Virginia Department of
Behavioral Health &
Developmental Services

Quality Management Plan
Annual Report and Evaluation
State Fiscal Year 2019

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Executive Summary

The Quality Management Annual Report and Evaluation outlines the comprehensive work conducted by and status of the Virginia Department of Behavioral Health and Developmental Services' (DBHDS) quality management program. The document summarizes the State Fiscal Year 2019 (SFY19) quality management activities, characteristics, and outcomes. Through this annual reporting process DBHDS will continue to improve program effectiveness and/or inform decisions about future program development.

The Quality Management Annual Report and Evaluation identifies strengths, challenges and opportunities for improvement. Utilizing a program evaluation tool, the organization assessed key components of the quality management program. The program evaluation included the assessment of the quality management plan and supporting infrastructure, implementation of processes to measure and ensure quality of care and services, and the capacity to build quality improvement among providers.

The DBHDS Quality Management System and quality committee framework aligned with the DBHDS vision, mission, and strategic plan, demonstrated leadership commitment, well defined structure and processes, and implemented nationally recognized quality improvement principles. This year in review highlights DBHDS' successful development and implementation of necessary structures and processes that continued the establishment of a quality management system which serves as the framework to implement quality improvements at the individual, provider and system levels. In SFY19, DBHDS expanded the Quality Management Plan to include a program description, developed and formalized charters and a work plan, and initiated a data quality plan. The Quality Management Program established overarching goal statements for each Key Performance Area (KPA) and developed performance measure indicators (PMIs) to assess the quality of developmental disability services. This Quality Management Annual Report and Evaluation demonstrates that the quality committees harnessed available data which, when evaluated together, provide a more global perspective about performance at a system level. Although targeted performance for some PMIs was not achieved, efforts to address identified gaps have been and are being implemented. Through leadership support, the organizational culture of quality is strengthened by putting in place critical support mechanisms focused on improving the quality of services provided across the continuum of care.

Key Accomplishments

1. DBHDS adopted a Building a Culture of Quality for DBHDS that is characterized by quality improvement standards/principles and included the existing model for Continuous Quality Improvement (AIM Statement and Plan, Do, Study, Act). The Building a Culture of Quality for DBHDS was presented to senior leadership, agency directors, and quality improvement subcommittees.
2. After formalizing a quality management committee structure, the quality improvement subcommittees initiated development of standardized committee charters which included statement of purpose, scope of authority, membership, and meeting/quorum requirements.
3. A framework for PMIs was developed to include baseline or benchmark data; targets, including a date by which targets are to be met; and definition of terms, data sources, and the methodology for collecting data.

4. The DBHDS Quality Management System (QMS) identified and monitored system performance in three primary areas, each of which include one or more quality of life and/or provider service domains. These primary areas, identified as KPAs, were monitored by subcommittees (under the direction of the Quality Improvement Committee). These KPA Workgroups developed goals for each of the three KPAs (health, safety, and well-being; community inclusion and integration; and provider competency and capacity) and identified PMIs for each of the eight domains on which the QMS is focused (safety and freedom from harm; physical, mental, and behavioral health and well-being; avoiding crises; stability; choice and self-determination; community inclusion; access to services; and provider capacity). These PMIs identified performance standards and set targets for achievement to drive the system toward improved outcomes.

Recommendations

As DBHDS builds upon this established foundation and addresses the identified challenges, the following have been identified for ongoing efforts: improvement of data collection and analysis; a revision and/or development of additional measures, to expand the quality oversight of the system of care (informed by active Regional Quality Councils); and continued training and guidance on risk management and quality improvement tools and processes.

I. Introduction

The Quality Management Plan for the Department of Behavioral Health and Developmental Services (DBHDS) is a three part document which includes this Annual Report and Evaluation for State Fiscal Year 2019 (SFY19). This document summarizes key accomplishments of the Quality Management 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 quality management program including quality committee performance, gaps identified, and challenges to meeting stated goals and quality improvement initiatives and activities implemented. Organizations outside of DBHDS support the work of the Quality Management System 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 support is to determine if the system is meeting the needs of individuals and families in a manner that aligns with Virginia's mission and vision and to provide an objective view of how the functionality of the service system is perceived by the community. In addition, DBHDS partners with the Virginia Department of Medical Assistance Services (DMAS); an external contractor, to conduct quality service reviews (QSRs); and with Human Service Research Institute and National Association of State Directors of Developmental Disabilities Services for the collection, analysis, and reporting of National Core Indicators (NCI) data.

The Commonwealth of Virginia's Quality Management System also includes the Centers for Medicare and Medicaid Services (CMS) approved waiver quality improvement plan. DBHDS, as the state authority for the Commonwealth's public behavioral health and developmental services system, and DMAS, as the state Medicaid authority, work in partnership to provide quality oversight of Developmental Disabilities (DD) Home and Community Based Services (HCBS). This multi-faceted approach includes quality committee data analysis and reporting of DMAS quality management reviews designed to ensure that the waivers are being implemented as intended. The DBHDS-DMAS Quality Review Team (QRT) jointly provides oversight of the quality of services delivered and recommends mitigating strategies for performance measures that fall below the target. The QRT provides the DBHDS Quality Improvement Committee (QIC) an annual report on the status of performance measures and any recommended quality improvement initiatives.

A key component of the DBHDS Quality Management System includes QSRs conducted by an external contractor. QSRs evaluate, through individual, family and provider interviews and individual record reviews, the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice. Annual reports from the external contractor on the results of these QSRs provide insight into Quality Management System strengths and opportunities for improvement.

In order to include a broad spectrum of data on the availability and accessibility of services, DBHDS also utilizes NCI data. NCI is a voluntary effort, used by public developmental disability agencies, to measure and track their own performance. Virginia is one of 46 states and the District of Columbia who participated and contributed data for the In-Person Surveys in 2018. The core indicators are valid, reliable measures used across states to assess the outcomes of services provided to individuals and families for that specific year of the study and improve DD system performance.

II. Key Accomplishments of the Quality Management Program

The integrated processes of quality assurance, risk management and quality improvement are core components of the DBHDS quality management program. This section outlines the SFY19 overall key accomplishments of these components of the program.

Quality Assurance

1. Revised Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, which became effective September 1, 2018, strengthen health and

safety requirements and require licensed providers to develop quality improvement and risk management programs.

2. The Office of Human Rights (OHR) conducted Community Look-Behind reviews of a statistically valid, random sample of reported allegations of abuse, neglect and exploitation; to ensure that providers conduct their investigations in compliance with the OHR regulations. This ongoing retrospective review process identifies areas where training or follow-up technical assistance is needed, to improve service provider investigative processes and outcomes.
3. The Office of Developmental Services, the Office of Community Quality Improvement, and the Office of Data Quality and Visualization worked collaboratively to finalize a Support Coordination Quality Review process, developed to monitor the quality of support coordination for individuals receiving waiver services. This quality review includes a record review of case management functions by the Community Services Boards (CSBs) and a retrospective record review by DBHDS.

Risk Management

1. The Office of Licensing (OL) created the structure for an Incident Management Unit (IMU) to shift responsibility for monitoring incidents from individual licensing specialists to a centralized team responsible for follow-up with providers and the trending of patterns across the system.
2. The OL provided training/support to licensed providers on how to report and enter into the Computerized Human Rights Information System (CHRIS) both serious incidents and deaths.
3. The RMRC added a case review process to its standing meeting agenda for identification of potential system level issues and initiated training to promote provider literacy regarding an individual's assured rights and corresponding provider duties.
4. The Mortality Review Committee (MRC) implemented processes and protocols to ensure the completion of mortality reviews within 90 days, enhancing their ability to identify potentially preventable deaths and initiate follow-up with providers.

Quality Improvement

1. The Data Quality Monitoring Plan provided an inventory of data sources used by DBHDS. This plan describes the content of each data source, assessment approach and components, data source evaluation efforts, and proposed next steps for addressing data quality enhancement needs and determines monitoring priorities.
2. The Office of Community Quality Improvement (OCQI) completed on-site visits to all 40 CSBs, providing consultation and technical assistance on case management processes and data reporting, to ensure CSBs report valid data as part of a comprehensive quality management process to improve case management outcomes. The OCQI also issued a summary report, "CSB Quality Reviews", which identified issues and barriers and recommended quality improvement activities at the CSB and system level.
3. In collaboration with the OL, OCQI also developed root cause analysis training which was made available to licensed providers.
4. To build core competencies, DBHDS updated the cross disability Case Management/Support Coordination modules to reinforce the case manager/support coordinators' ability to develop the

knowledge and expertise needed to complete core case management functions and strengthen natural support systems for each person served.

5. DBHDS issued the Support Coordination Manual – DD, to assist support coordinators/case managers as they work with Virginians with developmental disabilities and co-occurring behavioral health disorders.

III. Data Reports including Performance Measure Indicators

The DBHDS Quality Management 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 developmental disabilities 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 quality improvement initiatives. The PMIs allow for monitoring and tracking of performance standards and the efficacy of improvement efforts.

As previously noted, DBHDS-DMAS QRT monitors DD waiver performance measures included in the 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 DD waiver performance measures and requires remediation and/or a quality improvement initiative when the threshold of compliance with a measure is below 86%. These measures are designed to 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 DBHDS specific DD waiver performance measures in its PMIs. The QRT provides an annual report on the status of these PMIs and recommendations to the DBHDS QIC. The SFY19 QRT report outlines the data sources and sampling methodology for all performance measures and identified remediation activities for those performance measures below 86%. Remediation activities identified included 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 http://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 quality improvement initiative. This section includes an analysis of data reports, surveillance data, 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. Below, please find the key that defines measurement standards for each table presented within this section.

Performance Assessment Key:

✓ Fully Met ✓ Partially Met ✓ Not Met

- 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

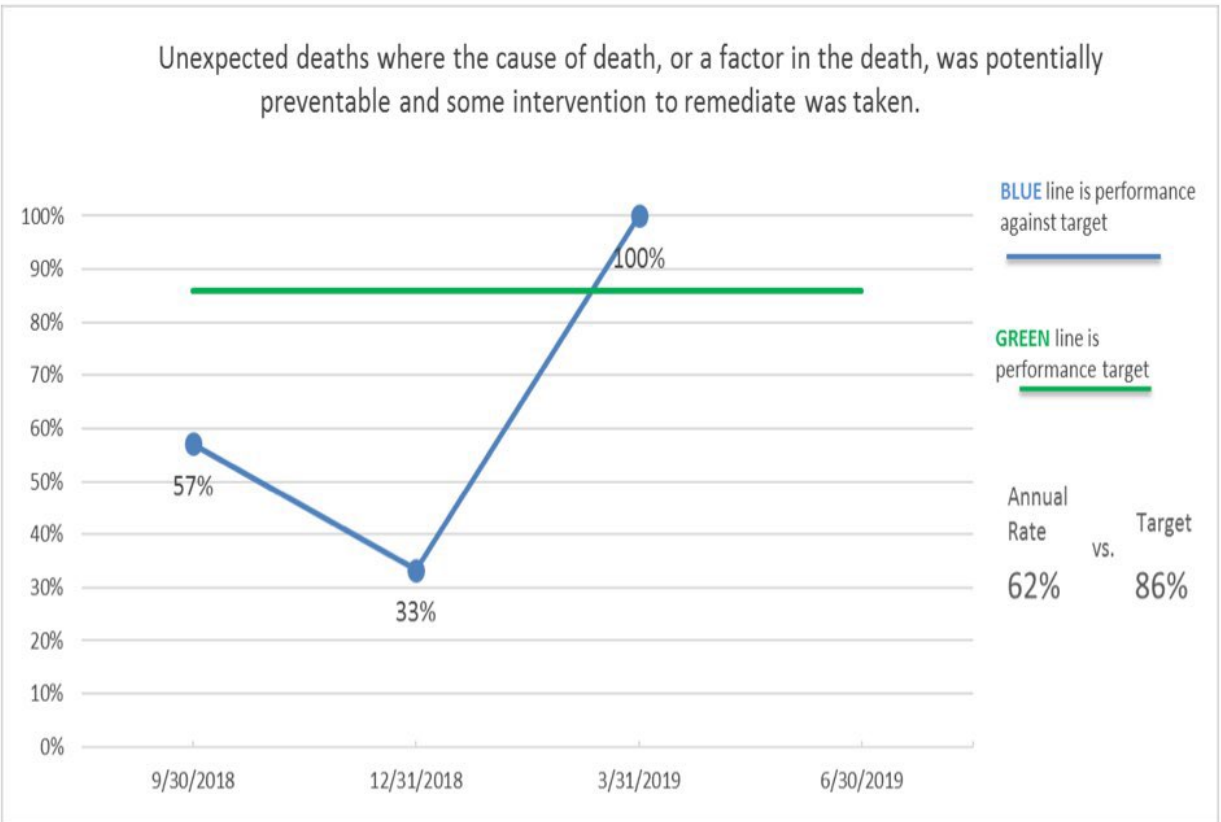
Key Performance Area: Health, Safety and Well-Being

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 and receive routine, preventative healthcare and behavioral health services and behavioral supports as needed. The data presented below is collected by the OHR, OL, and the Office of Community Support Services. Data is then analyzed and monitored by the KPA Workgroup, Risk Management Review Committee and the Mortality Review Committee. Please find below a brief synopsis of progress towards the achievement of PMIs relevant to this KPA.

Performance Measure Indicators – Safety and Freedom from Harm	Target	Result	Performance Assessment
Critical incidents are reported to the Office of Licensing within the required timeframes (24-48 hours)	86%	93%	✓
Licensed DD providers, that administer medications, are NOT cited for failure to review medication errors at least quarterly	86%	99%	✓
Corrective actions for substantiated cases of abuse, neglect and exploitation are verified by DBHDS as being implemented	86%	88%	✓
State policies and procedures, for the use or prohibition of restrictive interventions (including restraints), are followed	86%	100%	✓
The state policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed	86%	100%	✓
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%	✓

The DD Mortality Review Committee (responsible for monitoring the PMI related to unexpected deaths) conducts mortality reviews of deaths of individuals with an intellectual disability and/or developmental disability diagnosis who received services in a state operated facility or in the community through a DBHDS-licensed provider. Based on MRC determination of a potentially preventable deaths, the committee recommends remediation action. Most of the provider-level actions are related to the Corrective Action Plans issued by the OL, in addition to Safety Alerts created and distributed (via newsletter, emails, or posting to website) by the Office of Integrated Health (OIH). The MRC implemented a process improvement which included the development of a tracking protocol to capture and track remediation activities recommended. As a result, the 86% target (related to unexpected deaths, where the cause of death or a factor in the death that were potentially preventable, where some intervention to remediate was taken) was exceeded in the third quarter. These recommendations and actions are documented, tracked and

discussed at each MRC meeting until completion is achieved. When no deaths or factors in the death, within a quarter, are determined to be potentially preventable, resulting in no need for remediation actions to be developed or taken, no data is reported. While this overall annual target of 86% for SFY19 was not met, it is anticipated that process improvements will result in meeting or exceeding the target in SFY20.



The KPA workgroup monitors NCI data for the domain of physical, mental and behavioral health and well-being.

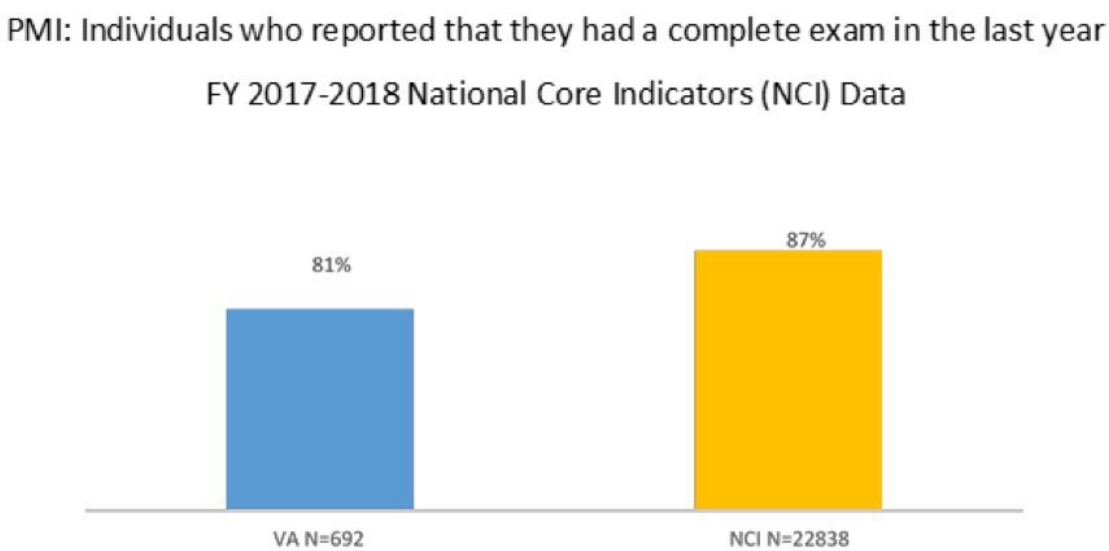
Performance Measure Indicators – Physical, Mental and Behavioral Health and Well-Being	Target NCI National Average	NCI Virginia Result	Performance Assessment
Individuals who reported that they have a primary care physician	97%	98%	✓

Individuals who reported that they had a complete physical exam in the past year	87%	81%	✓
Individuals who reported that they had a dental exam in the past year	81%	63%	✓

Source - FY 2018 NCI Data

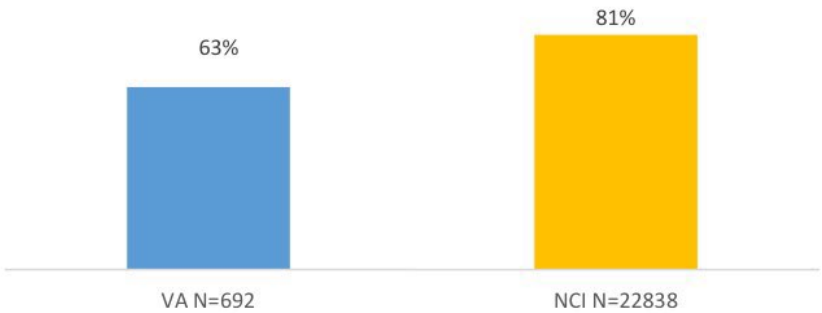
NCI indicators are categorized in five areas: Individual Outcomes, Health, Welfare and Rights, System Performance, Staff Stability and Family. The NCI randomly selects representative samples of adults who receive developmental disability services. Virginia's sample is stratified by region and includes 800 in-person surveys.

As indicated in the above chart, Virginia's performance related to completion of physical and dental exams was below the NCI reported national average for 2017-2018. Individuals reported and case managers validated that 81% of individuals received a physical exam in 2017-2018. In SFY19, DMAS-DBHDS QRT added a DD waiver performance measure to track the number of individuals (20 years and older) receiving DD waiver services who also received a doctor's visit (either a primary care visit or identified preventive care/wellness visit) at least once a year. Data collected in SFY19 demonstrated that 89% of individuals received a doctor's visit at least once per year.



PMI: Individuals who reported that they had a dental exam in the last year

FY 2017-2018 National Core Indicators (NCI) Data



Several mitigating strategies have been implemented in an attempt to increase the number of individuals who have a dental exam each year. DBHDS initiated protocols, which were approved by the Board of Health Professions, that allow dental hygienists to work under remote supervision of a dentist. This will increase flexibility in providing services to individuals who meet program criteria. DBHDS' Health Support Network provided dental services to 1,355 individuals through contracted basic and sedation dental services, and mobile services.

The Office of Community Support Services provides oversight of the following PMI.

Performance Measure Indicator – Avoiding Crisis	Target	Result	Performance Assessment
Individuals (on DD waivers and known to REACH) admitted to a Crisis Therapeutic Home (CTH) discharged to a community residence within 30 days of admission	86%	84%	✓

When individuals who have a developmental disability are experiencing a crisis event that puts them at risk for homelessness, incarceration, hospitalization, and/or danger to self or others, the Regional Education Assessment Crisis Services Habilitation program (REACH) is the statewide crisis system of care. REACH services are available statewide in each of the Commonwealth's five regions.

Brief residential crisis therapeutic services are available at a REACH Crisis Therapeutic Home (CTH) for stabilization of a crisis, a planned prevention, or as a step-down from a state hospital, training center, or jail. The CTH can provide in-depth assessments, a change in setting to allow for stabilization, and a highly structured and supportive environment to improve coping skills and work on other goals that aide in stabilizing the current crisis and/or aid in preventing future occurrences. As it is best practice and the least restrictive treatment approach to provide services in the setting in which the crisis occurred, the CTH is used only when community based crisis services or supports are not effective or are clinically inappropriate.

There has been an increase in the number of individuals admitted to CTHs who stay more than 30 days because they do not have an identified provider (that can meet their complex needs) to which they can transition within 30 days of their admission to the CTH. In an attempt to address this concern, DBHDS developed plans in SFY19 for the establishment of two adult transition homes which should allow people in SFY20 to be transitioned from the CTHs to community residences within 30 days of admission. These transition homes allow individuals to have a home while a provider who can meet their needs is located. DBHDS is within two percentage points of meeting this target.

In summary, several of the Health, Safety and Well Being targets were met during SFY19. However, continued data analysis and trending over time will be required for those PMIs. Where targets were not realized, DBHDS will focus on performance improvement efforts and continued monitoring of crisis and physical/dental exam data to determine whether initiatives implemented had the intended impact. In addition, development of new measures may become evident as DBHDS continues to surveil data from several sources, including but not limited to information such as serious incidents, through the monitoring of Human Rights complaints of abuse, neglect, and exploitation, as well as data provided by the IMU and through mortality review. The review will include specific monitoring of serious incident reports related to medical conditions common to individuals with developmental disabilities (e.g., aspiration pneumonia, bowel obstruction, decubitus ulcer). The OL issued Guidance for Serious Incident Reporting for licensed providers in November 2018 to assist providers in understanding reporting and monitoring requirements. As trends and patterns are identified, recommendations for quality improvement initiatives or enhanced training, education or guidance will be initiated.

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 that people with disabilities live in integrated settings, engage in all facets of community living, and are employed in integrated employment. The data presented below is collected by the Office of Community Support Services and Office of Community Housing and monitored by the KPA Workgroup. For the domain of choice and self-determination, the KPA Workgroup chose an NCI measure. Please find below a brief synopsis of progress towards the achievement of PMIs relevant to this KPA.

