COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

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August 3, 2023 UPDATED - *with combined recommendation matrix responses*

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.
2. **Recommendation Matrix:** In order to further develop the workgroup's recommendations to include in the department's report to the General Assembly, the use of a template as attached will be used to make it easier for the legislature to have a sense of the consensus and concerns of workgroup members. **Use this template and submit back by noon next Wednesday**, so that the responses can be compiled by the next day to facilitate discussion at the next meeting.

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 logistical questions, contact 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 #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 July 27th Meeting**
1:10 – 1:40 PM	**II.**	**CARF Presentation**
1:40 – 3:05 PM	**III.**	**Review Revised Draft Recommendations**
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	**Circe Black**	blackc@rbha.org
Advocacy-Providers	Virginia Association of Community Services Boards	**Nicole Lewis**	nlewis@southsidebh.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	Virginia Board for People with Disabilities (state)	**Teri Morgan**	teri.morgan@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

Sent: Friday, June 23, 2023 3:28 PM
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.

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 27, 2023

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Updated Agenda for Meeting #2, July 27, 2023

I. Introductions and Summary of July 20th Meeting (1:00 – 1:10 pm)

II. DBHDS Licensing and Human Rights System (1:10 – 2:00 pm)

III. Discussion (2:00 – 2:30 pm)

IV. Development of Workgroup Recommendations (2:30 – 3:25 pm)

V. ~~Public Comment (3:05 – 3:25 pm)~~ *No requests received.*

VI. Conclusion (3:25 – 3:30 pm)

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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.

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; 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	Circe Black; Nicole Lewis
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

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.

Summary of July 20th Meeting: Survey Results

- Reviewed survey results.
  - 86% identified as providers; 10% not providers; 4% no response
  - Most burdensome requirements:
    - Annual inspections.
    - Reporting serious incidents.
    - Implementing risk management and quality improvement requirements.
  - Over 70% support changes to reporting requirements:
    - 49% support reporting by next business day.
    - 23% other (48 hours, 3 business days, 2 business days, etc.).
    - 28% supported no change to requirements.
- Reviewed approaches to accreditation in other states.

Summary of July 20th Meeting: Discussion Questions

1. **Based on research from other states that are using accreditation, it may be advisable to begin with a pilot program. What recommendations does the group have for structuring a pilot?**

2. **What other background research would be helpful before moving forward with implementation of deemed accreditation?**

3. **Some states that use accreditation to deem licensing compliance have also required accreditation as a pre-requisite for licensure. Is this something that should be considered?**

4. **There were many recommendations to change the requirement for reporting serious incidents and complaints involving abuse/neglect from 24 hours to next business day.**

Development of Workgroup Recommendations

RECOMMENDATION 1: Changes to reporting requirements.

a. Amend regulations to change requirements to report allegations of abuse, neglect, and exploitation and level I and level II serious incidents from 24 hours to within the next business day.
b. Amend regulations to change the definition of what types of incidents are required to be reported within 24 hours.
c. Amend regulations to require different time frames for residential vs other services.
d. Amend guidelines for issuing citations to allow consideration of the provider size, and number of late reports as a percentage of all reports.
e. Make no change to reporting requirements.

RECOMMENDATION 2: Changes to inspection requirements.

a. Amend the Code of Virginia to allow providers with triennial licenses, without significant or unresolved health and safety violations, to be inspected once during their license period.
b. Leverage inspections and investigations from other agencies to reduce the number of reviews that occur.
c. Create central repository for documents that can be shared across different agencies and review entities.
d. Make no change to inspection requirements.

RECOMMENDATION 3: Accreditation.

a. Amend the Code of Virginia to allow providers that are accredited by a recognized national accreditation body, to have reduced frequency of inspections.
b. Conduct further study to determine how to best utilize accreditation status to minimize the administrative burden associated with licensing. This would include evaluating outcomes in other states that utilize deemed accreditation; conducting a crosswalk of accreditation organization standards with licensing requirements. This would include a request for funding.
c. Make no change - do not include a consideration of accreditation status in licensing oversight.

Virginia Department of Behavioral Health & Developmental Services

Number of Licensed Services by License Status

License Type	#	%	Definition
Triennial	1998	45	Services that have demonstrated full compliance with all applicable regulations and where violations during the previous license period did not pose a threat to the health or safety of individuals receiving services, and the provider or service has demonstrated consistent compliance for more than a year and has a process in place that provides sufficient oversight to maintain compliance.
Annual	1643	36	Demonstrates compliance with all the applicable regulations. *The term of the first full renewal license after the expiration of a conditional or provisional license shall not exceed one year. *Over 300 on an annual license because of the above regulatory mandate.*
1st Conditional	488	11	Issued to a new provider for **new services** that demonstrates compliance with administrative and policy regulations but has not demonstrated compliance with all the regulations.
2nd Conditional	310	7	A conditional license may be renewed if the provider is not able to demonstrate compliance with all the regulations at the end of the license period.
Provisional	02	<1	Issued to a provider for a service that has demonstrated an inability to maintain compliance with all applicable regulations, including this chapter and 12VAC35-115, has violations of HRs or OL regs that pose a threat to the health or safety of individuals, has multiple violations of HRs or OL regs, or has failed to comply with a previous corrective action plan.

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Virginia Department of Behavioral Health & Developmental Services

Varying Statutory Purview

STATUTORY PURVIEW OF THE OFFICE OF LICENSING

OL licenses providers defined as: *Any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse or (ii) residential services for persons with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization*

DBHDS Licensing (What OL does)	Purview of Providers or Other Government Responders (What OL does not do)
• License and monitor providers ongoing compliance with regulations. • Follow up with provider regarding their response to an incident	• Providers: Manage or supervise daily operations & intervene directly in an incident
• Review and triage incidents to provide technical assistance, make initial determination of regulatory compliance, decide if further action is warranted, track and trend data to determine areas for quality improvement initiatives.	• Case Management: provide assistance to individuals and family to locate, link or obtain needed services and resources. Monitoring the individual to assess ongoing progress and ensuring that authorized services are delivered;
• Investigate incidents as needed. • Investigate complaints. • Provide training and regulatory technical assistance.	• First responders: person(s) who are trained and authorized to **provide immediate assistance** in an **emergency.** Often dispatched by a **911 operator** or an **ambulance service** to respond to **medical or safety emergencies**.
• Collect, track and trend data	• Protective services: operate a hotline 24/7 to receive incidents and complaints (such as the CPS/APS hotline specialists).

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Current Requirement

RULES AND REGULATIONS FOR LICENSING PROVIDERS BY DBHDS

[12VAC35-105]

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

Virginia Department of Behavioral Health & Developmental Services

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Role of the IMU

Virginia Department of Behavioral Health & Developmental Services

ROLE OF THE OFFICE OF LICENSING: SERIOUS INCIDENT REPORTING

The OL Incident Management Unit (IMU) reviews incidents to:

- **Determine** -
  - Whether the incident meets the criteria of a reportable incident (Level II or Level III);
  - If the incident is reported within mandated time-frame;
  - If the incident has sufficient information to be able have a clear and complete picture of the incident and the provider's response.
- **Contact** the provider with questions, or if there are potential concerns, seek additional information or clarification.
- **Triage** any level II and level III incidents to a licensing specialist (LS) if there is a concern about a potential regulatory violation.
- **Identify situations** meeting care concern criteria to triage incident to other offices as appropriate (Office of Integrated Health, Office of Human Rights) for technical assistance and support.

