Virginia Department of Behavioral Health & Developmental Services

Risk Management Review Committee Annual Report

July 1, 2021 – June 30, 2022

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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 receiving developmental disability services. In SFY2022, the subcommittee monitored available data in a time of data system transitions. The data reviewed included licensing inspections, incident management data, training center risk management (RM) activities. Three performance measure indicators (PMIs) derived from this data were monitored. Two of the three, which focused on provider compliance with requirements for risk management and quality improvement programs did not meet their established goals.

The RMRC also continued the falls quality improvement initiative (QII), abandoned a medication error review QII, proposed a QII to improve compliance on two key risk management regulations (based on not meeting PMI goals); refined its processes for reviewing needs for new educational content and conducted two case reviews. The committee identified issues of data quality from the incident management system (CHRIS) which negatively impacted the committee's ability to identify system-wide trends. These issues have been prioritized for remediation and are expected to be completed in SFY2023.

RMRC made progress on several recommendations from previous years and made recommendations for the current year, many of which stemmed from the case reviews. Several of the recommendations addressed improvements in data quality:

- Reduce utilization of the 'Other' category in CHRIS,
- Align the service type and population across CONNECT, CHRIS, and the Data Warehouse to ensure the validity of reports by population served,
- Develop solutions to attribute incidents to unique individuals across providers and settings; and
- Provide licensing compliance data aggregated by region.

Additional recommendations came from case reviews and a review of performance measurement indicators (PMI):

- Develop tools to assist providers in conducting a root cause analysis of medication errors,

- Elevate a single episode of choking to be a 'care concern' and develop additional training for providers to reduce choking risks,
- Create a Health and Safety Alert on Down Syndrome and Alzheimer's Disease; and
- Develop a structured process for reviewing and revising 'care concerns.'

As RMRC enters SFY2023, RMRC will work to prioritize recommendations and activities to ensure implementation; monitor improvements in data availability so that review of crucial data can resume as soon as possible; and assess progress in implementing the current QIIs as it looks for additional QII opportunities.

Part 2. Committee Purpose and Structure

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. RMRC is charged with systematically reviewing and analyzing data related to serious incident reports (SIRs); deaths; abuse, neglect and exploitation (ANE) allegations; findings from licensing inspections and investigations; and other related data. RMRC also reviews related data collected from community service providers and the training center and data and information related to DBHDS program activities. 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 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 care, 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 of individuals receiving developmental disability services. 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 subcommittee.

In SFY2022, the RMRC had several workgroups to help move the work forward between meetings: the Data Workgroup, the Falls QII Workgroup and the 520C/D QII Workgroup. The Data Workgroup meets monthly between RMRC meetings, to plan and review data presentations made to the full committee, address data quality concerns and implement RMRC recommendations related to data. The workgroup has also focused on more detailed analyses of PMIs and surveillance data; refining operational definitions; identifying potential threats to the validity and reliability of measures; and discussing potential changes to PMIs.

Each QII workgroup includes staff from various departments across the agency and meets at least monthly to plan and implement activities related to the plan-do-study-act (PDSA) cycles of its initiative. The Falls QII workgroup focused on monitoring interventions that were implemented to reduce falls, reviewing data on their reach and effectiveness, and planned educational initiatives. The 520 C/D QII workgroup also included members of the Region V Regional Quality Council. This group conducted a root cause analysis of the barriers for providers to meet the risk management requirements, conducting key informant interviews with providers and licensing staff. They also began planning interventions to address the identified root causes.

The activities of the RMRC are discussed below, in sections aligning to the two key performance areas for which RMRC has performance measures - Health and Well-Being, and Provider Competency and Capacity.

Part 3. Health and Well Being

RMRC's overall process enables DBHDS to identify and prevent or substantially mitigate risks of harm. This aligns with the Health and Well-Being key performance area. RMRC reviews data and identifies trends and patterns, which aids in the determination of mitigating strategies and the need for new PMIs and QIIs. The following subsections describe the focus areas of the RMRC's work related to abuse, neglect and exploitation, serious incidents, risk mitigation and provider resources, and facility risk management programs. Each section discusses DBHDS office roles, data analysis and applicable findings. Further description of the role of each office can be found in the RMRC Program Description, available upon request.

Part 3a. Abuse, Neglect and Exploitation (ANE)

RMRC partners with the Office of Human Rights (OHR) to review abuse, neglect and exploitation (ANE) trend data and results from the OHR Community Look-Behind (CLB) quarterly, recommend the development of QIIs and address systemic needs. RMRC also reviews OHR materials and trainings, as requested, and provides input accordingly. More detailed information about these efforts in SFY2022 is provided below.

3a (1) Abuse, Neglect and Exploitation Reports and Trends

In SFY2022, valid and reliable ANE allegation and substantiation data were not available specific to individuals on a DD waiver. Please refer to Part 7 for additional information. In September 2021, the Office of Data Quality and Visualization (now referred to as the Office of Epidemiology and Health Analytics, or EHA) communicated to DBHDS leadership and key stakeholders that there did not appear to be a single comprehensive source of information classifying services by diagnosis group (i.e., Developmental Disability, Mental Health, Substance Abuse, Brain Injury). Specifically, all the lookup tables in the Office of Licensing Information System (OLIS), the Computerized Human Rights Information System (CHRIS), and the Data Warehouse were lacking complete information related to which program and service codes specialize in supporting individuals with DD. Without a reliable means of distinguishing between DD and non-DD

services, the ANE allegation and substantiation data retrieved from CHRIS may not be representative of all DD services. This would be especially problematic for the CLB study, which relies upon random sampling of ANE allegations to evaluate OHR business processes across the population of individuals with DD.

That said, OHR maintains the same business process and follows up on all allegations of ANE, irrespective of the service type. The information entered by providers into CHRIS and made available via Data Warehouse reports continues to inform the identification of trends and patterns to ultimately impact overall OHR outcomes regardless of service type. According to the Data Warehouse reports, there were 10,237 ANE allegations reported by licensed community providers of all service types (to include Developmental Disability, Mental Health, Substance Abuse and Brain Injury services) in SFY2022 with 1,049 (10% of the total), substantiated following the provider investigation and OHR review. This is a 2% increase in the overall number of substantiated allegations when compared to SFY2021 across all service types.

In September 2021, OHR provided an update about efforts to create additional categories of neglect, which was a recommendation from RMRC and multiple Regional Quality Councils (RQCs) in SFY2021. This grew out of analysis of SFY2021 data which found that the most frequently reported category of ANE was neglect; however, information about the specific types of neglect reported was not readily available. Adding specific categories of neglect will provide better information on the prevalence of types of neglect and assist in identifying improvement opportunities. In SFY2022, the OHR collaborated with EHA to explore the development of neglect categories in CHRIS. They reviewed all 485 neglect allegation reports between October 1, 2020, and March 31, 2021, that met inclusion criteria (entered by a CSB or community provider, individual receiving DD services on a waiver). Members of the OHR team reviewed the reports and categorized them into the following categories listed below. Inter-rater reliability analysis was included; a sample of 45 reports were categorized by multiple reviewers and checked for consistency. Findings indicated that the reviewers consistently identified the categories, with the percentages as follows.

- Medication error – 17%
- Elopement/AWOL (Absent Without Official Leave) – 14%
- Failure to provide nourishment, treatment, care, goods or services required – 41%
- Not neglect or insufficient information – 24%

It was recommended to move forward with adding "Medication Error", "Elopement/AWOL", and "Failure to provide nourishment, treatment, care, goods or services" as individual subcategories of neglect in CHRIS. These specific categories of neglect are not determined in regulation and therefore implementation only requires changes to the reporting system. OHR worked with the IT system administrators for CHRIS to identify an interface solution that would capture the detailed information at the "allegation" and "investigation" stage of the entry, as well as avoid loss or inability to correlate historical data. Updates to the application remain in the development phase, which will be followed by a testing phase (with a cross section of providers)

and provider/OHR staff training phase, prior to systemic implementation. Testing is expected to begin in January 2023, with implementation shortly after that.

OHR also updated RMRC on a quarterly basis regarding its efforts to update guidance for reporting medication errors as neglect. This was a recommendation from SFY2021. OHR has been working to develop this guidance for providers and has initiated consultation with the Board of Nursing, Department of Health Professions and internal DBHDS Offices such as Integrated Health, Pharmacy and Licensing to assess the varied terminology and systemic responses surrounding "medication errors". OHR has developed a draft document explaining expectations for licensed providers regarding when to report a medication error as potential abuse/neglect to OHR in CHRIS. The document contains defined terms (i.e., medication, medication administration, medication error, serious injury, abuse, etc.); expectations for a provider's internal review of medication errors; examples of medication errors that are reportable as potential abuse/neglect and under what circumstances a provider would not report a medication error to OHR in CHRIS as potential abuse/neglect.

3a (2) OHR Community Look-Behind (CLB)

OHR has operationalized a CLB process to validate that provider investigations are conducted in accordance with state regulations, and to identify where prevention efforts and mitigating strategies are needed. The CLB process provides data intended to demonstrate that reported cases of ANE are verified as properly investigated according to OHR regulations. The CLB uses a random sample of closed cases of abuse, neglect, and exploitation for individuals receiving DD services drawn from allegations in CHRIS. As the EHA prepared for the new year of the CLB, reviewing cases in SFY2022, they identified a data quality issue in OLIS that extended to CHRIS and the Data Warehouse tables. Without a means of distinguishing between DD and non-DD services, the sample of abuse, neglect, and exploitation cases retrieved from CHRIS for the CLB sample, may not be representative of all DD services. Rather, the sample would be representative of a subset of DD services that systematically excludes other DD services solely due to data quality errors. Without a clear way to group the program and service codes associated with DD services, it was not possible for EHA to retrieve a valid random sample of ANE allegations for DD services, and therefore OHR was not able to conduct the CLB in SFY2022.

Per EHA, this issue must be addressed in agency source systems before the ANE allegation and substantiation data could be considered reliable. EHA also does not support performing the CLB without a valid and reliable list of licensed services that includes the populations they serve, and this issue must be addressed before the CLB process can proceed. If the previous methodology for pulling the CLB sample were applied without this issue having been resolved in the source system, the CLB would suffer from systematic bias by potentially excluding DD services improperly classified as non-DD from the sample of cases eligible for review. This issue is especially pernicious as it would not be observable to OHR reviewers who are never assigned cases from non-DD services for review or validation.

As of November 2022, IT has modified the CHRIS interface such that providers now select from the specific services for which they are licensed. This now aligns with the services selected when reporting a serious incident. The specific services in CONNECT have been reviewed and verified that the population type for each licensed service is correct. However, there is a flaw within the CONNECT system where a user can change the service population type (i.e., Developmental Disability, Mental Health, Substance Abuse) for a specific provider service. For example, a user could inadvertently change the population type of a provider licensed for DD Group Home from Developmental Disability to Mental Health. A project is underway to establish a 1:1 relationship between each service and the population type so that it cannot be changed by individual users. This work is projected to be completed by the end of November 2022. Once this has been completed the CLB process will resume.

