

QUALITY PLAN

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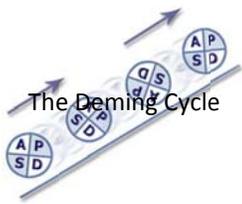
MISSION STATEMENT OF BEATRICE STATE DEVELOPMENTAL CENTER
Best Support for Dignity, Choice and learning for life

BSDC PILLARS
Community integration
Wellness and health
Safety
Dignity and respect
Stewardship
Stability

MISSION STATEMENT OF THE CQC/I TEAM

"The mission of the CQC/I team is to make quality a priority and to disseminate best practices across the campus of Beatrice State Developmental Center, in order to provide best support for dignity, choice, and learning for life" (Adapted from the Private Sector Council On Competitiveness, the Baldrige Quality Award)

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I. PREAMBLE

This document was created in collaboration with different leaders, managers, stakeholders, and senior members of BSDC and its ICFs. We obtained input at all levels, conducted literature and internet searches, and consulted with external sources in order to prepare the document. Also, we conducted a thorough review of Federal and State regulations, and considered all the recommendations from the Federal Department of Justice's (DOJ) Independent Examiner (IE) Team. We wish to thank all those who assisted us in developing this BSDC Quality Plan.

II. DEFINITIONS

II.1. Quality: BSDC's definition of quality is:

"Meeting or exceeding the expectations of people we support and serve, their families, guardians, and friends, and those of people who provide the service and support".

II.2. Quality indicators: These are measurable variables that reflect the performance (negative or positive) in a desired quality domain (e.g., respect and dignity). It should be noted that death and hospitalization, for example, are not in themselves quality indicators. Instead, they are outcomes of one or several quality indicators. Similarly, peer-to-peer (P-2-P) aggression and choking episodes, when preventable, are negative outcomes of proper medical, psychiatric, and/or psychosocial intervention strategies. These quality indicator outcomes follow the processes identified under Serious Reportable Incidents in the BSDC Policies and Procedures Manual.

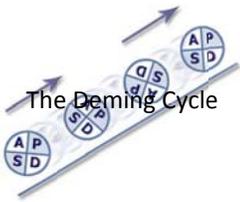
II.3. Observation period (OP): This represents the duration of observation for a particular quality measure. Typically, an OP is a quarter.

II.4. Baseline rate: Proportion of individuals with a target quality measure during a predefined observation period. Denominators vary depending on the measure of interest.

II.5. Benchmark rate: The established quality indicator rate for similar population. Since published benchmarks are mostly annual prevalence and the observation periods often are quarters. Therefore, quarterly rates of a particular quality indicator are annualized in order to compare them to benchmark rates.

II.6. Target rate: Pre-defined quality indicator measure during an observation period. Target rates are set to be better (higher for positive, and lower for negative outcomes) than benchmarks, when available, or significantly improved (rightly trending) over baseline rates when benchmarks are not established.

II.7. Trending: Slope of a measure vs. time curve. Trending (upwards for positive measures and downwards for negative ones) is considered relevant if change is considered non-random (i.e. true signal and not "measurement noise or artifact"). The determination of significant/relevant is based on appropriate statistical techniques (e.g., regression analysis).

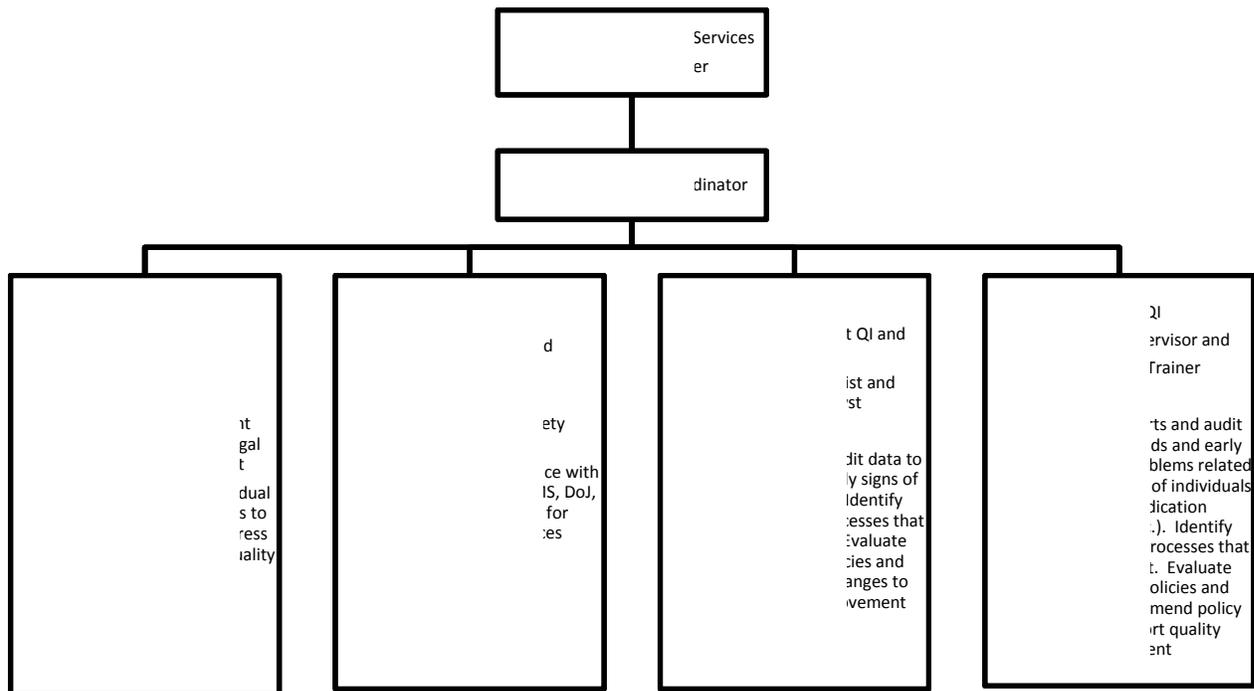


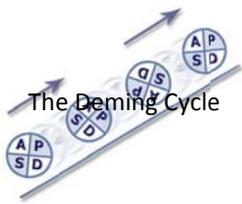
III. ORGANIZATIONAL STRUCTURE OF THE CONTINUOUS QUALITY CONTROL AND IMPROVEMENT TEAM

