Risk Management Review Committee
Annual Report
State Fiscal Year 2025

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Risk Management Review Committee Annual Report

July 1, 2024 – June 30, 2025

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 SFY2025, the data reviewed included licensing inspections, incident management data, reports of abuse and neglect, and training center risk management (RM) activities. Three performance measure indicators (PMIs) derived from this data were monitored. In SFY2025, the RMRC took the following actions related to quality improvement initiatives (QIIs).

- RMRC continued a QII to improve provider's compliance with licensing regulations that require providers to develop and implement risk management and quality improvement programs. While overall compliance has not yet improved, providers that have received technical assistance have shown improvements in compliance with specific regulations.
- RMRC proposed a QII to improve the three outcomes that are evaluated through the Office of Human Rights community look-behind process. This QII was approved by the QIC in June 2025; it will be implemented in SFY2026.

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

Previous Year Recommendations	Status
1. 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.	**In Progress.** A new Power BI dashboard was created which features more than ten additional interactive graphs about falls and trips.
2. Improve provider understanding of, and compliance with, requirements for RM and QI programs.	**In Progress.** A QII focused on this issue is in place.
3. Office of Licensing to report Health and Safety CAPS to the RMRC	**Ongoing.** The Office of Licensing is presenting an update on health and safety CAPs to the RMRC on a semi-annual basis.
4. Share risk data directly with providers	**Ongoing.** The RMRC began sharing risk data with providers through the Office of Licensing newsletter. Information shared: October 2024, January 2025, and April 2025.

RMRC also made the following recommendations, in SFY2025, for quality improvement that are planned to continue in SFY2026.

Recommendation	Status
1. Explore issues related to medication safety.	**Continuing.** A Medication Safety Study Group convened in SFY2025 and will continue to explore the topic and make recommendations in SFY2026.
2. Develop a table which explains the various reviews conducted by DBHDS of DD licensed providers.	**Planned for Completion.** A table was created and is targeted for posting in SFY2026 on the DBHDS Office of Community Quality Management webpage - https://dbhds.virginia.gov/wp-content/uploads/2025/10/DD-Review-side-by-side_FINAL.pdf
3. Consider the adoption of a PMI related to community integration.	**Not Yet Implemented.** This will need further evaluation and discussion in SFY2026.
4. Consider study group/learning collaborative related to medication safety	**Not implemented.** However, a medication safety workgroup is continuing to meet to explore opportunities for improvement.

Part 2. Committee Purpose and Structure

The purpose of the RMRC is to provide ongoing monitoring of serious incident reports (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 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.

Further description of the RMRC can be found in the RMRC Charter which is available online at: https://dojsettlementagreement.virginia.gov/dojapplication/external/documents/DD-RMRC-Charter-rev-6.23.25.pdf

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[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.

Part 3. Health and Well Being

RMRC's overall process enables DBHDS to identify and prevent or substantially mitigate risks of harm. This aligns with the Health and Well-Being Key Performance Area (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.

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 SFY2025 is provided below.

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

In SFY2025, 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 SFY2025, there were a total of 3,073 complaints alleging ANE reported by licensed community providers (of DD services). Of these, 1,029 were substantiated (33%). Compared to SFY2024, there was a small increase in number of total reports (from 3,064) with a 3% increase in number of reports substantiated. The total number of reports and substantiated cases by abuse type across SFY2024 and SFY2025 is shown in Figure 1A. The total number of reports and substantiated cases by quarter for SFY2025 is shown in Figure 1B.

Figure 1A. Total Reports and Substantiations of ANE by Quarter, SFYS2024-SFY2025

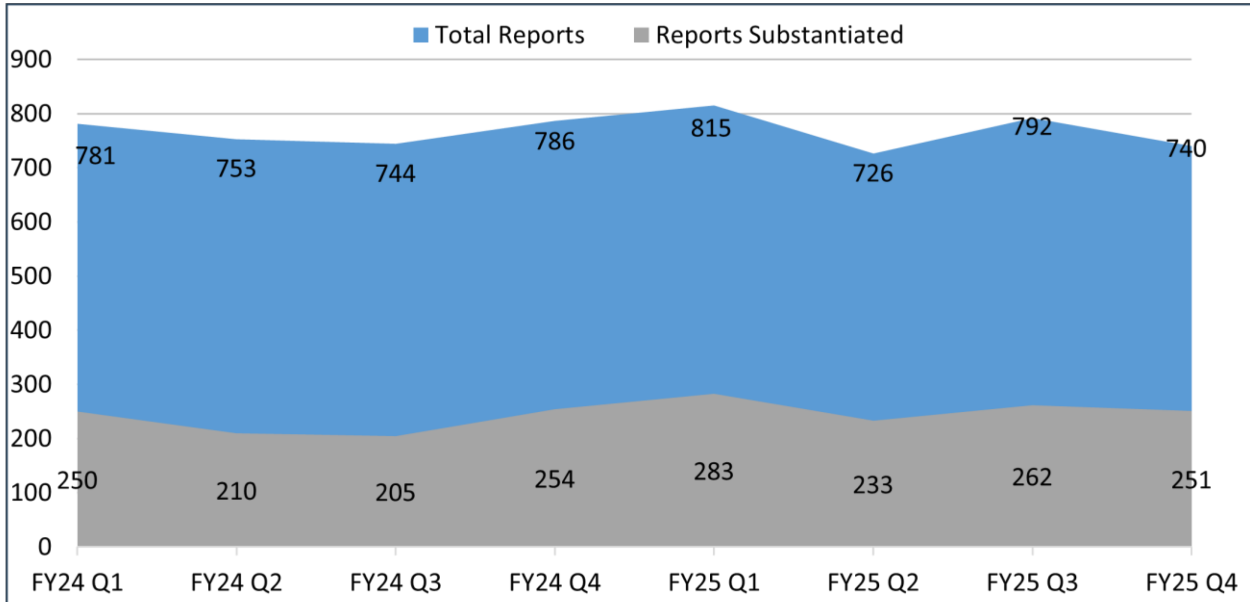
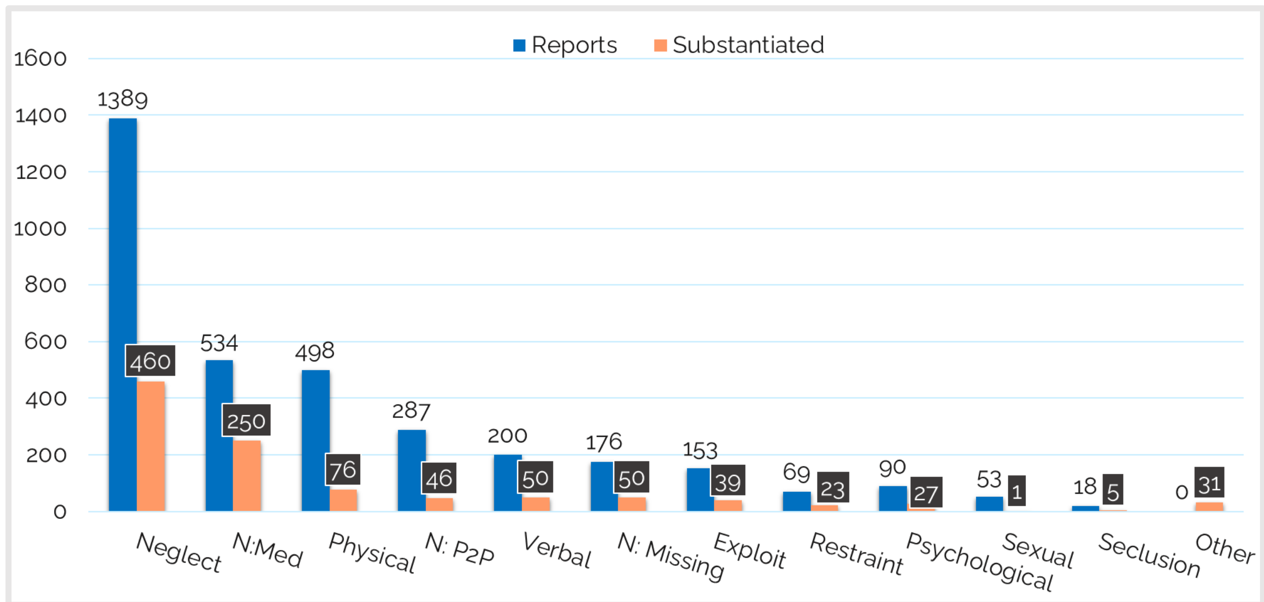
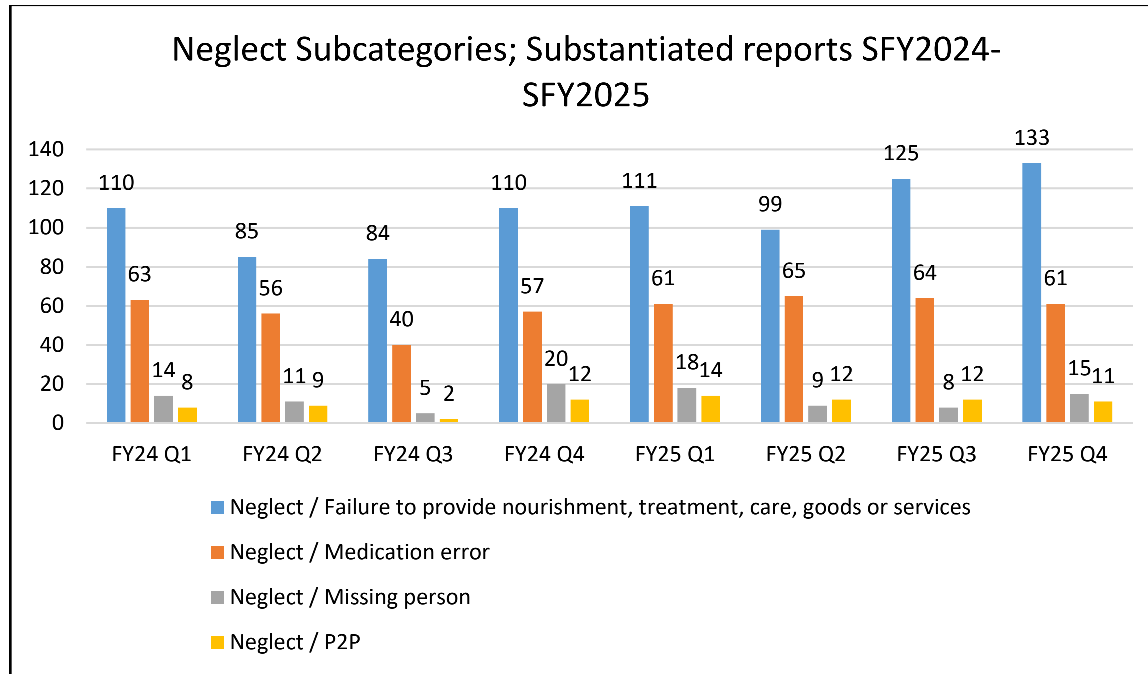


Figure 1B. Types of ANE Reported and Substantiated, SFY2025



The number of substantiated cases of neglect, by subcategory, is shown in Figure 2.

Figure 2. Substantiated Cases of Neglect by Sub-Category, SFY2025



Neglect consistently accounts for the most reported and substantiated type of human rights violation. Based on the multiple kinds of failures captured by the term “neglect”, the categories help identify key issues, to ensure the most appropriate corrective actions are implemented. In SFY2025, general failures related to a provider’s action or inaction during the delivery of services necessary for health and welfare represent the majority of neglect violations. Reports connected to lapses in provider supervision (i.e. missing individuals and peer aggression) remain relatively low and are less in number when compared to reports and violations of physical abuse.

