Virginia Department of Behavioral Health & Developmental Services

# Quality Management Plan FY 2020

Quality Management Plan FY 2020
Version 1
Effective 9/13/2019

# Quality Improvement Plan

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# Quality Management Plan

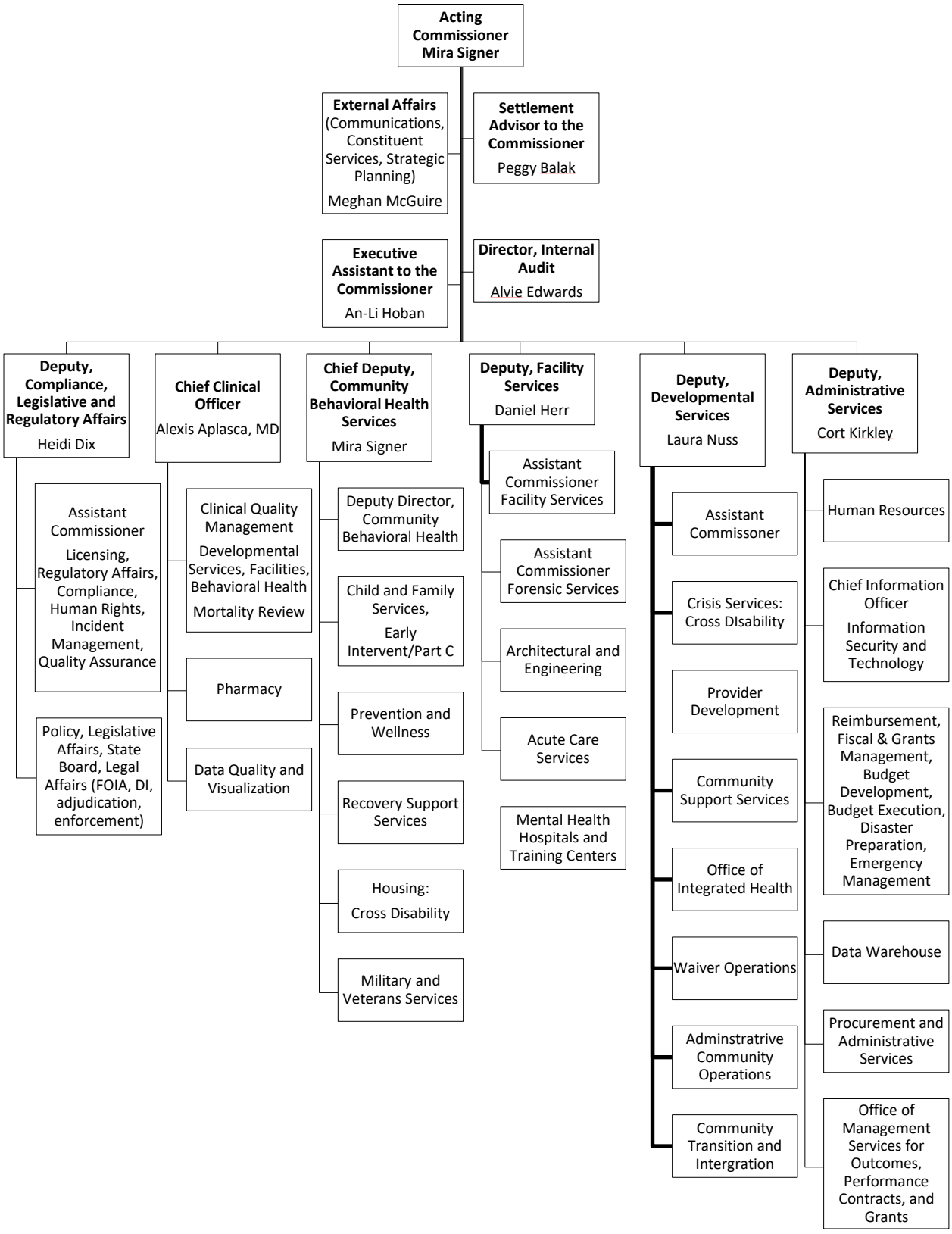
## Part 1- Quality Management Program Description

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is committed to Continuous Quality Improvement (CQI) which is an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes. The DBHDS Quality Management Plan is detailed in a three-part document: 1) Quality Management Program Description which describes the current structure and framework for discovery and remediation activities, and existing quality committees for the agency; 2) Quality Management Work Plan which contains the charters of each quality committee outlining the purpose and aims of the committee and anticipated quality initiatives; 3) Quality Management Annual Report and Program Evaluation which summarizes the key accomplishments of the Quality Management Program, work plans, and challenges to meeting stated goals. This document, the Quality Management Program Description, is the first of the three-part document series. The DBHDS Quality Management Plan will be reviewed and updated annually.

*"DBHDS must be strategic in shaping a system that effectively, equitably, and safely serves people with behavioral health and substance use disorders and developmental disabilities throughout Virginia. To do so requires careful planning, a commitment to continuous quality improvement from everyone involved in our system, and the courage to identify weaknesses while always striving for excellence. A Quality Management System is essential to establish the structure through which these efforts can be managed."*

Mira Signer, Acting Commissioner
Virginia Department of Behavioral Health and Developmental Services

# DBHDS Organizational Chart



## Standards for Quality

The DBHDS' Strategic Plan will be finalized in mid-September 2019. In its nearly complete draft form, the plan facilitates and promotes value-based care, person-centered values with families as partners and a healthcare system that includes all caregivers throughout the continuum of care, and a willingness to include all system partners in the quality of care effort.

Core Components of the Strategic Plan include a focus on population health and the Institute of Healthcare Improvement's Triple Aim:

1) Improving the individual experience of care
2) Reducing the per capita costs of Behavioral Health and Developmental Services
3) Improving the health of DBHDS populations

DBHDS System-wide Strategic Goals include:

- Providing value-based care informed by evidence and innovation
- Growing system capacity for access to quality services in the natural environment
- Building a culture of collaboration and communication driven by outcomes and well-being
- Being a learning and leading system for a healthy and well Virginia and
- Developing and aligning resources for the highest and best use.

With these strategic goals in mind, DBHDS's Quality Management Plan draws upon multiple quality frameworks to include the Institute of Medicine's six dimensions of quality, the Substance Abuse and Mental Health Services Administration (SAMHSA) quality framework, and the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS) quality strategy in the implementation of the DBHDS quality management system.

The Institute of Medicine identifies six dimensions of quality which are applicable to all individuals served regardless of whether they access for health care in hospitals, rehabilitation facilities, or in the community. These six dimensions are defined and represented in the graphic below:

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.


Focusing on substance abuse and mental health care, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides the following Quality Framework:

Aims:

- **Better Care:** Improve the overall quality, by making behavioral health care more person-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the behavioral health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of positive behavioral health in addition to delivering higher-quality behavioral health care.
- **Affordable Care:** Increase the value (cost-effectiveness) of behavioral health care for individuals, families, employers, and government.

Priorities:

- Promote the most effective prevention, treatment and recovery practices for behavioral health disorders
- Assure behavioral health care is person- and family-centered
- Encourage effective coordination within behavioral health care, and between behavioral health care and other health care and social support services
- Assist communities to utilize best practices to enable healthy living
- Make behavioral health care safer by reducing harm caused in the delivery of care

- Foster affordable high quality behavioral health care for individuals, families, employers, and governments by developing and advancing new delivery models.

The CMS HCBS Quality Framework identifies similar domains as indicated in the graphic below:

| Focus | Desired Outcome |
|---|---|
| Participant Access | *Individuals have access to home and community-based services and supports in their communities.* |
| Participant-Centered Service Planning and Delivery | *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community* |
| Provider Capacity and Capabilities | *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.* |
| Participant Safeguards | *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.* |
| Participant Rights and Responsibilities | *Participants receive support to exercise their rights and in accepting personal responsibilities.* |
| Participant Outcomes and Satisfaction | *Participants are satisfied with their services and achieve desired outcomes.* |
| System Performance | *The system supports participants efficiently and effectively and constantly strives to improve quality.* |

*Centers for Medicare and Medicaid Services, National Association of State Directors of Developmental Disabilities Services

## DBHDS Quality Management System

Every organization should implement a quality management system appropriate to its size, scope and populations served. The DBHDS Quality Management System is based on the DBHDS Vision, Mission and Strategic Plan and incorporates these nationally recognized quality principles. DBHDS developed a multi-faceted approach using these quality frameworks and principles to develop a culture of quality. When fully implemented, the system's infrastructure will be:

- Cross disability
- Supported through the organization's leadership who is:
    - Committed to the success of the QM plan
    - Supportive of the organizational culture of quality improvement

    - Prepared to designate resources for critical support mechanisms
    - Willing to give authority to staff to make changes
- Person and family-centered
- Characterized by employees and providers who are continuously learning and empowered as innovative change agents
- Effective in utilizing data for ongoing quality improvement
- Sustainable and continuous

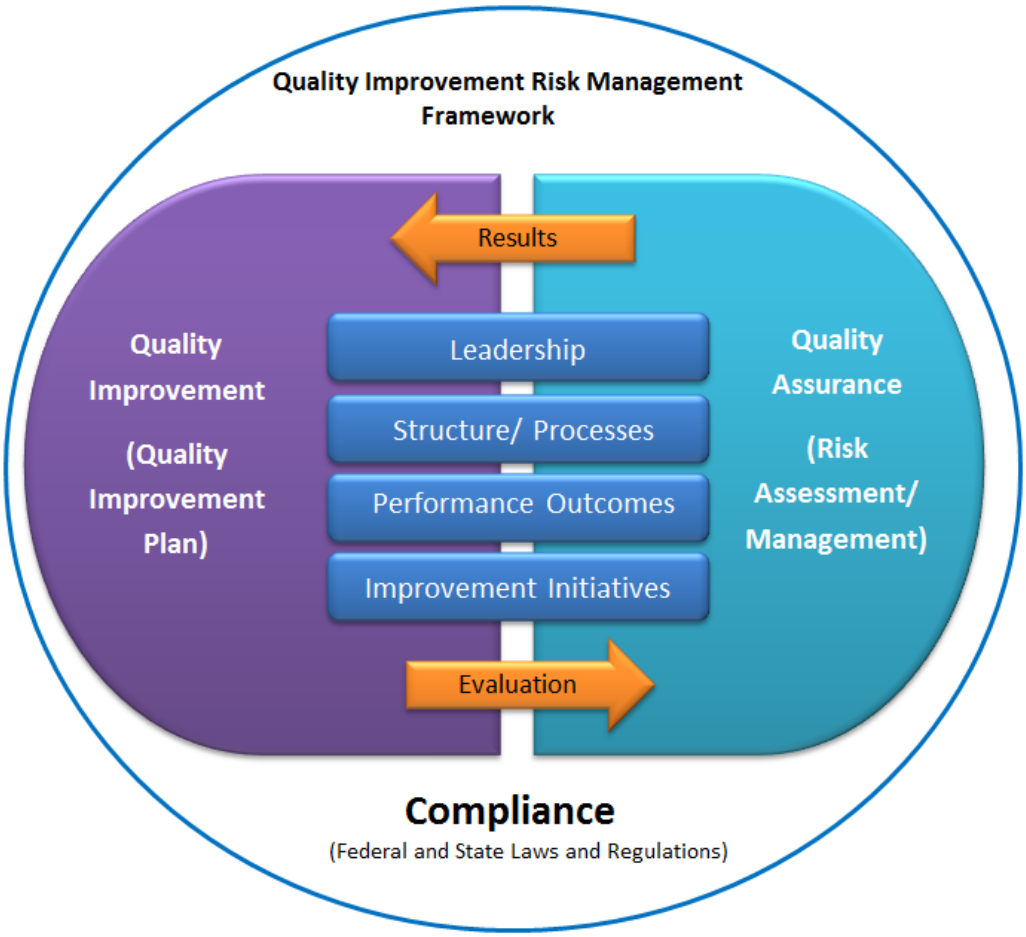
The graphic below illustrates that while compliance is what we must achieve, the ultimate goal is a system of quality services that allows individuals to direct their own lives and recovery, to access and fully participate in their community and balances risk, health, safety and well-being. An effective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

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

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

## Leadership

Leadership commitment for a culture of quality, structures and data driven processes, established performance outputs/outcomes, and continuous quality improvement initiatives are the backbone of the framework.




