DBHDS

Virginia Department of Behavioral Health and Developmental Services

Risk Management Review Committee Annual Report

July 1, 2023 – June 30, 2024

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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 to reduce risk and harm to individuals receiving developmental disability (DD) services. In SFY2024, 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. Two related to achieving compliance with licensing regulations related to quality improvement and risk management, and one PMI measuring the rate of fall related serious incidents, did not meet the target. The PMI related to timely reporting of serious incidents did meet the target. This PMI was retired in SFY2024 because it has consistently exceeded the target.

The RMRC took several actions related to quality improvement initiatives (QIIs).

- RMRC ended the QII to improve compliance on licensing regulations 520C and 520D after finding that the interventions did not lead to system improvement.
- RMRC completed a QII to improve submission of service-level seclusion and restraint data and achieved significant improvement, from a baseline of 46% participation in SFY2023 to 80% participation in SFY2024. The interventions from this activity have been incorporated into the standard process of the Office of Human Rights.
- RMRC also proposed a new QII to improve licensing regulations 520 and 620 which was approved. This QII builds upon knowledge that was gained from the 520C/520D QII mentioned above.

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

Previous Year Recommendations	Status
1. 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.	**Completed in SFY 2024**. OL has begun presenting Health and Safety CAP data to RMRC at least biannually.
2. Develop a flow chart to demonstrate how DBHDS uses risk data and information to identify providers that may need additional	**Completed** in SFY2024

corrective action or technical assistance. (C.I. 32.7).	
3. 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.	**In process.** Plan developed; preliminary data analysis completed; developing dashboard to streamline ongoing data analysis.

RMRC also made the following recommendations, in SFY2024, for quality improvement that is continuing in SFY2025.

Recommendation	Status
1. Remove Level I incident reports from the data.	**Completed in SFY 2024**
2. As a result of the Falls Analysis, further identify improvement opportunities related to multiple ER visits and/or hospitalizations or very serious injuries due to falls.	**This will continue into SFY2025.** The Data Warehouse has begun developing a PowerBI Visualization that will help with this.
3. Improve provider understanding of, and compliance with, requirements for RM and QI programs.	**Ongoing.** See information about the QII focused on improving RM compliance.
4. Office of Licensing begin reporting on Health and Safety CAPS to RMRC.	**Ongoing.** OL has begun reporting bi-annually.
5. Begin more regularly sharing risk data directly with providers.	**Ongoing.** Risk data shared in Office of Licensing October newsletter.

As RMRC enters SFY2025, RMRC will continue to 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[1] 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

[1] Throughout this report the term "provider" is used to refer collectively to community service board providers and private providers that are licensed by DBHDS

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 SFY2024, the RMRC utilized workgroups to help move the work forward between meetings: the Data Workgroup, and the Seclusion and Restraint 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 Seclusion and Restraint QII Workgroup focused on conducting a root cause analysis (RCA) to understand why providers were or were not submitting the required seclusion and restraint annual data, and planned interventions to address the root causes and improve participation.

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 SFY2024 is provided below.

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

In SFY2024, RMRC reviewed ANE data quarterly. The ANE information is entered by providers into CHRIS and made available via data warehouse (DW) reports, which continues to inform the identification of trends and patterns to ultimately impact overall OHR outcomes.

In SFY2024, there were 3,064 (3,319) complaints alleging ANE reported by licensed community providers (of DD services). Of these, 919 were substantiated (30.0%). This is an 8.6% increase in substantiated complaints when compared to SFY2023 (allegations=3,305; substantiations=846). The total number of reports and substantiated cases by abuse type is shown in Figure 1A. The total number of reports and substantiated cases by quarter is shown in Figure 1B.

Figure 1A. Table of Types of ANE Reported and Substantiated, SFY2024

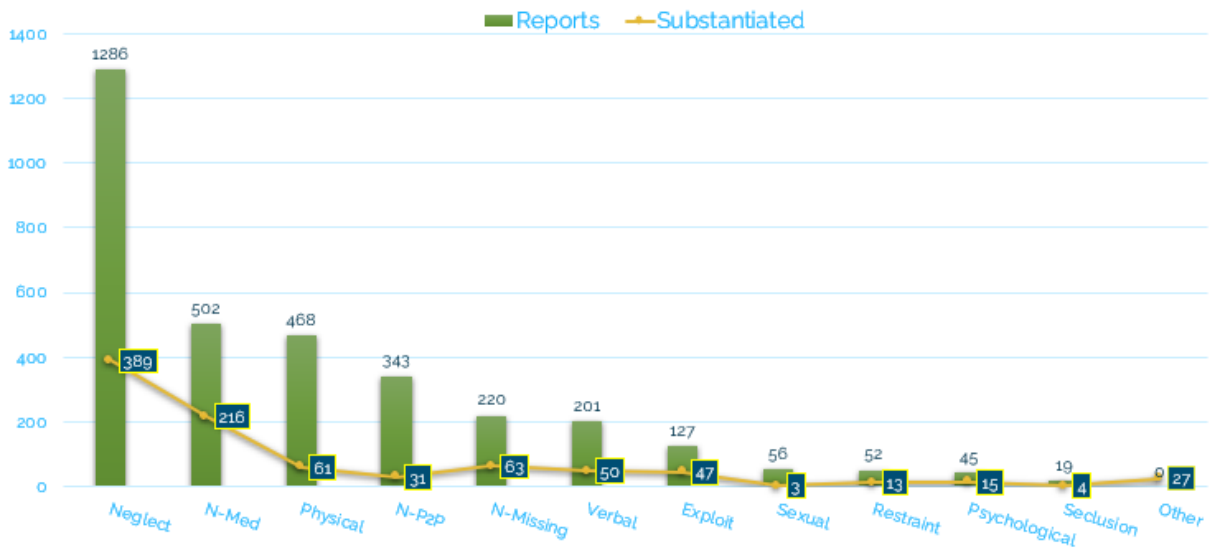
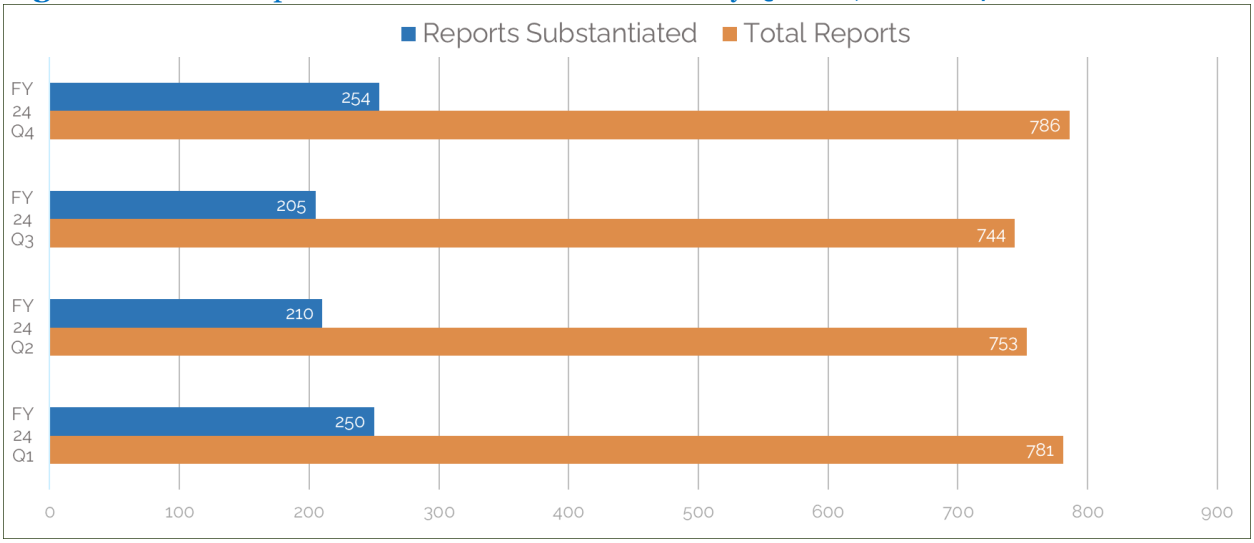
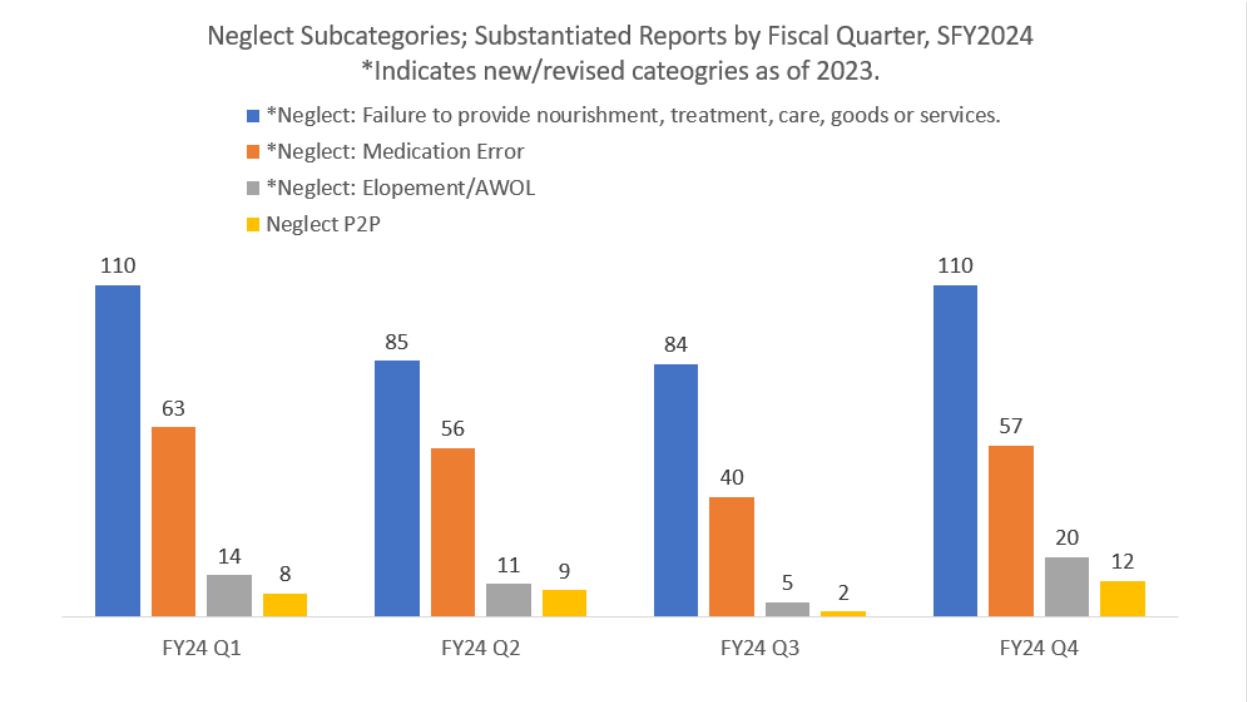


Figure 1B: Total Reports and Substantiations of ANE by Quarter, SFY2024



In July 2023, the following categories were made available as subcategories for neglect in CHRIS: "Medication Error", "Elopement/AWOL", and "Failure to provide nourishment, treatment, care, goods or services". These specific subcategories of neglect are not defined in regulation and therefore, implementation only requires changes to the reporting system. The number of substantiated cases of neglect, by subcategory, is shown in Figure 2.

