Virginia Department of Behavioral Health & Developmental Services

Developmental Disabilities Annual Report and Evaluation
State Fiscal Year 2022
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Part 3 – Annual Report and Evaluation

Executive Summary

The Developmental Disabilities (DD) Quality Management (QM) Annual Report and Evaluation summarizes the comprehensive work conducted by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Quality Management System (QMS) within its key performance areas (Health, Safety and Wellbeing, Community Inclusion and Integration, Provider Capacity and Competency), system improvements, and data quality. Embedded within the key performance areas (KPAs) are the components of quality assurance (QA), risk management (RM), and quality improvement (QI). The key accomplishments in state fiscal year (SFY) 2022 in each area were:

- Health, Safety and Wellbeing KPA: 1) The identification of choking, based upon a review of cases, as concern with recommendations to be implemented in SFY23. 2) The need for education on the relationship of Down Syndrome and Alzheimer's disease was identified with work to address this need to be done in SFY23. 3) The Office of Human Rights (OHR) finalized reporting categories for neglect, which will improve upon the identification of trends and patterns.
- Community Inclusion and Integration KPA: Individualized Service Plan (ISP) elements related to employment and integrated community involvement were enhanced in the Waiver Administration Management System (WaMS).
- Provider Capacity and Competency KPA: 1) Case Management Steering Committee (CMSC) refined and improved its Four Pillars performance monitoring process. 2) The Office of Community Quality Improvement (OCQI) completed a pilot project with select providers targeted towards improving provider understanding of 12VAC35-105-620.C.2 regulations and subsequently improve their compliance with the QI regulations.
- System Accomplishments: 1) CMSC added ISP entry and Support Coordinator Quality Review (SCQR) to its performance monitoring areas. CMSC requested an improvement plan for any low performance result in these areas. 2) The SCQR process showed increased alignment across reviewers. 3) The Mortality Review Committee (MRC) updated key definitions and applied them to case reviews beginning December 2, 2021. 4) The MRC incorporated standardized use of mortality prevention strategies within the actions taken by the MRC beginning December 2, 2021. 5) The Specialized Investigations Unit revised

their mortality review checklist for licensed providers to promote a more thorough mortality review of death investigations. 6) CONNECT, a new licensing information system was launched November 2021.

As the DD QMS continued to evolve, several changes occurred within the publication of the DD QM Plan (QMP). First, the publication of Parts 1 and 2 were moved to the beginning of the SFY as these provide program descriptions and planning for the fiscal year. Second, the DD QMP now includes DBHDS' path forward, in its Part 1 Program Description, as a plan for the year that the agency will subsequently report on in its Part 3 Annual Report and Program Evaluation. Path forward is a means of identifying improvement areas that the agency will target for improvement. Third, the DD QMP became more user friendly. Navigation links were embedded throughout all three parts of the document. Accessibility features have been added and efforts are underway to make the document easier to read overall.

The DD QMS continued to mature and the overall functioning of the QMS improved with enhancements and improvements to established processes. New processes were developed as well that further enhanced the maturing system. These processes included the incorporation of like work to reduce duplication in documentation. Some processes were internal to DBHDS; others applied to external stakeholders as well. An annual Performance Measure Indicator (PMI) review process was implemented with two annual reviews occurring within the fiscal year. This new process allowed DBHDS to objectively review the continued importance of current PMIs and determine, based upon established criteria and review of performance results, whether the current PMIs should be retained, retired, or removed.

The QMS reviewed each Key Performance Area (KPA) PMI to assess the quality of developmental disability (DD) services and initiated mitigating strategies to improve areas not meeting set targets and to address identified gaps. During SFY22, 23 quality improvement initiatives (QIIs) were implemented by the Quality Improvement Committee (QIC) subcommittees. The SFY22 QM Annual Report and Evaluation demonstrates: the continued growth of the quality committees in their data analysis, the identification of the need for additional information to inform further decisions or inferences, and the furtherance of their abilities to understand performance from a more global perspective. The document summarizes the SFY22 QM activities, characteristics, and outcomes (compared to previous fiscal year outcomes, where applicable).

The DD QMS continued in utilizing a program evaluation tool to assess key components of the QMS that included: assessment of the QMP and supporting infrastructure, implementation of processes to measure and ensure quality of care and services, and the capacity to build QI

among providers. Continued enhancements to the QIC subcommittee work plan, committee processes, reporting processes, and use of QI tools furthered the accomplishments of the QM System as demonstrated through the program evaluation completed by the quality committees. This assessment identified strengths and opportunities for improvement.

DBHDS continued efforts to improve upon data validity and reliability. Data source systems were reviewed. Categories of improvement were identified, and indication made if the system was planned for replacement. One data source system was replaced. Two data source systems will be integrated into WaMS in SFY23. Process documents and standard operating procedures were developed or enhanced; data validation controls were enhanced across multiple systems that included actions such as drop-down menus, validation messages, and locked fields. Modifications were made within the user interface for several systems to improve the quality of data entry such as tooltips, hover text and warning messages. Enhanced understanding of Business Ownership within the agency and improving maturity of data source systems continued with significant gains noted.

As public health restrictions, related to the pandemic, were lifted and practices such as face to face visits began occurring again, people returned to employment and participating in their communities. While improvements in the PMIs began to be seen, it will take a while before these numbers return to pre-pandemic levels. DBHDS furthered discussions on the pervasive and persistent staffing shortages that impact the delivery of services. These discussions highlighted the administrative burdened faced by CSBs and providers.

Introduction

The QMP for DBHDS is a three-part document, which includes this Annual Report and Evaluation for SFY22. This document summarizes key accomplishments of the DD QM Program's KPAs and system, followed by assessments of the PMIs regarding progress towards set targets, summary of data reports, updates on implemented QIIs, and the overall performance of the DD QMS including the quality committees' performance. Identified gaps and challenges to meeting stated goals plus plans to mitigate the circumstances around those challenges are discussed as well as other quality improvement activities implemented. Organizations outside of DBHDS support the work of the QMS through the collection, analysis and reporting of system outcomes and outputs across multiple cross-sections of DBHDS-funded services, programs, and persons served. The purpose of this report is to determine if the system is meeting the needs of individuals and families in a manner that aligns with the Commonwealth's mission and vision.

This following section outlines the SFY22 overall key accomplishments within the KPAs and key system improvements.

Key Accomplishments of the QM Program

Health, Safety and Wellbeing

1. The Risk Management Review Committee (RMRC) made several recommendations for implementation in SFY23 after reviewing several case studies that highlighted choking events experienced by individuals. These included:
    a. The Office of Integrated Health (OIH) to develop a recorded, on-demand training related to prevention of choking.
    b. To add a single choking event as a care concern
    c. The Office of Provider Development (OPD) to offer more in-depth training on all parts of the Individual Support Plan (ISP). This is to be incorporated into Provider Roundtable and Support Coordinator (SC) regional meetings.
2. RMRC identified the importance of providing more education on the relationship between Down syndrome and Alzheimer's disease. This will include OIH to create a list of resources for posting on the DBHDS website and to be presented to the Virginia Association of Community Rehabilitation Programs in SFY23, which will also be posted on the DBHDS website.
3. The OHR finalized specific reporting categories for neglect, which will improve the ability to identify patterns or trends. These categories are in the process of being incorporated into the CHRIS data source system, planned for SFY23.

Community Inclusion & Integration

1. The annual ISP update cycle continued with this cycle centered on necessary changes to increase clarity and improve data. The update process began in November 2021 and launched on May 17, 2022. Data obtained from the revised ISP was reviewed through the end of the fiscal year and then used for reporting beginning with the first quarter of the next year. The most significant ISP changes for SFY 22 included enhancing the elements related to employment and integrated community involvement discussions. The Department identified a need to increase discrete elements within the narrative for each community inclusion topic to ensure that conversations were comprehensive and consistent.

Provider Capacity and Competency

1. During SFY22, the CMSC continued to refine and improve its Four Pillars performance monitoring process. A CSMC Overview video was designed to convey the process to Community Service Boards and Behavioral Health Authority (hereafter known as CSBs), so that they understand how the committee reviews data and makes decisions about requesting performance improvement plans from CSBs and how targeted technical assistance is prescribed and conducted. The longest standing pillar of performance related to Regional Support Team (RST) referral timeliness has been challenging due to delays in receiving data, which is related to the manual data processing that must occur under the current process. To address this concern, and ease the overall RST referral process, the CMSC developed specifications for an RST WaMS module, which will be implemented in SFY23.

System Accomplishments

1. The CMSC announced to CSBs two additional performance monitoring areas, related to ISP entry and the SCQR, leaving one remaining area related to case management contacts, which is planned for implementation in FY23. The CMSC requested an improvement plan from the CSBs and provided technical assistance as needed, in effort to improve performance, when low performance results in these areas were identified.
2. The SCQR process showed increasing alignment in findings when completing the SCQR. This alignment was necessary to ensure the reliability and validity of data collected through the process. Review of the On-Site Visit Tool (OSVT) has been integrated directly in the survey and will continue to be monitored as part of the SCQR process.
3. The Mortality Review Committee (MRC) revised and updated key definitions of expected deaths and potentially preventable deaths. All MRC members were trained on these new definitions on December 2, 2021. These changes were applied to the review of deaths beginning December 2, 2021. These changes were made to clarify and be more inclusive of specific characteristics of deaths that may better identify potentially preventable deaths and develop individual and systemic QIIs.
4. The MRC incorporated the standardized use of mortality prevention strategies within the actions taken by the MRC. Starting on December 2, 2021, for actions taken by the MRC, the MRC considered and identified one of three prevention strategies further described in the key definitions. It is important to note that these prevention strategies aim to systematically identify and group the type(s) of actions recommended or taken by the MRC. This type of categorization aids in the development of more system wide interventions.

5. Effective July 2021, the MRC established a process in collaboration with the DBHDS OL's Special Investigations Unit to revise their mortality review checklist for licensed providers, to promote a more thorough mortality review.
6. A new licensing information system, CONNECT, was implemented in November 2021. The new system electronically manages the submission and approval of new applications for licensure, tracks the findings from inspections and investigations, manages the receipt of corrective action plans, and will also upload serious incident reports.

Data Quality

Critical to the success of the monitoring of PMIs, as well as in all the QI efforts employed by DBHDS, is data quality. Data quality involves many components that contribute to the reporting of data and the use of data to drive systemic changes and QI efforts. Included within the QMS is a plan for monitoring data quality.

The Data Quality Monitoring Plan (DQMP)

This annual report is a component of the DBHDS DD QMP and highlights improvements to the twelve data source systems that the Office of Data Quality and Visualization (DQV) assessed in Phase 1 of the DQMP.[1] Information was gathered using the methodology presented in the Annual Update Process[2]; this included interviews with Business Owners, review of Information Technology (IT) Project Management Office Status Updates, and review of documentation provided by the Data Pinnacle leadership. The methodology was developed to be as comprehensive as is feasible for an annual update while being inclusive of the effort expended by Business Owners to improve each data source system, and thus does not include the independent verification and validation of each finding.

The table below provides a list of the data source systems reviewed for this annual update, the categories in which improvements were made, and the replacement status for each system. Updates on the replacement status is noted in the following pages.

Source System	Categories of improvement	Replacement Status
Avatar	Key Documentation, Data Validation, User Interface, Business Ownership, Maturity	Planned replacement
Children in Nursing Facilities Spreadsheet	User Interface	Planned replacement

[1] DataQualityMonitoring2019_2020.PDF, pages 1-71
[2] DQMPAU_Process_v.2.0_12MAY2022

Source System	Categories of improvement	Replacement Status
CHRIS-OHR/SIR	Data Validation, User Interface, Maturity	Planned replacement
Employment Spreadsheet	Key Documentation, User Interface, Data Validation, Maturity	N/A
IFSP – Individual and Family Support Program	None	Planned integration
eMRF – Electronic Mortality Review Form	None	Planned replacement
OLIS – Office of Licensing Information System / Transitioned to CONNECT*	Key Documentation, Data Validation, User Interface, Business Ownership, Maturity	Complete
PAIRS - Protection and Advocacy Incident Reporting System	None	Planned replacement
REACH - Regional Educational Assessment Crisis Habilitation/Transitioning to the Crisis Data Platform*	Key Documentation, Data Validation, User Interface, Business Ownership, Maturity	In transition to Crisis Data Platform
Regional Support Team (RST) Workbook	Key Documentation, Data Validation, Business Ownership	Planned integration
WaMS - Waiver Management System	Key Documentation, Data Validation, Business Ownership, Maturity	N/A

System Replacements:

In fall 2021 the Office of Licensing Information System (OLIS), which stores information about licensed DD providers within the commonwealth, was replaced with CONNECT, a vendor supported application with enhanced security and data collection features when compared to OLIS.

Data Quality Improvements

Findings from the initial DQMP fell under the following headings: Key Documentation, Data Validation Controls, User Interface, Business Ownership, and Maturity. DQV organized this annual update by those headings to highlight the improvements made to each data source system; no improvements were identified outside of these categories. If a data source system is not mentioned within a category, no changes to the data source system were identified. Please see the first DQMP report for a complete list of recommendations for each data source system.

Key Documentation

Over the last year, there has been effort by business areas to produce and update key documentation. The team behind Avatar updated onboarding process documentation for the system and produced a user access termination document. Additionally, the team recently brought on a project manager to document standard operating procedures for data entry processes, develop a taxonomy of common definitions for terminology within the data source system, and publish data entry requirements for end-users. Lastly, the team provided requirements to the Office of Information Security (OIS) for the development of a business impact analysis, risk assessment, and system inventory definition for incorporation into a system security manual which will be produced in SFY23.

The Employment First team also made significant progress in developing key documentation for their revised Consolidated Employment Spreadsheet (CES). The team produced a data dictionary for all data elements contained within the CES, training materials, data entry instructions, and documented business rules for exceptions to data entry conventions that will be distributed alongside the data collection form. Lastly, the Employment First team developed process documentation that describes the entire Employment First data process; including all steps required to collect employment data, load the data into the CES, and to clean and transform the data for reporting. These documents will help ensure greater reproducibility in the Employment First data process, improving the reliability of the data for this data source system.

Other teams across the agency took steps to produce key documentation for their data source systems. After launching the new licensing information system, CONNECT, the OL produced training documents and process guides for the data source system. The Office of Integrated Support Services (OISS) not only made security documentation available for WaMS but also updated and produced process documentation, "Did you know" documents, and user guides for all new or and updated modules over the course of the year.

