DBHDS

Virginia Department of Behavioral Health and Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2024
1st and 2nd Quarters

DBHDS

Case Management Steering Committee

Semi-Annual Report FY24 1st and 2nd Quarters

Executive Summary

As a subcommittee of the Quality Improvement Committee (QIC), the Case Management Steering Committee (CMSC) is responsible for

- monitoring case management performance across responsible entities to identify and address risks of harm,
- ensuring the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and
- evaluating data to identify and respond to trends to ensure continuous quality improvement.

The committee is charged with reviewing data selected from, but not limited to, any of the following data sets: Community Services Board (CSB) data submissions, Support Coordination Quality Reviews (SCQR), Office of Licensing citations, Quality Service Reviews (QSR), DMAS' Quality Management Reviews, Regional Support Teams (RST), and the Waiver Management System (WaMS). The committee's analysis will identify trends and progress toward meeting established Support Coordination/Case Management targets. Based on this data review and system analysis, the committee will recommend systemic quality improvement initiatives (QIIs) to the QIC. The committee also recommends technical assistance based on review of CSB specific data. If CSB specific improvements are not demonstrated after receiving technical assistance, the committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings.

Committee membership includes the Director of Waiver Operations or designee, the Director of Provider Network Supports or designee, the Director of Community Quality Improvement or designee, the Settlement Agreement Director, one Quality Improvement Program Specialist (QIS), one Community Resource Consultant (CRC), and a Quality Research Specialist from the Office of Quality Assurance and Healthcare Compliance. Advisory members include a representative from the Office of Licensing and a Behavior Analyst. Standard operation procedures include: annual review and update of the committee charter, regular meetings, at least ten times annually, to ensure continuity of purpose, maintenance of reports and meeting minutes, and quality improvement initiatives consistent with Plan, Do, Study, Act (PDSA) model.

Key Accomplishments

From July to December 2023, the CMSC continued the implementation and refinement of a structured process of routine CSB performance monitoring. The CMSC also reported to the QIC in September and December 2023. The CMSC is responsible for seven performance measure indicators (PMIs) and monitors an additional 13 not included in PMI reporting.

The CMSC ceased monitoring one measure related to the development of employment goals for all individuals 18 to 64 since this measure is monitored by the Employment First Advisory Committee. In place of this PMI, the CMSC began tracking a new employment measure stated as "Proportion of Adults (aged 18-64) with a DD waiver receiving case management services that are interested in employment and have an ISP that contains employment outcomes." The CMSC needed to adjust a measure to align with changes in the FY23 SCQR data. A SCQR indicator related to provider and SC choice was separated so that each choice could be monitored separately.

Updates to the Individual Support Plan (ISP) were launched on May 2, 2023. The WaMS ISP format is updated annually, if needed, to improve the usefulness, content, and data related to individual plans.

In partnership with the Department of Medical Assistance Services (DMAS) Quality Management Review (QMR), a process was established to review ten case management indicators and associated DMAS CAPs.

The CMSC reviewed PMIs quarterly and produced a semi-annual report in September 2023 which covered FY23 Q3 and Q4.

The CMSC began working with the KPA Workgroups on a QII to integrate the Risk Awareness Tool into the ISP. A focus group was held on 11/14/23 and was followed by meetings with DMAS, the Office of Licensing, the Office of Human Rights, the electronic health record vendor group, and the DD Council. The CMSC recognizes the significance of this change and how it impacts timelines along with a concurrent DBHDS effort to transition away from CCS3. As of this report, concept slides have been drafted, a provider Part V has been drafted in a paper format for the WaMS vendor to review, and specifications are in the process of being drafted.

The CMSC continued a monthly review of CSB performance through the Four Pillar process. Across FY23, there were 32 total improvement plans requested 18 for ISP timeliness, 13 for RST timeliness, and one for SCQR results. 16 were successfully removed from the Watch List for achieving above target performance.

CMSC developed and distributed performance letters to CSBs in October 2023 and a recommendation letter to the DBHDS Commissioner in January 2024.

The CMSC completed updates to the Virginia Informed Choice form to ensure that individuals and families can request assistance with referrals for peer mentoring and family-to-family programs, as well as to clarify the instructions so that the first and last name of the chosen SC is recorded. This update completed public comment in August 2023 and made available for use.

The SCQR review for calendar year 2022, taking place in FY23 Q3 and Q4, had 100% CSB completion.

Changes continue to be made to the Support Coordinator Quality Review (SCQR) that over time will point to specific locations in the ISP where evidence will be held for various case management (CM) elements needing to be confirmed.

The CMSC worked last report period with the DBHDS Warehouse Team to refine the Data Quality Support Process. Development included the design of a process and data life cycle framework with a root cause analysis template that enables CSBs to integrate data concerns into their agency's Quality Improvement Plan (QIP). CRCs met with 13 randomly selected CSBs between 11/29/23 and 12/13/23 to review a sample of case management data. This process focused on confirming that data provided through CCS was reliable and valid. Where coding

was incorrect or dates were inaccurate, issues were discussed and identified for CSB correction. Support provided as necessary, and feedback was collected on the process.

As reported previously, the CMSC has been made aware of concerns centering on the administrative responsibilities and documentation requirements for Support Coordinators (SCs), which have impacted the manageability of the position. The Quality Improvement Committee (QIC) approved the CMSC's proposed quality improvement initiative (QII) in June of 2022 focused on improving SC retention. Through focus groups with SCs and CSBs, the CMSC collected ideas and concerns, which are driving recommendations to ease SC requirements where possible without compromising Virginia's compliance with state and federal requirements. To date, seven near term recommendations have been identified. The committee is focused on implementing individual changes as possible to reduce any delay in providing relief to stakeholders. This initiative includes tracking retention rates and continue to seek to make targeted changes in SC/CM responsibilities to increase the satisfaction and retention of SCs. Progress was seen in the development of a method for tracking SC retention for a related QII. Although baseline data was established and the format was further refined (so that the longevity of each individual SC is used in determining the retention rate across CSBs and system wide), the CMSC determined that an alternate method will be needed for the QII and is exploring the use of Quality Service Review data and CSB survey as options.

Another key accomplishment was the continuation of a cross-regional Regional Support Team. This was developed under one of the Committee's QIIs and is related to Curative Actions required for meeting Settlement Agreement requirements. Initiated in May 2022, the Committee began monitoring data with performance results reported below. The RST process transitioned to the WaMS in December with systemwide adoption on January 1, 2023. This transition replaces most manual referral and data management processes and is expected to ease and enhance the collection and reporting of RST data. A few system enhancements were completed following the launch of the RST module. DBHDS moved fully to WaMS in the 4th quarter of FY23 with the exception of missed referral data, which requires close review to determine when referrals are actually missed. While the method of this review will remain manual, DBHDS is working to integrate the results into the RST Dashboard so that all data is available in a single location.

Support Coordination Quality Review (SCQR)

In cooperation with the Independent Reviewer, the committee defined two phrases related to the provision of case management services, which included identifying and responding to "changes in status" and if "services are appropriately implemented." These definitions are designed to increase consistency in understanding and application across the developmental disability (DD) case management system. They are included in the ten elements assessed through the SCQR. The definitions include:

- "Change in status" refers to changes related to a person's mental, physical, or behavioral condition and/or changes in one's circumstances to include representation, financial status, living arrangements, service providers, eligibility for services, services received, and type of services or waiver.

- "ISP implemented appropriately" means that services identified in the ISP are delivered consistent with generally accepted practices and have demonstrated progress toward expected outcomes, and if not, have been reviewed and modified.

Materials developed include: a definitions document, a standardized tool format referred to as the On-site Visit Tool (OSVT), a summary of the Independent Reviewer report history related to non-compliance with the Settlement Agreement provision V.F.2., a reference chart as guidance, training slides, and a questions and answers document. This project is further defined in a CMSC QII that was approved by the QIC. Reporting per the compliance indicator metrics is dependent on the review of two consecutive quarters of CSB submissions. Technical assistance from the staff of OCQI occurs by October of each year as results are compared between each CSB and the DBHDS reviewer. Technical assistance was also provided by the DBHDS Office of Provider Development at the mid-point in FY23 submissions. While this technical assistance does not impact the record reviews underway, it is expected to improve the SCQR results occurring in FY24 when calendar year 2023 documentation is reviewed.

During the FY23 of the SCQR process, CSBs completed 100% of the sample. Due to adjustments made to the tool and technical guidance, DBHDS anticipates the reliability of the data to increase, which was evident between the second and third year of implementation. Opportunities to enhance this process occur once each year as new learning is incorporated. Main areas for improvement are providing clarity about expectations for each element assessed, as well as providing a designated location for holding information, so that results can be easily found. Annual ISP adjustments were made to provide locations for information assessed through the SCQR where no location previously existed. A comparison across FY21 to FY23 is available in the table below, which shows a decrease in compliance with three indicators, and an increase in seven, which is improvement over the last report.

Indicator	FY21 CSB-reported compliance	FY22 CSB-reported compliance	FY23 CSB-reported compliance
Old Indicator 1	88%	92%	
Old indicator 2	78%	78%	
...support coordinator? (named) [New indicator 1]	89%	79%	83%
...DD waiver providers? [New indicator 2]	98%	90%	93%
Indicator 3	83%	40%	54%
Indicator 4	85%	82%	88%
Indicator 5	100%	100%	100%
Indicator 6	69%	87%	84%
Indicator 7	92%	84%	89%
Indicator 8	93%	98%	99%
Indicator 9	50%	85%	84%
Indicator 10	75%	84%	84%
Records with either 9 or 10 indicators in compliance	**42%**	**53%**	**64%**

Key:

- **Indicator 1:** The CSB has offered each person the choice of case manager. (III.C.5.c) *
- **Indicator 2:** Individuals have been offered a choice of providers for each service. (III.C.5.c)
- **Indicator 3:** The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable. (III.C.5.b.i; III.C.7.b)
- **Indicator 4:** The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served. (III.C.5.b.i; III.C.5.b.ii)
- **Indicator 5:** The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individual's needs. (III.C.5.b.iii; V.F.2)
- **Indicator 6:** The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences. (III.C.5.b.ii; V.F.2)
- **Indicator 7:** The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team. (III.C.5.b.ii; V.F.2)
- **Indicator 8:** The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary. (III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)
- **Indicator 9:** The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences. (III.C.5.b.iii; V.F.2)
- **Indicator 10:** The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. (III.C.5.b.iii; V.F.2)

* In previous years, indicator one considered if the SC provided required signatures; however, this indicator was revised in the FY23 cycle to separate two elements that were combined in indicator two. The two elements are now established as indicator one and two for CM choice and provider choice respectively.

** Indicator 3 in the first year just included measurable outcomes. Employment discussions and outcomes have been incorporated since 2022 per the indicator language in calculating results.

The sampling methodology for the look behind calls for a minimum of two records per CSB to be sampled, with twenty additional reviews distributed by waiver population for 100 total retrospective reviews. The number sampled from each CSB ranges from two to four. The five OCQI specialists each complete ten interrater reviews, for a total of fifty interrater reviews. The percentage of records meeting nine or ten indicators shows steady improvement over the past three years. The FY2023 results showed that children can and should be included in the SCQR process. The differences between adults and children were minimal. In FY23, substantial agreement in the look behind was noted for 7 of the 10 indicators and in OCQI agreement for 9 of 10.

On-site Visit Tool

In November 2020, based on a review of a sample of On-site Visit Tools (OSVTs) during the pilot period and in collaboration with CSBs, revisions to the tool and process were made to improve use and effectiveness. Primary changes included: incorporating logic that leads to more definite determinations that a change in status and appropriate service implementation occurred, establishing the visit note as a companion document to reduce redundancy and duplication, and including a confirmation of who will be informed of the results. Other changes to streamline and enhance content were completed as well. These changes are also reflected in the SCQR survey technical guidance as we move in subsequent years for better alignment across documentation and its review.

In order to assist Support Coordinators with meeting requirements consistently, DBHDS collaborated with the Independent Reviewer for the Settlement Agreement to define the phrases "change in status" and "appropriately implemented services" and establish a process to support consistency. The On-site Visit Tool (OSVT) was introduced with training in a pilot phase in July 2020. Following the pilot, an OSVT work group met, with CSB representation, and together the group revised the tool based on findings in the pilot phase. The final version was given to the field for use beginning December 1, 2020.

