Virginia Department of Behavioral Health & Developmental Services

Developmental Disabilities Quality Management Plan
State Fiscal Year 2023

October 14, 2022

Part 1 Program Description
Part 2 Quality Committees

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Developmental Disabilties Quality Management Plan

"The best solutions are those that integrate a wide range of perspectives and emphasize partnership and collaboration."

Nelson Smith, Commissioner
Virginia Department of Behavioral Health and Developmental Services

Introduction

This report serves as a comprehensive document describing the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Developmental Disabilities (DD) Quality Management Plan (QMP) for State Fiscal Year (SFY) 2023. The DBHDS is committed to continuous quality improvement (CQI), which is an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes. The DBHDS DD QMP is a detailed in a three-part document. The DBHDS DD QMP is reviewed and updated annually.

- Part 1: The Quality Management (QM) Program Description
    - Describes the current structure and framework for discovery and remediation activities and provides a path forward for improvement activities.
- Part 2: The Quality Improvement Committees
    - Describes the organization of all the quality improvement committees comprised within the quality management system, the accountability structure, charter requirements, and describes the work plan used by each of the QIC Subcommittees to track the progress of performance measure indicators (PMI) and quality improvement initiatives (QII).
- Part 3: The Quality Management Annual Report and Program Evaluation
    - This is a summary of the key accomplishments of the QM Program, data reports, program evaluation, and the challenges to meeting stated goals, and plans to address them.

Part 1- Quality Management Program Description

Standards for Quality

The DBHDS' DD QMP was re-established in SFY2016 to fully integrate a culture of quality in every aspect of the DD operations and programs, create an organizational structure for improved efficiency and accountability, fully capture the high-quality work that is done throughout the system, and identify opportunities for ongoing improvement. The DD QMP has grown significantly as it relates to the number of quality committees, the number of performance measures indicators (PMIs), the integration of quality improvement program requirements, and additional data reports and program evaluation information was included.

The DBHDS DD QMP draws upon multiple quality frameworks to include the Institute of Medicine's six dimensions[1] of quality, the Substance Abuse and Mental Health Services Administration (SAMHSA) quality framework[2], and the Centers for Medicare & Medicaid Services (CMS) Home and Community Based Services (HCBS) Waivers Quality Framework[3] in the implementation of the DBHDS Quality Management system (QMS).

DBHDS Quality Management System

The DBHDS QMS incorporates the nationally recognized quality principles and programs. The system's infrastructure is:

- Supported through the organization's leadership who is:
  - Committed to the success of the QM plan
  - Supportive of the organizational culture of quality improvement (QI)
  - Prepared to designate resources for critical support mechanisms
  - Willing to give authority to staff to make changes
- Person and family-centered
- Characterized by employees and providers who are continuously learning and empowered as innovative change agents
- Effective in utilizing data for ongoing quality improvement
- Sustainable and continuous

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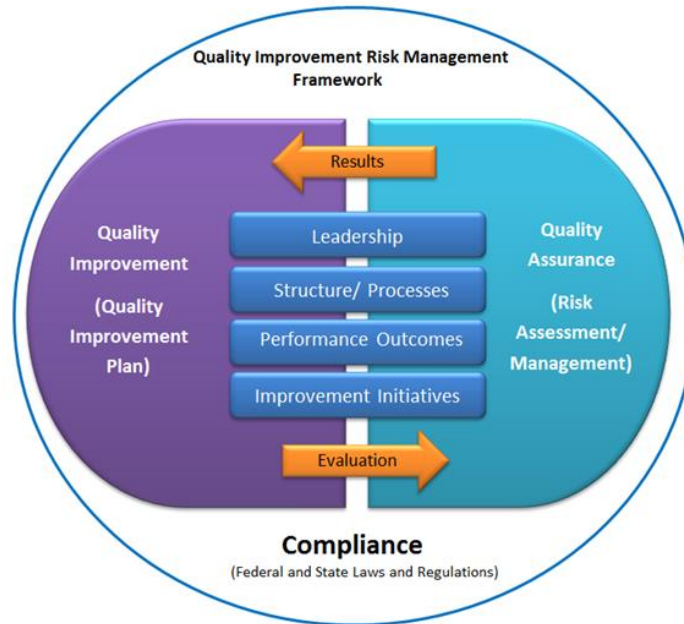
[1] Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.
[2] SAMHSA. National Framework for Quality Improvement in Behavioral Health Care, June 2011.
[3] Centers for Medicare and Medicaid Services HCBS Quality Framework, 2016. https://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

The graphic below illustrates that while compliance is what we must achieve, the goal is a system of quality services that allows individuals to direct their own lives and recovery, to access and fully participate in their community and balances risk, health, safety, and well-being. An effective quality/risk management (RM) structure includes quality assurance (QA), RM and QI processes.



The foundation of the framework is compliance with federal and state laws and regulations that focus on individual protections, rights, and liberties and standards, to ensure safe consistent quality of care. These include, but are not limited to:

- Americans with Disabilities Act (ADA) and the *Olmstead* decision
- Civil Rights of Institutionalized Persons Act (CRIPA)
- Home and Community Based Services (HCBS) Settings Rule
- The Joint Commission (hospital accreditation)
- Occupational Safety and Health Administration (OSHA)
- Health Insurance Portability and Accountability Act (HIPAA)
- State Board of Behavioral Health and Developmental Services Regulations
- CMS (Department of Medical Assistance Services (DMAS) – Waiver Assurances
- Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services (Human Rights Regulations)
- Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services

Leadership

Leadership commitment for a culture of quality, structures and data driven processes, established performance outputs/outcomes, and continuous quality improvement (CQI) are the foundation of the framework. DBHDS' leadership commitment is demonstrated through direction and support of the QMS and CQI. This is consistent with the vision and mission, and strategic plan, to ensure that a culture of quality permeates the agency, through employee engagement at all levels, and through the services provided by our community partners.

DBHDS strives towards a culture of quality, which recognizes that quality is a shared responsibility of all individuals within an organization. All employees are empowered to be change agents.

In an integrated QI/QA/RM system, these efforts identify opportunities for QI, include assessment of risks, and can result in the development of QIIs, which seek to improve systems and processes to achieve desired outcomes.

