Virginia Department of Behavioral Health & Developmental Services

Risk Management Review Committee Annual Report

July 1, 2022 – June 30, 2023

Table of Contents

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Part 1. Executive Summary

The Risk Management Review Committee (RMRC) is a subcommittee of the Department of Behavioral Health and Developmental Services (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 (DD) services. In SFY2023, the data reviewed included licensing inspections, incident management data, reports of abuse and neglect, and training center risk management (RM) activities. Four performance measure indicators (PMIs) derived from this data were monitored. Three of the four, which focused on provider compliance with requirements for risk management and quality improvement programs, as well as the rate of falls per one-thousand individuals, did not meet their established goals.

In the RMRC's work, the committee was able to overcome a few challenges. The RMRC was able to recommence reviewing serious incident and abuse, neglect, and exploitation data from CHRIS after over a year of waiting for important corrections to be made to the source system. RMRC also recommenced reviewing Incident Management look-behind data after Virginia Commonwealth University (VCU) assumed responsibility for this process.

The RMRC also made strides with quality improvement initiatives (QIIs). RMRC ended the falls QII after nearly three years. The RMRC continued a QII to improve compliance on licensing regulations 520C and 520D, based on not meeting PMI goals related to regulation 520. Finally, RMRC proposed a QII to improve submission of service-level seclusion and restraint data, which was approved.

RMRC made progress on several recommendations from previous years as noted below.

- Provided education on the proper utilization of the 'Other' category in CHRIS,
- Aligned the service type and population across CONNECT, CHRIS, and the Data Warehouse (DW) to ensure the validity of reports by population served,
- Implemented mitigating strategies to help reduce choking serious incidents (SIRs), which included elevating a single episode of choking to be a 'care concern' (CC) as of January 1, 2023, and developing additional training for providers to reduce choking risks. A care concern is a risk threshold set by DBHDS that, if it is met by a provider, initiates a process by which the provider receives additional support and TA from one or more DBHDS offices to help address the concern.

- Developed several samples of root cause analyses using "5 Whys" for medication errors, made available on the Office of Licensing (OL) website.

RMRC also made the following recommendations, in SFY23, for quality improvement in SFY2024.

- Explore setting a threshold for the number of Health and Safety CAPs to trigger a referral outside of the OL.
- Develop a flow chart to demonstrate how DBHDS uses risk data and information to identify providers that may need additional corrective action or technical assistance. (C.I. 32.7).
- Revise Virginia background questions on risk in the National Core Indicators survey, to improve the utility of the questions about risk .
- Develop a plan to further analyze serious incident data related to falls, to understand incidents of falls associated with hospitalization and injuries, and the percent of individuals who experience multiple falls.

As RMRC enters SFY2024, RMRC will work to improve availability and accessibility of serious incident and abuse, neglect and exploitation data using PowerBI visualizations, ensure recommendations from prior years are addressed, and implement the current QIIs while examining the data for additional QII opportunities.

Part 2. Committee Purpose and Structure

The purpose of the RMRC is to provide ongoing monitoring of SIRs and allegations of abuse, neglect and exploitation; 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; complaints alleging abuse, neglect and exploitation (ANE); findings from licensing inspections and investigations; and other related data. RMRC also reviews related data collected from community service providers, 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, DD, 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 DD 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 SFY2023, 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 (RCA) of the barriers for providers to meet the risk management requirements, conducting key informant interviews with providers and licensing staff. They also planned and implemented interventions to address the identified root causes.

The activities of the RMRC are discussed below, in sections aligning to the two key performance areas (KPA) 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 KPA. 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, SIRs, risk mitigation and provider resources, and facility risk management programs. Each section discusses DBHDS office roles in relation to risk management, 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 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 SFY2023 is provided below.

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

In SFY2023, RMRC reviewed ANE data twice. DBHDS proactively decided to not review data for one year until which time corrections could be made to look up tables within the source system. The information is entered by providers into CHRIS and made available via DW reports, which continues to inform the identification of trends and patterns to ultimately impact overall OHR outcomes. According to the DW reports, there were 3,305 complaints alleging ANE reported by licensed community providers (of DD services) in SFY2023, with 846 (25% of the total) substantiated (following the provider investigation and OHR review). This is an 11% increase in substantiated complaints when compared to SFY2022.

In SFY2022, the OHR collaborated with Office of Epidemiology and Health Analytics (OEHA) to explore the need for the development of subcategories of neglect in CHRIS. After the analysis, 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 subcategories of neglect are not defined 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 data entry while avoiding loss or inability to correlate historical data. The new categories were made available on July 6, 2023.

OHR also updated RMRC on a quarterly basis regarding its efforts to create guidance for reporting medication errors as neglect. This was a recommendation from SFY2021. OHR has developed a draft guidance 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, neglect 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. OHR circulated the draft guidance for review and consultation at the September 2023 Community Nurses Meetings facilitated through the Office of Integrated Health (OIH). OHR is working with the DBHDS Office of Regulatory Affairs (ORA) to have the draft document formalized into guidance by early 2024.

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 reports of abuse, neglect, and exploitation (for individuals receiving DD services) drawn from CHRIS.

As the Epidemiology and Health Analytics (EHA) team prepared for the CLB in SFY2022, they identified a data quality issue in OLIS that extended to CHRIS and the DW tables; an inability to reliably distinguish between DD and non-DD services. Although this only represented a small number of cases, there was concern that without a means of consistently distinguishing between DD and non-DD services, the sample of abuse, neglect, and exploitation cases retrieved from CHRIS (for the CLB sample), may not have been representative of DD services. Due to this concern, the RMRC decided to pend continuing review of the human rights look-behind data until this issue was resolved.

By November of 2022, service mapping problems that contributed to the lack of consistent service description classification processes across CHRIS, the licensing data base CONNECT, and the DW had been corrected. By January of 2023, the remaining problem; a need to ensure that, (within CONNECT), each licensed service was associated with a single population type, instead of multiple population types, was also corrected. The OHR resumed CLB reviews in June 2023, beginning with a review of investigations that were closed in quarter 3 of SFY2023 and then moving to those closed in quarter 4. The results were presented to the RMRC in August 2023.

The CLB evaluates three primary outcomes, each with a goal of 86% or greater. The results for SFY23, Q3 were as follows:

1. Comprehensive and non-partial investigations of individual incidents occur within prescribed timelines. Result=86% (62/75). Out of 13 cases not meeting this standard, five investigations were completed by people with no ANE investigation training.
2. The person conducting the investigation has been trained to conduct investigations. Result= 64% (48/75). This is an opportunity to intervene. CAPs reflect these people were trained subsequently.
3. Timely, appropriate CAPs are implemented by the provider when indicated – was the case closed within 60 days. Result=89% (67/75).

CLB Results for Q4, for the same measures, were as follows:

1. Result=81%.
2. Result=60%.
3. Result=87%.

In addition to these primary outcomes, the look-behind review also found that investigations often did not include interviews with involved staff (<75%) or the involved individuals (<50%).

As an initial action, RMRC recommended the OHR a develop provider memo addressing these findings and stressing the need for providers to adhere to timeframes to complete their

investigation (outcome 1) , to ensure that they have trained investigators (outcome 2), and that providers interview involved staff and individuals as part of their investigation.

Part 3b. Serious Incidents

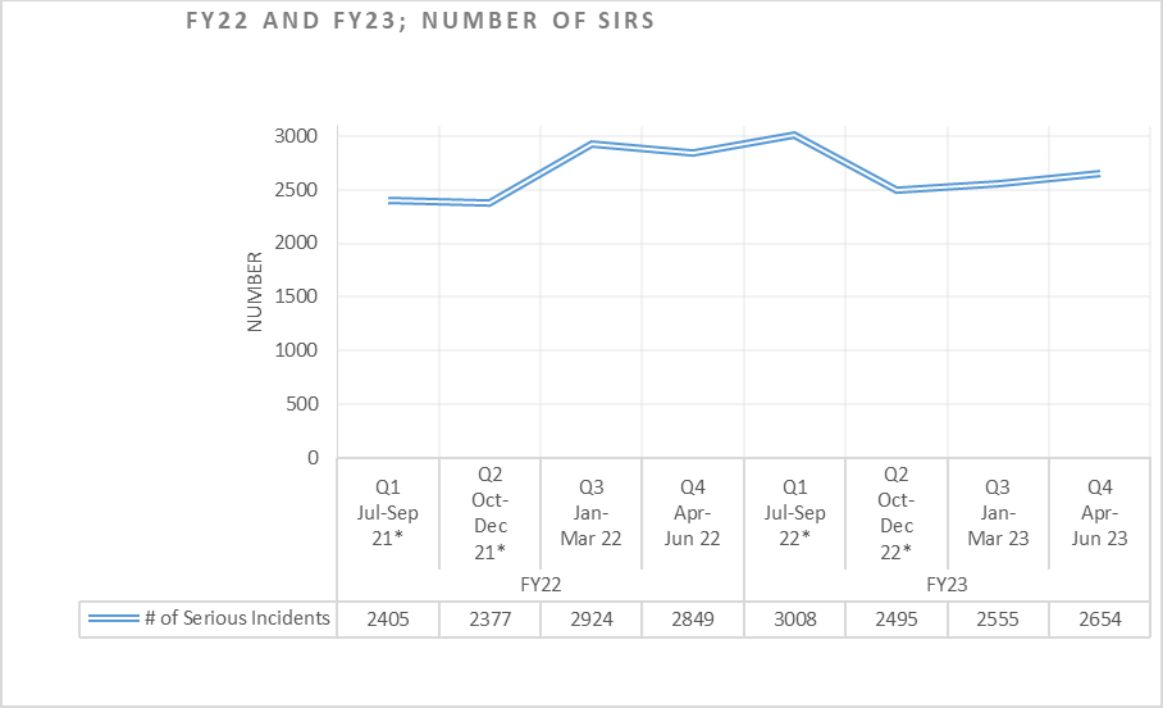
The RMRC is tasked with systematically reviewing and analyzing data related to the number and types of serious incidents, including specific surveillance measures, the Incident Management Unit (IMU) Look-Behind, timeliness of SIRs and related citations, CCs, and Medicaid claims reviews. Each task and 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 SIRs. In addition, the RMRC is responsible for developing an incident management process that monitors and responds to all reported SIRs. RMRC achieves this in partnership with the IMU) within the OL. The IMU reviews each serious incident to determine whether the information reported is complete and accurate using triage protocols to determine what 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.

IMU reported the number of SIRs (entered into CHRIS) for **licensed?? DD** service providers as follows: SFY2021: 9,753; SFY2022: 10,555; SFY2023: 10,712. Figure 1, below, depicts the number of serious incident reports for each quarter.

Figure 1. Number of Serious Incident Reports, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2022 and SFY2023



There were 10,712 Level II and Level III SIRs reported, across SFY22 and SFY23. The number and type of Level III SIRs, each quarter of SFY2023 (as reported by the IMU to RMRC), is depicted in the graph below.