The OSVT is designed to support the Support Coordinator's face-to-face visits in order to have improved monitoring and meaningful implementation of the Support Coordinator's oversight. The OSVT helps assure both "change in status" and "ISP implemented appropriately" are applied consistently across the state. The OSVT must be completed for each person receiving supports once each quarter for people with Targeted Case Management (TCM) and once per month for people with Enhanced Case Management (ECM).

DBHDS has integrated the review of the OSVT into the SCQR process to:

- Assure that Support Coordination services adequately meet the Settlement Agreement (provision V.F.2) in a consistent manner.
- Confirm that assessments occur in relation to change in status and ISP implemented appropriately.
- Assure reporting is occurring where concerns are noted.
- Formulate systemic responses to address areas of concern.

This review also seeks to assure consistently that people have needed supports, that the services they have are responsive and effective, and that they are healthy, safe and connected to their communities and to the people they care about.

From FY22, specific items regarding the use of the OSVT were incorporated into the SCQR survey for reviews by CSBs and subsequently by DBHDS in the look-behind process. This includes targeted questions regarding the completion of the tool, as well as confirmation that issues identified in the OSVT are documented properly in the record.

The completion of the OSVT is assessed through the SCQR survey questions 77, 79, 81, and 83. FY23 data showed that 5% (25/479) did not revise the ISP in response to a change in status, 3% (14/479) correctly noted changes and updated the ISP, 6% (28/479) correctly noted changes that did not require revision, and 86% (412/479) documented no change in status or needs. Of those requiring a need for reporting 9/26 (73%) did not have this need included in the progress note while 7/26 (27%) did have it included. Where additional actions were needed, 20/45 (44%) not have these actions included in the progress note while 25/45 (56%) did have them included.

Identified Concerns

The Independent Reviewer's 23rd Report to the Court was submitted on December 13, 2023 and did not include specific recommendations that relate to the work of the CMSC. The CMSC continues to work to achieve the remaining indicators included in the agreement.

As of last report, the CMSC incorporated children into the sample for the FY23 SCQR process and incorporated indicator elements 2.8, 2.10, and 2.14 into the SCQR survey and look-behind reviews as recommended in previous reporting. The CMSC has assisted with revising the WaMS Individual Support Plan, which launched on May 2, 2023. The annual ISP update cycle includes a focus on changes needed to increase consistency in understanding and documenting elements reviewed during the SCQR cycle. This process continues per standards previously established. As reported above, the integration of the Risk Awareness Tool into the ISP is currently in progress and is expected to assist planning teams with ensuring that risks are addressed during annual planning.

Quality Improvement Initiatives

Currently there are three active QIIs being implemented by the CMSC. Each QII is focused on an identified area of concern and is supported by information collected through discussions with stakeholders and seen in the data monitored by the committee. A new QII focused on ISP compliance was approved by the QIC in June 2023.

QII 1: *Supports respond to change in status with appropriately implemented services.*
Status: Completed

QII 2: *Individuals meeting criteria for Enhanced Case Management receive face-to-face assessments monthly with alternating visits in the home.*
Status: Completed

QII 3: *To ensure that people make informed choices about the services and supports they select and benefit from RST recommendations, there will be a 27% increase in the number of non- emergency referrals meeting timeliness standards during SFY22.*
Status: Active, being considered for closure in Q3 FY24

Regional Support Teams (RSTs) are established in all regions and seek to ensure informed choice and remove barriers to more integrated settings for people with DD. Three measures related to the RST process are monitored by the CMSC.

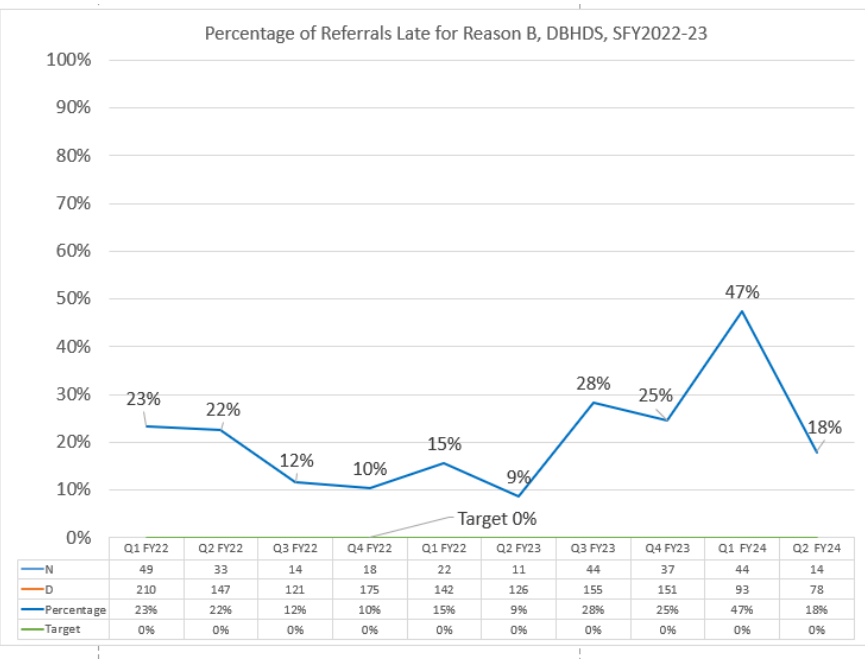
1. 86% of all statewide non-emergency referrals, as such referrals are defined in the DBHDS RST Protocol, meet the timeliness requirements of the DBHDS RST Protocol (Target 86%). III.D.6.

2. Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%). III.D.6.

3. People with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (defined as independent living supports, in- home support services, supported living, and sponsored residential) have access to an option that meets their preferences within nine months.

The first measure in the list above encompasses all currently tracked reasons for the lateness of RST referrals and is the focus of this QII. It includes situations in which the referral was overlooked and *not submitted* (Reason A), *where a person moved before the RST process could be completed* (Reason B), and situations in which *a provider did not notify the CSB* (Reason C). Through early analysis, it was determined that a person moving before the RST process could be completed (Reason B) has the most significant impact on performance for the first measure.

Following some success with establishing a sixth regional support team, unexpected closures, licensing changes, and other reasons result in temporary increases in Reason B referrals. The CMSC plans to end this QII in the coming quarter but will continue to monitor this data and performance, will maintain the cross-regional team, and attempt to reduce Reason B referrals where possible.



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22	Q1 FY22	Q2 FY23	Q3 FY23	Q4 FY23	Q1 FY24	Q2 FY24
N	49	33	14	18	22	11	44	37	44	14
D	210	147	121	175	142	126	155	151	93	78
Percentage	23%	22%	12%	10%	15%	9%	28%	25%	47%	18%
Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

QII 4: Our goal is to achieve and maintain a retention rate for Support Coordinators/Case Managers at or above 86% for two consecutive quarters by June 30, 2023.
Status: Active

This QII was approved in June of 2022 and focuses on making targeted changes that increase the manageability of the case management position resulting in an increase in Support Coordinator retention over time. This initiative relies on the input from Support Coordinators about what's working and not working with their responsibilities. It includes determining the retention rate of SCs. The Committee convened the standing Data Workgroup and hosted three webinar sessions with SCs to collect information to assist with prioritizing changes.

Three focus groups were held with Support Coordinators and Support Coordinator Supervisors throughout the state in September of 2022. Each focus group had representation from all regions and each group met for 2 hours. Focus Group 1 met on 9/27/22 and had 24 participants, Focus Group 2 met on 9/28/22 and had 17 participants, and Focus Group 3 met on 9/29/22 and had 15 participants. Questions were designed to elicit information from participants about their opinions and experience with being a Support Coordinator in Virginia, their role, what causes frustration, what could make it easier or better and any potential solutions. Different aspects of a support coordinator's role were reviewed in detail while asked about: What tasks, processes or other aspects of that component can cause frustration? In other words, what is not working?

- What could be done to make it easier or better?
- Have you found any solutions or strategies that work for you to make it easier?

These questions were explored in the areas of Assessing, Planning, Coordinating and Linking, Monitoring, and Other. Each focus group provided information and common themes emerged, which are proving critical in driving recommendations to ease SC workload requirements in the short and long-term. This information was organized and presented to the Case Management Steering Committee. Updates will continue to be reported to the Quality Improvement Committee and included in this report as work proceeds. As mentioned above, baseline data was established and the format was further refined (so that the longevity of each individual SC is used in determining the retention rate across CSBs and system wide), the CMSC determined that an alternate method will be needed for the QII and is exploring the use of Quality Service Review data and CSB survey as options. For the SC Retention QII, the package of changes identified based on SC focus groups and input include:

1) Reduce the requirement to complete the On-site Visit Tool for people receiving Targeted Case Management to once per quarter (completed 10/6/22).
2) Discontinue the requirement to use the Individual Planning Calendar in WaMS due to perceived lack of value and time needed for completion. (completed 11/3/22).
3) Clarify and simplify Enhanced Case Management guidance (completed 12/21/22). Note: Public comment period through February 2023 and became effective March 2, 2023.
4) Clarify and simplify the DD Support Coordination Handbook (pending public comment).
5) Develop and provide standardized SC Onboarding Training (pending, draft developed).
6) Clarify how to complete the ISP since employment discussions are not required for individuals less than 14 or over 64 (pending).
7) SC participation in Regional Support Team meetings on an as needed basis. (Completed 2/27/23)

As of Q2 FY24, two remaining changes listed above are being completed. The DD SC Handbook will close public comment on 1/17/24. DBHDS will adjust content based on the public comments submitted, respond to comments, and share the final file online once completed. The SC 101 training will be piloted initially with one CSB and then a CSB focus group in the 3rd quarter FY24 prior to finalizing and making available to all CSBs. These two actions complete the planned changes and survey development will process to assess the impact of the changes included in this QII.

QII 5: Our goal is by June 2024, 100% (all) of CSBs will meet the ISP Compliance performance standard at 86% or above, meaning that at least 86% of their ISPs are in the correct status which is ISP completed or pending provider completion.

Status: Active

This QII was established to determine stakeholder understanding and resources needed to improve ISP Compliance. This process also sets out to modify the ISP compliance report to meet the recommendations made by the Data Quality & Visualization Office in 2022. The actionable recommendation was from the "WaMS_Follow-up_29NOV2022" report included as #5: Ensure that ISPs are completed by their effective date.

Our goal is by June 2024, 100% (all) of CSBs will meet the ISP Compliance performance standard at 86% or above, meaning that at least 86% of their ISPs are in the correct status which is ISP completed or pending provider completion. The baseline data for SFY 2023-Q2 was 70% of CSBs meeting the performance standard of 86%. ISP Compliance is defined as the percent of ISPs in the correct status per the CMSC performance standard.

In June 2023 it was noted that 42.5% of CSBs had been required to submit an improvement plan for ISP compliance since FY22Q4 due to having less than 86% of their ISPs in the correct status. At the same time, the need to change the determination of compliance from proper status by "date of data pull" to the "effective date of each ISP" was identified. Discussions with Support Coordinator supervisors from CSBs identified a variety of reasons compliance standards have not been met. These reasons were organized, and guidance was developed into a slide deck with voiceover, which is currently under review. Once approved by the CMSC, this information will be announced and shared with all CSBs. Transition to the new parameter of determining compliance will become effective no less than 60 days following this announcement.

Performance Measures

The CMSC monitors CSB performance through 20 measures that correlate with the settlement agreement (SA) and improved outcomes in system performance or for people who have services in Virginia. Below is a list of measures currently monitored for SFY24. Certain measures are identified as "Performance Measure Indicators" (PMIs), which are also monitored by the DBHDS Quality Improvement Committee (QIC) to determine the overall health and direction of the DD system. Progress and lack of progress in these areas leads to individual technical assistance and recommendations for systemic change. Measures are organized below by domain.

