DBHDS

Virginia Department of Behavioral Health and Developmental Services

# Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2024

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***A Life of Possibilities for All Virginians***

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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). Notable key accomplishments in state fiscal year (SFY) 2024 in each area were:

- Health, Safety and Wellbeing KPA: 1) Removed Level I incident data from the incident reporting dashboard as these are not required to be reported, resulting in<5% decrease in the number of Level I incidents reported. 2) Created a falls dashboard that includes additional elements for analysis such as unique individuals with multiple falls, age, race, and gender to allow comparative analysis across different time periods. 3) Increased the percentage of providers reporting annual data on use of seclusion/restraint from 46% of services to 80% of services. 3) Embedded the Risk Awareness Tool (RAT) into the Person-Centered (PC) Individual Service Plan (ISP) to assure that risks and routine supports are addressed efficiently by all providers, streamlining and simplifying ISP elements and focusing outcome development on what matters to the person supported.
- Community Inclusion and Integration KPA: 1) Finalized the Medical Emergency Toolkit, which provides resources, tools and scenarios to help providers and caregivers prepare for medical emergencies. 2) Three of four community inclusion and integration Case Management Steering Committee (CMSC) measures achieved above target performance in SFY24.
- Provider Capacity and Competency KPA: 1) Implemented an initiative to increase the number of ISPs being in correct status (for Community Services Board (CSB) ISP compliance). 2) Trained 5,240 community partners in the REACH programs in addition to the individualized training provided to the individuals, care staff, families and community partners who support the individual.
- System Accomplishments: 1) Revised KPA outcomes to more effectively assess overall progress in each KPA. 2) Launched the Multi Agency Review Team (MART) process statewide to decrease administrative burden on CSB DD providers. 3) Provided

Consultation and Technical Assistance (CTA) to 43 provider agencies of which 22 had been cited for 620. C2. Out of those 22 provider agencies, 73% were not cited again for 620. C.2 in their next licensing review. 4) Expanded CTA by onboarding twelve positions to focus on 12VAC35-105-450, 12VAC35-105-520, 12VAC35-105-620, and a select element from the Quality Service Review (QSR). 5) Amended Office of Licensing (OL) and Office of Human Rights (OHR) regulations to ensure they support high quality crisis services, effective July 17, 2024. 6) Completed multiple root cause and gap analyses, to understand reasons for performance below the established standard, for several REACH measures, resulting in regional REACH teams developing and implementing action plans to improve performance.

During SFY24, the DD QMS' implemented work (several trainings, released tools and resources) driven by SFY23 data analysis and as referenced in the SFY23 DD QMP Annual Report and Evaluation to be completed in SFY24. Five performance measure indicators (PMIs) met target for the first time; three very nearly met target, and two PMIs with two or more components had all but one of the components met.

The expansion of MART to statewide implementation will have continued impact on both DBHDS and its community partners as well as lessen the administrative burden of external stakeholders in providing the same documents to multiple entities for reviews. Now that MART is statewide, targeted efforts to enhance the Master Scheduler and MART Portal are underway.

The expansion of CTA (ECTA) to identified providers/CSBs receiving either an approved corrective action plan (CAP)for licensure regulations 12VAC35-105-470, 12VAC35-105-520, 12VAC35-105-620, and/or receiving a QSR quality improvement plan (QIP) resulted in the onboarding of twelve positions during SFY24. ECTA offers providers and CSBs a unique opportunity to further their understanding and experience in using risk management and quality improvement principles and tools as each provider receives one on one attention from a singular DBHDS staff member. The focus of ECTA includes "meeting providers/CSBs where they are" and working with providers/CSBs with the desired goal of improved performance at the next licensing inspection or QSR review.

The incorporation of the RAT into the ISP was one systemic effort that generated a lot of excitement throughout SFY24. As a major update to the ISP, this initiative allows both CSBs and providers to effectively work towards increasing ongoing awareness of the individual's risks and the addressment of such in all ISP sections. CSBs and providers were represented in the planning and testing of the resulting ISP changes. This overhaul of the ISP provided the opportunity for other additional changes to be made throughout the ISP. While it is targeted to be released for

use in August 2025, everyone who participated in the testing expressed excitement with the changes as the ISP was streamlined.

The DD QMS targeted several systemic areas, as noted above, whose impact will be observed in subsequent years. Discussions continued around sustainability of quality improvement processes and meeting restructure for the Quality Improvement Committee (QIC) and Regional Quality Council (RQC) meetings. As noted in the previous report, these areas for improvement will take time and due consideration given their complexity.

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 SFY24. This document summarizes key accomplishments of the DD QMS KPAs and system, followed by assessments of the PMIs regarding progress towards set targets, summary of data reports, updates on implemented quality improvement initiatives (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 SFY24 overall key accomplishments within the KPAs and key system improvements.

# Key Accomplishments of the QM Program

## Health, Safety and Wellbeing

1. Continued focus on improvements in state level risk management processes, data validity and reporting, and identification of key trends by the Risk Management Review Committee (RMRC). Notable key accomplishments included:

- Removed level 1 incidents from the incident reporting dashboard as level 1 incidents are not required to be reported and the inclusion of such could impact data validity. The removal resulted in a slight (<5%) decrease in the number of incidents reported.
- Created a falls dashboard that incorporated additional analysis of falls to include unique individuals with multiple falls, age, race and gender to allow comparative analysis across different time periods. The RMRC will use this information to identify targets for future interventions to reduce the fall rate once the dashboard is in production. This may include a focus on specific groups of individuals most at risk of frequent or serious fall events.
- Implemented an initiative that focused on increasing the percentage of providers reporting annual data on the use of seclusion and restraints. This initiative was successful in increasing the percentage of reporting from 46% of services to 80% of services.
- Initiated sharing risk data process with providers and published an article of serious incident trends in the OL newsletter.

2. Improved performance with the two measures monitored by the CMSC in this KPA through the SFY24 Support Coordination Quality Review (SCQR) annual review and refinement process, completed in collaboration with CSBs. We have seen year-over-year improvements in both performance and reviewer agreement, which increases our confidence that the process is achieving its intended result as a quality improvement method.
3. Implemented an initiative integrating the RAT into the PC ISP to assure that risks and routine supports are addressed efficiently by all providers, streamlines and simplifies ISP elements, and focuses outcome development on what matters to the person supported.

## Community Inclusion & Integration

1. Finalized the Medical Emergency Toolkit, which provides resources to providers on emergency preparedness and scenarios to practice. Toolkit to be presented to licensed providers in SFY25 Q1.
2. Focused improvement in community inclusion and integration through the annual SCQR update process led by the CMSC. This resulted in seeing three of the four measures monitored in this area achieving above target performance in SFY24.

## Provider Capacity and Competency

1. Implemented an initiative to improve ISPs being in the correct status (either ISP completion or pending provider completion) for CSB ISP compliance.
2. Trained 5,240 community partners in the REACH programs. This training is in addition to the individualized training provided to the individuals, care staff, families, and community partners who support the individual.

## System Accomplishments

1. Revised each KPA outcome to more effectively assess overall progress in each KPA. These revised outcomes are listed at the beginning of each KPA.
2. Launched the MART process statewide to decrease adminsitrative burden on CSB DD service providers, with plans to extend to CSB BH providers and ultimately private providers of DD and BH services.
3. Proposed enhancements to the MART Master Scheduler and a MART Portal (to be used for submission of documentation) were made to the Enterprise Investment Board (EIB) to continue efforts in reducing administrative burden on CSBs.
4. Leveraged targeted case management (TCM) and enhanced case management (ECM) Power BI dashboards developed last year to assist the CMSC and CSBs have timelier, row level data, positioning them for better identification and monitoring of improvement efforts.
5. Provided CTA to 43 provider agencies of which 22 had been cited for 620.C2. Out of those 22 provider agencies, 73% were not cited again for 620. C.2 in their next licensing review.
6. Expanded CTA by onboarding twelve positions to focus on 12VAC35-105-450, 12VAC35-105-520, 12VAC35-105-620, and a select element from the QSR.
7. Amended OL and OHR regulations to ensure they support high quality crisis services, effective July 17, 2024.
8. Provided training relative to the amended regulations to licensed providers of crisis services and CSBs.
9. Completed root cause analysis (RCA) in crisis responses in community, identifying the root cause as mobile crisis response crisis assessment not occurring at location of the crisis; each regional REACH program developed and implemented an action plan.
10. Completed RCA on consistent completion of individual crisis education prevention plan (CEPP) within established timelines, identifying five overarching causes; each regional REACH program developed and implemented an action plan.
11. Completed RCA on the identification of residential placement within thirty days of an admission to either crisis therapeutic housing (CTH) or psychiatric hospital identifying six

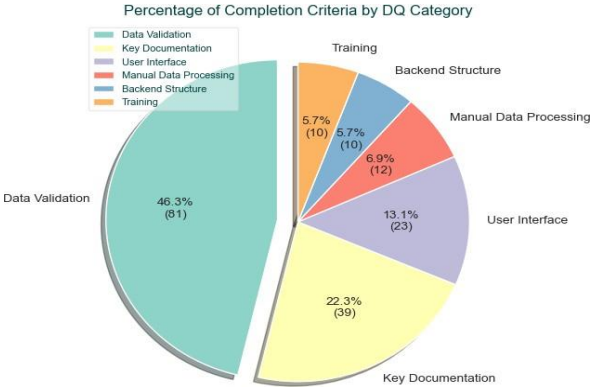
overarching root causes; each regional REACH program developed and implemented an action plan.