Figure 2. Number of Level III Serious Incident Reports, in CHRIS for Individuals Receiving DD Waiver Services, SFY2023

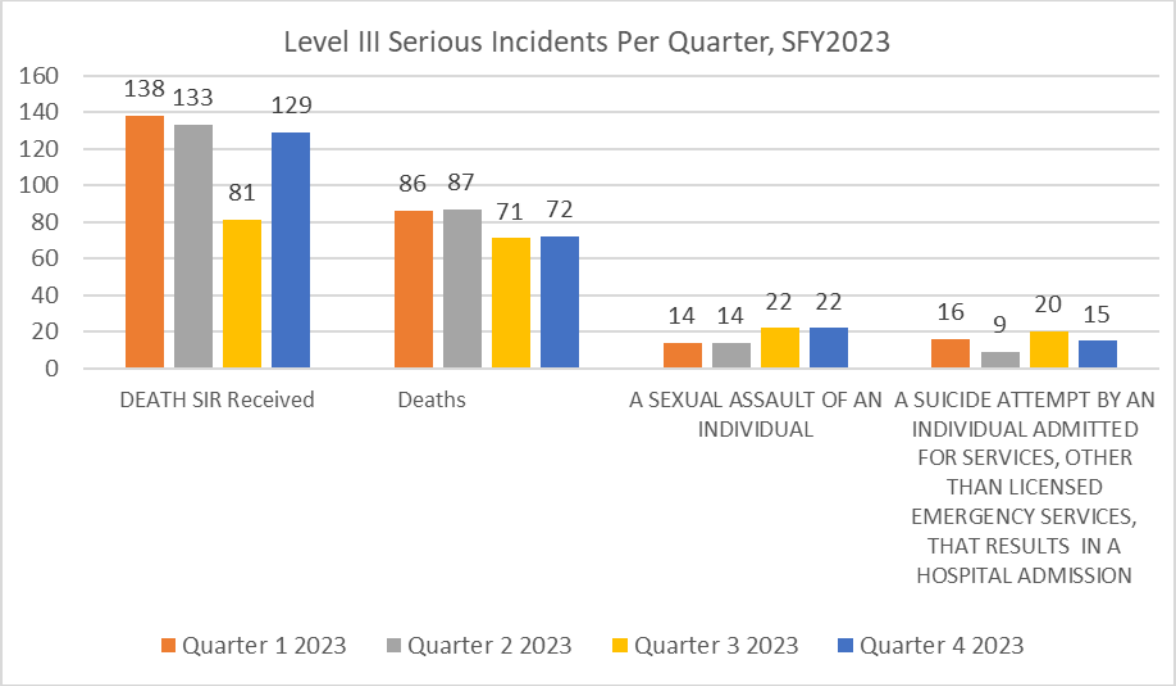


Figure 3. Number of Level II Serious Incident Reports by Type, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2023 (Sorted from Total, Highest to Lowest)

Serious Incident – Level II	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	Total FY23
ER Visit	1531	1521	1650	1708	6410
Unplanned Hospital Admission	410	403	442	422	1677
Other – Level 2	781	355	216	177	1529
Serious Injury – Requiring Medical Attention	164	127	133	180	604
Harm or Threat to Others	120	94	111	98	423
Unplanned Psychiatric Admission	80	72	106	124	382
Missing Individual	46	43	42	85	216
Decubitus Ulcer	30	22	25	46	123
Choking Incident	16	21	19	30	86
Bowel Obstruction	11	7	24	16	58
Aspiration Pneumonia	16	9	14	14	53
Ingestion of Hazardous Materials	4	7	3	10	24

Figure 4. Level II Serious Incident Reports, Top 5 Incident Types, in CHRIS, for Individuals Receiving DD Waiver Services – Trend Data SFY2020 Q2 – SFY2023 Q4

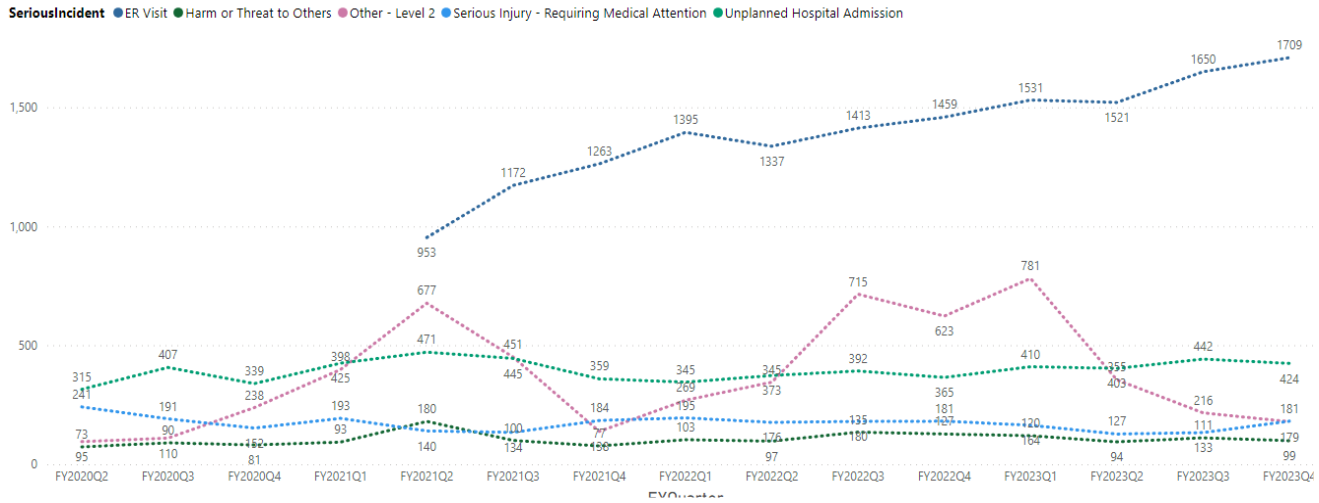


Figure 5. Number of Illnesses / Conditions Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2023 (Sorted from Total, Highest to Lowest)

Illness/Condition	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	Total FY23
Other Illness/Condition	587	627	710	694	2618
Covid-19	733	258	89	28	1108
Urinary Tract Infection (UTI)	154	159	169	158	640
Seizure	125	129	150	141	545
Mental Status Changes	106	113	127	121	467
Diarrhea/Vomiting	84	88	123	100	395
Pneumonia (Caused By Bacteria Or Virus)	68	88	81	86	323
Suicidal Thoughts/Behaviors	59	37	57	67	220
Blood Sugar Problem (High Or Low)	38	49	46	34	167
Constipation	36	39	40	43	158
Dehydration	45	27	38	47	157
Aspiration Pneumonia	34	20	35	26	115
Exacerbation Of A Chronic Medical Condition	28	26	18	32	104
Cardiac Event	22	22	25	27	96
Sepsis	18	22	27	20	87
Bowel Obstruction	18	11	24	18	71
Asthma	3	2	8	10	23
Stroke	5	9	3	4	21

Drug Or Alcohol Problem	1	1	3	2	7

Figure 6. Number of Illnesses/Conditions Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services – Top 5 Conditions Trend Data SFY2020 Q2 – SFY 2023 Q4

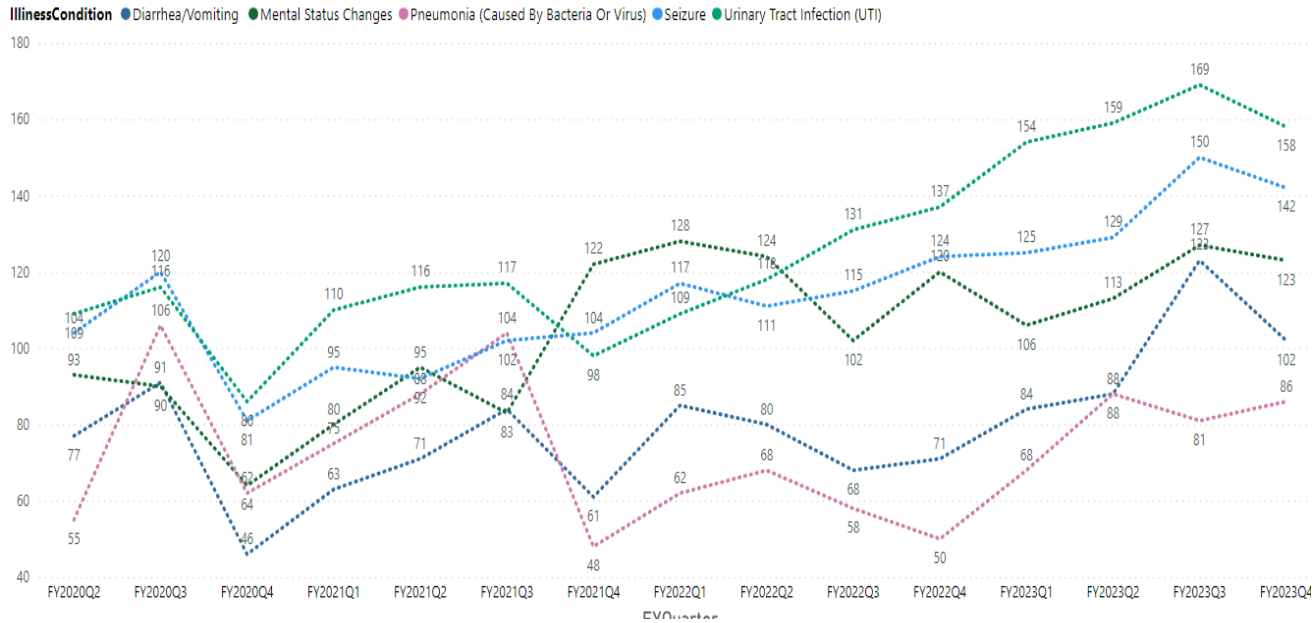


Figure 7. Number of Injuries Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2023 (Sorted from Total, Highest to Lowest)

Injury	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	Total FY23
Other Injury	250	205	231	268	954
Cut/Laceration	133	120	110	173	536
Bruise	108	81	108	129	426
Fracture	76	69	74	75	294
Bleeding	68	74	56	78	276
Pressure Injury (Decubitus Ulcer)	34	22	26	43	125
Sprain/Strain/Tear	28	31	19	33	111
Loss Of Consciousness	17	5	13	23	58
Bite/Sting	20	12	8	12	52
Obstructed Airway (Unable To Breathe, Turning Blue)	8	10	10	14	42
Allergic Reaction	7	4	9	8	28
Adverse Reaction To Medication	3	12	7	4	26
Concussion	2	1	4	7	14
Dislocation	4	4	1	4	13
Burn	2	1	2	6	11
Loss Or Serious Impairment Of Limb Or Other Body Part (E.G., Eyes, Arms, Legs)	2	2	3	2	9

Poisoning	3	1	0	2	6

Figure 8. Number Injuries Associated with Serious Injuries in CHRIS, for Individuals Receiving DD Waiver Services, – Top 5 Injuries Trend Data – SFY2020Q2 – SFY2023Q4

