Office of Licensing
Q&A 2024 DD Inspections Kickoff Training

Quality Improvement

Question: What is the difference between the quality improvement plan and the risk management plan?

Answer: A quality improvement (QI) plan is 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. A QI plan includes measurable goals and objectives as well as progress toward meeting those goals.

A written risk management plan focuses on identifying, monitoring, reducing, and minimizing harms and risk of harm through a continuous, comprehensive approach. The risk management plan should include identifying year-over-trends and patterns and the use of baseline data to assess the effectiveness of risk management systems.

Question: Are systemic risk assessments and analyses and quality improvement plans required if you have a small at-home business, you're the only employee, and you don't see any clients at your home? I only provide mobile crisis and community stabilization services.

Answer: Regulations 12VAC35-105 apply to all DBHDS licensed services unless specifically identified as exempt within these regulations.

"Service" means (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, medication assisted opioid treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

Question: Is there or will there be a 2024 QIP complete template to include all criteria? Per this training, I'm creating one now, however if there will be one soon or in the year's end to include new and 2025 updates, it will be greatly appreciated.

Answer: The Office of Licensing is working to finalize policy and form templates based on feedback from the recent DOJ study period.

Question: What is the difference between a Quality Improvement Plan and a Quality Improvement Policy? Can we have a sample of a QI and QI policy?

Answer: Per 12VAC35-105-620.A, providers are required to have written policies and procedures to demonstrate they have a QI Program. The policy and procedures should address and include the requirements as outlined in 620.A, 620.B and 620.D.1-3. Providers are also required to have a QI Plan (620.C.1-5) as a part of their program. A QI Program/Policy and QI Plan are two separate documents. Samples are located on the OL website under Quality Improvement and the Office of Licensing is working to finalize policy and form templates based on feedback from the recent DOJ study period.

Question: Should the specific measurable goal and measurable objective(s) that addresses meaningful work or meaningful community inclusion ALWAYS be included in the Quality Improvement Plan? Even after it is successfully met according to repeat monitoring and assessment, should it still be reflected on the QIP?

Answer: Unfortunately, not everyone is involved in their community as much as they would like**.** Therefore, once the goal and objective(s) related to Community Integration have been met, the provider should identify a new goal and objective(s) to address meaningful work or meaningful community inclusion.

Question: What are OL's expectations related to 620.C.2: The quality improvement plan shall: Define measurable goals and objectives?

Answer: According to LIC 16: Guidance for A Quality Improvement Program (November 2020), "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." The SMART method is a well-established tool that providers can use to plan and achieve goals and objective.

Question: For individuals who attend day support versus working, is it a requirement to have an objective educating them about meaningful work?

Answer: Licensed residential and day support providers of developmental services will be expected to track community integration as a statewide performance measure through their Quality Improvement (QI) Plan, as required by 12 VAC 35-105-620.C.3: The quality improvement plan shall: Include and report on statewide performance measures, if applicable, as required by DBHDS.

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. **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.**

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 I live with. Meaningful community inclusion can include activities that are done with paid and natural supports.*

Please refer to: 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 (November 2023).

Question: Our QI Plan goes from July 2023-June 2024, are we required to amend the current Plan to include all these or do we start doing things in July 2024?

Answer: To demonstrate compliance with the DBHDS Rules and Regulations, it is recommended that you complete an addendum to your current QI Plan as soon as possible so that you can address specific areas such as Community Integration (620.C.3), which is applicable to residential and day support providers only. Then at the annual review date, your agency would review all areas outlined in the QI Plan to determine if any updates need to be made.

Risk Management

Question: Is there a way to change the quarterly review periods in the Risk Tracking Tracker?

Answer: Yes, you can change the quarterly review periods monthly and individual risk tracking tools. To do this, you have to 'unprotect' the MONTHLY tab and the QUARTERLY tabs. You need to change the names of the months in the headers, but don't forget to re-protect the sheets when you are done.

Question: When we review the Systemic Risk Assessment (SRA) the following year, do we take off the risks that were low?

Answer: For risks you identified, if you implemented your recommendations and determine that those areas are no longer a risk then they can be removed from your systemic risk assessment**.**

Question: Would you consider each consumer's home as environment of care? Such as each of our individuals receiving in home supports?

Answer: An assessment of the environment of care for community-based services should include an analysis of the risks associated with the provision of services in the community, and any risks unique to the community locations where services are expected to be provided. While you may not have direct control over these risks, analysis of such risks will help the provider develop a plan to mitigate those risks.