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

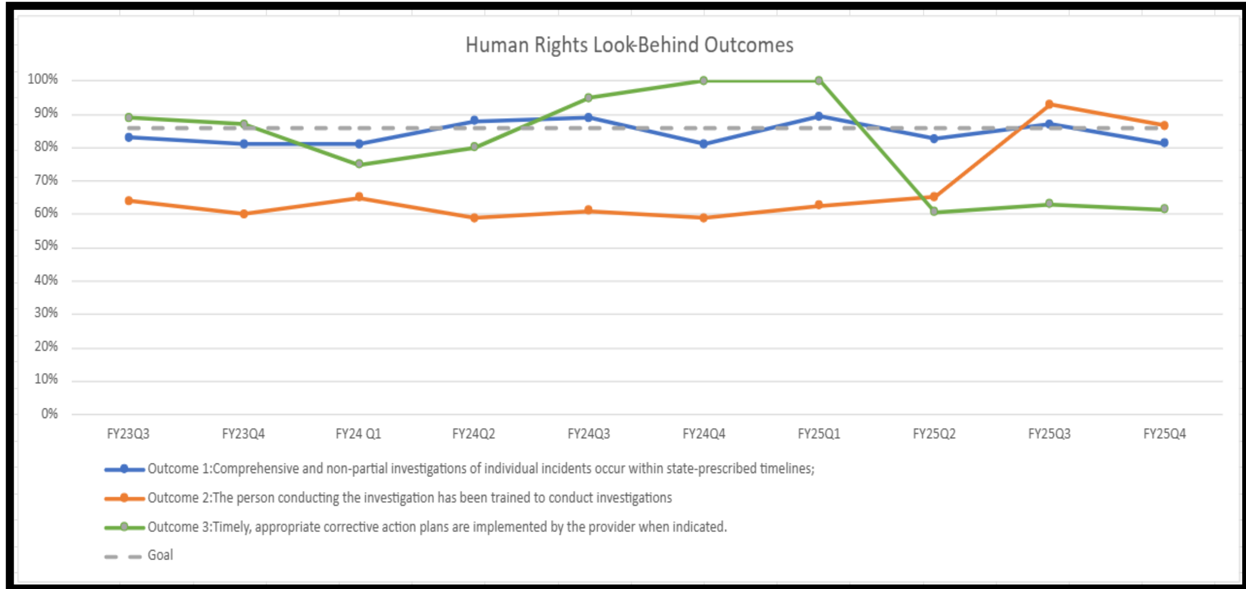
OHR has operationalized a CLB process to validate that provider investigations are conducted in accordance with state regulations, and to identify where prevention efforts and mitigating strategies are needed. The CLB process provides data intended to demonstrate that reported cases of ANE are verified 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.

Figure 3. Results of OHR Look-Behind Review, SFY2023 Q3 through SFY2025 Q4



In addition to these primary outcomes, the look-behind review also found that investigations often did not include interviews with all staff involved (Q4=83%) or the involved individual(s) (Q4=37%). Of note, OHR has been monitoring this data and incorporated a new module dedicated to interviewing witnesses in a revised version of the web-based investigation training that will be available to providers in SFY2026. The module includes strategies for interviewing uncooperative witnesses and individuals with communication differences.

The RMRC proposed a QII to address the look-behind outcomes; this is further discussed in Part 6.b below. As part of this QII, the OHR will conduct a root cause analysis to identify targets for intervention.

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

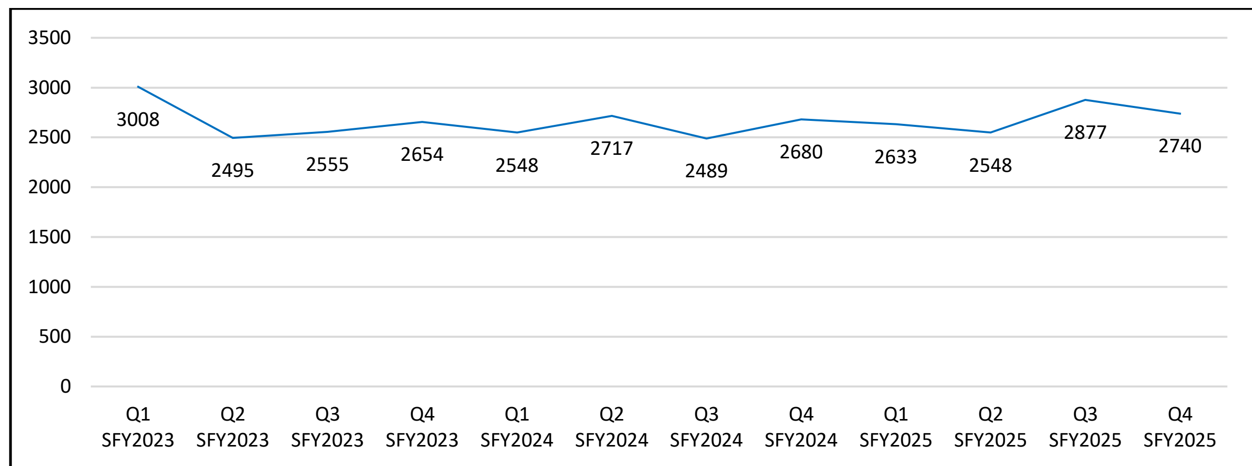
reviews at least two years of data to identify patterns or trends that may help to identify, mitigate, or prevent future risk of harm. In addition, the RMRC is responsible for developing an incident management process that monitors and responds to all reported SIRs. RMRC achieves this in partnership 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 six fiscal years is as follows:

- SFY2021: 9,753
- SFY2022: 10,555
- SFY2023: 10,712
- SFY2024: 10,434
- SFY2025: 10,798

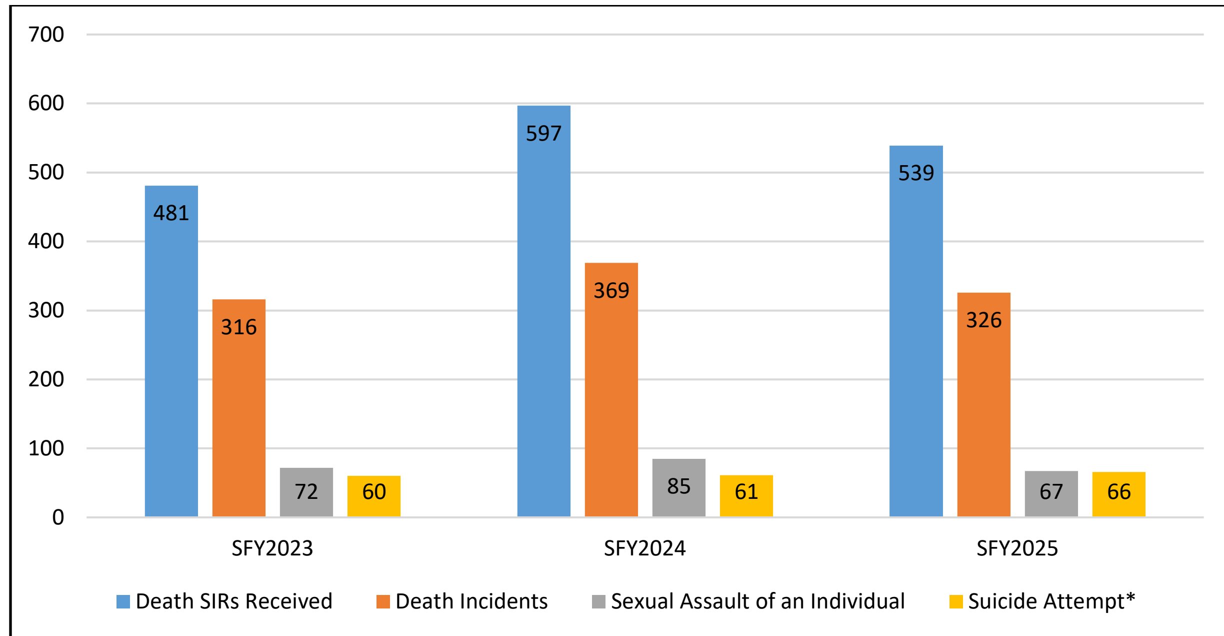
Figure 4, below, depicts the number of serious incident reports for each quarter.

Figure 4. Number of Serious Incident Reports, in CHRIS, for Individuals Receiving DD Waiver Services, by Quarter, SFY2023- SFY2025



The number and type of Level III SIRs, each quarter of SFY2025 (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-SFY2025



*Suicide Attempt by an Individual Admitted for Services, Other than Licensed Emergency Services, That Results in a Hospital Admission

*Table 1. Number of Level II Serious Incident Reports by Type, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2025 (Sorted from Total, Highest to Lowest) *Note: One incident may be reported in several categories.*

	Q1		Q2		Q3		Q4		Total	
SeriousIncident - Level2	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
ER Visit	1786	58.39%	1738	56.95%	2084	56.02%	1931	54.14%	7539	56.27%
Unplanned Hospital Admission	463	15.14%	506	16.58%	624	16.77%	499	13.99%	2092	15.61%
Serious Injury - Requiring Medical Attention	334	10.92%	372	12.19%	566	15.22%	637	17.86%	1909	14.25%
Unplanned Psychiatric Admission	105	3.43%	102	3.34%	113	3.04%	144	4.04%	464	3.46%
Other - Level 2	82	2.68%	75	2.46%	74	1.99%	86	2.41%	317	2.37%
Harm or Threat to Others	96	3.14%	73	2.39%	72	1.94%	71	1.99%	312	2.33%
Missing Individual	57	1.86%	47	1.54%	55	1.48%	54	1.51%	213	1.59%
Decubitus Ulcer	30	0.98%	44	1.44%	35	0.94%	35	0.98%	144	1.07%
Aspiration Pneumonia	39	1.27%	32	1.05%	32	0.86%	33	0.93%	136	1.02%
Choking Incident	28	0.92%	21	0.69%	25	0.67%	39	1.09%	113	0.84%
Bowel Obstruction	22	0.72%	30	0.98%	25	0.67%	19	0.53%	96	0.72%
Ingestion of Hazardous Materials	17	0.56%	12	0.39%	15	0.40%	19	0.53%	63	0.47%
Total	3059	100.00%	3052	100.00%	3720	100.00%	3567	100.00%	13398	100.00%

Figure 6. Level II Serious Incident Reports, Top 5 Incident Types, in CHRIS, for Individuals Receiving DD Waiver Services – Trend Data SFY2023 – SFY2025