DBHDS' leadership commitment is demonstrated through direction and support of the quality management program and continuous quality improvement, consistent with the mission, vision, and strategic plan, to ensure that a culture of quality permeates the agency through employee engagement at all levels and through the services provided by our community partners. Leadership values programs and services that are customer focused with the input of internal and external stakeholders, staff at all levels, individuals receiving services and their guardians/authorized representatives, providers, advocates, and others on emerging and ongoing issues.

Leaders encourage staff members to work together to eliminate complacency, promote collective mindfulness, and promote a learning environment (i.e., learning from safety events, including close calls and other system failures that have not yet led to the harm of an individual). In an integrated quality/risk management system, these efforts identify opportunities for quality

improvement, include assessment of risks, and can result in quality improvement initiatives which seek to improve systems and processes to achieve desired outcomes.

DBHDS strives towards a culture of quality which recognizes that quality is a shared responsibility of all individuals within an organization. While this may require a fundamental shift in perspective, all employees should be empowered to be change agents.

## Structure and Processes

Quality assurance, risk management and quality improvement are integrated processes that are the foundation of the quality management system. Quality assurance focuses on discovery activities to test compliance with standards, regulations, policies, guidance, contracts, procedures and protocols, and the remediation of individual findings of non-compliance. Regulatory compliance at minimum establishes the extent to which basic performance standards are met. DBHDS services are governed by DBHDS Licensing Regulations and by DMAS DD HCBS Waiver Regulations. Additional performance standards are set forth by the Division of Developmental Services and the Division of Behavioral Health in support of various program goals.

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

Quality improvement is the systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care.

The DBHDS quality management system includes the Division of Compliance, Legislative and Regulatory Affairs which oversees the regulatory, quality assurance and risk management processes, the Division of Developmental Services' Waiver Operations Unit, Provider Development Unit and DMAS which collaboratively implement the DD HCBS Waivers Quality Management Plans, the Office of Integrated Health which is responsible for the PASRR and the provision of clinical training and technical assistance, The Division of Administrative Services, Office of Management Services for Outcomes, Performance Contracts, and Grants, and The Division of the Chief Clinical Officer, Office of Clinical Quality Management which oversees the quality improvement processes. The Division of the Chief Clinical Officer, Office of Data Quality and Visualization provides critical support across quality management functions.

The Division of Developmental Services also manages discovery, remediation and data reporting activities for select DOJ Settlement Agreement compliance measures not captured by the departmental quality assurance system.

## Division of Compliance, Legislative and Regulatory Affairs

Recognizing that quality assurance involves determining the extent to which performance standards/regulations are met and taking action to remedy specific problems or concerns that arise, the DBHDS Division of Legislative and Regulatory Affairs includes the Offices of Licensing, Human Rights, Risk and Incident Management and Regulatory Affairs. These offices provide oversight and monitoring of providers to assure individuals' rights and that providers and services meet established standards and requirements.

### Office of Human Rights

The Office of Human Rights (OHR) is responsible for promoting the basic precepts of human dignity, advocating for the rights of persons with disabilities in the DBHDS service delivery systems and managing the DBHDS Human Rights dispute resolution program. Human rights advocates ensure compliance with human rights regulations, following up on complaints and allegations of abuse, neglect, and exploitation. Advocates respond to and assist in the complaint resolution process by monitoring provider reporting and reviewing provider investigations and corrective actions. Advocates also respond to reports of abuse by conducting independent or joint investigations with DBHDS partners and/or Virginia Department of Social Services (VDSS) and in cases where there are violations of the Human Rights Regulations, Advocates recommend citation through the Office of Licensing.

The OHR uses data to deploy advocates to programs and areas where there are serious concerns. As a proactive protection of rights, advocates visit newly licensed providers within 30 days of service initiation to ensure the basic knowledge of the human rights system, including review of the provider's human rights policies and training on the requirements and process for utilizing the department's web-based reporting application (CHRIS). The Office of Human Rights also provides new waiver provider validation for compliance with Home and Community Based Services (HCBS) Settings Rule.

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

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

The OHR has become a data driven decision making team, using the data warehouse to deploy Advocates to programs and areas where there are emergent issues. The OHR has 23 field Advocates, across the state, responsible for ensuring human rights protections to individuals served in our facilities and services offered through over 900 DBHDS licensed community providers. Advocates actively provide guidance, consultation and on-going technical assistance to community providers, facility staff, individuals, and family members via on-site inspections and reviews.

**Office of Licensing**

The Office of Licensing (OL) acts as the regulatory authority for the DBHDS' licensed service delivery system. Through quality assurance processes including but not limited to initial application reviews, initial site visits, unannounced inspections, review and investigation of serious incidents and complaints, and issuance of corrective action plans, the OL ensures the mechanisms for the provision of quality service are monitored, enforced and reported to the DBHDS leadership. For example, new regulations require that all providers develop and implement a quality improvement program and a risk management plan. The OL is responsible for ensuring that DBHDS licensed providers have developed and implemented risk mitigation and quality improvement processes addressing services to individuals with behavioral health and developmental disabilities.

Providers are required to report human rights complaints, allegations of abuse, neglect and exploitation and serious incidents as defined in licensing regulations in the DBHDS CHRIS system. These reports are monitored and may result in onsite visits and investigation by either Office of Licensing and/or the Office of Human Rights.

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

- Coordination with other agencies- DMAS, Managed Care Organizations (MCOs, Department of Social Services (DSS), State and local law enforcement, Attorney General (AG), Department of Health Professions (DHP)
- Coordination with other departments within DBHDS – Office of Human Rights, Office of Developmental Services, Behavioral Health, Substance Abuse, Internal Audit, Child and Family Services
- Utilization of a performance management system to ensure that CAPs, Inspections, and Investigations are being done according to office protocol and regulation.

The Office of Licensing includes an incident management unit and an investigations unit. The incident management unit is responsible for the daily review, triage, and follow-up on all reported serious incidents. Follow-up on incidents may include phone contact with the provider and/or individual to ensure immediate protections and health and safety follow-up has occurred;

desk review of records and reports; and on-site visits when indicated. The incident management unit will work closely with the investigations unit, licensing specialists, and human rights advocates to assure adequate follow-up.

Serious incidents include any event or circumstance (including injuries or deaths) that causes, or could cause harm to the health, safety, or well-being of an individual. Providers are required to report serious incidents to DBHDS through CHRIS within 24 hours of their identifying, or being notified of the incident. Upon review, the incident management unit will make a determination as to whether further follow-up is needed. Any incidents in which there is concern that the individual or others are at imminent risk will be referred for immediate investigation; all deaths of individuals with developmental disabilities will be referred to the Investigation Unit. Other concerns will be forwarded to the provider's licensing specialist for follow-up.

In addition to triage and follow-up of individual incidents, the incident management unit will also review data to identify trends, including providers that have a high volume of incidents, or several incidents of the same type (e.g., falls or medication errors); they will also identify patterns of incidents with the same individual that may indicate the need for a change in services, or the need for additional resources. This will include monitoring for risk trigger thresholds as established by the Risk Management Review Committee. The incident management unit will also report on trends across the system, such as total incidents and frequency of different types of incidents by provider, service, and for individuals. Trend reports will be reviewed with the Risk Management Review Committee to determine when system level quality improvement activities may be necessary.

The investigations unit will be responsible for the investigation of complaints, incidents, injuries, and deaths in accordance with office protocols and review criteria. The investigations unit will initially follow-up on all deaths of persons with developmental disabilities as described above, while other investigations will continue to be handled by the provider's licensing specialists. As additional resources are added to the unit, they will expand to include all investigations involving individuals with DD, and eventually to all investigations regardless of disability type.

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

## Division of Developmental Services

### DD HCBS Quality Management Plans

DMAS, the DDS Waiver Operations Unit and Provider Development Unit, with support from the Office of Integrated Services and Supports, collaboratively manage the implementation of these plans. The HCBS waivers contain performance measures as approved by CMS for the following areas: level of care; service planning and delivery; qualified providers; health and safety; fiscal accountability; and, quality improvement. Specific details regarding the frequency of review,

sample size, methods of discovery and remediation, and responsible parties are detailed in the respective DD HCBS waivers. The HCBS Waiver Quality Review Team meets on a quarterly basis to report on and review the results of the discovery and remediation activities for each performance measure, and establish systemic remediation strategies for those measures that fall below an 86% performance threshold when required. The HCBS Waiver Quality Review Team prepares an annual report for the DBHDS QI Committee for its review and consideration as part of the quality improvement process.

**Office of Integrated Health**

The Office of Integrated Health (OIH) ensures DBHDS meets the federal requirements for PASRR, pre-admission screening of individuals with developmental disabilities referred for nursing home level of care. In addition to ensuring individuals with developmental disabilities meet the required level of care for admission, the OIH ensures that any specialized needs are addressed and a connection between the CSB and nursing facilities are made to aid in discharge facilitation. When nursing home placement is determined to be appropriate, the PASRR team follows the individual to ensure they are receiving the supports and specialized services needed as identified by their person-centered plan. This includes the use of OBRA funding to support the services needed that are outside the usual scope of the nursing homes.

The Office of Integrated Health developed a *transitions team* directed at helping to move children currently living in nursing facilities to the community. The Community Transitions Nurse, in conjunction with the interdisciplinary teams at each of the two largest nursing facilities that serve children in the Commonwealth, identifies barriers and possibilities for community placement. If a child admitted to an additional nursing home as identified through the PASRR process, the same approach is implemented. The **Community Transition** team has developed a post-move monitoring process for children being discharged from a nursing facility to ensure that services and supports are in place at the time of their discharge and there are no gaps in care. OIH staff also participate in investigations as requested, develop training and educational materials in support of QI recommendations and provide on-going training and technical assistance to community providers.

**DOJ Settlement Agreement Compliance Measures**

The DOJ Settlement Agreement sets forth numerous compliance measures, some of which are not currently captured by the overarching DBHDS quality assurance system. Examples include, but are not limited to, the implementation of the Individual and Family Support Program, service utilization rates, growth in provider capacity, and effective transitions of individuals from training centers. The Division of Developmental Services ensures compliance measures are tracked and reported to the corresponding assigned quality improvement committee described below for review.