12. Implemented action plan in response to youth crisis therapeutic home survey findings.
13. Convened a statewide focus group to discuss low utilization of out of home short term crisis prevention services for youth with recommendations given to DBHDS for consideration.

# Data Quality

Data Source and Data Source System Assessment Results

Data source system and data source assessments result in the identification of data quality (DQ) concerns, overarching recommendations for quality improvement, and completion criteria (actions to be taken to address data source and data source system data validity and reliability concerns). This pie chart shows the percentage of completion criteria is depicted by data quality category. In SFY24, the top three greatest areas of need identified fell into the data validation, key documentation, and user interface DQ categories.




Progress related to data source system and data source assessment, by DQ category, is broken down by overarching recommendation and completion criteria noted in SFY24 assessments as well as progress noted by the business /program area as part of the SFY25 Annual Update cycle.

**Totals by DQ Recommendation Categories**

| | DQ Recommendations | | | Completion Criteria | | | Annual Update on Internal Progress | | |
|---|---|---|---|---|---|---|---|---|---|
| DQ Category | Recs | Met Recs | % Met Recs | Criteria | Met | % Met Criteria | Completed | In Progress | % Completed |
| User Interface | 14 | 6 | 43% | 23 | 6 | 26% | 5 | 14 | 53% |
| Data Validation | 39 | 14 | 36% | 81 | 16 | 20% | 35 | 46 | 54% |
| Key Documentation | 23 | 8 | 35% | 39 | 8 | 21% | 14 | 25 | 45% |
| Manual Data Processing | 8 | 2 | 25% | 12 | 2 | 17% | 8 | 4 | 80% |
| Training | 8 | 2 | 25% | 10 | 2 | 20% | 3 | 7 | 98% |
| Backend Structure | 6 | 1 | 17% | 10 | 1 | 10% | 7 | 3 | 78% |
| Total | 98 | 33 | 34% | 175 | 35 | 20% | 76 | 99 | 43% |

For data source systems and data sources with initial and follow-up assessments, the table shown summarizes the number of overarching recommendations and related completion criteria that have been determined to be 'Met' by the OCQM consultant in SFY24, as well as progress toward meeting recommendations and completion criteria remaining unmet (based on business/program area report.

**Totals by Source System (2+ Assessments)**

Data is from the most recent assessments

| | OCQM/DQV Assessments | | DQ Reccmmendations | | | Completion Criteria | | | Annual Update on Internal Progress | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| System | Assessments | Last Eval | Recs | Met Recs | % Met | Criteria | Met | % Met CC | Complete | In Progress | % Complete |
| REACH | 2 | 9/1/2023 | 4 | 1 | 25% | 9 | 2 | 22% | 2 | 7 | 22% |
| PAIRS | 2 | 8/31/2023 | 4 | 0 | 0% | 16 | 0 | 0% | 0 | 16 | 0% |
| CES | 3 | 8/24/2023 | 9 | 9 | 100% | 17 | 17 | 100% | 17 | 0 | 100% |
| CHRIS-HR | 2 | 8/24/2023 | 5 | 0 | 0% | 9 | 0 | 33% | 3 | 6 | 33% |
| CHRIS-SIR | 2 | 8/24/2023 | 4 | 0 | 0% | 7 | 0 | 29% | 2 | 5 | 29% |
| IFSP | 2 | 8/17/2023 | 3 | 2 | 67% | 3 | 2 | 67% | 2 | 1 | 67% |
| Avatar | 3 | 8/4/2023 | 6 | 3 | 50% | 14 | 6 | 50% | 7 | 7 | 50% |
| WaMS | 3 | 8/4/2023 | 9 | 2 | 22% | 20 | 5 | 25% | 5 | 15 | 25% |
| CNF | 2 | 7/18/2023 | 8 | 4 | 50% | 18 | 12 | 78% | 14 | 4 | 78% |
| Total | 21 | 9/1/2023 | 51 | 21 | 41% | 112 | 44 | 39% | 52 | 61 | 46% |

**Totals by Source System (One Assessment)**

Data is from the most recent assessments

| | OCQM/DQV Assessments | | DQ Recommendations | | Annual Update on Internal Progress | | |
|---|---|---|---|---|---|---|---|
| System | Assessments | Last Eval | Recs | Criteria | Complete | In Progress | % Complete |
| VCC | 1 | 2/8/2024 | 6 | 14 | 7 | 7 | 50% |
| CR | 1 | 8/17/2023 | 5 | 14 | 5 | 9 | 36% |
| RST | 1 | 8/16/2023 | 6 | 12 | 0 | 12 | 0% |
| Waitlist | 1 | 8/15/2023 | 3 | 8 | 2 | 6 | 25% |
| CONNECT | 1 | 7/18/2023 | 8 | 23 | 18 | 5 | 78% |
| SCQR | 1 | 6/29/2023 | 1 | 1 | 1 | 0 | 100% |
| OLIS | 1 | 6/:/2019 | 4 | 4 | 0 | 4 | 0% |
| Total | 7 | 2/8/2024 | 34 | 77 | 33 | 43 | 43% |

This table summarizes information related to data source systems, data sources or data source system modules with only one assessment. It is important to note that these systems will not have any 'Met' recommendations or completion criteria either because the data source or data source system was determined to have "met" all assessment recommendations and completion criteria or the data source or data source system does not come due for reassessment until SFY26/27.

# Performance Measure Indicators and Data Reports

The DBHDS QMS 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, Mortality Review Committee (MRC), CMSC, and the KPA Workgroups along with Office of Clinical Quality Management (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.

Prior to the annual PMI review, two PMIs assigned to CMSC were retired August 1, 2023, and are not included in SFY24 reporting. One PMI assigned to the CMSC was separated into two distinct PMIs, effective March 25, 2024, with the two PMIs included in the SFY24 PMI reporting. The annual review process involved 24 PMIs plus a review of their PMI process documents and attestations. This review determined that five PMIs would be retired and that the remainder would continue. One PMI was noted needing its methodology and target updated as the population used in the denominator had changed.

# 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. This KPA's outcomes focuses on the individual. *Individual:* People being served are safe, receive routine, preventative healthcare, and holistic, person-centered behavioral health services and supports.

The DBHDS OHR and RMRC, through CHRIS, collected the data presented below for the PMIs. The KPA Workgroups, and RMRC analyze and monitor the data, as applicable. MRC collected the

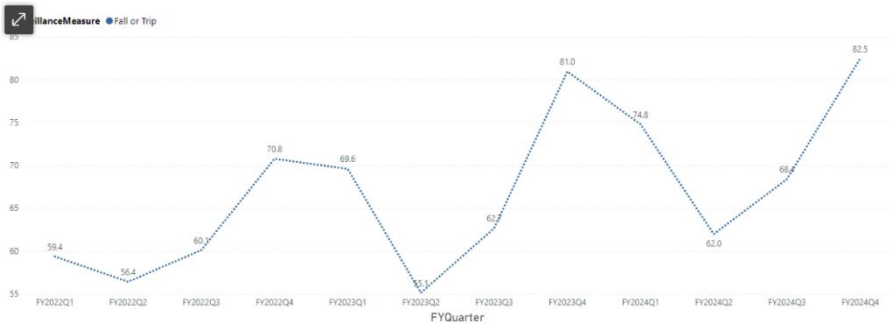
data for the last PMI and analyzes and monitors the data. Please find below a brief synopsis of progress towards the achievement of PMIs relevant to domain of safety and freedom from harm.

| Performance Measure Indicator – Safety and Freedom from Harm | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 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% | 99% | **Fully Met** |
| Annualized rates of "falls" or "trips" are 61.64* or less* | 61.64 per 1,000 | 45 | 61.64 | 67.05 | 71.88 | **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% | 100% | ** | 100% | 100% | **Fully Met** |

*Goal revised in SFY24 using updated baseline data, reflecting removal of level 1 incidents from reporting.
**The PMI was not approved for that SFY, thus the absence of data.

For the *Hierarchy of Restraint* PMI, the goal is to ensure that individual service recipients are free from abuse in the form of unauthorized seclusion and restraint. Even with the gradual increase each year in the number of individual service recipients and overall reports of abuse, this measure remains consistently above compliance at 99.9% of individual waiver recipients being free from unauthorized use of seclusion and/or restraint. As a result, it was determined this year that the *Hierarchy of Restraint* PMI would be retired based on sustained over target performance for over three consecutive years.

