COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
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July 20, 2023 UPDATED

To: Members
DBHDS 2023 Combined Study Workgroup

Fr: Dev Nair, Assistant Commissioner
Division of Provider Management

Re: Agendas and Zoom Log In Information (July 20, July 27, August 3)
and NOTICE: Opportunity for Public Comment by Interested Stakeholders

Thank you for accepting the invitation to provide technical assistance to this agency as a member of DBHDS 2023 Combined Study Workgroup convened in accordance with HB2255 (Hodges)/SB1155 (Mason) and SB1544 (Rouse).

→Follow Up from Today's Meeting

1. Please find attached the PowerPoint shared in today's meeting, and full survey results.
2. From Shannon Hartung, DSS: This may be of interest to some in regards to data around our Out of Family investigation numbers. https://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2022/DOOF_Investigations_Annual_Report_sfy2022.pdf

Public Comment

Please see the attached three agendas. A time for public comment is set aside as the last item in each meeting for 20 minutes. Persons wishing to give comment must submit an email to susan.puglisi@dbhds.virginia.gov no later than 5:00 p.m. *on the day prior* to the meeting, indicating that they wish to provide a brief verbal comment. As the names of these individuals are announced at the beginning of the public comment period, three minutes of comment may be offered, within the overall time allowed for comments. Written public comment may be sent by email no later than 10:00 a.m. on

the day of the meeting to susan.puglisi@dbhds.virginia.gov. Instructions for calling into the meeting are included below.

Workgroup Member Logistics
The same meeting link is set for all three meetings; workgroup members will receive a direct email to join as a panelist. If you have any questions prior to the first meeting or between the meetings, for logistical questions ruthanne.walker@dbhds.virginia.gov.

Cc: Jae Benz, Director
Office of Licensing

Taneika Goldman, State Human Rights Director
Office of Human Rights

DBHDS 2023 Combined Study Workgroup
ZOOM Webinar Log In Information
*(*panelists receive direct invitation to join)*

Description	The DBHDS 2023 Combined Study Workgroup to fulfill the requirements of Section 1 legislation passed last session, HB2255/SB1155 and SB1544.

DBHDS 2023 Combined Study Workgroup (HB2255/SB1155 and SB1544)

All Meetings

- **Every week on Thursday from 1:00 – 3:30 PM:**
  - **Jul 20, 2023 01:00 PM**
  - **Jul 27, 2023 01:00 PM**
  - **Aug 3, 2023 01:00 PM**
- **Please click the link below to join the webinar:**
  https://dbhds-virginia-gov.zoomgov.com/j/1604924388?pwd=ZTFwcEdlRDR0TDl6dG9icGJOZk9Tdz09
- **Passcode: 406238**

- **Or One tap mobile:**
  +16692545252,,1604924388#,,,,*406238# US (San Jose)
  +16468287666,,1604924388#,,,,*406238# US (New York)
- **Or Telephone:**

Dial (for higher quality, dial a number based on your current location):
+1 646 828 7666 US (New York)
+1 646 964 1167 US (US Spanish Line)
+1 551 285 1373 US
Webinar ID: 160 492 4388
Passcode: 406238

- **Or an H.323/SIP room system:**
  H.323: 161.199.138.10 (US West) or 161.199.136.10 (US East)
  Meeting ID: 160 492 4388
  Passcode: 406238
  SIP: 1604924388@sip.zoomgov.com
  Passcode: 406238

DBHDS
2023 COMBINED STUDY WORKGROUP

AGENDA #2
JULY 27, 2023
1:00 PM – 3:30 PM
ZOOM Meeting (see enclosed log in information; panelists receive separate invitation)

1:00 – 1:10 PM	**I.**	**Introductions and Summary of June 20th Meeting**
1:10 – 2:20 PM	**II.**	**Development of Workgroup Recommendations** a. Survey Results b. Other States c. Topics from Legislation and Discussion
2:20 – 3:05 PM	**III.**	**Discussion**
3:05 – 3:25 PM	**IV.**	**Public Comment** *3 minutes per speaker; written comments accepted until 10 a.m. the day of the meeting. Advanced registration required by 5:00 p.m. on July 26, 2023, to susan.puglisi@dbhds.virginia.gov.*
3:25 – 3:30 PM	**V.**	**Conclusion and Next Steps**

AGENDA #3
AUGUST 3, 2023
1:00 PM – 3:30 PM
ZOOM Meeting (see enclosed log in information; panelists receive separate invitation)

1:00 – 1:10 PM	**I.**	**Summary of June 27th Meeting**
1:10 – 1:40 PM	**II.**	**Review Revised Draft Recommendations**
1:40 – 3:05 PM	**III.**	**Discussion**
3:05 – 3:25 PM	**IV.**	**Public Comment** *3 minutes per speaker; written comments accepted until 10 a.m. the day of the meeting. Advanced registration required by 5:00 p.m. on August 3, 2023, to susan.puglisi@dbhds.virginia.gov.*
3:25 – 3:30 PM	**V.**	**Conclusion**

DBHDS 2023 Combined Study Workgroup

Only one panelist representative serving on a meeting at a time.

Type	Organization	Workgroup Member	Email
Advocacy-Individuals	Centers for Independent Living	**Maureen Hollowell**	mhollowell@endependence.org
Advocacy-Protection and Advocacy	DisAbility Law Center of Virginia	**Colleen Miller**	Colleen.Miller@dlcv.org
Advocacy-MH	Mental Health America-Virginia	**Barbara Barlow**	barlow@mhafred.org
Advocacy-MH	National Alliance on Mental Health-Virginia	**Kathy Harkey**	kathy.harkey@namicentralvirginia.org
Advocacy-Providers	Provider-Pinnacle	**Lori Ryland**	lori.ryland@pinnacletreatment.com
Advocacy-DD	The Arc of Virginia	**Tonya Milling**	tmilling@thearcofva.org
Advocacy-Providers	Loudoun County (SB1544)	**John Freeman**	John.Freeman@loudoun.gov
Advocacy-Providers	Loudoun County (SB1544)	**Hannah Hirschland**	hannah.hirschland@loudoun.gov
Advocacy-Providers	VaACCSES	**Karen Tefelski**	ktefelski@vaaccses.org
Advocacy-Providers	Virginia Association of Community Services Boards	**Jennifer Faison**	jfaison@vacsb.org
Advocacy-Providers	Virginia Association of Community-based Providers	**Mindy Carlin**	mindy.carlin@accesspointpa.com
Advocacy-Providers	Virginia Coalition of Private Provider Associations	**Michael Triggs**	michael.triggs@uhsinc.com
Advocacy-Providers	Virginia Hospital and Healthcare Association	**Jennifer Wicker**	jwicker@vhha.com
Advocacy-Providers	Virginia Network of Private Providers	**Deanna Rennon**	deanna@wallresidences.com
Advocacy-MH	VOCAL	**Heather Orrock**	heather@vocalvirginia.org
Agency	Virginia Board for People with Disabilities (state)	**Jen Krajewski**	Jennifer.Krajewski@vbpd.virginia.gov
Agency	Department for Aging and Rehabilitative Services - APS	**Paige McCleary**	paige.mccleary@dars.virginia.gov
Agency	Department of Medical Assistance Services	**Emily McClellan**	emily.mcclellan@dmas.virginia.gov

Agency	Department of Medical Assistance Services	**Lisa Jobe-Shields**	lisa.jobe-shields@dmas.virginia.gov
Agency	Department of Social Services - CPS	**Jennifer Phillips**	Jennifer.Phillips@dss.virginia.gov
Agency	Department of Social Services - CPS	**Shannon Hartung**	Shannon.Hartung1@dss.virginia.gov
Agency	DHP	**Erin Barrett**	erin.barrett@dhp.virginia.gov
Agency	DHP	**Jaime Hoyle**	jaime.hoyle@dhp.virginia.gov
Agency	DBHDS	**Dev Nair**	Dev.nair@dbhds.virginia.gov
Agency	DBHDS	**Heather Norton**	heather.norton@dbhds.virginia.gov
Agency	DBHDS	**Jae Benz**	Jae.benz@dbhds.virginia.gov
Agency	DBHDS	**Taneika Goldman**	taneika.goldman@dbhds.virginia.gov

Previous Correspondence

From: Walker, Ruth Anne (DBHDS) <RuthAnne.Walker@dbhds.virginia.gov>
Sent: Friday, June 23, 2023 3:28 PM
To: Walker, Ruth Anne (DBHDS) <RuthAnne.Walker@dbhds.virginia.gov>
Subject: Participation Requested: DBHDS 2023 Combined Study Workgroup (HB2255/SB1155 and SB1544)

Good Afternoon:

You are invited to participate on the DBHDS 2023 Combined Study Workgroup to fulfill the requirements of Section 1 legislation passed last year, HB2255/SB1155 and SB1544:

Bill	**HB2255 (Hodges)/SB1155 (Mason)**	**SB1544 (Rouse)**
Description	**Regulatory relief for licensed providers**	**Reporting simplifications**
Language	1. § 1. That the Department of Behavioral Health and Developmental Services (the Department) shall review its regulations that impact providers licensed by the Department in order to identify reforms to increase efficiency, reduce redundancy, and decrease regulatory burdens on providers. This review shall include consideration of how relief from licensing requirements may be authorized for providers that are accredited by recognized national accreditation bodies. The Department shall also consider adjustments to the frequency of licensing inspections for providers with triennial licenses that have had no health or safety violations or complaints for the previous year. The Department shall collaborate with stakeholders to conduct this review and shall report its recommendations to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2023.	1. § 1. That the Department of Behavioral Health and Developmental Services (the Department) shall review its regulations that require providers licensed by the Department to report allegations of abuse, neglect, and exploitation and incidents classified as Level II and Level III. The Department shall collaborate with stakeholders to develop solutions to reduce administrative burdens on licensed providers. The Department shall report its recommendations to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2023.

An invitation to the three Zoom webinars was sent earlier this afternoon regarding this combined study workgroup for your participation as a panelist. If you are able to serve as a panelist on July 20, July 27, and August 3 from 1 p.m. - 3:30 p.m., please use that emailed webinar invitation to join each meeting. If you are unable to accept this invitation to serve, wish to recommend a designee, or are not able to attend a particular meeting and wish to send an alternate, please reply to this email with that information. For members of the public, the log in information is available on Town Hall.

A packet of information will be sent prior to the meeting on July 20th. Each meeting will have an opportunity for public comment. In the coming days, the department will distribute broadly a survey to you, providers, and other interested stakeholders to gather valuable feedback on current Licensing and Human Rights regulations and the impacts to providers and members of the community. The results will be disseminated and used as points of discussion regarding recommendations at three workgroup meetings. Research has been and will continue to be conducted to collect information from other states and various sources on these issues. The required input and report from these studies will be combined.

Your input is valuable and we look forward to working with you.
Sent on behalf of Dev Nair, Jae Benz, and Taneika Goldman

PS - If you happen to serve on both this Combined Study Workgroup and the Licensing Overhaul Regulatory Advisory Panel (RAP), please be sure to look closely at the emailed invitations as the RAP meetings occur in June and the study workgroup dates are in July.

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Ruth Anne Walker
Director, Office of Regulatory Affairs; State Board Liaison
Division of Provider Management (DPM)
Va Dept. of Behavioral Health and Developmental Services
Jefferson Building, Room 411
Phone: (804) 225-2252; Cell: (804) 385-6549

Virginia Department of Behavioral Health & Developmental Services

2023 DBHDS Combined Study Workgroup: Licensing and Human Rights Regulatory Requirements

HB2255 (Hodges)/SB1155 (Mason) and SB1544 (Rouse)

July 20, 2023

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Agenda Meeting #1, July 20, 2023

I. **Introduction and Workgroup Objectives** (1:00 – 1:20 pm)

II. **Presentation of Survey Results** (1:20 – 1:50 pm)

III. **Findings from Other States** (1:50 – 2:20 pm)

IV. **Questions and Discussion** (2:20 – 3:05 pm)

V. **Public Comments** (3:05 – 3:25 pm)

VI. **Conclusion and Next Steps** (3:25 – 3:30 pm)

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Introduction of Workgroup Members

Organization	Member
Department for Aging and Rehabilitative Services	Paige McCleary
Department of Health Professions	Jaime Hoyle; Erin Barrett
Department of Medical Assistance Services	Lisa Jobe-Shields (7/20 L Reed); Emily McClellan
Department of Social Services	Jennifer Phillips; Shannon Hartung
Virginia Board for People with Disabilities	Jen Krajewski
The Arc of Virginia	Tonya Milling
Centers for Independent Living	Maureen Hollowell
DisAbility Law Center of Virginia	Colleen Miller; John Cimino
Loudoun County (SB1544)	John Freeman; Hannah Hirschland
Mental Health America-Virginia	Barbara Barlow
National Alliance on Mental Health-Virginia	Kathy Harkey
Pinnacle (Provider)	Lori Ryland
VaACCSES	Karen Tefelski
Virginia Association of Community Services Boards	Jennifer Faison
Virginia Association of Community-based Providers	Mindy Carlin
Virginia Coalition of Private Provider Associations	Michael Triggs
Virginia Hospital and Healthcare Association	Jennifer Wicker
Virginia Network of Private Providers	Deanna Rennon
VOCAL	Heather Orrock

Study Language

Bills	HB2255 (Hodges)/SB1155 (Mason)	SB1544 (Rouse)
Language	1. § 1. That the Department of Behavioral Health and Developmental Services (the Department) shall review its regulations that impact providers licensed by the Department in order to identify reforms to increase efficiency, reduce redundancy, and decrease regulatory burdens on providers. This review shall include consideration of how relief from licensing requirements may be authorized for providers that are accredited by recognized national accreditation bodies. The Department shall also consider adjustments to the frequency of licensing inspections for providers with triennial licenses that have had no health or safety violations or complaints for the previous year. The Department shall collaborate with stakeholders to conduct this review and shall report its recommendations to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2023.	1. § 1. That the Department of Behavioral Health and Developmental Services (the Department) shall review its regulations that require providers licensed by the Department to report allegations of abuse, neglect, and exploitation and incidents classified as Level II and Level III. The Department shall collaborate with stakeholders to develop solutions to reduce administrative burdens on licensed providers. The Department shall report its recommendations to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2023.

