Quality Improvement Committee Charter
QIC Approved September 27, 2021

Committee / Workgroup	Quality Improvement Committee
Statement of Purpose	The Quality Improvement Committee (QIC) is the designated oversight body for the Quality Management System of the Department of Behavioral Health and Developmental Services (DBHDS). The QIC ensures a process of continuous quality improvement and maintains responsibility for prioritization of needs and work areas.
Authorization/Scope of Authority	The Executive Sponsor of the QIC is the Commissioner of DBHDS and the Commissioner maintains executive authority over the actions taken by the QIC. In keeping with DBHDS's mission, vision and values, the QIC is the highest-level quality committee with all other quality subcommittees reporting to the QIC.
Charter Review	The QIC charter will be reviewed and/or revised on an annual basis or as deemed necessary by the committee.
DBHDS Quality Improvement Standards	**DBHDS is committed to a Culture of Quality that is characterized as:** • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS subcommittees assigned to implement QIIs will report data related to the QIIs to the QIC to enable the QIC to track implementation. Through data reviews and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the QIC identifies areas for development of QIIs. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions.

	• Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the QIC: • Approves new, revised or retired PMIs that are based in data analysis and in keeping with continuous quality improvement practices • Analyzes data and monitors for trends to identify areas for systemic improvement • Reviews annual reports and determines recommendations to be addressed through quality subcommittees; ensures that deficiencies have been addressed; • Develops strategic recommendations regarding any gaps or issues with availability of services identified through data reviews from Quality Service Reviews (QSRs) and National Core Indicators (NCI) related to the quality of services and individual level outcomes • Gathers stakeholder input to inform recommended actions • Approves proposed QIIs whose design follows the Model for Quality Improvement, addresses identified systemic area of concern, aligns with agency priorities, and agency resources permit implementation of the QII as written • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed
Structure of Committee / Workgroup:	
Membership	The QIC is composed of internal and external stakeholders who have clinical training and experience in quality improvement, quality management, resource management, intellectual disabilities/developmental disabilities, behavioral health, compliance, behavioral analysis, provider services, and data analytics. **<u>Voting members:</u>** • DBHDS Commissioner (Executive Sponsor) • Chief Deputy Commissioner, Community Services • Chief Clinical Officer • Senior Director of Clinical Quality Management • Chief Administrative Officer • Deputy Commissioner for Facilities • Deputy Commissioner for Quality Assurance and Government Relations • Assistant Commissioner for Developmental Disability Services **<u>Advisory members (non-voting):</u>** • Assistant Commissioner of Quality Assurance and Government Relations • Assistant Commissioner for Facilities • Director, Community Quality Management

	• Pharmacy Manager • Behavioral Health Facility Director • Training Center Director • Representative, Department of Medical Assistance Services • Liaisons, Regional Quality Councils • Quality Improvement Director, Community Services Board • Representative, Service Provider • Representatives, Associations as determined by the committee
Meeting Frequency	The QIC shall meet at a minimum four times a year. Meetings can occur in the absence of quorum; however, no action, where approval of the QIC is required, could be taken in this instance. In such instances, approval may be sought via email.
Quorum	A quorum shall be defined as 50% plus one of voting membership. These actions require quorum: approval of minutes, approval/denial of QIIs, PMIs (new, revised, ending), and charter revisions.
Leadership and Responsibilities	The Chief Clinical Officer and Senior Director of Clinical Quality Management shall serve as committee chair and co-chair and shall be responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics. <u>Standard Operating Procedures include</u>: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the committee's function • Analysis of PMIs to measure performance across the key performance areas, to determine if a PMI needs revised or retired, at least on an annual basis • Prioritizes needs and work areas • Directs the work of the QIC subcommittees The QIC: • Ensures a process of continuous quality improvement • Approves the creation/discontinuation of quality improvement subcommittees/workgroups • Approves all quality committees charters • Monitors quality subcommittees/workgroups • Holds QIC subcommittees accountable for QIIs • Reviews the progress of performance measure indicators (PMIs) across all eight domains • Approves and prioritizes QIIs resources

	• Reviews/monitors provider reporting measures semi-annually with input from the RQCs, identifies systemic deficiencies or potential gaps, issues recommendations, monitors measures, and makes revisions to QIIs as needed • Annually, assesses the validity of provider reporting measures • Reviews the recommendations reported by the RQCs and directs the implementation of any QII to the relevant DBHDS staff after approval by the QIC and the Commissioner • Directs the work of the Regional Quality Councils (RQCs) and reviews reports and/or recommendations presented by the RQCs; reports to the RQCs on any decisions and related implementation of RQC recommendations • 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 • Informs stakeholders of QIIs approved for implementation including those that result of trend analyses based on information from investigations of reports of suspected or alleged abuse, neglect, serious incidents or deaths Membership Approval: The DBHDS Commissioner shall approve the committee membership. The DBHDS Commissioner appoints advisory members. Internal members are appointed by role. Member Responsibilities: **Voting members**: • Have decision making capability and voting status. • Attend 75% of meetings per year; may send a proxy to one meeting per year • Review data and reports for meeting discussion • A designated proxy has the authority that the voting member maintains and therefore should be in a position reflective of that authority, including awareness of the organization or system impact of actions taken by the QIC **Advisory members**: • Perform in an advisory role for the QIC whose various perspectives provide insight on QIC performance goals, outcomes PMIs and recommended actions • Inform the committee by identifying issues and concerns to assist the QIC in voting and prioritizing meaningful QI initiatives • 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, save RQC liaisons, have no term limits. RQC liaisons can serve up to two consecutive terms (one term is three years). All members receive orientation and training, both as new to the committee and on an annual basis. Members shall be trained on the Quality Management System, QIC charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups - DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N - Sample size • National Core Indicators - Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety. • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or

	deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees - The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative (QII) - Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review - Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate: whether individuals' needs are being identified and met through person-centered planning and thinking; whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum - Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY) - July 1 to June 30 • Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Regional Quality Council Charter
QIC Approved September 27, 2021

Committee / Workgroup	Regional Quality Councils
Statement of Purpose	As a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), the Regional Quality Councils (RQCs) are to identify and address risks of harm and ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings. RQCs review and evaluate state and available regional data related to performance measure indicators (PMIs) and monitoring efforts to identify trends and recommend responsive actions in their respective regions to ensure continuous quality improvement.
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 PMIs guide the RQC's discussion and monitoring. The QIC directs the work of the RQCs. RQCs may request data that may inform quality improvement initiatives (QIIs) and if requested data is unavailable, RQCs may make recommendations for data collection to the QIC.
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: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and QIIs as indicated
Model for Quality Improvement	With the approval of regional QIIs implemented at the direction of the QIC, each RQC QII work group will report to the respective RQC regarding the status of the QII being implemented. This report, including associated data, will help the RQCs track implementation of the regional QII. The RQCs use the presented data (including trends and patterns), along with their analysis, to identify areas for development of QIIs at the individual, service-delivery, or systemic levels. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement?

	Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the RQC: • Reviews and evaluates data, trends, and monitoring efforts • Based on topics and data reviewed, recommends at least one QII to the QIC annually • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the RQC Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Committee / Workgroup:	
Membership	An interdisciplinary team approach will be achieved through representation from the following stakeholder groups: • Residential Services Providers • Employment Services Providers • Day Services Providers • Community Services Board (CSB) Developmental Services Directors • Support Coordinators/Case Managers • CSB Quality Assurance/Improvement staff • Provider Quality Assurance/Improvement staff • Crisis Services Providers • Individuals receiving services or on the Developmental Disability Waiver waitlist (self-advocate) • Family members of an individual previously or currently receiving services or on the waitlist *(Previously is defined as within the past 3 years, either the individual having passed or lost services for whatever reason.)* Membership will include one person from each of these stakeholder groups with an additional Support Coordinator/Case Manager and Self-Advocate for each region. In addition, the following DBHDS employees shall be standing members of each RQC: • Director, Community Quality Management or designee • Regional Quality Improvement Specialist • Community Resources Consultant <u>Process for recruiting/approval of members:</u>

	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 approved by the QIC chair/co-chair. Role of Alternates: 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 attend meetings in order to listen to discussions 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. Membership Term(s): RQC members (excluding DBHDS standing employee members) can serve up to two consecutive terms (one term is three years). The member would have one year of non-involvement before being eligible to serve as a member again. If a member resigns for any reason prior to the fulfillment of the term, if willing, the alternate will fill the vacated membership position. If the alternate agrees to fill the vacated membership position, another alternate representing the same stakeholder group will be nominated and approved by the QIC chair/co-chair to fill the now vacated alternate position. If the alternate is not willing to serve as the member, they will serve as proxy until a new member is nominated and approved by the QIC chair/co-chair. Alternates do not have term limits.
Meeting Frequency	The RQCs will meet on at least a quarterly basis. Each RQC shall meet with a quorum at least three (3) of the four (4) quarterly meetings in a state fiscal year. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is defined as at least 60% of members or their alternates, including representation from the following groups (One member may satisfy two roles): • 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. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, and proposed charter approval.
Leadership and Responsibilities	The DBHDS Regional Quality Improvement (QI) Specialist shall serve as chair of the RQC. The chair will be responsible for ensuring the council performs its functions.

