DBHDS

Virginia Department of Behavioral Health and Developmental Services

Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2023

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A Life of Possibilities for All Virginians

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797
PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

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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) 2023 in each area were:

- Health, Safety and Wellbeing KPA: 1) Two performance measures related (a) to the assessment of status or change in needs and (b) the modification of the plan as needed came within 2% of target for the first time. 2) The resolution of data validity and reliability issues within the Comprehensive Human Rights information System (CHRIS) system. 3) Implementation of activities to address the choking concern noted in SFY22. These activities included determining that any instance of choking was identified as a care concern, development of online trainings addressing choking and risks of choking and the creation of My Care My Passport, a tool designed to go with individuals for any medical appointment, including trips to the emergency room and hospitalizations. 4) Office of Human Rights (OHR) expanded the reporting capabilities in CHRIS to track subcategories or types of neglect. 5) The Individual Service Plan (ISP) was updated to include documentation of preventive screenings.
- Community Inclusion and Integration KPA: 1) Teen Employment Discussions performance measure rose to 59%, due to the improved collection of data around employment topics in the ISP.
- Provider Capacity and Competency KPA: 1) Case Management Steering Committee (CMSC) Implemented a Power BI dashboard and improved CSB accessibility to data for their use in ongoing program evaluation and improvement efforts as part of the Data Quality Support Process with Community Services Boards (CSBs). 2) The Risk Management Review Committee (RMRC) conducted several activities focused on improving provider capacity to implement risk management and quality improvement programs. These included partnering with Regional Quality Council (RQC) 5 in a quality improvement initiative (QII) aimed at improving providers' ability in completing annual systemic risk

assessments, and the expansion of the number of providers receiving technical assistance related to the Office of Licensing's QI regulations by the Office of Community Quality Improvement.

- System Accomplishments: 1) Through the Mortality Review Committee (MRC)'s identification of a consistent pattern of findings for a single provider resulting in negative outcomes for individuals served and a resulting corrective action plan, DBHDS was able to ensure the health, safety & wellbeing of the individuals served by this provider. 2) The DD QMS moved forward toward proactive solutioning. The Provider Issues Resolution Workgroup and System Issues Resolution Workgroup partnered together to recommend solutions in the following areas: administrative burden, system transformation, system functioning, education & training, and complex medical & behavioral needs (with Direct Support Professional (DSP) competencies process and the revision of the DSP Supervisory Training to increase value to supervisors being of primary focus).

As the DD QMS continued to mature, it became evident that some processes were not sustainable and would need to be revised. Discussion began around where the processes were not working and what potential revisions could be made. While the DD quality committees all experienced challenges in implementing these processes, it was determined that the path forward needs to be thoughtfully and intentionally structured to assure that any revised processes would meet DBHDS requirements. Administrative burden to the CSBs and providers continued to be reviewed, and where practical, was reduced, thereby improving sustainability. The positive impact of established processes became evident as PMI performance improved, and agreement within the Support Coordination Quality Review (SCQR) Process continued to improve.

The DD QMS expanded opportunities for stakeholder involvement through the work of the Provider Issues Resolution Workgroup and the System Issues Resolution Workgroup. Other efforts were seen in the expansion of external partners in QII implementation by the Quality Improvement Committee (QIC) subcommittees. To lessen administrative burden experienced by CSBs providing DD services, the multi-agency review team (MART) began testing its process in SFY23. MART involves streamlining the review processes of six review entities between DBHDS and DMAS (Department of Medical Assistance Services). The MART process involves a Master Scheduler (allowing reviewers to see the other scheduled reviews and, if possible, avoid starting reviews on the same day), a Master Document List (tells CSBs what documents will be required for each type of review) and a Repository for non-personal health information (PHI) documents. The Repository allows participating CSBs to upload commonly reviewed non-PHI documents only once. Then reviewers can quickly find those documents to complete their reviews, throughout the review. With testing completed, MART will move to training CSBs and review entities in the fall of SFY24 with statewide launch targeted for January 2024.

The DD QMS is well established and continues to mature in its operations and functioning as a system. This provides increased opportunities to examine more fully processes to assure their sustainability and revise to improve/increase sustainability where indicated.

Introduction

The Quality Management Plan (QMP) for DBHDS is a three-part document, which includes this Annual Report and Evaluation for SFY23. This document summarizes key accomplishments of the DD QM Program's KPAs and system, followed by assessments of the performance measure indicators (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 SFY23 overall key accomplishments within the KPAs and key system improvements.

Key Accomplishments of the QM Program

Health, Safety and Wellbeing

1. While the integration of the On-Site Visit Tool into the SCQR process was implemented in SFY22, the effectiveness of this inclusion became evident in SFY23. There was increased agreement between the Community Service Boards (CSBs) and the Office of Community Quality Improvement reviewers during the SFY23 SCQR regarding the measures on assessing a person's status or needs for services and supports have changed and that the plan was modified as needed. The CMSC found that these two measures came within 2% of target for the first time. Additionally, these measures continued to show increased agreement across reviewers, which increased the confidence of the CMSC in the near target (86%) results, as both measures achieved 84% for the first time.

2. The RMRC, along with IT developers and the Data Warehouse, resolved data validity and reliability issues with the CHRIS system. Standard reports were developed to track serious incidents and abuse and neglect. The RMRC evaluated both SFY22 and SFY23 data.
3. In response to the identification of choking as concern in SFY22, the RMRC determined that any instance of choking would be identified as a care concern. The Office of Integrated Health (OIH) implemented an ongoing practice of providing follow-up and technical assistance to providers reporting a choking incident. The OIH made several on-line trainings available to address choking and other risk issues:
    - Choking and airway obstruction
    - UTI Training
    - Sepsis Training
    - The Fatal Seven
    - My Care Passport
4. The OHR added additional reporting capabilities to track sub-categories or types of neglect to the CHRIS system. The intent was to provide greater insight into the types of neglect that are most prevalent and to inform future interventions.
5. The OIH continued to work toward individuals living in DD waiver residential settings receiving an annual physical exam which includes a review of preventive screenings (target 86%). To support this work, the ISP was updated to include documentation of 1) flu vaccination, 2) colonoscopy, 3) mammogram, 4) hearing exam, and 5) vision exam, in addition to the completion of the annual physical exam. The purpose of these additions was to begin to determine the status of the rate of completion and begin to gain insight to barriers to access of exams.

Community Inclusion & Integration

1. In May 2022, refinements to the ISP were implemented to improve data collection around employment for *Teen Employment Discussions* performance measure noted in the ISP. The Case Management Steering Committee (CMSC) saw the fruits of this change as the measure's results increased to 59%, which was the highest level seen to date for this performance measure.

Provider Capacity and Competency

1. The SFY22 implementation of the Data Quality Support Process with CSBs, which involved implementation of a Power BI dashboard and improved CSB accessibility to data for their use in ongoing program evaluation and improvement efforts, began showing positive results in SFY23. Targeted Case Management (TCM) face-to-face visits data showed above target performance for all quarters of SFY23. Overall results for

enhanced case management (ECM) face-to-face and ECM in the home showed incremental improvements yet remained below target for the year.

2. The RMRC conducted several activities focused on improving provider capacity to implement risk management and quality improvement programs and activities.
    - Partnering with RQC5, the RMRC implemented a quality improvement initiative that focused on improving provider's abilities to conduct annual systemic risk assessments, including incorporating risk triggers and thresholds into these assessments. This included:
        - Offered a 6-hour training on risk management, which included information on monitoring serious incidents over time
        - Developed and shared a risk tracking tool to assist in the identification of risk areas
        - Disseminated tools to assist providers in conducting a root cause analysis for medication errors
    - The Office of Community Quality Improvement expanded the number of providers meeting requirements who could receive technical assistance to develop measurable goals and objectives as part of their quality improvement program to seventy-five.

System Accomplishments

1. The MRC identified a consistent pattern of findings resulting in negative outcomes for individuals served by a singular provider. These findings and concerns were escalated up through DBHDS for development and implementation of an appropriate corrective action plan. The resulting corrective action plan and measures for this provider led to closure of several group homes and prompt implementation of enhanced policies and procedures. DBHDS continues to monitor this provider for adherence to actions, measures, and provision of care, to ensure the health, safety and well-being of IDD individuals served by this provider.
2. The DD QMS moved forward toward proactive solutioning. The Provider Issues Resolution Workgroup was reconvened to provide understanding of causes and recommendations in the following areas: administrative burden, system transformation, system functioning, education & training, and complex medical & behavioral with Direct Service Professional (DSP) competencies process and the revision of the DSP Supervisory Training to increase value to supervisors being of primary focus. A DD System Issues Resolution Workgroup, made up of individuals and family members, was formed to partner with the Provider Issues Resolution Workgroup. Recommendations will be finalized in SFY24 and presented to DBHDS.

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 following summarizes the annual report on data quality.

Originally, processes associated with assessing data sources and data source systems for threats to data validity and reliability (including but not limited to a review of data validation processes, data origination, and data uniqueness) were a function performed by the Office of Epidemiology and Health Analytics (EHA), in the then Division of the Chief Clinical Officer (now the Division of Clinical Quality Management). Following the dissolution of EHA (January 2023), the Office of Clinical Quality Management (OCQM) personnel and OCQM independent data system analyst consultants assumed the functions associated with EHA including implementation of processes as defined by EHA.

A "comprehensive" process was implemented to ensure awareness of data quality concerns. It included the assessment process as well as the following steps:

- Measure validation which serves to ensure that all measures used as part of the DD QMS meet established specifications
- Data process documents which serve to document data origination, management and use, business area ownership, and data quality concerns and mitigating strategies employed to address them (for all datasets used to assess data, as part of the DD QMS).
- Data attestations that serve to attest to data source and data source system ability to produce valid and reliable data, with appropriate mitigation strategies. These documents confirm that the data source and data source system produce what the data process documents describe.

Table 1 below displays the source systems reviewed, the categories in which enhancement needs were identified (if applicable), and the replacement status for each system.

Table 1

Source System	Categories of Enhancement	Replacement Status
Avatar	Key Documentation, Data Validation, User Interface	Planned Replacement
Children in Nursing Facilities (CNF) Spreadsheet	Key Documentation, User Interface, Data Validation, Manual Data Processing	N/A
CHRIS-Serious Incident Report (SIR)	Data Validation, Key Documentation, User Interface	Planned Replacement

Source System	Categories of Enhancement	Replacement Status
CHRIS-Human Rights (HR)	Data Validation, Key Documentation, User Interface, Manual Data Processing	Planned Replacement
Community Consumer Submission 3 (CCS3)	Data Validation	Planned Replacement
CONNECT	Data Validation, User Interface, Manual Data Processing	Complete
Consolidated Employment Spreadsheet	None	N/A
Protection and Advocacy Incident Reporting System (PAIRS)	Key Documentation, User Interface, Manual Data Processing	Planned Replacement
Quality Service Review (QSR)	Key Documentation, Data Validation	N/A
Regional Educational Assessment Crisis Habilitation (REACH)	Key Documentation, Data Validation, Manual Data Processing	In Transition to Crisis Data Platform
Support Coordinator Quality Review (SCQR)	Key Documentation	N/A
Waiver Management System (WaMS) Individual Support Plan (ISP) proper	User Interface, Key Documentation, Data Validation	N/A
WAMS Customized Rate Module	User Interface, Key Documentation	N/A
WaMS Individual and Family Support Program (IFSP) Module –	None	Complete
WAMS Regional Support Team (RST) Module	Data Validation, Key Documentation, User Interface Design	Complete
WAMS Waitlist Module	Key Documentation, User Interface, Data Validation	N/A

Data Quality Findings

Findings from the Data Quality Monitoring Plan fell under the following headings: Data Validation Controls, Key Documentation, Manual Data Processing, and User Interface and Backend Structure. In this section, a brief synopsis of findings per category has been provided.

Data Validation Controls

Eight data sources and data source systems had a combined total of 20 duplicated data quality issues (meaning that findings can apply to multiple data sources or data source systems) related to lack of or malfunctioning data validation controls. In general, data validation findings indicated an overall challenge with development and application of data validation controls that

prevent the entry of erroneous data. Findings fell into the following subcategories: 1) inability to ensure data uniqueness; 2) ability to enter data after a point when the record should have been closed (posthumous data entry); 3) inability to clearly define field or tool options; 4) inability to define field parameters within the system such as date ranges, restrictions on numeric values; and 5) records over ridden by new data entered.

Key Documentation

Nine data sources and data source systems had a combined total of 24 duplicated data quality issues (meaning that findings can apply to multiple data sources or data source systems) related to lack of or outdated key documentation. In general, key documentation findings indicated an overall challenge with development and maintenance of key documentation. Findings fell into the following subcategories: 1) lack of or incomplete business rules or advanced business rules; 2) no data dictionary; 3) no comprehensive system guidance; and 4) lack of or incomplete business glossary or glossary of terms.