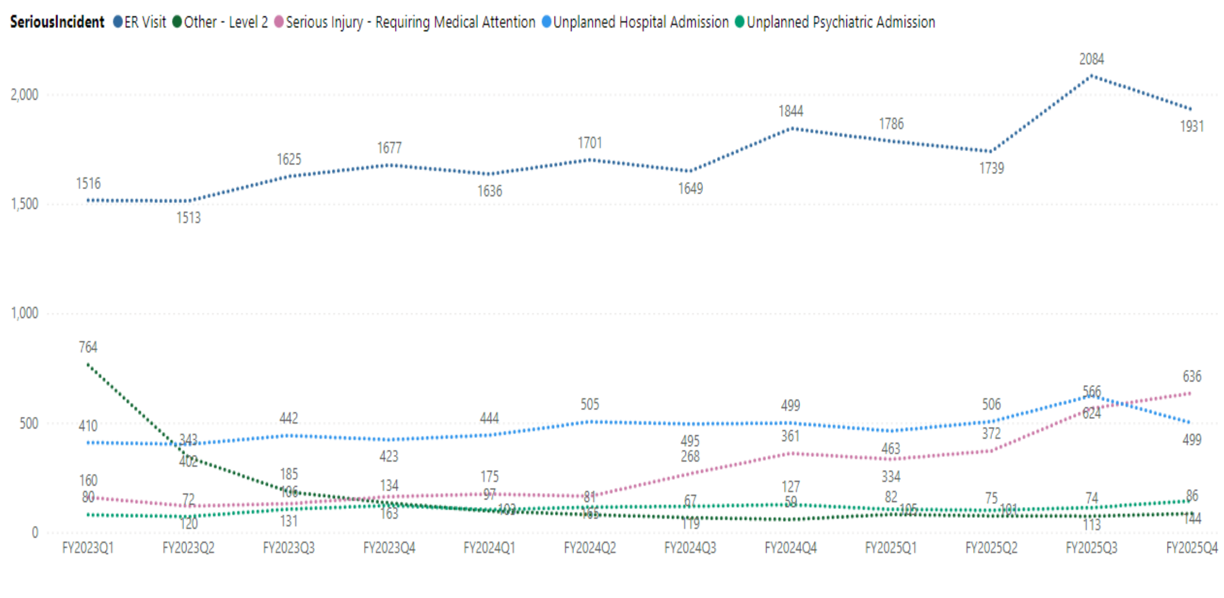


Table 2. Number of Illnesses / Conditions Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2025 (Sorted from Total, Highest to Lowest)

FiscalYear	2025										Total	
	Q1		Q2		Q3		Q4		Total			
IllinessCondition	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percen
Other Illness/Condition	656	34.80%	650	35.56%	893	39.48%	783	38.80%	2982	37.31%	2982	37.31
Urinary Tract Infection (UTI)	181	9.60%	161	8.81%	191	8.44%	162	8.03%	695	8.70%	695	8.70
Mental Status Changes	166	8.81%	168	9.19%	144	6.37%	193	9.56%	671	8.39%	671	8.39
Seizure	161	8.54%	152	8.32%	170	7.52%	154	7.63%	637	7.97%	637	7.97
Diarrhea/Vomiting	114	6.05%	139	7.60%	225	9.95%	141	6.99%	619	7.74%	619	7.74
Pneumonia (Caused By Bacteria Or Virus)	93	4.93%	139	7.60%	148	6.54%	115	5.70%	495	6.19%	495	6.19
Suicidal Thoughts/Behaviors	79	4.19%	80	4.38%	99	4.38%	111	5.50%	369	4.62%	369	4.62
Constipation	81	4.30%	57	3.12%	61	2.70%	68	3.37%	267	3.34%	267	3.34
Blood Sugar Problem (High Or Low)	43	2.28%	36	1.97%	46	2.03%	50	2.48%	175	2.19%	175	2.19
Dehydration	48	2.55%	39	2.13%	48	2.12%	37	1.83%	172	2.15%	172	2.15
Covid-19	79	4.19%	25	1.37%	52	2.30%	9	0.45%	165	2.06%	165	2.06
Aspiration Pneumonia	44	2.33%	35	1.91%	36	1.59%	45	2.23%	160	2.00%	160	2.00
Sepsis	31	1.64%	35	1.91%	39	1.72%	44	2.18%	149	1.86%	149	1.86
Cardiac Event	35	1.86%	38	2.08%	36	1.59%	35	1.73%	144	1.80%	144	1.80
Exacerbation Of A Chronic Medical Condition	29	1.54%	27	1.48%	35	1.55%	34	1.68%	125	1.56%	125	1.56
Bowel Obstruction	23	1.22%	29	1.59%	25	1.11%	19	0.94%	96	1.20%	96	1.20
Asthma	8	0.42%	9	0.49%	4	0.18%	10	0.50%	31	0.39%	31	0.39
Drug Or Alcohol Problem	10	0.53%	5	0.27%	4	0.18%	3	0.15%	22	0.28%	22	0.28
Stroke	4	0.21%	4	0.22%	6	0.27%	5	0.25%	19	0.24%	19	0.24
Total	1885	100.00%	1828	100.00%	2262	100.00%	2018	100.00%	7993	100.00%	7993	100.00

Figure 7. Number of Illnesses/Conditions Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services – Top 5 Conditions Trend Data SFY2023 – SFY2025 NOTE: COVID and "Other" are excluded as outliers.

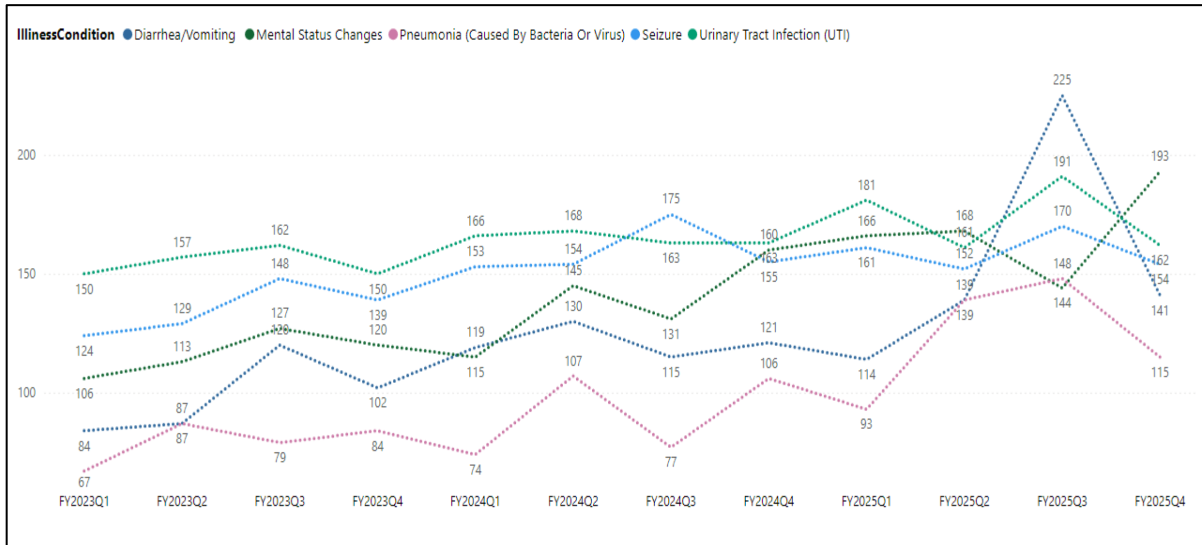


Table 3. Number of Injuries Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2025 (Sorted from Total, Highest to Lowest)

FiscalYear	2025										Total	
	Q1		Q2		Q3		Q4		Total			
Injury	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Other Injury	240	28.10%	218	27.18%	155	20.05%	154	17.52%	767	23.19%	767	23.19%
Cut/Laceration	139	16.28%	131	16.33%	131	16.95%	151	17.18%	552	16.69%	552	16.69%
Bruise	136	15.93%	113	14.09%	126	16.30%	145	16.50%	520	15.72%	520	15.72%
Bleeding	90	10.54%	94	11.72%	101	13.07%	99	11.26%	384	11.61%	384	11.61%
Fracture	97	11.36%	77	9.60%	82	10.61%	84	9.56%	340	10.28%	340	10.28%
Sprain/Strain/Tear	28	3.28%	42	5.24%	42	5.43%	57	6.48%	169	5.11%	169	5.11%
Pressure Injury (Decubitus Ulcer)	30	3.51%	44	5.49%	36	4.66%	36	4.10%	146	4.41%	146	4.41%
Loss Of Consciousness	18	2.11%	24	2.99%	32	4.14%	35	3.98%	109	3.30%	109	3.30%
Obstructed Airway (Unable To Breathe, Turning Blue)	18	2.11%	11	1.37%	18	2.33%	30	3.41%	77	2.33%	77	2.33%
Bite/Sting	20	2.34%	14	1.75%	12	1.55%	21	2.39%	67	2.03%	67	2.03%
Adverse Reaction To Medication	15	1.76%	10	1.25%	11	1.42%	19	2.16%	55	1.66%	55	1.66%
Allergic Reaction	9	1.05%	8	1.00%	6	0.78%	20	2.28%	43	1.30%	43	1.30%
Burn	6	0.70%	5	0.62%	5	0.65%	8	0.91%	24	0.73%	24	0.73%
Concussion	3	0.35%	5	0.62%	6	0.78%	7	0.80%	21	0.63%	21	0.63%
Dislocation	3	0.35%	2	0.25%	6	0.78%	9	1.02%	20	0.60%	20	0.60%
Poisoning	1	0.12%	3	0.37%	1	0.13%	4	0.46%	9	0.27%	9	0.27%
Loss Or Serious Impairment Of Limb Or Other Body Part (E.G., Eyes, Arms, Legs)	1	0.12%	1	0.12%	3	0.39%			5	0.15%	5	0.15%
Total	854	100.00%	802	100.00%	773	100.00%	879	100.00%	3308	100.00%	3308	100.00%

Figure 8. Number Injuries Associated with Serious Injuries in CHRIS, for Individuals Receiving DD Waiver Services, – Top 5 Injuries Trend Data – SFY2023 – SFY2025