Data Validation Controls

In SFY22, Business Owners built additional data validation controls into In SFY22, Business Owners built additional data validation controls into their data source systems. The Avatar team modified the underlying data tables of the data source system that lengthened several data elements in response to the evolving needs of the business area. Further, the team began a project to add a new module to Avatar that will allow for the validation of patient address data through an interface with the United States Postal System (USPS) address validation tool. Within CHRIS-SIR, a SQL Server Integration Services (SSIS) package was created to import data from daily extract files from CONNECT to tables into the CHRIS database. This effort led the team to disable several data entry fields and the entire Action Report page where these data are

displayed in the data source system. Meanwhile, CHRIS–HR restructured the entity field for providers in complaint and abuse reports, transitioning this free-text field to a dropdown menu with selections consistent with options available in CHRIS-SIR.

Within the revised CES, the Employment First team has implemented data validation controls to reduce the probability of data entry errors. These additions include dropdown menu controls, restricted text fields, and controls that ensure that data are entered in a format that aligns with the data requirements for these fields. Additionally, the revised CES makes use of locked fields to ensure that end-users are not able to alter formulas used to automatically calculate values within the CES.

In transitioning from OLIS to CONNECT, the OL ensured that additional data validation constraints were placed on the data source system, including the addition of dropdown menus, check boxes, restricted fields, and system logic that will prevent cases from being closed prematurely. Further, CONNECT also has fields that auto-populate based on selections made in other fields, such as the disability population for specific licenses, which now automatically populates based on what license was selected. Lastly, CONNECT interfaces with CHRIS-SIR for the investigation of serious incidents, late reporting citations, and for routine background checks of providers applying for licensure of services.

In planning for transition from REACH to the Crisis Data Platform, the Crisis Services team applied many data validation controls to data elements reported on using the new data source system, including the introduction of required fields and dropdown menus for categorical data elements. Within WaMS, OISS made several adjustments to the data validation controls applied across several modules. In constructing the new ISP 3.3 module, the functionality of this module included the use of required fields, invalid data format popups, and locked fields based on user-roles. Additionally, race was made a mandatory field within the data source system. A pre-existing date field within the Service Authorization module was adjusted to allow for Service Authorization staff to amend service dates not correctly entered within the data source system, reducing the amount of manual effort and communication required to correct these dates and improve the timeliness of service authorizations. Lastly, WaMS integrated connectivity with the Department of Medical Assistance Services (DMAS) Medicaid Enterprise Services, which will ensure secure, timely, and accurate exchange of data between these two platforms.

User Interface

Some data source systems within the agency implemented User Interface (UI) modifications aimed at improving data quality. Avatar implemented a system update to resolve issues with the User Interface for some forms in which data entry caused the display to rapidly scroll away from

the selected field, disorienting users and interrupting the flow of data entry. Within CONNECT, many features were implemented within the User Interface that aim to improve the accuracy and reliability of data entry; including help menus, tooltips that provide definitions of key terminology, and the linking of certain fields within the User Interface to prevent redundant data entry. Additionally, CONNECT's Provider Portal allows providers to review documentation received by the OL to ensure the timely provision of documentation required for licensure. The Crisis Data Platform contains many User Interface upgrades over the REACH data source system, including the capability to provide prompts such as tooltips, hover text, and warning messages.

The revised CES underwent many changes to the User Interface that have the capability to improve data quality. First, the Employment First team added additional worksheets to the Employment First data collection form that provides information about data entry, exceptions to standard data entry requirements, and detailed information about each data element collected within the form. Within the main data collection worksheet, the revised CES contains conditional formatting on all cells to inform users of potential duplicates in the data, data entry errors, and required data fields. As well as an error counter, pop-up messages now show a user when invalid data have been entered, and tooltips appear for each data field within the spreadsheet. Lastly, the User Interface has been modified to display the headers of each column regardless of the user's position within the worksheet and allows for the user to sort all data to ensure completeness of data entry.

Business Ownership

Throughout the fiscal year, some steps have been taken that reflect an enhanced understanding of Business Owners within the agency. For example, the Business Owner of Avatar has brought on a dedicated trainer for all processes related to data entry within that data source system and hired a Project Manager that will take stewardship of these processes. The WaMS team continues to take an active role in ensuring all processes are updated in accordance with the requirements set forth by the business area; including the process for Supports Intensity Scale (SIS) and Level of Care expirations and ensuring that these updates are effectively communicated to stakeholders and end-users. Further, the Business Owner of the Employment First team came to a data sharing agreement with the Department of Aging and Rehabilitative Services (DARS), allowing for the creation of a process by which all Employment data will be assessed for uniqueness across records.

The Business Owner of CONNECT has held regular meetings with stakeholders to identify issues and bugs with the new data source system and has overseen the establishment of a CONNECT helpdesk that provides technical assistance to end-users and reports novel issues with the data source system back to the Business Owner and support team for resolution. Additionally, the

Business Owner of CONNECT conducted numerous rollout trainings for end-users to better understand the functionality and use of the data source system. Similarly, the Business Owner of the Crisis Data Platform oversaw the production of training videos for data entry that have been displayed during training sessions for the data source system and has approved the production of more videos as additional functionality is implemented within the data source system.

Maturity

DBHDS has made some progress in improving the maturity of data source systems. Avatar security was improved with the latest version of JBoss, which allows for the use of higher versions of Java and converts the data source system from an HTTP connection to an HTTPS connection. The revised CES automated their data consolidation process, reducing the amount of manual effort required to transfer data from their data collection forms and protected both the revised CES and all data collection worksheets to prevent unauthorized changes to these documents.

With the launch of CONNECT in November 2021, the OL adopted a more mature data source system compared to OLIS. CONNECT allows for enhanced security features including roles-based access for both Licensing Staff and providers and allows for providers to assign security-based roles for staff members within their own organization. Further, the data source system allows the OL to automate workflows, accept payments for licensing fees and FOIA requests, and send automatic reminders to providers to inform them the status of updates, applications, corrective actions, and due dates, which serves to improve the timeliness of data collection within the data source system.

OISS will be integrating several new features within WaMS that will improve the maturity of the data source system, including the adoption of multi-factor authentication to improve data source system security, and an auto-save feature to ensure that users do not experience catastrophic data loss resulting from data source system or connectivity issues.

Potential Replacements and Integrations:

Over the last fiscal year, several developments have taken place that will result in the replacement or integration of some DBHDS data source systems assessed in the original DQMP report. In June 2021, agency leadership found that CHRIS-SIR, CHRIS-HR, and PAIRS were no longer able to adapt to meet the needs of the agency and decided that a replacement data source system would be necessary to usurp the functionality of these data source systems. The agency plans to replace these three data source systems with a unified Incident Management data source system; and as a result, will only amend the original data source systems with a focus on maintaining the data source systems until the time in which a replacement has been

procured and integrated into the agency workflow. Currently, the Incident Management data source system project is in the procurement phase and has no defined target completion date.

The business owner of Avatar also indicated the intent to replace Avatar in the coming years. At present, this project is in the Statement of Work phase, with an estimated completion date of July 1, 2024. The eMRF is currently a Microsoft Access based application and the business owner indicated they are currently working to replace the data source system by July 1st, 2022; however, no details of the replacement were provided.

While the Crisis Services team began the process of transitioning data from the Regional Educational Assessment Crisis Habilitation data source system (REACH), which stores information about mental and behavioral health crisis calls, to the Crisis Data Platform concerns were the Crisis Data Platform were identified before the end of the fiscal year. Crisis Services team determined to not move forward with using the Crisis Data Platform until these concerns could be resolved. The Crisis Services team will continue to use the REACH data source system.

During SFY22, there was a concerted effort to replace the Children in Nursing Facilities spreadsheets with a PowerApp developed by DQV within the Microsoft 365 data platform. The Department was unable to move forward with implementation of the PowerApp. The spreadsheets were moved into a SharePoint list, which resolved the identified issue.

Lastly, two data source systems assessed as part of the DQMP are undergoing the process of being integrated into WaMS as modules at various stages of development. A project has been underway over the last year to integrate the RST workbook into WaMS and is currently in the design phase with a projected completion date of July 1st, 2022. The IFSP web application was originally being developed as a standalone web application with a launch of Fall 2021. However, due to issues with data source system security, it has been determined that this process would likely benefit from being integrated into the WaMS Waitlist Portal. At present, the IFSP integration is still in the early phases of development with a target launch of Fall 2022.

Performance Measure Indicators and Data Reports

The DBHDS QM Program's KPAs align with the DBHDS vision and mission to address the availability, accessibility, and quality of service provision for individuals with DD in support of "a life of possibilities for all Virginians". DBHDS has established three KPAs and identified eight domains that it uses as its focus of the QMS. DBHDS, through the QIC subcommittees, collects

and analyzes data from multiple data source systems in each of the eight domains as indicated below:

Each domain includes at least one PMI to assist DBHDS in assessing the status of the domains and the KPA. These PMIs include both individual outcome and system-level output measures. Outcome measures focus on what individuals achieve because of services and supports (e.g., individuals have jobs). Output measures focus on what a system provides, or the products provided (e.g., incidents are reported within 24 hours). The PMIs allow for monitoring and tracking of performance standards and the efficacy of improvement efforts. Each PMI contains the following:

- ✓ Baseline or benchmark data, as available.
- ✓ The target that represents where the result should fall at or above.
- ✓ The date by which the target will be met.
- ✓ Definition of terms included in the PMI and a description of the population.
- ✓ Data sources (the origins for both the numerator and the denominator).
- ✓ Calculation (clear formula for calculating the PMI, utilizing a numerator and denominator).
- ✓ Methodology for collecting reliable data (a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation).
- ✓ Subject matter expert (SME) assigned to report and enter data for each PMI.
- ✓ A Yes/No indicator to show whether the PMI can provide regional breakdowns.

The DBHDS QIC and/or QIC subcommittees monitor the PMIs and surveil other significant data to identify patterns and trends that signify a need for improvement, which may include remediation, corrective action and/or the development of a QII. This section includes an analysis of PMIs and data reports. Where performance does not meet expectations (e.g., the measure is below the set target), the annual progress is provided with discussion of strategies implemented to improve performance. The Performance Assessment Key below defines measurement standards for each table presented within this section.

Performance Assessment Key:

- **Fully Met** indicates the measure meets or exceeds the set target
- **Partially Met** indicates the measure is within 10% of the set target
- **Not Met** indicates that the measure is 11% or greater below the set target

Green Line – Performance Target

Blue line – Performance against Target

A measure's annual rate – (sum numerators for each quarter/sum denominators for each quarter) X100

N=Sample

Quality Improvement Committee (QIC) subcommittee chairs from RMRC, Mortality Review Committee (MRC), CMSC and the KPA Workgroups plus the Office of Clinical Quality Management (OCQM) staff and staff from DQV participated in the annual PMI review process. This new process established criteria to determine when a PMI should be retained, retired, or removed. Additionally, by reviewing PMIs annually, DBHDS commits to assuring that PMIs remain current and important to the agency.

In the first review, the review process involved 37 PMIs plus a review of each of the PMI Measure Development forms including the identified threats for each PMI and the resolution of the identified threats. This review resulted in twelve PMIs being retired or removed and the identification of PMI Measure Development forms that needed to be updated or completed. The PMI and measure language was aligned. Throughout the review process, members determined the importance of each PMI to DBHDS as well as noted if the PMI was reported elsewhere. The second review of 25 PMIs resulted in 24 PMIs being retained and one PMI retired. The same review process was utilized. During the second review, data quality issues were noted in the CHRIS data source system with an update on the work being done to correct the data quality issues provided. The results of both reviews were applied to SFY22 for reporting purposes.

Key Performance Area: Health, Safety and Well-Being

This KPA includes data analysis of information relevant to the domains of safety and freedom from harm, physical, mental and behavioral health, and well-being, and avoiding crisis. The goal for this KPA is that people with disabilities are safe in their homes and communities; receive routine, preventative healthcare, and behavioral health services and behavioral supports as needed.

The DBHDS OHR and RMRC, through CHRIS, collected the data presented below for the PMI. The KPA Workgroups, and RMRC analyze and monitor the data, as applicable. Please find below a brief synopsis of progress towards the achievement of PMIs relevant to domain of safety and freedom from harm.

Performance Measure Indicator – Safety and Freedom from Harm	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans.	95%	**	**	98%	99%	Fully Met
Annualized rates of "falls" or "trips" are 56.88 or less	56.88	**	56.77	45	^	Unable to Determine

**The PMI was not approved for that SFY, thus the absence of data.
^ Data not available; explanation included in corresponding paragraph listed below.

The PMI relating to Individual service recipients, seclusion or restraints achieved its target every quarter, twice achieving it at 100%, despite facing several systemic challenges related to the pandemic. The Local Human Rights Committee (LHRC) postponed instead of cancelling LHRC meetings due to decreases in membership and in the reduction of the number of LHRCs. They procured necessary equipment and fortified processes that supported providers and individuals with continued virtual participation options. These efforts allowed OHR to support LHRCs as they conducted the important work of reviewing and approving behavioral treatment plans for individual service recipients, to assure their right to be free from the unnecessary or unauthorized use of seclusion or restraint.

In SFY2022, CHRIS data source system issues adversely impacted the ability of the RMRC to review serious incidents, as serious incident reports are counted to arrive at the rate of falls PMI. At the beginning of SFY22, data quality issues were identified. The issues included:

- Data exclusion of individuals with an unknown waiver type; when many of those individuals were receiving a waiver service and should have been included in the calculations.
- Inability to correctly identify individuals who were receiving DD services due to inconsistencies across service lists within CHRIS, WaMS, OLIS and CONNECT data source systems.
- The CHRIS drop-down selection list of provider service types, for the Human Rights side of CHRIS (abuse and neglect reports), differed from that of the Incident Management side of CHRIS (serious incident reports), thus introducing the possibility of DD providers selecting non-DD services and vice versa. (It must be noted that discrepancies at the level of the population type [e.g., DD, MH] were analyzed and found to be small.)
- The lack of a valid and reliable unique identifier for individuals within CHRIS prevents or negatively impacts several opportunities related to tracking individuals' risks and outcomes across providers and linking individuals to other data source systems such as WaMS. While reports from CHRIS may identify the number of incidents that are reported, it was not possible to determine how many unique individuals were impacted; and whether there were a small number of individuals who experienced most of the incidents. This issue is unlikely to be resolved 100% until a new incident reporting system is procured. DBHDS will be issuing an RFP for a new incident management system in SFY2023. Although the PMI measure was evaluating the rate of serious incidents that related to a fall (not the number of individuals who have had a fall), being able to determine the number of individuals impacted by falls will help in understanding how to best improve this measure.

