Good morning, all! and WELCOME TO SESSION 2 of 3 of the MINIMIZING RISK TRAINING SERIES,

Where we hope to help providers meet licensing regulations related to RISK, specifically regulations

- **160 C**
- **520 C**
- **520 D and beyond.**

This is a joint training offered by the OFFICE OF LICENSING and the OFFICE OF CLINICAL QUALITY MANGEMENT

Again, I remind you that this is 3-PART TRAINING SERIES, DESIGNED SUCH THAT EACH SESSION BUILDS OFF THE PREVIOUS SESSION.

PLEASE NOTE that EACH SESSION HAS A DIFFERENT REGISTRATION LINK – IF YOU HAVEN'T DONE SO ALREADY, make sure you have registered for DAY 3 BY CLICKING ON THE DATE OF THE 3RD SESSION SHOWN IN THE NOTICE THAT WAS SENT OUT BY THE OFFICE OF LICENSING ON MARCH 22. THAT LINK WILL TAKE YOU TO THE REGISTRATION.

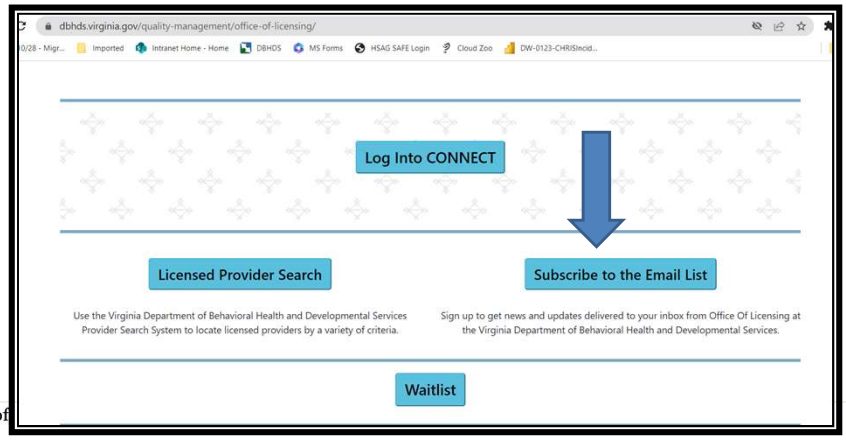
It remains our hope that EACH OF YOU WILL ATTEND EACH OF THE 3 SESSIONS.

We think this is especially important if your organization was previously found non-compliant on any of these regulations that we are coving over the 3-DAY SERIES.

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/



Virginia Department of Behavioral Health & Developmental Services

Slide 2

We greatly appreciate your being here. We know you are very busy and it means a lot to us that you are taking time out of your busy schedules to attend ALL 3 SESSIONS.

To make sure you get all future announcements from the OFFICE OF LICENSING, including training and other notices, please subscribe to the FREE EMAIL LIST!

The link to the OFFICE OF LICENSING'S WEBPAGE is provided on the slide. At that link, you will simply click the SUBSCRIBE TO THE EMAIL LIST button, indicated under the BLUE ARROW, shown on this slide.

Introductions – Your Presenters Today

- Office of Licensing:
  - Mackenzie Glassco, Associated Director of Quality and Compliance
    - Mackenzie.Glassco@dbhds.virginia.gov
  - Michele Laird, Manager, Incident Management Unit
    - Michele.Laird@dbhds.virginia.gov
  - Larisa Terwilliger, Training Coordinator
    - Larisa.Terwiliger@dbhds.virginia.gov
- Office of Clinical Quality Management:
  - Mary Beth Cox, Quality Improvement Coordinator
    - MaryBeth.Cox@dbhds.virginia.gov
  - Britt Welch, Director, Office of Community Quality Management
    - Britton.Welch@dbhds.virginia.gov

Virginia Department of Behavioral Health & Developmental Services

Slide 3

As in Session 1, you will be hearing from several presenters today:

From the OFFICE OF LICENSING, your presenters will be….

- **MACKENZIE GLASSCO, ASSOCIATE DIRECTOR OF QUALITY and COMPLIANCE**
- **MICHELE LAIRD, MANAGER of the INCIDENT MANAGEMENT UNIT, and**
- **LARISA TERWILLIGER, TRANING COORDINATOR**

From the OFFICE OF CLINICAL QUALITY MANGEMENT, your presenters will be….

- **MARY BETH COX, QUALITY IMPROVEMENT COORDINATOR, and**
- **Me, BRITT WELCH, DIRECTOR OF THE OFFICE OF COMMUNITY QUALITY MANAGEMENT**

Our two office came together to develop this training, and we look forward to partnering for future trainings!

Again, I wish the thank the different groups and colleagues that devoted numerous hours to produce this training.

Those folks include:

- **THE REGION 5 QUALITY COUNCIL MEMBERS**
- **THE MEMBERS OF THE RISK MANAGEMENT REVIEW COMMITTEE**
- **PROVIDER, CSB, and LICENSING SPECIAISTS WHO SERVED AS KEY INFORMANTS ON THE REGS AND TESTERS OF THE TOOLS YOU WILL BE INTRODUCED TO**
- **AND OUR COLLEAGUES FROM THE:**
    - **OFFICE OF COMMUNITY QUALITY IMPROVEMENT**
    - **THE OFFICE OF CLINICAL QUALITY MANAGEMENT**
    - **THE OFFICE OF INTEGRATED HEALTH, and**
    - **THE OFFICE OF LICENSING**

Housekeeping

PLEASE PUT QUESTIONS AND COMMENTS IN THE 'Q&A' FEATURE.

THE SLIDES AND DOCUMENTS WILL BE POSTED ON THE LICENSING WEBSITE **AT THE CONCLUSION OF THE 3RD TRAINING.**

THERE WILL BE A FAQ PRODUCED AFTER THE TRAINING SERIES.

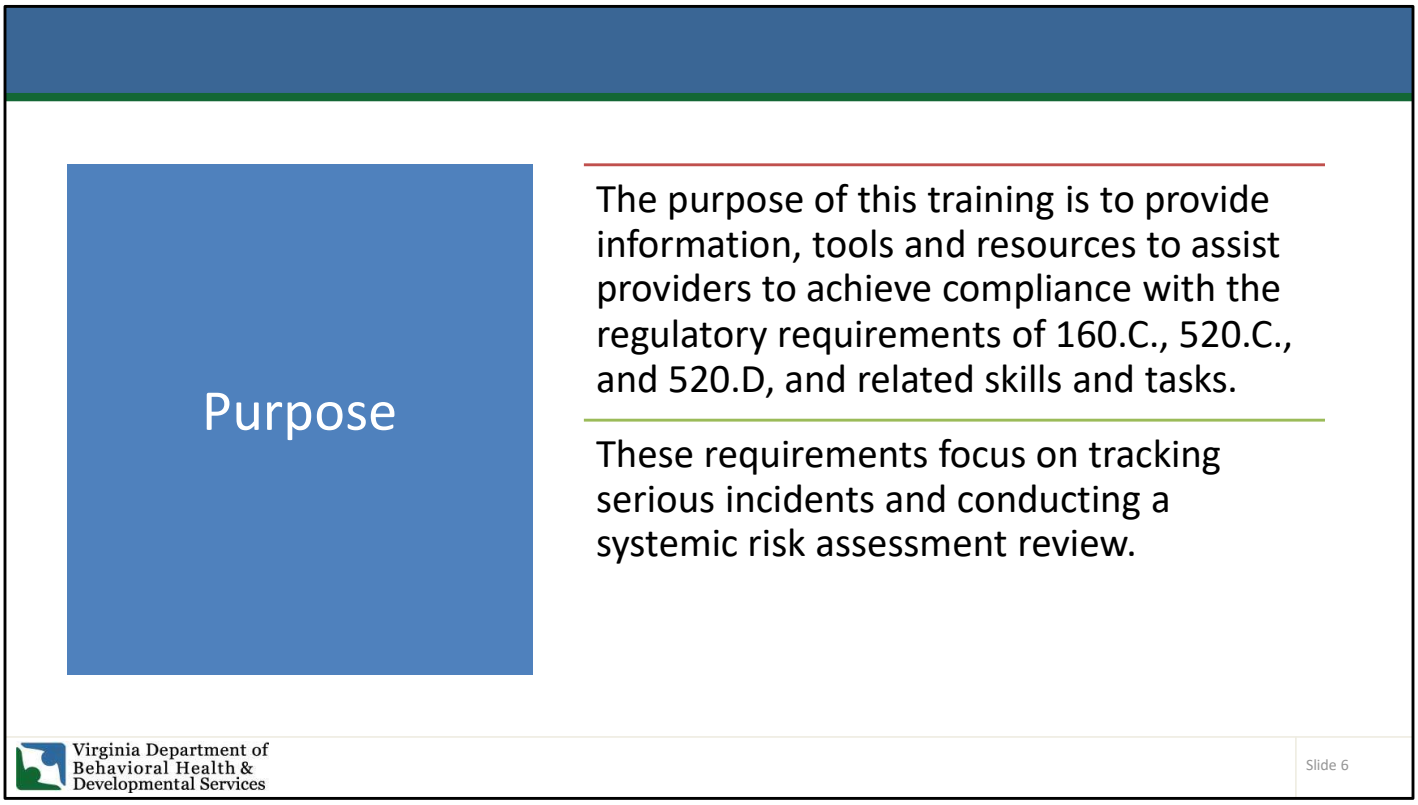
TO COVER JUST A FEW, BRIEF HOUSEKEEPING ITEMS:

- **Please put ALL your questions and comments in the "Q&A" feature, BY CLICKING ON THE "Q&A" ICON on your screen**
  - **Again, PLEASE USE THE "Q & A" feature for your questions and comments**
  - **Please note, we will try to answer some Questions during the training today.**
  - **However, we do have a time limit on the session and we want to ensure everybody sees the answers.**
  - **So most questions will be included in the FAQ which will be distributed AFTER the conclusion of the 3rd session next week.**

- **THE SLIDES AND DOCUMENTS WILL BE POSTED ON THE LICENSING WEBSITE**

- **AGAIN, there will be a FREQUENTLY ASKED QUESTIONS or FAQ document produced *AFTER* the training series.**

Let's get started!



The PURPOSE of the 3-DAY TRAINING SERIES is to PROVIDE YOU with INFORMATION...TOOLS...and RESOUCES that can ASSIST YOU in achieving COMPLIANCE with regulations:

- **160 C**
- **520 C and**
- **520 D, along with**
- **The related skills and tasks that need to be completed.**

As you are aware, these 3 regulations focus on:

- **TRACKING SERIOUS INCIDENTS and**
- **CONDUCTING a SYSTEMIC RISK ASSESSMENT REVIEW**

In SESSION 1, WE FOCUSED ON THE SYSTEMIC RISK ASSESSMENT

We discussed

- **Guidance for Risk Management**
- **Navigating the OFFICE OF LICENSING WEBSITE**
- **The 520 Regulations**
- **Provider responsibilities in meeting these regulations**
- **The DBHDS Approved Trainings Crosswalk**
- **The Risk Management Attestation and Risk Manager Job Description**
- **The Difference between a RISK MANAGEMENT PLAN and a QUALITY IMPROVEMENT PLAN**
- **The AT A GLANCE FLOW CHART for Incident Reviews**
- **We took a deeper dive into regulations 160 C, 520 C and 520 D**
- **Risk Triggers and Thresholds**
- **Care Concern Thresholds**
- **Safety Inspections**
- **The RISK ASSESSMENT TEMPLATE along with TIPS and REMINDERS**
- **The RISK MATRIX**
- **We posed questions to ask yourself AFTER COMPLETING YOUR SYSTEMIC RISK ASSESSMENT to DOUBLE CHECK YOUR WORK**
- **AND, we had some homework that we're going to get to in just a minute...**

But, WOW! It's exhausting just to think about everything we covered last time, isn't it???

Folks, we get that SESSION 1 was chocked full of information.

- **But that wouldn't have been your first rodeo. Y'all are a SMART crowd, and I contend that you WILL REALIZE THIS:**
- **EVERYTHING THAT WE COVERED IN SESSION 1,**
- **SERVES AS A *FOUNDATION*----A LAUNCHING PAD, if you will,**
- **FOR WHAT WE'RE ABOUT TO COVER TODAY AND**
- **WHAT WE *WILL* COVER IN SESSION 3, NEXT FRIDAY.**

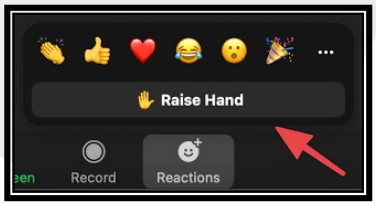
And, I'm going to remind you what I said at the 1st SESSION:

And that is: YOU....*CAN*....DO THIS! *YOU GOT THIS!*

Review Homework

- **Annual Systemic Risk Assessment**
- **What did you do to make progress on this? Did you...**
  - **Use the new template from the Office of Licensing?**
  - **Create or revise another form to use?**
  - **Identify your risk areas within each category?**
  - **Convene a team to work on it?**

- **<u>Raise your hand in Zoom to volunteer to share your progress out loud!</u>**



Let's take a look our homework!

The goal of the homework was 2-fold:
1. **GIVE YOU SOME PRACTICE ON DEVELOPING A SYSTEMIC RISK ASSESSMENT using the tools and concepts we covered in Session 1.**
2. **TO BEGIN MAKING PROGRESS ON DEVELOPING YOUR ORGANIZATION'S SYSTEMIC RISK ASSESSMENT**

So, WE'VE GOT A COUPLE OF QUESTIONS FOR YOU:
- **What was your experience like in developing your SYSTEMIC RISK ASSESSMENT? and**

- **What did you do to make progress in developing your SYSTEMIC RISK ASSESSMENT?**
  - **Did you...**
    - ✓ **Use the new template from the Office of Licensing?**
    - ✓ **Create or revise another form to use?**
    - ✓ **Identify your risk areas within each category?**
    - ✓ **Convene a team to work on it?**

Please raise your hand or indicate in Q&A that you'd like to share OUT LOUD what you did. Please click on the HAND RAISE icon to indicate you'd like to be unmuted and share!

Thank you for doing the homework and sharing your progress with us!

Let's move on to today's content.

Session Overview

- There are 3 sessions. They build on each other, so it is important to attend each session!
- **We will introduce new, useful tools you won't want to miss!**
- We also want to provide clarity and helpful tips.
- There will be homework after the first and second sessions. *Don't worry, you won't get a grade!*

- Session 1: Focus on Systemic Risk Assessment
- **TODAY! Session 2: Focus on Understanding and Tracking Serious Incidents and Care Concerns**
- Session 3: Pulling It Together and Taking It Further
- **Please do the post-test after each session!**

Handouts sent via email:

- ✓ Flow Chart for Incident Reviews
- ✓ Risk Tracking Tool_INDIVIDUAL
- ✓ Risk Tracking Tool_MONTHLY
- ✓ Risk Triggers and Thresholds Handouts
- ✓ Serious Incident Review and Root Cause Analysis Template
- ✓ Systemic Risk Assessment Template - with examples!

Virginia Department of Behavioral Health & Developmental Services

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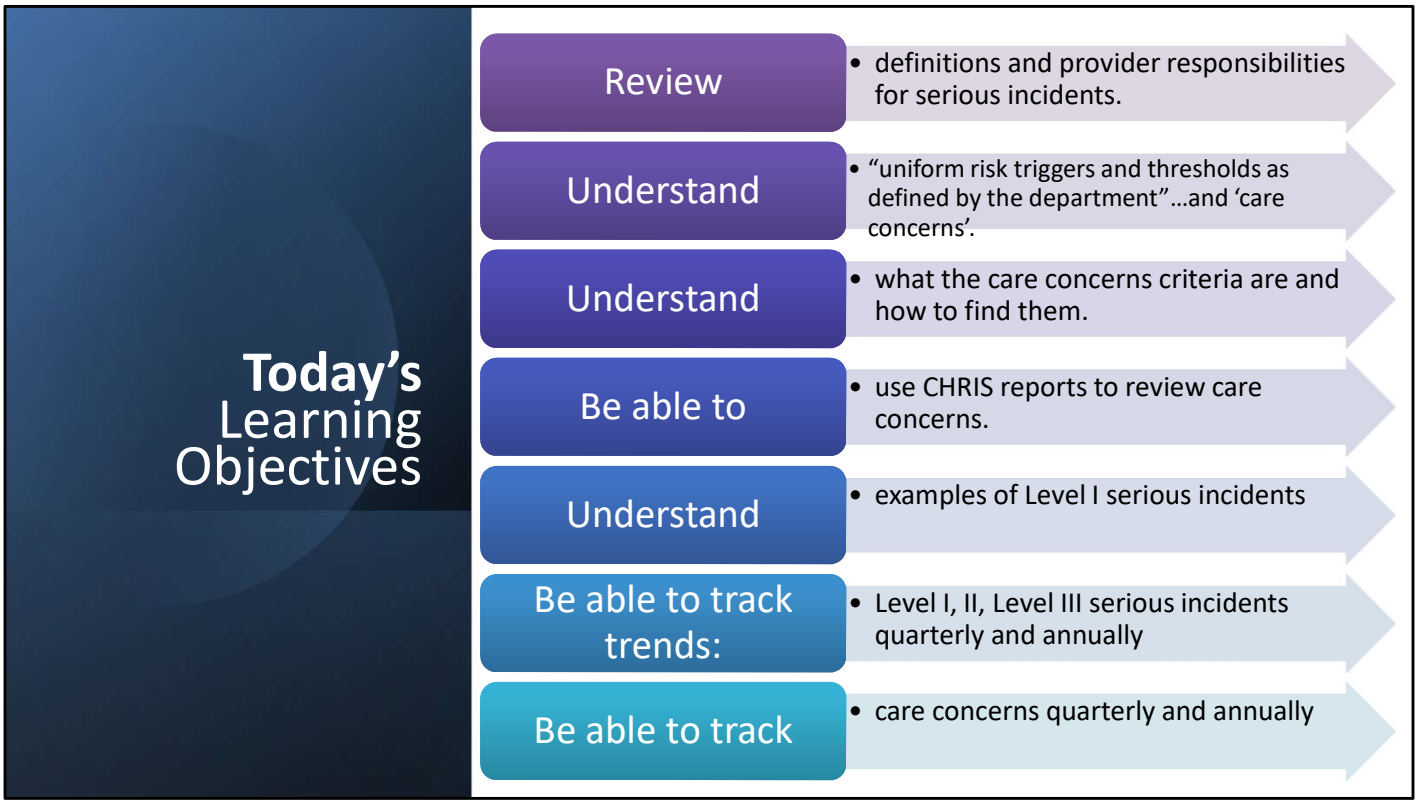
Today's session will focus on UNDERSTANDING and TRACKING SERIOUS INCIDENTS and CARE CONCERNS

- **There will be a post-test after EACH session. AND, THERE WILL ANOTHER POST-TEST TODAY.**

- **Last time, we had <u>nearly 500</u> persons that completed the Session 1 post-test and, OH....MY...GOODNESS!! THE RESULTS OF YOUR FEEDBACK...WERE FAN-TASTIC!!!**
- **TREMENDOUSLY HELPFUL TO US!**
- ***LET ME GIVE YOU A FEW EXAMPLES OF THE RESULTS:***
- ***Overall, participants gained knowledge on where to find licensing resources, and how to do a systemic risk assessment.***
  - ***64% of respondents said they plan to use the new Systemic Risk Assessment template.***
  - ***86% of respondents said they feel more capable of meeting regulations 520C and D!***
  - ***THESE RESULTS ARE PRECISELY WHERE WE WANT TO BE!***

- **SO, PLEASE....take time to do the post-test today. We're allowing time during the session to do it, and it truly helps us know where WE NEED TO MAKE IMPROVEMENTS!**

- **On the right hand side of the slide, you'll see the list of handouts that were sent to you prior to today's training.**
- **One thing we want to point out is, the Systemic Risk Assessment template sent out THIS TIME is a bit different than the previous one for last week.**
- **WHY? Because it includes EXAMPLES.**
- **So make sure you take a look at this version.**



AS I NOTED: Today we will Focus on UNDERSTANDING and TRACKING SERIOUS INCIDENTS and CARE CONCERNS

WE HAVE 6 OBJECTIVES FOR TODAY. THOSE ARE:

1. **Review definitions and provider responsibilities for serious incidents.**

2. **Understand "UNIFORM RISK TRIGGERS and THRESHOLDS AS *DEFINED BY THE DEPARTMENT* …along with "CARE CONCERNS..."**

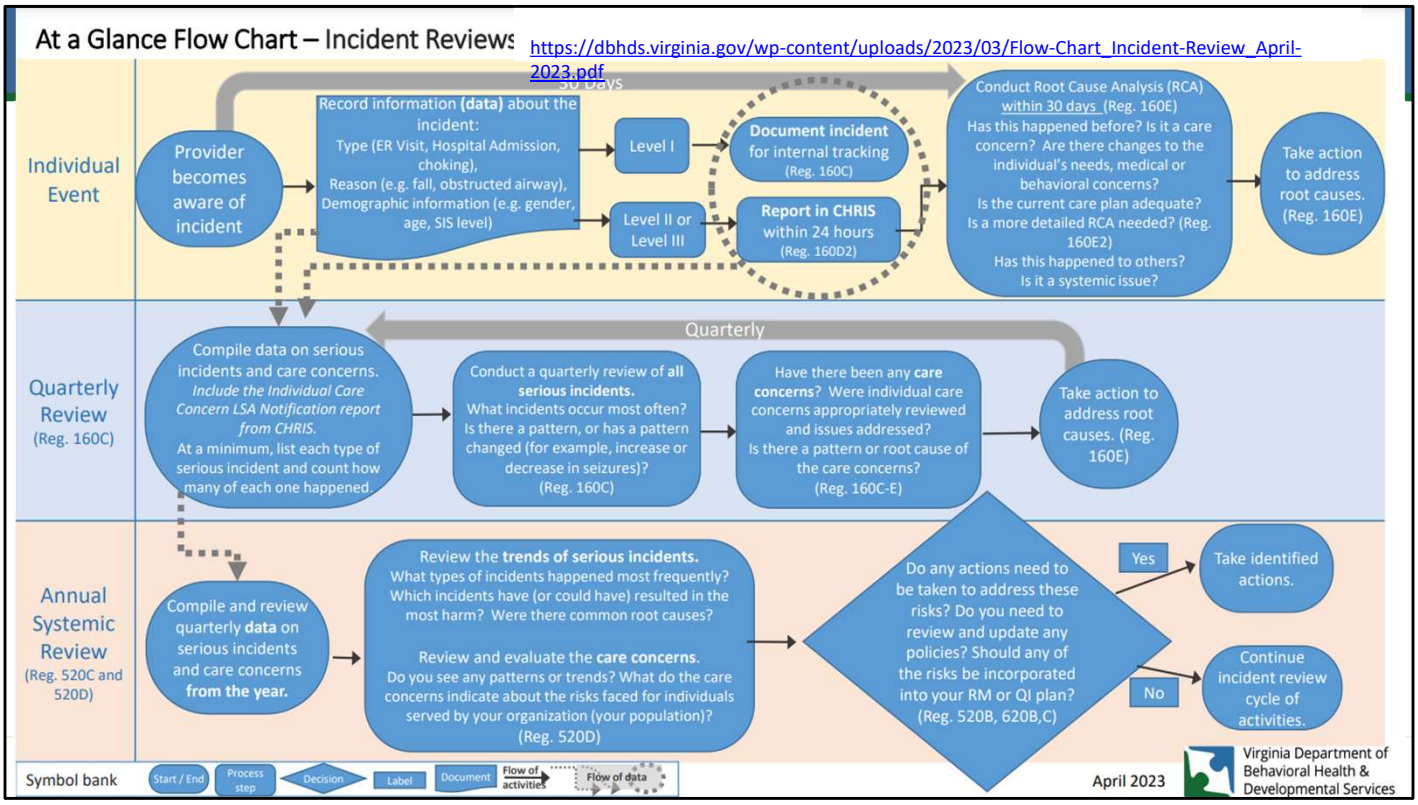
3. **Understand WHAT THE CARE CONCERNS CRITERIA ARE *and* HOW TO FIND THEM.**

