Virginia Department of Behavioral Health & Developmental Services

Quality Improvement Risk Management November 2020

A presentation for DBHDS Licensed Providers

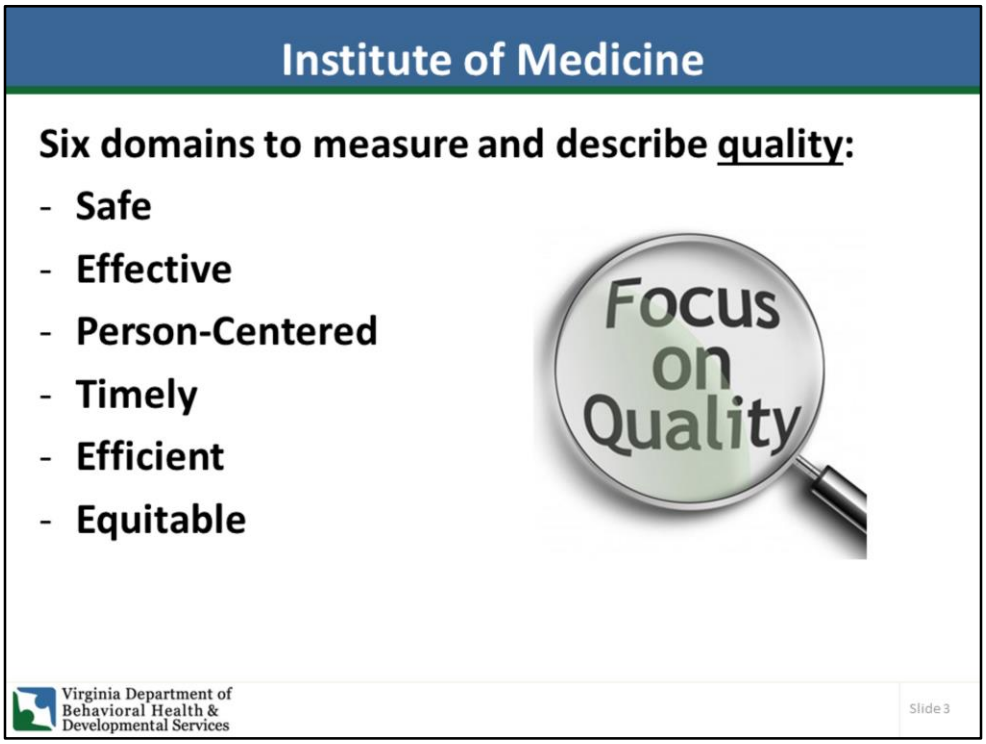
DBHDS Vision: A life of possibilities for all Virginians

The goals of this presentation are limited to quality improvement as it relates to Chapter 105 Rules and Regulations for Licensing Providers by DBHDS; specifically to 12VAC35-105-620 – Monitoring and Evaluating Service Quality and 12VAC35-105-520, Risk Management. There are numerous resources related to quality improvement, quality management, risk management, but this is limited to the requirements of the DBHDS Office of Licensing regulations. And remember, this is not meant to be a one size fits all – each provider is different. The complexity of a provider's quality program and risk management program will vary depending on the size and scope of the services offered. This presentation is intended to be a starting point.

Let's start with quality.

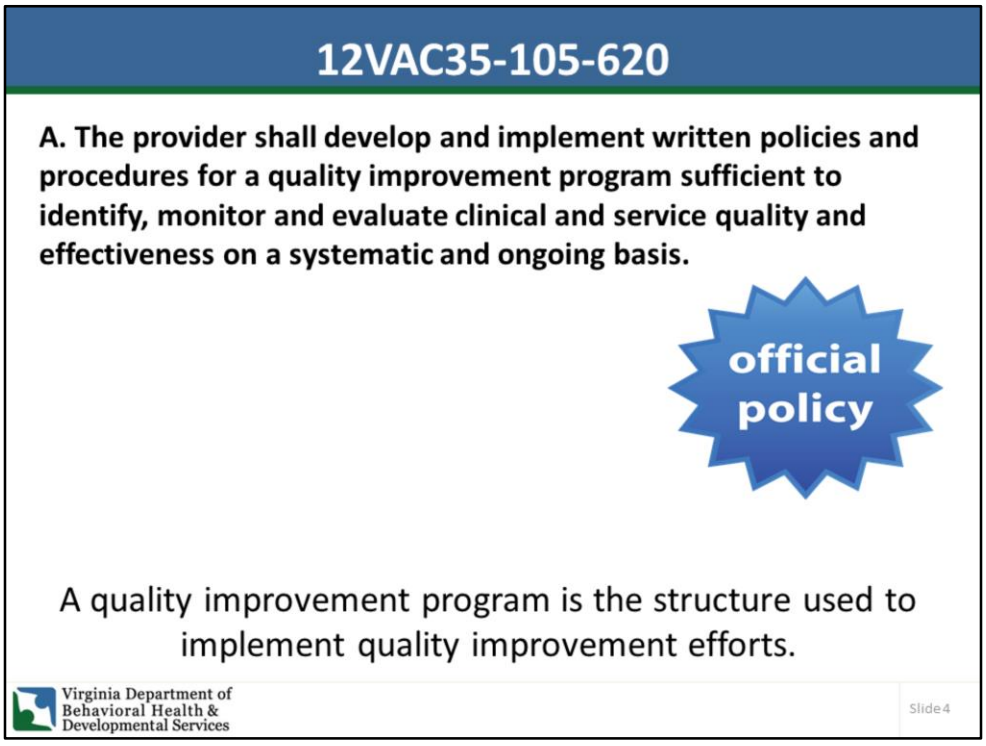
When it comes to quality, there are many terms and words that may be used interchangeably. For example, quality improvement, quality assurance, performance improvement project, quality improvement initiative, etc.

Bottom line – we all want to improve. That is why <u>quality</u> is about establishing a system or a habit. It is not just a one time act but should be continuous.

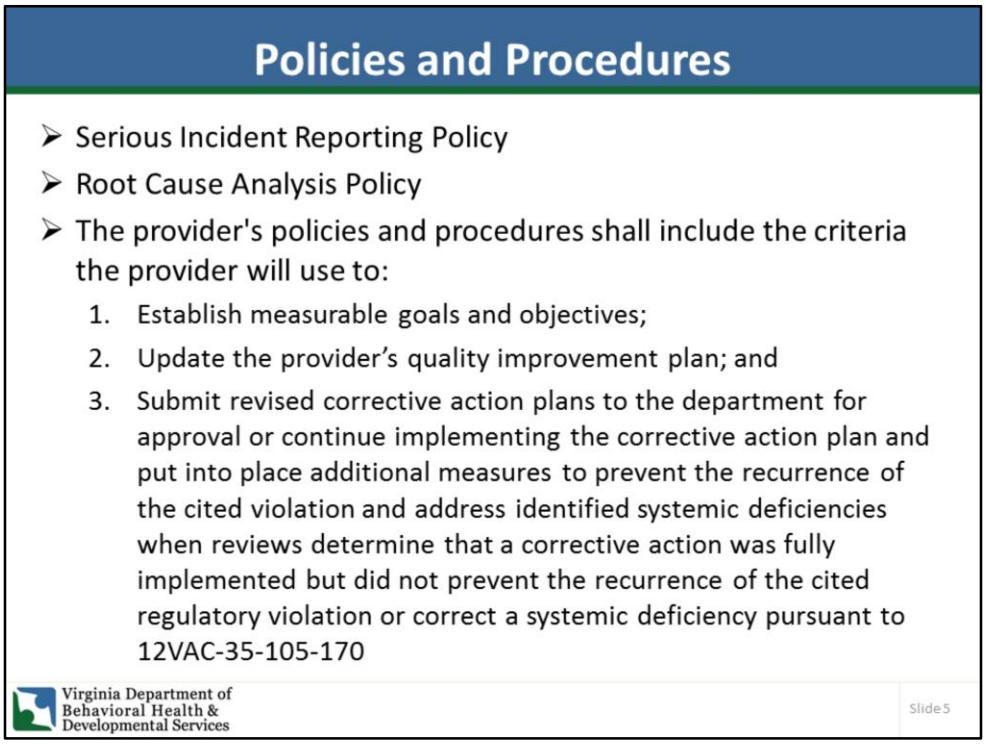


Health care quality is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes. In 1999, the Institute of Medicine released six domains to measure and describe quality of care in health:
safe – avoiding injuries to patients from care that is intended to help them
effective – avoiding overuse and misuse of care
patient-centered – providing care that is unique to a patient's needs (In adopting these domains in the DBHDS quality program, it was amended to be person-centered)
timely – reducing wait times and harmful delays for patients and providers
efficient – avoiding waste of equipment, supplies, ideas and energy
equitable – providing care that does not vary across intrinsic personal characteristics

What does quality mean? Defined differently by different organization, but one response could be “meeting or exceeding my customers’ expectations.” We have lots of customers – individuals served, their families, their friends, a provider’s staff, other providers, state agencies, each other. As a consumer of various goods and services (grocery stores, restaurants, hair salons), you probably don’t return if your customer expectations are not met.



620 is titled "Monitoring and evaluating service quality." In order to do so, policies and procedures must be in place to implement quality improvement efforts.



These are some examples of the policies that establish the framework for a quality improvement program.
Serious Incident Reporting
Root Cause Analysis
These policies need to include the criteria you will use.