Figure 2. Substantiated Cases of Neglect by Sub-Category, SFY2024 Q4



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, and guidance has been in development since February 2022, including involvement with and feedback from the DBHDS Offices of Integrated Health and Licensing and external experts like the Board of Nursing and Department of Health Professions.

Based on what providers reported in SFY2024, medication errors do not present a significant concern with harm. Most substantiated medication errors did not result in a Level II Serious Incident (such as an emergency room visit or hospitalization). Of the 919 total substantiated complaints, 699 (76%) identified a form of neglect with 216 (24%) being specific to medication related incidents. Out of the 216 substantiated medication related complaints, only nine (4%) indicated a resulting serious injury.

The RMRC has discussed the importance of supporting providers to identify, track, and internally investigate medication errors using quality improvement techniques (such as root cause analysis), while balancing the concern of being cited for what must be reported as potential neglect or a serious incident. OHR is working with the DBHDS Office of Regulatory Affairs (ORA) to formalize a draft document into guidance in 2025 to address these issues.

While the reported data has not identified medication errors as a serious issue, the RMRC remains concerned that medication errors may be underreported or that there are errors that may not rise to the level of a reportable incident, but failure to address the root cause of minor incidents could result in more significant incidents in the future. Therefore, the RMRC will continue to review medication errors on a quarterly basis from the perspective of allegations of abuse/neglect and, serious incidents to include a deeper dive into trends related to citations issued to providers for medication related noncompliance issues, as well as themes identified by Office of Integrated Health Support Network (OIHSN) as they conduct technical assistance activities with providers. The goal is to provide comprehensive recommendations for providers on tracking, reporting, and addressing medication errors.

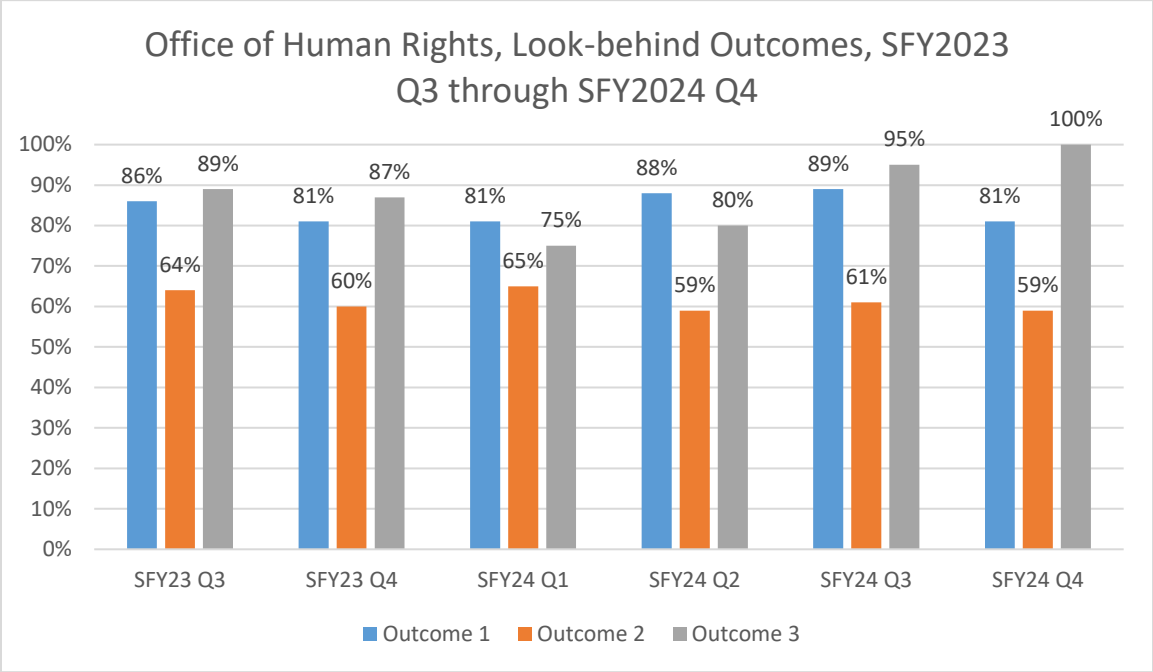
3a (2) OHR Community Look-Behind (CLB)

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.

The CLB evaluates three primary outcomes, each with a goal of 86% or greater which are outlined below.

1. Comprehensive and non-partial investigations of individual incidents occur within prescribed timelines.
2. The person conducting the investigation has been trained to conduct investigations.
3. Timely, appropriate CAPs are implemented by the provider when indicated – was the case closed within 60 days.

Figure 3. Results of OHR Look-Behind Review, SFY2023 Q3 – SFY2024 Q4



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 develop a 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.

The OHR and RMRC have identified the low results for Outcome 2 as a specific area of concern. The following actions have been accomplished to increase provider compliance with having trained investigators, and improve overall investigative outcomes:

- Added attestation for a trained investigator to the Human Rights Compliance Verification Checklist that providers must submit during their licensure process.
- Revised waiver validation onsite visit process to include verification of evidence of trained investigator. If the provider does not have a trained investigator, the Advocate will issue a citation and require completion of training within 30 days.

- Revised OHR new provider onboarding processes to include identification of five core OHR trainers, and development of a standardized New Provider Orientation PowerPoint. The Orientation will be offered monthly, virtually, to all providers who are in the process of being licensed or are newly licensed and will address core OHR requirements (to include explicit review and reference to having trained abuse/neglect investigators and ANE reporting requirements).
- Adopted new FAQs into OHR Provider training sessions based on feedback from CLB debrief sessions (also posted to the OHR Website)

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, care concerns, and Medicaid claims reviews. Each task and associated data are described further in the sections below.

3b (1) Serious Incidents

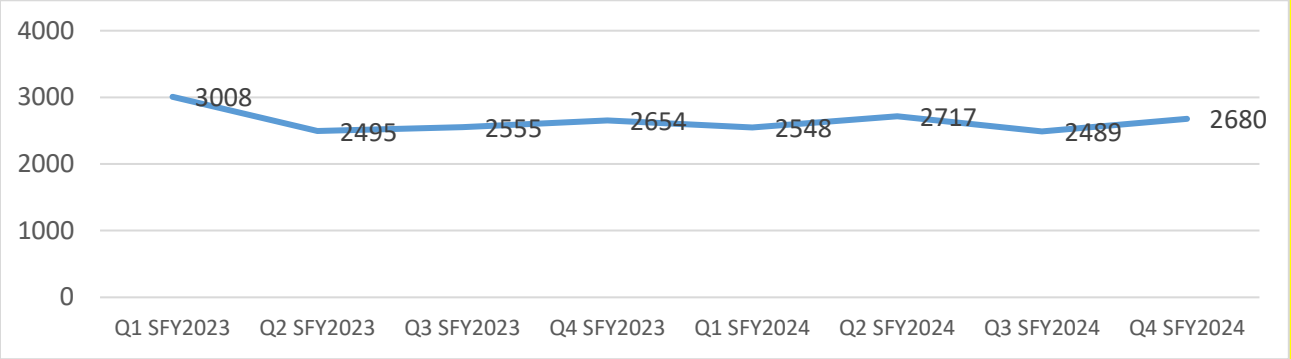
The RMRC reviews SIR surveillance data quarterly, which includes a review of trends in types of incidents as well as injuries, illnesses/conditions, and causes of SIRs. When available, the RMRC reviews at least two years of data to identify patterns or trends that may help to identify, mitigate, or prevent future risk of harm. 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.

The total number of SIRs (entered into CHRIS) for licensed DD service providers for the past four fiscal years is as follows:

- SFY2021: 9,753.
- SFY2022: 10,555.
- SFY2023: 10,712.
- SFY2024: 10,434.

Figure 4, below, depicts the number of serious incident reports for each quarter.

Figure 4. Number of Serious Incident Reports, in CHRIS, for Individuals Receiving DD Waiver Services, by Quarter, SFY2023 and SFY2024



The number and type of Level III SIRs, each quarter of SFY2024 (as reported by the IMU to RMRC), is depicted in the graph below. The category "DEATH SIR Received" represents the total number of incident reports received reporting a death. Since all providers that are responsible for an individual's care must report a level 3 incident (death) the number of reports of a death will be greater than the actual number of deaths (reflected on the "Deaths" chart).

Figure 5. Number of Level III Serious Incident Reports, in CHRIS for Individuals Receiving DD Waiver Services, SFY2023 and SFY2024

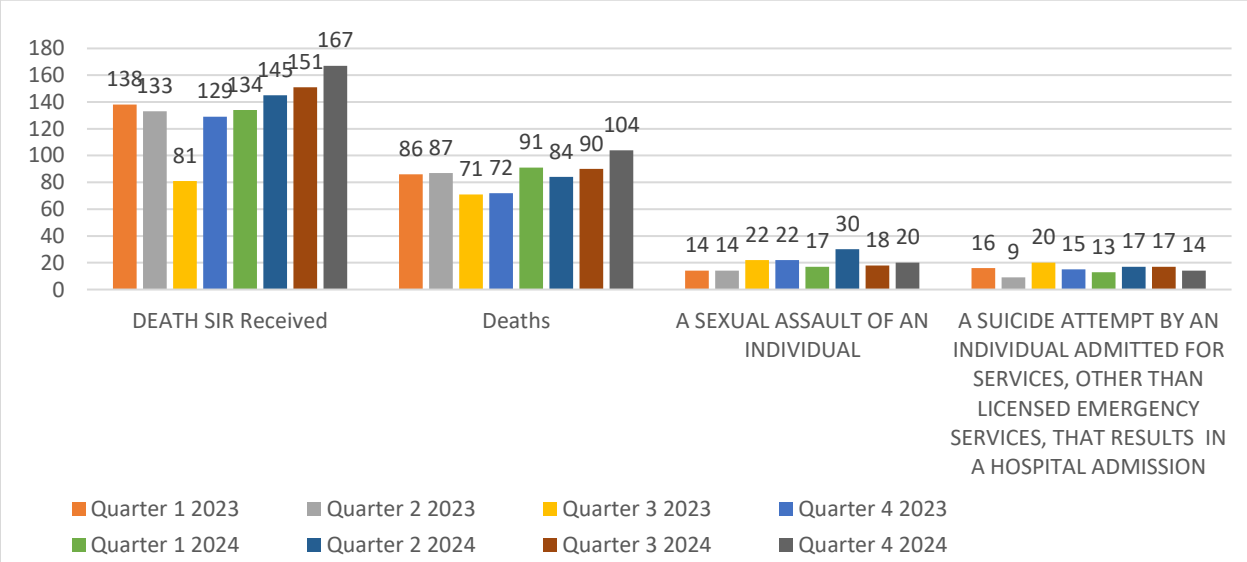


Figure 6. Number of Level II Serious Incident Reports by Type, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2024 (Sorted from Total, Highest to Lowest)