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Virginia Department of Behavioral Health & Developmental Services

Risks, Triggers, and Thresholds

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

- DBHDS has defined several risk triggers and thresholds that the Incident Management Unit tracks and triages using the CHRIS system. These are also known as care concerns (CC).
- Providers need to track on an ongoing basis their organization's serious incidents and care concerns.
- Care concern thresholds are:
  - Multiple (two or more) unplanned medical hospital admissions or ER visits for falls, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a 90-day timeframe for any reason.
  - Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional.
  - Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR.
  - Multiple unplanned psychiatric admissions within a 90-day timeframe for any reason.

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Virginia Department of Behavioral Health & Developmental Services

Result of DSI Reporting: Investigations/Care Concerns

Death or Serious Incident	Count of Death or Serious Incident	Count of Investigation	Percentage of Investigation	Count of Corrective Action Plan	Percentage of Investigations that resulted in CAPs	Count of CAPS Labeled as Health and Safety	Percentage of CAPs from Health and Safety
Death	1724	553	32.08%	98	17.72%	17	17.35%
Serious Incident	20949	332	1.58%	71	21.39%	12	16.90%
Total	22673	885	3.90%	169	19.10%	29	17.16%

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Role of IMU/OL related to Death and Serious Incident Reporting (cont)

- IMU is charged with **tracking and trending** incident data to discover patterns, identifying trends for individuals and providers, and to inform DBHDS senior management and external stakeholders of patterns and trends.
- The data and information is **aggregated, analyzed,** and used to identify sources of and contributing factors to risk and/or to evaluate existing systems.
- The data and information is used to **inform providers on potential risk and actual risk.**

- OL helps to ensure **compliance with the quality and risk requirements outlined in the regulations**; several of them are tied, in some way, to the reporting and reviewing of incident data.

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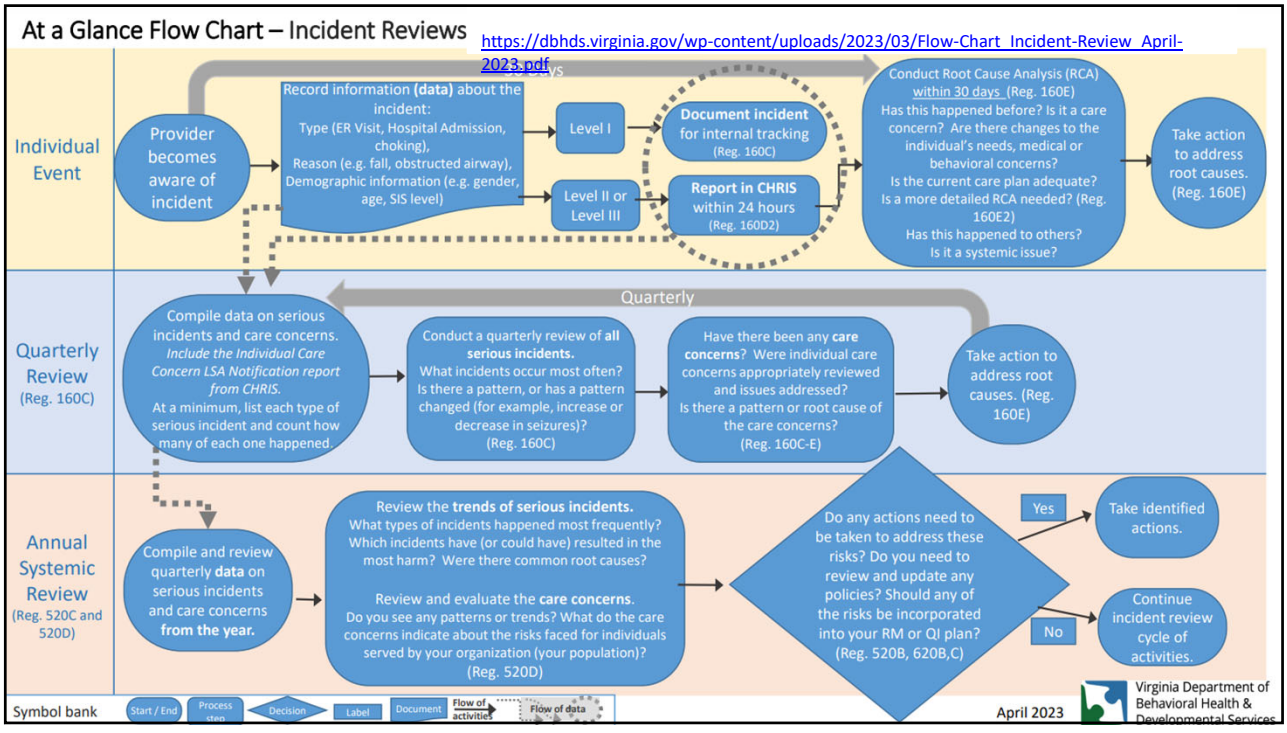

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Regulations

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Statutory Purview of the Office of Human Rights

What OHR Does	What OHR Does Not Do
• Monitor providers ongoing compliance with regulations. • Investigate and Examine all conditions or practices. • Provide training and regulatory technical assistance to individuals, family members and providers. • Represent individuals making a complaint. • Provide oversight, training and technical assistance to Local and State Human Rights Committees. • Track and trend data to determine areas for quality improvement initiatives. • Review reports of alleged violations to provide technical assistance, make determinations of regulatory compliance, and ensure due process for individuals.	• Providers: Manage or supervise provider daily operations. • First responders: Provide emergency medical care (EMS). • First responders: Provide emergency safety and other legal interventions (law enforcement). • Protective services: Remove individuals from immediate danger per statutory authority under very specific circumstances (APS/CPS).

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Reporting Abuse, Neglect, Exploitation (ANE): 12VAC35-115

Providers must report each complaint involving ANE via CHRIS within 24 hours of receipt of the complaint.

Providers must also take specific actions immediately or within 24 hours

- Contact Individual about the complaint
- Take immediate steps necessary to protect individual from retaliation and harm
- Notify the Legal Guardian
- If a crime is suspected, notify law enforcement
- Initiate impartial investigation ASAP
- Cooperate with any ANE investigation by local DSS

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"Process" Reporting vs Incident Reporting

Provider makes initial entry of ANE in CHRIS	Provider investigation must begin as soon as possible	Provider Director has 10 business days to decide	Identify and Implement Corrective Action	At Any Time. . .
Daily review and triage of reports	Ensure ANE investigators are trained	Ensure facts support finding	Ensure actions are appropriate	May conduct independent review
A.I.M. Response for priority complaints	Ensure thorough review of facts and evidence	Ensure notifications to Individual/Guardian in writing	Issue citations for identified violations	Ensure desired relief of individual
Individual informed of complaint resolution process	Monitor timeline and grant extensions as apporpriate	Assist individual with appeal, if applicable	A.I.M. Follow Up Response	Review data to discover patterns and identifying trends

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ANE Complaints with AIM Response

In FY23 licensed community providers (including CSBs) reported 9,447 complaints involving ANE in CHRIS. 119 (1.26%) complaints were identified as priority and resulted in an AIM Response.