Manual Data Processing

Five data sources and data source systems had a combined total of seven duplicated data quality issues with manual data processing (meaning that findings can apply to multiple data sources or data source systems) In general, manual data processing findings indicated an overall challenge with manual work; specifically, the presence of manual processes to categorize narrative responses, enter and clean data and revert records.

User Interface and Backend Structure

Six data sources and data source systems had a combined total of 35 data quality duplicated issues (meaning that findings can apply to multiple data sources or data source systems) with user interface. In general, user interface and backend structure findings indicated an overall challenge with data source and data source system operational efficiency. Findings fell into the following subcategories: 1) data, form, or record duplication; 2) system redundancies (obsoleteness); 3) premature system timeout; 4) lack of needed data elements that are missing elements or missing data; and 5) need to embed/prepopulate data into other areas of the system or in attachments or ensure data capture (connecting data between data sources or source systems).

Data Quality Improvements

Six data sources and data source systems have implemented or plan to implement system, process, or documentation enhancements (including CHRIS: HR and SIR sides of the system, Avatar, CNF, REACH, CCS3, WaMS and WaMS IFSP). There was a combined total of 34 duplicated enhancements and 25, planned enhancements (meaning that progress can apply to multiple data sources or data source systems) that have already been implemented.

Data sources and data source systems demonstrated progress as indicated below:

- Data Validation: 1) developing or enhancing unique identifiers; 2) embedding field/element parameters and guidance within the system; 3) elimination of record, form, and data duplication; and 4) addition of restrictions to data elements so that they cannot be modified by end users. There was a total of 10 implemented enhancements; with five additional enhancements planned for later implementation.
- Key Documentation: 1) developing data dictionaries; business rules, comprehensive systems operations documentation, business glossaries, and guidance for field clarifications and 2) documenting requirements for data entry to ensure a mutual understanding of business processes and operations and system use between system users and business owners. There was a total of 18 implemented enhancements and six planned enhancements.
- User Interface and Backend Structure: While there were no discernable patterns, it should be noted that there were five implemented enhancements and 10 planned enhancements.
- Manual Data Processing: While there were no discernable patterns, it should be noted that there was one implemented enhancement and two planned enhancements.
- Training: While there were no discernable patterns, it should be noted that there was one implemented enhancement and one planned enhancement.

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

QIC subcommittee chairs from RMRC, MRC, CMSC, and the KPA Workgroups and OCQM staff participated in the annual PMI review process. This process reviews PMI performance over the past several years to determine whether the PMI should be retained, retired, or removed. Through this process, DBHDS commits to assuring that PMIs remain current and important to the agency.

In the annual review, the review process involved 26 PMIs plus a review of PMI process documents and attestations. This review determined that all 26 PMIs should continue and the noted where methodology and/or changes in denominator should occur. Outcome and output designations were changed for two of the PMIs.

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. MRC collected the data for the last PMI and analyzes and monitors the data. 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	SFY23 Results	SFY23 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%	99%	**Fully Met**
Annualized rates of "falls" or "trips" are 63.78* or less*	63.78	**	56.77	45	62.43	68.43	**Not Met**
Unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken.	86%	62%	100%	100%	**	100%	**Fully Met**

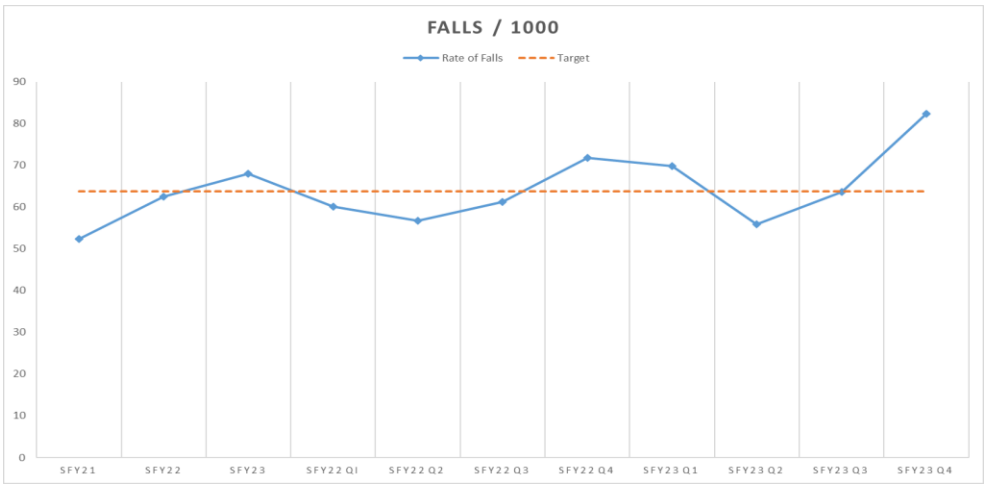
*Goal revised in SFY23 using updated baseline data.

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

Individual service recipients have a right to only have seclusion or restraints utilized to prevent imminent harm after less restrictive interventions are tried, and as outlined in individualized plans, in accordance with the Human Rights Regulations. The OHR utilized the logic of the data

warehouse to review, and research identified reports of unauthorized seclusion and restraint to determine the number of individuals who had a substantiated complaint alleging the unauthorized use of seclusion or restraint, and to ensure appropriate follow up has occurred. All substantiated complaints alleging the use of seclusion or restraint that do not comply with the Human Rights Regulations resulted in a licensing citation. Overall, the data reflected that most individuals receiving services are free from the unnecessary or unauthorized use of seclusion and/or restraint, and this PMI remains Fully Met. The OHR attributed these low instances of unauthorized and unnecessary instances of seclusion and restraint to proactive strategies that include offering routine access to training specific to "Restrictions, Behavioral Treatment Plans, & Restraints", and the OHR practice of reviewing and approving Human Rights policies for all newly licensed providers, to include onsite compliance visits for DD Waiver providers specifically.

Regarding the *Serious Incident Rates* PMI, the RMRC had implemented a QII focused on reducing the rate of falls in SFY20, which ended in SFY23. Several interventions were implemented to improve provider awareness of fall risk and fall prevention. While these interventions were successfully shared with providers and there was evidence that they were utilized, they did not appear to be effective in lowering the fall rate. The RMRC concluded that the reduction and subsequent increase in the fall rate was tied to restrictions that were put in place in response to the pandemic rather than to the QII interventions. No other systemic issue related to the Q4 increase was identified. The RMRC plans to conduct a further review of root causes of reported falls to determine further opportunities for improvement. The graph above shows the rate of reported falls per 1,000 individuals on a DD waiver.

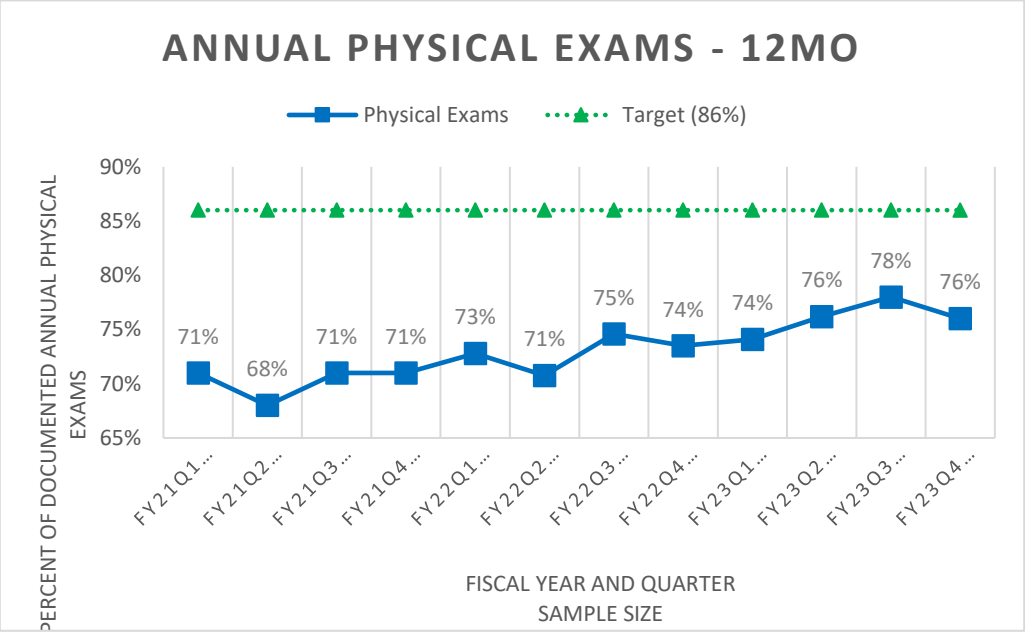


The *Unexpected Deaths* PMI was reinstated on 12.12.22 for reporting during SFY23 as it was determined that it was still important for the agency to report on as a PMI. This PMI was retired by the Annual PMI Review Workgroup and formally retired by the QIC on June 27, 2022, as it had been performing above target and the data was reported by the Quality Review Team (QRT). Since reinstatement, the PMI has been performing above target.

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	SFY23 Results	SFY23 Performance Assessment
Individuals in residential settings on the DD waivers will have a documented annual physical exam date.	86%	**	**	70%	74%	76%	**Partially Met**
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%	84%	**Partially Met**
Individual support plans are assessed to determine that they are implemented appropriately.	86%	**	**	50%	84%	84%	**Partially Met**

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



The *Annual Physical Exam* PMI has made slow, yet steady progress over the past three fiscal years. Looking at the third quarter of each of the past three years – year over year - there is a consistent increase in the numbers of individuals who have reported an annual physical exam. Specifically, the percent of individuals in SFY21Q3 = 71%; SFY22Q3 = 75%; and SFY23Q3 = 78% of individuals in DD Waiver residential settings, representing a positive trend year over year. For SFY23, there was a 2% increase overall from Q1 at 74% to Q4 at 76%.

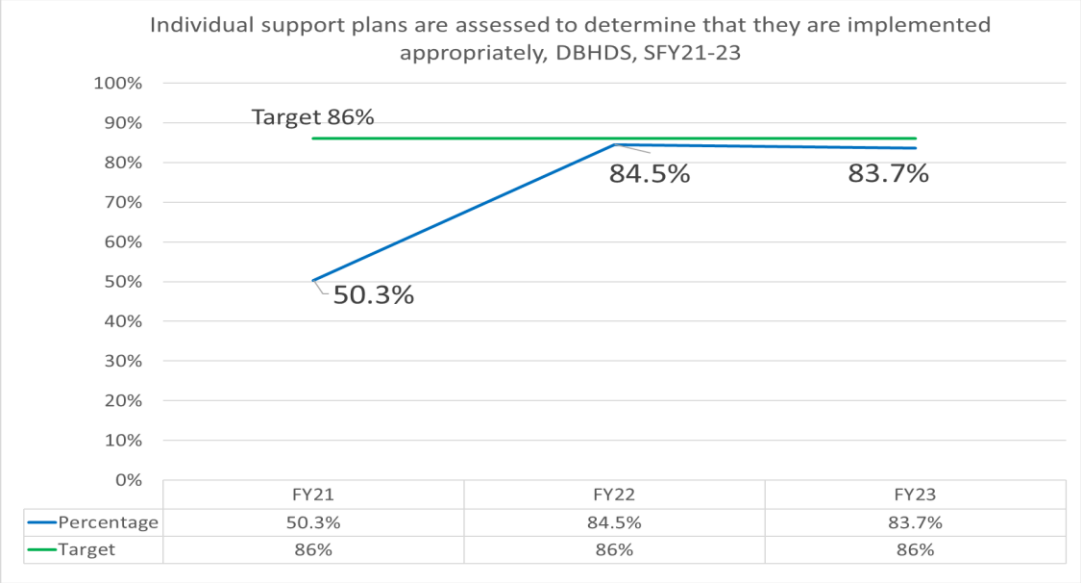
There were a wide variety of reasons why this target was not achieved. These reasons included but are not limited to difficulty locating a primary care physician, accessibility of the medical office, anxiety and fear of medical encounters, transportation, and for some, a support person / advocate to accompany them during the process. To address these issues and promote annual physical exams through education and outreach, the following activities were completed:

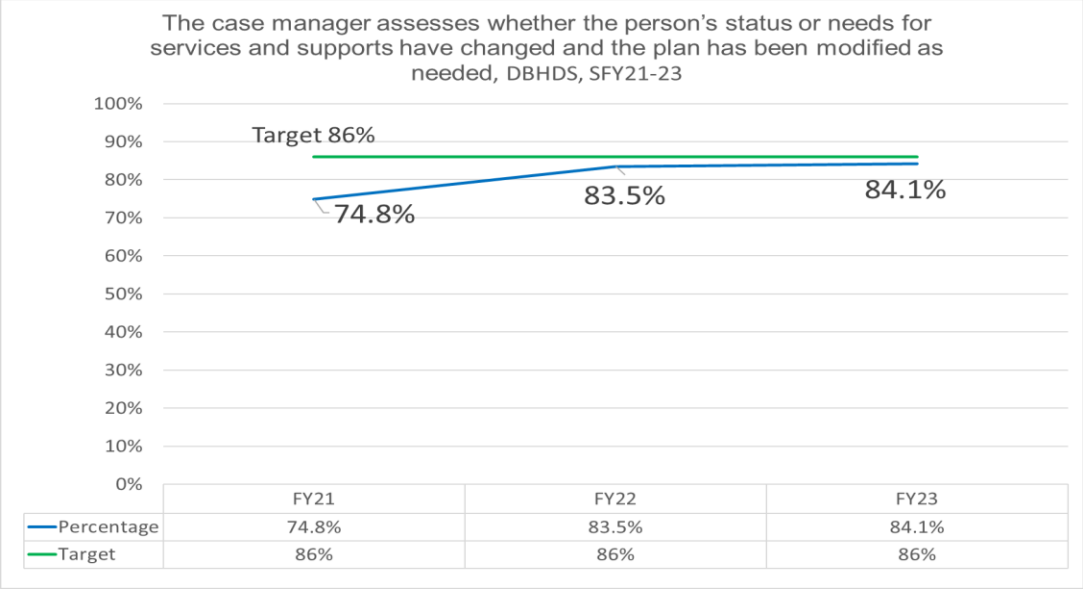
- In November 2022, OIH posted the DMAS cardinal care overview, to assure viewers were aware of upcoming changes.
- In February 2023, the Health Trends Newsletter main topic was Cardinal Care and the "Annual Exams Health and Safety Alert" were both posted to the OIH webpage and shared on the DD ListServ.
- Annual Healthcare Visit Toolkit was posted to DBHDS OIH website (scroll to Educational Resources then to The Annual Healthcare Visit Toolkit) that included a variety of components that can assist individuals, and caregivers to advocate and prepare for healthcare exams.