	Q1		Q2		Q3		Q4		Total	
SeriousIncident - Level2	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
ER Visit	1636	60.71%	1701	59.87%	1649	58.50%	1844	58.71%	6830	59.41%
Unplanned Hospital Admission	444	16.47%	505	17.78%	495	17.56%	499	15.89%	1943	16.90%
Serious Injury - Requiring Medical Attention	175	6.49%	165	5.81%	268	9.51%	361	11.49%	969	8.43%
Unplanned Psychiatric Admission	103	3.82%	115	4.05%	119	4.22%	127	4.04%	464	4.04%
Other - Level 2	97	3.60%	81	2.85%	67	2.38%	59	1.88%	304	2.64%
Harm or Threat to Others	65	2.41%	79	2.78%	53	1.88%	71	2.26%	268	2.33%
Missing Individual	65	2.41%	71	2.50%	52	1.84%	69	2.20%	257	2.24%
Decubitus Ulcer	34	1.26%	34	1.20%	29	1.03%	24	0.76%	121	1.05%
Choking Incident	34	1.26%	32	1.13%	30	1.06%	24	0.76%	120	1.04%
Aspiration Pneumonia	17	0.63%	30	1.06%	28	0.99%	28	0.89%	103	0.90%
Bowel Obstruction	19	0.71%	20	0.70%	16	0.57%	24	0.76%	79	0.69%
Ingestion of Hazardous Materials	6	0.22%	8	0.28%	13	0.46%	11	0.35%	38	0.33%
Total	2695	100.00%	2841	100.00%	2819	100.00%	3141	100.00%	11496	100.00%

Figure 7. Level II Serious Incident Reports, Top 5 Incident Types, in CHRIS, for Individuals Receiving DD Waiver Services – Trend Data SFY2020 Q2 – SFY2024 Q4

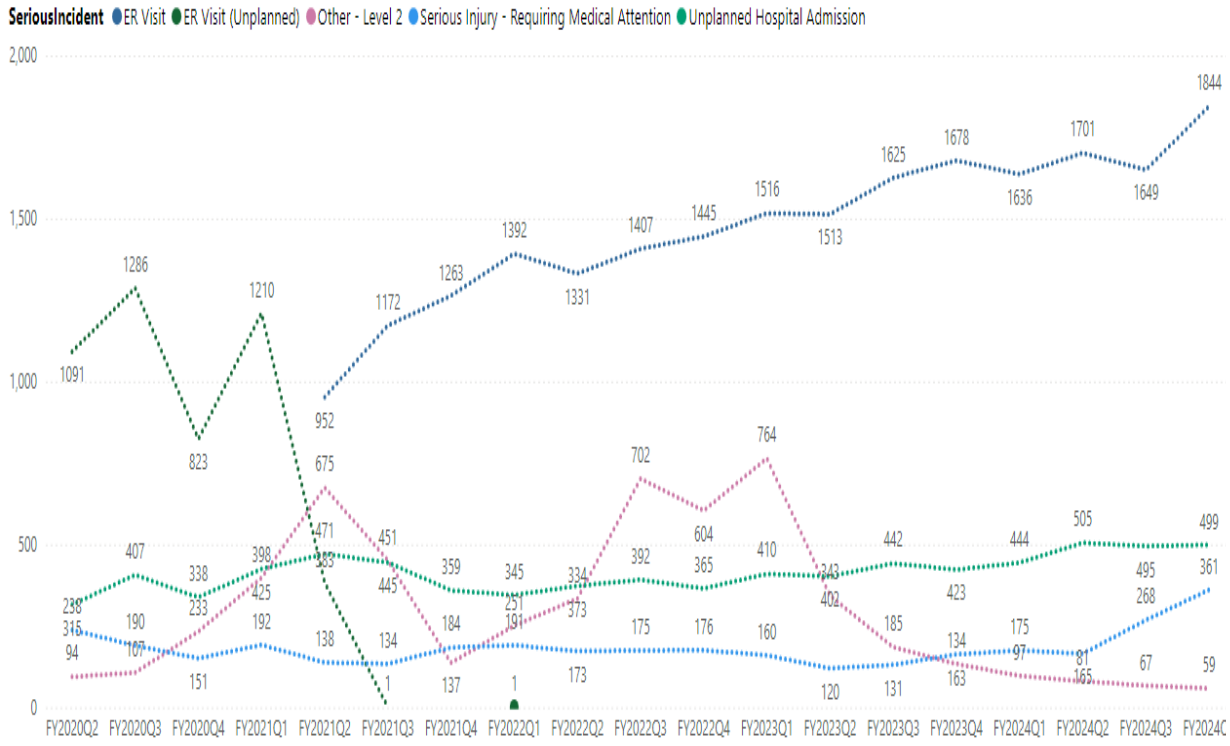


Figure 8. Number of Illnesses / Conditions Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2024 (Sorted from Total, Highest to Lowest)

FiscalYear	2024									
	Q1		Q2		Q3		Q4		Total	
IllinessCondition	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Other Illness/Condition	614	37.05%	691	37.72%	664	37.94%	694	37.43%	2663	37.54%
Urinary Tract Infection (UTI)	166	10.02%	168	9.17%	163	9.31%	163	8.79%	660	9.30%
Seizure	153	9.23%	154	8.41%	175	10.00%	155	8.36%	637	8.98%
Mental Status Changes	115	6.94%	145	7.91%	131	7.49%	160	8.63%	551	7.77%
Diarrhea/Vomiting	119	7.18%	130	7.10%	115	6.57%	121	6.53%	485	6.84%
Pneumonia (Caused By Bacteria Or Virus)	74	4.47%	107	5.84%	77	4.40%	106	5.72%	364	5.13%
Suicidal Thoughts/Behaviors	60	3.62%	68	3.71%	70	4.00%	78	4.21%	276	3.89%
Constipation	70	4.22%	48	2.62%	55	3.14%	63	3.40%	236	3.33%
Covid-19	72	4.35%	65	3.55%	62	3.54%	13	0.70%	212	2.99%
Dehydration	52	3.14%	47	2.57%	43	2.46%	58	3.13%	200	2.82%
Blood Sugar Problem (High Or Low)	41	2.47%	47	2.57%	30	1.71%	47	2.54%	165	2.33%
Sepsis	26	1.57%	38	2.07%	33	1.89%	44	2.37%	141	1.99%
Aspiration Pneumonia	22	1.33%	40	2.18%	33	1.89%	35	1.89%	130	1.83%
Cardiac Event	19	1.15%	22	1.20%	41	2.34%	34	1.83%	116	1.64%
Exacerbation Of A Chronic Medical Condition	21	1.27%	28	1.53%	25	1.43%	28	1.51%	102	1.44%
Bowel Obstruction	19	1.15%	22	1.20%	16	0.91%	24	1.29%	81	1.14%
Asthma	7	0.42%	6	0.33%	5	0.29%	15	0.81%	33	0.47%
Stroke	3	0.18%	4	0.22%	8	0.46%	8	0.43%	23	0.32%
Drug Or Alcohol Problem	4	0.24%	2	0.11%	4	0.23%	8	0.43%	18	0.25%
Total	1657	100.00%	1832	100.00%	1750	100.00%	1854	100.00%	7093	100.00%

Figure 9. Number of Illnesses/Conditions Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services – Top 5 Conditions Trend Data SFY2020 Q2 – SFY 2024 Q4 *NOTE: COVID and "Other" are excluded as outliers.*

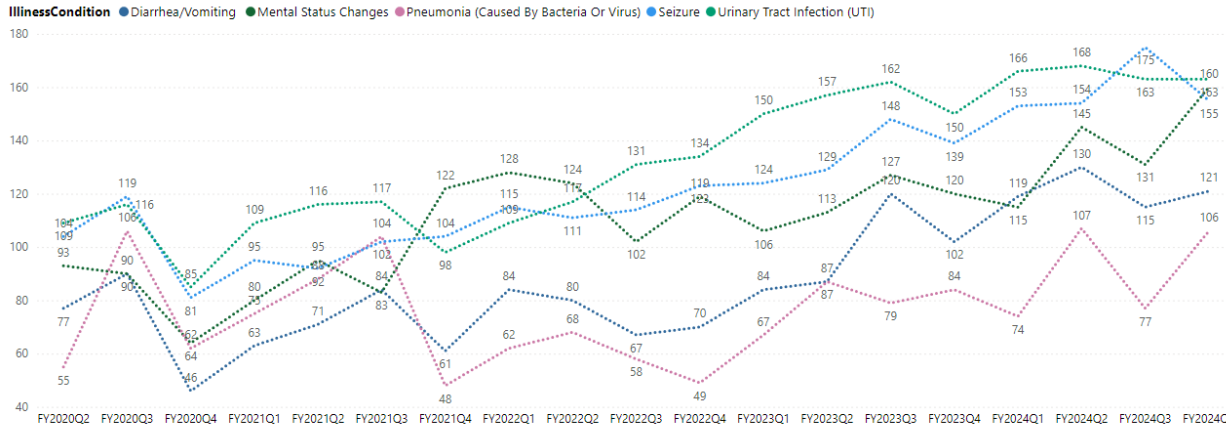


Figure 10. Number of Injuries Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2024 (Sorted from Total, Highest to Lowest)