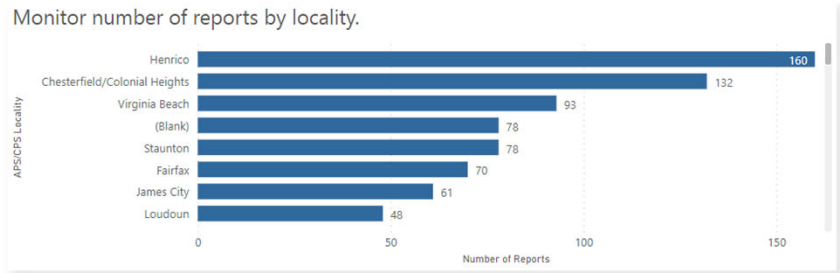
To assure a safe environment for individuals receiving services and to ensure follow-up on all substantiated complaints involving ANE, the Office of Human Rights established the A.I.M. Protocol in March 2019.

"A.I.M." represents the Advocate response of:

- **A**ssessing and **A**ssuring safety for the identified individual, as well as other individuals receiving services;
- **I**nitiating the DBHDS complaint resolution process; and
- **M**onitoring provider follow up through verification that the provider has completed an investigation and implemented appropriate corrective action(s).

High priority complaints, defined as any allegation of sexual assault; restraint with serious injury, and physical abuse with serious injury, receive an advocate response that includes an onsite visit within 24 hours of notification. Substantiated complaints result in an onsite review and verification of corrective action(s).

APS/CPS Referral Data: July 1, 2022 – June 30, 2023



Total Number of APS/CPS Reports Received

1236

Number of Valid APS/CPS Reports Received

1010

Number Unreported through CHRIS

352

Percent of Late/Unreported Through CHRIS

27%

Number of Late/Unreported Substantiated

29

Questions for Discussion

1. What are the benefits of requiring reporting of serious incidents and ANE to DBHDS within 24 hours?
2. A majority of survey respondents suggested changing the reporting requirements to next business day or later:
   a. What would be lost/what are the risks in doing this?
   b. What additional safeguards would be needed to make this change?
3. More than ¼ of respondents supported leaving the requirement in place.
   a. Are there other ways of reducing unnecessary administrative burden related to reporting?
4. What other strategies should this group consider?

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Development of Workgroup Recommendations

RECOMMENDATION 1: Changes to reporting requirements.

a. Amend regulations to change requirements to report allegations of abuse, neglect, and exploitation and level I and level II serious incidents from 24 hours to within the next business day.
b. Amend regulations to change the definition of what types of incidents are required to be reported within 24 hours.
c. Amend regulations to require different time frames for residential vs other services.
d. Amend guidelines for issuing citations to allow consideration of the provider size, and number of late reports as a percentage of all reports.
e. Make no change to reporting requirements

RECOMMENDATION 2: Changes to inspection requirements.

a. Amend the Code of Virginia to allow providers with triennial licenses, without significant or unresolved health and safety violations, to be inspected once during their license period.
b. Leverage inspections and investigations from other agencies to reduce the number of reviews that occur.
c. Create central repository for documents that can be shared across different agencies and review entities.
d. Make no change to inspection requirements

RECOMMENDATION 3: Accreditation.

a. Amend the Code of Virginia to allow providers that are accredited by a recognized national accreditation body, to have reduced frequency of inspections.
b. Conduct further study to determine how to best utilize accreditation status to minimize the administrative burden associated with licensing. This would include evaluating outcomes in other states that utilize deemed accreditation; conducting a crosswalk of accreditation organization standards with licensing requirements. This would include a request for funding.
c. Make no change - do not include a consideration of accreditation status in licensing oversight.

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Next Steps: Recommendations Development and Measure of Consensus

EXAMPLE from Recommendation Matrix
RECOMMENDATION 1: Changes to reporting requirements.

Policy Option	Panelists Support	Panelist Concerns
Option 1: Amend regulations to change requirements to report allegations of abuse, neglect, and exploitation and level I and level II serious incidents from 24 hours to within the next business day.		
Option 2: Amend regulations to change the definition of what types of incidents are required to be reported within 24 hours.		
Option 3: Amend regulations to require different time frames for residential vs other services.		
Option 4: Make no change to reporting requirements.		

Next Meeting

August 3, 2023, 1:00 – 3:30 pm

Public Comment

- Email Susan.Puglisi@dbhds.virginia.gov
  - By 5 pm August 2nd: Sign up to speak at August 3rd meeting.
  - By 10 am August 3rd: Submit written comment.

RECOMMENDATION 1: Changes to reporting requirements.

Policy Option	Panelist Support (Y/N)	Panelist Concerns
1. Option A: Amend regulations to change requirements to report allegations of abuse, neglect, and exploitation and level I and level II serious incidents from 24 hours to within the next business day.		
MHA-VA	YES - State agencies using these reports only review and take action on this information during regular working hours - no reports are evaluated on evenings, nights, weekends, and holidays. Since no action is taken during non-business hours, no additional harm is created with this change. Further, this change will reduce organizational costs because staff trained to complete these reports must now work weekends and holidays with the current requirement to submit them within 24 hours of the event.	The Government is imposing undue burdens and associated costs on providers. In response, representatives from state agencies suggested that the accuracy of the reports would be compromised if the 24-hour requirement was removed. However, no data or experience supports this claim. Furthermore, organizations shared that internal requirements already document events as they occur, and the employees who complete the required state reports use this information. This internal process could remain in place with this option while still cutting administrative costs for organizations.
Pinnacle Treatment	Y	Reporting timeframe should be changed to 48 hours. Not only would this align more with other states, but there are several items Executive Directors are responsible for that must happen immediately after a Level II and III incident. Often, the ED is still handling the situation, gathering all necessary information, ensuring the patient receives proper care, and proper reporting is provided internally. Allowing additional time for reporting to CHRIS would ensure more complete and comprehensive filings.
VACBP	Y	The VACBP strongly supports this change, which will ease the burden on providers, particularly those that do not operate 24-7, while not jeopardizing the health and safety of those they serve.
VACSB	Y	We support the proposed amendment to change the reporting requirements for allegations of abuse, neglect, exploitation, and level II and level III serious incidents from 24 hours to within the next business day. We are convinced that this change is a crucial step towards enhancing incident reporting and ensuring the welfare of the individuals served. Making this change would have a low risk of negative impact on individuals served. The acknowledgment that the Department of Behavioral Health and Developmental Services (DBHDS) does not take immediate action on reports during non-business days and beyond simple information review underscores the need for more efficient reporting practices. Moreover, the argument that all Community Services Boards (CSBs) typically provide residential care highlights the importance of a unified reporting system. Changing the requirements for different types of services might lead to increased administrative burden and confusion, as providers would have to manage multiple reporting standards. By implementing a standardized reporting timeframe applicable to all services, we can simplify the process and enhance consistency in incident management. A Aligning the reporting deadline with the state's operating hours (Monday to Friday, 9:00 AM to 5:00 PM, excluding holidays) is a practical and sensible approach that poses no additional risk of harm to individuals. Immediate actions to protect individuals (e.g., staff reassignments, obtaining medical treatment, making emergency notifications would still be expected to occur. It is only the administrative tasks of notification to DBHDS that would be deferred; the majority would likely be submitted to DBDHS by midday on that next business day, so it is unlikely for there to be a significant lag for any actions DBHDS might need to take.. It strikes a balance between responsiveness and the realistic constraints faced by DBHDS. In conclusion, we firmly believe that amending regulations to require reporting within the next business day is an essential step towards improving incident reporting practices. It streamlines the process, minimizes administrative burdens, and promotes consistency across all service providers