Except for one year, the *Serious Incidents Rates - Falls* PMI, which looks to keep the annual rate of falls at or below the target of 61.64/1000 reported falls/trips, has been above the goal of 61.64/1000 or less of reported falls/trips. The overall results for SFY24 were also greater than either SFY23 or SFY22, as shown in the graph. The RMRC had previously implemented a QII that aimed to reduce the rate of falls through general provider education on assessing and addressing fall risk, as well as follow-up with specific providers serving individuals with multiple falls (care concerns). This was not effective in reducing the rate of falls. During SFY24, the RMRC initiated a more detailed analysis of falls data with a goal of identifying specific factors that may be addressed in a future QII. This analysis is underway and will be completed in SFY25.



Open in Power BI
DW-0123-CHRISIncidentReport
Data as of 2/14/25, 12:05 AM
Filtered by **SurveillanceMeasure** (top 5 by Rate3), **FYQuarter** (is not FY2020Q1, FY2020Q2, FY2020Q3, FY2020Q4, FY2021Q1, FY2021Q2, FY2021Q3, FY2021Q4, FY2025Q2, FY2025Q3, or FY2025Q1), **SurveillanceMeasure** (is Fall or Trip)

The *Unexpected Deaths* PMI focuses on assuring that some intervention to remediate has occurred when the cause or a factor in the unexpected death was determined to be potentially preventable. The MRC utilizes the data to drive decision-making by identifying and addressing potential service gaps to promote quality care. The PMI continues to perform above target.

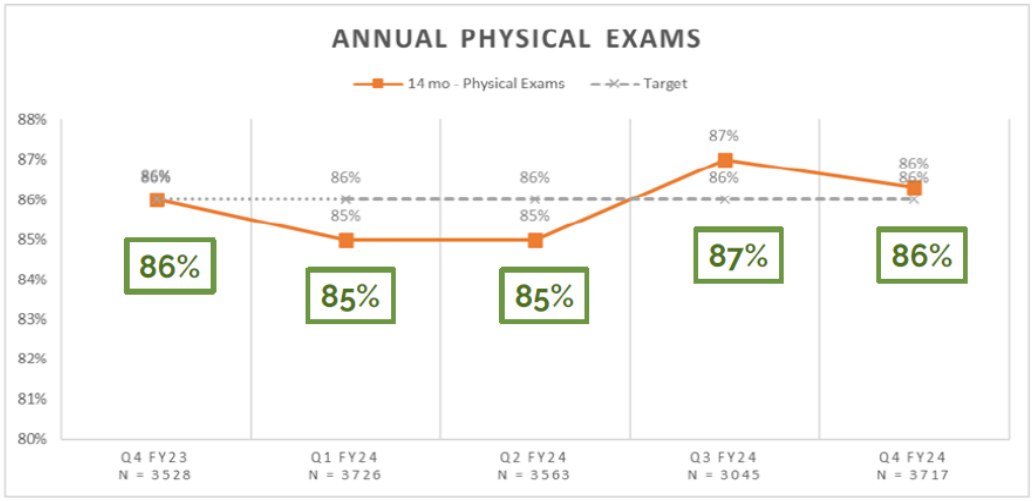
The Office of Integrated Support Services (OISS) and the CMSC, through the SCQRs, collected the data presented in the table below. The KPA Workgroups and the CMSC provide oversight, and monitor, and analyze the data. A brief synopsis of progress towards the achievement of PMIs relevant to the domain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

| Performance Measure Indicator – Physical, Mental and Behavioral Health and Wellbeing | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| Individuals in residential settings on the DD waivers will have a documented annual physical exam date. | 86% | 70% | 74% | 76% | 85.7%*^ | **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% | 90% | **Fully Met** |
| Individual support plans are assessed to determine that they are implemented appropriately. | 86% | 50% | 84% | 84% | 89% | **Fully Met** |

*PMI methodology corrected to account for all individuals within the 14 month ISP planning year versus using a 12 month ISP period.

^ Results are not rounded up to align with other reports.

The *Annual Physical Exam* PMI goal has been to increase the numbers of individuals who obtain annual exams by promoting the value of annual physical exams through education and outreach. When looking at the 14 months preceding the ISP renewal date, the percentage of individuals, completing an annual physical exam, each quarter in SFY24 has been incrementally on the rise. Beginning in SFY24, DBHDS changed the methodology (from using the 12 months prior to the ISP renewal date calculation to using the 14 months prior ISP renewal date calculation), which does not allow for a true comparison across fiscal years. Please note that 14 month calculation began in SFY23 Q4, which is why it is included in the graph above.




The Office of Integrated Health Network Supports (OIHNS) engaged in several initiatives directed towards improving the *Annual Physical Exam* PMI performance. These are outlined below and will continue during SFY25.

**Initiatives**

1. Promoted the "Annual Healthcare Visit Toolkit" found on the DBHDS website under Educational Resources. This toolkit is designed to help individuals and caregivers prepare for an annual healthcare visit.
2. Provided and presented the slide deck "Importance of Annual Physicals aka. Wellness Visits & Routine Check – ups." These slides highlight the benefits of an annual physical/wellness, what to expect, what insurance covers, and who to contact for help.
3. Provided and presented the Health and Safety Alert titled "Annual Healthcare Visits." This alert focuses on the benefits of annual healthcare visits, history, how to prepare, what questions to ask, and insurance coverage information.
4. Posted and promoted the "Recognizing Declining Health" training to the Commonwealth of Virginia Learning Center (COVLc) that furthers the community's understanding of the importance of having regular healthy visits to

the primary care provider (PCP), so everyone has a clear understanding of what the individual's baseline regarding health and wellness.

**Case Management Measures**

Two measures (*Change in Status and Modifying ISP* PMI [Indicator 9] and *ISPs Implemented Appropriately* PMI [Indicator 10]) are monitored by the CMSC in this KPA. The first measure is stated as "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. (Target 86%)" and the second as "individual support plans are assessed to determine that they are implemented appropriately. (Target 86%)." In SFY24, the results for both measures improved to above the target of 86%. Indicator 9 increased from 84% (SFY23) to 89%, and indicator 10 increased to 90%.

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 | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 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%<br>Q3 83% | Q1 81%<br>Q3 80% | Q1 87%<br>Q3 87% | **Fully Met** |

With the *Initial CEPPs* PMI, which focuses on those admitted into REACH mobile crisis supports having a CEPP completed within 15 days of their admission, the REACH programs were above the target of 86%, The regional REACH programs continued to have staff monitor the completion of CEPPs as per the REACH Standards as part of their quality assurance process.

# 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 have opportunities to engage in community-based activities, that support socialization, employment, recreation, and personal development for the purpose of building and strengthening relationships with others in their local community.

*"We do not "do" inclusion "for" people with disabilities. Rather, it is incumbent upon us to figure out how all the things we do can be inclusive."*
*Lisa Friedman: Removing the Stumbling Block*

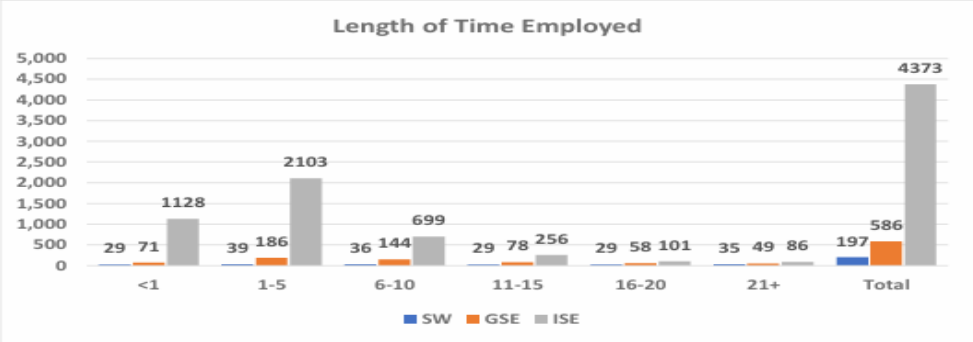
The OISS and Office of Community Housing (OCH) collected the data presented below. The KPA Workgroup and CMSC provide oversight, monitor, and analyze the data. The following tables and graphs describe the progress towards achievement of PMI goals relevant to the domains of stability, choice and self-determination,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

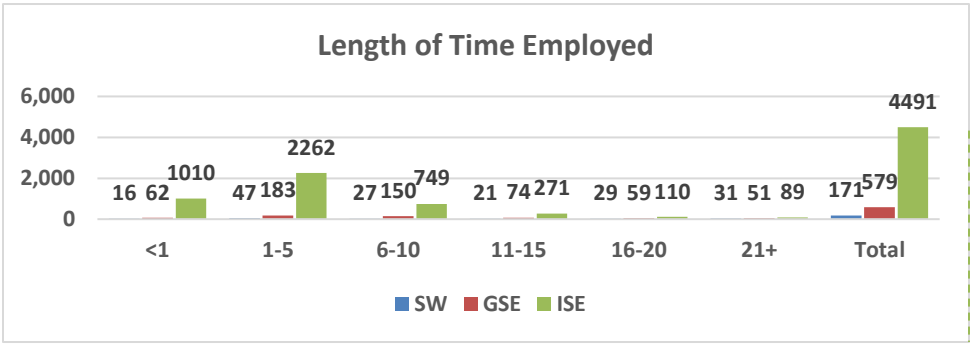
| Performance Measure Indicator - Stability | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| Individuals on the DD waiver and waitlist (aged 18-64) are working and receiving Individual Supported Employment (ISE) or Group Supported Employment (GSE) for 12 months or longer. | 80%* | 17% (25% target) | 17% (25% target) | 17% (25% target) | 78.8%** | **Partially Met** |
| Individuals have stability in the independent housing setting. | 85% | 97% | 92% | 99% | 100% | **Fully Met** |
| Individuals with a DD waiver and | 86% | 78% | 84% | 79% | 78% | **Partially Met** |

| Performance Measure Indicator - Stability | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| known to the Reach system who are admitted to Crisis Therapeutic Home (CTH) facilities and psychiatric hospitals will have a community residence identified within 30 days of admission. | | | | | | |

*The target was updated due to the denominator changing to reflect all those employed.
**Results are not rounded up to align with other reports.