FiscalYear	2024									
	Q1		Q2		Q3		Q4		Total	
Injury	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Other Injury	239	28.97%	187	27.06%	203	29.51%	217	25.44%	846	27.67%
Cut/Laceration	150	18.18%	130	18.81%	117	17.01%	162	18.99%	559	18.29%
Bruise	118	14.30%	96	13.89%	91	13.23%	130	15.24%	435	14.23%
Fracture	90	10.91%	74	10.71%	70	10.17%	108	12.66%	342	11.19%
Bleeding	78	9.45%	65	9.41%	77	11.19%	93	10.90%	313	10.24%
Sprain/Strain/Tear	33	4.00%	31	4.49%	25	3.63%	34	3.99%	123	4.02%
Pressure Injury (Decubitus Ulcer)	32	3.88%	34	4.92%	31	4.51%	22	2.58%	119	3.89%
Obstructed Airway (Unable To Breathe, Turning Blue)	18	2.18%	16	2.32%	15	2.18%	19	2.23%	68	2.22%
Loss Of Consciousness	14	1.70%	17	2.46%	11	1.60%	22	2.58%	64	2.09%
Bite/Sting	17	2.06%	12	1.74%	4	0.58%	7	0.82%	40	1.31%
Adverse Reaction To Medication	10	1.21%	12	1.74%	8	1.16%	9	1.06%	39	1.28%
Allergic Reaction	7	0.85%	6	0.87%	13	1.89%	4	0.47%	30	0.98%
Burn	8	0.97%	3	0.43%	6	0.87%	8	0.94%	25	0.82%
Dislocation	6	0.73%	2	0.29%	5	0.73%	11	1.29%	24	0.79%
Concussion	3	0.36%	3	0.43%	5	0.73%	3	0.35%	14	0.46%
Poisoning			3	0.43%	4	0.58%	2	0.23%	9	0.29%
Loss Or Serious Impairment Of Limb Or Other Body Part (E.G., Eyes, Arms, Legs)	2	0.24%			3	0.44%	2	0.23%	7	0.23%
Total	825	100.00%	691	100.00%	688	100.00%	853	100.00%	3057	100.00%

Figure 11. Number Injuries Associated with Serious Injuries in CHRIS, for Individuals Receiving DD Waiver Services, – Top 5 Injuries Trend Data – SFY2020Q2 – SFY2024Q4

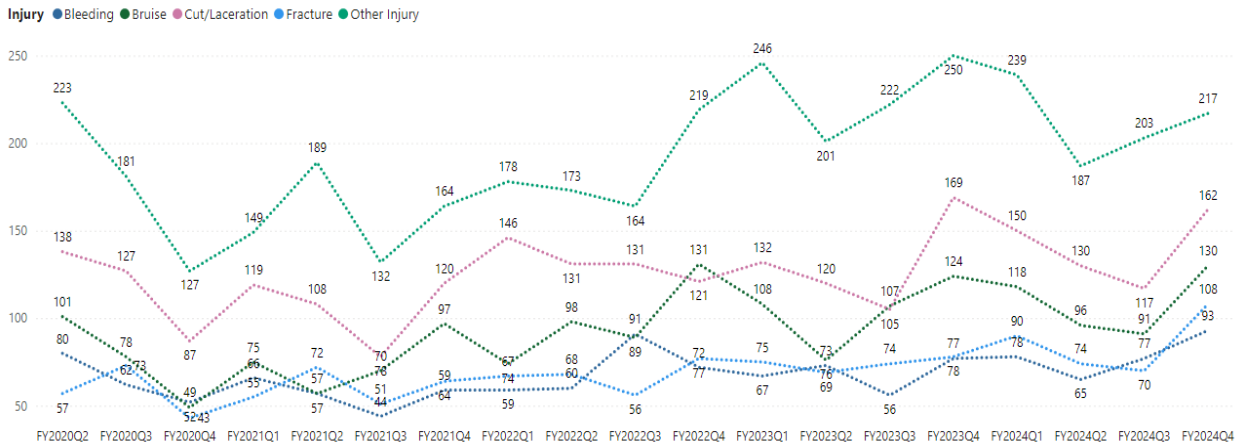
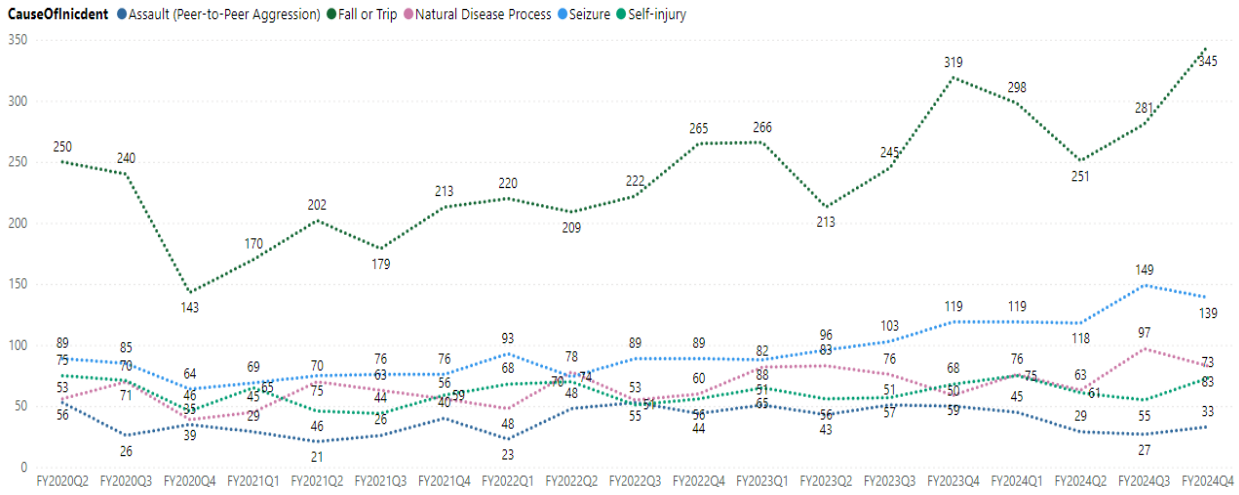


Figure 12. Number of Causes Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2024 (Sorted from Total, Highest to Lowest)

FiscalYear	2024									
	Q1		Q2		Q3		Q4		Total	
CauseOfInicdent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Unknown	856	41.55%	959	45.62%	896	43.60%	974	43.70%	3685	43.63%
Other	442	21.46%	464	22.07%	397	19.32%	414	18.57%	1717	20.33%
Fall or Trip	298	14.47%	251	11.94%	281	13.67%	345	15.48%	1175	13.91%
Seizure	119	5.78%	118	5.61%	149	7.25%	139	6.24%	525	6.22%
Natural Disease Process	76	3.69%	63	3.00%	97	4.72%	83	3.72%	319	3.78%
Self-injury	75	3.64%	61	2.90%	55	2.68%	73	3.28%	264	3.13%
Assault (Peer-to-Peer Aggression)	45	2.18%	29	1.38%	27	1.31%	33	1.48%	134	1.59%
Medical Equipment Malfunction (Adaptive Equipment)	20	0.97%	22	1.05%	17	0.83%	28	1.26%	87	1.03%
Motor Vehicle Accident	16	0.78%	12	0.57%	25	1.22%	25	1.12%	78	0.92%
Neglect	19	0.92%	16	0.76%	11	0.54%	19	0.85%	65	0.77%
Suicide Attempt	16	0.78%	18	0.86%	17	0.83%	14	0.63%	65	0.77%
Ingestion of Foreign or Hazardous Material	10	0.49%	15	0.71%	16	0.78%	13	0.58%	54	0.64%
Medication Error	17	0.83%	15	0.71%	10	0.49%	11	0.49%	53	0.63%
Accidental Injury (by another person)	15	0.73%	6	0.29%	11	0.54%	11	0.49%	43	0.51%
Assault (by others)	6	0.29%	17	0.81%	9	0.44%	10	0.45%	42	0.50%
Traumatic Event	5	0.24%	11	0.52%	8	0.39%	5	0.22%	29	0.34%
Assault (by staff or caregiver)	3	0.15%	8	0.38%	7	0.34%	5	0.22%	23	0.27%
Food Ingredients or Consistency	7	0.34%	5	0.24%	5	0.24%	4	0.18%	21	0.25%
Restraint/ Seclusion	3	0.15%	1	0.05%	7	0.34%	10	0.45%	21	0.25%
Total	2060	100.00%	2102	100.00%	2055	100.00%	2229	100.00%	8446	100.00%

Figure 13. Number of Causes Associated with Serious Incidents in CHRIS, for Individuals Receiving DD Waiver Services, – Top 5 Trend Data SFY2020Q2 – SFY2024Q4 *(Excluding "unknown" and "other".)*



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:

OUTCOME 1

The incident was triaged appropriately by the IMU according to developed protocols.

1.The IMU triaged the incident report the same day or the next business day after the report was submitted.

2.The IMU specialist assessed for a care concern in accordance with IMU protocols.

3.The IMU specialist assessed for imminent danger in accordance with IMU protocols.

4.The provider received a citation for late reporting.

OUTCOME 2

The provider's documented response ensured the recipient's safety and well-being.

5. The provider's documented response addressed ways to mitigate future occurrences of the incident.

OUTCOME 3

Appropriate action from the Office of Licensing Incident Management Unit occurred when necessary.

6. The IMU specialist contacted the provider for additional information.

7. The IMU specialist forwarded the incident to the Office of Human Rights (OHR) before closing the case.

8. The IMU specialist forwarded the incident for a licensing specialist investigation before closing the case.

9. The IMU specialist forwarded the incident to the Office of Integrated Health (OIH) before closing the case.

OUTCOME 4

Timely, appropriate corrective action plans are implemented by the provider when indicated.

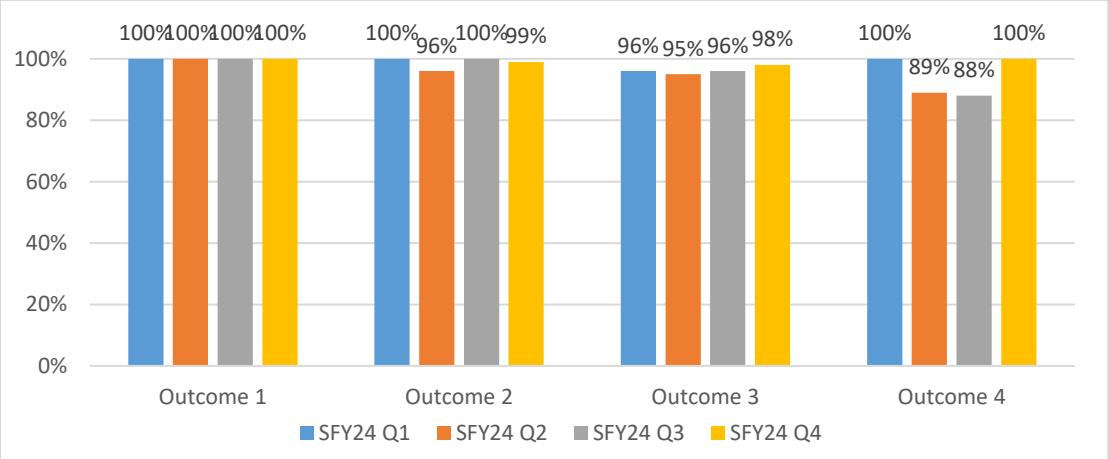
10. Provider reviewed the incidents that led to the care concern and made a determination as to whether or not corrective actions were necessary.

