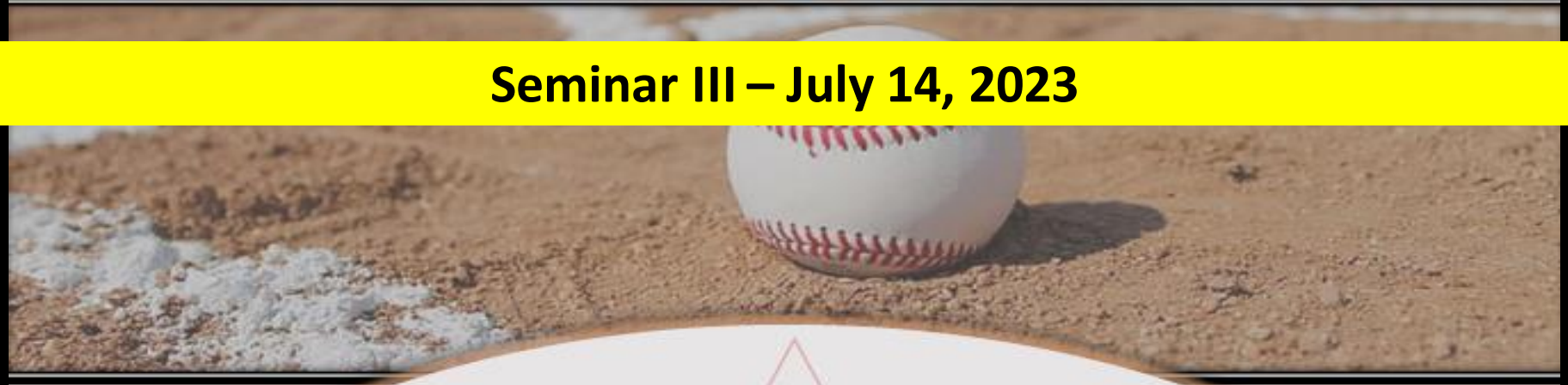
Seminar III – July 14, 2023



Be an All-Star Provider!

"Licensed Provider Coaching Seminar"

A comprehensive overview of provider roles and responsibilities for licensed providers of Mental Health, Substance Use and Developmental Disability services.

Please Attend All 3 Sessions - Register for each seminar using the links below:

Seminar I: Friday, June 30, 10 a.m. -12:00 p.m.

Seminar II: Friday, July 7, 10 a.m.-1:00 p.m.

Seminar III: Friday, July 14, 10 a.m. -12:00 p.m.

Virginia Department of Behavioral Health & Developmental Services

Introductions – Today's Starting Line Up

- **Mackenzie Glassco, Associate Director of Quality and Compliance**
  - Mackenzie.Glassco@dbhds.virginia.gov
- **Lars Messerschmidt, Regional Crisis Manager**
  - Lars.Messerschmidt@dbhds.virginia.gov
- **Larisa Terwilliger, Training Coordinator**
  - Larisa.Terwiliger@dbhds.virginia.gov

Department of Behavioral Health and Developmental Services (DBHDS)-

Office of Licensing

Mission:

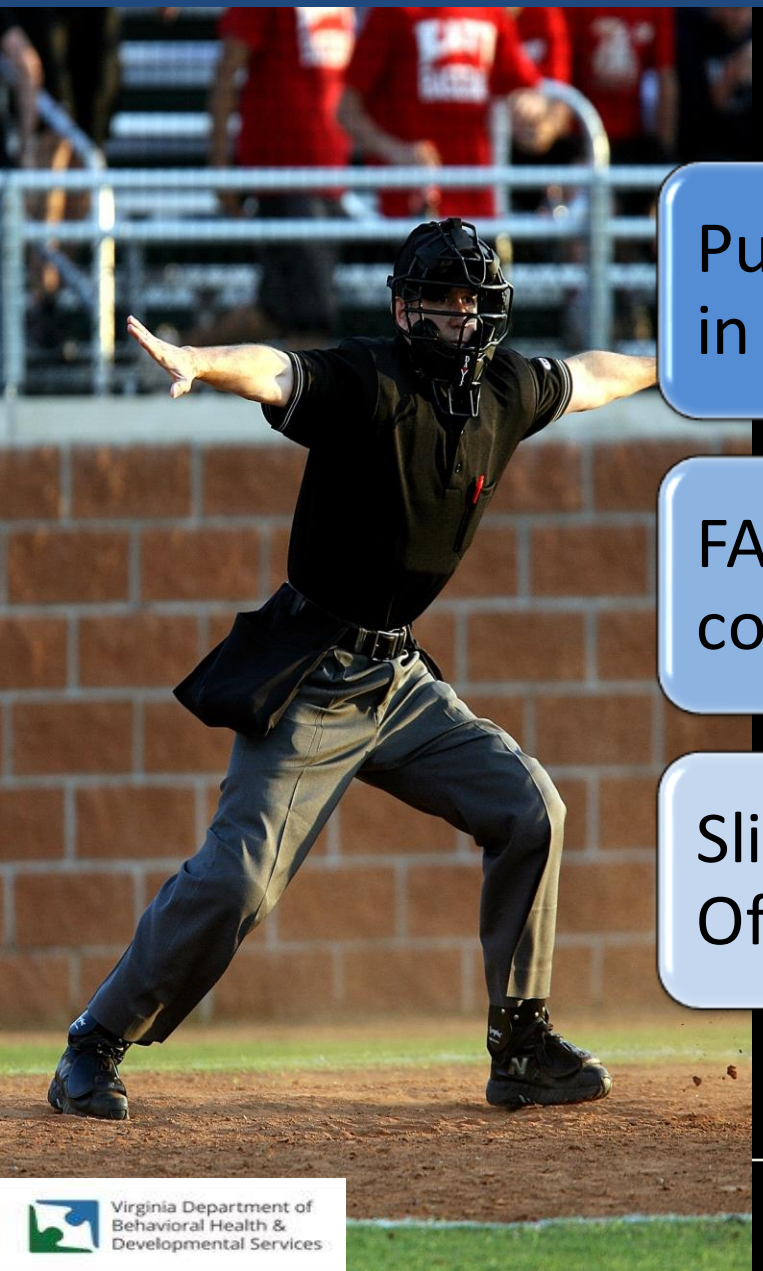
To be the regulatory authority for DBHDS licensed service delivery systems through effective oversight.

Vision:

The Office of Licensing will provide consistent, responsive, and reliable regulatory oversight to DBHDS licensed providers by supporting high quality services to meet the diverse needs of its clients.

Virginia Department of Behavioral Health & Developmental Services

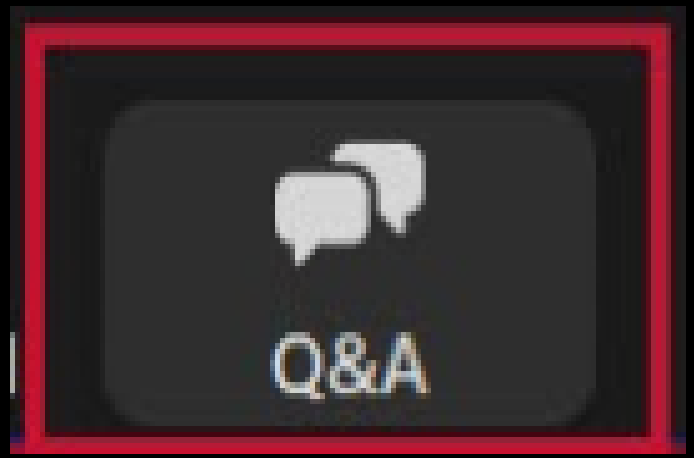
Housekeeping - Field Rules



Put questions and comments in the ‘Q&A’ feature.

FAQs will be posted after the conclusion of Seminar III.

Slides will be posted on the Office of Licensing website.



Purpose

- **The purpose of this Coaching Seminar is to prepare new DBHDS Licensed Providers for their role and corresponding responsibilities.**
- **Our goal is to equip new providers with the information, tools, and resources necessary to be informed, confident, and successful DBHDS Licensed Providers.**
- **Our hope is that this material will also serve as a refresher for experienced providers.**

GAME PLAN:

Today's Learning Objectives

Be Informed About

- The Office of Licensing website
- The DBHDS Division of Crisis Services

Be Familiar With

- Root Cause Analysis
- Risk Management
- Quality Improvement
- Inspections, Investigations and Corrective Action Plan (CAP)
- Renewal Requirements

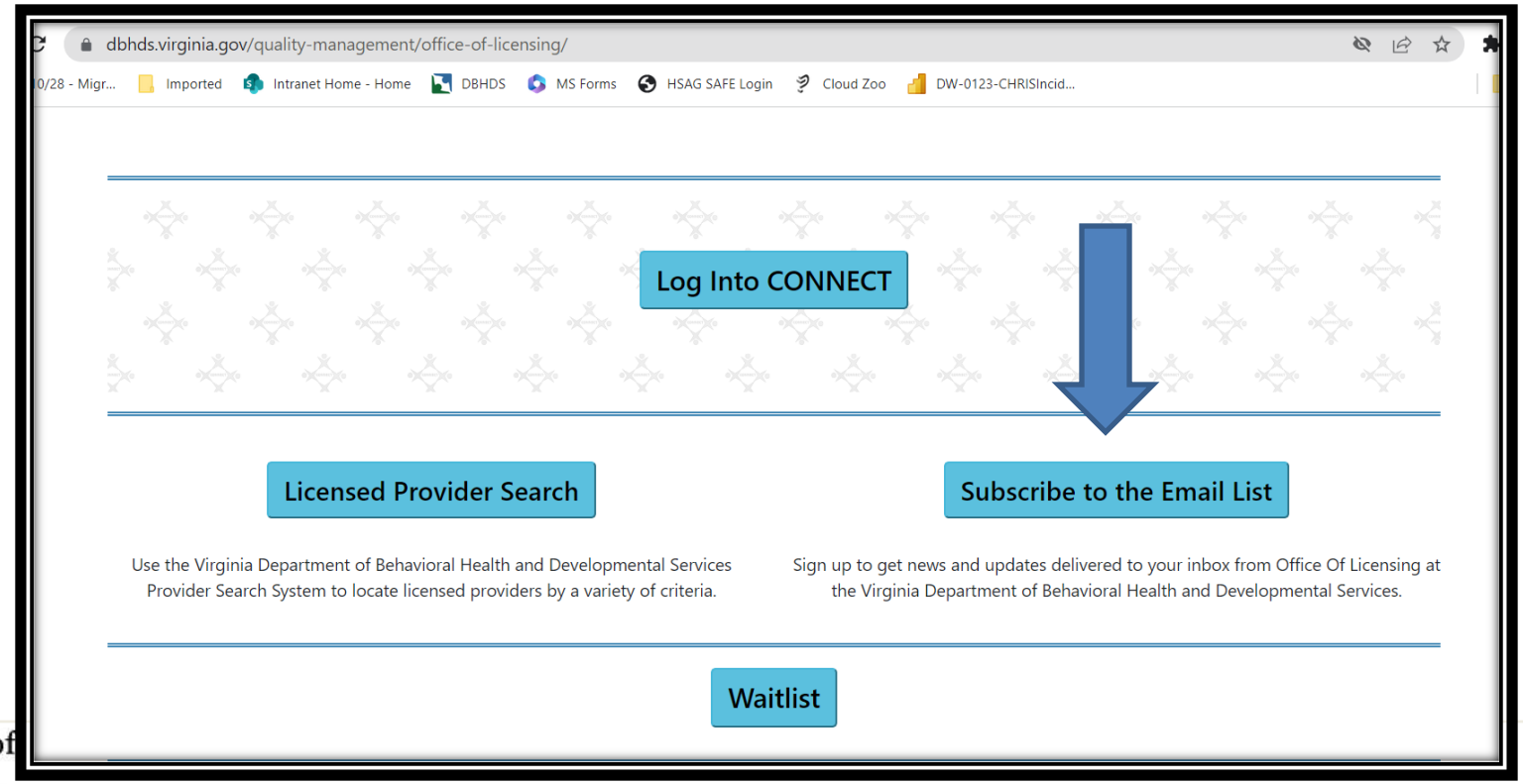
Be Confident

- That you can be an All-Star Provider!

Thank you for being here!

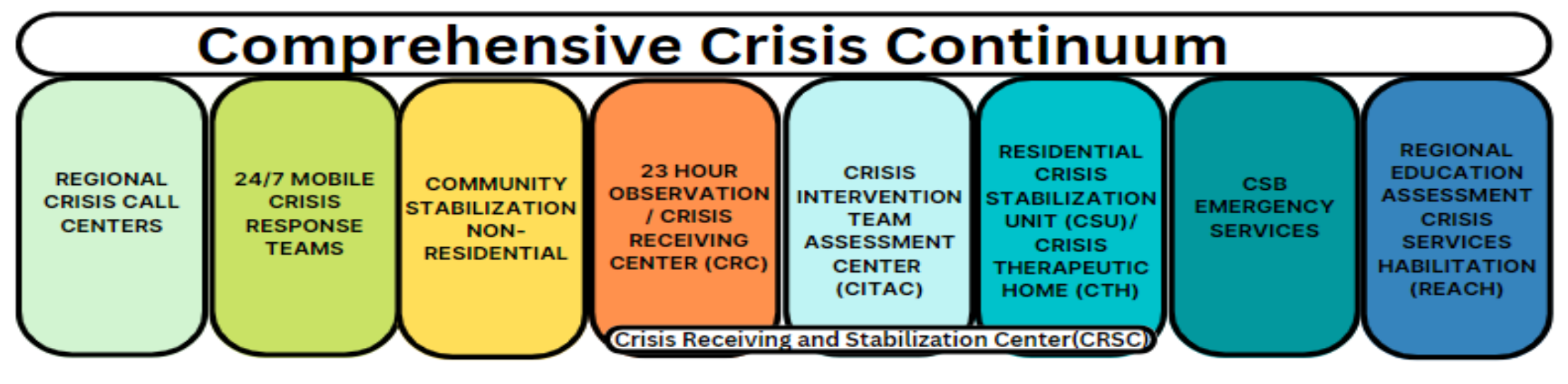
Make sure you get future announcements from the Office of Licensing. Subscribe to the email list.

https://dbhds.virginia.gov/quality-management/office-of-licensing/



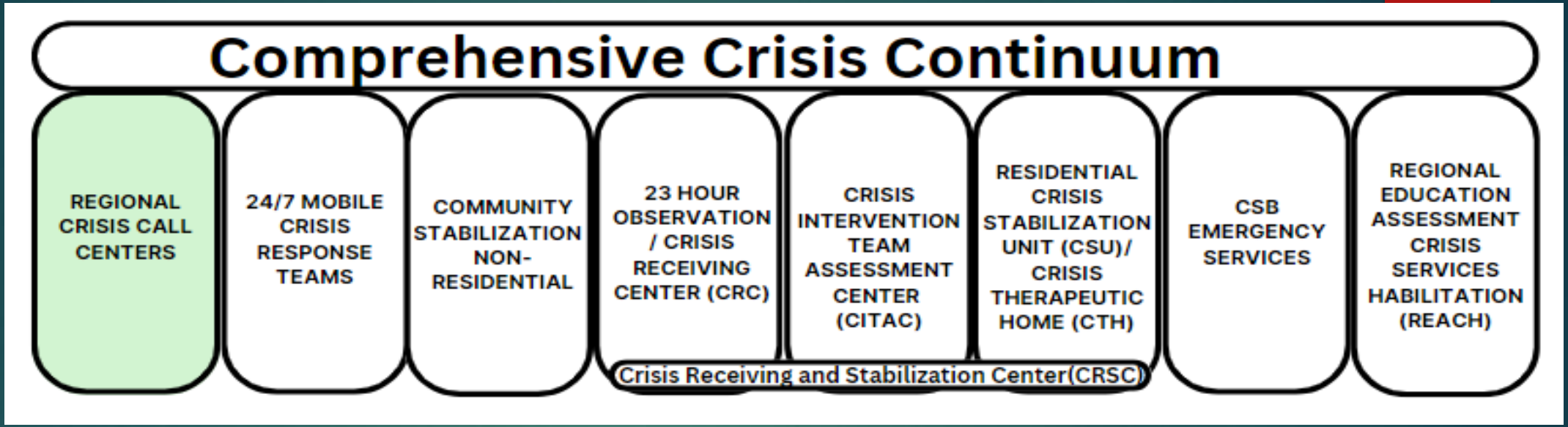
DBHDS Division of Crisis Services

LARS MESSERSCHMIDT
REGIONAL CRISIS MANAGER



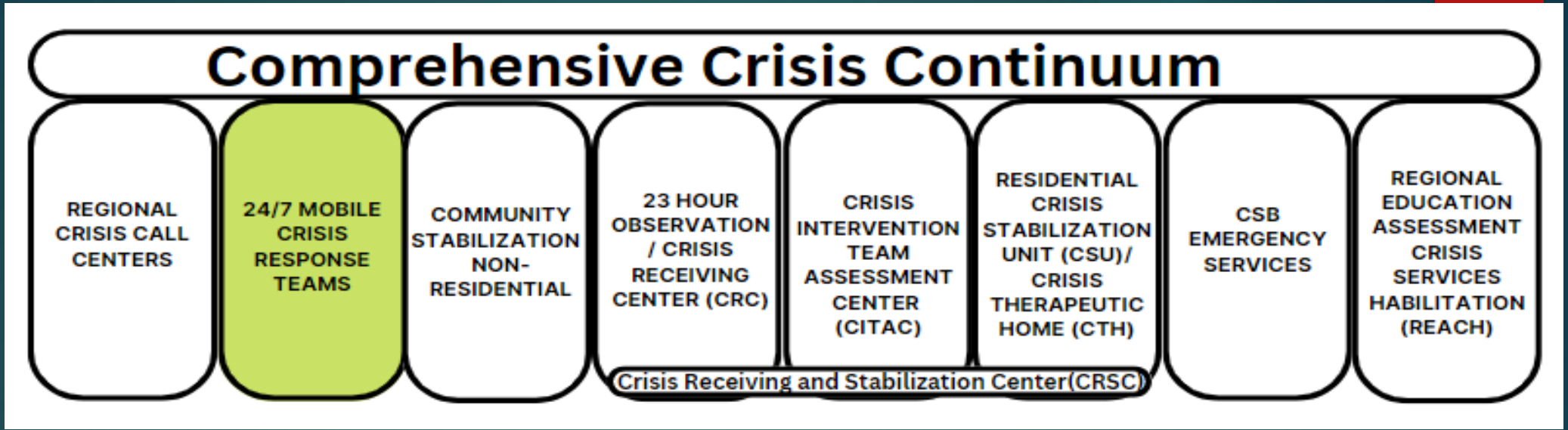
The Commonwealth of Virginia is in the process of a paradigm shift in how we care for each other during behavioral health crisis. The transformation is moving away from a system of primary law enforcement engagement to a statewide, integrated Crisis Continuum of care with someone to call, someone to respond, and somewhere to go. The services will ensure safety, support, stabilization, and connect to supports that can facilitate health and growth. The Crisis Continuum is inclusive, serving all Virginians, regardless of disability, age, or circumstance. This transformation will align the Commonwealth's Crisis Continuum with national best practice standards.

