Developmental Disabilities Quality Management Plan

Virginia Department of
Behavioral Health &
Developmental Services

Developmental Disabilities Quality Management Plan FY 2020

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Developmental Disabilities Quality Management Plan

Introduction

This report serves as a comprehensive document describing the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Developmental Disabilities Quality Management Plan (QMP) for Fiscal Year 2020. This year has been unprecedented because in the midst of this state fiscal year, the world was introduced to a novel coronavirus, COVID-19, which has resulted in a global pandemic and declaration of a public health emergency in the Commonwealth in March 2020. COVID-19 continues to pose a threat in Virginia, and the provider community should be commended for their ongoing dedication to serve individuals with DD in those critical settings despite the multiple workforce, financial, and service delivery challenges that have impacted all healthcare providers as a result of the pandemic. This report serves to acknowledge the accomplishments, commitment to quality, and the effects of the pandemic in the area of quality management. The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is committed to Continuous Quality Improvement (CQI) which is an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes. The DBHDS QMP is detailed in a three-part document: 1) Quality Management Program Description which describes the current structure and framework for discovery and remediation activities, and existing quality committees for the agency; 2) Quality Improvement Committee (QIC) and QIC Subcommittee charters of each quality committee and QIC subcommittee work plan, outlining the purpose and aims of the committee and detailing the tracking instrument used to track performance measure indicators and quality improvement initiatives; 3) Quality Management Annual Report and Program Evaluation which summarizes the key accomplishments of the Quality Management Program, work plans, and challenges to meeting stated goals. The DBHDS QMP will be reviewed and updated annually.

> *"DBHDS is committed to working collaboratively with external stakeholders to improve our current system and support individuals by promoting recovery, self-determination and wellness in all aspects of life. Quality management establishes the structure upon which we improve our systems of care. Through continuous quality improvement, we can grow system capacity, provide high-value care, and build a culture of collaboration"*

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

Part 1- Quality Management Program Description

Standards for Quality

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

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

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

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

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

Aims:

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

Priorities:

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

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

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

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

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

DBHDS Quality Management System

Every organization should implement a quality management system that is cross lifespan, appropriate to its size, scope and populations served. The DBHDS Quality Management System is based on the DBHDS Vision, Mission and Strategic Plan and incorporates these nationally recognized quality principles. DBHDS developed a multi-faceted approach using these quality frameworks and principles to develop a culture of quality. The system's infrastructure is:

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

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

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

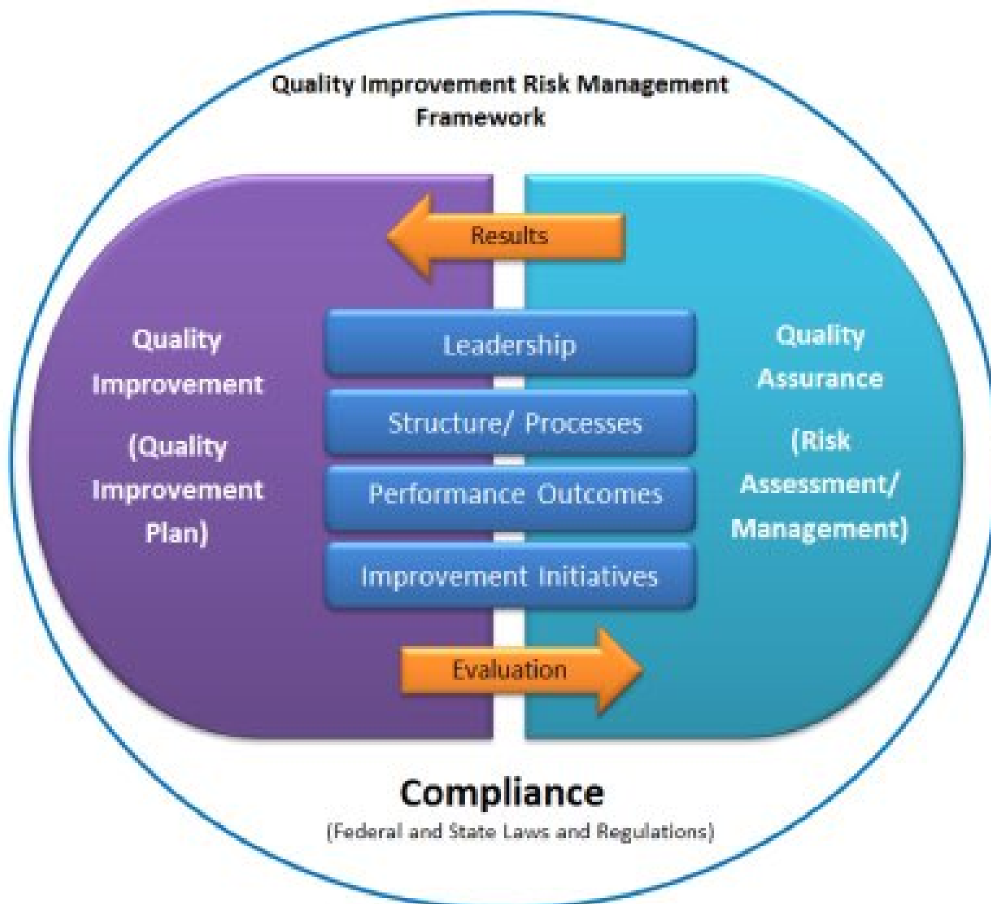
The graphic below illustrates that while compliance is what we must achieve, the ultimate goal is a system of quality services that allows individuals to direct their own lives and recovery, to access and fully participate in their community and balances risk, health, safety and well-being. An effective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

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

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

Leadership

Leadership commitment for a culture of quality, structures and data driven processes, established performance outputs/outcomes, and continuous quality improvement initiatives are the backbone of the framework.



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

Leaders encourage staff members to work together to eliminate complacency, promote collective mindfulness, and promote a learning environment (i.e., learning from safety events, including

close calls and other system failures that have not yet led to the harm of an individual). In an integrated quality/risk management system, these efforts identify opportunities for quality improvement, include assessment of risks, and can result in quality improvement initiatives which seek to improve systems and processes to achieve desired outcomes.

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

Structure and Processes

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

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

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

The DBHDS Quality Management System (QMS) includes the DBHDS Division of Quality Assurance and Government Relations, which oversees the regulatory, quality assurance, and risk

management processes; the DBHDS Division of Developmental Services, which manages discovery, remediation and collaborates with DMAS to implement the DD HCBS Waivers Quality Improvement Strategy, Preadmission Screening and Resident Review (PASRR), and the provision of training and technical assistance; the DBHDS Division of Administrative Services which includes the Office of Management Services for Outcomes, Performance Contracts, and Grants; and the DBHDS Division of the Chief Clinical Officer, which oversees QMS development and implementation and provides critical support across quality management functions.

DBHDS Division of Quality Assurance and Government Relations

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

DBHDS Office of Human Rights

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

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

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

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

The OHR utilizes data driven decisions, using the data warehouse to deploy advocates to programs and areas where there are emergent issues. The OHR has 23 field advocates across the state, responsible for ensuring human rights protections to individuals served in our facilities and services offered through over 900 DBHDS-licensed community providers. Advocates actively provide guidance, consultation and on-going technical assistance to community providers, facility staff, individuals, and family members via on-site inspections and reviews.

Office of Licensing

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

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

OL plays an integral, vital role in assessing the applicants to become providers and their potential in meeting the needs of individuals in safe, secure, and less restricted environments. OL ensures

the mechanisms for quality service provision are enforced, monitored and reported back to DBHDS leadership via data and other measures. In addition, OL is responsible for:

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

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

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

The IMU reviews data to identify trends, including providers that have a high volume of incidents or several incidents of the same type (e.g., falls or medication errors), and identifies patterns of incidents with the same individual that may indicate the need for a change in services or the need for additional resources. Through this review, the IMU identifies areas, based on serious incidents, where there is potential risk for more serious future outcomes. A review of a serious incident may raise concern about a provider's ability to ensure the adequacy of supports

to one or more individuals receiving their licensed service. As a result, that a provider may need to re-evaluate an individual's needs and supports, review the results of root cause analysis, and make systemic changes or updates to their risk management or quality improvement plan. The IMU has identified these situations as Care Concerns. Incidents of individuals or providers who meet Care Concern criteria will trigger follow-up by the IMU or other offices once notified by the IMU.

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

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

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

DBHDS Division of Developmental Services

DD HCBS Quality Management Plans

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

Case Management/Support Coordination

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

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

DBHDS Office of Provider Development

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

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

DBHDS Office of Integrated Health

The Office of Integrated Health (OIH) ensures DBHDS meets the federal requirements for PASRR, pre-admission screening of individuals with developmental disabilities referred for nursing home level of care. In addition to ensuring individuals with developmental disabilities meet the required level of care for admission, the OIH ensures that any specialized needs are addressed and a connection between the community services board (CSB) and nursing facilities are made to aid in discharge facilitation. When nursing home placement is determined to be appropriate, the PASRR team follows the individual to ensure they are receiving the supports and specialized services needed as identified by their person-centered plan. This includes the use of OBRA funding to support the services needed that are outside the usual scope of the nursing homes. Through the resident review process, the PASRR team continues to evaluate whether nursing home placement remains appropriate; these reviews occur at least every 180 days.

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

DBHDS Division of the Chief Clinical Officer

DBHDS Office of Clinical Quality Management

Quality improvement is a data driven process and involves analysis of data and performance trends captured in the quality assurance processes described above as well as through Community Services Board reporting, Waiver Management System (WaMS) and other data sources. This data analysis is used to determine quality improvement priorities. Office of Clinical Quality Management (OCQM) provides oversight of quality improvement efforts and responds to trends, by ensuring quality improvement initiatives are developed and corrective actions and

regulatory reforms are implemented, if necessary, to address weaknesses/service gaps in the system.
The OCQM is directed by the Chief Clinical Officer and led by the Senior Director of Clinical Quality Management. The OCQM supports the development and expansion of an agency-wide quality management plan by ensuring high quality service delivery focused on prevention, early intervention, effective treatment, and recovery and rehabilitation. The office works with interdisciplinary teams to achieve system wide community inclusion, safety and well-being, recovery and self-empowerment outcomes (related to behavioral health and developmental service provision) across all service setting areas, including community and hospital-based care. The office facilitates inter-departmental, inter-agency, and cross-sectoral alignment of quality improvement initiatives for DBHDS, and works to ensure compliance with the quality management requirements as outlined in the Settlement Agreement with the United States Department of Justice.

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

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

In addition, OCQI oversees and directs community-based quality review processes for DBHDS. DBHDS implements quality service reviews (QSRs) through a contracted vendor. QSRs are completed on a sample of individuals receiving services and include desk reviews, on-site visits, face-to-face interviews, in-person service observations, retrospective record reviews, and/or surveys of individuals receiving services. QSRs are completed to gain information about the

quality of services provided and/or to obtain individual and family input on services provided for the purpose of making improvements in the service experience, and to determine how to improve the array of services provided. QSRs include provider quality reviews, person-centered reviews, individual and family interviews and/ or surveys, Community Service Board Quality Record Reviews, and other DBHDS quality service reviews. Data collected from these processes is used in the evaluation of service quality at the individual, service, and systemic levels and to identify and implement quality improvement initiatives.

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

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

QSRs also provide an assessment of whether or not individuals' needs are being identified and met through person-centered planning and thinking, whether services are being provided in the most integrated setting (appropriate to the individuals' needs and consistent with their informed choice), and whether individuals are given opportunities for community integration in all aspects of their lives. Additionally, QSRs assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. Results of the QSRs are used to improve individual provider and system practice and service quality.

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

Support Coordination Quality Reviews are conducted at each CSB as part of the comprehensive quality improvement program. These quality reviews are completed by CSB case management/support coordination (SC) supervisors/QI specialists. DBHDS identifies a statistically significant stratified statewide sample of individuals receiving HCBS waiver services and provides each CSB with the names of individuals to be reviewed. CSB supervisors/QI specialists complete a portion of the reviews each quarter. These reviews include an assessment of core case management requirements. Data from the reviews is used by the CSB and the DBHDS Case Management Steering Committee (CMSC) to analyze implementation of case management processes and to develop quality improvement initiatives to strengthen areas of weakness. In order to ensure the integrity of the CSB quality reviews, members of the OCQI complete a retrospective review of a sample of records reviewed by each of the CSBs at least once per year using the same review process in order to measure agreement quantitatively. DBHDS provides technical assistance to SC supervisors/QI specialists to increase reliability of the results in future reviews and to identify any CSB specific improvements needed. The Case Management Steering Committee analyzes data throughout the process to determine systemic areas in need of improvement, including, as needed, recommendations for enforcement actions pursuant to the CSB Performance Contract and licensing regulations.

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

Office of Data Quality and Visualization

The DBHDS Office of Data Quality and Visualization (ODQV) approach quality improvement as a data driven process. The ODQV supports programs throughout the agency by working to identify, evaluate, refine and document processes that already exist in their respective areas and assist in determining where improvements can be made. Understanding the process from which data originate is a necessary component to deciding what data should be collected, reported and analyzed. The ODQV enables programs to communicate the story of their data both accurately and effectively.

The ODQV is responsible for the Data Quality Monitoring Plan (Plan). The purpose of the Plan is to guide the improvement of key data sources and monitor progress over time and to ensure that the Department is able to collect and analyze consistent reliable data. The Plan began in 2019 with the completion of an inventory of data sources used for DOJ Settlement Agreement reporting. The inventory describes the content of each data source and how the data are gathered,

organized, and stored. For each source, the inventory notes the presence or absence of unique identifiers, data validation measures, and documentation; these three components (validation, origination, and uniqueness) are essential to ensure data quality. Following the inventory, the ODQV developed the Plan with in-depth reviews of key source systems, reports, as well as an assessment of the data movement from source systems to the data warehouse. The reviews culminated in recommendations for improvements to data accuracy and reliability. The implementation of these improvements are monitored by the ODQV annually and reported to the QIC.

Office of Mortality Review

The purpose of the DBHDS Mortality Review Office (MRO) is to contribute to system-wide clinical quality improvement by conducting mortality review of deaths of individuals with an intellectual and/or developmental disability (I/DD) diagnosis admitted to a state operated facility and those who received services in the community from a DBHDS-licensed provider. The Mortality Review Committee provides ongoing monitoring and data analysis, identify trends and patterns, and make recommendations to promote the health, safety and well-being of said individuals, to reduce mortality rates to the fullest extent practicable.

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

The MRO is responsible for:

- Assuring receipt of documents from the Office of Licensing (with respect to deaths that occur in the community) and state facilities within 45 business days of date of death
- Reviewing the documentation from service providers and facilities and assessing for risk mitigation, health, safety, and freedom from harm concerns noted therein
- Compiling relevant information into a concise sequence of events into the electronic Mortality Review Form for the DBHDS MRC
- Classifying cases according to Tier classification, or reclassifying state facility Tier determinations, if and when circumstances warrant
- Requesting additional information, as needed
- Interviewing any persons having information regarding the individual's care

- Collecting, tracking, and analyzing facility and I/DD mortality data to identify trends, patterns, and problems at the individual service delivery and systemic levels

Organizational Quality Improvement Committee Structure

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

Description of Quality Committee Structure

Quality Improvement Committee

The QIC is the highest level quality committee for the agency and provides overall oversight of the quality management program. All other quality committees report to the QIC which in turn provides cross functional, cross disability data and triage to sub-committees. The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas and resource allocation to achieve intended outcomes for the agency and the Commonwealth

Regional Quality Councils

The DBHDS Commissioner established Regional Quality Councils (RQCs) for Developmental Disabilities in each of the five DBHDS regions in Virginia. With the direction of the QIC, the RQCs are expected to meet quarterly, at a minimum, to receive and analyze state and regional data, identify trends, and develop responsive actions by recommending quality improvement

initiatives to the QIC, monitor the status of the initiatives and support these targeted efforts. The RQCs report annually to the QIC.

Risk Management Review Committee

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

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

Mortality Review Committee

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

Case Management Steering Committee

The CMSC is responsible for monitoring case management performance across responsible entities to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of

services to meet individuals' needs in integrated settings. The CMSC evaluates data to identify and respond to trends to ensure continuous quality improvement and is responsible for reviewing data to determine progress toward meeting established Support Coordination/Case Management targets. Based on this data review and system analysis, the committee recommends systemic quality improvement initiatives to the QIC, provides technical assistance, and makes recommendations for action under the Performance Contract when targets are not met.

Health, Safety, and Well-being Workgroup

The Developmental Disabilities Health and Wellness Workgroup is responsible for the collection and analysis of data as it relates to helping individuals achieve positive health outcomes. The workgroup is tasked with establishing goals and performance measure indicators related to physical, mental, and behavioral health and well-being. Data related to prevention strategies, wellness trends, and clinical outcomes are monitored. The workgroup provides technical assistance and oversight for clinical QI strategies for these measures.

Community Inclusion and Integration Workgroup

The Developmental Disabilities Community Inclusion and Integration Workgroup is charged with promoting service provisions in the most integrated settings and ensuring full access and participation in community life. The workgroup recommends goals and performance measure indicators to ensure the most integrated settings appropriate to the individuals' needs, community stability, individual choice and self-determination and community inclusion.

Provider Capacity and Competency Workgroup

The Developmental Disabilities Provider Capacity and Competency Workgroup is charged with improving availability of and access to DBHDS services across the Commonwealth and facilitating provider training, competency and quality service provision. The workgroup recommends goals and performance measure indicators related to provider capacity and access to services and provider competency.

Quality Leadership Collaborative

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

HCBS Quality Management: DBHDS/DMAS Quality Review Team

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

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

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

The assurances include the following:

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

DBHDS and DMAS have primary responsibility for monitoring performance under the waiver assurances through the DD Waiver Quality Review Team (QRT). The QRT meets on a quarterly basis to report on and review the results of the discovery and remediation activities for each performance measure, and establish systemic remediation strategies for those measures that fall below the CMS-established 86% standard in a waiver year. The work of the QRT is accomplished by accessing data across a broad range of monitoring activities, including DBHDS licensing and human rights investigations and inspections; DMAS quality management reviews (QMR); serious incident reporting; case management data reporting; quality service reviews (QSR); mortality reviews; and DBHDS level of care evaluations performed by Community Services Boards (CSB).

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

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

DBHDS Quality Management System Quality Improvement Process Description:

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

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

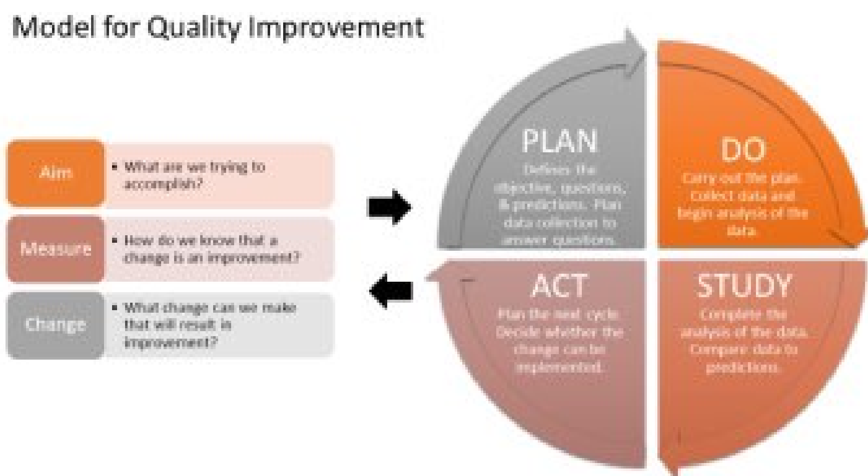
The following standard definitions apply to all quality committees:

- Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval.
- Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations

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

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

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



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

Performance Outcomes and Improvement Initiatives

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

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

Regardless of an organization's chosen quality model, leadership commitment, engagement of employees, defined structures and processes, defined performance measures, data driven quality initiatives, and customer focus are all essential elements of any quality management framework.

This framework sets the stage for our quality management work plan (Part 2) which includes committee charters and a template of the QIC subcommittees' work plan.

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

QIC and QIC Subcommittee Charters

Quality Improvement Committee Charter
QIC Approved September 21, 2020

Committee / Workgroup	Quality Improvement Committee
Statement of Purpose	The Quality Improvement Committee (QIC) is the designated oversight body for the Quality Management System of the Department of Behavioral Health and Developmental Services (DBHDS). The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas.
Authorization/Scope of Authority	The Executive Sponsor of the QIC is the Commissioner of DBHDS and the Commissioner maintains executive authority over the actions taken by the QIC. In keeping with DBHDS's mission, vision and values, the Quality Improvement Committee is the highest-level quality committee with all other quality subcommittees reporting to the QIC, which in turn provides cross-functional, cross disability data to subcommittees.
Charter Review	The QIC charter will be reviewed and/or revised on an annual basis or as deemed necessary by the committee.
DBHDS Quality Improvement Standards	**DBHDS is committed to a Culture of Quality that is characterized as:** • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated
Model for Quality Improvement	Determine the: • Aim: What are we trying to accomplish?

	• Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implement the Plan/Do/Study/Act (PDSA) Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented.
Structure of Committee / Workgroup:	
Membership	**Voting members:** DBHDS Commissioner (Executive Sponsor) Chief Deputy Commissioner, Community Services Chief Clinical Officer Senior Director of Clinical Quality Management Chief Administrative Officer Deputy Commissioner for Facilities Deputy Commissioner for Quality Assurance and Government Relations Assistant Commissioner for Developmental Disability Services **Advisory members (non-voting):** Assistant Commissioner of Quality Assurance and Government Relations Deputy Director for Community Services Assistant Commissioner for Facilities Director, Community Quality Improvement Pharmacy Manager Behavioral Health Facility Director Training Center Director Representative, Department of Medical Assistance Services Liaisons, Regional Quality Councils Quality Improvement Director, Community Services Board Representative, Service Provider Representatives, Associations as determined by the committee
Meeting Frequency	The QIC shall meet at a minimum four times a year.

Quorum	A quorum shall be defined as 50% plus one of voting membership.
Leadership and Responsibilities	The Chief Clinical Officer and Senior Director of Clinical Quality Management shall serve as committee chair and co-chair and shall be responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics. <u>Standard Operating /Procedures</u> include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the committee's function • Analysis of PMIs to measure performance across the key performance areas, to determine if a PMI needs revised or retired, at least on an annual basis • Quality improvement initiatives are consistent with the Plan, Do, Study, Act model The QIC: • Ensures a process of continuous quality improvement • Reviews goals and performance measure indicators (PMIs) • Gathers stakeholder input to inform recommended actions • Analyzes data and monitors for trends • Approves and prioritizes quality improvement initiatives and identifies resources • Monitors quality improvement committees/workgroups • Approves the creation/discontinuation of quality improvement committees/workgroups • Reviews quality improvement committee/workgroup charters • Holds programs accountable for quality improvement initiatives • Directs the work of the Regional Quality Councils (RQCs) and reviews reports and/or recommendations presented by the RQCs; reports to the RQCs on any decisions and related implementation of RQC recommendations • Reviews, and approves revised, added and/or retired PMIs at least annually and/or as needed • Reports publicly on an annual basis regarding the availability and quality of supports and services, gaps in supports and services, and provides recommendations for improvement • Develops strategic recommendations regarding any gaps or issues with availability of services identified through data reviews from Quality Service Reviews (QSRs) and National Core Indicators (NCI) related to the quality of services and individual level outcomes

	• Informs stakeholders of quality improvement initiatives approved for implementation including those that result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents or deaths • Reviews/monitors provider reporting measures semi-annually with input from the RQCs including issuing of recommendations and makes revisions to quality improvement initiatives as needed • Semi-annually, reviews and monitors provider reporting measures, identifies systemic deficiencies or potential gaps, issues recommendations, monitors measures, and makes revisions to QIIs as needed • Annually, assesses the validity of provider reporting measures • Reviews annual reports and determines recommendations to be addressed through quality subcommittees; ensures that deficiencies have been addressed Membership Approval: The DBHDS Commissioner shall approve the committee membership. The DBHDS Commissioner appoints advisory members. Internal members are appointed by role. Member Responsibilities: **Voting members**: • Have decision making capability and voting status. • Attend 75% of meetings per year; may send a proxy to one meeting per year • Review data and reports for meeting discussion • A designated proxy has the authority that the voting member maintains and therefore should be in a position reflective of that authority, including awareness of the organization or system impact of actions taken by the QIC **Advisory members**: • Perform in an advisory role for the QIC whose various perspectives provide insight on QIC performance goals, outcomes PMIs and recommended actions • Inform the committee by identifying issues and concerns to assist the QIC in voting and prioritizing meaningful QI initiatives • Attend 75% of meetings per year and may send a proxy to one meeting per year if the proxy represents the same advisory role (i.e. representing same subject matter, discipline, or DBHDS office) • Advisory members, excluding Association and DBHDS representatives, are appointed for a term of two (2) years and may be reappointed for an additional term **Definitions:** The following standard definitions as referenced in Part I of the Quality Improvement Plan (Program Description) are established for all quality committees:

	• Committee - Subject areas with expertise and accountability
	• Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees.
	  o Steering Committee - An advisory committee that provides direction, decides on priorities or order of business, and manages the general course of operations and reports to the QIC.
	  o Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight
	  o Council – Members are nominated by other council members and DBHDS staff
	• Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics
	• Key Performance Area – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity
	• Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, and recommend and prioritize quality improvement initiatives, to address identified issues for QIC review and approval.
	• Quality Management (QM) Plan - Ongoing organizational strategic quality management and improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders as well focuses on improving efficiency, effectiveness and output
	• Quality Improvement (QI) Initiative- Focuses on a specific area within a QM plan with identified actions

Regional Quality Council Charter
QIC Approved September 21, 2020
Revised
QIC Approved December 8, 2020

Committee / Workgroup	Regional Quality Councils
Statement of Purpose	As Quality Improvement Committee (QIC) subcommittees, the Regional Quality Councils (RQCs) are to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and evaluate data to identify and respond to trends to ensure continuous quality improvement. RQCs review and assess state and regional data related to quality indicators (performance measure indicators) for developmental disability services. The performance measure indicators are established by the Department of Behavioral Health and Developmental Services (DBHDS) and approved by the QIC and are in alignment with measures identified in the CMS approved Developmental Disability (DD) waiver(s). Each RQC reviews and evaluates the data, trends and monitoring efforts.
Authorization / Scope of Authority	The RQCs are part of the DBHDS quality oversight structure and represent each of the five DBHDS regions in Virginia. DBHDS provides the RQCs with relevant and reliable data to include comparisons with other internal or external data, as appropriate, as well as multiple years of data (as it becomes available). The performance measure indicators guide the RQC's discussion and monitoring. DBDHS QIC directs the work of the RQCs. RQCs may request available data that may assist in forming quality improvement initiatives and if requested data is unavailable, RQCs may make recommendations for data collection to the QIC.
Charter Review	The RQC charter is reviewed/revised on an annual basis or as needed and submitted to the QIC for approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis

	• Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives/projects as indicated
Model for Quality Improvement	Determine the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implement the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented.
Structure of Committee / Workgroup:	
Membership	An interdisciplinary team approach will be achieved through representation from the following stakeholder groups: • Residential Services Provider • Employment Services Provider • Day Services Provider • Community Services Board (CSB) Developmental Services Director • Support Coordinator/Case Manager (2) • CSB Quality Assurance/Improvement staff • Provider Quality Assurance/Improvement staff • Crisis Services Provider • An individual receiving services or on the Developmental Disability Waiver waitlist (self-advocate) • A family member of an individual previously (Previously is defined as within the past 3 years, either the individual having passed or lost services for whatever reason.) or currently receiving services or on the waitlist (2) In addition, the following DBHDS employees shall be standing members of each RQC: • Director, Community Quality Improvement or designee • Regional Quality Improvement Specialist • Community Resources Consultant Process for recruiting/approval of members:

	RQC members and alternates (excluding DBHDS standing employee members) are nominated by other RQC members, DBHDS regional staff, or DBHDS Quality Improvement staff. Quality Improvement staff contact nominees regarding the nominee's willingness to serve. All nominations of RQC members and alternates are reviewed and approved by the QIC chair/co-chair. Role of Alternates: An alternate for each membership role will serve as a proxy at meetings when the incumbent cannot attend. The alternate represents the same stakeholder group (i.e. employment provider) as the member and serves as the member's proxy for voting. Alternates receive meeting agendas, meeting minutes and reports to be considered at meetings, and attend meetings in order to listen to discussion and decisions. This ensures continuity by providing the alternate with the ability to be informed in the event the member is not able to attend and the alternate is called upon to represent the stakeholder group. Membership Term(s): RQC members (excluding DBHDS standing employee members) serve a three-year term, with an option to extend for one additional term. If a member resigns for any reason prior to the fulfillment of the term, if willing, the alternate will fill the vacated membership position. If the alternate is not willing to serve as the member, they will serve as proxy until a new member is nominated and approved by the QIC chair/co-chair. Another alternate representing the same stakeholder group will be nominated and approved by the QIC chair/co-chair.
Meeting Frequency	The RQCs will meet on at least a quarterly basis. Each RQC shall meet with a quorum at least three (3) of the four (4) quarterly meetings in a state fiscal year.
Quorum	A quorum is defined as at least 60% of members or their alternates, including representation from the following groups: a member of the DBHDS QIC, an individual experienced in data analysis, a Developmental Disability (DD) service provider, and an individual receiving services or on the DD Waiver waitlist or a family member of an individual receiving services or on the DD Waiver waitlist.
Leadership and Responsibilities	Leadership: The DBHDS Regional Quality Improvement Specialist shall serve as chair of the RQC. The chair will be responsible for ensuring the council performs its functions. RQC Liaison: Each RQC will appoint a member (excluding DBHDS employees) to serve as liaison to the QIC. Liaisons attend the QIC meetings, either in-person or remotely, representing their respective RQC. Liaisons are responsible for

	reporting all agreed upon RQC recommendations to the DBHDS QIC, If the liaison cannot attend the QIC (in-person or remotely), another member of that RQC shall be asked to represent that RQC at the QIC meeting. <u>RQC Responsibilities:</u> Each member, including alternates, shall be oriented to the purpose, operations and member responsibilities. This orientation is completed independently online or virtually/live with a QI Specialist. This training shall be offered and suggested to be completed within one month of receiving notification of approval of membership. All RQC members, including alternates, shall be provided with slides from previous trainings on quality improvement tools and methods and are asked to watch any related videos. For each of the topic areas identified by the RQC, the RQC either a) decides more information/data is needed for the topic area; b) prioritizes a quality improvement initiative for the region, and/or recommends a quality improvement initiative to DBHDS; or c) determines that no action will be taken in that area. For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC. Members are responsible for reviewing data and reports provided and engaging in discussions, which include an exchange of ideas from the perspective of the stakeholder group they represent. <u>Minutes:</u> Meeting minutes are reviewed and approved by the membership of the RQC to ensure accurate reflection of discussion, evaluation of data, and recommendations of the RQC. Approved meeting minutes are maintained by the DBHDS Office of Clinical Quality Management for 100% of meetings. <u>Standard Operating Procedures:</u> - Develop, update, and review annually the subcommittee charter - Meet regularly to ensure continuity of purpose - Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function - Analyze data to identify and respond to trends to ensure continuous quality improvement - Recommend quality improvement initiatives which are consistent with the Plan, Do, Study, Act model Each RQC will: • Review and evaluate data, trends, and monitoring efforts • Review and assess (i.e., critically consider) the data that is presented to identify: a) possible trends; b) questions about the data; and

	c) any areas in need of quality improvement initiatives (QIIs) and identifies and records themes in meeting minutes • Determine for each identified topic area if: a) more information/data is needed for the topic area; b) a quality improvement initiative should be prioritized for the region and/or recommended to DBHDS; or if c) no action is needed/will be taken in that area at this time • Based on topics and data reviewed, recommend at least one quality improvement initiative to the QIC annually. • Propose at least one measurable outcome for each QII recommended by the RQC • Monitor the regional status of any statewide quality improvement initiatives implemented as directed by the QIC • Report annually to the QIC on the results of the implemented QIIs • Present 100% of agreed upon recommendations to the QIC • Monitor and review provider reporting measures at least semi-annually The QIC reviews the recommendations reported by the RQCs and directs the implementation of any QII to the relevant DBHDS staff after approval by the QIC and the Commissioner. **Definitions:** The following standard definitions as referenced in Part I of the Quality Improvement Plan (Program Description) are established for all quality committees: • Committee - Subject areas with expertise and accountability • Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees. o Steering Committee - An advisory committee that provides direction, decides on priorities or order of business, and manages the general course of operations and reports to the QIC. o Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight o Council – Members are nominated by other council members and DBHDS • Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics • Key Performance Area – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity.

	• Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and prioritizes quality improvement initiatives to address identified issues for QIC review and approval. • Quality Management (QM) Plan - Ongoing organizational strategic quality management and improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders as well focuses on improving efficiency, effectiveness and output • Quality Improvement (QI) Initiative- Focuses on a specific area within a QM plan with identified actions

Risk Management Review Committee Charter
QIC Approved September 21, 2020
Revised
QIC Approved December 14, 2020

Committee / Workgroup	Risk Management Review Committee
Statement of Purpose	The purpose of the Department of Behavioral Health and Developmental Services (DBHDS) Risk Management Review Committee (RMRC) is to provide ongoing monitoring of serious incidents and allegations of abuse and neglect; and analysis of individual, provider and system level data to identify trends and patterns and make recommendations to promote health, safety and well-being of individuals. As a subcommittee of the DBHDS Quality Improvement Committee (QIC), the RMRC identifies and addresses risks of harm; ensures the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collects and evaluates data to identify and respond to trends to ensure continuous quality improvement. The RMRC has been established to improve quality of services and the safety of individuals with developmental disabilities (DD). Over time, the committee will be expanded to oversee services provided to individuals with mental health and substance use issues as well.
Authorization/Scope of Authority	This committee is authorized by the DBHDS Quality Improvement Committee (QIC) and is coordinated by the Division of Quality Assurance and Government Relations and the Office of Community Quality Improvement. The RMRC's overall risk management process enables DBHDS to identify, and prevent or substantially mitigate risks of harm. The RMRC reviews and analyzes related data collected from facilities and community service providers, including reports of serious incidents and allegations of abuse and neglect. The RMRC also reviews data and information related to DBHDS program activities, including licensing reviews, triage and review of serious incidents, and oversight of abuse/neglect allegations. The RMRC may also share data or findings with the Mortality Review Committee when significant patterns or trends are identified related to deaths.
Charter Review	The RMRC was established in December 2014. The charter will be reviewed and/or revised on an annual basis, or as needed, and submitted to the QIC for approval.

DBHDS Quality Improvement Standards	**DBHDS is committed to a Culture of Quality that is characterized as:** • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QII) as indicated
Model for Quality Improvement	Determine the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implement the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented.
Structure of Committee / Workgroup:	
Membership	RMRC is an internal inter-disciplinary team comprised of the following DBHDS employees with clinical training and experience in the areas of behavioral health, intellectual disabilities/developmental disabilities, leadership, forensics, medical, quality improvement, behavior analysis and data analytics: **Voting Members:** • Assistant Commissioner of Quality Assurance and Government Relations • Director, Community Quality Improvement, or designee • Director, Provider Development, or designee • Director, Office of Human Rights, or designee • Director, Office of Integrated Health. or designee • Incident Manager, Office of Licensing, or designee • Representative, Data Quality and Visualization • Settlement Agreement Director, or designee • Risk Manager, Training Center or designee • Office of Licensing Quality Improvement Review Specialist **Advisory Members:**

	• Deputy Commissioner of Quality Assurance and Government Relations • QI/QM Coordinator • Investigations Manager, Office of Licensing, or designee • Advisory consultants as needed/required
Meeting Frequency	The RMRC meets at least ten times a year with a quorum present; additional meetings may be scheduled as determined by the urgency of issues. Additional workgroups may be established as needed.
Quorum	A quorum is defined as 50% plus one of the approving members.
Leadership and Responsibilities	The Assistant Commissioner of Quality Assurance and Government Relations or designee chairs the RMRC. The standard operating procedures include: • Develop, update and review annually the committee charter • Meet regularly to ensure continuity of purpose • Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function • Analyze data to identify and respond to trends to ensure continuous quality improvement • Recommend quality improvement initiatives which are consistent with Plan, Do, Study, Act model The RMRC will: • Develop an incident management process that is responsible for review and follow-up of all reported serious incidents including protocols that identify a triage process, a follow-up and coordination process with licensing specialists and investigators, human rights advocates and referrals to other DBHDS offices as appropriate and documentation of trends, patterns and follow-up on individual incidents • Provide oversight for a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The reviews evaluate whether: i. The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols; ii. The provider's documented response ensured recipient's safety and well-being; iii. Appropriate follow-up from the Office of Licensing incident management team occurred when necessary; iv. Timely, appropriate, corrective action plans are implemented by the provider when indicated. v. The RMRC will review trends quarterly, recommend changes to processes, protocols, or quality improvement initiatives when necessary and track implementation of any changes or quality initiatives approved for implementation

	• Provide oversight of a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review evaluates whether: i. Comprehensive and non-partial investigations of individual incidents occur within state prescribed timelines; ii. The person conducting the investigation has been trained to conduct investigations; iii. Timely, appropriate, corrective action plans are implemented by the provider when indicated. iv. Trends will be reviewed at least quarterly; the RMRC will recommend quality improvement initiatives (QIIs) when necessary and track implementation of initiatives approved for implementation. v. The RMRC will review trends quarterly, recommend changes to processes, protocols, or quality improvement initiatives when necessary and track implementation of any changes or quality initiatives approved for implementation. • Systematically review and analyze data related to serious incident reports (SIR), deaths, human rights allegations of abuse, neglect and exploitation, findings from licensing inspections and investigations, and other related data • Review, analyze and identify trends related to DBHDS facility risk management programs to reduce or eliminate risks of harm • Review details of individual serious incident reports when indicated • Review the results of Quality Service Reviews (QSR) as it relates to identified risks of harm, including appropriate provider response to risks, address risk triggers and thresholds and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Utilize the findings from review activities to develop, or recommend, the development of guidance, training, or educational resources to address areas of risk prevalent within the DBHDS service population • Ensure the annual review of such guidance, training, or educational resources; and update as necessary • Review publications yearly and revise as necessary to ensure current guidance is sufficient and is included in each alert • Use data and information from risk management activities to identify topics for future content as well as determine when existing content needs revision • Report findings, conclusions, and recommendations to the QIC semi-annually, or more frequently when significant, or unusual patterns or trends are identified • Reviews and identifies trends from aggregated incident data, including allegations of abuse, neglect, and exploitation, at least four times per year by various levels such as by region, by Community Services Board (CSB), by provider locations, by individual, or by levels and types of incidents • Monitor aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators. When targets are not met the RMRC

	determines whether quality improvement initiatives are needed, and if so, monitors implementation and outcomes • Monitor the effective implementation of DI 401 (Risk and Liability Management) by reviewing facility data and trends, including risk triggers and thresholds to address risks of harm • Utilize data analysis to identify areas for improvement and monitor trends. The RMRC identifies priorities and determines quality improvement initiatives as needed, including identified strategies and metrics to monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts. • Establish performance measure indicators (PMIs) that align with the eight domains • Monitor progress towards achievement of identified performance measure indicators (PMIs) and for PMIs falling below target, determine actions that are designed to raise the performance • Assess PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices • Utilize approved system for tracking PMIs, and the efficacy of preventative, corrective and improvement measures • Develop and implement preventative, corrective, and improvement measures where PMIs indicate health and safety concerns • Recommend at least one QII per year designed to mitigate risks, and foster a culture of safety in service delivery based on data analysis • Implement approved QIIs within 90 days of the date of approval and report regularly to the QIC regarding the status of the QII • Monitor progress of QIIs and address concerns/barriers as needed • Evaluate the effectiveness of the QII for its intended purpose • Report to DBHDS QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs Membership Responsibilities: **Voting members:** • Have decision making capability and voting status • Review data and reports for meeting discussion • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting.