Question: Would the appointed Risk Manager need to complete the trainings again if they had already done so under a different/previous provider and that attestation is in our records?

Answer: Yes, the new Risk Manager would have to complete the training again within 15 business days of hire and the attestation would need to be signed by the Risk Manager's supervisor. The Risk Management Attestation Form is non-transferrable and the person responsible for the risk management function would need to retake the trainings and complete/file the Risk Management Attestation Form with their new employer.

Question: Can someone reiterate if the risk management attestation form is annual? Does the Risk Manager Attestation need to be signed annually? If it needs to be signed annually, do Risk Management Trainings need to be completed annually as well?

Answer: Annual retraining is not required, however the person responsible for the risk management function may review those trainings anytime as a refresher.

Question: Where do we find the template/excel spreadsheet that we were trained on?

Answer: The Individual and Monthly Risk Tracking Tools are located on the Office of Licensing's website, but the links are included here as well.

- Individual Risk Tracking Tool (April 2023)
- Monthly Risk Tracking Tool (April 2023)
- Instructional Video-Risk Tracking Tool (April 2023)

Question: Who do you contact if the excel tracking form is not tabulating numbers?

Answer: Some providers reported that they had issues with the tracking form, but it was typically because they had not downloaded it. Please remember to download the form before you begin working in it. If you encounter any issues, please contact licensingadminsupport@dbhds.virginia.gov and your question will be directed to the appropriate OL staff.

Question: On the risk tracker do the quarterly totals tab automatically add up data from the monthly tabs? As well as automatically feed into the graphs?

Answer: Yes, these automatically update on the tracker and the data feeds into the graphs.

Question: If you haven't used a risk tracking tool for 2023, will you be cited for non-compliance or non-determination?

Answer: Yes, you are not in compliance and will be cited. The requirements outlined in 160.C, 520.C.5 and 520.D have been clearly outlined and you need to start tracking serious incidents now. The Risk Tracking Tool that was reviewed during today's training was developed to assist providers with tracking serious incidents, but it's not a mandatory tool. However, providers are expected to have a tool to track incidents and care concerns. Using the Individual and Monthly Risk Tracking Tools will greatly increase the likelihood of being compliant.

Question: Does the Risk Manager position require the person to have a degree?

Answer: Not necessarily; however, please refer to 12VAC35-105-420, which is a requirement for all employees or contractors, "Qualifications of employees or contractors. A. Any person who assumes the responsibilities of any position as an employee or a contractor shall meet the minimum qualifications of that position as determined by job descriptions." Additionally, the person responsible for the risk management function is required to complete the trainings outlined in the Updated Crosswalk of DBHDS Approved Attestation Trainings (August 2022).

Question: Do providers have access to the DBHDS crosswalk? If so, where can they access the crosswalk?

Answer: Yes, this information is posted on the OL website under the risk management section and referenced in the annual determination chart. The links are also included below:

- Updated Crosswalk of DBHDS Approved Attestation Trainings (August 2022)
- Updated Risk Management Attestation Form (August 2022)

Question: Are large providers recommended or required to have 2 or more RM employees?

Answer: 12VAC35-105-520.A states, “A provider shall designate a person responsible for the risk management function who has completed department approved training.” Large agencies might have the Risk Manager delegate some of the risk management activities to other staff, however; there should be a main person designated as the person responsible for the risk management function; conversely very small providers, such as a provider who runs a singular group home, might have the person responsible for the risk management function serve in other roles as well.

Question: How is adequacy of staffing measured or what is required to meet this requirement for Support Coordination/Case Management?

Answer: As it relates to the Systemic Risk Assessment and adequacy of staffing, for case management services, the provider would need to ensure that there is an adequate number of staff who can provide the required services based on needs of the individuals being served. This would also include adequate number of staff to meet the expectation related to face-to-face visits as dictated by the individual’s ISP.

Root Cause Analysis

Question: Do you only use the Root Cause Analysis (RCA) when reviewing serious incidents, or can it be used with other areas of concern?

Answer: Root cause analysis is a method of problem solving designed to identify the underlying causes of a problem. RCA is a quality improvement tool that can be used any time an organization wants to have a better understanding of what is happening. Per regulation 12 VAC 35-105-160.E, a provider must utilize root cause analysis and have a root cause analysis policy. Additionally, root cause analysis can be used with other areas of concern.

