DBHDS

Virginia Department of Behavioral Health and Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2025
1st and 2nd Quarters

Case Management Steering Committee

Semi-Annual Report FY25 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 identifies trends and progress toward meeting established Support Coordination/Case Management targets. Based on this data review and system analysis, the committee recommends 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 makes 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 2024, the CMSC continued the implementation and refinement of a structured process of routine CSB performance monitoring. The CMSC also reported to the QIC in October and December 2024. The CMSC is responsible for seven performance measure indicators (PMIs) and monitors an additional 13 not included in PMI reporting. PMIs were reviewed quarterly and produced a semi-annual report in September 2024

which covered Q3 and Q4 FY24.

In September, the Office of Community Network Supports gave a presentation to the CMSC regarding Supported Decision-Making Agreements (SDMA). DBHDS has made a SDMA template available for the past two years. The number of people interested in SDMA has tripled from May 2023 to May 2024 but the number of people with SDMA has not increased. As of September 2024, 718 individuals had expressed interest in having a SDMA while 208 (30%) are reported to have one. Strategies to increase the use of SDMA included ongoing training for SCs both written and recorded, offering to provide SDMA meetings and CSB specific training, phone and email TA, and individual meetings. CMSC discussed various data collection reports to share information with CSBs.

In September 2024, CMSC monitored the release of the 4.0 version of the ISP. Apart from typical error messages seen in testing, two issues encountered were more significant and impacted the transition from v3.4 to v4.0.

First, there was an inability to update v3.4 using the v4.0 template, even with manual adjustments intended to resolve this issue. Due to the significant updates in v4.0, the typical process of using one file format was unachievable. The solution identified is the enabling of direct edits in the WaMS user interface for ISPs that were pushed through the system as v3.4. This update was released on 12/6/24 and required duplicate entry related to changes in Parts I and II of the v3.4 ISP during FY25 with a plan to return to a single file format in FY26.

The second issue impacting v4.0 was related to 166 files sent through the data exchange between the release on 9/16/24 and 10/11/24. A small number of these files were identified as having mismatches in the Potential Risk section of v4.0. The 166 files were reprocessed upon discovery to correct issues in Part III. FEI assumed the task of ensuring that all associated Part Vs completed aligned with the potential risks submitted through the data exchange for these 166 files. Findings include one individual with two Part Vs from the same provider where routine support labels were absent from the Part Vs. DBHDS worked with the related provider to revise these plans to resolve concerns.

It was also determined that timelines for updating Parts I-IV need to be extended to FY26. Shifting the next updates for Parts I-IV to FY26 will help reduce the time and effort needed to update ISPs in version 3.4 and minimize potential issues as we complete this transition year. The delays in uploading ISPs and resolving post-release issues are contained within the period from 9/16/24 to 12/8/24.

In January 2025, CMSC will participate in the “QII Showcase” with DBHDS Developmental Disabilities Quality Management Systems where CMSC highlighted shared what was being changed, strategies used, and the results of CMSC’s efforts in address the Support Coordination QII.

Support Coordination Quality Review (SCQR)

The Support Coordination Quality Review (SCQR) process was established to assess and improve the quality of support coordination (also referred to as “case management”) services provided by Community Services Boards (CSBs) to individuals on one of the home and community-based services waivers (HCBS Waivers). The results of the SCQR are designed to help determine if these services comply with the Department of Justice Settlement Agreement (DOJ SA) and Centers for Medicare and Medicaid Services (CMS) requirements. Ten elements related to the provision of case management services are assessed through the SCQR. Virginia needs to meet nine of

these ten elements at 86% or above for all records reviewed. In addition, the use of an On-Site Visit Tool (OSVT) is evaluated through the SCQR for two of the ten elements.

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 Network Supports at the mid-point in FY24 submissions. While this technical assistance does not impact the record reviews underway, it is expected to improve the SCQR results occurring in FY25 when calendar year 2024 documentation is reviewed.

The sampling methodology for a look behind process 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 four years. The FY2023 results showed that children can and should be included in the SCQR process as the differences between adults and children were minimal.

During the FY24 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 FY24 is available in the table below, which shows above target performance with nine of the ten indicators when considered individually and an increase to 72.3% when evaluating the overall result, which is improvement over the last report.

Indicator	2020	2021	2022	2023	2024
Indicator 01	91.4%	88.0%	91.8%	82.7%	87.0%
Indicator 02	79.9%	77.5%	77.8%	92.9%	96.8%
Indicator 03	92.5%	82.5%	40.3%	54.3%	68.5%
Indicator 04	81.8%	85.0%	82.0%	87.9%	90.0%
Indicator 05	99.7%	99.5%	100.0%	100.0%	100.0%
Indicator 06	87.4%	69.3%	86.8%	84.3%	89.8%
Indicator 07	87.4%	92.0%	84.0%	88.5%	93.8%
Indicator 08	97.9%	93.0%	97.5%	98.5%	99.0%
Indicator 09	94.7%	50.3%	84.5%	83.7%	89.3%
Indicator 10	95.7%	74.8%	83.5%	84.1%	90.0%
Records Meeting 9+	77.5%	41.5%	53.3%	63.7%	72.3%

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.

In FY24, 14 CSBs reported that 86% of records met at least nine indicators, up from 10 CSBs in FY2023. Following the Look Behind process, 72% of records were determined compliant, meaning nine out of ten indicators were met. This number has steadily increased over times outlined in the below table. Four indicators that were below 86% in FY2023 improved to over 86% in FY24.

Year over year increases in records meeting 9 of 10 indicators:

FY2021	FY2022	FY2023	FY2024
42%	53%	64%	72%

Indictor 3 has been the lowest indicator since employment questions were added in FY2022, but compliance has improved significantly, increasing from 40% in FY2022 to 69% in FY24. While the indicator remained below the 86% target, the steady rise in performance suggests quality improvement efforts are working. Additionally, agreement between OCQI and CSBs was in the substantial range for this indicator and continued to improve each year.

In preparation for the FY25 SCQR cycle, CMSC has been updating the technical guidance documents to align with the updated ISP 4.0. This SCQR cycle will only include ISPs effective 11/1/2024 to 3/15/2025 to enable a review of the most recent ISP using the 4.0 version. Changes to the SCQR were communicated through the DS Council

and feedback from stakeholders was sought prior to the announcement.

The SCQR Final Report FY24 is available at the link below:
https://dbhds.virginia.gov/wp-content/uploads/2025/02/SCQR-final-report-revised-November-4-2024-3.pdf

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.

To assist Support Coordinators with meeting requirements, the phrases "change in status" and "appropriately implemented services" were defined to establish a process to support consistency across the system. 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.

These two concepts are defined as:

- "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.

The OSVT is designed to support the Support Coordinator's face-to-face visits 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).

Materials developed for the use of OSVTs 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.

In FY22, DBHDS 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. The completion of the OSVT is assessed through the SCQR survey questions 73 through 80 during FY24.

Following the 25th Report from the Independent Reviewer, there was a concern regarding the use of the OSVT. Issues included failure to complete these forms as required, the failure to identify problems and gaps in service, as well as inaccuracies and inconsistences in the information. CMSC discussed the use of the OSVT and training materials together with the nurses from the IR and Office of Integrated Health (OIH). Additionally, during the FY24 SCQR cycle, it was noted the overall agreement for Indicator 10 dropped to moderate agreement from substantial level of agreement while Indicator 9 continued to meet the substantial threshold. Given this information, CMSC has developed a QII for the OSVT. The aim of this OSVT is to enhance materials and guidance to clarify the use and limit ambiguity. Training materials will be updated and a statewide training with pre-test, post-test, and evaluation will be used to determine any additional adjustments before posting materials online.

FY24 SCQR Final Report

Indicator 9

Question	CSB Responses	Look Behind	OCQI Agreement
Q73. Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	No 29 (7%) Yes 371 (93%)	Agreement 89% Maxwell RE 0.78	Agreement 98% Maxwell RE 0.96
Q75. Regarding the LAST FOUR OSVTs COMPLETED during the calendar year 2023, did all OSVTs have all areas under "Services Implemented Appropriately" completed?	No 24 (6%) Yes 376 (94%)	Agreement 86% Maxwell RE 0.72	Agreement 92% Maxwell RE 0.84
Indicator 9 overall	0 43 (11%) 1 357 (89%)	Agreement 81% Maxwell RE 0.62	Agreement 90% Maxwell RE 0.8

Indicator 9 requires "Yes" for Q73 and "Yes" for Q75.

Indicator 9: Look Behind

	CSB Met	CSB Not met
OCQI Met	76	3
OCQI Not met	16	5

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OCQI reviewers disagreed the indicator was met on 16 of the Look Behind records, typically because the reviewer could not locate one or more OSVTs or because the SC had marked "unable to assess." However, agreement was high enough to meet the "substantial" threshhold.