Part 3b. Serious Incidents

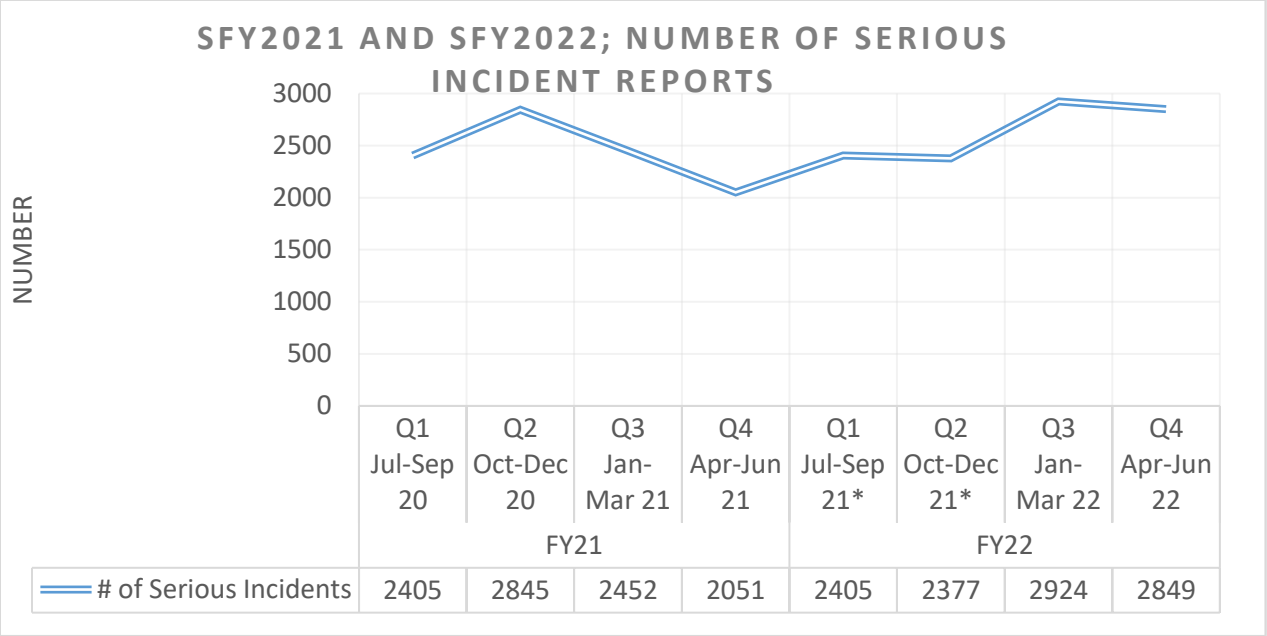
The RMRC is tasked with systematically reviewing and analyzing data related to SIRs, specific surveillance measures, the Incident Management Unit (IMU) Look-Behind, timeliness of SIRs and related citations, care concerns, and Medicaid claims reviews. Each task and associated data are described further in the sections below.

3b (1) Serious Incidents

The RMRC strives to review 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 monitors and responds to all reported serious incidents. RMRC achieves this in partnership with the Incident Management Unit (IMU) within the Office of Licensing (OL). The IMU reviews each serious incident to determine whether the information reported is complete and accurate using triage protocols to determine what technical assistance 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.

In SFY2021, the IMU reported that there were 9,753 serious incident reports entered into CHRIS for developmental disability service providers. In SFY2022, the IMU reported that there were 10,555 serious incident reports. Figure 1, below, depicts the number of serious incident reports for each quarter.

Figure 1. Number of Serious Incident Reports in CHRIS for Individuals on a DD Waiver, SFY2021 and SFY2022



The RMRC was unable to analyze DD service provider serious incident data during SFY2022 due to concerns with data source system validity and reliability. Please see Section 7 for additional information.

3b (2) IMU Look-Behind

The RMRC is responsible for providing oversight for the IMU Look-Behind, a review of a statistically valid, random sample of DBHDS serious incident reports and follow-up process. This process is housed within the IMU. The IMU is responsible for conducting look behinds of their efforts 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 whether at least three out five criteria listed below were 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 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 is whether the provider's documented response addressed ways to mitigate future occurrences.

c) Outcome 3 is whether appropriate action from IMU occurred. For this item, 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.
    iv. The IMU specialist forwarded the incident to the SIU before closing the case.

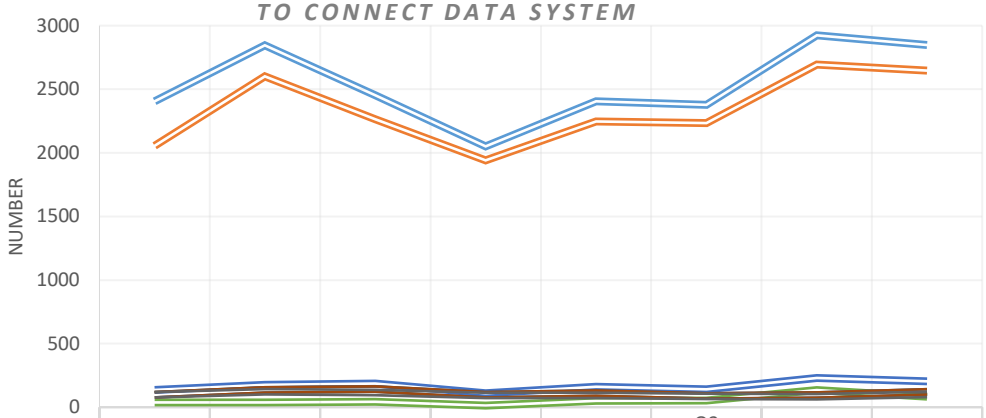
The IMU Look-Behinds were not conducted in SFY2022. In SFY2021 an inter-rater reliability review found low agreement among reviewers across all quarters reviewed. A significant issue in obtaining a high level of IRR has been the consistency of staff available to conduct the reviews. Reviewers were tapped from offices across the department; however, because of the time commitment involved, several have had to discontinue their participation. This lack of consistency compromises IRR and casts doubt upon findings from the IMU Look-Behinds. To address this issue, DBHDS decided to contract with the Virginia Commonwealth University Partnership for People with Disabilities to conduct the quarterly study. Due to the length of time that it took to complete a contract and initiate the new process, reviews were not completed in SFY2022; results will be reported to the RMRC beginning in SFY2023.

3b (3) Timeliness of Serious Incident Reports and Citations

The RMRC is responsible for monitoring aggregate data of provider compliance with serious incident reporting 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.

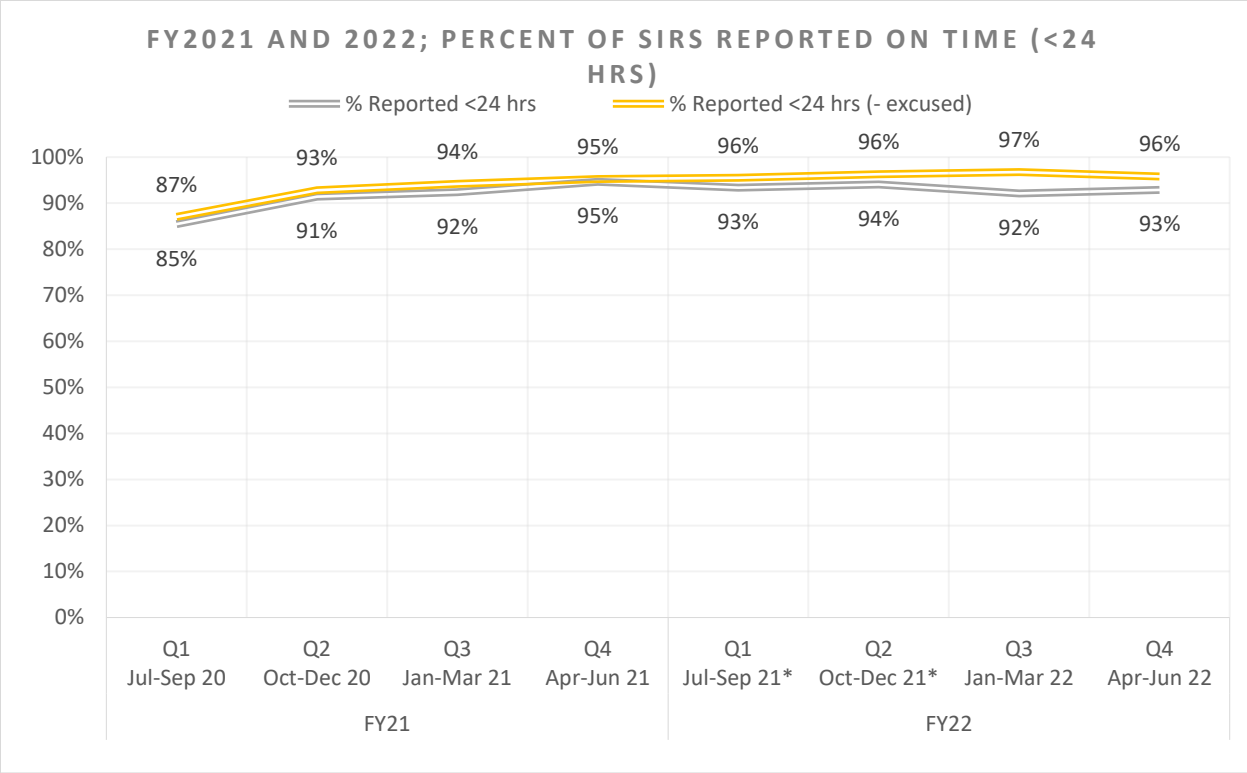
On a quarterly basis, the IMU provides data to the RMRC about late incident reporting, the number of incident reports entered by licensed providers of DD services (aggregated across the Commonwealth and by region), type of incident (death or serious incident), and status of the work of the IMU. In SFY2022, based on data from CHRIS, there were a total of 10,555 incident reports reported by licensed providers of DD services, 734 of which were reported late. Of those that were late, however, the IMU excused 322 for reasons such as the CHRIS application being unavailable during the reporting window and the provider otherwise notified the IMU of the incident within 24 hours. Therefore, there were a total of 412 unexcused late reports and 10,143 reported timely, meaning that 96% were reported within the required timeframes. This exceeds the target of 86%. As documented in the following graph, the goal has been exceeded for SFY2021 and SFY2022.