Performance Measure Indicator – Choice and Self-Determination	NCI National Average	NCI Virginia Result	Performance Assessment
Individuals who chose or had some input in choosing where they live if not living in the family home.	57%	67%	✓

Source - FY 2017-2018 National Core Indicators (NCI) Data

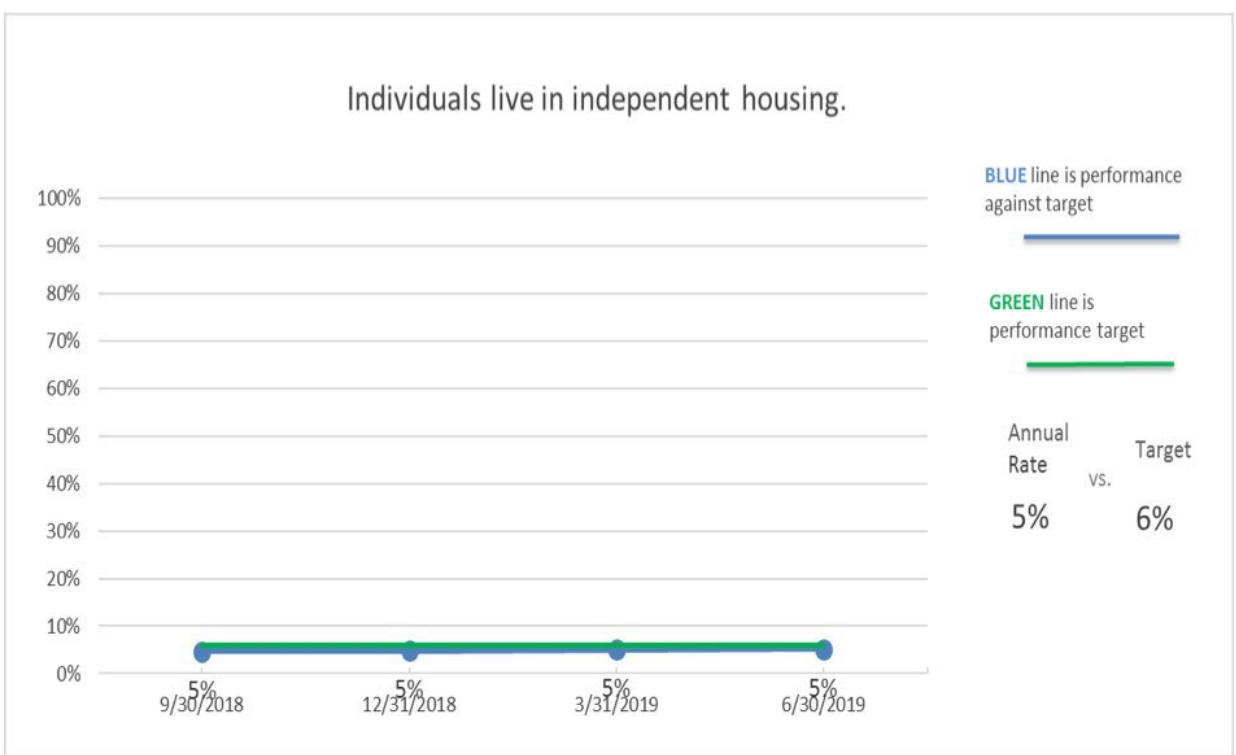
Developmental Services is responsible for oversight of this PMI

Performance Measure Indicators – Community Inclusion	Target	Result	Performance Assessment
Adults, who are active on the DD waiver or waitlist, who live or have lived in independent housing	6%	5%	✓
Individuals, on DD waiver, are employed and receiving Individual Supported Employment (ISE)	75%	48%	✓

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

As Virginia has transitioned individuals from institutions to the community, it has focused attention on how to facilitate true community integration for individuals with disabilities. Opportunities for living, working and engaging in social connectedness must be provided and choices offered in order for individuals to become active participants in their communities.

There has been a steady increase in the number of individuals who live or have lived in independent housing. Virginia is positioned to at least reach the national average of 10% by SFY21 for the percentage of adults with developmental disabilities who live independently. This was benchmarked, as of 2015, at 1,866 (approximately 10%) of adults with developmental disabilities on a Medicaid DD Waiver or Waiver waitlist. From there, annual targets for the number of adults with developmental disabilities who live independently were established for each SFY. DBHDS set an annual percentage target of 6% for SFY19 and 6.5% for SFY20 and 10% for SFY21. In SFY19, Virginia assisted 956 individuals to live in their own rental housing which is 5% of the individuals receiving waiver services or on the waiver waitlist. DBHDS secured funding to increase access to independent housing options for those on the DD waiver or waitlist and increased partnerships with other agencies (state and local) to expand rental assistance.



Although the program data for this measure in SFY19 remained flat, there was a demonstrated increase in the number of individuals in independent housing. However, due to a similar increase in the number of individuals on the waivers (denominator), this increase in the number of individuals in independent housing (numerator) was not substantial enough to achieve the SFY19 target of 6%.

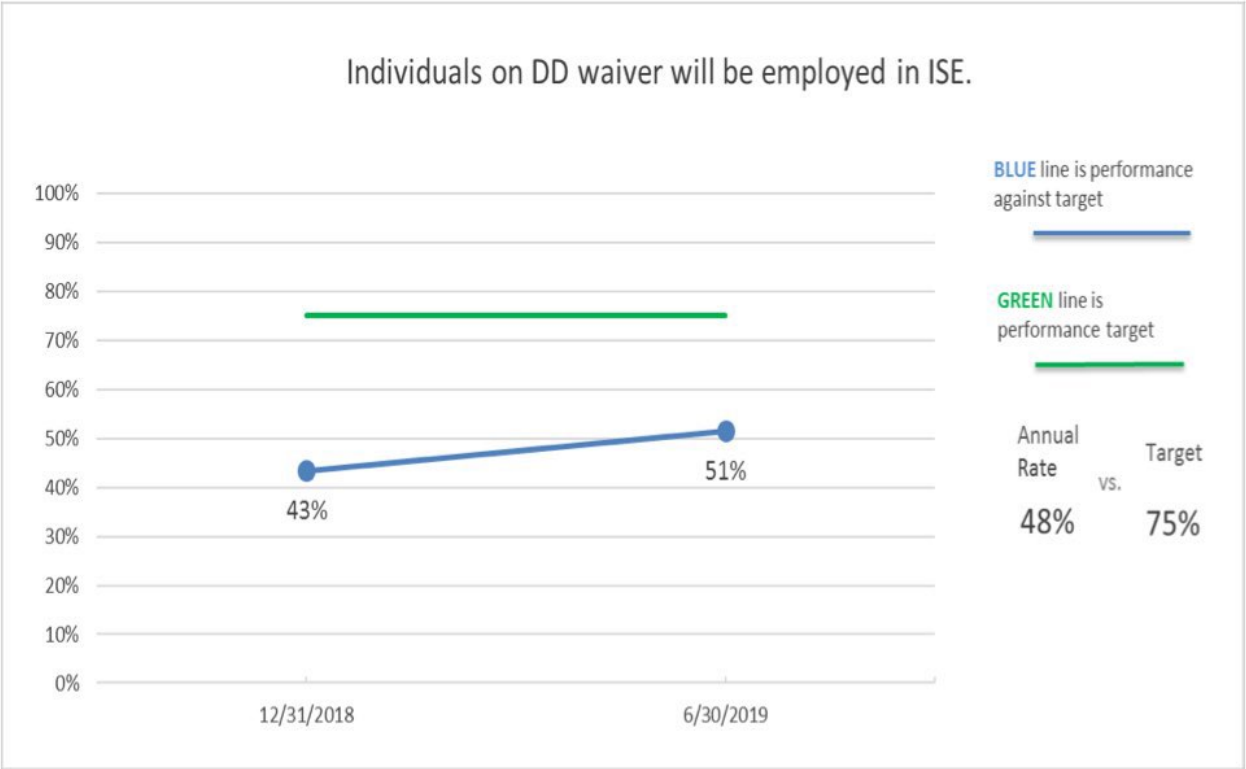
Additional housing resources have been secured every year, with a current total of $8.3 million invested in the DBHDS State Rental Assistance Program (SRAP) and 127 Housing Choice Vouchers committed to the target population by public housing agencies across the state. DBHDS also funded a Community Housing Development Initiative, providing $2.5 million in capital subsidies to develop ten units of affordable housing. It is anticipated that SRAP funding, along with housing authority vouchers and a range of interagency housing strategies, will facilitate Virginia's ability to reach the 10% target for SFY21.

The second PMI for Community Inclusion is related to individuals receiving Individual Supported Employment (ISE). Recognizing the importance of employment in the lives of individuals with and without disabilities, DBHDS has (in policy and in practice), undertaken efforts to support individuals with disabilities in having increased access to integrated community-based employment as the first and priority service option. Employment First is a national movement that calls for raising expectations, implementing better practices and aligning policies and reimbursement structures to promote competitive, integrated employment opportunities for all. The adoption of this formal policy, in 2012, requires that employment be offered to the individual before other services.

ISE is a service wherein an individual is supported one-on-one by a job coach in an integrated employment or self-employment situation and the individual is compensated at or above minimum wage in a job that meets personal and career goals. ISE expands the opportunities for individuals with disabilities to have relationships with co-workers and increases their sense of well-being. Group Support Employment (GSE) services are continuous supports provided in regular business, industry and community settings, to groups of two to eight individuals with disabilities, and involves interactions with the public and co-workers without disabilities. DBHDS advocates that individual competitive employment is more desirable, as it is the more integrated employment service.

Through the DD Waiver Redesign, DBHDS expanded the array of integrated day and employment related services meant to support individuals with gaining access to meaningful participation in their communities and increase the number of individuals joining the workforce.

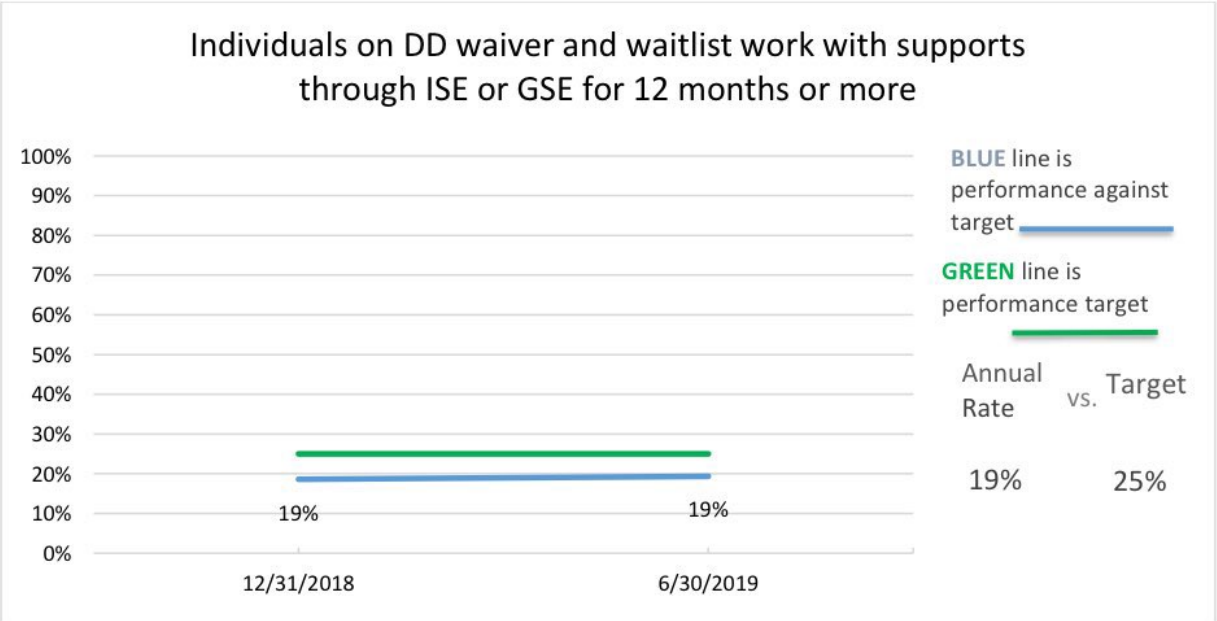
DBHDS began tracking the measure presented in the chart below to determine a baseline and growth in employment, by monitoring both ISE and GSE services authorized. Virginia set the target at 75% in SFY19. While there has been improvement in the last six months of SFY19, reported at 51%, the overall annual average number of individuals employed receiving ISE was 48%.



The Commonwealth remains committed to meeting established targets through various avenues, including continued expansion of employment opportunities, by providing technical assistance and training to new and existing providers; educating individuals and their families on the benefits of employment; and addressing transportation/accessibility issues.

Performance Measure Indicator – Stability	Target	Result	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%	✓

In defining stability, DBHDS looks at the stability of important aspects of an individual's life. One indicator of stability is employment (defined as being employed 12 months or more). DBHDS measures the number of individuals receiving employment supports under the waiver, whether ISE or GSE, and if the individual remained employed for 12 months or more. As of June 30, 2019, there were 4,331 people employed, with support, in ISE or GSE (which is a combined increase of 306 people from the previous data reported in December 2018). This is 24% of the total number of individuals between the ages of 18-64 who were on the waiver or the waiver wait list (17,964) at the time of reporting. There has been an increase in the number of individuals starting employment and transitioning from GSE into ISE. Additionally, more individuals are receiving ISE than GSE, which is a reflection of the increasing numbers of individuals gaining access to competitive, integrated employment in their communities.



In addressing both PMIs related to ISE and employment stability, DBHDS set a high target of 75% for ISE and a target of 25% for employment stability recognizing the shift related to expectations under the Workforce Innovation and Opportunity Act as well as the Home and Community Based Final Settings Rule. DBHDS through the waiver redesign created a new employment service, workplace assistance (WPA), to allow people with the most complex needs to be able to work in more integrated settings and to support individuals in maintaining employment. DBHDS continues to address the identified barriers to employment and accessing ISE services such as reimbursement rates, transportation, and availability of WPA service providers. Mitigating strategies include partnering Employment Service Organizations with day programs who have more access to direct support professionals who can serve as WPAs in addition to reviewing the current employment reimbursement rate structure.

In summary, the PMIs for Community Inclusion and Integration provide information regarding choice in living situations and individuals living independently and support and stability of employment as key indicators of community participation. DBHDS will continue to monitor data regarding participation in community life and also consider including additional measures in this KPA that expand to include other social determinants of participation in community life (i.e., individuals decide their daily schedule). DBHDS will continue to explore resources to support individuals' participation in community groups and activities as well as assist individuals in developing desired roles in the community.

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 data presented below is collected by the Office of Community Support Services and the Office of Provider Development and analyzed and monitored by the KPA workgroup and Case Management Steering Committee (CMSC). Please find a brief synopsis of progress towards the achievement of PMIs relevant to this key performance area.

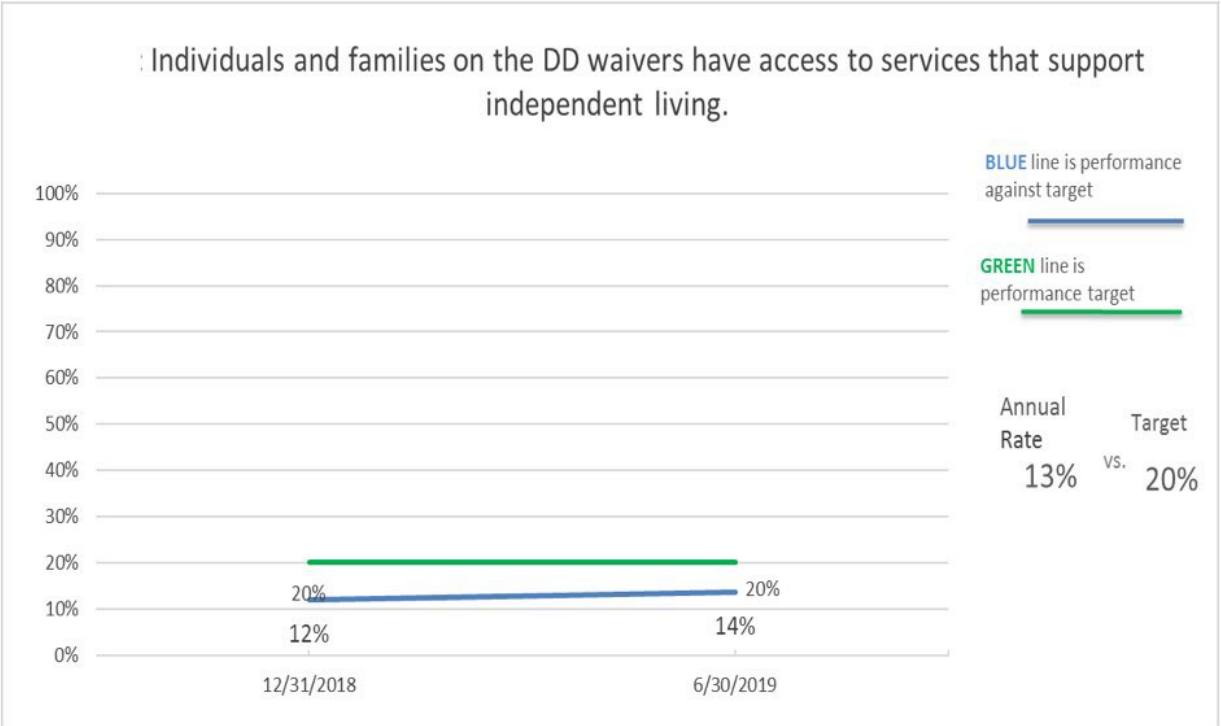
The Office of Community Support Services provides oversight of the following PMIs.

Performance Measure Indicators – Access to Services	Target	Result	Performance Assessment
Individuals and families, on the DD waivers, have access to services that support independent living	20%	13%	✓
Individuals and families on the DD waivers, have access to Community Engagement Services	45%	31%	✓

DBHDS' vision of "a life of possibilities for all Virginians" and strategic goals are focused on increasing the number of high quality community providers and the number of services offered in the most integrated settings. The services selected are the licensed waiver services that support living in the most integrated setting and promote community involvement and social connectedness. In order for individuals to receive the supports necessary, access to those services within their communities and localities is critical. As DBHDS and DMAS focus on promoting integration and inclusion through waiver redesign, it is important to measure the effectiveness of these process changes to determine whether the expected outcomes have been achieved. DBHDS monitors access through the availability of integrated residential and day services.

For the purposes of the next PMI, access means that, in a given locality, there are two or more services (in-home support services, independent living supports, supported living and/or shared living services) offered. There are 133 localities in Virginia. In June 2018, a baseline was established with 16 localities (12%) offering two of the four services.

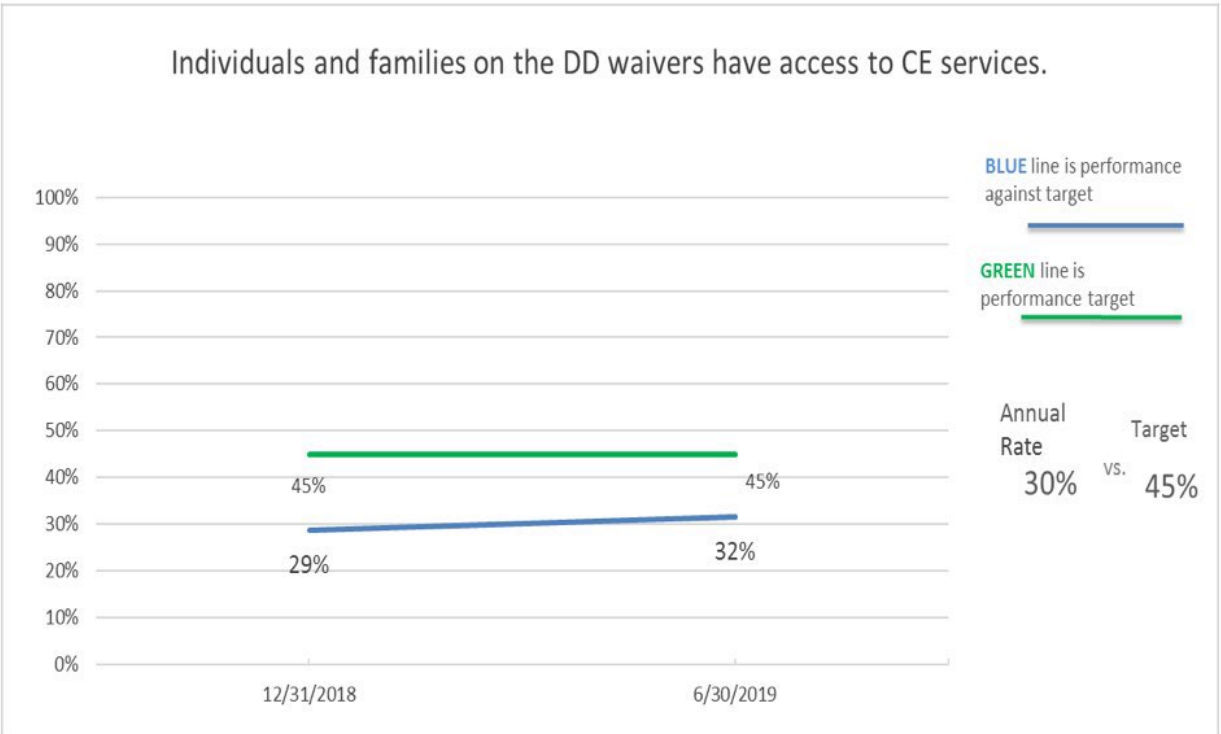
At the end of SFY19, the number of localities offering at least two of the four services increased to 18 localities.



Need or desire for services may exist in areas where providers are not currently offering those services, which may indicate an opportunity for growth in provider capacity. In this measure, DBHDS is assessing where services are offered. DBHDS identified some factors that may be impacting progress toward meeting the target, such as provider reluctance to develop new or expanded services when there is no identified need or demand for that service. A second issue identified is that even when there are providers in the locality providing two of the four services, the provider may not have the capacity to serve additional individuals.

DBHDS also measures access to integrated day services. Community Engagement (CE) and Community Coaching (CC) services were added to the waiver to support and facilitate individualized choice of what to do during the day and foster participation in community life and social connectedness. CE services aid in the ability of the individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability and personal choice necessary to access typical activities available in the community such as those chosen by the general population. These activities may include community education or training, recreation, community events and/or volunteer activities typically available in communities. CC is a service designed to assist people in acquiring a specific skill or set of skills to address a particular barrier(s) preventing a person from participating in activities of CE.

The CE PMI, depicted, was reported semi-annually in SFY19, at the end of the second quarter and the end of the fourth quarter. At the end of the fourth quarter, 32% of Virginia's 133 localities had two or more CE providers, which is a 3% increase over the 29% reported at the end of the second quarter.