	Standard Operating Procedures: • Develop, update, and review annually the subcommittee charter • Meet regularly to ensure continuity of purpose • Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function • Analyze data to identify and respond to trends to ensure continuous quality improvement • Recommend QIIs (at least one per fiscal year, based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC Each RQC will: • Review and assess (i.e., critically consider) the data that is presented to identify: a) possible trends; b) questions about the data; and c) any areas in need of QIIs and identifies and records themes in meeting minutes • Determine for each identified topic area if: a) more information/data is needed for the topic area; b) a QII should be prioritized for the region and/or recommend a QII to DBHDS; c) or if no action is needed/will be taken in that area at this time • Propose at least one measurable outcome for each QII recommended by the RQC • Monitor the regional status of any statewide quality improvement initiatives implemented as directed by the QIC • Monitor and review provider reporting measures at least semi-annually and provide input to the QIC on these measures • Review the results of Quality Service Reviews (QSR) and use findings to make recommendations to the QIC regarding identified needs. • Review and approve meeting minutes to ensure accurate reflection of discussion, evaluation of data, and recommendations of the RQC. The DBHDS Office of Community Quality Improvement maintains approved meeting minutes for 100% of meetings. • Report to the QIC for oversight and system-level monitoring at least three times per state fiscal year • Report annually to the QIC on the results of the RQC implemented QIIs • Present 100% of agreed upon recommendations to the QIC Member Responsibilities: Each member, including alternates, will be oriented to the purpose, operations and member responsibilities including quality improvement, data analysis and related practices. This orientation is completed independently online or

	virtually/live with a QI Specialist. This training shall be offered and suggested to be completed within one month of receiving notification of approval of membership. All RQC members, including alternates, will have the opportunity to review relevant training resources as they become available. 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. <u>RQC Liaison:</u> 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 QIC. 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.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups - DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N - Sample size

	• National Core Indicators - Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety. • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees - The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative - Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review - Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate: whether individuals' needs are being identified and met through person-centered planning and thinking; whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum - Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY) - July 1 to June 30 • Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Case Management Steering Committee Charter
QIC Approved September 27, 2021

Committee / Workgroup Name	**Case Management Steering Committee**
Statement of Purpose	The Case Management Steering Committee (CMSC), 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. This includes identifying and addressing risks of harm, ensuring the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings, and evaluating data to identify and respond to trends to ensure continuous quality improvement.
Authorization / Scope of Authority	The CMSC is authorized by the DBHDS QIC. 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.
Charter Review	The CMSC was established in June 2018. The charter shall be reviewed and/or revised on an annual basis, or as needed, and submitted to the QIC for review and approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement quality improvement initiatives (QIIs) will report data related to the quality improvement initiatives to the CMSC to enable the committee to track implementation. Through case management reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the CMSC identifies areas for development of QIIs. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data.

	• Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the CMSC: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the CMSC Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Workgroup / Committee:	
Membership	CMSC is an internal inter-disciplinary team comprised of the following DBHDS employees with clinical training and experience in the areas of case management, behavioral health, intellectual disabilities/developmental disabilities, leadership, quality improvement, behavioral analysis and data analytics: **Voting Members:** • Director of Waiver Operations or designee • Director of Provider Development or designee • Director of Community Quality Management or designee • Settlement Agreement Director • Quality Improvement Specialist • Representative, Office of Data Quality and Visualization

	Advisory Members (non-voting): • QI/QM Coordinator • Representative, Office of Licensing • Behavior Analyst • Other internal members as determined by the committee
Meeting Frequency	The committee will, at a minimum, meet ten times a year; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum shall be defined as 50% plus one of voting membership. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Director of Provider Development 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 chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter • Meet regularly to ensure continuity of purpose • Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function • Analyze data to identify and respond to trends to ensure continuous quality improvement • Recommend QIIs (at least one per fiscal year, based on data analysis) to the QIC, which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC. The CMSC will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI) • Establish a process to review a sample of case management (CM) contact data each quarter to determine reliability and provide technical assistance to CSBs as needed • Establish process to monitor compliance with performance standards • Establish process for annual retrospective reviews to validate findings of the CSB case management supervisory reviews; process includes sample stratification, quantitative measurement of both CSB and DBHDS Quality Improvement record reviews and inter-rater reliability process for DBDHS Quality Improvement staff

	• Establish two indicators in each of the areas of health and safety and community integration and based on review of the data from case management monitoring processes • Ensure CSBs receive their case management performance data semi-annually at a minimum • Analyze data and monitor for trends quarterly • Review and analyze CM data submitted to DBHDS that reports on CSB case management performance and related to the ten elements and at an aggregate level to determine CSB's overall effectiveness in achieving outcomes for the population they serve (such as employment, self-direction, independent living, keeping children with families) • Review the results of Quality Service Reviews (QSR) as it relates to case management and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Review the results of other data reports that reference case management and make recommendations for systemic improvements as applicable • Share data with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Provide technical assistance to individual CSBs as needed • Track cited regulatory non-compliance correction actions to ensure remediation • Provide to the QIC recommendations to address non-compliance issues with respect to case manager contacts for consideration of appropriate systemic improvements and the Commissioner for review of contract performance issues • Produce a semi-annual report to the QIC on the findings from the data review with recommendations for systemic improvement that includes: analysis and 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 replaced in 2019 by the Support Coordination Quality Review process, DBHDS Office of Community Quality Improvement retrospective reviews, Quality Service Reviews, and Performance Contract Indicator data • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs <u>Membership Responsibilities:</u> **Voting members:** • Have decision making capability and voting status • Review data and reports for meeting discussion

	• A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory members:** • Perform in an advisory role for the CMSC whose various perspectives provide insight on CMSC activities, performance outcomes, and recommended actions • Inform the committee by identifying issues and concerns to assist the CMSC in developing and prioritizing meaningful QI initiatives • Supports the CMSC in performing its functions All members receive orientation and training both as new to the committee and on an annual basis. Material shall include QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups - DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains.

	• N - Sample size • National Core Indicators - Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees - The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC) - Oversees the work of the QIC subcommittees • Quality Improvement Initiative (QII) - Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review (QSR) - Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate: whether individuals' needs are being identified and met through person-centered planning and thinking; whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum - Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY) - July 1 to June 30 • Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Community Inclusion and Integration KPA Workgroup Charter
QIC Approved September 27, 2021

Committee / Workgroup Name	**Community Inclusion and Integration Key Performance Area (KPA) Workgroup**
Statement of Purpose	As a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), the Community Inclusion and Integration (CII) KPA 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. The KPA Workgroup also assesses whether the needs of individuals enrolled in a DD waiver are met, whether individuals have choice in all aspects of their selection of services and supports, and whether there are effective processes in place to monitor the individuals' health and safety. This includes the domains of stability, choice and self-determination and community inclusion. The KPA Workgroup establishes goals and monitors progress toward achievement through the creation of specific KPA performance measure indicators (PMIs). The CII KPA Workgroup has established an outcome reflective of its purpose: *People with disabilities live in integrated settings, engage in all facets of community living and are employed in integrated employment.*
Authorization / Scope of Authority	This workgroup has been authorized by the DBHDS QIC. This workgroup's scope of authority includes identifying concerns/barriers in meeting the PMIs and implementing and/or recommending quality 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 KPA Workgroup charter will be reviewed and/or revised on an annual basis, or as needed, by the Community Inclusion and Integration Workgroup and submitted to QIC for approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the CII KPA Workgroup to enable the committee to track implementation. Through data reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the CII KPA Workgroup identifies areas for development of QIIs.

