Larisa-
Good afternoon, and welcome to the Office of Licensing 2025 DD Inspections Kickoff Training! We thank you all for choosing to share your time with us today, and appreciate the opportunity to help prepare you for success as we enter into the new year together. Today's training has been developed specifically for licensed providers of developmental services that are required to comply with Chapter 105, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services.

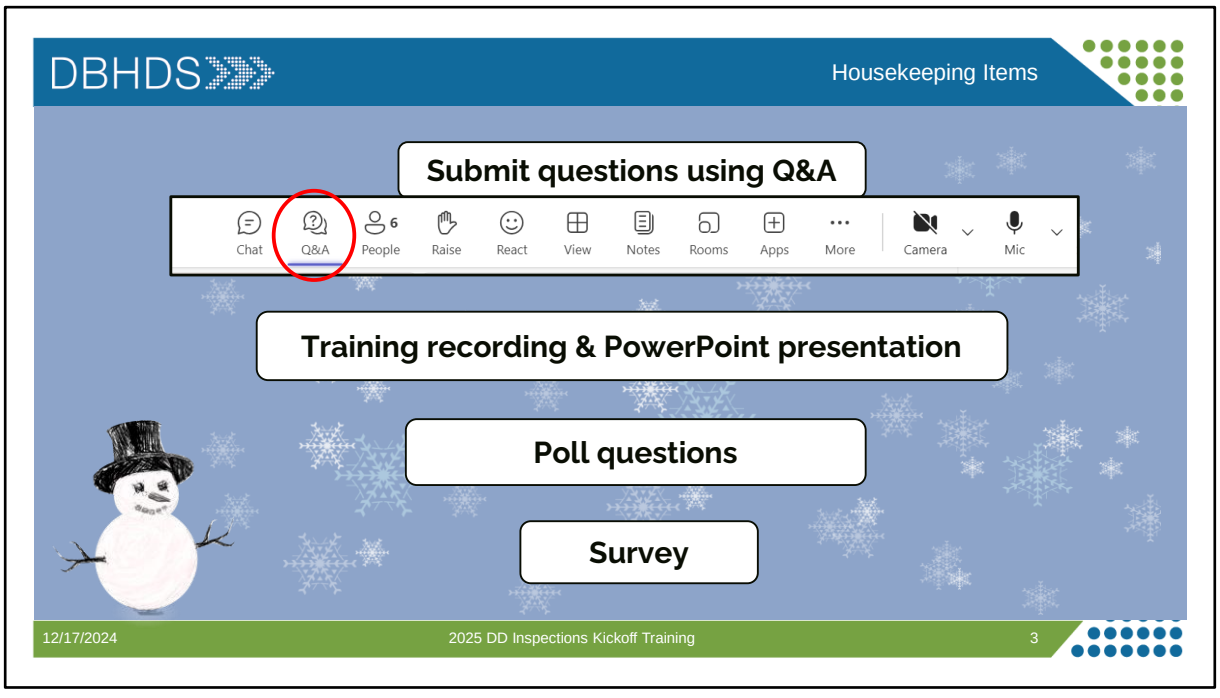
We want you to be successful- we want you to be prepared- and, most importantly, we want you to know what to expect when WE come knocking on YOUR door for your 2025 Annual Unannounced DD Inspection.

Larisa

First things first- let's look at the Mission and Vision of the DBHDS Office of Licensing:

Our *Mission* is to be the regulatory authority for DBHDS licensed service delivery systems through effective oversight.

Our *Vision* is to provide consistent, responsive, and reliable regulatory oversight to DBHDS licensed providers by supporting high quality services to meet the diverse needs of its clients.



Now, let's touch on a few Housekeeping items:

Feel free to use the Q&A feature to submit your questions as they arise throughout the training. Subject Matter Experts from the Office of Licensing and the Office of Community Quality Management will respond to questions in the Q&A as they are able. Any questions not answered during today's event will be answered and posted on the Office of Licensing website shortly after the training.

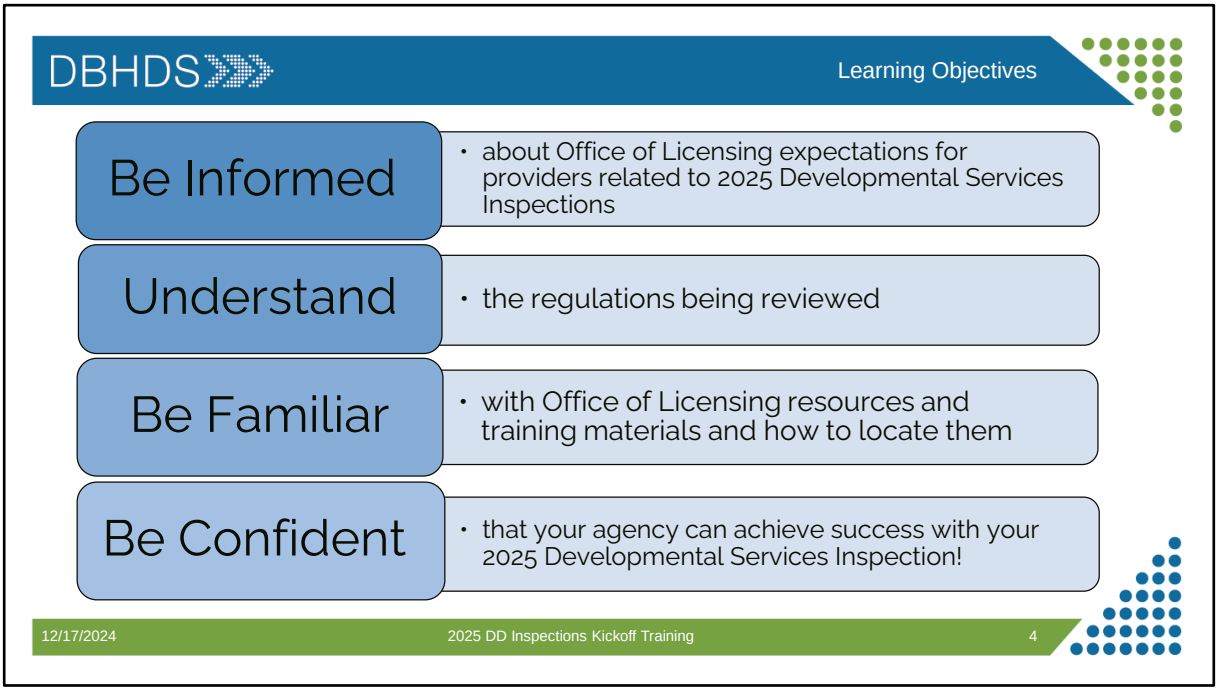
You all should have received a copy of this presentation in your email, so you're welcome to use that to follow along with us if you'd like. Also, the recorded video of today's training and the PowerPoint presentation will be posted on the Office of Licensing website. At the end of the training slides, we've included an additional 15 slides of links to resources and other helpful tools. We won't take your time to review these resources together today, but they will be included in the posted presentation on our website. We understand that this webinar includes A LOT of information in one session. We ask that you follow along with us today to familiarize yourself with the material and make note of any areas you'd like to revisit later as you plan for compliance for your specific service.

Karen will be popping up throughout the training today with some interactive poll questions to keep us engaged and on our toes. We hope you'll use these opportunities to

test your knowledge and increase awareness of key concepts related to your upcoming inspection.

And finally, at the conclusion of today's presentation, I'll share a link to a survey for you to complete to tell us all about your experience today.

We have allotted 3 hours for this training, but if we happen to run a few minutes over, we appreciate your understanding.



Larisa

Before we jump into the content of today's training, let's review our Learning Objectives. The purpose of today's training is to ensure you are:

Informed about the Office of Licensing expectations for providers related to 2025 Developmental Services Inspections.

That you *understand* the regulations being reviewed during inspections

That you are *familiar* with Office of Licensing resources and how to locate them

And finally, that you are *confident* that your agency can achieve success with your 2025 Developmental Services Inspection!

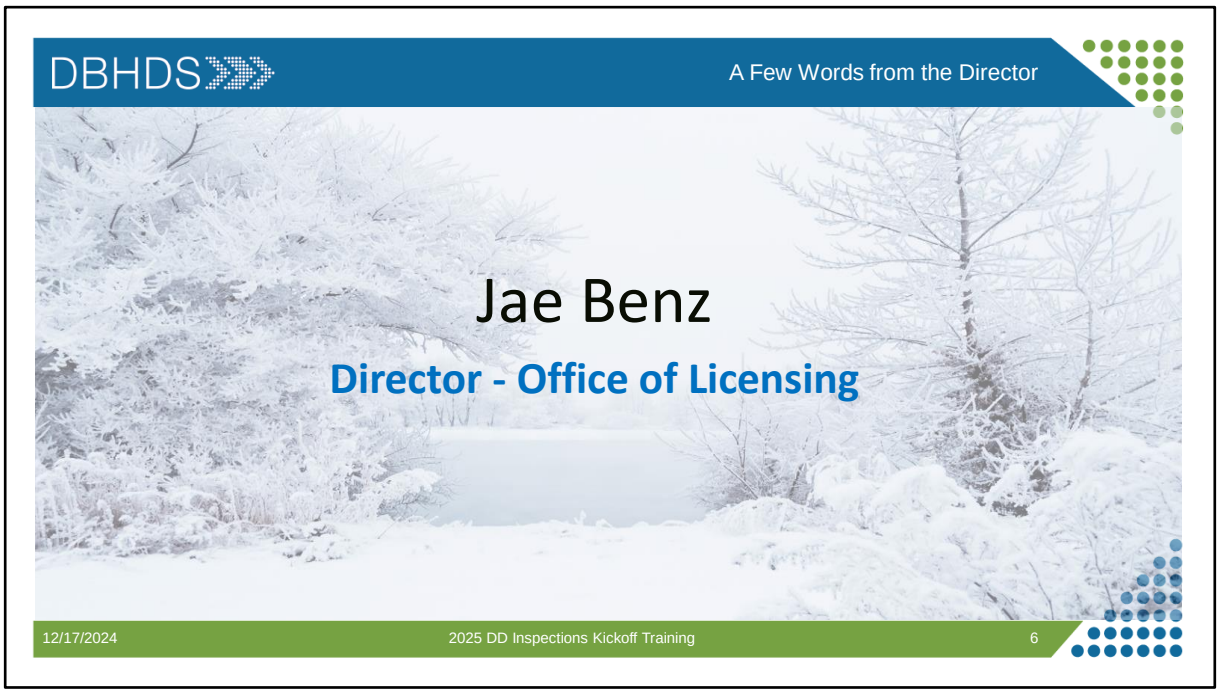
You will hear from different presenters throughout this presentation.

Your presenters from the Office of Licensing are:

- Mackenzie Glassco, Associate Director of Quality & Compliance, and
- Karen Matthews, Quality Improvement Review Specialist

Today we have some guest speakers joining us from the DBHDS Office of Community Quality Management. We have:

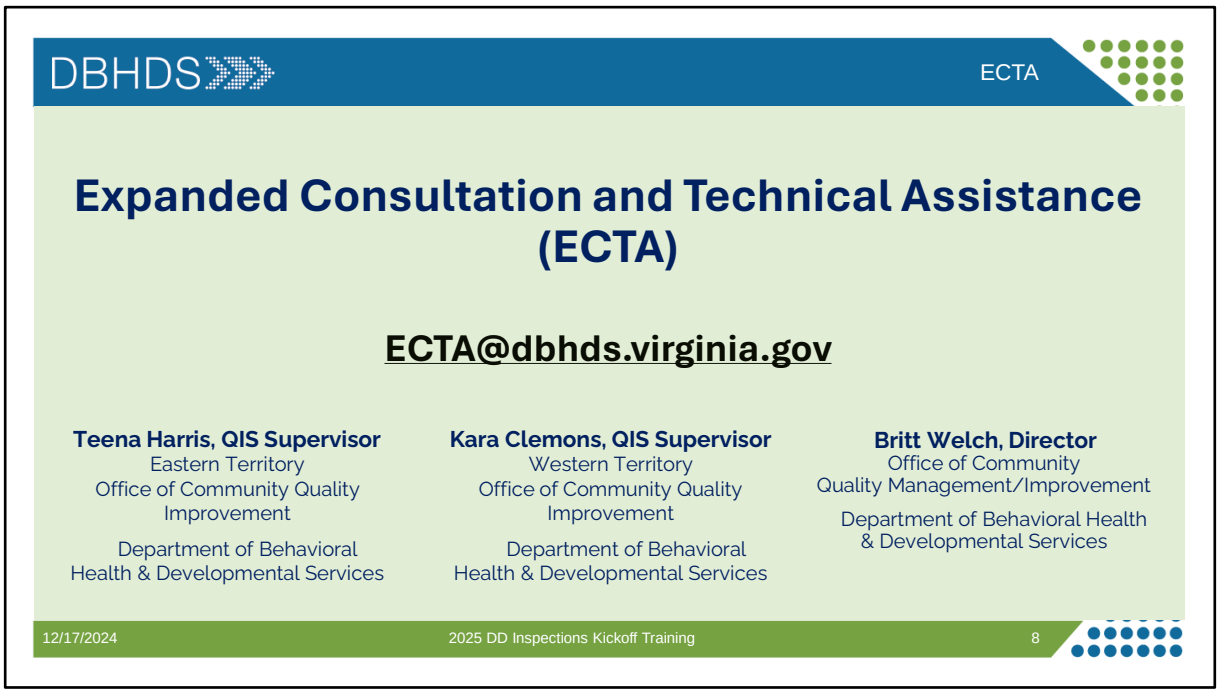
- Britt Welch, Director of the Office of Community Quality Management
- Teena Harris, Quality Improvement Specialist Supervisor for the Eastern Territory, and
- Kara Clemons, Quality Improvement Specialist Supervisor for the Western Territory. Thank you all for joining us today!



Now we will hear a few words from the Director of Licensing, Jae Benz.

Larisa

Thank you, Jae. And now a few words from Britt Welch, Director of the Office of Community Quality Management



Reference ECTA data in Resources section

- Based on the success that the Office of Community Quality Improvement had with provision of Consultation/Technical Assistance to providers with an approved CAP for regulation 620.C.2, we were asked to expand our CTA efforts

- Expanded Consultation/Technical Assistance
  - ✓ Focus on licensing regulations 620.A-E, 520.A-F, and 450
  - ✓ Element from the Provider Quality Reviews: *Providers' use of performance data for QI/RM (Starting in September)*

WHAT is being offered?

- QI Specialists will provide individualized consultation and technical assistance, tailored to your organization in the form of one-to-one sessions specific to:
  - The focus regulation(s) 620/520/450 as noted in your OL-approved CAP, and/or your
  - HSAG-approved QSR QIP for the subject data element: *"Does the provider collect and track performance data, including serious incidents and other risk information?"*

WHERE is ECTA offered?

- Sessions are offered via a combination of in-person and virtual meetings.

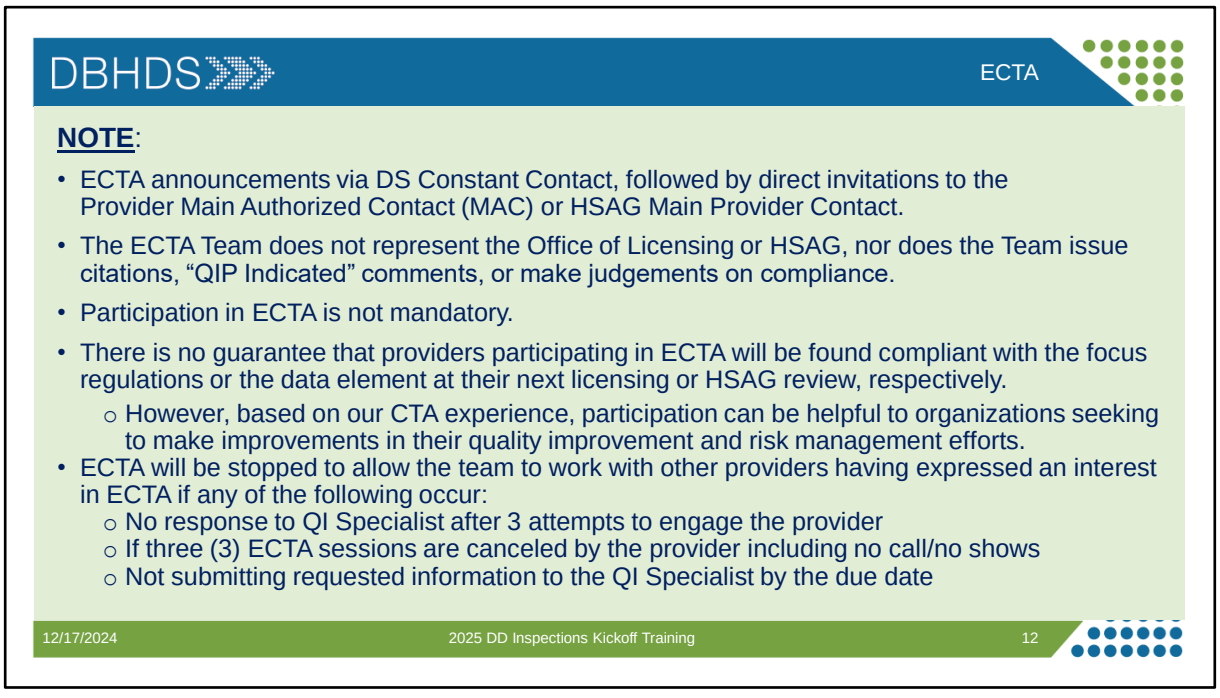
<u>WHO</u> is eligible?

1. Any licensed DD provider that has received a citation during their CY 24/25 unannounced licensing review **and** has an **<u>approved corrective action plan</u>** from the Office of Licensing specific to regulations 620.A-E, 520.A-F, 450, and/or
2. Has an approved QIP for the QSR Data Element(s)

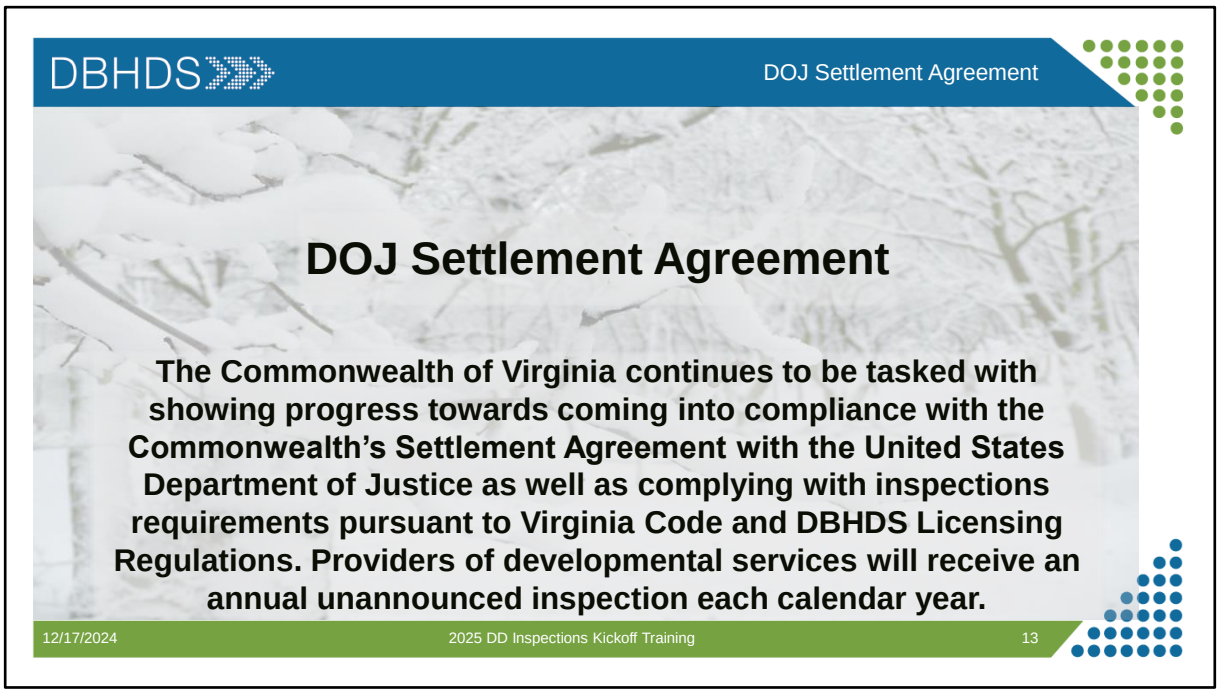
Note: CSBs/Providers ***must*** complete the **ECTA Readiness Assessment(s)*** and provide additional information requested by the QI Specialist on/before the due date noted by the QI Specialist to maintain be eligibility. *ECTA will not start without the Readiness Assessment(s)*.

**If a provider has both an OL-approved CAP and a HSAG-approved QIP, two Readiness Assessments are sent for completion. Both must be completed.*

Appear for all but asterick split



First 4 appear, 5th wipe, appear, then next 3 are split
Hand off to Mackenzie



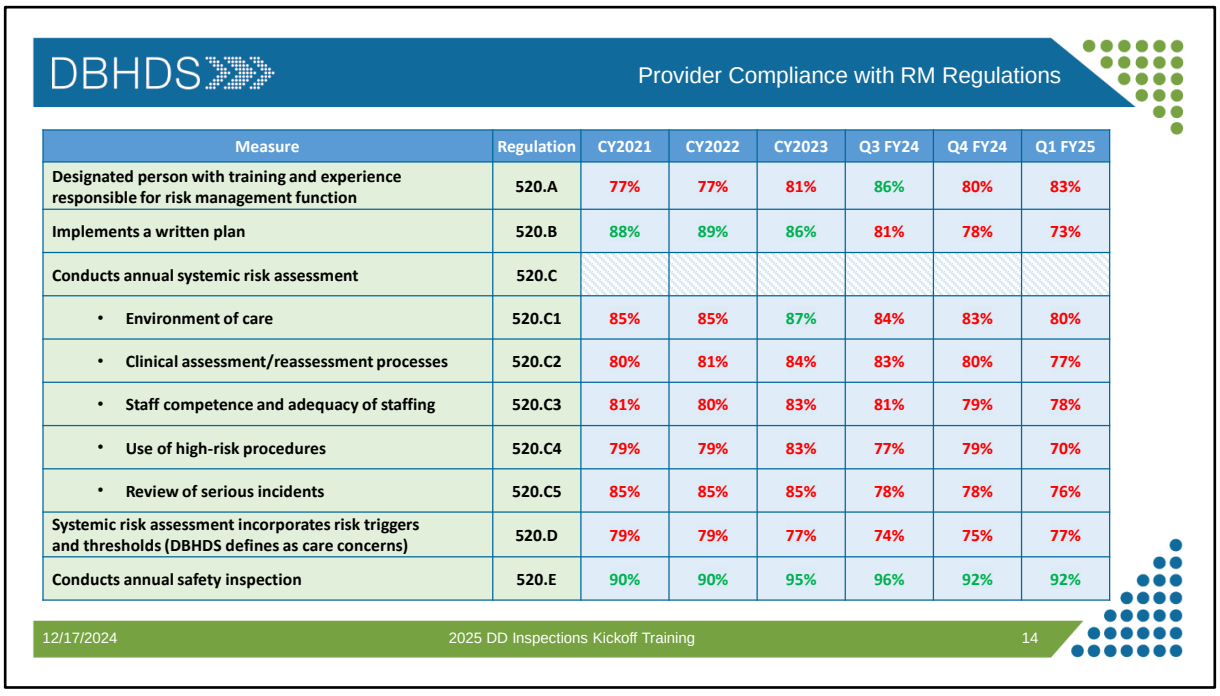
Mackenzie-

Thanks Britt and thank you all so much for taking the time to join us today. We will be covering a lot of content this afternoon but remember that the recorded webinar and PowerPoint will be posted on the OL website for future reference.

As you're aware, the Commonwealth of Virginia continues to be tasked with showing progress towards coming into compliance with the Commonwealth's Settlement Agreement with the United States Department of Justice as well as complying with inspection requirements pursuant to Virginia Code and DBHDS Licensing Regulations. Providers of developmental services will receive an annual unannounced inspection each calendar year.

During the unannounced inspection, the Office of Licensing determines if providers have adequate risk management and QI programs, in addition to ensuring provider compliance as it relates to the adequacy of supports.

We are coming into compliance with several of these areas, but there are still some areas in which we could benefit from improvement.



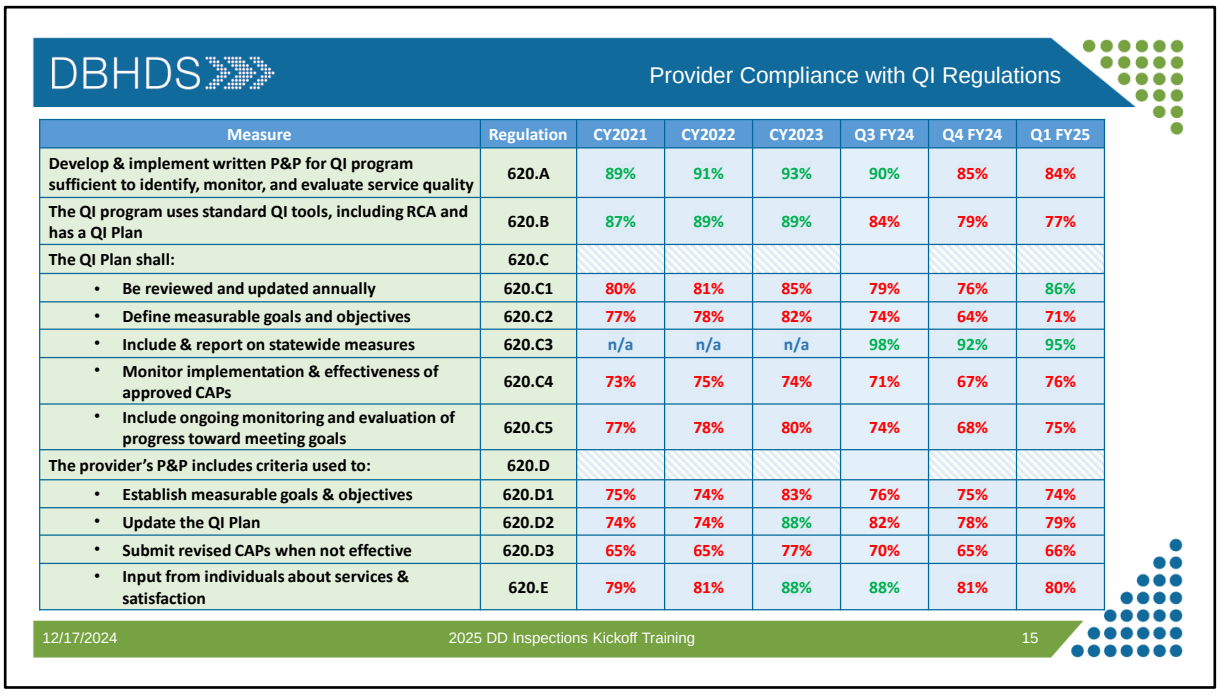
Measure	Regulation	CY2021	CY2022	CY2023	Q3 FY24	Q4 FY24	Q1 FY25
Designated person with training and experience responsible for risk management function	520.A	77%	77%	81%	86%	80%	83%
Implements a written plan	520.B	88%	89%	86%	81%	78%	73%
Conducts annual systemic risk assessment	520.C						
• Environment of care	520.C1	85%	85%	87%	84%	83%	80%
• Clinical assessment/reassessment processes	520.C2	80%	81%	84%	83%	80%	77%
• Staff competence and adequacy of staffing	520.C3	81%	80%	83%	81%	79%	78%
• Use of high-risk procedures	520.C4	79%	79%	83%	77%	79%	70%
• Review of serious incidents	520.C5	85%	85%	85%	78%	78%	76%
Systemic risk assessment incorporates risk triggers and thresholds (DBHDS defines as care concerns)	520.D	79%	79%	77%	74%	75%	77%
Conducts annual safety inspection	520.E	90%	90%	95%	96%	92%	92%

Before we go further, it's important for you all to understand where we currently stand related to compliance with risk management and quality improvement regulations. There are very specific DOJ compliance indicators related to these areas.

Let's look at this chart, these regulations are specific to risk management. The numbers in green show those regulations where provider compliance was at 86% or above, while those in red were below 86%. These percentages are based on those providers who received an annual unannounced inspection. Percentages are affected based on the number of providers in the sample.

Pause for a few seconds here

Now let's move on to data related to Quality Improvement



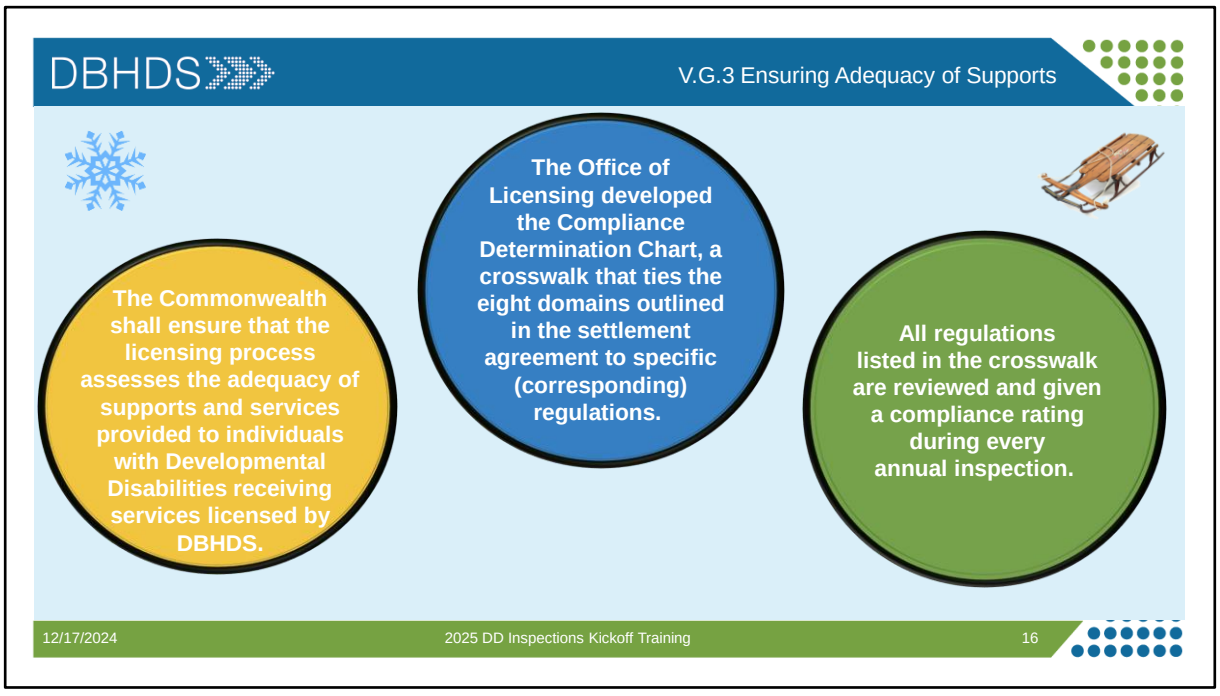
Measure	Regulation	CY2021	CY2022	CY2023	Q3 FY24	Q4 FY24	Q1 FY25
Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	620.A	89%	91%	93%	90%	85%	84%
The QI program uses standard QI tools, including RCA and has a QI Plan	620.B	87%	89%	89%	84%	79%	77%
The QI Plan shall:	620.C						
• Be reviewed and updated annually	620.C1	80%	81%	85%	79%	76%	86%
• Define measurable goals and objectives	620.C2	77%	78%	82%	74%	64%	71%
• Include & report on statewide measures	620.C3	n/a	n/a	n/a	98%	92%	95%
• Monitor implementation & effectiveness of approved CAPs	620.C4	73%	75%	74%	71%	67%	76%
• Include ongoing monitoring and evaluation of progress toward meeting goals	620.C5	77%	78%	80%	74%	68%	75%
The provider's P&P includes criteria used to:	620.D						
• Establish measurable goals & objectives	620.D1	75%	74%	83%	76%	75%	74%
• Update the QI Plan	620.D2	74%	74%	88%	82%	78%	79%
• Submit revised CAPs when not effective	620.D3	65%	65%	77%	70%	65%	66%
• Input from individuals about services & satisfaction	620.E	79%	81%	88%	88%	81%	80%

This chart is specific to provider compliance with Quality Improvement regulations. Again, the numbers in green show those regulations at 86% or above, those in red were below 86%.

PAUSE FOR PEOPLE TO READ

Soon, data will be pulled for both Risk and Quality for Quarter 2 of Fiscal Year 2025 which is from October 1, 2024-December 31, 2024.

We hope to see some more increases based on the trainings and resources available and all the hard work you all do!

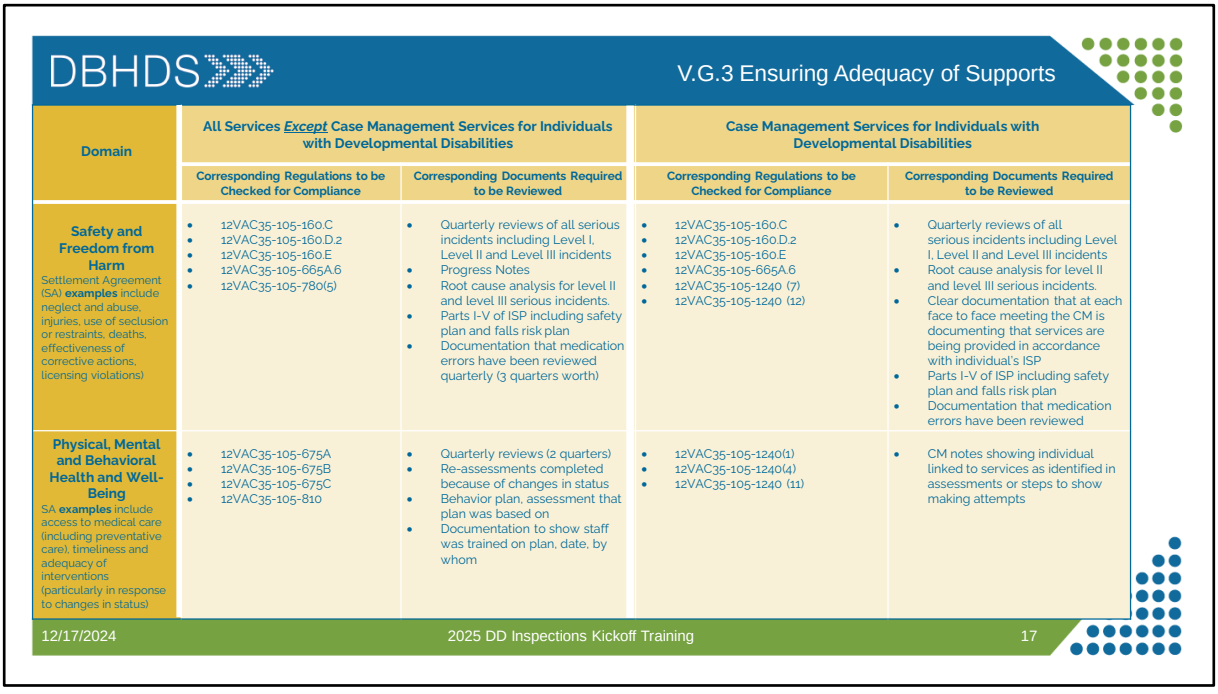


- In addition to compliance indicators related to risk and quality, there is a provision in the Settlement Agreement which requires the Commonwealth to ensure that the licensing process assesses the adequacy of supports and services provided to individuals with developmental disabilities receiving services licensed by DBHDS.

- The Office of Licensing uses a crosswalk that ties the domains outlined in the settlement agreement to specific regulations.

- All regulations listed in the crosswalk are reviewed and given a compliance rating during every annual inspection.

- Let's take a closer look at the crosswalk. This shows how we selected some of the minimum regulations that are reviewed.



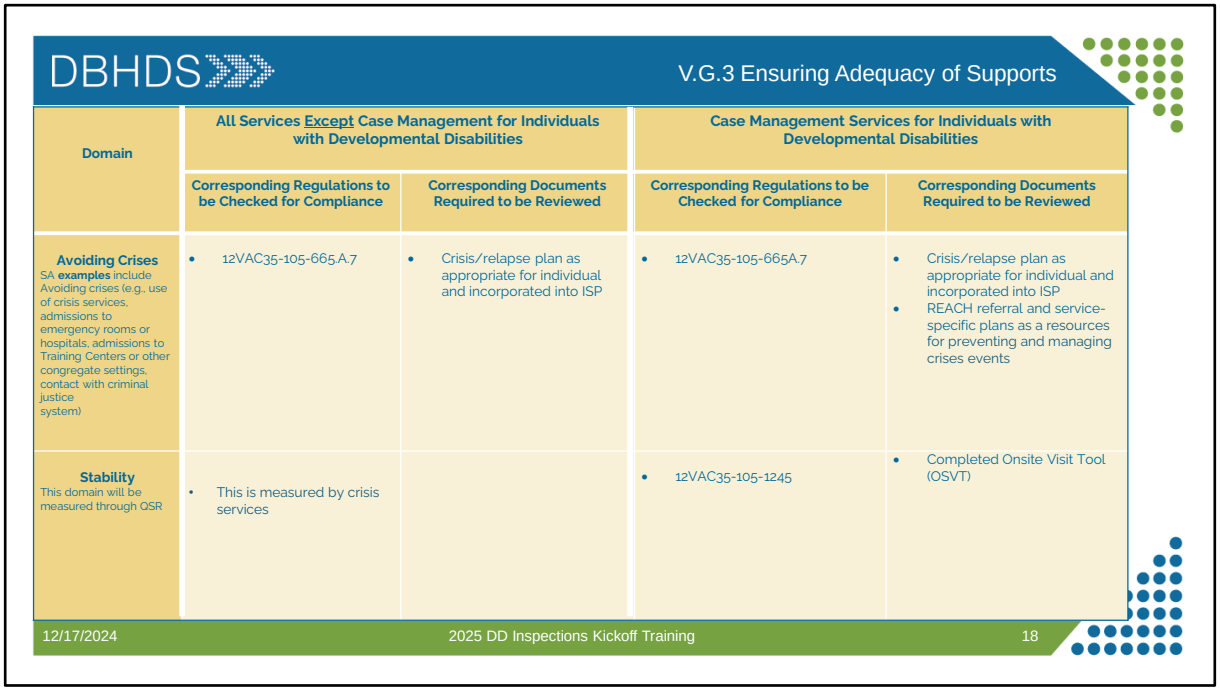
There are eight domains outlined in the settlement agreement.

The crosswalk displayed on these next few slides tie the eight domains outlined in the settlement agreement to several of the regulations that are reviewed during the annual unannounced inspection.

This crosswalk includes the domain, the corresponding regulations and the documents that are reviewed by the Office of Licensing as part of the annual inspection process. This is for both non-case management providers and case management providers of developmental services.

On this slide, the domains include safety and freedom from harm AND physical, mental and behavioral health and well-being.

This format is similar on the next few slides. ***Pause for a few seconds here***



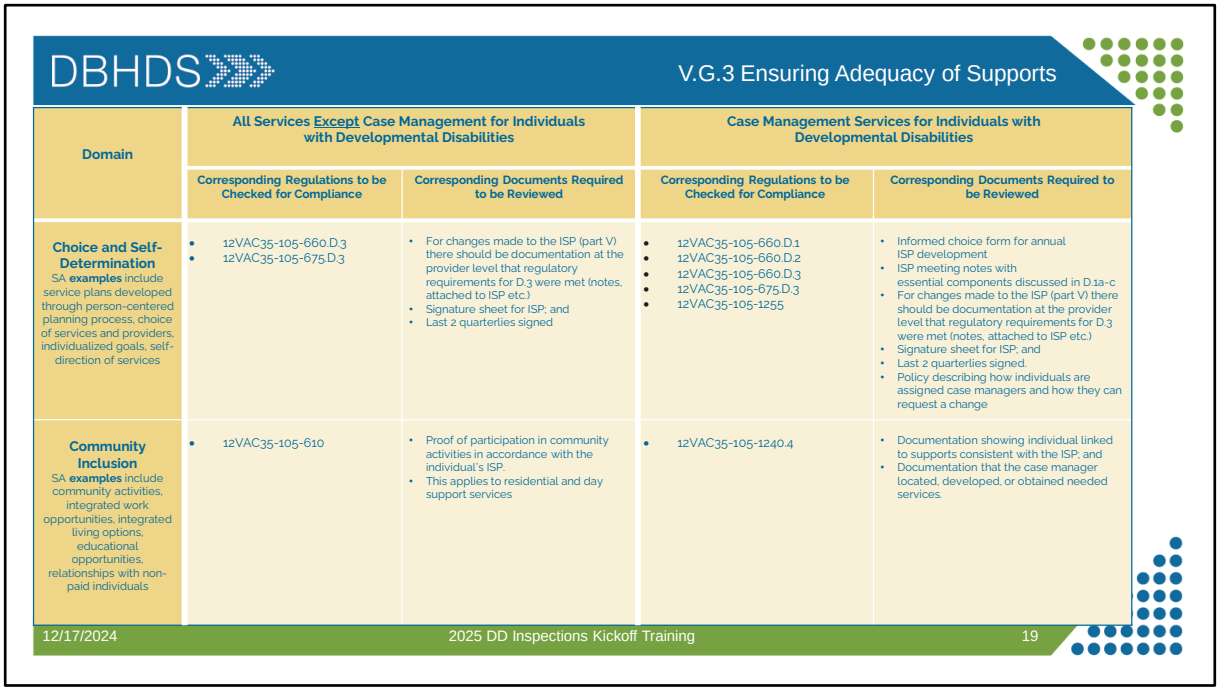
The domains listed here are avoiding crises AND stability

As you can see in the chart, there is no corresponding regulation that aligns with stability specific developmental disability private providers of non-case management services. The domain of stability does not directly tie to any regulations for licensed providers of non-case management services and is assessed through a measure of the percentage of individuals that are hospitalized or admitted to a REACH crisis therapeutic home who are able to return to their original living situation once the crisis has resolved.

The crisis services office measures stability as the number of individuals with a developmental disability who were not discharged by their residential services provider around the same general time of their crises and were either admitted to a crisis therapeutic home or to a psychiatric hospital. The goal is that 25% or less have had to move after their crisis.

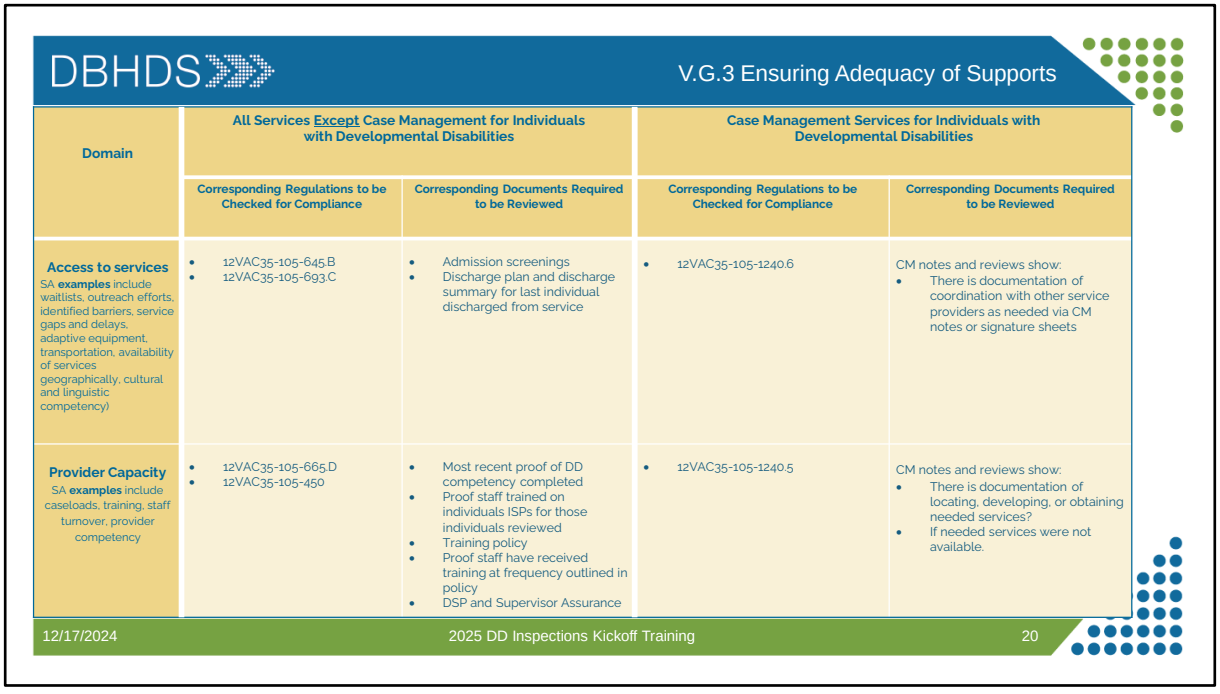
Keep up the great work providers!

Pause for a few seconds here



The domains listed here in the crosswalk are choice and self-determination AND community inclusion

Pause for a few seconds here

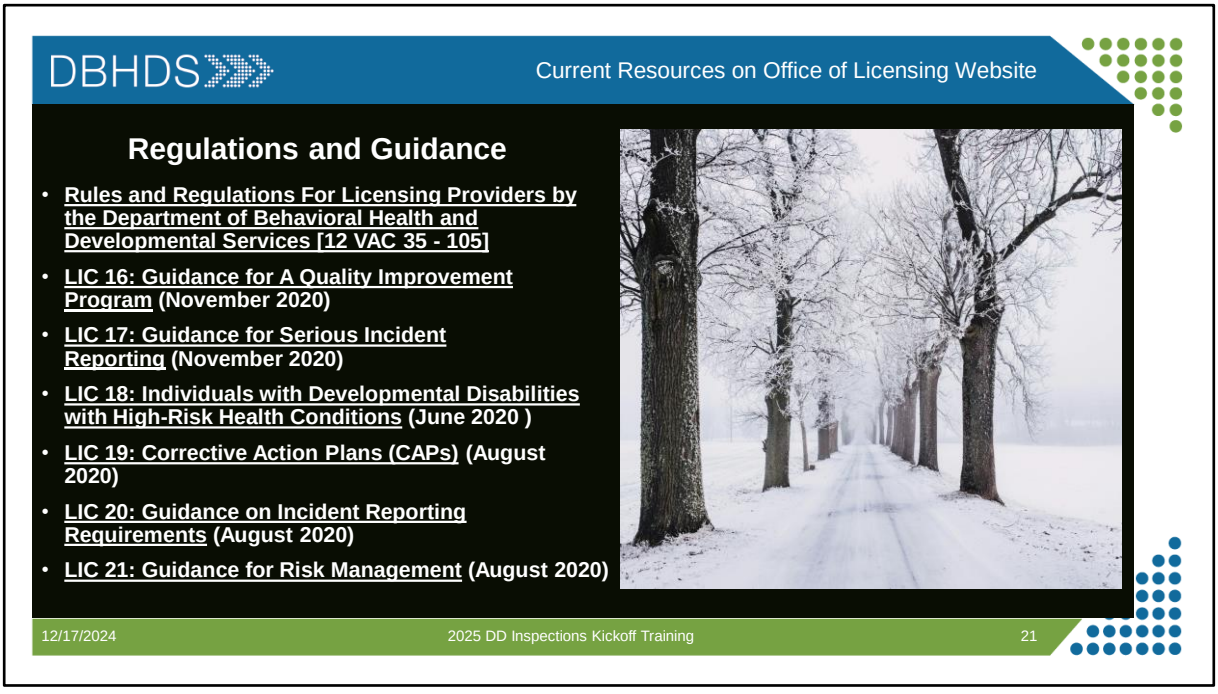


The last two domains of the crosswalk are access to services AND provider capacity

Keep in mind that the minimum regulations that are reviewed during the annual unannounced inspection are not tied to all of the domains, some are tied to other DOJ requirements that are not part of the adequacy of supports.

Pause for a few seconds here

Now **Karen** is going to take a few minutes to provide some reminders



KAREN

Before we continue, I want to remind everyone to sign up for Constant Contact. The Office of Licensing works extremely hard to provide trainings and resources for you all to have the tools you need to be successful. Ensuring that you're signed up for Constant Contact means you're guaranteed to receive the most up to date information from the Office of Licensing.

If you are not signed up to receive constant contacts please go to the Office of Licensing website, click on the blue "Subscribe to the Email List" button and register.

As you're probably aware, the Office of Licensing website includes the DBHDS regulations; correspondences, guidance, training and technical assistance; information related to serious incident reporting; CHRIS training; and CONNECT related resources.

We hope that you are familiar with the DBHDS rules and regulations. Providers should always read the regulations closely and have an understanding of what they mean. Providers should ensure that their policies and procedures align with the regulations. If you have a question about a regulation, please reach out to your licensing specialist.

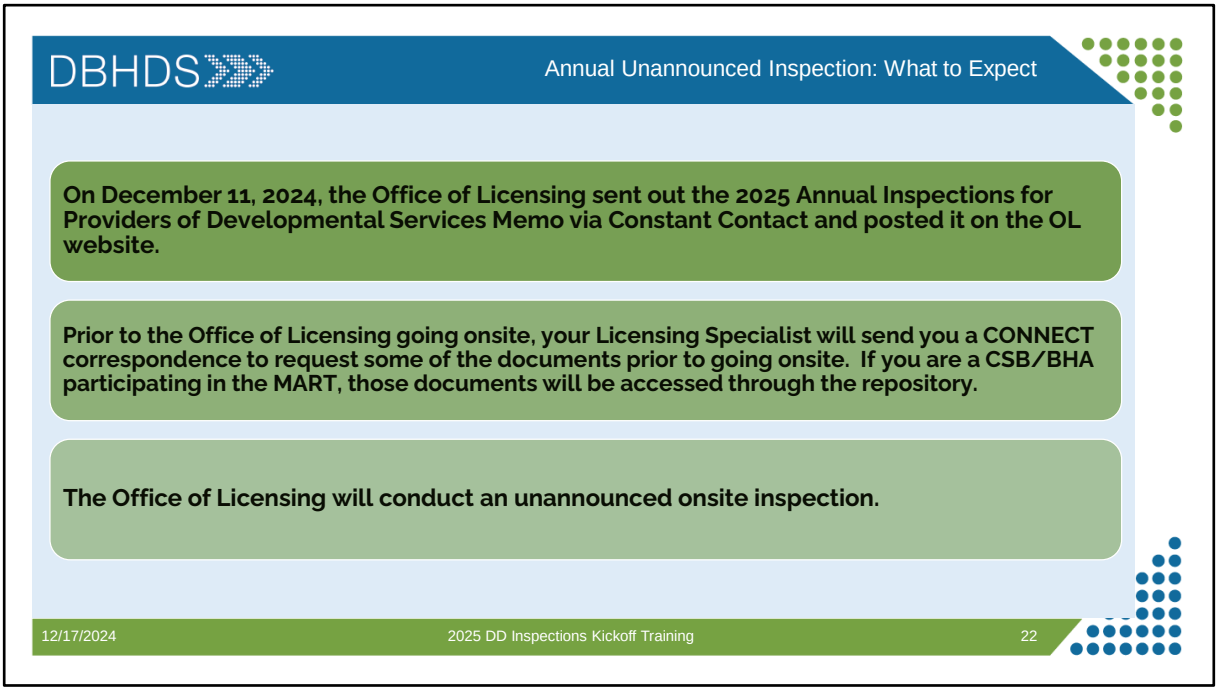
If you're comfortable with the regulations, we ask that you go one step further and familiarize yourself with Office of Licensing's guidance documents that are available.

Remember, a "guidance document" is any document developed by a state agency that provides information or "guidance" of a general nature to agency staff or to the public to interpret or implement statutes or the agency's regulations.

The Office of Licensing develops guidance documents when it is determined that more detailed explanations are needed related to interpreting the regulations. There are several guidance documents located on the Office of Licensing's website.

A provider who follows guidance documents and incorporates them into their policies and procedures is more likely to be compliant with the DBHDS rules and regulations.