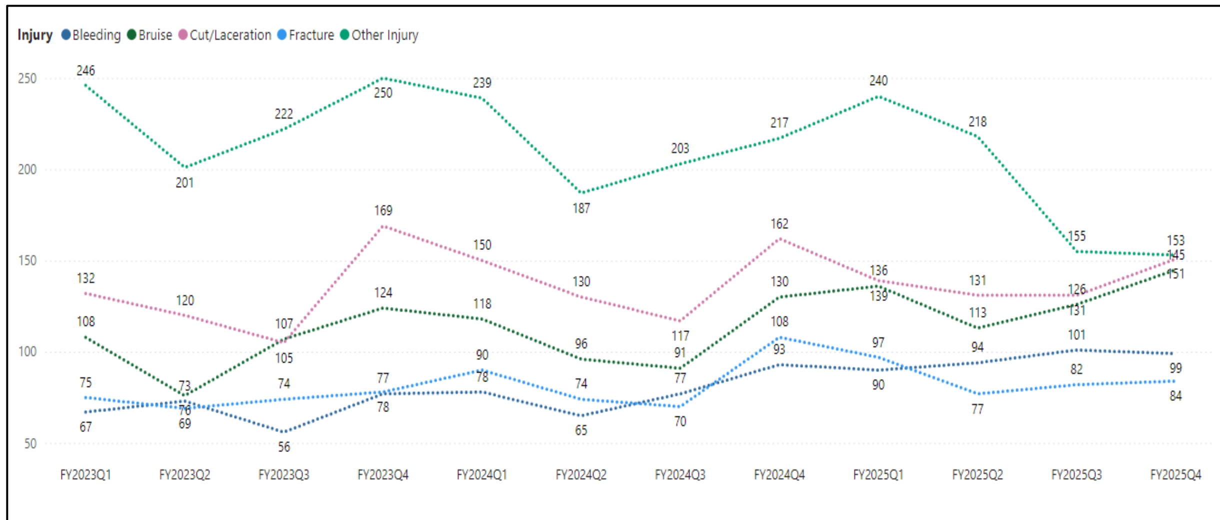
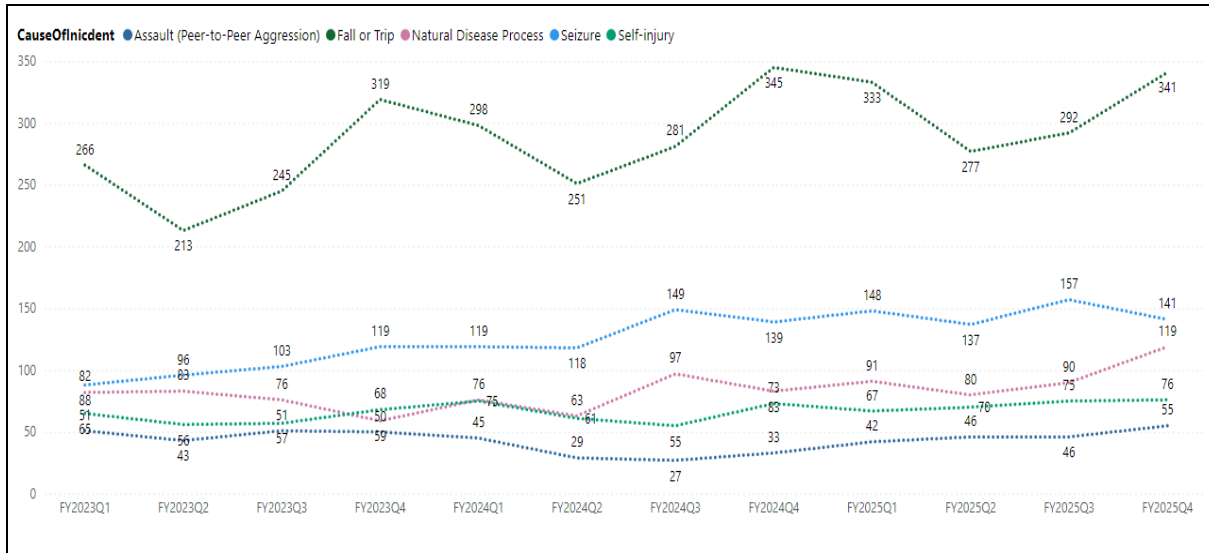


Table 4. Number of Causes Associated with Serious Incidents, in CHRIS, for Individuals Receiving DD Waiver Services, SFY2025 (Sorted from Total, Highest to Lowest)

FiscalYear	2025										Total	
	Q1		Q2		Q3		Q4		Total			
CauseOfInicdent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Unknown	945	42.23%	898	42.06%	1033	42.46%	960	40.37%	3836	41.77%	3836	41.77%
Other	430	19.21%	446	20.89%	533	21.91%	504	21.19%	1913	20.83%	1913	20.83%
Fall or Trip	333	14.88%	277	12.97%	292	12.00%	341	14.34%	1243	13.53%	1243	13.53%
Seizure	148	6.61%	137	6.42%	157	6.45%	141	5.93%	583	6.35%	583	6.35%
Natural Disease Process	91	4.07%	80	3.75%	90	3.70%	119	5.00%	380	4.14%	380	4.14%
Self-injury	67	2.99%	70	3.28%	75	3.08%	76	3.20%	288	3.14%	288	3.14%
Assault (Peer-to-Peer Aggression)	42	1.88%	46	2.15%	46	1.89%	55	2.31%	189	2.06%	189	2.06%
Medical Equipment Malfunction (Adaptive Equipment)	18	0.80%	25	1.17%	34	1.40%	24	1.01%	101	1.10%	101	1.10%
Motor Vehicle Accident	24	1.07%	27	1.26%	29	1.19%	20	0.84%	100	1.09%	100	1.09%
Neglect	18	0.80%	17	0.80%	24	0.99%	13	0.55%	72	0.78%	72	0.78%
Ingestion of Foreign or Hazardous Material	17	0.76%	15	0.70%	19	0.78%	18	0.76%	69	0.75%	69	0.75%
Suicide Attempt	20	0.89%	19	0.89%	17	0.70%	13	0.55%	69	0.75%	69	0.75%
Medication Error	16	0.71%	17	0.80%	17	0.70%	14	0.59%	64	0.70%	64	0.70%
Traumatic Event	17	0.76%	15	0.70%	11	0.45%	9	0.38%	52	0.57%	52	0.57%
Assault (by others)	6	0.27%	6	0.28%	14	0.58%	14	0.59%	40	0.44%	40	0.44%
Accidental Injury (by another person)	7	0.31%	6	0.28%	8	0.33%	13	0.55%	34	0.37%	34	0.37%
Restraint/ Seclusion	13	0.58%	5	0.23%	8	0.33%	6	0.25%	32	0.35%	32	0.35%
Assault (by staff or caregiver)	11	0.49%	7	0.33%	7	0.29%	5	0.21%	30	0.33%	30	0.33%
Food Ingredients or Consistency	3	0.13%	7	0.33%	9	0.37%	8	0.34%	27	0.29%	27	0.29%
Animal or Insect Bite/Sting	6	0.27%	6	0.28%	1	0.04%	12	0.50%	25	0.27%	25	0.27%
Overdose	3	0.13%	4	0.19%	6	0.25%	5	0.21%	18	0.20%	18	0.20%
Overexertion	1	0.04%	2	0.09%	1	0.04%	6	0.25%	10	0.11%	10	0.11%
Smoke or Fire Exposure	2	0.09%	2	0.09%	2	0.08%			6	0.07%	6	0.07%
Poisoning or Exposure to Toxic Substance			1	0.05%			2	0.08%	3	0.03%	3	0.03%
Total	2238	100.00%	2135	100.00%	2433	100.00%	2378	100.00%	9184	100.00%	9184	100.00%

Figure 9. Number of Causes Associated with Serious Incidents in CHRIS, for Individuals Receiving DD Waiver Services, – Top 5 Trend Data SFY2023 – SFY2025 (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.

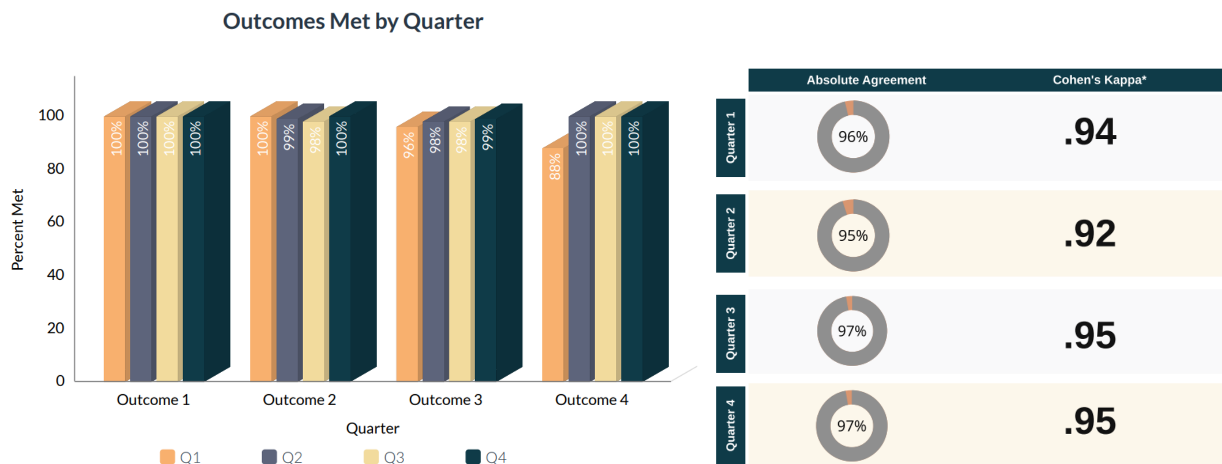
VCU completed comprehensive findings reports and submitted them to DBHDS for each quarter of SFY2025. These reports provided details about the SIRs submitted, whether outcomes were met, and recommendations for future look-behind reviews along with interrater reliability findings.

Outcomes consist of the following:

- Outcome 1: The incident was triaged appropriately by the IMU according to developed protocols.
- Outcome 2: The provider's documented response ensured the recipient's safety and well-being.
- Outcome 3: Appropriate action from the IMU occurred when necessary.
- Outcome 4: Timely, appropriate corrective action plans are implemented by the provider when indicated.

The chart below shows the percentages at which each outcome was met.

Figure 10. Incident Management Unit Look-Behind and Inter-rater Reliability Results – CY2024



- Outcome 1: Maintained a consistent 100% achievement rate across all four quarters.

[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.

- Outcome 2: Experienced slight declines in Quarters 2 and 3, indicating minor fluctuations in performance.
- Outcome 3: Showed a positive upward trend, with performance improving steadily from Quarter 1 through Quarter 4.
- Outcome 4: After an initial dip in Quarter 1, this outcome achieved and maintained 100% compliance in Quarters 2 through 4.

These trends reflect the IMU's ongoing efforts to monitor and improve performance across key outcome areas, with success in sustaining high achievement in Outcomes 1 and 4.
Regarding inter-rater reliability, VCU calculated both the level of absolute agreement and Cohen's Kappa. Cohen's Kappa ranges from 0 to 1, where 0 indicates no agreement beyond chance, and 1 indicates perfect agreement. VCU has consistently achieved an absolute agreement rate of 95% or higher, along with Cohen's Kappa score exceeding 0.90, demonstrating strong reliability in its review process.

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. The percentage of reports reported within the required time frames by quarter in SFY2025 is depicted in the following table. This exceeds the target of 86%.

Table 5. Timeliness of Serious Incident Reports

FY2025 Quarter	Percent of On-time and Waived Reports	Percent Late Reports Issued Citations
Q1	96.39%	100%
Q2	96.04%	100%
Q3	96.45%	100%
Q4	95.99%	100%

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."* The care concern (CC) criteria were most recently revised in January 2023.