During SFY23, a data calculation issue was discovered, which resulted in an undercounting of individuals who received annual physical exams. The PMI methodology was corrected, and the data process revalidated. Data reporting using the corrected methodology will begin in SFY24.

Case Management Measures

The charts below provide results as reported by CSBs in the SFY23 SCQR submitted results. The results for both measures showed positive results in compliance despite falling just short of the targets. Both Indicator 9 (related to *Services Being Appropriately Implemented PMI*) and indicator 10 (related to *Assessing for Changes in Status and Modifying Plans PMI*) maintained performance at 84% success Substantial agreement in the look-behind and interrater review during SFY23 provides increased confidence in the reliability of these results.



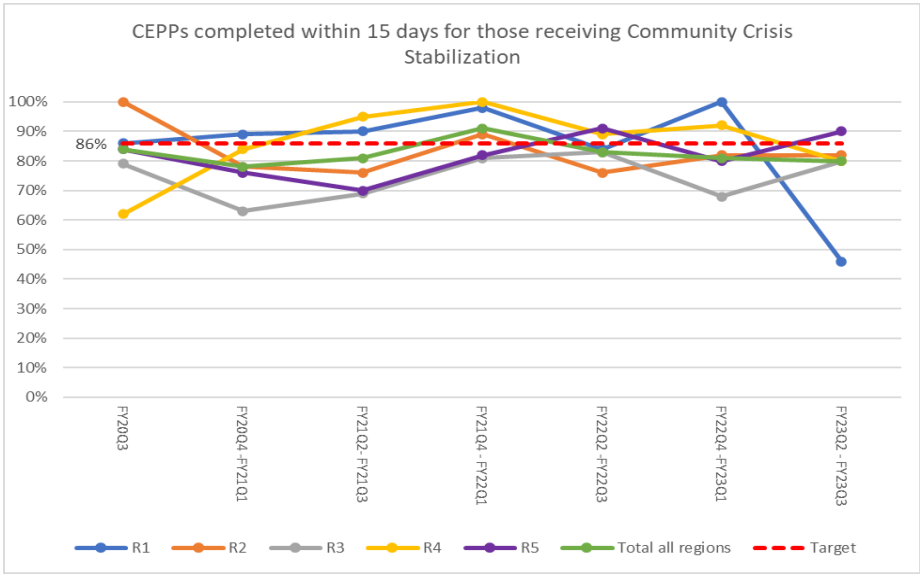


The Division of Crisis Services (DCS) collected the data presented in the table below. The KPA Workgroups provide oversight, and monitor, and analyze the data. A synopsis of the Commonwealth's progress towards the achievement of this PMI in the domain of avoiding crisis is detailed below.

Performance Measure Indicator – Avoiding Crisis	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY23 Results	SFY23 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%	Q1 81% Q3 80%	**Partially Met**

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

For the *CEPPs Completed within 15 days* PMI, REACH noted that individuals tend to drop out before the Crisis Education and Prevention Plan (CEPP) can be completed, which impacted this PMI's performance. It was also noted that the data shown here is reported at six-month intervals, with the first reporting period including the previous year's Q4 data. It was determined that a gap analysis and root cause analysis would be conducted early in SFY24 to understand the variables impacting this PMI more fully, beyond staffing shortages.



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

The Office of Integrated Support Services (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 - Stability	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY23 Results	SFY23 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%	17%	**Partially Met**
Individuals have stability in the independent housing setting.	86%	**	**	97%	92%	99%	**Fully Met**

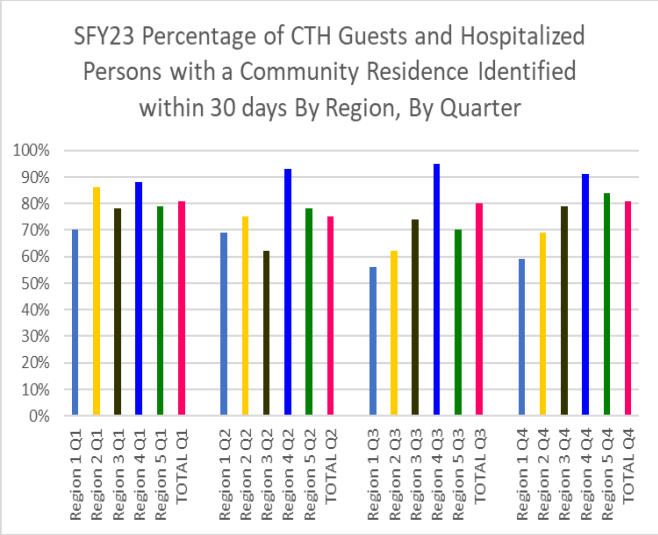
Performance Measure Indicator - Stability	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY23 Results	SFY23 Performance Assessment
Individuals with a DD waiver and known to the Reach system who are admitted to Crisis Therapeutic Home (CTH) facilities will have a community residence identified within 30 days of admission.	86%	84%	90%	78%	84%	79%	**Partially Met**

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

Employment Stability has been consistent over the past several years. The KPA Workgroup decided that they would prefer to report on stability for those who are employed and not stability based on the entire target population. This will change in SFY24.

The *Independent Housing* PMI continues to perform above target. It was noted that the PMI methodology may inadvertently not include everyone that should be. This will be addressed in SFY24. An opportunity to discuss housing with populations at risk for instability in housing was identified.

The *CTH to Residence* PMI was impacted primarily by staffing shortages. PMI performance was also impacted by the number of individuals admitted to CTH and to psychiatric hospitals. REACH continued to see an increase in those being admitted or referred to CTH with increased acuity level. REACH looked at each region and determined that there were unique factors influencing the PMI's performance, which were beyond REACH's ability to impact. A gap analysis and root cause analysis are planned for early 2024 to further understanding and to identify where additional actions to improve can occur. The chart shown here depicts the regional and statewide totals for performance.



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	SFY23 Results	SFY23 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%	100%	**Fully Met**
Individuals participate in an annual	86%	**	**	83%	90%	90%	**Fully Met**

Performance Measure Indicator – Choice and Self-Determination	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY23 Results	SFY23 Performance Assessment
discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff).							
Individuals are given choice among providers, including choice of support coordinator, at least annually.	86%	**	**	78%	78%	SCs 83% Providers 93%	**Partially Met**

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

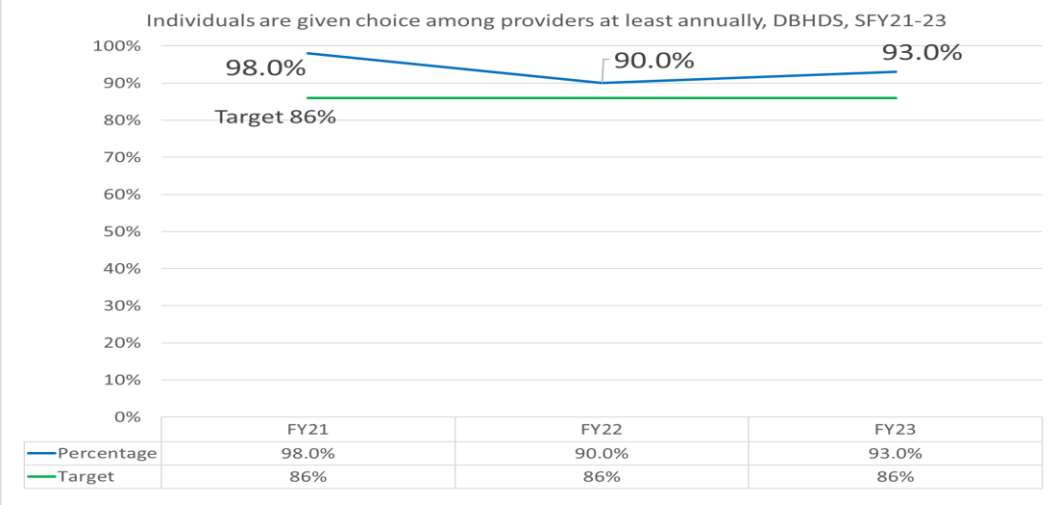
Performance with *Housing Choice* PMI has been consistently above target for three years.

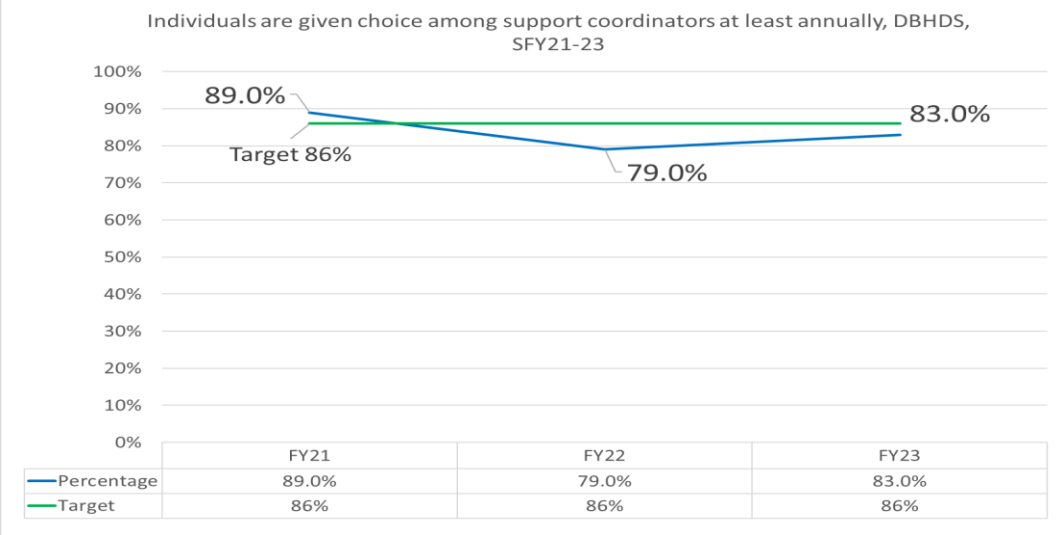
Case Management Measures

The measure related to *Relationships Discussion* was fully met in SFY23 at 90%. This is the second year in a row that target has been met.

The measure on *Provider and SC Choice* was divided into two results in SFY23 instead of one combined result. This change provided the opportunity to track SC choice and provider choice individually. With this change, the target was fully met for providers at 93% and partially met for SCs at 83%, so the overall result was partially met. The CMSC added clarified instruction to the Virginia Informed Choice (VIC) form available on the DBHDS website and submitted a change

request to WaMS Administration to ensure that the SC first and last names are added to the VIC. The charts below provide results as reported by CSBs in the past three years of the SCQR.



