Quality Review Team (QRT) Year End Report
7/1/2018-6/30/2019

Overview
Quality Review Team Reporting

I. QRT Charter - July 2019

The Quality Review Team (QRT), a joint Department of Behavioral Health and Developmental Services (DBHDS) and Department of Medical Assistance Services (DMAS) committee, is responsible for oversight and improvement of the quality of services delivered under the Commonwealth's Developmental Disabilities (DD) waivers as described in the waivers' performance measures.

Authorization / Scope of Authority

The QRT is responsible for reviewing performance data collected regarding the Centers for Medicare and Medicaid Services' (CMS) Home and Community Based Services waiver assurances:

- Waiver Administration and Operation: Administrative Authority of the Single State Medicaid Agency
- Evaluation/Reevaluation of Level of Care
- Participant Services - Qualified Providers
- Participant-Centered Planning and Service Delivery: Service Plan
- Participant Safeguards: Health and Welfare
- Financial Accountability

The work of the QRT is accomplished by accessing data across a broad range of monitoring activities, including those performed via DBHDS licensing and human rights investigations and inspections; DMAS quality management reviews and contractor evaluations (QMR); serious incident reporting; mortality reviews; and DBHDS level of care evaluations.

Each DD waiver performance measure is examined against the CMS standard of 86% or above compliance. Those measures that fall below this standard are discussed to identify the need for provider specific as well as systemic remediation. The committee may make recommendations for remediation such as:

- retraining of providers
- Information Technology system enhancements for the collection of data
- change in licensing status
- targeted QMR
- referral to the Provider Remediation Committee for mandatory provider remediation
- payment retraction or ceasing referrals to providers
- review of regulations to identify needed changes
- review of policy manuals for changes.

The team identifies barriers to attainment and the steps needed to address them. The QRT re-examines data in the following quarter to determine if remediation was successful or if additional action is required.

The QRT was established in August 2007 in response to CMS's new expectations that states implement a quality review process for HCBS waivers. This charter shall be reviewed by DBHDS and DMAS on an annual basis or as needed and submitted to the Quality Improvement Committee for review.

Model for Quality Improvement

The activities of the QRT are a means for DMAS and DBHDS to implement CMS's expected continuous quality improvement cycle, which includes:

- Design
- Discovery
- Remediation
- Improvement

Structure of Workgroup / Committee:

Membership DBHDS:

- Director of Waiver Operations or designee [Dawn Traver]
- Senior DD Policy Analyst [Deanna Parker]
- Director of Provider Development or designee [Eric Williams/Ronnitta Clements]
- Director of Office of Licensing or designee [Jae Benz]
- Director of Office of Human Rights or designee [Deb Lochart]
- Director of Office of Community Quality Improvement or designee [Challis Smith]
- Director, Mortality Review Committee or designee (Patricia Cafaro)
- Settlement Agreement Director (Jenni Schodt)

DMAS:

- Director of Division of Developmental Disabilities or designee [Ann Bevan]
- Program Advisor [Donna Boyce]
- Developmental Disabilities Program Manager or designee [Vacant]
- QMR Program Administration Supervisor or designee [Thren Baugh]
- DD Program Data Analyst (James Banks)

Quorum: A quorum shall be defined as 50% plus one of voting membership.

Meeting Frequency: The committee will, at a minimum, meet four times a year. The QRT review cycle is scheduled with two quarters' lag time to accommodate the 90-day regulatory requirement to successfully investigate and close cases reportable under the Appendix G Health and Welfare measures.

Leadership and The DBHDS: The Senior DD Policy Analyst shall serve as chair and will be responsible for ensuring the committee performs its functions including development of meeting agendas and convening regular meetings. The standard operating procedures include:

- Development and annual review and update of the committee charter
- Regular meetings to ensure continuity of purpose
- Maintenance and distribution of quarterly reports and/or meeting minutes as necessary and pertinent to the committee's function
- Maintenance of QRT data provenance
- CMS Evidentiary and state stakeholder reporting
- Quality improvement initiatives consistent with CMS's "Design, Discover, Remediate, Improve" model.

Meeting minutes are prepared and distributed to committee members prior to the meeting. Minutes shall reflect the committee's review and analysis of data and any follow up activity.

The QRT shall produce an annual report to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. The QRT's report will include an analysis of findings and recommendations based on review of the information regarding each performance measure.

CMS has indicated that reporting on the performance measures can be consolidated if all of the following requirements are met.

1. Design of the waivers is same/very similar
2. Sameness/similarity determined by comparing waivers on approved Waiver Application Appendices:
   - C: Participant Services
   - D: Participant-Centered Planning and Service Delivery
   - G: Participant Safeguards
   - H: Quality Management
3. Quality management approach is the same/very similar across waivers, including:
   - Methodology for discovering information (e.g., data systems, sample selection)
   - Manner in which individual issues are remedied
   - Process for identifying & analyzing patterns/trends
   - Majority of Performance Measures are the same
4. Provider network is the same/very similar

5. Provider oversight is the same/very similar

Additionally, the sampling method must be proposed in the Waiver application and approved by CMS and various sampling methods are acceptable. It is noted that, for the Commonwealth's DD waivers:

- All services are the same but not all are offered under each waiver.
- All individuals go through the same slot selection process.
- All waiver service providers use the same enrollment process as delineated by DMAS.
- All providers for the three waivers that are required to be licensed are done so through the DBHDS.
- All participants' service needs are determined through the Person Centered Planning process.
- All three waivers will have the same performance measures with the approval of the amendment for the Community Living Waiver.

Therefore, QRT data across the Community Living, Family & Individual Supports, and Building Independence waivers is consolidated for annual and triennial reporting to CMS. However, individual waiver level data may be reported and reviewed for internal quality management monitoring across waivers where feasible and necessary.

II. QRT Data Provenance

Quality Management Reviews (DMAS)

The data source for specifically identified performance measures is data collected during the Quality Management Reviews completed by the Health Care Compliance Specialists in the QMR Division of the Developmental Disabilities Unit at DMAS. These reviews monitor provider compliance with DMAS participation standards and policies and to ensure an individual's health, safety, and welfare and individual satisfaction with services and includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies, and procedures. *These measures are designated pink in the QRT data reporting tool.*

A representative sample of the participants in all three DD waivers is employed as the sampling methodology. Information demonstrating the level of compliance with the performance measures is gathered from case management records and from the Plans for Supports from service providers. Subsequently, there are two subsets of the population.

The following is noted with regard to determining the sample:

A. A SAS run is completed at the beginning of each quarter and yields a list of individuals with the following characteristics:

    a. The individual has received services, and

    b. DMAS has paid the provider's claim for services.