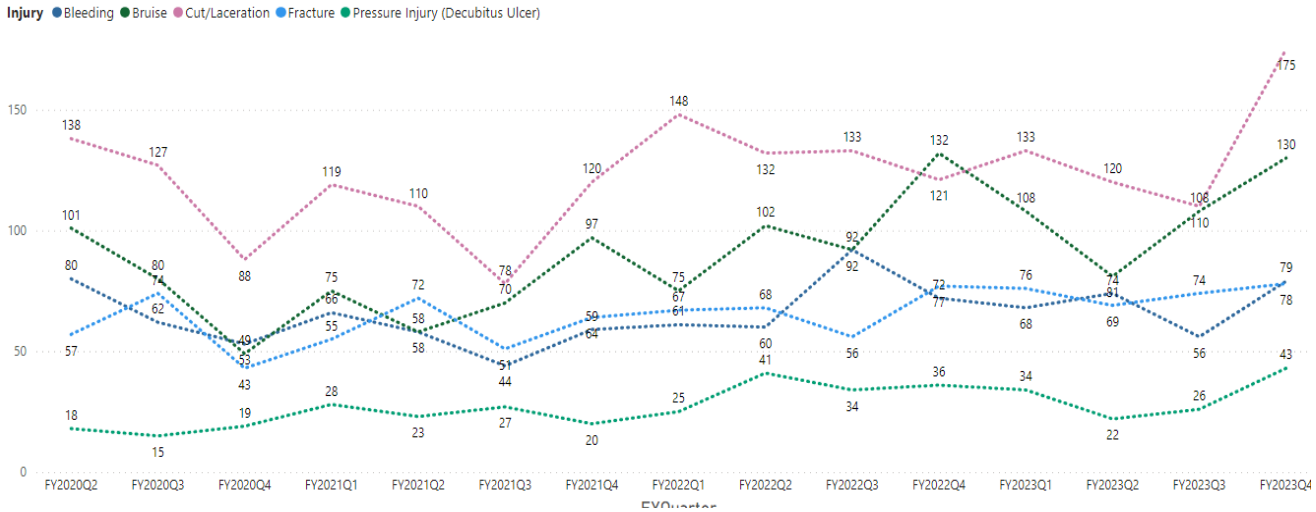
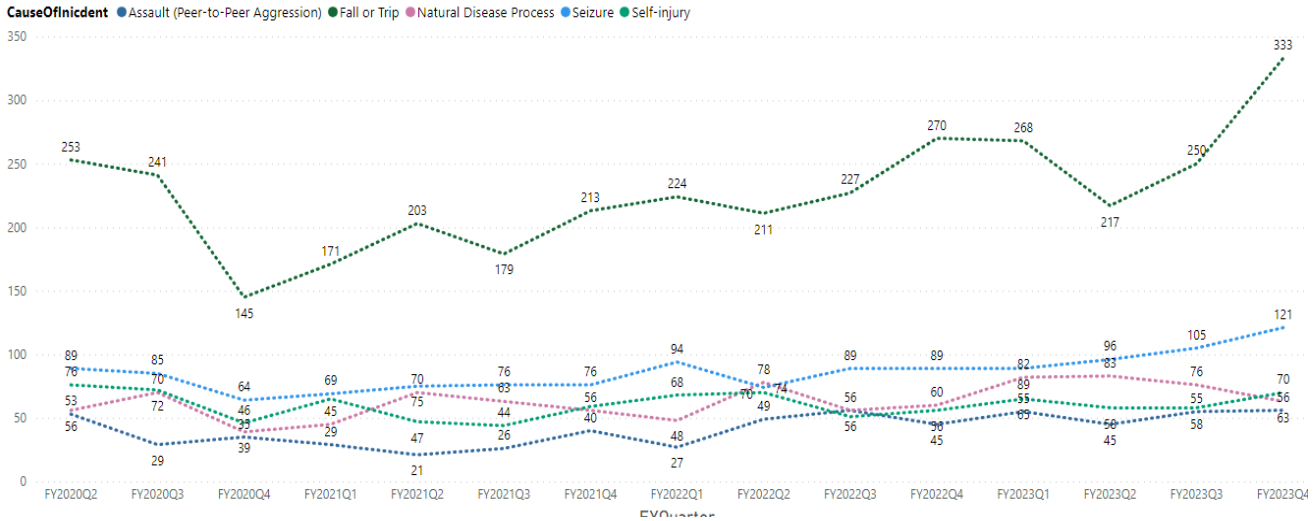


Figure 9. Number of Causes Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2023 (Sorted from Total, Highest to Lowest)

Cause Of Incident	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	Total
Unknown	1091	929	935	882	3837
Other	719	506	479	584	2288
Fall/trip	268	217	250	331	1066
Seizure	89	96	105	121	411
Natural Disease Process	82	83	76	63	304
Self-injury	65	58	58	68	249
Assault (Peer-to-Peer Aggression)	55	45	55	56	211
Medication Error	21	19	33	22	95
Motor Vehicle Accident	40	18	15	19	92
Medical Equipment Malfunction (Adaptive Equipment)	19	12	19	20	70
Neglect	21	10	15	23	69
Suicide Attempt	18	8	18	13	57
Accidental Injury (by another person)	11	12	10	13	46
Assault (by others)	8	13	9	13	43
Ingestion of Foreign or Hazardous Material	8	13	5	14	40
Traumatic Event	11	9	9	6	35
Restraint/ Seclusion	8	13	6	7	34

Cause Of Incident	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	Total
Assault (by staff or caregiver)	5	5	11	11	32
Animal or Insect Bite/Sting	10	8	1	5	24
Food Ingredients or Consistency	4	4	6	8	22
Overdose	1	2	4	4	11
Smoke or Fire Exposure		1	8	0	9
Overexertion	1	2		3	6
Poisoning or Exposure to Toxic Substance	2	1	1	0	4
Drowning	1	0	0	0	1

Figure 10. Number of Causes Associated with Serious Incidents in CHRIS, for Individuals Receiving DD Waiver Services, – Top 5 Trend Data SFY2020Q2 – SFY2023Q4



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 100 DBHDS SIRs and follow-up process. DBHDS contracts with VCU Partnership for People with Disabilities to conduct this review, which occurs quarterly and assesses the following outcomes:

a) Outcome 1: The incident was triaged appropriately by the IMU according to developed protocols.

To meet this outcome at least three out four criteria (listed below) must receive a finding of 'Yes' or "Not Applicable".

i. The IMU triaged the incident report the same day or the next business day after the report was submitted.
ii. The IMU specialist assessed for a CC in accordance with IMU protocols.

iii. The IMU specialist assessed for imminent danger in accordance with IMU protocols.
iv. The provider received a citation for late reporting.

b) Outcome 2: The provider's documented response ensured the recipient's safety and well-being.

To meet this outcome the reviewer must determine that the provider's documented response addressed ways to mitigate future occurrences.

c) Outcome 3: Appropriate action from the Office of Licensing Incident Management Unit occurred when necessary.

To meet this outcome the reviewer must determine a finding of "yes" for each of the following questions:

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 Serious Incident Unit (SIU) before closing the case.

d) Outcome 4: Timely, appropriate corrective action plans are implemented by the provider when indicated.

To review this outcome, VCU reviews any incidents in the sample that met the criteria for a CC and requests documentation from the provider to support their review and response to the incident. For each of these incidents the reviewer must be able to answer "yes" to the following questions:

i. The provider reviewed the incidents that led to the care concern and made a determination as to whether or not corrective actions were necessary.
ii. The provider took any necessary actions to identify and mitigate risks related to the care concern in a timely manner.

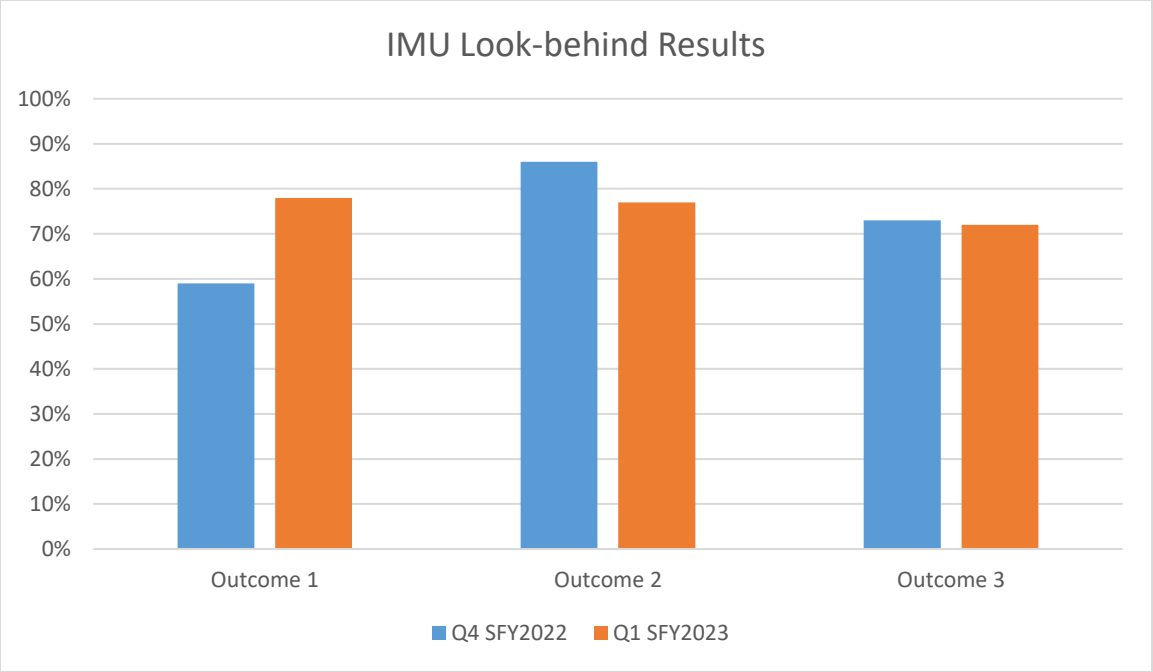
VCU's Partnership for People with Disabilities began conducting the IMU Look Behind reviews in SFY2023[1]. The VCU IMU Look Behind team completed 100 retrospective reviews of SIRs involving an individual receiving DD services, per quarter of the Calendar Year. The DBHDS

[1] DBHDS previously conducted look-behind reviews using internal staff. This was discontinued in 2022 due to issues with sustainability of reviewers and inter-rater reliability.

provided the Partnership with a report of all reported Level 2 and 3 SIRs involving a person receiving DD services. The Partnership then randomly generated a sample of 100 SIRs to complete look behind reviews. The VCU IMU Look Behind team consisted of three members including the Project Manager, Project Coordinator and one Quality Assurance Reviewers.

VCU completed comprehensive findings reports and submitted to DBHDS for Quarter 4 SFY2022 (April, May and June 2022) and Quarter 1 SFY2023 (July, August and September 2022). These reports provided details about the SIRs submitted, whether outcomes were met, recommendations for future look behind reviews along with interrater reliability findings. The chart below shows the percentages at which each outcome was met.

Figure 11. Incident Management Unit Look-Behind Results – April 2022 – September 2022



Initial reviews resulted in many questions, from the VCU Look Behind team, related to understanding the complexities of regulations and review protocols. The initial findings were believed to be negatively impacted, due to the review methodology in which the reviewers had to rely; requiring the use of an Excel spreadsheet, provided by DBHDS, to read through details about incidents and notes from the IMU. This initial process was cumbersome as the spreadsheets did not provide VCU reviewers with access to all of the information documented by IMU specialists. VCU recommended providing read-only access to the CONNECT system used by the IMU. Based on this recommendation OL worked with their vendor to provide VCU with read-only security access to the CONNECT system. This allowed reviewers direct access to incident reports and IMU review notes and promoted the reduction in the lag time between the end of the evaluation period and submission of the VCU Look-Behind analysis reports.

The initial reviews did not include an assessment of outcome 4 the process for assessment has not yet been finalized. The methodology for assessing outcome 4 will be finalized, with data reported beginning in SFY2024.

Following their initial review, VCU issued a number of recommendations for improvement, including:

i. The IMU should document the level number as well as the incident type to clarify that they have assigned a level number.
ii. The IMU should make clear in their notes if they provided technical assistance to providers regarding unreportable incidents.
iii. DBHDS should provide VCU reviewers with access to CONNECT, rather than providing information by spreadsheet and pdf copies of reports.
iv. The IMU include more details on other systems or information checked to determine if there are indications of suspected abuse, neglect or exploitation.

The IMU implemented several continuous quality improvement activities to address these recommendations. The IMU began conducting monthly audits and bi-weekly incident reviews to evaluate consistent application of protocols. In addition, the incident management manager now conducts supervision for each incident management specialist to review recommendations and corrective actions. Overall, the goal is to improve future outcomes by consistently reviewing Look Behind findings to offer guidance to the IMU specialists and DBHDS Licensed providers on improving standard practices.