Figure 2. Number of Serious Incident Reports, Timeliness and Citations, SFY2021 and SFY2022



	Q1 Jul-Sep 20	Q2 Oct-Dec 20	Q3 Jan-Mar 21	Q4 Apr-Jun 21	Q1 Jul-Sep 21*	Q2 Oct-Dec 21*	Q3 Jan-Mar 22	Q4 Apr-Jun 22
	FY21				FY22			
# of Serious Incidents	2405	2845	2452	2051	2405	2377	2924	2849
# Reported < 24 hrs	2055	2601	2265	1941	2246	2235	2694	2646
# of Late Reports	137	175	187	110	161	142	230	203
# of Reports Excused	38	39	44	13	51	53	135	83
# Late Reports (- Excused)	99	136	143	97	110	89	95	120
# of Citations	99	136	143	97	110	89	95	120
# of CAPS	97	122	117	92	94	86	83	100

Figure 3. Percent of Serious Incident Reports, Reported Within 24 Hours, SFY2021-2022



3b (4) Care Concerns

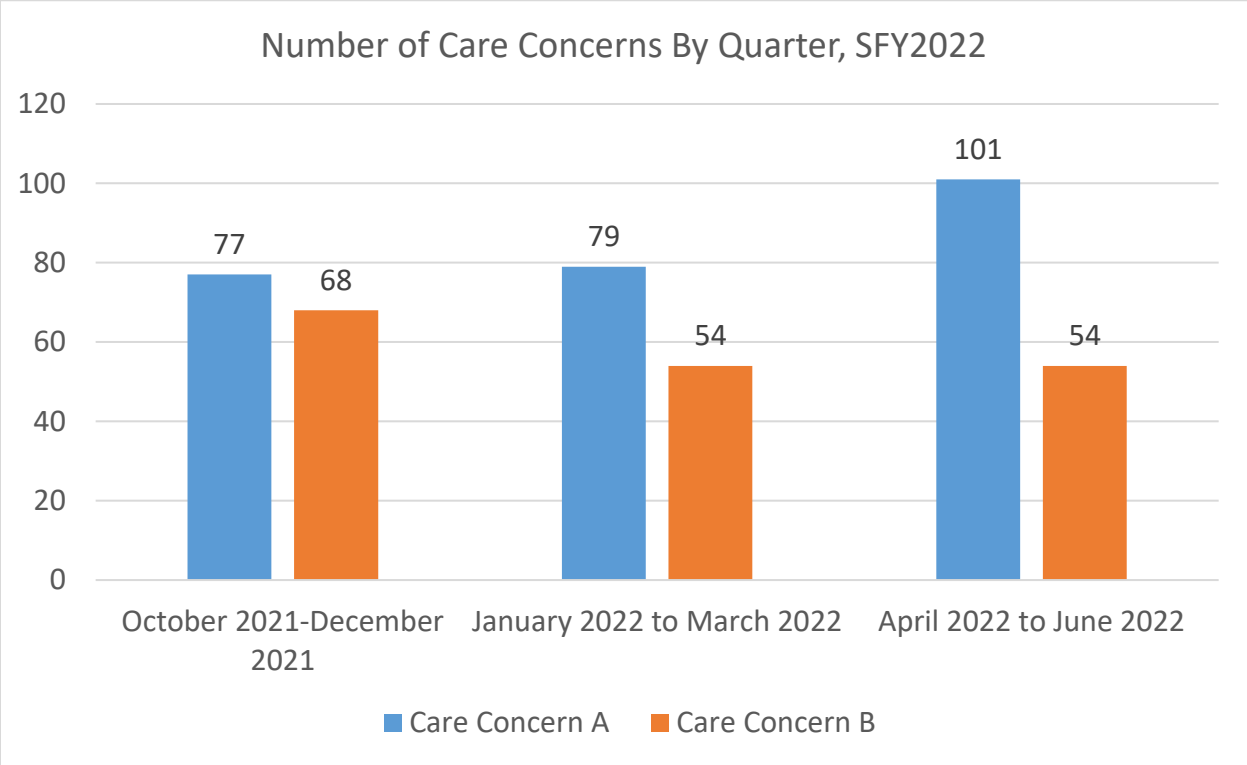
a) DBHDS has defined uniform risk triggers and thresholds to identify circumstances where there is potential risk for more serious future outcomes, which are called "care concerns". These uniform risk triggers and thresholds also further define the requirement outlined in Virginia regulation 12VAC35-105-520.D. 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. The IMU reports the number of care concerns for DD services to RMRC quarterly. In October 2021, the IMU revised the care concern criteria which are listed below. Multiple (two or more) unplanned hospital visits for a serious incident including: falls, choking, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day time-frame for any reason; and

b) Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional.

The IMU shares all care concerns with the appropriate Licensing Specialist and with OHR and OIH for follow-up and technical assistance as needed and to help determine where prevention focused trainings for providers are needed.

From Q2-Q4 of SFY2022, there was a total of 433 care concerns. There were 257 care concerns for criteria 'a' and 176 for criteria 'b'. The graph below shows the number of CCs by criteria type and by quarter during SFY2022. Data are not available for Q1 because this was a time of transition from the previous licensing information system (OLIS) to a new system called CONNECT; the care concerns criteria changed as well, as noted in the preceding paragraph.

Figure 4: Care Concerns by Quarter, SFY2022



Based on case study reviews that occurred over the course of the year, the RMRC recommended that a single choking episode be added as a new care concern threshold. In addition, the Department of Justice recommended that DBHDS consider adding multiple psychiatric hospitalizations as a new care concern threshold. Criteria for these new categories have been incorporated into the CONNECT system and will become effective January 1, 2023.

Care Concern Thresholds Criteria 2023
A. Multiple (2 or more) unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day time-frame for any reason.
B. Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional.
C. Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR.
D. Multiple (2 or more) unplanned psychiatric admissions within a ninety (90) day time-frame for any reason.

CONNECT

DBHDS launched the new licensing system, CONNECT, Wednesday, November 3, 2021. This system is used to capture all information related to licensed providers, including information about the provider, the specific provider services that are licensed, the locations of each of these services, as well as records of inspections and investigations and the provider's compliance with specific regulations. The system is a web-based application that has allowed the Office of Licensing to shift to a fully electronic system. CONNECT allows providers to submit all materials electronically, including their initial application for licensure, service modifications, and any corrective action plans. In addition, an interface between CONNECT and CHRIS imports all serious incidents into the CONNECT system. This allows incident management specialists (IMS) to review serious incidents from within the CONNECT system and document their review and follow-up actions. A file transfer between the two systems runs four times per day to ensure the data in each system is reconciled and kept up to date.

Importantly, EHA analysts have not completed a data quality review of the CONNECT source system because the system, as significant improvements were made to the system throughout the first year of implementation. A source system review will be scheduled in 2023.

Incorporating serious incidents into the licensing CONNECT system allows the IMU to better identify and track care concerns as they occur. Previously the identification of a care concern has been a manual process, with the IMS manually reviewing each incident to determine whether a care concern threshold has been met. IMU has been working with GL Solutions (the vendor for the CONNECT system) to develop the following queries and reports in CONNECT for the Care Concern Criteria.

- **Care Concern Results Query:** Allows the IMS to view all incidents relative to the Serious Incident Report that is automatically flagged as meeting the Individual Care Concern Threshold Criteria. This allows the IMS to verify that the flag is accurate.
- **Individual Care Concern by Provider Query:** To be used by the Licensing Specialist for inspections and by the IMU to verify Individual Care Concern Thresholds.
- **Care Concern Report:** To be used by the OIH and OHR to view Serious Injury Reports that meet Individual Care Concern Threshold Criteria. To be use by IMU to verify SIR that meet Individual Care Concern Threshold criteria.
- **Business Intelligence-DOJ Indicators-Care Concerns report:** To be used by the IMU to trend Individual Care Concern Thresholds by region, category, type, percentage of referrals and investigations.

3b (5) 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.

The DBHDS Data Warehouse worked with DMAS to extract the Medicaid claims that meet the above criteria, to determine the number that had a matching entry in CHRIS. For the time period 7/1/2021 – 9/30/2021, a total of 1,702 claims were identified as meeting the criteria above. The Data Warehouse was able to match these with 1,180 CHRIS reports, for a match rate of 69.33%. 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 individual may have been staying with family, or on leave from the residential setting at the time of the incident.

To determine the status of the remaining 522 claims that did not have a matching CHRIS entry, the Office of Integrated Health (OIH) made outreach to each provider that was associated with the unmatched claims. The DBHDS provider was determined by linking the Medicaid claim file with Waiver Management System (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, why not. Based on these responses, each unmatched claim was grouped into those that could be excused, or not excused. Excused included:

- 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 (or otherwise not at the residence during the time of the incident);
- There appeared to be multiple claims for a single incident (e.g., two separate emergency room (ER) bills when an individual remained in the ER over two days; an emergency room and hospital claim when a single incident resulted in an ER visit and admission)
- A planned hospital admission, procedure, or appointment.

Based on this review, a total of 243 of the claims were determined to be excused (either they were reported in CHRIS, or they did not meet the requirements for reporting). The chart below lists the primary reasons for which the lack of a matching CHRIS report was considered excused.

Table 1: Medicaid Claims – Reasons for Not Reported and Excused (July 1, 2021-September 30, 2021)

Reason	Number	Percent
Incident found in CHRIS	101	42%
Planned procedure	26	11%
Provider has no record/Not aware of the incident at the time	26	11%
Individual with family	34	14%
Multiple claims for one incident	2	1%
Not with provider during date of service	50	21%
Total	**239**	**100%**

Of the remaining claims, 279 were determined to have been incidents that should have been reported in CHRIS; or not enough information was provided to determine that a report was not required. In some of these cases the provider determined that the incident should have been reported but was not, due to an oversight; in several others the provider's explanation of why the incident was not reported reflected a misunderstanding of the reporting requirements. For example, 100 providers stated that they did not report emergency room visits because the emergency room visit was in lieu of a primary care visit. Although the emergency regulations did not initially require reporting of an emergency room visit in lieu of a primary care visit, this was changed in August 2020 when the final regulation were promulgated, requiring the reporting of all incidents that result in an emergency room visit. Providers that were identified as not reporting as required were contacted by the IMU and required to complete a training on incident reporting.

To determine the adjusted rate of timely reporting based upon information from this claim review, DBHDS added all 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 incident reports for the period 7/1/2021 – 9/30/2021 (Q1, SFY2021).

The IMU reported a total of 2,402 serious incident reports in CHRIS; of these 2,302 (96%) were timely. This claim review identified an additional 283 claims that represented serious incidents that should have been reported but were not. Adding this to the total number of serious incident reports brings the total number of reports to 2,685; the number reported timely remains at 2,302; thus 86% were reported timely.

Part 3c. Risk Mitigation and Provider Resources

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 risk management activities to identify topics for future educational content as well as determine when existing content needs revision. The RMRC instituted a new quarterly process in SFY2022 to ensure that occurs, in compliance with DOJ Compliance Indicator 32.7. At least quarterly the RMRC reviews risks that have been identified and discusses the need to develop new educational content, or revise existing content, to address these concerns. These activities are described below.

