional Support Coordinator/Case Manager and Self-Advocate for each region. In addition, the following DBHDS employees shall be standing members of each RQC: • Director, Community Quality Management or designee • Regional Quality Improvement Specialist

	• Community Resources Consultant Process for recruiting/approval of members: RQC members and alternates (excluding DBHDS standing employee members) are nominated by other RQC members, DBHDS regional staff, or DBHDS Quality Improvement staff. Quality Improvement staff contact nominees regarding the nominee's willingness to serve. All nominations of RQC members and alternates are reviewed and approved by the QIC chair/co-chair. Role of Alternates: An alternate for each membership role will serve as a proxy at meetings when the incumbent cannot attend. The alternate represents the same stakeholder group (i.e., employment provider) as the member and serves as the member's proxy for voting. Alternates receive meeting agendas, meeting minutes and reports to be considered at meetings, and attend meetings in order to listen to discussions and decisions. This ensures continuity by providing the alternate with the ability to be informed in the event the member is not able to attend and the alternate is called upon to represent the stakeholder group. Membership Term(s): RQC members (excluding DBHDS standing employee members) can serve up to two consecutive terms (one term is three years). The member would have one year of non-involvement before being eligible to serve as a member again. If a member resigns for any reason prior to the fulfillment of the term, if willing, the alternate will fill the vacated membership position. If the alternate agrees to fill the vacated membership position, another alternate representing the same stakeholder group will be nominated and approved by the QIC chair/co-chair to fill the now vacated alternate position. If the alternate is not willing to serve as the member, they will serve as proxy until a new member is nominated and approved by the QIC chair/co-chair. Alternates do not have term limits.
Meeting Frequency	The RQCs will meet on at least a quarterly basis. Each RQC shall meet with a quorum at least three (3) of the four (4) quarterly meetings in a state fiscal year. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is defined as at least 60% of members or their alternates, including representation from the following groups (One member may satisfy two roles): • a member of the DBHDS QIC • an individual experienced in data analysis • a Developmental Disability (DD) service provider • an individual receiving services or on the DD Waiver waitlist or a family member of an individual receiving services or on the DD Waiver waitlist. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, and proposed charter approval.

Leadership and Responsibilities	The DBHDS Regional Quality Improvement (QI) Specialist shall serve as chair of the RQC. The chair will be responsible for ensuring the council performs its functions. <u>Standard Operating Procedures:</u> • Develop, update, and review annually the subcommittee charter • Meet regularly to ensure continuity of purpose • Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function • Analyze data to identify and respond to trends to ensure continuous quality improvement • Recommend QIIs (at least one per fiscal year, based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC Each RQC will: • Review and assess (i.e., critically consider) the data that is presented to identify: a) possible trends b) questions about the data and c) any areas in need of QIIs and identifies and records themes in meeting minutes • Determine for each identified topic area if: a) more information/data is needed for the topic area b) a QII should be prioritized for the region and/or recommend a QII to DBHDS c) or if no action is needed/will be taken in that area at this time • Propose at least one measurable outcome for each QII recommended by the RQC • Monitor the regional status of any statewide quality improvement initiatives implemented as directed by the QIC • Monitor and review provider reporting measures at least semi-annually and provide input to the QIC on these measures • Review the results of Quality Service Reviews (QSR) and use findings to make recommendations to the QIC regarding identified needs. • Review and approve meeting minutes to ensure accurate reflection of discussion, evaluation of data, and recommendations of the RQC. The DBHDS Office of Community Quality Improvement maintains approved meeting minutes for 100% of meetings. • Report to the QIC for oversight and system-level monitoring at least three times per state fiscal year • Report annually to the QIC on the results of the RQC implemented QIIs • Present 100% of agreed upon recommendations to the QIC

	Member Responsibilities: Each member, including alternates, will be oriented to the purpose, operations and member responsibilities including quality improvement, data analysis and related practices. This orientation is completed independently online or virtually/live with a QI Specialist. This training shall be offered and suggested to be completed within one month of receiving notification of approval of membership. All RQC members, including alternates, will have the opportunity to review relevant training resources as they become available. Members are responsible for reviewing data and reports provided and engaging in discussions, which include an exchange of ideas from the perspective of the stakeholder group they represent. RQC Liaison: Each RQC will appoint a member (excluding DBHDS employees) to serve as liaison to the QIC. Liaisons attend the QIC meetings, either in-person or remotely, representing their respective RQC. Liaisons are responsible for reporting all agreed upon RQC recommendations to the QIC. If the liaison cannot attend the QIC (in-person or remotely), another member of that RQC shall be asked to represent that RQC at the QIC meeting.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members- Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions- DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains- Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity.

	• Key Performance Area Workgroups- DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N- Sample size • National Core Indicators- Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety. • Performance Measure Indicators (PMIs)-Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees- The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee- DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative- Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan- Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review- Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate whether individuals' needs are being identified and met through person-centered planning and thinking, 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. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum- Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY)- July 1 to June 30

	• Voting Members- Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Risk Management Review Committee Charter
QIC Approved September 27, 2021

Committee / Workgroup	Risk Management Review Committee
Statement of Purpose	The purpose of the Department of Behavioral Health and Developmental Services (DBHDS) Risk Management Review Committee (RMRC) is to provide ongoing monitoring of serious incidents and allegations of abuse and neglect; and analysis of individual, provider and system level data to identify trends and patterns and make recommendations to promote health, safety and well-being of individuals. As a subcommittee of the DBHDS Quality Improvement Committee (QIC), the RMRC identifies and addresses risks of harm; ensures the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collects and evaluates data to identify and respond to trends to ensure continuous quality improvement. The RMRC has been established to improve quality of services and the safety of individuals with developmental disabilities (DD).
Authorization/Scope of Authority	This committee is authorized by the DBHDS QIC and is coordinated by the Division of Quality Assurance and Government Relations and the Office of Clinical Quality Management. The RMRC's overall risk management process enables DBHDS to identify and prevent or substantially mitigate risks of harm. The RMRC reviews and analyzes related data collected from facilities and community service providers, including reports of serious incidents and allegations of abuse and neglect. The RMRC also reviews data and information related to DBHDS program activities, including licensing reviews, triage and review of serious incidents, and oversight of abuse/neglect allegations.
Charter Review	The RMRC was established in December 2014. The charter will be reviewed and/or revised on an annual basis, or as needed, and submitted to the QIC for approval.
DBHDS Quality Improvement Standards	**DBHDS is committed to a Culture of Quality that is characterized as:** • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QII) as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the RMRC to enable the committee to track implementation. Through look-behind reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the RMRC identifies areas for development of QIIs.

	To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the RMRC: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Reviews trends at least quarterly; utilizes data analysis to identify areas for improvement and monitor trends. The RMRC identifies priorities and determines QIIs as needed, including identified strategies and metrics to monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the RMRC Data reviews occur as part of quality improvement activities and as such are not considered research.

Structure of Committee / Workgroup:	
Membership	RMRC is an internal inter-disciplinary team comprised of the following DBHDS employees with clinical training and experience in the areas of behavioral health, intellectual disabilities/developmental disabilities, leadership, medical, quality improvement, and data analytics: **Voting Members:** • Assistant Commissioner of Quality Assurance and Government Relations or designee • Director, Community Quality Management, or designee • Director, Provider Development, or designee • Director, Office of Human Rights, or designee • Director, Office of Integrated Health. or designee • Incident Manager, Office of Licensing, or designee • Representative, Data Quality and Visualization • Settlement Agreement Director, or designee • Risk Manager, Training Center or designee • Office of Licensing Quality Improvement Review Specialist **Advisory Members:** • Deputy Commissioner of Quality Assurance and Government Relations • QI/QM Coordinator • Quality Improvement Specialists • Investigations Manager, Office of Licensing, or designee • Advisory consultants as needed/required
Meeting Frequency	The RMRC meets at least ten times a year with a quorum present; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is defined as 50% plus one of the approving members. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Assistant Commissioner of Quality Assurance and Government Relations or designee chairs the RMRC. The chair will be responsible for ensuring the committee performs its functions. The standard operating procedures include: • Develop, update and review annually the committee charter • Meet regularly to ensure continuity of purpose

	• Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function • Analyze data to identify and respond to trends to ensure continuous quality improvement • Recommend QIIs (at least one per fiscal year, based on data analysis designed to mitigate risks, and foster a culture of safety in service delivery based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC The RMRC will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001–Privacy Policies and Procedures for the Use and Disclosure of PHI) • Develop an incident management process that is responsible for review and follow-up of all reported serious incidents including protocols that identify a triage process, a follow-up and coordination process with licensing specialists and investigators, human rights advocates and referrals to other DBHDS offices as appropriate and documentation of trends, patterns and follow-up on individual incidents • Provide oversight for a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The reviews evaluate whether: o The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols o The provider's documented response ensured recipient's safety and well-being o Appropriate follow-up from the Office of Licensing incident management team occurred when necessary o Timely, appropriate, corrective action plans are implemented by the provider when indicated. o The RMRC will review trends quarterly, recommend changes to processes, protocols, or quality improvement initiatives when necessary and track implementation of any changes or quality initiatives approved for implementation. • Provide oversight of a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review evaluates whether: o Comprehensive and non-partial investigations of individual incidents occur within state prescribed timelines o The person conducting the investigation has been trained to conduct investigations o Timely, appropriate, corrective action plans are implemented by the provider when indicated. o The RMRC will review trends quarterly, recommend changes to processes, protocols, or quality improvement initiatives when necessary and track implementation of any changes or quality initiatives approved for implementation.

	• Systematically review and analyze data related to serious incident reports (SIR), deaths, human rights allegations of abuse, neglect and exploitation, findings from licensing inspections and investigations, and other related data • Review details of individual serious incident reports when indicated • Review and identify trends from aggregated incident data, including allegations of abuse, neglect, and exploitation, at least four times per year by various levels such as by region, by Community Services Board (CSB), by provider locations, by individual, or by levels and types of incidents • Monitor aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators. When targets are not met, the RMRC determines whether QIIs are needed, and if so, monitors implementation and outcomes. • Utilize the findings from review activities to develop, or recommend, the development of guidance, training, or educational resources to address areas of risk prevalent within the DBHDS service population • Review, analyze and identify trends related to DBHDS facility risk management programs to reduce or eliminate risks of harm • Monitor the effective implementation of DI 401 (Risk and Liability Management) by reviewing facility data and trends, including risk triggers and thresholds to address risks of harm • Review the results of Quality Service Reviews (QSR) as it relates to identified risks of harm, including appropriate provider response to risks, address risk triggers and thresholds and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Share data or findings with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Ensure the annual review of guidance, training, or educational resources; and update as necessary to ensure current guidance is reflected. Use data and information from risk management activities to identify topics for future content as well as determine when existing content needs revision. • Produce an annual report (based upon state fiscal year) for inclusion in the annual Quality Management Plan • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs. Report findings, conclusions and recommendations as unusual patterns or trends are identified <u>Membership Responsibilities:</u> **Voting Members:** • Have decision making capability and voting status

	• Review data and reports for meeting discussion • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members:** • Perform in an advisory role for the RMRC whose various perspectives provide insight on RMRC activities, performance outcomes, and recommended actions • Inform the committee by identifying issues and concerns to assist the RMRC in developing and prioritizing meaningful QIIs • Support the RMRC in performing its functions All members receive orientation and training both as new members to the committee and on an annual basis. Material shall include information pertaining to QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members- Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions-DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan- Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains- Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity.

	• Key Performance Area Workgroups- DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N- Sample size • National Core Indicators- Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety. • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees- The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee- DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative- Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review- Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate whether individuals' needs are being identified and met through person-centered planning and thinking, 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. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum -Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY)- July 1 to June 30

	• Voting Members- Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Mortality Review Committee Charter
QIC Approved September 27, 2021

Committee	Mortality Review
Statement of Purpose	The purpose of the DBHDS Developmental Disabilities (DD) Mortality Review Committee (MRC) is to focus on system-wide quality improvement by conducting mortality reviews of individuals who were receiving a service licensed by DBHDS at the time of death and diagnosed with an intellectual disability and/or developmental disability (I/DD), utilizing an information management system to track the referral and review of these individual deaths.
Authorization / Scope of Authority	The DBHDS Commissioner is the executive sponsor of the MRC and designates the Chief Clinical Officer (CCO) to establish and supervise the Mortality Review Office (MRO). Through the DBHDS incident reporting system, and in collaboration with the Office of Licensing, the MRC reviews deaths of individuals with I/DD who received a service licensed by DBHDS at the time of death. The MRC is a sub-committee of the Quality Improvement Committee (QIC). The MRC provides ongoing monitoring and data analysis to identify trends and/or patterns and then makes recommendations to promote the health, safety and well-being of said individuals. To the best of its ability, the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable. The MRC also develops and assigns specific relevant actions when needed.
Charter Review	The MRC charter is reviewed and/or revised on an annual basis, or as deemed necessary by the committee and approved by the QIC.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated DBHDS demonstrates on an on-going basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

	DBHDS develops and implements QIIs, either regionally or statewide, as recommended by the MRC and approved by the DBHDS Commissioner, to reduce mortality rates to the fullest extent practicable.
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the MRC to enable the committee to track implementation. Through mortality reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the MRC identifies areas for development of QIIs. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the MRC: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Share data or findings with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed

	• Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the MRC Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Committee:	
Membership	The MRC is composed of members with training and experience in the areas of I/DD, including but not limited to: Clinical expertise, Medical and pharmacy services, Quality improvement, Compliance, Incident management, Behavior analysis, and Data analytics. Required Mortality Review Committee DBHDS members include: • Chief Clinical Officer *(MD, and staff member with QI and programmatic/operational [P/O] expertise)* • Assistant Commissioner of Developmental Services, or designee *(staff member with QI and P/O expertise)* • Assistant Commissioner for Compliance, Risk Management, and Audit or designee *(staff member with QI, P/O, and regulatory expertise)* • Senior Director of Clinical Quality Management *(staff member with QI and P/O expertise)* • Director, Community Quality Management, or designee *(Clinician or staff member with QI and P/O expertise)* • Director, Office of Human Rights, or designee *(staff member with regulatory, QI and P/O expertise)* • Director, Office of Integrated Health, or designee *(staff member with QI and PO expertise)* • MRO Clinical Manager, MRC Co-Chair (*NP and staff member with QI and P/O expertise*) • OL Manager, Incident Team *(staff member with regulatory and P/O expertise)* • OL Manager, Investigation Team *(staff member with regulatory and P/O expertise)* • Office of Pharmacy Services Manager *(PharmD and staff member with regulatory, QI and P/O expertise)* • MRO Clinical Reviewer *(RN and staff member with QI and P/O expertise)* • MRO Program Coordinator *(Staff member with QI and P/O expertise)* • A member with clinical experience to conduct mortality reviews who is otherwise independent of the State *(medical doctor, nurse practitioner, or physician assistant, who is an external member with P/O expertise)* Advisory *(non-voting members*) nominated by the Commissioner or Chair of the MRC, which may include; • DBHDS Assistant Commissioner, Division of Quality Assurance and Government Relations • Representative, DBHDS Office of Data Quality and Visualization

	• Representative, Department of Medical Assistance Services • Representative, Department of Health • Representative, Department of Social Services • Representative, Office of Chief Medical Examiner • Representative, Community Services Board • Other Subject matter experts such as representatives from a DD Provider or Advocacy Organizations
Meeting Frequency	The MRC meets, at minimum, on a monthly basis or more frequently as necessary to conduct mortality reviews with 90 days of death. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is 50% of voting membership plus one, with attendance of at least: (One member may satisfy two roles) • A medical clinician (*medical doctor, nurse practitioner, or physician assistant*) • A member with clinical experience to conduct mortality reviews • A professional with quality improvement expertise • A professional with programmatic/operational expertise These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of quality improvement initiative (QII), PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The DBHDS Commissioner shall serve as the executive sponsor of the MRC and the CCO, or Clinical Manager (CM), shall serve as committee chair. The committee chair shall be responsible for ensuring the committee performs its functions, consideration and, as appropriate, approval of quality improvement activities, and MRC core processes. <u>Standard operating procedures</u>: • The Specialized Investigation Unit (SIU) reviews all deaths of individuals with I/DD reported to DBHDS through its incident reporting system. Available records and information are obtained for individuals with I/DD who were receiving a licensed service, and the OL Investigation (OLI) is submitted to the MRO within 45 business days (9 weeks) of the date the death was reported. • The MRO then has four weeks after receipt of the OLI to compile a case review. Within 90 calendar days of a death, (and for any unreported deaths, as defined on page 6), the Mortality Review Team (MRT) compiles a review summary of the death. This includes development of succinct clinical case summaries (definition page 11) within two weeks of reviewing and documenting the availability or unavailability, of: o Medical records: Including healthcare provider and nursing notes for three months preceding death o Incident reports for three months preceding death o Most recent individualized service program plan o Medical and physical examination records o Death certificate and autopsy report (when performed)

	○ Any evidence of maltreatment related to the death ○ Interviewing, as warranted, any persons having information regarding the individual's care ○ When additional documents are needed, the MRT will request these records from appropriate entities per Virginia Code §§2.2-3705.5, 2.2-3711, and 2.2-4002 amendment of the Virginia Code • The Clinical Reviewers document all relevant information onto the electronic Mortality Review Form and submits each clinical case summary for final review. The CCO or CM reviews all clinical case summaries and assigns a Tier category based on the sequential information related to the events surrounding that individual's death. The criteria for each Tier category is also utilized. These cases are then considered final clinical summaries (see Definitions, page 11). A facilitated discussion is conducted during MRC meetings for all Tier 1 cases and those cases where the Tier category could not be determined without MRC discussion and decision-making. • To ensure confidentiality and adhere to mandated privacy regulations and guidelines, case reviews are provided to MRC members during the meeting only. At that time, a facilitated narration with discussion occurs. <u>At each meeting the MRC members:</u> • Perform comprehensive clinical mortality reviews utilizing a multidisciplinary approach thataddresses relevant factors *(e.g., medical, genetic, social, environmental, risk, susceptibility, and others as specific to the individual)* and quality of service. • Evaluate the quality of the decedent's licensed services related to disease, disability, health status, service use, and access to care, to ensure provision of a reliable, person-centered approach. • Identify risk factors and gaps in service and recommend quality improvement strategies to promote safety, freedom from harm, and physical, mental and behavioral health and wellbeing. • Review OL Corrective Action Plans (CAPs) related to required recommendations, to ensure no further action is required and for inclusion in meeting minutes. • Make additional recommendations for further investigation and/or actions by other DBHDS Offices represented by MRC members, as appropriate. • Assign these recommendations and/or actions to specific MRC member(s) as appropriate. • Review and track the status of previously assigned recommended actions to ensure completion. The committee may also interview any persons having information regarding the individual's care. For each case reviewed, the MRC seeks to identify: • The cause of death (CoD) • If the death was expected (XP) • Whether the death was potentially preventable (PP)

	• Any relevant factors impacting the individual's death • Any other findings that could affect the health, safety, and welfare of these individuals • Whether there are other actions that may reduce these risks, to include provider training and communication regarding risks, alerts, and opportunities for education (see Definitions under "Leadership and Responsibilities" section). • If any actions are identified based on the case review, the MRC will then make and document relevant recommendations and/or interventions • Documentation is located in the Meeting minutes, Notes Summary, Action Tracking Log, and/or on the electronic Mortality Review Form The MRC will make recommendations *(including but not limited to, QIIs)* in order to reduce mortality rates to the fullest extent practicable. • The case may be closed or pended. If all determinations are made, the case is closed by the committee. If additional information is needed in order to make a determination, the case is pended until the next meeting. • Cases that are pended are considered reviewed within 90 days of the individual's death based on the beginning review date. • A pended case remains open until the following meeting, when the designated committee member provides an update, or specific information has been received, as requested. If all determinations are made, the pended case is closed by the committee. • Monthly, for quality assurance purposes and to attempt to identify deaths that were not reported through DBHDS' incident reporting system, the following occurs: o The MRO provides a list of identifying information for I/DD individuals in the Waiver Management System who received DBHDS-licensed services to the Virginia Department of Health (*VDH*) o VDH identifies names from that list for which a death certificate is on file and provides results back to the MRO. o The MRO forwards the information to the DBHDS OL SIU Manager, who researches DBHDS' incident reporting systems to determine if the individual was receiving a DBHDS licensed service at the time of death and therefore was not reported by a DBHDS licensed provider. SIU team investigates unreported deaths identified by this process and takes appropriate action in accordance with DBHDS licensing regulations and protocols. o Upon completion of the OL investigation, if a death is determined to require MRC review, the MRT will initiate the usual review process for the case as per current standard operating procedure (see pages 5 & 6).