FY24 Case Management Measures

Access to Services

1	86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process (Target 86%). **III.C.7.a.**
2	Proportion of Adults (aged 18-64) with a DD waiver receiving case management services that are interested in employment and have an ISP that contains employment outcomes. (Target 86%)
3 (**PMI**)	Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP. (Target 86%). **III.C.7.a.**
4	Individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process. (Target 86%). **III.C.7.a**
5 (**PMI**)	Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained integrated community involvement outcomes (Target 86%). **III.C.7.a.**
6	Individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. **III.C.7.a.**
7	Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. (Target 86%). *III.D.6.*
8	Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%). **III.D.6.**
9	People with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (defined as independent living supports, in-home support services, supported living, and sponsored residential) have access to an option that meets their preferences within nine months. **III.D.1**

Provider Capacity

10	People with DD Waiver receive face-to-face contacts from their support coordinator at least quarterly (Target 90%). **V.F.4.**
11	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month no more than 40 days apart (Target 90%). **V.F.4.**
12	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month in their residence (Target 90%). **V.F.4.**
13	Support coordination records reviewed across the state will be in compliance with a minimum of nine of the ten indicators assessed in the review. (Target 86%) **III.C.5.b.i**
14	86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations. **V.D.1.**
15	Individual Support Plans are available in the Waiver Management System by direct keyed entry or data exchange since October 7, 2019. **DBHDS Metric/Performance Contract**

Health, Safety, and Wellbeing	
16 (**PMI**)	The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed (Target 86%). **III.C.5.b.iii; V.F.2; V.F.5.**
17 (**PMI**)	Individual support plans are assessed to determine that they are implemented appropriately (Target 86%). **III.C.5.b.iii; V.F.2; V.F.5.**
Choice and Self-Determination	
18 (**PMI**)	Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff) (Target 86%). **V.D.3.f; V.F.5**
19 (**PMI**)	Individuals are given choice of support coordinator, at least annually. (Target 86%) **III.C.5.c; V.F.5**
20 (**PMI**)	Individuals are given choice among providers at least annually. (Target 86%) **III.C.5.c; V.F.5**

Access to Services

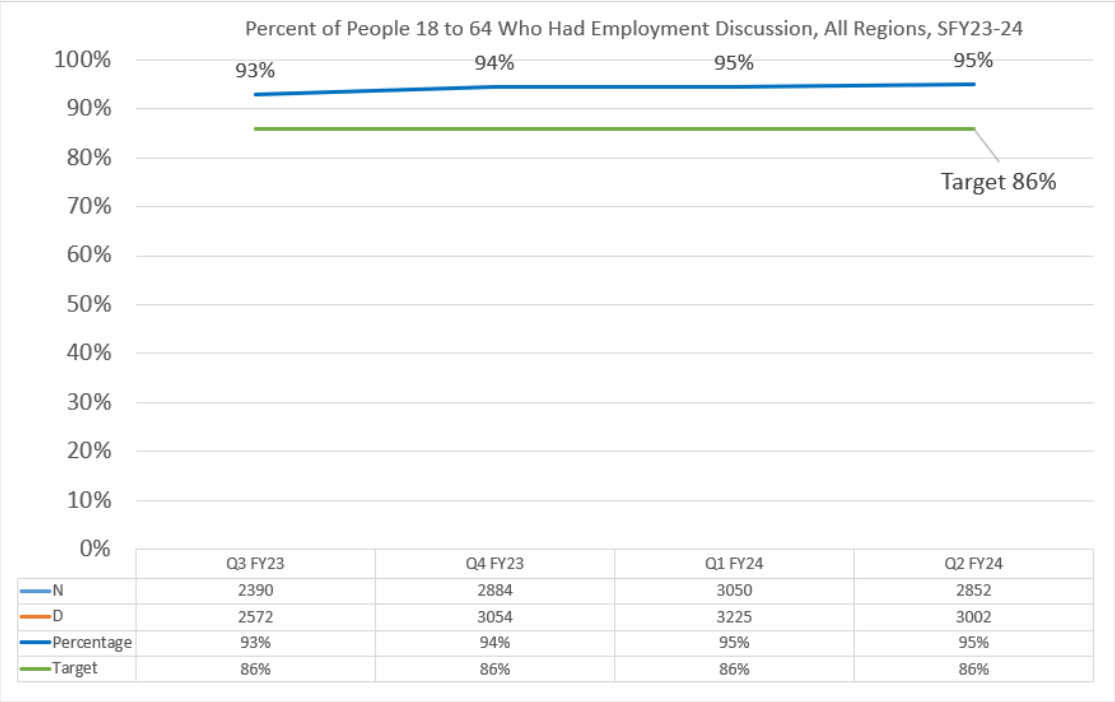
Employment Discussions and Goals

Reference	Measure	Numerator	Denominator
1 *Figure 1*	86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process (Target 86%). **III.C.7.a.**	N = Number of Individuals who had an Employment Discussion at Annual F2F ISP Meeting	D = Number of active individuals who had an Annual F2F ISP Meeting
2 *Figure 2*	Proportion of Adults (aged 18-64) with a DD waiver receiving case management services that are interested in employment (Denominator: Column 9) and have an ISP that contains employment outcomes.	N = Number of Individuals (18-64) who recorded Employment Outcomes at Annual F2F ISP Meeting	D = Number of active individuals (18-64) who had an Annual F2F ISP Meeting who also had Employment Status Looking (whether previously employed or not).
3 **(PMI)** *Figure 3*	Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP. (Target 86%) **III.C.7.a**	N = Number of individuals with the ISP element "Was there a conversation with the individual/substitute decision-maker about employment?" indicated yes, and where the two following discussion elements are confirmed: "what the person is working on at home and school that will lead to employment" and "alternate sources for funding (such as school or DARs)"	D = Number of individuals in active status in WaMS ages 14 to 17 who have a DD waiver

The measure related to the individual participating in a discussion about employment has been consistently above target for the last four quarters, while those with employment goals has consistently been below target. The CMSC has ceased monitoring employment goal development as has been previously reported. This measure continues to be monitored by the Employment First Advisory Group. Instead for the next report, the CMSC will be initiating a new measure stating “Proportion of Adults (aged 18-64) with a DD waiver receiving case management services that are interested in employment and have an ISP that contains employment outcomes.” Baseline for this measure was established in Q4 FY23 at 65% and saw some decline between Q1 and Q2 FY24. The CMSC will continue to monitor.

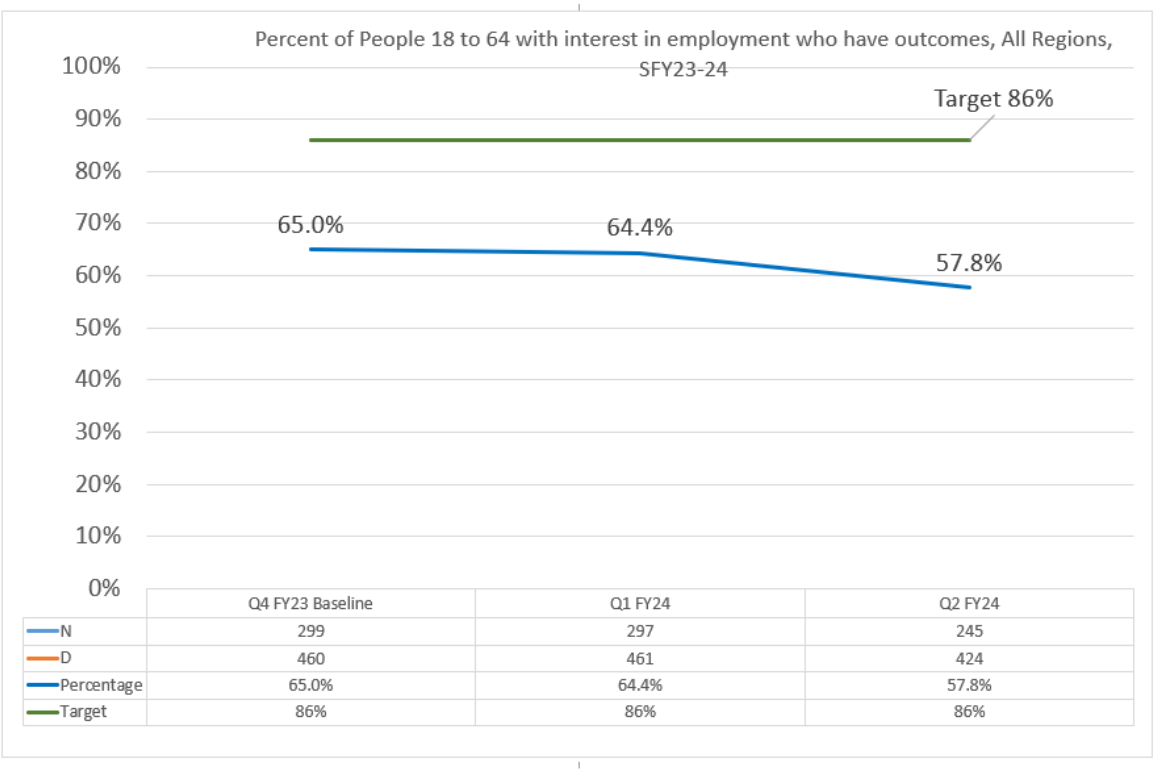
Baseline for the third measure related to transition age youth was established in the 1st quarter FY22, which was 32%. Related elements in the Individual Support Plan were refined in May 2022 to improve the collection of data around employment topics. Results for this measure have increased to 62%, five percent higher than the last report, and which is the highest level seen to date. The CMSC is aware of past efforts by the Regional Quality Council (RQC) in Region V, which sought to provide training and measure improvements in SC knowledge, as well as to measure an increase in employment outcomes for people supported. The CMSC will continue to monitor and ensure the provision of technical assistance through the Offices of Provider Network Supports and Community Quality Improvement. Current results indicate that the first measure remains largely consistent with past reporting. The second is new and will be monitored to determine if action is needed. Measure 3, related to employment discussions with youth, increased to 62% by the end of Q2 FY24.

Fig. 1 Employment Discussions FY23-24



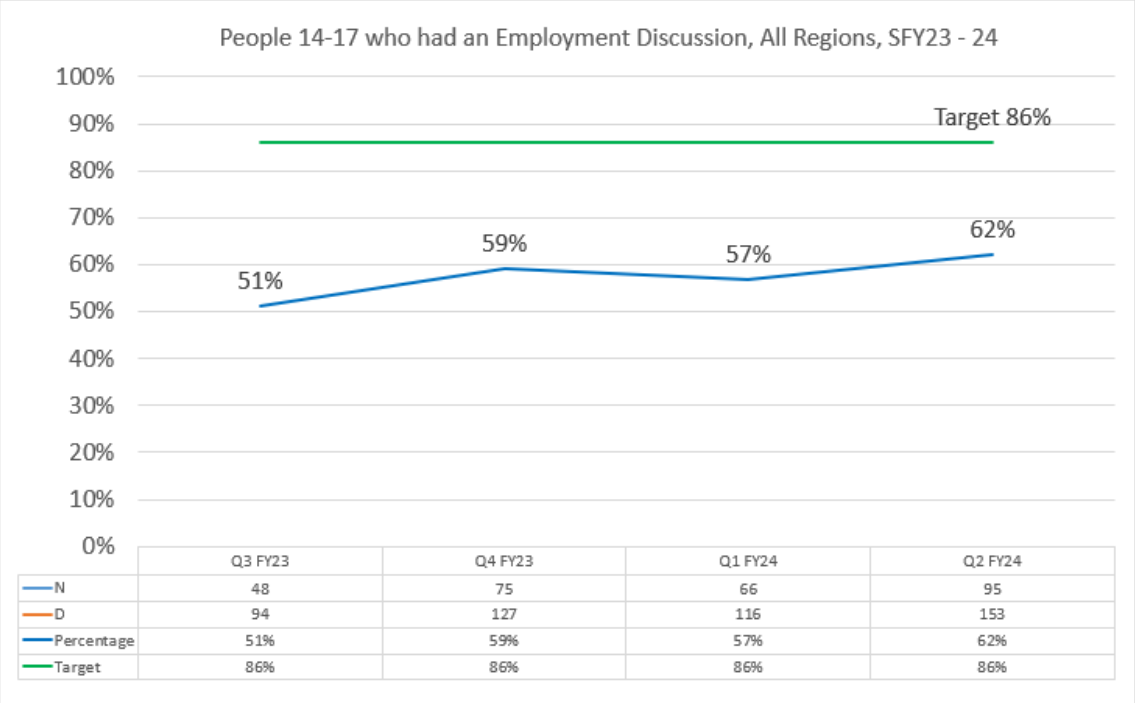
	Q3 FY23	Q4 FY23	Q1 FY24	Q2 FY24
N	2390	2884	3050	2852
D	2572	3054	3225	3002
Percentage	93%	94%	95%	95%
Target	86%	86%	86%	86%