As Larisa shared earlier, there are additional resources from the Office of Licensing and the Office of Community Quality Management at the end of this PowerPoint presentation.



KAREN

Now let's talk about what to expect during the Annual Unannounced Inspection

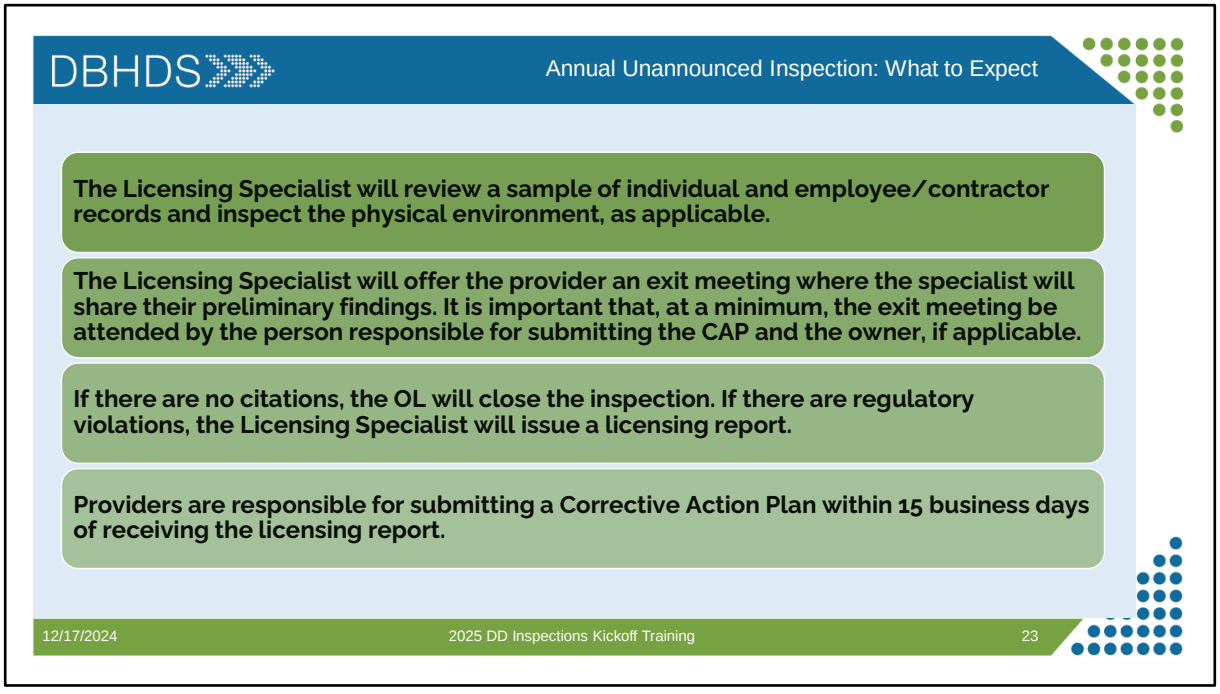
Last week, the Office of Licensing sent the "2025 Annual Inspections for Providers of Developmental Services Memo" out to those of you signed up for Constant Contact. This memo was also posted on the Office of Licensing's website under the "Correspondences" section.

Prior to going onsite, the Office of Licensing will send a letter to the provider requesting specific documents to be submitted via CONNECT. Providers are given 5 business days to submit the requested documents to the Office of Licensing. It is important that the documents being requested are submitted to Office of Licensing by the due date. The documents requested prior to going onsite are reviewed by the Licensing Specialist in detail prior to the onsite inspection.

If you are a CSB/BHA participating in the MART, those documents will be accessed through the repository.

The Office of Licensing will then conduct an unannounced onsite inspection to the provider.

If someone from the Office of Licensing arrives for an unannounced inspection, and no one from the provider is present, the Licensing Specialist will attempt to contact the provider so that the inspection can be completed. The Office of Licensing is unable to complete the inspection unless someone from the provider organization is present. It is imperative that providers respond immediately to calls from the Office of Licensing when a specialist is onsite for a review. Additionally, providers need to inform their staff of who should be contacted at their organization when someone from the Office of Licensing arrives.



KAREN

During the inspection the Office of Licensing will:

- review individual records as well as employee or contractor records

-inspect the physical environment, if applicable to the service and

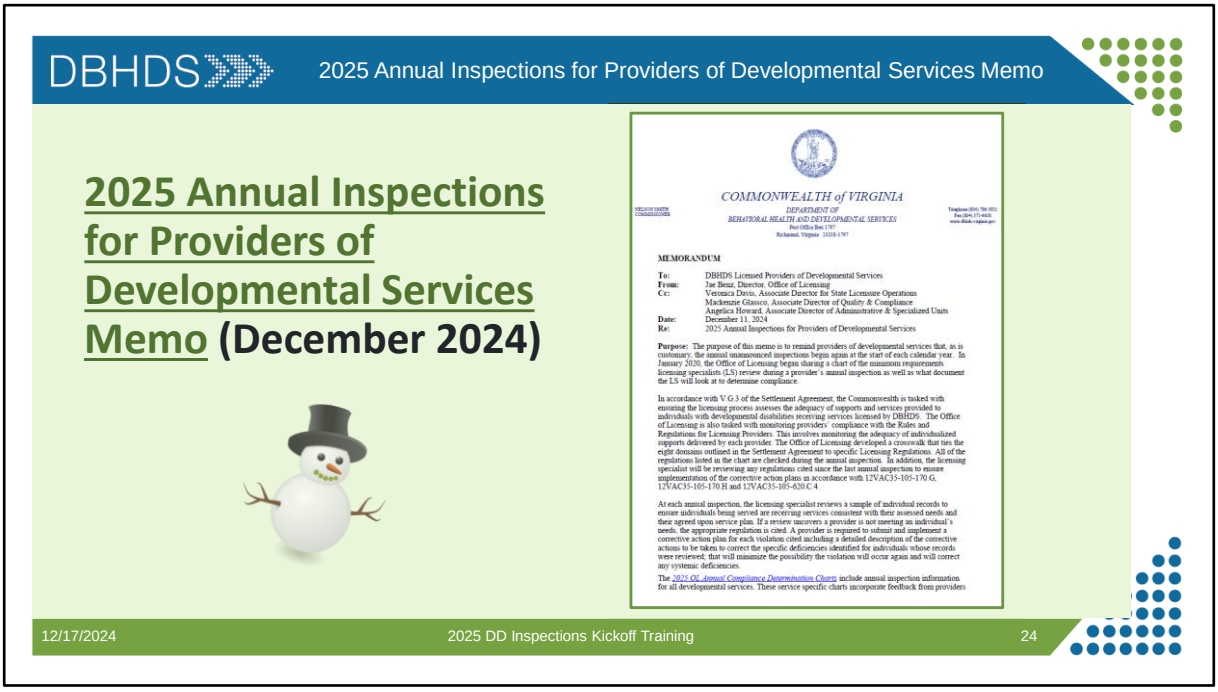
-offer the provider an exit meeting which should be attended at a minimum by the person responsible for submitting the CAP and the owner if there is one

-if there are no citations, the Office of Licensing will close the inspection

-if there are regulatory violations, the Office of Licensing will issue the licensing report

-Providers are required to submit their corrective action plan within 15 business days of receiving the Licensing Report. We will talk a bit more about corrective actions plans near the end of the presentation.

Now Mackenzie is going to take a few minutes to review the 2025 Annual Inspections for



Mackenzie

Thanks Karen, now that you have some background about what to expect, let's take a closer look at the 2025 Annual Inspections for Providers of Developmental Services Memo that Karen mentioned earlier.

As previously stated, this memo was sent out and posted on the OL website last week

The purpose of the memo is to remind providers of developmental services that annual unannounced inspections begin again at the start of each calendar year. In January 2020, the Office of Licensing began sharing a chart of the minimum requirements licensing specialists (LS) review during a provider's annual inspection as well as what documents the LS will look at to determine compliance.

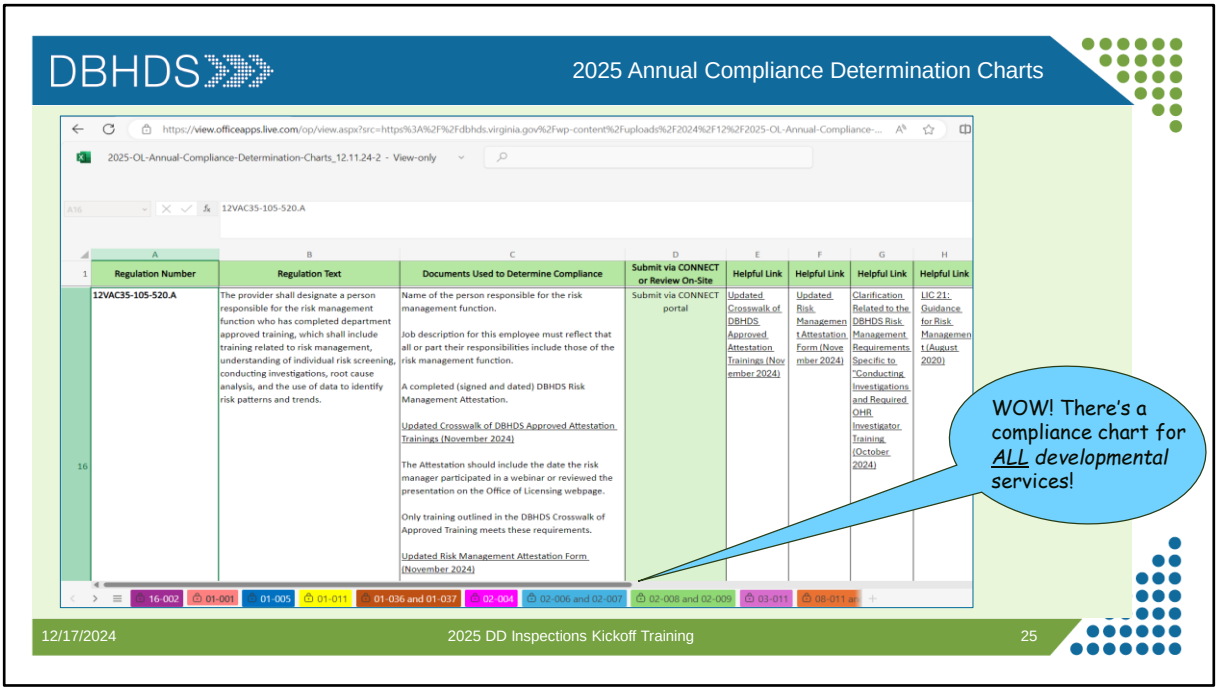
Historically, the chart of the minimum regulations reviewed have been listed within the memo. This year we have included a link to the *2025 OL Annual Compliance Determination Charts*, which is an excel workbook, within the memo. Once you click on the link, you will see service specific charts that incorporate feedback from providers as well as the consultants for the Independent Reviewer. Each chart outlines the minimum regulations that will be reviewed for each service, the documents that will be reviewed to

determine compliance, and whether the documents will need to be submitted via the CONNECT provider portal or viewed onsite during the inspection.

We ask that you carefully review the memo and the *2025 OL Annual Compliance Determination Charts*, specific to your licensed service(s); and provide all information when requested by your licensing specialist.

CSBs/BHAs participating in the Multi-Agency Review Team (MART) must ensure that the documents included in the Master Document List are uploaded to the repository by January 1, 2025.

Let's take a look at the next slide so that you can get an idea of what the *2025 OL Annual Compliance Determination Charts* look like



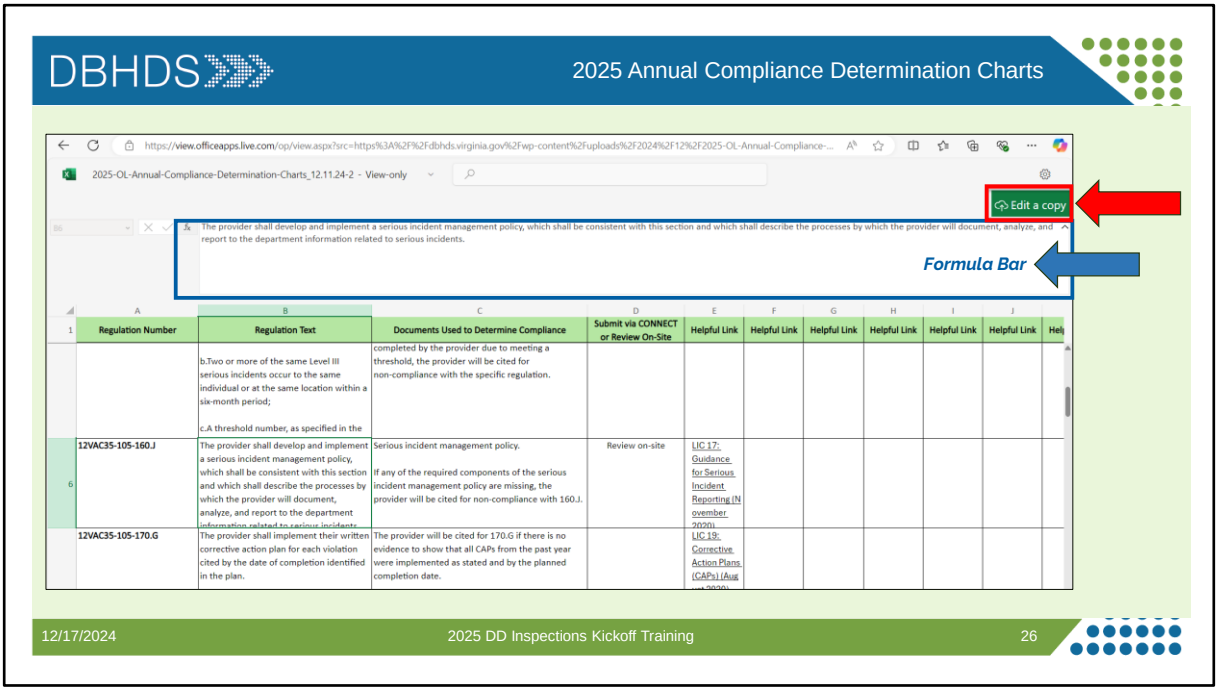
So here is a screenshot of what the 2025 OL Annual Compliance Determination Charts, again this is an excel workbook

Remember that the link is included in the 2025 Annual Inspections for Providers of Developmental Services Memo.

- If you take a look at the bottom of the workbook you will see that there is a tab for each developmental service which is pretty exciting
- Looking further at the chart, we've listed the minimum regulations that OL will be reviewing
- Regulatory text is provided so you don't have to go searching through the regulations
- The documents used to determine compliance are listed
- Each chart informs you as to whether the documents need to be Submitted via CONNECT Or Reviewed on-site. For 520.A you can see that documents will need to be submitted via CONNCT, those that need to be submitted in connect are also shaded light green.
- We've also included helpful links that if clicked will take you directly to the document on the OL website

Again, your licensing specialist will send you a CONNECT correspondence when it is time

for your agency to submit these requested documents. Please do not send anything to your specialist until you have been requested to do so.

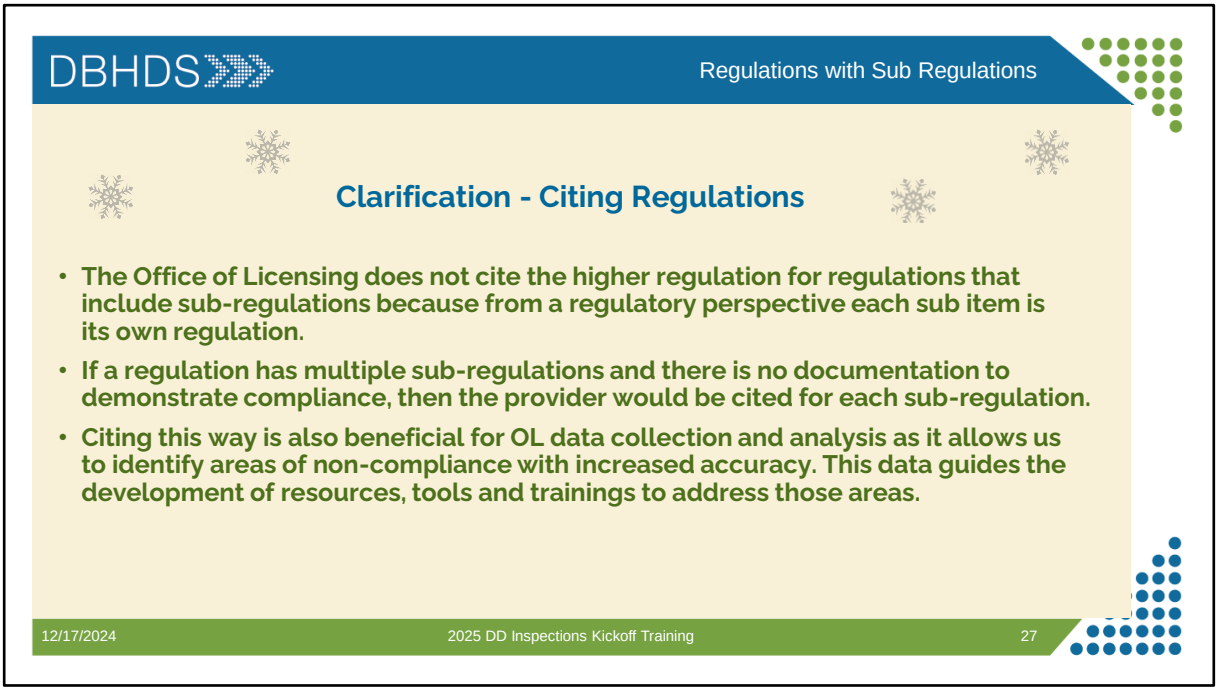


It is recommended that you download the excel workbook, so that you have access to all the excel features. To download it, you will need to go to "Edit a copy" which is shown in red on your screen. This may prompt you to sign in or create an account which is required by Microsoft. Once downloaded you can unprotect the workbook by clicking on Review in the ribbon and then select Unprotect workbook. This way you can adjust the cells or change the font size and even the color.

However, if you chose to review the document in view only and have trouble seeing all the information within a cell, it is recommended that you expand the formula bar, as noted with a blue arrow, then you can see all the text with a cell.

Keep in mind that today we will be reviewing some, but not all, of the regulations included in these charts. We will be reviewing regulations applicable to **all** licensed providers of developmental services and a few regulations specific to providers of case management services.

We want your inspection to be a success, and we highly recommend you review this chart and stay with us throughout the remainder of today's training.



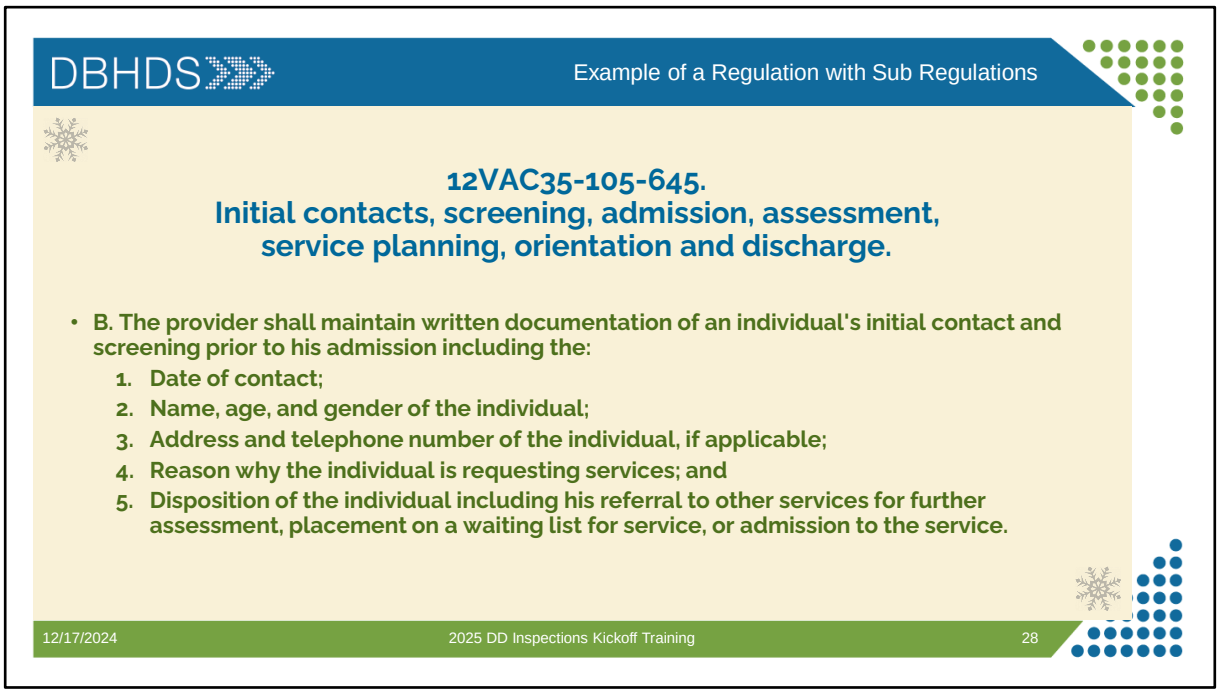
Before we go further, I want to provide some clarification related to how the Office of Licensing cites regulations

The Office of Licensing does not cite the higher regulation or "parent regulation," as it is sometimes referred, when there are other sub-regulations. From a regulatory perspective, each component of a regulation is its own regulation.

If a regulation has multiple sub-regulations and there is no documentation to demonstrate compliance, then the provider would be cited for each sub-regulation.

Also, you can think about it this way: If there is a regulation with multiple sub-regulations, it would not be fair for one provider to receive just one citation for the higher regulation due to not having completed the required document versus another provider who has the document with a few incomplete sections and being cited for multiple sub regulations.

Additionally, it is much more helpful as relates to collecting data because it allows the Office of Licensing to identify specific areas of non-compliance and develop resources, tools and trainings to address those needs.



Let's take a closer look at an example regulation that has a parent regulation with sub-regulations. 645.B is specific to the screening form.

If components or sections of a screening form are incomplete or left blank, then the provider would be cited specific to those regulations.

So, if a Licensing Specialist reviews a screening form and the date of contact and disposition of the individual are missing, then the provider would be cited for 645.B.1 and 645.B.5 *Pause here*

If a provider does not complete a screening form or they are unable to locate the screening form during the inspection, then the provider would be cited for 645.B.1, 645.B.2, 645.B.3, 645.B.4 and 645.B.5. Keep in mind that if you do not complete a screening, OL would not just cite 645.B.

This is the same for all regulations that have a parent regulation with sub-regulations.

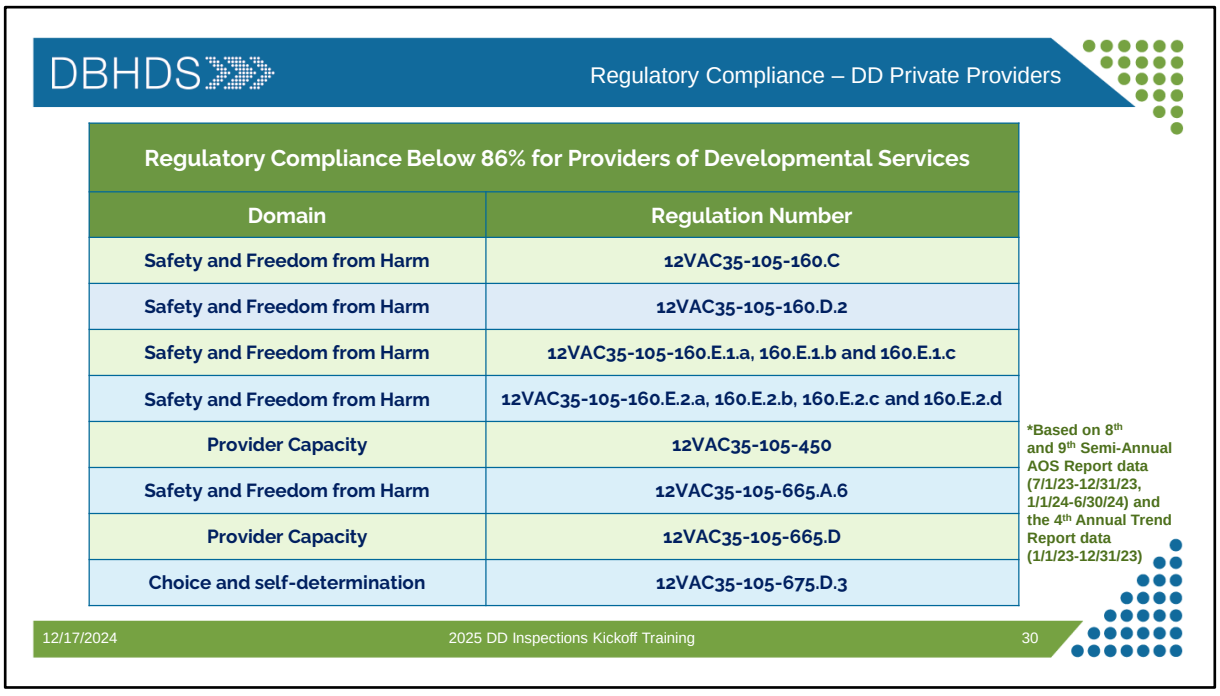
Now Karen is take us into Part I of the regulations overview.

KAREN

Let’s dive into the first part of our regulations overview. These regulations are specific to DOJ Compliance Indicator V (five).G.3.

Don't forget, we are only going to go over those regulations that could benefit from additional review, so that you can be successful this year.

This first set of regulations we will review are applicable to *ALL* providers of developmental services. This includes those who provide case management services, as well as those who provide non-case management services.



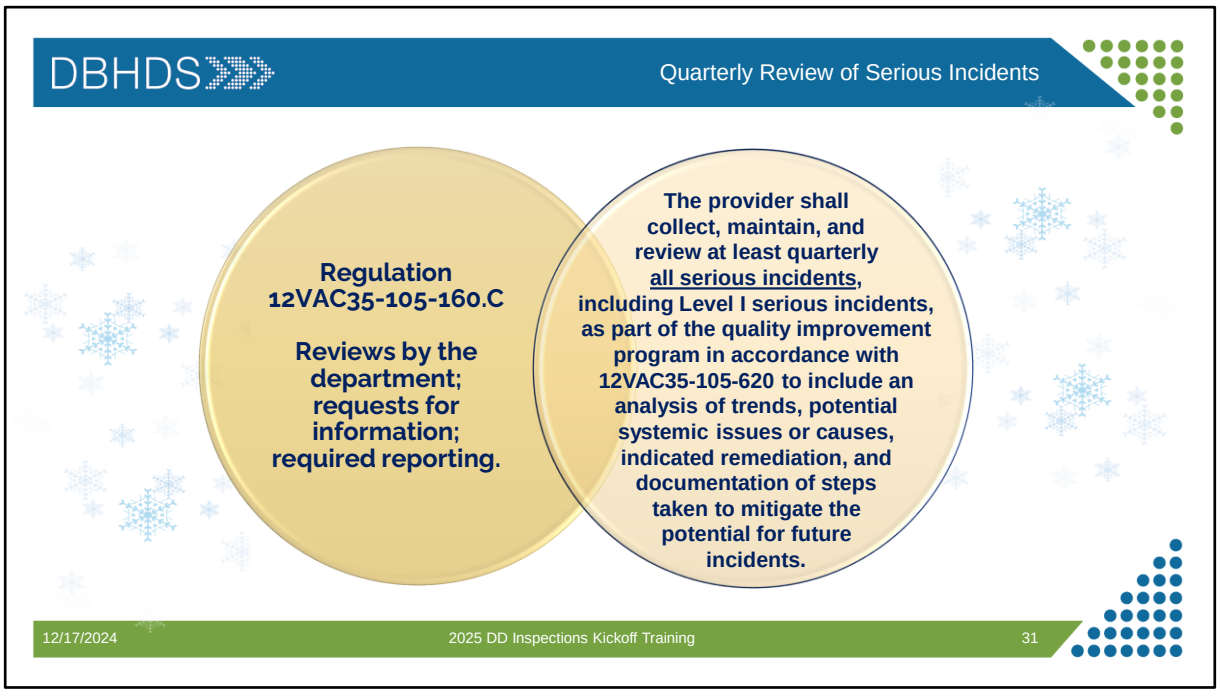
KAREN

The chart displayed here includes the specific regulations where developmental disability providers had difficulty meeting compliance.

We will talk more about each of these regulations later in the presentation.

As it relates to reporting Level II and Level III serious incidents to the department within 24-hours of discovery, which is regulation 160.D.2, that there are still some providers who are not reporting these serious incidents to the department as required.

Pause for a few seconds here



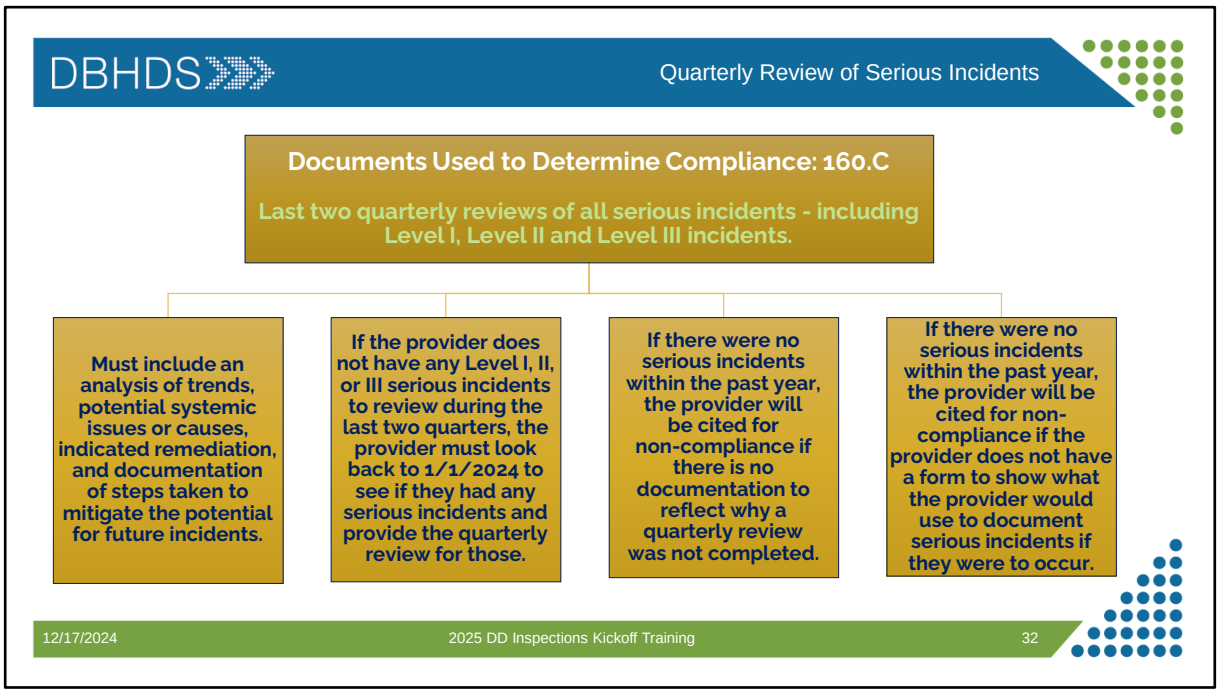
KAREN

For each regulation we discuss today, we will first review the regulation as this one is shown here. Then, we will review the specific documents that your licensing specialist will be looking for to determine compliance with each regulation.

Let's start with Regulation 160.C - Providers are responsible for collecting, maintaining, and reviewing, at least quarterly, all serious incidents.

This includes Level I, Level II and Level III serious incidents.

This review should include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.



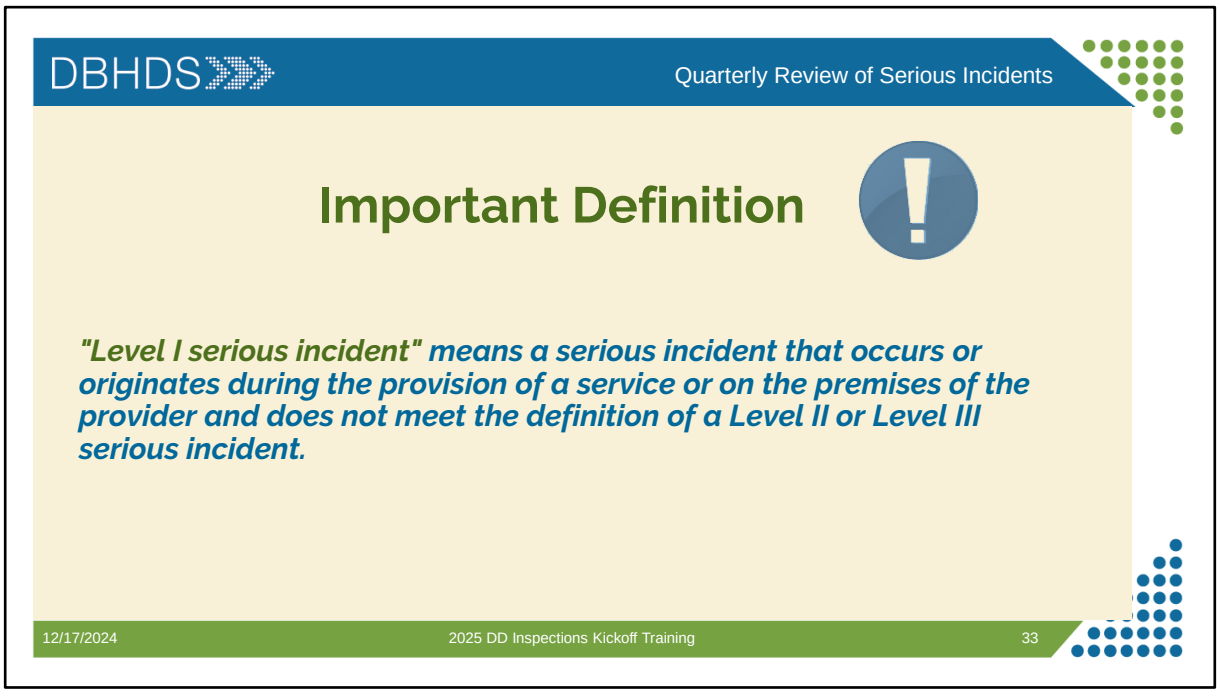
KAREN

These are the specific documents that the Office of Licensing will review to determine compliance with 160.C

The last two quarterly reviews of all serious incidents, including Level I, Level II and Level III incidents.

- The last two quarterly reviews must include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.
- If the provider does not have any Level I, Level II, or Level III serious incidents to review during the last two quarters, the provider must look back to 1/1/2024 to see if they had any serious incidents and provide the quarterly review for those.
- If there were no serious incidents within the past year, the provider will be cited for non-compliance if there is no documentation to reflect why a quarterly review was not completed.

- If there were no serious incidents within the past year, the provider will be cited for non-compliance if the provider does not have a form to show what the provider would use to document serious incidents if they were to occur.



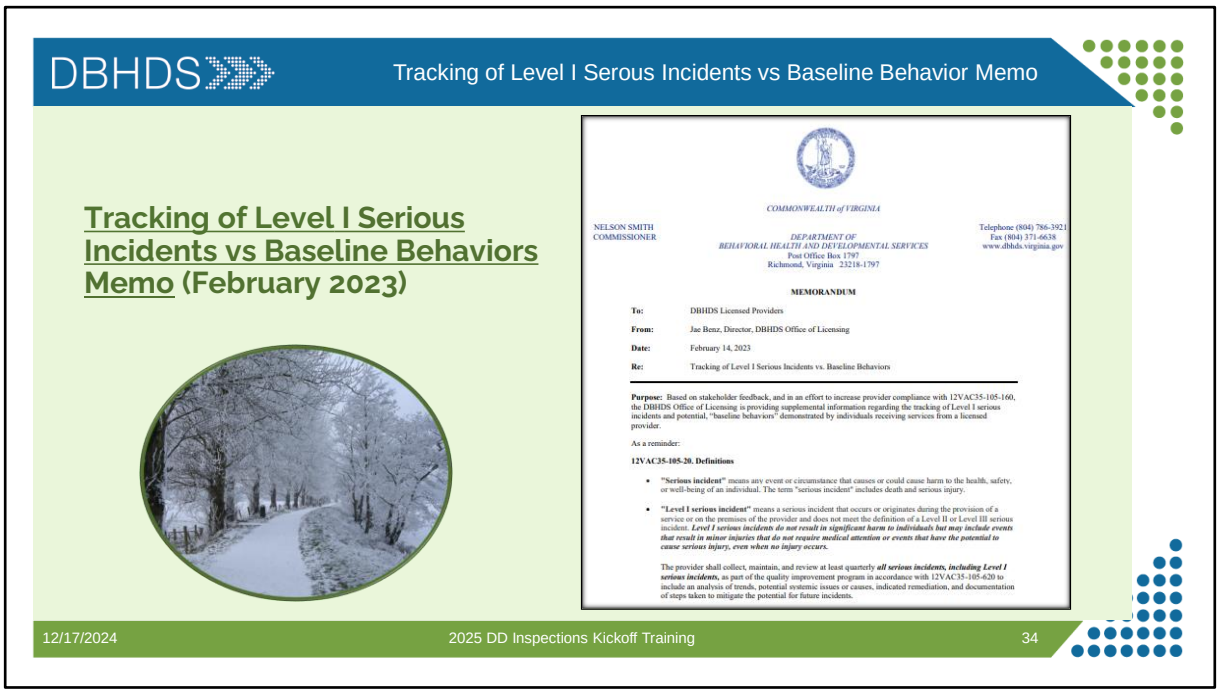
KAREN

"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident.

Level I serious incidents do not result in significant harm to individuals but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs.

Level I serious incidents do not need to be reported to the Office of Licensing.

Information related to Level II and Level III serious incidents will be provided in upcoming slides.



I want to remind everyone of the "Tracking of Level I Serious Incidents vs Baseline Behaviors Memo" that was posted in February 2023.

Baseline behaviors should be incorporated into the individual's ISP (Part V). Providers are expected to include a specific plan for addressing, "baseline behaviors" and, in order to monitor an individual's behavior(s), a behavior tracking tool or data collection system should be included in the individual's ISP (Part V).

It is expected that all employees or contractors responsible for implementing the ISP demonstrate a working knowledge of both the individual's "baseline behaviors" and the behavior tracking tool/data collection system being used.

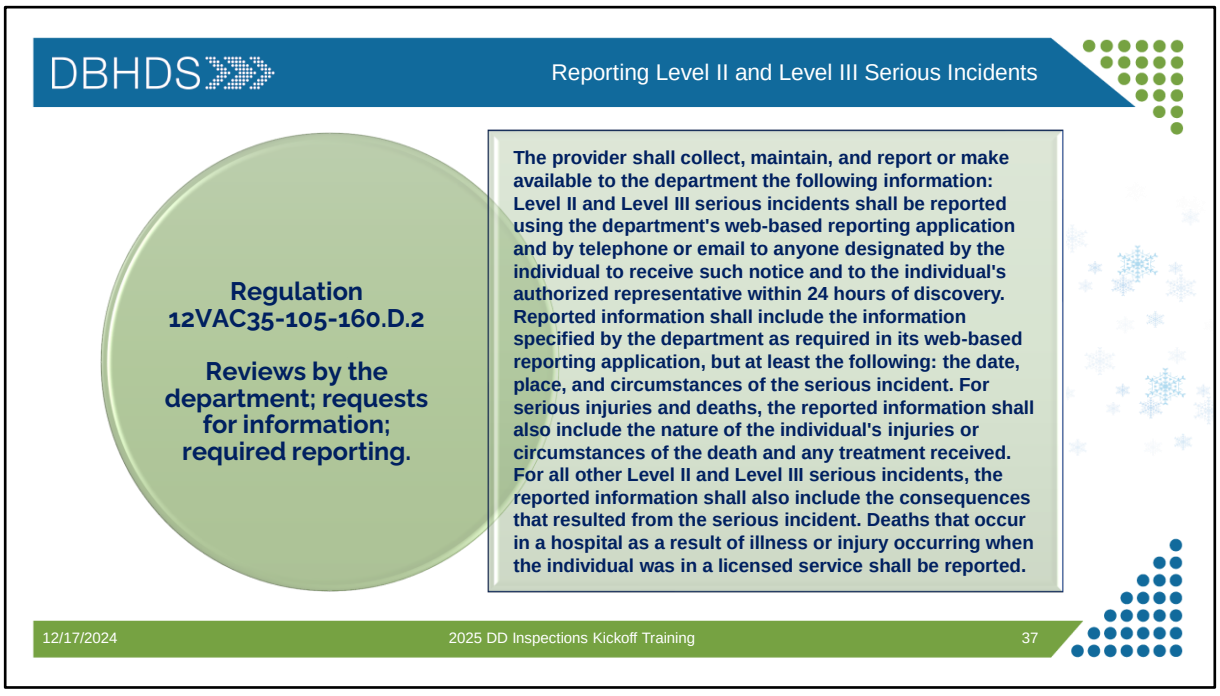
Providers should ensure that they describe "baseline behaviors" in detail so that any employee or contractor and regulatory entity is able to recognize a "baseline behavior(s)" versus a Level I serious incident.

Any observed changes in the severity, intensity, support needs, and/or injury may result in the behavior being classified as a Level I serious incident. If the change in behavior meets the definition of a Level II or Level III serious incident, then the serious incident would need to be reported using the department's web- based reporting application and by telephone

or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery.

Additionally, these behaviors should be evaluated by the provider, at a minimum, every three months as part of the quarterly review in order to determine if they are still considered “baseline behaviors.”

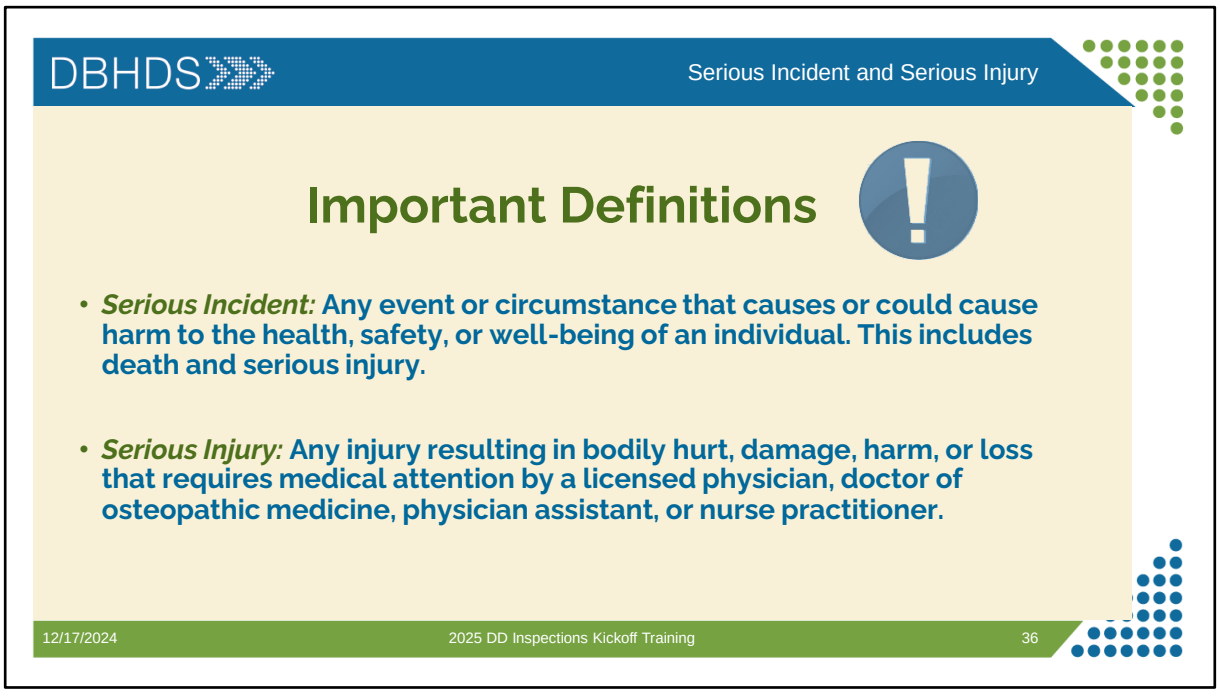
If you are not familiar with this memo, please take time to review it as several examples are provided.



KAREN

Before we discuss specific definitions, let's look at what the regulation says about reporting.

Regulation 160.D.2. of the Licensing Regulations requires providers to report all Level II and Level III serious incidents using the department's web-based reporting application and by telephone to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery of the serious incident.

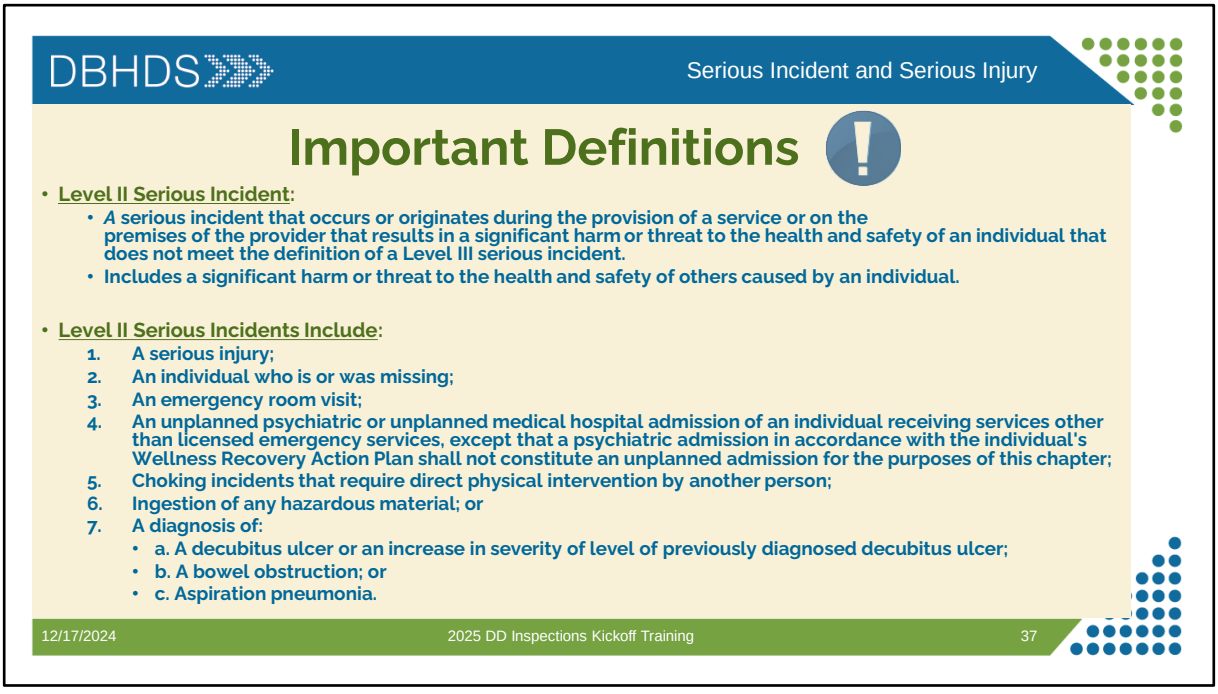


KAREN

Now, let's take a moment to clarify some definitions.

- A "**Serious incident**" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. This includes death and serious injury.

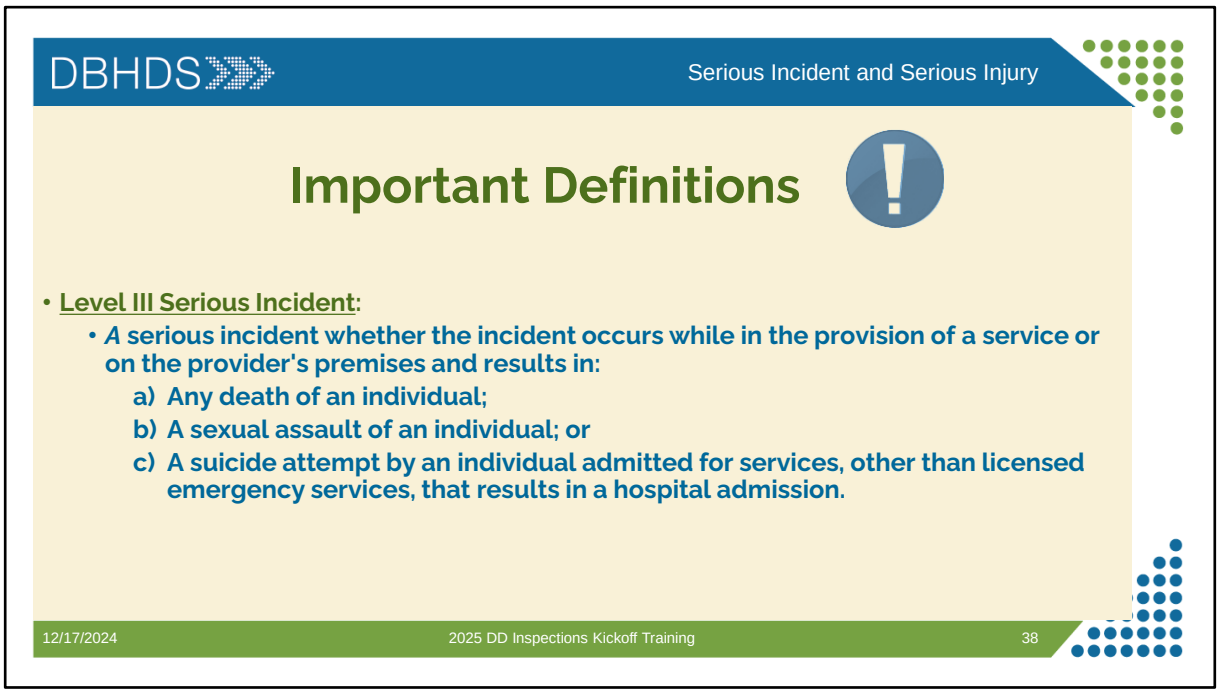
- A "**Serious injury**" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.



KAREN

- "Level II serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident. A “Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual.