Indicator 10

Question	CSB Responses	Look Behind	OCQI Agreement
Q73. Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	No 29 (7%) Yes 371 (93%)	Agreement 89% Maxwell RE 0.78	Agreement 98% Maxwell RE 0.96
Q78. Did all of the LAST FOUR OSVTs completed during calendar year 2023 have all areas under "Change In Status" and "Change in Status Determination" completed?	No 15 (4%) Yes 385 (96%)	Agreement 86% Maxwell RE 0.72	Agreement 98% Maxwell RE 0.96

Question	CSB Responses	Look Behind	OCQI Agreement
Q80. If any of the LAST FOUR OSVTs completed during calendar year 2023 identify a change in status within the "Change in Status Determination" section, were revisions made to the ISP?	No[0] 6 (2%) Not applicable: Changes noted, but no revision necessary. [2] 26 (6%) Not applicable: No changes in status or needs. [3] 354 (88%) Yes[1] 14 (4%)	Agreement 79% Maxwell RE 0.72	Agreement 82% Maxwell RE 0.76
Indicator 10 overall	0 40 (10%) 1 360 (90%)	Agreement 76% Maxwell RE 0.52	Agreement 84% Maxwell RE 0.68

Indicator 10 requires "Yes" for Q73 and "Yes" for Q78. For Q80, the response must be "Yes" or "Not applicable," either because no changes occurred or because the changes did not require a revision.

Indicator 10: Look Behind

	CSB Met	CSB Not met
OCQI Met	71	4
OCQI Not met	20	5

Agreement was in the moderate range for this indicator. OCQI disagreed the indicator was met on 20 records. As with Indicator 9, the reasons were that one or more OSVTs were missing, and/or the SC had marked "unable to assess."

Records that did not meet Indicator 9 tended to also not meet Indicator 10. According to OCQI reviewers, 17 records failed both indicators.

Identified Concerns

The Independent Reviewer's 25th Report to the Court was submitted on December 13, 2024, 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.

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 CMSC. 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: Completed

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 CMSC 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.

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. Themes from the focus groups included reducing excessive and duplicative paperwork; holding providers accountable; and improving efficiency and work-life balance.

The CMSC focused on implementing individual changes as soon as possible without compromising Virginia's compliance with state and federal requirements 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. As previously reported to and calculate retention rates, the CMSC sought approval of two surveys to present the following seven changes employed by the CMSC to reduce burden and improve the experience of SCs in the course of their work:

- In October of 2022, DBHDS reduced the requirement to complete the On-site Visit Tool (OSVT) for people receiving Targeted Case Management to once per quarter.
- In November 2022, DBHDS discontinued the requirement to use the Individual Planning Calendar

in WaMS due to perceived lack of value and time needed for completion.

- In December 2022, DBHDS clarified and simplified the Enhanced Case Management guidance.
- In February 2023, DBHDS reduced the requirement for SCs to participate in Regional Support Team meetings to an as needed basis. This was announced through the DS Council. In October 2023, DBHDS clarified how to complete the ISP since employment discussions are not required for individuals less than 14 or over 64. A memo was sent through the Provider Network Listserv.
- In June 2024, DBHDS developed and provided standardized SC Onboarding Training.
- In July 2024, DBHDS clarified and simplified the DD Support Coordination Handbook.

The survey detailed the changes implements by the CMSC, if the change was helpful, and if they were knowledgeable of the change. The questions reviewed each change individually while asking if the entity of the all the changes was impactful. Further, the survey also requested retention numbers from the CSB as well.

Change Implemented	Change was helpful %	AND Made work easier %	Original SCs aware of each change %
OSVT Reduction	74%	54%	66%
Discontinue IPC	89%	67%	84%
ECM Guidance	78%	52%	79%
RST Meeting	87%	57%	65%
Employment Discussion, 14-17 YO	83%	58%	78%
SC 101 Training	74%	87%	50%
SC Handbook easier	70%	35%	51%
Package of changes	92%	55%	n/a

There was variation in the percent of SCs employed at the time, who were aware of the change or not aware. SCs were most aware of discontinuing the use of the Individual Planning Calendar. SCs were least aware of the SC 101 training. Overall, 92% of SCs felt the package was helpful in some way. 54% of SCs said the package of changes made their work easier while 4% said the changes made their work harder. 41% indicated there was no change to their workload. Most SCs said each change was helpful (70-80%). SCs were more likely to think a change was helpful if they were aware of the change at the time. SCs not aware of the change seemed more likely to say it had no impact on their work.

The data highlights several key concerns and suggestions from SCs to improve their workload. Common themes include frustration with excessive, repetitive paperwork and a desire for smaller, more manageable caseloads. SCs also expressed a need for better pay, training, and ongoing support, especially when new policies or system changes are implemented. Many suggested improving the systems they use. This included updating WaMS to be more user-friendly and ensuring better integration between systems to reduce data entry. Additionally, SCs called for better oversight and accountability from service providers and leadership to ensure consistent standards. SCs also proposed designating specific staff for administrative tasks to dedicate additional time for individual interactions.

With 72% (29) of CSBs providing data, SC retention from 2022-2024 was 65%. The aim was not met. The seven changes were helpful to different degrees and easing the SC's workload. Because other factors could impact job retention, it is not possible to know how the changes impacted SC retention since there is no input of the SCs who left employment. Furthermore, due to the response rate to the SC and CSB surveys, the results may not be representative.

The CMSC with continue to increase efforts to ensure SCs are made aware of important changes impacting their role. Additionally, the CMSC will continue to explore additional opportunities to make the SC role more effective and efficient, based on their feedback.

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 and was distributed to the CSBs.

The CMSC has completed all changes related to this QII and is in the first quarter of data collection on the new method of calculating compliance. The first quarter of data will be available in October 2024 for CMSC review. The DBHDS data analyst is finalizing the format and calculations related to this data; results will be available in the next report. Pending approval from QIC, the CMSC voted to complete this QII. The CMSC will continue to monitor the new measure and propose a new QII should one be needed in the future.

QII 6: Our goal is to improve the following outcomes for individuals on the DD waiver by 10 percentage points by 6/30/2025 (target date). The baseline and aim for each are described below:
>>Employment outcomes for all individuals on the DD waiver: Baseline: FY24 Q1=26%; Aim = 36%
>>Employment outcomes for individuals interested in employment: Baseline: Q2=58%; Aim = 68%
>>ICI Outcomes: Baseline: FY24 Q2=60%; Aim = 70%
Status: Active

This QII was approved in March of 2024 and focuses on improving performance with three measures related to employment and integrated community involvement. Informational materials developed by the Regional Quality Council in Region 2 were presented at the vaACCSES provider conference. Additionally, training materials were developed and presented in Region 3 with various locations and dates. Following these in-person trainings, a survey collected feedback from participants was given. The feedback received will be incorporated into the training and the training will be released statewide via a video. Information regarding strengthening this QII and how to access additional training will be presented during the January Provider Roundtable.

QII 7: Our goal is to improve the level of agreement seen on Indicator 10 in the SCQR look behind process for SCQR reviews completed during the FY25 SCQR cycle from a moderate to substantial level of agreement by October 31, 2025.
Status: Active

In the effort to address Independent Reviewer (IR) reports and CSB needs/desires for more clarification, DBHDS will hold a focus group with CSBs, discuss enhancement with IR and DBHDS nurses, as well as provide an update training with a pre-test, post-test and evaluation to determine any final adjustments before posting online. Implementation will begin in Q3 FY25.

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 SFY25. 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.

FY25 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.** ***Community Inclusion Domain***
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**

Physical, Mental, and Behavioral Health and Well-Being

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. **III.C.7.a**	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* ***Note:*** *Community Inclusion Domain*	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 not only the last four quarters (see Fig. 1) but in previous reporting, while those with employment goals has consistently been below target (see Fig. 2). In Q3 FY23, the CMSC ceased monitoring employment goal development as has been previously reported. This measure continues to be monitored by the Employment First Advisory Group. Instead, the CMSC began 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 the measure was established in Q4 FY23 at 65%. Results continue to be below target but have remained largely consistent in the past 4 quarters with a slight decline in Q1 and Q2 FY25.