Fig. 2 Employment outcomes for people 18-64 with employment interest FY23-24



	Q4 FY23 Baseline	Q1 FY24	Q2 FY24
N	299	297	245
D	460	461	424
Percentage	65.0%	64.4%	57.8%
Target	86%	86%	86%

Fig 3. Employment Discussion 14-17 (both topics confirmed) FY23-24



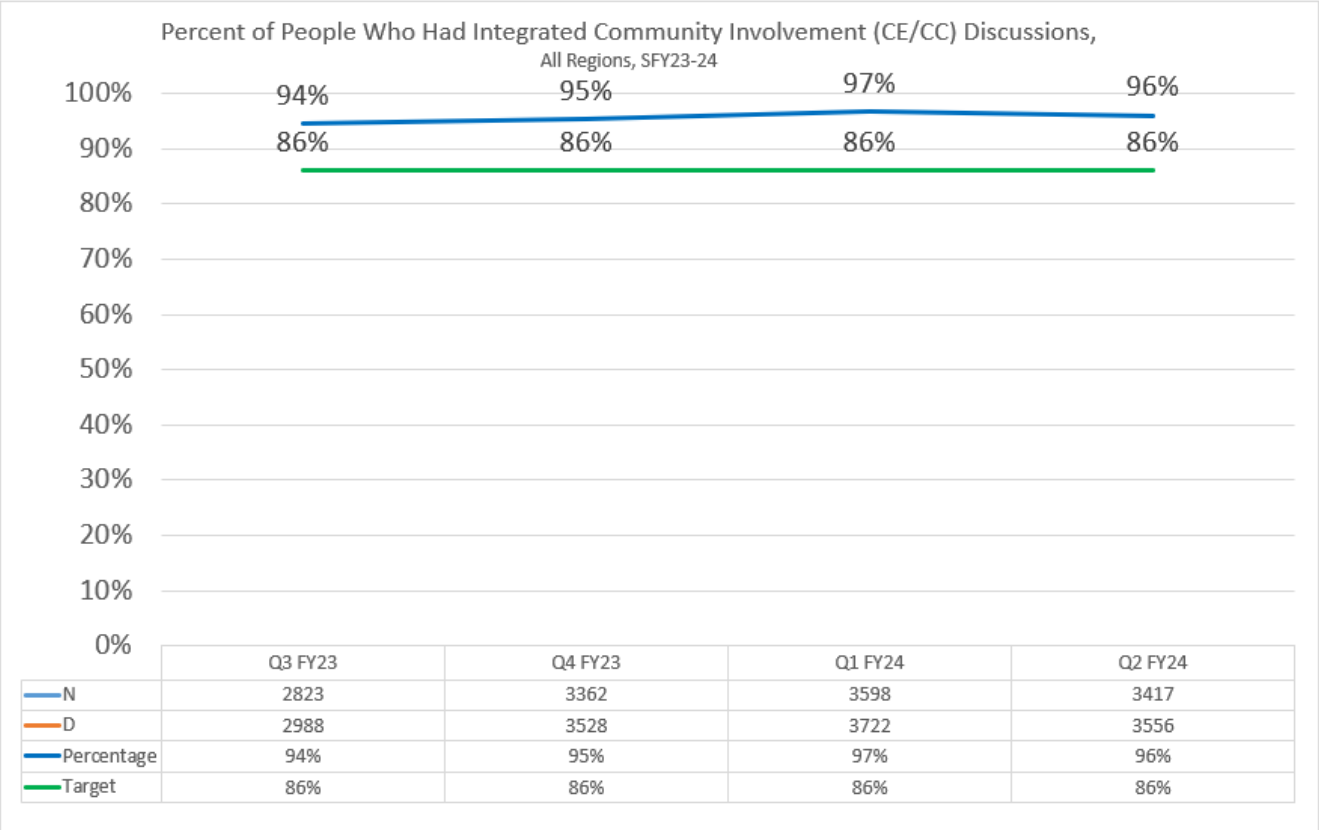
	Q3 FY23	Q4 FY23	Q1 FY24	Q2 FY24
N	48	75	66	95
D	94	127	116	153
Percentage	51%	59%	57%	62%
Target	86%	86%	86%	86%

Community Engagement Discussions and Goals

Reference	Measure	Numerator	Denominator
4 *Figure 4*	Individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process. **III.C.7.a**	N = number of Individuals who received Community Engagement Discussion at Annual F2F ISP Meeting	D = number of active Individuals who had an Annual F2F ISP Meeting
5 (**PMI**) *Figure 5*	Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained integrated community involvement outcomes (Target 86%) **III.C.7.a**	N = Number of Individuals recorded Integrated Community Involvement Outcomes at Annual F2F ISP Meeting	D = Number of active individuals who had an Annual F2F ISP Meeting
6 *Figure 6*	Individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. **III.C.7.a**	N = Number of ISPs with one or more outcomes under the Integrated Community Involvement and/or the Community Living life areas in the ISP: Shared Plan	D = Number of individuals in active status on one of the DD Waivers

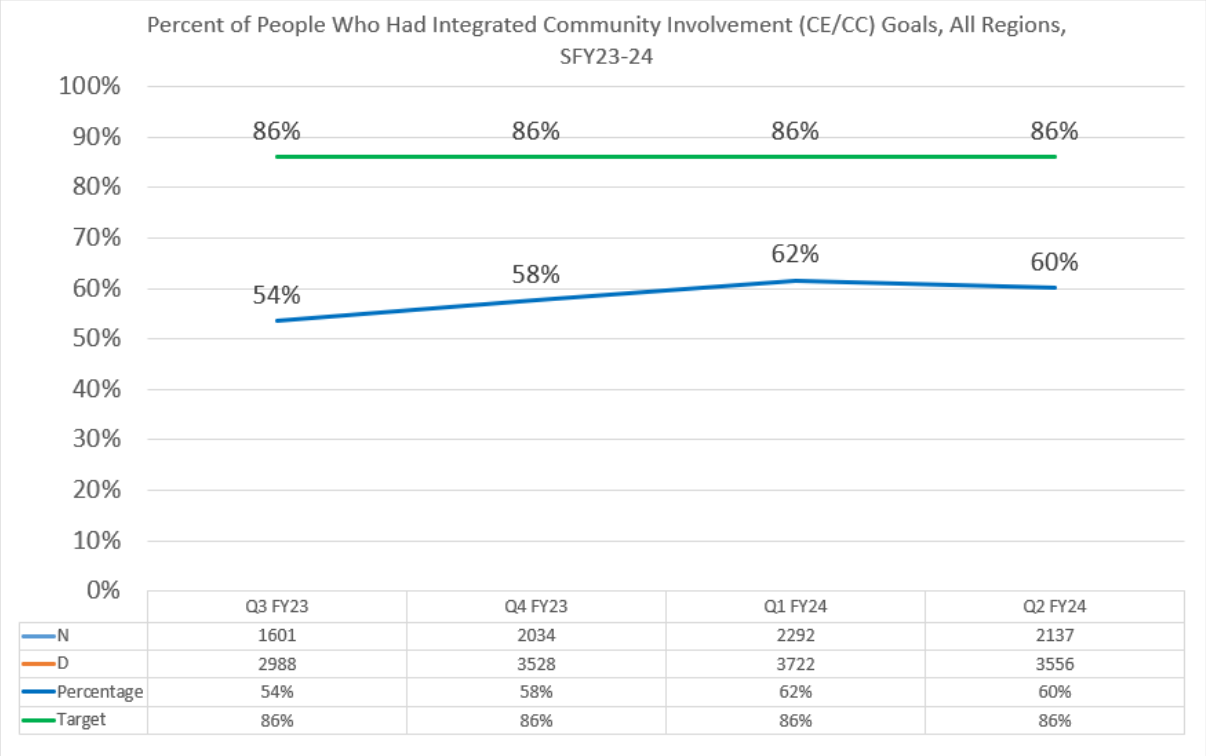
The measure related to individuals participating in a discussion about integrated community involvement has been consistently above target for the last four quarters, while the measure related to integrated community involvement outcomes has consistently been below target. The focus of these measures is on community involvement at a ratio of no more than one staff to three individuals regardless of the service utilized. The CMSC acknowledges the reality of current staffing concerns across the system and the receding pandemic as ongoing concerns around these measures. Baseline for the third measure (Figure 6) related to community involvement was established in the 1st quarter FY22. Results remain above target for this measure.

Fig. 4 Integrated Community Involvement (Community Engagement) Discussions FY23-24



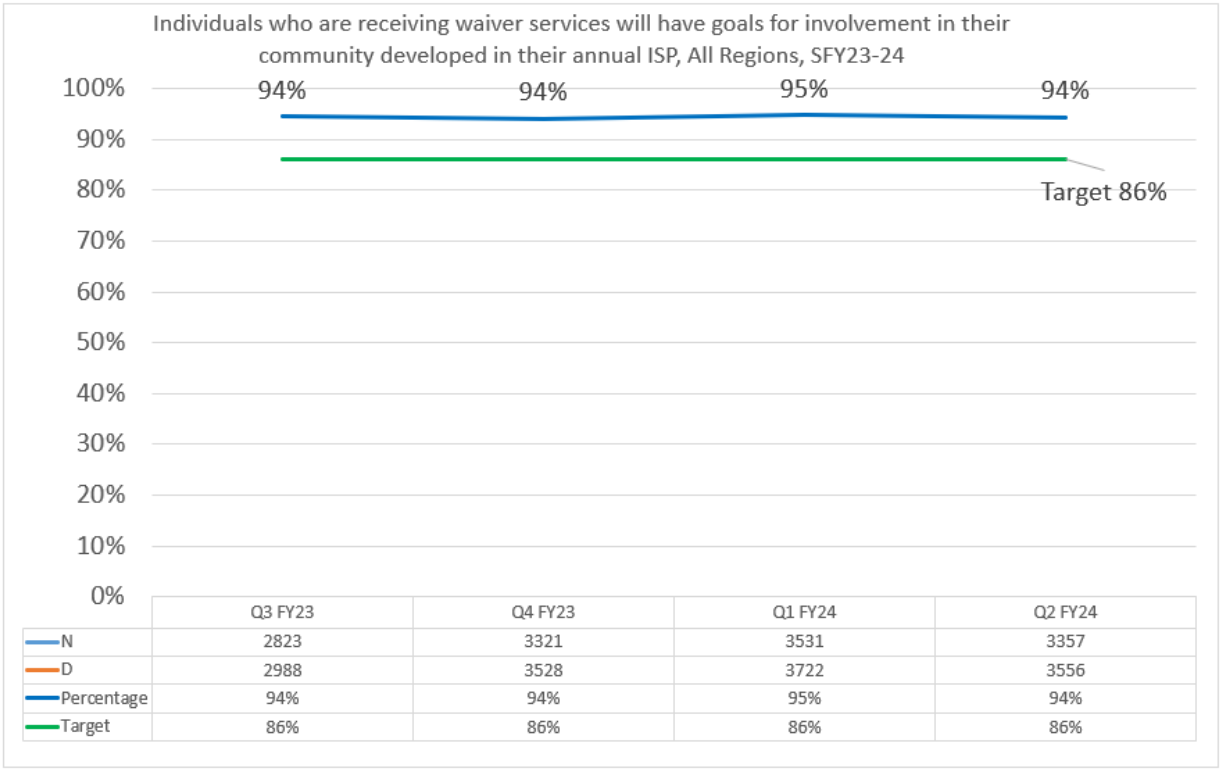
	Q3 FY23	Q4 FY23	Q1 FY24	Q2 FY24
N	2823	3362	3598	3417
D	2988	3528	3722	3556
Percentage	94%	95%	97%	96%
Target	86%	86%	86%	86%