- Here is a list of Level II serious incidents on the slide



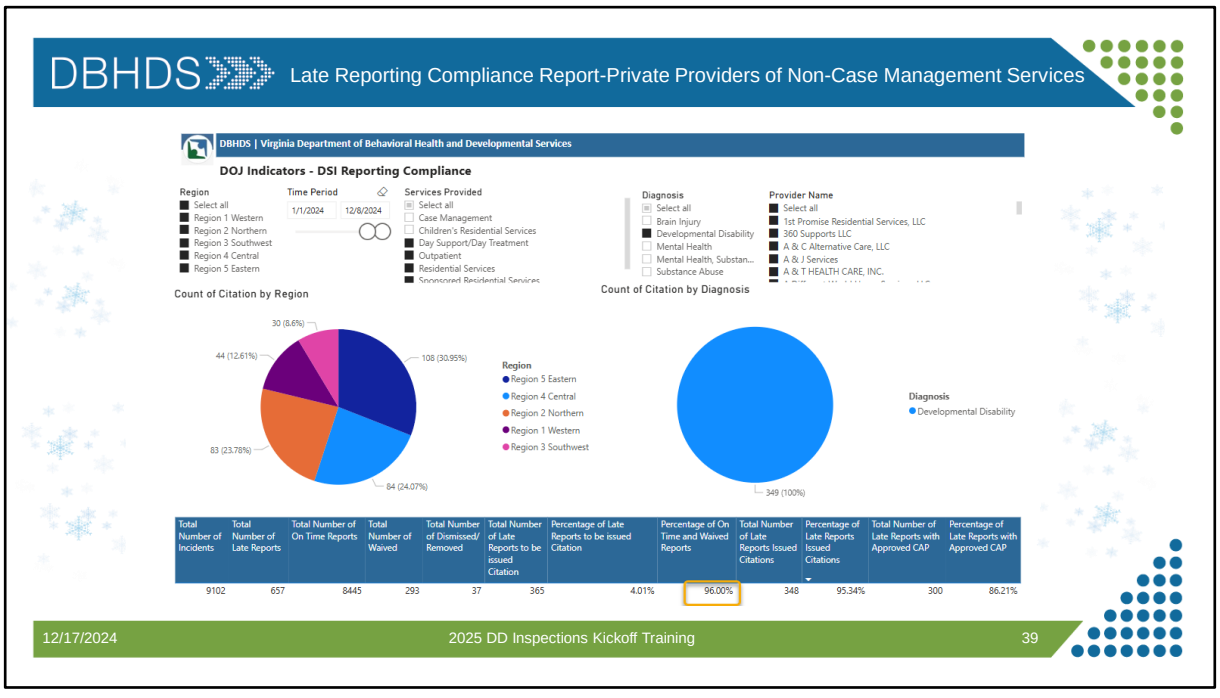
KAREN

- "Level III serious incident" means a serious incident whether the incident occurs while in the provision of a service *or* on the provider's premises and results in:

  a. Any death of an individual;

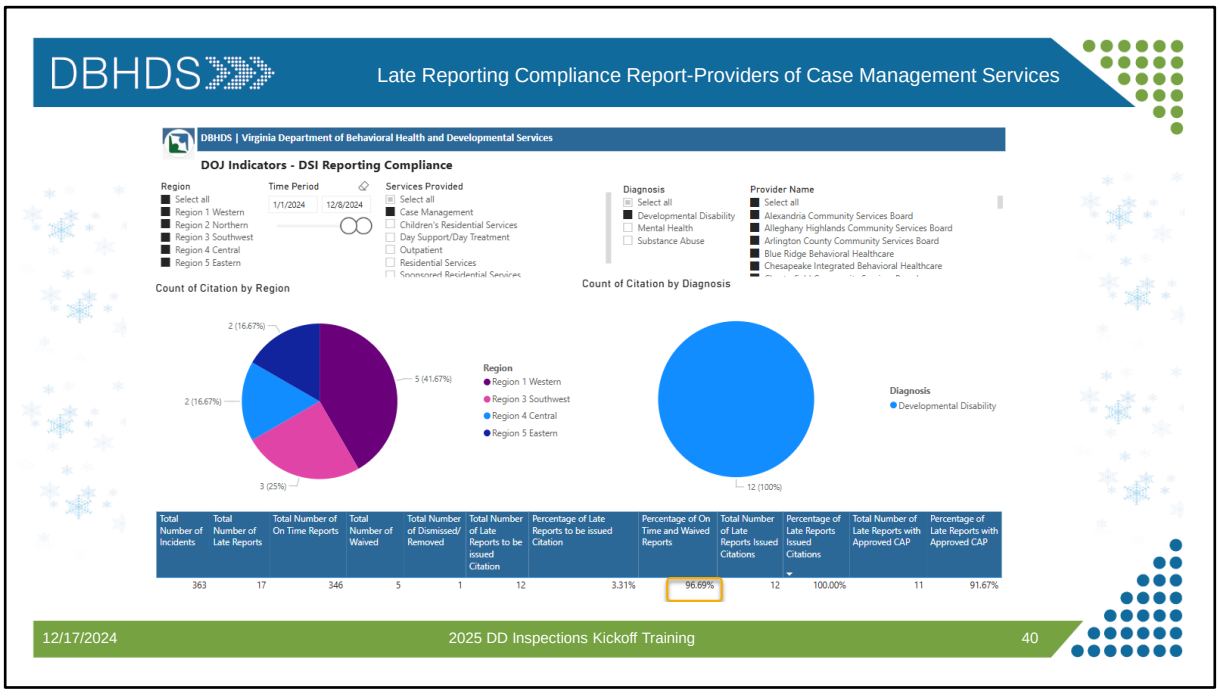
  b. A sexual assault of an individual; or

  c. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.



KAREN

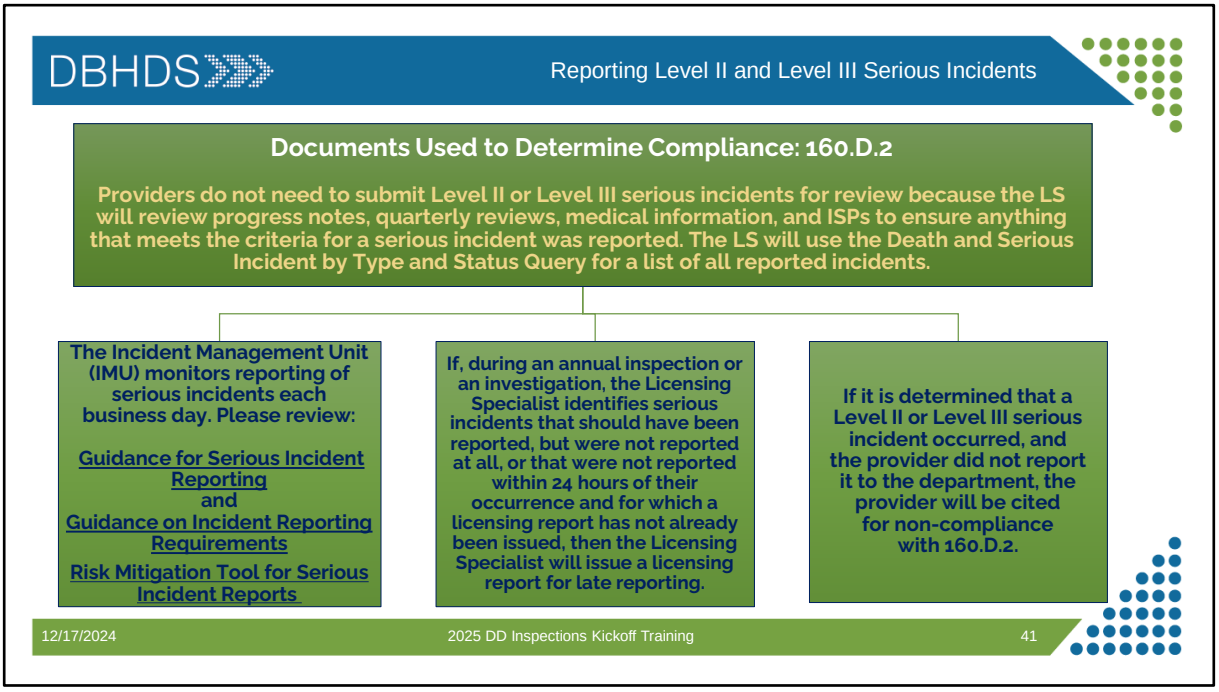
As it relates to reporting serious incidents to the department, from January 1, 2024 through December 8, 2024, the percentage of Developmental Disability Private Providers of Non-Case Management Services who reported Level II and Level III serious incidents on time was 96%. This means that those providers who are reporting, as required, are for the most part reporting within 24 hours of discovery which is great.



KAREN

During this same timeframe, Developmental Disability Providers of Case Management Services who reported Level II and Level III serious incidents on time was 96.69%.

Overall, providers are doing an excellent job reporting serious incidents. Keep it up!



KAREN

Documents the Office of Licensing will review to determine compliance with 160.D.2

- Providers do not need to submit Level II or Level III serious incidents for review because the licensing specialist will review progress notes, quarterly reviews, medical information, and ISPs to ensure anything that meets the criteria for a serious incident was reported. The licensing specialist will use the “Death and Serious Incident by Type and Status Query” for a list of all reported incidents.

- The Incident Management Unit (IMU) monitors reporting of serious incidents each business day. Please review the “Guidance for Serious Incident Reporting” and the “Guidance on Incident Reporting Requirements”.

- In addition, if, during an annual inspection or an investigation, the Licensing Specialist

identifies serious incidents that should have been reported, but were not reported at all, or that were not reported within 24 hours of their occurrence, and for which a licensing report has not already been issued, then the Licensing Specialist will issue a licensing report for late reporting.

- If it is determined that a Level II or Level III serious incident occurred and the provider did not report it to the department, the provider will be cited for non-compliance with 160.D.2.

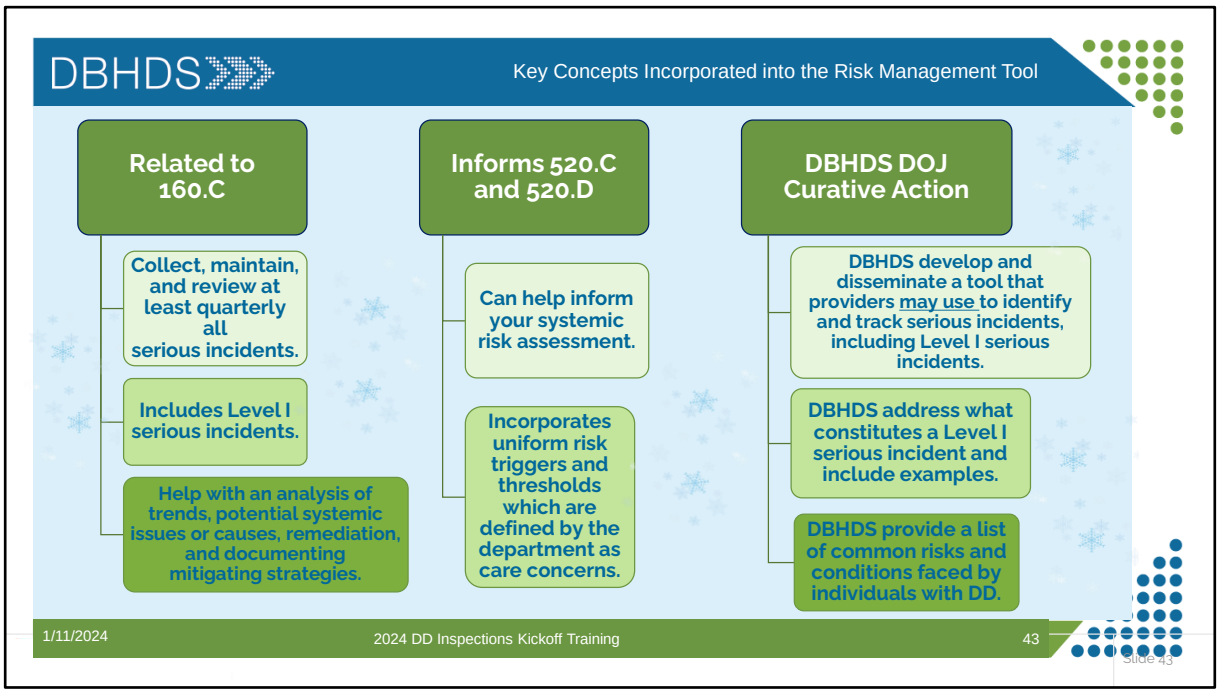
Now Mackenzie is going to talk about some helpful tools that you can use to track serious incidents and much more!

MACKENZIE

As a reminder, Risk Tracking Tools were first introduced during the Minimizing Risk Training in 2023 and these tools have been updated annually based on provider feedback

These tools are built in Excel to help providers collect, maintain, and review:

- Serious incidents
- Risks and conditions common to individuals with developmental disabilities and
- Risk Triggers and Thresholds which are defined by the department as Care Concerns



The Risk Tracking tool was designed to help providers move towards meeting compliance with regulations 160C, 520C and 520D.

For 160C, it helps providers

- Collect, maintain, and review at least quarterly all serious incidents.
- Includes Level I serious incidents.
- Helps with an analysis of trends, potential systemic issues or causes, remediation, and documenting mitigating strategies.

For 520C and D, it helps providers to inform their systemic risk assessment.

- The tool incorporates uniform risk triggers and thresholds which are defined by the department- as care concerns

It also includes the definition and examples of Level I incidents and provides a list of common risks and conditions faced by individuals with developmental disabilities.

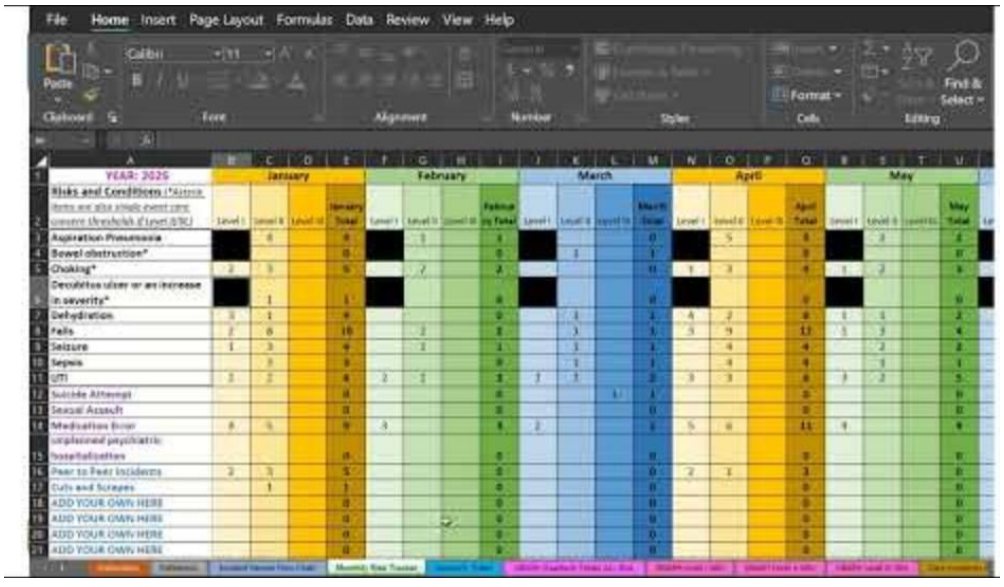
It is also designed to address components of a Curative Action that is part of the DOJ settlement agreement.

- It meets the requirement that DBHDS needs to disseminate a tool that providers may use to track and review serious incidents. This is not a required tool, but it is highly recommended to ensure that you are meeting the Curative Action as part of the DOJ

settlement agreement and to demonstrate compliance with the risk management requirements outlined within the regulations.

We have noticed that more and more providers are utilizing these tools which is wonderful. Make sure you are scrolling all the way to the right of the tool to access all tabs. The Systemic Risk Assessment template was recently added to the tool which is now the last tab of the workbook.

If these tools are used correctly, they will help you achieve compliance with these regulatory requirements and the curative action.



Mary Beth Cox, MSW, MPH
Quality Improvement Coordinator, DBHDS Office of Clinical Quality Management
Marybeth.Cox@dbhds.virginia.gov

Link to video:

Instructional Video-Risk Tracking Tool (November 2024)

Let's take a few minutes to watch the Instructional Video-Risk Tracking Tool that was updated in November 2024 so that you have a full understanding of it's functionality

This is presented by Mary Beth Cox, Quality Improvement Coordinator, with the DBHDS Office of Clinical Quality Management.

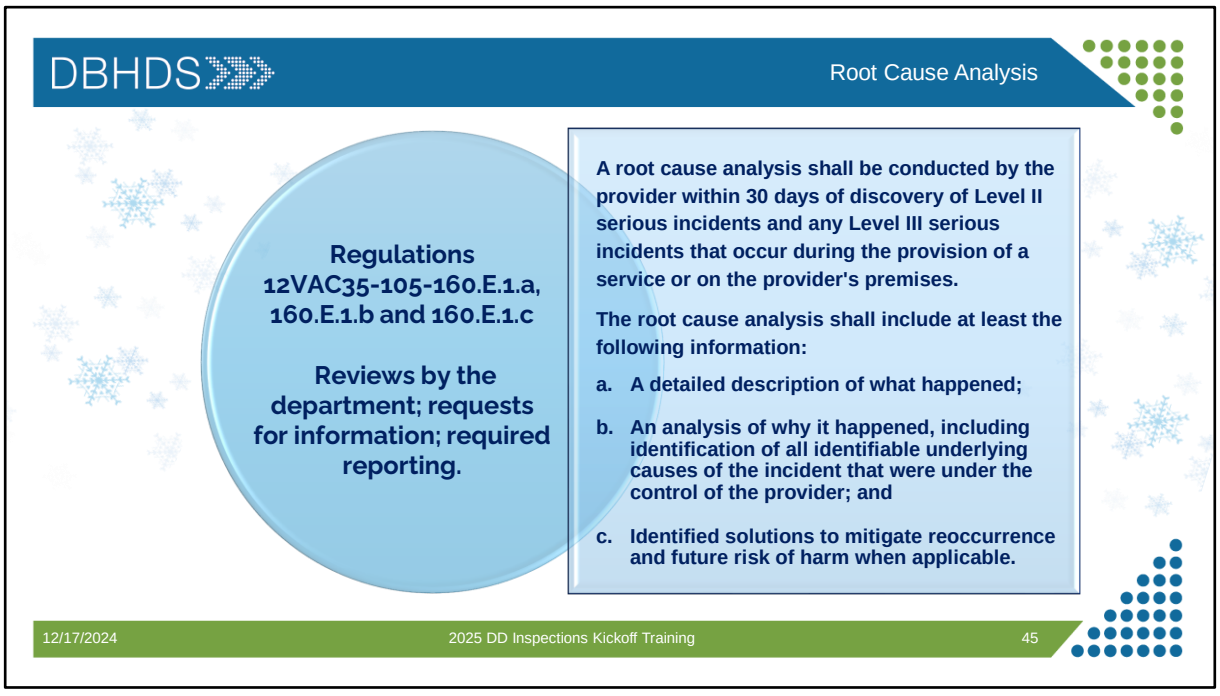
Larisa please play

We really appreciate Mary Beth and her team for developing this tool and updating it when needed

Again, providers using these tools have a higher level of compliance related to regulations 160.C, 520.C and 520.D

Okay, let's take a minute for a poll question from Karen (#1) *Pause for a few seconds here*

And now Karen is going to talk about the root cause analysis



KAREN

Let's move right along to Root Cause Analysis. "Root Cause Analysis" means a method of problem solving designed to identify the underlying causes of a problem.

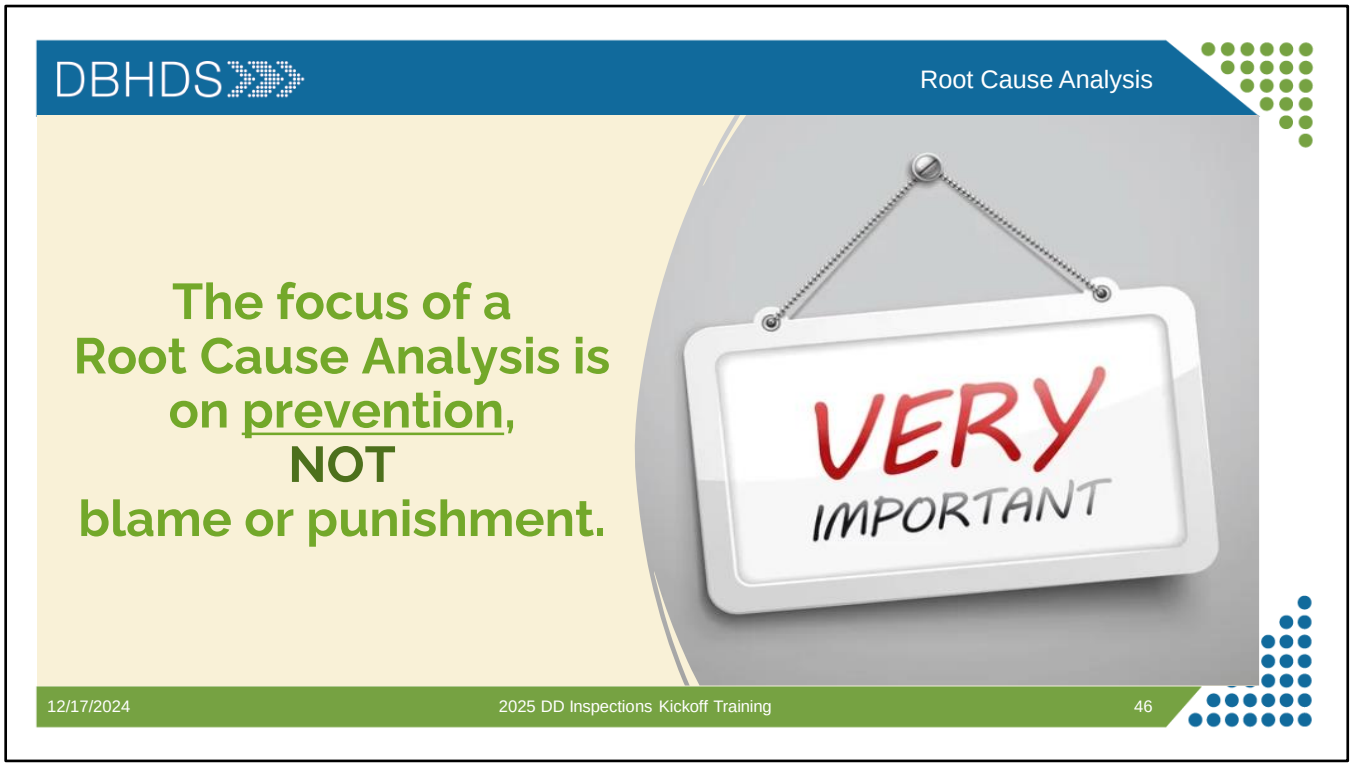
- A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises. This is 30 calendar days, not 30 business days.

- A root cause analysis does not focus on the people involved, but focuses on systems, processes, and outcomes that require change to reduce the risk of harm.

- The goal of a root cause analysis is to find out what happened, why it happened, and determine if action needs to be taken.

- A root cause analysis, as required in these regulations, should include, at a minimum, documentation that the three sub-regulations, 160.E.1.a, 160.E.1.b and 160.E.1.c, were considered to the extent that they are known, or could be known by the provider.

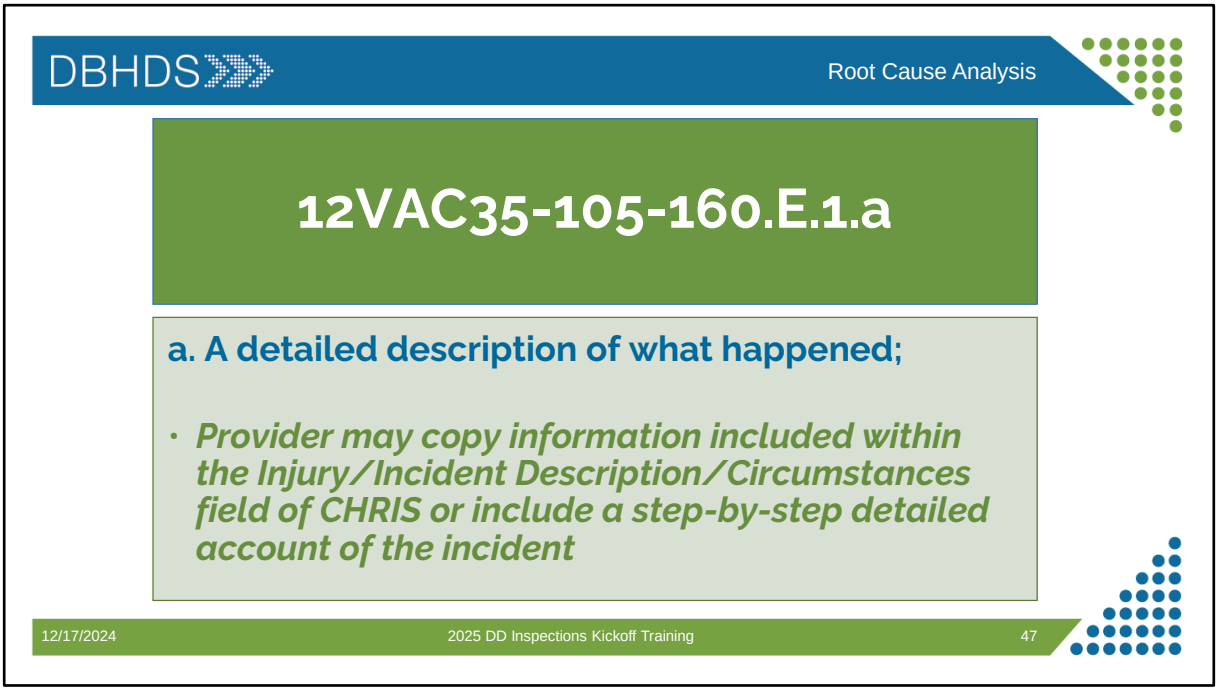
- Providers must ensure that the root cause analysis meets the regulatory requirements as outlined in 160.E.1.a, 160.E.1.b and 160.E.1.c, and that it is completed within 30 calendar days of discovery of the serious incident.



KAREN

- A root cause analysis begins with the assumption that no one comes to work intending to make a mistake or to hurt someone. People make mistakes, but awareness of errors is important in terms of improving systems. To develop a culture of safety, staff should be encouraged to report errors without fear of retribution and to look for ways to improve systems.

- That's not to say that a root cause analysis never uncovers intentional acts of harm. That may happen and when it does, you must take the appropriate action.

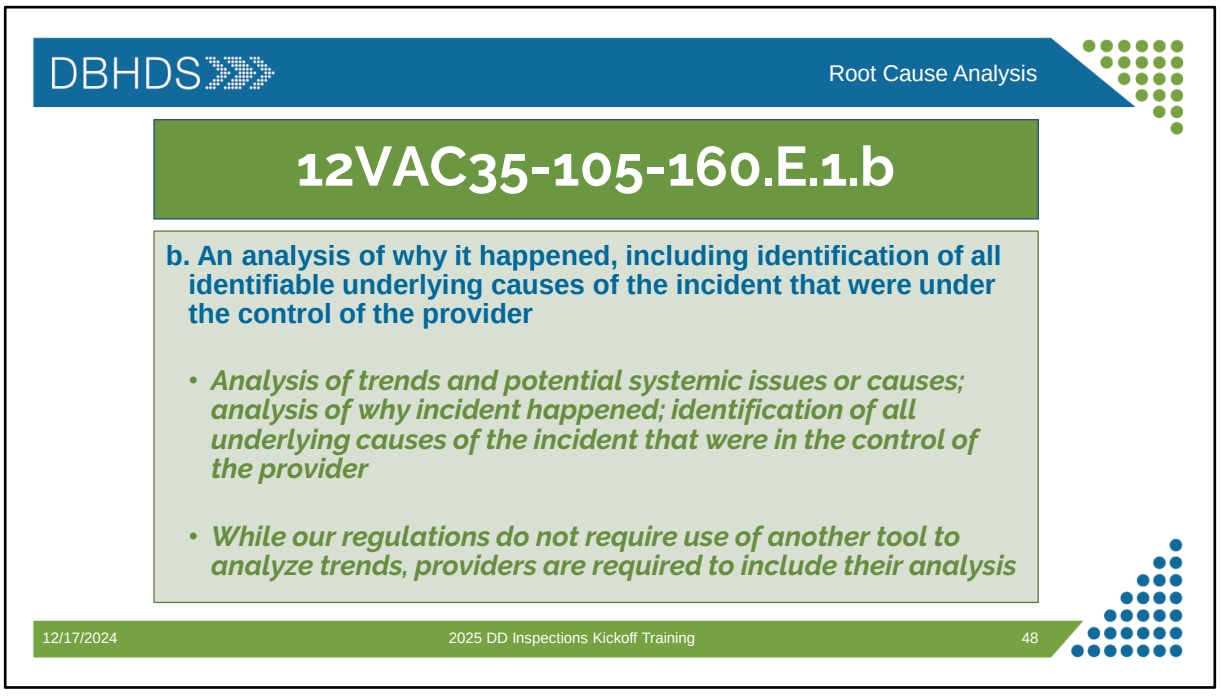


KAREN

Let's break down the sub-regulations for 160.E.1 to look at each more closely. We'll start with 160.E.1.a: A detailed description of what happened

- A provider can start with the incident report which provides the date, time, place, individuals involved, and a description of what happened. This should also include what immediate actions were taken. This initial sequence of events helps identify what occurred. Often it is a chain of events that resulted in an incident.

- If more than one staff member was involved, each staff member could write what happened from their perspective. It is possible that others may have seen something even if they were not directly involved in the incident (i.e. they saw something from the window).



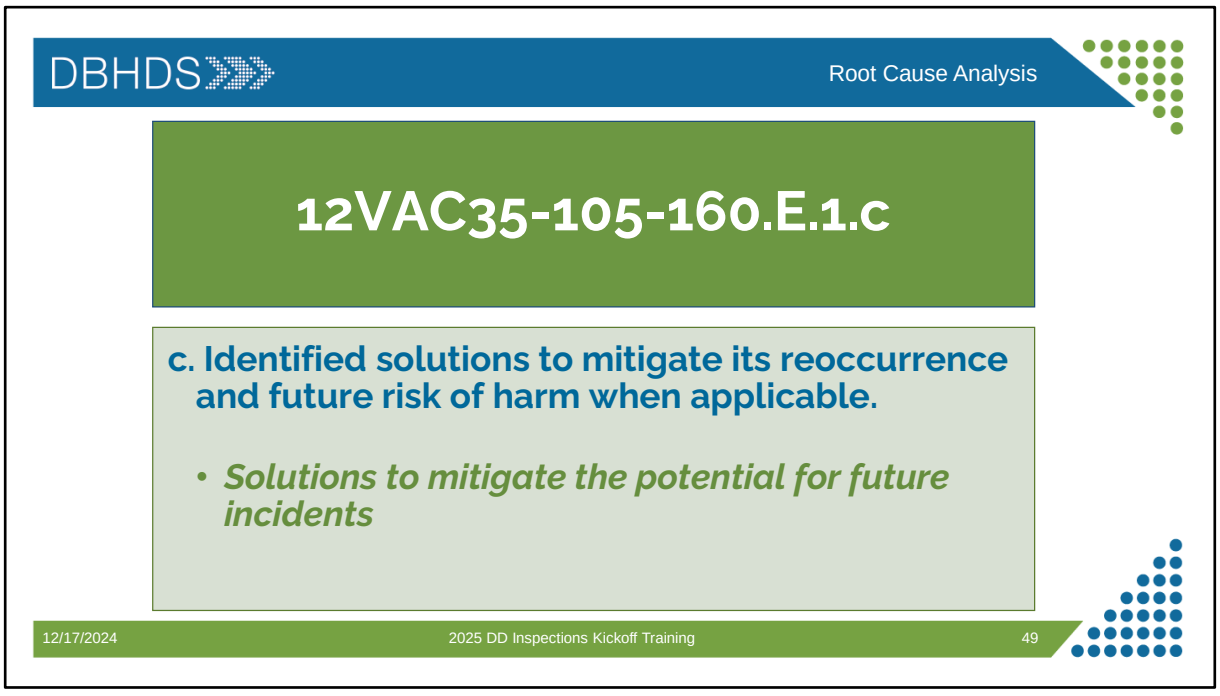
KAREN

This second sub-regulation is where the work begins, 160.E.1.b.

An analysis of "why" an incident occurred should:

- Compare what happened to what should have happened before, during, and after the incident.
- Compare the actions taken before, during, and after the incident to the requirements in the provider's policies and procedures, DBHDS licensing and other applicable regulations, accreditation standards, and applicable laws.
- Clearly identify the underlying causes of the incident that were under the control of the provider.

The "why" here is important. Based on the incident, you could complete a "5 Whys" approach.



KAREN

Finally, let's talk about the third sub-regulation, 160.E.1c.

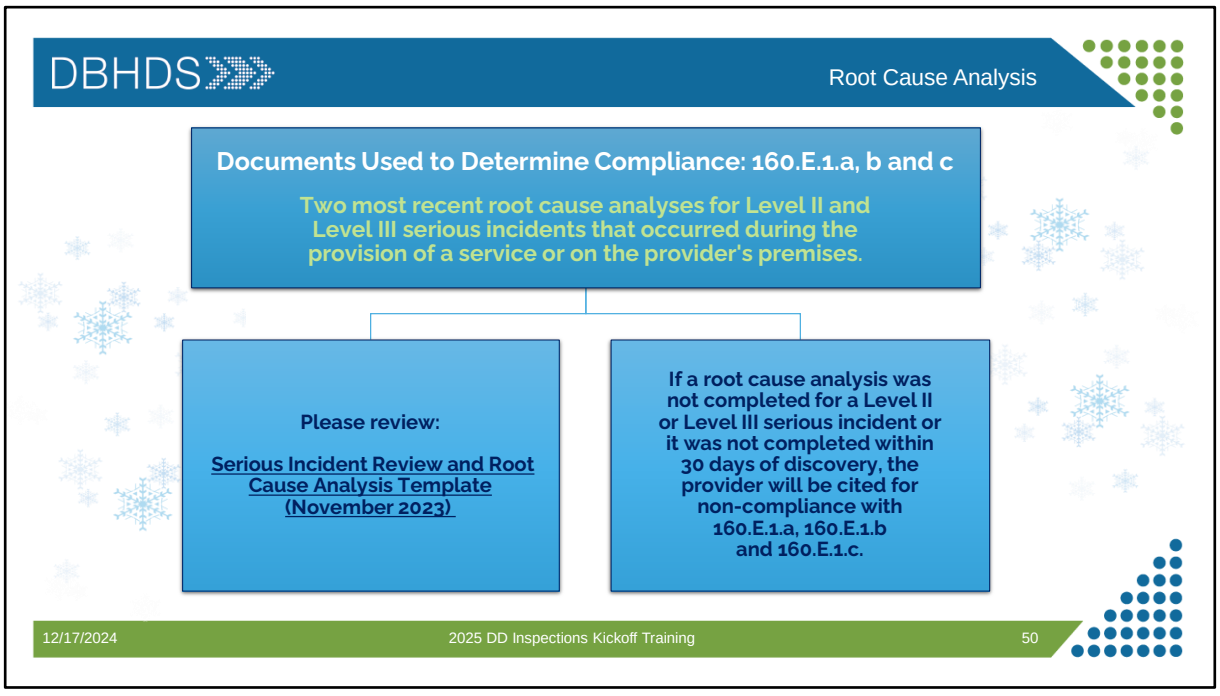
•The root cause analysis should identify solutions, as applicable, to be taken by the provider to keep the situation from occurring again or minimize the likelihood of its reoccurrence and future risk of harm, when applicable. Then the identified solutions to mitigate its reoccurrence should be implemented.

•These solutions should be both individual-specific and systemic as indicated by the analysis of the incident.

•Implementation of solutions and their efficacy could be monitored as part of the provider's quality improvement program.

Remember, the root cause analysis must be completed by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises. This is 30 calendar days not 30 business days.

Now, let's look at the documentation the Office of Licensing will review to determine compliance with 160.E.1.a, 160..E.1.b, and 160.E.1.c.

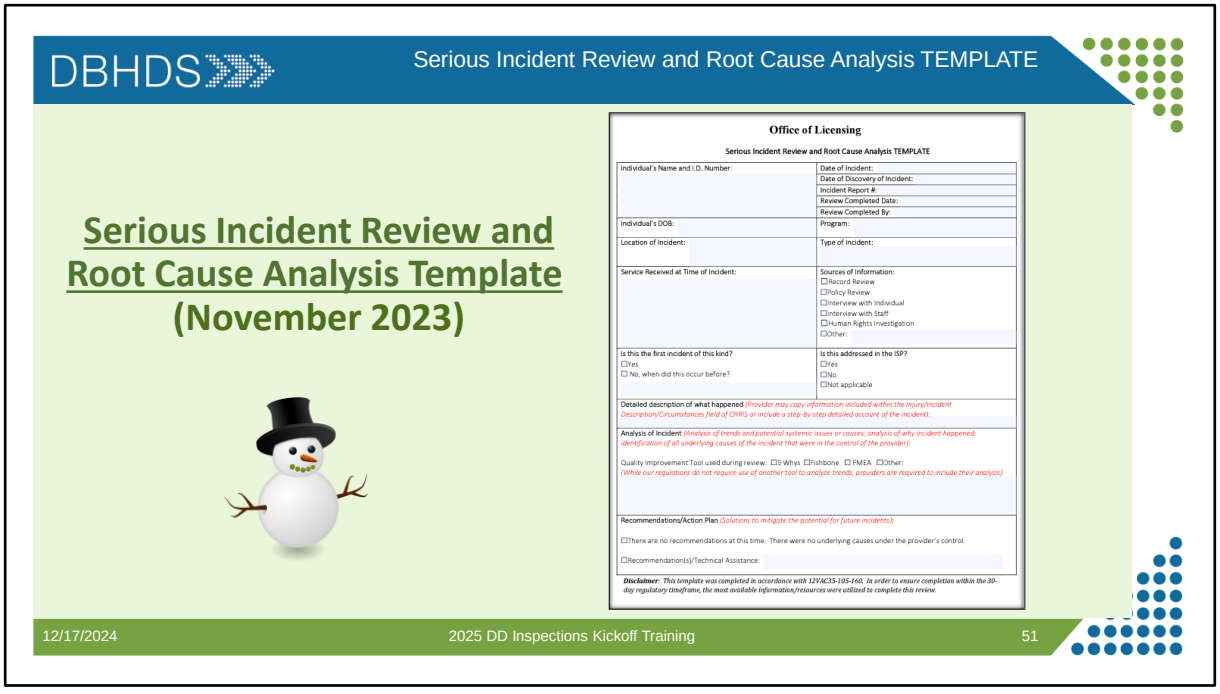


KAREN

Documents the Office of Licensing will review to determine compliance with the root cause analysis

- Two most recent root cause analyses for Level II and Level III serious incidents that occurred during the provision of a service or on the provider's premises.

- If a root cause analysis was not completed for a Level II or Level III serious incident, or it was not completed within 30 calendar days of discovery, the provider will be cited for non-compliance with 160.E.1.a, 160.E.1.b and 160.E.1.c.

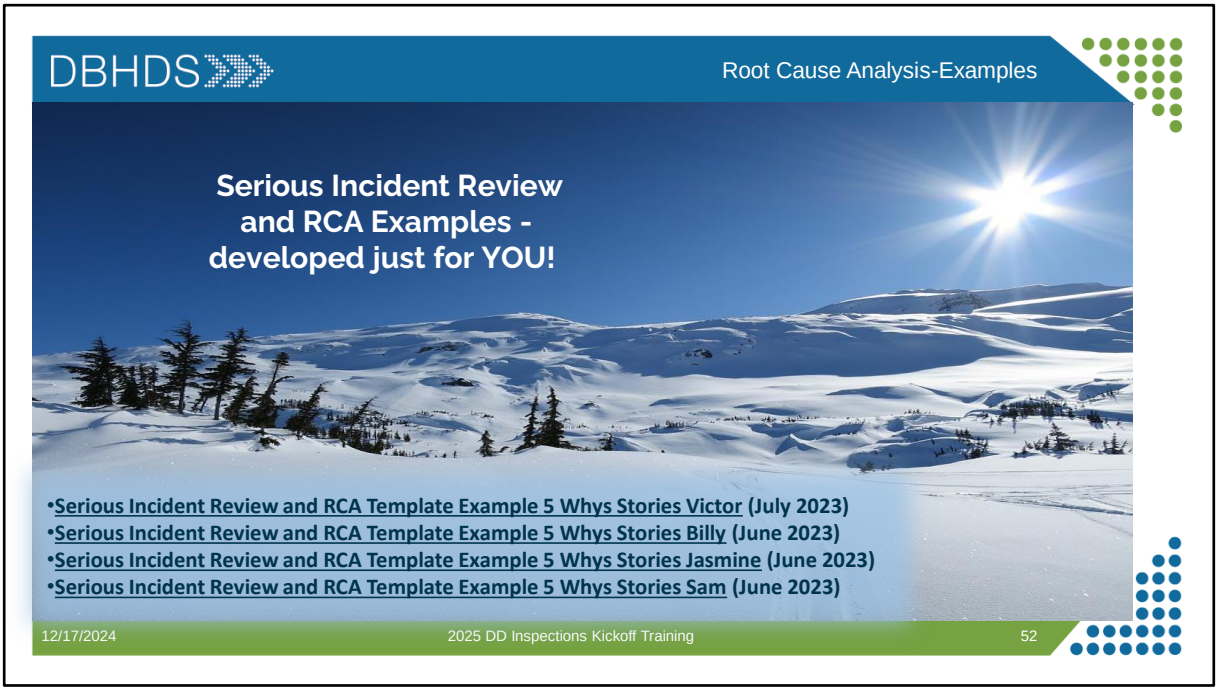


KAREN

I also want to remind everyone of the "Serious Incident Review and Root Cause Analysis Template" that was developed in 2023 and is located on the Office of Licensing website.

Remember, this is not a required template. However, utilization of this template will assist providers in achieving compliance with the regulatory requirements of 12VAC35-105-160.

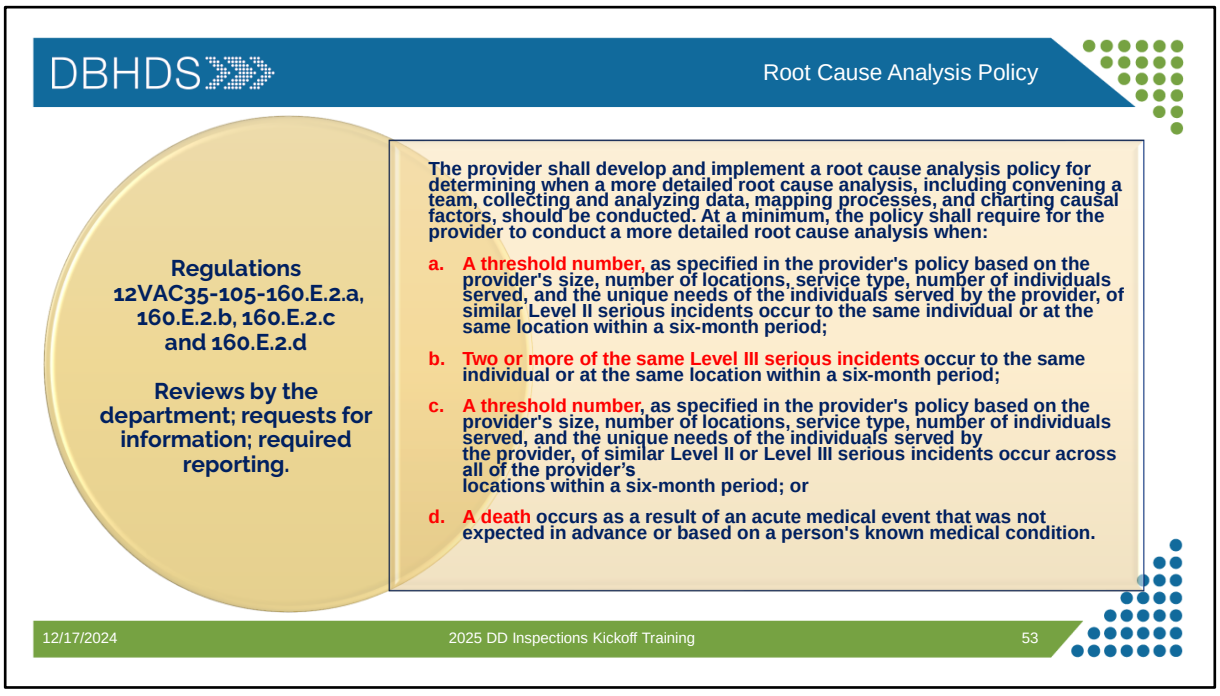
If your organization choses not use this template, then you must ensure that the root cause analysis is completed within 30-day of the discovery of the serious incident AND meets the regulatory requirements as outlined in 160.E.1.a, 160.E.1.b and 160.E.1c.



KAREN

If you are not sure of the requirements for a root cause analysis, I strongly encourage you to look at these Root Cause Analysis examples which are located on the OL website

Now Mackenzie is going to review the requirements for the Root Cause Analysis Policy



MACKENIZE

Thank you, Karen

- All providers are required to develop and implement a root cause analysis policy for determining when a more detailed root cause analysis will be conducted. This includes convening a team, collecting and analyzing data, mapping processes, and charting causal factors. At a minimum, the policy must indicate when the provider will complete a more detailed root cause analysis.

- The term threshold, as it relates to these regulations, mandates the provider to establish a criteria by setting an amount or number that, if met during a specific timeframe, will require them to conduct a more detailed root cause analysis.

- When developing the root cause analysis policy, providers must take into consideration the number of locations, the number of individuals receiving services, the types of services the provider provides, and the unique needs of the individuals.

- Once a threshold has been met, then the provider is responsible for conducting a more

detailed root cause analysis of these incidents that resulted in meeting the threshold. When a threshold has been met requiring a more detailed RCA, the 30 calendar day timeline for conducting RCAs remains the same. **Therefore, the RCA must be conducted within 30 calendar days of the occurrence of the incident that led to meeting the threshold.**

- The Root Cause Analysis policy could also outline who will appoint a team if a more detailed RCA is being conducted.

- Keep in mind that a provider's RCA policy can be part of the provider's Serious Incident Reporting policy.

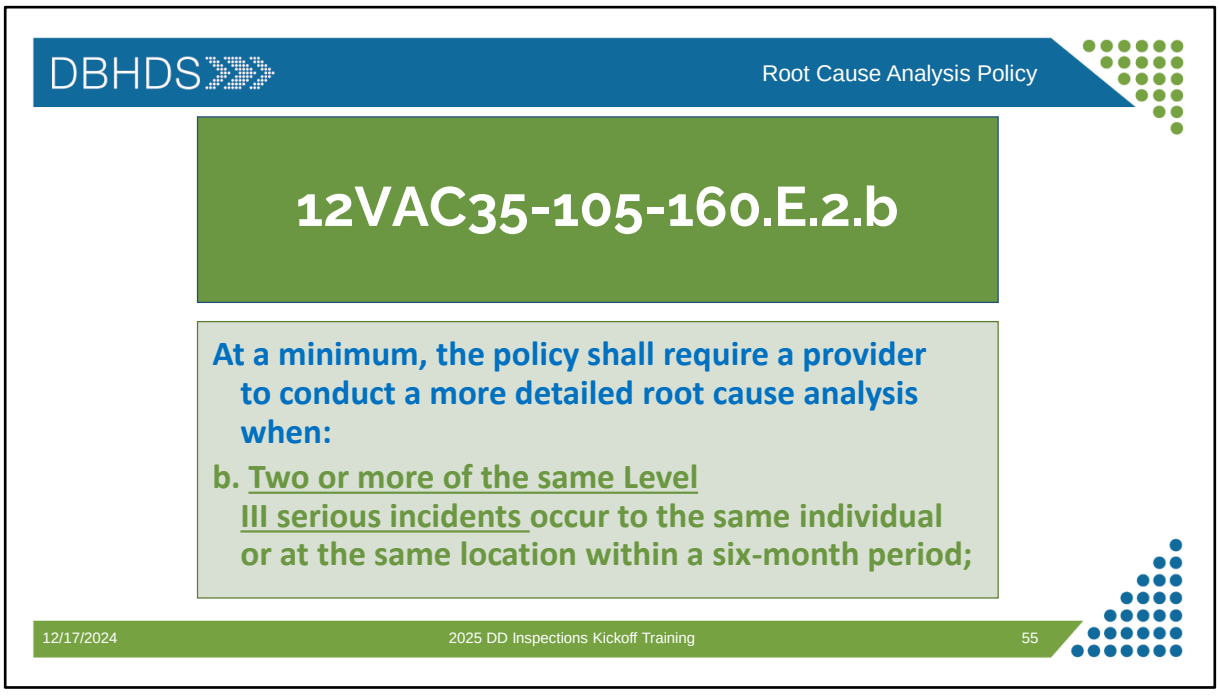
- Now we're going to take a closer look at each required component of the policy

12VAC35-105-160.E.2.a

At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when:

a. A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents occur to the same individual or at the same location within a six-month period;

- 160.E.2.a
- At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when:
- The threshold number is met as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents that occur to the same individual or at the same location within a six-month period;
- For this policy, the provider must determine their threshold number.



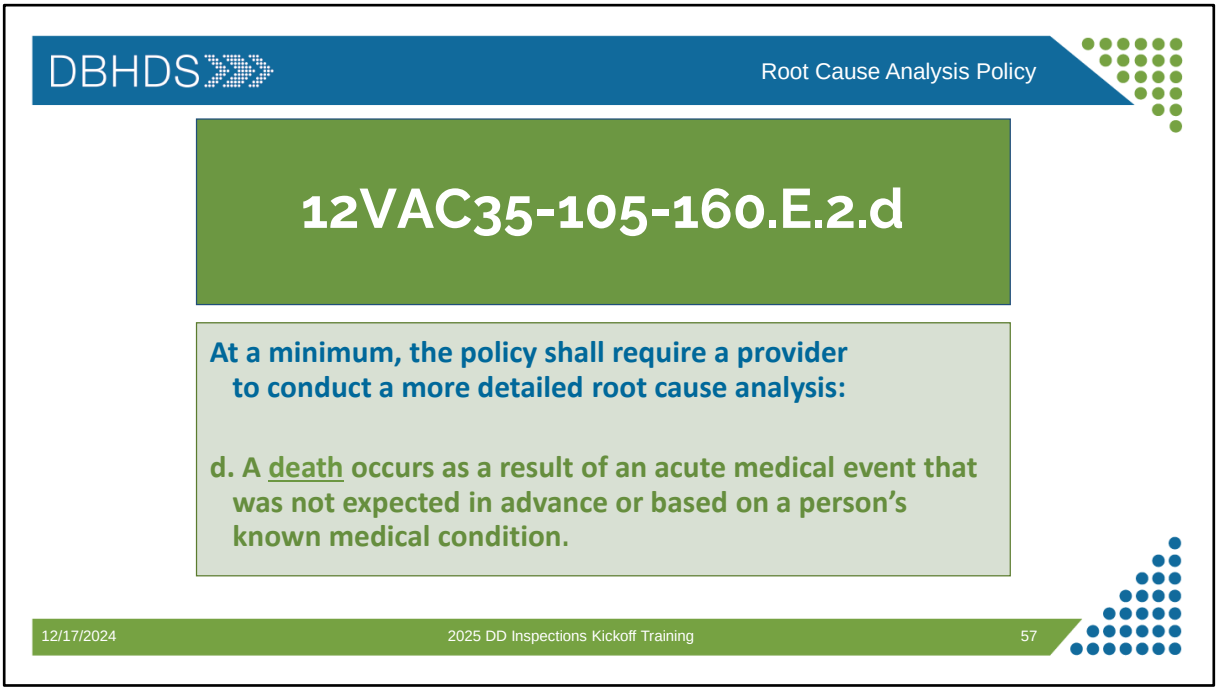
- 160.E.2.b
- At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when:
- Two or more of the same Level III serious incidents occur to the same individual or at the same location within a six-month period;
- As you can see here, the threshold number is already determined in this regulation and this is the minimum requirement for the policy,
- The provider's policy should include this regulation directly as stated.

12VAC35-105-160.E.2.c

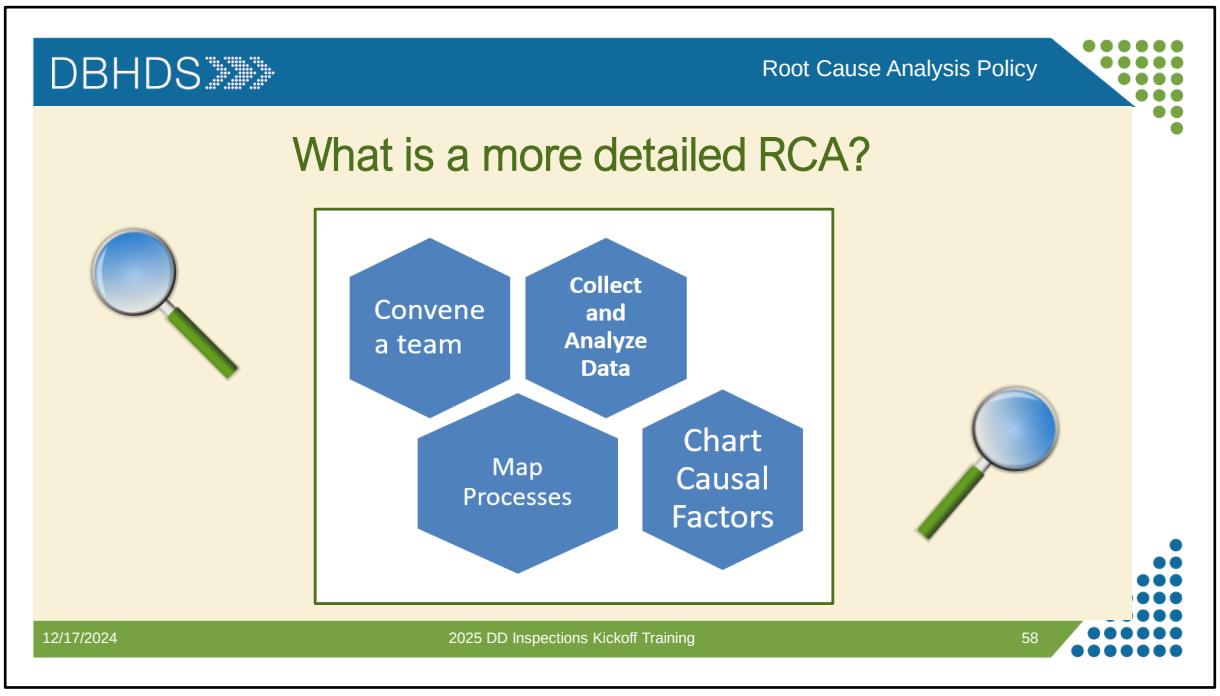
At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when:

c. A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents occur across all the provider's locations within a six-month period;

- 160.E.2.c
- At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when
- The threshold number is met as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II or Level III serious incidents that occur across all of the provider's locations within a six-month period;
- Similar to 160.E.2.a, the provider must determine a threshold number for their policy.