The BSDC Quality Improvement Department is overseen by the Deputy CEO for Indirect Services, who serves as the chief quality officer. The department is divided into two sections, habilitative and medical. The Quality Assurance Coordinator oversees the habilitative division which audits and monitors:

- A) Quality at the individual level, i.e., programs and plans to support the individual's progress towards independence and improved quality of life
 - B) Compliance with all regulatory agencies (CMS, DoJ, etc.) and identify areas for improvement of services
 - C) Incident, injury and investigation data to identify trends, early signs of potential problems, training needs, and processes that need improvement.
- Compliance with policies is also evaluated, and policy changes to support quality improvement are identified and recommended.

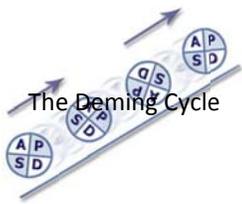
The Clinical Nurse Supervisor, in consultation with the medical department reviews processes and procedures to ensure the highest quality of medical care is maintained. This division reviews medical charts, audit data, and reports to identify trends, early signs of potential problems related to the medical needs of individuals (i.e., infections, medication administration, pressure ulcers, etc.), training needs, and processes that need improvement. Policies and procedures are evaluated. Policy changes to support quality improvement are recommended.





IV. FUNCTIONS OF THE ORGANIZATIONAL CONTINUOUS QUALITY CONTROL & IMPROVEMENT TEAM

- IV.1.** To develop the CQC/I team
- IV.2.** To design processes for optimal care and support, through
 - IV.2.a.** Training
 - IV.2.b.** Incident management
 - IV.2.c.** Monitoring for compliance and standards
 - IV.2.d.** Quality assurance (QA- residential and medical)
 - IV.2.e.** Analyzing
 - IV.2.f.** Annual plans for ongoing improvement of rendered services
- IV.3.** To oversee proper development of CQC/I plans through
 - IV.3.a.** FOD (fidelity of development), i.e. developing plans, which meet the following requirements:
 - IV.3.a.1.** Contextually, are true to the mission and vision of BSDC
 - IV.3.a.2.** Incorporate recommendations from all stakeholders
 - IV.3.a.3.** Are designed based on proper environmental scans and SWOT analyses
 - IV.3.a.4.** Are anticipated to provide measurable and tangible results
- IV.4.** To analyze
 - IV.4.a.** Ongoing measurements of organizational processes
 - IV.4.b.** Ongoing measurements of organizational outcomes
 - IV.4.c.** Ongoing measurements of service processes
 - IV.4.d.** Ongoing measurements of service outcomes
- IV.5.** To identify
 - IV.5.a.** Quality priorities and objectives
 - IV.5.b.** Proper quality tools (e.g., check lists, Pareto charts, fishbone graphs, scorecards, scatter plots, correlation graphs, satisfaction survey data and results, etc.)
 - IV.5.c.** Quality metrics, i.e. benchmarks, when available, quality targets, and measurable outcomes
 - IV.5.d.** Trends and patterns



IV.5.e. Improvement opportunities

IV.5.f. Early warning signs

IV.6. To formulate actions plans that are:

IV.6.a. Preventive

IV.6.b. Interventive

IV.6.c. Remedial

IV.7. To establish

IV.7.a. Timelines

IV.7.b. Expectations

IV.7.c. Accountabilities

IV.8. To monitor proper implementation of plans through FOI (fidelity of implementation), i.e. monitoring plans for effectiveness

IV.9. To implement

IV.9.a. Annual campus-wide self assessment

IV.9.b. Annual customer (individuals, guardians, families, friends, etc.) satisfaction surveys

IV.10. To facilitate shared learning and collaboration through

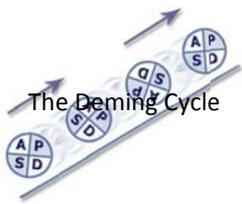
IV.10.a. Internal and external communications

IV.10.b. Education and training activities

V. GENERAL AND MEDICAL QUALITY DOMAIN METRICS

There are several principles that guide the development and evaluation of quality domain metrics (quality indicators). They are:

- Quality indicators address service provision quality at the facility level (systemic).
- Quality indicators address service provision quality at the individual's level (personal outcomes)
- Quality indicators are useful for comparisons against external quality metrics and benchmarks.
- Operational criteria/definitions are well established.
- Data elements (n, N) used are clearly specified, measurable (e.g., number of individuals who receive communication assistance based on needs defined in the IPP), well defined, and easy-to-understand.
- Data (qualitative and quantitative) collection methods are defined and consistently applied.
- Training on data and data collection methods should be established and ongoing.



VI. Calculation methods for data aggregation and data elements combinations are defined a-priori to assure consistency and avoid biases.