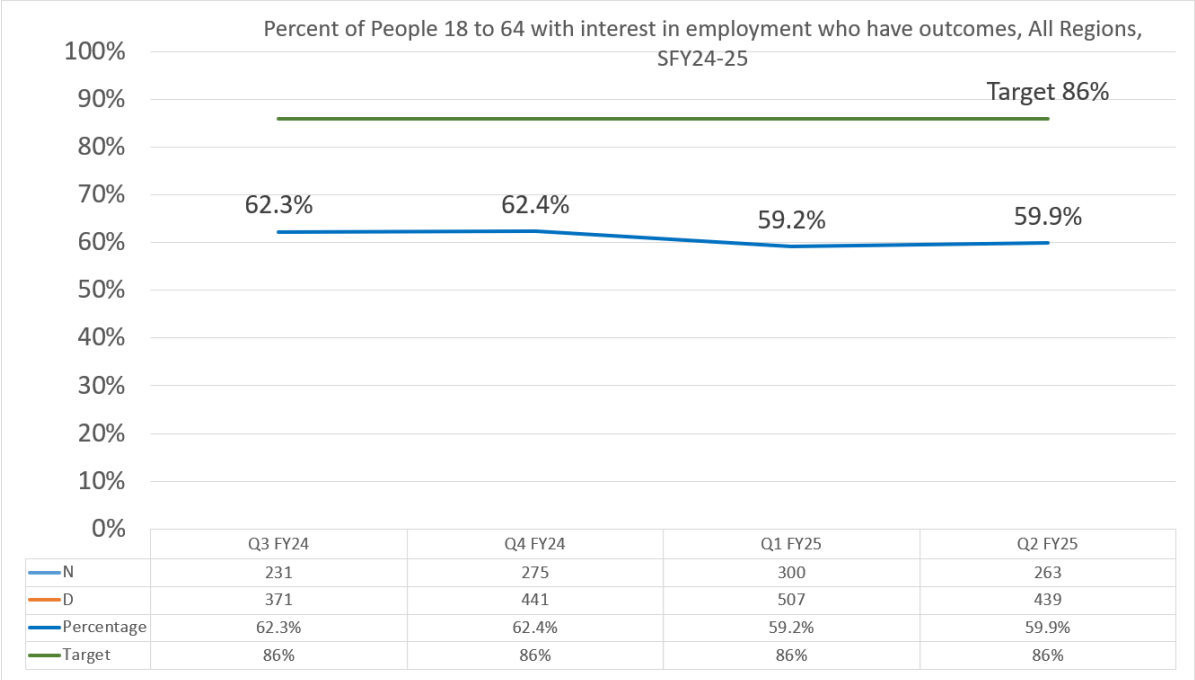
Baseline for the third measure related to transition age youth was established in the 1st quarter FY22, which was 32%. Related elements in the Individual Support Plan were refined in May 2022 to improve the collection of data around employment topics. The CMSC is aware of past efforts by the Regional 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 indicated that measure 3, related to employment discussion with youth, saw a slight decline from Q4 FY24 of 5% points but remains 5% above baseline data for Q1 and Q2 FY25.

The CMSC will continue to monitor these measures and make recommendations as appropriate.

Fig. 1 Employment Discussions FY24- 25

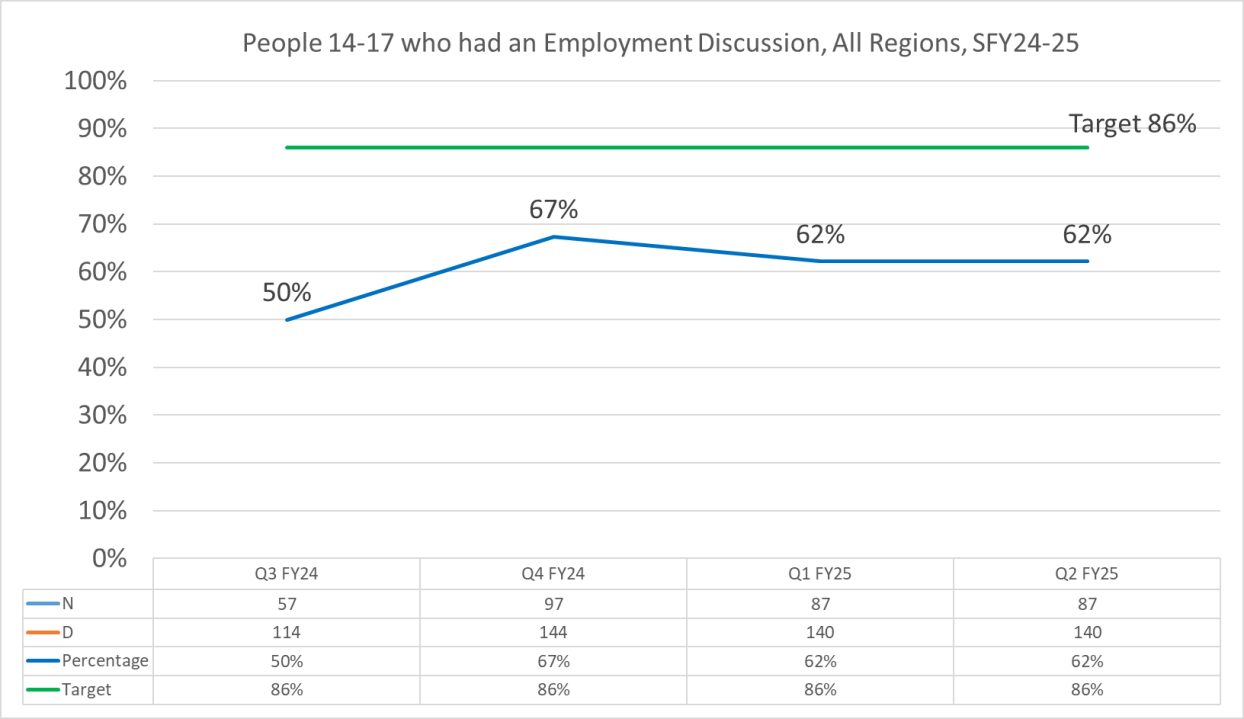
	Q3 FY24	Q4 FY24	Q1 FY25	Q2 FY25
N	2484	3060	3594	3193
D	2612	3163	3742	3290
Percentage	95%	97%	96%	97%
Target	86%	86%	86%	86%

Fig. 2 Employment Interest with Outcomes FY24- 25



	Q3 FY24	Q4 FY24	Q1 FY25	Q2 FY25
N	231	275	300	263
D	371	441	507	439
Percentage	62.3%	62.4%	59.2%	59.9%
Target	86%	86%	86%	86%

Fig 3. Employment Discussion 14-17 (both topics confirmed) FY24- 25



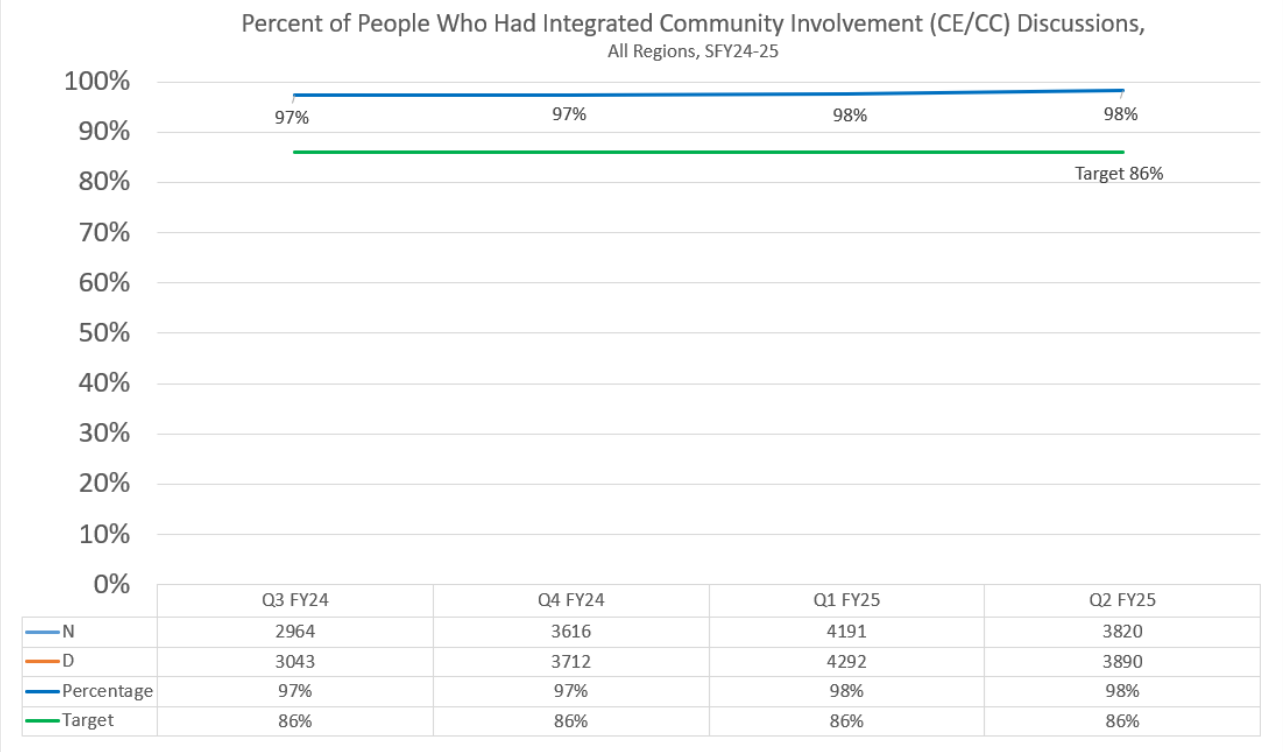
	Q3 FY24	Q4 FY24	Q1 FY25	Q2 FY25
N	57	97	87	87
D	114	144	140	140
Percentage	50%	67%	62%	62%
Target	86%	86%	86%	86%