## Division of the Chief Clinical Officer

### Office of Clinical Quality Management

Quality improvement is a data driven process and involves analysis of data and performance trends captured in the quality assurance processes described above as well as through Community Services Board reporting, Waiver Management System (WaMS) and other data sources. This data analysis is used to determine quality improvement priorities. Oversight of these quality improvement efforts is completed through the Office of Clinical Quality Management and responds to trends by ensuring quality improvement initiatives are developed and corrective actions and regulatory reforms are implemented, if necessary to address weaknesses/service gaps in the system.

The Office of Clinical Quality Management is directed by the Chief Clinical Officer and led by the Senior Director of Clinical Quality Management. The Office of Clinical Quality Management supports the development and expansion of an agency-wide quality management plan by ensuring high quality service delivery focused on prevention, early intervention, effective treatment, and recovery and rehabilitation across the lifespan. The office works with interdisciplinary teams to achieve system wide community inclusion, safety and well-being, recovery and self-empowerment outcomes (related to behavioral health and developmental service provision) across all service setting areas, including community and hospital based care. The office facilitates inter-departmental, inter-agency, and cross-sectoral alignment of quality improvement initiatives for the Commonwealth and will ensure compliance with the quality management requirements as outlined in the Settlement Agreement with the Department of Justice. The office includes:

- Community Quality Improvement (CQI)
- Facility Quality Improvement (FQI)

The office staff supports the Quality Improvement Committee structure which provides system-wide oversight of the quality management program. In addition, the office partners with and facilitates efforts within divisions to ensure that quality improvement activities, including best practices and evidence-based outcomes, are coordinated and integrated into the primary functions of the organization. The programmatic divisions (e.g. Community Behavioral Health, Developmental Services, and Facility Services) retain ultimate responsibility for and control over the quality improvement work occurring in their respective divisions.

Community Quality Improvement (CQI) directs, mentors and strengthens the quality improvement processes in community-based service providers. Through the development of outcome measures and analysis of trends, data driven decisions are made to improve the quality of services at systems, provider, and individual level. This includes providing technical assistance and consultation to internal and external state partners, and community-based licensed providers related to developing, implementing, and monitoring quality improvement programs. CQI develops and/or offers resources for evidence-based best practice guidance and training related to quality improvement and risk management for use by community-based providers.

In addition, CQI oversees and directs community-based quality review processes for DBHDS. DBHDS implements quality service reviews (QSRs) through contract. QSRs are completed on a sample of individuals receiving services and include desk reviews, on-site visits, face to face interviews, retrospective record reviews, and/or surveys of individuals receiving services. QSRs are completed to gain information about the quality of services provided and/or to get individual and family input on services provided for the purpose of making improvements in the service experience, and to determine how to improve the array of services provided. QSRs include provider quality reviews, person-centered reviews, individual and family interviews and/ or surveys, Community Service Board Quality Record Reviews and other DBHDS quality service reviews. Data collected from these processes are used in the evaluation of service quality and to identify and implement quality improvement initiatives.

DBHDS contracts with an external certified Quality Improvement Organization (QIO) to complete Quality service reviews (QSRs) which include provider quality reviews (PQRs) and person-centered reviews (PCRs). These QSRs are conducted to evaluate:

- The quality of services at an individual, provider (i.e., Community Service Board and private providers), and system-wide level and
- The extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.

QSRs also provide an assessment of whether or not individuals' needs are being identified and met through person-centered planning and thinking, whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives. Additionally, QSRs assess the quality and adequacy of providers' services, quality improvement and risk management strategies and provide recommendations to providers for improvement. Results of the QSRs are used to improve practice and service quality by providers, case management and at system wide levels.

The National Core Indicators Project is a collaboration between the National Association of State Directors of Developmental Disabilities Services (NASDDDS), the Human Services Research Institute (HRSI) and participating states, including Virginia. The core indicators are standard measures used across states to learn about the outcomes of supports and services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, health and safety and satisfaction. Individuals (and their families) who use services through the Developmental Disabilities Waivers are randomly selected to participate in the interview surveys. Virginia has participated in NCI since 2013. The Partnership for People with Disabilities conducts the surveys through contract with DBHDS.

As part of a comprehensive quality improvement program, retrospective record reviews of case management services are conducted at each CSB. These quality reviews are typically completed by CSB support coordination (SC)/case management supervisors/QI specialists. DBHDS identifies a statistically significant stratified statewide sample of individuals receiving HCBS waiver services and provides each CSB with the names of individuals to be reviewed. CSB

supervisors/QI specialists complete a portion of the reviews each quarter. These reviews include an assessment of core case management requirements. Data from the reviews is used by the CSB and the DBHDS Case Management Steering Committee to analyze implementation of case management processes and to develop quality improvement initiatives to strengthen areas of weakness. In order to ensure the integrity of the CSB retrospective reviews, and to provide consultation and technical assistance to SC supervisors/QI specialists, members of the Office of Community Quality Improvement will visit each CSB to review a sample of records at least once per year.

Facility Quality Improvement (FQI) directs, monitors, and strengthens the quality improvement in the DBHDS State Facilities. FQI works directly with the Division of Facilities Services to ensure the coordination and integration of quality improvement activities aimed toward the delivery of safe, high-quality care in state facilities. The goal is to maintain a systematic agency-wide approach to safety and performance improvement across three overlapping areas of focus: accreditation and regulatory compliance; incident management and risk reduction; and systematic and sustainable performance improvement.

**Office of Data Quality and Visualization**

Quality improvement as a data driven process is supported by the Office of Data Quality and Visualization (DQV), whose mission is to advance the use of quality data through inspiration, collaboration and empowerment. DQV assists programs throughout the agency by working to identify, evaluate, refine and document processes that already exist in their respective areas and assist in determining where improvements are needed. Data are captured from prescribed points in a process. Understanding the process from which data originate is a necessary component when deciding what data should be collected, reported and analyzed. By identifying the population, and the settings, a true sense of where the data originate can be understood and objectively evaluated. DQV enables programs to accurately and simply communicate the story of their data.

DQV is responsible for the development of a Data Quality Monitoring Plan that guides the improvement of key data sources and monitors progress over time. The Data Quality Plan consists of a two stage process. The first stage is comprised of the completion of an inventory of data sources used by the DBHDS. The inventory describes the content of each data source and explains how the data are gathered, organized, and stored. For each source, the inventory notes the presence or absence of unique identifiers, data validation measures, and documentation; these three components are essential to ensure data quality. Any additional concerns raised by data analysts or subject matter experts are also noted. In the second stage, DQV meets with business owners to recommend improvements to data source systems and processes. The implementation of these improvements will be monitored by the business owners on an ongoing basis, on a schedule that meets their needs. DQV will consult with business owners as needed to provide guidance and oversight of data quality monitoring.

Data quality reporting and monitoring is aligned with the DBHDS Mission, Vision and Strategic Plan and provides a structure for reporting to help demonstrate how individual data reports fit

together to determine if the DBHDS is meeting what the agency has set out to accomplish. This reporting structure identifies three Key Performance Areas (KPAs) which have cross disability applicability and focus quality improvement efforts toward outcomes that help the DBHDS achieve its mission and vision. These KPAs include a focus on health, safety and well-being, community inclusion and integrated service settings, and provider competency and capacity.

## Organizational Quality Improvement Committee Structure

The current structure of the Quality Management program includes collection and analysis of data by various interdisciplinary quality committees. The chart below illustrates the DBHDS Quality Committee Structure such that the existing committees report data and analysis to Regional Quality Councils and/or to the Quality Improvement Committee (QIC).


## Description of Quality Committee Structure

### Quality Improvement Committee

The Quality Improvement Committee (QIC) is the highest level quality committee for the agency and provides overall oversight of the quality management program. All other quality committees report to the QIC which in turn provides cross functional, cross disability data and triage to sub-committees. The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas. Identified priorities then informs resourcing. The QIC produces an annual quality report that includes the availability and quality of supports and services, gaps in supports and services, and provides recommendations for improvement.

## Regional Quality Councils

The DBHDS Commissioner established Regional Quality Councils (RQCs) for Developmental Disabilities in each of the five DBHDS regions in Virginia. With the direction of the QIC, the RQCs are expected to meet quarterly, at a minimum, to receive and analyze state and regional data, identify trends, and develop responsive actions by recommending quality improvement initiatives to the QIC, monitor the status of the initiatives and support these targeted efforts. The RQCs report annually to the QIC.

## Risk Management Review Committee

The Risk Management Review Committee (RMRC) seeks to improve quality and safety by learning from past performance, errors, and near misses, and to gain awareness of areas of vulnerability in practice and to improve these areas, thereby creating a safer environment for the delivery of services. Risk assessment and management is a key dimension of managing quality overall. Risk assessment and management involves identification and mitigation through incident reporting, investigation, and response to serious incidents to protect an individual's safety and well-being and to mitigate reoccurrence in both the facilities and in community-based services.

The primary task of the RMRC is to establish goals and performance measures that impact safety and freedom from harm and avoiding crises. This is achieved by establishing uniform risk triggers and thresholds, implementing processes to investigate reports of serious incidents and identifying remediation steps. In addition, the RMRC offers guidance and training on proactively identifying and addressing risks of harm, conducting root cause analyses, and developing and monitoring of corrective action plans. The RMRC reviews and analyzes trends to determine and recommend quality improvement initiatives to prevent and or substantially mitigate future risk of harm. Actions are recommended on providers who fail to report harm or fail to implement corrective action plans.

## Mortality Review Committee

The Mortality Review Committee (MRC) monitors the mortality among individuals with developmental disabilities and/or intellectual disabilities who receive services from a provider licensed by DBHDS. The committee's purpose is to identify and implement system wide quality improvement initiatives to reduce the rate of preventable deaths for this targeted population. The Mortality Review Committee conducts a trend analysis of mortality data to identify patterns at the individual service-delivery and system levels. The DBHDS mortality review process enhances quality by providing information that triggers corrective action to reduce future risk and affords a retrospective examination that informs the DBHDS regarding process and oversight, service level performance and adherence to standards, and utilization of risk mitigation tools to inform continuous quality improvement.

**Case Management Steering Committee**

This committee oversees and coordinates various activities underway to strengthen the case management system and collaborates with the Provider Capacity and Competency Workgroup. The committee's overall goal is to ensure and oversee the coordination of all internal/external quality improvement activities that affect both the transactional and transformational components of case management; to identify strengths, weaknesses and gaps in newly implemented products and processes; and to make recommendations for improvement.

**Health and Wellness Workgroup**

The Developmental Disabilities Health and Wellness Workgroup is responsible for the collection and analysis of data as it relates to helping individuals achieve positive health outcomes. The workgroup is tasked with establishing goals and performance measures related to physical, mental, and behavioral health and well-being. Data related to prevention strategies, wellness trends, and clinical outcomes are monitored. The workgroup provides technical assistance and oversight for clinical QI strategies for these measures.