DBHDS Provider Development conducts semi-annual data analysis to determine Virginia's progress toward the provision of developmental disabilities service options that support community inclusion. The analysis helps DBHDS and providers understand gaps in services across the Commonwealth and promotes provider decision making around business expansion and diversification in areas where there are identified service gaps. To facilitate provider growth across the Commonwealth, DBHDS implemented a program called Jump Start which is a funding initiative designed to encourage service development, especially in areas where there are limited or no services available. This one-time funding is used to develop infrastructure and capacity in community-based service organizations, to support specific individuals while preparing to meet future community needs (especially in geographically underserved areas). DBHDS continues to utilize Jump Start funding to address identified service gaps, indicated by ongoing data analysis.

The Office of Human Rights, Office of Provider Development, and the Office of Community Support Services are responsible for the following PMIs.

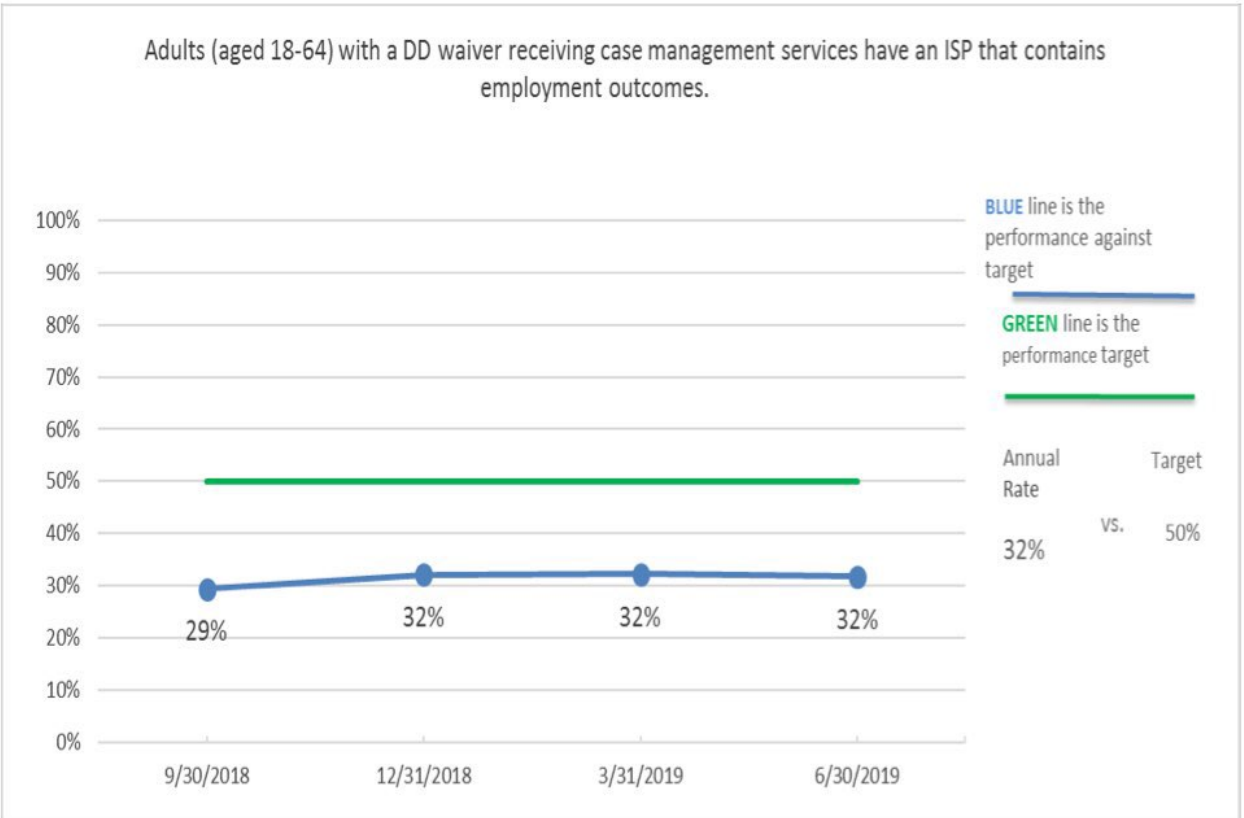
Performance Measure Indicators – Provider Competency and Capacity	**Target**	**Result**	Performance Assessment
The state demonstrates, on an ongoing basis, that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death, by verifying that investigations provided by licensed providers are conducted in accordance with regulations	86%	86%	✓
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%	✓

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%	✓
Support Coordinators will have meaningful discussions about employment benefits and options, face to face with individuals (ages 18-64) receiving DD Waivers	86%	93%	✓
Support Coordinators will have meaningful discussion about community engagement and community coaching, face to face with individuals receiving DD Waivers	86%	88%	✓
Employment goals are developed for individuals, ages 18-64, receiving DD Waivers	50%	32%	✓
Community Engagement and Community Coaching goals are developed for individuals receiving DD Waivers	86%	37%	✓
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%	✓
RST referrals are timely for individuals considering a move into group homes of 5 or more beds	86%	69%	✓

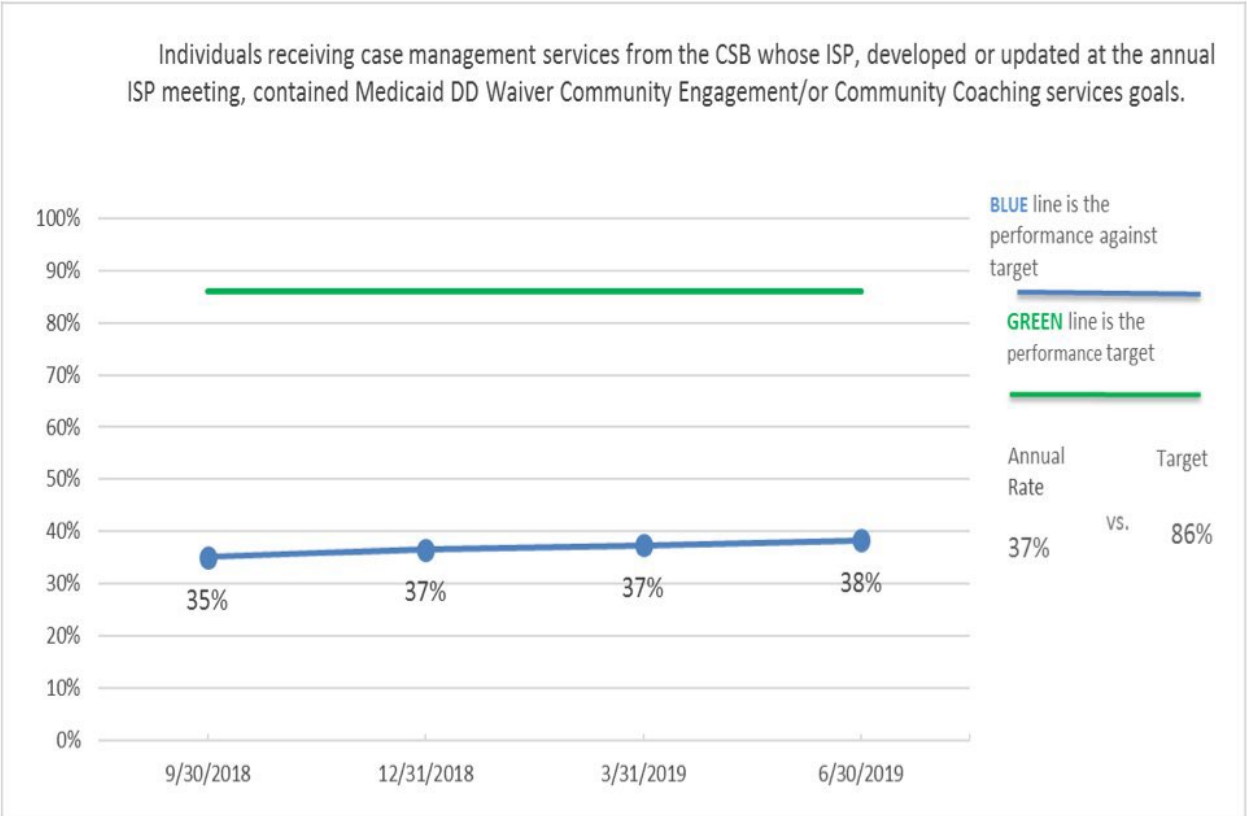
Quality service delivery starts at the provider level. This includes not only having enough providers in all areas but also ensuring that available providers are competent and provide quality services. To measure provider competency and capacity, DBHDS looks at direct service providers as well as case management provider competencies.

While the data indicates case managers/support coordinators are having discussions regarding employment, intended targets related to the number of individuals with employment and community engagement goals were not met. Additional DMAS services, including but not limited to benefits planning and employment and community transportation, were added to the waiver. It is anticipated that these services will assist in addressing some of the barriers identified in the OCQI's "CSB Quality Reviews" report. As individuals and authorized representatives/legal guardians become more aware of the benefits of employment exploration, DBHDS expects more individuals will choose employment, resulting in an increase in the number of individuals with employment outcomes.

The chart below provides information related to the individuals whose case managers/support coordinators discussed employment and whose ISP teams developed employment goals. The graph represents the number of individuals, ages 16-64, receiving DD waivers with employment outcomes.



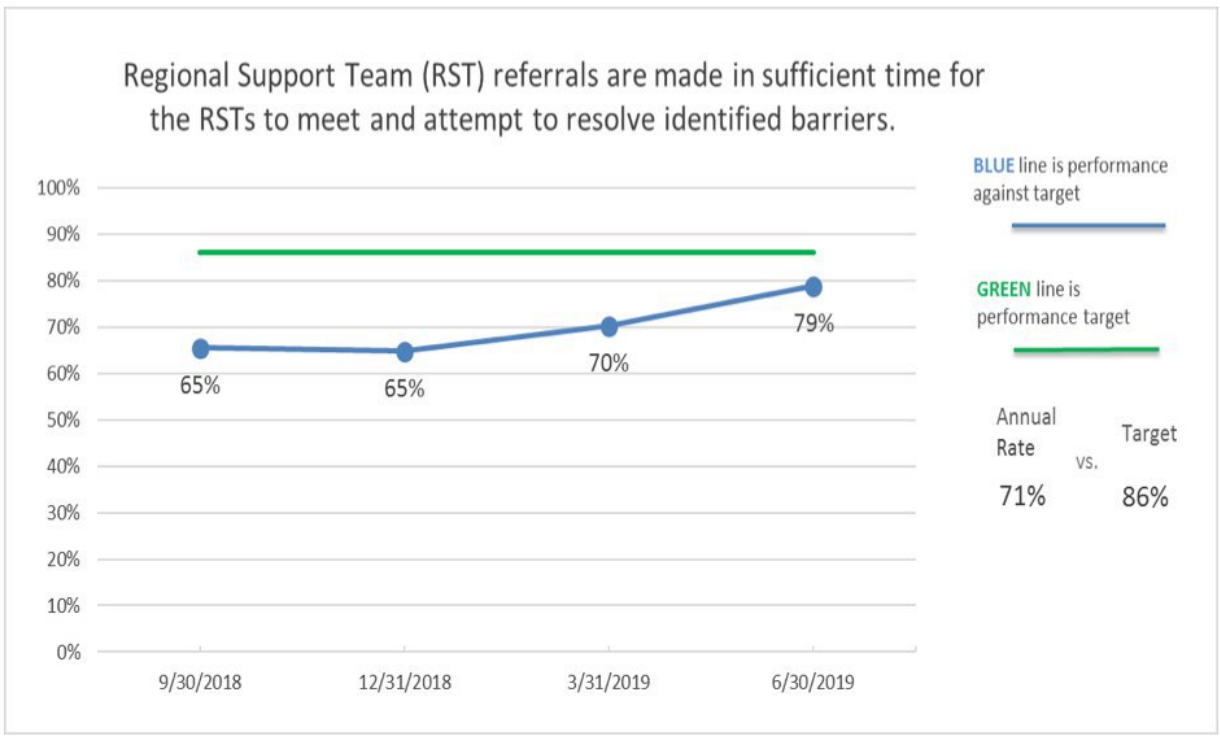
Information below represents data related to the individuals whose case managers/support coordinators discussed CE and CC services during the ISP team meeting. The chart represents the number of individuals with CE and CC goals.

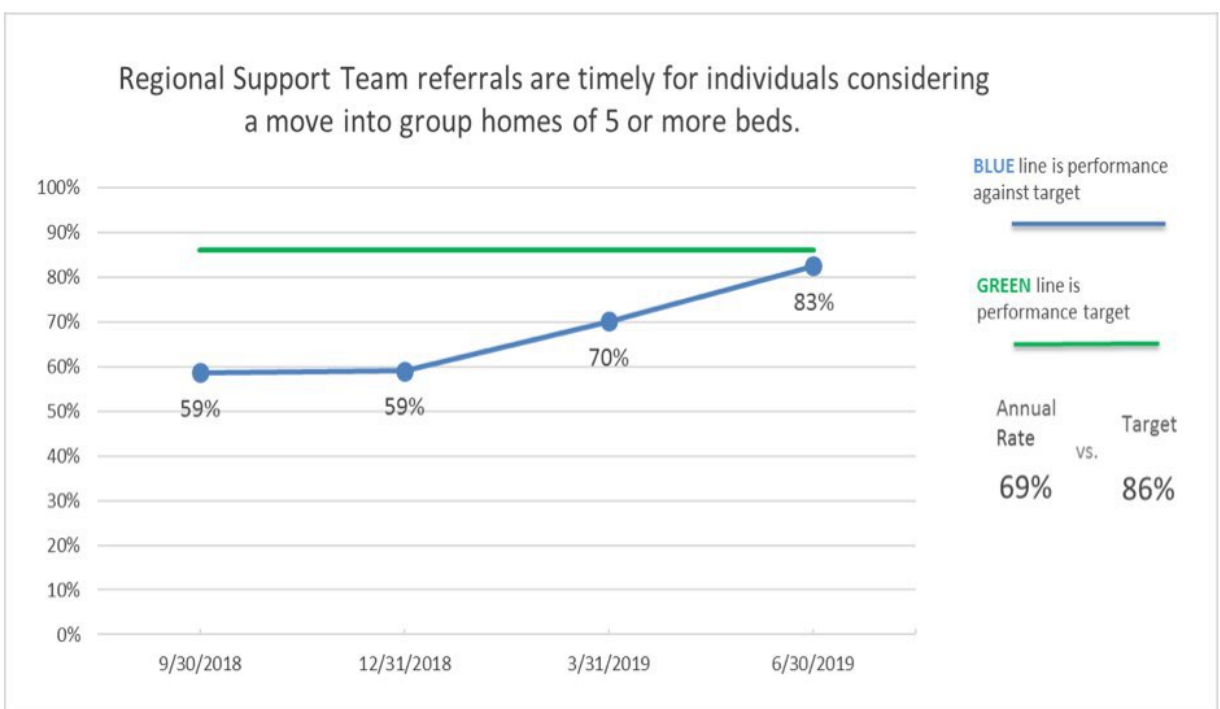


This measure had minimal change over the fiscal year and DBHDS will need to explore barriers related to the development of CE and CC goals to determine the way ahead.

In order to support individuals in making an informed choice of where they want to live, Virginia requires that case managers/support coordinators assist individuals and families in identifying and discussing the most integrated residential options. For individuals and families who indicate they are choosing a less integrated setting in a nursing facility, training center, and/or congregate residential settings with five or more individuals, case managers/support coordinators are required to make a referral to the Regional Support Team (RST) within five days of becoming aware of this choice. Through the referral and review by a RST (comprised of professionals with experience and expertise in serving individuals with DD and complex behavioral and medical needs), DBHDS assures that all available options of more integrated settings have been explored. Using baseline data collected during SFY18, it was determined, that when referrals were made in a timely manner, 68% of individuals and families chose a more integrated setting. DBHDS determined that improving the timeliness of referrals would have a positive impact on the number of individuals who chose more integrated settings. DBHDS began tracking timeliness of referrals, and the QIC approved a quality improvement initiative, which included streamlining the RST process, educating case managers/support coordinators about the importance and benefits of timely referrals and tracking referral timeliness. This initiative resulted in collecting the reasons for these late referrals. In February 2019, the DBHDS Commissioner sent a memorandum to CSBs establishing targets for the timely submissions of RST referrals.

Data analysis of timeliness of RST referrals demonstrated some improvement but did not yet reach set targets. As a result, DBHDS provided additional training in June 2019 to case managers/support coordinators and initiated a revision of the RST referrals form.





While DBHDS continues to explore barriers related to choice and/or referral to more integrated settings, some more integrated residential options are limited due to the number of providers available

geographically to provide more integrated services and/or due to the number of providers available to meet the complex needs of some individuals seeking integrated residential options. In addition, providers reported concerns about the inability to financially support individuals in more integrated settings, in some geographical areas, due to higher housing costs and reimbursement rates. As noted above, DBHDS implemented Jump Start to help support the growth of providers in all geographical areas of the state and to increase the number of providers who serve individuals in more integrated settings and or with more complex needs.

As the result of continued questions and concerns about the validity of case management data metrics and or the failure to reach set case management data targets, the QIC approved a quality improvement initiative which was initiated in SFY18 and culminated in SFY19 requiring the OCQI to visit each CSB. The onsite visits resulted in a comprehensive report ("CSB Quality Reviews") which identified issues, barriers, and recommendations reviewed by the CMSC as identified in the CMSC Semi-Annual Report to the QIC, which is an appendix to this report. Ongoing updates related to this quality improvement initiative were provided to the QIC. The visits included a review of the CSB specific case management data metrics and record reviews to validate data coding and identify areas in case management documentation that needed strengthening. OCQI developed quality improvement plans in collaboration with the CSBs. OCQI continued to work with CSBs to track their progress in implementing the quality improvement plans. In collaboration with other DBHDS staff, OCQI facilitated further development and refinement of processes to assist CSBs in monitoring their own data and internal processes to improve their data quality and strengthen case management documentation through data reporting analysis and incorporation of ongoing record reviews into their quality improvement processes. As a result, statewide, case management data metrics improved. Though some of the most complex issues and barriers identified (related to Community Consumer Submission 3 data platform) cannot be easily resolved, DBHDS continues to address recommendations from the "CSB Quality Reviews" report and is currently formulating a strategic plan to address data platform barriers in the short and long term.

Through various efforts, DBHDS sought to improve case management at the CSB level while also forming the CMSC to oversee and coordinate various activities designed to strengthen the case management system. The CMSC solicited applications and allotted pilot funding to seven CSBs to experiment with employment models for supporting transformational case management activities (discovering what individuals care about; ensuring desired changes are pursued, etc.), by reducing the time spent on transactional duties (actions that satisfy requirements but have little or no impact on the individual's quality of life). Working collaboratively with the Virginia Association of CSBs, DBHDS formed a workgroup to review and address identified issues related to data reporting and developed processes to improve CSB oversight of case management functions.

There were also concerted efforts by DBHDS, in SFY19, to focus on quality improvement of other non-case management providers. Virginia completed its first year as part of the Business Acumen Learning Collaborative with the HCBS Business Acumen Center. The Business Acumen Learning Collaborative project focuses on supporting the development of provider skills and competencies in financial judgments/decision making (acumen), market orientation, and strategic perspectives so that business acumen is built, expanded, and maintained among the provider network in Virginia, particularly for those waiting to be licensed. Held in March 2019, DBHDS hosted a Provider Innovation Collaborative that

focused on Quality Improvement, Best Practices, Supporting Crisis and Business Acumen. The event, attended by 400 participants, included speakers from Virginia and other states, as well as national experts.

Other provider competency initiatives implemented included the development of an orientation manual for Direct Support Professionals (DSPs) and a Provider Readiness Education Program (PREP). The DSP orientation manual is a six part training and basic staff competencies required for all providers of licensed services. The PREP is designed to support a network of quality DD providers in Virginia. It enables potential providers to increase their understanding of Virginia's expectations and requirements, and to give them the tools they need to be successful. PREP is based on a mixed method approach and includes online training, followed by an in person session, and access to additional resources to support their learning. The program was initiated in June 2019 and will continue on a semi-annual basis. Priority is given to providers who have been in queue for a license for at least six months or who have been licensed with the past 12 months.

A review of the measures in both of the domains in this KPA indicates that the majority of the targets were met or were nearing target. As noted, revisions to the access PMIs should result in a more accurate reflection of whether intended outcomes are met. The case management/support coordination measures which were not met relate to increasing the number of individuals with employment and community engagement outcomes as well as increasing the number of timely RST referrals. DBHDS provided information on the importance of employment and ensuring individuals have supports to participate in community groups and develop social roles in the community through training and via updates to the Case Management Modules, Support Coordination Manual – DD, and Direct Support Professional and Supervisor Orientation Training and Competencies (in response to data analysis). DBHDS, after reviewing recommendations from the QSR Annual Report, will determine if further enhancements are needed in these training documents and explore development of resources, specifically geared toward individuals and families, to enhance their knowledge on the benefits of competitive employment and social role development.

IV. Quality Management Program Evaluation

Using a Quality Management Program Assessment Tool, endorsed by the Institute of Healthcare Improvement (IHI), the DBHDS Quality Management team conducted a program evaluation. The tool assists organizations in assessing key components of their quality management programs and includes an assessment of the quality management plan and the program's supporting infrastructure, implementation of processes (to measure and ensure quality of care and services), and the capacity to build quality improvement among providers.

Based on the assessment tool, quality management 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.

Identified Strengths

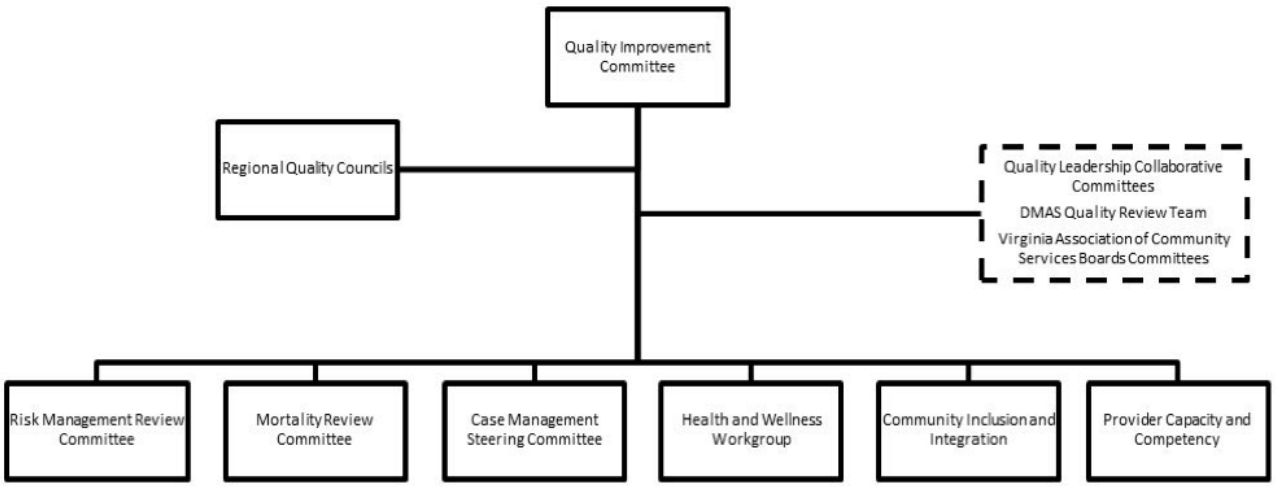
The evaluation identified several strengths in DBHDS' quality management program:

Quality Management System and Quality Management Plan (Part I and Part II of the Quality Management Plan)

The Quality Management Program is supprted by leadership with direct accountability to the Chief Clinical Officer and DBHDS Commissioner and has identified functions, resources, and a clear indication of responsibilities and accountability across the agency. The organizational quality improvement infrastructure developed is both sustainable and continuous. The DBHDS quality management plan, developed in SFY16, was expanded in SFY19 to include three parts which provide a guidance document for the direction and activities related to quality improvement. Part I outlines authority, functions, and resources of the quality management program. Part II includes committee charters and a workplan. Prior to SFY19, quality subcommittees had operating procedures. A concerted effort was initiated in SFY19 to establish standardized quality committee charters that include a statement of purpose, scope of authority, membership, quorum requirements, meeting and reporting expectations, consistent use of terms, and the model for quality improvement. The charters, along with Part 1, the Program Description, and Part 2, the Workplan, will guide committee work and hold the quality management program accountable. This annual report and evaluation, Part 3, summarizes efforts and provides a public reporting on the quality of supports, gaps in services, and quality improvement activities and initiatives.