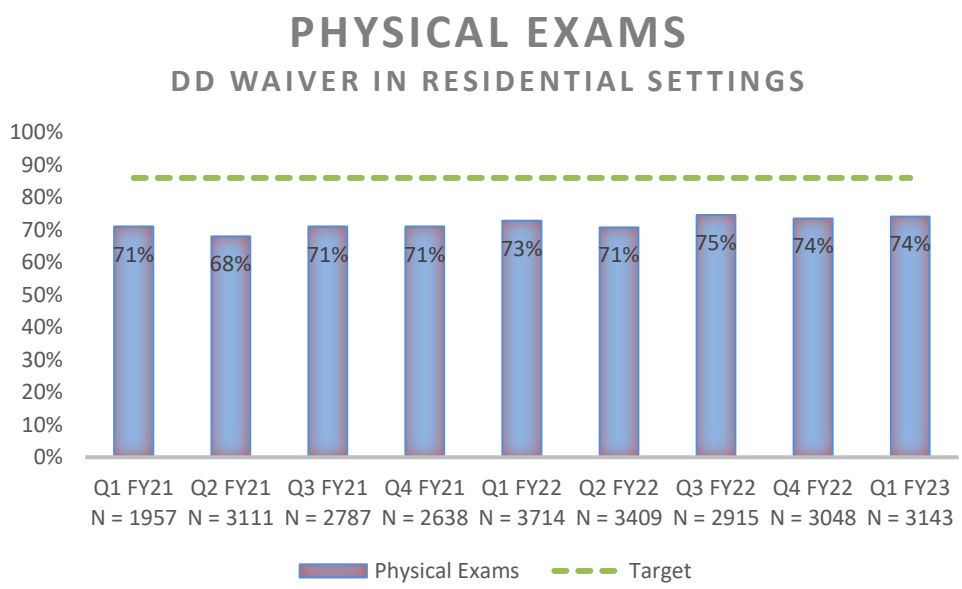
The RMRC voted to escalate these concerns to a newly created administrative body called the Data Forum, comprised of program leadership and IT leaders. Resolution of these data problems was not completed during SFY22 but is expected to be completed in SFY2023.

The OISS and the CMSC, through the SCQRs, collected the data presented in the table below. The KPA Workgroups and the CMSC provide oversight, and monitor, and analyze the data. A brief synopsis of progress towards the achievement of PMIs relevant to the domain of physical, mental and behavioral health and wellbeing is shown below.

Performance Measure Indicator – Physical, Mental and Behavioral Health and Wellbeing	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
Individuals in residential settings on the DD waivers will have a	86%	**	**	70%	74%	Not Met

Performance Measure Indicator – Physical, Mental and Behavioral Health and Wellbeing	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
documented annual physical exam date.						
The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.	86%	**	**	75%	84%	Partially Met
Individual support plans are assessed to determine that they are implemented appropriately.	86%	**	**	50%	84%	Partially Met

**The PMI was not approved for that SFY, thus the absence of data.



The KPA Workgroups analyzed data related to the completion of annual physical exams to ensure that individuals were receiving needed medical care. There was and still is no regulation, outside of the regulation for those enrolled in Opioid Treatment Programs, requiring annual physical exams was identified as a barrier to the PMI's performance. As indicated in the chart, 74% of individuals received their physical exam in SFY22. This represented an increase over SFY21 where the greatest percentage in any quarter was 71%. This was also consistent with the results of the National Core Indicators (NCI) In-Person State Report of 2020 – 2021 that reported 73% of respondents had completed an annual physical exam. It will be important to continue to

monitor this data for another year and to determine what, if any, the impact of the reduction in pandemic restrictions had on these numbers. OIH posted the slide deck, "The Importance of Annual Physicals" to the DBHDS website, which was presented during the October 2021 Provider Round Table meeting as a strategy to positively impact results. Development began on an Annual Physical Exam Toolkit to support individuals and their caregivers in preparing for and participating in an annual physical exam that includes a discussion about nationally recommended preventive screenings and vaccinations. The toolkit is expected to be available in late SFY23.

Case Management Measures

Indicator 9 (FY22)	Yes	FY22 Result	FY21 Result
Q75: Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	86%	84%	50%
Q77: Did all four OSVTs have all areas under "Services Implemented Appropriately" completed?	92%		

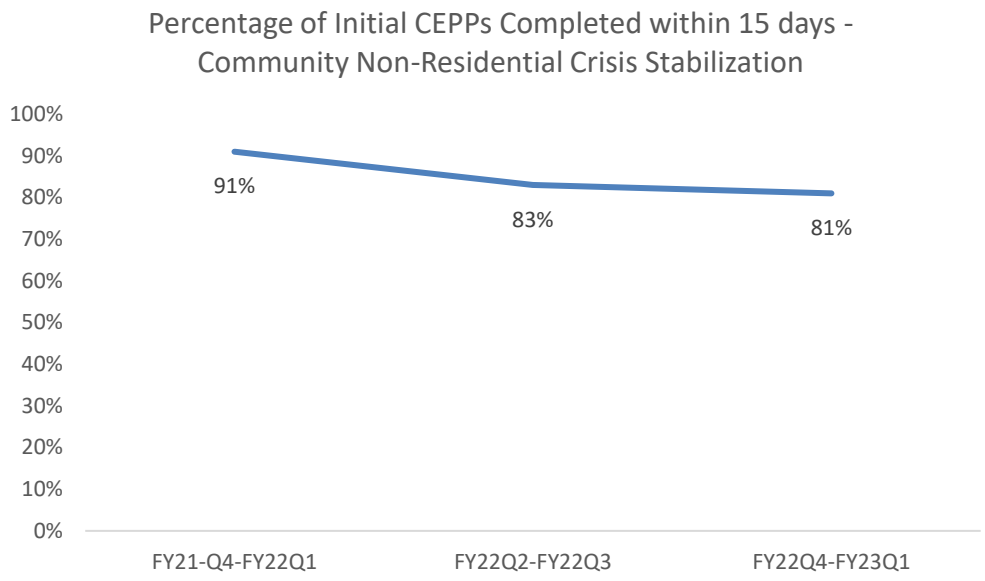
Indicator 10 (FY22)	Yes	FY22 result	FY21 Result
Q75: Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	86%		
Q79: Did each OSVT have all areas under "Change In Status" and "Change in Status Determination" completed?	94%	84%	75%
Q81: If any of the four OSVTs identified a change in status within the "Change in Status Determination" section, were revisions made to the ISP?	98%		

Data for these measures was collected through the SCQR survey, over a six-month period. SFY22 results, presented above, reflected the data that was provided by CSBs between January 1 and June 30, 2022. DBHDS accepts what the CSBs submit as true and then validate through the look-behind process. Where there is substantial agreement, we consider the data valid (where agreement is low, we revise the guidance for the next year). Analysis of these measures demonstrated that, as a group, 84% of CSBs assessed whether the person's status or needs for services and supports had changed and that the plan was revised as needed; 84% of CSBs assessed ISPs to determine if they were implemented appropriately. SCQR results indicated that increases were seen with both measures. Indicator 9 (related to appropriately implemented services) increased from 50% in SFY21 to 84% in SFY22. In the same manner, an increase was seen with indicator 10 (related to assessing and documenting a change in status) with results moving from 75% in SFY21 to 84% in SFY22. The OSVT utilized by SCs across the system continued as the primary means to better ensure a consistent understanding and assessment of these two key indicators.

The Office of Crisis Services & Supports (OCSS) collected the data presented in the table below. The KPA Workgroups provide oversight, and monitor, and analyze the data. A synopsis of the Commonwealth's progress towards the achievement of this PMI in the domain of avoiding crisis is detailed below.

Performance Measure Indicator – Avoiding Crisis	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
Individuals who are admitted into REACH mobile crisis supports will have a CEPP completed within 15 days of their admission into the service.	86%	**	**	80%	Q1 91% Q3 83%	Partially Met

**The PMI was not approved for that SFY, thus the absence of data.



Data for the PMI related to crisis education and prevention plan (CEPP) was collected in six-month intervals, which crosses over the SFY. This prohibited an overall result and sample size from being provided. There were several factors beyond REACH's ability to impact this PMI's performance. These factors included people, receiving REACH services, not re-engaging with REACH staff as pandemic restrictions eased and staffing shortages. Regional crisis managers continue to monitor completion of CEPPs in a timely manner. The declining results were problematic and are being included as part of the qualitative review that is completed quarterly by the managers. While this was partially impacted by people dropping out of services prior to the completion of the

CEPP, regional crisis managers will review the trend related to on time completion as well as why individuals are dropping out of services.

Key Performance Area: Community Inclusion and Integration

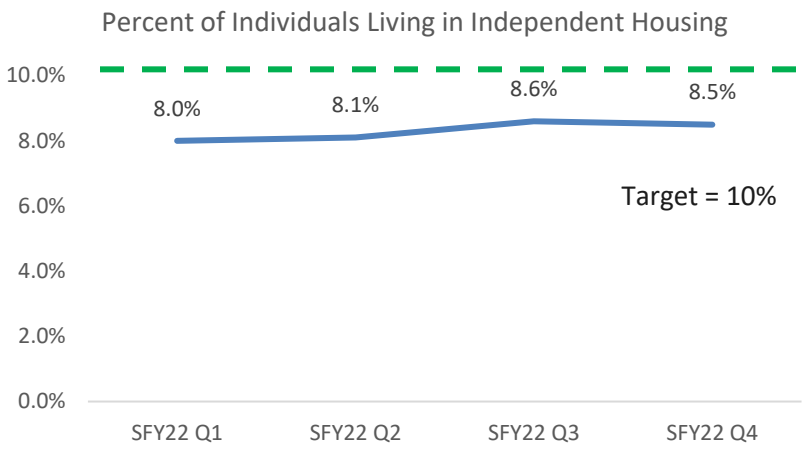
This KPA includes data analysis of information relevant to the domains of community inclusion, choice and self-determination, and stability. The goal of this KPA is to ensure that people with disabilities live in integrated settings, engage in all facets of community living, and are employed in integrated employment.

"*Merely residing outside of an institution does not equate to community integration*."
Virginia's Olmstead Strategic Plan 2019

OISS and Office of Community Housing (OCH) collect the data presented below. The KPA Workgroup and CMSC provide oversight, monitor, and analyze the data. The following tables and graphs describe the progress towards achievement of PMI goals relevant to the domains of community inclusion, stability and choice and self-determination.

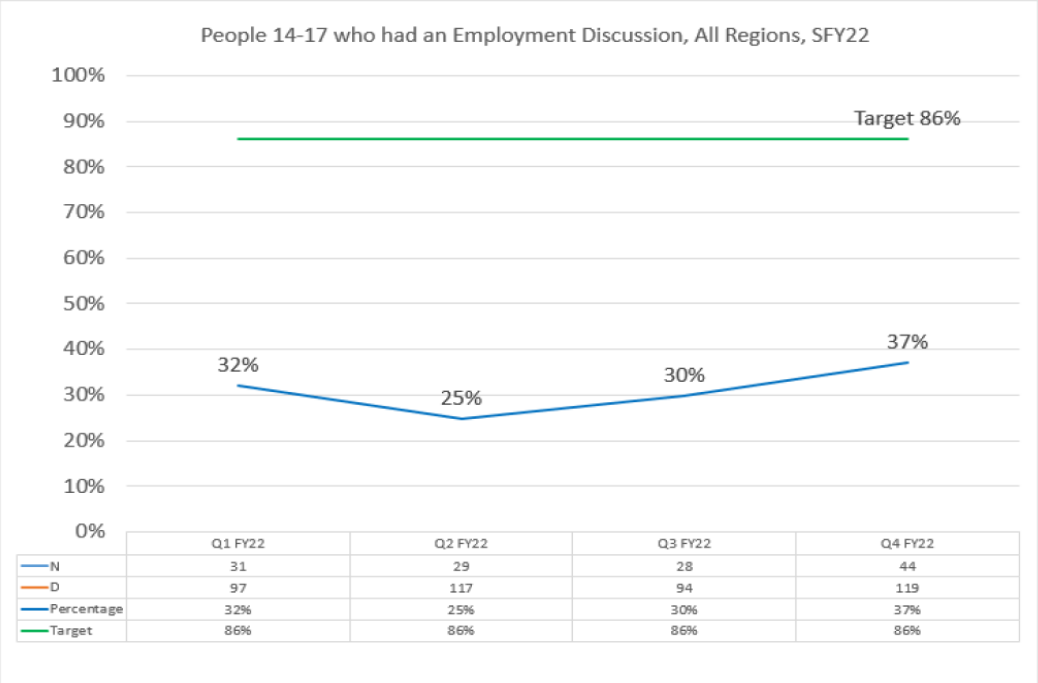
Performance Measure Indicator – Community Inclusion	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
Individuals live in independent housing	10%	5%	7%	8%	8%	Partially Met
Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.	86%	**	**	37% (derived from May and June 2021 data)	31%	Not Met

**The PMI was not approved for that SFY, thus the absence of data.



For the PMI related to individuals living in independent housing, it was important to note that the target increased to 10% during SFY22 to move Virginia closer to the current national benchmark of 18%; previously, the target was 8%. The State Rental Assistance Program (SRAP), along with housing subsidies dedicated by Virginia public housing agencies, have been funded at levels that permit continued progress toward the independent housing target; however, the pace of housing referrals was insufficient to reach the target this fiscal year. Pandemic and escalating rental costs have impacted the pace of housing individuals. DBHDS has implemented several strategies to increase the pace of housing referrals including targeted outreach and planning with CSBs (that make fewer housing referrals), direct outreach and education to individuals living in group homes, and funding tenancy supports for individuals on the Waiver waitlist.