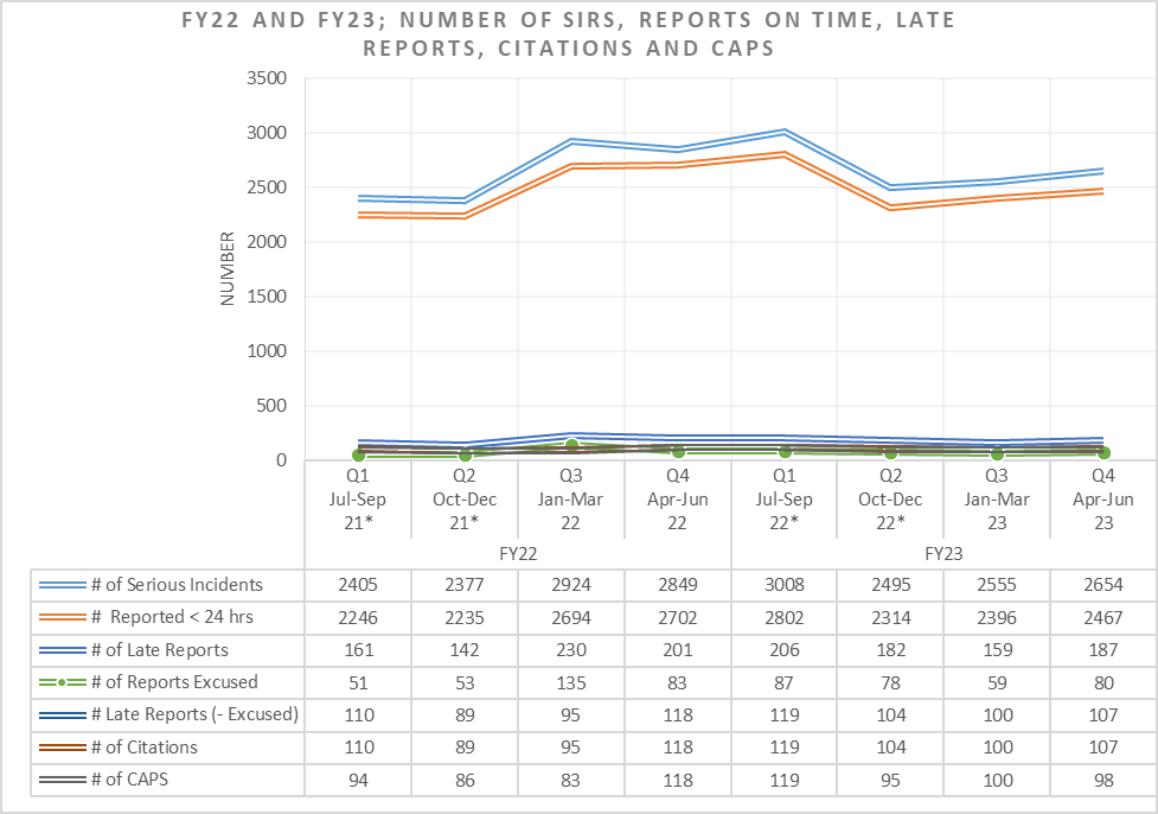
3b (3) Timeliness of Serious Incident Reports and Citations

The RMRC is responsible for monitoring aggregate data of provider compliance with SIR requirements and establishing targets for PMIs. To achieve this, the IMU identifies late, or unreported SIRs, 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 SFY2023, based on data from CHRIS, there were a total of 10,712 incident reports reported by licensed providers of DD services, 734 of which were reported late. Of those that were late, however, the IMU excused 304 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 430 unexcused late reports and 10,282 reported timely, meaning that 96% were reported within the required timeframes. This exceeds

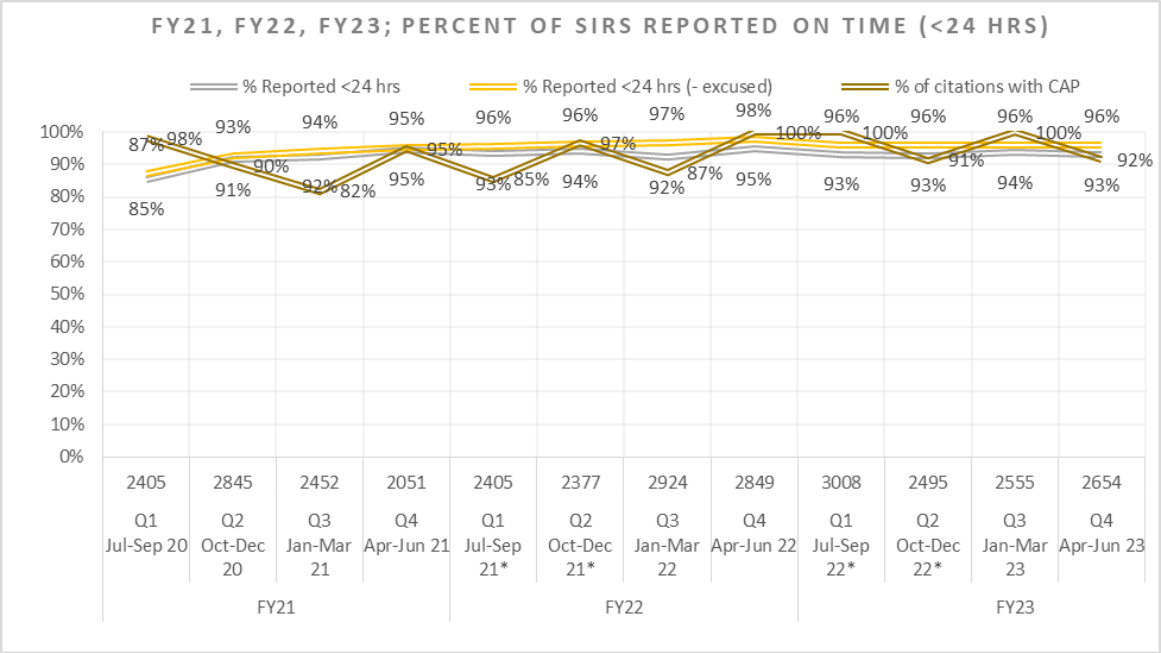
the target of 86%. As documented in the following graph, the goal has been exceeded for SFY2022 and SFY2023.

Figure 12. Number of Serious Incident Reports, in CHRIS, for Individuals Receiving DD Waiver Services, Timeliness and Citations, SFY2022 and SFY2023



	Q1 Jul-Sep 21*	Q2 Oct-Dec 21*	Q3 Jan-Mar 22	Q4 Apr-Jun 22	Q1 Jul-Sep 22*	Q2 Oct-Dec 22*	Q3 Jan-Mar 23	Q4 Apr-Jun 23
	FY22				FY23			
# of Serious Incidents	2405	2377	2924	2849	3008	2495	2555	2654
# Reported < 24 hrs	2246	2235	2694	2702	2802	2314	2396	2467
# of Late Reports	161	142	230	201	206	182	159	187
# of Reports Excused	51	53	135	83	87	78	59	80
# Late Reports (- Excused)	110	89	95	118	119	104	100	107
# of Citations	110	89	95	118	119	104	100	107
# of CAPS	94	86	83	118	119	95	100	98

Figure 13. Percent of Serious Incident Reports, in CHRIS, for Individuals Receiving DD Waiver Services, Reported Within 24 Hours, SFY2021-2023.



3b (4) Care Concerns

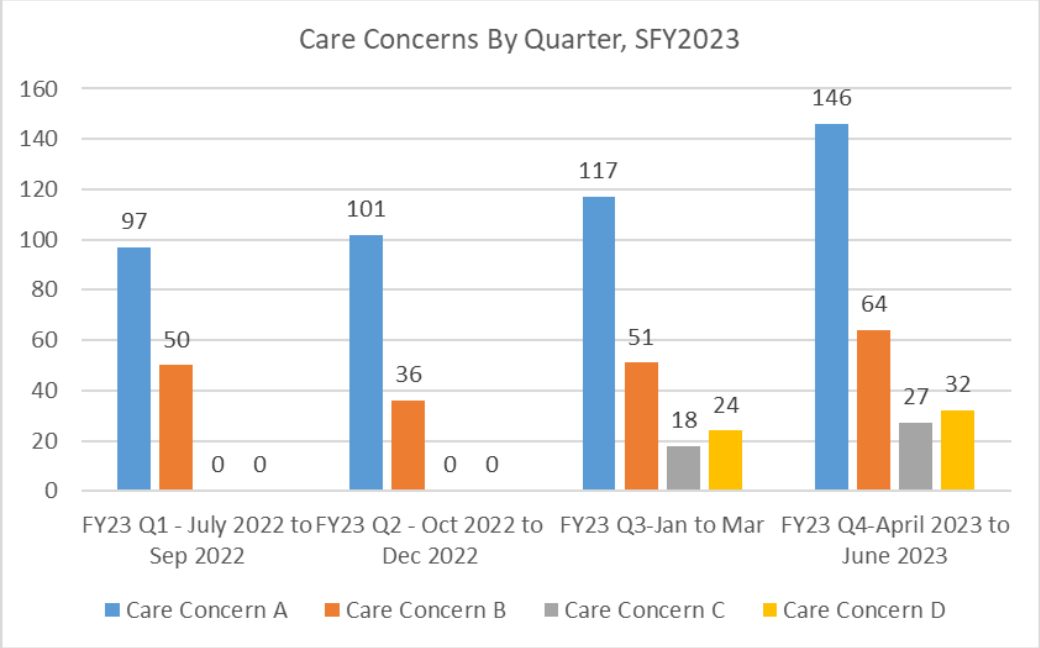
DBHDS has defined uniform risk triggers and thresholds to identify circumstances where there is potential risk for more serious future outcomes, which are called "care concerns". These uniform risk triggers and thresholds also further define the requirement outlined in Virginia regulation 12VAC35-105-520.D, which states "The systemic risk assessment process shall incorporate uniform risk triggers and thresholds as defined by the department." 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 CCs for DD services to RMRC quarterly. In January 2023, the IMU revised the CC criteria which are listed below.

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.

The IMU shares all CCs 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.

During SFY2023, there were a total of 763 CCs. There were 458 CCs for criteria 'a', 201 for criteria 'b,' 45 for criteria 'c,' and 56 for criteria 'd.'. The graph below shows the number of CCs by criteria type and by quarter during SFY2023.

Figure 14: Care Concerns by Quarter, SFY2023



Notably, as part of the RMRC QII on improving licensing regulations 520C and D, a handout was created with the goal of more clearly explaining risk triggers and thresholds, and CC, for provider (as this was identified as a significant area of confusion during the QII root cause analysis). The handout was introduced as part of a PowerPoint slide presentation from the IMU

to providers, posted on the OL website, and discussed as a resource during the Minimizing Risk training presented as part of the QII, in April 2023.

In SFY23 OIH began providing quarterly reports to the RMRC on the CCs process of providing follow-up support and technical assistance by the registered nurse care consultants (RNCCs). Once OIH receives notice of a CC from the IMU, OIH triages the case based on need for follow-up. Follow up can include providing written resources, training, support or referral to other DBHDS resources; and in some cases, providing case-specific consultation and technical assistance which can include individualized provider training and site visits.