	Advisory members:
	• Perform in an advisory role for the RMRC whose various perspectives provide insight on RMRC activities, performance outcomes, and recommended actions
	• Inform the committee by identifying issues and concerns to assist the RMRC in developing and prioritizing meaningful QI initiatives
	• Support the RMRC in performing its functions
	
	Definitions: The following standard definitions as referenced in Part I of the Quality Improvement Plan (Program Description) are established for all quality committees:
	• Committee - Subject areas with expertise and accountability
	• Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees.
	    o Steering Committee - An advisory committee that provides direction, decides on priorities or order of business, and manages the general course of operations and reports to the QIC.
	    o Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight
	    o Council – Members are nominated by other council members and DBHDS
	• Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics
	• Key Performance Area – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity.
	• Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and prioritizes quality improvement initiatives to address identified issues for QIC review and approval.
	• Quality Management (QM) Plan - Ongoing organizational strategic quality management and improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders as well focuses on improving efficiency, effectiveness and output
	• Quality Improvement (QI) Initiative- Focuses on a specific area within a QM plan with identified actions

Mortality Review Committee Charter
QIC Approved September 21, 2020
Revised
QIC Approved November 16, 2020

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

	DBHDS demonstrates on an on-going basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. DBHDS develops and implements quality improvement initiatives, either regionally or statewide, as recommended by the MRC and approved by the DBHDS Commissioner, to reduce mortality rates to the fullest extent practicable.
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement quality improvement initiatives will report data related to the quality improvement initiatives to the MRC to enable the committee to track implementation. Through mortality reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the MRC identifies areas for development of quality improvement initiatives. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the MRC: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Implements approved Quality Improvement Initiatives (QII) within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose

	• Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns
Structure of Committee:	
Membership	The MRC is composed of members with clinical training and experience in the areas of intellectual and developmental disabilities, medical and pharmacy services, quality improvement, compliance, incident management, behavior analysis and data analytics. Required Mortality Review Committee DBHDS members include: • Chief Clinical Officer *(MD, and staff member with QI and programmatic/operational [P/O] expertise)* • Assistant Commissioner of Developmental Services, or designee *(staff member with QI and P/O expertise)* • Assistant Commissioner for Compliance, Risk Management, and Audit or designee *(staff member with QI, P/O, and regulatory expertise)* • Senior Director of Quality Improvement *(staff member with QI and P/O expertise)* • Director, Community Quality Improvement, or designee *(RN and staff member with QI and P/O expertise)* • Director, Office of Human Rights, or designee *(staff member with regulatory, QI and P/O expertise)* • Director, Office of Integrated Health, or designee *(staff member with QI and PO expertise)* • Mortality Review Office (MRO) Clinical Manager, Co-Chair (*NP and staff member with QI and P/O expertise*) • Office of Licensing Manager, Incident Team *(staff member with regulatory and P/O expertise)* • Office of Licensing Manager, Investigation Team *(staff member with regulatory and P/O expertise)* • Office of Pharmacy Services Manager *(PharmD and staff member with regulatory, QI and P/O expertise)* • MRO Clinical Reviewer *(RN and staff member with QI and P/O expertise)* • MRO Program Coordinator *(Staff member with QI and P/O expertise)* • A member with clinical experience to conduct mortality reviews who is otherwise independent of the State *(medical doctor, nurse practitioner, or physician assistant, who is an external member with P/O expertise)* Advisory *(non-voting members)* nominated by the Commissioner or Chair of the MRC, which may include; • Representative, Department of Medical Assistance Services

	• Representative, Department of Health • Representative, Department of Social Services • Representative, Office of Chief Medical Examiner • Representative, Community Services Board • Other Subject matter experts such as representatives from a DD Provider or Advocacy Organizations
Meeting Frequency	The MRC meets, at minimum, on a monthly basis or more frequently as necessary to conduct mortality reviews with 90 days of death.
Quorum	A quorum is 50% of voting membership plus one, with attendance of at least: (One member may satisfy two roles) • A medical clinician (*medical doctor, nurse practitioner, or physician assistant*) • A member with clinical experience to conduct mortality reviews • A professional with quality improvement expertise • A professional with programmatic/operational expertise
Leadership and Responsibilities	The DBHDS Commissioner shall serve as the executive sponsor of the MRC and the Chief Clinical Officer, or Mortality Review Clinical Manager, shall serve as committee chair. The committee chair shall be responsible for ensuring the committee performs its functions; consideration and, as appropriate, approval of quality improvement activities, and MRC core processes. Standard operating procedures: • The Licensing Investigations Team reviews all deaths of individuals with a developmental disability reported to DBHDS through its incident reporting system and provides available records and information it obtains and the completed Licensing Investigation Report to the MRC within 45 business days of the date the death was reported. • Within 90 calendar days of a death, (and for any unreported deaths, as defined on page 6), the Mortality Review Team (MRT) compiles a review summary of the death. This includes development of a succinct, clinical case summary by reviewing, and documenting the availability or unavailability, of: ◆ Medical records: Including healthcare provider and nursing notes for three months preceding death ◆ Incident reports for three months preceding death ◆ Most recent individualized service program plan ◆ Medical and physical examination records ◆ Death certificate and autopsy report (if applicable) ◆ Any evidence of maltreatment related to the death ◆ Interviewing, as warranted, any persons having information regarding the individual's care

	• The Clinical Reviewer(s) documents all relevant information onto the electronic Mortality Review Form, and the Chief Clinical Officer/Clinical Manager completes a preliminary review of all case summaries prior to an MRC meeting. During the preliminary review, a case is identified as Tier 1 or Tier 2 (*see definitions*). ♦ A Tier 1 case requires a detailed, comprehensive review of multiple factors and areas of focus by the MRC. ♦ A Tier 2 case does not require a detailed, comprehensive review as the preliminary review was sufficient. • To ensure confidentiality and adhere to mandated privacy regulations and guidelines, case reviews are provided to MRC members during the meeting only. At that time, a facilitated narration with discussion occurs. <u>At each meeting the MRC members:</u> ♦ Perform comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors (*medical, genetic, social, environmental, risk, susceptibility, and others as specific to the individual*) and quality of service. ♦ Evaluate the quality of the decedent's licensed services related to disease, disability, health status, service use, and access to care, to ensure provision of a reliable,person-centered approach. ♦ Identify risk factors and gaps in service and recommend quality improvement strategies to promote safety, freedom from harm, and physical, mental and behavioral health and wellbeing. ♦ Review Office of Licensing Corrective Action Plans (CAPs) related to required recommendations, to ensure no further action is required and for inclusion in meeting minutes. ♦ Refer any required recommendations not included in the initial CAP to the Office of Licensing for further investigation, and/or other divisions represented by members, when appropriate. ♦ Assign recommendations and/or actions to MRC member(s) as appropriate. ♦ Review and track the status of previously assigned recommended actions to ensure completion. ♦ The committee may also interview any persons having information regarding the individual's care. After the case review, the MRC seeks to identify: • The cause of death

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

	review, the MRT will initiate the usual review process for the case as per usual standard operating procedure (*see page 4*). • The MRC documents recommendations for systemic quality improvement initiatives coming from patterns of individual reviews on an ongoing basis, and analyzes patterns that emerge from any aggregate examination of mortality data. ◆ From this analysis, the MRC makes one recommendation per quarter *(four recommendations/year)* for systemic quality improvement initiatives, and reports these recommendations to the QIC (*quarterly*) and the DBHDS Commissioner *(annually*). ◆ On a quarterly basis, the MRC also prepares and delivers to the QIC a report specific to the committee's findings. ◆ Within ninety days of a death, the MRC will prepare and deliver to the Commissioner of DBHDS, a report specific to the committee's deliberations, findings, and recommendations. If the MRC elected not to make any recommendations, documentation will affirmatively state that no recommendations were warranted. ◆ The MRC prepares an annual report of aggregate mortality trends and patterns for all individuals reviewed by the MRC, within six months of the end of the year. A summary of the findings is released publicly. <u>Membership responsibilities:</u> Pursuant to Virginia Code § 37.2-314.1, all MRC members and other persons who attend closed meetings of the MRC are required to sign a confidentiality agreement form. Members shall notify the MRC Co-Chair and/or MRO Program Coordinator prior to having a guest attend a meeting so that arrangements may be made for the guest to sign the confidentiality agreement form before (s)he is permitted to attend. Member confidentiality forms are valid for the entire term of MRC membership, and guest confidentiality forms are valid for repeat attendance at MRC meetings. • All MRC members must receive training that includes: ◆ Orientation to the MRC charter to educate the member on the scope, mission, vision, charge, and function of the MRC ◆ Review of the policies, processes, and procedures of the MRC ◆ Education on the role/responsibility of the member(s) ◆ Training on continuous quality improvement principles

	New members will receive training within 30 business days of joining the committee. • **Voting members:** ◆ Have decision making capability and voting status. ◆ Attend 75% of meetings per year and may send a designee that is approved by the MRC chair (*or Co-Chair*) prior to the meeting. ◆ Review data and reports for meeting discussion. ◆ May send a designee to MRC meetings but should attend at least one meeting per quarter. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. ◆ Absence is considered excused if the member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting that the member and/or designee are unable to attend. ◆ Recognize that an excused absence does not contribute to the 75% attendance requirement. • **Advisory members:** ◆ Are non-voting stakeholder members selected and approved by the QIC and DBHDS Commissioner whose various perspectives provide insight on MRC reviews, clinical insight, medical expertise, and MRC performance goals, outcomes, required and recommended actions. ◆ Inform the committee by identifying and prioritizing MRC decision making and recommendations. ◆ May be appointed for a term of two (2) years, and may be reappointed for up to two additional terms. ◆ Are expected to attend 75% of meetings per year, and may send a designee that is approved by the MRC chair prior to the meeting. An absence is considered excused if the advisory member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting, that the advisory member and/or designee are unable to attend. ◆ Recognize that an excused absence does not contribute to the 75% attendance requirement.
Recusal	Members must recuse themselves from MRC proceedings if a conflict of interest arises, in order to maintain neutrality (prevent bias) and credibility of the MRC mortality review process. Conflict of interest exists when an MRC member has a financial, professional or personal interest that could directly influence MRC determinations, findings or recommendations, such as: • The MRC member, or an individual from the member's family, was actively involved in the care of the decedent (*direct care r/t employment or financial as listed below*) • The MRC member may have participated in a facility or institutional mortality review of the decedent • The MRC member, or an individual from the member's family, has a financial interest or investment that could be directly affected by the mortality review (*including determinations and recommendations*) of the decedent, to include employment, property interests, research, funding or

	support, industry partnerships and consulting relationships Should a conflict of interest arise during the review process, the MRC member will: • Immediately disclose the potential conflict of interest and cease participation in the case review related to the existing or potential conflict of interest. • Disclose the conflict of interest privately to the Chair/Co-Chair, or publicly to the members in attendance. The MRC will then halt discussion of the conflict of interest case, move on to the next case and place the conflict of interest case at the end. This allows the MRC member with a conflict of interest to remain for the review of other cases, and then leave the proceedings prior to the discussion of the conflict of interest case.
Definitions	• Tier 1 case criteria: ♦ Cause of death cannot clearly be determined or established, or is unknown; ♦ Any unexpected death *(such as suicide, homicide or accident)*; ♦ Abuse or neglect is specifically documented; ♦ Documentation of investigation by or involvement of law enforcement *(including forensic)* or similar agency; and ♦ Specific or well defined risks to safety and well-being are documented. • Tier 2 case criteria: ♦ Cause of death can clearly be determined or established; ♦ An expected death, if no abuse or neglect, involvement of law enforcement or well defined safety and well-being risks are documented; ♦ An unexpected (*unexplained*) death that occurred as a result of an acute medical event, a new medical condition, or sudden and unexpected consequences of a known medical condition, as long as no abuse or neglect, involvement of law enforcement or well defined safety and well-being risks are documented; ♦ No documentation of abuse or neglect; ♦ No documentation of investigation by or involvement of law enforcement (*including forensic*) or similar agency; and ♦ No documentation of specific or well defined risks to safety and well-being noted. • 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 in place, and primary health care and palliative care teams, if applicable, were involved. The individual, legally authorized representative, power of attorney or legal guardian *(if the individual lacked capacity to make advance directive decisions)*, and family, were all aware that the illness or condition would result in death and had an opportunity to discuss, if not decide, end of life matters and clinical measures to be taken or not taken. • Unexpected Death denotes a death that occurred as a result of an acute medical event that was not expected in advance nor based on a person's known medical conditions. Examples might include suicide, homicide, accident, acute medical event, a new medical condition, or sudden and unexpected consequences of a known medical condition. An unexplained death also is considered an unexpected death. • Unknown indicates there is insufficient information to classify a death as either expected or unexpected or there is insufficient information to make a determination as to the cause of death. • Other (Cause of Death) denotes a cause of death that is not attributable to one of the major causes of death used by the MRC for data trending. • Potentially Preventable Deaths are deaths that are considered to be premature and may have been avoided, based on a combination of known medical, genetic, social, environmental, or other factors *(such as pre-morbid conditions)*. When the MRC determines a death is potentially preventable, the committee categorizes factors that might have prevented the death. 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 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 • The following standard definitions as referenced in Part I of the Quality Improvement Plan (*Program Description)* are established for all quality committees:

		- Committee - Subject areas with expertise and accountability - Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees. - Steering Committee - An advisory committee that provides direction, decides on priorities or order of business, and manages the general course of operations and reports to the QIC. - Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight - Council – Members are nominated by other council members and DBHDS - Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics - Key Performance Area (KPA) – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity. - Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and prioritizes quality improvement initiatives to address identified issues for QIC review and approval. - Quality Management (QM) Plan - Ongoing organizational strategic quality management and improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders as well focuses on improving efficiency, effectiveness and output. - Quality Improvement Initiative (QII)- Focuses on a specific area within a QM plan with identified actions.

Case Management Steering Committee Charter
QIC Approved September 21, 2020

Committee / Workgroup Name	Case Management Steering Committee
Statement of Purpose	The Case Management Steering Committee, a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), is responsible for monitoring case management performance across responsible entities to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings, and evaluate data to identify and respond to trends to ensure continuous quality improvement.
Authorization / Scope of Authority	The Case Management Steering Committee is authorized by the DBHDS Quality Improvement Committee (QIC). The committee is charged with reviewing data selected from, but not limited to, any of the following data sets: CSB data submissions, Case Management Quality Reviews, Office of Licensing citations, Quality Service Reviews, and DMAS' Quality Management Reviews, WaMS.
Charter Review	The Case Management Steering Committee was established in June 2018. The charter shall be reviewed on an annual basis, or as needed, and submitted to the QIC for review and approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated
Model for Quality Improvement	Determine the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implement the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions

	• Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented.
Structure of Workgroup / Committee:	
Membership	CMSC is an internal inter-disciplinary team comprised of the following DBHDS employees with clinical training and experience in the areas of case management, behavioral health, intellectual disabilities/developmental disabilities, leadership, quality improvement, behavioral analysis and data analytics: **Voting Members:** • Director of Waiver Operations or designee • Director of Provider Development or designee • Director of Community Quality Improvement or designee • Settlement Agreement Director • Two Quality Improvement Program Specialists • Representative, Office of Data Quality and Visualization **Advisory Members (non-voting):** • QI/QM Coordinator • Other internal members as determined by the committee
Meeting Frequency	The committee will, at a minimum, meet ten times a year; additional meetings may be scheduled as determined by the urgency of issues.
Quorum	A quorum shall be defined as 50% plus one of voting membership.
Leadership and Responsibilities	The Director of Provider Development shall serve as chair and will be responsible for ensuring the committee performs its functions including development of meeting agendas and convening regular meetings. The standard operating procedures include: - Development and annual review and update of the committee charter - Meet regularly to ensure continuity of purpose - Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function - Analyze data to identify and respond to trends to ensure continuous quality improvement - Recommend quality improvement initiatives, which are consistent with Plan, Do, Study, Act model.

	The CMSC will: • Establish a process to review a sample of case management contact data each quarter to determine reliability and provide technical assistance to CSBs as needed • Establish process to monitor compliance with performance standards • Analyze data and monitor for trends quarterly • Provide to the QIC recommendations to address non-compliance issues with respect to case manager contacts for consideration of appropriate systemic improvements and the Commissioner for review of contract performance issues • Review and analyze CM data submitted to DBHDS related to the ten elements and at an aggregate level to determine CSB's overall effectiveness in achieving outcomes for the population they serve (such as employment, self-direction, independent living, keeping children with families) • Produce a semi-annual report to the DBHDS QIC on the findings from the data review with recommendations for systemic improvement that includes: analysis and findings and recommendations based on review of the information from case management monitoring/oversight processes including: data from the oversight of the Office of Licensing, DMAS Quality Management Reviews, CSB Case Management Supervisors Quarterly Reviews, DBHDS Office of Community Quality Improvement retrospective reviews, Quality Service Reviews, and Performance Contract Indicator data • Analyze CM Quality Review data submitted to DBHDS that reports on CSB case management performance • Provide technical assistance to individual CSBs as needed • Ensure CSBs receive their case management performance data semi-annually at a minimum • Track cited regulatory non-compliance correction actions to ensure remediation • Establish process for annual retrospective reviews to validate findings of the CSB case management supervisory reviews; process includes sample stratification, quantitative measurement of both CSB and DBHDS Quality Improvement record reviews and inter-rater reliability process for DBDHS Quality Improvement staff • Review the results of other data reports that reference case management and make recommendations for systemic improvements as applicable • Establishes two indicators in each of the areas of health and safety and community integration and based on review of the data from case management monitoring processes • Establishes performance measure indicators (PMIs) that align with the eight domains • Monitors progress towards achievement of identified performance measure indicators (PMIs) and for PMIs falling below target, determine actions that are designed to raise the performance • Assess PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices

	• Recommend quality improvement initiatives (QIIs) to the DBHDS Quality Improvement Committee (QIC) (at least one per fiscal year, based on data analysis) • Implements approved QIIs within 90 days of the date of approval • Monitor progress of approved QIIs assigned to the workgroup and address concerns/barriers as needed • Evaluate the effectiveness of the approved QII for its intended purpose • Report to DBHDS QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns Membership Responsibilities: **Voting members:** • Have decision making capability and voting status • Review data and reports for meeting discussion • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory members:** • Perform in an advisory role for the CMSC whose various perspectives provide insight on CMSC activities, performance outcomes, and recommended actions • Inform the committee by identifying issues and concerns to assist the CMSC in developing and prioritizing meaningful QI initiatives • Supports the CMSC in performing its functions **Definitions:** The following standard definitions as referenced in Part I of the Quality Improvement Plan (Program Description) are established for all quality committees: • Committee - Subject areas with expertise and accountability

	• Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees. o Steering Committee - An advisory committee that provides direction, decides on priorities or order of business, and manages the general course of operations and reports to the QIC. o Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight o Council – Members are nominated by other council members and DBHDS • Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics • Key Performance Area – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity. • Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and prioritizes quality improvement initiatives to address identified issues for QIC review and approval. • Quality Management (QM) Plan - Ongoing organizational strategic quality management and improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders as well focuses on improving efficiency, effectiveness and output • Quality Improvement (QI) Initiative- Focuses on a specific area within a QM plan with identified actions

Health, Safety and Well-being Workgroup Charter
QIC Approved September 21, 2020

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

<table>
<tr><td>Model for Quality Improvement</td><td>Determine the:
• Aim: What are we trying to accomplish?
• Measure: How do we know that a change is an improvement?
• Change: What change can we make that will result in improvement?

Implement the Plan/Do/Study/Act Cycle:
• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions
• Do: Carry out the plan. Collect data and begin analysis of the data.
• Study: Complete the analysis of the data. Compare data to predictions.
• Act: Plan the next cycle. Decide whether the change can be implemented.</td></tr>
<tr><td colspan="2">Structure of Committee / Workgroup:</td></tr>
<tr><td>Membership</td><td><u>Voting Members:</u>
Director, Office of Human Rights
Assistant Commissioner for Developmental Disability Services
Senior Director, Clinical Quality Management
Director, Community Quality Improvement
Director, Office of Integrated Health
Director, Office of Licensing
Mortality Review Committee Clinical Manager
Representative, Office of Data Quality and Visualization
Settlement Agreement Director
Director, Provider Development
Representative, Office of Waiver Operations
Director, Office of Individual and Family Support
Director, Office of Housing

<u>Advisory Members (non-voting):</u>
QI/QM Coordinator
Other as determined by the Health, Safety and Wellbeing KPA Workgroup</td></tr>
<tr><td>Meeting Frequency</td><td>Meetings shall be held monthly, at least 10 times per year; additional meetings may be scheduled as determined by the urgency of issues.</td></tr>
<tr><td>Quorum</td><td>A quorum is 50% plus one of voting membership.</td></tr>
</table>

Leadership and Responsibilities	The Assistant Commissioner for Developmental Disability Services chairs the Health, Safety and Wellbeing KPA Workgroup. The chair will be responsible for ensuring the workgroup performs its functions. The chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function • Analysis of PMIs to measure performance across the KPA • Quality improvement initiatives are consistent with Plan, Do, Study, Act model • Monitoring of surveillance data on a regular schedule The KPA Workgroup will: • Establish at least one performance measure indicator (PMI) for each domain identified as either an outcome or output measure • Determine priorities when establishing the performance measure indicators (PMIs) • Consider a variety of data sources for collecting data and identify the data sources to be used • Measure performance across each domain and for PMIs falling below target, determine actions that are designed to raise the performance • Assess PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices • Analyze data and monitor for trends quarterly • Recommend quality improvement initiatives (QIIs) to the DBHDS Quality Improvement Committee (QIC) (at least one per fiscal year, based on data analysis) • Implements QIC approved QIIs within 90 days of the date of approval • Monitor progress of approved QIIs assigned to the workgroup and address concerns/barriers as needed • Evaluate the effectiveness of the approved QII for its intended purpose • Report to DBHDS QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs • Determines and finalizes surveillance data from a variety of sources. This data may be used for ongoing, systemic collection, analysis, interpretation, dissemination, and also serves as a source for establishing PMIs and/or quality improvement initiatives • Monitors surveillance data in each of the domains associated with the KPA Workgroup and responds to identified trends of concerns

	• Completes a committee performance evaluation annually that includes the accomplishments and barriers of the KPA Workgroup • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns Each PMI will contain the following: • Baseline or benchmark data as available • The target where results should fall above or below • The date by which the target will be met • Definition of terms included in the PMI and a description of the population • Data sources (origins for both numerator and denominator) • Calculation (clear formula for calculating the PMI utilizing the numerator and denominator) • Methodology for collecting reliable data (complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) • The subject matter expert (SME) assigned to report and enter data on each PMI • A yes/no indicator to show whether the PMI can provide regional breakdowns Member Responsibilities: **Voting Members**: • All members have decision-making capability and voting status • Members shall be responsible for entering, reviewing, and analyzing data related to the PMI as assigned • Members shall be responsible for reviewing surveillance data prior to the scheduled review date and highlight areas of concern • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members (non-voting)**:

	• Perform in an advisory role for the KPA Workgroup whose various perspectives provide insight on KPA Workgroup performance goals, outcomes PMIs and recommended actions
	• Inform the committee by identifying issues and concerns to assist the KPA Workgroup in developing and prioritizing meaningful QI initiatives
	• Supports the KPA Workgroup in performing its functions
	
	Definitions: The following standard definitions as referenced in Part I of the Quality Improvement Plan (Program Description) are established for all quality committees:
	• Committee - Subject areas with expertise and accountability
	• Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees.
	    o Steering Committee - An advisory committee that provides direction, decides on priorities or order of business, and manages the general course of operations and reports to the QIC.
	    o Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight
	    o Council – Members are nominated by other council members and DBHDS
	• Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics
	• Key Performance Area – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity.
	• Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and prioritizes quality improvement initiatives to address identified issues for QIC review and approval.
	• Quality Management (QM) Plan - Ongoing organizational strategic quality management and improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders as well focuses on improving efficiency, effectiveness and output
	• Quality Improvement (QI) Initiative- Focuses on a specific area within a QM plan with identified actions

Community Inclusion and Integration Workgroup Charter
QIC Approved September 21, 2020

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

Model for Quality Improvement	Determine the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implement the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented.
Structure of Committee / Workgroup:	
Membership	**Voting Members:** Director, Provider Development Assistant Commissioner for Developmental Disability Services Senior Director, Clinical Quality Management Director, Community Quality Improvement Director, Office of Housing Director, Office of Individual and Family Support Representative, Office of Data Quality and Visualization Settlement Agreement Director Mortality Review Committee Clinical Manager Director, Office of Human Rights Director, Office of Integrated Health Representative, Office of Waiver Operations Director, Office of Licensing **Advisory Members (non-voting):** QI/QM Coordinator Others as determined by the Community Inclusion and Integration KPA Workgroup
Meeting Frequency	Meetings shall be held monthly, at least 10 times per year; additional meetings may be scheduled as determined by the urgency of issues.
Quorum	A quorum is 50% plus one of voting membership.

Leadership and Responsibilities	The Assistant Commissioner for Developmental Disability Services chairs the Community Inclusion and Integration KPA Workgroup. The chair will be responsible for ensuring the workgroup performs its functions. The chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function • Analysis of PMIs to measure performance across the KPA • Quality improvement initiatives are consistent with Plan, Do, Study, Act model • Monitoring of surveillance data on a regular schedule The KPA Workgroup will: • Establish at least one performance measure indicator (PMI) for each domain identified as either an outcome or output measure • Determine priorities when establishing the performance measure indicators (PMIs) • Consider a variety of data sources for collecting data and identify the data sources to be used • Measure performance across each domain and for PMIs falling below target, determine actions that are designed to raise the performance • Assess PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices • Analyze data and monitor for trends quarterly • Recommend quality improvement initiatives (QIIs) to the DBHDS Quality Improvement Committee (QIC) (at least one per fiscal year, based on data analysis) • Implements QIC approved QIIs within 90 days of the date of approval • Monitor progress of approved QIIs assigned to the workgroup and address concerns/barriers as needed • Evaluate the effectiveness of the approved QII for its intended purpose • Report to DBHDS QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs • Determines and finalizes surveillance data from a variety of sources. This data may be used for ongoing, systemic collection, analysis, interpretation, dissemination, and also serves as a source for establishing PMIs and/or quality improvement initiatives • Monitors surveillance data in each of the domains associated with the KPA Workgroup and responds to identified trends of concerns

	• Completes a committee performance evaluation annually that includes the accomplishments and barriers of the KPA Workgroup • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns Each PMI will contain the following: • Baseline or benchmark data as available • The target where results should fall above or below • The date by which the target will be met • Definition of terms included in the PMI and a description of the population • Data sources (origins for both numerator and denominator) • Calculation (clear formula for calculating the PMI utilizing the numerator and denominator) • Methodology for collecting reliable data (complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) • The subject matter expert (SME) assigned to report and enter data on each PMI • A yes/no indicator to show whether the PMI can provide regional breakdowns Member Responsibilities: **Voting Members:** • All members have decision-making capability and voting status • Members shall be responsible for entering, reviewing, and analyzing data related to the PMI as assigned • Members shall be responsible for reviewing surveillance data prior to the scheduled review date and highlight areas of concern • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members (non-voting):**

	• Perform in an advisory role for the KPA Workgroup whose various perspectives provide insight on KPA Workgroup performance goals, outcomes PMIs and recommended actions
	• Inform the committee by identifying issues and concerns to assist the KPA Workgroup in developing and prioritizing meaningful QI initiatives
	• Supports the KPA Workgroup in performing its functions
	
	Definitions: The following standard definitions as referenced in Part I of the Quality Improvement Plan (Program Description) are established for all quality committees:
	• Committee - Subject areas with expertise and accountability
	• Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees.
	    o Steering Committee - An advisory committee that provides direction, decides on priorities or order of business, and manages the general course of operations and reports to the QIC.
	    o Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight
	    o Council – Members are nominated by other council members and DBHDS
	• Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics
	• Key Performance Area – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity.
	• Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and prioritizes quality improvement initiatives to address identified issues for QIC review and approval.
	• Quality Management (QM) Plan - Ongoing organizational strategic quality management and improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders as well focuses on improving efficiency, effectiveness and output
	• Quality Improvement (QI) Initiative- Focuses on a specific area within a QM plan with identified actions

Provider Capacity and Competency Workgroup Charter
QIC Approved September 21, 2020

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

Model for Quality Improvement	Determine the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implement the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented.
Structure of Committee / Workgroup:	
Membership	**Voting Members:** Director, Provider Development Director, Office of Licensing Assistant Commissioner for Developmental Disability Services Senior Director, Clinical Quality Management Director, Community Quality Improvement Director, Office of Human Rights Representative, Office of Waiver Operations Representative, Office of Data Quality and Visualization Settlement Agreement Director Director, Office of Integrated Health Mortality Review Committee Clinical Manager Director, Office of Individual and Family Support Director, Office of Housing **Advisory Members (non-voting):** QI/QM Coordinator Others as determined by the Provider Capacity and Competency KPA Workgroup
Meeting Frequency	Meetings shall be held monthly, at least 10 times per year; additional meetings may be scheduled as determined by the urgency of issues.
Quorum	A quorum is 50% plus one of voting membership.

Leadership and Responsibilities	The Assistant Commissioner for Developmental Disability Services chairs the Provider Capacity and Competency KPA Workgroup. The chair will be responsible for ensuring the workgroup performs its functions. The chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function • Analysis of PMIs to measure performance across the KPA • Quality improvement initiatives are consistent with Plan, Do, Study, Act model • Monitoring of surveillance data on a regular schedule The KPA Workgroup will: • Establish at least one performance measure indicator (PMI) for each domain identified as either an outcome or output measure • Determine priorities when establishing the performance measure indicators (PMIs) • Consider a variety of data sources for collecting data and identify the data sources to be used • Measure performance across each domain and for PMIs falling below target, determine actions that are designed to raise the performance • Assess PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices • Analyze data and monitor for trends quarterly • Recommend quality improvement initiatives (QIIs) to the DBHDS Quality Improvement Committee (QIC) (at least one per fiscal year, based on data analysis) • Implements QIC approved QIIs within 90 days of the date of approval • Monitor progress of approved QIIs assigned to the workgroup and address concerns/barriers as needed • Evaluate the effectiveness of the approved QII for its intended purpose • Report to DBHDS QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs • Determines and finalizes surveillance data from a variety of sources. This data may be used for ongoing, systemic collection, analysis, interpretation, dissemination, and also serves as a source for establishing PMIs and/or quality improvement initiatives • Monitors surveillance data in each of the domains associated with the KPA Workgroup and responds to identified trends of concerns

	• Completes a committee performance evaluation annually that includes the accomplishments and barriers of the KPA Workgroup • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns Each PMI will contain the following: • Baseline or benchmark data as available • The target where results should fall above or below • The date by which the target will be met • Definition of terms included in the PMI and a description of the population • Data sources (origins for both numerator and denominator) • Calculation (clear formula for calculating the PMI utilizing the numerator and denominator) • Methodology for collecting reliable data (complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) • The subject matter expert (SME) assigned to report and enter data on each PMI • A yes/no indicator to show whether the PMI can provide regional breakdowns Member Responsibilities: **Voting Members:** • All members have decision-making capability and voting status • Members shall be responsible for entering, reviewing, and analyzing data related to the PMI as assigned • Members shall be responsible for reviewing surveillance data prior to the scheduled review date and highlight areas of concern • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members (non-voting):** • Perform in an advisory role for the KPA Workgroup whose various perspectives provide insight on KPA Workgroup performance goals, outcomes PMIs and recommended actions

	• Inform the committee by identifying issues and concerns to assist the KPA Workgroup in developing and prioritizing meaningful QI initiatives
	• Supports the KPA Workgroup in performing its functions
	
	Definitions: The following standard definitions as referenced in Part I of the Quality Improvement Plan (Program Description) are established for all quality committees:
	• Committee - Subject areas with expertise and accountability
	• Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees.
	    o Steering Committee - An advisory committee that provides direction, decides on priorities or order of business, and manages the general course of operations and reports to the QIC.
	    o Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight
	    o Council – Members are nominated by other council members and DBHDS
	• Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics
	• Key Performance Area – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity.
	• Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and prioritizes quality improvement initiatives to address identified issues for QIC review and approval.
	• Quality Management (QM) Plan - Ongoing organizational strategic quality management and improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders as well focuses on improving efficiency, effectiveness and output
	• Quality Improvement (QI) Initiative- Focuses on a specific area within a QM plan with identified actions

Quality Review Team Charter
September 2019

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

	well as systemic remediation. The committee may make recommendations for remediation such as: • retraining of providers • Information Technology system enhancements for the collection of data • change in licensing status • targeted QMR • referral to the Provider Remediation Committee for mandatory provider remediation • payment retraction or ceasing referrals to providers • review of regulations to identify needed changes • review of policy manuals for changes • targeted or system-wide training The team identifies barriers to attainment and the steps needed to address them. The QRT re-examines data in the following quarter to determine if remediation was successful or if additional action is required. If remediation and/or improvement is not recommended for a performance measure that falls below 86%, the justification for that decision will be documented in the meeting minutes.
Charter Review	The QRT was established in August 2007 in response to CMS's new expectations that states implement a quality review process for HCBS waivers. This charter shall be reviewed by DBHDS and DMAS on an annual basis or as needed and submitted to the Quality Improvement Committee for review.
Model for Quality Improvement	The activities of the QRT are a means for DMAS and DBHDS to implement CMS's expected continuous quality improvement cycle, which includes: • Design

	• Discovery • Remediation • Improvement
Structure of Workgroup / Committee:	
Membership	**DBHDS:** Director of Waiver Operations or designee Senior DD Policy Analyst Director of Provider Development or designee Director of Office of Licensing or designee Director of Office of Human Rights or designee Director of Office of Community Quality Improvement or designee Director, Mortality Review Committee or designee Settlement Agreement Director **DMAS:** Director of Division of Developmental Disabilities or designee Developmental Disabilities Program Manager or designee QMR Program Administration Supervisor or designee
Quorum	A quorum shall be defined as 50% plus one of voting membership.
Meeting Frequency	The committee will, at a minimum, meet four times a year.
Leadership and Responsibilities	The DBHDS Senior DD Policy Analyst shall serve as chair and will be responsible for ensuring the committee performs its functions including development of meeting agendas and convening regular meetings. The standard operating procedures include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance and distribution of quarterly updates and/or meeting minutes as necessary and pertinent to the committee's function • Maintenance of QRT data provenance

	• CMS Evidentiary and state stakeholder reporting • Quality improvement initiatives consistent with CMS's Design, Discover, Remediate, Improve model. Meeting minutes are prepared and distributed to committee members prior to the meeting. Minutes shall reflect the committee's review and analysis of data and any follow up activity. The QRT shall produce an annual report to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. The QRT's report will include an analysis of findings and recommendations based on review of the information regarding each performance measure.

QIC SUBCOMMITTEES WORK PLAN

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

Committee Requirements

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

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

QIC Subcommittees to which this tool applies: CMSC, RMRC, KPA Workgroups, MRC,
Persons Responsible for Completion of This Document: QI/QM Coordinator or designee
Timeline for completion: Per QI subcommittee meeting schedule
Document Location: In Teams
Owner of the Document: Rebecca Laubach

Committee	**Date Met During SFY** *List meeting date in which these were discussed*	**Surveillance Data Element(s) Reviewed** *Describe the data being reviewed include pertinent details (report name, time frame, etc); indicate what patterns or trends are noteworthy, which require a deeper dive and any action the subcommittee is taking as result of the review and analysis of data. If surveillance data is not reviewed, simply state "not reviewed".*	**Additional Committee Charter Requirements** *Describe other work the committee performs such as look-behinds, case reviews development of materials, other data reviews that lead the committee to taking action, and so on. The focus is on what actions came out of these reviews (form changes, training, protocol changes, and so on. This column can be tailored to meet the specific charter requirements and should NOT include all charter requirements.*	**Ideas for Proposed QII** *Based upon data reviews (PMI, surveillance), list ideas the subcommittee is considering as potential QIIs. Provide enough detail that the subcommittee can use to further determine whether this should become a proposed QII or if other quality improvements measures should be implemented. This helps the subcommittee to see what ideas and QIIs have been proposed. These ideas should be incorporated into the QII PDSA Workbook.*	**Proposed QII** *List the proposed QIIs. This entry becomes important for tracking proposed QIIs that are disapproved by the QIC.*	**QIC Action: Approval/Disapproval** *The QIC action must be noted per proposed QIC. QIIs disapproved by the QIC can be modified and presented again. Information on approved QIIs can be found on the Approved QII Progress Tracking tab.*	**Data Requests** *List any requests for additional data from the RQCs (be specific in listing which RQC). List any follow-up questions from the RQCs as well. If there are no data requests, list NA.*	**Data Requests Follow-Up** *List the subcommittee's response to the data request(s) and answer to any questions posed. Identify if data request cannot be fulfilled and why. Identify if data request is determined to be unavailable. This information (responses to data requests and answers to questions) is shared with the RQC. The RQC will report to the QIC on unfulfilled data requests and any data determined to be unavailable. Once the data request has been fulfilled, indicate some type of closure including date.*	**Response to QSR Recommendations** *Describe the committee's actions in response to recommendations from the QSR vendor. If there are no QSR recommendations, list NA.*	**Response to Other Recommendations** *Describe the committee's actions in response to recommendations found in other reports such as those in the Independent Review Report, OSIG Report, etc. If there are no other recommendations that have come before the committee, list NA.*	**Other** *Describe any other work the committee does that is not captured in any of the columns listed in this work plan. Include rationale for the work, supporting data as applicable, identification of challenges/barriers and resolution to challenges/barriers.*	**QIC Presentations (PMI, report, Etc.)** *Briefly describe the committee's review and preparation of their report to the QIC. If not reviewed, list NA.*	**Comments** *Provide additional comments as needed to further support the preceding columns. Other pertinent information should be included if it impacts the work of the committee. If data trends support a proposed new PMI, list that information here.*

PMI Monitoring

The QI Committees Work Plan is the system for tracking PMIs and development, implementation, and progress of QIs across committees/councils/ workgroups consistently. In addition, the QI Committees Work Plan will assist the committee in completing its annual committee performance evaluation and committee report.

Column instructions are found in the italic font directly under each column header. Each QI subcommittee is responsible to review this work plan at least quarterly, before the QIC meeting. **If PMI is performing below target, comments must include what efforts will occur to raise performance. Subsequent monitorings must then indicate the effectiveness of these efforts.**

QIC Subcommittees to which this tool applies: CMSC, RMRC, KPA Workgroups, MRC
Persons Responsible for Completion of This Document: QI/QM Coordinator or designee
Timeline for completion: Quarterly
Document Location: in Teams
Owner of the Document: Rebecca Laubach

Committee	**PMI** *List the QIC Approved PMI*	**PMI Target (% and/or #)** *List PMI target*	**SFY Q1 Status (% and/or #)** *List the performance results*	**Comments** *List the date the comment is being made. Comment should support change in status (effectiveness of strategies, impact of other events or changes, etc. on performance). If data is not available, this should be noted (why) and when it will be available.*	**SFY Q2 Status (% and/or #)** *List the performance results*	**Comments** *List the date the comment is being made. Comment should support change in status (effectiveness of strategies, impact of other events or changes, etc. on performance). If data is not available, this should be noted (why) and when it will be available.*	**SFY Q3 Status (% and/or #)** *List the performance results*	**Comments** *List the date the comment is being made. Comment should support change in status (effectiveness of strategies, impact of other events or changes, etc. on performance). If data is not available, this should be noted (why) and when it will be available.*	**SFY Q4 Status (% and/or #)** *List the performance results*	**Comments** *List the date the comment is being made. Comment should support change in status (effectiveness of strategies, impact of other events or changes, etc. on performance). If data is not available, this should be noted (why) and when it will be available.*

QII Monitoring

The QI Committees Work Plan is the system for tracking PMs and development, implementation, and progress of QIIs across committees/councils/ workgroups consistently. In addition, the QI Committees Work Plan will assist the committee in completing its annual committee performance evaluation and committee report.

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

Committee	**Systemic Problem Area Identified** *A short phrase describing the problem leading to the QII.*	**Approved Quality Improvement Initiative** *Catchphrase for QII that best summarizes what the QII is about*	**Date Approved/ Date Implemented** *Include both the date approved and the date the QII was actually implemented*	**Date of QII Status Review** *List each date the QII is reviewed*	**Progress of Steps Towards Completion** *Now that the QII has begun, describe the progress seen to date.*	**Challenges/Barriers Identified** *What challenges/barriers have been identified since the QII was implemented?*	**Actions Implemented to Reduce Challenges/Barriers** *What actions did the QI subcommittee implement to reduce or eliminate the challenges/barriers? If an action is recommended and not implemented, this can be noted. If the recommended action needs to go to the QIC, it should be noted here and included in the report to the QIC.*	**Data Gathered on Impact of this QI Initiative/Effectiveness of Strategies** *What data has been collected that shows the impact the QII is having? Of the strategies used to reduce challenges/barriers, what data describes the effectivenes? If things are not working, describe.*	**List the Outreach, Education, or Training provided as part of this QI Initiative** *List the date and describe what outreach, education or training that has been done related to the QII. This will show the effectiveness of the outreach, education or training.*	**Date QI Project Revised/Replicated/Expanded/ Discontinued (Completed)** *List date of change and a description (revised, discontinued, replicated, expanded) as applicable*	**Comments** *Provide any additional details regarding support actions taken or other important information that should be known. If an approved QII needs revision, place supporting documentation here. Once the revision has been approved, the revised QII will be tracked under the original QII.*

Developmental Disabilities Quality Management Plan Annual Report and Evaluation

Virginia Department of
Behavioral Health &
Developmental Services

Developmental Disabilities Quality
Management Plan
Annual Report and Evaluation
State Fiscal Year 2020
Completed: October 2020

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 2020 (SFY20) quality management activities, characteristics, and outcomes (compared to SFY19 outcomes, where applicable). 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 DBHDS quality management plan (QMP) 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 is aligned with the DBHDS vision and mission, and serves as a well-defined structure and process for driving quality management. This is achieved through risk management and quality assurance and improvement activities, designed to ensure that individuals are healthy and safe, integrated into and included in their communities, and that service providers are competent and have the capacity to serve individuals at the individual, provider and system level. This year in review highlights DBHDS' successful implementation of the QMP, including revised program descriptions, quality committee charters and work plan, and an updated Annual Report and Evaluation. DBHDS implemented recommendations from the Data Quality Monitoring Plan and conducted a supplemental assessment of the Data Warehouse (DW), which identified additional recommendations that will improve upon the data collection, storage and use of data by the agency. The Quality Management Program reviewed each Key Performance Area (KPA) performance measure indicator (PMI) to assess the quality of developmental disability services and initiated mitigating strategies to improve areas not meeting set targets and to address identified gaps. The SFY20 Quality Management Annual Report and Evaluation demonstrates the continued growth of the quality committees in their data analysis, identification of the need for additional information to inform further decisions or inferences, and the developing ability to understand performance from a more global perspective. Through leadership support, the organizational culture of quality continues to be strengthened through the expansion of quality improvement (QI), quality assurance (QA), and risk management (RM) processes throughout the continuum of service delivery.

I. Introduction

The QMP for the Department of Behavioral Health and Developmental Services (DBHDS) is a three-part document, which includes this Annual Report and Evaluation for SFY20. 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 QII 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 report is to determine if the system is meeting the needs of individuals and families in a manner that aligns with the Commonwealth's mission and vision 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 the National Association of State Directors of Developmental Disabilities Services for the collection, analysis, and reporting of National Core Indicators (NCI) data.

DBHDS's QMS 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 CMS DD PMs that fall below the target. The QRT provides the DBHDS Quality Improvement Committee (QIC) an annual report on the status of CMS DD PMs with recommendations to QIC.

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 outcomes for individuals receiving DD services. In 2019-2020, a total of 46 states, the District of Columbia and 22 sub-state entities participated in NCI. Not all participating states do all surveys every year. VA conducted 512 valid surveys, with a margin of error of 4.25%. 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 QA, RM, and QI are core components of the DBHDS quality management program. This section outlines the SFY20 overall key accomplishments of these components of the program.

Quality Assurance (QA)

1. The DBHDS Office of Licensing (OL) developed and revised a number of guidance documents, associated with regulatory requirements, to enhance provider understanding of expectations and to clarify how licensing specialists will be determining compliance during inspections and investigations. The OL significantly increased the support/training/oversight of licensing specialists by increasing formal *All Staff* meetings from one time per quarter to a minimum of every other week, beginning in March of 2020. In addition, internal protocols were revised and templates developed to increase consistency of monitoring among specialists and Regional Managers throughout the state.
2. The DBHDS Office of Human Rights (OHR) continued Community Look-Behind reviews, which reviewed by the RMRC in August 2019 and April 2020. Concerns with the way reviewers were evaluating corrective action implementation (basing scoring on advocate documentation as opposed to action implementation) were noted. This will be addressed and corrected in SFY21 reviews.
3. The DBHDS Incident Management Unit (IMU) completed a look-behind review of a sample of serious incidents and reported look-behind outcomes to the RMRC in June SFY20 and recommended areas for potential improvement. The RMRC discussed the recommendations; as a result, a number of process improvements, to be implemented in SFY21, were identified.
4. The RMRC began monitoring provider compliance with requirements, through annual licensure inspections, to implement risk management and quality improvement programs, as well as requirements to conduct root cause analyses. Baseline data was established; the committee will determine if improvement activities are needed in SFY21.
5. The RMRC implemented a tracking log to monitor performance related to DOJ indicators including the QA measures described above, as well as others.
6. An OL representative attends DBHDS MRC meetings and brings information related to OL investigation findings before the committee for review. The committee may make additional recommendations based on those findings. The MRC put forth many efforts to make improvements toward reviewing at least 86% of deaths within 90 days of the death. These efforts included: Mortality Review Office (MRO) monitoring review timeframes, as well as complete retrospective clinical case summaries and preliminary reviews in time for the MRC to complete its reviews within 90 days; collaboration with the OL Specialized Investigation Unit (SIU) to ensure timely, complete document submission;

maintenance of the Master Document Posting Schedule (MDPS); and streamlined review processes to ensure thorough, quality, timely case reviews. During SFY20, the MRC reviewed 95.1% of cases within 90 days of death, exceeding its goal by 9.1%.

7. The DBHDS OPD, the DBHDS OCQI, and the DBHDS ODQV worked collaboratively to implement a SCQR process, to monitor the quality of support coordination for individuals receiving waiver services, establish review methodology, and test review instruments. This quality review included a record review of case management functions, by the Community Services Boards (CSBs), and a retrospective record review by DBHDS. This process is designed to enhance quality improvement efforts across CSBs and enable DBHDS to monitor case management performance at local and systemic levels. OCQI QI Specialists expect to conduct interrater reliability testing and SCQR retrospective record reviews (of CSB case management functions) in SFY21.

The SFY 2020 SCQR questions and technical guidance were written to assess compliance with the ten Department of Justice Settlement Agreement (DOJ SA) case management indicators as well as other facets of high-quality support coordination. In accordance with the DOJ SA compliance indicators, a statistically significant stratified statewide sample of individuals receiving Home and Community-Based Services (HCBS), through the developmental disability (DD) waivers, ensures record reviews of individuals at each CSB. The population used for the SFY2020 SCQR sample included adults age 18 or older who were enrolled in one of the HCBS Waivers as of July 1, 2018, in either an active, hold, or pending appeal status (with an authorization for least one HCBS waiver service). Case Management supervisors at each CSB completed the SCQR process via a survey in Qualtrics, a web-based survey platform, about the individuals served and the case management services they received.

The SCQR survey consisted of questions that required an answer and included display/question logic (to reduce respondent fatigue and to allow respondent to explain any negative responses). Explanations will be used to improve the quality of support coordination records and to revise the survey questions for subsequent years. CSBs completed the submission phase of the first year of the SCQR process. The committee provided data to CSBs via a secure online portal and included results in a performance letter provided to each CSB. The DBHDS Office of Data Quality and Visualization (ODQV) prepared a full report for each CSB, which will be used in the provision of technical assistance in the first quarter of SFY21 in tandem with the retrospective review process pictured below.

DBHDS Retrospective Review Process

8. During SFY20, the DBHDS KPA Workgroups focused on refining committee structure, to assure a focus on QA, RM, and QI. PMIs were updated based on prior performance. The focus this past year was around identifying surveillance data that the committee could review to assure that the workgroups had a well-rounded understanding of the issues surrounding health, safety and well-being, community inclusion and integration, and provider capacity and competency. The combination of surveillance data to be-reviewed includes data from a variety of sources and systems such as NCI, SCQR, QSR, WaMs, Community Consumer Submission (CCS3), DARS, DMAS, Licensure, CHRIS, Data Warehouse, Crisis, Housing, Baseline Measurement Tool, Mobile Rehab, OIH Mobile Dental, Commonwealth of Virginia Learning Center (COVLC), CM Modules, and Individual and Family Support Program(IFSP).