VII. GENERAL AND MEDICAL QUALITY INDICATORS DOMAINS

The quality indicators were selected to answer specific questions regarding the services and supports provided at BSDC. The domains are listed below; with a sample of indicators for each domain. For a complete listing of indicators and how they are measured, please refer to the Indicator Dictionary.

- VII.1.** Are individuals safe?
- VII.2.** Are individuals healthy?
- VII.3.** Are individuals supported to meet their personal goals?
- VII.4.** Are individuals treated with dignity and respect?
- VII.5.** Are employees following policies and procedures?
- VII.6.** Are employees cared for, respected and supported?
- VII.7.** Is BSDC the employer of choice in the Gage County area?

VII.8. Are individuals Safe?

VII.8.a. Proportion of individuals who are free from any form of physical abuse². Based on a review of reports of abuse and the investigations performed. Goal: 100%

VII.8.b. Portion of individuals who are free from any form of abuse, other than physical (e.g., verbal, emotional, psychological). Based on reports of abuse and the investigations performed. Goal: 100%

VII.8.c. Portion of individuals who are free from any form of neglect. Based on reports of neglect and the investigations performed. Goal: 100%

VII.8.d. Individuals are free from peer-to-peer aggression. Goal: 100%

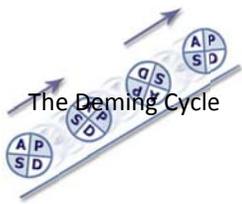
VII.8.e. Portion of individuals who are free from unexplained, reportable injury. Based on review of incident management database. Goal: 100%

Note: Each investigation is analyzed to determine the root cause of the incident regardless of the outcome of the investigation. Staff actions, training needs, communication issues, and other systemic issues are identified and corrective action plans created to address issues.

VII.8.f. Portion of individuals who feel safe and know how to report a situation in which they are being harmed. This data is collected through a quarterly interview process. All individuals are interviewed. Communication with people who are non-verbal is through a variety of methods based on the ability and the situation for each individual. Goal: 100%

VII.8.g. See Indicator Dictionary for complete listing.

²For the purpose of QI reporting, sexual abuse is considered a form of physical abuse.



VII.9. Are Individuals are Healthy?

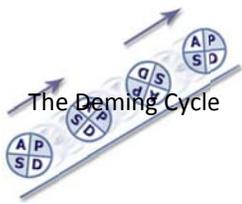
- VII.9.a.** Portion of dental examinations which rated quality of oral hygiene as good. Goal: 100%
- VII.9.b.** Rate of hospital or emergency room repeat transfers for treatment of same or related condition. Goal: 0%
- VII.9.c.** Infection rates (BSDC and its ICFs, with the assistance of the Infection Control Committee and the Medical Services Unit (MSU) monitor infections and infection rates based on established practices.³ All infections are reported to the MSU quarterly. In addition, key infections (pneumonia, UTI, MRSA, C-difficile infections, conjunctivitis, otitis media) are reported. Ongoing infections, for which patients receive suppressive therapy, in the absence of an acute exacerbation, are not included in the surveillance process. Target annual rate= 6.99/1,000 patient-days for all infections, 1.69/1,000 patient-days for key infections.⁴
- VII.9.d.** BMI Greater than 29. Goal: 0%
- VII.9.e.** See Indicator Dictionary for complete listing.

VII.10. Are Individuals supported in their personal goals to achieve independence?

- VII.10.a.** Individuals experience recreational activities in a community setting, based on their choices, needs, strengths and ability as defined in the IPP. Goal: 100%
- VII.10.b.** Individuals have the opportunity to work in a community setting. Goal: 40%
- VII.10.c.** Individuals receive the necessary support to make progress toward goals. Goal: 100%
- VII.10.d.** Individual's goals reflect the desires and interests of the individual. Goal: 100%
- VII.10.e.** Individuals participate in an activity to experience an alternative living environment to learn about other service providers to assist them in making informed choices. Goal: 80%
- VII.10.f.** Individuals with Behavior Support Plans (BSP) will graduate behavioral objectives within the designated timeframe. Goal: 25% per quarter
- VII.10.g.** Individuals with BSP who had psychiatric/psychoactive medications reduced due to meeting graduated behavior objectives that previously required medication. Goal: 20% per quarter
- VII.10.h.** See Indicator Dictionary for complete listing.

³From McGeer et al. (see **Section XII** for full citation)

⁴Previous year mean minus one standard deviation



VII.11. Are individuals treated with dignity and respect?

- VII.11.a.** During quarterly audits, observations are made throughout the day in all settings to determine if individuals are treated with dignity and respect. Examples of what the auditor is looking for include: staff talk and interact with individuals in a positive manner, people-first terminology is used, normal conversational tone is used, attention to obvious needs, clothing adjusted to assure privacy, mealtime is family style and all eat at the same time. Goal: 100%
- VII.11.b.** Each individual is provided opportunities to have an active social support network. This is measured by contact with family, guardian, friends, or others close to the individual who are not paid staff. Contact can be in person, verbal exchange or written exchange.
- VII.11.c.** Reduction in the number of behavior support plans with restrictive procedures. Goal: 20% per quarter
- VII.11.d.** See Indicator Dictionary for complete listing.

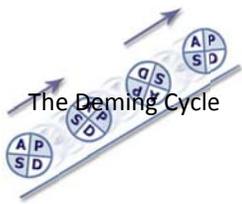
VII.12. Are employees following policies and procedures?

