Virginia Department of Behavioral Health & Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2021
3rd and 4th Quarters

Case Management Steering Committee

Semi-Annual Report FY21 3rd and 4th 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 Development or designee, the Director of Community Quality Improvement or designee, the Settlement Agreement Director, one Quality Improvement Program Specialists, and a representative from the Office of Data Quality and Visualization. Advisory members include the DBHDS QI/QM Coordinator, 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 model.

From January to June 2021, the CMSC continued the implementation and refinement of a structured process of routine CSB performance monitoring. The CMSC also reported to the QIC in March and June 2021. The CMSC is responsible for 11 performance measure indicators (PMIs) and monitors an additional eight not included in PMI reporting. Data reporting included six PMIs: employment discussions and goals, community engagement discussions and goals, timeliness of Regional Support Team (RST) referrals, and enhanced case management face to face visits. Four new measures were approved by the QIC in June

2020 related to case management assessment of changes in status and appropriately implemented services, as well as discussions about relationships and interactions with people (other than paid program staff) and individuals being given a choice of providers including a choice of support coordinator. One additional measure approved by the QIC in September 2020 relates to children age 14 to 17 with a waiver having a discussion about employment and how they are supported to be ready to work included in their Individual Support Plan (ISP). The measures are organized around domains and contain visualizations that offer insight into the progress and status of each measure. DBHDS is in the process of changing the data source for many existing measures from CCS3 to the WaMS ISP. Updates to the ISP were launched on May 1st, 2021 with the new source data beginning in 1st quarter FY22.

Key Accomplishments

During the reporting period, key accomplishments included initiating the second year of SCQR implementation. Of significance was the need to improve the collection of data through the WaMS ISP and ensure alignment of the data with the SCQR process. Changes were made to the 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. These changes were introduced in the May 2021 launch of the WaMS ISP version 3.2. Results from these changes are expected to become apparent when calendar year 2021 records are reviewed in 2022.

The On-Site Visit Tool (OSVT) was refined to assist with standardizing the understanding and application of the terms “change in status” and “appropriate implementation of services.” Specific changes in this process are expected to further support available evidence related to the assessment and recording of actions related to these terms. The OSVT was sampled during the report period to review the quantity and quality of the information collected and the effectiveness of the tool. Results from this review are included in this report. The tool has been priced for inclusion into WaMS in the future once the format is finalized and deemed effective.

There were ongoing efforts made related to ISP compliance, RST referral timeliness, and SCQR completion with technical assistance provided by Community Resource Consultants (CRCs) in April and the Office of Community Quality Improvement (OCQI) will conduct SCQR reviews through October 2021. Corrective Action Plans (CAPs) were requested from two additional CSBs related to underperformance with RST referral timeliness bringing the current total to six CSBs implementing plans for RST compliance. The CMSC submitted language for inclusion in Exhibit M of the Performance Contract to strengthen support to CSBs who are identified as underperforming in any area monitored by the CMSC. The submitted language compels CSBs to participate in technical assistance as recommended by the CMSC. This process is expected to begin in October 2021 once all performance contracts are signed.

Further the CMSC is charged with establishing a process to review the CSB data related to case management contacts and to ensure that data is valid and reliable and to provide technical assistance to improve this data over time. Currently, OCQI is meeting with CSBs around CM data quality, but a more formalized process is being developed with the DBHDS/VACSB Data Management Committee prior to

implementation. During the report period, a data verification survey was distributed to CSBs to collect descriptions of established data collection, analysis, and verification processes within in CSB. Thirty six of 40 CSBs responded to the survey. Results are further explained in this report.

Support Coordination Quality Review (SCQR)

