Virginia Department of Behavioral Health & Developmental Services

Risk Management Review Committee Annual Report

July 1, 2020 – June 30, 2021

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Part 1. Executive Summary

The Risk Management Review Committee (RMRC) is a subcommittee of the DBHDS Quality Improvement Committee (QIC) tasked with reviewing data and trends, making recommendations and implementing improvement initiatives in order to reduce risk and harm to individuals. In SFY2021, the committee met and reviewed data and trends related to serious incident reports (SIR), surveillance measures, abuse, neglect and exploitation (ANE) allegations, licensing inspections, training center risk management (RM) activities, performance measure indicators (PMIs), incident management and human rights look back analysis and more. The committee provided oversight and coordination for a Quality Improvement Initiative (QII) on falls and worked to identify a new QII. RMRC made progress on a number of recommendations from previous years and made recommendations for the current year, many of which were related to data quality, evaluation and guidance designed to ultimately support providers and improve services to individuals. As RMRC enters SFY2022, RMRC will continue to improve how data are reviewed and utilized to inform decisions, work to address data quality, implement and propose new quality improvement initiatives (QII).

Part 2. Recommendations

Based upon its review of SFY2021 activities and discoveries, the RMRC identified the following recommendations, some of which were addressed in SFY2021, with others targeted for completion in SFY2022. These are listed below followed by the recommendations made in SFY2019 and SFY2020 with comment as to the action taken during SFY2021.

SFY2021 RMRC Recommendations

Recommendation	Status
1. Conduct a detailed examination of urinary tract infection (UTI) SIRs	**Complete.** A UTI workgroup was formed and completed a study of 327 serious incidents involving a UTI during the period 10/1/19 – 9/30/20. The workgroup recommended mitigating strategies such as making additional training available to providers. The responsible offices will report on their progress quarterly in SFY2022.

Recommendation	Status
2. Analyze SIRs in which "other" is selected, in order to better understand and improve use of "other" as a category.	**Complete.** A review of 100 SIRs categorized as "other" was conducted by the QI Coordinator. Results and recommendations will be reviewed with the IMU and the Data Workgroup in SFY22.
3. Increase capability to better understand and describe neglect.	**In Progress.** The OHR is conducting a review of allegations of neglect reported between 10/1/20 – 3/31/21. This will inform development of additional sub-categories of neglect, which will facilitate identifying opportunities for improvement.
4. Develop better guidance for providers about reporting medication errors as neglect.	**In Progress.** OHR is working with external stakeholders to gather input on revised guidance for reporting medication errors.
5. Evaluate care concerns criteria and the impact of the care concerns process on the health and well-being of individuals.	**In Progress.** Explored the possibility of working with VCU to assist in evaluating through the Project Living Well grant. This work will continue into SFY22.
6. Improve performance on the licensing measure related to medication error reviews	**In Progress.** A QII to improve provider reviews of medication errors was proposed by the RMRC and approved by the QIC. A workgroup will develop and oversee implementation.
7. Improve provider understanding of, and compliance with, requirements for RM and quality improvement (QI) programs.	**In Progress.** During SFY21, OL provided updated training, tools and resources to help improve performance on these requirements, and reported to RMRC regularly. The RMRC will continue to monitor the impact of these efforts and identify additional strategies to improve compliance.

Part 3. Committee Purpose

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 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 is charged with systematically reviewing and analyzing data related to SIRs, deaths, ANE allegations, findings from licensing inspections and investigations, and other related data. RMRC reviews and analyzes related data collected from community service providers and the training center (beginning in SFY2021) and data and information related to DBHDS program activities,

including licensing reviews, triage and review of serious incidents, and oversight of abuse and neglect allegations.

Part 4. 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, medical, QI, 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. RMRC meets monthly and has an annual task calendar and a work plan. The task calendar identifies standing items and reports that will be reviewed throughout the year; identifying the specific month for each review. The work plan is used to track review and action on activities conducted by the RMRC, including QIIs, PMIs, and completion of actions recommended by the committee.

The RMRC works with several workgroups, established in SFY2021, to help move the work forward between meetings; the Data Workgroup, the UTI Workgroup, and QII workgroups. The Data Workgroup meets monthly, between RMRC meetings, and has helped prepare data presentations, address data quality concerns and implement RMRC recommendations related to data. The workgroup has also focused on more detailed analyses of performance measure indicators (PMI) and surveillance data; refining operational definitions; identifying potential threats to the validity of measures; and discussing potential changes to PMI. The UTI Workgroup met biweekly for 3 months and has helped to analyze UTI SIRs. The QII workgroup meets monthly to review trend data, to identify areas of systemic need for the purposes of developing QIIs and other mitigating strategies to be proposed to the RMRC for discussion, prioritization, and recommendation to the QIC (for implementation). Each workgroup includes staff from various departments across the agency in addition to the members of RMRC.

Part 5. Summary of Activities

RMRC's overall RM process enables DBHDS to identify and prevent or substantially mitigate risks of harm. RMRC reviews data and identifies trends and patterns, which aids in the determination of mitigating strategies, the need for new performance measure indicators and QIIs. The following six subsections describe the focus areas of the RMRC's work; ANE, serious incidents, licensing inspections, risk mitigation and provider resources, facility RM programs (training center), and other data review; detailing the DBHDS office roles and data analysis and findings, per subsection.

Part 5a. Abuse, Neglect and Exploitation

5a (1) RMRC Responsibilities and the Role of the Office of Human Rights

The Office of Human Rights (OHR) plays a critical role in risk management for DBHDS. OHR reviews and investigates allegations of abuse, neglect and exploitation, addresses complaints involving human rights, and provides education to individuals, families, and providers on various

topics related to the health, safety and well-being of individuals with developmental disabilities (DD). OHR also develops mitigating strategies such as working one on one with providers, developing and enhancing education and training materials, and collaborating with other departmental offices and agencies within the Commonwealth to develop and implement solutions. OHR provides the following trainings quarterly: *Reporting in CHRIS: Abuse, Neglect, and Human Rights Complaints*; *Restrictions, Behavioral Treatment Plans, & Restraints: Investigating Abuse & Neglect: An Overview for Community Providers*; and, *The Human Rights Regulations: An Overview* and several facility-specific trainings. In SFY2021, OHR hired a Training and Development Coordinator and began implementing a training program, dedicated to provider literacy, regarding individuals' assured rights and corresponding provider duties. OHR also implemented the *HR Access Initiative* to help ensure all individuals receiving services are aware of their human rights (and provider responsibilities), and that they can access this information.

RMRC partners with the Office of Human Rights (OHR) to review ANE trend data and results from the OHR Community Look-Behind quarterly and recommends the development of QIIs, to address systemic needs identified by the RMRC, and track implementation of QIC approved QIIs. More detailed information about these efforts in SFY2021 is provided below. RMRC also reviews OHR materials and trainings, as requested, and provides input accordingly.

5a (2) Data Analysis: ANE Trends, OHR Community Look Behind

In SFY2021 there were 2,155 reported allegations of ANE, with 418 (16%) of cases found to be substantiated. This included 1,062 reports of neglect, with 290 (21%) of these cases found to be substantiated; a decrease from SFY2019. The following tables display allegations by quarter and region, inclusive substantiated cases of ANE. Overall, the data displayed below indicates that neglect continues to be the most frequently reported type of ANE, followed by physical and verbal abuse. While the frequency of occurrence of all types of ANE was relatively steady throughout the year, there were increases in the number of cases, in the 4th quarter, except for the number of cases involving the use of restraints.

Table 1 reflects each type of alleged cases of ANE, as a separate allegation, although one report may allege multiple types of abuse. This is important to consider when reviewing rates of substantiation. Allegations of neglect were substantiated at the second highest rate (21%) followed by verbal abuse and restraint (at a rate of 19% respectively). Also of note, Table 1 reflects nearly 200 more allegations of ANE, in Q4, than in each of the previous quarters. Many of these reports were made by caregivers, on behalf of individuals served, and with alleged abuse dates across all 4 quarters. These reports were not considered late because the provider appropriately reported the allegation(s) when they were notified.

Table 1 - Allegations by Quarter, SFY2021

ABUSE TYPE	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total		
	Allegation	Substantiated	% Substantiated	Allegation	Substantiated	% Substantiated	Allegation	Substantiated	% Substantiated	Allegation	Substantiated	% Substantiated	Allegation	Substantiated	% Substantiated
Exploitation	10	1	9%	12	2	14%	14	3	18%	12	3	20%	**48**	**9**	**16%**
Neglect	220	68	24%	233	57	20%	255	57	18%	354	108	23%	**1062**	**290**	**21%**
Neglect P2P	111	3	3%	85	5	6%	75	9	11%	112	5	4%	**383**	**22**	**5%**
Other	25	2	7%	8	3	27%	11	0	0%	29	2	6%	**73**	**7**	**9%**
Physical	54	6	10%	76	10	12%	63	7	10%	98	8	8%	**291**	**31**	**10%**
Sexual	10	0	0%	13	0	0%	11	0	0%	11	0	0%	**45**	**0**	**0%**
Verbal	49	12	20%	47	11	19%	37	10	21%	51	10	16%	**184**	**43**	**19%**
Restraint	30	6	17%	11	3	21%	17	3	15%	11	4	27%	**69**	**16**	**19%**
Total	**509**	**98**	**16%**	**485**	**91**	**16%**	**483**	**89**	**16%**	**678**	**140**	**17%**	**2155**	**418**	**16%**

Table 2 reflects the relationship between provider density and reports of allegations. The average substantiation rate across Regions was 19%, with the highest being 24% (Region 3) and the lowest begin 13% (Region 5). Region 4 had the highest number of alleged and substantiated cases of ANE.

Table – 2 Allegations by Region, SFY2021

ABUSE TYPE	Region 1			Region 2			Region 3			Region 4			Region 5			Total		
	Allegation	Substantiated	% Substantiated	Allegation	Substantiated	% Substantiated	Allegation	Substantiated	% Substantiated	Allegation	Substantiated	% Substantiated	Allegation	Substantiated	% Substantiated	**Allegation**	**Substantiated**	**% Substantiated**
Exploitation	10	2	20%	3	0	0%	14	5	36%	7	1	14%	14	1	7%	**48**	**9**	**16%**
Neglect	195	57	29%	215	57	27%	151	47	31%	337	94	28%	164	35	21%	**1062**	**290**	**21%**
Neglect P2P	71	2	2%	80	7	8%	49	5	10%	105	7	6%	78	1	1%	**383**	**22**	**5%**
Other	9	0	0%	17	0	0%	13	4	31%	27	3	11%	7	0	0%	**73**	**7**	**9%**
Physical	35	4	11%	54	5	9%	23	3	13%	110	14	13%	69	5	7%	**291**	**31**	**10%**
Sexual	1	0	0%	6	0	0%	9	0	0%	12	0	7%	17	0	0%	**45**	**0**	**0%**
Verbal	35	6	17%	37	8	22%	26	5	19%	52	20	40%	34	4	11%	**184**	**43**	**19%**
Restraint	5	1	2%	11	3	27%	10	2	2%	35	7	2%	8	3	37%	**69**	**16**	**19%**
Total	**361**	**72**	**20%**	**423**	**80**	**19%**	**295**	**71**	**24%**	**685**	**146**	**21%**	**391**	**49**	**13%**	**2155**	**418**	**16%**

Although there is a relatively low substantiation rate for cases classified as 'other', the RMRC and OHR remain concerned about the number of cases so classified. As a result, OHR has included specific examples of what may appropriately be classified as 'other' in the CHRIS system, in both provider and OHR staff training.

