Virginia Department of Behavioral Health & Developmental Services

Risk Management Review Committee Annual Report

July 1, 2019 – June 30, 2020

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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.

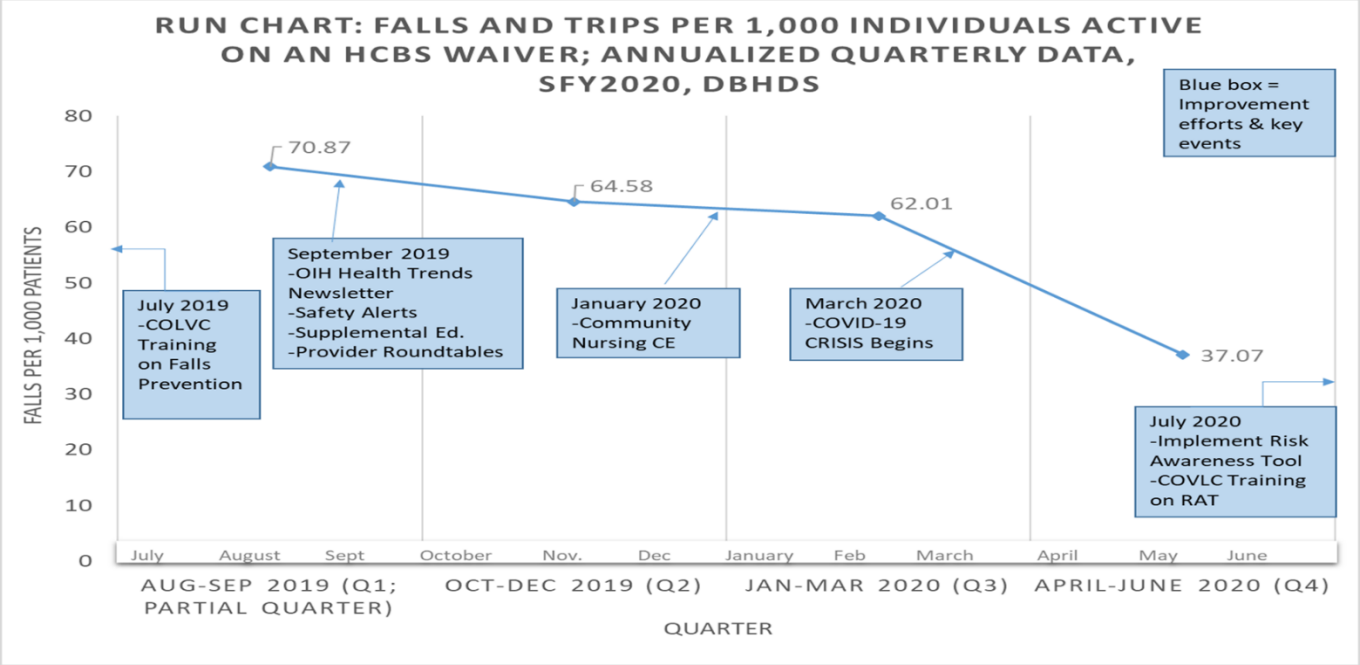
Falls Quality Improvement Initiative

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.

<u>Abuse, Neglect, and Exploitation</u>In *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.

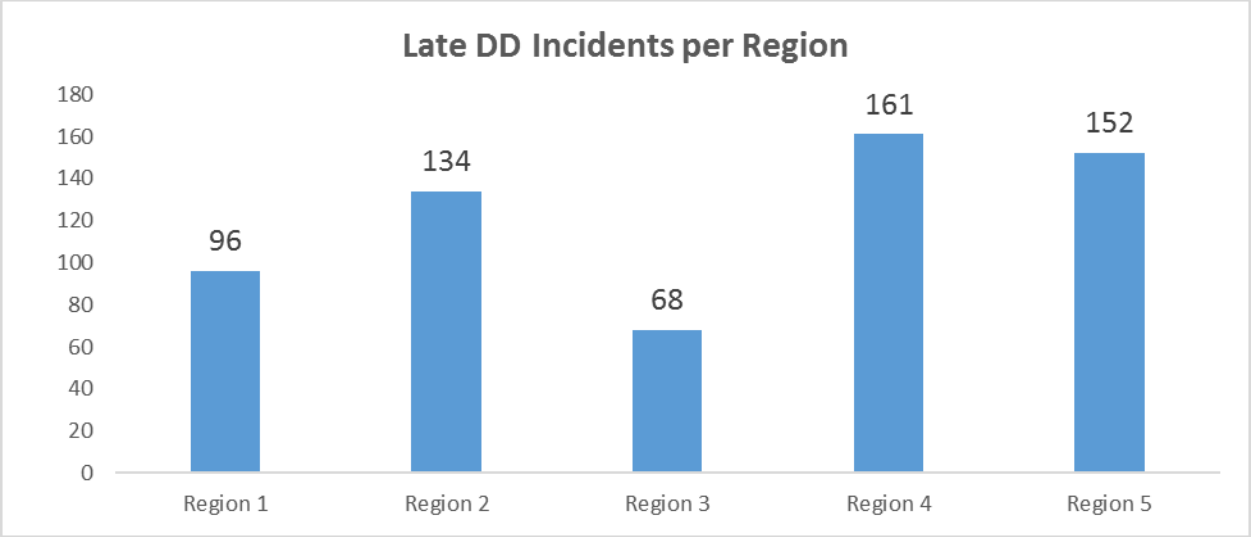
Incident Management Unit (IMU)