		without negative impact on individuals served.
VHHA	Y	Benefit communication and promote more comprehensive information being submitted via the reports. Adjustments to the timeline would align with the timeline of when reports are actually being reviewed. Level 1 incidents are usually not reported in this manner, did the option mean “level II and III”? We would support changing the time from 24 hrs to next business day. *Would prefer level 1 continue with tracking for noted trends and available for review during licensure/survey or request versus reported. *Suggest a review of the RCA (Root Cause Analysis) process and propose a reduction of required RCA’s unless significant injury/incident is involved. Weekend coverage to enter CHRIS reports can be challenging with various internet access and reliability issues. Business days and holidays, Can A&B be combined Level 1 should not be reportable
VNPP	N	Revise to read “Within 24 hours or Next Business Day if incident occurs on a weekend or holiday.” NBD reporting would REDUCE time providers have to report during work weeks and would not reduce regulatory burden. With this revision, we would support Option A.
DARS APS Division	Yes	More of a comment-since DBHDS doesn’t review incoming reports until the next business day, I am unclear why the provider needs to submit reports in 24 hours. On the other hand, the provider is still required to report suspicions of abuse, neglect, or exploitation to APS immediately so if the provider is making a report to one entity, I am not sure why a report to DBHDS can’t be made at the same time.
DMAS	N	We do not have enough information/data to proceed with this recommendation. Need to understand what types of consequences (positive or negative) would arise from this change before making this change. Would also want to attempt to align any changes to DBHDS regulations with the contract requirements of DMAS health plans. Currently, we are aligned with reporting incidents within 24 hours. It is DMAS’ understanding that these incidents are being tracked and care coordination is occurring for those that warrant, however, this is not happening on non-business days. Managed care has federal requirements for preventing, detecting and remediating critical incidents and is required by the contract with DMAS to have policies and procedures to address critical incidents. Managed care also potentially brings new opportunities for partnership given their role in network management, quality oversight, and provider training and development.

1. Option B: Amend regulations to change the definition of what types of incidents are required to be reported within 24 hours.		
MHA-VA	NO.	Increases complicity – with corresponding concerns about implementation.
Pinnacle Treatment	Y	Currently all Level 2 and 3 in Chris need to be reported Recommend only 3 is required.
VACBP	Y	The VACBP believes that the most serious of incidents may warrant being reported within 24 hours; however, this should depend on how the information will be used. If the reported information will not be acted upon to protect the health and safety of the individual involved as a direct result of the report within the 24-hour timeframe, reporting by the next business day should be sufficient.
VACSB	Conditionally	We conditionally support for the proposed amendment to change the definition of incidents that are required to be reported within 24 hours. While we believe this adjustment has the potential to enhance efficiency and accountability, our support hinges on the implementation of clear and well-defined lines to avoid unnecessary administrative burdens. Clarifying and streamlining the reporting requirements can undoubtedly yield numerous benefits. It can lead to a more focused approach, ensuring that critical incidents are promptly addressed while allowing the appropriate time for investigation and evaluation. However, as you have rightly highlighted, the effectiveness of this amendment largely depends on establishing precise protocols and guidelines to avoid confusion and excessive administrative complexities. A diverse and ambiguous set of reporting criteria may indeed result in an increased burden on agencies and staff. The need to sift through various types of incidents, train personnel on multiple protocols, and establish distinct procedures for each case could lead to inefficiencies and hinder the overall effectiveness of the reporting process. To avoid such pitfalls, it is crucial that the definition of reportable incidents is presented in a concise and unambiguous manner, taking into account the practical implications on all stakeholders. Therefore, we urge the careful consideration of these potential challenges during the amendment process. It is essential to collaborate with relevant stakeholders, including service providers, to ensure that the defined lines for incident reporting are practical, clear, and actionable. By working together to create a well-structured reporting framework, we can minimize administrative burdens while maximizing the effectiveness of the reporting system.
VHHA	Y	Unplanned medical admissions or ED visits should not be considered a Level II serious incident for patients that are on inpatient psychiatric units within medical hospitals as these patients are already hospitalized within the facility. And should just be considered extensions of the patient's care as they occur frequently within hospitals. Level II serious incidents for transfers to the hospital medical service require RCAs which are time-consuming for hospital risk and quality departments, and rarely, if ever, lead to a change in processes or policies. Most of these transfers are the result of a worsening of a medical condition that staff are monitoring on our unit. Definitions would have to be very clear and concise. Otherwise, my interpretation of definition would be incorrect. A trip to the ED should only warrant a report if it becomes a change in treatment/admission to a medical unit.
VNPP	N	
DARS APS Division	Yes	If the decision is to keep the 24-hour requirement, then a reduction in administrative burden may be achieved by refining the definition of what incidents need to be reported within 24 and other timeframes
DMAS	N	

1. Option C: Amend regulations to require different time frames for residential vs other services.		
MHA-VA	NO	Increases complicity – with corresponding concerns about implementation.
Pinnacle Treatment	N	Recommend 48 hours for any
VACBP	No position	There is not consensus among our members on this recommendation at this time.
VACSB	No	While we recognize the need for an efficient reporting system, we firmly believe that implementing distinct time frames would exacerbate administrative burdens for Community Services Boards (CSBs) and providers of multiple services. Many service providers, including the majority of CSBs provide residential care, and implementing separate reporting time frames for different service types would only add to their existing administrative challenges. Setting up different standards and requirements for various service lines will create confusion, inefficiency, and increased administrative complexity. It may also lead to inconsistencies in reporting practices and inadvertent late reporting, thereby, compromising the overall effectiveness of the reporting system. Furthermore, the argument that the Department of Behavioral Health and Developmental Services (DBHDS) does not take immediate action on reports during non-business days and beyond simple information review supports the need for uniform reporting requirements. If immediate action is not taken in either scenario, then maintaining separate time frames based on the type of service being provided appears redundant and unnecessary. Adopting varying reporting time frames for different services may also raise concerns about equity and fairness in incident management. All individuals served, regardless of the type of service they receive, deserve equal protection and timely attention. Establishing uniform reporting requirements based on the state's operating hours is a more practical and just approach. In conclusion, we firmly believe that implementing different time frames for reporting incidents in residential vs. other services is not the right course of action. It would burden CSBs and providers with unnecessary administrative
VHHA	N	Inpatient psychiatric units have much higher patient turnover than residential facilities, and therefore, have many more incidents requiring the completion of CHRIS reports. Creates mixed requirements within large organizations.
VNPP	N	
DARS APS Division	No	This option could lead to confusion about which entities are supposed to report and when. Reporting requirements should be incident based (category based), not based on location of the incident.
DMAS	N	