RMRC identified the low rate of peer to peer (P2P) substantiation; OHR explained that P2P are often unsubstantiated because, although there was physical interaction between individuals receiving services, the interaction is typically not found to be due to neglect by staff, as staff are typically found to be following policy. RMRC found that verbal abuse was substantiated at a higher rate (19%) than physical abuse (10%); probably due to determinations of verbal abuse being more subjective and the fact that there may be corroborating witnesses in cases of alleged verbal abuse. The substantiation of sexual abuse allegations is low because these cases are often screened out, as they typically do not involve a staff member or other individual receiving a services; DBHDS partners with Adult Protective Services and/or local Law Enforcement to address the allegation(s).

OHR Community Look Behind (CLB)

OHR conducts Community Look-Behinds (CLB) to validate that provider investigations are conducted in accordance with state regulations, and to identify where prevention efforts and mitigating strategies are needed. Historically, CLB involves a desk audit of CHRIS information, specific to the service provider, followed by onsite visits, conducted to review the provider's incident investigation documentation and to provide a face to face debrief (of findings) and technical assistance (TA). However, OHR suspended site visits in mid-March 2020, due to the impact of COVID-19, and temporarily suspended all requests for information from providers not related to AIM (*Assess and assure safety of the individual involved in the allegation as well as all other individuals receiving services; Initiate the complaint resolution process; and Monitor the provider investigation and outcome, to include verification of corrective action and/or next steps in the complaint resolution process)* or immediate real-time response to allegations of physical abuse with serious injury, sexual assault and restraint with injury.

In SFY2021, OHR continued to implement the CLB review to monitor the accuracy of provider's investigations. In July 2020 OHR decided to re-design the CLB by moving to conducting CLBs virtually, which involves a desk audit of CHRIS. However, In lieu of an onsite visit, 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 (TA).

Three hundred reviews were conducted in SFY2021; the results are presented in Table 3 below.

Table 3 – Community Look-Behind Results SFY2020-SFY2021

Measure	Inspection Closed Dates *CLB Review Date* Jul – Sep 2019 *Jul – Sep 2020*	Oct – Dec 2019 *Oct – Dec 2020*	Jan –Mar 2020 *Jan – Mar 2021*	Apr – Jun 2021 *Apr – Jun 2021*
i. Comprehensive, and non-partial investigations of individual incidents occur within state prescribed timelines	95%	89%	97%	96%
ii. The person conducting the investigation has been trained to conduct investigations	92%	88%	80%	80%
iii. Timely, appropriate corrective action plans are implemented by the provider when indicated - was the case closed w/in 60 days	95%	83%	97%	97%

Regarding measure (i), the CLB identified consistent compliance above 86% (as high as 97%) for the entire review period. In instances where the investigation was late, reviewers assessed whether the provider should or could have requested an extension (and offered this education to the provider during the CLB debrief) as well as reviewed the case to ensure the assigned advocate provided education and TA and then recommended citation to the Office of Licensing at the time of the investigation.

Regarding measure (ii), reviewers were tasked to observe a training certificate or training sign-in sheet for the provider staff person identified as having completed the investigation. Reviewers determined that compliance for this measure fell below the goal of 86% for Q3 and Q4. In all instances, for which there was no evidence of a trained investigator, providers were referred to the next available "Investigating Abuse and Neglect, An Overview for Community Providers" OHR training, offered virtually each quarter. Subsequently, OHR validated completion of training or issued a recommendation for citation to the (3) providers that failed to produce evidence of a trained abuse/neglect investigator. In addition, to address Measure (ii), OHR is working on a memo to providers reiterating that investigators must be trained so OHR is taking a three-prong approach: 1) making providers aware of the training requirement; 2) making them aware of the training resources available; and 3) a making them aware that a certificate of completion is required, for the investigator to be considered trained and the provider compliant.

Lastly, measure (iii) exceeded the goal of 86% in all quarters except in Q2 (83%). In the handful of cases that were not closed within 60 days, it was due to an appropriate extension in the timeline based on the individuals requested resolution (i.e., review by the Local Human Rights Committee or State Human Rights Committee) or based on the providers initial failure to report an allegation and their continued delinquency throughout the process. Reviewers ensured advocates recommended citations as appropriate for provider failures to report at all or on time.

In addition to the data above, the look-behind inter-rater reliability (IRR) process and analysis showed substantial agreement on all three measures using Maxwell's random error (RE) coefficient, a statistic that measures the degree of agreement.

Beginning in SFY2022, the OHR will make changes to the CLB process to ensure that the timing of reviews aligns more closely with the date that the investigation was closed. Historically incidents reviewed during the CLB were 6 months in the past; however, due to the delays associated with COVID-19 precautions, the study is now nearly 12 months behind. To address this issue, the OHR is piloting a process that will allow for cases to be pulled and reviewed on a monthly (rather than quarterly basis) which will result in reports being about four months in the past (following the close of a quarter, rather than over 12 months).

5a (3) Findings: Issues Identified and Mitigating Strategies

In response to the observation that incidents of neglect continue to be significantly higher than other types of ANE, the RMRC recommended that OHR and the RMRC better understand and describe neglect. As a result, OHR and RMRC are exploring the creation of additional neglect categories. Thus far, there have been only two categories of neglect reported – 'neglect' and 'P2P'; compared to at least three categories for physical abuse (verbal, physical, sexual). The RMRC Data Workgroup began collaborating with OHR to develop potential categories. This work will continue into SFY2022.

The RMRC also recommended developing better guidance for providers regarding the reporting of medication errors as neglect. It was recommended that medication errors be addressed separately, as research suggests that the handling of medication errors, in a non-punitive manner, is more effective at reducing the occurrence of fatal incidents. In the exploration of neglect categories, "medication error" is being proposed as a separate category. In addition, OHR is working to provide updated guidance for providers on reporting medication errors as neglect. OHR has begun this process to update and finalize a guidance document for providers, to be issued immediately following the prescribed regulations promulgation process, hopefully by early 2022.

In February 2021, the OHR provided data on financial exploitation allegations and substantiated reports; in calendar year 2020; out of the 2,507 ANE allegations, 49 alleged exploitation (12 of which were substantiated). In April OHR reported on mitigating strategies which centered on incorporating additional information into training for providers and individuals receiving services.

Part 5b. Serious Incidents

5b (1) RMRC Responsibilities and the Role of IMU

The RMRC is tasked with systematically reviewing and analyzing data related to serious incident reports (SIR). To achieve this, the RMRC reviews SIR surveillance data quarterly, which includes a review of trends in types of incidents as well as injuries, illnesses/conditions, and causes of serious incidents. In addition, the RMRC is responsible for developing 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 involving 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). RMRC achieves this in partnership with the Incident Management Unit (IMU) within the OL. The IMU reviews each serious incident, to determine whether the information reported is complete and accurate; using triage protocols to determine what TA is needed or whether further investigation is warranted, to determine if the provider's actions in relation to the incident were appropriate. The IMU focuses on where and how to improve the quality of care at an individual and program level.

The RMRC is also responsible for monitoring aggregate data of provider compliance with SIR requirements and establishes targets for PMIs. To achieve this, the IMU identifies late, or unreported serious incidents, and issues citations and corrective action plans (CAPS) when applicable, and reports these data to RMRC quarterly. In addition, the IMU has established monthly webinar trainings with providers including topics such as form completion and ongoing analysis of how to identify issues and improve the quality of data entry in CHRIS. OL also distributes memos and guidance to providers to share information about processes, citations and CAPs, and changes to CHRIS.

The RMRC is also responsible for providing oversight for a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. This process is housed within the IMU and is referred to as the IMU Look-Behind. The reviews evaluate whether:

i. The incident was triaged by the OL IMU appropriately, according to developed protocols;
ii. The provider's documented response ensured recipient's safety and well-being;
iii. Appropriate follow-up from the OL IMU occurred when necessary;
iv. Timely, appropriate, CAPs were implemented by the provider, when the need for a CAP was indicated.

5b (2) Data Analysis- SIR Trends, IMU Look Behind, Report Timeliness and Citations, Risk Triggers and Thresholds (Care Concerns)

Serious Incidents

RMRC reviewed SIRs quarterly. During SFY2021, there were 11,905 distinct serious incidents reported within 8,995 reports. There are more serious incidents than serious incident reports because a single incident report may include multiple incidents (e.g., if an individual had a bowel obstruction that also resulted in a hospitalization).

Table 4 – SFY2021 Serious Incident Reports (SIRs) and Distinct Serious Incidents

SFY2021 Quarter	Number of SIRs	Number of Distinct Serious Incidents
Q1	2,261	2,941
Q2	2,692	3,602
Q3	2,180	3,021
Q4	1,862	2,344
Grand Total	8,995	11,908

As demonstrated in the chart below, of all 11,908 SIRs, emergency room (ER) visits have remained the leading type of SIR (43.2% of SIRs), followed by COVID-19 (17.58%), and unplanned hospital admission (15.06%). COVID-19 related SIRs decreased from 27.8%, in Q3, to 1.4% in Q4. SIRS classified as 'other' comprised 6.88% of all SIRs. ER visits, as a percentage of reports, had dropped in SFY2020 Q4, but had increased again in SFY2021 Q1. The committee discussed potential reasons for the decline in ER visits, including individuals and families delaying seeking health care due to potential exposure to COVID-19, and potential implications of this, such as poorer health outcomes. The committee also noted that as providers faced staffing struggles, it is possible that some incidents were not reported due to staffing constraints or due to concerns associated with COVID-19.