12VAC35-105-620

B. The quality improvement program shall utilize standard quality improvement tools, including root cause analysis, and shall include a quality improvement plan.

Examples of Tools:

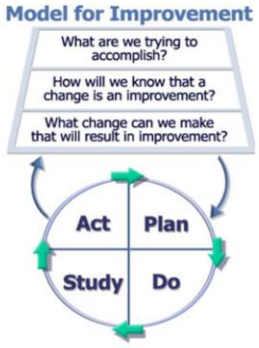
Root Cause Analysis

Run Charts

Failure, Mode and Effect Analysis

Flow Charts

PDSA



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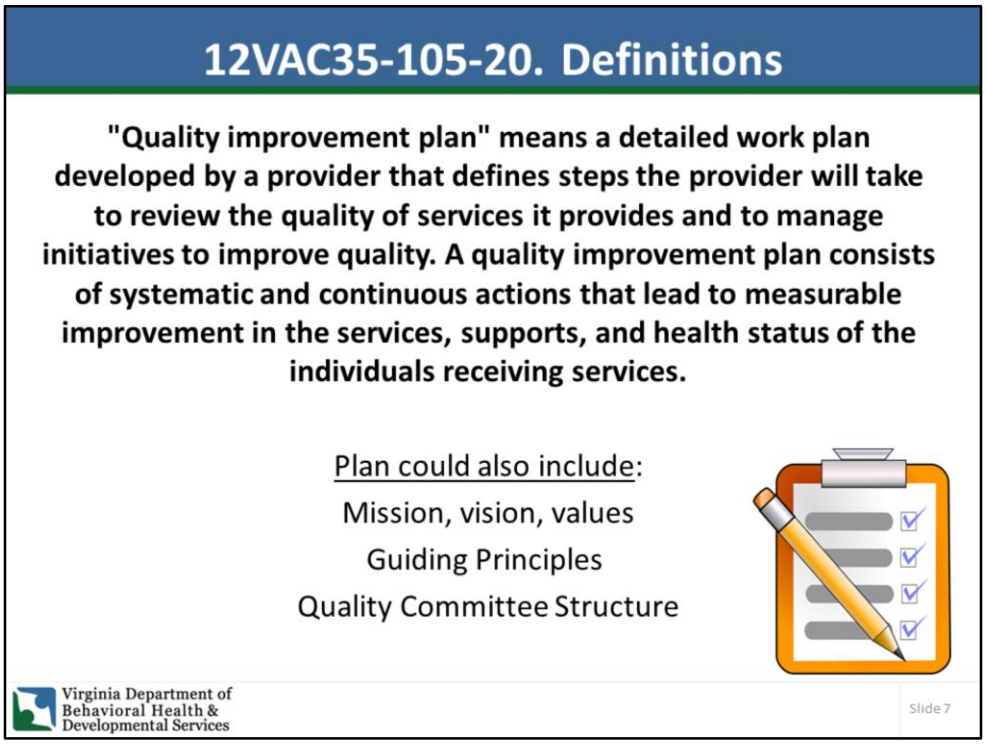
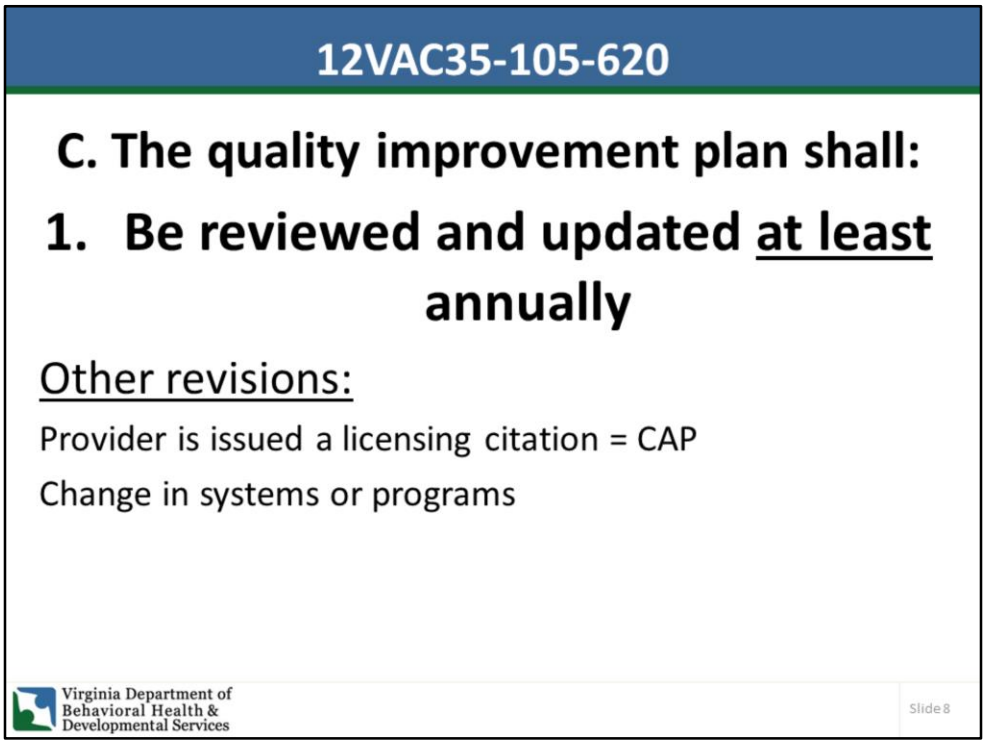
Slide 6

QI program shall utilize standard QI tools. There are many quality improvement tools so as your program grows, you may find you use more than one. There are many QI tools:
Root Cause Analysis
Failure, Modes, and Effects Analysis
Storyboards
Run charts
Pareto charts
Process maps
AIM/Measure/Change and Plan/Do/Study/Act (DBHDS utilizes this model for its quality management program)
Plan/Do/Check/Act

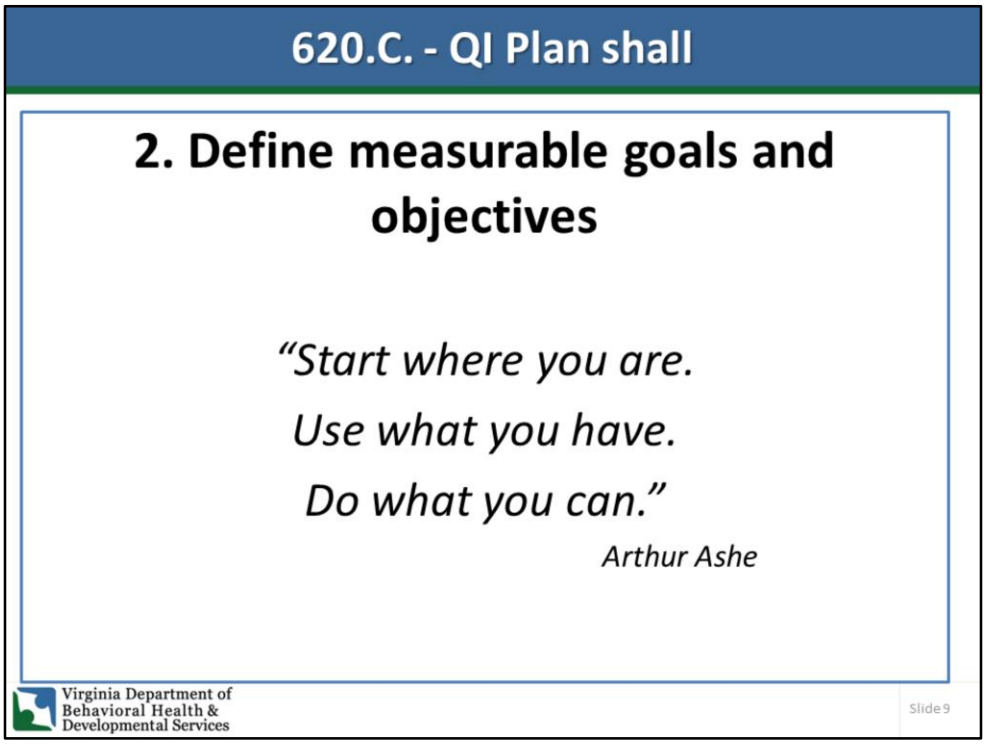


The regulations define a quality improvement plan. There is no specific template. It should be dated and signed. Some organizations may include their mission, vision, values and how that ties to their quality improvement plan. They may have guiding principles related to quality (I.e. data driven, person-centered, recovery-oriented). It may outline the structure of how the plan will be monitored throughout the year and even how it will be evaluated.



The QI Plan is your road map. The plan should be reviewed and updated at least annually. The year can be calendar year/state fiscal year (whatever works for your organization) but it should be reviewed and updated at least annually. Not just annually however as additional updates or revisions are need if you implement a Corrective Action Plan for a citation (will address later) or if your services change, etc.

Again, your quality program (policies) establishes who updates the QI plan (Quality Council, leadership, management). Remember to date and sign your QI plan as implemented and/or revised.



This Arthur Ashe quote is good advice for establishing measurable goals and objectives. Don't try to take on too much. You are already collecting data so start there.

There is no requirement for a specific number of goals or objectives in the regulations. Every organization needs to decide what is the most meaningful; focus on the wildly important; make sure that everyone can understand and put their attention towards the goals. If too many goals, you risk getting overwhelmed with the work and lose focus.