Workgroup Objectives

I. Review DBHDS regulations to identify reforms that could increase efficiency, reduce redundancy, and decrease regulatory burdens on providers.

II. Consider how relief from licensing requirements may be authorized for accredited providers.

III. Consider adjustments to the frequency of licensing inspections for triennial license holders.

IV. Review regulations to simplify reporting of allegations of abuse, neglect, and exploitation and incidents classified as Level II and Level III.

V. Consider balancing reduction in oversight with assurance of health, safety, and quality

Virginia Department of Behavioral Health & Developmental Services

Presentation of Survey Results

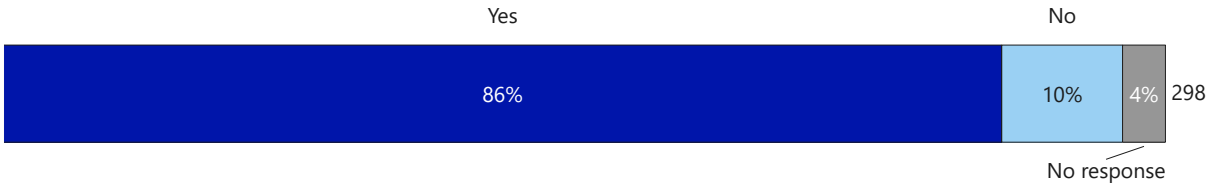
Survey for the DBHDS 2023 Combined Study Workgroup HB2255/SB1155 and SB1544

Survey administered July 7, 2023 through July 16, 2023

298 total respondents

Information was distributed via several large list serves, comprised of individuals receiving services, licensed providers, advocacy organizations and other interested stakeholders as well as posted to Town Hall as a General Notice

1. Are you a DBHDS-licensed provider?



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2. Which of the following licensing or human rights requirements require the most effort or administrative burden for your agency?

Requirement	Average Score	Rank	
Annual inspections	3.2	#1	Most burdensome
Reporting serious incidents	3.5	#2	
Quality improvement and risk management provisions	3.6	#3	
Developing/implementing corrective action plans	4.1	#4	
Reporting abuse/neglect	4.4	#5	
Provider investigation of abuse or neglect	4.7	#6	
Submit request for service modification	6.5	#7	
Submission of seclusion/restraint data annually	7.4	#8	
Other	7.7	#9	Least burdensome

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2. Which of the following licensing or human rights requirements require the most effort or administrative burden for your agency? OTHER

24-hour time requirement for reporting serious incidents, particularly over holidays and weekends and timeframe for human rights investigations	DSP Training Checklists (very long; especially when more than just DSP version are required)	License renewal	quarterly summary of incidents
All	Excessive, repetitive audits	licensing requirments should not be considered burdensome	RCA's
Audits	Finding resources in a timely manner	marketing restrictions	redundant reporting requirements within varying departments of DBHDS
audits & reviews	Getting corrections made to licenses issued with errors made by DBHDS; Reporting complaints; Submitting documents to advocates post incident/complaint	mortality reviews	Reporting human rights complaints
background & barrier crimes checks	having multiple audits on behalf of DBHDS (HSAG, QMRs, licensing)	multiple repetitive audits (HCBS, Licensing, DMAS)	reporting of sexual assaults that occur outside the provision of services.
Business Development Assistance	Having to submit verifications of CAPS twice, initially and with CAP and having to report serious incidents and human rights separately for the same incident	Multiple/duplicative contacts/requests from DBHDS staff (multiple positions and departments) regarding the same incident or investigation; requesting the same information, often giving short deadlines that don't align with the Department's own regulatory timelines. So many "hands in the pot" not knowing what the other one is doing, requiring provider to stop what they're doing to provide remediation plans before CAP deadlines or RCA deadlines are even reached. This has become incredibly burdensome for a provider to effectively manage and to be able to focus on actually addressing the situation in a mindful way.	Required amount of clinical paperwork
CHRIS 24 hour reporting	HIPAA Privacy Regulations and Related State Privacy Laws		Root Cause Analyses for Level II incidents
CHRIS SYSTEM ON A WHOLE	HSAG OSR QSR		Root Cause Analysis
competencies	I am a newly licensed provider		Root cause analysis of Level 2 & 3
Competencies and required training	I'm not a provider. I can't rank these		Root Cause Anaylsis/ Investigation for every serious incident
Criminal Background Checks and hiring	Initial Application		Service Authorization consistency
daily requirements for high level and volume of documentation to inlclude notes, OSVT, CRA, extensive annual plan. High quality providers leave the field to do less documentation heavy work. Items get added to the plate without anything being removed.	Initial application one license only rule	No control given to the Consumer	so many audits from different entities
	Initial Licensing Application Process	Nonstop changes to state policies, services, requirements.	State Mandated Reviews
DBHDS Website Navigation	Intermittent inspections during the course of a year when provider has a triennial license. A provider in good standing subjected to unannounced visits which are based on the License Specialist schedule.	Policies that are meant for residential settings when we are an outpatient setting.	Staying on top of ever-changing regulations
death investigations		QIP Biannual Review	The CHRIS System to Deliver Reporting
Detailed RCAs	Lack of provider training for newly implemented regulations	Quarterly and Threshold Analysis, RCAs	The investigation process including the communication between OHR
documentation/file audits, staff training			Too much redundant documentation
			Training dsp
			Working within the CONNECT Portal

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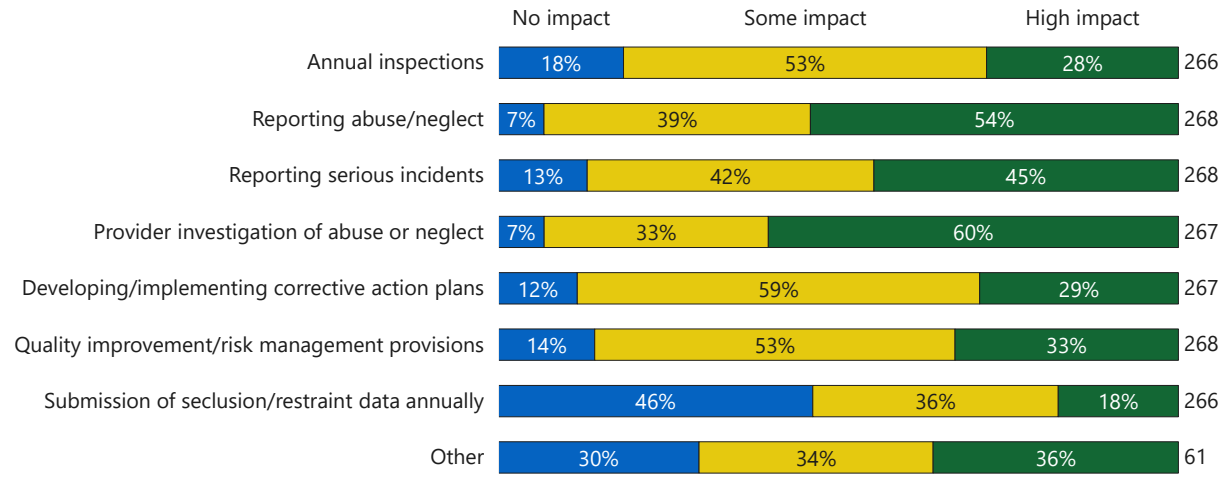
3. In your opinion, how impactful are the following licensing or human rights requirements to ensuring the health, welfare, and safety of individuals accessing services?



The total number of responses varies by item because some respondents left one or more items blank.

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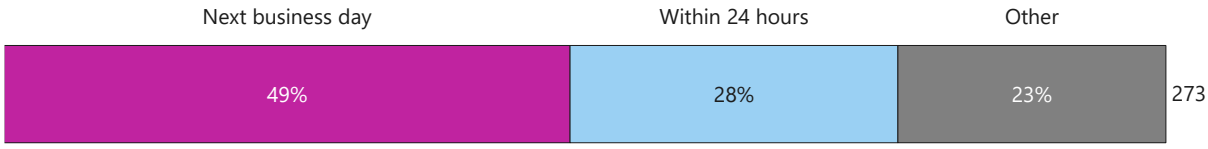
4. In your opinion, how quickly do you believe that reported allegations of abuse, neglect, and exploitation and incidents classified as Level II and Level III should be reported to DBHDS?



The total number of responses varies by item because some respondents left one or more items blank.

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4. In your opinion, how quickly do you believe that reported allegations of abuse, neglect, and exploitation and incidents classified as Level II and Level III should be reported to DBHDS? OTHER

*48 hours
*3 Business.
*2 business days/2 days
72 hours
As soon as possible
within 7 days
After the investigation
If founded
next business day
Level II by next business day
Level III within 24 hours
Level II within 72 hours
Level 3 Next business day
7 days
Same Day/24 hours
Weekdays only, within 48 hours
When staff are available to support submissions.

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5. What other agencies or safety mechanisms exist to ensure the safety of individuals until a report to DBHDS is submitted?

Top **External** Safety Mechanisms

- **CSB:** Support Coordinator, Crisis Teams, wrap-around services
- **911/EMS/Urgent Care Facilities**
- **Primary Care Physicians**
- **Other Healthcare Providers:** Behavior Specialists, Psychiatrists, Social Workers
- **Police**
- **Hotlines:** 988, Poison Control
- **REACH**
- **Family, Authorized Representatives, Legal Guardians**
- **Provider Networks**
- **State Agencies:** DMAS, APS/CPS, DHP, VDH, dLCV
- **Other Entities:** MCOs, LHRC, CARF, TJC

Top **Internal** Safety Mechanisms

- **Organizational Policies and Procedures**
  - Internal Review Committee infrastructure.
  - Protocols re: Crisis, Investigations, Safety Planning, etc.
- **Quality, Risk, Compliance & Human Resource Functions**
  - RCAs
  - Staff Performance Improvement Planning
- **Appropriate Staff:** Medical, Clinical, Licensed, Executive, Administrative, Security Officers
- **Family, Authorized Representative, Legal Guardians**
- **Appropriate and Ongoing Training:** Incident Reporting, Behavior Intervention, Verbal De-Escalation; Med Management; Human Rights
- **24/7 On -Call Systems and Processes**
- **Camera/Video systems**

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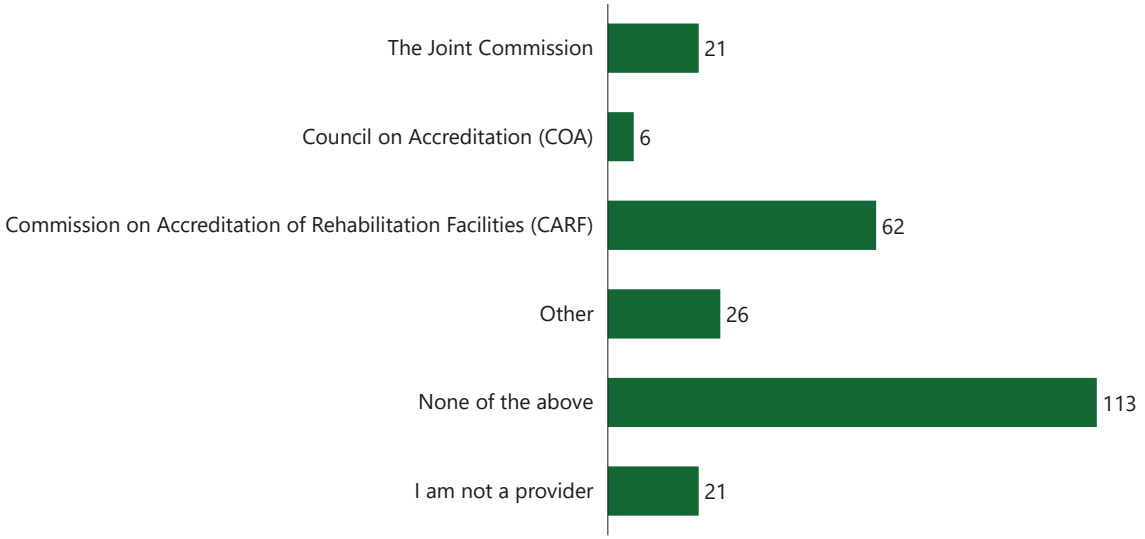
6. If you are a provider, is your organization accredited by any of the following organizations?



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6. If you are a provider, is your organization accredited by any of the following organizations? OTHER

ACA
Am in the business development process
American Association of Suicidology
CARF for MAT
CMS
Consumer for over 20 years
DBHDS
DNV
DSS and NCA
In process
Magnet organization
National Alliance for Children for our CAC program and DSS for our Foster Care and BIS program
National Alliance for children, DSS
National Children's Alliance and DSS
National Children's Alliance for Child Advocacy Center and DSS for Foster Care and Child Care Center
no idea
not sure
One program is CARF accredited
Praesidium
SAMSA; VDH
The National Alliance for Children, DSS/Department of Education for child care and foster care services
Unkonwn
VDSS
We are currently CARF accredited for employment services and Integrated IOP

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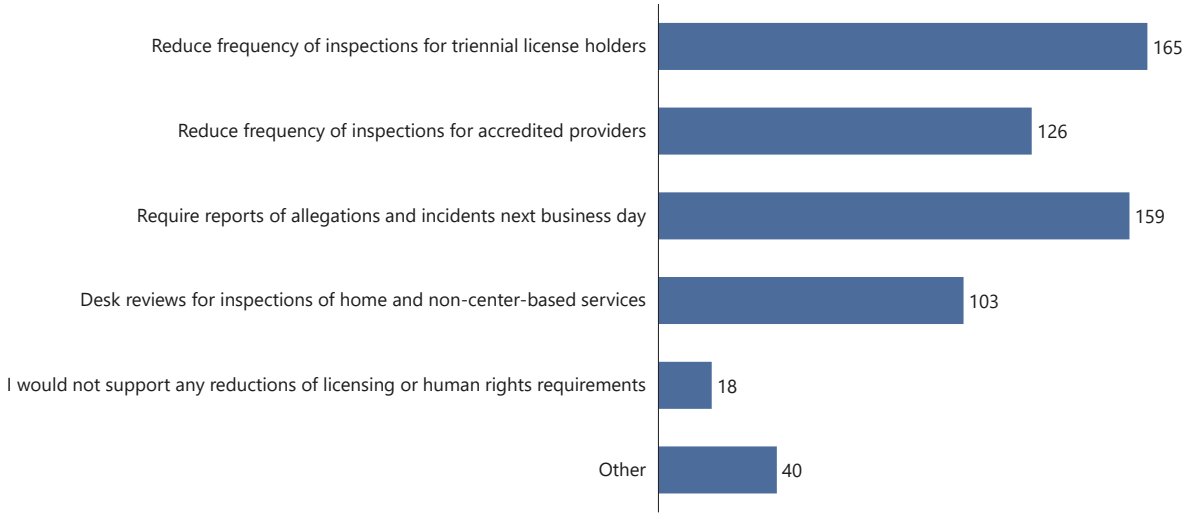
7. What strategies would you support to reduce the administrative burden related to licensing and human rights regulations? Please check all that apply.