Question: Is the 6-month period outlined in the Root Cause Analysis policy per year or within a 6-month period, let's say from October 2023 to January 2024?

Answer: No, the six-month period is based on when the first incident occurred to when the incident occurred causing the provider to meet their threshold number as outlined in their RCA policy. If a threshold number is met within a six-month period, then a more detailed RCA would need to be conducted within 30 days of discovery of the incident that caused the provider to meet their threshold. After the threshold number is met, tracking of the incidents would need to begin again and once the threshold is met within a six-month period, then a more detailed RCA would need to be completed. It is important that the provider implements and monitors the identified solutions to mitigate the reoccurrence of incident(s) and prevent future harm when applicable.

Example:
Sample Policy specific to 160.E.2.b:
“Acme, Inc. will conduct a more detailed Root Cause Analysis when two or more of the same Level III serious incidents occur to the same individual or at the same location within a six-month period.”

Data:
A Level III serious incident occurs on January 3, 2024, at Location A (this date starts the six month-period). Another Level III serious incident occurs on May 15, 2024, at Location A. This is the second incident of its type and since it occurred within six months of the first Level III serious incident it requires a more detailed root cause analysis.

Then on June 1, 2024 (this date starts a new the six-month period) a Level III serious incident occurs involving Individual #1. On December 2, 2024, another Level III serious incident occurs involving Individual #1. This is the second incident of its type for Individual #1, but a more detailed RCA does not need to be conducted since it did not occur within a six-month. June 1, 2024-December 2, 2024, is six months and one day.

Question: Regarding the requirement to complete a more detailed RCA in response to a "death that occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition." Is COVID considered an acute medical event?

Answer: COVID, may be an acute medical event and not always expected.

Question: Could detailed explanations about "mapping processes" and "charting causal factors" be provided since they are recommended for use during detailed RCAs when thresholds have been met?

Answer: Use Mapping processes – use items such as a flow chart, storyboards, process maps, etc. A process map is a quality improvement tool that shows the inputs, actions and outputs of a process in a clear, step-by-step map of the process. By using a process map it is possible to identify challenges and how to improve processes. Providers should be looking at the full picture, conducting an analysis of all the incidents that led to meeting the threshold in order to determine if there is a root cause. Causal factors can be defined as any "major unplanned, unintended contributor to an incident, a negative event or undesirable condition, that if eliminated would have either prevented the occurrence of the incident or reduced its severity or frequency.

Question: Do ALL serious incidents reported in CHRIS require an RCA?

Answer: 12VAC35-105-160.D states, *"The provider shall collect, maintain, and report or make available to the department the following information: 2. Level II and Level III serious incidents shall be reported using the department's web-based reporting application…"* Additionally, 12VAC35-105-160.E states, *"A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises.*
1. The root cause analysis shall include at least the following information:
a. A detailed description of what happened;
b. An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and
c. Identified solutions to mitigate its reoccurrence and future risk of harm when applicable."

Question: Are thresholds established per service or per location? For example, if DD CM, MH CM, DD Day Services operate from the same address, are three thresholds established (per service) or 1 for the location?

Answer: As it relates to the root cause analysis policy, the threshold number should be based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider. You do not need to develop separate thresholds for each service.

Question: As it relates to Care Concerns, once the provider is able to verify the care concerns flagged by DBHDS *Individual Care Concern Report* using an in-depth root cause analysis, what due date is expected of the provider? The care concern report may not be available until the beginning of the following month.

Answer: A more detailed root cause analysis is required once a threshold is met based on the providers Root Cause Analysis Policy (12VAC35-160.E.2.a, b, c, and d). This more detailed RCA should be completed within 30 days of discovery of when the threshold number was met. In addition, the Office of Licensing will continue to recommend providers take the following actions regarding incidents identified as meeting the Care Concern Thresholds criteria: 1) Determine the need to reassess the individuals' needs/services. 2) Identify possible systemic issues affecting provision of care through the following processes: a. Quarterly reviews of all serious incidents pursuant to 12 VAC 35-105-160.C.; b. Root cause analyses (RCA) for Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises within 30 days of discovery pursuant to 12 VAC 35-105-160.E.; c. Annual review and as needed systemic risk assessments pursuant to 12 VAC 35-105-520.C/520.D; and d. The use of standard quality improvement tools as part of their quality improvement program pursuant to 12 VAC 35-105-620.B.