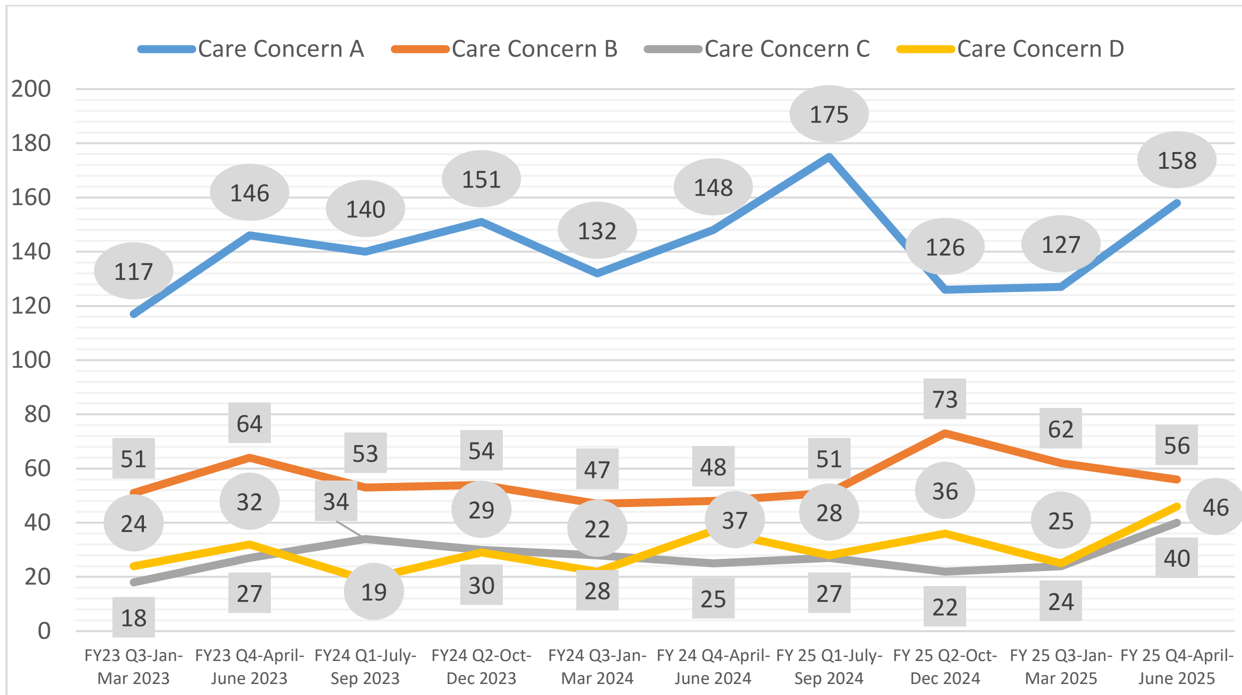
CC protocols serve as triggers for providers that a problem may exist, and that the provider should reassess the individual's care plan to determine whether additional services or supports are needed to mitigate risks. The IMU reports the number of CCs for DD services to RMRC quarterly.

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) daytime-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) daytime-frame for any reason.

The IMU triages care concerns to the appropriate Licensing Specialist/Investigator and with OHR and the Office of Integrated Health Support Network (OIHSN) for follow-up and technical assistance as needed and to help determine where prevention focused trainings for providers are needed.

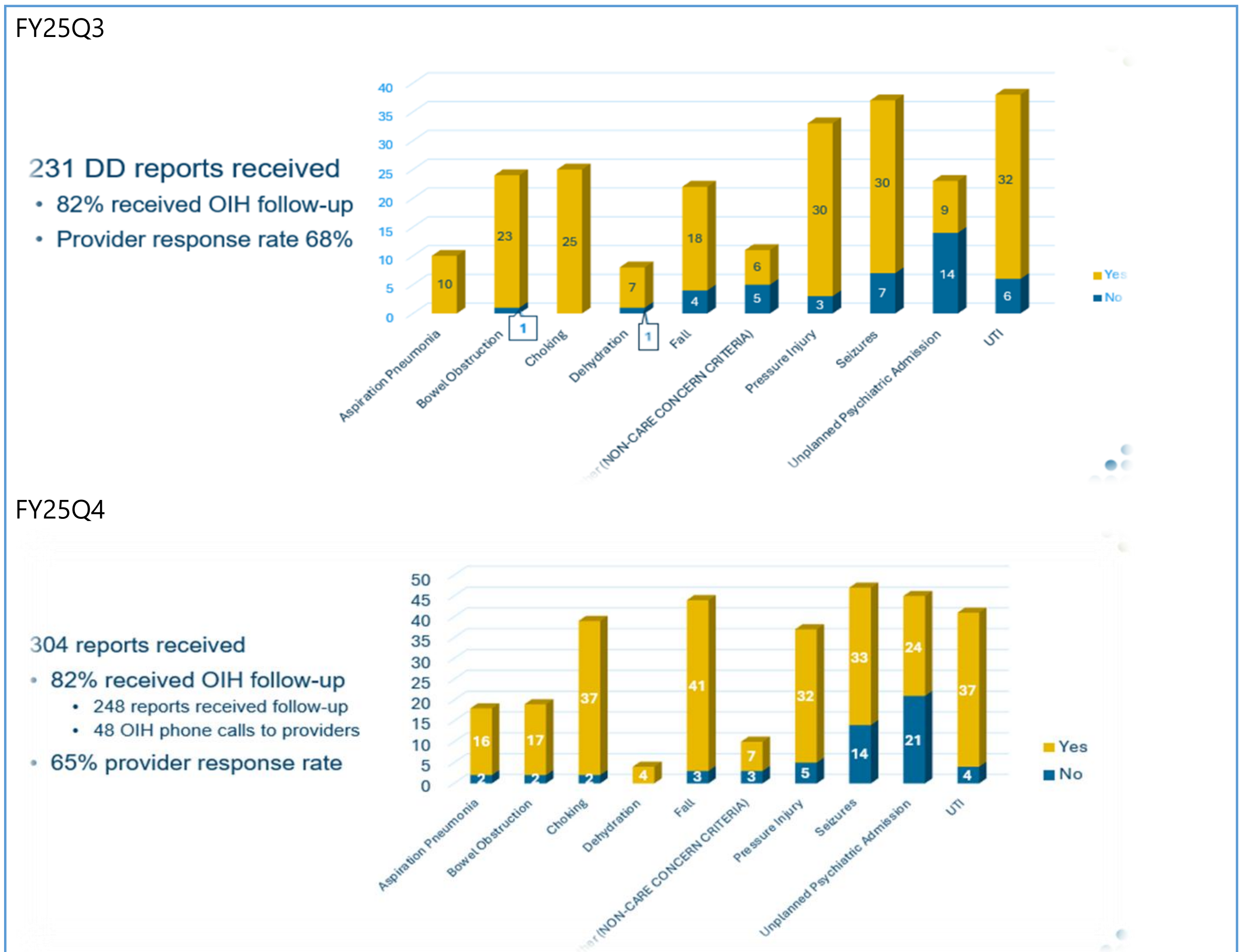
During SFY2025, there were a total of 1078 care concerns. There were 587 care concerns for criteria 'a', 248 for criteria 'b,' 114 for criteria 'c,' and 135 for criteria 'd.'. Six incidents met more than one individual care concern threshold. The graph below shows the number of CCs by criteria type and by quarter during SFY2025.

Figure 11: Care Concerns by Quarter, SFY2023 Q3 - SFY2025



In SFY2025, 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. During SFY2025, OIHSN began to report the percentage of care concerns that received follow – up and the percent of provider response by quarter. The following graphics represent the last two quarters of SFY2025.

Figure 12. Care Concern Follow-up



OIHSN followed up on more than 80% of the referred care 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.

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 with using 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 SFY2025, 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.

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 people with DD. They work to find new, innovative ways to effect change and decrease barriers across agencies (such as the Virginia Department of Health (VDH), Department of Medical Assistance Services (DMAS), and Department of Aging and Rehabilitative Services (DARS).

3c (1) Review of Educational Content

Health and Safety Alerts

The OIHSN issued five new Health and Safety Alerts during SFY2025 that represented updates to four that had been issued in previous years. The topic of constipation was divided into two parts. 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:

- The Grief and Loss Health & Safety Alert of 2021, last updated in *2023, was updated and expanded in June 2025 to provide education around E*nd-Of-Life Planning for Individuals with IDD.
- The Dental Health Awareness Health & Safety Alert of 2021 *last updated in 2023 was updated and expanded in November 2024 to provide education around D*ental Health Awareness that included a quiz.
- The Constipation: Care Management, Medications & Recognizing Bowel Obstruction Health and Safety Alert of 2020, last updated in 2023, *was updated and expanded into two parts in 2025 with both new parts including a quiz.*
- The Care Considerations: Epilepsy and Seizure Disorders Health and Safety Alert of 2020 was updated and expanded into two parts; the first posted in January 2025 provide education around Seizure Disorders and Epilepsy Basics included a quiz. Part 2 is planned for publication in 2026.

New Health and Safety Alerts posted included:

1) Mobile Rehab Engineering (MRE) Team Services Health and Safety Alert with Quiz for review
2) Medical Emergency Drills Health and Safety Alert with checklists to enhance utility
3) Recognizing Pain Health and Safety Alert including review of pain scales
4) Common Medical Emergencies Health and Safety Alert with Scenarios for discussion

5) Dehydration Health and Safety Alert with Quiz for review

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 SFY2025, each month after a new Health & Safety Alert was written, all previous Health & Safety alerts for that same month were reviewed for the previous five-year period. The Health and Safety Alerts focused on Falls and the My Care Passport were identified for updates in SFY2026. Due to extensive reviews in 2023, no additional edits beyond these and the five that were fully updated were needed. The results of reviews are presented to the RMRC annually.

Health Trends Newsletter

The OIHSN posted 12 Health Trends Newsletters in SFY2025. Each newsletter presented current topics and newsworthy announcements to interested stakeholders. They can be found on the Office of Integrated Health webpage, under "Newsletters" at https://dbhds.virginia.gov/office-of-integrated-health/

Education Resources Offered in SFY2025

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 SFY2025, caregiver training offered live virtually across the commonwealth addressed the following areas:

- **Dysphagia & Modified Diets** reviewed the signs, symptoms, and risks related to dysphagia, the effects on individual's quality of life, the connection to aspiration pneumonia and choking, how mealtime behaviors, medications, and some foods increase risk, diagnoses, tests and the physician's involvement, and how foods and liquid textures affect an individual's ability to swallow
- **Urinary Tract Infection (UTI)** reviewed the prevalence of UTI in the DD population, the different types UTI's, the risk factors, signs & symptoms, treatment, care considerations and possible complications related to a UTI. When seeking medical health, how to get a clean catch urine sample, and how to handle urine specimens, and how UTI can lead to sepsis.
- **Special Needs Oral Health** presented strategies to support individuals to improve oral care and prevent mouth diseases. Participants will have the information and tools to share with other staff in their agencies and improve overall staff training.
- **Nutrition Part 1** reviewed basic nutrition by learning about how food=calories=energy, the 6 essential nutrients to include in every diet, the USDA nutritional guidelines, 5 food groups, and myplate.gov. Review how nutrition affects the individual with DD, long term health conditions, and how caregivers play a part in encouraging healthy food choices.

- **Nutrition Part 2** The training reviews food shopping, food safety and reading food labels. Learn how to prepare before going grocery shopping, how to select foods at the store, how to properly store foods at home. Review serving sizes, sodium, sugar, fat content, and special diet symbols found on food labels.

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 SFY2025 is listed in the table below, by topic, along with the number of times the training was presented and number of attendees. General Trainings are those published on the training schedule. Provider Trainings are those specifically requested by a provider.

OIHSN reviewed the utilization of their provider training offerings which included quarterly live web-based training, private training, PPT slides, and training recorded on the Commonwealth of Virginia Learning Center (COVLC). The following table highlights the participation in training sessions offered virtually in SFY2025:

Table 6. Training Provided by the Office of Integrated Health Network Support, SFY2025

Type of Training	Count	Number of attendees
General Training		
Aspiration Pneumonia	1	61
Choking & Airway Obstruction	1	42
Dehydration	1	70
Diabetes Part 2	1	5
Nutrition Part 1	1	29
Nutrition Part 2	1	27
Oral Health	2	16
Recognizing Declining Health Part 1	1	24
Seizure	1	43
Skin Integrity & Pressure Injuries	1	73
SN/PDN Training	1	182
Urinary Tract Infections	1	56
Grand Total	**13**	**628**

The following table highlights the participation in training sessions requested by specific providers to augment their staff training in SFY2025:

Table 7. Training Delivered to Specific Providers

Type of Training	Count	Number of attendees
Provider		
(blank)	1	15
Aspiration Pneumonia	1	28
Choking & Nut Butters	1	32
Diabetes Part 1	2	21
Diabetes Part 2	1	9
Fatal Seven	6	131
Medication Error Training	3	41
Recognizing Declining Health Part 1	1	26
Skin Integrity & Pressure Injuries	2	26
Wheelchair Transitioning Training	1	8
Grand Total	19	337

In summary, during SFY2025, 628 people participated in at least one of 13 live trainings offered by OIHSN. In addition, 337 people participated in at least one of 19 trainings requested by private providers and presented by OIHSN. Finally, OIHSN offers eight PowerPoint training slide decks on the OIHSN website and 12 on the COVLC for providers and care givers to access on demand.