4. **Be able to use CHRIS REPORTS to review CARE CONCERNS.**

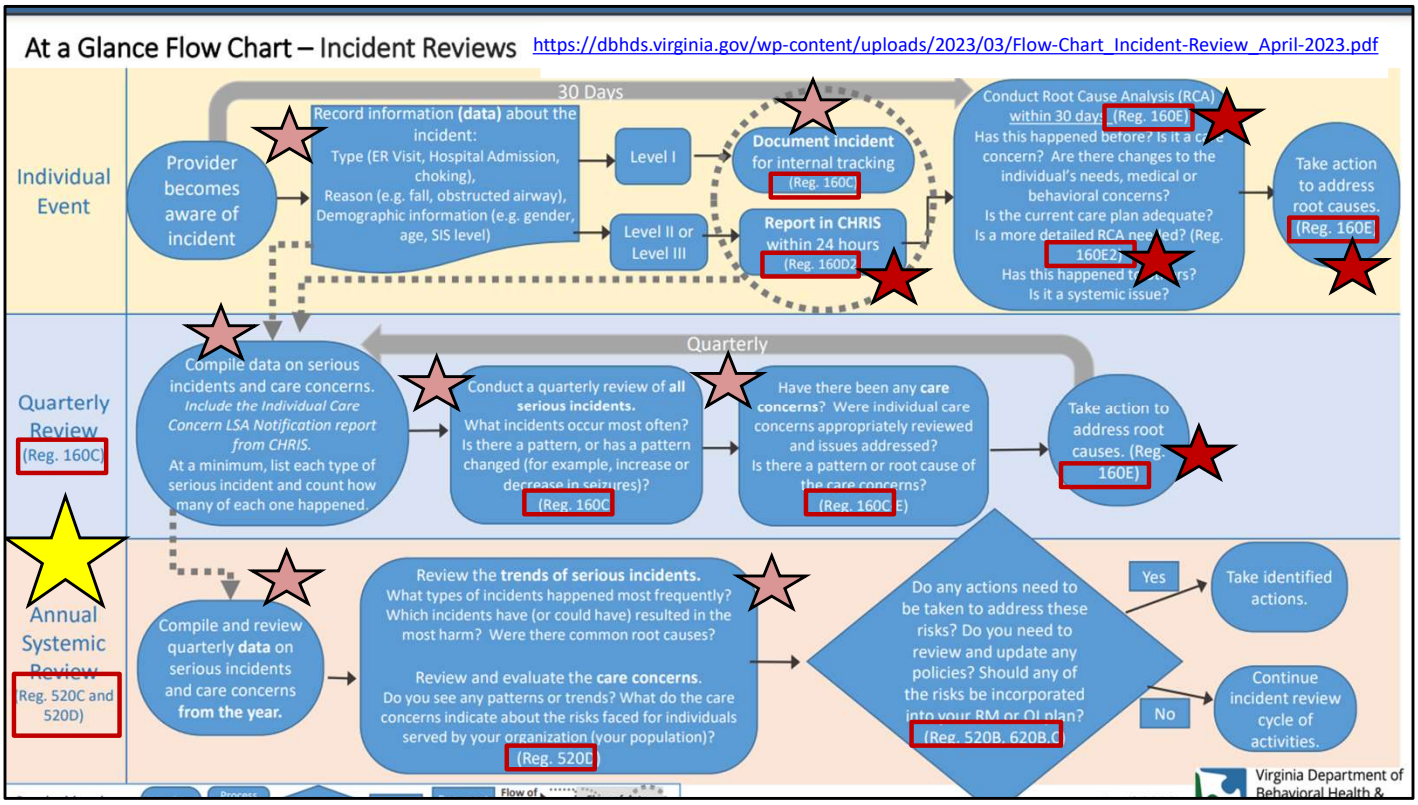
5. **Understand examples of *Level 1 SERIOUS INCIDENTS***

6. **Be able to track trends for:**
   - **Level 1, 2, and Level 3 serious incidents QUARTERLY and ANNUALLY**
   - **Along with CARE CONCERNS**
   - **And RISKS and CONDITIONS COMMON TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES**

WITHOUT ANY FURTHER WAITING, I WILL HAND-OFF THE PRESENTATION TO MY TEAMMATE, MARY BETH COX.



If you did not attend the first session, let's briefly review this flow chart.
We have heard time and again is, how do all the pieces of the risk licensing measures fit together?
In response to that, OCQM and OL partnered last year to create this flow chart.
It is an At a Glance Flow Chart for Incident Reviews.
It is on the licensing website as "Flow-Chart Incident Reviews (April 2023).
The link is provided in the upper right hand portion of the slide.
https://dbhds.virginia.gov/wp-content/uploads/2023/03/Flow-Chart_Incident-Review_April-2023.pdf
As a reminder, it starts at the Individual Event when the provider becomes aware of the incident. It walks through each step of the process and has references to the related licensing regulation along the way. The dotted lines indicate the flow of data and information in order to complete your quarterly and annual reviews. After the individual event lane, comes the quarterly review lane, then the annual systemic risk assessment lane.
We walked through it in detail last time so if you'd like to have that, you will be able to access the recording later.



Last time we talked about the Annual Systemic Risk Assessment Review (gold star).
Today we're going to talk about the part of the journey related to counting and reviewing serious incidents throughout the year (pink stars)
And touch on serious incident reporting and doing root cause analysis (red stars).
We will answer questions such as:

- How do you define serious incidents, and how can I find out more about reporting requirements?
- What are the requirements of doing a root cause analysis (RCA), and when do I need to do a more detailed RCA?
- How can you compile data in order to do quarterly and annual reviews of serious incidents?
- What questions should you ask during those reviews?
- and
- What are care concerns and how do they fit in?

You may be thinking – how am I doing this now? Am I doing what is needed?
Maybe these are new concepts to you, or you haven't done this before.
Or maybe you don't feel very comfortable with data.
That's why today, we're going to walk through what each step means and how to do it.
You can do it!
Our next speaker is going to review serious incident reporting definitions and requirements, including care concerns.
But first we have a few poll questions for you!

Poll Question

- In the 520D regulation, what does DBHDS call the “uniform risk triggers and thresholds as defined by the department”?
  - Care Concerns
  - Safety concerns
  - Care levels
  - Safety tiers

Virginia Department of Behavioral Health & Developmental Services

Slide 13

The correct answer is 'care concerns.'

Poll Question

- Which types of serious incidents do you need to collect, maintain and review at least quarterly?
  - Level I
  - Level II
  - Level III
  - Care Concerns
  - All of the above 

Virginia Department of Behavioral Health & Developmental Services

Slide 14

The correct answer is 'all of the above.'

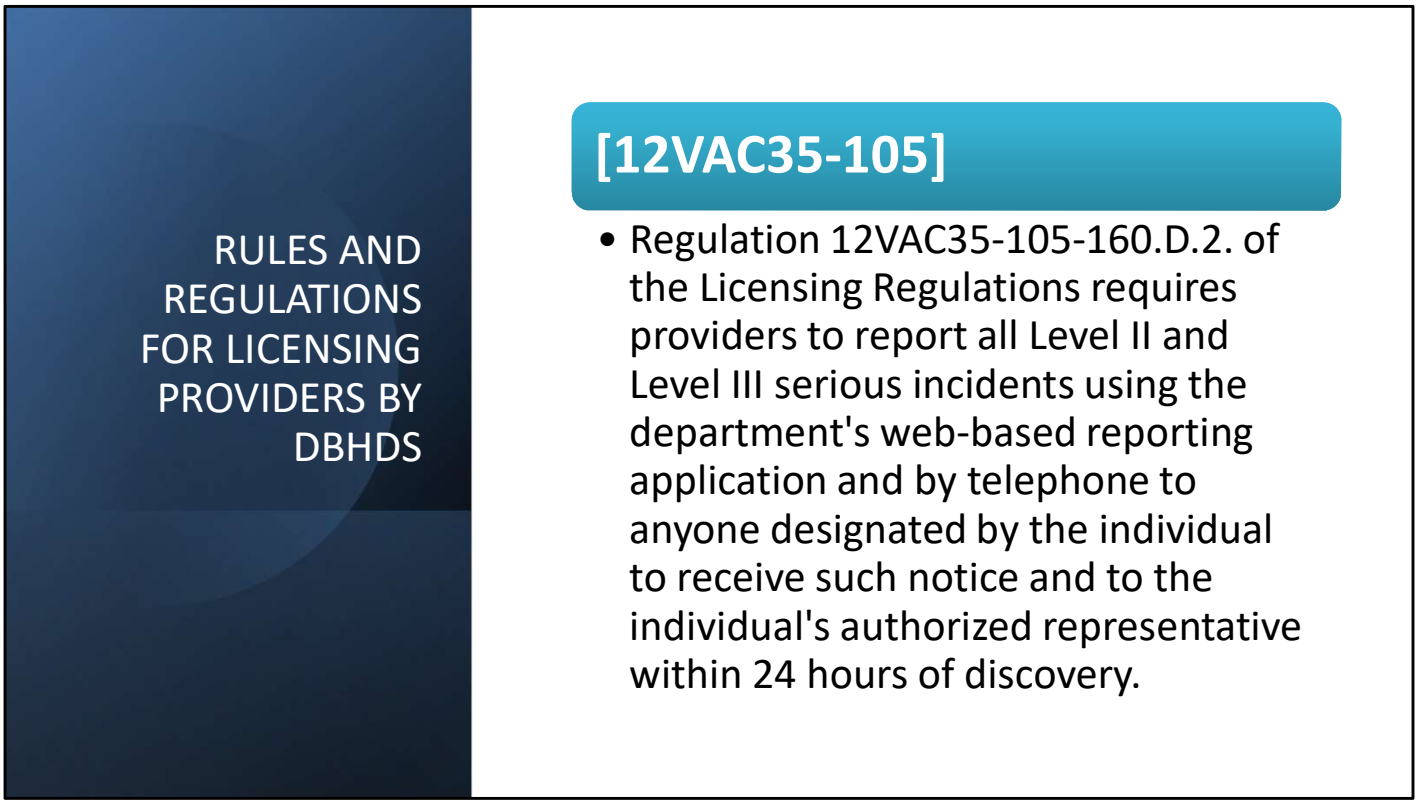
Virginia Department of Behavioral Health & Developmental Services

Review:
Serious Incident Definitions and Reporting & Care Concerns Criteria

Including a new Care concerns handout!

Michele Laird
Manager, Incident Management Unit
DBHDS Office of Licensing

Now I'm going to introduce Michele Laird. Michele is the manager for the Office of Licensing Incident Management Unit.
She is going to review for us the definitions of serious incidents and reporting requirements, and also care concerns criteria.
Welcome Michele!



Thank you MaryBeth. Before we discuss specific definitions, let's look at what the regulations says about reporting.

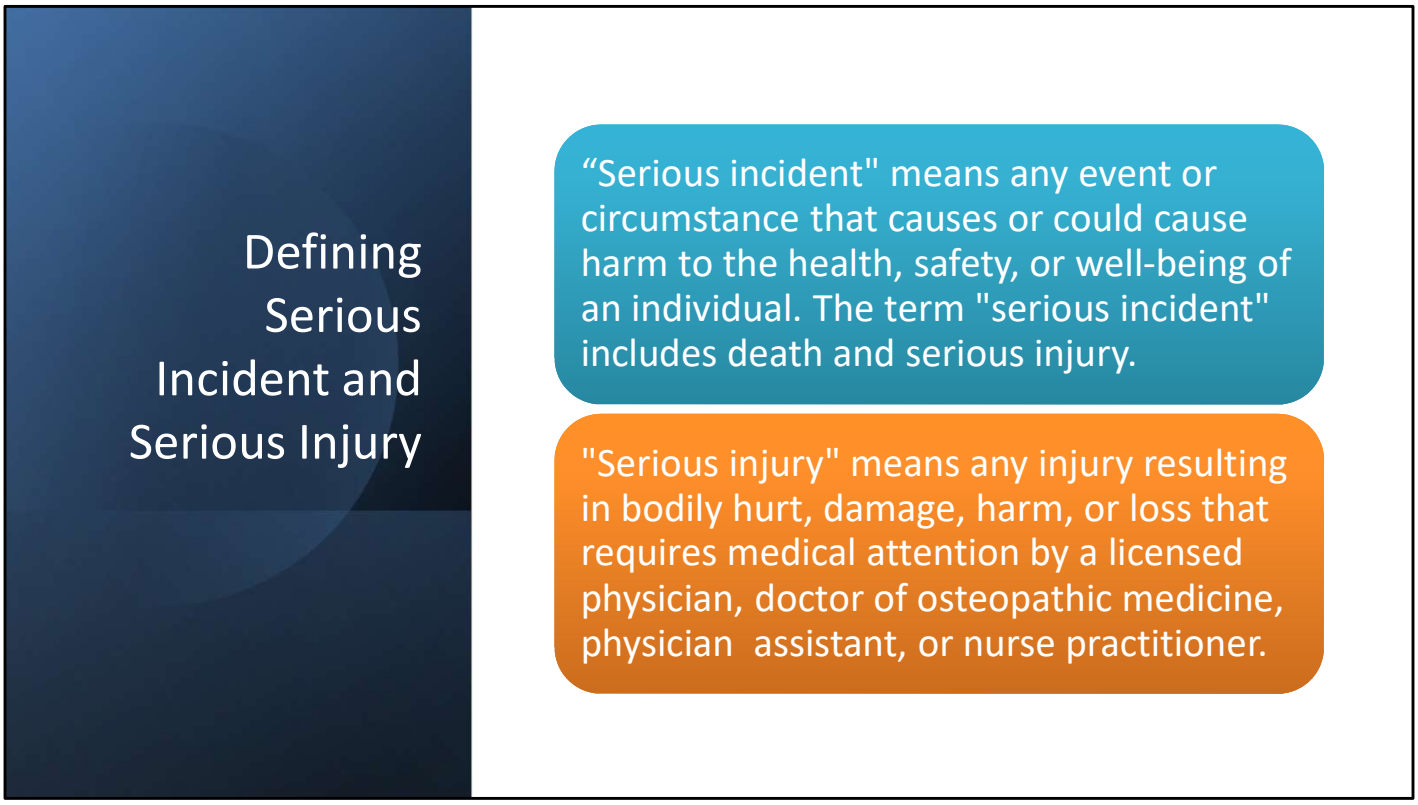
- Regulation 12VAC35-105-160.D.2. of the Licensing Regulations requires providers to report all Level II and Level III serious incidents using the department's web-based reporting application and by telephone to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery.

RULES AND REGULATIONS FOR LICENSING PROVIDERS BY DBHDS

[12VAC35-105]

- Although Level I serious incidents do not need to be reported to the Office of Licensing through the CHRIS system, regulation 12VAC35-105-160.C. requires all non-children's residential providers to collect, maintain, and review all serious incidents, including Level I serious incidents at least quarterly as part of the provider's quality improvement program.

- Although Level I serious incidents do not need to be reported to the Office of Licensing through the CHRIS system, regulation 12VAC35-105-160.C. requires all non-children's residential providers to collect, maintain, and review all serious incidents, including Level I serious incidents at least quarterly as part of the provider's quality improvement program.



Now, let's take a look at some definitions.

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

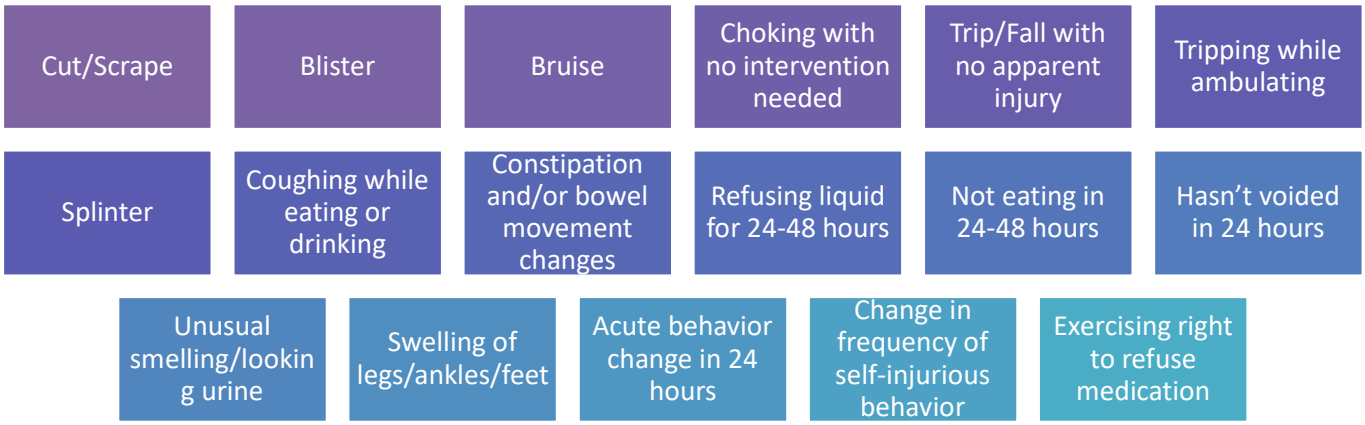
- "Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.

Defining Serious Incident

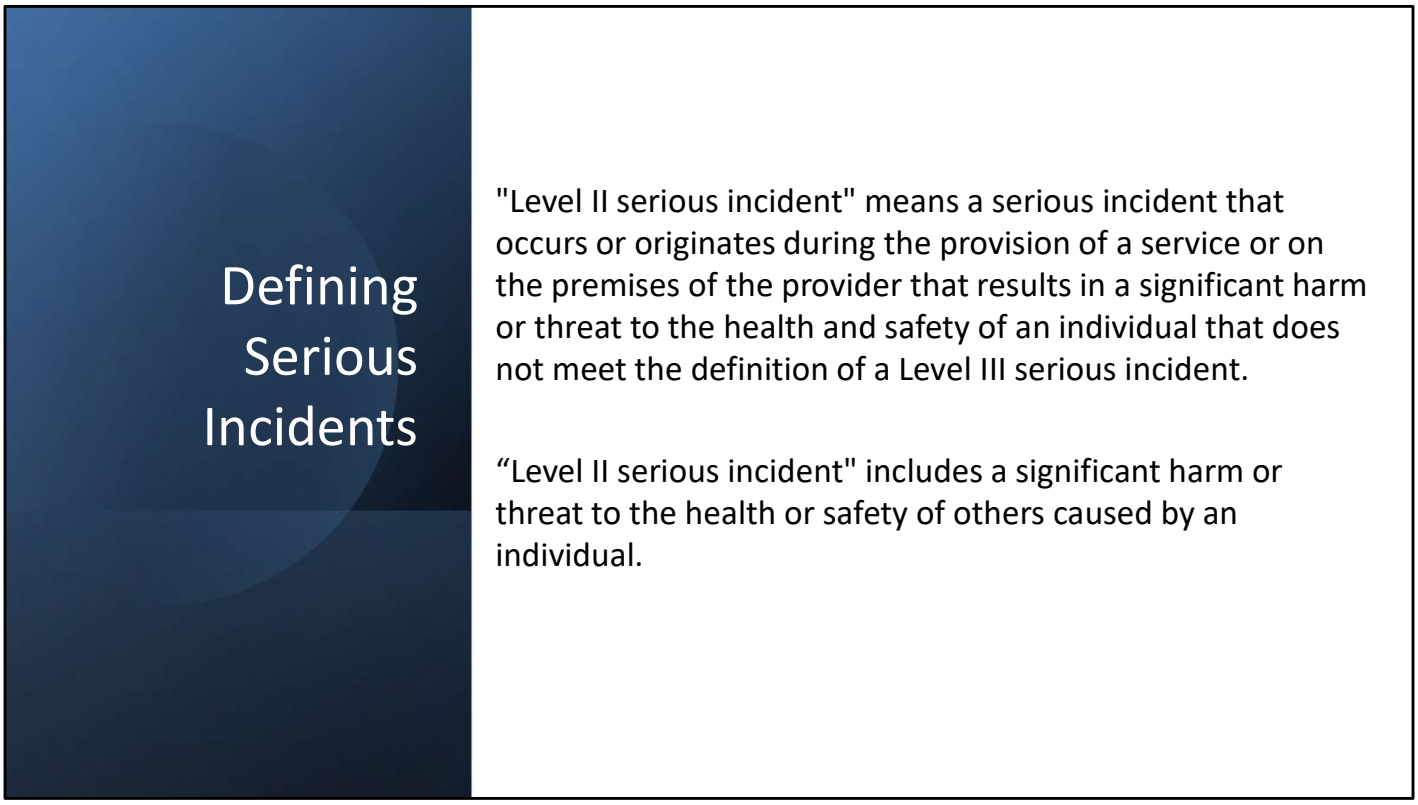
"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. Level I serious incidents do not result in significant harm to individuals, but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs.

- "Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident.
- Level I serious incidents do not result in significant harm to individuals, but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs.

Level 1 Examples



- We have all heard or read the definition of a Level 1 incident, but what does that really mean?
- What does a Level 1 serious incident look like?
- These questions come up frequently and so we wanted to provide you all with several examples.
- As you can see from these examples, not all Level I Serious Incidents may have injury or medical attention, but they are equally important.
- These are occurrences that are significant to an individual and are worth tracking, trending, and monitoring overtime as they may provide insight regarding the health and developing risk areas of an individual.



Now let's look at the definitions of incidents that are reported in the CHRIS application.

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

- “Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual.

Defining Serious Incidents

Level II serious incidents include:

1. A serious injury;
2. An individual who is or was missing;
3. An emergency room visit;
4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with the individual's Wellness Recovery Action Plan shall not constitute an unplanned admission for the purposes of this chapter;
5. Choking incidents that require direct physical intervention by another person;
6. Ingestion of any hazardous material; or
7. A diagnosis of:
    a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;
    b. A bowel obstruction; or
    c. Aspiration pneumonia.

- Level II serious incidents include:
    1. A serious injury;
    2. An individual who is or was missing;
    3. An emergency room visit;
    4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with the individual's Wellness Recovery Action Plan shall not constitute an unplanned admission for the purposes of this chapter;
    5. Choking incidents that require direct physical intervention by another person;
    6. Ingestion of any hazardous material; or
    7. A diagnosis of:
        a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;
        b. A bowel obstruction; or
        c. Aspiration pneumonia.

- Also, in the CHRIS application you will see two additional options under the Level II reporting categories:

1. ANY OTHER EVENT OR CIRCUMSTANCE THAT OCCURS OR ORIGINATES DURING THE PROVISION OF A SERVICE OR ON THE PREMISES OF THE PROVIDER THAT RESULTS IN A SIGNIFICANT HARM OR THREAT TO THE HEALTH AND SAFETY OF AN INDIVIDUAL THAT DOES NOT MEET THE DEFINITION OF A LEVEL III SERIOUS INCIDENT.
2. ANY ACTION BY THE INDIVIDUAL THAT CAUSED OR COULD CAUSE SIGNIFICANT HARM OR THREAT TO THE HEALTH OR SAFETY OF OTHERS. For example, this is often used to report

Level II peer-to-peer incidents.