11. 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[2]. The VCU IMU Look Behind team completes a retrospective review of a sample of 100 SIRs involving an individual receiving DD services, per quarter of the Calendar Year, using data provided by DBHDS. They pull a random sample of 25 cases to conduct an inter-rater reliability review. The VCU IMU Look Behind team consists of three members including the Project Manager, Project Coordinator and one Quality Assurance Reviewer.

VCU completed comprehensive findings reports and submitted to DBHDS for each quarter of SFY2024. 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 14. Incident Management Unit Look-Behind Results – SFY2024



Following their initial review, VCU provided recommendations for improvement, including:

- Document the correct type of incident in the IMU notes.
- Confirm incidents occurred during service provision.
- Review what constitutes a reportable incident.
- Confirm individual care concern incidents are flagged by the IMU specialist.
- Clearly indicate if the IMU requests updates from providers.

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

[2] 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.

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 SFY2024, based on data from CHRIS, there were a total of 10,434 incident reports reported by licensed providers of DD services, 716 of which were reported late. Of those that were late, however, the IMU excused 329 for reasons such as the CHRIS application being unavailable during the reporting window and the provider otherwise notifying the IMU of the incident within 24 hours. Therefore, there were a total of 387 unexcused late reports and 10,046 reported timely, meaning that 96% were reported within the required timeframes. This exceeds the target of 86%.

3b (4) Care Concerns

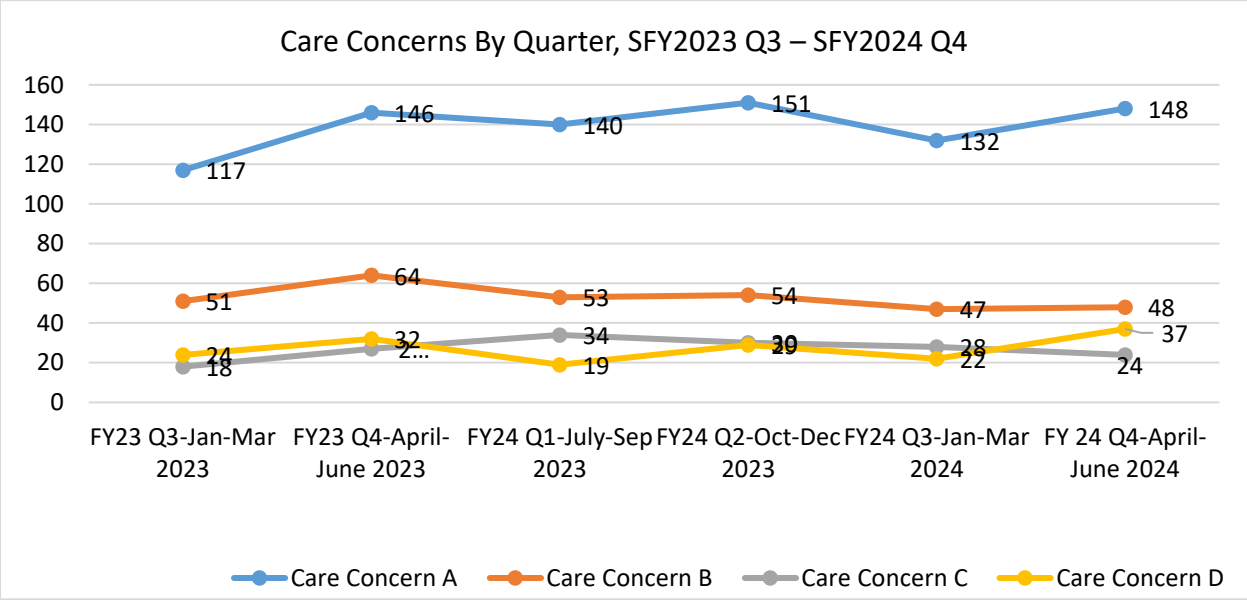
DBHDS has defined uniform risk triggers and thresholds to identify circumstances where there is potential risk for more serious future outcomes, which are called "care concerns". These uniform risk triggers and thresholds also further define the requirement outlined in Virginia regulation 12VAC35-105-520.D, 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. The CC criteria were most recently revised in January 2023.

Care Concern Thresholds Criteria (revised January 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 OIHSN for follow-up and technical assistance as needed and to help determine where prevention focused trainings for providers are needed.

During SFY2024, there were a total of 996 CCs. There were 571 CCs for criteria 'a', 202 for criteria 'b,' 116 for criteria 'c,' and 107 for criteria 'd.'. The graph below shows the number of CCs by criteria type and by quarter during SFY2024.

Figure 15: Care Concerns by Quarter, SFY2023 Q3 - SFY2024



In SFY2024, OIHSN continued to provide quarterly reports to the RMRC on the CC process of providing follow-up support and technical assistance by the registered nurse care consultants (RNCCs) to providers, a process that began in SFY2023. Once OIHSN receives notice of a CC from the IMU, OIHSN 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. The number of care concerns addressed by OIHSN is in Figure 16.

Figure 16. OIHSN Care Concerns by Primary Concern, SFY2023-SFY2024

Primary Concern	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FY24 Q1	FY24 Q2	FY24 Q3	FY24 Q4	Total
Aspiration	2	0	0	0	0	0	0	0	2
Aspiration Pneumonia	12	3	5	5	4	9	12	9	59
Bowel Impaction/Obstruction	20	13	24	20	21	21	18	21	158
Choking	3	4	18	26	33	29	30	22	165
Constipation	2	0	1	1	2	1	4	5	16
Dehydration	3	7	3	4	10	8	12	11	58
Fall with Injury	21	14	18	33	24	24	15	23	172
Fall without Injury	12	8	4	23	10	14	9	9	89
Pressure Injury/DU	41	23	26	45	37	32	35	21	260
Seizure	31	39	43	41	39	47	41	45	326
Sepsis	0	0	1	1	0	1	0	0	3
UTI	27	27	37	37	38	41	35	39	281
Total	175	138	181	236	219	227	211	205	1592

OIHSN followed up on nearly all these concerns, with the main reason for not following up being a recent repeat concern which they had already addressed. The most common resources and information that nurses shared with providers were a link to the Health and Safety Alerts and information about upcoming trainings and community nursing meetings.

To evaluate the potential reach and impact of this assistance, OIHSN reviewed the utilization of their provider 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 SFY2024, 2,102 people participated in at least one of 38 quarterly live trainings offered by OIHSN. In addition, 1,297 people participated in at least one of six trainings offered by OIHSN on the COVLC. Finally, OIHSN offers eight PowerPoint training slide decks for providers to use on demand.

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.

Beginning in SFY2021 the DBHDS Data Warehouse (DW) established a process with DMAS to extract the Medicaid claims that meet the above criteria, to determine the number that had a matching entry in CHRIS. The DBHDS provider is determined by linking the Medicaid claim file

with the Waiver Management System (WaMS) to identify the residential provider authorized for services during the date the claim was filed. For the period 7/1/2023 – 9/30/2023, a total of 1,896 claims were identified as meeting the criteria above. The DW was able to match these with 1,359 CHRIS reports, for a match rate of 72%. A matching CHRIS report may not be found for reasons other than a failure of the provider to report. 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 537 claims that did not have a matching CHRIS entry, OIHSN conducts outreach to each provider that was associated with the unmatched claims. The For each unmatched claim, OIHSN documents the provider's response as to whether they submitted a report in CHRIS for the incident and if they did not, documents why not. Based on these responses, each unmatched claim is grouped into those that can be excused and those that cannot be excused. Excused reasons 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.

At the time of this report, this review process had not yet been completed. The results will be reported to the RMRC once they have been finalized.

Part 3c. Risk Mitigation and Provider Resources

The RMRC is charged with utilizing the findings from review activities to develop, or recommend the development of guidance, training, or educational resources (to address areas of risk prevalent within the DBHDS DD service population); to ensure the annual review of such guidance, training, or educational resources and to update these materials as necessary; and to review publications yearly, revising 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 SFY2024, 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 OIHSN is a key partner for RMRC and leads the efforts to meet these requirements. OIHSN 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 (such as the Department of Health, Department of Medical Assistance Services, and Department of Aging and Rehabilitative Services).

3c (1) Review of Educational Content

Health and Safety Alerts

The OIHSN issued 10 new Health and Safety Alerts during SFY2024 and updated three that had previously been issued. The alerts serve 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. The alerts listed below were all topics at monthly community nursing meetings and provided CEUs for nurses.

The new and updated alerts are listed below:

- Recognizing Declining Health – July 2022 *Updated October 2023*
- Intellectual and Developmental Disabilities – August 2022 *Updated October 2023*
- Nut Butters and Choking – September 2022 *Updated October 2023*
- Medication Administration – July 2023
- Medication Reconciliation – August 2023
- Responding to Drug Reactions and Reporting Medication Errors – September 2023
- Infection Control with Quiz – November 2023
- Respiratory Syncytial Virus (RSV) with Quiz – January 2024
- COVID-19 Overview – January 2024
- Vital Signs – February 2024
- Healthcare Advocacy – March 2024
- Skin Integrity & Pressure Injury – April 2024
- Intellectual & Developmental Disabilities – May 2024

Annual Review of Health and Safety Alerts

The OIHSN regularly reviews and updates as applicable the content of Health & Safety alerts 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 SFY2024, twenty-five 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 2025, the Health & Safety alerts published in

January 2020, 2021, 2022, 2023 and 2024 will be reviewed. The results of the reviews are maintained in an Excel based database and are presented to the RMRC annually.

Health Trends Newsletter

The OIHSN posted 12 Health Trends Newsletters in SFY2024. 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 Offered in SFY2024

The OIHSN researches, creates and posts educational resources to support continued education and best practices in areas of health and safety. The OIHSN also offers training to caregivers on these topics. In SFY2024, caregiver training addressed areas such as The Fatal Seven, Nutrition, Wheelchair Transition Training, Skin Integrity and Pressure Injuries, Urinary Tract Infections, Dysphagia, Diabetes, Oral Health, Choking, and Fall prevention.

Training

The OIHSN researches, 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 SFY2024 is listed in the table below, by topic, along with the number of times the training was presented and number of attendees. RAT Training, Fatal Seven, Skin Integrity and UTI Trainings were the most popular. General Trainings are those published on the training schedule. Provider Trainings are those specifically requested by a provider.