- The MRC documents recommendations for systemic QIIs coming from patterns of individual reviews on an ongoing basis and analyzes patterns that emerge from any aggregate examination of mortality data for cases that were reviewed by the MRC on an ongoing basis.
    - From this analysis, the MRC makes one recommendation per quarter *(four recommendations/year)* for systemic QIIs and reports these recommendations to the QIC (*quarterly*) and the DBHDS Commissioner *(annually*).
    - The MRC prepares and delivers to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any, for 86% of deaths requiring review within 90 days of the death. If the MRC elected not to make any recommendations, documentation will affirmatively state that no recommendations were warranted.
    - The MRC prepares an annual report of aggregate mortality trends and patterns for all individual deaths that occurred in the state fiscal year and that were also reviewed by the MRC, within six months of the end of the fiscal year. A summary of the findings is released publicly.
- Provide relevant data (statewide aggregate) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available at least on an annual basis

<u>Membership responsibilities:</u>

Pursuant to Virginia Code § 37.2-314.1, all MRC members and other persons who attend closed meetings of the MRC are required to sign a confidentiality agreement form. Members shall notify the MRC Co-Chair and/or MRO Program Coordinator prior to having a guest attend a meeting so that arrangements may be made for the guest to sign the confidentiality agreement form before (s)he is permitted to attend. Member confidentiality forms are valid for the entire term of MRC membership, and guest confidentiality forms are valid for repeat attendance at MRC meetings. New members will receive training within 30 business days of joining the committee.

All members adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI).

- All MRC members must receive training that includes:
    - Orientation to the MRC charter to educate the member on the scope, mission, vision, charge, and function of the MRC
    - Review of the policies, processes, and procedures of the MRC
    - Education on the role/responsibility of the member(s)
    - Training on continuous quality improvement principles

- **Voting Members:**

	○ Have decision making capability and voting status. ○ Attend 75% of meetings per year and may send a designee that is approved by the MRC chair (*or Co-Chair*) prior to the meeting. ○ Review data and reports for meeting discussion. ○ May send a designee to MRC meetings but should attend at least one meeting per quarter. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. ○ Absence is considered excused if the member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting that the member and/or designee are unable to attend. ○ Recognize that an excused absence does not contribute to the 75% attendance requirement. • **Advisory Members:** ○ Non-voting stakeholder members selected and approved by the QIC and DBHDS Commissioner whose various perspectives provide insight on MRC reviews, clinical insight, medical expertise, and MRC performance goals, outcomes, required and recommended actions. ○ Inform the committee by identifying and prioritizing MRC decision making and recommendations. ○ May be appointed for a term of two (2) years and may be reappointed for up to two additional terms. ○ Are expected to attend one meeting every quarter (4/year) and may send a designee who is approved by the MRC chair prior to the meeting. An absence is considered excused if the advisory member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting, that the advisory member and/or designee are unable to attend. ○ Recognize that an excused absence does not contribute to the attendance requirement.
Recusal	Members must recuse themselves from MRC proceedings if a conflict of interest arises, in order to maintain neutrality *(prevent bias)* and credibility of the MRC mortality review process. Conflict of interest exists when an MRC member has a financial, professional or personal interest that could directly influence MRC determinations, findings or recommendations, such as: • The MRC member, or an individual from the member's family, was actively involved in the care of the decedent *(direct care r/t employment or financial as listed below*) • The MRC member may have participated in a facility or institutional mortality review of the decedent • The MRC member, or an individual from the member's family, has a financial interest or investment that could be directly affected by the mortality review (*including determinations and recommendations*) of the decedent, to include employment, property interests, research, funding or support, industry partnerships and consulting relationships Should a conflict of interest arise during the review process, the MRC member will: • Immediately disclose the potential conflict of interest and cease participation in the case

	review related to the existing or potential conflict of interest. • Disclose the conflict of interest privately to the Chair/Co-Chair, or publicly to the members in attendance. The MRC will then halt discussion of the conflict-of-interest case, move on to the next case and place the conflict-of-interest case at the end. This allows the MRC member with a conflict of interest to remain for the review of other cases, and then leave the proceedings prior to the discussion of the conflict-of-interest case.
Definitions	• Comprehensive clinical case summaries (CCS) denote an in-depth inclusive review of clinical and sequential information related to the events surrounding the individual's death. After review by the CCO or CM, CCS' are assigned a Tier category and considered final clinical summaries. These may be reassigned at the recommendation of the MRC. • Tier 1 case criteria: A case is categorized as Tier 1 when any of the following criteria exists: o Cause of death cannot clearly be determined or established, or is unknown o Any unexpected death *(such as suicide, homicide or accident*). This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to an acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. o Abuse or neglect is specifically documented o Documentation of investigation by or involvement of law enforcement or similar agency (*including forensic)* o Specific or well-defined risks to safety and well-being are documented. • Tier 2 case criteria: A case is categorized as Tier 2 when all the first 4 criteria exist: o Cause of death can clearly be determined or established o No documentation of abuse or neglect o No documentation of investigation by or involvement of law enforcementor similar agency (*including forensic*) o No documentation of specific or well-defined risks to safety and well-being are noted. o An expected death that occurred as a result of a known medical condition, anticipated by health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care. o An unexpected (unexplained) death that occurred as a result of a condition that was

	previously undiagnosed, occurred suddenly, or was not anticipated. This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to an acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. • Expected Death denotes a death that occurred as a result of a known medical condition, anticipated by health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care. • Unexpected Death denotes a death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. Deaths are considered unexpected when they are not anticipated or related to a known terminal illness or medical condition; are related to injury, accidents, inadequate care; or are associated with suspicions of abuse or neglect. An acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. An unexplained death is considered an unexpected death. • Unknown indicates there is insufficient information to classify a death as either expected or unexpected or there is insufficient information to make a determination as to the cause of death. • Other (Cause of Death) denotes a cause of death that is not attributable to one of the major causes of death used by the MRC for data trending. • Potentially Preventable (PP) Deaths denotes deaths in the opinion of the MRC that might have been prevented with reasonable valid intervention (*e.g., medical, social, psychological, legal, and educational*). Deaths determined to be PP have identifiable actions or care measures that should have occurred or been utilized. If the individual was provided with known effective medical treatment or public health intervention and died despite this provision of evidenced based care, the death is not considered potentially preventable. When the MRC determines a death is PP, the committee categorizes factors that might have prevented the death. For a death to be determined PP, the actions and events immediately surrounding the individual's death must be related to deficits in the timeliness or absence of, at least one of the following factors: o Coordination of care o Access to care, including delay in seeking treatment o Execution of established protocols o Assessment of the individual's needs or changes in status • Two data formats utilized o Reviewed – denotes actual cases examined by the MRC in a specified timeframe, which may include a death that happened at any point in time

	○ Occurred – denotes only deaths that transpired during a specified timeframe The following standard definitions as referenced in Part I of the Quality Management Plan (*Program Description)* are established for all quality committees: • Advising Members- Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions- DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan- Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains- Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers- provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups- DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N- Sample size • National Core Indicators- Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees- The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee- DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key

	Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative- Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan- Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review- Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate whether individuals' needs are being identified and met through person-centered planning and thinking, 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. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum- Number of voting members required for decision-making. • Regional Quality Councils (RQC)-DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY)- July 1 to June 30 • Voting Members- Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS)-The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Case Management Steering Committee Charter
QIC Approved September 27, 2021

Committee / Workgroup Name	**Case Management Steering Committee**
Statement of Purpose	The Case Management Steering Committee (CMSC), a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), is responsible for monitoring case management performance across responsible entities. This includes identifying and addressing risks of harm, ensuring the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings, and evaluating data to identify and respond to trends to ensure continuous quality improvement.
Authorization / Scope of Authority	The CMSC is authorized by the DBHDS QIC. The committee is charged with reviewing data selected from, but not limited to, any of the following data sets: CSB data submissions, Case Management Quality Reviews, Office of Licensing citations, Quality Service Reviews, and DMAS' Quality Management Reviews, WaMS.
Charter Review	The CMSC was established in June 2018. The charter shall be reviewed and/or revised on an annual basis, or as needed, and submitted to the QIC for review and approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement quality improvement initiatives (QIIs) will report data related to the quality improvement initiatives to the CMSC to enable the committee to track implementation. Through case management reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the CMSC identifies areas for development of QIIs. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle:

	• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the CMSC: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the CMSC Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Workgroup / Committee:	
Membership	CMSC is an internal inter-disciplinary team comprised of the following DBHDS employees with clinical training and experience in the areas of case management, behavioral health, intellectual disabilities/developmental disabilities, leadership, quality improvement, behavioral analysis and data analytics: **Voting Members:** • Director of Waiver Operations or designee • Director of Provider Development or designee • Director of Community Quality Management or designee

	• Settlement Agreement Director • Quality Improvement Specialist • Representative, Office of Data Quality and Visualization **Advisory Members (non-voting):** • QI/QM Coordinator • Representative, Office of Licensing • Behavior Analyst • Other internal members as determined by the committee
Meeting Frequency	The committee will, at a minimum, meet ten times a year; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum shall be defined as 50% plus one of voting membership. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Director of Provider Development shall serve as chair and will be responsible for ensuring the committee performs its functions including development of meeting agendas and convening regular meetings. The chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter • Meet regularly to ensure continuity of purpose • Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function • Analyze data to identify and respond to trends to ensure continuous quality improvement • Recommend QIIs (at least one per fiscal year, based on data analysis) to the QIC, which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC. The CMSC will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI) • Establish a process to review a sample of case management (CM) contact data each quarter to determine reliability and provide technical assistance to CSBs as needed • Establish process to monitor compliance with performance standards

	• Establish process for annual retrospective reviews to validate findings of the CSB case management supervisory reviews; process includes sample stratification, quantitative measurement of both CSB and DBHDS Quality Improvement record reviews and inter-rater reliability process for DBDHS Quality Improvement staff • Establish two indicators in each of the areas of health and safety and community integration and based on review of the data from case management monitoring processes • Ensure CSBs receive their case management performance data semi-annually at a minimum • Analyze data and monitor for trends quarterly • Review and analyze CM data submitted to DBHDS that reports on CSB case management performance and related to the ten elements and at an aggregate level to determine CSB's overall effectiveness in achieving outcomes for the population they serve (such as employment, self-direction, independent living, keeping children with families) • Review the results of Quality Service Reviews (QSR) as it relates to case management and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Review the results of other data reports that reference case management and make recommendations for systemic improvements as applicable • Share data with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Provide technical assistance to individual CSBs as needed • Track cited regulatory non-compliance correction actions to ensure remediation • Provide to the QIC recommendations to address non-compliance issues with respect to case manager contacts for consideration of appropriate systemic improvements and the Commissioner for review of contract performance issues • Produce a semi-annual report to the QIC on the findings from the data review with recommendations for systemic improvement that includes: analysis and findings and recommendations based on review of the information from case management monitoring/oversight processes including: data from the oversight of the Office of Licensing, DMAS Quality Management Reviews, CSB case management supervisors quarterly reviews replaced in 2019 by the Support Coordination Quality Review process, DBHDS Office of Community Quality Improvement retrospective reviews, Quality Service Reviews, and Performance Contract Indicator data • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs

	Membership Responsibilities: **Voting members:** • Have decision making capability and voting status • Review data and reports for meeting discussion • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory members:** • Perform in an advisory role for the CMSC whose various perspectives provide insight on CMSC activities, performance outcomes, and recommended actions • Inform the committee by identifying issues and concerns to assist the CMSC in developing and prioritizing meaningful QI initiatives • Supports the CMSC in performing its functions All members receive orientation and training both as new to the committee and on an annual basis. Material shall include QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members- Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions- DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan- Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains- Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers- provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver.

	• Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups- DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N- Sample size • National Core Indicators- Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety • Performance Measure Indicators (PMIs)-Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees- The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee- DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)- Oversees the work of the QIC subcommittees • Quality Improvement Initiative (QII) - Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan- Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review (QSR) - Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate whether individuals' needs are being identified and met through person-centered planning and thinking, 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. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum- Number of voting members required for decision-making.

	• Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY)- July 1 to June 30 • Voting Members- Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS)-The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Health, Safety and Wellbeing Workgroup Charter
QIC Approved September 27, 2021

Committee / Workgroup Name	**Health, Safety and Wellbeing Key Performance Area (KPA) Workgroup**
Statement of Purpose	As a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), the Health, Safety and Wellbeing (HSW) KPA Workgroup is charged with responsibilities associated with collecting and analyzing reliable data related to the domains of safety and freedom from harm, physical, mental and behavioral health and well-being, and avoiding crises. The KPA Workgroup also assesses whether the needs of individuals enrolled in a Developmental Disability (DD) waiver are met, whether individuals have choice in all aspects of their selection of services and supports, and whether there are effective processes in place to monitor the individuals' health and safety. The KPA Workgroup establishes goals and monitors progress toward achievement through the creation of specific KPA performance measure indicators (PMIs). The HSW KPA Workgroup has established an outcome reflective of its purpose: *People with disabilities are safe in their homes and communities, receive routine, preventive healthcare, and behavioral health services and behavioral supports as needed.*
Authorization / Scope of Authority	This workgroup has been authorized by the DBHDS QIC. This workgroup's scope of authority includes identifying concerns/barriers in meeting the PMIs and implementing and/or recommending quality improvement initiatives. The subcommittee is to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated setting and evaluate data to identify and respond to trends to ensure continuous quality improvement.
Charter Review	The KPA Workgroup charter will be reviewed and/or revised on an annual basis, or as needed, by the HSW KPA Workgroup and submitted to the QIC for approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement quality improvement initiatives (QIIs) will report data related to the QIIs to the HSW KPA Workgroup to enable the committee to track implementation.

	Through data reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the HSW KPA Workgroup identifies areas for development of quality improvement initiatives. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the HSW KPA Workgroup: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the HSW KPA Workgroup

	Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Committee / Workgroup:	
Membership	The KPA Workgroup is an internal inter-disciplinary team comprised of the following DBHDS employees with clinical training and experience in the areas of behavioral health, intellectual disabilities/developmental disabilities, leadership, quality improvement, behavioral analysis and data analytics. **Voting Members:** • Director, Office of Human Rights • Assistant Commissioner for Developmental Disability Services • Senior Director, Clinical Quality Management • Director, Community Quality Management • Director, Office of Integrated Health • Director, Office of Licensing • Mortality Review Committee Clinical Manager • Representative, Office of Data Quality and Visualization • Settlement Agreement Director • Director, Provider Development • Representative, Office of Waiver Operations • Director, Office of Individual and Family Support • Director, Office of Housing **Advisory Members (non-voting):** • QI/QM Coordinator • Quality Improvement Specialists (2) • Other as determined by the HSW KPA Workgroup
Meeting Frequency	Meetings shall be held monthly, at least 10 times per year; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is 50% plus one of voting membership. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Assistant Commissioner for Developmental Disability Services chairs the HSW KPA Workgroup. The chair will be responsible for ensuring the workgroup performs its functions. The chair may designate a co-chair as needed to assist. The standard operating procedures include:

	• Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function • Analysis of PMIs to measure performance across the KPA • Recommend QIIs (at least one per fiscal year, based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC • Monitoring of surveillance data on a regular schedule The KPA Workgroup will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI) • Establish at least one PMI for each domain identified as either an outcome or output measure • Determine priorities when establishing PMIs • Consider a variety of data sources for collecting data and identify the data sources to be used • Determine and finalize surveillance data from a variety of sources. This data may be used for ongoing, systemic collection, analysis, interpretation, dissemination, and also serves as a source for establishing PMIs and/or QIIs • Monitor performance across each domain and for PMIs falling below target, determine actions that are designed to raise the performance; analyze data and monitor for trends quarterly • Monitor surveillance data in each of the domains associated with the KPA Workgroup and respond to identified trends of concerns • Review the results of Quality Service Reviews (QSR) as it relates to the key performance areas and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Review the results of the annual National Core Indictors (NCI) In-Person Survey and use findings to implement quality improvement strategies or make recommendations for QIIs. Additional family and guardian surveys may be included as part of surveillance data review • Share data with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs Each PMI will contain the following:

	• Baseline or benchmark data as available • The target where results should fall above or below • The date by which the target will be met • Definition of terms included in the PMI and a description of the population • Data sources (origins for both numerator and denominator) • Calculation (clear formula for calculating the PMI utilizing the numerator and denominator) • Methodology for collecting reliable data (complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) • The subject matter expert (SME) assigned to report and enter data on each PMI • A yes/no indicator to show whether the PMI can provide regional breakdowns <u>Member Responsibilities:</u> **Voting Members:** • All members have decision-making capability and voting status • Members shall be responsible for entering, reviewing, and analyzing data related to the PMI as assigned • Members shall be responsible for reviewing surveillance data prior to the scheduled review date and highlight areas of concern • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members (non-voting):** • Perform in an advisory role for the KPA Workgroup whose various perspectives provide insight on KPA Workgroup performance goals, outcomes PMIs and recommended actions • Inform the committee by identifying issues and concerns to assist the KPA Workgroup in developing and prioritizing meaningful QIIs • Supports the KPA Workgroup in performing its functions All members receive orientation and training both as new to the committee and on an annual basis. Material shall include QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members- Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval.

	• Corrective Actions- DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan- Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains- Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers- provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups- DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N- Sample size • National Core Indicators- Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety. • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees- The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee- DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative- Addresses systemic quality issues identified through the work of the QIC subcommittees.

	• Developmental Disabilities Quality Management Plan- Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review- Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate whether individuals' needs are being identified and met through person-centered planning and thinking, 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. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum- Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY)- July 1 to June 30 • Voting Members- Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Community Inclusion and Integration Workgroup Charter
QIC Approved September 27, 2021

Committee / Workgroup Name	Community Inclusion and Integration Key Performance Area (KPA) Workgroup
Statement of Purpose	As a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), the Community Inclusion and Integration (CII) KPA Workgroup is charged with responsibilities associated with collecting and analyzing reliable data related to promoting full inclusion in community life and improvement in integrated services for people with developmental disabilities. The KPA Workgroup also assesses whether the needs of individuals enrolled in a DD waiver are met, whether individuals have choice in all aspects of their selection of services and supports, and whether there are effective processes in place to monitor the individuals' health and safety. This includes the domains of stability, choice and self-determination and community inclusion. The KPA Workgroup establishes goals and monitors progress toward achievement through the creation of specific KPA performance measure indicators (PMIs). The CII KPA Workgroup has established an outcome reflective of its purpose: *People with disabilities live in integrated settings, engage in all facets of community living and are employed in integrated employment.*
Authorization / Scope of Authority	This workgroup has been authorized by the DBHDS QIC. This workgroup's scope of authority includes identifying concerns/barriers in meeting the PMIs and implementing and/or recommending quality improvement initiatives. The subcommittee is to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated setting and evaluate data to identify and respond to trends to ensure continuous quality improvement.
Charter Review	The KPA Workgroup charter will be reviewed and/or revised on an annual basis, or as needed, by the Community Inclusion and Integration Workgroup and submitted to QIC for approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the CII KPA Workgroup to enable the committee to track implementation.

	Through data reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the CII KPA Workgroup identifies areas for development of QIIs. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the CII KPA Workgroup: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the CII KPA Workgroup Data reviews occur as part of quality improvement activities and as such are not considered research.

Structure of Committee / Workgroup:	
Membership	The KPA Workgroup is an internal inter-disciplinary team comprised of the following DBHDS employees with clinical training and experience in the areas of behavioral health, intellectual disabilities/developmental disabilities, leadership, quality improvement, behavioral analysis and data analytics. **Voting Members:** • Director, Provider Development • Assistant Commissioner for Developmental Disability Services • Senior Director, Clinical Quality Management • Director, Community Quality Management • Director, Office of Housing • Director, Office of Individual and Family Support • Representative, Office of Data Quality and Visualization • Settlement Agreement Director • Mortality Review Committee Clinical Manager • Director, Office of Human Rights • Director, Office of Integrated Health • Representative, Office of Waiver Operations • Director, Office of Licensing **Advisory Members (non-voting):** • QI/QM Coordinator • Quality Improvement Specialists (2) • Others as determined by the CII KPA Workgroup
Meeting Frequency	Meetings shall be held monthly, at least 10 times per year; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is 50% plus one of voting membership. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QII, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Assistant Commissioner for Developmental Disability Services chairs the CII KPA Workgroup. The chair will be responsible for ensuring the workgroup performs its functions. The chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter

	• Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function • Analysis of PMIs to measure performance across the KPA • Recommend QIIs (at least one per fiscal year, based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC • Monitoring of surveillance data on a regular schedule The KPA Workgroup will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI) • Establish at least one PMI for each domain identified as either an outcome or output measure • Determine priorities when establishing PMIs • Consider a variety of data sources for collecting data and identify the data sources to be used • Determine and finalize surveillance data from a variety of sources. This data may be used for ongoing, systemic collection, analysis, interpretation, dissemination, and also serves as a source for establishing PMIs and/or QIIs • Monitor performance across each domain and for PMIs falling below target, determine actions that are designed to raise the performance; analyze data and monitor for trends quarterly • Monitor surveillance data in each of the domains associated with the KPA Workgroup and respond to identified trends of concerns • Review the results of Quality Service Reviews (QSR) as it relates to the key performance areas and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Review the results of the annual National Core Indictors (NCI) In-Person Survey and use findings to implement quality improvement strategies or make recommendations for QIIs. Additional family and guardian surveys may be included as part of surveillance data review • Share data with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs Each PMI will contain the following: • Baseline or benchmark data as available

	• The target where results should fall above or below • The date by which the target will be met • Definition of terms included in the PMI and a description of the population • Data sources (origins for both numerator and denominator) • Calculation (clear formula for calculating the PMI utilizing the numerator and denominator) • Methodology for collecting reliable data (complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) • The subject matter expert (SME) assigned to report and enter data on each PMI • A yes/no indicator to show whether the PMI can provide regional breakdowns <u>Member Responsibilities:</u> **Voting Members:** • All members have decision-making capability and voting status • Members shall be responsible for entering, reviewing, and analyzing data related to the PMI as assigned • Members shall be responsible for reviewing surveillance data prior to the scheduled review date and highlight areas of concern • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members (non-voting):** • Perform in an advisory role for the KPA Workgroup whose various perspectives provide insight on KPA Workgroup performance goals, outcomes PMIs and recommended actions • Inform the committee by identifying issues and concerns to assist the KPA Workgroup in developing and prioritizing meaningful QIIs • Supports the KPA Workgroup in performing its functions All members receive orientation and training both as new to the committee and on an annual basis. Material shall include QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members- Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval.

