Virginia Department of
Behavioral Health &
Developmental Services

Risk Management Review Committee Annual Report

July 1, 2018 – June 30, 2019

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I. Committee Purpose

As established in their charter, the purpose of the Department of Behavioral Health and Developmental Services (DBHDS) Risk Management Review Committee (RMRC) is to provide ongoing monitoring of serious incidents and allegations of abuse and neglect; and analysis of individual, provider and system level data to identify trends and patterns and make recommendations to promote health, safety and well-being of individuals. As a subcommittee of the DBHDS Quality Improvement Committee (QIC), the RMRC identifies and addresses risks of harm; ensures the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collects and evaluates data to identify and respond to trends to ensure continuous quality improvement.

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

- Systematically review and analyze data related to serious incident reports (SIR), deaths, human rights allegations of abuse, neglect and exploitation, findings from licensing inspections and investigations, and other related data.
- Review details of individual serious incident reports when indicated
- Recommend quality improvement projects (QIPs) to the DBHDS Quality Improvement Committee (QIC) to promote health and well-being, mitigate risks, and foster a culture of safety in service delivery
- Monitor progress of QIPs and address concerns/barriers as needed
- Evaluate the effectiveness of the QIP for its intended purpose
- Report findings, conclusions, and recommendations to the QIC semi-annually or more frequently when significant or unusual patterns or trends are identified. The RMRC may also share data or findings with the Mortality Review Committee when significant patterns or trends are identified relating to deaths.

II. Committee Structure

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

III. Activities for Improvement

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

A. Challenges / Gaps

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

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

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

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

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

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

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

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

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

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

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

B. Office of Licensing

Mitigating Strategies

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

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

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

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

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

C. Human Rights

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

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

Table 1 FY 2019 Human Rights Data Reported by Community Providers

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

Mitigating Strategies

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

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

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

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

D. Performance Measurement Indicators

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

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

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

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

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

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

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

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

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

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

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

E. Serious Incident Data

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

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

F. Other Mitigating Strategies

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

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

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

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

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

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

IV. Data Sources

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

V. Summary

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

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

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

VI. Recommendations

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

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

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

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

VII. Next Steps

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

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

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