Structure and Processes

QA, RM and QI are integrated processes that are the foundation of the QMS. QA focuses on discovery activities to evaluate compliance with standards, regulations, policies, guidance, contracts, procedures and protocols, and the remediation of individual findings of non-compliance. Regulatory compliance establishes the extent to which basic performance standards are met, which include DBHDS Licensing and Human Rights Regulations, DMAS Developmental Disabilities (DD) HCBS Waiver Regulations, and the assurances built on the statutory requirements of the CMS 1915c Waiver program. Additional performance standards are set forth by the DMAS and DBHDS in support of various program goals.

RM assesses and identifies the probability and potential consequences of adverse events and develops strategies to prevent and substantially mitigate these events or minimize the effects. This is achieved for individuals receiving services using risk screening assessments and responsive care plans. At the systems level, DBHDS monitors critical risk triggers through reported data sources and initiates interventions as appropriate. At the provider level, DBHDS requires service providers to develop RM plans, including the identification of risk triggers and response strategies to mitigate the potential for harm. Comprehensive RM also includes requirements for the reporting, investigating and remediation pf critical incidents as indicated using corrective action plans (CAPs). DBHDS also employs a robust complaint system for allegations of abuse, neglect, and exploitation.

QI is the systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care. At the provider level, DBHDS requires service providers to develop RM plans, including the identification of risk triggers and response strategies to mitigate the potential for harm.

The DBHDS QMS includes (Divisions are further described below):

- Division of Provider Management,
- Division of Developmental Services
- Division of Administrative Services
- Division of Facilities Services
- Division of the Chief Clinical Officer

DBHDS Division of Provider Management

The DBHDS Division of Provider Management provides a quality assurance function for the agency, establishing basic requirements for provider organizations through regulation, determining the extent to which these standards/regulations are met and taking action to remedy specific problems or concerns that arise. The DBHDS Division of Provider Management includes the Offices of Licensing, Human Rights, and Regulatory Affairs. These offices provide oversight and monitoring of providers to assure individuals' rights and that providers and services meet established standards and requirements.

Office of Human Rights

The Human Rights Regulations outline the DBHDS' responsibility for assuring the protection of the rights of individuals receiving services in state operated facilities and community programs licensed and funded by DBHDS. The mission of the OHR is to promote basic precepts of human dignity by monitoring provider compliance with the Human Rights Regulations, managing the DBHDS' complaint resolution program and advocating for the rights of individuals with disabilities in the DBHDS service delivery system. OHR is divided into two specialized teams and utilizes data driven decisions to deploy advocates to state operated facilities and community programs where individuals are alleged or determined to be at imminent risk of harm. The Facility Operations team champion's compliance by state operated facilities in the same way the Community Operations team does with licensed and funded providers of services. Facility Advocates are assigned to each of the 12 state operated facilities (to include Southeast Virginia Training Center) and Community Advocates are mobilized to public and private community programs where high-profile incidents occurred or other trends impacting rights protections are identified.

OHR has a total of 23 field advocates who assist individuals and Authorized Representatives with complaint resolution by facilitating due process; monitoring provider reporting; and reviewing provider investigations and corrective actions. Advocates also respond to reports and allegations of abuse, neglect, and exploitation by conducting independent or joint investigations with DBHDS partners and/or external agencies such as state operated Facility Investigators and the Virginia Department of Social Services (VDSS). In cases where there are violations of the Human Rights Regulations, advocates recommend citation through the Office of Licensing (OL) or issue a Notice of Violation Letter (to state operated facilities only). As a proactive protection of rights, advocates also visit newly licensed providers within 30 days of service initiation to ensure the basic knowledge of the human rights system, including review of the provider's human rights policies and training on the requirements and process for utilizing the department's web-based reporting application (CHRIS). In addition, OHR also conducts onsite reviews of newly licensed Waiver providers to assess compliance with the HCBS Settings Rule.

OHR also has a code-mandate to provide system-wide training and technical assistance to promote literacy regarding individuals' assured rights and corresponding state operated facility and provider duties. In this regard, OHR facilitates a series of virtual training opportunities with companion resource materials available on the OHR webpage such as training slide decks, audio/video recordings, and FAQs.

To assure a safe environment for all individuals receiving services and to ensure follow-up on all substantiated abuse allegations, "high priority" cases, defined as any allegation of sexual assault, restraint with serious injurie(s), and physical abuse with serious injurie(s) receive an immediate advocate response to include a site visit within 24 hours of notification. In these instances, advocates assess and assure safety for the identified individual, as well as other individuals receiving services; the advocate ensures a provider investigation along with and the compliance resolution process has begun, and the advocate continues to monitor provider follow up through verification that the provider/state operated facility has completed a thorough investigation and implemented appropriate corrective action(s).

A shared protocol also exists between DBHDS, VDSS and the Department of Aging and Rehabilitation Services (DARS) to ensure all allegations of abuse, neglect and exploitation involving a state operated facility or licensed provider are appropriately reported to OHR. The protocol establishes a process for VDSS and DARS localities to send reports of abuse via secure email, fax, or US Postal Service that are triaged, tracked, and trended by OHR staff. DBHDS providers and state operated facilities are contacted regarding their failure to report abuse and advised about initiating the complaint resolution process. Citation is also recommended through the Office of Licensing when any violation is identified.

OHR has monitoring systems in place to ensure the health and welfare of the individuals served by DBHDS. These systems include:

- Comprehensive Human Rights Information System (CHRIS)

- Local Human Rights Committees (LHRC)
- State Human Rights Committee (SHRC)
- Pre and post move monitoring of individuals discharged from training centers
- Community and Facility provider look behind process
- Shared protocol with VDSS/DARS for Abuse/Neglect reporting
- Central Office Abuse/Neglect Advisory Panel
- Central State Hospital and VCBR Appeals Committees

Office of Licensing

The Office of Licensing (OL) acts as the regulatory authority for the DBHDS' licensed service delivery system. Through QA processes including but not limited to initial application reviews, initial site visits, unannounced inspections, review and investigation of serious incidents and complaints, and issuance of licensing reports requiring corrective action plans (CAPs), the OL ensures the mechanisms for the provision of quality services are monitored, enforced, and reported to DBHDS leadership. The OL is responsible for monitoring providers' compliance with regulatory standards including their responsibility for developing and implementing; 1) a quality improvement program that utilizes standard quality improvement tools, including root cause analysis, 2) a quality improvement plan, and 3) a written plan to identify, monitor, reduce, and minimize harms and risk of harm, as well as conducting an annual conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services.