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.

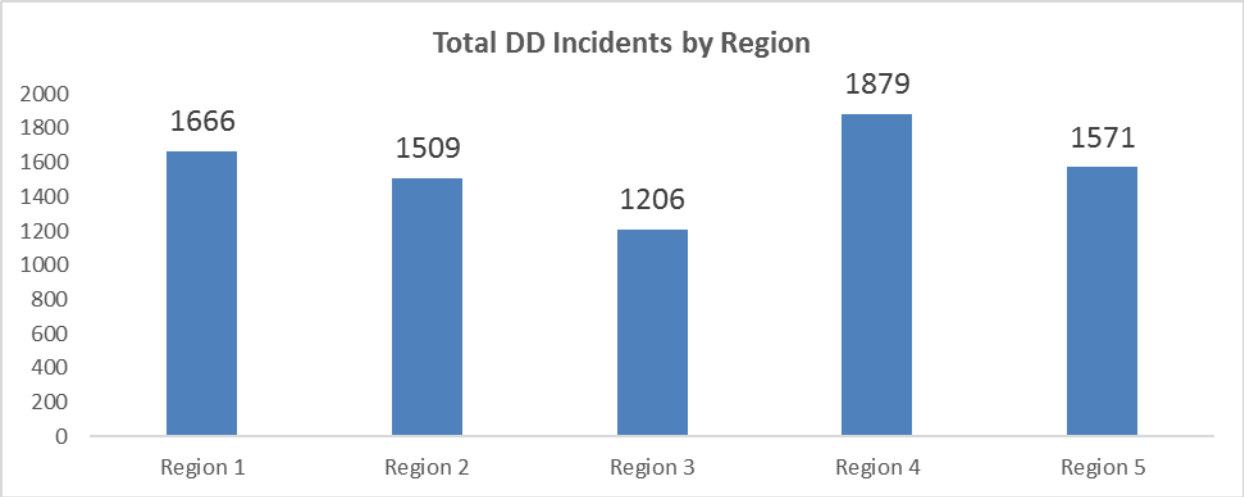
Based upon the data collected in CHRIS, there were a total of 7,831 incidents for individuals with developmental disabilities. Six-hundred and eleven of these (8%) were reported late; which meant that 92% were reported within the established time-frames; this exceeded the target of 86%.

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.