- Lastly, 160.E.2.d
- At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when a death occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.
- The provider's policy should include this regulation directly as stated.



We've reviewed the requirements for a root cause analysis,

Looked over the Serious Incident Review and Root Cause Analysis Template,

And talked about the requirements for a root cause analysis policy.

Now let's talk about the more detailed root cause analysis as outlined in regulation 160.E.2.

You need to remember that once a threshold has been met requiring a more detailed RCA, the 30 day timeline for conducting the RCA remains the same. Therefore, the RCA must be conducted within 30 days of the occurrence of the incident that led to meeting the threshold.

This process includes convening a team, collecting and analyzing data, mapping processes, and charting causal factors. Let's take some time to review exactly what these mean.

The provider would first begin by convening a team. It doesn't have to be a large team. In most cases, the Root Cause Analysis team may consist of 4-5 people and would be interdisciplinary. Different professional backgrounds can support creative thinking. The team members should be given a quick overview of what a Root Cause Analysis is and what it is not. Review rules of behavior, it's not about blame, also avoid hindsight bias. Teams can jump to conclusions so it's important to follow the outline of how to effectively conduct a Root Cause Analysis.

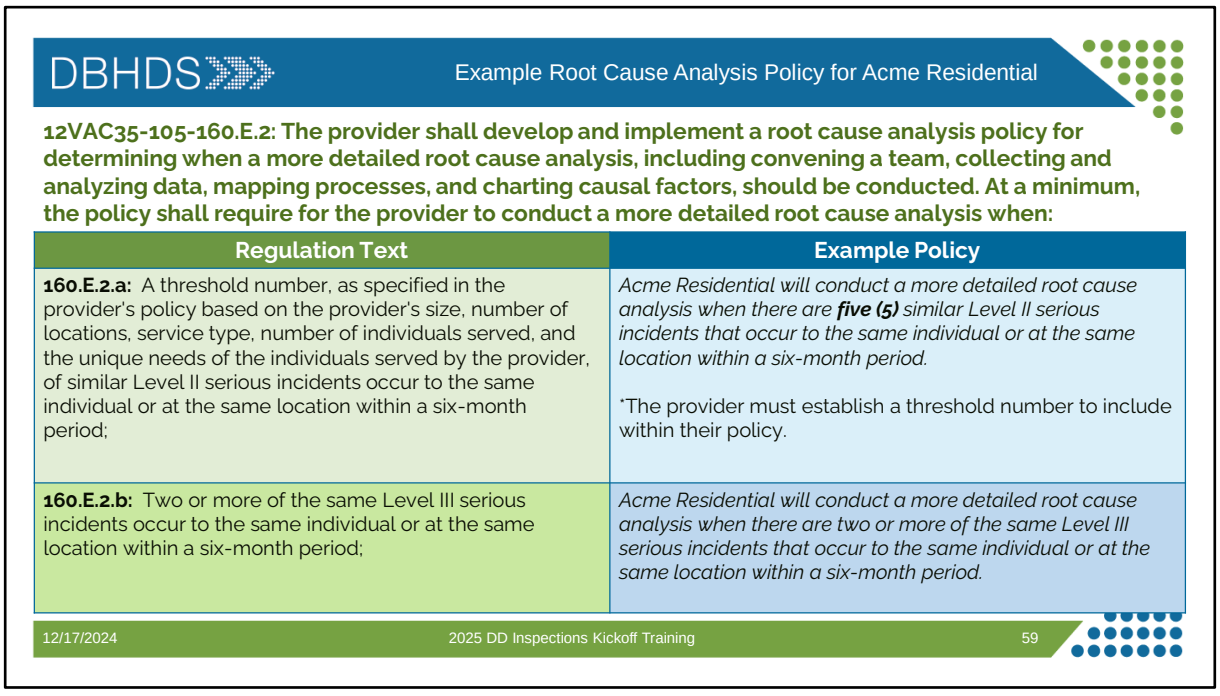
As a reminder, each provider must designate a person responsible for the risk management function who has training and expertise in conducting investigations, root cause analysis, and data analysis. Depending on the incident and the organization, this person (the designated risk manager) may serve as the lead on the Root Cause Analysis team or provide guidance and an overview of the team's charter.

The team would collect and analyze data, perhaps even conduct interviews to find out what happened from the perspective of the person or people involved

Use Mapping processes – use items such as a flow chart, storyboards, process maps, etc.

And Chart Causal factors – a causal factor can be defined as any "major unplanned, unintended contributor to an incident, a negative event or undesirable condition, that if eliminated would have either prevented the occurrence of the incident or reduced its severity or frequency."

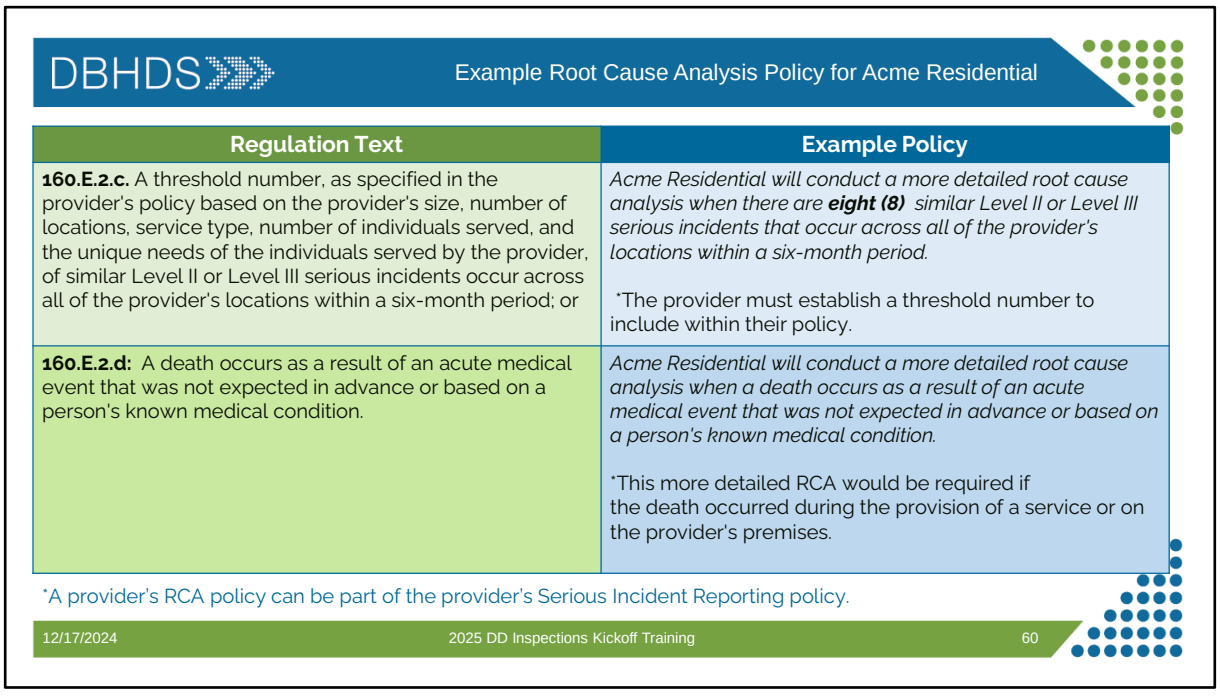
Now let's take a look at an example Root Cause Analysis policy.



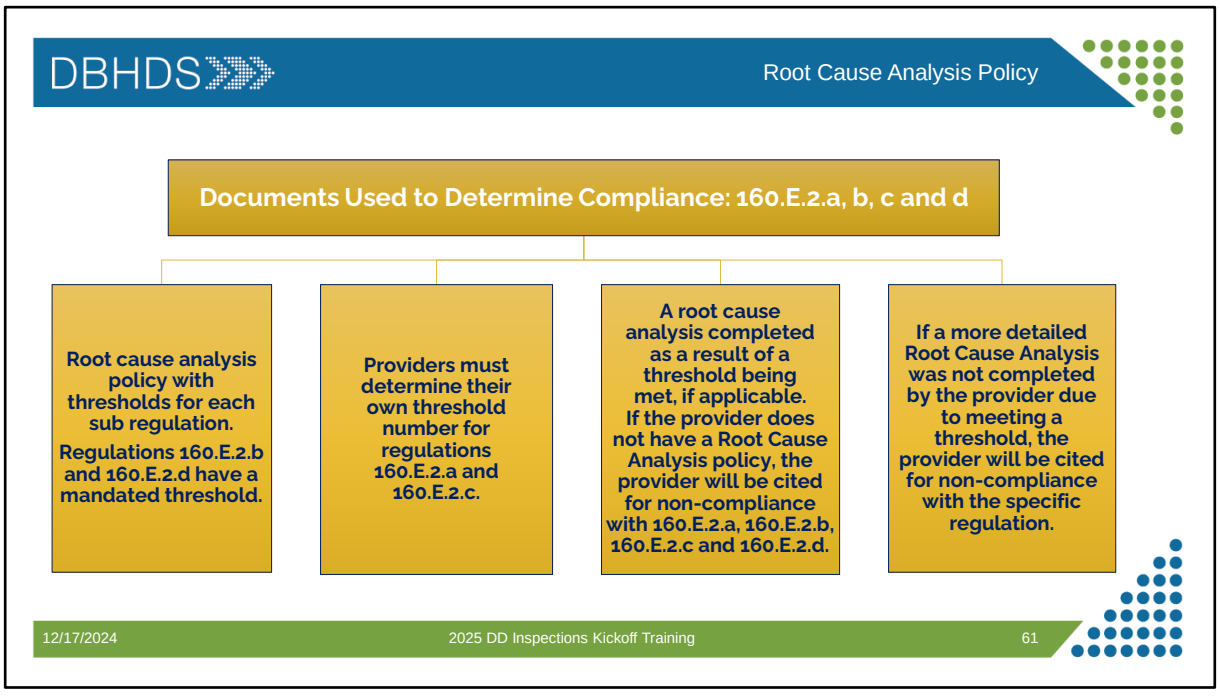
Here we see Acme Residential's Root Cause Analysis Policy.

- As you can see, there are two columns in the chart. For your reference we have the regulatory text on the left in green and an example policy on the right in blue.
- Just so you know, Acme Residential has eight group homes.
- For 160.E.2.a: Acme Residential's policy states that they will conduct a more detailed root cause analysis when there are five (5) similar Level II serious incidents that occur to the same individual or at the same location within a six-month period.
- Remember for this regulation, the provider must establish the criteria for when a more detailed RCA will be conducted. Acme Residential did this, as you can see their policy states "five". Once that threshold of five is met then Acme residential must conduct a more detailed Root Cause Analysis.
- For 160.E.2.b: Providers must include all of the elements of this regulation within their policy since it is the minimum requirement.
- Acme Residential's policy states that they will conduct a more detailed root cause

analysis when there are two or more of the same Level III serious incidents that occur to the same individual or at the same location within a six-month period. Once that threshold of two is met then Acme residential must conduct a more detailed Root Cause Analysis.



- For 160.E.2.c: Acme Residential's policy states that they will conduct a more detailed root cause analysis when there are eight (8) similar Level II or Level III serious incidents that occur across all of the provider's locations within a six-month period.
- Remember for this regulation, the provider must establish the criteria for when a more detailed RCA will be conducted. This provider did, their policy states eight. Once that threshold of eight is met then Acme residential must conduct a more detailed Root Cause Analysis within 30 days of when the threshold was met.
- For 160.E.2.d: Providers must include every element of this regulation within their policy since it is the minimum requirement.
- Acme Residential's policy states that they will conduct a more detailed root cause analysis when a death occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.
- Don't forget that the threshold number should take into account the agency's size, population served, and services provided. Once the threshold number has been met then the provider is responsible for conducting a more detailed root cause analysis of these incidents that resulted in meeting the threshold. Therefore, the RCA must be conducted within 30 days of the occurrence of the incident that led to meeting the threshold.



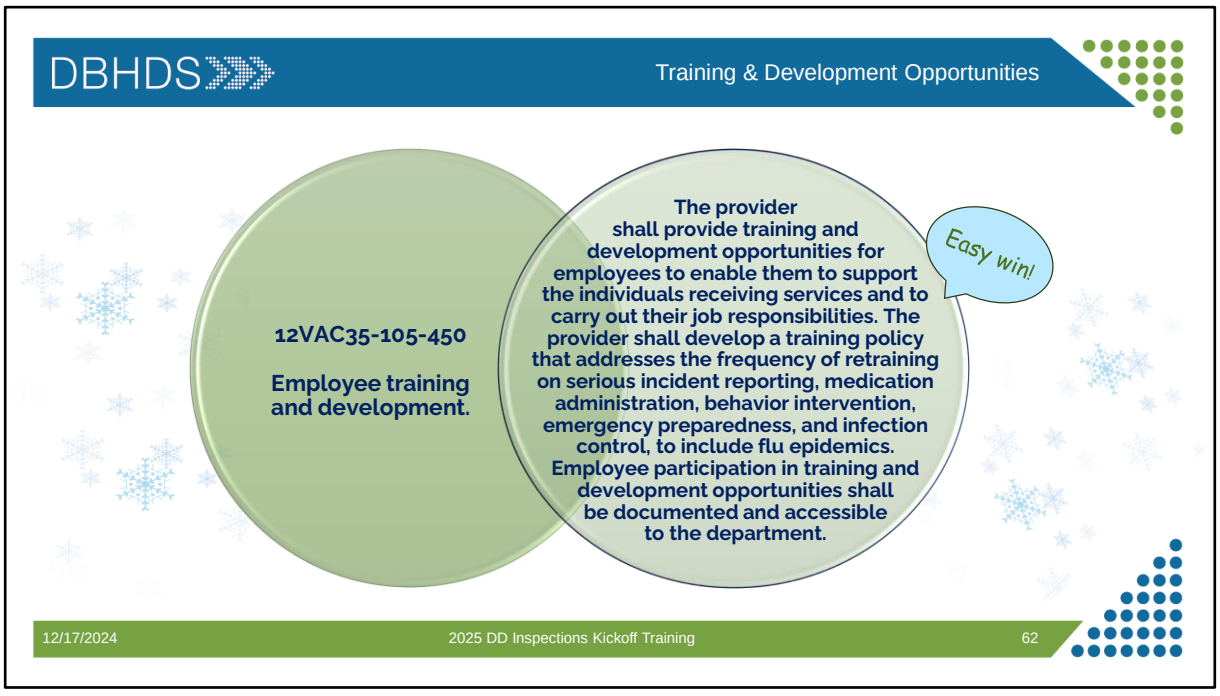
Documents the Office of Licensing will review to determine compliance with the Root Cause Analysis Policy

- Root cause analysis policy with thresholds for each sub regulation.
- Remember, regulations 160.E.2.b and 160.E.2.d have a mandated threshold per the regulations
- Providers must determine their own threshold number for 160.E.2.a and 160.E.2.c.
- We will be looking for a root cause analysis completed as a result of a threshold being met, if applicable, and it must be conducted within 30 days of when the threshold was met
- If the provider does not have a Root Cause Analysis policy, the provider will be cited for non-compliance with 160.E.2.a, 160.E.2.b, 160.E.2.c and 160.E.2.d.

•If a more detailed Root Cause Analysis was not completed by the provider due to meeting a threshold, the provider will be cited for non-compliance with the specific regulation.

•Okay, let's a few minutes for some **poll questions from Karen (#2, #3, and #4)**

Now Karen is going to review the regulation specific to training and development



KAREN

Let's move along to Regulation 450 which has to do with training and development. This regulation falls under the Adequacy of Supports, and another DOJ compliance indicator.

The provider shall provide training and development opportunities for employees to enable them to support the individuals' receiving services and to carry out their job responsibilities.

The provider shall develop a training policy that addresses the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics.

Employee participation in training and development opportunities shall be documented and accessible to the department.

This is an area that should be an easy win for you all. I know that with your hard work, we can get to 86%

KAREN

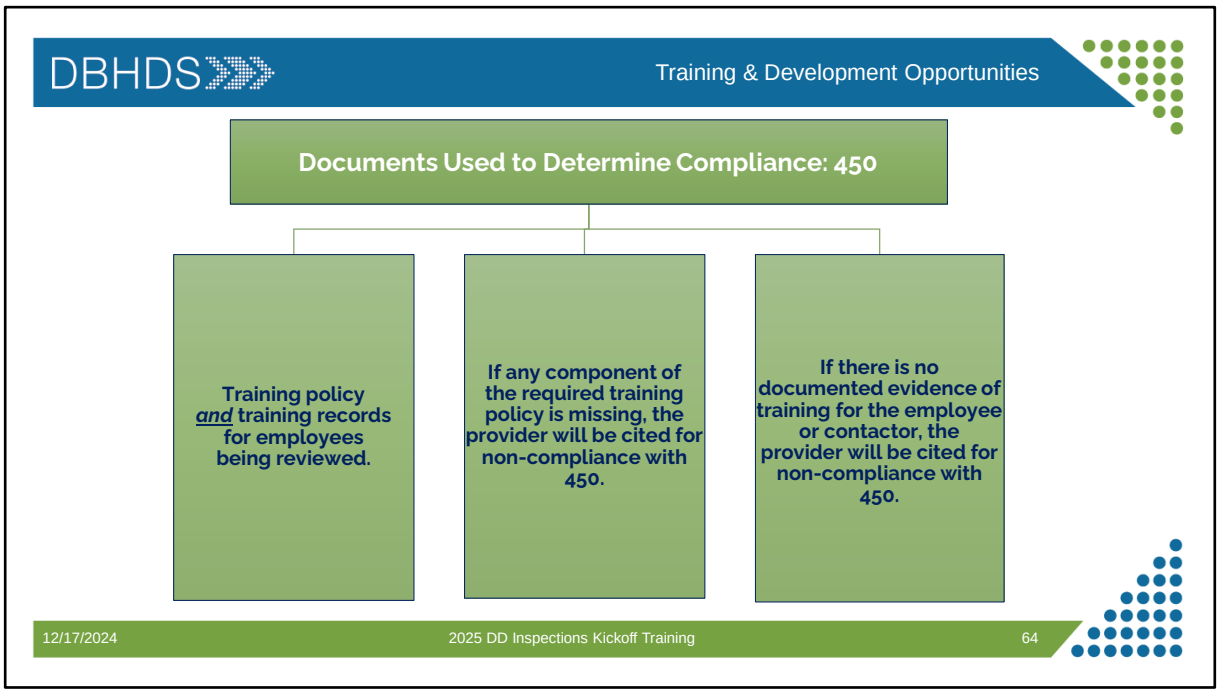
The Office of Provider Network Supports will be continuing their "Provider Readiness Education Program" known as (PREP) sessions. These online sessions are targeted to newly licensed providers who need basic information about the DD services system and provider requirements. Some topics include:

- Intro to DD services system
- Regulations and key players
- Provider Enrollment
- HCBS Settings Regulations
- WaMS and COVLC
- Individual Support Plan
- Orientation and Competencies
- Provider Network Listserv
- Settlement Agreement
- Choice and Person-centeredness
- Health, safety and risk

The next sessions occur on: January 28, 2025, February 25, 2025 and March 25, 2025 from

10a -noon

The links to register for these trainings were sent out through the provider network list serve recently. Please reach out to Jennifer Kurtz with the Office of Provider Network Supports if you have questions or need help registering.

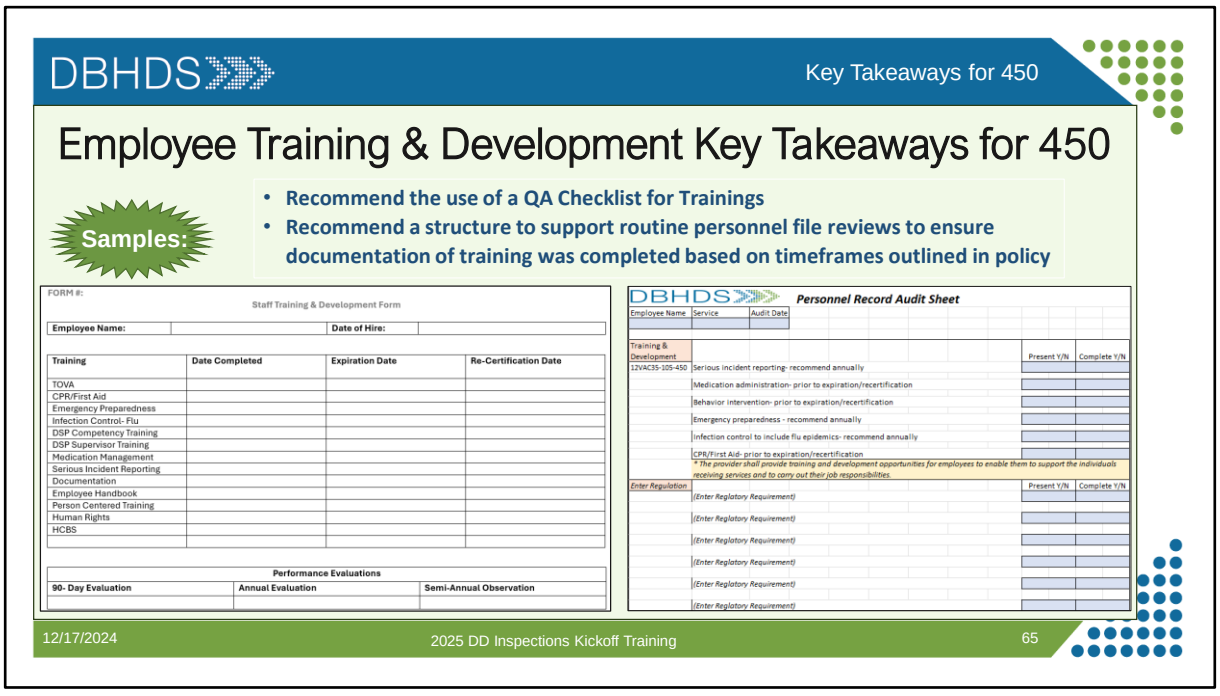


KAREN

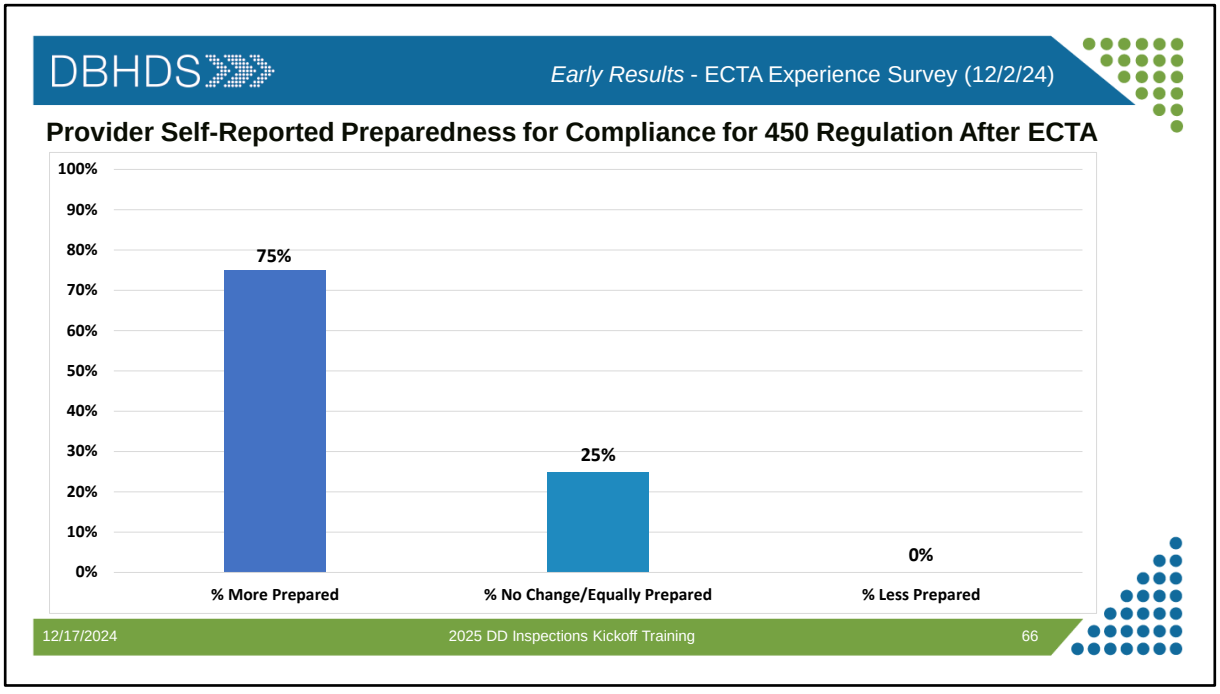
Documents the Office of Licensing will review to determine compliance for 450.

- Training policy; and
- Training records for employees being reviewed.
- If any component of the required training policy is missing, the provider will be cited for non-compliance with 450.
- If there is no documented evidence of training for the employee or contactor the provider will cited for non-compliance with 450.

Now we will hear from Teena who will share some Key Takeaways for 450

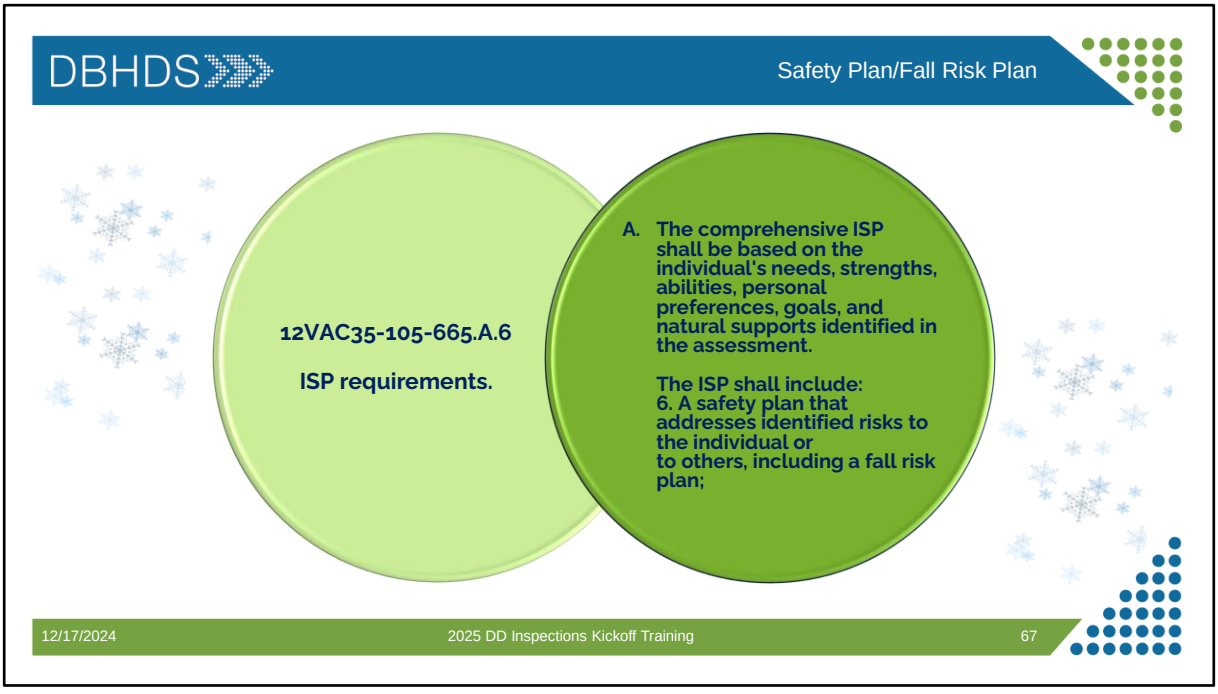


To update, reference slide in front of this one
Teena- barriers
Kara-tools
Teena- methods



Kara- survey results for 450

Now Mackenzie is going to talk about the safety plan



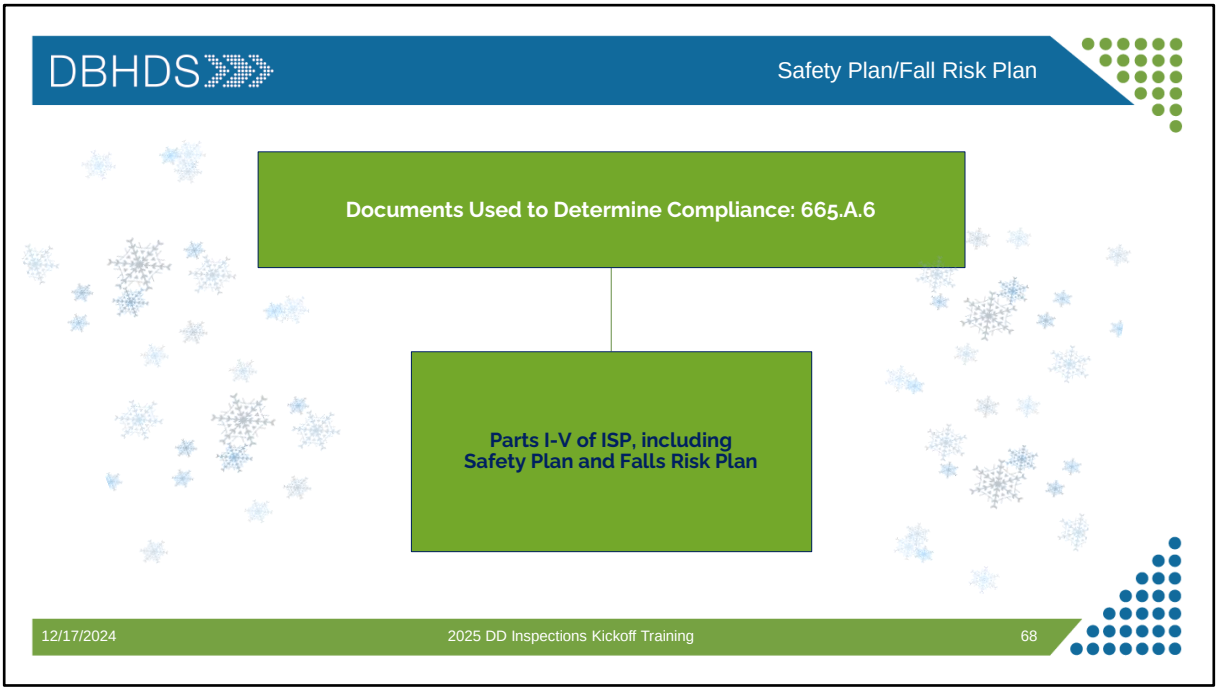
Mackenzie

665.A.6 states

The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the assessment.

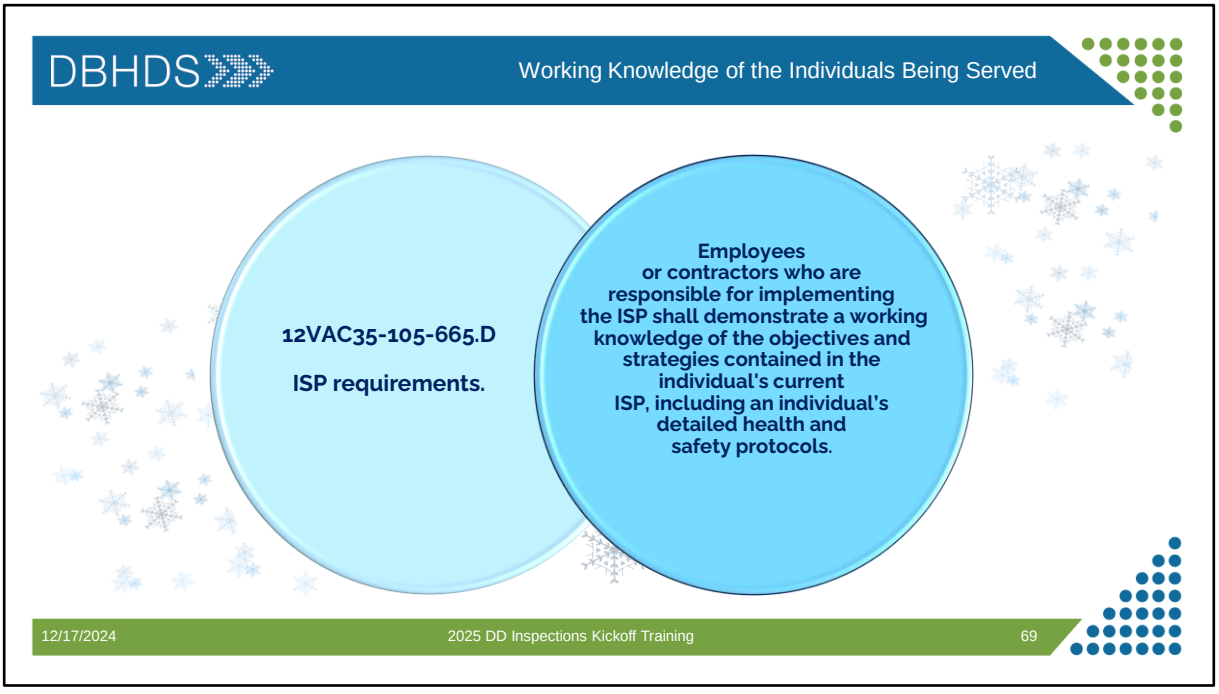
The ISP shall include:
A safety plan that addresses identified risks to the individual or to others, including a fall risk plan;

It is important that providers are assessing individuals at least annually, or as needed, to determine if a safety plan or fall risk plan needs to be included within their ISP.



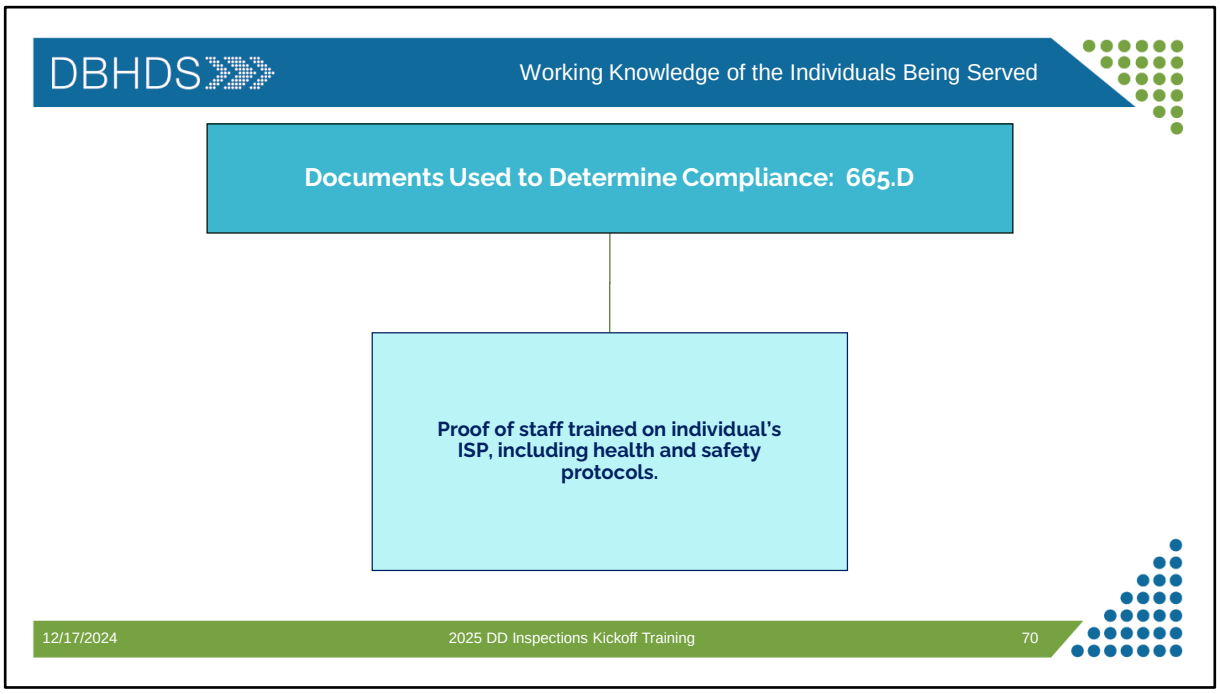
Documents the Office of Licensing will review to determine compliance

The licensing specialist will review Parts I-V of the ISP including any safety plan and/or fall risk plan.



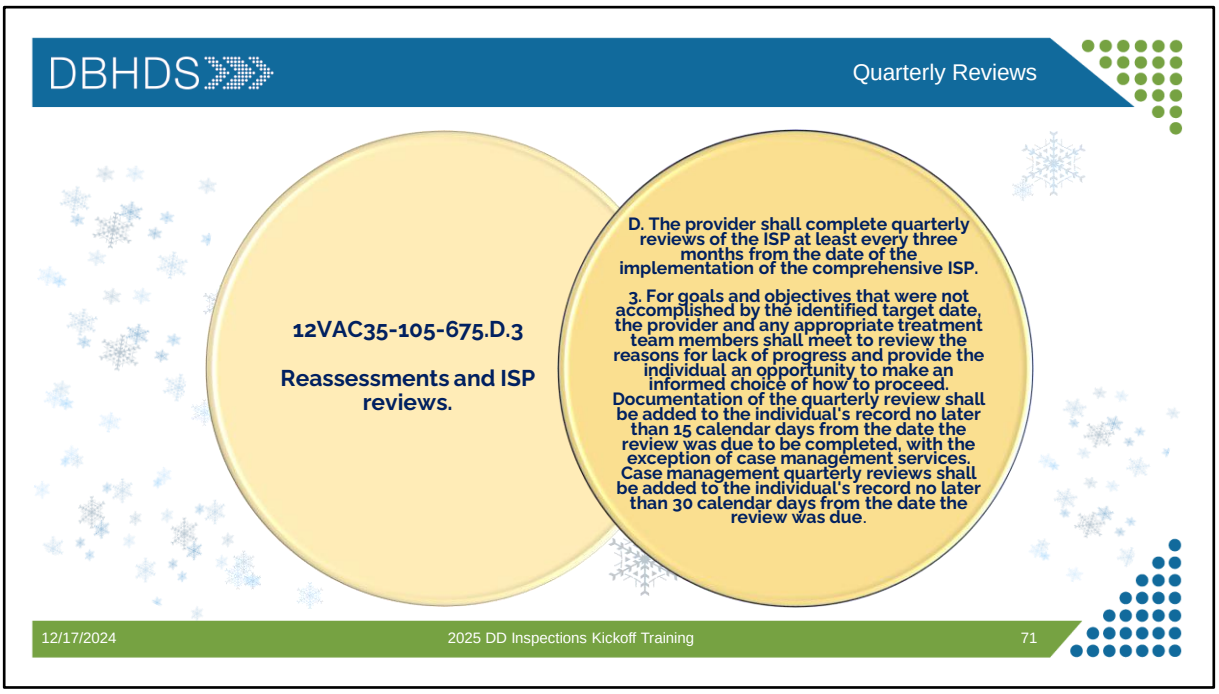
665.D. requires

Employees or contractors who are responsible for implementing the ISP shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols.



Documents the Office of Licensing will review to determine compliance

The Office of Licensing will review documentation to demonstrate that staff are trained on the individual's ISP, including health and safety protocols.



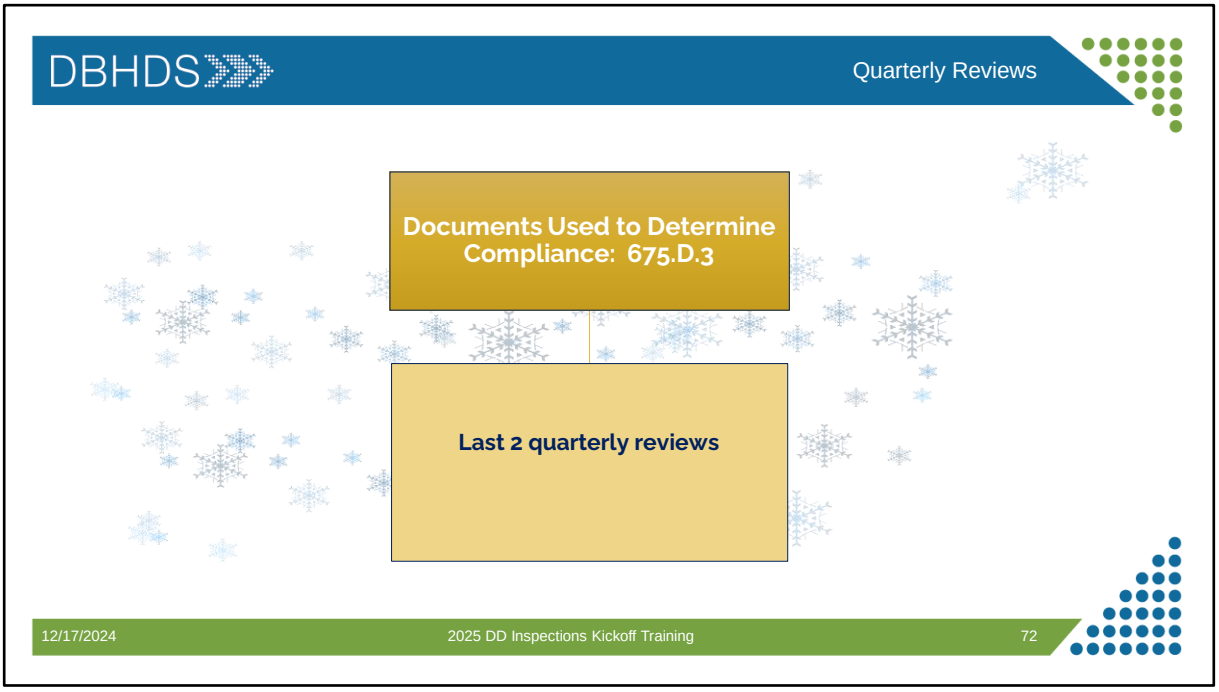
675.D.3 requires the provider to complete quarterly reviews of the ISP at least every three months from the date of the implementation of the comprehensive ISP.

For goals and objectives that were not accomplished by the identified target date, the provider and treatment team members must meet to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed.

Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed for providers of non-case management services.

Case management quarterly reviews must be added to the individual's record no later than 30 calendar days from the date the review was due.

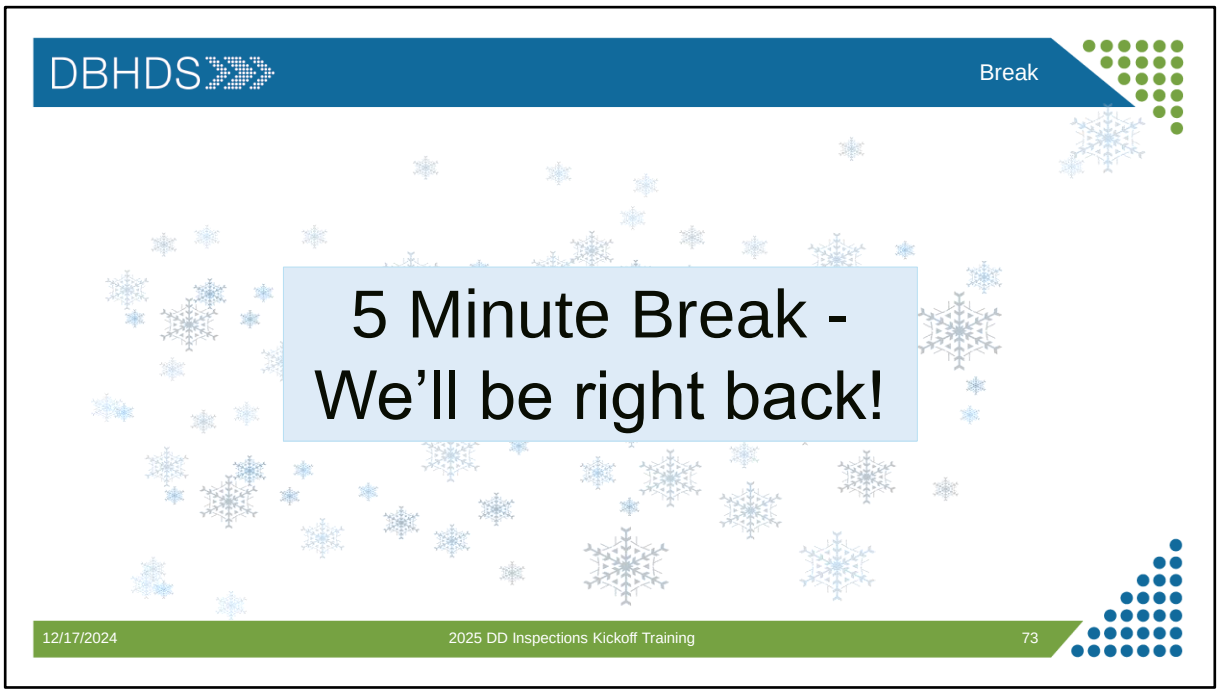
It is extremely important that these timeframes are met or the provider will be marked non-compliant



Documents the Office of Licensing will review to determine compliance

The OL will be reviewing the last two quarterly reviews for those individuals being reviewed.

This concludes Part I of the Regulations Overview. Now a quick word from Larisa.



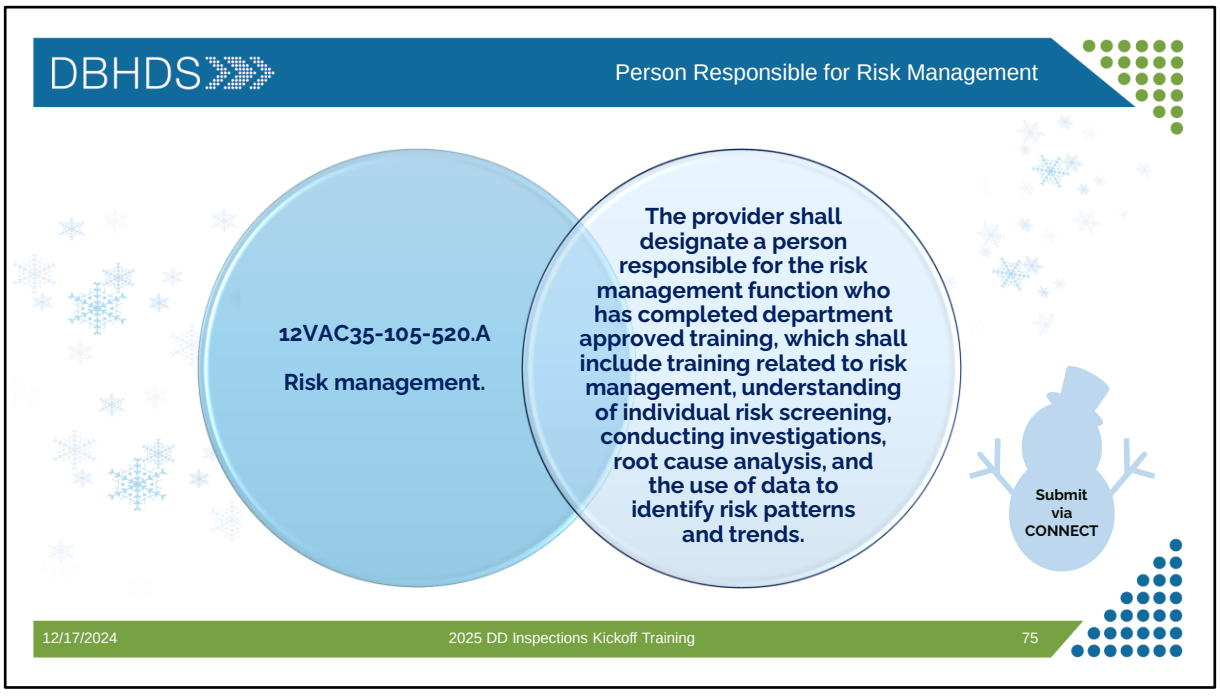
Okay, so now that we've made it through that first part of the Regulations Overview, who's ready for a break? Let's go ahead and take 5 minutes to stretch our legs and we'll be resume at *time. We'll be right back!

LARISA---READ SLIDE 74 after the break

Larisa

So now we're going to move along into the second part of our Regulations overview. These next few regulations we'll look at are specific to DOJ compliance indicators, and apply to developmental services Providers of Case Management AND Non-Case Management services.

Karen is going to start us off with the person responsible for the risk management function

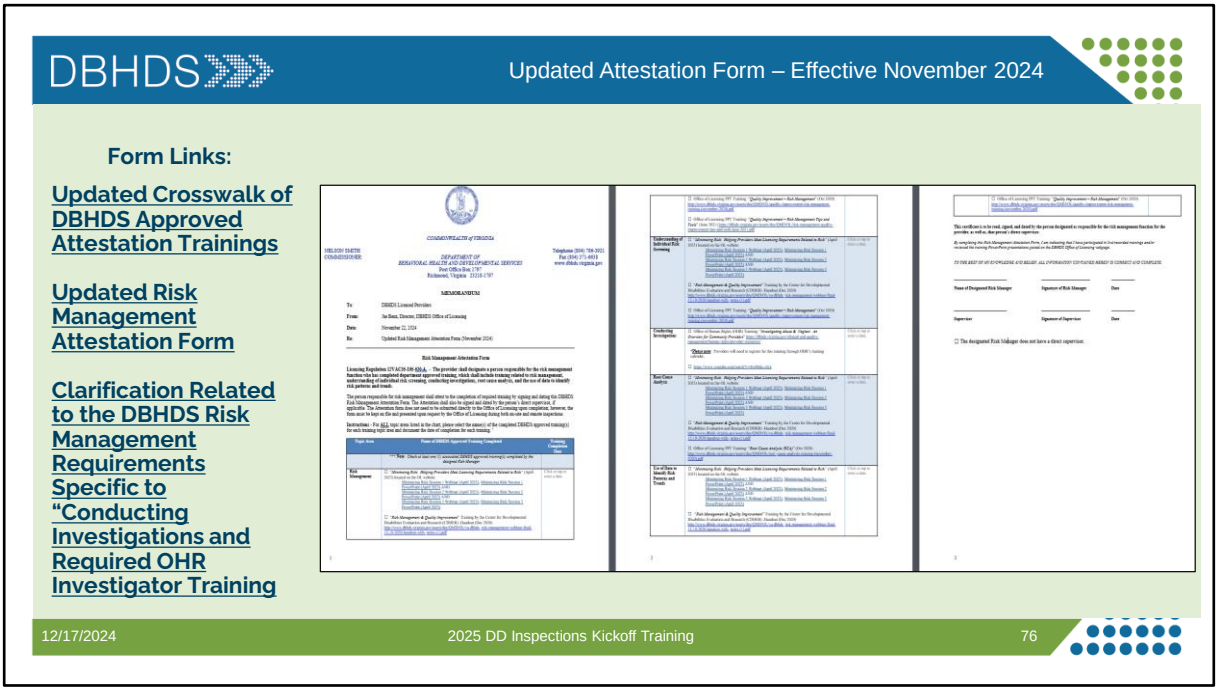


KAREN

Thanks Larisa

It is important to understand risk management, including the responsibilities of the person responsible for the risk management function.

Let's look first at Regulation 520.A, which states that 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.