Providers are required to report human rights complaints, allegations of abuse, neglect and exploitation, and serious incidents as defined in licensing and Human Rights regulations into CHRIS. OHR monitors these reports and may result in onsite visits by OHR and/or investigation by OL.

OL plays an integral, vital role in assessing the applicants to become providers and their potential in meeting the needs of individuals in safe, secure, and less restricted environments. OL ensures the mechanisms for quality service provision are enforced, monitored, and reported back to DBHDS leadership via data and other measures. In addition, OL is responsible for:

- Coordination with other agencies - DMAS, Managed Care Organizations (MCOs), Department of Social Services (DSS), State and local law enforcement, Office of the Attorney General (OAG), Department of Health Professions (DHP),
- Coordination with other departments within DBHDS – Office of Human Rights, Division of Developmental Services, Division of Community Behavioral Health, and Division of Compliance, Risk Management and Audit,

- Utilization of a performance management system to ensure that CAPs, Inspections, and Investigations are done in accordance with office protocol and regulations.

OL includes an incident management unit (IMU) and a special investigations unit (SIU). IMU is responsible for the daily review, triage, and follow-up on all reported serious incidents to identify and, where possible, prevent future risks of harm. Follow-up on incidents may include phone contact with the provider and/or individual to ensure immediate protections and health and safety follow-up has occurred and desk review of records relevant to the incident and reports. IMU works closely with SIU, licensing specialists, Office of Integrated Health (OIH) and human rights advocates to assure adequate follow-up.

Serious incidents include any event or circumstance (including injuries or deaths) that causes, or could cause harm to the health, safety, or well-being of an individual. Providers are required to report serious incidents to DBHDS through CHRIS within 24 hours of their identifying or being notified of the incident. IMU cites any provider who does not have a valid reason for entering a report into CHRIS within required time frame. Upon review of a serious incident, IMU decides as to whether further follow-up is needed. Any incidents that give rise to concerns that the individual or others are at imminent risk are referred for immediate investigation, and all deaths of individuals with developmental disabilities are referred to the SIU. Other concerns are forwarded to the provider's licensing specialist for follow-up. IMU also reviews and triages all laboratory confirmed positive COVID-19 cases. IMU calls the provider, checks the status of the individual(s), and asks pertinent questions based on a specially designed COVID-19 review form, which is shared with OIH and OHR.

IMU reviews data to identify trends, including providers that have a high volume of incidents or several incidents of the same type (e.g., falls or medication errors), and identifies patterns of incidents with the same individual that may indicate the need for a change in services or the need for additional resources. Through this review, IMU identifies areas, based on serious incidents, where there is potential risk for more serious future outcomes. A review of a serious incident may raise concern about a provider's ability to ensure the adequacy of supports to one or more individuals receiving their licensed service. As a result, a provider may need to re-evaluate an individual's needs and supports, review the results of root cause analysis, and make systemic changes or updates to their RM or QI plan. IMU has identified these situations as Care Concerns. Incidents of individuals or providers who meet Care Concern criteria will trigger follow-up by IMU or other offices once notified by IMU. OIH and OHR then follow-up and provide technical assistance to/for providers who have identified care concerns.

IMU also reports on trends across the system, such as total incidents and frequency of different types of incidents by provider, service, and for individuals. Trend reports are reviewed with the

Risk Management Review Committee (RMRC) to determine when system level QI activities may be necessary.

SIU is responsible for the investigation of deaths of individuals with developmental disabilities (DD) and for complaints of providers licensed to provide services to individuals with DD in accordance with office protocols and review criteria. As additional resources are added to the unit, they will expand to include all investigations involving individuals with DD, and eventually to all investigations regardless of disability type.

Investigators are responsible for contacting providers, requesting, and reviewing records, conducting on-site inspections, interviewing provider staff and individuals, coordinating with other agencies and law enforcement, identifying any regulatory violations, writing investigation reports, and following up with providers to ensure implementation of their CAPs.

DBHDS Division of Developmental Services

The Division of Development Services ensures planned, individualized, and person-centered services and supports are available to individuals with developmental disabilities. This is for the purpose of enabling these individuals to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible. Developmental Services is the operating entity for the Commonwealth's three Home and Community-Based Services (HCBS) waiver programs for children and adults with developmental disabilities. Additional primary roles include developing a robust provider network of community integrated services and supports, providing subject matter best practice leadership and technical assistance in developmental services, managing the HCBS waiver operations, ensuring access to dental and adaptive equipment services, managing the discharge planning for persons leaving Training Centers, and implementing of the Preadmission Screening and Resident Review (PASRR) and Omnibus Budget Reconciliation Act (OBRA) programs for children and adults with developmental disabilities.

DD HCBS Quality Management

The Division of Developmental Services (DDS), as the administrative entity for the Commonwealth's DD Waivers, has delegated authority over the quality of services delivered under the waivers. DMAS, as the state Medicaid agency, retains overall state level authority over the DD HCBS Waivers' Quality Improvement Strategy outlined in the waiver applications. DMAS and the DDS Waiver Operations Unit collaboratively oversee implementation of these plans using data derived from both DMAS and DBHDS designated offices with data, administrative and technical support from both agencies.

All HCBS waiver programs must operate in accordance with the CMS required waiver assurances. States develop CMS DD performance measures (PMs) under each assurance, which serve as the indicators of performance. Specific details regarding the frequency of review, sample size, methods of discovery and remediation, and responsible parties are detailed in the state's HCBS 1915c Waivers Applications.

Ongoing compliance with the assurances is necessary to maintain Virginia's DD Waivers program.

