Larisa

Hello, and welcome to the Office of Licensing 2026 DD Inspections Kickoff Training! We thank you all for choosing to share your time with us today, and appreciate the opportunity to help prepare you for success as we enter into the new year together. Today's training has been developed specifically for licensed providers of developmental services that are required to comply with Chapter 105, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services.

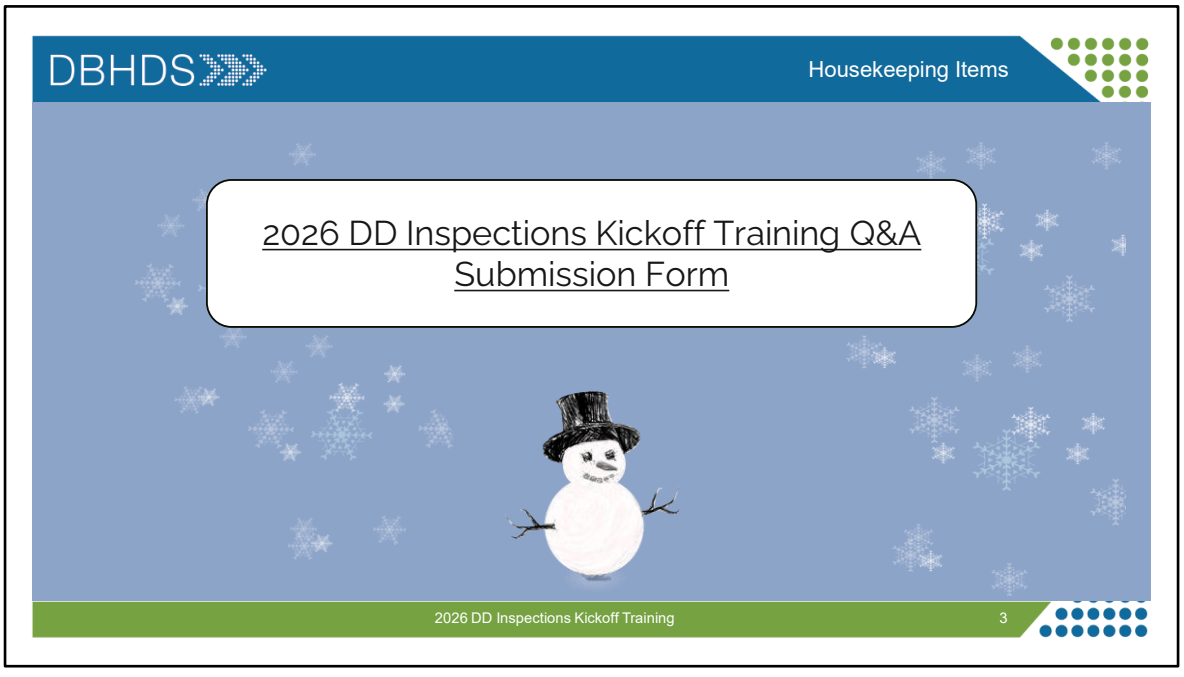
We want you to be successful- we want you to be prepared- and, most importantly, we want you to know what to expect when we come knocking on YOUR door for your 2026 Annual Unannounced DD Inspection.

Larisa

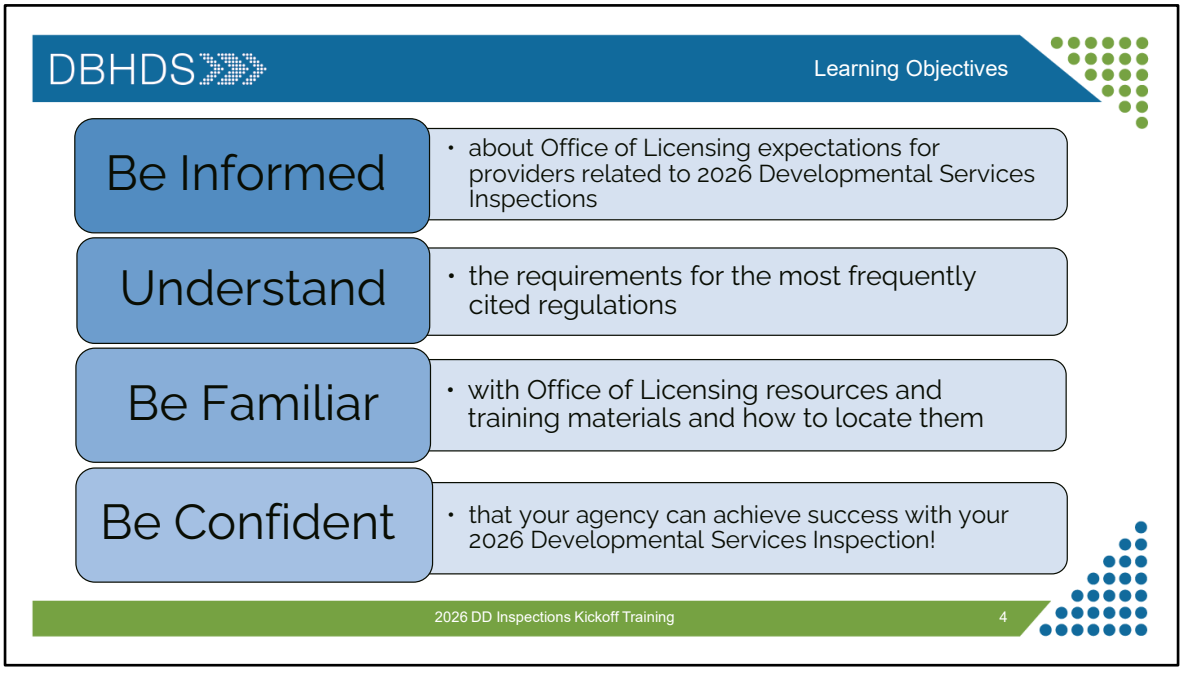
First things first- let's look at the Mission and Vision of the DBHDS Office of Licensing:

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

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



If you happen to have any questions related to today's presentation, please submit them by clicking on this link to the 2026 DD Inspections Kickoff Training Q&A Submission Form.



Larisa

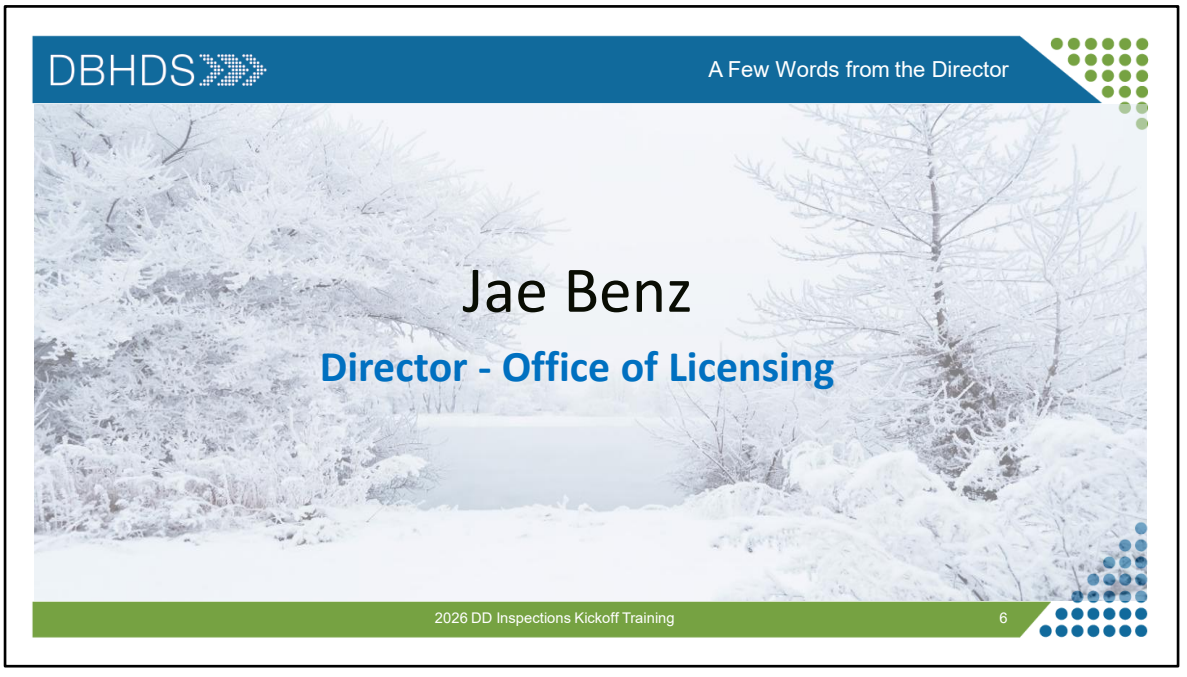
Before we jump into the content of today's training, let's review our Learning Objectives. The purpose of today's training is to ensure you are:

Larisa

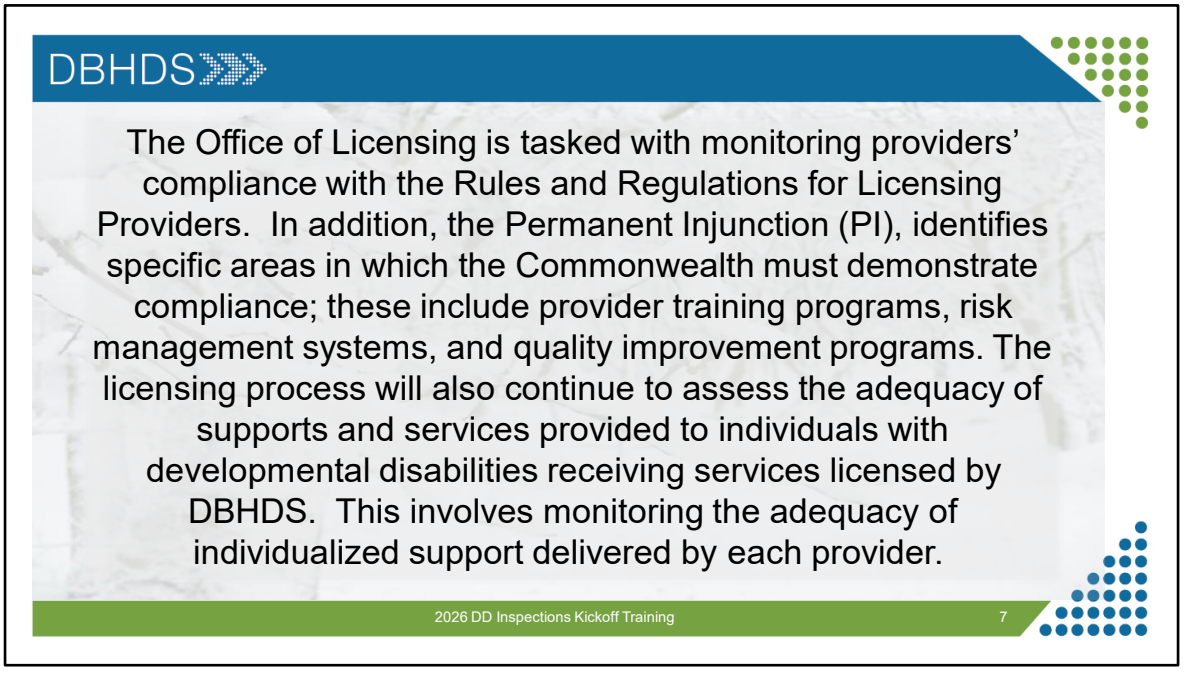
You will hear from different presenters throughout this presentation.

Your presenters from the Office of Licensing are:

- Mackenzie Glassco, Associate Director of Quality & Compliance,
- Karen Matthews, Quality Improvement Review Specialist and myself,
- Larisa Terwilliger, Training Coordinator



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

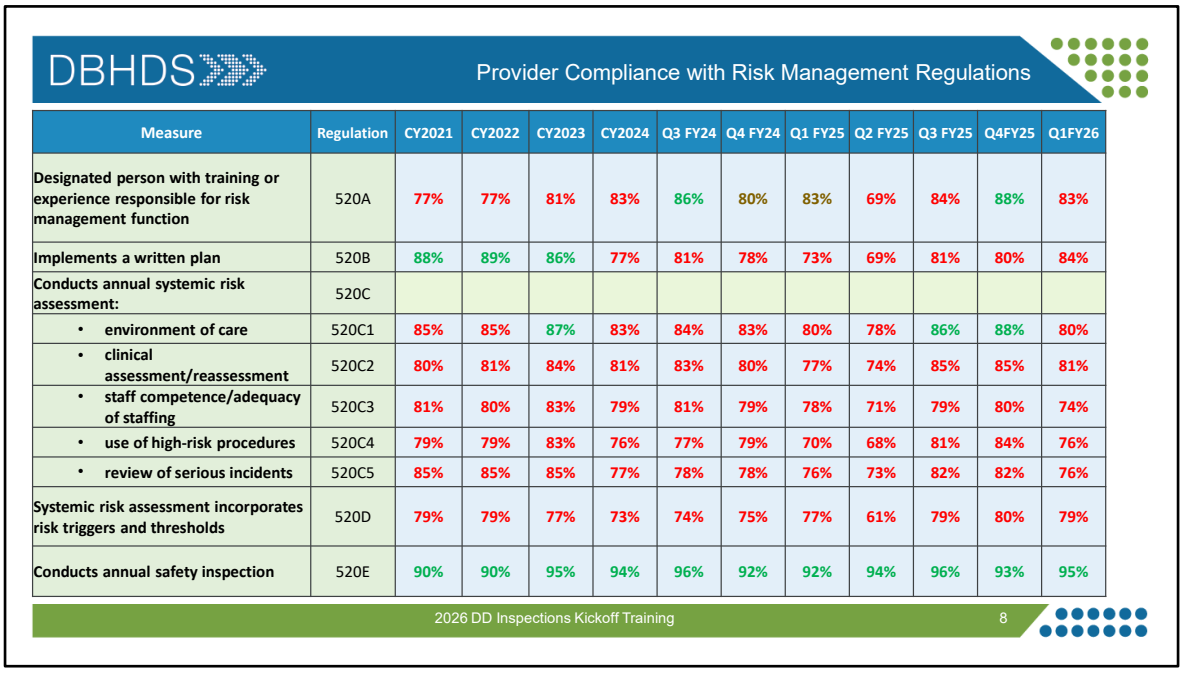


Mackenzie

Alright, thank you Jae and Larisa.

The Office of Licensing is tasked with monitoring providers' compliance with the Rules and Regulations for Licensing Providers. In addition, the Permanent Injunction, identifies specific areas in which the Commonwealth must demonstrate compliance; these include provider training programs, risk management systems, and quality improvement programs. The licensing process will also continue to assess the adequacy of supports and services provided to individuals with developmental disabilities receiving services licensed by DBHDS. This involves monitoring the adequacy of individualized support delivered by each provider.

Let's take a moment to review data related to provider risk management and quality improvement



Measure	Regulation	CY2021	CY2022	CY2023	CY2024	Q3 FY24	Q4 FY24	Q1 FY25	Q2 FY25	Q3 FY25	Q4FY25	Q1FY26
Designated person with training or experience responsible for risk management function	520A	77%	77%	81%	83%	86%	80%	83%	69%	84%	88%	83%
Implements a written plan	520B	88%	89%	86%	77%	81%	78%	73%	69%	81%	80%	84%
Conducts annual systemic risk assessment:	520C											
• environment of care	520C1	85%	85%	87%	83%	84%	83%	80%	78%	86%	88%	80%
• clinical assessment/reassessment	520C2	80%	81%	84%	81%	83%	80%	77%	74%	85%	85%	81%
• staff competence/adequacy of staffing	520C3	81%	80%	83%	79%	81%	79%	78%	71%	79%	80%	74%
• use of high-risk procedures	520C4	79%	79%	83%	76%	77%	79%	70%	68%	81%	84%	76%
• review of serious incidents	520C5	85%	85%	85%	77%	78%	78%	76%	73%	82%	82%	76%
Systemic risk assessment incorporates risk triggers and thresholds	520D	79%	79%	77%	73%	74%	75%	77%	61%	79%	80%	79%
Conducts annual safety inspection	520E	90%	90%	95%	94%	96%	92%	92%	94%	96%	93%	95%

Mackenzie

Before we go further, it's important for you all to understand where we currently stand related to compliance with risk management and quality improvement regulations.

Let's look at this chart, these regulations are specific to risk management.

The numbers in green show those regulations where provider compliance was at 86% or above. These percentages are based on developmental service providers who received an annual unannounced inspection. Percentages are affected based on the number of providers in the sample.

Areas of Lowest Compliance based on Quarter 1 of FY2026 –

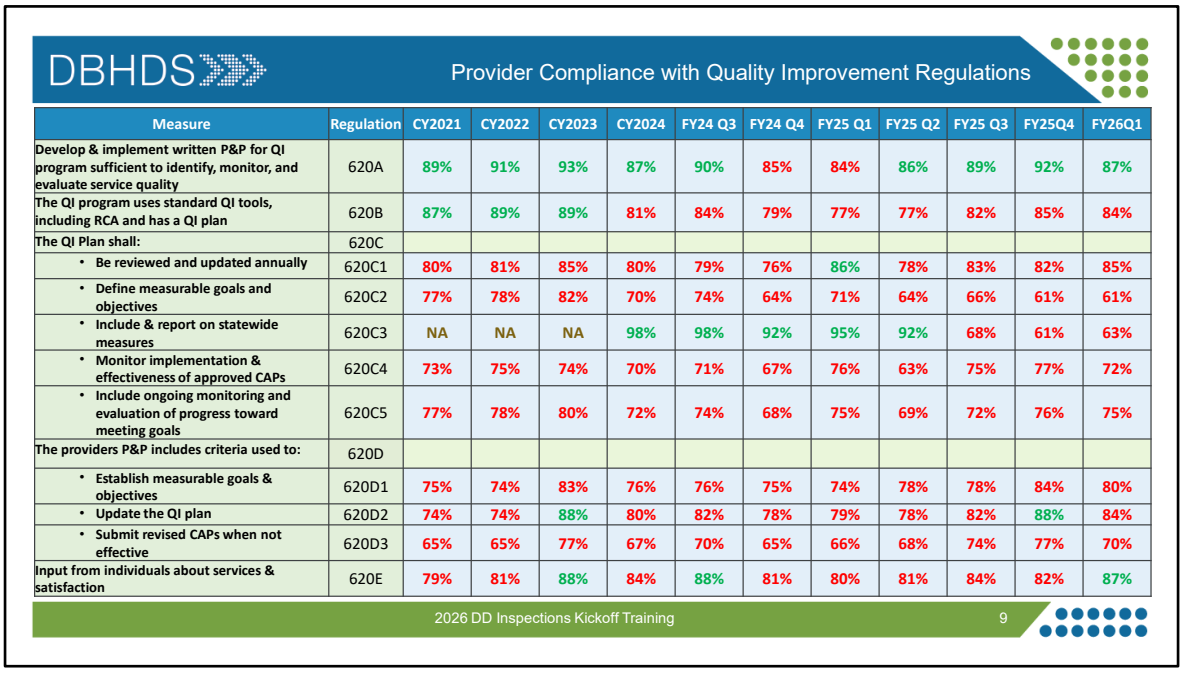
Are related to the Annual Systemic Risk Assessment requirements

- 520.C.3: Staff competence and adequacy of staffing (74%)
- 520.C.4: Use of high risk procedures (76%)
- 520.C.5: Review of serious incidents (76%)
- 520.D: Systemic risk assessment incorporates risk triggers and thresholds

which are defined by the department as care concerns (79%)

Pause for a few seconds here

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



Measure	Regulation	CY2021	CY2022	CY2023	CY2024	FY24 Q3	FY24 Q4	FY25 Q1	FY25 Q2	FY25 Q3	FY25Q4	FY26Q1
Develop & implement written P&P for QI program sufficient to identify, monitor, and evaluate service quality	620A	89%	91%	93%	87%	90%	85%	84%	86%	89%	92%	87%
The QI program uses standard QI tools, including RCA and has a QI plan	620B	87%	89%	89%	81%	84%	79%	77%	77%	82%	85%	84%
The QI Plan shall:	620C											
• Be reviewed and updated annually	620C1	80%	81%	85%	80%	79%	76%	86%	78%	83%	82%	85%
• Define measurable goals and objectives	620C2	77%	78%	82%	70%	74%	64%	71%	64%	66%	61%	61%
• Include & report on statewide measures	620C3	NA	NA	NA	98%	98%	92%	95%	92%	68%	61%	63%
• Monitor implementation & effectiveness of approved CAPs	620C4	73%	75%	74%	70%	71%	67%	76%	63%	75%	77%	72%
• Include ongoing monitoring and evaluation of progress toward meeting goals	620C5	77%	78%	80%	72%	74%	68%	75%	69%	72%	76%	75%
The providers P&P includes criteria used to:	620D											
• Establish measurable goals & objectives	620D1	75%	74%	83%	76%	76%	75%	74%	78%	78%	84%	80%
• Update the QI plan	620D2	74%	74%	88%	80%	82%	78%	79%	78%	82%	88%	84%
• Submit revised CAPs when not effective	620D3	65%	65%	77%	67%	70%	65%	66%	68%	74%	77%	70%
Input from individuals about services & satisfaction	620E	79%	81%	88%	84%	88%	81%	80%	81%	84%	82%	87%

Mackenzie

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

Areas of Lowest Compliance based on Quarter 1 of FY2026 –

As it relates to the QI Plan

- 620.C.2: Defines goals/objectives (61%)
- 620.C.3: Report on statewide measures, currently only applicable to residential and day support services (63%)
- 620.C.4: Monitors implementation of CAPs (72%)

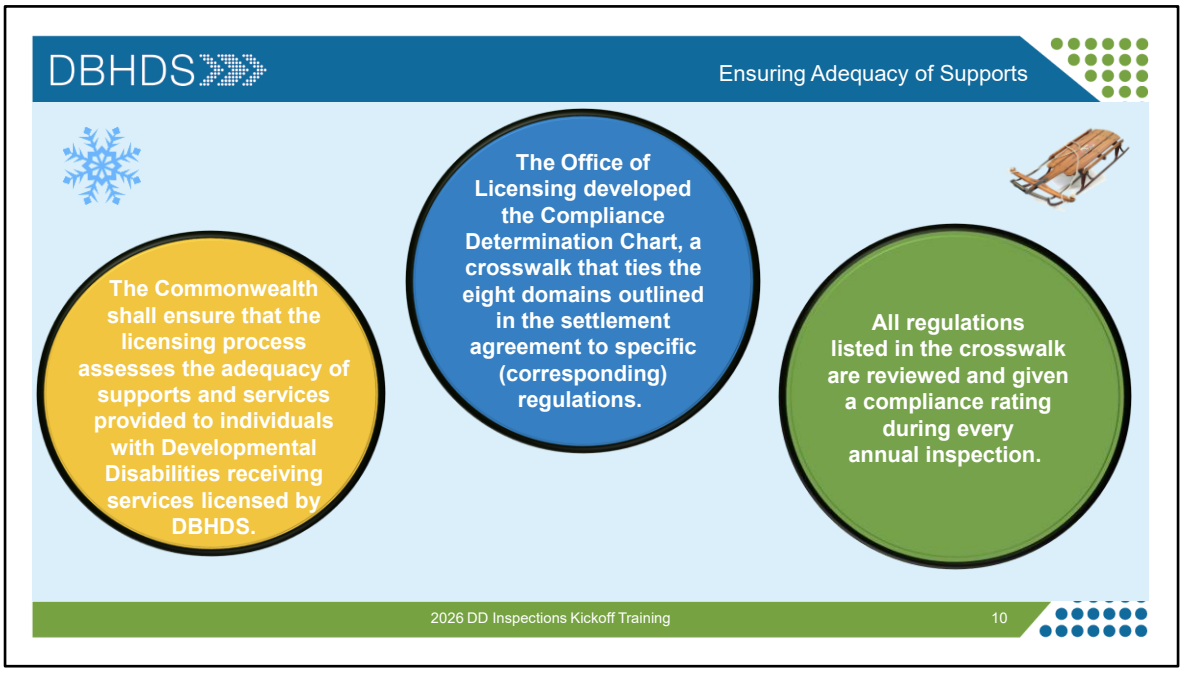
As it relates to the QI Program

- 620.D.3: Policies that describe the actions the provider will take when provider determines the CAP is not effective (70%)

PAUSE FOR PEOPLE TO READ

Soon, data will be pulled for both Risk and Quality for Quarter 2 of Fiscal Year 2026 which is from October 1, 2025-December 31, 2025.

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



Mackenzie

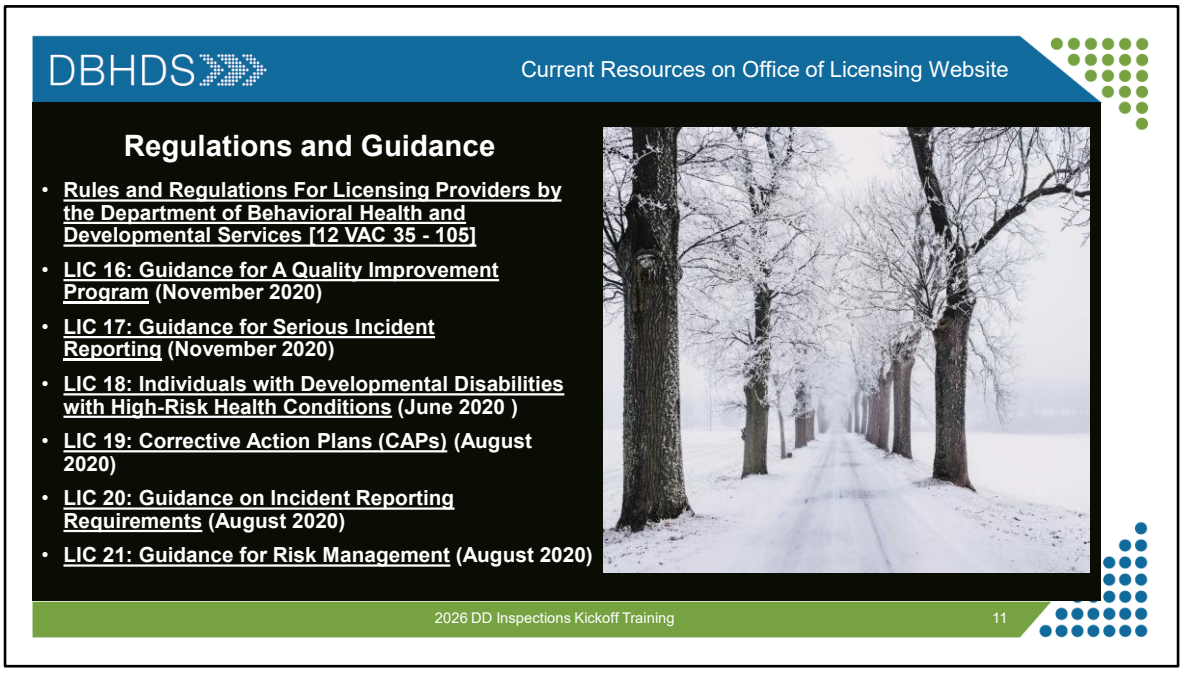
- In addition to assessing areas related to risk and quality, and meeting the terms outlined in the Permanent Injunction, the Commonwealth ensures that the licensing process assesses the adequacy of supports and services provided to individuals with developmental disabilities receiving services licensed by DBHDS.

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

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

- **Any regulations that fall under the adequacy of supports that were below 86% during CY 2025 will be reviewed with you during today's presentation.**

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



KAREN

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

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

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

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

your licensing specialist.

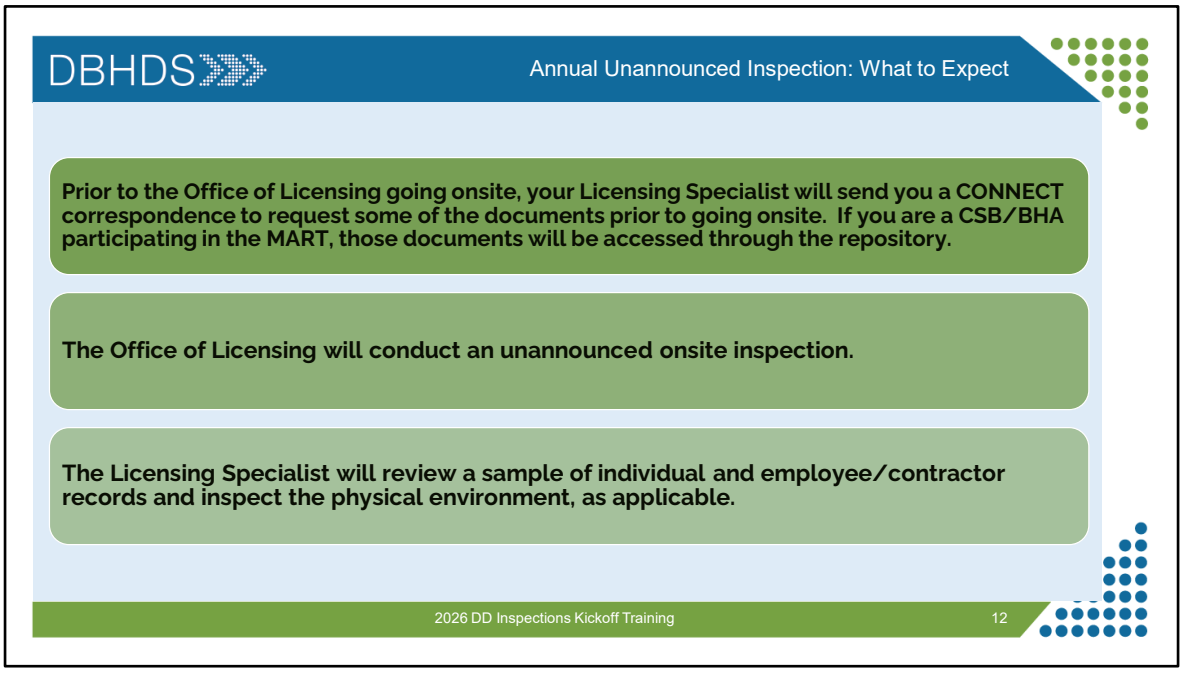
If you're comfortable with the regulations, we ask that you go one step further and familiarize yourself with Office of Licensing's guidance documents that are available.

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

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

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

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



KAREN

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

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

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

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

If someone from the Office of Licensing arrives for an unannounced inspection, and no one from the provider is present, the Licensing Specialist will attempt to contact the

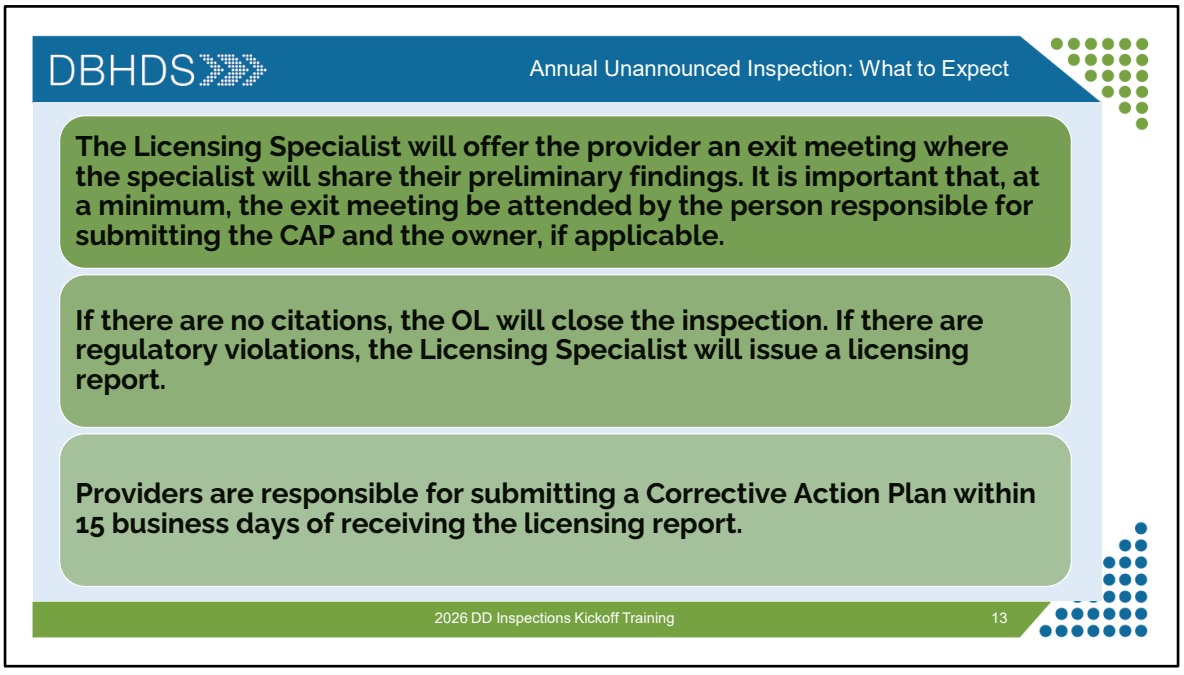
provider so that the inspection can be completed. The Office of Licensing is unable to complete the inspection unless someone from the provider organization is present. It is imperative that providers respond immediately to calls from the Office of Licensing when a specialist is onsite for a review. Additionally, providers need to inform their staff of who should be contacted at their organization when someone from the Office of Licensing arrives.

During the inspection, the Office of Licensing will:

- review individual records as well as employee or contractor records,

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

-may interview staff



KAREN

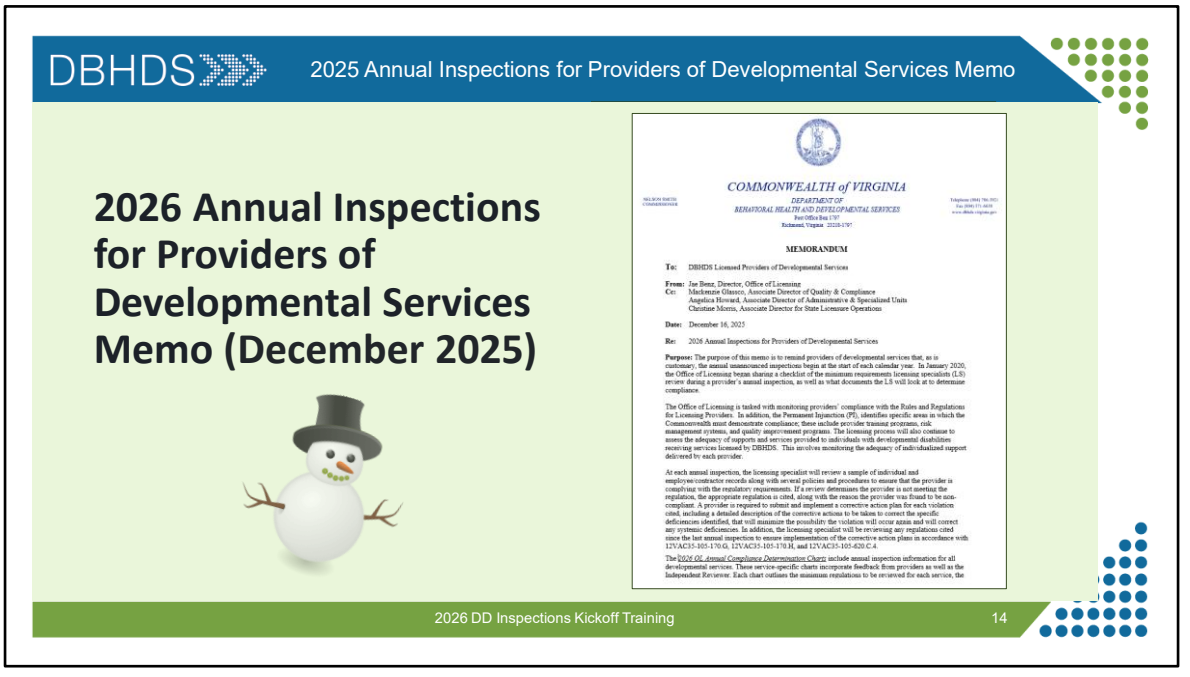
-Additionally, the OL will offer the provider an exit meeting which should be attended, at a minimum, by the person responsible for submitting the CAP and the owner if there is one

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

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

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

Now Mackenzie is going to take a few minutes to review the 2026 Annual Inspections for Providers of Developmental Services Memo



Mackenzie

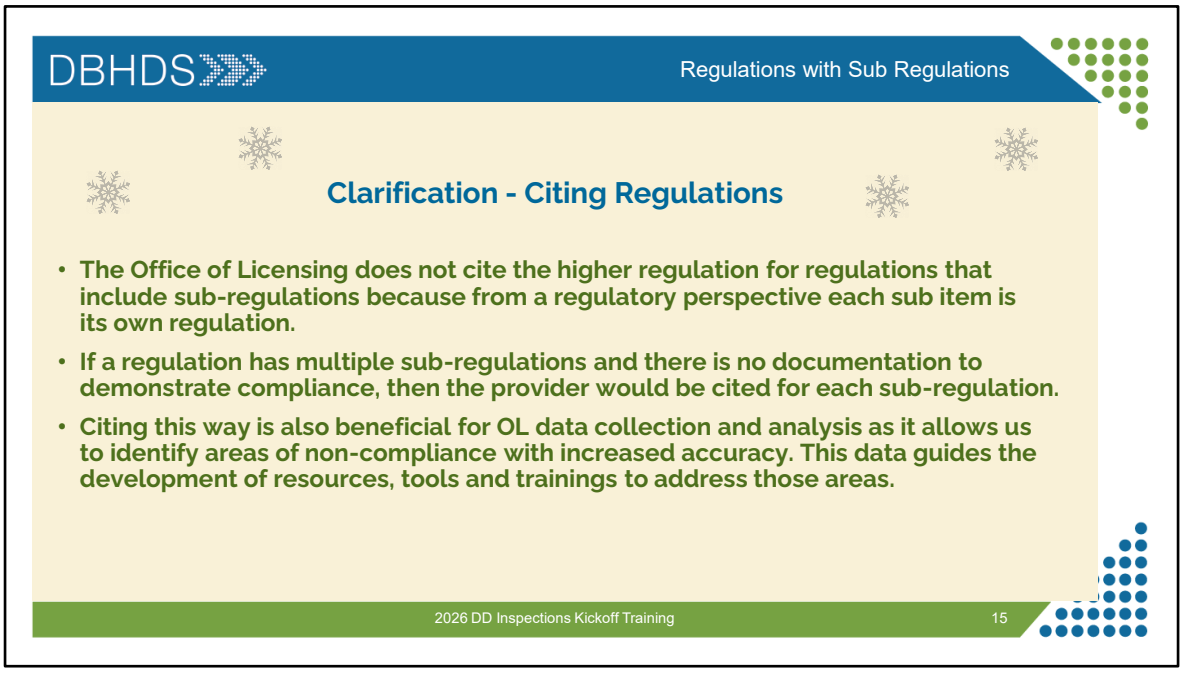
Thanks Karen, now that you have some background about what to expect, let's take a closer look at the 2026 Annual Inspections for Providers of Developmental Services Memo

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

In the memo, you will find the link to the *2026 OL Annual Compliance Determination Charts.* Once you click on the link, you will find service specific charts that incorporate feedback from providers as well as the consultants for the Independent Reviewer for all developmental services. Each chart outlines the minimum regulations that will be reviewed for each service, the documents that will be reviewed to determine compliance, and whether the documents will need to be submitted via the CONNECT provider portal or viewed onsite during the inspection.