B. All forty (40) of the Community Service Boards (CSBs) are sampled within a three (3) year period

C. Individual service providers are selected for review. Service providers are not randomly chosen; instead, a non-probability sampling method is utilized. Once a non-CSB has been reviewed, that

provider is filtered out of the SAS run for at least two years. Providers are selected based on the following factors:

1. Whether the individual CSB's review is due within the current three-year period.
2. Whether or not the service provider has been reviewed recently
3. Whether or not the service provider has been reviewed in the past
4. The type of service provided (if targeted reviews are being completed)
5. If there are existing concerns/complaints regarding a provider
6. If there is a history of non-compliance
7. The geographical location of the provider. *Due to staffing constraints, a large provider with many records who is closer geographically may be reviewed over a smaller provider with less records who is farther away.*
8. The number of individuals served. *A provider with a larger number of records who is providing services for all three waivers, may be prioritized over a smaller provider with less records who may only be providing services under one waiver.*

D. Once the service provider is selected, the recipients receiving services from that provider are identified for inclusion in the record review. A proportionate stratified sample is used to determine the number of records to be reviewed within each waiver. Using a sample size calculator such as Raosoft, a sample size is determined based on the total number of enrolled recipients using the following parameters and rounded up to the nearest 100:

1. 5% Margin of error
2. 95% confidence level
3. 50% distribution
4. The total number of individuals enrolled in the three (3) waivers is used as the population size.

   This method is used for both data subsets: case management records and individual plans for supports provided by enrolled service providers. The table below shows the proportionate sample stratified by waiver subgroups.

Step	CL Waiver	FIS Waiver	BI Waiver	Total
#1 Determine #of recipients enrolled in each waiver(subgroup)	11,204	1,723	296	13,223
#2	85% 84.7%	13% 13.03	2% 2.2	100%

Determine what % each waiver(subgroup) is of the whole				
#3 Determine sample size using noted parameters	374 rounded up to 400			
#4 Determine the number of recipient records to be reviewed in proportion to the percentage of enrolled recipients	340 85%of 400 = 340	52 13% of 400 = 52	8 2% of 400 = 8	400

The number of records to be reviewed at each CSB's is determined at the beginning of each fiscal year. The number of records selected for review is in proportion to the overall percentage of recipients receiving case management services for that fiscal year. For other (non-CSB) service providers, a minimum number of records will be reviewed based on the following SAS program:

a) Claim records are sorted by provider and members

b) The number of members with claims by a provider is determined

c) The percentage of members that will be selected for each provider is determined according to the chart below:

# Members Between	Sample %
0 - 15	100
16 - 24	70
25 - 39	60
40 - 50	50
51 - 61	40
62 - 75	35
76 - 90	**31**
90 - No Limit	**25**

d) Members are randomly selected based on the assigned percentage for each provider.

e) Claims records are included for each selected member.

f) Unduplicated records are selected from all random samples (from Step d) and merged.

III. Appendix G Performance Measures: Licensing, Human Rights, Mortality Review Committee (DBHDS and DMAS)

The Office of Licensing and Office of Human Rights jointly coordinates, communicates, consults and monitors the investigation of abuse and neglect allegations in licensed programs. The Mortality Review Committee reviews recent deaths of individuals with a developmental disability who received services in a state-operated facility or in the community through a DBHDS-licensed provider, to provide ongoing monitoring and data analysis to identify trends/patterns, system level quality improvement initiatives and recommendations that promote the health, safety and well-being of individuals while reducing mortality rates to the fullest extent practicable.

The data for the majority of the performance measures evaluating compliance with the CMS Appendix G waiver assurances, which serve to assure the waiver participant's health and safety, are collected by DBHDS during Office of Licensing site visits, retrospective Office of Human Rights reviews, and retrospective case reviews completed by the Mortality Review Committee. Additionally, three performance measures that fall under Appendix G of the CMS Waiver Application utilize DMAS QMR reviews as the data source.

Population

For DBHDS performance measures using data from the Comprehensive Human Rights Information System (CHRIS), the waiver population is defined below. Measures not using data from CHRIS include a description of the population.

- The population consists of individuals receiving DD services as reported by the provider in the "incident service type."

  This was chosen based on the consistency of providers entering the service type into CHRIS as compared to the waiver type.

  - This method relies on the assumption that those receiving DD services are on a waiver. DBHDS acknowledges this is not a 100% match; however, it is consistent with other reporting to DMAS from the CHRIS system.

Reporting Schedule

Data will be reported on the following delayed schedule unless otherwise noted:

Period of Occurrence	Data review and submission date
Q1 SFY 2020 (July 1 - Sept. 30, 2019)	February (March) 2020
Q2 SFY 2019 (Oct. 1 - Dec. 31, 2019)	May 2020
Q3 SFY 2019 (Jan. 1 – March 31, 2020)	August 2020
Q4 SFY 2019 (April 1 – June 30, 2020)	November 2019

The specific performance measures included under Appendix G include the following:

G1. Number and percent of closed cases of abuse/neglect/exploitation for which DBHDS verified that the investigation conducted by the provider was done in accordance with regulations.

N = number of closed cases of abuse/neglect/exploitation verified that the investigation was conducted in accordance with *regulations (i/e. Count of the cases where the response to the question was 'True.')*

D = number of closed cases of abuse/neglect/exploitation that were reviewed *(i.e. Total count of the cases reviewed (may be less than number distributed*).

Data Source

Office of Human Rights, Community Look-Behind (excel spreadsheet)

Calculation

The specific question from the look-behind that addresses this performance measure is "Did the facts of the provider investigation support the Director's finding?"

Discussion

The OHR retrospective review uses a random sample of closed cases of abuse, neglect, and exploitation for individuals receiving DD services drawn from allegations in the CHRIS system.

Implementation and Remediation by OHR

Human Rights Advocates provide ongoing regional training on human rights, to include investigations, for all existing service providers. Newly licensed providers are referred to the Office of Human Rights for an on-site visit, typically between 30-60 days after licensing. During these reviews, HAdvocates train providers on the necessary elements of a good investigation. Providers should demonstrate the ability to:

- Recognize the event (i.e. abuse, neglect) that requires an investigation
- Take immediate action to ensure safety of individual(s)
- Complete documentation required for initial reporting (CHRIS, DSS, Law Enforcement as applicable)
- Collect relevant facts (medical records, case notes, incident reports, photographs, videos etc.)
- Conduct interviews and collect written statements from everyone involved or knowledgeable of the incident
- Analyze, inventory and maintain evidence in accordance with procedures
- Identify Corrective Action
- Summarize and report findings along with corrective action plan to DBHDS and individual(s) involved

When it has been determined that a violation *has* occurred, the provider will implement and track any appropriate administrative or clinical care and treatment-related actions in order to prevent future occurrences. Such actions may be developed in consultation with the advocate and documented in CHRIS.