- VII.12.a.** Each ICF/ID will ensure compliance with the zero tolerance policy for any substantiated abuse or neglect. Goal: 100%
- VII.12.b.** All investigative reports regarding abuse or neglect will be completed by the 5th working day. Goal: 100%
- VII.12.c.** Individual's points of service plans are carried out and supported as written. Goal: 100%
- VII.12.d.** See Indicator Dictionary for complete listing.

VII.13. Are employees cared for, respected and supported?

- VII.13.a.** Employees who report suspected abuse or neglect are not subjected to retaliation. If an employee has concerns, safeguards will be put in place for the employee. Goal: 100%
- VII.13.b.** Minimize staff injuries that result from interaction with individuals (i.e., lifting individuals, transfer/reposition, Mandt or restraint related, behavior incident related).
- VII.13.c.** Reduce and eliminate mandatory overtime to 0%
- VII.13.d.** See Indicator Dictionary for complete listing.

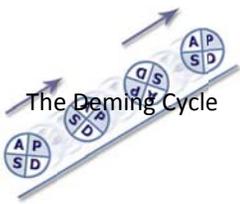
VII.14. Is BSDC the employer of choice in the Gage County area?



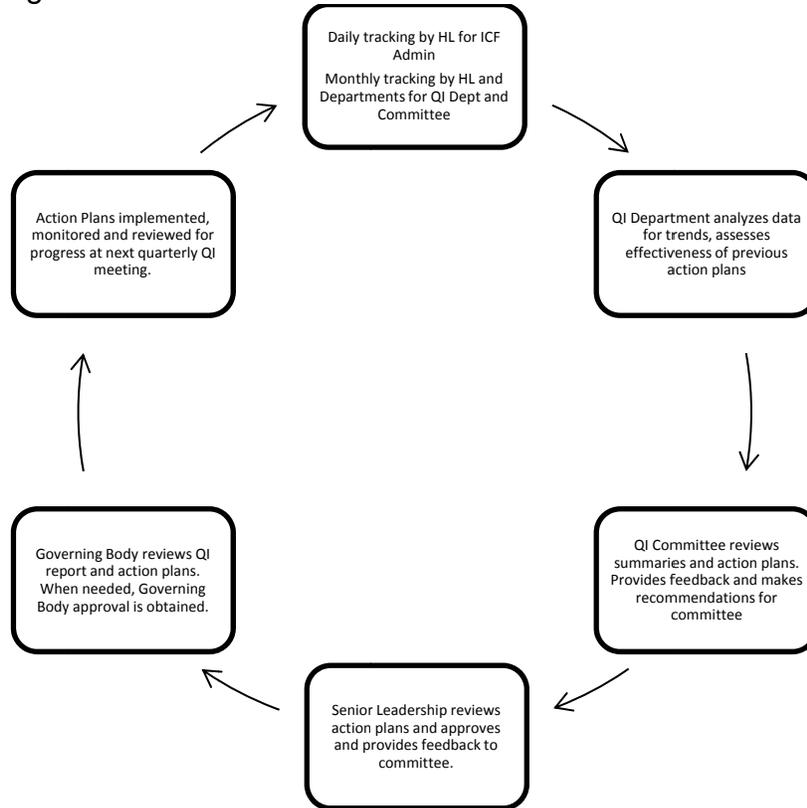
- VII.14.a.** Evaluation of the number of applications vs. the number of people hired – is there a good applicant pool?
- VII.14.b.** Reduction in staff vacancy rates
- VII.14.c.** Reduction in staff turnover rates (voluntary turnover)
- VII.14.d.** Reduce staff overtime rates
- VII.14.e.** Image management – ensure that the positive events at BSDC are publicized through one positive newspaper article, radio announcement, or TV broadcast each quarter.
- VII.14.f.** See Indicator Dictionary for complete listing.

VII.15. Quality assurance, improvement, and monitoring all are subcomponents of total quality management (TQM), and they are performed at all levels, specifically, 1:1 between support providers and individuals, 1:1 between support providers and their supervisor (s) within a home, within an ICF, at the department level, and organizationally. They each address the various angles of quality. Therefore and expectedly, afore-mentioned quality management levels have overlapping strategies and functions. It is expected that the three major levels of quality management have CQC/I plans that are developed annually and reviewed periodically, at each level and among levels, for ongoing improvement, shared-lessons, and integration.

Level	Location	Accountability	Frequency	Activities	Main objectives other than individual's safety, rights and wellbeing
I	Home	Direct Support Shift Supervisor Home Manager	Daily	<ul style="list-style-type: none"> •Observations •Immediate Corrective actions •Monitoring •Reporting to Administrator 	<ul style="list-style-type: none"> •Real-time interventions •Compliance
IIa	ICF	Aministrator	Weekly Monthly Quarterly Annually	<ul style="list-style-type: none"> •Monitoring •Data analysis •Data trending •Shared Lessons •Short/long term corrective actions •Reporting to QI Committee 	<ul style="list-style-type: none"> •Preemption and prevention •Integration •Compliance
IIb	Department	Director	Weekly Monthly Quarterly Annually	<ul style="list-style-type: none"> •Monitoring •Data analysis •Data trending •Shared Lessons •Short/long term corrective actions •Reporting to QI Committee 	<ul style="list-style-type: none"> •Preemption and prevention •Integration •Compliance
III	BSDC	CQC/I Team Depute CEO, Indirect Services	Monthly Quarterly Annually	<ul style="list-style-type: none"> •Monitoring •Data trending and analysis •Data mining •Long term solutions •CQI training •Reporting to Senior Cabinet 	<ul style="list-style-type: none"> •Systems improvement •Compliance •Continuing education and training