We ask that you carefully review the memo and chart specific to your licensed service; and provide all information when requested by your licensing specialist.

CSBs/BHAs participating in the Multi-Agency Review Team (MART) must ensure that the documents included in the Master Document List are uploaded to the repository by January 1, 2026.



Mackenzie

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

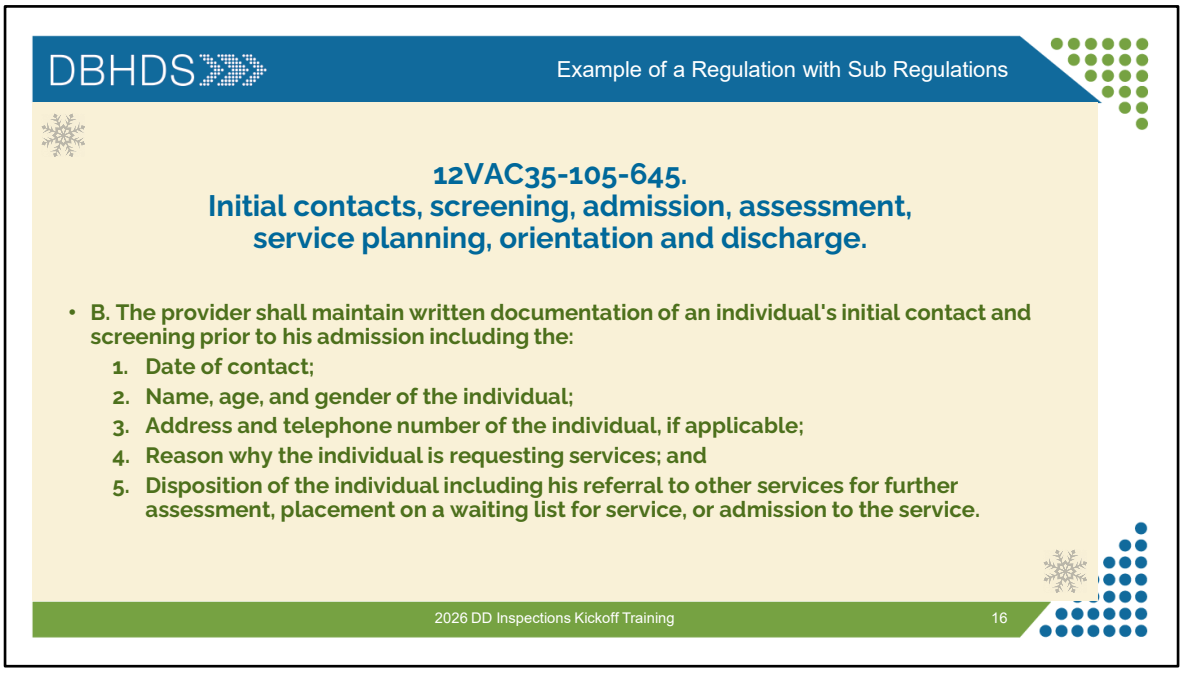
The Office of Licensing does not cite the higher regulation or "parent regulation," as it is sometimes referred, when there are other sub-regulations. From a regulatory perspective, each component of a regulation is its own regulation.

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

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

Additionally, it is much more helpful as relates to collecting data because it allows the

Office of Licensing to identify specific areas of non-compliance and develop resources, tools and trainings to address those needs.



Mackenzie

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

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

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

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

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

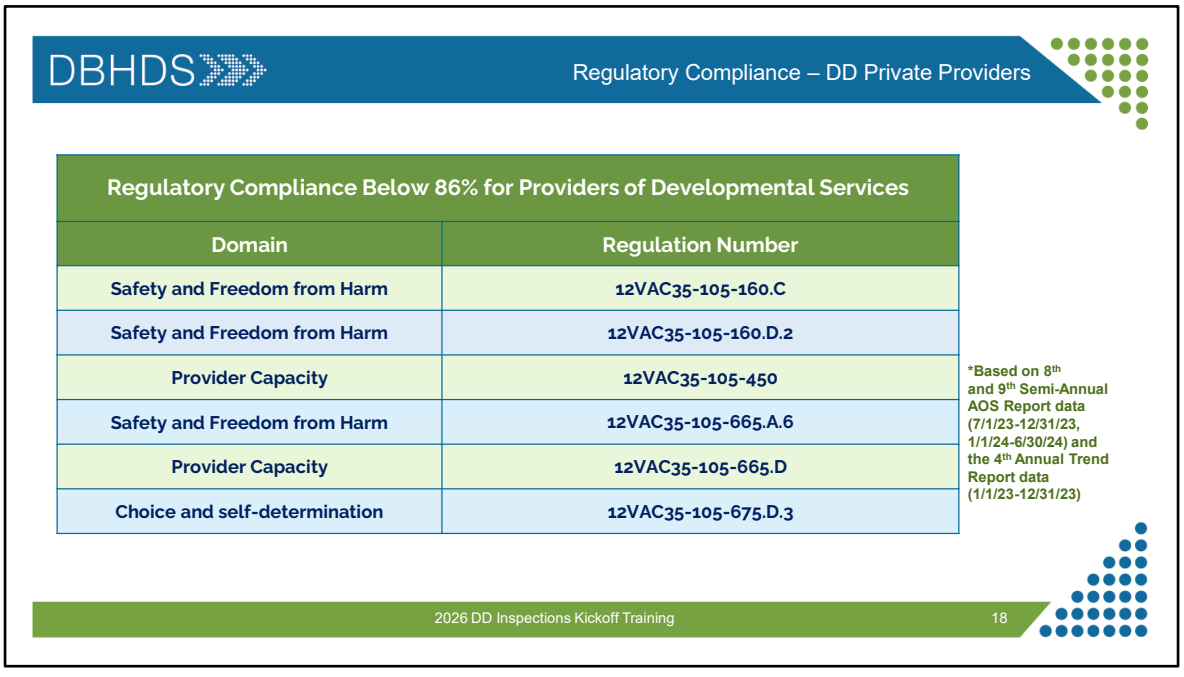
Now Karen is going to take us into Part I of the regulations overview.

KAREN

Let's dive into the first part of our regulations overview.

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

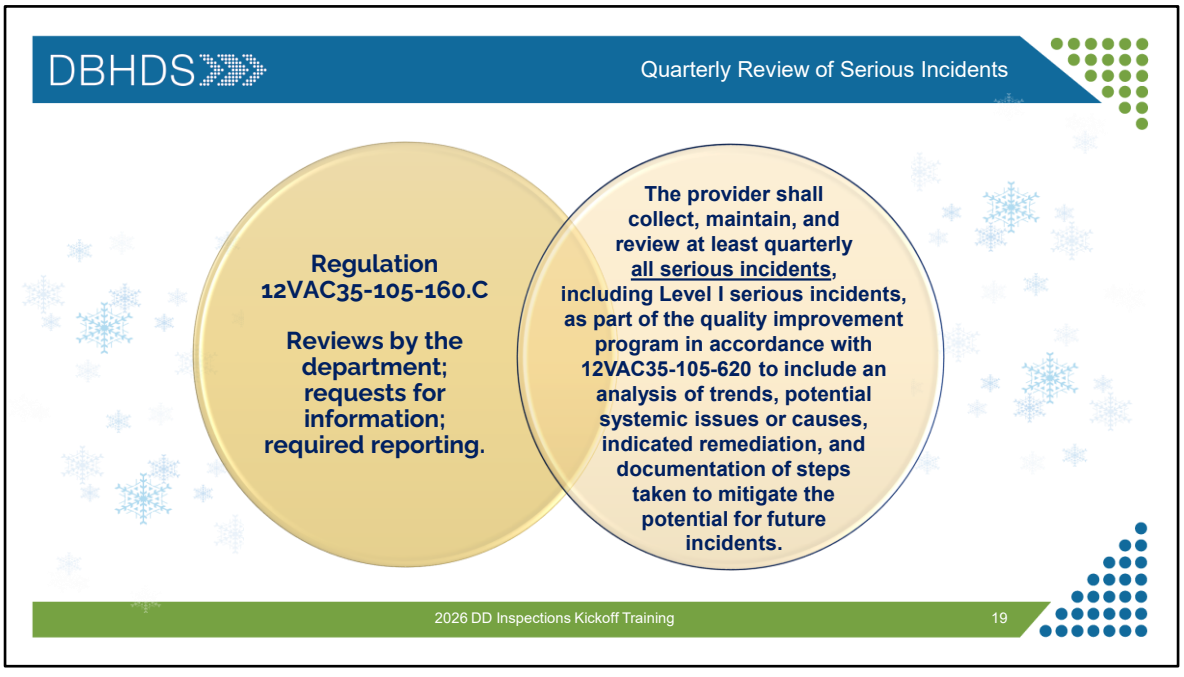
This first set of regulations we will review are applicable to *ALL* providers of developmental services. This includes those who provide case management services, as well as, those who provide non-case management services.



KAREN

Earlier we reviewed the regulations related to risk management and quality improvement that are below 86%. Here are some additional regulations where compliance is below 86% that will be reviewed with you today.

PAUSE FOR PEOPLE TO READ



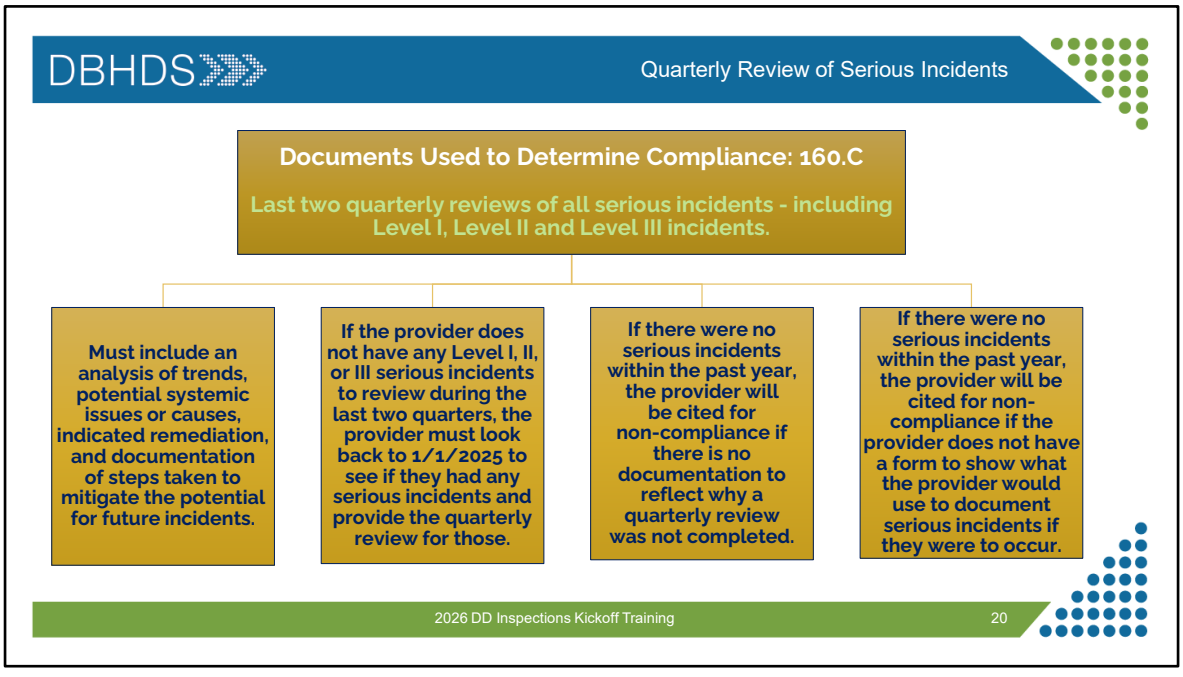
KAREN

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

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

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

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



KAREN

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

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

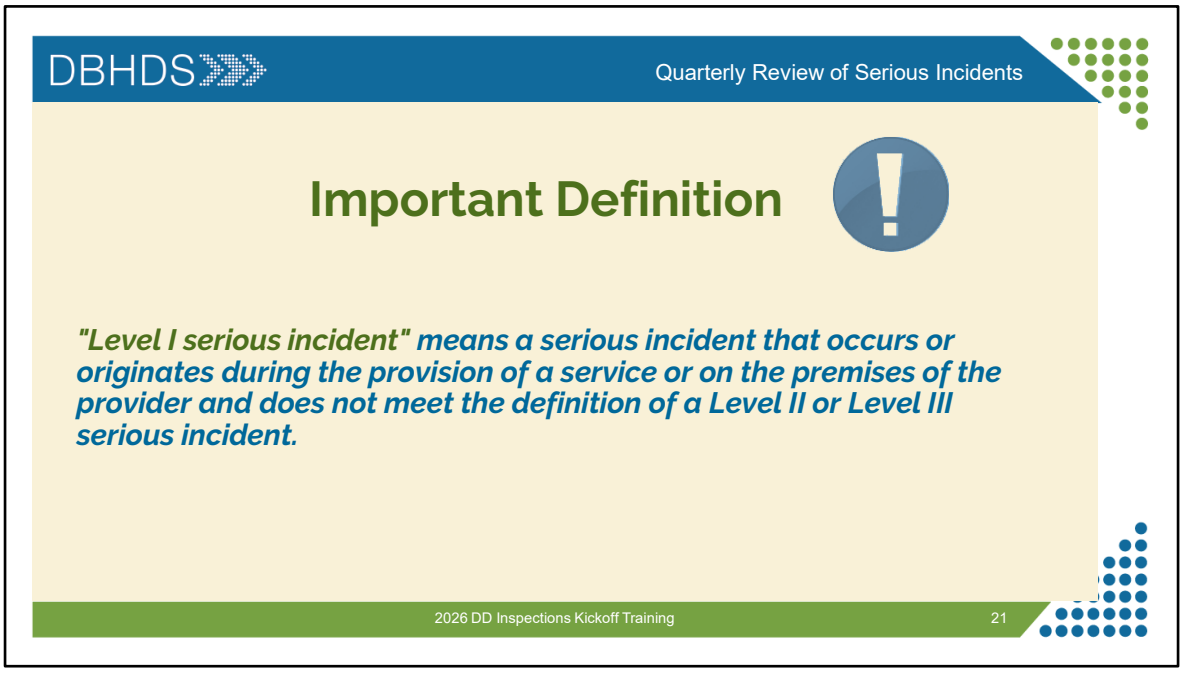
- The last two quarterly reviews must include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.

- If the provider does not have any Level I, Level II, or Level III serious incidents to review during the last two quarters, the provider must look back to 1/1/2025 to see if they had any serious incidents and provide the quarterly review for those.

- If there were no serious incidents within the past year, the provider will be cited for non-compliance if there is no documentation to reflect why a quarterly review was not completed.

- Providers need to ensure that they are completing quarterly reviews of serious incidents since this data is needed to complete the required annual systemic risk assessment. It is recommended that the provider use the risk tracking tools, located on the OL website, to track serious incidents. We will be sharing those links with you later in the presentation.

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



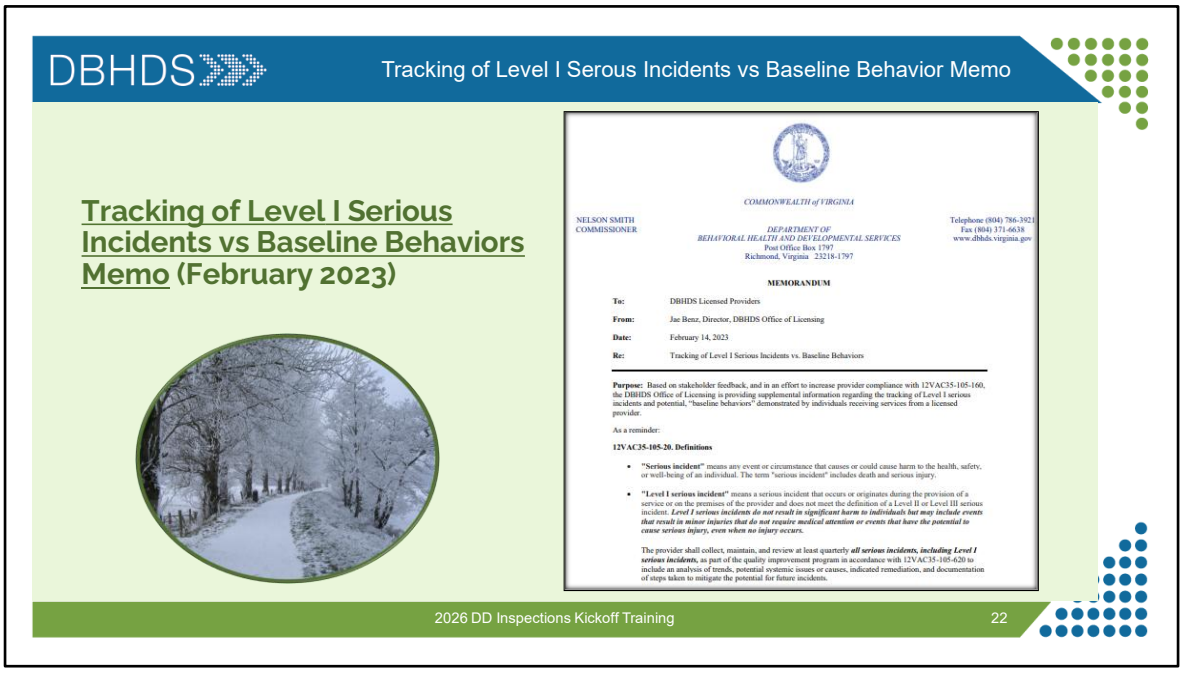
KAREN

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

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

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

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



KAREN

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

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

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

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

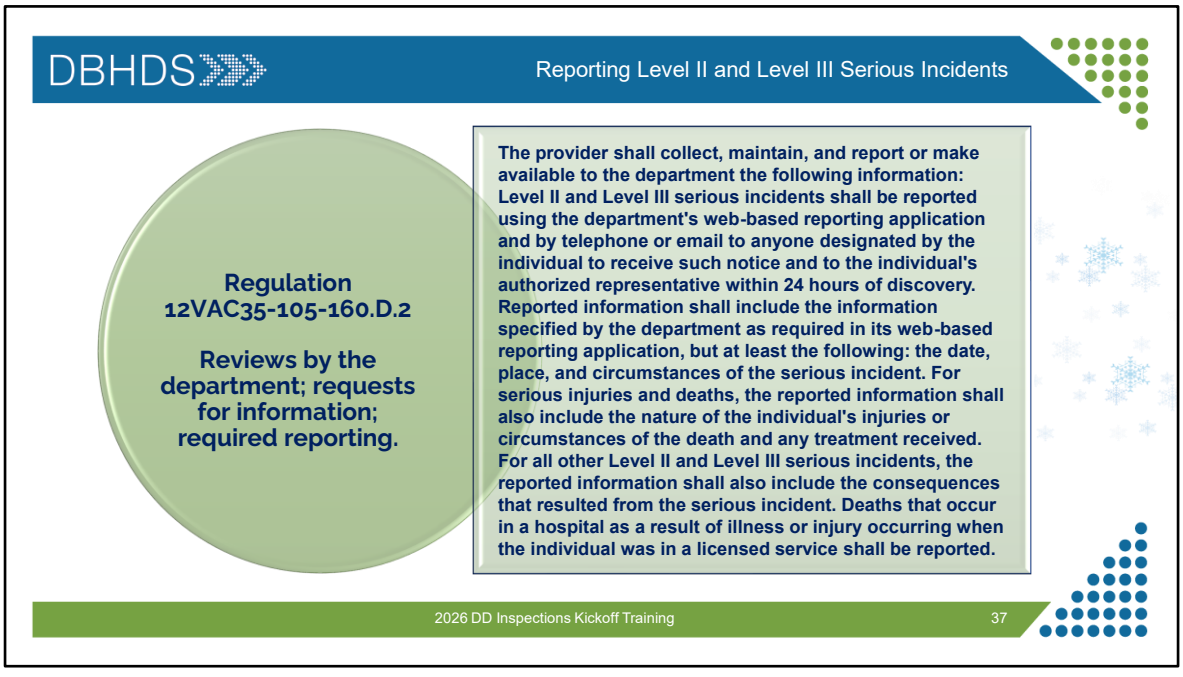
Any observed changes in the severity, intensity, support needs, and/or injury may result

in the behavior being classified as a Level I serious incident.

If the change in behavior meets the definition of a Level II or Level III serious incident, then the serious incident would need to be reported using the department's web- based reporting application and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery.

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

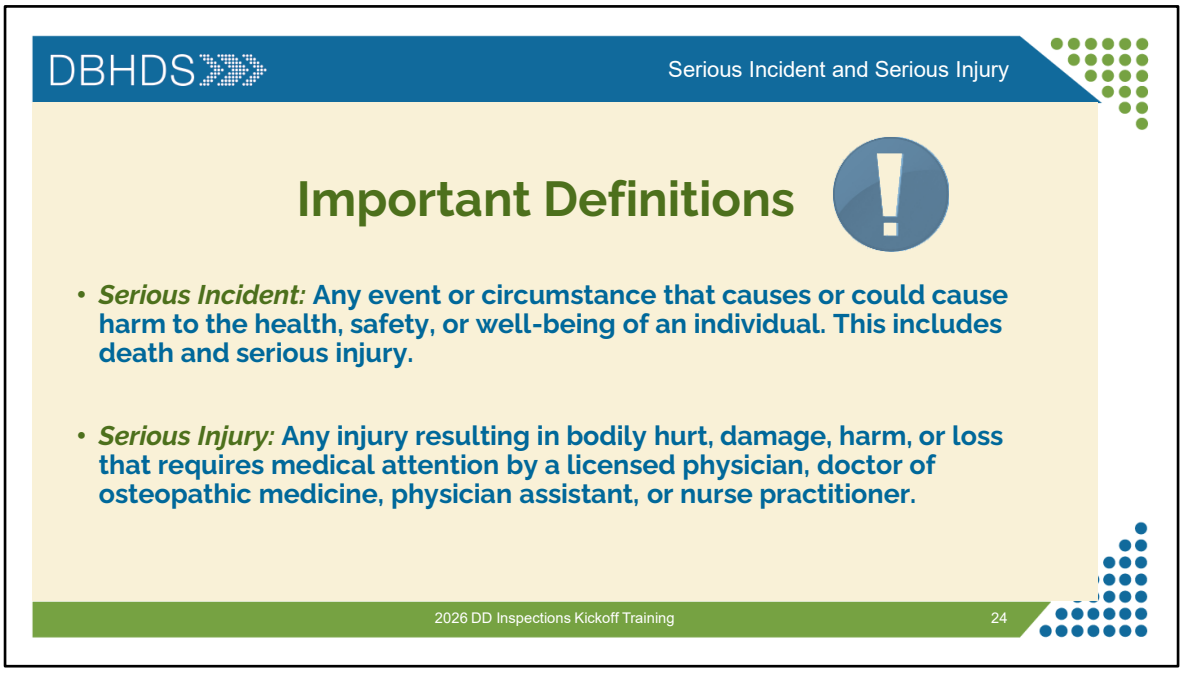
If you are not familiar with this memo, please take time to review it as several examples are provided.



KAREN

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

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

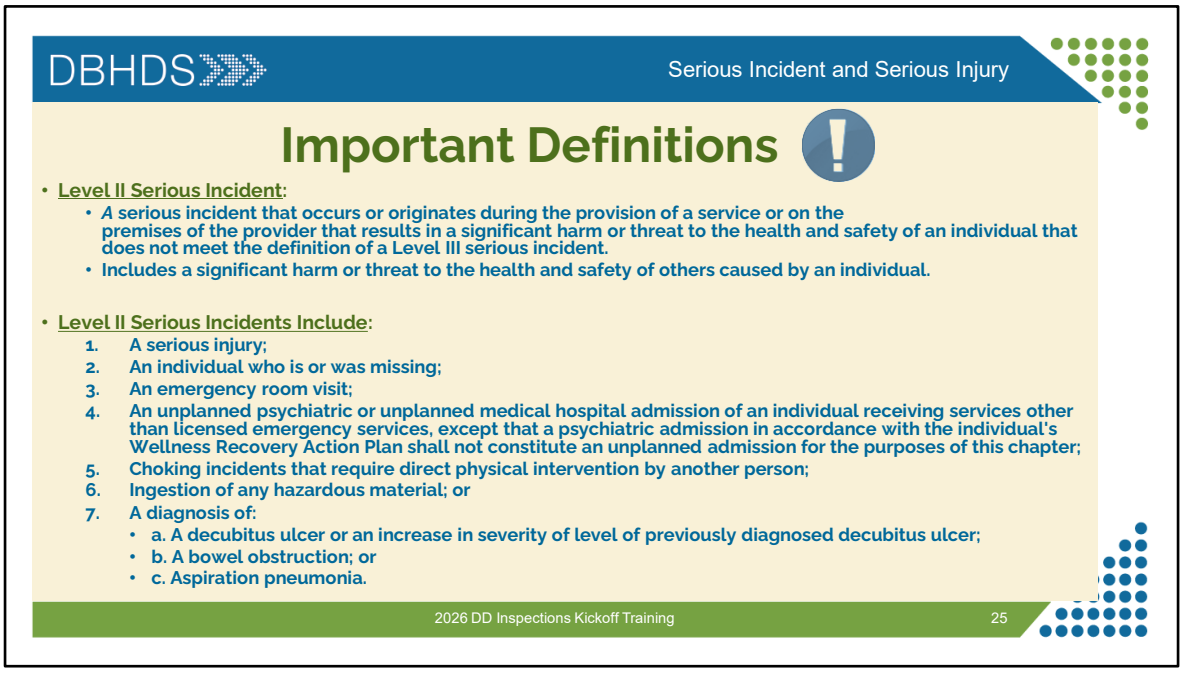


KAREN

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

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

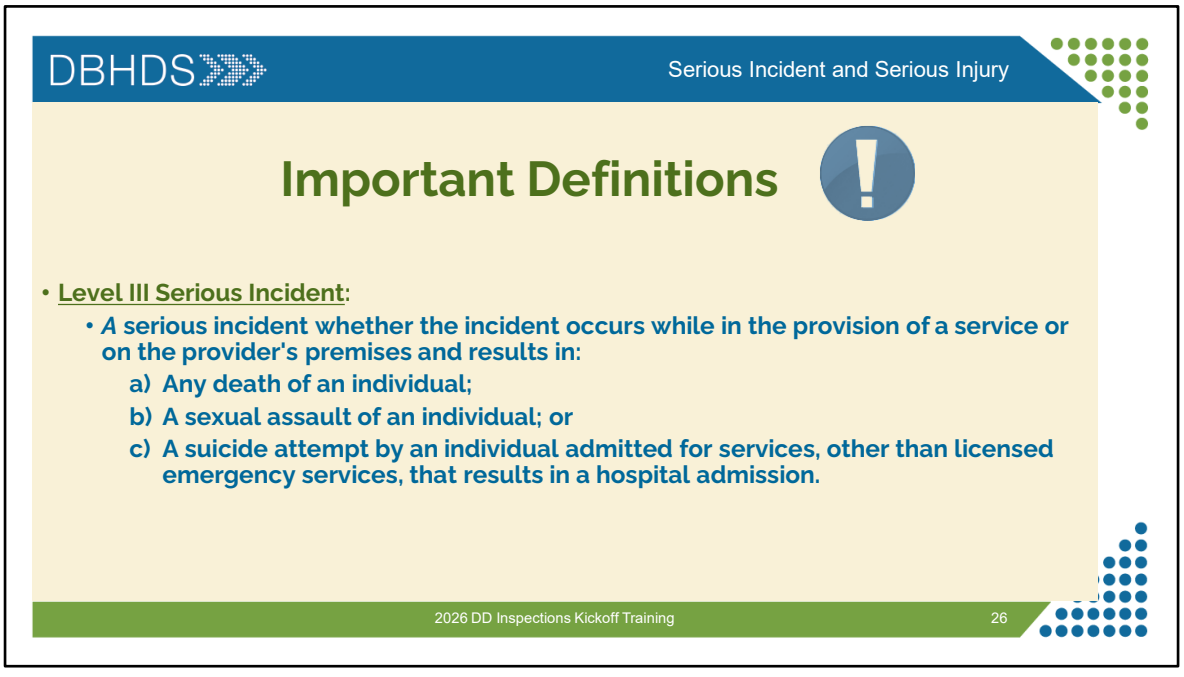
- A "**Serious injury**" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.



KAREN

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

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



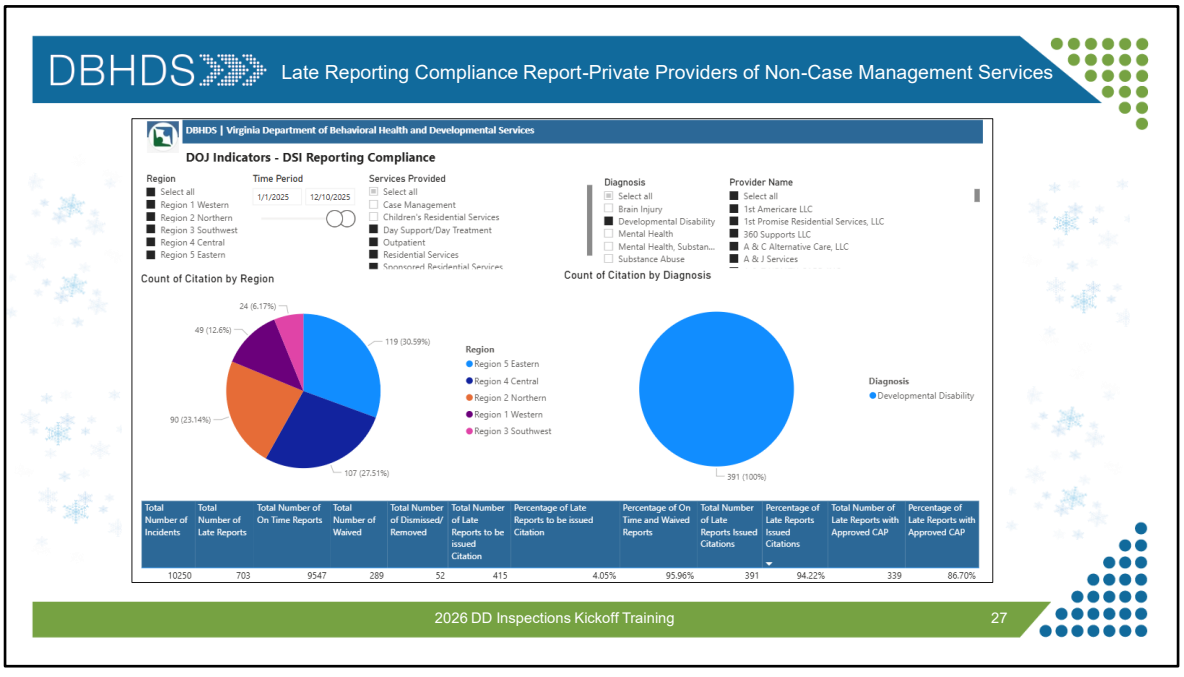
KAREN

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

  a. Any death of an individual;

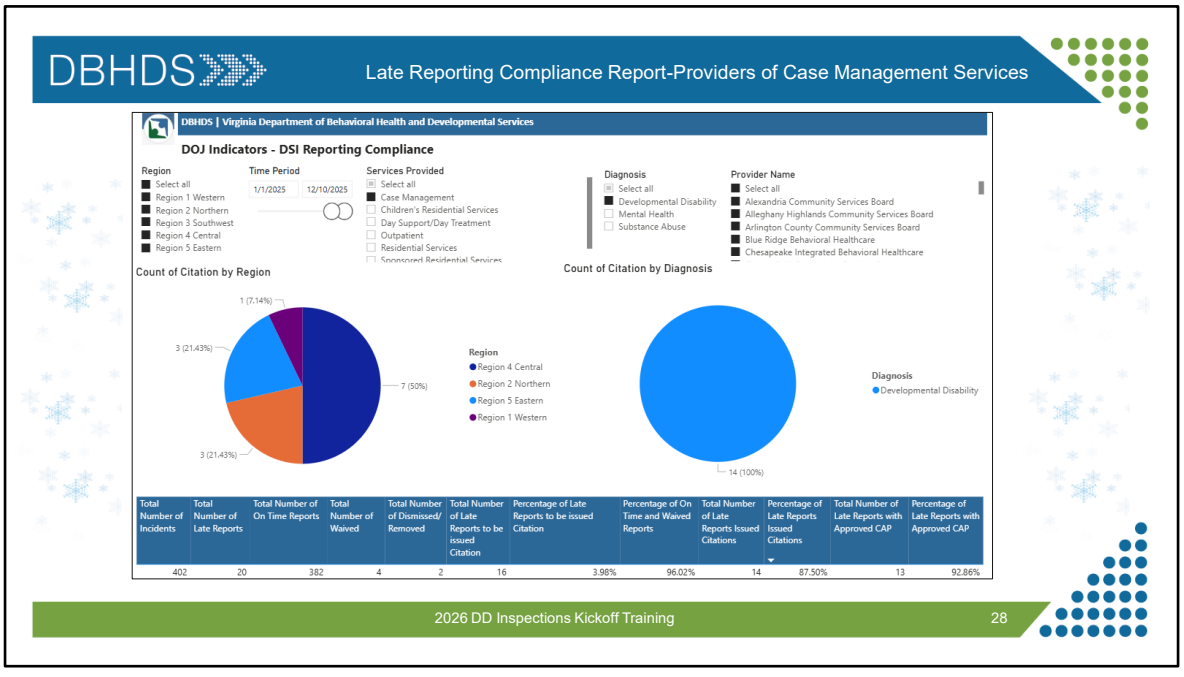
  b. A sexual assault of an individual; or

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



KAREN

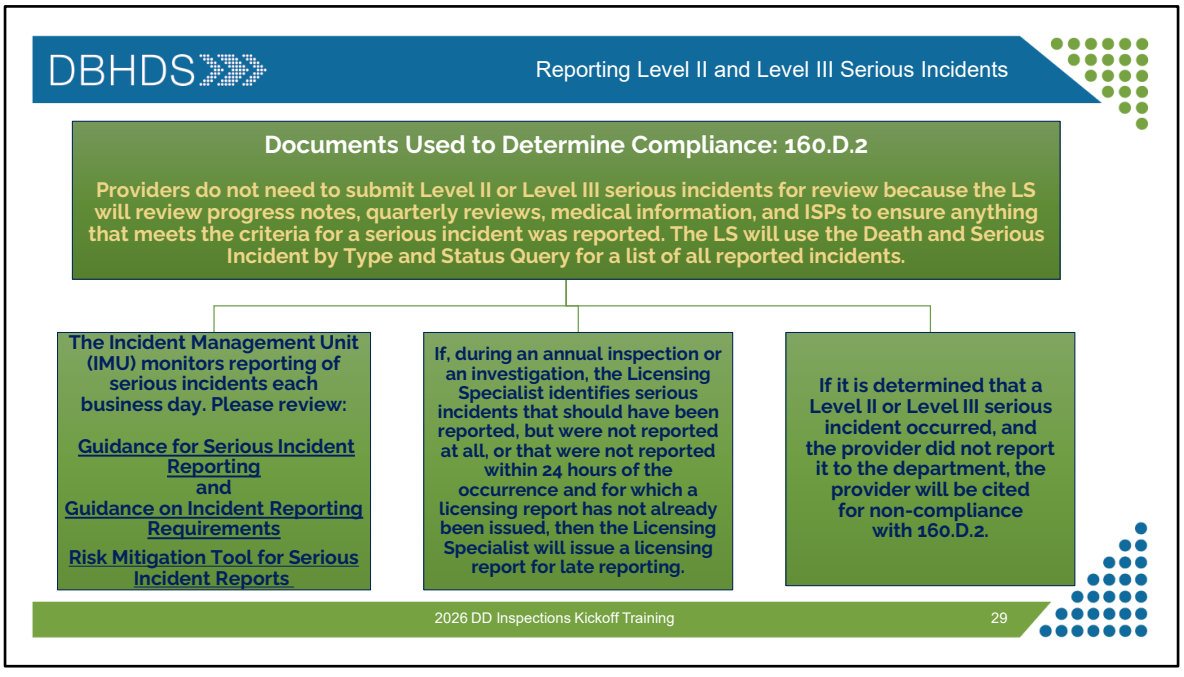
As it relates to reporting serious incidents to the department, from January 1, 2025 through December 10, 2025, the percentage of Developmental Disability Private Providers of Non-Case Management Services who reported Level II and Level III serious incidents on time was very close to 96%. This means that those providers who are reporting, as required, are for the most part reporting within 24 hours of discovery, which is great.



KAREN

During this same timeframe, Developmental Disability Providers of Case Management Services who reported Level II and Level III serious incidents on time was slightly over 96%.

Overall, providers who are reporting serious incidents are doing an excellent job of reporting within 24 hours of discovery!