Question: If an Individual has an incident in October and then a similar incident again in January of the following year, is that period considered within a 6-month period?

Answer: If you are referring to the provider's RCA policy, the six-month period is based on when the first incident occurred to when the incident occurred causing the provider to meet their threshold number as outlined in their RCA policy. If a threshold number is met within a six-month period, then a more detailed RCA would need to be conducted within 30 days of discovery of the incident that caused the provider to meet their threshold. After the threshold number is met, tracking of the incidents would need to begin again and once the threshold is met within a six-month period, then a more detailed RCA would need to be completed. It is important that the provider implements and monitors the identified solutions to mitigate the reoccurrence of incident(s) and prevent future harm when applicable.

Serious Incidents/Care Concerns

Question: Self-injurious behaviors, like bruises, need to be reported in CHRIS, correct?

Answer: Level II and Level III serious incidents shall be reported using the department's web-based reporting application. It is recommended that you review the following memo: Tracking of Level I Serious Incidents vs Baseline Behaviors Memo (February 2023).

Question: What type of report is submitted for a Level I if CHRIS is not used?

Answer: Level I serious incidents are NOT reported in the CHRIS application. The provider must collect, maintain, and review at least quarterly all serious incidents this includes including Level I, Level II and Level III serious incidents, as part of the quality improvement program. This also includes an analysis of trends, potential systemic issues or causes, remediation, and documentation of steps taken to prevent future incidents. It is highly recommended that you use the risk tracking tools that were reviewed today.

- Individual Risk Tracking Tool (April 2023)
- Monthly Risk Tracking Tool (April 2023)
- Instructional Video-Risk Tracking Tool (April 2023)

Question: Do you have to complete a serious incident form for a care concern or just document and report to Program Manager?

Answer: A care concern (CC) is a serious incident that meets the criteria outlined by DBHDS in our care concern power points and handouts. Therefore, a care concern is the result of specific incident or a serious of incidents that meet criteria. Per 12VAC35-105-520.D, providers need to incorporate these CC into the systemic risk assessment process. The provider should evaluate any incidents that meet the CC criteria and determine if an individual may need a revised assessment of their needs or an evaluation of the care that is being provided.

Question: Is there a quarterly template for tracking the serious incidents? Is there a quarterly template for tracking the serious incidents?

Answer: We recommend that you use the risk tracking tool that was presented during the training. They are located on the OL website under the Risk Management section.

Question: Regarding differences between Level 1 and 2 reporting, if an individual has a health concern that requires transport to an urgent care (not an emergency room visit) how does a provider determine if that is a level 1 or 2 incident?

Answer: Providers should not be reporting urgent care visits. Providers should only report emergency room visits, unless the cause or the result of the urgent care visit is due to meeting

the criteria outlined for level 1 or level II - such as a serious injury, bowel obstruction, aspiration pneumonia etc.

Question: If an individual calls their case manager and reports they are going to the emergency department, do we have to report that as a level 2 serious incident?

Answer: No, this does not need to be reported as the emergency room visit did not occur within the provision of the case management service.

Question: For clarification, will an agency receive a citation if they are not using the monthly risk tracking tool related to track Serious Incidents?

Answer: The Risk tracking tool was developed to assist providers, but it is not a mandatory tool. However, a provider is expected to have a tool to track incidents and care concerns. Using the form will greatly increase your likelihood of being in compliance.

Question: If an allegation of sexual misconduct (no touching involved) is reported by a client against a staff member (no longer employed with provider) and there are no witnesses, but provider believes the client, does an incident report have to submitted to the office of licensing as a level 3 incident? An allegation was submitted to OHR and APS.

Answer: Please review page 7 of OL's LIC 17: Guidance for Serious Incident Reporting (November 2020) which includes information related to reporting the sexual assault of an individual, not sexual misconduct. The provider did and should have reported the alleged sexual abuse by a person who was employed by the provider at the time of the incident to OHR.

Question: An individual became agitated, ran out of the home yelling and urinated in street and the neighbor called the police. The police responded when the individual had returned back to home, talked to him, determined that there was no further action and left. A level 1 incident was completed. One week later, APS called OHR with the same report that the neighbor had made the same day he called the police. Now a CHRIS report has to be entered according to the OHR– about a week later, because it now had to be investigated. Will the provider now be cited for late reporting in CHRIS?