Risk Management (RM)

1. A new interface for reporting serious incidents was implemented in August 2019, which aligned with new reporting requirements and allowed reports to separately track the type of incident, type of injury or illness, and the cause of that injury or illness.
2. To address recommendations contained within the Office of the State Inspector General's Review of Serious Injuries, the DBHDS OL implemented a specialized Incident

Management Unit (IMU) for the triage of serious incidents. The IMU allows for better monitoring of providers' compliance with the serious incident reporting requirements contained within the OL regulations. The IMU was implemented in Region 4 in August 2019. Due to the impact of the pandemic on resources, emergent response needs, and subsequent hiring freeze, the rollout of the IMU staff to all regions was delayed until September 15, 2020.

3. The IMU provided regular training and technical assistance to providers and monitored data including specific individual, provider and system trends related to serious incidents and deaths. Trend analysis was shared with internal teams.
4. The RMRC, working with the DBHDS Office of Integrated Health (OIH) and IMU, outlined a strategy for implementing risk triggers and thresholds which focused on individual risk screening/awareness (using the Risk Awareness Tool – completed during the ISP process) and event based triggers (care concerns, identified by the IMU from serious incident reports).
5. To identify care concerns, the IMU reviewed data identified trends, including providers that have a high volume of incidents, or several incidents of the same type (e.g., falls or medication errors); identified patterns of incidents with the same individual that may indicate the need for a change in services, or the need for additional resources. Through this review, the IMU was able to identify areas, based on serious incidents, where there was potential risk for more serious future outcomes. Individual incidents or providers who meet care concern criteria will trigger IMU or other DBHDS office follow-up. The RMRC will begin to look at patterns of care concerns beginning in FY21.
6. The RMRC began more systemic review of serious incident data and recommended initiating a fall prevention QII. A preliminary review of data suggested a decreasing trend in the rate of falls. Additionally, training activities and educational materials developed/issued by the OIH during September 2019 – January 2020 are located on DBHDS' OIH website.
7. The mortality case review process identified a systemic issue related to direct support staff failure to contact 911 in emergencies, without first receiving approval of their supervisors, as a quality concern (which is being addressed by the Mortality Review Committee (MRC)).
8. The DBHDS Office of Human Rights (OHR) implemented an A.I.M.24 protocol to ensure onsite review by an advocate in the case of any reported abuse in which immediate health or safety is an immediate concern (such as cases of sexual abuse, restraint with injury, or abuse with injury).
9. The RMRC monitored new cases of COVID-19 among individuals served by DBHDS licensed providers and the impact on other incidents. The IMU and OIH collaborated to identify new outbreaks and offer technical assistance to licensed providers.
10. The MRC, in collaboration with the RMRC, recommended that direct support professional (DSP) training be reviewed to determine if it addressed provider policy requirements for

staff initiation of CPR and calling 911 (prior to calling a director *or any other staff member*). Both committees recommended that the OIH speak about appropriate use of CPR and 911 protocols during Provider Round Tables. A DBHDS OIH Registered Nurse Care Consultant (RNCC) attended each of the provider round tables during the second quarter of SFY20. Although provider competencies did note that provider policies should be adhered to in emergencies, DBHDS Office of Provider Development (OPD) updated the competencies to specifically indicate that 911 should be called before notifying anyone else of an emergency. Additionally, OPD updated case management modules and revised emergency protocols in an effort to increase licensed provider execution of established 911 protocols.

11. The DBHDS OIH also reviewed, revised, developed, and/or, provided the following alerts: Home Blood Pressure Monitoring (*Jan 2020*); Care Considerations and Epilepsy/Seizure Disorders (*Mar 2020*); Constipation: Care Management, Medication and Recognizing Bowel Obstruction (*Apr 2020*); and Stroke Awareness, (*May 2020*).
12. The CMSC defined two terms related to the provision of case management services: "changes in status" and "ISP appropriately implemented." The definitions were described in a guidance document that provides the basic components of the definitions, examples of each phrase, and a list of generally accepted practices for consideration. In collaboration with CSBs, the CMSC designed and implemented a standardized process for Support Coordinators (SCs) to assess for change in status and ISP appropriately implemented at face-to-face meetings with each individual. During the pilot phase, an "On-site Visit Tool" was implemented and used during one face-to-face visit per month (when visits occur), resulting in the establishment of a schedule of monthly completion for people receiving enhanced case management (ECM) and one to three times quarterly for people with a targeted case management (TCM) level of service. The definitions are as follows:

- "Change in status" refers to changes related to a person's mental, physical, or behavioral condition and/or changes in one's circumstances to include representation, financial status, living arrangements, service providers, eligibility for services, services received, and type of services or waiver.

- "ISP implemented appropriately" means that services identified in the ISP are delivered consistent within generally accepted practices and have demonstrated progress toward expected outcomes, and if not, have been reviewed and modified.

SC supervisors were trained on these terms and how to implement them using the following materials: a definitions document, a standardized tool format referred to as the On-site Visit Tool (OSVT), a summary of the Independent Reviewer report history related to non-compliance with the DOJ SA provision V.F.2., a reference chart as

guidance, training slides, and a questions and answers document produced following a webinar provided on June 26, 2020. This project is further defined in a CMSC QII that was approved by the QIC in June 2020 for implementation.

13. During SFY20, the DBHDS KPA Workgroups identified several new indicators specific to health and safety to help mitigate risk to the individual: individuals on the DD waiver will have a documented annual physical exam; individuals with an active waiver status and a documented annual physical exam in the ISP in WaMS will have an actual annual physical exam date recorded; initial CEPPs (Crisis Education and Prevention Plans) are developed within 15 days of assessment; and seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk of physical safety) and as outlined in human rights committee approved plans. This work, combined with efforts from the RMRC, will ensure that we are assessing risks from a variety of perspectives including individual, provider and system.

Quality Improvement (QI)

1. The RMRC identified the rate of falls as a quality issue, recommended initiating a QII aimed at reducing the rate of falls, and implemented a PMI that included the rate of falls so that ongoing performance can be tracked. Preliminary data indicated a decreasing trend in the rate of falls.
2. The DBHDS OL formalized and increased the training and technical assistance offered to providers related to quality improvement and risk management requirements. This took the form of guidance materials, regularly scheduled trainings, informative memos and participation in provider organization meetings.
3. The DBHDS OL added staff positions to oversee the systemic monitoring of provider compliance with the risk management and quality improvement regulations and implemented standards related to mandatory regulations to be reviewed by DBHDS during each annual inspection. This resulted in significant increase in the percentage of providers assessed for compliance with quality and risk management requirements (increasing from around 30-40%, at the beginning of the year, to over 95% by the end of the year).
4. The MRC proposed four QII during SFY20:

    i. Propose legislation allowing MRC to obtain documents from agencies and facilities related to case reviews when/as needed
    ii. Reduce the number of Potentially Preventable deaths to less than 15% of total DD deaths reviewed
    iii. Decrease the number of 'Unknown' as cause of death (CoD)

iv. Reduce the number of Potentially Preventable deaths where the factor in the death was failure to execute established protocol, by increasing execution to the specific response protocol

5. The CMSC worked with the DBHDS OPD to produce three videos that provided an overview of the DOJ SA and its impact on services and supports, to include how quality improvement efforts are enhanced through the DOJ SA indicators. Individuals, families, providers, and support coordinators were granted access to these videos online.
6. The QII identified by the CMSC centers on the implementation of the On-Site Visit Tool mentioned above. In addition to addressing concerns with risk, this tool and related guidance is designed to increase the consistency in application of face-to-face assessments, completed by all developmental disability SCs. A pilot of the process is planned to occur between July and September 2020, with enhancements and revisions made following the pilot phase.
7. During SFY20, the DBHDS KPA Workgroups identified three separate QII for implementation. The first QII focused on increasing individuals' involvement in independent housing, the second focused on increasing the number of crisis assessments that occur in the community versus a hospital, and the last focused on improving DSP competency.

Data Quality

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

The Data Quality Monitoring Plan

The Data Quality Monitoring Plan (the Plan) was developed by the DBHDS ODQV, in SFY19, to assess DBHDS resources and processes used for developmental disability (DD) reporting. It was first implemented in SFY20 with a review in three phases:

Phase 1 examined the collection of data and storage within the source systems. These assessments:

- Provided an inventory of the major DD data sources used by DBHDS,
- Explored the user interface (UI),
- Described the content of each data source,
- Identified data validation and advanced business rules,

- Examined the roles of business ownership and reporting analysts, and
- Reviewed the source system documentation.

Phase 2 examined data warehouse extract, transform, and load (ETL) processes and procedures, such as those related to data transfer and restructuring. These assessments:

- Explored the Master Data Management algorithm and DBHDS ID linking process,
- Examined the Structured Query Language (SQL)2008 data warehouse architecture, and
- Reviewed available meta-data and procedural documentation.

Phase 3 examined the business area analytics and reporting of programmatic data. These assessments:

- Studied the major data reports related to the source systems used in Phase 1,
- Examined any procedures for the tracking or remediation of quality issues, and
- Reviewed meta-data and key business area documentation.

The Plan also included information about the approach and components used for each Phase, proposed next steps for addressing data quality enhancement needs, and provided recommendations for determining monitoring priorities. Additionally, ODQV produced detailed roadmaps and timelines to help guide these improvements.

DBHDS further implemented an assessment of its data source system and engaged in multiple activities to improve its data source system and address recommendations. The following activities were completed:

- Conducted 19 stakeholder interviews; reviewed the current state of data warehouse, business processes, lifecycle management, security, etc.
- Documented the current state operating model for data/analytics delivery
- Conducted scoring of criteria for various components of the data warehouse including reports, ETLs and tables
- Completed a test upgrade to SQL server 2016
- Documented high level architecture and data flows into the data warehouse, including files
- Conducted deep dive research on the Data Quality Application (DQA)
- Conducted deep dive into LIDS data anomaly and DBHDS ID

This assessment looked at the areas of data program management, business data alignment, data governance and data delivery modernization. Since the assessment was completed, the following progress has been noted:

- The ODQV initiated a deep dive analysis into the DQA to enable adjustments to the system within the current architecture. A refresh of Data Warehouse (DW) development environment from Production along with understanding of SQL job structure, documentation of data flows and business rules "archeology" occurred.
- Initial analysis and inventory of overlapping data entities in the warehouse has begun.

- Impact Makers' presented on features of Azure DevOps and Workflows.
- A detailed implementation plan was outlined which could be used to execute the upgrade project, and a draft resource plan was outlined.

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 CMS DD waiver PMs included in the DD HCBS Waivers Quality Improvement Strategy for the DD waivers and reports the status of those measures to CMS. CMS requires states to submit an evidentiary report on CMS DD waiver PMs and requires remediation when a performance measure falls below 86% for any year during the three-year cycle covered by the evidentiary report and/or development of a Quality Improvement Project (QIP) which details systemic activities to improve compliance which are approved and monitored by CMS. These measures demonstrate that states have implemented an effective system for assuring waiver participant health and welfare and that states have met other CMS-required HCBS standards. DBHDS quality subcommittees also monitor the state's CMS DD waiver PM within their PMIs. The QRT provides an annual report on the status of these PMs and recommendations to the DBHDS QIC. The SFY19 QRT report outlines the data sources and sampling methodology for all PMs and identified remediation activities for those PMs 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: https://www.dbhds.virginia.gov/developmental-services/provider-development.

The DBHDS QIC and/or subcommittees or workgroups monitor the PMIs and surveil other significant data to identify patterns and trends that signify a need for remediation, corrective action and/or the development of a QII. This section includes an analysis of data reports, 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. The Performance Assessment Key below defines measurement standards for each table presented within this section.

Performance Assessment Key:

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

Green Line – Performance Target

Blue line – Performance against Target

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

Key Performance Area: Health, Safety and Well-Being

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

The DBHDS offices of Human Rights, Licensing, and the Community Support Services (OCSS) collect the data presented below. Data is then analyzed and monitored by the KPA Workgroup, Risk Management Review Committee (RMRC), and the MRC. Please find below a brief synopsis of progress towards the achievement of PMIs relevant to domain of safety and freedom from harm.

Performance Measure Indicators – Safety and Freedom from Harm	Target	SFY19 Results	SFY20 Results	SFY20 Performance Assessment
Critical incidents are reported to the Office of Licensing within the required timeframes (24-48 hours)	86%	93%	92%	✓
Licensed DD providers, that administer medications, are NOT cited for failure to review medication errors at least quarterly	86%	99%	88%	✓
Corrective actions for substantiated cases of abuse, neglect and exploitation are verified by DBHDS as being implemented	86%	88%	99%	✓
State policies and procedures, for the use or prohibition of restrictive interventions (including restraints), are followed	86%	100%	NA	—

The state policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed	86%	100%	99%	✓
Unexpected deaths, where the cause of death or a factor in the death that were potentially preventable, where some intervention to remediate was taken	86%	62%	100%	✓
Licensed providers meet regulatory requirements for risk management programs:	86%	NA	82%	✓
Licensed providers meet regulatory requirements for quality improvement programs	86%	NA	75%	✓
Individuals are free from harm, as reflected in the rates of serious incidents that are related to risks which are prevalent in individuals with developmental disabilities: Falls	56.88	NA	56.77	✓

The RMRC monitored PMIs related to critical incidents, medication errors, corrective action plans, and restraint and seclusion. These five established PMIs were met throughout the reporting year. The PMI on corrective actions was below target in quarter 1 of SFY19, but following intervention, has consistently been above target. The PMI related to providers not being cited for failing to review medication errors quarterly met the overall annual target; however, it decreased significantly from the first to the fourth quarter. Upon review of the data, and after consulting with the licensing specialists via structured meetings, the OL Director implemented a new internal protocol that requires specialists to document a compliance rating for all regulations checked during an inspection of providers of DD services. Previously, only regulations deemed non-compliant were documented in a licensing report, making it difficult to ensure all necessary regulations were reviewed. Finally, additional information, related to how compliance with this PMI is determined, was documented and shared with both the provider community and the OL staff to increase consistency among specialists across the state. The combination of structured meetings along with implementation of the protocol outlined above and sharing of how compliance is rated resulted in a decrease in PMI performance for SFY20. (This also accounts for the decrease in performance noted from SFY19 to SFY20.) This PMI should continue to be monitored due to the importance of providers' completing quarterly review of any medication errors as part of their quality improvement program.

Three new PMIs were added in SFY20. These PMIs address provider compliance with risk management programs, provider compliance with quality improvement programs, and reducing the rate of falls. The target for falls was set at 56.88/1000 individuals on the DD waivers. This was based on targeting a 10% reduction in the baseline rate of falls of 63.2/1000 during the

baseline period of 10/1/19 – 3/31/20. This measure was reported for the last 3 quarters of SFY20. The rate of falls was above the target during the first two quarters, but dropped significantly in the fourth quarter, bringing the overall rate over three quarters to just below the target. The OIH implemented a number of interventions aimed at reducing the rate of falls, which included website posting a training on fall reduction, distribution of published health alerts and newsletters addressing fall prevention via the provider list serve and posted on OIH website, and hosting a continuing education event for nurses, focused on fall prevention. In addition to these interventions, the onset of COVID-19 may have also played a role in the reduction in the rate of falls. The RMRC members noted that due to a number of temporary closures and limited access to community activities, individuals were not traveling away from home as much and had fewer transitions of care, which may have resulted in less exposure to situations presenting a risk for falls. In line with this decrease, the number of emergency room visits decreased by 33%, from 1,362 in the second quarter to 916 in the third quarter.

The other two PMIs were approved on June 30, 2020, and are measures of the percentage of providers that have been determined to be compliant with requirements to implement risk management and quality improvement programs. Baseline data collected for SFY20 indicates that both measures were below the goal of 86%, with 82% of providers meeting the overall risk management requirements and 75% of providers meeting the quality improvement requirements. The RMRC will work with the DBHDS Office of Licensing (OL) to identify specific areas in which providers are having difficulty with compliance and develop interventions to improve performance. As Quality Service Review (QSR) data becomes available, the RMRC will also utilize these results to guide improvement efforts. QSR data, which is used for the PMI addressing the following of state policies and procedures regarding the use or prohibition of restraints, was not available for SFY20 due to the existing QSR contract having ended and the process of obtaining a new QSR contract was underway.

The DD Mortality Review Committee (MRC) is responsible for monitoring the PMI related to unexpected deaths. For each DD case, the MRC seeks to identify:

- The cause of death
- If the death was expected
- Whether the death was potentially preventable (PP)
- Any relevant factors impacting the individual's death
- Any other findings that could affect the health, safety, and welfare of these individuals
- Whether there are other actions that may reduce these risks, to include provider training and communication regarding risks, alerts, and opportunities for education *(see Definitions under "Leadership and Responsibilities" section)*

If any actions are identified based on the case review, the MRC will then make and document relevant recommendations and/or interventions.

The MRC made recommendations for all unexpected PP deaths in order to reduce mortality rates to the fullest extent practicable. When the MRC determined a death was PP, the committee categorized factors that might have prevented the death. Based on the MRC's determination of a PP death, the committee recommended remediation/corrective measures. Most of the provider-level recommendations were 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 OIH. The MRC utilized a tracking protocol that capture and monitor recommended remediation activities. These recommendations and actions are reviewed and discussed at each MRC meeting until completion of the action is achieved. When no deaths or factors in the death are determined to be PP, resulting in no need for remediation actions to be recommended, no data can be reported.

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. In SFY19, the MRC reviewed 312 deaths, and in SFY20, the MRC reviewed 354 total I/DD deaths.

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 in SFY19 that more deaths were determined to be expected than unexpected. Prior to SFY19, the highest percentage of expected deaths was 36.4 percent in SFY18. In SFY19, the committee determined 163 deaths (52%) were expected, 141 (45%) were unexpected, and eight (3%) were not able to be determined by the committee as expected or unexpected and, therefore, were classified as unknown. In SFY2020, the MRC determined 214 deaths (60%) were expected, 139 deaths (39%) were unexpected, and one (0.3%) was not able to be determined by the committee as expected or unexpected and, therefore, were classified as unknown.

In SFY19, the MRC continued a process first implemented in SFY18 to identify PP deaths and collect information related to contributing factors in these deaths. In addition, the MRC continued to ensure the identification of the factor(s) that may have prevented the PP death, as mentioned previously. In SFY18, the MRC classified 56 deaths (21%) as PP. By contrast, in SFY19, the MRC classified only 11 deaths (4%) as PP. The MRC notes this dramatic change in year-to-year data may be due to the significant changes made by the MRC in SFY19 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, along with increased attendance and participation of committee members, clarification of the PP definition, and identifying contributing factors to the individual's death. These changes have likely contributed to the committee's ability to more clearly make determinations related to PP deaths.

The number of PP deaths identified in SFY20 was 17 (5%). This increase from SFY18 and SFY19 is attributed to the expanded MRC process that included clarification of expected and unexpected (unexplained) definitions and ensuring identification of contributing factors to the unexpected and PP deaths discussed during each meeting. A 'failure to execute established protocols' was the factor identified for nine of the 11 deaths classified as PP (82%) in SFY19, and 14 of the 17 (82%) in SFY20. This contrasts with findings from SFY18, but given the small number of PP deaths in SFY19, these differences may be epiphenomenal. However, since the definition of a PP death was first introduced in SFY18, multiple changes occurred in SFY19, and this PP factor has remained at 82%, a QIC approved QII targeting this factor was implemented in SFY20. This QII addressed the need to follow the established protocol of calling 911 in emergencies. Ongoing monitoring of the effect of these changes is needed in subsequent years.

The type of documentation and records available related to the circumstances of a death can affect the synthesis of the clinical and service related factors that contribute to mortality. To enhance the mortality review process, legislation was sought that would allow the MRC to request and receive medical records and other pertinent documents related to I/DD deaths. This legislation became effective on July 1, 2020. Outcomes and data related to the effect of this legislation will be tracked and reported on for SFY21.

In SFY20, the MRC was to 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. This goal is still in progress as it requires input from other divisions within DBHDS and is expected to be completed in SFY21.

The MRC successfully implemented procedural changes to ensure that prompt, appropriate follow-up is completed based on the recommendations from the MRC related to unexpected, potentially preventable deaths in residential community settings. The committee assigns each recommended action to a specific committee member, and follow-up for pending actions is reviewed during each MRC meeting. The MRC discusses whether to complete an action based on documented follow-up. During SFY20, 100% of unexpected, potentially preventable deaths in residential community settings had some intervention to remediate. Moving forward, this procedure will continue as the PMI target goal (86%) was achieved in the last two quarters of SFY19 and has exceeded the target goal for SFY20.

The DBHDS KPA Workgroup monitors NCI data for the domain of physical, mental and behavioral health and well-being. The following table and graphs further detail NCI data reviewed and monitored and the Commonwealth's performance against NCI national data.

Performance Measure Indicators – Physical, Mental and Behavioral Health and Well-Being	Target (NCI National Average)	2018 NCI Virginia Result	2019 NCI Virginia Result	Performance Assessment
Individuals who reported that they have a primary care physician	98%	98%	99%	✓
Individuals who reported that they had a complete physical exam in the past year	89%	81%	82%	✓
Individuals who reported that they had a dental exam in the past year	81%	63%	65%	✓

Source - FY 2018-2019 National Core Indicators (NCI) Data

NCI indicators are categorized in five areas: Individual Outcomes, Health, Welfare and Rights, System Performance, Staff Stability and Family. NCI randomly selects representative samples of adults who receive DD waiver services. The Commonwealth's sample is stratified by region and typically includes 800 in-person surveys. However, in SFY 20, the onset of COVID-19 resulted in a decrease in the total number of surveys conducted.

As indicated in the chart below, the Commonwealth's performance, related to completion of physical exams was below the NCI reported national average for 2018-2019. Individuals reported and case managers validated that 82% of individuals received a physical exam in 2018-2019. This represents one percentage point improvement since 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.

The SFY19 NCI survey results reflect an increase of 2% over SFY18 in individuals who reported that they had received a dental exam. The chart below indicates that the Commonwealth's performance, related to completion of dental exams, was below the NCI reported national average for 2018-2019.

Several mitigating strategies were implemented in SFY19 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 allowed dental hygienists employed by DBHDS to work under the remote supervision of a dentist. This increased flexibility in providing services to individuals who meet OIH's Dental Clinic program criteria. DBHDS' Health Support Network provides dental services for 2,089 individuals, through contracted basic and moderate sedation dental services and mobile services.

The OCSS provides oversight of the following PMI specific to the domain of avoiding crisis. A synopsis of the Commonwealth's progress towards the achievement of this PMI is detailed below.

Performance Measure Indicators – Avoiding Crisis	Target	SFY19 Results	SFY20 Results	SFY20 Performance Assessment
Individuals (on DD waivers and known to REACH) admitted to a Crisis Therapeutic Home (CTH) have a residential provider within 30 days of admission	86%	84%	87%	✔

When individuals with developmental disabilities 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.

DBHDS met the target established by the indicator for this fiscal year and will continue to monitor and address challenges for placement as they are identified.

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.

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

Developmental Services is responsible for oversight of the domains of community inclusion and stability. The following table and graph describe the progress towards achievement of PMIs relevant to these domains. The data presented below is collected by the OCSS and Office of Community Housing (OCH) and monitored by the KPA Workgroup. A synopsis of the Commonwealth's progress towards the achievement of this PMI is detailed below.

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

Individuals, on DD waiver, are employed and receiving Individual Supported Employment (ISE)	75%	48%	60%	✔

Independent housing and employment are key factors in individuals being fully included in their communities in a meaningful way. During the past year, individuals supported through independent housing continued to exceed expectations. DBHDS also saw a significant increase in the percentage of individuals who were employed with support through individual supported employment. This percentage may be slightly artificially inflated due to the impact of COVID-19 on group-supported employment, although, there were impacts on individual supported employment as well. This graph below depicts increase made towards individual receipt of ISE.

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Percent Of Individuals On DD Waiver Employed And Receiving Individual Supported Employement (ISE)

SFY19
SFY19 Annual Rate: 48%
N=977

SFY20
SFY20 Annual Rate: 60%
N=1,172

Performance Measure Indicators – Stability	Target	SFY19 Results	SFY20 Results	SFY20 Performance Assessment
Individuals on the DD waiver and waitlist (aged 18-64) are working and receiving Individual Supported Employment (ISE) or Group Supported Employment (GSE) for 12 months or more	25%	19%	17%	✔

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, 2020, there were 3,512 people employed, with support, in ISE or GSE, which is a combined decrease of 713 people from the previous data reported, which is directly related to the impact of the COVID-19 in limiting transmission risks in the community. This represents 19% of the total number of individuals between the ages of 18-64 who received waiver services or were on the waiver wait list (18,621) at the time of reporting. The following graph depicts the combined decrease in the percentage of individuals working and receiving Individual Supported Employment (ISE) or Group Supported Employment (GSE) for 12 months or more.

The KPA Workgroup monitors NCI data for the domain of choice and self-determination. The following table and graphs further detail NCI data reviewed and the Commonwealth's performance relative to the NCI National Average data.

Performance Measure Indicators – Choice and Self-Determination	Target NCI National Average	2018 NCI Virginia Result	2019 NCI Virginia Result	SFY20 Performance Assessment
Individuals who chose or had some input in choosing where they live if not living in the family home.	58%	67%	67%	✓

Source - FY 2018-2019 National Core Indicators (NCI) Data

Individual choice is a right of people with disabilities. Having a choice about where one lives is critical to a successful outcome in the living environment. In SFY19, there was no change in the percent of individuals who had input into the choice of where they would live.

Key Performance Area: Provider Capacity and Competency

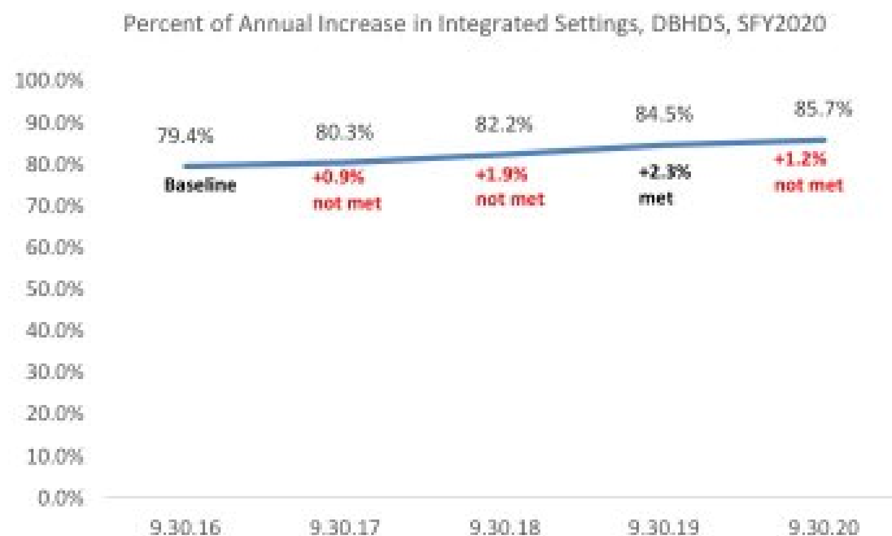
This key performance area includes data analysis of information relevant to the domains of access to services and provider capacity and competency. The goal of this KPA is to improve individuals' access to an array of services that meet their needs, support providers in maintaining a stable and competent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

The data presented below, relevant to the domains of access to services and provider capacity and competency, is collected by the OCSS analyzed by OPD and monitored by the DBHDS KPA Workgroup and DBHDS Case Management Steering Committee (CMSC). The table, charts, and graphs below detail the Commonwealth's progress towards these PMIs.

Performance Measure Indicators – Access to Services	Target	SFY19 Results	SFY20 Results	SFY20 Performance Assessment SFY20
Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings. (FY19 5.1%)	2% annual	1.9%	1.2%	✓
Data continues to indicate that at least 90% of individuals new to the waiver, including individuals with a "supports need level" of 6 or 7, since FY16 are receiving services in the most integrated setting.	90%	NA	85%	✓
The Data Summary indicates an increase in services available by locality over time.	↑ trend for all services	10/15	6/15	✓

DBHDS tracks the number of individuals in integrated versus non-integrated settings on a semi-annual basis. When considering a baseline of 2016 (as shown in the chart below), data shows a successive increase in the overall percentage of people in integrated settings with the annual target being met for the first year in 2019 with 2.3% with a smaller increase between 2019 and 2020 of 1.2%. The overall result in 2020 of 1.2% does not fall within 10% of target. DBHDS continues to incentivize integrated residential settings by making Jump-Start funding available to providers who seek to diversify or fill gaps in integrated services statewide. There have been two

semi-annual Provider Data Summary reports and webinars, which have increasingly combined detailed data about the DD Waiver population and provider activity across the 133 localities in Virginia. During SFY20 (July 2019 through June 2020), the Provider Development Team offered 1:1 assistance to 35 different providers throughout the state. The assistance offered included provider remediation, provider development, and technical assistance. The Provider Development team also offered numerous regional trainings throughout the year that targeted ISP development, documentation, and RST. DBHDS will continue to engage providers on a semi-annual and ongoing basis to encourage and support transitions to more integrated models of service.



In the May 2020 Provider Data Summary report, DBHDS included data related to people who were new to the waiver being supported in more integrated settings. This data report established a baseline of 85% in March of 2020, which falls below, but is within 10%, of the 90% target. To ensure that individuals with Supports Intensity Scale (SIS) levels 6 and 7 needs are considered in the results, a separate percentage is included, which established that 58% of people new to the waiver with SIS levels 6 or 7 needs are residing in more integrated settings. People newly enrolling into the waiver are introduced to the various system changes that have been undertaken by Virginia in recent years, such as person-centered practices, informed choice, Settlement Agreement requirements, and the Home and Community-Based Services residential settings rule. It is anticipated that with the continuation and development of these practices, more and more people will choose more integrated settings initially. DBHDS is working to increase independent housing and stand up Peer Mentoring Services, so that people have the opportunity to choose a home in the community that they control.

DBHDS monitors the trend in service development across localities. Information at the locality level is contained in the DBHDS Baseline Measurement Tool (BMT), which shows population and provider changes at the local level over time. Beginning in November of 2019, data from the BMT was structured in the Provider Data Summary report around "sub-areas." This change was made to ease provider use of the data in considering expansion. For example, a consideration of offering Skilled Nursing in one locality should be informed by looking at data from adjacent localities. The creation of sub-areas provides this level of information, so that expansions can more easily and thoughtfully be considered. Virginia has seen an ongoing increase in most integrated and critical services since June of 2018 (baseline). Some services have faced delays in implementation due to coordination and system issues such as the implementation of Peer Mentoring, which is expected to begin in October of 2020, and Employment and Community Transportation, which has experienced delays at the Medicaid agency. The only services that have experienced a decrease from baseline are Private Duty Nursing (-2) and Crisis Support Services (-1). Reviewing the Provider Data Summary report provides more specific information. For example, Benefits Planning was established in the Waivers in 2016 and as of May 2020, four providers have begun offering services. Line graphs in the report shed light on demand, as 158 people became authorized by 4.30.20. In a similar result, use of Electronic Home-Based Services doubled between 10.31.19 and 4.30.20, increasing from 24 to 49 authorizations across this six-month period. Time and continued efforts to educate and encourage informed choices for people receiving DD waiver services and supporting providers to shift to more integrated service models is expected to further impact these results. The chart below details the increase in provider services throughout the reporting period.

Number Of New Service Providers, Per Reporting Period

	Benefits Planning	Community Coaching	Community Engagement	Community Guide	Electronic Home-Based Services	Employment and Community Transportation	Independent Living Supports	In-home Supports	Peer Mentoring	Shared Living	Supported Living	Crisis Support Services	Private Duty Nursing	Skilled Nursing	Sponsored Residential
6.14.18	0	45	126	0	0	0	12	96	0	0	18	6	81	42	64
10.31.19	4	58	133	0	3	0	19	108	0	1	19	5	85	37	70
4.30.20	4	57	133	1	3	0	22	115	0	1	20	5	79	44	73

The Offices of Human Rights, Provider Development, and the OCSS are responsible for the domain of provider capacity and competency that include the following PMIs. The table and graphs below detail the Commonwealth's progress towards these PMIs.

Performance Measure Indicators – Provider Competency and Capacity	Target	SFY19 Results	SFY20 Results	SFY20 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%	92%	✓
Individuals receiving Developmental Disability Waiver services, identified as meeting ECM criteria, will receive face to face visits every month no more than 40 days apart	86%	89%	83%	✓
Individuals receiving Developmental Disability Waiver services, identified as meeting ECM criteria, will receive face to face visits every other month in their residence	86%	86%	77.5%	✓
Support Coordinators will have meaningful discussions about employment benefits and options, face to face with individuals (ages 18-64) receiving DD Waivers	86%	93%	93%	✓
Support Coordinators will have meaningful discussion about community engagement and community coaching, face to face with individuals receiving DD Waivers	86%	88%	90%	✓
Employment goals are developed for individuals, ages 18-64, receiving DD Waivers	50%	32%	30%	✓
Community Engagement and Community Coaching goals are developed for individuals receiving DD Waivers	86%	37%	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%	58%	✓
RST referrals are timely for individuals considering a move into group homes of 5 or more beds	86%	69%	78.5%	✓

Case Management Contact Measures

The percentage of ECM visits declined beginning the third quarter SFY20, when compared to SFY19; the overall success of meeting these two measures moved to "partially met" by the end

of SFY20, as indicated in the graphs below. This graph reflects the percentage of individuals receiving Developmental Disability Waiver services, identified as meeting ECM criteria, who received face to face visits every month (no more than 40 days apart). The decline in achievement can be attributed to the occurrence of a state of emergency related to the COVID-19 pandemic.

The percentage of ECM visits occurring in the home declined beginning the third quarter SFY20, when compared to SFY19; the overall success previously experienced, in meeting this measure, shifted to "partially met" by the end of SFY20, as indicated in the graph below. The chart below reflects the percentage of individuals receiving DD Waiver services identified as meeting ECM criteria that received face to face visits every other month in their residence. This decline in achievement can also be attributed to the impact of the state of emergency related to the COVID-19 pandemic, in ensuring mitigating transmission risks. In the effort to minimize the impact on case management contact data results, CSBs were advised to code telehealth contacts as face-to-face with a notation of telehealth in the contact note. Based on results depicted in the graphs above and below, in person, face-to-face contacts declined and the extent to which telehealth contacts were notated in the documentation may have been limited or not utilized.

The DBHDS OCQI will begin implementing a data verification process in the second quarter SFY20. This activity is expected to improve data reliability and is designed:

- To provide consultation and technical assistance to the CSB on data reporting requirements to ensure CSBs are submitting accurate data as part of a comprehensive quality management process to improve reporting of case management outcomes.
- To assist the CSBs in completing a root cause analysis that identifies the underlying causes for why it is not meeting case management process measure targets by identifying gaps and or issues in the CSBs' case management data reporting processes that impact the CSBs' performance in meeting case management performance measure targets
- To assist in resolving identified case management data reporting process gaps and issues and determine action steps needed to make system process and outcome changes to ensure that case management processes are reported accurately and as required.

Employment and Community Engagement Goal Measures

While the data indicates case managers/support coordinators are having discussions regarding employment, the intended target related to the number of individuals with employment goals was not met. These results remain consistent with data provided in SFY19, as depicted in the graph below (which reflects the percentage individuals receiving DD waiver services who had employment goals developed).

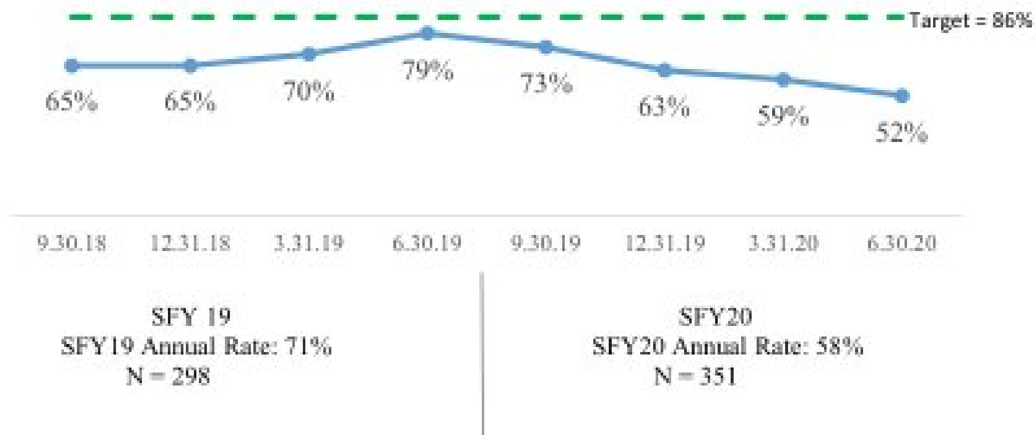
While the data indicates case managers/support coordinators are having discussions regarding community engagement, the intended target related to the number of individuals with community engagement goals was not met. These results remain consistent with data provided in SFY19, as depicted in the graphs below (which reflects the percentage of individuals receiving DD waiver services who had Community Engagement and Community Coaching goals developed).

As mentioned in relation to other measures, the COVID-19 pandemic was declared a state of emergency in Virginia in the 3rd quarter of SFY20, which interrupted access to employment and community engagement as people were directed by local and national government to stay at

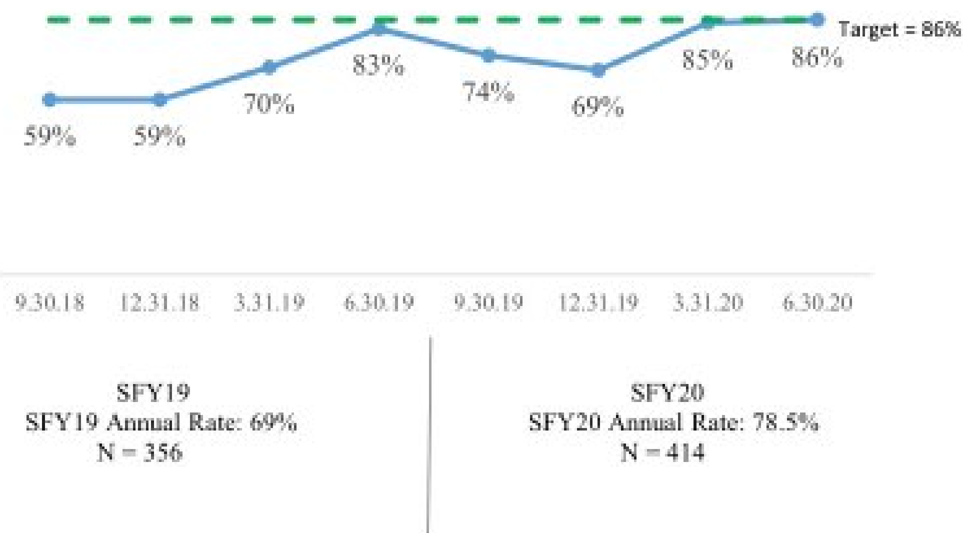
home. Despite this state of emergency, the development and addition of goals to individual ISPs for these activities were maintained throughout SFY20 with minimal fluctuation. It is unclear if the state of emergency hindered additional progress with improving these results, but based on the SFY19 report, establishing new services were identified as a means to increase goal development, and the pandemic has significantly impacted service development. Provider Development continues to implement a Jump-Start Funding program, which provides up $50,000 per year to organizations seeking to diversify or expand service options in the services system where gaps exist. DBHDS has modified requirements to ease the application process and will continue to explore ways to increase usage of Jump-Start funding. In addition, updates have been made to the Case Management Module for Employment to ensure more successful discussion and exploration of options to include considering activities that lead to employment, increase connections with others, and more employment-focused support for transition age youth. This module is scheduled to be released for use on November 1, 2020.

Regional Support Team Measure

In order to support individuals in making an informed choice of where they want to live, the DBHDS 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. The overall result in SFY19 was 71%, with an increase to 73% in the first quarter of SFY20 noted before declining. There has been a steady decline in SFY20 since the 2nd quarter reaching a low of 52% in the 4th quarter. The graph below reflects percentage of non-emergency referrals made in sufficient time for the RSTs to meet and attempt to resolve identified barriers.



Of note, the second measure, regarding residential referrals, met the target of 86% for the first time in the 4th quarter of SFY20 and remained within 10% of target in overall results. The graph below reflects the percentage of RST referrals that were made timely enough for individuals considering a move into group homes of 5 or more beds.



A root cause analysis will be discussed with the CMSC regarding this trend. One potential rationale for this data is that changes in residential placement may have occurred before the committee convened to complete its review (as opposed to meetings occurring before the change

in residential placement occurred). One of the challenges to be explored is how to more effectively process referrals and determine other factors impacting this measure. RST forms and processes have been refined during SFY20, and communication with CSBs continues to occur through regional and statewide Support Coordination meetings. RST continues to be a standing item on the agendas. Ongoing communication with CSBs along with the provision of quarterly compliance letters and the provision of data is considered helpful in meeting this measure.

A review of the measures and activities for SFY20 indicates that, despite the COVID-19 pandemic, accomplishments were made. This was demonstrated by increasing the availability of data in WaMS, and for the first time, CSBs met the target for the RST measure related to residential services. However, a decline in the number of case management contacts, which coincides with the onset of the state's declaration of a state of emergency due to COVID-19 (during which in-person contact became limited), was noted toward the end of SFY20. Despite efforts to mitigate this adverse effect, the overall average remains within 10% of the 86% target. Of additional concern was the lack of movement in measures related to goal development for employment and community engagement; outcomes remained largely consistent with SFY19 results. The CMSC will explore activities that may improve results in the coming year and will focus on understanding and addressing the timeliness of non-emergency RST referrals. Finally, the CMSC has worked to establish a process of collecting and reviewing data that includes a review schedule to allow more time to focus on specific sets of data and determine options to impact results. In the coming year, this will be necessary to adequately address the increased number of measures being monitored through the committee and implement actions that improve DD services and supports in the Commonwealth.

IV. Quality Management Program Evaluation

Using a Quality Management Program Assessment Tool, endorsed by the Institute of Healthcare Improvement (IHI), the DBHDS Quality Management quality improvement committee chairs conducted a program evaluation of each subcommittee and for the quality management program as a whole. The tool assists organizations in assessing key components of their quality management programs and includes an assessment of the QMP 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.

DBHDS Internal Quality Management Program Evaluation

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

Identified Strengths

Quality Management Program

The DBHDS Quality Management Program is supported by leadership with direct accountability to the DBHDS Chief Clinical Officer (CCO) and DBHDS Commissioner and has identified functions, resources, and a clear indication of responsibilities and accountability across the agency. Leadership continued to build and expand the Quality Management Program and the DBHDS Office of Clinical Quality Management in SFY20 with the addition of a Senior Director of Clinical Quality Management and Quality Improvement Specialists to support both internal and external quality efforts. The organizational quality improvement infrastructure developed is both sustainable and continuous. Additionally, DBHDS issued a new departmental instruction (DI) which describes the framework for and components of the DBHDS's Quality Management System (QMS) for individuals with DD who receive services licensed, funded or operated by DBHDS. The QMS is comprised of quality assurance, quality improvement, and risk management and, through the collection and evaluation of data, identifies and responds to data trends to ensure continuous quality improvement. Most importantly, this DI specified the activities encompassed by the QMS that are intended to ensure that appropriate services are available and accessible to individuals receiving services, including the collection and evaluation of data (to identify and respond to trends and ensure continuous quality improvement). The OCQM is responsible for maintaining the quality management framework and provides technical assistance and guidance across the QMS. The CCO and Senior Director of Clinical Quality Management serve as co-chairs of the QIC. Subcommittees of the QIC are as follows:

- Mortality Review Committee (MRC);
- Risk Management Review Committee (RMRC);
- Case Management Steering Committee (CMSC);
- Regional Quality Councils (RQCs); and
- Key Performance Area (KPAs) Workgroups, including:
    - Health, Safety and Well-Being;
    - Community Inclusion and Integration; and
    - Provider Capacity and Competency.