Committee Structure and Performance

The quality committee framework is a definitive strength of the quality management program. The framework includes the QIC (the highest level quality committee), three subcommittees, three KPA Workgroups and five Regional Quality Councils (RQCs) in addition to a joint DBHDS-DMAS quality improvement team and quality collaboratives with the Virginia Association of Community Services Boards.



In SFY19, the QIC and quality subcommittees met regularly, reviewed data, identified issues, and made recommendations for corrective actions and process improvements. Each committee maintained meeting minutes reflecting membership attendance, actions and follow-up.

The QIC met quarterly and was restructured to include DBHDS senior leadership, to ensure that a culture of quality is established throughout the agency and the system. Leadership researched best practice of quality improvement committee structures utilizing national quality improvement and risk management practice models as well as best practices in other states to help influence the design and implementation of the DBHDS' quality management system to include identified PMI with set targets.

The QIC reviewed reports such as the Annual Mortality Report, Semi-Annual Case Management Steering Committee Report, Semi-Annual Employment Reports, Serious Incident Reporting, Quality Service Review Annual Report and National Core Indicators Annual Report, in order to gain a more global perspective of the funtionality of Virginia's developmental services service system. In addition, the subcommittees moved to reporting to the QIC more regularly, which allowed the committee to assess the status of the PMIs as well as other data to identify and address health and risks of harm and ensure accesibility and quality of services to meet individuals' needs in integrated settings. The QIC meetings also included an opportunity for the RQC liaisons to report on recommendations or request additional data/information.

While DBHDS senior leadership provides oversight, representatives from internal offices (e.g., Office of Licensing, Office of Human Rights, Office of Community Quality Improvement, Office of Community Support Services, Office of Provider Development, and the Office of Integrated Health) are dynamic members of the committees and workgroups. Representatives from external partners are also active participants as priorities and initiatives are discussed (e.g., individuals receiving services, family members, and providers on the QIC and RQCs). Input and recommendations are also solicited from internal and external partners and advisory councils (e.g., Employment First Advisory Group and Individual and Family Support Program Councils). Some quality subcommittees added members to the committee membership,

as additional or specific expertise was identified. The Mortality Review Committee included consistent attendance by an independent clinician member and each subcommittee includes support from the Office of Data Quality and Visualization and the Office of Community Quality Improvement to support and facilitate improvements in the review and discussion of data and principles of quality improvement.

To further emphasize the importance of data analysis in quality improvement processes, a concerted effort was made by the QIC subcommittees in SYF19 to review and analyze a variety of data sources and expand the use of data to identify trends, gaps and the need for corrective actions. Other strengths identified included efforts to delineate between outcome and output measures and to clearly define measures and provide consistency across quality improvement committees and workgroups. Given the breadth of the system, DBHDS prioritzed the number and scope of performance measure indicators and ensured alignment with DBHDS strategic goals.

The Office of Data Quality and Visualization (ODQV) developed a comprehensive Data Quality Plan built on a three-tiered approach: assess, strategize, and execute. This three-tiered method also supports the Plan, Do, Study, Act quality improvement model that has been widely adopted throughout DBHDS. The first tier of the plan assesses data quality through a variety of measurement and review tools that focus on the main phases of the data migration: the source systems, the Extract Transform Load (ETL) processes and outbound reporting. The second tier focuses on the development of agency-identified objectives, as well as the brainstorming of strategies aimed at the overall improvement of quality data use. Because the data infrastructure will be assigned in phases (1-3), the second tier can be conducted after each phase and again after all three phases have been completed. The third tier aims to utilize subject matter expertise and agency resources in support of data quality improvement initiatives.

Recognizing the importance of data utilization and analysis, several committees made efforts to incorporate data review into committee prcesses, such as the RMRC's use of reports and data generated through CHRIS. The committee reviewed aggregated serious incident reports and human rights abuse, neglect and exploitation (ANE) data (by provider, incident type, service and region). The RMRC also reviewed the Office of Inspector General Report entitled "2019-DBHDS-002 Review of Serious Injuries Reported by Licensed Providers of Developmental Services" and scheduled planned activities, including significant development by the Office of Licensing toward implementation of a coordinated Incident Management Unit (which was established to analyze incident management data). A case review process was initiated in SFY19 to review reports of ANE to determine how systemic or provider issues could be identified and resolved. RMRC responded to the QSR recommendations that individuals with developmental disabilities receive training to enhance their understanding of ANE. This recommendation led to the establishment (through the State Human Rights Committee) of a training specifically geared toward individuals with developmental disabilities explaining how to recognize abuse, neglect and exploitation and to whom and how to report concerns. In addition, the OHR initiated regional training opportunities to promote provider literacy regarding an individual's assured rights and corresponding provider duties. Training sessions, open to all licensed providers, include information about reporting abuse/neglect in CHRIS, an overview of the human rights regulations, review of the use of restraint and restrictions, and new regional provider orientation.

Efforts by the Mortality Review Committee (MRC) to improve oversight processes and the collection and analysis of data resulted in the identification of four factors of provider care that were deemed to be potentially preventable with discussions of intervention or remedies for a specific provider or with regard to a system change. The enhanced committee processes include tracking completion of assigned recommended actions. If PMIs fall below an acceptable level, potential steps for remediation through dedicated time during committee meetings include understanding and addressing the barriers to follow-up, and identifying additional units within DBHDS that could support the MRC in this effort to ensure completion of assigned recommendations.

The Case Management Steering Committee utilized aggregate data from the Community Services Boards self-assement study, findings of the Partnership for People with Disabilities case management study, the DBHDS CSB Review, and review of the case management data metrics to make recommendations in their semi-annual reports to the QIC. These reports highlight various activities and improvement projects implemented, including the update of the Case Management/Support Coordination Modules and the development of a Support Coordination Manual – DD and the SCQR process.

The Key Performance Area Workgroups considered a variety of data sources for establishing a baseline and the methodology for collecting data for each of the PMIs in the eight identified quality of life and/or provider service provision domains. The Health, Safety, and Well-Being and Community Inclusion and Integration workgroups prioritized PMIs, and reviewed National Core Indicators data (selecting several measures), which helped the workgroups understand the effectiveness and perceptions of Virginia's developmental disability system of care. The Provider Capacity and Competency Workgroup reviewed provider data related to incident reporting and data related to access and from the DMAS Quality Management Reviews (QMRs). Given that several subject matter experts were members of all three workgroups, the workgroups met collectively in an attempt to avoid overlap and further discuss PMIs. The committee members began to broaden their perspective on how multiple measures, when viewed collectively, can demonstrate comprehensive statewide performance for services for people with developmental disabilities.

The Regional Quality Councils met consistently, in all five regions, throughout SFY19 and reviewed numerous data reports related to incident reporting, employment, case management, Regional Support Teams, an overview of the Home and Community Based Settings Rule, National Core Indicators, Quality Service Reviews, as well as data for the Key Performance Areas. This data review led to RQC discussions regarding various topic areas such as transportation issues (affecting outcomes in some regions), the availability of community engagement providers, and the need for the training and involvement of family members (regarding employment benefits for individuals with disabilities). The RQCs made recommendations to the QIC regarding the need for regional data and requested training on the role of the RQC members (resulting in the development of a training on the DBHDS quality improvement program and quality improvement principals, scheduled for early SFY2020 for RQC members).

DBHDS also works collaboratively with DMAS in the oversight and improvement of the quality of services delivered under the Commonwealth's DD waivers. The QRT, while not a subcommittee of the QIC, provided an annual report to the QIC inclusive of remediation activities to address performance measures that had not achieved set targets. The work of the QRT was 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, serious incident reporting, mortality reviews, and DBHDS level of care evaluations. The team identified barriers to attainment and the steps needed to address them.

The QIC and QIC subcommittees reviewed and analyzed data to update work processes, revised regulations to strengthen provider oversight of individuals served, and initiated quality improvement activities and initiatives. Utilizing the Plan, Do, Study, Act quality improvement model, the QIC and quality improvement subcommittees monitored PMIs and reviewed applicable data from a variety of sources to ensure continued movement toward set targets and identified potential gaps in service delivery. In doing so, DBHDS used these quality improvement processes to develop quality improvement initiatives and/or to enhance outreach and education. DBHDS initiated quality improvement initiatives to strengthen case management/support coordination processes and data reporting. DBHDS determined a need to provide additional guidance and education to case managers/support coordinators. The case management/support coordination modules were revised in SFY19 to enhance training in many areas (including the Employment First, identification of risks, and case management/support coordination roles and responsibilities) and an online manual was developed for DD case managers/support coordinators. The RMRC developed and/or enhanced training and guidance, to strengthen the quality of services throughout the provider network, through the provision of regional Human Rights training and training targeted to individuals with developmental disabilities. Licensing guidance on quality improvement and risk management requirements and root case analysis training was developed and provided. The RMRC also worked with the Office of Integrated Health to publish Safety Alerts on various topics such as drug disposal, bowel obstruction and constipation, medication management and Tardive Dyskinesia.

Challenges

The IHI Quality Management Program Assessment Tool also provided an opportunity to highlight challenges and areas in which further development is needed. Using this objective evaluation, judgments can be made and opportunities for improvement and program development identified.

One planned program development is to utilize the established system/infrastructure to effectively serve across disabilities. Acknowledging that the primary quality committee structure and activities have been driven by Department of Justice Settlement Agreement and therefore quality improvement efforts focused on DD services, it is the intent to expand the structure to include behavioral health and substance use services. As the quality management program includes other disabilities, it is also expected that participation in the evaluation of the quality management program will be inclusive of additional stakeholders. This will broaden stakeholders' perspective on quality management activities and expectations in implementing a quality management program.

In its committee evaluation, the RMRC noted challanges around meaningfully evaluating data to draw conclusions about systemic risks or identifying additional opportunities for improvement largely due to the lack of standardized data that could be evaluated consistently over time. The RMRC anticipates that

improvements to the CHRIS reporting interface and subsequent data analysis will begin to address this issue.

The five Regional Quality Councils did not consistently have a quorum at every meeting, as the volunteer members have competing priorities, but several new members and alternates for the various required roles were appointed by the end of SFY19 to address the councils' ability to consistently meet quorum requirements. To strengthen support of the RQCs, the OCQI initiated a reorganization of Quality Improvement Specialist responsibilities. Previously, one QI Specialist supported all of the RQCs. The reorganization included assignment of a Quality Improvement Specialist in each region to strengthen support to each RQC. As data evaluation improves, DBHDS acknowledges that more regional data is imperative if the RQCs are to make regional recommendations for quality improvement initiatives. The availability of regional data with comparative analysis across regions and over time will facilitate the RQC's ability to identify patterns and trends and then recommend responsive actions to identified issues.

While the quality management program enhanced subcommittee data analysis, an identified challenge in this process is determining appropriate data sources for performance measures and how the data is to be gathered, organized and stored. The Office of Data Quality and Visualization's Data Quality Monitoring Plan will guide the enhancement of key data sources, monitor progress over time, and strengthen data quality. It is critical to ensure measures are operationally defined and augmented with specific targets, including desired outcomes, and that strategies to analyze data are detailed. The Division of Administrative Services is working in concert with Office of DQV and with other offices to review data sources and reporting processes (to identify opportunities for enhancement and strategically planning for the development and implementation of short and long term solutions to barriers resulting in data concerns).

The quality management program assessment also identified the importance of training staff on quality improvement tools and methodologies for the development of measures and to ensure consistency in analysis of performance data. DBHDS initiated training with the presentation of Building a Culture of Quality.

Other recognized challenges related to the QSR process methodology, inter-rater reliability, and comprehensiveness of QSR assessments. DBHDS addressed ongoing concerns related to the QSR tool methodology and criteria for determining compliance with standards, and will work in collaboration with a QSR contractor to improve inter-rater reliability processes and QSR reviewer training and develop methodology to assess clinically driven indicators.

It is also acknowledged that expanded training and technical assistance in quality management for staff and licensed providers is critical. While limited training on quality improvement has been provided in the past, additional resources will be developed in order to build capacity internally and externally to providers throughout the DBHDS system of care.

V. Summary

The DBHDS quality management program has made significant strides in SFY19 by developing a robust quality management program and quality improvement structure and identified area for improvement.

Continued leadership support and commitment of resources will be required to maintain the progress made in SFY19 and to ensure a sustainable and effective program. As DBHDS expands the quality management program across the agency and throughout provider services, it is expected that additional resources will be needed to support this effort.

Recommendations for SFY2020 include:

- Develop additional measures to enhance assessment of services at an individual, provider and systemic level.
- Ensure that measures include complete, accurate and timely data.
- Prioritize and monitor quality improvement initiatives.
- Surveil data including data collection and continuous monitoring on various factors over a regular interval of time in order to identify issues and gaps not included in the PMIs.
- View measures collectively in order to demonstrate comprehensive statewide performance.
- Extend quality management process to external services providers across the system of care.
- Provide additional training, technical assistance and consultation to licensed providers relative to developing, implementing and monitoring quality improvement and risk management programs.

These additional measures will help to strengthen the system's ability to monitor performance and the effectiveness of supports and services.

As the system matures, quality committee processes will improve. As performance measures are developed, committees will become more reflective on whether data sources are available, whether the intent of the measure is clear, and whether the outcome is achievable (given the available resources and in a given time period). In addition, as surveillance data and PMIs are reviewed; trends and gaps are identified; and quality improvement initiatives are identified, prioritized, and implemented on an ongoing basis at an individual, provider and system level, the quality of services will continuously improve.

DBHDS will continue to report publicly on the quality of supports and services and the effectiveness of the quality management program.

Appendices

- Annual Mortality Report
- Case Management Steering Committee Semi-Annual Reports
- Risk Management Review Report
- IHI Quality Management Assessment Tool
- Glossary of Acronyms

Virginia Department of Behavioral Health & Developmental Services

SFY 2019 Annual Mortality Report

Presented by the DBHDS Mortality Review Committee

May 2020

Annual Mortality Report

State Fiscal Year 2019

Executive Summary

This is the fifth Annual Mortality Report of the Virginia Department of Behavioral Health and Developmental Disabilities (DBHDS). DBHDS conducts mortality reviews of individuals with intellectual or developmental disability who received services in a state-operated facility or in the community through a DBHDS-licensed provider. The information contained within this report is based on reviews of deaths during the timeframe July 1, 2018 through June 30, 2019 as reported to the DBHDS via its incident reporting systems, and is scheduled for release to the public by the end of each year. The information presented compares mortality results in SFY 2019 to data collected in previous years. The interpretation of the information presented in this report is not intended to be used as a direct comparison with other states' mortality reviews and reports as those reports may have utilized different methods or analyzed data from different populations. Generalizing findings or comparing mortality rates is limited due to difference in population definitions, waiver programs, and requirements of other state agencies.

The Commonwealth's estimated population in 2018 was over 8.5 million residents (UVA Weldon Cooper Center, Demographics Research Group, 2019), and an estimated 123,080 have an intellectual or developmental disability (SA Larson, 2013). The Community Living Waiver, Family and Individual Supports Waiver, and Building Independence Waivers are providing twenty-seven different services to thousands of Virginia residents (rbha.org/services). As of June 30, 2019, there were 13,861 individuals on a Virginia Developmental Disability (DD) waiver.

Since the inception of the Mortality Review Committee in 2012, the system of care has significantly shifted to community integration from institutional and congregate care settings. A strong, effective system of community support and services is a major factor for a successful transition. This shift is the result of the collaboration, support and partnership of the individuals and families who receive care, dedicated service providers, state sister agencies, and the Virginia General Assembly. The body of evidence on effective medical and psychosocial interventions grows, and this is important to maintain as the community system continues to evolve. Understanding factors that contribute to preventable deaths and utilizing positive advances in public health improves the life expectancy and quality of life of individuals. This report reflects the commitment to continuous quality improvement initiatives within the Virginia system of care.

Key Findings

- In SFY 2019, the MRC reviewed 312 deaths. This is the highest number of deaths reviewed by the committee since its creation, and may be due to the revised case summary development process which decreased a reservoir of cases. According to a 2018 study conducted by the National Institute on Disability, Independent Living and Rehabilitation Research (NIDILRR), the population of individuals with disabilities has increased from 2008 to 2017 from 12.7 percent to 13.2 percent. This may be reflected in the number of deaths reviewed for this target population.

- The median age at time of death was 58 years; the mean age at death was 54 years. While other states' mortality review reports may not directly equate to the Virginia population being reported on through this report, these median ages of death fall within similar ranges reported by other states (*e.g.*, 2018 Annual Report, GA Dept. of Behavioral Health and Developmental Disabilities; 2017 Mortality Data Review, Indiana Division of Disability and Rehabilitative Services).

- As the committee processes for obtaining and reviewing pertinent information for aggregate analysis and outcomes of MRC recommendations have improved, for the first time since 2012 when the MRC first began reviewing deaths, the committee determined more deaths to be expected than unexpected. Prior to SFY 2019, the highest percentage of expected deaths was 36.4 percent in SFY 2018. In SFY 2019, the committee determined 163 deaths (52%) were expected, 141 (45%) were unexpected, and 8 (3%) were not able to be determined by the committee as expected or unexpected and therefore classified as unknown. This represents a 44 percent increase in the percentage of deaths determined to be expected. An analysis of the quality of the data and the challenges of accuracy and completion of data collection is needed to provide interpretation of the submitted information.

- The MRC determined 11 deaths (4%) to be potentially preventable in SFY 2019 – a decrease from 56 deaths (21%) in SFY 2018. Nine of the 11 deaths determined to be potentially preventable involved a failure to execute established protocols.

- The crude mortality rates in SFY 2019 are the highest they have been for individuals on the DD waiver with SIS Levels of 1, 3, 4, 5, and 6 since DBHDS began reporting this data in SFY 2017. From SFY 2018 to 2019, the crude mortality rate increased for individuals on the DD waiver with all SIS Levels except those of 2 and 7. By contrast, the crude mortality rate decreased slightly for those individuals with a SIS Level of 2 or 7, continuing a trend from SFY 2017 through SFY 2018.

- Between SFY 2017 and 2019, the crude mortality rate for individuals living in congregate settings increased faster than the rate for those living independently. In SFY 2019, the crude mortality rate among those living in congregate settings was 29 deaths per 1,000 population, compared to SFY 2017's rate of 16.6 deaths per 1,000 population. In contrast, the crude mortality rate among those living independently increased from 9.6 deaths per 1,000 population in SFY 2017 to 11.6 deaths per 1,000 population in SFY 2019.

Recommendations

The recommendations of the Mortality Review Committee for the SFY 2019 Annual Mortality Report build from the recommendations of the previous year utilizing data from this report. DBHDS recognizes that continued efforts are needed to address strategies in meeting these targets. Quality and process improvement initiatives to address these recommendations were in the planning and implementation phase at the time this report was prepared. The recommendations are as follows:

Recommendation 1: DBHDS should maintain an established target of less than 10% of deaths reviewed to be classified as "Unknown" for the cause of death and continue to utilize the process improvement plan that better identifies causes of death through the mortality review process. DBHDS did not meet this target for FY19, and further process improvements are needed to achieve this, specifically for individuals living in private residences.

Recommendation 2: DBHDS should maintain an established target that potentially preventable deaths make up less than 15% of the total DD deaths per year. DBHDS determined that less than 4% of deaths in FY19 were potentially preventable, and of those, failure to adhere to established protocol was determined to be the reason in 82% of cases, whereas in FY18, this was the cause in only 52% of deaths. The data indicates that this recommendation should be renewed and that additional quality improvement initiatives are needed to specifically address this.

Recommendation 3: For FY19, 11 deaths were classified as potentially preventable, and each different cause of death was only represented by one or two individual cases (i.e., one due to pneumonia, one due to motor vehicle accident, two due to cardiac arrest). Targeting one of these causes of death for a quality improvement initiative based on the FY19 data would not be reflective of the known causes of death common for individuals with developmental disabilities as was reported in previous years. Thus, based on cumulative past data related to causes of death in the potentially preventable category, DBHDS should review system incident report data for potentially preventable causes of death that did not lead to mortality in the rates as per previous years.

Recommendation 4: DBHDS should evaluate the contributory factors leading to the increased crude mortality rates of individuals on the waiver with respect to SIS level.