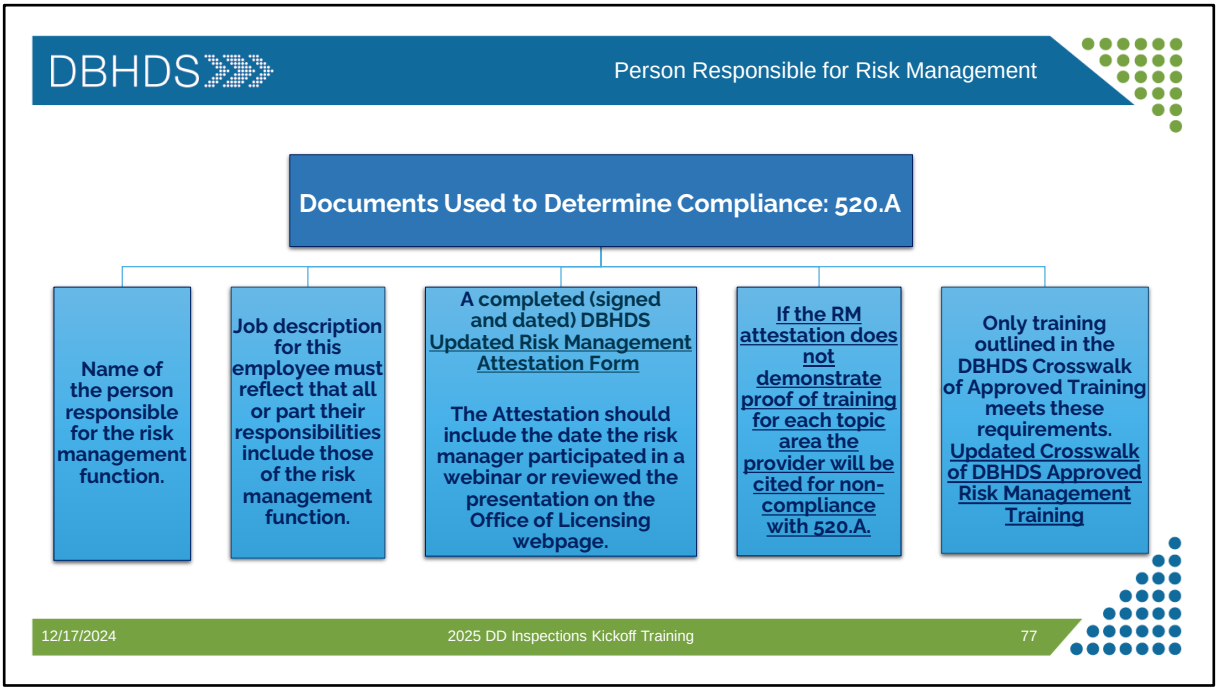


KAREN

- The Crosswalk of DBHDS Approved Trainings and attestation form were updated this year.
- In October 2024, the Office of Licensing clarified in a memo that to demonstrate compliance with 12VAC35-105-520.A, specific to the topic area "Conducting Investigations," the Office of Licensing does not require the designated risk manager to be a trained investigator. Therefore, they may choose to attend a live training offered by the Office of Human Rights or watch the YouTube video as outlined in the Crosswalk and the Risk Management Attestation Form.
- However, it is important to note that the Office of Human Rights (OHR) has different requirements. Compliance with 12VAC35- 115-175.F.4. requires that any person conducting abuse and neglect investigations be trained to conduct investigations. Proof of training is a certificate of completion from a "live" investigation training offered by the OHR or another investigation training offered by another entity. Proof of training must be maintained in the investigator's personnel file.
- As of November 2024, the person responsible for the risk management function may take the *"Minimizing Risk Training: Helping Providers Meet Licensing Requirements Related to Risk"* to meet the training requirements for the following four topic areas: *Risk Management, Understanding of Individual Risk Screening, Root Cause Analysis; and Use of Data to Identify Risk Patterns and Trends.*
- Upon completion of a DBHDS approved training for each topic area, the person designated as the risk manager should complete this Risk Management Attestation Form. Training is required for 5 topic areas - which again are Risk Management, Understanding of Individual Risk Screening, Conducting Investigations, Root Cause Analysis, and Use of Data to Identify Risk Patterns and Trends.
- For ALL topic areas listed in the chart, the person responsible for the risk management function must select the name of the completed DBHDS approved training and document the date of completion for each. Again, additional information related to the DBHDS approved trainings and the requirements of regulation 520.A. can be found within the "*Crosswalk of DBHDS Approved Risk Management Training."*
- To be determined as Compliant, the provider should select at least one approved training in each of the five topic areas; complete the training, check the box, enter the training completion date and ensure that it's signed and dated by the person responsible for the risk management function and their supervisor, if applicable – it's that simple!
- Remember that the training is not required to be completed annually. Once the required trainings have been completed, the completed attestation form should be placed in the personnel record. Of course, it's never a bad idea to have the person responsible for the risk management function review this information as a refresher.

Just a few additional reminders:

1. The Attestation form does not need to be submitted directly to the Office of Licensing upon completion. However, the form must be kept on file and presented upon request to the Office of Licensing.
2. Only the DBHDS Risk Management Attestation form can be used to demonstrate compliance. Training certificates from other organizations do not meet compliance for this regulation.
3. You can access the current crosswalk and attestation on the Office of Licensing website.

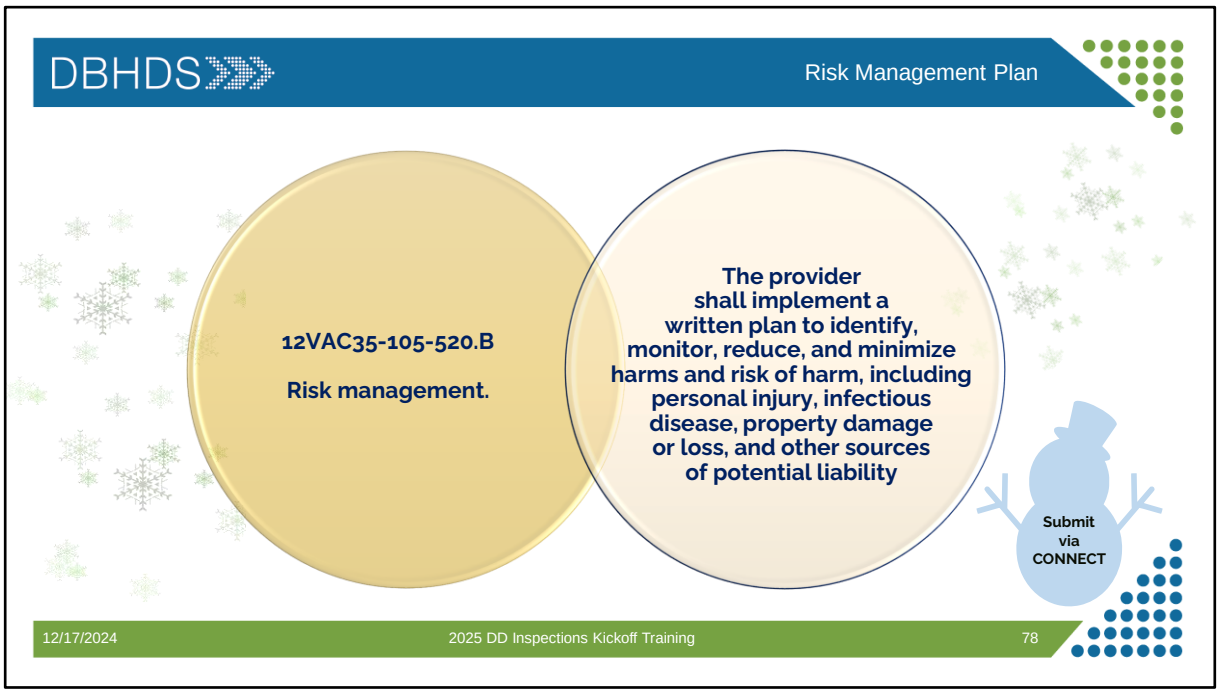


KAREN

The documents the Office of Licensing will review to determine compliance with 520.A are:

- Name of the person responsible for the risk management function.
- The job description for this employee that reflects all or part of their responsibilities include those of the risk management function.
- A completed (signed and dated) DBHDS Risk Management Attestation.
- If the Risk Management attestation form does not demonstrate proof of training for each of the 5 topic areas, the provider will be cited for non-compliance with 520.A.

- As a reminder, only training outlined in the DBHDS Crosswalk of Approved Training meets these requirements.



KAREN

Next, we'll take a look at Regulation 520.B regarding the Risk Management Plan.

Regulation 520.B. states: 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.

To be determined as Compliant, Risk Management Plans should include:

- How the provider would identify risks;
- How the provider would monitor risks; and
- How the provider would reduce and minimize risks.

A provider's Risk Management Plan should also outline how the provider will identify, monitor and reduce risks associated with:

- Personal injury
- Infectious diseases
- Property damage/loss

- And other sources of potential liability.

Risks can be identified in several ways, such as using the systemic risk assessment, safety inspections, serious incident reporting, infectious disease reporting, financial reports, documented medication errors, instances of property damage/loss, emergency preparedness responses, and personal injury sustained on the provider's premises.

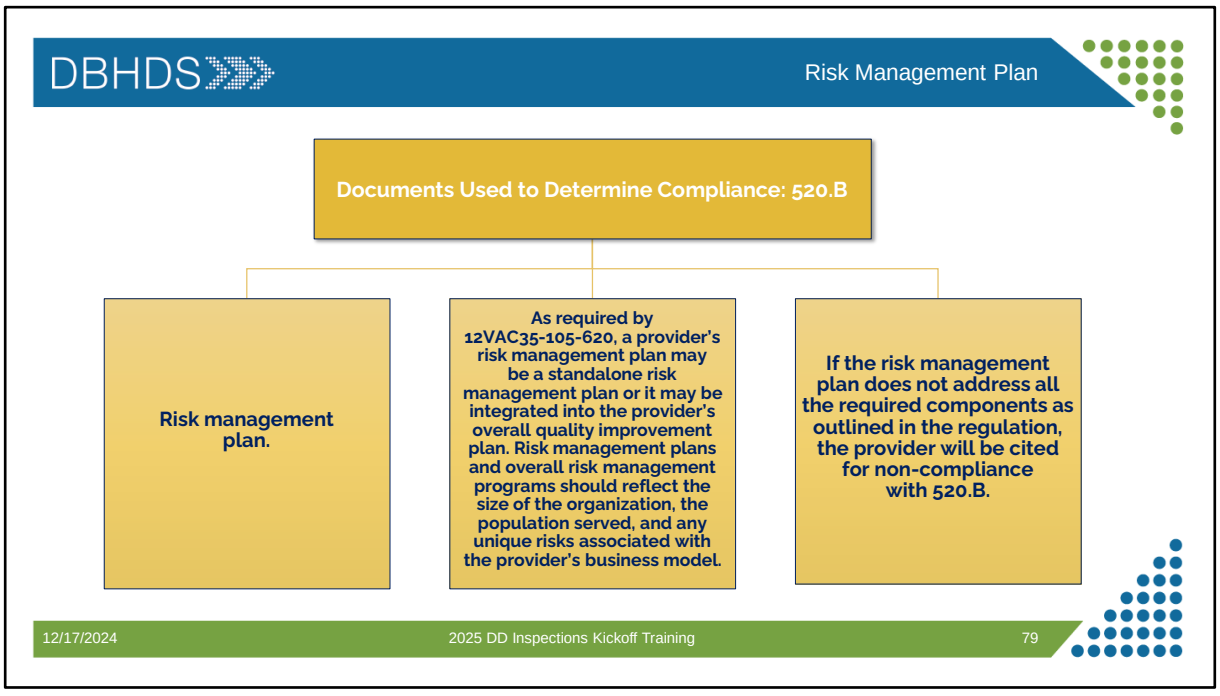
A provider can monitor risks through their review of serious incidents and through their review of care concerns.

A provider can reduce and minimize risk by conducting a root cause analysis, proposing an initiative to minimize risk related to findings from the systemic risk assessment, and even implementing new training.

Some providers choose to combine their risk management plan and their quality improvement plan.

- For Risk Management Plans that are integrated with an overall Quality Improvement Plan, the provider is expected to identify the sections that address the Risk Management requirements.

- The combined plan would need to be dated since the Quality Improvement Plan is required to be updated *at least annually*.



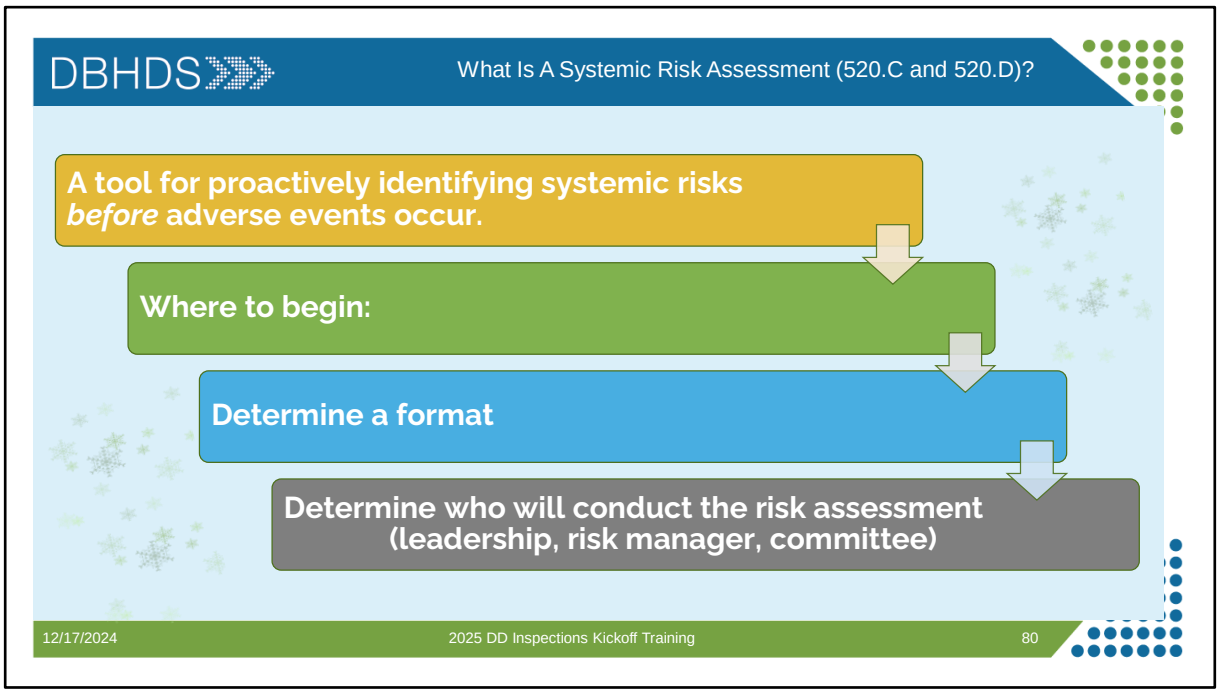
KAREN

Documents the Office of Licensing will review to determine compliance

Risk management plan, which should reflect the size of the organization, the population served, and any unique risks associated with the provider's business model.

If the risk management plan does not address how you 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 which are required per the regulation then the provider will be cited for non-compliance with 520.B.

Now Mackenzie is going to talk about the systemic risk assessment



MACKENZIE

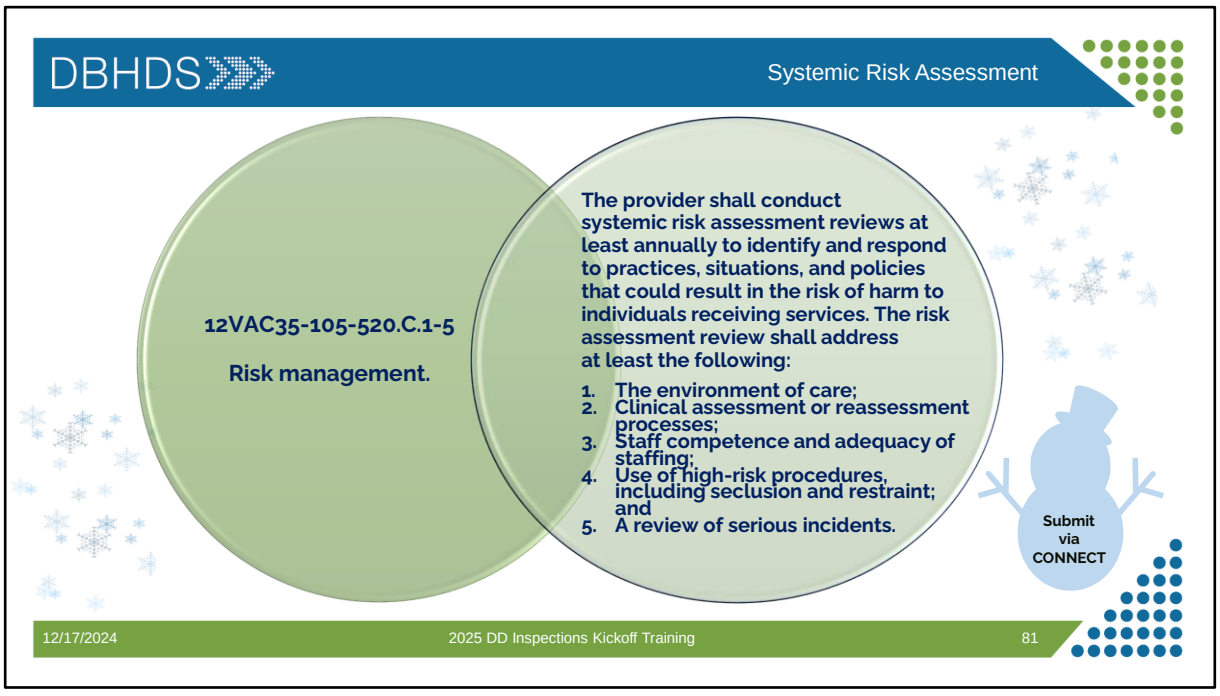
What is a risk assessment?

A risk assessment is a tool used to identify internal and external factors or situations that could cause harm to individuals served or that could negatively impact the organization.

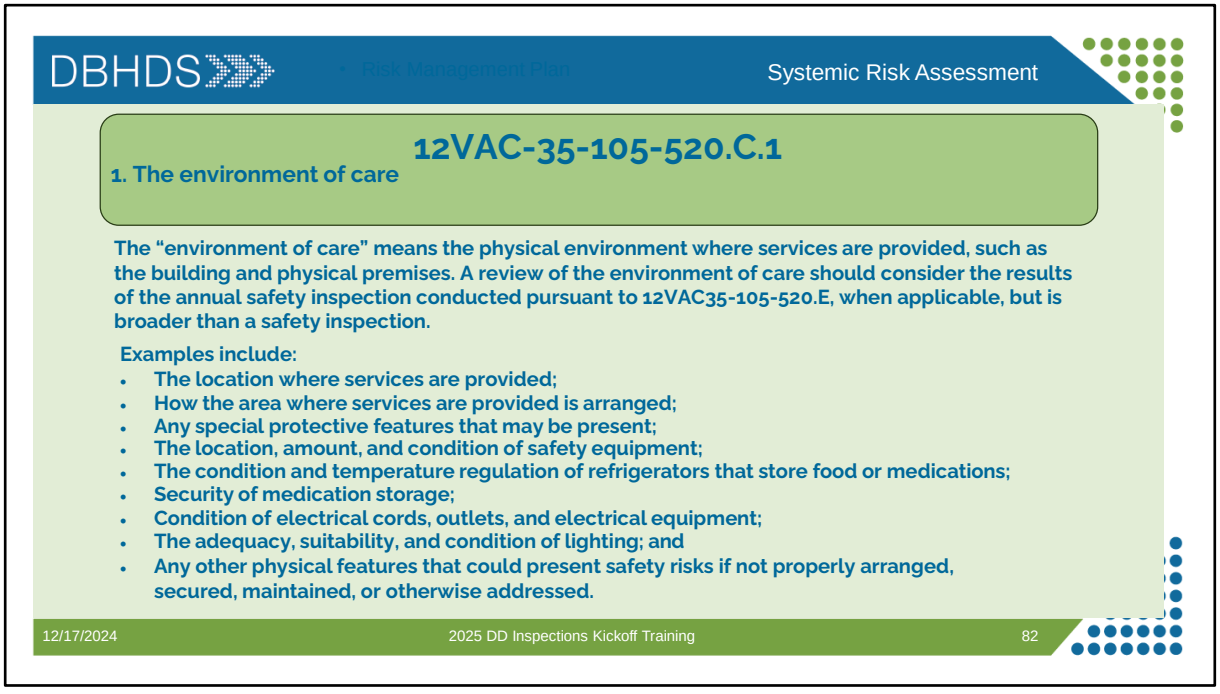
Conducting a risk assessment can lead to a better understanding of actual or potential risks and how best to minimize those risks. Systemic risk assessments vary depending on numerous factors such as an organization's size, population served, location, or business model. The risk assessment process is focused on identifying both existing and potential harms and risks of harm. We know that you all want to reduce risk, if at all possible, and the systemic risk assessment can be used to inform your risk management systems and may prompt you to update your risk management plan.

To begin developing your risk assessment, first determine a format and then determine who will conduct the risk assessment. Is it leadership, the risk manager or a committee?

Now let's review the regulatory requirements specific to the Systemic Risk Assessment.



- An annual risk assessment review is a necessary component of a provider's risk management plan.
- This review should include consideration of harms and risks identified and lessons learned from the provider's quarterly reviews of all serious incidents conducted pursuant to 12VAC35-105- 160.C., including an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.
- Identifying risks and potential risks helps to prevent harm to the individuals served, to staff, and to the organization.
- There are many risks that may affect an organization and a provider's risks could change from year to year.
- Don't forget, even if a provider has NOT served any individuals, the provider is still able to identify potential risks
- Now we will break down each of the required components starting with the environment of care.

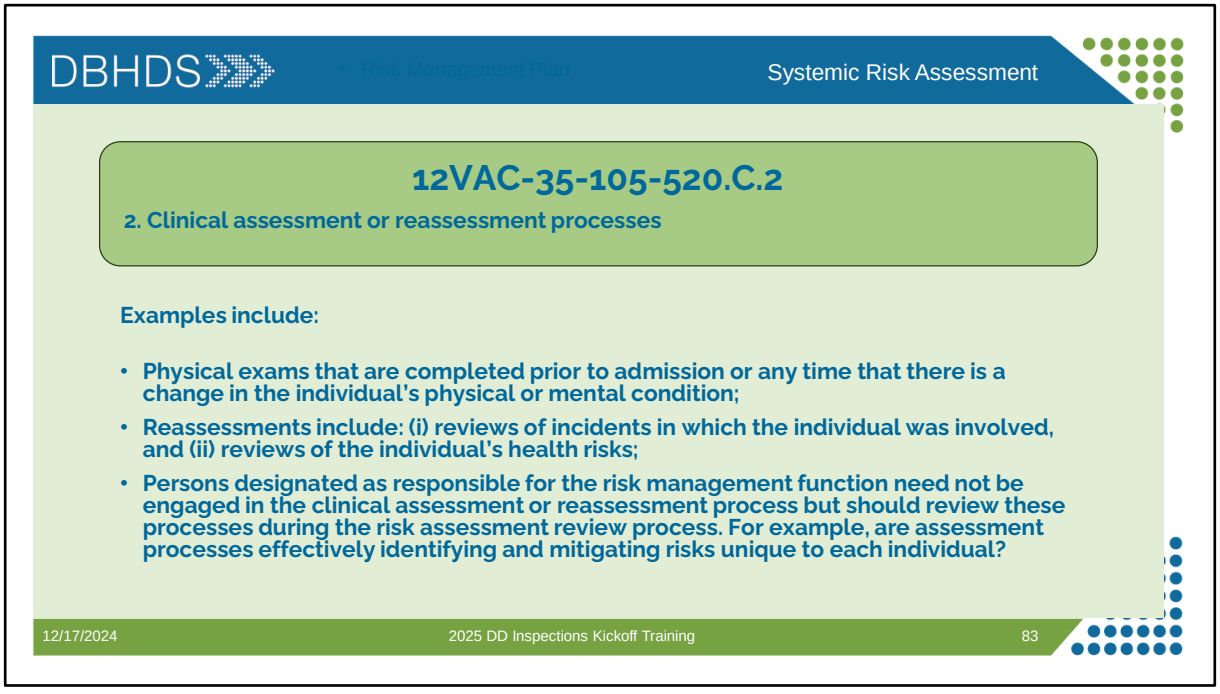


This review should address the environment of care. This is not the safety inspection but may include results of safety inspections

As you know, regulation 520.E requires that the provider conduct and document that a safety inspection has been performed at least annually for each service location owned, rented, or leased by the provider. Recommendations for safety improvement shall be documented and implemented by the provider. There are several examples included here.

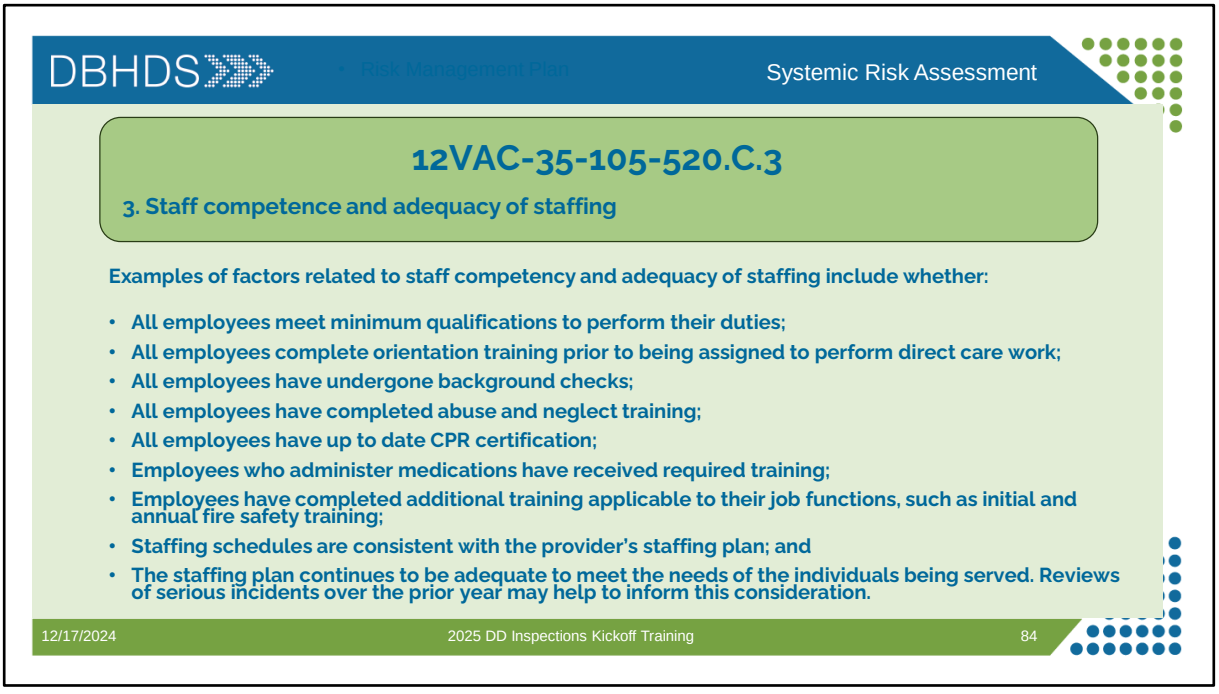
- The location where services are provided (e.g. in individual's own home, at a correctional facility, or at a location under the provider's control). How the area where services are provided is arranged;
- Any special protective features that may be present;
- The location, amount, and condition of safety equipment
- The condition and temperature regulation of refrigerators that store food or medications;
- Security of medication storage;
- Condition of electrical cords, outlets, and electrical equipment;
- The adequacy, suitability, and condition of lighting; and
- Any other physical features that could present safety risks if not properly arranged, secured, maintained, or otherwise addressed.

- Additionally, environment of care considerations will be different when services are provided at a location that is not under the direct control of the provider, such as at an individual's own home. While providers are more limited in their ability to assess some factors in these locations, providers should consider any unique risks associated with the provision of services in these locations during its risk assessment review. In such cases the review does not need to consider each location individually, but should identify risks that may be common across the different locations or settings.



This review should address clinical assessment or reassessment processes

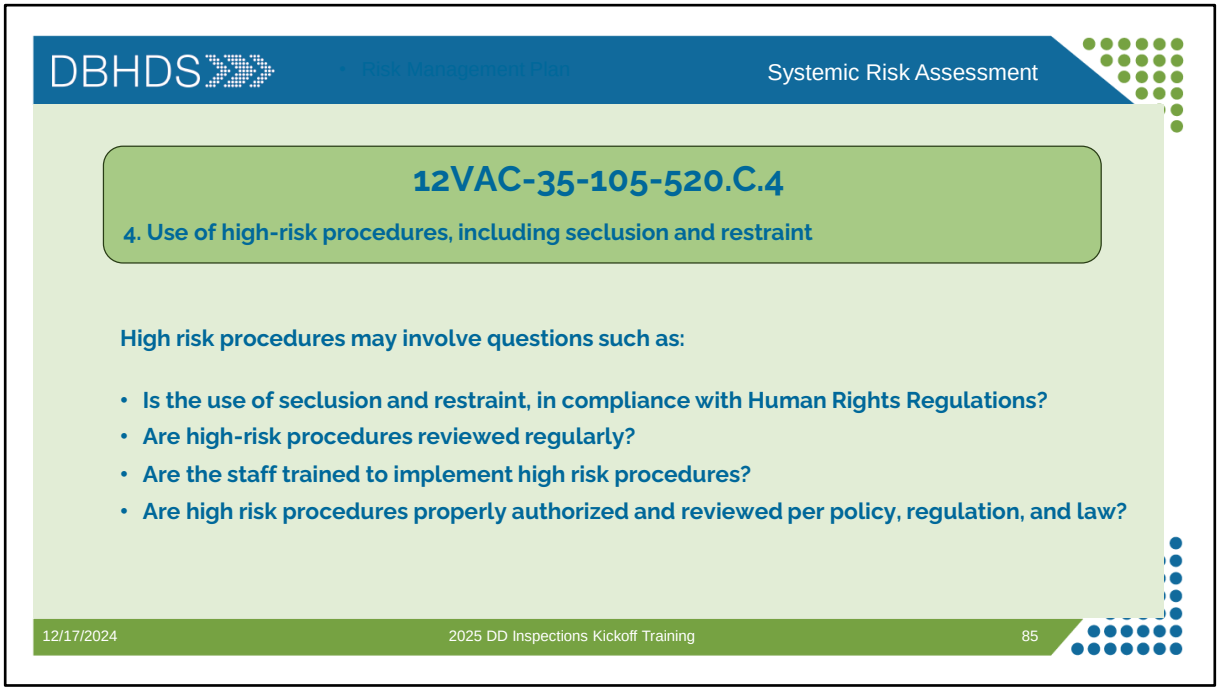
- Examples of assessments include physical exams that are completed prior to admission
- Reassessments completed when there is a change in an individual's physical, medical, psychiatric, behavioral, or other status
- Reassessments include: reviews of incidents in which the individual was involved, and reviews of the individual's health risks.
- Persons 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. For example, are assessment processes effectively identifying and mitigating risks unique to each individual?



This review should include both staff competence and adequacy of staffing.

Remember, risks vary according to the licensed provider

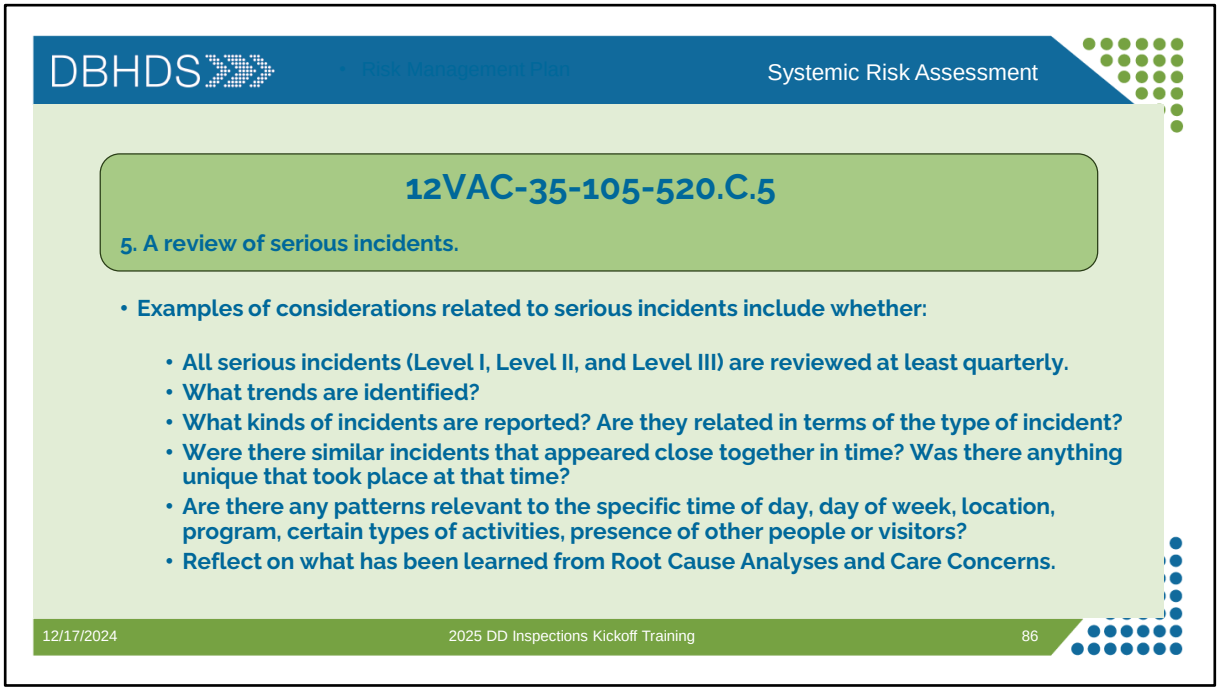
- Examples of factors related to staff competency and adequacy of staffing include whether:
- All employees meet minimum qualifications to perform their duties;
- All employees complete orientation training prior to being assigned to perform direct care work;
- All employees have undergone background checks;
- All employees have completed abuse and neglect training;
- All employees have up to date CPR certification;
- Employees who administer medications have received required training;
- Employees have completed additional training applicable to their job functions, such as initial and annual fire safety training;
- Staffing schedules are consistent with the provider's staffing plan; and
- The staffing plan continues to be adequate to meet the needs of the individuals being served. Reviews of serious incidents over the prior year may help to inform this consideration.
- It has been noted that adequacy of staffing is not consistently included in the systemic risk assessment review. As a reminder, 520.C.3 must address both staff competency AND adequacy of staffing.



This review should address the use of high-risk procedures.

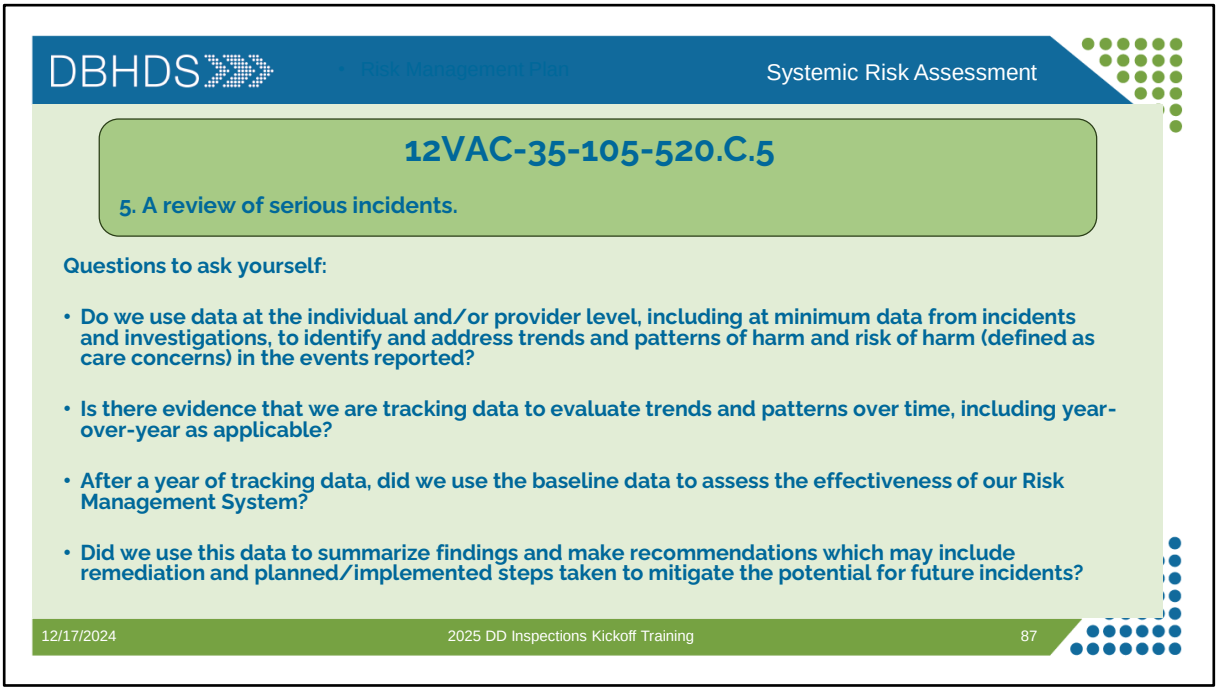
High risk procedures may involve questions such as:

- Is the use of seclusion and restraint in compliance with Human Rights Regulations?
- Are high-risk procedures reviewed regularly?
- Are the staff trained to implement high risk procedures?
- Are high risk procedures properly authorized and reviewed per policy, regulation, and law?
- Other Examples include:
- High risk methods of medication administration
- All staff are trained on how to safely transfer individuals
- All staff will refrain from the use of seclusion and restraints
- All staff are trained on how to use CPI techniques



This review shall evaluate serious incidents at least annually.

- Examples of considerations related to serious incidents include whether:
    - Review at least quarterly all serious incidents. This includes Level I, Level II, and Level III serious incidents
    - Identify trends by asking
        - What kinds of incidents are reported? Are they related in terms of the type of incident?
        - Were there similar incidents that appeared close together in time? Was there anything unique that took place at that time?
        - Are there any patterns relevant to the specific time of day, day of week, location, program, certain types of activities, presence of other people or visitors?
    - Reflect on what has been learned from Root Cause Analyses and Care Concerns
- FOR REFERENCE
- All serious incidents are reported to the Authorized Representative within 24-hours of discovery
- Medication errors are reviewed quarterly



Some Questions to ask yourself as it relates to 520.C.5

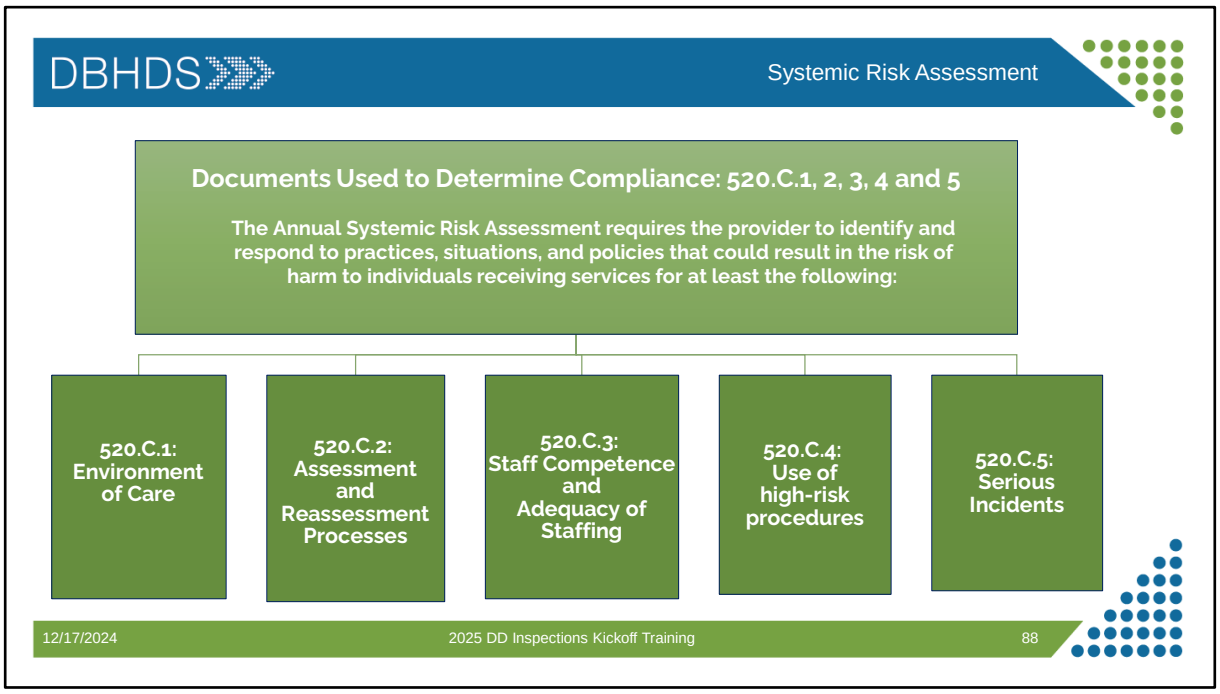
Do we use data at the individual and/or provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm (which are defined as care concerns) in the events reported?

Is there evidence that we are tracking data in order to evaluate trends and patterns over time, including year-over-year as applicable?

After a year of tracking data, did we use the baseline data to assess the effectiveness of our Risk Management System?

Did we use this data to summarize findings and make recommendations which may include remediation and planned/implemented steps taken to mitigate the potential for future incidents?

It's important for you to know this is an area of focus for the independent reviewer and consultants as it relates to the DOJ Settlement Agreement. Use of the Risk Tracking tool can assist providers with being compliant with this regulation.



Documents the Office of Licensing will review to determine compliance

The provider must ensure that each sub-regulation of 520.C is addressed within their annual systemic risk assessment.

The Annual systemic Risk assessment reviews must be completed at least annually

Any updates, as appropriate, made since the last review as a result of the provider identifying new risk areas that could result in the risk of harm to individuals receiving services.

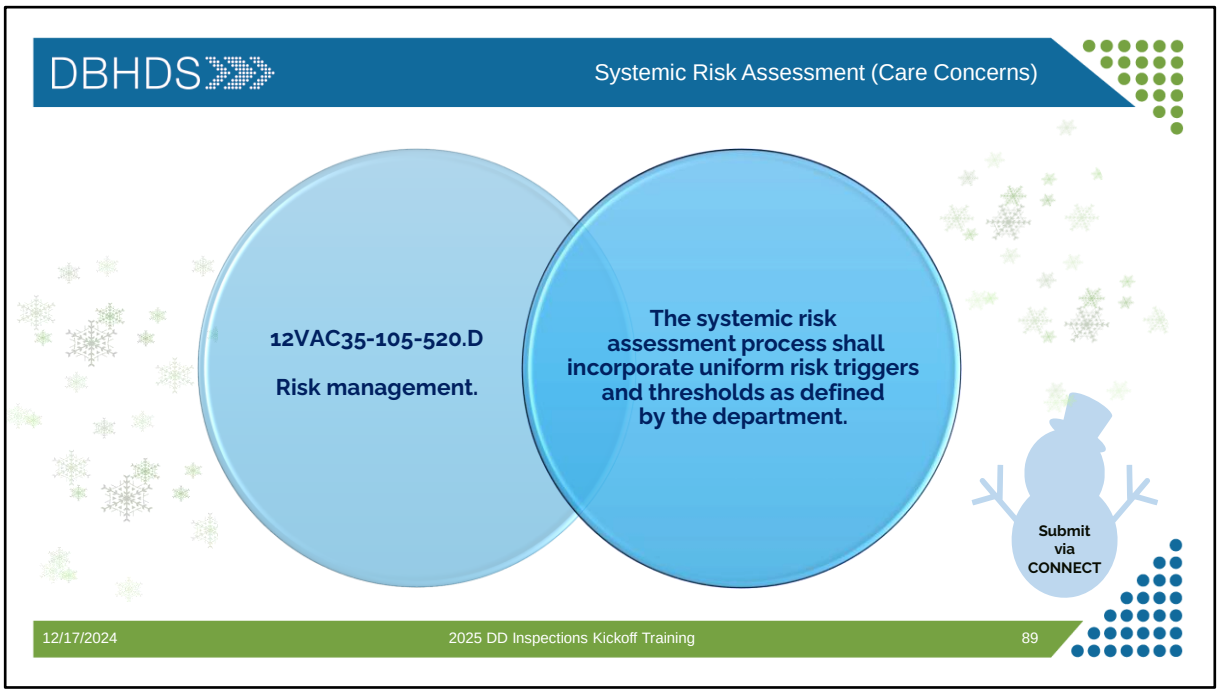
An example may be new risk areas identified as part of the quarterly review of serious incidents that was not already covered and how the provider plans to respond to serious

incidents.

Remember that if a systemic risk assessment is not completed the provider will be cited for non-compliance with 520.C.1, 520.C.2, 520.C.3, 520.C.4 and 520.C.5, same would apply if the SRA was not completed at least annually

If any components are missing or not addressed, the provider will be cited for that specific regulation.

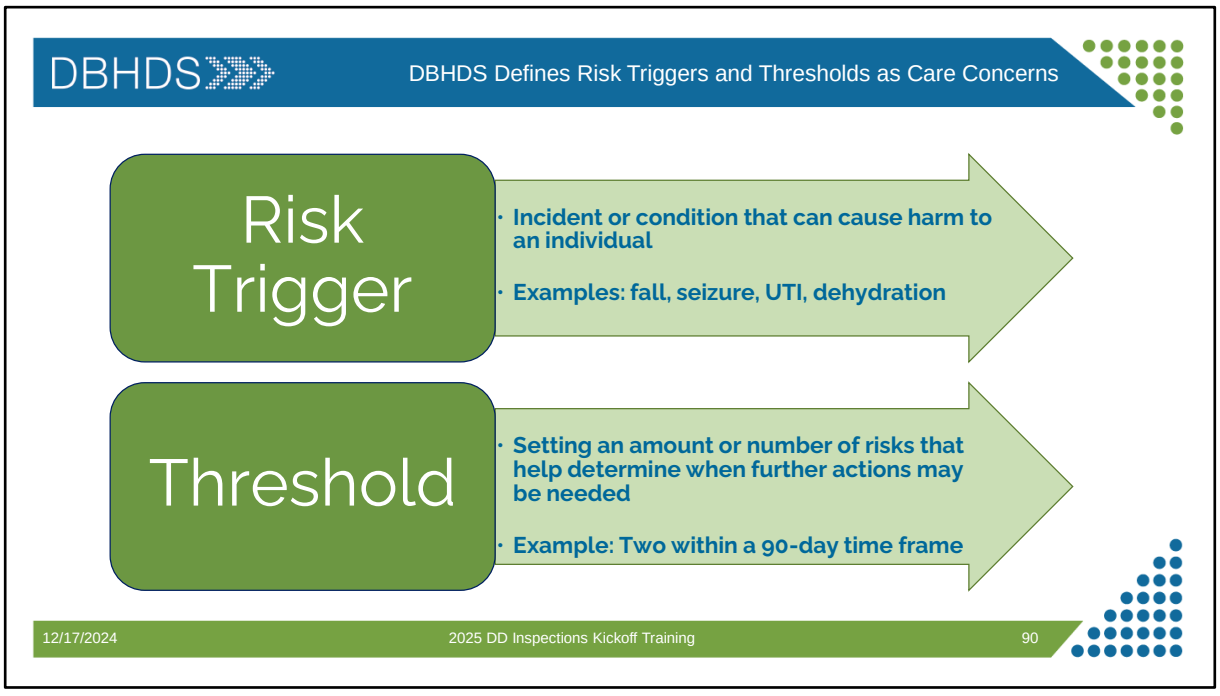
If a provider has not served any individuals, a Systemic Risk Assessment review would still need to be completed at least annually. Things to consider may be privacy (PHI), training for staff, emergency management protocols, etc.



Keep in mind that the systemic risk assessment process must also incorporate uniform risk triggers and thresholds as defined by the department.

The department defines risk triggers and thresholds as “care concerns”.

Let's take a few minutes to review what this means



A “Risk trigger” is an incident or condition that can cause harm to an individual.

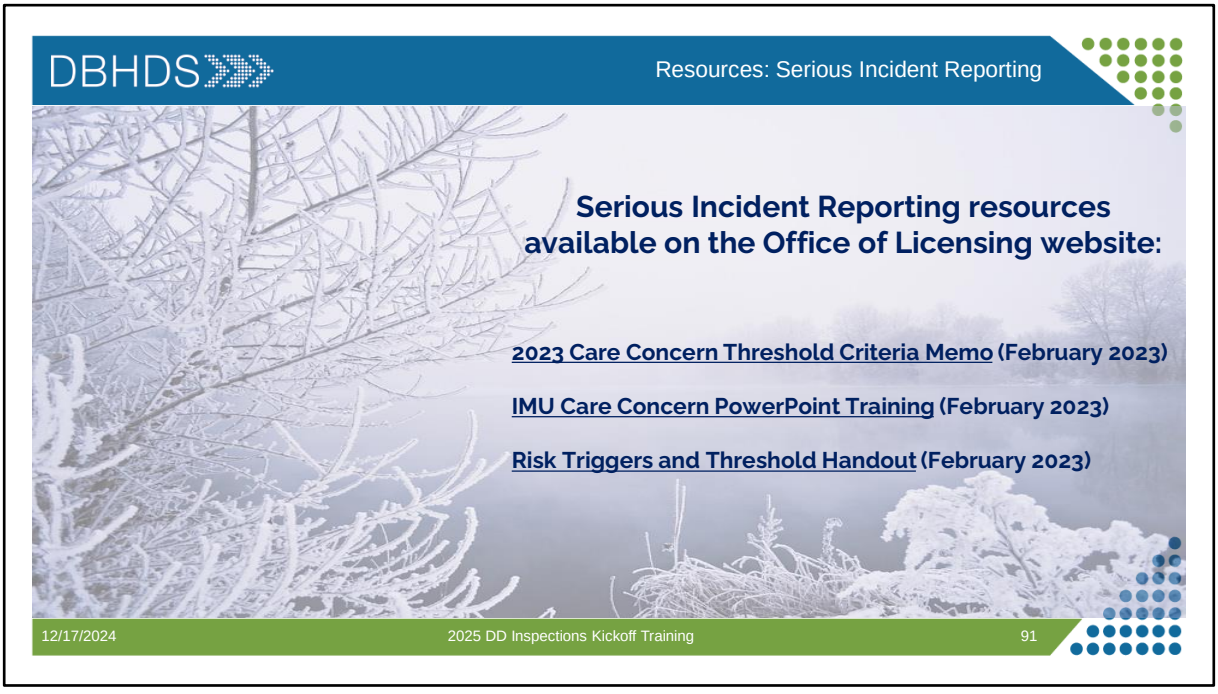
Examples of this could be a fall, seizure, UTI, dehydration, etc.

A “Threshold” is setting an amount, or number, of risks that help determine when further actions may be needed.

An example of this may be “two within a 90 day time-frame”.

When these are combined, we have an example of a “risk trigger and threshold”, which is “two falls within a 90-day time period”.

In this example, the “fall” is the risk trigger and “two within a 90-day time period” is the threshold.



As a reminder the "Guidance for Serious Incident Reporting" is available on the Office of Licensing webpage, along with the "2023 Care Concern Threshold Criteria Memo", the IMU Care Concern PowerPoint training, and the "Risk triggers and Thresholds Handout". There have been no changes to the Care Concern Thresholds which are outlined in the handout.