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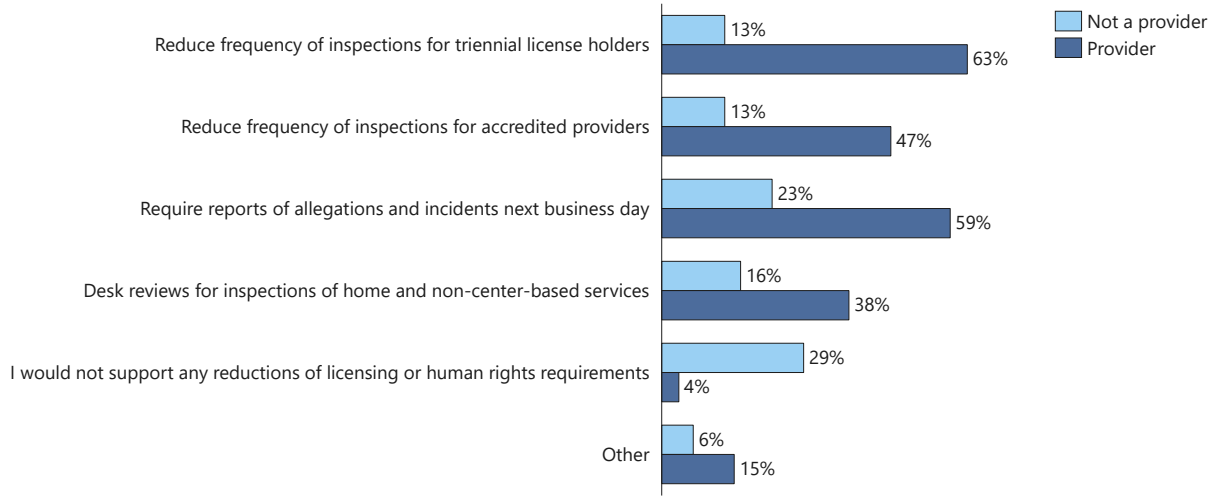
7. What strategies would you support to reduce the administrative burden related to licensing and human rights regulations? Please check all that apply.



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7. What strategies would you support to reduce the administrative burden related to licensing and human rights regulations? OTHER

Agency understands the importance of reviews, however the duplication of materials reviewed and the volume requested can be very burdensome. A shared easy to use file sharing database for reviewers with an agency would be a good solution.
Align DBHDS and MCO reporting for one report instead of duplicate reporting
alleviate some of barrier crimes restrictions
Allow more time for reporting and remove the progressive discipline piece to late reporting.
CHRIS reporting 48 business hours
coordinated and collaborative audits/ review- we have many bodies that audit and the burden negatively impacts the care
Coordination of inspecting agents to prevent reviewing the same materials and creating excess administrative burden
coordination with DMAS to ensure regulations match and do not add admin burden
DD Inspections
Desk review once per year with an onsight review once a year as well. License renewal every five years when there are no major violations during the two annual inspections
eliminating redundancy of reporting to multiple DBHDS departments, consider limiting reporting to not include level 2 and 3 events
Expand timeframe allowed for abuse/neglect investigation from 10 business to 15 business days
Extend period of time to complete human rights investigations from 10 to 15 business days.
For those with many years of good standing and ability to follow rules/regs, less frequent reporting/auditing requirements
Greater collaboration with other entities to reduce duplicative work (i.e. we as a provider are required to have all information in the client's file that is already in the WAMs database-no need to have the same information in multiple systems"
Have a central computerized platform for staff to obtain training and keep record as well more user friendly platform to file reports and upload data requested by multiple agencies
Have one location for all documents to reduces duplicative work
I think there should be a rider stating some standard for reduction. For example cannot have health and safety violations or more than a specific number of citations over the last 2 years?
Implement changes in civil commitment laws to allow participation of family and certified peer providers in civil and criminal specialty courts overseen by district judges and/or specialty justices to reduce unnecessary HIPAA related privacy exclusion of family supporters of those with mental health disabilities, such as SMI, ASD, and ID
More collaboration from Human Rights and the Office of Licensing with the providers as the two subsides do not communicate effectively in order to meet teh provider's needs.

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7. What strategies would you support to reduce the administrative burden related to licensing and human rights regulations? OTHER

More time for reporting incidents
Not requiring reports of non admission er visits
Office of Licensing resume the consultative capacity intended and abandon the punitive CAPS process for insignificant violations, and non-life threatening regulations. The QA requirements and SIRs are the most time consuming and unfunded mandate created and it does not necessarily prevent harm or risk.
Once you send information to one part of DBHDS It would be helpful if it can be retrieved so others within the agency can get it also instead of requiring the provider to send it yet again to another section of the same department
other than lengthening the time to file a CHRIS report nothing. The processes are critical to support patient Rights and Safety.
Reassess need for RCA
Redefine the definition of Serious Incidents to exclude event that occur outside/before the provision of services - such as sexual assault. Also remove the requirement that CSB report hospitalizations that result from prescreenings initiated when the individual was receiving another services. - Assisting individual in crisis is what we are licensed to do.
Reduce annual inspections for home services that have had positive inspections over a period of time (ie reinstitute triennial licenses which I have been told are not given to small organizations any longer.) I agree with inspection and oversight, but it needs to change to be helpful rather than punitive.
Reduce the documentation needed for the MRC or request remote access to EHR to review those documents
Reduce the number of audits conducted by various organizations that are reviewing the same information. Administrative burden.
Reduced redundancies in paperwork. Focus inspection criteria on important criteria involving observing the staff providing services, services, seeing individuals receiving services, and person centered planning goals instead of catching providers with errors or when quarterly reports are sent to support coordinators or if all of the boxes are checked on DSP checklists.
Reduction of uploading information to a repository
Remove barrier crime requirements , require background checks fone by sgency with certification from provider that each employee is fit to work
require incident reports within two business days
require reports and allegations in 5 business days.
Require reports of allegations and incidents within 2 business days
Review necessity of root cause analysis for all Level 2 &3, and the "enhanced" RCA requirement
Risk Management/QIP to have general regulations, currently it is too broad.
Streamline Incident/Investigation communications and align with regulatory timelines except for steps needed to protect immediate health and safety
To lessen administrative work for Employees of Record, close the gap between minimum and living wage for Consumer Directed in-home attendants. This would alleviate attendant turnover rate for Consumers, thus decreasing the Employee of Record's new attendant registration packets being received and processed (administrative work) by Fiscal Agents.

19

8. Please enter any suggestions for administrative changes that have not been addressed above.

Streamline audits across offices and agencies

- Have all agencies review same items and in the same way.
- Have one place where documents can be uploaded.
- Having one agency accept other agencies' audits.
- Alternative who completes audits during any given year.

Replace/Revamp CHRIS

- Look at alternative application.
- Provide 24 hour application support.
- Use CONNECT interface to submit abuse/neglect (A/N) and serious incident reports (SIR).
- Reduce duplication of efforts by allowing providers to enter information into one side of CHRIS regardless of if it is A/N allegation or SIR.

20

8. Please enter any suggestions for administrative changes that have not been addressed above.

Revised Reporting Requirements
- Revise reporting requirements for Level III incidents that occur outside of the provision of services.
- Revise reporting requirements for A/N allegations.

Reduce Risk Management and Quality Improvement documentation
Requirements related to completing root cause analysis (RCA).
- Trending data related to SIRs.
- Monitoring care concerns.
- Completing annual risk assessments.

Other most frequent recommendations
- Reduce other regulatory requirements – items discussed during recent Regulatory Advisory Panel meetings.
- Reduce the number of corrective action plans (CAPs) a provider must respond to either by multiple agencies or because of multiple Licensing reports or Human Rights citations.

21

9. Are there any other issues, considerations, or recommendations related to licensing requirements you would like the workgroup to address?

Reporting
- RCA requirement is burdensome - particularly ER visits related to medical conditions.
- Medication errors reported as abuse/neglect may result in employee discipline which can discourage, rather than encourage reporting of errors. Consider removing unless related to adverse event.
- Revision of incidents that require report:
  - Sexual assault should not be Level III.
  - ER visits with no treatment (or PCP level care) considered Level I.
- Change 24 hr time frame/next business day.
- Issue citations with consideration for size/number of reports.

Alignment / Coordination with other Agencies
- Ensure synergy and congruence between DMAS and DBHDS regulations.
- Share information between DBHDS, HSAG, DMAS (QMR, HCBS)..
- Same information to each agency; but findings often contradict each other
- Address credentialing process following licensure.

22

9. Are there any other issues, considerations, or recommendations related to licensing requirements you would like the workgroup to address?

Systems

- CHRIS functionality needs to be improved/updated:
  - Run reports from CHRIS.
  - Single report for incidents and abuse and neglect.
  - Allow CHRIS to accept data from other provider reporting systems or HER.
- Improve organization of DBHDS website.
- Merge provider reporting portals (MES/CHRIS/WaMS) or single landing page.

Training

- QA training, with examples of treatment plans and progress notes in person centered language.
- Series of trainings on risk management/quality improvement that build on each other. Organizational risk assessment.
- More focus on MH and SA services (vs DD).

23

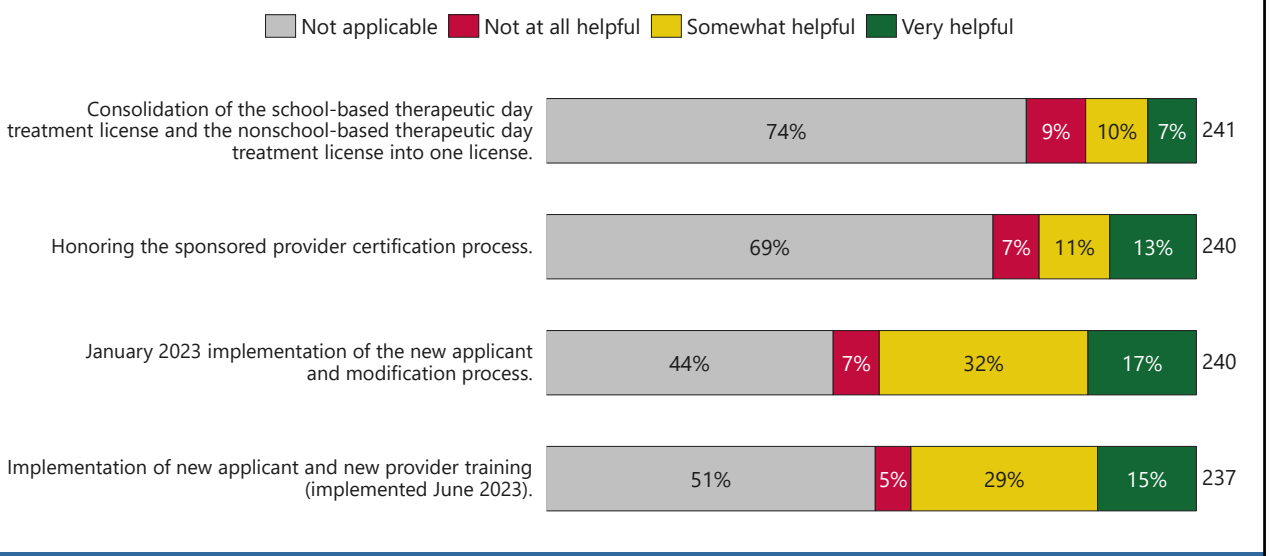
9. Are there any other issues, considerations, or recommendations related to licensing requirements you would like the workgroup to address?

Regulations /Inspections

- Different requirements for residential vs. homebased services.
- Reduce frequency of inspections for accredited providers.
- Increase oversight of providers with a high number of serious incidents.
- Complaint process (investigation of individuals that have left services difficult; appeal process burdensome).
- Consistency between what specialists review and their determinations.
- Too much weight on a single omission (e.g.,. citation for a missing signature). Consider reviewing larger number of records and citation for pattern of violations.
- Focus on training vs citations.
- Timing of inspections:
  - Coordinate timing of inspections by different entities.
  - Eliminate unannounced inspections, or coordinate timing with provider.

24

8. How helpful have the following Office of Licensing administrative changes been in reducing administrative burden on providers?



The total number of responses varies by item because some respondents left one or more items blank.

25

Virginia Department of Behavioral Health & Developmental Services

Findings from Other States: Licensing and Accreditation

26

State Licensure and Accreditation

** A number of states license either by disability or by service type. Therefore, a provider may need to be licensed by multiple state agencies, requiring multiple inspections per year. In Virginia, all clinically based services are licensed by one office in one agency.