The QIC ensures a continuous quality improvement process and is responsible for the prioritization of needs and work areas. The QIC ensures that providers, case managers, and other stakeholders are informed of any QII approved for implementation as the result of trend analyses. This trend analysis is based on information from data related to suspected or alleged abuse, neglect, serious incidents, and deaths; and patterns in data related to case management, NCI, QSRs, quality management reviews, housing, employment, community engagement and inclusion, RST, home and community-based setting, provider data summary information, licensure citations, staff training and competency, crises, IFSP, and other data.

The QMS infrastructure and quality management framework is further detailed in the annual DBHDS QMP. The QMP, inclusive of three parts, serves as the guidance document for the direction and activities related to the Quality Management System. Part I of DBHDS QMP outlines authority, functions, and resources of the quality management system inclusive of the quality assurance, risk management, and quality improvement functions, as well as the quality committee framework. Part II includes quality committee charters and a workplan. The QIC established and annually reviews and approves standardized 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 work plan tracks the monitoring of surveillance data, performance measure indicators including mitigating strategies where performance is below target, and the implementation of approved QIIs, including the identification of barriers and efforts to mitigate circumstances around those barriers. Data is recorded within the work plan, which allows committees to identify potential QIIs and is structured so as to assist the OCQI team in the provision of support to QIC Subcommittees in completion of their work. The charters, along with Part I and Part II, and the Quality Management DI guide committee work and hold the quality management system accountable. The SFY19 Annual Report and Evaluation, Part III, summarized quality improvement efforts, reporting on the quality of supports, gaps in services, and quality improvement activities and initiatives.

QIC and QIC Subcommittee Structure

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

To ensure the highest level of leadership support and to solicit input and make recommendations for quality improvement activities, the committee structure includes broad representation of both

internal and external stakeholders. The QIC voting membership was restructured in SFY20 to include DBHDS senior leadership to ensure department-wide leadership oversight through the QIC. Clinical and program representatives from internal offices (e.g., OL, OHR, OCQI, OCSS, OPD, and the OIH) serve as dynamic members of the QIC subcommittees and workgroups demonstrating a department-wide commitment to continuous quality improvement and the importance of inclusion of input from DBHDS personnel at various position levels within the DBHDS organizational structure. External partners representatives also serve as active participants on the QIC and several QIC Subcommittees.

QIC Subcommittee Performance

Advisory membership on the QIC was expanded, in SFY20, to include representation from individuals that are representatives for provider organizations.These advisory members inform the QIC of issues and concerns important to the provider community and provide an external stakeholder perspective related to the DBHDS quality improvement efforts. Additionally, some QIC Subcommittees recognized the need for additional or specific expertise needed to identify concerns and recommend solutions, resulting in the addition of new members. For example, the MRC included an independent clinician member to provide additional support to the MRC in the review of mortality cases. Input and recommendations were also solicited from internal and external partners and advisory councils that do not participate in the QIC Subcommittees (e.g., Employment First Advisory Group and Individual and Family Support Program Councils).

QIC Subcommittees met regularly to ensure oversight and implementation of quality processes: 1) collectively identifying and addressing the overall health, safety, and well-being of individuals served (including individuals with complex needs); 2) identifying and addressing risks of harm; 3) ensuring service accesibility and quality service provision; 4) ensuring that individuals were integrated into their community and were included in decision-making about their lives; and 5) assessing provider competency. QIC Subcommittees reviewed and monitored the status of approved PMIs, identifying trends, barriers, issues, and gaps in services based on the purpose of each committee. In addition to monitoring PMIs, each QIC Subcommittee identified surveillance data to ensure a broader perspective on services at an individual, provider, or system level. Reports by each of the committees to the QIC related to the status of PMIs and surveillance data reviewed resulted in identification of areas of success as well as recommendations for corrective actions and/or quality improvement initiatives, for areas that did not meet expected outcomes or demonstrated concerns otherwise. Each committee maintained meeting minutes reflective of this analysis and included membership attendance and any actions or follow-up required or taken.

Recognizing the importance of data utilization and analysis, DBHDS QIC Subcommittees made concerted efforts in SFY20 to incorporate data review and analysis following processes in place to measure and analyze performance data. Each QIC subcommittee identified additional data

sources, to expand the scope of their review beyond the identified PMIs. Selection of the PMIs was based on past performance and involved the acquisition of cross departmental input; measures included clinical and support service indicators (selected over various domains and key performance areas). Additionally, DBHDS collaborated with the DMAS quality improvement team and Community Services Boards/Behavioral Health Authority (BHA), through the Data Management and Quality and Outcomes Committees, to develop, implement, and monitor the PMIs that reflect accepted standards of care. QIC Subcommittee chairs shared the Commonwealth's progress towards achievement through PMI progress presentation to the RQCs and QIC. Additionally, the OCQI reported and discussed case management measures with the CSB/BHA to facilitate discussion regarding movement toward PMI set targets and to improve data quality collection processes. As all providers further develop their risk management and quality improvement programs and begin reporting on newly identified performance measure indicator, these measures will also be monitored to determine further opportunities for improvement.

The purpose of the 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. In SFY 20, the RMRC completed its work plan and the Annual RMRC report for SFY20 (included as an Appendix to the QMP). The RMRC reviewed data on serious incident reports, injuries, and deaths; allegations of abuse and neglect; as well as preliminary data regarding the results of licensing inspections of provider risk management and quality improvement programs. RMRC review of incidents of sexual abuse by staff identified the need to further educate individuals on recognizing and reporting abuse and resulted in the development of human rights training geared specifically toward enhancing the ability of individuals with developmental disabilities in recognizing abuse, neglect and exploitation. Additionally, the RMRC, through the OIH, made sure that case managers and providers know how to recognize individuals with risk factors that require medical and behavioral support needs and know to subsequently connect individuals to professionals to address these concerns. Several supplemental trainings were developed by OIH to facilitate awareness of conditions common to people with developmental disabilities.

Further, the RMRC data review identified circumstances when provider staff waited for supervisor approval to contact EMS prior to calling 911 at the onset of an emergency. This issue was also identified in the MRC. The RMRC subsequently worked collaboratively with the MRC to develop actions to be taken to address this systemic issue. Further review of incident data revealed a high number of falls, prompting the RMRC to develop a QII to reduce the rate of falls among individuals with developmental disabilities; the RMRC oversaw the implementation of this QII. The components of this QII included fall prevention training, newsletters, and health alerts all developed by the Office of Integrated Health. As a result, the rate of falls has been

trending downward and the RMRC continues to monitor progress on these quality improvement activities.

While the RMRC initially developed PMIs to meet requirements of CMS HCBS waivers, over the past year, the RMRC identified additional measures (surveillance data). While some of the additional measures identified were required by the DOJ SA, others were chosen based on input from clinical and program staff. New indicators included the rate of occurrence of conditions common in people with developmental disabilities.

The MRC purpose is to focus on system-wide quality improvement by conducting mortality reviews of individuals who were receiving a service licensed by DBHDS at the time of death and diagnosed with an intellectual disability and/or developmental disability (I/DD), utilizing an information management system to track the referral and review of these individual deaths. The MRC completed its work plan and ensured that charter requirements were met in SFY20. The MRC completed an Annual MRC report, which includes an analysis of the MRC reviews is attached as an Appendix to the QMP.

The MRC completed its work plan and ensured that charter requirements were met in SFY20. For all 23 meetings, the committee met the quorum requirements as outlined in the charter. A work plan was developed, and charter standard operating procedures were followed. The MRC completed an Annual MRC report, which includes an analysis of the MRC reviews is attached as an Appendix to the QMP.

The MRC reviewed and made determinations and recommendations for the 345 deaths reviewed and tracked the referral and review of individual deaths. MRC members, including internal (across multiple DBHDS divisions) and external program and clinical representatives, conducted monthly mortality reviews for unexplained or unexpected deaths of I/DD individuals, reported through the DBHDS incident reporting system and monitored the MRC PMI and quality improvement initiatives. The need for quality improvement projects and initiatives was derived from data analysis conducted by the MRC. The MRC presented the findings of data analysis to the QIC quarterly and provided a separate quarterly report of findings to the DBHDS Commissioner.

Multiple recommendations for individual and systemic level quality healthcare actions and activities were made by the MRC based on review of individual cases and data and/or trends and patterns identified. Licensed providers around the state contribute documentation related to a DD individual's death, as mandated by OL regulations. The OL MRC member representative of the MRC notified licensed providers of licensing violations and MRC review recommendations noted during the MRC case review. Additionally, the OIH MRC member of the MRC fosters quality improvement activities for licensed providers and families (for private residence deaths)

when recommended by the MRC. The OHR MRC member provides information regarding identified provider violations. MRC recommendations were triaged to regional human rights staff for follow-up when additional health and safety concerns were identified. As a result of MRC data analysis of trends and patterns identified in aggregated retrospective chart review documentation and of problems identified at individual service delivery and systemic levels, the MRC identified and recommended the development of QII. These recommendations, among others, included proposing legislation that allows the MRC to review information and records regarding an individual whose death is being reviewed by the Committee, including (i) any report of the circumstances of the death maintained by any state or local law-enforcement agency or the Office of the Chief Medical Examiner and (ii) information or records about the person maintained by any facility, hospital, nursing home, or health care provider that provided services to the individual, any social services agency that provided services to the individual, or any court shall be provided to the Chief Clinical Officer or his designee. Any presentence report prepared pursuant to §19.2-299 for any person convicted of a crime that may have led to the death of the person whose death is the subject of review by the Committee shall be made available to the Chief Clinical Officer or his designee for inspection. In addition, the Chief Clinical Officer or his designee may inspect and copy from any health care provider in the Commonwealth, on behalf of the Committee, any health or mental health record of the individual, without authorization. That legislation became effective July 1, 2020.

The CMSC is responsible for monitoring case management performance across responsible entities to identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and evaluate data to identify and respond to trends to ensure continuous quality improvement. The CMSC completed its work plan and ensured that charter requirements were met in SFY20 and met a total of 13 times in SFY20. The CMSC completed two Semi-Annual CMSC reports summarizing data analyzed and committee actions completed; the reports are attached as an Appendix to the QMP. The CMSC met meeting quorum requirements at each of the 13 meetings held in FY20, exceeding meeting requirements detailed in the charter (to meet 10 times annually). The CMSC implemented a schedule for ensuring the systematic review of PMIs and surveillance data to ensure systematic review of data. The schedule corresponds with a performance data workbook that contains data reviewed by the CMSC, visualizations of results, technical assistance provided, and CMSC decisions. The last two months of SFY20 included refining how the CMSC processes and considers data.

Case management data was collected from various sources, analyzed and reports disseminated to the CSB/BHAs to inform and foster quality improvement activities at the local, regional and state levels. Six PMIs were reviewed regularly by the CMSC. Four new measures were discussed and developed to focus on 1) improvement in case management assessment of changes

in status, 2) appropriate implementation of ISPs, 3) individuals' relationships and interactions with people (other than paid program staff), 4) and allowances of individuals' choice of provider (including a choice of support coordinator) were approved by the QIC. CMSC measures to be implemented in SFY21 were also considered in SFY 20. CMSC measures to be implemented in SFY21 were considered. The CMSC shared data with CSBs/BHA via a secure method, produced letters reflecting CSB performance, and reported to the QIC routinely on CMSC progress.

The CMSC provided oversight of the implementation of data collected through the SCQR process, reviewed submission phase data, made recommendations as a result of the data analysis, and provided technical assistance. Additionally, the CMSC published guidance and a question and answer document about case management options for people on the DD waiver wait list. The CMSC developed and obtained approval on a QII to increase consistency across the state in understanding, assessment, and implementation of two critical case management terms: change in status and the appropriate implementation of the ISP.

The KPA Workgroups are responsible for collecting and analyzing reliable data related to the domains of safety and freedom from harm, physical, mental and behavioral health and well-being, and avoiding crises. The KPA Workgroup also assesses whether the needs of individuals enrolled in a DD waiver are met, whether individuals have choice in all aspects of their selection of services and supports, and whether there are effective processes in place to monitor the individuals' health and safety. In SFY20, the KPA Workgroups continued to meet as a combined group, inclusive of the Health, Safety and Well-Being Workgroup, the Community Inclusion and Integration Workgroup and the Provider Capacity and Cometency Workgroup. KPA Workgroups completed their work plans and ensured that charter requirements were met in SFY20. The Workgroups identified several data sources, containing data related to each of the eight domains, to consider as surveillance data, to further to assist the Workgroup in identifying patterns, trends, and/or gaps that may not be evident in the review of the PMIs. There was extensive discussion regarding each Workgroup data measure and the development of new PMIs. Data review included, but was not limited to, the Year 4 QSR Report, the NCI Report, the Housing Report, and the Semi-Annual Provider Data Summary. The past year was spent organizing the work and confirming the PMIs. The KPA Workgroup was diligent and successful in its efforts to enhance its meeting structure, establish data reporting processes, and focus on increasing opportunities for SME engagement and ensuring the regular review of PMI.

A review of crisis data, related to the location where crisis assessments occur, led the KPA Workgroups to recommend enhanced training and develop a crisis risk assessment tool, with a goal of getting people connected to crisis services prior to needing hospitalization. DBHDS shared the tool with the CSBs/BHA in June 2020 and incorporated feedback received. Implementation of the crisis risk assessment tool will begin in SFY 2021.

KPA Workgroup data analysis resulted in the development of three quality improvement initiatives focused on independent housing, crisis assessments occurring in the community, and provider competency. The Independent Housing QII addresses the need to increase the number of referrals that result in more individuals living in independent housing. The DBHDS Office of Community Housing (OCH) began collaborating with the DBHDS OPD to provide training and to share housing outcomes and resource information with providers and individuals through further data analysis. The second QII focused on increasing the number of crisis assessments occurring in the community, as data analysis showed more crisis assessments were occurring at either the hospital or emergency room department as opposed to in the community. The third QII focused on increasing the number of trained, competent DSPs who support people receiving DD waiver services. This QII is targeted for implementation in SFY21.

The RQCs are to identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and evaluate data to identify and respond to trends to ensure continuous quality improvement. The RQCs completed their work plan and ensured that charter requirements were met in SFY20. RQC membership included a QIC member, an individual experienced in data analysis, CSBs/BHA and case management programs service providers, and individuals receiving services or on the DD waiver waitlist for services and or family members of individuals receiving services or on the DD waiver waitlist.

These RQC community stakeholders provided input from a statewide prespective with an emphasis on identifying strengths and gaps at a regional level. This perspective promotes and recognizes the unique aspects and challenges within each region of the state and serves to provide grassroots feedback to the QIC. To determine gaps and trends, RQCs posed questions to subcommittee presenters and/or asked for additional data to assist in further analysis. Each RQC, through small group discussions, completed an in-depth review of data presented in each KPA, determined an area of focus, prioritized potential quality improvement proposals, and selected one QII to recommend and present to the QIC. Additionally, the RQC liaisons, on behalf of the RQC, provided quarterly reports to the QIC.

In SFY19, the DBHDS Quality Management Annual Report and Evaluation identified an issue related to RQC ability to meet quorum requirments consistently but recognized that the volunteer members have competing priorities. To strengthen support of the RQCs, the OCQI initiated a reorganization, which included assignment of a DBHDS Quality Improvement Specialist in each region. These efforts proved successful through the ongoing COVID-19 pandemic, which required that all meetings be held virtually. In SFY20, all five RQCs met quarterly, with all but one RQC meeting achieving charter defined quorum requirements. RQCs reviewed and assessed data presented in each key performance area as well as numerous data reports related to incident reporting, employment, case management, Regional Support Teams, human rights allegations, NCI, QSR, and data related to the DD waivers reported through the DBHDS/DMAS Quality Management Review process.

In determining the need for training for RQC members, DBHDS OCQI, in collaboration with the Partnership for People with Disabilities (the Partnership), planned and implemented an annual training summit for RQC members and alternates in August 2019 that was attended by 83 people. The Summit included training presented by DBHDS, the Partnership, and national SMEs from the National Association of State Developmental Disability Directors, Human Services Research Institute, and Mission Analytics. Training included information on the DBHDS quality framework as well as the following trainings: Using Data to Promote Health Safety and Quality of Life, Quality Matters, and Roles and Responsibilities of a Quality Council: Using Data to Improve System Performance. The OCQI, using key information from these trainings, developed a RQC orientation training video to assist RQC members in understanding the DBHDS QIC Subcommittee quality framework, their roles and responsibilities, using data for quality improvement purposes, and understanding the Plan, Do, Study, Act Model and other quality improvement tools. These efforts resulted in over 90% of RQC members receiving and completing an orientation. The OCQI worked with the Partnership in SFY20 to plan the SFY21 RQC Summit and to develop training modules that can be used to assist with future orientation of RQC members. Modules developed can also be used the provider community to build provider capacity to develop quality improvement processes throughout the provider system of care.

Meeting quarterly, the QIC monitored the DBHDS' quality management system to include monitoring the status updates of PMIs presented by the QIC subcommittees, to identify areas of strength and areas in need of improvement. Presentations by the QIC subcommittees included actions taken and or recommended by the subcommittee when established PMI targets were not met. The QIC actively solicited input from the RQCs, provided requested data when available, and ensured questions were answered through QIC subcommittee presentations to ensure the RQCs could provide meaningful input regarding the DBHDS quality improvement efforts. The QIC critically reviewed recommended QII from each of the subcommittees and the RQCs, with several QIIs approved and forwarded to the Commissioner for implementation. The QIC reviewed reports such as the DBHDS/DMAS Quality Review Team Report related to the DD waiver, Annual Mortality Report, Semi-Annual Case Management Steering Committee Reports, Semi-Annual Employment Reports, Risk Management Review Committee Annual Report inclusive of Serious Incident Reporting and Human Rights Allegations Reporting, Year Four Quality Service Review Annual Report, and National Core Indicators Annual Report. Through this oversight, the QIC evaluated data and was responsive to trends identified, addressing health and risks of harm and expanding and improving accessibility and the quality of services developed and implemented to meet individuals' needs while promoting choice in all aspects of their goals and supports within integrated settings, thereby ensuring a process for continuous quality improvement.

Data Quality

The ODQV and the OCQI support the QIC Subcommitttees in the facilitation of data review and analysis and in promoting implementation of quality improvement principles. The DBHDS Quality Management Program evaluation in SFY19 determined that, to improve data quality, it would be critical to ensure identified performance measure indicators are operationally defined and augmented with specific targets, including desired outcomes and detailed strategies to analyze data. In response to recommendations to improve the quality of data evaluated through quality activities, ODQV routinely engaged in activities to enhance data reliability and validity and increase the availability of data, including ensuring the collection and consistent analysis of reliable data. ODQV supports each committee to develop data-driven insights that improve quality monitoring at a systems-level and works closely with business area SMEs to develop measures and generate data to improve data monitoring at the individual and provider levels. In order to support the QMP directive to track PMIs efficiently, ODQV created the PMI Measure Development Form, which organized and preserved important documentation for each measure.

The success of this form prompted the establishment of new processes around measure development in SFY20 that included the use of this form by the DBHDS ODQV and DBHDS OCQI teams. Each KPA PMI now goes through a two-tiered development process. First, the OCQI team works with the business area to outline the initial quality improvement elements of the PMI (the question to be answered; if the PMI can be addressed using the data from existing SME reports, identifying the variables that would meet the PMI needs; the importance of the PMI; the measure; the numerator and denominator; the data source; how the SME intends to validate that the measure has positively impacted the service system; and the frequency of data collection and review). The ODQV staff then works with the measure steward to document the data quality sections on the form (measure methodology, calculation steps, baseline data, population, regional breakdown, annual target, indicate measure type-output or input, and relevant business definitions and processes). Under the Data Quality Monitoring Plan, ODQV also assesses data quality at a system level, including the validity and reliability of data, and makes recommendations to the Commissioner on how agency-wide issues may be remediated. ODQV applied the major findings from the Plan's first year implementation to provide feedback to SMEs regarding PMIs that may be affected by these results. As a result, ODQV recommended the inclusion of and did incorporate a section on the PMI Measure Development Form that allowed ODQV to provide specific feedback for each PMI, related to data quality concerns and collaborate with SMEs on suggestions for improvement.

Identified Opportunities for Enhancement

Data quality and the timely availability of data continues to be an ongoing process of improvement. There were changes in reporting requirements for licensed providers in August of 2018 and also

to the incident reporting CHRIS interface to capture these new requirements in August of 2019. Changes made during the course of any fiscal year impact reported results for that respective year. To account for system changes and ensure reliable and valid data, the RMRC completed a partial review of SFY19 data (9/1/18 – 6/30/19) and SFY20 data (8/5/19 – 6/30/20). The RMRC identified issues related to data quality in the SFY19 serious incident data, which included a high use of the category "other" to describe the incident type, and a number of duplicate entries. Both of these issues may be reduced with the introduction in SFY20 of the DBHDS IMU which triaged each incident and addressed data quality issues.

Additionally, DBHDS acknowledges that regional data continues to be imperative for the RQCs to make regional recommendations for QIIs. Increasing the amount of data available regionally and the enhancing efforts to ensure that regional data is received timely and is inclusive of comparative analysis across regions and over time, will enhance DBHDS's capability to facilitate the RQC's ability to identify patterns and trends and then recommend responsive actions to identified issues.

While the DBHDS Quality Management Program enhanced subcommittee data analysis, an identified need in the process is defining the data sources for the DBHDS performance measure indicators and how the data is to be gathered, organized and stored. The DBHDS ODQV 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 new measures are operationally defined and augmented with specific targets, including desired outcomes, and that strategies to analyze data are detailed. The DBHDS Division of Administrative Services is working in concert with ODQV and 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).

It is also acknowledged that the provision of expanded DBHDS OCQI training, technical assistance, and consultation in quality management should be provided to QIC Subcommittee members and for licensed providers; this is critical to ensuring an increase in a focus on quality. While training on quality improvement has been provided in the past, additional training for some QIC Subcommittee members has occurred and, for providers, additional resources have been posted on the DBHDS website; licensing data, related to provider quality improvement and risk management citations, indicates that further training and technical assistance may be needed. DBHDS continues to expand training resources related to quality improvement and risk management in order to build capacity internally and externally throughout the DBHDS system of care.

The Commonwealth also acknowledges a need to creatively demonstrate how quality impacts the department within each program and service area and how each QIC subcommittee member's

work contributes to the overall success of the DBHDS QMS. In the coming year, the OCQI will begin the work of establishing creative ways to share the impact of the QMS at a DBHDS department, division, and office level and establish processes and protocols to ensure the sustainability of consistent practices designed to ensure awareness of the QMS and how it impacts the success of individuals served.

V. Summary

DBHDS's well-established quality management program continued to mature in SFY20 as the quality committees continued fully establish and solidify their processes and protocols. Continued leadership support and the commitment of resources (needed to implement QIIs and PMIs and to meet the requests of the RQCs) will be required to maintain the progress made in SFY20 and to ensure continued growth of the program. As the Commonwealth 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.

The Commonwealth continues to work towards enhancing data quality and in so doing continues to work closely with ODQV and the Division of Administrative Services to identify and prioritize areas of concern and develop short and long term solutions to mitigate circumstances surrounding these concerns. For this effort to be successful, it will require collaboration across department divisions and with DBHDS service providers.

The Commonwealth will continue to work with licensed providers to ensure that they are meeting regulatory requirements for risk management programs and quality improvement programs. This will require the OL to continue its focus on regular review of the provider policies and procedures and implementation of same, as it relates to these requirements and for the Commonwealth to regularly examine QSR findings related to DBHDS provider findings related to the appropriateness of DBHDS service provider quality improvement programs.

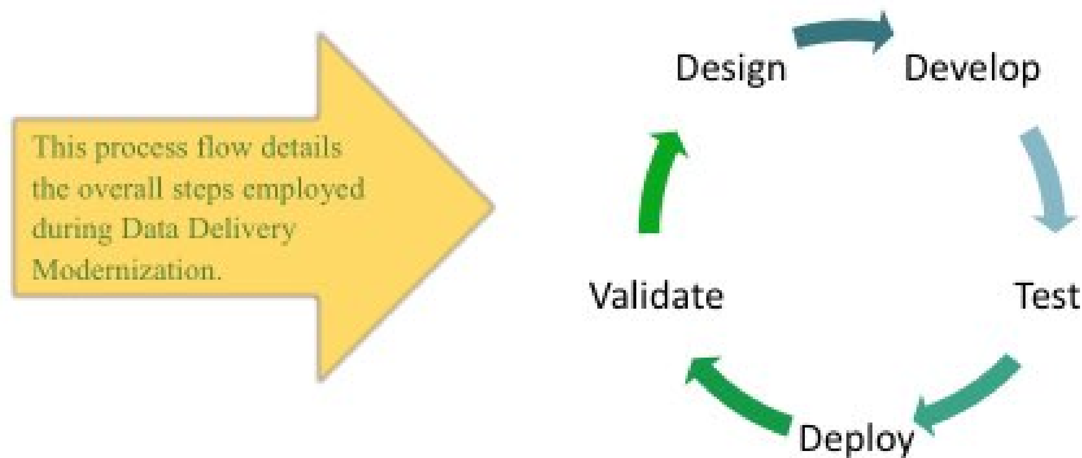
The Commonwealth will continue to focus its efforts on ensuring individuals are free from harm. While an initial PMI and QII focused on falls prevention, an additional 10 surveillance measures have been developed. These surveillance measures focus on the regular review of conditions or incidents most commonly experienced by DD individuals.

Recommendations are also included in the attached subcommittee reports, however based on this year's annual QM evaluation, the following recommendations for SFY21 focus on operational improvements, oversight and monitoring, and enhancing and developing expertise on quality improvement throughout the agency, to meaningfully affect change at the individual, service level, and system levels. The recommendation are:

- Implementation and monitoring the effectiveness of the new QSR process;

- Monitoring the implementation of the newly established PMIs;
- Monitoring the implementation of the newly established KPA surveillance data process and the outcome of data analysis;
- Continuing to support the DBHDS/DMAS collaboration related to initiatives implemented through the QRT;
- Identification of the need for additional information, to inform further decisions or inferences related to the work of the quality committees;
- Enhancement of the department's ability to understand performance from a more global perspective;
- Development of a system to prioritize recommended QIIs;
- Strengthening the quality management processes of DBHDS services providers, across the system of care;
- Providing additional training, technical assistance and consultation to licensed providers in the development, implementation, and monitoring of quality improvement and risk management programs;
- Continuing to facilitate and support the implementation of the DBHDS Data Quality Monitoring Plan, to ensure that the following recommendations for data delivery modernization are reviewed, prioritized and addressed as the DBHDS finds it appropriate to do so:
    - Develop Enterprise level Data Program to drive increased capabilities and accountability
    - Implement Data Product Management (Product Owner)
    - Create transparent delivery process
    - Align Data Warehouse and Data Quality team charters
    - Establish Business Power Users (Inject Operational Reporting into Business Areas)
    - Generate Business Capability Roadmap for 2020
    - Align DW data model to key subject areas and improve conformity
    - Design and implement key changes to the Data Quality Application (DQA)
    - Conform major data entities: individuals, providers, locations, addresses, services
    - Publish DW data models
    - Remove duplicate or unused data from the warehouse and reporting environment
    - Develop data governance practices and processes to drive organizational alignment
    - Implement data working group and process
    - Publish DW metadata and facilitate data discovery
    - Create automated data standards measurement to identify quality issues
    - Define data quality remediation process for sources and DW
    - Upgrade and improve the current data ecosystem.
    - Upgrade data warehouse platform
    - Enable faster business delivery through application lifecycle improvements
    - Delivery through cross-functional teams

- Strengthen security practices
- Develop Cloud Roadmap and Readiness plan



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

As the subcommittees become more proficient in data analysis, and as system changes result in increased data availability, validity, and reliability, these quality committees will grow in their ability to examine the root cause for performance improvement and decline, identify trends and gaps within the service system, determine mitigating strategies to address and the identified gaps and ultimately, and further support quality committee ability to make data-driven decisions regarding the need for increased monitoring and the development of additional PMIs and QIIs. Internal and external stakeholder collaborations will continue to evolve and enhance the Commonwealth's ability to ensure implementation of an effective QMS.

The Commonwealth commits to the pursuit of opportunities to creatively and effectively improve performance amidst the COVID-19 pandemic, to ensure a high quality, and responsive system of care. This commitment is made toward successfully supporting DBHDS service providers, individuals, and families. The Commonwealth values quality services, the providers who ensure it, and the individuals and families that receive it and looks forward to partnering with the community to ensure service stability, safety, and access.

Appendices

- Annual Mortality Report
- Case Management Steering Committee Semi-Annual Reports
- Risk Management Review Report

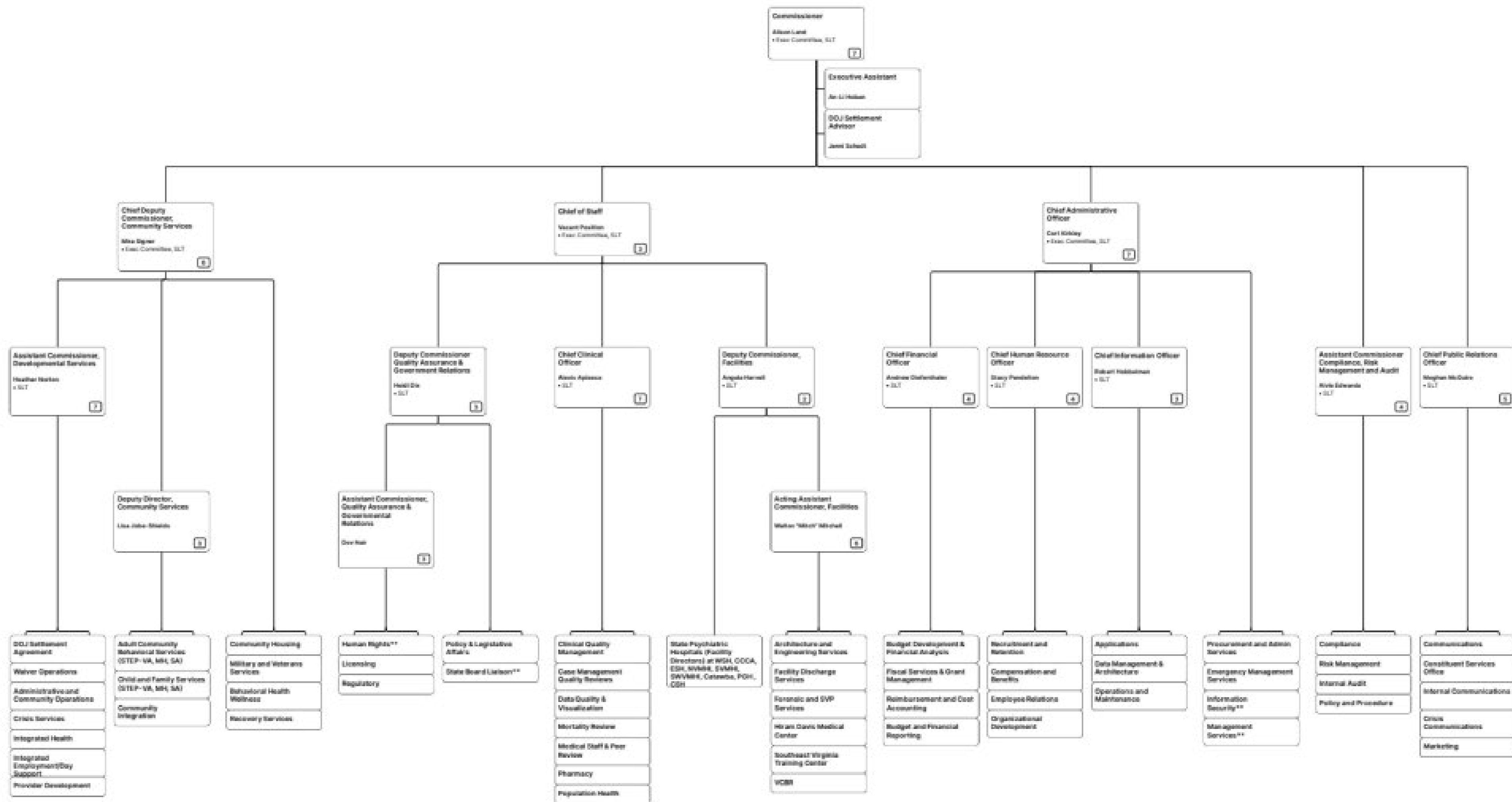
- Institute for Healthcare Improvement Quality Management Assessment Tool Quality Management Assessment Tool
- Glossary of Acronyms

Glossary of Acronyms

Acronym	Full Form
ANE	Abuse, Neglect, and Exploitation
BMT	Baseline Measurement Tool
BHA	Behavioral Health Authority
CoD	Cause of Death
CC	Community Coaching
CCO	Chief Clinical Officer
CCS3	Community Consumer Submission
CE	Community Engagement
CHRIS	Comprehensive Human Rights Information System
CM	Case Manager
CMS	Centers for Medicare and Medicaid Services
PM	Performance Measure (CMS DD performance measure)
CMSC	Case Management Steering Committee
COVLC	Commonwealth of Virginia Learning Center
CPR	Cardiopulmonary Resuscitation
CRC	Community Resource Consultant
CSBs	Community Services Boards
CTH	Crisis Therapeutic Home
DARS	Department of Aging and Rehabilitative Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
DI	Departmental Instruction
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice
DQA	Data Quality Application
DSP	Direct Support Professional
DW	Data Warehouse
ECM	Enhanced Case Management
EHR	Electronic Health Record
ETL	Extract, Transform, Load
FAQ	Frequently Asked Questions
GSE	Group Supported Employment
HCBS	Home and Community Based Services
IHI	Institute of Healthcare Improvement
IMU	Incident Management Unit
ISE	Individual Supported Employment
ISP	Individual Support Plan
KPA	Key Performance Area
LIDS	Local Inmate Data System
MDPS	Master Document Posting Schedule
MRC	Mortality Review Committee

MRO	Mortality Review Office
NCI	National Core Indicators
NIDILRR	National Institute on Disability, Independent Living and Rehabilitation Research
OCH	Office of Community Housing
OCSS	Office of Community Support Services
OCQI	Office of Community Quality Improvement
OCQM	Office of Clinical Quality Management
ODQV	Office of Data Quality and Visualization
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
OSVT	On-Site Visit Tool
OPD	Office of Provider Development
PCR	Person Centered Review
PMI	Performance Measure Indicator
PP	Potentially Preventable
PQR	Provider Quality Review
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QMP	Quality Management Plan
QMR	Quality Management Review
QMS	Quality Management System
QRT	Quality Review Team
QSR	Quality Service Review
REACH	Regional Education Assessment Crisis Services Habilitation
RM	Risk Management
RMRC	Risk Management Review Committee
RNCC	Registered Nurse Care Consultant
RQC	Regional Quality Council
RST	Regional Support Team
SC	Support Coordinator
SCQR	Support Coordinator Quality Review
SA	Settlement Agreement
SFY	State Fiscal Year
SIU	Specialized Investigations Unit
SME	Subject Matter Expert
TCM	Targeted Case Management
UI	User Interface
VACSB	Virginia Association of Community Services Board
VIC	Virginia Informed Choice
WaMS	Waiver Authorization Management System

DBHDS Organization Chart



Virginia Department of Behavioral Health & Developmental Services

SFY 2020 Annual Mortality Report

Presented by the DBHDS Mortality Review Committee
November 2020

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Annual Mortality Report

State Fiscal Year 2020

Executive Summary

This is the sixth Annual Mortality Report of the Virginia Department of Behavioral Health and Development Services (DBHDS). The information contained in this report is based on reviews of the deaths of individuals with a developmental disability that occurred during the timeframe of July 1, 2019 to June 30, 2020 as reported in the DBHDS incident reporting systems. This report compares state fiscal year (SFY) 2020 mortality review data to that in previous years. The interpretation of information presented in this report is not intended to be used for direct comparison with the mortality reviews and reports of other states. Each state utilizes its own specified population, definitions, processes, and different methods or analyzed data which is relevant to their need or state requirements, and generalized findings or comparisons of mortality rates is limited.

As of June 30, 2020, there were 14,834 individuals enrolled on a Virginia Developmental Disability (DD) Home and Community Based Services (HCBS) waiver[1]. DBHDS authorizes approximately ninety services to thousands of residents for the following waivers: Community Living, Family and Individual Supports, and Building Independence.

As a commitment to the Commonwealth of Virginia, DBHDS and the Developmental Disabilities Mortality Review Committee (MRC or Committee) contribute to system of care improvements through integration of clinical evidence, data driven determinations, and evidenced based quality improvement recommendations. Deaths of all individuals who were receiving a service licensed by DBHDS at the time of death and diagnosed with an intellectual disability and/or developmental disability (I/DD) are reviewed and analyzed. Analysis of the mortality trends, patterns, and problems can identify opportunities for system improvements to reduce risks to all individuals with developmental disabilities receiving behavioral health and/or developmental services. On an ongoing basis, DBHDS seeks to prevent instances of abuse, neglect, exploitation, and unexplained or unexpected death by identifying and addressing relevant factors during mortality reviews. Mortality review determinations are then utilized to develop quality improvement initiatives in order to reduce mortality rates to the fullest extent practicable.

In the midst of this state fiscal year, the world was introduced to a novel coronavirus, COVID-19, which has resulted in a global pandemic and declaration of a public health emergency in the Commonwealth. This respiratory illness quickly impacted congregate care settings as public health leaders fought to study and contain the virus. Research has grown indicating that the

[1] Virginia Waiver Management System. Accessed by DBHDS on Aug 13, 2020.

elderly and those with chronic medical conditions were the most susceptible to severe illness, and thousands across the United States have died from the disease. When the COVID-19 pandemic was declared a state of emergency in March 2020 by Governor Ralph Northam, there was significant concern regarding the impact that the pandemic would have on the DD population. DBHDS licenses a number of congregate settings, which were the settings of many COVID-19 outbreaks across the country. This report does not include the total number of individuals with DD who were infected with COVID-19; however, COVID-19 accounted for approximately ten percent of deaths in quarter four of this study period, rivaling sudden cardiac death, which is the leading cause of death overall in this population. COVID-19 continues to pose a threat in Virginia, and the provider community should be commended for their ongoing dedication to serve individuals with DD in those critical settings despite the multiple workforce, financial, and service delivery challenges that have impacted all healthcare providers as a result of the pandemic.

Finally, one of the most monumental events of this study year for the Commonwealth's developmental disabilities system of care was the closure of Central Virginia Training Center (CVTC) in the spring of 2020. Only one training center will remain open, Southeastern Virginia Training Center. CVTC opened in 1910 and at its peak in 1972, 3,686 individuals resided there. Its closure signified tremendous effort and commitment toward transitioning individuals from four training centers into the community to live and prosper.

Key Findings

- The DBHDS DD MRC reviewed 354 deaths that occurred during SFY 2020. This is a 13.5 percent increase from the 312 deaths reviewed by the Committee during SFY 2019. This is the highest number of deaths reviewed by the Committee since its creation.
    - In SFY 2019, the DBHDS DD MRC commenced a two-tier review process which allowed the DBHDS DD MRC to focus more specifically on unexpected or unexplained deaths. These deaths were categorized as Tier 1, and all others fell into Tier 2[2]. Of the 354 deaths reviewed in SFY 2020, 116 deaths were categorized as a Tier 1, and 238 deaths were categorized as Tier 2.
- The median age at time of death was 58 years; the mean age at death was 54 years.
- Sudden cardiac death was the leading cause of death in SFY 2020 (43 deaths, 12%), followed by sepsis (40 deaths, 11%), cancer (34 deaths, 10%), and heart disease (28 deaths, 8%).
- The DBHDS DD MRC determined COVID-19 to be the cause of 10 deaths between April and June of 2020, making up 10% of deaths for that quarter.
- In earlier years after inception of the DBHDS DD MRC, there were significant challenges to obtaining key data to inform causes of death and, therefore, the increased the

[2] Full definitions of Tier 1 and Tier 2 are on page 10 of this report.

difficulty of determining whether deaths were Expected or Unexpected. This has improved significantly in SFY19 and SFY 20 such that the Committee determined more deaths to be Expected than Unexpected.

- The DBHDS DD MRC could not determine the cause of death in 16 deaths (5%). This is the lowest percentage of deaths in which the cause is Unknown since the Committee's 2012 inception.
- The DBHDS DD MRC determined 17 deaths (5%) to be potentially preventable in SFY 2020. Similar to SFY 2019, the majority of deaths determined to be potentially preventable in SFY 2020 (14 of 17) involved a failure to execute established protocols. Potentially preventable as defined by the DBHDS DD MRC is specific to identifying modifiable factors within the service delivery system that are required through regulation but may have been missed. However over the past two years, while the standardized application of the definition has been achieved, this definition has identified a relatively small number of individuals. The Committee will continue to evaluate what is considered to be potentially preventable in order to adequately identify potentially preventable deaths in order to reduce mortality rates to the fullest extent practicable and improve quality of services for individuals with DD.
- Compared to SFY 2019, the crude morality rates increased for all age groups, except among individuals aged 18-30. Increases were observed in the crude mortality rate among individuals aged 0-17, which had decreased in SFY 2018 and SFY 2019, and among those aged 81 or over, which had decreased in SFY 2019.
- The crude mortality rates for individuals in SIS Levels 2, 6, and 7 increased from SFY 2019, while those for Levels 1, 3, 4, and 5 decreased. The crude mortality rate for individuals with a SIS Level of 5 decreased from 60.6 to 31.5 per 1,000 population.
- For the first time since SFY 2015, average community tenure decreased among individuals discharged from training centers. However, the median community tenure among these individuals increased from 44 months in SFY 2019 to 48 months in SFY 2020.

Recommendations

An important component of health and safety oversight within DBHDS involves the analysis and review of mortality data to: identify important patterns and trends that may help to decrease risk factors; provide information to guide system enhancements through process improvements; and determine recommendations in response to these findings.

The DBHDS DD MRC documents recommendations for systemic quality improvement initiatives coming from patterns of individual reviews on an ongoing basis, to ensure the provision of safe, effective, client-centered, timely, efficient and equitable care to all I/DD individuals. From this analysis, including a review of the data presented in this report, the DBHDS DD MRC also makes

four recommendations annually for systemic quality improvement initiatives, and reports these recommendations to the QIC and the DBHDS Commissioner. Recommendations in this report build upon the recommendations of previous years as well as integrate new findings and data from the current study year.

The recommendations are as follows:

Recommendation 1: In the 2019 Annual Report, it was recommended that DBHDS should maintain an established target that potentially preventable deaths make up less than 15% of the total DD deaths per year. Similar to last year, the SFY 2020 data indicated that 5% of deaths were determined to be potentially preventable and again, the primary reason was due to failure to adhere to established protocol. Failure to adhere to established 911 protocol was identified by the DBHDS DD MRC as the major contributor to the potentially preventable factor of 'Execution of Established Protocols.' The DBHDS DD MRC implemented a quality improvement initiative to improve providers' adherence to 911 protocols, for which the baseline data determined that an average of 30% of deaths where 911 was a factor, properly followed the correct protocol. In SFY 2021, DBHDS should implement a quality improvement initiative to increase the number of mortality review cases in which 911 protocol was followed to greater than 60%.

Recommendation 2: In the 2019 Annual Report, it was recommended that DBHDS should maintain an established target of less than 10% of deaths reviewed to be classified as "Unknown" for the cause of death. The DBHDS DD MRC established improved processes, such that only 5% (16 deaths) in SFY20 were determined to be Unknown. Determining the cause of death is a key factor to understand and develop systemic quality improvement initiatives, and having access to pertinent information and records facilitates that determination. In 2020, SB482 was passed by the General Assembly to legislatively establish the Developmental Disabilities Mortality Review Committee, which provides greater access to information and records regarding an individual whose death is being reviewed by the Committee from providers beyond those licensed by DBHDS. This legislation went into effect on July 1, 2020, and DBHDS should track the impact on the DBHDS DD MRC for determining the cause of death, to maintain the established target.

Recommendation 3: Death certificates are a critical piece of information for understanding mortality trends and data. For SFY21, DBHDS should increase the number of death certificates available for DBHDS DD MRC review and establish a baseline for the number of I/DD individuals with a death certificate available for mortality review to >90%.

Recommendation 4: Death due to sepsis represented 11% of deaths in this study year. While sepsis, once it occurs, can often lead to mortality, there are a number of contributory illnesses that may benefit from early detection and intervention to prevent death. For SFY21, DBHDS should further evaluate underlying causes and conditions that lead to increase in sepsis deaths in this population.