KAREN

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

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

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

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

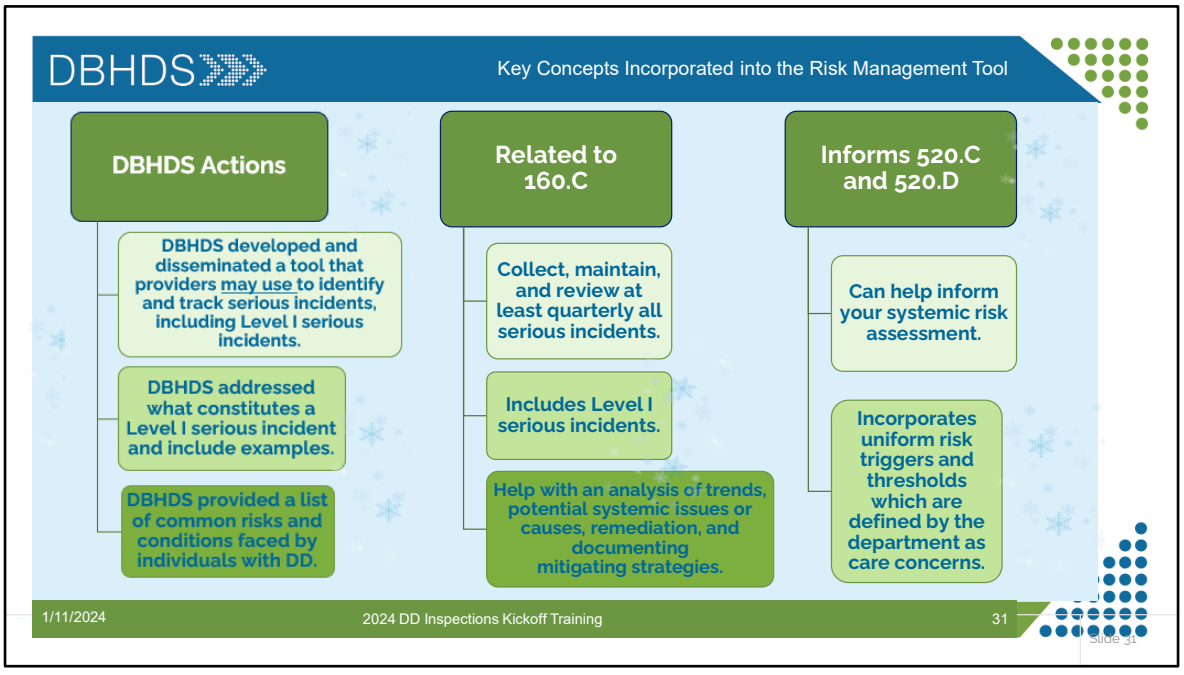
Specialist identifies serious incidents that should have been reported, but were not reported at all, or that were not reported within 24 hours of the occurrence, and for which a licensing report has not already been issued, then the Licensing Specialist will issue a licensing report for late reporting.

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

KAREN

One of the most helpful tools a provider can use to track serious incidents is the risk tracking tool.

Risk Tracking Tools were first introduced during the *Minimizing Risk Training* in 2023. These tools are built in excel and were last updated in 2024 based on feedback from providers.



KAREN

DBHDS developed and disseminated the risk tracking tools that providers may use to identify and track serious incidents, including Level I serious incidents.

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

For **160C**, it helps providers

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

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

- The tool incorporates uniform risk triggers and thresholds, which are defined by the department- also known or referred to as “care concerns”.
- It also includes the definition and examples of Level I incidents and provides a list of common risks and conditions faced by individuals with developmental disabilities.

We have noticed that more providers are utilizing these tools. If you are using the tool, please make sure you are scrolling all the way to the right of the tool to access all tabs. In 2024, the Systemic Risk Assessment template was added to the tool, which is located on the last tab of the workbook.

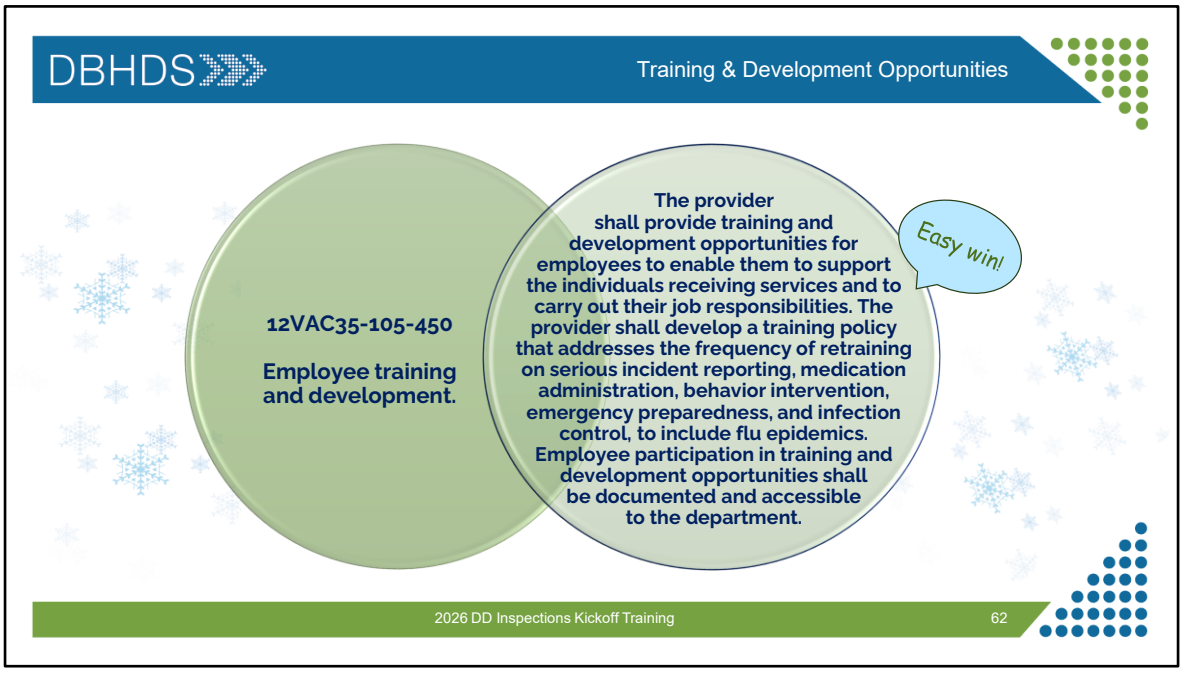
If these tools are used correctly, you are more likely to achieve compliance with these regulatory requirements.

KAREN

If you would like to learn more about the risk tracking tools and their functionality, Mary Beth Cox, Quality Improvement Coordinator with the Office of Clinical Quality Management will be offering a live training on January 8, 2026, from 10am-11am.

The link to register is included on the slide.

Now I'm going to pass it over to Mackenzie who is going to talk about provider training and development.



MACKENZIE

Thanks Karen.

Let's move along to Regulation 450 which includes requirements for employee training and development. This regulation falls under the Adequacy of Supports, and the Permanent Injunction.

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

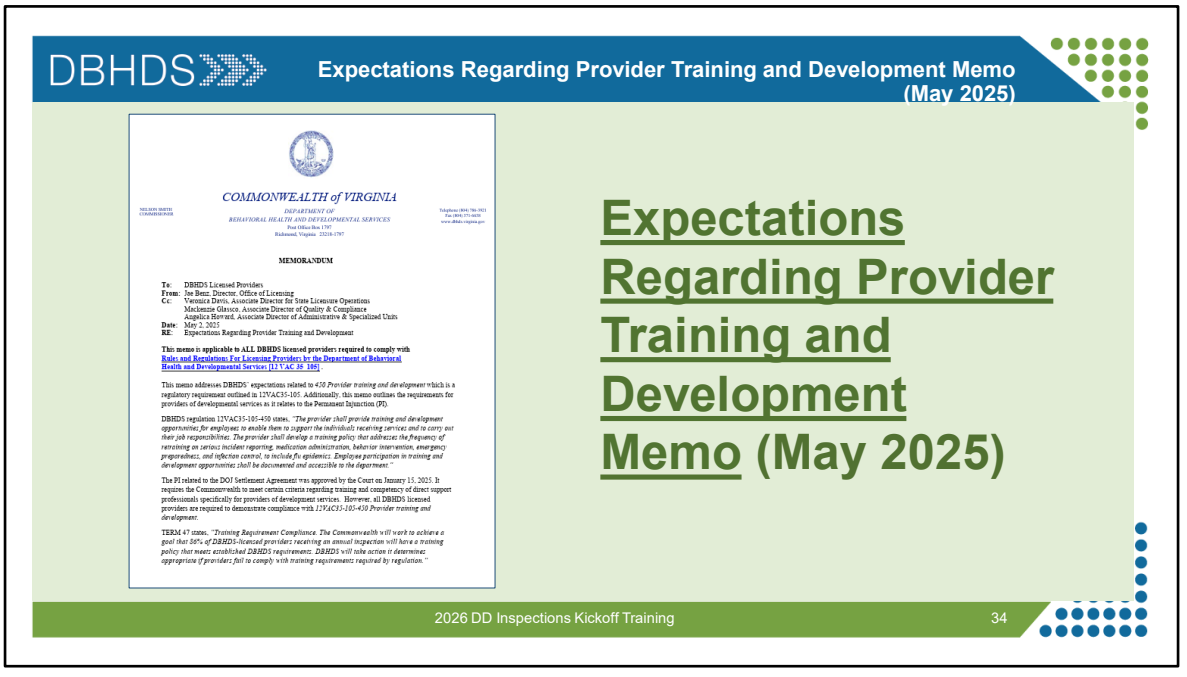
The provider shall develop a training policy that addresses the frequency of retraining

on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics.

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

Based on data, the primary reason providers are non-compliant with this regulation is because providers are not maintaining documentation within the employee or contractor record to demonstrate their participation in training and development activities.

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

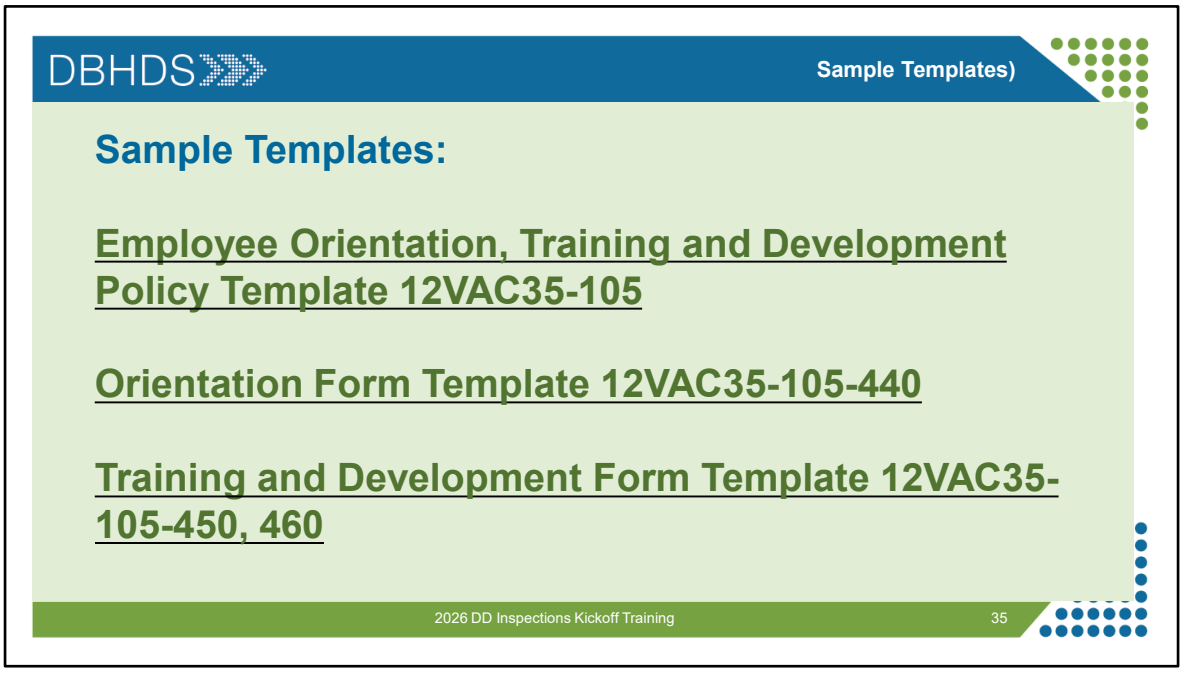


MACKENZIE

In May 2025, the OL posted the "Expectations Regarding Provider Training and Development" memo.

If it is determined during an annual inspection that any licensed service failed to comply with any component of regulation 12VAC35-105-450, the Office of Licensing will issue a licensing report describing the noncompliance and request the provider submit a Corrective Action Plan (CAP) that addresses all components of the cited violation. Additionally, the provider is required to submit their revised training policy, which must include the effective date, and proof that they are compliant with their training policy.

DBHDS also developed policy and form templates to assist providers with meeting the training and development requirements.

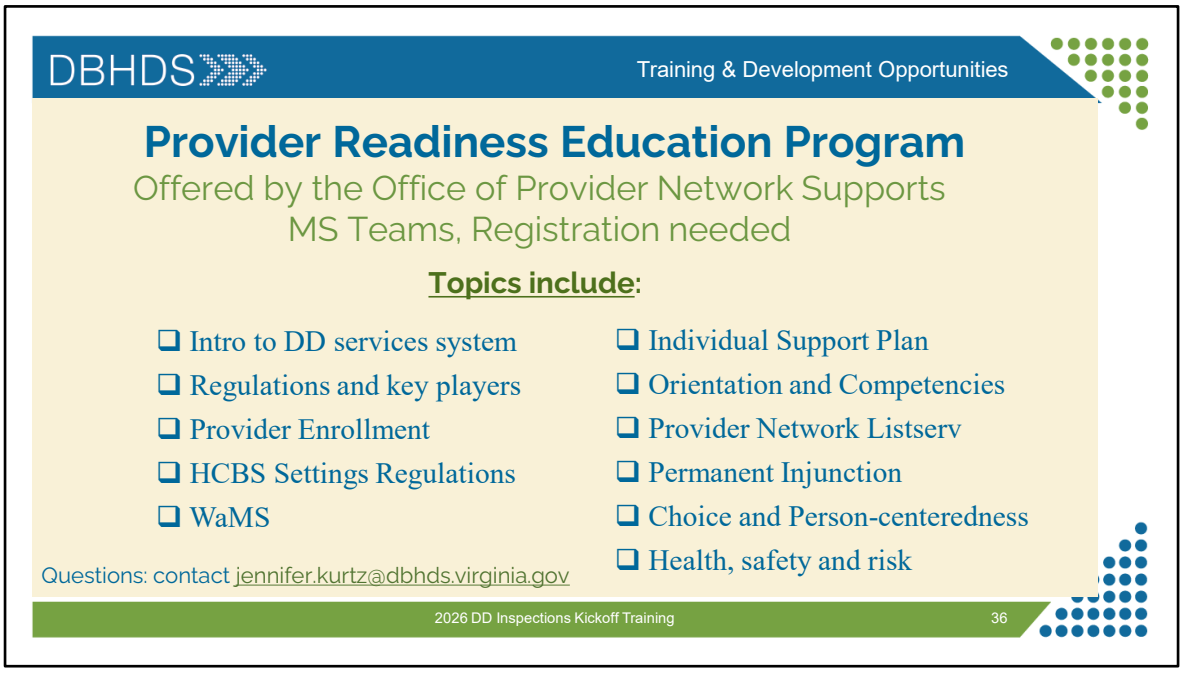


MACKENZIE

The links on this slide are included in the provider training and development memo

- Employee Orientation, Training and Development Policy Template
- Orientation Form Template and
- Training and Development Form Template

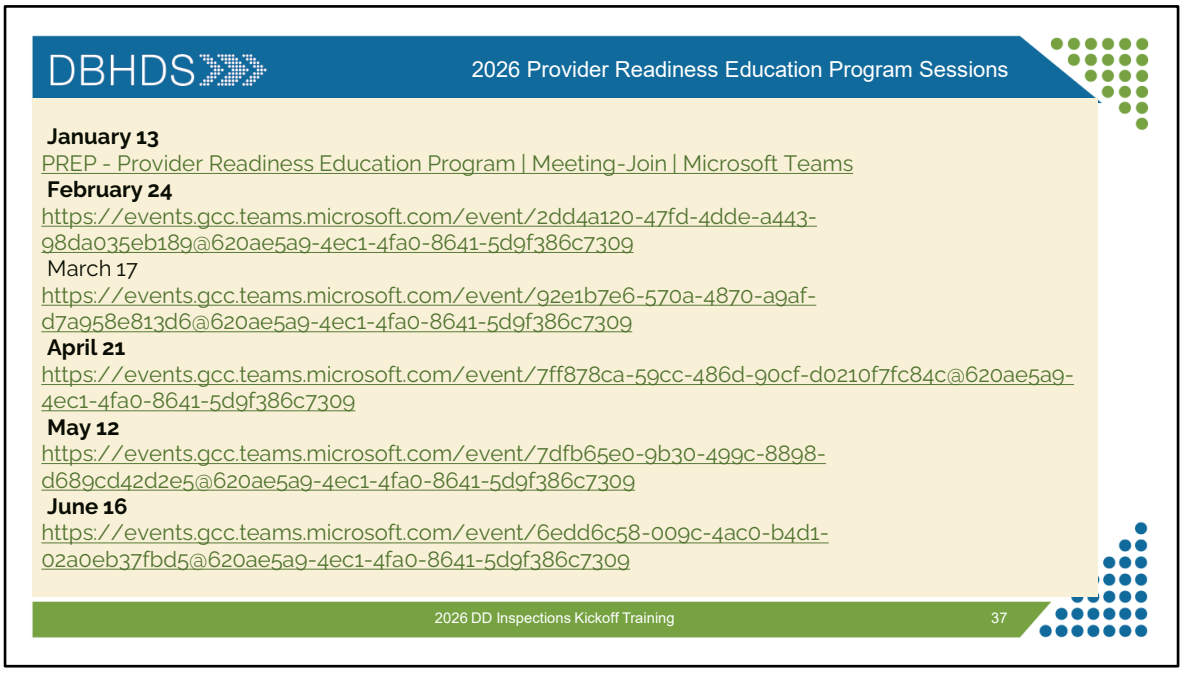
We highly encourage you to utilize these tools.



MACKENZIE

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

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



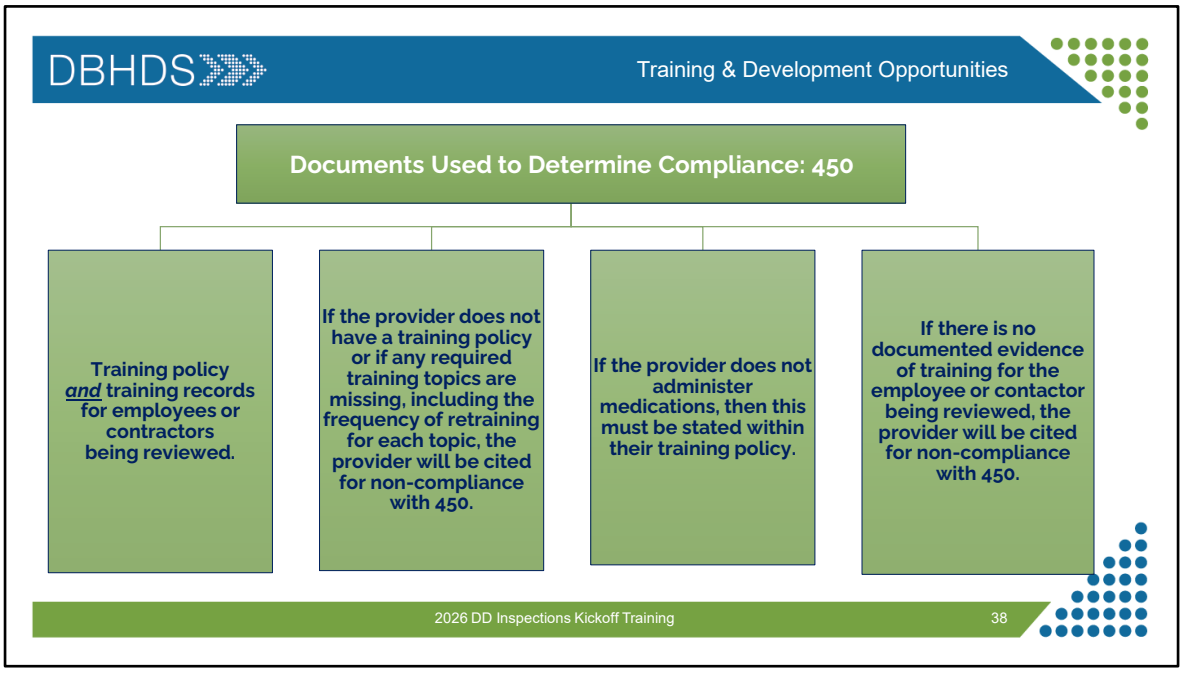
MACKENZIE

Links to register for these trainings are sent out through the provider network list serve.

This slide shows the schedule for the PREP sessions offered by the Office of Provider Network Supports through June 2026

All classes are held from 10am-Noon

Please reach out to Jennifer Kurtz with the Office of Provider Network Supports if you have questions or need help registering.

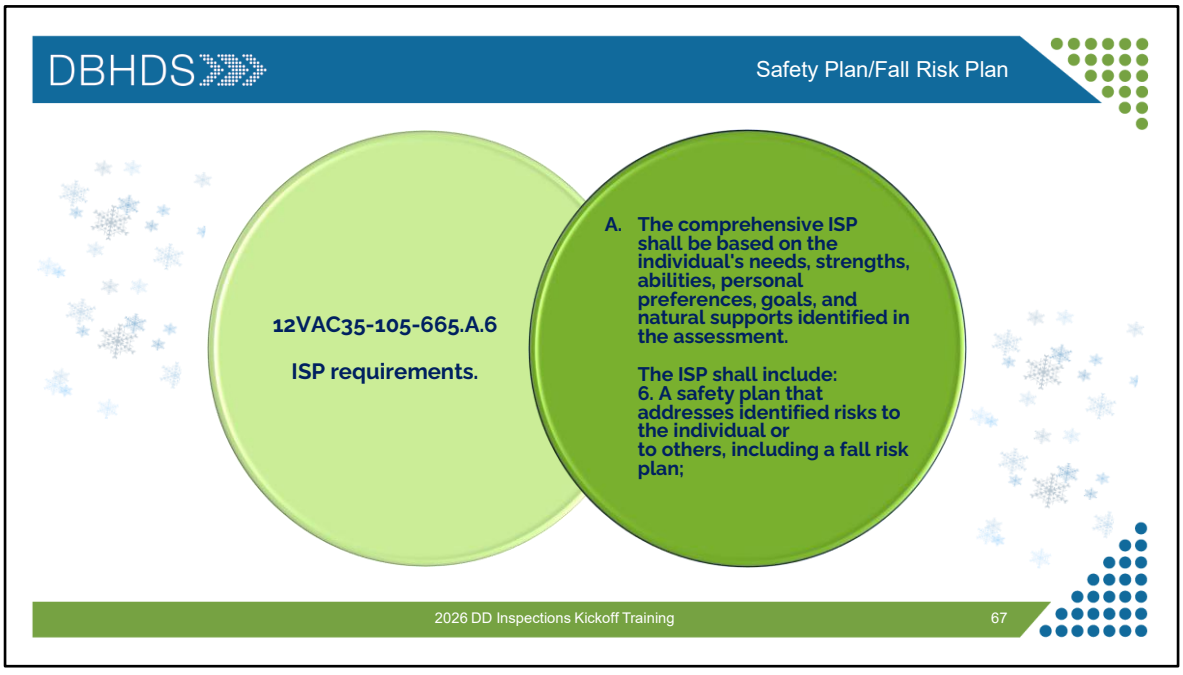


MACKENZIE

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

- Training policy; and
- Training records for employees or contractors being reviewed.
- If the provider does not have a training policy or if any required training topics are missing, including the frequency of retraining for each topic, the provider will be cited for non-compliance with 450.
- If the provider does not administer medications, this must be stated within their training policy.
- If there is no documented evidence of training for the employee or contactor being

reviewed, the provider will cited for non-compliance with 450.



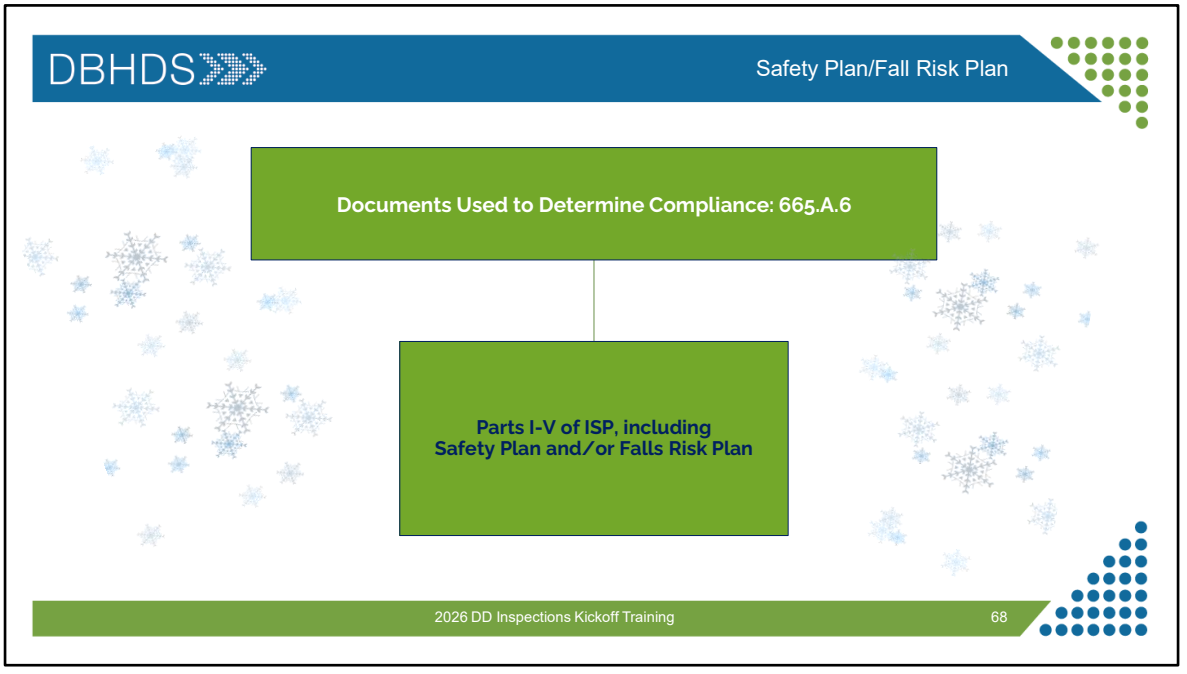
MACKENZIE

665.A.6 states

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

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

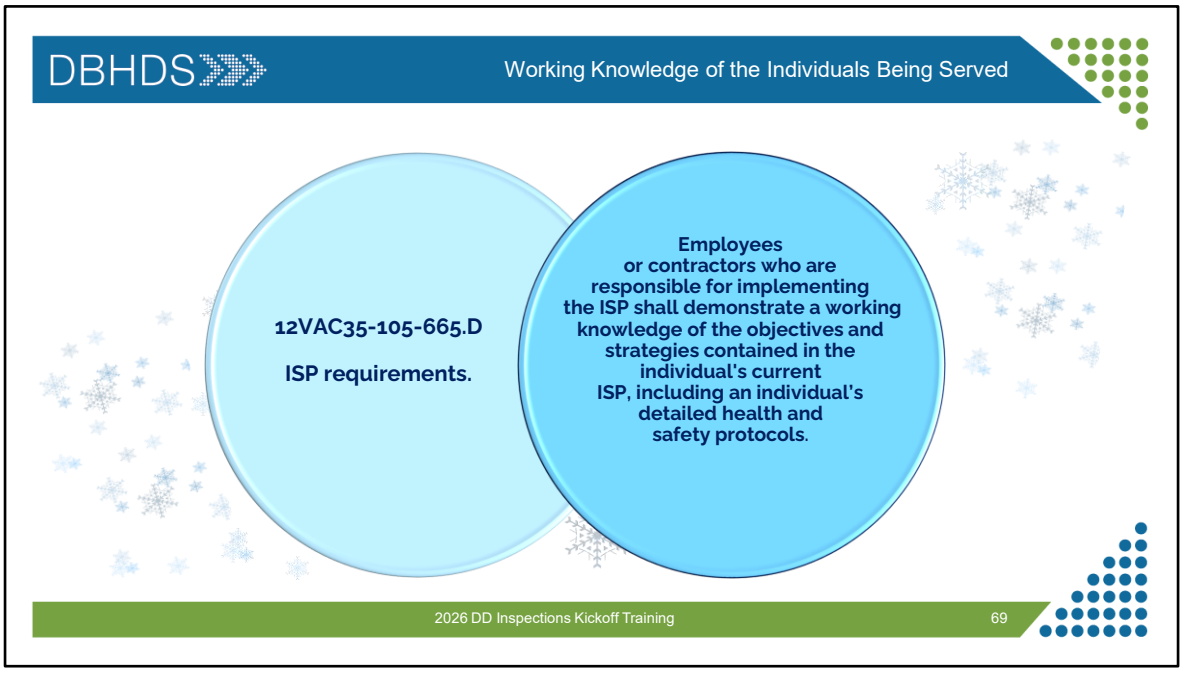
It is important that providers are assessing individuals at least annually, or as needed, to determine if a safety plan or fall risk plan needs to be included in their ISP or if their current plan needs to be updated.



MACKENZIE

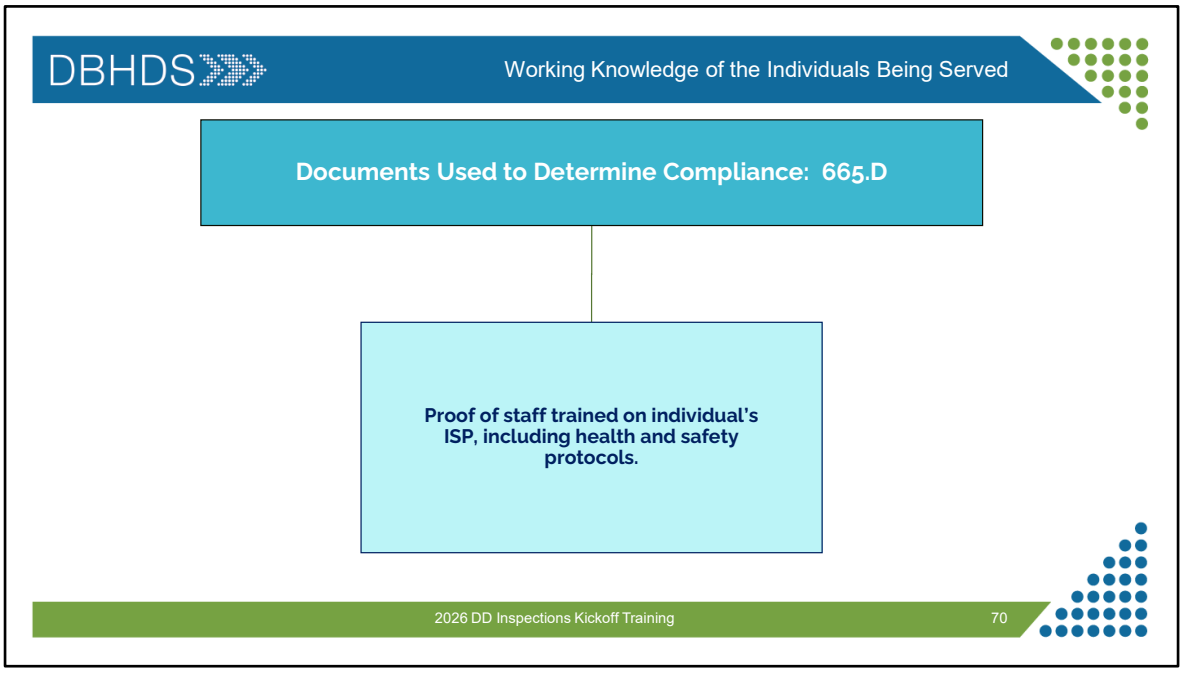
Documents the Office of Licensing will review to determine compliance

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



MACKENZIE

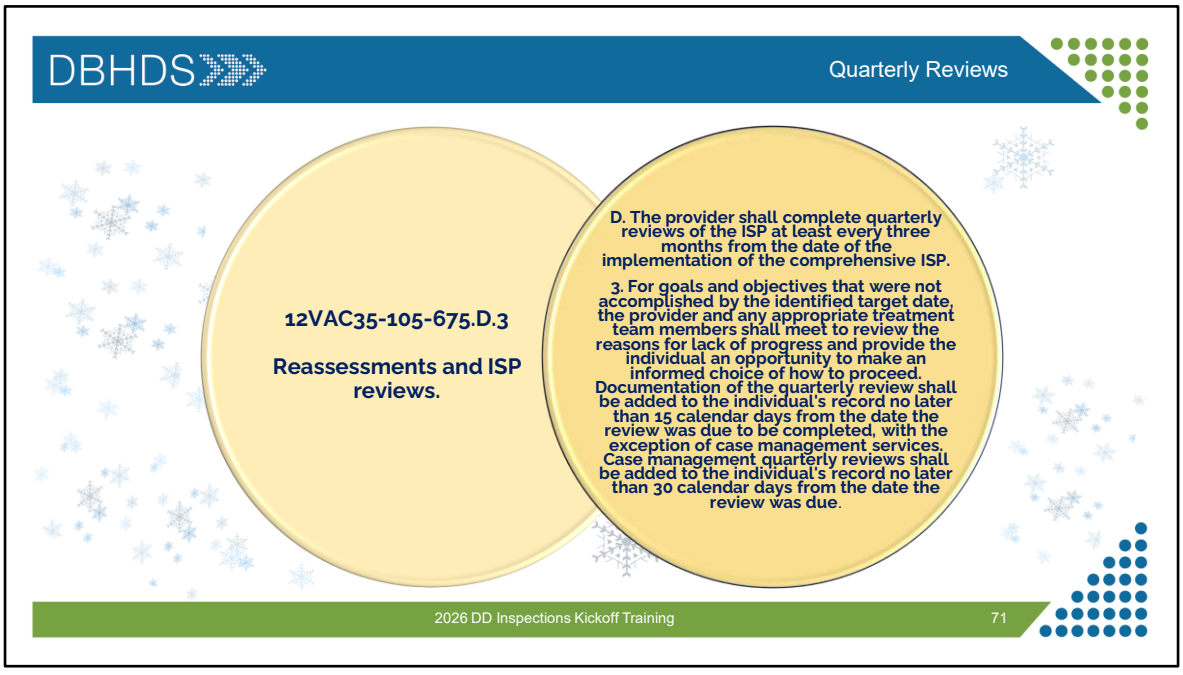
665.D. requires employees or contractors who are responsible for implementing the ISP to demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP, including the individual's detailed health and safety protocols.



MACKENZIE

Documents the Office of Licensing will review to determine compliance

The Office of Licensing will review documentation to demonstrate that staff are trained on the individual's ISP, including health and safety protocols. This could include a staff training logs, signature sheets to acknowledge training was received or other documentation to demonstrate compliance.



MACKENZIE

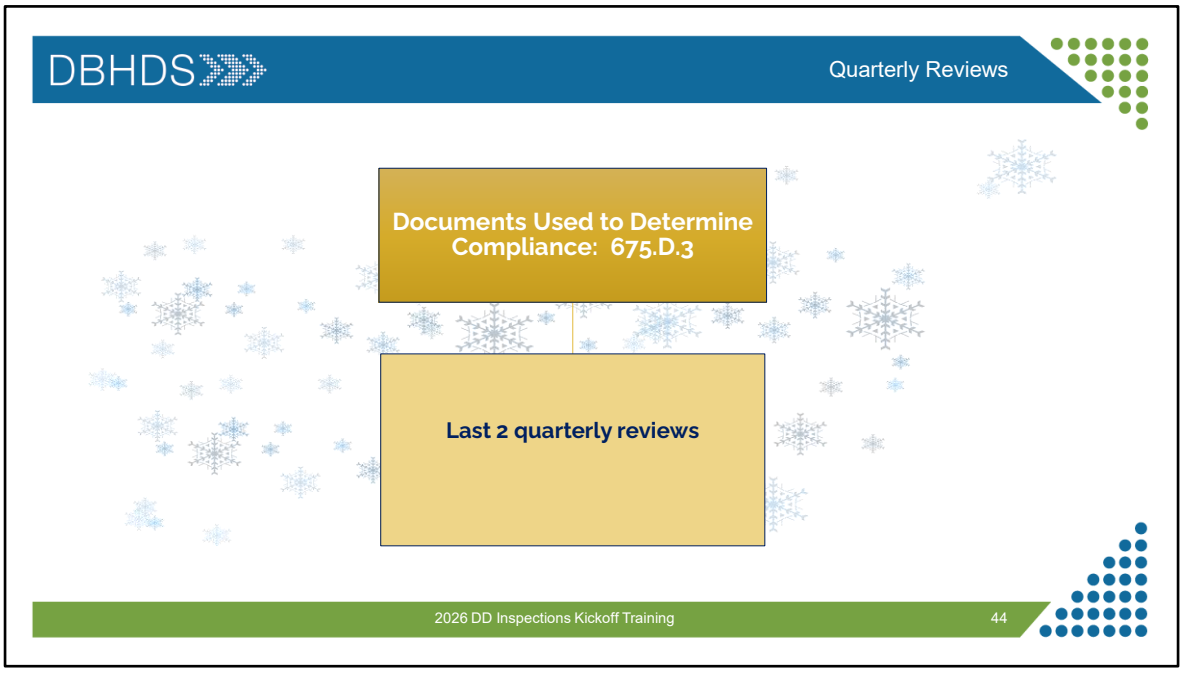
675.D.3 requires the provider to complete quarterly reviews of the ISP at least every three months from the date of the implementation of the comprehensive ISP.