	To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the CII KPA Workgroup: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the CII KPA Workgroup Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Committee / Workgroup:	

Membership	The KPA Workgroup 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, quality improvement, behavioral analysis and data analytics. **Voting Members:** • Director, Provider Development • Assistant Commissioner for Developmental Disability Services • Senior Director, Clinical Quality Management • Director, Community Quality Management • Director, Office of Housing • Director, Office of Individual and Family Support • Representative, Office of Data Quality and Visualization • Settlement Agreement Director • Mortality Review Committee Clinical Manager • Director, Office of Human Rights • Director, Office of Integrated Health • Representative, Office of Waiver Operations • Director, Office of Licensing **Advisory Members (non-voting):** • QI/QM Coordinator • Quality Improvement Specialists (2) • Others as determined by the CII KPA Workgroup
Meeting Frequency	Meetings shall be held monthly, at least 10 times per year; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is 50% plus one of voting membership. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QII, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Assistant Commissioner for Developmental Disability Services chairs the CII KPA Workgroup. The chair will be responsible for ensuring the workgroup performs its functions. The chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function

	• Analysis of PMIs to measure performance across the KPA • Recommend QIIs (at least one per fiscal year, based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC • Monitoring of surveillance data on a regular schedule The KPA Workgroup will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI) • Establish at least one PMI for each domain identified as either an outcome or output measure • Determine priorities when establishing PMIs • Consider a variety of data sources for collecting data and identify the data sources to be used • Determine and finalize surveillance data from a variety of sources. This data may be used for ongoing, systemic collection, analysis, interpretation, dissemination, and also serves as a source for establishing PMIs and/or QIIs • Monitor performance across each domain and for PMIs falling below target, determine actions that are designed to raise the performance; analyze data and monitor for trends quarterly • Monitor surveillance data in each of the domains associated with the KPA Workgroup and respond to identified trends of concerns • Review the results of Quality Service Reviews (QSR) as it relates to the key performance areas and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Review the results of the annual National Core Indictors (NCI) In-Person Survey and use findings to implement quality improvement strategies or make recommendations for QIIs. Additional family and guardian surveys may be included as part of surveillance data review • Share data with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs Each PMI will contain the following: • Baseline or benchmark data as available • The target where results should fall above or below • The date by which the target will be met • Definition of terms included in the PMI and a description of the population

	• Data sources (origins for both numerator and denominator) • Calculation (clear formula for calculating the PMI utilizing the numerator and denominator) • Methodology for collecting reliable data (complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) • The subject matter expert (SME) assigned to report and enter data on each PMI • A yes/no indicator to show whether the PMI can provide regional breakdowns <u>Member Responsibilities:</u> **Voting Members:** • 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 • Members shall be responsible for reviewing surveillance data prior to the scheduled review date and highlight areas of concern • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members (non-voting):** • Perform in an advisory role for the KPA Workgroup whose various perspectives provide insight on KPA Workgroup performance goals, outcomes PMIs and recommended actions • Inform the committee by identifying issues and concerns to assist the KPA Workgroup in developing and prioritizing meaningful QIIs • Supports the KPA Workgroup in performing its functions All members receive orientation and training both as new to the committee and on an annual basis. Material shall include QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues.

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

	planning and thinking; whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum - Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY) - July 1 to June 30 • Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Health, Safety and Wellbeing KPA Workgroup Charter
QIC Approved September 27, 2021

Committee / Workgroup Name	**Health, Safety and Wellbeing Key Performance Area (KPA) Workgroup**
Statement of Purpose	As a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), the Health, Safety and Wellbeing (HSW) KPA 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 crises. The KPA Workgroup also assesses whether the needs of individuals enrolled in a Developmental Disability (DD) waiver are met, whether individuals have choice in all aspects of their selection of services and supports, and whether there are effective processes in place to monitor the individuals' health and safety. The KPA Workgroup establishes goals and monitors progress toward achievement through the creation of specific KPA performance measure indicators (PMIs). The HSW KPA Workgroup has established an outcome reflective of its purpose: *People with disabilities are safe in their homes and communities, receive routine, preventive healthcare, and behavioral health services and behavioral supports as needed.*
Authorization / Scope of Authority	This workgroup has been authorized by the DBHDS QIC. This workgroup's scope of authority includes identifying concerns/barriers in meeting the PMIs and implementing and/or recommending quality 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 KPA Workgroup charter will be reviewed and/or revised on an annual basis, or as needed, by the HSW KPA Workgroup and submitted to the QIC for approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement quality improvement initiatives (QIIs) will report data related to the QIIs to the HSW KPA Workgroup to enable the committee to track implementation. Through data reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the HSW KPA Workgroup identifies areas for development of quality improvement initiatives.

	To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the HSW KPA Workgroup: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the HSW KPA Workgroup Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Committee / Workgroup:	

Membership	The KPA Workgroup 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, quality improvement, behavioral analysis and data analytics. **Voting Members:** • Director, Office of Human Rights • Assistant Commissioner for Developmental Disability Services • Senior Director, Clinical Quality Management • Director, Community Quality Management • Director, Office of Integrated Health • Director, Office of Licensing • Mortality Review Committee Clinical Manager • Representative, Office of Data Quality and Visualization • Settlement Agreement Director • Director, Provider Development • Representative, Office of Waiver Operations • Director, Office of Individual and Family Support • Director, Office of Housing **Advisory Members (non-voting):** • QI/QM Coordinator • Quality Improvement Specialists (2) • Other as determined by the HSW KPA Workgroup
Meeting Frequency	Meetings shall be held monthly, at least 10 times per year; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is 50% plus one of voting membership. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Assistant Commissioner for Developmental Disability Services chairs the HSW KPA Workgroup. The chair will be responsible for ensuring the workgroup performs its functions. The chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function

	• Analysis of PMIs to measure performance across the KPA • Recommend QIIs (at least one per fiscal year, based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC • Monitoring of surveillance data on a regular schedule The KPA Workgroup will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI) • Establish at least one PMI for each domain identified as either an outcome or output measure • Determine priorities when establishing PMIs • Consider a variety of data sources for collecting data and identify the data sources to be used • Determine and finalize surveillance data from a variety of sources. This data may be used for ongoing, systemic collection, analysis, interpretation, dissemination, and also serves as a source for establishing PMIs and/or QIIs • Monitor performance across each domain and for PMIs falling below target, determine actions that are designed to raise the performance; analyze data and monitor for trends quarterly • Monitor surveillance data in each of the domains associated with the KPA Workgroup and respond to identified trends of concerns • Review the results of Quality Service Reviews (QSR) as it relates to the key performance areas and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Review the results of the annual National Core Indictors (NCI) In-Person Survey and use findings to implement quality improvement strategies or make recommendations for QIIs. Additional family and guardian surveys may be included as part of surveillance data review • Share data with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs Each PMI will contain the following: • Baseline or benchmark data as available • The target where results should fall above or below • The date by which the target will be met • Definition of terms included in the PMI and a description of the population

	• Data sources (origins for both numerator and denominator) • Calculation (clear formula for calculating the PMI utilizing the numerator and denominator) • Methodology for collecting reliable data (complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) • The subject matter expert (SME) assigned to report and enter data on each PMI • A yes/no indicator to show whether the PMI can provide regional breakdowns <u>Member Responsibilities:</u> **Voting Members:** • 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 • Members shall be responsible for reviewing surveillance data prior to the scheduled review date and highlight areas of concern • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members (non-voting):** • Perform in an advisory role for the KPA Workgroup whose various perspectives provide insight on KPA Workgroup performance goals, outcomes PMIs and recommended actions • Inform the committee by identifying issues and concerns to assist the KPA Workgroup in developing and prioritizing meaningful QIIs • Supports the KPA Workgroup in performing its functions All members receive orientation and training both as new to the committee and on an annual basis. Material shall include QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues.

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

	planning and thinking; whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum - Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY) - July 1 to June 30 • Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Provider Capacity and Competency KPA Workgroup Charter
QIC Approved September 27, 2021

Committee / Workgroup Name	**Provider Capacity and Competency Key Performance Area (KPA) Workgroup**
Statement of Purpose	As a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Quality Improvement Committee (QIC), the Provider Capacity and Competency (PCC) KPA 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. The KPA Workgroup also assesses whether the needs of individuals enrolled in a DD waiver are met, whether individuals have choice in all aspects of their selection of services and supports, and whether there are effective processes in place to monitor the individuals' health and safety. The KPA Workgroup establishes goals and monitors progress toward achievement through the creation of specific KPA performance measure indicators (PMIs). The PCC KPA Workgroup has established an outcome reflective of its purpose: *People with disabilities have access to an array of services that meet their needs and providers maintain a stable and competent workforce, are able to meet licensing regulations and maintain compliance.*
Authorization / Scope of Authority	This workgroup has been authorized by the DBHDS QIC. This workgroup's scope of authority includes identifying concerns/barriers in meeting the PMIs and implementing and/or recommending quality 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 KPA Workgroup charter will be reviewed and/or revised on an annual basis, or as needed, by the PCC KPA Workgroup and submitted to the QIC for approval.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement quality improvement initiatives (QIIs) will report data related to the QIIs to the PCC KPA Workgroup to enable the committee to track implementation. Through data reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the PCC KPA Workgroup identifies areas for development of QIIs.