Background

Purpose

The purpose of the DBHDS Developmental Disabilities (DD) Mortality Review Committee (MRC) is to focus on system-wide quality improvement by conducting mortality reviews of individuals who were receiving a service licensed by DBHDS at the time of death and diagnosed with an intellectual disability and/or developmental disability (I/DD), utilizing an information management system to track the referral and review of these individual deaths. DBHDS demonstrates on an on-going basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation and unexplained and unexpected deaths.

At each meeting the DBHDS DD MRC:

- Performs comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors (*e.g.*, medical, genetic, social, environmental, risk, susceptibility, and others as specific to the individual*)* and quality of service.
- Evaluates the quality of the decedent's licensed services related to disease, disability, health status, service use, and access to care, to ensure provision of a reliable, person-centered approach.
- Identifies risk factors and gaps in service and as appropriate, specifies whether these are systemic recommendations or recommendations to specific providers, to promote safety, freedom from harm, and physical, mental and behavioral health and wellbeing.
- Reviews citations issued by Office of Licensing related to required recommendations, to determine whether further action is required and for inclusion in meeting minutes.
- Refers any required recommendations not included in the initial citation and Corrective Action Plan (CAP) to the Office of Licensing for further investigation, and/or other divisions represented by members, when appropriate.
- Assigns recommendations and/or actions to DBHDS DD MRC member(s) as appropriate.
- Reviews and tracks the status of previously assigned recommended actions to ensure implementation and completion.

The DBHDS DD MRC provides ongoing monitoring and data analysis in order to identify trends, patterns and issues of concern at the individual and systems levels of provided services. Once identified, and in order to reduce mortality rates to the fullest extent practicable, the DBHDS DD MRC develops and implements quality improvement initiatives (QII) in order to promote the health, safety and well-being of I/DD individuals.

Process

As described in the DBHDS DD MRC Charter, which is updated annually, the DBHDS DD MRC must convene as frequently as necessary to ensure that deaths are reviewed within 90 days of the date of death, and must have attendance by required members. During SFY 2020, the DBHDS DD MRC met 23 times, and the membership requirements were met at every meeting.

For all I/DD decedents, and within 90 calendar days of a death, the Mortality Review Office (MRO) compiles a sequence of events summary leading up to the death based on the preceding three months' worth of documentation received. For each case review, the DBHDS DD MRC seeks to identify and determine:

- The cause of death
- If the death was Expected or Unexpected
- Whether the death was potentially preventable
- Any relevant factors impacting the individual's death
- Any other findings that could affect the health, safety, and welfare of these individuals
- Whether there are other actions that may reduce these risks of mortality, to include provider training and communication regarding risks, alerts, and opportunities for education.
- If additional measures are needed based on the case review, the DBHDS DD MRC will then make and document relevant recommendations and/or interventions.

Mortality Review Process Augmentations in SFY 2020

- Provided training and orientation for all DBHDS DD MRC members to ensure understanding of DBHDS DD MRC mission, scope and mortality review process. Application of the principles of continuous quality improvement was also included in the March 2020 training.
- SB482 was passed by the 2020 General Assembly and became effective on July 1, 2020. This legislatively established the DBHDS DD MRC and provides greater access to information and records regarding individuals whose deaths are being reviewed by the Committee.

- Collaborated with the Virginia Department of Health Office of Vital Records to obtain death certificates. This process was initiated in May 2020, and for the last quarter of SFY 2020, death certificates were obtained for 99% of deaths reviewed by the DBHDS DD MRC.
- Implemented a tier process in June 2019 whereby the Chief Clinical Officer or Clinical Manager screens all I/DD cases and refers to the DBHDS DD MRC any case where there is a finding of abuse, neglect or other documented circumstances that may have impacted the individual's death or warrants further review.
- Established a process in collaboration with the DBHDS Office of Licensing Special Investigation Team for the receipt of required provider documents, including licensing documents. This process was implemented in July 2020.

The goal of these process enhancements was to obtain additional information and provide more relevant documentation for the retrospective case reviews in order to augment clinical validity and utility related to the DBHDS DD MRC determinations. Changes that were implemented in the last quarter of SFY 2020 will be reflected in the data analysis for SFY 2021.

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 in place, and primary health care and palliative care teams, if applicable, were involved. The individual, legally authorized representative, power of attorney or legal guardian *(if the individual lacked capacity to make advance directive decisions)*, and family, were all aware that the illness or condition would result in death and had an opportunity to discuss, if not decide, end of life matters and clinical measures to be taken or not taken.
- Unexpected Death denotes a death that occurred as a result of an acute medical event that was not expected in advance nor based on a person's known medical conditions. Examples might include suicide, homicide, accident, acute medical event, a new medical condition, or sudden and unexpected consequences of a known medical condition. An Unexplained death also is considered an Unexpected death.
- Unknown indicates there is insufficient information to classify a death as either Expected or Unexpected or there is insufficient information to make a determination as to the cause of death.

- Other (Cause of Death) denotes a cause of death that is identified but not attributable to one of the major causes of death used by the DBHDS DD MRC for data trending.
- Potentially Preventable Deaths are deaths that are considered to be premature and may have been avoided, based on a combination of known medical, genetic, social, environmental, or other factors *(such as pre- morbid conditions)*. When the DBHDS DD MRC determines a death is potentially preventable, the Committee categorizes factors that might have prevented the death. 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
    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
- A Tier 1 case requires a detailed, comprehensive review of multiple factors and areas of focus by the mortality review Committee. Tier 1 deaths may meet any of the following criteria:
    - Cause of death cannot clearly be determined or established, or is Unknown
    - Any unexpected death (such as suicide, homicide or accident)
    - Abuse or neglect is specifically documented
    - Documentation of investigation by or involvement of law enforcement (including forensic) or similar agency
    - Specific or well-defined risks to safety and well-being are documented

- A Tier 2 case must meet all of the following criteria:
    - Cause of death can clearly be determined or established
    - An Expected death, if no abuse or neglect, involvement of law enforcement or well defined safety and well-being risks are documented
    - An Unexpected (Unexplained) death that occurred as a result of an acute medical event, a new medical condition, or sudden and unexpected (unexplained) consequences of a known medical condition
    - No documentation of abuse or neglect
    - No documentation of investigation by or involvement of law enforcement (including forensic) or similar agency
    - No documentation of specific or well-defined risks to safety and well-being noted.

Virginia Deaths

In the fall of 2019, a novel virus, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) emerged in Wuhan, China. By February of 2020, the virus had expanded globally, and the World Health Organization (WHO) named the disease "COVID-19". In March of 2020, the first death due to COVID-19 was reported in Virginia[3].

The DBHDS DD MRC also made nomenclature changes to three diseases in alignment with ICD-10 coding, retrospective clinical and health records, and medical terminology, which had no effect on the cause of death classifications.

SFY 2019 Name	Name change in SFY 2020
Chronic lower respiratory disease	Respiratory Disease
Flu	Influenza
Septicemia	Sepsis

The DBHDS DD MRC determined a cause of death in 338 of 354 (95.5%) deaths reviewed. In SFY 2019, the leading cause of death was Unknown. The leading cause of death in SFY 2020 was sudden cardiac death (43 deaths, 12.1%), followed by sepsis (40 deaths, 11.3%) and cancer (34 deaths, 9.6%). This is a significant improvement after a three-year trend of increasing Unknown cause of death, which peaked in SFY2019 of 13.5% of deaths categorized as Unknown cause. Individuals who live in private residences, as opposed to settings licensed by DBHDS, continue to pose challenges to making determination of the cause of death; however, these determinations have improved due to greater access to death certificates and other information and records.

In the fourth quarter of SFY 2020, the DBHDS DD MRC noted 100 total deaths, and during this time period, of those 100, the DBHDS DD MRC determined COVID-19 as cause of death in 10 cases (10%). This was determined via death certificate in nine of the ten cases; one death attributed to COVID-19 occurred out of state, and the documentation submitted for that review supported and also listed cause of death due to COVID-19. Early during the pandemic, Virginia, like many states across the country, experienced a rapid rise in cases coupled with limited resources related to a national PPE shortage, testing supplies, and healthcare services, coupled with the many individuals with DD who have co-morbid chronic medical conditions.

[3] https://www.vdh.virginia.gov/coronavirus/

Consideration of these factors were reviewed, such that the COVID-19 deaths reviewed in SFY 2020 were determined to not be potentially preventable based on the DBHDS DD MRC's definition[4]. However, the deaths due to COVID-19 in the DD population reported here is significant, rivaling sudden cardiac death, which is the top cause of death overall. As resources and more robust public health guidance becomes available, DBHDS will continue to monitor the impact of COVID-19 in SFY 21, and continue to utilize this data to advocate for prioritization of the needs of individuals with DD.

Unlike deaths in which the specific cause of death is "Unknown", deaths classified as "Other" causes have known etiologies that exist outside of the DBHDS DD MRC's primary categories for statistical trending. The DBHDS DD MRC classified 15 deaths (4.2%) as having "Other" causes of death in SFY 2020. The most common causes of "Other" deaths in SFY 2020 were trauma, nutritional deficiencies, traumatic brain injuries, anoxic brain injuries, and accidents, each of which accounted for two deaths. The remaining five deaths were each the result of singular causes.

The table below includes a summary of the causes of death. The 2019 and 2020 columns include two numbers in each row. The first is the total number of deaths for that category and the second indicates the number of those deaths where the individual was not receiving a DBHDS-licensed residential service.

Table 1. Number of Annual Deaths by Cause of Death, SFY 2017 – 2020[5]
(Sorted by Frequency in 2020)

Cause of Death	2017	2018	2019	2020	Total
Sudden Cardiac Death	35	22	22/9	43/18	122
Sepsis	14	14	19†/10	40/15	88
Cancer	14	23	30/14	34/20	101
Heart Disease	22	19	17/8	28/15	86
Pneumonia	27	21	20/7	22/10	90
FTT/Slow Decline	7	4	10/4	21/7	42
Acute Respiratory Failure**	-	-	7/3	16/7	23
Complications of a Genetic Condition	6	11	9/8	16/11	42

[4] DBHDS DD MRC definition of Potentially Preventable is found on page 10 of this report.

[5] In Table 1, causes of death marked with a single asterisk (*) were added by the DBHDS DD MRC in SFY 2020. Fields marked with a hyphen (-) do not have measurable values because the categories used to classify deaths did not exist at the time of the Committee determinations. The totals marked with two asterisks (**) differ from previously reported totals due to differentiation of deaths due to "acute respiratory failure" and "respiratory disease" per ICD-10 classification and death certificate delineation. Finally, the totals marked with a dagger (†) differ from previously reported totals due to a misclassification of an "Other" deaths as caused by "sepsis."

Unknown	31	34	42/24	16/14	123
Aspiration Pneumonia	-	-	13/4	15/2	28
Other	21	34	18†/5	15/5	87
Seizure	10	6	7/3	12/5	35
COVID-19	-	-	-	10/2	10
Respiratory Disease**	22	18	30/17	10/3	80
Stroke	3	3	7/2	8/4	21
Multi-system Organ Failure*	-	-	-	8/6	8
Neurodegenerative Diseases	3	4	18/2	7/3	32
Gastrointestinal Disease	-	-	3/1	6/3	9
Kidney Disease	9	9	10/5	6/4	34
Choking	1	0	2/0	5/1	8
Complications of a Congenital Condition	-	2	13/10	5/4	20
Aspiration	13	25	5/1	4/0	47
Bowel Obstruction	4	7	7/2	4/2	22
Postoperative Complications	6	5	3/1	3/2	17
Total	**248**	**261**	**312/140**	**354/163**	**1,175**

Expected and Unexpected Deaths

Following the cause of death determination, the DBHDS DD MRC determines whether a death was Expected or Unexpected. The leading cause of Unexpected deaths in SFY 2020 was sudden cardiac death (37 deaths), followed by "Unknown" (14 deaths) and "Other" (12 deaths). The leading causes of Expected deaths were cancer (34 deaths), sepsis (33 deaths), and failure to thrive (21 deaths). The DBHDS DD MRC was unable to determine whether one death was Expected or Unexpected.

Fig. 1. Expected and Unexpected Deaths, SFY 2017 – 2020

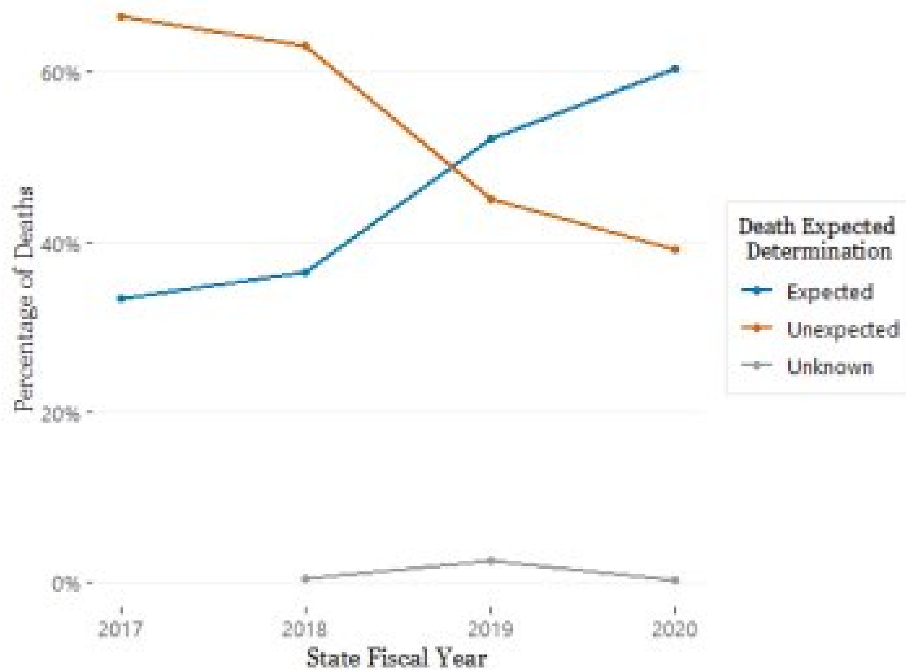


Table 2. Expected and Unexpected Deaths, SFY 2017 – 2020

Determination	2017		2018		2019		2020	
	Deaths	Percent	Deaths	Percent	Deaths	Percent	Deaths	Percent[6]
Expected	83	33.5%	95	36.4%	163	52.2%	214	60.5%
Unexpected	165	66.5%	165	63.2%	141	45.2%	139	39.3%
Unknown	0	0	1	0.4%	8	2.6%	1	0.3%

As was observed for the first time in SFY 2019, the DBHDS DD MRC determined more deaths to be Expected than Unexpected in SFY 2020. The percentage of deaths the DBHDS DD MRC determined to be expected increased from 52.2 percent of deaths in SFY 2019 to 60.5 percent of in deaths in SFY 2020.

Potentially Preventable Deaths

In SFY 2020, the DBHDS DD MRC continued a process first implemented in SFY 2018 to identify potentially preventable deaths and collect information related to contributing factors in these deaths. Potentially preventable as defined by the DBHDS DD MRC is specific to identifying modifiable factors within the service delivery system that are required through regulation but

[6] Due to rounding, these column percentages add to more than 100 percent.

may have been missed. However over the past two years, while the standardized application of the definition has been achieved, this definition has identified a relatively small number of individuals. The Committee will continue to evaluate what is considered to be potentially preventable in order to adequately identify potentially preventable deaths in order to reduce mortality rates to the fullest extent practicable and improve quality of services for individuals with DD. For the purposes of the DBHDS DD MRC, this definition does not include preventable risk factors and health behaviors such as smoking or unhealthy diets. These modifiable risk factors are addressed though the Health and Safety Key Performance Area Workgroup whose focus is on health prevention and maintenance of wellness. Through this process, the DBHDS DD MRC assessed not only whether actions leading to the death itself were preventable, but also whether there was an opportunity to improve quality of care regardless of whether or not the death was potentially preventable, as defined above.

The DBHDS DD MRC classified 17 deaths (5%) as potentially preventable in SFY 2020. Of these 17 deaths determined to be potentially preventable, 14 (82%) were identified as a failure to execute established protocols. Similarly, in SFY 2019 the failure to execute established protocols was associated with nine of the 11 potentially preventable deaths (82%). In SFY 2020, of the 17 potentially preventable deaths, four were due to choking, two were due to bowel obstruction, and one each were due to nutritional deficiency, traumatic brain injury, and anoxic brain injury. In SFY 2019, the DBHDS DD MRC determined that 14% of the deaths reviewed were Unknown related to potentially preventable. By contrast, in SFY 2020, the DBHDS DD MRC determined 'Unknown' related to potentially preventable status for 3%.

Table 3. Potentially Preventable Deaths, SFY 2018 – 2020

Determination	2018		2019		2020	
	Deaths[7]	Percent	Deaths	Percent[8]	Deaths	Percent[9]
Not Potentially Preventable	184	71%	258	83%	328	93%
Potentially Preventable	55	21%	11	4%	17	5%
Unknown	20	8%	43	14%	9	3%

[7] Two deaths that occurred during SFY 2018 did not include any data for this determination and are therefore omitted from this column.

[8] Due to rounding, these column percentages add to more than 100 percent.

[9] Due to rounding, these column percentages add to more than 100 percent.

Population Demographics

This section includes demographic trends for individuals reviewed by the DBHDS DD MRC. For SFY 2020, a separate comparison shows mortality rates for individuals authorized to receive DD waiver services. The crude mortality rate is the total number of deaths within a specific time-frame divided by the mid-interval population, adjusted per 1000. Crude mortality rate here is reported for the DD waiver population as the denominator can be validated and compared from year to year. There are a number of factors that impact crude mortality rate such as age, gender, and race, which are further broken down within this section. Additional breakdown is conducted for the individual's service program. In Virginia, the Supports Intensity Scale is used as an assessment to develop a service program that reflects the array of services and supports that an individual may receive to meet their needs.

Age

- As previously observed in SFYs 2018 and 2019, the plurality of deaths reviewed by the DBHDS DD MRC in SFY 2020 occurred among individuals aged 61 to 70.
- Slightly more than two thirds of all deaths reviewed by the DBHDS DD MRC were for individuals 51 years of age or older.
- As in SFY 2019, the median age at time of death was 58 years; the mean age at death was 54 years.

Fig. 2. Age at Death, SFY 2020

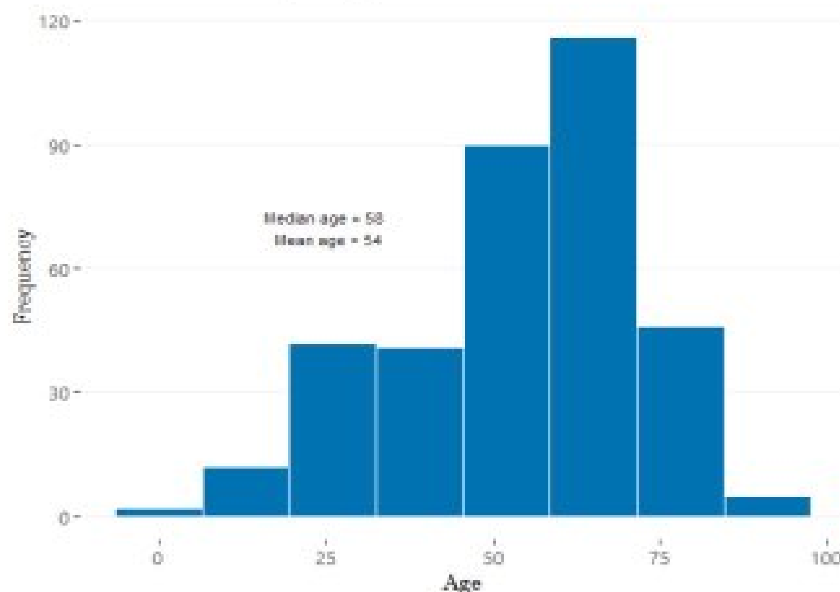
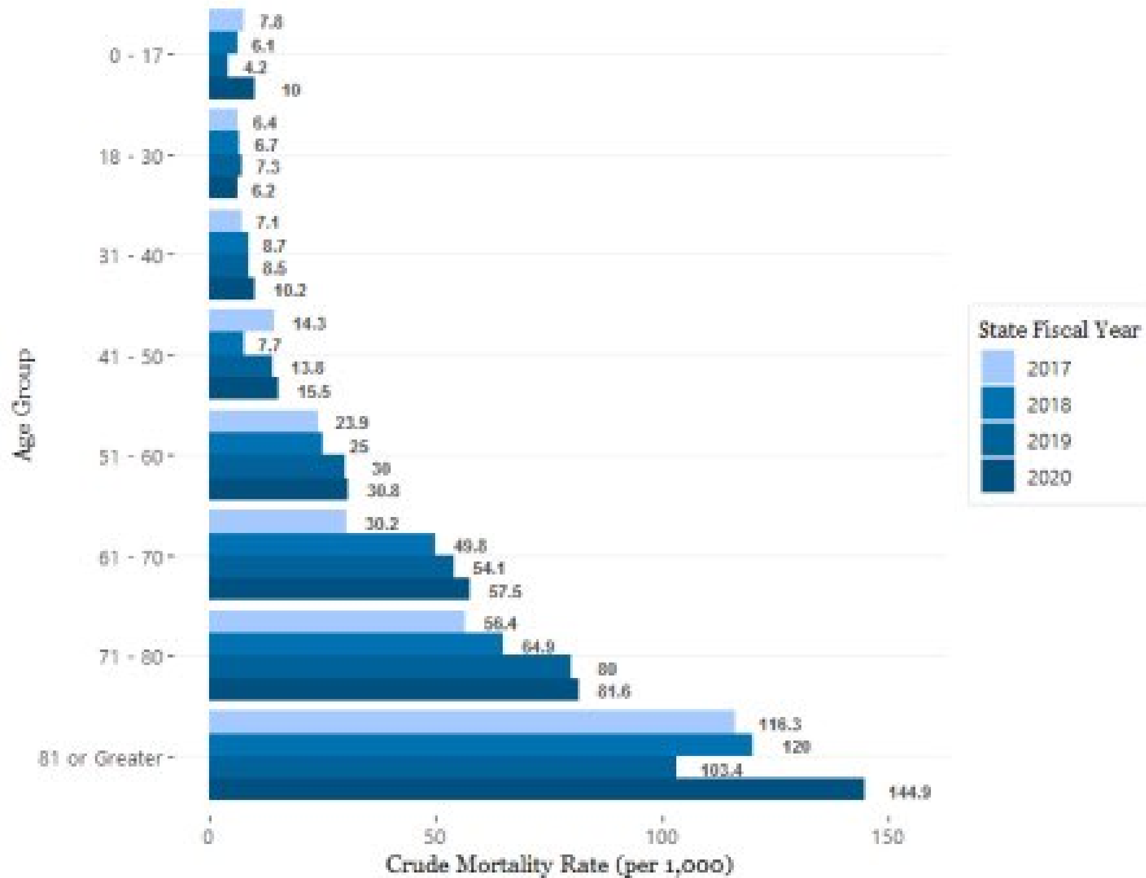


Table 4. Crude Mortality Rates by Age per 1,000 population, SFY 2020

Age Group	Deaths	DD Waiver Population	Crude Mortality Rate
0 - 17	10	997	10.03
18 - 30	30	4,820	6.22
31 - 40	30	2,936	10.22
41 - 50	30	1,941	15.46
51 - 60	62	2,014	30.78
61 - 70	75	1,305	57.47
71 - 80	31	380	81.58
81 or Greater	10	69	144.93
Total	**278**	**14,462**	**19.22**

- Between SFYs 2017 and 2020, the crude mortality rate among individuals on a DD Waiver increased for all age groups between 51 and 80 years of age.
- Compared to SFY 2019, the crude mortality rate among the DD Waiver population increased for all age ranges except among individuals between the ages of 18 and 30.
- In the DD waiver population, 137 decedents were between the ages of 51-70, and 54 of those individuals (39%) were known to be receiving hospice services.

Fig. 3. Crude Mortality Rates by Age per 1,000 DD Waiver Population, SFY 2017 – 2020



Gender

Males comprised the majority of individuals whose deaths the DBHDS DD MRC reviewed in SFY 2020, consistent with trends from previous fiscal years. The table below includes the gender breakdown of individuals the DBHDS DD MRC reviewed that were in the DD Waiver population.

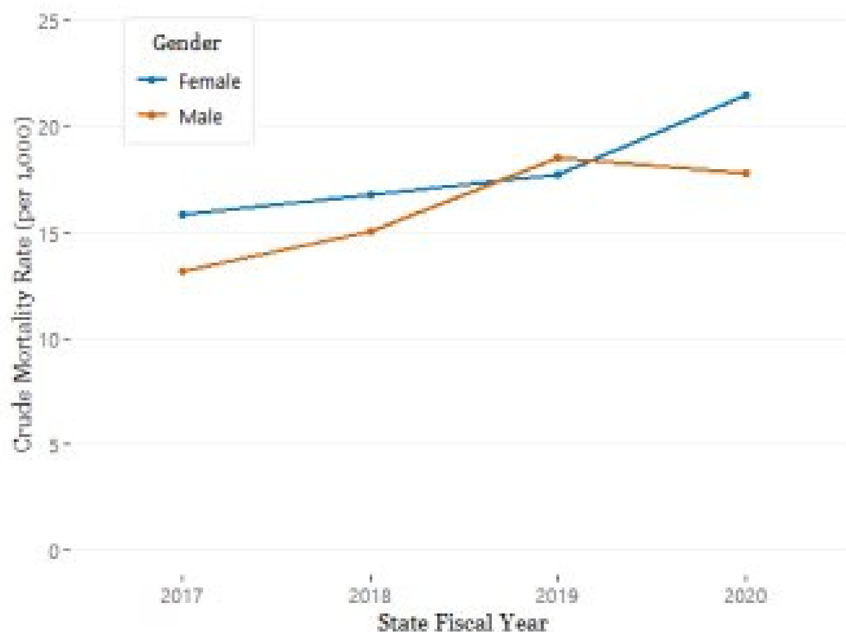
Table 5. Crude Mortality Rates by Gender per 1,000 population, SFY 2020

Gender	Deaths	DD Waiver Population	Crude Mortality Rate
Female	122	5,675	21.50
Male	156	8,785	17.76
Unknown	0	2	0
Total	**278**	**14,462**	**19.22**

Since SFY 2017, the crude mortality rate among females on a DD Waiver has consistently increased, from 15.9 deaths per 1,000 population in SFY 2017 to 21.5 deaths per 1,000 population in SFY 2020. In contrast, among males on a DD Waiver, the crude mortality rate has fluctuated in recent years: increasing from SFY 2017 to SFY 2019 before decreasing in the

current fiscal year. For males on a DD Waiver, the crude mortality rate increased from 13 deaths per 1,000 population in SFY 2017 to 18.5 per 1,000 population in SFY 2019, and then decreased to 17.8 deaths per 1,000 population in SFY 2020.

Fig. 4. Crude Mortality Rates by Gender per 1,000 population, SFY 2017 – 2020



The overall gender breakdown for SFY 2020 was 201 male and 153 female deaths. The leading cause of death among all males in SFY 2020 was sudden cardiac death (26 deaths, 13% of male deaths), followed by sepsis (24, 12%), then heart disease (17, 8%). Among females, the leading cause of death was cancer (18 deaths, 12% of female deaths), followed by sudden cardiac death (17, 11%), sepsis (16, 10%), heart disease and pneumonia (each accounting for 11 deaths, 7%).

Race

Consistent with data from previous years, the majority of deaths reviewed by the DBHDS DD MRC were of individuals identified as White/Caucasian (238 deaths, 67%). Individuals identified as Black/African American accounted for 29 percent of deaths reviewed by the Committee. Individuals of all other races combined for approximately 4 percent of deaths reviewed by the Committee.

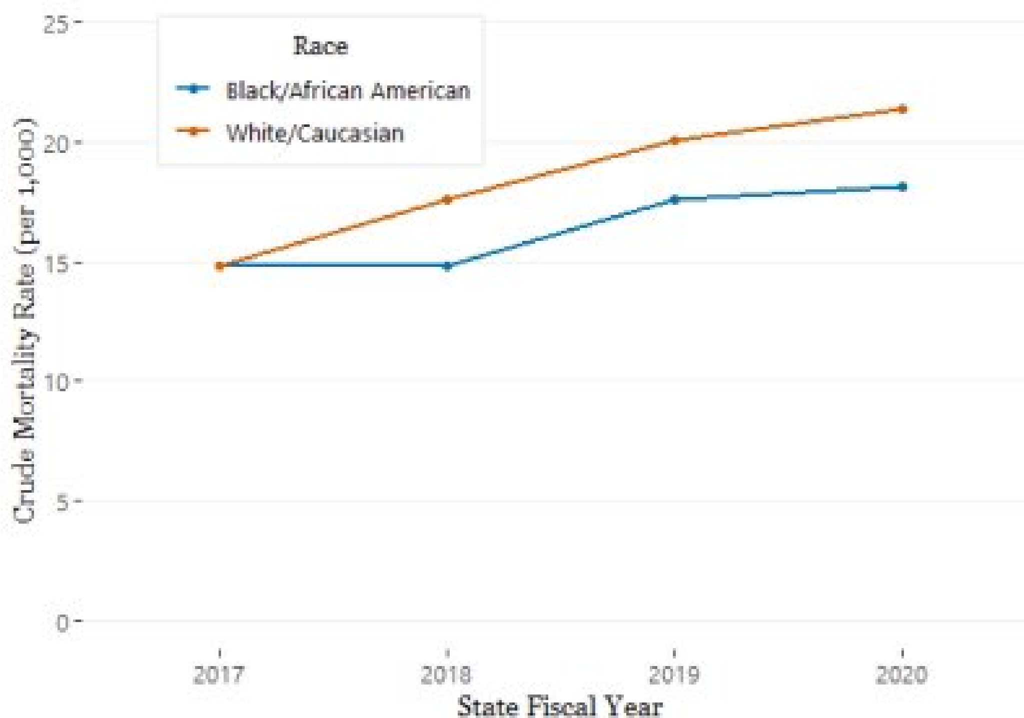
Table 6. Crude Mortality Rates by Race per 1,000 population, SFY 2020

Race	Deaths	DD Waiver Population	Crude Mortality Rate
White/Caucasian	193	9,022	21.39

Black/African American	77	4,250	18.12
Other	8	1,132	7.07
Unknown	0	58	0
Total	**278**	**14,462**	**19.22**

The crude mortality rate among individuals identified as White on the DD waiver was 21.4 deaths per 1,000 population in SFY 2020—an increase from 20 deaths per 1,000 population in SFY 2019. Similarly, the crude mortality rate among individuals identified as Black/African American on the DD waiver also increased from 17.6 deaths per 1,000 population in SFY 2019 to 18.1 deaths per 1,000 population.

Fig. 5. Crude Mortality Rates by Race per 1,000 population, SFY 2017 – 2020



Services and Supports

DBHDS uses the Supports Intensity Scale (SIS)[10] to assign individuals on a DD waiver to one of seven levels. Each level includes an array of services and supports, reflecting a service program

10 http://www.dbhds.virginia.gov/library/developmental%20services/mlmc%20support%20levels%20and%20tiers%20adults%206-30-16.pdf

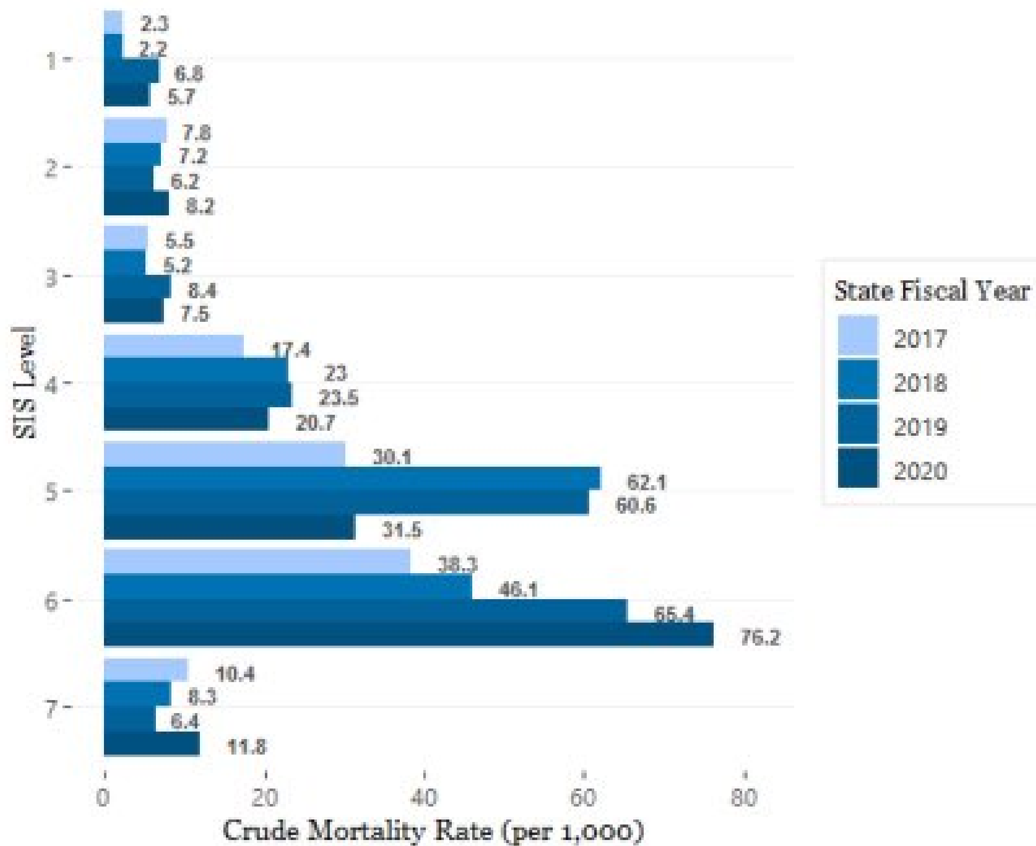
that meets the individuals' needs. Individuals categorized within a Level 1 service program includes individuals with the fewest support needs and Levels 6 and 7 includes individuals with an intensive need for medical and behavioral supports and services, respectively. After the initial SIS assessment is completed, SIS levels are re-evaluated and completed every three years for those over age 16, and every two years for those age 5-15. A SIS level may be re-evaluated before that time if there is a documented significant and sustained change over 6 months in any of two domains or 'Exceptional Medical Behavioral Supports Needs'.

Table 7. Crude Mortality Rates by SIS Level per 1,000 population, SFY 2020

SIS Level	Deaths	DD Waiver Population	Crude Mortality Rate
1	5	873	5.73
2	45	5,503	8.18
3	4	533	7.50
4	104	5,029	20.68
5	13	413	31.48
6	96	1,260	76.19
7	10	844	11.85
Unknown	1	7	142.86
Total	**278**	**14,462**	**19.22**

From SFY 2019 to 2020, the crude mortality rate increased for individuals on the DD waiver with SIS Levels 2, 6, and 7 and decreased for those with SIS Levels of 1, 3, 4, and 5. In SFY 2020, the highest crude mortality rate on the waiver by SIS Level was for SIS Level 6, which captures the population of individuals with the highest level of intensive medical needs. The crude mortality rate among individuals with a SIS Level of 6 increased to 76.2 deaths per 1,000 population in SFY 2020. For individuals with a SIS Level of 5, the crude mortality rate decreased from 60.6 deaths per 1,000 population in SFY 2019 to 31.5 deaths per 1,000 population in SFY 2020.

Fig. 6. Crude Mortality Rates by SIS Level Group per 1,000 population, SFY 2017 – 2020



Residential Setting

Due to the low number of individuals in certain residential settings, the DBHDS DD MRC analyzed death reviews using the following groupings for residence type for the purposes MRC reporting:

- *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 Facility* include Commonwealth-operated training centers, 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 DBHDS DD MRC review.

Table 8. Deaths by Residential Setting, SFY 2017 – 2020

Residential Setting	2017		2018		2019		2020	
	Deaths	Percent	Deaths	Percent	Deaths	Percent	Deaths	Percent
Congregate	82	33.1%	109	41.8%	147	47.1%	165	46.6%
Facility	20	8.1%	15	5.7%	16	5.1%	6	1.7%
Independent	100	40.3%	106	40.6%	127	40.7%	136	38.4%
Institutional	40	16.1%	31	11.9%	20	6.4%	45	12.7%
Unknown	6	2.4%	0	0%	2	0.6%	2	0.6%
Total	**248**	-	**261**	-	**312**	-	**354**	-

In SFY 2020, the leading cause of death among those living independently was sudden cardiac death (22 deaths, 16%), followed by cancer (15, 11%), and heart disease, pneumonia, and "Unknown" (each 10 deaths, 7%). Among those individuals who lived in congregate settings, the leading cause of death was sepsis (25, 15%), followed by sudden cardiac death (17, 10%), and failure to thrive/slow decline (14, 8%).

In SFY 2020, the percentage of deaths among individuals in state facilities continued to decrease, a trend established in SFY 2017. By contrast, the percentage of deaths in Community Institutional settings increased to 12.7 percent of deaths reviewed by the DBHDS DD MRC, from a low of approximately six percent in SFY 2019; however, based on trend analysis, the data from SFY 2019 appears to be the outlier, as previous years have ranged from 11.9 to 16.1%.

Table 9. Crude Mortality Rates by DD Waiver Residential Setting per 1,000 population, SFY 2020

Residential Living Group	Deaths	DD Waiver Population[11]	Crude Mortality Rate
Congregate Living	159	4,551	34.9
Independent Living	101	9,911	10.2
Total	**260**	**14,462**	**18.0**

Table 9 presents the crude mortality rates of individuals on a DD Waiver in SFY 2020. Six of the individuals who died in a congregate settings and 35 of the individuals who died in an

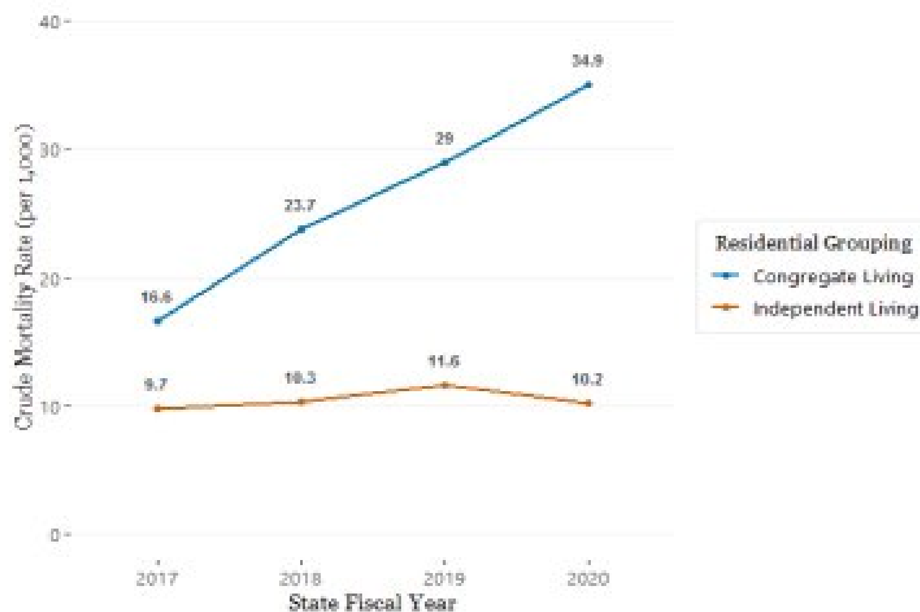
[11] Population estimates for the congregate living and independent living groups utilize the "Living Situation on Waiver" field in the Waiver Management System (WaMS) enrollment data.

independent setting were not receiving a licensed service on a DD Waiver; thus, they could not be included in the calculation of this rate. Table 10 presents the crude mortality rates of individuals in non-waiver settings.

Table 10. Crude Mortality Rates by Non-Waiver Residential Setting per 1,000 population, SFY 2020

Residential Living Group	Deaths	Estimated Population[12]	Crude Mortality Rate
Facility	6	400	15.0
Institutional	29	8,401	3.4

Fig. 7. Crude Mortality Rates by Residential Grouping per 1,000 population, SFY 2017 – 2020



In SFY 2020, the crude mortality rate among those living in congregate settings was 34.9 deaths per 1,000 population, an increase from 29 deaths per 1,000 population in SFY 2019. In contrast, the crude mortality rate among those living independently decreased from 11.6 deaths per 1,000 population in SFY 2019 to 10.2 deaths per 1,000 population in SFY 2020. The crude mortality rate for individuals living independently decreased to its lowest point since SFY 2017.

[12] Estimated populations for facilities are based on a mid-year snapshot. For the Institutional estimate, the total number of individuals with a DD diagnosis from the most recent private hospital census data (SFY 2019) is added to the maximum bed capacity for adult and child ICF/IIDs.

None of the deaths reviewed by the DBHDS DD MRC among individuals who lived independently were considered potentially preventable, while approximately 10 percent of deaths among those in congregate settings were potentially preventable (16 deaths).

Individuals Discharged from Training Centers

For decades, DBHDS has worked to transition individuals residing in state-funded training centers (TCs) 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 within two years receive an additional review by the DBHDS Community Integration Project Team.

In SFY 2020, the DBHDS DD MRC reviewed 46 deaths among individuals discharged from a training center into the community. Sepsis was the leading cause of death among individuals discharged from TCs (8, 17%), followed by sudden cardiac death (7, 15%) and COVID-19 (5, 11%). Four deaths (9%) that occurred among those discharged from TCs were potentially preventable.

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 included in these calculations.

Table 11. Age at Death and Community Tenure for Individuals Discharged from Training Centers[13]

SFY	Deaths	Average Age at Death	Median Age at Death	Average Community Tenure (months)	Median Community Tenure (months)
2015	16	60	59	17	18
2016*	31	60	60	24	25
2017	23	62	61	31	34
2018*	30	60	62	40	44
2019	36	64	64	45	44
2020	46	64	65	43	48

For the first time, average community tenure decreased among individuals discharged from training centers. Nonetheless, the median community tenure among these individuals increased from 44 months in SFY 2019 to 48 months in SFY 2020. While both mean and median are

[13] The totals marked with an asterisk (*) differ from previously reported totals. Previously, 28 deaths were reported among this population in SFY 2016; 31 in SFY 2018. These discrepancies were identified during quality reviews of the source data.

measures of central tendency, the mean is more likely than the median to be influenced by outliers. In SFY 2020, there were nine individuals who were discharged from a training center (20%) within less than or equal to 12 months of their deaths. From July 1, 2019 to June 30, 2020, only two TCs remained open, and there were no TC deaths that occurred within 30 days of discharge to a congregate or independent living setting.

Conclusion

Individuals with disabilities in Virginia and across the country continue to experience significant differences in health characteristics and management compared to those without disabilities. Individuals with I/DD experience a higher mortality than the general population[14]. Addressing persistent health risk factors through early recognition and intervention by DBHDS licensed providers for all I/DD individuals is a priority. The DBHDS DD MRC support efforts to include individuals with disabilities in disease prevention, health promotion, and emergency response activities, while working to remove barriers to health care and improve access to routine preventive services. This report is an important contribution towards those efforts.

The quality management process, consisting of a planned, systemic, organization-wide approach to designing and improving initiatives, has improved over the past several years. The current plan is comprehensive and interdisciplinary and addresses critical functions such as: health and safety, person-centered service planning, access to services, human rights/freedom from abuse and neglect, and outcome management. The focus is shifting to also include identification of risk factors versus contributory factors that predispose individuals with I/DD to negative outcomes and the role those factors play in implementing interventions. These will be evaluated as the DBHDS DD MRC implements and tracks resulting data from these initiatives and recommendations.

[14] Reppermund S, Srasuebkul P, Dean K, Trollor JN. Factors associated with death in people with intellectual disability. J Appl Res Intellect Disabil. 2020 May;33(3):420-429. doi: 10.1111/jar.12684. Epub 2019 Dec 1. PMID: 31786826.