Connecticut	• Connecticut Department of Public Health (DPH) allows for deemed status for certain hospitals and healthcare services. • Examples of some of the approved accreditation bodies: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), the Joint Commission, or the National Association for the Education of Young Children (NAEYC). • Currently existing deemed status language that covers hospitals. • Under HB 6155, a department may waive, for deemed status license or certification renewals, the inspection and investigation that would otherwise be required for standard renewals. This does not limit any department's authority to inspect providers, suspend or revoke a license or certification, or take any other legal action to address complaints or non-compliance under the law.	An Act Authorizing Deemed Status License Renewals for Certain Nonprofit Community Service Providers.

State Licensure and Accreditation

Illinois	Adult day services are considered to meet licensing standards if accredited by a nationally recognized entity. • Surveyors do not review the rule sections for which deemed status has been granted. • Deemed status may be nullified if the department finds the agency is in substantial noncompliance with one or more rules. • The department shall, at least quarterly, review the services being provided to assure compliance with the standards.	20 ILCS 1705/Mental Health and Developmental Disabilities Administrative Act. (ilga.gov)
Indiana	The following services are considered to meet licensing standards if accredited by a nationally recognized entity: • Community mental health centers (not accepting new applicants). • Opioid treatment programs (not accepting new applicants). • Private mental health institutions. The state requires accreditation for addiction treatment services.	https://www.in.gov/fssa/dmha/for-providers/provider-certification-and-licensure/

State Licensure and Accreditation

Maryland	Requirements may be waived for agencies providing behavior support services, if accredited. Certain services are required to be both licensed AND accredited.	Decision Tree.pdf (maryland.gov)
Missouri	Certificate granted upon application of an organization with CARF, JC, or COA accreditation. • The state currently has a moratorium on its application process while working through a backlog of applications and incorporating additional monitoring requirements.	MO CARF/licensure crosswalk
North Carolina	Facilities are awarded "deemed status" and licensed if accredited, though inspections are still required.	NC Deemed Status

Virginia Department of Behavioral Health & Developmental Services

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State Licensure and Accreditation, continued

Ohio	OhioMHAS recognizes the following national accreditation organizations: CARF, COA, TJC. Deemed status means "evidence of compliance." When deemed status is granted, the licensing body is accepting the agency's appropriate national behavioral health accreditation as evidence of compliance with the standards. • Incident reporting and risk management are not exempt from deemed status; i.e., a provider granted deemed status must continue to report incidents to OhioMHAS as specified by the rule. The department may conduct follow up surveys of a random sample of agencies in order to validate the accrediting body's continued ability to satisfactorily address requirements	National Accreditation/Deemed Provider | Department of Mental Health and Addiction Services (ohio.gov) https://codes.ohio.gov/ohio-revised-code/section-5126.082
Tennessee	Accreditation streamlines the licensure process, though site visits are still required.	

Virginia Department of Behavioral Health & Developmental Services

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Agenda Meeting #1, July 20, 2023

I. **Introduction and Workgroup Objectives** (1:00 – 1:20 pm)

II. **Presentation of Survey Results** (1:20 – 1:50 pm)

III. **Findings from Other States/** (1:50 – 2:20 pm)

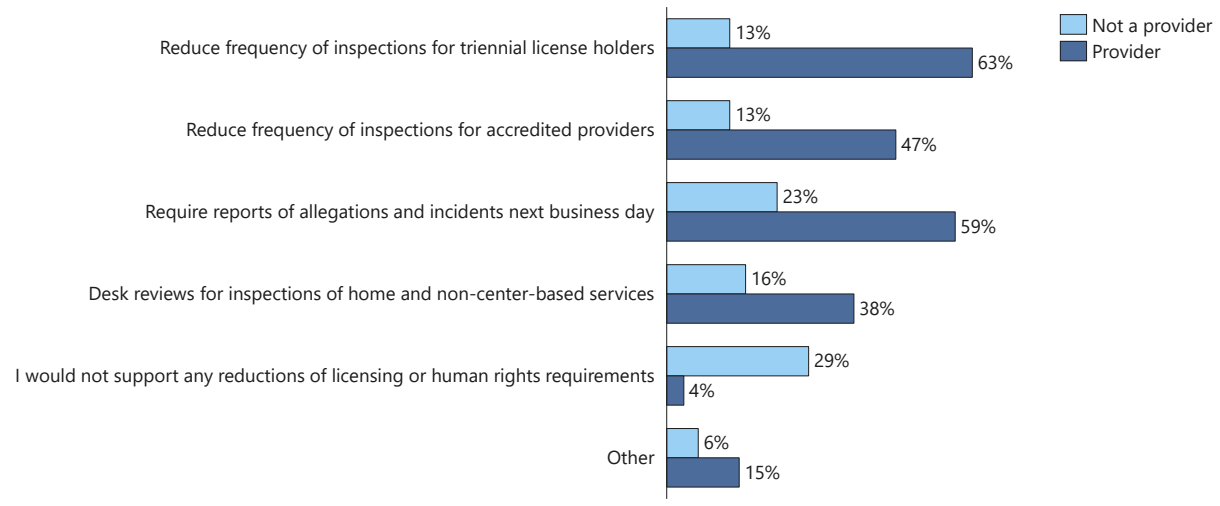
IV. Questions and Discussion (2:20 – 3:05 pm)

V. Public Comments (3:05 – 3:25 pm)

VI. Conclusion and Next Steps (3:25 – 3:30 pm)

- **Today's presentation will be posted to Town Hall in an updated package for Meeting #2, Thursday, July 27, 1:00 – 3:30 p.m.**

7. What strategies would you support to reduce the administrative burden related to licensing and human rights regulations? Please check all that apply.



1

5. What other agencies or safety mechanisms (internal or external to your organization) exist to ensure the safety of individuals until a report to DBHDS is submitted?

- All safety actions are taken immediately
- Clinical skill and knowledge - The DBHDS system is set-up in a way to find what was done wrong. It would be great if agencies were also consistently told what they have done right.
- Coordination with the Case Manager assigned to the individual - We reassign or put staff on Admin leave until the investigation is concluded - Supervisors at all levels of the program are involved in reviewing the incident/allegation and determining our agency's response.
- Internally, Incident Reports regarding Human Rights allegations and/or Serious Incidents are submitted as soon as possible (less than 24 hours after the time of discovery). Our organization utilizes electronic systems that ensure when those reports are submitted, members of the management team receive notifications and immediately triage the incident report. We also have on-call systems in place for after-hours and on weekends to ensure 1) there are designated personnel to notify of incidents, and 2) there are designated personnel to monitor incident submission notifications to ensure an immediate assessment and response to the situation. -Authorized Representatives and Support Coordinators are notified within 24 hours of an incident, per regulatory requirements and internal policies. -Per external requirements and internal expectations, APS is immediately notified (within 24 hours) of any situation involving suspected abuse, neglect or exploitation. -The initial actions above ensure the incident/situation is assessed, required actions are taken, and immediate risk reduction activities are put in place. Notifying the Authorized Representative and Support coordinator also ensures transparency and additional problem solving. Notifying APS also provides an additional mechanism to ensure the safety of individuals.
15 minute checks; referral to higher level of care; verbal de-escalation; medication management; redirection to Sensory Room
24-hour Clinical On Call and Administrator; Crisis Teams in Community (CSB)
988, 911, CPS, APS as needed. depending on the situation, there are many protocols to support individuals needs within residential programs as well.
A report does not ensure safety of individuals, first of all. APS, the police, REACH, relocation to family or another safe place.
A report to DBHDS is only administrative. It does not ensure safety of an individual. Safety is insured once an incident occurs and then a clinical staffing to include safety planning is addressed. Clinical staff working with individuals do not even have access to report in CHRIS in our agency.
active quality and compliance dept who conducts internal investigations/trainings/etc.
Administrative oversight and actions. Ongoing training.
Adult protective Services, Community Service Board, Executive Director of the Agency
adult protective services, other human rights entities, support networks
Agency procedure requires staff to submit the report internally to MRCS Incident Management "as soon as possible but no later than by the end of one's shift." This triggers our Incident Managment specialist or designee to review the incident immediately and provide feedback on any emergent or urgent issues. This also initiates review by the Risk Manager for an RCA or a trend analysis.

All of the requirements for reporting outside our organization are required internally too. We are reporting on the same things and having to submitted multiple reports for different systems. It is very redundant.
An internal hierarchy to include Human Resources and a Quality Management team dedicated to the thorough review of serious incidents and complaints. Also cameras and video/audio systems, and in the worst case, police and EMS.
APS
APS reporting, internal QA measures, behavioral management training
APS, CPS, Department of Health Professions, etc
APS, internal quality department, video footage of home, supervisor overview
APS, local police and hospitals, internal crisis support
APS/CPS DHP Internal report and review by Office of Consumer Affairs/CQI Officer to assure safety mechanisms are in place. Internal Safety Committee RCA Internal Investigations
APS/CSP, licensed providers providing services to individuals
Available 24x7: Internal - Program management, Clinical staff, QA staff, Risk Manager, Executive leadership, Medical staff, Facilities staff; External - Community medical care, DSS, Community mental health care
Calling 911; Hospital ER; PCP; Family/guardian; Chris report;
CARF
CARF Accreditation Quality Assurance Unit Internal Policies and Procedures Division of Local Government, Henrico County Hierarchy
Child and Adult Protective Services mandated reporting; Civil Commitment process.
Clinical care provision including safety planning. CPS/APS
Close monitoring of the individual, internal investigating, and communications with staff, pcp's, hospital staff, etc
Communication with Compliance Officer
Communication with the Support Coordinators, Health Care Providers, and other support team members.
company policies, emergency medical treatment
CPS, APS, DSS
CPS/APS Safety Committee Quality Committee
CSB APS Police Dept.
Csb, guardians, director, supervisor, admin and staff in general
CSB's provide needed support and follow up after pertinent incidents.

Department of Social Services, law enforcement and National Children's Allicance
Developing and implementing policies and procedures to address issues.
dLCV, APS
DSS, Law enforcement, REACH, Emergency services, Risk manager/QA/Incident management coordinator.
EEO, Labor department, CARF, Natural Marketing efforts to provide quality care in order to receive recommendations. Internal quality improvement measures reported annually to our stakeholders.
Emergency Services (police, EMS, etc), APS, REACH Team
Emergency services, crisis services, police/988
Employees are to immediately notify the administration team or nurse on call so that immediate action to ensure the individual(s) are no longer at risk. This may include initiating an investigation or conducting a preliminary investigation, furloughing employees who are named in an allegation, temporary removal of an at-risk individual(s) from their home to ensure safety (i.e. if the allegation is against an individual(s). Notification to the DBHDS via CHRIS or by phone if CHRIS is unavailable. Depending on the nature of the allegation, we may contact the HR advocate, APS or local police as necessary.
Generally, all critical actions have already been taken by providers prior to reporting to DBHDS. In other words, reporting doesn't ensure safety of individuals, it's the actions of providers taken before reporting that have an impact. APS, CPS, 911, engagement of case managers, families, etc. as appropriate.
Good clinical judgment of licensed, experienced providers.
Hierarchy of reporting to supervisor, QA, and Executive Leadership
Human Rights and Adult Protective Services
I am an “Interested Stakeholder” who is a Consumer. The survey has no entry selection option for Consumers, it simply asks if you’re a Provider or not. This survey also is directed towards agencies. I'm a Consumer. Create surveys opportunities for Consumers. Count Consumers in data collection and use the data to pay Consumer Directed in-home personal care attendants a living wage.
I would follow our protocol for each issues
If a report is submitted by our agency, then we are typically involved via the provision of ongoing wrap around services. Other external entities may also be involved such as DSS, etc. We also have 24/7 crisis services available with follow up protocols.
If there are additional sponsor homes with available beds, the individual will be temporarily relocated until the investigation is complete. This is a challenge for a small company that doesn't have additional homes licensed to temporarily relocate an individual until the investigation is complete.
Improved Risk Management Planning
In the CSB we have a supervisory chain of command that is notified to ensure safety.
Incident Report and Review Monthly Medication Regimen review Daily staff supervision Quarterly QIP Committee Meeting Ongoing staff training Staff Write-up and Performance Improvement Plan Annual Staff Evaluation

Organization's Policies and Procedures Adhoc staff meetings and in-service/education
Incident report within 6 hours Notification/involvement of immediate supervisor and Senior leadership as needed
Individual safety is number one priority then report will be submitted.
Internal - Incident reporting system, daily incident report huddle, monthly safety meetings, policies and procedures, on site social workers, risk manager, comprehensive layered management positions and schedules, parents and guardians, QI program and Quality nurse, escalated reporting pathway for suspected abuse and neglect, Interdisciplinary team meetings, quarterly QI meetings, follow licensing regs and va code. External - CPS, APS, families, mandated reporters, physicians
Internal - Supervisors and Staff. Policy and Procedures. External - DSS and Emergency Room and Local Law Enforcement.
internal compliance procedures
Internal direct care staff and supervisors are competent to respond to safety concerns until a report is submitted.
Internal incident reporting
internal incident reporting, contact to APS, CPS, or police if applicable, and initial review of incident by QA, team leader, and /or on call supervisor
Internal incident reports which automatically inform agency leadership. DBHDS does not investigate on holiday's or weekends so next business day reporting makes sense. This will also help ensure the quality of the report is sufficient.
internal investigations, robust quality improvement plan, continuous training, leadership fully invested in the care of children, team meetings, collaboration meetings, outside locality reviews, continuous engagement of parents/guardians A report to DBHDS does nothing to ensure safety. It is a report.
internal policies and procedures
Internal policies and procedures. Child and/or Adult Protective Services. Law enforcement.
Internal policies, law enforcement, healthcare providers, behavioral health providers
Internal policy and procedures for submitting incident reports (aka General Event Reports) and reporting incidents up chain of command to ensure immediate health and safety measures have been taken
Internal policy and procedures for submitting incident reports and reporting incidents to ensure health and safety measures have been taken.
Internal Policy and Procedures Relationships with other Providers Relationships with the CSB and onsite walkthru's with Support Coordinators Staff Training Mandated Reporating to APS
Internal policy is for front line staff to immediately assist the individual to ensure safety, and staff report the incident to supervisory staff. Front line staff and supervisory staff will take the necessary immediate actions. Staff to submit an incident report to the Quality staff by the end of shift. The Quality staff is available 7 days a week for assistance and review of incident reports. Quality staff complete a timely review of the incident and make recommendations to mitigate risks to the individual and the organization. Quality staff then submit a report to DBHDS.
Internal process and procedures ensures the safety of individuals including the Quality and risk analysis teams .