	• Corrective Actions- DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan- Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains- Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers- provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups- DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N- Sample size • National Core Indicators-Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees- The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee- DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative- Addresses systemic quality issues identified through the work of the QIC subcommittees.

	• Developmental Disabilities Quality Management Plan- Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review- Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate whether individuals' needs are being identified and met through person-centered planning and thinking, 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. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum- Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY)- July 1 to June 30 • Voting Members-Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Provider Capacity and Competency Workgroup Charter
QIC Approved September 27, 2021

Committee / Workgroup Name	Provider Capacity and Competency Key Performance Area (KPA) Workgroup
Statement of Purpose	As a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), the Provider Capacity and Competency (PCC) KPA Workgroup is charged with responsibilities associated with collecting and analyzing reliable data related to the domains of access to services for people with developmental disabilities and provider capacity and competency. The KPA Workgroup also assesses whether the needs of individuals enrolled in a DD waiver are met, whether individuals have choice in all aspects of their selection of services and supports, and whether there are effective processes in place to monitor the individuals' health and safety. The KPA Workgroup establishes goals and monitors progress toward achievement through the creation of specific KPA performance measure indicators (PMIs). The PCC KPA Workgroup has established an outcome reflective of its purpose: *People with disabilities have access to an array of services that meet their needs and providers maintain a stable and competent workforce, are able to meet licensing regulations and maintain compliance.*
Authorization / Scope of Authority	This workgroup has been authorized by the DBHDS QIC. This workgroup's scope of authority includes identifying concerns/barriers in meeting the PMIs and implementing and/or recommending quality improvement initiatives. The subcommittee is to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated setting and evaluate data to identify and respond to trends to ensure continuous quality improvement.
Charter Review	The KPA Workgroup charter will be reviewed and/or revised on an annual basis, or as needed, by the PCC KPA Workgroup and submitted to the QIC for approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement quality improvement initiatives (QIIs) will report data related to the QIIs to the PCC KPA Workgroup to enable the committee to track implementation.

	Through data reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the PCC KPA Workgroup identifies areas for development of QIIs. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the PCC KPA Workgroup: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the PCC KPA Workgroup Data reviews occur as part of quality improvement activities and as such are not considered research.

Structure of Committee / Workgroup:	
Membership	The KPA Workgroup is an internal inter-disciplinary team comprised of the following DBHDS employees with clinical training and experience in the areas of behavioral health, intellectual disabilities/developmental disabilities, leadership, quality improvement, behavioral analysis and data analytics. **Voting Members:** • Director, Provider Development • Director, Office of Licensing • Assistant Commissioner for Developmental Disability Services • Senior Director, Clinical Quality Management • Director, Community Quality Management • Director, Office of Human Rights • Representative, Office of Waiver Operations • Representative, Office of Data Quality and Visualization • Settlement Agreement Director • Director, Office of Integrated Health • Mortality Review Committee Clinical Manager • Director, Office of Individual and Family Support • Director, Office of Housing **Advisory Members (non-voting):** • QI/QM Coordinator • Quality Improvement Specialists (2) • Others as determined by the PCC KPA Workgroup
Meeting Frequency	Meetings shall be held monthly, at least 10 times per year; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is 50% plus one of voting membership. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Assistant Commissioner for Developmental Disability Services chairs the PCC KPA Workgroup. The chair will be responsible for ensuring the workgroup performs its functions. The chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter

	• Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function • Analysis of PMIs to measure performance across the KPA • Recommend QIIs (at least one per fiscal year, based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC • Monitoring of surveillance data on a regular schedule The KPA Workgroup will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI) • Establish at least one PMI for each domain identified as either an outcome or output measure • Determine priorities when establishing PMIs • Consider a variety of data sources for collecting data and identify the data sources to be used • Determine and finalize surveillance data from a variety of sources. This data may be used for ongoing, systemic collection, analysis, interpretation, dissemination, and also serves as a source for establishing PMIs and/or QIIs. • Monitor performance across each domain and for PMIs falling below target, determine actions that are designed to raise the performance; analyze data and monitor for trends quarterly • Monitor surveillance data in each of the domains associated with the KPA Workgroup and respond to identified trends of concerns • Review the results of Quality Service Reviews (QSR) as it relates to the key performance areas and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Review the results of the annual National Core Indictors (NCI) In-Person Survey and use findings to implement quality improvement strategies or make recommendations for QIIs. Additional family and guardian surveys may be included as part of surveillance data review • Share data with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs Each PMI will contain the following: • Baseline or benchmark data as available

	• The target where results should fall above or below • The date by which the target will be met • Definition of terms included in the PMI and a description of the population • Data sources (origins for both numerator and denominator) • Calculation (clear formula for calculating the PMI utilizing the numerator and denominator) • Methodology for collecting reliable data (complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) • The subject matter expert (SME) assigned to report and enter data on each PMI • A yes/no indicator to show whether the PMI can provide regional breakdowns <u>Member Responsibilities:</u> **Voting Members:** • All members have decision-making capability and voting status • Members shall be responsible for entering, reviewing, and analyzing data related to the PMI as assigned • Members shall be responsible for reviewing surveillance data prior to the scheduled review date and highlight areas of concern • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members (non-voting):** • Perform in an advisory role for the KPA Workgroup whose various perspectives provide insight on KPA Workgroup performance goals, outcomes PMIs and recommended actions • Inform the committee by identifying issues and concerns to assist the KPA Workgroup in developing and prioritizing meaningful QIIs • Supports the KPA Workgroup in performing its functions All members receive orientation and training both as new to the committee and on an annual basis. Material shall include QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members -Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval.

	• Corrective Actions -DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan- Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains- Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers- provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups- DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N- Sample size • National Core Indicators- Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety. • Performance Measure Indicators (PMIs)-Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees- The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee- DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative (QII) - Addresses systemic quality issues identified through the work of the QIC subcommittees.

	• Developmental Disabilities Quality Management Plan- Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review- Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate whether individuals' needs are being identified and met through person-centered planning and thinking, 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. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum- Number of voting members required for decision-making. • Regional Quality Councils (RQC)-DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY)- July 1 to June 30 • Voting Members- Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS)-The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Quality Review Team Charter
May 2021

Committee / Workgroup Name	Quality Review Team
Statement of Purpose	The Quality Review Team (QRT), a joint Department of Behavioral Health and Developmental Services (DBHDS) and Department of Medical Assistance Services (DMAS) committee, is responsible for oversight and improvement of the quality of services delivered under the Commonwealth's Developmental Disabilities (DD) waivers as described in the approved waivers' performance measures.
Authorization / Scope of Authority	The QRT is responsible for reviewing performance data collected regarding the Centers for Medicare and Medicaid Services' (CMS) Home and Community-Based Services (HCBS) waiver assurances: • Waiver Administration and Operation: Administrative Authority of the Single State Medicaid Agency • Evaluation/Reevaluation of Level of Care • Participant Services - Qualified Providers • Participant-Centered Planning and Service Delivery: Service Plan • Participant Safeguards: Health and Welfare • Financial Accountability The work of the QRT is accomplished by accessing data across a broad range of monitoring activities, including those performed via DBHDS licensing and human rights investigations and inspections; DMAS quality management reviews and contractor evaluations (QMR); serious incident reporting; mortality reviews; and level of care evaluations. Each DD waiver performance measure is examined against the CMS standard of 86% or above compliance. Those measures that fall below this standard are discussed to identify the need for provider specific as well as systemic remediation. The committee may make recommendations for remediation such as: • Retraining of providers • Targeted Technical Assistance • Information Technology system enhancements for the collection of data • Change in licensing status • Targeted QMR • Referral for mandatory provider remediation • Payment retraction or ceasing referrals to providers

	• Review of regulations to identify needed changes • Review of policy manuals for changes The team identifies barriers to attainment and the steps needed to address them. The QRT re-examines data in the following quarter to determine if remediation was successful or if additional action is required.
Charter Review	The QRT was established in August 2007 in response to CMS's new expectations that states implement a quality review process for HCBS waivers. This charter shall be reviewed by DBHDS and DMAS on an annual basis or as needed and submitted to the Quality Improvement Committee for review.
Model for Quality Improvement	The activities of the QRT are a means for DMAS and DBHDS to implement CMS's expected continuous quality improvement cycle, which includes: • Design • Discovery • Remediation • Improvement
Structure of Workgroup / Committee:	
Membership	**DBHDS:** • Director of Waiver Operations or designee • Senior DD Policy and Compliance Staff • Director of Provider Development and/or designee • Director, Office of Integrated Health, and/or designee • Director of Office of Licensing and/or designee • Director of Office of Human Rights or designee • Director of Office of Community Quality Improvement or designee • Director, Mortality Review Committee and/or designee • Settlement Agreement Director **DMAS:** • Director of Division of Developmental Disabilities or designee

	• Program Advisor • Developmental Disabilities Program Manager or designee • QMR Program Administration Supervisor or designee • Sr. Policy Staff
Quorum	A quorum shall be defined as 50% plus one of voting membership.
Meeting Frequency	The committee will, at a minimum, meet four times a year. The QRT review cycle is scheduled with two quarters' lag time to accommodate the 90-day regulatory requirement to successfully investigate and close cases reportable under the Appendix G Health and Welfare measures.
Leadership and Responsibilities	The DBHDS Senior DD Policy and Compliance Staff shall serve as chair and will be responsible for ensuring the committee performs its functions including development of meeting agendas and convening regular meetings. The standard operating procedures include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance and distribution of quarterly updates and/or meeting minutes as necessary and pertinent to the committee's function • Maintenance of QRT data provenance • CMS Evidentiary and state stakeholder reporting • Quality improvement initiatives consistent with CMS's Design, Discover, Remediate, Improve model. The meeting summary is prepared and distributed to committee members prior to the meeting and shall reflect the committee's review and analysis of data and any follow up activity. The QRT shall produce an annual report (QRT End of Year (EOY) Report) to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. The QRT's report will include an analysis of findings and recommendations based on review of the information regarding each performance measure. CMS has indicated that reporting on the performance measures can be consolidated if all of the following requirements are met. 1) Design of the waivers is same/very similar 2) Sameness/similarity determined by comparing waivers on approved Waiver Application Appendices: C: Participant Services

	D: Participant-Centered Planning and Service Delivery G: Participant Safeguards H: Quality Management 3) Quality Management approach is the same/very similar across waivers, including: 4) Methodology for discovering information (e.g., data systems, sample selection) 5) Manner in which individual issues are remediated 6) Process for identifying & analyzing patterns/trends 7) Majority of Performance Measures are the same 8) Provider network is the same/very similar 9) Provider oversight is the same/very similar Additionally, the sampling method must be proposed in the Waiver application and approved by CMS and various sampling methods are acceptable. It is noted that, for the Commonwealth's DD waivers: • All services are the same but not all are offered under each waiver • All individuals go through the same slot selection process • All waiver service providers use the same enrollment process as delineated by DMAS. • All providers for the three waivers are required to be licensed are done so through the DBHDS. • All participants' service needs are determined through the Person-Centered Planning process. • All three waivers will have the same performance measures with the approval of the amendment for the Community Living Waiver. Therefore, the QRT data across the Community Living, Family & Individual Supports, and Building Independence waivers is consolidated for annual and triennial reporting to CMS. However, individual waiver level data may be reported and reviewed for internal quality management monitoring across waivers where feasible and necessary.

QIC Subcommittees Work Plan

The QIC Subcommittee Work Plans provide a means for all quality subcommittees, workgroups, and councils to document areas of focus, including quality improvement efforts, and ensures consistent reporting to the QIC. This work plan is used to consistently identify patterns and trends and track the subsequent development and implementation of quality improvement initiatives (QIIs) related to their regular review of data within their focus areas. The work plan template, provided below is used by the DBHDS Quality Improvement Specialists, Quality Improvement Coordinator and the Quality Management Coordinator to document achievement of committee requirements to monitor performance measure indicators and QII implementation.

Committee Requirements

The QIC Subcommittees Work Plan is the system for tracking PMIs and development, implementation, and progress of QIIs across subcommittees/council/ workgroups consistently. In addition, the QIC Subcommittees Work Plan will assist the subcommittee in completing its annual subcommittee performance evaluation and subcommittee report.

Column instructions are found in the italic font directly under each column header. Each QIC subcommittee is responsible to review this work plan at least quarterly, before the QIC meeting.

QIC Subcommittees to which this tool applies: CMSC, RMRC, KPA Workgroups, MRC,
Persons Responsible for Completion of This Document: QI/QM Coordinator or designee
Timeline for completion: Per QI subcommittee meeting schedule with the **completed SFY QIC Subcommittee Work Plan due to the QM Coordinator by COB July 31, 2023**
Document Location: in Teams

Date Met During SFY *List meeting date in which these were discussed*	**Surveillance Data Element(s) Reviewed** *Describe the data being reviewed include pertinent details (report name, time frame, etc.); indicate what patterns or trends are noteworthy. If surveillance data is not reviewed, simply state 'not reviewed'.*	**Actions in Response to Surveillance Data Review and Analysis** *Describe the sub-committee's response to the data review and analysis. This can include taking a deeper dive into the data, formal/informal changes, training, protocol revisions, mitigation strategies, other improvement strategies, developing a PIP or even preparing a QII. If the surveillance data analysis came through QCOR review and brought to the sub-committee's attention, please indicate as such.*	**Ideas for Potential QIIs** *Based upon data review (PMI, surveillance, QSR, etc.), list the ideas the sub-committee is considering as potential QIIs and include the data prompting the idea, if available. This helps the sub-committee track what ideas for potential QIIs have been noted. This column should be incorporated into the QII Toolkit as the sub-committee is discussing potential QIIs.*	**Proposed QII** *List the proposed QII. This entry becomes important for tracking proposed QIIs that are disapproved by the QIC. Additional details can also be noted as needed.*	**QIC Action: Approval/Disapproval** *The QIC action must be noted per proposed QII. QIIs disapproved by the QIC can be modified and presented again. Information on approved QIIs can be found on the Approved QII Progress Tracking tab.*	**Data Requests** *List any requests for additional data from the RGCs (be specific in listing which RGC). List any follow-up questions or recommendations from the RGCs as well. If there are no data requests, list NA. Include date received.*	**Data Requests Follow-Up** *List the subcommittee's response to the data request(s) and answer to any questions posed. Identify if data request cannot be fulfilled and why. Identify if data request is determined to be unavailable. This information (responses to data requests and answers to questions) is shared with the RGC. The RGC will report to the QIC on unfulfilled data requests and any data determined to be unavailable. Once the data request has been fulfilled, indicate some type of closure including date.*	**Response to QSR Recommendations** *Describe the sub-committee's actions in response to recommendations from the QSR reviewer. If there are no QSR recommendations, list NA.*	**Response to Other Recommendations** *Describe the sub-committee's actions in response to recommendations found in other reports such as those in the Independent Review Report, QSR Report, etc. If there are no other recommendations that have come before the sub-committee, list NA.*	**Other** *Describe any other work the subcommittee does that is not captured in any of the columns listed in this work plan. Include rationale for the work, supporting data as applicable, identification of challenges/barriers and resolution to challenges/barriers. This can include any requests from other subcommittees and the resulting response/action.*	**Comments** *Provide additional comments as needed to further support the preceding columns. Other pertinent information should be included if it impacts the work of the subcommittee. If data trends support a proposed new PMI, list that information here.*

PMI Monitoring

The QIC Subcommittees Work Plan is the system for tracking PMIs and development, implementation, and progress of QIIs across subcommittees/councils/ workgroups consistently. In addition, the QIC Subcommittees Work Plan will assist the subcommittee in completing its annual subcommittee performance evaluation and subcommittee report.

Column instructions are found in the italic font directly under each column header. Each QIC subcommittee is responsible to review this work plan at least quarterly, before the QIC meeting. If PMI is performing below target, comments must include what efforts will occur to raise performance. Subsequent monitorings must then indicate the effectiveness of these efforts. If data is not available at the time of review, the reason must be listed under comments. Per KPA Documentation, DQV has established a data review and submission schedule as follows: Q1 (July 1-Sept 30) = January of next year; Q2 (Oct 1-Dec 31) = April of next year; Q3 (Jan 1-Mar 31) = July of same year; Q4 (April 1-June 30) = October of same year

QIC Subcommittees to which this tool applies: CMSC, RMRC, KPA Workgroups, MRC
Persons Responsible for Completion of This Document: QI/QM Coordinator or designee
Timeline for completion: Quarterly with the completed SFY QIC Subcommittee Work Plan due to the QM Coordinator by COB July 31, 2023
Document Location: in Teams
Owner of the Document: Rebecca Laubach

The PMI data contained below is not the primary or official source of PMI data. This data is used in conjunction with subcommittee activities found within this spreadsheet. The spreadsheet is designed for tracking and monitoring of status and interventions.

PMI *List the QIC Approved PMI*	**PMI Target (% and/or #)** *List PMI target*	**List Data Source** Per KPA Documentation form (Measure Development form)	**List Data Reporting Period (Q, Semi-Annual, Yearly, note if FY or calendar year)**	**Date of Review**	**Results**	**Comments** *If data is not available, provide rationale and any actions underway to address the issue.*

QII Monitoring

The QIC Subcommittees Work Plan is the system for tracking PMIs and development, implementation, and progress of QIIs across subcommittees/councils/ workgroups consistently. In addition, the QIC Subcommittees Work Plan will assist the subcommittee in completing its annual subcommittee performance evaluation and subcommittee report.

Column instructions are found in the italic font directly under each column header. Remember to use QII Toolkit as well. Each QI subcommittee is responsible to review this work plan at least quarterly, before the QIC meeting.

QIC Subcommittees to which this tool applies: CMSC, RMRC, KPA Workgroups , MRC
Persons Responsible for Completion of This Document: QI/QM Coordinator or designee
Timeline for completion: Quarterly with the completed SFY QIC Subcommittee Work Plan due to the QM Coordinator by COB July 31, 2023.
Document Location: in Teams
Owner of the Document: Rebecca Laubach

** information pertaining to previously completed activities for continued QIIs can be found on SFYXX XXXX QIC Subcommittee Work Plan **

Committee	QII Catchphrase *Catchphrase for QII that best summarizes what the QII is about*	QII Aim *List the Aim Statement from the QII Toolkit and as approved by the QIC*	Date Approved/ Date Implemented *Include both the date approved and the date the QII was actually implemented*	Date Subcommittee Conducts QII Status Review *List each date the QII is reviewed (oldest to most recent)*	Where are you in your PLAN? *Now that the QII has begun, describe steps taken towards completion.*	Where are you in your DO? *Describe what's happened/what worked well and the data collected. Please note that challenges and barriers are described in a separate column.*	Challenges/Barriers Identified *What challenges/barriers have been identified since the QII was implemented?*	Actions Implemented to Reduce Challenges/Barriers *What actions were implemented to reduce or eliminate the challenges/barriers? If the recommended action needs to go to the QIC, it should be noted here and included in the report to the QIC.*	How are you Studying? *List the results of data analysis. Describe the impact the QII is having. Were the unexpected results? Expected? Were the challenges/barriers eliminated/reduced?*	Lessons Learned & How you will ACT next? *Describe what you learned and what you will do next. Do you Adopt (headed right direction, needs tweaking)? Do you Adopt (incorporate change into practice and expand where appropriate)? Do you Abandon (change did not work, not worth trying again) and revisit Aim and Plan to start fresh?*	List the Outreach, Education, or Training provided as part of this QI Initiative *List the date and describe what outreach, education or training that has been done related to the QII. This will show the effectiveness of the outreach, education or training.*	Date QII Determined to be Completed (Aim has been achieved) or Discontinued (Priority changed, QII no longer needed) *List date of change and a describe reason for completion or discontinuance.*	Comments *Provide any additional details regarding support actions taken or other important information that should be known. If an approved QII needs revision, place supporting documentation here. Once the revision has been approved, the revised QII will be tracked under the original QII.*

Developmental Disabilities Quality Management Plan Annual Report and Evaluation

Virginia Department of
Behavioral Health &
Developmental Services

Developmental Disabilities Quality
Management Plan
Annual Report and Evaluation
State Fiscal Year 2021
Completed:

Executive Summary

The Quality Management (QM) Annual Report and Evaluation summarizes the comprehensive work conducted by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Quality Management System (QMS) in the areas of quality assurance (QA), risk management (RM), quality improvement (QI) and data quality. The QMS made some key accomplishments in each area, in State Fiscal Year 2021 (SFY21).