When it is determined that a violation *has not* occurred, the provider will decide whether an administrative intervention is necessary (i.e., policy review, continued fact-finding.). The provider may also seek consultation

from appropriate DBHDS staff (i.e. DBHDS Community Resource Consultant, Licensing and Human Rights) in making this determination.

G2. Number and percent of substantiated cases of abuse/neglect/exploitation for which the required corrective action was verified by DBHDS as being implemented.

Numerator: Number of substantiated cases of ANE for which the required corrective action was verified as being implemented within 90 days. *(i.e. Count of 'closed in 90 days'*)

Denominator: Number of substantiated cases of ANE. *(I.e. total count of cases in the report)*

Data Source

CHRIS via Data Warehouse Report # 0071-OHR90Days

Calculation

Run the report for those dates that occurred in the reporting quarter. Filter on Status "Closed."

A calculation table is displayed at the bottom/last page of the report.

Discussion

- Operating assumption: By designating the case as closed, the advocate has therefore received verification of the approved corrective action. Therefore, it would not be appropriate to include status "Pending" cases in the denominator.
- This measure uses 90 days as the maximum amount of time that a substantiated case should be open.

Implementation and Remediation by OHR

- Appropriate OHR Employee Work Profiles were updated to include a performance measure requiring the assigned advocate to close CHRIS cases within 60 days of initial notification. The Regional Manager monitors this process using Data Warehouse Report #0052-OHR_Incident.
- Office protocols 102-2016 (Management of the complaint process) and 106–2016 (Guidelines for investigation of human rights issues) were also updated requiring the responsible advocate to verify that all provider corrective actions are being implemented. Cases will not be closed until verification of implementation is documented by the advocate in the appropriate *advocate action* section of CHRIS. In the event that the timeframe is extended due to a pending higher level appeal or when there is a delayed response from the provider, the assigned advocate will refer the case to the regional manager for further action.
- The advocate may verify implementation of any corrective action through additional onsite visits; review of policies and/or other documents.
- The Office of Human Rights (OHR) advocates follow protocols to verify the implementation of the corrective action. The protocol for this PM was revised after the first quarter when it was determined that a gap existed in reporting. These protocols now include a weekly tracking by the Office of Human Rights regional manager

G3. Performance Measure Indicator: Unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken.

N= # of unexpected deaths where the cause of death/a factor in the death, was potentially preventable & some intervention to remediate was taken *(i.e. Number of "unexpected" deaths that occurred in a community residential setting deemed as "potentially preventable" AND some action or remediation was taken within 90 days of the review closed date)*

D= # of unexpected deaths where the cause of death/a factor in the death, was potentially preventable

Data Source

Mortality Review Committee (MRC) Action Tracking Log

Calculation

Numerator: Count of "yes" in the potentially preventable column that have "date" in completed date column. The "date" entered must be within 90 days of the end review date for the case for it to count.

Denominator: Total count of "yes" in the potentially preventable column on the MRC tracker

Calculation Steps

- Filter on "Committee CLOSED date" for only those dates in the reporting quarter.
- Example: The April – June 2018 reporting period should only include cases 'closed' in that period.
- Filter on "Facility" to only include 'no' (this excludes facility deaths).
- Filter on "Death Expected?" to only include 'no' (this excludes expected deaths).
- Filter on "Potentially Preventable" to only include 'yes' (this excludes deaths that were not deemed to be potentially preventable).
- The resulting denominator will be displayed in the gray bar on the lower left corner of Excel.spreadsheet.
- Assess which of these cases has a "Date of completed MRC action" within 90 days of the "Committee CLOSED date." The count of cases with a valid date within this 90 days is the numerator.

Discussion

- DBHDS licenses providers who offer services to individuals with mental illness, developmental disabilities or substance use disorders, to report deaths within 24 hours of discovery. From the DBHDS incident-reporting systems, reports of deaths for anyone receiving a licensed DD service with a DD diagnosis and/or in a state-operated facility are referred to the Mortality Review Committee (MRC) of DBHDS for case review.
- For compliance with the settlement agreement and waiver assurance monitoring, the committee reviews unexplained and/or unexpected deaths, cause of death, and determination of preventability.
- This PM demonstrates that the MRC recommended interventions for all unexpected deaths identified as potentially preventable (where the cause of death, or a factor in the death, was potentially preventable) and documents that the recommended interventions to remediate were taken within 90 days.
- Cases are to be reviewed by the committee within 90 days of the death of the individual. All interventions or actions to remediate must be completed within 90 days of review by the MRC.
- The follow-up remediation actions taken and the responsible entity are reported to the QRT retrospectively on a quarterly basis through the Action Tracking Log in the same location as the Excel spreadsheet described in the "Calculation" section above *(see page 12, last bullet)*.
- The dates used for reporting will be when the MRC reviewed the death, not when the death occurred.

- For the reporting quarter, the 'final MRC review' date will be used, not the 'incident' date or 'date of death'.
- To the best of its ability, the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable. Remediation related to unexpected, potentially preventable deaths are made in order to reduce mortality rates to the fullest extent practicable.
  - "Unexpected Death" - denotes a death that occurred as a result of an acute medical event that was not expected in advance nor based on a person's known medical conditions. Examples might include; suicide, homicide, accident, a new medical condition, or sudden and unexpected consequences of a known medical condition.
  - "Potentially preventable" – a death is determined potentially preventable if the actions and events on the part of the provider immediately surrounding the individual's death were related to deficits in the timeliness or absence of, (at least) one of the following factors:
    1. Coordination of care (including medication management)
    2. Access to care, including delay in seeking treatment
    3. Execution of established protocols
    4. Assessment of the individual's needs or changes in status
  - Remediation: Any system based action or recommendation related to an unexpected potentially preventable death. The focus is to improve standards of care that will promote the health, safety and well-being of individuals served by DBHDS. All actions or interventions to remediate must be completed within 90 days of the closed review (date the case was closed).
  - A more detailed remediation protocol was developed after the first quarter and then evaluated after the second quarter. After this second quarter evaluation, the MRC determined a gap in the process, which did not fully account for delegated follow-up remediation activities. As a result, the protocol was revised after the second quarter. These protocols now include a bi-weekly tracking by the Mortality Review Team Program Coordinator and reviewing the status of recommendations at each MRC meeting. Following the change, PM targets have been achieved since the third quarter.
  - The 6/30/2019 data reflects that there were *no unexpected potentially preventable deaths*, so this is considered to be 100% (zero potentially preventable deaths = zero remediation). However, the average for the three quarters is at 78%, which is within 8% of set target.
  - The MRC will maintain and monitor this measure, to ensure the revised protocols are consistently implemented and targets continue to be reached.