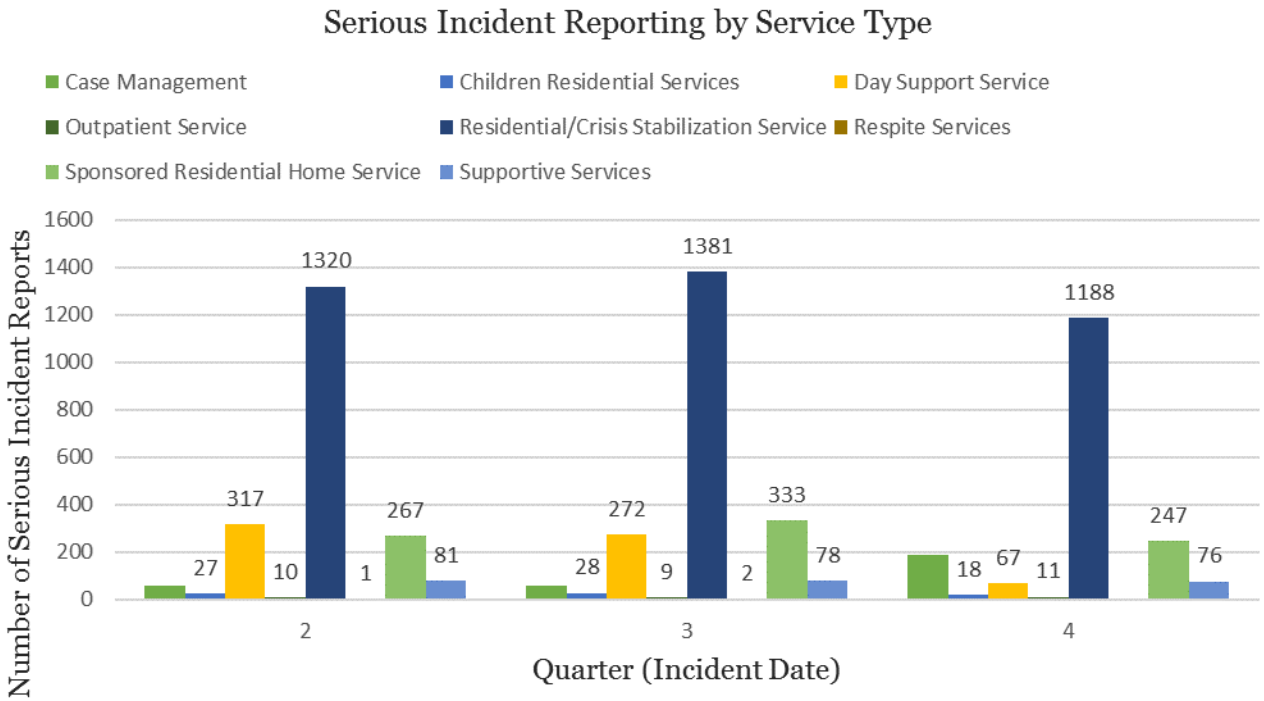
The other two PMIs were approved on June 30, 2020, and are measures of the percentage of providers that have been determined to be compliant with requirements to implement risk management and quality improvement programs. Both of these measures are specifically tied to DOJ compliance indicators. Baseline 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.

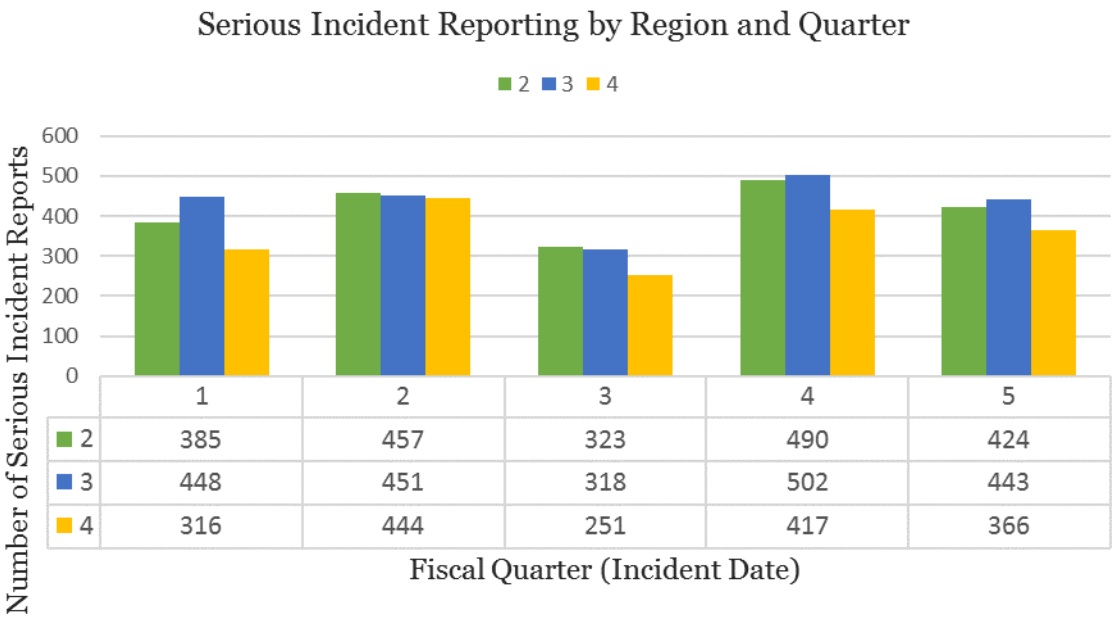
Serious Incident Report (SIR)

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.