- The area of QA 1) provided new training and/or enhanced existing training; 2) developed licensure regulation modifications, designed to better target provider improvement needs; 3) established external partnerships to provide an additional level of program oversight, through the conducting of look behind reviews; 4) expanded the use of existing tools, to enhance the ability to identify gaps and track and trend data; 5) enhanced definitions and processes, to address needs around access to medical records; and 6) developed strategies to improve the timeliness and processes around record reviews and the provision of education and planning.
- The area of RM: 1) Collected and shared sample policies, protocols, best practices; 2) enhanced data interfaces to provide more accurate data and eliminate the need for manual review of the notes section of incident reports, by DBHDS staff; 3) published monthly Health & Safety Alerts and newsletters, providing information on health conditions experienced by the population and on vaccinating individuals, with developmental disabilities (for COVID-19); 4) offered technical assistance with infection prevention; to help mitigate ongoing risks; and 5) launched the Crisis Risk Assessment and Risk Awareness tools.
- The area of QI: 1) provided webinars and training on requirements and expectations as well as on the importance of calling 911; 2) followed up on care concerns; 3) provided resource materials, revised the 911/Emergency protocol, updated the CM modules, and updated DSP competencies; 4) submitted language for inclusion in Exhibit M of the Performance Contract, to compel CSBs to participate in technical assistance, establish and implement a corrective action plan (CAP) process, related to CSB underperformance; 5) established a CSB focus group, to provide input on the current ECM guidance, to decrease the complexity of implementation; 6) developed and provided an automated worksheet that supports decisions around initiating and ceasing ECM; and 7) developed and distributed a process map, that reflects the various paths to employment.

The quality committees monitored a combined 37 performance measure indicators (PMIs) and implemented 15 quality improvement initiatives (QIIs) during SFY21. The QMS reviewed each Key Performance Area (KPA) PMI to assess the quality of developmental disability (DD) services and initiated mitigating strategies to improve areas not meeting set targets and to address identified gaps. The SFY21 QM Annual Report and Evaluation demonstrates: the continued

growth of the quality committees in their data analysis, the identification of the need for additional information to inform further decisions or inferences, and the furtherance of their abilities to understand performance from a more global perspective. The document summarizes the SFY21 QM activities, characteristics, and outcomes (compared to previous fiscal year outcomes, where applicable).

Utilizing a program evaluation tool, the organization assessed key components of the QMS that included: assessment of the Quality Management Plan (QMP) and supporting infrastructure, implementation of processes to measure and ensure quality of care and services, and the capacity to build QI among providers. Continued enhancements to the QIC subcommittee work plan, committee processes, reporting processes, and use of QI tools furthered the accomplishments of the QM System as demonstrated through the program evaluation completed by the quality committees. This assessment identified strengths and opportunities for improvement.

DBHDS continued efforts to improve upon data validity and reliability. Twelve data source systems were reviewed with identification of categories of improvement and indication if the system was in the process of being replaced. In the annual update to the Data Quality Monitoring Plan, the areas of key documentation, data validation controls, user interface, business ownership, and maturity all showed positive changes leading to improved documentation, improved results, improved functionality of source systems and improved data validity and reliability.

As the pandemic continued throughout SFY21, numerous PMIs were directly impacted by the pandemic as individuals could not work or participate in the community as before. Face to face visits, look behinds and onsite reviews occurred remotely until restrictions lifted allowing these quality activities to resume; some providers reduced their service offerings, others closed temporarily or permanently; providers experienced staffing shortages. The quality committees improved in their data analysis, which led to improvements in reporting and documentation. DBHDS continued to identify mitigating strategies and continued in their efforts to make improvements. Business owners and subject matter experts (SMEs) worked to address data quality issues identified by the Office of Data Quality and Visualization (DQV).

Quality Service Reviews (QSRs) resumed, under a new vendor, with two rounds being completed in SFY21. QSR results were group according to key performance areas as well as separated out according to ISP assessment, development and implementation, interaction, quality improvement plan, risk/harm, incidents/disputes, provider competency and capacity compliance elements and individual interview results. Using information obtained from the QSRs, DBHDS and HSAG revised the tools used, improved the timeliness of submitted reports, revised HSAG methodology and training of HSAG staff and reviewers. These improvements were necessary to more accurately evaluate service provision. As not all providers participated in both rounds, DBHDS and DMAS collaborated with HSAG to improve provider participation in QSRs and assure compliance to the

CMS requirement on provider participation through the issuance of a memo that notified providers of this requirement.

I. Introduction

The QMP for the Department of Behavioral Health and Developmental Services (DBHDS) is a three-part document, which includes this Annual Report and Evaluation for SFY21. This document summarizes key accomplishments of the QM Program; the Key Performance Area (KPA) Performance Measure Indicators (PMIs), including an analysis of the data and effectiveness of meeting set targets; and the overall performance of the QM Program including QIC Subcommittee performance, identified gaps, challenges to meeting stated goals, plans to mitigate the circumstances around those challenges, and QIIs and other activities implemented. Organizations outside of DBHDS support the work of the Quality Management System (QMS) through the collection, analysis and reporting of system outcomes and outputs across multiple cross-sections of DBHDS-funded services, programs, and persons served. The purpose of this report is to determine if the system is meeting the needs of individuals and families in a manner that aligns with the Commonwealth's mission and vision.

II. Key Accomplishments of the Quality Management Program

The integrated processes of QA, RM, and QI are core components of the DBHDS QM Program. This section outlines the SFY21 overall key accomplishments of these components of the program.

Quality Assurance

1. Office of Human Rights (OHR), working with the Office of Data Quality and Visualization (DQV), conducted a review of allegations of neglect that identified specific sub-categories.
2. Final licensing regulations adopted in August 2020 included modifications to the regulations for provider RM programs and provider QI programs. These modifications help break out specific requirements into sub-regulations to be reviewed and tracked separately, allowing the Office of Licensing (OL) and the Risk Management Review Committee (RMRC) to identify specific requirements that providers are having difficulty meeting, and to target improvement efforts accordingly.

3. DBHDS contracted with the Virginia Commonwealth University, Partnership for People with Disabilities to conduct the incident management look-behind reviews in SFY22.
4. OHR facilitated a series of trainings throughout the year that focused on educating providers on human rights regulations, reporting allegations of abuse and neglect, conducting investigations into abuse and neglect allegations, and the requirements for implementing restrictions, behavioral treatment plans, and restraints.
5. Mortality Review Committee (MRC) published the SFY2020 Annual Mortality Report in December 2020, which included the analysis of 345 mortality reviews; 95.1 percent of the reviews were completed within 90 calendar days.
6. MRC expanded use of the electronic Mortality Review Form (eMRF) to track, record, and store data for identification of trends, patterns, service gaps, and data reporting.
7. MRC engaged with the Center for Developmental Disabilities Evaluation and Research (CDDER) at the Shriver Center at the University of Massachusetts Medical School, to enhance MRC definitions and processes.
8. Through collaboration with the OL, the Data Warehouse (DW) and Virginia Department of Health (VDH), MRC validated the QA purpose for the potential unreported death process. Mortality Review Office (MRO) established this process to identify any missed deaths that may have occurred, allowing for investigation by OL and review by MRC.
9. MRC established a collaborative process with the OL Special Investigation Unit (SIU) related to mortality review to ensure a thorough clinical mortality review of documents within required timeframes.
10. In collaboration with Information Technology (IT) & Security Offices, the MRC developed a process to utilize §§2.2-3705.5, 2.2-3711, and the 2.2-4002 Amendment of the Code of Virginia authorizing the MRO to obtain medical records via an electronic, secure, limited access only, facsimile application (Sfax®).
11. During SFY21, 80.2% of cases reviewed by MRC were performed within 90 days of the individuals' deaths.
12. Office of Provider Development (OPD), Office of Community Quality Improvement (OCQI), and DQV worked collaboratively to implement the second year of a Support Coordinator Quality Review (SCQR) process, to monitor the quality of support coordination for individuals receiving waiver services. This process is designed to enhance QI efforts across Community Service Boards (CSBs) and enable DBHDS to monitor CM performance at local and systemic levels.
13. The Individual Support Plan (ISP) was updated in Waiver Management System (WaMS). Recommendations for planned improvements included:
    a. Adding elements to the ISP to confirm discussions about employment, integrated community involvement, and natural supports.

b. Additional elements were added with respect to integrated community involvement and natural supports (i.e., relationships) so that qualitative information can be obtained
c. Life areas in the ISP were modified to capture the most inclusive level of support provided.

14. Employment First Advisory Group developed improved training for case managers around employment services.
15. REACH teams developed strategies to improve the timeliness of crisis education and prevention plans.

Risk Management

1. Incident Management Unit (IMU) began operating statewide in September 2020, with expansion into regions 1 and 5. IMU reviewed 9,753 serious incidents and flagged 1,561 potential care concerns (based on established risk triggers and thresholds).
2. A workgroup reviewed incident reports of urinary tract infections (UTIs) and made recommendations for additional support and education of providers to mitigate this risk. These recommendations included:
    a. Reviewing and updating provider training and educational resources (atypical signs and symptoms of UTI, critical role of provider, provider skill building related to personal care/hygiene; discussing body parts; health literacy, how other diagnoses, diseases and medications interplay with a diagnosis of a UTI, with a focus on developing more targeted and effective protocols which may either prevent, or extend time between reoccurrence)
    b. Collecting and sharing sample policies, protocols, best practices related to preventing initial and recurrent UTIs
    c. CMSC review of the role of the SC in assuring appropriate services in place for individuals with chronic/recurrent UTIs
    d. Collaboration with MRC to better monitor and respond to trends
3. At the recommendation of RMRC, a specific checkbox was added to the CHRIS interface for providers to report individuals' receiving a positive diagnosis of COVID-19. This provided more accurate data on new COVID-19 cases and eliminated the need for manual review of the notes section of incident reports by DBHDS staff.
4. Office of Integrated Health (OIH) published monthly Health & Safety Alerts and newsletters on topics such as urinary tract infections (March 2021), sepsis (January 2021), choking (November 2020), and pressure injuries (July 2020). In addition, they published guidance for providers regarding vaccinating individuals, with developmental disabilities, for COVID-19 and posted a series of power point trainings on managing common health risks.

5. IMU and OIH, along with VDH, worked to identify cases and outbreaks of COVID-19 in DBHDS residential provider settings and offered technical assistance with infection prevention to help mitigate ongoing risks.
6. OIH and the DBHDS pharmacist collaborated with VDH to facilitate COVID-19 vaccinations for individuals and staff within the DBHDS service system.
7. DQV assisted in the development of Tableau visualizations to track and trend serious incident data, including surveillance rates of risk measures, and abuse and neglect reports to facilitate ongoing review of standardized reporting indicators.
8. In collaboration with CSBs, the Case Management Steering Committee (CMSC) designed and implemented a standardized process for Support Coordinators (SCs) to assess for both change in status and appropriate implementation of the ISP during face-to-face meetings with each individual. During a pilot phase, the On-site Visit Tool (OSVT) was implemented. The tool was used during monthly face-to-face visits, resulting in the establishment of a regular schedule of enhanced case management (ECM) and targeted case management (TCM) visits.
   As part of the process, the following definitions were established:
   - "Change in status" refers to changes related to a person's mental, physical, or behavioral condition and/or changes in one's circumstances to include representation, financial status, living arrangements, service providers, eligibility for services, services received, and type of services or waiver.
   - "ISP implemented appropriately" means that services identified in the ISP are delivered consistent within generally accepted practices and have demonstrated progress toward expected outcomes, and if not, have been reviewed and modified.

   SC supervisors were made aware of and trained on these term definitions and their applicability. The following materials were referenced: a definitions document, a standardized tool format referred to as the OSVT; a summary of the Independent Reviewer report history related to non-compliance with the DOJ SA provision V.F.2.; a reference chart as guidance; training slides, and a questions and answers document produced following a webinar provided on June 26, 2020. This project was further defined in a CMSC Quality Improvement Initiative (QII) that was approved by the QIC in June 2020 for implementation.
9. OPD completed the first qualitative review of the OSVT process in June 2021. The review included a random sample of 301 OSVTs with corresponding contact notes from the first and second quarter of 2021 (July 1, 2020 – December 31, 2020). The OSVT and corresponding notes reflect the identified issues and additional actions taken to address them. Issues identified in the OSVT matched the corresponding note in 75% of reviews. With the modifications to the tool for a December 2020 release, the requirement for detailed notes transitioned from the OSVT to the contact note at the request of the CSBs and work group.
10. CMSC reviewed findings of this evaluation to determine how to improve the process and made recommendations for system changes as needed. As a result of this first

OSVT review, it was recommended that OPD communicate to CSBs that monthly or quarterly visits require completion of the OSVT as part of the visit, even if the person or family requests a telehealth visit.

11. Crisis Risk Assessment was developed and implemented during this past year to ensure that individuals were referred to crisis services early.
12. Risk Awareness Tool was launched this year to help better understand people's complex medical and behavioral needs and assure they were connected to appropriate supports and services.

Quality Improvement

1. The Falls QII demonstrated sustained reduction in the rate of falls throughout SFY21, with a rate of approximately 45 reported falls/1000 individuals on the DD waivers; this was below the target goal of less than 56.88 falls/1000. The Falls workgroup evaluated the impact of interventions, including implementation of the RAT, dissemination of fall prevention training, and follow-up on care concerns related to falls. Evaluation indicated that efforts at training and education were moderately successful, with over 400 participants since 2019. Of those who responded to a survey, 72% reported that they learned new strategies. The workgroup continues to evaluate the impact of the RAT and follow-up on care concerns.
2. In November 2020, OL conducted webinars on specific requirements and expectations for RM and QI programs, as well as access to CDDER's on-line courses. In April 2021, OL conducted a follow-up webinar on implementing RM and QI programs; and additional tools to assist in developing QI and RM plans.
3. Due to challenges in meeting the target goal for the medication errors PMI, the RMRC recommended a QII to assist providers in developing tools and resources to better identify medication errors and conduct root cause analysis to identify and address systemic causes. This QII was approved on June 28, 2021, for implementation.
4. MRC continued the 911 QII, which addressed licensed DBHDS providers' staff failure to contact 911 first in emergencies. MRO collaborated with OIH and OL Special Investigative Team to increase awareness on the importance of calling 911. Training, on the importance of calling 911, was provided as well as resource materials, distributed through alerts and newsletters. OPD revised the 911/Emergency protocol and updated the CM modules to indicate that 911 should be called first, rolling it out to providers through meetings (e.g., Roundtable and Quarterly). Although provider competencies indicated adherence to established provider policies, OPD updated the competencies to indicate that 911 should be called before notifying anyone else of an emergency and making other calls only after 911 was called. MRC case reviews found that providers increased their compliance to 911/Emergency protocol from 62% Q1 to 79% Q4 (target is 61%).

5. MRC developed a QII to address the number of death certificates available for MRC review. Having the death certificates available for review aided the committee in their review of cases and the determinations the committee made relative to cause of death, whether the death was expected/unexpected and, if unexpected, if the death was potentially preventable. MRC surpassed its target of 91% during each quarter of the year (Q1- 98%, Q2- 96%, Q3- 96%, Q4- 96%) with an overall rate of 97% of death certificates made available for review.
6. MRC developed two QIIs to address DBHDS provider knowledge of sepsis identification and ongoing assessment of the individual's change in status. The first sepsis QII focused on decreasing the number of deaths caused by sepsis, through the identification of the top two infectious factors not previously identified during MRC case reviews, and determining the training and education needed to address these factors. As aspiration pneumonia, pressure injury and UTIs are common contributing factors to sepsis, OIH provided training on these as part of a "Fatal 7" training. During the "Fatal 7" training, participants requested further training on sepsis to target areas such as symptom recognition, early awareness, individuals at risk, and resulting actions that should be taken. Data analysis resulting from MRC case reviews and the training feedback supported a more comprehensive training on sepsis. 52% of cases reviewed identified a genetic disorder as the largest contributing factor to sepsis. Therefore, a new QII targeting a comprehensive sepsis training was identified. The second sepsis QII focused on providing a "stand-alone" sepsis training. OIH provided this training on June 4, 2021. OIH created a recorded training, which allowed providers to access it on demand on the COVLc site.
7. MRC proposed two QIIs during Q4 of the fiscal year that were approved on June 28, 2021:
    - The first focuses on decreasing the COVID-19 mortality rate for the I/DD population as MRC had identified 50 COVID-19 related deaths as of May 17, 2021. Key components of this QII include continued education on vaccination, continued support for execution of infection control measures and enhanced surveillance and early detection of COVID-19.
    - The second focuses on reducing the crude mortality rate of individuals with a Supports Intensity Scale (SIS) level 6, as the SFY20 crude mortality rate for SIS level 6 was 76.2 deaths/1,000 individuals. A key component of this QII focuses on addressing risk factors for heart disease, as data from SFY20 revealed that the top two causes of death for individuals with a classification of SIS level 6 were sepsis and sudden cardiac death.
8. CMSC implemented several strategies to improve CSB quality related to CM requirements around ISP compliance, Regional Support Team (RST) timeliness and

SCQR completion. CMSC submitted language for inclusion in Exhibit M of the Performance Contract to strengthen support to CSBs identified as underperforming in any area monitored by the CMSC. The submitted language compels CSBs to participate in technical assistance as recommended by the CMSC. CMSC established and implemented a corrective action plan (CAP) process related to CSB underperformance. Performance Contract language is included as follows:

Targeted Technical Assistance

- The CSB shall participate in technical assistance as determined by the CMSC. Technical assistance may be comprised of virtual or on-site meetings, trainings, and record reviews related to underperformance in any of the following areas monitored by the committee: RST referrals, SCQR results, ISP entry completion, and case management contact data.
- DBHDS shall provide a written request that contains specific steps and timeframes necessary to complete the targeted technical assistance process.
- The CSB shall accommodate technical assistance when recommended within 45 days of the written request.
- CSB failure to participate in technical assistance as recommended or demonstrate improvement within 12 months may result in further actions under Exhibit I of this contract.

9. Currently, there are three QIIs being implemented by the CMSC. Each QII is focused on an identified area of concern and is supported by information collected through discussions with stakeholders and seen in the data monitored by the committee.
    - **QII 1** focuses on ensuring that people with DD have supports that respond to changes in status with appropriately implemented services. CMSC established definitions for "change in status" and "appropriate implementation of services" and a process through which support coordinators in Virginia would apply the same definitions, in the same manner, through face-to-face visits with individuals who use services. Following a pilot phase, the OSVT was established and finalized for use on December 20, 2020, to support consistent understanding and application of these important phrases. DBHDS completed a review of the first two quarters of SFY21 that included a comparison of 301 completed tools and corresponding contact notes. Issues identified in the OSVT matched those identified in the corresponding note in 75% of reviews.
    - **QII 2** centers on improving the frequency with which individuals receive Enhanced Case Management (ECM) visits as defined in Virginia's Settlement Agreement. A focus group of CSBs provided input on the current ECM guidance to decrease the complexity of implementation. The input has resulted in the development and provision of an automated worksheet that supports

decisions around initiating and ceasing ECM. A questions and answers document was also provided to all CSBs through the work of this group.

- **QII 3** focuses on RST referrals occurring timely. CMSC tracks late RST referral reasons including referrals not submitted (Reason A), individuals moving before the RST process could be completed (Reason B), and providers not informing CSBs that the individual has moved (Reason C). Through early analysis, it was determined that a person moving before the RST process could be completed has the most significant impact on performance for the first measure. Early analysis shows that Reason B included many referrals that should be considered emergencies and therefore without impact on this measure. For example, a house fire and immediate relocation would be reported as late for Reason B under current processes rather than as an emergency.

10. Each Regional Quality Council (RQC) implemented a QII within their designated region.
    - RQC1's QII focused on increasing In-Home Support service providers as this service allows individuals' an opportunity to live in the most integrated setting, appropriate to meet their needs. RQC1 surveyed 98 providers within their region.
    - RQC2's QII focused on preventing the rate of falls within Region 2, from returning to pre-COVID levels and focused on maintaining the lower rate of falls. RQC2 gathered falls data and requested providers submit their RCAs with PII/PHI removed, for identifying potential improvement opportunities.
    - RQC3's QII focused on improving statewide DSP competency completion rate within their region. RQC3 surveyed all providers operating within the region.
    - RQC4's QII focused on increasing the recorded employment outcomes in ISPs, which would work to increase employment for those ages 18-64, within Region 4. RQC4 developed a process map that reflect the various paths to employment (individual, SC and DARS) that was distributed to a sample of Region 4 SCs.
    - RQC5's QII focused on increasing the number of individuals ages 18-64 reporting they have an employment outcome. SCs in Region 5 were surveyed.
11. Each KPA Workgroup implemented a QII during FY21. The Independent Housing QII and Crisis QII were determined to be completed by the end of the fiscal year. The DSP Competency QII will continue into SFY22, as the effectiveness of the QII on improving results had not yet been determined.
    - Community Inclusion and Integration focused on Independent Housing specifically the goal to increase the number of adults with developmental disabilities on a DD Waiver or waitlist who live in independent housing.
    - Health, Safety and Wellbeing focused on improving the identification of individuals likely to experience a crisis in order to get them connected to crisis supports and services early.