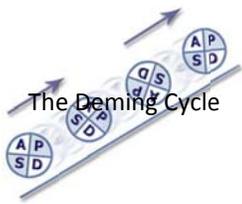


The interaction between the different departments can be illustrated through the following diagram:

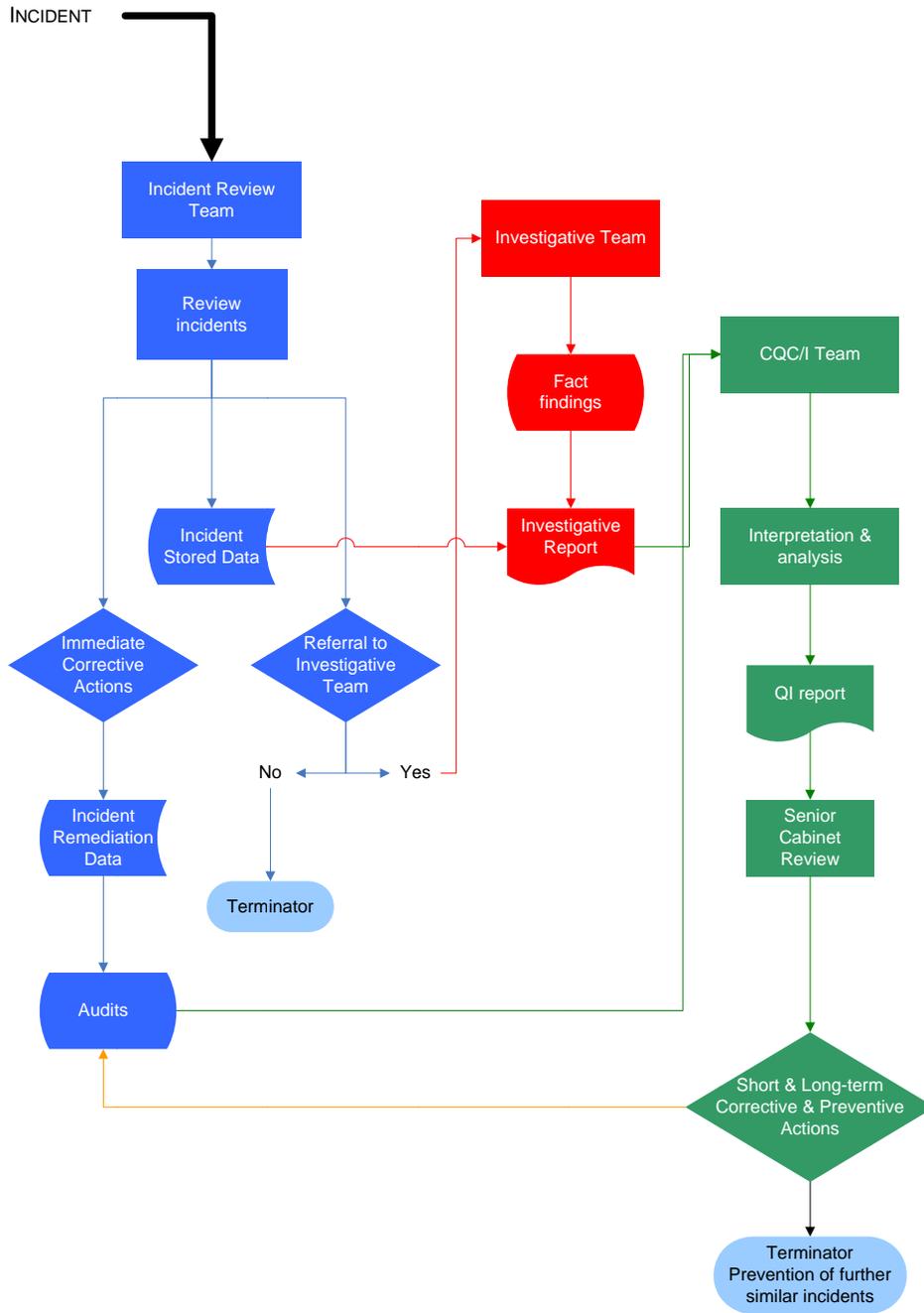
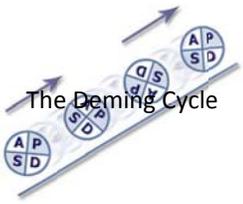


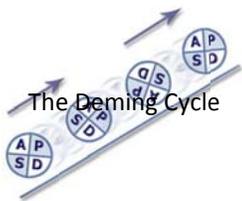
Data is tracked on several different levels:

- The Home Leader and shift supervisors perform daily QI check for the ICF Administrators, and provide daily feedback. Corrective actions are taken immediately.
- The Home Leader and other departments perform monthly checks and report data to the ICF Administrators and departments affected by the findings for corrective actions, and quarterly to the QI Department for analysis. QI Department analyzes incidents on a monthly basis and if trends or patterns are noted, the ICF Administrator and IDT are notified.
- The QI department analyzes data on a quarterly basis, tracks and trends, reviews for systemic issues.
- Initially quarterly indicators will be reviewed and adjusted as needed. Annually, all indicators are reviewed and adjusted to evaluate the goals established by the organization.
- Tracking and trending is conducted at the ICF level for each ICF as well as tracking and trending for the BSDC campus as a whole.