In March 2023, OIH reported on UTI related care concerns during Q3 and Q4 of SFY22. In summary, there were 77 CCs that involved a UTI serious incident. OIH followed up on 73 of these concerns, noting the main reason for not following up included a repeat concern on which they had already followed up. The most common supports that nurses gave providers were sharing a link to the Health and Safety Alert on UTIs and sharing information about upcoming trainings and community nursing meetings. They also shared that between 2021-2023, OIH offered five trainings on UTIs and had 613 participants.

In June 2023, OIH shared data about CCs for SFY23, Q1-Q3. There were 492 CCs referred to OIH. The top three conditions identified were seizure (N=113), UTI (N=91) and pressure injury/decubitus ulcer (N=90). OIH provided follow-up support to 93% of cases, and 32% received a phone call from OIH. OIH reviewed their training offerings which include quarterly live web-based training, private training, PPT slides and trainings recorded on the Commonwealth of Virginia Learning Center (COVLC). During this time, 2,318 people participated in at least one of 39 quarterly live trainings offered by OIH. OIH provided private training for eight provider organizations, reaching 423 staff. OIH offers eight PowerPoint training slide decks for providers to use on demand. Finally, 265 people participated in at least one of six trainings offered by OIH on the COVLC.

3b (5) Medicaid Claims Review

To further validate that SIRs 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 links the Medicaid claim file with CHRIS to determine whether there are claims for hospital admissions or ER visits without a corresponding SIR.

The DBHDS DW 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 period 7/1/2022 – 9/30/2022, a total of 1,713 claims were identified as meeting the criteria above. The DW was able to match these with 1,196 CHRIS reports, for a match rate of 70%. 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 517 claims that did not have a matching CHRIS entry, 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, documented 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);
- The individual had a planned hospital admission, procedure, or appointment.

Based on this review, a total of 231 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.

Figure 15: Medicaid Claims – Reasons for Not Reported and Excused (7/1/22 – 9/30/22)

Reason	Number	Percent
Incident found in CHRIS	93	**40%**
Planned procedure	33	**14%**
Provider has no record/Not aware of the incident at the time	17	**7%**
Individual with family	26	**11%**
Scheduled appointment	6	**3%**
CHRIS system issues	3	**1%**
Not with provider during date of service	53	**23%**
Totals	**231**	**100%**

Of the remaining claims, 286 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, 35 providers stated that they did not report emergency room visits because the emergency room visit was in lieu of a primary care visit (this is down from 100 who provided this reason last year). 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 regulations were promulgated, requiring the reporting of all incidents that result in an emergency room visit. Providers that were identified as not reporting as required are 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 SIRs for the period 7/1/2022 – 9/30/2022 (Q1, SFY2023).

The IMU reported a total of 3,008 SIRs in CHRIS; of these 2,889 (96%) were reported timely. This claim review identified an additional 286 claims that represented SIRs that should have been reported but were not. Adding this to the total number of SIRs brings the total number of reports to 3,294; the number reported timely remains at 2,889; thus 88% 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 risks prevalent within the DBHDS DD 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 Health and Safety Alert newsletter. 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. At least quarterly in SFY2023 the RMRC continued a process developed the prior year, in which 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 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

Health and Safety Alerts

The OIH Support Network issued 10 Health and Safety Alerts during SFY2023 as means to assist providers in identifying and reducing the risk of adverse events due to health and safety risks. These alerts include mitigating strategies that can assist with reducing risk.

They are listed below:

- Recognizing Declining Health – July 2022 *Updated 10.2023*
- Intellectual and Developmental Disabilities – August 2022 *Updated 10.2023*
- Nut Butters and Choking – September 2022 *Updated 10.2023*
- Lower Risk of a Fatal Opioid Overdose with REVIVE! Training – November 2022
- Substance Use Disorders (SUD) – November 2022
- Respiratory Infections Overview – January 2023
- Annual Healthcare Visits – February 2023
- Home Health and Safety – March 2023
- Choking – April 2023
- Pica – May 2023

Annual Review of Health and Safety Alerts

The OIH Support Network regularly reviews and updates as applicable the content of Health & Safety alerts and to ensure that information pertaining to the identification and prevention of risks, risk assessment and mitigation of risks remains current. Health & Safety Alerts have been reviewed bi-annually and updated to align with current best practices. In SFY23 three alerts were updated to ensure accuracy of content, resources and that links are active; the review process was also updated. The new process for review is now monthly. Each month after a new Health & Safety Alert is written, all previous Health & Safety alerts for that same month are reviewed for

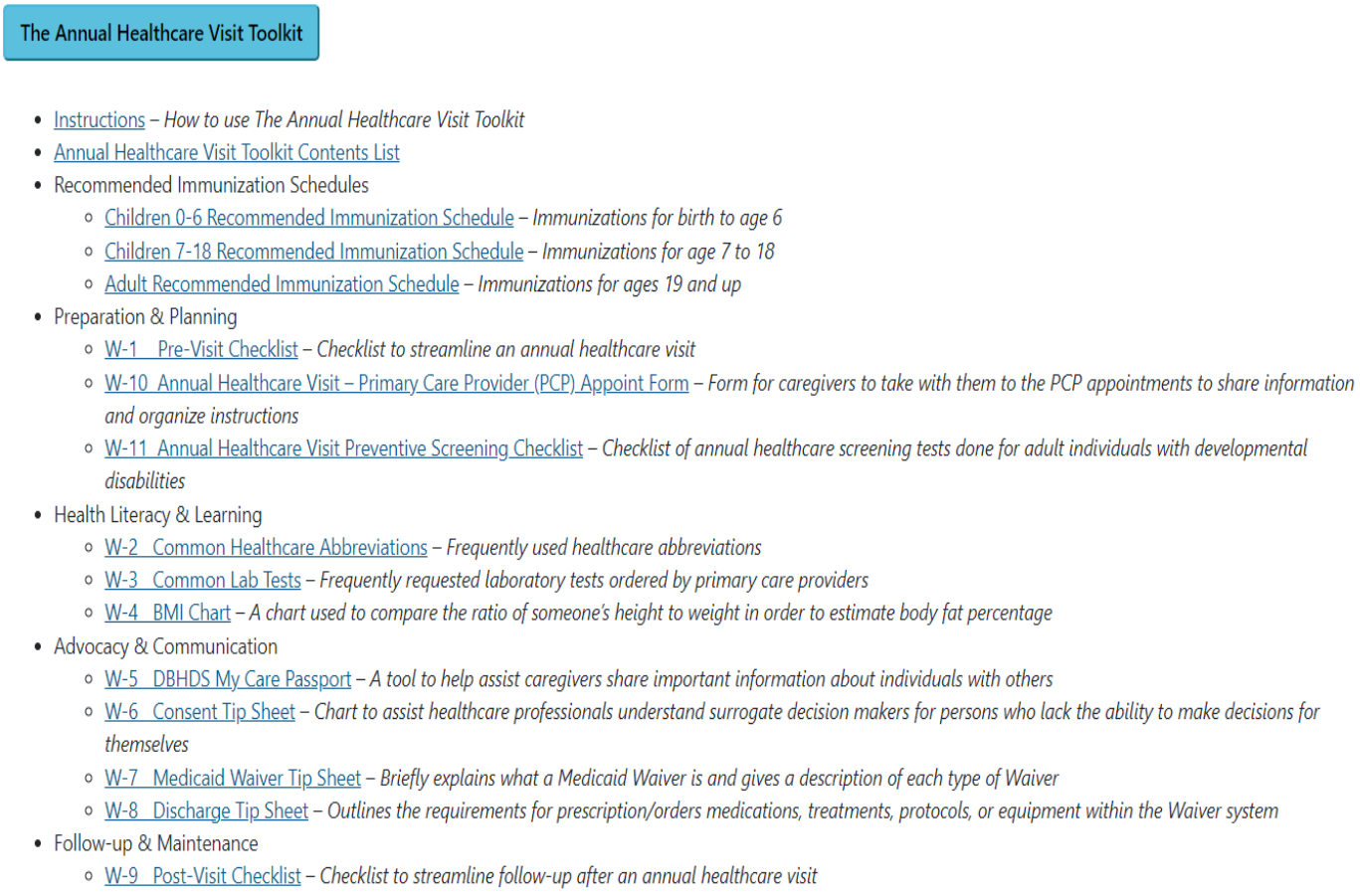
the previous five-year period. For example: In January 2024, the Health & Safety alerts published in January 2020, 2021, 2022 and 2023 will be reviewed. The results of the reviews are maintained in an excel based data base and are presented to the RMRC annually.

Health Trends Newsletter

The OIH Support Network posted 12 Health Trends Newsletters in SFY23. Each newsletter presented current topics and newsworthy announcements to interested stakeholders. They can be found at Office of Integrated Health - Virginia Department of Behavioral Health and Developmental Services

Education Resources added to the DBHDS website in SFY2023

The OIH Support Network researches, creates and posts educational resources to support continued education and best practices in areas of health and safety. The focus of educational material in SFY23 was the development of a tool kit that supports annual physical exams. The initial tool kit content can be found at this link: Office of Integrated Health - Virginia Department of Behavioral Health and Developmental Services The current content in the tool kit is pictured below:



Training

The OIH Support Network completes the research, creates and presents training to support the continued education of paid and unpaid caregivers, both professional and paraprofessional, with a focus on best practices in areas of health and safety. Training presented in SFY23 from August 1, 2022 to June 30, 2023, is listed in the table below by topic and the number of times the training was presented.

Count of Trainings

Enter type of Training	Count
911 & Choking	1
Caregiver Training	1
Choking & Nut Butters	5
Diabetes Part 1	8
Diabetes Part 2	5
Dysphagia and Modified Diets	4
Emergency Preparedness Part 3	3
Falls	2
Fatal Seven	6
Medication Error Training	1
MRE	13
My Care Passport	3
Nutrition Part 1	1
Nutrition Part 2	1
Oral Health	4
Pressure Injury	1
RAT	4
Sepsis	2
Skin Integrity & Pressure Injuries	5
SN/PDN Training	5
Transfers Training	2
Urinary Tract Infections	5
Vital Signs	2
Wheelchair Transitioning Training	2
Grand Total	86

Quarterly Review: Each quarter in SFY2023, 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 risk topics reviewed included;

- Provider familiarity with the mobile rehabilitation engineering team,
- Provider compliance with risk management and quality improvement regulations,
- Information on addressing risks related to choking, UTIs, and nutrition,
- Providers understanding of conducting RCAs on medication errors,
- Coordination across offices regarding providers with multiple health and safety citations,
- Increases in the number of reported deaths and CCs.

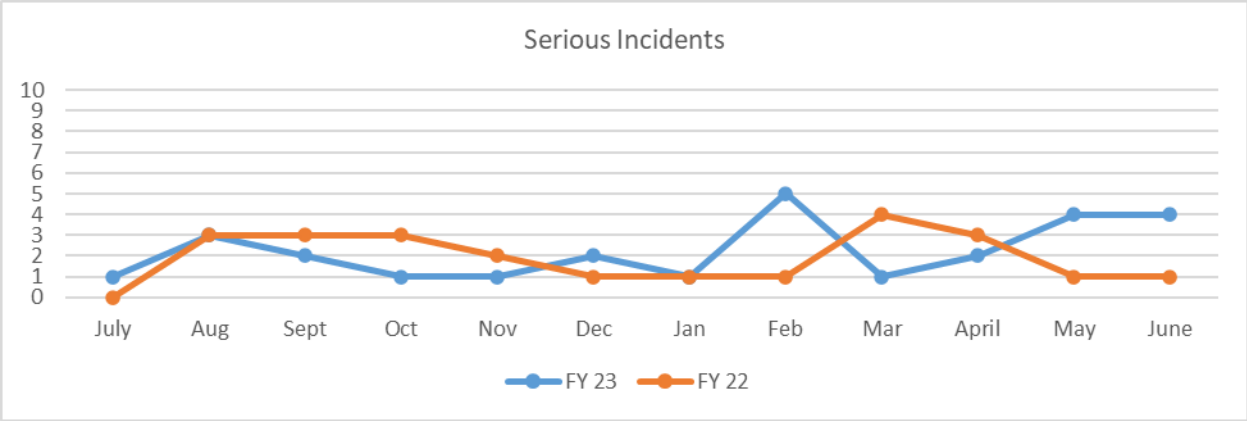
The committee determined that, for most of the topics reviewed, there was already existing content that addressed the issue, or educational material was in development.