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. They work to find new, innovative ways to effect change and decrease barriers across agencies.

3c (1) Review of Educational Content

Annual Review: OIH issued the following health alerts and newsletters during SFY2022 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
  - Anaphylaxis – June 2022
  - Direct Support Professionals (DSP) – May 2022
  - Wheelchair Safety and Maintenance – April 2022
  - Leading Causes of Fatalities in DD – March 2022

    - My Care Passport & Advocacy Tip Sheets – February 2022
    - Emergency Preparedness Part 1 – January 2022
    - Nut Butters and Choking – December 2021
    - Clostridium Difficile – November 2021
    - Polypharmacy –November 2021
    - Vital Signs –November 2021
    - Aspiration Pneumonia – October 2021
    - Grief and Loss Health & Safety Alert –September 2021
    - Dysphagia Health & Safety Alert – August 2021
    - Dental Health Awareness Health & Safety Alert – July 2021
- Newsletters
    - Food Allergies – June – 2022
    - Negativity vs. Positivity in the Workplace – May – 2022
    - Safe Transfers – April – 2022
    - The Fatal Seven – March – 2022
    - My Care Passport – February – 2022
    - Emergency Evacuation Devices – January – 2022
    - Advocacy in Acute Care Settings – December 2021
    - Antibiotic Resistant Infections – November 2021
    - Influenza Vaccination – October 2021
    - The COVID-19 Vaccine and the Delta Variant – September – 2021
    - Importance of Positioning– August – 2021
    - New Medicaid Adult Dental Benefit – July – 2021
- Education Resources added to the DBHDS website in SFY2022
    - DBHDS My Care Passport (pdf)
    - My Care Passport and Advocacy Tips Narrated Training
    - Consent Tip Sheet
    - Discharge Tip Sheet
    - Medicaid Waiver Tip Sheet
    - Fall Prevention Resources
    - Movement for Better Health
- Training open to anyone across the Commonwealth
    - 7/15/2021 Fatal Seven
    - 7/20/2021 Oral Health
    - 8/12/2021 MRE, DME, Assistive Technology
    - 8/24/2021 Sepsis
    - 9/14/2021 Fall Prevention
    - 9/23/2021 When to Call 911 and Choking
    - 10/5/2021 Wheelchair Transitions
    - 10/12/2021 Oral Health
    - 10/21/2021 Skin Integrity & Pressure Injuries
    - 11/9/2021 Urinary Tract Infections

- 11/18/2021 Sepsis
- 12/9/2021 Fatal Seven
- 12/14/2021 Vital Signs
- 1/11/2022 Oral Health
- 1/13/2022 MRE, DME, Assistive Technology
- 1/20/2022 Emergency Preparedness: Part 1 Planning Tips & Resources
- 2/8/2022 Urinary Tract Infections
- 2/10/2022 Emergency Preparedness: Part 2 Specific Virginia Emergencies
- 2/17/2022 Skilled Nursing and Private Duty Nursing
- 2/22/2022 Wheelchair Transitions
- 2/24/2022 My Care Passport
- 3/8/2022 Fall Prevention
- 3/17/2022 Skin Integrity & Pressure Injuries
- 3/22/2022 Emergency Preparedness: Part 3 Fire Emergencies
- 4/5/2022 Oral Health
- 4/12/2022 Emergency Preparedness: Part 1 Planning Tips & Resources
- 4/14/2022 Sepsis
- 4/21/2022 Choking & Nut Butters
- 5/10/2022 Fatal Seven
- 5/19/2022 Emergency Preparedness: Part 2 Specific Virginia Emergencies
- 5/24/2022 Wheelchair Transitions
- 5/26/2022 Emergency Preparedness: Part 3 Fire Emergencies
- 6/14/2022 Vital Signs
- 6/21/2022 Urinary Tract Infections
- 6/23/2022 My Care Passport & Advocacy Tip Sheets

Quarterly Review: Each quarter in SFY2022, the RMRC reviewed all risk topics presented during the most recent quarter and, for each, evaluated whether a) there was a need for new educational content on the topic, or b) existing content needed to be revised. The committee determined that, for the topics reviewed, there was already existing sufficient content, the educational material was in development, or the need had been identified already in previous discussions. The committee agreed it was a useful process to review this quarterly to assess progress and identify potential gaps. The review identified the following educational needs:

1. Development of an online, on-demand module on choking. OIH has a choking training, but it is currently offered only in live, virtual settings.
2. Development of an online, on-demand module on urinary tract infections (UTIs). OIH has a UTI training, but it is currently offered only in live, virtual settings.
3. Additional training, tools and resources to help providers achieve compliance with the risk management and quality improvement licensing regulations.
4. Training and information for CHRIS users on ensuring correct utilization of check box options when reporting serious incidents.

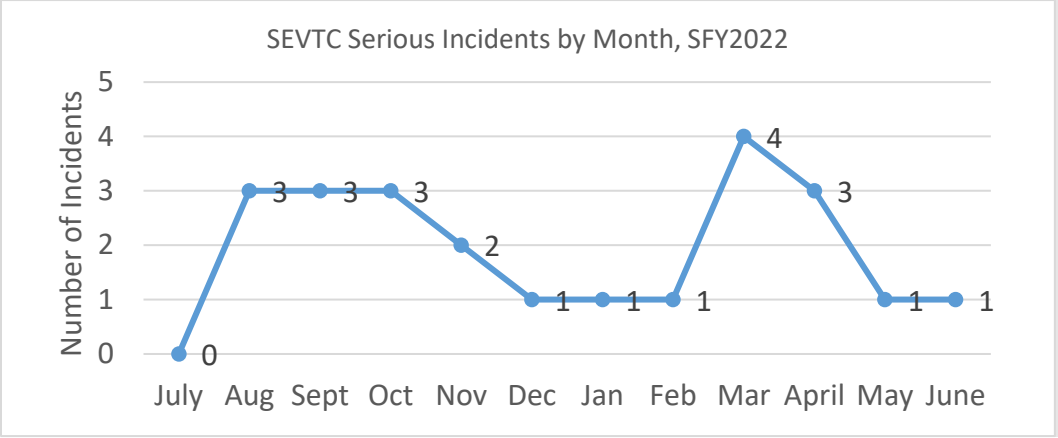
5. Training for providers on strategies, including good communication practices, for 'connecting the dots,' to ensure health and safety when providing services for the same individual.
6. Development of sample root cause analysis tools and other resources for providers, to be used during their quarterly review of medication errors.
7. Creation of a Health and Safety Alert on Down syndrome and Alzheimer's disease.

Part 3d. Facility Risk Management Programs - Training Center

RMRC is charged to review and analyze data and identify trends related to DBHDS facility risk management programs, to reduce or eliminate risks of harm and to monitor the effective implementation of Departmental Instruction 401 (Risk and Liability Management). Southeastern Virginia Training Center Facility (SEVTC) reports quarterly data to the RMRC. SEVTC also has a Quality Council Committee which oversees a variety of quality improvement committees including a risk management patient safety committee and a mortality review committee.

Each quarter in SFY2022, SEVTC reported to RMRC, for each risk trigger and threshold in place, whether it was met and a summary of actions that were taken to address individuals' health and safety needs. For example, SEVTC reported 74 physical restraints for SFY2022 and 40 mechanical restraints. In another example, SEVTC reported that there were 23 serious incidents for SFY2022, with the most common type being laceration (N=7), abrasion (N=4) and red area (N=3). Figure 4 shows a graph shared by SEVTC showing trends in serious incidents during SFY2022.

Figure 4. Southeast Virginia Training Center, Serious Incidents by Month, SFY2022



SEVTC also shares information about quality improvement efforts. For example, SEVTC shared information about a performance initiative to reduce, by 60%, the number of PRN (as needed) medications required for constipation, from a baseline of a monthly average of 36 during September 2021 – January 2022, to 15 or less per month. SEVTC is implementing multiple evidence-based changes, such as reviewing and adjusting medications that may cause constipation and having a dietician conduct dietary reviews. SEVTC has identified and worked to address barriers and reported seeing progress but not yet meeting the goal.

Part 3e. Case Presentations

In SFY2022, RMRC had the opportunity to conduct two case reviews. Case reviews are presented to the committee to highlight issues that may be of interest or concern to the committee. As specified in the RMRC Program Description, criteria for selecting a case for review may include:

- A single individual who has had multiple incidents, with concerns that risk has not been mitigated.
- A provider who has had a pattern of multiple incidents that have not been appropriately addressed or resolved.
- A pattern of multiple incidents across different individuals and/or different providers that represent a previously unidentified, or unaddressed risk.
- A single serious incident that represents a previously unidentified or unaddressed risk of potential concern to others.
- A recommendation from another quality subcommittee, such as the Mortality Review Committee.

The first case review centered on multiple individuals who had choking events associated with aphasia, two of which were fatal. These incidents were brought to OIH's attention as care concerns, as the IMU alerts the OIH to all care concerns for follow up. OIH presented the case over the course of two RMRC meetings. OIH presented the facts of the case and identified root causes and prevention opportunities. Main concerns focused on dietary recommendations not been clearly documented, understood and/or followed. OIH identified several gaps and breakdowns in processes, procedures and communications, and provided on-site training and technical assistance for the providers involved. A small group of RMRC members met and identified the following recommendations, which were supported by the RMRC as a result of this case presentation:

1. OIH should make recorded, on-demand training available related to choking and UTIs. This would fill in the remaining gaps for having on-demand training on all risks associated with care concerns.
2. OIH should make recorded, on-demand training available on nutrition.
3. Provider Development should offer a more in-depth training on all parts of the Individual Support Plan (ISP) for DD providers.
4. Provider Development and Licensing/IMU should partner to develop an interactive workshop to 'connect the dots', using a case study and adult learning principles. (virtual)
    a. Audience: Support Coordinators, Topic: "Helping multiple providers work with the same individual"; Content includes roles and communication.
    b. Audience: Providers, Topic: "How to interact with other providers to support the same individual"; Content includes documentation and sharing essential supports.

5. Develop a checklist as an example tool (like the 'post move monitoring tool') that the residential provider can fill out, which also goes to the day support and everybody at the initial meeting letting providers know the essential supports. This could be used as part of the 'Connecting the Dots' training.
6. DBHDS should consider adding single event choking incidents as a care concern.
7. RMRC should explore opportunities to establish criteria that would result in a provider being required to complete relevant risk training.

The second case review was recommended to the RMRC by the MRC. The case centered on an individual who had complicated medical issues with multiple diagnoses and medications. After learning all the facts of the case, RMRC members could not identify any opportunities for improvement. Discussion centered on the fact that individuals with Down syndrome have an elevated risk of Alzheimer's disease, and at an earlier age than other individuals. The committee discussed whether there could be an opportunity to put supports in place or start doing screenings earlier. The committee recommended OIH develop and distribute a Health and Safety Alert about the relationship between Down syndrome and Alzheimer's disease.