Implementation and Remediation by MRC

- As part of the new tracking protocol, the necessary fields for data capture were added to the MRC data collection spreadsheet. These include a yes/no question inquiring whether the deaths, or factors in the death, were potentially preventable, what aspect was deemed potentially preventable, and if the recommended follow-up occurred.

- Discussion of whether an unexpected death has a cause or factor that was potentially preventable takes place after every death determination; however, for this measure only the unexpected deaths are included.
- Intervention or action to remediate could include action directed at a specific provider or an action directed at system change.
- If the percentage falls below the acceptable level, potential steps for remediation include: dedicating time during committee meetings to better understand/address the barriers to following up, identifying additional units within DBHDS that could support the MRC in follow-up activities, and formation of a and MRC sub-committee focused solely on follow-up/completion of remedial interventions..
- Cases which are identified as unexpected/unexplained, potentially preventable, with follow-up remediation and assigned entity - are compiled using the MRC Action Tracking Log and provided quarterly to the QRT.

G4. Number and percent of individuals who receive annual notification of rights and information to report ANE

N= Number of records containing documentation confirming notification of rights and how to report ANE. (i.e., Provider Record Review - The provider used the preferred language or format to ensure the person understands his/her rights.)

D= Total number of records received.

Compliance with this performance measure is monitored via DMAS QMR reviews. Please see above section with regard to sampling methodology for DMAS Quality Management Reviews.

G5. Number and percent of critical incidents reported to the Office of Licensing within the required timeframes as specified in the approved waiver.

N = Number of critical incidents reported to the Office of Licensing within the required timeframe.

D = Number of critical incidents reported to the Office of Licensing regarding individuals receiving DD waiver services (*i.e.,* Number of serious incidents reported to OL *-total count of cases in the report)*

Data Source

CHRIS via Data Warehouse

Calculation

- Run the report for those dates that occurred in the reporting quarter.
- Example: The April – June 2018 reporting period should only include cases in that period.
- Filter on Type "Injuries."
- The denominator is the number of cases. The numerator is the number of cases reported within 2 days.
- Run the report again. Filter on Type "Deaths."
- The denominator is the number of cases. The numerator is the number of cases reported within 2 days.
- Add the two numerators.
- Add the two denominators.

Discussion

- DBHDS licenses providers who offer services to individuals with mental illness, developmental disabilities or substance abuse disorders.

- The numerator and denominator is accessed via CHRIS query. A standalone report through the Data Warehouse is under development.
- Critical incidents, defined as a "serious incident" *means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual*.

- The required timeframe is 24 hours. Because there is no time element on the discovery date, the calculation allows for two days (same or next day compared to incident date) as the required timeframe.
- This performance measure demonstrates that DBHDS has verified that at least 86% of Licensed DD providers have reported a serious incident within the required timeframes as specified in the Licensing regulations.

- Level II and Level III serious incidents shall be reported using the department's web-based reporting application and by telephone to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery

- Reported information shall include the information specified by the department as required in its web-based reporting application, but at least the following: the date ~~and~~, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's injuries or circumstances of the death and any treatment received.

- For all other Level II and Level III serious incidents, the reported information shall also include the consequences or risk of harm that resulted from the serious incident.

- Deaths that occur in a hospital resulting from illness or injury and occurring when the individual was in a licensed service shall be reported.

<u>Post-period reporting</u>

The following recommended changes to Licensing protocols will take effect upon approval and implementation of the Licensing regulations:

- On July 22, 2019, the Incident Management Unit (IMU) within the OL began piloting a specialized unit for the triage of serious incidents in Region IV. The IMU oversees a centralized triage process to review all serious incidents at the time they are reported to the Office of Licensing. The IMU allows the Office of Licensing to better support recommendations contained within the Office of the State Inspector General's Review of Serious Injuries Reported by Licensed Providers of Developmental Services. The IMU facilitates better monitor providers' compliance with and implementation of the changes to the serious incident reporting requirements contained within the Office of Licensing Emergency Regulations for Compliance with Virginia's Settlement Agreement with US DOJ.

- The IMU ensures all incidents are reviewed and responded to each business day. Following the initial review of the serious incident report, the IMU makes a determination as to whether follow up is needed, the incident requires further review, or an investigation is needed. The IMU then tracks each incident to ensure the provider has completed the appropriate follow-up. Follow-up on incidents may include phone contact with the provider and/or individual, a desk review of records and reports, or an on-site visit/investigation when indicated.

- In addition to the triage of serious incident reports, the IMU gathers data and information and conducts trend analyses. Future trend analyses may result in recommendations by providers or the implementation of action plans to address areas of systemic concerns.
- The OL distributed a memo to all providers on September 30, 2019 to reinforce the reporting requirements set forth in the Rules and Regulations for Licensing Providers by the Department of Behavioral Health ("DBHDS") and Developmental Services regulation 12VAC35-105-160 D.2, as well as the DBHDS Office of Licensing ('OL") Guidance for Serious Incident Reporting. The memo advised providers that beginning on October 7, 2019 the IMU began issuing Corrective Action Plans (CAPs) statewide for all five regions for all incidents not reported within the required 24-hour timeframe.

G6. Number and percent of licensed DD providers that administer medications that were not cited for failure to review medication errors at least quarterly.

N: # of licensed DD providers that administer medications not cited for failure to review medication errors at least quarterly (The numerator identifies the DD providers cited under 12VAC35-105-780(5)

D: # of licensed DD providers that administer medications that were reviewed by Office of Licensing in the quarter (The denominator identifies the number of OL annual inspections in a quarter to providers of DD services who administer medication. Those providers include the following: Group home, Sponsored Residential, Center based Group Day, Non-Center-based Group Day)

Data Source

- CHRIS via Data Warehouse report DW-0058: "Licensing Regulation Compliance Overview" provides the numerator (# of providers cited under 780.5.)
- OLIS via DW-0034: "Licensing Visit Detail" provides the denominator (# of providers reviewed).

Discussion

- As part of monitoring and evaluating service quality, DBHDS licensed providers are required by Section 12VAC35-105-620 to develop and implement a quality improvement program sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. Patterns of med errors are reviewed, evaluated, and to be remediated as part of this process.
- 12VAC35-105-780(5): *medication errors and drug reactions* require providers to review med errors at least quarterly.
- For annual unannounced DD provider inspections, the specialist will review the provider's quarterly review of med errors. Citations will be issued when a noncompliance is identified.

G7. Number and percent of individuals reviewed who did not have unauthorized restrictive interventions.