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

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

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

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



MACKENZIE

Documents the Office of Licensing will review to determine compliance

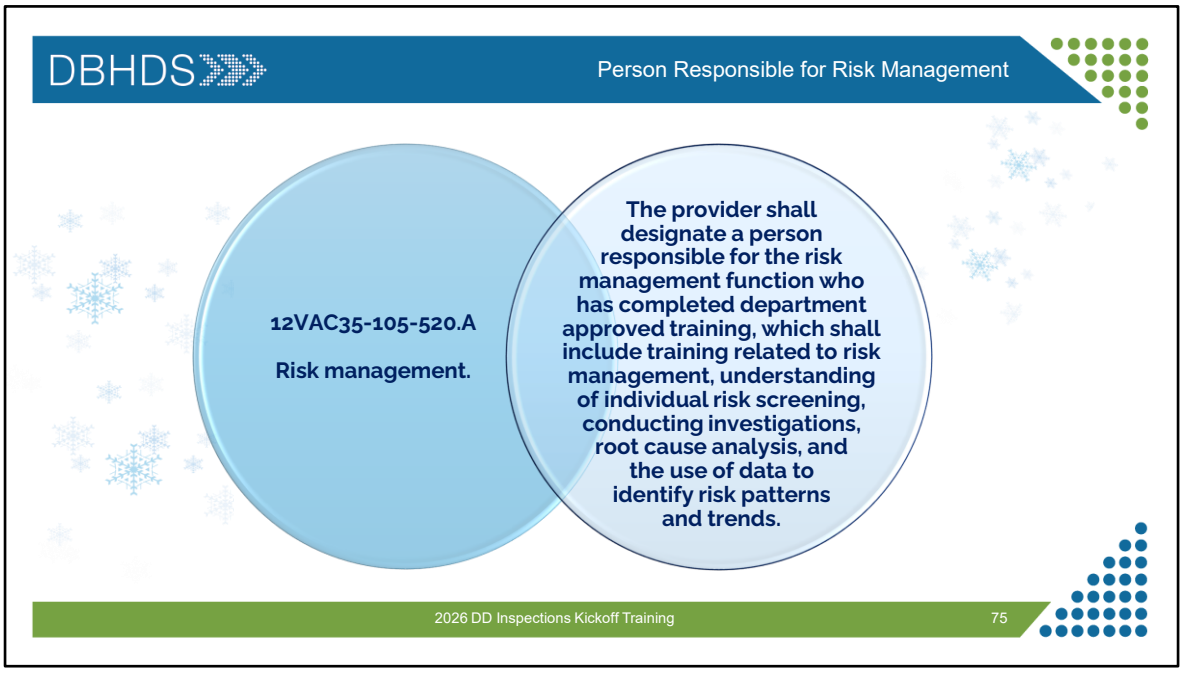
The OL will be reviewing the last two quarterly reviews for those individuals being reviewed.

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

Larisa

So now we're going to move along into the second part of our Regulations overview. These next few regulations we'll look at are specific to a provider's risk management and quality improvement programs. These regulations are applicable to Providers of Case Management AND Non-Case Management services.

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



KAREN

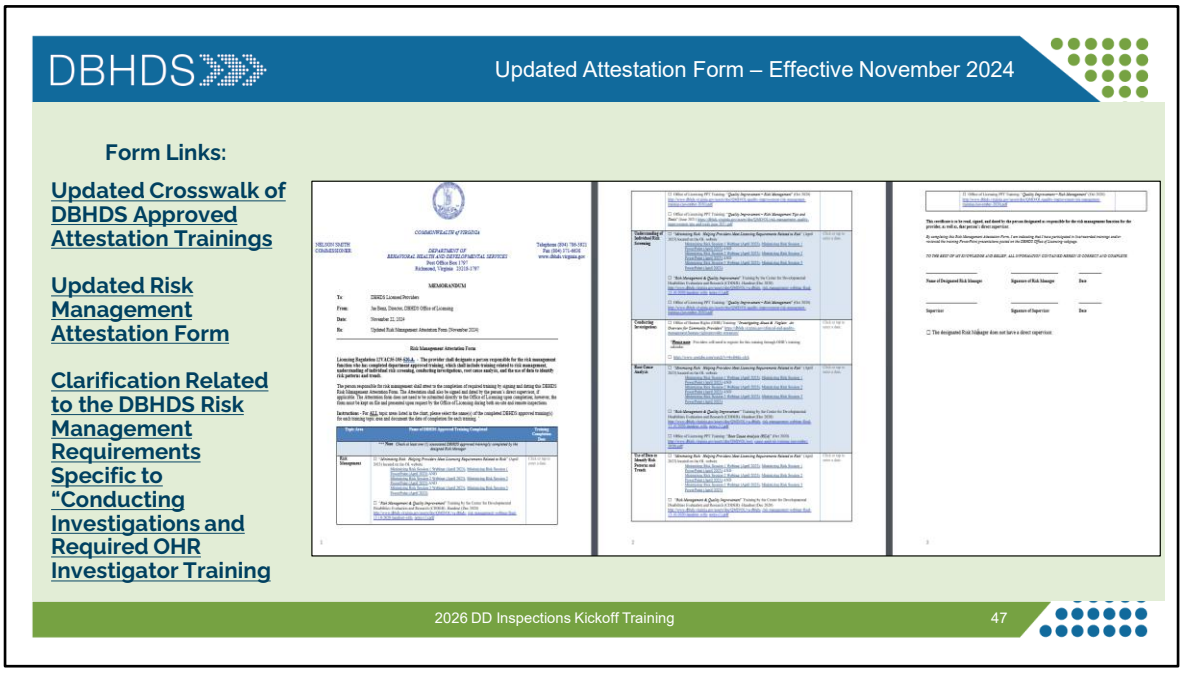
Thanks Larisa

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

Let's look first at Regulation **520.A**, which states that the provider shall designate a person responsible for the risk management function who has completed department approved training, which shall include training related to risk management, understanding of individual risk screening, conducting investigations, root cause analysis, and the use of data to identify risk patterns and trends.

A provider may have multiple staff responsible for risk management tasks. However, the

provider must designate a “primary” person responsible for the risk management function. Information for the “primary” person responsible for this function must be submitted to the department for review.

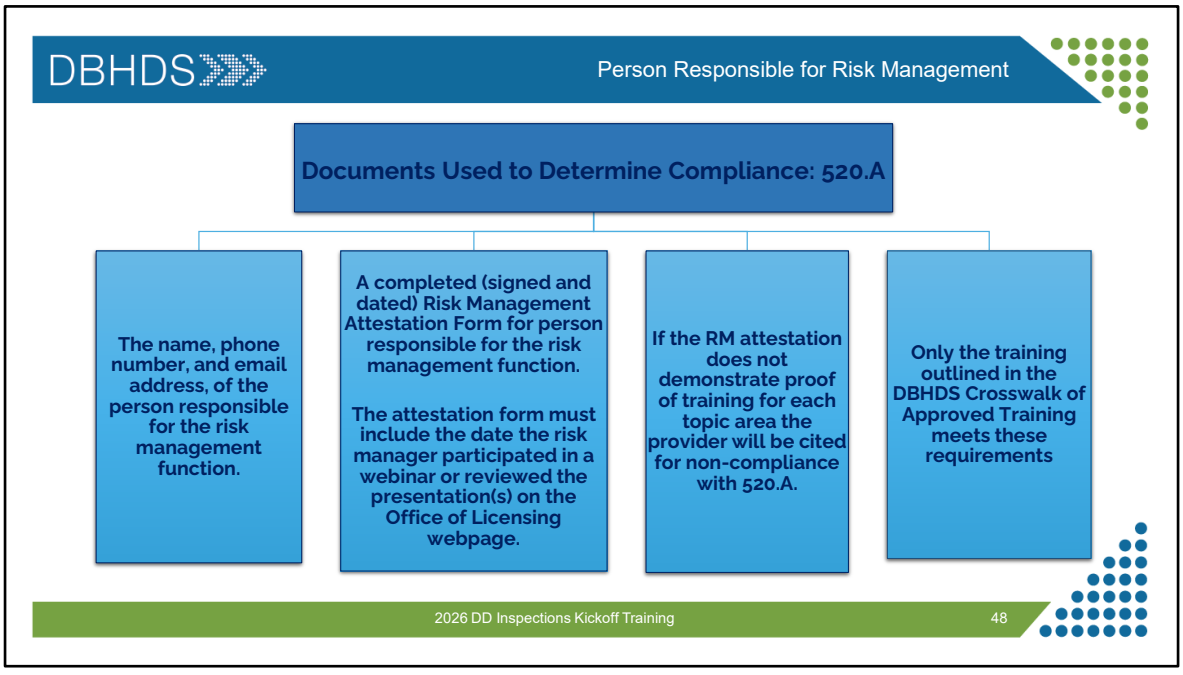


KAREN

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

Just a few additional reminders:

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



KAREN

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

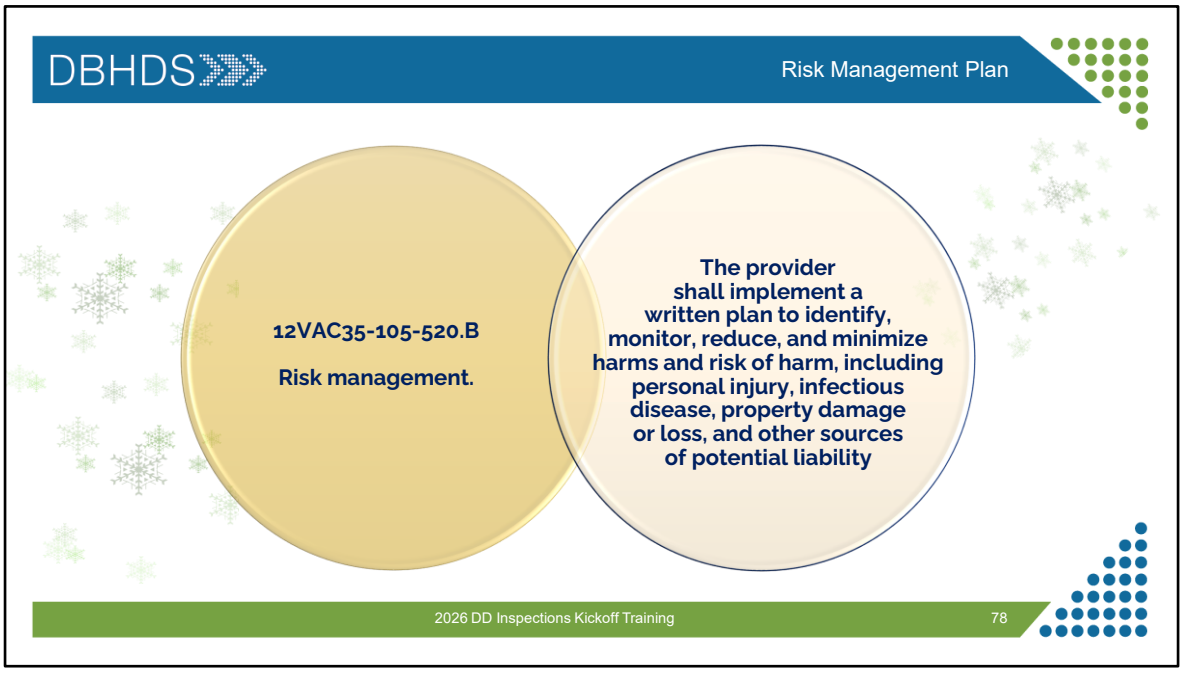
- The name, phone number, and email address of the person responsible for the risk management function.

- A completed (signed and dated) DBHDS Risk Management Attestation form.

- If the Risk Management attestation form does not demonstrate proof of training for each of the 5 topic areas, the provider will be cited for non-compliance with 520.A.

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

- **Providers are not required to submit the job description for the designated risk manager.**



KAREN

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

Regulation 520.B. states: The provider shall implement a written plan to identify, monitor, reduce, and minimize harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability.

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

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

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

- Personal injury
- Infectious diseases

- Property damage/loss
- And other sources of potential liability.

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

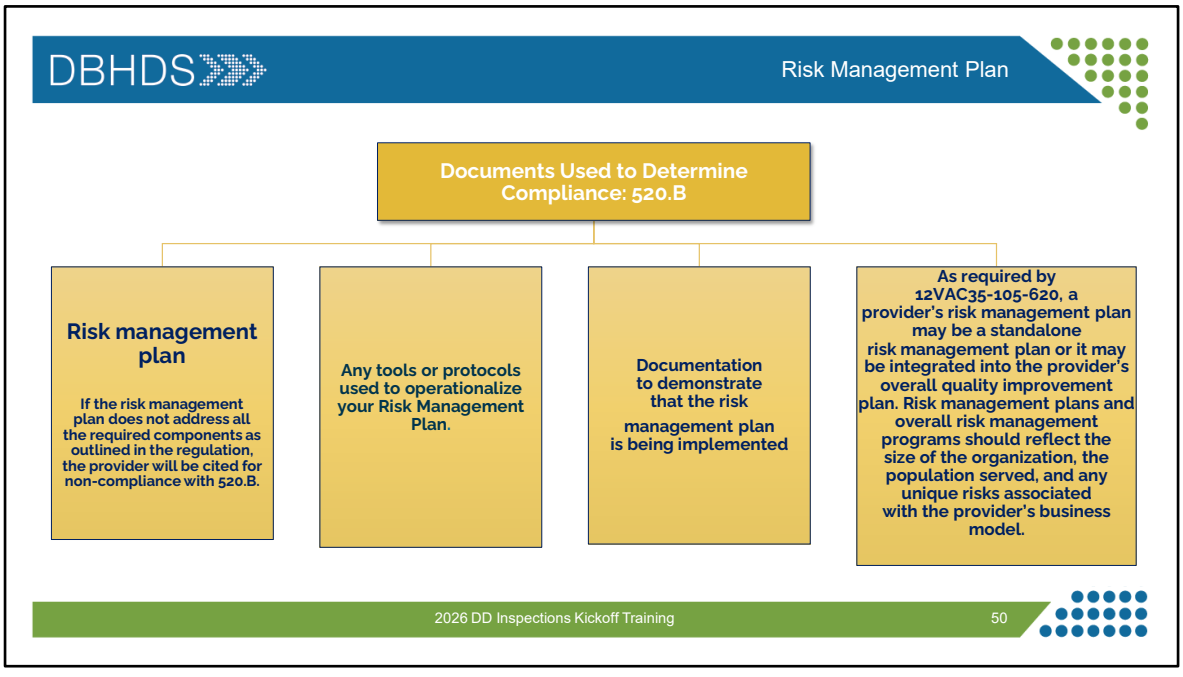
A provider should monitor risks through their review of serious incidents and through their review of care concerns.

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

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

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

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



KAREN

Documents the Office of Licensing will review to determine compliance

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

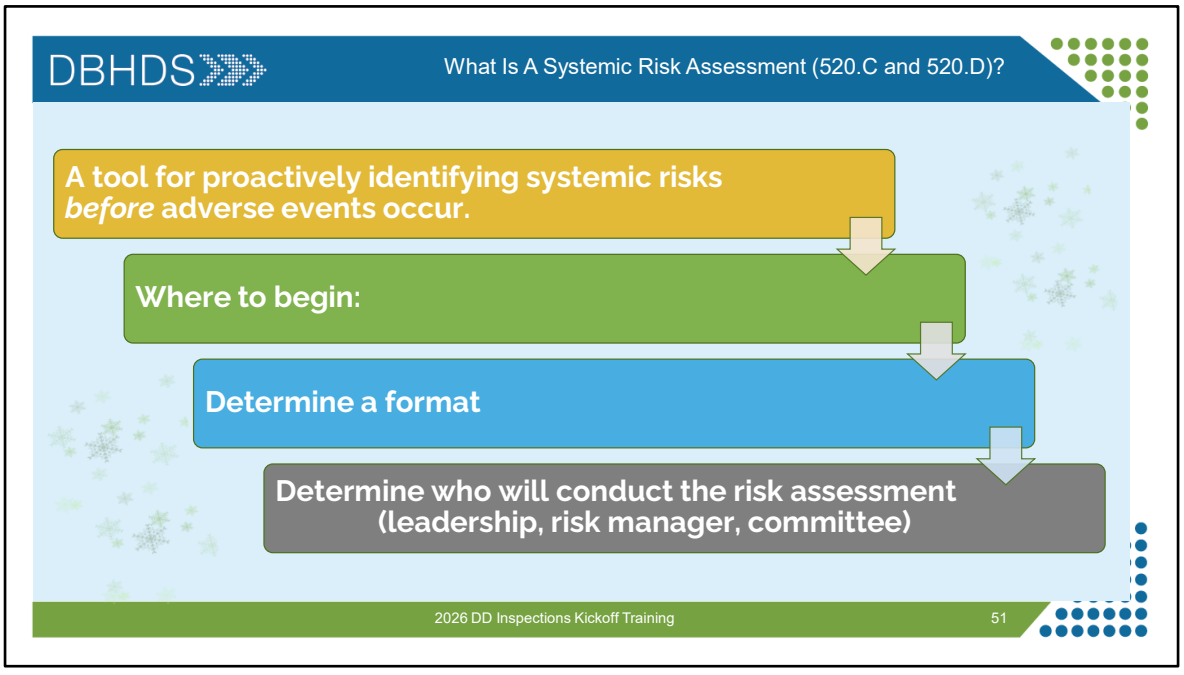
If the risk management plan does not address how you identify, monitor, reduce, and minimize harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability, which are required per the regulation, then the provider will be cited for non-

compliance with 520.B.

If there no evidence that the risk management plan is being implemented, then the provider will be cited for non-compliance.

The Office of Licensing will also review any tools or protocols used to operationalize your Risk Management Plan.

It's important that providers review the Expectations Regarding Risk Management Programs for Providers of Developmental Services Memo (August 2025)



KAREN

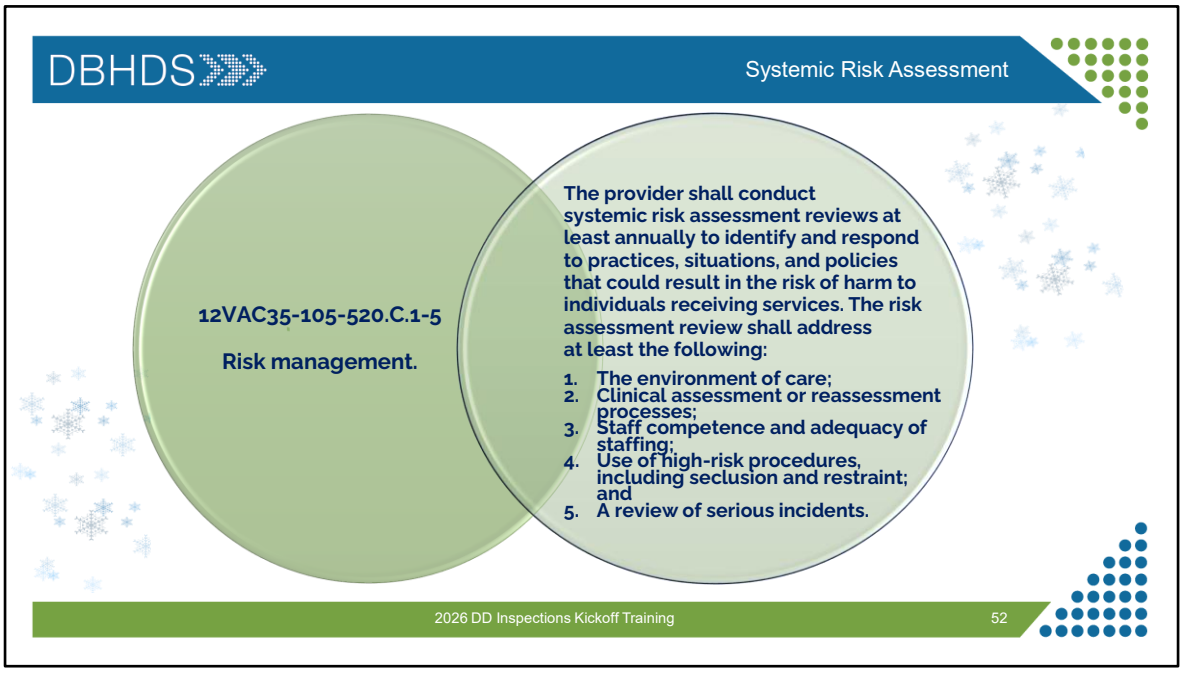
What is a risk assessment?

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

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

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

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



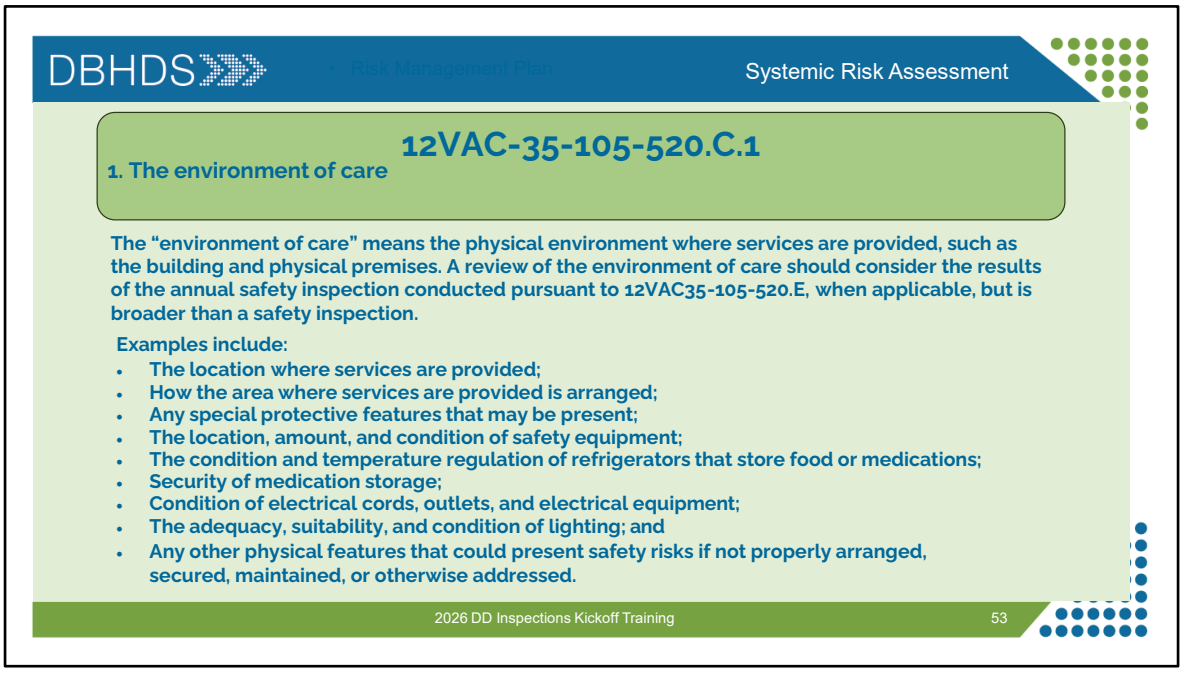
KAREN

- An annual risk assessment review is a necessary component of a provider's risk management plan.
- The SRA must include the month, date and year it was conducted to determine if it was reviewed and updated at least annually. If the plan does not include the full date, the LS will mark the provider Non-Compliant.
- This review should include consideration of harms and risks identified and lessons learned from the provider's quarterly reviews of all serious incidents conducted pursuant to regulation160.C., which should include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.
- Identifying risks and potential risks helps to prevent harm to the individuals served, to staff, and to the organization.
- There are many risks that may affect an organization, and a provider's risks could

change from year to year.

- Don't forget, even if a provider has NOT served any individuals, the provider is still able to identify potential risks

- Now we will break down each of the required components starting with the environment of care.



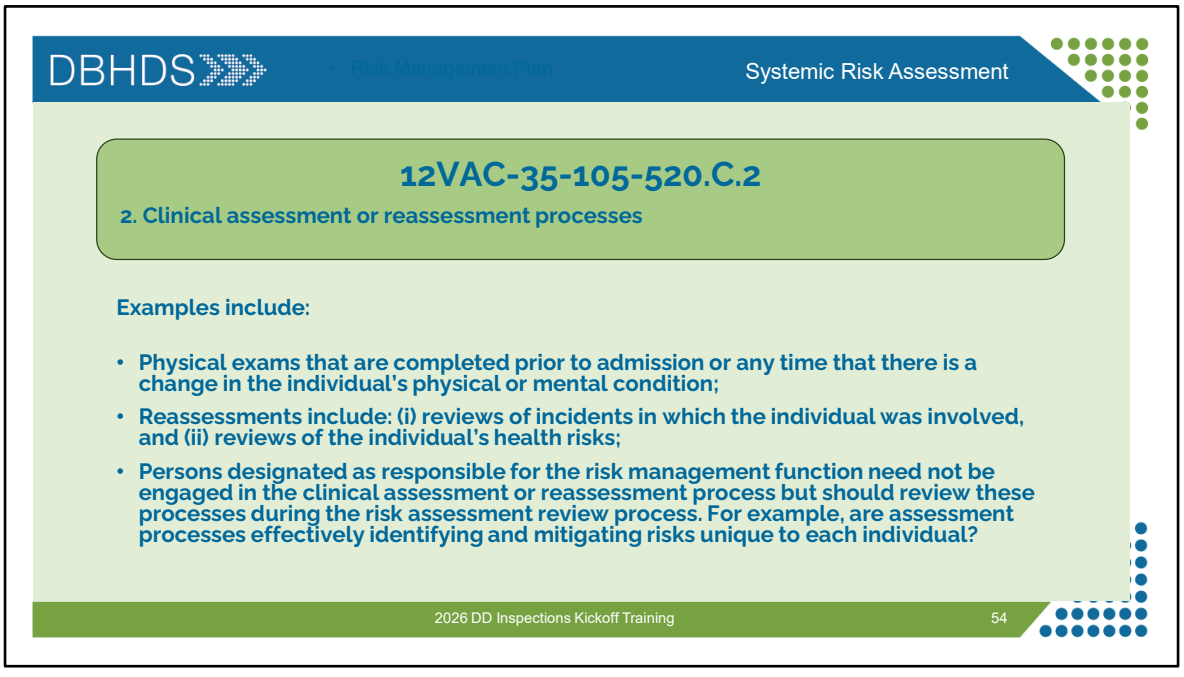
KAREN

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

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

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

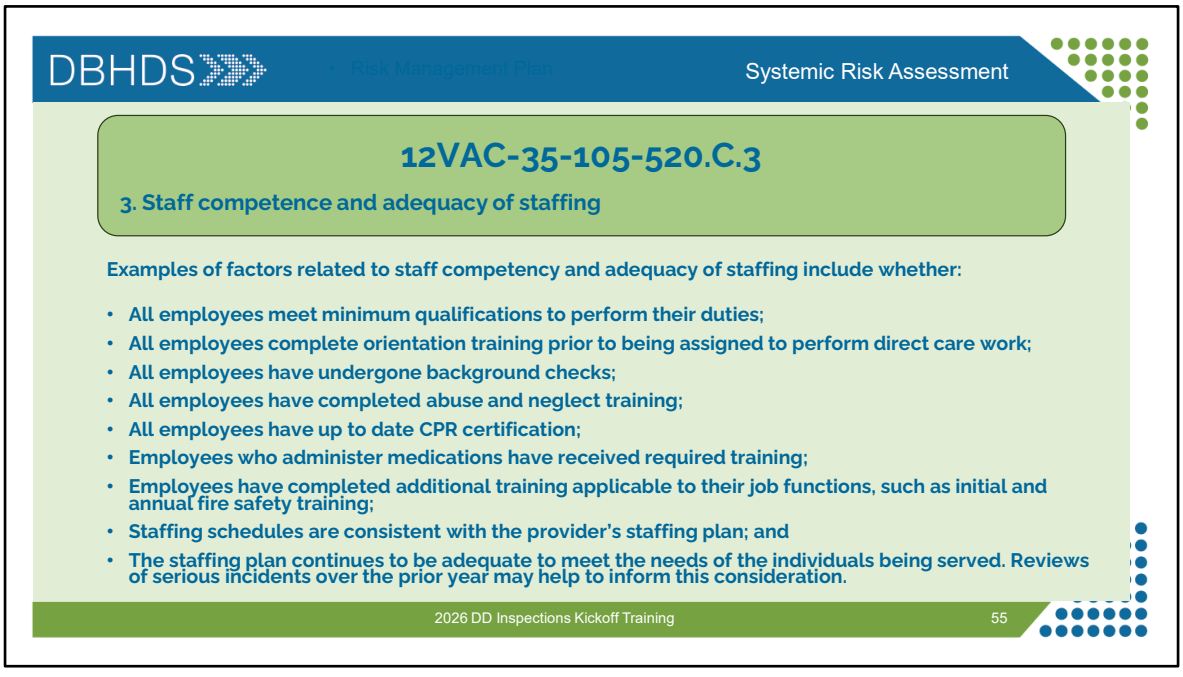
Additionally, environment of care considerations will be different when services are provided at a location that is not under the direct control of the provider, such as at an individual's own home. While providers are more limited in their ability to assess some factors in these locations, providers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



KAREN

This review should address **clinical assessment or reassessment** processes

- Examples of assessments include physical exams that are completed prior to admission
- Reassessments completed when there is a change in an individual's physical, medical, psychiatric, behavioral, or other status
- Reassessments include: reviews of incidents in which the individual was involved, and reviews of the individual's health risks.
- Persons designated as responsible for the risk management function need not be engaged in the clinical assessment or reassessment process, but should review these processes during the risk assessment review. For example, are assessment processes effectively identifying and mitigating risks unique to each individual?



KAREN

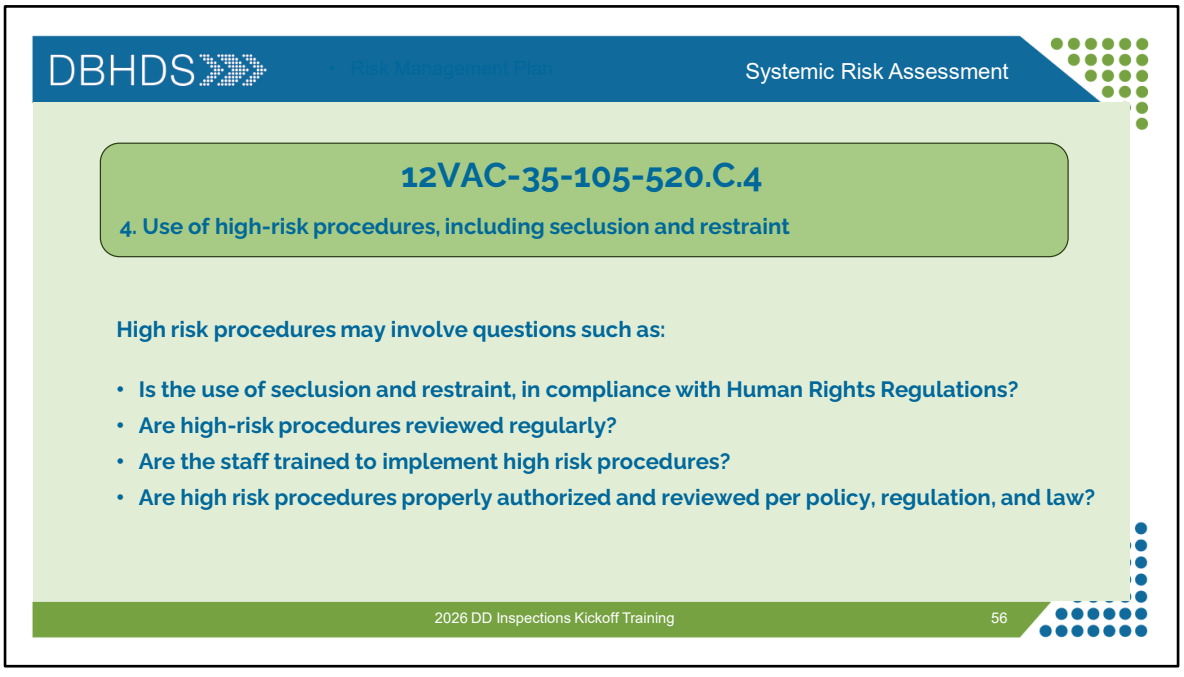
This review should include address both **staff competence and adequacy of staffing**.

Remember, risks vary according to the licensed provider.

Examples of factors related to staff competency and adequacy of staffing include whether:

- All employees meet minimum qualifications to perform their duties;
- All employees complete orientation training prior to being assigned to perform direct care work;
- All employees have undergone background checks;
- All employees have completed abuse and neglect training;
- All employees have up to date CPR certification;
- Employees who administer medications have received required training;
- Employees have completed additional training applicable to their job functions, such as initial and annual fire safety training;
- Staffing schedules are consistent with the provider's staffing plan; and
- The staffing plan continues to be adequate to meet the needs of the individuals being served. Reviews of serious incidents over the prior year may help to inform this consideration.

It has been noted that adequacy of staffing is not consistently included in the systemic risk assessment review. As a reminder, 520.C.3 must address both staff competency AND adequacy of staffing.



KAREN

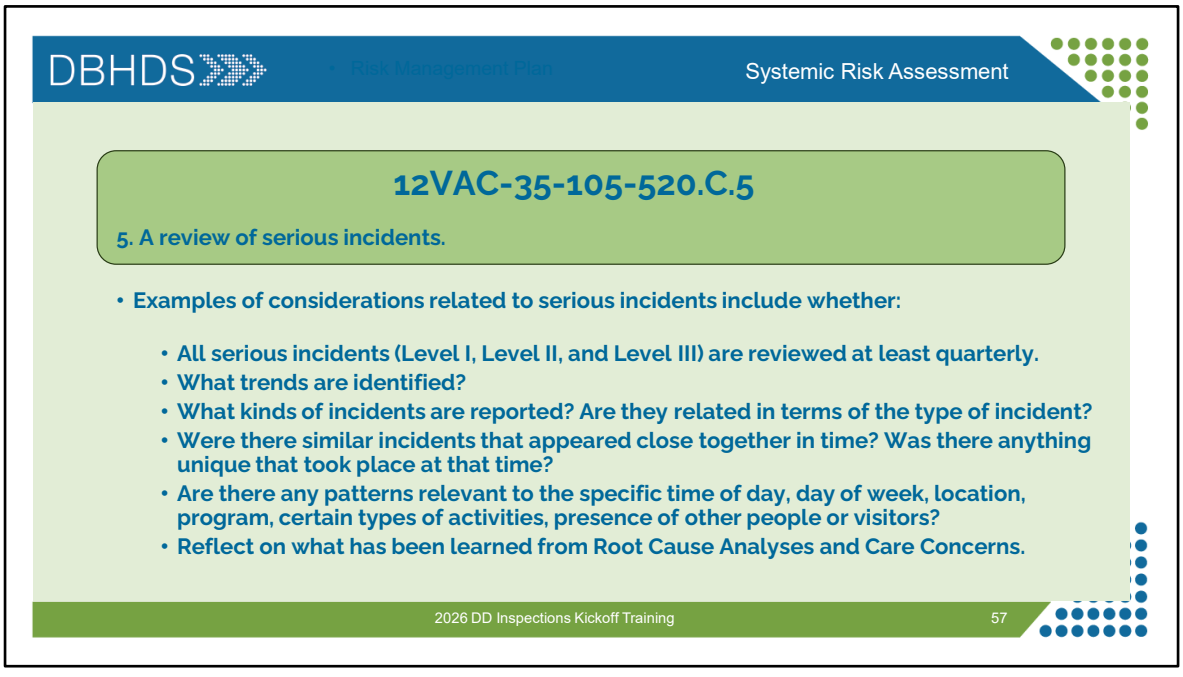
This review should address the use of **high-risk procedures**.

High risk procedures may involve questions such as:

- Is the use of seclusion and restraint in compliance with Human Rights Regulations?
- Are high-risk procedures reviewed regularly?
- Are the staff trained to implement high risk procedures?
- Are high risk procedures properly authorized and reviewed per policy, regulation, and law?

Other Examples include:

- High risk methods of medication administration
- All staff are trained on how to safely transfer individuals
- All staff will refrain from the use of seclusion and restraints
- All staff are trained on how to use CPI techniques



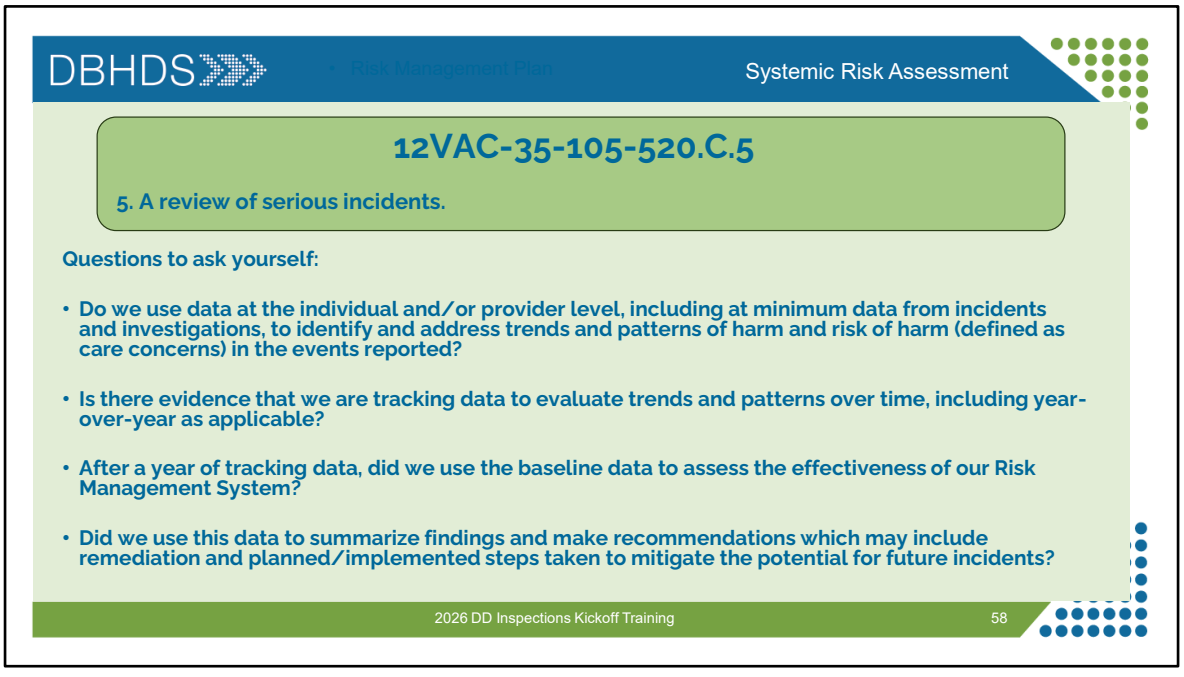
KAREN

- This review should address a **review of serious incidents**

- Examples of considerations related to serious incidents include whether the provider is:

    - Reviewing, at least quarterly, all serious incidents. This includes Level I, Level II, and Level III serious incidents.
    - Identifying trends by asking
        - What kinds of incidents are reported? Are they related in terms of the type of incident?
        - Were there similar incidents that appeared close together in time? Was there anything unique that took place at that time?
        - Are there any patterns relevant to the specific time of day, day of week, location, program, certain types of activities, presence of other people or visitors?
    - Reflecting on what has been learned from Root Cause Analyses and Care Concerns

As a reminder:
- All serious incidents should be reported to the Authorized Representative within 24-hours of discovery; and
- Medication errors should be reviewed quarterly.