Background

Purpose and Approach

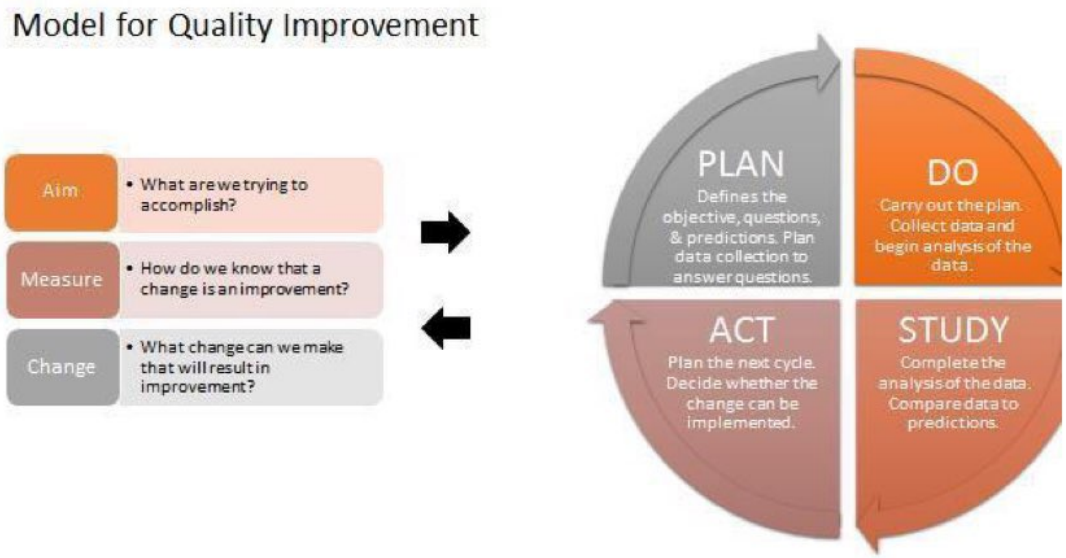
The purpose of the DBHDS Developmental Disabilities Mortality Review Committee (MRC) is to contribute to system-wide quality improvement through the conduction of mortality reviews of deaths of individuals with an intellectual disability and/or developmental disability (I/DD) diagnosis who received services in a state-operated facility or in the community through a DBHDS-licensed provider. The MRC provides ongoing monitoring and data analysis to identify trends, patterns and problems at the individual service- delivery and systems levels. Once identified, development and implementation of quality improvement initiatives are determined in order to promote the health, safety and well-being of said individuals and reduce mortality rates to the fullest extent practicable.

DBHDS quality improvement involves reviewing performance trends and determining quality improvement priorities. Quality improvement efforts should respond to trends by ensuring corrective actions and regulatory reforms are implemented if necessary to address weaknesses/service gaps in the system.

Quality improvement is a continuous process that involves:

- Data collection
- Data analysis
- Evaluating the effectiveness of the overall systems
- Determining findings and conclusions
- Identifying trends that need to be addressed
- Identifying corrective actions or remedies as needed
- Implementing corrective actions or remedies, and
- Evaluating the effectiveness of implemented corrective actions or remedies

DBHDS' quality improvement office partners with and assists divisions in ensuring that quality improvement activities, including best practices and evidence-based outcomes, are coordinated and integrated into the primary functions of the organization. The programmatic divisions (e.g. Community Behavioral Health, Developmental Services, and Office of Integrated Health) retain ultimate responsibility for and control over the quality improvement work occurring in their respective divisions.
DBHDS is committed to Continuous Quality Improvement (CQI) which is an ongoing cycle of collecting data and using it to make decision to improve programs and processes. The MRC makes recommendations on quality improvement initiatives to the DBHDS Quality Improvement Committee and the specific actions of the MRC and status of these initiatives are reported in further detail in the Annual Quality Management Plan Annual Report and Evaluation.



DBHDS requires all state-operated facilities and DBHDS-licensed community providers to report deaths within 24 hours of discovery. From the DBHDS incident reporting systems, reports of deaths for anyone receiving a licensed DD service, has a DD diagnosis, and/or is in a state-operated facility is referred to the MRC for case review. Cases are to be reviewed by the committee within 90 days of the death of the individual. The committee reviews unexplained and unexpected deaths and, to the best ability, determines the cause of an individual's death and whether the death was potentially preventable. A mortality review is not intended to assess clinical competence or violations of regulations. The DBHDS Office of Licensing conducts licensing investigations when notified of deaths by licensed providers. Issues of staff competency are addressed through administrative means identified by applicable professional licensure boards, state laws, and regulatory requirements.

Key Definitions

- *Expected Death* denotes a death that was consistent with, and as a result of, an individual's previously diagnosed terminal condition. A death can be expected if the person had a known terminal condition (*e.g.*, end stage renal disease) or if the person was elderly and had a period of deterioration and increasing medical frailty. In both cases, the person, family and caregivers were aware that the condition was terminal, end of the life decisions were made, and primary health care and/or palliative care teams were involved.
- *Unexpected Death, which includes unexplained deaths,* denotes a death that occurred as a result of an acute medical event, accident, or other event that was not expected within the context of a person's known medical conditions or not attributable to an identified cause.
- *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 Deaths* are deaths that are considered premature and may have been avoided based on a combination of known medical, genetic, social, environmental, or other factors.

Virginia Deaths

In SFY 2019, the MRC revised the categories it uses to classify causes of death. Most notably, the committee added acute respiratory failure and aspiration pneumonia as causes of death for SFY 2019, distinguishing them from respiratory disease and aspiration, respectively. One possible explanation for the decline in deaths due to aspiration and respiratory disease during SFY 2019 is the added clarity of the new categories used for cause of death.

The MRC classified more deaths as "unknown" in SFY 2019 (42 deaths, 13.5%) than in any fiscal year prior to 2016. Approximately 22 percent of all decedents who resided in private residences had unknown causes of death. Obtaining documentation related to the circumstances leading up to the death of individuals living in private residences poses a challenge as medical and other pertinent clinical information is often not provided through the DBHDS incident reporting system. The challenge of lack of data for the deaths classified as "unknown" may have impacted the validity of the unexpected death classification, and could impact the number and rate of potentially deaths.

Unlike deaths in which the specific cause of death is "unknown", deaths classified as "other" causes have known etiologies that exist outside of the MRC's primary categories for statistical trending. The MRC classified 14 deaths as having "other" causes of death in SFY 2019. The most common causes of "other" deaths in SFY 2019 were traumatic brain injury (4 deaths) and GI disease (3 deaths). The remaining seven cases were comprised of one or two occurrences of each.

Table 1 Number of Annual Deaths by Cause of Death, SFY 2016 – 2019[1]
(Sorted by Frequency in 2019)

Cause of Death	2016	2017	2018	2019	Total
Unknown	47	31	34	42/24	154
Acute Respiratory Failure*	-	-	-	31/16	31
Cancer	41	14	23	30/14	108
Sudden Cardiac Death	39	35	22	22/9	118
Pneumonia	27	27	21	20/7	95
Sepsis	30	14	14	20/10	78

1 In Table 1, causes of death marked with a single asterisk (*) were added by the MRC in SFY 2019. Fields marked with a hyphen (-) do not have measureable values because the categories used to classify deaths did not exist at the time of the committee determinations. Finally, the totals marked with two asterisks (**) differ from previously reported totals due to unreported deaths that were recently identified by DBHDS – one in SFY 2017 and one in SFY 2018.

Cause of Death	2016	2017	2018	2019	Total
Neurodegenerative Disease	3	3	4	18/2	28
Heart Disease	23	22	19	17/8	81
Other	21	15	24	14/3	61
Aspiration Pneumonia*	-	-	-	13/4	13
Complications of a Congenital Condition	-	-	2	13/10	15
FTT/Slow Decline	6	7	4	10/4	27
Kidney Disease	10	9	9	10/5	38
Complications of a Genetic Condition	-	6	11	9/8	26
Multiple Medical Problems	-	7	10	8/3	25
Bowel Obstruction	8	4	7	7/2	26
Seizure	0	10	6	7/3	23
Stroke	10	3	3	7/2	23
Respiratory Disease	17	22	18	6/4	63
Aspiration	14	13	25	5/1	57
Postoperative Complications	15	6	5	3/1	29
Total	**311**	**248****	**261****	**312/140**	**1,132**

For the SFY 2019 column in Table 1 above, the first number is the total number of deaths for that category and the second number indicates that number of those deaths where the individual was not receiving a DBHDS-licensed residential service. This number is an estimate based on the groupings that were available at the time of the review. In SFY 2020, the MRC will incorporate a process within the mortality review deliberations wherein a definitive determination as to whether the individual was receiving a DBHDS-licensed service is made.

Expected and Unexpected Deaths

Immediately following the cause of death determination, the MRC determines whether a death was expected or unexpected. The leading causes of unexpected deaths in SFY 2019 were "unknown" (34) and cardiac arrest (15). The leading cause of expected deaths was cancer (27).

Fig.1 Expected and Unexpected Deaths, SFY 2016-2019

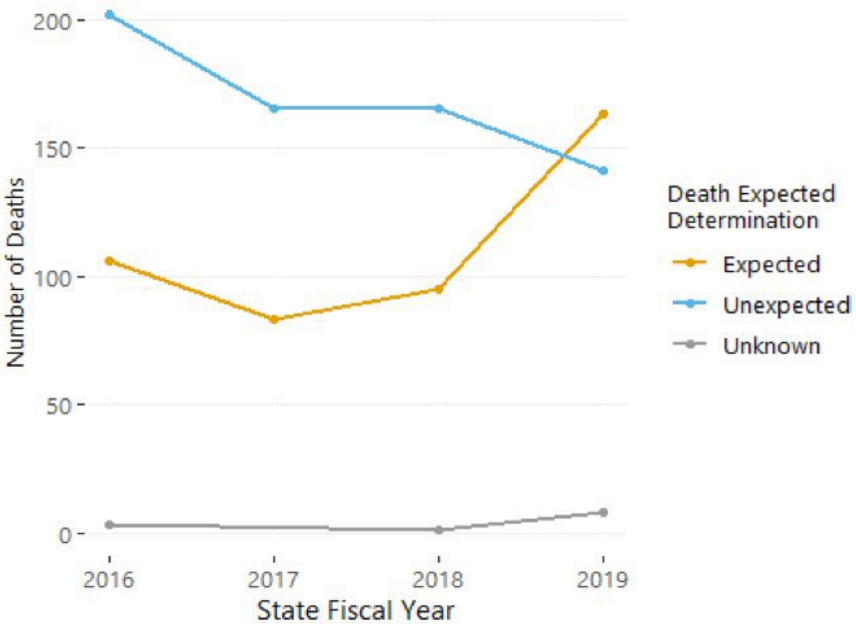


Table 2 Expected and Unexpected Deaths, SFY 2016-2019

Determination	2016		2017		2018		2019	
	Deaths	Percent	Deaths	Percent	Deaths	Percent	Deaths	Percent
Expected	106	34.1%	83	33.5%	95	36.4%	163	52.2%
Unexpected	202	65.0%	165	66.5%	165	63.2%	141	45.2%
Unknown	3	1.0%	0	0	1	0.4%	8	2.6%

For the first time since the MRC began reviewing deaths in 2013, the committee determined more deaths to be expected than unexpected. This increase from SFY 2018 is attributed to the expanded MRC membership that included; a broader range of clinical subject matter experts, increased attendance and participation of committee members, clarification of expected and unexpected (unexplained) definitions and identification of contributing factors to that individual's death. The additional 71.5% increase in the number of deaths may also have been a factor.

Potentially Preventable Deaths

In SFY 2019, the MRC continued a process first implemented in SFY 2018 to identify potentially preventable deaths and collect information related to contributing factors in these deaths. In addition, the MRC ensures one of the following factors is always identified for each potentially preventable case. The MRC may also identify one of these four factors for deaths that were not potentially preventable, if circumstances warrant. Through this process, the MRC assessed not only whether actions leading to the

death itself were preventable, but also whether co-morbid conditions existed that were potentially preventable.

For a death to be determined potentially preventable, 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:

1. Coordination of care (including medication management)
2. Access to care, including delay in seeking treatment
3. Execution of established protocols
4. Assessment of the individual's needs or changes in status

In SFY 2018, the MRC classified 56 deaths (21%) as potentially preventable. By contrast, in SFY 2019, the MRC classified only 11 deaths (4%) as potentially preventable. The MRC notes this dramatic change in year to year data may be due to; In SFY 2019, the MRC made significant changes to improve the processes of the committee and its structure. Changes included increased membership to include a broader range of clinical and systems subject matter experts, increased participation of committee members and attendance, clarification of definitions of potentially preventable and identifying contributing factors to the individuals death. These changes have likely contributed to the committee's ability to more clearly make determinations related to potentially preventable deaths. However, since the definition of a potentially preventable death was only first introduced in SFY 2018 and multiple changes have occurred in SFY 2019, ongoing monitoring of the effect of these changes is needed in subsequent years.

When the MRC determines a death is potentially preventable, the committee categorizes factors that might have prevented the death. In SFY 2019, nine of the 11 deaths classified as potentially preventable (82%) involved a failure to adhere to established protocols. This contrasts with findings from SFY 2018, but given the small number of potentially preventable deaths in SFY 2019 these differences may be epiphenomenal. The causes of these eleven deaths include one each for sepsis, pneumonia, intracranial hematoma, motor vehicle accident, multisystem organ failure, traumatic brain injury, and complications secondary to impaction, and two each for cardiac arrest and choking.

Table 3 Potentially Preventable Deaths, SFY 2018-2019

Determination	2018		2019	
	Deaths	Percent	Deaths	Percent[2]
Not Potentially Preventable	184	71%	258	83%
Potentially Preventable	55	21%	11	4%
Unknown	20	8%	43	14%

2 Due to rounding, these column percentages add to more than 100 percent.

Population Demographics

This section includes demographic trends for individuals reviewed by the MRC. For SFY 2019, a separate comparison shows mortality rates for individuals receiving DD waiver services.

Age

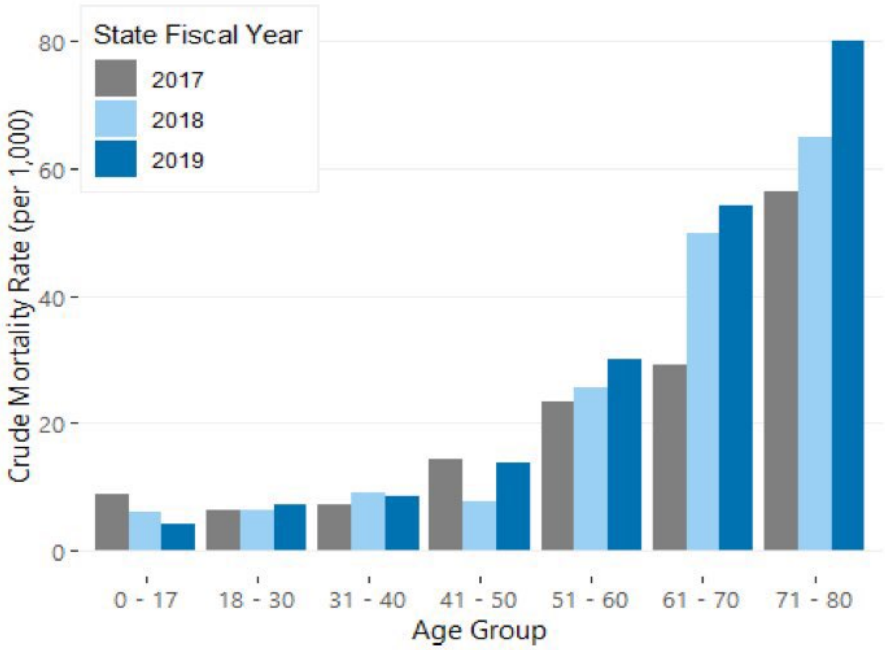
Prior to SFY 2018, the plurality of deaths reviewed by the MRC occurred among individuals 51 to 60 years old. However, in both SFY 2018 and 2019, the plurality of deaths occurred among individuals aged 61 to 70. Approximately two-thirds of all deaths reviewed by the MRC occurred among individuals aged 51 or older.

Table 4 Crude Mortality Rates by Age per 1,000 population, SFY 2019

Age Group	Deaths	DD Waiver Population	Crude Mortality Rate
0 - 17	4	945	4.2
18 - 30	31	4,218	7.3
31 - 40	23	2,710	8.5
41 - 50	26	1,885	13.8
51 - 60	61	2,032	30
61 - 70	65	1,202	54.1
71 - 80	28	350	80
81 or Greater	6	58	103
Unknown	0	3	0
Total	**244**	**13,403**	**18.20**

- Between SFY 2017 and 2019, the crude mortality rate increased for all age groups between 51 and 80 years of age. Among individuals 0 to 17 years of age, the crude mortality rate has decreased from 8.9 deaths per 1,000 population in SFY 2017 to 4.2 deaths per 1,000 population in SFY 2019. The median age at time of death was 58 years; the mean age at death was 54 years. While other states' mortality review reports may not directly equate to the Virginia population being reported on through this report, these median ages of death fall within similar ranges reported by other states (*e.g.*, 2018 Annual Report, GA Dept. of Behavioral Health and Developmental Disabilities; 2017 Mortality Data Review, Indiana Division of Disability and Rehabilitative Services).

Fig. 2 Crude Mortality Rates by Age per 1,000 population, SFY 2017-2019



Gender

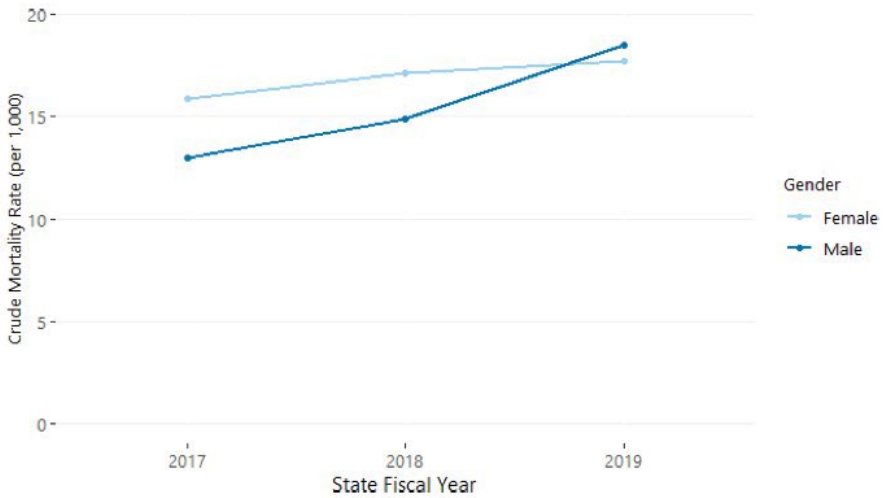
Males comprised the majority of individuals whose deaths were reviewed by the MRC in SFY 2019, consistent with trends from previous fiscal years.

Table 5 Crude Mortality Rates by Gender per 1,000 population, SFY 2019

Gender	Deaths	DD Waiver Population	Crude Mortality Rate
Female	94	5,304	17.7
Male	150	8,093	18.5
Unknown	0	6	0
Total	**244**	**13,403**	**-**

Between SFY 2017 and 2019, the crude mortality rates increased within both gender groups on the DD waiver. The crude mortality rate among females on the DD waiver increased from 15.9 deaths per 1,000 population in SFY 2017 to 17.7 deaths per 1,000 population in SFY 2019. Among males on the DD waiver, the crude mortality rate increased from 13 deaths per 1,000 population in SFY 2017 to 18.5 deaths per 1,000 population in SFY 2019. For the first time since DBHDS began reporting crude mortality rates in SFY 2017, the crude mortality rate among males on the DD waiver surpassed the rate for females.

Fig. 3 Crude Mortality Rates by Gender per 1,000 population, SFY 2017-2019



The leading cause of death among males in SFY 2019 was "unknown" (22, 11%), followed by cancer (16, 8%), and then cardiac arrest and septicemia (both accounting for 15 deaths). Among females, the leading cause of death in SFY 2019 was also "unknown" (20, 17%), followed by cancer (14, 12%), and then respiratory failure (10, 8%).

Race

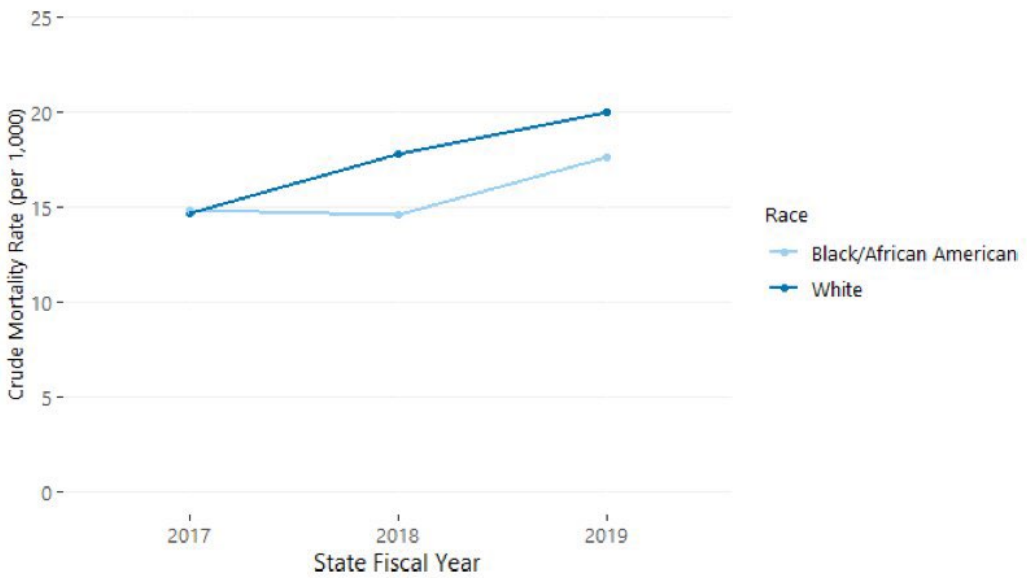
Consistent with data from previous years, the majority of deaths reviewed by the MRC were of individuals identified as White (225 deaths, 72%). Individuals identified as Black/African American accounted for 26 percent of deaths reviewed by the committee. Individuals of all other races combined for approximately 2 percent of deaths reviewed by the committee. Racial disparity of deaths warrant a closer examination of the psychosocial contributing factors.

Table 6 Crude Mortality Rates by Race per 1,000 population, SFY 2019

Race	Deaths	DD Waiver Population	Crude Mortality Rate
Caucasian	170	8,482	20
African American	69	3,928	17.6
Other	5	931	5.4
Unknown	0	62	0
Total	**244**	**13,403**	**-**

The crude mortality rate among individuals identified as Caucasian on the DD waiver was 20 deaths per 1,000 population in SFY 2019 – an increase from 17.8 deaths per 1,000 population in SFY 2018. Similarly, the crude mortality rate among individuals identified as African American on the DD waiver also increased from 14.6 deaths per 1,000 population in SFY 2018 to 17.6 deaths per 1,000 population.

Fig. 4 Crude Mortality Rates by Race per 1,000 population, SFY 2017-2019



SIS Level

DBHDS uses the Supports Intensity Scale (SIS) to assign individuals on a DD waiver to one of seven levels, labeled 1 through 7, related to their support needs. These levels were developed by DBHDS and its consultants, with Level 1 representing individuals with the fewest support needs while Levels 6 and 7 represent individuals with the greatest need for support. While a plurality of all individuals reviewed by the MRC in SFY 2018 were on SIS Level 4, the plurality of DD waiver recipients during that time were on SIS Level 2.