The assurances include the following:

1. Administrative Authority -The State Medicaid agency is responsible for the oversight of the waiver and is ultimately responsible for all facets of the program.
2. Evaluation/Reevaluation of Level of Care - Individuals enrolled in the waiver have needs consistent with an institutional level of care.
3. Person-Centered Planning and Service Delivery - Service Plan-Participants have a service plan that is appropriate to their needs, and services/supports specified in the plan are received.
4. Qualified Providers - Waiver providers are qualified to deliver services/supports.
5. Health and Welfare - Participants' health and welfare are safeguarded and monitored.
6. Financial Accountability - Claims for waiver services are paid according to state payment methodologies.

DBHDS and DMAS have primary responsibility for monitoring performance under the waiver assurances through the DD Waiver Quality Review Team (QRT). QRT meets on a quarterly basis to report on and review the results of the discovery and remediation activities for each performance measure and establish systemic remediation strategies for those measures that fall below the CMS-established 86% standard in the state fiscal year. The work of the QRT is accomplished by accessing data across a broad range of monitoring activities, including DBHDS licensing and human rights investigations and inspections; DMAS QM reviews (QMR); serious incident reporting; case management (CM) data reporting; QSRs; mortality reviews; and DBHDS level of care evaluations performed by CSBs.

QRT identifies barriers to performance and the steps needed to address them. These remediation steps are in addition to state agency required provider or individual-level remediation. First level systemic remediation includes statewide or regional provider training and targeted technical assistance conducted by DDS Provider Development and/or OIH. Remediation strategies may include, but are not limited to, targeted communication to the provider community, changes in protocols or processes designed to ensure the health and safety of individuals, IT system enhancements for collecting and reporting data, changes to state standards (regulations and policy manual), payment retractions, change in licensing status, targeted QMRs by DMAS, and ceasing referrals to providers.

A requirement for participation in the Medicaid HCBS Waiver program is multi-year evidence reporting to CMS during the third year of each waiver's five-year approval cycle. The purpose of the reporting is to ensure that the waivers are being implemented as intended through review of waiver program data and QI activities. States are required to report performance regarding the state's specific CMS DD PMs related to the six required CMS assurances. States must demonstrate a certain level of compliance (currently set by CMS at 86%) for each performance measure.

Office of Provider Development

The Office of Provider Development (OPD) focuses on developing and sustaining a qualified community of providers in Virginia so that people who have DD and their families have choice and access to options that meet their needs. Work is organized across three capacity-building teams at the individual, provider, and system levels that is carried out through Community Resource Consultants (CRCs) who offer technical assistance to community stakeholders through a variety of methods such as regional meetings, virtual and on-site training, and ongoing communications. OPD also includes staff dedicated to the development and implementation of Supported Decision-Making Agreements and an Employment Specialist who focuses on providing technical expertise to providers of employment services. OPD has established a comprehensive approach to program development. This approach includes Regional Support Teams (RST) that bolster informed choice in Virginia's system by ensuring the consideration of more integrated support options. Also included, a Provider Data Summary process that evaluates and shares gaps in integrated services with the provider community, maintains an online provider database that includes a Provider Designation process for the identification and promotion of provider expertise. The remaining approaches include access to Jump-Start funding to develop integrated service options where needs exist; and monitoring and improving the performance of Support Coordinators (SCs) through the provision of materials and technical assistance deigned to support success with Settlement Agreement (SA) requirements. In addition, OPD seeks to promote best practices through implementation of the HCBS settings rule, a Direct Support Professional (DSP) and DSP Supervisor training and competencies process, the development and use of a Person-Centered Individual Support Plan (ISP), and access to a variety of person-centered practices training opportunities.

Case Management/Support Coordination

Case Management/Support Coordination (CM/SC) is the core service that Virginians with DD and behavioral health disorders use to help navigate and access needed and desired services, while building on the individuals' strengths and natural supports systems. This essential QA role includes coordinating the development of a person-centered plan, assessing, and monitoring to ensure the plan is implemented appropriately and updated when a change in status occurs, linking individuals with services, identifying and balancing health and safety needs with dignity of risk, while also strengthening and supporting each person's right to determine the life they

want. Often referred to as the linchpin that holds the elements of a complicated structure together, the CM/SC is of critical importance in helping individuals achieve positive outcomes, avoid harm, maintain stable community living, and increase integration, independence, and self-determination in all life domains.

CM/SCs facilitate the development of the ISP to assist and support individuals in determining what is important to and for them including proactively identifying risks and developing mitigating strategies while recognizing and supporting the individual in making informed choices. Additional assessments were added to the ISP process to assist the CM/SC in identifying risks. These include a crisis risk assessment to identify potential risks for crisis and a proactive referral process to crisis support services as well as a risk awareness assessment to identify risks commonly associated with individuals with DD. CM/SC monitor implementation of the ISP. This monitoring process now includes a standardized on-site visit assessment tool (OSVT) to assist in determining if the ISP is implemented appropriately and identifying if there has been a change in status, which will initiate an update to the ISP.

The OPD works in cooperation with the Case Management Steering Committee and Community Services Boards to develop and make available a variety of resources that support effective case management in line with state and federal requirements. Activities include developing and maintaining a DD Support Coordination Handbook, designing, and updating the Virginia Person-Centered Individual Support Plan, facilitating an electronic health record data exchange process with CSB vendors, holding focus groups and regional meetings with CSBs to gather input, providing technical assistance, and training, and assisting with the implementation of a Data Quality Support process designed to increase the reliability of data received from CSB.

Office of Integrated Health

Office of Integrated Health (OIH) ensures DBHDS meets the federal requirements for PASRR, pre-admission screening of individuals with DD referred for nursing home level of care. In addition to ensuring individuals with DD meet the required level of care for admission, OIH ensures that any specialized needs are addressed and a connection between the community services board/behavioral health authority hereafter referred to as CSB and nursing facilities are made to aid in discharge facilitation. When nursing home placement is determined to be appropriate, the PASRR team follows the individual to ensure they are receiving the supports and specialized services needed as identified by their person-centered plan. This includes the use of OBRA funding to support the services needed that are outside the usual scope of the nursing homes. Through the resident review process, the PASRR team continues to evaluate whether nursing home placement remains appropriate; these reviews occur at least every 180 days.