	To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the PCC KPA Workgroup: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the PCC KPA Workgroup Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Committee / Workgroup:	
Membership	The KPA Workgroup 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, quality improvement, behavioral analysis and data analytics.

	Voting Members: • Director, Provider Development • Director, Office of Licensing • Assistant Commissioner for Developmental Disability Services • Senior Director, Clinical Quality Management • Director, Community Quality Management • Director, Office of Human Rights • Representative, Office of Waiver Operations • Representative, Office of Data Quality and Visualization • Settlement Agreement Director • Director, Office of Integrated Health • Mortality Review Committee Clinical Manager • Director, Office of Individual and Family Support • Director, Office of Housing **Advisory Members (non-voting):** • QI/QM Coordinator • Quality Improvement Specialists (2) • Others as determined by the PCC KPA Workgroup
Meeting Frequency	Meetings shall be held monthly, at least 10 times per year; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is 50% plus one of voting membership. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Assistant Commissioner for Developmental Disability Services chairs the PCC KPA Workgroup. The chair will be responsible for ensuring the workgroup performs its functions. The chair may designate a co-chair as needed to assist. The standard operating procedures include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance of reports and/or meeting minutes as necessary and pertinent to the workgroup's function • Analysis of PMIs to measure performance across the KPA • Recommend QIIs (at least one per fiscal year, based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC

	• Monitoring of surveillance data on a regular schedule The KPA Workgroup will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI) • Establish at least one PMI for each domain identified as either an outcome or output measure • Determine priorities when establishing PMIs • Consider a variety of data sources for collecting data and identify the data sources to be used • Determine and finalize surveillance data from a variety of sources. This data may be used for ongoing, systemic collection, analysis, interpretation, dissemination, and also serves as a source for establishing PMIs and/or QIIs. • Monitor performance across each domain and for PMIs falling below target, determine actions that are designed to raise the performance; analyze data and monitor for trends quarterly • Monitor surveillance data in each of the domains associated with the KPA Workgroup and respond to identified trends of concerns • Review the results of Quality Service Reviews (QSR) as it relates to the key performance areas and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Review the results of the annual National Core Indictors (NCI) In-Person Survey and use findings to implement quality improvement strategies or make recommendations for QIIs. Additional family and guardian surveys may be included as part of surveillance data review • Share data with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs Each PMI will contain the following: • Baseline or benchmark data as available • The target where results should fall above or below • The date by which the target will be met • Definition of terms included in the PMI and a description of the population • Data sources (origins for both numerator and denominator) • Calculation (clear formula for calculating the PMI utilizing the numerator and denominator)

	• Methodology for collecting reliable data (complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) • The subject matter expert (SME) assigned to report and enter data on each PMI • A yes/no indicator to show whether the PMI can provide regional breakdowns <u>Member Responsibilities</u>: **Voting Members:** • 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 • Members shall be responsible for reviewing surveillance data prior to the scheduled review date and highlight areas of concern • A quorum of members shall approve all recommendations presented to the QIC • Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory Members (non-voting):** • Perform in an advisory role for the KPA Workgroup whose various perspectives provide insight on KPA Workgroup performance goals, outcomes PMIs and recommended actions • Inform the committee by identifying issues and concerns to assist the KPA Workgroup in developing and prioritizing meaningful QIIs • Supports the KPA Workgroup in performing its functions All members receive orientation and training both as new to the committee and on an annual basis. Material shall include QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4)

	stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups - DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N - Sample size • National Core Indicators - Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety. • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees - The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative (QII) - Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review - Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate: whether individuals' needs are being identified and met through person-centered planning and thinking; whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having

	opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum - Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY) - July 1 to June 30 • Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Risk Management Review Committee Charter
QIC Approved September 27, 2021

Committee / Workgroup	Risk Management Review Committee
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. The RMRC has been established to improve quality of services and the safety of individuals with developmental disabilities (DD).
Authorization/Scope of Authority	This committee is authorized by the DBHDS QIC and is coordinated by the Division of Quality Assurance and Government Relations and the Office of Clinical Quality Management. The RMRC's overall risk management process enables DBHDS to identify, and prevent or substantially mitigate risks of harm. The RMRC reviews and analyzes related data collected from facilities and community service providers, including reports of serious incidents and allegations of abuse and neglect. The RMRC also reviews data and information related to DBHDS program activities, including licensing reviews, triage and review of serious incidents, and oversight of abuse/neglect allegations.
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.
DBHDS Quality Improvement Standards	**DBHDS is committed to a Culture of Quality that is characterized as:** • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QII) as indicated
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the RMRC to enable the committee to track implementation. Through look-behind reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the RMRC identifies areas for development of QIIs. To that end, the committee determines the: • Aim: What are we trying to accomplish?

	• Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the RMRC: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Reviews trends at least quarterly; utilizes data analysis to identify areas for improvement and monitor trends. The RMRC identifies priorities and determines QIIs as needed, including identified strategies and metrics to monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the RMRC Data reviews occur as part of quality improvement activities and as such are not considered research.
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, medical, quality improvement, and data analytics:

	Voting Members: • Assistant Commissioner of Quality Assurance and Government Relations or designee • Director, Community Quality Management, or designee • Director, Provider Development, or designee • Director, Office of Human Rights, or designee • Director, Office of Integrated Health. or designee • Incident Manager, Office of Licensing, or designee • Representative, Data Quality and Visualization • Settlement Agreement Director, or designee • Risk Manager, Training Center or designee • Office of Licensing Quality Improvement Review Specialist **Advisory Members:** • Deputy Commissioner of Quality Assurance and Government Relations • QI/QM Coordinator • Quality Improvement Specialists • Investigations Manager, Office of Licensing, or designee • Advisory consultants as needed/required
Meeting Frequency	The RMRC meets at least ten times a year with a quorum present; additional meetings may be scheduled as determined by the urgency of issues. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is defined as 50% plus one of the approving members. These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of QIIs, PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The Assistant Commissioner of Quality Assurance and Government Relations or designee chairs the RMRC. The chair will be responsible for ensuring the committee performs its functions. The standard operating procedures include: • Develop, update and review annually the committee charter • Meet regularly to ensure continuity of purpose • Maintain reports, meeting minutes, and/or actions taken as necessary and pertinent to the subcommittee's function • Analyze data to identify and respond to trends to ensure continuous quality improvement

	• Recommend QIIs (at least one per fiscal year, based on data analysis designed to mitigate risks, and foster a culture of safety in service delivery based on data analysis), which are consistent with Plan, Do, Study, Act model and implement QIIs as directed by the QIC The RMRC will: • Adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI) • Develop an incident management process that is responsible for review and follow-up of all reported serious incidents including protocols that identify a triage process, a follow-up and coordination process with licensing specialists and investigators, human rights advocates and referrals to other DBHDS offices as appropriate and documentation of trends, patterns and follow-up on individual incidents • Provide 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: o The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols; o The provider's documented response ensured recipient's safety and well-being; o Appropriate follow-up from the Office of Licensing incident management team occurred when necessary; o Timely, appropriate, corrective action plans are implemented by the provider when indicated. o The RMRC will review trends quarterly, recommend changes to processes, protocols, or quality improvement initiatives when necessary and track implementation of any changes or quality initiatives approved for implementation. • Provide oversight of a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review evaluates whether: o Comprehensive and non-partial investigations of individual incidents occur within state prescribed timelines; o The person conducting the investigation has been trained to conduct investigations; o Timely, appropriate, corrective action plans are implemented by the provider when indicated. o The RMRC will review trends quarterly, recommend changes to processes, protocols, or quality improvement initiatives when necessary and track implementation of any changes or quality initiatives approved for implementation. • 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 • Review details of individual serious incident reports when indicated