Defining Serious Incidents

"Level III serious incident" means a serious incident whether or not the incident occurs while in the provision of a service or on the provider's premises and results in:

a. Any death of an individual;

b. A sexual assault of an individual; or

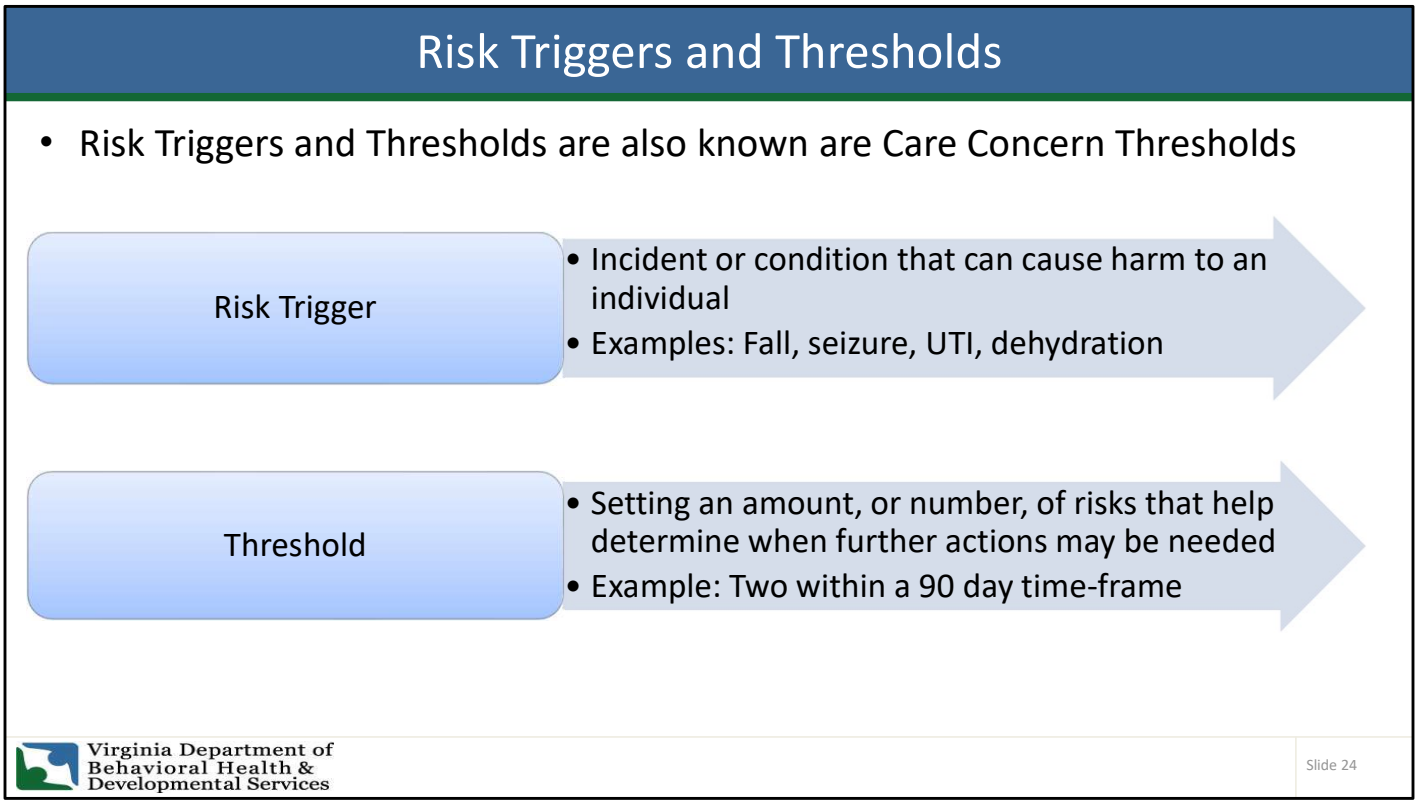
c. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

- "Level III serious incident" means a serious incident whether or not the incident occurs while in the provision of a service or on the provider's premises and results in:

  a. Any death of an individual;

  b. A sexual assault of an individual; or

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



- The Department defines Risk Triggers and thresholds as Care Concerns. Let's take a few minutes to dissect this.
- A Risk trigger is an incident or condition that can cause harm to an individual. Examples of this could be a fall, seizure, UTI, dehydration, etc.
- A Threshold is setting an amount, or number, of risks that help determine when further actions may be needed. An example of this may be two within a 90 day time-frame.
- When these are combined, we have an example of a risk trigger and threshold, which is two falls within a 90-day time period. In this example, the fall is the risk trigger and two within a 90-day time period is the threshold.

Guidance and other Important Information

Available on the Office of Licensing Web Page
Guidance
LIC 17: Guidance for Serious Incident Reporting (November 2020)
Risk Management – 12VAC35-105-520 • *Care Concerns*
2023 Care Concern Threshold Criteria Memo (February 2023)
IMU Care Concern PowerPoint Training (February 2023)
Risk Triggers and Threshold Handout (February 2023)

- As a reminder the Guidance for Serious Incident Reporting is available on the OL webpage along with the 2023 Care Concern Threshold Criteria Memo, training and the Risk triggers and Thresholds Handout.
- MaryBeth, if you will open the Guidance for Serious Incident Reporting, we just want to show the audience what this will look like when the link is accessed.

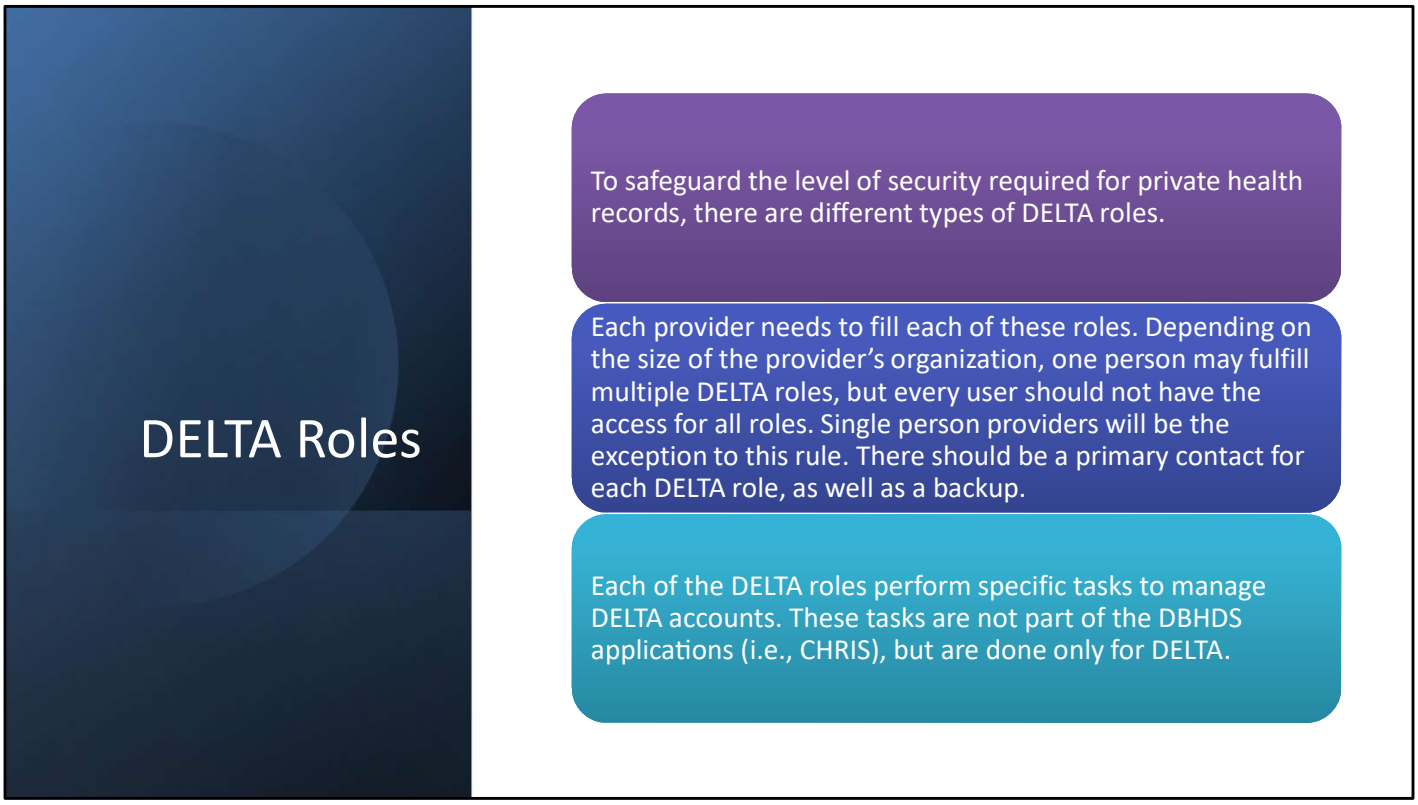
DELTA

The DELTA application is available at the bottom of the Department's webpage. https://dbhds.virginia.gov/

- Now, that we have talked about what to report, lets talk about how to report. We have already reviewed that Level II, III and death reports are reported in the CHRIS application. However, it is vital to know how we get there!

- DELTA is the web-based security portal used by DBHDS to ensure the privacy and protection of the health information records used by state facilities, CSBs, and private providers. Each user that works with DBHDS applications such as CHRIS must logon to DELTA to access those applications.

- You can find easy access to DELTA by visiting the DBHDS webpage, scroll to the bottom of the page and click the DELTA Icon. You can then add this to your favorites for easier access.



- What else do you need to know about DELTA?

  - You need to know that there are different types of DELTA Roles and role assignments that are required for use.
  - Each of the DELTA roles perform specific tasks to manage DELTA accounts.
  - These tasks are not part of the DBHDS applications (i.e., CHRIS), but are done only for DELTA. This is to safeguard the level of security required for private health records.
  - Also, each provider needs to fill each of these roles.
  - Depending on the size of the provider's organization, one person may fulfill multiple DELTA roles, but every user should not have the access for all roles.
  - Single person providers will be the exception to this rule, but in general there should be a primary contact for each DELTA role, as well as a backup.

Before we go further, we have a poll question for you!

Poll Question

- For locked accounts, who should you contact? **Check all that apply.**
  - My agency's security officer
  - DeltaProd@dbhds.virginia.gov
  - Incident Management Unit
  - My licensing specialist
  - The DBHDS Commissioner's office

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The first two answers are correct.

DELTA Roles

In the event that the appointed security officers are locked out of their accounts, the only other option to unlock those accounts is for the provider to email: DeltaProd@dbhds.virginia.gov

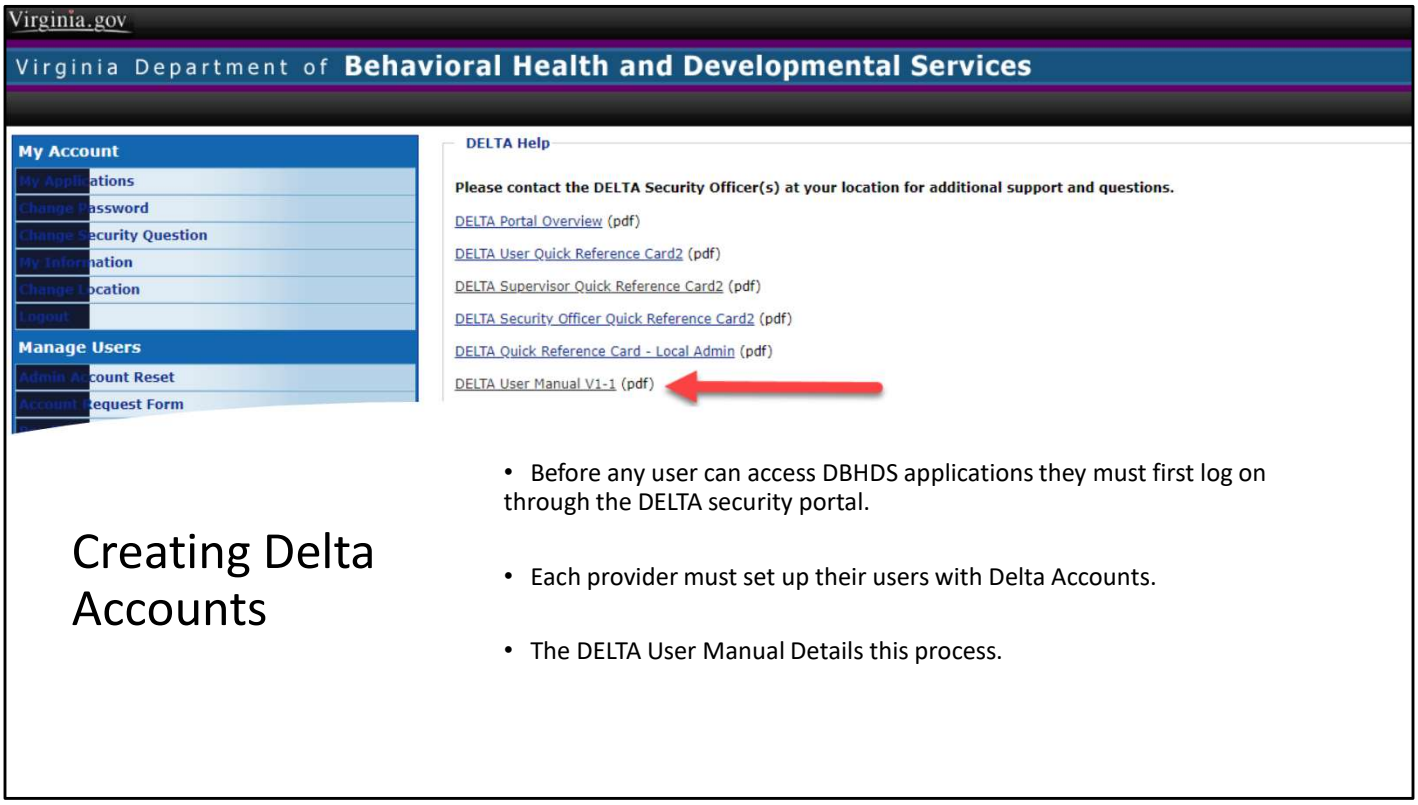
DELTA SUPERVISOR: This person is chosen by the agency head to manage the DELTA accounts for their location. The DELTA Supervisor role is assigned to individuals who are familiar with the agency's employees and their responsibilities, and how those responsibilities relate to the DBHS applications, and know when an employee joins or leaves their organization. DELTA Supervisors request accounts for the users at their location. If a agency's size requires, there may be more than one DELTA Supervisor for that agency.

DELTA SECURITY OFFICER: This person is chosen by the agency head to approve the DELTA accounts for their location. The DELTA Security Officers are able to validate that users have completed annual HIPAA and any other required security training. DELTA Security Officers approve or deny the accounts that have been requested for their location. Security Officers also help users with password resets. If an agency's size requires, there may be more than one DELTA Security Officer at the site.

LOCAL ADMINISTRATOR: This person is selected by the agency head and is the primary contact at an agency for a particular DBHDS application or applications. The Local Administrator is familiar with the application and the access each user of the application needs. Each agency can have one Local Administrator for all DBHDS applications used at their location, or a Local Administrator for each separate application. Once accounts have been requested and approved, the Local Administrator gives the users the application accesses needed to perform their jobs.

DELTA USER: Anyone who uses DBHDS applications to perform a specific job or function is a DELTA User. Users have access only to the particular applications and data needed to complete their jobs. If additional access is needed, the DELTA Supervisor must request a change to the User's account.

- Here are the DELTA Roles. I will not read over each role, but do want to draw your attention to the Delta Security Officer. This is the person at your agency that will help users with password resets when accounts are locked!
- In the event that the appointed security officers are locked out of their accounts, the only other option to unlock those accounts is for the provider to email DeltaProd@dbhds.virginia.gov
- And, for your information, you can find this list of roles in DELTA under Help, titled DELTA Portal Overview.



- What do you need to know about Creating DELTA Accounts?
- First, each provider must set up their user accounts for DELTA.
- Before any user can access the DBHDS applications (CHRIS), you must first long on through the DELTA security portal.
- To review additional information about creating DELTA accounts, access the DELTA user manual available in DELTA Help.
- Also, there is a "DELTA Overview" training posted on the Office of Licensing's webpage, which is another great resource available to you.
- MaryBeth, if you will advance the slide, I will show everyone where this is located on the OL webpage.

Additional DELTA/CHRIS Training

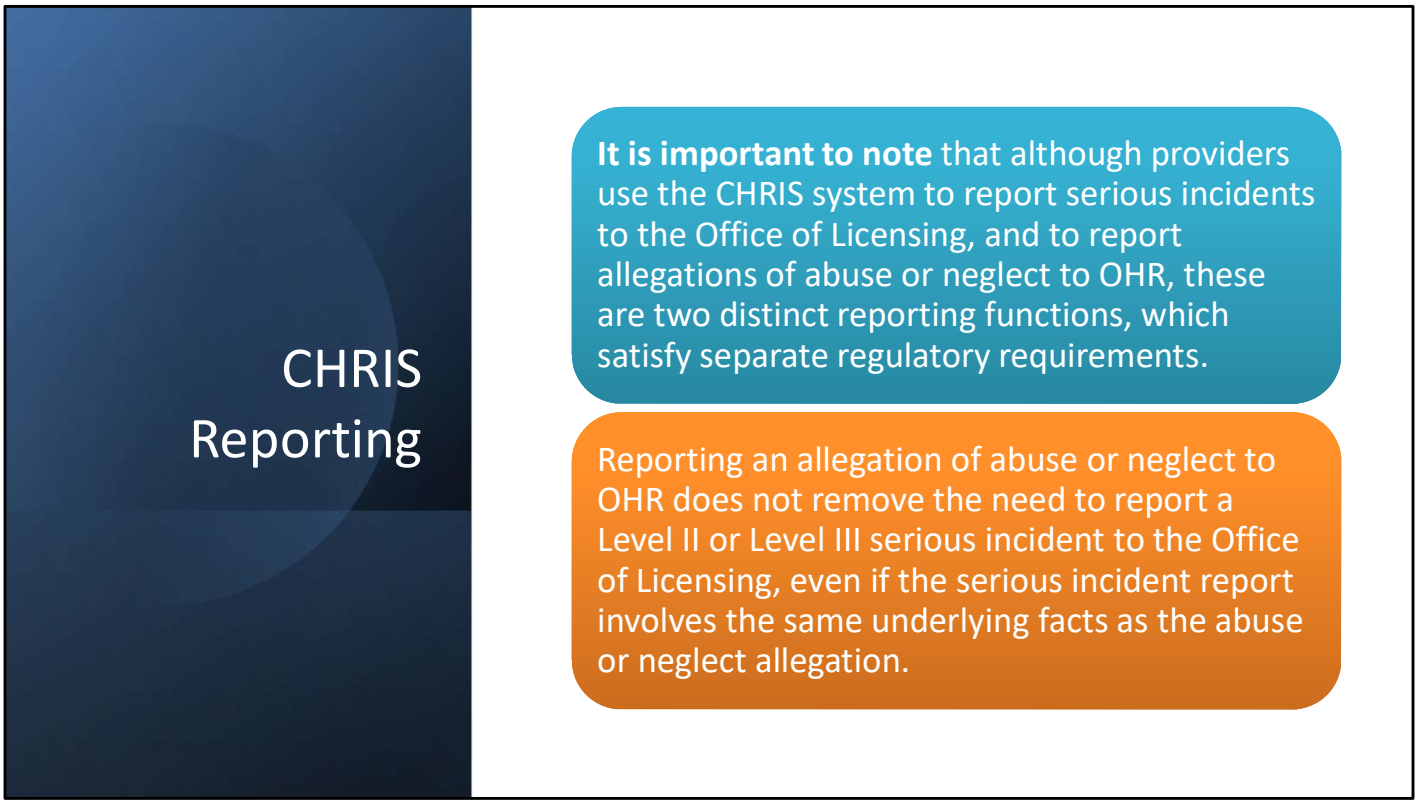
Available on the Office of Licensing Web Page

SERIOUS INCIDENT REPORTING AND CHRIS TRAINING

- Serious Incident Reporting-Covid-19 (December 2022)
- Individual and Systematic Risk – How to Report and Respond to Incidents (April 2022)
- Memo – Revoking A User Access (February 2020)
- CHRIS System Training (May 2021)
- Creating A New Serious Incident Case (August 2019)
- Creating A New Death Case (August 2019)
- Updating A Serious Incident (August 2019)
- Updating A Death Record (August 2019)
- DELTA Overview

- As you can see, trainings are available under Serious Incident Reporting and CHRIS Training.

- In addition to the Delta overview, there are trainings related to entering serious incidents and death reports, revoking a user in Delta and others. Please visit the web page and use these tools that are available to you!



- CHRIS Reporting
- It is important to note that although providers use the CHRIS system to report serious incidents to the Office of Licensing, and to report allegations of abuse or neglect to OHR, these are two distinct reporting functions, which satisfy separate regulatory requirements.
- Reporting an allegation of abuse or neglect to OHR does not remove the need to report a Level II or Level III serious incident to the Office of Licensing, even if the serious incident report involves the same underlying facts as the abuse or neglect allegation.
- Please note that the Office of Licensing is working to ensure any future incident reporting system eliminates the need for double entry.
- Another important fact is that the IMU issues late reporting CAPs for serious incidents reported to the Office of Licensing only. Please keep this in mind when responding to a CAP.

Reporting CHRIS Issues

- If a provider is unable to report a serious incident in CHRIS due to:
  - CHRIS system error (please include a screenshot of the issue a detail description of the issue) or
  - a network outage

❖The provider must notify the Office of Licensing's Incident Management Unit (IMU) via e-mail **within 24 hours of the discovery date** of the incident at incident_management@dbhds.virginia.gov.

❖If provider is unable to access both the CHRIS system and email for reasons outside of the provider's control, then the provider may notify their regional Incident Management Unit (IMU) representative by telephone.

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Reporting CHRIS Issues

- What does a Provider do if they experience issue when trying to report in the CHRIS application?

- If a provider is unable to report a serious incident in CHRIS due to:
  - CHRIS system error (such as a missing location or a runtime error when you save) **OR**
  - a network outage

❖ The provider must notify the Office of Licensing's Incident Management Unit (IMU) via e-mail **within 24 hours of the discovery date** of the incident at incident_management@dbhds.virginia.gov.

❖ If provider is unable to access both the CHRIS system and email for reasons outside of the provider's control, then the provider may notify their regional Incident Management Unit (IMU) representative by telephone.

- For CHRIS system issues please include a screenshot of the issue a detailed

description of the issue. This will save both of us time!

12VAC35-105-520.D

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

Care Concerns (Last Revised 1/1/2023)

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- Care Concerns
- We learned about care concerns in Session I. Specifically, The regulations states that "**The systemic risk assessment shall incorporate uniform risk triggers and thresholds as defined by the department."**
- The DBHDS Incident Management Unit (IMU) will triage any incidents that fall into the care concern categories to the Office of Human Rights (OHR) and/or Office of Integrated Health (OIH) for review and follow up.
- Incident reports designated as care concerns will be triaged to the **assigned Licensing Specialist for investigation only** if the IMU determines from a review of the incident report that individuals served may be at an imminent risk of harm or if there are any outstanding regulatory concerns after the OHR/OIH review is complete.

Care Concern Thresholds Criteria Effective 1/1/2023

Visit the Office of Licensing Web page for Care Concern resources: https://dbhds.virginia.gov/quality-management/Office-of-Licensing/

Care Concern Thresholds Criteria 2023
A. Multiple (Two or more) unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day time-frame for any reason.
B. 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.
C. Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR.
D. Multiple (Two or more) unplanned psychiatric admissions within a ninety (90) day time-frame for any reason.