OIH developed a transitions team directed at helping to move children currently living in nursing facilities to the community. DBHDS Community Transitions Nurse, in conjunction with the interdisciplinary teams at each of the two largest nursing facilities that serve children in the Commonwealth, identifies barriers and possibilities for community placement. OIH staff also participate in investigations as requested, develop training and educational materials in support of QI recommendations and provide on-going training and technical assistance to community providers.

DBHDS Division of Facilities Services

The DBHDS Division of Facilities Services directs, monitors, and strengthens QI in the DBHDS State Facilities. Each facility ensures the coordination and integration of QI activities aimed toward the delivery of safe, high-quality care in its facility. The goal is to maintain a systematic facility-wide approach to safety and performance improvement across three overlapping areas of focus: accreditation and regulatory compliance; incident management and risk reduction; and systematic and sustainable performance improvement.

The DBHDS Compliance Management team provides oversight and advances compliance and risk management initiatives with DBHDS facilities related to agency policy and procedure requirements, external regulatory requirements, and Joint Commission (JC) and Centers for Medicare and Medicaid Services (CMS) accreditation standards. The Compliance and Risk Management program is responsible for coordinating related efforts for oversight activities, policy management, and training curriculum initiatives with DBHDS facilities and related Central Office functions. This program also works with third party oversight and stakeholder groups, conducts related investigations, and completes other special projects on behalf of agency leadership.

DBHDS Division of Administrative Services

The Division of Administrative Services provides the support and infrastructure of the operationalization of all program areas of DBHDS. The Division includes the Offices of Finance, Procurement, Human Resources, Internal Audit, Information Technology, and Information Security. These offices serve to support all areas to ensure business efficiencies, procure goods and services that support the quality management system, manage, and maintain the IT sources and data systems from which all program areas rely on for daily operations, data, and continued enhancement to make data driven decisions.

DBHDS Division of Clinical and Quality Management

The Division of Clinical and Quality Management provides cross-disability clinical and technical expertise and support across all program areas of the agency to aid in leading system-wide transformation and enhance cross-disability collaboration. The aim of the division is to support the agency in ensuring that all individuals receive high quality care and integrates evidence, best practices, and data to drive decision-making, inform behavioral health and developmental disabilities policy and implement system change. The Division is comprised of the following offices: Pharmacy Services, Epidemiology and Health Analytics, Mortality Review, Clinical Quality Management, Community Quality Improvement, and Compliance Management.

Office of Clinical Quality Management

The Office of Clinical Quality Management (OCQM) supports the development and expansion of an agency-wide QM Plan by ensuring high quality service delivery focused on prevention, early intervention, effective treatment, and recovery and rehabilitation. OCQM works with interdisciplinary teams to achieve system wide community inclusion and integration; health, safety, and wellbeing; and provider capacity and competency (developmental service provision) across all service setting areas, including community and t raining center programs. The office facilitates inter-departmental, inter-agency, and cross-sectoral alignment of QIIs for DBHDS, and works to ensure compliance with the QM requirements established by the agency.

The office staff supports the quality improvement committee structure, which provides system-wide oversight of the QM Program. In addition, the office partners with and facilitates efforts within DBHDS divisions to ensure that QI activities are coordinated and integrated into the primary functions of the organization. QI is a data driven process and involves analysis of data and performance trends is used to determine QI priorities. OCQM provides oversight of QI efforts and responses to trends, by ensuring QIIs are developed, and corrective actions and regulatory reforms are implemented, if necessary, to address weaknesses/service gaps in the system.

OCQM oversees and directs community-based quality review activities for DBHDS through both internal agency activities and using contracted vendors to conduct quality related activities. DBHDS utilizes a contracted vendor to conduct Quality Service Reviews (QSR) focused on obtaining data on the quality of services at the provider and individual level, and in aggregate across the system. DBHDS contracts with The Partnership for People with Disabilities to conduct the surveys required for the National Core Indicators project. DBHDS uses the data from both the QSRs and NCI to identify opportunities for quality improvement.

QSRs are completed on a sample of individuals receiving services and include desk reviews, on-site visits, face-to-face interviews, in-person service observations, retrospective record reviews,

and/or surveys of individuals receiving services. QSRs are completed to gain information about the quality of services provided and/or to obtain individual and family input on services provided for making improvements in the service experience, and to determine how to improve the array of services provided. QSRs include provider quality reviews, person-centered reviews, individual and family interviews and/ or surveys, CSB Quality Record Reviews, and other DBHDS quality service reviews. QSRs also provide an assessment of whether individuals' needs are being identified and met through person-centered planning and thinking, whether services are being provided in the most integrated setting (appropriate to the individuals' needs and consistent with their informed choice), and whether individuals are given opportunities for community integration in all aspects of their lives. Additionally, QSRs assess the quality and adequacy of providers' services, QI, and RM strategies, and provide recommendations to providers for improvement. Results of the QSRs are used to improve individual provider and system practice and service quality.

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. Virginia is one of 48 states, the District of Columbia and 22 sub-state entities that voluntarily participates in the NCI project, with Virginia participating since 2013. The NCI evaluation of service quality occurs at the individual, service, and systemic levels using data collected from the quality review processes. NCI helps agencies measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including person-centered planning, employment, rights, service planning, community inclusion, choice, health and safety, and satisfaction. NCI surveys include the In-Person Survey, three family surveys and a staff stability survey. Virginia regularly participates in the In-Person Survey and the three family surveys. Individuals (and their families) who use services through the DD Waivers are randomly selected to participate in the interview surveys. These surveys provide valuable insight concerning the outcomes of supports and services from the individual's and family's perspective and are used to identify areas needing improvement.

Office of Community Quality Improvement

Office of Community Quality Improvement (OCQI), under the oversight of the Director of the Office Community Quality Management, analyzes a variety of data for the identification of trends and patterns that inform data-driven decisions aimed at improving the quality of services at the provider and system levels. OCQI provides technical assistance and consultation, to internal and external state partners and community-based licensed providers, related to developing, implementing, and monitoring QI programs; develops and/or offers resources for evidence-based best practice guidance and training related to QI and RM for use by

community-based providers. OCQI also conducts CM data reviews at least semi-annually. Quality Improvement Specialists (QIS) review CM data and provide technical assistance to the CSBs relative to CM data.