	• Review and identify 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 • Monitor 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 QIIs are needed, and if so, monitors implementation and outcomes. • Utilize the findings from review activities to develop, or recommend, the development of guidance, training, or educational resources to address areas of risk prevalent within the DBHDS service population • Review, analyze and identify trends related to DBHDS facility risk management programs to reduce or eliminate risks of harm • Monitor the effective implementation of DI 401 (Risk and Liability Management) by reviewing facility data and trends, including risk triggers and thresholds to address risks of harm • Review the results of Quality Service Reviews (QSR) as it relates to identified risks of harm, including appropriate provider response to risks, address risk triggers and thresholds and use findings to inform providers of recommendations as well as use systemic level findings to update guidance that is then disseminated • Share data or findings with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Provide relevant data (statewide aggregate, regional) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available • Ensure the annual review of guidance, training, or educational resources; and update as necessary to ensure current guidance is reflected. Use data and information from risk management activities to identify topics for future content as well as determine when existing content needs revision. • Produce an annual report (based upon state fiscal year) for inclusion in the annual Quality Management Plan • Report to the QIC for oversight and system-level monitoring at least three times per year including identified PMIs, outcomes and QIIs. Report findings, conclusions and recommendations as unusual patterns or trends are identified <u>Membership Responsibilities:</u> **Voting members:** • Have decision making capability and voting status • Review data and reports for meeting discussion • A quorum of members shall approve all recommendations presented to the QIC

	• Members may designate an individual (designee) to attend on their behalf when they are unable to attend. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. **Advisory members:** • Perform in an advisory role for the RMRC whose various perspectives provide insight on RMRC activities, performance outcomes, and recommended actions • Inform the committee by identifying issues and concerns to assist the RMRC in developing and prioritizing meaningful QIIs • Support the RMRC in performing its functions All members receive orientation and training both as new members to the committee and on an annual basis. Material shall include information pertaining to QM System, charter, committee responsibilities and continuous quality improvement.
Definitions	The following standard definitions as referenced in Part I of the Quality Management Plan (Program Description) are established for all quality committees: • Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations • Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues. • Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity. • Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver. • Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups - DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains.

	• N - Sample size • National Core Indicators - Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety. • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees - The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative - Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review - Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate: whether individuals' needs are being identified and met through person-centered planning and thinking; whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum - Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY) - July 1 to June 30 • Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Mortality Committee Charter
QIC Approved September 27, 2021

Committee	Mortality Review
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 an intellectual disability and/or developmental disability (I/DD), utilizing an information management system to track the referral and review of these individual deaths.
Authorization / Scope of Authority	The DBHDS Commissioner is the executive sponsor of the MRC and designates the Chief Clinical Officer (CCO) to establish and supervise the Mortality Review Office (MRO). Through the DBHDS incident reporting system, and in collaboration with the Office of Licensing, the MRC reviews deaths of individuals with I/DD who received a service licensed by DBHDS at the time of death. The MRC is a sub-committee of the Quality Improvement Committee (QIC). The MRC provides ongoing monitoring and data analysis to identify trends and/or patterns and then makes recommendations to promote the health, safety and well-being of said individuals. To the best of its ability, the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable. The MRC also develops and assigns specific relevant actions when needed.
Charter Review	The MRC charter is reviewed and/or revised on an annual basis, or as deemed necessary by the committee and approved by the QIC.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated DBHDS demonstrates on an on-going basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. DBHDS develops and implements QIIs, either regionally or statewide, as recommended by the MRC and approved by the DBHDS Commissioner, to reduce mortality rates to the fullest extent practicable.

Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the MRC to enable the committee to track implementation. Through mortality reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the MRC identifies areas for development of QIIs. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the MRC: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Share data or findings with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training

	• Completes a committee performance evaluation annually that includes the accomplishments and barriers of the MRC Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Committee:	
Membership	The MRC is composed of members with training and experience in the areas of I/DD, including but not limited to: Clinical expertise, Medical and pharmacy services, Quality improvement, Compliance, Incident management, Behavior analysis, and Data analytics. Required Mortality Review Committee DBHDS members include: • Chief Clinical Officer *(MD, and staff member with QI and programmatic/operational [P/O] expertise)* • Assistant Commissioner of Developmental Services, or designee *(staff member with QI and P/O expertise)* • Assistant Commissioner for Compliance, Risk Management, and Audit or designee *(staff member with QI, P/O, and regulatory expertise)* • Senior Director of Clinical Quality Management *(staff member with QI and P/O expertise)* • Director, Community Quality Management, or designee *(Clinician or staff member with QI and P/O expertise)* • Director, Office of Human Rights, or designee *(staff member with regulatory, QI and P/O expertise)* • Director, Office of Integrated Health, or designee *(staff member with QI and PO expertise)* • MRO Clinical Manager, MRC Co-Chair (*NP and staff member with QI and P/O expertise*) • OL Manager, Incident Team *(staff member with regulatory and P/O expertise)* • OL Manager, Investigation Team *(staff member with regulatory and P/O expertise)* • Office of Pharmacy Services Manager *(PharmD and staff member with regulatory, QI and P/O expertise)* • MRO Clinical Reviewer *(RN and staff member with QI and P/O expertise)* • MRO Program Coordinator *(Staff member with QI and P/O expertise)* • A member with clinical experience to conduct mortality reviews who is otherwise independent of the State *(medical doctor, nurse practitioner, or physician assistant, who is an external member with P/O expertise)* Advisory *(non-voting members*) nominated by the Commissioner or Chair of the MRC, which may include; • DBHDS Assistant Commissioner, Division of Quality Assurance and Government Relations • Representative, DBHDS Office of Data Quality and Visualization • Representative, Department of Medical Assistance Services • Representative, Department of Health • Representative, Department of Social Services • Representative, Office of Chief Medical Examiner

	• Representative, Community Services Board • Other Subject matter experts such as representatives from a DD Provider or Advocacy Organizations
Meeting Frequency	The MRC meets, at minimum, on a monthly basis or more frequently as necessary to conduct mortality reviews with 90 days of death. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
Quorum	A quorum is 50% of voting membership plus one, with attendance of at least: (One member may satisfy two roles) • A medical clinician (*medical doctor, nurse practitioner, or physician assistant*) • A member with clinical experience to conduct mortality reviews • A professional with quality improvement expertise • A professional with programmatic/operational expertise These actions require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of quality improvement initiative (QII), PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The DBHDS Commissioner shall serve as the executive sponsor of the MRC and the CCO, or Clinical Manager (CM), shall serve as committee chair. The committee chair shall be responsible for ensuring the committee performs its functions, consideration and, as appropriate, approval of quality improvement activities, and MRC core processes. <u>Standard operating procedures</u>: • The Specialized Investigation Unit (SIU) reviews all deaths of individuals with I/DD reported to DBHDS through its incident reporting system. Available records and information are obtained for individuals with I/DD who were receiving a licensed service, and the OL Investigation (OLI) is submitted to the MRO within 45 business days (9 weeks) of the date the death was reported. • The MRO then has four weeks after receipt of the OLI to compile a case review. Within 90 calendar days of a death, (and for any unreported deaths, as defined on page 6), the Mortality Review Team (MRT) compiles a review summary of the death. This includes development of succinct clinical case summaries (definition page 11) within two weeks of reviewing and documenting the availability or unavailability, of: ♦ Medical records: Including healthcare provider and nursing notes for three months preceding death ♦ Incident reports for three months preceding death ♦ Most recent individualized service program plan ♦ Medical and physical examination records ♦ Death certificate and autopsy report (when performed) ♦ Any evidence of maltreatment related to the death ♦ Interviewing, as warranted, any persons having information regarding the individual's care ♦ When additional documents are needed, the MRT will request these records from appropriate entities per Virginia Code §§2.2-3705.5, 2.2-3711, and 2.2-4002 amendment of the Virginia Code

- The Clinical Reviewers document all relevant information onto the electronic Mortality Review Form, and submits each clinical case summary for final review. The CCO or CM reviews all clinical case summaries and; assigns a Tier category based on the sequential information related to the events surrounding that individual's death. The criteria for each Tier category is also utilized. These cases are then considered final clinical summaries (see Definitions, page 11). A facilitated discussion is conducted during MRC meetings for all Tier 1 cases and those cases where the Tier category could not be determined without MRC discussion and decision-making.

- 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.

<u>At each meeting the MRC members:</u>

- ♦ Perform comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors *(e.g., medical, genetic, social, environmental, risk, susceptibility, and others as specific to the individual)* and quality of service.
- ♦ Evaluate 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.
- ♦ Identify risk factors and gaps in service and recommend quality improvement strategies to promote safety, freedom from harm, and physical, mental and behavioral health and wellbeing.
- ♦ Review OL Corrective Action Plans (CAPs) related to required recommendations, to ensure no further action is required and for inclusion in meetingminutes.
- ♦ Make additional recommendations for further investigation and/or actions by other DBHDS Offices represented by MRC members, as appropriate.
- ♦ Assign these recommendations and/or actions to specific MRC member(s) as appropriate.
- ♦ Review and track the status of previously assigned recommended actions to ensure completion.
- ♦ The committee may also interview any persons having information regarding the individual's care.