KAREN

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

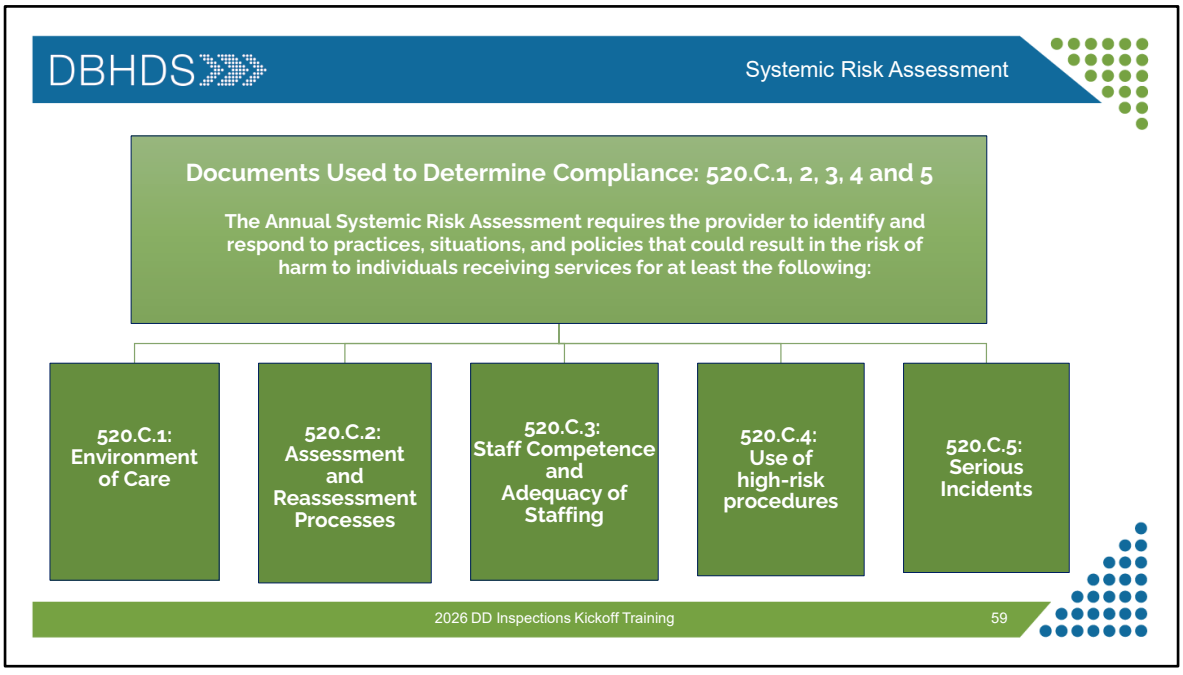
1. Do we use data at the individual and/or provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm (which are defined as care concerns) in the events reported?

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

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

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

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



KAREN

Documents the Office of Licensing will review to determine compliance:

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

- The Annual systemic Risk assessment reviews must be completed within the past 365 days.

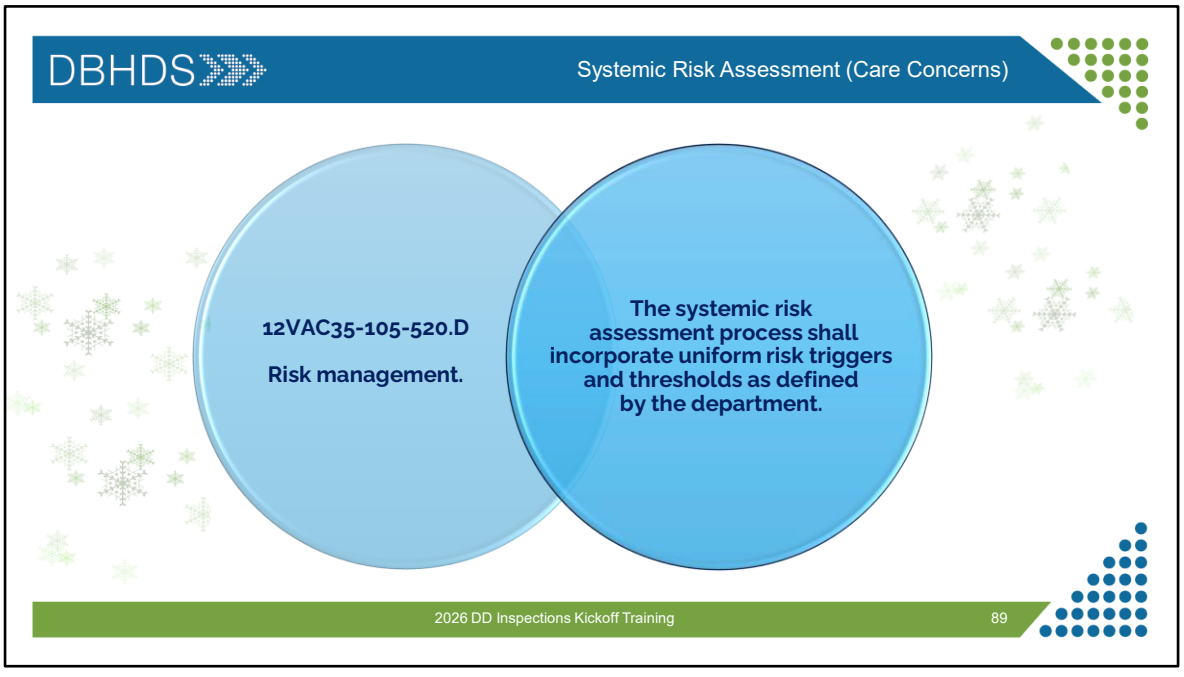
- Any updates, as appropriate, made since the last review as a result of the provider identifying new risk areas that could result in the risk of harm to individuals receiving services.

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

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

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

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

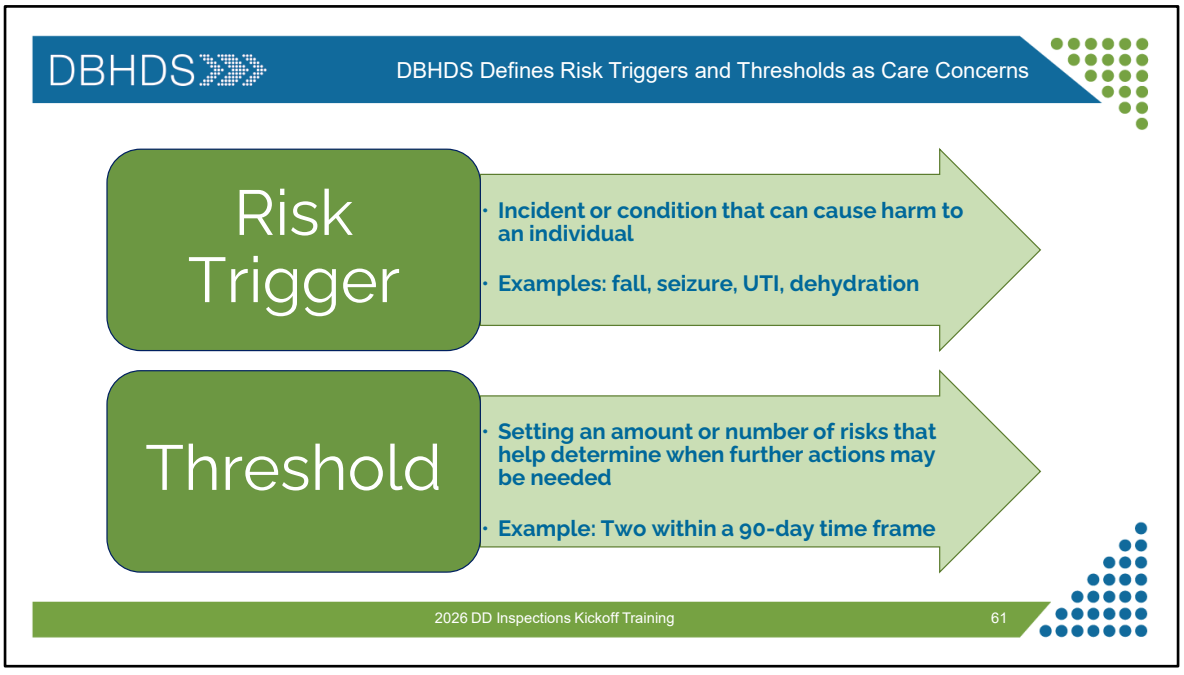


KAREN

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

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

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



KAREN

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

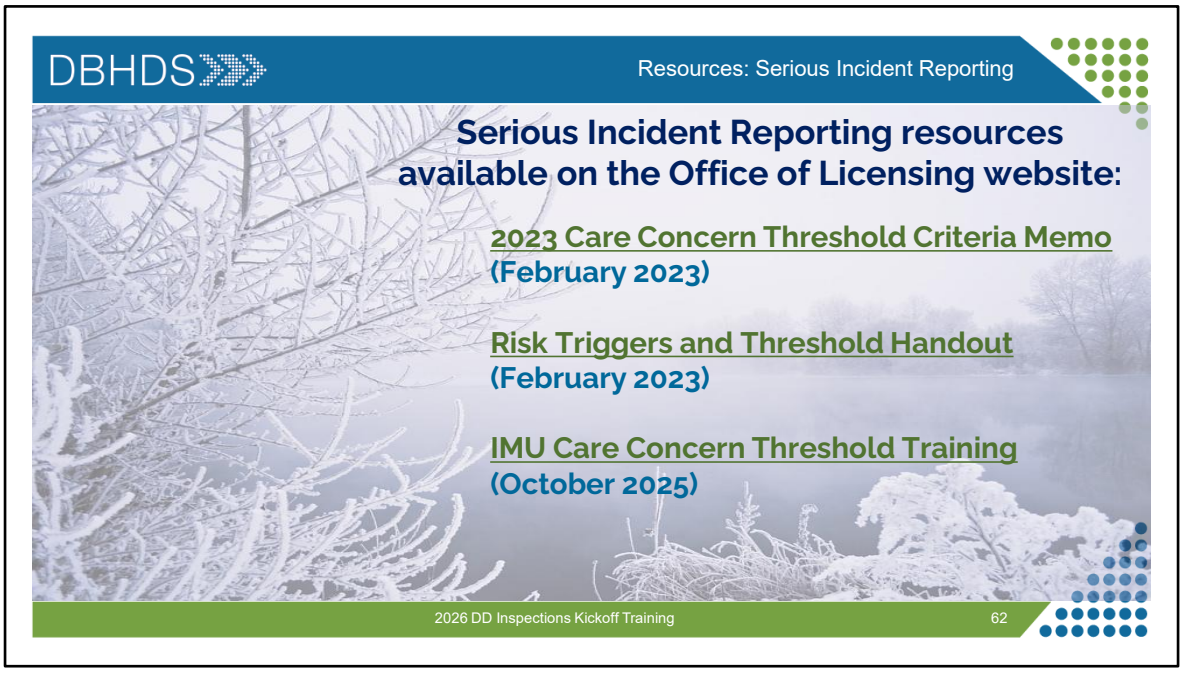
- Examples of this could be a fall, seizure, UTI, dehydration, etc.

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.



KAREN

As a reminder the "*Guidance for Serious Incident Reporting*" is available on the Office of Licensing webpage, along with the "*2023 Care Concern Threshold Criteria Memo*", the "*Risk triggers and Thresholds Handout*" and the IMU Care Concern PowerPoint training which was updated in October 2025. There have been no changes to the Care Concern Thresholds which are outlined in the handout.

Effective 01/2023 the Care Concern Thresholds are:

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

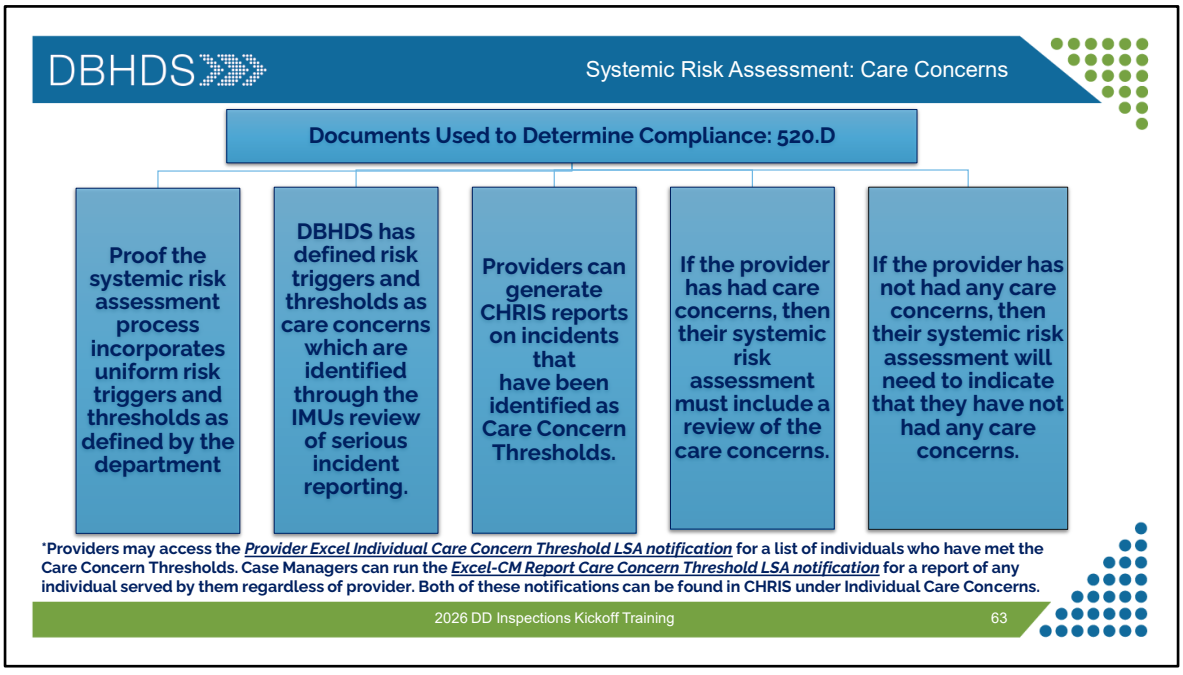
• Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional.

• Any choking incident that requires physical aid by another person, such as abdominal

thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR.

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

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



KAREN

Documents the Office of Licensing will review to determine compliance

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

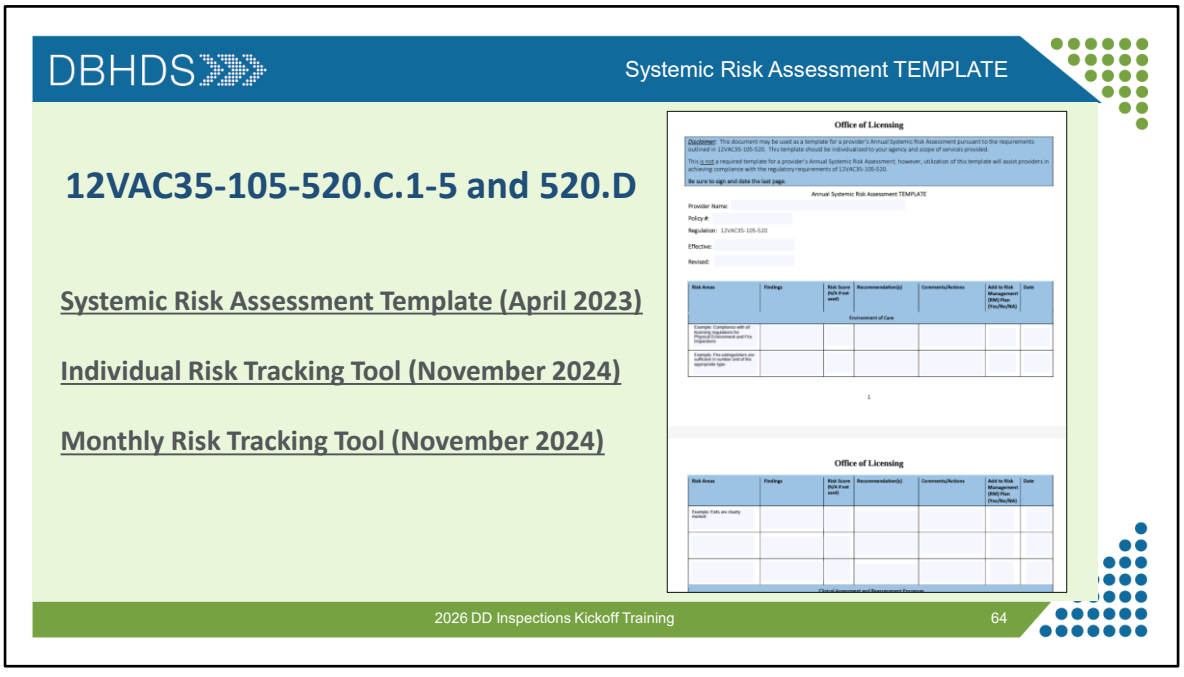
- DBHDS has defined risk triggers and thresholds as care concerns which are identified through the IMUs review of serious incident reporting.

- Providers can generate CHRIS reports on incidents that have been identified as

Care Concern Thresholds.

- If the provider has had care concerns, then their systemic risk assessment must include a review of the care concerns.

- **If the provider has not had any care concerns, then their systemic risk assessment will need to indicate that they have not had any care concerns.**



KAREN

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

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

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

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

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

Keep in mind that this template includes an **effective date** which would be the date your agency began to implement use of the template, and the **revised date** is used to indicate when an agency has made a change to the format of the template. The **review date** is for the agency to indicate the date the SRA was actually conducted.

DBHDS

Tips and Reminders

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

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

1.The environment of care;

2. Clinical assessment or reassessment processes;

3. Staff competence and adequacy of staffing;

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

5. A review of serious incidents.

AND

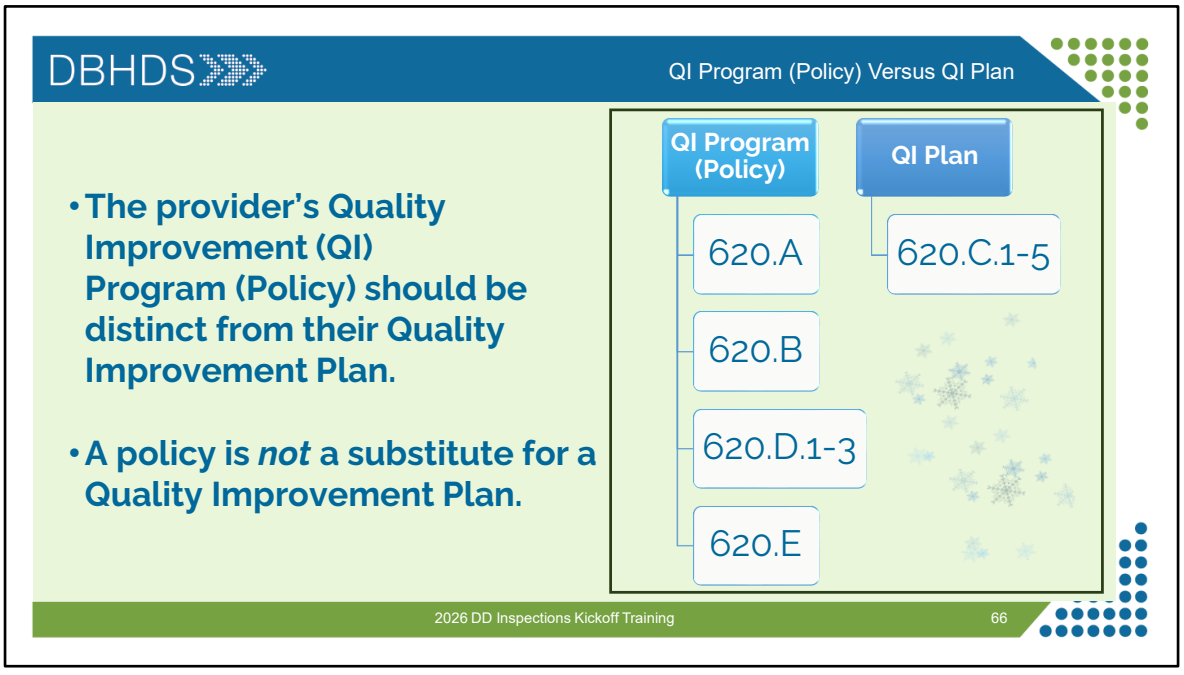
12VAC35-105-520.D. *The systemic risk assessment review process shall incorporate uniform risk triggers and thresholds. These are defined by the department as Care Concerns.*

KAREN

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

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

Now Mackenzie is going to review regulation 620 related to Quality Improvement.



MACKENZIE

Thanks Karen!

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

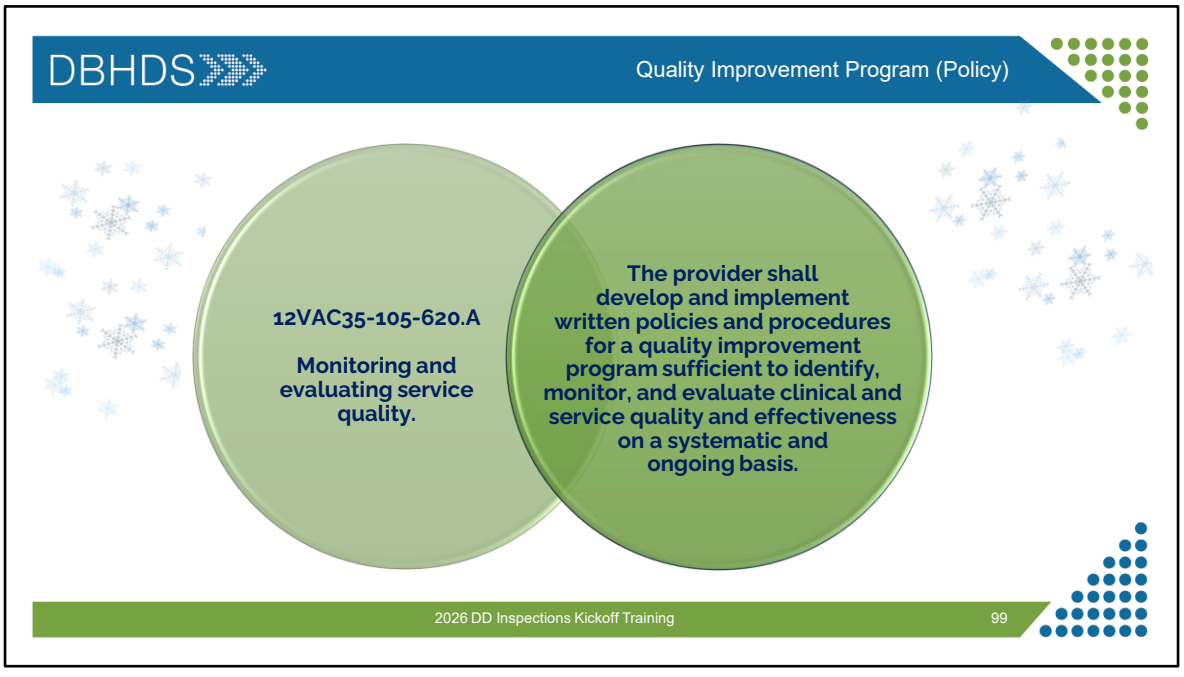
As you can see on the screen, providers are required to have a QI Program, which is the written Policy, AND a QI Plan.

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

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

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

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

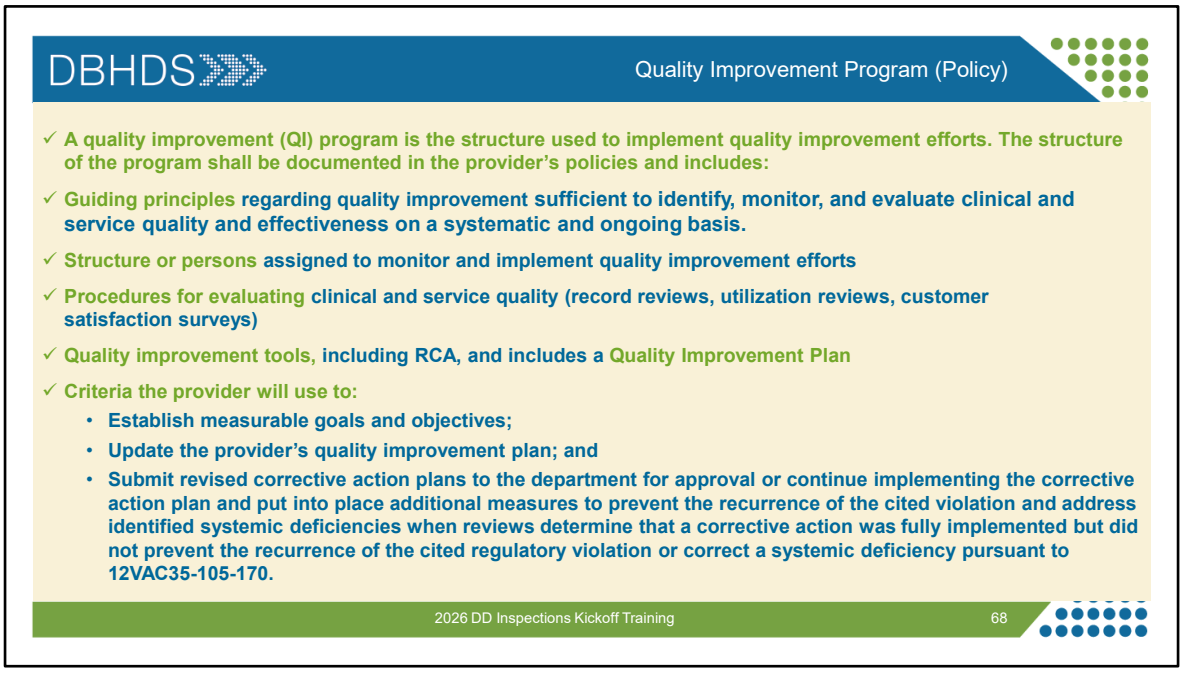


MACKENZIE

620.A

Let's start with the program

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



MACKENZIE

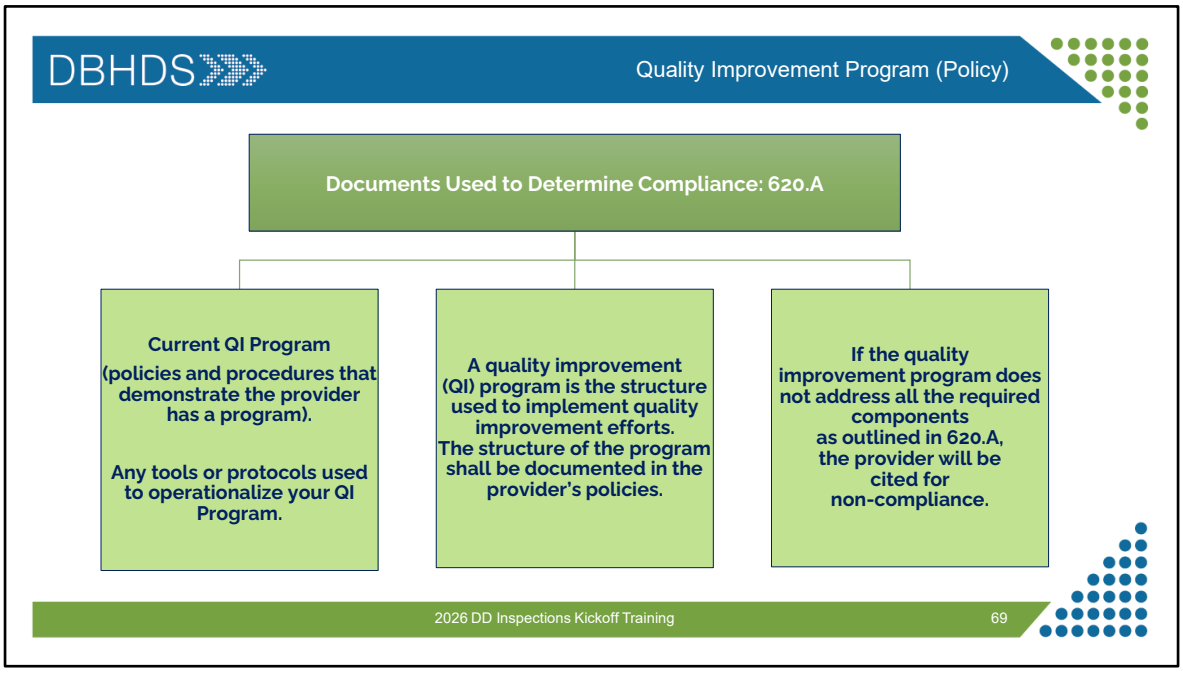
What does that look like? Well, a quality improvement (QI) program is the overarching structure used to implement quality improvement efforts. The structure of the program shall be documented in the provider's policies/procedures, and it should include:

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

- A Quality improvement Plan

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

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



MACKENZIE

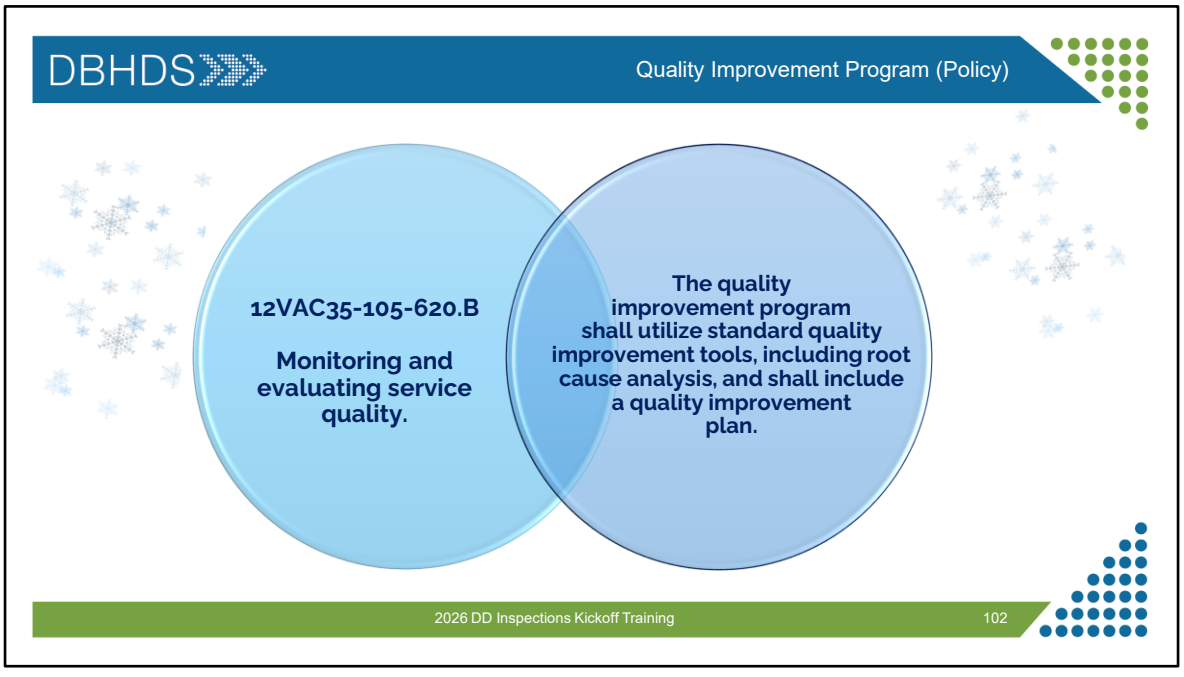
Documents the Office of Licensing will review to determine compliance

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

Any tools or protocols used to operationalize your QI Program.

The quality improvement program must indicate how the provider identifies, monitors, and evaluates clinical and service quality and effectiveness on a systematic and ongoing basis. Make sure each of these areas are addressed or you will be cited for non-

compliance.

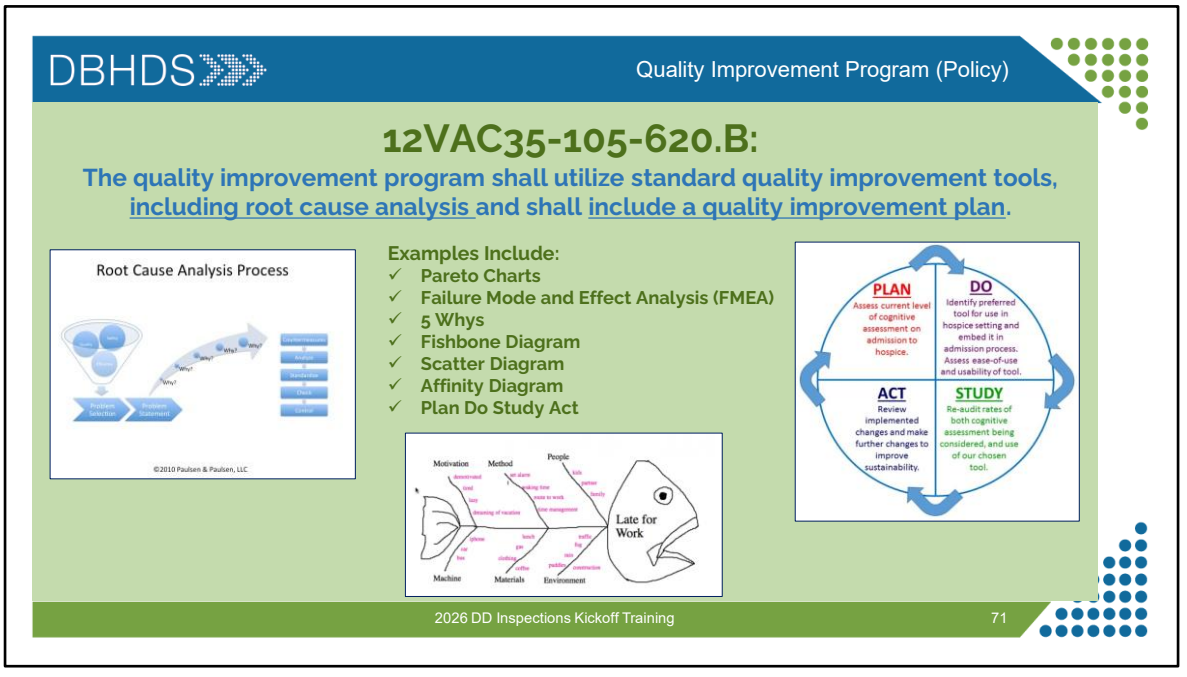


MACKENZIE

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

This means that your QI program, your written policy, must list the QI Tool that you use.

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



MACKENZIE

Remember that your QI Program must utilize standard quality improvement tools. Providers must be able to demonstrate use of root cause analysis.

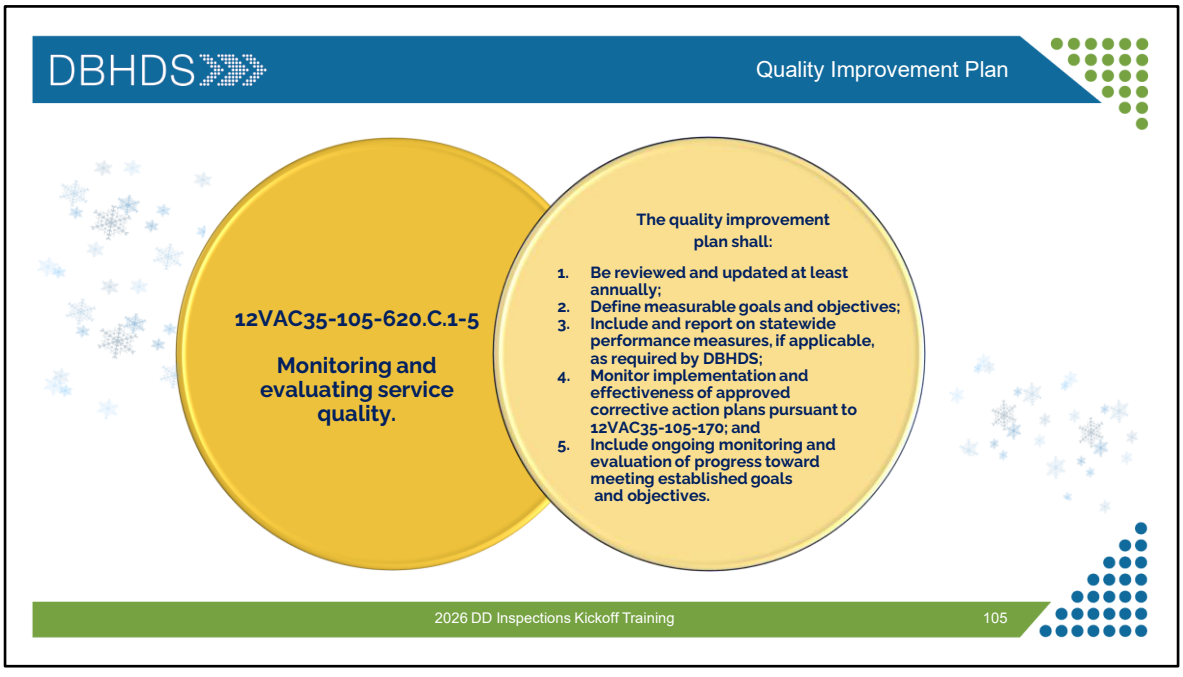
Providers may also use other QI tools such as:

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

MACKENZIE

Documents the Office of Licensing will review to determine compliance

- Current QI program-your written policy to determine if it lists the QI tools used
- If the policy does not list the quality improvement tools used by the provider, then the provider will be cited for non-compliance with 620.B
- Is there evidence that the provider is using the QI tools that are outlined in their policy? Remember that providers are required to utilize root cause analysis.
- If there is no evidence to demonstrate that the provider utilizes their QI tools, then the provider will be marked non-compliant.