OCQI also participates in the Support Coordination Quality Reviews (SCQRs), which include an assessment of core CM requirements. Each CSB conducts SCQRs as part of the comprehensive QI program. DBHDS identifies a statistically significant stratified statewide sample of individuals receiving HCBS waiver services and provides each CSB with the names of individuals to be reviewed. CSB CM/SC supervisors/QI specialists complete these quality reviews. To ensure the integrity of the CSB quality reviews, OCQI staff complete a retrospective review of a sample of records reviewed by each of the CSBs at least once per year using the same review process to measure agreement quantitatively. Data from the reviews is used by the CSB and the DBHDS Case Management Steering Committee (CMSC) to analyze implementation of CM processes and to develop QIIs to strengthen areas of weakness. DBHDS provides technical assistance to SC supervisors/QI specialists to increase reliability of the results in future reviews and to identify any CSB specific improvements needed. CMSC analyzes data throughout the process to determine systemic areas in need of improvement, including, as needed, recommendations for enforcement actions pursuant to the CSB Performance Contract and licensing regulations.

Office of Epidemiology and Health Analytics

The Office of Epidemiology and Health Analytics, formerly the Office of Data Quality and Visualization (DQV), was established to support efforts for DBHDS to become an insight-driven organization and to align resources with the increasing demand for data analytics. The mission of the office is to advance the use of quality data through collaboration and empowerment. The team promotes analytics as a key component in quality monitoring and decision-making throughout the agency by assisting subject matter experts (SMEs) and QIC subcommittees with the creation of specialized deliverables or services, including:

- Analytic consultation
- Data collection, restructuring, and reconciliation
- Ad-hoc data reporting and visualization
- Methodological development and reporting logic
- Documentation of data processes and cleaning procedures
- Survey development
- Sampling methodology
- Retrospective studies
- Queries for ad-hoc analysis
- Process mapping for data flow
- Advanced statistical analyses

The office also supports the identification, evaluation, refinement, and documentation of processes that already exist in their respective areas and assists in determining where improvements can be made. Understanding the process from which data originate is a necessary component to deciding what data should be collected, analyzed, and reported. Therefore, it is essential that team members gain a foundational understanding of business processes to assist SMEs with the development of effective data questions and analyses.

To support the mission, team members also work to assess data, measures, and source system integrity for data quality issues. Established profiling criteria are used in these assessments including completeness, validity, reliability, accuracy, consistency, availability, timeliness, usefulness, uniqueness, relevance, and format.

When data quality issues have been identified using these criteria, team members alert the QIC subcommittees in a variety of ways. A representative from the office is an active member of each committee to participate in various processes including different aspects of data entry, measure development, monitoring, visualization, reporting, improvement strategies, and future planning. This valuable position ensures they have an opportunity to ask questions, raise concerns, and provide education on specific issues. Team members identify and verbally address most issues during QIC subcommittee meetings; however, if data quality concerns are more pervasive, team members may communicate the issue through specially designated meetings or formalized reports and presentations.

In addition to identifying and communicating data quality concerns, team members provide technical assistance to subject matter experts (SMEs) and QIC subcommittees as they work to brainstorm solutions, utilize data collection tools, streamline procedures, and standardize documentation. Team members then work to educate SMEs, senior level staff, and other relevant stakeholders on the creation of new processes and workflows to implement these solutions and improvement strategies based on available agency resources. Team members may also advise on potential future resources, where appropriate.

Team members collaborate one-on-one with SMEs to document the details associated with each QIC approved PMI, including a comprehensive methodology and set of calculation steps. After working with a SME to complete a measure development form, a team member conducts an assessment to identify potential threats to validity and reliability associated with each specific performance measure and documents them within each form.

There are several procedures inherent in how the office functions. These procedures are conducted to continuously monitor, measure, and improve data quality. To exercise the versatility of the process and establish models for ongoing quality monitoring, the office

regularly applies a process established by Avedis Donabedian to the development of their quality monitoring efforts. General steps in this model of quality monitoring and improvement include:

1. Determining what to monitor
2. Determining priorities in monitoring
3. Selecting an assessment approach
4. Formulating criteria and standards
5. Obtaining the necessary information
6. Choosing when and how to monitor
7. Constructing a monitoring system
8. Bringing about behavior change

The office utilized this model of quality monitoring and improvement in its development of a comprehensive Data Quality Monitoring Plan (DQMP). The DQMP was designed to be an objective assessment of the quality of the major data source systems used for agency reporting. The results of this plan will be used to guide the improvement of key data sources, monitor progress over time, and ensure that the Department is able to collect and analyze consistent, reliable data.

Mortality Review Office

Mortality Review Office (MRO) focuses on system-wide QI by conducting mortality reviews of all individuals with an intellectual and/or developmental disability (I/DD) diagnosis who received any DBHDS licensed services. MRO also provides oversight for all deaths that occur in any state operated facility. MRC provides ongoing monitoring, data analysis, identification of trends and patterns, and makes recommendations to promote the health, safety, and well-being of said individuals, to reduce mortality rates to the fullest extent practicable.

As a commitment to the Commonwealth of Virginia, MRO contributes to the system of care improvements through integration of clinical evidence, data driven determinations, and evidenced based QI principles. Review, identification and analysis of trends, patterns, and issues related to the deaths of these individuals, can indicate opportunities for system improvement to reduce risks to all individuals receiving behavioral health or developmental services. On an ongoing basis, DBHDS seeks to prevent instances of abuse, neglect, exploitation, and unexplained death by identifying and addressing relevant factors during mortality reviews.