For each case reviewed, the MRC seeks to identify:

- The cause of death (CoD)
- If the death was expected (XP)
- Whether the death was potentially preventable (PP)
- Any relevant factors impacting the individual's death
- Any other findings that could affect the health, safety, and welfare of these individuals
- Whether there are other actions that may reduce these risks, to include provider training and

communication regarding risks, alerts, and opportunities for education (see Definitions under "Leadership and Responsibilities" section).

- If any actions are identified based on the case review, the MRC will then make and document relevant recommendations and/or interventions
- Documentation is located in the Meeting minutes, Notes Summary, Action Tracking Log, and/or on the electronic Mortality Review Form

The MRC will make recommendations *(including but not limited to, QIIs)* in order to reduce mortality rates to the fullest extent practicable.

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  - The MRO provides a list of identifying information for I/DD individuals in the Waiver Management System who received DBHDS-licensed services to the Virginia Department of Health (*VDH*)
  - VDH identifies names from that list for which a death certificate is on file and provides results back to the MRO.
  - The MRO forwards the information to the DBHDS OL SIU Manager, who researches DBHDS' incident reporting systems to determine if the individual was receiving a DBHDS licensed service at the time of death and therefore was not reported by a DBHDS licensed provider. SIU team investigates all unreported deaths identified by this process and takes appropriate action in accordance with DBHDS licensing regulations and protocols.
  - Upon completion of the OL investigation, if a death is determined to require MRC review, the MRT will initiate the usual review process for the case as per current standard operating procedure (see pages 5 &6).

- The MRC documents recommendations for systemic QIIs coming from patterns of individual reviews on an ongoing basis, and analyzes patterns that emerge from any aggregate examination of mortality data for cases that were reviewed by the MRC on an ongoing basis.

- From this analysis, the MRC makes one recommendation per quarter *(four recommendations/year)* for systemic QIIs, and reports these recommendations to the QIC (*quarterly*) and the DBHDS Commissioner *(annually*).
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- The MRC prepares an annual report of aggregate mortality trends and patterns for all individual deaths that occurred in the state fiscal year and that were also reviewed by the MRC, within six months of the end of the fiscal year. A summary of the findings is released publicly.

- Provide relevant data (statewide aggregate) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available at least on an annual basis

<u>Membership responsibilities:</u>

Pursuant to Virginia Code § 37.2-314.1, all MRC members and other persons who attend closed meetings of the MRC are required to sign a confidentiality agreement form. Members shall notify the MRC Co-Chair and/or MRO Program Coordinator prior to having a guest attend a meeting so that arrangements may be made for the guest to sign the confidentiality agreement form before (s)he is permitted to attend. Member confidentiality forms are valid for the entire term of MRC membership, and guest confidentiality forms are valid for repeat attendance at MRC meetings. New members will receive training within 30 business days of joining the committee.

All members adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI).

- All MRC members must receive training that includes:
  - Orientation to the MRC charter to educate the member on the scope, mission, vision, charge, and function of the MRC
  - Review of the policies, processes, and procedures of the MRC
  - Education on the role/responsibility of the member(s)
  - Training on continuous quality improvement principles

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

	♦ Review data and reports for meeting discussion. ♦ May send a designee to MRC meetings but should attend at least one meeting per quarter. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. ♦ Absence is considered excused if the member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting that the member and/or designee are unable to attend. ♦ Recognize that an excused absence does not contribute to the 75% attendance requirement. • **Advisory members:** ♦ Are non-voting stakeholder members selected and approved by the 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. ♦ Inform the committee by identifying and prioritizing MRC decision making and recommendations. ♦ May be appointed for a term of two (2) years, and may be reappointed for up to two additional terms. ♦ Are expected to attend one meeting every quarter (4/year), and may send a designee whom is approved by the MRC chair prior to the meeting. An absence is considered excused if the advisory member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting, that the advisory member and/or designee are unable to attend. ♦ Recognize that an excused absence does not contribute to the attendance requirement.
Recusal	Members must recuse themselves from MRC proceedings if a conflict of interest arises, in order to maintain neutrality *(prevent bias)* and credibility of the MRC mortality review process. Conflict of interest exists when an MRC member has a financial, professional or personal interest that could directly influence MRC determinations, findings or recommendations, such as: • The MRC member, or an individual from the member's family, was actively involved in the care of the decedent *(direct care r/t employment or financial as listed below*) • The MRC member may have participated in a facility or institutional mortality review of the decedent • The MRC member, or an individual from the member's family, has a financial interest or investment that could be directly affected by the mortality review (*including determinations and recommendations*) of the decedent, to include employment, property interests, research, funding or support, industry partnerships and consulting relationships Should a conflict of interest arise during the review process, the MRC member will: • Immediately disclose the potential conflict of interest and cease participation in the case review related to the existing or potential conflict of interest.

	• Disclose the conflict of interest privately to the Chair/Co-Chair, or publicly to the members in attendance. The MRC will then halt discussion of the conflict of interest case, move on to the next case and place the conflict of interest case at the end. This allows the MRC member with a conflict of interest to remain for the review of other cases, and then leave the proceedings prior to the discussion of the conflict of interest case.
Definitions	• Comprehensive clinical case summaries (CCS) denotes an in-depth inclusive review of clinical and sequential information related to the events surrounding the individual's death. After review by the CCO or CM, CCS' are assigned a Tier category and considered final clinical summaries. These may be reassigned at the recommendation of the MRC. • Tier 1 case criteria: A case is categorized as Tier 1 when any of the following criteria exists: ♦ Cause of death cannot clearly be determined or established, or is unknown ♦ Any unexpected death *(such as suicide, homicide or accident*). This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to an acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. ♦ Abuse or neglect is specifically documented ♦ Documentation of investigation by or involvement of law enforcement or similar agency (*including forensic)* ♦ Specific or well-defined risks to safety and well-being are documented. • Tier 2 case criteria: A case is categorized as Tier 2 when all the first 4 criteria exists: ♦ Cause of death can clearly be determined or established ♦ No documentation of abuse or neglect ♦ No documentation of investigation by or involvement of law enforcement or similar agency (*including forensic*) ♦ No documentation of specific or well-defined risks to safety and well-being are noted. ♦ An expected death that occurred as a result of a known medical condition, anticipated by health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care.

- An unexpected (unexplained) death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to an acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death.

- Expected Death denotes a death that occurred as a result of a known medical condition, anticipated by health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care.
- Unexpected Death denotes a death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. Deaths are considered unexpected when they: are not anticipated or related to a known terminal illness or medical condition; are related to injury, accidents, inadequate care; or are associated with suspicions of abuse or neglect. An acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. An unexplained death is considered an unexpected death.
- Unknown 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.
- 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.
- Potentially Preventable (PP) Deaths denotes deaths in the opinion of the MRC that might have been prevented with reasonable valid intervention (*e.g., medical, social, psychological, legal, educational*). Deaths determined to be PP have identifiable actions or care measures that should have occurred or been utilized. If the individual was provided with known effective medical treatment or public health intervention and died despite this provision of evidenced based care, the death is not considered potentially preventable. When the MRC determines a death is PP, the committee categorizes factors that might have prevented the death. For a death to be determined PP, the actions and events immediately surrounding the individual's death must be related to deficits in the timeliness or absence of, at least one of the following factors:
    - Coordination of care
    - Access to care, including delay in seeking treatment
    - Execution of established protocols

	♦ Assessment of the individual's needs or changes in status
	
	• Two data formats utilized;
	  • Reviewed – denotes actual cases examined by the MRC in a specified timeframe, which may include a death that happened at any point in time
	  • Occurred – denotes only deaths that transpired during a specified timeframe
	
	The following standard definitions as referenced in Part I of the Quality Management Plan (*Program Description)* are established for all quality committees:
	
	• Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval.
	
	• Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations
	
	• Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues.
	
	• Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity.
	
	• Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver.
	
	• Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity.
	
	• Key Performance Area Workgroups - DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains.
	
	• N - Sample size

	• National Core Indicators - Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees - The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative - Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review - Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate: whether individuals' needs are being identified and met through person-centered planning and thinking; whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement. • Quorum - Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions.

	• State Fiscal Year (SFY) - July 1 to June 30 • Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.