internal process of licensed supervisor or state clinical director being contacted when any incidences occur and submit a report to internal team even if not something that needs to be entered in to CHRIS. Follow up is done internally
Internal process to reduce further harm to individuals.
Internal report submission & review, internal investigations
Internal reporting structure
Internal reporting system, program oversight, access to medical supports if needed.
Internal reports are due immediately
Internal risk management and compliance. Internal processes to investigate concerns at all levels through committees
Internal safety policies and procedures, sound therapeutic clinical interventions, provision of emergency services, proactively seeking technical assistance from the OHR or OL with complex service situation and external mandatory reporting requirements - law enforcement, DSS, DMAS, MCOs. HCS rarely if ever receives feedback post reporting that impacts safety of individuals. Many of the incidents reported are unrelated to the actual provision of services.
Internal support mechanisms based on policy and procedure are in place which include management team, Quality and Compliance team, and program staff. Health and safety concerns are identified through a team approach and action plans are developed for immediate implementation. All outside reporting (e.g. DSS) are made as appropriate.
Internally our staff are trained to respond and provide the necessary supports to maintain there safety.
Internally we notify our Quality Assurance Director externally we notify APS and polices if necessary.
LHRC
Licensed clinicians are capable of ensuring safety to allow reports to be submitted by the next business day.
Local Community Services Boards, Local police, local hospitals (including psychiatric)
Local law enforcement Hospitals Emergency contact Safety contracts Crisis supports
Local law enforcement Local medical facilities
Manager and Director review; Internal Human Rights investigation procedures
Monthly Service, Risk, and Environment Checks that are documented, reviewed and progress monitored.
Multi-person reporting team, training, On-call and supervisory staff
N/a
NA
Note: Emergency room visits and unplanned psychiatric/unplanned medical hospital admissions should be moved to a Level 1 category as the visits and admissions are standard and routine practice and expected to occur because of the nature of the vulnerable and medical/psychiatric fragile populations that we serve. Staff maintain up-to-date medical/psychiatric information, service plans to address chronicity of individuals' vulnerabilities with interventions, have active certifications in first aid/cpr, access to CSB Emergency Services, access to PCPs & Urgent Care facilities, utilize 911 for

emergencies, on-call nurses, assigned and on-call physicians/psychiatrists, REACH, on-call managers and directors, CPS, APS, and Police.
Notifications to the parents/guardians, case managers, and any other pertinent person involved with the individual. Also, we are a small agency. So, often times, any incidents that occur the owners are directly involved to remediate, communicate, and ensure that things are handled in a timely manner to ensure the safety and well being of the individuals served.
Notifying other agencies is all that is available at this time.
Numerous internal Policies & Procedures DBHDS and DSS regs Internal QI Department Staff trainings (Incident reports, Bx Mgmt, De-Escalation techniques, Human Rts, etc) Training/guiding/supervising our staff.
On call Managment reporting systems for supervisor supports to staff exists. Nursing staff available. Safety protocols to activate Emergency Medical Services/911, Poison Control, and APS/CPS-DSS reporting for abuse/neglect/ exploitation.
On call system
On call system with 24/7 access to administrative and clinical support.
On-call Manager and Nursing assignments.
Once an issue is identified, it is addressed and remedied immediately whether it requires submission to the Dept or not.
Ongoing checks with clients in the community and a multi-tiered approach to following up with problems or incidents as they occur. Multiple levels of follow up ensure client issues are stabilized until a report is submitted.
Organizationally we have 24 - hour on-call staff and managers that can respond or elevate concerns when notified to appropriate internal staff or external authorities (rescue, police, fire, DSS (APS/CPS) or respond in person.
Our community providers are instructed to communicate with us ASAP when there is a shared consumer. Our security officers and NPD also notify us if issues come up with our consumers in the community.
Our organization is fully accredited by CARF and therefore we have many internal committees such as Risk Management, Peer Review, Service Quality medical record reviews, etc. We already had an internal event reporting process before DBHDS made it a requirement.
Our policies and procedures Our compliance department Our licenses for clinical practice that bind us to practice ethically
Patient Advocate, administrator on-call, corporate compliance (high-level incidents)
QA and APS
QDDP Agency Staff QMHP Agency Staff APS Medical Services CSB Crisis services REACH
Quality and Safety Committee at unit level and org level (internal)
Quality Improvement Team/ Risk manager on site
REACH

REACH
REACH LOCAL EMERGENCY ROOM
Reporting to family, support coordinators. Being mandated reporters, hospital. All measures taken now
Reports to CPS, APS, schools and law enforcement. Policies and procedure in place for SI risk screening, assessment, and safety planning and interventions. Policies and procedures in place for ensuring safe Environment of Care and Emergency Management activities.
Reports to DSS and internal supervisors.
Risk management Leadership team (AOC) Clinical emergency policies and procedures
Safety Inspections/internal and external Reporting, contact, liaison with legal guardian/locality/case manager A/N/E reporting to DSS
Safety procedures are immediately implemented internally upon the recipt of an internal report. Corrective actions are immeidately identified and implemented as necessary, as well. APS Police PCP, Emergency Room Urgent Care Support Coordinator Family Communication REACH Behavior Specialist Psychiatric Hospital CSB
SBH employees are mandated reporters and report all allegations to DSS or other responsible agencies. For incidents related to medical issues, SBH has an RN nursing manager that handles all incidents.
SIR reporting Emergency Response Guide (in-house) Internal Compliance department checks and balances
submission of incident report to the program leadership and to CQI. This allows for immediate actions to be taken, such as ensuring someone receives medical follow up, staff member might be reassigned, implementation of additional supports.
Submitting a report to DBHDS does NOT ensure the safety of individuals....the only thing I can think that has come from submitting incident reports to DBHDS is some literature on UTIs...report generation does not positively impact the individuals we support-it only hampers their privacy and confidentiality
Supervision, small (8bed) operation
Support Team, medical professionals, trained staff, support coordinator, family
The internal team will make decisions immediately upon knowledge of an incident to protect the rights and interests of all program participants.

Internal Risk Management practices When necessary, hospitals and/or law enforcement is also involved. APS/CPS are involved when needed.
The provider who is making the report is responsible for ensuring the safety of the individuals, whether internally within their own agency, seeking medical evaluation, or through contacting APS, police, or other contacts as needed if immediate safety is a concern. Submitting a report to DBHDS does nothing to protect immediate safety. For a Serious Incident Report, the provider is reporting the medical treatment that has already been sought. For an allegation, the provider is reporting APS and external contacts already made. Additionally, DBHDS staff may not even see that report for days after submission.
The Safety & Risk management committee and the Director of Quality Improvement and Program Integrity.
This isn't applicable to us, but if it were, we would notify the service user's SDM, start an internal investigation, transfer staff, and make environmental accommodations if needed.
TRAINED STAFF AND ER
Turning in Incident reports immediately to Supervisor (internal polic)
Turning in incident reports to supervisor immediately (internal policy).
Unsure.
Upper management at the Agencys will still be notified and safety protocols followed. Submitting within 24 hours (when no one is reviewing it at DBHDS does not help the safety of the individual)
Use of administrative leave
UVA Risk Management, University Police/Security, Adult Protective Services
VDH, CMS, TJC
Virginia Department of Corrections policies, which are largely based on the ACA (American Correctional Association) national requirements.
We are an Emergency Services provider. They function 24/7 and are available to assist individuals until regular providers arrive next business day.
We follow all state, federal guidelines. We ensure safety and medical/psych stabilization first.
We follow our robust risk management protocols.
We follow strictly our internal notification process covered by our policies which requires immediate notification all the way to CEO with immediate safety plan followed by immediate review, investigation and response.
We have a heavy focus on Workplace Violence & a culture of safety for staff to report any concerns or adverse events that occur with patients. We have a program that we implemented to assist patients at the 1st sign of escalation to help with de-escalation sooner rather than later.
We have a Risk & Quality Assurance Department internally
We have a safety official and a risk management team.
We have a strong program leadership and effective QA and compliance processes
We have extensive safety mechanisms for reporting and accountability. Policy and all reports are looked at internally regardless of a reporting requirement
We have Regulatory Affairs Department and A Dedicated Behavioral Health Administrator on Call 24/7
We provide 24-hour care with supervision constantly. The provider has video surveillance apart of its risk management in order to provide a thorough investigation for SIR or allegations of abuse of neglect. Utilization and collaboration with most of the surrounding community service boards to

ensure that resources for the individuals are being utilized appropriate as they are offered. The provider has attempted to build repor with other providers in the community in order to bring more awareness to the dually diagnosed intellectual disabled population. The provider utilizes report with the licensing specialist in order to be able to implement new processes within the organization. The provider utilizes additional community resources in order to train its staff to include Maintenace personnel in order to provide a safe environment for the individuals that are served.
We provide the needed service, medical care or psychiatric. Staff utilize supervisors to determine safety, need and action. That's where safety happens. Reporting is after the fact and we are often confused as to what is reportable or not.
We seek appropriate assistance for our consumers depending on the situation. These include crisis or inpatient services, medical interventions, or reports to DSS. All these take place without consideration of submitting information to DBHDS. We have internal checks to ensure these steps are taken such as staffing, documentation, and trainings.

8. Please enter any suggestions for administrative changes that have not been addressed above:

A consolidation of forms and documents
A National including individual State format blueprints, in full, would be helpful to those Agencies in Research and Development and functioning as volunteer to help amongst the national domestic violence crisis poverty field which was revealed through the pandemic of COVID-19. The process of utilizing multi State Continuing Education Unit models, with diverse areas of concentration, has been exceptionally helpful for resource findings and awareness. So, the blueprints of how to access proper applicable branches of infrastructure partnerships on unique perspectives as they present themselves, allowing definitely the Collaboration with other Federal and State Agencies already functioning at full capacity, is all Essential Action in times of crisis and domestic divisions missing any transparency trust. From licensing to connecting with Stakeholders and other Community OPEN Businesses ready and in function for Community betterment.
A portal that all policy requirements can be uploaded to for all auditing sources Most time consuming is when more than one audit is occuring at a time and we are having to send multiple sources to multiple places in multiple formats. Becomes tedious process
A service-specific review checklist for unannounced reviews
ability to enter more than one location for a location modification. For example, HCA recently received full license for SUD OPT (child) and we would like to add this to all our offices. But, having to do a mod packet for each location is cumbersome.
Address the need for meaningful revision in Virginia's civil and criminal commitment laws under, among other provisions of law, the Virginia Behavioral Health Dockets Act and Titles 19.2, and 37.2 to allow greater participation by responsible family members of adult at risk" target populations, consistent with HIPAA federal privacy law, for those with serious mental health disabilities (Adult SMI, ASD, ID, DD, TBI). These classes of "at risk" adults are often in urgent and critical need of psychiatric emergency services and diversion to community based agencies and services (private and public) and housing. Many of these same adult populations present in the criminal justice system and are equally in need of emergency services. Revisions should be considered especially to VA 37.2-817 (Mandatory Outpatient Treatment or MOT) related to the diversion option and proposed law known as EDCOT currently authorized for study by the State Legislature's Behavioral Health Commission in 2023. Current MOT law mandates a "two time revolving door requirement" before an MOT order can be ordered thereby substantially worsening the prospects for recovery of individuals presenting with SMI and related mental health disabilities who remain at heightened risk for relapse and exacerbation of illness each time they go through the "revolving door" and a worsening of their prognosis for sustained recovery that is largely preventable if treated early. This provision of this statute should be replaced with a first time TDO court order with provision for a Direct or Step-down (or "Combined" inpatient/MOT order) on first TDO petition for MOT related services in the community. This would be with follow-up "status" and "review" hearings remaining in effect until satisfactory completion of treatment and negotiation by the respondent with support of his/her family and other legal advocates and with the successful negotiation of a Virginia legal advance directive and crisis prevention plan . A voluntary civil "stay" of a Direct MOT outpatient commitment order should also be considered as an option on first timeTDO petition for presumed competent respondents to participate in community based treatment. Such a "voluntary" court order would based on "supported' or "shared" decision making case management models in the community, financed with discretionary State general funds, and with court oversight remaining in effect on a transitional basis until the court order is dismissed. This is to encourage sustained adherence to the order with family support and involvement -- whether this be on an

"involuntary" Direct, Step-down, or "combined" MOT order or a "voluntary" stay of an MOT order. Such judicial oversight would be in transition to longer-term community based outpatient services and care, per the CCBHC model. This suggestion potentially enhances adherence by targeted "at risk" populations as well as family and community based support. Direct participation by responsible family members in their adult loved ones' treatment with mental health disabilities is in keeping with the finest traditions of volunteerism in public service while preserving legal adherence to treatment, due process, and privacy rights under current HIPAA law. This is because all participants would be under direct court supervision until final dismissal of the court order Direct and Step-down MOT orders by the general district court through the use of "specialty" courts (drug, family, veteran, assisted outpatient) in the community also enhance the prospects for responsible family involvement for their criminally involved adult loved ones, decrease administrative costs over the long-run, and address the current workforce shortage of mental health professions. This would occur by diversion of the general district court judge, in most instances by special docket, on the basis of a direct or "combined" MOT order with criminal misdemeanor charges dismissed by prosecutorial discretion "with" or "witlhout" prejudice. This would be effected clincially primarily through targeted voluntary efforts and involvements of court approved responsible family members in their adult "at risk" loved ones' welfare through HIPAA compliant policies through the use of therapeutic jurisprudence and evidence-based legal diversion strategies. Similar innovative legal strategies have recently been endorsed by nationally recognized organizations, such as the NCSC and TAC, and are consistent with the findings and recommendations of the National Judicial Task Force and the Equitas National Model Law Group (NCSC publication, 10/22). Similar innovation diversion strategies through the general district court system are currently in effect or in the process of being implemented in states such as California (CARE Courts) and Michigan (direct probate diversion to AOT and/or Alternative Dispute Legal Resolution Models). It is further recommended that the State endorse the National Judicial Task Force's call for interbranch (legislative, judicial, executive) collaboration in developing civil diversion at all levels of forensic participation and at all stages of sequential interception..
All auditing agencies being consistent with information/instructions with the regulations. Agents at times appear subjective with the regulations causing confusion and the provider is the one penalized for it.
As outpatient SUDs providers many of our policies say that if we had the policy, it would be X but we don't provide X so we don't do X (physical exam, certain notes, Legally Authorized Representatives, Holds/Restraints, Community Participation, Health Care, Falls Assessment, Behavior Intervention/Supports, Receiving Funds/Form, etc.
As someone who has recently gone through the initial licensing application for a day support program, I will say that the modifications made at the beginning of 2023 have been helpful in creating a more streamlined process. However, the process can still be confusing, and the recent changes have led to instances of creating an organizational document or policy based on information prior to the 2023 changes, then having to re-do the document or policy to incorporate the new modifications, which adds more time and work on administrative staff. Additionally, information how to format and what to include in the organizational documents in the initial application can be difficult to find on the DBHDS website/Connect Portal, which increases the chances of an application being denied a conditional license due to a problem that might have been resolved if the requirements were more easily accessible.