1. Option D: Amend guidelines for issuing citations to allow consideration of the provider size, and number of late reports as a percentage of all reports.		
MHA-VA	NO	Increases complicity – with corresponding concerns about implementation.
Pinnacle Treatment	N	
VACBP	No position	There is not consensus among our members on this recommendation at this time.
VACSB	Yes	We support the proposal to amend the guidelines for issuing citations by considering the size of the provider and the number of late reports as a percentage of all reports. This proposed amendment is crucial in recognizing the diversity and uniqueness of Community Services Boards (CSBs) and ensuring fairness in the citation process. Forthcoming Licensing regulations requiring providers to determine their capacity for all services (not just for residential services) may provide DBHDS with some information to establish relevant parameters. Community Services Boards are incredibly diverse in terms of their sizes, resources, and capabilities. Each CSB serves a distinct community with its own set of challenges and circumstances. As such, it is essential to acknowledge that a one-size-fits-all approach to issuing citations can be inherently unfair. Penalizing all CSBs equally fails to consider the varying capacities and constraints that they face, often beyond their control. By factoring in the size of the provider, the amendment would allow for a more nuanced understanding of the CSBs' ability to comply with reporting requirements. Smaller CSBs may have limited staff and resources, making it more challenging to meet deadlines for incident reports. Conversely, larger CSBs may have more extensive administrative support, making it relatively easier for them to meet reporting deadlines. By taking provider size into account, the amendment seeks to level the playing field and promote equitable treatment for all CSBs. The same applies to private providers who also operate different sizes programs throughout the state. Additionally, considering the number of late reports as a percentage of all reports is a sensible approach to gauge the overall performance of a CSB. This approach is more balanced and fair because it considers the proportion of late reports in the context of the CSB's total reporting load. A single late report in a smaller CSB would have a more significant impact on their compliance percentage compared to a larger CSB with a larger number of total reports. Furthermore, acknowledging the unique differences in incident reports within CSBs is crucial for maintaining accuracy and integrity in the citation process. Not all incidents are the same, and various factors can influence the reporting timeline. Some incidents may require more information gathering, leading to a slight delay in reporting. By recognizing these differences and the complexities involved, the proposed amendment demonstrates a commitment to fair evaluation and judgment. In conclusion, we wholeheartedly support amending the guidelines for issuing citations to incorporate considerations of the provider size and the number of late reports as a percentage of all reports. We firmly believe that this amendment will lead to more equitable outcomes and a stronger collaborative effort to improve services and safety for all.
VHHA	Y	Consideration for percentages could mitigate the risk of larger providers having more citations. Late reporting has become punitive, requiring a corrective action, that shouldn't be the intent. Errors in 6 months
VNPP	Y	This would greatly reduce provider burden and we would support this Amendment.
DARS APS Division	Yes	
DMAS	Y	

1. Option E: Make no change to reporting requirements.		
MHA-VA	NO	The government is placing an unnecessary burden on organizations, which is mitigated in option A. Further, representatives of state agencies did not share that individuals were harmed because their employees only acted on filed reports during normal business hours. The only consequence of moving from 24-hour reporting was a potential loss of details. However, this was merely an assumption because state agencies had no data or evidence that this was happening. Further, organizations have internal requirements for reporting, which is the bases for completing reports filed with the state. Therefore, details about events are being captured.
Pinnacle Treatment	N/A	
VACBP	N	
VACSB	No	While we understand the need for stability and consistency in regulations, the arguments presented in previous responses highlight critical issues that warrant reconsideration. The primary concern lies in the existing 24-hour reporting window, which, as mentioned, can pose challenges for prompt action and response. The Department of Behavioral Health and Developmental Services (DBHDS) may not be able to take immediate action during non-business days, and the lack of swift response beyond mere information review may undermine the effectiveness of the reporting system. Furthermore, the suggestion to amend regulations and require different time frames for residential vs. other services, though not supported, emphasizes the need for a thoughtful approach to incident reporting. The proposal to keep the status quo disregards the potential improvements that could be achieved through a well-structured reporting framework. As seen from the argument in favor of amending regulations to change reporting requirements, there is a consensus that aligning reporting deadlines with the state's operating hours (next business day) would not adversely affect the health, safety, or welfare of individuals served. This approach acknowledges practical constraints while ensuring adequate attention to all incidents. By making no change to the reporting requirements, we may inadvertently perpetuate administrative burdens and inconsistencies in the reporting process. It is vital to recognize the value of an efficient and streamlined system, and the opportunity to create a unified reporting standard based on the state's hours of operation. In conclusion, we urge you to reconsider maintaining the current reporting requirements and instead explore the possibility of amending regulations to align reporting time frames with the next business day. This approach would demonstrate a commitment to enhanced accountability and responsiveness while alleviating unnecessary administrative burdens.
VHHA	N	
VNPP	N	
DARS APS Division	No	
DMAS	N	

RECOMMENDATION 2: Changes to inspection requirements.

Policy Option	Panelist Support (Y/N)	Panelist Concerns
2. Option A: Amend the Code of Virginia to allow providers with triennial licenses, without significant or unresolved health and safety violations, to be inspected once during their license period.		
MHA-VA	NO	It needs to be clearly stated what impact this would have on clients. Every three years seems like a long time between inspections. This concern was only partially explored during these sessions.
Pinnacle Treatment	Y	For sites that have a triennial, unless a CHRIS report or other HR complaint is made, they should have one review during the licensing timeframe. During the reviews they see the smallest glimpse into the program and we are immediately cited for any wrongdoing. Allowing sites to actually operate without the "fear" that state is coming to inspect at any given moment will allow for the site to address any errors internally. State should plan to have one longer inspection to better understand the workings of each program moving forward.
VACBP	Y	The VACBP supports this recommendation to align inspections with the licensing period, allowing those providers that have met the standards required to hold a triennial license to be inspected once during their three-year license period so long as no health or safety issues been raised.
VACSB	Yes	We support amending the Code of Virginia to allow providers with triennial licenses, without significant or unresolved health and safety violations, to be inspected once during their license period. This proposed change addresses an important question concerning the purpose of triennial licenses when all providers are already required to undergo annual reviews. The current situation, where all providers are subjected to annual reviews regardless of their license type, raises doubts about the necessity and effectiveness of triennial licenses. It seems counterintuitive to maintain a triennial licensing system if the ultimate goal is an annual review for all providers. By updating the Code to allow for a single inspection during the license period for providers with triennial licenses, we can promote efficiency and allocate resources more effectively. Furthermore, it is essential to acknowledge that providers who have been granted triennial licenses have demonstrated a track record of compliance and adherence to health and safety regulations. By maintaining a record free of significant or unresolved health and safety violations, these providers have exhibited a commitment to delivering high-quality services and care. Therefore, incentivizing such providers with decreased oversight makes logical sense. Additionally, advancements in digital technologies, such as CONNECT, have revolutionized the process of license renewal submissions, making it more user-friendly and streamlined. This means that providers can now submit their license renewal applications more efficiently, allowing for a smoother and faster process overall. In conclusion, amending the Code of Virginia to allow for a single inspection during the license period for providers with triennial licenses, as long as they have maintained a clean health and safety record, is a commendable step towards optimizing the oversight process. This change will help reduce unnecessary administrative burdens, improve resource allocation, and provide a well-deserved incentive for providers who consistently meet and exceed the required standards.
VHHA	Y	Please include new license requests. Inspection is a necessary part of validating compliance –it is appropriate – when there are no other concerns to do 1 very short notice (maybe 24 hours) visit in the triennial period. *Consider options of virtual as managed in COVID and ability to upload documents, policies, disaster drills in advance for timely response and performance improvement. We were inspected twice within a year, once for our psychiatric licensure and a second time for our substance licensure. The inspection should encompass both and be performed at the same time since almost all of the requirements are the same.