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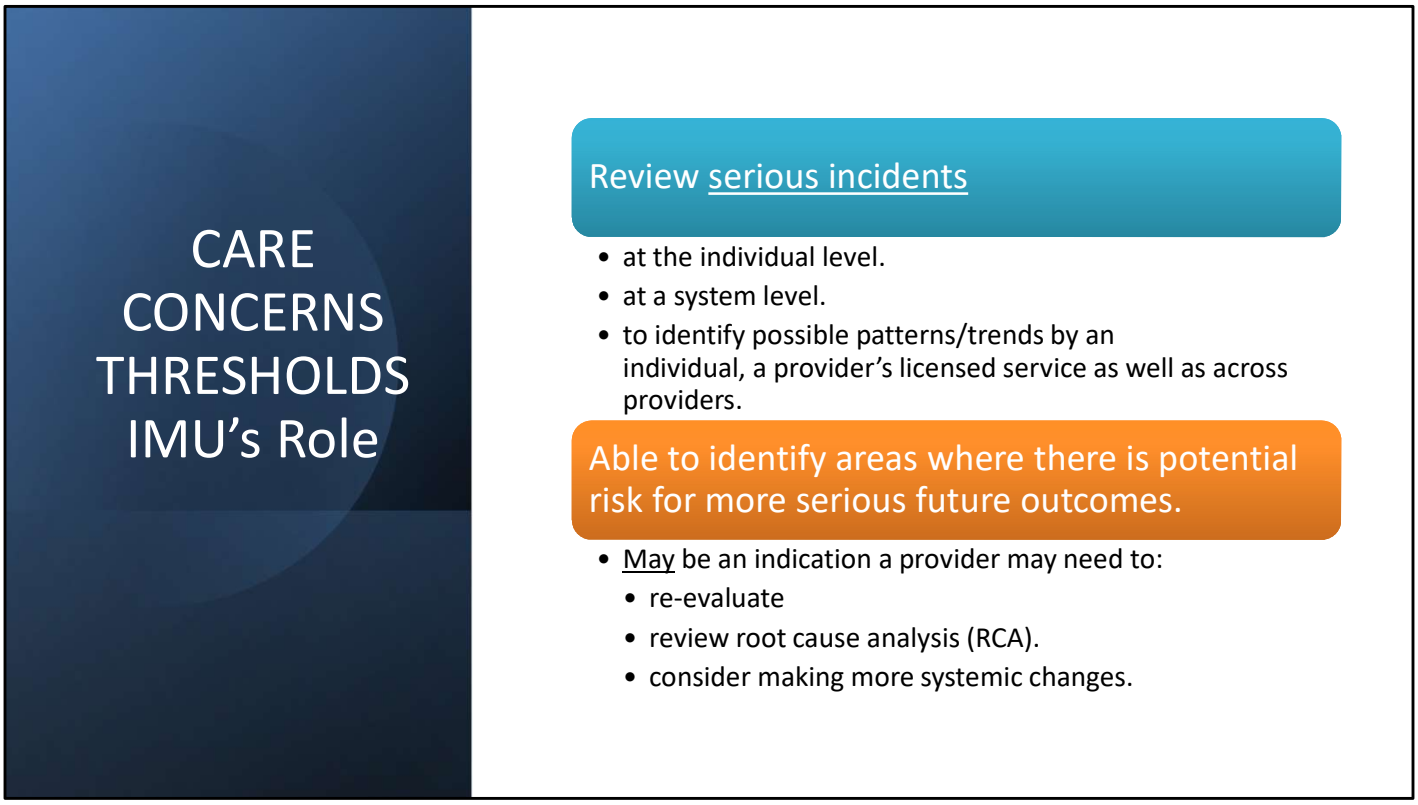
- As we mentioned during the last session, there are currently 4 Care Concern Thresholds Criteria identified by DBHDS. Let's review that criteria.
  - Criteria A. Multiple (Two or more) unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day time-frame for any reason.
  - Criteria B. 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.
  - Criteria C. Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR.
  - Criteria D. Multiple (Two or more) unplanned psychiatric admissions within a ninety (90) day time-frame for any reason.
- Please, visit the Office of Licensing web page for Care concern Resources including: 2023 Care Concern Threshold Criteria Memo, IMU Care Concern PowerPoint Training, Risk Triggers and Threshold Handout



- The IMU reviews serious incidents not only on an individual level but systematically as well to identify possible patterns/trends by individuals, a provider's licensed service, and across providers.

- Through this review, the IMU can identify areas, based on serious incidents, where there is potential risk for more serious future outcomes.

- When care concerns thresholds are met it may be an indication a provider may need to re-evaluate an individual's needs and supports, review the results of their root cause analysis or even consider making more systemic changes.

Role of OHR and OIH

- OHR is notified, by the IMU, of individual care concerns that indicate the possibility of the potential for abuse/neglect.
- OIH is notified, by the IMU, of individual care concerns that indicate a potential for a health and safety concern.

Why?

- To determine if it would be helpful to follow up with provider to offer information, training, resources or technical assistance.
- It does not mean the provider has done anything wrong.
- It is a way of sharing information and ensuring providers are aware of trends we are seeing at the state level.

- The OHR is copied on care concerns when there is a possibility that the concern may indicate the potential for abuse/neglect. The OHR will assess if there is a need to follow-up to get more information or to provide TA.

- The same thing occurs when a care concerns indicates a potential for a health and safety concern. The OL shares the care concern with the OIH who assesses the need to follow up with provider to offer information, training, resources or technical assistance.

- Having OHR or OIH contact you about a care concern does not mean you have done something wrong, it is our internal way of sharing information and ensuring providers are aware of trends we are seeing at the state level. Please remember we have new providers, old providers, frequently changing provider staff and we want to make sure we can share information with you all as

appropriate.

Care Concern Thresholds – What it is NOT

Doesn't necessarily mean there is a provider concern.

- Individuals with higher needs may have a higher number of incidents.

Doesn't always equate to an investigation.

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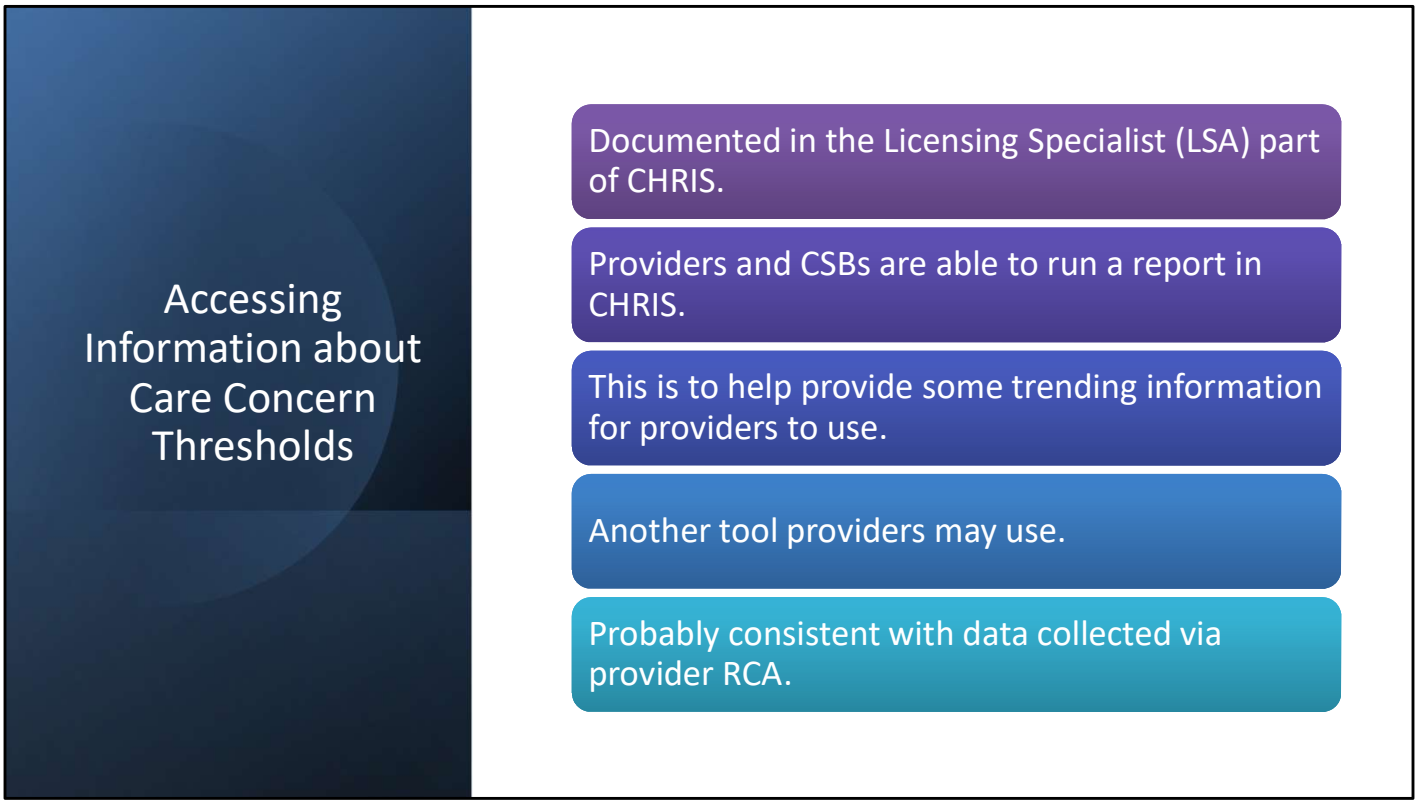
- Now we realize that providers who take individuals with higher needs may have a higher number of incidents just because an individual may be at higher risks for incidents/injuries that may result in events such as medical or psychiatric hospitalizations.
- So just because an incident meets a care concern threshold does not mean that there is concern a provider is not doing what they are supposed to be doing.
- In addition, there are times when a care concern may also become a general concern for the OL and then the concern is passed along to a specialist to determine if there is a need to open an investigation but this is not necessarily always the case.

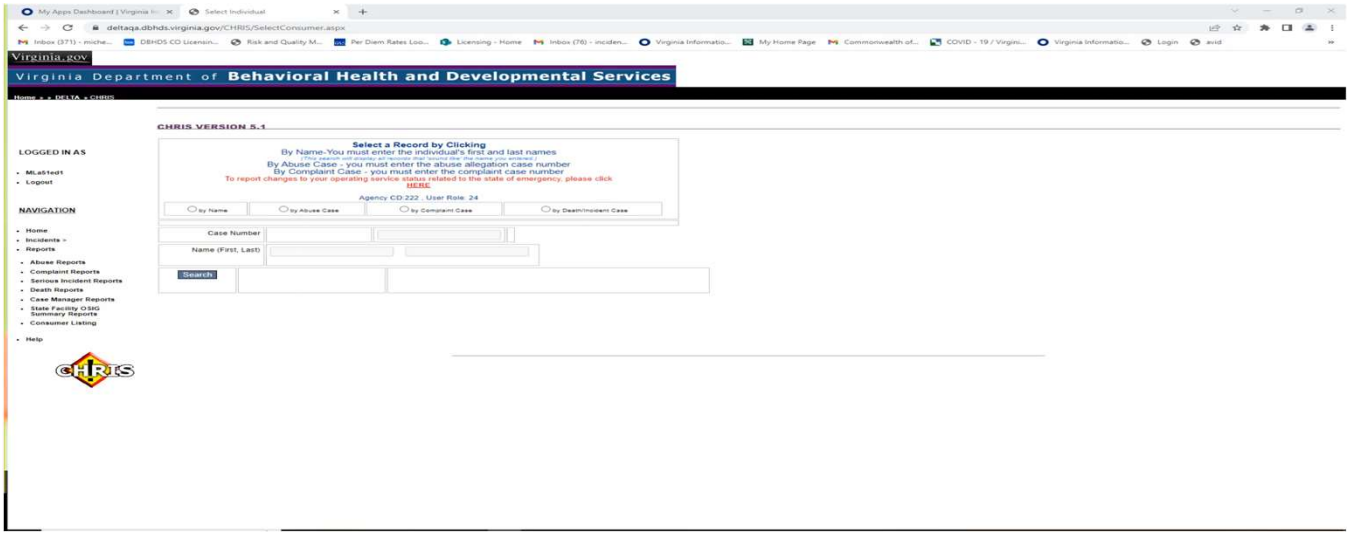


- IMU shares the information with providers by putting information into the LS Action part of CHRIS. Also providers are able to run a report in CHRIS to see which individuals have met care concern criteria. This is to help provide some trending information for providers to use.

- This is just another tool providers may use to assess if an individual is getting supports they need or if there may be a need to be some changes on an individual or a provider level.

- This may very likely mirror when a provider has determined to conduct a more detailed RCA in accordance with our regulations and their own RCA policy

Care Concern Threshold Report Video



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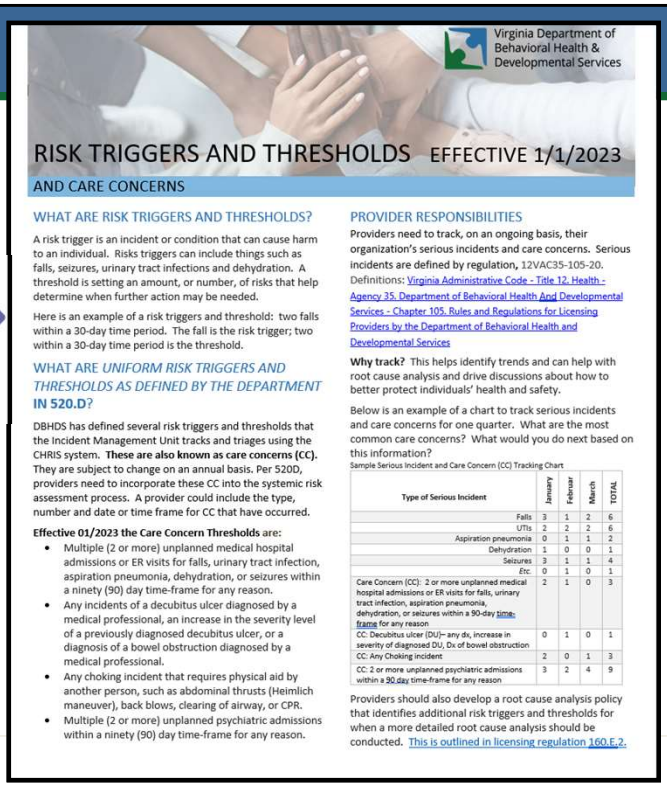
- Now we will watch a short video about How to Find the Individual Care Concern Report in CHRIS for Providers (*Serious Incident Reports) and Case Managers (*Case Manager Reports).
- Just to let you know, if you have not reviewed the Care Concern Threshold Training, this video is also included in that power point.
- Click the play button to watch video.

Quick Reference Handout

New Tool! Risk Triggers and Threshold Handout

This is a one-page, quick reference guide for providers that list the Care Concern Thresholds, provides links to regulation and an example tracking chart.



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RISK TRIGGERS AND THRESHOLDS EFFECTIVE 1/1/2023

AND CARE CONCERNS

WHAT ARE RISK TRIGGERS AND THRESHOLDS?

A risk trigger is an incident or condition that can cause harm to an individual. Risks triggers can include things such as falls, seizures, urinary tract infections and dehydration. A threshold is setting an amount, or number, of risks that help determine when further action may be needed.

Here is an example of a risk triggers and threshold: two falls within a 30-day time period. The fall is the risk trigger; two within a 30-day time period is the threshold.

WHAT ARE *UNIFORM RISK TRIGGERS AND THRESHOLDS AS DEFINED BY THE DEPARTMENT* IN 520.D?

DBHDS has defined several risk triggers and thresholds that the Incident Management Unit tracks and triages using the CHRIS system. **These are also known as care concerns (CC).** They are subject to change on an annual basis. Per 520D, providers need to incorporate these CC into the systemic risk assessment process. A provider could include the type, number and date or time frame for CC that have occurred.

Effective 01/2023 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.

PROVIDER RESPONSIBILITIES

Providers need to track, on an ongoing basis, their organization's serious incidents and care concerns. Serious incidents are defined by regulation, 12VAC35-105-20. Definitions: Virginia Administrative Code - Title 12. Health - Agency 35. Department of Behavioral Health And Developmental Services - Chapter 105. Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services

Why track? This helps identify trends and can help with root cause analysis and drive discussions about how to better protect individuals' health and safety.

Below is an example of a chart to track serious incidents and care concerns for one quarter. What are the most common care concerns? What would you do next based on this information?

Sample Serious Incident and Care Concern (CC) Tracking Chart

Type of Serious Incident	January	Februar	March	TOTAL
Falls	3	1	2	6
UTIs	2	2	2	6
Aspiration pneumonia	0	1	1	2
Dehydration	1	0	0	1
Seizures	3	1	1	4
Etc.	0	1	0	1
Care Concern (CC): 2 or more unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a 90-day time-frame for any reason	2	1	0	3
CC: Decubitus ulcer (DU)– any dx, increase in severity of diagnosed DU, Dx of bowel obstruction	0	1	0	1
CC: Any Choking incident	2	0	1	3
CC: 2 or more unplanned psychiatric admissions within a 90 day time-frame for any reason	3	2	4	9

Providers should also develop a root cause analysis policy that identifies additional risk triggers and thresholds for when a more detailed root cause analysis should be conducted. This is outlined in licensing regulation 160.E.2.

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- Let's look at a New Tool. This is the Risk Triggers and Threshold Handout. Marybeth, will open the link so we can take a closer look. This information will be posted on the Website.

- Essentially, this is a one-page, quick reference tool for providers that list the Care Concern Thresholds, provides links to regulation and an example tracking chart. Hopefully, this a great resource for you! We wanted to design something you could easily assess and possible add to you desktop/computer just as a reminder.

Now we have one more poll question for you!

Poll Question

- True or false?
- Providers don't need to track care concerns because the IMU will alert the provider when there is a care concern.
- True
- False 

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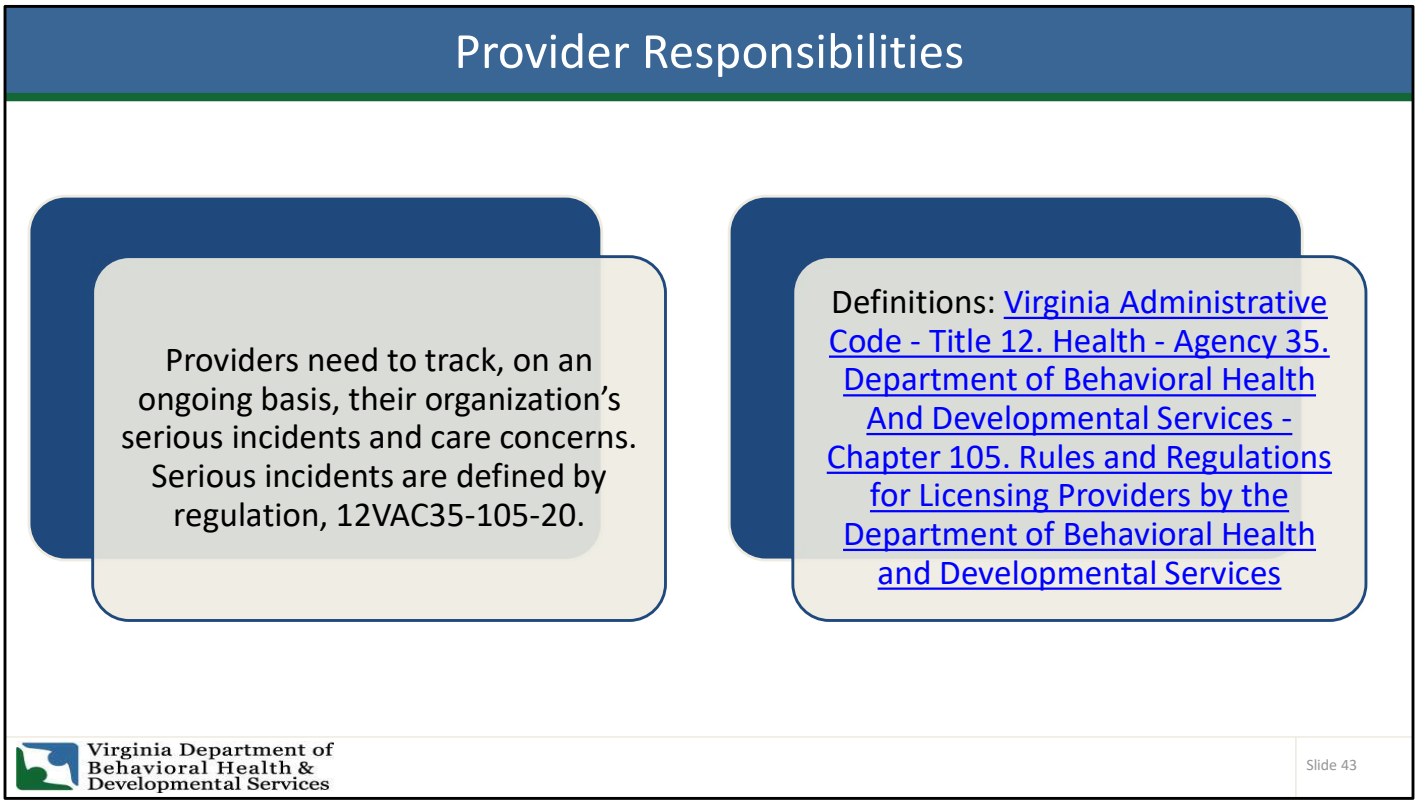
This statement is false. Providers DO Need to track care concerns.



- We have talked about reporting including what to report, how to report, care concerns and all that other good stuff. Now, what do you do with it? What are your responsibilities? Any guesses? Oh, come on, no need to be a Nancy Drew or Sherlock Holmes to guess this.

- You MUST track, on an ongoing basis, serious incidents and care concerns.

Why track?

- To identify trends.
- To support or identify the need for Root Cause Analysis.
- To promote discussions about how to better protect individuals' health and safety.

Sample Serious Incident and Care Concern (CC) Tracking Chart

Cause / Type of Serious Incident	January	February	March	TOTAL
Falls	3	1	2	6
UTIs	2	2	2	6
Aspiration pneumonia	0	1	1	2
Dehydration	1	0	0	1
Seizures	3	1	1	4
Etc.	0	1	0	1
Care Concern (CC): 2 or more unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a 90-day time-frame for any reason	2	1	0	3
CC: Decubitus ulcer (DU)– any dx, increase in severity of diagnosed DU, Dx of bowel obstruction	0	1	0	1
CC: Any Choking incident	2	0	1	3
CC: 2 or more unplanned psychiatric admissions within a 90 day time-frame for any reason	3	2	4	9

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- Why? Why do all this work?
- It's simple. Incident Management is a tool.
- Incidents can be reviewed for trends, patterns and causation. This will give you, as the provider, the opportunity to discuss risk areas and how to mitigate these risks.
- Some questions to ask could include: What are the most common care concerns? What would you do next based on the information gathered? You get the point.
- Overall, it is important to protect individual's' health and safety to fullest extent possible. Tracking incident and relevant information, promotes discussions about how best to do this.

12VAC35-105-160.E.2

Providers shall develop a root cause analysis policy that identifies additional risk triggers and thresholds for when a more detailed root cause analysis should be conducted.

This is outlined in licensing regulation 160.E.2.

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- Another responsibility is defined in regulation 160.E.2.
- Providers must develop a root cause analysis policy that identifies additional risk triggers and thresholds for when a more detailed root cause analysis should be conducted.
- You will be hearing more about this in just a few minutes, so stay tuned.

Contacts and Resources

OIH Health & Safety Alerts, Newsletters, Community Nursing Meeting Agendas, Information on MRE, Dental, and Community Nursing are located on the DBHDS website under the Office of Integrated Health @ https://dbhds.virginia.gov/office-of-integrated-health/. There are additional resources related to common medical concerns for the ID/DD population including Health Risk PPTs under the Educational Resources tab under this same link.

OFFICE OF LICENSING CONTACT INFORMATION

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

- What else do you need to know?