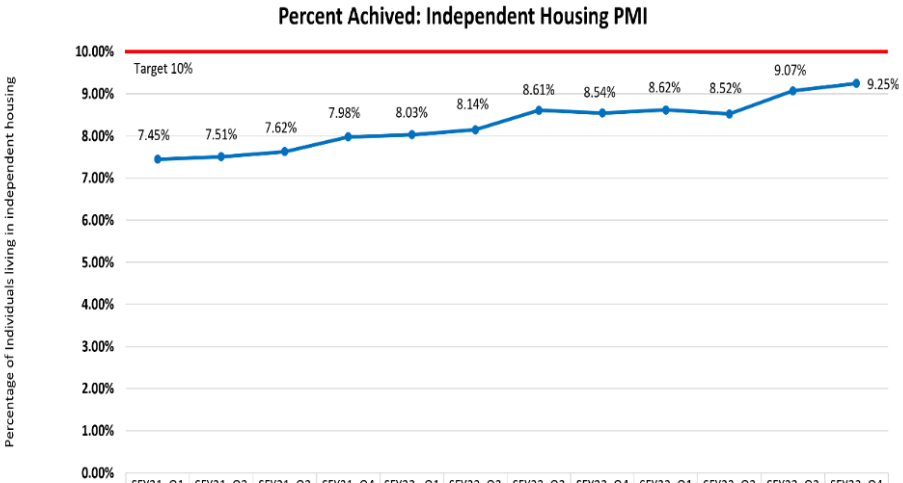


Performance Measure Indicator – Community Inclusion	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY23 Results	SFY23 Performance Assessment
Individuals live in independent housing	10%	5%	7%	8%	8%	8.87%	**Partially Met**
Individuals aged 14-17 who are receiving waiver	86%	**	**	37% (derived from	31%	53%	**Not Met**

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.				May and June 2021 data)			
86% of providers demonstrate a commitment to community inclusion by demonstrating actions that lead to participation in community integration activities (Using the QSRs, providers report on number who promote meaningful work, promote individuals participating in non-large group activities, and encourages participation in community outings with people other than those with whom they live.)	86%	**	**	**	**	**Round 4:** PQR: a. 97% b. 97% c. 98% PCR d. 89% e. 95% f. 24% g. 26% **Round 5** PQR a. 93% b. 96% c. 96% PCR d. 87% e. 92% f. 12% g. 28%	**Fully Met**

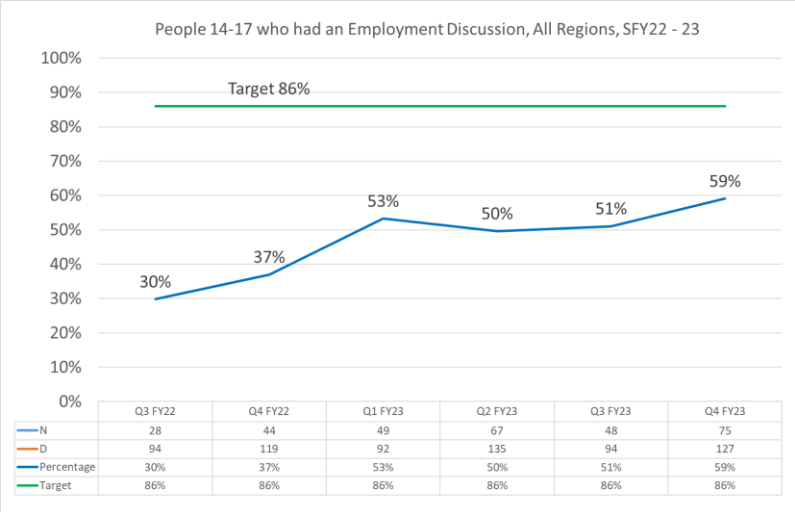
**The PMI was not approved for that SFY, thus the absence of data.
PQR a. promotes meaningful work
PQR b. promote individuals participating in non-large group activities
PQR c. encourages participating on community outings with people other than those with whom they live
PCR d. Did support coordinator discuss employment goals and options with the individual?
PCR e. Did support coordinator discuss integrated day opportunities with the individual?
PCR f. Do you have a job? Do you want one?
PCR g. Would prefer to do something else during the day?

Independent Housing PMI inched close to target and is simply a matter of time to reach target. One factor that influenced the results included how the PMI was calculated (based on the number living independently in the quarter), as well as affordable housing availability. It was noted that housing costs had increased over 40% during the year and had not yet significantly decreased. DBHDS will be looking at how we might revise calculations for this measure to assess more accurately those living independently long term. This chart shows the steady increase in the number of individuals living independently.



	SFY21_Q1	SFY21_Q2	SFY21_Q3	SFY21_Q4	SFY22 _Q1	SFY22_Q2	SFY22_Q3	SFY22_Q4	SFY23_Q1	SFY23_Q2	SFY23_Q3	SFY23_Q4
Percent Achived	7.45%	7.51%	7.62%	7.98%	8.03%	8.14%	8.61%	8.54%	8.62%	8.52%	9.07%	9.25%
Numerator	1470	1512	1562	1654	1689	1732	1806	1807	1860	1872	2023	2084
Denominator	19,738	20,145	20,488	20,737	21,039	21,268	20,978	21,153	21,582	21,962	22,305	22,536

The *Teen Employment Discussions* PMI increased to 51% and 59% in quarters three and four of SFY23 respectively with 59% being the highest result seen to date. ISP refinements to improve data collection for this measure, made in May 2022, contribute to the improved results. The upward trend in performance is seen here.



	Q3 FY22	Q4 FY22	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	28	44	49	67	48	75
D	94	119	92	135	94	127
Percentage	30%	37%	53%	50%	51%	59%
Target	86%	86%	86%	86%	86%	86%

The *Provider Reporting Measure Community Inclusion* PMI focuses on providers promoting community inclusion and integration. This PMI used QSR data and was determined to be met in both Rounds 4 and 5. Although met, an opportunity to revisit the wording of the QSR Person Centered Review (PCR) questions was identified to look for opportunities to better understand

whether individuals are truly having the opportunity to participate in meaningful community inclusion opportunities. This opportunity will be considered for QSR Round 6 PCR questions.

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 Office of Provider Development (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	SFY23 Results	SFY23 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%	2.3%	**Fully Met**
Data continues to indicate that at least 90% of individuals new to the waiver, including	90%	**	85%	87%	95%	95%	**Fully Met**

Performance Measure Indicator – Access to Services	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY23 Results	SFY23 Performance Assessment
individuals with a "supports need level" of 6 or 7, since FY16 are receiving services in the most integrated setting.							
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%	**Round 4** 94% **Round 5** 77%	**Partially 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%	56%	**Not Met**
Adults (aged 18-64) with a DD waiver receiving case management services from the CSB whose ISP,	50%	32%	30%	28%	26%	26%	**Not Met**

Performance Measure Indicator – Access to Services	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY23 Results	SFY23 Performance Assessment
developed, or updated at the annual ISP meeting, contains employment outcomes, including outcomes that address barriers to employment.							
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%	60%	**Not Met**

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

The *Services in Most Integrated Settings – Overall* measure was met for the first time in SFY23 with a 2.3% increase. Regarding *Services in Most Integrated Settings – New* PMI, we continued to see two consecutive years of 95% or better performance, which is above the 90% target.

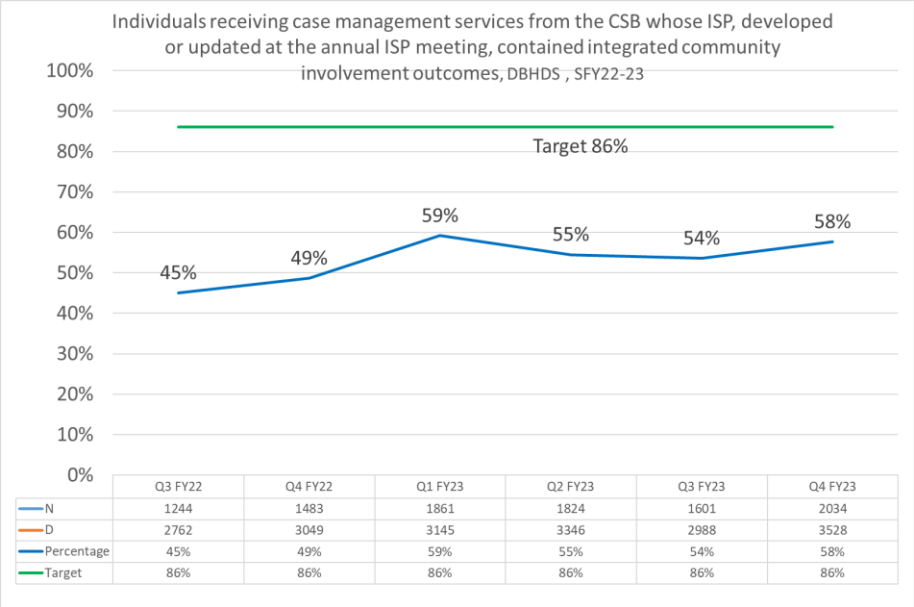
The *Transportation* PMI performance decreased from the previous year as Round 5 did not include 'could not determine (CND)' responses in the calculation. Round 4 results only included yes/no responses and did not account for CND responses. In reviewing Round 5 results, the KPA Workgroups identified that more information was needed for CND responses. It was determined that CND responses should not be included in the overall performance for this PMI for Round 5. Round 5 results as reported above only include yes responses. Table 2 below shows a comparison between Round 4 and Round 5.

Table2

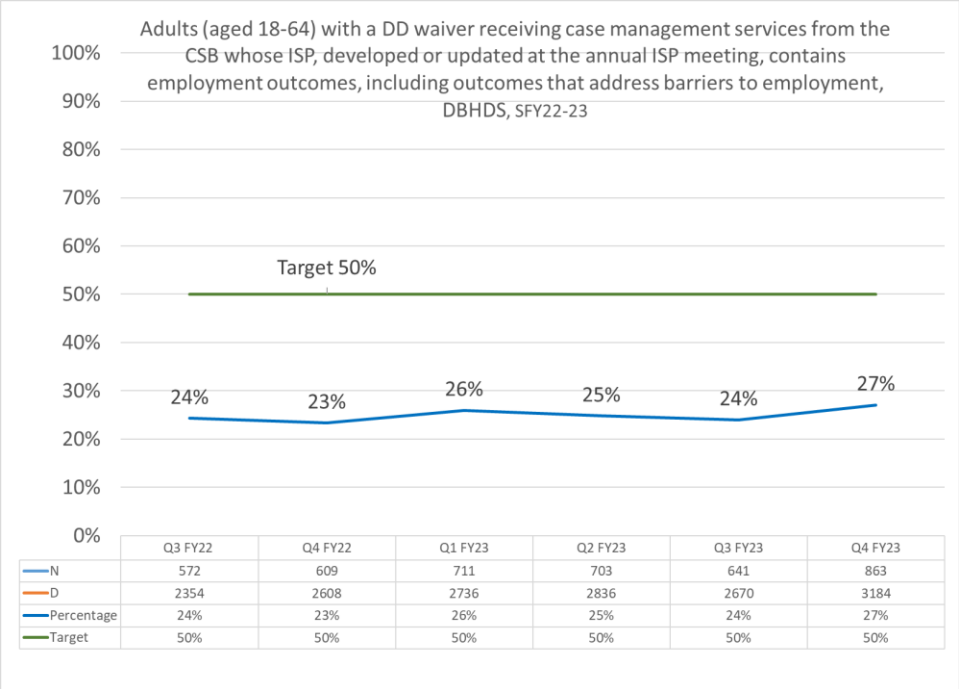
Round	How many people interviewed	Does Your Provider Take You			Can You get Where you Want to Go Without Problems	Provider takes them without problems	Percent who get where they want w/o problems	Percent who got where they wanted without problems +CND
		Yes	No	CND	Answered No- when answer to previous question was Yes	# who answered yes		
Round 4	417	339	4	74	16	323	77%	95%
Round 5	456	376	8	72	19	357	78%	94%

Case Management Measures

As shown below, the *Integrated Community Involvement* measure continued to be consistently below target across SFY22 and 23, though a slight upward trend is evident moving from 45% to 58% over time. The focus of this measure remained on community involvement at a ratio of no more than one staff to three individuals regardless of the service utilized.



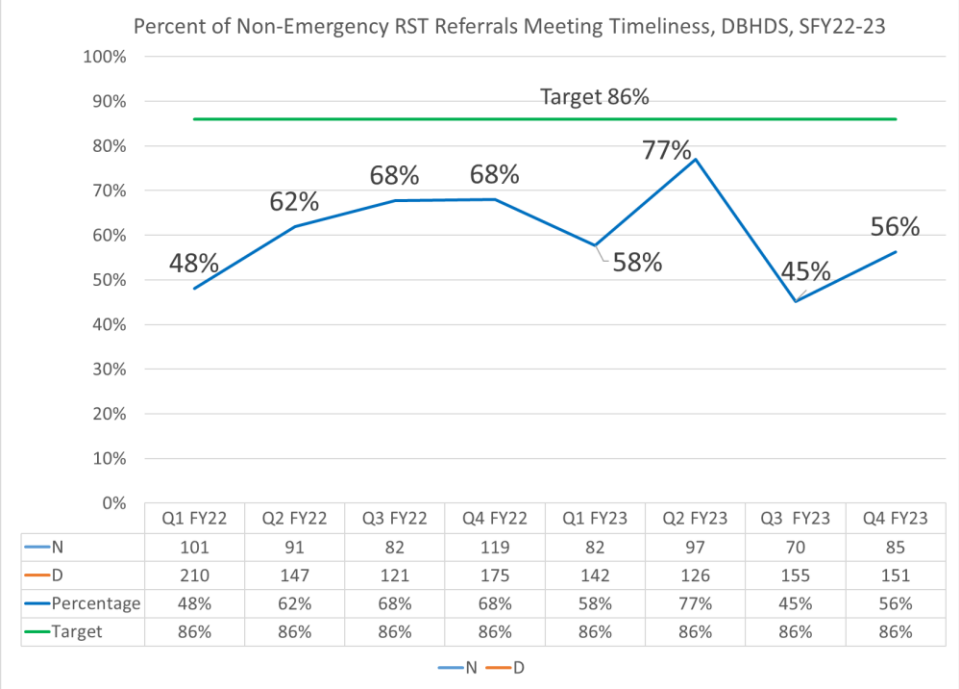
The *Employment Discussions* measure remained consistently below target, as shown here.