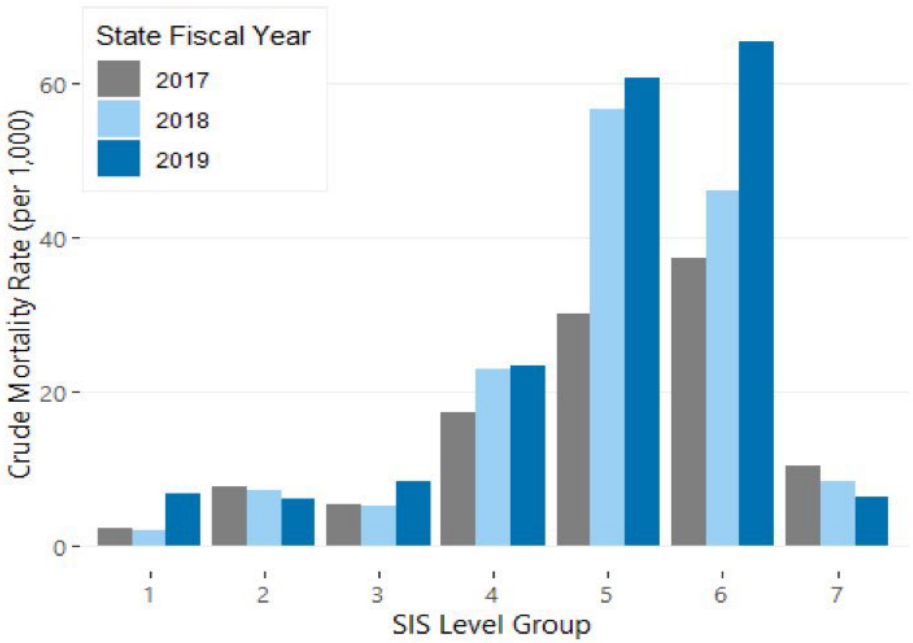
Table 7 Crude Mortality Rates by SIS Level per 1,000 population, SFY 2019

SIS Level Group	Deaths	DD Waiver Population	Crude Mortality Rate
1	6	882	6.8
2	33	5,345	6.2
3	5	596	8.4
4	103	4,382	23.5
5	14	231	60.6
6	77	1,178	65.4
7	5	784	6.4
Total	243	13,398	_

From SFY 2018 to 2019, the crude mortality rate increased for individuals on the DD waiver with all SIS Levels except those of 2 and 7. In fact, the crude mortality rates in SFY 2019 are the highest they have been for individuals on the DD waiver with SIS Levels of 1, 3, 4, 5, and 6 since DBHDS began reporting this

data in SFY 2017. By contrast, the crude mortality rate decreased slightly for those individuals with a SIS Level of 2 or 7, continuing a trend from SFY 2017 through SFY 2018. SIS level 6 captures the population of individuals with the highest level of intensive medical needs, which correlates with the highest crude mortality rate of all individuals on the waiver; however, additional data analysis is needed to better understand potential contributing factors associated with each SIS level.

Fig. 5 Crude Mortality Rates by SIS Level Group per 1,000 population, SFY 2017-2019



Residential Setting

Due to the low number of individuals in certain residential settings, the MRC analyzed death reviews using the following groupings for residence types: independent living, congregate living, institutional living, state facility, and unknown.

For the purposes of this report:

- *Independent Living* includes family homes, sponsored placement, supported living, supervised living, and private residences where the individual may be living independently or with less than 24-hour supervision.
- *Congregate Living* is a residential service that provides 24-hour supervision in a community-based home with other residents. Settings include group homes and congregate community residential settings.
- *Community Institutional Living* is a non-state operated setting in the community that provides comprehensive and individualized health care and rehabilitation services to individuals. Institutional settings include inpatient care, nursing home/physical rehabilitation, residential ICF-IID, residential treatment/alcohol and drug rehabilitation, and other institutional settings.

- *State Facilities* include training centers, including Hiram Davis Medical Center, and state hospitals where an individual had a DD diagnosis at the time of death based on ICD-10 codes.
- *Unknown* means the residence type was unknown at the time of death and MRC review.

Table 8 Deaths by Residential Setting, SFY 2016-2019

Residential Living Group	2016		2017		2018		2019	
	Deaths	Percent	Deaths	Percent	Deaths	Percent	Deaths	Percent
Congregate Setting	107	34.4%	82	33.1%	109	41.8%	147	47.1%
Facility	26	8.4%	20	8.1%	15	5.8%	16	5.1%
Independent Living	118	37.9%	100	40.3%	106	40.6%	127	40.7%
Institutional Setting	39	12.5%	40	16.1%	31	11.9%	20	6.4%
Unknown	21	6.8%	6	2.4%	0	0	2	0.6%
Total	**311**	-	**248**	-	**261**	-	**312**	-

The increase in crude mortality rates for congregate settings is attributed to the record number (312) of cases reviewed in SFY 2019, which is higher than in any previous year.

As in SFY 2018, the MRC reviewed fewer deaths among those living independently in SFY 2019 than among those living in congregate settings. In SFY 2019, the leading cause of death among those living independently was "unknown" (24, 19%), followed by cancer (15, 12%) and respiratory failure (11, 9%). If the decedent lived in a private home, lived independently, or resided in a nursing facility, the MRC is far less likely to have access to sufficient information to conduct a review. The MRC may request information from these settings or from a family, but the committee has no authority to require documentation from non-licensed settings.

Among those individuals who lived in congregate settings, the leading cause of death in SFY 2018 was "other" (16, 14.7%), followed by sudden cardiac death (15, 13.8%). "Unknown" (5, 16.7%), followed by pneumonia (4, 13.3%), were the leading causes of death among individuals who resided in institutional settings. Pneumonia (3, 20%) was the leading cause of death among those who resided in facilities.

Among those individuals who lived in congregate settings, the leading cause of death in SFY 2019 was "other" (19, 12.9%), followed by "unknown" (16, 10.9%). Kidney disease and respiratory failure (each 3, 15%), were the leading causes of death among individuals who resided in institutional settings. Heart disease (3, 18.8%) was the leading cause of death among those who resided in facilities.

As in fiscal years 2017 and 2018, the majority of deaths reviewed by the MRC in SFY 2019 were of individuals who lived in congregate settings. While fewer than 35 percent of individuals on the DD waiver

or receiving a licensed service, reside in congregate settings, this population accounted for more than 56 percent of all deaths reviewed by the MRC.

Table 9a Crude Mortality Rates by Residential Setting per 1,000 population, SFY 2019

Residential Living Group	Deaths	DD Waiver Population	Crude Mortality Rate
Congregate Living	134	4,624	29
Independent Living	102	8,779	11.6
Total	**236**	**13,403**	**-**

Table 9b Crude Mortality Rates by Residential Setting per 1,000 population, SFY 2019

Residential Living Group	Deaths	Population Estimate	Crude Mortality Rate
Facility	16	347	46
Institutional	20	8,633	2.3

Table 9a presents the crude mortality rates of individuals on a DD Waiver or receiving a licensed service in SFY 2019. There are 13 individuals that died in a congregate setting and 25 in an independent setting that were not on a waiver (not receiving a licensed service) and were not included in these rates. Their exclusion from the calculation of these rates is due to the total population (denominator) of individuals living in these settings not being known or able to be estimated by DBHDS.

Table 9b presents the crude mortality rates of individuals in non-waiver settings. Estimates of the population are based on the midpoint of the SFY. The "Institutional" group includes several settings where the total population is unknown to DBHDS resulting in the crude mortality rate to be a conservative estimate.

Between SFY 2017 and 2019, the crude mortality rate for individuals living in congregate settings increased faster than the rate for those living independently. In SFY 2019, the crude mortality rate among those living in congregate settings was 29 deaths per 1,000 population, an increase from 23.7 deaths per 1,000 population in SF18 and SFY 2017's rate of 16.6 deaths per 1,000 population. In contrast, the crude mortality rate among those living independently increased from 9.6 deaths per 1,000 population in SFY 2017 to 9.9 deaths per 1,000 population in SFY 2018 and 11.6 deaths per 1,000 population in SFY 2019. Data from the past three years is indicative of a trend, and further analysis is needed to determine the contributing factors to this increase rate in both congregate and independent living settings.

Less than 1 percent of all deaths reviewed by the MRC among those who lived independently were potentially preventable (3 deaths), while approximately 2.6 percent of deaths among those in congregate settings were potentially preventable (8 deaths).

Individuals Discharged from Training Centers

For decades, DBHDS has worked to transition individuals residing in state-funded training centers into more inclusive, community-based supports. The pace of this shift has increased dramatically since 2011, prompted by the Commonwealth's decision to close four training centers. Deaths among individuals
discharged from training centers receive an additional review by the Community Integration Project Team.

In SFY 2019, the MRC reviewed 36 deaths among individuals discharged from a training center into the community (community tenure). Aspiration pneumonia was the leading cause of death among individuals discharged from training centers (7, 19.4%), followed by septicemia (5, 13.9%). One death that occurred among those discharged from training centers was potentially preventable.

Community tenure continued to increase in SFY 2019, and the average age at death among individuals discharged from training centers increased from 62 years in SFY 2017 and 60 years in SFY 2018 to 64 years in SFY 2019. Community tenure is defined as the length of time an individual spent in the community between the date of discharge from a training center (under the Commonwealth's settlement agreement with the United States Department of Justice) and the individual's date of death. Individuals who transfer to another facility or out-of-state are not considered discharges to the community and do not have community tenure. Due to the shifting population out of training centers, mortality rates for individuals that died in a training center are subject to large fluctuations. Such a rate would be considered unstable, and is therefore not included in this report.

Table 10 Age at Death and Community Tenure for Individuals Discharged from Training Centers

SFY	Deaths	Average Age at Death	Average Community Tenure (months)
2015	16	60	17
2016	28	59	22
2017	23	62	31
2018	31	60	39
2019	36	64	45

Conclusion

As a commitment to the Commonwealth of Virginia, DBHDS and the Mortality Review Committee continue to improve the system of care through integration of clinical evidence, data-driven determinations and evidence-based quality improvement recommendations. The Commonwealth continues to make significant improvements in the delivery of state system care to meet the health and wellness needs of individuals with intellectual and developmental disabilities. Identification of risk factors and development of specific systemic interventions are essential to making a positive impact on the reduction of preventable deaths. Promoting the health, safety, and well-being of these individuals and their families, in order to promote overall quality of life and life-expectancy,

continues to be the primary goal for service providers in the Commonwealth.

Acronym Glossary

Acronym	
ANE	Abuse, Neglect and Exploitation
CC	Community Coaching
CCS3	Community Consumer Submission
CE	Community Engagement
CHRIS	Comprehensive Human Rights Information System
CMS	Centers for Medicare and Medicaid Services
CMSC	Case Management Steering Committee
CSBs	Community Services Boards
CTH	Crisis Therapeutic Home
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
DMAS	Department of Medical Assistance Services
DSP	Direct Support Professional
GSE	Group Supported Employment
HCBS	Home and Community Based Services
IHI	Institute of Healthcare Improvement
IMU	Incident Management Unit
ISE	Individual Supported Employment
KPA	Key Performance Area
MRC	Mortality Review Committee
NCI	National Core Indicators
OCQI	Office of Community Quality Improvement
ODQV	Office of Data Quality and Visualization
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
PMI	Performance Measure Indicator
PREP	Provider Readiness Education Program
QIC	Quality Improvement Committee
QMR	Quality Management Review
QMS	Quality Management System
QRT	Quality Review Team
QSR	Quality Service Review
REACH	Regional Education Assessment Crisis Services Habilitation
RMRC	Risk Management Review Committee
RQC	Regional Quality Council
RST	Regional Support Team
SCQR	Support Coordinator Quality Review
SFY	State Fiscal Year
WaMS	Waiver Authorization Management System
WPA	Workplace Assistance

Quality Management Program Assessment Tool

Developed by HRSA's HIV/AIDS Bureau and the National Quality Center
Source – Institute for Healthcare Improvement*

Date completed: _____
Staff completing: _____

Quality Management Plan					
A.1. Is a comprehensive statewide quality management plan in place with clear definitions of leadership, roles, resources and accountability?					
Score 0	**Score 1**	**Score 2**	**Score 3**	**Score 4**	**Score 5**

Score 0	Program has no or minimal written quality plan in place; if any in existence, written plan does not reflect current day-to-day operations.
Score 1	Program has only loosely outlined a quality management plan; written plan reflects only in part current day-to-day operations.
Score 2	
Score 3	A written statewide quality management plan is developed describing the quality infrastructure, frequency of meetings, indication of leadership and objectives; the quality plan is shared with staff; the quality plan is reviewed and revised at least annually; some areas of detail and integration are not present.
Score 4	
Score 5	A comprehensive and detailed specific, statewide quality management plan is developed/refined, with a clear indication of responsibilities and accountability across the department, quality committee infrastructure, outline of performance measurement strategies, and elaboration of processes for ongoing evaluation and assessment; engagement of other department representatives is described; quality plan fits within the framework of other statewide QI/QA activities; staff and providers are aware of the plan and are involved in reviewing and updating the plan.
Comment:	

A.2. Are appropriate performance and outcome measures selected, and methods outlined to collect and analyze statewide performance data?					
Score 0	**Score 1**	**Score 2**	**Score 3**	**Score 4**	**Score 5**

Score 0	No appropriate performance or outcome measures are selected; methods to collect and analyze statewide performance data are not outlined.
Score 1	Only those indicators are selected that are minimally required; no process takes place to annually review and update indicators and its definitions; methods to collect data are not described.
Score 2	
Score 3	Selection of indicators is based on results of past performance data and some input of departmental representatives; indicators include appropriate clinical or support service

	measures; indicators reflect accepted standards of care; indicator information is shared with staff; processes are outlined to measure and analyze statewide performance data.
Score 4	
Score 5	Portfolio includes clinical and support service indicators with written indicator descriptions; measures are annually reviewed, prioritized and aligned with quality goals; all indicators are operationally defined, and augmented with specific targets or target ranges, including desired health outcome; performance measurement activities include partnering with other agencies, and unmet need are integrated; statewide data collection plans are clearly outlined and strategies to analyze data are detailed.
Comment:	

A.3. Does the work plan specify timelines and accountabilities for the implementation of the statewide quality of care program?

Score 0	Score 1	Score 2	Score 3	Score 4	Score 5

Score 0	No work plan is specified for the implementation of the statewide quality of care program.
Score 1	A work plan is only loosely outlined; no specific timelines for the implementation of the statewide quality of care program are established; no formal process to assign timelines and responsibilities; follow-up of quality issues only as needed.
Score 2	
Score 3	A written, annual work plan which outlines the implementation is in place; timetable is shared with appropriate staff; updates in the work plan are discussed in quality committee(s); quality activities are planned before execution.
Score 4	
Score 5	A process to assign timelines and responsibilities for quality activities is in place and clearly described; annual plan for resources is established; staff are aware of timelines and responsibilities; quality committees are routinely updated and consulted on the implementation of the statewide quality program.
Comment:	

Organizational Infrastructure

B.1. Does the program have an organizational structure in place to oversee planning, assessment and communication about quality?

Score 0	Score 1	Score 2	Score 3	Score 4	Score 5

Score 0	No quality structure is in place to oversee planning, assessment and communication about quality.
Score 1	Only a loose quality structure is in place; a few representatives are involved; knowledge of quality structure among staff is limited.
Score 2	
Score 3	Senior representatives heads the quality program; representatives from some internal departments are represented in the quality structure; findings and performance data results are shared; staff for the quality program are identified; resources for the quality program are made available.

Score 4	
Score 5	Senior leaders actively support the program infrastructure and planned activities; key staff are identified and supported with adequate resources to initiate and sustain quality improvement activities; staff are routinely trained on quality improvement tools and methodologies; findings and performance data results are frequently shared internally and externally.
Comment:	

B.2. Is a quality management committee with appropriate membership established to solicit quality priorities and recommendations for quality activities?

Score 0	Score 1	Score 2	Score 3	Score 4	Score 5

Score 0	No quality management committee is established to solicit quality priorities and recommendations for quality activities.
Score 1	Quality meetings are held with only a few members; ad hoc meetings are only used to discuss immediate issues.
Score 2	
Score 3	Quality committee is established that engages various representatives; routine quality committee meetings are held to solicit quality priorities and recommendations for quality activities; reporting of committee updates in place.
Score 4	
Score 5	Senior leader, key providers and consumer representatives are actively involved in quality committee(s) to establish priorities and solicit recommendations for current and future quality activities; membership is reviewed and updated annually; quality meetings include written minutes and reporting mechanisms.
Comment:	

B.3. Does the quality program involve providers, consumers and representatives?

Score 0	Score 1	Score 2	Score 3	Score 4	Score 5

Score 0	Quality program does not involve providers, consumers and other representatives.
Score 1	Quality program includes only internal staff, with limited input from other departments; neither providers nor consumers are involved.
Score 2	
Score 3	Representatives from a few departments, providers and at least one consumer representative are participating in quality committee meetings.
Score 4	
Score 5	Representatives from all appropriate internal offices, providers and consumers are actively engaged in the statewide quality of care.
Comment:	

B.4. Are processes established to evaluate, assess and follow up on quality findings and data being used to identify gaps?

Score 0	Score 1	Score 2	Score 3	Score 4	Score 5

Score 0	Processes are not established to evaluate, assess and follow up on quality findings.
Score 1	No processes are established to evaluate the quality program; quality infrastructure and its activities are reviewed only if necessary; when establishing/updating the annual work plan, past performance is not considered; quality of care program does not learn from past successes and failures.
Score 2	
Score 3	Review process is in place to evaluate the quality infrastructure, and assess the performance data; findings are generated for follow up and used to plan ahead; summary of findings are documented.
Score 4	
Score 5	Process to annually assess effectiveness of quality program; data findings are used to identify gaps in care and service delivery; staff are actively involved; assessments and follow ups are documented; leadership is well aware and involved in evaluation of quality program; findings and past performance scores are used to facilitate and shape quality program.
Comment:	

Implementation of Quality Plan and Capacity Building					
C.1. Are appropriate performance data collected to assess the quality of care and services statewide?					
Score 0	**Score 1**	**Score 2**	**Score 3**	**Score 4**	**Score 5**

Score 0	No performance data are collected to assess the quality of care and services statewide.
Score 1	Basic performance measurement systems are in place; only utilization data are collected; no process established to share data or only used for punitive purposes; data are not collected statewide.
Score 2	
Score 3	A system to measure key quality aspects among providers is established; data are collected, analyzed and routinely disseminated to providers; data are collected from most providers around the state.
Score 4	
Score 5	The quality, including clinical and support services across the state, is measured by selected process and include outcome measures; organizational assessments of provider quality infrastructures are conducted; results and findings are routinely shared with providers to inform and foster quality improvement activities; data are collected from the entire state.
Comment:	

C. 2. Does the quality program conduct quality improvement projects to improve systems and/or quality of care issues?					
Score 0	**Score 1**	**Score 2**	**Score 3**	**Score 4**	**Score 5**

Score 0	The quality program does not conduct quality improvement projects to improve systems and/or quality of care issues.

Score 1	Quality improvement activities focus on individual cases or incidents only; projects are primarily used for inspection; selection of quality activities is done by single person.
Score 2	
Score 3	A few staff members have input in the selection of quality projects; quality improvement activities focus on issues related to structures and processes only; at least one quality project was conducted in the last 12 months to improve systems and/or quality of care issues; internal quality improvement activities are tracked.
Score 4	
Score 5	Structured process of selection and prioritization of quality projects is in place; quality improvement projects are informed by the data and are outcome related; staff across several departments is involved in quality improvement projects; findings are routinely shared with entire staff, presented to the quality committee, and used to inform subsequent projects.
Comment:	

C.3. Does quality program offer QI training and technical assistance on quality improvement to providers?

Score 0	Score 1	Score 2	Score 3	Score 4	Score 5

Score 0	The quality program does not offer QI training and/or technical assistance on quality improvement to providers.
Score 1	No structured process in place to train providers on quality improvement; limited technical assistance resources available for providers to build capacity for quality improvement.
Score 2	
Score 3	Capacity to train providers and provide technical assistance on quality improvement is available; process in place to triage TA requests from individual providers; some resources are available and mostly used in response to TA requests.
Score 4	
Score 5	A quality workshop program is established to routinely train clinical and service providers on quality improvement priorities, tools and methodologies; an annual training schedule is developed with quality topics based on needs assessment including input by providers; trainings are well attended and evaluations are routinely kept and analyzed and used to improve future training; technical assistance is provided to clinical and service providers through on-site visits by quality experts.
Comment:	

Virginia Department of Behavioral Health & Developmental Services

Case Management Steering Committee

Semiannual Report

1st and 2nd Quarter Fiscal Year 2019

I. Overview

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) undertook a focused effort beginning at the onset of state Fiscal Year (FY) 2018 to improve case management services in Virginia. This effort included multiple facets including adding to the scope of work in a contract with Virginia Commonwealth University Partnership for People with Disabilities (PPWD), whose first deliverable was a study of Developmental Disability (DD) support coordination/case management in Virginia. In addition, in January 2018, a memo from Interim DBHDS Commissioner, Dr. Jack Barber, went out to all CSB Executive Directors which identified nine outcomes needed to meet the expectations of the DOJ Settlement Agreement, along with a self-assessment with ten questions to which each community service board was asked to respond.

Based on the preliminary findings of the study of DD support coordination/case management by the PPWD and the results of the CSB self-assessment activities (see Section II of this report), DBHDS initiated multiple additional activities designed to support the case management system as a whole. DBHDS undertook additional projects focusing on: technical support during DBHDS Case Management Quality Reviews site visits; assuming regulatory duties of the DD waiver waitlist; development of Person Centered ISP Guidance; funding for exploration of Transactional DD Case Management duties; and Individual Support Plan (ISP) streamlining in coordination with the Virginia CSB Board.

Due to the volume of activities underway and the complexity of the Case Management system, DBHDS established an internal Case Management Steering Committee in June 2018 to oversee and coordinate the various activities currently underway to strengthen the Case Management system. Committee membership includes DBHDS Waiver Operations, Provider Development, Community Quality Improvement, Office of Licensing, Settlement Agreement, and Data Quality and Visualization representatives. The committee gathers face to face bi-monthly and maintains an interactive information sharing system for ongoing project oversight, and assessment of case management quality and effectiveness.

II. Purpose

As described in the committee charter of the Steering Committee, the overall goal is to

ensure and oversee the coordination of all internal/external quality improvement activities that affect both the transactional and transformational components of case management; identify strengths, weakness and gaps in newly implemented products and processes and make recommendations for improvement to the DBHDS Quality Improvement Committee (QIC). The Steering Committee will ultimately be responsible for the ongoing coordination of the intake and processing of case management/support coordination data and information, and oversee quality improvement protocols at the direction of the QIC.