VNPP	Y	We would support this amendment. It would be a reduction in regulatory burden for current providers with triennial licenses and it would encourage providers striving for triennial licensing.
DARS APS Division	No	Not in favor of one inspection every 3 years.
DMAS	N	We do not have enough information/data to proceed with this recommendation. Need to understand what types of consequences (positive or negative) would arise from this change before making this change. How would this affect the safety of individuals? How would we assess if the safety of individual's would be impacted?

2. Option B: Leverage inspections and investigations from other agencies to reduce the number of reviews that occur.		
MHA-VA	NO	This option may not address the various state agencies' different needs and statutory requirements, which were not fully explored during these sessions.
Pinnacle Treatment	Y	Improve efficiencies by using other surveys such as accrediting bodies (CARF Joint Commission)
VACBP	Y	The VACBP supports this recommendation to allow reviewing inspections and investigations that are being conducted by other agencies on the same issues on which DBHDS is inspecting to be coordinated to reduce duplicative reviews that do not contribute to the safe delivery of services. To advance this recommendation, we would need to determine what other agencies would be involved and how information can be shared. Creation of a central repository for documents could be the mechanism to share information between multiple agencies.
VACSB	Yes	We support the idea of leveraging inspections and investigations from other agencies to reduce the number of reviews that occur. This approach holds significant potential for alleviating the inspection burden that currently falls heavily on IDD services, particularly the HSAG (Health and Safety Advocacy Group) and SCQR (Service Coordination and Quality Review) reviews, combined with Licensing inspections each January as part of the Department of Justice (DOJ) settlement, and the annual license review. The existing inspection load on IDD services can be overwhelming, consuming valuable time and resources that could be better utilized in providing exceptional care to the individuals we serve. By leveraging inspections and investigations conducted by other agencies, especially those pertaining to related aspects of our services, we can achieve several crucial benefits: 1. Resource Optimization: Repeating multiple rounds of inspections per year can lead to duplicative efforts and increased administrative burdens. Leveraging inspections from other agencies would allow us to optimize resources, streamlining the review process and freeing up personnel to focus on improving service quality. 2. Enhanced Collaboration: Collaborating with other agencies' inspection processes can foster a stronger sense of coordination and communication within the healthcare system. It promotes a holistic view of our services, ensuring that assessments and improvements are comprehensive and aligned across all aspects of care. 3. Streamlined Compliance: As we endeavor to meet the standards set by various regulatory bodies, leveraging inspections can help consolidate compliance efforts. This approach ensures that we address all necessary compliance requirements while minimizing disruptions to the day-to-day operations of the facilities. 4. Reduced Burden on Staff: Regular inspections can put considerable strain on staff members, taking their focus away from their core responsibilities. By streamlining the inspection process, we can create a more sustainable work environment that empowers staff to deliver the best possible care. 5. Improved Service Delivery: With reduced administrative overhead and improved collaboration, we can enhance the quality and efficiency of our services. This, in turn, benefits the individuals we serve, providing them with the best possible support and care. In conclusion, leveraging inspections and investigations from other agencies in lieu of multiple reviews conducted by DBHDS OL due to the DOJ for DS services is a progressive and pragmatic approach. It demonstrates our commitment to continuous improvement, resource efficiency, and providing the highest standard of care to our community.
VHHA	Y	Inspections need to be more reasonable. For example, if you're an organization with 6 different programs in 1 location, doing 10 chart reviews for each program takes too much time as well as 3 employee reviews for each service. CMS and TJC ensure psychiatric units are meeting the required standards.
VNPP	N	

DARS APS Division	No	Are other agencies looking at the same issues during inspections or investigations? For example, it would not be appropriate to use an APS investigation in lieu of a DBHDS investigation as APS is investigating the needs of an adult, not a facility. The facility may have no part in why APS is investigating or why the adult is being maltreated. APS does not inspect facilities either, so the APS investigation findings may not be helpful in context to the need for DBHDS to conduct an inspection.
DMAS	N	We do not have enough information/data to proceed with this recommendation. Need to understand what types of consequences (positive or negative) would arise from this change before making this change. Need to develop a cross walk of each agency's standards during inspections/investigations. The goal/priority of these inspections may have different purposes and thus measure different standards. An inspection from another agency may not encompass the DBHDS regulatory standards.

2. Option C: Create central repository for documents that can be shared across different agencies and review entities.		
MHA-VA	YES – Mentioned during these sessions was a system already being developed that could be a central repository after including one more additional form. Still, it was not stated if compatibility and access already exist across state agencies. However, with one system, it should be easier for organizations to learn and work on one online platform – if possible. Further, transparency and access to the same data among all oversight state agencies could improve oversight outcomes.	This is the best option if doable. Many questions need to be answered and not addressed during the previous sessions of this workgroup. More time is needed to examine this option fully.
Pinnacle Treatment	N	Raises confidentiality issues
VACBP	Y	The VACBP supports consideration of this recommendation.
VACSB	Conditionally	We provide conditional support for the proposal to create a central repository for documents that can be shared across different agencies and review entities. While the concept holds significant potential for streamlining processes and enhancing collaboration, we believe that it should only be implemented if there is an agreement from all State agencies to use this repository and agreement to contact providers if there are questions. The idea of a central repository is undoubtedly appealing as it promises to consolidate documents and facilitate seamless information sharing. However, we are concerned that if not all agencies participate and adhere to this system, it could inadvertently add to the administrative burden rather than alleviate it. For the repository to achieve its intended benefits, it is crucial to secure unanimous cooperation and commitment from all involved parties. Moreover, it appears that MART has already been implemented to some extent. If this is indeed the case, we need to carefully evaluate its effectiveness and learn from the experiences of other CSBs currently testing it. Based on your feedback, it seems that there are limitations, such as the inability to upload Protected Health Information (PHI), which hinder its full potential. Addressing these issues and working towards enabling PHI uploads in the future could significantly enhance the repository's utility. I understand the logic behind avoiding redundancies in PHI by granting auditors remote access to our Electronic Health Records (E.H.R.s). However, there are instances where additional requests or difficulties in locating specific information make the central repository invaluable. Therefore, it is vital to strike a balance that caters to the diverse needs of different agencies while safeguarding sensitive information. In conclusion, we believe that the concept of a central document repository has merit, but we must proceed with caution and with a collective commitment from all relevant agencies. Before fully embracing this approach, we should address the shortcomings of MART, such as the inability to upload PHI, and explore ways to integrate the repository more seamlessly into existing workflows. By doing so, we can ensure that the repository serves as a valuable tool in enhancing efficiency and collaboration across agencies.
VHHA	N	
VNPP	Y	This would greatly reduce regulatory burden for commonly requestion non PHI documentation such as policy and QI/RM reports.
DARS APS Division	Tentative yes, though details need to be ironed out.	Unclear what is meant by different agencies. Are these DBDHS units or does this mean that outside agencies like LDSS, DHP, and DMAS could pull down information about certain providers from the repository? Would other licensed or regulated providers have access to information about other providers? I think this may require more study/planning.
DMAS	Y	