Mortality Review Committee Charter
QIC Approved September 27, 2021
Revised
QIC Approved December 13, 2021

Committee	Mortality Review
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 an intellectual disability and/or developmental disability (I/DD), utilizing an information management system to track the referral and review of these individual deaths.
Authorization / Scope of Authority	The DBHDS Commissioner is the executive sponsor of the MRC and designates the Chief Clinical Officer (CCO) to establish and supervise the Mortality Review Office (MRO). Through the DBHDS incident reporting system, and in collaboration with the Office of Licensing, the MRC reviews deaths of individuals with I/DD who received a service licensed by DBHDS at the time of death. The MRC is a sub-committee of the Quality Improvement Committee (QIC). The MRC provides ongoing monitoring and data analysis to identify trends and/or patterns and then makes recommendations to promote the health, safety and well-being of said individuals. To the best of its ability, the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable. The MRC also develops and assigns specific relevant actions when needed.
Charter Review	The MRC charter is reviewed and/or revised on an annual basis, or as deemed necessary by the committee and approved by the QIC.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated DBHDS demonstrates on an on-going basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

	DBHDS develops and implements QIIs, either regionally or statewide, as recommended by the MRC and approved by the DBHDS Commissioner, to reduce mortality rates to the fullest extent practicable.
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the MRC to enable the committee to track implementation. Through mortality reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the MRC identifies areas for development of QIIs. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the MRC: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Share data or findings with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose

	• Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training • Completes a committee performance evaluation annually that includes the accomplishments and barriers of the MRC Data reviews occur as part of quality improvement activities and as such are not considered research.
Structure of Committee:	
Membership	The MRC is composed of members with training and experience in the areas of I/DD, including but not limited to: Clinical expertise, Medical and pharmacy services, Quality improvement, Compliance, Incident management, Behavior analysis, and Data analytics. Required Mortality Review Committee DBHDS members include: • Chief Clinical Officer *(MD, and staff member with QI and programmatic/operational [P/O] expertise)* • Assistant Commissioner of Developmental Services, or designee *(staff member with QI and P/O expertise)* • Assistant Commissioner for Compliance, Risk Management, and Audit or designee *(staff member with QI, P/O, and regulatory expertise)* • Senior Director of Clinical Quality Management *(staff member with QI and P/O expertise)* • Director, Community Quality Management, or designee *(Clinician or staff member with QI and P/O expertise)* • Director, Office of Human Rights, or designee *(staff member with regulatory, QI and P/O expertise)* • Director, Office of Integrated Health, or designee *(staff member with QI and PO expertise)* • MRO Clinical Manager, MRC Co-Chair (*NP and staff member with QI and P/O expertise*) • OL Manager, Incident Team *(staff member with regulatory and P/O expertise)* • OL Manager, Investigation Team *(staff member with regulatory and P/O expertise)* • Office of Pharmacy Services Manager *(PharmD and staff member with regulatory, QI and P/O expertise)* • MRO Clinical Reviewer *(RN and staff member with QI and P/O expertise)* • MRO Program Coordinator *(Staff member with QI and P/O expertise)* • A member with clinical experience to conduct mortality reviews who is otherwise independent of the State *(medical doctor, nurse practitioner, or physician assistant, who is an external member with P/O expertise)* Advisory *(non-voting members*) nominated by the Commissioner or Chair of the MRC, which may include; • DBHDS Assistant Commissioner, Division of Quality Assurance and Government Relations • Representative, DBHDS Office of Data Quality and Visualization • Representative, Department of Medical Assistance Services • Representative, Department of Health

	• Representative, Department of Social Services • Representative, Office of Chief Medical Examiner • Representative, Community Services Board • Other Subject matter experts such as representatives from a DD Provider or Advocacy Organizations
Meeting Frequency	The MRC meets, at minimum, on a monthly basis or more frequently as necessary to conduct mortality reviews with 90 days of death. Meetings can occur in the absence of quorum; however, no actions can be taken during the meeting. Additional workgroups may be established as needed.
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- Whether there are other actions that may reduce these risks, to include provider training and communication regarding risks, alerts, and opportunities for education (see Definitions under "Leadership and Responsibilities" section).
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The MRC will make recommendations *(including but not limited to, QIIs)* in order to reduce mortality rates to the fullest extent practicable.

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  - ♦ VDH identifies names from that list for which a death certificate is on file and provides results back to the MRO.
  - ♦ The MRO forwards the information to the DBHDS OL SIU Manager, who researches DBHDS' incident reporting systems to determine if the individual was receiving a DBHDS licensed service at the time of death and therefore was not reported by a DBHDS licensed provider. SIU team investigates all unreported deaths identified by this process and takes appropriate action in accordance with DBHDS licensing regulations and protocols.
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reviews on an ongoing basis, and analyzes patterns that emerge from any aggregate examination of mortality data for cases that were reviewed by the MRC on an ongoing basis.

- From this analysis, the MRC makes one recommendation per quarter *(four recommendations/year)* for systemic QIIs, and reports these recommendations to the QIC (*quarterly*) and the DBHDS Commissioner *(annually*).
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- Provide relevant data (statewide aggregate) to the RQCs which includes comparisons to other internal or external data as appropriate and include multiple years as available at least on an annual basis

<u>Membership responsibilities:</u>

Pursuant to Virginia Code § 37.2-314.1, all MRC members and other persons who attend closed meetings of the MRC are required to sign a confidentiality agreement form. Members shall notify the MRC Co-Chair and/or MRO Program Coordinator prior to having a guest attend a meeting so that arrangements may be made for the guest to sign the confidentiality agreement form before (s)he is permitted to attend. Member confidentiality forms are valid for the entire term of MRC membership, and guest confidentiality forms are valid for repeat attendance at MRC meetings. New members will receive training within 30 business days of joining the committee.

All members adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI).

- All MRC members must receive training that includes:
  - Orientation to the MRC charter to educate the member on the scope, mission, vision, charge, and function of the MRC
  - Review of the policies, processes, and procedures of the MRC
  - Education on the role/responsibility of the member(s)
  - Training on continuous quality improvement principles

- **Voting members:**
  - Have decision making capability and voting status.

	♦ Attend 75% of meetings per year and may send a designee that is approved by the MRC chair (*or Co-Chair*) prior to the meeting. ♦ Review data and reports for meeting discussion. ♦ May send a designee to MRC meetings but should attend at least one meeting per quarter. The designee shall have decision-making capability and voting status. The designee should come prepared for the meeting. ♦ Absence is considered excused if the member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting that the member and/or designee are unable to attend. ♦ Recognize that an excused absence does not contribute to the 75% attendance requirement. • **Advisory members:** ♦ Are non-voting stakeholder members selected and approved by the 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. ♦ Inform the committee by identifying and prioritizing MRC decision making and recommendations. ♦ May be appointed for a term of two (2) years, and may be reappointed for up to two additional terms. ♦ Are expected to attend one meeting every quarter (4/year), and may send a designee whom is approved by the MRC chair prior to the meeting. An absence is considered excused if the advisory member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting, that the advisory member and/or designee are unable to attend. ♦ Recognize that an excused absence does not contribute to the attendance requirement.
Recusal	Members must recuse themselves from MRC proceedings if a conflict of interest arises, in order to maintain neutrality *(prevent bias)* and credibility of the MRC mortality review process. Conflict of interest exists when an MRC member has a financial, professional or personal interest that could directly influence MRC determinations, findings or recommendations, such as: • The MRC member, or an individual from the member's family, was actively involved in the care of the decedent *(direct care r/t employment or financial as listed below*) • The MRC member may have participated in a facility or institutional mortality review of the decedent • The MRC member, or an individual from the member's family, has a financial interest or investment that could be directly affected by the mortality review (*including determinations and recommendations*) of the decedent, to include employment, property interests, research, funding or support, industry partnerships and consulting relationships Should a conflict of interest arise during the review process, the MRC member will:

	• Immediately disclose the potential conflict of interest and cease participation in the case review related to the existing or potential conflict of interest. • Disclose the conflict of interest privately to the Chair/Co-Chair, or publicly to the members in attendance. The MRC will then halt discussion of the conflict of interest case, move on to the next case and place the conflict of interest case at the end. This allows the MRC member with a conflict of interest to remain for the review of other cases, and then leave the proceedings prior to the discussion of the conflict of interest case.
Definitions	• Comprehensive clinical case summaries (CCS) denotes an in-depth inclusive review of clinical and sequential information related to the events surrounding the individual's death. After review by the CCO or CM, CCS' are assigned a Tier category and considered final clinical summaries. These may be reassigned at the recommendation of the MRC. • <u>Tier 1</u> case criteria: A case is categorized as Tier 1 when <u>any</u> of the following criteria exists: ♦ Cause of death cannot clearly be determined or established, or is unknown ♦ Any unexpected death *(such as suicide, homicide or accident*). This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to an acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. ♦ Abuse or neglect is specifically documented ♦ Documentation of investigation by or involvement of law enforcement or similar agency (*including forensic)* ♦ Specific or well-defined risks to safety and well-being are documented. • <u>Tier 2 case criteria:</u> A case is categorized as Tier 2 when <u>all the first 4</u> criteria exists: ♦ Cause of death can clearly be determined or established ♦ No documentation of abuse or neglect ♦ No documentation of investigation by or involvement of law enforcement or similar agency (*including forensic*) ♦ No documentation of specific or well-defined risks to safety and well-being are noted. ♦ An expected death that occurred as a result of a known medical condition, anticipated by

health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care.