Virginia Department of
Behavioral Health &
Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2020
1st and 2nd Quarters

Case Management Steering Committee

Semi-Annual Report FY20 1st and 2nd Quarters

Executive Summary

In 2019, the Case Management Steering Committee (CMSC) reviewed their charter and submitted revisions to the Quality Improvement Committee (QIC) for review. As a subcommittee of QIC, the CMSC is responsible for monitoring case management performance across responsible entities to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and evaluate data to identify and respond to trends to ensure continuous quality improvement. In addition, the CMSC is responsible for performance monitoring of case management by responsible entities. The committee is charged with reviewing data selected from, but not limited to, any of the following data sets: CSB data submissions, Case Management Quality Reviews, Office of Licensing citations, Quality Service Reviews, DMAS' Quality Management Reviews, and WaMS. The committee's analysis will identify trends and progress toward meeting established Support Coordination/Case Management targets. Based on this data review and system analysis, the committee will recommend systemic quality improvement initiatives to the QIC. The committee recommends technical assistance based on review of CSB specific data. If CSB specific improvements are not demonstrated after receiving technical assistance, the committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings. Committee membership includes Director of Waiver Operations or designee, Director of Provider Development or designee, Director of Community Quality Improvement or designee, Settlement Agreement Director, two Quality Improvement Program Specialists, and Office of Data Quality and Visualization. Standard operation procedures include: annual review and update of the committee charter, regular meeting to ensure continuity of purpose and at least ten times annually, maintenance of reports and meeting minutes, and quality improvement initiatives consistent with Plan, Do, Study, Act model.

The CMSC reported to the Quality Improvement Committee (QIC) in September and December of 2019. Committee charter revisions were presented in September and data reporting in December. Data reporting included six Performance Measure Indicators (PMIs): employment discussions and goals, community engagement discussions and goals, timeliness of Regional Support Team (RST) referrals, and enhanced case management face to face visits. Key accomplishments include: implementation of a redesigned Support Coordinator Quality Review (SCQR) process, Transactional Developmental Disability Support Coordination Pilot for 7 CSBs, completed CSB Quality Reviews, streamlined the WaMS ISP, assisted with Commissioner's request for CSBs to improve case management performance (CSB self-assessment, WaMS data exchange transition, increasing employment, and reducing late RST referrals), and updated the Case Management Modules and developed an online DD Support Coordination manual.

DOJ Settlement Agreement Status

The Independent Reviewer's 15th Report to the Court submitted on December 15th 2019 included a review of III.C.5.c, III.C.5.d, and V.F.4. This reporting period did not include a full study of case management. The following Independent Reviewer's (IR) findings are the result of the Individual Service Reviews and the Quality Improvement and Risk Management study. Provision III.C.5.c has now been found in compliance for the second consecutive reporting period as evidenced by the IR's findings: the Individual Services Review studies during the tenth, eleventh, twelfth, thirteenth and fifteenth periods found that case managers had offered choices of residential and day providers. The offer of a choice of case managers is now documented as part of the ISP process and was documented for 53 of 54 (98.1%) of the individuals studied in the fourteenth and fifteenth periods. Provisions III.C.5.d and V.F.4 remain non-compliant given the IR's findings: Licensing protocols continue to not include a review of the adequacy of case management services, including a review of whether case managers are fulfilling their responsibilities to determine whether services are being delivered appropriately and remain appropriate to the individual; and DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to assess CSB compliance with their performance standards relative to case manager contacts.

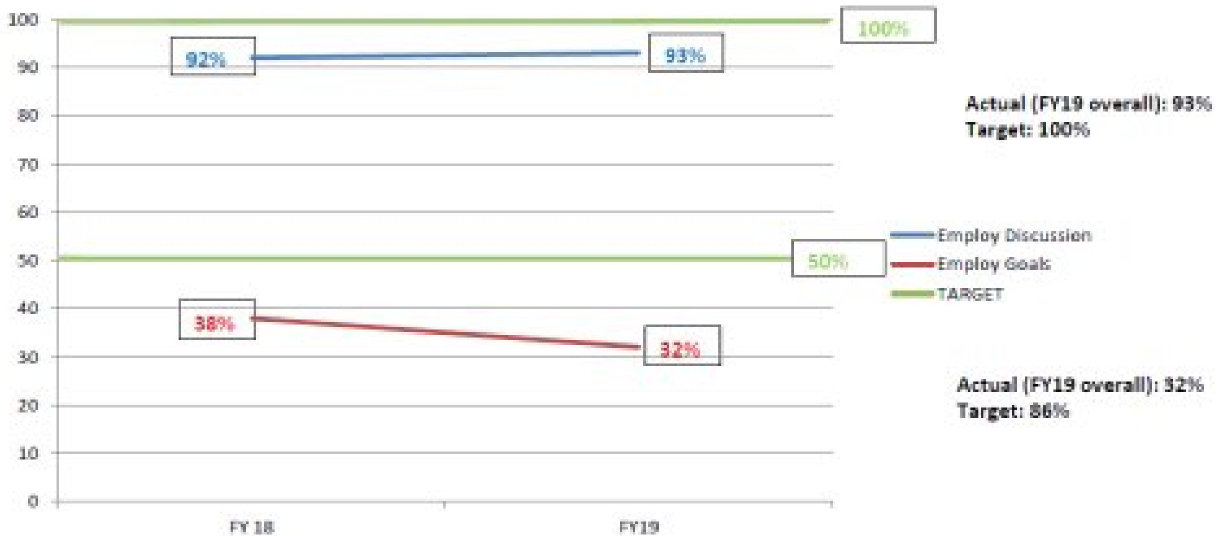
Performance Measure Indicators

Employment Discussions and Goals

Performance Measure Indicator: Support Coordinators will have meaningful discussions about employment benefits and options face to face with individuals receiving DD Waivers ages 18 64 during their annual ISP meeting and develop employment ; Employment discussion target 100%/Employment Goals target is 50%.

- Numerator: Individuals receiving DD Waivers ages 18 64 whose support coordinator had an annual ISP meeting and discussed employment options and whose ISP included employment goals
- Denominator: Individuals on the Waiver ages 18 to 64 who had an ISP meeting completed

Fig. 1 Meaningful Employment Discussions and Goals FY18 and FY19

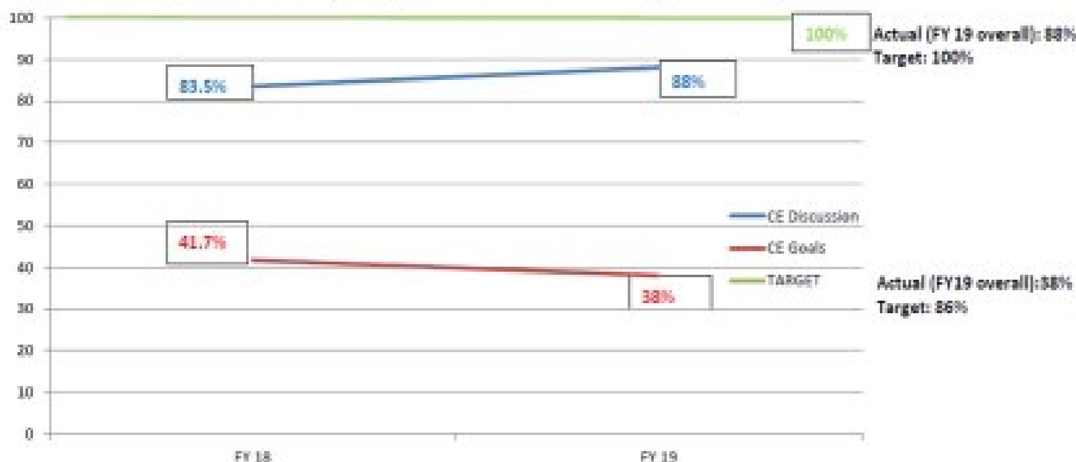


Community Engagement Discussions and Goals

Performance Measure Indicator: Support Coordinators will have meaningful discussions about Community Engagement (CE) and Community Coaching (CC) face to face with individuals receiving DD Waivers ages 18 64 during their annual ISP meeting and develop CE and or CC goals ; CE and CC discussion target 86%/CE/CC Goals target is 75%.

- Numerator: Individuals receiving Developmental Disabilities Waiver services whose support coordinator had an annual ISP meeting and discussed community engagement (CE) and community coaching (CC) and whose ISP included a CE/CC goal
- Denominator: Individuals receiving Developmental Disabilities Waiver services who had an ISP meeting completed

Fig. 2 Meaningful Community Engagement and Community Coaching Discussions and Goals FY18 and FY19

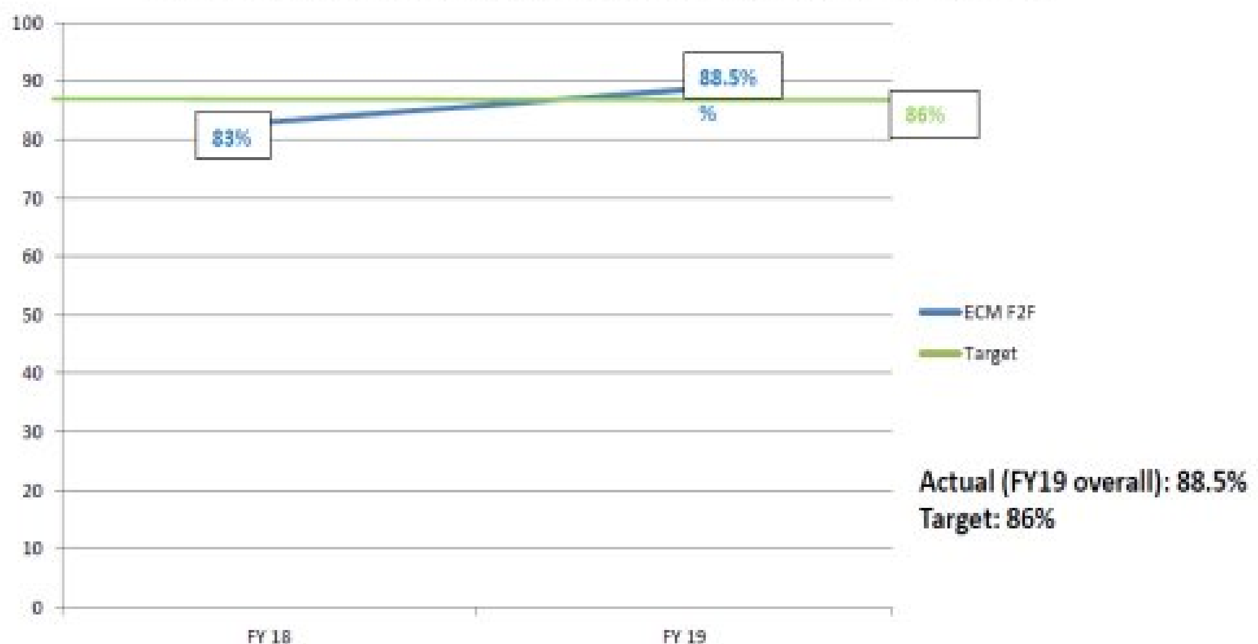


Enhanced Case Management (ECM) Face to Face Visits (F2F)

Performance Measure Indicator: Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month no more than 40 days apart: Annual target 86%.

- Numerator: Individuals receiving Developmental Disabilities Waiver services who met ECM criteria and received a F2F visit during the month that was no more than 40 days after the last visit in the previous month.
- Denominator: Individuals receiving Developmental Disabilities Waiver services identified as meeting ECM criteria.

Fig. 3 ECM Face to Face Visits per Performance Contract Standards FY18 and FY19

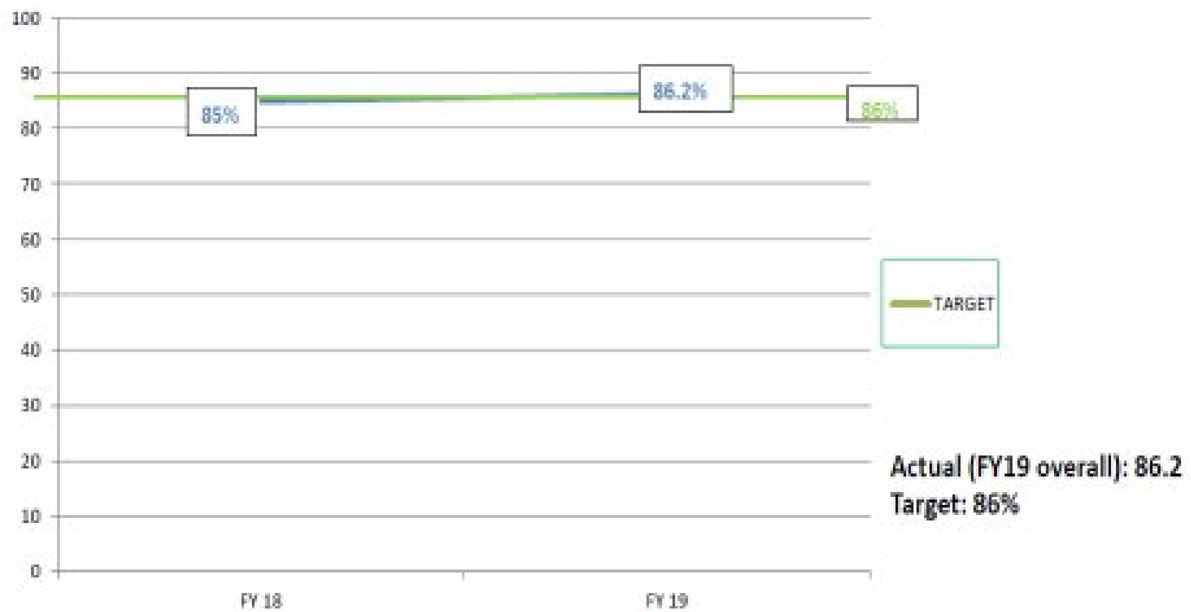


Enhanced Case Management F2F In Home Visits

Performance Measure Indicator: Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month in their residence: Annual target 86%.

- Numerator: Individuals receiving Developmental Disabilities Waiver services who met ECM criteria in the current month and received a face to face visit every other month in the individual's home.
- Denominator: Individuals receiving Developmental Disabilities Waiver services identified as meeting ECM criteria.

Fig. 4 ECM In Home Face to Face Visits per Performance Contract Standards FY18 and FY19

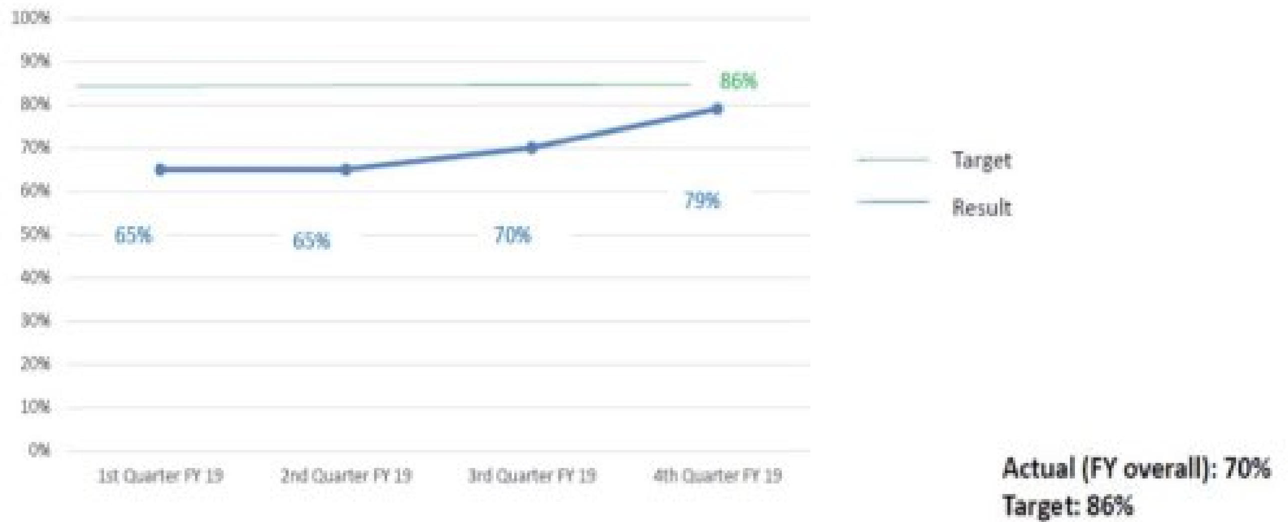


Regional Support Teams and Timeliness of Referrals

Performance Measure Indicator: Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. Data reported quarterly; annual target 86%.

- Numerator: Number of non-emergency RST referrals made on time. (324 referrals made on time; 145 were late)
- Denominator: Number of non-emergency RST referrals. (469 total referrals)

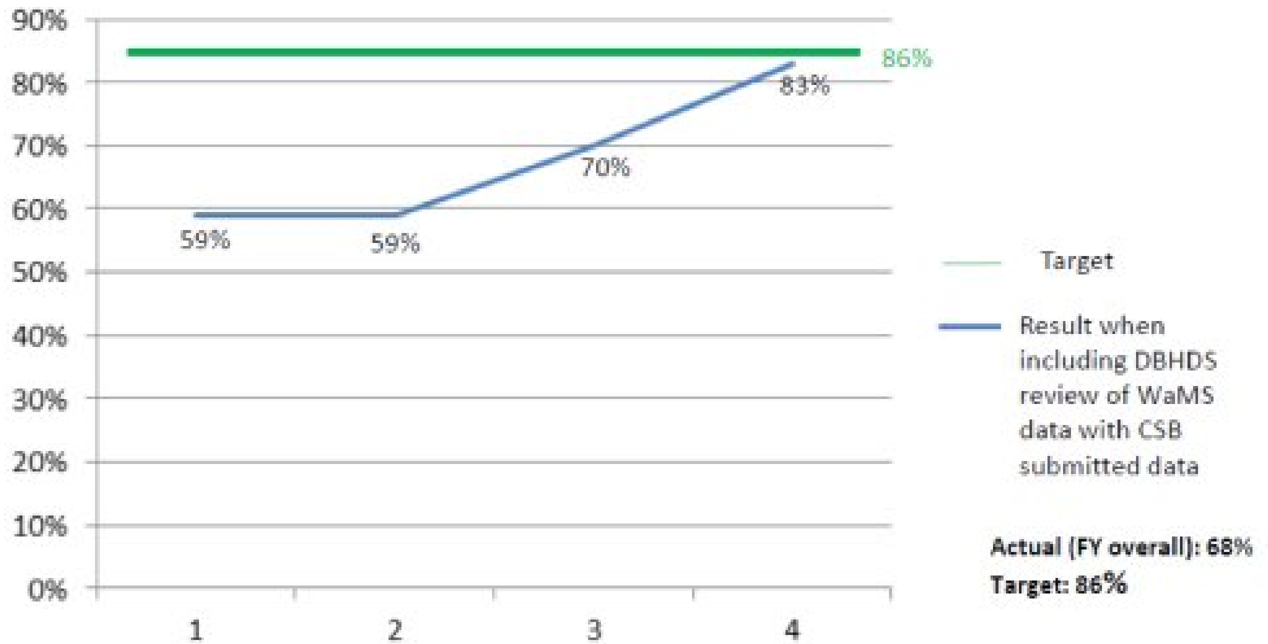
Fig. 5 Regional Support Team Referrals Submitted per Performance Contract Standards FY19



RST Timely Referrals for Those Considering a Move into Group Homes of 5 or More Beds

Performance Measure Indicator: RST referrals are timely for individuals considering a move into group homes of 5 or more beds. Data reported quarterly; annual target 86%.

- Numerator: Total Referrals Submitted within Expected Time Frames
- Denominator: Total Referrals Submitted and Required Not Submitted



Data Monitoring

Case Management Training and Competency

Fig. 7 Case Management Module Completion FY2020

Month	Certificates Completed
July 2019	102
August 2019	91
September 2019	111
October 2019	222
November 2019	131
December 2019	79
Total	736

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

CSB Performance Contract Measure – ISPs in WaMS revised February 25, 2019

1. By July 1, 2019, 70% of all ISPs resulting from ISP meetings held from April 1 – June 30, 2019 will be live in WaMS either through direct entry or data exchange. Denominator for the determination of the percentage will be based on Annual Plans that are due 5/1-7/30/2019. This assumes meetings occur at least one month prior to their initiation date.
   - ↓ Not Met – 11 of 40 CSBs met the 70% target; and 12 CSBs remain at 0%
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.
   - ↓ Not Met see Figure 5 above at 70% for state fiscal year 2019

   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
   - ↓ Not met see Figure 6 above at 68% for state fiscal year 2019

Support Coordination Quality Review

The fiscal year (FY) 2020 SCQR questions and technical guidance were written to assess compliance with the ten DOJ SA case management indicators as well as other facets of high-quality support coordination. In accordance with the DOJ SA compliance indicators, a statistically significant stratified statewide sample of individuals receiving HCBS waiver services ensures record reviews of individuals at each CSB. The population used for the FY 2020 SCQR sample included adults aged 18 or older who were enrolled in one of the HCBS Waivers as of July 1, 2018, in either an active or hold or pending appeal status with an authorization for least one HCBS Waiver service. Case Management Supervisors at each CSB will complete the survey in Qualtrics, a web-based survey platform. The SCQR was formatted such that all questions must be answered. Display logic was utilized to reduce respondents' fatigue and to allow respondents to explain their negative responses. Explanations will be used not only to improve the quality of support coordination records but also to revise the survey questions in subsequent years. The link to the FY 2020 SCQR was disseminated to the CSBs by the Director of Provider Development via secure email. Reporting per the compliance indicator metrics is dependent on the review of two consecutive quarters of CSB submissions. The CMSC FY20 3rd and 4th FY20 report on the surveillance data currently being monitored.

Recommendations

Previous Report

The recommendations from the 3rd and 4th Quarter CMSC Report have been implemented and reported on in previous sections of this report. This is the third consecutive semi-annual report including findings from a broad range of surveillance data sources that includes CCS3, Licensing, RST, Training, and DMAS QMR.

Recommendations

As reported to the QIC on December 2019, the CMSC has identified the following opportunities for improvement:

- CSBs are not consistently meeting targets for case management data metrics
- Some CSBs are not making RST referrals as required to ensure that individuals are provided with the most integrated options available
- Ensure all ISPs in WaMS electronically either by direct entry or through data exchange
- Further develop data reporting capabilities for collecting and providing reports to the CSBs

Virginia Department of Behavioral Health & Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2020
3rd and 4th Quarters

Case Management Steering Committee

Semi-Annual Report FY20 3rd and 4th Quarters

Executive Summary

As a subcommittee of the Quality Improvement Committee (QIC), the Case Management Steering Committee (CMSC) is responsible for

- monitoring case management performance across responsible entities to identify and address risks of harm,
- ensuring the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and
- evaluating data to identify and respond to trends to ensure continuous quality improvement.

The committee is charged with reviewing data selected from, but not limited to, any of the following data sets: Community Services Board (CSB) data submissions, Support Coordination Quality Reviews (SCQR), Office of Licensing citations, Quality Service Reviews, DMAS' Quality Management Reviews, and WaMS. The committee's analysis will identify trends and progress toward meeting established Support Coordination/Case Management targets. Based on this data review and system analysis, the committee will recommend systemic quality improvement initiatives (QIIs) to the QIC. The committee also recommends technical assistance based on review of CSB specific data. If CSB specific improvements are not demonstrated after receiving technical assistance, the committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings.

Committee membership includes Director of Waiver Operations or designee, Director of Provider Development or designee, Director of Community Quality Improvement or designee, Settlement Agreement Director, two Quality Improvement Program Specialists, and a representative from the Office of Data Quality and Visualization. Standard operation procedures include: annual review and update of the committee charter, regular meetings to ensure continuity of purpose and at least ten times annually, maintenance of reports and meeting minutes, and quality improvement initiatives consistent with Plan, Do, Study, Act model.

From January to June 2020, the CMSC continued the implementation and refinement of a structured process of routine CSB performance monitoring as required by Virginia's Settlement Agreement. The CMSC also reported to the QIC in March and June. Data reporting included six

Performance Measure Indicators (PMIs): employment discussions and goals, community engagement discussions and goals, timeliness of Regional Support Team (RST) referrals, and enhanced case management face to face visits. Four new measures were developed in accordance with the indicator for provision V.F.5. to focus on case management assessment of changes in status and appropriately implemented services, as well as discussions about relationships and interactions with people (other than paid program staff) and individuals being given a choice of providers including a choice of support coordinator. One additional measure being recommended for FY 21 relates to children age 14 to 17 with a waiver having a discussion about employment and how they are supported to be ready to work included in their ISP.

Key accomplishments in the reporting period include: designed and implemented a CSB Performance Monitoring data workbook, updated internal committee procedures related to reviewing data and providing technical assistance, designed and implemented an On-site Visit Tool, completed the submission phase of the Support Coordination Quality Review (SCQR) process, provided data and performance summary letters to CSBs, assisted with the development of Settlement Agreement Indicator Overview videos for stakeholders, published guidance and a question and answer document about case management options for people on the DD Waiver waiting list, and refined CMSC measures to be implemented in FY21.

In cooperation with the Independent Reviewer, the committee defined two phrases related to the provision of case management services, which included identifying and responding to "changes in status" and if "services are appropriately implemented." The definitions are described in a guidance document that provides the basic components of the definitions, examples of each phase, and a list of generally accepted practices for consideration. In collaboration with CSBs, the committee then designed a standardized process for Support Coordinators (SCs) to assess for these conditions at face to face meetings with each individual. During the pilot phase an "On-site Visit Tool" was implemented at one face to face visit per month when visits occur. This established a schedule of completion monthly for people receiving enhanced case management (ECM) and one to three times quarterly for people with a Targeted Case Management (TCM) level of service. The definitions include:

- "Change in status" refers to changes related to a person's mental, physical, or behavioral condition and/or changes in one's circumstances to include representation, financial status, living arrangements, service providers, eligibility for services, services received, and type of services or waiver.

- "ISP implemented appropriately" means that services identified in the ISP are delivered consistent within generally accepted practices and have demonstrated

progress toward expected outcomes, and if not, have been reviewed and modified.

Materials developed include: a definitions document, a standardized tool format referred to as the On-site Visit Tool (OSVT), a summary of the Independent Reviewer report history related to non-compliance with the Settlement Agreement provision V.F.2., a reference chart as guidance, training slides, and a questions and answers document produced following a webinar provided on June 26, 2020. This project is further defined in a CMSC QII that was approved by the QIC in June for implementation. A pilot of the process will occur between July and September 2020 with enhancements and revisions made following the pilot phase.

Support Coordination Quality Review (SCQR)

The fiscal year (FY) 2020 SCQR questions and technical guidance were written to assess compliance with the ten Settlement Agreement (SA) case management indicators as well as other facets of high-quality support coordination. In accordance with the SA compliance indicators, a statistically significant stratified statewide sample of individuals receiving Home and Community-Based Services (HCBS) through the developmental disability (DD) waivers ensures record reviews of individuals at each CSB. The population used for the FY 2020 SCQR sample included adults aged 18 or older who were enrolled in one of the HCBS Waivers as of July 1, 2018, in either an active or hold or pending appeal status with an authorization for least one HCBS waiver service. Case Management Supervisors at each CSB completed the survey in Qualtrics, a web-based survey platform.

The SCQR was formatted such that all questions must be answered. Display logic was utilized to reduce respondents' fatigue and to allow respondents to explain their negative responses. Explanations will be used not only to improve the quality of support coordination records but also to revise the survey questions in subsequent years. Reporting per the compliance indicator metrics is dependent on the review of two consecutive quarters of CSB submissions.

Given the structure of submissions described in the SCQR methodology, submissions from CSBs will occur during two quarters of the state fiscal year in March and June. Technical assistance will be provided in this first year following the completion of submissions in June by the Office of Provider Development (OPD), and then by the Office of Community Quality Improvement (OCQI) following the retrospective review process slated to begin in July 2020. In subsequent years, technical assistance from the staff of OPD will occur at the mid-point of submissions after March of each year.

Technical assistance from the staff of OCQI will then occur by October each year as results are compared between each CSB and the DBHDS reviewer. CSBs completed the submission phase of the first year of the SCQR process. The committee provided data to CSBs via a secure online portal and included results in a performance letter provided to each CSB. The DBHDS Office of Data Quality and Visualization (DQV) prepared a full report for each CSB, which will be used in the provision of technical assistance in the first quarter of FY21 in tandem with the retrospective review process (figure 1).

Figure 1

DOJ Settlement Agreement Status

The Independent Reviewer's 16th Report to the Court submitted on June 13th 2020 included a study of case management. The following Independent Reviewer's (IR) findings are the result of the Case Management Study, which included discrepancy audits for 35 individuals. Results of the study included concerns with measurable outcome language and individual support plans (ISPs) changing in response to individual needs and circumstances. Independent Reviewer recommendations and DBHDS planned actions include:

- Clarify and emphasize to CSBs that school personnel should be included or invited to participate in the ISP process, and that school programs are an appropriate community site for the case managers' face-to-face visits that alternate with individuals' residences

DBHDS Response: DBHDS will add to the quarterly regional SC meeting agenda that school personnel should be included or invited to participate in the ISP process, and that school programs are an appropriate community site for the case managers' face-to-face visits that alternate with individuals' residences. Notes from these meetings are shared statewide, so will be available through posting on the DBHDS Provider Network Listserv that is comprised of DD waiver providers, DD Support Coordinators, and others interested in obtaining information from the Division of Developmental Services at DBHDS.

- Modify the ISP procedure so that ISPs can be more easily changed. The revisions need to ensure a paper trail to the logic behind and background to the change, and that ISP team members, appropriate professionals and caregivers are all included in the change process

  DBHDS Response: DBHDS has identified a lack of understanding in how updating the ISP occurs. A recent FAQ document provided to all CSBs in July 2020 included the following clarification: Q5. To ensure ability to have the plan being a more "living document" are changes being made to WaMS to make updating any part of the plan more feasible? A5. Currently, Parts I and II can be updated at any time by the SC through direct entry or through a data exchange through an EHR. The ISP in WaMS was designed for Part III updates to be made through the provider Part V revision process. This was due in part because of the manageability concerns of an SC entering multiple outcomes changes across multiple providers and services. It was also designed to ensure that providers apply plan changes at the point of the Part V, which has been signed by the person and substitute decision-maker as applicable. To facilitate a change in outcomes, the SC should communicate with the individuals and providers and discuss/request a revised Part V. Once the SC clicks approve, the locked Part III will automatically update to reflect the change.

- Make improvements to: The Guidance document relative to ISP measurable/observable outcomes, to ensure supervisors ask the question, "If I go into the individual's file, can I find a record of occurrences or activities toward the outcome statements that will demonstrate progress toward the outcome?" and the supervisor training on measurable/observable outcomes

  DBHDS Response: DBHDS recommends adding this content to the training development recommendation in 8 below (next bullet point).

- Add a specialized SC/CM training module regarding ISP measurable/observable outcomes for delivery during the SCQR technical assistance process

  DBHDS Response: DBHDS will develop a targeted outcome training on known issues with ISP completion for use during SCQR technical assistance that will also be posted publicly for increased access and use.

- Encourage a peer review process at CSBs for the production of the annual ISPs. Reviewers frequently find errors including gender pronouns, duplicative statements, wrong individuals' names, checklist boxes not checked where needed, and other mistakes that appear attributable to cutting and pasting erroneous information

  DBHDS Response: DBHDS will discuss with the VACSB who can assess the degree to which this is currently occurring and will encourage the sharing of helpful peer review practices across regions/CSBs.

- Establish a clear policy, procedure or protocol with regard to the expectations for the Virginia Informed Choice Form.

  DBHDS Response: DBHDS has developed a Virginia Informed Choice (VIC) form protocol. This protocol has been developed and provided to the DBHDS web master for posting online. It will be announced once posted for CSB use.

The sixteenth report indicates that while data is frequently available, additional reports are pending, which is necessary to establish compliance. These additional processes were developed and documented during the reporting period with implementation being in the first half of FY21. As a result, the Commonwealth remains in noncompliance with Section III.C.5.b.i.-iii.; III.C.5.d.; and V.F.2., 4., and 5. Provision III.C.5.c has now been found in compliance for the third consecutive reporting period as evidenced by the IR's findings.

Performance Measure Indicators

The CMSC monitors CSB performance through several measures that correlate with the SA and improved outcomes in system performance or for people who have services in Virginia. Below is a list of upcoming PMIs that have been identified for SFY21, which is followed by more specific results related to measures tracked in SFY20. Progress and lack of progress in these areas leads to individual technical assistance and recommendations for systemic change.

FY21 Case Management Performance Measure Indicators

Access to Services	
1	Individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process (Target 86%).
2	Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained Medicaid DD Community Engagement or Community Coaching services goals (Target 86%).
3	86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process (Target 86%).
4	Adults (aged 18-64) with a DD waiver receiving case management services have an ISP that contains employment outcomes (Target 50%).
5	At least 86% of individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP (Target 86%).
6	86% of all statewide non-emergency referrals, as such referrals are defined in the DBHDS RST Protocol, meet the timeliness requirements of the DBHDS RST Protocol (Target 86%).
7	Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%).
Provider Capacity	
8	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month no more than 40 days apart (Target 86%).
9	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month in their residence (Target 86%).
Health, Safety, and Wellbeing	
10	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 (Target 86%).
11	Individual support plans are assessed to determine that they are implemented appropriately (Target 86%).
Choice and Self-Determination	
12	Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff) (Target 86%).
13	Individuals are given choice among providers, including choice of support coordinator, at least annually (Target 86%).

Additional CMSC Measures related to the Settlement Agreement for FY21

14	People with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (defined as independent living supports, in-home support services, supported living, and sponsored residential) have access to an option that meets their preferences within nine months. **III.D.1**
15	People with DD Waiver receive face-to-face contacts from their support coordinator at least quarterly. **V.F.4**

16	Support coordination records reviewed across the state will be in compliance with a minimum of nine of the ten indicators assessed in the review. **III.C.5.b.i.**
17	Individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. **III.C.7.a**
18	Individual Support Plans are available in the Waiver Management System by direct keyed entry or data exchange since October 7, 2019. **DBHDS Metric/Performance Contract**

Employment Discussions and Goals

Performance Measure Indicator: Support Coordinators will have meaningful discussions about employment benefits and options face to face with individuals receiving DD Waivers ages 18 to 64 during their annual ISP meeting and develop employment outcomes/goals; Employment discussion target 86%/Employment outcomes/goals target is 50%.

- Numerator 1: Individuals receiving DD Waivers ages 18 to 64 whose support coordinator had an annual ISP meeting and discussed employment options (figure 2) and
- Numerator 2: Individuals whose ISP included employment outcomes/goals (figure 3)
- Denominator: Individuals on the Waiver ages 18 to 64 who had an ISP meeting completed

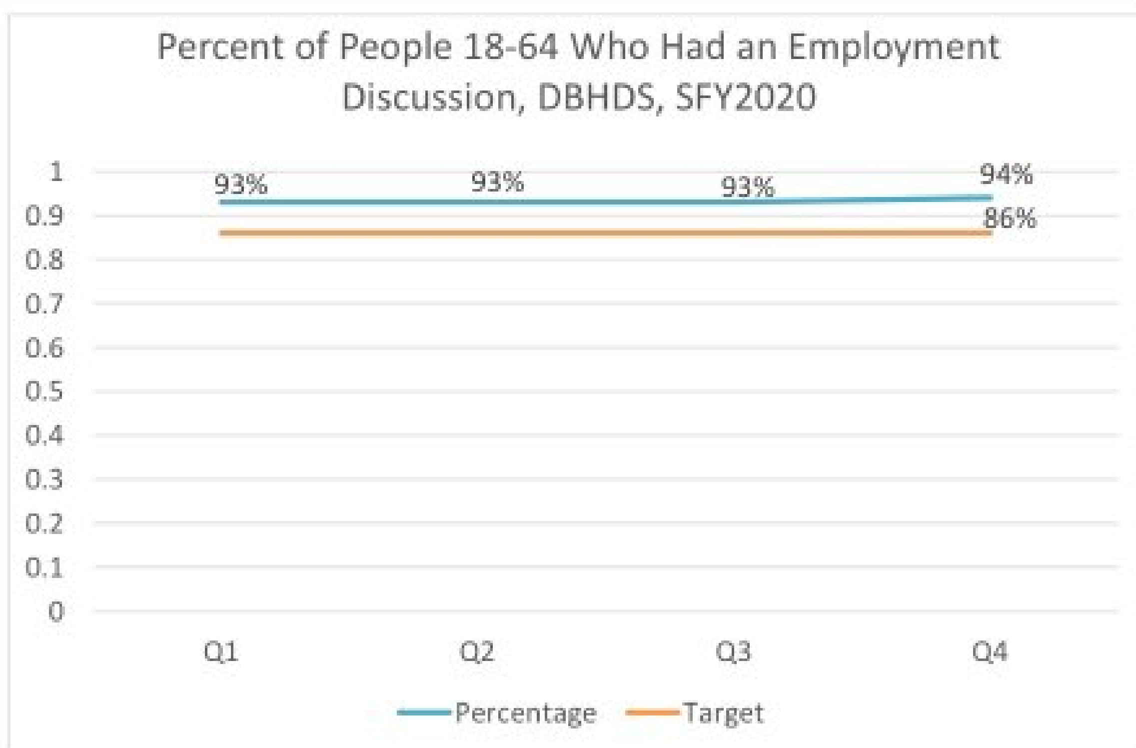


Fig. 2 Meaningful Employment Discussions from July 2019 to June 2020

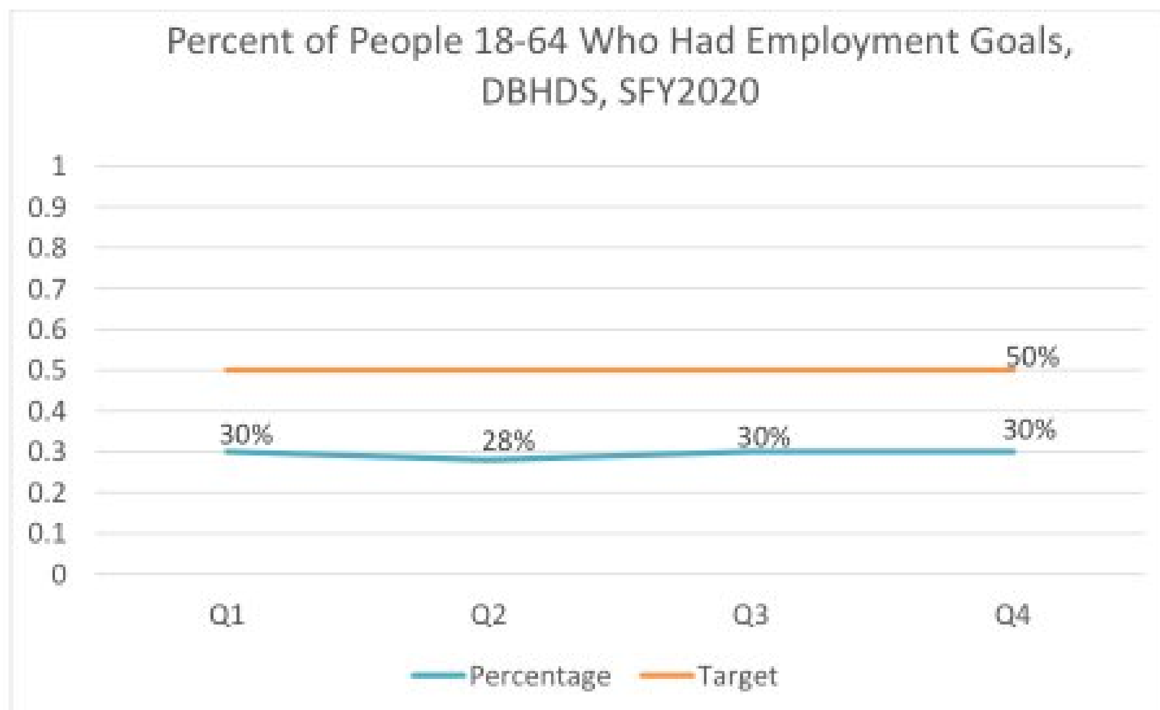


Fig. 3 Employment Outcomes/Goals from July 2019 to March 2020

Community Engagement Discussions and Goals

Performance Measure Indicator: Support Coordinators will have meaningful discussions about Community Engagement (CE) and Community Coaching (CC) face to face with individuals receiving DD Waivers ages 18 to 64 during their annual ISP meeting and develop CE and or CC outcomes/goals; CE and CC discussion target 86%/CE/CC Outcomes/Goals target is 86%.

- Numerator 1: Individuals receiving Developmental Disabilities Waiver services whose support coordinator had an annual ISP meeting and discussed community engagement (CE)/community coaching (CC) (figure 4)
- Numerator 2: Individuals receiving Developmental Disabilities Waiver services whose ISP included a CE/CC goal (figure 5)
- Denominator: Individuals receiving Developmental Disabilities Waiver services who had an ISP meeting completed

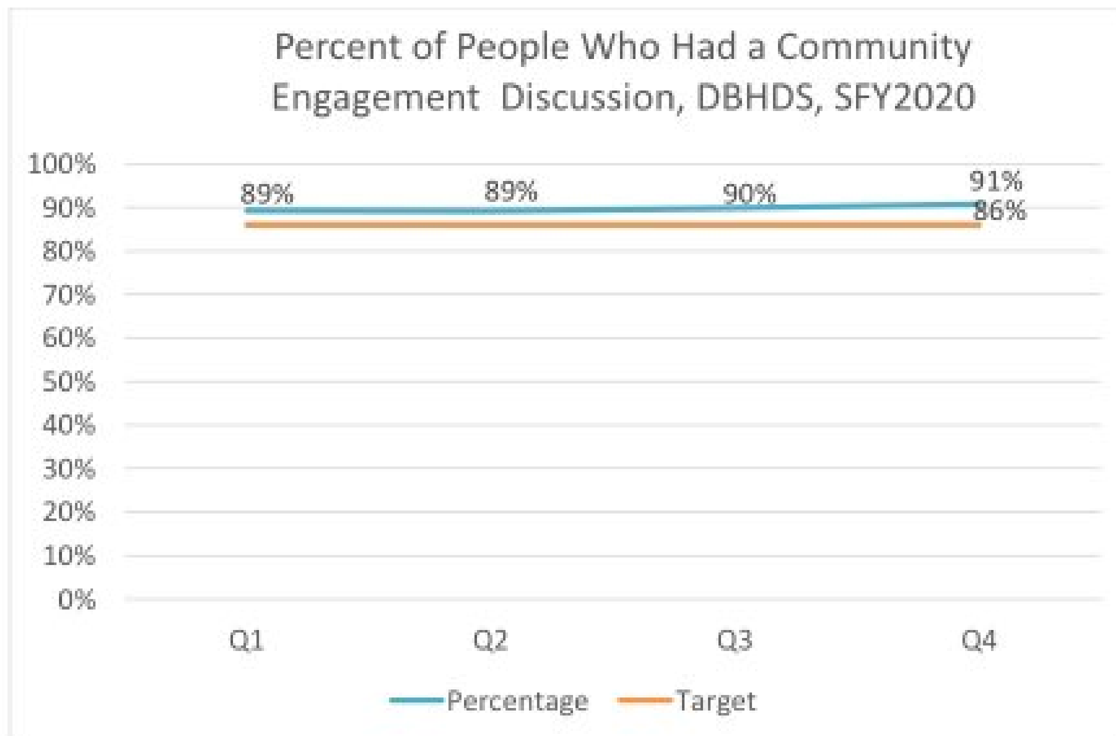


Fig. 4 Meaningful Community Engagement/Coaching Discussions from July 2019 to June 2020 (updated 11.18.20)

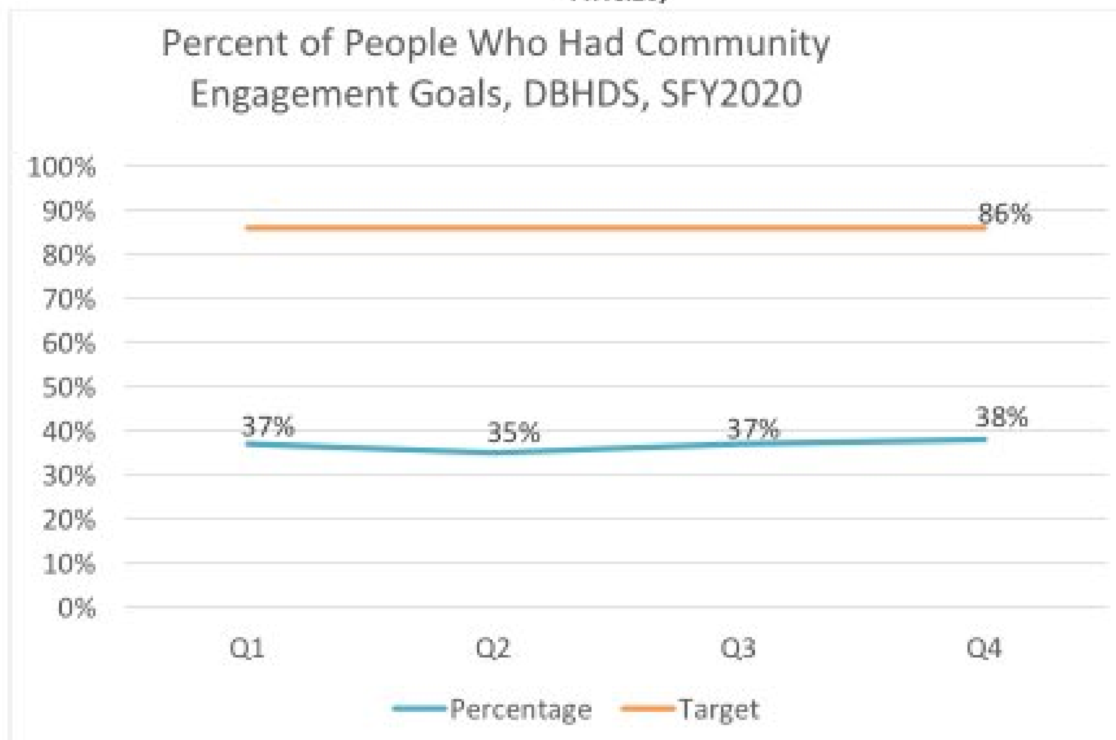


Fig. 5 Meaningful Community Engagement/Coaching Outcomes/Goals from July 2019 to June 2020

Enhanced Case Management (ECM) Face to Face Visits (F2F)

Performance Measure Indicator: Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month no more than 40 days apart: Annual target 86% (figure 6).