What does it mean to be measurable?

- Is it clear what is being measured and why?
- What collection methods and sources of data are available?
- What is the frequency of measurement?
- What is the timeframe for achieving the goal or objective?
- What is the baseline?
- How will the provider know if goals and objectives were met?

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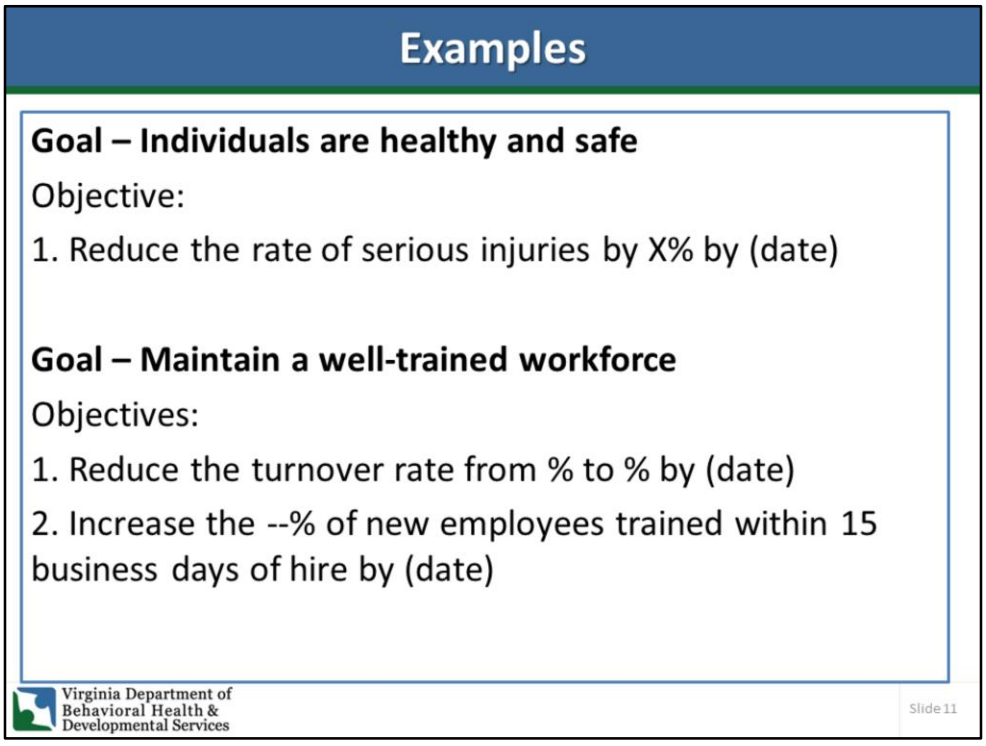
Many resources are available for developing goals and objectives (e.g. Smart Goals = Specific, Measurable, Attainable, Relevant, Time-Bound).

You may wish to consider compliance with the Home and Community Based Setting requirements, if applicable, to the licensed setting.
When prioritizing goals, providers may wish to choose how to improve overall performance, clinical services, staff development, etc. You may wish to consider relevance to the agency mission, level of risk, available resources, level of effort, meaningfulness.

When establishing goals and/or objectives, be realistic (an attainable goal). Remember - some is not a number; soon is not a time. Be specific.



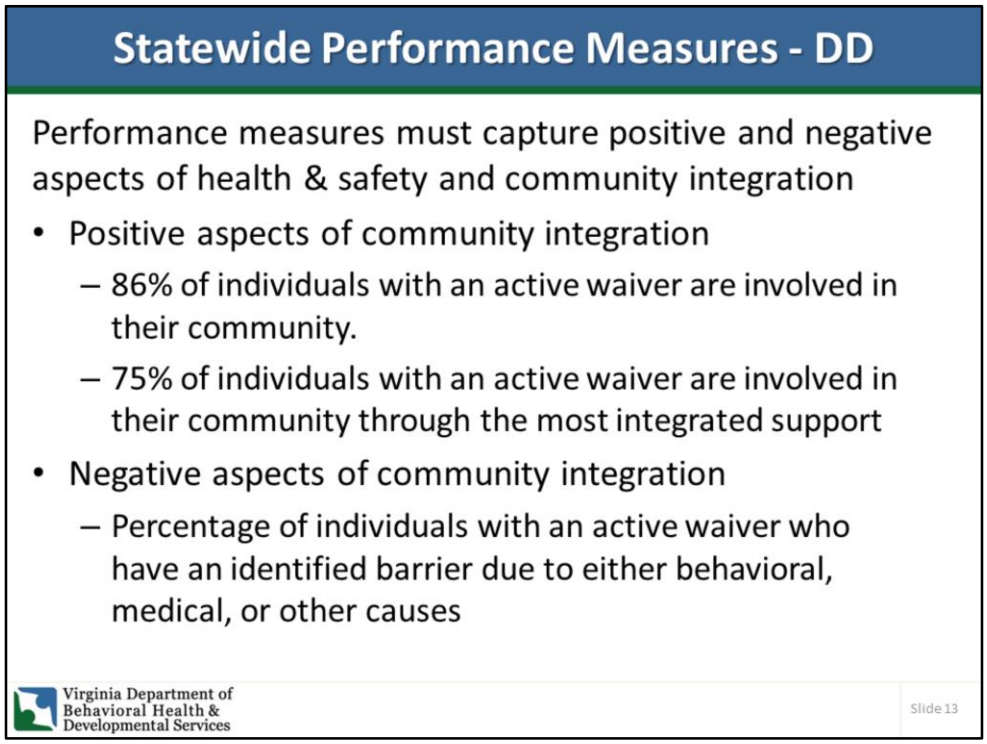
These are just examples and you do not need to have a set number. Start with a few goals and then revise or expand as analysis may indicate.

620.C - QI Plan shall…

3. Include and report on statewide performance measures, if applicable, as required by DBHDS.

The statewide performance measures currently only apply to providers of DD services.

Already reporting to DBHDS; operationally collecting through WaMS and CHRIS.



For Positive Community Integration –

Involved in Community

The **numerator** will be the number of people who had a completed ISP (determined as the most current and recent one based on the field a effective start date that falls within the quarter and has a status of either "completed by support coordinator" or "pending provider input": data field name is just called 'status') where the community activities were identified through for the previous quarter. There is a *yes/no* field that asks the Support Coordinator if the individual is involved in community activities. We will include those that have a 'yes' answer. The question cannot be left unanswered.

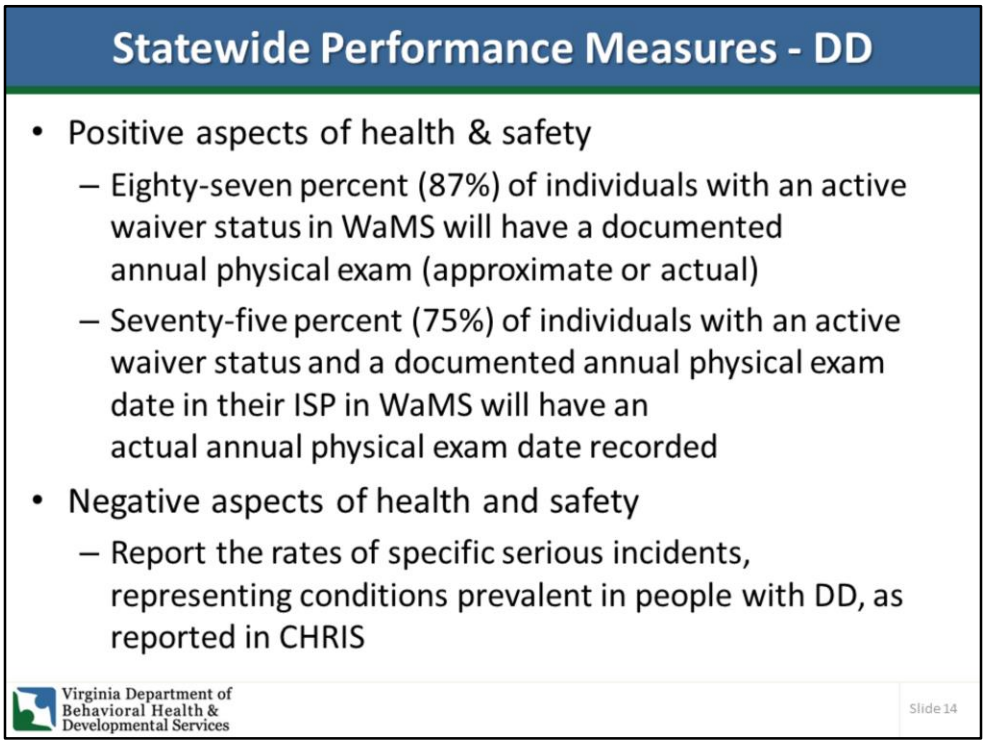
The **denominator** will be determined as the number of people with an active waiver (status codes: active).

Integrated Support

The **numerator** will be the number of people who had a completed ISP (determined as the most current and recent one based on the field a effective start date that falls within the quarter and has a status of either "completed by support coordinator" or "pending provider input": data field name is just called 'status') where the community activities were identified through for the previous quarter as delivered through the most integrated supports (Natural support, Community Engagement and/or Community Coaching).