The trends in SIRs are shown in the tables below:

Table 5: SIR by Type and Quarter SFY2021

	Q1		Q2		Q3		Q4		Grand Total	
Serious Incident	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Unplanned ER Visit	1269	43.15%	1376	38.20%	1210	40.05%	1296	55.29%	5151	43.26%
COVID-19	493	16.76%	997	27.68%	570	18.87%	33	1.41%	2093	17.58%
Unplanned Hospital Admission	455	15.47%	493	13.69%	471	15.59%	374	15.96%	1793	15.06%
Other - Level 2	197	6.70%	172	4.78%	311	10.29%	139	5.93%	819	6.88%
Serious Injury - Requiring Medical Attention	201	6.83%	143	3.97%	139	4.60%	180	7.68%	663	5.57%
Harm or Threat to Others	103	3.50%	188	5.22%	98	3.24%	80	3.41%	469	3.94%
Unplanned Psychiatric Admission	79	2.69%	75	2.08%	90	2.98%	88	3.75%	332	2.79%
Missing Individual	39	1.33%	57	1.58%	39	1.29%	65	2.77%	200	1.68%

	Q1		Q2		Q3		Q4		Grand Total	
Serious Incident	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Decubitus Ulcer	25	0.85%	17	0.47%	23	0.76%	18	0.77%	83	0.70%
Sexual Assault	16	0.54%	16	0.44%	13	0.43%	23	0.98%	68	0.57%
Choking Incident	12	0.41%	18	0.50%	16	0.53%	16	0.68%	62	0.52%
Suicide Attempt with Hospital Admission	10	0.34%	16	0.44%	16	0.53%	14	0.60%	56	0.47%
Aspiration Pneumonia	20	0.68%	12	0.33%	14	0.46%	7	0.30%	53	0.45%
Bowel Obstruction	7	0.24%	9	0.25%	7	0.23%	6	0.26%	29	0.24%
Ingestion of Hazardous Materials	5	0.17%	8	0.22%	4	0.13%	5	0.21%	22	0.18%
Serious Injury - Permanent Impairment	10	0.34%	5	0.14%		0.00%		0.00%	15	0.13%
Grand Total	2941	100%	3602	100%	3021	100%	2344	100%	11908	100%

RMRC also monitors the illnesses/conditions as well as injuries and causes associated with SIRs. Analysis of this data assists RMRC in determining whether a QII, continued monitoring or mitigating strategies are needed. In SFY2021, the leading causes of SIRs were identified as unknown (34.73% of causes), COVID-19 (23.13%), other (16.93%), fall/trip (8.89%), and seizure (3.39%). During the first half of the year, the RMRC identified COVID-19 as the most frequently occurring incident and significant risk to the health of individuals, although COVID-19 decreased dramatically in Q4. The leading illnesses and conditions were identified as COVID-19, other (27.72%), UTIs (6.16%), seizures (5.49%) and mental status changes (5.33%). Leading injuries were identified as other (28.77%), cut/laceration (19.08%), bruise (13.48%) and fracture (10.47%). See Tables 6-8 below for more detailed information regarding SFY2021 SIR patterns.

Table 6: Serious Incident Cause by Type and Quarter SFY2021

Cause	Q1		Q2		Q3		Q4		Grand Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Unknown	786	35.63%	878	31.17%	775	34.77%	703	39.16%	3142	34.73%
COVID-19	493	22.35%	997	35.39%	570	25.57%	33	1.84%	2093	23.13%
Other	385	17.45%	367	13.03%	357	16.02%	423	23.57%	1532	16.93%
Fall/trip	185	8.39%	208	7.38%	191	8.57%	220	12.26%	804	8.89%
Seizure	72	3.26%	76	2.70%	78	3.50%	81	4.51%	307	3.39%
Natural Disease Process	49	2.22%	72	2.56%	65	2.92%	59	3.29%	245	2.71%
Self-injury	68	3.08%	49	1.74%	47	2.11%	53	2.95%	217	2.40%

Cause	Q1		Q2		Q3		Q4		Grand Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Assault (Peer-to-Peer Aggression)	28	1.27%	22	0.78%	27	1.21%	41	2.28%	118	1.30%
Medication Error	23	1.04%	25	0.89%	22	0.99%	16	0.89%	86	0.95%
Motor Vehicle Accident	8	0.36%	22	0.78%	5	0.22%	19	1.06%	54	0.60%
Neglect	13	0.59%	15	0.53%	10	0.45%	15	0.84%	53	0.59%
Suicide Attempt	13	0.59%	14	0.50%	13	0.58%	10	0.56%	50	0.55%
Medical Equipment Malfunction (Adaptive Equipment)	5	0.23%	10	0.35%	12	0.54%	20	1.11%	47	0.52%
Traumatic Event	16	0.73%	10	0.35%	9	0.40%	10	0.56%	45	0.50%
Assault (by others)	7	0.32%	8	0.28%	9	0.40%	11	0.61%	35	0.39%
Accidental Injury (by another person)	8	0.36%	10	0.35%	6	0.27%	8	0.45%	32	0.35%
Assault (by staff or caregiver)	8	0.36%	1	0.04%	9	0.40%	14	0.78%	32	0.35%
Blunt Force Trauma	10	0.45%	9	0.32%	3	0.13%	8	0.45%	30	0.33%
Restraint/ Seclusion	8	0.36%	7	0.25%	2	0.09%	11	0.61%	28	0.31%
Ingestion of Foreign or Hazardous Material	5	0.23%	4	0.14%	3	0.13%	10	0.56%	22	0.24%
Food Ingredients or Consistency	4	0.18%	3	0.11%	5	0.22%	7	0.39%	19	0.21%
Animal or Insect Bite/Sting	6	0.27%	2	0.07%	1	0.04%	9	0.50%	18	0.20%
Overdose	1	0.05%	5	0.18%	6	0.27%	4	0.22%	16	0.18%
Smoke or Fire Exposure	1	0.05%	2	0.07%	2	0.09%	7	0.39%	12	0.13%
Overexertion	1	0.05%		0.00%	1	0.04%	3	0.17%	5	0.06%
Poisoning or Exposure to Toxic Substance	3	0.14%	1	0.04%	1	0.04%		0.00%	5	0.06%
Grand Total	2206	1000%	2817	100%	2229	100.%	1795	1000%	9047	100.%

Table 7: Illness or Condition by Type and Quarter SFY2021

Illness or Condition	Q1		Q2		Q3		Q4		Grand Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Covid-19	494	28.75%	1001	44.77%	909	41.97%	66	4.91%	2470	33.09%

Illness or Condition	Q1		Q2		Q3		Q4		Grand Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Other Illness/Condition	533	31.02%	506	22.63%	501	23.13%	529	39.36%	2069	27.72%
Urinary Tract Infection (UTI)	117	6.81%	121	5.41%	117	5.40%	105	7.81%	460	6.16%
Seizure	98	5.70%	97	4.34%	104	4.80%	111	8.26%	410	5.49%
Mental Status Changes	86	5.01%	97	4.34%	91	4.20%	124	9.23%	398	5.33%
Pneumonia (Caused By Bacteria Or Virus)	78	4.54%	90	4.03%	113	5.22%	50	3.72%	331	4.43%
Diarrhea/Vomiting	67	3.90%	73	3.26%	86	3.97%	66	4.91%	292	3.91%
Suicidal Thoughts/Behaviors	44	2.56%	40	1.79%	41	1.89%	55	4.09%	180	2.41%
Constipation	27	1.57%	31	1.39%	51	2.35%	52	3.87%	161	2.16%
Aspiration Pneumonia	35	2.04%	35	1.57%	29	1.34%	21	1.56%	120	1.61%
Dehydration	29	1.69%	29	1.30%	29	1.34%	32	2.38%	119	1.59%
Exacerbation Of A Chronic Medical Condition	21	1.22%	30	1.34%	19	0.88%	39	2.90%	109	1.46%
Sepsis	22	1.28%	28	1.25%	23	1.06%	18	1.34%	91	1.22%
Blood Sugar Problem (High Or Low)	18	1.05%	21	0.94%	16	0.74%	35	2.60%	90	1.21%
Cardiac Event	22	1.28%	16	0.72%	17	0.78%	18	1.34%	73	0.98%
Bowel Obstruction	16	0.93%	13	0.58%	13	0.60%	16	1.19%	58	0.78%
Stroke	4	0.23%	2	0.09%	4	0.18%	4	0.30%	14	0.19%
Asthma	5	0.29%	5	0.22%	2	0.09%	1	0.07%	13	0.17%
Drug Or Alcohol Problem	2	0.12%	1	0.04%	1	0.05%	2	0.15%	6	0.08%
Grand Total	1718	100.00%	2236	100.00%	2166	100.00%	1344	100.00%	7464	100.00%

Table 8: Injuries by Type and Quarter SFY2021

Injury Type	Q1		Q2		Q3		Q4		Grand Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Other Injury	169	27.89%	195	32.34%	138	28.75%	166	26.22%	668	28.77%
Cut/Laceration	126	20.79%	110	18.24%	83	17.29%	124	19.59%	443	19.08%
Bruise	81	13.37%	61	10.12%	72	15.00%	99	15.64%	313	13.48%
Fracture	53	8.75%	73	12.11%	52	10.83%	65	10.27%	243	10.47%
Bleeding	69	11.39%	61	10.12%	47	9.79%	61	9.64%	238	10.25%
Pressure Injury (Decubitus Ulcer)	28	4.62%	22	3.65%	27	5.63%	19	3.00%	96	4.13%
Sprain/Strain/Tear	14	2.31%	17	2.82%	15	3.13%	22	3.48%	68	2.93%
Loss Of Consciousness	17	2.81%	12	1.99%	11	2.29%	17	2.69%	57	2.45%
Adverse Reaction To Medication	6	0.99%	13	2.16%	7	1.46%	13	2.05%	39	1.68%
Obstructed Airway (Unable To Breathe, Turning Blue)	12	1.98%	9	1.49%	10	2.08%	8	1.26%	39	1.68%

Injury Type	Q1		Q2		Q3		Q4		Grand Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Bite/Sting	13	2.15%	7	1.16%	2	0.42%	15	2.37%	37	1.59%
Dislocation	5	0.83%	9	1.49%	7	1.46%	11	1.74%	32	1.38%
Allergic Reaction	4	0.66%	7	1.16%	4	0.83%	10	1.58%	25	1.08%
Concussion	2	0.33%	3	0.50%	2	0.42%	2	0.32%	9	0.39%
Burn	4	0.66%	1	0.17%	1	0.21%		0.00%	6	0.26%
Loss Or Serious Impairment Of Limb Or Other Body Part (E.G., Eyes, Arms, Legs)	2	0.33%	2	0.33%	2	0.42%		0.00%	6	0.26%
Poisoning	1	0.17%	1	0.17%		0.00%	1	0.16%	3	0.13%
Grand Total	606	100.00%	603	100.00%	480	100.00%	633	100.00%	2322	100.00%

Surveillance Measures

The RMRC has identified 12 surveillance measures and reviewed these rates at least quarterly. These are presented in Table 9.

Table 9 – Surveillance Measures by Quarter SFY2021 (Rate per 1,000 individuals in the DD waiver population)

Surveillance Measure	Q1	Q2	Q3	Q4	Total, SFY2021
Aspiration Pneumonia (RMRC1a)	8.5	7.8	6.8	5	7
Bowel Obstruction (RMRC1b)	4.6	3.8	3.2	4.2	3.9
Sepsis (RMRC1c)	5.5	6.4	5.3	4.4	5.4
Decubitus Ulcer (RMRC1d)	7.7	6.2	5.5	5	6
Fall or Trip (RMRC1e)	45.1	45.3	44.4	45.4	45.1
Dehydration (RMRC1f)	7.1	7.2	6.6	6.5	6.8
Seizures (RMRC1g)	23.5	23.9	23.9	26.1	24.3
Urinary Tract Infection (RMRC1h)	27.6	26.6	25.5	25	26.2
Choking (RMRC1i)	2.5	4.3	3.4	3.4	3.4
Self-injury (RMRC1j)	16.9	10.2	9.5	11.2	12
Sexual Assault (RMRC1k)	3.6	2.4	3.2	5.5	3.7
Suicide Attempt (RMRC1l)	2.73	2.1	3.7	2.3	2.6

As presented in Table 9, the falls measure continues to be the surveillance measure with the highest rate of occurrence (45.1 per 1,000 DD waiver population), followed by UTI (26.2 per 1,000), and seizures (24.3 per 1,000). RMRC observed a significant decrease in the rate of falls, coinciding with the onset of the COVID-19 pandemic. Prior to March 2020, the rate of falls had averaged approximately 65 falls/1000 individuals; this dropped to approximately 45 falls/1000

individuals after March 2020. The RMRC continues to monitor changes in the fall rate, while implementing interventions intended to maintain a lower rate. The RMRC also formed a UTI Workgroup to conduct an analysis of UTI reports, resulting in recommendations for additional education and TA for providers to reduce UTI risks. The RMRC is currently monitoring efforts by several departments to increase provider knowledge and awareness related to UTI prevention. Efforts include: OIH is developing and providing a training for providers on UTIs, OHR is assuring that their staff are trained in UTIs, and Provider Development is making providers aware of the resources available to promote knowledge about UTIs.