Regarding the recommendations to make on-demand trainings available for choking, UTIs and nutrition, OIH has shared that the script for the choking training is complete and is pending narration prior to being posted to the Commonwealth of Virginia Learning Center (COVLC). The UTI training, once it is fully scripted and narrated, is expected to be complete in Q3, SFY2023. The OIH Nutrition training is planned to be scripted and narrated for completion in Q4, SFY2023.

Regarding the recommendation to offer a more in-depth training on the ISP, the Community Resource Consultants (CRCs) in the Office of Provider Development (OPD) are collaborating to provide clarity to Support Coordinators (SCs) and providers on the accurate inclusion of risk (behavioral and medical) into the ISP. Information was incorporated into the Provider Roundtable held on Oct. 26, 2022, as well as the SC regional meetings, which began Oct. 26, 2022, and will continue through Nov. 10, 2022. In advance of that training a session will be held for DMAS/ Quality Management Review (QMR) and DBHDS/ internal offices staff (e.g., OIH, PD, OL).

Training on completion of the Risk Awareness Tool (RAT) exists on the COVLC; providing 24-hour access. OIH has provided many training sessions for individual Community Service Boards (CSBs). OPD has presented a training on how the RAT translates to the ISP, which is available as a recording on the DBHDS website. In addition, OIH and OPD are planning a statewide training on the RAT, for January 31, 2023. Incorporation of Risk into the ISP has also been a part of the new "PC ISP Development Academy" being held with CSB SCs and providers. Additionally, related content will be added into the COVLC ISP trainings, which will be released in late 2022. The CRC System Team continues to provide guidance to CSBs when a question or issue is noted in this area from QMR or other entities.

Regarding the recommendation to provide a 'Connect the Dots' training, OPD Teams 2 and 3 are proposing to implement a webinar for SCs and providers on training on communication techniques and how to work together to reduce and mitigate risk. OIH has worked to promote the MyCarePassport, which was designed to improve communication between healthcare providers but has utility in many settings.

Regarding the recommendation to create a resource on Down syndrome and Alzheimer's disease, OIH is working to create a list of resources to be posted on the DBHDS website and is exploring potential collaboration with Virginia Association of Community Rehabilitation Programs (vaACCSES). In August 2022, Thomas Buckley Ed.D. gave a presentation designed specifically for Virginia on this topic at the vaACCSES Provider Conference. The slide deck will be posted on the OIH DBHDS Page as part of the project.

Part 4. Provider Competency and Capacity

The RMRC is tasked with systematically reviewing and analyzing data related to findings from licensing inspections and investigations. Measures developed for data analysis fall within the key performance area of Provider Competency and Capacity. The Office of Licensing is responsible for conducting licensing inspections and investigations and assessing providers' compliance with risk management and quality improvement program requirements.

4a. Data Analysis: Licensing Measures – Risk Management & Quality Improvement

Since SFY2020, RMRC has been closely monitoring the measures associated with risk management and quality improvement licensing regulations. Despite efforts to provide education and support to providers, these regulations have remained below the goal of 86%. The following table shows the results for each licensing regulation monitored by RMRC related to risk management and quality improvement compliance. Note that the data are presented by calendar year because licensing inspections occur on a calendar year basis. Compliance with other licensing regulations can be found in Appendix 1. Additional RMRC Surveillance Measures, SFY2022, page 40.

Data for the licensing measures are pulled from the CONNECT system (see CONNECT, page 15). This system was implemented in November 2021. Historical data from the previous licensing system (OLIS) was transferred into CONNECT, with the exception of data for providers who were no longer operating as of the implementation date. The data for all of the licensing measures was reported entirely from the CONNECT system and therefore would not have included data for providers that were inspected earlier in the year, but no longer licensed as of November 3, 2021 (this was a small number of providers and therefore is not thought to have significantly impacted the data).

CONNECT

Table 2: Risk Management & Quality Improvement Compliance

Note: Data are presented for calendar year. Red indicates below 75%; Yellow indicates between 75% and 85%; and Green indicates 86% and above.

RMRC Measure / Performance Measure Indicator (PMI)	CY2021
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))	**61%**
• 520A - Designated person with training or experience responsible for risk management function	**77%**
• 520B - Implements a written plan	**89%**
• 520C - Conducts annual systemic risk assessment	--
• 520C1 - environment of care	**85%**
• 520C2 - clinical assessment/reassessment	**81%**
• 520C3 -staff competence / adequacy of staffing	**80%**
• 520C4 - use of high-risk procedures	**79%**
• 520C5 - review of serious incidents	**85%**
• 520D - Systemic risk assessment incorporates risk triggers and thresholds	**79%**
• 520E - Conducts annual safety inspection	**90%**
Quality Improvement Program Requirements	
% Of providers that are compliant with 100% of the QI Requirements	**52%**
• 620A - Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	**91%**
• 620B - The QI program uses standard QI tools, including RCA and has a QI plan	**89%**
• 620C - The QI Plan shall:	--
• 620C1 - Be reviewed and updated annually	**81%**
• 620C2 - Define measurable goals and objectives	**78%**
• 620C3 -Include & report on statewide measures	**87%**
• 620C4 - Monitor implementation & effectiveness of approved CAPs	**75%**
• 620C5 - Include ongoing monitoring and evaluation of progress toward meeting goals	**78%**
• 620D - The providers P&P includes criteria used to:	--
• 620D1 - Establish measurable goals & objectives	**74%**
• 620D2 - Update the QI plan	**74%**
• 620D3 - Submit revised CAPs when not effective	**65%**
Input from individuals about services & satisfaction	**81%**

In response to these trends in the data, the OL has implemented several mitigating strategies to improve provider compliance with regulations related to RM and QI. These include:

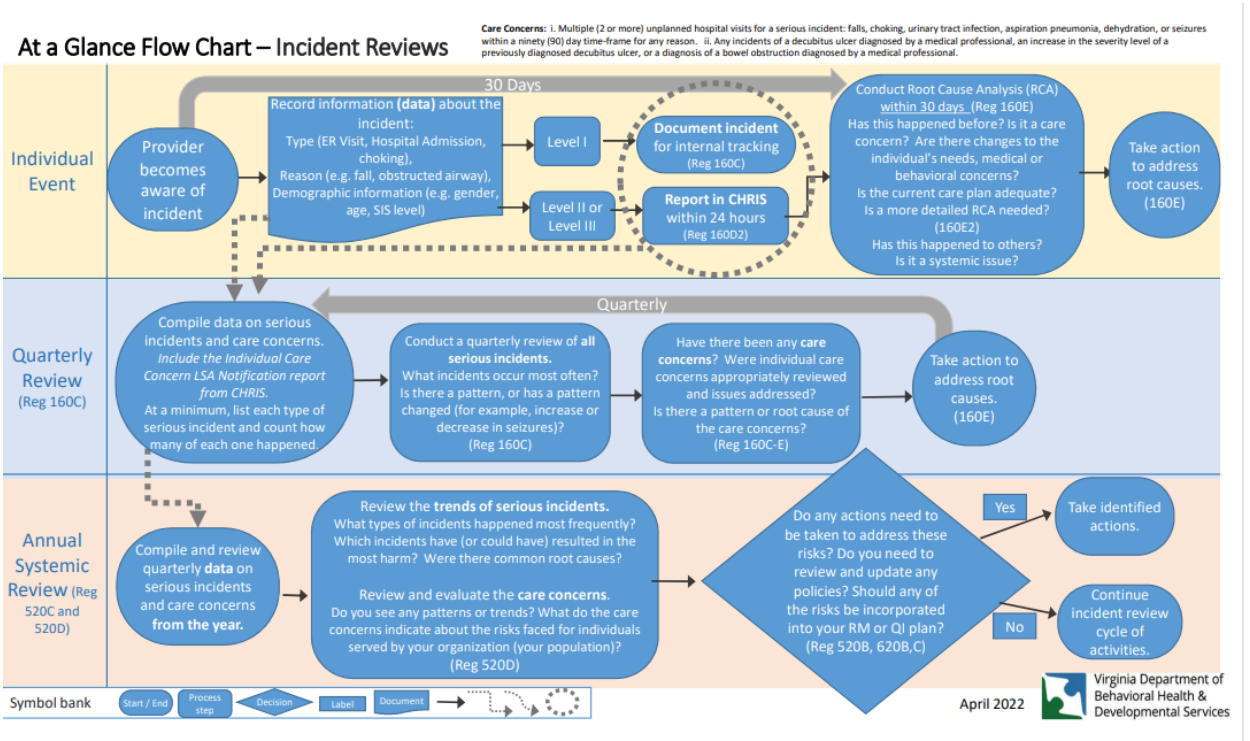
- Hiring a Quality Improvement Specialist (QIS) in SFY2021.
- Providing additional guidance and a series of webinars to review the DOJ regulations and highlight the RM and QI provisions and expectations.
- Offering an opportunity for the Center for Developmental Disabilities Evaluation and Research (CDDER) to provide training in December 2020. A recording of this training in on the DBHDS website and available on demand.

- Publishing, in June 2021, additional information and training on a sample RM plan, a sample systemic risk assessment review and a sample QI plan.
- Publishing in February 2022, a sample Provider Systemic Risk Assessment, and Tools for Developing a Quality Improvement Program.
- In February 2022, providing further training and information on these regulations.

In addition, the Office of Community Quality Improvement (OCQI) initiated a technical assistance activity, in which they provided assistance to ten providers that had not met the requirement to develop a quality improvement program with measurable goals and objectives (620C.2). Staff from the OCQI met with each provider over three sessions to provide assistance in understanding the licensing requirements for quality improvement; develop measurable goals and objectives; and understanding how to use various quality improvement tools (e.g., 5 whys, fishbone diagram, run charts). Following provision of this technical assistance, all 10 providers were found to be compliant on all of the quality improvement regulations at their next licensing inspection. Next steps will involve determining how to expand this assistance to a greater number of providers.

The members of the RMRC also identified a need to support these mitigating strategies by developing a flow chart depicting how multiple licensing requirements fit together in a process that begins with becoming aware of and reviewing individual incidents, culminating in conducting an annual systemic risk assessment review to include risk triggers and thresholds. Development of this flow chart was coordinated by the Office of Clinical Quality Management (OCQM) QI Coordinator, informed by the OL, IMU, OIH and other stakeholders, and launched by the IMU during a training in April 2022 and published on the website at this link: https://dbhds.virginia.gov/wp-content/uploads/2022/05/Flow-Chart_Incident-Review_April-2022.pdf. See Figure 5.

Figure 5. At a Glance Flow Chart of Incident Reviews



The RMRC also decided to focus on licensing regulations 520C and D for its proposed quality improvement initiative for SFY2022, which is described in more detail in Part 6 of this report.