The following slides will provide information related to each service starting with the initial call to the highest level of care found with emergency services. Our REACH program provides the same service levels noted along with comprehensive crisis continuum, but specific to the ID/DD population. It is also worth noting that the Crisis Receiving and Stabilization Center (CRSC) provides 23 hour; CITAC, and RCSU treatment.



Regional Crisis Call Centers

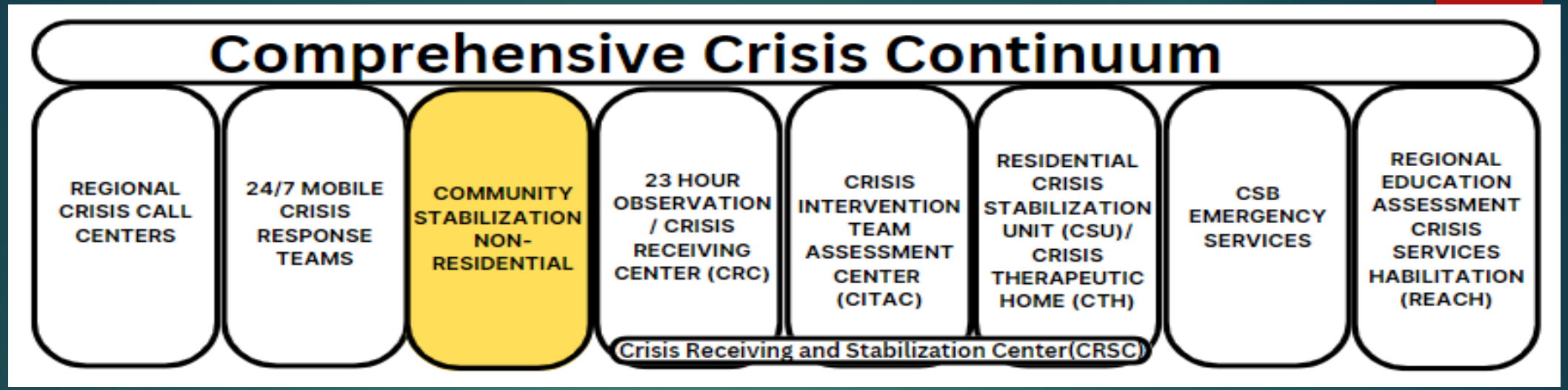
A regional crisis call center (RCCC) offers real-time access to a trained, crisis worker 24 hours a day, 7 days a week, and 365 days a year. A RCCC is clinically supported 24 hours a day and provides telephonic crisis intervention services to all callers. A RCCC is required to meet National Suicide Prevention Lifeline (NSPL) operational guidelines regarding suicide risk assessment and engagement and offers air traffic control (ATC) quality coordination of crisis care in real-time. It is a best practice for a RCCC to offer text and chat options to expand access and engagement of all communities in care.



Mobile Crisis Response

Mobile Crisis Response is an essential component of the comprehensive crisis care, no-wrong-door, system. This service is provided 24 hours a day, seven days a week. The purpose of this service includes prevention of acute exacerbation of symptoms, prevention of harm to the individual or others, provision of quality intervention in the least restrictive setting, and development of an immediate plan to maintain safety in order to prevent the need for a higher level of care.

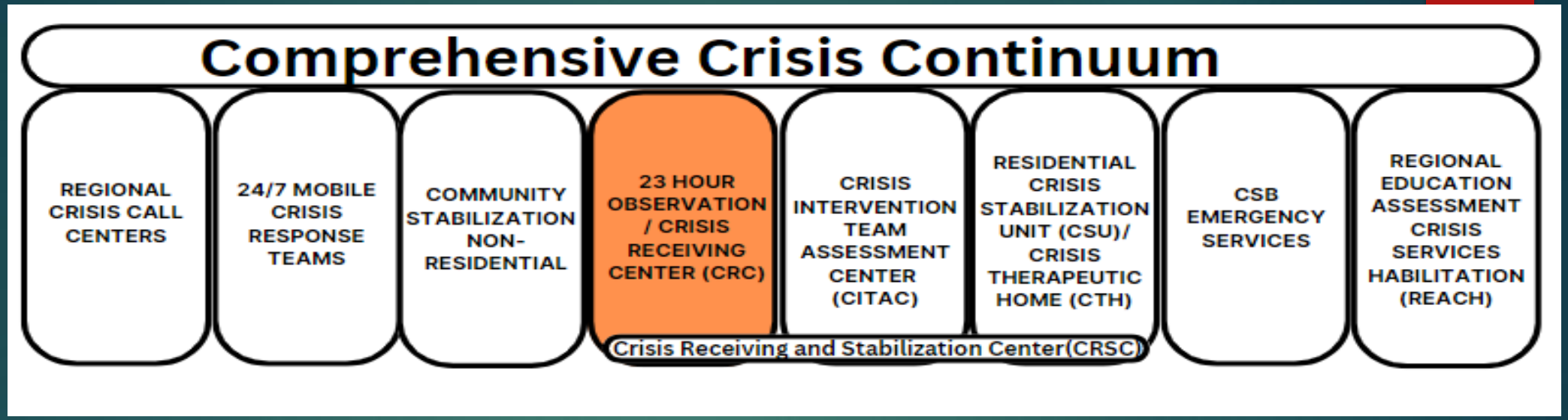
Mobile Crisis Response; Community Stabilization; Outpatient services/crisis stabilization 07-006



Community Stabilization- Non-Residential

Community Stabilization services are available 24 hours a day, seven days a week, to provide for short-term assessment, crisis intervention, and care coordination to individuals experiencing a behavioral health crisis. Services may include brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Services involve advocacy and networking to provide linkages and referrals to appropriate community-based services and resources assisting the individual and their natural support system in accessing other benefits or assistance programs for which they may be eligible.

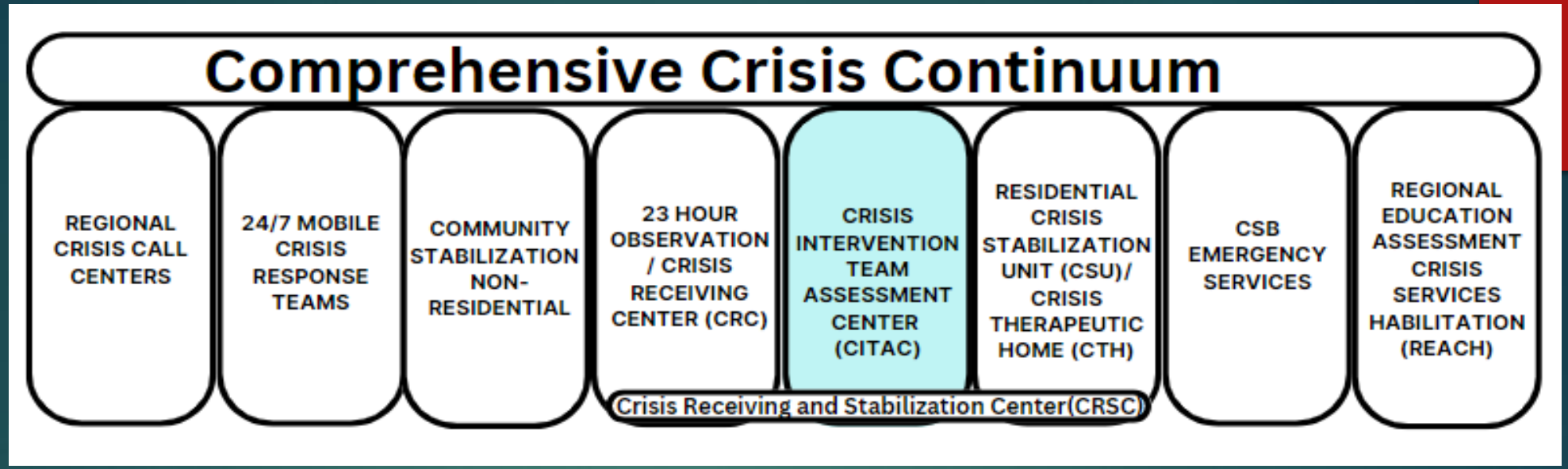
Community Stabilization-non residential; Community Stabilization outpatient services/crisis stabilization 07-006 or 07-009 for DD



23-hour Observation

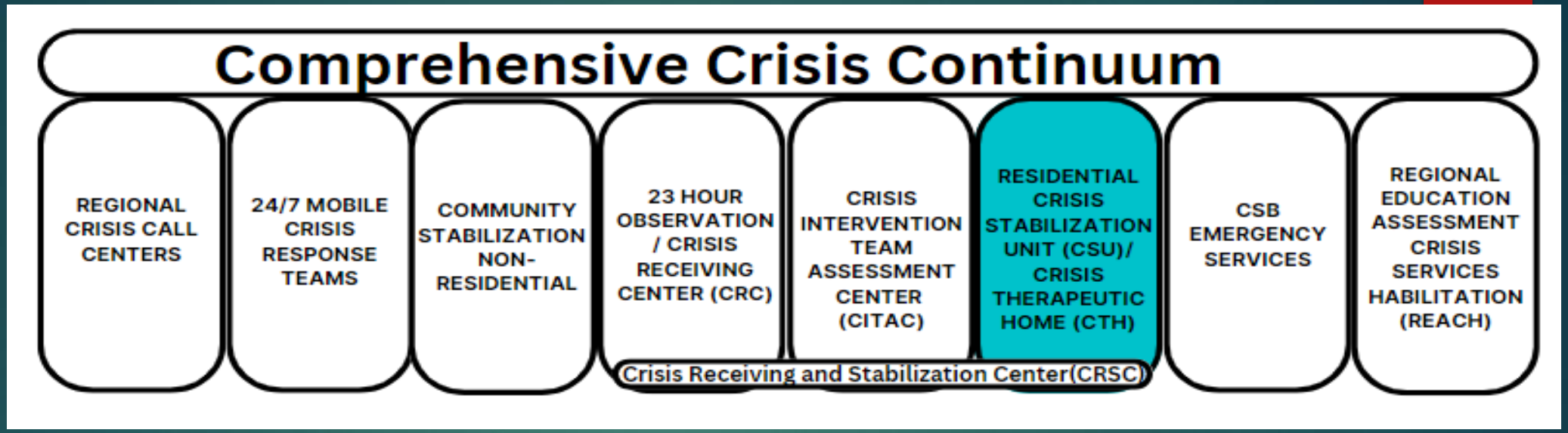
Crisis Receiving Centers (CRC) programs that provide licensed site-based crisis observation provide outpatient assessment and treatment for a period of up to 23 hour and 59 minutes. CRCs fill a critical role in an effective crisis system by accepting referrals from a crisis line, mobile crisis teams, law enforcement, and through walk-ins and self-referrals. CRC goals are to determine the immediate needs of the individual in crisis, provide appropriate treatment throughout the 23 hours, and coordinate care for continued psychosocial needs and supports as well as health literacy counseling for the individual's return to the community. Crisis Receiving and Stabilization Center (CRSC) is a crisis services location that offers a CITAC, a CRC, and a CSU in the same location with access to the services across the spectrum of care between them.

23 Hour/CRC 07-006 must contact LS to approve location and staffing plan



CITAC

Individuals experiencing a crisis and have come into contact with, or contact with law enforcement is imminent, may be transported by any safe means to the Crisis Intervention Team Assessment Center (CITAC) where they will be greeted by, at minimum, a CIT trained law enforcement officer or security officer who may then accept legal transfer of custody of any person under Emergency Custody Order as defined in the Code of Virginia §37.2-808(E). Once at the center, programs will commence the code mandated pre-admission screening as soon as practicable, whether in person or by secure virtual communications. As available, persons with lived experience (Peers) are encouraged to be available during the de-escalation and evaluation process to provide emotional support, feedback about the involuntary custody process throughout the individual's stay at the CITAC.
*CITAC is an assessment site and law enforcement maintains the custody of the individual when an ECO has been issued. The services within are the same as they would be anywhere else a crisis may occur. Emergency Services provides the same service they would anywhere else when conducting an assessment and completing a prescreen. Law enforcement do not provide oversight or supervision over the clinician(s) or peer(s) that are on site.



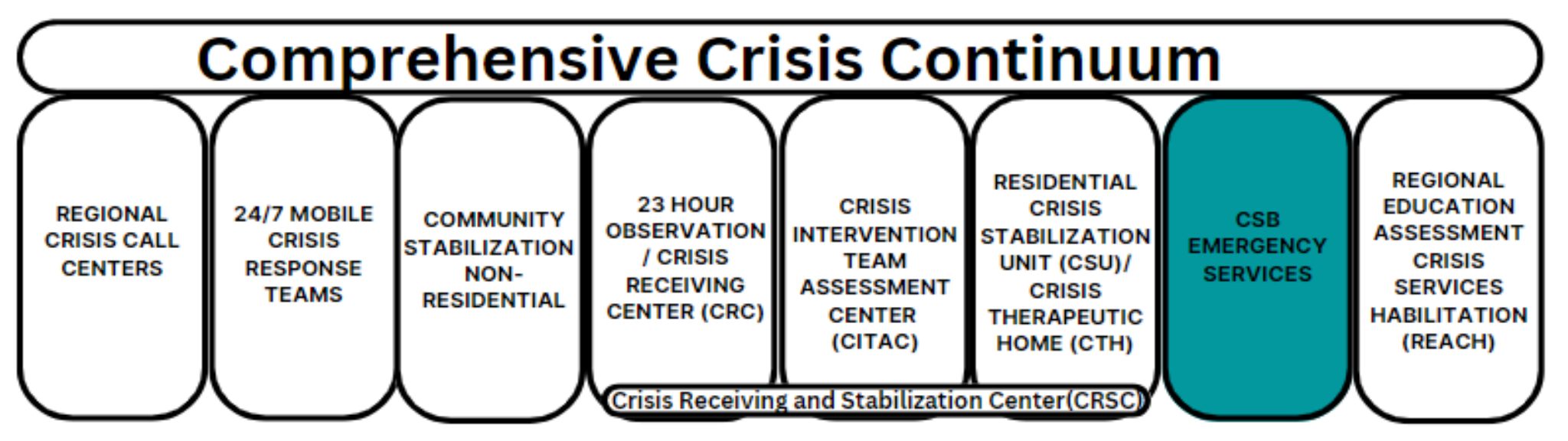
Community Stabilization – Residential

The goals of Residential Crisis Stabilization Unit services are as follows but are not limited to 1) stabilize the individual in a community-based residential setting and support the individual and natural support system; 2) Reduction of acute symptoms; and 3) Identification and mobilization of available resources including support networks. This service occurs in a non-hospital, community-based crisis stabilization residential unit with no more than 16 beds. RCSUs may co-locate with 23- Hour Crisis Stabilization.

Refer to the DMAS Mental Health Services manual for program requirements and service definitions: Appendix G- Comprehensive Crisis Services

Residential Community Stabilization (RCSU): Mental Health Crisis Stabilization-Residential 01-019 for adult; 01-020 (children), 04-015(SA services for adults) ASAM Level 3.7: Substance Abuse Medically Monitored Intensive Inpatient for adults" 04-016 (children)

01-041 Group Home Service REACH (CTH)

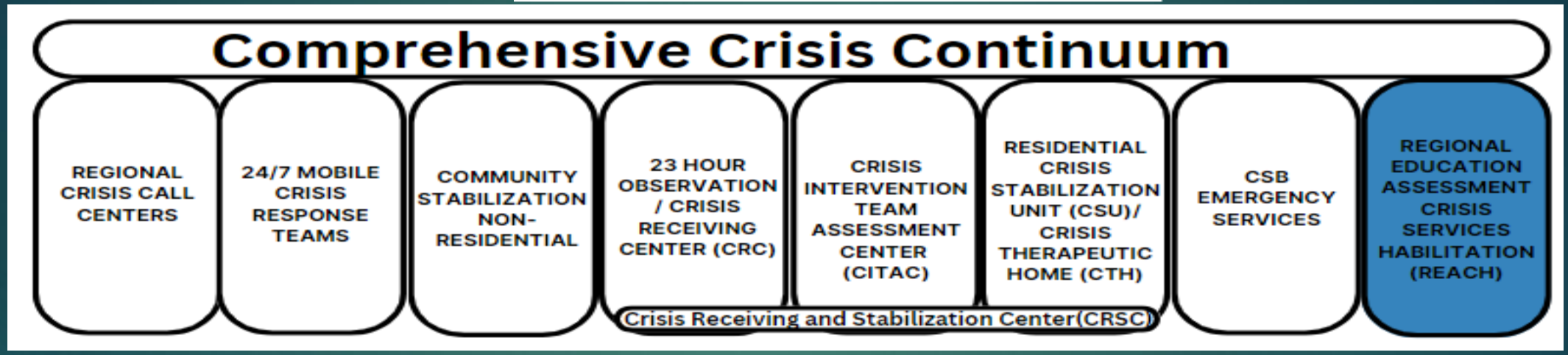


CSB Emergency Services

Emergency Services staff complete preadmission screening and civil commitment hearing activities as required for by Chapter 8 in Title 37.2 of the Virginia Code. Other services provided may vary by Community Services Board.