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

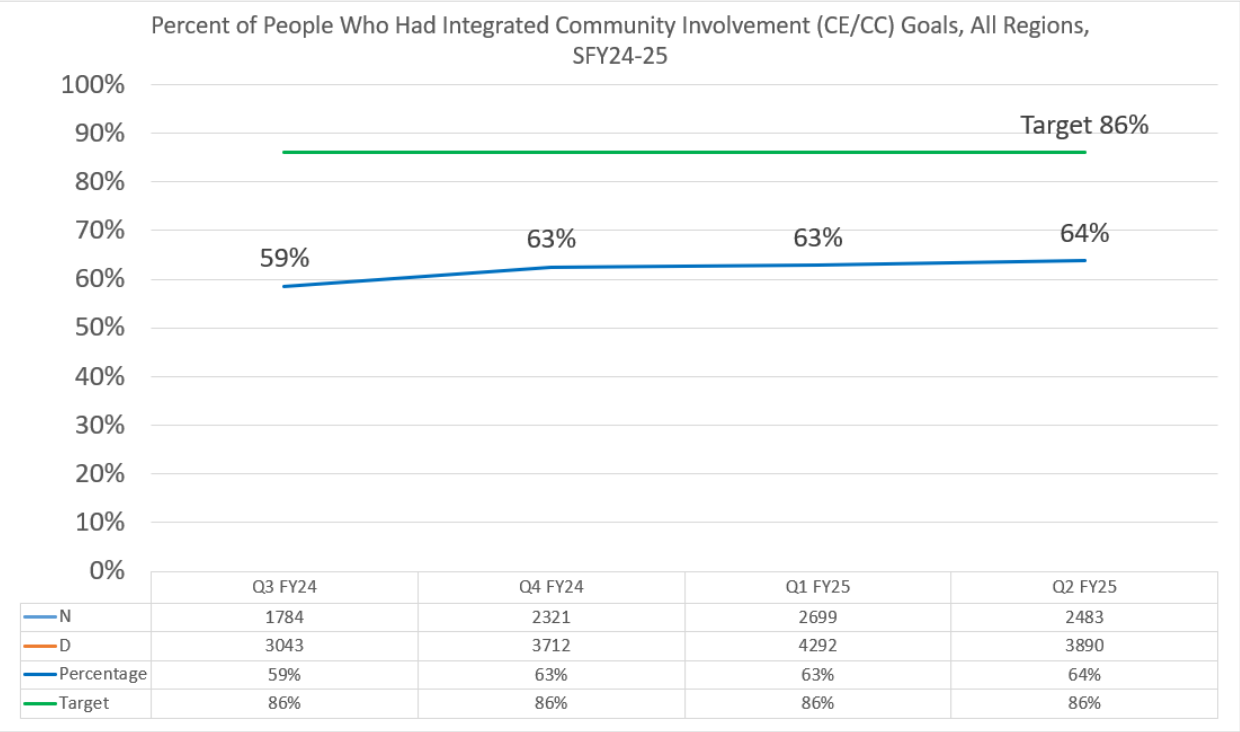
The measure related to individuals participating in a discussion about integrated community involvement has been consistently above target for the last four quarters (Figure 4), while the measure related to integrated community involvement outcomes has consistently been below target (Figure 5). The focus 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 as an ongoing concern around these measures. As previously mentioned in this report, additional training and guidance has been developed and provided to CSBs to increase this measure. Baseline for the third measure (Figure 6) related to community involvement was established in FY22 Q1. Results remain above target for this measure.

Fig. 4 Integrated Community Involvement (Community Engagement) Discussions FY24



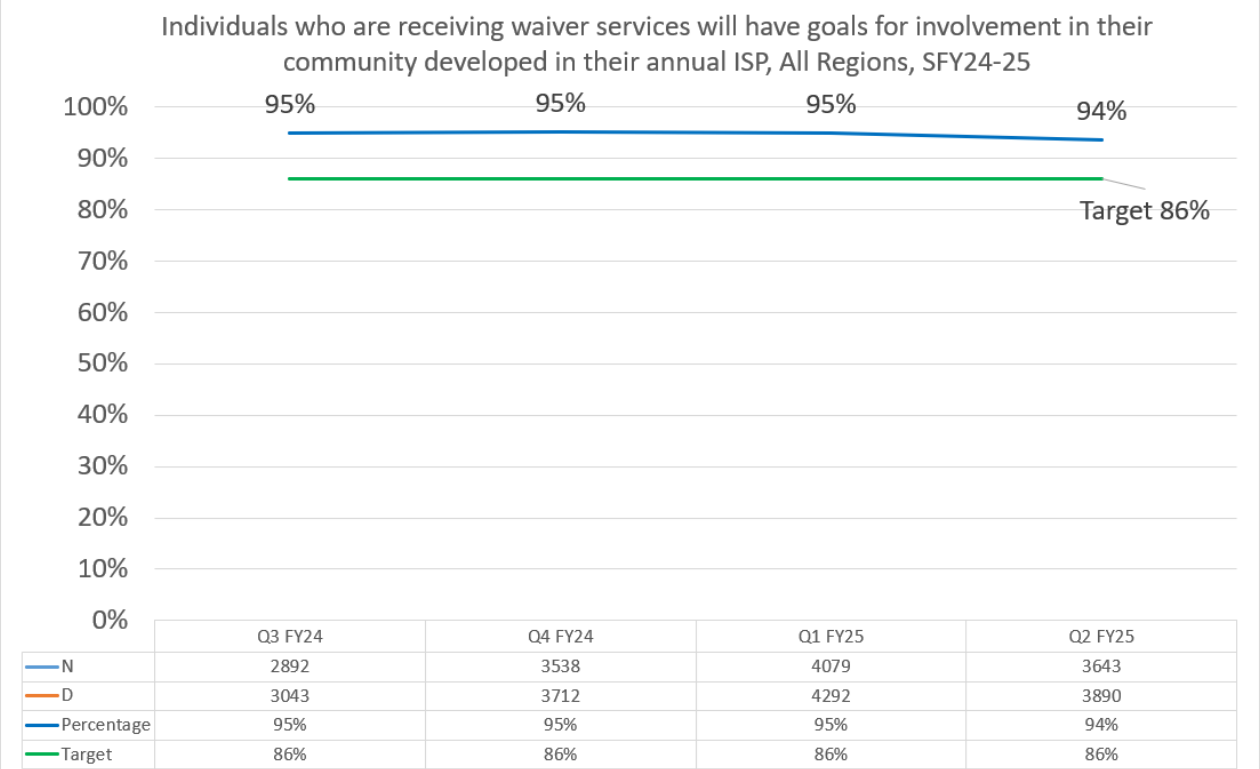
	Q3 FY24	Q4 FY24	Q1 FY25	Q2 FY25
N	2964	3616	4191	3820
D	3043	3712	4292	3890
Percentage	97%	97%	98%	98%
Target	86%	86%	86%	86%

Fig. 5 Integrated Community Involvement (Community Engagement) Outcomes FY24-25



	Q3 FY24	Q4 FY24	Q1 FY25	Q2 FY25
N	1784	2321	2699	2483
D	3043	3712	4292	3890
Percentage	59%	63%	63%	64%
Target	86%	86%	86%	86%

Fig. 6 Community Involvement Outcomes FY24-25



	Q3 FY24	Q4 FY24	Q1 FY25	Q2 FY25
N	2892	3538	4079	3643
D	3043	3712	4292	3890
Percentage	95%	95%	95%	94%
Target	86%	86%	86%	86%

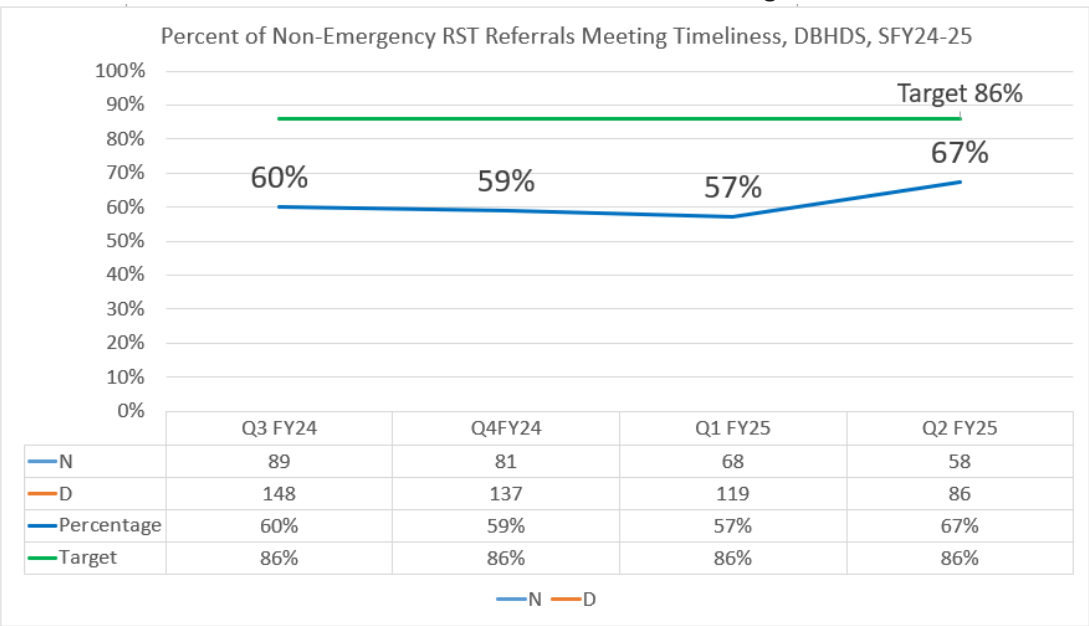
Regional Support Teams and Timeliness of Referrals

Reference	Measure	Numerator	Denominator
7 *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.** **CMSC RST report (copy from report)**	N = Number of non-emergency RST referrals made on time.	D = Number of non-emergency RST referrals.
8 *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.** **RST report (Copy from report)**	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** **RST report (copy from report)**	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.