N = number of individuals reviewed who did not have unauthorized restrictive interventions. (i.e., *count of how many PCR alerts were issued to OHR that were NOT due to unauthorized restrictive interventions)*

D = number and percent of individuals reviewed (i.e. *total # of PCR reviews)*

Discussion

- The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
- This performance measure demonstrates that DBHDS has verified that providers are not using unauthorized restrictive interventions. The presence of an unauthorized restrictive intervention does not mean there was abuse or that restraints were used.
- Quality Service Reviews are the vehicle used to report on this performance measure.
- Each quarter the OHR Director or designee will receive and review each incident reported. Any incident of seclusion, as defined in 12VAC35-115-110 identified will be forwarded to the regional manager for immediate investigation and possible citation for human rights violation.
- Numerator: Number of individuals reviewed who DID NOT have unauthorized restrictive interventions.
- Denominator: Number of individuals reviewed (PCRs).
- This performance measure demonstrates that DBHDS has verified that providers are not using unauthorized seclusion.
- In accordance with 12VAC35-115-110. Use of Seclusion, Restraint and Time out (C)(3) seclusion may not be used in the HCBS settings.
- OHR will read the case descriptions to determine the number of cases demonstrating seclusion and report that number to the committee quarterly. By design, the dataset to be screened by OHR will include false positives as to decrease the probability of missing potential cases
- Any incidents of seclusion identified will be forwarded to the appropriate regional advocate for investigation and possible citation for human rights violation.

G8. Number and percent of individuals who did not have unauthorized seclusion.

N = number of individuals who did not have unauthorized seclusion (i.e., Number of cases that were NOT identified as unauthorized seclusion)

D = number of abuse allegations + complaints submitted via CHRIS (i.e., Total number of abuse and complaint allegations)

Data Source

The OHR uses a Data Warehouse report to collect this information.

Discussion

When an allegation occurs, providers are expected to:

- Recognize the event (i.e., abuse, neglect) that requires an investigation
- Take immediate action to ensure safety of individual(s)
- Complete and documenting required initial reporting (CHRIS, DSS, Law Enforcement as applicable)
- Collect relevant facts (medical records, case notes, incident reports, photographs, videos etc.)
- Conduct interviews and collect written statements from everyone involved or knowledgeable of the incident
- Analyze, inventory and maintain evidence in accordance with procedures
    - Identify Corrective Action
    - Summarize and report findings along with corrective action plan to DBHDS and individual(s) involved

- When it is determined that a violation has occurred, implement and track any appropriate administrative or clinical care and treatment-related actions in order to prevent future occurrences. Such actions may be developed in consultation with the dvocate and documented in CHRIS.
- When it is determined that a violation has not occurred, decide whether an administrative intervention is necessary (i.e., policy review, continued fact-finding.). The provider may also seek consultation from appropriate DBHDS staff (i.e. Community Resource Consultant, Licensing, and/or Human Rights) in making this determination.

- The OHR developed an AIM protocol (**A**ssess Safety, **I**nitiate Complaint Resolution Process, **M**onitor Compliance) for review of allegations.
- Once an ANE complaint has been substantiated, this protocol requires that the Advocate must go onsite within 30 working days to the provider to verify corrective actions are being implemented. The case is closed when this action is completed.
- With this performance measure there is an operating assumption that if a case is reported as closed, the Human Rights Advocate has verified implementation of the approved corrective action.

IV. 2018-2019 Quality Team Reporting

A. Administrative Authority:

Assurance: The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Performance Measure A1: Number and percent of satisfactory Medicaid-initiated operating agency and contractor (i.e. DBHDS, Xerox & CDCN) evaluations. (DMAS)

This PM seeks to demonstrate that Medicaid-initiated contractor evaluations show satisfactory performance. This PM requires the initiation of an operating agency contract evaluation during the quarter. Contracts potentially reviewable include DBHDS, CDCN, and Conduent. Question #6 of the evaluation "satisfaction with contractor performance" is the standard for evaluating contractor performance. There is ongoing discussion with regard to establishing congruence between information reported as part of operational monitoring for the Interagency Agreement between DMAS and DBHDS and information collected for the QRT meeting.

The aggregate total for this PM in FY 2019 is 100%. No remediation is needed.

Performance Measure A2: Number and percent of DBHDS provider memorandums pertaining to the waiver approved by DMAS prior to being issued by DBHDS.

There is no data for this PM as there were no provider memorandums issued by DBHDS and reviewed by DMAS during FY 2019.

Performance Measure A3: Number and percent of slots allocated to CSB's in accordance with the standardized statewide slot assignment process (DBHDS).

This PM seeks to demonstrate that all DD waiver slots were allocated and distributed appropriately within CSB's. This assurance is 100% as the operational process requires DBHDS Regional Supports Unit staff routinely to review and confirm all WSAC rankings prior to assigning slots.

The aggregate total for this PM in FY 2019 is 100%. No remediation is needed.

B. Level of Care

Assurance: The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care

Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Performance Measure B1: Number and percent of all new enrollees who have a level of care evaluation prior to receiving waiver services (DBHDS)

This PM seeks to demonstrate that all individuals newly enrolled in the waiver had a recent level of care evaluation (VIDES) completed confirming eligibility for waiver services, prior to receipt of services.

The data, as is, shows 78% compliance with the aggregate waivers, which is below the required threshold.

The Data Warehouse report used to capture data from the WaMS system was configured to determine whether the VIDES was completed within 6 months of the start of waiver services (i.e., no older than 6 months when services are **authorized**). However, SA staff may have been verifying that the VIDES was completed no more than 6 months prior to **the date of enrollment**, which is a different standard. This may have resulted in the low compliance shown. Enrollment, as reported in WaMS and in the system in general, is not well-defined; therefore, determining the specific parameters of the information to include/exclude in WaMS to ensure timely completion of level of care assessments, has been difficult. The PM language only requires the VIDES to be completed prior to receiving waiver services; it does not specify the date of enrollment or initial date of service authorization.

Remediation: To improve consistency in reporting, DMAS and DBHDS agreed that the reporting standard should match the regulatory requirement that the "*level-of-care determination through the Virginia Intellectual Developmental Disabilities Eligibility Survey (VIDES) appropriate to the individual according to his age, be completed* ***no more than six months prior to waiver enrollment."*** An e-mail communication was distributed to all waiver providers to clarify the timeline for completion of level of care enrollments recorded in WaMs and provide advance notice of resulting impacts to service authorization requests. SA staff were directed to reject all requests in WaMS when the initial VIDES submitted showed a date more than six months from the enrollment date (in WaMS this is actually the **initial service authorization date**). In the interim, the counts will be tabulated manually and an Ad Hoc report from WaMS will be created to capture data for this PM, while a permanent report is created in the Data Warehouse. Further investigation by DBHDS will ensure that the data reflects information that retrieved from the correct data fields and that service authorization staff are appropriately denying requests for services where the level of care date falls outside of the acceptable range.