2. Option D: Make no change to inspection requirements.		
MHA-VA	NO	More time is needed to fully explore Recommendation 2, which means this option is not recommended.
Pinnacle Treatment	N/A	
VACBP	N	
VACSB	No	We do not support the statement advocating for no changes to the current inspection requirements. While we understand the value of stability and continuity in regulatory processes, the insights gained from our previous discussions have highlighted some valid concerns and opportunities for improvement that we cannot overlook. One significant concern revolves around the inspection burden disproportionately affecting IDD services, particularly the HSAG and SCQR reviews, in conjunction with the Licensing inspection each January due to the Department of Justice (DOJ) settlement, and the annual license review. The workload associated with these multiple inspections can be overwhelming for providers, diverting valuable resources from providing optimal care. As such, we should explore ways to reduce this burden and improve the efficiency of the inspection process. Additionally, the concept of a central document repository, with the unanimous agreement of all agencies, holds considerable promise in streamlining processes and promoting collaboration. However, if not all agencies are on board with utilizing this repository, it could inadvertently lead to inefficiencies and create an additional administrative burden. Before dismissing this idea outright, we should consider the potential benefits of a central repository and work towards addressing concerns raised by those testing the MART. Furthermore, acknowledging the limitations of MART, such as the inability to upload Protected Health Information (PHI), it becomes apparent that we have an opportunity to enhance this tool to better support the inspection process. If we can address these limitations and create a more comprehensive and inclusive system, it may lead to improved outcomes for all stakeholders. In conclusion, while maintaining some level of stability in inspection requirements can be advantageous, we should not overlook the valuable insights and opportunities for improvement brought forth by our earlier discussions. Addressing the inspection burden on IDD services, exploring the feasibility of a central document repository, and enhancing MART to support PHI uploads are all valid considerations to optimize the inspection process.
VHHA	N	
VNPP	N	
DARS APS Division	No	
DMAS	N	

RECOMMENDATION 3: Accreditation.

Policy Option	Panelist Support (Y/N)	Panelist Concerns
3. Option A: Amend the Code of Virginia to deem certain licensing requirements as met (e.g., annual inspection, compliance with quality improvement regulations, etc.) for providers that are accredited by a recognized national accreditation body.		
MHA-VA	NO	More time is needed to review and evaluate options before making recommendations. Option 2 provides this opportunity.
Pinnacle Treatment	Y	CARF and JACHO have strict and comprehensive requirements that go above and beyond state regulations. Any organization that is accredited by one of these organizations must show compliance in all standards to receive a 1 or 3 year accreditation. Both outside accrediting bodies conduct longer and more comprehensive surveys often lasting up to three days. This allows for them to delve deeper into all aspects of the program. After completing an accreditation survey, reports can be sent to state to show compliance. If a QIP is needed, response could also be sent to state. This should count towards and annual licensing inspection.
VACBP	Yes (see comments)	While the VACBP would like to see DBHDS moving in this direction, we believe more study is needed to ensure there are no important functions being performed by the Office of Licensing that are not being performed by the accreditation organization(s). The issue of how to address the differences between the various accreditation organizations also needs to be considered prior to taking action as proposed in this option. In addition, the VACBP believes accreditation should continue to be optional.
VACSB	Yes	We support the proposed amendment to the Code of Virginia, which seeks to allow providers accredited by a recognized national accreditation body to have a reduced frequency of inspections. This amendment holds great promise in streamlining the oversight process for accredited providers, resulting in numerous benefits for both service providers and the authorities involved. There are several compelling reasons why this amendment is worthy of consideration. Firstly, the implementation of a crosswalk system to ensure coordination between different types of reviews, such as CARF and DEA, would serve as a mechanism for harmonizing the assessment criteria. By aligning these various reviews with the inspections conducted by the Virginia Department of Behavioral Health and Developmental Services (DBHDS OL), we can ensure that critical aspects of service provision are uniformly assessed and met. This synergy would facilitate a comprehensive evaluation of service quality while avoiding duplication of efforts and unnecessary bureaucratic burden. Additionally, the process of providing copies of accreditation reports to DBHDS OL would foster transparency and accountability. Such a measure could strengthen the collaboration between accrediting bodies and government agencies, promoting a more robust and holistic approach to regulatory oversight. With access to these accredited reports, DBHDS OL would be better equipped to focus their inspections on areas of potential concern, ensuring that scarce resources are optimally utilized. The level of coordination required to enact this amendment is indeed achievable. Through open communication channels and interagency cooperation, the exchange of information between different accrediting bodies and DBHDS OL can be facilitated efficiently. Emphasizing the importance of shared goals, we can foster an environment where all parties work towards a common objective - promoting the highest standards of care and safety for the individuals receiving services. The benefits of reduced inspection frequency for accredited providers cannot be overstated. By alleviating administrative burdens and minimizing disruptions caused by frequent inspections, accredited organizations can direct more resources toward delivering exceptional services to their clients. This enhanced focus on service provision can lead to improved outcomes and an overall elevation of the quality of care offered. While this amendment may initially impact specific services, the ripple effect is undeniable. The reduction in inspection frequency for accredited providers sets a precedent for promoting excellence and recognizing organizations committed to upholding the highest standards. This, in turn, may encourage more service providers to pursue accreditation, further driving the improvement of services across the board. In conclusion, we support the proposed amendment to amend the Code of Virginia to allow accredited providers to have a reduced frequency of inspections. The introduction of a coordinated crosswalk system and the sharing of accreditation reports with DBHDS OL will streamline the regulatory process, reduce administrative burdens, and promote excellence in service delivery. We firmly believe that this amendment represents a significant step forward in enhancing the overall quality of care for those in need of behavioral health and developmental services.