In addition, decubitus ulcers (6.0 per 1,000), dehydration (6.8 per 1,000) and sepsis (5.4 per 1,000) appeared to occur at a higher rate in SFY2021 compared to SFY2020, although they were beginning to trend down again toward the end of SFY2021. However, the group concluded that more analysis needed to be performed, to determine the existence of duplicate incidents that may be driving this trend; this analysis will continue into SFY2022.

COVID-19

SFY2021 saw the continued detrimental impact of COVID-19 and the introduction and distribution of the COVID-19 vaccines. The chart below demonstrates a steady increase in COVID-19 cases in SFY2021, with a peak in Q2, followed by a steep decline, as vaccines were made available and vaccine uptake increased. This trend was also observed in each region.

Figure 1: COVID-19 Trend

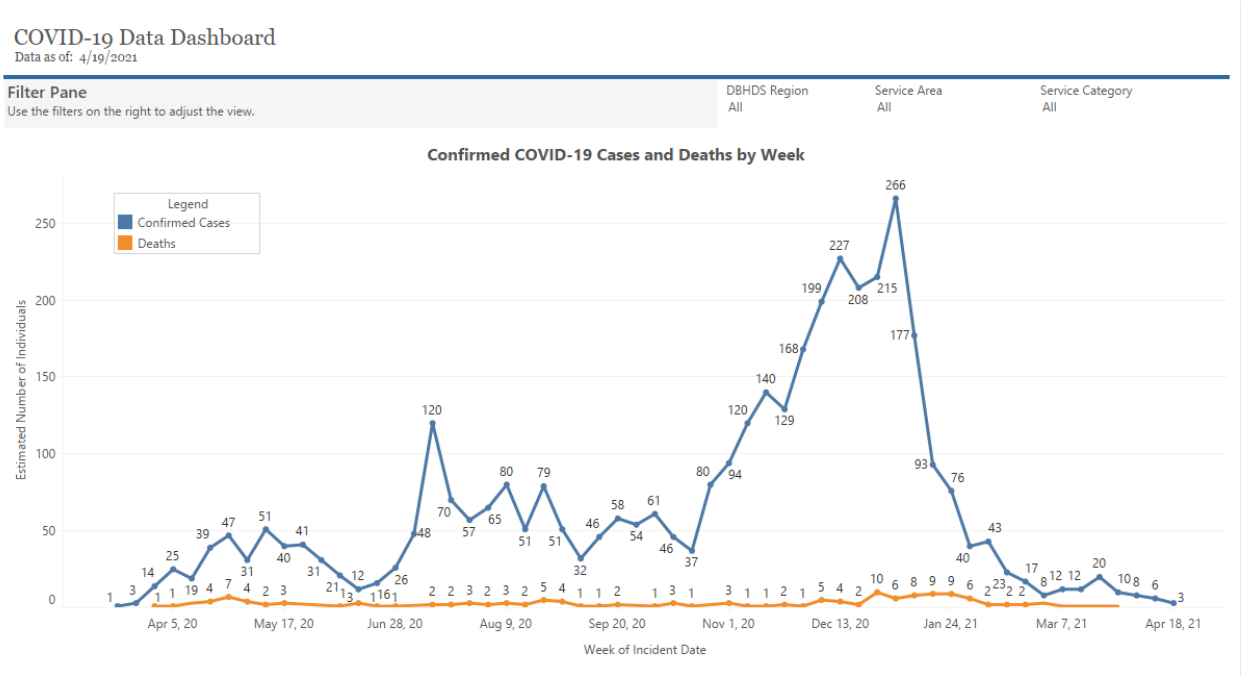
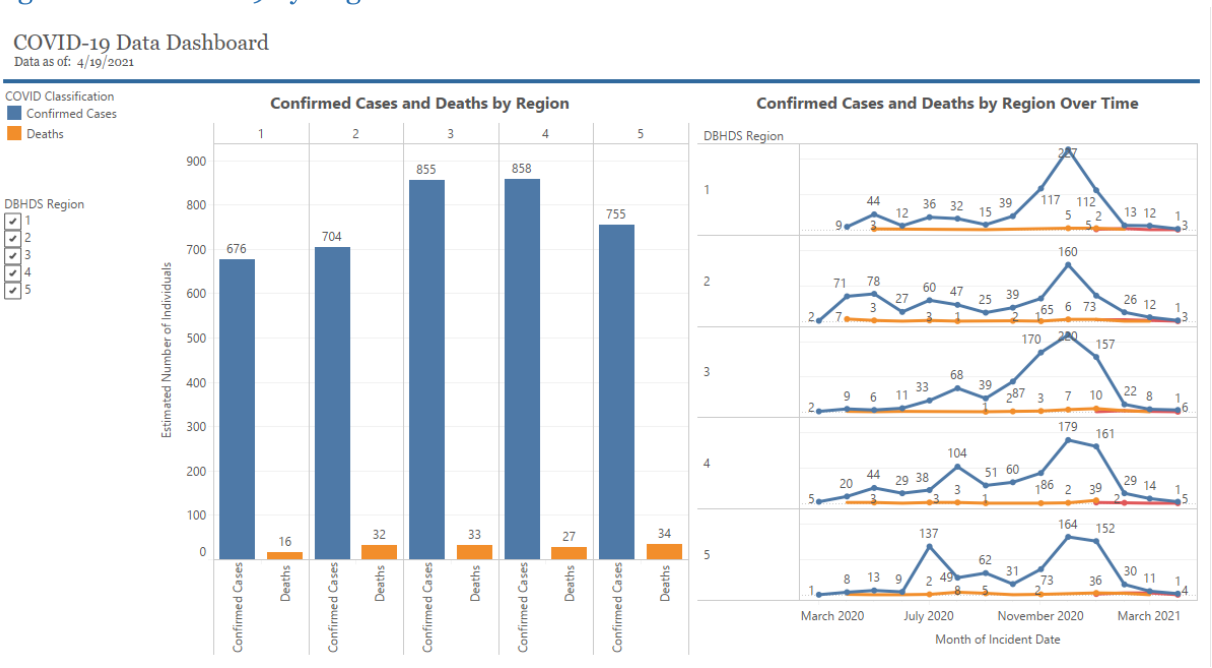


Figure 2 – COVID-19 by Region



RMRC monitored trends in reported serious incidents related to COVID-19 infections and deaths among individuals receiving services. In terms of SIRs, there was an increase across Q1 and Q2, largely driven by COVID-19 which accounted for 20-25% of SIRs. By December 2021, COVID-19 was reported in 45% of SIRs, and COVID-19 was the leading cause of ER visits followed by UTIs and seizures. COVID-19 was the leading risk to the DD population.

In SFY2021 RMRC continued, through the efforts of OIH, OHR, and OL, to help guide providers in assuring COVID-19 safety precautions were taken and that COVID-19 diagnoses were reported in CHRIS. IMU and OIH continued to follow up on all outbreaks and positive cases. DBHDS collaborated with the Virginia Department of Health (VDH) to help connect providers and individuals with testing facilities, respond to outbreaks, and make rapid antigen test kits available to providers. As vaccines were made available, the OIH team reached out to each provider to build a relationship and connect them with a long-term acute pharmacy to facilitate vaccine distribution. OIH and OL collaborated on identifying and providing TA to 190 DD providers; the OIH also posted guidelines for vaccinating individuals with DD and assisted residential providers in getting individuals vaccinated, including posting a training entitled "How to provide vaccines for individuals with DD."

RMRC, through partnership with OL, IMU and DQV, helped improve the tracking of COVID-19 data. They developed a COVID-19 checkbox in CHRIS and ensured it was implemented in a timely manner. Prior to that, identification of COVID-19 incidents was largely a manual search through narrative text in CHRIS. This enhancement reduced staff time and effort in identifying COVID-19 cases and resulted in more accurate reporting and trend data.

IMU Look-Behind

The IMU Look-Behind Committee utilizes reviewers from various offices, across DBHDS, with the purpose of reviewing the consistency of IMU adherence to their protocols and expectations for responding to serious incidents. The IMU has developed a training guide as well as a tool for the Look-Behind Committee's use when completing the IMU Look Behinds. IMU excludes death SIRs, as these are investigated by Special Investigations Unit (SIU) and reviewed by the Mortality Review Committee. IMU conducts look behinds of their work to assess the following outcomes:

a) Outcome 1 is whether the incident was triaged appropriately, by the IMU, according to developed protocols. To evaluate this outcome, the Look-Behind Committee reviews the level classification for the incident and at least three out five criteria list below was answered with a 'Yes' or "Not Applicable" for this item.
    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; and
    v. The provider received a citation for late reporting.
b) Outcome 2 is whether the provider's documented response addressed ways to mitigate future occurrences.
c) Outcome 3 is whether appropriate action from IMU occurred, the Look-Behind Committee determines whether all criteria listed below were met.
    i. The IMU specialist contacted the provider for additional information;
    ii. The IMU specialist forwarded the incident to OHR before closing the case;
    iii. The IMU specialist forwarded the incident for a licensing specialist investigation before closing the case; and
    iv. The IMU specialist forwarded the incident to the SIU before closing the case.

Look-Behinds were conducted for four quarters: Q3 of SFY2020 and Q1, Q2 and Q3 in SFY2021. As of Q4 of SFY2021, the Look-Behind process is planned to transition to an external contractor so those data are not yet available. The incidents eligible for review included:

- ✓ Serious injury report involving an individual receiving a licensed DD service;
- ✓ Submitted within any region;
- ✓ Triaged by IMU specialist; and
- ✓ Closed during the preceding quarter.

The annual sample size was calculated using the projected annual population of eligible incident reports (14,800) that IMU will review from SFY2020 Q3 through SFY2021 Q3. The IMU Look-Behind Committee reviewed one-fourth of the annual sample per quarter (rounded up to 47 reports). The sample was stratified using the level recorded by the provider within the body of the SIR (i.e. Level II or Level III.). 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. During SFY2021 Q1, which used records closed in SFY2020 Q4, 901 eligible SIRs were triaged with 97% classified as Level II and 3% classified as Level III. During SFY2021 Q2, which used records closed in SFY2021 Q1, 1,312 eligible SIRs were triaged with 100% classified as Level II. In SFY2021 Q3, which included records closed in SFY2021 Q2, there were 2,664 eligible records. Results of the IMU Look-Behinds are presented in Table 10 below.