*Employment Stability* PMI, focuses on those aged 18-64 being employed with either ISE or GSE for 12 months or longer, had its target updated as the denominator had changed to only



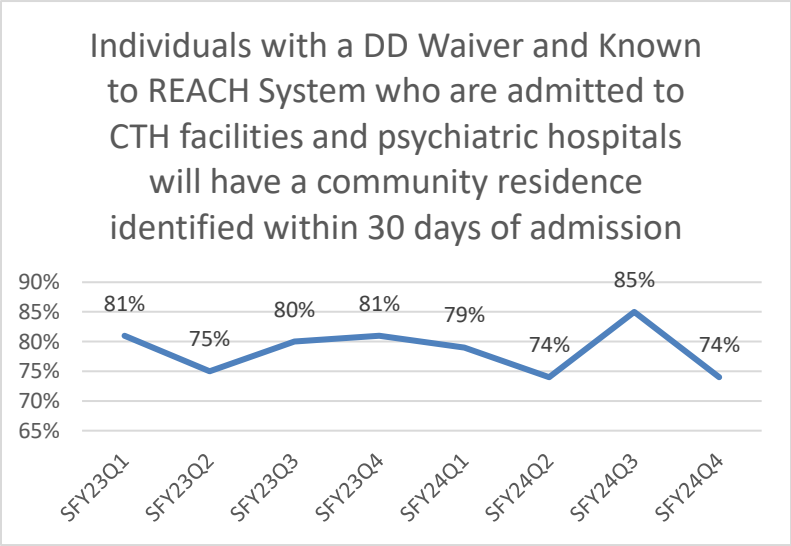




looking at those employed. SFY24 results cannot be compared to earlier years due to the change in target. The first graph shows July 1 – December 31, 2023, data; the second graph shows graph shows January 1 – June 30, 2024, data for length of time in years employed in current position has been broken down to better understand the number of years a person is employed and to see where individuals are currently choosing to

gain employment. 78.8% of individuals have been employed for over a year. This is an increase of .6% from the last reporting cycle. Employment stability is reported twice a year.

*Independent Housing Stability* PMI, which focuses on those living independently for 12 months or longer, continued to perform above target.

*CTH to Residential* PMI, which focuses on those admitted to CTH and psychiatric hospitals having a community residence identified within 30 days of admission, was not met in SFY24. One factor influencing performance is the need for stabilization, which varies from person to person. Historically, those admitted to hospital settings have greater needs than those admitted to CTH. However, when separating out the CTH data from the hospital data the criteria of 86% was met for the year, FY24Q1 – 88%, FY24Q2 – 93% and FY24 Q3 and Q4 –88%. In SFY24, DBHDS completed a request for proposal (RFP) process to bring on additional residential providers with the capacity and competencies to support people with co-occurring conditions using a person-centered/trauma-informed/positive behavioral practices approach to 1) prevent crises and hospitalizations, 2) to provide a permanent home to individuals discharged from CTHs and psychiatric hospitals.




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 | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| At least 75% of people receiving services who do not live in the family home/their | 86% | 100% | 100% | 100% | 100% | **Fully Met** |

| Performance Measure Indicator – Choice and Self-Determination | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| authorized representatives chose or had some input in choosing where they live. | | | | | | |
| Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff). | 86% | 83% | 90% | 90% | 93% | **Fully Met** |
| Individuals are given choice among providers, at least annually. ** | 86% | PMI Not Approved for Reporting | PMI Not Approved for Reporting | PMI Not Approved for Reporting | 97% | **Fully Met** |
| Individuals are given choice of support coordinator, at least annually. ** | 86% | PMI Not Approved for Reporting | PMI Not Approved for Reporting | PMI Not Approved for Reporting | 87% | **Fully Met** |

** Prior to 3.25.24, these PMIs were reported as a single PMI. 86%

The *Housing Choice* PMI focuses on integrating the choice of waiver services and providers into standard processes to ensure individuals and substitute decision-makers participate in decisions about where, when, and from whom to receive services. These decisions are documented on the Virginia Informed Choice (VIC) form. Results continue to be above target.

**Case Management Measures**

The *Relationships Discussion* PMI, which focuses on the annual discussion regarding the unpaid relationships the individual has, has been performing above the 86% target for three consecutive years with the highest result noted in SFY24 as 93%.

The *Provider Choice (SCQR Indicator 02)* and *SC Choice* (SCQR Indicator 01) PMIs were previously reported as one PMI. In SFY24, they were separated to more accurately reflect individual choices with providers and case managers (CM) /support coordinators (SC). Data related to these measures was collected through the SCQR. Performance with SC choice was above target in all years, except for SFY23, when the below target performance was seen at 83%. Choice of providers reached above target performance in SFY23, with continued improvement in SFY24, where the result was 97%. The primary form (VIC) utilized to confirm choice was enhanced in 2022 and is undergoing additional review. Along with the technical assistance provided to each CSB twice per year, the review and update of the VIC supports continued improvement in this area.

| Indicator | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Indicator 01 | 91.4% | 88.0% | 91.8% | 82.7% | 87.0% |
| Indicator 02 | 79.9% | 77.5% | 77.8% | 92.9% | 96.8% |

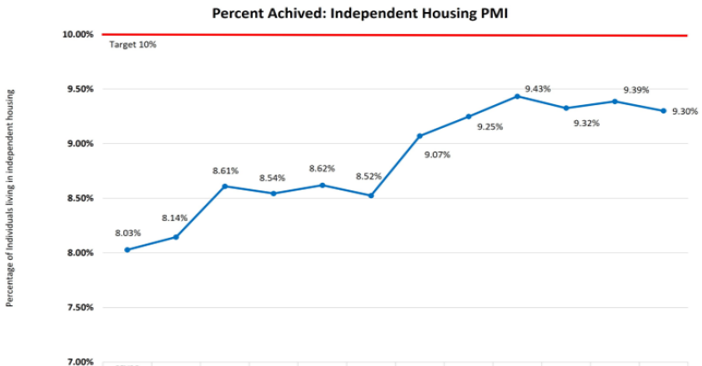
Indicator 1: The CSB has offered each person the choice of case manager. (III.C.5.c)
Indicator 2: Individuals have been offered a choice of providers for each service. (III.C.5.c)

| Performance Measure Indicator – Community Inclusion | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| Individuals live in independent housing | 10% | 8% | 8% | 8.87% | 9.30% | **Partially Met** |
| Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP. | 86% | 37% (derived from May and June 2021 data) | 31% | 53% | 60% | **Not Met** |

| Performance Measure Indicator – Community Inclusion | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| 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:**<br>PQR:<br>a. 97%<br>b. 97%<br>c. 98%<br><br>**Round 5**<br>PQR<br>a. 93%<br>b. 96%<br>c. 96% | **Round 6**<br>PQR:<br>a. 81%<br>b. 98%<br>c. 97% | **Partially Met** |

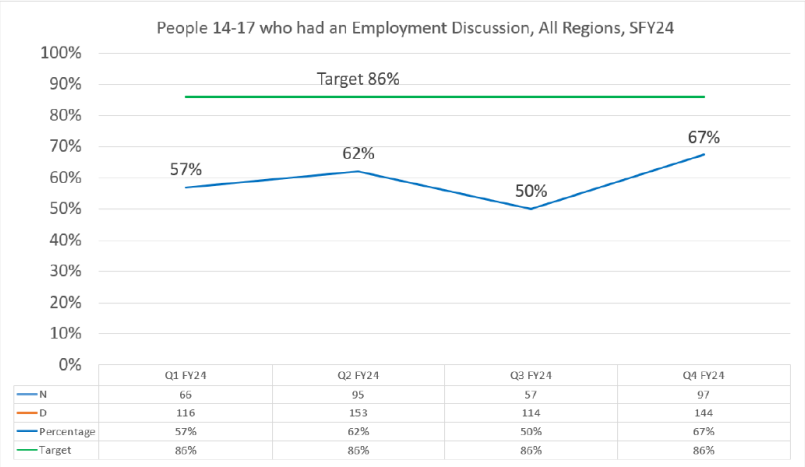
**The PMI was not approved for that SFY, thus the absence of data.
PQR a. promotes meaningful work
PQR b. promote individuals participating in non-large group activities
PQR c. encourages participating on community outings with people other than those with whom they live