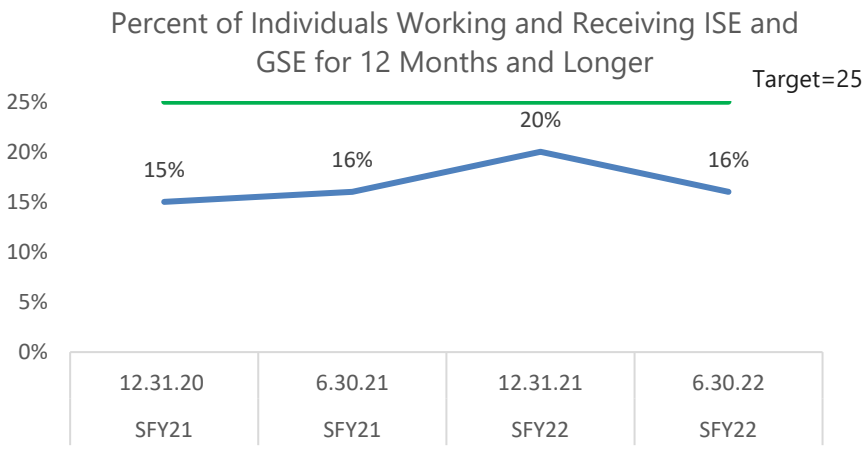
Baseline for the measure related to teen employment was established in the first quarter of SFY22. Additional monitoring will be required to see if there is continued upward trend in performance. Related elements in the ISP were refined in May 2022 to improve the collection of data around employment topics. Training on these updates emphasized expectations and the components of a meaningful discussion and goal development. The CMSC was aware of past efforts by the Regional Quality Council (RQC) 5 (Region 5), which sought to provide training and measure improvements in SC knowledge, as well as to measure an increase in employment outcomes for people supported.



Performance Measure Indicator - Stability	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
Individuals on the DD waiver and waitlist (aged 18-64) are working and receiving Individual Supported Employment (ISE) or Group Supported Employment (GSE) for 12 months or longer.	25%	19%	17%	16%	17%	Partially Met
Individuals have stability in the independent housing setting.	86%	**	**	97%	92%	Fully Met
Individuals with a DD waiver and known to the	86%	84%	90%	78%	84%	Partially Met

Performance Measure Indicator - Stability	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
Reach system who are admitted to Crisis Therapeutic Home (CTH) facilities will have a community residence identified within 30 days of admission.						

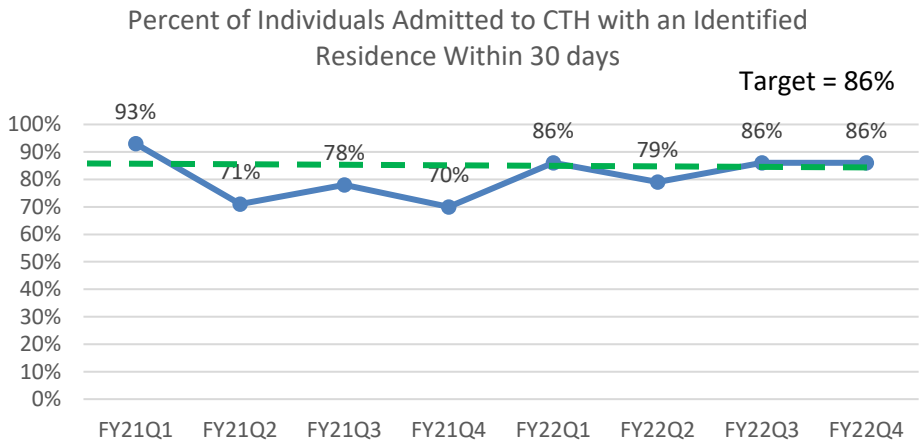
**The PMI was not approved for that SFY, thus the absence of data.



The PMI regarding ISE and GSE employment for one year or more has seen a decrease this past year. This was directly attributable to individuals re-entering the employment market after the pandemic, which resulted in high rates of job loss either through furlough, quitting, or employers going out of business. In the most recent data report, 26% of people are within their first year of employment and our employment rate for individuals with developmental disabilities has rebounded from a low of 16%, at the height of the pandemic back to 21% as of June 2022, while the number of individuals, on the waiver and the waiver wait list, continued to increase.

Regarding the PMI on individuals living independently, those who secure rental assistance to support independent living have exceptionally high rates of housing stability. These positive outcomes were a testament to the effectiveness of this type of housing assistance, paired with waiver services and natural supports, and can be used to support further system change, to offer independent housing to individuals with more significant support needs, especially individuals living in congregate settings.

For the PMI relating to CTH admission and identified residence, there were 204 admissions in SFY22, a decrease from SFY21. As with many programs, CTH admissions continued to be impacted by staffing challenges and COVID exposures, which impacted the availabilty of open beds. During SFY22, individuals in crisis were more consistently getting connected to residences in 30 days.



SFY21 257 admissions | SFY22 204 admissions

Beginning in SFY21, the KPA Workgroups began using WaMS ISP data for the PMI regarding choice in living situation; CMSC uses SCQR data for the remaining two PMIs. This data is included within the following table.

Performance Measure Indicator – Choice and Self-Determination	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
At least 75% of people receiving services who do not live in the family home/their authorized representatives chose or had some input in choosing where they live.	86%	67% NCI Virginia Result 2018	65% NCI Virginia Result 2020	100%	100%	Fully Met
Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff).	86%	**	**	83%	90%	Fully Met
Individuals are given choice among providers,	86%	**	**	78%	78%	Partially Met

Performance Measure Indicator – Choice and Self-Determination	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
including choice of support coordinator, at least annually.						

**The PMI was not approved for that SFY, thus the absence of data.

For the PMI related to individuals choosing or having input in choosing where they live, the results were consistently above 99% per quarter for SFY22. This measure will continue to be monitored.

Case Management Measures

Data for the two measures involving SCs was collected through the SCQR survey, over a six-month period each year. SFY22 results presented below reflect data provided by CSBs between January 1 and June 30, 2022. The first measure related to individuals having a discussion about relationships with people other than paid program staff increased from the 83%, seen in SFY21, to 90% in SFY22, as reflected in the person-centered (PC) ISP. The second measure, related to having a choice of SC and providers, remained at 78% as seen in SFY21. For this measure, SFY22 data showed that when considered individually (using the Virginia Informed Choice (VIC) form), individuals were given the choice of providers 90% of the time and SC 79% of the time. For the indicator to be fully met, both items must be confirmed as true, which occurred 78% of the time. These elements have been integrated into the SC workflow, so overtime, the increased awareness of the importance of choice should become evident in the data.

Measure 18	Yes	Either Yes, Met
Q54: Is it evident in the PC ISP that the SC/CM discussed relationships and interactions with people other	85%	90%
Q55: Is there evidence elsewhere in the record that the SC/CM discussed relationships and interactions with people other than paid program staff?	5%	

Measure 19	Yes Support Coordinator Choice	Yes Provider Choice	Both Yes, Met
Q22: Does the completed VIC confirm that the individual was offered a choice of . . . support coordinator (named)?	79%		78%
Q22: Does the completed VIC confirm that the individual was offered a choice of . . . .DD Waiver providers?		90%	

Key Performance Area: Provider Capacity and Competency

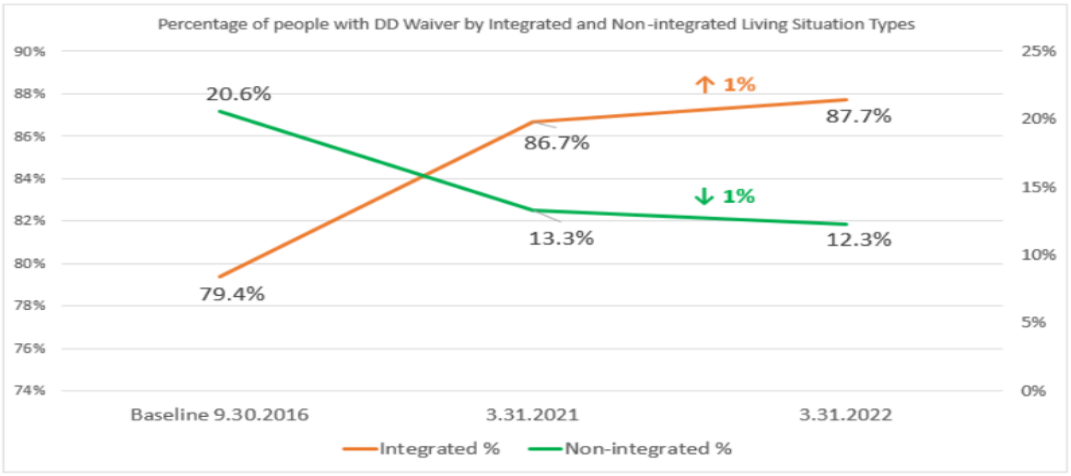
This key performance area includes data analysis of information relevant to the domains of access to services and provider capacity and competency. The goal of this KPA is to improve individuals' access to an array of services that meet their needs, support providers in maintaining a stable and competent provider workforce and provide resources to assist providers in attaining and maintaining compliance with licensing regulations.

The OPD, OISS, and HSAG (Health Services Advisory Group) collected the data presented below. The KPA Workgroups and CMSC provide oversight, monitor, and analyze the data. The table, charts, and graphs below detail the Commonwealth's progress towards achievement of these PMIs in the domain of access to services.

Performance Measure Indicator – Access to Services	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings. (FY19 5.1%)	2%	1.9%	1.2%	1.5%	1%	Partially Met
Data continues to indicate that at least 90% of individuals new to the waiver, including individuals with a "supports need level" of 6 or 7, since FY16 are receiving services in the most integrated setting.	90%	**	85%	87%	95%	Fully Met

Performance Measure Indicator – Access to Services	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
Transportation provided by waiver service providers (not to include NEMT) is provided to facilitate individuals' participation in community activities and Medicaid services per their ISPs.	86%	**	**	Round 1=84% Round 2=91%	Round 3=97%	Fully Met
Individuals receiving case management services from the CSB whose ISP, developed, or updated at the annual ISP meeting, contained integrated community involvement outcomes.	86%	37%	37%	38%	50%	Not Met
Adults (aged 18-64) with a DD waiver receiving case management services from the CSB whose ISP, developed, or updated at the annual ISP meeting, contains employment outcomes, including outcomes that address barriers to employment.	50%	32%	30%	28%	26%	Not Met
Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers	86%	71%	58%	64%	60%	Not Met

**The PMI was not approved for that SFY, thus the absence of data.



	Integrated #	Integrated %	Non-integrated #	Non-integrated %
Baseline 9.30.2016	9425	79.4%	2446	20.6%
3.31.2021	13292	86.7%	2044	13.3%
3.31.2022	13527	87.7%	1901	12.3%

The PMI related to services in the most integrated settings – overall and new to the waiver, there was an overall shift of 1% toward more integrated settings. This was the lowest noted increase since data collection began. With nearly 88% of individuals overall in integrated settings and nearly 95% of individuals new to the waiver in the most integrated settings, there is less room for continued growth. The potential for growth will be discussed further in SFY23 along with additional data review to determine the viability for growth. DBHDS altered its method of reporting to provide a cumulative total for all FYs as of July 1, 2016.

For the PMI related to transportation, individuals consistently report, through the Quality Service Review (QSR), that they have access to transportation through their providers to places they want to visit.

Case Management Measures

The charts below reflect the performances of the PMIs on employment and integrated community involvement goals, by region. In SFY22, ISP elements were enhanced to improve discussions about employment and integrated community involvement. With the introduction of the revised elements, training and guidance was made available to SCs that emphasized not only the discussion, but also the development of outcomes related to these discussions during ISP development. The CMSC continued to provide CSBs with their ISP data on a monthly and quarterly basis to assist in their efforts to monitor their own progress with these measures. Furthermore, during FY22, data related to each CSBs performance with integrated community involvement was added to CSB performance letters, made available to each CSB. The provision

of the data was to make performance readily available and increase attention in this area. CMSC will continue to monitor performance of these PMIs to determine the effectiveness of the strategies employed to improve performance.

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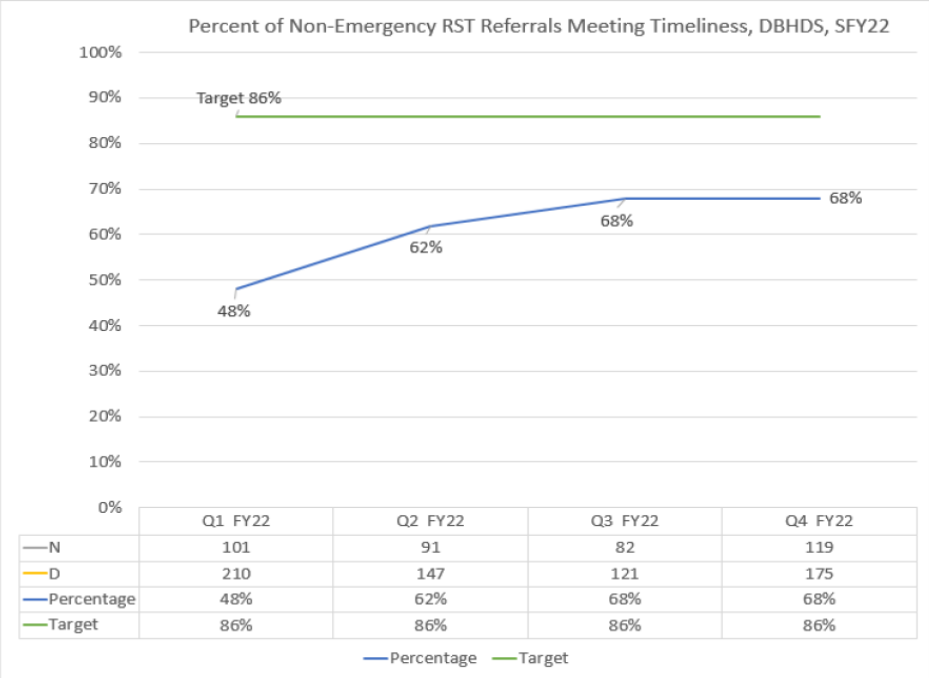
	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	852	709	572	609
D	3051	2610	2354	2608
Percentage	28%	27%	24%	23%
Target	50%	50%	50%	50%

	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	1981	1541	1244	1483
D	3512	3073	2762	3049
Percentage	56%	50%	45%	49%
Target	86%	86%	86%	86%

The last measure related to RST referral timeliness is being addressed under a QII and is included as a curative action under the SA. Following discussions with RSTs and the development of a Pareto Chart, to determine the most impactful actions that could be taken, a sixth cross-region RST was formed to assist with mitigating issues with late referrals. RST data related to all reasons for lateness showed consistently below target performance for SFY22 but trending upwards toward the end of the year, which coincides with the initial implementation of a sixth Regional Support Team.