III. Findings from CSB Self-Assessment and PPWD Study

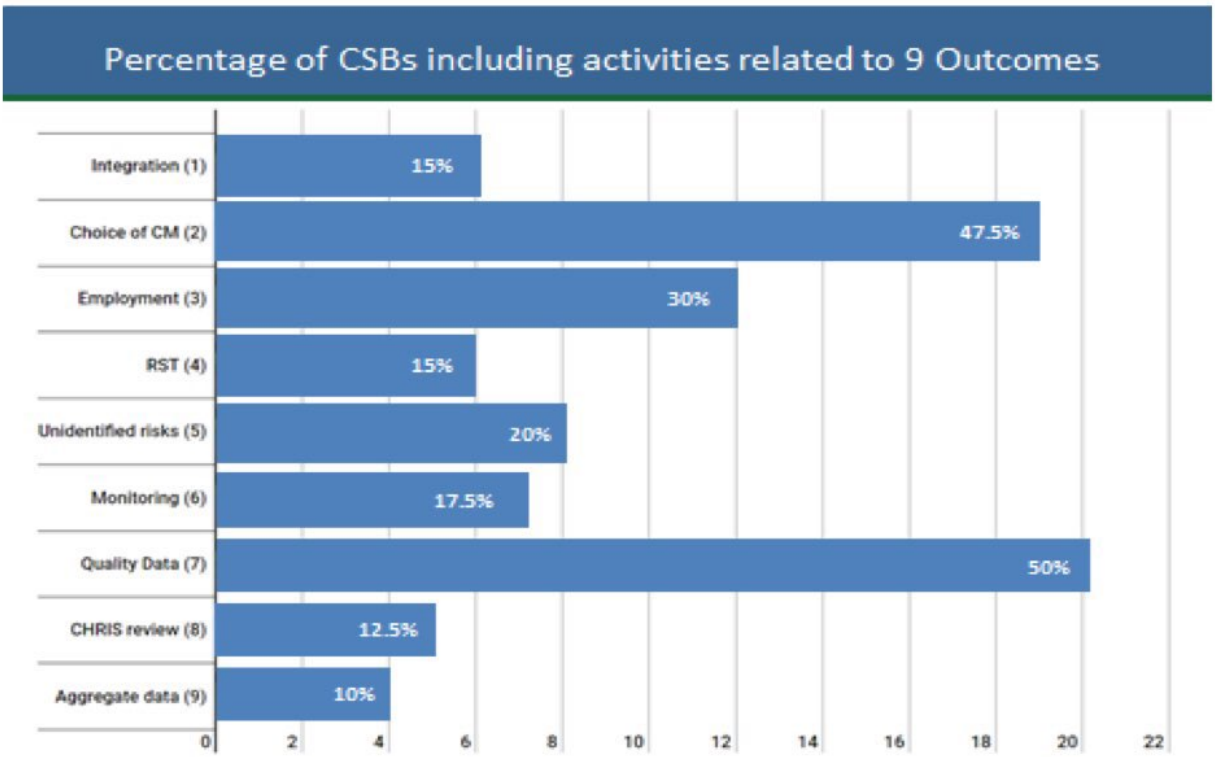
CSB Self-Assessment

All 40 CSBs submitted their self-assessments by the May 15, 2018 due date. DBHDS reviewed and prepared a preliminary set of presentation slides on aggregated data, and submitted an individualized response to each CSB in October 2018. These response letters included an optional outcome tracking tool for CSBs to use in tracking the current status, validation measure, and action steps for achieving each of the nine outcomes.

The bar graph below represents the aggregate data on CSB reported activities that correspond to activities related to the nine outcomes: (1) Annual assessments (at a minimum) need to reflect that CMs are examining opportunities to increase the individual's integration in terms of residence, employment, and social/recreational activities, i.e. that we do not accept the status quo (even though it may take a long time or may never happen). (2) CSBs are offering a choice of service providers, including choice/changing of case manager annually. (3) The ISPs indicate that case managers are developing and discussing employment services and goals. (4) CMs are submitting timely referrals to the CRCs and the Regional Support Teams per the RST criteria/protocol. (5) The plans indicate assessment of the individual's previously "unidentified risks … or other changes in status and address medical and behavioral risks/needs". (6) Records indicate appropriate CM monitoring of the individual support plans with recorded assessments as to whether the individual's support plan is being implemented appropriately. (7) The data submitted by the CSBs are reliable for quality and integrity and reflected in the Department's dashboards. (8) Documentation that CMs are reviewing available CHRIS data for those individuals for whom they provide case management. (9) Aggregate data with respect to employment, day activities, and residence need to demonstrate increases in the numbers and percentages of more, versus less, integrated

services and activities.

The outcomes with the greatest percentage CSBs reporting related activities include Quality Data at 50% and Choice of Case Manager at 47.5%. Four of the nine outcome areas fall at or below 15%. They include: RST submissions, exploring opportunities for integration, reviewing CHRIS information and aggregate data.



The CSBs were asked to report on the following questions: (1) Does the organizational structure and distribution of tasks and supports need to be adjusted or changed in order to achieve the outcomes delineated above. (2) Do Policies/Procedures ensure service recipients have choice of providers & case managers and there is internal compliance monitoring inclusive of individual/family feedback? (3) Determine reasonable case load sizes for case managers that take into account intensity level (behavioral and/or medical) and need for enhanced visits on any given case load. (4) Establish on-boarding process for new case managers to ensure sufficient orientation and competency prior to taking on a full case load. (5) Determine reasonable supervision structure including supervisor to

CM ratio and oversight requirements to ensure appropriate management of CM through such things as mandated case/ record review and peer review processes. (6) Review all data systems to ensure internal quality checks are in place prior to submission to ensure reliability of data for use by CSB, DBHDS and other external reviewers. (7) Determine and ensure adequate administrative assistance to support case management functions. (8) Ensure access to sufficient clinical supports for case management functions including clinical case consultation and technical assistance. (9) Ensure job descriptions for case managers include the basic responsibilities of assessment, planning, linkage/referral and monitoring as well as the additional SA requirements that are outlined in the performance contract including: Enhanced Case Management requirements; RST Referrals; and development & discussion of employment goals. (10) Procedures ensure adequate quality assurance, quality improvement and risk management functions are in place and resourced to perform at an acceptable level. Aggregate data from the self-assessment responses reflects that 72.5 percent of the CSBs report having issues with staff turnover.

72.5% of CSBs reported issues with turnover

The memo also introduced the differentiation between transactional and transformational case management activities. As described in the memo, transactional activities satisfy a regulation or requirement, but have little or no impact on the person's quality of life, and may often be done by someone other than the case manager. By contrast, transformational activities are fundamental to the role of the case manager; lead to discovering what people care about; ensure desired changes are pursued, and; supports a person having a voice in his or her life. Multiple improvement activities support efforts to allow case managers more resources for transformation activities.

Findings from PPWD Case Management Study

Findings were divided into seven main categories. (1) General Responsibilities, SCs/CMs largely identified their duties according to code, but there were notable variations in specialization and available administrative support. (2) Caseload Size, most respondents felt current caseloads were unmanageable. Proportions of enhanced case management, individuals with high needs, and long travel times all influenced caseload manageability. (3) Documentation requirements and paperwork reportedly comprised 60-95% of SC/CM workload. Specific redundancies and labor-intensive requirements were identified related to service authorizations, individual support plans, and quarterly reporting. (4) Enhanced Case Management (ECM), SCs/CMs expressed concern that people were placed on ECM unnecessarily. Questions were raised about whether 30-day visits are always needed or productive, especially if a person is behaviorally or medically stable. (5) Provider Relationships, SCs/CMs often found it challenging to obtain information from some service providers, making it difficult for them to adequately monitor services. Some services are difficult to access in some areas of the state. (6) Recruitment, Training, and Retention, rules about university degrees, experience and increasing competition from the private sector make it difficult to find qualified applicants for SC/CM positions. More training on documentation procedures and high-needs populations was desired. Extreme stress, low pay, and changing work demands were described as being the primary drivers of turnover. (7) Commitment to the job, despite challenges, SCs/CMs share a strong desire to provide the best supports possible to people with DD, and have many stories to highlight their efforts to improve people's lives.

IV. Activities for Improvement of Case Management

Based on the findings of the CSB Self-Assessment and PPWD Case Management Study, the following activities were undertaken to improve the system.

DBHDS Case Management Quality Reviews

December of 2017 through July 2018 DBHDS Quality Improvement staff completed onsite technical assistance visits with each of the 40 community services boards (CSBs). Their purpose was to provide consultation and technical assistance on using data to improve case management outcomes. This included assisting each CSB in completing a root cause analysis to identify underlying gaps and/or issues. Each CSB was provided feedback during the review, as well as a document summarizing the visit with recommendations as appropriate and a Quality Improvement Plan. The following key initial findings were reported to DBHDS Quality Improvement Committee, DOJ Attorneys, Independent Reviewer, VA CSB Board, and the Settlement Agreement Stakeholder group: (1) Data coding and mapping issues in combination with lack of consistent ongoing processes to ensure data quality and integrity. (2) Data measure specifications were not clearly defined and/or consistently interpreted. (3) Risks were not consistently identified in ISP and/or not all risks consistently monitored. (4) Individual Support Plan (ISP) outcomes were not measurable. (5) Inconsistent interpretation of Enhanced Case Management (ECM) criteria. (6) Depth of employment and community engagement discussions were not clearly evident in documentation. (7) Employment and community engagement outcomes were inconsistently coded due to lack of clarity about what constitutes an employment and/or community engagement goal.

Developmental Disability Funding

DBHDS solicited applications for approximately $42K for a total of $300,000 in Transactional Developmental Disability funds through an open application process. The funds allow for experimenting with employment models, testing alternate models to support transformational CM activities by reducing time spent on transactional duties. 17 applications were received and 7 approved. A few examples of how the CSBs are using the funds include: (1) On boarding of CM transactional specialist. (2) Tracking causal factors in CM turnover. (3) Tools for identifying stress factors for CMs. (4) Internal quality review of records and data input. December 2018 instructions went out, and initial reports came in January 2019 and served as the initial report in a three step report process with the final due to DBHDS by October 2019.

Developmental Disability Waiver Waitlist Management

In April 2018, DBHDS assumed responsibility for the regulatory requirement that each individual on the Developmental Disability (DD) waivers waiting list receive an annual contact and be requested to update his or her choice of DD waiver services over Intermediate Care Facility (ICF)/IDD placement. To accomplish this, DBHDS has been sending a secure email request (or postal mail for those without email) to each person (and legal representative, if applicable) on the DD waiver waiting list at the beginning of the anniversary month of their addition to the waiting list. This serves as an additional means of lifting transactional duties from community services boards to allow them to give additional focus on the transformational functions embedded in the case management service.

Person Centered ISP Guidance

In response to the need for quality Person Centered Individual Support Plans (PC ISPs) that meet all regulatory requirements and expectations, DBHDS issued guidance for writing and reviewing PC ISPs. The methods and practices include are expected to lead to more success with person-centered planning. Specifically, the measurability of plans is needed for agreement with the Centers for Medicare and Medicaid (CMS) Home and Community Services (HCBS) Settings Regulations, the Settlement Agreement, and DBHDS licensing and developmental disability (DD) waiver regulations. This paper details changes in thinking and writing to improve outcomes for people with DD Waivers in Virginia. Developmental Services developed PC ISP Guidance which was posted June 2018 on Virginia Regulatory Town Hall for public comment. Comments were considered and incorporated as indicated. Training on the new Guidance was initiated.

Virginia Association of Community Service Boards (VACSB) Settlement Agreement Case Management Work Group

In March of 2018 the VACSB with support from DBHDS developed a case management workgroup that included CSBs and DBHDS Developmental Services and Quality Improvement staff to develop strategies to address the nine outcomes and improve the overall quality of case management services. Key results of this workgroup include: (1) May 2018 Key Concerns Chart (2) CSBs implement annual choice of CM agency and CM (3) ISP streamlining to reduce the burden on support coordinators allowing more time for transformational activities (4) ISP specifications drafted with a planned production date of July 2019 to assist in resolving issues identified in extracting data from the EHR into Waiver Management System (WaMS) (5) Online Settlement

Agreement CM Status Report components which DBHDS transferred to an online software tool for interactive data visualization. The tool is currently on hold due to security concerns.

Virginia Commonwealth University Partnership for People with Disabilities (PPWD) contracted in 2017 for the following deliverables:

1. **PPWD VCU Case Management Report**: completed May 2018
2. **Case Management Training Modules** - project to review and modify existing Case Management Training Modules. The voice over is complete and are now in final review with feedback to the PPWD. A Release Memo and a User Guide document with instructions on accessing the new modules have been drafted. Each module includes a competency based assessment. Modules will be maintained on the PPWD website and track completion of modules, provide certificates of completion and reports Support Coordinators/Case Managers hired after April 1st 2019 are required to complete all 11 modules within 30 days of employment.
3. **Case Management Manual:** Case Management Manual is intended to clearly articulate the mission and values of the Virginia case management system; coordinated with the development of the training modules; describe the roles and responsibilities of case managers, describe the case management process; explain how CM activities are to be conducted and documented as well as be a resource tool for all new and veteran case managers to improve statewide consistency. The Manual was released for public comment in December 2018 and posted for comment on Town Hall through January 2019. Feedback on the comments and internal recommendations are being considered for final changes in the manual. This was shared with the PPWD to incorporate in the final on-line manual. The manual will be hosted on the PPWD website with a release date no later than April 1, 2019.
4. **Quality Review Tool:** A comprehensive quality review tool was developed to increase consistency among all case management monitoring activities. The Quality Review Tool for use by case management supervisors is currently drafted in Qualtrics software for demonstration and discussion with a PPWD stakeholder workgroup and with a demonstration period April, May, and June of 2019.
5. **Core Competencies:** The contract included the development of Support

Coordination/Case Management core competencies. At this time, competencies are included in the revised training modules and quality review tool.

V. Data Reports Reviewed by the Steering Committee

During this reporting period, the CM Steering Committee reviewed the following data reports: Community Consumer Submission (CCS3) on Case Management which includes data submitted by CSBs and compiled by the DBHDS Data Warehouse; DBHDS Regional Support Team Reports specific to timely RST referral submissions; and CSB Self-Assessment Aggregate Data.

Potential data reports for upcoming review by the committee include: Quality Review Team Evidentiary Report from Quarterly Supervisory Reviews received from the Department of Medical Assistance Services (DMAS); Case Management Settlement Agreement Status Report; DBHDS Licensing Corrective Action Plans related to case management services; and Community Quality Improvement and Risk Management Aggregate Report on visits completed in 2018.

VI. Case Management Indicators for Settlement Agreement Compliance

In response to a September 2018 directive from United States District Court presiding over United States v. Commonwealth, 3:12-cv-00059 the committee provided input on the development of a set measurable proposed indicators that will bring the Commonwealth into compliance with the Settlement Agreement with respect to case management related provisions that remain in non-compliance. The following indicators were proposed and entered into negotiations with the Department of Justice.

1. 80% of case management records reviewed demonstrate that case managers are monitoring individual ISPs to ensure appropriate implementation. Verified in semi-annual report of CM Steering Committee.
2. 80% of case management records reviewed demonstrate that ISPs are revised as needed when there has been a change in the individual's status. Verified in semi-annual report of CM Steering Committee.
3. 80% of case management records reviewed demonstrate that case managers are making referrals for appropriate services. Verified in semi-annual report of CM Steering Committee

4. 80% of case management records reviewed demonstrate that choice of case manager is being offered to individuals via Virginia Choice Forms at least annually. Verified in semi-annual report of CM Steering Committee
5. Documentation indicates that data reports from monitoring reviews, including licensing inspections and investigations of CSB case management are reviewed by the CM Steering Committee, as indicated by CM Steering Committee quarterly reports and that recommendations are submitted to the QIC, as indicated by the QIC annual report.

VII. CSB Accountability Metrics for FY2019

Metrics related to the Performance Contract sent to CSB Executive Directors from Commissioner Melton in December 2018 address the following target areas:

(1) Process: ISPs in WaMS

(2) Case Managers making timely RST referrals on everyone seeking less integrated residential authorizations.

(3) Increased number of individuals receiving supports for employment on waiver and waitlist.

VII. Recommendations

The Case Management Steering Committee will continue to:

- Track progress towards case management data metrics and targets.
- Facilitate the release of Case Management tools in cooperation with the PPWD
  - Modules, Manual, Competencies, and Quality Review Tool
- Reassess and revise needed actions based on Independent Reviewer's current study of case management and recommendations.
- Continue analysis of multiple data sources CCS3, Licensing, RST, and DMAS QMR and internal assessments.

Virginia Department of Behavioral Health & Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2019
3rd and 4th Quarters

Case Management Steering Committee

Semi-Annual Report FY19 3rd and 4th Quarters

Executive Summary

In June of 2018, DBHDS established a Case Management Steering Committee (CMSC) to oversee and coordinate various activities designed to strengthen the Case Management (CM) system. Committee membership includes DBHDS Waiver Operations, Provider Development, Office of Community Quality Improvement, Office of Licensing, Settlement Agreement, and Data Quality and Visualization representatives. Due to the volume of activities underway and the complexity of the Case Management system, the committee gathers face to face bi-monthly data and maintains an interactive information sharing system for ongoing project oversight.

The CMSC reported to the Quality Improvement Committee (QIC) in March and June of 2019. Data reported to the QIC included results from the Community Service Boards (CSB) self-assessment study, results of the CSB Quality Reviews, and findings of the Partnership for People with Disabilities CM study. In conjunction with external stakeholders, the following work products were completed this reporting period: updating the online Developmental Disability (DD) CM Training Modules, development and publication of a DD Support Coordination Manual, and streamlining of the Individual Service Plan (ISP) in the Waiver Management System (WaMS). Projects continued from previous quarters include the finalization and reporting of the CSB Quality Reviews which included on-site visits for each of the 40 CSBs in the Commonwealth during the last two quarters of FY2018 and reported on in the 4th quarter of FY2019. Ongoing projects include implementation of a redesigned Support Coordinator/Case Management Quality Review process, funding a Transactional DD Support Coordination Pilot program for seven Community Services Boards (CSBs), and assistance with the Commissioner's request for CSBs to improve Case Management through monitoring of performance metrics for WaMS data exchange transition, meeting employment targets, and increasing the timeliness for Regional Support Team (RST) referrals. Case management performance data was submitted to each CSB in both the 3rd and 4th quarters, and reviewed by the CMSC. Data elements include measures of Enhanced Case Management face to face visit compliance, Regional Support Team timeliness of referrals, timeliness of Individual Service Plan (ISP) reviews, and Community Engagement and Supported Employment discussions and goal development.

DOJ Settlement Agreement Status

The Independent Reviewer's 14th Report to the Court submitted on June 13, 2019 included a study of the Case Management provisions resulting in the addition of a new compliance rating for the Commonwealth. This compliance rating is specific to community efforts in offering individuals choice of case management service providers (III.C.5.c). It is important to note, this is one of the nine targeted outcomes included in the CSBs Self-Assessment improvement initiative for which there has been 100% CSB participation. Also noted in the Independent Reviewer's 14th report, the Commonwealth has developed and implemented three broad initiatives to make substantive changes as essential precursors to fulfilling the requirements of the agreement. One of those such broad initiatives is the implementation a "multi-faceted initiative to improve and transform CSB case management services."

In response to the 2018 Court directive, negotiations with the Department of Justice (DOJ) resulted in a set of measurable CM compliance indicators agreed upon in April 2019. The purpose of the indicators is to add precise and measurable language for determining compliance of provisions currently in non-compliance status. Tables 1 and 2 below represent the correlation between the case management Settlement Agreement provisions in non-compliance at the onset of negotiations (8) and the resulting compliance indicators (38).

Fig. 1 CM Compliance as of June 13th 2019

Provision	Provision Description	Indicators
III.C.5.a	Individuals receiving case management services	
III.C.5.c	Providing choice of case management providers (as of 6/13/19)	1
V.F.1	Adhering to frequency of face to face visits	
V.F.3.a-f	Adhering to frequency of face to face visits for enhanced monitoring	
V.F.6	Training materials for case managers	
5	Total	1

Fig. 2 CM Non-Compliance as of June 13th 2019

Provision	Provision Description	Indicators
III.C.5.b.i	Assembling professionals for plan development	15
III.C.5.b.ii	Appropriate linkage to services	3
III.C.5.b.iii	Monitoring individual and implementation of the ISP	3
III.C.5.d	Mechanism for monitoring compliance with performance standards	4
V.F.2	Monitoring implementation of plan, risk, and plan development	6

V.F.4	Evidence at the policy level of reliable mechanisms to assess CSB compliance with their performance standards relative to case manager contacts.	2
V.F.5	Evidence at the policy level of a reliable mechanism to capture CM findings	4
7	Total	37

Quality Improvement Initiatives

CSB On-Site Quality Reviews

In response to the Quality Improvement Committee (QIC) monitoring of the case management data metrics and concerns regarding the quality of developmental disability case management data , the DBHDS Office of Community Quality Improvement (CQI) developed and implemented a Quality Improvement Initiative and visited each CSB over the course of the last two quarters of state fiscal year (SFY) 2018. CQIRM reviewed a total of 282 records across the state. An average of seven records was reviewed at each CSB. In the process of working on-site with individual CSBs, CIQ identified systemic as well as CSB specific issues. CSB specific issues identified were provided to each CSB in the form of a quality improvement plan. The following issues are included in the DBHDS April 2019 CSB Quality Review report with corresponding recommendations, many of which are already in process.

- Multiple EHR systems limit state-wide consistency of forms and processes and, depending on EHR vendor packages, report generating capability.
- Limited capability to identify and correct errors in data reporting in a timely manner.
- The current data reporting requirements exceed the capability of the CCS 3 platform.
- Limited Information Technology (IT) and QI staff with varying levels of expertise; difficulty with recruitment and retention of key IT and QI staff.
- Data coding and mapping issues in combination with lack of consistent ongoing processes to ensure data quality and integrity.
- Confusion about acceptable employment and community engagement discussion and outcomes.
- Physical and Dental exam discussions were not captured and/or coded.
- Confusion about ECM criteria and how to capture visits.
- Outcomes that are not measurable.
- Inconsistent recording of risks and attributes associated with risks.

- Regional Support Team (RST) referrals are not made as required and/or within required timelines.
- Lack of providers in key service areas, including behavioral consultation skilled nursing, in-home and personal assistance services.
- Support coordinator retention and recruitment impacts quality and continuity of services provided.