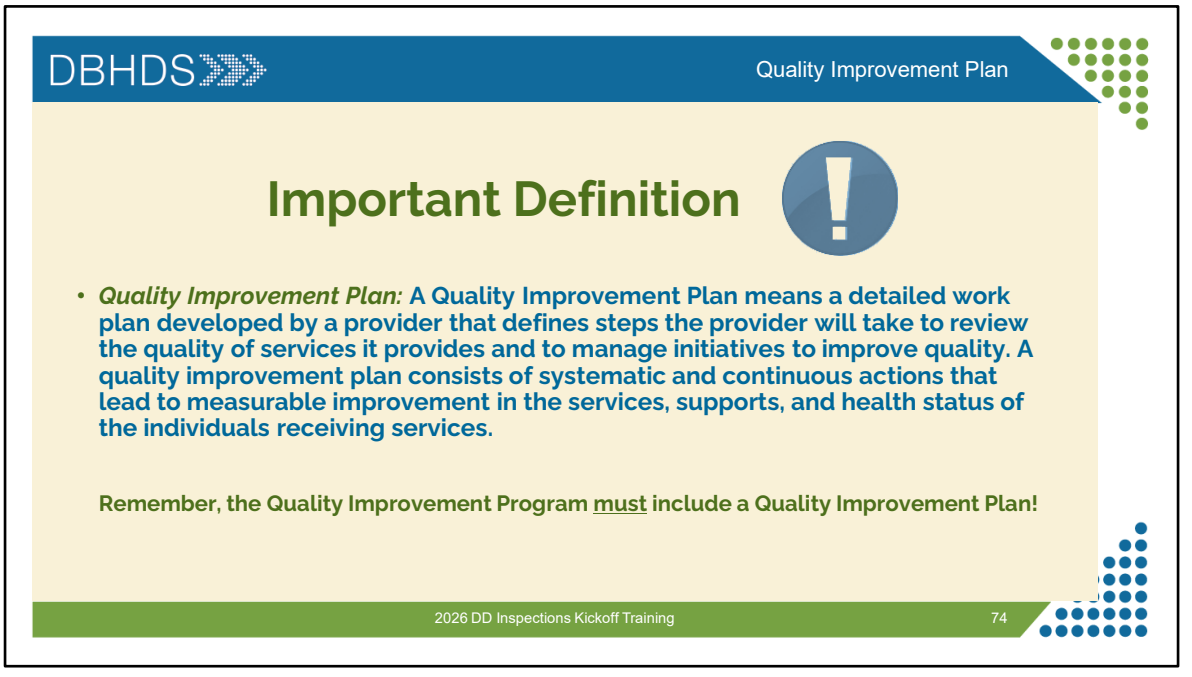


MACKENZIE

620.C

Now let's switch gears and review the required components for QI Plan.

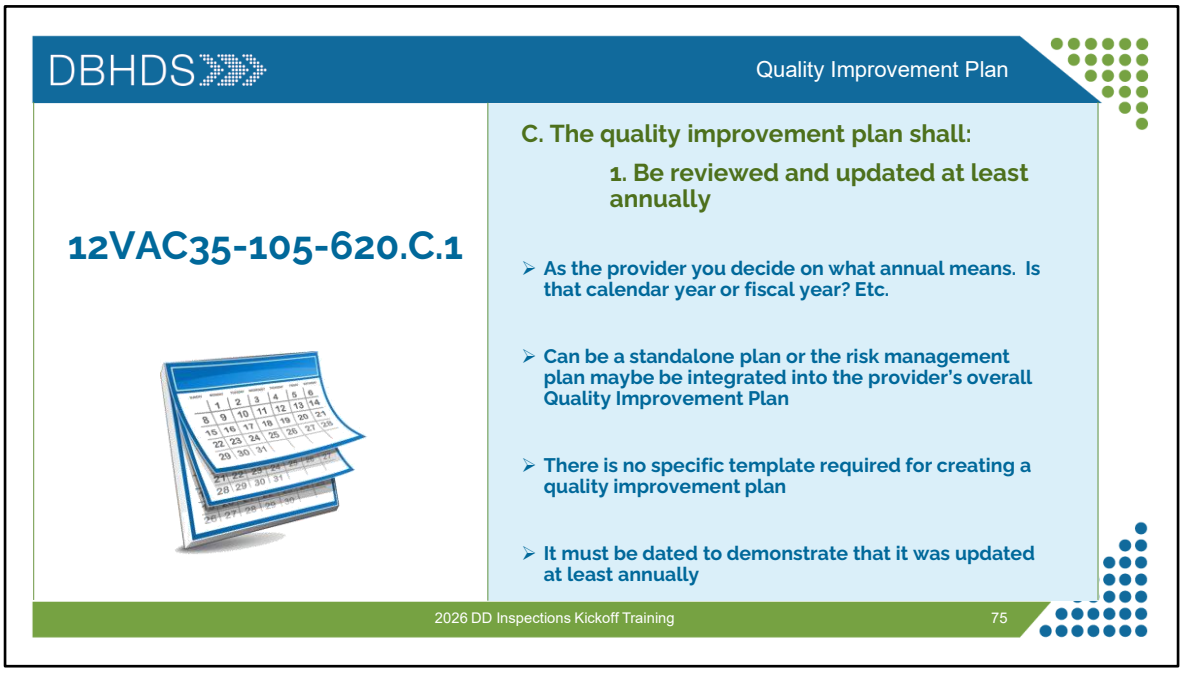
There are 5 parts to a QI Plan, but first, what is a QI Plan?



MACKENZIE

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

Let's take a look at the QI Plan requirements



MACKENZIE

620. C..1 The quality improvement plan shall:
Be reviewed and updated at least annually

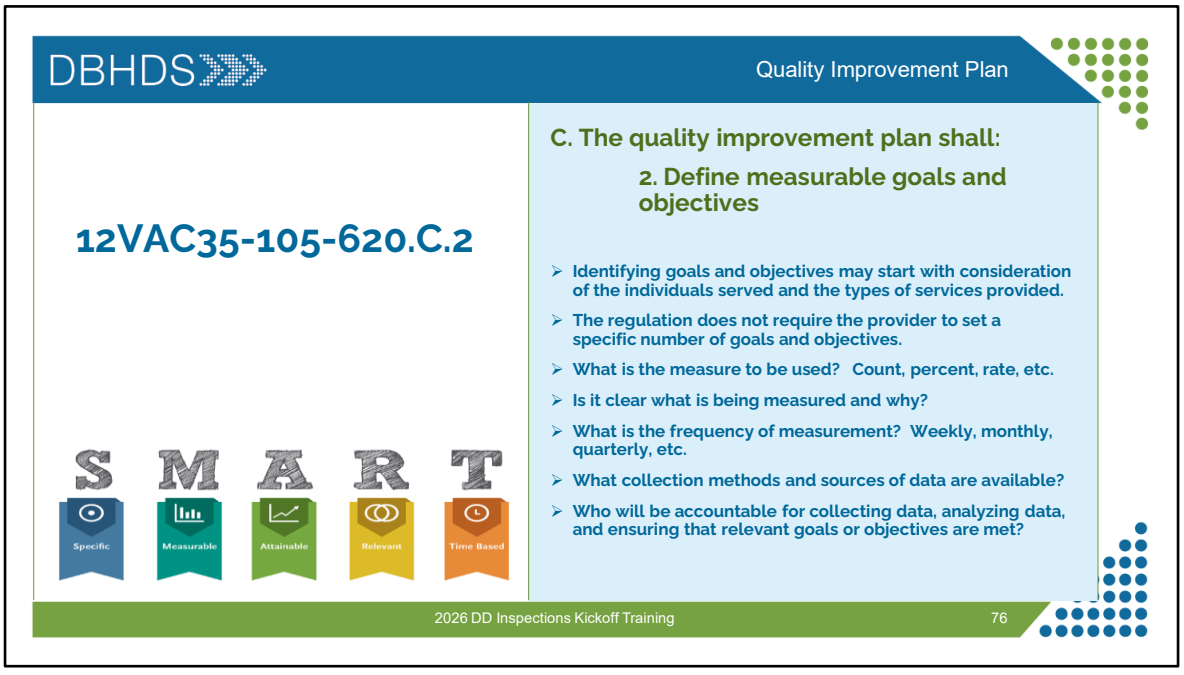
- There is no specific template required for creating a quality improvement plan; however, staff responsible for implementation of the quality improvement plan must review and update the plan at least annually (every 365 days). As the provider you decide on what annual means.

- The quality improvement plan should be dated and signed to indicate when it is implemented and when any updates occur.

- Annual and other reviews of the quality improvement plan should include evaluation of the components of the program, efficacy of the plan, and whether any updates are needed to accomplish the plan's goals.

- Can be a standalone plan or the risk management plan maybe be integrated into the provider's overall Quality Improvement Plan

- If needed, the provider can update their plan more frequently based on defined goals and the occurrence of relevant events, such as the issuance of a licensing report.



Mackenzie

620. C.2 The quality improvement plan shall:
Define measurable goals and objectives

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

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

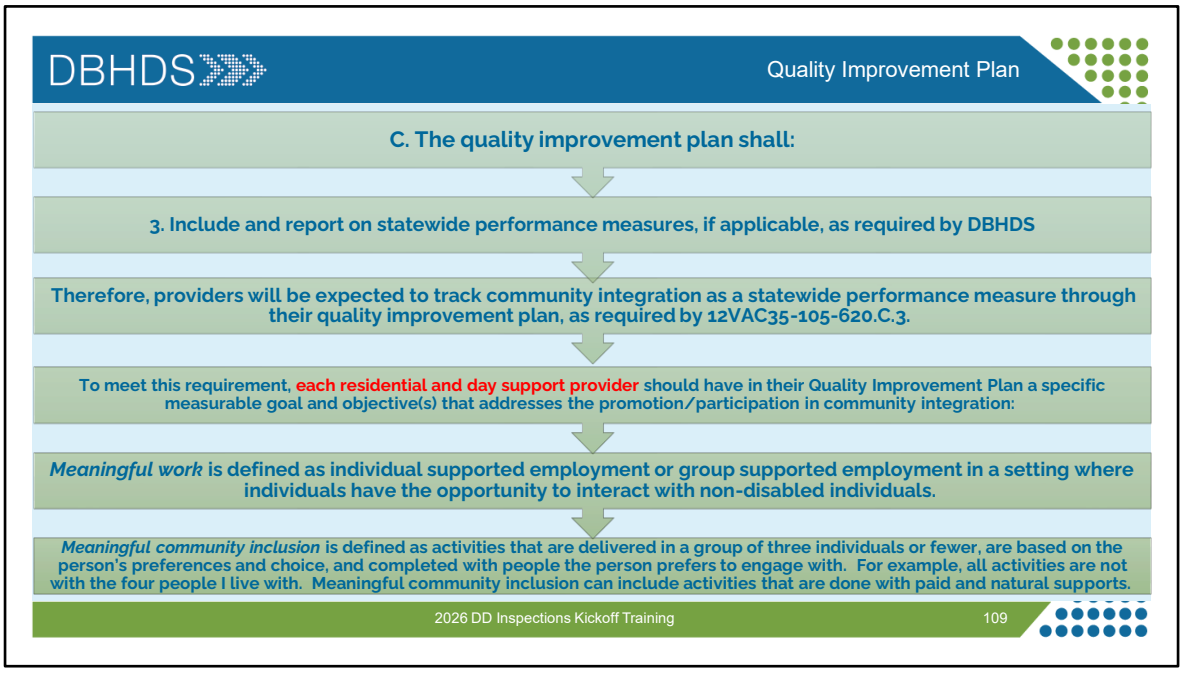
Establishing a measurable objective may start with the question, "How will I know that there has been improvement or that the objective was achieved?" For example, if the objective of a residential provider is to reduce the number of injuries sustained, this objective could be stated as, "Reduce the rate of serious injuries by X% by June 1, 2026."

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

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

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

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



MACKENZIE

620. C.3 The quality improvement plan shall:

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

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

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

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

Meaningful community inclusion is defined as activities that are delivered in a group of

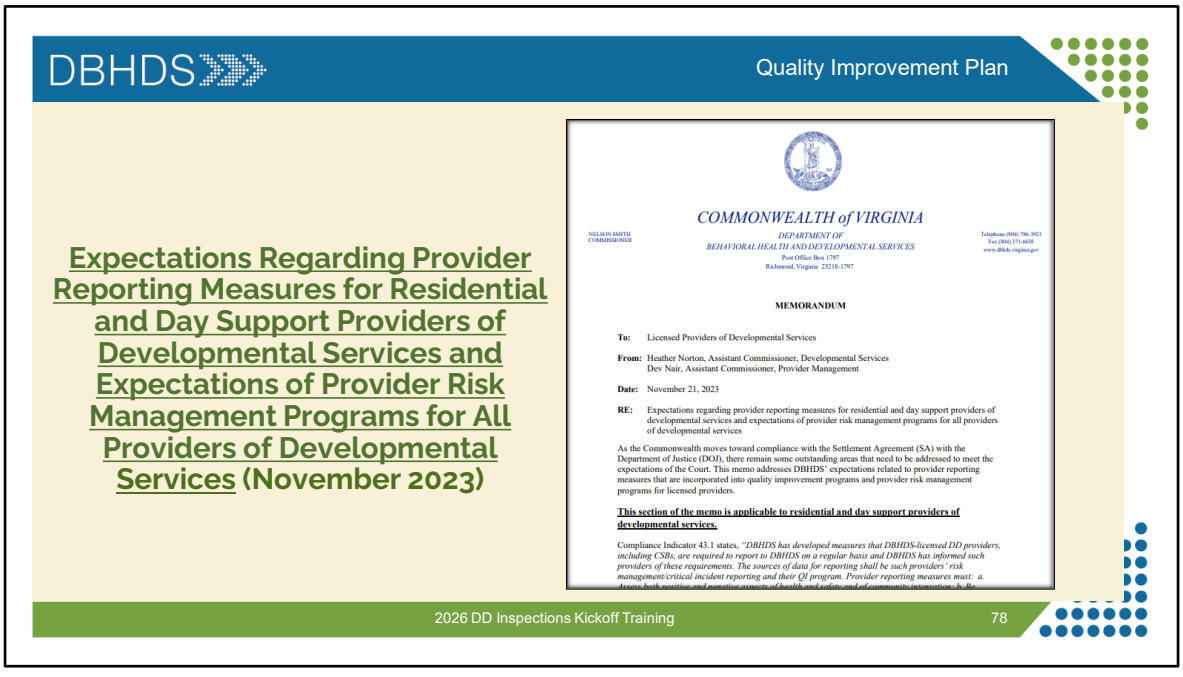
three individuals or fewer, are based on the person's preferences and choice, and completed with people the person prefers to engage with. For example, all activities are not with the four people they live with. Meaningful community inclusion can include activities that are done with paid and natural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

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

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

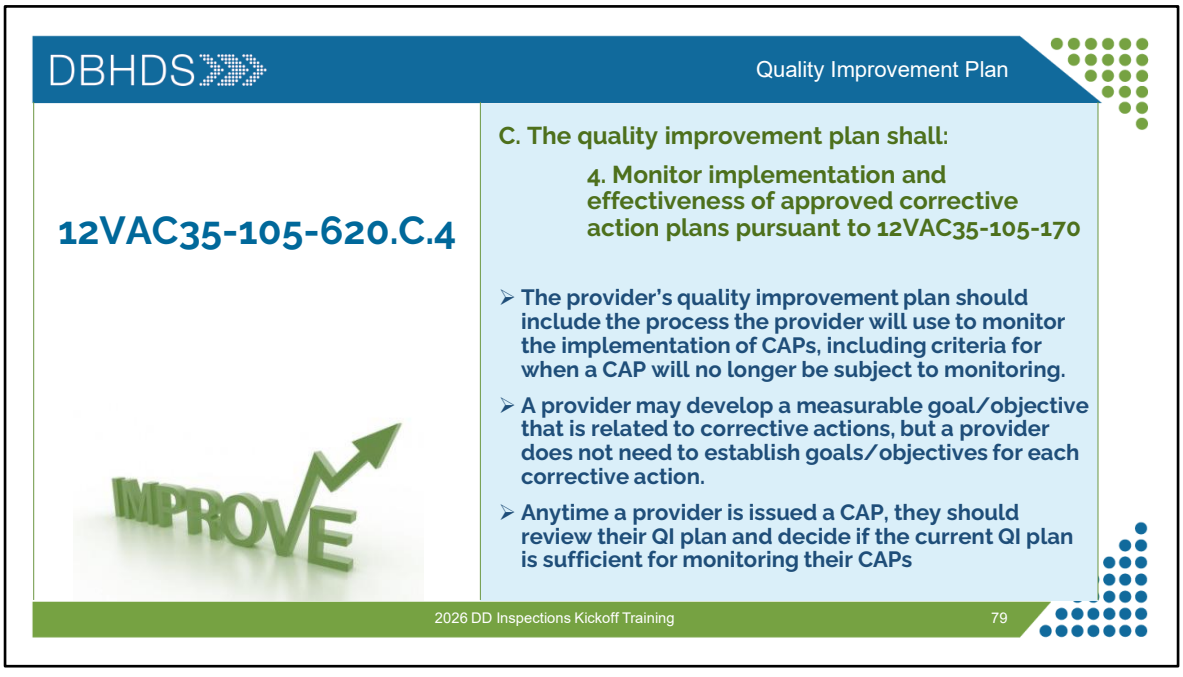
Information related to provider compliance will continue to be assessed during Quality Service Reviews

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



MACKENZIE

As it relates to 620.C.3, I want to remind providers that in November 2023, the Expectations Regarding Provider Reporting Measures for Residential and Day Support Providers of Developmental Services and Expectations of Provider Risk Management Programs for All Providers of Developmental Services memo was posted on the OL website. If you are unsure of the expectation related to statewide performance measures, please make sure that you have reviewed this memo and update your QI Plan accordingly.



MACKENZIE

620.C.4 The quality improvement plan shall:
Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170

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

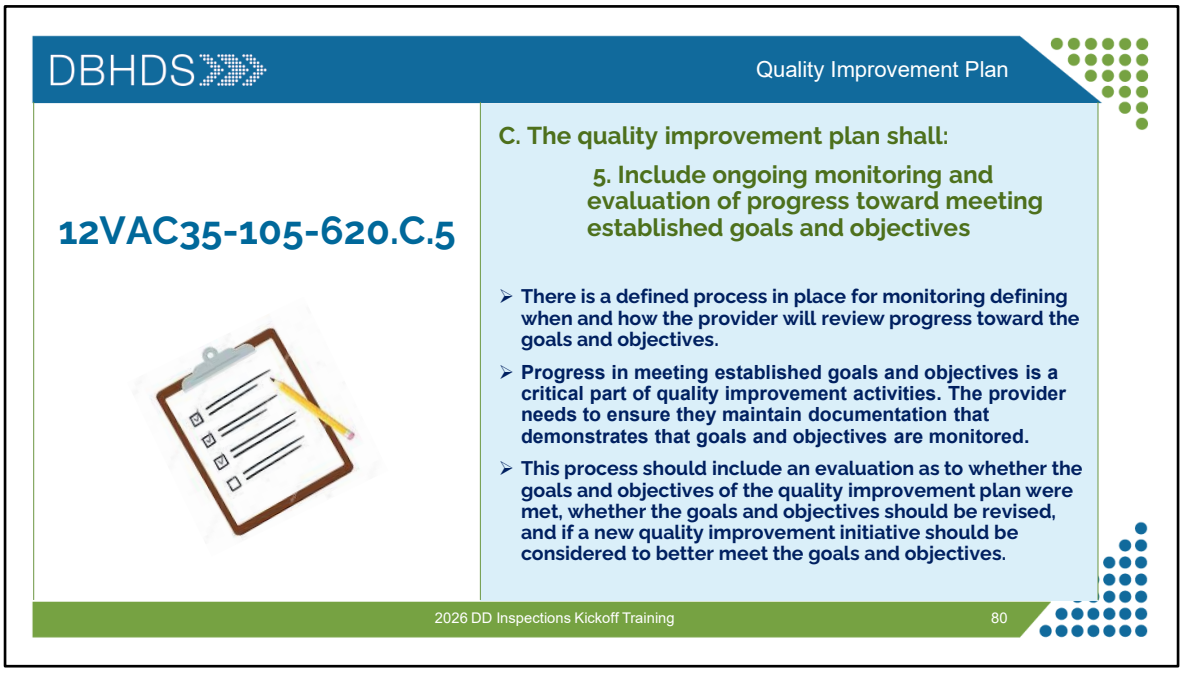
- The provider should identify any systematic actions that may be taken to address deficiencies identified by citations or CAPs and incorporate these into their quality improvement plan.

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

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

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

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



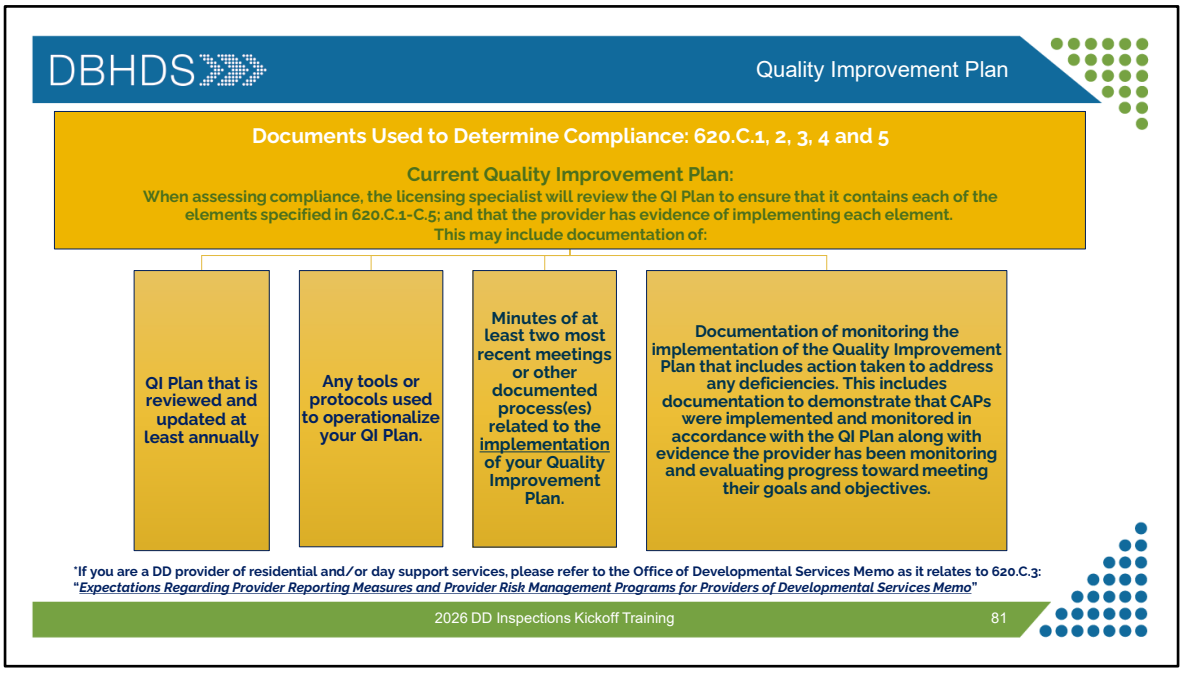
MACKENZIE

620. C.5: The quality improvement plan shall:
5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives

- Does the QI Plan define the process the provider will use to review progress toward the goals and objectives of the plan and include actions that will be taken when goals/objectives have not been met?
- Does the provider have documentation to demonstrate that the goals and objectives are being monitored?
- This process should include an evaluation as to whether the goals and objectives of the quality improvement plan were met, whether the goals and objectives should be revised, and if a new quality improvement initiative should be considered to better meet the goals and objectives.

FOR REFERENCE ONLY
Monitoring goals and objectives may occur through establishing a quality council that regularly meets to review progress or through an established meeting structure.

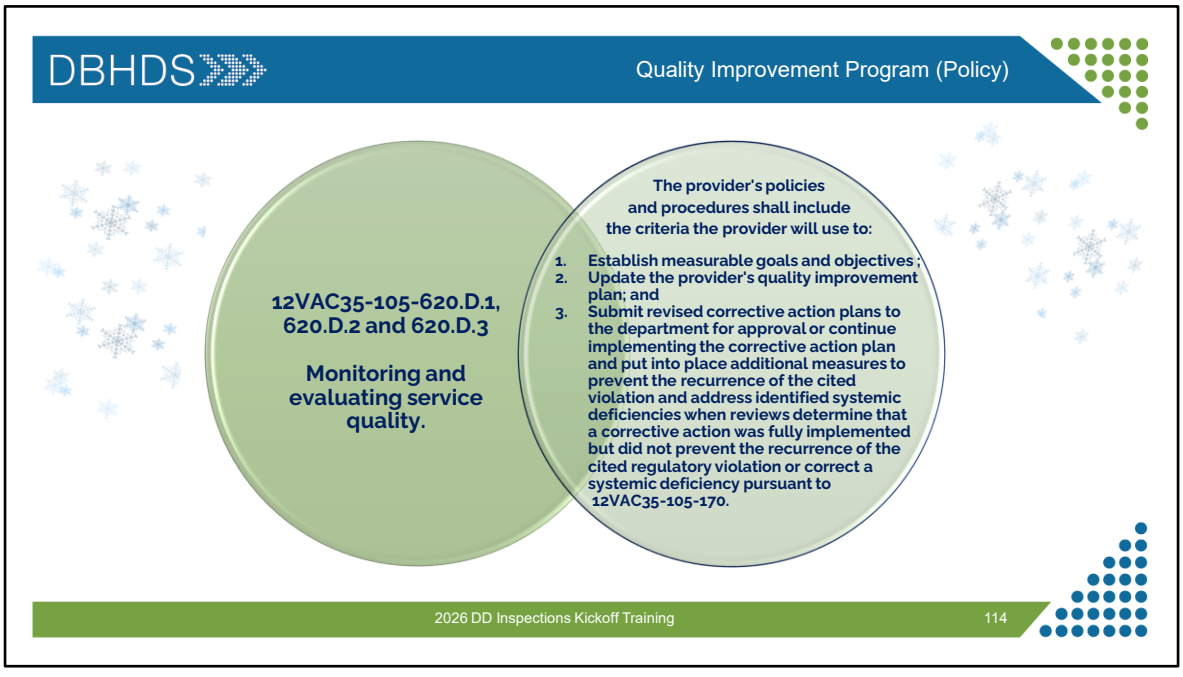
“The provider’s quality committee will meet quarterly to review progress toward the established goals and objectives. As the results of data collection are analyzed, the provider will look for trends, identify progress in meeting the goals and objectives, whether the goals should be revised, and consider whether a quality improvement initiative is necessary. A report of quarterly data is attached as an appendix to the quality improvement plan”.
“Progress in meeting established goals and objectives is a critical part of quality improvement activities. The goals and objectives are monitored (monthly/quarterly) and based on identified trends, the provider initiates quality improvement projects”.
“An addendum to the quality improvement plan outlines the data and meeting minutes reflect the quality improvement committee’s discussion regarding progress toward meeting the goals and objectives”.
“If progress is not demonstrated, the provider identifies barriers to improvement and/or makes changes to the goals/objectives.
When a goal/objective is met, the committee determines the necessity for continuing to monitor or focuses on other priorities”.



MACKENZIE

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

- QI Plan that is reviewed and updated at least annually
- Any tools or protocols used to operationalize your QI Plan.
- Minutes of at least two most recent meetings or other documented process(es) related to the implementation of your Quality Improvement Plan.
- Documentation of monitoring the implementation of the Quality Improvement Plan that includes action taken to address any deficiencies. This includes documentation to demonstrate that CAPs were implemented and monitored in accordance with the QI Plan along with evidence the provider has been monitoring and evaluating progress toward meeting their goals and objectives.
- If the provider does not have a QI Plan, the provider will be cited for non-compliance with each regulation
- If specific components of the QI Plan are missing the provider will be cited for non-compliance specific to that regulation.



MACKENZIE

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

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

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

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

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

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

CAP, etc

AND

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

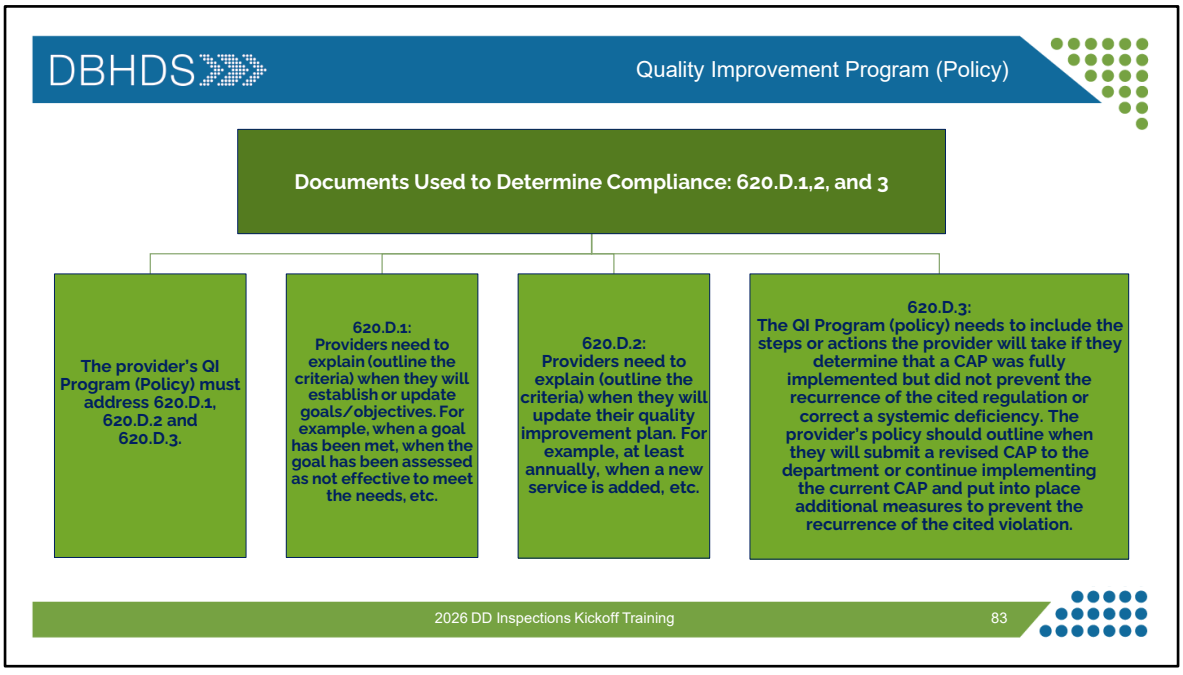
Example: even though a CAP was fully implemented, the provider determined that they are still not in compliance, or an underlying systemic deficiency was not resolved

In this scenario, the provider may:

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

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

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



MACKENZIE

Documents the Office of Licensing will review to determine compliance

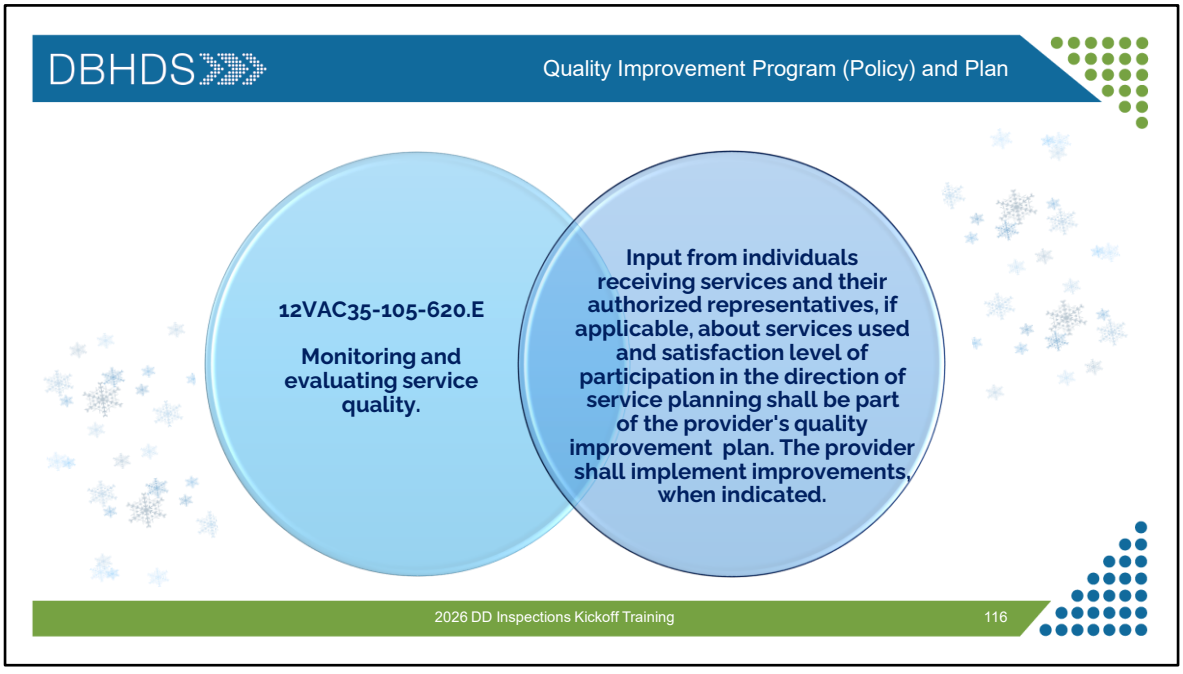
- Provider's QI policy needs to explain when they will establish or update goals/objectives.
- Provider's QI policy needs to explain when they will update their quality improvement plan.

Providers are required to monitor implementation and effectiveness of approved CAPs as part of their QI plan (620.C.4).

- If the provider is monitoring their CAP(s) and they determine that the CAP is not

effective, does the policy indicate what steps or actions they will take to address the issue?

- A provider's policy must outline the steps or actions the provider will take when they are monitoring their CAP and determine that the CAP is not effective. If a provider's policy does not include the steps or actions they will take, then the provider will be marked non-compliant.



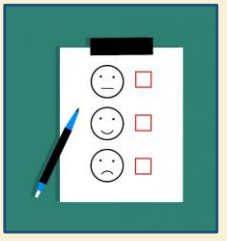
MACKENZIE

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

DBHDS

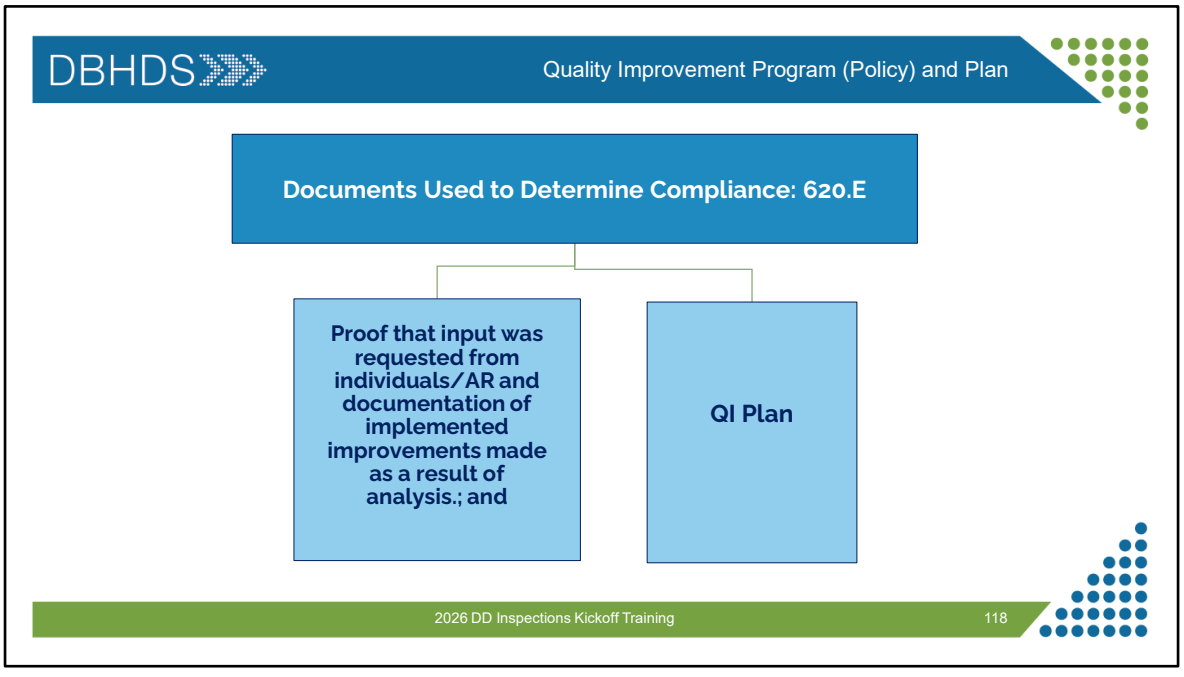
Quality Improvement Program (Policy) and Plan

- A provider's quality improvement program (policy) should include the procedures for how this input will be obtained.
- A provider's quality improvement plan must incorporate input from individuals and their authorized representatives, when applicable, including input related to the level of satisfaction with the level of participation for individuals related to service planning; and, when improvements are indicated based on this input, such improvements shall be implemented.
- No requirement for how frequent a provider requests input from individuals/AR's (i.e. quarterly, annually, etc.)
- No requirement on the method a provider uses to obtain input (i.e. surveys, phone call, etc.)
- Satisfaction of services should be documented by the provider
- Providers are required to collect and analyze input from individuals receiving services and their authorized representatives
- Providers are required to implement improvements based on results of the input received



MACKENZIE

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



MACKENZIE

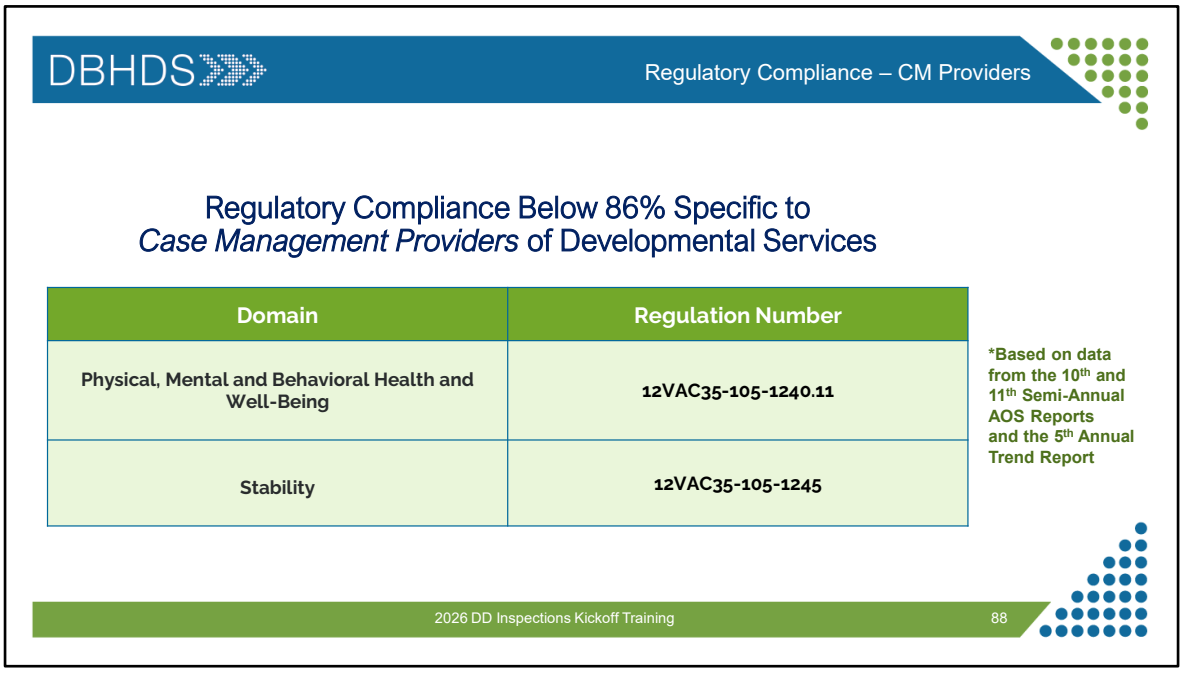
Documents the Office of Licensing will be reviewing the

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

Larisa is going to review just a few regulations specific to case management and then we will talk about corrective action plans.