Table 10: IMU Look-behind Results, Quarter 3 SFY 2020 – Quarter 3 SFY 2021

Expected IMU Performance Outcomes	Q3 SFY2020 Regions 3 & 4	Q1 SFY2021 Statewide	Q2 SFY2021 Statewide	Q3 SFY2021 Statewide
Number of incidents reviewed	47	47	47	31
Outcome 1: Triaged Appropriately	96%	94%	100%	97%
Outcome 2: Provided Documented Mitigation	64%	53%	91%	94%
Outcome 3: Appropriate Follow-Up from IMU	53%	40%	77%	90%

In SFY2021, a formal inter-rater reliability (IRR) process for the Look Behind reviews began. Seventeen cases were randomly selected, from the sample, and then reviewed (16 cases were reviewed for IRR in Q3). In the Look-Behind review conducted in SFY2021 Q1, the IRR agreement among the reviewers ranged from 11.8% to 94.1%; in the review conducted in Q2, agreement ranged from 5.9% to 94.1%; while in Q3 agreement ranged from 12.5% to 100%. The low consistency between reviewers indicated that additional training for reviewers was needed to ensure common understanding of procedures and expectations. In Q2 SFY2021, the IMU conducted additional training for reviewers in order to improve IRR but low IRR has persisted through Q2 and Q3.

A significant issue in obtaining a high level of IRR has been the consistency of staff available to conduct the reviews. Reviewers were tapped from offices across the department; however, because of the time commitment involved, several have had to discontinue their participation. This ongoing turnover in reviewers was identified as one factor impacting IRR. Another factor identified has been the complexity of pulling information to conduct the review, which comes from multiple systems that may not be familiar to all of the reviewers. The SFY2021 Q3 review was delayed due to staffing changes in DQV, limiting the capacity to analyze the results. In SFY2021 Q4, the look-behind review process was suspended due to limited staff capacity. To address these issues, DBHDS decided that it would be best to contract with an outside organization to conduct future reviews. These reviews will resume in SFY2022.

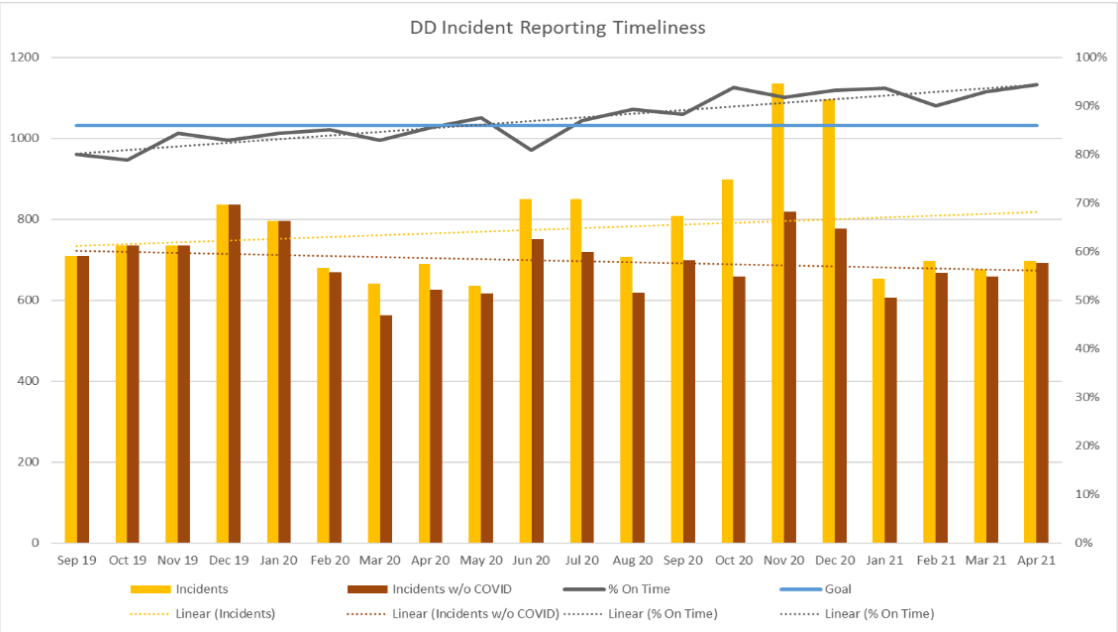
Late Reporting of Serious Incidents and Citations

On a quarterly basis, the IMU provides data to the RMRC about late reporting, the number of incidents for DD individuals (aggregated, region), type of incident (death or serious incident), and status of their work. IMU began collecting data in August 2019 when they began working in Region 4. In SFY 2021, based on data from CHRIS, there were a total of 9,753 incidents for individuals with DDs, 609 of which were reported late. Of those that were late, however; 134 were excused for reasons such as the CHRIS application being unavailable during the reporting window and the provider contacted the IMU through other means, within 24 hours, to let them

know of the incident. Therefore, there were a total of 475 unexcused late reports and 8,996 reported timely, meaning that 92% were reported within the required timeframes. This exceeds the target of 86%.

As indicated in the graph below, reporting timeliness has improved over time since SFY2020 and has consistently met or exceeded the goal of 86% since Q1 SFY2020 (Figure 3).

Figure 3: Incident Reporting Trend



5b (3) Medicaid Claims Review

To further validate that serious incidents are reported as required, DBHDS conducts an annual review of Medicaid claims data to identify potential incidents that may not have been reported as required. Specifically, DBHDS works with the Department of Medical Assistance Services (DMAS) to obtain claims for individuals receiving services under one of the DD waivers, who are also receiving a residential service, and who had a claim for an ER visit or a hospital admission. To identify instances in which an incident was not reported as required, DBHDS attempts to link the Medicaid claim file with CHRIS to determine whether there are claims for hospital admissions or ER visits without a corresponding SIR.

For SFY2021 DBHDS evaluated claims that were submitted during the time period 7/1/2020 – 9/30/2020. DMAS identified a total of 1,614 claims that met the matching criteria. The DBHDS Data Warehouse linked these claims with the CHRIS database and found 960 matching CHRIS reports for an initial match rate of 59.5%. It is possible that a matching CHRIS report was not found for reasons other than a failure of the provider to report. Potential reasons include:

- The incident may have been reported using a different spelling of the individual's name or Medicaid number, which could result in a match not being found;Regulations require reporting of an *unplanned* hospitalization; it is possible that the claim submitted was for a planned hospitalization, which would not have required reporting; The emergency regulations in effect during the time period of this review did not require reporting ER visits that occurred *in lieu of a PCP visit* (this has been changed in the final regulations). To determine the status of the remaining 654 claims that did not have a matching CHRIS entry, the OIH made contact with each provider that was associated with the unmatched claims. The DBHDS provider was determined by linking the Medicaid claim file with WaMS to identify the residential provider authorized for services during the date the claim was filed. For each unmatched claim, OIH documented the provider's response as to whether or not they submitted a report in CHRIS for the incident; and if they did not, the reason. Based on these responses, each unmatched claim was grouped into those that could be excused, or not excused; those falling into the 'excused' category were those where:

- Claims in which a report was filed in CHRIS but not identified during the matching process;
- The individual was on leave and staying with family during the incident;
- The ER visit was in lieu of a primary care visit (during the time period of the review these were not required to be reported);
- There appeared to be multiple claims for a single incident (e.g., two separate ER bills when an individual remained in the ER over two days; an ER and hospital claim when a single incident resulted in an ER visit and admission);
- There was a planned hospital admission or procedure.

Based on this review, a total of 388 of the claims were determined to be excused (either they were reported in CHRIS, or they did not meet the requirements for reporting). In the chart below, unreported incidents are broken down by reason for each of the 388 incidents.

Table 11: Medicaid Claims – Not Reported (July 1, 2020-September 30, 2020)

Reason	Number	Percent
Incident found in CHRIS	146	38%
ER in lieu of PCP visit	116	30%
Planned procedure	55	14%
Provider has no record/Not aware at time	31	8%
Individual with family	21	6%
Multiple Claims for 1 incident	11	3%
Not with provider during DOS	8	2%
Grand Total	388	

Of the remaining claims, 89 were determined to have been incidents that should have been reported in CHRIS. In some of these cases the provider determined that the incident should

have been reported but was not, due to an oversight or a misunderstanding of the reporting requirements. For example, several providers stated that they did not report ER visits because the individual was not admitted to the hospital. Information was not able to be obtained on the remaining 177 claims. For purposes of determining timely reporting (below), these are considered to be incidents that were not reported in CHRIS, until determined otherwise.

To determine the adjusted rate of timely reporting based upon information from this claim review, DBHDS added all of the claims that did not have a matching CHRIS entry and were not determined to be excused, from reporting, to the total number of serious incidents for SFY2021. The IMU reported a total of 9,753 serious incidents reported in CHRIS; of these 8,996 (92%) were timely. This claim review identified an additional 266 claims that represented serious incidents that should have been reported but were not (89 claims determined to represent incidents that required reporting + 177 claims for information regarding the incident was not obtained). Adding this to the total number of serious incidents brings the total number of serious incidents to 10,019; the number reported timely remains at 8,996; thus 90% were reported timely.

Care Concerns

DBHDS has set risk triggers and thresholds to identify circumstances where there is potential risk for more serious future outcomes, which are called "care concerns". Care concern (CC) protocols serve as triggers for providers that a problem may exist and that the provider should reassess the individual's care plan to determine whether additional services or supports are needed to mitigate risks. IMU identified the following thresholds as individual CCs that require further review.

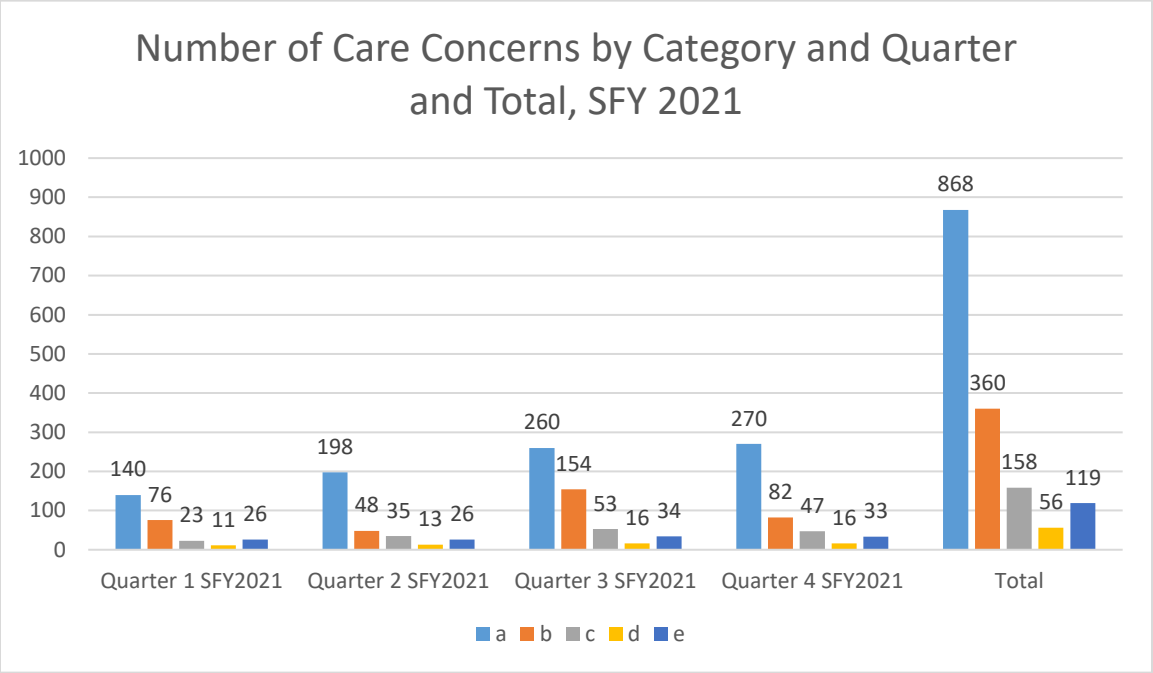
a. Three or more unplanned medical hospital admissions, ER visits, or psychiatric hospitalizations within a ninety (90) day timeframe for any reason.
b. Multiple (two or more) unplanned medical hospital admissions or ER visits, for the same condition or reason, that occur within a thirty (30) day timeframe.
c. Any combination of three or more incidents, of any type, within a thirty (30) day timeframe.
d. Multiple (two 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 timeframe
e. Any serious incidents involving medically verified decubitus ulcers or bowel obstructions

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

- Multiple (five or more) serious incidents occurring at a licensed location within a 30 day timeframe.
- Repeat citations (three or more) for a provider who has failed to report serious incidents within required timeframes.