Barrier to Community Integration

The **numerator** will be the number of people who had a completed ISP (determined as the most current and recent one based on the field a effective start date that falls within the quarter and has a status of either “completed by support coordinator” or “pending provider input”: data field name is just called ‘status’) where there was a barrier to community activities identified by the Support Coordinator for the previous quarter. There is a *yes/no* field that asks the Support Coordinator if the individual has a barrier to community activities.



Positive Health & Safety

Numerator 1 - all individuals with an active waiver status that have an annual physical exam date (approximate or actual) documented in their completed ISP in WaMS
Denominator 2- all individuals with an active waiver status in WaMS

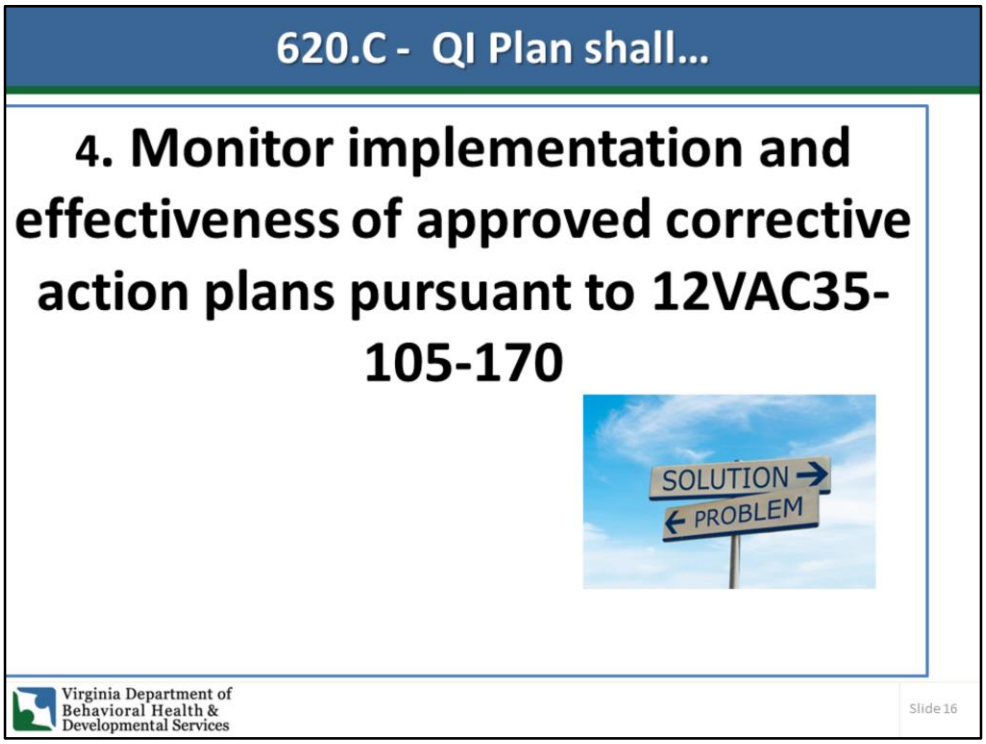
Numerator 2 – all individuals with an active waiver status that have an actual annual physical exam date documented in their completed ISP in WaMS
Denomintor 2 - all individuals with an active waiver status that have an annual physical exam date (approximate or actual) documented in their completed ISP in WaMS

Negative Health & Safety
Report the rates of 12 conditions or incidents that represent risks that are common to individuals with DD

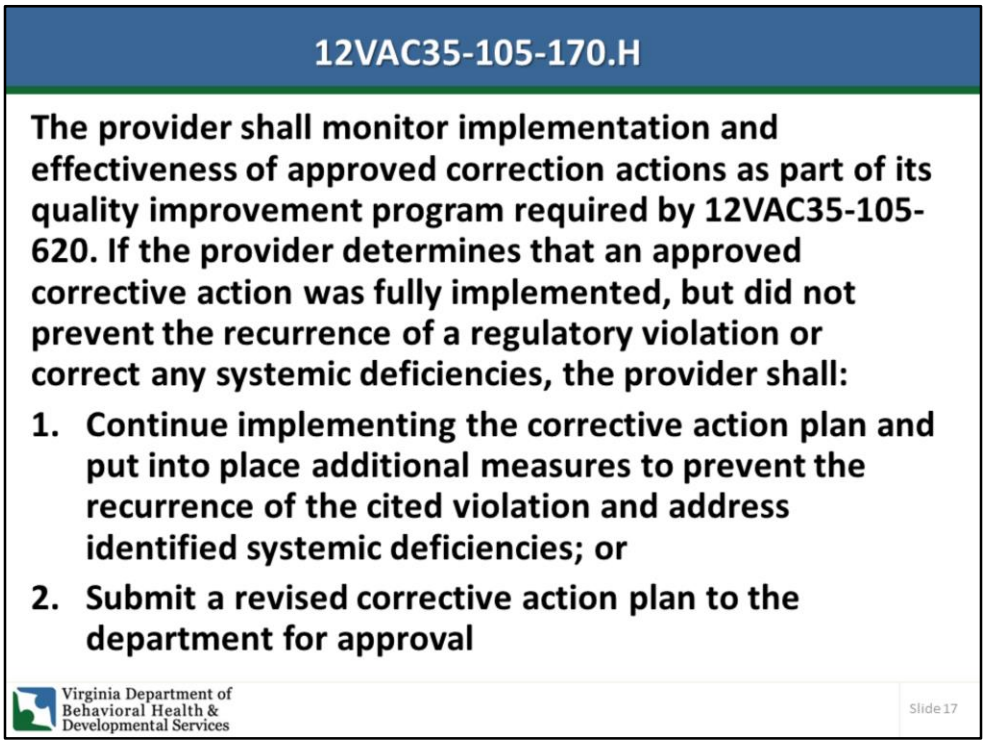
The rates reflect the number of reported incident per 1,000 individuals on the DD waivers – they are taken from data reported in CHRIS and reviewed quarterly.

Serious Incident Rates

Performance Measure Indicators – Safety and Freedom from Harm	Target	FY20 QTR1 Results	FY20 QTR2 Results	FY20 QTR3 Results	FY20 QTR4 Results	FY20 Overall Results	Performance Assessment
Serious Incident Rates							
Fall	56.88		67.65	63.93	38.72	56.77	✓
Seizures	Monitoring		32.99	33.20	22.52	29.57	
Urinary Tract Infection	Monitoring		27.40	29.08	23.07	26.61	
Self-injury	Monitoring		20.13	18.11	10.71	16.32	
Aspiration Pneumonia	Monitoring		6.99	6.04	7.14	6.72	
Dehydration	Monitoring		5.59	7.13	3.84	5.52	
Decubitus Ulcer	Monitoring		5.31	5.21	5.77	5.43	
Sepsis	Monitoring		4.75	6.04	3.84	4.97	
Suicide attempt	Monitoring		5.03	5.21	4.39	4.88	
Bowel Obstruction	Monitoring		6.15	4.66	2.75	4.52	
Choking	Monitoring		5.31	4.94	3.02	4.42	
Sexual assault	Monitoring		3.91	4.94	1.65	3.50	



#4 – monitor implementation and effectiveness of CAPs. For example, if a provider was cited for errors in medication administration, the CAP could includes a plan to reduce errors and a specific measurable objective. This could be measured through chart review and reported as part of the provider's quality improvement plan. If a problem is identified, there needs to be corrective action plan to address and then you monitor to make sure it was effective. The next slide gives the reference here to 170.



Your QI program shall include how you are going to monitor any Corrective Action Plans (CAPs).

Guidance on Corrective Action Plans (dated August 22, 2020) is on the Office of Licensing website. There will be upcoming training related to Corrective Action Plans.

620.C - QI Plan shall…

5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.

Examples:

- Process for when and how you review progress
  - Reporting calendar (monthly, quarterly, annually)
  - Program outlines who (committee/management)
- Evaluation/analysis

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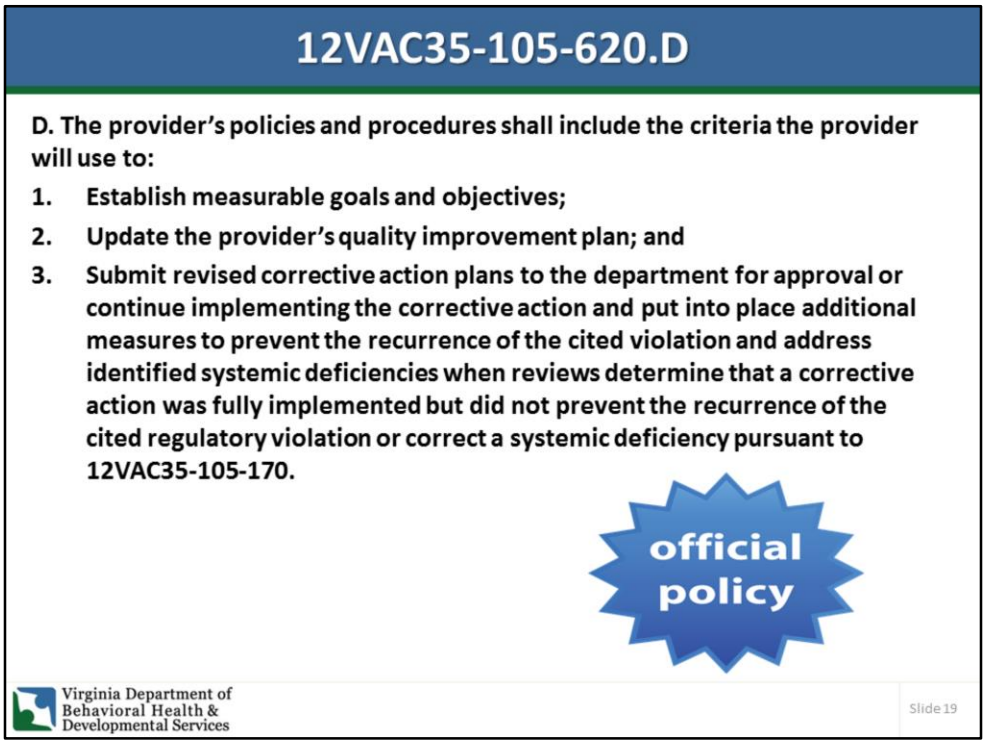
A quality improvement program includes a process defining when and how the provider will review progress toward the goals and objectives. This provision is about monitoring your progress throughout the year and responding to identified concerns. If a provider does not identify any progress toward meeting identified goals and objectives, a quality improvement initiative could be considered.



