DBHDS

Virginia Department of Behavioral Health
and Developmental Services

Part 3
Developmental Disability Quality Management System System Accomplishments

State Fiscal Year 2024

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Part 3 DD QMS System Accomplishments

While the DBHDS DD Quality Management Plan (QMP) has focused primarily on the accomplishments of the DD quality committees, data validity and reliability efforts, and the inclusion of select report areas (HCBS, SCQR, QSR and NCI), we broadened the notation of system accomplishments to include both impacts to the system overall and quality actions resulting in significant impact for individuals. We also wanted to acknowledge the external partners that comprise our system beyond the typical groupings of individuals and families, CSBs, and licensed providers. These are identified separately below, by program area.

System Accomplishments

Office of Integrated Health Network Support (OIHNS)
Training offered live virtually or in – person in SFY24

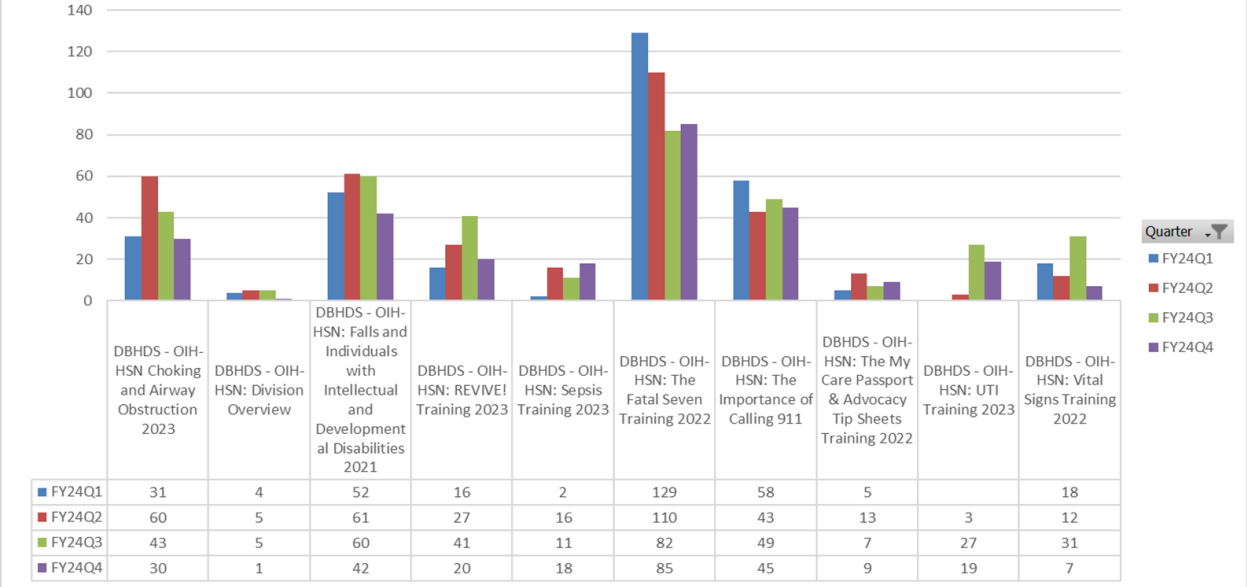
- General Training = is defined as those that are announced on the quarterly training schedule.
- Provider Training = is defined as those that are specifically requested by a DBHDS licensed or DD Waiver provider.
- Fatal Seven, Skin Integrity and Urinary tract Infections were the most popular

General Training		
Choking & Airway Obstruction	1	74
Diabetes Part 1	2	78
Dysphagia and Modified Diets	2	84
Fatal Seven	2	144
Nutrition Part 1	1	67
Nutrition Part 2	1	72
Oral Health	2	59
RAT	3	834
Skin Integrity & Pressure Injuries	3	124
SN/PDN Training	2	86
Transfers Training	2	72
Urinary Tract Infections	2	113
Wheelchair Transitioning Training	2	103
Provider		
Choking & Airway Obstruction	1	12

Diabetes Part 1	1	15
Diabetes Part 2	1	15
Dysphagia and Modified Diets	1	10
Falls	1	29
Fatal Seven	4	78
Medication Error Training	1	17
Recognizing Declining Health Part 1	1	3
SN/PDN Training	2	13
Grand Total	**38**	**2102**

Provider utilization of on – line COVLc Trainings for SFY24

- Training available on the COVLc is available on – demand 24 hours a day.
- Total number of participants (unique email address) was 783.