There were a total of 1,561 CCs identified in SFY2021. The graph below shows the number of CCs by type (a-e) and by quarter during SFY2021. The most common CC was "a" (868) and was more than double the second most common CC "b" (360).

Figure 4: Care Concerns



The IMU shares all CCs with the Licensing Specialist and with OHR and OIH for follow-up and TA, as needed and to help determine where prevention focused trainings for providers are needed. In September 2020, three CC reports were made available in CHRIS to all providers: "Individual Care Concerns," "Provider Care Concerns," and "Case Management Care Concerns". These reports enable the providers to identify when a new incident has met the threshold for classification as a CC. Providers are expected to monitor CHRIS to track when the threshold for a care concern has been identified and to review the individual's care plan accordingly.

The IMU and the OIH have noted that the number of CCs, that are identified on the basis of the existing triggers and thresholds, and have identified a number of cases in which additional follow-up, or changes to the care plan have not appeared to be necessary. The IMU and OIH identified the need to narrow the scope and focus on the most critical cases. Therefore the list of triggers and thresholds are being revised for SFY2022. In addition, the RMRC has reached out to Project Living Well (PLW) which is a grant funded effort coordinated by Virginia Commonwealth University (VCU), to conduct a review of the current triggers and thresholds and make recommendations of changes to the risk criteria, as well as assist in evaluating their impact. Additional information on this effort will be available in SFY2022.

5b (4) Findings: Issues Identified and Mitigating Strategies

In the previous annual report, RMRC noted the concerns with obtaining valid and reliable data and the impact this has on review and analysis of data. These issues continued into SFY2021. For example, there is not a single unique identifier for individuals in CHRIS which presents challenges toward identifying unique individuals that are affected by serious incidents and in linking this data to WaMS. Thus, while reports from CHRIS may identify the number of incidents that are reported, it is not possible to determine how many individuals are impacted; and whether there are a small number of individuals who are experiencing a majority of the incidents. This issue is unlikely to be resolved 100% until there is an enterprise system developed. DBHDS is working towards developing an enterprise system which will hopefully be available within the next 1-2 years.

Despite these known issues, RMRC addressed various challenges regarding the collection, review, and analysis of data; multiple reporting issues were resolved during the fiscal year through collaborative efforts of IMU, OIH, DQV and the Data Warehouse. For example, during SFY2021, IMU staff worked diligently to remove duplicate entries in CHRIS when applicable. In addition, RMRC addressed the concern of incorrect region codes being associated with SIRs, in order to assure the accuracy of regional data.

The RMRC continued to be concerned about "other" being a leading category for serious incident causes, illness/conditions, and injuries. In SFY2021 there continued to be a high number of conditions and injuries that are described as "other" with "other" being the 2nd leading cause (16.93%), the leading illness/condition (27.72%) and the leading injury (28.77%). During SFY2021, the RMRC Data Workgroup conducted an analysis of SIRs in which "other" was selected as the only injury, illness or cause and provided recommendations to the OL. Recommendations centered on improving staff training and exploring the creation of several additional categories that would better describe SIRs. This work will carry into SFY2022

In early SFY2021, RMRC further explored questions related to SIS level and risk, in response to questions raised at RMRC during SFY2020. RMRC reviewed data and information provided by the Office of Waiver Service (OWS) related to assigning a SIS default of Level 2 and timeliness of SIS assignment. The RMRC concluded that the default of Level 2 seems appropriate and was satisfied that OWS is implementing mitigation strategies to improve the timeliness of SIS assignment.

Part 5c. Licensing Inspections

5c (1) RMRC Responsibilities and the Role of the Office of Licensing

The RMRC is tasked with systematically reviewing and analyzing data related to findings from licensing inspections and investigations. OL is responsible for conducting licensing inspections and investigations and assessing providers' compliance with QI and RM program requirements.

5c (2) Data Analysis: OL Measures Reviewed

In the previous year of SFY 2020, RMRC observed that several licensing measures associated with two RMRC Performance Measure Indicators (PMIs) were below the target of 86%; these are indicated by yellow shading in the table below.

Table 12: SFY2020 Risk Management & Quality Improvement Compliance

Note: Red indicates below 75%; Yellow indicates between 75% and 85%; and Green indicates above 86%

RMRC Measure / Performance Measure Indicator (PMI)	SFY2020
PMI: "Licensed providers meet the regulatory requirements for risk management programs. (Approved Sept. 2020) (% of providers that were assessed for RM requirements, that met RM requirements)	NA
Component A. Designated person with training or experience responsible for risk management function	89%
Component B. Implements a written plan	92%
Component C. Conducts annual systemic risk assessment	80%
Component D. Conducts annual safety inspection	88%
Component E. Documents serious injuries to employees, volunteers, etc.	86%
Measure: % of providers inspected that are in compliance with root cause analysis (RCA) requirements.	79%
PMI: "Licensed providers meet the regulatory requirements for quality improvement programs. (Approved Sept. 2020) (% of providers that are in compliance with QI provisions of licensing regulations; or who have implemented a corrective action plan.)	75%

Modifications to the licensing regulations, that took effect in SFY2021, enumerated specific requirements therefore it is not possible to directly compare SFY2020 with SFY2021. For example, the requirement under 12VAC35-105-520.C, to conduct an annual systemic risk assessment, was separated into seven separate regulations to address each requirement. Results for reviews conducted in SFY2021 are presented below.

Table 13: SFY2021 Risk Management & Quality Improvement Compliance

Note: Red indicates below 75%; Yellow indicates between 75% and 85%; and Green indicates above 86%

RMRC Measure / Performance Measure Indicator (PMI)	SFY2021 (Q3 & Q4)
Risk Management Program Requirements	
% of licensed DD providers that have met 100% of the risk management requirements (excludes Not Applicable and Not Determined (NA and ND))	**71%**
• 520A - Designated person with training or experience responsible for risk management function	**88%**
• 520B - Implements a written plan	**86%**
• 520C - Conducts annual systemic risk assessment	**85%**
• 520C1 - environment of care	**80%**
• 520C2 - clinical assessment/reassessment	**81%**

• 520C3 -staff competence / adequacy of staffing	79%
• 520C4 - use of high risk procedures	85%
• 520C5 - review of serious incidents	79%
• 520D - Systemic risk assessment incorporates risk triggers and thresholds	90%
• 520E - Conducts annual safety inspection	71%
Quality Improvement Program Requirements	
% of providers that are compliant with 100% of the QI Requirements	62%
• 620A - Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	87%
• 620B - The QI program uses standard QI tools, including RCA and has a QI plan	92%
• 620C - The QI Plan shall:	80%
• 620C1 - Be reviewed and updated annually	77%
• 620C2 - Define measurable goals and objectives	84%
• 620C3 -Include & report on statewide measures	73%
• 620C4 - Monitor implementation & effectiveness of approved CAPs	77%
• 620C5 - Include ongoing monitoring and evaluation of progress toward meeting goals	87%
• 620D - The providers P&P includes criteria used to:	75%
• 620D1 - Establish measurable goals & objectives	74%
• 620D2 - Update the QI plan	65%
• 620D3 - Submit revised CAPs when not effective	79%
Input from individuals about services & satisfaction	62%

5c (3) Findings: Issues identified and Mitigating Strategies

In response to these trends in the data, the OL implemented mitigating strategies to improve provider compliance with regulations related to RM and QI. During SFY2021, OL hired a Quality Improvement Specialist (QIS). This QIS led the development of additional guidance, revised regulations, and trained specialists to promote standardization. OL identified the need to give providers information on where to start with developing a QI program. OL also provided a series of webinars to review the DOJ regulations and highlight the RM and QI provisions and expectations. OL provided training on the Final Regulations (October 2020) and QI, RM and root cause analysis (November 2020). The Center for Developmental Disabilities Evaluation and Research (CDDER) provided additional training, via Zoom, on QI and RM (December 2020) and OHR provided training on conducting investigations (March/June 2021); DBHDS posted the trainings to the OL webpage and included "Frequently Asked Questions." In addition, DBHDS provided four free training modules for DD providers through CDDER: data analysis, incident management, risk screening and RCA. Over 150 people attended each module. In February 2021, OL issued a RM crosswalk and attestation, listing the training providers' risk managers must complete for compliance. If a provider fails to provide an attestation of completed training, they receive a citation; the CAP is not accepted without a completed attestation. In June 2021, OL also published and provided training on a sample RM plan, a sample systemic risk assessment plan and a sample QI plan.

The RMRC and OL will continue to evaluate providers with these RM and QI requirements and will implement additional strategies, as needed, to improve provider understanding and compliance.

Part 5d. Risk Mitigation and Provider Resources

5d (1) RMRC Responsibilities and the Role of OIH

The RMRC is charged with utilizing 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; to ensure the annual review of such guidance, training, or educational resources; and update as necessary and to review publications yearly and revise as necessary to ensure current guidance is sufficient and is included in each alert. RMRC is also charged to use data and information from RM activities to identify topics for future content as well as determine when existing content needs revision.

The Office of Integrated Health (OIH) is a key partner for RMRC and leads the efforts to meet these requirements. OIH assesses the needs and resources available for providing health services and supports to persons with DD. While OIH is primarily focused on individuals with DD, they broaden their focus when needed to assist expanding the needs of individuals with serious mental illness. They work to find new, innovative ways to effect change and decrease barriers across agencies.

5d (2) Risk Awareness Tool

During SFY2020, the OIH developed a Risk Awareness Tool (RAT) to help improve providers' awareness of individuals' health and safety risks and to plan next steps accordingly. The tool focuses on the leading risks known to individuals with DD. The areas assessed are: Pressure Injury, Aspiration Pneumonia, and fall with Injury, Dehydration, Bowel Obstruction, Sepsis, Seizure, Community Safety Risks, Self-Harm, Elopement, and Lack of Safety Awareness. The expectation is that providers complete the RAT at least annually, during the annual ISP meeting and upload the summary page into WaMS. In July of 2020, this tool was launched and, after some user feedback and final edits, was fully implemented statewide by November 2020. Supplemental trainings were also made available to providers. As of December 2020, 1,315 people had completed the online RAT Supplemental Training.