The *Independent Living* PMI, which focuses on those living independently saw improved performance over SFY23. Housing costs continued to remain at higher levels, impacting available housing resources for those interested in living independently. Additionally, the increased number of waiver slots impacted the population, which increases the number needed living independently. The graph below shows progress beginning with SFY22 through SFY24.




| | SFY22_Q1 | SFY22_Q2 | SFY22_Q3 | SFY22_Q4 | SFY23_Q1 | SFY23_Q2 | SFY23_Q3 | SFY23_Q4 | SFY24_Q1 | SFY24_Q2 | SFY24_Q3 | SFY24_Q4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Percent Achived | 8.03% | 8.14% | 8.61% | 8.54% | 8.62% | 8.52% | 9.07% | 9.25% | 9.43% | 9.32% | 9.39% | 9.30% |
| Numerator | 1689 | 1732 | 1806 | 1807 | 1860 | 1872 | 2023 | 2084 | 2122 | 2140 | 2165 | 2185 |
| Denominator | 21,039 | 21,268 | 20,978 | 21,153 | 21,582 | 21,962 | 22,305 | 22,536 | 22,496 | 22,950 | 23,066 | 23,496 |

The Teen Employment PMI focuses on a noted discussion in the ISP regarding the teen's interest in employment, current activities the teen is working on at home and school toward employment after graduation, and how waiver services can support their readiness for work. Results for this measure have increased to 67% for Q4 SFY24, which is the highest level of performance seen to date. A Teen Employment Discussion resource, developed through RQC1's Teen Employment QII, was added to WaMS to assist SCs statewide in having teen employment discussions. The CMSC will continue to monitor this PMI's performance and ensure the provision of technical assistance through the Offices of Provider Network Supports (OPNS) and Community Quality Improvement (OCQI).




The *Provider Reporting Measure Community Inclusion* PMI, which focuses on a provider's demonstration of their commitment to community inclusion, incorporates three elements from the Provider Quality Review (PQR) portion of the QSR: promotion of meaningful work, promotion of participation in non-large group activities, and encouragement of participation in community outings with people other than those with whom they live. The results for promotion of meaningful work fell below the 86% target. The results of the other two elements remained above target again for QSR Round 6.

**Provider Quality Review:**

**N:** The number of providers who promote meaningful work

**D:** Number of providers reviewed

| QSR Round | Providers Reviewed | Promote Meaningful Work | Percentage |
|---|---|---|---|
| Round 3 | 566 | 552 | 98% |
| Round 4 | 317 | 307 | 97% |
| Round 5 | 302 | 280 | 93% |
| Round 6 | 307 | 248 | 81% |

# 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: Having

enough providers, who are knowledgeable, trained, and experienced, in our network to ensure equitable and timely access to supports/services.

The OPNS, OISS, and the QSR vendor 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 | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 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% | 1.5% | 1% | 2.3% | 1% | **Partially Met** |
| Data continues to indicate that at least 90% of individuals new to the waiver, including individuals with a "supports need level" of 6 or 7, since FY16 are receiving services in the most integrated setting. | 90% | 87% | 95% | 95% | 96% | **Fully Met** |
| Transportation provided by waiver service providers (not to include NEMT) is provided | 86% | Round 1=84% Round 2=91% | Round 3=97% | **Round 4** 94% | **Round 6 96%** | **Fully Met** |

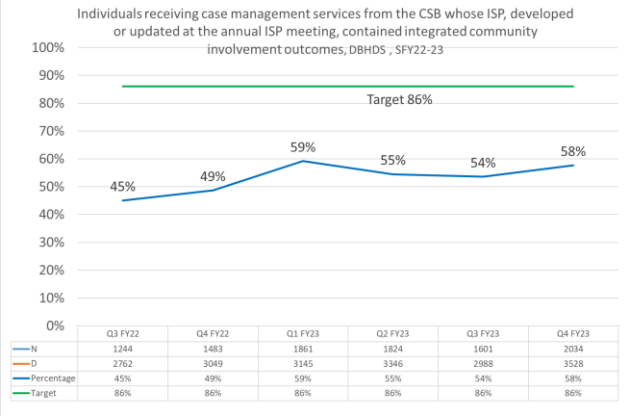
| Performance Measure Indicator – Access to Services | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| to facilitate individuals' participation in community activities and Medicaid services per their ISPs. | | | | **Round 5** 77% | | |
| Individuals receiving case management services from the CSB whose ISP, developed, or updated at the annual ISP meeting, contained integrated community involvement outcomes. | 86% | 38% | 50% | 56% | 61% | **Not Met** |

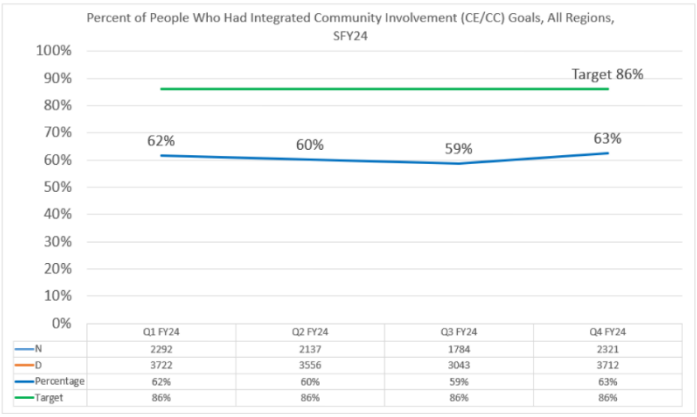
For the *Integrated Settings – Overall* PMI, which focuses on an annual 2% increase overall in individuals receiving services in the most integrated settings, Virginia has an overall integration result of 91.3%. This high level of integration systemwide is considered to inhibit Virginia's ability to realize the 2% annual increase established in the measure. DBHDS continues to support more integrated services and monitors this progress. The *Integrated Settings – New* PMI, focuses on those new to the wavier receiving services in the most integrated setting, continued to perform above target. DBDHS tracks the overall result to determine progress but continues to report supplemental results related to individuals with significant medical and behavioral needs to demonstrate success for those with the most complex needs. These two PMIs were retired in March of SFY24 as it was determined they no longer needed to be a PMI and would continue to be reported in the Provider Data Summary.

The *Transportation* PMI, which focuses on individuals getting to places, utilizes QSR data. Round 6 results reflect improved performance over the previous round. During March 2024, it was determined that this PMI would be retired as it was no longer needed.

**Case Management Measures**

The *Integrated Community Involvement* PMI, which focuses on the ISP containing integrated community involvement outcomes, showed consistent performance across SFY24, with the highest result being 63% in Q4 SFY24 as well overall improvement compared to SFY22 and SFY23, as shown below. A CMSC QII was approved by the QIC to focus on performance improvement with this measure, as well as other employment-related surveillance measures. As reported below under the QII section, this effort is active and continues at this time.




OHR, 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 | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| Critical incidents are reported to the Office of Licensing within the required timeframe (24 hours). | 86% | 95% | 96% | 96% | 96% | **Fully Met** |
| Percentage of licensed | 86% | ** | 61% (2023 calendar year) | 56% (2023 calendar year) | Reported by calendar year; 2024 | **Not Met** |

| Performance Measure Indicator – Provider Capacity | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| 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. | | | | | results not yet available | |
| 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% (2023 calendar year) | 56% (2023 calendar year) | Reported by calendar year; 2024 results not yet available | **Not Met** |
| People with DD waiver are supported by trained, competent Direct | 95% | 78% Training | Round 3<br>90% training<br>92% competencies | **Round 4**:<br>85% training<br>91% competencies<br>**Round 5**:<br>78% training | **Round 6:**<br>87% training<br>78% competencies | **Not Met** |

| Performance Measure Indicator – Provider Capacity | Target | SFY21 Results | SFY22 Results | SFY23 Results | SFY24 Results | SFY24 Performance Assessment |
|---|---|---|---|---|---|---|
| Support Professionals (DSPs). | | 60% Competencies | | 85% competencies | | |

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

*Critical Incident Reporting* PMI focuses on the timely reporting of critical incidents has consistently exceeded the goal of 86%, reaching 96% each quarter for the past 3 years. As a result, the committee has decided to discontinue reporting this as a PMI; however, the RMRC will continue to monitor this on a quarterly basis.

The *Compliance with RM regulations* PMI focuses on provider compliance with 100% of the risk management regulations and has consistently fallen below the goal of 86%. The table shown below (as Figure 20) shows the calendar year results through calendar year 2023; calendar year 2024 results were not yet available and therefore unable to included. The RMRC and RQC5 initiated a QII that focused on improving compliance with regulations 520C and 520D. Interventions included conducting a three-part risk management training and disseminating tools to assist providers in tracking risks and conducting and documenting a systemic risk assessment. Compliance ratings with the risk management requirements remained unchanged after the training. It was thought that the three-part large-scale training did not provide specific enough details and guidance that providers needed, and that one-on-one training might be needed.