Work Products Completed

Support Coordination/Case Management Training Modules
Support Coordination Manual Developmental Disabilities

The updated online Case Management Modules launched in March 2019 on a platform through the Partnership for People with Disabilities VCU (PPWD). The launch effort included a User Guide and official launch memo from the Commissioner. Each module includes a competency base assessment maintained on the PPWD website. Support Coordinators hired after March 1st are required to complete all 11 modules within 30 days of employment. Accessible online as well as printable, the DD Support Coordinator Manual has been finalized and posted on the PPWD platform. Figure 3 below shows the number of personnel statewide who started and completed all modules with a passing score.

Fig. 3 Case Management Module Completion 4th Quarter FY19

Month	Certificates Completed
April 2019	80
May 2019	114
June 2019	143
Total	337

ISP Outcome Development Trainings

DBHDS initiated ISP Outcomes Trainings across the state based on support coordinator feedback. A focused curriculum included: Identifying and Addressing Risk, Writing Measurable Outcomes, and Completing a Shared Plan. During this reporting period, 48 sessions were held providing training and materials to 1,678 participants.

Data Monitoring

Commissioner's Accountability Measures

The Commissioner's memo sent in December of 2018 included the following directive: "These three metrics are designed to establish common points of measurement across all CSBs. They are related to Performance Contract requirements and will adjust over time as reporting needs change. In some cases, your CSB might already meet the established targets. Where targets are not met, incremental review may lead to technical assistance, remediation, or contract modification. The Department needs your active participation to meet the targets by the deadlines listed below." Two of the three metrics are monitored by the CMSC

1. By April 1, 2019, 70% of all ISP's with annual plan prior to March 1 entered into WaMS.
   ↓ Not Met – deadline extended to July in consideration of ISP Streamlining

   By June 30, 2019: 90% of all ISPs with plan date of prior to June 1, live in WaMS
   ↓ Not Met – deadline extended in consideration of ISP Streamlining
2. By April 1, 2019: 90% of individuals approved for a new non-integrated residential setting in the previous quarter (Jan - Mar) went through the RST process timely.
   ↓ 82% Statewide: not met – CSB letters submitted quarterly

   By June 30, 2019: 90% of individuals approved for a new non-integrated residential setting in the previous quarter (Apr - Jun) went through the RST process timely
   ↓ 83% Statewide - not met – CSB letters submitted quarterly

Case Management Face to Face Visits

Fig. 4 Enhanced Case Management (ECM) Face to Face Visits January – February 2019

Month	Total ECM	Total Visits	Percentage	Visits In-Home	Percentage
January	*5093*	4368	86%	4401	86%
February	*5109*	4578	90%	4465	87%

Support Coordination Quality Review

The Support Coordination Quality Review (SCQR) process was established to assess and improve the quality of support coordination (also referred to as "case management") services provided by CSBs to individuals on one of the DD home- and community-based services waivers (HCBS Waivers). The SCQR is designed to help determine if these services comply with the Department of Justice Settlement Agreement (DOJ SA) and Centers for Medicare and Medicaid Services (CMS) requirements. In May of 2019 a demonstration period was initiated to gather stakeholder

feedback and test the questionnaire. Results of the demonstration will be available for review by the CMSC in July 2019.

For the purpose of Settlement Agreement compliance, the ten core elements listed in the compliance indicators are included in the SCQR review questions. The compliance indicators set out a clear path as to the operation of the process for meeting compliance standards.

- *DBHDS will perform a quality review of case management services through CSB case management supervisors/QI specialists, who will conduct a Case Management Quality Review that reviews the bulleted elements listed below.*
- *DBHDS will pull an annual statistically significant stratified statewide sample of individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB.*
- *DBHDS analysis of the data submitted will allow for review on a statewide and individual CSB level. The Case Management Quality Review will include review of whether the following ten elements are met:*
    1. *The CSB has offered each person the choice of case manager.*
    2. *The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team.*
    3. *The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.*
    4. *The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences.*
    5. *The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable.*
    6. *The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served.*
    7. *The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary.*
    8. *Individuals have been offered choice of providers for each service*
    9. *The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences.*
    10. *The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individuals' needs.*

The ten elements listed above and the metrics below were presented to the QIC in June of 2019. Regional Quality Councils (RQC) provided positive feedback from a CSB perspective on obtaining compliance with indicators one through nine, although there was some concern over how to measure indicator #10. The compliance benchmarks are defined as:

- *86% of the records reviewed across the state will be in compliance with a minimum of 9 of the elements assessed in the review.*
- *Any individual CSB that has 2 or more records that do not meet 86% compliance with Case Management Quality Review for two consecutive quarters will receive additional technical assistance provided by DBHDS.*

Recommendations

The recommendations from the 1st and 2nd Quarter CMSC Report were presented and reviewed by the DBHDS Quality Improvement Committee in March of 2019.

- Continue to track progress toward CM data metrics and targets - ongoing
- Release CM tools (Modules, Manual, Quality Review Tool) - completed
- Reassess and revise needed actions based on Independent Reviewer's current study of CM and recommendations - completed
- Continue analysis of multiple data sources for CM (CCS3, Licensing, RST, and DMAS QMR) and internal assessments – ongoing

The Independent Reviewer's recommendations from the 14th review period were reviewed by the CMSC and corresponding action steps taken. The CMSC reviewed and revised the committee charter and presented to QIC and approved by the Commissioner September 2019. The Charter includes language consistent with the Case Management compliance indicators filed in April 2019. The June 2019 CMSC report to the QIC included the Ten Key Sub-Indicators and two compliance indicator metrics. The CMSC recommended moving forward with implementation of the compliance indicators, and the QIC approved June 6th 2019.

Virginia Department of
Behavioral Health &
Developmental Services

Risk Management Review Committee Annual Report

July 1, 2018 – June 30, 2019

Risk Management Review Committee Annual Report

July 1, 2018 – June 30, 2019

I. Committee Purpose

As established in their charter, 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.

RMRC has been established to improve quality of services and the safety of individuals with developmental disabilities. Over time, the committee will be expanded to oversee services provided to individuals with mental health and substance use issues as well. The RMRC will:

- 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
- Recommend quality improvement projects (QIPs) to the DBHDS Quality Improvement Committee (QIC) to promote health and well-being, mitigate risks, and foster a culture of safety in service delivery
- Monitor progress of QIPs and address concerns/barriers as needed
- Evaluate the effectiveness of the QIP for its intended purpose
- Report findings, conclusions, and recommendations to the QIC semi-annually or more frequently when significant or unusual patterns or trends are identified. The RMRC may also share data or findings with the Mortality Review Committee when significant patterns or trends are identified relating to deaths.

II. Committee Structure

RMRC is an internal inter-disciplinary team comprised of DBHDS employees with clinical training and experience in the areas of behavioral health, intellectual disabilities/developmental disabilities, leadership, forensics, medical, quality improvement, behavior analysis and data analytics. The RMRC reports to the QIC and may also share data or findings with the Mortality Review Committee (MRC) when significant patterns or trends are identified related to deaths.

III. Activities for Improvement

RMRC reviewed a variety of data and resources to ensure continuous quality improvement and recommended quality improvement initiatives. RMRC reviewed serious incident reports (SIR), deaths, human rights allegations of abuse, neglect and exploitation, findings from licensing inspections and investigations, and other related data. In SFY19, 13,479 individuals with developmental disabilities were served who receive waiver services and a total of 7,225 incidents for this population were reported to DBHDS via the Computerized Human Rights Information System (CHRIS). Of these, there were 6,756 unique incident reports; 5,428 were for individuals identified as receiving DD waivers.

A. Challenges / Gaps

1. The National Association of State Directors of Developmental Disability Services (NASDDDS) completed a report, Health and Welfare Review - Discovery, Remediation, Prevention and Systemic Improvement Strategies Related to Abuse, Neglect and Exploitation in November 2017. This study looked at 12 states, including Virginia "to understand state processes to identify and prevent instances of abuse, neglect and exploitation in Home and Community Based settings for individuals with developmental disabilities." As part of this project, NASDDDS developed a State Self-Assessment Tool that states could use to evaluate their current incident management structure and identify gaps for quality improvement. Some of the gaps the report identified, included:

    a. Need for data balanced by addressing factors that could challenge the ability of the state to meet health and safety standards to address serious incidents and mortalities.
    b. Additional training was needed at all levels for personnel, individuals and families.
    c. Effective incident management systems need to include triaging incidents, monitoring trends and the ability to respond quickly when indicated at local and state levels.

RMRC members completed the NASDDDS Self-Assessment Tool in July 2019 independent of one another. In compiling results, all members scored DBHDS as falling in the mid-range, which states: "The state's incident management system has begun to

develop effective practices, and provides multiple areas to enhance or expand either development or execution."

a. RMRC identified some strengths as:
    i. Incident reporting and management expectations, including reporting roles and duties, are in regulations.
    ii. Reports of incidents are made to a central repository/location outside of a service provider.
b. Some gaps were identified as:
    i. The state does not have established protocols for timely review of all submitted incident data to identify issues requiring immediate state-level intervention and to inform targeted or broad systemic improvement efforts (i.e., dedicated daily team briefings at local or state level, weekly data review strategies, monthly or quarterly quality meetings, etc.).
    ii. The state does not have established data analysis practices to compare the information gained from the incident reporting information with other key data sets (for example, using Medicaid claims data to determine any unreported, injury-related emergency department visits).

2. A report completed by the Office of the State Inspector General (OSIG), DBHDS: Review of Serious Injuries Reported by Licensed Providers of Developmental Services in December 2018 observed the following challenges:

    a. Definitions of serious incidents were unclear, resulting in mislabeling incidents, and overuse of the category "other" and further issues related to reporting incidents in CHRIS resulting in data that was not valid, nor reliable.
    b. Quality Improvement Committee and the Regional Quality Councils (RQC) need to improve in how they review/respond to data on serious incident reporting to support analyses and process improvement.

3. The Independent Reviewer continued his reviews of a sample of Serious Incident Reports and deaths. His recommendations included development of additional safety alerts, identifying risk triggers and thresholds, update / revision of licensing standard practices, including root cause analysis (RCA), and clarification of the requirements of investigations.

RMRC reviewed all reviews conducted by the Independent Reviewer of SIRs and deaths in an effort to identify and analyze trends, establish priorities for action, develop strategies for system improvement, and evaluate effectiveness of these strategies. A procedure was implemented to track DBHDS response and actions related to these reviews. A decision was made in SFY2019 to separate review of serious incidents and deaths to avoid duplication of effort with the MRC.

4. The Independent Reviewer include several recommendations related to risk management in his 13th review, including but not limited to the draft Quality Improvement Risk Management (CQIRM) Framework, incident management, CHRIS and health risk assessments.

It is planned that the CQIRM Framework / Toolkit will be developed in SFY2020 as a series of online competency based quality improvement modules in partnership with the Virginia Commonwealth University Project for People with Disabilities Project Living Well grant. RMRC researched health risk assessments (HRAs) and how they could be used to better identify and mitigate risks. DMAS Managed Care Organizations complete HRAs, but these are not consistently accessible to case managers/support coordinators. DBHDS and DMAS are collaborating and considering options how to improve risk assessment process.

B. Office of Licensing

Mitigating Strategies

1. Effective September 2018, the Office of Licensing issued Emergency Licensing Regulations, and included regulatory changes related to risk management that improved definitions of serious incidents, established levels of severity of risks and triage, and encompassed additional requirements for providers to complete risk assessments, conduct root cause analyses of incidents to develop solutions to mitigate reoccurrence and develop quality improvement plans.

2. Office of Licensing began the process in SFY2019 to replace CHRIS with a more robust interface. In the interim, they initiated revisions to CHRIS to align with Emergency Regulations that includes improved definitions of incidents, increased capability for DBHDS to analyze track and trend data and produce quality reports for stakeholders, ability to capture severity levels of incidents. It is anticipated that the CHRIS changes and training will be implemented in SFY2020.

5. Office of Licensing provided training in a variety of modalities to providers on emergency regulations and requirements, developed training on the DBHDS website on Root Cause Analysis, Emergency Regulation Changes Training: Risk Management & Quality Improvement (October 2018).

6. DBHDS Office of Licensing began development of an Incident Management Unit (IMU) and Specialized Investigation Unit (SIU) to support recommendations contained within the NASDDS report and the OSIG Review of Serious Injuries Reported by Licensed Providers of Developmental Services. The IMU will use a triage process to review SIRs, correct inaccuracies, identify corrective action and analyze/track/trend data at provider, regional and state level. The SIU will

investigate all deaths of individuals with developmental disabilities. It is anticipated that these two units will be fully implemented in SFY2020.

C. Human Rights

DBHDS operates an internal human rights system for its state facilities and for licensed community services. This system is authorized by Virginia Code and is governed by the Regulations to Assure The Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by DBHDS. More detailed information about human rights activities can be found at www.dbhds.virginia.gov/ on the human rights page. This year, 218,894 individuals received services from CSBs, and thousands of additional individuals received services from other community providers licensed by DBHDS and subject to the human rights regulations.

- There were 1028 human rights complaints filed in community programs, and 121 complaints (11.7 percent of the total) resulted in violations being determined.
- There were 8768 allegations of abuse, neglect, or exploitation filed, and 1265 (14.4 percent of the total) were founded.

Table 1 FY 2019 Human Rights Data Reported by Community Providers				
Total Number of Human Rights Complaints				1,028
Total Number of Complaints That Resulted in a Violation of Human Rights				121
Total Number of Allegations of Abuse, Neglect, or Exploitation				8768
Total Number of Substantiated Allegations of Abuse, Neglect, or Exploitation				1265
Substantiated Allegations by Type		Exploitation	30	
Physical Abuse	150	Neglect	817	
Verbal Abuse	92	Neglect (Peer-to-Peer)	140	
Sexual Abuse	12	Other	24	
Resolution Levels for the 1,028 Human Rights Complaints and 8768 Allegations of Abuse, Neglect, or Exploitation				
Director and Below	9781	State Human Rights Committee		3
Local Human Rights Committee	12	DBHDS Commissioner		0

Mitigating Strategies

1. In September 2018, the Office of Human Rights began conducting quarterly "look behind" reviews of a random sample of closed ID/DD abuse/neglect investigations of licensed community providers and state operated facilities to determine compliance with the Human Rights Regulations and those standards established by DBHDS. The look-behind process identifies trends in reporting, assesses the appropriateness of corrective actions taken as well as evaluates regional and statewide provider training needs.

   Data collected for allegations that occurred during calendar year 2018 found that 88% of investigations were completed within the required timeframes; there was evidence that the person conducting the investigation had received training in 75% of cases; and the facts of the investigation supported the provider's finding in 86% of cases. Based on

feedback from the Independent Reviewer, the look-behind reviews are being shifted from being conducted annually to quarterly to allow the provision of more timely feedback to providers.

2. In SFY2019, the Office of Human Rights began development of additional training to individuals and families to understand Abuse / Neglect/ Exploitation (A/N/E) Training that is planned to be implemented in SFY2020.

D. Performance Measurement Indicators

The RMRC monitored five PMIs during FY2019, all five of these met their performance goals.

- **The state policies and procedures for the use or prohibition of restrictive interventions (including restraint) are followed.** Target: 86%

  This indicator measures the percent of individuals that did not have unauthorized restrictive interventions. During the reporting period, no unauthorized restrictive interventions were identified.

- **State policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed.** Target: 86%

  This indicator measures the percent of individuals that did not have restrictive seclusion. During the reporting period, there were three instance of restrictive seclusion out of a 2,867 CHRIS reports. Meaning that 99.9% of individuals reviewed did not have a restrictive seclusion.

- **Corrective actions for substantiated cases of ANE are verified by DBHDS as being implemented.** Target: 86%

  This is a measure of the percentage of provider who have substantiated cases of abuse or neglect, who have completed their agreed upon corrective actions. DBHDS advocates verify the completion of corrective actions within 90 days. There were 736 corrective actions verified as complete, out of a total of 835 substantiated cases; which equates to 88%. DBHDS did not meet the target in the first quarter, with only 65% of corrective actions verified as complete. The Office of Human Rights reviewed this data and determined that advocates were not consistently verifying completion and closing cases with 90 days. Additional training regarding this expectation was communicated to all specialists, resulting in compliance over the next three quarters.

- **Licensed DD providers that administer medications are NOT cited for failure to review medication errors at least quarterly.** Target: 86%

  This is a measure of provider compliance with regulations to review medication errors at least quarterly. It is assessed during inspections to providers that offer medication

services. Over the fiscal year, 99% of providers (1,978 of 1,991 assessed) were compliant with this measure.

- **Critical incidents are reported to OL within the required timeframes.** Target: 86%
  Providers are required to report serious incidents to the Office of Licensing within 24 hours; this measure assesses the percentage of incident that complied with that standard. However, because the reporting system did not capture the time that the provider was notified of the incident, the system tracks the number of incidents reported within one day. This has been corrected with the CHRIS modifications that were rolled out in August 2019. Providers complied with this requirement on 93% of the serious incidents reported.

E. Serious Incident Data

Table 2: Serious Incidents ID/DD – 9/1/2018 – 6/30/2019

Type of Injury	Frequency	Percent of Total Reports
Other	3131	46.3%
Falls	803	11.9%
Abrasion/Cut/Scratch	474	7.0%
Seizure/Convulsion	461	6.8%
Redness/Swelling	411	6.1%
Change in Mental Status	398	5.9%
Vomiting	348	5.2%
Fever	259	3.8%
Urinary Tract Infection	239	3.5%
Aspiration Pneumonia/Pneumonia	213	3.2%

F. Other Mitigating Strategies

1. The Committee reviewed incident data in April for the period 9/1/18 – 3/31/19. This data indicated that falls were the highest specific type of incident, with a frequency of 608; this was behind "other" which had a frequency of 2,452. Based upon this review along with recommendations from the Office of the State Inspector General, the RMRC recommended development of a quality improvement initiative: Fall Prevention. This initiative will involve developing fall prevention training and encouraging providers who report a fall with injury to participate in the training. As part of this initiative, newsletter articles and fall prevention activities were widely distributed to all providers. The initiative will be fully initiated in SFY2020 .

2. The Office of Provider Development developed a training on Identifying Risk in May 2019 as part of their Person-Centered Individual Service Plan module training series that is available on the DBHDS website.

3. Training on risk assessment and mitigation was included in the online Support Coordination Manual – Developmental Disabilities and the competency-based Support Coordination / Case Management Training Modules released in 2019.

4. The Office of Integrated Health published alerts on:
    a. Drug Disposal – August 2018
    b. Bowel Obstruction and Constipation – October 2018
    c. Choking – October 2018
    d. Psychotropic Medications – March 2019
    e. Medication Management Alert – March 2019
    f. Tardive Dyskinesia Alert – March 2019

5. The Office of Integrated Health continued providing in person provider quarterly training on skin integrity with the Department of Health oral / dental care as well as monthly Health Trends newsletters.

6. RMRC explored and refined data collection of serious incident / death reporting in combination with data sources to drill down into data for improved analysis of trends and began expanded use of regional reporting for use by the QIC and RQCs.

IV. Data Sources

RMRC reviewed a variety of aggregate and individual data, reports and resources to promote continuous quality improvement and recommend quality improvement initiative(s). This included: CHRIS (SIR and death) data for individuals with developmental disabilities; human rights allegations of abuse, neglect and exploitation; findings from licensing investigations; Waiver Management System (WaMS) data; data warehouse reports; Supports Intensity Scale (SIS) Report; reviews from the Independent Reviewers of serious injuries and death; external reports: OIG Ensuring Beneficiary Health and Well Being in Group Homes Through State Compliance Oversight – January 2018; OSIG DBHDS: Review of Serious Injuries Reported by Licensed Providers of Developmental Services, December 2018; NASDDDS Health and Welfare Review: Report and NASDDDS State Self-Assessment Tool - Discovery, Remediation, Prevention and Systemic Improvement Strategies Related to Abuse, Neglect and Exploitation.

V. Summary

All five of the PMIs monitored by the RMRC met their performance targets. In addition to monitoring PMIs, the Committee made better use of data over the past year, using reports and data generated through the data warehouse. These reviews led to identification of fall risks as an area of concern and the implementation of a quality improvement activity. The Committee did review some aggregate break outs of incident data, including by provider, provider type, service, and by region. However, the Committee was not able to meaningfully evaluate this data to draw conclusions about systemic risks, or identify additional opportunities for improvement. This was largely due to the high number of incidents that were classified as "other" and the lack of standardized data that could be evaluated consistently over time. It is anticipated that the improvements to the CHRIS reporting interface and subsequent data will begin to address these challenges. The RMRC also added staff from the Office of Data Quality and Visualization to the membership to facilitate improvements in the review and discussion of data.

In September 2018, the licensing regulations were amended through an emergency action, which changed the requirements for serious incident reporting by providers. These changes expanded reporting beyond what was captured in CHRIS. The CHRIS interface is being updated effective August 2019, which is expected to result in more meaningful data in SFY2020. The RMRC will monitor this serious incident data, including falls reported with injury and implementation of the fall prevention initiative being rolled out in SFY2020 by the Office of Integrated Health fall prevention training initiative to determine effectiveness of the training and impact on falls.

Based on case review findings, the Committee also identified abuse of individuals receiving services as an area of concern. As a result, the State Human Rights Committee began an initiative to develop and disseminate information to individuals and families to facilitate the identification and reporting of potential abuse. This issue will be further studied over the coming year.

VI. Recommendations

Recommendation #1: Establish a goal that less than 30% of serious incidents are classified only as "Other"

Recommendation #2: Establish a quality improvement activity aimed at decreasing the rate of falls.

Recommendation #3: Establish a quality improvement activity aimed at enhancing the understanding of abuse, neglect, and exploitation of individuals with developmental disabilities.

Recommendation #4: Develop standard surveillance measures that are trended over time to identify potential opportunities for improvement.

VII. Next Steps

A primary focus over the coming year will be improving the data that is available for review by the Committee and the quality of review that is conducted. An incident management unit has been established, who will be responsible for triaging and following up on all serious incidents. They will also work with providers to improve the quality and reliability of their data.

Indicators for compliance with the Settlement Agreement will require the RMRC to review data on serious incidents and allegations of abuse and neglect by various levels, including, provider, region, types of incidents. This data must be used to monitor trends and identify areas for improvement, including quality improvement initiatives. To address these, and other required indicators, the RMRC will focus on developing measures that will need to be reported and reviewed by the RMRC to comply with new Settlement Agreement indicators; this will use standardized measures that identify population trends and can be reviewed over time. A preliminary review has identified 40 measures that the RMRC will need to review (in addition to detailed surveillance of incident data) to comply with the new Settlement Agreement indicators. To address this data focus, the RMRC will develop a data subcommittee that will meet regularly to develop data reports and reporting processes.

The RMRC will develop a schedule of activities to be reviewed over the course of the year to assure that required activities occur. Additionally, the RMRC will focus on working with the Office of Integrated Health to develop and roll out risk triggers and thresholds prior to the end of SFY2020.