Fig. 5 Integrated Community Involvement (Community Engagement) Outcomes FY23-24



	Q3 FY23	Q4 FY23	Q1 FY24	Q2 FY24
N	1601	2034	2292	2137
D	2988	3528	3722	3556
Percentage	54%	58%	62%	60%
Target	86%	86%	86%	86%

Fig. 6 Community Involvement Outcomes FY23-24



	Q3 FY23	Q4 FY23	Q1 FY24	Q2 FY24
N	2823	3321	3531	3357
D	2988	3528	3722	3556
Percentage	94%	94%	95%	94%
Target	86%	86%	86%	86%

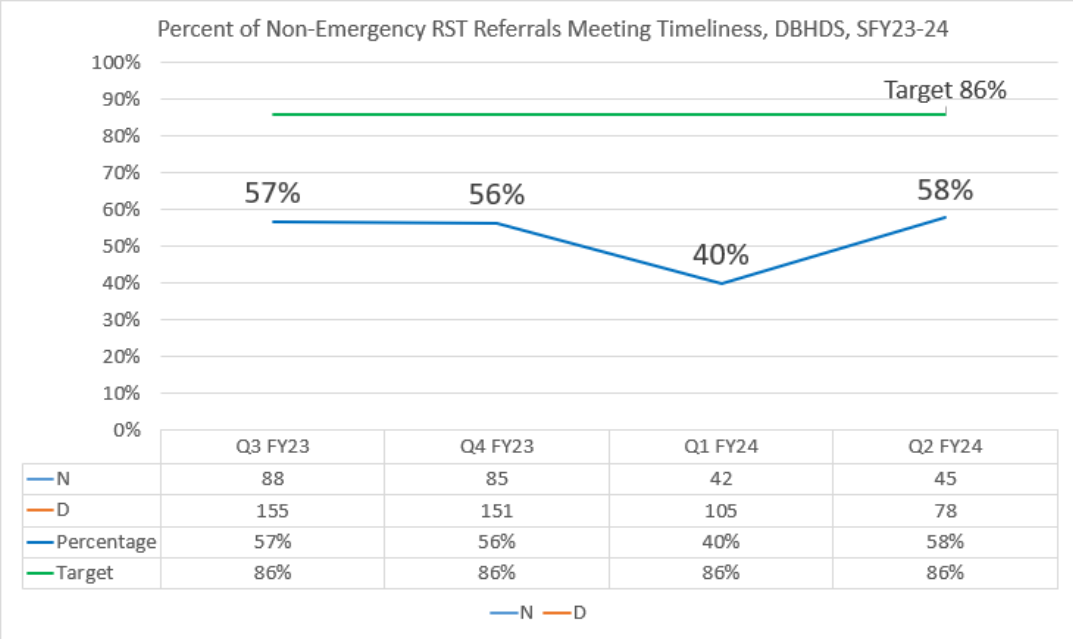
Regional Support Teams and Timeliness of Referrals

Reference	Measure	Numerator	Denominator
7 **(PMI)** *Figure 7*	Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. (Target 86%). **III.D.6.**	N = Number of non-emergency RST referrals made on time.	D = Number of non-emergency RST referrals.
8 **(PMI)** *Figure 8*	Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%). **III.D.6.**	N = Number of on time non-emergency referrals for individuals selecting a less integrated residential waiver option submitted by CSBs	D = Number of non-emergency RST referrals submitted by CSBs
9 Figure	People with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (defined as independent living supports, in-home support services, supported living, and sponsored residential) have access to an option that meets their preferences within nine months. **III.D.1**	N = Number of individuals moving to a location that meets their needs and preferences within 9 months.	D = Number of individuals identified with Barrier 2, "Services not available in desired location," on an RST referral.

On January 1st, 2023, DBHDS moved the Regional Support Team (RST) process into the Waiver Management System (WaMS) as required by III.D.6. The first of two RST WaMS module overview sessions occurred on October 27th, 2022, in preparation for the transition to WaMS. This recording is available on the DBHDS website and shows the features and process of using the RST referral form and associated Virginia Informed Choice (VIC) form. CSBs had the option of using the new WaMS RST Module for referrals through December 2022 to adapt to the new process leading up to January 1. Overall, the launch of the module was considered successful

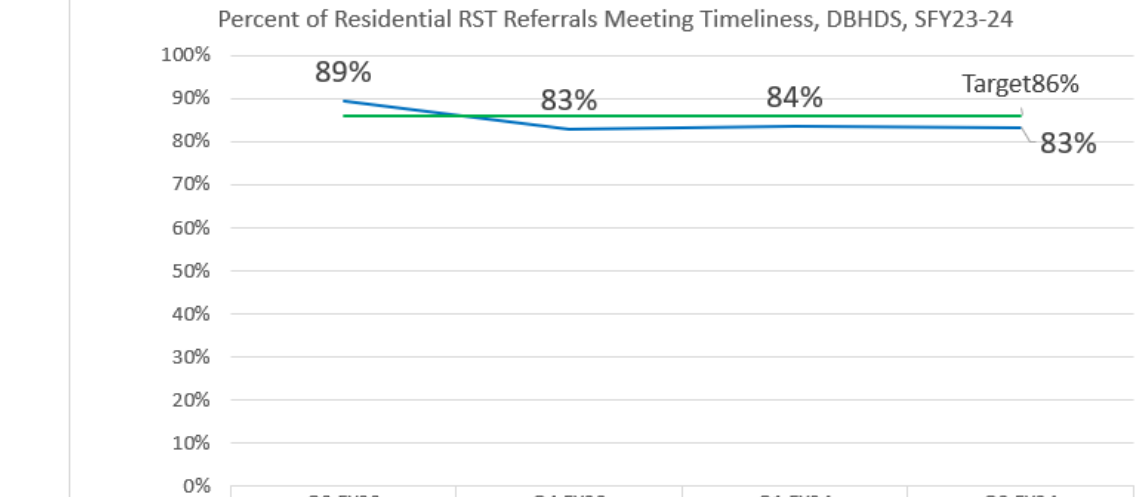
Data from the WaMS RST module has been added to a PowerBI dashboard and significant work has gone into development, which will be refined and improved over time. Beginning with Q4 FY23, all data derives from the WaMS system with the exception of missed referrals, which by necessity remains a manual process with results being added to the dashboard once completed. In Q2, the systemwide measure for RST referral timeliness reached 58%, which is the highest in the past four quarters. The residential related measure maintained closely in relation to last report. The CMSC will work with the RST coordinator to determine specific causes for lower counts and explore opportunities to improve performance.

Fig. 7 RST Referral Timeliness FY23-24



	Q3 FY23	Q4 FY23	Q1 FY24	Q2 FY24
N	88	85	42	45
D	155	151	105	78
Percentage	57%	56%	40%	58%
Target	86%	86%	86%	86%

Fig. 8 RST Residential Community Referral Timeliness FY23-24



	Q3 FY23	Q4 FY23	Q1 FY24	Q2 FY24
N	135	121	82	60
D	151	146	98	72
Percentage	89%	83%	84%	83%
Target	86%	86%	86%	86%

Fig. 9 Number of individuals meeting criteria for Indicator #13

RST Referral Form Question: Are more integrated residential options (to include Independent Living Supports, In-home Support Services, Supported Living, Sponsored Residential) not operating in the desired location, if requested?

Region	2024 Q1 No	2024 Q1 Total	2024 Q2 No	2024 Q2 Total	Total
Region I	29	**29**	18	**18**	**47**
Region II	11	**11**	10	**10**	**21**
Region III	19	**19**	17	**17**	**36**
Region IV	21	**21**	15	**15**	**36**
Region V	13	**13**	8	**8**	**21**
Total	**93**	**93**	**68**	**68**	**161**

Q1 and Q2 Result

Numerator and Denominator	Count
Numerator = Number of referrals confirmed as resolved within the 9-month timeframe calculated in WaMS	N/A
Denominator = Number of RST referrals where the RST confirmed the barrier stated as "Are more integrated residential options (to include Independent Living Supports, In-home Support Services, Supported Living, Sponsored Residential) not operating in the desired location, if requested?" as yes.	0

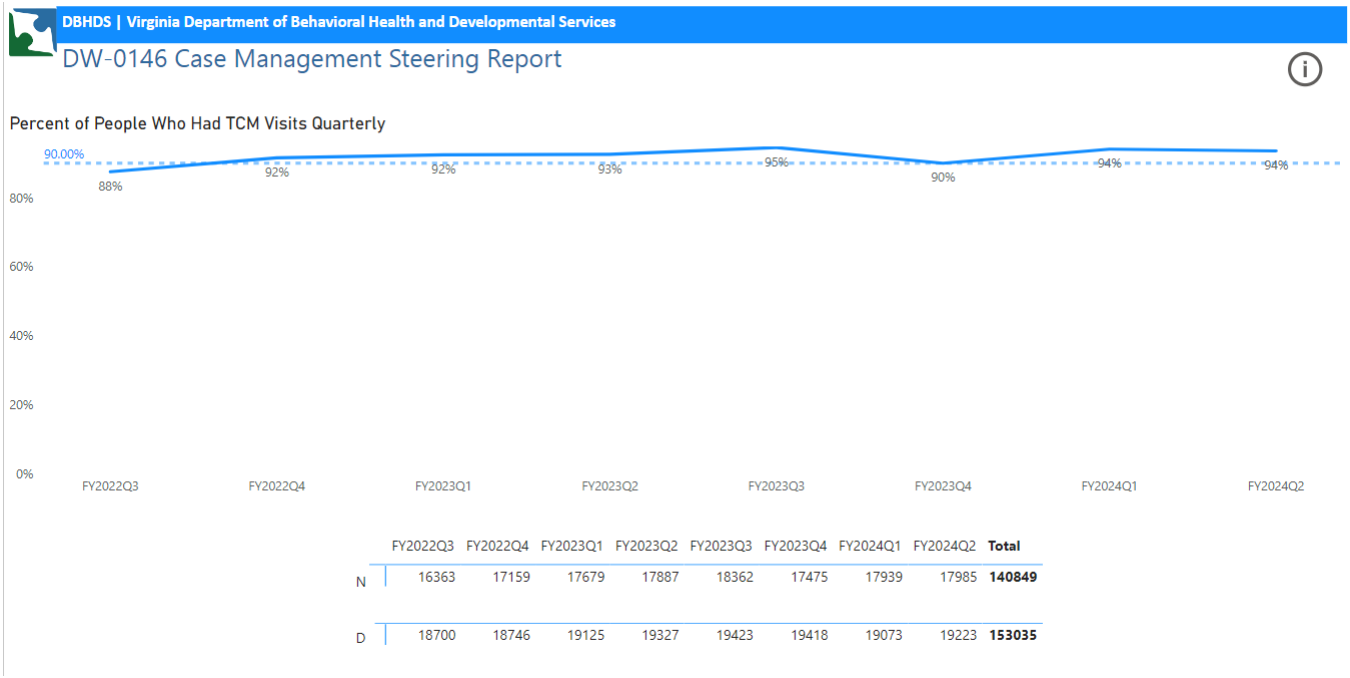
Provider Capacity

Case Management Face to Face Visits (F2F) and Effectiveness

Reference	Measure	Numerator	Denominator
10 *Figure 10*	People with DD CM Services receive face-to-face contacts from their support coordinator at least quarterly. (Target 90%) **V.F.4**	N = Number of individuals with DD Case Management Services with at least one face to face contact quarterly.	D = Number of individuals with DD Case Management services 200/320
11 *Figure 11*	Individuals enrolled in a Developmental Disability Waiver identified as meeting ECM criteria will receive face to face visits every month no more than 40 days apart. (Target 90%) **V.F.4**	N = Number of individuals identified as needing ECM who have a documented face to face visit at least monthly with no more than 40 days between visits.	D = Number of individuals with DD Case Management services 200/321
12 *Figure 12 and 12a*	Individuals enrolled in a Developmental Disability Waiver identified as meeting ECM criteria will receive face to face visits every other month in their residence. (Target 90%) **V.F.4**	N = Number of individuals identified as needing ECM who have a documented face to face in the home setting every other month.	D = Number of individuals with DD Case Management services 200/322
13 *Figure 13*	Support coordination records reviewed across the state will be in compliance with a minimum of nine of the ten indicators assessed in the review. (Target 86%) **III.C.5.b.i.**	N = Number of records identified as meeting at least 9 of the 10 identified CM elements per III.C.5.b.i.	D = Number of records of individuals, enrolled in a DD waiver with at least one approved waiver service, reviewed, through the SCQR instrument, by CSBs.
14 *Figure 14*	86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations **V.D.1.**	N = Number of individuals authorized for one or more DD waiver services within 5 months of enrollment.	D = Number of individuals enrolled in a DD waiver.
15 Figure 15	Individual Support Plans are available in the Waiver Management System by direct keyed entry or data exchange since October 7, 2019. (Target 86%) **DBHDS Metric/Performance Contract**	N = Number of individuals with WaMS ISPs in Pending Provider Completion or ISP Completed status.	D = Number of individuals with WaMS ISPs due in the reporting quarter.