- VII.16.** Annually, or more frequently as is deemed necessary, the Quality Assurance Coordinator meets with each department manager and ICF Administrator to guide and assist them in developing their QI plans. The Quality Assurance Coordinator queries each manager or director about quality processes in their area. Also, managers and directors are asked, among others, about their quality goals, quality indicators (QI), quality measures, metrics, definitions of quality successes and failure, and lessons-learned from past years. Subsequently, ICF- and departmental-level Quality Plans are developed and/or modified.
- VII.17.** Quality is achieved when the Mission of BSDC and its ICFs is met. In order to do so, maintaining compliance with policies, practice standards, CMS regulations, and the DOJ settlement agreement are essential. This is accomplished through audits and monitoring that Home Leaders, Clinical Nurse Trainers, Supervisor and others conduct. The results of such audits, which are conducted regularly, are shared and discussed with the departmental directors, the ICF Administrators, the IDT leaders, the QI Coordinator, and others as appropriate. Immediate concerns are addressed through action plans (AP), deliverables and timelines for resolution, and the outcomes of these APs are monitored by the ICF Administrator, Departmental Directors, the CQC/I Committee, and Senior Leadership. Disagreements on corrective actions, APs, or audit results are brought to the attention of the Depute CEO for Indirect Services for mediation and resolution.
- VII.18.** Audits, monitoring results, corrective actions, and APs are aggregated and presented at the QI Committee regularly-scheduled meetings.
- VII.19. Incident Management:** Quality is achieved both through preventive (anticipatory) and reactive (remedial) strategies. When an incident occurs, which is expected as “*To err is human*” (IOM), improvement (s) is/are needed to be instituted in order to address the immediate consequences of the Incident and mitigate future occurrences. All members of the Quality Team collaborate and jointly plan to address the incident, once it has occurred. The diagram shown below depicts the interactions between the various teams to address an incident.





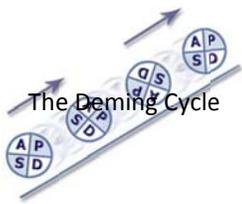
VIII. ORGANIZATIONAL CONTINUOUS QUALITY CONTROL AND IMPROVEMENT REVIEWS AND PROCESSES

VIII.1. Review Cycles for CQC/I

- VIII.1.a. Quarterly,**
- VIII.1.a.1.** To monitor quarterly-reported quality indicators
- VIII.1.a.2.** To follow up on action plans from previous meetings, and/or those submitted by ICF Administrators and Departmental Directors, with the goal of ensuring proper implementation and compliance with stated actions
- VIII.1.a.3.** To follow up on plans of correction from previous meetings, and/or those submitted by ICF Administrators and Departmental Directors, with the goal of ensuring proper implementation and compliance with stated actions
- VIII.1.a.4.** To address action items identified in previous meetings.
- VIII.1.b. Annually,**
- VIII.1.b.1.** To monitor annually-reported quality indicators
- VIII.1.b.2.** To follow up on action plans, plans of correction, and action items from previous meetings during that calendar year
- VIII.1.b.3.** To assess annual quality performance, based on benchmarks, targets, quality indicators, incident management reports, investigations, and others as appropriate
- VIII.1.b.4.** To establish strategic directives for the upcoming calendar year
- VIII.1.b.5.** To revise, when necessary, target rates
- VIII.1.b.6.** To introduce, when necessary, new compliance and/or QI measures and metrics.
- VIII.1.c.** When needed, as advised by the Depute CEO for Indirect Services.

VIII.2. Senior Leadership: Recommendations from the CQC/I committee are submitted to Senior Leadership for review and consideration.

VIII.3. Monitoring and Follow-up: Approved recommendations, action plans and plans of corrections are tracked regularly as above-indicated. Corrective and Action Plans that fail to reach the desired goal are addressed through the Administrative Review process that the QA Coordinator monitors, and which include one or more members of Senior



Leadership.

IX. MEDICAL CONTINUOUS QUALITY CONTROL & IMPROVEMENT (MQ)

"We are what we repeatedly do. Excellence, then, is not an act but a habit" (Aristotle)

The medical QI process is monitored by the BSDC CQC/I committee and by the Medical Services Unit. A detailed technical review is conducted by the medical services unit and reported to the CQC/I committee and monitored through the medical quality indicators.

MQ I. MISSION STATEMENT OF THE MEDICAL SERVICES UNIT

The Medical Services Unit at BSDC is committed to excellence in providing person-centered, standards-based, innovation-driven, and outcomes-focused medical quality care to individuals we serve.

MQ II. DEFINITIONS

II.1. Quality care: (adopted from the Institute of Medicine's definition)

"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".

II.2. Medical quality indicators (MQI): Medical quality indicators are measures, both preventive (PQI) and interventive (IQI), which are markers of medical services provision by a health provider or at a health institution/facility. Quality indicator measures could be positive –higher rates are indicators of good medical quality (e.g., rates of antithrombotic agent utilization for people with cardiovascular risks, rates of completed and indicated immunizations) or negative –higher rates are indicators of undesirable medical quality (e.g., rates of medical restraint utilization, rates of polypharmacy use for people with non-intractable epilepsy).

MQ III. APPROACH TO MEDICAL QUALITY

The approach to medical quality at the Medical Services Unit is:

III.1. Planned, based on published standards, collaboration across disciplines and department, and data

III.2. Systematic, utilizing standard quality tools and metrics, and relevant statistical methods

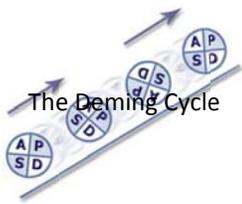
III.3. Person-centered

III.4. Systemic, i.e. using aggregate data to plan, do, study, and act at all levels (individual → home → ICF → departmental → campus → Division)

MQ IV. METHODOLOGIES

IV.1. Process design

IV.2. Training on medical issues to non-medical care/support providers, i.e. ongoing translation to support staff of:



IV.2.a. The what, when, and how to observe for medical signs, red flags, early warnings, etc.