Performance Measure B2: The number and percent of VIDES (LOC) completed within 60 days of application for those for whom there is a reasonable indication that service may be needed in the future.

This PM seeks to demonstrate the timeliness of level of care evaluations (VIDES) (within 60 days for individuals requesting services.)

The aggregate total for FY 2019 is 94.8%, which is above the required threshold. No remediation is needed.

a. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.

Performance Measure B3: Number and percent of VIDES determinations that followed the required process, defined as completed by a qualified CM, conducted face-to-face with the individual and those who know him (if needed).

This PM seeks to demonstrate that the results of level of care evaluations determining eligibility for waiver services (VIDES), followed the appropriate process (were completed by a qualified CM/SC as outlined in the regulations, include evidence that the evaluation was conducted face to face with the individual and that individuals who know the individual were included). Evidence for all three requirements must be present to demonstrate compliance with the measure.

The aggregate total for this PM in 2019 is 70%, which is well below the required threshold.

For review of this PM, DMAS QMR requests that the provider show proof that the review was conducted face to face (i.e., progress notes or other designation in the record which includes language indicating that the VIDES was conducted in person.) If the QMR reviewer is unable to locate the documentation in their records, the provider is requested to locate it for the reviewer. If it is unable to be located, then the provider will receive a corrective action. The team discussed the need for a universal mechanism to document that the review is conducted face to face.

Remediation: DBHDS is exploring the addition of a field in WaMS indicating that the review was conducted face to face with the individual when other Electronic Health Record related changes are made to WaMS (around 7/1/2020). Reminders about this requirement continue to be incorporated into the Provider Roundtable meetings and are included as a standing item on all agendas. This requirement has also been added to the Part V training.

Performance Measure B4: Number and percent of VIDES determinations for which the appropriate number of criteria were met to enroll or maintain a person in the waiver.

This PM seeks to demonstrate that individuals were appropriately screened and meet the required eligibility criteria to receive waiver services prior to being enrolled or maintained in the DD Waivers program.

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

Appendix C. Participant Services - Qualified Providers

Assurance: The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-Assurance a) The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measure C1: Number and percent of licensed/certified waiver provider agency enrollments for which the appropriate license/certificate was obtained in accordance with waiver requirements prior to service provision.

This PM seeks to demonstrate that waiver provider agencies had the appropriate license prior to providing services to individuals on the DD Waivers.

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

Performance Measure C2: Number & percent of licensed/certified waiver provider agency staff who have criminal background checks as specified in policy/regulation with satisfactory results.

This PM seeks to demonstrate that licensed and/or certified waiver provider agency staff completed criminal background checks, with satisfactory results, according to regulatory requirements.

The aggregate total for all waivers for FY 2019 is 92%, which is above the required threshold. No remediation is needed.

Performance Measure C3: Number & percent of enrolled licensed/certified provider agencies, continuing to meet applicable licensure/certification following initial enrollment.

This PM seeks to demonstrate that waiver provider agencies continued to maintain their license/certification after initial enrollment.

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

Sub-Assurance b) The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Performance Measure C4: Number and percent of non-licensed/noncertified provider agencies that meet waiver provider qualifications. (DMAS)

This PM seeks to demonstrate that non-licensed/non-certified provider agencies meet the appropriate provider qualifications prior to providing services to individuals on the DD Waivers.

There is no data for this PM in 2019.

The number of services initially included in the DMAS sample of non-licensed/non-certified providers was very small. When applying the DMAS sampling methodology, often samples extracted did not contain enough

providers of the referenced services for QMR to review. Following QRT team discussion and agreement on appropriate providers of services to be included in the sample, DMAS will make a concerted effort to review providers of the following identified services: Therapeutic Consultation, Respite, Assistive Technology, Environmental Modifications, Electronic Home-Based Supports, Group Supported Employment Services, PERS, and Community Guide. Employment and Community Transportation and Peer Mentor Services will be added once there are individuals authorized for that service. However, because QMR reviewers have just begin to include these services in their sampling, there is no data on this PM for the year.

Remediation: DMAS will designate staff to review the sample each quarter to make sure that there is a provider identified for each waiver sample.

Performance Measure C5: Number & percent of non-licensed/noncertified provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results. (DMAS)

This PM seeks to demonstrate that non-licensed and/or non-certified provider DSP staff completed criminal background checks, with satisfactory results, according to regulatory requirements.

There is no data for this PM in 2019.

As with PM C4, the team discussion focused on the determination of which services should be included in the sample. These services are outlined in C4. There will be data for this PM in future years.

Performance Measure C6: Number of new consumer-directed employees who have a criminal background check at initial enrollment.

This PM demonstrates that consumer-directed employees had completed a criminal background check upon initial enrollment.

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

Performance Measure C7: # of consumer-directed employees who have a failed criminal background who are barred from employment (DMAS)

This PM seeks to ensure that consumer directed employees who failed their criminal background check were not able to be employed as consumer-directed staff.

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

Sub-Assurance: c) The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure C8: Number and percent of provider agency staff meeting provider orientation training requirements (DMAS)

This PM seeks to demonstrate that provider agency staff had completed the annual DSP orientation training and documentation is present in the provider's record.

The aggregate total for all waivers for 2019 is 83.96%, which is below the required threshold.

Compliance with this measure, to a large degree, is dependent on the DMAS provider sample drawn during a particular quarter (i.e., for the FIS and BI waiver, there were two quarters for which there were no DSP records reviewed during the quarter.)

Remediation: When DBHDS initiated the core competencies, some providers believed that they were no longer required to complete the staff orientation training/testing, so the compliance with this measure decreased. The Provider Development team have been reminding providers at the Provider Roundtable meetings that the staff orientation is still a requirement. DMAS will combine the new hires (staff employed less than a year) with those staff who have an annual review due, to measure compliance with the competencies. The team discussed the fact that the variation in compliance each quarter is likely continue to some degree since different providers are sampled each quarter.

Performance Measure C9: Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements.

This PM seeks to ensure that all provider agency DSP's completed competency training requirements and that this documentation is present in the provider's record.

The aggregate total for all waivers for 2019 is 55.89%, which is well below the required threshold.

The issues identified with this PM are related to poor recordkeeping and misunderstanding/confusion about the competency requirements, which have only been in place a few years. QMR reviews reveal similar issues to those identified in C8 with providers unable to provide documentation of completion of the staff orientation.