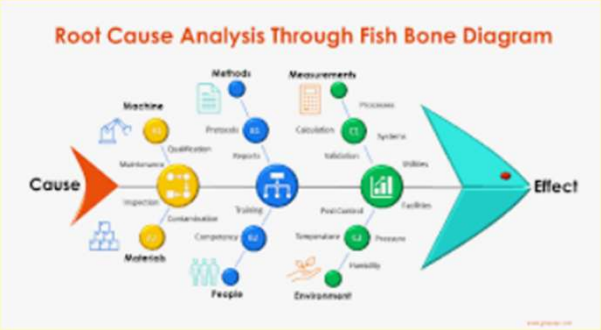
- Know this...there are additional resources beyond what is provided on the Office of Licensing web page to support you.

- The OIH Health & Safety Alerts, Newsletters, Community Nursing Meeting Agendas, Information on MRE, Dental, and Community Nursing are located on the DBHDS website under the Office of Integrated Health @ https://dbhds.virginia.gov/office-of-integrated-health/. There are additional resources related to common medical concerns for the ID/DD population including Health Risk PPTs under the Educational Resources tab under this same link.

- Also, as references earlier, Office of Licensing Contact Information is posted on the Department's website under the Office of Licensing Contact Information

Incident Management Unit Regional Contact

Root Cause Analysis (RCA) and Thresholds



Mackenzie Glassco,
Associate Director of Quality
and Compliance
Office of Licensing

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- You all just heard a presentation from Michele where she talked about serious incidents and CHRIS, but she also provided additional information related to those risk triggers and thresholds, also known as care concerns.
- Since the term "threshold" is also referenced in other regulations we thought it might be helpful to discuss those further.
- If you're familiar with the regulations related to root cause analysis then you know that thresholds are a requirement of a provider's root cause analysis policy
- With that being said, we're going to take a few minutes to discuss the requirements related to a root cause analysis then move on to the root cause analysis policy.

Guidance

- LIC 16: Guidance for A Quality Improvement Program (November 2020)
- LIC 17: Guidance for Serious Incident Reporting (November 2020)
- LIC 18: Individuals with Developmental Disabilities with High Risk Health Conditions (June 2020)
- LIC 19: Corrective Action Plans (CAPs) (August 2020)
- LIC 20: Guidance on Incident Reporting Requirements (August 2020)
- LIC 21: Guidance for Risk Management (August 2020)

Root Cause Analysis – 12VAC35-105-160.E.2

• *Sample(s)*

- Sample Root Cause Analysis Policy (February 2022)

• *Training(s)*

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

• *FAQs*

- Root Cause Analysis Q&A's (Updated July 2022)

Don't forget to sign up for constant contact. Stay informed!

- Before we continue, I want to remind you that the Office of Licensing's website includes training, technical assistance and guidance documents related to root cause analysis.
- The guidance for serious incident reporting provides additional information related to RCA's Remember that providers who follow guidance are more likely to be in compliance.
- Don't forget to subscribe to the email list so that you can stay informed.

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.

Root Cause Analysis (RCA): 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.

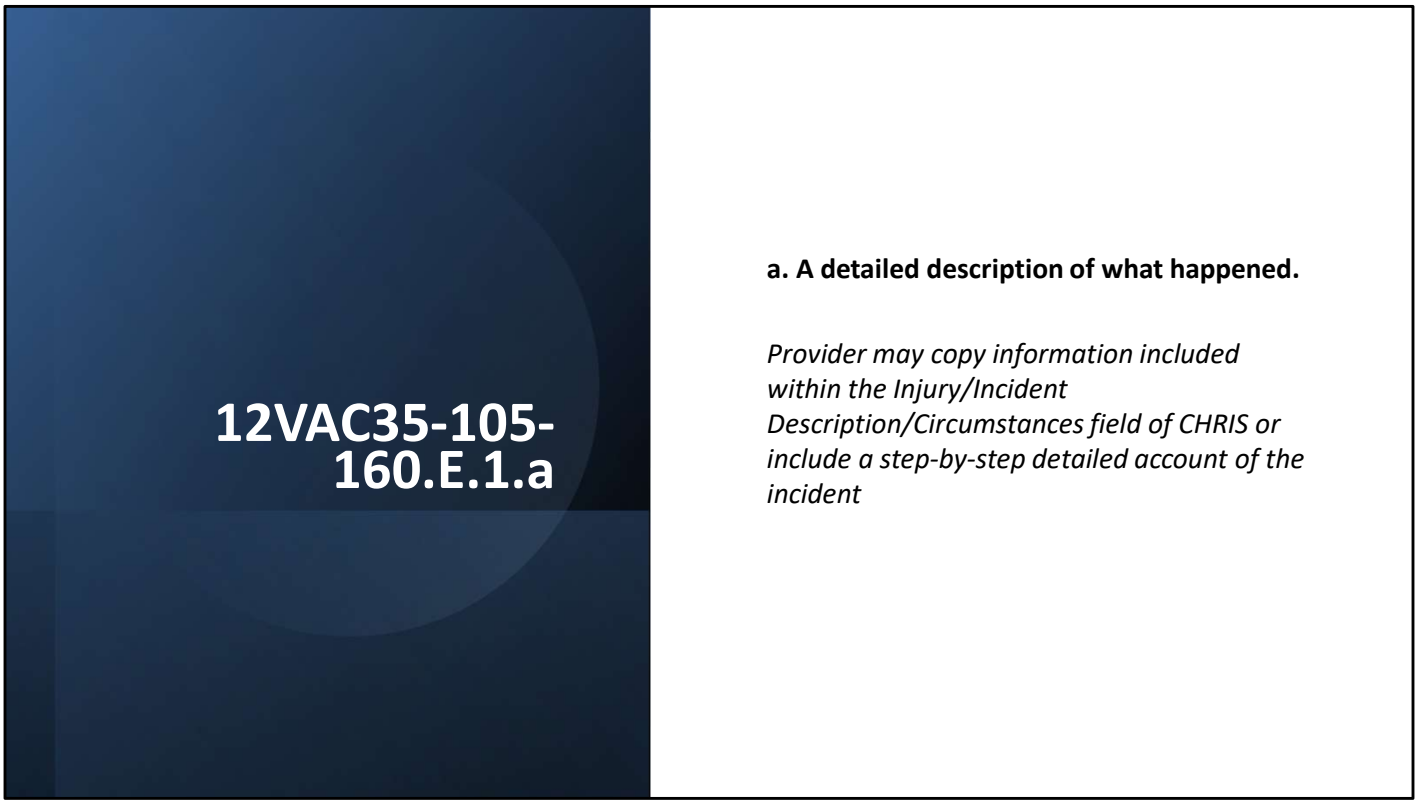
1. The root cause analysis shall include at least the following information:
   a. A detailed description of what happened;
   b. An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and
   c. Identified solutions to mitigate its reoccurrence and future risk of harm when applicable.

- **Root Cause Analysis (RCA) - is a method of problem solving used 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.**

- A root cause analysis does not focus on the people involved but focuses on systems, processes, and outcomes.
- The goal of a root cause analysis is to find out what happened, why it happened, and determine if action needs to be taken.
- A root cause analysis, as required in these regulations; should include, at a minimum, documentation that the three elements were considered to the extent that they are known, or could be known by the provider.

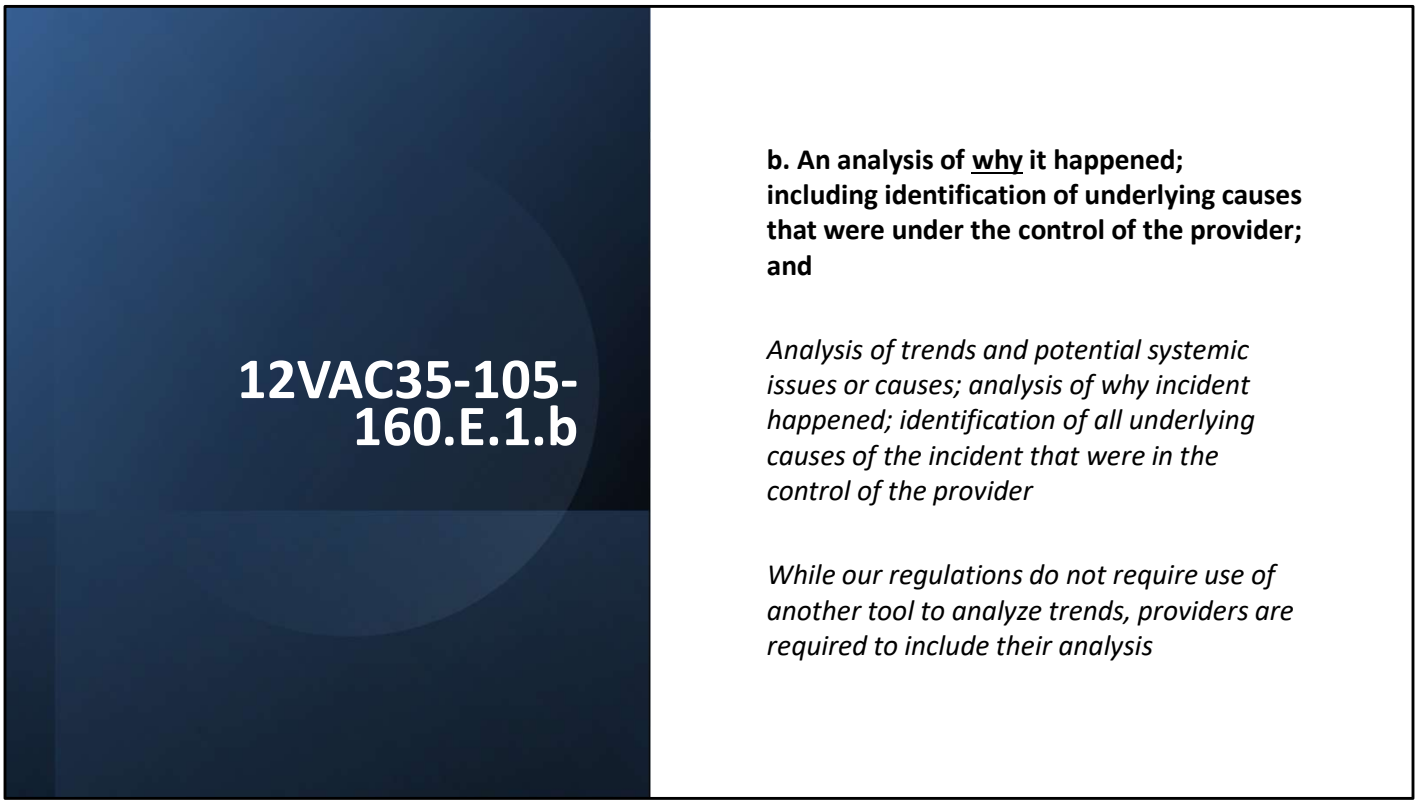
- In a few minutes, I'll be introducing the Serious Incident Review_Root Cause Analysis Template.

- If your organization choses not use this template, then you must ensure that the root cause analysis meets the regulatory requirements as outlined in 160.E.1.a, b and c.



Always begin by making sure all three minimum requirements are covered.
Let's start with 160.E.1.a:

- A detailed description of what happened – A provider can start with the incident report which provides date, time, place, individuals involved, and a description of what happened. This should also include what immediate actions were taken. This initial sequence of events helps identify what occurred. Often it is a chain of events that resulted in an incident.
- If more than one staff member was involved, each staff member could write what happened from their perspective. It is possible that others may have seen something even if they were not directly involved in the incident (i.e. they saw something from the window).



- This second minimum requirement is where the work begins, 160.E.1.b.

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

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

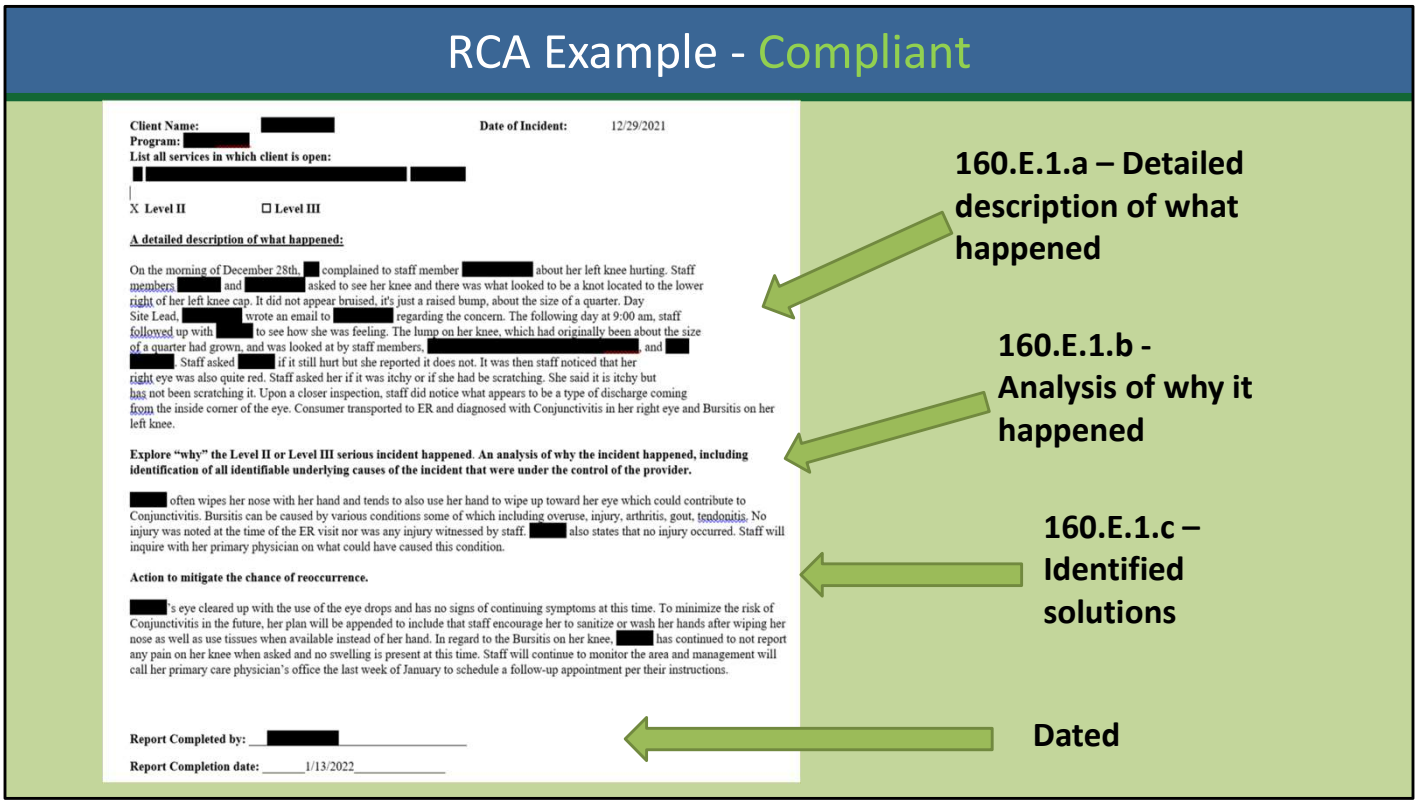
12VAC35-105-160.E.1.c

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

Solutions to mitigate the potential for future incidents

- The whole purpose of a root cause analysis is to prevent reoccurrence. The question is “what should we do to prevent this in the future?” **not** “What should we have done to prevent this from having occurred?”
- Mitigating future risk is the most important question providers can ask as a part of their incident reporting, risk management, and quality improvement process.
- The root cause analysis should identify solutions, as applicable, to be taken by the provider to keep the situation from occurring again or minimize the likelihood of its reoccurrence and future risk of harm when applicable. Then the identified solutions to mitigate its reoccurrence should be implemented.
- These solutions should be both individual-specific and systemic as indicated by the analysis of the incident.
- Implementation of solutions and their efficacy could be monitored as part of the provider’s quality improvement program.

RCA Example - Compliant

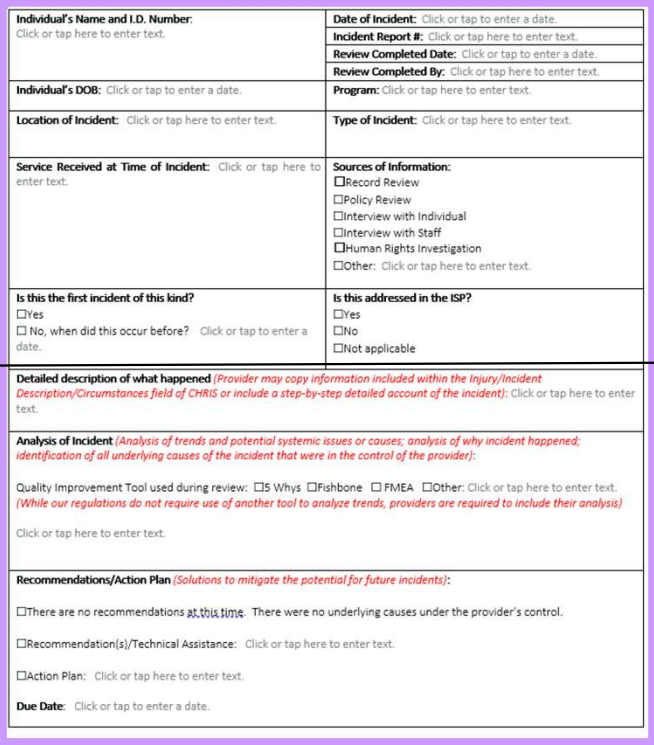


- Here's an example of a root cause analysis that was determined to be compliant with the regulations
- First off, there is a section for the provider to address each regulatory requirement. It also includes a signature line and a section to enter the date of completion
- It includes a detailed description of *what* happened so the provider would be marked compliant with 160.E.1.a
- It includes an analysis of *why* it happened so the provider would be compliant with 160.E.1.b
- It also includes a list of *identified solutions* so the provider would be marked compliant with 160.E.1.c.
- AND I want to emphasize that it is dated.
- It is important for you to know that if this provider had not dated their root cause analysis then they would have been marked non-compliant for 160.E.1.a, 160.E.1.b and 160.E.1.c.

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

- Introducing the Serious Incident Review and Root Cause Analysis Template: *This template was completed in accordance with regulation 12VAC35-105-160.*
- The 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
- You're not required to use this template; however, utilization of this template will assist providers in achieving compliance with the regulatory requirements of 12VAC35-105-160.
- Mary Beth, please open the link to the tool.
- As you can see, there are several sections that are required to be completed. Let's close this out and move to the next slide so that we can discuss each section in further detail.



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.

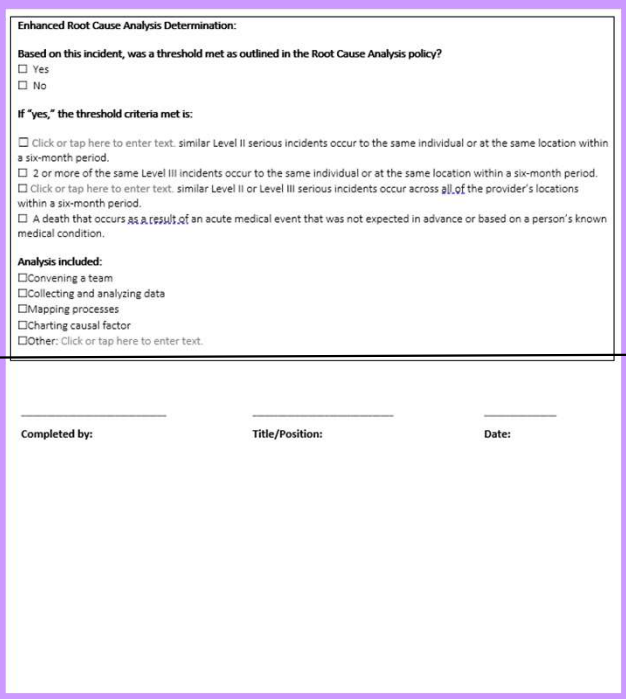
This section of the template is for your root cause analysis.
160.E.1.a: . A detailed description of what happened
160.E.1.b: An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider
160.E.1.c: Identified solutions to mitigate its reoccurrence and future risk of harm when applicable

- The top half of the template is where the provider enters the individual's information, incident date, report number which may be the CHRIS number or an internal report number, name of the person completing the form, date the form is completed, the type of incident and the provider can identify sources of information. It also includes sections to indicate whether this was the first incident of it's type and if this is being addressed in the ISP.

- This bottom half of the template is where you complete the root cause analysis. You will need to address all of the regulatory requirements outlined in 160.E.1.a, 160.E.1.b and 160.E.1.c.

- Regarding 160.E.1.b, when analyzing the incident our regulations do not require use of another QI tool such as the 5 Whys, Fishbone diagram or Failure Mode and Effects Analysis, just to name a few. However, the provider is required to include their analysis.

- Some tools are very detailed and complex, but they all focus on one simple approach – asking questions.



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.

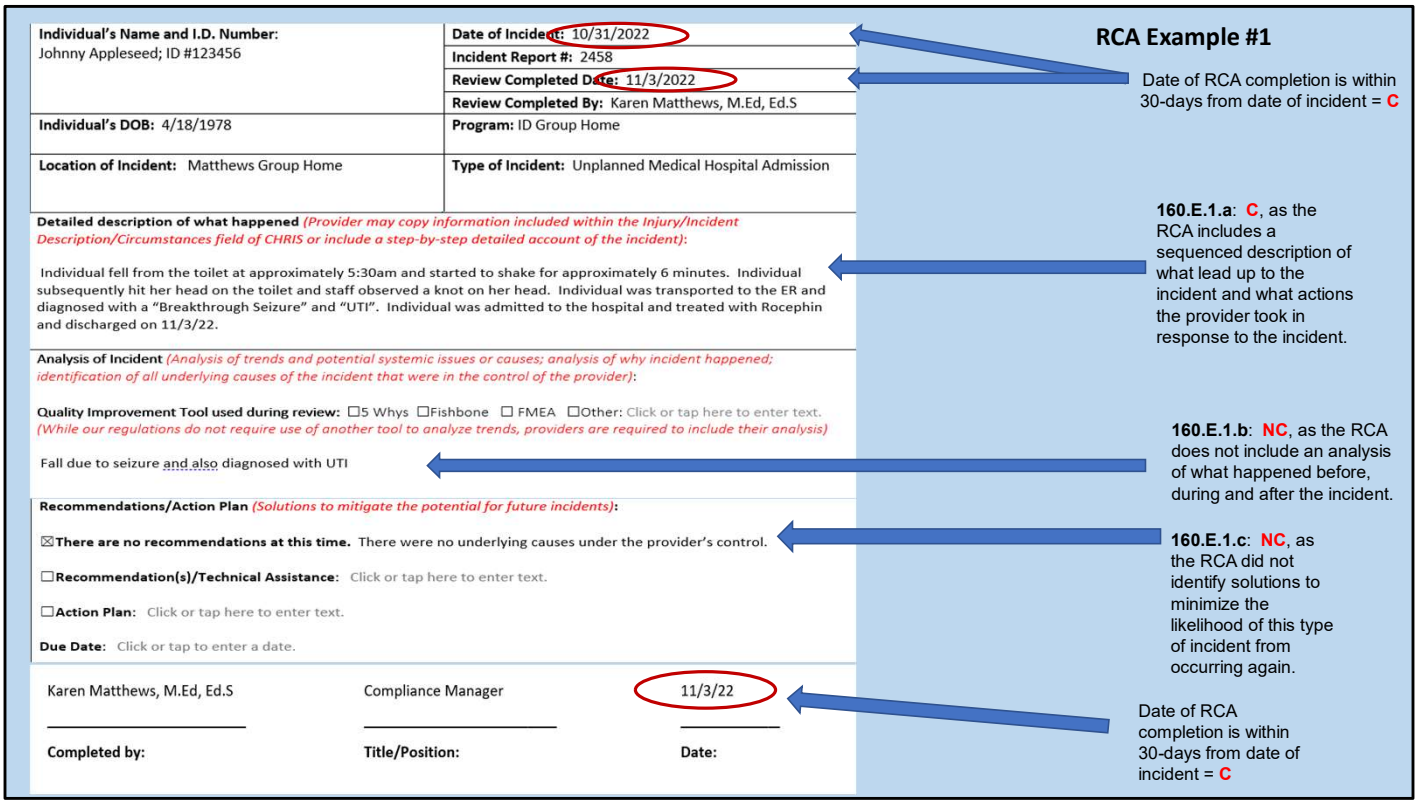
This section requires the signature of the person who completed the form, their title or position and the date completed.