IV.2.b. The when and how to intervene and/or seek assistance, and

IV.2.c. The what, when, how, and to whom to report needed information

IV.3. Ongoing data collection

IV.3.a. Synchronous, which is highly desirable if available

IV.3.b. Asynchronous

IV.4. Monitoring of medical quality indicator (MQI) data (data accuracy, reliability and consistency)

IV.5. Analysis, interpretation, trending, and mining of MQI data

IV.6. Developing improvement and implementation strategies to reach desired outcomes

IV.7. Monitoring of implementation and improvement strategies (FOI) through quality monitoring tools such as audits and peer reviews

MQ V. MACRO-LEVELS OF MEDICAL QUALITY CONTROL AND COMMITMENT

V.1. Divisional-Departmental (e.g., Speech)

V.2. Departmental-Institution Divisional (e.g., Nursing)

V.3. Institution Divisional-Institutional (e.g., Medical Services)

MQ VI. MEDICAL QUALITY INDICATORS DIMENSIONS

VI.1. Physical Health and wellbeing

VI.2. Mental health and wellbeing

MQ VII. MEDICAL QUALITY INDICATORS AND DOMAINS

Medical quality indicators are governed by the Three “S” principles, i.e. (a) applying **S**tandards of medical practice; (b) ensuring **S**afety; and (c) optimizing **S**taff support to meet the medical needs of the individuals. Please see Indicator Dictionary for complete listing.

VII.1. Standards of care

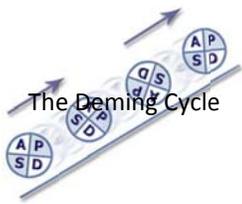
VII.1.a. Rates of antipsychotic polytherapy.⁵ (Annual reporting to Organizational CQC/I and quarterly to Medical Services and others as appropriate, e.g., Pharmacy and Therapeutics Committee)

VII.1.b. Rates of constipation.^{6,7,8} (Annual reporting to Organizational CQC/I and quarterly to Medical Services)

⁵Negative quality indicator measure

⁶Rome criteria (see **Section XIII.1**)

⁷Negative quality indicator measure



- VII.1.c.** Rates of laxative and/or prokinetic polytherapy for constipation.⁹ (Annual reporting to Organizational CQC/I and quarterly to Medical Services and others as appropriate, e.g., Pharmacy and Therapeutics Committee)
- VII.1.d.** Rates of antiepileptic drug (AED) polytherapy.¹⁰ (Annual reporting to Organizational CQC/I and quarterly to Medical Services and others as appropriate, e.g., Pharmacy and Therapeutics Committee)
- VII.1.e.** Rates of intractable epilepsy.^{11,12} (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.1.f.** Proportion of individuals with intractable epilepsy who either did not undergo neuro-stimulative (e.g., VNS) or –ablative interventions, or have not been considered for one or the other.¹³ (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.1.g.** Anti-thrombotic medication (s) utilization rates for people with moderate to high CV (cardiovascular risks), unless medically-contraindicated. (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.1.h.** Rates of required, scheduled immunizations. (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.1.i.** Rates of completed annual physical examinations within 30 days of scheduled date. (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.1.j.** Rates of completed annual dental examinations within 30 days of scheduled date. (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.1.k.** Adherence to screenings/monitoring schedules, based on external guidelines (e.g., MHQP)¹⁴ and internal procedures.¹⁵ (Annual reporting to Organizational CQC/I and quarterly to Medical Services)

⁸Primary care providers will identify and report to Lana Criner all individuals who meet Rome’s criteria for constipation and every annual, and at the quarterly reviews if such a diagnosis is established during that period.

⁹Negative quality indicator measure

¹⁰Negative quality indicator measure

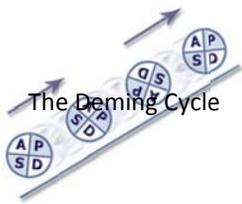
¹¹Defined as having >10 seizures per year and one of: (a) ≥ 2 AEDs, at optimal doses, for seizure control; (b) neuro-stimulative device such as VNS

¹²Negative quality indicator measure

¹³Negative quality indicator measure

¹⁴Examples are: Diabetes mellitus (HbA1c screens, HbA1c <7.5-8.0 in patients with DM); cancer (colorectal, breast, cervical, prostate); DSDS for patients with Trisomy 21 over 40 y old.

¹⁵Annual Health Risk Screen [HRS]; Annual Spine and Gait Screen [SGS]; Annual Physical Nutritional Management Screen [PNMS] or enteral feeding screen [EFS] if on enteral feeding regimen; Annual Behavioral Problems Inventory [BPI]; Quarterly AIMS, when applicable; Quarterly medication reviews; Required periodic nutritional assessments; Required periodic expanded (beyond routine physical examination) visual and auditory assessments.



- VII.1.i.** Compliance with T- and DDM internal guidelines. (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.1.m.** Rates of obesity.¹⁶ (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.1.n.** Rates of medically-diagnosed malnutrition.¹⁷ (Annual reporting to Organizational CQC/I and quarterly to Medical Services)

VII.2. Safety.