Quarterly Review: **Each** quarter in SFY2025, 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 observations, RMRC identified these in-process or new opportunities for education:

- **Improving compliance with the 520/620 regulations:**
  - OCQM would begin offering quarterly webinars focused on helping providers use the Excel Risk Tracking Tool and develop SMART Goals and Objectives.
  - OCQM developed a video titled "Using Data to Drive Quality".
  - OCQM would develop and distribute a Quality Manual.

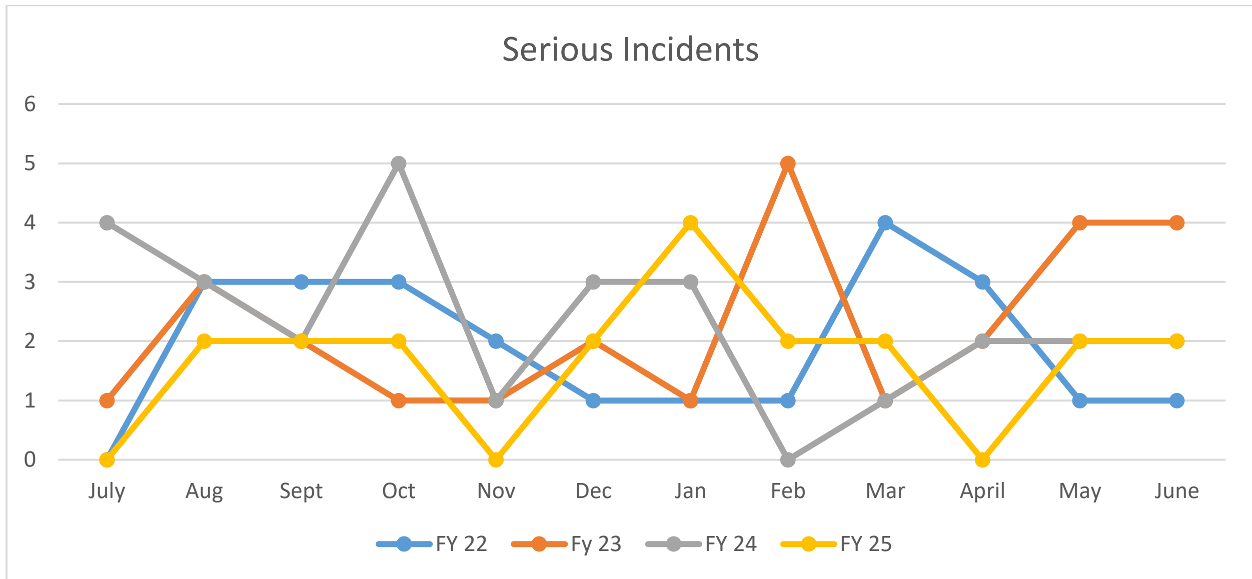
- **Restraint:** RMRC would explore how to work with SEVTC to share successful practices to reduce restraint, including use of the DEFUSE program.
- **QSR results:** OCQM would develop a diagram to explain QSR / OL distinctions.
- **Choking:** Region 1 Quality Council was doing a QII focused on reducing choking risk.
- **Dignity of Risk:** Region 2 Quality Council was doing a QII on Dignity of Risk, including a handout.
- **Falls/trips:** Region 4 Quality Council was doing a QII on Falls, including an educational handout.
- **OHR Look-behind:** RMRC planned to propose a QII to improve the OHR community look-behind results.

Part 3d. Facility Risk Management Programs - Training Center

RMRC is charged with reviewing and analyzing data and identifying 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 therein, 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.

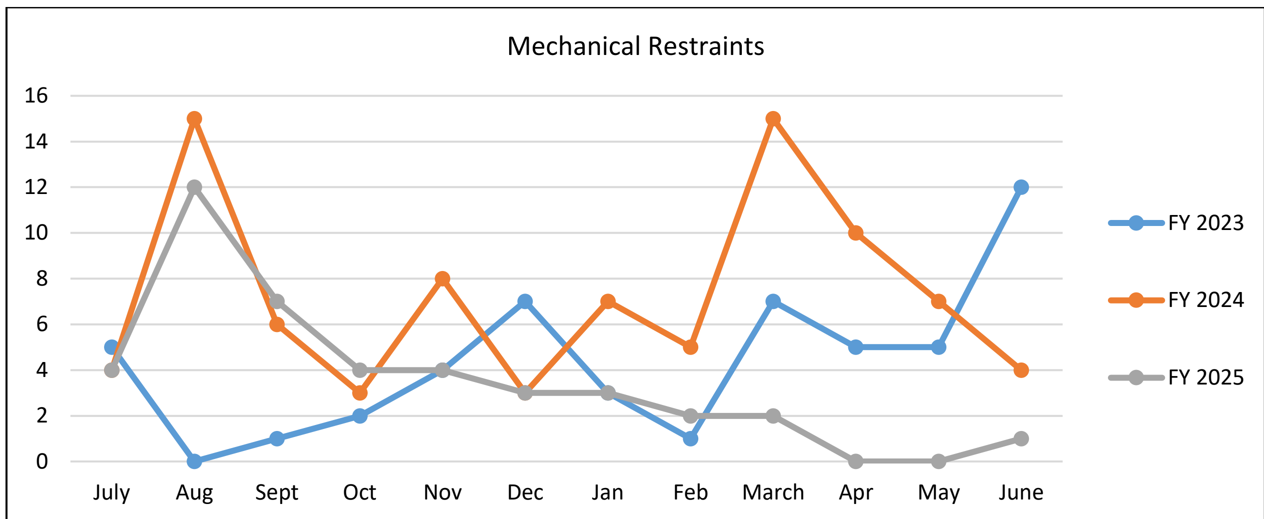
Each quarter in SFY2025, SEVTC reported to RMRC, for each risk trigger and threshold in place, whether it was met and a summary of actions that were taken to address individuals' health and safety needs. For example, Figure 13 shows a graph shared by SEVTC showing trends in SIRs during SFY2022-SFY2025.

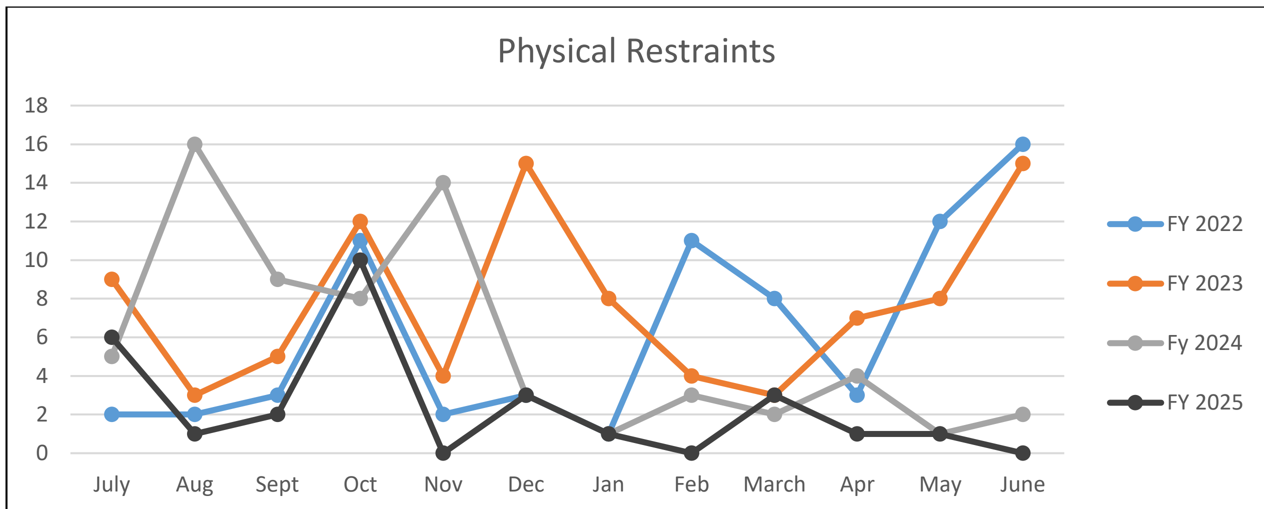
Figure 13. Southeast Virginia Training Center, Serious Incidents by Month, SFY2022, 2023-SFY2025



SEVTC shared information about quality improvement efforts. SEVTC implemented an initiative to reduce the number of physical restraints, implementing DEFUSE training with a focus on anticipating and preventing escalating behavior that could lead to restraint. Data from SFY2025 indicates that the number of physical restraints was consistently lower than previous years since December 2023.

Figure 14. Mechanical and Physical Restraints, SEVTC, SFY2023-SFY2025





Part 3e. Medication Safety Work Group

During SFY2025, the RMRC convened a work group to specifically study medication safety. They obtained and examined data from serious incidents related to medication errors, medication-related neglect for substantiated abuse and neglect cases, and results from providers non-compliant with medication related licensing regulations 12VAC35-105-770 and 12VAC35-105-780. Results from ANE substantiated cases and licensing citations prompted the work group to do a further root cause analysis into reason for 12VAC35-105-70.C. citations: *"Medications shall be administered only to the individuals for whom the medications are prescribed and shall be administered as prescribed."*

A review of corrective action plans for 12VAC35-105-770C citations showed that the leading reason for citation was that medication was not given as prescribed, primarily because it was not

available and/or not on site. The study group will continue to explore quality activities that can help address this concern at a systemic level.

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 fell within the KPA of Provider Competency and Capacity. OL is responsible for conducting licensing inspections to assess providers' compliance with risk management and quality improvement program requirements.

Part 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 to risk management and quality improvement. Note that the data are presented by calendar year (CY) because licensing inspections occur on a calendar year basis.