Effective 01/2023 the Care Concern Thresholds are:

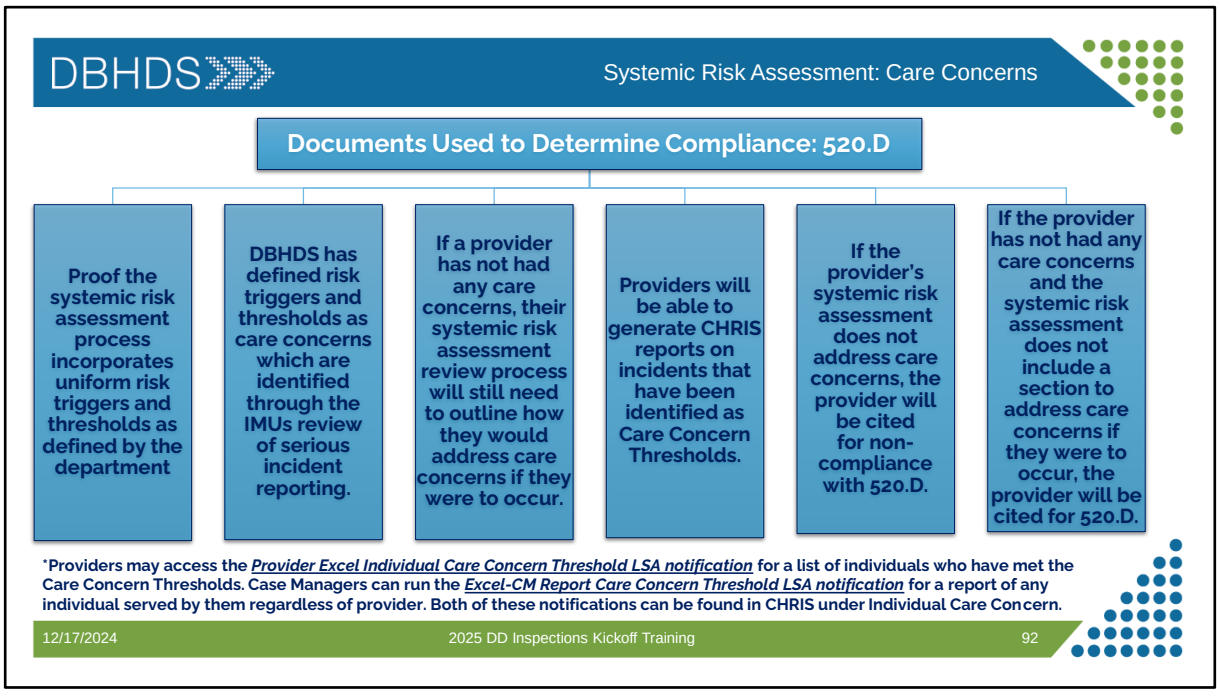
• Multiple (Two or more) unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day time-frame for any reason.

• Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional.

• Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR.

• Multiple (Two or more) unplanned psychiatric admissions within a ninety (90) day time-frame for any reason.

Remember that providers need to track, on an ongoing basis, their organization's serious incidents and care concerns.



Documents the Office of Licensing will review to determine compliance

- Proof the systemic risk assessment process incorporates care concerns which are identified through the Incident Managements Unit's (IMU) review of serious incident reporting. The SRA really has six components if you include 520.D

- If a provider has not had any care concerns, their systemic risk assessment review process would still need to outline how they would address care concerns if they were to occur.

- Providers can generate CHRIS reports on incidents that have been identified as Care Concern Thresholds.

- If the provider's systemic risk assessment does not address care concerns, the provider will be cited for non-compliance with 520.D.

- If the provider has not had any care concerns and the systemic risk assessment does not include a section to address care concerns if they were to occur, the provider will be cited for 520.D.

- **Now Karen is going to talk about some tools you can use to complete your systemic risk assessment.**

DBHDS

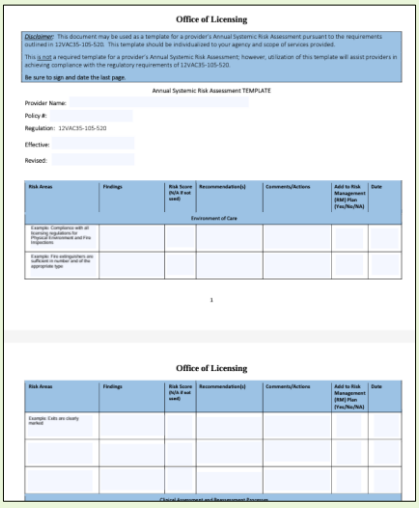
Systemic Risk Assessment TEMPLATE

12VAC35-105-520.C.1-5 and 520.D

Systemic Risk Assessment Template (April 2023)

Individual Risk Tracking Tool (November 2024)

Monthly Risk Tracking Tool (November 2024)


Office of Licensing

Annual Systemic Risk Assessment TEMPLATE

Provider Name:

Policy #:

Regulation: 12VAC35-105-520

Effective:

Revised:

Environment of Care

Office of Licensing

12/17/2024 2025 DD Inspections Kickoff Training 93

KAREN

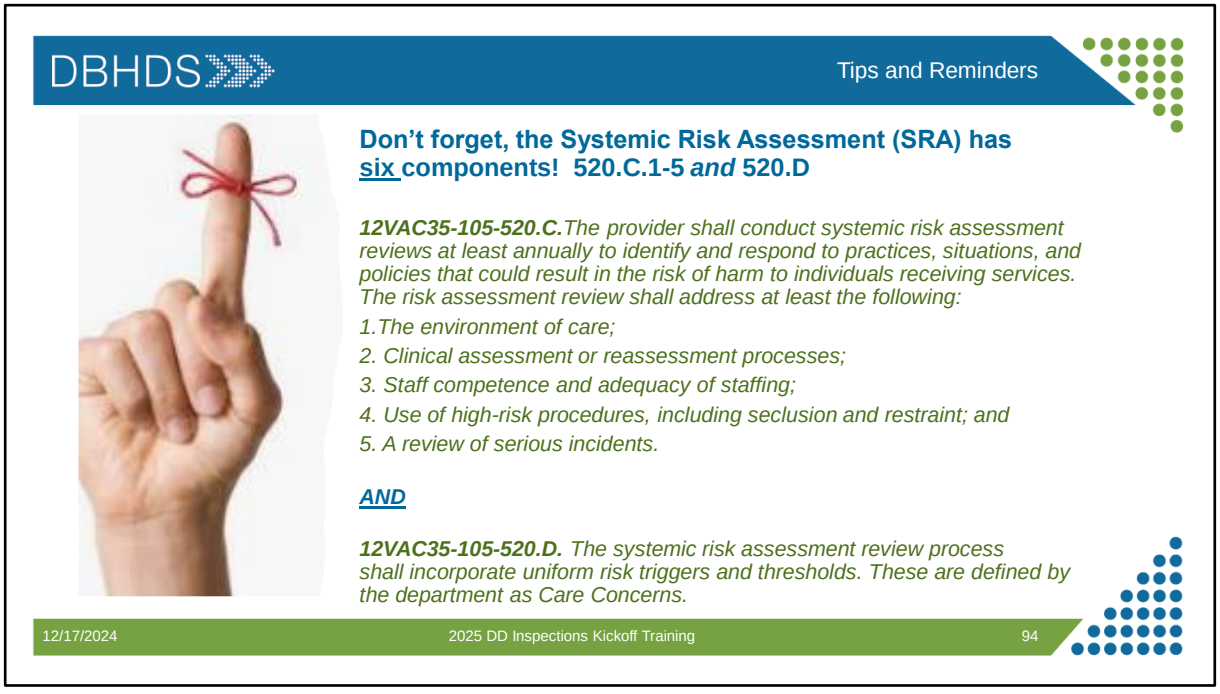
The "Systemic Risk Assessment Template" was introduced in April 2023 and the SRA is now included as a tab within the Individual and Monthly Risk Tracking Tools. All these links are included here.

It is recommended that your systemic risk assessment form include a section for each of the required risk areas, a column where you will list identified risks or findings for that topic area, a column to enter any of your recommendations *and* a column for you to enter the date in which you implemented your recommendations. Our template also includes sections for a risk score, comments and actions and a prompt as to whether your risk management plan should be updated or not.

- Providers may choose to use this template. Remember that the risk tracking tools were updated to include the Systemic Risk Assessment.

- This is not a required template for a provider's Annual Systemic Risk Assessment; however, utilization of the OL template will assist providers in achieving compliance with the regulatory requirements of 520.

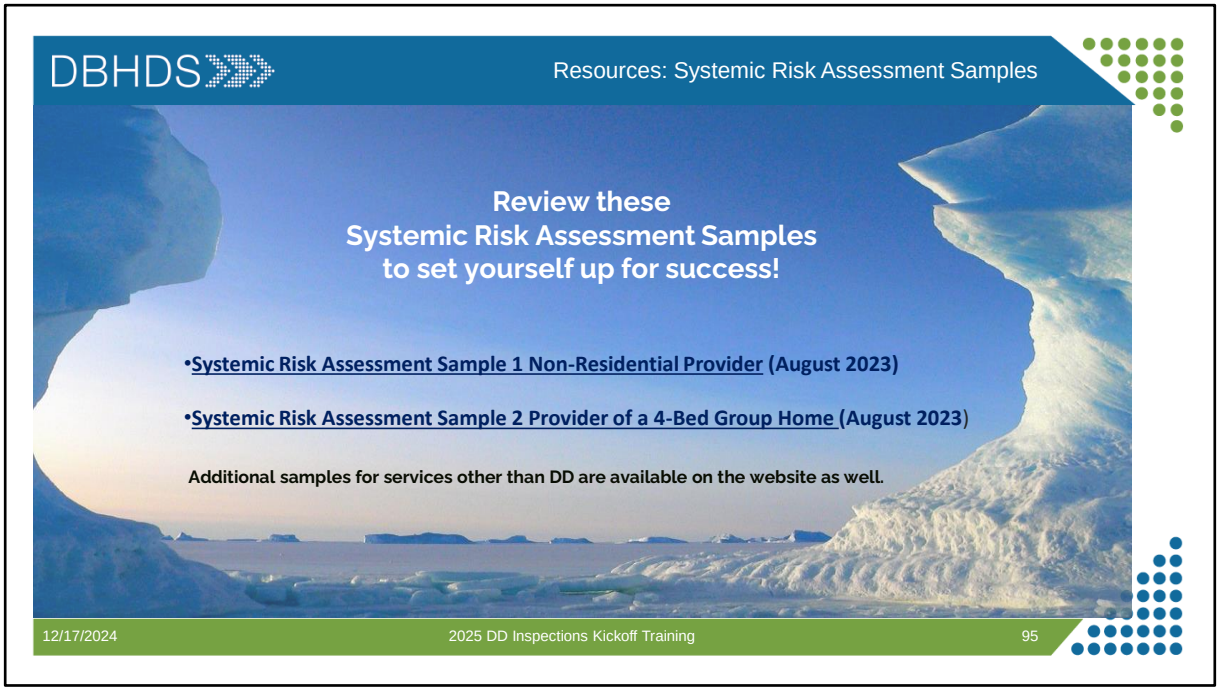
- This template and that risk tracking tools are located on the Office of Licensing's website.



KAREN

And, don't forget, the Systemic Risk Assessment really has six components! 520.C.1-5 and 520.D

Make sure all components of your Systemic Risk Assessment are clearly labeled and don't forget to address care concerns as it relates to 520.D



KAREN

There are several systemic risk assessment samples located on the Office of Licensing's website

The two shown here are specific to developmental services

Please take time to review these if you are not sure how to complete a systemic risk assessment.

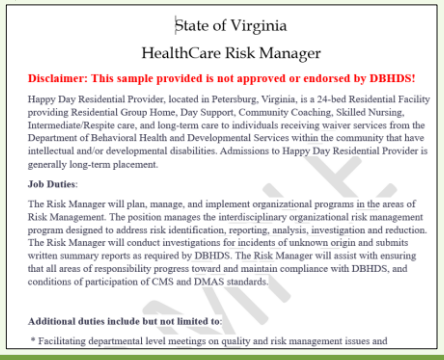
Now we will hear from Teena who will share some Key Takeaways for 520

Risk Management Key Takeaways for 520

Tip: High Risk procedures can include a lot more than just seclusion & restraint

Samples:

- **Recommend review of the Risk Manager's Job Description**
- **Highly recommend the use of the Risk Management Plan Sample from Office of Licensing AND the Risk Tracking Tool**



State of Virginia

HealthCare Risk Manager

Disclaimer: This sample provided is not approved or endorsed by DBHDS!

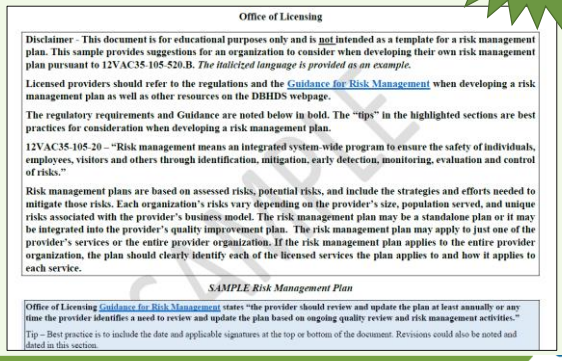
Happy Day Residential Provider, located in Petersburg, Virginia, is a 24-bed Residential Facility providing Residential Group Home, Day Support, Community Coaching, Skilled Nursing, Intermediate/Respite care, and long-term care to individuals receiving waiver services from the Department of Behavioral Health and Developmental Services within the community that have intellectual and/or developmental disabilities. Admissions to Happy Day Residential Provider is generally long-term placement.

Job Duties:

The Risk Manager will plan, manage, and implement organizational programs in the areas of Risk Management. The position manages the interdisciplinary organizational risk management program designed to address risk identification, reporting, analysis, investigation and reduction. The Risk Manager will conduct investigations for incidents of unknown origin and submits written summary reports as required by DBHDS. The Risk Manager will assist with ensuring that all areas of responsibility progress toward and maintain compliance with DBHDS, and conditions of participation of CMS and DMAS standards.

Additional duties include but not limited to:

* Facilitating departmental level meetings on quality and risk management issues and



Office of Licensing

Disclaimer - This document is for educational purposes only and is not intended as a template for a risk management plan. This sample provides suggestions for an organization to consider when developing their own risk management plan pursuant to 12VAC35-105-520.B. ***The italicized language is provided as an example.***

Licensed providers should refer to the regulations and the Guidance for Risk Management when developing a risk management plan as well as other resources on the DBHDS webpage.

The regulatory requirements and Guidance are noted below in bold. The "tips" in the highlighted sections are best practices for consideration when developing a risk management plan.

12VAC35-105-20 – "Risk management means an integrated system-wide program to ensure the safety of individuals, employees, visitors and others through identification, mitigation, early detection, monitoring, evaluation and control of risks."

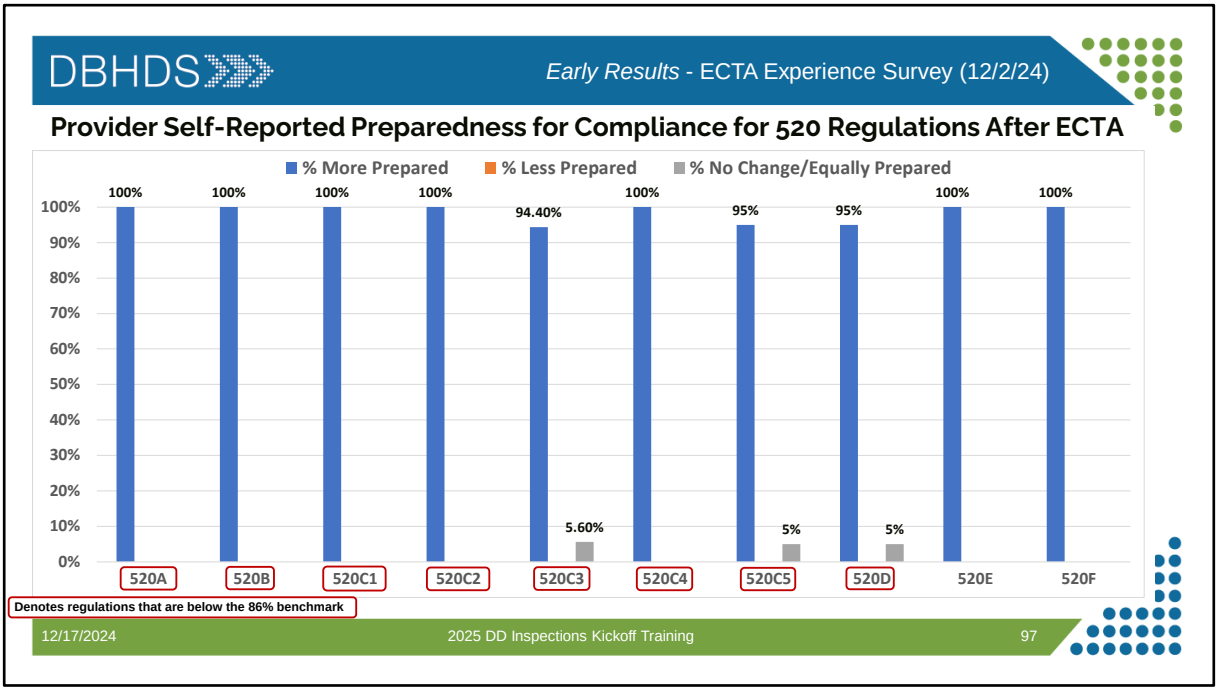
Risk management plans are based on assessed risks, potential risks, and include the strategies and efforts needed to mitigate those risks. Each organization's risks vary depending on the provider's size, population served, and unique risks associated with the provider's business model. The risk management plan may be a standalone plan or it may be integrated into the provider's quality improvement plan. The risk management plan may apply to just one of the provider's services or the entire provider organization. If the risk management plan applies to the entire provider organization, the plan should clearly identify each of the licensed services the plan applies to and how it applies to each service.

SAMPLE Risk Management Plan

Office of Licensing Guidance for Risk Management states "the provider should review and update the plan at least annually or any time the provider identifies a need to review and update the plan based on ongoing quality review and risk management activities."

Tip – Best practice is to include the date and applicable signatures at the top or bottom of the document. Revisions could also be noted and dated in this section.

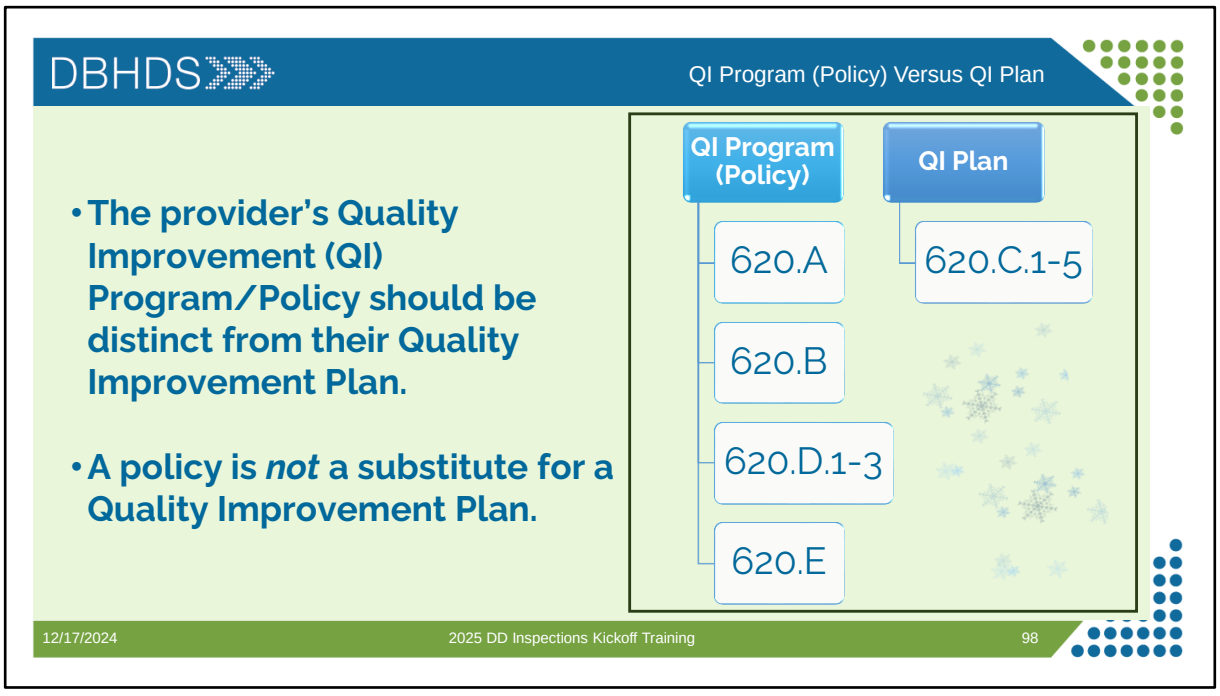
To update, reference slide in front of this one
Teena- Barriers and RM Job description/training
Kara- Risk Mgmt Plan and Risk Tracking Tool



Teena

Okay, let's a few minutes for some **poll questions from Karen (#5, #6, #7, #8, #9)**

Now we will move on to Quality Improvement with Mackenzie



MACKENZIE

Thanks Teena

So before we dive into quality, let's take a quick look at this diagram.

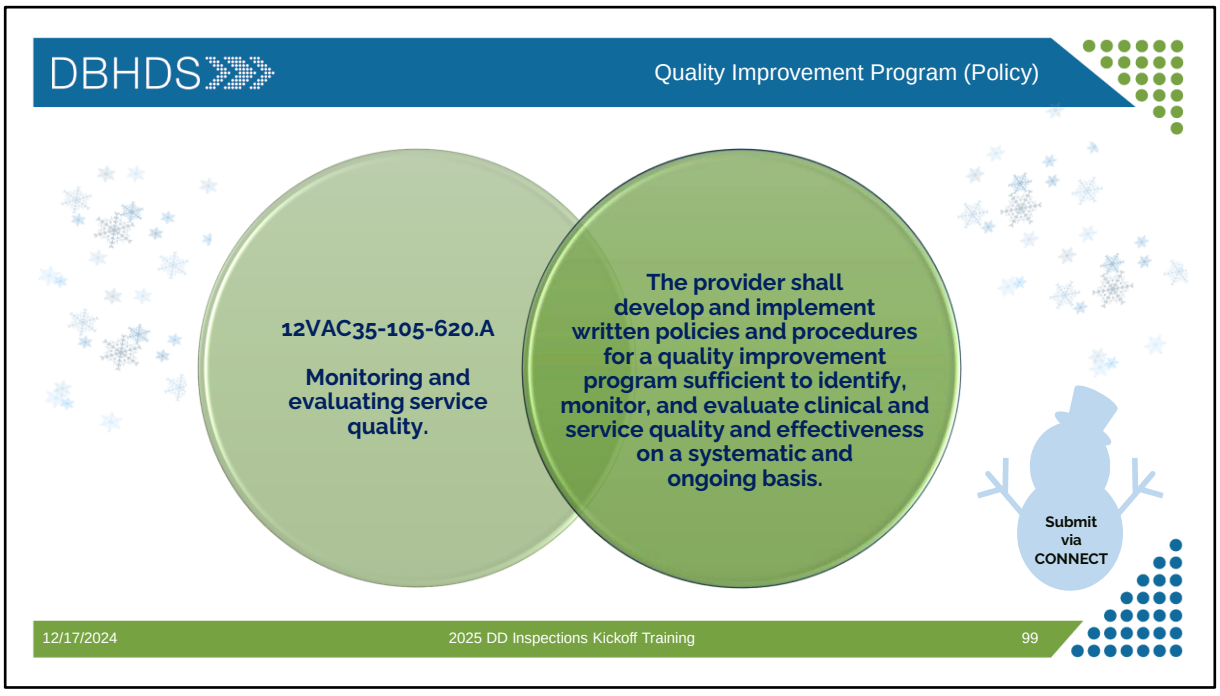
As you can see on the screen, providers are required to have a QI Program, which is the written Policy, AND a QI Plan.

The Quality Improvement (QI) Program should be distinct from the Quality Improvement Plan.

Remember that a policy is *not* a substitute for a plan.

Your QI Program should address all elements outline in 620.A, 620.B, 620.D.1- 3 and 620.E

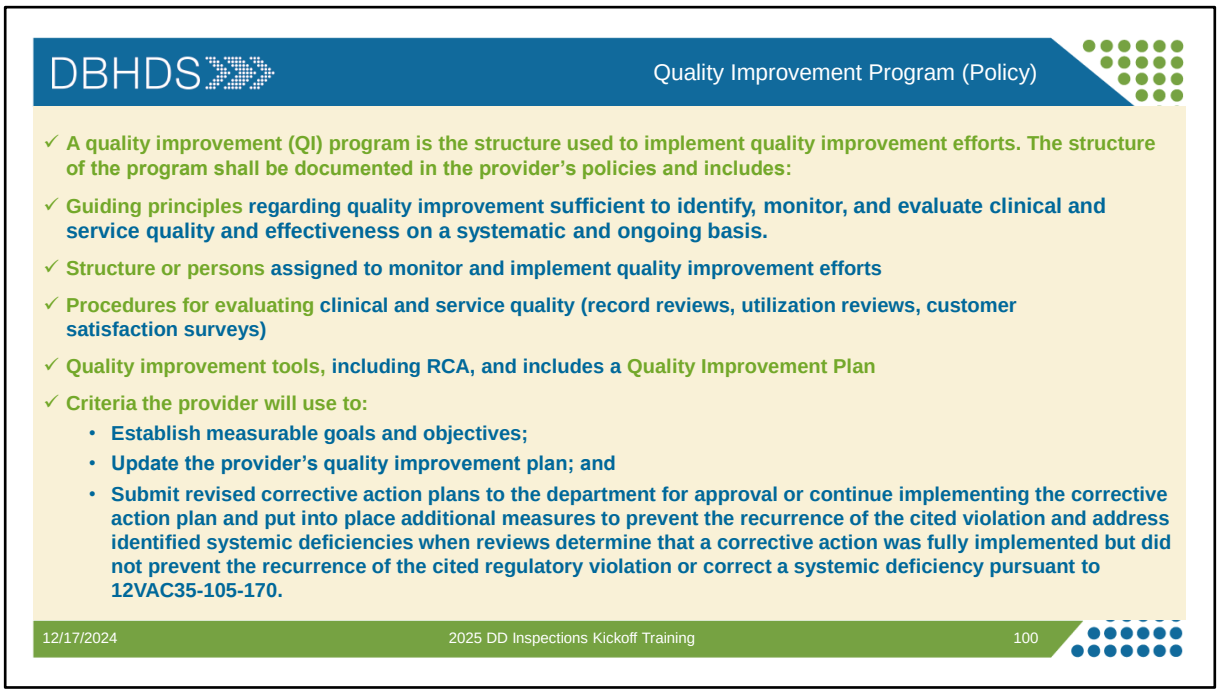
You QI plan should address all elements outlined in 620.C.1-5



620.A

Let's start with the program

The provider shall develop and implement written policies and procedures for a quality improvement program sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis.

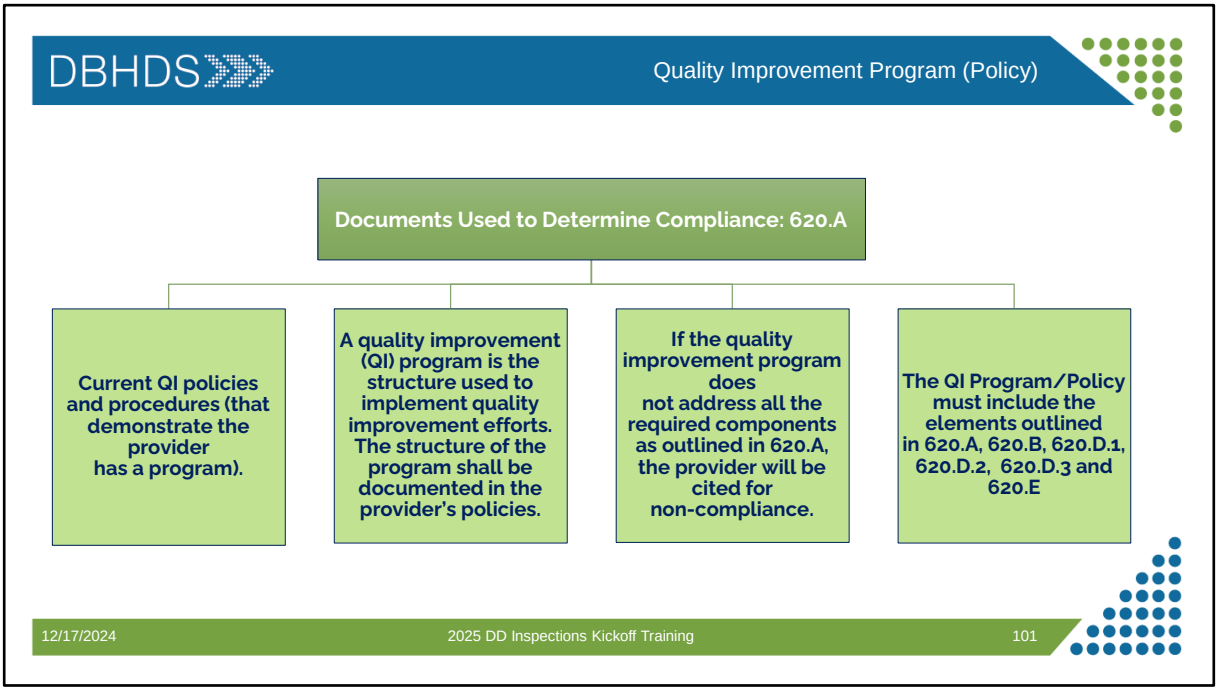


What does that look like? Well, a quality improvement (QI) program is the overarching structure used to implement quality improvement efforts. The structure of the program shall be documented in the provider's policies/procedures, and it should include:

- Guiding principles regarding quality improvement sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis.
- Structure or persons assigned to monitor and implement quality improvement efforts
- Procedures for evaluating clinical and service quality (record reviews, utilization reviews, customer satisfaction surveys)
- Quality improvement tools, including RCA
- A Quality improvement Plan

A provider's QI Program must also include the criteria the provider will use to:

- Establish measurable goals and objectives;
- Update the provider's quality improvement plan; and
- Submit revised corrective action plans to the department for approval or continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies when reviews determine that a corrective action was fully implemented but did not prevent the recurrence of the cited regulatory violation or correct a systemic deficiency pursuant to 12VAC35-105-170.

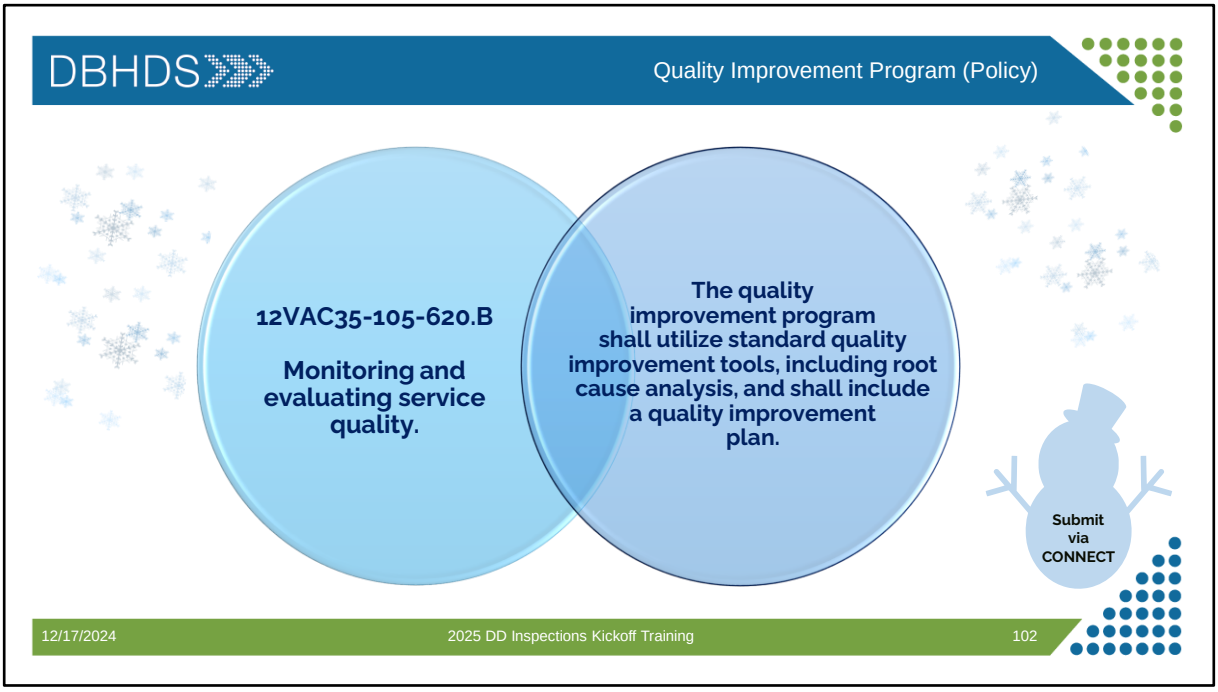


Documents the Office of Licensing will review to determine compliance

Current Quality Improvement program-these are the written policies and procedures that demonstrate the structure of the QI program

The quality improvement program must indicate how the provider identifies, monitors, and evaluates clinical and service quality and effectiveness on a systematic and ongoing basis. Make sure each of these areas are addressed.

The QI Program must include the regulatory requirements outlined in 620.A, 620.B, 620.D.1, 620.D.2, 620.D.3 and 620.E



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

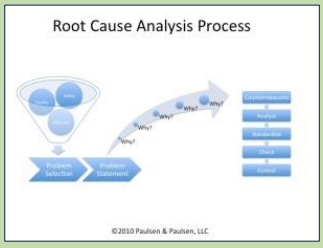
This means that your QI program, your written policy, must list the QI Tools that you use. One of the tools must must be root cause analysis which is already required per regulation 160.E.

This regulation also requires the provider's QI program to include a Quality Improvement Plan.

Your written policy needs to list all the QI tools your agency uses, and your agency must have a QI Plan.

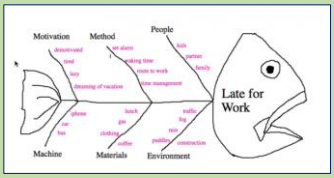
12VAC35-105-620.B:

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



Examples Include:

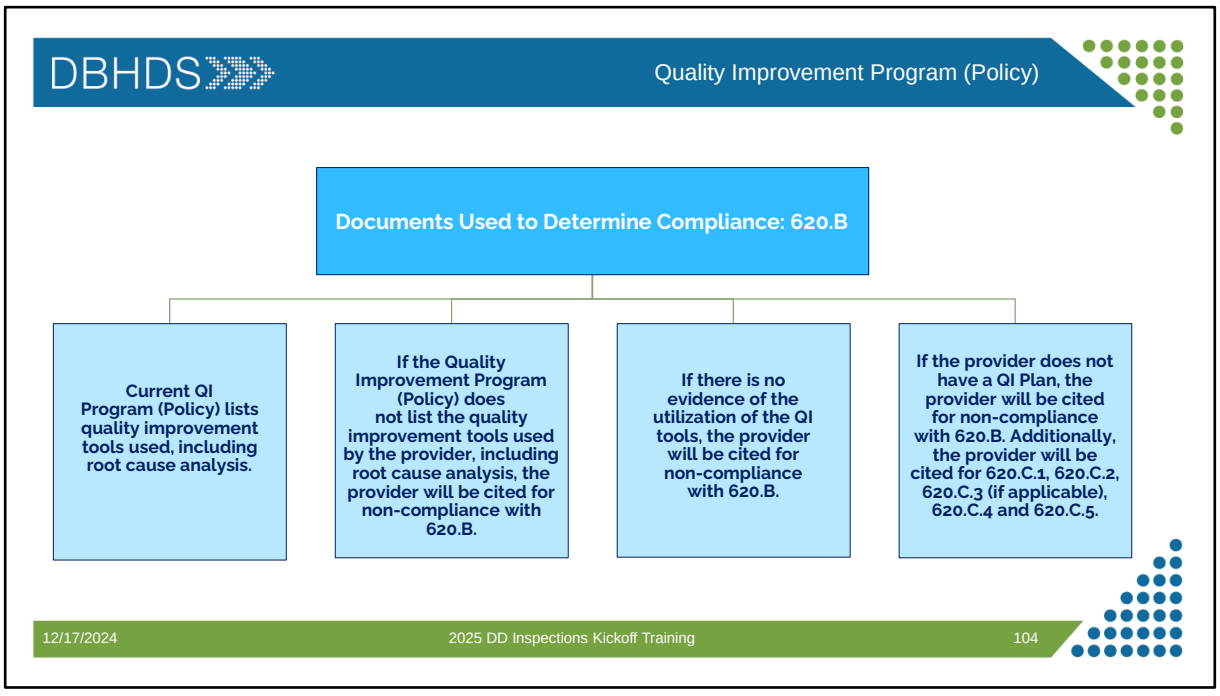
- ✓ Pareto Charts
- ✓ Failure Mode and Effect Analysis (FMEA)
- ✓ 5 Whys
- ✓ Fishbone Diagram
- ✓ Scatter Diagram
- ✓ Affinity Diagram
- ✓ Plan Do Study Act



Remember that your QI Program must utilize standard quality improvement tools, including root cause analysis.

Other QI Tools include you may want to use are

- Pareto Charts
- Failure Mode and Effect Analysis (FMEA)
- 5 Whys
- Fishbone Diagram
- Scatter Diagram
- Affinity Diagram
- Plan Do Study Act



Documents the Office of Licensing will review to determine compliance

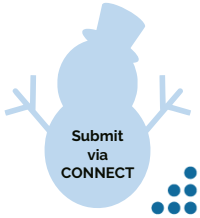
- Current QI program-your written policy
- Does the policy list quality improvement tools used, including root cause analysis?
- If the policy does not list the quality improvement tools used by the provider, then the provider will be cited for non-compliance with 620.B
- Is there evidence that the provider is using the QI tool that are outlined in their policy?
- Remember the provider must have a QI Program and a QI Plan, if the provider does not have a QI Plan, they will be cited for non-compliance with 620.B. and for 620.C.1, 620.C.2, 620.C.3 (if applicable), 620.C.4 and 620.C.5.

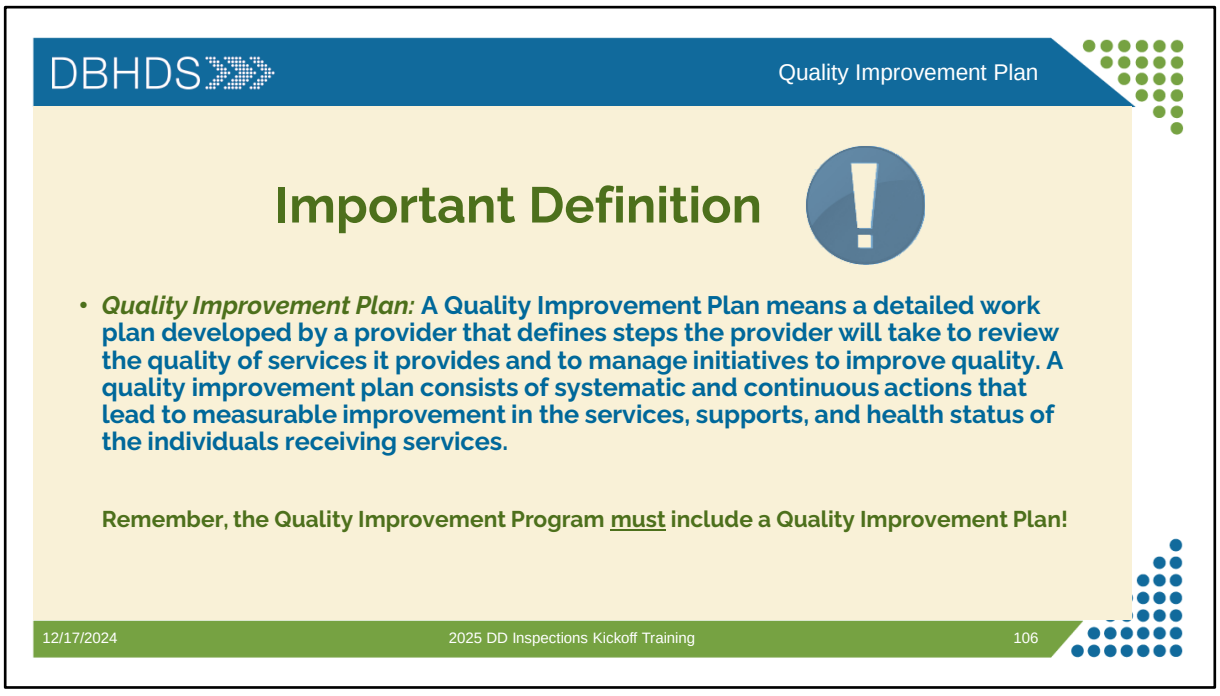
12VAC35-105-620.C.1-5

Monitoring and evaluating service quality.

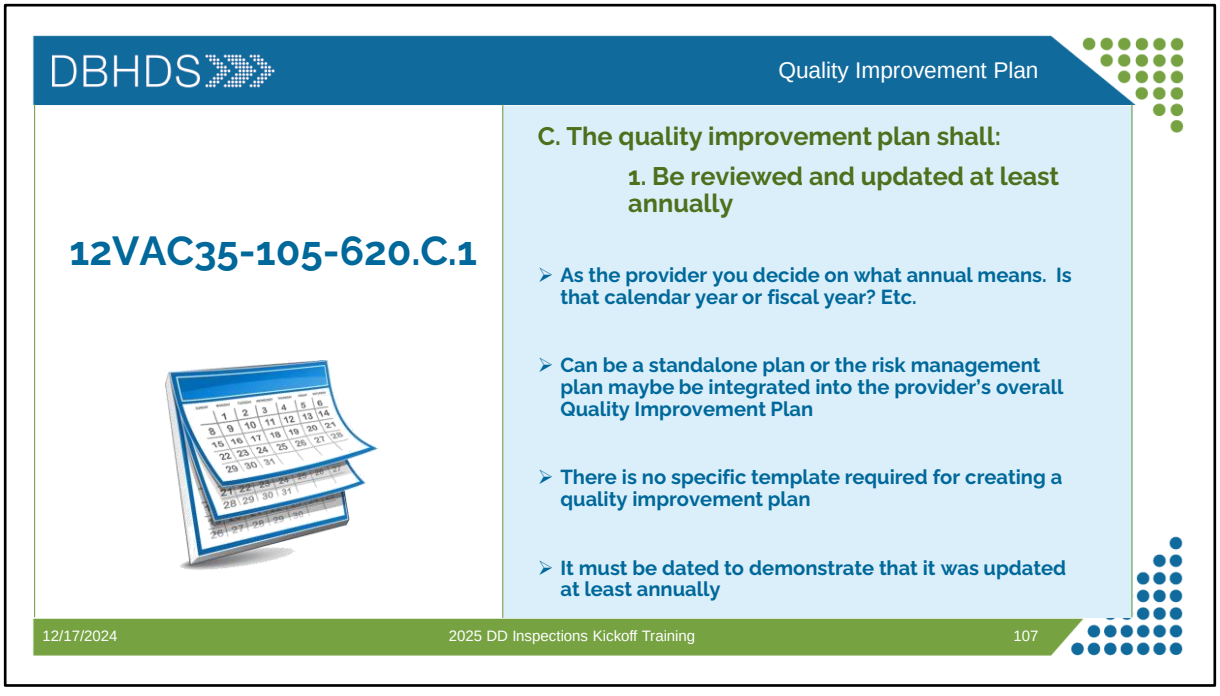
The quality improvement plan shall:

1. Be reviewed and updated at least annually;
2. Define measurable goals and objectives;
3. Include and report on statewide performance measures, if applicable, as required by DBHDS;
4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170; and
5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.

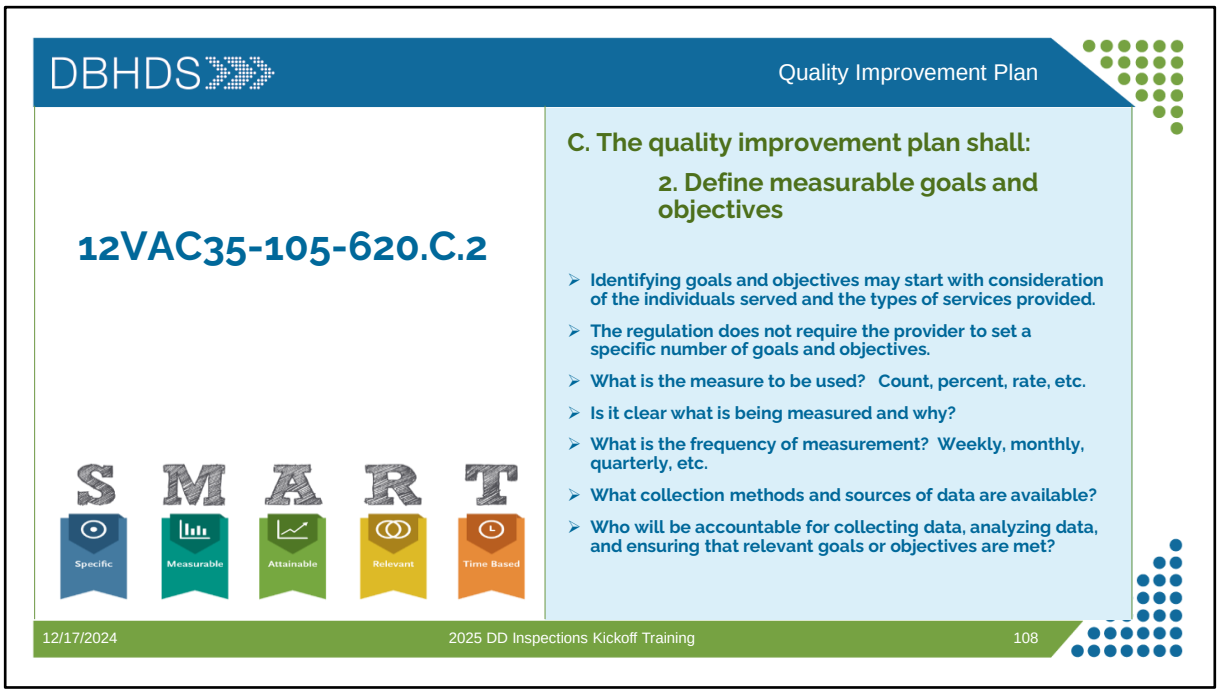




A Quality Improvement Plan means a detailed work plan developed by a provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.



- There is no specific template required for creating a quality improvement plan; however, staff responsible for implementation of the quality improvement plan must review and update the plan at least annually (every 365 days). As the provider you decide on what annual means.
- The quality improvement plan should be dated and signed to indicate when it is implemented and when any updates occur.
- Annual and other reviews of the quality improvement plan should include evaluation of the components of the program, efficacy of the plan, and whether any updates are needed to accomplish the plan's goals.
- Can be a standalone plan or the risk management plan maybe be integrated into the provider's overall Quality Improvement Plan
- If needed, the provider can update their plan more frequently based on defined goals and the occurrence of relevant events, such as the issuance of a licensing report.



The quality improvement plan must include measurable goals and measurable objectives

A provider's quality improvement plan should include goals and objectives that are operationally defined and measurable, and a schedule for monitoring progress towards achieving the planned goals and objectives.

Identifying goals and objectives may start with consideration of the individuals served and the types of services provided. Providers collecting data already may consider using the data to identify areas for improvement

Establishing a measurable objective may start with the question, "How will I know that there has been improvement or that the objective was achieved?" For example, if the objective of a residential provider is to reduce the number of injuries sustained, this objective could be stated as, "Reduce the rate of serious injuries by X% by June 1, 2024."

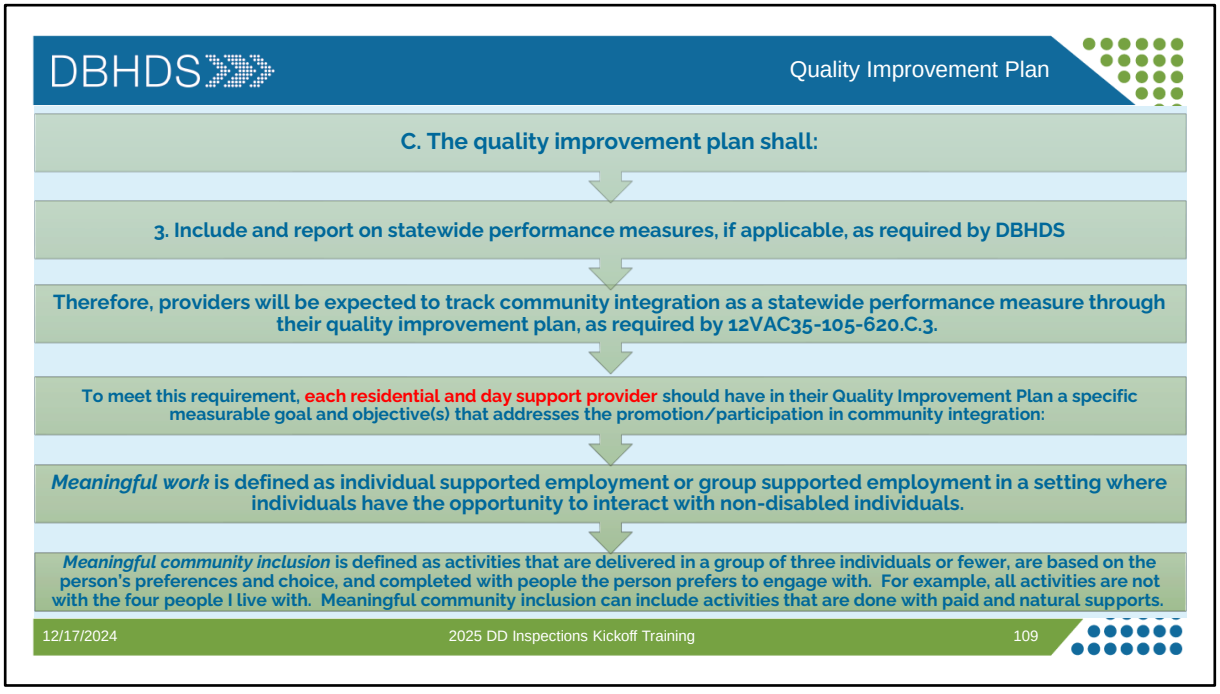
This regulation does not require the provider to set a specific number of goals and objectives. Providers may wish to select only a few goals and then revise or expand the list as evaluations indicate.

If you want to create measurable goals and objectives, be SMART about it

FOR REFERENCE ONLY

When establishing measurable goals and objectives, a provider may consider the following:

- Is it clear what is being measured and why?
- Is there a statement that defines what is to be measured?
- What collection methods and sources of data are available?
- What is the baseline data, if available?
- What is the frequency of measurement? (e.g., monthly, quarterly, semiannually)
- How will the provider know if goals and objectives were met?
- What is the timeframe for achieving the goal or objective?
- Who will be accountable for collecting data, analyzing data, and ensuring that relevant goals or objectives are met?



The quality improvement plan must include and report on statewide performance measures, if applicable, as required by DBHDS.

Residential and day support providers are expected to track community integration as a statewide performance measure through their quality improvement plan.

To meet this requirement, each residential and day support provider should have in their QI Plan a specific measurable goal and measurable objective(s) that addresses meaningful work or meaningful community inclusion as defined by the Division of Developmental Services.

Meaningful work is defined as individual supported employment or group supported employment in a setting where individuals have the opportunity to interact with non-disabled individuals.