Larisa

Now let's move into the third part of our Regulations overview. This next set of Regulations are applicable ONLY to providers of case management services. If you are not a provider of case management services, you might prefer to skip to the end of our presentation which includes links to several resources and tools.

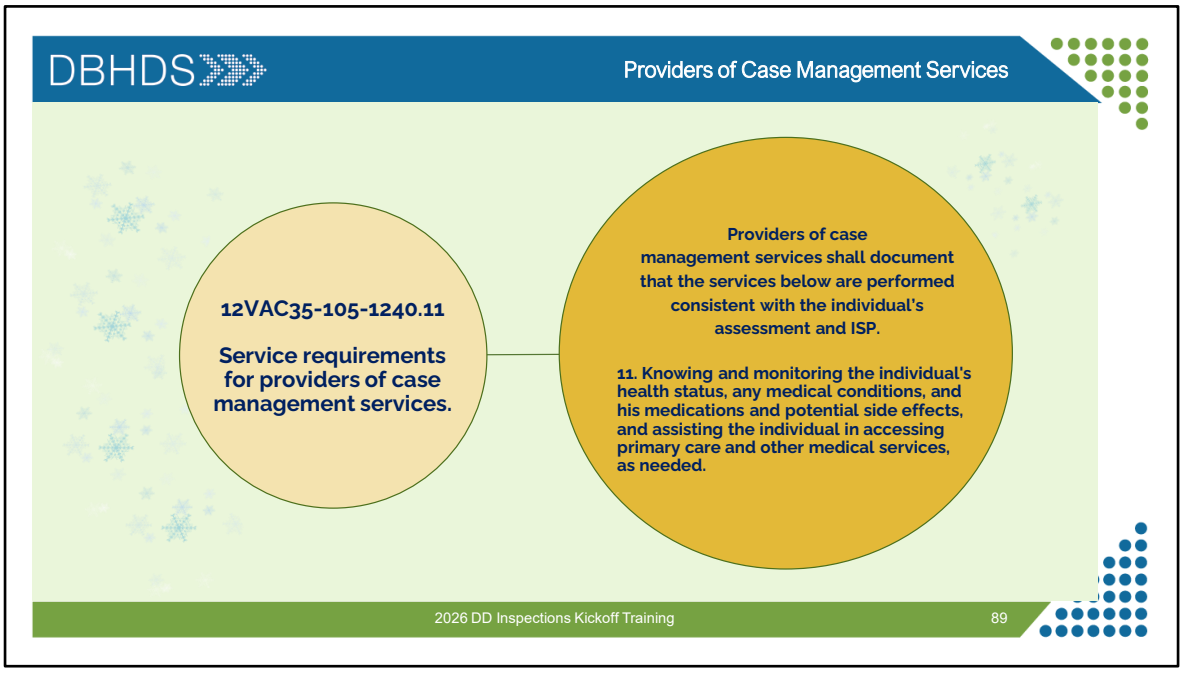


Larisa

The chart shown here includes the specific regulations where developmental disability providers of case management services had difficulty meeting compliance and are below 86%

Pause for a few seconds here

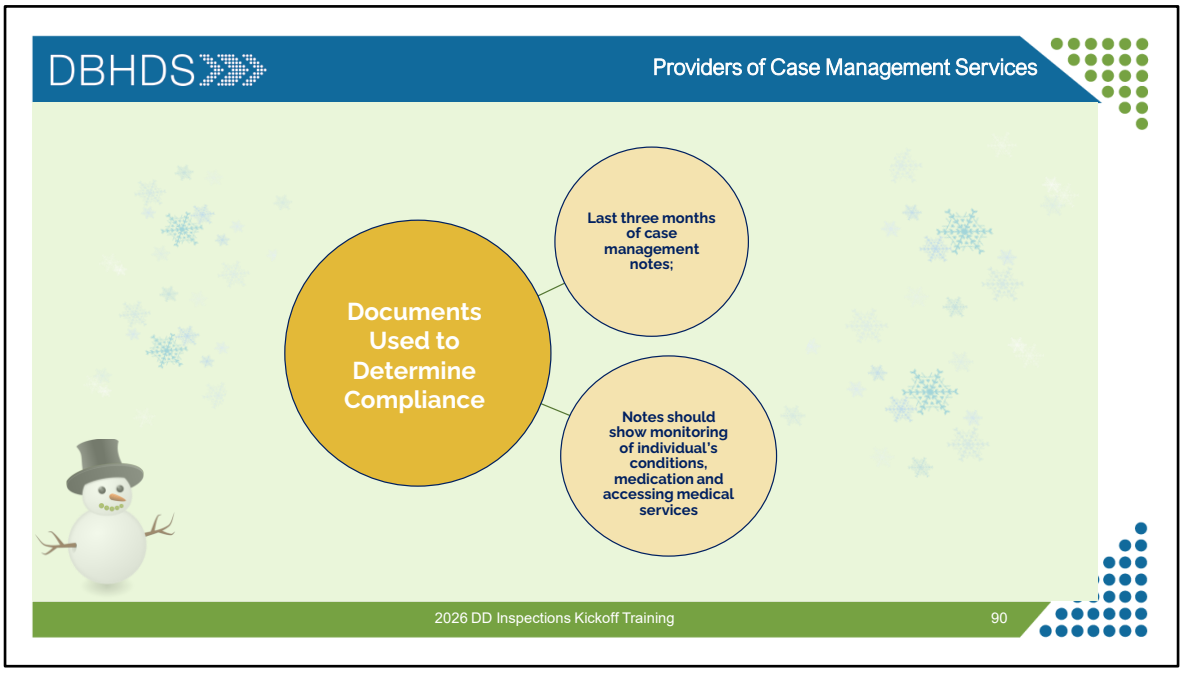
Let's talk a little more about each of these regulations



KAREN

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

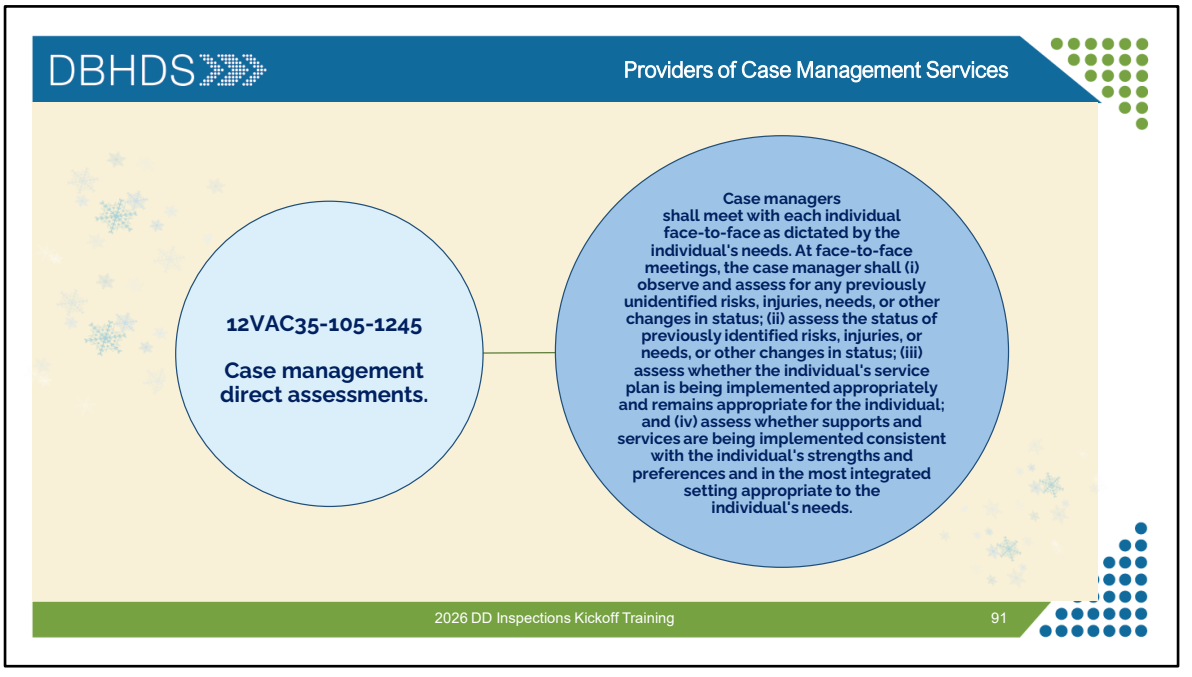
- If an individual's status or medications change, is this reflected in case management notes?
- Does the quarterly report reflect changes to the individual's status or needs?



KAREN

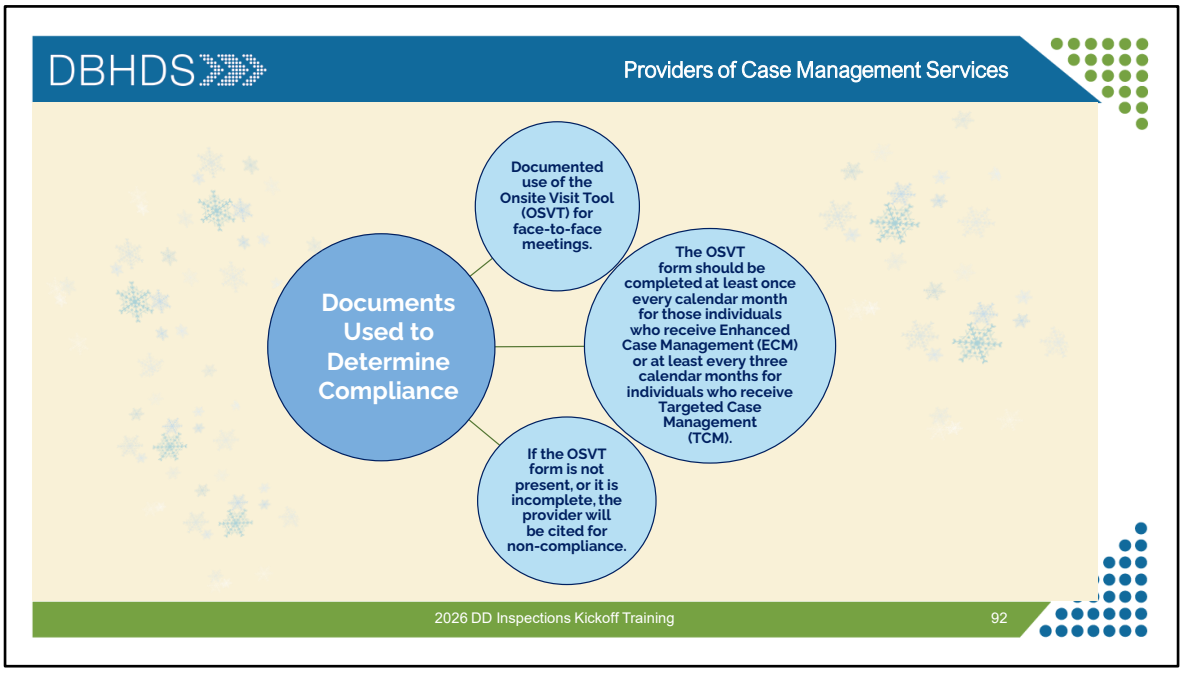
Documents the Office of Licensing will review to determine compliance

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



Larisa

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

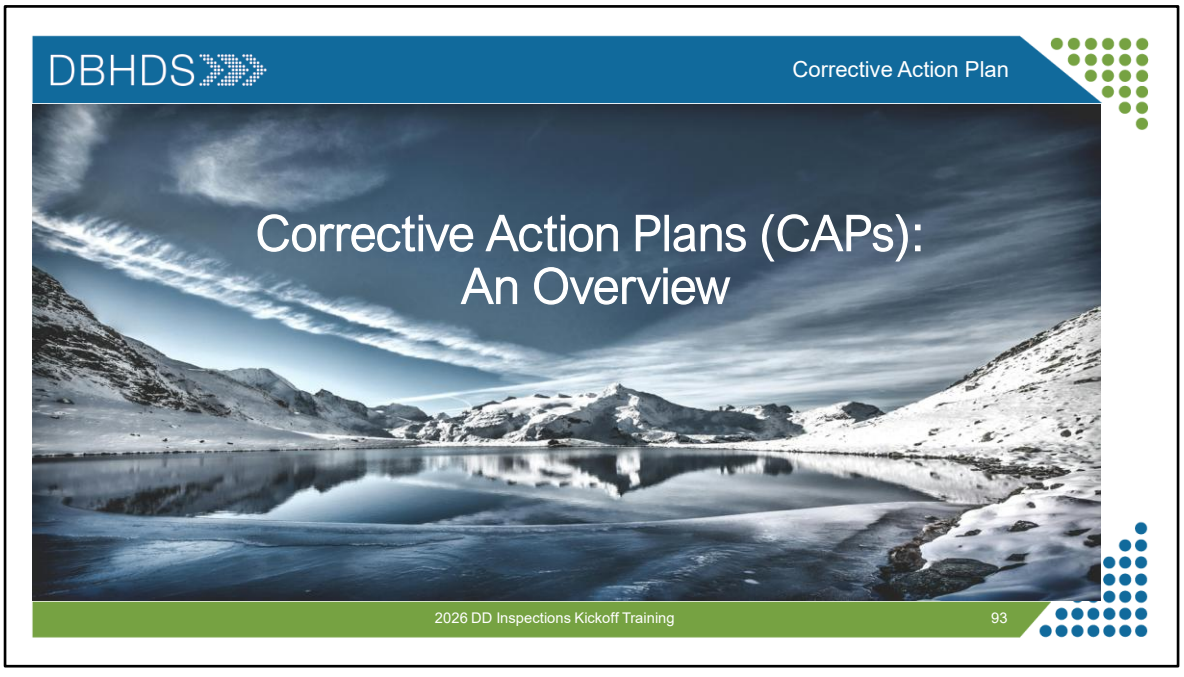


Larisa

Documents the Office of Licensing will review to determine compliance for 1245:

- Documented use of the Onsite Visit Tool (OSVT) for face-to-face meetings.
- This form should be completed at least once every calendar month for those individuals who receive Enhanced Case Management (ECM), with every other month being in the home or at least every three calendar months for individuals who receive Targeted Case Management (TCM).
- All components of the Onsite Visit Tool must be completed.

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

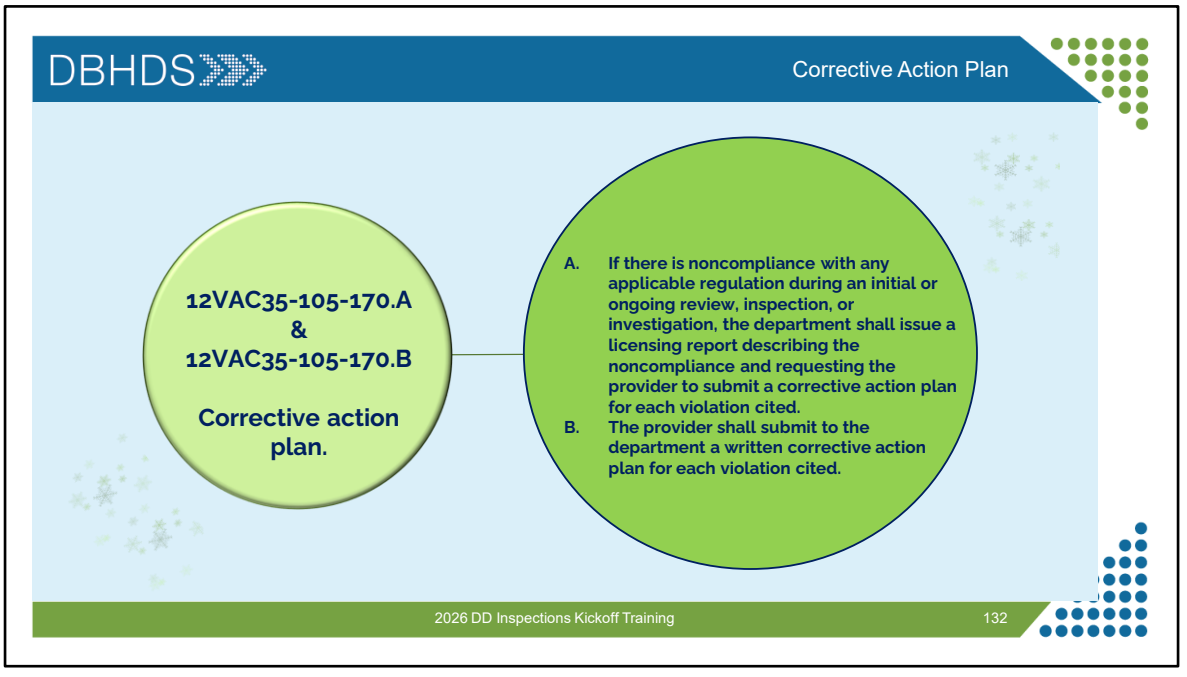


Mackenzie

Thanks Larisa

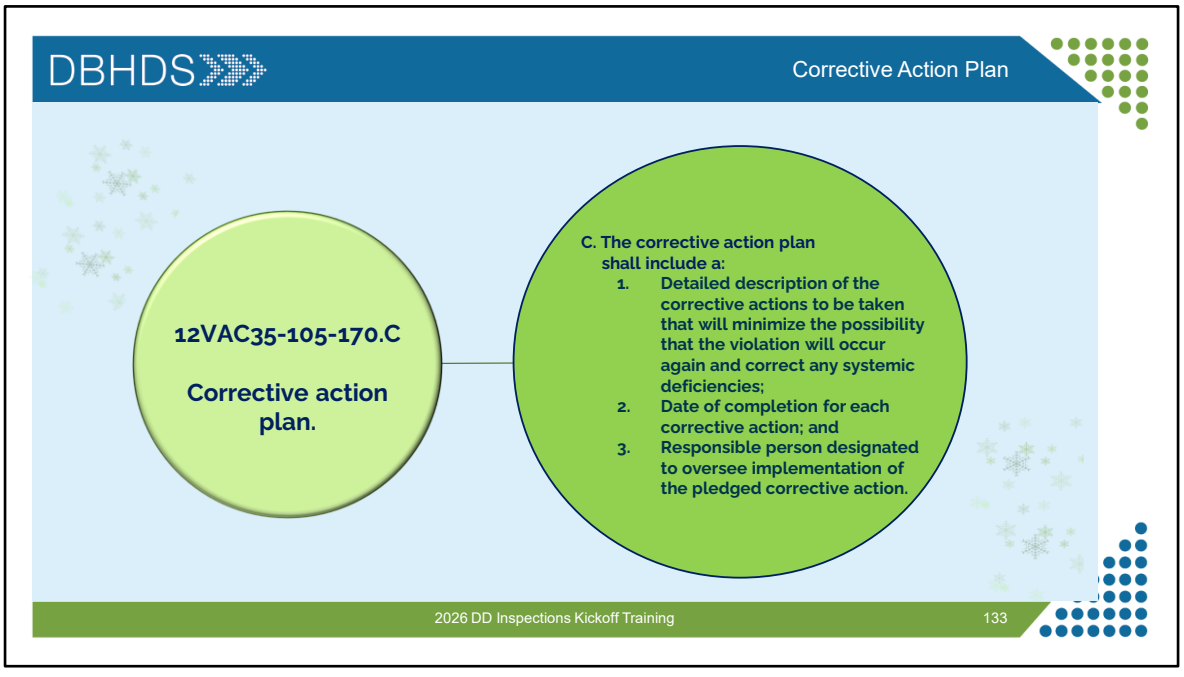
Before we wrap up for today, let's take a few minutes to talk about the Corrective Action Plan.

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



Mackenzie

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



Mackenzie

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

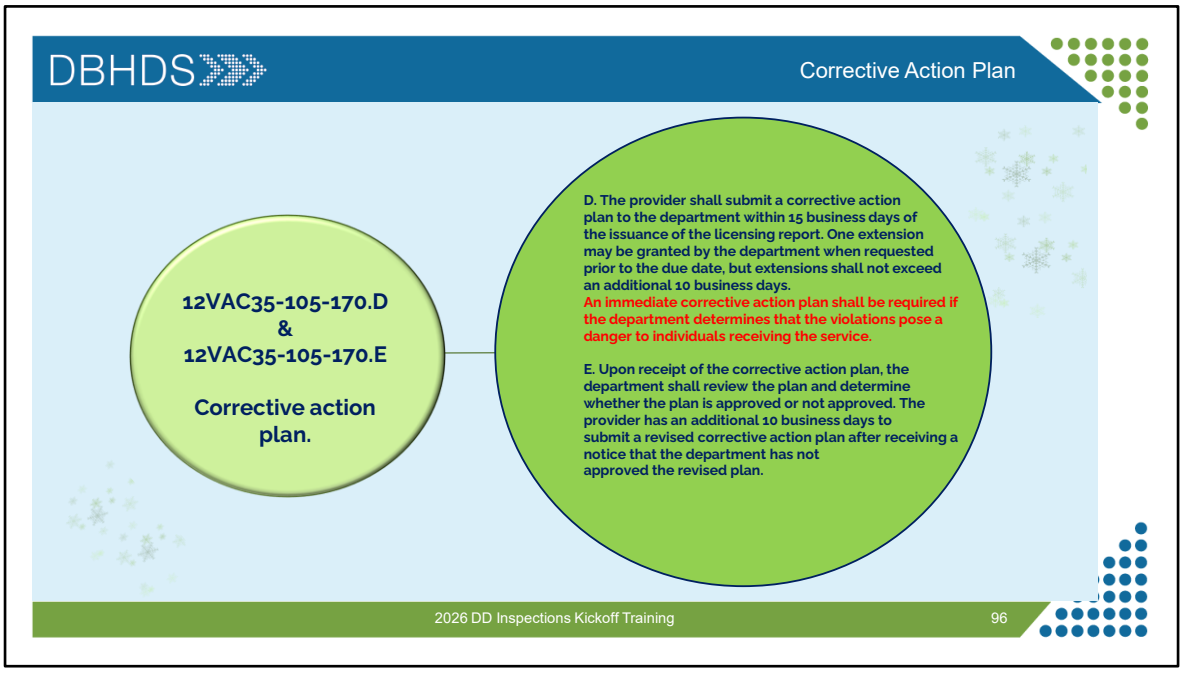
- Address all problems documented in each violation by identifying the root cause(s) of the violation;
- Develop a systemic plan of action, if applicable, to address each problem. This may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or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

AND

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

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

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



Mackenzie

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

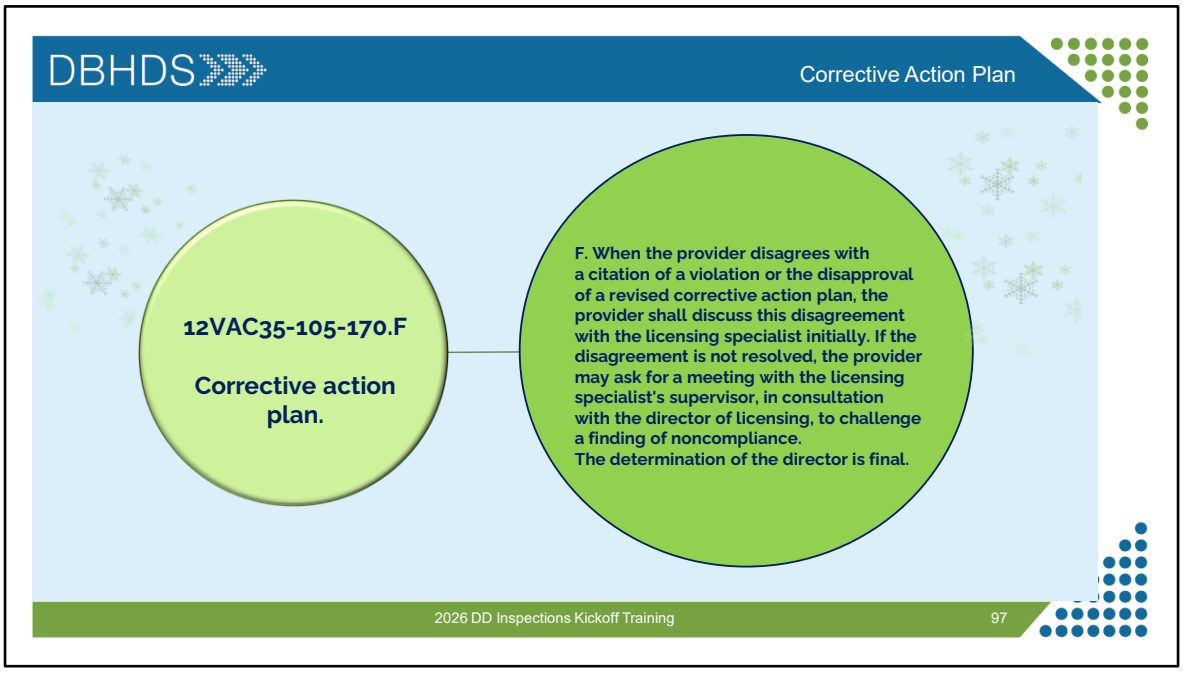
Requests for an extension must be submitted via CONNECT.

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

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

The Office of Licensing will respond to CAPs within 15 business days of receipt of the

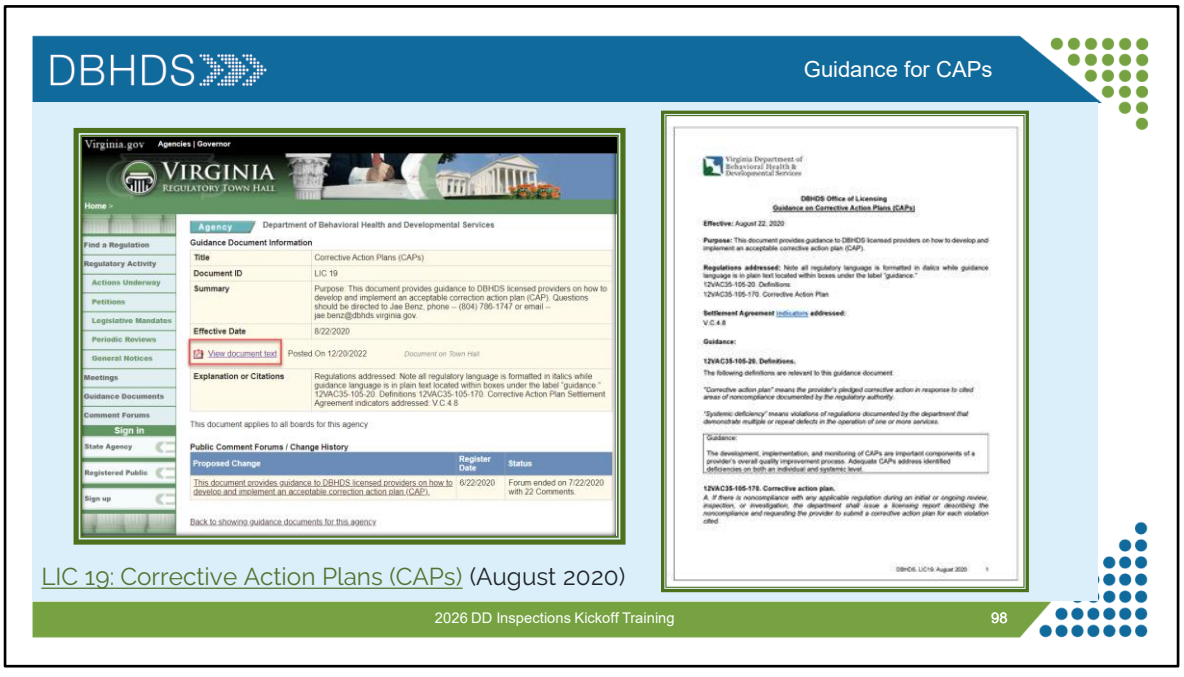
provider’s CAP.



Mackenzie

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

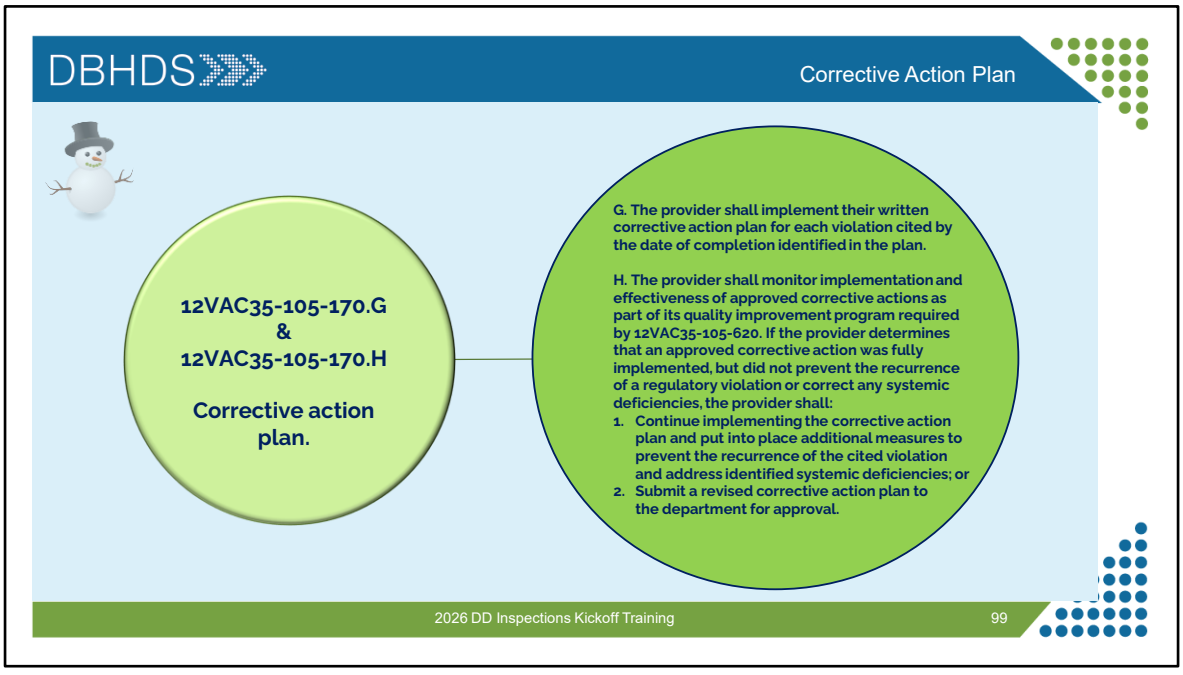
Providers need to follow the CAP Dispute Resolution Process as outlined in the Guidance on Corrective Action Plans (CAPs).



Mackenzie

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

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



Mackenzie

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

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

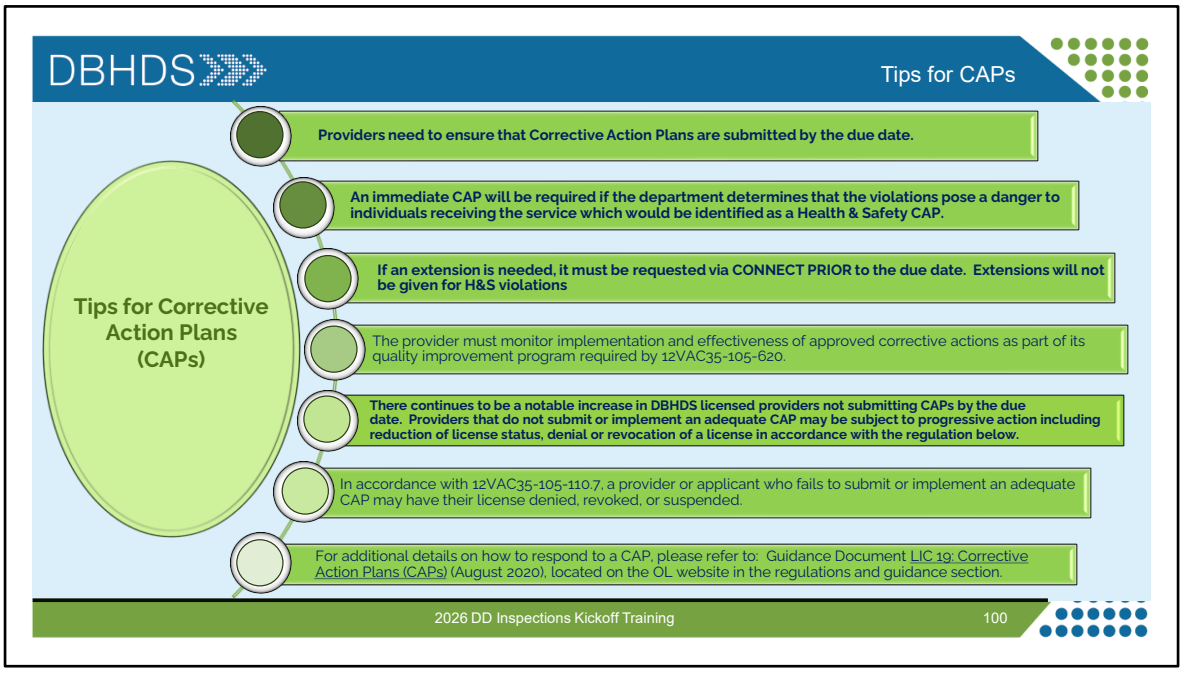
In order to demonstrate compliance with this regulation, each provider must show proof of monitoring all CAPs for implementation and effectiveness.

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

1. If the CAP was not fully implemented as intended, the provider should evaluate and address any barriers to implementation.
2. If the CAP was fully implemented, the provider should assess the reasons that the issue recurred and make a determination as to whether changes to the corrective action plan are necessary.

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

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



Mackenzie

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

•Ensure that CAPs are submitted by the due date.

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

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

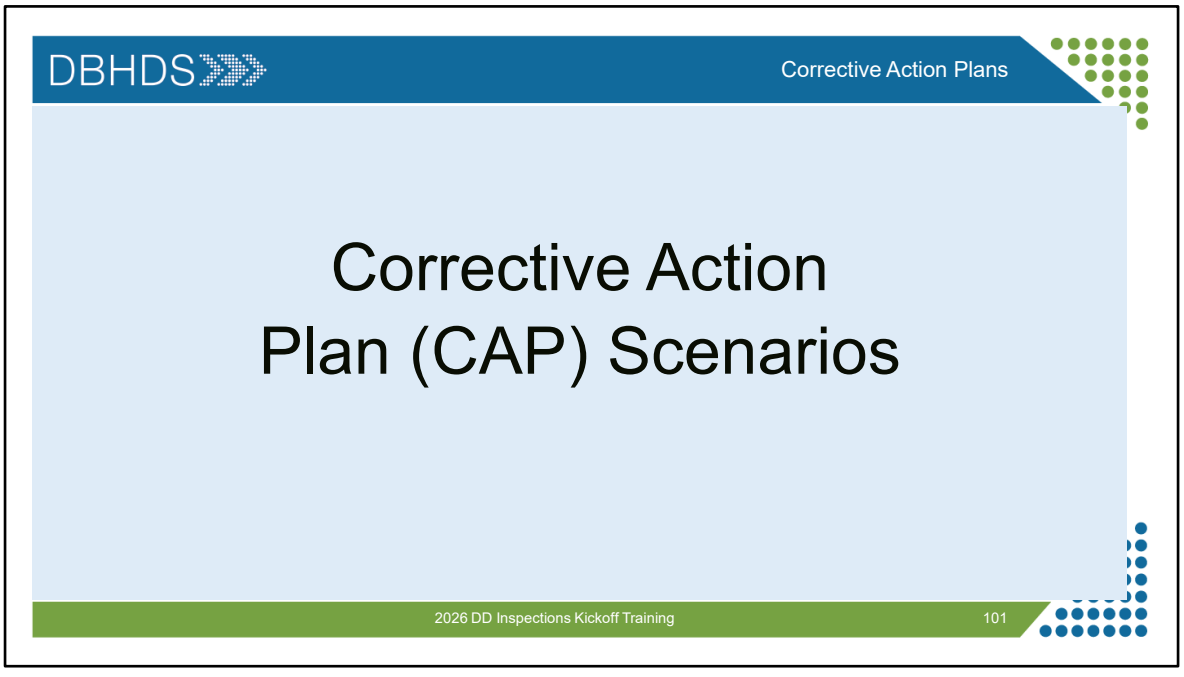
•The provider must monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 620.