Table 8. Compliance with Risk Management & Quality Improvement Regulations

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

RMRC Measure / Performance Measure Indicator (PMI)	CY2021	CY2022	CY2023	CY2024
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% --	52% ↓
• 520A - Designated person with training or experience responsible for risk management function	77%	72%↓	81%↑	83% ↑
• 520B - Implements a written plan	89%	88%--	86%↓	77% ↓
• 520C1 - Environment of care	85%	85% --	87%↑	83% ↓
• 520C2 - Clinical assessment/reassessment	81%	83%↑	84%↑	81% ↓
• 520C3 -Staff competence / Adequacy of staffing	80%	84%↑	83%↓	79% ↓
• 520C4 - Use of high-risk procedures	79%	81%↑	83%↑	76% ↓
• 520C5 - Review of serious incidents	85%	85% --	85%--	77% ↓
• 520D - Systemic risk assessment incorporates risk triggers and thresholds	79%	75%↓	77%↑	73% ↓
• 520E - Conducts annual safety inspection	90%	93%↑	95%↑	94% ↓
Quality Improvement Program Requirements				
% Of providers that are compliant with 100% of the QI Requirements	52%	55%↑	56%↑	46% ↓

RMRC Measure / Performance Measure Indicator (PMI)	CY2021	CY2022	CY2023	CY2024
• 620A - Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	91%	94%↑	93%↓	87% ↓
• 620B - The QI program uses standard QI tools, including RCA and has a QI plan	89%	92%↑	89%↓	81% ↓
620C - The QI Plan shall:	--	--	--	--
• 620C1 - Be reviewed and updated annually	81%	86%↑	85%↓	80% ↓
• 620C2 - Define measurable goals and objectives	78%	85%↑	82%↓	70% ↓
• 620C3 -Include & report on statewide measures	NA	NA	NA	98%
• 620C4 - Monitor implementation & effectiveness of approved CAPs	75%	81%↑	74%↓	70% ↓
• 620C5 - Include ongoing monitoring and evaluation of progress toward meeting goals	78%	85%↑	80%↓	72% ↓
620D - The providers P&P includes criteria used to:	--	--	--	--
• 620D1 - Establish measurable goals & objectives	74%	85%↑	83%↓	76% ↓
• 620D2 - Update the QI plan	74%	87%↑	88%↑	80% ↓
• 620D3 - Submit revised CAPs when not effective	65%	78%↑	77%↓	67% ↓
Input from individuals about services & satisfaction	81%	83%↑	88%↑	84% ↓

These results, from CY2024, show that in general, compliance scores for nearly all the regulations decreased when compared with CY2023. This occurred despite offering training opportunities, as well as tools and templates to assist providers in meeting these requirements. In hypothesizing root causes for this decrease in compliance, the committee identified several possible factors: 1) the regulatory requirements are complex and have been difficult for providers to understand and operationalize; 2) many smaller providers do not have dedicated risk management or quality improvement staff, which makes it more difficult to meet these requirements; 3) many new providers have been licensed and it may take them time to develop and implement a quality or risk management program; and 4) as licensing has further developed guidance for these regulations, the bar for meeting the requirements has also increased.

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, DBHDS expanded its consultation and technical assistance program by hiring several new quality improvement specialists and now offering this assistance to any provider that has received a citation for any risk management or quality improvement regulation. Further details are discussed below in the section of quality improvement initiatives (Part 6a. 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 SFY2025, RMRC reviewed information from Round 6 and made the following recommendations.

- QI activity: Create a QSR vs. OL infographic to explain the commonalities and differences.

  The RMRC coordinated content development across several DBHDS offices to create an infographic addressing several different review types. This is planned for posting in early SFY2026

- QI activity: Evaluate if there's a way to make RM/QI training & resources more accessible online.

  The RMRC discussed training and resources that are currently available and decided additional action was not necessary at this time.
  - Tools and archived training sessions are available on the Office of Licensing webpage (https://dbhds.virginia.gov/clinical-and-quality-management/office-of-licensing/) under the Training and Technical Assistance section.
  - Some of this material is also linked on the Clinical and Quality webpage (https://dbhds.virginia.gov/clinical-and-quality-management/), along with additional tools.
  - A Quality Manual to assist providers with improve their knowledge of quality management principles is planned to be added to the Clinical and Quality webpage in SFY2026.

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.

Part 6a. 520/620 QII

The RMRC proposed a QII in SFY2024, the aim of which is to improve the percentage of licensed DD providers that are compliant with all 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 was determined to be 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 a team of QI Specialists in the Office of Community Quality Improvement (OCQI) will provide 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.

The Expanded Consultation and Technical Assistance (ECTA) program began in August of 2024, offering ECTA to licensed DD providers who were cited as noncompliant by the Office of Licensing (OL) and had an OL-approved Corrective Action Plan (CAP) for regulations 450, 520, and/or 620. For FY July 1, 2024-June 30, 2025, 213 licensed DD providers completed ECTA. In supporting these providers, the ECTA team provided 695 sessions for a total of 1043.5 hours of service provision.

The OCQI found that the main barriers to compliance include lack of 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; being unaware of available resources; and QI/RM staff turnover. As applicable to the provider(s), the ECTA Team addressed each of these barriers during the ECTA sessions.

Results of ECTA evaluation so far demonstrate:

- Providers report having a much better understanding of the ECTA focus regulations (i.e., regulations 520 and 620)
- Providers report having a greater understanding of the application and using QI/RM concepts, principles, and tools after receiving ECTA
- Providers report feeling that they are in a better position to comply with the focus regulations, going forward
- Providers would recommend that other providers take advantage of ECTA offerings

In addition, OCQM staff offered quarterly webinars entitled Quality in Focus, on two topics: Use of the Excel Risk Tracking Tool (which can assist with regulation 520 and more) and writing SMART goals and objectives (which can assist with regulation 620.D.).

The Risk Tracking Tool webinar was offered twice in 2025.	The SMART Goals and Objectives webinar was offered twice in 2025.
• April 10, 2025 (285 participants) • July 10, 2025 (200 participants)	• April 24, 2025 (236 participants) • July 24, 2025 (132 participants)
121 participants completed an evaluation. • Of 56 who were using the tool, 82% said it helped them learn to use the tool more effectively • Of 63 not using the tool, 76% said they plan to start using it. • 99% said they learned something new and/or useful at the webinar.	129 participants completed an evaluation. • 91% said they learned something new about developing SMART statements • 80% said they felt better prepared to develop measurable goals and objectives

Part 6b. Office of Human Rights Look-behind QII

In SFY2025, the RMRC proposed a QII to improve the Office of Human Rights community look-behind (CLB) results because they were not consistently above the goal of 86%. The CLB uses a sampling and review process that examines the following outcomes:

- Outcome i: Comprehensive, and non-partial investigations of individual incidents occur within state prescribed timelines
- Outcome ii. The provider staff conducting the investigation have been trained to conduct investigations
- Outcome iii. Timely, appropriate corrective action plans are implemented by the provider and verified as being implemented by the assigned advocate

As the data for all three outcomes fell below the 86% goal, the RMRC developed a plan for a QII, which was approved by the QIC on 6/23/2025. The details for the QII are as follows.

- **Aim:** Our goal is to improve the results of the OHR community look-behind (CLB) to 86% or higher by June 30, 2026. The baseline for SFY2025 Q2 was i=83%, ii=65%, and iii=100%.
- **Measure:** We will measure the results of the OHR look-behind every quarter and obtain data from the OHR look-behind report, presented to the RMRC quarterly.
- **Change:** The main root cause(s) were determined to be provider lack of awareness/ understanding. The first change is to develop a training module for investigator training, with a test requirement. The second change will be to ensure all providers are cited for not having a trained investigator and that corrective action plans include designating a person to complete the investigator training. A third change will be to implement guidance on what constitutes appropriate training for trained investigators while we prepare for a change to OHR regulatory language to include more detailed requirements. Although these proposed changes only directly impact outcome 2 (staff are trained to conduct investigations), the QII team has hypothesized that having trained

investigators will indirectly lead to improvements in conducting a comprehensive non-partial investigation (outcome 1) and implementing appropriate corrective actions (outcome 3).

This QII is underway and will continue during SFY2026.

Part 7. 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 SFY2025, the RMRC monitored three PMIs (as indicated in the table below).

Performance Measure Indicators, SFY2022- SFY2025

Table 9. Percentage of Providers Compliant with 100% of Risk Management Regulations & with 100% of the Quality Improvement Regulations

Performance Measure Indicators	Target	CY 21	CY 22	CY 23	CY 24	CY25*	Performance Assessment
Licensed providers meet 100% of regulations for risk management programs	≥86%	**61%**	**56%**	**59%**	**52%**		**Goal not met**
Licensed providers meet 100% of regulations for quality improvement programs	≥86%	**52%**	**56%**	**55%**	**46%**		**Goal not met**

*- calendar year measure, available in early 2026

DBHDS disseminated a significant amount of information to providers, including tools and resources, to help them come into compliance with these regulations. These PMIs were the focus of a QII – see section 6a.

Table 10. Annualized Rate of Falls

Performance Measure Indicators	Target	SFY 22	SFY 23	SFY 24	SFY25 Q1	SFY25 Q2	SFY25 Q3	SFY25 Q4	SFY 25	Performance Assessment
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	**61.6**	**67.1**	**71.9**	**78.9**	**64.7**	**66.1**	**75.8**	**71.5**	**Goal not met**

Except for one quarter, the rate of falls has been above the goal of 63.6 /1000 or less. The overall results for SFY2025 were slightly less than SFY2024. 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 continued a more detailed analysis of falls data with a goal of identifying specific factors that may be addressed in a future QII. A new visualization was developed by the data warehouse that allows a more detailed analysis of falls by individual, as well as by different demographic characteristics such as age, gender, and race. The visualization also includes views on falls that resulted in emergency room visits or hospitalizations, and the types of injuries sustained. Analysis of this data is underway and will be completed in SFY2026.

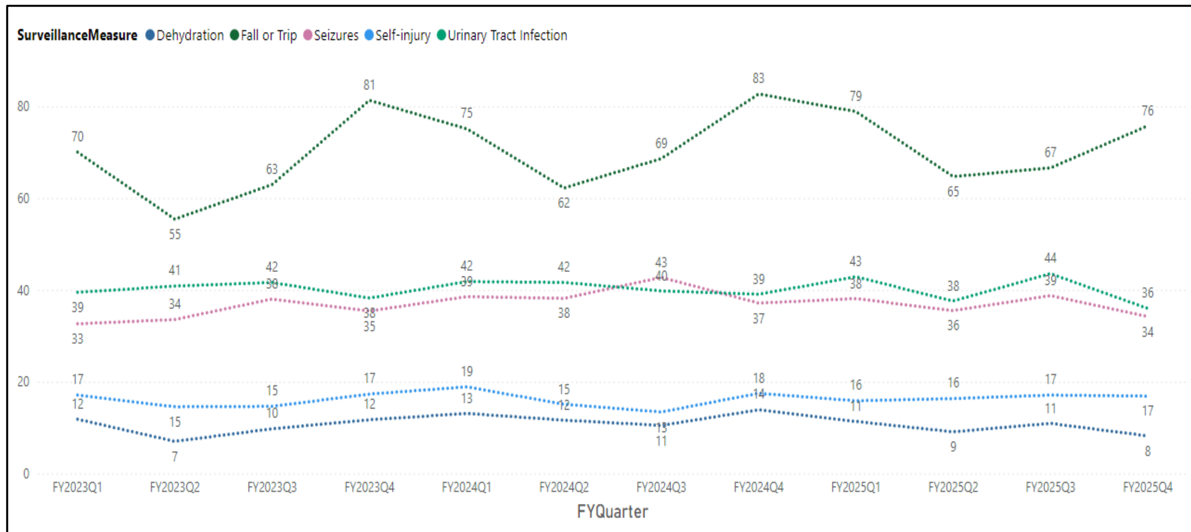
Part 8. Surveillance Measures

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 this data is 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 Table 11 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.