- Numerator: Individuals receiving Developmental Disabilities Waiver services who met ECM criteria and received a F2F visit during the month that was no more than 40 days after the last visit in the previous month.
- Denominator: Individuals receiving Developmental Disabilities Waiver services identified as meeting ECM criteria.

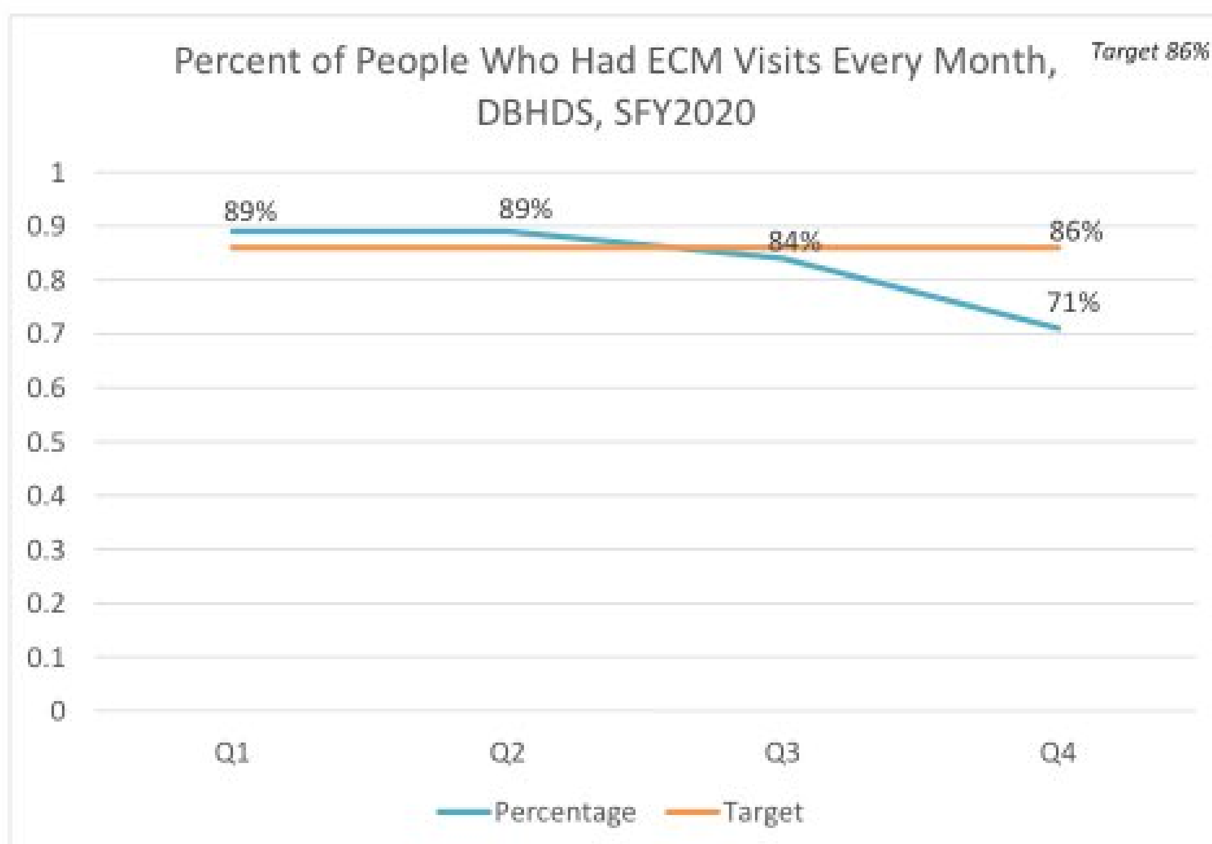


Fig. 6 ECM Face to Face Visits per Performance Contract Standards from July 2019 to June 2020

Enhanced Case Management F2F in the Home Visits

Performance Measure Indicator: Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month in their residence: Annual target 86% (figure 7).

- Numerator: Individuals receiving Developmental Disabilities Waiver services who met ECM criteria in the current month and received a face to face visit every other month in the individual's home.
- Denominator: Individuals receiving Developmental Disabilities Waiver services identified as meeting ECM criteria.

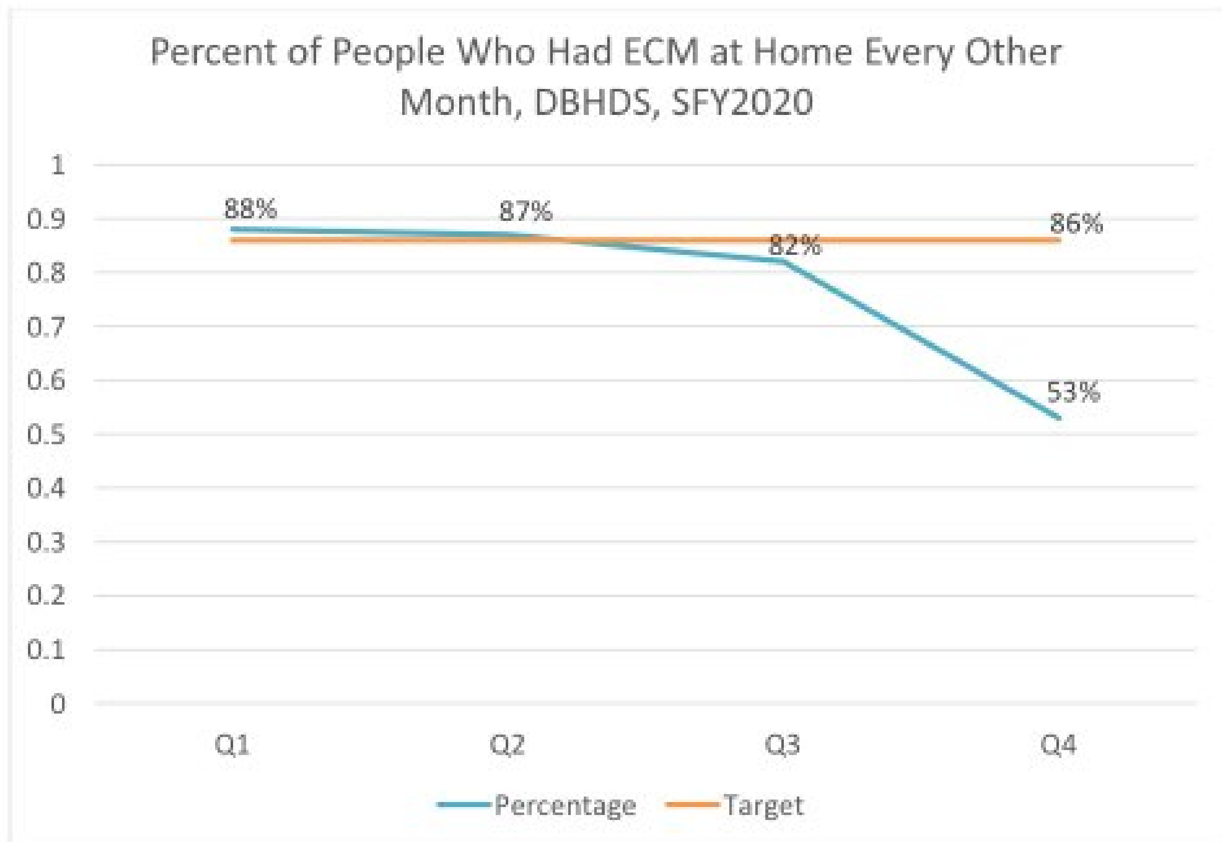


Fig. 7 ECM Face to Face Visits in the Home per Performance Contract Standards from July 2019 to June 2020

Regional Support Teams and Timeliness of Referrals

Performance Measure Indicator: Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. Data reported quarterly; annual target 86% (figure 8).

- Numerator: Number of non-emergency RST referrals made on time.
- Denominator: Number of non-emergency RST referrals.

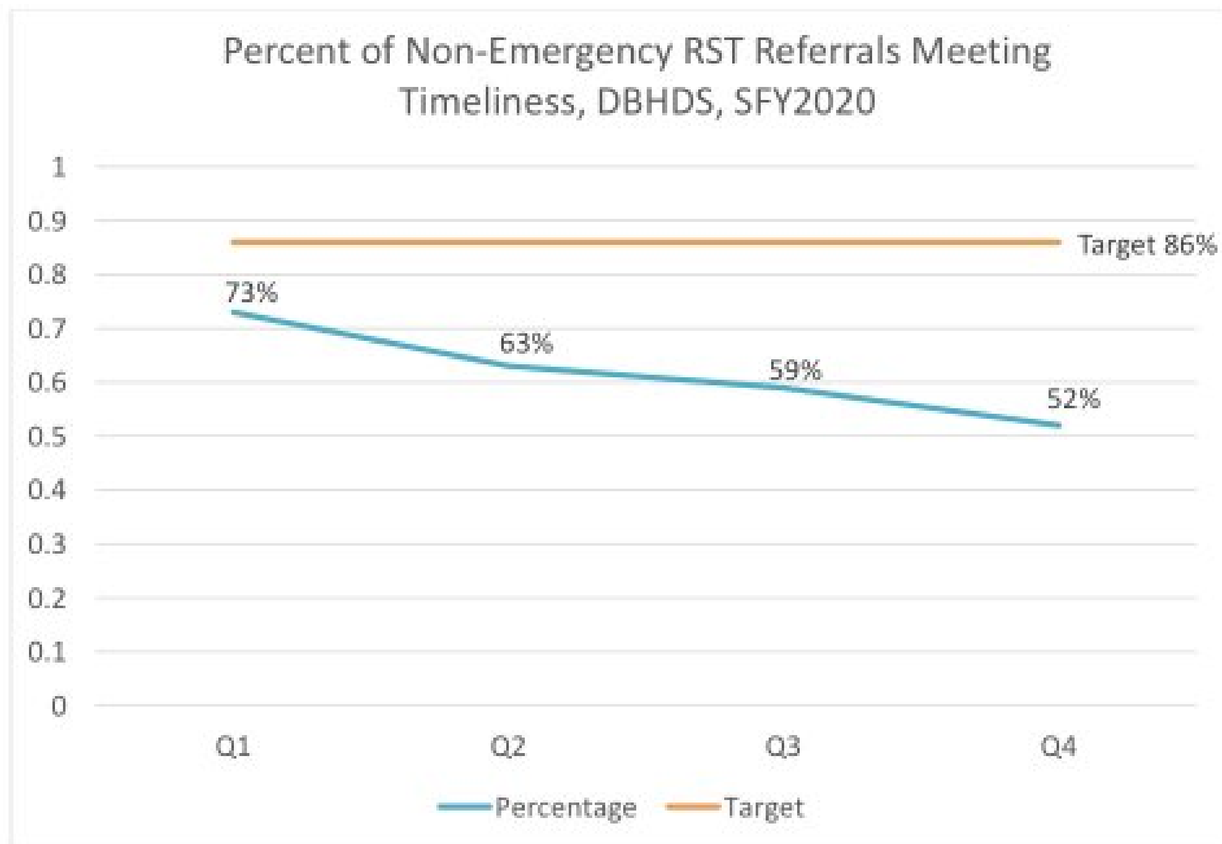


Fig. 8 Regional Support Team Referrals Submitted per Performance Contract Standards SFY2020

RST Timely Referrals for Those Considering a Move into Group Homes of 5 or More Beds

Target 86%

Performance Measure Indicator: RST referrals are timely for individuals considering a move into group homes of 5 or more beds. Data reported quarterly; annual target 86% (figure 9).

- Numerator: Total Referrals Submitted within Expected Time Frames
- Denominator: Total Referrals Submitted and Required Not Submitted, which accounts for the referrals provided by CSBs along with those identified as missing through a review of WaMS authorizations

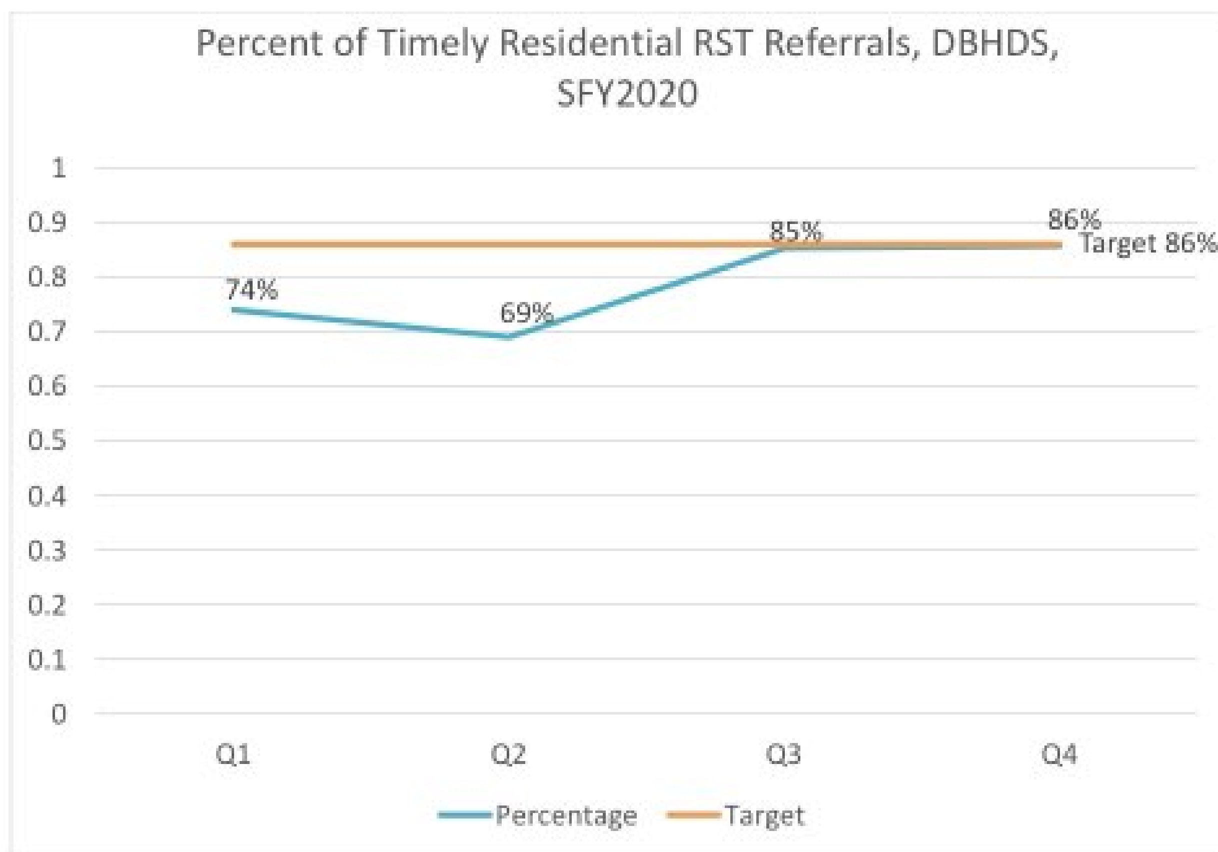


Fig. 9 Regional Support Team Referrals Submitted per Performance Contract Standards SFY2020

Data Monitoring

Case Management Training and Competency

Support Coordinators/Case Managers are required to complete the DBHDS Case Management training online modules within 30 days of hire. A review of module usage between January and June 2020 shows that the completion rate was at or above 88% for each months reported. The first chart below conveys the number of DD CMs reported as hired per month and the number and percentage who completed the modules within required timeframes (figure 10). The second chart shows, for each of five DBHDS regions, the number of DD SC/CMs who completed the modules compared to people in other roles who completed the modules (figure 11).

Month	Number of DD SCs hired	Number (percentage) completed ≤ 30 days of number hired
January 20	15	14 (93%)
February 20	17	17 (100%)
March 20	16	15 (94%)
April 20	8	7 (88%)

May 20	6	6 (100%)
June 20	12	11 (92%)

Fig. 10 Case Management Module Completion January to June SFY2020

Region	Total number DD SCs Jan to June	Total number other roles Jan to June	Total Certificates Jan to June
1	12	18	30
2	23	4	27
3	16	15	31
4	13	12	25
5	23	19	42
Not reported	5	21	26

Fig. 11 Case Management Module Completion January to June SFY2020

Data Availability and Integrity

The CMSC monitors performance related to the availability of data in the Waiver Management System (WaMS), as well as the integrity of the data provided through CCS3. Specifically regarding the requirements related to ISP entry, the CMSC has been monitoring the availability of WaMS ISP data per the Performance Contract reporting requirements. CSBs are required to provide ISP data either through an electronic data exchange or through direct keyed entry if the CSB does not use or is unable to use the data exchange. Results have been monitored at regular intervals as depicted in the graph below to establish progress towards meeting a statewide target of 86% by October 6, 2020 (figure 12).

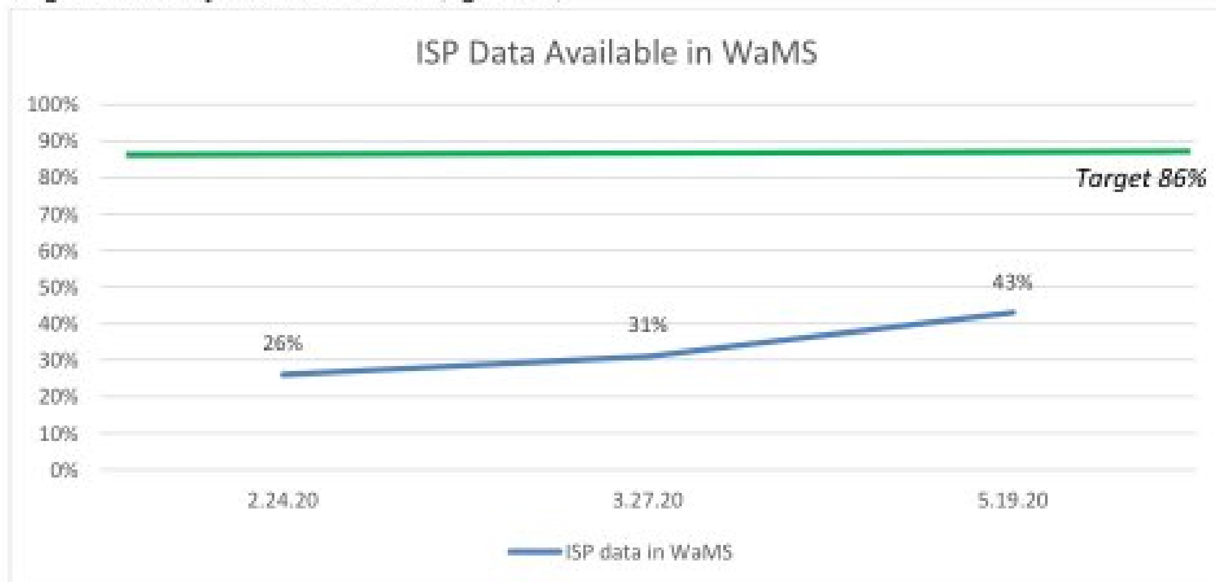


Fig. 12 ISP Data Available in WaMS

A new process is being developed to support CSBs to examine the integrity of the data provided in relation to face to face contacts submitted through CCS3. This process will begin in FY21 and be implemented through the DBHDS Office of Community Quality Improvement with the following primary outcomes:

- Identify issues related to data reporting and Settlement Agreement case management requirements related to case management performance measures
- Identify potential barriers to accurate coding and reporting
- Identify additional technical assistance needed
- Implement CSB data quality improvement plan needed for system process and outcome changes, ensuring that case management processes are reported accurately and as required

Office of Licensing Data

The DBHDS Office of Licensing (OL) provided and Adequacy of Supports Report and related data for CMSC review. Through aggregate reporting OL reported the following trends: Overall Private providers are able to meet individuals support needs 81.3% of the time and Case Managers are meeting individuals' support needs 92.5% of the time. The domain where adequacy of support is lowest is the avoiding crisis domain, which ties to regulation 665.A.7. This regulation requires the comprehensive ISP to be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the assessment including a crisis or relapse plan, if applicable. Both private providers and case managers were compliant with this regulation only 59% of the time. It is important to note that only one regulation is tied to the avoiding crisis domain so it is precipitous to draw conclusions about this domain without considering data from other sources. The provider community scored high in their ability to meet individuals' community inclusion support needs, with both the private providers and CSB case management service providers receiving an almost 100% compliance rating.
The CMSC will consider additional actions and/or a Quality Improvement Initiative that could help impact the low percentage of compliance seen around crisis plans. As mentioned in the summary, the CMSC will also consider alternate sources of surveillance data that might provide more insight into this result.

Recommendations

Below are recommendations that were made by the CMSC in the previous report followed by additional recommendations from this current report. There have been steady increases in the percentage of ISPs available in WaMS with an expectation that a target of 86% can be achieved by October 6, 2020. The status of each CSBs success with this effort will be examined after this date for additional recommendation or actions under the Performance Contract. One positive change seen in the 4th quarter is that CSBs met the timeliness requirements of having 86% of RST referrals related to moves to less integrated settings. The CMSC will continue to monitor for maintaining or increasing this percentage. The CMSC should continue to work to make data available to CSBs, so that internal monitoring and improvement abilities can be strengthened.

Previous Report

As reported to the QIC on December 2019, the CMSC has identified the following opportunities for improvement:

- CSBs are not consistently meeting targets for case management data metrics
- Some CSBs are not making RST referrals as required to ensure that individuals are provided with the most integrated options available
- Ensure all ISPs are in WaMS electronically either by direct entry or through data exchange
- Further develop data reporting capabilities for collecting and providing reports to the CSBs

Recommendations

- Implement methods to increase Support Coordinator/Case Manager abilities in developing measurable outcome statements
- Refine processes to ease the manageability of SC/CM processes and requirements to the extent possible
- Implement accountability steps (recommendations to the Commissioner and corrective action plans) as required by the Settlement Agreement for underperformance
- Continue recommendation to determine methods of sharing data with CSBs to support internal monitoring abilities and quality improvement practices

CMSC Glossary

Term	Definition
Aggregate total	A total amount that is arrived-at by adding together all related data under one area or group being considered.
Best Practices	Practices that have been shown by research and experience to produce optimal results and that is established or proposed as a standard suitable for widespread adoption.
Case Manager	See "Support Coordinator." This is a term frequently used by the Departments of Medical Assistance Services and DBHDS, the Community Services Boards, and the Independent Living Centers
Choice	The right, power, or opportunity to choose; option. Informed choice: When an individual is informed of all of the options that are available and understands these options and the impact of the choice.
Competency	The ability to do something successfully or efficiently.
CRC	Community Resource Consultants; Staff employed by DBHDS in the Office of Provider Development who provide technical assistance and support providers and community services boards with understanding

	state and federal requirements and who support best practices such as Person-Centered Thinking and planning.
Data Integrity	The overall accuracy, completeness, and consistency of data.
Demographics	Statistical data relating to Virginia's DD population and particular groups within it.
Individual Support Plan	An individual's plan for supports and actions to be taken during the year to lead toward his or her desired outcomes. It is developed by the individual and partners chosen by the individual to help. It is directed by the individual's vision of a good life, his or her talents and gifts, what's important to the individual on a day-to-day basis and in the future, and finally, what's important for the individual to keep healthy and safe and a member of communities.
Integrated setting	A setting where four or fewer unrelated individuals with developmental disabilities reside and/or receive Home and Community-Based waiver services.
Key Performance Measures	Statements that describe the expected performance of an individual, group, organization, system or component, which is required by the Settlement Agreement or approved by a DBHDS-approved committee for quality improvement purposes.
Meaningful activities	Activities that individuals indicate are personally meaningful to them.
Natural support	Supports that occur naturally within the individual's environment. These are not paid supports, but are supports typically available to all community members. Natural supports should be developed, utilized and enhanced whenever possible. Purchased services should supplement, not supplant, the natural supports. Some examples of natural supports are the family members, church, neighbors, co-workers, and friends (from: Indiana's Disabilities and Rehabilitation - Person Centered Planning Guidelines).
Non-integrated setting	A setting where five or more unrelated individuals with developmental disabilities reside and/or receive Home and Community-Based waiver services.
Outcome	A desired result that happens following an activity or process.
Person-Centered Planning	A planning process that focuses on the needs and preferences of the individual (not the system or service availability) and empowers and supports individuals in defining the direction for their own lives. Person-centered planning promotes self-determination, community inclusion and typical lives.
Person-Centered Practices	Practices that focus on the needs and preferences of the individual, empower and support the individual in defining the direction for his/her life, and promote self-determination, community involvement, contributing to society and emotional, physical and spiritual health.
Promising Practices	Practices that include measureable results and report successful outcomes, however, there is not yet enough research evidence to prove that they will be effective across a wide range of settings and people.
Providers	Agencies and their staff who provide DD waiver services in Virginia. Can be a private provider or a provider of services operating under a community services board.

Quality Improvement Initiative (QII)	Strategies designed to support quality improvement activities, whose implementation and use follow the PDSA (Plan Do Study Act) cycle to achieve these improvements. QIIs seek to improve systems and processes to achieve desired outcomes; strengthen areas of weakness, to prevent and/or substantially mitigate future risk of harm.
RST	Regional Support Team; Five Regional Support Teams (RSTs) were implemented in March 2013 by the Department of Behavioral Health and Development Services (DBHDS) with Virginia's emphasis on supporting individuals with developmental disabilities in the most integrated community setting that is consistent with their informed choice of all available options and opportunities. The RST is comprised of professionals with experience and expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs.
Support Coordinator	A person who assists an individual in developing and implementing a person-centered plan, including linking an individual to supports identified in the plan and assisting the individual directly for the purpose of locating, developing, or obtaining needed supports and resources.

Virginia Department of
Behavioral Health &
Developmental Services

Risk Management Review Committee Annual Report

July 1, 2019 – June 30, 2020

Risk Management Review Committee Annual Report

July 1, 2019 – June 30, 2020

I. Executive Summary

Throughout SFY 2020, Risk Management Review Committee (RMRC) continued refining processes around serious incident reporting (SIR) review and analysis of data, improving the quality of data entry in CHRIS Comprehensive Human Rights Information System), in the development and publication of materials specific to risk assessment including triggers and thresholds. The issuance of memo stressing the importance of calling 911 immediately in the event of an emergency came in response to the identification of direct care staff not following established 911 protocols. (The Mortality Review Committee (MRC) noted this as a contributing factor in the identification of potentially preventable deaths.) The Falls quality improvement initiative (QII) was implemented to reduce the rate of falls as falls and trips was identified as a leading cause in SIR. As COVID-19 became an increasing impactful event for all, RMRC provided recommendations to improve a COVID-19 FAQ document, helped informed the management of CHRIS reporting for individuals diagnosed with COVID-19, tracked COVID-19 cases and provided input in improving the tracking of COVID-19 cases, and the identification and response to provider needs related to COVID-19. Input was provided for Abuse, Neglect and Exploitation training for individuals and families at the request of the Office of Human Rights. Surveillance measures were identified and the tracking of associated data began as well.

RMRC, through the work of the Incident Management Unit (IMU), identified and addressed several data entry issues specific to CHRIS. This has resulted in increased accuracy of information being entered into CHRIS. IMU's work also brought to light some additional challenges providers faced in using CHRIS and determined two key causal factors (Internet browser and accessing CHRIS during upgrades) and addressed them (recommended using Internet Explorer and CHRIS notifications of system upgrades with reminder to providers to not access CHRIS during upgrades).

II. Recommendations

Based upon its review of SFY2020 activities and discoveries, RMRC identified the following recommendations to be targeted for completion in SFY2021. These are listed below followed by the recommendations made in SFY2019 with comment as to the action taken during SFY2020.

SFY2020:

1. Enhance the ability to query additional details such as age, race, region more readily to further identify disparities and trends during data reviews.
2. Broaden the scope of data review to include outside data trends as applicable to the risks of all individuals (such as earlier tracking of viral or illness trends).
3. Determine the role of SIS in risk. Is the SIS level correlated with greater risk and vulnerability? Evaluate adequate supports needs in placement settings systemically and determine what is needed to ensure a healthy and safe living plan. Assess need for interim SIS assessments to occur from time a DD waiver is assigned to the time of the initial SIS assessment.
4. Substantiated reports of neglect should be looked into more closely to better understand what is happening.
5. Assess further the impact of COVID-19 on results including long-term hidden impacts. Identify changes in routines/practices that had a positive impact on reducing illnesses or conditions as reportable incidents to determine efficacy in replication after the pandemic has ended.
6. Develop a centralized location to address concerns/issues individuals and families have relative to questions regarding availability of services, provider development across disabilities. (This should involve other offices and sister agencies.)
7. Develop a framework for review of financial exploitation and determine who receives notification of financial exploitation; identify program requirements for maintenance of financial documents.
8. Assess existing guidance for handling of situations involving escalation of behaviors and revise accordingly to ensure that:
    a. staffing requirements and workflows that meet individuals' needs on all shifts;
    b. changing of restraint protocols at facilities to include a debrief of staff after incident;
    c. increase availability of behavior specialists to consult with facilities;
    d. share behavior plans of individuals who are admitted to hospitals and have a behavior plan; and
    e. inclusion in policies and procedures of what not to do in situations that may result in escalation of behavior.

SFY2019 RMRC Annual Report Recommendations:

SFY2019 Recommendation #1: Establish a goal that less than 30% of serious incidents are classified only as "Other". In SFY 2019, there were 2,452 serious incidents classified as "other." With the clarity given to serious incident classifications in CHRIS and the work of the Incident Management Unit (IMU), SFY2020 there was a decrease in the classification of serious incidents as "other. " However, there continue to be a high number of conditions and injuries that are described as "other." This will continue to be evaluated in FY21.

SFY2019 Recommendation #2: Establish a quality improvement activity aimed at decreasing the rate of falls. The RMRC identified falls as a significant issue and recommended targeting improvement efforts toward reducing the rate of falls. Based on this recommendation a number of educational initiatives were implemented in early FY20. The Quality Improvement Committee (QIC) formally approved the Falls quality improvement initiative (QII) on June 30, 2020. Data collected throughout SFY2020 found that the rate of falls and trips steadily decreased throughout the year going from a rate of 71/1000 individuals receiving waiver services in the first quarter to a rate of 62/1000 by the third quarter. This rate then dropped dramatically to 37/1000 in the fourth quarter. The RMRC concluded that much of this latter decrease was likely due to the implementation of Executive Order #53 in response to COVID-19 pandemic. For example, with most individuals remaining in their residence and not attending day support programs or other community activities, there were fewer transitions of care and reduced situations that might contribute to a fall.

SFY2019 Recommendation #3: Establish a quality improvement activity aimed at enhancing the understanding of abuse, neglect, and exploitation of individuals with developmental disabilities. The Office of Human Rights (OHR) created a training specific to individuals' understanding of abuse, neglect, and exploitation and implemented it during SFY2020 (Self-Advocate training).

SFY2019 Recommendation #4: Develop standard surveillance measures that are trended over time to identify potential opportunities for improvement. Surveillance measures were identified during SFY2020 that included serious incident data. These measures stem from the Compliance Indicators. Data began being collected during SFY2020.

III. Committee Purpose

As established in their charter, the purpose of the 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.

IV. 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, behavioral analysis and data analytics. The RMRC reports to the QIC and may share data or findings with the Mortality Review Committee (MRC) when significant patterns or trends are identified related to deaths.

V. Summary of Activities

A. Identification, Prevention, and Mitigation of Risks of Harm

The RMRC's overall risk management process enables DBHDS to identify, and prevent or substantially mitigate risks of harm. RMRC reviews and analyzes related data collected from community service providers (information from training centers will be added in SFY21), including reports of serious incidents and allegations of abuse and neglect. RMRC also reviews data and information related to DBHDS program activities, including licensing reviews, triage and review of serious incidents, and oversight of abuse/neglect allegations. The Emergency Licensing Regulations are on track to become permanent in August 2020.

The *Independent Reviewer 15th Report to the Court* assessed the status of the risk management program during the 15th review period. Much of the findings echo earlier reports and focus around the use of valid and reliable data, timely response to trends, risk triggers and thresholds, health risk assessment, and inability of case managers to access CHRIS. The following concerns were noted: timely (proactive) systemic response to risks, determination of effectiveness of interventions employed during QII implementation, inclusion of case managers as integral to the functions of risk management, CHRIS design and architecture, and inclusion of plan

requirements in the critical incident management system RFP. The topic areas below include how RMRC responded to this report.

Abuse, Neglect and Exploitation

The Office of Human Rights (OHR) provides education to advocates, families, and providers on various topics, review and investigate allegations of abuse, neglect and exploitation, and address complaints involving human rights. Trainings relate to using CHRIS, who to contact, how to get help, how to file a complaint, confidentiality, consent, and how to conduct abuse/neglect investigations. RMRC reviews materials and trainings as requested and provides input accordingly. A key project for OHR titled "Improving the Education and Understanding of Human Rights" was distributed during SFY2020.

OHR continuously looks to identify factors that may result in abuse, neglect and exploitation and addresses those factors through education with providers, individuals and families. OHR identifies potential sources of unreported abuse, neglect and exploitation (for example, Adult Protective Services (APS) reports), indicators of hidden abuse (either not reported by providers or occurring outside of provider settings), and events that may impact data, (responses to COVID-19 pandemic and possible ramifications of temporary limitations to individuals' access to complaint process). OHR develops mitigating strategies through working one to one with providers, developing and enhancing education and training materials, and in collaboration with other departmental offices and agencies within the Commonwealth.

OHR conducts Community Look-Behinds to validate that provider investigations are conducted in accordance with state regulations, and to identify where prevention efforts and mitigating strategies are needed. OHR uses the calendar year when conducting the look-behinds. Process includes on-site record reviews and interviews. During the COVID-19 pandemic, on-site record reviews were temporarily halted beginning in March 2020. Prior to the end of the state fiscal year, OHR began conducting reviews remotely.

OHR Case Reviews

OHR provides case reviews to RMRC that identify potential systemic concerns for remediation that may not appear as observable data. These systemic concerns may indicate a process need not previously identified or indicate where further guidance is needed to ensure protection of individuals from abuse, neglect and exploitation. Case reviews highlighted the need to:

a. Expand planning in emergency response plans specific to the handling of situations involving behavioral outbursts (staffing requirements and workflows that meet individuals' need on all shifts, changing of restraint protocols at facilities to include

debrief of staff after incident, increase availability of licensed behavior specialists to consult with facilities, sharing of behavior plans with hospitals when individuals who have behavior plans are admitted)

b. Develop a centralized location to address concerns/issues individuals and families have relative to questions regarding availability of services, provider development across disabilities (This should involve other offices and sister agencies.)
c. Develop a framework for review of financial exploitation and determine who receives notification of financial exploitation; identify program requirements for maintenance of financial documents.
d. Provider policies and procedures should include what not to do in situations that may result in escalation of behaviors (example: talking about restraints escalates behaviors).
e. Evaluate adequate supports needs in placement settings systemically and determine what is needed to ensure a healthy and safe living plan.

COVID-19

SFY2020 saw the rise of COVID-19, a novel coronavirus that required alterations to routines and practices to limit the exposure and transmission of the coronavirus. The Commonwealth of Virginia temporarily issued a stay-at-home order (Executive Order #53) that included requirements for social distancing, public gatherings and wearing of facemasks when in public and one is not able to maintain social distancing. The stay-at-home order involved the temporary forced closure of non-essential businesses. RMRC assisted in the release of FAQs for community services boards (CSBs) and providers and other materials related to the education of staying safe during the pandemic. RMRC identified and addressed these unique challenges directly related to keeping staff and individuals safe: assisting providers in obtaining needed personal protective equipment (PPE) supplies for providers, as providers are not deemed medical personnel and the temporary need for quarantine measures resulting in a temporary lifting of regulations to allow for isolation due to having COVID-19. RMRC through the efforts of OIH, OHR, and OL guided providers in balancing safety and care and the management of reporting COVID-19 in CHRIS. OIH collaborated with the Virginia Department of Health (VDH) in testing facilities and residences showing outbreaks.

Access to and obtaining the necessary PPE for providers has been a huge obstacle faced during the pandemic. Concerns over the availability and quality of PPE remain. OIH, DBHDS COVID-19 Incident Management Team and VDH continue to address this issue.

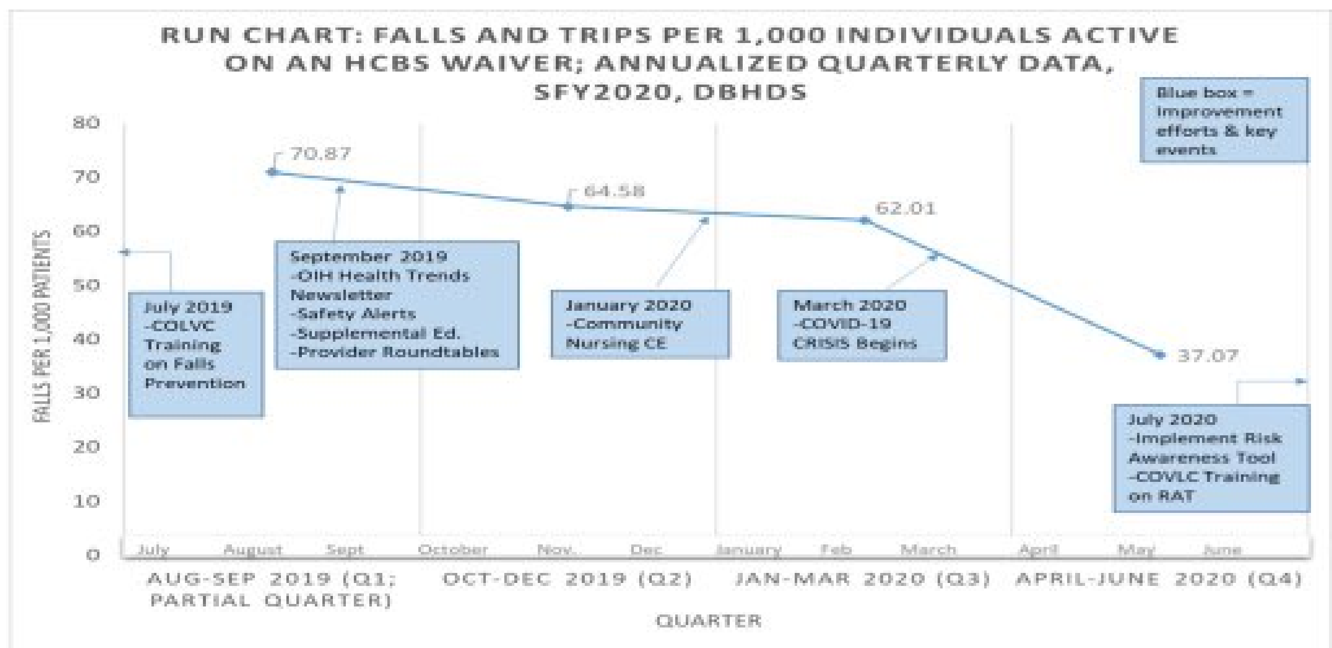
Falls Quality Improvement Initiative

In SFY19 the RMRC identified falls as a leading cause of serious incidents and recommended the development of a QII aimed at reducing the rate of falls. Inadequate fall assessment and fall mitigation strategies resulting from a lack of knowledge or awareness of fall risks, and the inadequate assessment of individuals who may be at risk and appropriate strategies to minimize risk were identified as a potential causes. Some initial interventions were discussed and implemented through the OIH, including;

i) Developing and posting a fall prevention training, with a plan to invite all providers reporting a fall with injury to take the training (posted July 2019)
ii) Disseminating a series of fall prevention communications coinciding with fall prevention month. These included a safety alert, newsletter issue devoted to fall prevention, a first aid for fall prevention training, and a fall prevention Jeoparody game (all posted September 2019).
iii) Informational discussions at provider roundtable meetings (September 2019)
iv) OIH Community Nursing CE on Fall Prevention (January 2020)

Changes in the CHRIS interface implemented in August 2019 led to delays in reporting serious incident data until early in 2020. This impacted our ability to identify specific providers reporting falls with injury. As data became available in 2020, it indicated that falls continued to be a leading cause for hospitalizations, emergency room visits and serious incidents. ,
The Falls QII was formally approved by the QIC on June 30, 2020.

Preliminary trend analysis indicated that the rate of falls decreased slightly over the year, with a dramatic decrease in the 4th quarter of SFY20, coinciding with the spread of COVID-19 and the implementation of the Governor's Executive Order #53. The committee concluded that much of the decrease in the 4th quarter was due to stay at home restrictions that were put in place to limit the spread of COVID-19, resulting in fewer transitions of care. This will be further explored along with other data through the QII during SFY21. The QII will also look to further falls prevention training through use of updated training materials, the implementation of the Risk Awareness Tool and follow-up by the Incident Management Unit on care concerns.



Incident Management Unit (IMU)

The IMU was established within the Office of Licensing (OL) to triage serious incident reports submitted by providers through CHRIS. IMU focuses on where and how to improve the quality of care at a program level. IMU reviews each incident to determine whether the information reported is complete and accurate, and uses triage protocol to determine what technical assistance is needed, or whether further investigation is needed to determine if the provider's actions in relation to the incident have been appropriate. The IMU identifies late, or unreported serious incidents, and issues citations and corrective action plans (CAPS) when applicable. IMU began operating in Region 4 in August 2019. They expanded into Region 3 in November 2019 and Region 2 in May 2020. Regions 1 and 5 are targeted for expansion in September 2020. By early SFY21, IMU aims to triage all serious incidents reports.

Care concern protocols serve as triggers for providers that a care concern may exist and that the provider should reassess the individual's care plan and determine whether additional services or supports are needed to mitigate risks. IMU identified the following thresholds as triggers for potential individual care concerns that require further review:

i. Three (3) or more unplanned medical hospital admissions, ER visits or psychiatric hospitalizations within a ninety (90) day time-frame for any reason.
ii. Multiple (2 or more) unplanned medical hospital admissions or ER visits for the same condition or reason that occur within a thirty (30) day time-frame.
iii. Any combination of 3 or more incidents of any type within a thirty (30) day time-frame.

iv. Multiple (2 or more) unplanned hospital admissions or ER visits for any combination of : falls, choking, urinary tract infection, aspiration pneumonia, or dehydration within a ninety (90) day time-frame
v. Any incidents of medically verified decubitus ulcers or bowel obstruction

In addition, the IMU has identified thresholds for potential provider level care concerns as:

i. Multiple (5 or more) serious incidents occurring at a licensed location within a 30 day time frame.
ii. Repeat citations (3 or more) for a provider who has failed to report Serious Incidents within required timeframes.