- An unexpected (unexplained) death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to an acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death.

- Expected Death denotes a death that occurred as a result of a known medical condition, anticipated by health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care. Clear evidence that the individual received appropriate and timely care for the medical condition exists.
- Unexpected Death denotes a death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. Deaths are considered unexpected when they: are not anticipated nor related to a known terminal illness or medical condition; are related to injury, accidents, inadequate care; or are associated with suspicions of abuse or neglect. An acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. An unexplained death is considered an unexpected death.
- Unknown 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.
- 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.
- Potentially Preventable (PP) Deaths denotes deaths in the opinion of the MRC that might have been prevented with reasonable valid intervention (*e.g., medical, social, psychological, legal, educational*). If the individual was provided with known effective medical treatment or public health intervention and died despite this provision of evidenced based care, the death is not considered potentially preventable. A death may be determined to be PP regardless of whether the death is actionable by DBHDS or within the control of DBHDS. Deaths that occur in settings that are not licensed by DBHDS may be PP deaths. Deaths that do not indicate a violation of a licensing standard may be PP. Deaths determined to be PP have identifiable actions or care measures that should have occurred or been utilized. When the MRC determines a death is PP, the committee categorizes factors that might have prevented the death. For a

death to be determined PP, the actions and events immediately surrounding the individual's death must be related to deficits in the timeliness or absence of, at least one of the following factors:

- ♦ Coordination and optimization of care
- ♦ Access to care, including delay in seeking treatment
- ♦ Execution of established protocols
- ♦ Assessment of, and response to, the individual's needs or change in status

- For actions recommended by the MRC, the MRC shall consider if one of the following prevention strategies may be utilized:
  - ♦ Primary Prevention Strategies—Educational and changes to services designed to help prevent a condition or event from taking place, that have been found to contribute to morbidity or mortality, such as education on reducing falls
  - ♦ Secondary Prevention Strategies—Focus on early detection and timely treatment of conditions or injuries to minimize harmful effects and prevent further morbidity or mortality, such as interventions that support and promote cancer screening
  - ♦ Tertiary Prevention Strategies—Optimization of the treatment and management of conditions or injuries, such as ensuring access to evidence-based treatment

- Two data formats utilized;
  - Reviewed – denotes actual cases examined by the MRC in a specified timeframe, which may include a death that happened at any point in time
  - Occurred – denotes only deaths that transpired during a specified timeframe

The following standard definitions as referenced in Part I of the Quality Management Plan (*Program Description)* are established for all quality committees:

- Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval.
- Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations
- Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues.
- Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding

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

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

Quality Review Team
May 2021

Committee / Workgroup Name	Quality Review Team
Statement of Purpose	The Quality Review Team (QRT), a joint Department of Behavioral Health and Developmental Services (DBHDS) and Department of Medical Assistance Services (DMAS) committee, is responsible for oversight and improvement of the quality of services delivered under the Commonwealth's Developmental Disabilities (DD) waivers as described in the approved waivers' performance measures.
Authorization / Scope of Authority	The QRT is responsible for reviewing performance data collected regarding the Centers for Medicare and Medicaid Services' (CMS) Home and Community-Based Services (HCBS) waiver assurances: • Waiver Administration and Operation: Administrative Authority of the Single State Medicaid Agency • Evaluation/Reevaluation of Level of Care • Participant Services - Qualified Providers • Participant-Centered Planning and Service Delivery: Service Plan • Participant Safeguards: Health and Welfare • Financial Accountability The work of the QRT is accomplished by accessing data across a broad range of monitoring activities, including those performed via DBHDS licensing and human rights investigations and inspections; DMAS quality management reviews and contractor evaluations (QMR); serious incident reporting; mortality reviews; and level of care evaluations. Each DD waiver performance measure is examined against the CMS standard of 86% or above compliance. Those measures that fall below this standard are discussed to identify the need for provider specific as well as systemic remediation. The committee may make recommendations for remediation such as: • Retraining of providers • Targeted Technical Assistance • Information Technology system enhancements for the collection of data • Change in licensing status • Targeted QMR • Referral for mandatory provider remediation • Payment retraction or ceasing referrals to providers • Review of regulations to identify needed changes

	• Review of policy manuals for changes The team identifies barriers to attainment and the steps needed to address them. The QRT re-examines data in the following quarter to determine if remediation was successful or if additional action is required.
Charter Review	The QRT was established in August 2007 in response to CMS's new expectations that states implement a quality review process for HCBS waivers. This charter shall be reviewed by DBHDS and DMAS on an annual basis or as needed and submitted to the Quality Improvement Committee for review.
Model for Quality Improvement	The activities of the QRT are a means for DMAS and DBHDS to implement CMS's expected continuous quality improvement cycle, which includes: • Design • Discovery • Remediation • Improvement
Structure of Workgroup / Committee:	
Membership	**DBHDS:** • Director of Waiver Operations or designee • Senior DD Policy and Compliance Staff • Director of Provider Development and/or designee • Director, Office of Integrated Health, and/or designee • Director of Office of Licensing and/or designee • Director of Office of Human Rights or designee • Director of Office of Community Quality Improvement or designee • Director, Mortality Review Committee and/or designee • Settlement Agreement Director **DMAS:** • Director of Division of Developmental Disabilities or designee • Program Advisor

	• Developmental Disabilities Program Manager or designee • QMR Program Administration Supervisor or designee • Sr. Policy Staff
Quorum	A quorum shall be defined as 50% plus one of voting membership.
Meeting Frequency	The committee will, at a minimum, meet four times a year. The QRT review cycle is scheduled with two quarters' lag time to accommodate the 90-day regulatory requirement to successfully investigate and close cases reportable under the Appendix G Health and Welfare measures.
Leadership and Responsibilities	The DBHDS Senior DD Policy and Compliance Staff shall serve as chair and will be responsible for ensuring the committee performs its functions including development of meeting agendas and convening regular meetings. The standard operating procedures include: • Development and annual review and update of the committee charter • Regular meetings to ensure continuity of purpose • Maintenance and distribution of quarterly updates and/or meeting minutes as necessary and pertinent to the committee's function • Maintenance of QRT data provenance • CMS Evidentiary and state stakeholder reporting • Quality improvement initiatives consistent with CMS's Design, Discover, Remediate, Improve model. The meeting summary is prepared and distributed to committee members prior to the meeting and shall reflect the committee's review and analysis of data and any follow up activity. The QRT shall produce an annual report (QRT End of Year (EOY) Report) to the DBHDS Quality Improvement Committee on the findings from the data review with recommendations for system improvement. The QRT's report will include an analysis of findings and recommendations based on review of the information regarding each performance measure. CMS has indicated that reporting on the performance measures can be consolidated if all of the following requirements are met. 1) Design of the waivers is same/very similar 2) Sameness/similarity determined by comparing waivers on approved Waiver Application Appendices: C: Participant Services D: Participant-Centered Planning and Service Delivery G: Participant Safeguards

	H: Quality Management 3) Quality Management approach is the same/very similar across waivers, including: 4) Methodology for discovering information (e.g. data systems, sample selection) 5) Manner in which individual issues are remediated 6) Process for identifying & analyzing patterns/trends 7) Majority of Performance Measures are the same 8) Provider network is the same/very similar 9) Provider oversight is the same/very similar Additionally, the sampling method must be proposed in the Waiver application and approved by CMS and various sampling methods are acceptable. It is noted that, for the Commonwealth's DD waivers: • All services are the same but not all are offered under each waiver • All individuals go through the same slot selection process • All waiver service providers use the same enrollment process as delineated by DMAS. • All providers for the three waivers are required to be licensed are done so through the DBHDS. • All participants' service needs are determined through the Person Centered Planning process. • All three waivers will have the same performance measures with the approval of the amendment for the Community Living Waiver. Therefore, the QRT data across the Community Living, Family & Individual Supports, and Building Independence waivers is consolidated for annual and triennial reporting to CMS. However, individual waiver level data may be reported and reviewed for internal quality management monitoring across waivers where feasible and necessary.