07-001 A mental health/substance abuse emergency/crisis intervention service for children, adolescents, and adults

REACH
Developmental Disabilities
Crisis Supports



REACH Advisory Council: The REACH Advisory Councils are made up of a group of regional community stakeholders who review the REACH outcomes and challenges while representing the needs and values of the community and service recipients. A regional council may have responsibility for both the adult and children's programs if regional representation is encompassing both children and adult services and supports, equally. There is one REACH Advisory Council per service region.

REACH DD Crisis Stabilization 07-007; DD Crisis Stabilization non residential services 07-009 A non-residential crisis stabilization REACH service for (children, adolescent, and/or adults) with a co-occurring diagnosis of developmental disability and behavioral health needs

DD Crisis Stabilization non residential services 07-009: A developmental disability non-residential crisis stabilization service

Previous Trainings

Licensed Provider Coaching Seminar

- Seminar I: June 30, 2023
- Seminar II: July 7, 2023
- Seminar III: July 14, 2023

Initial Applicant Orientation

- June 26, 2023

Minimizing Risk Training

- April 14, 2023
- April 21, 2023
- April 28, 2023

Don't forget to sign up for Constant Contact and remember to use the resources provided on the OL website.

We’re sure you’ll hit a Home Run!

DBHDS Rules and Regulations

This training is specific to the Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35 - 105]. However, the tools and resources provided today can be adapted and used for providers that provide Children's Residential Services under Regulations for Children's Residential Facilities 12VAC35-46.

Virginia Department of Behavioral Health & Developmental Services

Understanding DBHDS Regulations

12VAC35-105-160.E.1.a-b

Root Cause Analysis

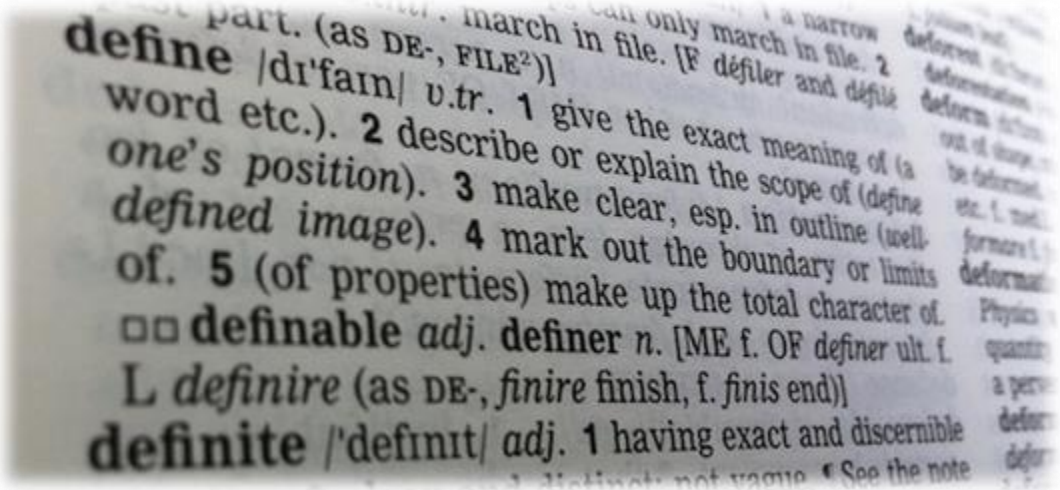
12VAC35-105-160.E.2.a-d

Root Cause Analysis Policy

Definition

12VAC35-105-20:

- "Root cause analysis" means a method of problem solving designed to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm.


part. (as DE-, FILE²)]
define /dɪ'faɪn/ *v.tr.* **1** give the exact meaning of (a word etc.). **2** describe or explain the scope of (define one's position). **3** make clear, esp. in outline (well-defined image). **4** mark out the boundary or limits of. **5** (of properties) make up the total character of.
□□ **definable** *adj.* **definer** *n.* [ME f. OF *definer* ult. f. L *definire* (as DE-, *finire* finish, f. *finis* end)]
definite /'defɪnɪt/ *adj.* **1** having exact and discernible

12VAC35-105-160.E.1.a-c

E. 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.

1. The root cause analysis shall include at least the following information:

   a. A detailed description of what happened;

   b. An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and

   c. Identified solutions to mitigate its reoccurrence and future risk of harm when applicable.

12VAC35-105-160.E.1.a

a. A detailed description of what happened.

Provider may copy information included within the Injury/Incident Description/Circumstances field of CHRIS or include a step-by-step detailed account of the incident

12VAC35-105-160.E.1.b

b. An analysis of <u>why</u> it happened; including identification of underlying causes that were under the control of the provider; and

Analysis of trends and potential systemic issues or causes; analysis of why incident happened; identification of all underlying causes of the incident that were in the control of the provider

While our regulations do not require use of another tool to analyze trends, providers are required to include their analysis

12VAC35-105-160.E.1.c

c. Identified solutions to mitigate its reoccurrence and future risk of harm when applicable.

Solutions to mitigate the potential for future incidents

RCA Example - Compliant

Client Name: [redacted] **Date of Incident:** 12/29/2021
Program: [redacted]
List all services in which client is open:
[redacted]

X **Level II** ☐ **Level III**

A detailed description of what happened:

On the morning of December 28th, [redacted] complained to staff member [redacted] about her left knee hurting. Staff members [redacted] and [redacted] asked to see her knee and there was what looked to be a knot located to the lower right of her left knee cap. It did not appear bruised, it's just a raised bump, about the size of a quarter. Day Site Lead, [redacted] wrote an email to [redacted] regarding the concern. The following day at 9:00 am, staff followed up with [redacted] to see how she was feeling. The lump on her knee, which had originally been about the size of a quarter had grown, and was looked at by staff members, [redacted], and [redacted]. Staff asked [redacted] if it still hurt but she reported it does not. It was then staff noticed that her right eye was also quite red. Staff asked her if it was itchy or if she had be scratching. She said it is itchy but has not been scratching it. Upon a closer inspection, staff did notice what appears to be a type of discharge coming from the inside corner of the eye. Consumer transported to ER and diagnosed with Conjunctivitis in her right eye and Bursitis on her left knee.

Explore "why" the Level II or Level III serious incident happened. An analysis of why the incident happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider.

[redacted] often wipes her nose with her hand and tends to also use her hand to wipe up toward her eye which could contribute to Conjunctivitis. Bursitis can be caused by various conditions some of which including overuse, injury, arthritis, gout, tendonitis. No injury was noted at the time of the ER visit nor was any injury witnessed by staff. [redacted] also states that no injury occurred. Staff will inquire with her primary physician on what could have caused this condition.

Action to mitigate the chance of reoccurrence.

[redacted]'s eye cleared up with the use of the eye drops and has no signs of continuing symptoms at this time. To minimize the risk of Conjunctivitis in the future, her plan will be appended to include that staff encourage her to sanitize or wash her hands after wiping her nose as well as use tissues when available instead of her hand. In regard to the Bursitis on her knee, [redacted] has continued to not report any pain on her knee when asked and no swelling is present at this time. Staff will continue to monitor the area and management will call her primary care physician's office the last week of January to schedule a follow-up appointment per their instructions.

Report Completed by: [redacted]

Report Completion date: 1/13/2022

160.E.1.a – Detailed description of what happened

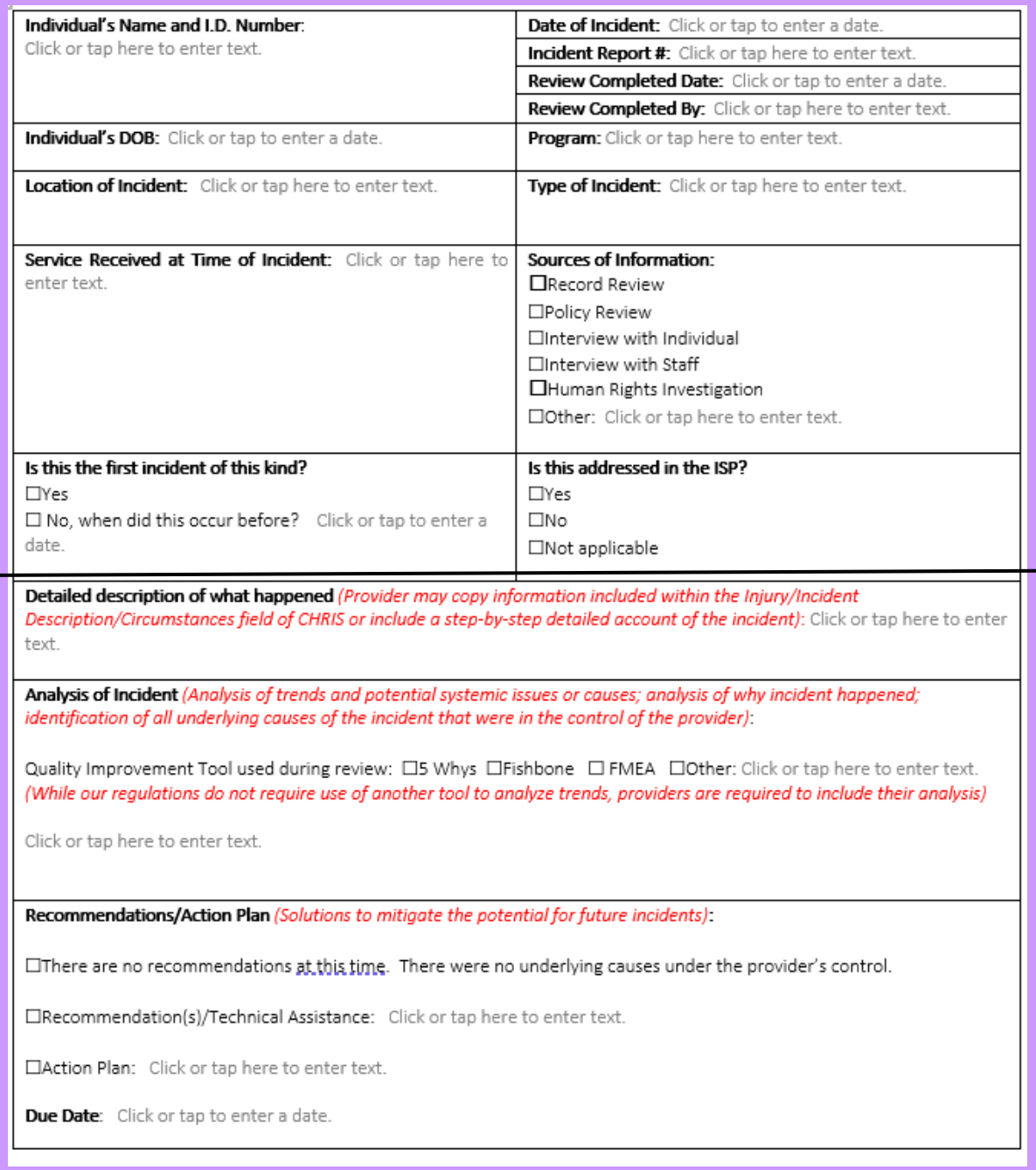
160.E.1.b - Analysis of why it happened

160.E.1.c – Identified solutions

Dated

Serious Incident Review and Root Cause Analysis Template

- Introducing the Serious Incident Review and Root Cause Analysis Template: *This template was completed in accordance with 12VAC35-105-160.*
- This template was developed to be used as:
  - An internal reporting tool for serious incidents
  - A tool for completing a Root Cause Analysis
  - A tool that can be used to determine if a more detailed Root Cause Analysis is needed
- 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.
- Serious Incident Review and Root Cause Analysis Template (April 2023)



Individual's Name and I.D. Number: Click or tap here to enter text.	**Date of Incident:** Click or tap to enter a date. **Incident Report #:** Click or tap here to enter text. **Review Completed Date:** Click or tap to enter a date. **Review Completed By:** Click or tap here to enter text.
Individual's DOB: Click or tap to enter a date.	**Program:** Click or tap here to enter text.
Location of Incident: Click or tap here to enter text.	**Type of Incident:** Click or tap here to enter text.
Service Received at Time of Incident: Click or tap here to enter text.	**Sources of Information:** ☐Record Review ☐Policy Review ☐Interview with Individual ☐Interview with Staff ☐Human Rights Investigation ☐Other: Click or tap here to enter text.
Is this the first incident of this kind? ☐Yes ☐ No, when did this occur before? Click or tap to enter a date.	**Is this addressed in the ISP?** ☐Yes ☐No ☐Not applicable

Detailed description of what happened *(Provider may copy information included within the Injury/Incident Description/Circumstances field of CHRIS or include a step-by-step detailed account of the incident)*: Click or tap here to enter text.

Analysis of Incident *(Analysis of trends and potential systemic issues or causes; analysis of why incident happened; identification of all underlying causes of the incident that were in the control of the provider)*:

Quality Improvement Tool used during review: ☐5 Whys ☐Fishbone ☐ FMEA ☐Other: Click or tap here to enter text.
(While our regulations do not require use of another tool to analyze trends, providers are required to include their analysis)

Click or tap here to enter text.

Recommendations/Action Plan *(Solutions to mitigate the potential for future incidents)*:

☐There are no recommendations at this time. There were no underlying causes under the provider's control.

☐Recommendation(s)/Technical Assistance: Click or tap here to enter text.

☐Action Plan: Click or tap here to enter text.

Due Date: Click or tap to enter a date.

Understanding the Serious Incident Review and Root Cause Analysis Template

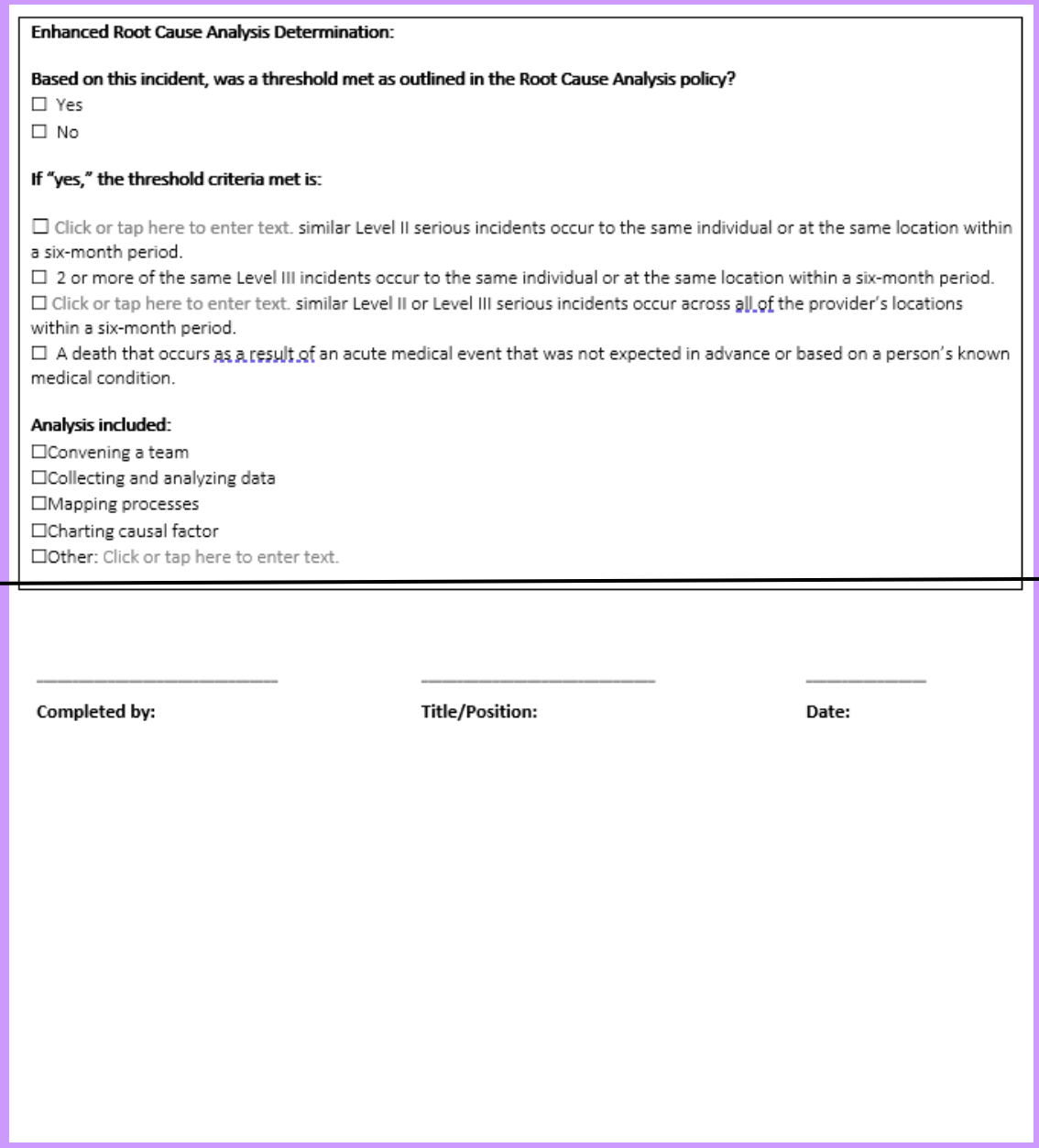
This top half of the template is where the provider enters the individual's information, incident date, report number, name of the person completing the form, date form completed, type of incident, sources of information, includes a section to indicate whether this was the first incident of this type and if this is being addressed in the ISP.

This section of the template is for your root cause analysis.

160.E.1.a: . A detailed description of what happened

160.E.1.b: An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider

160.E.1.c: Identified solutions to mitigate its reoccurrence and future risk of harm when applicable



Enhanced Root Cause Analysis Determination:

Based on this incident, was a threshold met as outlined in the Root Cause Analysis policy?