MRO is responsible for:

- Assuring receipt of documents from the OL (with respect to deaths of individuals receiving a DBHDS licensed service at the time of their death)) within 45 business days of date of death

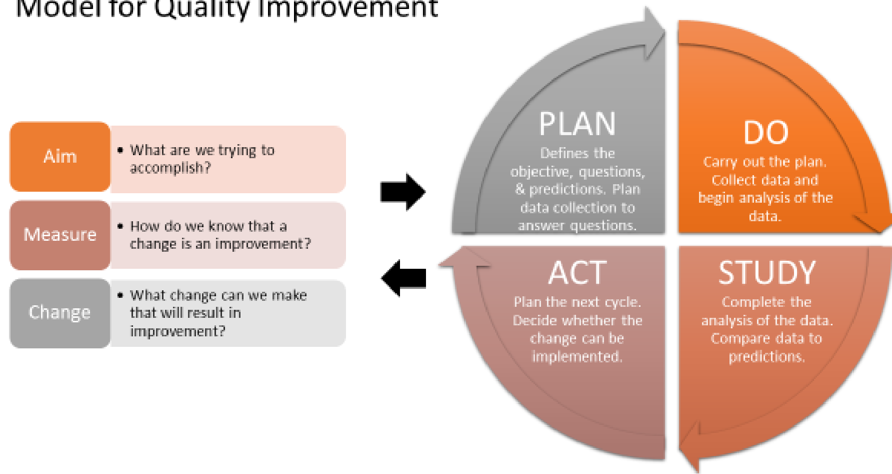
- Reviewing documentation from any provider or facility who performed care (or other service) for that I/DD individual and assessing for risk mitigation, health, safety, and freedom from harm concerns noted therein
- Composing relevant information into a succinct clinical summary for the MRC to review, within 90 calendar days of the date of death
- Reviewing all state facility deaths via 45-day reports submitted within 60 days of date of death
- Classifying cases according to Tier category or reclassifying state facility determinations if circumstances warrant
- Requesting additional information as needed
- Interviewing any persons having information regarding the individual's care
- Collecting, tracking, analyzing, and reporting facility and I/DD mortality data to identify trends, patterns, and issues at the individual, service delivery and systemic levels
- Documenting MRC determinations, recommendations, and assigned actions.
- Developing reports (data and quality improvement) and presenting them quarterly to the MRC and DBHDS Commissioner (except for the MRC Annual Report which is developed and presented yearly in December)
- Ensuring that the I/DD and Facility MRCs adhere to and maintain, their oversight responsibilities

With these described processes laying the foundation for the QMS' operations, DBHDS also structures its QI efforts to inform its system of care. The following section provides an overview of DBHS' QI process.

DBHDS Quality Management System Quality Improvement Process Description

The DBHDS QM program utilizes the Plan-Do-Study-Act[4] quality improvement model depicted below.

[4] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.



Quality is a continuous process, rather than a one-time activity, and connects with the agency's mission and vision. This process involves:

- Development of quality outputs and outcomes
- Data collection
- Data analysis
- Evaluating the effectiveness of the overall system
- Determining findings and conclusions
- Identifying trends that need to be addressed
- Identifying corrective actions, remedies, or quality improvement initiatives as needed
- Implementing quality improvement initiatives, corrective actions, or remedies; and
- Evaluating the effectiveness of implemented corrective actions, remedies, and or quality improvement initiatives.

As DBHDS uses these QA, RM and QI processes in its QMS operations and engages in CQI activities, key areas are targeted for improvement (known as Path Forward).

Data reliability and validity is a key component for the quality management system and the development of quality improvement initiatives. Processes to evaluate and improve upon data quality are integrated throughout the quality management system which include use of i.e., known, and accepted benchmarks, inter-rater reliability tools, use of standardized tools and measures, internal validation processes, and updating and enhancing existing sources of data.

Path Forward

Using its QM Program Evaluation, DBDHS determines the path forward, for targeted improvement for the coming year. DBHDS may include other Path Forward items based on strategic plan and associated priorities, external audit findings, or emerging needs. An assessment of these items will be included in Part 3: Annual Report and Evaluation.

- 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.

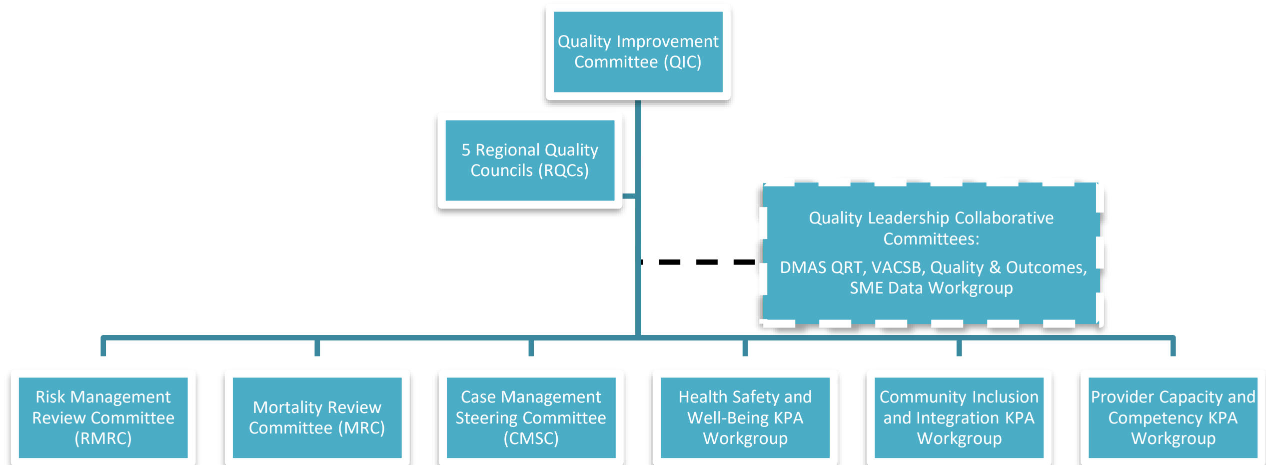
- DBHDS will continue to enhance the ability to utilize data in driving decision-making, in identifying service gaps, and in identifying QI efforts, including statewide initiatives.
- DBHDS will collaborate with providers on evaluating their own programs and services to utilize QA, and RM data to inform 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.

This framework and path forward set the stage for our quality committee framework (Part 2) which includes a description of the quality committee structure, general charter requirements and description of the work plan used by the QIC subcommittees.

Part 2 Quality Committees

Organizational Quality Improvement Committee Structure

DBHDS has established a quality committee framework as part of its QMS, as outlined below. The quality improvement committee (QIC) oversees the work of the QIC subcommittees (subcommittee, workgroup, council). The current structure of the QM Program includes collection and analysis of data by various interdisciplinary quality committees. The chart below illustrates the DBHDS quality committee structure.