	Q3 FY22	Q4 FY22	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	572	609	711	703	641	863
D	2354	2608	2736	2836	2670	3184
Percentage	24%	23%	26%	25%	24%	27%
Target	50%	50%	50%	50%	50%	50%

Related elements in the Individual Support Plan were refined in May 2022 to improve the collection of data around employment topics, which positively impacted the results. There have been several QIIs implemented over the years targeting employment discussions with limited, sustained impact. CSB staffing shortages continued to impact both the Integrated Community Involvement and Employment Discussions measures.

On January 1st, 2023, DBHDS moved the RST process into the Waiver Management System (WaMS). The first RST WaMS module overview sessions occurred on October 27th, 2022, in preparation for the transition to WaMS. This recorded session, available on the DBHDS website, showed the features and process of using the RST referral form and associated Virginia Informed



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	101	91	82	119	82	97	70	85
D	210	147	121	175	142	126	155	151
Percentage	48%	62%	68%	68%	58%	77%	45%	56%
Target	86%	86%	86%	86%	86%	86%	86%	86%

Choice (VIC) form. Overall, the launch of the module was considered successful. By January 20th, 2023, needed enhancements were identified and requested to improve the system. SFY23 Q4 results for the *RST Timeliness* PMI were pulled exclusively from the new system and process. This transition and a related QII have increased the CMSC's ability to understand variations in data from quarter to quarter.

OHR, HSAG (QSR vendor), 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**	**SFY23 Results**	**SFY23 Performance Assessment**
Critical incidents are reported to the Office of Licensing within the required timeframe (24 hours).	86%	93%	92%	95%	96%	96%	**Fully Met**
Percentage of licensed providers, by service, that were determined to be compliant with 100% of the risk management regulations that were able to be reviewed during their annual inspections.	86%	**	**	**	61%	56%	**Not Met**

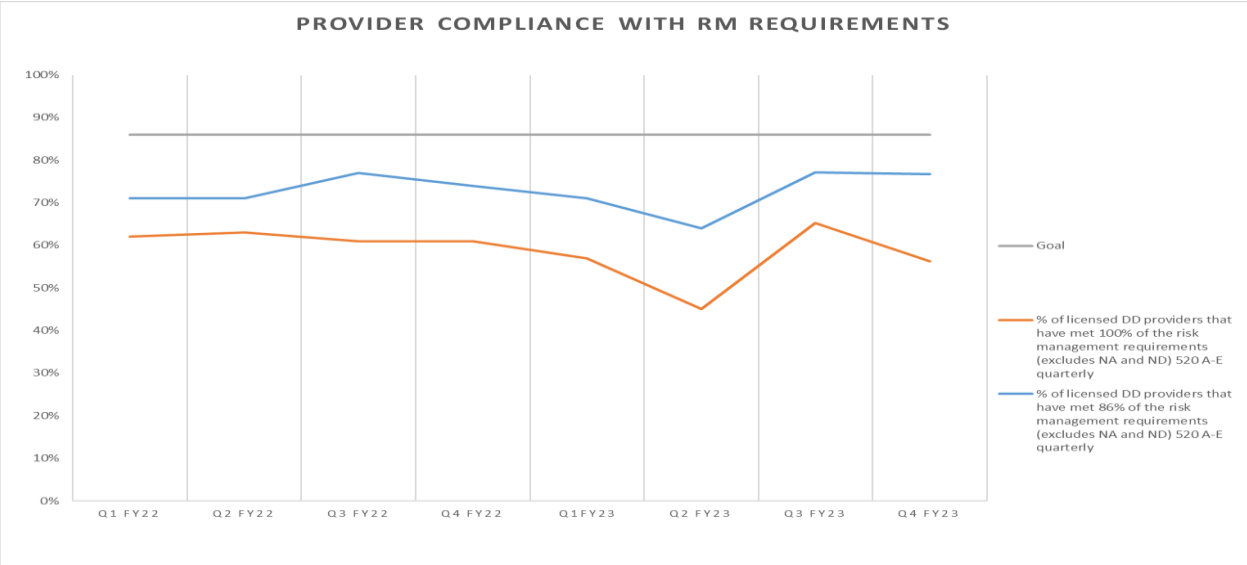
Performance Measure Indicator – Provider Capacity	Target	SFY19 Results	SFY20 Results	SFY21 Results	SFY22 Results	SFY23 Results	SFY23 Performance Assessment
86% of licensed DD providers, by service, that were determined to be compliant with 100% of the quality improvement regulations assessed during an annual inspection.	86%	**	**	**	52%	56%	**Not Met**
People with DD waiver are supported by trained, competent Direct Support Professionals (DSPs).	95%	**	**	78% Training 60% Competencies	Round 3 92%	**Round 4**: 85% 91% **Round 5**: 78% 85%	**Not Met**

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

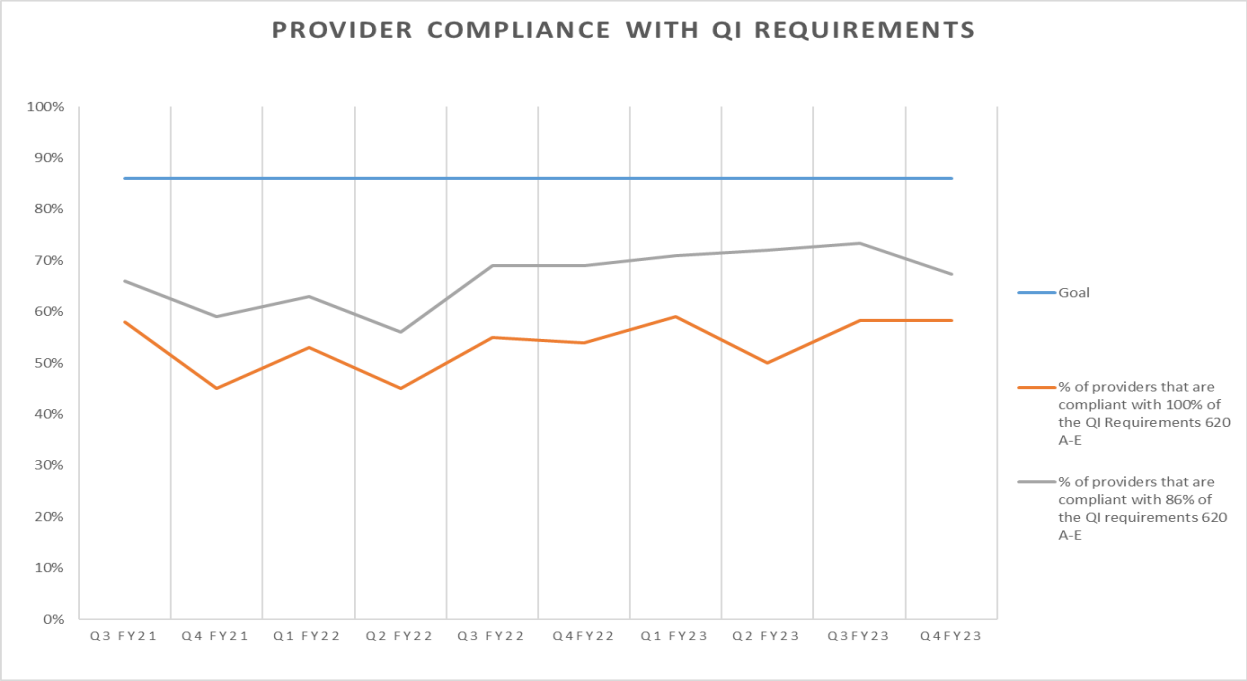
The *Incidents Reported within 24 Hours* PMI has continued to be above target since SFY2019. Each reported incident was reviewed by the Office of Licensing Incident Management Unit (IMU) and health and safety concerns were followed up by the IMU, a licensing specialist, the Office of Integrated Health, or the Office of Human Rights. Providers that did not report within 24 hours were issued citations and required to develop a corrective action plan.

For the *Compliance with RM Regulations and Compliance with QI Regulations* PMIs, most providers met the requirements to implement risk management or quality improvement programs, with slightly over half of providers meeting all the requirements. The Office of Licensing provided annual training to providers on the expectations for risk management and quality improvement programs and examples of what is needed to meet these requirements.

However, despite the annual training, overall compliance with these requirements remained low. To address this, the RMRC partnered with RQC5 to implement a quality improvement initiative aimed at improving provider compliance with the risk management requirements. A root cause analysis, which included key informant interviews identified several avenues for improvement, including development of tools and resources, the need for more in-depth training and technical assistance, as well as the need for providing additional training for licensing specialists. A workgroup from the Office of Clinical Quality Management, Office of Licensing, and members of RQC5 collaborated to develop in depth training and tools on risk management processes, including tracking and trending incidents, and conducting a root cause analysis. The following graphs and charts show the performance of these PMIs.



Measure	Regula	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22	Q1FY23	Q2 FY23	Q3 FY23	Q4 FY23
Goal		86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
Designated person with training or experience responsible for risk management function	520A	80%	75%	75%	76%	81%	78%	72%	66%	90%	80%
Implements a written plan	520B	90%	88%	91%	87%	86%	87%	88%	89%	90%	84%
Conducts annual systemic risk assessment	520C	90%	83%								
- environment of care	520C1	89%	82%	84%	77%	90%	88%	83%	79%	89%	87%
- clinical assessment/reassessment	520C2	86%	75%	80%	77%	88%	84%	80%	80%	84%	87%
-staff competence / adequacy of staffing	520C3	88%	75%	79%	77%	90%	85%	82%	80%	83%	85%
- use of high risk procedures	520C4	86%	73%	79%	74%	87%	82%	80%	74%	85%	84%
- review of serious incidents	520C5	90%	80%	83%	83%	91%	87%	83%	83%	89%	86%
Systemic risk assessment incorporates risk triggers and thresholds	520D	88%	71%	76%	83%	79%	76%	75%	68%	85%	78%
Conducts annual safety inspection	520E	93%	87%	92%	82%	89%	95%	92%	91%	97%	95%

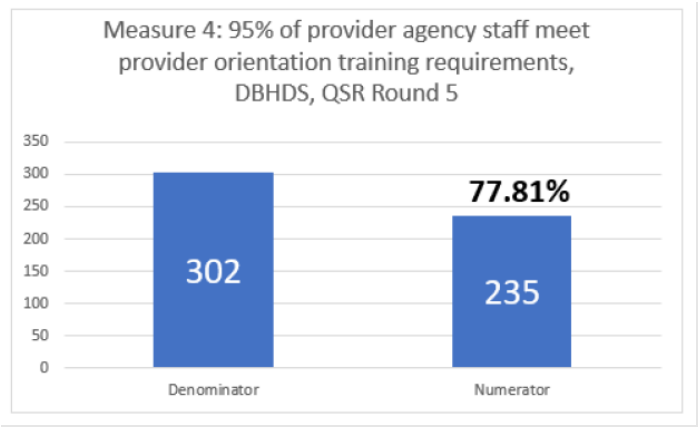


Measure		Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4FY22	Q1 FY23	Q2 FY23	Q3FY23	Q4FY23	CY2021	CY2022
Goal		86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	620A	90%	91%	94%	93%	93%	94%	94%	94%	93%	94%	89%	91%
The QI program uses standard QI tools, including RCA and has a QI plan	620B	90%	85%	92%	92%	93%	93%	92%	89%	91%	88%	87%	89%
The QI Plan shall:	620C	93%	90%									92%	
- Be reviewed and updated annually	620C1	83%	78%	82%	71%	84%	86%	84%	89%	89%	87%	80%	81%
- Define measurable goals and objectives	620C2	81%	75%	80%	74%	80%	86%	81%	84%	89%	82%	77%	78%
-Include & report on statewide measures	620C3	92%	71%	92%	94%	88%	94%	89%	100%	100%	70%	84%	87%
- Monitor implementation & effectiveness of approved CAPs	620C4	76%	70%	79%	67%	72%	78%	79%	79%	80%	77%	73%	75%
- Include ongoing monitoring and evaluation of progress toward meeting goals	620C5	79%	76%	81%	71%	76%	82%	82%	81%	87%	82%	77%	78%
The providers P&P includes criteria used to:	620D	88%	86%									87%	
- Establish measureable goals & objectives	620D1	78%	72%	75%	73%	84%	84%	88%	86%	84%	82%	75%	74%
- Update the QI plan	620D2	76%	73%	79%	70%	89%	86%	86%	90%	90%	88%	74%	74%
- Submit revised CAPs when not effective	620D3	68%	63%	68%	66%	77%	78%	79%	75%	81%	75%	65%	65%
Input from individuals about services & satisfaction	620E	81%	77%	85%	86%	78%	81%	87%	80%	92%	89%	79%	81%