Part 5. Review of Quality Service Review (QSR) Data

RMRC, along with the other QIC Subcommittees, is responsible for reviewing Quality Service Review (QSR) findings. In October 2021, RMRC reviewed the results from Round 2 of the QSR, which occurred between May 1, 2020 and October 31, 2020, and included 600 providers. The committee observed that, for QSR measures related to other data reviewed by RMRC, the results were similar for the most part.

- Developing a QI plan: the QSR result was 89%, which is similar to the findings of licensing measure 620A data analysis, where the most recent result for Q1, SFY2022 was 89%.
- QI plan is reviewed annually: QSR result was 89%, and this corresponds to the findings of licensing measure 620.C.1, where the results showed 87% for Q1, SFY2022.
- Implementing RM processes including risk triggers and thresholds: the QSR result was 90% and the findings of licensing measure 520.D. were 79% for SFY2021. It was noted that QSR may be examining whether the provider reviewed risk triggers and thresholds, while OL may be examining whether risk triggers and thresholds were part of RM processes.
- Developing a RM Plan: the QSR result was 91%, which is similar to the findings of licensing measure 520B, where the most recent result was 88% for SFY2021.

It was noted that the setting with greater opportunity for improvement in terms of developing a QI plan was Group Homes, and, for reviewing the QI plan annually, Independent Living Supports and Group Homes with Four or Fewer Individuals.

RMRC is tasked to measure and track DOJ compliance indicator 29.24 *"At least 95% of individual service recipients are adequately protected from serious injuries in service settings."* RMRC, at the time, had decided to use the QSR results for "Providers proactively identify and address risks of harm and develop and monitor corrective actions" as a proxy for that measure. The Round 2 results for this was 78%. Concerns were raised about the nature of the QSR item, which was indicated as "met" when "the ISP and/or individual record documentation confirms that risks of harm were identified AND addressed AND that corrective actions were developed AND monitored if a risk was identified." This was identified as having multiple components and when HSAG was asked if the data could be disaggregated to identify contributing factors, RMRC was informed it could not be disaggregated and that the question was being removed from the provider QSR tool. Thus, RMRC began working to identify an alternative method of measuring for C.I. 29.24; work towards addressing this need will continue in SFY2023.

Part 6. Quality Improvement Initiatives

RMRC is tasked with proposing a new QII each year. The status of each QII is discussed in the following sections.

6a. Preventing Falls and Trips

The Falls QII was approved in SFY2020 and continued during SFY2022. 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 reportable serious incidents caused by falls by 10%, down from a baseline of 63.2 per 1,000 individuals in the waiver population during the period 10/1/19 – 3/31/20, to 56.88 per 1,000 during SFY2021. (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.
- Conducting specific outreach to providers that have reported multiple falls with hospitalizations or ER visits.

A Falls QII Workgroup has met monthly since November 2020 to oversee implementation of the Falls QII, assess and document progress using the PDSA (plan-do-study-act) cycle, identify

barriers and plan solutions, and report regularly to the RMRC. The Falls QII Workgroup consisted of representatives from OIH, OHR, Provider Development, the IMU and OCQM. Each strategy and its most recent status in the Plan, Do, Study, Act cycle is described in the following table. In summary, two of the strategies were adopted: conducting follow-up for providers with fall related care concerns and delivering educational content about reducing the risk for falls. The other two strategies, implementing the Risk Awareness Tool and incorporating it into the ISP process, and monitoring falls data in CHRIS, are pending additional data. The RMRC hopes to complete this QII as soon as data on those two strategies are available to review.

Table 3: SFY2022 Falls QII Implementation

Change / Strategy	Hypothesis (Prediction)	Plan / Do	Study	Act
Implement Risk Awareness Tool, incorporate into ISP process.	*RAT will identify new fall risks and, as a result, ISPs will be updated to incorporate prevention strategies*	Implemented November 2020	Number and percent of RAT tools that identified fall risk • Of 300 individuals reviewed during Q1/Q2, 157 had a RAT tool. Of those, 23 (14.6%) identified new fall diagnosis and 37 (23.6%) identified new fall risk. • *As of the writing of this report, data to compare SFY2022 to SFY2021 are pending.* Percent of completed ISPs incorporating RAT • Of RAT that identified fall risk, ~74% ISPs had incorporated results. **Lessons Learned:** The RAT appears to help identify new risks for falls and for the most part, results are incorporated into the ISP.	2021: OIH provided TA to CSBs on correct use of the RAT – including individual guidance to support coordinators **2022:** The group wants to compare FY22 results to FY21 results to inform next steps.
Identify providers that have reported multiple falls of an individual, resulting in hospitalization or emergency room visit (care concerns); encourage review of	*Providers with fall-related CCs will voluntarily* complete falls training and report increased knowledge and intention to incorporate fall prevention strategies into their work (*It*	Fully implemented as of April 2021; Follow up included invitation to Falls Training and resources: *First Aid for Falls Health & Safety Alert; First Aid for Falls PPT Training; Falls Prevention Health*	Number of providers meeting risk triggers for falls • From April 1 – June 2: Out of 480 CCs, 44 (9.2%) involved falls (39 providers). Number or percent providers who receive follow up • Result: 100% have received follow up. Percent of providers receiving invitations who participated in training • 22 providers responded to a follow-up survey on the training.	Adopted

Change / Strategy	Hypothesis (Prediction)	Plan / Do	Study	Act
individual's care plan, conduct environmental assessment; inform them of resource materials and invite them to take on-line fall prevention training.	*is not required)*	*& Safety Alert; Falls Health Risk PPT Supplemental RAT Training; OIH Newsletter focused on Fall Prevention*	Of those who responded, 18 (82% of respondents) said that direct service professionals completed the recommended Falls training. **Lessons Learned:** • OIH identified the need to improve communication and the process for tracking and following up on care concerns. • The best way to collect data proved to be follow-up phone questionnaire.	

Disseminate information on fall prevention to varied audiences through Various educational events including Fall Prevention Training and RAT training	*People will complete falls training, report increased knowledge and intention to incorporate fall prevention strategies into work*
	People will access educational materials on the OIH DBHDS website
		• RAT training w/ Falls component; implemented Fall 2020
		• COVLC Training launched 2019 (invite only); Global invite Feb. 2021; Updated June 2021
		• Wheelchair transitions – May 25, 2021
		• Other Edu. resources are available on the OIH website (newsletters, health alerts)
		Fall Prevention Month 2020 – Postponed until 2021 (not implemented)
			Number of providers accessing and completing training materials through COVLC Training
			• RAT training including falls:
			  • Dec. 2020: N=1,315 people completed.
			  • As of May 2022: N=1,471 completed.
			• COVLC Falls Prevention Strategies Training:
			  • From Feb 4- May 2021, 222 people completed.
			  • As of May 2022: N=464 completed.
			• A survey of participants (46 responses) showed: 72% '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.
			Track downloads and access to resources (newsletters, health alerts) on website
			• The group abandoned this study strategy because DBHDS IT has not been able to come up with a method to report this information.
			Lessons Learned:
			• While the overall response rate to a post training survey was
				Adopted

Change / Strategy	Hypothesis (Prediction)	Plan / Do	Study	Act
			low, those who did respond provided support of a positive impact. • Participation in training spiked in 2021 after OIH promoted it to providers but not in 2022. • DBHDS IT has not been able to track web traffic and this presents a barrier to measuring the impact of online outreach and engagement with educational resources.	
Regularly monitor data	*We will understand the trend and whether our strategies have an impact.*	Data are pulled monthly from Tableau	Since COVID began ~March 2020, available data indicate that the rate of falls has stayed below the QII goal of 56.88 per 1,000. This data has not been available during SFY2022 due to issues with data validity.	RMRC will continue to work with IT to address data validity issues.

In addition to continuing to implement and monitor the progress of the Falls QII, the Falls QII Work Group also developed and delivered a presentation about the Falls QII, to providers during a Provider Roundtable quarterly webinar (hosted by the Office of Provider Development). Over 300 providers attended the event. The presentation focused on describing the purpose and structure of the RMRC and the reason addressing falls was selected for a quality improvement initiative and included a review of the change strategies and the sharing of the falls data from CHRIS, available at that time. The presentation was well received, and the RMRC hopes to have more opportunities in the future to share data and information about QIIs directly with providers.

6b. Quarterly Review of Medication Errors

The Medication Error QII was proposed in SFY2021 and abandoned in early SFY2022. During June 2021, RMRC had proposed, and QIC approved, a QII to improve the PMI *"Licensed DD providers that administer medications are NOT cited for failure to review medication errors at least quarterly"*. A QII work group was formed and began to meet in July 2021 to further understand the measure. During a review of the measure reliability between the RMRC Data Workgroup and EHA (formerly DQV), the data for Q3 could not be replicated by following the documented data processes. Following the documented data process produced a result of 70% achievement, as opposed to 89% reported to the RMRC. It was discovered that 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%). After updating the quarterly calculations, results

showed that this measure had been consistently above the 86% goal for all quarters. The work group recommended to discontinue the QII, and this was approved by the RMRC in August 2021.

6c. Systemic Risk Assessment - Licensing Measures 520 C and D

The RMRC proposed a quality improvement initiative in SFY2022 to improve provider compliance with conducting an annual systemic risk assessment (licensing regulations 520C and D). The QII was pended by the QIC in June of 2022, because the Region 5 Quality Council (RQC5) proposed a very similar QII. The QIC requested the two committees to meet and develop a plan to move forward. The decision was that RMRC and RQC5 would collaborate on the QII as equal partners.

The PMI "% of licensed DD providers that have met 100% of the risk management requirements (excludes NA and ND)" has been below the target of 86%. The results for the past 4 quarters are:

- SFY2021, Q3=55%
- SFY2021, Q4=62%
- SFY2022, Q1=62%
- SFY2022, Q2=58%

Of the nine regulations that comprise the RM requirements, 520.C1-C5 and 520.D, which focus on systemic risk assessment, have continued to be below the goal of 86% despite efforts from the Office of Licensing to provide training and tools. RMRC believes that the ability to conduct a systemic risk assessment is a core component of a risk management program, and if 520C1-C5 and 520D improve, it could improve the overall PMI. This QII is important because providers that have effective risk management programs will be better equipped to identify and address potential risks and minimize harm. RMRC used the Could-This-Be-A-QII, Which-QII-Should-We-Choose to determine this need for this QII.

The QII Aim is to improve compliance with regulations 520C and 520D for licensed DD providers to 86% by SFY2023, Q4 (June 30, 2023). The goal for each is 86%, and the percent at baseline in CY2021 and goal for each regulation is as follows:

- 520C.1: 86%
- 520C.2: 81%
- 520C.3: 80%
- 520C.4: 79%
- 520C.5: 85%
- 520D: 79%

The change we plan to test is to develop and implement a multi-part training series designed to increase providers' knowledge, attitudes and practices related to systemic risk assessments (520C and D). The specific components of this training will be informed by conducting a formal

root cause analysis using a Fish Bone Diagram and soliciting providers' opinions, to better understand the reasons why providers are not meeting these licensing requirements. The plan for testing this change is to obtain and review provider feedback on training materials and tools that are developed; evaluate provider knowledge and skill acquisition; and review and evaluate overall provider compliance with each of the risk management requirements.