The *Compliance with QI regulations* PMI focuses on provider compliance with 100% of the quality improvement regulations and has also performed consistently below target, as shown below in the table labeled Figure 20. DBHDS has disseminated much information to providers on the various components of a QI program. Similar to risk management requirements, it is likely that providers will need more individualized consultation and technical assistance to master these skills.

## Figure 20: Risk Management & Quality Improvement Compliance

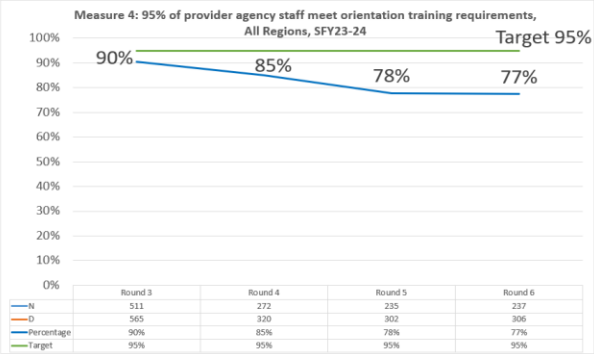
*Note: Data are presented for calendar year. Red indicates below 75%; Yellow indicates between 75% and 85%; and Green indicates 86% and above.*

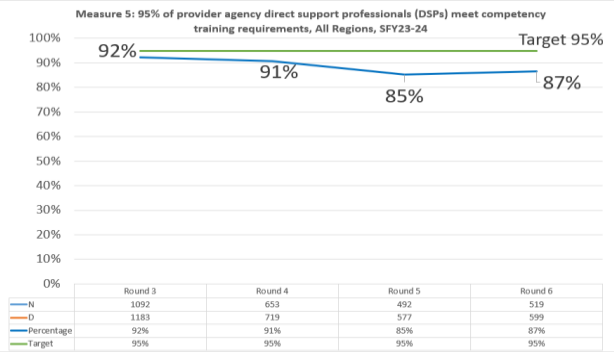
| RMRC Measure / Performance Measure Indicator (PMI) | CY2021 | CY2022 | CY2023 |
|---|---|---|---|
| **Risk Management Program Requirements** | | | |
| **% Of licensed DD providers that have met 100% of the risk management requirements (excludes Not Applicable and Not Determined (NA and ND))** | 61% | 56%↓ | 56% -- |
| • 520A - Designated person with training or experience responsible for risk management function | 77% | 72%↓ | 81%↑ |
| • 520B - Implements a written plan | 89% | 88%-- | 86%↓ |
| • 520C1 - environment of care | 85% | 85% -- | 87%↑ |
| • 520C2 - clinical assessment/reassessment | 81% | 83%↑ | 84%↑ |
| • 520C3 -staff competence / adequacy of staffing | 80% | 84%↑ | 83%↓ |
| • 520C4 - use of high-risk procedures | 79% | 81%↑ | 83%↑ |
| • 520C5 - review of serious incidents | 85% | 85% -- | 85%-- |
| • 520D - Systemic risk assessment incorporates risk triggers and thresholds | 79% | 75%↓ | 77%↑ |
| • 520E - Conducts annual safety inspection | 90% | 93%↑ | 95%↑ |
| **Quality Improvement Program Requirements** | | | |
| **% Of providers that are compliant with 100% of the QI Requirements** | 52% | 55%↑ | 56%↑ |
| • 620A - Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality | 91% | 94%↑ | 93%↓ |
| • 620B - The QI program uses standard QI tools, including RCA and has a QI plan | 89% | 92%↑ | 89%↓ |
| • 620C - The QI Plan shall: | -- | -- | -- |
| • 620C1 - Be reviewed and updated annually | 81% | 86%↑ | 85%↓ |
| • 620C2 - Define measurable goals and objectives | 78% | 85%↑ | 82%↓ |
| • 620C3 -Include & report on statewide measures | NA | NA | NA |
| • 620C4 - Monitor implementation & effectiveness of approved CAPs | 75% | 81%↑ | 74%↓ |
| • 620C5 - Include ongoing monitoring and evaluation of progress toward meeting goals | 78% | 85%↑ | 80%↓ |
| • 620D - The providers P&P includes criteria used to: | -- | -- | -- |
| • 620D1 - Establish measurable goals & objectives | 74% | 85%↑ | 83%↓ |
| • 620D2 - Update the QI plan | 74% | 87%↑ | 88%↑ |
| • 620D3 - Submit revised CAPs when not effective | 65% | 78%↑ | 77%↓ |
| Input from individuals about services & satisfaction | 81% | 83%↑ | 88%↑ |

The RMRC determined that a new QII was needed to address the performance of both the RM and QI Compliance PMIs. The focus of this QII involved OCQI hiring 12 quality improvement specialists to provide individual consultation and technical assistance to each provider to help

them understand the components and principles in developing and implementing risk management and quality improvement frameworks

*DSP Competence* PMI incorporates both DSP training and competencies, using data from the QSRs. The QSR Round 6 results for this PMI are in line with the previous round, as shown below. The KPA workgroups proposed a QII to address performance that would include reviewing all DSP competency materials to streamline content, update instructions and guidance, and reintroduce the DSP training and competency process once updates to materials are completed.




## 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 (designated safeguards) in Administration, Level of Care, Qualified Providers, Service Plan, Health and Welfare, and Financial Accountability. 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 Quality Review Team (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 Department of Medical Assistance Services (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 SFY24. For a description of the PMs, refer to the SFY23 QRT End of Year Report.

SFY24 QRT End of Year Report has not been made available by DMAS yet, however, preliminary data shows that the Commonwealth of Virginia met 81% of the overall performance measures (35 PMs) and as compared to the SFY23 77% (33 PMs). Eight PMs were not met this year in the following Assurances: Qualified Providers (2), Service Plan (3), and Health and Welfare (3). There were three PMs that did not meet the 86% threshold in SFY23 but met threshold in SFY24. Preliminary results are provided for Qualified Providers, Service Plan and Health and Welfare below. It was noted that for C9, consistent common issues with completion, such as not being aware, not completed or not in file, or proficiency boxes not checked off remained present during reviews.

| **C - Qualified Providers Summary** | **Target** | **SFY23 Results** | **Preliminary SFY24 Results** |
|---|---|---|---|
| C5. Numbers & percent of non-licensed/non-certified provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results | 86% | Results unable to be reported due to sample size | ↓ |
| C9. Number & percent of provider agency direct support professionals (DSPs) meeting competency training requirements | 86% | 59% | 78% |
| **D - Service Plan Summary** | **Target** | **SFY23 Results** | **Preliminary SFY24 Results** |
| D1. Number & percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes | 86% | 57% | 51% |
| D3. Number & percent of individual who Plan for Supports include a risk mitigation strategy when the risk assessment indicated a need | 86% | 54% | 49% |
| D6. Number & percent of individuals whose service plan was revised as needed, to | 86% | 71% | 81% |

| | | | |
|---|---|---|---|
| address changing needs (Individual Support Plan was updated/revised when individual's needs changed) | | | |
| **G - Health & Welfare Summary** | **Target** | **SFY23 Results** | **Preliminary SFY24 Results** |
| G1. Number & percent of closed cased of abuse/neglect/exploitation for which DBHDS verified that the investigation conducted by the provider was done in accordance with regulations hovers around | 86% | 82% | 80% |
| G4. Number & percent of individuals who received annual notification of rights and information to report ANE | 86% | 66% | 82% |
| G10. Number & percent of participants 19 and younger who had an ambulatory or preventive care visit during the year | 86% | 65% | 63% |

Improvements of PMs that were not met in SFY23 that did reach the 86% threshold for SFY24 include: D4. Number & percent of service plans that include a back-up plan when required for services to include in home supports, personal assistance, respite, companion, and shared living from 69% in SFY23 to 89% in SFY24 an increase of 20%; D7. Number & percent of individual who received services in the frequency specified in the service plan also saw significant increase from 79% in SFY23 to 87% in SFY24 a total increase of 8%; and D11 Number & percent of individuals who received services in the amount specified in the service plan increased by 10% from 81% in SFY23 to 91% in SFY24.

Once the official report is developed and available to the community, DBHDS will solicit CSB feedback based on the QRT identified issues and recommendations.

## Support Coordination Quality Reviews

The Support Coordination Quality Review (SCQR) process was established to assess and improve the quality of support coordination (also referred to as "case management") services provided by CSBs to individuals with DD who are receiving one of the HCBS waivers. The results of the SCQR are intended to inform improvements to the system overall.

Support coordination supervisors review records, according to ten established indicators, and report the results in an online survey form. The OCQI reviews a subset of these records to determine reliability. All CSBs receive feedback and technical assistance from OCQI and the OPNS.