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

- The Enhanced Root Cause Analysis Determination 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 when we talk about the RCA policy requirements.
- As you can see there is also a signature line for the person who completed the form, a line for their title or position to be entered and a section for the date completed.
- Remember, 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.
- Whether you chose to use this template or not, make sure your Root Cause Analysis is dated!

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

- A root cause analysis begins with the assumption that no one comes to work intending to make a mistake or to hurt someone. People make mistakes but awareness of errors is important in terms of improving systems. To develop a culture of safety, staff should be encouraged to report errors without fear of retribution and to look for ways to improve systems.
- That's not to say that a root cause analysis never uncovers intentional acts of harm. That may happen and when it does, you must take the appropriate action.
- Now let's take a look at a few examples using this new tool

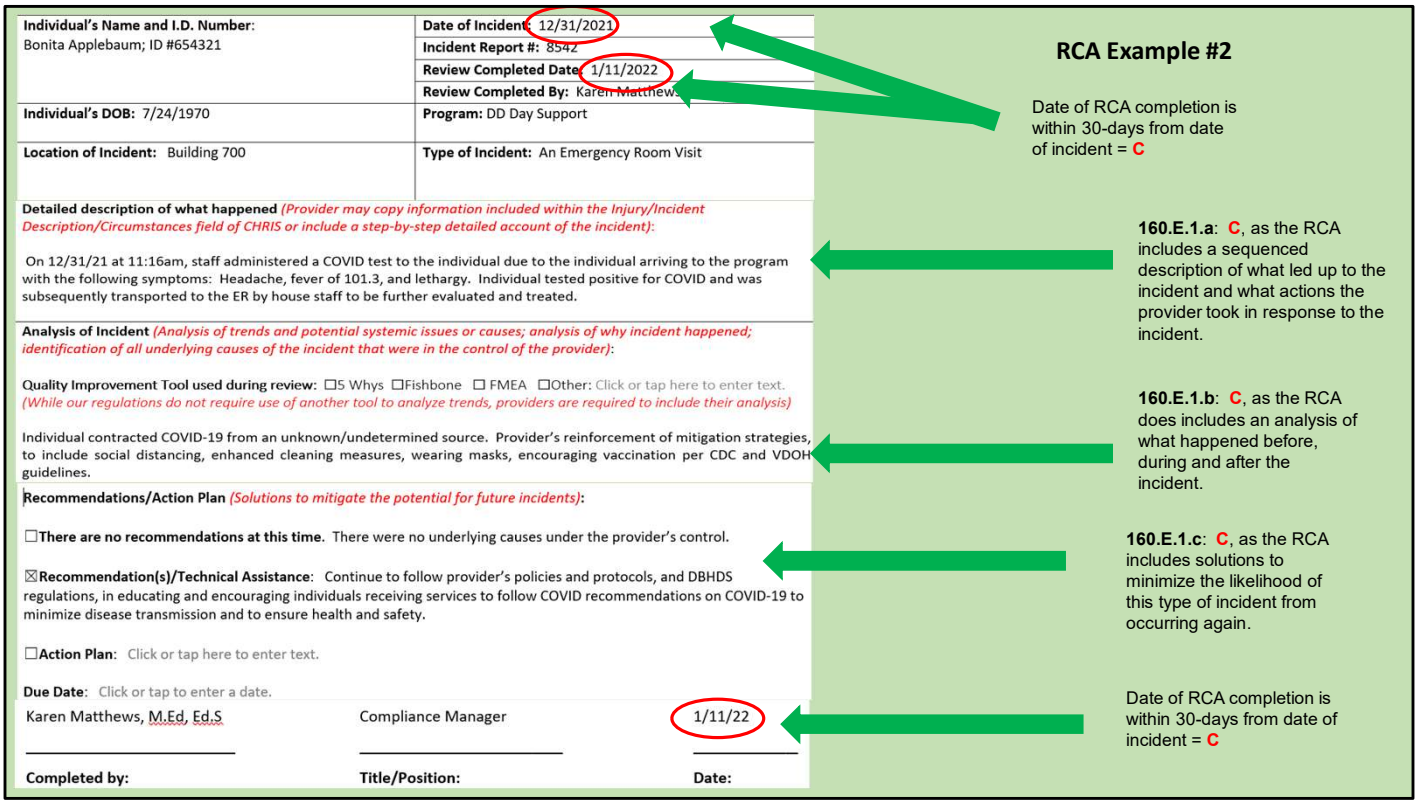


As you can see, the provider's RCA is dated and it was completed within 30 days of discovery of the incident

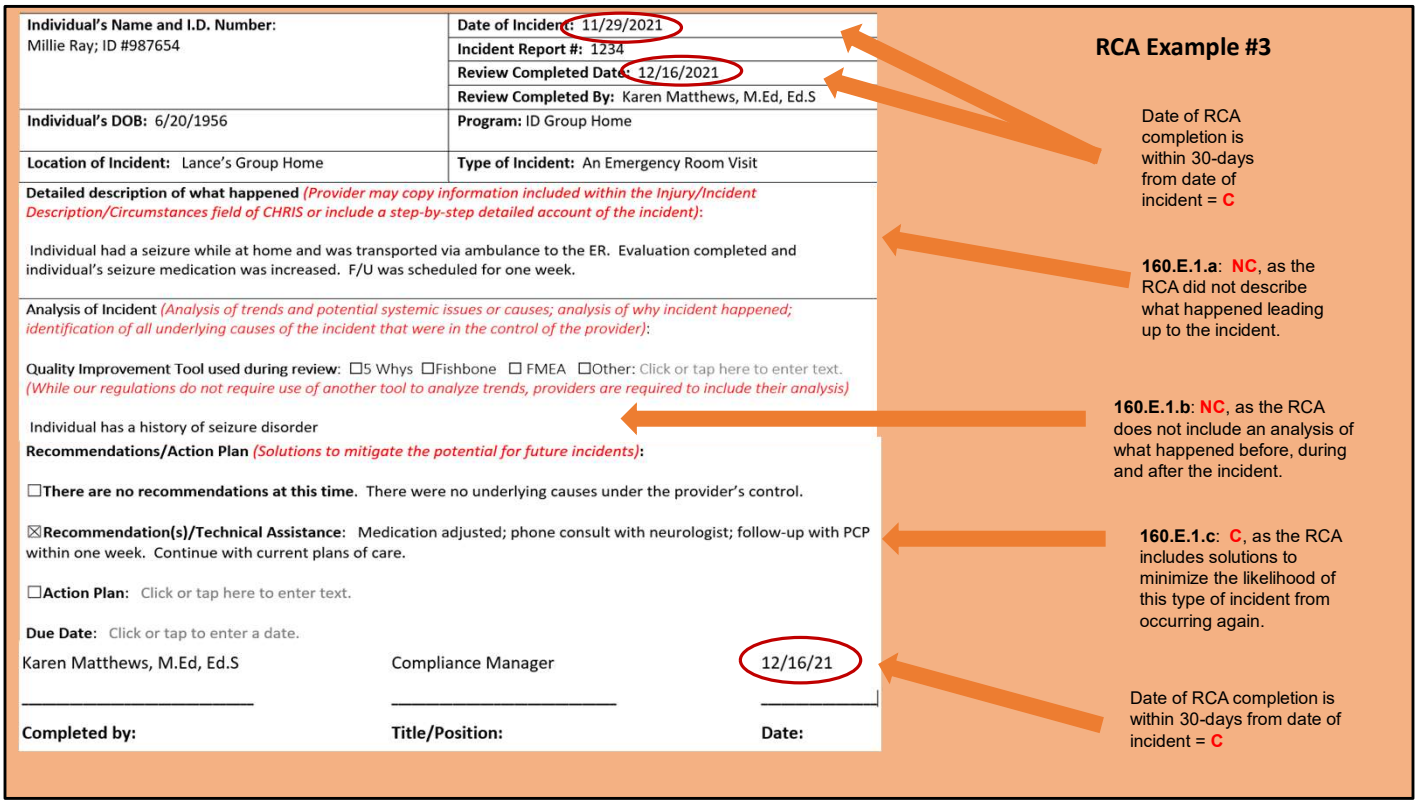
It includes a sequenced description of what led up to the incident and what actions the provider took in response to the incident.

However, it does not include an analysis of what happened before, during and after the incident.

Nor does it identify solutions to minimize the likelihood of this type of incident from occurring again.



- As you can see, this RCA was also a completed within 30 days of discovery of the incident.
- It includes a sequenced description of what led up to the incident and what actions the provider took in response to the incident.
- It includes an analysis of what happened before, during and after the incident.
- And it includes solutions to minimize the likelihood of this type of incident from occurring again.
- Keep in mind that if this provider had not completed this RCA within 30 days of discovery of the incident then they would have been marked non-compliant for each of the three regulatory requirements even though all areas were addressed.



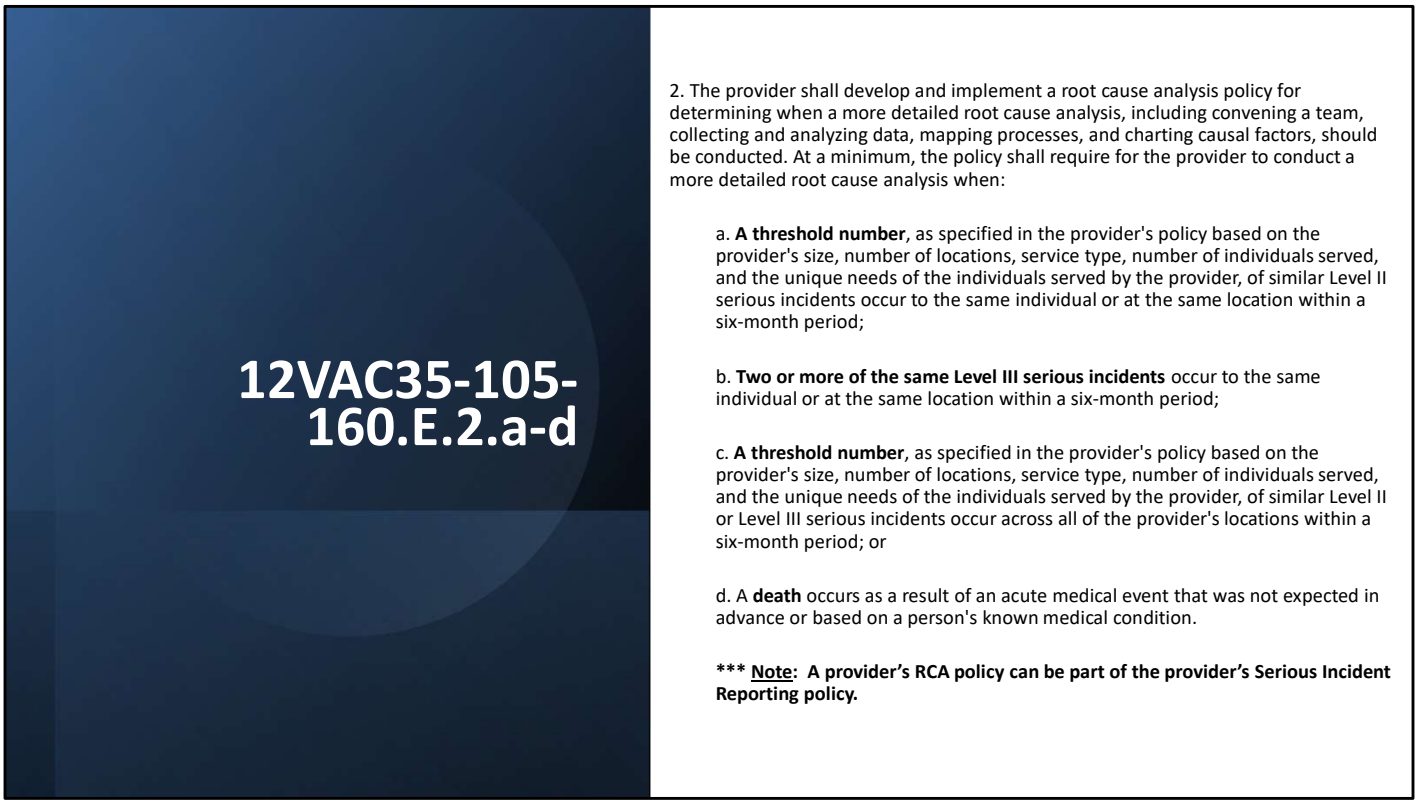
Let's take a look at the last example

- This RCA was completed within 30 days of discovery and it includes solutions to minimize the likelihood of this type of incident from occurring again.
- However, the provider did not fully describe what happened leading up to the incident nor did they include an analysis of what happened before, during and after the incident.

Root Cause Analysis Policy

Now that we've reviewed the requirements for a root cause analysis, let's move on the root cause analysis policy.

This is where, in the regulations, you also see the term, "threshold."



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

- The term threshold, as it relates to 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.

- 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.

- Once this threshold number has been met, then the provider is responsible for conducting a more detailed root cause analysis of these incidents that resulted in meeting the threshold.

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

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

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

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

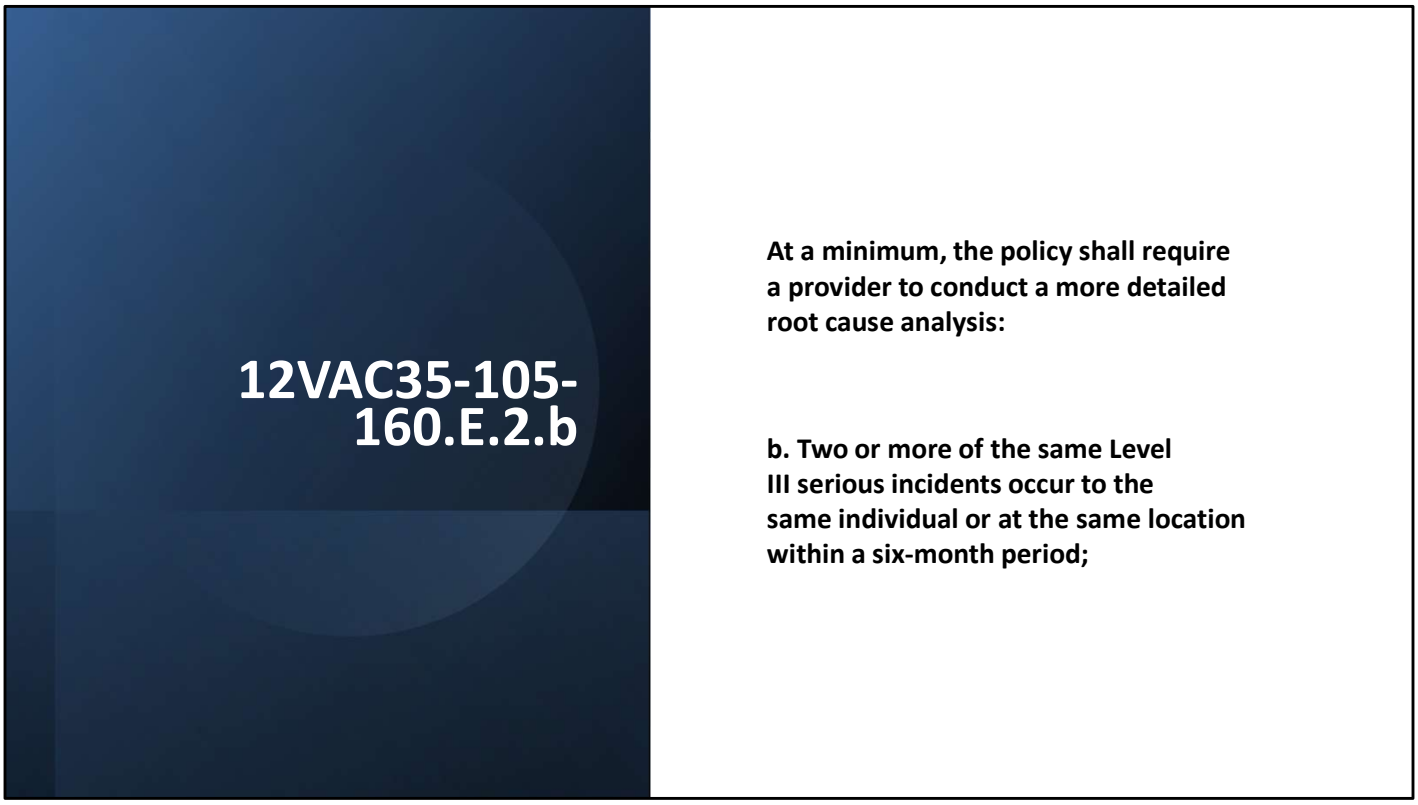
a. A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents occur to the same individual or at the same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

- 160.E.2.a

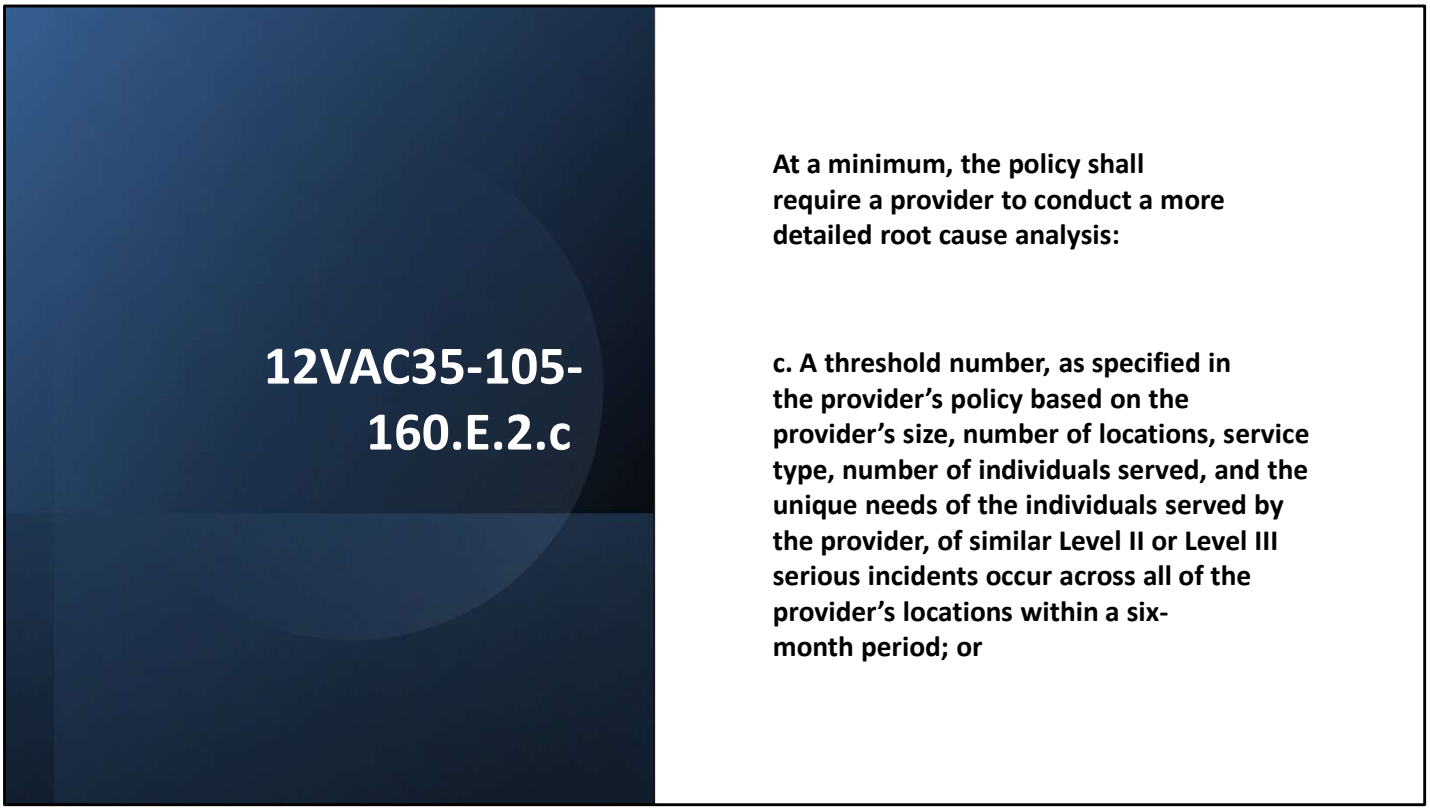
- At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when:

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

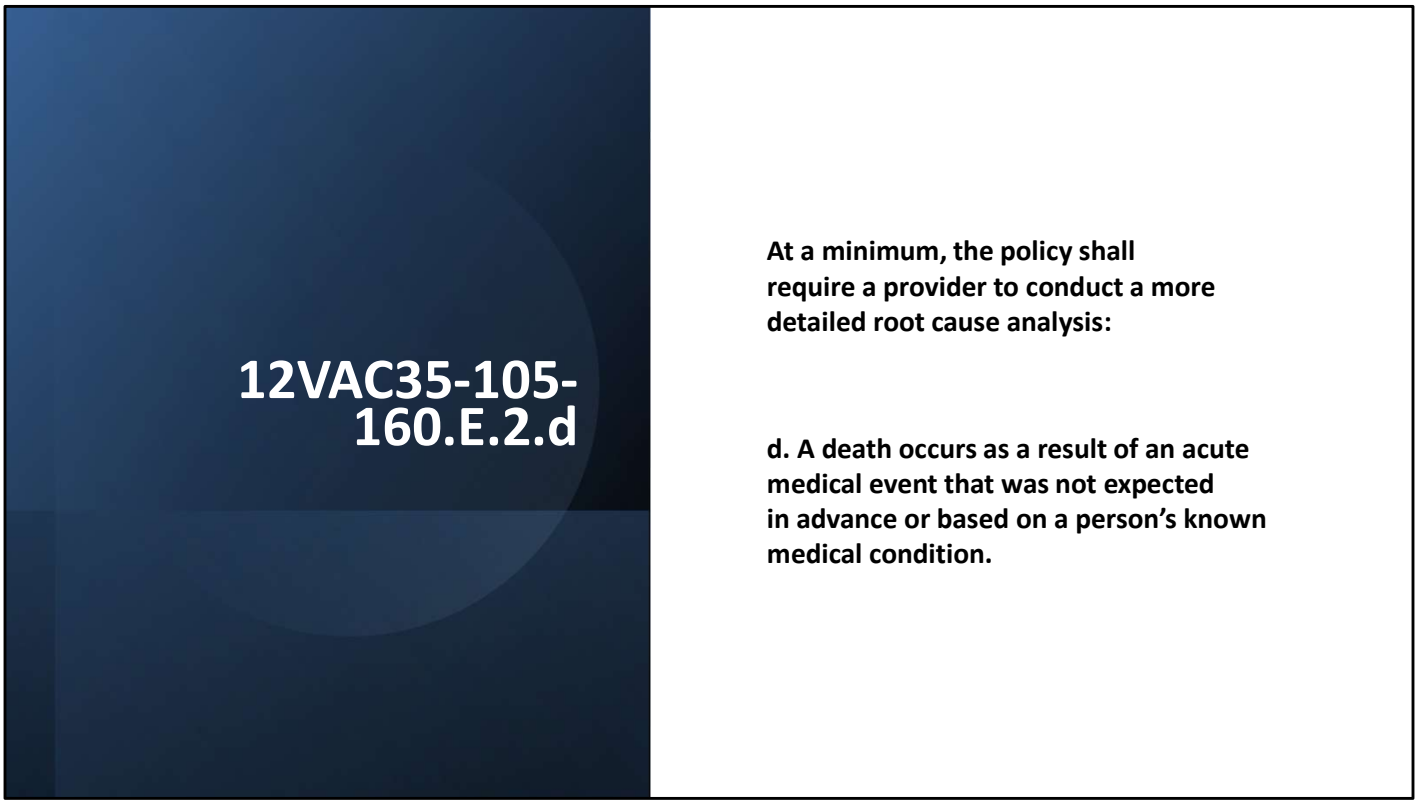
- For this policy, the provider must determine their threshold number.