	DBHDS - OIH-HSN Choking and Airway Obstruction 2023	DBHDS - OIH-HSN: Division Overview	DBHDS - OIH-HSN: Falls and Individuals with Intellectual and Developmental Disabilities 2021	DBHDS - OIH-HSN: REVIVE! Training 2023	DBHDS - OIH-HSN: Sepsis Training 2023	DBHDS - OIH-HSN: The Fatal Seven Training 2022	DBHDS - OIH-HSN: The Importance of Calling 911	DBHDS - OIH-HSN: The My Care Passport & Advocacy Tip Sheets Training 2022	DBHDS - OIH-HSN: UTI Training 2023	DBHDS - OIH-HSN: Vital Signs Training 2022
FY24Q1	31	4	52	16	2	129	58	5		18
FY24Q2	60	5	61	27	16	110	43	13	3	12
FY24Q3	43	5	60	41	11	82	49	7	27	31
FY24Q4	30	1	42	20	18	85	45	9	19	7

Regional Community Nursing Meetings

The OIHNS Regional Community Nursing Meetings are a "safe space for nurses to discuss challenges, experiences, and ask questions." The purpose of these meetings is to ensure individuals with intellectual and developmental disabilities (IDD) are receiving needed services; to provide a forum in which nurses (and others) can discuss ideas, challenges, policy needs (e.g., health policies) which affect individuals with IDD, to bring policy needs forward; and to provide a forum for caregivers to interact with state agency representatives, to express concerns, develop educational tools and resources, and further enhance train-the-trainer models.

Regional Community Nursing Meetings were held virtually to serve all five regions across the Commonwealth. In SFY24, an average of 3.5 meetings were held each month. See table below.

Row Labels	Count	Sum of Number of attendees
Regional Nursing Meeting		
(blank)	40	814
Grand Total	**40**	**814**

Each of the monthly meetings presented a topic for learning and discussion and free continuing education units (CEU) for nurses licensed in Virginia.

In July 2023, the guest speaker was Dr. Michele Thomas, DBHDS pharmacist. She reviewed medication safety and the rights of medication administration. Her presentation included a scenario of a real medication error, and practical suggestions on how to avoid errors when passing meds. The CNE topic was the OIHNS Medication Health & Safety Alert with quiz/evaluation.

In September 2023, the guest speaker was Taneika Goldman, State Human Rights Director, DBHDS. She gave a presentation on how medication administration impacts an individual's human rights and other aspects of human rights requirements for provider agencies. The CNE topic was the OIHNS Responding to Drug Reactions and Medication Errors Health & Safety Alert with quiz/evaluation.

In November 2023, the guest speaker was Alexander Trumble, Program Manager for the DBHDS Infectious Disease & Epidemiology department. He gave a presentation on how DBHDS tracks infectious diseases, and the current focus of the DBHDS epidemiology department. The CNE topic was the OIHNS Infection Control Health & Safety Alert with quiz/evaluation.

In February 2024, the guest speaker was Michele Laird from the DBHDS Office of Licensing. She reviewed the who, what, when and why of making a CHRIS report per the OL CHRIS reporting document requirements. The CNE topic is Vital Signs Health & Safety Alert with quiz/evaluation.

In March 2024, the guest speaker was Sara Thompson, DBHDS Supported Decision-Making Community Resource Consultant. She gave a presentation on the importance of Supported Decision-Making to the individual with intellectual and developmental disabilities. The CNE topic was Healthcare Advocacy Health & Safety Alert with quiz/evaluation.

In April 2024, the guest speaker was David Wilson, the OIHNS physical therapist (PT), Certified Wound Specialist (CWS), and Assistive Technology Professional (ATP). He led a conversation about how to direct care when a wound is identified. This was an interactive presentation and discussion.