Answer: Providers are required to report complaints of abuse/neglect and/or events that cause the provider to suspect abuse/neglect in CHRIS, within 24 hours of the date and time of discovery. In this scenario, the provider did not have reason to suspect abuse/neglect occurred at the time of the incident. And until the neighbor contacted APS, there was no complaint. When the provider was made aware of the complaint by the OHR, that became the date and time of discovery, and the provider is then required to report the complaint in CHRIS within 24 hours. If the provider fails to report after that, a citation for late reporting is warranted.

Question: What information is needed when or if there were no serious incident reports? I understand that one form is showing how they would be documented if it happens.

Answer: If there were no serious incidents within the past year, the provider will be cited for non-compliance if there is no documentation to reflect why a quarterly review was not completed. If there were no serious incidents within the past year, the provider will be cited for non-compliance if the provider does not have a form to show what the provider would use to document serious incidents if they were to occur.

Question: If a sponsored residential individual is their own guardian and goes to the ER without telling their sponsor until past the 24-hour mark, how do we report it?

Answer: It would need to be reported in CHRIS within 24 hours of discovery.

Miscellaneous

Question: If a provider is up for renewal of their triennial license in March, will they also have an unannounced visit in the same year?

Answer: Each licensed service receives an annual inspection each calendar year regardless of the license type or renewal date.

Question: How would we determine (or find out) who our licensing representative is?

Answer: Contact information is located on the OL website. In addition, a notification is sent out when you are assigned a licensing specialist or when the specialist changes. In addition, we are working on an enhancement that will add a specific place in the provider portal that lists the assigned licensing specialist.

Question: Does the Dec 19 Attachment A include all components that we were assessed during year 2023's licensing inspection? In other words, if no citations occurred (or a CAP was accepted), a provider might assume their current policies and documentation methods (with data updates of course) are adequate for 2024?

Answer: The 2024 Annual Inspections for Providers of Developmental Services Memo (January 2024) has the same regulations, but some of the criteria for compliance have been updated based on feedback provided by the IR consultants. For example: 520.C.5 and 620.C.3. Therefore, it is essential that providers review their policies and procedures to ensure that they meet current requirements.

Question: When a citation is received, does the provider need to submit proof of corrections by date outlined in CAP response?

Answer: A provider should be prepared to submit proof of correction by the date the provider outlined in their CAP. This can be a date, that is later than when the CAP is due if the completion date is listed in the CAP. If the citation is the result of something considered to be health and safety or imminent danger than proof of compliance is expected at time of CAP due date. The LS will indicate this when they send out the licensing report.

Question: There is confusion amongst providers on whether they need to have a copy of the Informed Choice form from the CSB or complete their own. Does the provider have the obligation to inform individuals of all waiver services or only the services that they provide? We are now being cited if we do not have it from the support coordinator. We have difficulty getting them from SC's at the CSB. We are now placing the email in charts showing effort to get the choice form.

Answer: It is the responsibility of the CSB case manager/support coordinator to inform individuals of all waiver services. Regulation 12VAC35-105-660.D relates to informed choice. If you review attachment A of the 2024 Annual Inspections for Providers of Developmental Services Memo (January 2024) you will see that 12VAC35-660.D.1.a, 660.D.1.b, 660.D.1.c. and

660.D.2 will only be reviewed for case management services. 12VAC35-105-660.D.3 will be reviewed for Case Management and Non-Case Management Services.

Question: If my licensing specialist completes my inspection after my license expires, how long do I have before I cannot bill for services?

Answer: OL is not involved in billing. This question would need to be directed to your payor source. If the LS does not complete a review before your renewal is due, then you will be issued a status letter, which allows your license to continue to be active for up to 6 months.

Question: Can I get a link to any and all training that you offer?

Answer: All of our trainings are posted on the Office of Licensing's website under specific topic areas. Please sign up to receive constant contact notifications from the Office of Licensing.

Question: Is the memo available somewhere else? it was not received by our CSB this year.

Answer: The 2024 Annual Inspections for Providers of Developmental Services Memo (January 2024) is posted on our website under correspondences. This is also a reminder to ensure that those at your agency are signed up to receive constant contact notifications from the Office of Licensing.

Question: How do we sign up for Constant Contact?

Answer: Please sign up to receive constant contact notifications from the Office of Licensing.

Question: Is sponsored residential a separate category?