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



- 160.E.2.c
- At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when
- The threshold number is met, 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 that occur across all of the provider's locations within a six-month period;
- Similar to 160.E.2.a, the provider must determine a threshold number for their policy.



- 160.E.2.d
- At a minimum, the policy shall require a provider to conduct a more detailed root cause analysis when...
- For this regulation, the minimum requirement to be compliant with this regulation states that the provider must 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.

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.

- Identified Issues
- During inspections it has been determined that some providers still do not have a root cause analysis policy that includes when a more detailed RCA would be conducted. If you don't have a policy, what's stopping you? Get going and write that policy!
- Also, in some instances, providers have just copied and pasted the regulatory language verbatim even including the term "threshold number" instead of indicating their threshold number
- I'm saying this again, when developing the RCA 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 when determining their threshold number.
- Every provider will need to determine (by its policy) the minimum thresholds.
- Don't forget, regulations 160.E.2.a and 160.E.2.c both require the provider to determine a threshold for their policy.
- Now let's talk about Acme Residential's Root Cause Analysis policy.

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.*

Virginia Department of Behavioral Health & Developmental Services

Slide 68

- We are going to take a few minutes to talk about Acme Residential, they have five residential homes.
- As you can see, there are two columns in the chart. For your reference we have the regulatory text on the left and an example policy on the right.
- For 160.E.2.a: 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.
- Remember for this regulation, the provider must establish the criteria for when a more detailed RCA will be conducted. This provider did, their policy states five.
- For 160.E.2.b: Providers must include all of the elements of this regulation within their policy since it is the minimum requirement.
- Acme Residential 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

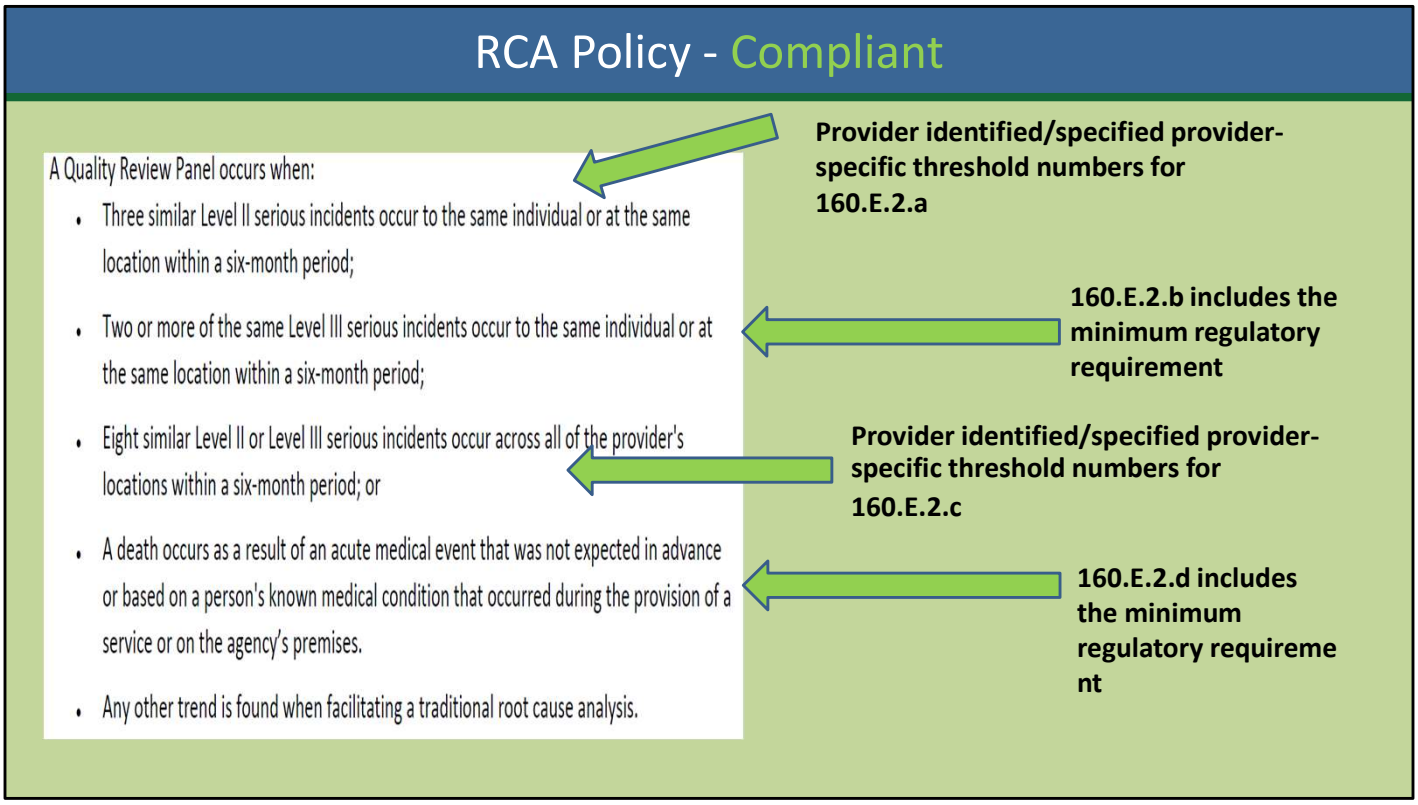
Regulation Text	Example Policy
160.E.2.c. A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II or Level III serious incidents 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.

Virginia Department of Behavioral Health & Developmental Services

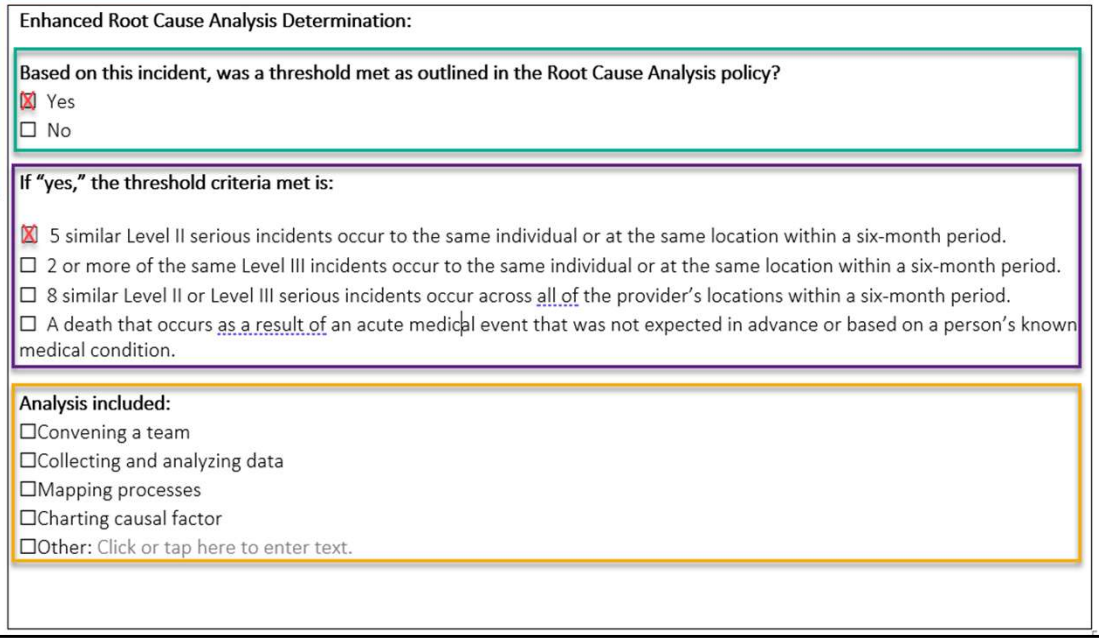
Slide 69

- For 160.E.2.c: 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.
- Remember for this regulation, the provider must establish the criteria for when a more detailed RCA will be conducted. This provider did, their policy states eight.
- For 160.E.2.d: Providers must include all of the elements of this regulation within their policy since it is the minimum requirement.
- 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.
- Don't forget that the threshold number should take into account the agency's size, population served and services provided. Once this threshold number has been met then the provider is responsible for conducting a more detailed root cause analysis of these incidents that resulted in meeting the threshold.



- Here is an example of a compliant root cause analysis policy
- For 160.E.2.a, the provider indicated that they would conduct a more detailed root cause analysis when *three* similar Level II serious incidents occur to the same individual or at the same location within a six-month period. The provider included a threshold number of three.
- For 160.E.2.b: The provider included the minimum requirement per the regulation which states that 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;
- For 160.E.2.c: the provider indicated that they would conduct a more detailed root cause analysis when there are *eight* similar Level II or Level II serious incidents that occur across all of the provider's locations within a six-month period. The provider included a threshold number of eight.
- For 160.E.2.d: The provider included the minimum requirement per the regulation which states that if 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.
- Again, if any of these thresholds are met then the provider must conduct a more detailed root cause analysis. It's nots simply having a policy, you must follow your policy by conducting a more detailed root cause analysis of the incidents when a threshold is met.

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

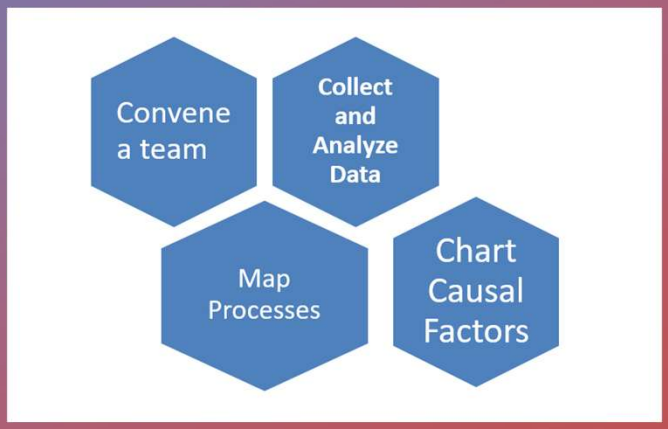
☐Mapping processes

☐Charting causal factor

☐Other: Click or tap here to enter text.

- Now let's revisit the Serious Incident Review and Root Cause Analysis Template. Specifically, the Enhanced Root Cause Analysis Determination section
- This first section of the template (refer to the green box) starts off by asking if a threshold was met based on the provider's root cause analysis policy. If yes, a threshold was met, then the provider would then indicate which threshold by marking the appropriate box (refer to the purple box).
- Let's talk again about Acme Residential. As you can see, they've decided to use this template. You can tell because they've updated the form to reflect their thresholds as outlined in their root cause analysis policy. Take a look at the purple box.
- If you recall Acme Residential indicated that they will conduct a more detailed root cause analysis when there are five (5) similar Level II serious incidents that occur to the same individual or at the same location within a six-month period which addresses 160.E.2.a
- 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 which addresses 160.E.2.b
- 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 which addresses 160.E.2.c
- AND
- 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 which addresses 160.E.2.d.
- See that red X ? Acme Residential has marked which threshold was met. They will now need to conduct a more detailed RCA.
- Now, take a look at the box outlined in yellow. As they complete the regulatory requirement for a more detailed root cause analysis they can mark the box.

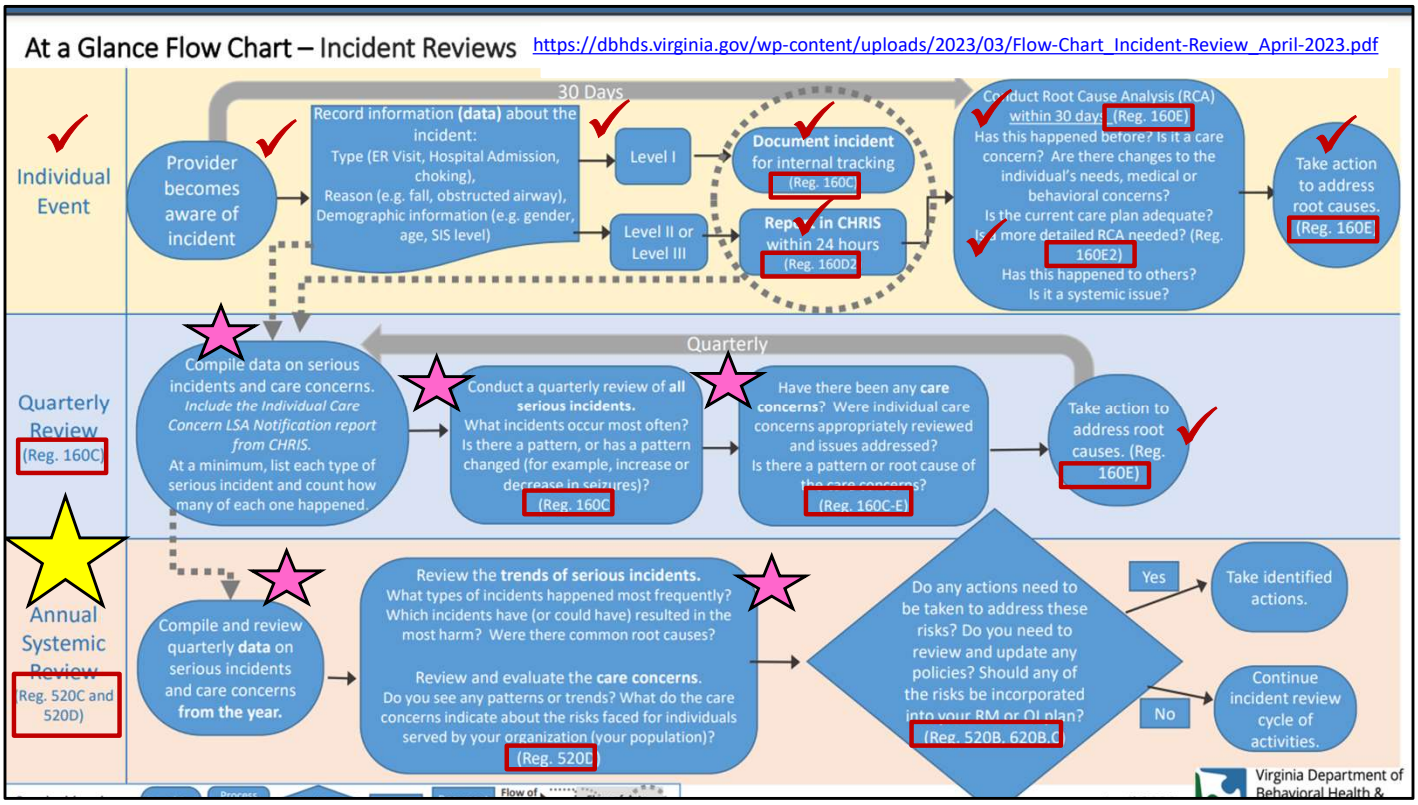
What is a more detailed RCA?



- We've reviewed the requirements for a root cause analysis
- Shared with you the Serious Incident Review and Root Cause Analysis Template
- And talked about the requirements for a root cause analysis policy.
- Before we head back over to Mary Beth I just want to talk a bit more about the more detailed root cause analysis as outlined regulation 160.E.2. Remember, includes convening a team, collecting and analyzing data, mapping processes, and charting causal factors. Let's take some time to review exactly what these mean.
- The provider would first begin by convening a team. It doesn't have to be a large team. In most cases, a RCA team may consist of 4-5 people and would be interdisciplinary. Different professional backgrounds can support creative thinking. The team members should be given a quick overview of what a RCA is and what it is not. Review rules of behavior, it's not about blame, also avoid hindsight bias. Teams can jump to conclusions so it's important to follow the outline of how to effectively conduct a RCA.
- During the last session you were reminded that regulations require that a provider designate a person responsible for the risk management function who has training and expertise in conducting investigations, root cause analysis, and data analysis. Depending on the incident and the organization, this person (the designated risk manager) may serve as the lead on the RCA team or provide guidance and an overview of the team's charter.
- The team would collect and analyze data, perhaps even conduct interviews to find out what happened from the perspective of the person or people involved
- Use Mapping processes – use items such as a flow chart, storyboards, process maps, etc
- And Chart Causal factors – causal factor can be defined as any "major unplanned, unintended contributor to an incident (a negative event or undesirable condition), that if eliminated would have either prevented the occurrence of the incident or reduced its severity or frequency."

Quality Improvement/Risk Management

- To conclude my part of today's presentation, I want to show this radial circle to demonstrate the relationship to a central idea which is the health, safety and welfare of individuals served.
- The information in the outer ring of circles contributes to the central idea.
- Root cause analysis as part of a risk management and quality improvement program ensures that systemic issues are being identified and addressed.
- It is one of many tools that can be used to support continuous quality improvement.
- Continuous quality improvement is what every organization seeks - to make things better for people served.
- Providers can use a root cause analysis in several ways and through such use will become more proficient with the tool. More importantly, the organization, and employees empowered to be change agents, will see the value in the process.
- [I'm going to turn the presentation back over to Mary Beth who in is going to present the new Risk Tracking Tool.]



That was a lot of great information *about doing a Root Cause Analysis and when a more detailed RCA is needed.*

Let's look at our flow chart again to see what all we've covered!

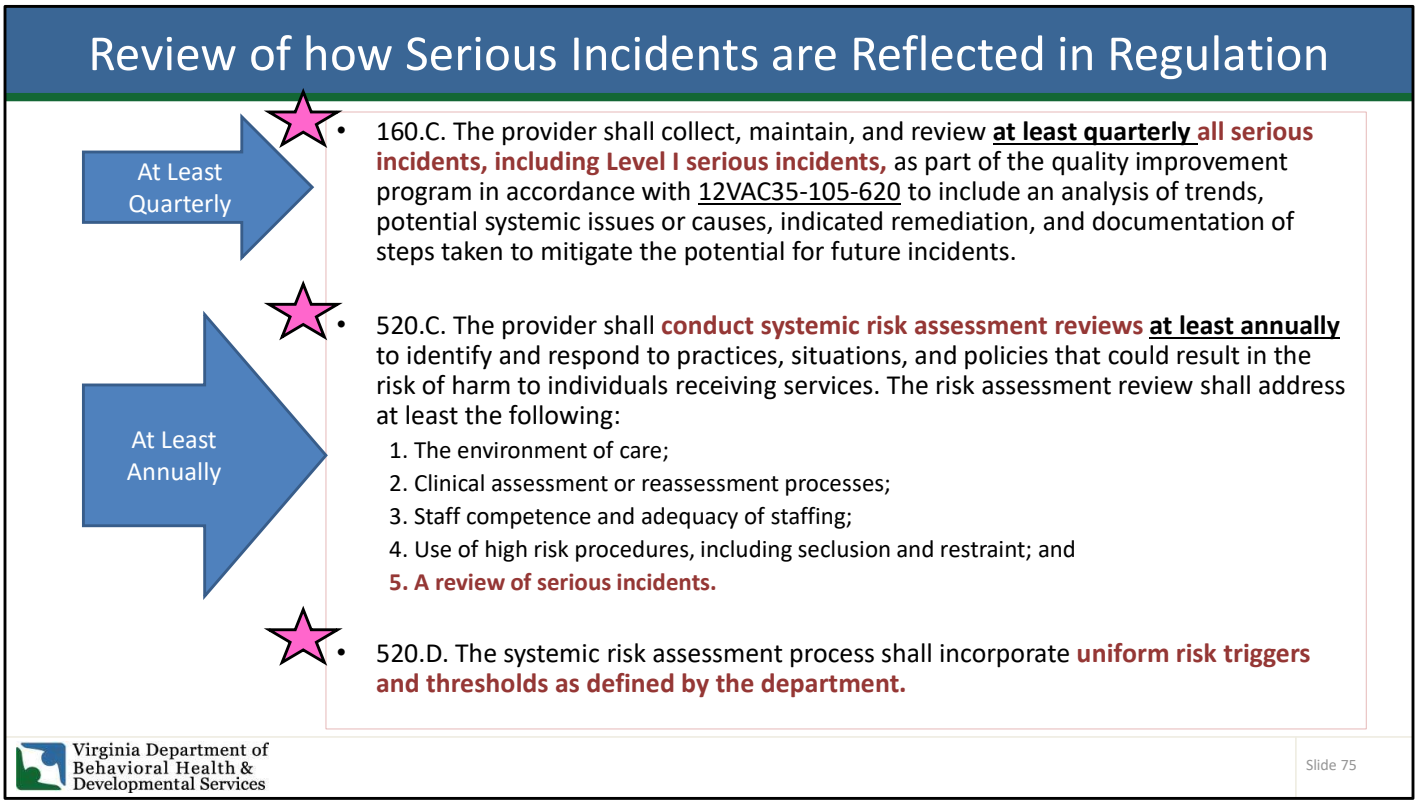
We've reviewed the steps in the flow chart overall, from individual to quarterly to annual.

We've learned about the definitions of Level I, II and III incidents and important reporting information.

We've heard about conducting root cause analysis, and when to conduct a more detailed root cause analysis, and the importance of identifying solutions when issues are identified.

The Office of Licensing even presented a NEW template to help make sure we meet the root cause analysis requirements!

For the rest of today's training, I'm going to focus on the pink stars on the map, which walk us through collecting data and doing the quarterly and annual reviews of serious incidents and care concerns.



These steps in the map all relate to the regulations that were the reason for today's training: 160C, 520C and 520D.
They require providers to collect, review and maintain serious incident data quarterly and annually.
In a nutshell, 160C is focused on a **quarterly** data collection and review process.
520C is focused on the systemic risk assessment reviews being done **at least annually** to include elements 1-5
AND 520D states that it needs to incorporate uniform risk triggers and thresholds as defined by the department, which we learned are called Care Concerns.
We've also learned that this means the systemic risk assessment actually has SIX components.

Risk Tracking Tool

- Introduce the Risk Tracking Tool: A Tool build in Excel to help providers collect, maintain, and review :
  - Risks and conditions common to individuals with developmental disabilities
  - Serious Incidents
  - Care Concerns / Risk Triggers and Thresholds
- This tool is **optional but highly encouraged**, if you don't already have something you use for this purpose.

I am going to introduce to you a **new tool** called the Risk Tracking Tool.