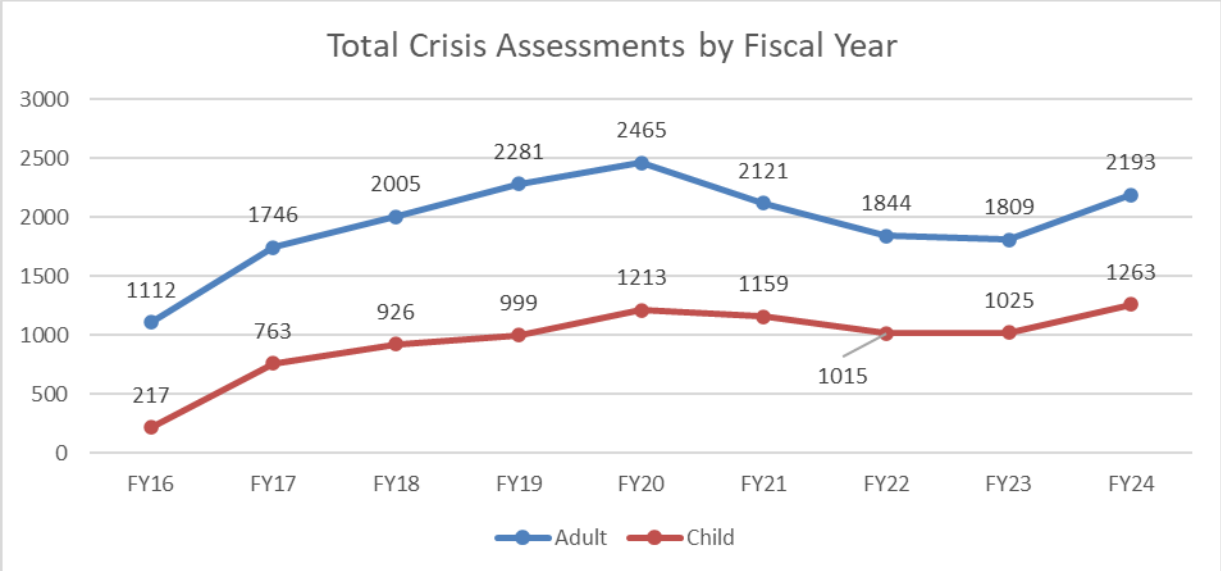
The CNEs topic was the OIHNS Skin Integrity & Pressure Injury Health & Safety Alert with quiz/evaluation.

In May 2024, the guest speaker was Nathan Habel, DBHDS DS Director of Behavioral Services and Projects, and/or Brian Phelps, DBHDS OIHNS Board Certificated Behavior Analyst (BCBA). They gave a presentation for Mental Health Awareness Month on the basics of behavior analysis, behavioral plans, DBHDS resources and how to locate a BCBA in your region when needed. The CNEs topic was on the OIHNS Intellectual and Development Disabilities Health & Safety Alert with quiz/evaluation.

REACH:

REACH continued to provide crisis services to children and adults diagnosed with a developmental disability. In SFY24, the program admitted individuals ranging in age from 4 to 77 years old. Referrals to the program increased for adults by 7% and youth by 20% as compared to the previous fiscal year with 2,038 adult referrals and 1,505 youth referrals occurring in SFY24.

For SFY24, there was a 21% increase in crisis assessments completed with adults and a 23% increase in those completed with children as compared to SFY23. SFY24 saw the highest number of crisis assessment completed in a fiscal year by the REACH staff with youth who are diagnosed with developmental disabilities.



Training for community partners and to the direct support systems of the individuals and their families is an integral part in prevention and in decreasing stressors that may lead to a crisis for the individual or family/provider. The REACH programs trained 5,240 community partners in SFY24. This training is in addition to the individualized training provided to the individuals, care staff, families, and community partners who support the individual.

Office of Human Rights (OHR):

Coordination with Protective Services:

DBHDS via OHR has a Code of Virginia-mandated responsibility to ensure that individuals who are receiving services from providers licensed, funded, or operated by DBHDS are not abused, neglected, or exploited. A shared protocol between the Virginia Department of Social Services (VDSS), the Virginia Department of Aging and Rehabilitative Services (DARS), and DBHDS governs inter-agency exchange of information and supports the efficient execution of this DBHDS-OHR responsibility. Most allegations of abuse and neglect reported to Adult Protective Services (APS) and Child Protective Services (CPS) involving DBHDS-licensed programs and DBHDS-operated facilities should also be reported to OHR via CHRIS; however, providers do not always report these occurrences timely or at all. When any of the 120 VDSS localities receives a report that appears to involve a DBHDS affiliated program or service, OHR is to receive a copy of the report. OHR tracks, triages, and trends data from these reports to verify "valid" reports are entered in CHRIS, and when they are not, ensure follow-up directly with the identified providers, offer technical assistance and ensure the complaint investigation and resolution processes have been initiated and are completed. When a violation is identified through this process, citations are issued to licensed community providers and violation letters are issued to DBHDS-operated and funded providers. A "valid" report means 1) the involved services provider is licensed, funded, or operated by DBHDS, 2) the alleged abuser was or is an employee or agent of the services provider at the time of the alleged abuse or neglect, and 3) the alleged victim was or is an individual who was or is receiving the service.