- Provider Development focused on DSP competency and improving the number of DSPs who were determined to be competent in delivering services.

12. Each KPA Workgroup also proposed new QIIs, based upon available data that addresses the particular focus on the KPA. These QIIs were approved for implementation by the QIC on June 28, 2021.
    - Health, Safety and Wellbeing focused on increasing awareness of the adult Medicaid dental benefit that begins July 1, 2021.
    - Community Inclusion and Integration developed two QIIs. The first focuses on meaningful employment conversations resulting in employment goal development (to decrease barriers to employment). The second focuses on meaningful community involvement conversations that lead to goal development (to decrease barriers to community involvement).
    - Provider Capacity and Competency focused on increasing the number of providers of Employment and Community Transportation services in each region.

Data Quality

Critical to the success of the monitoring of PMIs, as well as in all of the QI efforts employed by DBHDS, is data quality. Data quality involves many components that contribute to the reporting of data and the use of data to drive systemic changes and QI efforts. Included within the QMS is a plan for monitoring data quality.

The Data Quality Monitoring Plan (DQMP)

This annual report is a component of the DBHDS DD QMP and highlights improvements to the twelve source systems that the Office of Data Quality and Visualization (DQV) assessed in Phase 1 of the DQMP. Information was gathered using the methodology presented in the Annual Update Process; this includes interviews, document review, and attendance at relevant training. The methodology was developed to be as comprehensive as is feasible for an annual update.

The table below provides a list of the source systems reviewed for this annual update, the categories in which improvements were made, and whether these systems are in the process of being replaced.

Source System	Categories of Improvement	Replacement Pending
Avatar	Data Validation	No
Children in Nursing Facilities Spreadsheet	None	Yes
CHRIS-OHR/SIR	Key Documentation, Data Validation, User Interface, Business Ownership	Yes

Employment Spreadsheet	Key Documentation, Data Validation, Business Ownership	No
IFSP- Individual and Family Support Program	None	Yes
eMRF- Electronic Mortality Review Form	Key Documentation, Data Validation, User Interface, Business Ownership, Maturity	Yes
OLIS- Office of Licensing Information System	Key Documentation, Business Ownership	Yes
PAIRS-Protection and Advocacy Incident Reporting System	None	No
REACH- Regional Educational Assessment Crisis Habilitation	Key Documentation, Data Validation	Yes
RST- Regional Support Team	Key Documentation, Data Validation, Business Ownership	Yes
WaMS- Waiver Management System	Key Documentation, User Interface	No

Data Quality Improvements

Findings from the initial DQMP fell under the following headings: Key Documentation, Data Validation Controls, User Interface, Business Ownership, and Maturity. DQV organized this annual update by those headings to highlight the improvements made to each system; no improvements were identified outside of these categories. If a system is not mentioned within a category, no changes to the system were identified. Please see the first Data Quality Monitoring Plan report for a complete list of recommendations for each source system.

Key Documentation

There has been significant effort by business areas to produce and update key documentation. In August 2020, OHR updated training documentation related to CHRIS, Quick Reference Guides, and the CHRIS-HR User Navigation Guide. Similarly, OL updated system-training documents for CHRIS-SIR, including instructions for how to get approved users in Delta and the CHRIS-SIR navigation guide. OL also updated and produced a variety of internal training materials for OLIS to improve the reliability of data entered into the system, including internal standard operating procedures and how-to guides.

For the RST spreadsheet, OPD produced the “Internal Process Guide”, which documents the complete life cycle of RST data. The WaMS team produced standard operating procedures for processes performed by their statistician, as well as guidance documents for new modules. The Business Owner of the Employment Spreadsheet created and documented a process for the system that outlines the data collection and reporting process, and updated the Instructions sheet to include business definitions, data entry procedures, and guidance for data interpretation.

The eMRF implemented a change log that documents every change to the form since its creation in September 2019. Further, the eMRF developer created user interaction diagrams and developer documentation that stores all new code implemented in the source system. Within REACH, data definitions have been refined through continuous review to help users more accurately capture data in the system.

Data Validation Controls

Business owners have built some additional data validation controls into their source systems. CHRIS-SIR implemented the use of required fields and added format controls for all date fields within the system; while CHRIS–HR added time stamps for date fields to accurately capture the date and time allegations are reported. The RST spreadsheet added data validation controls to their workbook, including dropdown menus and a data migration process to automatically populate data tables. REACH saw the addition of mandatory fields, checkboxes, and new classifications to dropdown menus to improve the accuracy of the data entered into the system. In addition to numerous data validation controls, a system-initiated "completeness check" was added to the eMRF that ensures all data are entered before records can be submitted.

Avatar integrated a Web Services Interface for importing data from the facilities' EMR through HL7 messaging, standardized billing service codes, and installed an update that prevents imported service codes from overwriting existing service codes for historical data validation. Lastly, the Employment Spreadsheet implemented a hierarchical diagnosis classification system that prevents individuals with multiple active diagnoses from being incorrectly categorized in the system.

User Interface

Overall, many source systems within the agency implemented User Interface (UI) modifications aimed at improving data quality across the agency. CHRIS–SIR added and changed some internal reports that are able to be pulled directly through the UI, improving the efficiency of OL operations. OHR updated the DBHDS Advocate Report section within CHRIS-HR to reflect several new actions that an advocate can take during a provider's investigation. One significant change to the CHRIS User Interface that impacts both CHRIS-SIR and CHRIS-HR prevents CHRIS from opening a previously viewed record when the web application is launched; a problem that previously resulted in some data being overwritten by mistake. WaMS received an enhanced search functionality for "My List", a tool that allows users to identify which ISPs are due to be updated, and an update to the user interface that allows the system to accommodate multiple open modules within a reduced-size window without losing access to unsaved modules. These changes to WaMS were made to help ensure that ISP data is updated within a timely manner, and to help prevent users from being required to re-enter data that could not be accessed in the reduced size windows.

The eMRF received a complete re-build of the front-end user interface. Display logic was added along with conditional visibility of certain fields, a workflow status flag that helps users identify when records can be edited, an advanced search feature that allows users to identify the correct records, and a report through which users can review all data in the record at any time during the data entry process.

Business Ownership

Since the first DQMP review, steps have been taken that reflect an enhanced understanding of business ownership. The CHRIS-SIR business owner (BO) and SME began issuing monthly updates to users about common data entry errors, data highlights, and system alerts. OL has also revised the CHRIS-SIR training process and has begun uploading training videos to their website. OHR revised the training process for CHRIS-HR, so that providers are now scheduled for training by OHR advocates, rather than selecting their own training dates. The BO of CHRIS-HR has also taken a more proactive approach by distributing memos about system issues or updates.

For the eMRF, a change control process was developed where stakeholders can propose changes to the system, which are reviewed annually. OL revised their training process for OLIS so that new users are paired with OL specialists for a detailed walkthrough of the system. Lastly, the Employment Spreadsheet adopted a change control process in which the Employment First Advisory Committee develops and proposes updates to the source system, which are reviewed by the BO prior to implementation.

Maturity

DBHDS has made some progress in improving the maturity of source systems. The eMRF underwent a near-complete re-build to create a more mature system. There has also been effort by the agency to pursue Enterprise-level solutions for data collection and storage issues through the integration of Microsoft Dynamics 365 into the agency workflow. This product can perform a variety of functions related to data collection, storage, and analytics, and may supplant some informal data sheets and less mature source systems. Work has also been done to replace outdated systems. For example, OL continued work to finalize the development of CONNECT, a new system which is expected to replace OLIS, fall of 2021.

III. Data Reports Including Performance Measure Indicators

The DBHDS QM Program's KPAs align with the DBHDS vision, mission, and strategic plan to address the availability, accessibility, and quality of service provision for individuals with DD in support of "a life of possibilities for all Virginians". DBHDS, through the QIC subcommittees, collects and analyzes data from multiple sources in each of the eight quality of life and provider

service domain areas. These eight domains are included in one of the three KPAs as indicated below:

DBHDS KPA	Domain
Health, Safety, and Well-Being	Domain 1: Safety and Freedom from Harm Domain 2: Physical, Mental, and Behavioral Health and Well-being Domain 3: Avoiding Crises
Community Integration and Inclusion	Domain 4: Stability Domain 5: Choice and Self-Determination Domain 6: Community Inclusion
Provider Competency and Capacity	Domain 7: Access to Services Domain 8: Provider Capacity

In addition, each domain includes a PMI to assist DBHDS in assessing the status of the domains and the KPA. Each PMI contains the following:

- Baseline or benchmark data, as available
- The target that represents where the result should fall at or above
- The date by which the target will be met
- Definition of terms included in the PMI and a description of the population
- Data sources (the origins for both the numerator and the denominator)
- Calculation (clear formula for calculating the PMI, utilizing a numerator and denominator)
- Methodology for collecting reliable data (a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation)
- Subject matter expert assigned to report and enter data for each PMI
- A Yes/No indicator to show whether the PMI can provide regional breakdowns.

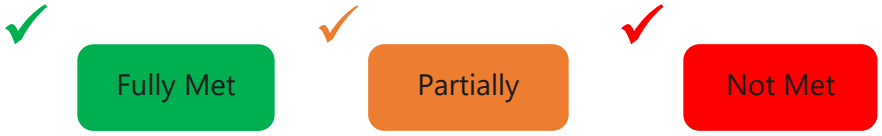
These PMIs include both individual outcome and system-level output measures. Outcome measures focus on what individuals achieve as a result of services and supports (e.g., individuals have jobs). Output measures focus on what a system provides, or the products provided (e.g., incidents are reported within 24 hours). DBHDS uses these PMIs to recommend and prioritize QIIs. The PMIs allow for monitoring and tracking of performance standards and the efficacy of improvement efforts.

As previously noted in Part 2 of the DBHDS DD QM Plan, DBHDS-DMAS QRT monitors CMS DD waiver performance measures (PMs) included in the DD HCBS Waivers Quality Improvement Strategy for the DD waivers and reports the status of those measures to CMS. CMS requires states to submit an evidentiary report on CMS DD waiver PMs and requires remediation when a performance measure falls below 86% for any year during the three-year cycle covered by the

evidentiary report and/or development of a Quality Improvement Project (QIP), which details systemic activities to improve compliance, which are approved and monitored by CMS. These measures demonstrate that states have implemented an effective system for assuring waiver participant health and welfare and that states have met other CMS-required HCBS standards. DBHDS quality subcommittees also monitor the state's CMS DD waiver PM within their PMIs. QRT provides an annual report on the status of these PMs and recommendations to the DBHDS QIC. The SFY20 QRT report outlines the data sources and sampling methodology for all PMs and identified remediation activities for those PMs below 86%. Remediation activities shown in the report include provider training and technical assistance for providers with multiple citations in an identified area and revisions to sampling to improve data provenance. The full report, including measures that did not meet target and specific recommendations, is located at: https://www.dbhds.virginia.gov/developmental-services/provider-development.

The DBHDS QIC and/or subcommittees or workgroups monitor the PMIs and surveil other significant data to identify patterns and trends that signify a need for remediation, corrective action and/or the development of a QII. This section includes an analysis of data reports and PMIs and an assessment of positive and negative outcomes in each KPA. Where performance does not meet expectations (e.g., the measure is below the set target), the annual progress is provided with discussion of strategies implemented to improve performance. The Performance Assessment Key below defines measurement standards for each table presented within this section.

Performance Assessment Key:



- Fully Met indicates the measure meets or exceeds the set target
- Partially Met indicates the measure is within 10% of the set target
- Not Met indicates that the measure is 11% or greater below the set target

Green Line – Performance Target

Blue line – Performance against Target

A measure's annual rate = (sum numerators for each quarter / sum denominators for each quarter) X 100

Key Performance Area: Health, Safety and Well-Being

This KPA includes data analysis of information relevant to the domains of safety and freedom from harm; physical, mental and behavioral health and well-being; and avoiding crisis. The goal for this KPA is that people with disabilities are safe in their homes and communities; receive routine, preventative healthcare, and behavioral health services and behavioral supports as needed.

The DBHDS offices of Human Rights, Licensing, and Mortality Review collect the data presented below. -The KPA Workgroup, RMRC, and MRC provide oversight, and monitor, and analyze the data, as applicable. Please find below a brief synopsis of progress towards the achievement of PMIs relevant to domain of safety and freedom from harm.

Performance Measure Indicators – Safety and Freedom from Harm	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY21 Performance Assessment
Critical incidents are reported to the Office of Licensing within the required timeframes (24-48 hours)	86%	93%	92%	95%	✓
Licensed DD providers, that administer medications, are NOT cited for failure to review medication errors at least quarterly	86%	99%	88%	^	^
Corrective actions for substantiated cases of abuse, neglect and exploitation are verified by DBHDS as being implemented	86%	88%	99%	98%	✓
State policies and procedures, for the use or prohibition of restrictive interventions (including restraints), are followed	86%	100%	*	100%	✓
The state policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed	86%	100%	99%	100%	✓
Licensed providers meet regulatory requirements for risk management programs:	86%	**	82%	^	Retired
Licensed providers meet regulatory requirements for quality improvement programs	86%	**	75%	^	Retired
Individuals are free from harm, as reflected in the rates of serious incidents that are related to risks which are prevalent in individuals	56.88	**	56.77	45	✓

with developmental disabilities: Falls					
Unexpected deaths, where the cause of death or a factor in the death that were potentially preventable, where some intervention to remediate was taken	86%	62%	100%	100%	✓
Individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans.	95%	**	**	98%	✓

*There were no QSRs completed in SFY20, thus the absence of data.
**The PMI was not approved for that SFY, thus the absence of data.
^ Data not available; explanation included in corresponding paragraph listed below.

RMRC was responsible for monitoring eight Health, Safety, and Well-Being PMIs, all of which were related to the Licensure requirements for reporting of critical incidents, reviewing medication errors, implementing CAPs, following regulations (regarding restraint and seclusion), and meeting requirements for provider QI and provider RM programs. Changes in Licensure regulations and reporting interfaces resulted in changes to provider QI and RM PMIs.

The PMIs that measure 1) compliance around reporting critical incidents within 24 hours; 2) verification of the implementation of corrective actions; 3) provider adherence to regulations around the implementation of seclusion and restraint; and 4) the rate of falls, all met their identified performance goal. Although the reduced rate of falls has been sustained throughout SFY21, RMRC identified the reduction in activities related to the pandemic as a potential contributor to reduced falls and therefore decided to continue the Falls QII through SFY22.

Changes to the CHRIS interface and subsequent improvement to DW reports has increased the accuracy of the calculations for the PMI that measures "compliance with timeframes around licensed provider reporting of critical incidents." While regulations require providers to report critical incidents within 24 hours of discovery, the CHRIS interface did not capture time of discovery. Consequently, this measure previously calculated the percent of providers that reported incidents within one day of the incident, which could have been up to 48 hours (e.g., incident at 12:01 am 10/1/20 reported by 11:59 pm 10/2/20 would be considered compliant, even though it is over 47 hours from the event). Beginning in November 2020, the DW report was able to calculate the timeliness of incidents to the minute. While this change resulted in fewer incidents being recorded as timely, it did not have a significant impact on the percentage of incident considered timely.

The emergency licensing regulations that established requirements for provider RM and QI programs became final in August 2020 and included changes that necessitated revisions to two PMI measures. Specifically, the final regulations separated some requirements of the regulation into additional sub-regulations such that the requirements for provider RM programs increased from five to 10 sub-regulations (12VAC35-105-520), and the requirements for provider QI programs increased from a single regulation to 13 sub-regulations (12vac35-105-620). These two measures were revised to measure the percentage of providers that are compliant with 100% of the regulations for which they were evaluated. RMRC and OL will continue to review overall compliance on each of the specific sub-regulations to determine which areas providers need assistance.

The baseline data from quarter 3 and quarter 4 indicated that 62% of providers met all of the applicable requirements for RM programs; only 51% of providers met all of the applicable requirements for QI programs. OL provided training on developing RM and QI programs in November and December 2020 and then provided additional tools to help providers meet these requirements in April of 2021. It is too early to tell the extent to which these efforts may have helped to increase compliance. RMRC and OL will review quarter 1 and quarter 2 data to determine additional areas where further improvements are needed.

The reliability of the measure assessing provider compliance with the requirement to conduct quarterly reviews of medication errors is being re-assessed and therefore data for SFY21 is not available. An effort to demonstrate measurable reliability, by attempting to replicate previous results by following the documented data processes utilized when reporting data for quarter 3 was unsuccessful. Following the documented data processes produced a result of 70%, as opposed to the 89% reported to the RMRC. While reviewing this discrepancy, the data workgroup noted that the documented process did not exclude Licensure findings of “not-applicable” and “not-determined” from the denominator. The workgroup recommended the measure be revised to exclude said finings, to ensure a more valid representation of the provider compliance with this requirement. Revised PMIs will be presented to the QIC for approval in SFY22.

The MRC is responsible for monitoring the PMI related to unexpected deaths. In SFY21, the MRC reviewed 378 deaths of which 207 were determined to be unexpected (UXP). Of those 207, 33 were determined to be possibly preventable (PP) and for each of those 33 PP deaths the MRC identified an action or recommendation that could have been taken to potentially prevent the death. The MRC determined, in SFY21, that more deaths were determined to be UXP than expected (XP), as compared to SFY20 data where more deaths were determined to be XP than UXP.

The chart below shows that the MRC identified 36 PP deaths during SFY21, which is more than double the number of PP deaths in SFY20.

Quarter	FY 2020 PP Deaths	FY 2021 PP Deaths
Q1	4	**11**
Q2	4	**7**
Q3	4	**11**
Q4	3	**7**
Total	15	**36**

This increase could be explained by the following factors: 1) the addition of the OL Specialized Investigation Unit (SIU); 2) attainment of additional information (from medical records) that decreased the potential for information gaps, and 3) better informed committee discussions around PP deaths, including the identification of reasonable valid actions or care measures that should have occurred or been utilized.

When a death is determined to be PP, the MRC categorizes contributing factors from four PP provider factors. In reviewing the chart below, it should be noted that each case may have more than one potentially preventable factor. During SFY20 and SFY21, *'Execution of Established Protocols'* was the most commonly assigned factor.

Description of PP Cause/Factor	FY 20 Total	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total
Coordination of Care	8	1	2	3	4	**10**
Access to Care	4	1	3	4	3	**11**
Execution of Established Protocols	13	10	4	5	4	**23**
Assessment of Needs/Change in Status	4	4	4	7	5	**20**

During SFY21, 100% of UXP PP deaths, occurring in DBHDS licensed residential community settings, documented remediation interventions, which resulted in providers exceeding the target goal of 86%. This PMI target goal of 86% has been exceeded since January 2020 (*last two quarters of SFY19*) and is projected to continue moving forward *(validation of successful process change made in SFY 2019)*.

The PMI relating to "Individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans," achieved its target of 95% by 3%. This PMI was new for reporting in SFY21.

The Office of Integrated Support Services (OISS) and the CMSC through the SCQRs collected the data presented in the table below. The KPA Workgroup and the CMSC provide oversight,

and monitor, and analyze the data. A brief synopsis of progress towards the achievement of PMIs relevant to the domain of physical, mental and behavioral health and wellbeing is shown below.

Performance Measure Indicators-Physical, Mental and Behavioral Health and Well-Being	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY21 Performance Assessment
Individuals on the DD waivers will have a documented annual physical exam date.	86%	**	**	70%	✓
Individuals on the DD waivers will have an actual annual physical exam date.	86%	**	**	51%	✓
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.	86%	**	**	75%	✓
Individual support plans are assessed to determine that they are implemented appropriately.	86%	**	**	50%	✓

**The PMI was not approved for that SFY, thus the absence of data.

KPA workgroup began analyzing data related to physical exams this first year to ensure that individuals were receiving needed medical care. As indicated above 70% of individuals received their physical exam within the past year. An additional 25% received their physical between one and two years. It will be important to monitor this data for the upcoming year to determine what, if any, impact the pandemic had on these numbers so we can better assess. Additionally, OIH is reviewing the data and assessing the data, according to living situation and SIS level, to determine if these have any additional impact on the frequency of physical exams.