A review of the RAT process in SFY2021 showed that, of a sample of 300 individuals (150 each from Q1 and Q2 in SFY2021 with representation from each Community Services Board), 52.3% of individuals had a RAT summary page uploaded. When the summary page was not uploaded it means it was not uploaded properly; it does not mean that the RAT tool was not done. OIH has been providing individualized TA to CSBs to help ensure correct utilization of the RAT going forward. As data becomes available, RMRC will review and analyze it 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.

5d (3) Health Alerts, Newsletters and Education Resources

OIH issued the following health alerts and newsletters during SFY2021 as means to assist providers in identifying and preventing health and safety risks. These alerts include mitigating strategies as well. Alerts are reviewed bi-annually and updated to align with medical guidance. 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.

Health and Safety Alerts:

- August 20 -Dysphagia Health & Safety Alert
- July 2021-Dental Health Awareness Health & Safety Alert
- May 2021-Basic Nutrition Health & Safety Alert
- April 2021Healthcare Advocacy
- March 2021-Urinary tract infection H&S Alert
- February 2021-Psychotropic Medications
- January 2021-Sepsis
- December 2020 -Diabetes Overview - Part 1
- December 2020 -Diabetes Management - Part 2
- November 2020 -Choking
- October 2020-Pneumococcal Vaccine
- October 2020-Influenza
- September 2020-Recognizing Pain
- July 2020-Pressure Injury

Newsletters:

- July 2020 – Fatal Four
- August 2020 – Skin Integrity
- September 2020 – Pain Awareness Month
- October 2020 - Influenza (Flu) Vaccines & Pneumococcal Vaccine
- November 2020 - Advocacy
- December 2020 - Diabetes during the Holidays
- January 2021 - Sepsis
- February 2021 - Neuroleptic Malignant Syndrome (NMS)
- March 2021 - National Kidney Month
- April 2021 - National Minority Health Month
- May 2021 - Food Allergy Awareness
- June 2021 - About the COVID-19 Vaccine

Education Resources

- Additional supplemental resources were published that provide key information to individuals, families and direct support professionals using everyday language.

Training

- Special Needs Oral Health (collaboration with VDH)
- Skin Integrity & Pressure Injury
- Falls
- Mobile Rehab Engineering and Everything Durable Medical Equipment (DME) and Assistive Technology
- Fatal 7

Guidance for Vaccinating Individuals with IDD - posted April 2021 - FY2021Q4

- Part1_Guidance for Vaccinating Individuals with IDD
- Part2_Guidance for Vaccinating Individuals with IDD

Health Risks - all posted October 2020 - FY2021, Quarter 2

- Aspiration Pneumonia PP
- Constipation and Bowel Obstructions PP
- Dehydration PP
- Falls PP
- Pressure Injury Training PP
- Seizures PP
- Sepsis PP

Nursing Continuing Education Units were offered on the following topics:

- Dehydration
- Care and Management of Pressure Injuries
- Pain Awareness
- Flu and Pneumonia Vaccines
- Choking
- SEPSIS
- Psychotropic Medications
- Urinary Tract Infection
- Healthcare Advocacy
- Nutrition

COVID Follow- up

- OIH Registered Nurse Care Consultants (RNCCs) collaborated with OL to follow up and provide educational resources on infection control (specific to COVID 19) and offer TA on related health and safety topics for concerns identified for 1,610 people, with a developmental disability, and 2,600 people, receiving MH and SA services, who had been reported as testing positive for COVID-19.

- Follow-up activities involved 280 providers, 190 of which represented DD licensed providers.

Part 5e. Facility Risk Management Programs - Training Center

RMRC is charged to review and analyze data and identify trends related to DBHDS facility RM programs, to reduce or eliminate risks of harm and to monitor the effective implementation of Departmental Instruction 401 (Risk and Liability Management), by reviewing facility data and trends, including risk triggers and thresholds (to address risks of harm). In SFY2021, Southeastern Virginia Training Facility (SEVTC) began reporting quarterly data to the RMRC. SEVTC's quality council committee oversees a variety of QI committees including a RM patient safety committee and a mortality review committee. In SFY2021, SEVTC shared its data showing trends in serious incidents, abuse/neglect/exploitation allegations and substantiated reports, UTIs, falls, and use of restraints. The data showed a significant reduction in physical restraints (11 in CY2018, 11 in CY2019 and 2 in CY2020) and mechanical restraints (13 in CY2018, 5 in CY2019 and 0 in CY2018), a decline in UTIs from 29 individuals with UTIs diagnosed in CY 2019 to 26 individuals in CY 2020, and a slight decrease in the fall rate from 0.38 in CY2019 to 0.32 in CY2020. The QI efforts were focused on staff turnover, reduction in peer-to-peer incidents, flu vaccines, reducing falls and developing UTI protocols.

Part 5f. Other Data Review

5fa. Quality Service Review Data

RMRC, along with the other QIC Subcommittees, is responsible for reviewing Quality Service Review (QSR) findings. RMRC reviewed the results from Round 1 of the SFY2021 QSR. The results related to provider implementation of QI and RM programs seems similar to or slightly higher than the OL data that the RMRC reviewed. RMRC identified the biggest opportunities for enhancement exist in the areas of crisis support services, independent living supports and group program (with four or fewer individuals) and determined that this may warrant targeting improvement efforts toward group residential programs. It was noted that results were consistent with what RMRC is seeing in OL reviews or provider QI and RM programs. OL has already identified this as a concern and is working to improve the results; see Section 5c(3).

Part 6. Quality Improvement Initiatives

6a. Falls/Trips QII

In SFY2019 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. The Falls QII was formally approved by the QIC on June 30, 2020. The Aim was to reduce the rate of hospitalizations, ER visits, or serious incidents that are caused by a fall, among DD waiver recipients, by 10%, down from a baseline of 63.2 per 1,000 waiver population during the period 10/1/19 – 3/31/20, to 56.88 per 1,000 during SFY20202021. (Numerator: SIRs in which "Fall/Trip" checkbox is checked. Denominator: Waiver population from WaMS, estimated using midpoint of fiscal quarter)

The change focused on the following strategies:

- Developing educational/training materials that address risk awareness and fall prevention;
- Increasing provider awareness, through the development of informational resources and training;
- Implementing structured risk awareness tools and processes; and
- Conducting specific outreach to providers that have reported multiple falls with hospitalizations or ER visits.

A Falls QII Workgroup met monthly during SFY2021 and oversaw implementation of the Falls QII, assessed and documented progress using the PDSA (plan-do-stud-act) cycle, identified barriers and planned solutions, and reported regularly to the RMRC. The Falls QII Workgroup consisted of representatives from OIH, OHR, Provider Development, the IMU and OCQM. Each strategy and its status in the Plan, Do, Study, Act cycle is described in the following table.

Table 14: SFY2021 Falls QII Implementation

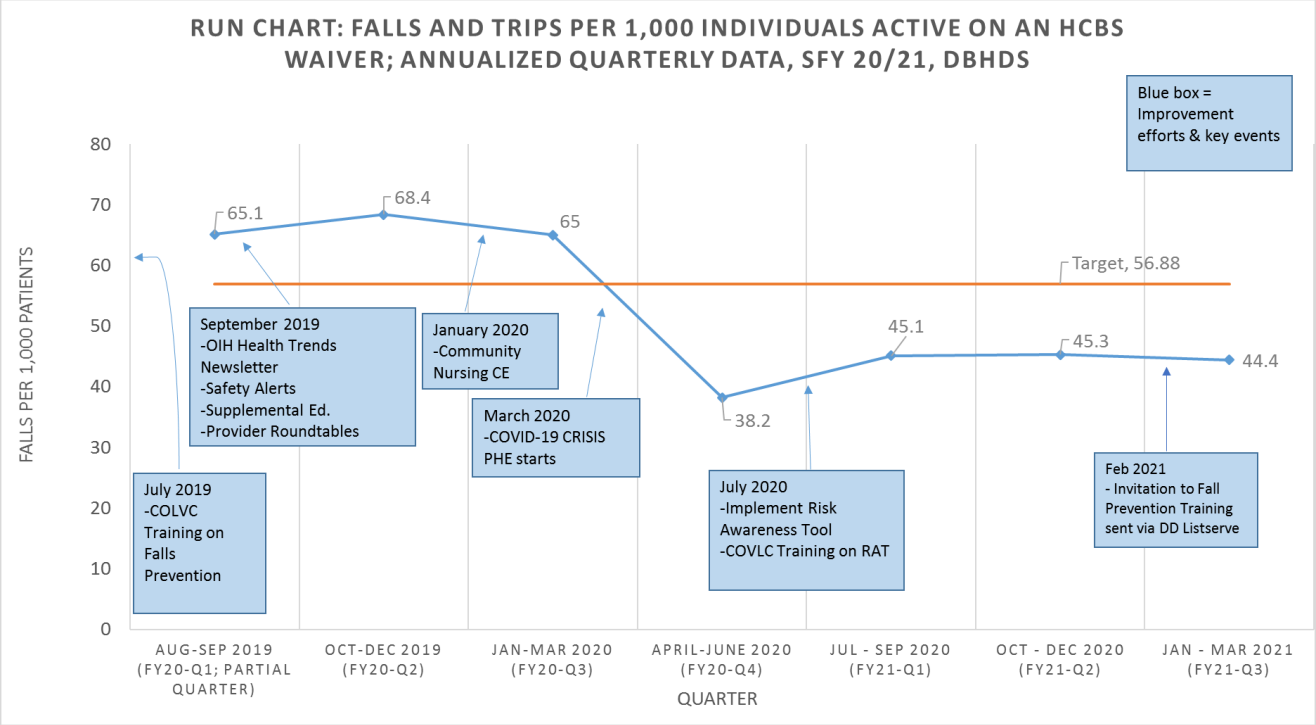
SFY2021 Falls QII Implementation S (Plan-Do-Study-Act Cycle):				
Change / Strategy	**Hypothesis (Prediction)**	**Plan / Do**	**Study**	**Lessons Learned / Act**
1. DBHDS will Implement Risk Awareness Tool, and it will be incorporated into ISP process	We believe the RAT will identify new fall risks and, as a result, ISPs will be updated to incorporate prevention strategies	RAT launched July 2020 Fully Implemented November 2020 Of 300 individuals reviewed, during Q1/Q2, 157 had a RAT completed.	We evaluated the #, % of RAT tools that identified fall risk. Results: • Of those with a completed RAT, 23 (14.6%) RATs identified new fall diagnoses and 37(23.6%) identified new fall risks • % of completed ISPs incorporating RAT • Pending: OIH will examine the percent of ISPs (with fall risk identified) updated based on identified fall risk in the RAT	We learned… -The RAT appears to help identify new risks for falls -Half of sample did not have RAT uploaded correctly <u>Act:</u> OIH will provide TA to CSBs on correct use of RAT – including individual guidance to SCs
2. OIH and IMU will identify providers that reported care concerns (CC), encourage providers to review of individual's care plan and conduct environmental assessment; inform providers	We believe providers with fall-related CCs will voluntarily* complete falls training have increased knowledge and intention to incorporate fall prevention strategies into their work.	The CC follow up process was fully implemented April 2021. Follow up included invitation to Falls Training and the provision of resources: *First Aid for Falls Health & Safety Alert;* First Aid for Falls PPT Training; Falls Prevention	We evaluated the # of providers meeting risk triggers for falls • Result: From April 1 – June 2: Out of 480 CCs, 44 (9.2%) CCs involved falls (39 providers) We evaluated the #/% providers who receive follow up • Result: 100% have received follow up	We learned… -OIH identified the need to improve communication and the process for tracking and following up on CCs • <u>Act:</u> Actively engaged in the testing phase