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), specific to Virginia Training Centers. As part of the processes listed there in, 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 SFY2023, 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 94 physical restraints for SFY2023 and 52 mechanical restraints. In another example, SEVTC reported that there were 23 SIRs for SFY2022, and 27 in SFY2023. Figure 15 shows a graph shared by SEVTC showing trends in SIRs during SFY2023 compared to SFY2022.

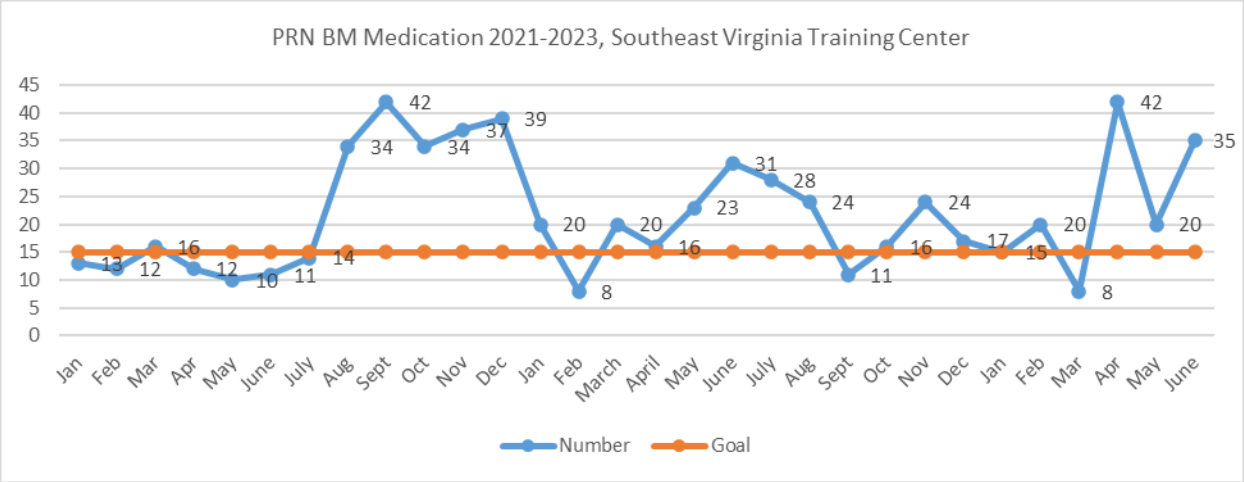
Figure 16. Southeast Virginia Training Center, Serious Incidents by Month, SFY2022 and SFY2023



SEVTC also shares information about quality improvement efforts. SEVTC completed a performance improvement initiative to reduce the number of PRN (as needed) medications required for constipation. The goal was to reduce PRN medications **used for constipation f**rom

a baseline of a monthly average of 36 during September 2021 – January 2022, to 15 or less per month. SEVTC implemented multiple evidence-based changes, such as reviewing and adjusting medications that may cause constipation and having a dietician conduct dietary reviews. While SEVTC was not able to maintain a rate of prescription PRNs below their goal, a review of individuals receiving medication determined that the medications were administered appropriately, following individualized protocols, and that no individuals were hospitalized for bowel obstruction. The focus has shifted to ensuring that staff are not administering PRN medication inappropriately and that individual protocols are being followed. SEVTC completed the QII.

Figure 17. Southeast Virginia Training Center, PRN BM Medication, 2021-2023 for Quality Improvement Project



Part 3e. Case Presentations

Case reviews can be 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 RMRC had one case presentation in SFY2023. In July 2023, OIH presented a case of a CC of an individual with a bowel obstruction that involved a medication error. Multiple concerns were noted including: the provider not conducting appropriate medication reconciliation activities; lack of internal communication in the provider agency; and unprepared staff accompanying the individual to a specialist medical appointment. OIH provided on-site technical assistance to the provider and emphasized their plans to offer training on medication reconciliation and additional resources related to preventing medication errors.

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 KPA of Provider Competency and Capacity. OLis 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.

Figure 18: 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	CY2022
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%	56%↓
• 520A - Designated person with training or experience responsible for risk management function	77%	72%↓
• 520B - Implements a written plan	89%	88%--
• 520C1 - environment of care	85%	85% --
• 520C2 - clinical assessment/reassessment	81%	83%↑
• 520C3 -staff competence / adequacy of staffing	80%	84%↑
• 520C4 - use of high-risk procedures	79%	81%↑
• 520C5 - review of serious incidents	85%	85% --
• 520D - Systemic risk assessment incorporates risk triggers and thresholds	79%	75%↓

• 520E - Conducts annual safety inspection	90%	93%↑
Quality Improvement Program Requirements		
% Of providers that are compliant with 100% of the QI Requirements	52%	55%↑
• 620A - Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	91%	94%↑
• 620B - The QI program uses standard QI tools, including RCA and has a QI plan	89%	92%↑
• 620C - The QI Plan shall:	--	--
• 620C1 - Be reviewed and updated annually	81%	86%↑
• 620C2 - Define measurable goals and objectives	78%	85%↑
• 620C3 -Include & report on statewide measures	87%	78%↓
• 620C4 - Monitor implementation & effectiveness of approved CAPs	75%	81%↑
• 620C5 - Include ongoing monitoring and evaluation of progress toward meeting goals	78%	85%↑
• 620D - The providers P&P includes criteria used to:	--	--
• 620D1 - Establish measurable goals & objectives	74%	85%↑
• 620D2 - Update the QI plan	74%	87%↑
• 620D3 - Submit revised CAPs when not effective	65%	78%↑
Input from individuals about services & satisfaction	81%	83%↑

These results, from CY2022, show that six of the 520 and 620 sub regulations were met at 86% or above; 12 were between 75%-85%, and four were below 75%. Notably, only four sub regulations showed a decrease in compliance from CY21 to CY22, while 15 showed an increase in compliance from CY21 to CY22.

In response to these trends in the data, the OL and the RMRC have continued to implement mitigating strategies to improve provider compliance with regulations related to RM and QI. Activities in SFY2023 included holding a three-part provider training on risk management and quality improvement, which included introducing a tool for tracking SIRs as well as a template for documenting an annual systemic risk assessment. In addition, the OL conducted a three-part provider coaching seminar that covered the full range of licensing regulations, but also focused specifically on conducting a root cause analysis, risk management requirements, and quality improvement requirements as well as shared a template for conducting a root cause analysis and examples of conducting a "5 Whys" exercise.

In addition, the Office of Community Quality Improvement (OCQI) expanded its consultation and technical assistance (CTA) offerings to help providers that had not met the licensing requirement that Quality Management Plans contain measurable goals and objectives (regulation 620.C.2). Between January-June 2023, a total of 17 providers self-selected to participate in 620.C.2. CTA. QI Specialists from the OCQI met with each provider over three sessions to assess their understanding of developing measurable goals and objectives and the difference between QA and QI. Based on where the providers were in their knowledge and use

of QI principles and tools, the QI Specialists presented various tools such as the explanation and use of SMART goals, RCA tools (e.g., "5 Whys", fishbone diagram, run charts), and discussed the use of provider-generated data available to them in-house that could be used for focusing their QI efforts. Post-CTA experience surveys completed by providers showed that learning occurred during the sessions, that learning would be incorporated into future QI efforts, and that those providers would highly recommend the CTA to other providers.

The RMRC also focused on licensing regulations 520C and D for its proposed QII for SFY2023. The changes and results associated with this QII are discussed 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 SFY2023, RMRC reviewed the results of the QSR from Round 3 in October 2022, and Round 4 in April 2023. The committee took the following actions, as a result of its review.

The QSR in Round 3 found that 16% and 17% of medical and behavioral needs, respectively, identified in the SIS were not addressed in the ISP. RMRC requested that the Case Management Steering Committee (CMSC) examine this concern. CMSC responded and described mitigating strategies that are being implemented to address this issue, including multiple educational and informational avenues for providers.

The QSR, in Round 4, found that 66% of all risks identified in the Part II of the ISP were addressed under an outcome of Part III. RMRC also asked CMSC to review this concern. CMSC responded that there is a QII in place to integrate the Risk Awareness Tool into WaMS which will make it easier for providers to put risk information from Part II into Part III.

RMRC did not identify any QII at the time, as a result of the QSR report.

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 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.

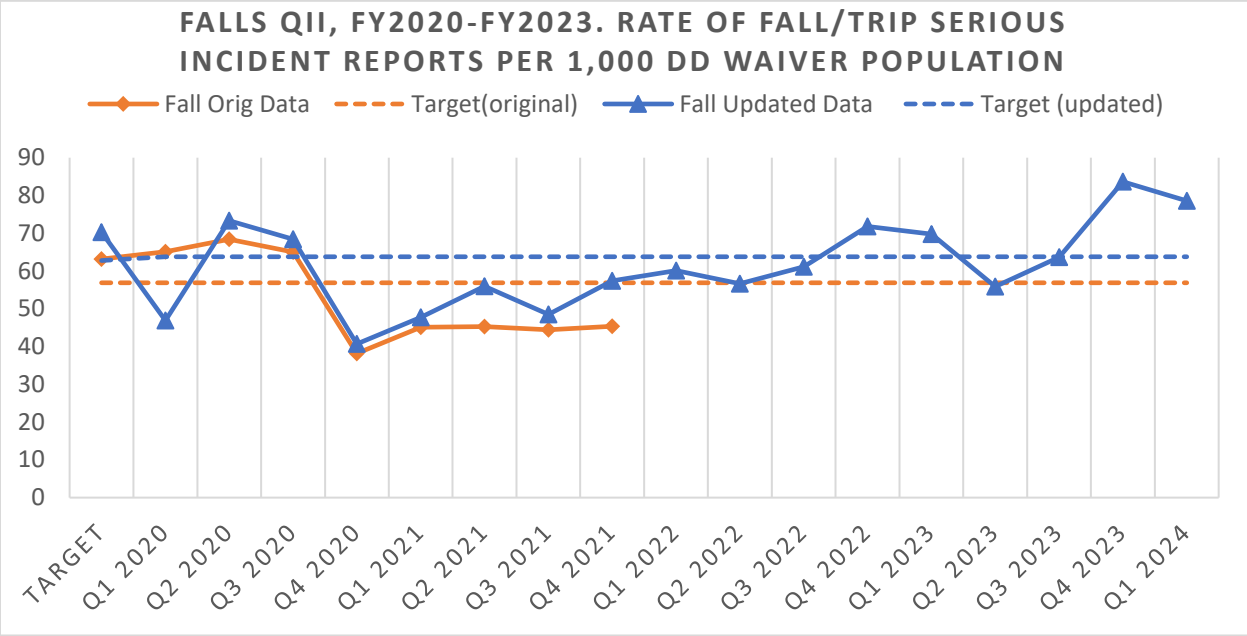
A Falls QII Workgroup met regularly since November 2020 to oversee implementation of the Falls QII, assess and document progress using the PDSA cycle, identify barriers and plan solutions, and report regularly to the RMRC. The Falls QII Workgroup consisted of representatives from OIH, OHR, Provider Development, the IMU and OCQM.