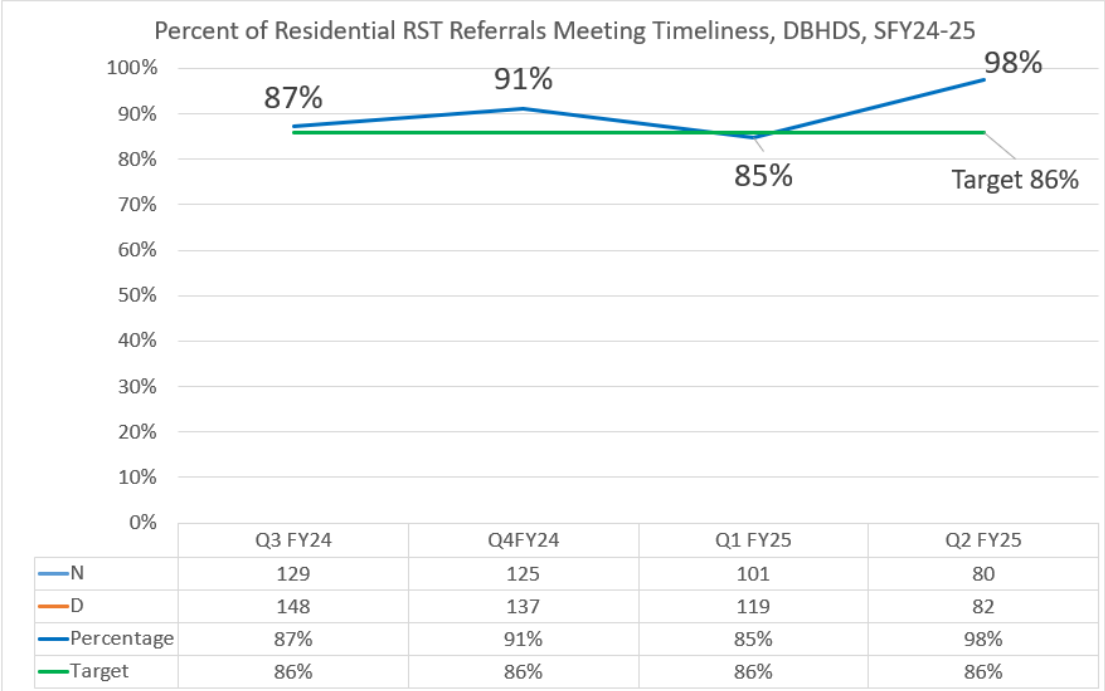
Beginning with Q4 FY23, all data derives from the WaMS system except for missed referrals, which by necessity remains a manual process with results being added to the dashboard once completed. In Q1 FY25, the systemwide measure for RST referral timeliness reached 57% and rose to 67% in Q2 FY25. The residential related measure increased significantly in relation to last report. The measure related to CSB accountability for residential moves is seen at 98% success in Q2 FY25, which is the highest result seen to date. No referrals in the report period met the criteria for Measure 9 as seen below.

Fig. 7 RST Referral Timeliness FY24-25



	Q3 FY24	Q4FY24	Q1 FY25	Q2 FY25
N	89	81	68	58
D	148	137	119	86
Percentage	60%	59%	57%	67%
Target	86%	86%	86%	86%

Fig. 8 RST Residential Community Referral Timeliness FY24-25



	Q3 FY24	Q4FY24	Q1 FY25	Q2 FY25
N	129	125	101	80
D	148	137	119	82
Percentage	87%	91%	85%	98%
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?

Q1 and Q2 Result FY25

	2025 Q1		Total
Region	No	**Total**	
Region I	24	**24**	**24**
Region II	20	**20**	**20**
Region III	27	**27**	**27**
Region IV	21	**21**	**21**
Region V	20	**20**	**20**
Total	**112**	**112**	**112**

	2025 Q2		Total
Region	No	**Total**	
Region I	11	**11**	**11**
Region II	32	**32**	**32**
Region III	10	**10**	**10**
Region IV	16	**16**	**16**
Region V	16	**16**	**16**
Total	**85**	**85**	**85**

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

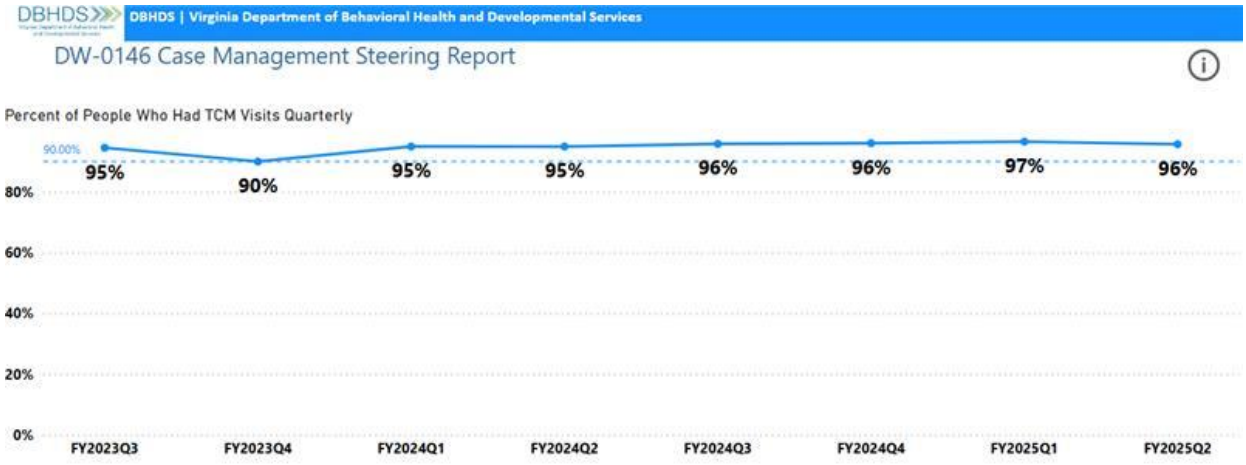
Provider Capacity

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.

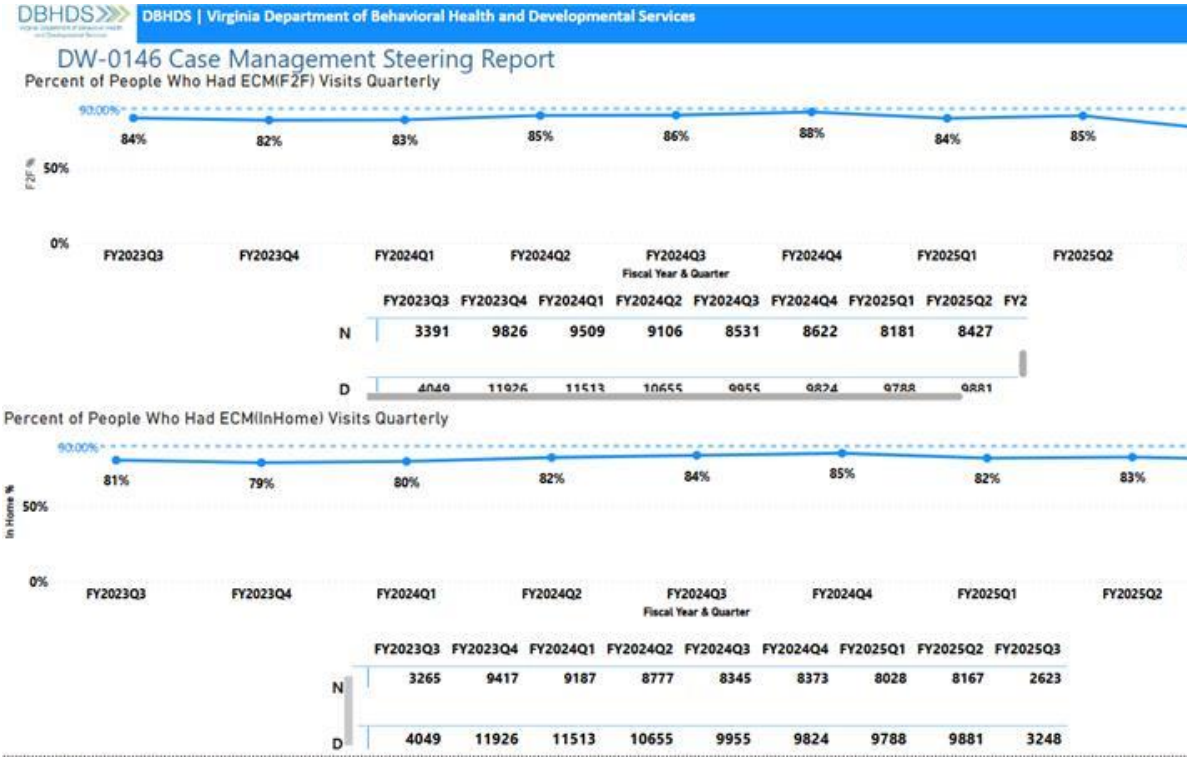
Data regarding TCM face-to-face visits is available for FY24. Based on the results below, there was above target performance for the four quarters of this reporting period maintaining at 96% and 97% for all four quarters. (Figure 10). Overall results for FY24 ECM face-to-face (Figure 11) and ECM in the home (Figure 12) were within 10% below target and both show stable performance during the report period. 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. A finalized PowerBI dashboard was developed for conducting these reviews in calendar year 2023. This process will be reviewed in Q1 FY26 once the transition to the DBHDS Enterprise Data Warehouse (EDW) is complete.