The line graph at the bottom of Figure #1 *FY 2024 Protective Services Data* below, depicts that on average, the OHR receives over 100 reports per month. The bar graph at the top reflects localities based on the number of referrals received - from the most to the least. In FY 2024, OHR received and reviewed a total of 1,350 APS and CPS reports. Of the total reports received, 1,064 were determined to be "valid" reports that alleged abuse, neglect or exploitation by a licensed community provider or DBHDS-operated facility. Review by the OHR revealed that 391 of these reports were not entered into CHRIS. Additional OHR follow-up directly with provider staff, as well as involved individuals, determined that 29% of these valid APS and/or CPS reports involved circumstances that were previously made known to the provider staff. This means that the provider/DBHDS-operated facility should have, but did not, appropriately enter the report into CHRIS and they should have, but did not, properly initiate the investigation or complaint resolution process. This is explicitly the reason for this process - to identify unreported potential human rights violations to ensure safety, freedom from abuse/neglect and access to due process for the individuals involved.

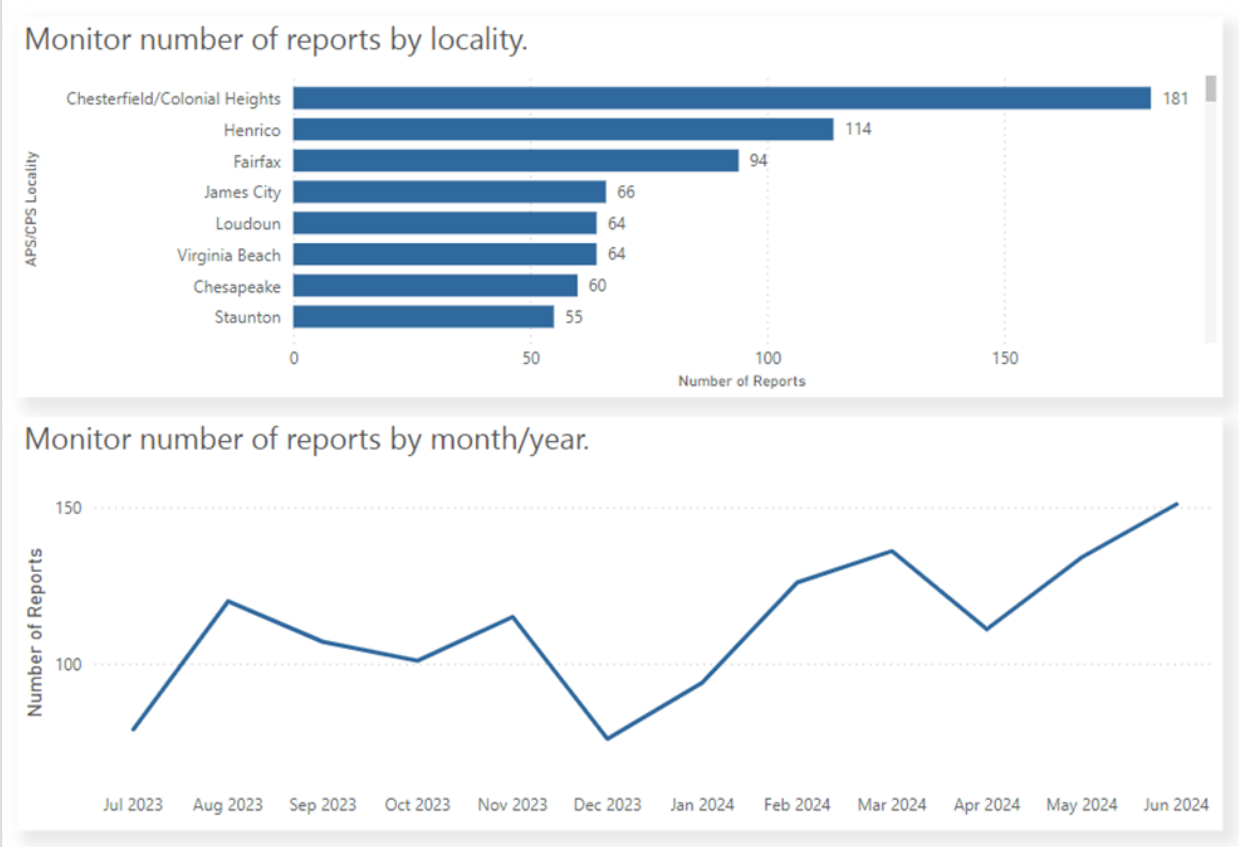


Figure #1: FY 2024 Protective Services Data

Quality Actions Resulting in Significant Impact for Individuals (Improved Outcomes)

OHR:

Due Process Reviews:

A large part of the mandate and mission of the OHR is to manage the department's complaint resolution program to ensure individuals and their authorized representatives' access to due process when the believe their human rights have been violated. Both the State and Local Human Rights committees play an important role in facilitating due process through activities like fact-finding hearings when an individual disagrees with a provider about a potential human rights violation. The Local Human Rights Committees (LHRC) also conduct reviews of individual restrictions and Behavioral Treatment Plans that contain the use of restraint or timeout, as well as appointment of authorized representatives, and individuals' participation in human research. Each of the more than 90+ citizen volunteers that serve on the 17 Human Rights Committees

receive on-going technical assistance, training, guidance and administrative support to ensure the Commonwealth's independent human rights infrastructure is maintained, and in SFY24, 208 due process reviews were facilitated.

REACH:

During the last quarter of SFY23 and into the first quarter of SFY24, GAP and root cause analyses (RCA) were completed in the areas of crisis assessments (mobile crisis response - "MCR") not occurring at the site of the crisis, consistent completion of the CEPP within the deadlines set forth in the REACH Standards, and identification of a placement within thirty days of admission to a REACH crisis therapeutic home (CTH) or psychiatric hospital. Additionally, a survey was developed around services in the youth CTH, and a focus group was convened regarding out of home prevention services for youth.