Figure 17. Training Provided by the Office of Integrated Health Support Network, FY2024

General Training	Number of Events	Attendees
Choking & Airway Obstruction	1	74
Diabetes Part 1	2	78
Dysphagia and Modified Diets	2	84
Fatal Seven	2	144
Nutrition Part 1	1	67
Nutrition Part 2	1	72
Oral Health	2	59
RAT	3	834
Skin Integrity & Pressure Injuries	3	124
SN/PDN Training	2	86
Transfers Training	2	72
Urinary Tract Infections	2	113
Wheelchair Transitioning Training	2	103

General Training	Number of Events	Attendees
Provider Specific Training		
Choking & Airway Obstruction	1	12
Diabetes Part 1	1	15
Diabetes Part 2	1	15
Dysphagia and Modified Diets	1	10
Falls	1	29
Fatal Seven	4	78
Medication Error Training	1	17
Recognizing Declining Health Part 1	1	3
SN/PDN Training	2	13
Grand Total	**38**	**2102**

Quarterly Review: Each quarter in SFY2024, 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 compliance with risk management and quality improvement regulations,
- Serious incident data, including, the types of serious incidents, the number of individuals with a serious injury, and rates of incidents related to falls, UTIs, and choking,
- Substantiated reports of abuse and neglect,
- Care concerns reviewed by both the IMU and OIH,
- Results of the look-behind reviews of the investigation of abuse/neglect cases and serious incident reviews

In response to these discussions and other RMRC observations, the OIHSN decided to make UTIs the focus of the DBHDS Annual Nursing Conference in October 2024. In addition, the RMRC decided to prioritize conducting analysis of falls data. A preliminary analysis (see section 3.f Falls Analysis) was completed in August 2024 which will be used to build out a reporting dashboard to allow real-time drill down into falls related data. In addition, the Office of Human Rights sent a memo to providers addressing the importance of providers adhering to required timeframes to complete an investigation, having (and using) someone that is trained to conduct investigations, and interviewing all parties that may have been involved or have information about the allegations.

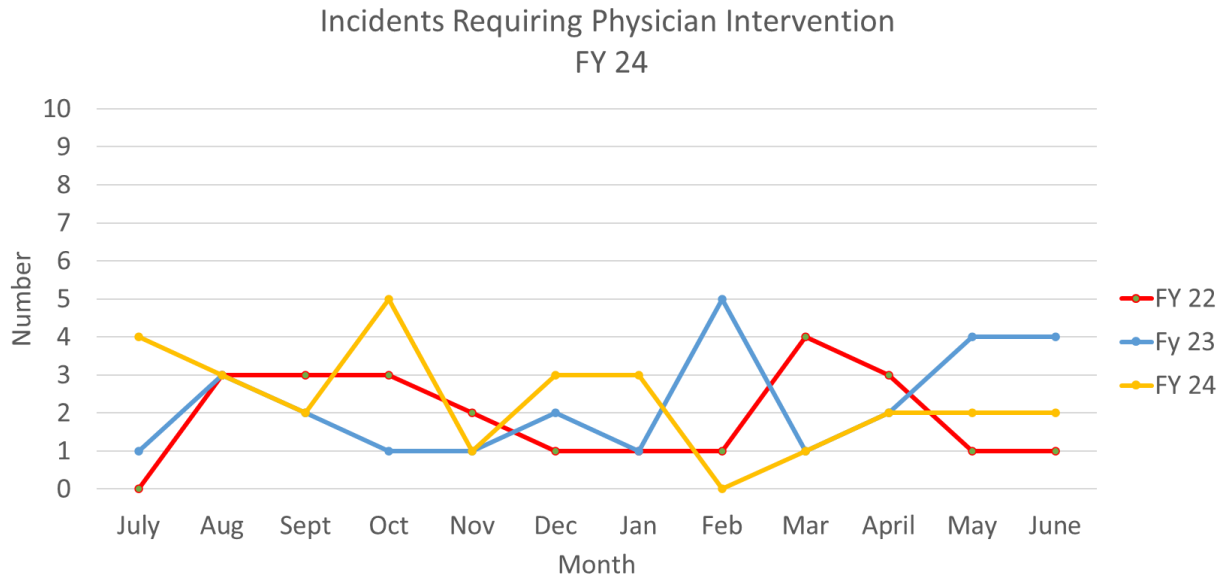
Part 3d. Facility Risk Management Programs - Training Center

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.

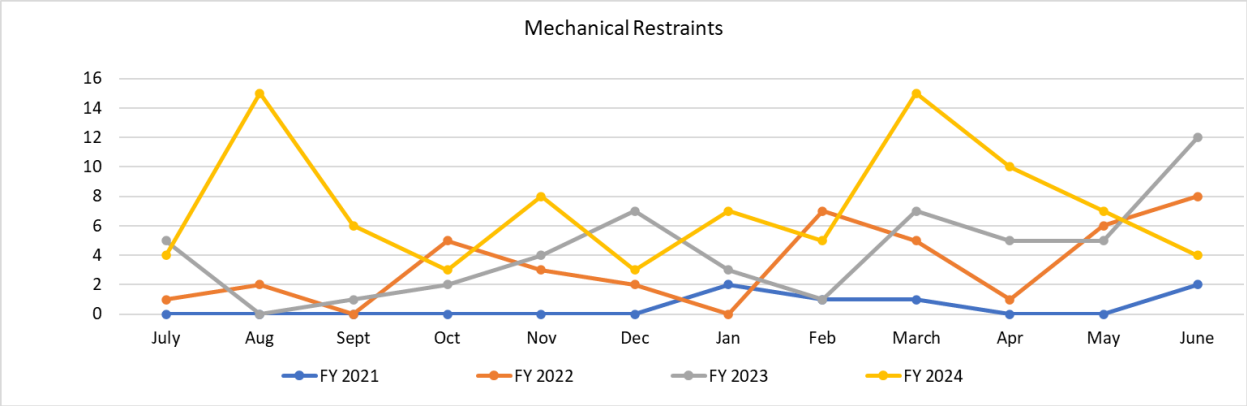
Each quarter in SFY2024, SEVTC reported to RMRC, for each risk trigger and threshold in place, whether it was met and a summary of actions that were taken to address individuals' health and safety needs. For example, Figure 18 shows a graph shared by SEVTC showing trends in SIRs during SFY2022-SFY2024.

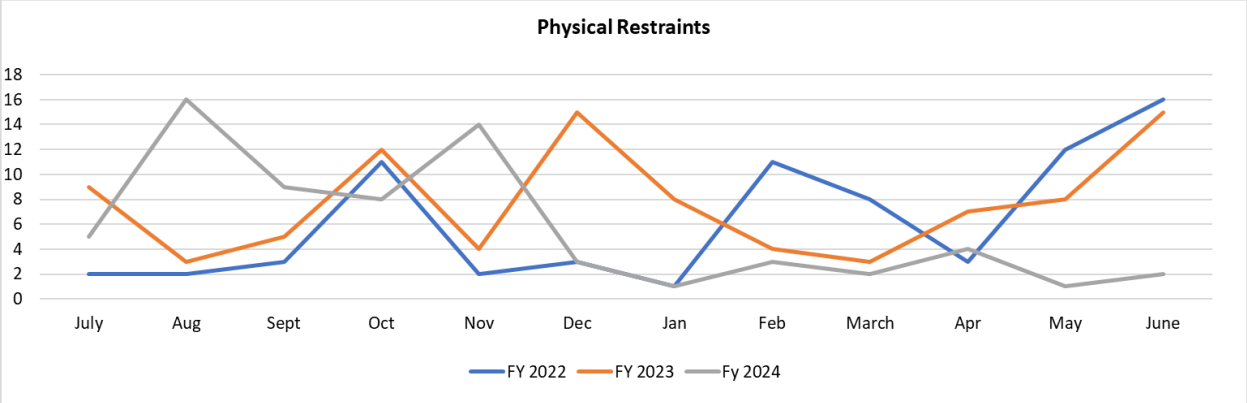
Figure 18. Southeast Virginia Training Center, Serious Incidents by Month, SFY2022, 2023, and 2024



SEVTC also shares information about quality improvement efforts. SEVTC discussed an initiative to reduce the number of physical restraints, and data from SFY2024 does show that the number of physical restraints has been consistently lower than previous years since December 2023.

Figure 19. Mechanical and Physical Restraints, SEVTC, SFY2021-SFY2024





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 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 DBHDS quality subcommittee, such as the Mortality Review Committee.
- Other issues of concern identified by committee members.

The RMRC had one case presentation in SFY2024. In April 2024, the IMU and OIHSN presented a case of an individual with a choking related serious incident. The incident involved the provider

failing to do the Root Cause Analysis in a timely manner, confusion between choking and aspiration, and incomplete information about medical history and choking risk in the ISP. The case presentation helped enhance members' understanding about the potential complexities in choking related serious incidents.

3f. Falls Analysis – FY2024

The RMRC conducted analysis of all fall related serious incidents during the time period of October 2020 through July 2024, a period of nearly five years. Below is a summary of the findings and recommendations.

- In total, there were 3,067 falls and trips that were the cause of a serious incident.
- 1,746 individual experienced at least one serious incident caused by a fall; of these, 89% had an injury.
- On average, there were 1.75 falls per individual who experienced a fall.

Demographics

- 55% of people who fell were age 51 and over; 45% were 50 and younger.
- 54% were male; 46% female.
- Most individuals with a fall were in SIS Tier 4 (51%), followed by SIS Tier 2 (22%), and SIS Tiers 6 and 7 (9% each).
- Region 4 had the highest proportion of falls (26.1%) while Region 2 had the lowest (15.7%).

Fall Incidence

- Among people who had a fall related serious incident report (SIR) (N=1748):
    - 65% only had one fall SIR.
    - 35% had 2 or more.
    - 17% had 3 or more.
    - 9% had 4 or more.
- Among people who had a fall related SIR (N=1748)
    - 11% had no injury reported
    - 46% had 1 injury reported
    - 42% had 2 or more injuries reported
    - 21% had 3 or more injuries reported

Serious Incident Reports and Injuries

- There were 3,791 Level II Serious Incident events (e.g. ER visit, hospitalization) where the Cause was a Fall or Trip

- These fell into the following Level II SIR Categories[3]:
    - 2,429 were ER visits (64%)
    - 985 were Serious Injuries Requiring Medical Attention ("SIRM") (26%)
    - 236 were Unplanned Hospitalizations (6%)
    - 140 were Other Level II types (4%)
- The most common injury was cut/laceration (ER=722, SIRM=337, hospitalization=36), followed by 'other' injury and bruise.
    - Looking at more serious injuries, fracture was the most common (ER=344 fractures, SIRM=277 fractures, and Hospitalization=99 fractures), followed by loss of consciousness (ER=30, SIRM=7, Hosp=9) and Concussion (ER=19, SIRM=6, Hosp=1).
    - Loss or impairment of body part was part of 2 ER SIRS, and 2 SIRM SIRs.
- Recommendations
    - Develop a data visualization to be able to track more detailed fall information over time.
    - Consider further analysis focused on higher risk subgroups in the data set.
    - Analyze root causes of Fall SIRs for higher risk subgroups.
    - Higher risk subgroups to consider:
        - Individuals with 5 or more falls during the period, N=86
        - Individuals with 5 or more injuries during the period, N=117
        - Individuals with Unplanned hospitalizations for falls during this period, N=236
        - Individuals with Multiple unplanned hospitalizations during the period, N=17
        - Individuals with 4 or more ER visits during the period, N=108

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. OL is responsible for conducting licensing inspections and investigations and assessing providers' compliance with risk management and quality improvement program requirements.