A provider's policies and procedures for the quality program would outline the criteria for establishing measures, updating your plan or revising CAPs. The criteria may be the same for all three items. The provider's criteria could be based on data collected, prioritization, what is meaningful, not seeing improvement over time, etc.

12VAC35-105-620.E

620.E – Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality improvement plan. The provider shall implement improvements, when indicated.

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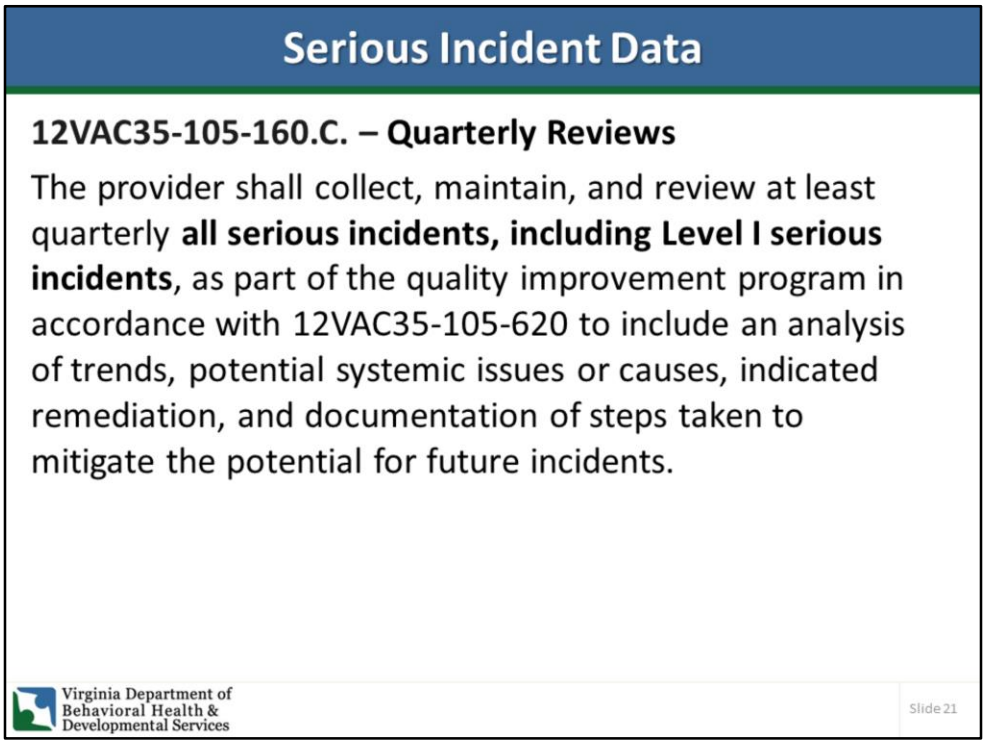
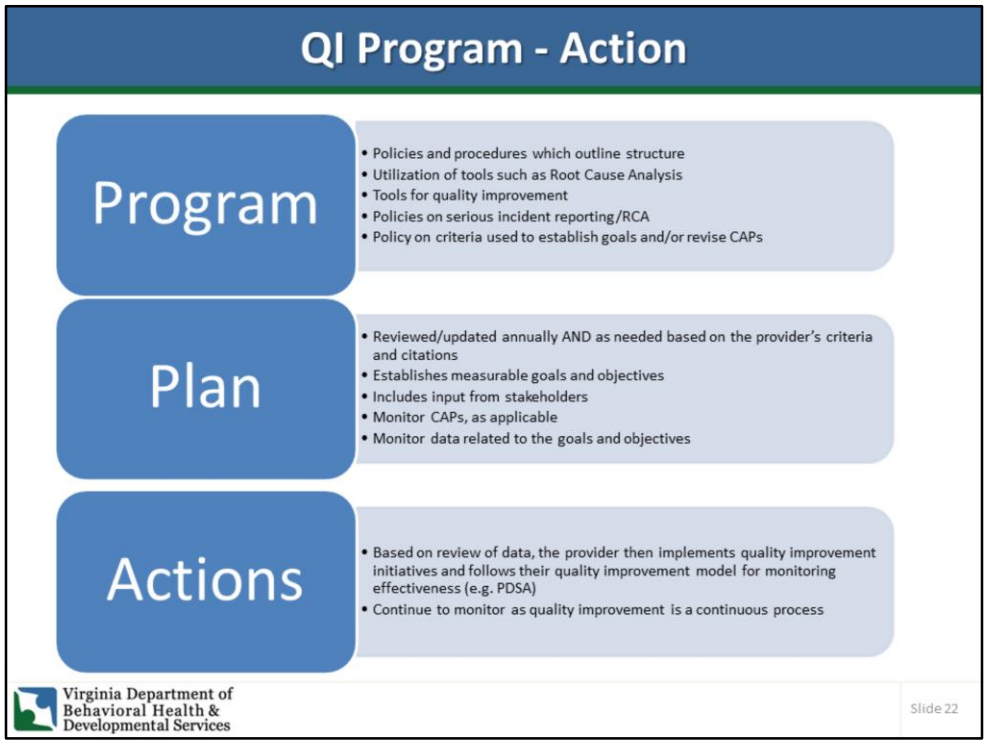
Slide 20

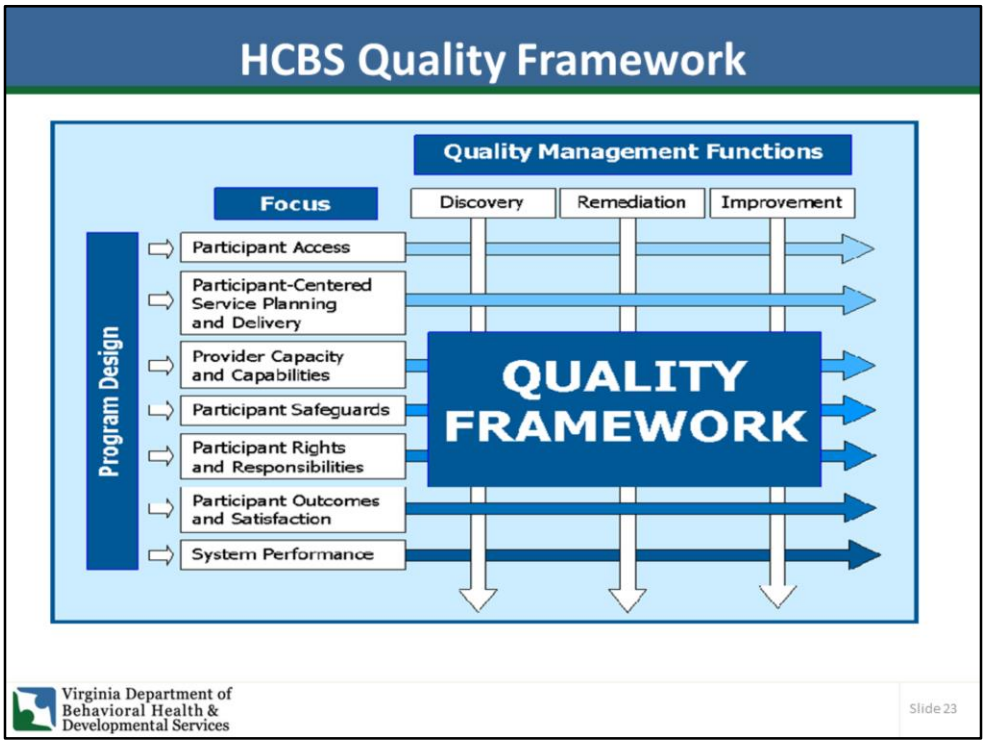
There are no requirements for how often or for the specific vehicle for obtaining this input. It should be determined by the provider as part of their quality management program. You can conduct a survey; in-person or via an online mechanism. Input from individuals receiving services and their authorized representatives would be specific to your organization. Then the organization needs to determine how best to use those results in terms of making improvements. As mentioned earlier in the presentation, one definition of quality is meeting or exceeding your customers' expectations.



On a quarterly basis all serious incidents should be reviewed to look for any possible trends, etc.