REACH collects a significant amount of data on demographics, services rendered and related outcomes as part of the DOJ SA review process. This data is reported out quarterly and was the bases for the services analyzed as part of the GAP and RCA analyses.

- Crisis responses in community (MCR): a GAP analysis was completed to delineate regional trends regarding % of assessments completed in the community over the fiscal years. The DBHDS regional crisis manager completed a RCA to determine the "whys" for the collective information derived from all the reviews and data analyses. The analyses targeted only where the crisis call resulted in a mobile response since that was the focus of the DOJ criteria. The RCA defined the problem as "MCR Crisis Assessments not at location of Crisis". Six overarching causes emerged: Source (who requested); Regulations/Practices; Public Relations; Transportation; Resources; Staffing; and CEPPs:
- Initial CEPPs: a GAP analysis was completed to trend out data on percentage of initial CEPPs developed within fifteen days of the assessment for community crisis stabilization service. A group of staff representing each regional REACH program and DBHDS regional crisis managers met to complete a RCA to determine the "whys" for the collective information derived from all the reviews and data analyses. Five overarching causes were identified: Family/Individual scheduling conflict, Provider scheduling conflict, REACH, Dropped out of Service, and Hospitalization.
- Identification of a residence within 30 days of admission to a CTH or psychiatric hospital: a GAP analysis was completed to trend out data on percentage of identified placements within 30 days as per the DOJ compliance indicator (CI) which combines the two types of admission and has a criterion of 86% for admissions within a quarter. Additionally, data was separated to trend percentages for the CTH versus hospitalization. A group of staff representing each regional REACH program met to complete a RCA to determine the "whys" for the collective information derived from all the reviews and data analyses. Six

overarching causes were identified: Community Residences Market, Waiver System/Other Funding, Miscellaneous, Events affecting Choice Identification Timeframe, Follow-up Practices, and Acuity.

For all of the previously mentioned RCAs, the overarching causes and the respective contributing information to the causes were displayed in a fishbone diagram, actions steps taken and newly developed in each REACH region program or in the larger crisis system were identified in addition to identifying upcoming action steps. Subsequently, each regional REACH program met and identified steps to address specific action steps given the regional nuances. These plans were implemented in SFY24.