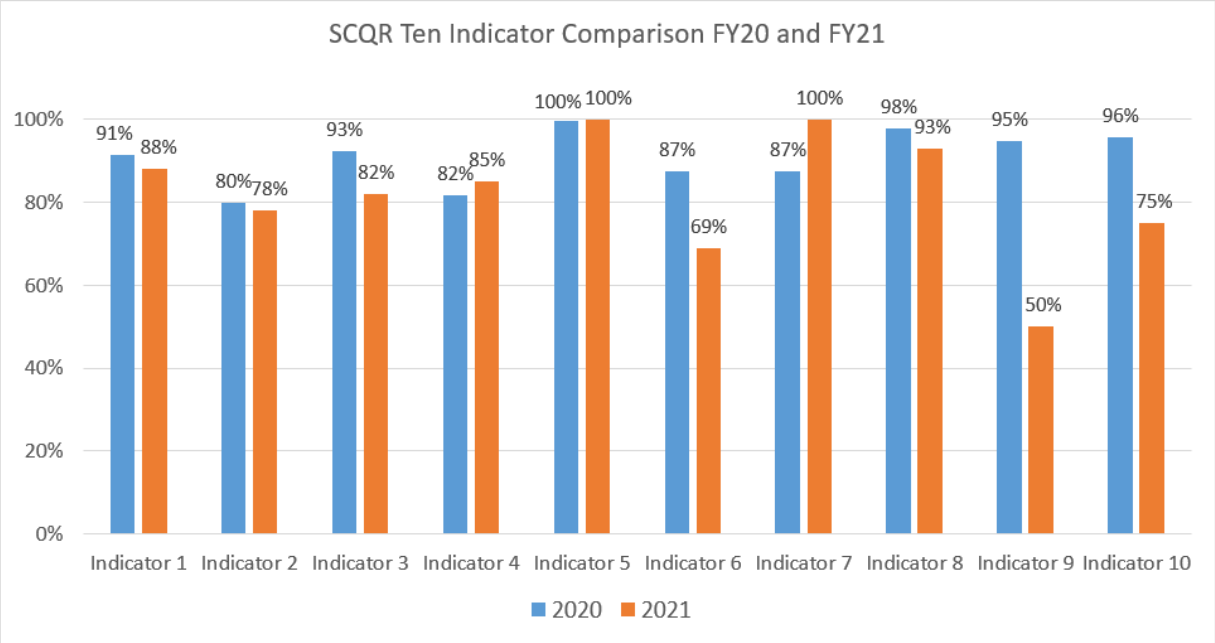
In cooperation with the Independent Reviewer, the committee defined two phrases related to the provision of case management services, which included identifying and responding to "changes in status" and if "services are appropriately implemented." These definitions are designed to increase consistency 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 within 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 Quality Improvement Initiative (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 FY21 submissions. While this technical assistance does not impact the record reviews underway, it is expected to improve the SCQR results occurring in FY22 when FY21 documentation is reviewed.

During this second year of the SCQR process, CSBs completed 100% of the sample. Due to adjustments made to the tool and technical guidance following the first year, DBHDS anticipates the reliability of the data to increase, but compliance to decrease as boards adjust to the changes and scrutinize records more carefully. 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. The ISP adjustments were made to provide locations for information assessed through the SCQR where no location previously existed. A comparison across the two years available in the graph below shows a decrease in compliance with seven indicators, and an increase in two with one unchanged.



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)

On-site Visit Tool

In November 2020, based on a review of a sample of OSVTs during the pilot period and 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 favoring a Support Coordinator assurance 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 these phrases 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 month when visits occur, but no less than one time per quarter. This equates to once per month for people with Enhanced Case Management (ECM) and at least once every three months for people with Targeted Case Management (TCM).

The OSVT captures information to include the name, location of visit, date of visit and the service provided. A list of questions guides the assessment with a checklist format for clear documentation of findings. Details regarding the assessment are captured in the contact note from the visit, which is completed by the Support Coordinator and stored in the electronic health record at the CSB or BHA.

DBHDS collects results from the OSVT and a sample of Support Coordinator notes 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

The DBHDS 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 OSVT is made up of 17 focus-area questions, divided into sections that include:

- Change in Status
- Change in Status Determination
- Services Implemented Appropriately
- Services Implemented Appropriately Determination
- Reporting and Plan Changes

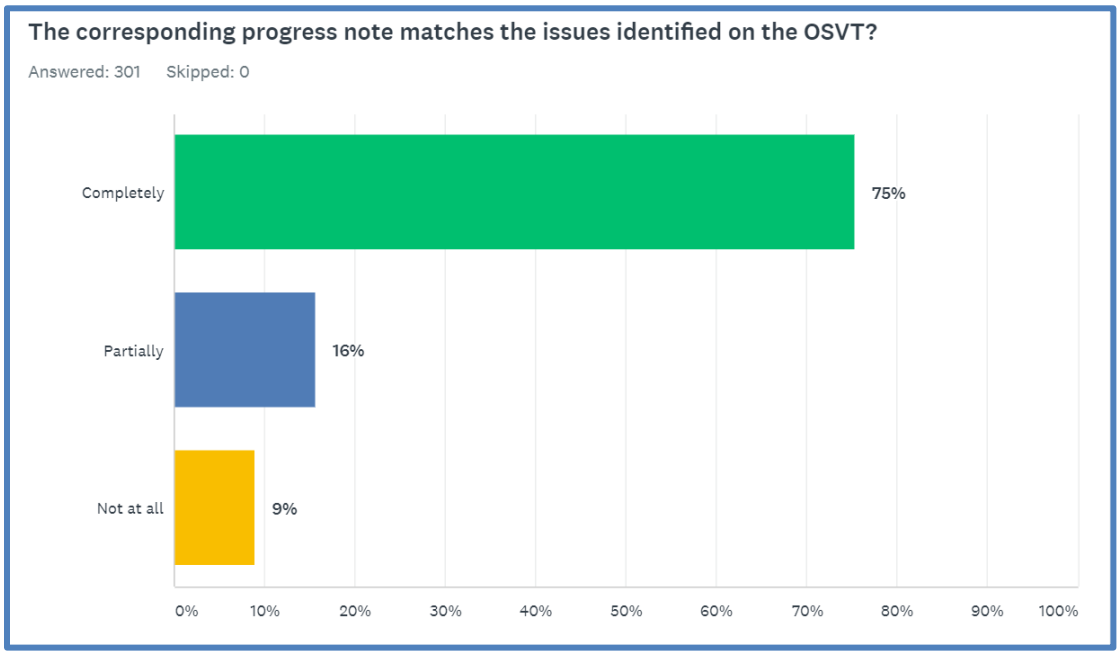
The Office of Provider Development completed the first qualitative review in June 2021. The review included a random sample of 301 On-site Visit Tools with corresponding contact notes from the first and second quarter of 2021 (July 1, 2020 – December 31, 2020). All CSBs and BHA's were included and participated. CSBs/BHAs were notified of the documentation requirements April 30, 2021 to be submitted by May 31, 2021.