Fig. 10 TCM visits FY23-25



	FY2023Q3	FY2023Q4	FY2024Q1	FY2024Q2	FY2024Q3	FY2024Q4	FY2025Q1	FY2025Q2	Total
N	18362	17475	18276	18447	18710	18879	18970	19011	148130
D	19423	19418	19247	19430	19526	19657	19648	19864	156213

Fig. 11 ECM face to face visits and ECM visits in-home FY23-25



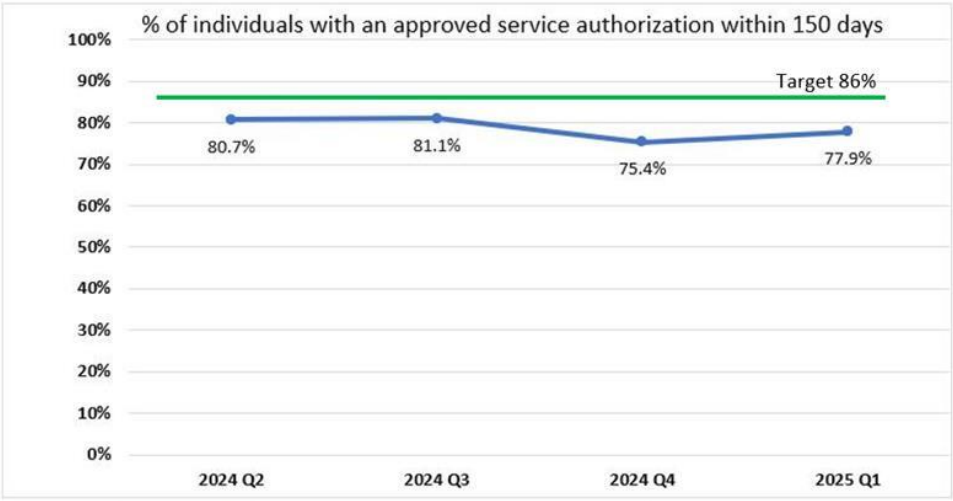
For Measure 13, 72% of records were found in compliance on at least nine out of ten indicators based on CSB-submitted data in FY24. This was an improvement from FY23, when 63.7% of records were found in compliance. Agreement between CSBs and OCQI has been improving on most indicators, with no significant decreases. The percentage of CSBs reporting compliance with each indicator are displayed, with the percentage from FY20 to FY24 reported for comparison purposes. (Figure 13).

Fig. 13 Records in compliance with 9 of 10 assessed indicators FY20-24

Indicator	2020	2021	2022	2023	2024
Records Meeting 9+	77.5%	41.5%	53.3%	63.7%	72.3%

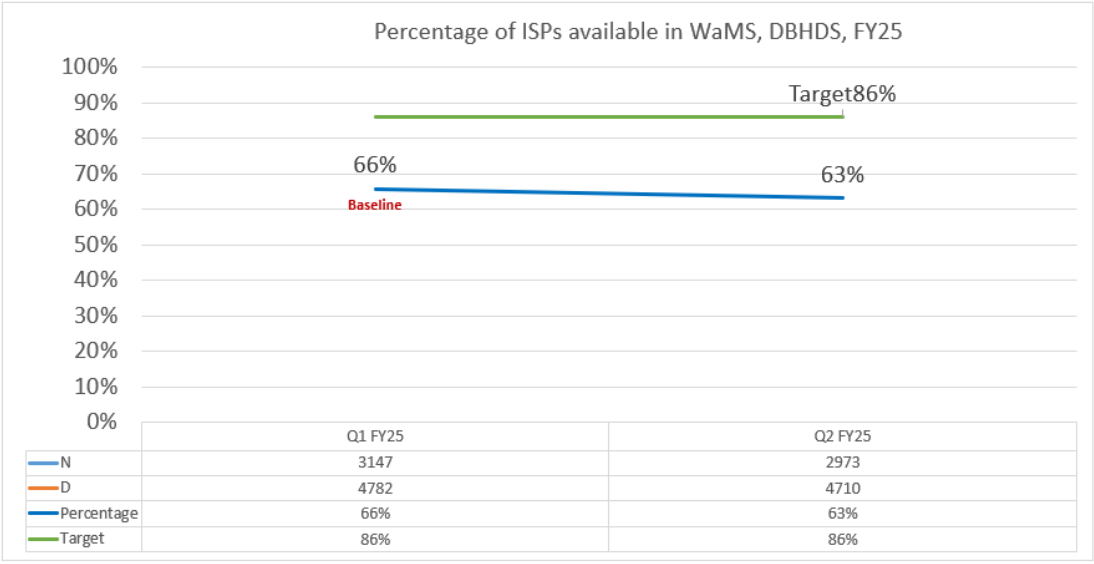
Beginning with this report, reporting has shifted from an annual result to quarterly. Annual results for statistics regarding 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations, is established as 81% for Q2 FY24 ending at 78% in Q1 FY25 (Figure 14).

Fig. 14 Services within 150 days of Waiver FY24-FY25 results



The ISP compliance target was modified beginning in Q1 FY25, which resulted in an expected decrease in performance from previous reporting (Fig. 15). Data reporting now aligns with recommendations from the DBHDS source system analysis, 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 has been adjusted to this new method with an explanation of the reason for the change which was introduced through a Quality Improvement Initiative in the past year. The CMSC will continue to monitor and support CSBs to understand the new requirement to improve performance over time through established monitoring processes employed by the Committee.