OHR, Quality Review Team (QRT), OCSS, and OISS collected the data presented below. The KPA Workgroups and CMSC provide oversight, monitor, and analyze the data. The following table, charts, and graphs depict the Commonwealth's progress of towards the achievement of PMIs relevant to the domain of provider competency.

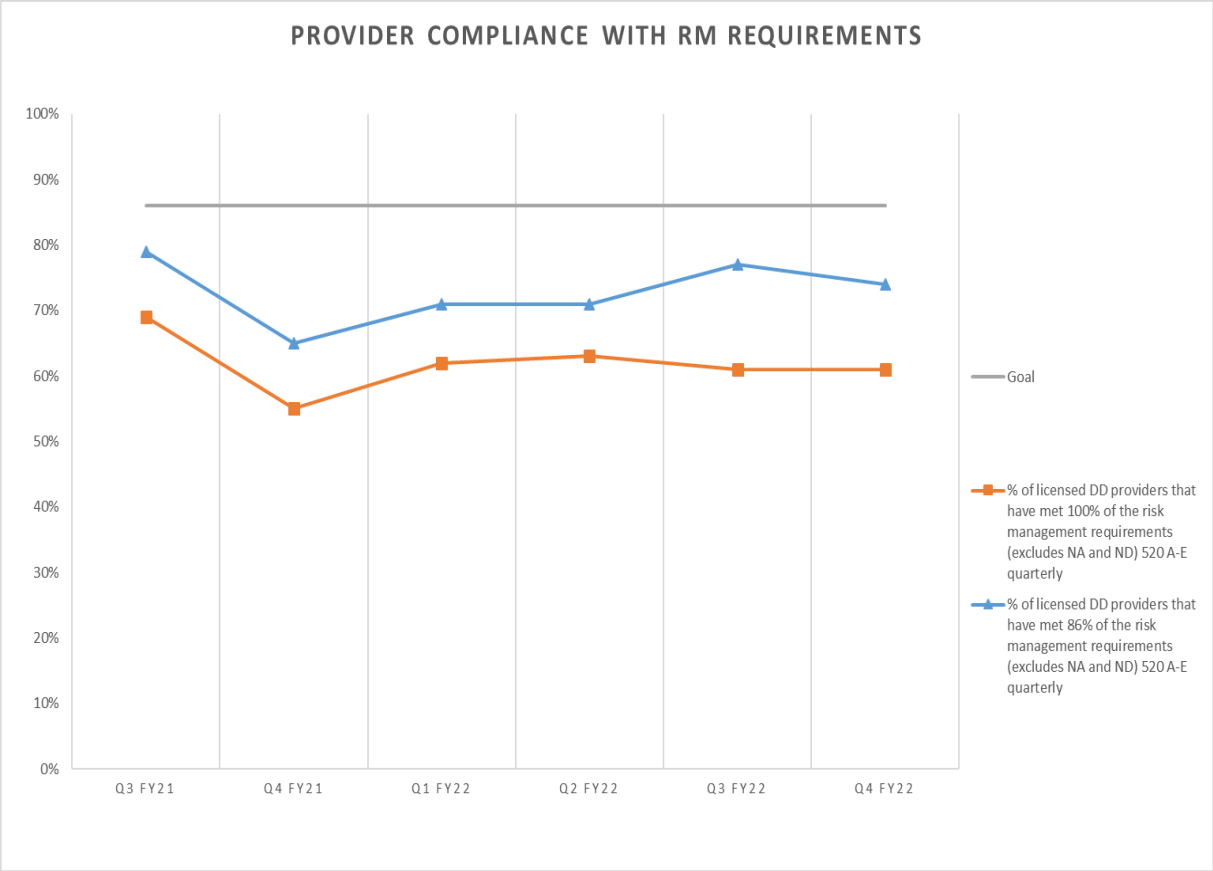
Performance Measure Indicator – Provider Capacity	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
Critical incidents are reported to the Office of Licensing within the required timeframe (24 hours).	86%	93%	92%	95%	96%	Fully Met
Percentage of licensed providers, by service, that were determined to be compliance with	86%	**	**	**	61%	Not Met

Performance Measure Indicator – Provider Capacity	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY22 Performance Assessment
100% of the risk management regulations that were able to be reviewed during their annual inspections.						
86% of licensed DD providers, by service, that were determined to be compliant with 100% of the quality improvement regulations assessed during an annual inspection.	86%	**	**	**	52%	Not Met
People with DD waiver are supported by trained, competent Direct Support Professionals (DSPs).	95%	**	**	78% Training 60% Competencies	Round 3 92%	Partially Met

**The PMI was not approved for that SFY, thus the absence of data.

Relative to the PMI on critical incidents being reported within the 24-hour timeframe, performance remained above target. This PMI will continue to be monitored.

For the PMI related to meeting regulatory requirements for RM programs, a review of the specific regulations addressing RM found that providers were most likely to comply with 520B, implementing a written RM plan, and 520E, conducting an annual safety inspection. Providers were least likely to comply with 520A, designating a person who is trained in RM, and 520D, conducting a systemic risk review that incorporates risk triggers and thresholds. Results are shown in the table below.



For the PMI regarding meeting regulatory requirements for QI programs, a review of the specific regulations addressing quality improvement found that providers were less likely to comply with regulations requiring a policy and procedure on the criteria they would use to establish measurable goals and objectives, update their QI plan, and submit a revised CAP when the plan was not effective. In addition, providers had low compliance with defining measurable goals and objectives, monitoring progress toward meeting goals, and monitoring the implementation and effectiveness of CAPs. Results are shown below reflect both quarterly and overall calendar year performance per QI requirement.

Measure	Data Source	Frequency	Goal	Q3 FY2021	Q4 FY2021	Q1 FY2022	Q2 FY2022	Q3 FY2022	Q4 FY2022	CY 2021
% of providers that are compliant with 100% of the QI Requirements	**620A-E**	quarterly	**86%**	58%	45%	53%	45%	55%	54%	52%
% of providers that are compliant with 86% of the QI requirements	**620A-E**	quarterly	**86%**	66%	59%	63%	56%	69%	69%	63%
Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	620A	quarterly	**86%**	90%	91%	94%	93%	93%	94%	91%
The QI program uses standard QI tools, including RCA and has a QI plan	620B	quarterly	**86%**	90%	85%	92%	92%	93%	93%	89%
The QI Plan shall:	620C	quarterly	**86%**	93%	90%					
- Be reviewed and updated annually	620C1	quarterly	**86%**	83%	78%	82%	71%	84%	86%	81%
- Define measurable goals and objectives	620C2	quarterly	**86%**	81%	75%	80%	74%	80%	86%	78%
-Include & report on statewide measures	620C3	quarterly	**86%**	92%	71%	92%	94%	88%	94%	87%
- Monitor implementation & effectiveness of approved CAPs	620C4	quarterly	**86%**	76%	70%	79%	67%	72%	78%	75%
- Include ongoing monitoring and evaluation of progress toward meeting goals	620C5	quarterly	**86%**	79%	76%	81%	71%	76%	82%	78%
The providers P&P includes criteria used to:	620D	quarterly	**86%**	88%	86%					
- Establish measureable goals & objectives	620D1	quarterly	**86%**	78%	72%	75%	73%	84%	84%	74%
- Update the QI plan	620D2	quarterly	**86%**	76%	73%	79%	70%	89%	86%	74%
- Submit revised CAPs when not effective	620D3	quarterly	**86%**	68%	63%	68%	66%	77%	78%	65%
Input from individuals about services & satisfaction	620E	quarterly	**86%**	81%	77%	85%	86%	78%	81%	81%

The OL implemented several strategies to improve compliance with requirements for RM and QI programs, including:

- Providing additional guidance and a series of webinars to review the regulations and highlight the RM and QI provisions and expectations.
- Publishing in February 2022, a sample Provider Systemic Risk Assessment, and Tools for Developing a Quality Improvement Program.
- In February 2022, providing further training and information on these regulations.

In addition, OCQI initiated a consultation and technical assistance (CTA) pilot project, in which they provided TA to ten providers that had not met the requirement to develop a QI program with measurable goals and objectives (620C.2). The effectiveness of the pilot project will not be known until all the participants have received their annual inspection.

The RMRC also identified a need to support these mitigating strategies by developing a flow chart (depicting how multiple licensing requirements fit together in a process that begins with becoming aware of and reviewing individual incidents, culminating in conducting an annual systemic risk assessment review to include risk triggers and thresholds). Development of this flow chart was coordinated by the OCQM QI Coordinator, informed by the OL, Incident

Management Unit (IMU), OIH and other stakeholders, and launched by the Incident Management Unit during a training in April 2022.

The RMRC also recommended initiating a quality improvement activity to improve compliance with the requirements for conducting an annual systemic risk assessment. This should be initiated in SFY23.

For the PMI related to DSPs, the data source system changed to QSRs. Two measures, from the QSR tools, are used to determine PMI progress. Both measures must achieve 95% for the PMI to be met. These measures are specific to orientation and training and competencies requirements for DSPs.

The first measure looks at orientation, training, and competency requirements as listed in the Provider Quality Review (PQR) tool. Health, Safety, and Wellbeing Alerts (HSW) related to a lack of training are reported through the PQR process. Success is dependent on providers completing the QSR process without DBHDS receiving an alert related to DSP competency. Counts for individuals with SIS level six and seven support needs, where an alert occurred, are provided in results. All providers receiving an alert were informed of the next quarterly DSP Competency training session provided by the Office of Provider Development. QSR Round 3 PQR results for this measure are listed below.

	Number with DSP Competency Alert	Number with Level 6 Support Needs	Number with Level 7 Support Needs	Number without DSP Competency Alert	Total Number Reviewed	Success %
PQR	54	N/A	N/A	511	565	90.4%

The second measure looks at competency requirements as listed in the Person-Centered Review (PCR) process. Alerts for observed DSP competency concerns are provided through the PCR process. Success with this measure is dependent on providers completing the QSR process without DBHDS receiving an alert related to DSP competency. Counts for individuals with SIS level six and seven support needs, where an alert occurred, are provided in results. All providers receiving an alert were informed of the next quarterly DSP Competency training session provided by the Office of Provider Development. QSR Round 3 PCR results for this measure are listed below.

	Number with DSP Competency Alert	Number with Level 6 Support Needs	Number with Level 7 Support Needs	Number without DSP Competency Alert	Total Number Reviewed	Success %
PCR	91	10	11	1092	1183	92.3%

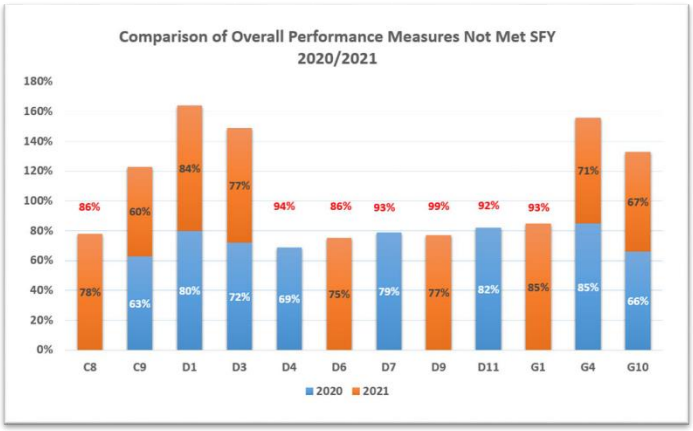
Neither of the related measures reached the target of 95%. Some additional work is needed to accurately reflect performance in this area. The data reported above is based on individual records, which resulted in a small amount of duplication in the counts. In the next reporting period, the data will be aggregated by agency instead of by individual records to ensure a more accurate reflection of performance in this area.

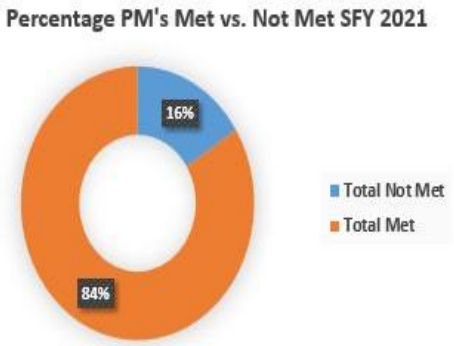
HCBS Quality Management

All states operating a 1915(c) Home and Community Based Services (HCBS) Medicaid Waivers program must annually report waiver performance under Center for Medicare and Medicaid Services (CMS) required assurances. The CMS assurances and related sub-assurances are built upon the statutory requirements of the §1915(c) waiver program with related state-specific performance measures (PMs) tied to each assurance/sub-assurance. Remediation must be demonstrated for any waiver PM with less than 86% compliance. Annual performance is reviewed on a triennial schedule in preparation for the state's waivers renewal. CMS reviews QRT data to ensure the state has sufficient evidence to demonstrate compliance with the waiver assurances. Ongoing demonstrated compliance is necessary to maintain federal financial participation in the waiver program.

The DMAS Division of High Needs Supports and DBHDS DD Waiver Operations Unit collaboratively oversaw waiver performance under these assurances quarterly using data derived from both DMAS and DBHDS, and from provider and CSB reviews through QRT reporting. The data reviewed ensured remediation occurred where it was indicated, identified trends and areas where systemic changes were needed, and identified the need to collect different data or improve its quality. Based upon the QRT review schedule and the availability in which it received data from its data source systems, the data provided for this report is from SFY21.

In SFY21, 84% of PMs met compliance; 16% (9) did not. Three PMs determined non-compliant in SFY20 met compliance in





SFY21. Five PMs remained non-compliant in SFY20 and SFY21. Four new PMs were determined non-compliant in SFY21. The overall comparison of waiver PM performance for SFY20 and SFY21 is shown on the previous page. Though the specific PMs that did not meet compliance varied during SFY20 and SFY21, the overall total number of PMs not met was comparable in both years. For a description of the PMs, refer to the FY21 QRT End of Year Report.