Case Management Measures

Data for these measures was collected through the SCQR survey, over a six-month period. SFY21 results, presented above reflect the data that was provided by CSBs between January 1 and June 30, 2021. Analysis of these measures demonstrated that, as a group, 75% of CSBs assessed whether the person's status or needs for services and supports had changed and that the plan has been modified as needed; 50% of CSBs assessed ISPs to determine if they were implemented appropriately. These two PMIs were embedded in the OSVT, which was not implemented in its final format until December 1, 2020, following a pilot phase that was initiated on July 1, 2020. The timeline for OSVT implementation resulted in data only being available for one month, in the 12-month review period from which the sample was drawn. As revisions to the SCQR process from the first cycle are integrated and as CSBs scrutinize their records more

closely, the second cycle of SCQRs is expected to reflect decreases in compliance and increases in reliability.

The OCSS collected the data presented in the table below. The KPA Workgroup provides oversight, and monitors, and analyzes the data. A synopsis of the Commonwealth's progress towards the achievement of this PMI in the domain of avoiding crisis is detailed below.

Performance Measure Indicators-Avoiding Crisis	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY20 Performance Assessment
Initial CEPPs are developed within 15 days of assessment.	86%	NA**	NA**	80%	✓

**The PMI was not approved for that SFY, thus the absence of data.

The HSW KPA Workgroup has been monitoring data on the completion of Crisis Education and Prevention Plans (CEPP) being completed timely. Initial data indicated that DBHDS was 6% below the target. The Regional Crisis Managers are working with the programs to assess and identify ways that they can assure CEPPs are developed in a timely manner so that individuals and their support systems have appropriate strategies to use to mitigate crises in a timely manner.

Key Performance Area: Community Inclusion and Integration

This KPA includes data analysis of information relevant to the domains of community inclusion, choice and self-determination, and stability. The goal of this KPA is to ensure that people with disabilities live in integrated settings, engage in all facets of community living, and are employed in integrated employment.

"Merely residing outside of an institution does not equate to community integration."
Virginia's Olmstead Strategic Plan 2019

OISS and Office of Community Housing (OCH) collect the data presented below. The KPA Workgroup and CMSC provide oversight, monitor, and analyze the data. The following tables and graphs describe the progress towards achievement of PMI goals relevant to the domains of community inclusion, stability and choice and self-determination.

Performance Measure Indicators-Community Inclusion	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY21 Performance Assessment
Adults, who are active on the DD waiver or waitlist, who live or have lived in independent housing	6%	5%	7%	8%	✓

Individuals with an active waiver are involved in their community through the most integrated support.	86%	**	**	^	^
Individuals with an active waiver are involved in their community without barriers.	86%	**	**	^	^
Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.	86%	**	**	37% (derived from May and June 21 data)	✓

**The PMI was not approved for that SFY, thus the absence of data.
^ Data not available; explanation included in corresponding paragraph listed below.

Data related to community involvement was collected starting in May of 2021 and will be reported in SFY 2022. The percentage of individuals in independent housing continued to grow and exceeded the target.

Teen Employment Discussion

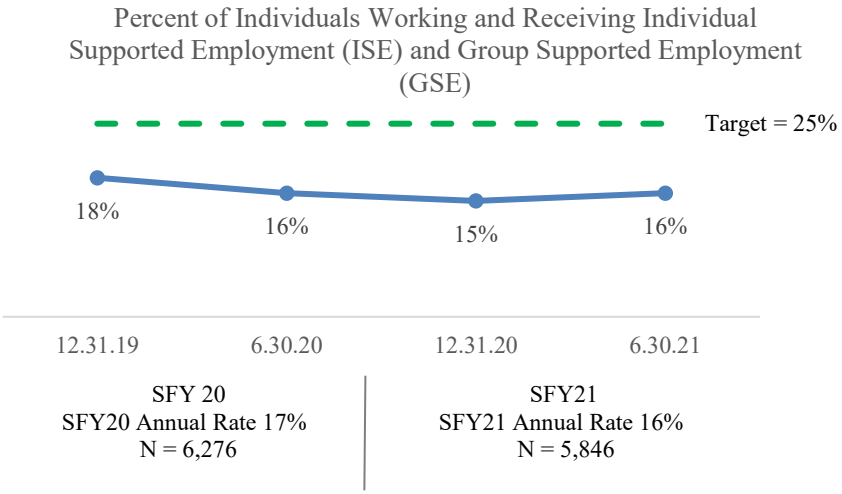
DBHDS worked through SFY21 to incorporate elements into the WaMS ISP, to collect data for this measure. Data from May and June of SFY21 included 721 ISPs, of which 30 were completed for youth between ages 14 and 17. Of the 30 ISPs, 26 (87%) confirmed a discussion regarding employment. Fifteen ISPs (50%) confirmed discussing what they were working on (at home and school) towards employment, while 11 ISPs (37%) reported discussing alternate sources of funding. Eleven ISPs (37%) confirmed both topics were included in the measure. Data for this measure will be monitored to determine what, if any, actions are needed to improve results

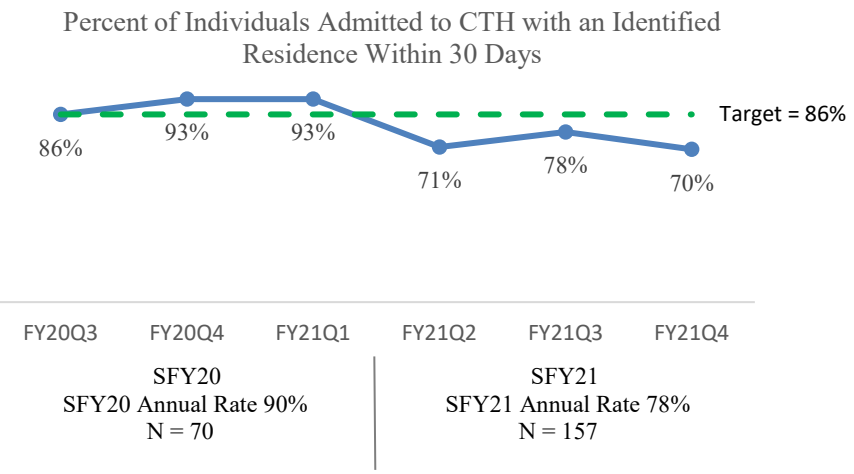
Performance Measure Indicators-Stability	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY21 Performance Assessment
Individuals on the DD waiver and waitlist (aged 18-64) are working and receiving Individual Supported Employment (ISE) or Group Supported Employment (GSE) for 12 months or more	25%	19%	17%	16%	✓
Individuals have stability in the independent housing setting.	86%	**	**	97%	✓
Individuals with a DD waiver and known to the Reach system who are admitted to CTH facilities will have a	86%	84%	90%	78%	✓

community residence identified within 30 days of admission.					

**The PMI was not approved for that SFY, thus the absence of data.

The KPA workgroup continues to monitor data around employment, housing, and crisis to ensure stability of services for individuals. Employment stability decreased this and last fiscal year, but this is directly related to the pandemic (due to staff furloughs and layoffs, business closures, and people being let go from their positions otherwise. It may take a year or more to rebound, for individuals to find new jobs and then remain in those jobs. Similarly, we saw COVID impacts on the ability of individuals to have a community residence identified in 30 days (related to staffing concerns as well as the increase in COVID 19 positivity rates, at various times, throughout SFY 2021). Conversely, those who lived independently were able to maintain stability in their housing throughout this fiscal year. The graphs below show the impact of the pandemic on both employment and those needing a community residence identified within 30 days.





Beginning in SFY21, the KPA Workgroup began using WaMS ISP data for the PMI regarding choice in living situation; CMSC uses data from the SCQRs for the remaining two PMIs. This data is included within the following table.

Performance Measure Indicators-Choice and Self-Determination	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY21 Performance Assessment
Individuals who chose or had some input in choosing where they live if not living in the family home. **Source-FY 2018-2019 National Core Indicators (NCI) Data; FY2019-2020 VA NCI data**	86%	67% NCI Virginia Result 2018	65% NCI Virginia Result 2020	100%	✓
Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff).	86%	**	**	83%	✓
Individuals are given choice among providers, including choice of support coordinator, at least annually.	86%	**	**	78%	✓

**The PMI was not approved for that SFY, thus the absence of data.

Initially, data for the "choose where you live" measure was derived from the NCI report for Virginia. The SFY19-20 Virginia NCI report indicated that 65% of individuals either chose or had some input into where they lived. Beginning in SFY21, the data source for this measure changed to the Waiver Management System (WaMS) Individual Support Plan (ISP). This enabled DBHDS to review progress at an increased frequency. The overall result for the first three quarters of SFY21 is 100% of individuals receiving DD waiver services confirmed that

they had chosen or had input into where they lived, which was above the 86% target. Data reporting changed with the use of the WaMS ISP version 3.2, which launched on May 1, 2021. Results from May 1 to June 30, 2021, showed 100% success, which is in line with past reporting. The overall result is 100%, which will serve as a new baseline, derived from changes in reporting. DBHDS will continue to monitor this measure.

Case Management Measures

Data for the two measures involving SCs was collected through the SCQR survey, over a six-month period each year. SFY21 results presented here reflect data provided by CSBs between January 1 and June 30, 2021. Results for the relationship measure were derived from a combination of two SCQR questions in the SFY21 Technical Guide (Q57 and Q58). These questions sought evidence of discussing natural supports within the ISP or elsewhere in the record, respectively. The second measure correlates to Indicator 2 in the SCQR results. In order for a record to meet indicator 2, there must be confirmation of evidence for both choice of SC and choice of provider in the record. The measure on choice of provider found that twenty-three CSBs (58%) achieved at least 86% with this indicator. DBHDS identified areas of need and made updates to the SCQR process, tools, and guidance as well as the WaMS ISP to encourage consistency in the content and location of documentation reviewed through the survey.

Key Performance Area: Provider Capacity and Competency

This key performance area includes data analysis of information relevant to the domains of access to services and provider capacity and competency. The goal of this KPA is to improve individuals' access to an array of services that meet their needs, support providers in maintaining a stable and competent provider workforce and provide resources to assist providers in attaining and maintaining compliance with licensing regulations.

The OCSS, OISS, and HSAG (QSR vendor) collect the data presented below. The KPA Workgroup and CMSC provide oversight, monitor and analyze the data. The table, charts, and graphs below detail the Commonwealth's progress towards achievement of these PMIs in the domain of access to services.

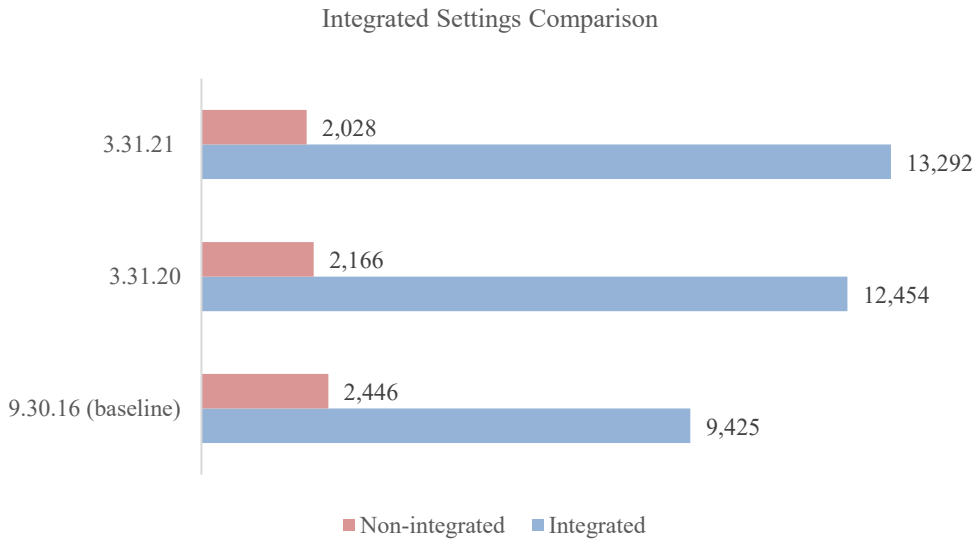
Performance Measure Indicators- Access to Services	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY21 Performance Assessment
Data continues to indicate an annual 2% increase in the overall DD waiver population receiving	2%	1.9%	1.2%	1.5%	✓

services in the most integrated settings. (FY19 5.1%)					
Data continues to indicate that at least 90% of individuals new to the waiver, including individuals with a "supports need level" of 6 or 7, since FY16 are receiving services in the most integrated setting.	90%	**	85%	87%	✓
The Data Summary indicates an increase in services available by locality over time.	↑ trend for all services	10/15	6/15	+38 localities provider count +41 localities service type	✓
Assess if transportation provided by waiver service providers (not to include NEMT) is being provided to facilitate individuals' participation in community activities and Medicaid services per their ISPs.	86%	**	**	Round 1 = 84% Round 2 = 91%	✓
Employment goals are developed for individuals, ages 18-64, receiving DD Waivers	50%	32%	30%	28%	✓
Community Engagement and Community Coaching goals are developed for individuals receiving DD Waivers	86%	37%	37%	38%	✓
Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers	86%	71%	58%	64%	✓
RST referrals are timely for individuals considering a	86%	69%	78.5%	89%	✓

move into group homes of 5 or more beds					

**The PMI was not approved for that SFY, thus the absence of data.

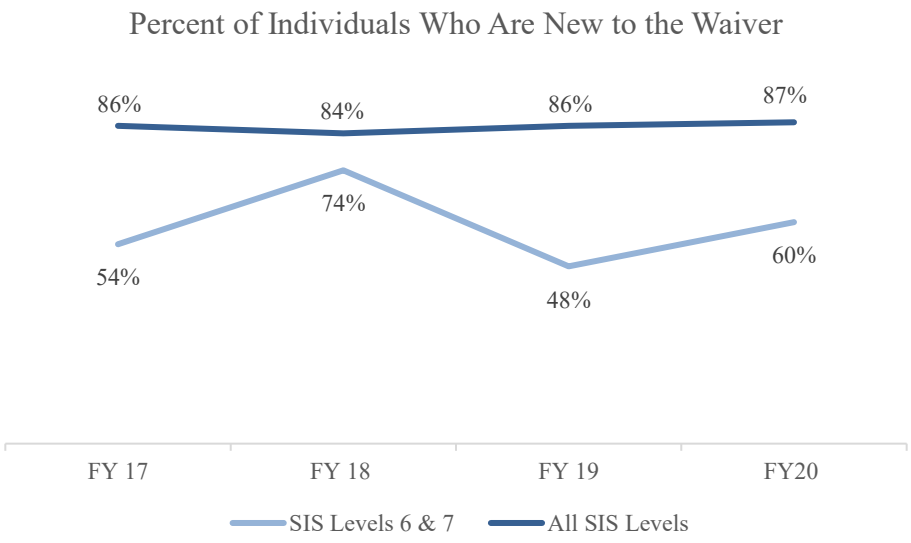
The "annual 2% increase in the number of individuals living in integrated settings" measure showed an increase from 1.2% to 1.5% but did not meet its target of 2% increase. Development of these options was, and continued to be, hampered by the global pandemic, which limited access to service options. RQC1 implemented a QII focused on increasing the number of In-Home providers within Region 1 to increase the number of individuals living in integrated settings. Routine Provider Development activities, along with the resolution of the pandemic, are expected to improve results over time for this PMI. The following graph and table depict the changes to the number of individuals living in integrated and non-integrated settings.



Setting Type	Baseline 9.30.16		3.31.20		3.31.21		Change from Baseline
Integrated	9,425	79.40%	12,454	84.50%	13,292	86.80%	41%
Non-integrated	2,466	20.60%	2,166	15.50%	2,028	13.20%	-17%
Total	11,871	100%	14,620	100%	15,320	100%	29%

Reporting on the PMI for "individuals who were new to the waiver" was refined over the past year. Initially, reporting was provided only for an annual or quarterly look back period but in May of 2021, the aggregate results, per year, were provided to show the individual level of increases by year. While previous reporting shows the percentage of increase from year to year, it does not provide an aggregate result for all years combined, which is necessary to demonstrate cumulative results. While the percentages, related to individuals with SIS support needs levels 6 or 7, are broken out in the chart below, they are supplemental to the overall total of individuals, new to the waiver, receiving services in the most integrated settings and are broken out to

demonstrate their impact to overall measure results. Refining the calculation of this measure is necessary to provide greater accuracy in understanding progress and in determining if the measure has been met. The following graph shows the percent of individuals who are new to the waiver.



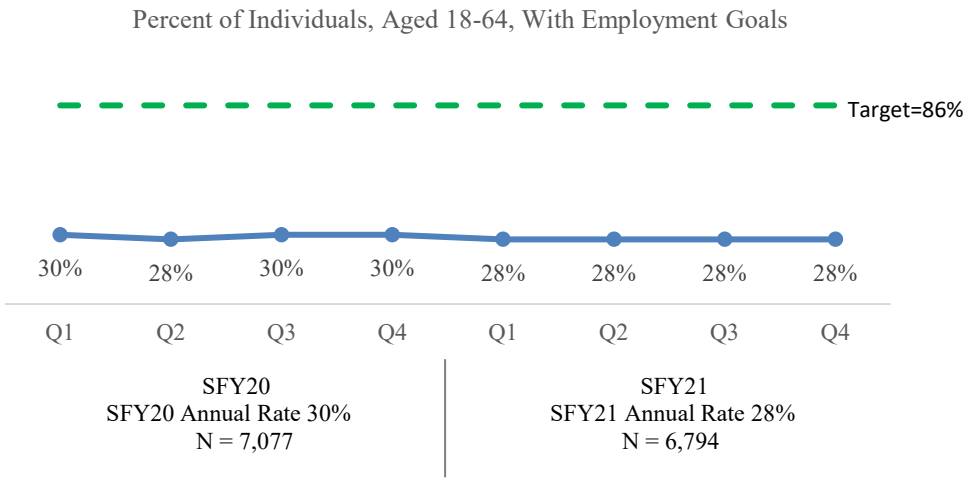
Regarding the "Data Summary indicates an increase in services available by locality over time" measure, DBHDS has worked over the past year to more accurately report progress with this measure. Prior reporting did not reflect any changes in service availability at the locality level, which made it difficult to determine what changes, had occurred, at the locality level, in service availability. Enhanced data reporting now tracks the number of localities with a gain, loss, or no change in either the number of providers or types of integrated services. In November 2020, 40 localities saw an increase in the number of providers of integrated services and 40 saw an increase in the types of integrated services offered. In May of 2021, there was a slight decrease in the number of localities from 40 to 38 localities. Despite this decrease, the measure was reported as met due to a single locality experiencing growth in the types of integrated services offered. Growth must be seen in at least one of these areas to be considered progress for the purposes of reporting. As mentioned above, the global pandemic has resulted in slow growth or a decrease in available services. Gains in many services remain above what they were at baseline, but prolonged pandemic conditions and staffing shortages continue to impact the development of service options across most localities.

The "transportation being provided by waiver service providers (not to include NEMT) to facilitate individuals' participation in community activities and Medicaid services per their ISP" measure uses QSR data as the data source for determining progress. To date, two rounds of QSR reviews have been completed. In the first round, the QSR element used for this measure was

stated as "Do you have problems with transportation;" 84% responded "No". In round 2, the question was revised to more closely align with this measure. The QSR element used for this measure was stated as "Does your provider transport you to community activities you choose and want to attend". When asked during the second round, the results improved to 91%. The new element will continue to be monitored, in future rounds, to ensure transportation is occurring in accordance with the individual's desires and plans.

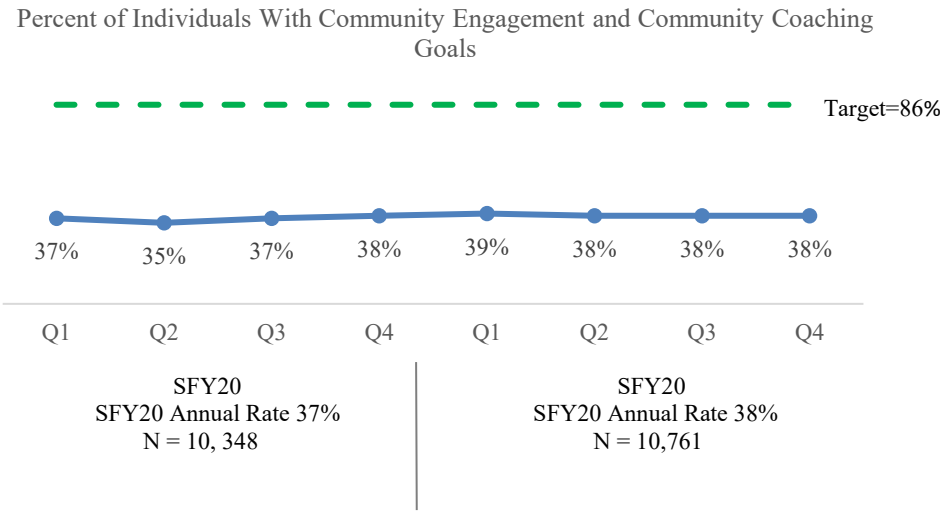
Case Management Measures

The "employment goals are developed for individuals, aged 18-64" measure, an increased focus over this past year was on the number of people who have outcomes in their ISP that support or lead to employment. This is an ongoing topic with RQCs; the CMSC is aware of efforts, at the local level, to increase access and opportunities for employment. One such effort is underway in Region V where the RQC has established a QII to increase the number of individuals with employment outcomes. Efforts focused on providing training, increasing resource access, and facilitating work sessions with support coordinators. In addition, the Region IV RQC QII involves developing an employment process map to clarify processes and increase consistency in understanding how to access and navigate options for work. The following graph depicts the percentage of individuals, aged 18-64, with employment goals listed in their ISP.