RMRC ended the QII on April 21, 2023. A summary of the changes can be found below.

Change	Plan/Do Status	Summary of Study Results	Act / Recommendations
1. Educational activities and resources for falls	Implemented, 2020-current	• 1,400 participants in RAT training • 460 people completed Falls training in COVLC. • 360 people completed live training on falls. • May 2021 – positive results from training survey	Adopt • DBHDS will continue to offer these trainings. • RMRC recommends being able to count downloads on the DBHDS website. • RMRC recommends having a better training platform to track progress and completion.
2. OIH Care Concern follow up for falls	Implemented, 2021-current	• 100% of providers received follow up from OIH • 2021 Survey showed 82% of DSPs completed recommended training	Adopt • OIH will continue to provide follow-up.
3. Risk Awareness Tool utilization & evidence in ISP	Implemented, 2020-current	• Identification of new fall risk • Evidence in the ISP	Adopt • There are plans to integrate RAT into the ISP going forward.

There was an 18+ month delay in obtaining falls data due to the lengthy time to address concerns about data validity and subsequently produce a new report. As a result of having updated data on SIRs, the baseline and goal for the Falls QII were updated. The new baseline for the period of 10/1/19-3/31/20 was 70.85; the new goal to achieve by June of 2022 was 63.78 per 1000 individuals receiving DD waiver services. This Aim was not achieved. The rate of falls for Q4 of SFY2022 was 71.76, per 1000 individuals receiving DD waiver ps. The PDSAs and tests of change, while successful independently, did not serve to achieve a sustained 10% reduction in the rate of Fall SIRs. RMRC elected to end this QII, continue to monitor the trend, and possibly consider another QII focused on falls in the future. See Figure 18 for Falls data through the lifetime of the QII.

Figure 19. The rate of Falls/Trips Serious Incidents Per 1,000 Individuals Receiving DD Waiver Services; SFY2020 Q2 through SFy2023 Q4.



6b. Reducing Risk of Medication Errors

RMRC remains interested in reducing the risk of medication errors. The following three areas of work are reported on quarterly at the request RMRC.

1. Development of a new medication curriculum training program. OIH reported in October 2022 that the funding, for development, was approved. However, in March 2023 they reported encountering multiple barriers and as of June 2023 have decided to postpone this activity. Instead, OIH is developing a 3-part series on medication administration through the Health and Safety alert publication. This will be published in SFY2024.
2. Revising guidance related to reporting medication errors as neglect. This work began in 2021 and continued during SFY2023.
3. Conducting root cause analysis for medication error SIRs. TA workgroup, formed by RMRC, developed four examples of medication error RCAs using the "5 Whys" approach, and the OL Serious Incident Review and RCA Template. These are available on the OL website.

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

In SFY2023, the RMRC continued the QII to improve provider compliance with conducting an annual systemic risk assessment (licensing regulations 520C and D). This QII is in partnership with the Regional Quality Council in Region 5 (RQC5). 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 for each regulation is as follows:

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

A work group met regularly to implement this QII. The work group was comprised of CSB quality staff, private providers, a family member of an individual receiving services, as well as DBHDS staff from OCQM, OHR, and OL. The team first completed a root cause analysis which entailed doing key informant interviews with licensing specialists, compliant providers, and non-compliant providers to learn what helped and hindered compliance with these regulations. The leading root causes included: providers not understanding risk triggers and thresholds, not understanding CCs, not understanding what to include in a systemic risk assessment and having some misinformation and misconceptions about requirements. To clear up confusion and help providers achieve success with these regulations, the team developed several tools and resources, and a 3-day training described below. Components were studied to determine effectiveness.

- **Minimizing Risk Training:** A 3-part training series conducted in April 2023 designed to directly address root causes of noncompliance with licensing regulations 160C, 520C, 520D and beyond. It focused on providing clear information on how to meet the regulations and demonstrated how to use the tools listed above. As many as 800 participants attended, and the post-tests demonstrated participants gained knowledge and confidence related to meeting the regulations.
    - There were 800 attendees for Day 1, and 682 for day 2 and 627 for day 3.
    - For Day 1, participants reported an increase in understanding the difference between a RM plan and a QI plan, where to find OL resources, and how to do a systemic risk assessment. 86% felt more capable to meet the requirements of 520C and D.
    - For Day 2, participants reported a better understanding of how to track SIRs and CCs and how to look at data trends.
    - For Day 3, 93% reported they feel more confident about completing a systemic risk review (a feature of 520C/D). More than 87% felt that the new tools/resources introduced were somewhat helpful (~22%) or very helpful (~65%).
- **Flow chart of incident reviews:** 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. This was developed in SFY2022 and featured in the Minimizing Risk training.

- **Risk trigger threshold / care concerns handout:** A one-page handout was created with the goal of more clearly explaining risk triggers and thresholds, and CCs for providers. This is available on the OL website.
    - Results of a brief survey showed show a positive shift, among those who reviewed the information, in their understanding of risk triggers/thresholds, CCs, and the importance of tracking SIRs.
- **Excel Risk Tracking tool:** An optional tool that providers can use to enter the number of SIRs each month, including Level I incidents. It automatically creates graphs for each Level of incident (I, II, III) and total number of incidents quarterly and annually. It also has a worksheet to help teams review their SIRs on a quarterly and annual basis, a requirement of regulation 160C. They can then use this information to help complete the annual systemic risk assessment, which is part of regulation 520D. This is available on the OL website.
    - 89% of Minimizing Risk Training participants who did the post-test/evaluation survey said they found the Excel risk tracking tool helpful and 68% said they plan to use it.
- **Systemic risk assessment template:** A template developed by OL that providers can use to document their annual systemic risk assessment. It includes all the required elements and is designed for providers to easily fill in their information.
    - 89% of Minimizing Risk Training participants who did the post-test/evaluation survey said the SRA template was helpful, and 68% said they plan to use it.

All the tools and resources listed above are available on the OL website, including the PowerPoint slide decks and recordings of the training sessions.

RMRC is awaiting more recent licensing inspection data to determine if the Aim was met for this QII.

Part 7. Efforts to Improve Data Quality

In SFY2023, DBHDS and the RMRC addressed previously identified data source system issues that adversely impacted the ability of the RMRC to review SIRs and ANE allegations and substantiations, and to conduct the OHR look-behinds. The issues, put simply, included:

- Data exclusion of individuals with an unknown DD 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 waiver services due to incorrect or different lists of services across CHRIS, WaMS, OLIS and CONNECT (which replaced OLIS in November of 2021).
- The CHRIS drop-down selection list of provider service types, for the Human Rights side of CHRIS (ANE reports) differed from that of the Incident Management side of CHRIS (SIRs), 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 does not track 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 issued an RFP for a new incident management system in SFY2023.

The majority of these issues were resolved in SFY2023, allowing for RMRC to resume reviewing these data beginning in February 2023. The resolution included aligning the licensed services with the population type (DD, MH, SA) across CHRIS and CONNECT ensuring a 1:1 relationship between the licensed service and the population type; aligning the reporting interfaces between SIRs and ANE, such that providers were presented with the same interface and only allowed to select those services for which they were licensed; and modifying the query for calculating surveillance rates to include all individuals receiving a DD waiver services, which addressed the potential error associated with selecting an unknown waiver. The improvements did not address the issue of a unique identifier; thus, reports represent a valid count of the number of incidents reported, but not of the number of individuals that have experienced a serious incident or ANE.

An RFP (request for proposals) has been issued to replace the CHRIS incident reporting system; requirements for the new system include the ability to assign incidents to unique individuals. It is anticipated that a new system may be implemented in SFY2025. In the meantime, validation of individual reports occurs through the IMU review process. The IMU reviews incidents for duplicates and flags the duplicate as such. In addition, the IMU process includes reaching out to providers when clarification or corrections are needed. The IMU holds regular trainings for providers including training on the regulations pertaining to reporting, how to submit a serious incident report, how to access CHRIS and how to revoke access to the CHRIS system, updating serious incident reports, who the regional IMU specialists are and how to contact them. In addition, trainings are posted on the Office of Licensing website and the regional IMU specialists provide individual technical assistance to the providers in their area via email and phone calls. Additionally, it is possible that some information on the numbers of individuals experiencing serious incidents may be derived from combining identifiers (first name, last name, date of birth). While this may erroneously count the same individual as two different people if the spelling of the name differs, or there is error in the date of birth, this will err on the side of overreporting. Possibilities for using this data will be explored in SFY2024.

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. In SFY2023, the RMRC monitored four PMIs (as indicated in the table below).

Figure 20: Performance Measure Indicators, SFY2022-SFY2023

Performance Measure Indicators	Target	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY22 Overall Results	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4	SFY2023 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%**	96%	96%	96%	96%	**96%**	**Exceeded Goal**
Licensed providers meet 100% of regulations for risk management programs	≥86%	62%	63%	61%	61%	**61%***	57%	45%	65%	56%	**56%****	**Below Goal**
Licensed providers meet 100% of regulations for quality improvement programs	≥86%	53%	45%	55%	54%	**52%***	59%	51%	60%	58%	**56%****	**Below Goal**
Individuals are free from harm, as reflected in the rates of serious incidents that are related to risks which are prevalent in individuals with developmental disabilities: **Falls**	≤ ~~56.88~~ **NEW GOAL = 63.78 or less**	62.43	56.67	61.16	71.76	**62.43**	69.85	55.95	63.70	84.20	**68.43**	**Goal not met**

* Data for calendar year 2021 **Data for calendar year 2022

Provider reporting of SIRs 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, nor has it met the goal of having a rate of falls at or below 63.78 per 1000 individuals receiving DD waiver services.

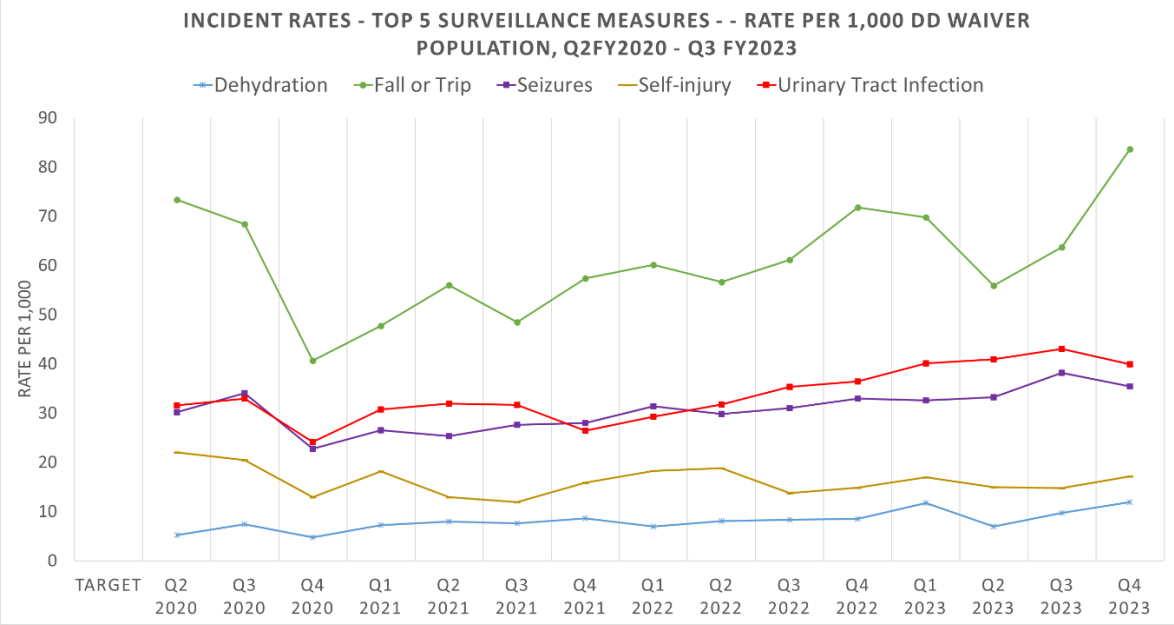
Part 9. Surveillance Measures

In addition to the PMIs listed in Part 8, RMRC is also responsible for tracking additional surveillance measures. RMRC Chair is responsible for ensuring these data are collected and available for review by the committee. The RMRC routinely tracks and reviews the rates of twelve select risks and conditions, as listed in Figure 20 below. These were selected because of the elevated risk associated with adverse outcomes and mortality for individuals with DD.