As required by CMS, all non-compliant PMs received some level of remediation. This remediation included targeted and group training, technical assistance, recorded videos, newsletters, targeted memoranda, and written provider guidance. For specific areas of non-compliance that persisted for more than two quarters despite intervention, additional remediation activities were developed and targeted to the area of need. This included the implementation of approved QIIs following the DBHDS QIC QII approval process. All waiver PMs were tracked for compliance with CMS reporting through the QIC committee structure and the statewide DBHDS DD QMP.

Several ongoing systemic barriers to compliance were identified. First, comprehensive provider contact information was not readily accessible. There was no universal location for accessing provider contact information or statewide mandate or regulatory requirement for providers to update their contact information; essential information delivered by the state reached only a fraction of the intended population. While OL maintains a provider listserv, which was reviewed by QRT, it did not contain all the needed information and was often not current. Second, the sampling methodology utilized in some reviews likely indirectly impacted compliance reporting. Quality Management Reviews, conducted by DMAS, allow for different providers to be sampled each quarter, increasing the likelihood of non-compliance for any PM. A third barrier (identified for several years) was the data reporting capability. During SFY22, DBHDS and DMAS implemented a Mandatory Provider Remediation (MPR) process, designed to assist those providers who struggle in meeting compliance or have had serious performance issues, in attempt to improve compliance. DBHDS and DMAS, through QRT, began discussion on utilizing the review of supplemental data as surveillance data and potentially substitute existing data source systems with the supplemental data in the 2023 waiver renewal. In mid-2022, a new automated QRT app was developed to help automate QRT data collection, monitoring, analysis, and presentation. DMAS has also committed to developing an ongoing comprehensive listing of provider contacts that will serve multiples uses statewide, including as a statewide information dissemination tool. These efforts will be monitored in the coming year to determine effectiveness.

Support Coordination Quality Reviews

PD, OCQI and DQV worked collaboratively to implement the third year of a SCQR process, which monitored the quality of support coordination for individuals receiving waiver services. This quality review included a record review of case management functions, by the CSBs, and a retrospective record review by DBHDS. This process was designed to enhance QI efforts across CSBs and enable DBHDS to monitor case management performance at local and systemic levels. OCQI QI Specialists conducted interrater reliability testing and SCQR retrospective record reviews (of CSB case management functions) in SFY22, which continue to occur from July to October of each calendar year.

The SCQR survey consisted of questions that require an answer and included display/question logic (to reduce respondent fatigue and to allow respondent to explain any negative responses). Explanations were used to improve the quality of SC records and an annual revision process of the questions was completed to refine and improve the survey. The CMSC provided data to CSBs via a secure online portal and included results in a performance letter provided to each CSB in April 2022. DQV prepared a full report for each CSB, which was used in the provision of TA and in tandem with the retrospective review process.

The results of the SFY22 SCQR indicated that the SCQR process was useful for improving the quality of case management. Overall, compliance increased somewhat (as measured by the number of records in compliance) but perhaps more importantly, agreement between OCQI and CSBs improved significantly. These improvements meant that SC supervisors were better equipped to determine whether records met DBHDS' standards. Additionally, the results of the SCQR and Look Behind facilitated productive conversations on a variety of topics during site visits and TA meetings. However, considerable room to improve on both compliance scores and agreement was noted. The survey questions and technical guidance will be updated with the goal of further improving reliability in the SFY23 administration of the SCQR. Additionally, this year's SCQR process is expected to improve compliance in future years.

Quality Service Reviews

Quality Service Reviews (QSRs) assess the quality of services provided. QSRs ask questions of both individuals and their families and providers. QSRs are required to be conducted for 100% of providers once every two to three years. Round 3 occurred November 29, 2021 – June 30, 2022. The review period covered January 1, 2021 – June 30, 2021. In-person on-site visits resumed in March 2022. Six hundred and fourteen provider quality reviews (PQR) and 1,200 person-centered reviews (PCR) were completed.

DBHDS and HSAG (QSR vendor) revised the PQR tool and PCR tool, processes and training used in Round 3 of the QSRs. Transportation and dental exam questions were rephrased to be clearer. Only applicable service types were required to include a back-up plan as part of service

planning. Training and competency of direct support professionals (DSPs) questions were added.

Round 3 looked at compliance elements in the areas of ISP Assessment, ISP Development and Implementation, Quality Improvement Plan, Risk/Harm, Incidents, Licensed Provider Competency and Capacity, and Community Integration and Inclusion. Round 3 results showed a 90% or greater compliance for 29 of 44 elements. Individuals receiving DD waiver services reported being satisfied with staff and satisfaction within their community-based services. They liked where they lived and felt safe where they lived. They reported no significant barriers to accessing their communities. For additional information on the aggregate report, please visit Developmental Services website and click on QSR.

As part of the QSR process, HSAG required providers submit a QI Plan (QIP) when the provider was determined to be below the benchmark of 90%. The table below highlights the number of providers in each round that required a QIP. HSAG will review the effectiveness of the providers' QIP during Round 4.

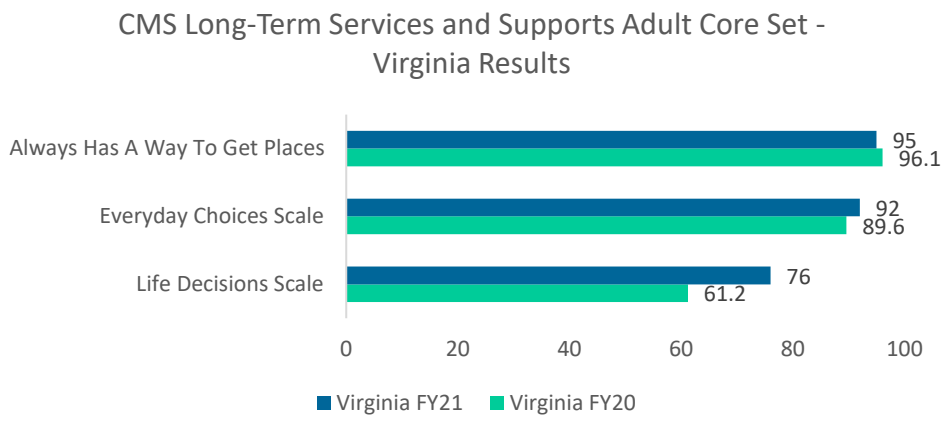
QSR Round	Number of Providers	Received a QIP	Did not receive a QIP
1	569	243	326
2	600	362	238
3	614	385	229

Not all providers participated in Round 3. Forty-nine providers did not participate. Some reasons for provider failure to participate included providers no longer being in operation or providing the service being reviewed and being unable to contact the provider/lack of response from the provider. HSAG continues to work with providers in addressing barriers to participation as lack of participation or failure to participate impacts DBHDS' ability to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice as well as meet requirements regarding QSRs.

National Core Indicators

The NCI Project is a collaboration between the National Association of State Directors of Developmental Disabilities Services (NASDDDS), the Human Services Research Institute (HSRI) and voluntary state participants, including Virginia. The core indicators are standard measures used across states to learn about the outcomes of supports and services provided to individuals and

families. Indicators address important elements of person-centered planning, including employment, rights, service planning, community inclusion, choice, health and safety and satisfaction. NCI has two initiatives. One targets the measurement and improvement of state performance in their aging and physical disabilities service system (NCI-AD). The other targets the measurement and improvement of state performance in their development disabilities service systems (NCI-IDD). Virginia participates in the NCI-IDD In-Person Survey, conducted yearly, and in three family surveys.



In FY20, the Centers for Medicare and Medicaid Services (CMS) added two scales and one measure from the NCI In-Person Survey to the Long-Term Services and Supports Adult Core Set. CMS' core set of health care quality measures for adults supports federal and state efforts in using standard measures to drive improvement in the quality of care provided to Medicaid beneficiaries. Virginia's results are reflected in this chart according to the NCI In-Person Survey Results from SFY20 and SFY 21. It is important to note that in SFY20, NCI calculated data differently than in previous reporting years due to not all the participating states meeting the higher margin of error used (10% compared to 5%) for SFY20 and that no risk adjustments occurred due to states' limitations in participating in NCI surveys during the pandemic.

In reviewing NCI-IDD In-Person Survey results for FY21, the QIC subcommittees identified areas where a QII could potentially be developed to address systemic issues demonstrated in the survey results. In SFY23, DBHDS looks to expand its use of NCI data.

Quality Improvement Initiatives

This summary details the QIIs implemented during SFY22 along with the QIIs proposed during SFY22. The QIC subcommittees continued work on ten QIIs approved in previous fiscal years. Five QIIs were abandoned and three were completed. Fifteen QIIs were proposed and either approved with implementation occurring in SFY22, approved for implementation in SFY23, or not approved as written.

Health, Safety and Wellbeing KPA:

1. CMSC OSVT QII focused on ensuring individuals have supports that respond to changes in status by ensuring that services were appropriately implemented. This QII was approved in SFY20 and implemented throughout SFY21 and SFY22 with completion occurring in SFY22. Following the initial review of OSVTs in 2021, specific elements were added to the SCQR survey, which ensured a qualitative review of 400 OSVTs as part of the annual SCQR cycle. This review included a DBHDS look-behind process, a comparison of results with CSBs, and technical assistance to improve performance with OSVT completion and related actions.
2. MRC SIS Level QII focused on reducing the mortality rate for individuals with DD and classified as SIS Level 6. Work focused on developing a planning form for individuals and their caregivers to use in preparation for annual visits to their primary care physician. Development of a toolkit, with emphasis on increasing the health literacy of individuals and their caregivers, was initiated.
3. MRC COVID-19 Mortality QII was proposed and approved during SFY22 for implementation. It focused on enhancing vaccination rates, continuing support for execution of infection control measures, and enhancing surveillance and early detection of COVID-19. While COVID-19 continues to be a leading cause of death in the DD population, COVID-19 deaths declined from 15 percent (SFY 21) to 11 percent (SFY 22), not yet meeting the intended metric of less than 10 percent of deaths.
4. MRC Frailty QII, proposed and approved during SFY22 for implementation, looked at the identification of a standard frailty tool (for use by the MRC during case reviews) to predict mortality in the DD population. The implementation of this QII was hindered by competing priorities of those offices involved with this QII.
5. MRC proposed a QII in Quarter 4 focused on decreasing choking as a cause of death. Baseline data indicated steady increases since SFY18 in choking as a cause of death. The QIC did not approve this QII for implementation due to identified capacity issues impacting the department's ability to implement the QII, at the time of the QII proposal.
6. The RMRC Falls QII, approved in SFY20, focused on reducing the rate of reportable serious incidents. Two strategies were adopted as standard practice: conducting follow-up for providers with fall related care concerns and delivering educational content about reducing the risk for falls. The other two strategies, implementing the Risk Awareness Tool and incorporating it into the ISP process, and monitoring falls data in CHRIS, are pending receipt of additional data. The RMRC hopes to complete this QII in SFY23 as soon as data on those two strategies are available to review.
7. KPA Workgroups Dental Benefit QII focused on increasing awareness of the new adult dental benefit effective July 1, 2022. OIH continued providing educational resources to providers and those in the dental community due to turnover within the provider community and the dental community.

8. KPA Workgroups Dental Exam QII focused on improving the percentage of individuals receiving an annual dental exam. This QII was approved by the QIC on 6.27.22 for implementation in SFY23.
9. RQC2 Maintain Low Falls QII focused on preventing the rate of falls from returning to pre-pandemic levels in DBHDS Region 2. RQC2 developed, in collaboration with James Madison University and the Office of Integrated Health, a video presentation: Movement for Better Health - YouTube. The video contained two portions. The first portion focused on why it's important for people to do activities that keep them strong and help reduce the risk of falling. The second portion reviewed various risks and fitness options and how each can help an individual be stronger and asked if the individual was interested in trying the activity. RQC2 also created a companion list of resources in the Northern Virginia area, which included a companion checklist that could be used while watching the video. These can be found at: Moving-for-Better-Health-Resources.pdf (virginia.gov) andMovement-Improvement-Checklist.pdf (virginia.gov). These were distributed throughout DBHDS Region 2. The impact of efforts will be assessed once the rate of falls data becomes available in SFY23.
10. RQC4 Urinary Tract Infection QII focused on reducing the rate of urinary tract infections in DBHDS Region 4. As there were known limitations to the CHRIS data source system that impacted the availability of data, the QIC did not approve this QII until the data becomes available.

Community Inclusion and Integration KPA:

1. KPA Workgroups Employment QII focused on increasing successful meaningful conversations around Employment, with individuals receiving DD waiver services. Specifically, work was completed to update the SCQR to ensure all elements were included in the tool when determining if employment conversations were meaningful. Additionally, the ISP was updated to ensure that meaningful conversation was better captured in documentation. The impact of these activities will be assessed in SFY23.
2. KPA Workgroups Community Involvement QII focused on improving the community involvement conversations leading to community involvement goal development. Specifically, work was completed to update the SCQR to ensure all elements were included in a community involvement conversation. Additionally, the ISP was updated to ensure that community involvement conversations were better captured in documentation. The impact of these activities will be assessed in SFY23.
3. KPA Workgroups proposed a QII focused on improving the race and ethnicity data entered in WaMS during Quarter 4. The QIC deferred approval on this QII (effectively disapproving it) on 6.27.22, due to the burden it places on SCs and lack of funding to implement it.

4. RQC4 Employment QII, approved in SFY20, focused on developing a process map for SCs to use in assisting individuals in gaining employment. SC feedback indicated that a better understanding of the DARS process and not a process map was needed, resulting in RQC abandonment of the QII on 1.13.22. From this result, RQC4 learned to include subject matter experts in the planning process much earlier in the QII and to ask the right question of the right audience at the right time. These lessons will be applied to future QIIs that RQC4 develops.
5. RQC5 Employment QII, approved in SFY20, focused on increasing the number of individuals who reported having an employment outcome in DBHDS Region 5. RQC5 conducted three employment in-services for DBHDS Region 5 SCs. In-service survey results indicated an increase in participant knowledge. RQC5 will review employment outcomes data in SFY23 to determine the overall effectiveness of the QII.
6. RQC1 Electronic Home-Based Services QII focused on increasing the use of Electronic Home-Based Services in DBHDS Region 1, to increase the number of people who live more independently. This QII was approved 6.27.22 by the QIC for implementation in SFY23.
7. RQC2 Integrated Community Involvement Outcomes QII focused on increasing the percentage of integrated community involvement outcomes found in ISPs of individuals receiving case management services in DBHDS Region 2. This QII was approved 6.27.22 by the QIC for implementation in SFY23.