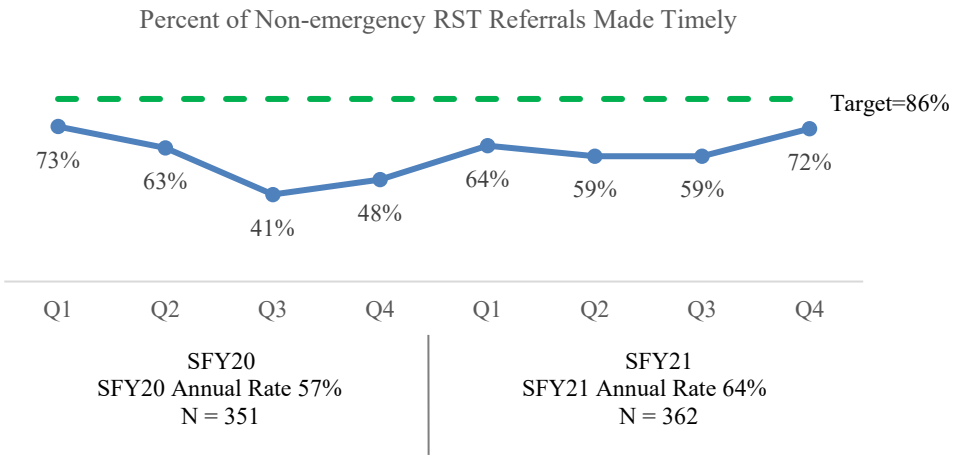
Beyond employment, the Commonwealth has focused on increasing integrated community involvement with an emphasis on connecting people with disabilities to other community members and unpaid natural supports. The PMI focused on the development of outcomes/goals for achieving integrated community involvement remained below 40% for the past year. Changes in SFY21 data collection could impact this result as training, guidance, and the creation of quantifiable elements in the ISP provide a location and pre-determined topics to guide conversations. Efforts to further

CSB and provider understanding of what is being measured and how data is collected occurred that supports CSB and provider follow through on supporting individuals to have more opportunities for integration and how to document. The following graph depicts the percent of individuals with Community Engagement and Community Coaching goals in their ISP.



There are two PMIs, involving RST, that function in all regions of the Commonwealth. These teams are comprised of cross agency professionals and work to support informed choice and resolve the barriers to more integrated living. A review of the measures and activities for SFY21 indicates that, despite the COVID-19 pandemic, accomplishments were made.

Accomplishments resulted from increasing the availability of data in WaMS. CSBs have maintained performance close to or above the target of 86%, for the RST measure related to residential services (see chart below). However, a decline in the number of case management contacts (which coincided with the onset of the state's declaration of a state of emergency, due to COVID-19, resulted in limited capacity to provide in-person services and contacts) toward the end of SFY20 and into SFY21. Despite efforts to mitigate this adverse effect, performance fell well below target in the 1st and 2nd quarters of SFY21. In the last 2 quarters of SFY21, the public health emergency ended, and face-to-face visits resumed, largely via telehealth. As we enter SFY22, it is apparent that the trajectory of the pandemic remains uncertain. DBHDS will continue to monitor data related to CM contacts in the coming year. The graph below depicts the changes in performance for non-emergency RST referrals occurring timely.



In summary, a maturing quality improvement structure and enhanced use of data has led to a collective, increased focus on points of low performance. During the year, considerable effort was made to enhance the elements in Virginia's Person-Centered ISP that resides in WaMS. Changes implemented during SFY21 centered on enhancing the content around conversations about employment, integrated community involvement, and natural supports. Several elements, designed to provide quantifiable data around employment conversations and to better ensure the reliability of the data were added. CMSC will explore activities focused on understanding and addressing the timeliness of non-emergency RST referrals, which may improve results in the coming year. Finally, CMSC has worked to establish a process of collecting and reviewing data that includes a review schedule, to allow more time to focus on specific sets of data and determine actions that will impact results. In the coming year, this will be necessary to adequately address the increased number of measures being monitored, through the committee, and to implement actions that improve DD services and supports in the Commonwealth.

OHR, QRT, OCSS and OISS collect data presented below. The KPA Workgroup and CMSC provide oversight, monitor and analyze the data. The following table charts and graphs depict the Commonwealth's progress of towards the achievement of PMIs relevant to the domain of provider competency.

Performance Measure Indicators- Provider Capacity	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY21 Performance Assessment
The state demonstrates, on an ongoing basis, that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death, by verifying that	86%	86%	92%	94%	✓

investigations provided by licensed providers are conducted in accordance with regulations					
People with DD waiver are supported by trained, competent Direct Support Professionals.	95%	**	**	78% Training 60% Competencies	✓
Individuals receiving Developmental Disability Waiver services, identified as meeting ECM criteria, will receive face to face visits every month no more than 40 days apart	86%	89%	83%	84%	✓
Individuals receiving Developmental Disability Waiver services, identified as meeting ECM criteria, will receive face to face visits every other month in their residence	86%	86%	77%	77%	✓

**The PMI was not approved for that SFY, thus the absence of data.

OHR conducts Community Look-Behinds (CLBs) to validate that provider investigations are conducted in accordance with state regulations and to identify where prevention efforts and mitigating strategies are needed. A traditional CLB involves a desk audit of CHRIS followed by onsite visits by the reviewer to review the provider's investigation documentation and provide a face to face debrief and learning session. OHR suspended site visits in mid-March 2020 and in July 2020, due to COVID 19. OHR decided to re-initiate the CLB through virtual means. In lieu of an onsite visit, OHR reviewers requested that providers email their investigation documentation to the reviewer, who in-turn reviewed it and met with the provider virtually to debrief and provide technical assistance.

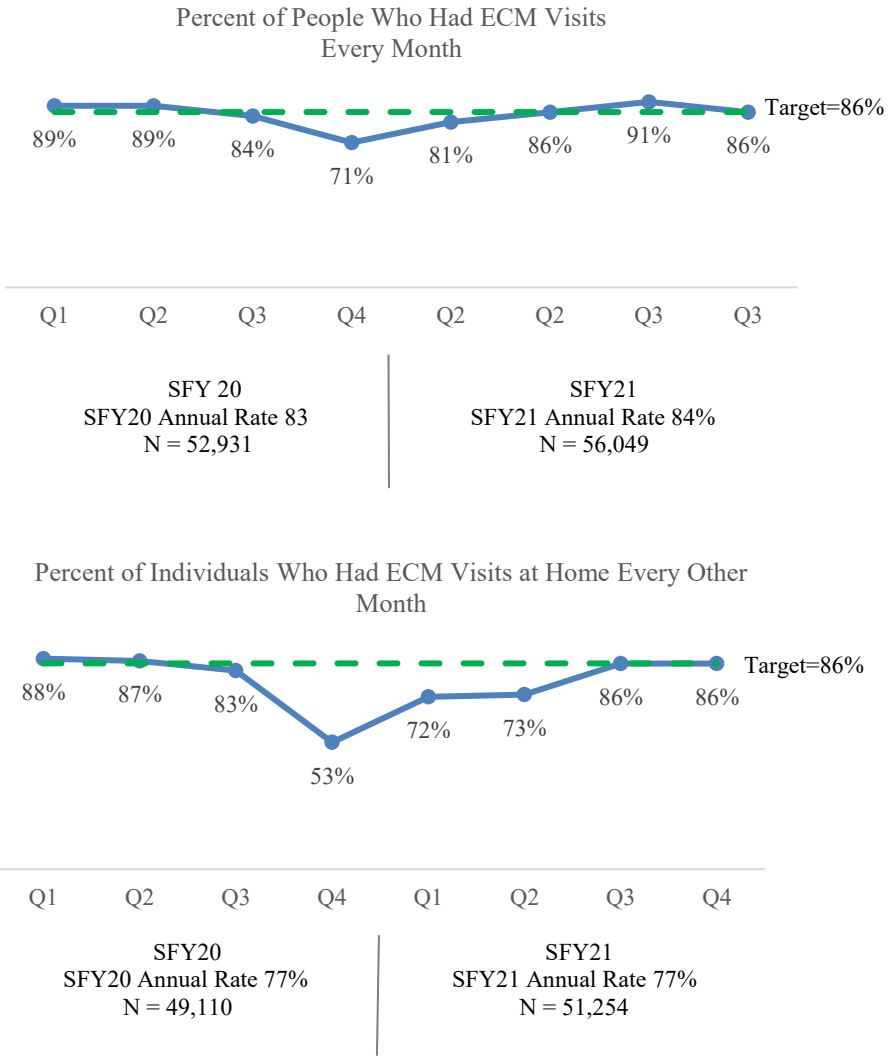
Three hundred CLBs reviews were conducted in SFY21. The results are presented in the first cell of the table above. Regarding whether comprehensive and non-partial investigations of individual incidents occurred within state prescribed timelines (i.e., 10 working days), the CLB identified consistent compliance above 86% (as high as 97% in some cases) for the entire review period. In instances where the investigation was late, reviewers assessed whether the provider should or could have requested an extension (and offered this education to the provider during the CLB debrief). Reviewers also reviewed the case to ensure the assigned advocate provided education and technical assistance and then recommended a citation to the OL pursuant to 12VAC35-115-230(A)(3), for failure to report the results of the completed investigation within 10 working days, at the time of the investigation.

The PMI on "people with DD waiver being supported by trained, competent Direct Support Professionals (DSPs)" is comprised of two measures, tracked and reported by the QRT, that are

utilized to determine progress with the PMI. The first measure examines the number of agencies who have been reviewed by the DMAS and demonstrated compliance with Medicaid Waiver DSP and Supervisor orientation training and testing requirements. The second measure considers if agencies were found compliant with Medicaid Waiver requirements for completing an observed competencies process for DSPs and DSP supervisors, as required by DMAS. To achieve this measure, both QRT measures must be achieved with 95% success. Overall, results for SFY21 demonstrated success with training and testing at 78%, which is lower than that of SFY20, which was 87%. Success with competencies declined from 66% in SFY20 to 60% in SFY21. Two QIIs were implemented over the past year to affect positive change with this measure. OPD, through the PCC KPA Workgroup, established a targeted remediation process for providers identified as not meeting DMAS requirements. The Region III RQC is conducting a survey to identify and address barriers to meeting competency requirements. This measure will continue to be monitored in the coming year.

Case Management Contacts

The two PMIs monitored for case management contacts include one related to the occurrence of monthly visits, with no more than 40 days in between visits. The second is related to alternating visits in the home. An emphasis on correctly coding these visits, combined with improvements in the status of the pandemic resulted increased progress toward goal attainment over the past year, though some decline is seen in the 4th quarter as information about increases in viral variants emerged. DBHDS is working with a joint CSB Data Management Committee to survey CSBs regarding internal practices related to data analysis, collection, and verification. The planned result of these efforts will be to establish a method through which DBHDS and CSBs can review a sample of data submitted to the Department through the CCS3 system to determine the reliability and validity of that data. This project also provides the opportunity to collect and share best practices across CSBs over time. The following graphs depict the changes in performance for both PMIs.



Quality Service Reviews

DBHDS contracted with HSAG, a quality improvement organization (QIO), to conduct QSRs. QSRs involve desk reviews, on-site visits, face-to-face interviews, in-person service observations, retrospective record reviews, and/or surveys of individuals receiving services. QSRs are completed to gain information about the quality of services provided and/or to obtain individual and family input on services provided for the purpose of making improvements in the service experience, and to determine how to improve the array of services provided. QSRs utilized information collected from Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs") evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and preferences.

During SFY21, HSAG completed two rounds of QSRs. Round 1 QSRs were conducted virtually due to the global pandemic. Round 2 QSRs were conducted in-person and on-site. Through aggregated reporting, HSAG reported findings on an individual, provider, service, and system level.

In SFY21, DBHDS and HSAG realized that there were some improvements to be made relative to the tools used, processes and training. Improvements involved revisions to PCR and PQR tools, the timeliness of the submission of individual provider reports, HSAG methodology, and HSAG and HSAG reviewer training. It was determined that PCR and PQR questions required revisions to more accurately evaluate service provision and provider expectations. For example, to obtain accurate and relevant results, four PCR and PQR questions pertaining to transportation and dental exams were reworded to directly assess transportation availability and dental exam access and completion. The tool guidance of the requirement for back-up plans to be included in service planning will now be required solely for the applicable service provider types as not all services require a back-up plan. Revisions to the PCR and PQR assessment tools and guidance documents for QSR Round 3 have been updated to reflect this specificity. Although HSAG utilized clinical staff to complete reviews, it was noted that their clinical referral processes, as detailed in the Methodology and Clinical Decision Tree, were not consistently exercised as described. This too, is planned to be updated by HSAG in Round 3.

While DBHDS is required to conduct QSRs for 100% of providers every two-three years, during Rounds 1 and 2, HSAG identified providers who did not participate in the QSR process. Despite DBHDS identified acceptable reasons for not participating, reasons for provider failure to participate included:

- Unable to contact/lack of response
- COVID related (temporary suspension or permanent closure), R2-20
- Incomplete Review

After the conclusion of Round 2, HSAG reported that in Round 1, forty-three of 569 providers and, in Round 2, 80 of 600 providers did not participate in QSRs. HSAG, in collaboration with DBHDS and DMAS, worked to increase provider participation and compliance with this CMS requirement, by notifying providers of this requirement. Subsequently, on October 5, 2021, a memo titled “Department of Medical Assistance Services Regulation Violation Warning: Provider Requirements” was issued to providers that did not participate in one or both rounds of the QSR process. The table below provides further details regarding results of follow-up with non-participating providers.

Non-Participating Providers Follow-Up Results					
Round 1 (43 non-participating providers)			**Round 2** (80 non-participating providers)		
Reason	**Number**	**Percent**	**Reason**	**Number**	**Percent**
Closed	5	12%	Closed	5	6%
Re-engaged	20	47%	Re-engaged	55	69%
Bad Contact Info	4	9%	Bad Contact Info	2	3%

Never Responded	10	24%	Never Responded	14	18%
Follow-Up Initiated	4	9%	Follow-Up Initiated	4	5%

In Round 1, QSRs were conducted from July 27, 2020 through December 31, 2020 (the look-behind review period covered October 1, 2019 – March 31, 2020). Two thousand five hundred and thirty-two individuals participated along with 569 providers and CSBs. In Round 2, QSRs were conducted from February 16, 2021 through June 30, 2021 (the look behind review period covered May 1, 2020 – October 31, 2020). Two thousand seven hundred sixty-eight individuals participated along with 600 providers and CSBs.

As part of the QSR process, when a provider is determined to be below the HSAG established benchmark of 90%, HSAG requires that the provider submit to HSAG a QI Plan (QIP). HSAG will assess these QIPs implementation as part of the QSR Round 3 reviews. The table below highlights the number of providers for SFY21 in each round that required a QIP.

QSR Round	Total Providers	Required a QIP	Did Not Require a QIP	QIP In Both Rounds
1	569	243	326	N/A
2	600	362	238	243*

*All providers that received a QIP in Round 1 also were issued a QIP in Round 2.

After the conclusion of Round 2, HSAG reported that in Round 1, twenty-four of 243 providers and, in Round 2, 80 of 362 providers did not complete a required QIP.

Round 2 results showed:

- ✓ Greater than 90% compliance for three of four ISP Assessment elements
- ✓ A 90% or greater compliance for six of 11 ISP Development and Implementation elements
- ✓ Greater than 90% compliance for two of four ISP Interaction elements
- ✓ Less than 90% compliance for all three QIP elements
- ✓ A 90% or greater compliance for two of three Risk/Harm elements. CSB-specific results demonstrated 90 percent or greater compliance for all three Risk/Harm elements
- ✓ Greater than 90% compliance for two of two Incidents/Disputes elements.
- ✓ A 90% or greater compliance for one of three Competency and Capacity elements

DBHDS will continue to annually review PCR and PQR tools to ensure continued accuracy; providing additional guidance and proposed tool revisions as the need arises. At the conclusion of Round 1, DBHDS and HSAG worked to revise the provider reports to help expedite the completion and distribution of those reports. In preparation for Round 3, HSAG methodology and associated decision tree will be updated to be reflective of HSAG's actual processes. In preparation for Round 2, HSAG reviewers were provided training around the fatal eight and

other training that served as guidance for reviewer decision making. Beginning in Round 3, as part of HSAG's communication plan, providers will be notified of expectations for participation.

IV. Quality Management Program Evaluation

Using a QM Program Assessment Tool, endorsed by the Institute of Healthcare Improvement (IHI), the DBHDS quality committee chairs conducted a program evaluation of each committee and for the QM Program as a whole. The tool assisted DBHDS in assessing key components of its QM programs and included an assessment of the QMP and the program's supporting infrastructure, implementation of processes (to measure and ensure quality of care and services), and capacity to build QI among providers.Based on the assessment tool, QM programs should have the following characteristics:

- Be a systematic process with identified leadership, accountability, and dedicated resources available to the program;
- Use data and measurable outcomes to determine progress toward relevant, evidenced-based benchmarks;
- Focus on linkages, efficiencies, and provider and individual expectations in addressing outcome improvement;
- Be a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement activities;
- Ensure that data collection is fed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes.

Progress Since the SFY20 Program Evaluation

In SFY20, DBHDS identified several areas of enhancement. Ideally, each identified area of enhancement would be addressed in the subsequent state fiscal year. However, there are a few areas where identified improvements remain underway or are planned to occur in SFY22. While DBHDS has worked to further define data sources, used for the DBHDS PMIs, there is a need for governance around how the data is to be gathered, organized, and stored. This will become the work of the DW, as DBHDS moves to streamline mechanisms for data collection and reporting. In SFY22, measure validation began to include all PMIs (as opposed to those specifically categorized as KPA PMIs), to ensure consistency in measure development. Work towards improving data validity and reliability, specific to data source systems and the work of the DW continues.

In the areas of training and technical assistance, DBHDS has provided training (regarding QIC and QIC subcommittee expectations as well as QI practices and principles) to quality committees. However, DBHDS still needs to begin the work of sharing the impact of the QMS at a DBHDS department level and establishing processes and protocols to ensure the sustainability

of consistent practices designed to ensure awareness of the QMS and how it impacts the success of individuals serve. In SFY 21, trainings were developed but have not yet been shared with DBHDS personnel. In the SFY21 assessment provided below, you will see that some of these same concerns are reflected.

SFY21 DBHDS Internal Quality Management Program Evaluation

The DBHDS internal evaluation of the QM Program identified several strengths in DBHDS' QM Program and several opportunities for enhancement. Please find them detailed below, along with DBHDS recommendations, activities, and plans to address identified concerns.

Identified Strengths

Quality Management Program

The DBHDS QM Program continued to be supported by senior leadership with direct accountability to the CCO and DBHDS Commissioner. To further support the QM Program, OCQM added additional personnel resources to the team that included a full-time QSR Coordinator, a QI Coordinator, and four new QIS'. In general, the goal of these personnel was to expand QI concepts, principles and tools throughout the department, QIC subcommittees and the provider network. More specifically, these additions were important to support the following:

- Development, implementation and monitoring of key performance measures and indicators
- Data and root cause analysis, recommendations for development and implementation of QI or requirements for the development of CAPs and QIIs
- Data and data source verification of measure validity and reliability

QIC and QIC Subcommittee Structure

The QM committee framework and implemented processes continue to be a definitive strength of the QMS. This framework oversees planning, assessment and communication and includes the QIC (the highest-level quality committee), the QIC subcommittees (three subcommittees, three KPA Workgroups, and five RQCs), quality collaboratives with DBHDS-DMAS QRT and the Virginia Association of Community Services Boards. The QM committee framework is depicted in Part I of the QMP.

To ensure the highest level of leadership support and to solicit input and make recommendations for quality improvement activities, the committee structure includes broad representation of both internal and external stakeholders. Clinical and program representatives from internal offices

(e.g., OL, OHR, OCQI, OPD, and the OIH) serve as dynamic members of the QIC subcommittees demonstrating a department-wide commitment to CQI and the importance of inclusion of input from DBHDS personnel at various position levels within the DBHDS organizational structure. External partner representatives also serve as active participants on the QIC and several QIC subcommittees.

Overall Performance of the QM Program

The QM Program has a statewide QMP in place with clear definitions of leadership, roles, resources and accountability. Performance and outcome measures are selected, and methods outlined to collect and analyze statewide performance data have been established. Work plans with specific timelines and accountabilities for the implementation of developed statewide QIIs have been established. The QM Program has an organizational structure in place to oversee planning, assessment and communication about quality. The QIC and its related subcommittees have appropriate membership and have been established to solicit quality priorities and recommendations for quality activities. The QM Program involve providers, consumers and representatives. Processes have been established to evaluate, assess and follow up on quality findings and data being used to identify gaps. The QM Program collects appropriate performance data to assess the quality of care and services statewide. It offers QI training and technical assistance on QI to providers.