Table 11. Rate of Select Level II Risks in CHRIS for Individuals on a DD Waiver, per 1,000 Waiver. Population (annualized), SFY2025

SurveillanceMeasure	Q1	Q2	Q3	Q4	Total
Fall or Trip	78.87	64.71	66.61	75.77	71.49
Urinary Tract Infection	42.87	37.61	43.57	35.99	40.01
Seizures	38.13	35.51	38.78	34.22	36.66
Self-injury	15.87	16.35	17.11	16.89	16.56
Dehydration	11.37	9.11	10.95	8.22	9.91
Sepsis	7.34	8.18	8.90	9.78	8.55
Decubitus Ulcer	7.11	10.28	7.98	7.78	8.29
Aspiration Pneumonia	9.24	7.48	7.30	7.33	7.84
Choking	6.63	4.91	5.70	8.67	6.48
Bowel Obstruction	5.21	7.01	5.70	4.22	5.54
Suicide Attempt	4.74	4.44	3.88	2.89	3.99
Sexual Assault	3.32	3.97	3.65	4.44	3.85
Total	**19.23**	**17.46**	**18.34**	**18.02**	**18.26**

Figure 15. Top 5 Most Prevalent Rates of Select Level II Risks in CHRIS for Individuals on a DD Waiver, per 1,000 Waiver Population (annualized), SFY2022 – 2025 Trend



Although not one of the most prevalent risks, the RMRC identified concerns with the rate of choking incidents, noting the significance of the greater risk of death associated with choking. In response to concerns about choking incidents in previous years, an episode of choking was elevated to a care concern, prompting additional follow-up from the IMU and the OIHSN. In addition, the OIHSN implemented training and educational content to raise provider awareness of the risks of choking and ways to reduce this risk. Despite these efforts, reports of choking incidents continued to increase (see Figure 16). One hypothesis was that increased reports of choking incidents were linked to the elevation of choking incidents as a care concern and greater awareness of choking risks and the need to intervene quickly.

To better understand the level of risk and that relationship between choking and deaths, the RMRC collaborated with the Mortality Review Committee (MRC) to calculate a case fatality rate for choking (number of deaths due to choking / number of reported choking incidents). The data, calculated for SFY2020 – 2025 showed an increase in choking incidents, while choking deaths significantly decreased in SFY2024 and SFY2025; the case fatality rate peaked at 12.5% in SFY2023, and dropped to 3.3% in SFY 2024 (see figure 17).

Figure 16. Number of Choking Incidents / 1000 individuals receiving DD waiver services

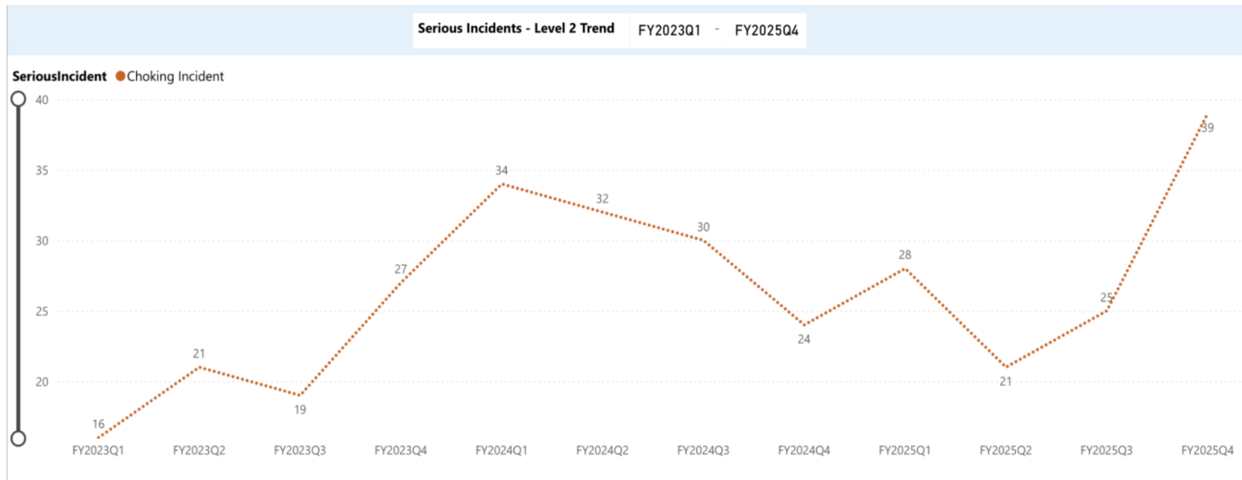
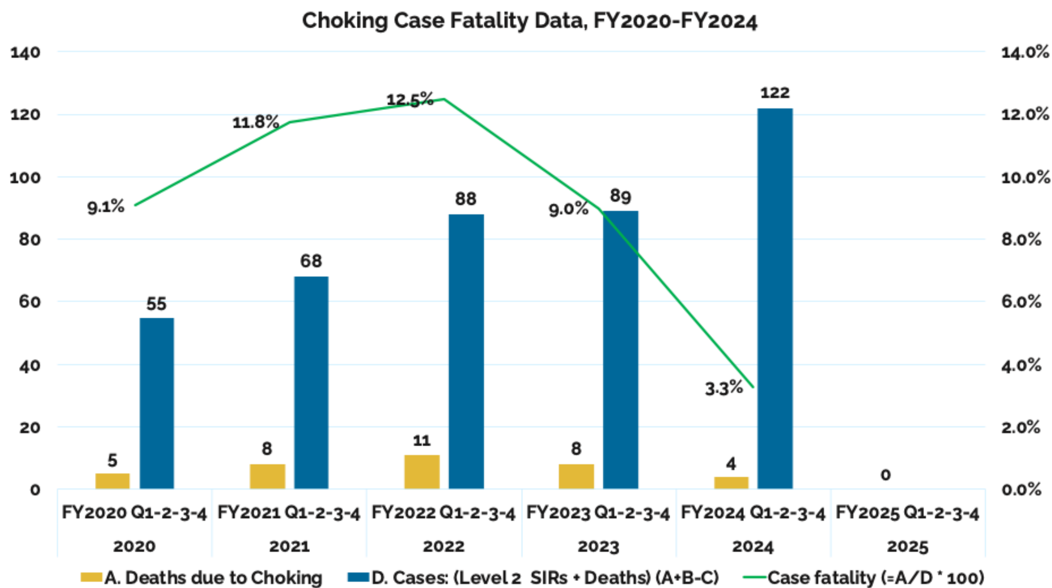


Figure 17. Choking Case Fatality Rate



Part 9. Recommendations

Based upon its review of SFY2025 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 SFY2025, while others are targeted for completion in SFY2026. Also, listed below are recommendations from prior years and the status of each taken during SFY2025.

Recommendations Identified in SFY2025

Recommendations	Status as of SFY2025 Report
1. Explore issues related to medication safety and consider a learning collaborative related to medication safety.	**Continuing.** A Medication Safety Study Group convened inSFY2025 and will continue to explore the topic and make recommendations in SFY2026.
2. Develop a table which explains the various reviews conducted by DBHDS of DD licensed providers.	**Continuing.** A table was created and it will be posted on the DBHDS Office of Community Quality Management webpage in SFY2026
3. Consider the adoption of a PMI related to community integration, possibly focusing on dignity of risk.	**Not Yet Implemented.** This will need further evaluation and discussion in SFY2026.
4. Further explore the morbidity of choking episodes by collaborating with the Mortality Review (MRC) Committee to calculate a choking case fatality rate.	**Completed.** The data showed a decrease in the choking case fatality rate in SFY2024 and SFY2025. The RMRC will continue to work with the MRC to calculate this data on an annual basis.

Status of Recommendations from Previous Years

Recommendations from previous years	Status as of SFY2025 Report
1. 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.	**In Progress.** The RMRC worked with the data warehouse to develop a report to further analyze fall data by the number of incidents per individual, the types of injuries, and demographic characteristics. This information will be used in SFY2026 to identify potential improvement opportunities.
2. 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.	**Closed.** Improvements in the consumer ID will be addressed with the development of a new incident management system; expected in SFY2027.
3. May 2022 - Provide licensing data broken down by region (RQC recommendation).	**Closed.** This will be revisited when licensing data is modeled in the Enterprise Data Warehouse (EDW); probably SFY2027.
4. June 2022 - Develop criteria and/or a process for revising care concerns, as needed.	**In progress.** Reporting on care concerns has expanded, with additional information being presented by OIHSN on the specific types of issues they have reviewed and offered technical assistance.
5. Develop better guidance for providers about reporting medication errors as neglect.	**In Progress.** OHR continues to gather feedback on draft revised guidance. Draft guidance is under review and targeted for publication in SFY2026.

Part 11. Conclusion

The RMRC is 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 SFY2025, the RMRC continued to fulfill its charter requirements by reviewing data, identifying additional data needs and implementing quality improvement initiatives.

The RMRC monitored serious incidents and allegations of abuse and neglect. While the absolute number of reports of both types has increased slightly each year, when calculated as a rate, the number of serious incidents per 1,000 individuals on a DD waiver has slightly decreased over time. Despite interventions, a fall continues to be the most frequent known cause of a serious incident. To better understand underlying causes that may be driving the rate of falls, the RMRC worked with the data warehouse to create a dashboard that will allow the committee to further drill into falls data to identify additional patterns. This will be further explored in SFY2026.

The RMRC had previously highlighted incidents relating to choking as a concern. In SFY2025, the RMRC worked with the MRC to calculate a case fatality rate, which showed that while choking incidents were increasing, choking deaths were decreasing. This will continue to be evaluated in SFY2026.

The RMRC oversaw the implementation of two QIIs. The first, focused on improving provider compliance with quality and risk management requirements was initiated in SFY2024 and centered around the provision of targeted consultation and technical assistance to providers that had not been able to demonstrate compliance with these regulations. As of the time of this report, this effort has shown that participating providers report having a better understanding of the requirements. Preliminary data indicates that a majority of providers met requirements that had previously not met; however, improvement in the overall measure (percent of providers that meet all the risk management and quality improvement requirements) has not yet been achieved. This will continue to be evaluated in SFY2026.

A second QII focused on improving the outcomes of three measures that are evaluated by the human rights look-behind process; i) comprehensive, and non-partial investigations of individual incidents occur within state prescribed timelines, ii) the provider staff conducting the investigation have been trained to conduct investigations, and iii) timely, appropriate corrective action plans are implemented by the provider and verified as being implemented by the assigned advocate. A workgroup was formed to oversee the implementation of this activity. A root cause analysis was completed, and initial interventions were implemented, focusing on ensuring appropriate training of investigators. This activity will continue through SFY2026.

Appendix 1. Acronym List

Acronym	Full Form
AWOL	Absent Without Official Leave
ANE	Abuse, Neglect, and Exploitation
CC	Care Concern
COVLC	Commonwealth of Virginia Learning Center
CLB	Community Look-Behind
CSBs	Community Services Boards
CHRIS	Comprehensive Human Rights Information System
CAP	Corrective Action Plan
DW	Data Warehouse
DBHDS	Department of Behavioral Health and Developmental Services
DOJ	Department of Justice
DMAS	Department of Medical Assistance Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
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
ND	Not Determined
OCQM	Office of Clinical Quality Management
OCQI	Office of Community Quality Improvement
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
PMI	Performance Measure Indicator
PDSA	Plan-Do-Study-Act
QI	Quality Improvement
QIC	Quality Improvement Committee

QII	Quality Improvement Initiative
QSR	Quality Service Review
RQC	Regional Quality Council
RM	Risk Management
RMRC	Risk Management Review Committee
SIR	Serious Incident Report
SEVTC	Southeastern Virginia Training Center
SFY	State Fiscal Year
UTI	Urinary Tract Infection
VCU	Virginia Commonwealth University
WaMS	Waiver Authorization Management System