Part 7. Efforts to Improve Data Quality

In SFY2022, data source system issues adversely impacted the ability of the RMRC to review serious incidents, ANE allegations and substantiations, and conduct the OHR look-behinds. This was primarily because data quality issues were identified at the beginning of SFY2022 that resulted in the Office of Data Quality and Visualization (now the Office of Epidemiology and Health Analytics) to suspend data analytic support pending the resolution of those issues. The issues, put simply, included:

- Data exclusion of individuals with an unknown waiver type; when many of those individuals were receiving a waiver service and should have been included in the calculations.
- Inability to correctly identify individuals who were receiving DD services due to incorrect or different lists of services across CHRIS, WaMS, OLIS and CONNECT (which replaced OLIS in September/October of 2021 or mid-SFY2022).
- The CHRIS drop-down selection list of provider service types, for the Human Rights side of CHRIS (abuse and neglect reports) differed from that of the Incident Management side of CHRIS (serious incident reports), thus introducing the possibility of DD providers selecting non-DD services and vice versa. (It must be noted that discrepancies at the level of the population type [e.g., DD, MH] were analyzed and found to be small.)
- The lack of a valid and reliable unique identifier for individuals within CHRIS, which prevents or negatively impacts a number of opportunities related to tracking individuals' risks and outcomes across providers and linking individuals to other data systems such as WaMS. While reports from CHRIS may identify the number of incidents that are reported, it is not possible to determine how many unique 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 a new incident reporting system is procured. DBHDS will be issuing an RFP for a new incident management system in SFY2023.

The RMRC voted to escalate these concerns to a newly created administrative body called the Data Forum, comprised of program leadership and Information Technology (IT) leaders, tasked with identifying priorities for the agency and developing workplans to address data needs. Resolution of these data problems was not completed during SFY2022, despite being rated as a high priority in its initial meetings.

Part 8. Performance Measure Indicators

RMRC routinely reports on the performance measure indicators (PMIs) listed in the chart 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 surveillance measure needs to be elevated to a PMI or addressed with the establishment of a QII. Four PMIs were retired in SFY2022 as indicated in the chart, which also includes the reason for the retirement. In SFY2022, the RMRC monitored four PMIs (as indicated in the table below).

Table 4: Performance Measure Indicators, SFY2022

Performance Measure Indicators	Target	Q1 Results	Q2 Results	Q3 Results	Q4 Results	SFY2022 Overall Results	Performance Assessment
Critical incidents are reported to the Office of Licensing within the required timeframes (24-48 hours)	86%	95%	96%	97%	96%	**96%**	Exceeded Goal
Licensed DD providers, that administer medications, are NOT cited for failure to review medication errors at least quarterly	86%	Retired 12/14/21 because it was determined not necessary for the provider capacity domain; and is being tracked separately by the Quality Review Team (QRT).					
Corrective actions for substantiated cases of abuse, neglect and exploitation are verified by DBHDS as being implemented	86%	Retired on 12/14/21 because this measure consistently exceeded the goal for the previous two years; and it is tracked separately by the Quality Review Team.					
State policies and procedures, for the use or prohibition of restrictive interventions (including restraints), are followed	86%	Retired on 12/14/21 because this measure consistently exceeded the goal for the past three years; and it is tracked separately by the Quality Review Team.					
The state policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed	86%	Retired on 12/14/21 because this measure consistently exceeded the goal for the past three years; and it is tracked separately by the Quality Review Team.					
Licensed providers meet 100% of regulations for risk management programs (new PMI approved Sept 2021)	≥86%	62%	63%	61%	61%	**61%***	Below Goal
Licensed providers meet 100% of regulations for quality improvement programs (new PMI approved Sept 2021)	≥86%	53%	45%	55%	54%	**52%***	Below Goal
Individuals are free from harm, as reflected in the rates of serious incidents	≤ 56.88	N.A.	N.A.	N.A.	N.A.	**Not available**	Not available

that are related to risks which are prevalent in individuals with developmental disabilities: Falls							

* Data for calendar year 2021

Provider reporting of serious incidents continues to exceed the goal of at least 86% reported within 24 hours of discovery.

DBHDS has not met the goal of having at least 86% of providers meet all the risk management requirements or the quality improvement requirements. Valid and reliable data were not available during SFY2022 to assess progress on the rate of falls.

Part 9. Surveillance Measures

In addition to the PMIs listed in Part 8, RMRC is also responsible for tracking additional surveillance measures. The RMRC Chair is responsible for ensuring these data are collected and available for review by the committee. These are included in Appendix 1.

Part 10. Recommendations

Based upon its review of SFY2022 activities and discoveries, the RMRC identified the following recommendations. Some recommendations were addressed in SFY2022, while others are targeted for completion in SFY2023. Listed below are also unresolved recommendations from prior years and the status of each taken during SFY2022.

SFY2022 RMRC Recommendations

Recommendation	Status as of SFY2022 Report
1. August 2021 - Help improve correct utilization of 'Other' category in CHRIS.	**In Progress.** The IMU included information in CHRIS user trainings about correctly using checkboxes and information for Licensing Specialists on how to provide support.
2. September 2021 - Discontinue the Medication Error QII (which was approved in June 2021), due to the recalculation showing that it had been met at or above 86% for the previous four quarters	**Completed, September 2021.** The QII Was abandoned.
3. September 2021 – Develop tools and information to help providers conduct root cause analysis (RCA) for medication errors.	**In Progress.** The OL/IMU and OIH partnered to draft educational information to help providers conduct medication error RCAs.
4. December 2021 - RMRC recommends that the following issues be escalated to the DBHDS Data Forum for resolution within CHRIS:	**In Progress.** The Data Forum has identified these issues as top priority items and, as of July 2022, most of

• Verify timely and accurate data transfer from CONNECT to CHRIS to maintain valid classification of DBHDS licensed services • Alter ANE reporting process in CHRIS so that providers have the same experience as when reporting serious incidents • Update OHR reports in Data Warehouse to reflect this new alignment between licensed services and service program classifications (i.e., which populations are served by each service)	these recommendations have been implemented. Additional changes enforcing a 1:1 relationship between license type and service population needs to be finalized in CONNECT and new Data Warehouse reports will need to be created.
5. February 2022 - Further review the issue of multiple consumer IDs and escalate to Data Forum and add it to DOJ steering committee as a barrier.	**In Progress.** This issue was elevated as a priority barrier. The solution is multifaceted; some aspects may be implemented in existing system; others may require implementation of a new incident management system (which is in the process of being procured).
6. February 2022 – Recommendations made as a result of reviewing several choking incident case studies: 1) OIH should make training available in COVLC or otherwise online on choking and urinary tract infections (UTIs), so that each care concern has a related training resource. 2) OIH should make nutrition available in COVLC or otherwise online. 3) OPD should offer more in-depth ISP training. 4) OPD and OL/IMU should develop an interactive 'connect the dots' workshop to focus on building communication among providers serving the same individual. 5) Develop a checklist that the residential provider would complete that would go to day support, so everybody knows the essential supports. There were also two recommendations that need further discussion: 6) Explore whether single choking events should be considered as a care concern.	**In Progress.** For items 1-2, the suggested trainings are available for on-demand purposes from OIH and will be integrated into the COVLC. Item 3 is in progress by the Office of Provider Development via a new ISP Academy training. Items 4 and 5 are not yet in development. Item 6 will be implemented beginning January 1, 2023. Item 7 has been discussed and dismissed in favor of other existing mechanisms of support.

7) Explore criteria that would result in providers being required to complete relevant risk training.	
7. April 2022 - Create a Health and Safety Alert on Down Syndrome and Alzheimer's Disease	**Pending.** This has not yet been developed.
8. May 2022 - Provide licensing data broken down by region (RQC recommendation)	**Pending.** This has not yet been addressed. It is a new agenda item for the RMRC Data Work Group to explore.
9. June 2022 - Develop criteria and/or a process for revising care concerns	**Pending.** This has not yet been addressed. RMRC has discussed creating an annual process for this.

RMRC Recommendations from Prior Years

Recommendation	Status as of SFY2021 report	Status as of SFY2022 report
1. 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.	**In Progress.** The OHR collaborated with EHA to identify categories of neglect. Categories are pending incorporation into the CHRIS system.
2. 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.	**In Progress.** OHR continues to gather feedback from stakeholders into this process.
3. 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.	**Completed.** The VCU Partnership for People with Disabilities submitted a report sharing how other states address risk triggers and thresholds and included several recommendations for DBHDS to consider.
4. Improve performance on the licensing measure	**In Progress.** A QII to improve provider reviews of medication	**Abandoned.** The RMRC initiated a QII, which was approved by the

related to medication error reviews	errors was proposed by the RMRC and approved by the QIC. A workgroup will develop and oversee implementation.	QIC, related to this measure. After recalculating the data for the previous year, results showed providers were meeting the performance consistently above 86%. The QII was abandoned.
5. Improve provider understanding of, and compliance with, requirements for RM and quality improvement (QI) programs.	**In Progress.** During SFY2021, 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.	**In Progress.** During SFY2022, OL continued to provide training and resources. In addition, the RMRC proposed a QII to improve 520C and D (which focus on systemic risk assessment reviews) which was approved by the QIC in June 2022. It will be implemented in FY23 in collaboration with RQC5.

Part 11. Conclusion

The RMRC was chartered by the Quality Improvement Committee to identify and address risks of harm and to ensure the sufficiency, accessibility, and quality of services to meet individuals'' needs in integrated settings; and to collect and evaluate data to identify and respond to trends to ensure continuous quality improvement. Issues with data quality limited the ability of the RMRC to analyze system wide incident data; however, the committee utilized information from case reviews to identify risks related to choking as a significant concern and recommended interventions to address this risk. The implementation and impact of these interventions will be monitored in SFY2023. The committee also continued to monitor quality improvement efforts targeted at reducing fall risk, which included follow-up by the OIH on 'care concerns' related to falls and the continued provision of training on identifying and addressing fall risk.

Data from licensing reviews and the QSR highlighted the need for continued improvement in the development and implementation of provider risk management and quality improvement programs. While the data shows that many providers are able to individual requirements, only about half of all providers have demonstrated compliance with all requirements. In addition to training and tools offered by the OL, the OCQI provided technical assistance to ten providers to facilitate their compliance with developing measurable goals and objectives (regulation 620C.2). In addition, the RMRC initiated a QII focused on improving compliance with requirements for providers to conduct an annual systemic risk assessment (regulations 520C and 520D). This is carried forward into SFY2023.