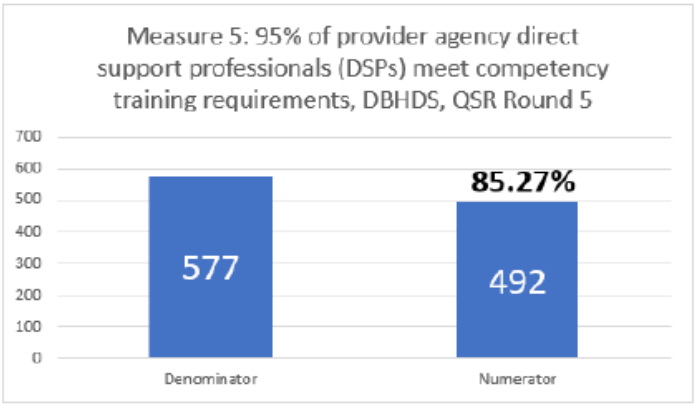
Two measures were used to determine success with the *Direct Support Professionals Competency* PMI. Both measures needed to show performance at or above 95% to fully meet the target. The method for calculating these measures was refined and validated in SFY23 making comparison

to past reports less reliable. The SFY23 Round 5 results for both measures are reported below, including measure language.

- 95% of provider agency staff meet provider orientation training requirements. Two hundred and thirty-five of 302 provider quality reviews (PQRs) did not have an alert for competency issues, which provided the result of 77.81% for Round 5 of the Quality Services Reviews. At 78% rounded, measure not met.



- 95% of provider agency direct support professionals (DSPs) meet competency training requirements. Four hundred and ninety-two of 577 PCRs did not have an alert for competency issues, which provide the result of 85.27% for Round 5 of the Quality Services Reviews. At 85% rounded, measure not met.



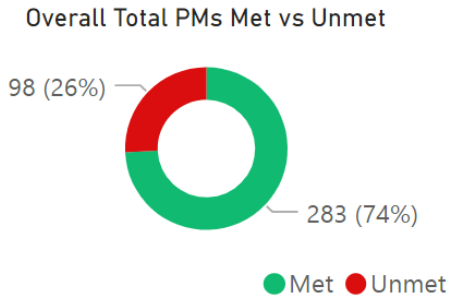
HCBS Quality Management

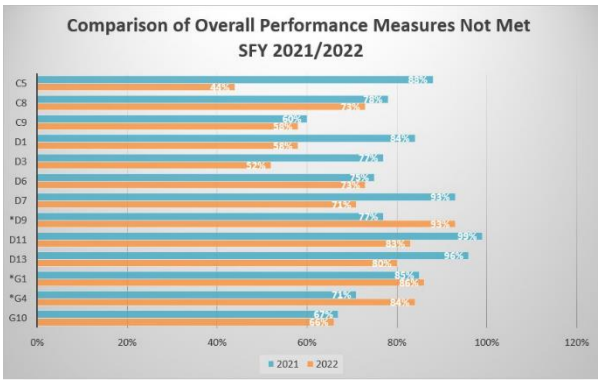
All states operating a 1915(c) Home and Community Based Services (HCBS) Medicaid Waivers program must annually report waiver performance under Center for Medicare and Medicaid Services (CMS) required assurances. The CMS assurances and related sub-assurances are built

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 SFY22. For a description of the PMs, refer to the [SFY22 QRT End of Year Report.]

The charts shown here reflect the overall findings of the PMs as well as compares individual results for SFY21 and SFY22. In SFY22, 74% of PMs met compliance; 26% (11) did not. Two PMs determined to be non-compliant in SFY21 met compliance in SFY22. Eight PMs remained non-compliant in SFY21 as well as in SFY22. Three new PMs were determined non-compliant in SFY22. While the specific PMs that did not meet compliance varied from SFY21 to SFY22, the overall total number of PMs not met remained similar in both years.





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. Implemented QIIs

related to Preventive Screenings, Supports Intensity Scale (SIS) Level and RM contained activities that worked towards remediation and targeted the area of need. All waiver PMs were tracked for compliance with CMS reporting through the QIC and the statewide DBHDS DD QMP.

Several ongoing systemic barriers to compliance were identified. First, comprehensive provider contact information was not readily accessible. Provider lists were often generated via a combination of DBHDS licensing data, DMAS billing data, and information voluntarily submitted through other electronic systems and platforms. Further, there was no universal location for accessing provider contact information or statewide mandate or regulatory requirement for providers to update their contact information. Providers contact information was likely to be reported differently in each department or electronic platform. Therefore, essential information delivered by the state reached only a fraction of the intended population. DMAS continues their commitment to developing an ongoing comprehensive listing of provider contacts (including non-licensed providers) that will serve multiple uses statewide, including as a statewide information dissemination tool. Second, disengaged DD waiver providers (non-licensed providers) were less likely to be familiar with the requirements, resulting in an increased likelihood of non-compliance for any PM. Community Resource Consultants work to reinvolve these providers; however, their participation is voluntary. Third, Quality Management Reviews, conducted by DMAS, allowed for different providers to be sampled each quarter, increasing the likelihood of non-compliance for any PM. 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. Fourth, which has been identified for several years, was the data reporting capability. This issue is two-fold. The first part involves the sample size reviewed each quarter and how that sample is shown in the data. The second part relates to the timely receipt of data. In mid-2022, a new automated QRT app was developed to help automate QRT data collection, monitoring, analysis, and presentation. Struggles and technical issues with the new QRT app provided some setbacks in accurately reflecting differences between certain PMIs. DMAS plans to assume responsibility for future QRT data, facilitation of meetings, and data reports beginning in SFY24. DBHDS and DMAS, through QRT, began discussion on utilizing the review of supplemental data as surveillance data and potentially substituting existing data source systems data with the supplemental data in the 2023 waiver renewal.

Support Coordination Quality Reviews

During SFY23 of the SCQR process, CSBs completed 100% of the online survey forms for those included in the sample. DBHDS continued to adjust the SCQR tool and technical guidance, which resulted in improved data reliability between the second and third year of implementation.

SFY23 improvements provided clarity about expectations for each element assessed and provided a designated location for holding information so that results could easily be found. ISP adjustments were made to provide locations for information assessed through the SCQR where no location previously existed. The table below compares results from SFY21 to SFY23, which demonstrates improvements since the last report. Red font indicates result is below the target of 86%.

Indicator	**SFY21 CSB Reported Compliance**	**SFY22 CSB Reported Compliance**	**SFY23 CSB Reported Compliance**
Old Indicator 1	88%	92%	
Old Indicator 2	78%	78%	
…support coordinator? (named) [New Indicator 1]	89%	79%	83%
…DD waiver providers? [New Indicator 2]	98%	90%	93%
Indicator 3	83%	40%	54%
Indicator 4	85%	82%	88%
Indicator 5	100%	100%	100%
Indicator 6	69%	87%	84%
Indicator 7	92%	84%	89%
Indicator 8	93%	98%	99%
Indicator 9	50%	85%	84%
Indicator 10	75%	84%	84%
Records with either 9 or 10 indicators in compliance	**42%**	**53%**	**64%**

Indicators:

• Indicator 1: The CSB has offered each person the choice of case manager. (III.C.5.c) *

• Indicator 2: Individuals have been offered a choice of providers for each service. (III.C.5.c)

• Indicator 3: The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable. (III.C.5.b.i; III.C.7.b)

• Indicator 4: The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served. (III.C.5.b.i; III.C.5.b.ii)

• Indicator 5: The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individual's needs. (III.C.5.b.iii; V.F.2)

• Indicator 6: The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences. (III.C.5.b.ii; V.F.2)

• Indicator 7: The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team. (III.C.5.b.ii; V.F.2)

• Indicator 8: The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary. (III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)
• Indicator 9: The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences. (III.C.5.b.iii; V.F.2)
• Indicator 10: 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. (III.C.5.b.iii; V.F.2)
* In previous years, Indicator 1 considered if the SC provided required signatures; however, this indicator was revised in the SFY23 cycle to separate two elements that were combined in Indicator 2. The two elements are now established as Indicator 1 and two for CM choice and provider choice respectively.

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 4 occurred July 2022 – December 2022. The review period covered July 1, 2021 – April 30, 2022. Three hundred and sixty PQRs and 720 PCRs were completed in Round 4. Round 5 occurred March 2023 – July 2023, with the record reviews, interviews and observations completed between March and June 2023. The review period covered May 1, 2022 – December 31, 2022. Three hundred and twenty PQRs and 720 PCRs were completed in Round 5.

PQR and PCR tools were reviewed and criteria for assessing each element was revised for both Rounds 4 and 5. Additional questions were added in Round 5 to help further tell the story of the quality of services provided.

For additional information on the aggregate reports, please visit Developmental Services website and click on QSR.

A quality improvement plan (QIP) was required of both CSBs and providers for any element found to be <90% compliance. HSAG (QSR vendor) provided a QIP template for use and technical assistance upon request. This table compares the number of CSBs and licensed providers who required a QIP to those who did not for Rounds 4 and 5.

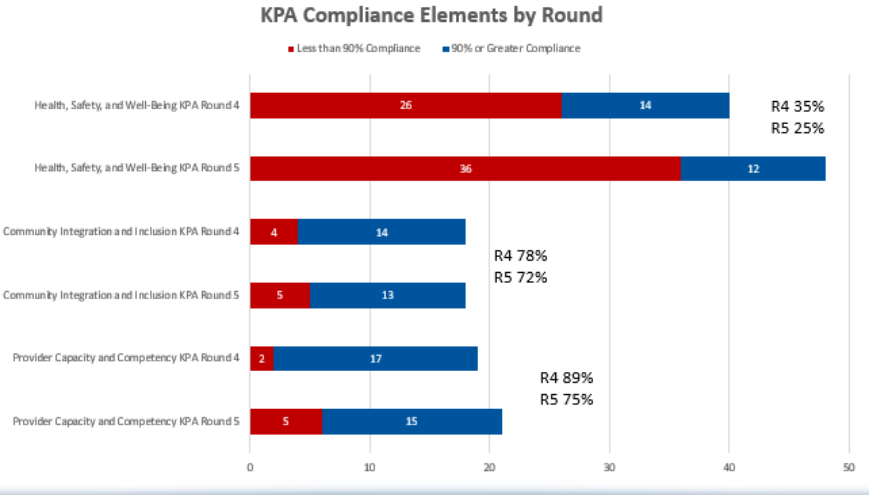
Community Service Board QIP Results

QSR Round	CSBs (PQR & PCR)	CSBs (PQR only)	QIP Required	QIP not required
4	20	20	37 (93%)	3 (7%)
5	20	19[1]	39 (100%)	0

[1]*One CSB did not participate in the review due to no individuals in the random selection for review associated with CSB.*

Licensed Providers QIP Results

QSR Round	Licensed Providers	Closed/non-responsive	QIP Required	QIP not required
4	340	43 (13%)	211 (62%)	86 (25%)
5	300	18 (6%)	257 (86%)	25 (8%)



The QSR tools structured the elements according to the same KPAs utilized by DBHDS. This aided in reporting, discussion of performance, and in the identification of quality improvement opportunities. This chart portrays the number of elements per KPA that met compliance and those that did not for Rounds 4 and 5. As both elements and criteria for assessing compliance changed between rounds and new elements added for Round 5, this impacts the results for Round 5.

National Core Indicators

The National Core Indicators (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. The subcommittees identified how they used NCI data during the year.