This is a Tool build in Excel to help providers collect, maintain, and review :

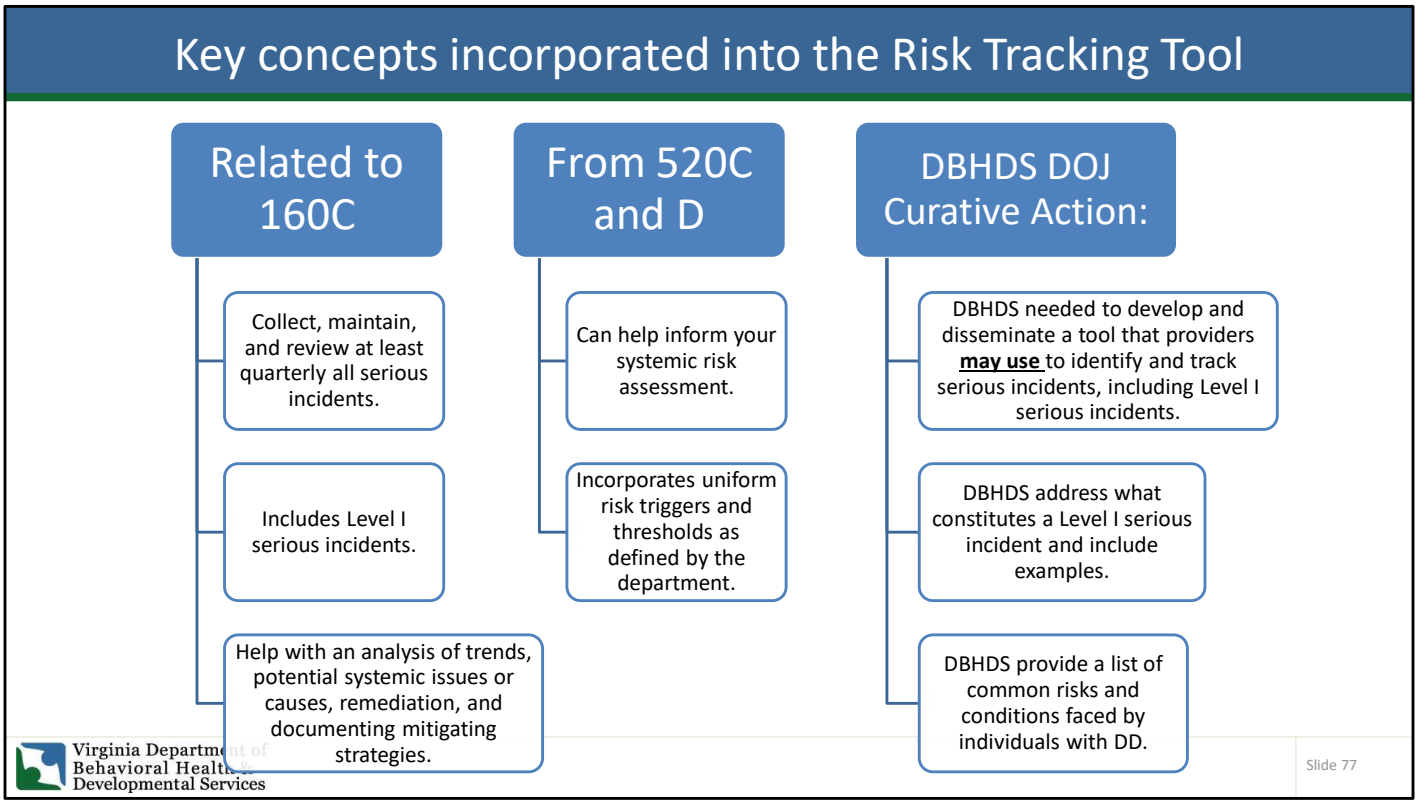
Risks and conditions common to individuals with developmental disabilities

Serious Incidents

Care Concerns / Risk Triggers and Thresholds

This tool is **optional but highly encouraged**, if you don't already have something you use for this purpose.

If you DO have something you already use for this purpose, this information may give you new ideas.



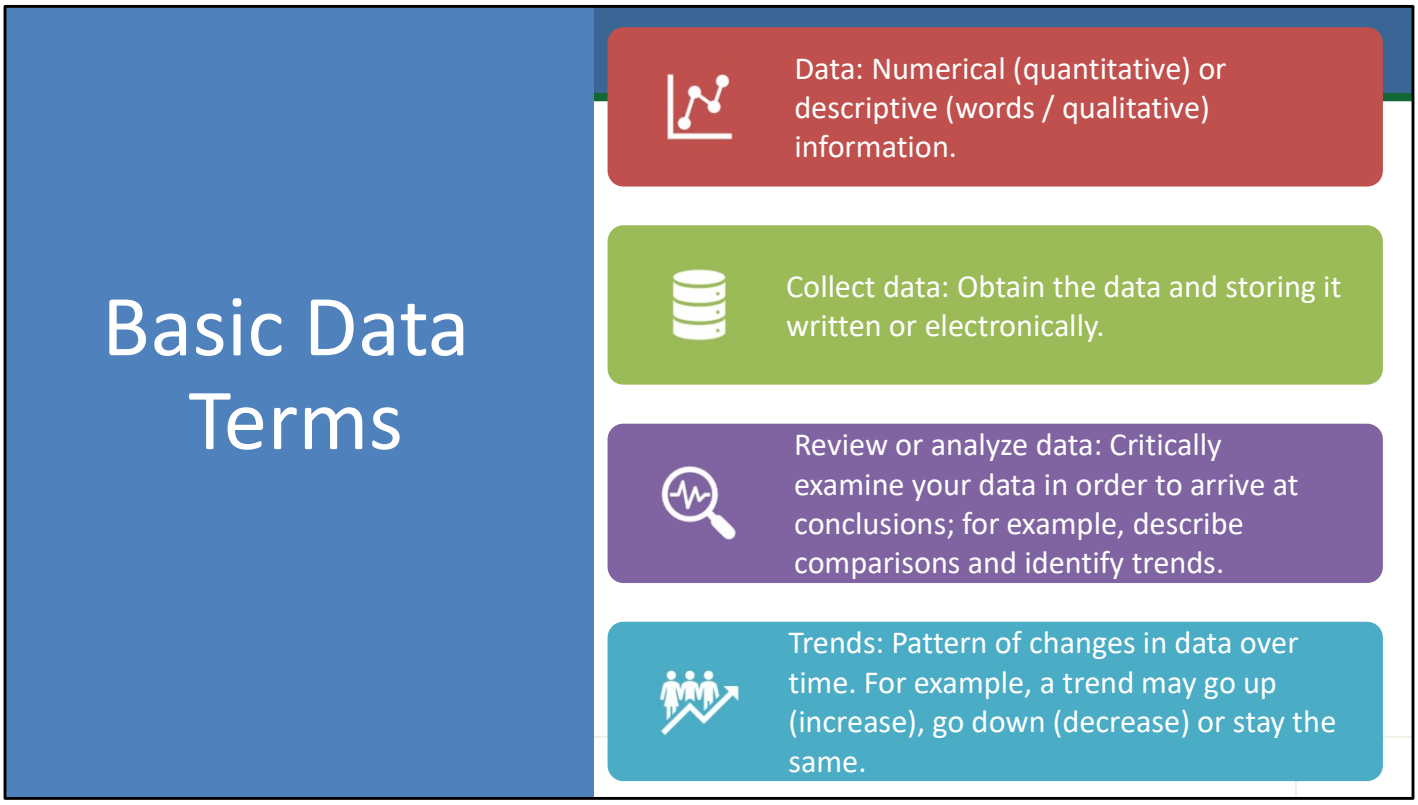
Th Risk Tracking tool has been designed to help providers move towards meeting compliance with 160C, 520C and D.

For 160C, it helps…

For 520C and D, it helps…

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

- It meets the requirement that DBHDS needs to disseminate a tool that providers **may use** to track and review serious incidents. (Note: Not required to use.)
- It also includes the definition and examples of Level I incidents, and provides a list of common risks and conditions faced by individuals with DD.



Before we get into the tool, let's briefly review some basic terms when working with data.

What is data? You can think of data as either numerical or descriptive information. Numerical data uses numbers to count things, such as how many or how often, and is also called quantitative data.

Descriptive data uses words to describe information and is also called qualitative data.

Collecting data means obtaining it and storing it either written or electronically.

Reviewing and analyzing data means that you critically examine your data in order to try to draw conclusions. For example, you ask – how does this compare to something else? Is it higher or lower? Has it gone up or down?

Finally, what are trends? A trend is a pattern of change in data over time. For example, your data may go up or down over time or stay the same. That is your trend.

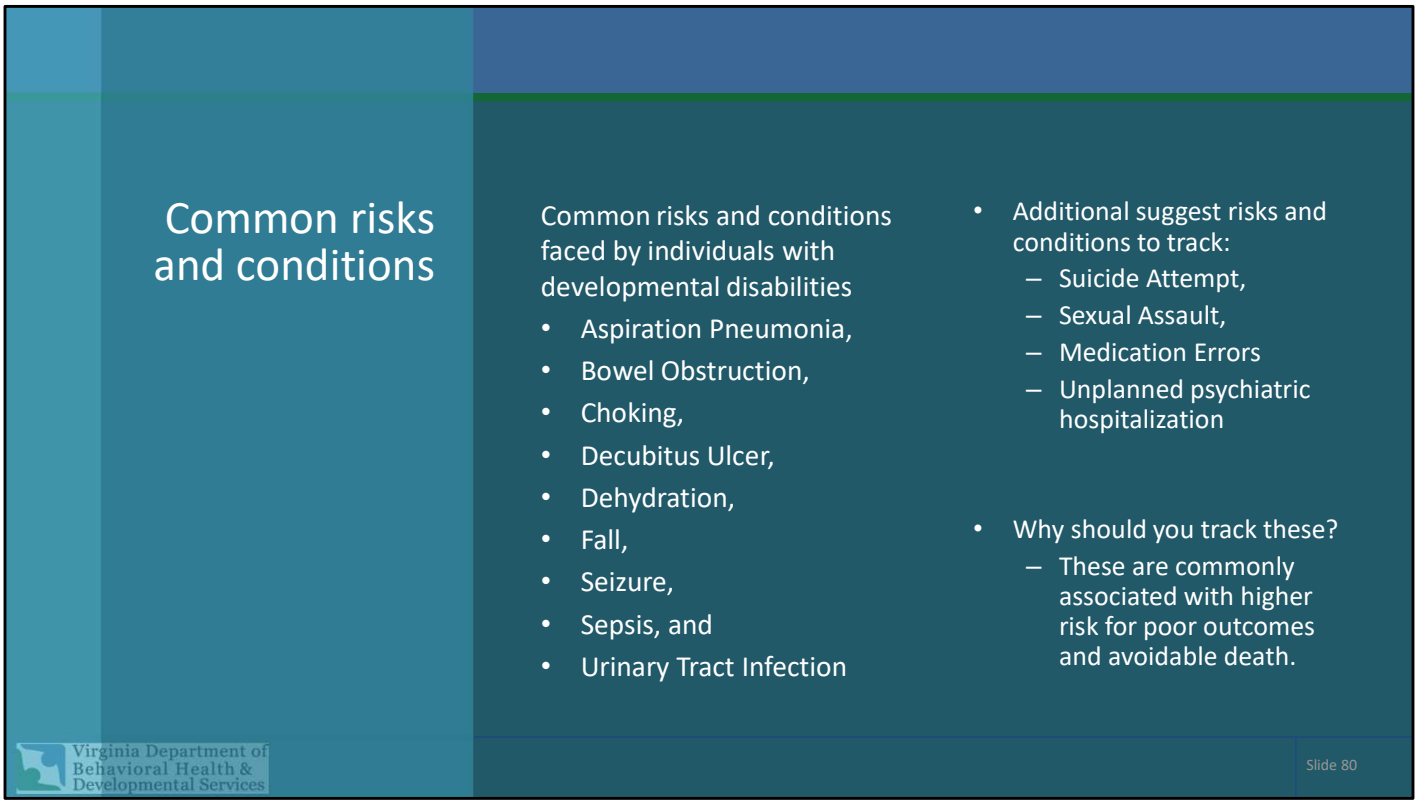
Some Good Practices for Data Entry and Review

ACCURACY: DOUBLE CHECK WHEN ENTERING DATA; AVOID MISTAKES.

TIMELINESS: ENTER DATA IN A TIMELY MANNER; DON'T DELAY! GET INTO A ROUTINE AND SCHEDULE THE TIME.

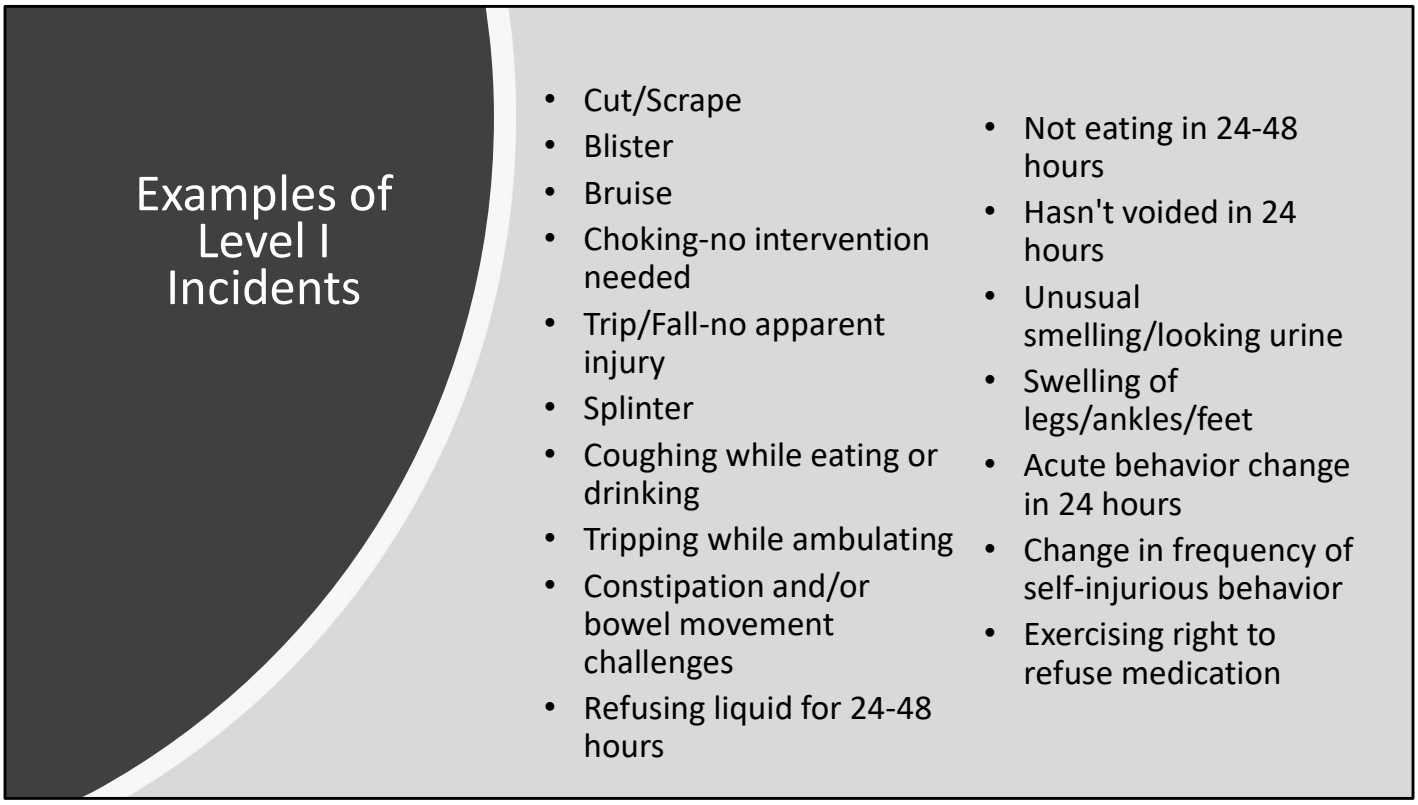
USE A TEAM-BASED APPROACH: REVIEW AND DISCUSS DATA WITH YOUR TEAM.

Next, let's look at a few good practices for data collection and review.
You want to do your best to make sure your data are accurate. You can do this by taking steps to avoid mistakes such as double checking to make sure you are entering data for the correct person or event, and have entered the correct numbers and information.
You also want to make sure your data are entered in a timely manner. If you delay data entry, you risk forgetting to do it at all, or the data entry may pile up creating more work for you. It may also impact reporting for you or others.
When it comes to reviewing data, it's a good strategy to use a team based approach to review your data. A team can help you interpret the data and decide if it represents a concern or not and what to do about it.



Ok. Now let's talk about some information that it's in the Risk Tracking tool.
On this slide, you'll see the list of common risks and conditions that are included in the tool. They are…. [read]
These were selected because they are commonly associated with increased risk for poor outcomes and the potential for death among individuals with DD. **For providers who see individuals with DD, it is recommended that you collect data on these risks and conditions for the reasons just described, if you are not already doing so.**
For providers who don't see individuals with DD, there may be other risks that are common to the population you serve and you will be able to add these risks in the tool which we will see in a moment.

There are additional SUGGESTED risks and conditions in the tool to track.
Suicide attempt and sexual assault are included as they are associated with Level III serious incidents.
Medication errors are included because they can present high risk and providers are required to review them quarterly.
Unplanned psychiatric hospitalization is also suggested; and now two of those incidents constitutes a care concern.



This is the list of examples of Level I incidents. It is the same list that Michele Laird showed earlier.
This list was developed in partnership with the DBHDS Office of Integrated Health.
This list is included in the tool itself, as you will shortly see, but since this list is a new resource, we wanted to pull it out here specifically.
You can have this list as a reference, whether you use the Risk Tracking Tool or not.

Demo: Risk Tracking Tool

- Demonstrate the Risk Tracking Tool: A Tool build in Excel to help providers collect, maintain, and review:
  - Risks and conditions common to individuals with DD
  - Serious Incidents
  - Care Concerns / Risk Triggers and Thresholds

- This tool is **optional but highly encouraged**, if you don't already have something you use for this purpose.

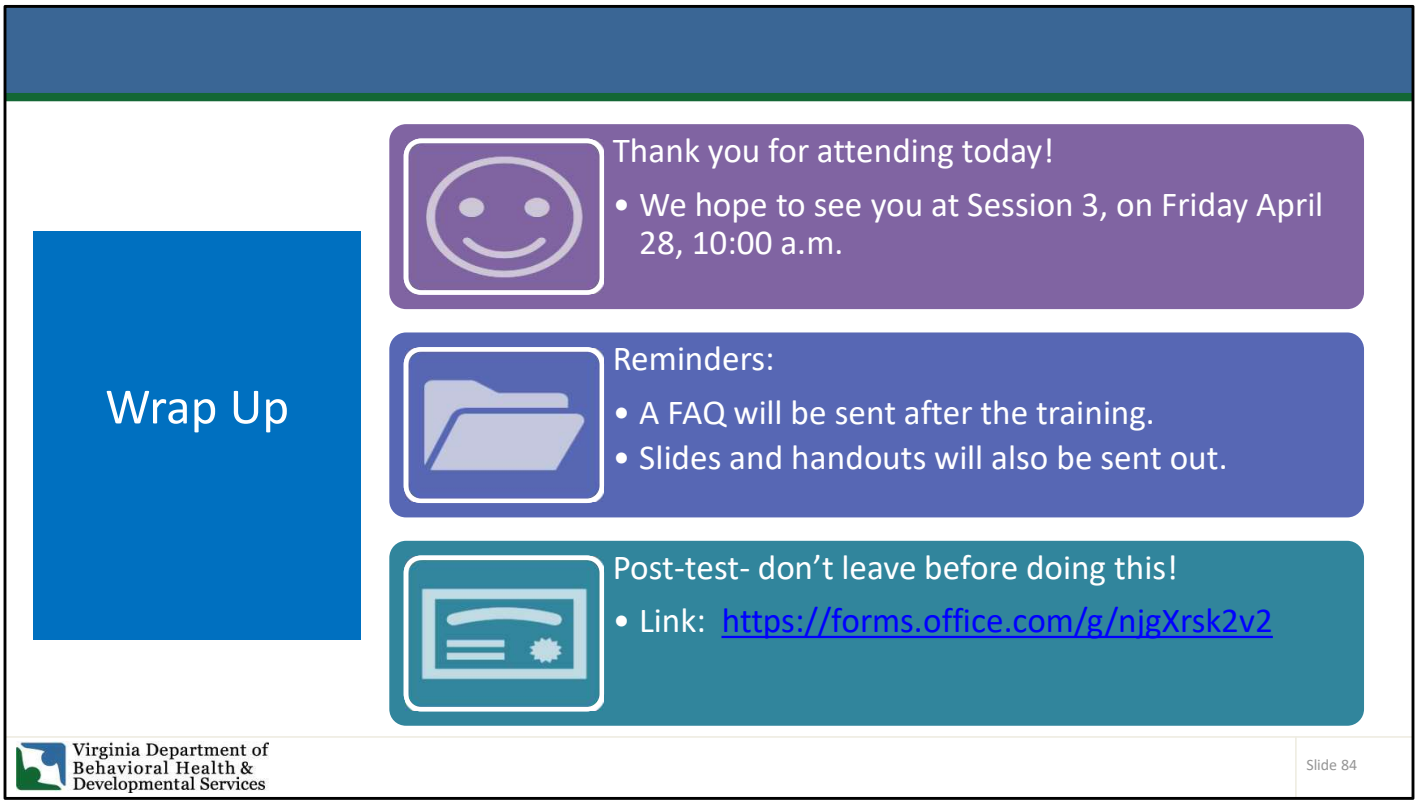
Video is a separate link.

At long last, let's look at the new Risk Tracking Tool!
I'm going to show a video that demonstrates the tool and how to use it. It's about 18 minutes long.
This video will be available on the DBHDS website after the 3rd training session is complete and we'll let you know how to access it via email.
Again, this tool is optional but highly encouraged especially if you don't already have something you use for this purpose.
Even if you DO Have something you use, it may spark other ideas for you.
Lets' get going.

Homework

- Begin tracking serious incidents and care concerns right now.
  - OR review your process and identify if any updates are needed.
- Find out how your organization tracks serious incidents and care concerns.
  - What tool or process do you use?
- If you don't use one, try the new ***Excel Risk Tracking tool!***
- If you have a tool/method, does it need to be updated in any way?
- **Be prepared to share next week!**

That bring us to the homework for today's session!
We have covered a lot of ground today and we appreciate you being on this journey with us!
Your homework is to begin tracking serious incidents and care concerns right now, or review your process for doing so and identify if any updates are needed.
Think about – what tool or process do you use right now?
If you don't have a tool yet, try the new Excel Risk Tracking Tool!
If you DO have a tool or method, does it need to be updated in any way?



That brings us ALMOST to the end of today's session.
If you have any more Questions for the Q&A, please put them in the Q&A now to make sure we capture them.

We want to thank you for attending today's session and hope to see you at next Friday's session!
IN SESSION 3, "WE'RE GONNA PULL IT ALL TOGETHER, SO YOU DON'T WANT TO MISS OUT!!!"

As a reminder, a FAQ along with the slides and handouts will be available after the training.

Last but not least, we have a post-test! Please take time to do the post test!
I'm going to put the link in the chat. We'd love for you to take the time to do it NOW while the training is fresh on your mind.
The link will also be emailed to you and we will keep it open until Tuesday, April 26 at Noon. It's important for us to hear from you…We need to know what you got out of the training and how we can improve it.

•Link: ….
•The next three slides have additional resources, so you'll have them available when you receive the slides.
•Again, please go take the post-test.

Existing Risk Management Resources

QI-RM-RCA Webinar Recording December 2021 (February 2022)

QI-RM-RCA Webinar (December 2021)

Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation and Research – Handout (December 2020)

Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation & Research – Recorded Webinar (December 2020)

Updated Crosswalk of DBHDS Approved Attestation Trainings (August 2022)

Updated Risk Management Attestation Form (August 2022)

Sample Provider Systemic Risk Assessment (February 2022)

Sample Provider Risk Management Plan (June 2021)

Flow-Chart Incident Reviews (April 2022)

Existing Risk Management Resources

QI-RM-RCA Webinar (December 2021)

Regulatory Compliance with Risk Management Regulations Training (December 2021)

Risk Management Tips and Tools Training (June 2021)

Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation & Research – Recorded Webinar (December 2020)

Risk Management Training (November 2020)

2023 Care Concern Threshold Criteria Memo (February 2023)

IMU Care Concern PowerPoint Training (February 2023)

Risk Triggers and Threshold Handout (February 2023)

Risk Management Q&A's (Updated July 2022)

Additional Resources

- Office of Clinical Quality Improvement
  - DBHDS YouTube Videos on Quality Improvement: https://www.youtube.com/playlist?list=PLmFe443VQ9xUxxc85z--thJUFCjjKrTfL
  - List of Quality Improvement Resources: https://dbhds.virginia.gov/wp-content/uploads/2022/10/QI-Resources_revised-10.22.pdf

Virginia Department of Behavioral Health & Developmental Services

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WORK ON THIS

This concludes today's training. See you next week!