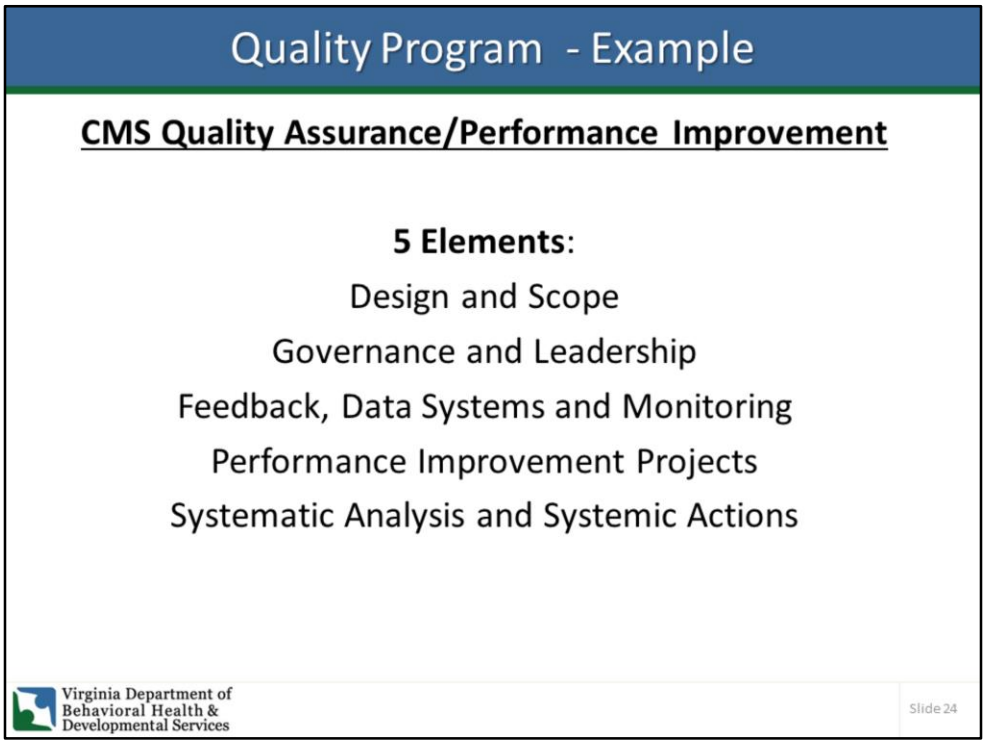


Compliance with 620 involves more than just saying you have a quality improvement plan. Your quality improvement program establishes how this is an ongoing effort. It is not a once and done.



As noted in the Guidance for a QI Program, if you a provider of group home, sponsored residential, supervised living residential, or day support services offered in the DD waivers, and you agency is currently engaged in efforts to come into compliance with the Home and Community Based Settings requirements, consider including those efforts into your QI program.

The Home and Community Based Services Quality Framework encompasses three functions:
Discovery: Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths, and opportunities for improvement.
Remediation: Taking action to remedy specific problems or concerns that arise.
Continuous Improvement: Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.



The CMS Quality Assurance Performance Improvement (QAPI) website provides excellent information on how to establish a quality program. While the QAPI program was developed for nursing homes, it can be adapted for purposes of any health care provider. The link to the CMS QAPI website is provided in the resources on the next slide. Please note that there are also other websites that provide quality improvement structures. This is just one example. Every organization is going to be at a different point in building a quality program. The QAPI site also includes a tool to utilize if you are just beginning to develop a quality program. The tool could also be used when you evaluate your program.

CMS outlines 5 key elements for a quality program.
Design and Scope:
- this might include a provider's mission/vision/values
- establish the structure (I.e. when/where the QI plan will be reviewed/updated)
- outline guiding principles related to quality improvement

Governance/Leadership – how the board/governance/leadership is committed to quality improvement.
Quality committee structure –

membership of the quality committee(s), (could be called council, workgroup, teams; this group would be seen as providing the backbone for the quality structure),
how often the quality committee meets,
who might chair (or co-chair) the quality committee;
Outline in a committee/council charter the responsibilities of the quality committee(s) such as reviewing/updating the plan, approving quality improvement projects or initiatives, etc.

Feedback, Data Systems, Monitoring
- what a provider wants to monitor
- how the provider will collect data
- how the provider will establish goals
- how data is used to drive decisions
- how feedback from customer satisfaction surveys are included

Quality Improvement Resources

Guidance on Corrective Action Plans

https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\720\GDoc_DBHDS_6875_v1.pdf

CMS Quality Assurance/Performance Improvement

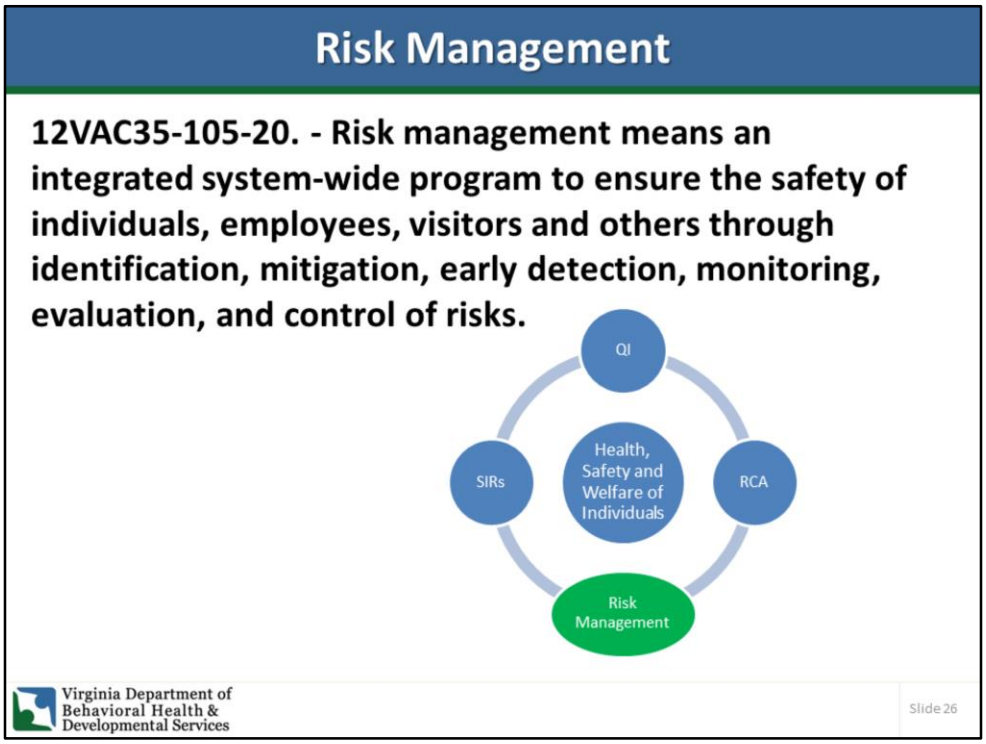
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessToolFramework.pdf

Home and Community Based Services Quality Framework

https://nasddds.org/uploads/documents/HCBSQualityFramework%28rev06-05%29.pdf

Guidance for Quality Improvement Program

https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\720\GDoc_DBHDS_6414_v3.pdf



Quality improvement focuses on achieving best possible outcomes; this can be achieved through examining and managing risks to the healthcare organization. By fostering a culture where healthcare providers are empowered to speak up, risk management involves using incident reports and other sources of information to manage risk, influence key decision makers, and ultimately impact health, safety and welfare of individuals served and quality outcomes.

12VAC35-105-520. Risk Management

A. The provider shall designate a person responsible for the risk management function who has completed department approved training, which shall include training related to risk management, understanding of individual risk screening, conducting investigations, root cause analysis, and the use of data to identify risk patterns and trends.

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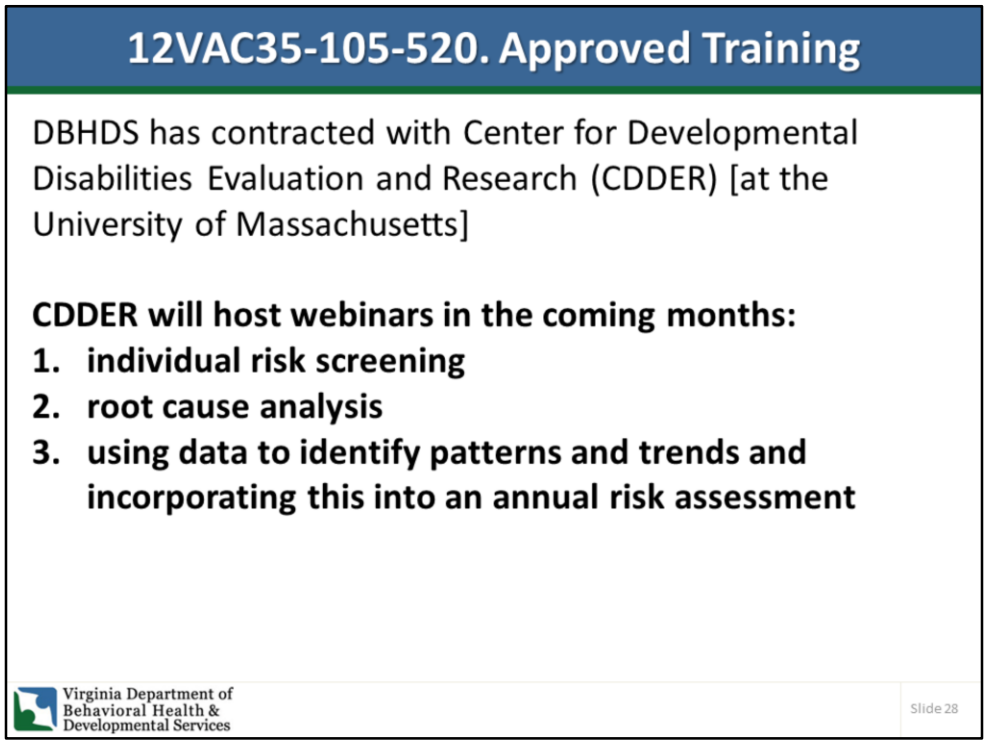
No two organizations are exactly alike when it comes to quality/risk management functions. It is often driven by the size of the organization, the services provided, etc. Each provider however shall designate a person responsible for risk management function.