Answer: DBHDS licensed providers of sponsored residential services receive an annual unannounced inspection and a review of the minimum regulations outlined in the 2024 Annual Inspections for Providers of Developmental Services Memo (January 2024). There are also additional regulatory requirements for providers of sponsored residential services outlined in the licensing regulations.

Question: Why does it take so long to approve new or additional services?

Answer: Providers are required to submit a modification application which is reviewed and approved by the licensing specialist within 30 days. There may be circumstances where the provider may not have submitted all of the requirements per the modification application, which may delay adding an additional service Additionally, regulation 12 VAC 35-105-50. states, "*Issuance of licenses. A. The commissioner may issue the following types of licenses: d. A provider holding a conditional license shall not add services or locations during the conditional period*." As it relates to initial applicants, the Commissioner's goal is to have all initial applicants licensed within 90 days of submission of a completed application. However, the OL has a prioritization list that may also contribute to the timeframe in which the application is reviewed.

Question: Where are statewide performance measures located?

Answer: They can be found on the DOJ Settlement Agreement Library. Specifically, you will want to look at the Provider Data Summary Report for Community Inclusion and the Semi-Annual Employment Report for Employment.

Question: In regard to risk tracking, not all the risks listed on the risk tracker would necessarily be considered a level 2 or 3 serious incident. For example, will a provider be found non-compliant if they are not tracking all UTI occurrences?

Answer: The incidents that are listed are in 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 (November 2023) memo were listed for your reference as they are reported by providers through the CHRIS system and monitored by the DBHDS Risk Management Review Committee. DBHDS recommends that providers track the occurrence of these events and/or other risks and conditions that are significant for the population they serve.

Question: What dictates the needs of the individuals in reference to frequency of case manager face to face visits?

Answer: Quarterly per Medicaid standards unless the person meets Enhanced Case Management criteria. See bottom of page 2 and top of page 3 here for criteria: https://dbhds.virginia.gov/wp-content/uploads/2023/04/ECM-Guidance-2022-Final.pdf**.** For additional questions related to this, please contact the Division of Developmental Services.

Question: Do quarterly reviews have to be completed by QDDPs or just reviewed by the QDDP?

Answer: The provider's written policy would indicate who is responsible for completing the quarterly review. The OL recommends that the quarterly review be completed by a QDDP or, at a minimum, reviewed and signed off by a QDDP.

Question: Do Quarterly Reviews have to be signed by the individual/Guardian/Family Member?

Answer: Individuals/SDMs are not required to sign the quarterly review. There should be some evidence via note or otherwise that the content was reviewed with them. The signature line for them on the quarterly is optional and convenient way to document the review. However, if there is a signature line on the form then it is the expectation from the Office of Licensing that it be signed by the individual and/or their authorized representative. If it is not signed, a note indicating why a signature could not be obtained and documentation indicating that the individual and/or their authorized representative participated would need to be present.

Question: I noticed that licensing may cite multiple regulations for the same violation. Though that violation may be relevant to other regulations, is there any plan to condense CAPs to group violations into one citation with all relevant regulations listed in one place rather than have redundancy in both citation and provider response?

Answer: Regulations are separate for a reason. If the issue touches multiple areas within, then it may be necessary to cite multiple regulations. The OL is going through a regulatory overhaul in which we are developing service specific chapters. This information is located on the OL Website under 2023 OVERHAUL REGULATORY ADVISORY PANEL (RAP) DRAFTS.

Question: What is the process in submitting a revised corrective action plan? Does updating the QIP suffice?

Answer: If you need to submit a revised CAP, please contact your assigned licensing specialist who can assist you with this process. Regarding the QIP, a provider may 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.

Question: Is there a possibility of extending the 6-month deadline for new Providers due to the significant challenge they are facing in finding clients, compounded by difficulties in reaching CSB staff?

Answer: No, the OL will not be extending any timeframes for providers on a conditional license. It is the responsibility of the provider to have a business plan that outlines the steps for acquiring admissions. Providing services long enough for OL to determine substantial compliance of the regulations is required. This includes completion of the initial and comprehensive assessments, development of the initial and comprehensive ISPs, progress notes or other documentation to demonstrate implementation of the goals and objectives outlined in the plan, quarterly reviews, demonstrating medication administration (if applicable), staff training requirements, etc. Please review the following:

- Initial Applicant Orientation Webinar (June 2023)
- Initial Applicant Orientation PowerPoint (June 2023)