<u>Provider Capacity and Competency KPA:</u>

1. CMSC ECM QII focused on increasing the number and percent of individuals who meet the criteria for enhanced case management (ECM) that receive face to face visits monthly with alternating visits in the home by identifying perceived challenges and enhancing, to the extent possible, guidance that is available to SCs so that implementation can be less complex and more successful. This QII was implemented on May 12, 2021, in response to QSR data. Lower performance was seen in quarter 3 for both measures (face to face visits and alternating visits in the home) but increased to 76% and 75% in the 4th quarter respectively. An automated worksheet that supports decisions around initiating and termination of enhanced case management was developed and provided to CSBs. An Enhanced Case Management questions and answers document was provided to all CSBs. Recommendations to the 2017 DBHDS guidance document were made, with edits focused on simplifying the content to the extent possible, while retaining the integrity of the process. A public comment period will occur in FY23 prior to finalizing the document.
2. CMSC RST Timeliness QII focused on increasing the number of non-emergency referrals meeting timeliness standards. RSTs have been established in all regions and seek to ensure informed choice and remove barriers to more integrated settings for people with

DD. The CMSC collected recommendations from RST members on strategies to address referrals that are late for Reason B (where a person moved before the RST process could be completed). Based on these recommendations, a cross-regional RST group was formed in Quarter 3, SFY22. This cross-regional group was designed and implemented as a process to review referrals that occur 1) when there is a lack of sufficient time to complete typical RST processes and 2) when informed choice is clearly evident in the documentation provided. Adding the cross-regional team was expected to decrease the amount of time many referrals must wait in queue, which will positively impact the related measure: "Statewide non-emergency referrals, as such referrals are defined in the DBHDS RST Protocol, meet the timeliness requirements of the DBHDS RST Protocol (III.D.6)." Initial data from the formation of the cross-regional team showed that there was a significant reduction in Reason B referrals that coincides with the formation and implementation of this additional RST. The CMSC will continue this QII in SFY23 to determine the effectiveness of the sixth RST.

3. CMSC proposed a QII targeting improving SC Retention in Quarter 4. This QII was approved 6.27.22 for implementation in SFY23. It focuses on making targeted changes that increase the manageability of the case management position resulting in an increase in SC retention over time.
4. MRC 911 protocol, approved for implementation in SFY21, was abandoned 12.16.21 as it did not achieve the desired outcome of reducing PP deaths to less than 15% of total deaths reviewed. The MRC examined provider barriers related to potentially preventable deaths and calling 911 and identified a new QII.
5. MRC Medical Emergency QII was proposed and approved for implementation during Quarter 3 of SFY22. It focuses on increasing the percentage of adherence to the execution of provider established protocols for medical emergencies.
6. MRC Opioid Overdose QII was proposed and approved for implementation in Quarter 2. The QII focuses on increasing knowledge of substance use disorders (SUD), and training in REVIVE! to promote health and safety outcomes for high-risk DD individuals with SUD and/or experiencing an opioid overdose.
7. KPA Workgroups DSP Competencies QII was approved in SFY20 and abandoned 12.3.21 as there were noted data validity and reliability concerns with the QRT data source system in use. The KPA Workgroups worked with DQV to assess needed actions to address the noted concerns. Gathering data differently with more information will be used to inform a more comprehensive plan forward regarding DSP competency. For the associated PMI (People with DD waiver are supported by trained, competent Direct Support Professionals.), the data source system switched to QSRs. In SFY 22, assessment of staff competency became a part of the QSR process, which included a formal process

for QSR vendor notification to DBHDS of provider staff that do not meet established expectations for staff competency.

8. KPA Workgroups ECT QII focused on increasing the number of providers offering Employment and Community Transportation service. This service became available at the beginning of the pandemic. With the emphasis on health and safety and restrictions imposed by the Commonwealth for community gatherings, this service was not widely utilized. Work focused on reminding providers of the existence of this service option. Through this work, DBHDS learned that there are concerns with the amount of administrative work required, by Medicaid, around the implementation and documentation of this service.
9. KPA Workgroups Provider Designations QII focused on increasing the number of providers statewide who hold a specialty designation in each of the following specialty areas: autism, behavioral supports, complex health, or accessibility. This QII was approved by the QIC on 6.27.22 for implementation in SFY23.
10. RMRC Med Error QII, approved in SFY21, was abandoned 9.20.21 because when the RMRC began implementation, it was determined that the baseline data for the QII had been miscalculated and once calculated correctly, the data did not support a need for the QII.
11. Both RMRC and RQC5 proposed a QII in Quarter 4 that focused on improving the percentage of providers found compliant with the RM regulations. These QIIs were similar and the QIC deferred approval (disapproval) of both the RMRC and RQC5 QII until they determined how they would proceed.
12. RQC1 Increase In-Home Supports QII focused on increasing provider capacity in offering this service in DBHDS Region 1, which allows individuals the opportunity to live in the most integrated setting, appropriate to meet their needs. This QII was completed in June 2022 as the goal of the QII had been met. The resulting work was shared statewide, and data demonstrated an increase in In-Home Support providers statewide.
13. RQC3 DSP Competency QII focused on improving DSP competency completion rates as noted in the associated PMI (People with DD waiver are supported by trained, competent Direct Support Professionals.). Approved in SFY21, this QII was in response to a review of QRT data. It was abandoned 2.24.22 due to not having a statistically relevant sample of DSPs or the ability to truly measure progress in this area.
14. RQC3 proposed a QII focused on increasing the rate of DSP competency requirement measures determined compliant for all service providers in DBHDS Region 3 during Quarter 4. On 6.27.22, the QIC deferred approval on this QII due to concerns with the data and the small number of providers in the sample for the proposed QII. While data from the new data source system indicates PMI performance meeting target, RQC3 will reassess PMI performance in SFY23.

System Focused QIIs:

1. MRC's Available Death Certificate QII, approved for implementation in SFY20, was completed on 11.18.21. The processes implemented to obtain death certificates and have available for mortality review proved effective. The Mortality Review Office incorporated these processes into their standard operations.

SFY22 DBHDS Internal Quality Management System Evaluation

Using a QM Program Assessment Tool, endorsed by the Institute of Healthcare Improvement (IHI), the DBHDS quality committee chairs conducted a program evaluation of each committee and for the DD QMS as a whole. The tool assisted DBHDS in assessing key components of its QMS and included an assessment of the DD QMP and the supporting infrastructure, implementation of processes (to measure and ensure quality of care and services), and capacity to build QI among providers. Based on the assessment tool, a QMS should have the following characteristics:

- Be a systematic process with identified leadership, accountability, and dedicated resources available to the program;
- Use data and measurable outcomes to determine progress toward relevant, evidenced-based benchmarks;
- Focus on linkages, efficiencies, and provider and individual expectations in addressing outcome improvement;
- Be a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement activities;
- Ensure that data collection is fed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes.

Progress Since the SFY21 Program Evaluation

In SFY22, DBHDS identified several areas of enhancement. Ideally, each identified area of enhancement would be addressed in the subsequent SFY. However, there are a few areas where identified improvements remain underway or are planned to occur from SFY23 – SFY25. While DBHDS worked to further define data sources and data source systems used for the DBHDS PMIs, there remained a need for governance around how the data is to be gathered, organized, stored, and reported. Work continued towards improving data validity and reliability, specific to data source systems.

In the areas of training and technical assistance, OCQM has provided training (regarding QIC and QIC subcommittee expectations as well as QI practices and principles) to quality committees. In SFY 22, trainings were developed and shared with QIC subcommittee chairs but have not been shared with all DBHDS personnel. OCQI developed and implemented a CTA Pilot with 10 self-selected providers, focused on standard 12VAC35-105-620.C2 (measurable goals and objectives). As part of implemented QIIs mentioned earlier, QIC subcommittees and designated offices developed and presented training specific to the applicable QII.

Additionally, OCQM developed and piloted QI Tools trainings; made available to QIC subcommittee chairs and other QI personnel in SFY 22, that introduced root cause analysis tools such as run charts, PDSA Cycle, fishbone diagram, and The Five Why's. In SFY 23, these trainings will be posted to the DBHDS YouTube channel for public access. In SFY 22, DBHDS also began to plan the development of a quality management and improvement web series; open to all DBHDS employees, via the department's "Lunch and Learn" series and a 'quality' newsletter designed to highlight how the various offices within the agency view and ensure quality in their respective program areas. In SFY 23, DBHDS will promote the use of its QII Toolkit, via additional YouTube videos.

DBHDS needs to continue its enhancement of the QMS and awareness of the QMS and how the QMS impacts the success of the individuals served.

The DBHDS internal evaluations of the QMS continued to mature as did the QMS throughout the year. Most interesting about this year's evaluations was that the various KPA Workgroups evaluated themselves more stringently than last year, often times scoring their respective performance lower than the previous year. This seemed to be the result of several converging factors including, a better grasp of QI concepts and tools, a better understanding of the data (need, use and analysis of), the QM structure being more grounded and now branching out across the DS system, a better understanding of how QI fits into the delivery of services, and having a clearer vision of what the system needs to do to be better able to serve individuals with disabilities. In short, the KPA Workgroups were more accurately able to see where they are in their functioning as a quality committee and where they need to be in supporting the QMS.

The DBHDS internal evaluation of the QMS identified several strengths in DBHDS' QM Program and several opportunities for enhancement. Please find them detailed below, along with DBHDS recommendations, activities, and plans to address identified concerns.

Identified Strengths

Quality Management System

The DBHDS QMS continued to be supported by senior leadership with direct accountability to the Chief Clinical Officer (CCO) and DBHDS Commissioner.

QIC and QIC Subcommittee Structure

The quality committee framework and implemented processes continue to be a definitive strength of the QMS. This framework oversees planning, assessment and communication and includes the QIC (the highest-level quality committee), the QIC subcommittees (three subcommittees, three KPA Workgroups, and five RQCs), quality collaboratives with DBHDS-DMAS QRT and the Virginia Association of Community Services Boards (VACSB). The QM committee framework is depicted in Part I of the DD QMP.

To ensure the highest level of leadership support and to solicit input and make recommendations for quality improvement activities, the committee structure includes broad representation of both internal and external stakeholders. Clinical and program representatives from internal offices (e.g., OL, OHR, OCQI, OPD, and OIH) serve as dynamic members of the QIC subcommittees demonstrating a department-wide commitment to CQI and the importance of inclusion of input from DBHDS personnel at various position levels within the DBHDS organizational structure. External partner representatives including consumers either receiving DD waiver services or on the DD waiver waitlist and family members also serve as active participants on the RQCs. External partner representatives serve on the QIC and select QIC subcommittees.

Overall Performance of the QMS

The QMS has a statewide QMP in place with clear definitions of leadership, roles, resources, and accountability. The QMS has an organizational structure in place to oversee planning, assessment, and communication about quality. The QIC and its related subcommittees have appropriate membership and have been established to solicit quality priorities and recommendations for quality activities. Processes have been established to evaluate, assess, and follow up on quality findings and data being used to identify gaps. The QMS collects appropriate performance data to assess the quality of care and services statewide. It offers QI training and technical assistance on QI to providers.

QIC Subcommittee Performance

As noted previously, QIC subcommittee chairs utilized the QM Program Assessment tool to evaluate performance of their respective quality committees. All quality committees participated in the assessment of the QMS, including the QIC. This assessment allowed for an aggregate review of overall performance across the QMS. Based on the results of this assessment, SFY22 was a year marked with successes and opportunities for enhancement in SFY23. A summary of the quality committees' work is included.

General Successes

- SFY22 marked a concerted effort by QIC subcommittees to present more granular data. When possible, more data reports broke measures down by age, gender, residential setting, region etc. This led to more informed and focused discussions in meetings and, in several cases, the development of QIIs.
- QIC subcommittees matured in their prioritization and development of QIIs and in their adherence to the PDSA cycle.
- Restructure of presentations to the QIC and RQCs focused on a targeted KPA per meeting and provided for more integrated discussion.
- The establishment and implementation of an annual PMI review process.
- Process improvements in the SCQR process based upon CSB feedback.

Risk Management Review Committee (RMRC) Key Activities and Challenges:

RMRC Activities:

- The RMRC established measures that were developed to ensure compliance with CMS HCBS waivers and the Settlement Agreement with the Department of Justice. The measures were adjusted, and goals were developed based upon input from committee and departmental representatives.
- The RMRC used its processes to evaluate and follow-up on quality findings and measure aspects of performance. The committee has monitored compliance with provider implementation of quality and RM programs to identify the need for quality improvement in this area; as well as utilized data to assess the implementation of a QII to reduce falls.
- The RMRC utilized structured tools and data to inform its selection of QIIs.

- Committee members, representing staff across several departments, contributed to the selection and development of QIIs.

RMRC Challenges:

- In SFY22, the committee ran into difficulties utilizing data due to identified issues with the data source systems. For example, identification of data issues in the CHRIS incident reporting system impacted both OHR and OL reporting from CHRIS, as well as the transition of the licensing database from OLIS to CONNECT limited data review. Actions to address these issues are planned to be addressed in the coming fiscal year.

RMRC Areas of Planned Improvement:

- The RMRC identified specific improvements needed with the CHRIS system to ensure that the data reported on serious incidents and abuse and neglect represented unique individuals receiving services for developmental disabilities and that the reported incidents were correctly linked with the service the individual was receiving. These issues were presented to the IT department and a plan for addressing these issues has been implemented. The RMRC data workgroup is monitoring the progress of this plan.
- The RMRC will evaluate the potential utilization of other data sources to identify potential risks (e.g., results from the NCI survey).
- The RMRC will develop clear descriptions of why measures are important, identify barriers, and surveil additional sources of data as identified using the QI KPA Identification process.

<u>Mortality Review Committee (MRC) Key Activities and Challenges</u>:

MRC Activities:

- During SFY22, MRC reviewed the deaths of 396 individuals receiving at least one DD licensed service.
- The MRC developed and made recommendations for individual and systemic level quality healthcare actions/activities, based on individual cases and/or trends and patterns noticed in aggregate, from its retrospective chart reviews.