All care concerns are sent to OHR and OIH for follow-up and technical assistance as needed, as well as to help determine where prevention focused trainings for providers are needed. CHRIS informs providers when threshold for designation as care concern has been met. Additionally, CHRIS report now includes recommending review of plan of care to determine whether any changes are necessary.

IMU established monthly webinar trainings with providers including form completion and ongoing analysis of how to identify issues and improve quality of data entry in CHRIS. OL memos and guidance distributed to providers as IMU refined processes, identified circumstances in which citations and CAPS would be issued, changes within CHRIS (medical treatment needed, external notification including name and designated support coordinator, time of incident fields added) and access to CHRIS changes.

As protection of confidentiality is of key concern, IMU identified two access areas for mitigation. First, there was not a means to manage CHRIS access specific to removal of those provider staff who no longer needed access to CHRIS. This potentially allowed provider staff access to information after employment had ended. Local programs now designate a local administrator to manage local access; anyone with access who does not access CHRIS within six months will have their access terminated. Second, protecting confidential information while informing staff of on-going incidents so shift staff are aware and responsive to individuals' changing needs. CHRIS user roles now delineate privileges that allows the user specific access and specific functions such as read only and read/write.

IMU Look-Behind Committee utilizes reviewers from various offices across DBHDS with the purpose of reviewing the consistency of IMU in following their protocols and responding to serious incidents. IMU developed a training guide as well as a tool for the committee's use when completing the IMU Look Behinds. IMU excludes death serious incident reports as these are

investigated by Special Investigations Unit and reviewed by the Mortality Review Committee. IMU conducts look behinds of their work to determine:

a) Outcome 1 - The incident was triaged appropriately by the IMU according to developed protocols. The level classification for the incident is reviewed. At least three out five criteria list below must be answered "Yes" or "Not Applicable" for this item to be answered.
   i. The IMU triaged the incident report the same day or the next business day after the report was submitted.
   ii. All of the questions within the IMU triage form were answered.
   iii. The IMU specialist assessed for a care concern in accordance with IMU protocols.
   iv. The IMU specialist assessed for imminent danger in accordance with IMU protocols.
   v. The provider received a citation for late reporting.

b) Outcome 2 - The provider's documented response addressed ways to mitigate future occurrences.

c) Outcome 3 - Appropriate action from IMU occurred. All criteria listed below must be met for this item to be answered.
   i. The IMU specialist contacted the provider for additional information.
   ii. The IMU specialist forwarded the incident to the Office of Human Rights OHR before closing the case.
   iii. The IMU specialist forwarded the incident for a licensing specialist investigation before closing the case.
   iv. The IMU specialist forwarded the incident to the Specialized Investigations Unit SIU before closing the case.

The first look behind review was completed in June 2020 and included a review of serious incidents that occurred during the 3rd quarter of SFY20. The initial review found that outcome 1 was met, at 96%; however, both outcomes 2 and 3 fell below the goal of 86%, at 64% and 53% respectively. Further analysis will be conducted to identify barriers for meeting outcomes 2 and 3, which will inform future improvement efforts.

Health Alerts, Newsletters, and Education Resources

OIH issued the following health alerts and newsletters during SFY2020 as means to assist providers in identifying and preventing health and safety risks. These alerts included mitigating strategies as well. Alerts are reviewed and updated to align with medical guidance; an intitial review occurred in June 2020.

Alerts:

- Dehydration - June 2020
- Stroke Awareness - May 2020
- Constipation: Care Management, Medications and Recognizing Bowel Obstruction - April 2020
- Care Considerations: Epilepsy and Seizure Disorders - March 2020
- The Importance of Calling 911 - February 2020
- Home BP Monitoring - January 2020
- Dementia - December 2019
- Stroke Awareness - December 2019
- Fall Prevention - September 2019
- Fall First Aid - September 2019

Newsletters:

- Newsletter – Opioid Use - July- 2019
- Newsletter – Stroke - August- 2019
- Newsletter – Fall Prevention -September- 2019
- Newsletter – Breast Cancer Awareness - October 2019
- Newsletter – Chronic Obstructive Pulmonary Disease - November- 2019
- Newsletter – Dementia - December- 2019
- Newsletter – Nutrition and Physical Activity - January - 2020
- Newsletter – Heart Health - February - 2020
- Newsletter – Epilepsy and Seizure Disorders - March - 2020
- Newsletter – Constipation and the Importance of Bowel Monitoring - April - 2020
- Newsletter – What is Dysphagia? - May - 2020
- Newsletter – National Safety Month -June - 2020

Education Resources:

Additional supplemental resources were published that provide key information to individuals, families and direct support professionals using everyday language. It is noted that these materials are not a substitute for seeking appropriate medical care. Topics included COVID-19 infection control, calling 911, general infection control tips, information relating to falls prevention and falls first aid.

Risk Assessment

Over the course of the year, a finalized risk awareness tool was developed that incorporates the top risks known to individuals with developmental disabilities. The tool asks specific questions relative to diagnosis within the past year as well as common indicators associated with that

diagnosis that may have occurred within the past year for the following: pressure injury, aspiration pneumonia, fall with injury, dehydration, bowel obstruction, sepsis, seizure, community safety – law enforcement involvement, community safety – non-law enforcement involvement, self-harm, elopement, and lack of safety awareness. Based upon the answers provided, a risk awareness plan would then be developed that identifies those risk factors indicating a referral to the appropriate qualified professional to help develop a plan to reduce the likelihood of the risk from materializing, that an evaluation by a qualified professional occurred as needed. Through the completion of the Risk Awareness Tool, the individual's ISP team is led to take specific steps based upon the identified risk factors for the individual. These actions are designed to trigger conversation regarding health, safety and well-being needs as well to recommend, when indicated, further evaluation to determine needed, preventive steps that can be incorporated into the individual's ISP.

The Risk Awareness Tool and associated guidance document as well as supplemental trainings were made available to providers by the end of SFY2020. For now, the tool is completed manually and will be incorporated into WaMS. As data becomes available, RMRC will review and analyze to determine the effectiveness of the tool and supplemental trainings at reducing and/or preventing the rates of occurrence. RMRC will also have more data available specific to the identified risks to review and determine where specific intervention is needed. OIH regularly reviews and updates as applicable the content of health alerts and guidance to ensure that information pertaining to the identification and prevention of risks, risk assessment and mitigation of risks remains current.

B. Review and Analysis of Data

RMRC regularly reviewed data specific to serious incident reports (SIR), human rights allegations of abuse, neglect and exploitation, findings from licensing inspections and investigations, and other related data to promote continuous quality improvement and recommend quality improvement initiative(s). Additionally, RMRC reviews look behind data from both OHR and IMU. As COVID-19 began affecting Virginians with developmental disabilities, RMRC began monitoring data related to COVID-19. Data sources include CHRIS (SIR, COVID-19), Waiver Management System (WaMS), Data Warehouse reports, and the 15th Review Report from the Independent Reviewer. Data reviews and analysis identify trends and patterns, which aids in the determination of mitigating strategies including prevention, determination of need for new performance measures and quality improvement initiatives.

Abuse, Neglect, and ExploitationIn *SFY19 there were 2700 reported allegations of abuse, neglect and exploitation with 877 substantiated.* SFY2020 saw 1,120 reports of neglect

with 361 of these reports found substantiated. Substantiated reports decreased from SFY2019. In 2018 OHR implemented a Community Look Behind (CLB) review to monitor the accuracy of provider's investigations. We found that providers were inaccurately reporting peer-to-peer incidents as well as medication errors. This office was able to issue guidance and provide onsite support as to what would constitute a reportable event. OHR concludes that the numbers reflect a trend towards more accurate reporting of allegations into the CHRIS system. Substantiated numbers in Region 4 were the steadiest, only increased slightly. It was noted that Region 4 contains a dense population of DD providers. Neglect, neglect peer-to-peer and physical abuse were the most prevalent types of abuse reported during SFY2020 with neglect, physical abuse and verbal abuse the most prevalent types of substantiated abuse during SFY2020. The next four tables describe these results.

Table 1
SFY2020 Reported ANE

	Exploitation	Neglect	Neglect P2P	Other	Physical	Sexual	Verbal	Grand Total
Q1	17	290	156	31	81	11	44	**630**
Q2	16	269	162	5	89	12	38	**591**
Q3	8	306	177	12	120	17	23	**663**
Q4	8	255	136	11	49	8	17	**484**
Grand total	**49**	**1120**	**631**	**59**	**339**	**48**	**122**	**2368**

Table 2
SFY2020 Substantiated ANE

	Exploitation	Neglect	Neglect P2P	Other	Physical	Sexual	Verbal	Grand Total
Q1	13	99	8	1	15	0	14	**150**
Q2	7	103	6	1	24	5	15	**161**
Q3	1	89	7	1	21	1	4	**124**
Q4	3	70	7	0	4	1	7	**91**
Grand total	**23**	**361**	**28**	**3**	**64**	**7**	**40**	**526**

Table 3 SFY2020 Reported Neglect						
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Grand Total**
Q1	63	67	56	53	51	**290**
Q2	45	57	42	69	56	**269**
Q3	58	61	42	72	73	**306**
Q4	51	49	38	74	43	**255**
Grand total	**217**	**234**	**178**	**268**	**223**	**1120**

Table 4 SFY2020 Substantiated Neglect						
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Grand Total**
Q1	22	16	24	17	20	**99**
Q2	21	20	27	17	18	**103**
Q3	18	17	17	19	18	**89**
Q4	6	17	16	20	11	**70**
Grand total	**67**	**70**	**84**	**73**	**67**	**361**

Concerns noted during analysis:

a) Ongoing issue with "other" designation – there are few, if any cases that should warrant use of "other." While education of providers has led to a decrease in this category, it is still utilized inappropriately.
b) Impact of COVID-19 on reporting
c) Impact of SIS level – Does it make individuals more vulnerable? What is the role of SIS level in risk? The difference between the initial timeline of receiving a SIS and the timeline for updated SIS could be a factor.
d) Difference between less reporting and better reporting
e) Hidden indicators of abuse (either not reported by providers or occurring outside of provider settings)

Reviewing ER claims, Medicaid claims, or APS reports may identify unreported abuse. Further review of data on age, region, race, and other demographics as well as identifying other codes specific to abuse and neglect would indicate disparities across age, race, and region and identify particular trends not otherwise noted. Substantiated reports of neglect should be looked into

more closely to better understand what is happening - look specifically at medication errors, incorrect reporting. Medication errors should be reviewed separately as research supports handling of medication errors in a non-punitive manner is more effective at reducing any fatal incidents occurring. These issues will be evaluated more closely through the data workgroup and brought back to the RMRC.

OHR Community Look Behind (CLB) data

Look behind reviews generally occur onsite. A traditional CLB involves a desk audit of CHRIS followed by onsite visits by the reviewer to the provider to review their investigation documentation and provide a F2F debrief/learning session. OHR suspended site visits in mid-March due to COVID and temporarily suspended all requests for information from providers not related to AIM, immediate real-time response to allegations of physical abuse w/ serous injury, sexual assault and restraint with injury. This led to a delay in conducting the 3rd and 4th quarter CLB reviews.

In July 2020 OHR decided to re-engage providers through a virtual CLB which still involves a desk audit of CHRIS; however, in lieu of an onsite visit by the reviewer to the provider, the reviewer emails the provider and requests that they email their investigation documentation to the reviewer who then reviews it and meets with the provider virtually, either by video or phone to debrief and provide technical assistance. As a result of this change in process, only 3 CLB reviews occurred in FY20. The plan is to catch up with 5 reviews in FY21.

Summary results for three primary outcomes:

Measure	Quarter 1 (Jan – Mar 2019)	Quarter 2 (Apr – June 2019)	Quarter 3 (July-Sep 2019)
Comprehensive, and non-partial investigations of individual incidents occur within state prescribed timelines	89%	81%	95%
The person conducting the investigation has been trained to conduct investigations	87%	81%	92%
Timely, appropriate corrective action plans are implemented by the provider when indicated - was the case closed w/in 60 days	83%	93%	93%

COVID-19

As Virginia implemented restrictions to protect its citizens from COVID-19 exposure (Executive Order #53), DBHDS began tracking data across disabilities. Data tracked included reporting by service type (#positive, # deaths), by region, as well as by demographic characteristics (such as age, gender, race), # outbreaks within residential settings,. IMU and OIH followed up on

outbreaks and positive cases. Results reflected Virginia's overall trends in community spread with providers in Region 2 and Region 4 reporting higher numbers than the other regions. As more individuals were tested, the lag time in receiving results increased as well.

Providers are required to report COVID-19 through CHRIS using "other". The RMRC recommended that COVID-19 be added to the menu selection in CHRIS, as this will allow for easier review and analysis of COVID-19 data (positive cases and deaths). Initially, data showed more reports for individuals with DD; beginning in May, numbers increased as behavioral health providers began reporting. As Virginia began lifting restrictions on social gatherings and non-essential businesses began re-opening, numbers began to increase, which corresponded to the increases seen state-wide. Data was reviewed as cases by service area and type, outbreaks, age, and race.

Anecdotally, members wondered whether increased reporting of suicidal ideation and suicide attempts would become evident. This was not observed in Q4 data; a slight decrease was noted in Q4 in SIR listing suicide thought/ideation (See graph titled Illness or Condition by Type and Quarter SFY2020). It is recognized that the impacts of social distancing and prohibitions, temporary forced changes in routines, and resulting lack of services for the population overall (inclusive of all ages) and, especially, for those with behavioral health, developmental disabilities or other health conditions at a minimum, increase stress and may exacerbate existing conditions or tensions. RMRC, along with other DBHDS offices has published tips on remaining mentally healthy and dealing with stress during the pandemic. DBHDS created a warm line to assist anyone struggling with these and other stressors during this period.

The impact of programs temporarily or permanently closing because of the pandemic had a correlating impact on other data collected and reviewed by RMRC. COVID-19 influences on ANE and SIR data identified decreases in serious incidents. The total number of serious incidents decreased by about 15% in Q4; from an average of 2,089 in Q2 and Q3 to 1,774. This was driven primarily by decreases in emergency room visits (decrease of 28%); serious injuries requiring medical attention (decrease by 23%); and hospitalizations (decrease by 11%). In addition, as noted above, a significant decrease in reported falls and trips was noted; and incidents related to motor vehicle accidents decreased by 87% (from an average of 30 to 4). The committee hypothesized that this may be due to temporary closures and individuals remaining in their residences due to the stay at home order. Common transitions that occur while getting on/off transportation have been significantly reduced since the stay-at home order began. While there has been some re-opening of businesses, there has been a very mindful and intentional method to reopening with the intention of keeping everyone safe. Fewer reports are being made stemming possibly from fewer incidents actually occurring or that fewer people are aware of

potential incidents. As providers faced staffing struggles, it is possible that some incidents were not reported due to staffing constraints or due to concerns with COVID-19 testing, protocols, etc.

Facilities (state hospitals, training center) dealt with social distancing, prohibitions, needs for quarantine as positive cases occurred, and high census counts as added challenges during SFY2020. Several facilities saw outbreaks and had to temporarily close their doors as a result, which placed increased burden on the care for individuals experiencing significant mental health concerns and need for treatment. As of June 18, 2020, facilities saw 32 staff positive and one individual positive for COVID-19. It is anticipated that as Virginia re-opens, numbers will fluctuate.

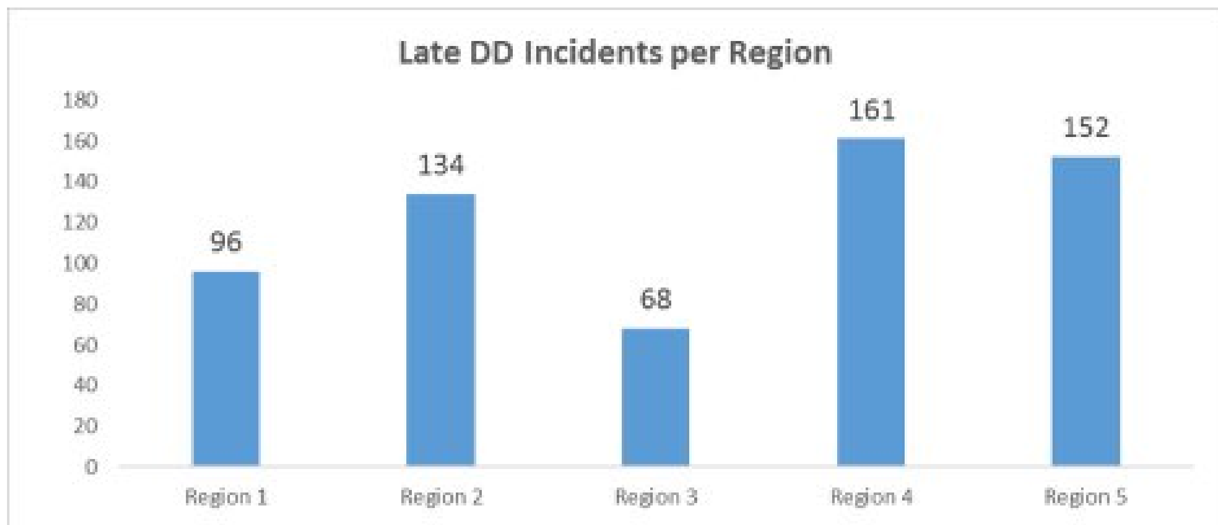
Incident Management Unit (IMU)

Established in Region 4 in August 2019, the IMU had expanded to three regions by the end of FY20 (regions 2, 3, and 4). While IMU has reviewed and analyzed a significant amount of data, IMU has focused on improving their processes and improving the quality of data entry into CHRIS. As noted earlier, IMU identified three barriers and worked diligently with Data Warehouse, providers, OL and OHR to address these barriers. The accuracy of data entry and the reporting of incidents were two key focus areas for IMU. IMU worked diligently with providers to convey the significance of the data entered into CHRIS, and the impacts of reporting inaccurate data. This was accomplished through individual outreach and technical assistance to providers, as well as regular webinar that focused on training and addressing common reporting issues.

The IMU provided data to the RMRC specific to late reporting, # of incidents for DD individuals (aggregate, region), type of incident (death, SI), and status of their work. IMU began collecting data in August as they started in Region 4 in August. All data shown is reflective of the period August 5, 2019 through June 30, 2020.

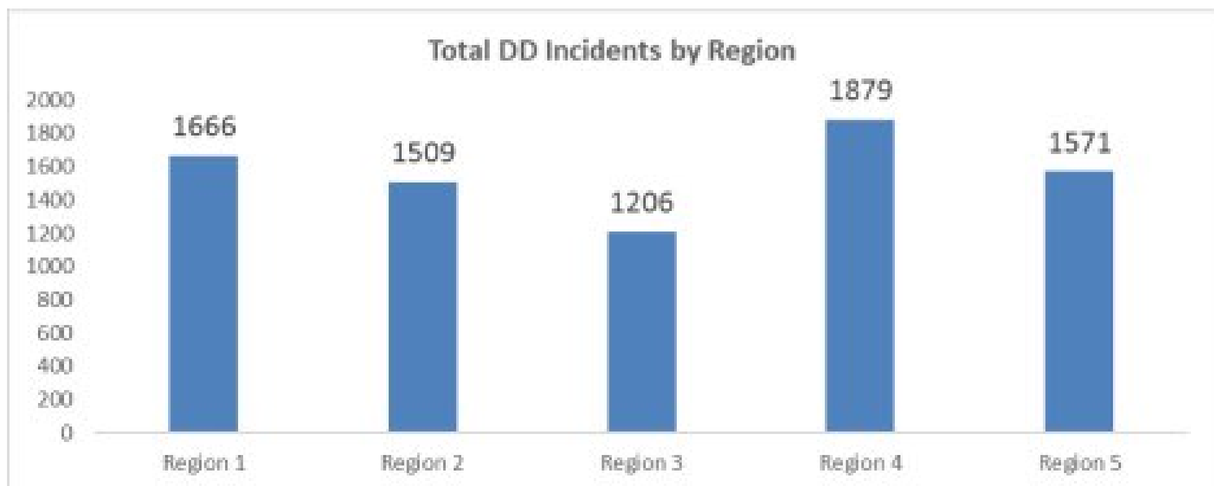
Based upon the data collected in CHRIS, there were a total of 7,831 incidents for individuals with developmental disabilities. Six-hundred and eleven of these (8%) were reported late; which meant that 92% were reported within the established time-frames; this exceeded the target of 86%.

IMU reports the following figures in the table below. Region 4 has a higher density of DD providers, which may account for the higher total.



There were 7,831 DD incidents reported within the time frame of August 5, 2019-June 30, 2020.

IMU also identified the number of late incidents per region and by category as reflected in the graphs below.



There were 611 late incidents reported.

One of IMU's functions involves the issuance of citations for late reporting. reporting. OfOf the 611 late reports, 376 were issued a citation for late reporting; all of these required development of a corrective action plan. In August the OL issued additional guidance to providers on the requirements for incident reports as well as steps for progressive action if late reports continue to be cited. The IMU continues to work with IT to address system issues that impact providers' ability to report in a timely manner.

IMU Look Behind

IMU look behinds began in June 2020 using SFY20 QTR3 data. Those incidents eligible for review included:

- ✓ Serious injury report involving an individual receiving a HCBS waiver
- ✓ Submitted within DBHDS Regions 3 and 4
- ✓ Triaged by IMU specialist
- ✓ Closed during the preceding quarter, SFY20, Q3

During SFY20 Q3, 685 eligible serious incident reports were triaged with 98% classified as Level 2 and 17% classified as Level 3. The annual sample size was calculated using the projected annual population of eligible incident reports (14,800) that IMU will review from SFY20 Q3 through SFY21 Q3. The IMU Look-Behind Committee reviews one-quarter of the annual sample each quarter (rounded up to 47 reports). The sample was stratified using the level recorded by the provider within the body of the incident report. IMU assessed the accuracy of incident level classification as part of this look behind process as IMU does not always agree with the provider's classification. Results of the first IMU Look-Behind:

SFY2020 Q3 IMU Look-Behind Results

Regions 3 & 4	47 Incidents
Triaged Appropriately	96%
Provided Documented Mitigation	64%
Appropriate Follow-Up from IMU	53%

A preliminary inter-rater reliability (IRR) process was conducted, with three randomly selected records being reviewed by a second reviewer. The agreement between the two reviewers ranged from 57% to 79%. While a more rigorous IRR process will be implemented for future reviews, the low consistency between reviewers based on this small sample suggested that additional training for reviewers needed to ensure common understanding of procedures and expectations would be beneficial, including;

i. Retrain look behind committee members
ii. Operationalize terms better
iii. Consider adding additional questions to guide members through the process.

Performance Measure Indicators (PMIs)

RMRC routinely reports on the PMIs listed below. These measures provide a partial view into how the system is managing risk for the individuals served. In reviewing the Compliance Indicators, measures were identified and determined as relevant for surveillance with only one measure being classified as a PMI. This measure addresses rates of reported serious incident for selected risk conditions for individuals with DD receiving waiver services. A tracking log was created reflecting all surveillance and PMI measures that allows for easy review of data to determine trends and determine if the measure needs to be elevated to a PMI or addressed as a QII.

Performance Measure Indicators – Safety and Freedom from Harm	Target	FY20 QTR1 Results	FY20 QTR2 Results	FY20 QTR3 Results	FY20 QTR4 Results	FY20 Overall Results	Performance Assessment
Critical incidents are reported to the Office of Licensing within the required timeframes (24-48 hours)	86%	93%	89%	93%	94%	92%	✓
Licensed DD providers, that administer medications, are NOT cited for failure to review medication errors at least quarterly	86%	99%	99%	81%	74%	88%	✓
Corrective actions for substantiated cases of abuse, neglect and exploitation are verified by DBHDS as being implemented	86%	100%	100%	100%	99%	99%	✓
State policies and procedures, for the use or prohibition of restrictive interventions (including restraints), are followed	86%	NA	NA	NA	NA	NA	—
The state policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed	86%	100%	100%	100%	99%	99%	✓

Five established PMIs were met throughout the reporting year, with sustained improvements in verification of the implementation of corrective actions. This measure was below target in Q1 of FY19, but following intervention, has consistently been above target since that time.

The PMI assessing providers not being cited for failing to review medication errors quarterly met the overall annual target, however, it decreased significantly from the first to the fourth quarters and represents an 11% decrease from SFY19. Upon review of the data and after consulting with the licensing specialists via structured meetings, the OL reported that the decrease in compliance is likely the result of a combination of factors leading to a more accurate result. The Director implemented a new internal protocol that requires specialists to document a compliance rating for all regulations checked during an inspection of providers of DD services; previously only regulations deemed non-compliant were documented in a licensing report, making it difficult to ensure all necessary regulations were reviewed. Finally, additional information related to how compliance with this regulation is determined was documented and shared with both the provider community and the OL staff to increase consistency among specialists across the state. This regulation should continue to be monitored as an official PMI due to the importance of provider's completing quarterly review of any medication errors as part of their quality improvement program.

This PMI measures the percentage of providers who report serious incidents to the Office of Licensing within 24 hours. During SFY2020, the overall result was 92%, which exceeds the target. The results remain consistent to those found in SFY2019 (93%).

Approved PMIs for FY20

Performance Measure Indicators – Safety and Freedom from Harm	Target	FY20 QTR1 Results	FY20 QTR2 Results	FY20 QTR3 Results	FY20 QTR4 Results	FY20 Overall Results
Serious Incident Rates						
Aspiration Pneumonia	Monitoring		6.99	6.04	7.14	6.72
Bowel Obstruction	Monitoring		6.15	4.66	2.75	4.52
Sepsis	Monitoring		4.75	6.04	3.84	4.97
Decubitus Ulcer	Monitoring		5.31	5.21	5.77	5.43

Performance Measure Indicators – Safety and Freedom from Harm	Target	FY20 QTR1 Results	FY20 QTR2 Results	FY20 QTR3 Results	FY20 QTR4 Results	FY20 Overall Results
Fall	56.88		67.65	63.93	38.72	56.77
Dehydration	Monitoring		5.59	7.13	3.84	5.52
Seizures	Monitoring		32.99	33.20	22.52	29.57
Urinary Tract Infection	Monitoring		27.40	29.08	23.07	26.61
Choking	Monitoring		5.31	4.94	3.02	4.42
Self-injury	Monitoring		20.13	18.11	10.71	16.32
Sexual assault	Monitoring		3.91	4.94	1.65	3.50
Suicide attempt	Monitoring		5.03	5.21	4.39	4.88
Performance Measure Indicators – Safety and Freedom from Harm	Target					FY20 Baseline
Licensed providers meet regulatory requirements for risk management programs:	86%					82%
Designated person with training or experience responsible for risk management function	86%					89%
Implements a written plan	86%					92%
Conducts annual systemic risk assessment	86%					80%
Conducts annual safety inspection	86%					88%
Documents serious injuries to employees, volunteers, etc	86%					86%
Licensed providers meet regulatory requirements for quality improvement programs	86%					75%

Fourteen new PMIs were added for FY20. This includes twelve measures assessing the rate of reported concerns that are common to individuals with developmental disabilities (e.g., aspiration pneumonia, bowel obstruction, decubitus ulcer). With the exception of falls, a specific target has not been established for these measures. The target for falls was established as part of a quality improvement initiative; the other measures will be monitored over the next year.

The target for falls was set at 56.88/1000 individuals on the DD waivers. This was based on targeting a 10% reduction in the baseline rate of falls of 63.2/1000 during the baseline period of 10/1/19 – 3/31/20. This measure was reported for the last 3 quarters of FY20. The rate of falls was above the target during the first two quarters, but dropped significantly in the fourth quarter, bringing the overall rate over three quarters to just below the target. The Office of Integrated Health implemented a number of initiatives aimed at reducing the rate of falls, which included posting a training on fall reduction; publishing health alerts and newsletters addressing fall prevention; and hosting a continuing education event for nurses focused on fall prevention. In addition to these interventions, the onset of COVID-19 may have also played a role in the reduction in the rate of falls. The RMRC members noted that due to a number of services being closed and limited community activities, individuals were not traveling away from home as much, had fewer transitions of care, and therefore there may have been less exposure to situations presenting a risk for falls. Consistent with this, the number of emergency room visits decreased by 33%, from 1,362 in the second quarter, to 916 in the third quarter.

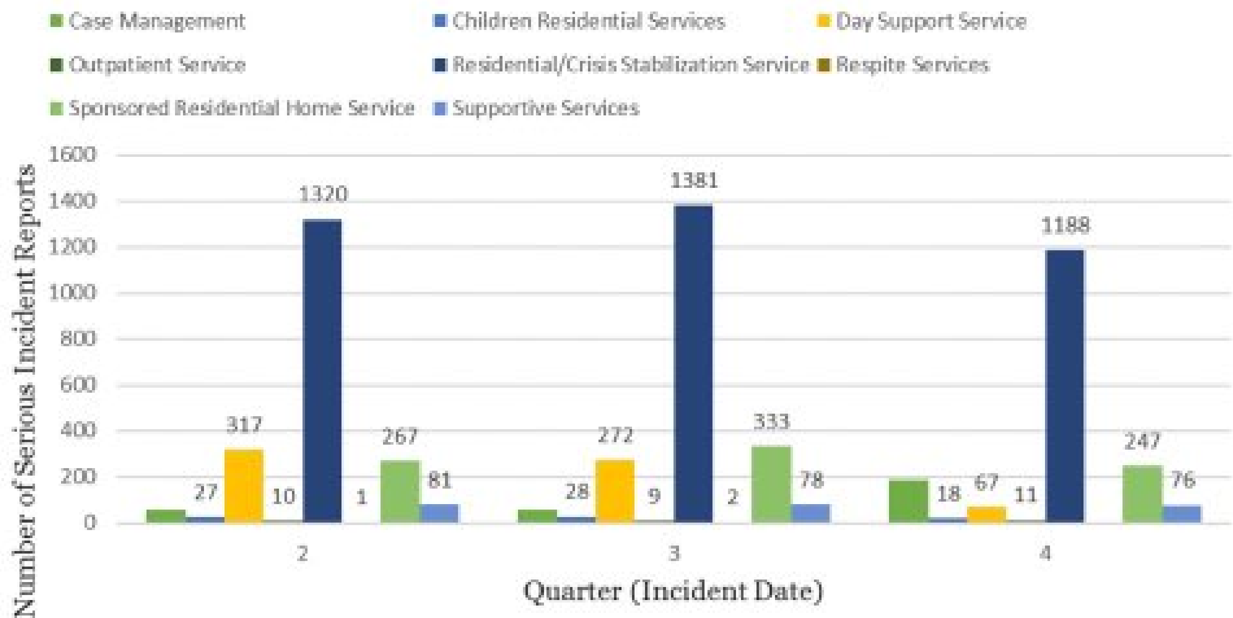
The other two PMIs were approved on June 30, 2020, and are measures of the percentage of providers that have been determined to be compliant with requirements to implement risk management and quality improvement programs. Both of these measures are specifically tied to DOJ compliance indicators. Baseline data collected for FY20 indicates that both measures were below the goal of 86%; with 82% of providers meeting the overall risk management requirements and 75% of providers meeting the quality improvement requirements. The committee will work with the Office of Licensing to identify specific areas that providers are having difficulty with compliance and develop interventions to improve performance. As Quality Service Review (QSR) data becomes available, the committee will also utilize these results to guide improvement efforts.

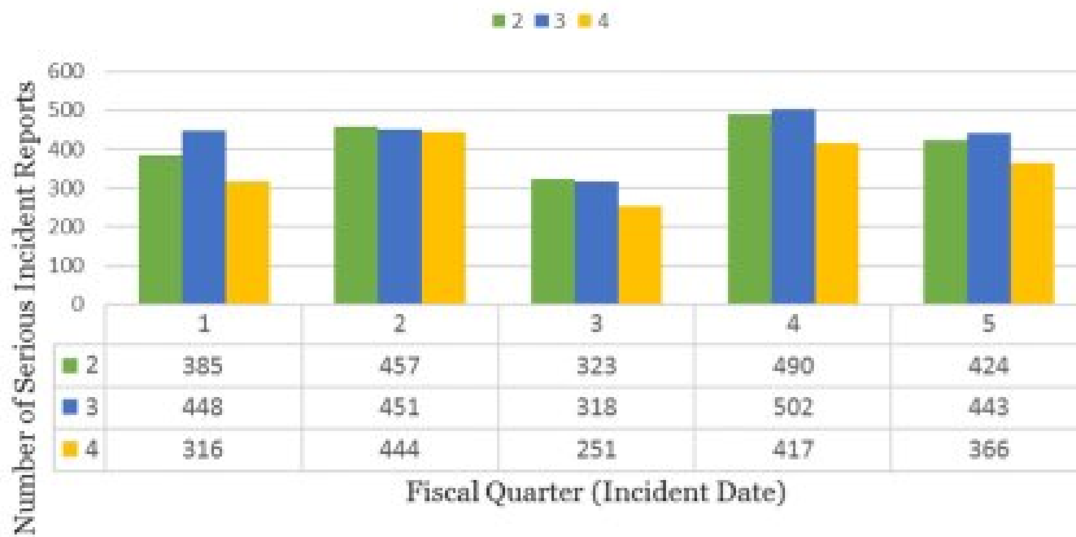
Serious Incident Report (SIR)

SIR surveillance data from October 1, 2019 through June 30, 2020 was reviewed due to the CHRIS interface changes that occurred during the first quarter. This particular review focused on

individuals with developmental disabilities only; eventually, all disabilities will be included. There were 6,035 serious incidents reported during this period.

The impact of necessary restrictions (Executive Order #53) implemented by the state of Virginia to protect its citizens during the COVID-19 pandemic was evident as businesses and programs deemed non-essential were temporarily closed for several months with some closing permanently. In addition, provider capacity to enter data and otherwise use CHRIS was significantly impacted as staff were furloughed and staff were limited in working across settings to limit potential COVID-19 exposure. Telehealth became an active means of ensuring the health of individuals. As the two graphs below depict, there was a noticeable decrease in serious incident reporting in Q4 with the exception of Region 2. Changes to service operations may contribute to decreased reporting but the evidence is inconclusive. Closed locations with suspended operations submitted fewer reports than in Q2 and Q3, but those locations did not account for the majority of SIRs. Locations utilizing telehealth submitted more reports in Q4 than in Q2 and Q3, but also did not account for the majority of SIRs. The vast majority of locations reporting serious incidents did not report any changes to service. There is a strong possibility of omitted variable bias – some unobserved factor driving changes to services or a provider's willingness/ability to report the changes to services.





Of key interest to RMRC is the type of incidents reported and the percentage reported. The trends are shown in the table below. Q4 results likely reflect the increases in individuals testing positive for COVID-19 requiring medical care; three types saw nominal increase. It is noted that most types of incidents reported decreased in Q4, some significant. As COVID-19 is an impactful event, there are likely connections to decreases in incidents and changes to routines/practices implemented in response to Executive Order #53 and the phased re-opening of Virginia.

Serious Incidents by Type and Quarter SFY 2020

Incident Type	Fiscal Quarter, SFY 2020							
	2		3		4		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Unplanned ER Visit	1229	52.03%	1362	55.16%	916	41.04%	3507	49.65%
Unplanned Hospital Admission	370	15.66%	429	17.38%	349	15.64%	1148	16.25%
Serious Injury - Requiring Medical Attention	289	12.24%	204	8.26%	192	8.60%	685	9.70%
Other - Level 2	108	4.57%	117	4.74%	174	7.80%	399	5.65%
COVID-19	0	0.00%	8	0.32%	305	13.66%	313	4.43%
Harm or Threat to Others	90	3.81%	100	4.05%	97	4.35%	287	4.06%
Unplanned Psychiatric Admission	91	3.85%	86	3.48%	69	3.09%	246	3.48%
Serious Injury - Permanent Impairment	43	1.82%	34	1.38%	32	1.43%	109	1.54%

Incident Type	Fiscal Quarter, SFY 2020							
	2		3		4		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Missing Individual	31	1.31%	38	1.54%	28	1.25%	97	1.37%
Decubitus Ulcer	25	1.06%	18	0.73%	18	0.81%	61	0.86%
Choking Incident	21	0.89%	19	0.77%	10	0.45%	50	0.71%
Sexual Assault	23	0.97%	18	0.73%	7	0.31%	48	0.68%
Suicide Attempt with Hospital Admission	14	0.59%	19	0.77%	8	0.36%	41	0.58%
Aspiration Pneumonia	12	0.51%	6	0.24%	12	0.54%	30	0.42%
Bowel Obstruction	12	0.51%	5	0.20%	6	0.27%	23	0.33%
Ingestion of Hazardous Materials	4	0.17%	6	0.24%	9	0.40%	19	0.27%
Grand Total	2362	100.00%	2469	100.00%	2232	100.00%	7063	100.00%

Also important for RMC monitoring are the illnesses/conditions that may result in a SIR. Analysis of this data assists RMRC in determining whether a QII is needed at this time, if continued monitoring is needed, or where mitigating strategies are needed. Q4 (Illness or Condition by Type and Quarter SFY2020 shows the sharp increase of individuals testing positive for COVID-19. Other illnesses/conditions, seizures, and urinary tract infections (UTIs) remain the leading causes of illnesses/conditions reported in SFY2020. Although is noted that these three saw significant decreases from Q3 to Q4, RMRC plans a further look into UTIs as it can be leading cause of sepsis and has remained a leading cause of serious incidents. As nearly all listed illnesses or conditions saw decreases by Q4 with some decreases being significant, there is a likely connection between the noted decreases and changes in routines/practices related to COVID-19, especially those practices directed towards increased cleaning and disinfecting of surfaces and limiting the exposure to viruses/bacteria that can occur during regular, public interactions. Further assessment of these changes in routines/practices could potentially identify practices that could be applied during non-pandemic events that would increase the likelihood of sustained decreases in illnesses or conditions reported as serious incidents.

Illness or Condition by Type and Quarter SFY 2020

Illness or Condition	Fiscal Quarter, SFY 2020							
	2		3		4		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
OTHER ILLNESS/CONDITION	493	40.71%	598	42.84%	414	32.42%	1505	38.75%
SEIZURE	121	9.99%	130	9.31%	90	7.05%	341	8.78%
URINARY TRACT INFECTION (UTI)	112	9.25%	123	8.81%	93	7.28%	328	8.44%
COVID-19	0	0.00%	8	0.57%	305	23.88%	313	8.06%
MENTAL STATUS CHANGES	103	8.51%	97	6.95%	70	5.48%	270	6.95%
PNEUMONIA (CAUSED BY BACTERIA OR VIRUS)	59	4.87%	106	7.59%	77	6.03%	242	6.23%
DIARRHEA/VOMITING	87	7.18%	100	7.16%	49	3.84%	236	6.08%

Illness or Condition	Fiscal Quarter, SFY 2020							
	2		3		4		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
SUICIDAL THOUGHTS/BEHAVIORS	36	2.97%	39	2.79%	28	2.19%	103	2.65%
CONSTIPATION	40	3.30%	24	1.72%	17	1.33%	81	2.09%
EXACERBATION OF A CHRONIC MEDICAL CONDITION	22	1.82%	31	2.22%	28	2.19%	81	2.09%
ASPIRATION PNEUMONIA	25	2.06%	22	1.58%	29	2.27%	76	1.96%
DEHYDRATION	21	1.73%	30	2.15%	16	1.25%	67	1.73%
SEPSIS	18	1.49%	26	1.86%	17	1.33%	61	1.57%
BOWEL OBSTRUCTION	22	1.82%	21	1.50%	10	0.78%	53	1.36%
CARDIAC EVENT	24	1.98%	14	1.00%	13	1.02%	51	1.31%
BLOOD SUGAR PROBLEM (HIGH OR LOW)	10	0.83%	12	0.86%	14	1.10%	36	0.93%
ASTHMA	9	0.74%	11	0.79%	2	0.16%	22	0.57%
STROKE	8	0.66%	2	0.14%	3	0.23%	13	0.33%
DRUG OR ALCOHOL PROBLEM	1	0.08%	2	0.14%	2	0.16%	5	0.13%
Grand Total	1211	100.00%	1396	100.00%	1277	100.00%	3884	100.00%

In the previous annual report, RMRC noted the struggles with obtaining valid and reliable data and the impact these struggles had on review and analysis of data. As SFY2020 progressed, RMRC addressed various challenges regarding the collection, review and analysis of data. These challenges included:

- Updates to CHRIS resulted in:
  a) Incorrect FIPS code (region/locality) being assigned
  b) Inability to pull reports from CHRIS which impacted IMU and required them to manually complete reports and impacted OIH in determining which providers were in need of falls training.
  c) Select fields not populating properly.
- Use of "other" when listing incident – IMU identified that providers were incorrectly classifying incidents either to uncertainty about terms. Descriptions as what terms meant was provided resulting in fewer incorrect uses of other as an incident type.
- As the year progressed, IMU found that some providers would avoid using key words or certain injury types in the erroneously belief that it would prevent further scrutiny. IMU correctly identified the potential risk this poses for ensuring the health and safety of individuals receiving services as well as the adverse impact this action has on reporting (results in inaccurate reporting which leads to inaccurate review and analysis). Providers were informed that corrective action plans (CAPS) would be issued for inaccurate and/or incomplete reporting when this occurs.
- Duplication of data – Two issues were identified.

a) As there is not a single identifier to use when filing an incident in CHRIS that compares to WaMS, data pulls often find duplicate entries. This issue is unlikely to be resolved 100% until there is an enterprise system in use. DBHDS is working towards an enterprise system and it is hoped that this system will be available within the next year or so. In the meantime, IMU staff are removing the duplicate entries when applicable.
b) Duplicate entries – multiple reports from the same provider occur, as CHRIS does not provide feedback to the user that the submission is being processed (hourglass or spinner shown) and the user hits "submit" multiple times. There are times when regulations require duplicate entries (Level III). This is due to reporting requirements. A single identifier would benefit as the reports could be linked together.

CHRIS data reporting issues were resolved during the fiscal year through collaborative efforts of IMU, OIH and Data Warehouse and ongoing monitoring continues to ensure no new issues arise, unless noted below. Analysis showed that the use of Chrome internet browser for CHRIS entry resulted in data not being pulled correctly. Clearer definition of type of incident including a narrowing what "other" involves proved effective; although "other" continues to be used frequently when noting the condition or illness associated with a serious incident. Therefore, "other" will continue to be analyzed to determine whether additional categories need to be added and items rarely used will be considered for removal from the listing. The challenges provided opportunities to identify additional data needs such as medical treatment needed, external notification including name and designated supports coordinator, and time of serious incident that were added as required fields to the serious incident report.

VI. Conclusion

RMRC increased its capacity to review and analyze serious incident report data, alleged and substantiated abuse, neglect and exploitation data at various levels – region, types of incidents, providers and so on. RMRC recognizes that further assessment and inclusion of additional data (age, race, and residence type) will prove useful in determining trends and patterns needed to further inform on necessary interventions or quality improvement initiatives that may be needed. The value of the Incident Management Unit was seen early on in SFY2020 as IMU staff identified inaccuracies in data entry, determined the cause of the inaccuracies, and worked diligently with Data Warehouse, OL, and providers to reduce/eliminate the inaccuracies. As RMRC continued its expansion in data review and analysis, more timely responses to identified needs occurred. RMRC identified work-around solutions where possible to address data analysis needs as temporary measures until new data systems are available.

Quality Management Program Assessment Tool

Developed by HRSA 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:	

A) Background & Purpose:

Goals of a Quality Program are to: 1) create or revise a quality management plan and supporting infrastructure; 2) implement processes to measure and ensure quality of care and services; and 3) build capacity for quality improvement among providers.

Evaluations of the quality of care should consider: (1) the quality of the data being input; (2) the quality of the service delivery process; and (3) the quality of outcomes, in order to continuously improve systems of care for individuals and populations.

Quality Management Programs Should Have the Following Characteristics:

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

B) Definitions of Terms:

Quality Management Plan:

A Quality Management Plan is a written document that outlines the Quality Program, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and elaboration of processes for ongoing evaluation and assessment of the program.

Quality Management Infrastructure:

The Quality Management Infrastructure represents the organizational structure of the formal quality program which includes the committee structures with stakeholders, providers and consumers, the performance measurement systems to collect clinical and non-clinical data, and the involvement of internal divisions that shape the quality program.

Implementation/Capacity Building:

Capacity Building embodies all internal and external quality improvement activities related to the quality program, including QI project activities, performance measurement activities, and QI training and educational activities.

*Adapted and used with approval from the Institute of Healthcare Improvement