Change the time frame for reporting from 24 hours to 5 business days.
Changes to the annual inspection process, not requiring so many documents for multiple programs.
CHRIS system: allow for simultaneous reporting to OL and OHR vs having to do 2 different reports; this system also times providers out before anyone can get through the report questions without typing up the report in Word format first and then copying and pasting into system- extend time out period as this is very frustrating and creates re-work/double work.
Communicating with providers on new requirements to get input before unleashing new forms. Procedures etc to ensure it is necessary and does not create more paperwork burden Streamlining audits across regulatory bodies so not reviewing ht same thing back to back audits Creating more cohesive training requirements and access--- ex: get rid of duplication between competencies and dsp orientation
Connect and CHRIS systems are not very user-friendly and should be updated. Human Rights allegations have to be entered by the provider if called in to the OHR (instead of the OHR advocate)
Connect System is not user friendly and burdensome. CHRIS System Re-evaluate the need for Serious Incident Reporting Review the use of "systemic" non compliance citations. This is often used when it is not statistically supported. Review the IMU death morality review committee and process for DD Services
Consider a more collegial approach to create a collaborative relationship between providers and DBHDS. DBHDS departments should be limited to operate within their scopes of practice. DBHDS should approach situations with an unbiased view prior to receiving all of the details of a situation. Providers are required to report and communicate the same information with multiple departments in DBHDS. This creates excessive workload and redundant monitoring.
consolidating school based therapeutic licenses under one agency license instead of each school address.
Credentialing Process/ Payout from the MCO'S. The real issue is how providers have to wait such a long time to get Credentialing after a license has been provided. Licensure, Medicaid, and MCO'S need to be on the same page as far as regulations and billing practices.
DBHDS and DMAS understanding that MOST providers are attempting to follow rules, procedures, and policies on a daily basis. The administrative burden should not contribute to staff burnout, individuals deciding to change careers, client confusion of which services they qualify for, or quality providers deciding to sell their company to less qualified individuals.
Due to the performance contact and CCS moving to a BI platform data reporting CSBs have a higher level accountability and transparency. Consideration of having different reporting process/standards for CSBs would be helpful. Allow the CHRIS enter for longer that 15 minutes. Change the layout so if the issue is also an OHR issue there is a simple checkbox that is checked. The duplicate entry is tedious and confusing.
Fixing the CHRIS website issue where it will time out quickly would be very helpful when trying to report detailed and accurate information
For a large organization with multiple licensed services, expanding the regulations to service specific creates more administrative burdens. Additional funding is needed to expand QA staff to keep up with the growing regulatory requirements.
For providers who do not have any major health or safety issues and have been in business for over 10 years, should receive a triennial license.
For SIR's CHRIS supports should be available 24 hours a day7 days a week in the event that there is a system error and reports are not able to be submitted in a timely fashion

Greater collaboration with other entities to reduce duplicative work (i.e. we as a provider are required to have all information in the client's file that is already in the WAMs database-no need to have the same information in multiple systems
Have ONE source/site of documentation, reviews, and inspections, which is then shared and available to all the different entities.
I am looking forward to a repository for collecting data to prevent having to send the same data out multiple times to different DBHDS departments.
I am unable to provide an informed opinion about the previous few questions.
I don't know what any of the above changes are and as an already existing provider who doesn't currently provide all of those services, I'm not sure that they would even impact me. I need changes that are going to help me with day to day paperwork too. - Change expectations for daily progress note documentation to include checklists or other systems that could be completed faster. My staff are spending an hour in the afternoon writing progress notes for all of the staff in our Group Day Support program (could be 7 individuals for each staff member) and we lose out on time for staff training and team meetings which would actually help us improve our services. Consolidate the DSP checklist items to ensure supervisors are able to spend time training the staff instead of making sure each box is checked and each year is signed. Those documents are extremely long and we provide services to individuals who have autism and significant behavioral challenges so we have to complete all 3 checklists for each new staff member (each year). Streamline the service authorization process so providers spend less time making sure their service authorizations re approved. If an individual receives services from multiple providers, the only person who knows if the schedules that are submitted overlap are the support coordinators. There has to be a better way to address this where each provider can see each other's schedule- possibly submitted in WaMS somehow. Customized Rate staffing is needed to support individuals with significant behavioral and medical needs. This process took us 3 months to go through for an individual and when it was approved it was authorized to start over a month ago. How was I supposed to know this? Should I have started staffing this individual 1:1 when I submitted the request and hoped for the approval to be quick? I was not aware it was going to take 3 months to get through each round. Collaborate with other departments and audits in DBHDS, etc. The Quality Service Reviews and the annual inspections are very similar. It takes a lot of time to organize and submit all of the needed documentation for each one of these reviews, let alone multiple of them back to back to back during a global pandemic.
I feel that agencies would not feel so overwhelmed with desk or in-person visits if we were not also being reviewed by a third-party contractor for identical information.
I like the idea of considering using the national accreditation as general review/acceptance with process for investigating complaints.
I think the abuse guidelines need to be if WE suspect there's been some kind of abuse or neglect. We investigate any and all adverse events reported by patients. If we can quickly determine there was nothing that we contributed or it's simple untrue, it's unclear why we would have to report those events. There have been many reports we were required to enter, that were just simply unnecessary.

I will just say that, after working at a CSB in VA for almost 20 years, DBHDS seems to always make things more complicated and burdensome on the therapists in the trenches doing the real work with clients - making our work lives (and our freaking out supervisors) focused on VA Licensure, Reporting, continuously new Rules/Regs, etc. making it harder and more demoralizing to do our actual work with clients.
I will suggest that the time between the annual inspection and report be shortened to prevent the provider license from expiring and, therefore, not being reimbursed by DMAS. Also, the approval of the CAP when submitted by the Provider to the Licensing Specialist be shortened - this can allow the Provider to start implementing the CAP sooner than later.
I would suggest the requirement for reporting allegations of abuse and neglect be modified to only include cases that occur within our organization. We already report the others to DSS so reporting to both is duplicative work that does not benefit the consumer or our agency.
If possible, any way to simplify standardization of basic regulations among providers that also encourage or eliminate multiple audits with multiple opinions from multiple entities (DMAS, HCBS, etc.) would greatly relieve some administrative burden. I realize much of this may not be possible; however, having one agency accept the other's audit/inspection would be wonderful.
I'm a Consumer. Create surveys opportunities for Consumers. Count Consumers in data collection and use the data to pay Consumer Directed in-home personal care attendants a living wage.
I'm not sure if there is a way to map out when inspections, audits, etc are done, but we usually experience most of it happening at the same time. Then whatever corrective actions that come from QSR, licensure we end up trying to create and implement at the same time.
Improve CONNECT so that submission of information is a smoother, more intuitive process. Location Manager is particularly difficult entry to make. Allow multiple selection for some modifications (e.g., often a change to MH outpatient means the same change for SUD outpatient). Allow relocation/move as a single option vs needing to both add a location AND close the old location.
Increase provider payment for their services rendered so we can hire more administrative staff.
Issue the entire report to providers when they are reviewed When licensing only issues the CAP there are absolutely no positive points highlighed. The reporting by HSAG provides positive feedback in their reporting and including this would give the whole picture regarding the Provider's Services There should be in-person meetings/trainings with the option of on-line via Zoom. Administrative reviews should include opportunities for best practices to be shared when their is a cited correction MORE TRAINING in person
It would be more helpful and appreciated if DBHDS could develop more friendly users forms for providers to use or as a template so we all provided could have somewhat the same content to follow.
Just a concern I have. With the smaller programs such as ours, set in a rural community, it would be helpful to take into consideration that smaller agencies aren't in the same category as a large program.
Less paperwork
Making the regulations specific to community based versus residential services to decrease the administrative burden on community based providers.
More or better resources and sampling for QIP, Risk Management, Root-Cause Analysis, etc.
More than one incident of the same type being defined as a “systemic” issue.
Move to next day reporting of serious incidents (Monday-Friday, excluding Holidays)
N/A
NA

Necessity of monthly fire and evacuation drills should be reviewed.
neglect/peer to peer aggression causes a lot of confusion for level IIs for providers reporting CHRIS /abuse/neglect within 24 hours may be best if it's next business day being that some staff is not around on weekends and/or folks may be out and the supervisor assigned may be out. quality provisions should be clear as to what is expected
No need for HSAG or HCBS if accredited by national recognized organization.
None
None
None of these have impacted group home or community engagement, which is what sunny haven provides. Having to hire a full time risk management and qi person is a high cost and increased administrative burden. Having multiple caps for one issue is increasing administrative burden. Administrative expenses are more expensive than ever before and this would be better utilized to pay our direct care workers more.
None.
noneno
Pay increases, certifications.
please do something about making providers enter chris reports within 24 hours. The focus of the report is turning from a quality and safety tool to a frantic dash to simly "get it in the system" vs actually doing the work required to make impactful change.
Please share all information between DBHDS, DMAS and any other required reviewing agency (QSR, HCBS, etc.) due to DOJ. The burden to constantly be reviewed by various outside agencies and DBHDS and DMAS, often overlapping is extreemly disruptive to services for individuals.
Provide a more prescriptive list of guidelines that are easily followed by the provider and DBHDS. State the guidelines and allow the provider to develop a plan to achieve. No special circumstances for licensing specialist preference. This way everyone knows what bar should be met and there is no grey area. Example: Some licensing specialists like things one way while others like things another way which can create a grey area and confusion for providers attempting to prepare for inspections and/or regulation interpretation.
provider oversight is key to protecting individuals from abuse, neglect and exploitation. This is especially critical as services become more and more integrated into the community.
Quality Improvement and Risk training, templates and tools were very helpful. In the future, these trainings, templates and tools would be beneficial to providers earlier on in the requirement process.
Re-classifying Level II or III incidents that require reporting and RCAs. We report and review many incidents (i.e. routine psych admissions, ED visits for pre-screenings or CSU admissions, sexual assaults, etc.) that did not truly "originate" during services and for which we simply helped facilitate higher level care. RCAs very often have little to no benefit in these circumstances.
Reduce CHRIS reporting; reduce CAPs issued
Reduce duplication of Quality Reviews ex. QSR review, HCBS and Annual Inspection.
Reduce the required analysis of incidents entered into CHRIS or provide software to help providers complete the needed analysis.
Remove the requirement to report incidents when they occur outside/unrelated to the provision of services – such as deaths and sexual assaults (which are duplicative reporting to DSS). Also, consideration be given to CSBs about removing the requirement for reporting when a MH hospitalization occurs as a result of staff referring the individual to Crisis Services during the provision of services.