As noted in the guidance document, these are minimum requirements, depending on the organization, the designated risk manager could require additional training related to other areas of potential risk to the provider (infection control, privacy, emergency management).



DBHDS has contracted with the Center for Developmental Disabilities Evaluation and Research (CDDER) [at the University of Massachusetts] to provide risk management training to providers. Within the next few months, CDDER will conduct a webinar on risk management processes for providers of developmental services. This will address conducting individual risk screening, root cause analysis, and using data to identify patterns and trends and incorporating this into an annual risk assessment. While this training is focused on developmental disability services, the concepts are applicable across disability areas.

12VAC35-105-520. Approved Training

DBHDS shall:

- post a crosswalk from training offered by the Office of Licensing to the components for training required in 520A

Provider shall:

- complete an attestation stating that the risk manager has completed the required training, including all essential components
  - attestation is then signed by the risk manager and the supervisor
  - attestations shall be available for review by OL Specialist or Investigator upon request

12VAC35-105-520. Risk Management

B. The provider shall implement a written plan to identify, monitor, reduce and minimize harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability.

- Written plan (reviewed and updated at least annually or any time that the provider identifies a need to review and update)
- A stand-alone document or integrated into the quality improvement plan

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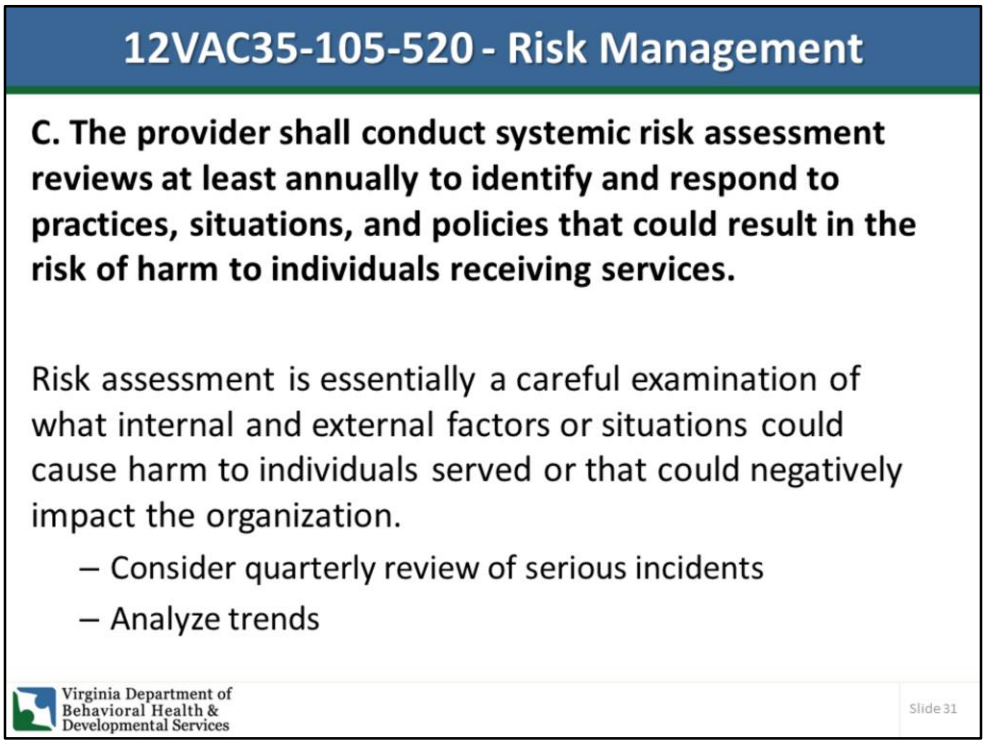
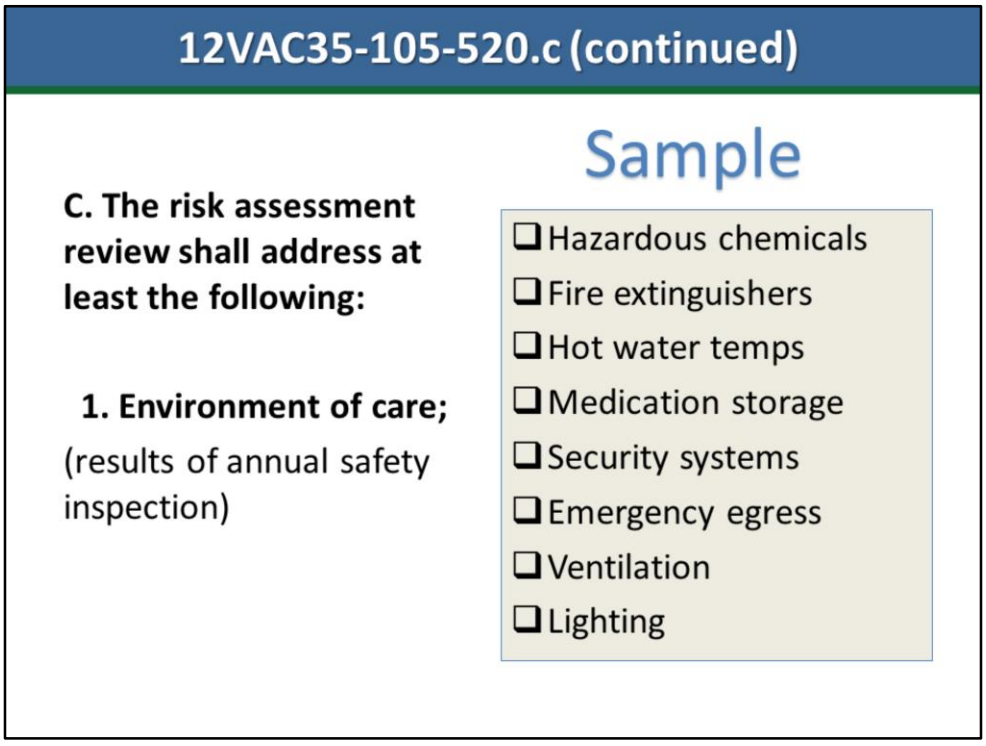
Providers should reference the Guidance for Risk Management (dated August 27, 2020) for additional information and guidance on what to consider when developing the risk management plan.

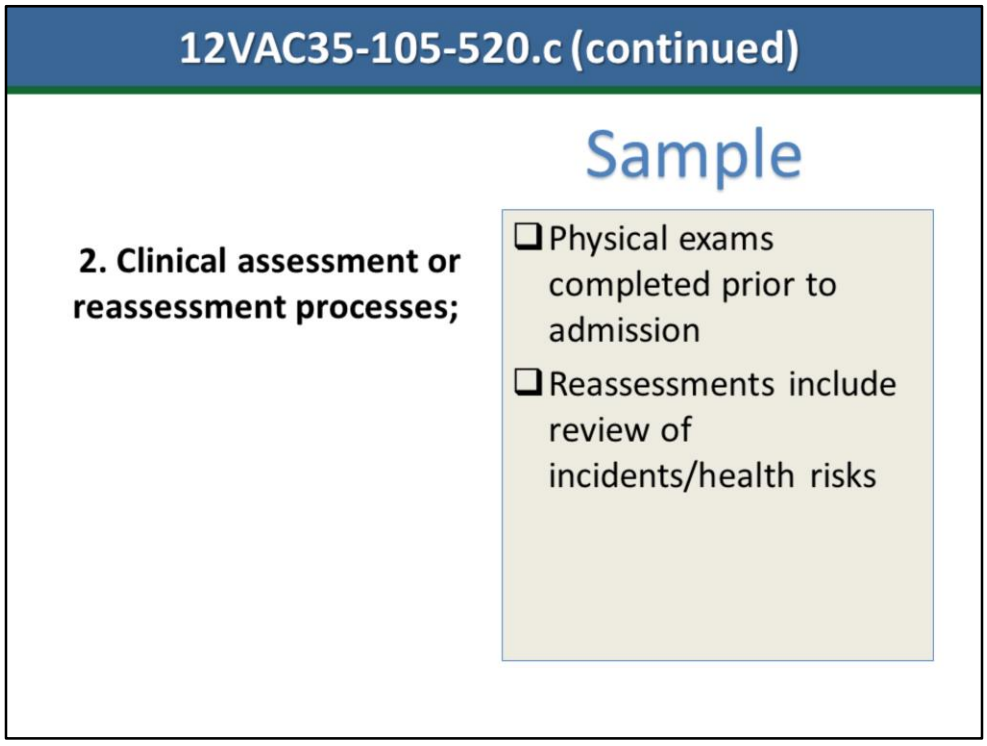


There is a wide range of potential risks – financial, privacy breaches, environmental hazards, etc.
Risk assessment is about being proactive and preparing for potential risks before incidents happen.