**Community Inclusion/Integrated Settings Workgroup**

The Developmental Disabilities Community Inclusion/Integrated Settings Workgroup is charged with promoting service provisions in the most integrated settings and ensuring full access and participation in community life. The workgroup recommends goals and performance measures to ensure the most integrated settings appropriate to the individuals' needs, community stability, individual choice and self-determination and community inclusion.

**Provider Capacity and Competency Workgroup**

The Developmental Disabilities Provider Capacity and Competency Workgroup is charged with improving availability and access of services across the Commonwealth and facilitating provider training, competency and quality service provisions. The workgroup recommends goals and performance measures related to provider capacity and access to services and provider competency.

**Quality Leadership Collaborative**

DBHDS Quality Leadership Collaborative provides an opportunity for enhanced collaboration and coordination of quality aims at a cross agency or cross sectoral level. The aim of Quality Leadership Collaborative is to align shared missions and visions, and provide a forum to enhance communication and data sharing through a single process. The work of the Quality Leadership Collaborative may inform the work of the DBHDS QIC but is not considered to be a sub-committee of the DBHDS QIC. The current Quality Leadership Collaborative in which DBHDS participates includes the DBHDS/DMAS Quality Review Team.

*DBHDS/DMAS Quality Review Team*

The Commonwealth's Quality Management System includes the CMS-approved waiver quality improvement plan and the DBHDS Quality Management System. A requirement for participation in the Medicaid Home and Community Based Services Waiver program is multi-year evidence reporting to CMS. The purpose of the reporting is to ensure that the waivers are being implemented as intended through review of waiver program data and quality improvement activities. States are required to report performance regarding six CMS assurances in which states must demonstrate a certain level of compliance (currently set at 86%). Each assurance includes specific performance measures determined by the state, which serve as the indicators for determining compliance. The Virginia Department of Medical Assistance Services (DMAS) is the state Medicaid authority and DBHDS is the operating agency for the Developmental Disabilities Waivers. The performance measures under the assurances require either DMAS, DBHDS, or joint agency oversight. This oversight responsibility is assigned to the DBHDS/DMAS Quality Review Team and consists of monitoring of its data used to measure compliance with the identified performance measures.

**Process Description:**

In accordance with this structure, the creation and/or discontinuation of a DBHDS quality committee/workgroup shall be approved by the QIC. Basic standard operating procedures apply to all quality committees and include:

- Development and annual review and update of the committee charter
- Committees are expected to meet regularly to ensure continuity of purpose
- Committees are expected to maintain reports and/or meeting minutes as necessary and pertinent to the committee's function
- Quality improvement initiatives in each committee follow the Plan, Do, Study, Act Model

The following standard definitions are established for all committees:

Committee - Subject areas with expertise and accountability

Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees

Steering Committee - An advisory committee that provides direction and decides on priorities or order of business and manages the general course of operations

Workgroup - Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight

Council – An advisory body formally constituted and meeting regularly. Members are nominated by other council members and/or DBHDS staff and approved by the QIC

Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics

Quorum – 50% of the voting members plus one, unless otherwise required (exceptions to this standard are noted on respective charters).

QI Plan - Ongoing organizational strategic quality improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders

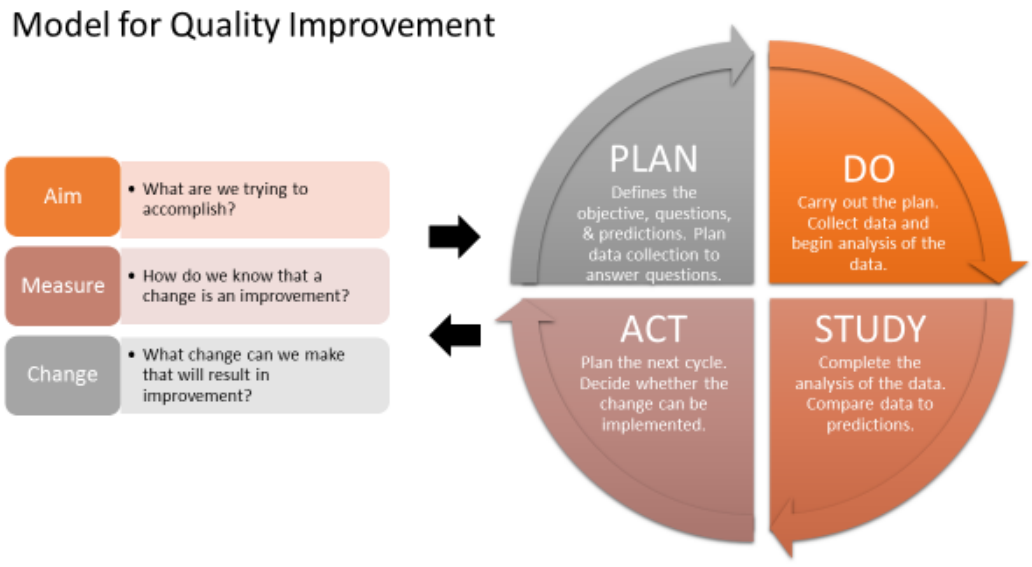
QI Project - Focuses on a specific area within a QI plan with identified actions

Performance Improvement Plan - Focuses on processes and procedures that improve efficiency, effectiveness and output

Performance Measure Indicators (PMIs) – Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review.

Key Performance Area – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity.

The DBHDS Quality Management program utilizes the following model for quality improvement:



**Performance Outcomes and Improvement Initiatives**

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

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

Regardless of an organization's chosen quality model, leadership commitment, engagement of employees, defined structures and processes, defined performance measures, data driven quality initiatives and customer focus are all essential elements of a quality management framework.

This framework sets the stage for our quality management work plan (Part 2) which includes committee charters, and details of the committees' work plan.

# Part 2 Quality Improvement Committee, Council, and Workgroups

**Quality Improvement Committee (QIC) Charter**
**September 2019 (QIC Approved September 5, 2019)**

| Committee / Workgroup | Quality Improvement Committee |
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| **Statement of Purpose** | The Quality Improvement Committee (QIC) is the designated oversight body for the Quality Improvement Program of the Department of Behavioral Health and Developmental Services (DBHDS). |
| **Authorization/Scope of Authority** | In keeping with DBHDS's mission, vision and values, the Quality Improvement Committee is the highest level quality committee with all other quality subcommittees reporting to the QIC which in turn provides cross functional, cross disability data and triage to subcommittees. The QIC:<br><br>• Ensures a process of continuous quality improvement<br>• Reviews goals and performance measure indicators (PMIs)<br>• Gathers stakeholder input to inform recommended actions<br>• Analyzes data and monitors for trends<br>• Recommends and prioritizes quality improvement initiatives and identifies resources<br>• Approves/monitors new quality improvement committees/workgroups<br>• Reviews quality improvement committee/workgroup charters<br>• Holds programs accountable for quality improvement project initiatives<br>• Directs the work of the Regional Quality Councils (RQCs) and reviews reports and/or recommendations presented by the RQCs<br>• Reviews, revises, adds and/or deletes PMIs at least annually and/or as needed<br>• Reports publicly on an annual basis regarding the availability and quality of supports and services, gaps in supports and services, and provides recommendations for improvement |
| **Charter Review** | The QIC charter will be reviewed and/or revised on an annual basis or as deemed necessary by the committee. |

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| **DBHDS Quality Improvement Standards** | **DBHDS is committed to a Culture of Quality that is characterized as:**<br><br>• Supported by leadership<br>• Person Centered<br>• Led by staff who are continuously learning and empowered as change agents<br>• Supported by an infrastructure that is sustainable and continuous<br>• Driven by data collection and analysis<br>• Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated |
| **Model for Quality Improvement** | Determine the:<br>• Aim: What are we trying to accomplish?<br>• Measure: How do we know that a change is an improvement?<br>• Change: What change can we make that will result in improvement?<br><br>Implement the Plan/Do/Study/Act (PDSA) Cycle:<br>• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions.<br>• Do: Carry out the plan. Collect data and begin analysis of the data.<br>• Study: Complete the analysis of the data. Compare data to predictions.<br>• Act: Plan the next cycle. Decide whether the change can be implemented. |
| **Structure of Committee / Workgroup:** | |
| **Membership** | **<u>Voting members:</u>**<br>DBHDS Commissioner (Executive Sponsor)<br>Chief Deputy, Community Behavioral Health Services<br>Chief Clinical Officer<br>Deputy Commissioner of Administration<br>Deputy Commissioner for Facility Services<br>Deputy Commissioner for Developmental Services<br>Deputy Commissioner for Compliance, Legislative and Regulatory Affairs<br><br>**<u>Non-voting members:</u>**<br>Assistant Commissioner of Compliance, Legislative and Regulatory Affairs<br>Assistant Commissioner for Community Behavioral Health<br>Assistant Commissioner for Facility Operations<br>Assistant Commissioner for Developmental Disability Services |

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| | Senior Director, Clinical Quality Management<br>Director, Community Quality Improvement<br>Pharmacy Manager<br>Behavioral Health Facility Director<br>Training Center Director<br>Representative, Department of Medical Assistance Services<br>Liaisons, Regional Quality Councils<br>Quality Improvement Director, Community Services Board<br>Representative, Service Provider<br>Representatives, Associations as determined by the committee |
| **Meeting Frequency** | The QIC shall meet at a minimum four times a year. Additional workgroups or subcommittees may be established as needed. |
| **Quorum** | A quorum shall be defined as 50% plus one of voting membership. |
| **Leadership and Responsibilities** | • The Chief Clinical Officer, or designee, shall serve as committee chair and shall be responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics.<br><br>• Standard Operating /Procedures include:<br>- Development and annual review and update of the committee charter<br>- Regular meetings to ensure continuity of purpose<br>- Maintenance of reports and/or meeting minutes as necessary and pertinent to the committee's function<br>- Quality improvement initiatives are consistent with the Plan, Do, Study, Act model<br><br>• Membership Approval: The committee membership shall be approved by the DBHDS Commissioner. Advisory members are appointed by the DBHDS Commissioner. Internal members are appointed by role.<br><br>Member Responsibilities:<br><br>• **Voting members**:<br><br>- Have decision making capability and voting status.<br>- Attend 75% of meetings per year; may send a proxy to one meeting per year<br>- Review data and reports for meeting discussion<br><br>• **Advisory members**:<br><br>Non-voting members perform in an advisory role for the QIC whose various perspectives provide insight on QIC |

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| | performance goals, outcomes PMIs and recommended actions. These members inform the committee by identifying issues and concerns to assist the QIC in identifying and prioritizing meaningful QI projects. Advisory members are expected to attend 75% of meetings per year and may send a proxy to one meeting per year if the proxy represents the same advisory role (i.e. representing same subject matter, discipline, or DBHDS office). Advisory members, excluding Association representatives, are appointed for a term of two (2) years and may be reappointed for an additional term.<br><br>**Definitions:** The following standard definitions as referenced in Part I of the Quality Improvement Plan (Program Description) are established for all quality committees:<br>• Committee - Subject areas with expertise and accountability<br>• Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees.<br><br>o Steering Committee - An advisory committee that provides direction and decides on priorities or order of business and manages the general course of operations and reports to the QIC.<br>o Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight<br>o Council – Members are nominated by other council members, DBHDS staff and approved by the QIC<br><br>• Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics<br><br>• Quorum – 50% plus one of the voting membership<br><br>• QI Plan - Ongoing organizational strategic quality improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders<br><br>• QI Project - Focuses on a specific area within a QI plan with identified actions<br><br>• Performance Improvement Plan - Focuses on processes and procedures that improve efficiency, effectiveness and output<br><br>• Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, |