In SFY24, 14 CSBs reported that at least 86% of records met at least nine indicators, up from 10 CSBs in SFY23. In SFY24, average compliance was above 86% for all indicators except for Indicator 3, which has two components and is stated as "The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable." Because the results are very different for the two components of Indicator 3, the CMSC splits the indicator into two parts when reviewing results, Indicator 3a and Indicator 3b. The CSBs report almost perfect compliance with Indicator 3a, with only one record scored as not met. However, while there has been improvement over time, the CSBs continue to experience challenges related to employment discussion and facilitation. The ten indicators are listed below.

| **SCQR Indicators** |
|---|
| Indicator 1: Signed choice form and individual offered a choice of support coordinator |
| Indicator 2: Signed choice form and individual offered a choice of DD Waiver providers |
| Indicator 3: Specific and measurable outcomes, meaningful employment discussion, employment facilitation |
| Indicator 4: Participation in the development of Part V of the PC ISP |
| Indicator 5: Disagreement and resolution in Part IV of PC ISP |
| Indicator 6: PC ISP addresses risks, needs, and preferences |
| Indicator 7: Risk awareness and risk mediation plan |
| Indicator 8: Linkages, referrals and service authorizations |
| Indicator 9: Services Implemented appropriately |
| Indicator 1-: Change in status and ISP revision |

The CMSC requests improvement plans for CSBs that report two or more indicators below 60% compliance, excluding indicators that do not achieve substantial agreement (meaning that both raters' results closely align) between CSBs and OCQI. (This year, Indicators 6, 7, and 10 were excluded as their agreement was outside of moderate or substantial.). Improvement plans were requested from eight CSBs following the SFY24 SCQR cycle.

Year-over-year improvement can be seen in the results shown, where the percentage of records meeting at least nine indicators has increased incrementally since SFY21, reaching 72% in SFY24. The results for the Look Behind analysis, which compares CSB responses with those of OCQI reviewers, were weak (meaning that both raters' results align very little) for Indicator 6 and Indicator 7, and agreement dropped to the moderate range (meaning that both

Percentage of Records Meeting at Least Nine Indicators

| FY2021 | FY2022 | FY2023 | FY2024 |
|---|---|---|---|
| 42% | 53% | 64% | 72% |

raters' agreement was middle of the road) for Indicator 10. The remaining seven indicators were in the substantial range. Finally, this year saw DBDHS reviewer agreement in the substantial range for all ten indicators. The OCQI reviewers engage in training and practice reviews each year to achieve these results.

## Quality Service Reviews

Quality Service Reviews (QSRs) assess the quality of services provided. QSRs ask questions of both individuals and their families and providers. Between rounds, the provider quality review (PQR) and person-centered review (PCR) tools were reviewed. The criteria for assessing each element were revised for Round 6. Each year, an aggregate report is produced at the conclusion of the round. For additional information on the aggregate report, please visit Developmental Services website and click on QSR.

QSRs are required to be conducted for 100% of providers once every two to three years. Round 6 review period was conducted during April 2024 – July 2024. Three hundred and thirty PQRs and 720 PCRs were completed in Round 6. It was noted that 310 of the active, licensed providers had not been reviewed in Round 5.

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. The tables below compare the number of CSBs and licensed providers who required a QIP to those who did not for Rounds 4, 5 and 6.

Community Service Board (CSB) 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 | 39 (100%) | 0 |
| **6** | 37 | 0 | 37 (100%) | 0 |

Licensed Provider 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%) |
| **6** | 330 | 2 (.6%) | 280 (85%) | 50 (15%) |

# 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 continued in their use of NCI data during the year.

In looking at the Community Inclusion Scale, Virginia's results are returning to results similar to those before the pandemic.

| Scale | FY18-19 | FY19-20* | FY20-21 | FY21-22 | FY22-23 |
|---|---|---|---|---|---|
| Community Inclusion Scale (includes shopping, errands, out to eat and entertainment) | 88% N=805 | 84% N=510 | 51% N=717 | 75% N=715 | 82% N=762 |

*2019-2020 data should not be compared to data from previous years as this data was subject to protocols/processes that differed from NCI usual protocol.

# Quality Improvement Initiatives

This summary details the QIIs implemented and proposed by the QIC subcommittees during SFY24. Twenty-seven QIIs were implemented during SFY24, with twenty-one carried over from previous years. Eight were proposed in June 2024, pending approval for implementation in SFY25. Nine QIIs were completed/ended and two 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 |
|---|---|---|---|
| # 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 |
| 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". | Completed | 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 |
| 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% | Continuing | 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% | Continuing | 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 | Completed | MRC |
| Provider policies on individual rights do not always include the right to make an informed choice, to engage in experiences meaningful to him/her, and which are necessary for personal | To improve the percentage of providers having policies addressing the rights of a person to making an informed choice, to engage in experiences meaningful to him/her, and which are necessary for personal growth and development | Continuing | RQC2 |

| Problem to be Addressed | QII Focus | QII Status | Assigned Subcommittee |
|---|---|---|---|
| growth and development. | | | |

- ✓ Began expansion of DBHDS OIHNS Dental Team and Mobile Dental Program
- ✓ Updated listing of dental care providers in DBHDS Region 3 and surrounding counties who accepted Medicaid, accepted new patients, ability to accommodate wheelchair usage, ability to accommodate the those within the DD population, and interest in receiving additional training regarding providing support to the DD population
- ✓ Completed a urinary tract infection learning collaborative in DBHDS Region 4 with all modules being posted on the DBHDS website
- ✓ Identified environmental factors in cases where the cause of death was choking and developed recommendations, interventions and other actions for each factor
- ✓ Incorporated the RAT into the ISP, with launch of new ISP targeted for August 2024, which integrates the RAT into the PC ISP so that risks and routine supports are addressed efficiently by all providers, streamlines and simplifies ISP elements, and focuses outcome development on what matters to the person supported

As part of the data reviews and subsequent identification of areas of potential improvement, the QIC subcommittees proposed QIIs throughout SFY24. While most were approved for implementation, several were not. QIIs proposed and not approved included the following areas for improvement: increasing consistent use of dysphagia management activities,

**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. | Ended | KPA Workgroups |
| Support Coordinators do not understand what constitutes meaningful community involvement conversation and developing a goal that | To ensure that 86% of individuals receiving DD waiver services have meaningful conversations regarding Community Involvement, that | Ended | KPA Workgroups |

| Problem to be Addressed | QII Focus | QII Status | Assigned Subcommittee |
|---|---|---|---|
| decreases barriers to community involvement/increases potential community involvement. | lead to goal development, resulting in an increased potential/to decrease barriers to Community Involvement by March 31, 2022. | | |
| 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%. | Completed | 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). | Continue | 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. | Continue | RQC2 |
| 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. | Continue | RQC5 |

- ✓ Shared developed Fact Sheets regarding integrated community involvement and employment outcomes across all regions. The success of this QII prompted additional QIIs in the areas of integrated community involvement and employment outcomes.
- ✓ Involved external stakeholders including those with DD in development of survey on technology use
- ✓ Developed and distributed a fact sheet regarding unpaid relationships and how to discuss in DBHDS Region 5

**Provider Capacity and Competency KPA:**

| Problem to be Addressed | QII Focus | QII Status | Assigned Subcommittee |
|---|---|---|---|
| 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. | Completed | CMSC |
| The lack of providers of Employment and Community Transportation (ECT) services in each region has a negative impact on access to reliable transportation. | To increase the number of providers of Employment and 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. | Continue | KPA Workgroups |
| 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 medical emergencies to >70% for I/DD individuals residing in DBHDS licensed provider residences, by the end of SFY23 Q3 (March 31, 2023). | Continue | MRC |
| The number of fatal opioid related drug overdoses in the Commonwealth has sharply increased since 2012. | MRC goal is to increase the percentage of I/DD providers completing REVIVE! Training by SFY22 Q4 to 30%. | Ended | 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. | Completed | 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. | Continue | KPA Workgroups |

| Problem to be Addressed | QII Focus | QII Status | Assigned Subcommittee |
|---|---|---|---|
| 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. | Continue | CMSC |
| The PMI "% of licensed DD providers that have met 100% of the risk management requirements (excludes NA and ND)" continues to be below the target of 86%. | Our goal is to improve compliance with regulations 520C and 520Dfor licensed DD providers to 86% by FY23, Q4 (June 30, 2023). | Completed | 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. | Abandoned | KPA Workgroups |
| 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. | Continue | 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. | Completed | RMRC |
| Licensed providers and CSBs continue to be challenged in being found compliant with 100% of the 520 and 620 | Our goal is to improve the percent of licensed DD providers that are compliant with 100% of the 520 and 620 (Risk Management and | Continue | RMRC |

| Problem to be Addressed | QII Focus | QII Status | Assigned Subcommittee |
|---|---|---|---|
| (risk management and quality improvement regulations). | Quality Improvement regulations) to 86%. We will examine results by June 30, 2025 (interim measure), the end of Calendar Year 2025, our target date. | | |
| Licensed providers policies are not specific to dignity of risk and individual choice and determination. Providers struggle in understanding the balance between self-determination/risk and the health and safety responsibilities for providers. | Our goal is to increase the percentage of providers with policies that address the rights of a person to make an informed choice, to engage in in experiences meaningful to him/her, and which are necessary for personal growth and development, | Continue | RQC2 |