•There continues to be be a notable increase in DBHDS licensed providers not submitting their Corrective Action Plan (CAP) by the due date. Providers that do not

submit or implement an adequate corrective action plan may be subject to progressive action.

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

Now Karen is going to take a few minutes to review some CAP scenarios



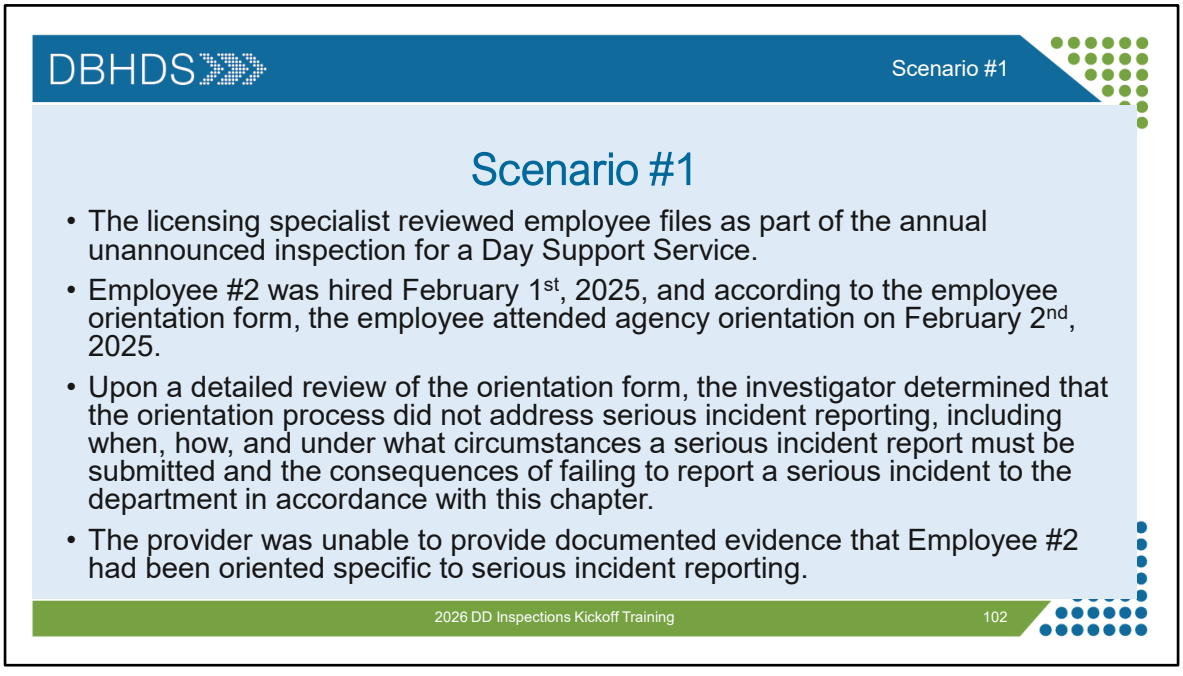
KAREN

Thanks Mackenzie

Wow, that was a lot of information, but hopefully, you are more familiar with the regulations specific to Corrective Action Plans and have a better understanding of the CAP requirements

Now, I'd like to take a few minutes to review some CAP Scenarios.

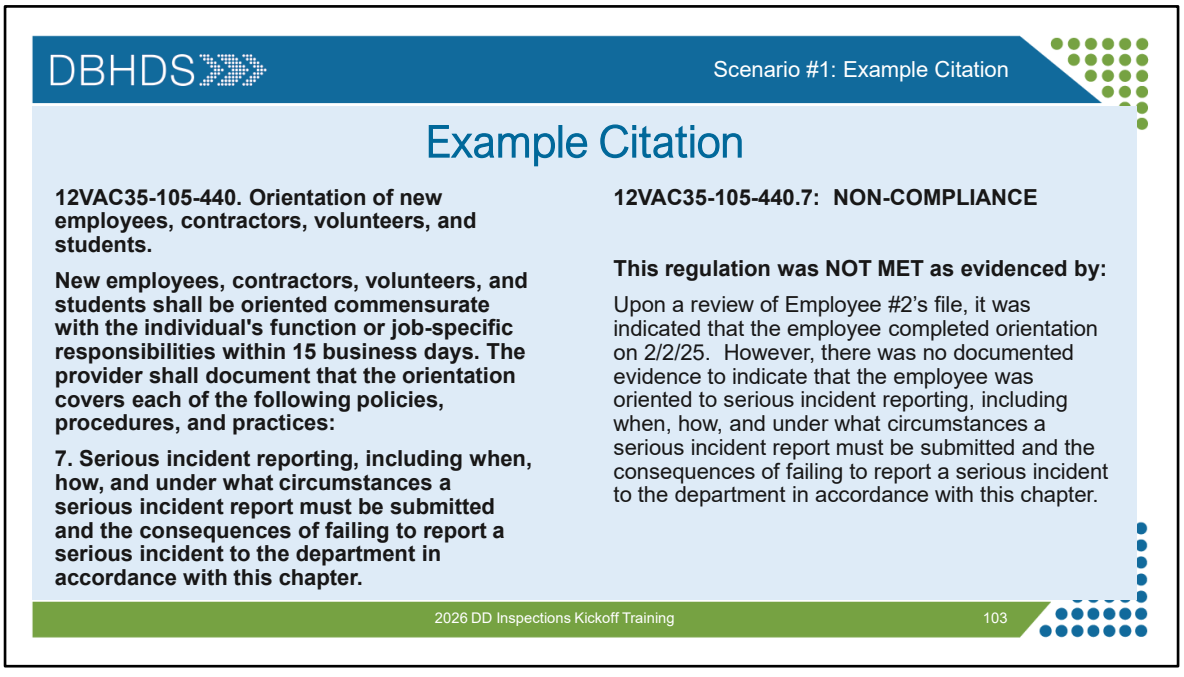
Being a DBHDS licensed provider is hard work and there may be a time in which are cited for non-compliance. We hope that these scenarios will provide you with a better understanding of how to respond to the Office of Licensing if you receive a citation.



KAREN

Scenario #1

[READ SLIDE]



KAREN

When you receive a licensing report, the regulation number and regulatory text will be provided along with the reason for non-compliance.

The regulatory text for the scenario would be: 12VAC35-105-440. Orientation of new employees, contractors, volunteers, and students.

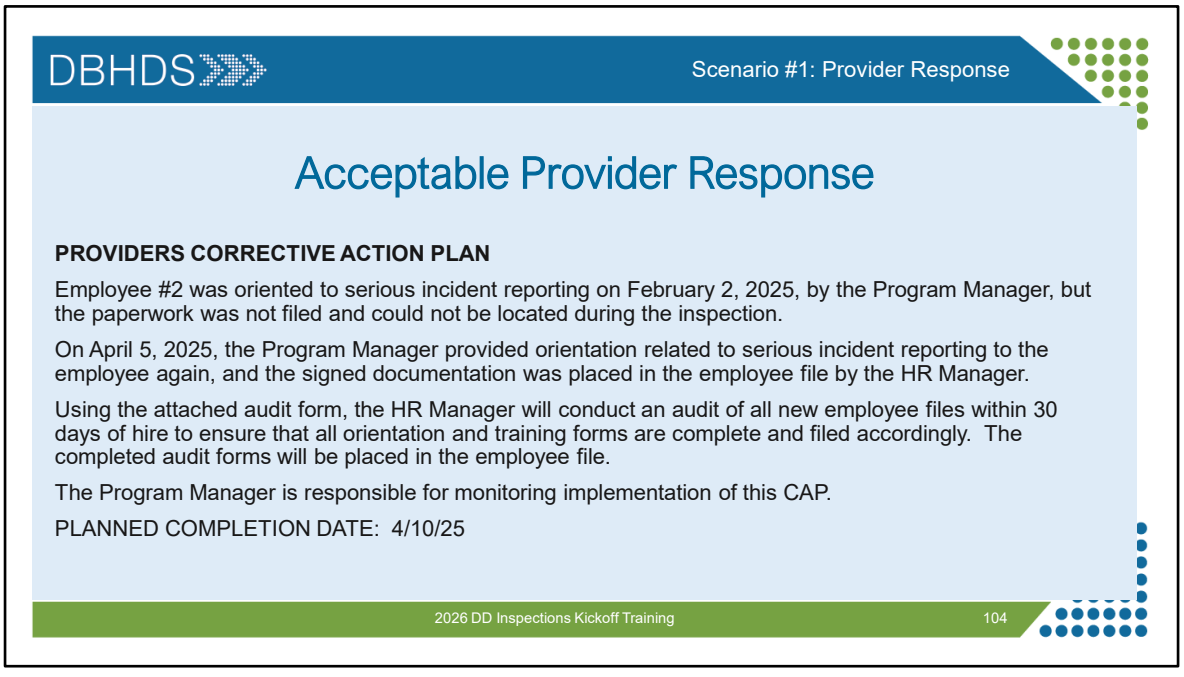
Which reads, "New employees, contractors, volunteers, and students shall be oriented commensurate with the individual's function or job-specific responsibilities within 15 business days. The provider shall document that the orientation covers each of the following policies, procedures, and practices:

And the specific sub-regulation of 440 would be number 7, which reads "Serious incident reporting, including when, how, and under what circumstances a serious incident report must be submitted and the consequences of failing to report a serious incident to the department in accordance with this chapter."

In this scenario, 440.7 was marked non-compliant and the reason for non-compliance could read as:

“This regulation was NOT MET as evidenced by:

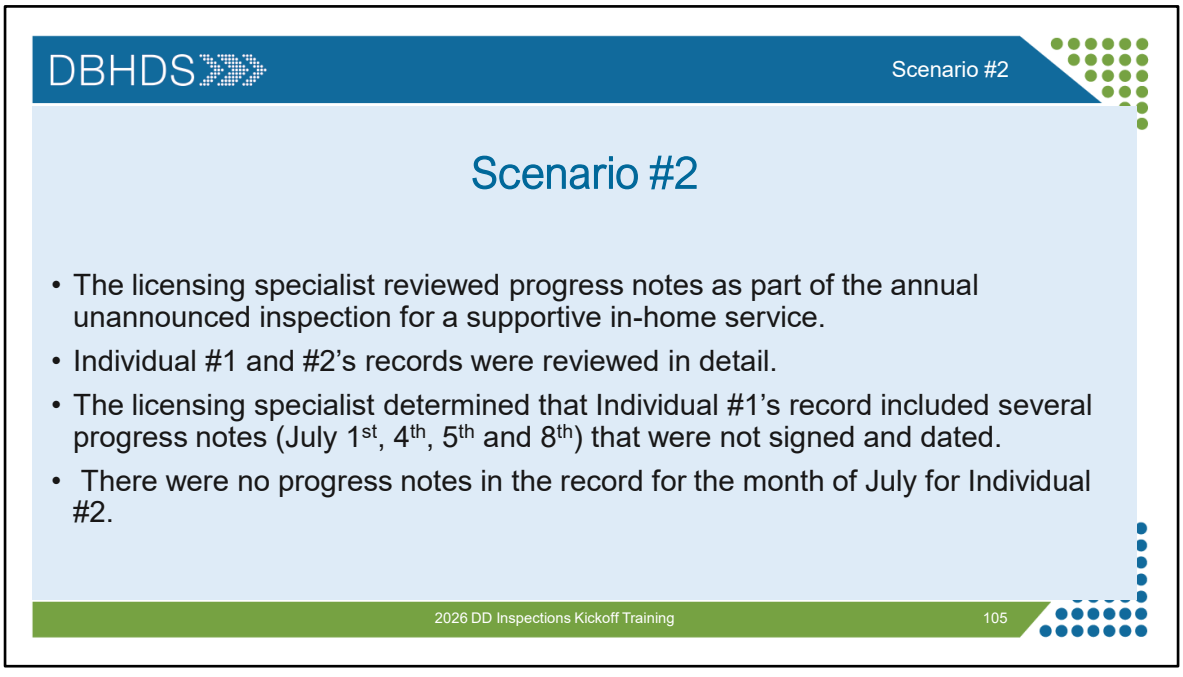
Upon a review of Employee #2’s file, it was indicated that the employee completed orientation on 2/2/25. However, there was no documented evidence to indicate that the employee was oriented to serious incident reporting, including when, how, and under what circumstances a serious incident report must be submitted and the consequences of failing to report a serious incident to the department in accordance with this chapter”.



KAREN

Now here's an example of an Acceptable Provider Response

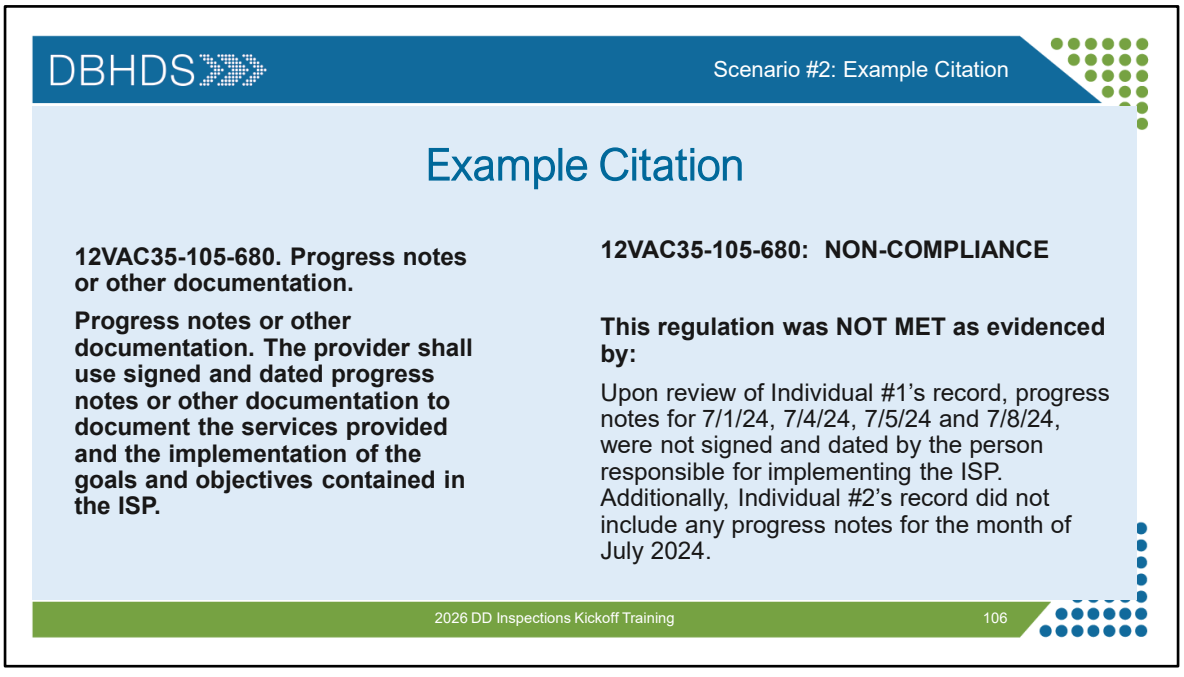
[READ SLIDE]



KAREN

Scenario #2

[READ SLIDE]



KAREN

Remember, when you receive a licensing report, the regulation number and regulatory text will be provided along with the reason for non-compliance.

The regulatory text for the scenario would be: 12VAC35-105-680. Progress notes or other documentation.

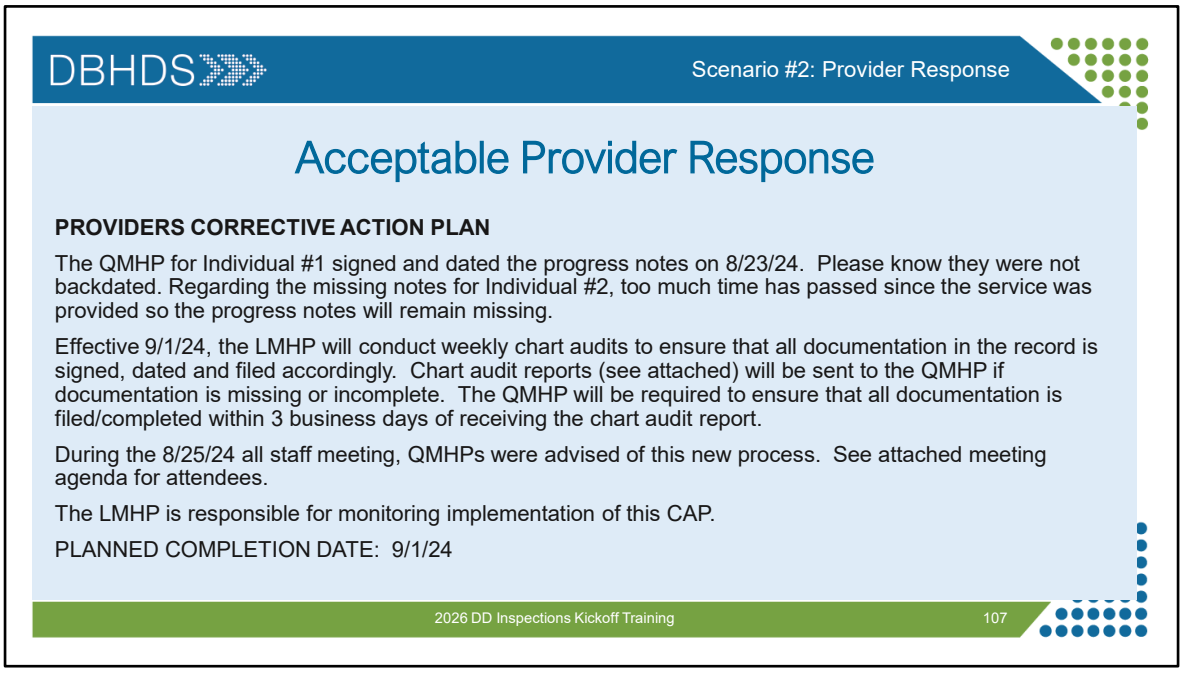
Which reads, "Progress notes or other documentation. The provider shall use signed and dated progress notes or other documentation to document the services provided and the implementation of the goals and objectives contained in the ISP."

In this example, the provider was cited for non-compliance with 680 and the reason for non-compliance could read as:

"This regulation was NOT MET as evidenced by:

Upon review of Individual #1's record, progress notes for 7/1/24, 7/4/24, 7/5/24 and 7/8/24, were not signed and dated by the person responsible for implementing the ISP.

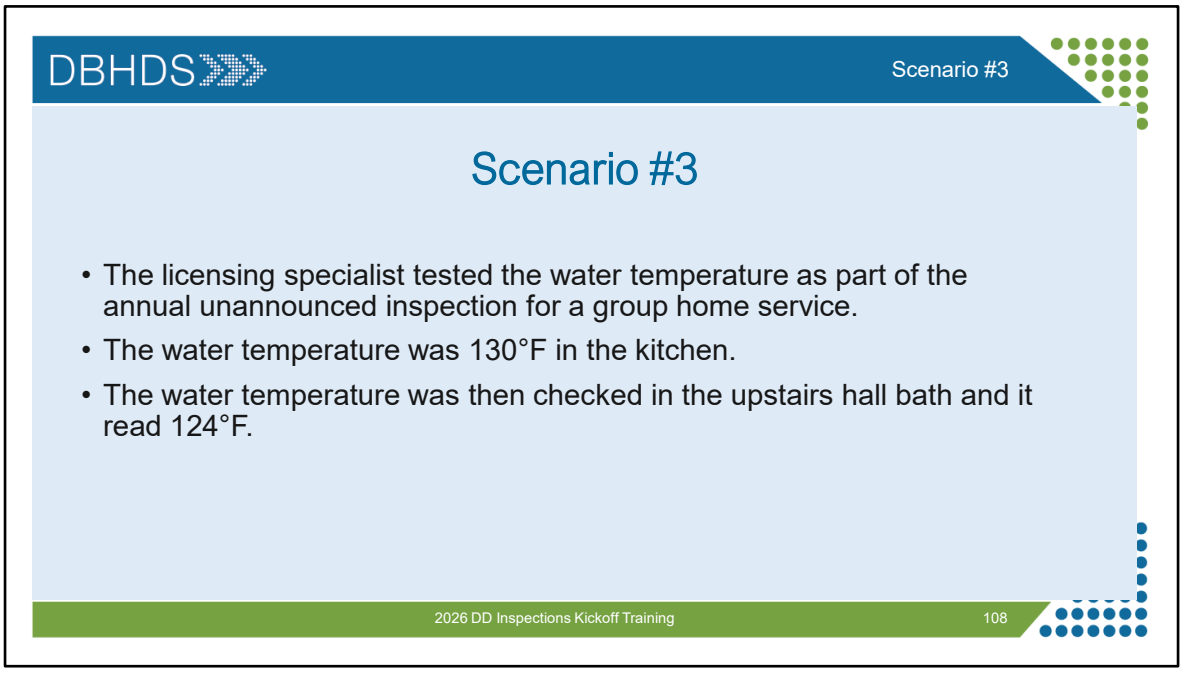
Additionally, Individual #2's record did not include any progress notes for the month of July 2024."



KAREN

Here's another example of an Acceptable Response for a CAP

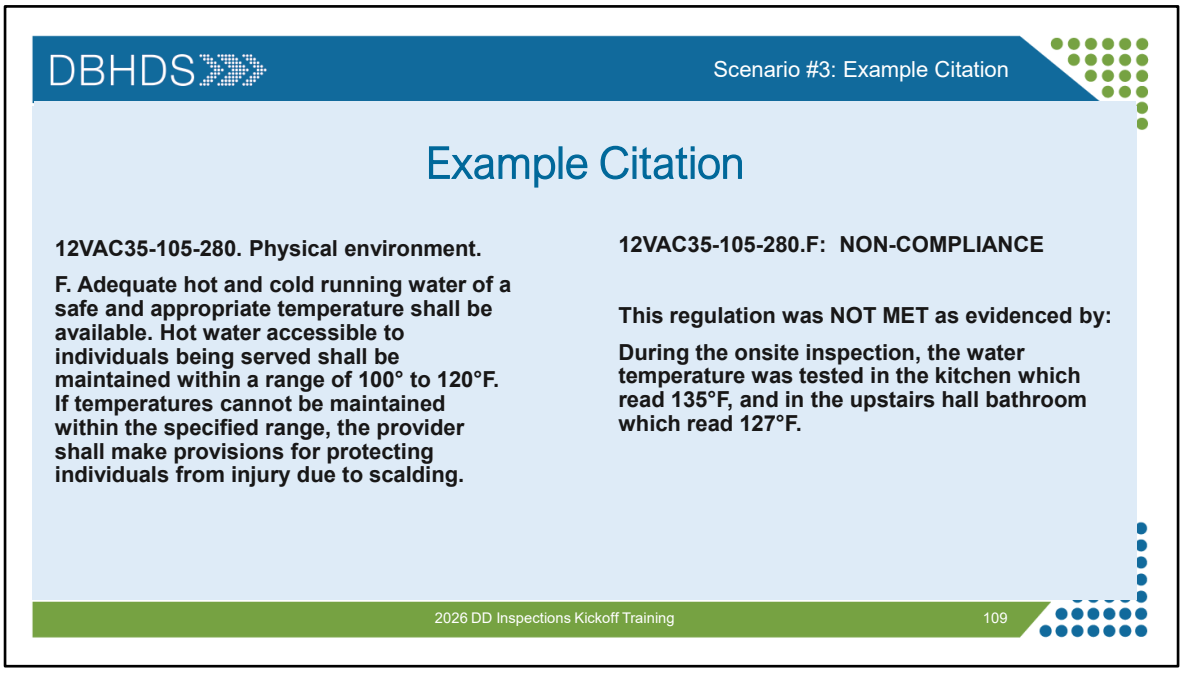
[READ SLIDE]



KAREN

Scenario #3

[READ SLIDE]



KAREN

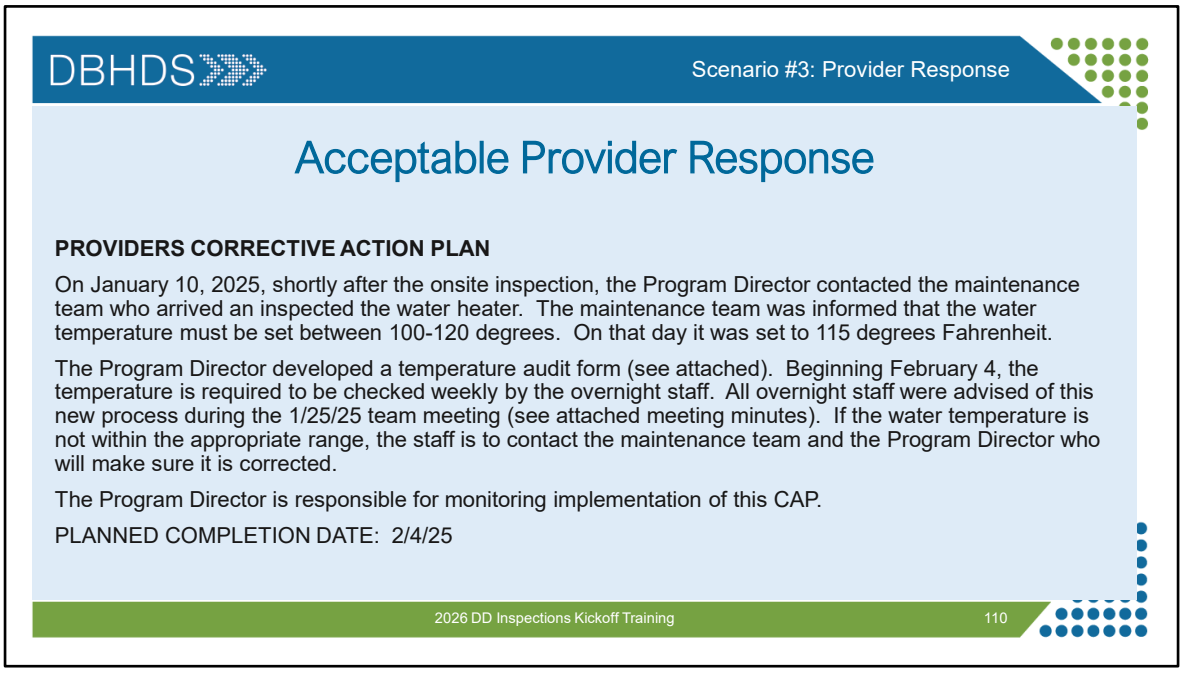
The regulatory text for the scenario would be: 12VAC35-105-280. Physical environment.

And the specific sub-regulation of 280 would be "F", which reads, "Adequate hot and cold running water of a safe and appropriate temperature shall be available. Hot water accessible to individuals being served shall be maintained within a range of 100° to 120°F. If temperatures cannot be maintained within the specified range, the provider shall make provisions for protecting individuals from injury due to scalding."

In this example, the provider was cited for 280.F and the reason for non-compliance could read as:

"This regulation was NOT MET as evidenced by:

During the onsite inspection, the water temperature was tested in the kitchen which read 135 degrees, and in the upstairs hall bathroom which read 127 degrees."



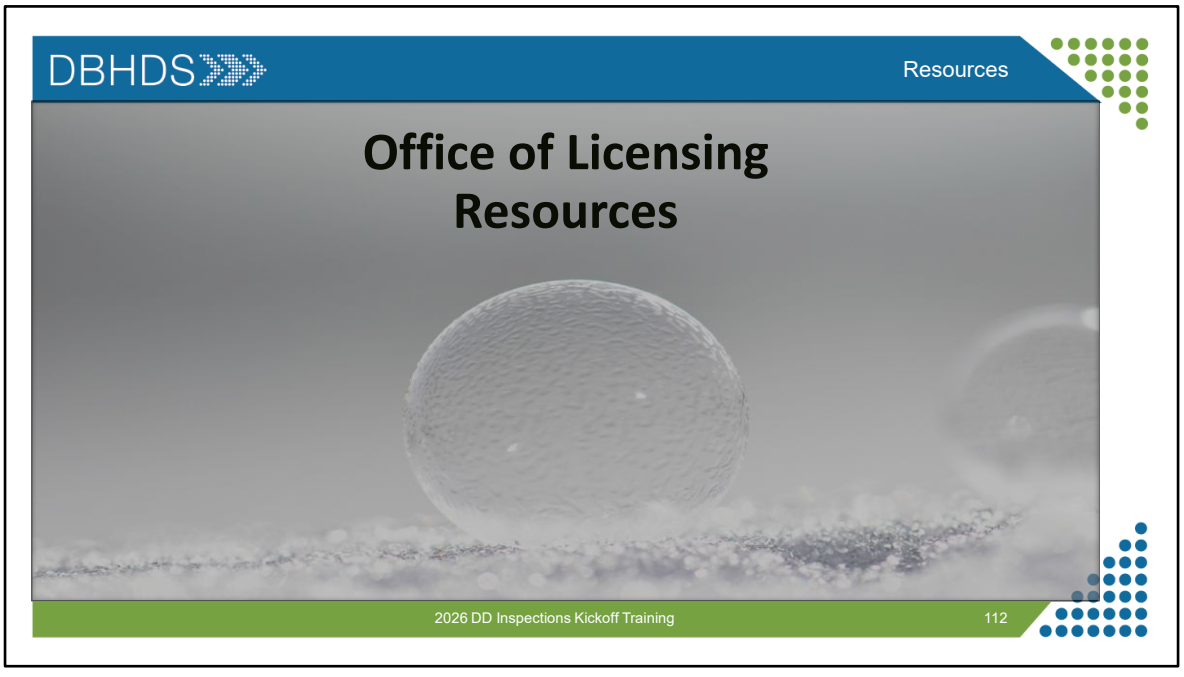
KAREN

Here's an example of an Acceptable Response for a CAP

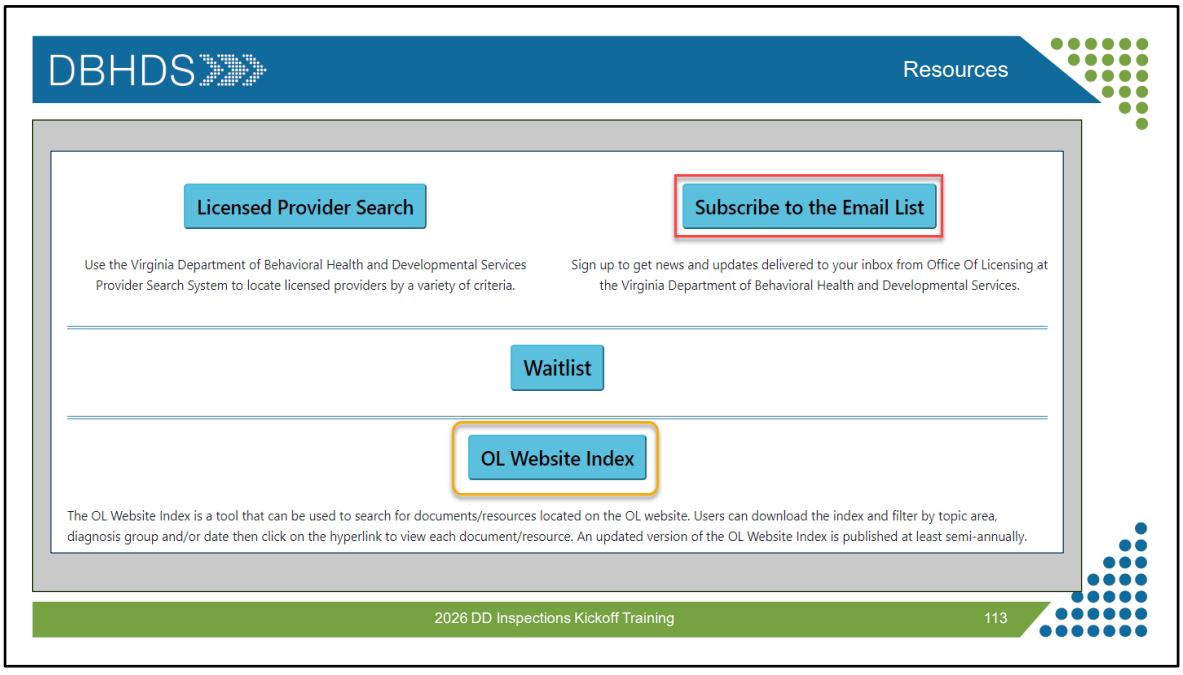
[READ SLIDE]

Now I'm going to pass it over to Larisa.

Once again, we appreciate you sharing your time with us today. We wish you all a wonderful winter and great success in 2026! Thank you for being part of our Team!! This concludes today's presentation.



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



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

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

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

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Office of Licensing Website Resources - Root Cause Analysis

Samples

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

Trainings

- Flow-Chart Incident Reviews (April 2023)
- Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation and Research – Handout (December 2020)
- Root Cause Analysis Training (October 2020)

Information related to root cause analysis

Information related to risk management

DBHDS

OL Website Resources - Risk Management & Care Concerns

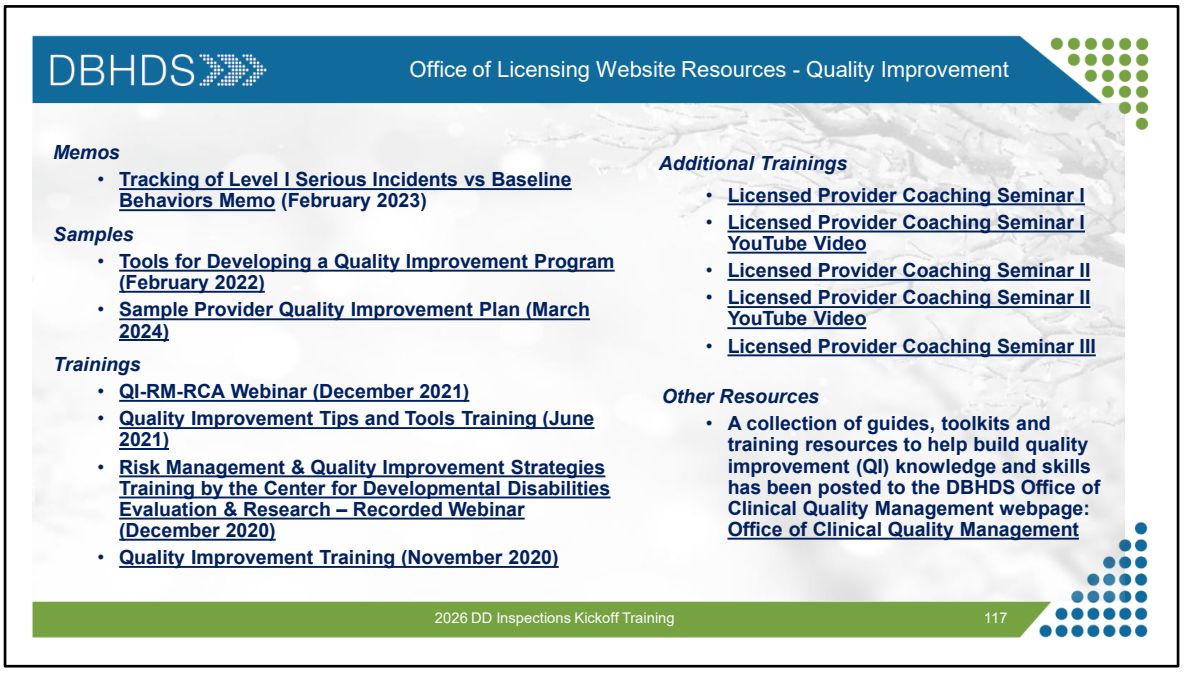
Risk Management

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

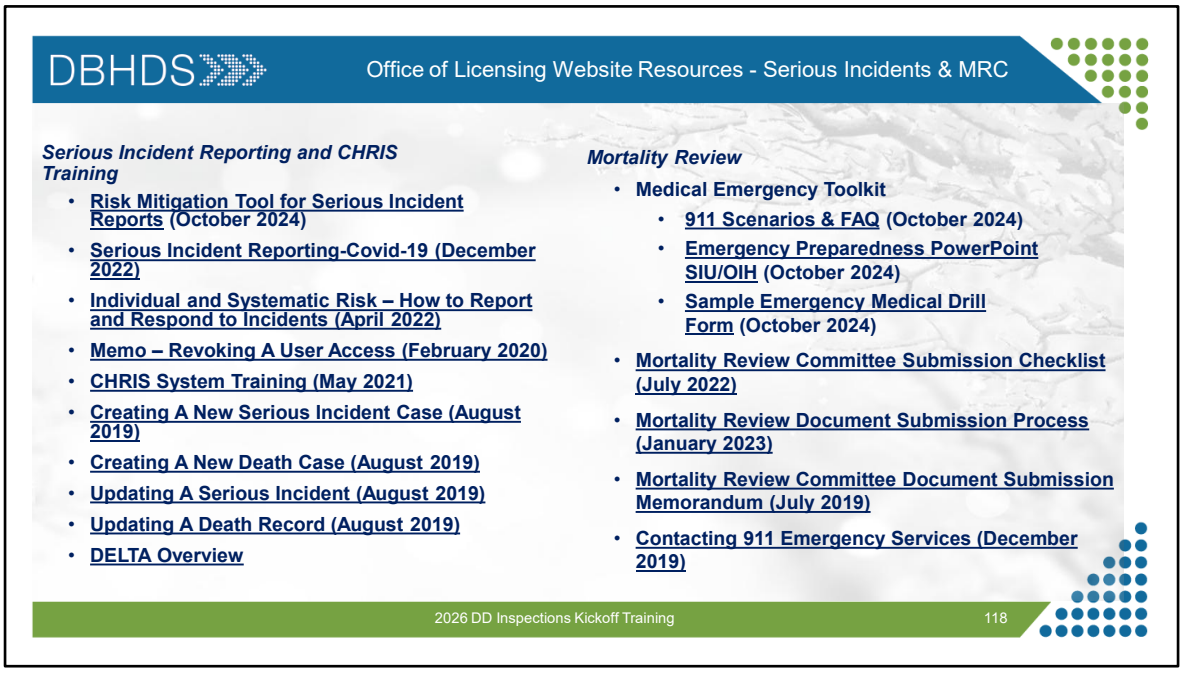
Care Concerns

- 2023 Care Concern Threshold Criteria Memo (February 2023)
- Risk Triggers and Threshold Handout (February 2023)
- IMU Care Concern Threshold Training (October 2025)

Risk Management training and information related to care concerns



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



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