of resource materials and invite them to take on-line fall prevention training.	(*It is not required.)	Health & Safety Alert; Falls Health Risk PPT Supplemental RAT Training; and OIH Newsletter focused on Fall Prevention.	We plan to study the % of providers receiving invitations who participated in OIH falls training • Pending OIH training survey results	
3. Disseminate information on fall prevention, to varied audiences through Various educational events including Fall Prevention training and RAT training.	We believe people will complete falls training, report increased knowledge and intention to incorporate fall prevention strategies into work. We believe people will access educational materials on the DBHDS OIH website.	• The RAT training w/ Falls component was implemented Fall 2020. • The COVLC Falls training launched 2019 (invite only); Global invite Feb. 2021; Updated June 2021. • The Wheelchair Transitions training launched May 25, 2021. • Other educational resources are available on the OIH website (newsletters, health alerts). • Fall Prevention Month 2020 – Postponed until 2021	We evaluated the # of providers accessing and completing training materials through COVLC training. A survey of participants indicated that: • 72% (42/58) learned new strategies or interventions' • 18% used the info to update an ISP • 26% used the info to change an individual's Fall Risk Plan • 15% used the info to update the QA plan We plan to track downloads and access to resources (newsletters, health alerts) on website. • Pending action by I.T.	We learned… • People will complete the training and preliminary results show it has a positive impact • Participation in training spikes after OIH promotes it to providers • Tracking clicks to web resources is more difficult than imagined <u>Act:</u> Actively engaged in testing phase
4. Regularly monitor data	We believe we will understand the trend and whether our strategies are having an impact.	Data are pulled monthly from Tableau and shared with the QII Workgroup and RMRC committee.	Since COVID-19 began, in March 2020, the rate of falls has stayed below the QII goal of 56.88 per 1,000.	<u>Act:</u> Continue monitoring this at least quarterly.

Preliminary trend analysis indicated that there was a dramatic decrease in the rate of falls at the beginning of Q4 of SFY2020; the rate has remained at a lower rate than the RMRC target (Aim) (see below). The fall rate fluctuated from a high of 76.29 per 1,000, in January 2020 (pre-COVID-19), to a low of 19.09 per 1,000 in April 2020, coinciding with the Governor's 'stay at home' order and restrictions on businesses due to COVID-19. The average falls rate continued to be lower than all incidents and it dropped more than the overall rate of SIRs. RMRC hypothesized that at least some of the decrease 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. Thus it is not possible to know how much of the decrease may have been due to the QII activities. RMRC has decided to continue the QII during SFY2022 to be able to monitor the rate of falls as services re-open and individuals return to pre-COVID-19 transitions.

Figure 5: Falls QII – Run Chart



Beginning in October 2020, RMRC was able to review serious incident data, including falls, in the Tableau dashboard, using various filters to include 2 week intervals and demographic variables. The data showed that the falls rate for females tended to be higher than for males; people identifying as white showed a disproportionately higher rate of falls; people over age 50 had a higher rate of falls than younger people. This type of information will continue to be reviewed; the RMRC observed that the ability to identify impact to a subset of the population could result in the ability to target a sub-population with improvement initiatives.

6b. Medication Error Review QII

During SFY2021, RMRC considered several potential topics for a QII. The topics considered were:

- Improving licensed provider ability to meet the regulatory requirements for RM programs;
- Improving licensed provider ability to meet the regulatory requirements for QI programs;
- Improving the rate of SIRs with UTI as the illness/condition; and
- Increasing the percent of providers licensed to administer medication that are NOT cited for failure to review medications quarterly.

RMRC used the QII Toolkit, developed in November 2020 by OCQM, specifically the "Could This Be a QII" and "Which QII Should We Choose" portions of the tool to determine which QII to select. The RMRC decided not to focus on improving licensed provider ability to meet regulatory requirements for RM and QI programs because the licensing regulations and definitions for these terms changed in November 2020 so the data would not be consistent from FY2021 to FY2020. Additionally, OL is already implementing mitigating strategies in these areas. RMRC did not focus on improving the rate of SIRs with UTI as the illness/condition because they felt that mitigating strategies could be tried first, and that improvement would rely heavily on OIH to implement the changes but they are already heavily involved in multiple QIIs. Thus, the RMRC's focus on increasing the percent of providers licensed to administer medication that are NOT cited for failure to review medications quarterly A QII was proposed and approved by the QIC on June 28, 2021.

Part 7. Performance Measure Indicators

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. A tracking log, reflecting all surveillance and PMI measures, was created to allow for easy review of data to identify trends and determine if the measure needs to be elevated to a PMI or addressed in the development of a QII. While no new PMIs were added for SFY2021; the PMIs for provider compliance with the requirements for RM and QI programs were revised at the end of SFY2021 to align with changes in the final Licensing regulations (promulgated in SFY2021) which separated RM and QI program requirements into individual sub-regulations.

In SFY2021, the RMRC monitored eight PMIs (as indicated in the table below) related to the reporting of critical incidents, reviewing medication errors, implementing corrective action plans, following regulations regarding restraint and seclusion, and meeting requirements for provider QI and RM programs. The PMIs for reporting serious incidents within 24 hours; verifying implementation of corrective actions; following regulations for implementation of seclusion and restraint; and the rate of falls, all met their identified performance goal. The licensed providers meet regulatory requirements for RM programs and "licensed providers meet regulatory requirements for QI programs" PMIs were retired in SFY2021 due to changes to in Licensing regulations and in CHRIS reporting interfaces; these changes resulted in the need to change the PMIs for provider QI and RM.

Table 15: Performance Measure Indicators, SFY2021

Performance Measure Indicators – Safety and Freedom from Harm	Target	SFY2021 Q1 Results	SFY2021 Q2 Results	SFY2021 Q3 Results	SFY2021 Q4 Results	SFY2021 Overall Results	Performance Assessment
Critical incidents are reported to the Office of Licensing within the required timeframes (24-48 hours)	86%	96%	95%	94%	95%	95%	√ Meeting target

Licensed DD providers, that administer medications, are NOT cited for failure to review medication errors at least quarterly	86%	Data Not Available*	Data Not Available*	Data Not Available*	Data Not Available*	Data Not Available*	Data Not Available*
Corrective actions for substantiated cases of abuse, neglect and exploitation are verified by DBHDS as being implemented	86%	100%	99%	99%	96%	98%	√ Meeting target
State policies and procedures, for the use or prohibition of restrictive interventions (including restraints), are followed	86%	100%	100%	100%	100%	100%	√ Meeting target
The state policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed	86%	99.7%	100%	100%	99%	99.8%	√ Meeting target
Licensed providers meet regulatory requirements for risk management programs: (average of 5 regulations – retired)	≥86%	82%	80%	NA	NA	NA	Retired
Licensed providers meet 100% of regulations for risk management programs (new PMI approved Sept 2021)	≥86%	NA	NA	69%	55%	62%	Baseline Below target
Licensed providers meet regulatory requirements for quality improvement programs (based on single regulation – retired)	≥86%	70%	90%	NA	NA	NA	Retired
Licensed providers meet 100% of regulations for quality improvement programs (new PMI approved Sept 2021)	≥86%	NA	NA	58%	45%	51%	Baseline Below target
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	45.1	45.3	44.4	45.9	45.1	√ Meeting target

*The reliability of the measure of provider compliance with the requirement to conduct quarterly reviews of medication errors is being re-assessed and therefore data for SFY2021 is not available.

The emergency licensing regulations that established requirements for provider RM and QI programs became final in August 2020. The final regulations separated some requirements of the regulation into additional sub-regulations such that the requirements for provider RM programs increased from five to ten sub-regulations; and the requirements for provider QI

programs increased from a single regulation to 13 sub-regulations. To best align with the wording of the Settlement Agreement compliance indicators, these two measures were revised to measure the percentage of providers that are compliant with 100% of the regulations for which they were evaluated. The RMRC and the OL will continue to review overall compliance on each of the specific sub-regulations to determine which areas providers need assistance.

Additionally, changes to the CHRIS interface and subsequent improvement in Data Warehouse reports has allowed more accurate calculation of the PMI that measures the reporting of serious incidents. While regulations require providers to report serious incidents within 24 hours of discovery, the CHRIS interface only captured the date, but not time of discovery. Consequently this measure previously calculated the percent of providers that reported incidents within one day of the incident; which could have been up to 48 hours (e.g., incident at 12:01 am 10/1/20 reported by 11:59 pm 10/2/20 would be considered compliant, even though it is over 47 hours from the event). Beginning in November 2020, the Data Warehouse report was able to calculate the timeliness of incidents to the minute. While this change resulted in fewer incidents being recorded as timely, it did not have a significant impact on the percentage of incident considered to be reported timely.

The baseline data from Q3 and Q4 indicated that 62% of providers met all of the applicable requirements for RM programs, and only 51% of providers met all of the applicable requirements for QI programs. The OL provided training on developing RM and QI programs in November and December 2020 and then provided additional tools to help providers meet these requirements in April of 2021. It is too early to tell the extent to which these efforts may have helped to increase compliance. The RMRC and OL will review SFY2022 Q1 and Q2 data to determine additional areas where further improvements are needed.

During a review of the measure reliability between the RMRC Data Workgroup and DQV, the data for Q3 could not be replicated by following the documented data processes; following the documented data processes produced a result of 70% achievement, as opposed to 89% previously reported to the RMRC. This was primarily because the documented process did not exclude non-applicable and non-determined (NA and ND) findings from the denominator; this resulted in an artificially low result (70%). RMRC recommended the measure be revised to exclude NA and ND from the denominator as a more valid representation of the provider compliance with this requirement. This will be presented to the QIC in SFY2022.

Part 8. Conclusion

Over the past year RMRC continued to fulfill the responsibilities outlined in its charter. RMRC implemented a number of recommendations made in previous years, including adding the capacity to examine trends in serious incidents and abuse, neglect and exploitation data, by adding variables such as age and gender to the CHRIS system, and following up on concerns regarding SIS assignment and financial exploitation. RMRC took steps to address serious incidents categorized as 'other' as well as furthering the understanding of neglect. RMRC

formed workgroups including a falls workgroup, a UTI workgroup, a medication error workgroup, and other QII workgroups to focus on specific QIIs and mitigating strategies. This has led to a greater focus to each initiative and helped to ensure the completion of follow-up on planned activities, including following the plan-do-study-act cycle. Over the next year, efforts will continue to focus on refining the collection and presentation of data, with a focus on ensuring consistently reliable data are trended over time. The RMRC will also utilize specific QI tools that have been developed to increase consistency in the review, and follow-up of opportunities for improvement.