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| | corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review.<br><br>• Key Performance Area – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity. |

**Regional Quality Council Charter**
**September 2019 (QIC Approved September 5, 2019)**

| **Committee / Workgroup** | **Regional Quality Councils** |
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| **Statement of Purpose** | As Quality Improvement Committee (QIC) subcommittees, the Regional Quality Councils (RQCs) are to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and evaluate data to identify and respond to trends to ensure continuous quality improvement. RQCs review and assess state and regional data related to quality indicators (performance measure indicators) for developmental disability services. The performance measure indicators are established by the Department of Behavioral Health and Developmental Services (DBHDS) and approved by the QIC and in alignment with measures identified in the CMS approved Developmental Disability (DD) waiver(s). Each RQC reviews and evaluates the data, trends and monitoring efforts. |
| **Authorization / Scope of Authority** | The RQCs are part of the DBHDS quality oversight structure and represent each of the five DBHDS regions in Virginia. DBHDS provides the RQCs with relevant and reliable data to include comparisons with other internal or external data, as appropriate, as well as multiple years of data (as it becomes available). The performance measure indicators guide the RQC's discussion and monitoring.<br><br>Each RQC reviews and assesses (i.e., critically considers) the data that is presented to identify:<br>a) possible trends;<br>b) questions about the data; and<br>c) any areas in need of quality improvement initiatives and identifies and records themes in meeting minutes.<br><br>RQCs may request available data that may inform quality improvement initiatives and if requested data is unavailable, RQCs may make recommendations for data collection to the QIC. Based on topics and data reviewed, each RQC recommend at least one quality improvement initiative to the QIC annually. The QIC reviews the recommendations reported by the RQCs and directs the implementation of any quality improvement initiatives to the relevant DBHDS staff after approval by the QIC and the Commissioner. The QIC directs the RQC to monitor the implementation of any quality improvement initiatives implemented and the RQC reports annually to the QIC on the results of the implemented quality improvement initiatives. |
| **Charter Review** | The RQC charter is reviewed/revised on an annual basis or as needed and submitted to the QIC for approval. |
| **DBHDS Quality Improvement Standards** | DBHDS is committed to a Culture of Quality that is characterized as:<br><br>• Supported by leadership<br>• Person Centered<br>• Led by staff who are continuously learning and empowered as change agents<br>• Supported by an infrastructure that is sustainable and continuous |

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| | • Driven by data collection and analysis<br>• Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives/projects as indicated |
| **Model for Quality Improvement** | Determine the:<br>• Aim: What are we trying to accomplish?<br>• Measure: How do we know that a change is an improvement?<br>• Change: What change can we make that will result in improvement?<br>Implement the Plan/Do/Study/Act Cycle:<br>• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions<br>• Do: Carry out the plan. Collect data and begin analysis of the data.<br>• Study: Complete the analysis of the data. Compare data to predictions.<br>• Act: Plan the next cycle. Decide whether the change can be implemented. |
| **Structure of Committee / Workgroup:** | |
| **Membership** | An interdisciplinary team approach will be achieved through representation from the following stakeholder groups:<br>• Residential Services Provider<br>• Employment Services Provider<br>• Day Services Provider<br>• Community Services Board (CSB) Developmental Services Director<br>• Support Coordinator/Case Manager (2)<br>• CSB Quality Assurance/Improvement staff<br>• Provider Quality Assurance/Improvement staff<br>• Crisis Services Provider<br>• An individual receiving services or on the Developmental Disability Waiver waitlist (self-advocate)<br>• A family member of an individual receiving services or on the waitlist (2)<br><br>In addition, the following DBHDS employees shall be standing members of each RQC:<br>• Director, Community Quality Improvement or designee<br>• Quality Improvement Specialist<br>• Community Resources Consultant<br><br><u>Process for recruiting/approval of members:</u><br>RQC members and alternates (excluding DBHDS standing employee members) are nominated by other RQC members, DBHDS regional staff, or DBHDS Quality Improvement staff. Quality Improvement staff contact nominees regarding the nominee's willingness to serve. All nominations of RQC members and alternates are reviewed and |

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| | approved by the QIC.<br><br>Role of Alternates:<br>An alternate for each membership role will serve as a proxy at meetings when the incumbent cannot attend. The alternate represents the same stakeholder group (i.e. employment provider) as the member and serves as the member's proxy for voting. Alternates receive meeting agendas, meeting minutes and reports to be considered at meetings, and attends meetings in order to listen to discussion and decisions. This ensures continuity by providing the alternate with the ability to be informed in the event the member is not able to attend and the alternate is called upon to represent the stakeholder group.<br><br>Membership Term(s):<br>RQC members (excluding DBHDS standing employee members) serve a three-year term, with an option to extend for one additional term. If a member resigns for any reason prior to the fulfillment of the term, if willing, the alternate is nominated to complete the term of the vacated position and is reviewed and approved by the QIC. When an alternate is appointed to complete the term of a former incumbent, another alternate representing the same stakeholder group will be nominated and approved by the QIC using the aforementioned process. |
| **Meeting Frequency** | The RQCs will meet on at least a quarterly basis. |
| **Quorum** | A quorum is defined as at least 60% of members or their alternates and must include representation from the following groups: a member of the DBHDS QIC, an individual experienced in data analysis, a Developmental Disability (DD) service provider, an individual receiving services or on the DD Waiver waitlist; or a family member of an individual receiving services or on the DD Waiver waitlist. Each RQC shall meet with a quorum at least three (3) of the four (4) quarterly meetings in a state fiscal year. |
| **Leadership and Responsibilities** | Leadership:<br>The DBHDS Quality Improvement Specialist shall serve as chair of the RQC.<br><br>RQC Liaison:<br>Each RQC will appoint a member (excluding DBHDS employees) to serve as liaison to the QIC. Liaisons attend the QIC meetings, either in-person or remotely, representing their respective RQC. Liaisons are responsible for reporting all agreed upon RQC recommendations to the DBHDS QIC and reporting annually on the results of the implemented quality improvement initiatives. If the liaison cannot attend the QIC (in-person or remotely), another member of that RQC shall be asked to represent that RQC at the QIC meeting.<br><br>Minutes: |

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| | Meeting minutes are reviewed and approved by the membership of the RQC to ensure accurate reflection of discussion and evaluation of data and recommendations of the RQC. Approved meeting minutes are maintained by the DBHDS Office of Clinical Quality Management.<br><br><u>Standard Operating Procedures:</u><br>- Develop, update and review annually the subcommittee charter<br>- Meet regularly to ensure continuity of purpose<br>- Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function<br>- Analyze data to identify and respond to trends to ensure continuous quality improvement<br>- Recommend quality improvement initiatives/projects which are consistent with Plan, Do, Study, Act model<br><u>RQC Responsibilities:</u><br>For each of the topic areas identified by the RQC, the RQC either a) decides more information/data is needed for the topic area; b) prioritizes a quality improvement initiative for the region, and/or recommends a quality improvement initiative to DBHDS; or c) determines that no action will be taken in that area. For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC.<br><br>Members are responsible for reviewing data and reports provided and engaging in discussions which include an exchange of ideas from the perspective of the stakeholder group they represent. |

**Risk Management Review Committee Charter**
**September 2019 (QIC Approved September 5, 2019)**

| Committee / Workgroup | Risk Management Review Committee |
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| **Statement of Purpose** | The purpose of the Department of Behavioral Health and Developmental Services (DBHDS) Risk Management Review Committee (RMRC) is to provide ongoing monitoring of serious incidents and allegations of abuse and neglect; and analysis of individual, provider and system level data to identify trends and patterns and make recommendations to promote health, safety and well-being of individuals. As a subcommittee of the DBHDS Quality Improvement Committee (QIC), the RMRC identifies and addresses risks of harm; ensures the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collects and evaluates data to identify and respond to trends to ensure continuous quality improvement<br><br>RMRC has been established to improve quality of services and the safety of individuals with developmental disabilities. Over time, the committee will be expanded to oversee services provided to individuals with mental health and substance use issues as well. The RMRC will:<br>• Systematically review and analyze data related to serious incident reports (SIR), deaths, human rights allegations of abuse, neglect and exploitation, findings from licensing inspections and investigations, and other related data.<br>• Review details of individual serious incident reports when indicated<br>• Recommend quality improvement projects (QIPs) to the DBHDS Quality Improvement Committee (QIC) to promote health and well-being, mitigate risks, and foster a culture of safety in service delivery<br>• Monitor progress of QIPs and address concerns/barriers as needed<br>• Evaluate the effectiveness of the QIP for its intended purpose<br>• Report findings, conclusions, and recommendations to the QIC semi-annually, or more frequently when significant, or unusual patterns or trends are identified. The RMRC may also share data or findings with the Mortality Review Committee when significant patterns or trends are identified relating to deaths. |
| **Authorization/Scope of Authority** | The RMRC reports to the QIC and may also share data or findings with the Mortality Review Committee when significant patterns or trends are identified related to deaths<br><br>The RMRC's overall risk management process enables DBHDS to identify, and prevent or substantially mitigate, risks of harm. The RMRC:<br>• Reviews and identifies trends from aggregated incident data, including allegations of abuse, neglect, and exploitation, at least four times per year by various levels such as by region, by Community Services Board (CSB), by provider locations, by individual, or by levels and types of incidents.<br>• Utilizes data analysis to identify areas for improvement and monitor trends. The RMRC identifies priorities and determines quality improvement initiatives as needed, including identified strategies and metrics to |

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| | monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts. The RMRC ensures that each approved quality improvement initiative is implemented and reported to the QIC. The RMRC will recommend at least one quality improvement initiative per year.<br>• Monitors aggregate data of provider compliance with serious incident reporting requirements and establishes targets for performance measurement indicators. When targets are not met the RMRC determines whether quality improvement initiatives are needed, and if so, monitors implementation and outcomes.<br>• Conducts, or provides oversight for a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The reviews evaluate whether:<br>i. The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols;<br>ii. The provider's documented response ensured recipient's safety and well-being;<br>iii. Appropriate follow-up from the Office of Licensing incident management team occurred when necessary;<br>iv. Timely, appropriate corrective action plans are implemented by the provider when indicated.<br><br>• Conducts, or provides oversight of a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review evaluates whether:<br>i. Comprehensive, and non-partial investigations of individual incidents occur within state prescribed timelines;<br>ii. The person conducting the investigation has been trained to conduct investigations;<br>iii. Timely, appropriate corrective action plans are implemented by the provider when indicated.<br>iv. Trends will be reviewed at least quarterly; the RMRC will recommend quality improvement initiatives when necessary and track implementation of initiatives approved for implementation.<br><br>For each of the look behind reviews, the trends are reviewed at least quarterly and the RMRC recommends quality improvement initiatives when necessary and tracks implementation of initiatives approved for implementation.<br><br>The RMRC reviews and analyzes related data collected from facilities and community service providers. The RMRC is coordinated and managed by the Division of Compliance, Legislative and Regulatory Affairs and the Office of Quality Improvement. |
| **Charter Review** | The RMRC was established in December 2014. The charter will be reviewed and/or revised on an annual basis or as needed and submitted to the QIC for approval. |