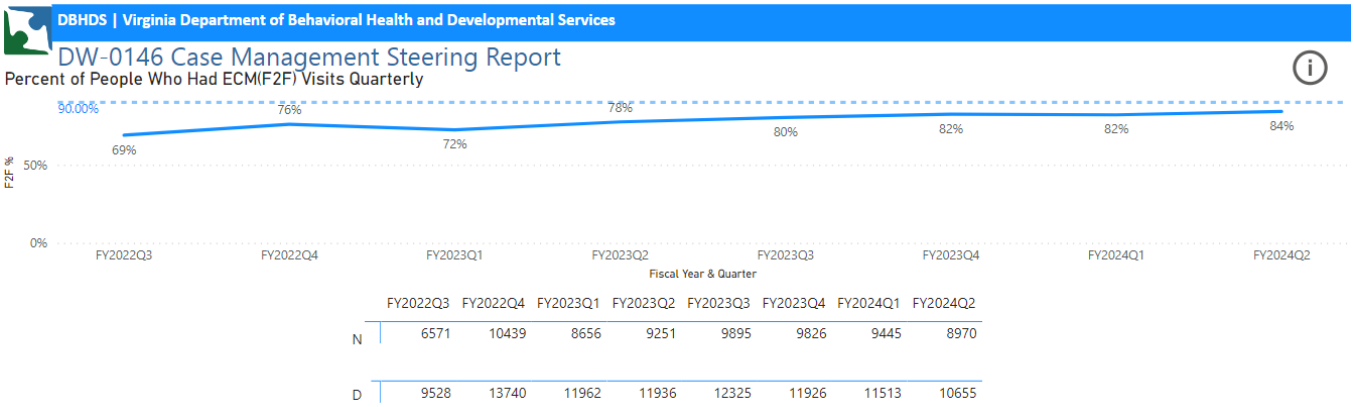
Data regarding TCM face-to-face visits is available for FY24. Based on the results below, there was at or above target performance in all quarters of FY23 (Figure 10). Overall results for FY23 ECM face-to-face (Figure 11) and ECM in the home (Figure 12) ended below target for the year, however both show an incremental improvement throughout FY23. In the third quarter FY22, the Office of Provider Network Supports began a Data Quality Support Process with CSBs to examine a sample of case management contact data to enable comparisons between CCS, WaMS, and CSB electronic health records. The primary focus of these sessions is to support CSBs with identifying and resolving any data reliability and validity issues. This process continues with an annual sample of CSBs and CSBs will be included based on under performance in this area. The implementation of the SC Retention QII reported above is expected to support improvements in this area as well. As of this report, a finalized PowerBI dashboard was developed for conducting these reviews in calendar year 2023.

Fig. 10 TCM visits FY22-24



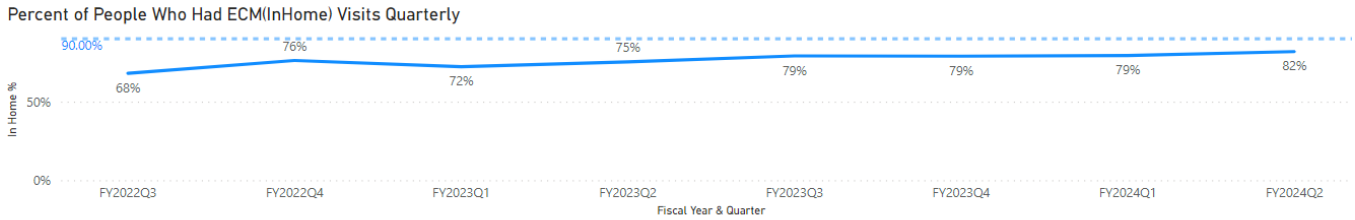
	FY2022Q3	FY2022Q4	FY2023Q1	FY2023Q2	FY2023Q3	FY2023Q4	FY2024Q1	FY2024Q2	Total
N	16363	17159	17679	17887	18362	17475	17939	17985	**140849**
D	18700	18746	19125	19327	19423	19418	19073	19223	**153035**

Fig. 11 ECM face to face visits FY22-24



	FY2022Q3	FY2022Q4	FY2023Q1	FY2023Q2	FY2023Q3	FY2023Q4	FY2024Q1	FY2024Q2
N	6571	10439	8656	9251	9895	9826	9445	8970
D	9528	13740	11962	11936	12325	11926	11513	10655

Fig. 12 Face to face ECM visits in-home FY22-24



	FY2022Q3	FY2022Q4	FY2023Q1	FY2023Q2	FY2023Q3	FY2023Q4	FY2024Q1	FY2024Q2
N	6485	10466	8642	8991	9750	9417	9140	8720
D	9528	13740	11962	11936	12325	11926	11513	10655

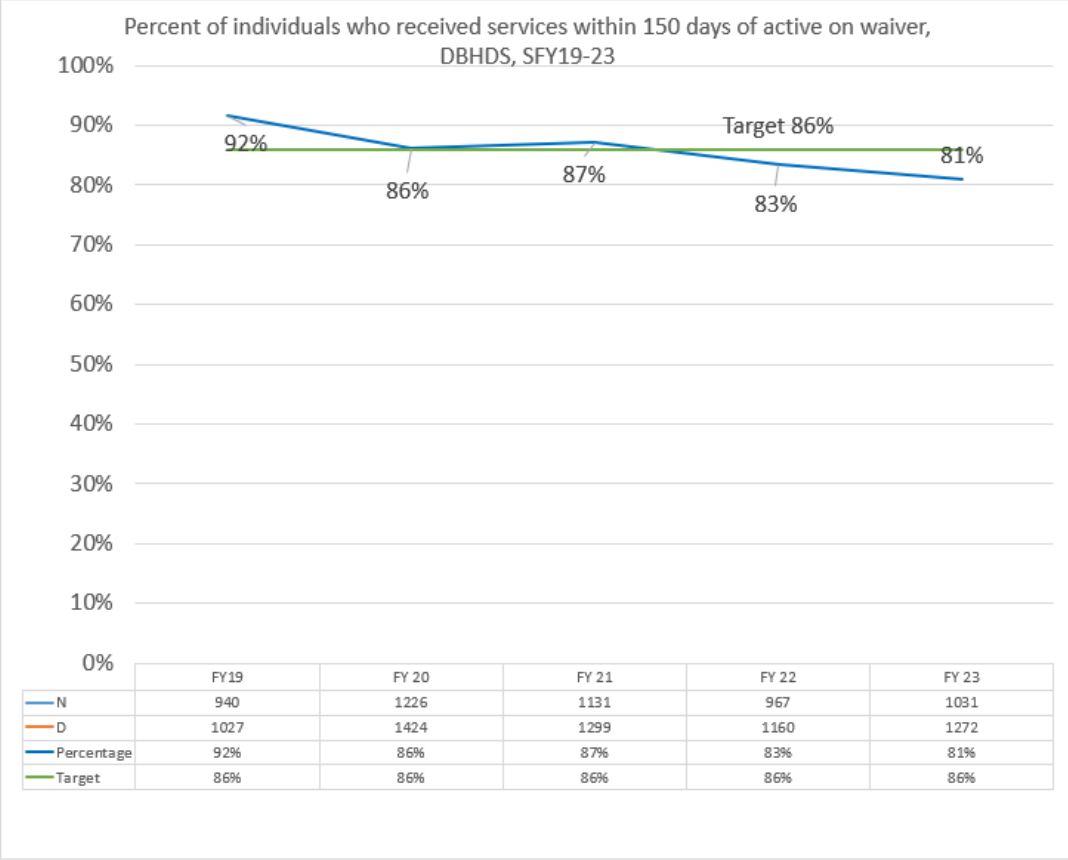
Sixty-four percent of records were found in compliance on at least nine out of ten indicators. This is an improvement from FY22, when 53% of records were found in compliance. Agreement between CSBs and OCQI has been improving on most indicators, with no significant decreases. The percentage of CSBs reporting compliance with each indicator are displayed, with the percentage from FY21 to FY23 reported for comparison purposes. (Figure 13).

Fig. 13 Records in compliance with 9 of 10 assessed indicators FY23

Indicator	FY21 CSB-reported compliance	FY22 CSB-reported compliance	FY23 CSB-reported compliance
Records with either 9 or 10 indicators in compliance	**42%**	**53%**	**64%**

Annual results for statistics regarding 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations, is established as at or above target for the three years between FY19 and FY21 (Figure 14). Performance dropped below target in FY22 where the result was 83%. Joint efforts with the Department of Medical Assistance Services (DMAS) have occurred in FY23 to initiate services with individuals following the national public health emergency ends. Data for FY23 will be transitioning to quarterly tracking for Q1 FY24 in Q3 FY24 and will be available once the 150-day post-period occurs each quarter and will be reported in the next semi-annual report.

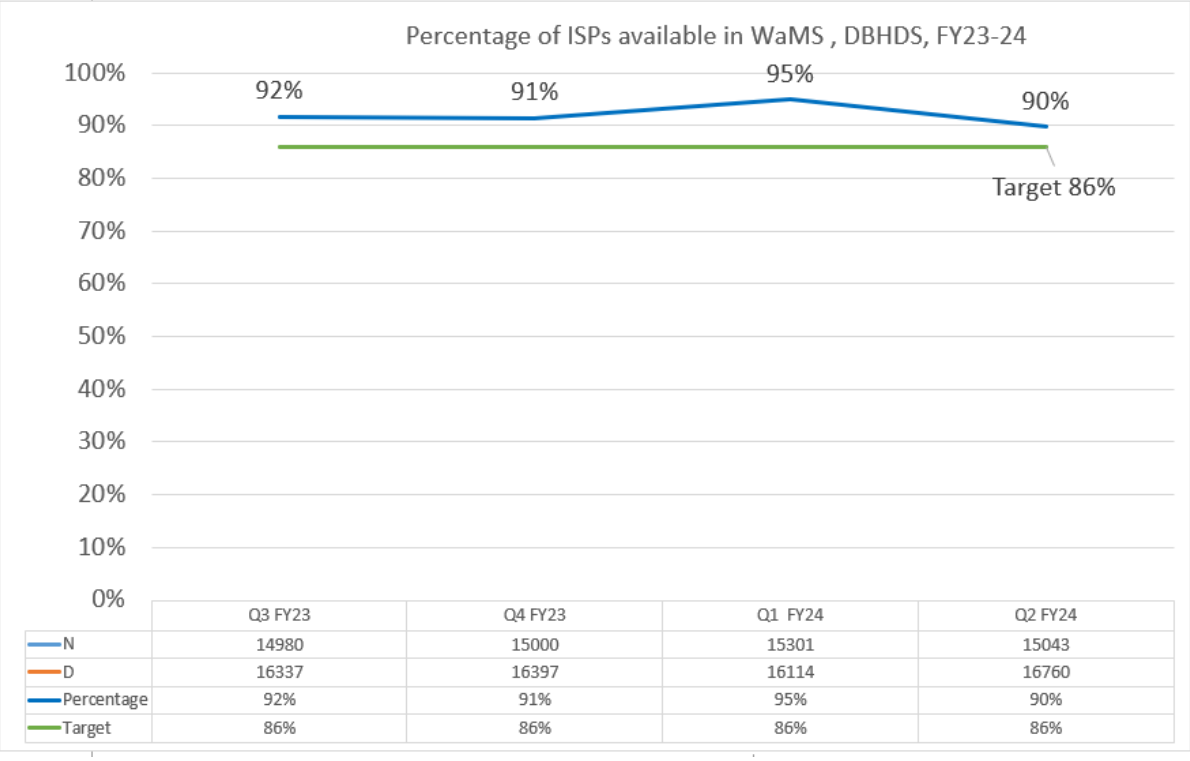
Fig. 14 Services within 150 days of Waiver FY19-FY23 results



	FY19	FY 20	FY 21	FY 22	FY 23
N	940	1226	1131	967	1031
D	1027	1424	1299	1160	1272
Percentage	92%	86%	87%	83%	81%
Target	86%	86%	86%	86%	86%

The ISP compliance target returned to above target performance in the second quarter of FY23 with the past four quarters remaining above target (Fig. 15). The CMSC is working to begin a transition in data reporting for this measure in FY23. Currently, compliance is calculated on the status of ISPs at the point of the data pull. Once this effort is completed, data reporting will align with recommendations from the former DBHDS Office of Epidemiology and Health Analytics, which centered on ensuring that data is entered into a proper status by the effective date of each ISP. The data reporting provided to CSBs will be adjusted to this new method with an explanation of the reason for the change and a voice over video explaining the new standard.