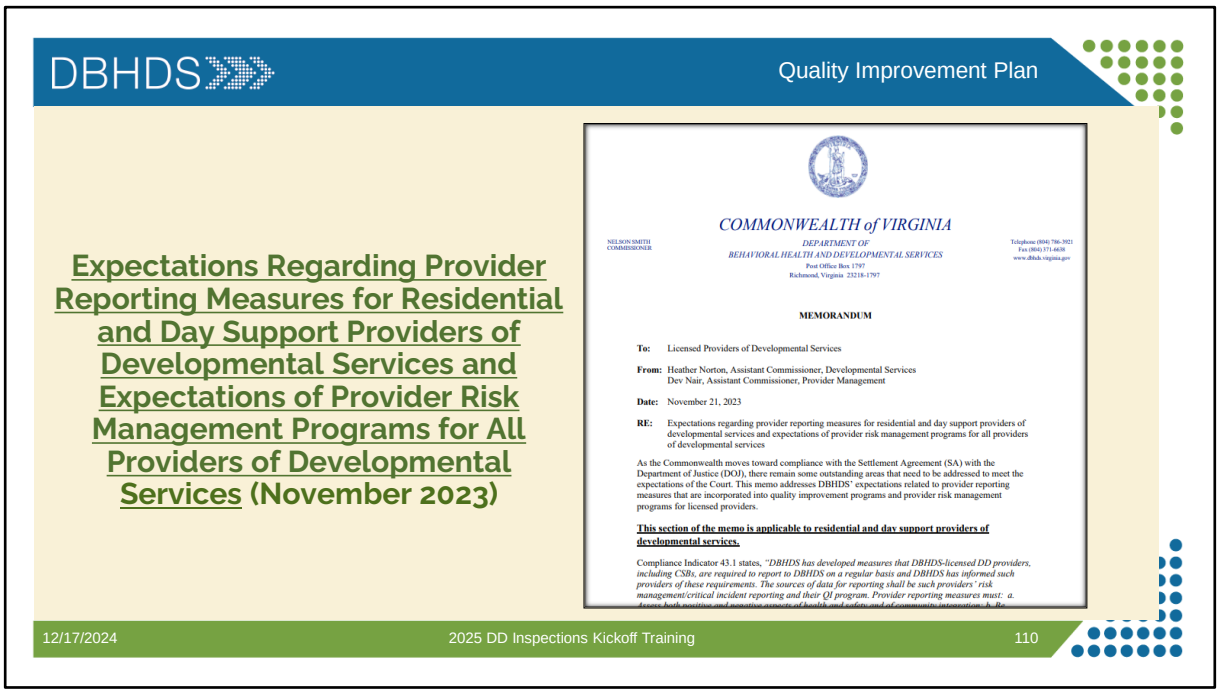
Meaningful community inclusion is defined as activities that are delivered in a group of three individuals or fewer, are based on the person's preferences and choice, and completed with people the person prefers to engage with. For example, all activities are not with the four people they live with. Meaningful community inclusion can include activities that are done with paid and natural supports

Providers are not required to develop a measurable goal for both meaningful work and meaningful community inclusion, they must develop a measurable goal and measurable objective(s) for one or the other.

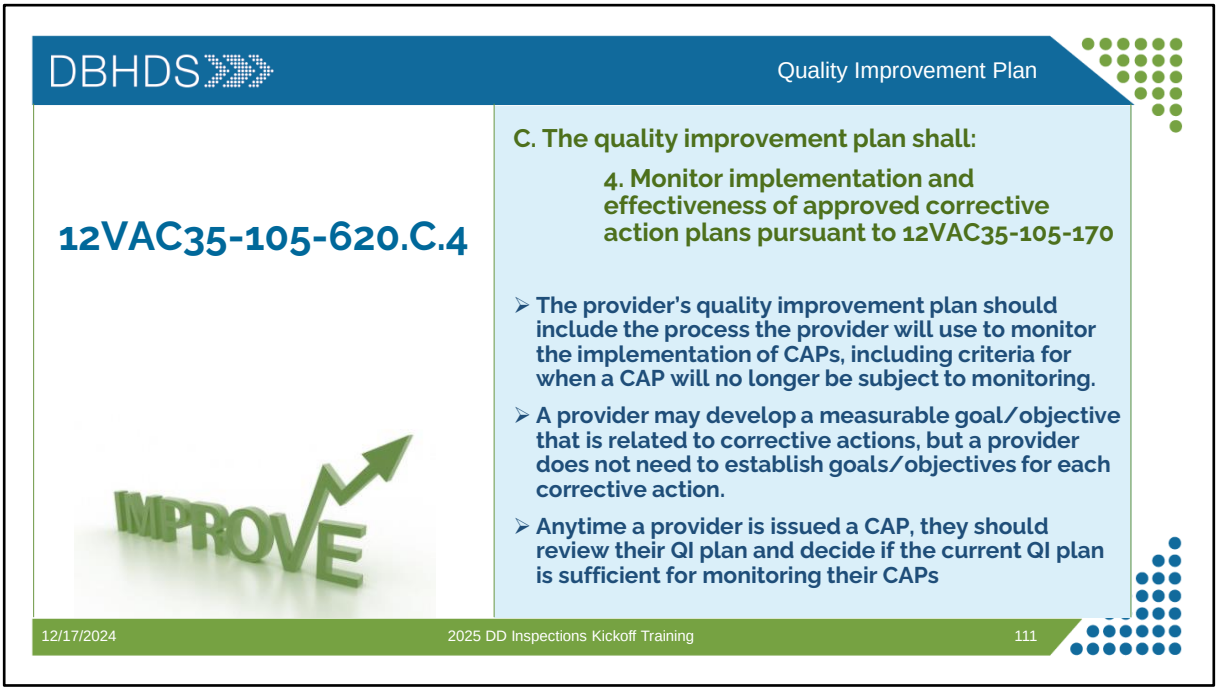
If a day support or residential provider has developed a goal and objective(s) to address the promotion/participation in community integration, then they will be given a rating of Compliant. For 2025, residential and day support providers who have not developed a measurable goal and measurable objective(s) to meet this requirement will be given a rating of Non-Compliant.

Information related to provider compliance will continue to be assessed during Quality Service Reviews

If additional statewide performance measures are developed, DBHDS will provide information regarding reporting and expectations to licensed providers.



I want to remind providers that in November 2023, the Expectations Regarding Provider Reporting Measures for Residential and Day Support Providers of Developmental Services and Expectations of Provider Risk Management Programs for All Providers of Developmental Services memo was posted on the OL website. If you are unsure of the expectation related to statewide performance measures, please make sure that you have review this memo and update your QI Plan accordingly.



The quality improvement plan must monitor implementation and effectiveness of approved corrective action plans

- Providers should have a clear written plan which should include the process the provider will use to monitor the implementation of CAPs and include the criteria for when a CAP will no longer be subject to monitoring.

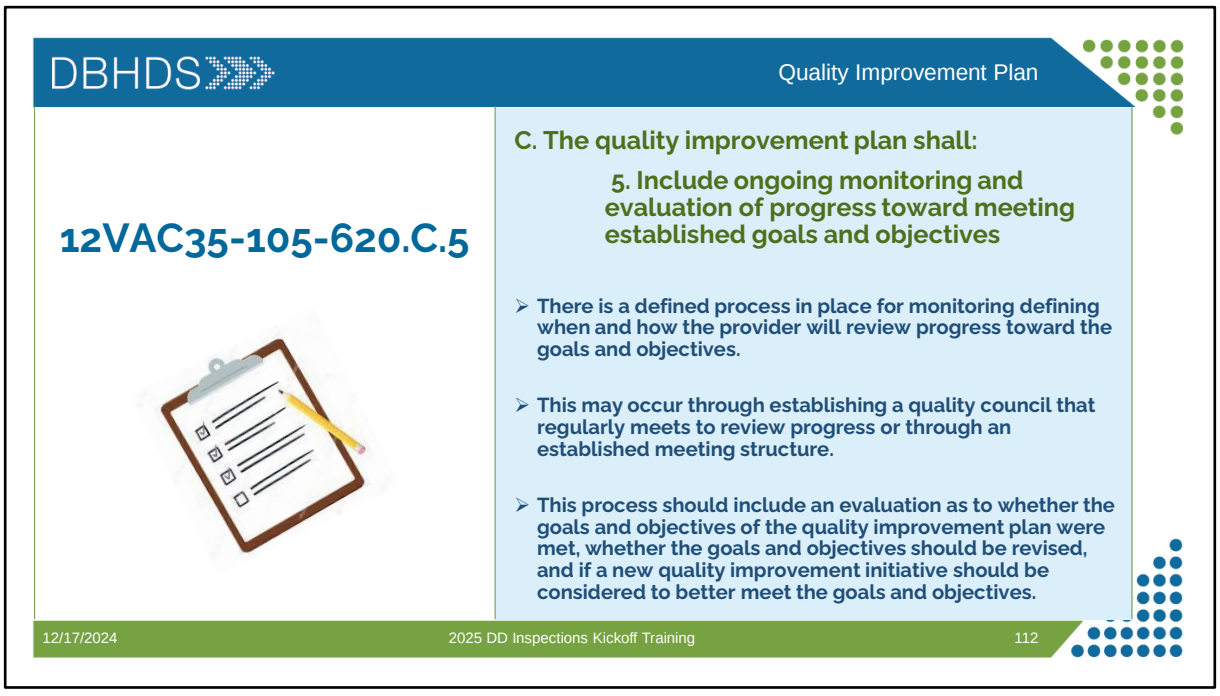
- The provider should identify any systematic actions that may be taken to address deficiencies identified by citations or CAPs and incorporate these into their quality improvement plan.

- A provider may decide to develop a measurable goal/objective that is related to corrective actions, but a provider does not need to establish goals/objectives for each corrective action. A consideration may be made to develop a goal/objective for systemic corrective actions or health and safety CAPs.

- For example, if a provider was cited for errors in medication administration, they may develop a CAP to reduce errors, and then establish a specific objective for X% reduction in number of medication errors in the next quarter. This could be measured through a chart review and reported as part of the quality improvement program.

- Keep in mind that anytime a provider is issued a licensing report, the provider should review their quality improvement plan to determine whether their current plan for monitoring CAPs is sufficient to address the concerns identified in the licensing report and to monitor compliance with the provider's pledged CAP.

- Providers are not required to update their quality improvement plan each time a licensing report is issued. However, if the current quality improvement plan is not sufficient, then the provider will need to update the plan accordingly.

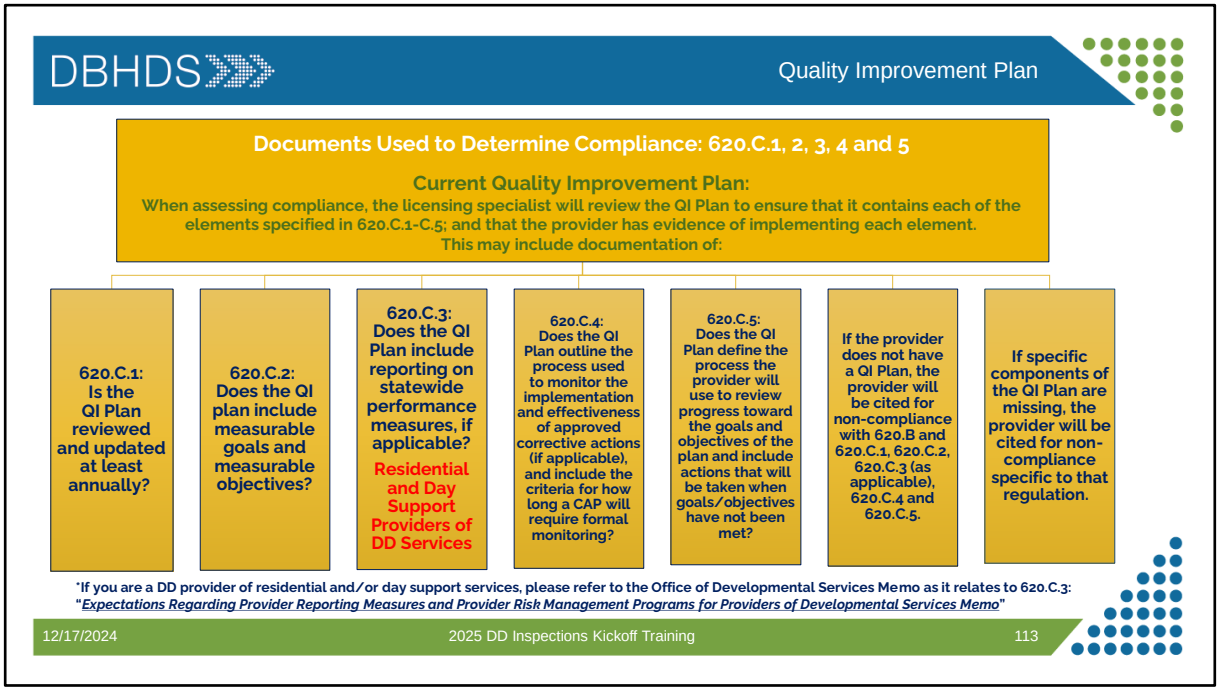


The quality improvement plan must include ongoing monitoring and evaluation of progress toward meeting established goals and objectives

- Does the QI Plan define the process the provider will use to review progress toward the goals and objectives of the plan and include actions that will be taken when goals/objectives have not been met?
- This may occur through establishing a quality council that regularly meets to review progress or through an established meeting structure.
- This process should include an evaluation as to whether the goals and objectives of the quality improvement plan were met, whether the goals and objectives should be revised, and if a new quality improvement initiative should be considered to better meet the goals and objectives.

FOR REFERENCE ONLY
“The provider’s quality committee will meet quarterly to review progress toward the established goals and objectives. As the results of data collection are analyzed, the provider will look for trends, identify progress in meeting the goals and objectives, whether the goals should be revised, and consider whether a quality improvement initiative is necessary. A report of quarterly data is attached as an appendix to the quality improvement plan”.

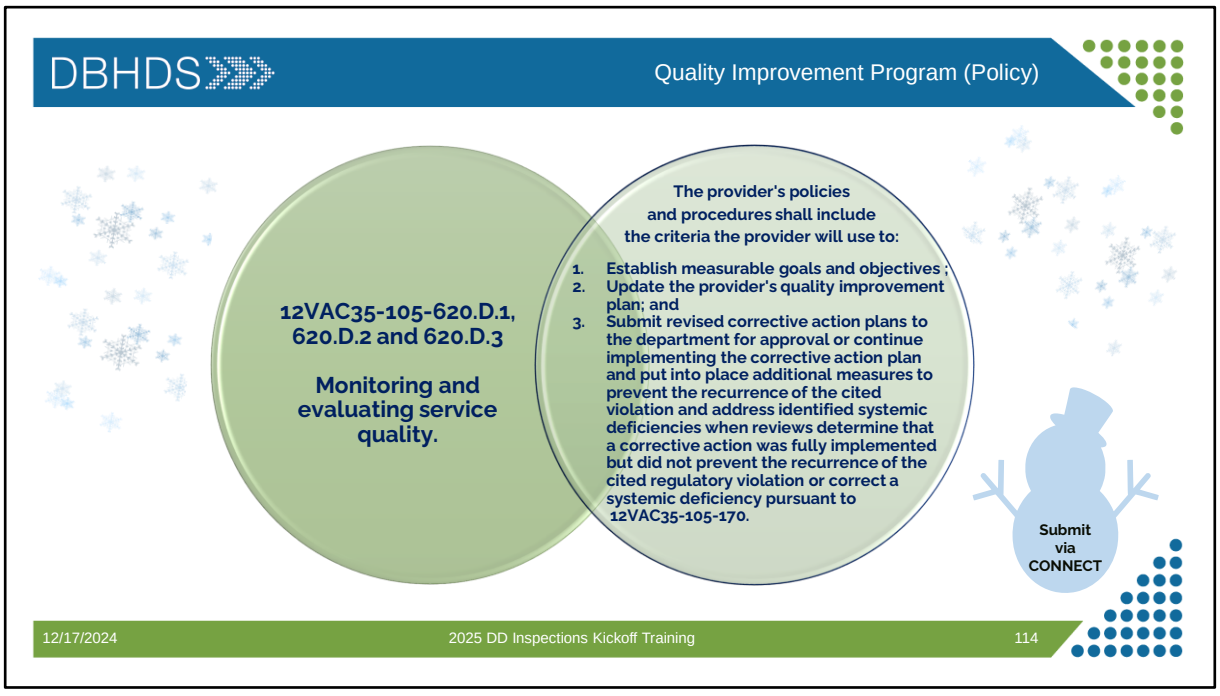
“Progress in meeting established goals and objectives is a critical part of quality improvement activities. The goals and objectives are monitored (monthly/quarterly) and based on identified trends, the provider initiates quality improvement projects”.
“An addendum to the quality improvement plan outlines the data and meeting minutes reflect the quality improvement committee’s discussion regarding progress toward meeting the goals and objectives”.
“If progress is not demonstrated, the provider identifies barriers to improvement and/or makes changes to the goals/objectives.
When a goal/objective is met, the committee determines the necessity for continuing to monitor or focuses on other priorities”.



Documents the Office of Licensing will review to determine compliance with the Quality Improvement Plan

The OL will review the current QI Plan to determine

- If the plan is reviewed and updated at least annually, so is it dated?
- If the plans includes measurable goals and measurable objectives?
- If the QI plan includes reporting on statewide performance measures? Remember that this is a requirement for residential and day support services
- If the QI plan outlines the process used to monitor the implementation and effectiveness of approved corrective actions (if applicable), and include the criteria for how long a CAP will require formal monitoring
- If the QI plan defines the process the provider will use to review progress toward the goals and objectives of the plan and include actions that will be taken when goals/objectives have not been met
- If the provider does not have a QI Plan, the provider will be cited for non-compliance with 620.B and 620.C.1, 620.C.2, 620.C.3 (as applicable), 620.C.4 and 620.C.5.
- If specific components of the QI Plan are missing the provider will be cited for non-compliance specific to that regulation.



In addition to the requirements outlined in 620.A and 620.B the quality improvement policy must include the requirements outlined in 620.D.1, 2 and 3

Provider policies and procedures must include the processes by which the provider will develop, implement, and update its quality improvement plan, and thereby demonstrate an ongoing, constant process. This means that the written policy for your QI Program must include:

1. The criteria the provider will use to Establish measurable goals and objectives.

For example, when a goal has been met, when the goal has been assessed as not effective to meet the needs, etc.

2. The criteria the provider will use to Update the provider's quality improvement plan.

For example, at least annually, when a new service is added, when required to submit a CAP, etc

AND

3. The provider's policies and procedures must address the steps that the provider will take when the provider determines that an approved CAP was fully implemented, but did not resolve the underlying issue (still not in compliance) – either submit a revised CAP to the department or continue implementing the CAP and put into place additional measures to prevent recurrence of the cited violation and address identified systemic deficiencies.

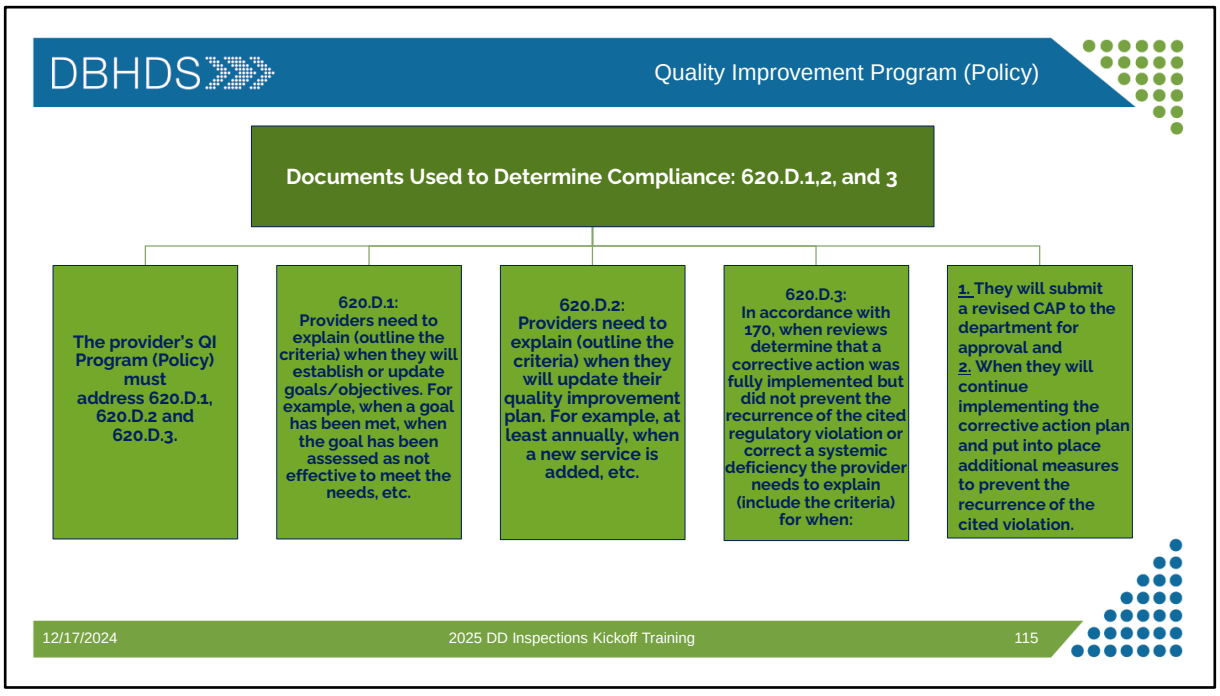
Example: even though a CAP was fully implemented, the provider determined that they are still not in compliance, or an underlying systemic deficiency was not resolved

In this scenario, the provider may:

o Continue to implement the CAP, but adopt additional corrective measures and incorporate those additional measures into the quality improvement plan, or

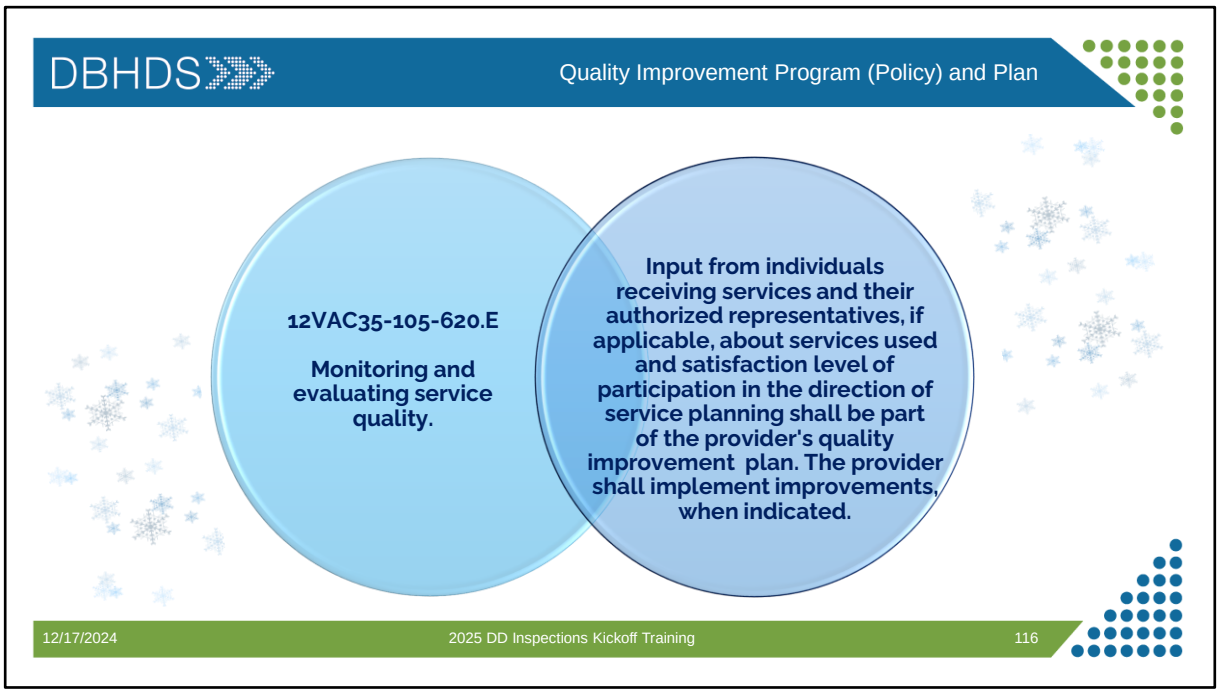
o If the provider wishes to revise the CAP, the provider must submit a revised CAP to the department for approval.

Remember that the criteria for when a provider continues to implement their CAP and put into place additional measures to prevent the recurrence of the violation, or submit a revised CAP to the department must be outlined in the providers QI Policy. It is the provider's responsibility to include in their policy what will prompt them to do one or the other.

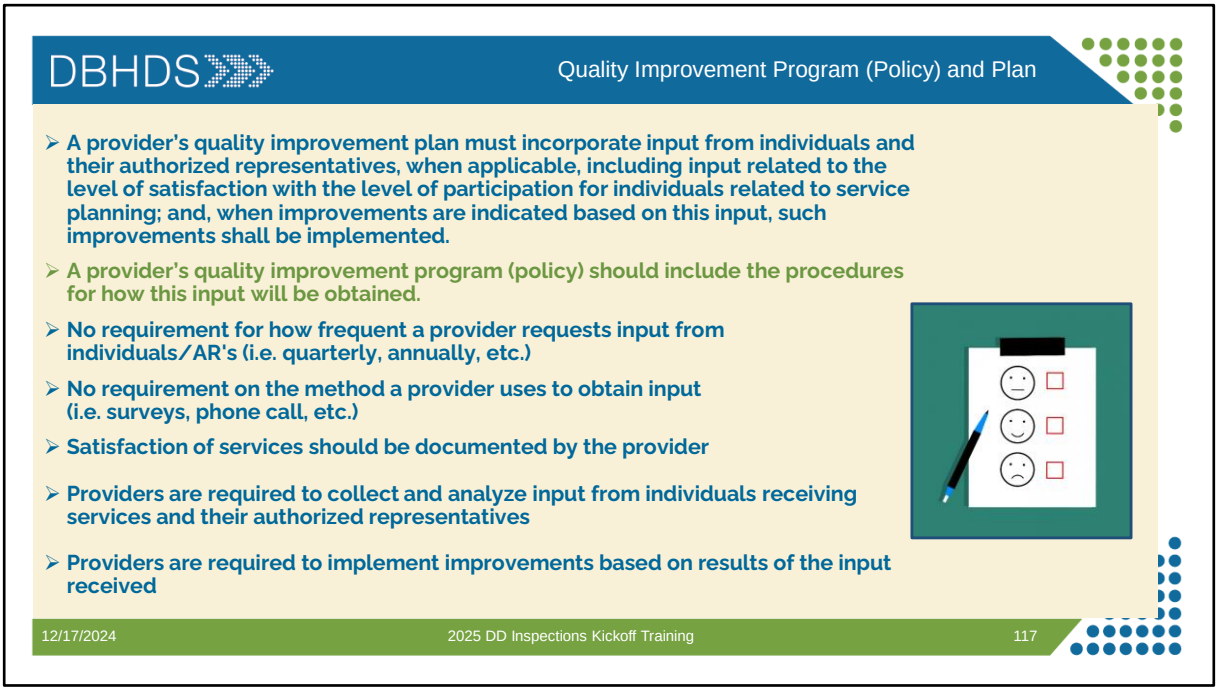


Documents the Office of Licensing will review to determine compliance

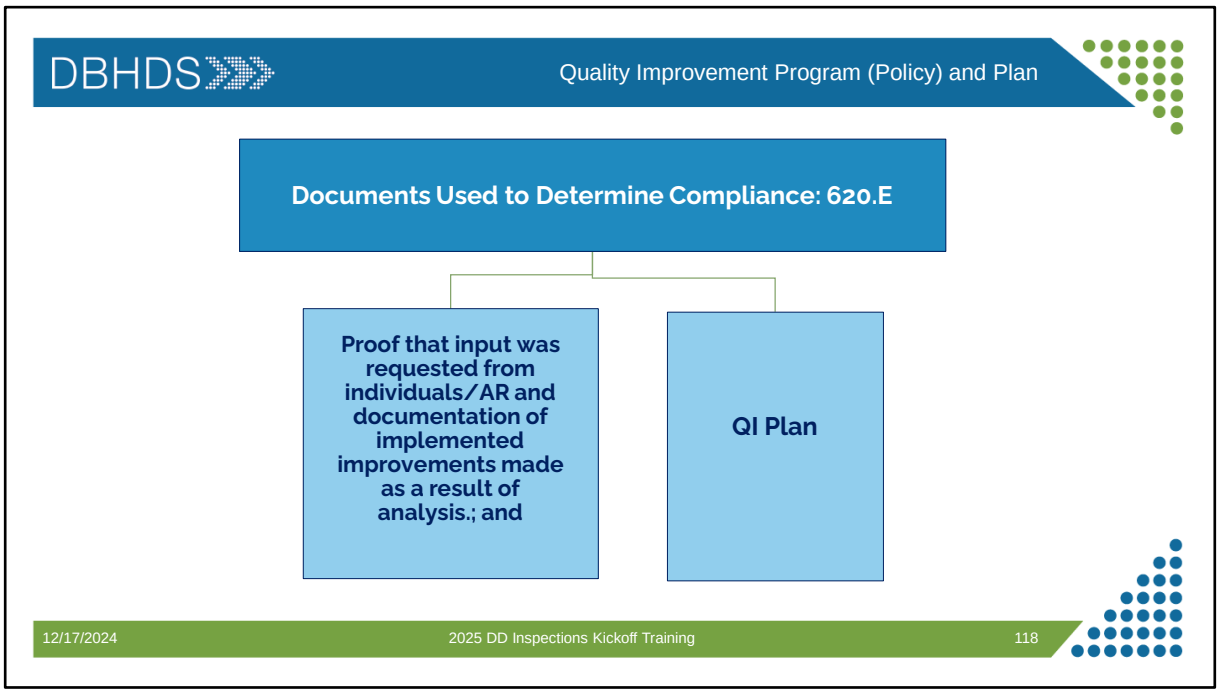
- Provider's QI policy needs to explain when they will establish or update goals/objectives.
- Provider's QI policy needs to explain when they will update their quality improvement plan.
- In accordance with 170, when reviews determine that a corrective action was fully implemented but did not prevent the recurrence of the cited regulatory violation or correct a systemic deficiency the provider's QI policy needs to explain when to submit a revised CAP to the department for approval and when to continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation.



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.



- A provider's quality improvement plan must incorporate input from individuals and their authorized representatives, when applicable.
- A provider's quality improvement program, their written policy, should include the procedures for how this input will be obtained
- There's no requirement for how frequent a provider requests input from individuals/AR's (it could be quarterly, annually, etc.)
- There's no requirement on the method a provider uses to obtain input (a provider could use surveys, phone call, or have a meeting, etc.)
- Satisfaction of services should be documented by the provider
- Providers are required to collect and analyze input from individuals receiving services and their authorized representatives
- Providers are required to implement improvements based on results of the input received



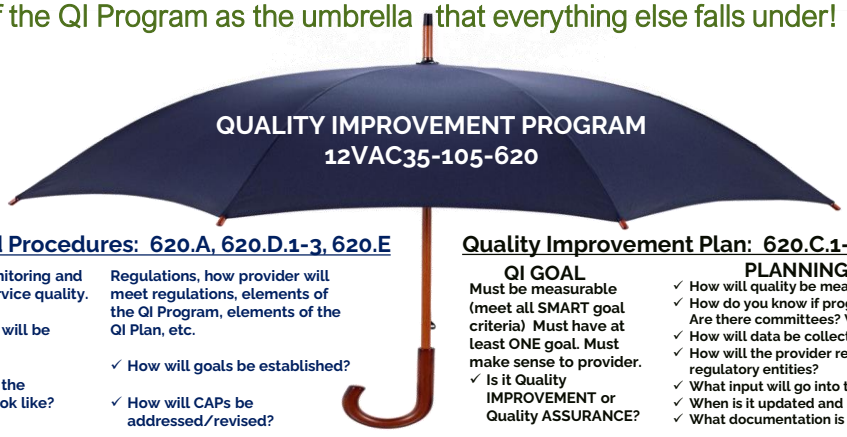
Documents the Office of Licensing will be reviewing the

- Proof that input was requested from individuals/AR and documentation of implemented improvements made as a result of the analysis, and
- QI Plan

Now Teena and Kara will discuss some Key Takeaways for 620

Quality Improvement Key Takeaways for 620

Think of the QI Program as the umbrella that everything else falls under!



Policies and Procedures: 620.A, 620.D.1-3, 620.E

Pertain to monitoring and evaluating service quality.

- ✓ What tools will be used?
- ✓ What does the structure look like?

Regulations, how provider will meet regulations, elements of the QI Program, elements of the QI Plan, etc.

- ✓ How will goals be established?
- ✓ How will CAPs be addressed/revised?

Quality Improvement Plan: 620.C.1-5, 620.E

QI GOAL

Must be measurable (meet all SMART goal criteria) Must have at least ONE goal. Must make sense to provider.

- ✓ Is it Quality IMPROVEMENT or Quality ASSURANCE?

PLANNING

- ✓ How will quality be measured?
- ✓ How do you know if progress is made? Are there committees? Who is involved?
- ✓ How will data be collected?
- ✓ How will the provider respond to regulatory entities?
- ✓ What input will go into the plan, from who?
- ✓ When is it updated and how?
- ✓ What documentation is kept as evidence?

To update, reference slide in front of this one
Teena- Barriers and Intro to standard tools

Quality Improvement Key Takeaways for 620

- Highly recommend the use of the **Quality Improvement Plan Sample** from Office of Licensing AND the **Tools for Developing a Quality Improvement Program**

Samples:

SAMPLE Quality Improvement Plan

12VAC35-105-620.C.1 – The quality improvement plan shall be reviewed and updated at least annually. Office of Licensing Guidance for a Quality Improvement Program states "the quality improvement plan should be dated and signed to indicate when it is implemented and when any updates occur."

Tip – Best practice is to include a section for the date and other information at the top or bottom of the document. Revisions could also be noted and dated in this section.

Example:

*Date:*_____; *Signature:* _____: *Title of Person:* _____

*Revision Date:*_____; *Signature:* _____; *Title of Person:* _____

Tip – Best practice is to include a Table of Contents depending upon the length of the quality improvement plan to clearly indicate sections and pages.

DBHDS Office of Licensing
Tools for Developing a Quality Improvement Program

Disclaimer – This document is for educational purposes only and is NOT intended as a template.

This document provides suggestions for an organization to consider when developing a quality improvement program in accordance with 12VAC35-105-620. Licensed providers are encouraged to refer to the Licensing Regulations and the Guidance for a Quality Improvement Program for additional information related to quality improvement programs. This document is not a SAMPLE quality improvement plan. Please see the SAMPLE Quality Improvement Plan for suggestions to consider when developing a quality improvement plan for compliance with 12VAC35-105-620.C.

There is no "one size fits all" quality improvement program. Quality improvement programs are based on the population served, the organization's size and services provided. Licensed providers may use this resource to create, review and/or add to their quality improvement program.

The **bold/underlined** section headings are offered as examples providers may wish to consider. The *italicized language* is for purposes of illustration. The inserted boxes highlight the regulatory language.

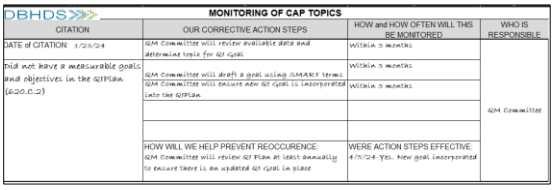
Policy Title – Quality Improvement Program

Issue Date: _____
Revisions: _____
Responsible Staff: _____

To update, reference slide in front of this one
Kara- QI policy and procedure vs. QI plan

Quality Improvement Key Takeaways for 620

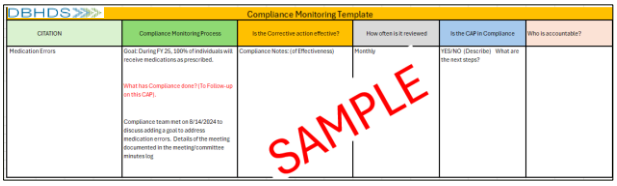
- Recommend the use of templates for your Quality Improvement activities around monitoring progress towards your **Measurable Goals & Objectives** and **CAPs**



DBHDS

MONITORING OF CAP TOPICS

CITATION	OUR CORRECTIVE ACTION STEPS	HOW and HOW OFTEN WILL THIS BE MONITORED	WHO IS RESPONSIBLE
DATE of CITATION: 1/25/24	QM Committee will review available data and determine topic for QI Goal	Within 3 months	QM Committee
Did not have a measurable goals and objectives in the QIPlan (620.0.2)	QM Committee will draft a goal using SMART terms	Within 3 months	
	QM Committee will ensure new QI Goal is incorporated into the QIPlan	Within 3 months	
	HOW WILL WE HELP PREVENT REOCCURENCE: QM Committee will review QI Plan at least annually to ensure there is an updated QI Goal in place	WERE ACTION STEPS EFFECTIVE: 4/5/24-Yes. New goal incorporated	

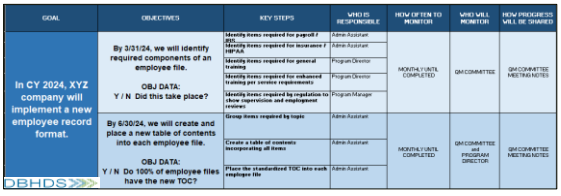


DBHDS

Compliance Monitoring Template

CITATION	Compliance Monitoring Process	Is the Corrective action effective?	How often is it reviewed	Is the CAP in Compliance	Who is accountable?
Medication Errors	Goal: During FY 25, 100% of individuals will receive medications as prescribed. What has Compliance done? (To Follow-up on this CAP). Compliance team met on 8/14/2024 to discuss adding a goal to address medication errors. Details of the meeting documented in the meeting/committee minutes/log	Compliance Notes: (of Effectiveness)	Monthly	YES/NO (Describe) What are the next steps?	

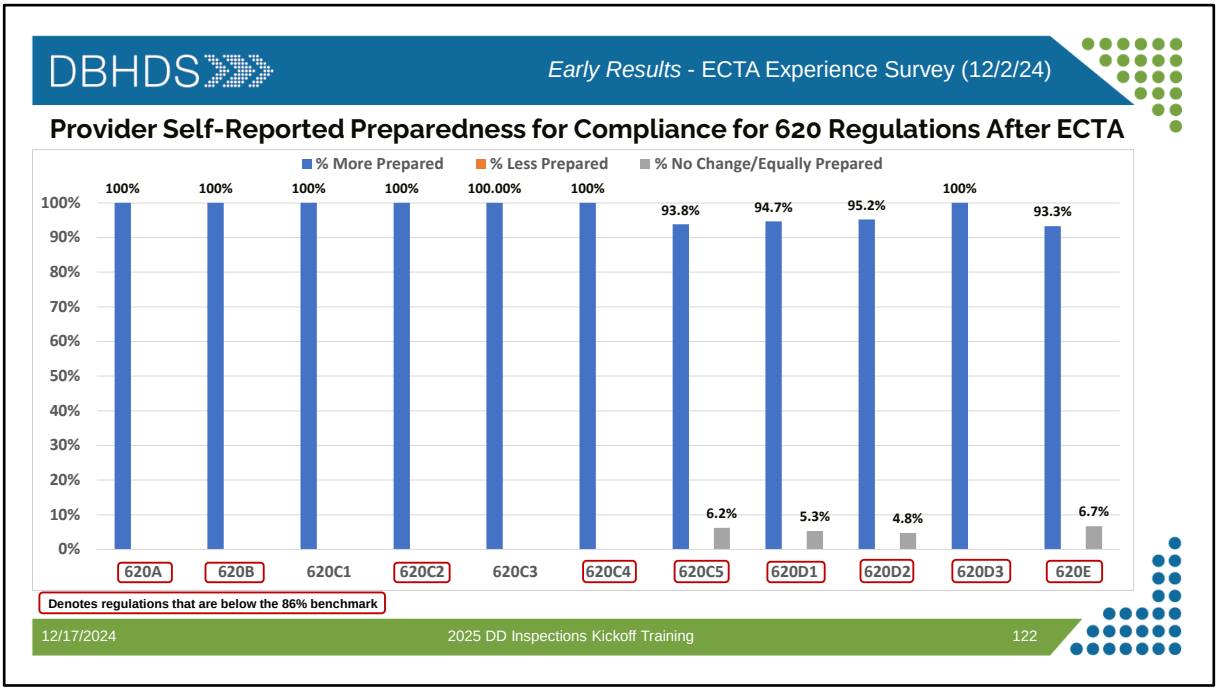
SAMPLE



GOAL	OBJECTIVES	KEY STEPS	WHO IS RESPONSIBLE	HOW OFTEN TO MONITOR	WHO WILL MONITOR	HOW PROGRESS WILL BE SHARED
In CY 2024, XYZ company will implement a new employee record format.	By 3/31/24, we will identify required components of an employee file. OBJ DATA: Y / N Did this take place?	Identify items required for payroll ?	Admin Assistant	MONTHLY UNTIL COMPLETED	QM COMMITTEE	QM COMMITTEE MEETING NOTES
		Identify items required for insurance ? HIPAA	Admin Assistant			
		Identify items required for general training	Program Director			
		Identify items required for enhanced training per service requirements	Program Director			
		Identify items required by regulation to show supervision and employment reviews	Program Manager			
	By 6/30/24, we will create and place a new table of contents into each employee file. OBJ DATA: Y / N Do 100% of employee files have the new TOC?	Group items required by topic	Admin Assistant	MONTHLY UNTIL COMPLETED	QM COMMITTEE and PROGRAM DIRECTOR	QM COMMITTEE MEETING NOTES
		Create a table of contents incorporating all items	Admin Assistant			
		Place the standardized TOC into each employee file	Admin Assistant			

DBHDS

To update, reference slide in front of this one
Teena- Tools for monitoring measurable goals/objectives and monitoring CAPs

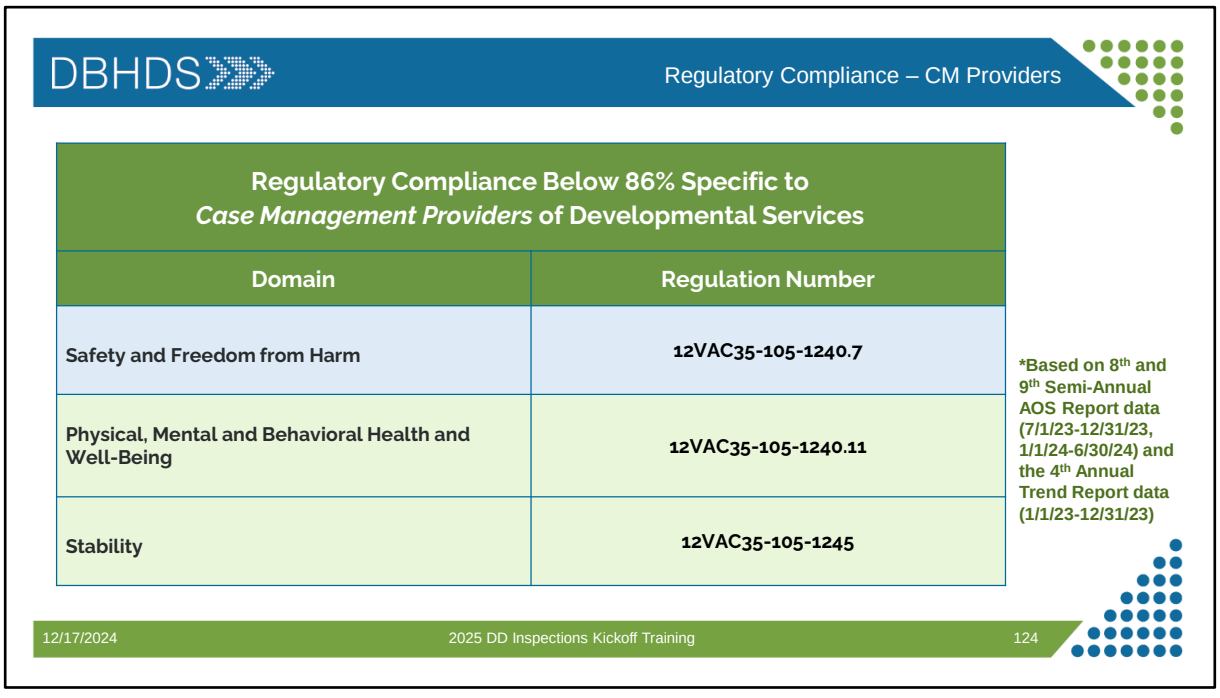


Kara- survey results for 620

Okay, let's take a few minutes for some final **poll questions from Karen (Questions #10-15)**

KAREN

Now let's move along to the third part of our Regulations overview. This next set of Regulations we will review are applicable ONLY to providers of case management services.

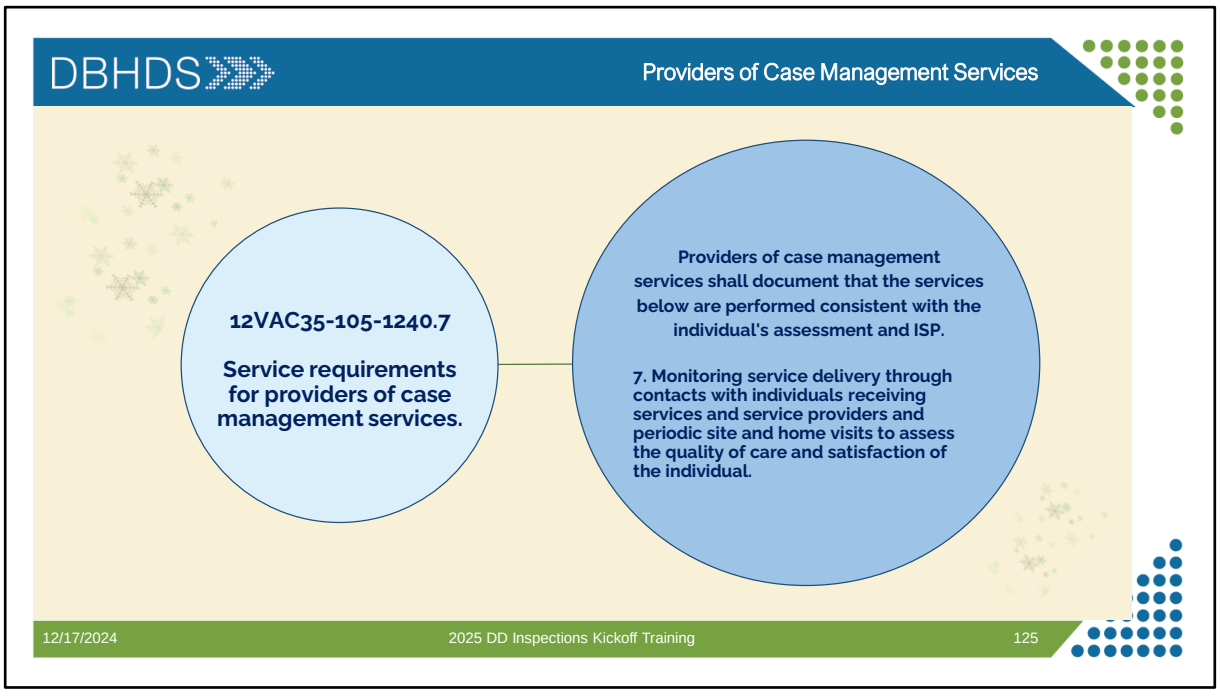


KAREN

The chart displayed here includes the specific regulations where developmental disability providers of case management services had difficulty meeting compliance.

Pause for a few seconds here

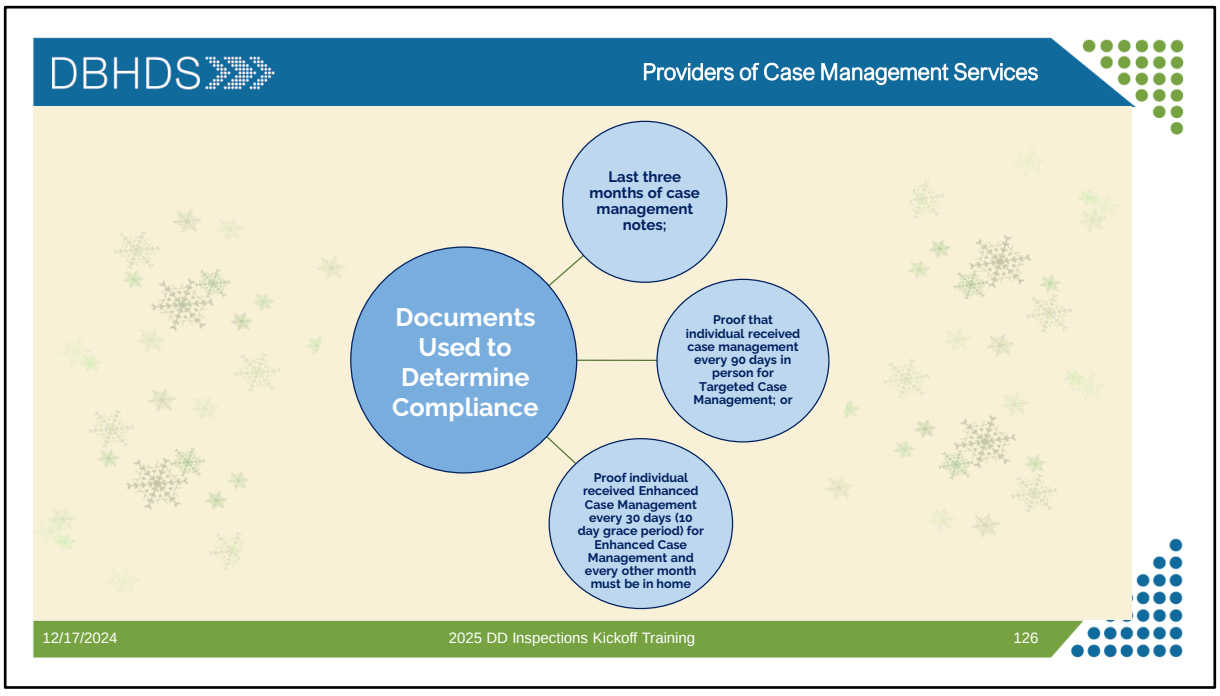
We will now talk more about each of these regulations



KAREN

1240.7: Providers of case management services must document that they are monitoring service delivery through contacts with individuals receiving services and service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual.

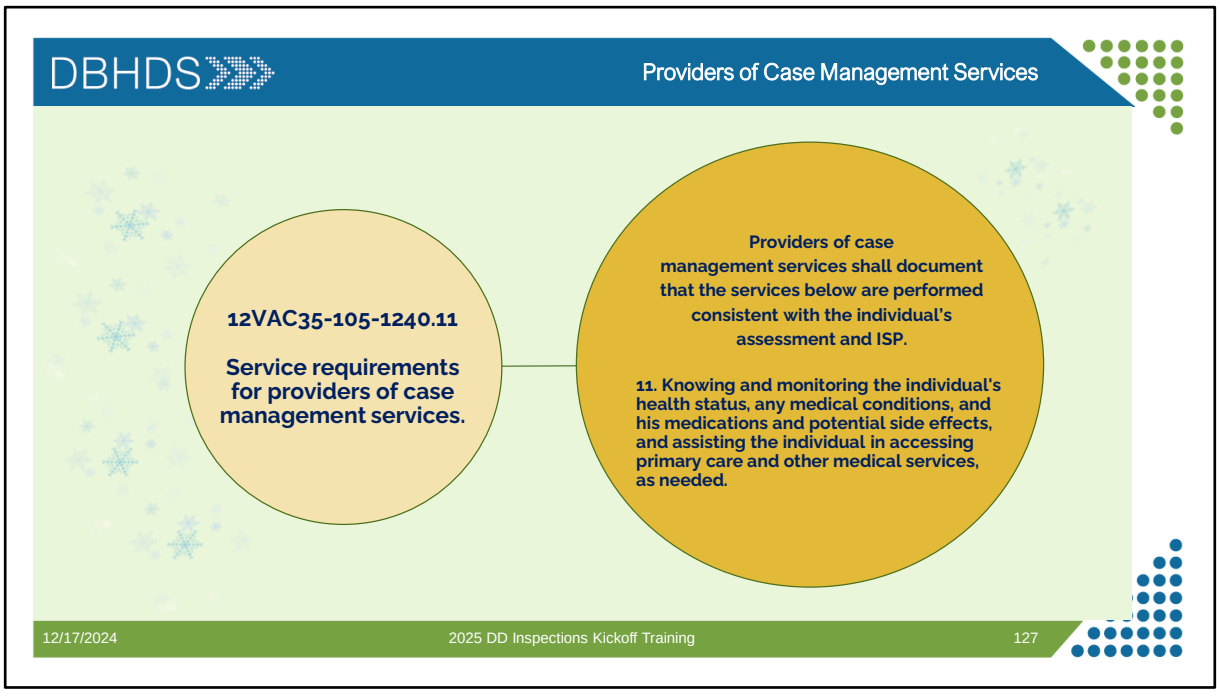
- Did contact occur at the frequency identified in ISP?
- Is there proof that the individual received case management every 90 days in person for Targeted Case Management; or
- Is there proof that the individual received Enhanced Case Management every 30 days?
- Remember that for Enhanced Case Management visits must be in the home every other month.