Fig. 15 ISP compliance FY25



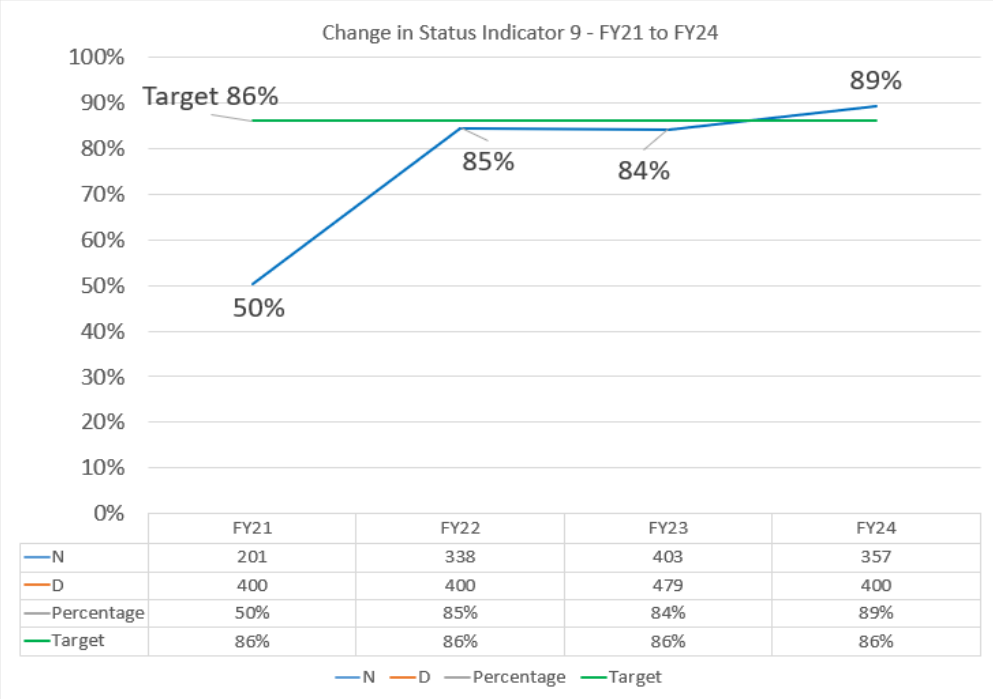
Health, Safety, and Wellbeing

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

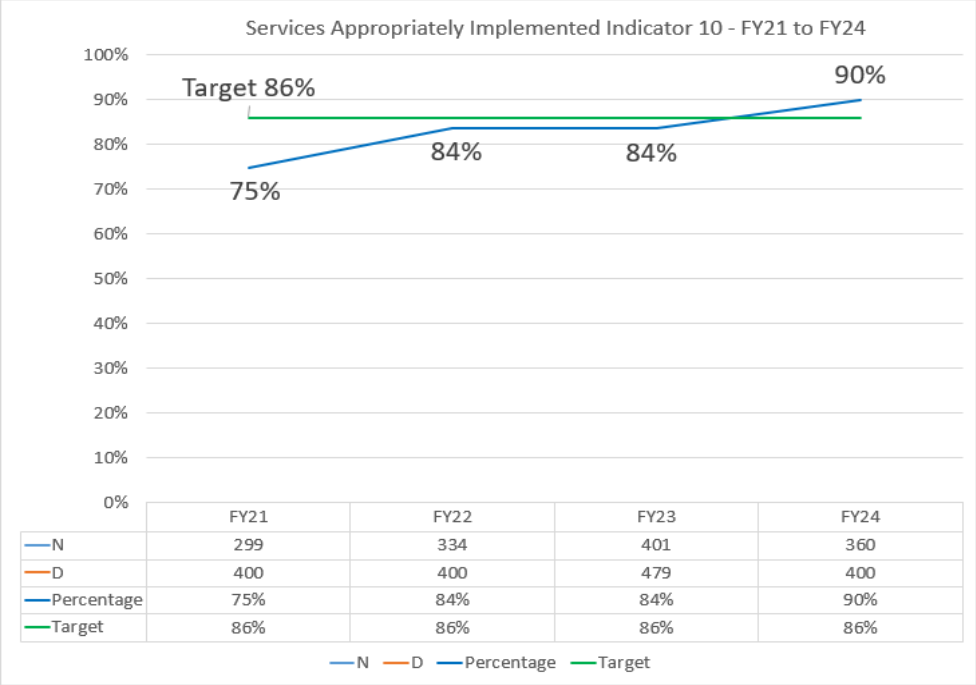
The charts below provide results as reported by CSBs in the FY24 SCQR submitted results. The results for both measures showed maintenance in compliance. Indicator 9 increased from 84% to 89% since FY23 and indicator 10 increased to 90% in FY24 placing both measures above the target of 86%. FY25 data will be available in the next report.

Fig. 16 FY21-24 results for change in status.



	FY21	FY22	FY23	FY24
N	201	338	403	357
D	400	400	479	400
Percentage	50%	85%	84%	89%
Target	86%	86%	86%	86%

Fig. 17 FY21-FY24 results for appropriately implemented services



	FY21	FY22	FY23	FY24
N	299	334	401	360
D	400	400	479	400
Percentage	75%	84%	84%	90%
Target	86%	86%	86%	86%

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** **SCQR**	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** **SCQR**	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, all measures reflect above target performance in FY24. FY25 data will be available in the next report.

Measure 18, Fig. 18 FY24 results for unpaid relationships discussion

Measure 18, FY24	No	Yes	Total	Percentage
Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff). (Target 86%)	30	370	400	93%

Measure 19, Fig. 19 FY20 to FY24 results for choice

Indicator	2020	2021	2022	2023	2024
Indicator 01	91.4%	88.0%	91.8%	82.7%	87.0%
Indicator 02	79.9%	77.5%	77.8%	92.9%	96.8%

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)

Office of Licensing Data

In October 2024, the Office of Licensing shared the 9th semi-annual reporting period (from 1/1/224 thru 6/30/24) 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.

During this reporting period, overall adequacy of supports rating increased to 90.67% (1030/1136) from 0%. During previous reporting period, the safety and freedom from harm and stability domain had 0% compliance. This reporting period they increased to 89.00% (437/491) and 87.18% (34/39), respectively. OL also reviewed what steps they have taken to support Developmental Disability Providers with increasing compliance.

DMAS Quality Review Team

DBHDS is the operating agency for the DD Waiver program with oversight from DMAS. As directed by CMS, each Waiver must have its own quality assurance system. The quality assurance system requires the state demonstrate performance in six assurance areas. The assurances include the following:

1. Administrative Authority- The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.
2. Evaluation/ Reevaluation of Care- Individuals enrolled in the waiver have needs consistent with an institutional level of care.
3. Person-Centered Planning and Service Delivery: Service plan- Participates have a service plan that tis appropriate to their needs, and services/supports specified in the plan are received.
4. Qualified Providers: Waiver providers are qualified to deliver services/supports.
5. Health and Welfare- Participants' health and welfare are safeguarded and monitored.
6. Financial Accountability- Claims for wavier services are paid according to state payment methodologies.

Per VD I-35.6 of the Settlement Agreement and Performance Contact, each CSB/BHA must review and provide feedback on the QRT End of the Year report annually. Data collected represent 2023 averages across all three waivers population and represents a snapshot of compliance for a PM. Different providers are sampled each quarter. Six Performance Measures were identified to be systemic issues with 3 years of noncompliance.

24 of 40 CSBs/BHAs responded to a survey via Survey Monkey that was available for 2 weeks. Generally, the CSBs/BHAs agreed with the primary reasons as to why each of the PMs were not met. If the CSBs/ BHAs disagreed with the primary reason for noncompliance alternate reasons specific to Support Coordination included time/ workload demands of the Support Coordinator, SC turnover, and training issues. The top three remediations areas included CSB/BHA have worked with individual providers to remediate noncompliance in the area, CSB/BHA have referred providers to DBHDS for training, and CSB/BHA have attended a DBHDS training for technical assistance to include Provider Roundtables/SC meetings regarding discussed topics.

DMAS Quality Management Reviews

Data from DMAS Quality Management Reviews is included in the Quality Review Team reports, which were reviewed by the CMSC initially 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 CMSC.

The CMSC 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 indicate progress 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 this FY25 Q1 and Q2 reporting period, nine CSBs were reviewed by DMAS. One CSB received no citations. No citations were issued for lack of choice of support coordinator, having specific, measurable outcomes, or solving disagreements during the ISP process of those CSBs reviewed. Of the remaining eight CSBs, seven citations were issued related to assesses risks, addressing risks, and including the necessary services/ supports to achieve outcomes. Three CSBs received citations related to developing the ISP professionals/ nonprofessionals/ persons important to the individual and lack of choice for providers for each service. Two CSBs

received citations surrounding failing to modify the plan when needs change and ensuring the ISP is implemented appropriately during face-to-face visits. Technical assistance was accepted by four CSBs while technical assistance was declined by the remaining four CSBs.

The CMSC has been in discussion with DMAS in looking at ways to increase specificity of determining compliance with the indicators. The CMSC will continue these efforts related to process quality improvements. Additionally, the CMSC will continue to monitor data and Provider Network Supports will offer technical assistance as identified.

Quality Service Reviews

In January, the CMSC reviewed the Round 6 QSR report. Recommendations from this review included ensuing staff are trained on WaMS and identifying systemic approaches to ISP deficiencies and their relationship to current QIIs. These recommendations will be taken to the KPA workgroups. The CMSC noted they found it helpful QIIs were referenced in the past.

Based on the previous HSAG recommendation, the CMSC drafted suggested support coordinator competencies to assist CSBs in developing and evaluating SC positions. The list of recommended competencies for SCs can be used by CSBs to review, adopt, and use in their personal practices. This draft will be shared with the DD Council and stakeholder feedback will be encouraged and incorporated into the document. A draft of the document is below:

Suggested Support Coordinator Competencies

This document is designed to assist Community Services Boards (CSBs), Behavioral Health Authorities (BHAs), and contracted entities with understanding core competencies that assist Support Coordinators (SCs) in successfully fulfilling their role under Virginia's Developmental Disability (DD) Waivers. The contents relate to various state and federal regulations and policies regarding the provision of DD Targeted Case Management (TCM) services. Support Coordinators are charged with a critical role in supporting people with DD to live a desired life in their community. These suggested competencies are being provided to assist CSBs, BHAs, and contracted entities in the development and evaluation of SC positions. CSBs, BHAs, and contracted entities can use these competencies to guide the SC job development and their knowledge, skills, and abilities of their staffing. These competencies seek to empower SCs to be more effective within their case management role.

Competency Area #1

Explore and Plan: *Support Coordinators lead teams through a person-centered planning process, resulting in an integrated, comprehensive plan that reflects the individual's strengths, interests, needs, and desired outcomes.*

- ***Exploration and Assessment:*** *Assist in identifying personal goals and the services and supports needed to achieve them.*
- ***Plan Development:*** *Collaboratively create a person-centered plan that offers a comprehensive view of the individual's needs and desires, alongside an actionable plan for services and supports.*
- ***Implementation:*** *Help individuals set goals and make informed choices about strategies to achieve those goals.*

Competency Area #2

Connect to Integrated Supports and Services: *Support Coordinators assist teams in cultivating a variety of resources to meet the individual's needs, utilizing both paid and unpaid supports.*

- ***Navigate:*** *Support individuals in identifying and accessing resources, supports, and services appropriate to their life stage and cultural context.*
- ***Inform:*** *Clearly communicate available services and the role of the support team to the individual and their network.*
- ***Network:*** *Leverage personal and professional connections to create opportunities for individuals to access integrated supports.*
- ***Negotiate:*** *Help individuals address barriers to securing necessary services.*

Competency Area #3

Facilitate Long-Term Services and Supports: *Support Coordinators guide the exploration and acquisition of paid supports from various funding sources, ensuring that services maximize the use of resources to meet goals while minimizing risks.*

- ***Gather and Assess Information:*** *Collect, review, and analyze data from multiple sources to track progress and guide collaborative support efforts.*
- ***Monitor and Manage Risk:*** *Identify potential positive and negative outcomes to maximize individual progress and satisfaction, while mitigating abuse, neglect, exploitation, or other negative consequences.*
    - ***Resource Management and Stewardship:*** *Manage the use of available support dollars from various funding sources to ensure timely service delivery that aligns with the individual's needs and goals.*