- The MRC used its review process to assess MRC quality improvement performance and mortality review activities and data requirements.
- MRC members expanded definitions used by the MRC to support case specific determinations (cause of an individual's death, whether the death was expected, if the death was PP, factors in a PP death, and mortality prevention risk mitigation strategy) during case reviews.
- The Mortality Review Office began work to expand the electronic Mortality Review Form (eMRF) to increase the number of measurable data fields (decrease the amount of narrative information captured); provide more accessible surveillance data, communicate with other DBHDS electronic database systems, and increase the validity and reliability of data (i.e., decrease the need for manual data entry).

MRC Challenges:

- The MRC faced challenges in the implementation of ongoing and newly approved QIIs due to capacity issues within the Mortality Review Office and OIH. QIIs can remain in progress for a year or more, which impacts the capacity of both offices. The work generated by the QIIs was significant despite support provided by OIH.
- The eMRF was designed to collect data in narrative form which made it difficult to quantify. This meant that it was difficult to count or measure mortality data, and determinations are based on cases where interventions, actions and outcomes of interest have already occurred. Thus, data analysis outcomes are conceptual, cannot be retrospectively acted upon, and considered only as an approach for a potential prevention strategy, if a factor or event is considered repeatable.

MRC Areas of Planned Improvement:

- A redesign of the eMRF to improve the collection of quantifiable data for use by the MRC.
- Increase use of surveillance data (from eMRF)
- Improve upon the percentage of case reviews occurring within 90 days of the decedent's death

- Improve the capacity of the Mortality Review Office through the hiring of Mortality Review Office staff
- The MRC will develop clear descriptions of why measures are important, identify barriers, and surveil additional sources of data as identified using the QI KPA Identification process.

Case Management Steering Committee (CMSC) Key Activities and Challenges:

CMSC Activities:

- CMSC currently tracks 19 measures that include 11 PMIs, which required development of additional internal processes to track these measures.
- The CMSC developed additional subgroups to better facilitate meeting updates and the overall work of the CMSC.
- The CMSC made considerable progress in advancing the "four pillars" model of performance monitoring and the SCQR process.
- Microsoft TEAMS channels were established for each CSB for the dissemination of data reports and other information.
- The implementation of the Data Quality Support process, as well as the incorporation of the review of the OSVT into the SCQR process during SFY22 (SCQR process occurs per calendar year), contributed to the CMSC's progress.

CMSC Challenges:

- The volume of data and complexity of some processes posed challenges that the CMSC is working to overcome by working with other DBHDS offices, state agencies, CSBs, and the RQCs.

CMSC Areas of Planned Improvement:

- The CMSC will develop clear descriptions of why measures are important, identify barriers, and surveil additional sources of data as identified using the QI KPA Identification process.

- The CMSC will work to increase clarity and understanding of the importance of using additional data sources to improve the understanding of issues and provide more confidence as improvement efforts are developed and implemented.
- The committee will establish subgroups as needed to help manage the work of CMSC and improve the efficiency of its meetings.

KPA Workgroups (KPAW) Key Activities and Challenges:

KPAW Activities:

- The KPAW completed a task this year, using the QI KPA Identification Process, around the importance of the indicators which will shift the way we review data, identify surveillance data for review, as well as identify what we are trying to address using data.
- The KPAW maintained a detailed data review schedule and workplan that was refined to match an "all reports" timeline to allow subject matter experts appropriate time to develop presentations for review with the workgroup.
- The KPAW improved its processes to evaluate, assess and follow-up on quality findings and data. This new process included improving the understanding of the importance of data and how the workgroups review and address surveillance data as a means of improving quality in future.

KPAW Challenges:

- PMIs remained based primarily on concerns identified by the Department of Justice. KPA Workgroups, through its data reviews, will identify new PMIs as warranted.

KPAW Areas of Planned Improvement:

- The KPAW will work to leverage and improve upon its use of the QI KPA Identification Process.
- The KPAW will look for additional ways to review and utilize data to further the effectiveness of the workgroups.

Regional Quality Council (RQC) Key Activities and Challenges:

Unlike other QIC subcommittees, RQC do not have specific PMI or surveillance data. Rather, RQCs received quarterly data presentations on the same from subject matter experts.

RQC Activities:

- The RQCs reviewed and analyzed data provided by the RMRC, MRC, CMSC and KPAW at each of its quarterly meetings. This included PMIs, QSR, NCI and Employment data, along with the sharing of the annual REACH Reports and Provider Data Summary. Subject matter experts presented statewide and regional data, where applicable.
- The RQCs continued their respective work on SFY21 QIIs, as applicable, and presented proposed QIIs for SFY22 to the QIC. Some RQCs invited consultants from the DARS, James Madison University, the DBHDS Service Authorization Office and the DBHDS Office of Integrated Health to participate in their respective QII development and implementation.
- The RQCs again partnered with the Virginia Commonwealth University – Partnership for People with Disabilities to co-host the Joint RQC Summit which brought all five RQCs together for the first meeting of the new fiscal year.

RQC Challenges:

- The RQCs continued to be challenged with the limited amount of regional data available for review as it limited their abilities to identify regional areas of need. The RQCs continue to work with DBHDS regarding regional data.
- With the increase in data reports provided during RQC meetings, the RQCs have been challenged in managing time for report reviews vs. time for discussions. The presentation format was changed to improve discussion time and will be implemented in SFY23.

RQC Areas of Planned Improvement:

- To further RQC membership understanding and knowledge of PMIs, the meeting structure will be changed to promote discussions of why a particular PMI and

accompanying data is important and a focus will be placed on the identification of regional barriers to achieving the desired outcome of the PMI.

- RQC chairpersons will seek to further increase member participation during meeting discussions.
- RQC chairpersons will seek to leverage the Microsoft Teams platform for the RQC members to receive materials for review for each of the RQC meetings, in advance of, and during the meeting. The goal will be for RQC members to access meeting information more easily as opposed to searching through email to find it. This will decrease the potential for multiple emails to members, who have server limitations on the cumulative size of attachments they can receive via email, and serve as an efficient way to provide updates, announcements, and vacancy information.

Quality Improvement Committee (QIC) Key Activities and Challenges:

QIC Activities:

- Reviewed data presented by the QIC subcommittees as well as QSR, NCI, QRT data, Adequacy of Supports Trend data.
- Reviewed proposed QIIs and available resources and approved/disapproved/deferred QIIs.
- Reviewed updates to implemented QIIs.
- Directed the work of the QIC subcommittees.
- Restructured meeting format to focus on a targeted key performance area one per quarter for three quarters of the fiscal year.
- Moved to a summary format inclusive of the QIC subcommittee reports, which provides an interdisciplinary and cohesive discussion of the presented information.

QIC Challenges:

- Determining how to best expand involvement of consumers, providers, and representatives in quality committees.

- Improving upon the data availability, validity, and reliability for review and use by the quality committees,
- Continued limited human capital needed for QIC subcommittee QII implementation

QIC Plans for Improvement:

- Distribute DD QMP throughout agency, in turn increasing awareness of the DD QMP agencywide, continue posting on website
- Increase stakeholder involvement in quality committees
- Determining how to obtain provider input on the DD QMP.
- Increasing awareness of the PDSA process, both for informal and formal quality improvement initiatives
- Streamlining of TA across offices to assure the same message is being provided and to reduce overlap with DMAS TA

Identified Opportunities for Enhancement

The QM Program, through use of the QM Program Assessment tool and QIC subcommittee input, identified the following opportunities for enhancement.

- Increase communication and explanation of the DD QMP and importance of quality throughout DBHDS.
- Promote the use of the QII Tool Kit and other QI tools, such as root cause analysis, throughout DBHDS to better understand problems and resolve them throughout the agency.
- Increase stakeholder involvement and input.
- Establish a public data dashboard, granting access to service providers to assist in their efforts to track performance.
- The QM Program needs to work more closely with providers to help them evaluate their own programs and services and to utilize QA data to inform their QI efforts.
- DQV will continue to support programs throughout the agency to identify and evaluate new and existing data sources used by the agency. As new or existing data sources are identified across the agency, DQV will integrate these systems into the queue, to be evaluated in accordance with the procedures dictated by the process set forth in Actionable Recommendations process.

- DQV will continue to conduct Actional Recommendations Assessments until each of the original data source systems or their replacements have been reviewed. IT must collaborate with the respective business areas to address findings from the initial DQMP data source system and data warehouse assessments.

Path Forward Summary

Using its QM Program Evaluation, DBDHS determined the following path forward, for targeted improvement, for the coming year.

- DBHDS will continue to address data validity and reliability concerns including data provenance and data governance as identified in the Data Quality Monitoring Plan. While DBHDS has worked to further define data sources, used for the DBHDS PMIs, there is a need for governance around how the data is to be gathered, organized, and stored. DBHDS will need to determine if this will become the work of the Data Warehouse, as DBHDS moves to look for opportunities to streamline mechanisms for data collection and reporting.
- DBHDS will continue to enhance the ability to utilize data in driving decision-making, in identifying service gaps, and in identifying QI efforts, including statewide initiatives.
- DBHDS will collaborate with providers on evaluating their own programs and services to utilize QA, and RM data to inform their QI efforts.
- DBHDS will promote the use of root cause analysis and QI tools throughout the agency to better understand problems and their resolution.
- DBHDS will expand the awareness of the importance of quality and awareness of the QM Plan throughout DBHDS. DBHDS still needs to begin the work of sharing the impact of the QMS at a DBHDS department level and establishing processes and protocols to ensure the sustainability of consistent practices designed to ensure awareness of the QMS and how it impacts the success of individuals served.
- DBHDS will continue to increase the amount of involvement and input from individuals, families, and providers to incorporate into Part 3 of the DD QMP: Annual Report and Evaluation.

Conclusion

As the DD QMS continued to mature, the improvements made in previous years became more evident. The impact of additional improvements made by offices and QIC subcommittees targeted, at improving the functioning of the system, may not fully be seen for several years

following strategy implementation. The DD QMS continued to mature in its development of QIIs and other QI strategies that furthered its maturity.

The impact of the pandemic continued to impact the performance of PMIs. While it was anticipated that performance would improve as people returned to employment and community involvement, these improvements will take a year or two to materialize. As the pandemic continued, DBHDS shifted focus from pandemic impacts and instead began focusing on the pervasive and persistent staffing shortages impacting everyone from the individuals served and their families to the licensed providers and CSBs delivering supports and services to the agency. Given the persistent and pervasive nature of the staffing shortages, it will take several years of combined and collaborative work with stakeholders to make sustaining headway.

In the area of health, safety & wellbeing, DBHDS has an opportunity to increase performance to levels beyond current performance. The agency's focus on working collaboratively with stakeholders should serve to improve performance statewide. While the CHRIS data source system continues to be utilized, DBHDS determined that a new data source system was ultimately needed and will pursue a new incident management system.

In the area of community inclusion & integration DBHDS has an opportunity to increase performance to levels beyond current performance. The agency's focus on working collaboratively with stakeholders should serve to improve performance statewide. As DBHDS deployed several changes in data collection, the PMI results are anticipated to improve in the next reporting year.

In the area of provider capacity & competency DBHDS has an opportunity to increase performance to levels beyond current performance. The agency's focus on working collaboratively with stakeholders should serve to improve performance statewide. While efforts to improve provider understanding of QI and RM regulations requirements were made throughout the year, it will take at least another year to see the full impact of those efforts.

Over SFY22, DBHDS Business Owners and subject matter experts have taken many steps to address known data quality issues within DBHDS data source systems. Furthermore, several Business Owners are taking steps to procure new data source systems to replace several data source systems that are challenged to successfully serve the growing needs of the business area, to integrate current data source systems into more mature data source systems and make improvements to the user interface and data validation rules for some of the existing data source systems. These activities are in various stages of development and will be captured in

subsequent data quality updates. These improvements and plans for improvements by Business Owners are steps in the right direction to sufficiently address data quality as outlined in the original DQMP and Actionable Recommendations reports.

Glossary of Acronyms

Acronym	Full Form
CEPP	Crisis Education and Prevention Plan
CHRIS	Comprehensive Human Rights Information System
CMS	Centers for Medicare and Medicaid Services
CMSC	Case Management Steering Committee
CONNECT	Office of Licensing's data source system
CSBs	Community Services Boards
CES	Consolidated Employment Spreadsheet
CTH	Crisis Therapeutic Home
DARS	Department of Aging and Rehabilitative Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
DMAS	Department of Medical Assistance Services
DQMP	Data Quality Monitoring Plan
DQV	Office of Data Quality and Visualization
DSP	Direct Support Professional
ECM	Enhanced Case Management
eMRF	Electronic Mortality Review Form
GSE	Group Supported Employment
HCBS	Home and Community Based Services
HSAG	Health Services Advisory Group
IFSP	Individual and Family Support Program
IMU	Incident Management Unit
IT	Information Technology
ISE	Individual Supported Employment
ISP	Individual Support Plan
KPA	Key Performance Area
LHRC	Local Human Rights Committee
MRC	Mortality Review Committee
NCI	National Core Indicators
OCH	Office of Community Housing
OCSS	Office of Crisis Services & Supports
OCQI	Office of Community Quality Improvement
OCQM	Office of Clinical Quality Management
OHR	Office of Human Rights
OIH	Office of Integrated Health

Acronym	Full Form
OISS	Office of Integrated Support Services
OL	Office of Licensing
OLIS	Office of Licensing Information System
OSVT	On-Site Visit Tool
OPD/PD	Office of Provider Development
PAIRS	Protection and Advocacy Incident Reporting System
PCR	Person Centered Review
PMs	Performance Measure (CMS DD performance measure)
PMI	Performance Measure Indicator
PQR	Provider Quality Review
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QIP	Quality Improvement Plan or Quality Improvement Project
QM	Quality Management
QMP	Quality Management Plan
QMR	Quality Management Review
QMS	Quality Management System
QRT	Quality Review Team
QSR	Quality Service Review
REACH	Regional Education Assessment Crisis Services Habilitation
RM	Risk Management
RMRC	Risk Management Review Committee
RQC	Regional Quality Council
RST	Regional Support Team
SC	Support Coordinator
SCQR	Support Coordinator Quality Review
SFY	State Fiscal Year
SIS	Supports Intensity Scale
SIU	Specialized Investigations Unit
WaMS	Waiver Authorization Management System

Appendices

- Annual Mortality Report
- Case Management Steering Committee Semi-Annual Reports
- Risk Management Review Report
- Institute for Healthcare Improvement Quality Management Assessment Tool