As noted earlier, a survey was developed to assess utilization of the youth crisis therapeutic homes (YCTH). To analyze and assess Virginia's performance across these areas, the DBHDS Crisis Office met with REACH Directors, this included those YCTH Directors in regions 2 and 4 that operate a YCTH in their region. A dedicated meeting with leadership occurred to discuss the DOJ findings and the recommendation of review with stakeholders and providers for service satisfaction when utilizing the YCTH. The REACH programs submitted names and contact information of stakeholders to DBHDS. A ten question YCTH satisfaction survey was developed and reviewed for use as a tool to determine satisfaction across stakeholders. Of those submitted names and contact information, 260 surveys were sent out beginning on 7.3.23 through 7.25.23. Of those 260 surveys, 4% responded to the 10-question survey. Review of the respondents' findings indicate that 55.5% of respondents stated their experience with the YCTH was positive. Of those who did not utilize the YCTH, 20% indicated location was a factor in their decision, 20% were looking for another service, and 60% indicated "other" reasons which included alternative summer services in place, child needing higher level of care, and updated clinical testing that excluded the child from REACH services. Additionally, the survey queried the preferences of the respondents as to alternates short term crisis services for their youth, questioned if transportation was a barrier to choosing the YCTH, asked about the admission process and communication during the youth's stay at the CTH, and questioned about receipt of information about alternative out of home short term options other than the YCTH. Actions steps were developed and implemented in SFY24.

As noted previously, a focus group convened to discuss low utilization of out of home short term crisis prevention services for youth. The focus group charge was to review what is and isn't working from their point of view and to identify regional nuances, and what we can do moving forward. A statewide focus group was held virtually for one hour September 20, 2023, and consisted of: Region 1 REACH youth intake; two DD case managers from Region 2; Region 3 Clinical Director; New River Valley CSB housing specialist; Region 4 REACH Director; Region 4 REACH Youth case manager; Region 4 youth intake; Region 5 hospital liaison; program director for Serenity C&C; one parent; and two DBHDS regional crisis managers. These individuals agreed to participate after requests were made of all regions for participant suggestions. After a level set of the understanding of the service, points of discussion centered around a set of

questions to evoke information on their understanding of the service, the frequency of referrals, barriers to making a referral, response time to the request, barriers to accepting, service expectations, and transportation and distance. The group ended with recommendation being made based on the conclusion formulated during the group. These recommendations were brought back to DBHDS management.

Mortality Review Office/Mortality Review Committee (MRC)

REVIVE! Opioid Overdose Awareness Modules: During the MRC's Opioid Overdose Quality Improvement Initiative, there was an intensive push from the Governor's office for REVIVE! Training to be promoted and utilized, which expanded the resources for REVIVE! training. This support increased the availability of REVIVE! training and therefore more participation by licensed providers and IDD family members. It also supported the legislation that allowed Narcan to be sold over the counter.

Addition of Mortality Prevention Strategies

The MRC utilized three Mortality Prevention Strategies for potentially preventable deaths. The application of these mortality prevention strategies will continue to be refined to tailor approaches and achieve meaningful outcomes. To promote positive outcomes and minimize the risk for potential events, training and education on prevention awareness, early recognition, and advocacy actions, were the focal points for the addition of specific mortality prevention strategies to be identified by the MRC at each meeting. This shift in focus involved the identification of risk factors predisposing individuals with IDD to negative outcomes, emphasizing the role these factors play in implementing interventions to ensure the provision of evidence-based standards of care.

For actions recommended by the MRC, when a death has been determined to be potentially preventable, the MRC shall consider if one of the following Mortality Prevention Strategies[1] may be utilized:

- Primary Prevention Strategies - Educational and changes to services designed to help prevent a condition or event from taking place, that have been found to contribute to morbidity or mortality, such as education on reducing falls.
- Secondary Prevention Strategies – Focus on early detection and timely treatment of conditions or injuries to minimize harmful effects and prevent further morbidity or mortality, such as interventions that support and promote cancer screening.
- Tertiary Prevention Strategies – Optimization of the treatment and management of conditions or injuries, such as ensuring access to evidence-based treatment.

[1] Staugaitis, S., Lauer, E. (2015). *Risk Management Mortality Review & Reporting in Developmental Disabilities*. Univ of Mass Press, (69).