Remove the requirement to report incidents when they occur outside/unrelated to the provision of services - such as deaths and sexual assaults (which are duplicative reporting to DSS). Also, consideration given to CSBs in removing the requirement for reporting when a MH hospitalization occurs as a result of staff referring the individual to Crisis Services.
Removing peer-to-peer aggression as a neglect allegation. Can require providers to track internally, report if it involves same individual as the aggressor.
Reporting should be the last piece when it comes to protecting people served! DBHDS doesn't respond immediately and certainly not on weekends, so the 24-hour rule has frustrated providers and created a lot of unnecessary stress and corrective action plan writing.
Revisiting what should be considered a Level II serious incident and how neglect is defined. Not having to report an incident in 2 places in CHRIS would be hugely helpful- ie a medication error- find a way to have one report flag for both items.
Some sort of consolidation or accepting of a different type of review each year to satisfy the needs of Licensing, HCBS and QSR reviews would be helpful. Each year could be a different agency's speciality, with in person reviews or desk audits, and the results are accepted by the other agencies. Or an agreed upon framework for each agency, perhaps, conducted on rotating basis.
Staffing burden and number of inspections providers receive from different agencies. for example: HSAG, Licensing, DMAS, Human Rights, etc.
Start posting the training videos and powerpoints as soon as possible (no later than a week) so providers have access to the information to go back to refer to.
stop the HSAG audits - they occur three to four times per year on top of other audits. This takes a tremendous amount of time to coordinate, respond and participate in these audits. This is too much on top of Licensure and DMAS audits.
Streamline Incident/Investigation communications and align with regulatory timelines except for steps needed to protect immediate health and safety (see previous responses).
Streamline/minimize information for reports, reconsider which reports require submission, look to streamline with MCO's required duplicate reports (Serious Incident Reporting (DBHDS) and Critical Incident Reporting (MCO), consider EDCC notifications as a means of consistent notification of those reports which involve hospitalization/ED visits as sufficient for DBHDS and MCOs.
The administrative tools that are available are part of the problem. I find CHRIS a very difficult system to work with. There has to be a better way. I also think that the DBHDS Connect is a great idea - but it is not easy to work with. A change as simple a being able to upload folders in lieu of single document upload would be an improvement.
The burden of submitting the same paperwork to licensing, QSR, etc. is extremely time consuming and redundant, when agencies care unable to stay fully staffed, it is detrimental to individuals being served. An example would be my latest inspection. My agency has had 1 cap in the past several years, yet cap for more explanation for needs and how to mitigate on plans that were coming due in a few months. Licensing would not allow us to wait until annual date (June CAP to Aug annual) to revise.
The DLA-20 is bust. It is not being used as intended by the developers and does not produce the desired care guidance.
The increase in quality assurance documentation such as Root Cause Analyses, monitoring care concerns, and annual risk assessments are difficult to manage for smaller agencies that already have significant quality assurance oversight by their accreditation bodies, and none of the documents follow accreditation standards.
The time it takes to receive a login and password for CHRIS to report incidents in a timely manner for new providers. Consider adding to the CONNECT Portal for easier submissions of Serious incident reports

The trainings are for new providers and billed as a refresher for the existing providers, but it comes across as patronizing and as though DBHDS believes providers illiterate.
The use of the RCA needs to be revamped for hospital admissions. CSU's are being asked to take more and more medically and psychiatrically acute pts and until CSU have more medical resources, pts will continue to need to be sent out to ED's for medical issues. Especially given the fact that many providers work via telehealth, so meaningful assessment is not completed on-site. Consequently, CSU's should not receive CAP's or RCA's for following protocol when it comes to the safe medical management of pts. We cannot be asked to admit these pts and then be penalized when they need additional care elsewhere.
There are more than just the annual audits that have been occurring. If the provider is audited by HSAG, why cant that count as the annual audit? Also, if the provider has not had any issues, why cant the audit be aligned with the triennial licensure renewal process?
There needs to be more on-site visits to group homes and sponsor homes. People are still living in deplorable, untenable conditions. We all know resources are limited; however, there should not be licensed, operating homes where clients are living in these conditions. We all know of a home or two where we "would not send our worst enemy." Stop focusing on paperwork and committees and start focusing on delivery of the best care for our population.
Too many redundant audits. Lack of coordination between auditors. Very heavy administrative burden results in less time and money focusing on client care and innovation in providing services. The CHRIS System is redundant with having to report incidents on both OHR and Licensing. Double work. The system time out feature is faulty and results in frequent time out and then have to rekey everything.
Tracking incident report data and establishing/tracking thresholds to determine when an ERCA needs to be completed is a very time consuming and cumbersome process. It would be helpful if DBHDS sponsored/paid for a program/software to track this requirement for SIR's and some parameters around thresholds (i.e. a percentage of individuals served in a licensed service) to create more consistency and uniformity as each CSB does this differently. Or since all the data is entered into CHRIS, could reports be run in CHRIS by the provider, similar to care concern reports to avoid duplicate data entry.
Update some of the documents required for lower level services such as Outpatient Therapy.
We did not experiences these, thus were NA
When a provider is reaching out for assistance the process should be more helpful and provide more assistance without feeling like you’re doing something wrong or you’re a bother or should already know what you’re requesting for help. When calling and asking for assistance and you get no response at all is frustrating as well.
When licensing does inspections they give astronomical amounts of citations that must be responded to in a short period of time and it has been expressed from the licensing specialist that they are pressured to do things this way. It feels much like a punitive system of punishment for creating more burden on a provider to in a sense have to write hundreds of sentences as if we're being punished at school. As an example there is a staff file that goes back 10 years the licensing specialist comes in and finds that certain things in the initial application process are not within the file as those things were not in place 10 years ago and say some of those documents could have 30 different items on them. And maybe that staff works both in the residential home and in the day Support Program. We end up getting a citation for both programs and have to respond to every single one of the 30 items from one document instead of just getting one Citation for a document not being there. It is overwhelming I myself have had to sit there responding to almost 200 items which required the proper wording and documentation to be attached to each item. Furthermore the citations become very confusing as they say things like employee one two and three and individual one two and three and then you have all

these citations to respond to and you have no idea who one two or three is so how do you even respond to it. It's completely overwhelming especially when you have small providers that do not have the ability to have entire administrative staffs that take care of particular things but you have one staff who acts as a director, hr, care provider, driver, QA, risk manager, trainer, plan writer, hands on care, scheduling, etc etc I could list many more. It's maddening to many and you always feel like you're just treading water and about to give up.
While I understand the need for accountability, it feels like a duplication of work to document IRs and follow through with necessary action steps (i.e., investigations, accountability conversations, re-trainings, etc.) and to then have to report on those specific details to licensing, especially for smaller incidents that do not involve a safety concern or injury.
Work with DLCV, ACLU, & Legal Aid to continue to provide legal supports.
would be helpful to offer new providers up to a year of consultation and support to ensure they are successful.

9. Are there any other issues, considerations, or recommendations related to licensing requirements you would like the workgroup to address?

1) Forthcoming Licensing regulations have sections requiring the submission of substantively revised policies before implementation. This will create an additional burden, for both providers and DBHDS. Larger providers may have upwards of 100 policies and may update regularly. Other options include semi-annual submission of all updated policies or review during inspections. 2) Consider changing what constitutes a medication errors requiring investigation to be more in line with standards in medical settings. (Rights) 3) Do not implement requirements for training on plans in services where the writer is the provider (e.g., outpatient therapy) or for physicians and physician extenders. 4) Desk audits present a greater administrative burden than actual visits.
1. For a CSB, and having the requirement to provide emergency services, the reporting of psychiatric admissions is part of our responsibilities and question why this is reported to DBHDS. 2. The reporting of emergency room visits, is this needed? There are other ways to obtain this information. 3. Staff feel overburdened with internal and external oversight and the growing regulations, care concerns, etc. It feels crippling to do their jobs. 5. Feedback is provided during public comment periods regarding the administrative burdens that seem to have little impact. 6. The managing and cross referencing of the Quality Improvement Plan, the Risk Management Plan and Systemic Risk Assessment is burdensome.
1. RCAs are required for all level 2 which include sending someone to the ED. Psych and SUD facilities are not equipped with the diagnostic equipment to assess medical conditions and often have to send patients out as a precautionary measure. Having to "investigate" the necessity of these transfers puts an unnecessary burden on the provider when the provider is only looking out for the best interest of the patient. 2. Discharged patients/and families will often call back with complaints which we are required to place in CHRIS. Consider eliminating this requirement as it should only apply to inpatient population. The investigations are difficult to conduct as the patient is no longer available to meet with and will often not return calls. 3. Peer to peer events occur without injury and are often in the presence of staff. Consider eliminating the requirement to enter these into CHRIS. 4. Medication errors are reported as abuse/neglect and the employees are disciplined because of it. This is an old school approach to reporting errors. Fostering an environment of transparency and honesty should be the approach. If employees think they are in "trouble" they are less likely to report. Consider removing med errors as a reportable, unless the patient suffers an adverse event. The facility would still track, trend and educate but the stigma associated with making an error would be lessened.
48-hour submission into CHRIS or the next business day. The new OHR serious incident reporting (elopement, self-harm without intent to cause serious injury) mirrors licensing. This is extra administrative work.
A National including individual State format blueprints, in full, would be helpful to those Agencies in Research and Development and functioning as volunteer to help amongst the national domestic violence crisis poverty field which was revealed through the pandemic of COVID-19. The process of utilizing multi State Continuing Education Unit models, with diverse areas of concentration, has been exceptionally helpful for resource findings and awareness. So, the blueprints of how to access proper applicable branches of infrastructure partnerships on unique perspectives as they present themselves,

allowing definitely the Collaboration with other Federal and State Agencies already functioning at full capacity, is all Essential Action in times of crisis and domestic divisions missing any transparency trust.
addressing how human rights regulations work for minor children in the care of their parents. the current regulations take away parenting when the goal is for parents to parent their children
Align DMAS and DBHDS regulatory standards. Ensure synergy and congruence between the DMAS (WaMS) system and DBHDS regulations. Provide detailed trainings and guidance that clearly outline the expectations set by DBHDS regulatory standards.
Allow providers more time to focus on supporting individuals by lessening the administrative burden through more efficient processes that still allows for ensuring health and safety of the individuals.
Allowing more time for new services with Conditional licenses to get up and running before renewal needed. Currently only 6 months is provided but with the credentialing/contracting process with the MCOs taking so long, there is not sufficient time to get clients into service before the 6 months elapses and an inspection is required to renew the Conditional license.
Alternating Desk audits when licensing has visited the Provider previously.
Categorizing sexual assault as level III. It should only be a required reporting if it is related to service provision - occurred on the property or while receiving services. Providers are mandatory reports, reporting to both DSS and DBHDS particularly situations that occurred outside of the provision of services or prior to receiving services is needlessly duplicative to both systems and intrusive to the individual's privacy. The definition of abuse and neglect for DSS and DBHDS is not the same. Mandating that providers report to DSS for situations that do not meet DSSs definition is needlessly duplicative and non productive.
Charlottesville, for example, is an area of the Commonwealth that is almost-entirely lacking in services, partly due to the higher cost of living. These high costs prevent many potential providers from being able to start in the area due to lack of funding. Though licensed services can apply for Jump Start Funding, it is not accessible to those with conditional licenses, and not not fully cover the program's needs to get off of the ground in these high-cost areas. A possible solution to this could be to create another grant similar to Jump Start, but solely being directed toward those trying to become a provider in areas with high costs of living or within historically disadvantaged communities.
CHRIS and CONNECT systems need to be modernized. Increase the timeframe requirement for updates needed in CHRIS from 48 hours to 72 hours.
CHRIS functionality
CHRIS is obsolete and a new database needs to be developed where the incident and/or complaint is entered one time and based on the type of issue it routes to OLS or HR or both. It would also be great if it could interface with an EHR.
Clearer regulation requirements- often subject to interpretation of the auditor would help to have more focused training on regulations When I first started in field we had interpretive guidelines to better clarify expectations
Consider adjusting reporting timeline to three days, or establish exceptions to CAPs for all late reporting. Consider ER visit without treatment or treatment that could be provided by a PCP (antibiotics, etc.) to be a Level 1 incident.

Allow providers to determine if AWOL events warrant a neglect report, or establish a threshold or exception.
Consider including all provider types in the workgroup.
Consider licensing requirements related to education/license requirements for workforce. Consider creating experience based/skills based certifications when feasible to expand available workforce.
Currently being addressed.
Different agencies not being on the same page, dbhds employees that make judgments based on opinions. For example we had someone coming through inspecting for HCBS compliance that was Finding problems with everything in the entire setup which ended up costing the company hundreds of thousands of dollars for making changes shutting down homes moving people discharging people because they had a different opinion because when another HCBS inspection came through they found no problems with all the things that we had to change in order to receive compliance. It was absolutely outrageous. They're also needs to be some kind of place to file complaints or be heard when providers are having issues with particular dbhds employees such as having an issue with a CRC or some other state employee that seems to like to nitpick or be out right unprofessional or punitive.
DMAS and DBHDS work closer together so that there are no gray areas
Due to the high standards CARF and/or Council for Quality Leadership (CQL) accreditation, we are in favor of DBHDS relieving the licensing requirements, as well as reducing the frequency of inspections, for accredited providers that have had no health or safety violations.
Enhancement of oversight for providers who have a high frequency of Level II and III reporting. Enhancement of consequence strategies for providers who maintain high frequency of Level II and III incidents (training requirements for providers over a certain threshold, increased licensing specialists unannounced visits).
Enhancements to the CHRIS software are needed to allow more time to enter without the software timing out. The ability to run additional reports from the CHRIS software would be helpful, too.
For QA - person centered trainings for BH and DD would be helpful, to include examples of treatment plans and progress notes and person centered language. Education/experience for DD providers is not clear (example QDDP). Regulatory requirements around reporting within 24 hours is very cumbersome for staff, as there has to be 24 hour coverage to include weekends, when DBHDS is not working on weekends and does not receive the report until the next business day.
Has this survey been offered to service recipients themselves?
Having Day Support ratios that vary based on level of support needs and are reflected in the rates (more than currently with the different SIS scores) would provide more opportunities for individuals to be successful in services like these. We are turning away a lot of people who have more support needs than can be met in a 1:7 ratio. Many individuals have significant toileting needs that require 1:1 attention for extended periods of time which is challenging to balance along with individuals who have significant behavioral challenges. The system needs to be designed to support people with more varying needs without requiring them to stay home or in other more restricted environments.
Having ongoing trainings such as a series of training sessions that build on each other for risk management and quality improvement plans and the organizational risk assessment would be helpful.
Having updated policy changes and other changes in one central location. The DBHDS website is like a maze for finding information.