- The RMRC delved into the risk related data from the NCI 2021-2022 In-Person Survey. They met with VCU's Partnership for People with Disabilities to talk more in depth about the survey construct of risk related questions.
- The MRC reviewed the 2021-2022 NCI In-Person Survey health data that related to QIIs being implemented by the MRC and utilized NCI data in the development of QIIs, as appropriate. NCI data may be referenced during discussions related to potential QIIs or in furthering understanding of reported health conditions impacting Virginians with DD.
- CMSC referenced NCI data when looking at potential support issues such as SCs connecting people to natural supports Through the QI KPA Identification exercise, CMSC identified additional areas where NCI data could be used to explore ideas and make comparisons to other data sets.
- NCI data was used for tracking success with one surveillance measure reported through the Provider Data Summary on a semi-annual basis: at least 75% of people with a job in the community chose or had some input in choosing their job. As of May 2023, the Virginia average was reported at 92%, which is above the 75% target for this measure.
- The KPA Workgroups used NCI data as part of its surveillance data reviews that accompany PMI data reviews. NCI data was compared to QSR and SCQR data and discussed when variances between results were noted. The KPA Workgroups developed a NCI data work group that regularly met with VCU Partnership for People with Disabilities to further understanding of NCI data, how VCU uses NCI data, and to identify opportunities to further DBHDS' use of NCI data.
- RQC2 and RQC5 identified an area within the Medications chapter of the 2021-2022 NCI In Person Survey that they wanted to explore further (use of medication without a mental health diagnosis noted in their record). After an initial discussion with VCU Partnership for People with Disabilities, they recommended to the QIC that a focus group be formed to delve into this topic.

Quality Improvement Initiatives

This summary details the QIIs implemented and proposed by the QIC subcommittees during SFY23. Twenty-two QIIs were implemented during SFY23, with twenty-one carried over from previous years. Nine were approved on 6.26.23 and were noted as not yet implemented. Three QIIs were completed and four were abandoned. Three were proposed and not approved. The current process in identifying and developing an initiative to propose to the QIC, along with the existing QIIs in implementation continued to tax resources as several offices support multiple

QIIs in different subcommittees. There were competing priorities in offices that impacted the implementation of the QIIs.

Throughout this section, for each KPA, the QIIs will be represented in a chart format. After each chart, a listing of completed activities will be shown, including any results.

Health, Safety and Wellbeing KPA:

Problem to be Addressed	QII Focus	QII Status	Assigned Subcommittee
Limited number of dentists accepting Medicaid, access to dental care and documentation of annual dental exams	To ensure that 86% of individuals receiving DD waiver services have good oral health through receiving an annual dental exam	Abandoned 7.28.22	KPA Workgroups
# of deaths caused by cancer is rising for individuals with DD. It is not always known if any an individual received preventive screenings.	To improve the percentage of IDD individuals receiving preventive screenings (mammogram, Pap smear, colonoscopy) reported through the NCI In-Person Survey	Continuing	MRC
There is no frailty data collected; assessment of decedent's needs or change in status is a major factor attributed to potentially preventable deaths.	To collect baseline data to inform if a frailty tool could be used as a predictor of mortality.	Abandoned 1.23.23	MRC
COVID-19 is a risk factor for high-risk individuals with DD.	To decrease the COVID-19 mortality rate in the IDD waiver population to <10%	Completed 4.24.23	MRC
Falls/trips are the most common reported cause associated with a serious incident in CHRIS.	To reduce the rate of falls reported as a serious incident	Completed April 2023	RMRC
It is important to maintain a reduced rate of falls for those with DD.	To prevent the rate of falls from returning to pre-COVID levels and "Maintain the Gain".	Continuing	RQC2
Individuals with DD do not receive routine annual dental exams.	To improve the percentage of individuals, enrolled in DD waivers, who receive an annual dental exam to 86%	Continuing	KPA Workgroups

Problem to be Addressed	QII Focus	QII Status	Assigned Subcommittee
Region 4 accounted for the third highest number of reported Urinary tract infections (UTIs) are the third highest number in Virginia for FY21 Q1-FY23 Q2.	To reduce the rate of reported UTIs statewide in the DD waiver population by 5%	Implemented 6.27.23	RQC4
ISPs may not contain identified risks from risk assessment tools or outcomes addressing the identified risk.	To improve the number of ISP assessments and ISP Development and Implementation elements determined to be in compliance by the QSR for CSBs to 90%	Due to be implemented in SFY24	KPA Workgroups
The number of choking deaths has increased over the past four years and choking was the top cause of potentially preventable deaths in SFY22.	To sustain and/or decrease the number of potentially preventable deaths related to choking	Due to be implemented in SFY24	MRC

- ✓ A Health and Safety Alert on annual visits and preventive screenings was released to DBHDS providers that helps providers prepare for annual visits and preventive screenings. It also included which preventive screenings were now included in the DBHDS WaMS system, effective January 2023.
- ✓ A check list, of recommended preventive screenings and vaccinations (for review with health care provider, during medical visit) was included in the Annual Physical Exam Tool Kit.
- ✓ Upon resolution of CHRIS data validity issues, baseline serious incident falls data was updated to 70.85/1,000 waiver population for the period 10/1/19-3/31/20; the Falls QII goal was updated to 63.78/1,000 waiver population.
- ✓ Began development of a Dental Care Toolkit that would help individuals and their caregivers prepare for dental visits.
- ✓ Survey sent to Region 4 providers to identify possible root causes for UTIs

As part of the data reviews and subsequent identification of areas of potential improvement, the QIC subcommittees proposed QIIs throughout SFY23. While most were approved for implementation, several were not. QIIs proposed and not approved included the following areas for improvement: increasing the percentage of annual physical exams noted in the ISP

increasing the knowledge of pica interventions available for providers to improvement when pica has been identified as a risk, behavior supports noted, or when a pica event has occurred, and improving access to dental care as evidenced by the percentage of those receiving annual dental exams improving.

Community Inclusion and Integration KPA:

Problem to be Addressed	QII Focus	QII Status	Assigned Subcommittee
Support Coordinators do not understand what constitutes meaningful employment conversation and developing a goal that reduces barriers to employment/leads to employment.	To ensure that 86% of individuals, ages 18-64, receiving DD waiver services have meaningful employment conversations resulting in employment goal development (to decrease barriers to employment) by March 31, 2022. Currently, 28% of individuals have employment goals; 96% have had documented employment conversations.	Continue	KPA Workgroups
Support Coordinators do not understand what constitutes meaningful community involvement conversation and developing a goal that decreases barriers to community involvement/increases potential community involvement.	To ensure that 86% of individuals receiving DD waiver services have meaningful conversations regarding Community Involvement, that lead to goal development, resulting in an increased potential/to decrease barriers to Community Involvement by March 31, 2022. Currently, 92% of individuals have documented community involvement conversations and 38% have community involvement goals.	Continue	KPA Workgroups
Employment outcomes are not consistently written in ISPs.	By June 2022, increase by 10% the number of individuals in Region 5 aged 18-64 who reported they have an employment outcome in data reported via CCS3 and/or WaMS for Region 5	Abandoned 3.30.23	RQC5
Provider 911 policies and procedures are not utilized appropriately.	The goal is to increase the percentage of adherence to the execution of provider established protocols for	Continue	MRC

Problem to be Addressed	QII Focus	QII Status	Assigned Subcommittee
	medical emergencies to >70% for I/DD individuals residing in DBHDS licensed provider residences, by the end of SFY23 Q3 (March 31, 2023). Baseline 63%		
The utilization of electronic home-based services (EHBS) in Region 1 is at a low rate.	Our goal is to increase the use of Electronic Home-Based Services in Region 1 by 80 percent (which is 10 individuals) to 23 individuals, by June 2023, which will result in an increase in the number of people who live more independently. The baseline was 13 individuals as stated in the Provider Development Report in May of 2021.	Completed 3.24.23	RQC1
DBHDS has not met the target of 86% for the PMI focused on community involvement.	Our goal is by June 2023, increase the percentage of integrated community involvement (ICI) outcomes found in ISPs for individuals receiving case management services in Region 2 from a baseline of 56% to 86%.	Continue	RQC2
Only 24% of individuals, per the 2021-2022 NCI In-Person Survey use technology daily to be more independent.	Our goal is to improve the Virginia response to "Uses technology in everyday life to help them do more things on their own" question in the NCI In-Person Survey for individuals with developmental disabilities to 35% by March-April of 2025 (tentative release date for the 2023-2024 NCI In-Person Survey). The baseline was 24% in the 2021-2022 NCI In-Person Survey.	Due to be implemented in SFY24	KPA Workgroups
Employment Outcomes PMI data for Region 2 SFY23 Q3 was 32.4%.	Our goal is to improve the percent of ISPs that contain employment outcomes for those individuals who have an DD waiver from 32.4% to 42% by July 2024. The baseline was	Due to be implemented in SFY24	RQC2

Problem to be Addressed	QII Focus	QII Status	Assigned Subcommittee
	32.4% during FY23-Q3 in Region 2.		
Region 5 has struggled in meeting the target of 86% for unpaid relationship discussion in SFY22 Q3-SFY230Q2.	Our goal is to improve Unpaid Relationship Discussions for DD waiver recipients in Region 5 to 86% by June 2024. The baseline was 73% during FY23/Q2.	Due to be implemented in SFY24	RQC5

- ✓ Began developing a medical emergency toolkit that includes practice scenarios and 'hands-on' drills, which providers can use in to enhance and support their existing emergency preparedness policies, procedures, and training
- ✓ Developed a process map regarding the EHBS process to help identify bottlenecks where services may be hindered
- ✓ Created in Integrated Community Involvement Fact Sheet to assist Support Coordinators in developing integrated community involvement outcomes; presented in Region 2
- ✓ Created a cheat sheet for ISP Life Areas to assist Support Coordinators in identifying which ISP Life Areas information is found in; presented in Region 2

Provider Capacity and Competency KPA:

Problem to be Addressed	QII Focus	QII Status	Assigned Subcommittee
Case management visits are not occurring at the frequency required.	Increase 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 from a baseline of 73% to 86% by June 2022	Completed March 2023	CMSC
People with DD need to be informed about the services and supports they select.	CMSC goal is to ensure that people (those on the DD Waiver) make informed choices about the services and supports they select and benefit from RST recommendations, there will be a 27% increase in the number of non-emergency referrals meeting timeliness standards by June 30, 2022 (baseline 59%, 2nd Quarter SFY21).	Continue	CMSC
The lack of providers of Employment and	To increase the number of providers of Employment and	Continue	KPA Workgroups

Problem to be Addressed	QII Focus	QII Status	Assigned Subcommittee
Community Transportation (ECT) services in each region has a negative impact on access to reliable transportation.	Community Transportation (ECT) services in each region from 0 to 2 by June 30, 2022, so that individuals receiving DD waiver services have access to reliable transportation. The current baseline data is 0 providers as these services are new.		
The number of fatal opioid related drug overdoses in the Commonwealth has sharply increased since 2012.	MRC goal is increase the percentage of I/DD providers completing REVIVE! Training by SFY22 Q4 to 30%. There is no baseline data for the number of providers who have completed REVIVE! Training.	Continue	MRC
Analysis of the SFY20 data for individuals with a SIS level 6 revealed that the top 2 causes of death were sepsis and sudden cardiac death.	MRC goal is to reduce the crude mortality rate by 5 per 1000 deaths, each year for the next two years (SFY22 & SFY23) of individuals with SIS level 6. In SFY20, the highest crude mortality rate on the waiver was SIS level 6 (*76.2 per 1000 deaths) [baseline]*.	Continue	MRC
A review of current data demonstrates lower than expected participation in existing resources designed to increase access to services, including specialized services for complex needs.	Our goal is to increase the number of providers on the statewide database who hold a specialty designation to at least five unique providers in each specialty area by June 30, 2023. The baseline is currently 2 providers holding an autism designation, 4 providers holding a behavioral designation, 2 holding a complex health designation, and 1 provider holding a designation in accessibility.	Continue	KPA Workgroups
Support Coordinators/Case Managers play a pivotal role in in the system of support for individuals with developmental disabilities. In 2021, staff retention was the #1 concern cited by DBHDS Regional quality Councils as needing improvement.	Our goal is to achieve and maintain a retention rate for Support Coordinators/Case Managers at or above 86% for two consecutive quarters by June 30, 2023. Current baseline data is not available as we are choosing to not use the VCU 2018 study data as baseline due to differences in	Continue	CMSC

Problem to be Addressed	QII Focus	QII Status	Assigned Subcommittee
	the data source and method of collection and DBHDS has not previously established a SC/CM retention baseline. We will establish a baseline rate of SC/CM retention using WaMS assignment data to determine individual SC/CM retention rates for all CSBs.		
The PMI "% of licensed DD providers that have met 100% of the risk management requirements (excludes NA and ND)" has been below the target of 86%; the results for the past 4 quarters are: FY21,Q3=55%,FY21,Q4=62%, FY22,Q1=62%,FY22,Q2=58%.	Our goal is to improve compliance with regulations 520C and 520Dfor licensed DD providers to 86% by FY23, Q4 (June 30, 2023). The baseline percentages of each licensing regulation are listed below during FY22, Q2 (Oct-Dec 2021). Each has a goal of 86% by (FY23, Q4). The Baseline (CY 21) percents are as follows: 520C.1 85%; 520C.2 81%; 520C.3 80%; 520C.4 79%; 520C.5 85%; 520D 79%.	Continue	RMRC with RQC5
SFY22/23 IFSP Annual Satisfaction Survey found that 19/306 respondents indicated that they would like more support from waitlist case management.	Our goal is to increase access to information about eligibility for Targeted Case Management (TCM) while on the DD Waitlist by ensuring that a link to an informational video is shared with 95% of individuals/families on the DD Waitlist by June 30, 2024. Baseline is zero as of May 24, 2023.	Due to be implemented in SFY24	KPA Workgroups
In FY23Q1, twelve CSBs were required to submit Improvement Plans (IPs) to CMSC for not meeting the ISP Compliance performance standard in WaMS at least 86% of the time for two consecutive quarters. It is important that all individuals' ISPs are in the correct status so they can be included in the data that are used for reporting on PMIs	Our goal is by June 2024, 100% (all) of CSBs will meet the ISP Compliance performance standard at 86% or above, meaning that at least 86% of their ISPs are in the correct status which is ISP completed or pending provider completion. The baseline data for SFY 2023-Q2 was 70% of CSBs meeting the performance standard of 86%.	Due to be implemented in SFY24	CMSC