Fig. 15 ISP compliance FY23-24



	Q3 FY23	Q4 FY23	Q1 FY24	Q2 FY24
N	14980	15000	15301	15043
D	16337	16397	16114	16760
Percentage	92%	91%	95%	90%
Target	86%	86%	86%	86%

Health, Safety, and Wellbeing

Change in Status and Appropriately Implemented Services

Reference	Measure	Numerator	Denominator
16 *(**PMI**) Figure 16*	The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. (Target 86%) **III.C.5.b.iii; V.F.2; V.F.5**	N = Number of records confirming all SCQR questions 77 AND also confirming "yes" or "not applicable" on Q79	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs
17 **(PMI)** *Figure 16*	Individual support plans are assessed to determine that they are implemented appropriately. (Target 86%) **III.C.5.b.iii; V.F.2; V.F.5**	N = Number of records confirming all SCQR questions 72 and 74	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs

The charts below provide results as reported by CSBs in the FY23 SCQR submitted results. The results for both measures showed maintenance in compliance. Indicator 9 and 10 both increased from 75 to 84% since FY21 and both show substantial agreement in the look-behind and interrater review provides increased confidence in the reliability of these results.

Fig. 16 FY23 results for change in status.

	No	Yes	Total	Percentage
Measure 16 :The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. (Target 86%) *(SCQR Indicator 10)*	76	403	479	84.1%

FY21	FY22	FY23
75%	84%	84%

Indicator 10: 84.1%

Question	CSB Responses	Look Behind	OCQI Agreement
Q72. Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	No 68 (14%) Yes 411 (86%)	Agreement 86% Maxwell RE 0.72	Agreement 100% Maxwell RE 1
Q77. Did each OSVT have all areas under "Change In Status" and "Change in Status Determination" completed?	No 37 (8%) Yes 442 (92%)	Agreement 81% Maxwell RE 0.62	Agreement 98% Maxwell RE 0.96
Q79. If any of the four OSVTs identified a change in status within the "Change in Status Determination" section, were revisions made to the ISP?	No[0] 25 (5%) Not applicable: Changes noted, but no revision necessary. [2] 28 (6%) Not applicable: No changes in status or needs. [3] 412 (86%) Yes[1] 14 (3%)	Agreement 70% Maxwell RE 0.6	Agreement 86% Maxwell RE 0.81

Fig. 17 FY23 results for appropriately implemented services and change in status.

	No	Yes	Total	Percentage
Measure 17 : Individual support plans are assessed to determine that they are implemented appropriately. (Target 86%) *(SCQR Indicator 9)*	78	401	479	83.7%

FY21	FY22	FY23
75%	84%	84%

Indicator 9: 83.7%

Question	CSB Responses	Look Behind	OCQI Agreement
Q72. Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	No 68 (14%) Yes 411 (86%)	Agreement 86% Maxwell RE 0.72	Agreement 100% Maxwell RE 1
Q74. Did all four OSVTs have all areas under "Services Implemented Appropriately" completed?	No 58 (12%) Yes 421 (88%)	Agreement 84% Maxwell RE 0.68	Agreement 100% Maxwell RE 1

Choice and Self-Determination

Reference	Measure	Numerator	Denominator
18 *(***PMI***)* *Figure 18*	Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff). (Target 86%) **V.D.3.f; V.F.5**	N = Number of individual records for which the response was "Yes" to SCQR Q42	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs
19 (**PMI**) *Figure 19*	Individuals are given choice among providers, including choice of support coordinator, at least annually. (Target 86%) **III.C.5.c; V.F.5**	N = Number of individual records for which the response was "Yes" to both components of SCQR Q26	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs annually

The charts below provide results as reported by CSBs in the current year of the SCQR. These results are based on CSB-submitted data and will include the levels of agreement found through the look-behind process in the next report. The CMSC has added clarified instruction to the Virginia Informed Choice (VIC) form available on the DBHDS website and has submitted a change request to WaMS Administration to ensure that the SC first and last names are added to the VIC. Of the three measures reported below, indicator 1 was below target with only 82.7% meeting the requirement. Substantial agreement seen across all measures in FY23.

Measure 18, Fig. 18 FY23 results for unpaid relationships discussion

	Yes	No	Percentage
Measure 18: Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff). (Target 86%)	430	49	89.8%

Q42. Is it evident in the PC ISP that the SC/CM discussed relationships and interactions with people other than paid program staff?	No 49 (10%) Yes 430 (90%)	Agreement 88% Maxwell RE 0.76	Agreement 98% Maxwell RE 0.96

Measure 19, Fig. 19 FY21 to FY23 results for choice

Indicator	FY21 CSB-reported compliance	FY22 CSB-reported compliance	FY23 CSB-reported compliance
...support coordinator? (named) [New indicator 1]	89%	79%	83%
...DD waiver providers? [New indicator 2]	98%	90%	93%

Indicator 1: 82.7% Met

Question	CSB Responses	Look Behind	OCQI Agreement
Q18. Is there a signed Virginia Informed Choice (VIC) DMAS 460 form for the current PC ISP?	No 27 (6%) Yes 452 (94%)	Agreement 92% Maxwell RE 0.84	Agreement 100% Maxwell RE 1
Q20. Does the completed VIC confirm that the individual was offered a choice of... - ...support coordinator (named)?	No 56 (12%) Yes 396 (83%) NA 27 (6%)	Agreement 83% Maxwell RE 0.74	Agreement 100% Maxwell RE 1

Indicator 2: 92.9% Met

Question	CSB Responses	Look Behind	OCQI Agreement
Q18. Is there a signed Virginia Informed Choice (VIC) DMAS 460 form for the current PC ISP?	No 27 (6%) Yes 452 (94%)	Agreement 92% Maxwell RE 0.84	Agreement 100% Maxwell RE 1

Question	CSB Responses	Look Behind	OCQI Agreement
Q20. Does the completed VIC confirm that the individual was offered a choice of... - ...DD Waiver providers?	No 7 (1%) Yes 445 (93%) NA 27 (6%)	Agreement 89% Maxwell RE 0.84	Agreement 100% Maxwell RE 1

Office of Licensing Data

In October, the Office of Licensing shared the 7th semi-annual reporting period (from 1/1/23- 6/30/23) results for CM providers. This report is related to V.G.3 of the Settlement Agreement. A crosswalk is used by the Licensing Specialist conducting the review that is related to the domains in the Settlement Agreement, as well as the Licensing regulations. The Licensing Specialist reviews a sample of individual records at each inspection, and if a CSB or provider is found not in compliance, the related regulation is cited. All the domains in the report were above compliance except for Stability. Stability increased from 42.86% to 84.09% due to having a larger sample size. Regulations below 86% during the 7th semi-annual reporting period are 1240.11, 160D.2, 1240.12 and 1245. In the coming quarter, the committee with consider regulation 1245, which may overlap with SCQR indicators 9 and 10.

DMAS Quality Management Reviews

Data from DMAS Quality Management Reviews is included in the Quality Review Team reports, which were reviewed by the CMSC in January 2022. The CMSC considered all measures monitored by the QRT and identified those that are correlated with the work of the CMSC. The results of these measures will be considered as surveillance data when looking at individual and system wide CSB performance and can enhance any subsequent recommendations made by the committee.

The Committee also partnered with the Department of Medical Assistance Services (DMAS) to develop a process related to indicator 2.20 of the Settlement Agreement joint filing:

> "All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or DBHDS licensing regulations. Corrective actions for cited regulatory non-compliance will be tracked to ensure remediation."

To meet the indicator stated above, DBHDS and DMAS work collaboratively to identify and respond to citations related to the ten CM elements included in the Support Coordinator Quality Review (SCQR). QMR reviews each CSB once every three years. In addition to monitoring and technical assistance provided through the Support Coordination Quality Review (SCQR), these QMR reviews enable the identification and tracking of elements identified outside of the SQCR sample. This process includes consideration of citations related corrective actions that are monitored on a quarterly basis through a joint meeting that includes QMR Analysts from DMAS and Community Resource Consultants from DBDHS.

Identified CSBs are included as a standing item at these meetings. DMAS provides the names of CSBs cited along with any progress made in programmatic changes or approved Corrective Action Plans that indicateprogress or lack of progress toward resolving concerns.

Basic steps include:

- Letters are provided to DBHDS by QMR
- Names of CSBs are added to the quarterly meeting agenda for cross-agency discussion
- Tracking the remediation of issues is included with each agenda; any unresolved remediation will carry over from meeting to meeting until resolved

- Findings will be shared with the DBHDS Case Management Steering committee when technical assistance is declined and/or at the discretion of the group when remediation efforts are deemed ineffective.

As determined by the group, additional support to identified CSBs will be provided by DBHDS in the effort to ensure successful remediation of identified issues.

In Q3 FY23, DMAS provided input into the final spreadsheet for discussion and tracking by the joint group. The focus of this process is ensuring that corrective actions related to the ten indicators are addressed in the CSB action plan that is subsequently approved by DMAS. Community Resource Consultant support will be offered to CSBs to assist with remediating identified issues and preparing planned actions for DMAS approval. Any subsequent citations will be tracked and remediated as identified.

During the report period, four CSBs were cited for one or more indicators. Two of the four accepted CRC technical assistance following the CAP. Across these four CSBs all were cited for the following elements: 2 (assessing risk), 3 (change in status), 4 (CM developing comprehensive ISP), 5 (measurable outcomes), 6 (shared ISP development), and 7 (necessary services and supports).

Quality Service Reviews

In November, the CMSC reviewed the Round 5 QSR report. The Committee was uncertain about what was behind some of the results and will review HSAG survey guidance in the next Round to better understand how individual items are assessed. There was a recommendation related to SC competencies. While there are no observed competencies in place, the CMSC will consider how competency standards might be achieved through the SC 101 training currently under development.

To address past HSAG recommendations, the Office of Provider Network Supports has updated the DD Support Coordination Handbook, which will complete public comment in January 2024 and will be made available to CSBs following this process. The CMSC continues implementing a QII focused on SC retention, which is expected to have an impact on SC role manageability and satisfaction.

Performance Contract Indicator Data

As reported above, the CMSC is implementing an Improvement Plan process that includes issuing requests for improvement plans from CSBs who meet the established threshold for underperformance with Regional Support Team referrals, which is stated in the Settlement Agreement joint filing as

> "DBHDS will require CSBs to submit corrective action plans through the Performance Contract when there is a failure to meet the 86% criteria for 2 consecutive quarters for submitting referrals or timeliness of referrals.
> 7. Failure of a CSB to improve and meet the 86% criteria over a 12-month period following a corrective action plan will lead to technical assistance, remediation, and/or sanctions under the Performance Contract."

The Performance Contract with CSBs contains the specific activities to be carried out by DBHDS and by CSBs under contract with the DBHDS. The CMSC is working to expand the Improvement Plan process to identify and

support the improvement of CSB performance in key areas monitored by the Committee. The Improvement Plan (IP) process has been implemented by the CMSC that includes a "four pillars" of performance focus.