Home based services are VERY different than residential services and should not fall under the same reporting and other requirements.
How citations are issued. One citation is spread out to create six or more citations.
I have only been licensed since November 2022, so have not had much experience with what is being mentioned with the exception of incident reporting- CHRIS systems could definitely use updates as it is frustrating when it is timed out and kicks you off. QA/QI can be a burden on administrative staff. As a new provider, I was Cited for my orientation dates, not being within the 15 business day window of our staff being hired. We had a hire date of July, but waited to educate everyone closer to our licensing date, of November, because we were not sure how soon we could orient everyone with the trainings without being licensed. I think that for new providers, that needs to be clear so that they don't get cited. I think they need to know that it does not matter if they had their trainings a year prior to being licensed as long as the original trainings, are within the 15 business days. That was not clear to us. Maybe now that will not be an issue since they are not waiting as long to license new providers, where we were in the process for a year and a half once placed on the list.
I think general contact would be helpful. Sometimes it seems we only talk to our DBHDS specialist if we're adding a new service or if we have a problem. I am always wanting to improve relationships and procedures.
I would advocate that RN's do not need to be certified as QMHP-A's to do their job. It's a very foreign designation for nurses and none of them have this credential.
I would like to see a more user friendly DBHDS website. Maybe alphabetize to streamline search results. This could makes policy findings easier.
I would look at the reports we have to complete in Chris. They are not user friendly. Also, on a training webinar, I asked if all Abuse claims would also be a serious event. I was told that was a gray area - sometimes yes, sometimes no. If the instructor for DBHDS cannot answer that question, how do you expect a provider to answer that question. We have gotten reprimanded for not doing both. I think 2 reports on the same event that goes to the same organization is extremely burdensome and duplicative.
I would love for the DELTA system to work with Google Chrome.
I would recommend: Resuming in person provider round tables (which all provider the opportunity to connect and share) Highlight best practices observed in the field and share with all providers
If reporting has to be completed, most if not all accredited organizations have other SSE reporting systems. This additional reporting leads to extra work for staff. Allow or develop a data feed from the Chris system that will allow providers to upload and/or link already reported data to flow into the Chris system.
If there is serious consideration being undertaken to reduce administrative burden for providers that are also accredited it might be helpful to consider those accreditation standards that are the same as and/or similar so there does not continue to be administrative and duplicative work for providers (i.e. risk management, quality plans and metrics, financial administration, and workforce development (Humanr resources, requirements and competency based trainings) and Health and safety requirements
If we could install a grace period of reporting incidents (48 hours) along with a new time frame of reporting would be excellent. The goals is that DBHDS wants to know when incidents occur correct? My fear is that providers are going to begin to not report because of the strictness. Also staff turnover and training with the providers we are experiencing in workforce right now is a challenge to say the least.

Instead of stopping attendant pay during a Service Authorization pend(s) stop pay to the Provider for that one Consumer. Shorten the Service Authorization pend from 30 days to 7 days. Pends result in no attendant pay and attendants quitting. Give Consumers control during an annual Service Authorization. State the reason for a pend to the Consumer. (accountability on submitted on correct date, transparency for reason for pends, etc) Stop the split of hours when an individual receives services through an Agency. Because as a Consumer I need to use those hours for my CD attendant if the Agency Directed is absent for work. As a Consumer I ask for a way to see what hours Agencies bill to Medicaid. Currently I don't know if Agencies are being paid for hours not worked. Currently, Consumers aren't given an opportunity to verify that agencies are billing for the correct amount of hours. The attendant pay rates increase with how the care setting most resembles an institution. Count Consumers in data collection to funded to show how many Consumers have hired an attendant (who lives outside the home) by using annual data going back ten years. Use this data to show the requirement to end inequable attendant pay rates in the 5 care settings and to show that funds must be redirected to pay Consumer Directed in-home attendants a living wage.
It would be helpful if the department considered using a threshold or formula prior to citing providers for late reports that would take into consideration their size and scope. Our agency has approximately 600 clinical staff that can complete an incident report at any given time; there will naturally be human error due to the volume of reportable incidents for larger organizations. For example, to address a systematic issue could the department cite agencies if they exceed 5 % or more for late reports within a 6 month time period? For example, RBHA reported 391 level II and III incident reports in the calendar year of 2020; we received 13 CAP's for citation 160. D 2 during the same calendar year. This reflects a 3.32% of all of our reportable incidents, which we would not consider a systemic issue across the agency. We are also no longer able to make recommendations/suggestions when submitting CAP's in CONNECT. Where/how should providers include this feedback to DBHDS?
Learning and explaining to providers about insurance. It can be issuse to have to prove and provide 90 days of evidence of funds. When insurance doesn't approve contracts for at least 45 days to 7 months and funds go strictly to renting an office space! As a new provider that's been the biggest issue. We have show all these things but most don't start making revenue until 3 months into opening. Also, when trying to add on a service the company still has to prove of a day 90 budget. Some services shouldn't require to have to show proof of funds because adding on that service could help with business revenue and the community needs.
Length of time to add a service and communication from assigned licensed specialists who is our point of contact
License by Level of Care and Type of Service and have the Policies & Procedures reflect this!
License Specialist must consult with the provider during the inspection to review what areas are not in compliance or give provider time to locate document or "proof" of compliance, so the provider is not surprised to see a written non-compliance report of a regulation not previously discussed during or in an exit interview. A provider in good standing (or not) subjected to unannounced inspections without considering the provider's schedule. At least give a week's notice so a provider can respond if a particular day will be a schedule conflict. Note, the license department schedules unannounced visits according to their own schedule.

Make sure the licensing, HSAG, Human Rights and DBHDS in general can share information between them especially for inspections etc.
Medication procedures for people who do not need administration but just assistance specifically in programs that are not 24/7.
Merging portals (MES/CHRIS/WAMS etc...) or having a landing page that point to portals providers need to access to.
More time to submit desk review documentation. Schedule inspections so that a dialog can occur between provider/director and licensing specialist to as not disrupt the resident's environment/service …rather than "unannounced." Consistency in what is being reviewed. Through out the years, our experience is that each specialist has a different set of priorities. Lastly…. The process is demeaning. A good provider is given citations for a missing signature or a single word. If this could be a discussion for correction rather than a "hit" it would help!
More training on licensing expectations
My agency prefers onsite reviews over desk audits. It is too cumbersome to scan, label, upload and decipher each regulatory body's preferred method of file transfer. Often information is missed during a desk audit that may be present and without face to face questionining and ability to explain.
n/a
NA
need more oversight and monitoring of providers that are not meeting the expected standards of quality care for individuals preferably before things get really bad.
No
No.
None
None
None at this time.
Not at this time
Not at this time.
not imposing a licensing reviewer's interpretation of the regulations as a requirement - if the item is not in the regulation, then the issue cannot be cited. Address that human rights apply to active individuals in licensed services. Align DBHDS training requirements with the State Performance Contract training requirements. Definition of medication error - narrow to prescribed medications. Remove the requirement for First Responder training under Detoxification Services - not really clear as to what this is.
Nothing that I can think of at this time
Offer ongoing, regularly scheduled (virtual) trainings on the Licensure Regulations, so that new staff or staff who need a refresher can access the training and receive any important updates. The training could even be recorded, as long as the content remains up-to-date. Another option is to send out brief reminders about different sections of the regs, via a newsletter.
One size fits all approach to late incident reports. We have a 98% on time rate but are still considered frequently late based on the current process
Ongoing changes within DBHDS with licensing specialist has made it very difficult to obtain quality rapport. If there could be some type of direct provider advocacy line or e-mail available where we

could ask questions about various changes or requirements, it would be much appreciated! There have been 3 different occasions within the last 2 years where our agency did not have an official licensing specialist assigned. This made it almost impossible to obtain service renewals as well as ask questions about the multitude of changes that have been taking place.
Over regulating is a clear danger to designing a new framework of regulations. Home based services are very different from other congregate settings, which tends to be lumped in with these other settings and can become so strictly regulated that it loses the Person-Centered focus that is the setting's strength.
Patient complaint process- can DBHDS determine if a provider's resolution is reasonable and make the "appeal" process less burdensome? Individuals will sometimes demand resolutions that are not reasonable and continue to escalate a complaint after the provider has offered very accommodating resolutions.
Please insure licensure specialist are correctly reading and applying the regulations
Please provide written guidance on reporting medication errors in CHRIS. At times, we receive different information from OL and OHR specialists on similar incidents. When regulations are changing, please seriously consider comments that are posted and make changes when needed. This would help build a more cohesive relationship between OL and providers.
Please reduce documentation expectations on clinicians
Prioritize the team work and training opportunities between agencies and providers vs. the citations and punitive reviews.
Provider enrollment issues
Reduction in administrative burden. Reduce audits that consist of same information. Conduct more desk audits with EHR access to reduce administrative burden. Relax reporting Level II and Level III to next business day as DBHDS does not review incident until next business day.
Remove Unannounced visit. Schedule all Licensing/inspection visits to programs/providers.
Reporting on weekends - many reporting staff do not work weekends
Required use of the CONNECT Portal for communication. It is not very user friendly.
Requirement of medical emergency drills
review of medications administered is too vague leaving providers to interpret what is acceptable best practice. Where is the follow-through when something is found with a consumer in one setting due to the quality of care in another setting?
See above.
See above.
Stop group homes from taking their residents earnings and exploitation people with disabilities. This is modern day slavery and is equivalent to a plantation mentality. This should not be allowed at all in a HCBS setting. Who works for a paycheck and the group home provider gets rich. How awful and unfair! Isn't this a work first state, it was never purported that the group home provider can take the individuals paycheck and enhance their own pocketbooks. This should record and tracked by the IRS, to prevent tax evasion, and the behavior of they work for it, but we keep it. This should be illegal and is newsworthy that the state in HCBS settings allows this to occur! Please stop individuals from being financially exploited and abused!!!!!!!
Streamline HCBS, HSAG and Licensing reviews. We were sending the same information to each entity. The administrative burden is significant and very time consuming. In some cases, the agencies

contradict each other. It is hard to know how to address findings, especially between Licensing and HCBS.
Streamlining the process for entry into services to be more consumer friendly. Reducing data reporting requirements to be more strategic and outcome-focused.
the above
The background check process takes a lot of time and money to complete and then the staff does not stay on the job. Job Recruitment & Retention needs to be addressed.
The CHRIS system time-out is an issue. The interface of the platform is not user friendly or setup in an innate or intuitive manner. Also, for small providers that may be dealing with an emergency and it is an ongoing matter. The 24 hour reporting time can be easily missed. I believe that a 48 hour reporting window for most incidents is reasonable. But when you are dealing with an ER visit, getting the individual back home and setup, picking up new medications, informing staff and reviewing new care protocols--that in and of itself can take up the 24 hour period.
The CONNECT/MES/CHRIS are very difficult to utilize and maneuver especially when they are constantly being updated and changed and timing out.
The constant auditing and oversight of programs and services by other entities (HSAG, HCBS) that consistently drain the resources of time and energy from program staff, managers and directors.
The credentialing process once you are license.
The expectations for evidence based/BRAVO practices make it more difficult for providers to manage those services. FFT, for example, could be licensed under an outpatient or IIH license as they ask for 90%+ of the services to be provided within the home. We are exploring current evidence based programs and consistently hear that it is impossible to keep a service going without contracts with DJJ or CSA that allow for per diem costs as Medicaid's unit rates are not sustainable considering the costs to provide the evidence based services. MST, alone, is $56,000 annually to remain certified, without including any salary, administrative, or overhead costs. Medicaid rates and funding do not make the evidence based programs attractive or sustainable to providers, especially smaller providers.
The focus is so heavily on the ID/DD services and I do understand that but after the trainings I felt there was so little on MH services. This has likely lead to our on going discussions of - Is this reportable?
The hiring requirements for DSP's
The impending plan to greatly expand and increase the expectations for providers with the proposed changes to the regulations which will obliterate any potentially good work completed to lessen the administrative burden to providers.
The increasing rate of DSP turnover.
The internal abuse investigation process and requirements are extremely unrealistic for small providers to follow. The burden on the staff responsible for the investigation completely halted our operations for 8 business days.
The QSR be reduced to one per year and not completed within the same timeframe as the annual inspection.
The reviews are done in a black and white manner. If one personnel chart does not have evidence of one required training, then there's a CAP. There will never be perfection. The reviews might consider reviewing 10 charts and report on a pattern rather than one incident.
There is no straightforward way for ASAM 3.5 to have the meds onsite to provide withdrawal management services to clients coming in
Those conducting prescreening evaluations under the proposed EDCOT diversion law proposed by the UVA Institute of Law Psychiatry and Public Policy, and under study by the Virginia Legislature Behavioral Health Commission, should be at least Masters level or above with specialized training in

Virginia civil and commitment competency law for those accused of misdemeanor offenses. . Evaluations of felony offenders with histories of SMI should continue to be evaluated by doctoral level licensed forensic psychologists or board certified forensic psychiatrists meeting the Institute's current certification requirement.
Though both offices have increased their trainings to the community, the process of just reading the regulation is not helpful. More examples of how the regulations play out in day to day services would be helpful. Recognizing that all providers do not provide services impacted by The Settlement. The inclusion of mental health and substance disorder services into trainings. Hopefully reducing the administrative tasks of providers will also reduce the administrative functions of licensing and human rights specialist, so that they may be supportive and informative in the development and implementation of regulations to achieve and maintain effective services.
Timeframe for reporting is extremely burdensome to the CSB. The expectation to do within a certain timeframe with no flexibility also causes stress on staff for Level 2 and 3. If the client was actually abused by a staff person or accused of abuse from a staff person, then I could see the need for a more shift timeframe, but not if a client gets psychiatrically hospitalized or goes to the ER for a medical condition. It just seems that way too much information is being reported, unnecessarily.
Timing out of the CHRIS software and reporting timelines for serious incidents.
Training Academy for DSPs to create universal training for DSPs (besides current DBHDS DSP Training) for DSPs & Supervisors to access for free. Human Rights Training with situational examples of abuse/neglect, HCBS training, Emergency Preparedness, Serious Incidents (at least with need to report what type of incidents- with providers following up with their policies) to start and the competencies being taken and stored in state system that then follows the DSP between providers if they change where they work and allows auditors to see these trainings. Same idea for DSP Competency and Advanced Competencies being completed and stored in state system for auditors and alerts providers of upcoming due dates for new hires and annuals.
Understanding that this oversight is necessary to ensure the wellbeing and safety of those we serve, it would be very helpful to look at how they are being conducted and scheduled. Having HCBS and licensing review asking for the same information - means we spend a lot of time compiling the same data and then working to provide it in a different manner for each review. Why can't there be a consolidation of these efforts so we are not jumping through the same hoops in a different order, over and over. CARF does a thorough review and all three groups seem to be looking for the same things, but definitions and processes are different which adds admin focus that can take away from our time to provide the best services. The focus at times from DMAS/HCBS, CARF and DBHDS on very important concerns like Risk Management needs to be wrapped up in packages that are saying the same thing, but each organization seems to want the format to fit their expectation.
Universal state training for DSP's. Bring back the College of Direct Supports for DSP/Frontline Supervisors.