This is applicable to the type of provider and population served. Each provider would want to tailor to your organization. This is just a sample of items and certainly not all inclusive.

Please refer to the Guidance for Risk Management on the DBHDS Licensing website dated August 27, 2020 for more suggestions.



As noted in the Guidance for Risk Management, the person designated as responsible for the risk management function need not be engaged in the clinical assessment or reassessment process, but should review these processes during the risk assessment review process.

12VAC35-105-520.c (continued)

3. Staff competence and adequacy of staffing;

Sample

- ❑ Background checks
- ❑ CPR certification
- ❑ Abuse/Neglect and Exploitation Training
- ❑ Turnover rates

12VAC35-105-520.c (continued)

4. Use of high risk procedures, including seclusion and restraint; and

Sample

- ❑ High risk meds
- ❑ Seclusion/restraint
- ❑ Transfer procedures
- ❑ Training related to the above

12VAC35-105-520.c (continued)

5. A review of serious incidents (Refer to 160.C)

Reminder –

12VAC35-105-780.5 -

Provider shall review medication errors at least quarterly as part of quality assurance

Sample

- ❑ Quarterly review of serious incidents
- ❑ Annual review of serious incidents
- ❑ Identified trends or patterns

12VAC35-105-520.D.

D. The systemic risk assessment review process shall incorporate uniform risk triggers and thresholds as defined by the department.

DBHDS defined risk triggers and thresholds as care concerns through review of serious incident reporting conducted by the Incident Management Unit.

Below are the list of individual care concern thresholds:

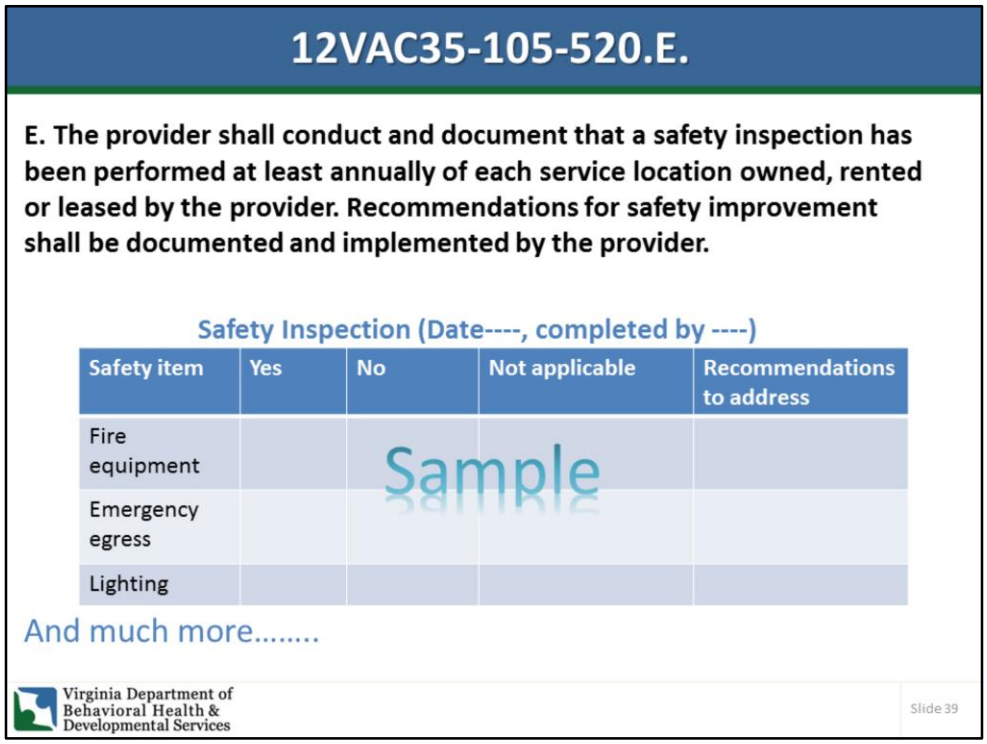
- Three (3) or more unplanned medical hospitalizations, ER visits or psychiatric hospitalizations within a ninety (90) day time-frame for any reason.
- Multiple (2 or more) unplanned medical hospitalizations or ER visits for the same condition or reason that occur within a thirty (30) day time-frame.
- Any combination of three (3) or more incidents of any type within a thirty (30) day time-frame.
- Multiple (2 or more) unplanned hospital visits for falls, choking, urinary tract infection, aspiration pneumonia, or dehydration within a ninety (90) day time-frame for any reason.
- Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity of level of a previously diagnosed decubitus ulcer, or diagnosis of a bowel obstruction diagnosed by a medical professional.

12VAC35-105-520.D.

Systemic risk assessment reviews shall include review of risk triggers that were met and whether they were addressed.

Example:

- Did provider review the care concerns and determine whether there was need for further action?
- If further action was needed, did it occur?
- If not, what were the barriers?
- If actions were implemented, did this mitigate further risks?



An annual safety inspection must be completed at each service location. A safety inspection checklist could be created which corresponds to the regulations.
When doing a safety inspection, involve staff. This provides a great learning opportunity as to "why" these items are being inspected and creates more ownership of all employees to report safety concerns, etc.

As noted in the summary of the quality improvement slides, action is then needed. Once a safety inspection is completed and any recommendations are documented, the provider should demonstrate that action was taken to implement as much as possible. Not all risks can be eliminated, but efforts should be made to mitigate as possible.

12VAC35-105-520.F.

F. The provider shall document serious injuries to employees, contractors, students, volunteers, and visitors that occur during the provision of a service or on the provider's property. Documentation shall be kept on file for three years. The provider shall evaluate serious injuries at least annually. Recommendations for improvement shall be documented and implemented by the provider.

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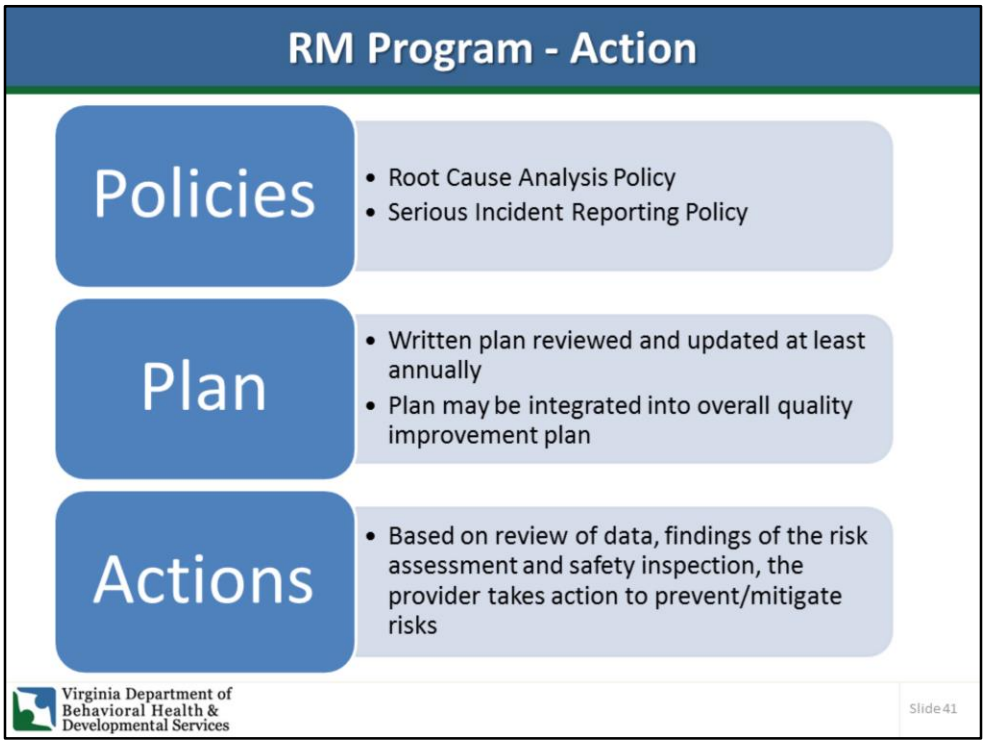
While everyone wants to prevent injuries, accidents do happen. Providers should document such injuries to anyone on their property, review at least on an annual basis, and make recommendations for improvement.

As noted in the Guidance for Risk Management, Level II incidents include a "significant harm or threat to the health or safety of others caused by an individual." Therefore, if a serious injury was caused by an individual to an employee, contractor, student, volunteer, or visitor during the provision of services or on the provider's premises, the serious injury should also be reported into CHRIS within 24 hours of discovery as a Level II serious incident.



Similar to the QM program summary noted above, risk management is about having policies and procedures, making a plan, and then taking steps or actions to mitigate or eliminate risks. There are many risks and this is not an exhaustive list but a provider should consider financial risks, workforce related risks, environmental, and much more.

Risk Management Resources

Guidance for Risk Management

https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\720\GDoc_DBHDS_6874_v3.pdf

Guidance on Corrective Action Plans

https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\720\GDoc_DBHDS_6875_v1.pdf

Guidance on Incident Reporting Requirements

https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\720\GDoc_DBHDS_6415_v2.pdf

Assuring Health and Safety for Individuals with DD

http://www.dbhds.virginia.gov/assets/doc/OIH/assuring-health-and-safety-for-individuals-with-dd.pdf