QIC Subcommittee Performance

As noted previously, subcommittee chairs utilized the QM Program Assessment tool to evaluate performance of their respective QM teams. All quality committees participated in the assessment of the QM Program, including the QIC. This assessment allowed for an aggregate review of overall performance across the QM Program. Based on the results of this assessment, SFY21 was a year marked with successes and opportunities for enhancement in SFY22. A brief summary of the work is included.

General Successes

- All subcommittees fulfilled their charter requirements, including meeting specific quorum requirements and following all procedures as outlined in their respective charters.
- Each subcommittee continued to identify additional data sources, expanding the scope of their reviews beyond the identified PMIs. Selection of the PMIs was based on past performance and involved the acquisition of cross-departmental input. Measures included clinical and support service indicators (selected across the various domains and KPAs). In total, DBHDS selected 37 PMIs.
- SFY 21 marked a concerted effort by subcommittees to present more granular data. When possible, more data reports broke measures down by age, gender, residential setting,

region etc. This led to more informed and focused discussions in meetings and, in several cases, the development of QIIs.

- Two major QI process focuses, in SFY21, were the utilization of the QII Took Kit and QIC subcommittee Work Plans:
    - Each QIC subcommittee received training on the QII Tool Kit, which included QII workflow, Root Cause Analysis models, determining the need for a QII, QII selection, and the PDSA model of QI. The PDSA worksheet served as a guide to the implementation of QIIs, establishing and tracking timelines for completion of QIIs, and assisting the subcommittee in maintaining focus on the QII's AIM.
    - Each QIC subcommittee completed subcommittee-specific work plans, which provided a system for tracking PMIs and tracking the development, implementation and progress of QIIs, across the QM System. Work plans were updated routinely and assisted with subcommittees' year-end self-evaluations.
- Each QIC subcommittee developed and implemented, if not completed, at least one QII.

Risk Management Review Committee (RMRC) Activities and Challenges

In SFY21 the RMRC:

- Established an annual task calendar, to which all committee members had access, which identified standing items and reports (that were reviewed throughout the year).
- Utilized the work plan to review and track RMRC actions.
- Used the QII Toolkit to determine which QII to recommend to the QIC, from four options.
- Established a data workgroup that focused on more detailed analyses of measures, refining operational definitions, identifying potential threats to the validity of measures, and discussing potential measure revisions.
- Established workgroups to focus on specific areas (Falls QII, UTI and medication errors); this allowed greater focus on the work and assured follow-up activities occurred. RMRC reviewed data on serious incidents, including types of incidents; rates of specified conditions; and patterns of incidents (referred to as care concerns). During the first half of the year, RMRC identified COVID-19 as the most frequently occurring incident and significant risk to the health of individuals. IMU and OIH worked closely to identify COVID 19 outbreaks and provide technical assistance to providers on infection prevention and control.

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- RMRC monitored trends in COVID infections and deaths among individuals receiving behavioral health and developmental services. In response trends noticed by the RMRC, OIH and OL collaborated on the identification and provision of technical assistance to 190 DD providers. OIH also posted guidance for vaccinating individuals with DD, and assisted residential providers in getting individuals vaccinated
- In response to a noted relatively high rate of UTIs, RMRC conducted an analysis of reports of UTIs, resulting in recommendations for additional education and technical assistance for providers to reduce UTI risks. RMRC continues to monitor efforts by several offices within DBHDS to increase provider knowledge and awareness related to UTI prevention.
- RMRC review of abuse and neglect data identified the need to delineate further the types of neglect reported.

Data validity and reliability remained the biggest challenge for RMRC. Over the next year, efforts will continue to focus on refining the collection and presentation of data, with a focus on ensuring consistent, reliable data are trended over time. RMRC also utilize specific QI tools that have been developed to increase consistency in the review and follow-up of opportunities for improvement.

Mortality Review Committee (MRC) Activities and Challenges

In SFY21 the RMRC:

- Used their work plan to note activities completed, in relation to the actions taken by MRC, in response to determinations made during case reviews; only those actions related to broader QI activities are noted as the majority of MRC actions are in response to the individual cases.

- MRC's scope and purpose were reviewed, and determinations made as to whether the identified area was appropriate for MRC or another subcommittee to address.
- MRC noted significant improvement in the availability of medical records for review; this was due to an amendment to the Virginia Code giving MRC the ability to request information. This improvement enhanced MRC's discussions and determinations.
- MRC members assured that definitions used by the MRC, to guide them in their work, were used consistently by MRC, which supported their determinations of the cause of an individual's death, whether the death was expected, and if the death was potentially preventable) during case reviews.
- MRC members participated actively in the determination of which QIIs to recommend to the QIC. MRC looks to expand their electronic mortality review form to capture additional data noted during case reviews, which will provide more accessible surveillance data to use in their recommendations for QIIs.

The most noted challenge for MRC members related to the increased number of complex cases for review, which rose in part due to the increased number of deaths that occurred during the fiscal year. Members found that as they assured consistent application of definitions and determinations, additional time was needed, in order to ensure enough time to include data discussions and QII reviews. Meetings were lengthened to three hours or longer and, occasionally, additional meetings were convened to meet this need.

Case Management Steering Committee (CMSC) Activities and Challenges
In SFY21 the CMSC:

- Developed more structured methods for monitoring, reviewing, and responding to issues identified in data from a variety of sources.
- Standardized its agenda, leveraged electronic resources for meetings, and established a schedule through which work was accomplished.
- Utilized their work plan and the QII Toolkit to note additional CMSC activities undertaken.

- Began developing a "four pillars" of performance framework to monitor key CM performance areas. This work will be further developed, trialed and implemented in the coming year.
- Developed a CAP process that enabled the committee to take meaningful action where case management underperformance was identified. Data was routinely shared across the 40 CSBs and, increasingly, in formats helpful to them.
- Oversaw the shift in data source systems from CCS3 to the WaMS ISP. This change will be effective in SFY22; many of the CMSC measures will be derived from this data. Furthermore, raw data from the ISP will be provided on a monthly basis, going forward, for CSBs' internal monitoring.
- Defined definitions of 'change in status' and "ISP appropriately implemented' (key Department of Justice Settlement Agreement indicators), communicated, and incorporated them into a standardized tool and process for statewide use.
- Identified the need for the development of a targeted technical assistance process, for CSBs, to ensure CSB participation in remediation and support activities. This identified need resulted in the drafting and submission of DBHDS performance contract language, providing DBHDS the authority to require said participation, recommended to be applied to the SFY22 Performance Contact.
- Considerable efforts were made by CSBs and DBHDS to ensure that 100% of the SCQR sample was completed in SFY21. CSBs were informed of the changes to the SCQR process and tool, via email and during regional roundtable meetings. OCQM staff provided reminders of the SCQR process and timeline during CM data reviews and issued reminders during VACSB QLC February meeting and sent an email reminder to CSB DD Directors in March, and OPD provided specific outreach to those CSBs who hadn't started the process by mid-March (with follow-up provided by CRCs to those who had not responded to OPD's email. This resulted in 100% of the SCQR sample being completed.
- Reviewed the "Adequacy of Supports" report, as provided by the Office of Licensing, during SFY21. While CMSC did not take action on the report, it acknowledged concerns with Crisis Services. In SFY22, CMSC will consider appropriate actions that could be taken.

- CMSC is working to expand the population for two current PMIs. Began work with the DW is underway to expand the population (for two current PMIs) to include people with DD case management services, as the ECM and TCM measures currently consider only people with DD waiver.
- CMSC is also working closely with the VACSB Data Management Committee to establish best practices for data verification and to implement a data quality support process around CM contact data, provided through CCS3.
- The development of a "four pillars" framework will continue as the committee established a standardized way to review data, determine technical assistance needs, and engage CSBs in their efforts to improve the quality of CM services organizationally and statewide.

CMSC has a maturing system of performance and outcome system management. The challenge faced by the committee is the large volume of measures and related information and concurrent CAP, QII, and program development processes being undertaken. The activities and support to the committee over the past year have helped refine the work to a more manageable level.

Key Performance Area (KPA) Workgroup Activities and Challenges

In SFY21 the KPA Workgroups:

- Developed the "All Reports Timeline", to address struggles with data availability at the time of regularly scheduled data reviews. When completed, this document will assure data presentations align to data availability.
- Grouped data points together, across PMI and surveillance data, to see their interrelated impacts. There was significant improvement in synthesizing the data and in the robustness of conversations around the data; however, work is still needed to assure that members come prepared to present and discuss data at the appointed time.
- Modified the standing agenda and developed specific questions, used during regular meetings, designed to encourage more robust conversations.
- Utilized the work plan to note actions taken by the KPA Workgroups during meetings.

Challenges the KPA Workgroup faced included seeing the interrelated impacts of PMIs and surveillance data, as data reviews did not always occur together, and member understanding of

surveillance data and its relationship to the PMI, domain and KPA varied. The KPA Workgroups will further align PMI and surveillance data and further the understanding of the interrelatedness of PMI and surveillance data, the domain, and the KPA. This should lead to more informed discussions and decision-making. The KPA Workgroups look to engage in a more collaborative QII process in the coming year as well as to better document the various quality improvement activities that are not considered formal QIIs. In SFY22, using data to drive more decisions will be an area of focus

Regional Quality Council (RQC) Activities and Challenges

Unlike other subcommittees, RQC do not have specific PMI or surveillance data. Rather, RQCs received quarterly data presentations on the same from SMEs. In SFY21 the RQCs:

- Reviewed numerous data reports related to incident reporting, employment, CM, RST, human rights allegations, QSRs, and data related to the DD waivers reported through the QMR process. Data from these presentations were reviewed and analyzed.
- Received more regional data, which allowed the RQCs to identify patterns and trends specific to their region. Chief among these patterns was the negative impact of COVID 19 on individuals, providers and services.
- Developed QIIs for each council.
- Provided quarterly reports to the QIC.
- Utilized the work plan to track data presented, recommendations made (including requests for information) and the QIC subcommittee's response to recommendations. This led to the development of the-Process for Receiving and Responding to RQC Requests to QIC Subcommittees, which has improved the QIC subcommittee response time to the request.
- Revised the RQC orientation to include more targeted QI training.
- Worked around ongoing membership challenges as well as completing all actions during the quarterly meeting (the majority of members are volunteers with other responsibilities).
- Established a QII workgroup and collaborated, as needed, with other QIC subcommittees, and DBHDS offices. The RQCs look to evaluate the use of Microsoft Teams to more quickly disseminate materials for review prior to RQC meetings; solicit input from

members around the QM Plan, to dedicate time each meeting to fully discuss and communicate the RQC QII status and continue to provide training on data collection and interpretation.

One challenge noted by the RQCs dealt with was the large amount of information presented (it can be dense and hard to digest) and otherwise made available during meetings; meetings were extended to accommodate time for review and discussion. RQCs also continued to struggle with meeting membership requirements as membership is voluntary. RQCs noted a third challenge; increasing member involvement in the QII process, including increasing communication regarding QIIs to all members.

Quality Improvement Committee (QIC) Activities and Challenges

In SFY21 the QIC:

- Reviewed data presented by the subcommittees as well as QSR, NCI, QRT data.
- Reviewed and approved QIIs.
- Reviewed updates to implemented QIIs.
- Approved, other CMSC recommended systemic improvements, for inclusion in performance contracts.
- Directed the work of the QIC subcommittees.
- Implemented an orientation for new members that provides crucial details regarding committee function and expectations.
- Expanded the QIC meeting length to three hours to accommodate the QIC Subcommittee and other reports presented during meetings and to allow more time for meaningful data discussions.
- Continued to refine QIC Subcommittee report formats for reporting to the QIC. Determined that the current QIC reporting structure was not sustainable, for members (volume of information presented and length of meeting) and will establish a new reporting structure in the coming year.

The human capital for QII implementation was recognized as a challenge as a limited number of staff are responsible for many of the activities and, as a result, are stretched to provide adequate

resources. The QIC also noted that data validity and reliability continue to be a challenge for the agency; improvements have been noted and efforts to address them continue. Members recognized that not all agency staff may be aware of the quality management structure and therefore not understand their role in quality, which would have an impact on all outcomes for the agency.

Identified Opportunities for Enhancement

The QM Program, through use of the QM Program Assessment tool and subcommittee input, identified the following opportunities for enhancement.

- Increase communication and explanation of the QM Plan and importance of quality throughout DBHDS.
- Identify a means of tracking informal quality work that occurs throughout different offices but that is not captured as part of the QM Plan.
- Improve and establish, where needed, data provenance (how data is obtained) and data governance (processes for how the data is cleaned for analysis and interpretation, frequency of receiving data reports, etc.).
- Increase internal stakeholder understanding of how work plans are related to and used in the overall QM Program.
- Promote the use of the QII Tool Kit and other QI tools, such as root cause analysis, throughout DBHDS to better understand problems and resolve them throughout the agency.
- Find additional means of sharing information, relative to the QM Plan, with DBHDS staff and garnering input from providers, individuals and family members
- Enhance the ability to utilize data to identify service gaps, developing and QIIs to address same.
- DBHDS establish a public data dashboard, granting access to service providers so as to assist in their efforts to track performance.
- QIC Subcommittees should increase their use of the QII Tool Kit, to improve their efforts to analyze data and pinpoint root causes; leading to greater data-driven decision-making and the continued development of QIIs and other mitigating strategies needed to address identified needs.
- The QM Program needs to work more closely with providers to help them evaluate their own programs and services and to utilize QA data to inform their QI efforts.
- DQV will conduct another assessment, as requested by the request of the DOJ SA Steering Committee (in order for DBHDS to address and act upon the recommendations outlined in the SFY2020 DQMP). This assessment will result in the development of actionable recommendations in SFY 2022. This will include the execution of an entirely new methodology by which DQV will shadow personnel that enter the data, obtain access

to the appropriate system environment to test the data, and conduct interviews with numerous personnel to obtain the most holistic perspective of each system. Through this in-depth process, DQV will identify major threats to data validity and reliability within each data source system and develop a list of up to twelve actionable recommendations that must be successfully addressed by IT or the BO in order for the Chief Clinical Officer to attest to the validity and reliability of the data source system. Concurrently, IT must collaborate with the respective business areas to address findings from the initial DQMP data source system and DW assessments.

- DQV will continue to support programs throughout the agency to identify and evaluate new and existing data sources used by the agency for policy or decision-making. As new or existing data sources are identified across the agency, DQV will integrate these systems into the queue to be evaluated in accordance with the procedures dictated by the process set forth in Phase 1 of the DQMP.

V. Conclusion

Despite the continuation of the global pandemic, the Commonwealth continued to make strides in achievement. Although COVID 19 adversely impacted the Commonwealth's ability to conduct in-person onsite regulatory reviews and case management activities, the ability of individuals to meet expectations around community involvement and inclusion and, to some degree, service provider ability to remain open (for the better part of if not all of the fiscal year) the Commonwealth adapted; working across departments of state to shift to virtual visits, to ensure the continuation of service provision and connectivity with the individuals served, and moving from a reactive to proactive approaches. Although the effects of the pandemic persist, the Commonwealth expects to see the gains, experienced before its onset, return (following the nation's rebound from COVID 19). Therefore, the Commonwealth will continue to track performance, relative to all KPAs, looking to demonstrate increased and sustained improvement as was accomplished in SFY 21.

In SFY 21 the Commonwealth sustained improvement efforts in the Health, Safety and, Wellbeing KPA, for 58% of PMIs (for which SFY21 data was available); 8% of PMIs performed within 10% of the measure's target. Sustained improvement indicates that the Commonwealth's processes and policies (around incident reporting; assurances of the prohibition of restrictive interventions; and expectations around the implementation of corrective action plans for substantiated cases of abuse, neglect and exploitation), are being followed in support of overall efforts to ensure that individuals served are safe and free from harm. However, the Commonwealth should focus improvement efforts on addressing the needs around documenting annual physical exams, case manager assessment of the status or needs for services and supports and any associated ISP

modifications, as well as documentation of ISP assessment and determinations around appropriate implementation.

In the Community Inclusion and Integration KPA, the Commonwealth sustained improvement efforts for 38% of PMIs (for which SFY21 data was available); 58% of PMIs performed within 10% of the measure's target. Sustained improvement in these areas indicates that the individuals served have and are taking the opportunity to live independently, are stabile the independent housing setting, and have input regarding choice in where they live. However, the Commonwealth should focus improvement efforts on ensuring that discussions, about individuals' interests in employment and what they are working on while at home and in school toward obtaining employment upon graduation and how waiver services can further support their readiness for work, are occurring and documented in the ISP.

In the Provider Capacity and Competency KPA, the Commonwealth sustained improvement efforts for 33% of PMIs (for which SFY21 data was available); 25% of PMIs performed within 10% of the measure's target. Sustained improvement in these areas indicates that the Commonwealth identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death and assesses transportation services to ensure that it is provided, to facilitate individuals' participation in community activities and Medicaid services per their ISPs.; ensures that RST referrals are timely, for individuals considering a move into group homes of 5 or more beds and that there is an increase in services available by locality over time. However, the Commonwealth should focus improvement efforts on increasing the number of individuals receiving services in the most integrated settings, ensuring the competency of personnel providing DD services, ensuring employment, community engagement and community coaching goals are developed for individuals receiving DD Waiver services, and RST non-emergency referrals are made in a timely manner.

The Commonwealth has made advancements in the area of data quality and validity; beginning to address, in its "Year of Data" focus, SFY19 Data Quality Monitoring Plan recommendations, so as to increase its potential to ensure and attest to the validity and reliability of data source systems. DBHDS business owners and SMEs have taken steps to address data quality issues and future efforts would benefit from a formal process in which IT documents plans to address the issues identified in the DQMP assessments. Further, several business owners are taking steps to procure new source systems to replace several outdated systems or making improvements to the user interface and data validation rules for some of the existing systems. Though BO improvements and plans for improvements are steps in the right direction, additional efforts are needed to sufficiently address data quality as outlined in the original DQMP report.

Glossary of Acronyms

Acronym	Full Form
BHA	Behavioral Health Authority
BO	Business Owner
CoD	Cause of Death
CC	Community Coaching
CCO	Chief Clinical Officer
CCS3	Community Consumer Submission
CDDER	Center for Developmental Disabilities Evaluation and Research
CE	Community Engagement
CHRIS	Comprehensive Human Rights Information System
CLBs	Community Look-Behinds
CM	Case Manager
CMS	Centers for Medicare and Medicaid Services
CM/SC	Case Manager/Support Coordinator
CMSC	Case Management Steering Committee
COVLC	Commonwealth of Virginia Learning Center
CRC	Community Resource Consultant
CSBs	Community Services Boards
CTH	Crisis Therapeutic Home
DARS	Department of Aging and Rehabilitative Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
DHP	Department of Health Professions
DI	Departmental Instruction
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice
DQMP	Data Quality Monitoring Plan
DQV	Office of Data Quality and Visualization
DSP	Direct Support Professional
DW	Data Warehouse
ECM	Enhanced Case Management
GSE	Group Supported Employment
HCBS	Home and Community Based Services
HSRI	Human Services Research Institute
IHI	Institute of Healthcare Improvement
IMU	Incident Management Unit
ISE	Individual Supported Employment
ISP	Individual Support Plan
KPA	Key Performance Area
KPAW	KPA Workgroup (s)
LHRC	Local Human Rights Committee
MCO	Managed Care Organization

MRC	Mortality Review Committee
MRO	Mortality Review Office
NASDDDS	National Association of State Directors of Developmental Disability Services
NCI	National Core Indicators
OBRA	Omnibus Budget Reconciliation Act
OCH	Office of Community Housing
OCSS	Office of Community Support Services
OCQI	Office of Community Quality Improvement
OCQM	Office of Clinical Quality Management
OHR	Office of Human Rights
OIH	Office of Integrated Health
OISS	Office of Integrated Support Services
OL	Office of Licensing
OSVT	On-Site Visit Tool
OPD	Office of Provider Development
PCR	Person Centered Review
PM	Performance Measure (CMS DD performance measure)
PMI	Performance Measure Indicator
PP	Potentially Preventable
PQR	Provider Quality Review
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Plan
QMP	Quality Management Plan
QMR	Quality Management Review
QMS	Quality Management System
QRT	Quality Review Team
QSR	Quality Service Review
REACH	Regional Education Assessment Crisis Services Habilitation
RM	Risk Management
RMRC	Risk Management Review Committee
RQC	Regional Quality Council
RST	Regional Support Team
SC	Support Coordinator
SCQR	Support Coordinator Quality Review
SA	Settlement Agreement
SFY	State Fiscal Year
SHRC	State Human Rights Committee
SIU	Specialized Investigations Unit
SME	Subject Matter Expert
TCM	Targeted Case Management
VACSB	Virginia Association of Community Services Board

VCBR	Virginia Center for Behavioral Rehabilitation
WaMS	Waiver Authorization Management System

Appendices

- Annual Mortality Report
- Case Management Steering Committee Semi-Annual Reports
- Risk Management Review Report
- Institute for Healthcare Improvement Quality Management Assessment Tool Quality Management Assessment Too