☐ Yes
☐ No

If "yes," the threshold criteria met is:

☐ Click or tap here to enter text. similar Level II serious incidents occur to the same individual or at the same location within a six-month period.
☐ 2 or more of the same Level III incidents occur to the same individual or at the same location within a six-month period.
☐ Click or tap here to enter text. similar Level II or Level III serious incidents occur across all of the provider's locations within a six-month period.
☐ A death that occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.

Analysis included:

☐Convening a team
☐Collecting and analyzing data
☐Mapping processes
☐Charting causal factor
☐Other: Click or tap here to enter text.

_____ _____ _____

Completed by: **Title/Position:** **Date:**

Understanding the Serious Incident Review and Root Cause Analysis Template

This section should be used to assist the provider in determining if a more detailed root cause analysis is needed based on their root cause analysis policy. We will talk more about this section in more detail in just a few minutes.

This section requires the signature of the person who completed the form, their title or position and the date completed.

Whether you chose to use this template or not, make sure your RCA is dated!

The focus of a Root Cause Analysis is on prevention, not blame or punishment.

RCA Example #1

Individual's Name and I.D. Number: Johnny Appleseed; ID #123456	**Date of Incident:** 10/31/2022
	Incident Report #: 2458
	Review Completed Date: 11/3/2022
	Review Completed By: Karen Matthews, M.Ed, Ed.S
Individual's DOB: 4/18/1978	**Program:** ID Group Home
Location of Incident: Matthews Group Home	**Type of Incident:** Unplanned Medical Hospital Admission

Date of RCA completion is within 30-days from date of incident = **C**

Detailed description of what happened *(Provider may copy information included within the Injury/Incident Description/Circumstances field of CHRIS or include a step-by-step detailed account of the incident)*:

Individual fell from the toilet at approximately 5:30am and started to shake for approximately 6 minutes. Individual subsequently hit her head on the toilet and staff observed a knot on her head. Individual was transported to the ER and diagnosed with a "Breakthrough Seizure" and "UTI". Individual was admitted to the hospital and treated with Rocephin and discharged on 11/3/22.

160.E.1.a: **C**, as the RCA includes a sequenced description of what lead up to the incident and what actions the provider took in response to the incident.

Analysis of Incident *(Analysis of trends and potential systemic issues or causes; analysis of why incident happened; identification of all underlying causes of the incident that were in the control of the provider)*:

Quality Improvement Tool used during review: ☐5 Whys ☐Fishbone ☐ FMEA ☐Other: Click or tap here to enter text.
(While our regulations do not require use of another tool to analyze trends, providers are required to include their analysis)

Fall due to seizure and also diagnosed with UTI

160.E.1.b: **NC**, as the RCA does not include an analysis of what happened before, during and after the incident.

Recommendations/Action Plan *(Solutions to mitigate the potential for future incidents)*:

☒**There are no recommendations at this time.** There were no underlying causes under the provider's control.

☐**Recommendation(s)/Technical Assistance:** Click or tap here to enter text.

☐**Action Plan:** Click or tap here to enter text.

Due Date: Click or tap to enter a date.

160.E.1.c: **NC**, as the RCA did not identify solutions to minimize the likelihood of this type of incident from occurring again.

Karen Matthews, M.Ed, Ed.S	Compliance Manager	11/3/22
Completed by:	**Title/Position:**	**Date:**

Date of RCA completion is within 30-days from date of incident = **C**

RCA Example #2

Individual's Name and I.D. Number: Bonita Applebaum; ID #654321	**Date of Incident:** 12/31/2021 **Incident Report #:** 8542 **Review Completed Date:** 1/11/2022 **Review Completed By:** Karen Matthews
Individual's DOB: 7/24/1970	**Program:** DD Day Support
Location of Incident: Building 700	**Type of Incident:** An Emergency Room Visit

Date of RCA completion is within 30-days from date of incident = **C**

Detailed description of what happened *(Provider may copy information included within the Injury/Incident Description/Circumstances field of CHRIS or include a step-by-step detailed account of the incident)*:

On 12/31/21 at 11:16am, staff administered a COVID test to the individual due to the individual arriving to the program with the following symptoms: Headache, fever of 101.3, and lethargy. Individual tested positive for COVID and was subsequently transported to the ER by house staff to be further evaluated and treated.

160.E.1.a: **C**, as the RCA includes a sequenced description of what led up to the incident and what actions the provider took in response to the incident.

Analysis of Incident *(Analysis of trends and potential systemic issues or causes; analysis of why incident happened; identification of all underlying causes of the incident that were in the control of the provider)*:

Quality Improvement Tool used during review: ☐5 Whys ☐Fishbone ☐ FMEA ☐Other: Click or tap here to enter text.
(While our regulations do not require use of another tool to analyze trends, providers are required to include their analysis)

Individual contracted COVID-19 from an unknown/undetermined source. Provider's reinforcement of mitigation strategies, to include social distancing, enhanced cleaning measures, wearing masks, encouraging vaccination per CDC and VDOH guidelines.

160.E.1.b: **C**, as the RCA does includes an analysis of what happened before, during and after the incident.

Recommendations/Action Plan *(Solutions to mitigate the potential for future incidents)*:

☐**There are no recommendations at this time.** There were no underlying causes under the provider's control.

☒**Recommendation(s)/Technical Assistance**: Continue to follow provider's policies and protocols, and DBHDS regulations, in educating and encouraging individuals receiving services to follow COVID recommendations on COVID-19 to minimize disease transmission and to ensure health and safety.

160.E.1.c: **C**, as the RCA includes solutions to minimize the likelihood of this type of incident from occurring again.

☐**Action Plan**: Click or tap here to enter text.

Due Date: Click or tap to enter a date.

Karen Matthews, M.Ed, Ed.S	Compliance Manager	1/11/22
Completed by:	**Title/Position:**	**Date:**

Date of RCA completion is within 30-days from date of incident = **C**

RCA Example #3

Individual's Name and I.D. Number: Millie Ray; ID #987654	**Date of Incident:** 11/29/2021
	Incident Report #: 1234
	Review Completed Date: 12/16/2021
	Review Completed By: Karen Matthews, M.Ed, Ed.S
Individual's DOB: 6/20/1956	**Program:** ID Group Home
Location of Incident: Lance's Group Home	**Type of Incident:** An Emergency Room Visit

Detailed description of what happened *(Provider may copy information included within the Injury/Incident Description/Circumstances field of CHRIS or include a step-by-step detailed account of the incident)*:

Individual had a seizure while at home and was transported via ambulance to the ER. Evaluation completed and individual's seizure medication was increased. F/U was scheduled for one week.

Analysis of Incident *(Analysis of trends and potential systemic issues or causes; analysis of why incident happened; identification of all underlying causes of the incident that were in the control of the provider)*:

Quality Improvement Tool used during review: ☐5 Whys ☐Fishbone ☐ FMEA ☐Other: Click or tap here to enter text.
(While our regulations do not require use of another tool to analyze trends, providers are required to include their analysis)

Individual has a history of seizure disorder

Recommendations/Action Plan *(Solutions to mitigate the potential for future incidents)*:

☐**There are no recommendations at this time**. There were no underlying causes under the provider's control.

☒**Recommendation(s)/Technical Assistance**: Medication adjusted; phone consult with neurologist; follow-up with PCP within one week. Continue with current plans of care.

☐**Action Plan**: Click or tap here to enter text.

Due Date: Click or tap to enter a date.

Karen Matthews, M.Ed, Ed.S	Compliance Manager	12/16/21
Completed by:	**Title/Position:**	**Date:**

Date of RCA completion is within 30-days from date of incident = **C**

160.E.1.a: **NC**, as the RCA did not describe what happened leading up to the incident.

160.E.1.b: **NC**, as the RCA does not include an analysis of what happened before, during and after the incident.

160.E.1.c: **C**, as the RCA includes solutions to minimize the likelihood of this type of incident from occurring again.

Date of RCA completion is within 30-days from date of incident = **C**

Root Cause Analysis Policy

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

2. The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the 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;

b. **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;

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 or Level III serious incidents occur across all of the provider's locations within a six-month period; or

d. 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.

*** **Note: A provider's RCA policy can be part of the provider's Serious Incident Reporting policy.**

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

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

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;

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

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

b. 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;

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

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

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 or Level III serious incidents occur across all of the provider's locations within a six-month period; or

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

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

d. 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.

Identified Issues

Providers did not have a root cause analysis policy to include when a more detailed RCA would be conducted.

Providers just copied and pasted the regulatory language.

"A threshold number" needs to be determined by the organization.

Example-Root Cause Analysis Policy for Acme Residential

12VAC35-105-160.E.2: The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the provider to conduct a more detailed root cause analysis when:

Regulation Text	Example Policy
160.E.2.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;	*Acme Residential 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.* *The provider must establish a threshold number to include within their policy.
160.E.2.b: 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;	*Acme Residential 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.*

Example-Root Cause Analysis Policy for Acme Residential

Regulation Text	Example Policy
160.E.2.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 or Level III serious incidents occur across all of the provider's locations within a six-month period; or	*Acme Residential 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.* *The provider must establish a threshold number to include within their policy.
160.E.2.d: 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.	*Acme Residential 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.* *This more detailed RCA would be required if the death occurred during the provision of a service or on the provider's premises.

*A provider's RCA policy can be part of the provider's Serious Incident Reporting policy.

RCA Policy - Compliant

A Quality Review Panel occurs when:

- Three similar Level II serious incidents occur to the same individual or at the same location within a six-month period;
- 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;
- Eight similar Level II or Level III serious incidents occur across all of the provider's locations within a six-month period; or
- 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 that occurred during the provision of a service or on the agency's premises.
- Any other trend is found when facilitating a traditional root cause analysis.

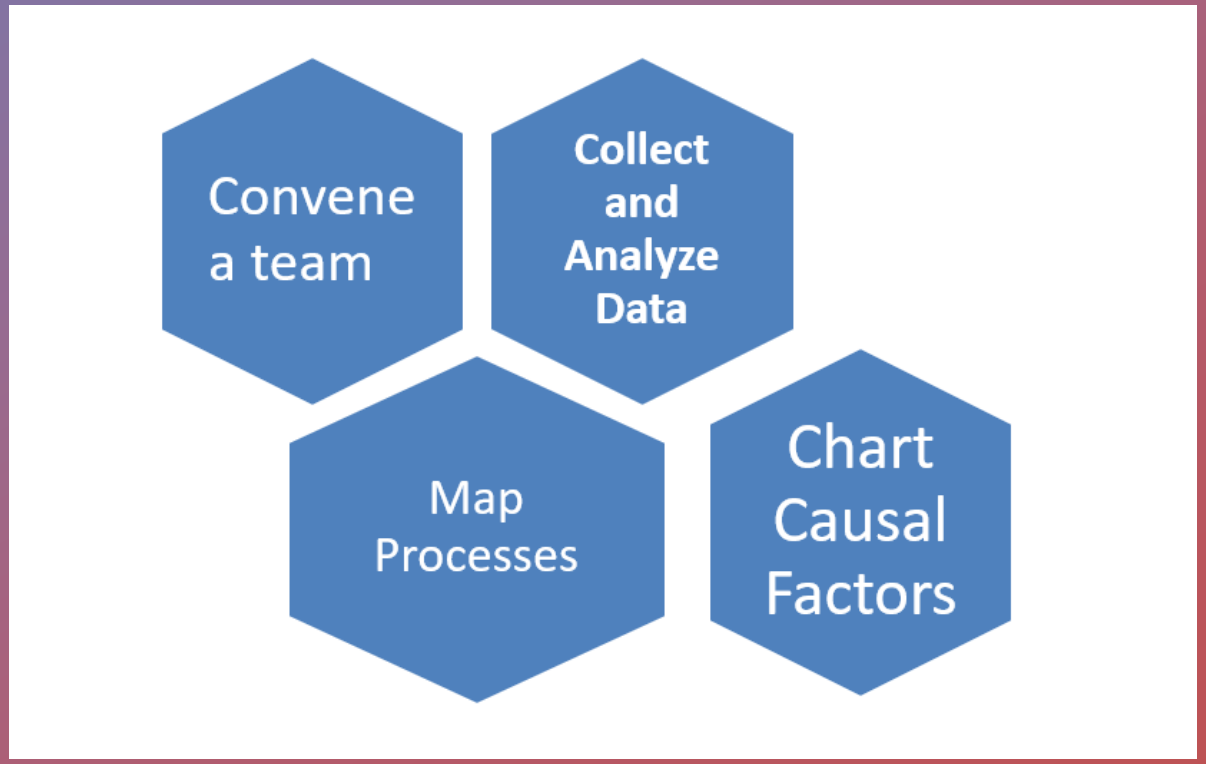
Provider identified/specified provider-specific threshold numbers for 160.E.2.a

160.E.2.b includes the minimum regulatory requirement

Provider identified/specified provider-specific threshold numbers for 160.E.2.c

160.E.2.d includes the minimum regulatory requirement

What is a more detailed RCA?



Example-Serious Incident Review and Root Cause Analysis Template for Acme Residential

Enhanced Root Cause Analysis Determination:

Based on this incident, was a threshold met as outlined in the Root Cause Analysis policy?

☒ Yes
☐ No

If "yes," the threshold criteria met is:

☒ 5 similar Level II serious incidents occur to the same individual or at the same location within a six-month period.
☐ 2 or more of the same Level III incidents occur to the same individual or at the same location within a six-month period.
☐ 8 similar Level II or Level III serious incidents occur across all of the provider's locations within a six-month period.
☐ A death that occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.

Analysis included:

☐Convening a team
☐Collecting and analyzing data
☐Mapping processes
☐Charting causal factor
☐Other: Click or tap here to enter text.

12VAC35-105-160.E.2.a-d: Tips and Reminders

Policy	When developing the root cause analysis policy, providers should take into consideration the number of locations, the number of individuals receiving services, the type of services the provider provides, and the unique needs of the individuals. The term threshold, as it relates to the regulations, mandates that the provider must establish a criteria by setting an amount or number that, if met, will require them to conduct a more detailed root cause analysis.
160.E.2.a and 160.E.2.c	Regulations 160.E.2.a and 160.E.2.c both require the provider to determine a threshold number for their policy.
160.E.2.b and 160.E.2.d	The regulations include the minimum regulatory requirement for the policy.
Threshold	Once a threshold has been met, then the provider is responsible for conducting a more detailed root cause analysis of the incident(s) that resulted in meeting the threshold.
Serious Incident Review and Root Cause Analysis Template was developed to be used as:	An internal reporting tool for serious incidents A tool for completing a Root Cause Analysis A tool that can be used to determine if a more detailed Root Cause Analysis is needed. Utilization of this template will assist providers in achieving compliance.

12VAC35-105-520. Risk Management

Why is risk management important?

12VAC-35-105-520

- A risk means there is a chance of an adverse event or outcome.
- Risk management helps us understand and reduce risks.
  - Clinical aspects of the service, such as risks happening to individuals (for example: infections, falls).
  - Administrative aspects that support the service such as risks to your organization/business (for example: staff turnover, financial viability).
- Improve outcomes for individuals.
- Improve effectiveness of services.

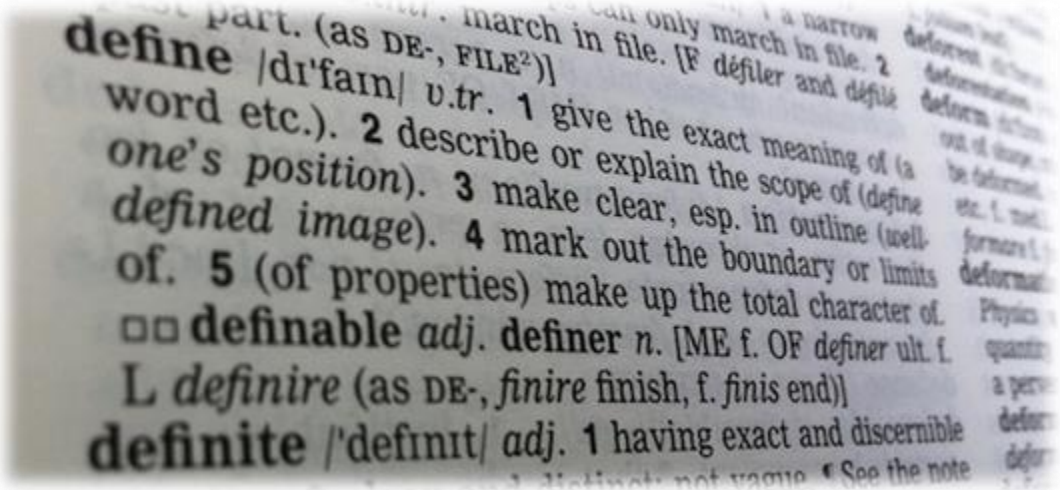
Why?

- Regulatory requirements
- Providers are assessed for their compliance with risk management in the Licensing Regulations during their annual inspections.