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| **DBHDS Quality Improvement Standards** | **DBHDS is committed to a Culture of Quality that is characterized as:**<br>• Supported by leadership<br>• Person Centered<br>• Led by staff who are continuously learning and empowered as change agents<br>• Supported by an infrastructure that is sustainable and continuous<br>• Driven by data collection and analysis<br>• Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated |
| **Model for Quality Improvement** | Determine the:<br>• Aim: What are we trying to accomplish?<br>• Measure: How do we know that a change is an improvement?<br>• Change: What change can we make that will result in improvement?<br>Implement the Plan/Do/Study/Act Cycle:<br>• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions<br>• Do: Carry out the plan. Collect data and begin analysis of the data.<br>• Study: Complete the analysis of the data. Compare data to predictions.<br>• Act: Plan the next cycle. Decide whether the change can be implemented. |
| **Structure of Committee / Workgroup:** | |
| **Membership** | RMRC is an internal inter-disciplinary team comprised of the following DBHDS employees with clinical training and experience in the areas of behavioral health, intellectual disabilities/developmental disabilities, leadership, forensics, medical, quality improvement, behavior analysis and data analytics:<br>• Assistant Commissioner of Compliance, Legislative and Regulatory Affairs<br>• Director, Clinical Quality Improvement, or designee<br>• Director, Provider Development, or designee<br>• Director, Office of Human Rights, or designee<br>• Director, Office of Integrated Health. or designee<br>• Incident Manager, Office of Licensing, or designee<br>• Investigations Manager, Office of Licensing, or designee<br>• Representative, Data Quality and Visualization<br>• Settlement Agreement Director, or designee<br>• Advisory consultants as needed/required |
| **Meeting Frequency** | The RMRC meets at least nine times a year with a quorum present. Additional workgroups may be established as |

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| | needed. |
| **Quorum** | A quorum is defined as 50% plus one of the members. |
| **Leadership and Responsibilities** | The RMRC is chaired by the Assistant Commissioner of Compliance, Legislative and Regulatory Affairs or designee.<br><br>The standard operating procedures include:<br>- Develop, update and review annually the committee charter<br>- Meet regularly to ensure continuity of purpose<br>- Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function<br>- Analyze data to identify and respond to trends to ensure continuous quality improvement<br>- Recommend quality improvement initiatives/projects which are consistent with Plan, Do, Study, Act model<br>The RMRC will recommend at least one quality improvement initiative per year to the QIC. |

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**Mortality Review Committee Charter**
**September 2019 (QIC Approved September 5, 2019)**

| **Committee / Workgroup** | **Mortality Review** |
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| **Statement of Purpose** | The purpose of the DBHDS Developmental Disabilities (DD) Mortality Review Committee (MRC) is to focus on system-wide quality improvement by conducting mortality reviews of individuals who were receiving a service licensed by DBHDS at the time of death and diagnosed with a developmental disability (DD). |
| **Authorization / Scope of Authority** | This committee is authorized by the DBHDS Quality Improvement Committee (QIC), and is coordinated and managed by the Mortality Review Team in the Division of the Chief Clinical Officer. The MRC reviews deaths of individuals with DD who received a licensed service by DBHDS at the time of death.<br><br>The MRC periodically reviews and analyzes mortality data to identify trends, patterns and problems at the individual service delivery and systemic level related to deaths; the development and implementation of quality improvement initiatives to reduce mortality rates to the fullest extent practicable; and the reporting of quality improvement initiatives to the DBHDS Quality Improvement Committee. After the case review for said individual, the MRC seeks to identify:<br><br>• The cause of death<br>• If the death was expected<br>• Whether the death was potentially preventable<br>• Any relevant factors impacting the individual's death<br>• Any other findings that could affect the health, safety, and welfare of these individuals<br>• If there are other actions which may reduce these risks, to include provider training and communication regarding risks, alerts, and opportunities for education *(see Definitions under "Leadership and Responsibilities" section)*, the MRC identifies and reports this information. Based on this review, the MRC will then recommend actions and/or interventions.<br><br>After these determinations have been identified and documented, the MRC closes the case reviewed.<br><br>The MRC will notify providers of the final decision by MRC including date of review and any recommendations or interventions determined. |
| **Charter Review** | The Mortality Review Committee charter is reviewed and/or revised on an annual basis, or as deemed necessary by the committee. |
| **DBHDS Quality** | DBHDS is committed to a Culture of Quality that is characterized as: |

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| **Improvement Standards** | • Supported by leadership<br>• Person Centered<br>• Led by staff who are continuously learning and empowered as change agents<br>• Supported by an infrastructure that is sustainable and continuous<br>• Driven by data collection and analysis<br>• Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated<br><br>DBHDS demonstrates on an on-going basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. |
| **Model for Quality Improvement** | Determine the:<br>• Aim: What are we trying to accomplish?<br>• Measure: How do we know that a change is an improvement?<br>• Change: What change can we make that will result in improvement?<br><br>Implement the Plan/Do/Study/Act Cycle:<br>• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions.<br>• Do: Carry out the plan. Collect data and begin analysis of the data.<br>• Study: Complete the analysis of the data. Compare data to predictions.<br>• Act: Plan the next cycle. Decide whether the change can be implemented. |
| **Structure of Committee / Workgroup:** | |
| **Membership** | The MRC is composed of members with clinical training and experience in the areas of intellectual and developmental disabilities, medical and pharmacy services, quality improvement, incident management, behavior analysis and data analytics.<br><br>Required Mortality Review Committee members include:<br>• Chief Clinical Officer<br>• Deputy Commissioner of Developmental Services, or designee<br>• Assistant Commissioner of Compliance, Legislative and Regulatory Affairs, or designee<br>• Senior Director of Clinical Quality Management<br>• Director, Community Quality Improvement, or designee<br>• Director, Data Quality and Visualization, or designee<br>• Director, Office of Human Rights, or designee<br>• Clinical Manager, Mortality Review (Co-Chair)<br>• Manager, Incident Team (Office of Licensing) |

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| | • Manager, Investigation Team (Office of Licensing)<br>• Manager, Pharmacy Services<br>• MRC Clinical Reviewer<br>• MRC Program Coordinator<br>• Registered Nurse from Office of Integrated Health<br>• A member with clinical experience to conduct mortality reviews who is otherwise independent of the State<br><br>Advisory (non-voting members) nominated by the Commissioner or Chair of the MRC, which may include;<br>• Representative, Department of Medical Assistance Services<br>• Representative, Department of Health<br>• Representative, Department of Social Services<br>• Representative, Office of Chief Medical Examiner<br>• Representative, Community Services Board<br>• Other Subject matter experts such as representatives from DD Provider or Advocacy Organizations |
| **Meeting Frequency** | The MRC meets at minimum, on a monthly basis. |
| **Quorum** | A quorum is 50% of voting membership plus one, with attendance of at least: *(One member may satisfy two roles)*<br>1. A medical clinician<br>2. A member with clinical experience to conduct mortality reviews<br>3. A professional with quality improvement expertise<br>4. A professional with programmatic/operational expertise |
| **Leadership and Responsibilities** | The Chief Clinical Officer, or Mortality Review Clinical Manager, shall serve as committee chair and shall be responsible for ensuring the committee performs its functions, the quality improvement activities and core monitoring metrics.<br><br><u>Standard operating procedures include:</u><br><br>Within 90 days of a death, the Mortality Review Team develops a succinct case summary by reviewing and documenting the availability/unavailability of:<br><br>• Medical records: Including healthcare provider and nursing notes for three months preceding death<br>• Previous three months' incident reports<br>• Most recent individualized service program plan<br>• Medical and physical examination records |

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| | • Death certificate and autopsy report (if applicable)<br>• Any evidence of maltreatment related to the death.<br><br>The Clinical Reviewer(s) documents all relevant information onto the Mortality Review Form and the Chief Clinical Officer/Clinical Manager completes a preliminary review of all case summaries prior to an MRC meeting. During the preliminary review, a case is identified as Tier 1 or Tier 2.<br><br>• A Tier 1 case requires a detailed, comprehensive review of multiple factors and areas of focus by the MRC.<br>• A Tier 2 case does not require a detailed, comprehensive review as the preliminary review was sufficient.<br><br>To ensure confidentiality and adhere to mandated privacy regulations and guidelines, case reviews are provided to MRC members during the meeting only. At that time, a facilitated narration with discussion occurs.<br><br><u>The MRC then:</u><br><br>• Performs comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors *(medical, genetic, social, environmental, risk, susceptibility, and others as specific to the individual)* and quality of service.<br>• Evaluates the quality of the decedent's licensed services related to disease, disability, health status, service use, and access to care, to ensure provision of a reliable, person-centered approach.<br>• Identifies risk factors and gaps in service and recommends quality improvement strategies to promote safety, freedom from harm, and physical, mental and behavioral health and wellbeing.<br>• Reviews Office of Licensing Corrective Action Plans (CAPs) related to required recommendations, to ensure no further action is required and for inclusion in meeting minutes.<br>• Refers any required recommendations not included in the initial CAP to the Office of Licensing for further investigation.<br>• Closes a case after it: 1) has been reviewed, within 90 days of the date of death; 2) has determined the cause of death, whether the death was expected or unexpected, and if it was potentially preventable or not; and 3) has made recommendations in cases where deaths were determined to be preventable.<br>• Notifies providers of the final decision by MRC including the date of review and any recommended actions or interventions determined.<br><br>The committee may also interview any persons having information regarding the individual's care. |

To the best ability, the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable. The MRC will make recommendations related to unexpected, potentially preventable deaths in order to reduce mortality rates to the fullest extent practicable.

Quarterly, the MRC will prepare and deliver to the QIC and Commissioner of DBHDS, a report specific to the committee's findings and recommendations.

Membership responsibilities:
Each member is required to receive orientation and training on the Mortality Review charter, policies, procedures, education on the role/responsibility of the member(s), and continuous quality improvement principles - to ensure that participation meets the purpose of the committee.

Members are expected to recuse themselves in the event that there is a conflict of interest specific to the individual being reviewed.

- **Voting members:**
  - Have decision making capability and voting status
  - Attend 75% of meetings per year and may send a proxy that is approved by the MRC chair (or Co-Chair) prior to the meeting
  - Review data and reports for meeting discussion

- **Advisory members:**
  - Advisory members are non-voting stakeholder members selected and approved bythe QIC and DBHDS Commissioner whose various perspectives provide insight on MRC reviews, clinical insight, medical expertise, and MRC performance goals, outcomes, required and recommended actions.

These members inform the committee by identifying and prioritizing MRC decision making and recommendations. Advisory members may be appointed for a term of two (2) years, and may be reappointed for up to two additional terms. Advisory members are expected to attend 75% of meetings per year, and may send a proxy that is approved by the MRC chair prior to the meeting.