4a. 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

[3] *SIRs can be reported in multiple Level II categories*

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 20: 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	CY2023
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%↓	56% --
• 520A - Designated person with training or experience responsible for risk management function	77%	72%↓	81%↑
• 520B - Implements a written plan	89%	88%--	86%↓
• 520C1 - environment of care	85%	85% --	87%↑
• 520C2 - clinical assessment/reassessment	81%	83%↑	84%↑
• 520C3 -staff competence / adequacy of staffing	80%	84%↑	83%↓
• 520C4 - use of high-risk procedures	79%	81%↑	83%↑
• 520C5 - review of serious incidents	85%	85% --	85%--
• 520D - Systemic risk assessment incorporates risk triggers and thresholds	79%	75%↓	77%↑
• 520E - Conducts annual safety inspection	90%	93%↑	95%↑
Quality Improvement Program Requirements			
% Of providers that are compliant with 100% of the QI Requirements	52%	55%↑	56%↑
• 620A - Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	91%	94%↑	93%↓
• 620B - The QI program uses standard QI tools, including RCA and has a QI plan	89%	92%↑	89%↓
• 620C - The QI Plan shall:	--	--	--
• 620C1 - Be reviewed and updated annually	81%	86%↑	85%↓
• 620C2 - Define measurable goals and objectives	78%	85%↑	82%↓
• 620C3 -Include & report on statewide measures	NA	NA	NA
• 620C4 - Monitor implementation & effectiveness of approved CAPs	75%	81%↑	74%↓
• 620C5 - Include ongoing monitoring and evaluation of progress toward meeting goals	78%	85%↑	80%↓
• 620D - The providers P&P includes criteria used to:	--	--	--
• 620D1 - Establish measurable goals & objectives	74%	85%↑	83%↓
• 620D2 - Update the QI plan	74%	87%↑	88%↑
• 620D3 - Submit revised CAPs when not effective	65%	78%↑	77%↓
Input from individuals about services & satisfaction	81%	83%↑	88%↑

These results, from CY2023, show that

- Seven of the 520 and 620 sub regulations were met at 86% or above; this is an increase from six in CY2022.
- 11 were between 75%-85%,
- Only one was below 75%.

While eight sub regulations showed an increase in compliance from CY2022 to CY2023, the remaining 10 showed a decrease in compliance. Most of the changes (increase or decrease) were within two percentage points. Some notable exceptions were:

- A nine-percentage point increase (to 81%) in providers with a designated person with training in risk management. This likely reflects continued efforts by the Office of Licensing to educate providers on what is required to demonstrate compliance with this standard.
- A seven-percentage point decrease (to 74%) in providers monitoring the implementation and effectiveness of corrective action plans.
- A five-percentage point decrease (to 80%) in providers monitoring progress toward meeting goals.

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.

To assist in facilitating increased compliance, the OL posted additional tools and training on their website, including: four samples of a systemic risk assessment (August 2023), revised serious incident review and root cause analysis template (November 2023), a series of coaching seminars (June/July 2023), training on expectations for annual inspections (January 2024) and updated the Sample Provider Quality Improvement Plan (March 2024). In January 2024, the OL posted the OL Website Index which is a tool that can be used to search for documents/resources located on the OL website. Users can download the index and filter by topic area, diagnosis group and/or date then click on the hyperlink to view each document/resource. An updated version of the OL Website Index is published at least semi-annually.

In SFY2023, the RMRC, in conjunction with RQC5, implemented a QII that aimed to improve provider compliance with conducting an annual systemic risk assessment (regulations 520C and 520D). The primary intervention focused on developing and implementing a detailed three-part training on risk management, along with disseminating tools to assist providers in tracking and trending serious incidents and documenting a systemic risk assessment. The provider training was well attended and received positive feedback, with many providers voicing their intent to implement the tools that were shared. However, despite the positive response, there was no corresponding improvement in provider's compliance with these, or other risk management requirements (see 6a. 520C and D QII). The RMRC concluded that the use of large-scale trainings such as this are not effective in shifting provider understanding of how to implement complex requirements involved in implementing a risk or quality improvement program. This QII was

discontinued, and new initiative was implemented in SFY2024 that focused on providing individual consultation and technical assistance (CTA) to providers that were not meeting all of the QI or RM requirements (see 6c. 520/620 QII).

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 SFY2024, RMRC reviewed the results of the QSR from Round 5 in November 2023. The committee had several questions about QSR definitions and methodology, which resulted in some recommendations for changes to the QSR questions in Round 6. 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. 520C and D QII

In SFY2024, the RMRC completed the QII to improve provider compliance with conducting an annual systemic risk assessment (licensing regulations 520C and D). This QII was in partnership with the Regional Quality Council in Region 5 (RQC5). The QII Aim was to improve compliance with regulations 520C and 520D for licensed DD providers to 86% by SFY2023, Q4 (June 30, 2023). The goal was not achieved, as the result as of June 20, 2023 was 56%. However, the following trainings and tools were developed as part of the QII, and the majority of participants reported they were helpful and had intention to use them.

1. **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.
2. **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.
3. **Risk trigger threshold / care concerns handout:** A one-page handout that clearly explains risk triggers and thresholds, and CCs for providers. This is available on the OL website.
4. **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.

5. **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.

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

6b. Seclusion and Restraint QII

Providers are required to report each instance of seclusion and restraint to the Office of Human Rights (OHR) on an annual basis. Although required by law, the percentage of providers/services reporting this information has been below 50%. This low rate of reporting makes it difficult to draw conclusions about the use of seclusion and restraint across all providers and consequently difficult to identify system-wide concerns that may need to be addressed. To address this issue the RMRC implemented a QII that focused on improving provider awareness of the need to report and the importance of this information. As a result of these interventions, the rate of reporting increased from 46% in 2023 to 80% in 2024. Although this was slightly below the goal of 86%, the RMRC concluded that efforts were successful and officially completed the QII but will continue to implement these efforts in 2025 through OHR ongoing operations.

6c. 520/620 QII

The RMRC proposed a QII in SFY2024, the aim of which is to improve the percent of licensed DD providers that are compliant with all of the 520 and 620 (Risk Management and Quality Improvement regulations) to 86% (desired %, rate, etc.) by June 30, 2025 (interim measure) and at the end of Calendar Year 2025 (target date). The baseline was 56% for CY2023 for both regulations. The root cause is that, although tools, training and resources have been made available, providers may lack dedicated staff and/or struggle with how to find, understand and/or apply the information in their organization.

The change being tested is that QI Specialists in the Office of Community Quality Improvement (OCQI) will provide intensive consultation and technical assistance (CTA) to noncompliant providers, who elect to participate, to help them achieve compliance. In the process, OCQI will collect information via a Readiness Assessment that will help identify additional root causes that can be addressed.

As of the writing of this report in December 2024, 68 providers have completed ECTA, 39 are In-progress. Another 193 have been assigned or are in the initial steps to receive ECTA.

The OCQI is finding that the main barriers to providers being compliant with these regulations are as follows:

- Understanding the regulations
- Limited knowledge of QI Tools (e.g., RCA Tools, Risk Tracking Tool, Risk Matrix, etc.) and QI concepts

- Limited knowledge and use of data for QI/RM
- Limited QI/RM staff time
- Unawareness of available resources
- QI/RM staff turnover

As applicable to the provider(s), the ECTA Team addresses each of these barriers during the ECTA sessions.

An additional project has been interviewing small providers who have been successfully compliant with all the 520 and 620 regulations for the past two inspections (2023 and 2024). OCQI/OCQM staff conducted interviews with five providers and summarized what they reported as best practices. These will also be shared via a handout posted online, and a webinar in early 2025.

Part 7. Efforts to Improve Data Quality

In SFY2024, DBHDS and the RMRC have been working with staff from the Data Warehouse on the following data related improvements:

- Ensuring that Level 1 incidents, incorrectly reported in CHRIS, are excluded from the data reports and tables.
- Beginning to add other filters to the DW0123 report. Currently there are reports for Level II and Level III serious incidents, and illnesses, causes and conditions, broken down by fiscal quarter/year, region, and program service area of DBHDS (DD, Substance Abuse, Mental Health and Brain Injury). RMRC has asked the Data Warehouse to add provider and DD Service types as filters. This is in progress.

An RFP (request for proposals) was issued in June 2023 to replace the CHRIS incident reporting system; requirements for the new system included the ability to assign incidents to unique individuals. The RFP received 8 total Vendor responses; 2 Vendors were shortlisted for product demonstrations. After the demos concluded, and after careful evaluation of all vendor proposals, DBHDS determined that none of the proposals would adequately meet the requirements. Consequently, the RFP was cancelled on 5/28/24 with a "No Award" determination. Following the review of a subsequent RFI (request for information), DBHDS decided to move forward with an internal build of a new system. Requirements and a project plan for this system will be fully developed in SFY25.

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 SFY2024, the RMRC monitored four PMIs (as indicated in the table below).

Figure 21: Performance Measure Indicators, SFY2022- SFY2024

Performance Measure Indicators	Target	SFY22	SFY23	SFY24 Q1	SFY24 Q2	SFY24 Q3	SFY24 Q3	SFY24	Performance Assessment
Critical incidents are reported to the Office of Licensing within the required timeframes (24-48 hours)	86%	96%	96%	96%	96%	96%	96%	96%	Exceeded Goal RETIRED
Licensed providers meet 100% of regulations for risk management programs	≥86%	61%*	56%**	49%	100%	53%	55%	59%***	Goal not met
Licensed providers meet 100% of regulations for quality improvement programs	≥86%	52%*	56%**	48%	80%	49%	43%	55%***	Goal not met
Individuals are free from harm, as reflected in the rates of serious incidents that are related to risks which are prevalent in individuals with DD: **Falls**	≤63.6	61.64	67.05	74.77	61.95	68.37	82.43	71.88	Goal not met

* Data for calendar year 2021 **Data for calendar year 2022 ***Data for calendar year 2023.

Provider reporting of SIRs continues to exceed the goal of at least 86% being reported within 24 hours of discovery. This PMI was retired in SFY2024 but will continue to be monitored by RMRC.