Definition

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



Virginia Department of Behavioral Health & Developmental Services

Understanding DBHDS Regulations

12VAC35-105-520.A

Risk Manager

12VAC35-105-520.B

Risk Management Plan

12VAC35-105.520.A

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

UPDATED Crosswalk of DBHDS Approved Trainings Effective August 2022

Training Topic Area	Crosswalk of DBHDS Approved Training and Hyperlink Access
Risk Management	1. Risk Management and Quality Improvement Strategies Webinar by CDDER http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds- risk-management-webinar-final-12-10-2020-handout-with- notes-(1).pdf 2. Office of Licensing PPT Training on Quality Improvement – Risk Management (Nov 2020) http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-managment-training-(november-2020).pdf 3. Office of Licensing Quality Improvement – Risk Management Tips and Tools (June 2021) https://dbhds.virginia.gov/assets/doc/QMD/OL/risk-management-quality-improvement-tips-and-tools-june-2021.pdf
Understanding of Individual Risk Screening	1. Risk Management and Quality Improvement Strategies Webinar by CDDER http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds- risk-management-webinar-final-12-10-2020-handout-with- notes-(1).pdf 2. Office of Licensing PPT Training on Quality Improvement – Risk Management (Nov 2020) http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-managment-training-(november-2020).pdf
Conducting Investigations	1. OHR Investigating Abuse & Neglect: An Overview for Community Providers https://dbhds.virginia.gov/assets/doc/QMD/human-rights/ohr-2021-statewide-training-calendar_current1.docx https://www.youtube.com/watch?v=4wB4dx-olyk
Root Cause Analysis	1. Risk Management and Quality Improvement Strategies Webinar by CDDER http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds-risk-management-webinar-final-12-10-2020-handout-with- notes-(1).pdf 2. Office of Licensing PPT Training on Root Cause Analysis (Nov 2020) http://www.dbhds.virginia.gov/assets/doc/QMD/OL/root- cause-analysis-training-(november-2020).pdf
Use of Data to Identify Risk Patterns and Trends	1. Risk Management and Quality Improvement Strategies Webinar by CDDER http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds- risk-management-webinar-final-12-10-2020-handout-with- notes-(1).pdf 2. Office of Licensing PPT Training on Quality Improvement – Risk Management (Nov 2020) http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-managment-training-(november-2020).pdf

UPDATED ATTESTATION FORM – EFFECTIVE AUGUST 2022

Topic Area	Name of DBHDS Approved Training Completed	Training Completion Date
	*** **Note**: *Check the associated DBHDS approved training(s) completed by the designed Risk Manager*	
Risk Management	☐ Risk Management and Quality Improvement Strategies Webinar by CDDER http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds- risk-management-webinar-final-12-10-2020-handout-with- notes-(1).pdf Or ☐ Office of Licensing PPT Training on Quality Improvement – Risk Management (Nov 2020) http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-managment-training-(november-2020).pdf Or ☐ Office of Licensing Quality Improvement – Risk Management Tips and Tools (June 2021) https://dbhds.virginia.gov/assets/doc/QMD/OL/risk-management-quality-improvement-tips-and-tools-june-2021.pdf	Click or tap to enter a date.
Understanding of Individual Risk Screening	☐ Risk Management and Quality Improvement Strategies Webinar by CDDER http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds- risk-management-webinar-final-12-10-2020-handout-with- notes-(1).pdf Or ☐ Office of Licensing PPT Training on Quality Improvement – Risk Management (Nov 2020) http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-managment-training-(november-2020).pdf	Click or tap to enter a date.
Conducting Investigations	☐ OHR Investigating Abuse & Neglect: An Overview for Community Providers https://dbhds.virginia.gov/assets/doc/QMD/human-rights/ohr-2021-statewide-training-calendar_current1.docx https://www.youtube.com/watch?v=4wB4dx-olyk	Click or tap to enter a date.
Root Cause Analysis	☐ Risk Management and Quality Improvement Strategies Webinar by CDDER http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds- risk-management-webinar-final-12-10-2020-handout-with- notes-(1).pdf Or ☐ Office of Licensing PPT Training on Root Cause Analysis (Nov 2020) http://www.dbhds.virginia.gov/assets/doc/QMD/OL/root- cause-analysis-training-(november-2020).pdf	Click or tap to enter a date.
Use of Data to Identify Risk Patterns and Trends	☐ Risk Management and Quality Improvement Strategies Webinar by CDDER http://www.dbhds.virginia.gov/assets/doc/QMD/OL/va-dbhds- risk-management-webinar-final-12-10-2020-handout-with- notes-(1).pdf Or ☐ Office of Licensing PPT Training on Quality Improvement – Risk Management (Nov 2020) http://www.dbhds.virginia.gov/assets/doc/QMD/OL/quality-improvement-risk-managment-training-(november-2020).pdf	Click or tap to enter a date.

Updated Attestation Form Continued…

This certificate is to be read, signed, and dated by the person designated as responsible for the risk management function for the provider, as well as, that person's direct supervisor.

By completing this Risk Management Attestation Form, I am indicating that I have participated in live/recorded trainings and/or reviewed the training PowerPoint presentations posted on the DBHDS Office of Licensing webpage.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE.

_____	_____	_____
Name of Designated Risk Manager	**Signature of Risk Manager**	**Date**
_____	_____	_____
Supervisor	**Signature of Supervisor**	**Date**

☐ The designated Risk Manager does not have a direct supervisor.

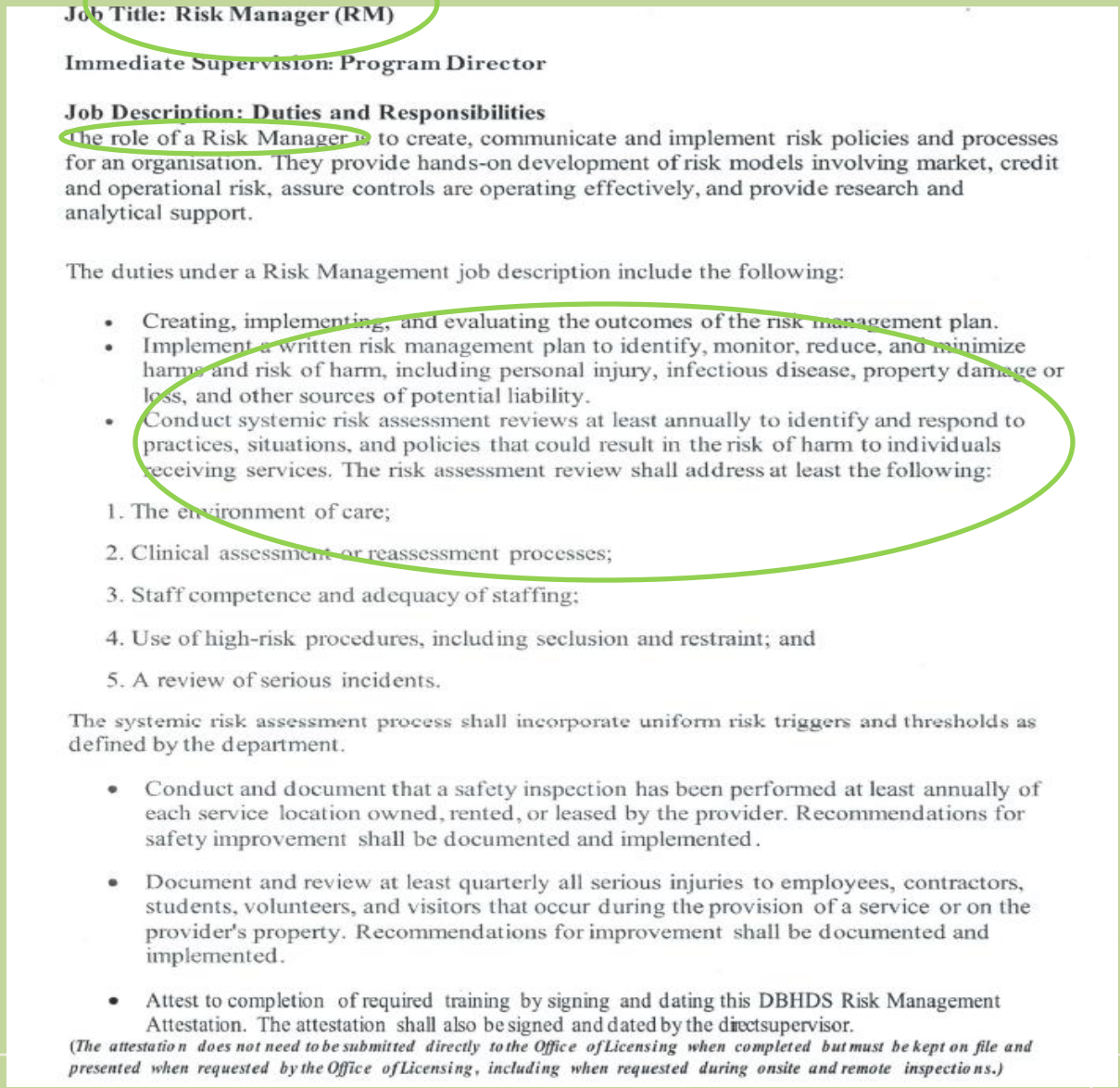
RM Attestation

- Providers can access the Updated Crosswalk of DBHDS Approved Attestation Trainings (August 2022) and the Updated Risk Management Attestation Form (August 2022) by accessing DBHDS Office of Licensing.

- 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.

Job Description Example: Compliant

This job description includes "Risk Management" language and the duties of a risk manager.



Job Title: Risk Manager (RM)

Immediate Supervision: Program Director

Job Description: Duties and Responsibilities

The role of a Risk Manager is to create, communicate and implement risk policies and processes for an organisation. They provide hands-on development of risk models involving market, credit and operational risk, assure controls are operating effectively, and provide research and analytical support.

The duties under a Risk Management job description include the following:

- Creating, implementing, and evaluating the outcomes of the risk management plan.
- Implement a written risk management plan to identify, monitor, reduce, and minimize harm and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability.
- Conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address at least the following:

1. The environment of care;
2. Clinical assessment or reassessment processes;
3. Staff competence and adequacy of staffing;
4. Use of high-risk procedures, including seclusion and restraint; and
5. A review of serious incidents.

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

- Conduct and document that a safety inspection has been performed at least annually of each service location owned, rented, or leased by the provider. Recommendations for safety improvement shall be documented and implemented.
- Document and review at least quarterly all serious injuries to employees, contractors, students, volunteers, and visitors that occur during the provision of a service or on the provider's property. Recommendations for improvement shall be documented and implemented.
- Attest to completion of required training by signing and dating this DBHDS Risk Management Attestation. The attestation shall also be signed and dated by the direct supervisor.

(The attestation does not need to be submitted directly to the Office of Licensing when completed but must be kept on file and presented when requested by the Office of Licensing, including when requested during onsite and remote inspections.)

12VAC35-105-520.A

Complete Required Training	Complete the required training for each topic area as outlined in the Crosswalk of DBHDS Approved Risk Management Training. Indicate on the risk management attestation form the training the risk manager completed and include the date completed. https://dbhds.virginia.gov/wp-content/uploads/2022/08/Updated-Crosswalk-of-DBHDS-Approved-Attestation-Trainings_August-2022.pdf Updated Risk Management Attestation Form (August 2022) 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.
Sign the Attestation	Ensure the Risk Management Attestation form is complete and that it is signed by the designated risk manager and their supervisor. Annual retraining is not required; therefore the attestation form does not need to be completed annually. However, a new attestation form must be completed when there is a change in the designated risk manager as the new risk manager would be required to complete the approved risk management training. Also, attestations do not transfer from provider to provider.
Job Description	Ensure the Risk Manager's job description includes the risk management functions and responsibilities.

12VAC35-105-520.B

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

RM Plan vs QI Plan

Risk Management (RM) Plan (520.B)	Quality Improvement (QI) Plan (620.C.1-5)
Providers must have a written risk management plan focused on identifying, monitoring, reducing, and minimizing harms and risk of harm through a continuous, comprehensive approach. This plan should include identifying year-over-trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The written risk management plan should be reviewed and updated at least annually, or any time that the provider identifies a need to review and update the plan based on ongoing quality review and risk management activities, such as during its quarterly reviews of all serious incidents.	A written 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).

A provider must have a:

- **Risk Management (RM) Plan and a Quality Improvement (QI) Plan.**
- **A provider's risk management plan may be a standalone risk management plan, or it may be integrated into the provider's overall quality improvement plan. Risk management plans and overall risk management programs should reflect the size of the organization, the population served, and any unique risks associated with the provider's business model.**

Compliant Risk Management Plans

Include:

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

That identify risks associated with:

- ✓ Personal injury (incident reporting; employee injuries)
- ✓ Infectious diseases (hand hygiene, COVID protocols)
- ✓ Property damage/loss (financial risks, weather related property damage)

For Risk Management Plans that are integrated with an overall Quality Improvement Plan (620.C 1-5) the provider is expected to identify the sections that address the Risk Management requirements of regulation 520.B. The combined plan would need to be dated since Quality Improvement Plan is required to be updated at least annually.

The Systemic Risk Assessment

- An annual risk assessment review is a necessary component of a provider's risk management plan.

- A risk assessment…
  - is a careful examination of what the provider identifies as internal and external factors or situations that could cause harm to individuals served or that could negatively impact the organization.
  - should lead to a better understanding of actual or potential risks and how best to minimize those risks.
  - varies depending on numerous factors such as an organization's size, population served, location, or business model.

- 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.

12VAC35-105-520.B

Must address all components	Make sure the risk management plan includes all the components outlined in 520.B.
Risk Management *Plan*	Make sure it is a "plan" and not a policy.
RM Plan and QI 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.

Virginia Department of Behavioral Health & Developmental Services

Understanding DBHDS Regulations
12VAC35-105-520.C.1-5
12VAC35-105-520.D
Systemic Risk Assessment, including Risk Triggers and Thresholds

What is a systemic risk assessment?

A tool for proactively identifying systemic risks **before** adverse events occur.

Where to begin:

1. Determine a format

2. Determine who will conduct the risk assessment (leadership, risk manager, committee)

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

The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services.

The risk assessment review shall address *at least* the following:

1. **The environment of care;**
2. **Clinical assessment or reassessment processes;**
3. **Staff competence and adequacy of staffing;**
4. **Use of high-risk procedures, including seclusion and restraint; and**
5. **A review of serious incidents**

12VAC35-105-520.C.1: Environment of Care

Objective	The objective is to provide a safe, functional and effective environment for individuals served, staff members and others.
Safety Inspections	Results of safety inspections should be incorporated into the systemic risk assessment.
Risks	Organizations will have different risks associated with its environment of care and providers need to think about its environment of care and the potential risks.
Internal and External Factors	Conduct an examination of what internal and external factors or situations could cause harm to the individuals served or that could negatively impact the organization.
Optional Template	Use of the Annual Systemic Risk Assessment Template developed by DBHDS will assist providers in achieving compliance.

12VAC35-105-520.C.2: Clinical Assessment or Reassessment Processes

Assessment	Examples of assessments include physical exams that are completed prior to admission or any time that there is a change in the individual's physical or mental condition.
Reassessments	Reassessments include reviews of incidents in which the individual was involved and reviews of the individual's health risks.
Risk Manager	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.
Other Examples	"Admission assessments include risk of harm to self or others"; "Physical exams for individuals are completed annually"; "Assessments and reassessments include a fall risk assessment"; "Reassessments include a review of incidents in which the individual was involved"
Optional Template	Use of the Annual Systemic Risk Assessment Template developed by DBHDS will assist providers in achieving compliance.

12VAC35-105-520.C.3: Staff Competency and Adequacy of Staffing

Staff Competence and Adequacy of Staffing	Staff competency and adequacy of staffing must both be addressed in the systemic risk assessment review
As part of the annual systemic risk assessment, the provider might ask such questions:	Do all employees meet the minimum qualifications to perform their duties? Have the employees/contractors received the necessary training to enable them to support the individuals' receiving services and to carry out their job responsibilities? What was the staff turnover rate? What issues impacted the staffing plan over the past year?
Optional Template	Use of the Annual Systemic Risk Assessment Template developed by DBHDS will assist providers in achieving compliance.

12VAC35-105-520.C.4: Use of high-risk procedures, including seclusion and restraint

Consider what high risk procedures are being used	Do we use seclusion and restraint? Do we administer high risk medications? How do we transfer individuals who are non-ambulatory? Much more...
Based on a provider's high-risk procedures, they should ask the following	Are we following applicable laws and regulations that govern their use? Are we reviewing procedures to determine whether they are still appropriate? Are staff who are implementing high risk procedures qualified to do so? Is the use of seclusion and restraint, in compliance with Human Rights Regulations?
Optional Template	Use of the Annual Systemic Risk Assessment Template developed by DBHDS will assist providers in achieving compliance.

12VAC35-105-520.C.5: Review of Serious Incidents

Policy	The provider should maintain an updated policy that defines who has the authority and responsibility to act when a serious incident or a pattern of serious incidents indicates that an individual is at risk.
Review of Incidents	Quarterly-In accordance with 160.C, all serious incidents (Level I, II and III) are to be reviewed at least quarterly to analyze for trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. Annually-Conduct the systemic risk assessment and include all data from serious incidents
Analyzing Trends	**The provider must have evidence that they completed an analysis of trends from their quarterly review of serious incidents, identified potential systemic issues or causes, indicated remediation and planned/implemented steps taken to mitigate the potential for future incidents. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems.**
Common Risks and Conditions	Provider's systemic risk assessment should identify the incidences of common risks and conditions that occurred. DD providers would focus on incidences of common risks for individuals served.
Optional Tool and Template	Use of the Individual Risk Tracking Tool, Monthly Risk Tracking Tool and the Annual Systemic Risk Assessment Template developed by DBHDS will assist providers in achieving compliance..

12VAC35-105-520.D

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

12VAC35-105-520.D-Risk Triggers and Thresholds (Care Concerns)

The Department of Behavioral Health and Developmental Services (DBHDS) defines risk triggers and thresholds as **care concerns** through review of serious incident reporting conducted by the Incident Management Unit.