**Definitions:**

- *Expected Death* denotes a death that was consistent with and as a result of an individual's previously diagnosed terminal condition. A death can be expected if the person had a known terminal *condition*

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| | *(e.g., end stage renal disease)*, or if the person was elderly and had a period of deterioration and increasing medical frailty. In both cases, the person, family and caregivers were aware that the condition was terminal, end of the life decisions were made, and primary health care and/or palliative care teams were involved.<br><br>• *Unexpected Death* denotes a death that occurred as a result of an acute medical event, accident, or other event that was not expected within the context of a person's known medical conditions.<br><br>• *Unknown/Unexplained* indicates there is insufficient information to classify a death as either expected or unexpected or there is insufficient information to make a determination as to the cause of death.<br><br>• *"Other (Cause of Death)"* denotes a cause of death that is not attributable to one of the major causes of death used by the MRC for data trending.<br><br>• *Potentially Preventable Deaths* are deaths that are considered to be premature and may have been avoided, based on a combination of known medical, genetic, social, environmental, or other *factors (such as pre- morbid conditions)*. When the MRC determines a death is potentially preventable, the committee categorizes factors that might have prevented the death. For a death to be determined potentially preventable, the actions and events immediately surrounding the individual's death must be related to deficits in the timeliness of, or absence of, at least one of the following factors:<br><br>1. Coordination of care (including medication management)<br>2. Access to care, including delay in seeking treatment<br>3. Execution of established protocols<br>4. Assessment of the individual's needs or changes in status |

**Case Management Steering Committee Charter**
**September 2019 (QIC Approved September 5, 2019)**

| **Committee / Workgroup Name** | **Case Management Steering Committee** |
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| **Statement of Purpose** | The Case Management Steering Committee, a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), is responsible for monitoring case management performance across responsible entities to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and evaluate data to identify and respond to trends to ensure continuous quality improvement. |
| **Authorization / Scope of Authority** | The Case Management Steering Committee is responsible for performance monitoring of case management by responsible entities. The committee is charged with reviewing data selected from, but not limited to, any of the following data sets: CSB data submissions, Case Management Quality Reviews, Office of Licensing citations, Quality Service Reviews, and DMAS' Quality Management Reviews, WaMS.<br><br>The committee's analysis will identify trends and progress toward meeting established Support Coordination/Case Management targets. Based on this data review and system analysis, the committee will recommend systemic quality improvement initiatives to the QIC.<br><br>The committee recommends technical assistance based on review of CSB specific data. If CSB specific improvements are not demonstrated after receiving technical assistance, the committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings. |
| **Charter Review** | The Case Management Steering Committee was established in June 2018. The charter shall be reviewed on an annual basis or as needed and submitted to the Quality Improvement Committee for review and approval. |
| **DBHDS Quality Improvement Standards** | DBHDS is committed to a Culture of Quality that is characterized as:<br>• Supported by leadership<br>• Person Centered<br>• Led by staff who are continuously learning and empowered as change agents<br>• Supported by an infrastructure that is sustainable and continuous<br>• Driven by data collection and analysis<br>• Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated |
| **Model for Quality Improvement** | Determine the:<br>• Aim: What are we trying to accomplish? |

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| | • Measure: How do we know that a change is an improvement?<br>• Change: What change can we make that will result in improvement?<br><br>Implement the Plan/Do/Study/Act Cycle:<br>• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions<br>• Do: Carry out the plan. Collect data and begin analysis of the data.<br>• Study: Complete the analysis of the data. Compare data to predictions.<br>• Act: Plan the next cycle. Decide whether the change can be implemented. |
| **Structure of Workgroup / Committee:** | |
| **Membership** | Director of Waiver Operations or designee<br>Director of Provider Development or designee<br>Director of Community Quality Improvement or designee<br>Settlement Agreement Director<br>Two Quality Improvement Program Specialists<br>Representative, Office of Data Quality and Visualization |
| **Meeting Frequency** | The committee will, at a minimum, meet ten times a year. |
| **Quorum** | A quorum shall be defined as 50% plus one of voting membership. |
| **Leadership and Responsibilities** | The Settlement Agreement Director 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:<br>- Development and annual review and update of the committee charter<br>- Regular meetings to ensure continuity of purpose<br>- Maintenance of reports and/or meeting minutes as necessary and pertinent to the committee's function<br>- Quality improvement initiatives consistent with Plan, Do, Study, Act model<br><br>Meeting minutes are prepared and distributed to committee members prior to the meeting. Minutes shall reflect the committee's review and analysis of data.<br><br>Other responsibilities:<br>Ensure that the CSBs receive their case management performance data semi-annually at a minimum.<br><br>Produce a semi-annual report to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. The Case Management Steering Committee's report will include an analysis of findings and recommendations based on review of the information from case management monitoring/oversight processes including: data from the oversight of the Office of Licensing, DMAS Quality Management Reviews, CSB Case Management Supervisors Quarterly Reviews, DBHDS Office of Community |

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| | Quality Improvement retrospective reviews, Quality Service Reviews, and Performance Contract Indicator data.<br><br>The Case Management Steering Committee will report to the Quality Improvement Committee at least semi-annually. |

**Health and Wellness Workgroup Charter**
**September 2019 (QIC Approved September 5, 2019)**

| **Committee / Workgroup Name** | **Health and Wellness Workgroup** |
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| **Statement of Purpose** | The Health and Wellness Workgroup is charged with responsibilities associated with collecting and analyzing reliable data related to the domains of safety and freedom from harm, physical, mental and behavioral health and well-being, and avoiding crisis.<br><br>The Workgroup will:<br>• Establish at least one performance measure indicator (PMI) based on priorities for each domain<br>• Determine priorities when establishing the performance measure indicators (PMIs)<br>• Consider a variety of data sources for collecting data<br>• Utilize evidenced based practices and national benchmarks whenever possible<br>• Include baseline data when establishing PMIs if available and applicable<br>• Define measures and the methodology for collecting data<br>• Establish a target and timeline for achievement<br>• Identify data and performance measures on a regional and state level<br>• Measure performance across the Key Performance Area (KPA)<br>• Analyze data and monitor for trends<br>• Recommend quality improvement projects (QIPs) to the DBHDS Quality Improvement Committee (QIC)<br>• Monitor progress of QIPs assigned to the workgroup and address concerns/barriers as needed<br>• Evaluate the effectiveness of the QIP for its intended purpose<br>• Report to DBHDS QIC for oversight and system-level monitoring |
| **Authorization / Scope of Authority** | This workgroup has been authorized by the DBHDS Quality Improvement Committee (QIC). This workgroup's scope of authority includes identifying concerns/barriers in meeting the PMIs and implementing and/or recommending performance improvement initiatives. The subcommittee is to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated setting and evaluate data to identify and respond to trends to ensure continuous quality improvement. |
| **Charter Review** | The Health and Wellness Workgroup charter will be reviewed and/or revised on an annual basis or as needed and submitted to the QIC for approval. |
| **DBHDS Quality Improvement Standards** | DBHDS is committed to a Culture of Quality that is characterized as:<br>• Supported by leadership<br>• Person Centered<br>• Led by staff who are continuously learning and empowered as change agents |

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| | • Supported by an infrastructure that is sustainable and continuous<br>• Driven by data collection and analysis<br>• Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated |
| **Model for Quality Improvement** | Determine the:<br>• Aim: What are we trying to accomplish?<br>• Measure: How do we know that a change is an improvement?<br>• Change: What change can we make that will result in improvement?<br><br>Implement the Plan/Do/Study/Act Cycle:<br>• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions<br>• Do: Carry out the plan. Collect data and begin analysis of the data.<br>• Study: Complete the analysis of the data. Compare data to predictions.<br>• Act: Plan the next cycle. Decide whether the change can be implemented. |
| **Structure of Committee / Workgroup:** | |
| **Membership** | Director, Office of Human Rights, or designee<br>Assistant Commissioner for Developmental Disability Services, or designee<br>Director, Community Quality Improvement, or designee<br>Director, Office of Integrated Health, or designee<br>Director, Office of Licensing, or designee<br>Mortality Review Committee Clinical Manager, or designee<br>Representative, Office of Data Quality and Visualization |
| **Meeting Frequency** | Meetings shall be held at least quarterly but will be determined by the urgency of issues, on a schedule determined by the chair and members of the workgroup. |
| **Quorum** | A quorum is 50% plus one of voting membership. |
| **Leadership and Responsibilities** | The chair will be responsible for ensuring the workgroup performs its functions.<br><br>The standard operating procedures include:<br>- Development and annual review and update of the committee charter<br>- Regular meetings to ensure continuity of purpose<br>- Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function<br>- Analysis of PMIs to measure performance across the KPA<br>- Quality improvement initiatives are consistent with Plan, Do, Study, Act model<br><br>All members have decision-making capability and voting status. Members shall be responsible for entering, reviewing, |

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| | and analyzing data related to the PMI as assigned. |

**Community Inclusion and Integrated Settings Workgroup Charter**
**September 2019 (QIC Approved September 5, 2019)**

| **Committee / Workgroup Name** | **Community Inclusion and Integration Workgroup** |
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| **Statement of Purpose** | The Community Inclusion and Integration Workgroup is charged with responsibilities associated with collecting and analyzing reliable data related to promoting full inclusion in community life and improvement in integrated services for people with developmental disabilities. This includes the domains of stability, choice and self-determination and community inclusion.<br><br>The Workgroup will:<br>• Establish at least one performance measure indicator (PMI) based on priorities for each domain<br>• Determine priorities when establishing the performance measure indicators (PMIs)<br>• Consider a variety of data sources for collecting data<br>• Utilize evidenced based practices and national benchmarks whenever possible<br>• Include baseline data when establishing PMIs if available and applicable<br>• Define measures and the methodology for collecting data<br>• Establish a target and timeline for achievement<br>• Identify data and performance measures on a regional and state level<br>• Measure performance across the Key Performance Area (KPA)<br>• Analyze data and monitor for trends<br>• Recommend quality improvement projects (QIPs) to the DBHDS Quality Improvement Committee (QIC)<br>• Monitor progress of QIPs assigned to the workgroup and address concerns/barriers as needed<br>• Evaluate the effectiveness of the QIP for its intended purpose<br>• Report to DBHDS QIC for oversight and system-level monitoring |
| **Authorization / Scope of Authority** | As a subcommittee of the DBHDS Quality Improvement Committee (QIC), this workgroup's scope of authority includes identifying concerns/barriers in meeting the PMIs and implementing and/or recommending performance improvement initiatives. The subcommittee is to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated setting and evaluate data to identify and respond to trends to ensure continuous quality improvement. |
| **Charter Review** | The Community Inclusion and Integration Workgroup charter will be reviewed and/or revised on an annual basis or as needed and submitted to QIC for approval. |
| **DBHDS Quality Improvement Standards** | DBHDS is committed to a Culture of Quality that is characterized as:<br>• Supported by leadership<br>• Person Centered<br>• Led by staff who are continuously learning and empowered as change agents |