Figure 21. Rate of Select Level II Risks in CHRIS for Individuals on a DD Waiver, per 1,000 Waiver Population(annualized), SFY2023 (Sorted from SFY23, Highest to Lowest)

Rates	Q1 2023	Q2 2023	Q3 2023	Q4 2023	FY23
1. Fall or Trip (*PMI)	70	56	64	84	68
2. Urinary Tract Infection	40	41	43	40	41
3. Seizures	33	33	38	35	35
4. Self-injury	17	15	15	17	16
5. Dehydration	12	7	10	12	10
6. Decubitus Ulcer	8	6	6	12	8
7. Sepsis	5	6	7	5	6
8. Choking	4	5	5	8	6
9. Sexual Assault	4	4	5	6	5
10. Bowel Obstruction	3	2	6	5	4
11. Suicide Attempt	5	2	5	3	4
12. Aspiration Pneumonia	4	2	4	4	3

Figure 22. Top 5 Most Prevalent Rates of Select Level II Risks in CHRIS for Individuals on a DD Waiver, per 1,000 Waiver Population (annualized), SFY2023



The RMRC also tracks other measures. The Chair reviews these measures quarterly and brings issues to the attention to the full committee as needed. These are included in Appendix 1.

Part 10. Recommendations

Based upon its review of SFY2023 activities and discoveries, the RMRC identified the following recommendations. In the table below, each recommendation is listed along with its status. Some

recommendations were addressed in SFY2023, while others are targeted for completion in SFY2024. Also listed below are recommendations from prior years and the status of each taken during SFY2023.

Figure 22. Recommendations from SFY2023

1. (April 2023) Explore the idea of setting a threshold of the number of Health and Safety CAPs to trigger a referral outside of the Office of Licensing.	**In progress.** This is planned for SFY2024. The focus has shifted to planning for OL to report to the RMRC at least biannually on the Health and Safety CAP process and resulting actions.
2. (May 2023) Develop a flow chart to demonstrate how DBHDS uses risk data and information to identify providers that may need additional corrective action or technical assistance. (C.I. 32.7).	**In progress.** This work began in SFY2023 and is planned for completion in SFY2024.
3. Revise Virginia background questions on risk in the National Core Indicators survey.	**Completed, July 2023.** Proposed revisions submitted to Virginia Commonwealth University for consideration.
4. Develop a plan to further analyze falls serious incident data, to understand incidents of falls associated with hospitalization and injuries, and the percent of individuals who experience multiple falls.	**Pending.** This is planned for SFY2024.

Status of Recommendations from Previous Years

Recommendations from previous years	Status as of SFY2023 Report
1. August 2021 - Help improve correct utilization of 'Other' category in CHRIS.	**Complete.** 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 – Develop tools and information to help providers conduct root cause analysis (RCA) for medication errors.	**Complete.** RMRC, OL/IMU and OIH partnered to develop examples of medication error root cause analysis using the 5 Why's format. These are posted on the Office of Licensing website.

3. December 2021 - RMRC recommends that the following issues be escalated to the DBHDS Data Forum for resolution within CHRIS: • 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).	**Complete.** Most of the identified issues were corrected by December 2022. The Data Warehouse updated existing abuse/neglect reports to reference the correct data fields and worked with the RMRC chair to develop new serious incident reports. Basic incident report data was available by February 2023 and work continues to include more detailed trend and break-out reports.
4. 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).
5. February 2022 – Recommendations following the review of several choking incident case studies. In summary: a. OIH should make training available in COVLC or otherwise online on choking, urinary tract infections (UTIs), & nutrition available in COVLC or otherwise online. b. OPD should offer more in-depth ISP training. c. OPD and OL/IMU should promote communication among providers serving the same individual. d. Develop a checklist so everybody knows the essential supports. e. Explore whether single choking events should be considered as a care concern. f. Explore criteria that would result in providers being required to complete relevant risk training.	**Complete.** Mitigating strategies to help address choking have been taken by the Office of Licensing and the Office of Integrated Health, to the satisfaction of the RMRC. Specifically, items a, b, c, and e have been addressed. The RMRC will continue to monitor the data to discern if further improvement efforts are warranted.
6. April 2022 - Create a Health and Safety Alert on Down Syndrome and Alzheimer's Disease.	**Pending.** This is planned for SFY2024.
7. May 2022 - Provide licensing data broken down by region (RQC recommendation).	**Pending.** This is planned for SFY2024.
8. June 2022 - Develop criteria and/or a process for revising care concerns.	**In progress.** This is planned for SFY2024.

9. (SFY2021) Increase capability to better understand and describe neglect.	**Complete.** As of June 2023, categories for neglect have been incorporated into the CHRIS system. Data will be available in SFY2024.
10. Develop better guidance for providers about reporting medication errors as neglect.	**In Progress.** OHR continues to gather feedback on draft revised guidance.
11. Improve provider understanding of, and compliance with, requirements for RM and quality improvement (QI) programs.	**In Progress.** See Section 8 regarding the QII focused on improving RM compliance. This is an ongoing recommendation

Part 11. Conclusion

The RMRC was chartered by the QIC 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.

In SFY2023, the RMRC implemented recommendations from prior years, notably making choking a stand-alone CC, resulting in OIH providing choking related education and support to more providers ultimately benefiting individuals. The RMRC also partnered with member offices to provide helpful tools to providers, including examples of medication error root cause analysis, an Excel Risk Tracking Tool, a one-page handout on CC, and a template for Systemic Risk Assessments. RMRC also helped facilitate the development of neglect subcategories in CHRIS, which OHR saw to fruition in SFY2023.

RMRC was able to resume reviewing serious incident and abuse, neglect and exploitation data after an 18-month hiatus. This allowed RMRC to assess updates in trends in Level II and Level III risks and conditions and evaluate progress on the Falls QII. The RMRC completed the Falls QII; while it did not show a sustained improvement on the rate of Falls, the although the individual changes that were implemented were rated positively (e.g., high participation in training, participants reporting that they planned to make changes as a result of training, use of RAT to identify fall risk). Based on these findings, training on falls, CC follow-up related to falls, and assessing fall risk through the Risk Awareness Tool will continue to support efforts of providers and the system to reduce the risk of falls. The RMRC will conduct further root cause analysis of fall incident reports to determine the potential for further intervention.

Licensing data shows that providers continue to struggle with meeting the risk management and quality improvement regulations. The RMRC continued a QII focused on improving compliance with the requirements, offering a new consultation and technical assistance opportunity for 620.C.2., and several new tools, resources and training modules to help improve compliance with 160C, 520C, and 520D. The RMRC will evaluate the impact of these

interventions on regulatory compliance in SFY2024 and will look to identify further initiatives to assist providers in developing and implementing quality and risk management programs.

Appendix 1. Additional RMRC Surveillance Measures, SFY2023

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 2023	Q2 2023	Q3 2023	Q4 2023	SFY 2023
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		97%	97%	94%	87%	95%
			% of inspections in which providers were **determined** to be compliant with requirement for reporting serious incidents within 24 hrs.	CONNECT 160.D.2	quarterly		97%	98%	97%	98%	99%
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		98%	97%	94%	88%	95%
			% of inspections in which the provider is **determined** to be compliant with requirements for quarterly review of incidents	CONNECT 160.C	quarterly		87%	77%	84%	81%	83%
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		98%	97%	94%	88%	95%

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2023	Q2 2023	Q3 2023	Q4 2023	SFY 2023
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		**97%**	**96%**	**94%**	**86%**	**95%**
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		**98%**	**96%**	**93%**	**88%**	**95%**
		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		**92%**	**89%**	**90%**	**87%**	**91%**
		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		**91%**	**92%**	**88%**	**88%**	**92%**
		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		**91%**	**91%**	**89%**	**86%**	**92%**
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%**	**98%**	**98%**

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2023	Q2 2023	Q3 2023	Q4 2023	SFY 2023
V.B	29.24	At least 95% of individual service recipients are adequately protected from serious injuries in service settings.	The case manager assesses risk (RAT), and risk mediation plans are in place as determined by the ISP team.	SCQR Data	annual	**95%**					89% (CY 2022)
V.C.1 #4	30.04	**At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. Inspections will include an 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.**	**% of licensed DD providers that had assessment of the following RM requirements during annual inspection.**	**CONNECT 520A- E**			95%	96%	90%	85%	95%
			Designated person with training or experience responsible for risk management function	520A	quarterly		98%	97%	92%	98%	97%

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2023	Q2 2023	Q3 2023	Q4 2023	SFY 2023
			Implements a written plan	520B	quarterly		98%	97%	92%	98%	97%
			Conducts annual systemic risk assessment	520C	quarterly						
			- environment of care	520C1	quarterly		98%	97%	92%	99%	97%
			- clinical assessment/reassessment	520C2	quarterly		98%	97%	92%	99%	97%
			-staff competence / adequacy of staffing	520C3	quarterly		98%	97%	92%	99%	97%
			- use of high risk procedures	520C4	quarterly		97%	97%	92%	99%	97%
			- review of serious incidents	520C5	quarterly		98%	97%	92%	98%	97%
			Systemic risk assessment incorporates risk triggers and thresholds	520D	quarterly		96%	97%	91%	98%	96%
			Conducts annual safety inspection	520E	quarterly		96%	96%	91%	98%	96%
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		93%	96%	95%	96%	93%
	42.03		Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	620A			98%	98%	97%	99%	97%
	42.03		The QI program uses standard QI tools, including RCA and has a QI plan	620B			98%	98%	97%	99%	96%
	42.03		The QI Plan shall:	620C							
	42.03		- Be reviewed and updated annually	620C1			98%	98%	97%	99%	97%
	42.03		- Define measurable goals and objectives	620C2			98%	98%	97%	99%	97%
	42.03		-Include & report on statewide measures	620C3			98%	98%	98%	99%	97%

Provision	Compliance Indicator	DOJ Indicator (if applicable)	Measure (if applicable)	Data Source	Frequency	Target	Q1 2023	Q2 2023	Q3 2023	Q4 2023	SFY 2023
			- Monitor implementation & effectiveness of approved CAPs	620C4			98%	98%	97%	98%	97%
			- Include ongoing monitoring and evaluation of progress toward meeting goals	620C5			97%	98%	97%	87%	97%
			The providers P&P includes criteria used to:	620D							
			- Establish measurable goals & objectives	620D1			97%	98%	97%	98%	96%
			- Update the QI plan	620D2			96%	98%	97%	98%	96%
			- Submit revised CAPs when not effective	620D3			97%	98%	97%	98%	96%
			Input from individuals about services & satisfaction	620E			96%	97%	97%	97%	95%

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