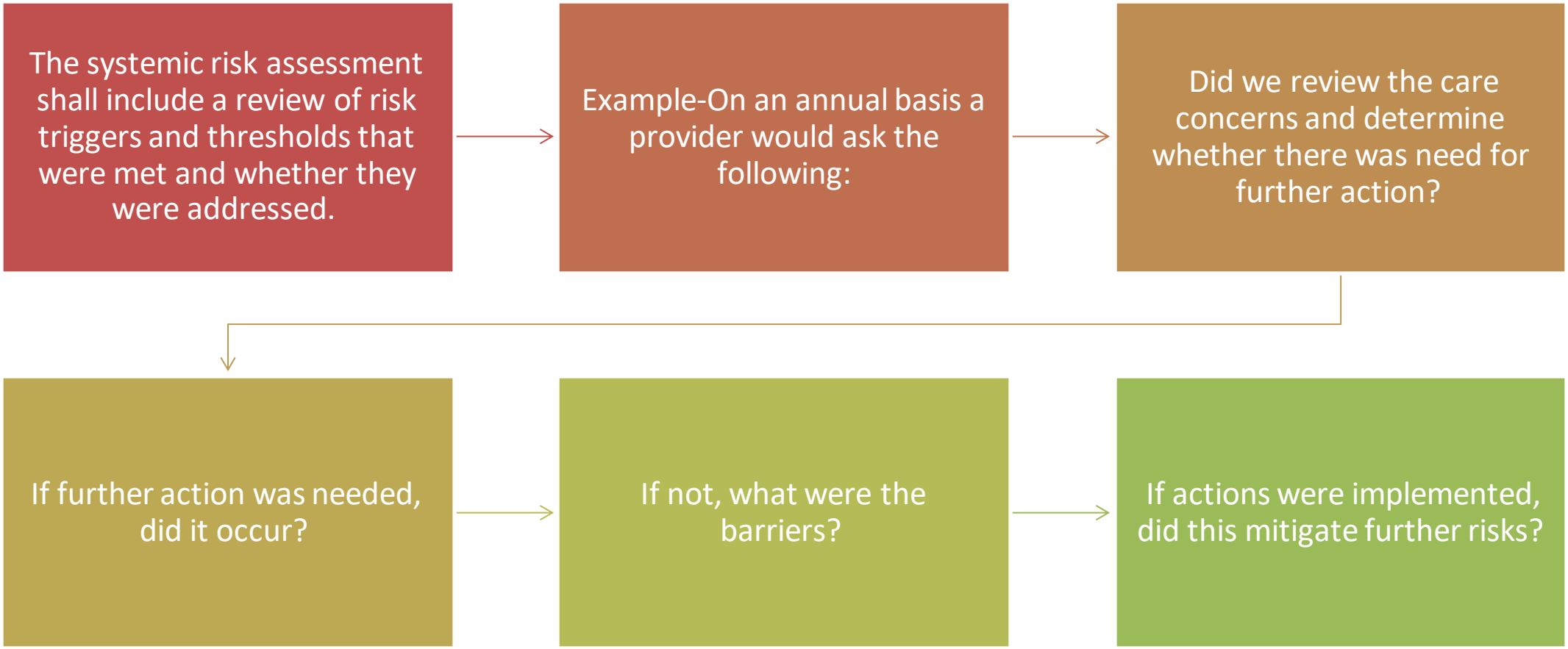
A	B
12VAC35-105-520 Risk Management	**Prompts to Determine Compliance**
D. The systemic risk assessment review process shall incorporate uniform risk triggers and thresholds as defined by the department.	
	D - Did the provider include Care Concerns? If the provider did not have any Care Concerns for the year, the risk assessment should address what they would do to address if identified.

The provider's Systemic Risk Assessment (SRA) must incorporate risk triggers and thresholds (care concerns) as defined by the department.

Effective **January 2023**, the Care Concern Thresholds are:

- Multiple (2 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 (2 or more) unplanned psychiatric admissions within a ninety (90) day time-frame for any reason.

Risk Triggers and Thresholds (Care Concerns)

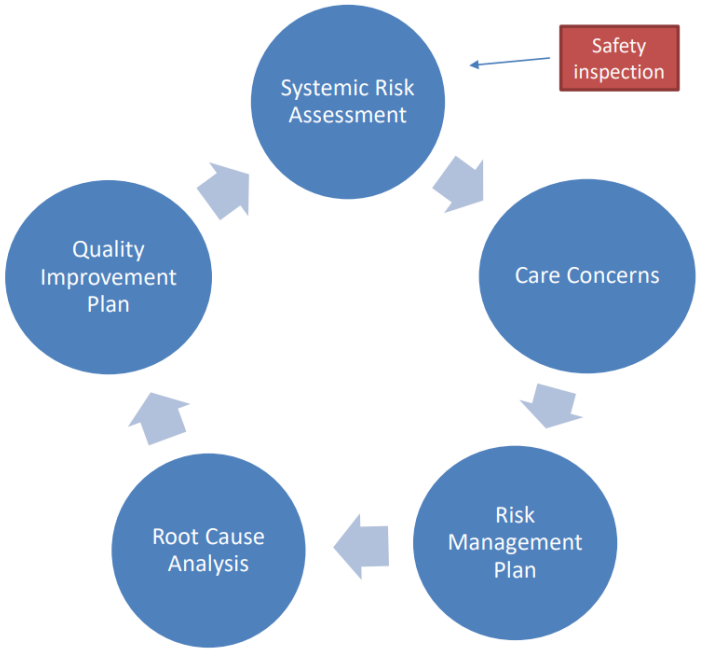


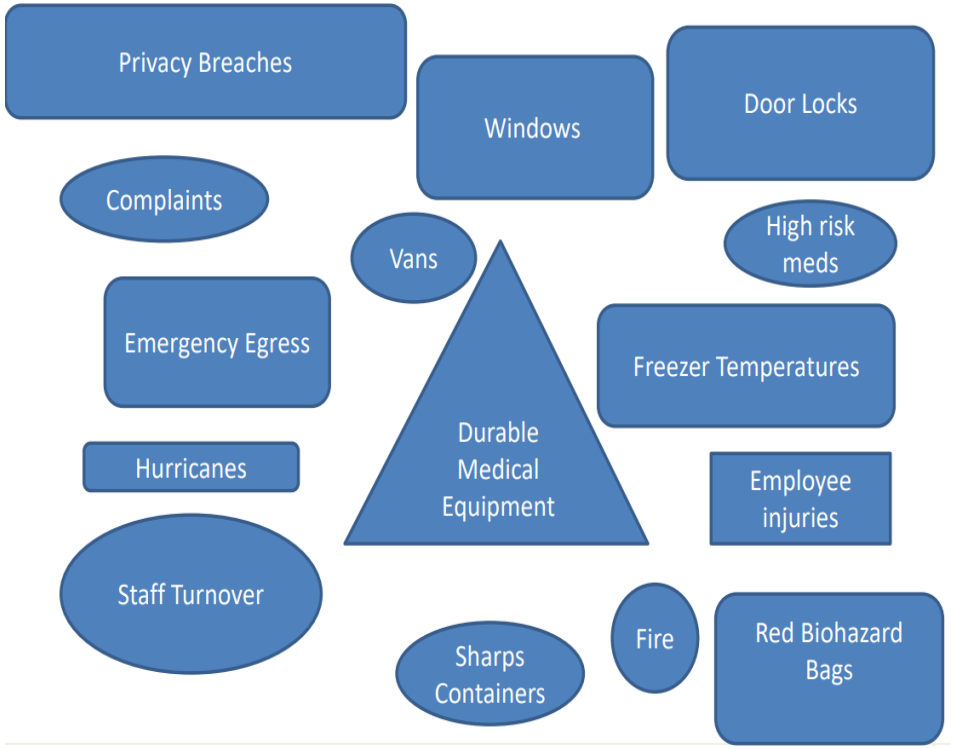
12VAC35-105-520.D: Care Concerns

Care Concerns	Providers who had care concerns must indicate in their Systemic Risk Assessment how they addressed the care concerns in their risk management process.
No Care Concerns	If the provider has not had any care concerns, the Systemic Risk Assessment review process must outline how they we would address care concerns if they were to occur.
Optional Tool and Template	Use of the Individual Risk Tracking Tool, Monthly Risk Tracking Tool and the Annual Systemic Risk Assessment template developed by DBHDS will assist providers in achieving compliance.

Systemic Risk Assessment (SRA)

- A systemic risk assessment is required for all service types and all required areas must be reviewed.
- As noted in the Guidance for Risk Management, the annual systemic risk assessment is a necessary component of a provider's risk management plan.
- Upon completion of the risk assessment, the provider should consider next steps:
  - Assign recommendations to appropriate staff members, departments and/or committees.
  - Determine what recommendations to include in the risk management plan.
  - Determine how to monitor risk reduction strategies for effectiveness.
  - Continue to conduct systemic risk assessment reviews as needed.





Systemic Risk Assessment Template and Reminders

Systemic Risk Assessment Template (April 2023)

- Providers may use the new DBHDS Systemic Risk Assessment (SRA) Template.
- This is not a required template for a provider's Annual Systemic Risk Assessment; however, utilization of this template will assist providers in achieving compliance with the regulatory requirements of 12VAC35-105-520.
- This template is located on the Office of Licensing's website.
- Systemic Risk Assessment Template (April 2023)

Systemic Risk Assessment Template (April 2023)

Office of Licensing

Disclaimer: This document may be used as a template for a provider's Annual Systemic Risk Assessment pursuant to the requirements outlined in 12VAC35-105-520. This template should be individualized to your agency and scope of services provided.

This is not a required template for a provider's Annual Systemic Risk Assessment; however, utilization of this template will assist providers in achieving compliance with the regulatory requirements of 12VAC35-105-520.

Be sure to sign and date the last page.

Annual Systemic Risk Assessment TEMPLATE

Provider Name: Name of Provider

Policy #: Enter Policy Number

Regulation: 12VAC35-105-520

Effective:

Revised: Click or tap to enter a date.
Click or tap to enter a date.
Click or tap to enter a date.

Risk Areas	Findings	Risk Score (N/A if not used)	Recommendation(s)	Comments/Actions	Add to Risk Management (RM) Plan (Yes/No/NA)	Date

Systemic Risk Assessment Template (April 2023)

Risk Areas	Findings	Risk Score (N/A if not used)	Recommendation(s)	Comments/Actions	Add to Risk Management (RM) Plan (Yes/No/NA)	Date
520.C.1			Environment of Care			
Floors clean and free of tripping hazards	Cracked bathroom tile floor	2	Replace cracked tile	Work completed	No	4/14/23
Recycling, composting and garbage do not create a nuisance or invite insects or rodents	No issues identified	1	No recommendations at this time.	N/A	No	
Ventilation	Age of the home presents risk	3	Contract with a company to evaluate further	Assigned to Risk Manager who will provide an update by 4/21/23	Yes	
Click or tap here to enter text.						

Systemic Risk Assessment Template (April 2023)

Risk Areas	Findings	Risk Score (N/A if not used)	Recommendation(s)	Comments/Actions	Add to Risk Management (RM) Plan (Yes/No/NA)	Date
520.C.3	Staff Competence and Adequacy of Staffing					
Employee CPR/First Aid Certification	1 of 13 employees had an expired CPR/FA certification	3	Remove employee from solo overnight shift and recertification to be completed immediately	Assign to Program Manager to complete by 4/12/23; Revise monitoring system to ensure compliance	Yes	4/12/23
DSP and Supervisor Competencies	1 of 13 DSPs had an incomplete competency in their file	2	Increase frequency of employee audits and finalize the competency with the DSP.	Assign to Program Manager who is also responsible for providing updates during leadership meetings	No	
Insufficient number of staff during the evening shift	Employee burnout resulting in high turnover	3	Increase recruitment efforts using various marketing tools	Assigned to Human Resources to monitor and provide updates to leadership	Yes	
Click or tap here to enter text.						

Systemic Risk Assessment Template (April 2023)

Risk Areas	Findings	Risk Score (N/A if not used)	Recommendation(s)	Comments/Actions	Add to Risk Management (RM) Plan (Yes/No/NA)	Date
520.C.4			Use of High-Risk Procedures			
High risk medications are administered	Documentation of quarterly review of medication errors was not present	3	Nurse manager to report quarterly to the Quality Improvement Committee on medication errors	Quality Improvement (QI) Committee will monitor and determine need for any QI initiatives to address these errors	Yes	
Transportation of individuals using wheelchair accessible vans	No incidents	1	Conduct spot checks to ensure safety protocols are followed	Program Manager to report quarterly on spot checks		
Click or tap here to enter text.						

Systemic Risk Assessment Template (April 2023)

Risk Areas	Findings	Risk Score (N/A if not used)	Recommendation(s)	Comments/Actions	Add to Risk Management (RM) Plan (Yes/No/NA)	Date
520.C.5			Review of Serious Incidents			
Serious injury to employees, contractors, volunteers and visitors	Review of incidents indicate increase in incidents involving visitors and contractors	2	Further analysis regarding need for more safety procedures	Risk Manager to present to leadership	No	
Quarterly review of serious incidents	Level I, II and III serious incidents were reviewed per policy and regulatory requirements	N/A	More analysis of serious incidents to determine if there are identified trends and/or other systemic issues	Nurse manager and risk manager to conduct trend analysis and report to Risk Mgmt Committee	Yes	
Serious incident review	Reviews are conducted per policy. Slight increase in incidents involving elopement over the past year.	3	Program Manager and Risk Manager to review findings of root cause analysis and ensure recommendations have been effective in mitigating risks related to elopement.	Add efforts to mitigate risks to Risk Management Plan	Yes	
Click or tap here to enter text.						

Systemic Risk Assessment Template (April 2023)

520.D

Risk Areas	Findings	Risk Score (N/A if not used)	Recommendation(s)	Comments/Actions	Add to Risk Management (RM) Plan (Yes/No/NA)	Date
Risk Triggers and Thresholds (Care Concerns)						
Process in place to monitor care concerns	Individual care concerns involving decubitus ulcers have been addressed through a quality improvement (QI) initiative and performance objective added to the quality improvement plan	3	Continue to monitor all care concerns	Assigned to nursing manager	Yes	4/13/23
Additional Risks						
LEIE (List of Excluded Individuals/Entities)	Documentation not present for DMAS Quality Management Review	3	Human Resources to establish system per Corrective Action Plan	Report quarterly to Risk Management Committee	Yes	
Financial risks	Vehicular liability insurance increasing	2	Research other insurance companies/rate	Assign to Executive Director	No	

Systemic Risk Assessment Template (April 2023)

Office of Licensing

Risk Matrix for use when determining a risk score:

4/10/23

[Provider Designee Signature] [Date]

- Remember the Systemic Risk Assessment is required to be completed at least annually and it must be dated.
- If your Systemic Risk Assessment includes a signature line then it must be signed.

Questions To Ask After Completing the SRA

- Is our agency's Systemic Risk Assessment (SRA) dated?
- Does our Systemic Risk Assessment (SRA) incorporate a review of identified risks associated with Environment of Care?
- Does our Systemic Risk Assessment (SRA) incorporate a review of identified risks associated with Clinical Assessment or Reassessment Processes?
- Does our Systemic Risk Assessment (SRA) incorporate a review of identified risks associated with Staff Competence and Adequacy of Staffing?
- Does our Systemic Risk Assessment (SRA) incorporate a review of identified risks associated with Use of High Risk Procedures?
- Does our Systemic Risk Assessment demonstrate that individual care concern triggers were reviewed and includes the actions our agency took when the threshold was met? If our agency has not had any care concerns, does our Systemic Risk Assessment review process outline how we would address care concerns if they were to occur?
- Did we identify year-over-trends and patterns and the use of baseline data to assess the effectiveness of risk management systems? Based on this information, do these risks need to be addressed in our Risk Management Plan or as part of our Quality Improvement Plan?

Systemic Risk Assessment - Non-Compliant

- Environment of Care section is missing. The risk area labeled as "Environmental Safety" suggests the completion of mandated safety inspections.
- Review of Serious Incidents should also include a review of Level 1 incidents.
- SRA does not identify risks based on the provider's size, population served, and/or unique risks associated with the provider's business model.
- SRA does not include both internal and external risk factors.
- SRA does not include any "findings", recommendations/action plan, or how to monitor identified risk.
- SRA does not include risk triggers and thresholds.

[redacted]

Systemic Risk Assessment Review Form

Risk Areas	Measure
Clinical Assessments Timely	[redacted] shall develop a crisis intervention and clinical emergency plan to implement in the event of emergency situations as measured by ensuring that emergency medical information is readily available to employees
Environmental Safety	[redacted] shall conduct and document annual safety inspections for the residential site such as fire extinguishers, first aid kits, emergency exits, fire drills, and other emergency evacuation drills as measured by monthly inspections.
Serious Incidents Level II / Level III	[redacted] shall report all serious incidents to an individual receiving services by reporting and forwarding to all parties within 24 hours of discovery as measured by constant monitoring and a daily checklist.
Staff competence and adequacy of staffing.	[redacted] shall review staff competencies monthly as measured by testing, updating new materials as measured by DBHDS updated information.
Use of high risk procedures, including seclusion and restraint; and	[redacted] shall train all staff seclusion and restraint of T.O.V.A. annually. Restraint is not the first answer of high use risk procedure, but if the individual becomes aggressive and attacks all staff of [redacted] shall learn to restrain and protect themselves and the individual with 100% accuracy as measured by an assessment, videos, and meetings discussions.

Origination Date: 8/22/2021 **Revision Date:**

Systemic Risk Assessment (SRA)- Compliant

COMPLETED BY: [redacted] Date: 10/1/21

Environment of Care	Findings	Risk Score	Recommendations	Comment/Actions	Date
Compliance with all licensing regulations for Physical Environment and Fire Inspections	Sensor light on the side of the house not working properly	2	Have Electrician replace it	Work Completed	10/20/2021
There is a working fire alarm systems	Fire alarm beeping	2	Replace battery	Work Completed	11/3/2021
Assessment and Reassessment					
Physical exams and TB tests for individuals are completed prior to admission	No issues Identified	1	No Recommendations at this time	N/A	
Physical exams for individuals are completed annually	No issues Identified	1	No Recommendations at this time	N/A	

- ✓ SRA is dated
- ✓ All components of the SRA are clearly labeled.
- ✓ Includes the five (5) elements (520.C.1-5: Environment of care, Clinical assessment and reassessment processes, Staff competence and adequacy of staffing, Use of high-risk procedures, and A review of serious incidents)

SRA Example Continue-Compliant

- ✓ It also includes a section to address risk triggers and thresholds (520.D) which are known as care concerns.

- ✓The systemic risk assessment identifies specific risks associated with each of the six regulatory elements and how those risks are being addressed.