VHHA	Y	Joint Commission inspections are more rigorous than the DBHDS ones. Specific to accreditation bodies such as TJC and CARF. Just an outline or form that would indicate what items would be met by which agency might be helpful if this transition occurs. CMS and TJC ensure psychiatric units are meeting the required standards. What would be the process of ensuring the other licensing requirements are met?
VNPP	N	
DARS APS Division	No	Think this option requires further study.
DMAS	N	Before this occurs we need to identify what accrediting bodies and types of accreditation will be accepted by doing a full study. We do not have enough information/data to proceed with this recommendation. Need to understand what types of consequences (positive or negative) would arise from this change before making this change. National certifications can be helpful building blocks for state requirements but they are also very complex and there is a lot of variation. So, definitely not a simple solution or a cure-all. Each one must be considered carefully regarding what quality standard it truly puts in place and whether that quality standard is aligned with the needs of the different authorities and payers with a stake in quality. If not, something that does not works for all authorities involved, can run the risk of being just one more administrative burden, or worse, can represent nothing more than that a provider has paid a fee to a third party with little actual quality verification or ongoing oversight. But, when they meet the needs of multiple authorities or payers and provide a reliable indicator of quality care, they can be a huge benefit and solution.

3. Option B: Conduct further study to determine how to best utilize accreditation status to minimize the administrative burden associated with licensing. This would include evaluating outcomes in other states that utilize deemed accreditation, and conducting a crosswalk of accreditation organization standards with licensing requirements. This would include a request for funding.		
MHA-VA	YES – more time is needed to review and evaluate options before making recommendations.	
Pinnacle Treatment	Y	Improve efficiencies
VACBP	Y	The VACBP supports a more thorough evaluation of requirements by accreditation organizations and the Office of Licensing. Issues to be considered include: • How to manage the differences between the various accreditation organizations. • How to determine which accreditation entities will be honored and which won't, and what factors are considered in determining this. • How the existing licensing process would align with the accreditation? Whether changes would impact the work of other agencies, i.e., DMAS.
VACSB	Yes	We support the proposal to conduct a comprehensive study aimed at maximizing the utilization of accreditation status to alleviate the administrative burden associated with licensing. This study, which involves evaluating outcomes from states employing deemed accreditation and performing a crosswalk between accreditation organization standards and licensing requirements, holds significant potential to benefit accredited services and enhance the overall regulatory process. Undoubtedly, the proposed study represents a crucial step towards fostering efficiency and effectiveness in the licensing and accreditation procedures. By closely examining the outcomes of other states that have implemented deemed accreditation, we can draw valuable insights and learn from their successes and challenges. This comparative analysis will provide a well-informed foundation for developing tailored solutions that address the unique needs and characteristics of our state's service providers. The crosswalk of accreditation organization standards with licensing requirements will be a pivotal aspect of the study. Such an assessment will enable us to identify areas of overlap, alignment, and potential gaps between the two processes. By streamlining the congruence between accreditation and licensing, we can significantly reduce duplication of efforts and administrative redundancies, resulting in a more streamlined and coherent regulatory framework. We acknowledge that the current adoption of accreditation by service providers might be cost-prohibitive for many organizations, leading to a relatively low percentage of licensed services being accredited by external entities. However, it is essential to recognize that the potential benefits of accreditation extend beyond the immediate impact on the accredited services alone. Implementing measures to promote accreditation utilization can be a strategic investment in the long-term improvement of service quality across the board. It is reasonable to consider the financial implications of this endeavor, including additional funding requirements. Allocating resources for this study should be viewed as an investment in the pursuit of efficiency, quality improvement, and overall service excellence. The reduction in administrative burden through effective accreditation utilization can lead to improved resource allocation, increased focus on service delivery, and ultimately better outcomes for the individuals receiving these vital services. Moreover, the study's findings may pave the way for developing financial incentives or support mechanisms to encourage more service providers to pursue accreditation. By addressing the cost barriers, we can expand the adoption of accreditation among licensed services, creating a positive cycle of quality enhancement and regulatory simplification. In conclusion, we firmly believe that conducting a thorough study to explore how best to leverage accreditation status for minimizing the administrative burden associated with licensing is a step in the right direction. By assessing outcomes in other states and conducting a comprehensive crosswalk, we can tailor solutions that benefit accredited services while also providing a solid foundation for the improvement of services at large.

		Though it may initially impact only a portion of licensed services, the long-term advantages, coupled with potential financial incentives, make this study a valuable and worthwhile endeavor.
VHHA	Y	Best option, as this study would certainly provide answers to already resolved issues and concerns with deemed accreditation.
VNPP	Y	We would support additional information related to this possibility.
DARS APS Division	Yes	
DMAS	Y	

3 Option C: Make no change; do not include a consideration of accreditation status in licensing oversight.		
MHA-VA	NO	More time is needed to review and evaluate options before making recommendations. Option 2 provides this opportunity.
Pinnacle Treatment	N/A	
VACBP	N	
VACSB	No	We disagree with the proposal to make no change and exclude the consideration of accreditation status in licensing oversight. As evidenced by the statements above, there are compelling reasons to consider and study how accreditation can positively impact licensing oversight processes and alleviate administrative burdens. The proposal to conduct a thorough study to determine how best to utilize accreditation status in licensing oversight is a sound and forward-thinking initiative. By evaluating outcomes in other states that have already implemented deemed accreditation and conducting a crosswalk of accreditation organization standards with licensing requirements, we have the potential to streamline and optimize our regulatory framework. As we have discussed, this study represents an opportunity to draw upon successful models from other states, learning from their experiences and applying best practices to our unique context. The comparison will help us identify strategies and approaches that have demonstrated positive outcomes, thus enabling us to make informed decisions tailored to our state's specific needs. A crosswalk of accreditation organization standards with licensing requirements is an essential step toward harmonizing the two processes. This alignment will not only reduce the administrative burden on providers but also improve the overall efficiency and effectiveness of licensing oversight. Minimizing duplicative efforts and establishing congruence between accreditation and licensing criteria can lead to more focused evaluations, saving valuable resources and time for both service providers and regulatory agencies. While it is true that a percentage of licensed services are currently accredited due to cost constraints, we should not disregard the potential benefits that effective accreditation utilization can bring to the healthcare landscape. By conducting this study and considering ways to support providers in pursuing accreditation, we create a pathway for improving the quality of care and services offered. Moreover, this endeavor should not be solely assessed in terms of its immediate impact on a limited number of accredited services. Instead, it should be seen as a strategic investment in the long-term improvement of our healthcare system. By streamlining licensing oversight and promoting quality standards through accreditation, we lay the foundation for a more robust and sustainable healthcare ecosystem, benefiting all stakeholders involved. In conclusion, we strongly urge you to reconsider the decision to maintain the status quo and exclude the consideration of accreditation status in licensing oversight. The proposal to conduct further study and explore the potential benefits of accreditation holds immense promise in enhancing the efficiency and effectiveness of our regulatory processes. By aligning our standards with successful models, we can create a more streamlined, effective, and equitable healthcare environment that ultimately benefits the entire community.
VHHA	N	
VNPP	N	
DARS APS Division	No	
DMAS	N	