Competency Area #4

Engagement: *Support Coordinators build and maintain relationships with individuals and their teams to promote effective communication, collaboration, and overall well-being.*

- ***Relationship-Building:*** *Establish professional relationships grounded in mutual respect and trust with individuals and their support teams.*
- ***Communication:*** *Use positive, respectful verbal, non-verbal, and written communication to ensure clear understanding and coordination among all team members.*
- ***Holistic Perspective:*** *Address the individual's physical, social, emotional, behavioral, and spiritual well-being across all life stages and life areas.*

Competency Area #5

Empowerment: *Support Coordinators enhance an individual's capacity for self-direction by fostering awareness of rights and responsibilities and facilitating access to necessary resources.*

- ***Advocacy:*** *Help individuals increase self-direction by supporting them in advocating for themselves with providers, family, and community, while encouraging system changes that remove barriers to self-determination.*
- ***Education:*** *Educate individuals and support teams about rights, responsibilities, resources, and options, highlighting the benefits and risks of each choice.*

- ***Capacity Building:*** *Strengthen autonomy, resilience, and skill development by providing the appropriate level of support tailored to individual needs and circumstances.*

Competency Area #6

Foundational Values, Beliefs, and Skills: *Support Coordinators are knowledgeable, adaptable professionals who consistently demonstrate ethical behavior and professionalism across all core competencies.*

- ***Disability Values and Knowledge:*** *Understand and communicate the philosophies and practices involved in supporting individuals with disabilities, ensuring that services and supports align with established systems and paradigms.*
- ***Self-Awareness:*** *Recognize and address any personal or professional values or behaviors that may impede the ability to provide ethical, unbiased, and culturally competent support.*
- ***Professionalism:*** *Continuously develop and apply personal and professional skills to effectively manage both routine and unexpected tasks with responsibility and responsiveness.*

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. 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 CMSC. 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, with an IP being requested if there are two or more SCQR indicators below 60% with moderate or substantial agreement. The IP process also includes monitoring case management face-to-face data once it becomes available through the new, DBHDS Enterprise Data Warehouse. A suggested IP document is also being developed.

The CMSC continued a monthly review of CSB performance through the Four Pillar process. During Q1 and Q2 FY25, there were eight total improvement plans requested for SCQR. Three IPs for ISP timeliness and four for RST timeliness were removed from the Watch List because the data collection method was been changed as

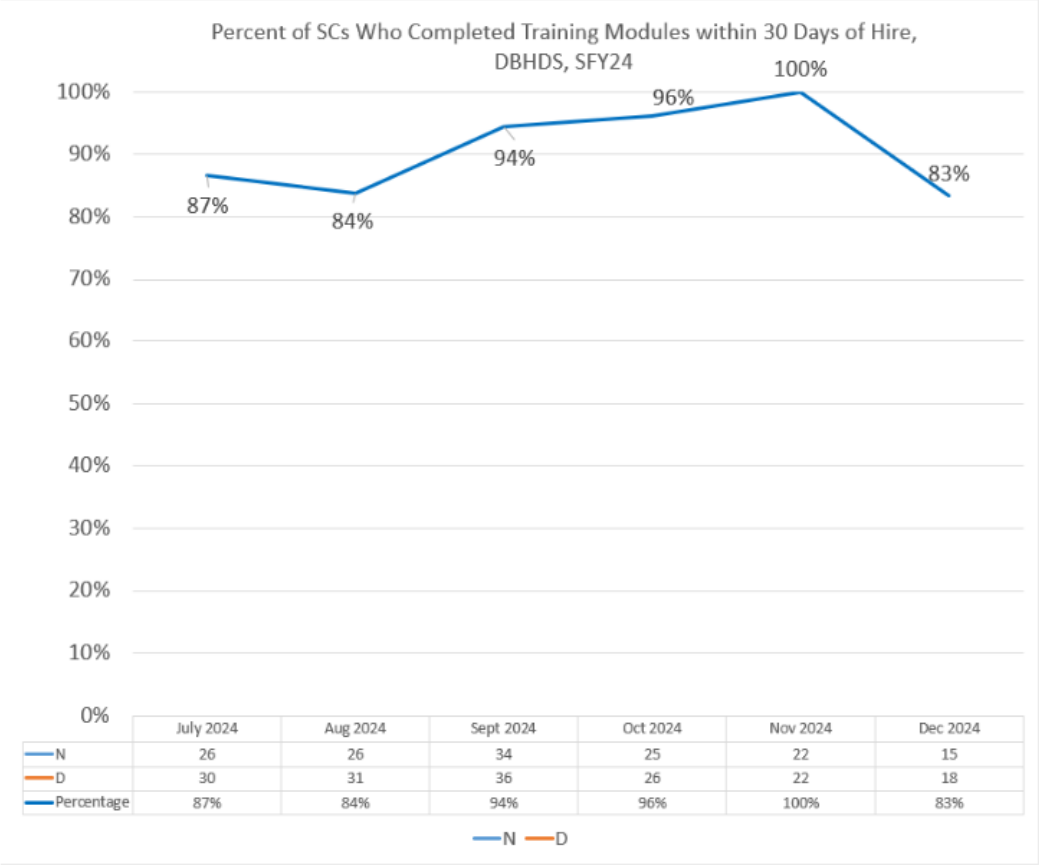
discussed previously in this report. The CMSC will continue to review CSB performance through the Four Pillar process.

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 January and July 2024 shows that the completion rate exceeded 86% in four of the six months reviewed and reach 100% success in November. 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 July to December SFY2024



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 previously 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.
CC3S is currently transitioning to the new DBHDS Data Enterprise Warehouse (EDW) with a planned completion date of 6/30/25. The DQS process will resume once this transition is complete. Preliminary data will be reviewed by CMSC to work towards understanding the impact of this transition.

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.

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.

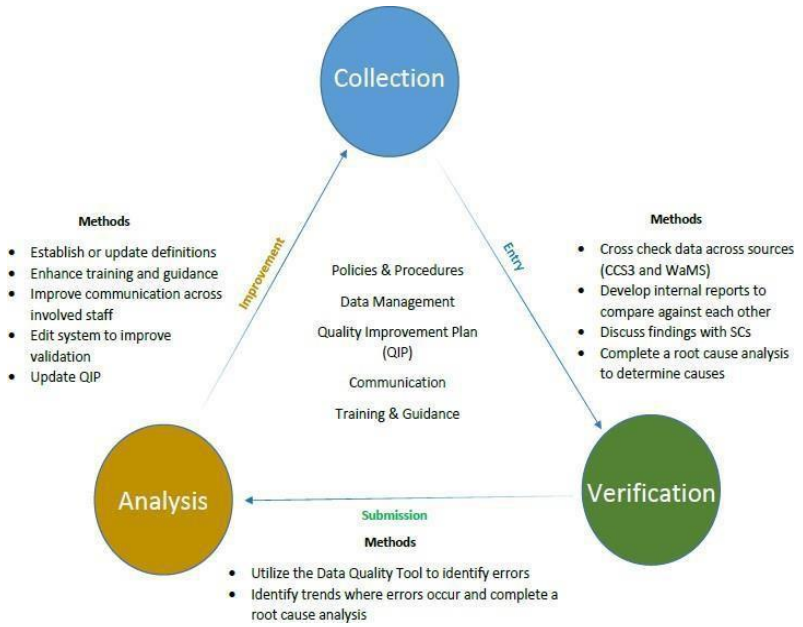


Fig. 21 Data Quality Framework

The Data Quality Process implemented by the CMSC includes the Office of Provider Network Supports 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.

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:

- Develop an online dashboard in PowerBi to assist the CMSC in an expedited, more manageable review of CSB performance across quarters.
- Review data related to the change in calculating ISP compliance under the revised standard to determine next steps.
- Ensure the transition away from CCS3 includes the successful retrieval of data related to case management contacts.
- Determine additional data elements, which can be obtained from the PC ISP v4.0 and include in reporting.
- Begin calculating RST compliance on a rolling four quarters method.
- Request improvement plans from CSBs under the new criteria for achieving success with the 9 of 10 case management elements assessed through the SCQR.
- Implement a QII focused on the understanding and use of the OSVT.

Current Recommendations Include:

- Obtain case management visit data from the DBHDS EDW and proceed with the FY25 Data Quality Support Process and implement the final "pillar" in the performance monitoring process
- Continue the implementation of a OVST QII to improve clarity and usefulness of the tool
- Work with DBHDS to identify and plan for system changes focused on improving processes and reducing administrative burden
- Revisit Enhanced Case Management ECM to evaluate impact and determine additional process improvements
- Develop an online dashboard in PowerBi to assist the CMSC in an expedited, more manageable review of CSB performance across quarters.
- Determine additional data elements, which can be obtained from the PC ISP v4.0 and include in reporting and plan for the development of user accessible reports directly within the WaMS user interface.
- Develop a video overview or training for CSBs covering the 10 case management elements included in the Permanent Injunction and assessed through the SCQR to increase understanding across the system of these elements and how success can be achieved.

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.