Employee Competency and Adequacy of Staffing					
Staffing schedules are consistent with the provider's staffing plan	No issues Identified	1	No Recommendations at this time	N/A	
Employees or contractors are trained to meet the specialized health needs of individuals	No issues Identified	1	No Recommendations at this time	N/A	
Use of High-Risk Procedures					
The organization has defined high risk procedures to include, at a minimum, the use of seclusion, restraint, and electroconvulsive therapy (ECT).	No issues Identified Richmond Home does not practice the use of seclusion, restraint and electroconvulsive therapy	2	No Recommendations at this time	N/A	
A root cause analysis is conducted for Level II and Level III incidents within 30 days of incident	No issues Identified	1	No Recommendations at this time	N/A	
Review of Serious Incidents					
Medication errors are reviewed whether or not they resulted in an injury or harm.	No issues Identified	1	No Recommendations at this time	N/A	
There is a review and follow-up whenever a single serious incident or a pattern of incidents is identified	No issues Identified	1	No Recommendations at this time	N/A	
Risk Triggers and Thresholds					
Reports are run in CHRIS to determine if any individual care concern thresholds have been met.	N/A				
Have any thresholds been met?	N/A				

Tips and Reminders

Don’t forget, the Systemic Risk Assessment (SRA) really has six components! 520.C.1-5 and 520.D

12VAC35-105-520.C.The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address at least the following:

1.The environment of care;

2. Clinical assessment or reassessment processes;

3. Staff competence and adequacy of staffing;

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

5. A review of serious incidents.

AND

12VAC35-105-520.D.The systemic risk assessment review process shall incorporate uniform risk triggers and thresholds as defined by the department. Defined by the department as Care Concerns.

More Tips and Reminders

Determine a format. Every provider can use their own format, as every providers' risks will vary.

Determine who will conduct the systemic risk assessment (leadership, risk manager, committee, etc.).

Think outside the box when identifying risk areas. There is not a set number of risks for each section.

Ensure the systemic risk assessment (SRA) is:

- Conducted at least annually, **which is verified by including the date(s) the provider conducted their annual risk assessment**;
- Informs the risk management plan; and
- Incorporates uniform risk triggers and thresholds.

The Annual Systemic Risk Assessment (SRA) must be dated so reviewers can verify that it was conducted at least annually.

12VAC35-105-520.E

The provider shall conduct and document that a safety inspection has been performed at least annually of each service location owned, rented, or leased by the provider. Recommendations for safety improvement shall be documented and implemented by the provider.

12VAC35-105-520.E-Safety Inspections

E. The provider shall conduct and document that a safety inspection has been performed at least annually of each service location owned, rented, or leased by the provider. Recommendations for safety improvement shall be documented and implemented by the provider.

- An annual safety inspection must be completed at least annually for ALL service locations.

Safety Inspection

- ✓ Fire extinguishers
- ✓ Tripping hazards
- ✓ Water temperatures
- ✓ Flashlights

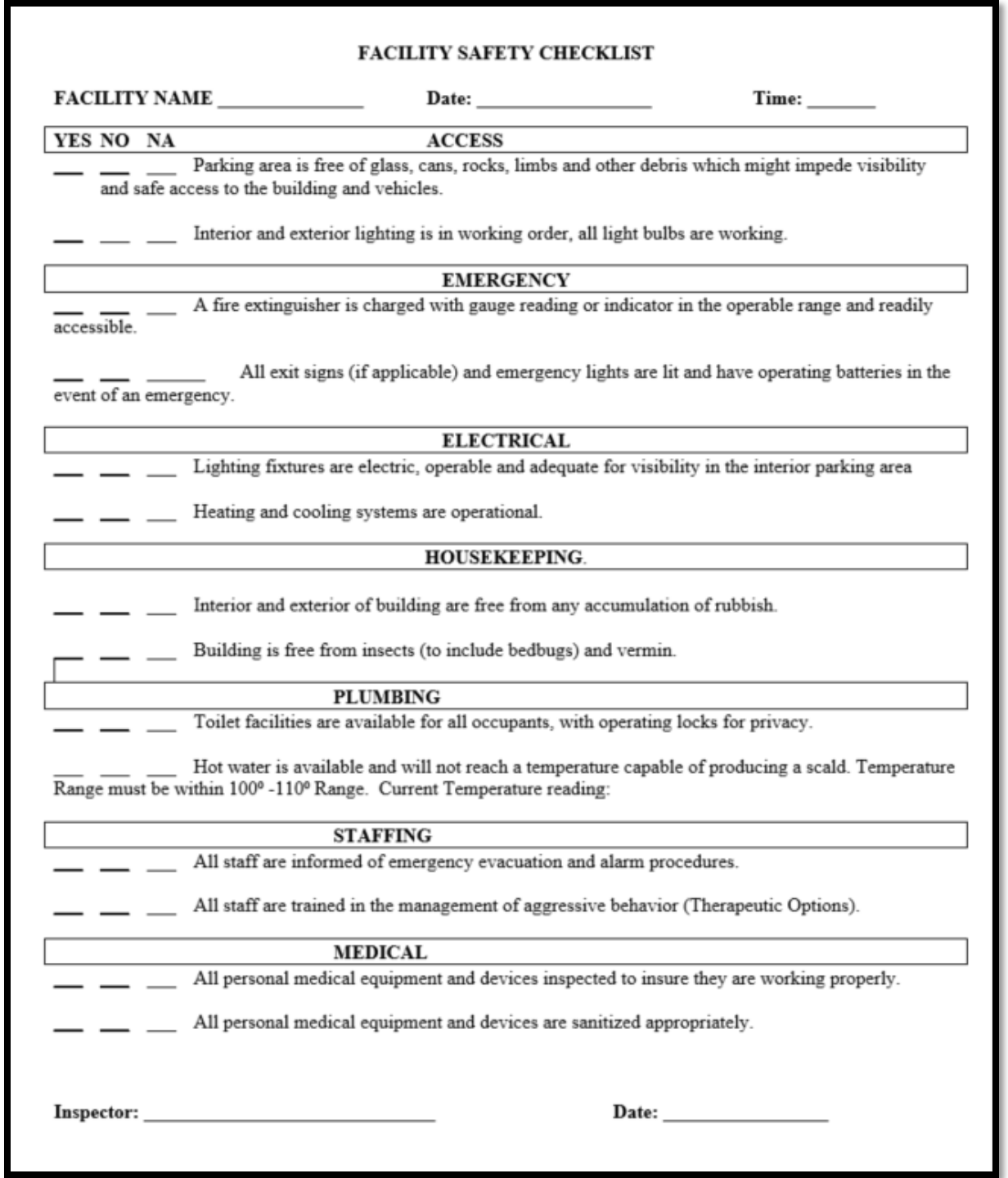
Monthly	Quarterly	Annually

- The provider must document and implement recommendations for safety improvement from the safety inspection.

- **A review of the environment of care (12VAC35-105-520.C.1) should consider the results of the annual safety inspections (12VAC35-105-520.E), when applicable, but is broader than a safety inspection.**

Safety Inspection (520.E) VS Environment of Care Risk Assessment (520.C.1)

- Safety inspections focus exclusively on the physical environment.
- Safety inspections are performed at least annually at each service location.
- Safety inspections make recommendations for safety improvement.
- Results of annual safety inspection should be included in the Systemic Risk Assessment.



FACILITY SAFETY CHECKLIST

FACILITY NAME _____ **Date:** _____ **Time:** _____

YES	NO	NA	ACCESS
—	—	—	Parking area is free of glass, cans, rocks, limbs and other debris which might impede visibility and safe access to the building and vehicles.
—	—	—	Interior and exterior lighting is in working order, all light bulbs are working.
			EMERGENCY
—	—	—	A fire extinguisher is charged with gauge reading or indicator in the operable range and readily accessible.
—	—	—	All exit signs (if applicable) and emergency lights are lit and have operating batteries in the event of an emergency.
			ELECTRICAL
—	—	—	Lighting fixtures are electric, operable and adequate for visibility in the interior parking area
—	—	—	Heating and cooling systems are operational.
			HOUSEKEEPING.
—	—	—	Interior and exterior of building are free from any accumulation of rubbish.
—	—	—	Building is free from insects (to include bedbugs) and vermin.
			PLUMBING
—	—	—	Toilet facilities are available for all occupants, with operating locks for privacy.
—	—	—	Hot water is available and will not reach a temperature capable of producing a scald. Temperature Range must be within 100º -110º Range. Current Temperature reading:
			STAFFING
—	—	—	All staff are informed of emergency evacuation and alarm procedures.
—	—	—	All staff are trained in the management of aggressive behavior (Therapeutic Options).
			MEDICAL
—	—	—	All personal medical equipment and devices inspected to insure they are working properly.
—	—	—	All personal medical equipment and devices are sanitized appropriately.

Inspector: _____ **Date:** _____

Tips and Reminders
12VAC35-105.520.E: Safety Inspections

Safety Inspection	The provider shall conduct and document that a safety inspection has been performed at least annually of each service location owned, rented, or leased by the provider. Recommendations for safety improvement shall be documented and implemented by the provider.
Environment of Care 520.C.1	A review of the environment of care (12VAC35-105-520.C.1), should consider the results of the annual safety inspections (12VAC35-105-520.E), when applicable, but is broader than a safety inspection. The environment of care is not the safety inspection but may include results of safety inspections.

Virginia Department of Behavioral Health & Developmental Services

Understanding DBHDS Regulations

Quality Improvement

12VAC35-105-620.A

12VAC35-105-620.B

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

12VAC35-105-620.D.1-3

12VAC35-105-620.E

12VAC35-105-620.A

- A. 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.

12VAC35-105-620.A

- ✓ **A quality improvement (QI) program is the structure used to implement quality improvement efforts. The structure of the program shall be documented in the provider's policies and includes:**

- ✓ **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, and includes a Quality improvement Plan

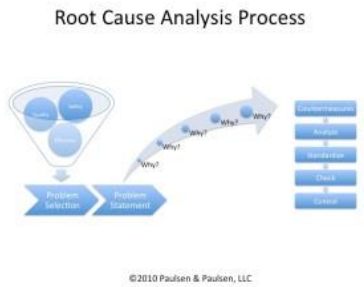
- **Criteria the provider will use to:**
  - Establish measurable goals and objectives;
  - Update the provider's quality improvement plan; and
  - Submit revised corrective action plans to the department for approval or continue implementing the corrective action plan and put into place additional measures 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.

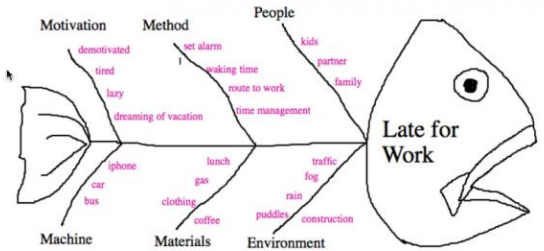
12VAC35-105-620.B

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

12VAC35-105-620.B

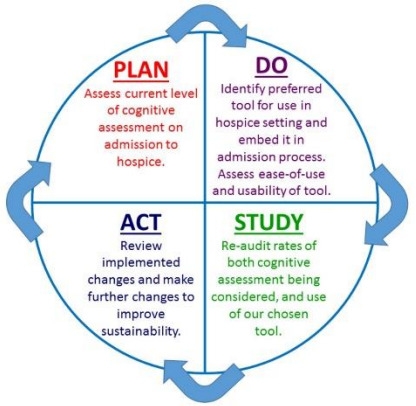
B. The quality improvement program shall utilize standard **quality improvement tools**, <u>including root cause analysis</u>, **and shall include a quality improvement plan.**





<u>Examples</u> include:

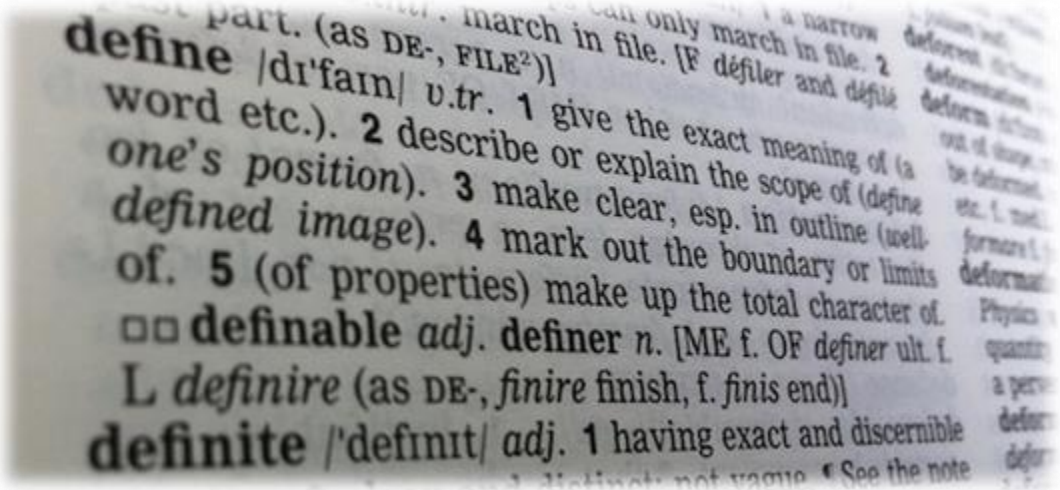
- ✓ Pareto Charts
- ✓ Failure Mode and Effect Analysis (FMEA)
- ✓ 5 Whys
- ✓ Fishbone Diagram
- ✓ Scatter Diagram
- ✓ Affinity Diagram
- ✓ Plan Do Study Act



Definition

12VAC35-105-20:

- "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.



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

C. 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

12VAC35-105-620.C.1

C. The quality improvement plan shall:

1. Be reviewed and updated at least annually

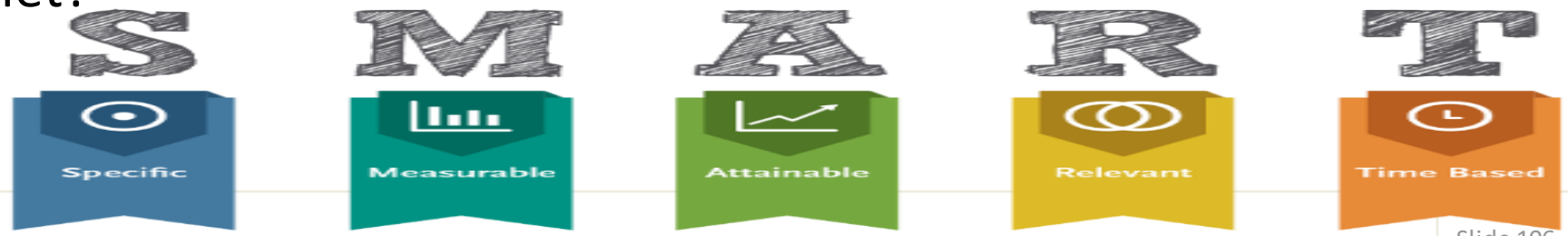
- ❑ As the provider you decide on what annual means. Is that calendar year or fiscal year? Etc.
- ❑ Can be a standalone plan or the risk management plan maybe be integrated into the provider's overall Quality Improvement Plan
- ❑ There is no specific template required for creating a quality improvement plan
- ❑ It must be dated in order to demonstrate that it was updated at least annually

12VAC35-105-620.C.2

C. The quality improvement plan shall:

2. Define measurable goals and objectives;

- ❑ Identifying goals and objectives may start with consideration of the individuals served and the types of services provided.
- ❑ The regulation does not require the provider to set a specific number of goals and objectives.
- ❑ What is the measure to be used? Count, percent, rate, etc.
- ❑ Is it clear what is being measured and why?
- ❑ What is the frequency of measurement? Weekly, monthly, quarterly, etc.
- ❑ What collection methods and sources of data are available?
- ❑ Who will be accountable for collecting data, analyzing data, and ensuring that relevant goals or objectives are met?



12VAC35-105-620.C.3

C. The quality improvement plan shall:

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

Statewide performance measures currently in effect were developed by the DBHDS Office of Developmental Services and apply only to DBHDs licensed providers of developmental services.

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

12VAC35-105-620.C.4

C. The quality improvement plan shall:

4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170

- A provider's quality improvement plan should include the process the provider will use to monitor the implementation of CAPs, including 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.
- This may include establishing measurable objectives that are related to the corrective actions and evaluating the degree to which these objectives have been achieved.

12VAC35-105-620.C.5

- **C. The quality improvement plan shall:**

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

- ❑ There is a defined process in place for monitoring defining when and how the provider will review progress toward the goals and objectives.
- ❑ 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 or not 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.

Quality Improvement Program VS Quality Improvement Plan

Quality Improvement Program is the **structure** used to implement quality improvement efforts, to define when and how the provider will review progress towards the goals/objectives, and to identify, monitor, and evaluate service quality on an ongoing basis.

Quality Improvement Plan means a **detailed work plan** that defines steps the provider will take to review the quality of services being provided and to manage initiatives to improve quality.

12VAC35-105-620.D.1-3

D. The provider's policies and procedures shall include the criteria the provider will use to

1. Establish measurable goals and objectives ;

2. Update the provider's quality improvement plan; and

3. 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.

12VAC35-105-620.D.1

The provider's policies and procedures shall include the criteria the provider will use to

1. Establish measurable goals and objectives

Criteria examples:

- ❑ The provider will establish measurable goals and objectives that are based on identified areas of non-compliance.
- ❑ The provider will establish measurable goals and objectives that will result in improved outcomes for individuals served.
- ❑ The provider will establish measurable goals and objectives for which valid data is accessible.
- ❑ The provider will establish measurable goals and objectives based on areas of high risk.
- ❑ The provider will establish measurable goals and objectives based in part on what is identified through customer satisfaction results.
- ❑ The provider will establish measurable goals and objectives using the SMART approach (specific, measurable, attainable, relevant and time bound).

12VAC35-105-620.D.2

The provider's policies and procedures shall include the criteria the provider will use to

2. Update the provider's quality improvement plan;

Criteria examples:

- ❑ The provider will update the quality improvement plan at least annually.
- ❑ The provider will update the quality improvement plan whenever there is a change in service.
- ❑ The provider will update the quality improvement plan when a new goal is developed.

12VAC35-105-620.D.3

The provider's policies and procedures shall include the criteria the provider will use to:

3. 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.