Finally, the RMRC refined its process of reviewing educational content and conducted two case reviews, resulting in a number of recommendations that included prioritizing the development of recorded, on-demand trainings on choking and urinary tract infections.

Appendix 1. Additional RMRC Surveillance Measures, SFY2022

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

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2022	Q2 2022	Q3 2022	Q4 2022	SFY 2022
V.B #3	29.03	*i. Serious incidents required to be reported under the Licensing Regulations are reported within 24 hours of discovery*	% of inspections in which providers are **assessed** for reporting serious incidents within 24 hrs	CONNECT 160.D.2	quarterly		91%	68%	85%	94%	93%
			% of inspections in which providers were **determined** to be compliant with requirement for reporting serious incidents within 24 hrs	CONNECT 160.D.2	quarterly		98%	98%	80%	99%	98%
V.B #3	29.04	*ii. The provider has conducted at least quarterly review of all level I serious incidents,*	% of inspections in which the provider is **assessed** for compliance with requirements for quarterly review of incidents	CONNECT 160.C	quarterly		91%	74%	85%	94%	93%
			% of inspections in which the provider is **determined** to be compliant with requirements for quarterly review of incidents	CONNECT 160.C	quarterly		90%	89%	80%	82%	88%
V.B #3	29.04	*and a root cause analysis of all level II and level III serious incidents; iii. The root cause analysis, when required by the Licensing Regulations, includes i) a detailed description of what happened; ii) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and iii)*	% of inspections in which the provider is **assessed** for compliance with RCA requirements	CONNECT 160.E	quarterly						

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2022	Q2 2022	Q3 2022	Q4 2022	SFY 2022
		identified solutions to mitigate its reoccurrence.									
V.B #3	29.04	*and a root cause analysis of all level II and level III serious incidents; iii. The root cause analysis, when required by the Licensing Regulations, includes i) a detailed description of what happened;*	% of inspections in which the provider is **assessed** for compliance with RCA requirements: **a: a detailed description of what happened**	CONNECT 160.E.1.a	quarterly		**90%**	**69%**	**87%**	**94%**	**90%**
V.B #3	29.04	*ii) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider;*	% of inspections in which the provider is **assessed** for compliance with RCA requirements: **b: an analysis of why it happened**	CONNECT 160.E.1.b	quarterly		**90%**	**69%**	**87%**	**94%**	**90%**
V.B #3	29.04	*and iii) identified solutions to mitigate its reoccurrence.*	% of inspections in which the provider is **assessed** for compliance with RCA requirements: **c: identified solutions to mitigate reoccurrence**	CONNECT 160.E.1.c	quarterly		**90%**	**69%**	**86%**	**93%**	**90%**
		and a root cause analysis of all level II and level III serious incidents; iii. The root cause analysis, when required by the Licensing Regulations, includes i) a detailed description of what happened;	% of inspections in which the provider is **determined** to be compliant with RCA requirements: **a: a detailed description of what happened**	CONNECT 160.E.1.a	quarterly		**95%**	**94%**	**90%**	**91%**	**93%**
		ii) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider;	% of inspections in which the provider is **determined** to be compliant with RCA requirements: **b: an analysis of why it happened**	CONNECT 160.E.1.b	quarterly		**95%**	**97%**	**91%**	**92%**	**94%**

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2022	Q2 2022	Q3 2022	Q4 2022	SFY 2022
		and iii) identified solutions to mitigate its reoccurrence.	% of inspections in which the provider is **determined** to be compliant with RCA requirements: **c: identified solutions to mitigate reoccurrence**	CONNECT 160.E.1.c	quarterly		95%	97%	92%	93%	93%
V.B	29.23	At least 95% of individual service recipients are free from neglect and abuse by paid support staff.	At least 95% of individual service recipients are free from neglect and abuse by paid support staff.	DW33, DW38 and OISS dashboard	quarterly	**95%**	99%	99%	99%	99%	99%
V.B	29.24	At least 95% of individual service recipients are adequately protected from serious injuries in service settings.	QSR item: The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation Percent with 'Yes plus NA' divided by all individuals in the sample.	QSR Data	annual	**95%**					44%
V.C.1 #4	30.04	**At least 86% of DBHDS-licensed providers of DD services <u>have been assessed for their compliance</u> with risk management requirements in the Licensing Regulations during their annual inspections. Inspections will include an**	**% of licensed DD providers that had assessment of the following RM requirements during annual inspection.**	**CONNECT 520A- E**			84%	61%	78%	92%	89%

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2022	Q2 2022	Q3 2022	Q4 2022	SFY 2022
		assessment of whether providers use data at the individual and provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations.									
			Designated person with training or experience responsible for risk management function	520A	quarterly		91%	74%	86%	94%	93%
			Implements a written plan	520B	quarterly		91%	74%	86%	94%	93%
			Conducts annual systemic risk assessment	520C	quarterly						
			- environment of care	520C1	quarterly		88%	71%	84%	95%	91%
			- clinical assessment/reassessment	520C2	quarterly		88%	72%	84%	95%	92%
			-staff competence / adequacy of staffing	520C3	quarterly		88%	72%	83%	94%	92%
			- use of high risk procedures	520C4	quarterly		88%	72%	84%	94%	92%
			- review of serious incidents	520C5	quarterly		88%	71%	83%	94%	92%

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2022	Q2 2022	Q3 2022	Q4 2022	SFY 2022
			Systemic risk assessment incorporates risk triggers and thresholds	520D	quarterly		92%	71%	84%	93%	92%
			Conducts annual safety inspection	520E	quarterly		90%	66%	82%	92%	92%
V.C.6	34.06	DBHDS reviews and approves corrective action plans that are in response to serious incidents, abuse, neglect, or death in accordance with the Licensing and Human Rights Regulations. DBHDS follows-up on approved corrective action plans to ensure that they have been implemented and are achieving their intended outcomes as follows: a. For serious injuries and deaths that result from substantiated abuse, neglect, or health and safety violations, the Office of Licensing verifies that corrective action plans have been implemented within 45 days of their start date.	% of CAPS for SI/death with health and safety violation that are implemented < 45 days (30 business days)	Tracking log / CONNECT	quarterly	**86%**	71%	71%	65%		
V.C.6	34.06	b. In cases of substantiated abuse or neglect that do not involve serious injury or death, the Office of Human Rights verifies that corrective action plans have been implemented within 90 days of their start date.	% of CAPS for substantified ANE that are implemented < 90 days PMI wording: "Corrective actions for substantiated cases of abuse, neglect and exploitation are verified by DBHDS as being implemented. (HSW4)"	CMS assurances	quarterly	86%	96%	94%	95%	79%	90%
V.C.6	34.06	c. On an annual basis, at least 86% of corrective action plans related to substantiated abuse	Percentage of corrective action plans related to abuse, neglect, or health and safety		Annual	**86%**	94%	93%	92%		

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2022	Q2 2022	Q3 2022	Q4 2022	SFY 2022
		or neglect, serious incidents, or deaths are fully implemented as specified in this indicator or, if not implemented as specified, DBHDS takes appropriate action as determined by the Commissioner in accordance with the Licensing Regulations.	violations that are implemented within their required timeframes								
V.E.1	42.03	On an annual basis at least 86% of DBHDS licensed providers of DD services have been assessed for their compliance with 12 VAC 35-105- 620 during their annual inspections.		CONNECT 620A-E	quarterly		78%	55%	75%	86%	81%
	42.03		Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	620A			90%	72%	85%	94%	94%
	42.03		The QI program uses standard QI tools, including RCA and has a QI plan	620B			89%	72%	83%	93%	94%
	42.03		The QI Plan shall:	620C							
	42.03		- Be reviewed and updated annually	620C1			87%	74%	86%	94%	94%
	42.03		- Define measurable goals and objectives	620C2			88%	74%	86%	94%	94%
	42.03		-Include & report on statewide measures	620C3			88%	72%	85%	95%	94%
			- Monitor implementation & effectiveness of approved CAPs	620C4			87%	68%	86%	94%	93%
			- Include ongoing monitoring and evaluation of progress toward meeting goals	620C5			85%	69%	86%	94%	92%

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2022	Q2 2022	Q3 2022	Q4 2022	SFY 2022
			The providers P&P includes criteria used to:	620D							
			- Establish measurable goals & objectives	620D1			85%	69%	84%	94%	90%
			- Update the QI plan	620D2			83%	68%	83%	94%	90%
			- Submit revised CAPs when not effective	620D3			83%	62%	83%	94%	89%
			Input from individuals about services & satisfaction	620E			86%	62%	81%	91%	90%

Appendix 2. Acronym List

Acronym	Full Form
ANE	Abuse, Neglect, and Exploitation
AWOL	Absent Without Official Leave
CAP	Corrective Action Plan
CC	Care Concern
CDDER	Center for Developmental Disabilities Evaluation and Research at the University of Massachusetts
CHRIS	Comprehensive Human Rights Information System
CLB	Community Look-Behind
CMS	Centers for Medicare and Medicaid Services
CMSC	Case Management Steering Committee
COVLC	Commonwealth of Virginia Learning Center
CRC	Community Resource Consultant
CSBs	Community Services Boards
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
DI	Departmental Instruction
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice
DQV	Office of Data Quality and Visualization
DSP	Direct Support Professional
DW	Data Warehouse
EHA	Office of Epidemiology and Health Analytics (Formerly DQV)
ER	Emergency Room
HCBS	Home and Community Based Services
IHI	Institute of Healthcare Improvement
IMS	Incident Management Specialist
IMU	Incident Management Unit
ISP	Individual Support Plan
IT	Information Technology
KPA	Key Performance Area
MH	Mental Health
MRC	Mortality Review Committee
NA	Not Applicable
NCI	National Core Indicators

Acronym	Full Form
ND	Not Determined
OCQI	Office of Community Quality Improvement
OCQM	Office of Clinical Quality Management
ODQV	Office of Data Quality and Visualization
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
OLIS	Office of Licensing Information System (no longer in use)
OPD	Office of Provider Development
PDSA	Plan-Do-Study-Act
PLW	Project Living Well at Virginia Commonwealth University
PMI	Performance Measure Indicator
PP	Potentially Preventable
PRN	Pro Re Nata (as needed)
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QIS	Quality Improvement Specialist
QMP	Quality Management Plan
QMR	Quality Management Review
QRT	Quality Review Team
QSR	Quality Service Review
RAT	Risk Awareness Tool
RM	Risk Management
RMRC	Risk Management Review Committee
RQC	Regional Quality Council
SC	Support Coordinator
SA	Substance Abuse
SA	Settlement Agreement
SEVTC	Southeastern Virginia Training Center
SFY	State Fiscal Year
SIR	Serious Incident Report
UTI	Urinary Tract Infection
vaACCSES	Virginia Association of Community Rehabilitation Programs
VACSB	Virginia Association of Community Services Board
VCU	Virginia Commonwealth University
WaMS	Waiver Authorization Management System