KAREN

Documents the Office of Licensing will review to determine compliance

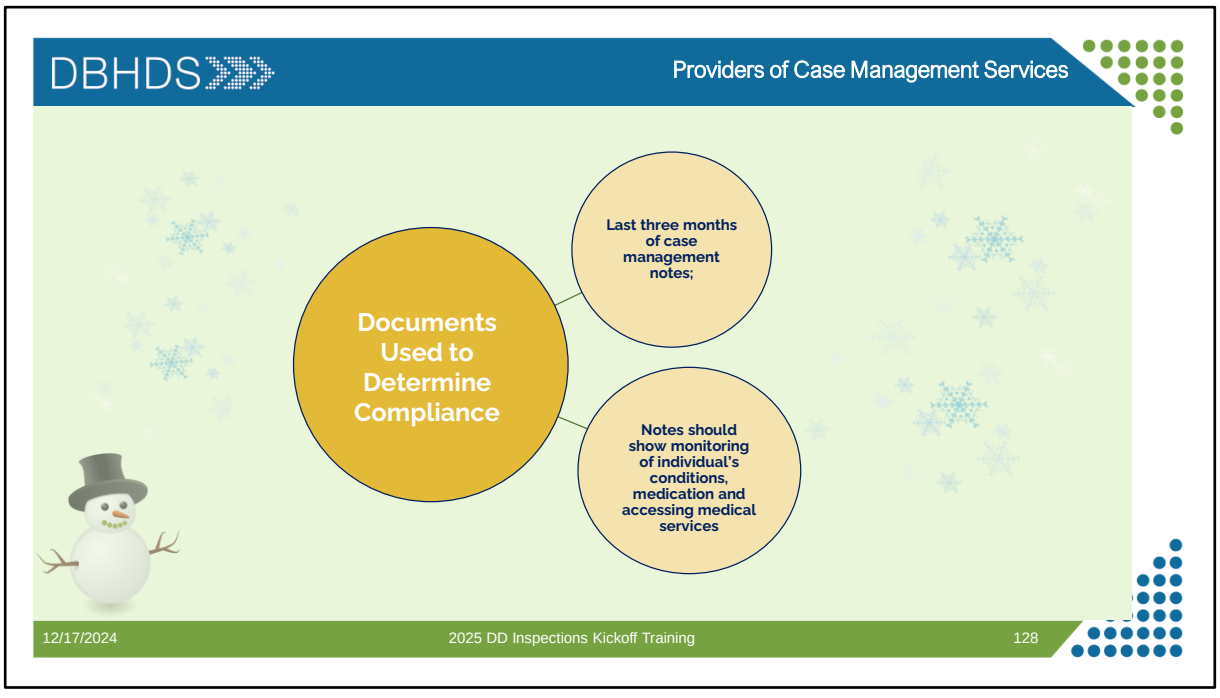
- Last three months of case management notes;
- Proof that individual received case management every 90 days in person for Targeted Case Management; or
- Proof individual received Enhanced Case Management every 30 days (there is a 10 day grace period) for Enhanced Case Management and every other month must be in the home.



KAREN

1240.11 : Providers of case management services must know and monitor the individual's health status, any medical conditions, and medications and potential side effects, and assist the individual in accessing primary care and other medical services, as needed.

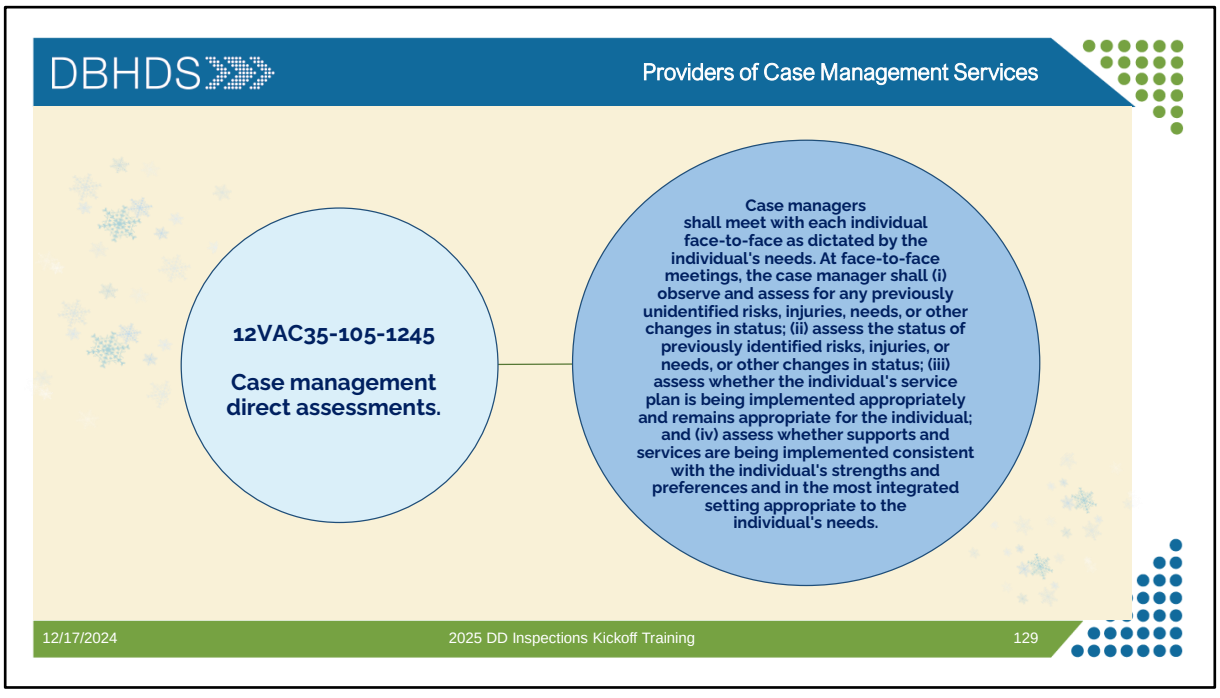
- If an individual's status or medications change, is this reflected in case management notes?
- Does the quarterly report reflect changes to the individual's status or needs?



KAREN

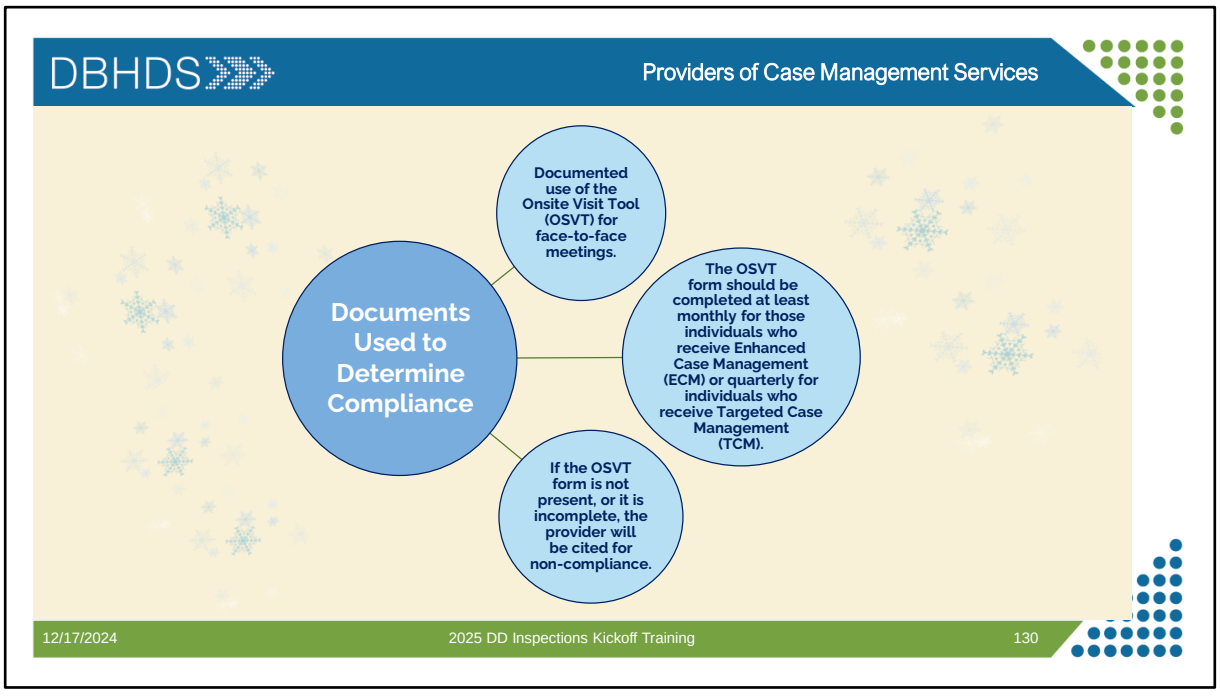
Documents the Office of Licensing will review to determine compliance

- Last three months of case management notes;
- Notes should show monitoring of individual's conditions, medications and accessing medical services



KAREN

1245: Case managers shall meet with each individual face-to-face as dictated by the individual's needs. At face-to-face meetings, the case manager shall (i) observe and assess for any previously unidentified risks, injuries, needs, or other changes in status; (ii) assess the status of previously identified risks, injuries, or needs, or other changes in status; (iii) assess whether the individual's service plan is being implemented appropriately and remains appropriate for the individual; and (iv) assess whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.

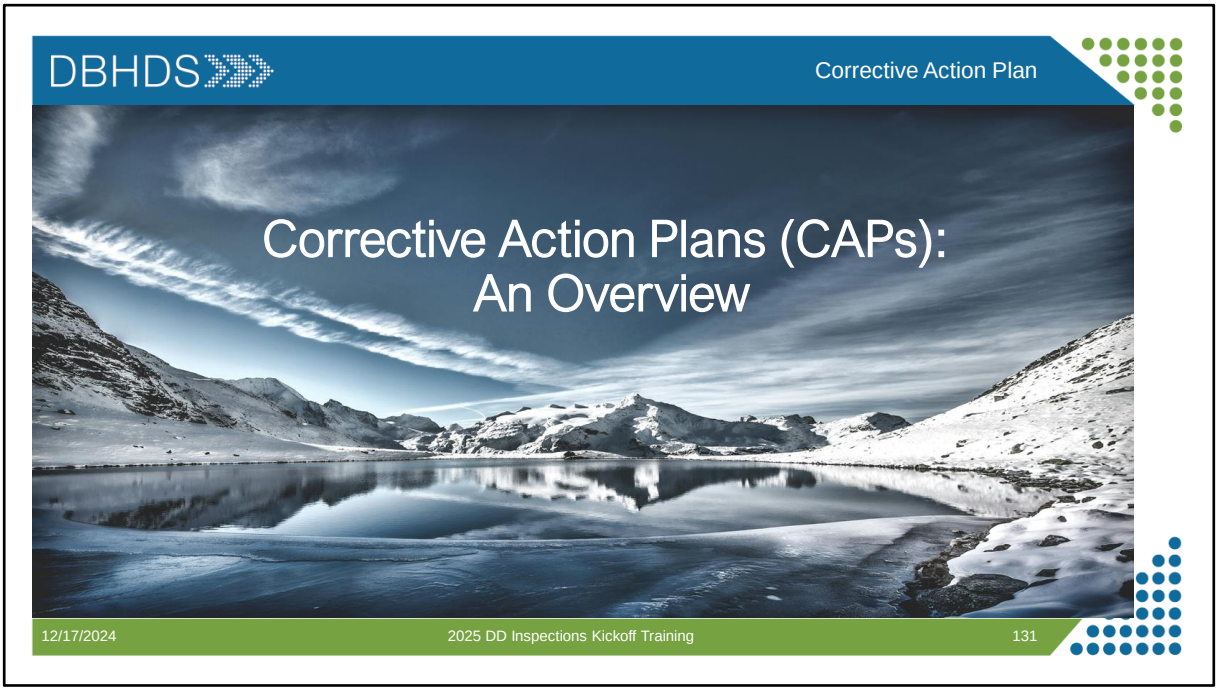


KAREN

Documents the Office of Licensing will review to determine compliance

- Documented use of the Onsite Visit Tool (OSVT) for face-to-face meetings.
- This form should be completed at least monthly for those individuals who receive Enhanced Case Management (ECM) or quarterly for individuals who receive Targeted Case Management (TCM).
- All components of the Onsite Visit Tool must be completed

Mackenzie, I'll turn it over to you to talk about Corrective Action Plans.

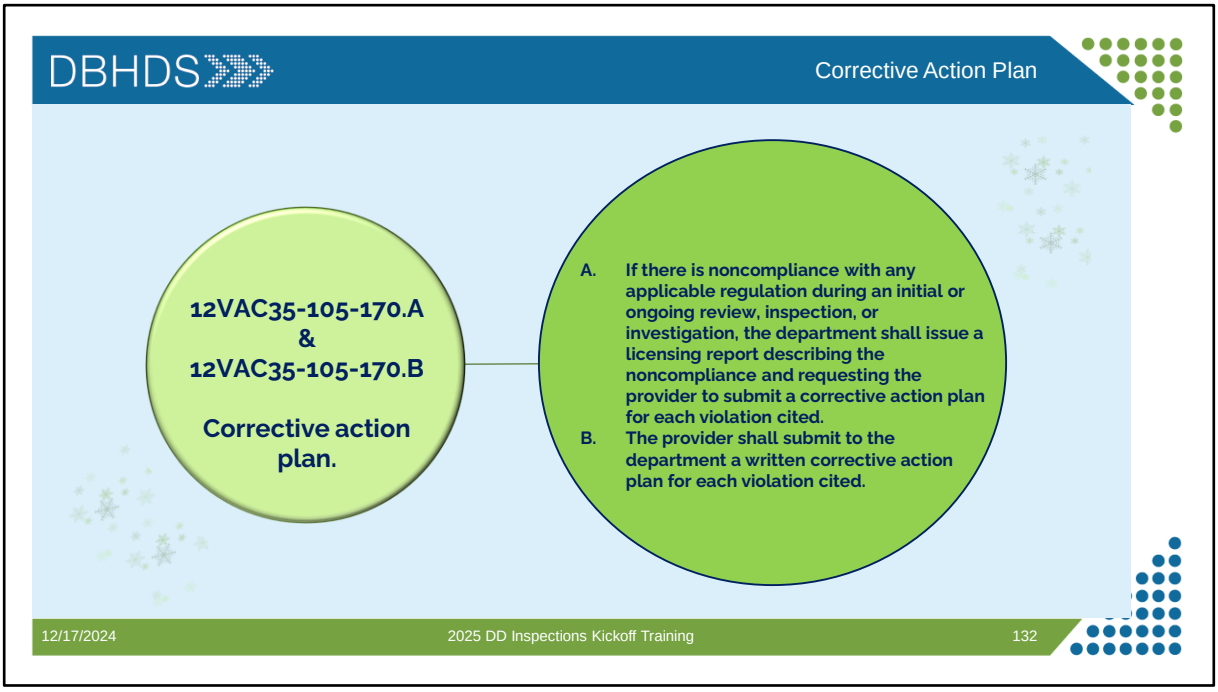


Mackenzie

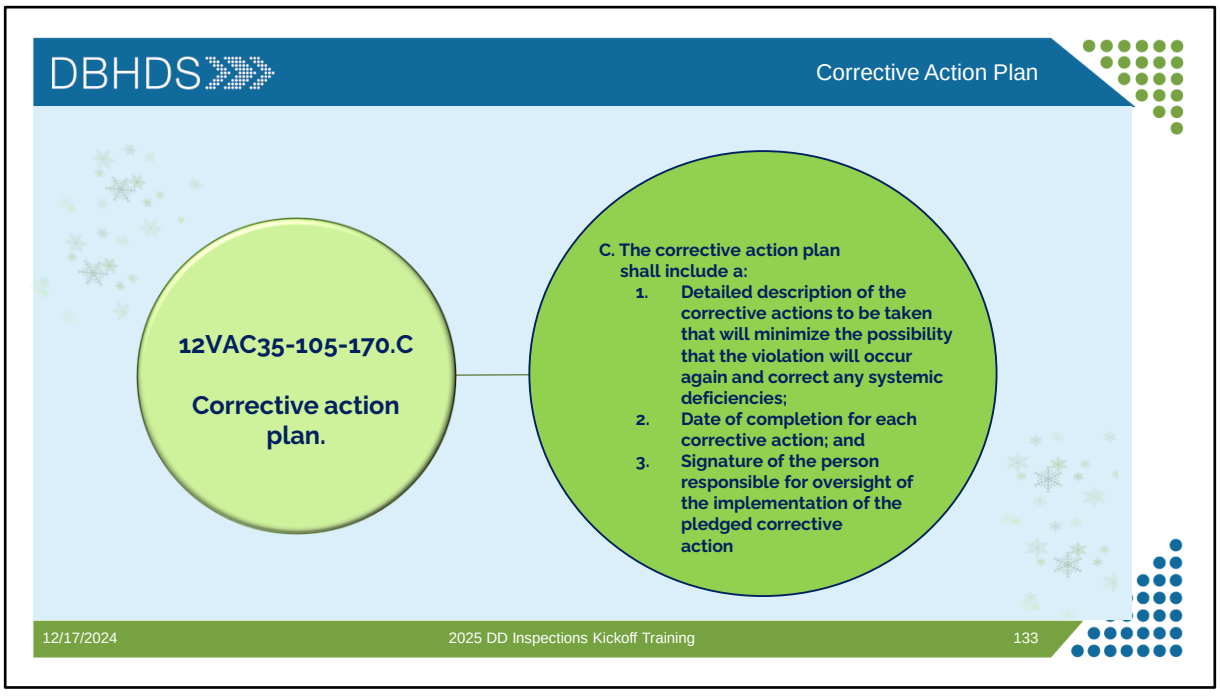
Thanks Karen.

Before we wrap up for today, let's take a few minutes to talk about the Corrective Action Plan.

If a provider is determined to be non-compliant during an inspection, then the provider is responsible for submitting a Corrective Action Plan



As stated, if noncompliance with any applicable regulation is identified during the inspection, the department will issue a licensing report describing this noncompliance and request the provider to submit a corrective action plan for each violation cited.



Providers should consider the following steps when writing a Corrective Action Plan:

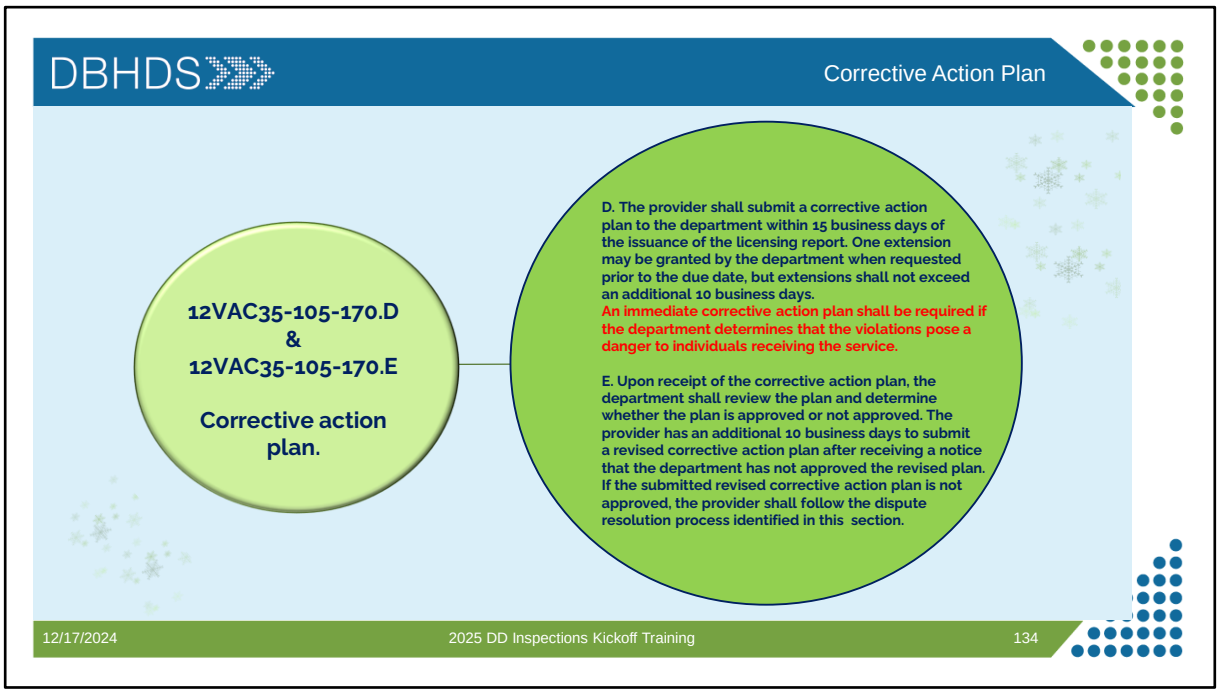
- Address all problems documented in each violation by identifying the root cause(s) of the violation;
- Develop a systemic plan of action, if applicable, to address each problem. This may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again; and
- Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist).
- Identify the staff position(s) responsible for monitoring implementation

AND

- Include a date of completion for each corrective action. Providers should ensure that completion dates for planned activities are realistic, and that the those responsible for oversight of the CAP monitor and verify the completion of the planned activities.

- Providers should maintain a copy of all their approved CAPs. Anytime a provider is issued a licensing report, the provider should review their quality improvement plan, specific to 620.C.4, to determine whether their current QI plan is sufficient to address the concerns identified in the licensing report and to monitor compliance with their pledged CAP. If the current quality improvement plan is not sufficient, then the provider will need to update their plan accordingly.

- Remember, a provider's QI Program, specifically 620.D.2, should outline the criteria they will use to update their quality improvement plan.



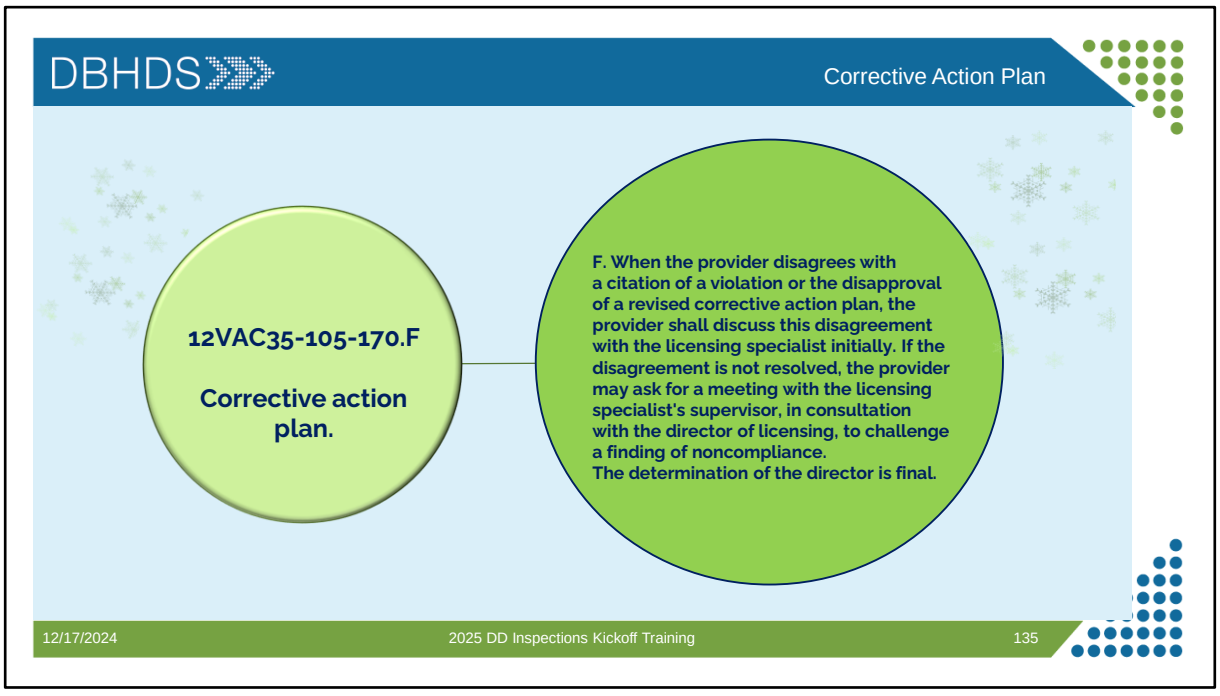
The provider must submit a corrective action plan to the department within 15 business days of the issuance of the licensing report. One extension may be granted by the department when requested prior to the due date, but extensions shall not exceed an additional 10 business days.

Requests for an extension must be submitted via CONNECT.

An immediate corrective action plan will be required if the department determines that the violations pose a danger to individuals receiving the service which would be identified as a Health & Safety CAP and an extension will not be given.

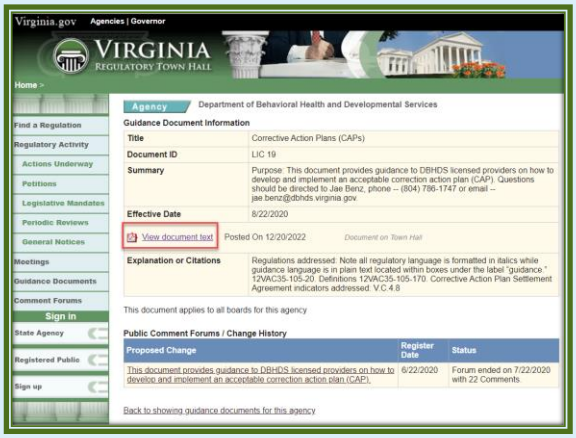
Upon receipt of the corrective action plan, it is reviewed to determine whether the plan is approved or not approved. The provider has an additional 10 business days to submit a revised corrective action plan after receiving a notice that the department has not approved the revised plan.

The Office of Licensing will respond to CAPs within 15 business days of receipt of the provider's CAP.



If a provider disagrees with a citation of a violation or the disapproval of a revised corrective action plan, the provider shall discuss this disagreement with the licensing specialist initially

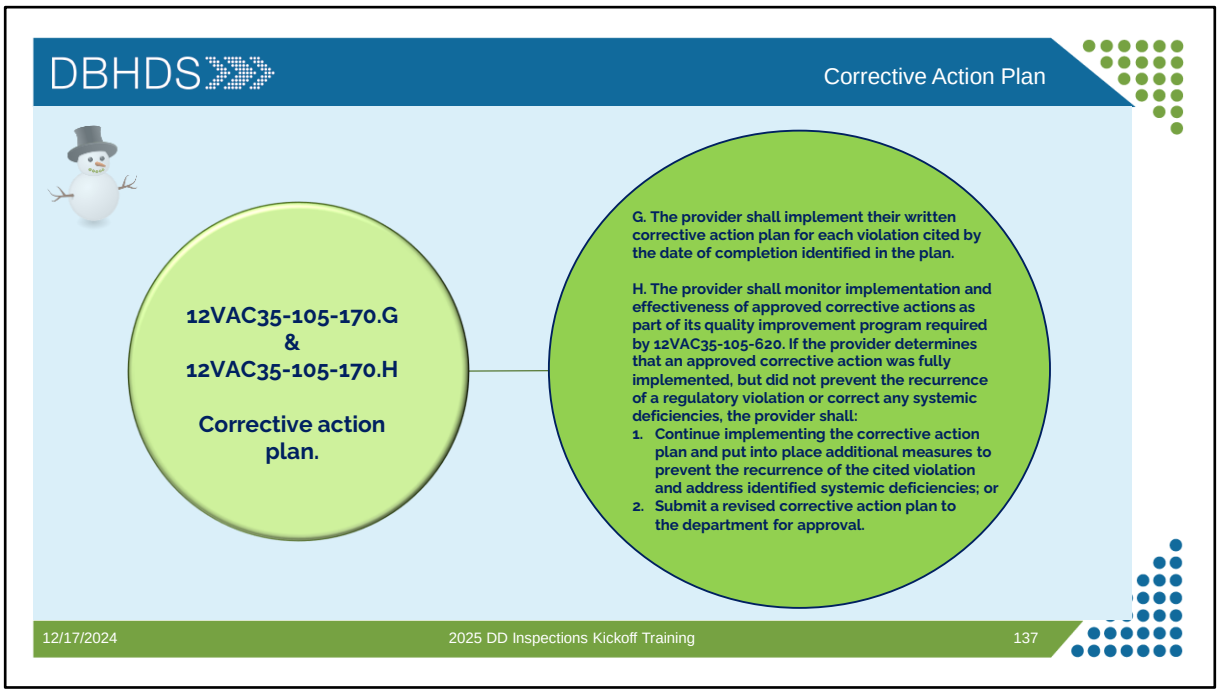
Providers need to follow the CAP Dispute Resolution Process as outlined in the Guidance on Corrective Action Plans (CAPs).



LIC 19: Corrective Action Plans (CAPs) (August 2020)

In 2020 the Office of Licensing published guidance related to Corrective Action Plans

Please make sure you are familiar with this document. If you are cited, this document can be used as a guide to assist when submitting your CAP response.



The provider shall implement their written corrective action plan for each violation cited by the date of completion identified in the plan.

For serious injuries and deaths that result from substantiated abuse, neglect, or health and safety violations, the Office of Licensing verifies that CAPs are implemented within 30 business days of the date the corrective action plan was approved. Failure to implement a written CAP will result in a licensing report citing 170.G.

In order to demonstrate compliance with this regulation, each provider must show proof of monitoring all CAPs for implementation and effectiveness.

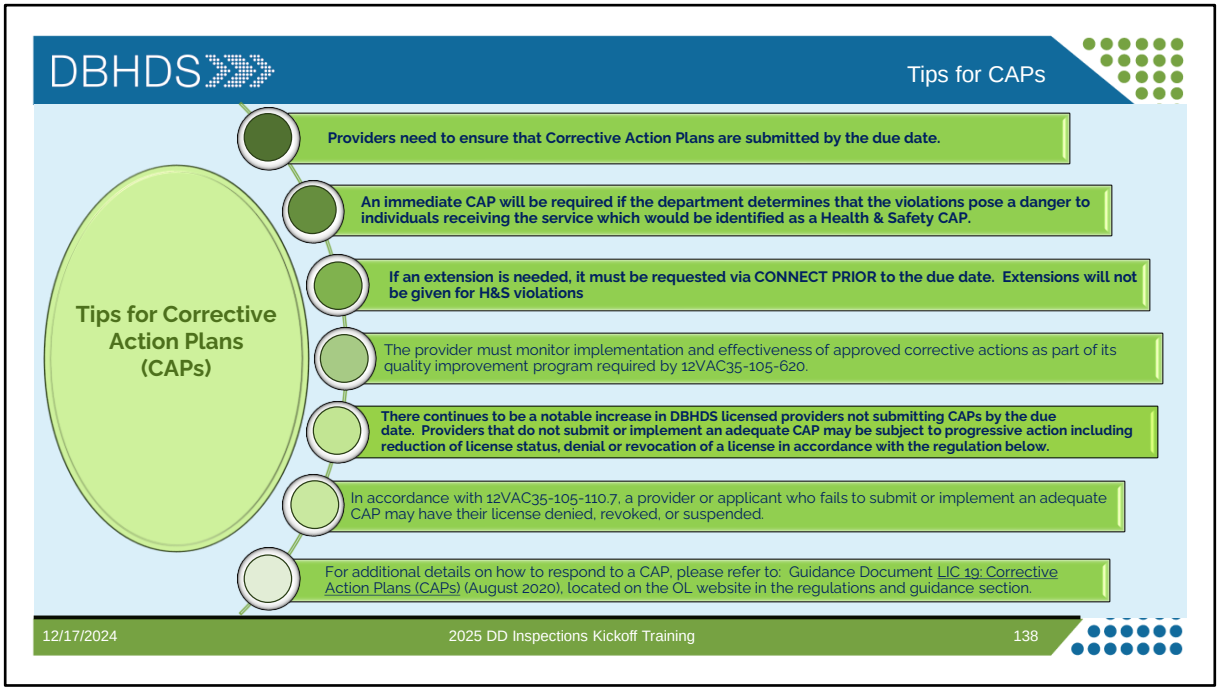
If after completion of the planned activities the provider determines that the issue that led to a citation occurred again, then the provider shall implement the provider's own policies and procedures for updating the provider's quality improvement plan, if applicable, or submitting revised corrective action plans, pursuant to 12VAC35-105-620.D. This may include determining whether or not the CAP was implemented as intended.

1. If the CAP was not fully implemented as intended, the provider should evaluate and address any barriers to implementation.
2. If the CAP was fully implemented, the provider should assess the reasons that the issue

recurred and make a determination as to whether changes to the corrective action plan are necessary.

- While prevention of a second regulatory violation may not always be possible, prevention is the goal. If a second regulatory violation occurs, the provider should always analyze whether the current CAP is the most effective means of preventing reoccurrence or if additional steps could be taken.
- A provider may determine after review that the recurrence of a regulatory violation was not due to the insufficiency of the implemented corrective actions, and that the planned corrective actions remain the most effective means of preventing or substantially mitigating future recurrences. If this is the case, then the provider should clearly document through the quality improvement program the basis for this conclusion and continue implementing the planned corrective actions without additional measures.
- If the provider determines that revisions to the CAP are necessary, those revisions should be submitted to the licensing specialist for review and approval. The provider should document through the quality improvement program, if applicable, when it is determined that an issue has been corrected and monitoring may be discontinued.

- There is an excellent example of this in the CAP guidance document that was just shared with you.



Let's take a moment to summarize what was said about CAPs because this is a very important part of the annual unannounced inspection.

•Ensure that CAPs are submitted by the due date.

•An immediate corrective action plan will be required if the department determines that the violations pose a danger to individuals receiving the service which would be identified as a Health & Safety CAP.

•If an extension is needed, it must be requested via CONNECT PRIOR to the due date. Remember, extensions will not be given for H&S violations

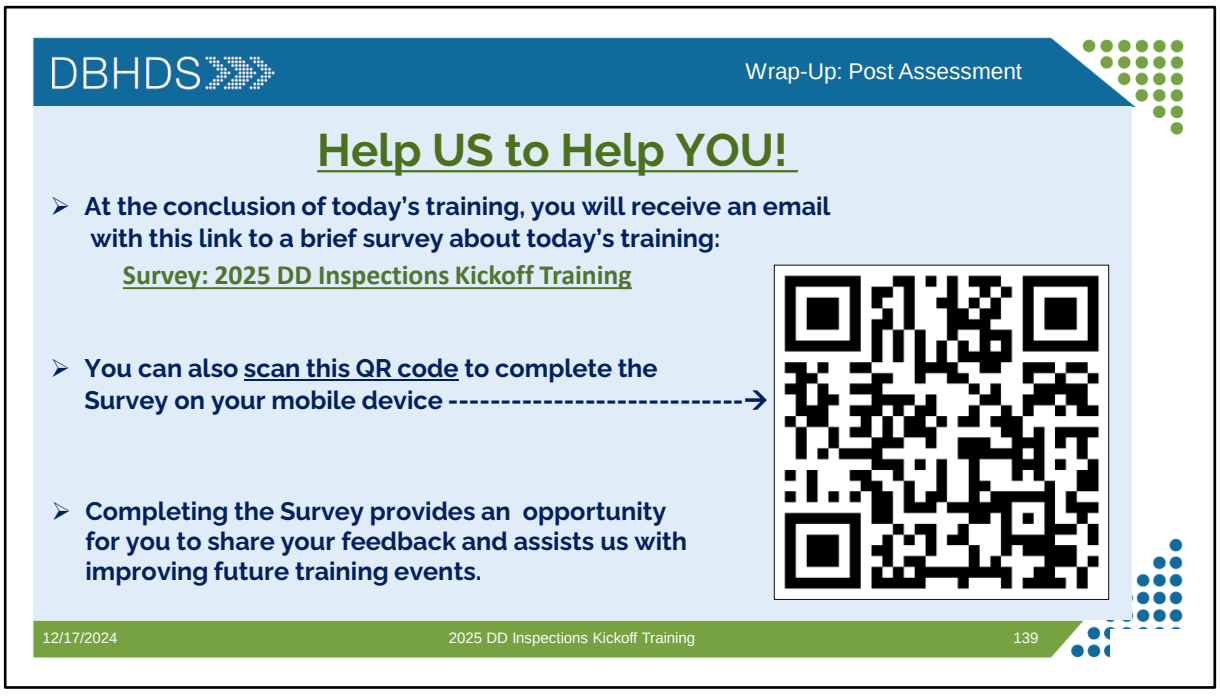
•The provider must monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 620.

•There continues to be be a notable increase in DBHDS licensed providers not submitting their Corrective Action Plan (CAP) by the due date. Providers that do not submit or implement an adequate corrective action plan may be subject to progressive action.

For additional details on how to respond to a CAP, please refer to the CAP Guidance located

on the OL website

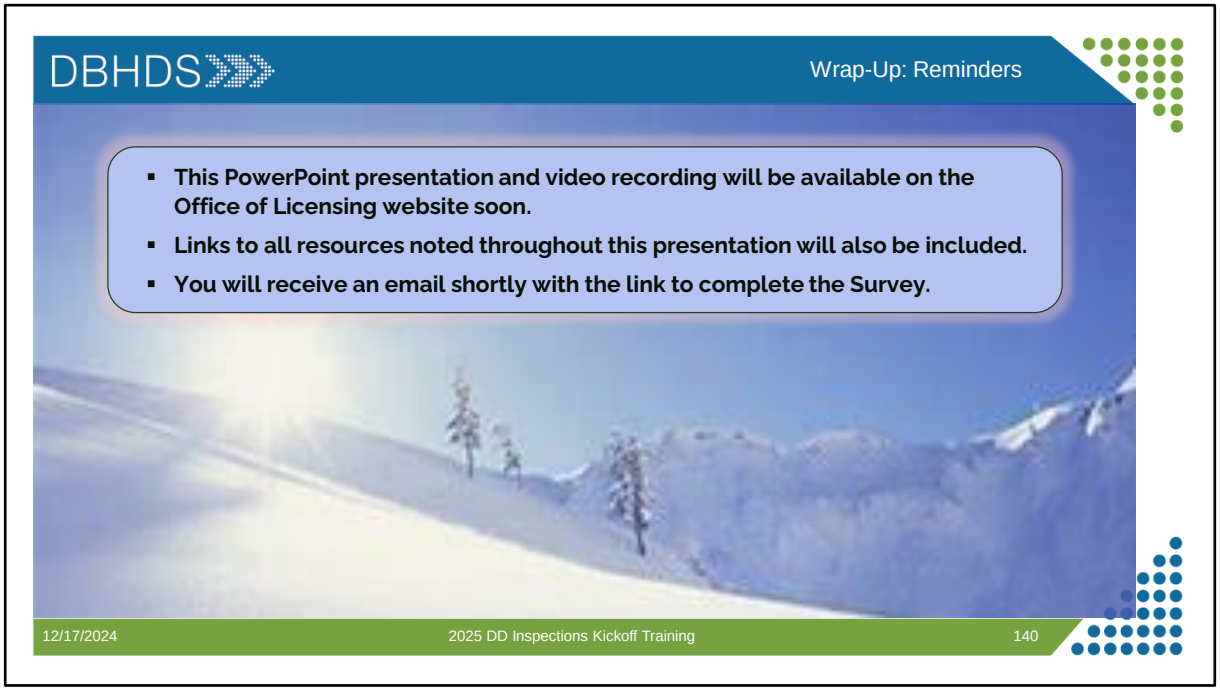
This concludes the training material for today. Larisa, I'll pass it back over to you now to wrap us up. Thank you everyone!



LARISA

Hi Again-

I would like to ask you all to please help *us* to help *you* by taking a quick few minutes to complete the Survey for today's Training. I will send out an email shortly with the survey link. If it's easier, you can click the live link shown here in green and complete the survey right now! We've also included the scannable QR code on this slide if you would prefer to use your mobile device. Completing this survey gives you the opportunity to share your feedback, which helps us as we develop future training events. We've gotten some great constructive feedback from you all through these surveys in the past, and we look forward to continuing to partner with you this way as we move forward into 2025.
I'll pause here for just a minute to allow you to click the survey link or scan the QR code if needed. *Pause*

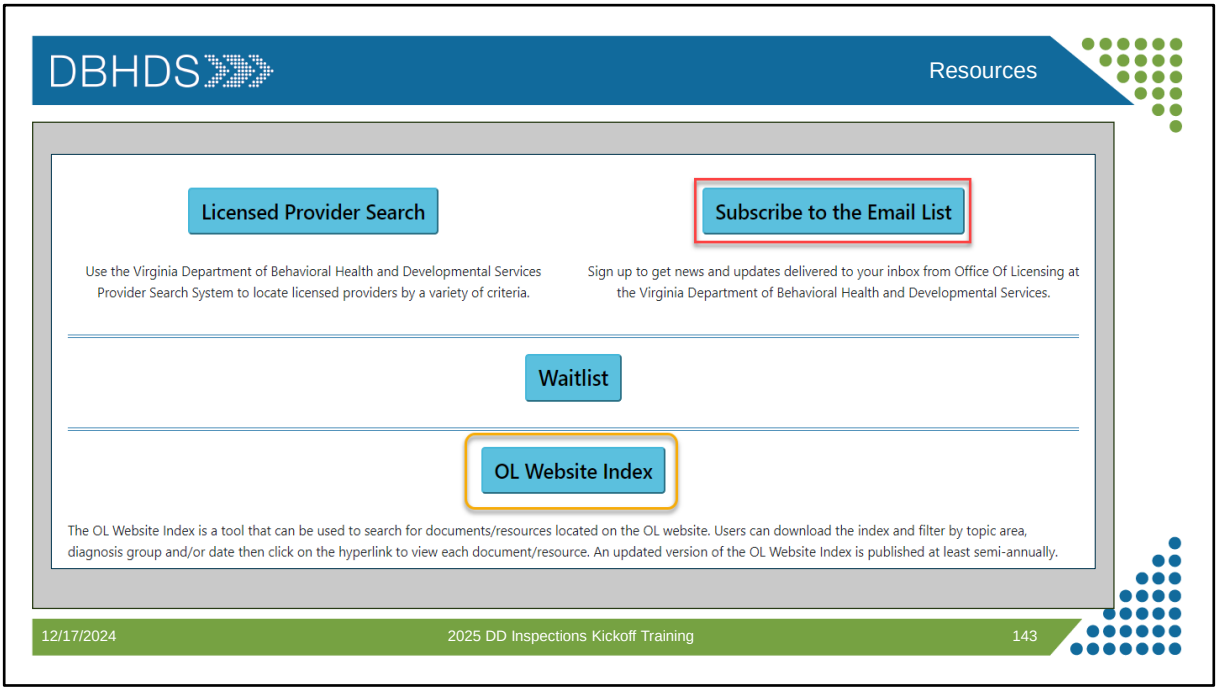


Now for a few quick reminders:

- This PowerPoint presentation and recording will be available on the Office of Licensing website soon.
- Links to all resources noted throughout this presentation will be included.
- You will receive an email shortly with the link to the Survey we talked about in the last slide. Please do take just a few moments of your time to help us to help YOU!

Once again, we appreciate you sharing your time with us today. We wish you all a wonderful winter and great success in 2025! Thank you for being part of our Team!! This concludes today's presentation.

[Office of Licensing Staff Contact Information]
[Licensing Regional Contacts]
[Incident Management Unit Regional Contacts]
[Specialized Investigation Unit Regional Contacts]



Don't for get to subscribe to the email list by going to the OL website and clicking Subscribe to the Email List.

Also, one specific tool that we want to bring to your attention is the OL Website Index

This tool can be used to search for documents and resources located on the OL website. Users can download the index and filter by topic area, diagnosis group and/or the date then click on the hyperlink to view each document or resource. An updated version of the OL Website Index is published at least semi-annually. The next update will be January 2025.

DBHDS

Office of Licensing Website Resources - Root Cause Analysis

Samples

- Serious Incident Review and RCA Template Example 5 Whys Stories Victor (July 2023)
- Serious Incident Review and RCA Template Example 5 Whys Stories Billy (June 2023)
- Serious Incident Review and RCA Template Example 5 Whys Stories Jasmine (June 2023)
- Serious Incident Review and RCA Template Example 5 Whys Stories Sam (June 2023)
- Serious Incident Review and Root Cause Analysis Template (November 2023)

Trainings

- Flow-Chart Incident Reviews (April 2023)
- QI-RM-RCA Webinar (December 2021)
- Regulatory Compliance with Root Cause Analysis Regulations Training (December 2021)
- Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation and Research – Handout (December 2020)
- Root Cause Analysis Training (October 2020)

Information related to root cause analysis

Information related to risk management

DBHDS

OL Website Resources - Risk Management & Care Concerns

Risk Management

- Day 1: Minimizing Risk Session 1 Webinar (April 2023)
- Minimizing Risk Session 1 PowerPoint (April 2023)
- Day 2: Minimizing Risk Session 2 Webinar (April 2023)
- Minimizing Risk Session 2 PowerPoint (April 2023)
- Day 3: Minimizing Risk Session 3 Webinar (April 2023)
- Minimizing Risk Session 3 PowerPoint (April 2023)
- Flow-Chart Incident Reviews (April 2023)
- QI-RM-RCA Webinar (December 2021)
- Regulatory Compliance with Risk Management Regulations Training (December 2021)
- Risk Management Tips and Tools Training (June 2021)
- Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation & Research – Recorded Webinar (December 2020)
- Risk Management Training (November 2020)

Care Concerns

- 2023 Care Concern Threshold Criteria Memo (February 2023)
- IMU Care Concern PowerPoint Training (February 2023)
- Risk Triggers and Threshold Handout (February 2023)

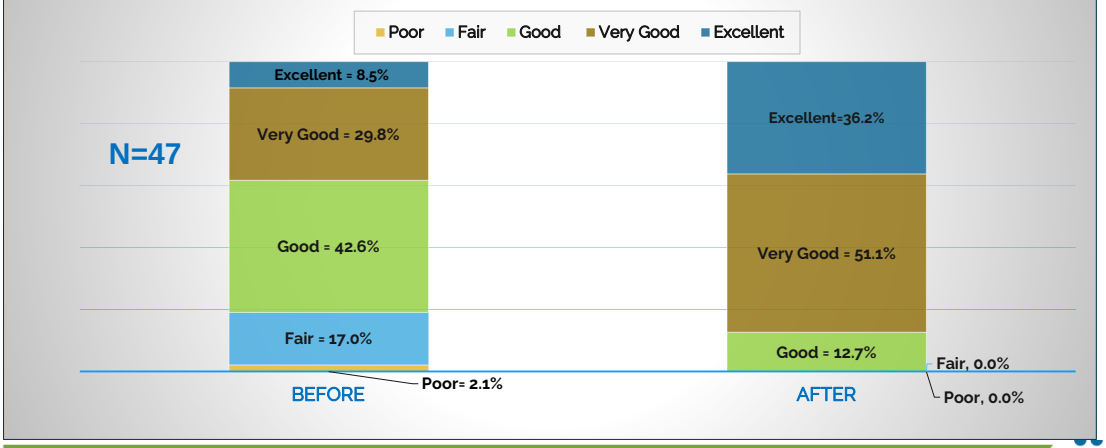
Risk Management training and information related to care concerns

Memos, samples, trainings, and other resources related to Quality Improvement

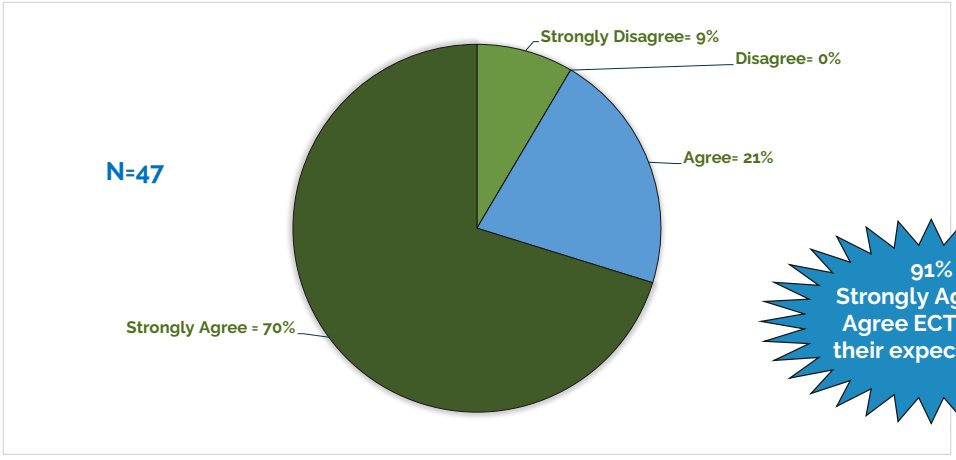
And, information related to serious incident reporting and CHRIS training, as well as Mortality Review,

Office of Community Quality Management Resources

Provider Understanding: Difference Between QI & QA Before/After ECTA



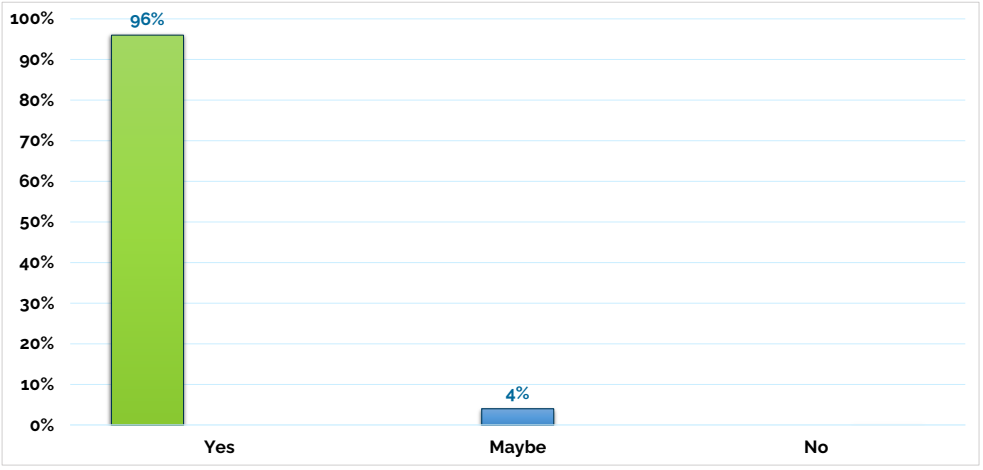
Q26: How much do you agree with: *The consultation/technical assistance met my expectations.*



91% Strongly Agree or Agree ECTA met their expectations

Q30: Would you recommend this consultation to other providers?

N=47



What Providers are saying about ECTA!

Pause a few seconds between clicks to allow attendees time to read comments

"I was able to understand the regulation better as well as the appropriate tools."

"The QIS did a great job listening to the compliance related barriers."

"I believe that the eagerness and level of engagement of the provider is what really sets the tone for this experience. I had a wonderful experience that was flexible, adaptable, and tailored to my needs, questions, and what I felt I needed to focus on to improve our plans and address the citations."

"The resources, guidance and feedback from the consultant was extremely helpful in understanding 520 regulations."

"The QIS did an excellent job and were very professional and knowledgeable."

DBHDS

Expanded CTA Team

Western Territory	Eastern Territory
 Kara Clemons, QIS Supervisor Western Territory	Teena Harris, QIS Supervisor Eastern Territory 
 Leanna Craig, QIS Southwest Region	Lisette Bennett, QIS Coastal Region 
 Jordan Hyde, QIS Southwest Region	Lauren Gibson, QIS Coastal Region 
 David Crews, QIS Western Region	Sophia Dunn, QIS Central Region 
 McKinley Harris, QIS Western Region	Irvin Goode, QIS Central Region 
Vacant, QIS Western Region	Andrew Williams, QIS NOVA Region 

Mackenzie is next