Percentage of Providers Compliant with 100% of Risk Management Regulations – This measure has consistently fallen below the goal of 86%. The RMRC and RQC5 initiated a QII that focused on improving compliance with regulations 520C and 520D. Interventions included conducting a three-part risk management training and disseminating tools to assist providers in tracking risks and conducting and documenting a systemic risk assessment. The training was well attended and received positive feedback from providers, with many reporting that they intended to incorporate the information and the tools into their risk management programs. However, despite this, compliance ratings with the risk management requirements remained unchanged. One explanation is that the complexity of meeting these requirements by developing and implementing a risk management program requires more specific training and guidance than can be provided in a large-scale webinar. To address this, the Office of Community Quality Improvement (OCQI) has hired 12 quality improvement specialists who will provide **individual** consultation and technical assistance to each provider to help them implement a compliant risk management program.

Percentage of Providers Compliant with 100% of the Quality Improvement Regulations – Although the RMRC has not implemented a formal QII to address this measure, DBHDS has disseminated much information to providers on the various components of a QI program. Similar to risk management requirements, it is likely that providers will need more individualized

consultation and technical assistance to master these skills. The OCQI will be addressing quality improvement programs as part of their consultation and technical assistance.

The PMIs for risk management and quality improvement requirements are being addressed through a QII (6c. 520/620 QII).

Annualized Rate of Falls

Except for one quarter, the rate of falls has been above the goal of 61.64/1000 or less. The overall results for FY2024 were also greater than either FY2023 or FY2022. The RMRC had previously implemented a QII that aimed to reduce the rate of falls through general provider education on assessing and addressing fall risk, as well as follow-up with specific providers serving individuals with multiple falls (care concerns). This was not effective in reducing the rate of falls. This year, the RMRC initiated a more detailed analysis of falls data with a goal of identifying specific factors that may be addressed in a future QII. This analysis is underway and will be completed in SFY2025.

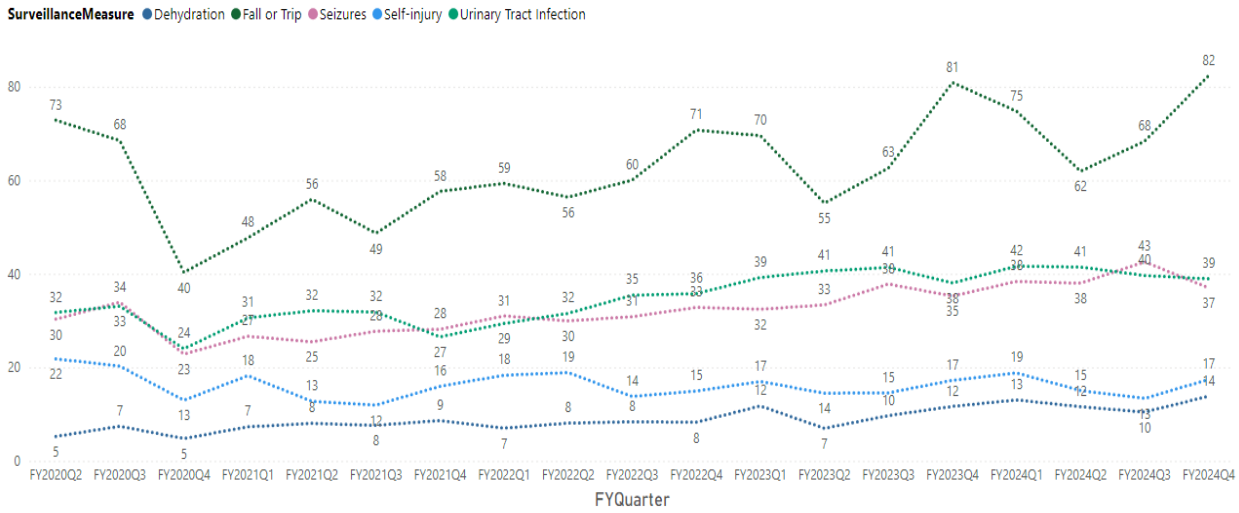
Part 9. Surveillance Measures

In addition to the PMIs listed in Part 8, RMRC is also responsible for tracking additional surveillance measures. The RMRC Chair is responsible for ensuring these data are collected and available for review by the committee. The RMRC routinely tracks and reviews the rates of twelve select risks and conditions, as listed in Figure 21 below. These were selected because of the elevated risk associated with adverse outcomes and mortality for individuals with DD. Most of these risks are directly or indirectly addressed on the Risk Awareness Tool.

Figure 22. Rate of Select Level II Risks in CHRIS for Individuals on a DD Waiver, per 1,000 Waiver Population(annualized), SFY2024

SurveillanceMeasure	Q1	Q2	Q3	Q4	Total
Fall or Trip	74.77	61.95	68.36	82.42	**71.88**
Urinary Tract Infection	41.65	41.46	39.65	38.94	**40.43**
Seizures	38.39	38.01	42.57	37.03	**39.00**
Self-injury	18.82	15.06	13.38	17.44	**16.18**
Dehydration	13.05	11.60	10.46	13.86	**12.24**
Sepsis	6.52	9.38	8.03	10.51	**8.61**
Decubitus Ulcer	8.53	8.39	7.06	5.73	**7.43**
Choking	8.53	7.90	7.30	5.73	**7.37**
Aspiration Pneumonia	4.27	7.40	6.81	6.69	**6.29**
Sexual Assault	4.27	7.40	4.38	5.02	**5.27**
Bowel Obstruction	4.77	4.94	3.89	5.73	**4.83**
Suicide Attempt	4.01	4.44	4.14	3.34	**3.98**
Total	**18.97**	**18.16**	**18.00**	**19.37**	**18.62**

Figure 23. Top 5 Most Prevalent Rates of Select Level II Risks in CHRIS for Individuals on a DD Waiver, per 1,000 Waiver Population (annualized), SFY2020 – 2024 Trend



Part 10. Recommendations

Based upon its review of SFY2024 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 SFY2024, while others are targeted for completion in SFY2025. Also listed below are recommendations from prior years and the status of each taken during SFY2024.

Recommendations from SFY2024

Recommendations	Status as of SFY2024 Report
1. Remove Level I incident reports from the data.	**Completed in SFY2024**
2. As a result of the Falls Analysis, identify improvement opportunities related to multiple ER visits and/or hospitalizations or very serious injuries due to falls.	**This will continue into SFY2025.** The Data Warehouse has begun developing a PowerBI Visualization that will help with this.
3. Improve provider understanding of, and compliance with, requirements for RM and QI programs.	**Ongoing.** See information about the QII focused on improving RM compliance.
4. Office of Licensing begin reporting on Health and Safety CAPS to RMRC	**Ongoing.** OL has begun reporting bi-annually.
5. RMRC recommended more regularly sharing risk data directly with providers	**This will continue into SFY2025.** RMRC will include an article in the quarterly OL newsletter focusing on risk data.

Status of Recommendations from Previous Years

Recommendations from previous years	Status as of SFY2024 Report
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.	**Completed** in SFY2024. OL has begun presenting Health and Safety CAP data to RMRC at least biannually.
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).	**Completed** in SFY2024.
3. 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.	**Completed** in SFY2024.
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 with the development of a master patient index; others may require implementation of a new incident management system.
5. April 2022 - Create a Health and Safety Alert on Down Syndrome and Alzheimer's Disease.	**Pending.** This will be revisited in 2025.
6. May 2022 - Provide licensing data broken down by region (RQC recommendation).	**Pending.** This will be revisited in 2025.
7. June 2022 - Develop criteria and/or a process for revising care concerns, as needed.	**In progress.** This will be revisited in 2025.
8. Develop better guidance for providers about reporting medication errors as neglect.	**In Progress.** OHR continues to gather feedback on draft revised guidance. This will be revisited in 2025.

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 SFY2024, the RMRC continued to fulfill its charter requirements by reviewing data, identify additional data needs, and implementing quality improvement initiatives.

While the number of reported serious incidents has continued to increase, the overall rate, when viewed in relation to the number of individuals on a developmental disability waiver has decreased slightly. The RMRC has identified rates of falls, urinary tract infections, and choking as areas of concern. Falls and urinary tract infections are concerning because of their high prevalence (as compared with other risks), whereas choking is a lower prevalence but has been directly associated with a number of deaths. While interventions have been implemented through the RMRC and some RQCs, the statewide rates have not yet shown improvements.

RMRC was also able to complete a more in-depth analysis of falls and trips data. The data showed the extent to which people experience multiple falls and trips, and multiple ER visits and hospitalizations. This highlighted an opportunity to focus on the group of people experiencing more frequent and more serious fall events and identify additional opportunities to reduce the risk of falls. This work will continue in SFY2025.

The RMRC successfully completed a QII resulting in an increase in providers reporting seclusion and restraint, from 46% of services to 80% of services. The RMRC will consider specific data or measures that can be developed using seclusion and restraint data to better monitor any risks or concerns in this area.

The PMIs measuring provider compliance with risk management and quality improvement regulations have both been consistently below the target of 86%. To address this performance RMRC completed a 520C and D QII which included the development of several helpful trainings and tools. Providers found this information helpful, however, it was not sufficient to improve performance. These training and tools will now be incorporated into the new QII focused on providing individualized technical assistance to noncompliant providers.

The OIHSN has addressed many of the health and safety risk areas providing training and technical assistance to providers, both individually and to larger groups. This has included outreach to providers in response to identification of care concerns, health and safety alerts posted on the DBHDS website, and a number of trainings focused on health risks such as choking and airway obstruction, skin integrity and pressure injuries, use of the Risk Awareness Tool, urinary tract infections, falls, medication errors, and more.

Appendix 1. Acronym List

Acronym	Full Form
ANE	Abuse, Neglect, and Exploitation
AWOL	Absent Without Official Leave
CAP	Corrective Action Plan
CC	Care Concern
CHRIS	Comprehensive Human Rights Information System
CLB	Community Look-Behind
COVLC	Commonwealth of Virginia Learning Center
CSBs	Community Services Boards
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice
DW	Data Warehouse
ER	Emergency Room
IMS	Incident Management Specialist
IMU	Incident Management Unit
ISP	Individual Support Plan
KPA	Key Performance Area
MH	Mental Health
NA	Not Applicable

Acronym	Full Form
ND	Not Determined
OCQI	Office of Community Quality Improvement
OCQM	Office of Clinical Quality Management
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIHSN	Office of Integrated Health Support Network
OL	Office of Licensing
OPD	Office of Provider Development
PDSA	Plan-Do-Study-Act
PMI	Performance Measure Indicator
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QSR	Quality Service Review
RM	Risk Management
RMRC	Risk Management Review Committee
RQC	Regional Quality Council
SEVTC	Southeastern Virginia Training Center
SFY	State Fiscal Year
SIR	Serious Incident Report
UTI	Urinary Tract Infection
VCU	Virginia Commonwealth University
WaMS	Waiver Authorization Management System