The first area relates to the indicator listed above for RST referrals, which has a threshold that is established by the Settlement Agreement and has been in use since October of 2020. The second pillar relates to ISP entry with the standard being moved from "proper status prior to data pull" to "proper status prior to the effective date of each ISP." SCQR is the most recent implemented pillar, which began with an IP being requested if there were three or more SCQR indicators below 50%. This will be increased in the coming months to ensure technical assistance is provided as necessary based on performance issues. The final pillar relates to case management visits and will be implemented in FY25.

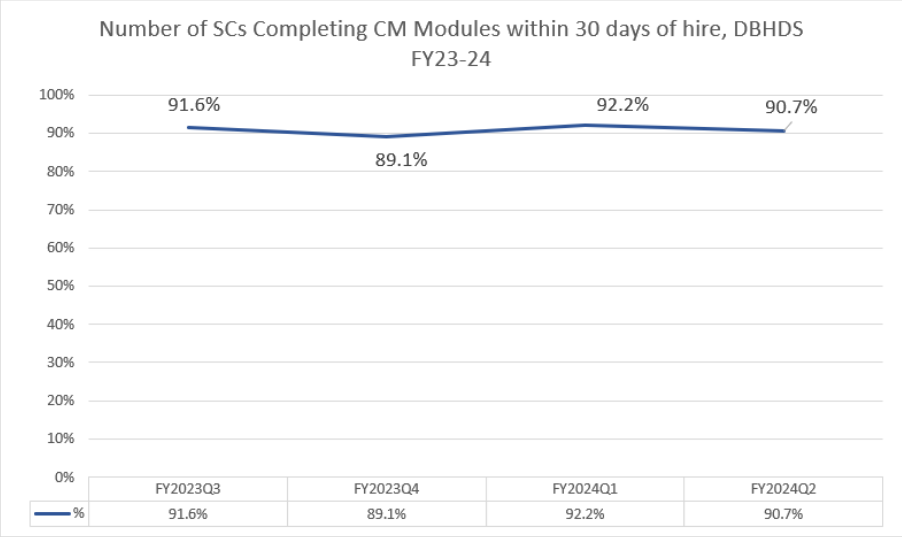
The CMSC continued a monthly review of CSB performance through the Four Pillar process. Across FY23, there were 32 total improvement plans requested 18 for ISP compliance, 13 for RST timeliness, and one for SCQR results. 16 were successfully removed from the Watch List for achieving above target performance. At the end of this reporting period, there were three open IPs for RST referral timeliness and five for ISP entry.

Data Monitoring

Case Management Training and Competency

Support Coordinators/Case Managers are required to complete the DBHDS Case Management training online modules within 30 days of hire. A review of module usage between July and December 2023 shows that the completion rate exceeded 86% in the last four quarters. This shows a comparable performance from the last report. The chart below conveys the percentage of DD CMs who completing the modules and the percentage who completed the modules within required timeframes (figure 20).

Fig. 20 Case Management Module Completion January to June SFY2023



Data Availability and Integrity

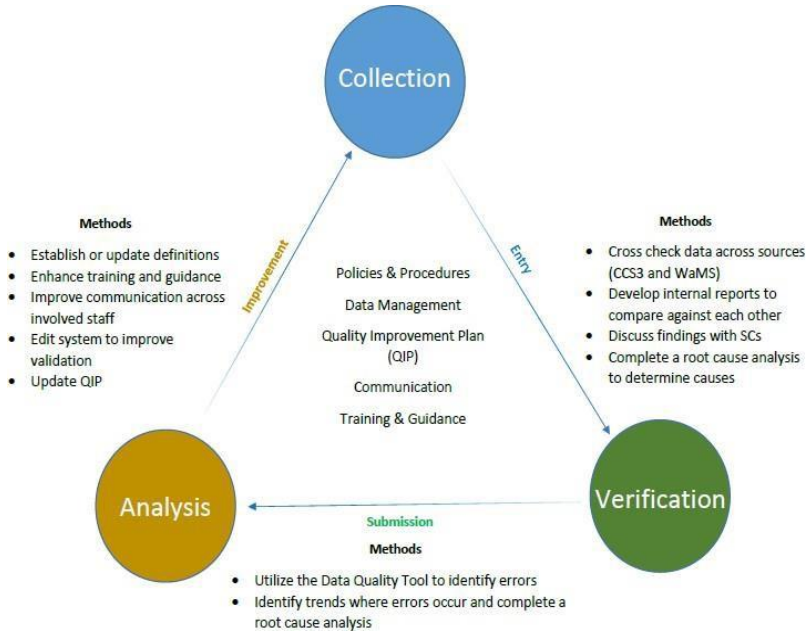
The CMSC monitors performance related to the availability of data in the Waiver Management System (WaMS), as well as the integrity of the data provided through CCS3. Specifically, regarding the requirements related to ISP entry, the CMSC has been monitoring the availability of WaMS ISP data per the Performance Contract reporting requirements. CSBs are required to provide ISP data either through an electronic data exchange or through direct keyed entry if the CSB does not use or is unable to use the data exchange.

A process has been developed to support CSBs to examine the integrity of the data provided in relation to face-to-face contacts submitted through CCS3. A Data Quality Framework (Figure 21), root cause analysis template, and process have been developed through collaboration with the DBHDS/VACSB Data Management Committee. This process, which includes reviewing a sample of CSB case management contact data, began in FY22. DBHDS will be transitioning to a new system and will cease using CCS3 by January of 2025. This process will be reviewed once the new system is online.

The focus of the work is on the following:

- Identify issues related to data reporting and case management requirements related to case management performance measures.
- Identify potential barriers to accurate coding and reporting.
- Identify additional technical assistance needed.
- Implement CSB data quality improvement plan needed for system process and outcome changes, ensuring that case management processes are reported accurately and as required.

Fig. 21 Data Quality Framework



The Data Quality Process implemented by the Committee includes the Office of Provider Development providing technical assistance to CSBs on data reporting requirements. This assistance is designed to support CSB efforts to improve the quality of case management contact data reported to the Department. It includes the completion of a root cause analysis, if needed, to identify the underlying causes for not meeting case management measure targets and helps in identifying gaps and/or issues that impacted the CSB's performance A sample of seven CSBs were reviewed in the current cycle.

Provider Network Supports worked with the Data Warehouse to obtain clarifications on findings during the FY23 reviews. Issues included:

- An individual being discharged from Waiver and opened at the CSB again without waiver led to a lack of waiver data for review.
- The lack of a Social Security Number in WaMS resulted in the inability to link CCS3 and WaMS for an individual in the sample.
- A needed clarification on how the face-to-face visits are calculated in CCS, which prevents a late entry from impacting data.
- Some duplicate entries in the data potentially being caused by two entries on the same day.
- Two incidents where test data was found in the system resulting in the need to delete the records from submissions to correct data going forward. Along with the clarification that test data does not go into production and is only requested by DBHDS during UAT at times when the CCS3 application is being updated.
- A CSB concern centered on the extended timeframe, which resulted in the clarification that the DQS process helps us uncover issues in data entry that might be longstanding and need correcting. Looking at 8 quarters assists in providing enough data to find issues.
- Finally, clarification was needed to explain that sampled data is based on scheduled snapshots of system data, so some data might not be captured if occurring after the snapshot.

Recommendations

Below are recommendations that were made by the CMSC in the previous report followed by additional recommendations from this current report. The CMSC will continue to work to make data available to CSBs, so that internal monitoring and improvement abilities can be strengthened.

As of the last semi-annual report, the CMSC made the following recommendations:

- Complete the public comment period for the SC Operational Guidelines related to Enhanced Case Management and the DD SC Handbook.
- Develop specifications for the ISP that incorporate Risk Awareness Tool elements and automate populating risk factors in the WaMS ISP.
- Continue the development of standard SC onboarding training materials to be made available across the system.
- Establish baseline data for SC Retention and begin monitoring progress over time as system improvements are implemented.
- Produce and publish guidance for SCs regarding employment discussions with children younger than age 14 and adults over 64.

Current Recommendations Include:

- Update the SC Handbook and respond to public comments.
- Convene CSB focus group for final edits to SC 101 training prior to distribution to CSBs.
- Establish a set of statements that encompass core SC competencies.
- Develop a survey to assess SC retention and the impact of changes made to increase SC role manageability and satisfaction.
- Distribute training on changes in how ISP compliance is calculated to move from compliance by "date of data pull" to "effective date of each ISP."

CMSC Glossary

Term	Definition
Aggregate total	A total amount that is arrived-at by adding together all related data under one area or group being considered.
Best Practices	Practices that have been shown by research and experience to produce optimal results and that is established or proposed as a standard suitable for widespread adoption.
Case Manager	See "Support Coordinator." This is a term frequently used by the Departments of Medical Assistance Services and DBHDS, the Community Services Boards, and the Independent Living Centers.
Choice	The right, power, or opportunity to choose; option. Informed choice: When an individual is informed of all of the options that are available and understands these options and the impact of the choice.
Competency	The ability to do something successfully or efficiently.
CRC	Community Resource Consultants; Staff employed by DBHDS in the Office of Provider Development who provide technical assistance and support providers and community services boards with understanding state and federal requirements and who support best practices such as Person-Centered Thinking and planning.
Data Integrity	The overall accuracy, completeness, and consistency of data.
Demographics	Statistical data relating to Virginia's DD population and particular groups within it.
Individual Support Plan	An individual's plan for supports and actions to be taken during the year to lead toward his or her desired outcomes. It is developed by the individual and partners chosen by the individual to help. It is directed by the individual's vision of a good life, his or her talents and gifts, what's important to the individual on a day-to-day basis and in the future, and finally, what's important for the individual to keep healthy and safe and a member of communities.
Integrated setting	A setting where four or fewer unrelated individuals with developmental disabilities reside and/or receive Home and Community-Based waiver services.

Key Performance Measures	Statements that describe the expected performance of an individual, group, organization, system or component, which is required by the Settlement Agreement or approved by a DBHDS-approved committee for quality improvement purposes.
Meaningful activities	Activities that individuals indicate are personally meaningful to them.
Natural support	Supports that occur naturally within the individual's environment. These are not paid supports but are supports typically available to all community members. Natural supports should be developed, utilized and enhanced whenever possible. Purchased services should supplement, not supplant, the natural supports. Some examples of natural supports are the family members, church, neighbors, co-workers, and friends (from: Indiana's Disabilities and Rehabilitation - Person Centered Planning Guidelines).
Non-integrated setting	A setting where five or more unrelated individuals with developmental disabilities reside and/or receive Home and Community-Based waiver services.
Outcome	A desired result that happens following an activity or process.
Person-Centered Planning	A planning process that focuses on the needs and preferences of the individual (not the system or service availability) and empowers and supports individuals in defining the direction for their own lives. Person-centered planning promotes self-determination, community inclusion and typical lives.
Person-Centered Practices	Practices that focus on the needs and preferences of the individual, empower and support the individual in defining the direction for his/her life, and promote self-determination, community involvement, contributing to society and emotional, physical and spiritual health.
Promising Practices	Practices that include measurable results and report successful outcomes, however, there is not yet enough research evidence to prove that they will be effective across a wide range of settings and people.
Providers	Agencies and their staff who provide DD waiver services in Virginia. Can be a private provider or a provider of services operating under a community services board.
Quality Improvement Initiative (QII)	Strategies designed to support quality improvement activities, whose implementation and use follow the PDSA (Plan Do Study Act) cycle to achieve these improvements. QIIs seek to improve systems and processes to achieve desired outcomes; strengthen areas of weakness, to prevent and/or substantially mitigate future risk of harm.
RST	Regional Support Team; Five Regional Support Teams (RSTs) were implemented in March 2013 by the Department of Behavioral Health and Development Services (DBHDS) with Virginia's emphasis on supporting individuals with developmental disabilities in the most integrated community setting that is consistent with their informed choice of all available options and opportunities. The RST is comprised of professionals with experience and expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs.
Support Coordinator	A person who assists an individual in developing and implementing a person-centered plan, including linking an individual to supports identified in the plan and assisting the individual directly for the purpose of locating, developing, or obtaining needed supports and resources.