- VII.2.a.** Infection rates¹⁸
BSDC and its ICFs, with the assistance of the Infection Control Committee and the Medical Services Unit (MSU) monitor infections and infection rates based on established practices.¹⁹ All infections are reported to the MSU quarterly. In addition, key infections (pneumonia, UTI, MRSA, C-difficile infections, conjunctivitis, otitis media) are reported to the organizational CQC/I annually, or more frequently as necessary. Ongoing infections, for which patients receive suppressive therapy, in the absence of an acute exacerbation, are not included in the surveillance process. (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.2.b.** Medication error rates^{20,21} (see Medication errors rates for 2011 in **Section XIII** below). (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.2.c.** Medication errors with harmful outcomes. (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.2.d.** Fall rates.^{22,23} (Annual reporting to Organizational CQC/I and quarterly to Medical Services)
- VII.2.e.** Pressure ulcer rates.²⁴ (Annual reporting to Organizational CQC/I and quarterly to Medical Services)

¹⁶Negative quality indicator measure

¹⁷Negative quality indicator measure

¹⁸Negative quality indicator measure

¹⁹From McGeer et al. (see **Section XII** for full citation)

²⁰Medication error: This refers to any error made in the process of prescribing, transcribing, dispensing, or providing a drug or treatment whether or not any adverse consequences occurred.

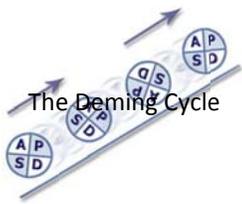
²¹Negative quality indicator measure

²²Fall as defined by Kellogg International Working Group. An event which results in an a person coming to rest, non-purposely to the ground or other lower level and is not the result of the following:

1. sustaining a violent blow,
2. loss of consciousness,
3. sudden onset of paralysis, as in a stroke,
4. or an epileptic seizure

²³Negative quality indicator measure

²⁴Negative quality indicator measure



- VII.2.f.** Rates of physical or mechanical restraints for aberrant behaviors.²⁵ (Quarterly reporting to Organizational CQC/I and Medical Services)
- VII.2.g.** Rates of chemical restraints.^{26,27} (Annual surveillance for deviation from policy)
- VII.2.h.** Rates of medical restraints.²⁸ (Annual reporting to organizational CQC/I and quarterly to Medical Services)

VII.3. Staff Support

- VII.3.a.** Number of nursing, medical, allied health, psychology, and dentistry peer reviews during OP.
- VII.3.b.** Rates of timely (within 14 days) completion of written informed consents.
- VII.3.c.** Rates of timely evaluations of internal referrals.^{29,30}
- VII.3.d.** Annual guardian satisfaction scores. Target= $\geq 80\%$ of surveyed guardians and individuals, if applicable, are somewhat satisfied, satisfied, or extremely satisfied with the services provided for their wards.
- VII.3.e.** Continuing educations rates.
- VII.3.f.** Turnout numbers at medical emergency drills.

MQ VIII. MEDICAL QUALITY METRICS:

VIII.1. Medical Quality Indicators are based on published literature from various sources including the AHRQ and NQI. In order to optimize quality, baseline measures are established (e.g., rate of pressure ulcers per patient-days), observable rates are compared to baseline rates, are expected to right-trend when benchmarks are not established and/or will

²⁵Negative quality indicator measure

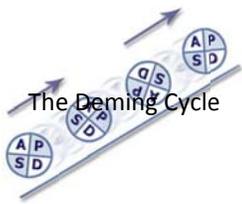
²⁶BSDC and its ICFs adopt the following definition of chemical restraint: The administration of a drug (a) for the management of a maladaptive, aberrant and/or violent behavior, which is unpredicted, and (b) that is not prescribed/ordered for a symptom or symptoms complex of an established mental illness. Medications used for behavioral crisis intervention are NOT considered chemical restraints. Another accepted definition of chemical restraint is unscheduled medication (s) use for control of aberrant or maladaptive behavior, which is not a symptom of an underlying Axis I mental illness.

²⁷Negative quality indicator measure

²⁸Negative quality indicator measure

²⁹This quality metric refers to timeliness. Missed appointments are detailed under **Sections VIII.9.k.** and **VIII.9.i.** of the Organizational Quality Section.

³⁰An initial analysis (3-4Q11) of the timeliness to response for Developmental Therapy appointments indicates that the mean \pm standard deviation are 8.74 \pm 6.30 days. An arbitrary target was initially set at 10 days and in view of the data, the Department was asked to consider a 5-day time-to-response target. Similar analyses will be conducted during CY2012 across all medical, dental, and clinical referrals in order to establish the baselines and targets for the timeliness-of-internal-referrals quality indicator.



be targeted for significant improvement over benchmarks rates, if available.

VIII.2. Quality, medical, residential, facility-based or home-based, cannot be achieved without proper collection, analysis, and interpretation of observable information (data). Therefore, appropriate statistical methods will be applied throughout the processes of studying data. The following are some examples of statistical techniques, which are used:

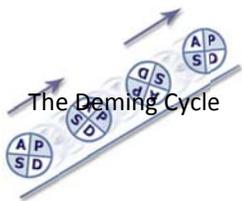
VIII.2.a. Descriptive statistics such as means, standard errors, confidence intervals, etc.

VIII.2.b. Comparative statistical analyses, such as hazard ratios, chi-square, independent proportion tests, analysis of variance, correlation analyses, etc.

VIII.2.c. Trend analyses such as CMH, regression, etc.

VIII.2.d. Outliers analyses

VIII.2.e. Others as deemed appropriate and relevant



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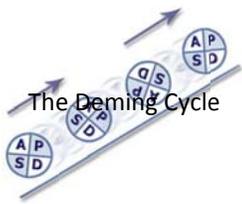
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