- ✓ REVIVE! Training with voiceover was placed on COVLc site for licensed providers to access on demand. Governor Youngkin's endorsement of REVIVE! Training furthered the availability of the training, which increased the number of providers and family members taking the training. Additionally, legislation was passed that allowed Narcan to be sold over the counter
- ✓ Continued 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 an Employment and Community Transportation Toolkit for provider use statewide
- ✓ Provided webinar with potential providers on the provider designation process
- ✓ Simplified the DD Support Coordination Handbook, targeted release in July 2024
- ✓ Provided SC101 trainings in June 2024
- ✓ Distributed a guidance document on completing the ISP relative to employment discussions as these are not required for those <14 and >64
- ✓ Changed SC participation in Regional Support Team meetings to as needed basis
- ✓ Developed and distributed a job aid and educational document on teen employment discussions that included Department of Education and Department of Aging and Rehabilitative Services (DARS) logos in DBHDS Region 1
- ✓ Increased clarity in OHR memo on requirement that providers complete the annual seclusion-restraint report
- ✓ Posted to OHR website a training on the seclusion/restraint reporting requirements, including how to complete the form

- ✓ Hired 12 positions that focus on providing individual consultation and technical assistance to providers/CSBs who receive an approved corrective action plan (CAP) in the employee training, risk management and quality improvement and/or who receive a QSR QIP relative to their use of performance measure data

# DBHDS Internal Quality Management System Evaluation

Using the QM Program Assessment Tool utilized over the past years, endorsed by the Institute of Healthcare Improvement (IHI), the DBHDS quality committee chairs conducted a program evaluation of their respective 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 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 SFY23 Program Evaluation

During SFY24, the DD QMS expanded it's use of Power BI dashboards in reviewing data, maintained efforts in assuring valid and reliable data, and continued to refine the functionality of the QIC subcommittees. Efforts to increase inclusion of external stakeholders were most noticed in QII development and implementation.

Noted progress for the DD QMS included:

- ✓ piloted Upskill: A Data Literacy Program to one quality subcommittee and then released it internally for DBHDS. Videos were posted in DBHDS YouTube

- ✓ continued publication of The Quality Beat, a quarterly, internal newsletter devoted to increasing the awarenss and understanding of quality management and quality improvement
- ✓ continued leveraging  of the QII Toolkit for DBHDS quality committees to use regularly
- ✓ continued to provide training and share resource information related to OL RM and QI regulations
- ✓ began developing a QI Academy for both internal and external stakeholders
- ✓ utilized the QI KPA Identification process in the QIC subcommittees to determine QI opportunities

As noted in the SFY23 DD QMP Part 3 Annual Report, the opportunities for enhancement were incorporated into the Path Forward for SFY24. The identified opportunities for enhancement relative to sustainability and meeting structure would require additional consideration and input from DBDSH executive leadership as well as input from external stakeholders and as such were noted, yet not included in the Path Forward. During SFY24, discussions continued on these topics (building into meeting structure additional discussion time, 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).

As in previous years, the quality committee chairs evaluated how well the DD QMS functioned. Results of the SFY24 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, specifying timelies and accountability for implementation
- ✓ Data was collected and routinely analyzed for performance measures and as surveillance purposes
- ✓ Quality committee structure remained in place
- ✓ Quality committee membership included internal and external stakeholders (including individuals, family members, providers and other representatives); however it is believed that this can improve
- ✓ Processes remained in place to address data validity and reliability, that support the functioning of the quality committees, and in managing the DD QM Plan
- ✓ QIC subcommittees developed, proposed, implemented newly approved  QIIs and continued continued implementation of in-progress QIIs, previously approved

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 SFY25 DD QMP Parts 1 & 2.). Each quality committee engaged in continuous quality improvement throughout the year.

# Path Forward Summary

In SFY24 DD QM Plan Parts 1 & 2, DBHDS identified the following items in its Path Forward for SFY24. Part 3, the Annual Report, summarizes the work completed by DBHDS towards these items.

| Path Forward Item | Work Completed Toward Path Forward Item |
|---|---|
| DBHDS will continue to address data validity and reliability concerns including data provenance and data governance as identified in the Data Quality Monitoring Plan. | DBHDS continued to assure that data process documents identified and addressed concerns with data validity and reliability concerns; attestations verified these were addressed, producing valid and reliable data. |
| 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 continued efforts of the Data Warehouse as well as in streamlining data collection and reporting. |
| DBHDS will continue to enhance the ability to utilize data in driving decision-making, in identifying service gaps, and in identifying QI efforts, including statewide initiatives. | DBHDS piloted Upskill: A Data Literacy Program to one QIC subcommittee and released it agency-wide. |
| DBHDS will collaborate with providers on evaluating their own programs and services | OCQI expanded its ability to provide consultation and technical assistance by hiring twelve staff to focus on 12VAC35-105-450, 12 VAC35-105-520, 12VAC-35-105-620. |

| Path Forward Item | Work Completed Toward Path Forward Item |
|---|---|
| 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. | OCQM offered monthly webinars introducing QI and tools internally.<br>REACH conducted several root cause analyses into PMIs that struggle to meet the desired target. |
| 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. | OCQM continued publication of The Quality Beat, a newsletter focused on increasing the awareness, understanding, and application of quality principles and tools to DBHDS staff. Discussions began relative to addressing sustainability concerns within the QMS; these discussions will continue into SFY25 before any actions will be taken. |
| 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. | Efforts to increase the amount of involvement from individuals, families and providers to incorporate into Part continue. |

Using its QM Program Evaluation, DBDHS determined the following path forward for SFY25, for targeted improvement, for the coming year.

- DBHDS will continue the work initiated in SFY24, as listed in the SFY25 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 QIC and RQCs.

# Conclusion

The DD QMS continues to be very robust. Improvement efforts targeted identified areas of need or provided enhancements to existing processes, resources and training. DBHDS remains diligent in assuring that the data used is valid and reliable. Data source system assessments and annual review of progress on actionable recommendations continued. This annual review of progress on actionable recommendations serves to close the loop on identified threats and needs and the

work done to address those identified threats and needs. Processes specific to data collection and methodology continue to be updated to assure the process remains current to practice. DBHDS Division of Administration continues in its efforts to establish data governance and an enterprise data warehouse, priming DBHDS for future endeavors. Progress towards PMIs continued upward with several meeting target for the first time. For those not meeting target, efforts to improve performance were noted, including where initiatives were implemented.

Using data to determine opportunities for improvement resulted in a variety of QIIs being proposed with most being approved for implementation. Topics ranged from addressing health needs such as reducing the rate of urinary tract infections, addressing risks in the ISP, to addressing provider policies on individual rights to make informed decisions and their dignity of risk and improving provider compliance with risk management and quality improvement regulations. Some QIIs focused on regional efforts with the intent to move statewide, when interventions prove successful. Other QIIs focused on systemic impact such as the RAT to ISP QII.

The DD QMS remains primed for moving forward in addressing systemic challenges and planned changes/enhancements to processes.

## Glossary of Acronyms

| Acronym | Full Form |
|---|---|
| BH | Behavioral Health |
| CAP | Corrective Action Plan |
| CEPP | Crisis Education and Prevention Plan |
| COVLc | Commonwealth of Virginia Learning Center |
| CHRIS | Comprehensive Human Rights Information System |
| CMS | Centers for Medicare and Medicaid Services |
| CMSC | Case Management Steering Committee |
| CSBs | Community Services Boards |
| CTA | Consultation and Technical Assistance |
| CTH | Crisis Therapeutic Home |
| DQ | Data Quality |
| DBHDS | Department of Behavioral Health and Developmental Services |
| DD | Developmental Disability (inclusive of individuals with an intellectual disability) |
| DMAS | Department of Medical Assistance Services |
| DSP | Direct Support Professional |
| ECTA | Expanded Consultation and Technical Assistance |
| HCBS | Home and Community Based Services |
| HSAG | Health Services Advisory Group |

| Acronym | Full Form |
|---|---|
| IFSP | Individual and Family Support Program |
| IMU | Incident Management Unit |
| ISP | Individual Support Plan |
| KPA | Key Performance Area |
| MART | Multi Agency Review Team |
| MRC | Mortality Review Committee |
| NCI | National Core Indicators |
| OCQI | Office of Community Quality Improvement |
| OCQM | Office of Clinical Quality Management |
| OHR | Office of Human Rights |
| OIHNS | Office of Integrated Health Network Supports |
| OIT or IT | Office of Information Technology |
| OISS | Office of Integrated Support Services |
| OL | Office of Licensing |
| OPNS | Office of Provider Network Supports |
| PAIRS | Protection and Advocacy Incident Reporting System |
| PC | Person-Centered |
| 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 |
| RAT | Risk Awareness Tool |
| 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 |

| Acronym | Full Form |
|---|---|
| SIS | Supports Intensity Scale |
| TCM | Targeted Case Management |
| 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
- Part 3 DD QMS System Accomplishments