Remediation: For a cleaner sample in FY20 and for remediation purposes, DMAS has proposed for the sample to include two groups – those who need to demonstrate only the initial competencies and those who should demonstrate one or more annual updates. It should be noted that the variation in compliance is likely continue to some degree as different providers are sampled each quarter. Subsequent reviews would be conducted based on the annual review, plus the new orientation. The variation in compliance is likely continue to some degree as different providers are sampled each quarter.

Performance Measure C10: Number of service facilitators meeting training requirements and passing competency testing (DMAS).

This PM seeks to demonstrate that service facilitators (CL and FIS waiver) met provider training requirements and passed the competency test with at least the minimum score.

The aggregate total for all waivers for 2019 is (82.60%) which is below the required threshold.

Remediation: the team discussed specific actions that can be taken to address service facilitators performing poorly who do not participate in required training. These actions would include SF's in the general provider population subject to the new regulatory provision referring noncompliant providers to the Mandatory Provider Remediation process under development. This would provide parity with providers who are now being required to participate in mandatory training and technical assistance if demonstrating similar deficits.

D. Service Plan

Assurance: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-assurance a) Service plans address all participants assessed needs including health and safety risk factors and personal goals, either by the provision of waiver services or through other means.

Performance Measure D1: Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes. (DMAS)

This PM seeks to ensure that service plans addressed all needs/desires of the individual receiving services. If the plan identifies a need, a measurable outcome should be included in the plan, to be provided through waiver services or other means (natural supports, etc.).

The aggregate total for 2019 is 87%, which is within the required threshold. No remediation is necessary.

Performance Measure D2: Number and percent of individual records that indicate that a risk assessment was completed as required.

This PM seeks to demonstrate that individuals receiving waiver services received a risk assessment, as required.

The aggregate total for 2019 is 96%, which is well above the required threshold. No remediation is necessary.

Performance Measure D3: Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.

This PM seeks to ensure that a risk mitigation strategy was included in the provider's Plan for Supports, if the completed risk assessment identified a risk factor for the individual.

The data shows **yearly average compliance with the PM for the FIS waiver at only 83.1%;** however, the aggregate number for all three waivers combined is within the required threshold (91**%)**. No remediation required.

Performance Measure D4: Number and 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.

The PM seeks to demonstrate that service plans for the following DD waiver services included a back-up plan as required: In-home Supports, Personal Assistance, Respite, Companion, and Shared Living.

This PM is monitored through review of Services Facilitator records for CD services. CD services are available in the CL and FIS waivers.

Yearly compliance with the PM for the CL waiver is at 83.1%.

The aggregate number for all three waivers combined is within the required threshold (86%).

Sub-assurance: c) Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measure D5: Number and percent of service plans reviewed and revised by the case manager by the individual's annual review date.

This PM seeks to demonstrate that service plans were reviewed by the individual's annual review date and revised by the case manager (as needed).

The aggregate total for this PM in 2019 is 100%. No remediation needed.

Performance Measure D6: Number and percent of individuals whose service plan was revised, as needed, to address changing needs.

This PM seeks to ensure that the Individual Support plan was updated/revised by the case manager, whenever an individual's needs or desires change (irrespective of annual reviews).

Annual 2019 totals show the CL waiver at 49%, and the FIS waiver at 50% (samples only for 3rd and 4th quarter).

The aggregate number for all three waivers **(50%)** combined is well below the required threshold.

Remediation: This is an area of continued challenge. Performance with regard to this measure will be addressed with approval and implementation of a new waiver regulatory requirement for mandatory provider training and technical assistance for those providers with multiple citations in an identified area. Additionally, DBHDS is planning the release of specific support instructions for providers to make changes in WaMS, as well as recorded webinars, a guidance document, etc. to make it easier to document changes to plans when needed.

Sub-assurance d: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the physician of waiver services or through other means.

Performance Measure D7: Number and percent of individuals who received services in the frequency specified in the service plan

This PM seeks to demonstrate that services were delivered to the individual in the required frequency as outlined in the service plan and evidenced by documentation in the provider record (indicating how often services were being delivered to the individual and the presence of a support activity).

Compliance with this PM reflected poor recordkeeping, with most citations representing various items missing in the provider record, such as the annual plan.

Annual 2019 totals for the CL waiver are at 83%.

The aggregate number for all three waivers combined is just below the required threshold (85%).

Remediation: To address specific instances where a plan was not located in provider's records, DBHDS will conduct internal follow-up as remediation to determine how the provider was authorized for services without a plan. A review will also be conducted for all providers cited (without a Plan for Supports) to establish which

services were provided. Provider documentation will continue to be addressed via provider training and technical assistance.

Performance Measure D8: Number and percent of individuals who received services in the duration specified in the service plan

This PM seeks to ensure that services were delivered to the individual in the required duration as outlined in the service plan, and evidenced by documentation in the provider record.

Citations for the PM represent various items missing in the provider record, such as the annual plan.

The aggregate total for 2019 is 94%, which is well above the required threshold. No remediation is needed.

Performance Measure D9: Number and percent of individuals who received services in the type specified in the service plan

This PM seeks to ensure that the appropriate type of services were delivered to the individual as outlined in the service plan and evidenced by documentation in the provider record.

The aggregate total for 2019 is 94%, which is well above the required threshold. No remediation is needed.

Performance Measure D10: Number and percent of individuals who received services in the scope specified in the service plan

This PM seeks to ensure that services were delivered to the individual in the required scope (plan included all services needed by the individual) as outlined in the service plan and evidenced by documentation in the provider record.

The aggregate total for 2019 is 94%, which is well above the required threshold. No remediation is needed.

Performance Measure D11: Number and percent of individuals who received services in the amount specified in the service plan

This PM seek to ensure that services were delivered to the individual in the amount required (correct amount of time/number of hours individual received services daily) as outlined in the service plan and evidenced by documentation in the provider record.

The aggregate total for 2019 is 91%, which is above the required threshold. No remediation is needed.

Sub-assurance e: Participants are afforded choice between/among waiver services and providers.

Performance Measure D12: Number and percent of individuals whose case management records documented that choice of waiver providers was provided to and discussed with the individual. (DMAS)

The PM seeks to ensure that individual case management records reviewed by QMR, contained the form used by the state to document that choice of waiver providers was offered to the individual receiving services.

The aggregate number for all three waivers combined is within the required threshold **(92%).** No remediation is needed.

Performance Measure D13: Number and percent of individuals whose case management records contain an appropriately completed and signed form that specifies choice was offered among waiver services

The PM seeks to ensure that individual case management records reviewed by QMR, contained the form used by the state to document that choice was provided among waiver services.

The aggregate number for all three waivers combined is within the required threshold (**95.4%).**

G. Participant Safeguards: Health and Welfare - The state demonstrates that it has designed and implemented an effective system for assuring waiver participant health and welfare.