12VAC35-105-620.D.3

Criteria examples:

- ❑ The provider will submit revised CAPs if progress is not being made to correct the deficiency of the cited violation after X number of months.
- ❑ The provider will conduct a root cause analysis to determine why the CAP is not effective in addressing the identified deficiency.
- ❑ The provider will continue to monitor and then identify additional measures to address the deficiency.

Example – CAP implemented but no improvement in compliance.

Are you following your written policy for when to submit a revised CAP?

12VAC35-105-620.E

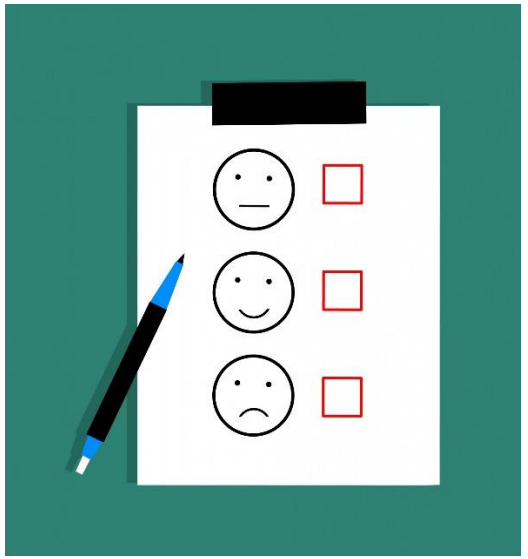
E. Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality improvement plan. The provider shall implement improvements, when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

Identified Issues

Providers included in their policy/program that they would obtain customer satisfaction but there was no proof. If the provider did not use a survey, there should be documentation of how customer satisfaction was obtained.

12VAC35-105-620.E

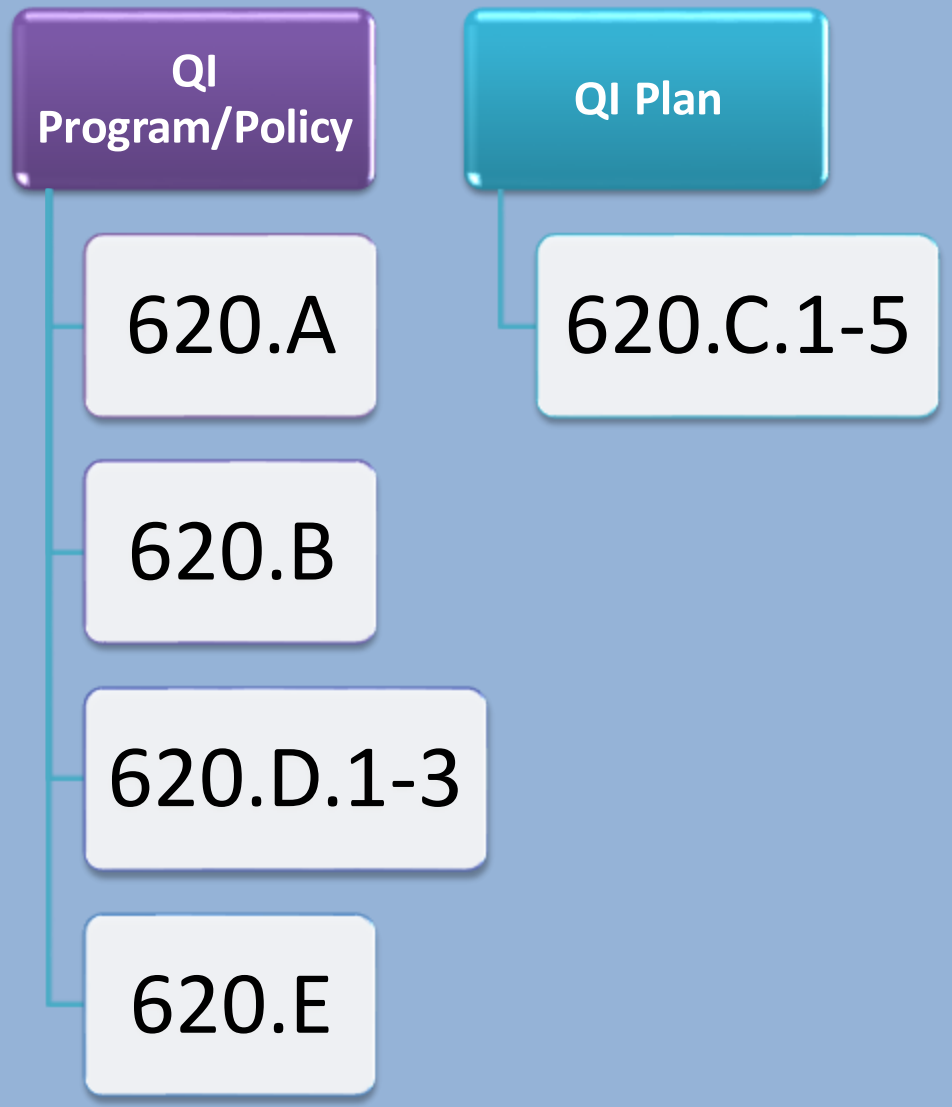
- A provider quality improvement plan must incorporate input from individuals and their authorized representatives, when applicable, including input related to the level of satisfaction with the level of participation for individuals related to service planning; and, when improvements are indicated based on this input, such improvements shall be implemented.



- No requirement for how frequent a provider requests input from individuals/AR's (i.e. quarterly, annually, etc..)
- No requirement on the method a provider uses to obtain input (i.e. surveys, phone call, etc..)
- Specific to the organization and service type
- Satisfaction of services should be documented by the provider
- How is the provider collecting and analyzing input from individuals receiving services and their authorized representatives, if applicable?
- Is the provider implementing improvements based on results of the input received?

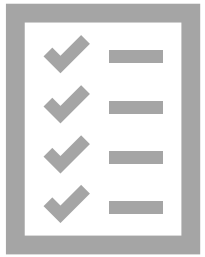
QI Program VS QI Plan

- A provider's Quality Improvement (QI) Program/Policy should be distinct from their Quality Improvement Plan.
- A policy is not a substitute for a Quality Improvement Plan.



Reminders

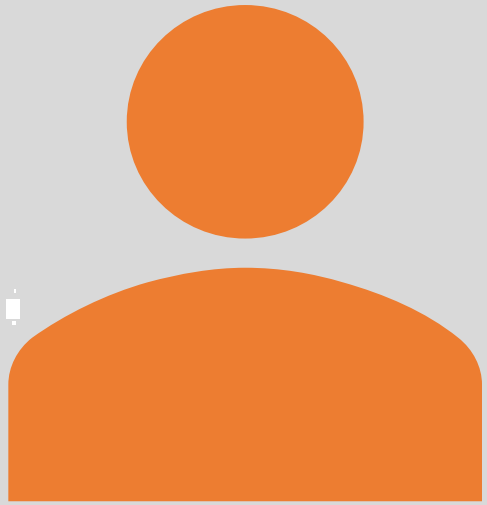
Staffing



Background and Central Registry Checks

Training and Staff Development

Reminders: Staffing



Children's Residential Services: The staffing plan complies with the requirements within 12VAC35-46-320 through 12VAC35-46-390. All staff hired will meet the qualifications outlined in the position description for their position and the ratio of staff to residents shall be at least one staff to eight residents for facilities during the hours residents are awake.

General Regulations: The staffing plan complies with the requirements for supervision within 12VAC35-105-590(C). All staff hired will meet the qualifications outlined in the position description for their position and staffing allocations will be appropriate for the service provided.

Don't forget about the staff schedule!

Reminders: Criminal Background Checks and Registry Searches

- Central Registry Checks are conducted through the Department of Social Services, Office of Background Investigations (OBI).

- Background checks are conducted through the DBHDS Background Investigations Unit. Any questions related to this process should be sent to: **backgroundinvestigations@dbhds.virginia.gov**

- Licensed providers need to continue to review Attachment 2: Barrier Crimes List for DBHDS Direct Consumer Care Providers (Effective January 1, 2023)
- Don't forget, the crimes listed here are considered Barrier Crimes in Virginia.

Reminders: Criminal Background Checks and Registry Searches for Children's Residential Services

- For Children's Residential Services 12VAC35-46-300.B.7

For all individuals that began providing services after July 1, 2007, the actual date that the individual began working with children should be documented in the personnel record. This may be the same date as the date the individual began his actual duties. For individuals who work alone with children, the date they began working alone with children should be documented. **The criminal background check must be received by the provider before an individual can begin working with children. The child protective services check must be received by the provider before an individual can work alone with children.**

Reminders: Training/Staff Development

12VAC35-105-450
12VAC35-105-460

12VAC35-46-310

- Ensure that employees and contractors are oriented to the service and receive the required trainings as outlined in the DBHDS regulations and the provider's own policies.
- Develop a Training Policy that addresses areas related to serious incident reporting, medication administration, behavior intervention, emergency preparedness, infection control; including flu epidemics, CPR/First Aid Certification, and others as applicable. This policy should also include the frequency of retraining.
- Licensed providers must refer to the regulatory requirements to ensure that all areas are addressed as it relates to orientation, required trainings and staff development.

Home and Community Based Services (HCBS)

Home and Community Based Services (HCBS)

Home and community-based services (HCBS) provide opportunities for individuals to receive Medicaid waiver services in their own home or community rather than in institutions or other isolated settings. Providers of *group home, sponsored residential, supervised living, and group day services* available in a **Developmental Disabilities (DD)** waiver **must demonstrate full compliance with HCBS settings requirement in ALL settings in order to receive reimbursement for services**. (42 CFR Part 430, 431).

Home and Community Based Services (HCBS)

- **Providers are reminded to** visit the **HCBS Toolkit** on the DMAS website to view resources and other information to help develop your HCBS policies. Providers **must** submit their HCBS policies to: **hcbscomments@dmas.virginia.gov** for internal review prior to enrolling with Medicaid as a DD waiver provider and in order to receive reimbursement for services.
- For additional information, please visit the Department of Medical Assistance Services or click on the links below:
- **New Providers HCBS Overview:** Home and Community-Based Services (HCBS) Settings Rule (virginia.gov)
- **New Settings Guidance:** CMS Home and Community-Based Services (HCBS) Regulations: Developmental Disability (DD) Waivers (virginia.gov)
- If you have additional questions related to HCBS please contact: **hcbscomments@dmas.virginia.gov**

Renewals and Inspections

Virginia Department of Behavioral Health & Developmental Services

Renewing the License

- "12VAC35-105-40. Application requirements.

C. The provider shall confirm his intent to renew the license prior to the expiration date of the license and notify the department in advance of any changes in service or location."

- CONNECT sends the provider a renewal reminder notification 90 days prior to the expiration of the license.

- A renewal application and proof of SCC must be submitted via CONNECT prior to the expiration of the license.

- For this document to be accepted with your application, your SCC registration should be in an "Active" Status on the SCC website. Additionally, the name on the license and the name of the organization on the SCC website should match. If the license is not active or the name does not match; then the renewal will not be processed, and the license will be at risk for closure.

Inspections and Investigations

- The department conducts announced and unannounced onsite reviews of all new providers and services to determine compliance with the DBHDS regulations
- The department conducts unannounced onsite reviews of licensed providers and each service at any time and at least annually to determine compliance with these regulations.
- The annual unannounced onsite reviews are focused on preventing specific risks to individuals, including an evaluation of the physical facilities in which the services are provided.
- The department may also conduct announced and unannounced onsite reviews at any time as part of the investigations of complaints or incidents to determine if there is a violation of regulations.

Inspections and Investigations

- In most cases, onsite reviews require a review of individual records, personnel records and an inspection of the physical environment.
- For onsite reviews, it is imperative that the provider identify a designated staff who is available any time for such reviews.
- This designated staff should be able to quickly provide a roster of individuals and employees/contractors.
- Additionally, the designated staff should have access to all individual records, personnel records, the licensed location and be able to answer questions.
- Providers are expected to maintain all records in a consistent and organized manner.

Corrective Action Plans (CAP)

12VAC35-105-170. Corrective action plan.

A. If there is noncompliance with any applicable regulation during an initial or ongoing review, inspection, or investigation, the department shall issue a licensing report describing the noncompliance and requesting the provider to submit a corrective action plan for each violation cited.
B. The provider shall submit to the department a written corrective action plan for each violation cited.
C. The corrective action plan shall include a:
    1. Detailed description of the corrective actions to be taken that will minimize the possibility that the violation will occur again and correct any systemic deficiencies;
    2. Date of completion for each corrective action; and
    3. 3. Signature of the person responsible for oversight of the implementation of the pledged corrective action

*For additional details on how to respond to a CAP, please refer to the: Guidance Document LIC 19: Corrective Action Plans (CAPs) (August 2020)

Virginia Department of Behavioral Health & Developmental Services

Billing for DBHDS Licensed Services

- Department of Behavioral Health and Developmental Services (DBHDS) licensed providers are eligible to bill and receive payment for administering services.
- The Office of Licensing (OL) only issues the license and monitors the service being provided.
- **The OL is not responsible or involved in billing or payment of providers. Those questions should be directed to the agencies responsible for paying the provider for services.**

All-Star Player Spotlight: DBHDS Licensed Mental Health Provider

Larisa Terwilliger

Training Coordinator

All-Star Player Spotlight: DBHDS Licensed Mental Health Provider

- **Randi Paxton**
- Executive Director
- EHS Support Services

Wrap Up: Feedback Survey

Help US to Help YOU!

- At the conclusion of today's Seminar, you will receive an email with this link to a brief survey about today's training:
  Survey - Licensed Provider Coaching Seminar III

- You can also scan this QR code to complete the survey on your mobile device ----------→

- Completing the survey provides an opportunity for you to share your feedback and assists us with improving future training events.

Wrap Up: The Final Inning

Thank you for attending Licensed Provider Coaching Seminar III!

REMINDERS:

- FAQs and Slides from all 3 Seminar sessions will be posted on the OL website.
- Links for all resources noted throughout this and the other Seminar sessions will be included in the posted presentation on the OL website.

This training series has been developed by the Office of Licensing in collaboration with:

- Office of Human Rights
- Office of Crisis Services
- Background Investigations Unit
- Division of Developmental Services
  - Office Waiver Network Supports
  - Office of Health & Safety Network Supports (OIH)
  - Office of Provider Network Supports
  - Office of Transition Network Supports
  - Office of Community Network Supports

*Special thanks to our All-Star Providers, Veronica Onsurez-Pannell and Randi Paxton, and to Jae Benz, Veronica Davis, Mackenzie Glassco, Chesna Gore, Angelica Howard, Michele Laird, Malinda Roberts, Dwayne Lynch, Jamie Ball, Taneika Goldman, Carl Henderson, Nicole DeStefano, Eric Williams, Susan Moon, Deanna Parker, Nanshill Wilson, Lars Messerschmidt and Bill Howard.

Helpful Resources: Seminar I

- Websites:
  - Office of Licensing Website
  - Prioritization List
  - Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services
  - Regulations for Children's Residential Facilities
  - DBHDS CONNECT Provider Portal System
- Forms:
  - CONNECT Blast Newsletter (June 2023)
- Videos:
  - How Do I Submit a Service Modification?
  - How Do I Submit an Application to Add a Location to an Existing Service?

Helpful Resources: Seminar II

- Websites:
  - Office of Licensing Website
  - DELTA
  - OHR Web Page
  - Human Rights Regulations
  - OHR Email/Memo Sign Up
  - HCBS Toolkit
  - Medicaid Provider Enrollment
  - CSB Directory
  - Provider Development
  - DSP & Supervisor Orientation Training & Competencies
  - Community Nursing Team List

- Forms:
  - Guidance Documents
  - LIC 17: Guidance for Serious Incident Reporting (November 2020)
  - 2023 Care Concern Threshold Criteria Memo (February 2023)
  - IMU Care Concern PowerPoint Training (February 2023)
  - Risk Triggers and Threshold Handout (February 2023)
  - Mobile Rehab Engineering Request Form
  - Physical Therapy Request Form
  - Dental Referral Form

- Email Addresses
  - DeltaProd@dbhds.virginia.gov
  - incident_management@dbhds.virginia.gov.
  - Office of Licensing Staff Contact Information
  - Licensing Regional Contacts
  - Incident Management Unit Regional Contact
  - Specialized Investigation Unit Regional Contact
  - taneika.goldman@dbhds.virginia.gov (State Human Rights Director)
  - customerservice@myfieldprint.com (Fieldprint Help Desk)
  - backgroundinvestigations@dbhds.virginia.gov (DBHDS BIU)
  - crs_operations@dss.virginia.gov (DSS OBI Central Registry Unit)
  - hcbscomments@dmas.virginia.gov (to initiate the HCBS Provider Self-Assessment)
  - communitynursing@dbhds.virginia.gov
  - mrc_documents@dbhds.virginia.gov (questions about Mortality Review Committee documentation)

Helpful Resources: Seminar III

- Websites:
  - Office of Licensing Website
  - DMAS Mental Health Services Manual- Crisis
  - Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services
  - Regulations for Children's Residential Facilities
  - DSS Website
  - HCBS Toolkit
  - Department of Medical Assistance Services
  - Home and Community-Based Services (HCBS) Settings Rule (virginia.gov)
  - CMS Home and Community-Based Services (HCBS) Regulations: Developmental Disability (DD) Waivers (virginia.gov)

- Forms:
  - Serious Incident Review and Root Cause Analysis Template (April 2023)
  - Updated Crosswalk of DBHDS Approved Attestation Trainings (August 2022)
  - Updated Risk Management Attestation Form (August 2022)
  - Systemic Risk Assessment Template (April 2023)
  - Request for Search of the Child Protective Services (CPS) Central Registry
  - Barrier Crimes List for DBHDS Direct Consumer Care Providers (Effective January 1, 2023)
  - LIC 19: Corrective Action Plans (CAPs) (August 2020)

- Email Addresses
  - backgroundinvestigations@dbhds.virginia.gov
  - hcbscomments@dmas.virginia.gov

Thank you for being part of our Team!