Description of Quality Committee Structure

The Committees are established to create an organizational structure for accountability, standardized execution of the work conducted by all other committees, and coordination of activities and use of resources. The QIC is the highest-level quality committee. The QIC subcommittees report to the QIC. They are responsible for prioritization of needs and work areas and for resource allocation, to achieve intended outcomes for the agency and the Commonwealth. DBHDS' quality committees focus on these key performance areas (KPAs): Health, Safety and Wellbeing, Community Inclusion and Integration, Provider Capacity and Competency. DBHDS has established these KPAs as the umbrella for assessing how the agency is performing according to assigned indicators both at a statewide and regional level. Within these KPAs is the designation of domains which further describe the focus of each KPA.

Each quality committee includes voting and advisory members. Members may include external representation either as a voting or advisory member. Each quality committee has a charter that outlines the specific roles and designation as voting or advisory member. In accordance with this structure, the QIC approves the creation and/or discontinuation of a DBHDS quality committee/workgroup. Basic standard operating procedures apply to all quality committees and include but are not limited to:

- Development and annual review and update of the committee charter
- Expectations for meeting regularly, to ensure continuity of purpose
- Expectations for maintaining reports and/or meeting minutes as necessary and pertinent to the committee's function
- Expectations for the development of quality improvement initiatives using the Plan-Do-Study-Act Model

Quality Committee Charters

Each quality committee operates under the parameters outlined in its charter. Each charter is tailored to the unique purpose of the quality committee.

All charters contain the following elements: purpose, scope of authority, charter review schedule, DBHDS quality improvement standards, model for quality improvement, membership, meeting frequency, quorum, leadership and responsibilities, and definitions. Approved charters can be found in the Appendices.

QIC Subcommittee Work Plan

Each quality subcommittee completes a work plan, per state fiscal year, that reflects the work done within the parameters outlined in its charter.

The QIC Subcommittee Work Plan provides a means for all quality subcommittees, workgroups, and councils to document areas of focus, including quality improvement efforts, and ensures consistent reporting to the QIC. Each quality subcommittee/workgroup/council uses the work plan to identify patterns and trends, to monitor progress of the assigned performance measure indicator(s) (PMIs) and track the subsequent development and implementation of QIIs related to their regular review of data within their focus areas. Each work plan is individualized to the quality subcommittee/workgroup/council, which promotes tailored areas of focus as determined by the subcommittee/workgroup/council. Work plans are completed according to the state fiscal year and each QIC subcommittee maintains their own work plan.

The following standard definitions apply to all quality committees.

Definitions

- Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs, and other activities requiring approval.
- Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations

- Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues.
- Eight Domains - Outline the key focus areas of the DBHDS Quality Management System (QMS): (1) safety and freedom from harm; (2) physical, mental, and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity.
- Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver.
- Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Wellbeing; Community Inclusion and Integration; and Provider Capacity and Competency.
- Key Performance Area Workgroups - DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains.
- N - Sample size
- National Core Indicators - Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families, and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health, and safety
- Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review.
- Quality Committees - The QIC and QIC Subcommittees collectively
- Quality Improvement Committee (QIC) Subcommittee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee).
- Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees
- Quality Improvement Initiative (QII) - Addresses systemic quality issues identified through the work of the QIC subcommittees.

- Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS.
- Quality Service Review (QSRs) - Review conducted for evaluation of services at individual, provider, and system-wide levels to determine whether individuals' needs are being identified and met through person-centered planning and thinking, whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals have opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, QI, and RM strategies, and provide recommendations to providers for improvement.
- Quorum - Number of voting members required for decision-making.
- Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions.
- State Fiscal Year (SFY) - July 1 to June 30
- Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs, and other activities requiring approval.
- Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Glossary of Acronyms

Acronym	Full Form
BHA	Behavioral Health Authority
CCO	Chief Clinical Officer
CHRIS	Comprehensive Human Rights Information System
CLBs	Community Look-Behinds
CM	Case Manager
CMS	Centers for Medicare and Medicaid Services
CM/SC	Case Manager/Support Coordinator
CMSC	Case Management Steering Committee
CQI	Continuous Quality Improvement
CRC	Community Resource Consultant
CSBs	Community Services Boards
DARS	Department of Aging and Rehabilitative Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
DHP	Department of Health Professions
DMAS	Department of Medical Assistance Services
DQMP	Data Quality Monitoring Plan
DQV	Office of Data Quality and Visualization

Acronym	Full Form
DSP	Direct Support Professional
HCBS	Home and Community Based Services
HSRI	Human Services Research Institute
IMU	Incident Management Unit
ISP	Individual Support Plan
KPA	Key Performance Area
KPAW	KPA Workgroup (s)
LHRC	Local Human Rights Committee
MCO	Managed Care Organization
MRC	Mortality Review Committee
MRO	Mortality Review Office
NASDDDS	National Association of State Directors of Developmental Disability Services
NCI	National Core Indicators
OAG	Office of the Attorney General
OBRA	Omnibus Budget Reconciliation Act
OCQI	Office of Community Quality Improvement
OCQM	Office of Clinical Quality Management
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
OPD	Office of Provider Development
PASRR	Pre-Admission Screening and Resident Review
PCR	Person Centered Review
PMs	Performance Measure (CMS DD performance measure)
PMI	Performance Measure Indicator
PQR	Provider Quality Review
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Plan
QMP	Quality Management Plan
QMR	Quality Management Review
QMS	Quality Management System
QRT	Quality Review Team
QSR	Quality Service Review
RM	Risk Management
RMRC	Risk Management Review Committee
RQC	Regional Quality Council
RST	Regional Support Team
SC	Support Coordinator
SCQR	Support Coordinator Quality Review

Acronym	Full Form
SA	Settlement Agreement
SFY	State Fiscal Year
SHRC	State Human Rights Committee
SIU	Specialized Investigations Unit
VACSB	Virginia Association of Community Services Board
VCBR	Virginia Center for Behavioral Rehabilitation
VDSS	Virginia Department of Social Services
WaMS	Waiver Authorization Management System

Appendix

- Approved Charters
- SFY23 Subcommittee Work Plan Template