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| | • Supported by an infrastructure that is sustainable and continuous<br>• Driven by data collection and analysis<br>• Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated |
| **Model for Quality Improvement** | Determine the:<br>• Aim: What are we trying to accomplish?<br>• Measure: How do we know that a change is an improvement?<br>• Change: What change can we make that will result in improvement?<br><br>Implement the Plan/Do/Study/Act Cycle:<br>• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions<br>• Do: Carry out the plan. Collect data and begin analysis of the data.<br>• Study: Complete the analysis of the data. Compare data to predictions.<br>• Act: Plan the next cycle. Decide whether the change can be implemented. |
| **Structure of Committee / Workgroup:** | |
| **Membership** | Director, Provider Development, or designee<br>Assistant Commissioner for Developmental Disability Services, or designee<br>Director, Community Quality Improvement, or designee<br>Director, Office of Housing, or designee<br>Director, Office of Individual and Family Support, or designee<br>Representative, Office of Data Quality and Visualization |
| **Meeting Frequency** | Meetings shall be held at least quarterly but will be determined by the urgency of issues, on a schedule determined by the chair and members of the workgroup. |
| **Quorum** | A quorum is 50% plus one of voting membership. |
| **Leadership and Responsibilities** | The chair will be responsible for ensuring the workgroup performs its functions.<br><br>The standard operating procedures include:<br>- Development and annual review and update of the committee charter<br>- Regular meetings to ensure continuity of purpose<br>- Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function<br>- Analysis of PMIs to measure performance across the KPA<br>- Quality improvement projects are consistent with Plan, Do, Study, Act model<br><br>All members have decision-making capability and voting status. Members shall be responsible for entering, reviewing, and analyzing data related to the PMI as assigned. |

**Provider Capacity and Competency Workgroup Charter**
**September 2019 (QIC Approved September 5, 2019)**

| **Committee / Workgroup Name** | **Provider Capacity and Competency Workgroup** |
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| **Statement of Purpose** | The Provider Capacity and Competency Workgroup is charged with responsibilities associated with collecting and analyzing reliable data related to the domains of access to services for people with developmental disabilities and provider capacity and competency.<br><br>The Workgroup will:<br>• Establish at least one performance measure indicator (PMI) based on priorities for each domain<br>• Determine priorities when establishing the performance measure indicators (PMIs)<br>• Consider a variety of data sources for collecting data<br>• Utilize evidenced based practices and national benchmarks whenever possible<br>• Include baseline data when establishing PMIs if available and applicable<br>• Define measures and the methodology for collecting data<br>• Establish a target and timeline for achievement<br>• Identify data and performance measures on a regional and state level<br>• Measure performance across the Key Performance Area (KPA)<br>• Analyze data and monitor for trends<br>• Recommend quality improvement projects (QIPs) to the DBHDS Quality Improvement Committee (QIC)<br>• Monitor progress of QIPs assigned to the workgroup and address concerns/barriers as needed<br>• Evaluate the effectiveness of the QIP for its intended purpose<br>• Report to DBHDS QIC for oversight and system-level monitoring |
| **Authorization / Scope of Authority** | This workgroup has been authorized by the DBHDS Quality Improvement Committee (QIC). This workgroup's scope of authority includes identifying concerns/barriers in meeting the PMIs and implementing and/or recommending performance improvement initiatives. The subcommittee is to identify and address risks of harm, ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated setting and evaluate data to identify and respond to trends to ensure continuous quality improvement. |
| **Charter Review** | The Provider Capacity and Competency Workgroup charter will be reviewed and/or revised on an annual basis, or as needed, and submitted to the QIC for approval. |
| **DBHDS Quality Improvement Standards** | DBHDS is committed to a Culture of Quality that is characterized as:<br>• Supported by leadership<br>• Person Centered<br>• Led by staff who are continuously learning and empowered as change agents<br>• Supported by an infrastructure that is sustainable and continuous |

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| | • Driven by data collection and analysis<br>• Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated |
| **Model for Quality Improvement** | Determine the:<br>• Aim: What are we trying to accomplish?<br>• Measure: How do we know that a change is an improvement?<br>• Change: What change can we make that will result in improvement?<br><br>Implement the Plan/Do/Study/Act Cycle:<br>• Plan: Defines the objective, questions and predictions. Plan data collection to answer questions<br>• Do: Carry out the plan. Collect data and begin analysis of the data.<br>• Study: Complete the analysis of the data. Compare data to predictions.<br>• Act: Plan the next cycle. Decide whether the change can be implemented. |
| **Structure of Committee / Workgroup:** | |
| **Membership** | Director, Provider Development, or designee<br>Director, Office of Licensing, or designee<br>Director, Community Quality Improvement, or designee<br>Director, Office of Human Rights, or designee<br>Representative, Office of Waiver Operations<br>Representative, Office of Data Quality and Visualization |
| **Meeting Frequency** | Meetings shall be held at least quarterly but will be determined by the urgency of issues, on a schedule determined by the chair and members of the workgroup. |
| **Quorum** | A quorum is 50% plus one of voting membership. |
| **Leadership and Responsibilities** | The chair will be responsible for ensuring the workgroup performs its functions.<br><br>The standard operating procedures include:<br>- Development and annual review and update of the committee charter<br>- Regular meetings to ensure continuity of purpose<br>- Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function<br>- Analysis of PMIs to measure performance across the KPA<br>- Quality improvement projects are consistent with Plan, Do, Study, Act model<br><br>All members have decision-making capability and voting status. Members shall be responsible for entering, reviewing, and analyzing data related to the PMI as assigned. |

## QI COMMITTEE, COUNCIL AND WORKGROUP WORK PLAN

The QI Committee, Council and Workgroup Work Plan serves as the *proposed* tool for ensuring consistent reporting to the QIC. These QI Teams will utilize these tools to document areas of focus and QI system efforts. We propose the use of these documents as part of a quarterly internal tracking process designed to ensure that we are able to consistently identify patterns and trends and subsequently track the development and implementation of any corrective action plans and/or initiatives born out of each team's regular review of data related to their focus areas.

### METRICS AND REPORTING SCHEDULE

| COMMITTEE/WORKGROUP/COUNCIL | METRICS | DATA SOURCE | PERSON/OFFICE ACCOUNTABLE | INTERNAL REPORTING SCHEDULE |
|---|---|---|---|---|
| Health, Safety & Well Being | Critical incidents are reported to the Office of Licensing within the required timeframes. | CHRIS via Data Warehouse. (updating report) | Jae Benz | Quarterly |
| Health, Safety & Well Being | Licensed DD providers that administer medications are NOT cited for failure to review medication errors at least quarterly. | Data Warehouse report **DW-0058**: "Licensing Regulation Compliance Overview" (gives you the providers with that citation: 708.5) and **DW-0034:** "Licensing Visit Detail" (gives you providers reviewed) | Jae Benz | Quarterly |
| Health, Safety & Well Being | Unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken. | Action Tracking Log (excel spreadsheet) | Patricia Cafaro | Quarterly |
| Health, Safety & Well Being | DBHDS verifies that providers' corrective actions for substantiated cases of ANE are implemented. | Data Warehouse Report (DW-0071-OHR90Days). | Deb Lochart | Quarterly |
| Health, Safety & Well Being | State policies and procedures for the use or prohibition of restrictive interventions (including restraint) are followed. | Quality Services Reviews | Deb Lochart | Quarterly |
| Health, Safety & Well Being | State policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed. | Numerator comes from Data Warehouse Report DW-0070: OHR Community Seclusion and the Denominator comes from both Data Warehouse Reports DW-0030: OHR CSB Incident and DW-0038: OHR Provider Incident. | Deb Lochart | Quarterly |
| Community Inclusion/Integrated Settings | Individuals on the DD waiver and waitlist (aged 18-64) who are working and receiving Individual Supported Employment (ISE) and Group Supported Employment (GSE) for 12 months or more. | ESOs/DARS reports and WaMS | Heather Norton | Quarterly |
| Community Inclusion/Integrated Settings | Individuals are given choice among providers, including choice of support coordinator. | SC/CM Quality Record Review data | Eric Williams | Quarterly |
| Community Inclusion/Integrated Settings | Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. | Regional Support Team (RST) spreadsheet | Eric Williams | Quarterly |
| Community Inclusion/Integrated Settings | Regional Support Team referrals are timely for individuals considering a move into a group home of 5 or more beds. | Regional Support Team (RST) spreadsheet | Eric Williams | Quarterly |
| Community Inclusion/Integrated Settings | Individuals live in independent housing | DDS Housing Outcomes Table and WaMS | Kristin Yavorsky | Quarterly |
| Community Inclusion/Integrated Settings | Number and percent of individuals whose case management records contain an appropriately completed and signed form that specifies choice was offered among waiver services. | DMAS QRT data | Deanna Parker | Quarterly |
| Community Inclusion/Integrated Settings | Individuals on DD waiver will be employed in Individual Supported Employment (ISE). | Employment data | Heather Norton | Quarterly |
| Provider Capacity Competency | Provider investigations of abuse and neglect allegations are conducted in accordance with regulations of the Office of Human Rights. | Office of Human Rights, Community Look-Behind (excel spreadsheet) and quarterly monitoring reports for state level data and regional breakdowns. | Deb Lochart | Quarterly |

## Performance Measure Indicator Strengths

| Metric | Metric Target (% and/or #) | FY 19 Q1 Status (% and/or #) | FY 19 Q2 Status (% and/or #) | FY 19 Q3 Status (% and/or #) | FY 19 Q4 Status (% and/or #) |
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| Critical incidents are reported to the Office of Licensing within the required timeframes. | | | | | |
| Licensed DD providers that administer medications are NOT cited for failure to review medication errors at least quarterly. | | | | | |
| Unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken. | | | | | |
| DBHDS verifies that providers' corrective actions for substantiated cases of ANE are implemented. | | | | | |
| State policies and procedures for the use or prohibition of restrictive interventions (including restraint) are followed. | | | | | |
| State policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed. | | | | | |
| Individuals on the DD waiver and waitlist (aged 18-64) who are working and receiving Individual Supported Employment (ISE) and Group Supported Employment (GSE) for 12 months or more. | | | | | |
| Individuals are given choice among providers, including choice of support coordinator. | | | | | |
| Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. | | | | | |
| Regional Support Team referrals are timely for individuals considering a move into a group home of 5 or more beds. | | | | | |
| Individuals live in independent housing | | | | | |
| Provider investigations of abuse and neglect allegations are conducted in accordance with regulations of the Office of Human Rights. | | | | | |

## Overall Areas of Improvement

| Metric | Metric Target (% and/or #) | FY 19 Q1 Status (% and/or #) | FY 19 Q2 Status (% and/or #) | FY 19 Q3 Status (% and/or #) | FY 19 Q4 Status (% and/or #) |
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## Performance Initiatives Proposed

| Systemic Problem Area Identified | Proposed Performance Initiatives Recommended | Date of Recommendation to QIC | QIC Approval/Declination/Placed on Hold | Approved QI Project Implementation Date | Progress Towards Implementation | Metric Target Status | Status Date | Challenges/Barriers | QI Project Revised/Replicated/Expanded/Discontinued |
|---|---|---|---|---|---|---|---|---|---|
| Falls with injuries | Fall Prevention | Pending | | | | | | | |
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## Corrective Action Plans Required

| Agency/Organization | Review Date | Actions Requiring a CAP | CAP Submission Deadline | CAP Implementation Deadline | Proposed Date of Committee Follow-up | Date Resolution Verified |
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