Sub-assurance: a) The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Performance Measure G1: Number and percent of closed cases of abuse/neglect/exploitation for which DBHDS verified that the investigation conducted by the provider was done in accordance with regulations.

This PM seeks to demonstrate that fact-finding in reported cases of abuse, neglect, and exploitation (ANE), once closed, were verified as properly investigated according to Human Rights regulations.

The aggregate number for all three waivers (86.97%) is within the required threshold.

Performance Measure G2: Number and percent of closed cases of abuse/neglect/exploitation for which the required corrective action was verified by DBHDS as being implemented

This PM seeks to demonstrate that DBHDS has verified that providers who had substantiated cases of ANE implemented corrective actions. The OHR retrospective review uses a random sample of closed cases of ANE for individuals receiving DD services. This sample is drawn from allegations in the CHRIS system. The OHR Advocates follow protocols to verify the implementation of the corrective action.

The aggregate number for all three waivers (88%) is within the required threshold.

Performance Measure G3: Number and percent of unexpected deaths where the cause of death/a factor in the death, was potentially preventable & some intervention to remediate was taken. (DBHDS)

This PM seeks to demonstrate that the Mortality Review Committee (MRC) of DBHDS, recommended interventions for all unexpected deaths identified as potentially preventable (where the cause of death, or a factor in the death, was potentially preventable). It ensures that the MRC has documented that the recommended interventions to remediate were taken within 90 days of the closed review date.

The yearly aggregate average for the PM is well below the required threshold at **62%.**

Remediation: After low percentages reported at the beginning of the fiscal year, a new process for tracking cases and remediating cases of preventable death to prevent recurrence was initiated. This process involves directing follow-up remediation activities to appropriate DBHDS departments with resolution reported back to

the MRC within 90 days. This resulted in significantly improved results during the latter half of the year. Data for the next year should also reflect these improved processes.

Performance Measure G4: Number and percent of individuals who receive annual notification of rights and information to report ANE

This PM seeks to demonstrate that individuals were notified annually of their human rights and how to report ANE information to appropriate authorities.

The yearly aggregate average for the PM is within the required threshold at 88%. No remediation required.

Sub-assurance: b) The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible as determined by the number and percent of critical incidents reported to the Office of Licensing within the required timeframes as specified in the approved waiver.

Performance Measure G5: Number and percent of critical incidents reported to the Office of Licensing within the required timeframes as specified in the approved waiver.

This PM seeks to demonstrate that an incident management system was in place to ensure that incidents are reported to the DBHDS Office of Licensing within the required timeframes, to help resolve and prevent similar incidents to the extent possible.

The data show 93.3% compliance with this measure for 2019 yearly aggregate reporting. No remediation is needed.

The Office of Licensing has instituted a new Level I-III critical incident reporting protocol. Level II and Level III serious incidents are required to be reported using the department's web-based reporting application and by telephone to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Though compliance with this PM is within the required threshold, it was noted that the data may show different percentages by the next quarter following implementation of the new incident reporting protocol.

Performance Measure G6: Number and percent of licensed DD providers that administer medications that were not cited for failure to review medication errors at least quarterly.

This PM seeks to demonstrate that providers were reviewing medication errors at least quarterly, with documentation of these reviews available in the provider record.

The yearly aggregate average for the PM is within the required threshold at **99%.** No remediation is required.

Although the level of compliance is demonstrably high, under the new Licensing protocol, all regulations are noted for compliance versus for non-compliance. Therefore, the data reviewed in subsequent quarters may show different numbers.

Performance Measure G7: Number and percent of individuals reviewed who did not have unauthorized restrictive interventions.

This PM seeks to demonstrate that DBHDS verified that providers were not using unauthorized restrictive interventions (including restraints and seclusion).

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

Performance Measure G8: Number and percent of individuals who did not have unauthorized seclusion.

This PM seeks to demonstrate that DBHDS verified that providers were not using unauthorized seclusion.

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

OHR reads the case descriptions of staff activity scanning for use of words that may indicate that an instance of seclusion occurred. By design, the dataset to be screened by OHR includes false positives to decrease the probability of missing potential instances.

Performance Measure G9: Number and percent of participants 20 years and older who had an ambulatory or preventive care visit during the year.

The PM seeks to demonstrate that individuals receiving waiver services received a doctor's visit (either a primary care visit or identified preventive care/wellness visit) at least once a year.

The data shows 89% compliance with this measure for the annual yearly aggregate reporting, which is within the required threshold.

The team discussed the codes that are being included in this reporting to determine what constitutes an ambulatory or preventive care visit. The KPA group (DBHDS Quality Reporting) has expressed interest in this information as well. DMAS will follow up to determine if this data can be extracted for review. This will assist in the collection of background information on the methodology for data reporting for data provenance.

Performance Measure G10: Number and percent of participants 19 years and younger who had an ambulatory or preventive care visit during the year.

See notes for previous (related) PM #G9.

The aggregate number for all three waivers (87%) is within the required threshold.

I. Financial Accountability

Assurance: State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Sub-assurance: a) The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Sub-assurance: b) The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible as determined by the number and percent of critical incidents reported to the Office of Licensing within the required timeframes as specified in the approved waiver.

Performance Measure I1: Number and percent of adjudicated waiver claims that were submitted and reimbursed using the correct rate in accordance with the approved DMAS rate schedule.

The PM seeks to demonstrate that adjudicated waiver claims were submitted and paid according to the approved rate reimbursement methodology outlined in the waiver regulations.

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

I2. Number and percent of adjudicated waiver claims that were submitted using the correct procedure codes

The PM seeks to demonstrate that adjudicated waiver claims were submitted using the correct procedure codes.

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

I3. Number and percent of claims adhering to the approved rate/rate methodology in the waiver application

The PM seeks to demonstrate that paid claims were reimbursed according to the approved rate methodology as outlined in the waiver regulations

The aggregate total for this PM in 2019 is 100%. No remediation is needed.

Appendix A

Acronym Guide

ANE Abuse, neglect, and exploitation (allegations of human rights violations)

CHRIS Comprehensive Human Rights Information System

CMS Centers for Medicare and Medicaid Services

DBHDS Department of Behavioral Health and Developmental Services

DD Developmental Disability (inclusive of individuals with an intellectual disability)

DMAS Department of Medical Assistance Services

DW Data Warehouse

ISP Individual Supports Plan

KPA Key Performance Areas (DOJ Settlement Agreement Quality Monitoring)

MRC Mortality Review Committee

OHR Office of Human Rights

OL Office of Licensing

PM Performance Measure

QRT Quality Review Team RST Regional Support Teams

QSR Quality Service Review

RST Regional Support Team

SC Support Coordinator