External Stakeholder Involvement

Office of Integrated Health Network Supports (OIHNS)
OIHNS conducted virtual regional Community Nursing Meetings monthly. As discussed above, most of these meetings presented a topic for learning and discussion and free continuing education units (CEU) for nurses licensed in Virginia. Speakers for these educational offering were both internal and external subject matter specialists. In August 2023, Kirsten Kelley, M.S. Associate Executive Director of Field Marketing at Radford University presented an overview of Radford University's continuing nursing education programs that are designed to provide comprehensive continuing education for nurses promoting best practices. Her presentation supported the August 2023 Regional Community Nursing Continuing Nursing Education topic on the importance of conducting Medication Reconciliation.

REACH: In addition to the stake holders who participated in the RCAs, youth survey, and focus groups in SFY24, each Regional REACH program convenes an Advisory Committee at least semi-annually to review the adult and youth crisis services offered by the programs.

Mortality Review Committee and External Data Acquisition
The MRC expanded collaboration with the Virginia Department of Health (VDH) and the DBHDS data warehouse to identify IDD deaths requiring mortality review for those deaths that occurred outside of Virginia (which in this state fiscal year included Tennessee and West Virginia). These efforts were undertaken to address and decrease gaps in available demographic data.

Office of Provider Network Supports (OPNS)

The quality improvement activities of the OPNS are carried out with the participation of various providers, CSBs, DBHDS sister agencies, as well as individuals with services and their families. Many of these activities were previously established and rely on focus groups, workgroups, in-person and virtual meetings, surveys, and other forms of information sharing.

The My Life My Community (MLMC) Provider Database and Provider Designation Process were initially launched on November 15, 2019. SFY24, saw increased effort to remind providers of these resources. All DD Waiver providers are encouraged to register on the database, which will serve as the centralized location for finding DD services in Virginia. Collectively, four providers hold badges in Autism, Accessibility, Behavioral Support, and/or Complex Health Supports.

OPNS continues to hold statewide Provider Roundtable meetings quarterly via webinar. The May 29, 2024, Provider Roundtable meeting hosted 554 providers and the September 25, 2024, meeting hosted 586 providers. These meetings serve as a forum to exchange information about

topics impacting providers and support coordination, as well as provide space for shared learning.

During the past year, OPNS activities included Community Resource Consultants meeting with 135 providers seeking to diversify or expand services. Region 1 had 41 providers; Region 2 had 10 providers, Region 3 had 19 providers, Region 4 had 35 providers, and Region 5 had 18 providers. The Developmental Disabilities Waiver services being added or considered by current providers include Group Home (21), Therapeutic Consultation Behavior (6), Therapeutic Consultation Speech (1), Therapeutic Consultation Recreational Therapy (1), Employment & Community Transportation (10), In-Home Supports (9), Supported Living (6), Community Engagement/Coaching (11), Sponsored Residential (36), Group Day Support (5), Personal Assistance (7), skilled nursing (1), Service facilitation (4), individual and family caregiver training (6), Respite (3), Independent Living Supports (1), Peer Mentoring (1), Individual and Family Caregiver Training (4), and uncertain (4). Barriers include adjusting to changes in requirements for legally responsible adults providing services, rates, needing business license, needing DBHDS license, and regulations not permitting provider to offer employment services in a segregated setting, not understanding requirements, paperwork required was burdensome, and needing to obtain a DBHDS license before providing services.

Members of the OPNS Provider Team also provided Technical Assistance regarding various aspects of the DD Waiver to 378 providers over the last two semi-annual report periods. The Jump-Start Funding Program awarded $77,472.92 during this same time period. Funds continue to be available to assist providers with expansion of integrated services in all regions and include Skilled Nursing, Private Duty Nursing, Children's Sponsored Residential and Behavioral Consultation. Program requirements have been revised to allow for submission of application prior to the identification of individuals intending to use the new and/or expanded services. For this reporting period, Community Resource Consultants have provided ISP Training to a total of 29 participants, Part V Training to 154 participants, Documentation Training was provided to 189 participants, Person Centered Thinking Training to 446 participants, and Regional Support Team Training to 125 participants. Technical Assistance was provided to 191 providers, which includes 83 providers specifically related to the development or expansion of new service options. A total of 1611 provider agency staff completed online supervisory training with 45 completing competency training in person. The Provider Readiness Education Program training was attended by 433 provider staff. Additionally, the office continued to hold Provider Roundtable meetings to share updates and training information and answer questions with the provider community. Collective participation in these quarterly meetings totaled 1706.