Problem to be Addressed	QII Focus	QII Status	Assigned Subcommittee
and measures that use the WaMS ISP data.			
Region 1 has been under the 86% target for *Teen Employment Discussions* PMI for seven quarters.	Our goal is to increase the number of DD waiver recipients (age 14-17) in Region 1 who have a conversation regarding interest in employment and/or what they are working on while at home and at school toward obtaining employment to 86% by June 30, 2024. The baseline is 58.3% according to FY23 Q3 WaMS ISP Data Reports.	Due to be implemented in SFY24	RQC1
Provider participation in the human rights regulation 12 VAC 35-115-230 C.2 has been low for multiple years, resulting in DBHDS and RMRC not being able to utilize the data	Our goal is to improve the percent of licensed services that have an annual report of each instance of seclusion or restraint, or both submitted by the end of January each year, per human rights regulation 12 VAC 35-115-230 C.2. to 86% by April 2024. The baseline was 48% during FY23 (for CY2022). Of the 3,436 licensed services, 1,666 responded for a result of 48%.		RMRC

- ✓ Developed Annual Physical Exam Toolkit and posted to OIH website to help individuals and their caregivers prepare for annual exams
- ✓ Adapted REVIVE! Training to include voice over and posted to COVLc to increase on-demand access to REVIVE! Training and promote health and safety outcomes for those experiencing an opioid overdose
- ✓ Posted Substance Use Disorder Health & Safety Alert to OIH website to increase awareness of how substance use disorder may look for individuals with DD
- ✓ Developed tools and resources to help providers have easy to find information on risk triggers and thresholds including relationship to care concerns, track trends in Level I, II and III risks, conditions, or incidents over time, achieve success with the RM regulations
- ✓ Delivered a three-day training on RM to help further provider understanding of RM and achieve success with the RM regulations
- ✓ Reduced completion of the On-Site Visit Tool to quarterly for those receiving TCM, to improve SC work experience and reduce turnover

- ✓ Discontinued requirement to use the Individual Planning calendar due to perceived lack of value and time needed for completion
- ✓ Simplified/revised ECM guidance
- ✓ Automated ECM worksheet
- ✓ Provided a questions and answers document for ECM
- ✓ Revised ECM guidance published to Town Hall
- ✓ Simplified the DD Support Coordination Handbook, public comment scheduled for SFY24 Q2
- ✓ Implemented SC participation in RST meetings on an as needed basis only, to improve SC work experience and reduce turnover
- ✓ Hosted a provider roundtable where an experienced ECT provider shared how they operationalized the service successfully, to encourage providers in adding ECT as a service offering
- ✓ Surveyed providers regarding the Provider Designation Process and use of My Life My Community website to identify what improvements were needed
- ✓ Provided on overview of My Life My Community website and designation survey access at the provider roundtable to increase provider awareness of both the website and how to complete the designation survey

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 SFY22 Program Evaluation

In SFY22, seven opportunities for enhancement were identified for the DD QMS. These opportunities focused on the following:

- increasing communication and explanation of the DD QMP and importance of quality throughout DBHDS,
- promoting use of the QII Toolkit and other QII tools thoughout DBHDs,
- increasing stakeholder involvement and input,
- establishing a public dashboard for services providers to assist their efforts in tracking performance, assisting providers in evaluating their programs and services to utilize QA data to inform their QI efforts,
- DQV supporting DBHDS offices in identifying and evaluating new and existing data sources used by DBHDS, and continuing Actionable Recommendations Assessments until each of the data source systems or their replacements have been reviewed.

The DD QMS worked throughout SFY23 in implementing strategies to meet these opportunities. Strategies utilized included:

- ✓ DD QMP presentation to the QIC
- ✓ DQMP presentation to the QIC
- ✓ A three part series on why quality matters was made available to DBHDS staff; this series introduced staff to the importance of quality, the role of the QMS, and using data to drive change
- ✓ The Quality Beat, a quarterly, internal newsletter devoted to increasing the awarenss and understanding of quality management and quality improvement, began publication in SFY23
- ✓ Released a QI job aid and PDSA template including FOCUS (a model used to determine which improvement approach is right for use) for DBHDS staff to use regularly
- ✓ Posted webinars on QI, the model for improvement, and use of PDSA (Plan-Do-Study-Act) model to DBHDS YouTube channel
- ✓ Continued training and sharing of resource information related to OL RM and QI regulations
- ✓ Continued emphasis on valid and reliable data

- ✓ Engaged two external stakeholder workgroups to recommend ways of improvement in these areas: Administrative Burden, Education & Training, Complex Needs, System Functioning, and System Transformation
- ✓ TCM and ECM dashboards were developed in Power BI. These dashboards are designed to help the CMSC and CSBs have timelier row level data and be able to identify the need for and monitor improvement efforts more effectively. Trainings for the CSBs were conducted the week of June 26 on using these dashboards.

As in previous years, the quality committee chairs evaluated how well the DD QMS functioned. Results of the SFY23 program evaluation showed that the DD QMS was well established:

- ✓ Performance measures were in place and were consistently monitored; process in place for the development of new performance measures
- ✓ Work plans reflected the work of the QIC subcommittees
- ✓ Data was collected and routinely analyzed for performance measures and as surveillance
- ✓ Quality committee structure remained in place
- ✓ Quality committee membership included internal and external stakeholders (including individuals, family members, providers and other representatives)
- ✓ Processes in place that addressed data validity and reliability, that supported the functioning of the quality committees, and in managing the DD QM Plan
- ✓ QIC subcommittees developed, proposed, implemented newly approved QIIs as well as continued implementation of in progress QIIs
- ✓ Various offices with the DD QMS offered training and technical assistance

The quality committee framework, its structure and implemented processes continued as a strength. The quality committees fulfilled the obligations outlined in their charters. (Charters are included as an appendix to the SFY24 DD QMP Parts 1 & 2.) The QIC subcommittees identified opportunities for improvement through a QI KPA Identification Process. This process involved asking the importance of each assigned PMI, identifying barriers to the PMI, identifying additional potential data that could be used in monitoring, and identifying opportunities for improvement. Quality committee membership was diverse, respresenting multiple divisions and offices throughout DBHDS. Select committees also include external stakeholders.

During data reviews, subcommittee members discussed methodology, and data limitations, and how the impacts on those being served. Additional discussions focused on other data elements such as population, region, and other factors that influence performance. Each discussion drove the point of seeing the story being told through data and the role that tools and instruments used to measure the data play in telling the story. The QIC subcommittees expanded use of

Power BI in their data reviews and visualizations. (Power BI is a tool that allows for the analysis and visualization of raw data to determine actionable steps.)

Identified Opportunities for Enhancement

Opportunities for enhancment were identified by the DD QMS through the use of the QM Program Assessment tool, QIC subcommittee input, the Data Quality Monitoring Plan, and through assessment of continuous quality improvement efforts throughout the DD QMS. Most enhancement opportunities are summarized below in the Path Forward; noted opportunities for enhancement not included in the Path Forward included enhancements to meeting structure to build in additional discussion time.

The performance evaluation also identified several areas where sustainability of a process may not be as viable as orignially thought. Information on sustainabiltiy was requested as part of OCQM's ongoing cycle of quality assessment and improvement. Two areas where the long term sustainability was questioned related to processes around the amount of data review required for review as it diverts resources away from reviewing and identifying emergent issues and the processes around the identification, development and implementation of QIIs. Addressing these concerns with sustainability will require additional consideration and input from DBHDS executive leadership and those outside of DBHDS. These were not included in the Path Forward.

From the Data Quality Monitoring Plan, OCQM data system analyst consultants observed that there had been several advancements, in most cases. In other cases, there were new opportunities, to address threats to data quality, identified and acknowledgements that previous recommendations had not been completely addressed yet. Progress towards achievement is detailed above in the "Data Quality Improvements Section." Data quality recommendations made by the OCQM data system analyst consultants fell under the following headings: Data Validation, Key Documentation, Manual Data Processing, User Interface and Backend Structure, and Training. There was a combined total of 123 duplicated recommendations (meaning that recommendations can apply to multiple data sources or data source systems). These recommendations are included in the Path Forward items related to data quality.

Path Forward Summary

In SFY23 DD QM Plan Parts 1 & 2, DBHDS identified the following items in its Path Forward for SFY23. Part 3, the Annual Report, summarizes the work completed by DBHDS towards these items.

- 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. This will become the work of the Data Warehouse (DW), as DBHDS moves to streamline mechanisms for data collection and reporting. In SFY20, measure validation began to include all PMIs (as opposed to those specifically categorized as KPA PMIs), to ensure consistency in measure development. Work towards improving data validity and reliability, specific to data source systems and the work of the DW continues
- 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: Annual Report and Evaluation.

Using its QM Program Evaluation, DBDHS determined the following path forward for SFY24, for targeted improvement, for the coming year.

- DBHDS will continue the work initiated in SFY23, as listed in the SFY23 DD QMP Parts 1& 2.
- DBHDS will improve sustainability of the QII process.
- DBHDS will improve upon the meeting formats (structure and content) for the Quality Improvement Committee and the Regional Quality Councils.

Conclusion

In implementing the DD QMS, DBHDS realized the positive impacts efforts of previous years, as some performance measures saw significant gains for the first time, as CSBs received timely data (for their use in improving SC/CM performance, in the easing of administrative burden for CSBs and providers, and in system updates that improved ease of data entry). These efforts, along with the planned improvement efforts implemented during SFY23, demonstrated that DBHDS' DD QMS was well established and effective.

As stated earlier, OCQM began looking at the sustainability of processes utilized by the DD QMS. As potential revisions were identified, the determination to move forward in a thoughtful and intentionally structured manner to assure that any revised processes would meet DBHDS requirements was deemed an appropriate course of action.

While other sustainable efforts occurred such as in the reduction of administrative burdens for CSBs and providers and in the streamlining of information in WaMS, the sustainability of the CSB and provider workforce remained a constant focus. While this shortage within the workforce is not unique to Virginia, the Commonwealth engaged in efforts outside of DBHDS to reduce the shortages experienced. The quality committees discussed the various impacts these shortages had on the individuals served. Two workgroups, Provider Issues Resolution Workgroup and System Issues Resolution Workgroup, met to identify problem areas and make recommendations to DBHDS on several topics that touch on staffing shortages. Work in understanding the complexities of staffing shortages, administrative burdens, and the resulting impacts on performance continued. Recommendations are planned to be presented during SFY24.

DBHDS is well positioned to continue to advance, successfully, through the replacement of CCS3 the crisis data store, and its incident management systems (PAIRS and CHRIS), as expectations for system build out will include mechanisms designed to address identified data quality concerns. DBHDS has also developed processes for managing data quality concerns, while additional solutions are being stood up that aid the business area in meeting their needs with a focus on less manual data management. The DBHDS Division of Administration establishment of the Data Governance Plan and expectations for OIT to lead the process for data source system assessment; subsequently tracking progress to successful resolution, will serve to increase collaboration between the business area and OIT, thus strengthening processes designed to ensure effective, efficient, and sustainable solutions.

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
DMASCSBs	Community Services Boards
CTH	Crisis Therapeutic Home
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
DMAS	Department of Medical Assistance Services

Acronym	Full Form
DSP	Direct Support Professional
ECM	Enhanced Case Management
HCBS	Home and Community Based Services
HSAG	Health Services Advisory Group
IFSP	Individual and Family Support Program
IMU	Incident Management Unit
ISP	Individual Support Plan
KPA	Key Performance Area
MRC	Mortality Review Committee
NCI	National Core Indicators
OCQM	Office of Clinical Quality Management
OHR	Office of Human Rights
OIH	Office of Integrated Health
OIT or IT	Office of Information Technology
OISS	Office of Integrated Support Services
PAIRS	Protection and Advocacy Incident Reporting System
PCR	Person Centered Review
PMs	Performance Measure (CMS DD performance measure)
PMIs	Performance Measure Indicators
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
SCQR	Support Coordinator Quality Review
SFY	State Fiscal Year
SIS	Supports Intensity Scale
TCM	Targeted Case Management

Acronym	Full Form
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