Each Region in Virginia participated and submitted required documentation. All 301 reviews were completed. The OSVT was either uploaded to WaMS or placed in Box for submission. Some noted results include:

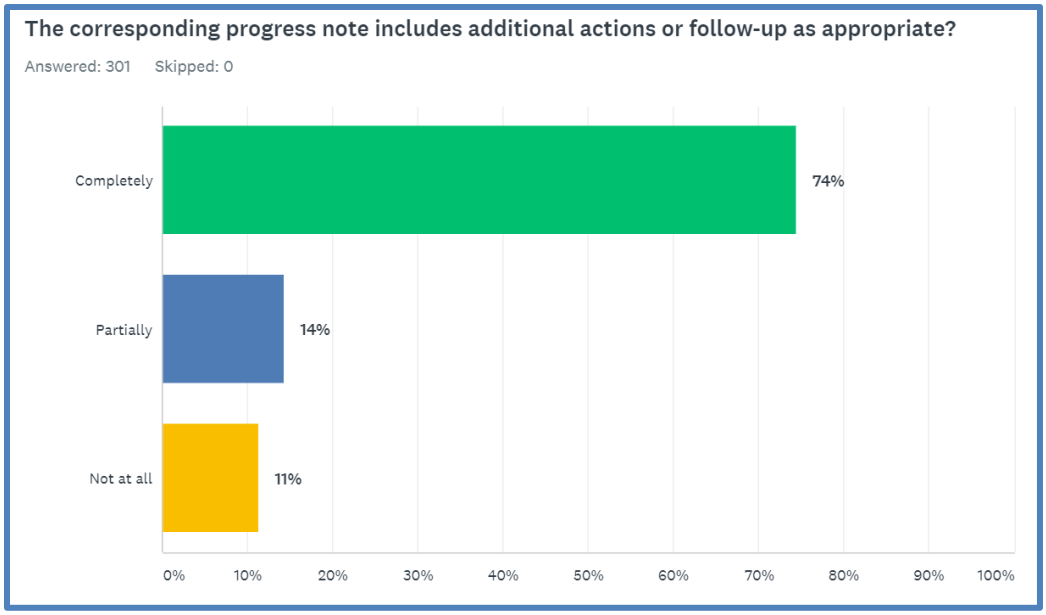
- 95% - 99% of OSVT's contained required name, location of visit and date of visit
- 95% of OSVT's had a corresponding progress note
- Visits were conducted face to face (19%), by telephone (52%), and video teleconference (24%). There were 6% that were unable to be confirmed by reading the note.
- 92% had completely filled out the Change in Status element on the OSVT
- 92% had completely filled out the ISP Implemented Appropriately element on the OSVT
- 65% of OSVT's had notes specific to the individual, while 35% did not
- A Change in Status was identified in 13% of OSVTs
- 13% of OSVT's reported that the ISP was being implemented appropriately

Two important elements in the use of the OSVT and corresponding notes are the issues identified and additional actions taken to address them. Issues identified in the OSVT matched the corresponding note in 75% of reviews. With the modifications to the tool for the December 2020 release, the requirement for detailed notes transitioned from the OSVT to the contact note at the request of the CSBs and work group. The CSBs reported it was duplicative to have detailed

information in both the OSVT and the contact note, and that the information was already being placed in the contact note. In many cases, when there were notes placed in the OSVT, they were copied from the contact note and were exact. In other cases, the issues matched in both documents but were not copied. For those that "Partially" matched, typically there was an issue identified through the questions on the OSVT that then was not addressed in the contact note. For the reviews that were scored as a "Not at All", most of them were because we did not receive a corresponding note. At least 6-7% of the reviews did not have a contact note submitted. Please see below.



The majority (74%) of corresponding progress notes included additional actions or follow-up as appropriate, critical to the care of the people being served. It was clear from review of the detailed notes that the Support Coordinator took actions such as initiating new outcomes and a new service, updating the ISP, collaborating with physicians, providers and family members, and generally supporting the person's needs through action. For those that "Partially" matched, typically there was an issue identified through the questions on the OSVT that then was not addressed in the contact note through any noted action. For the reviews that were scored as a "Not at All", most of them were because we did not receive a corresponding note. At least 6-7% of the reviews did not have a contact note submitted.



As a result of this OSVT review, the following recommendations were made:

- Communicate with CSBs/BHAs that if they are completing their monthly or quarterly visit, they need to complete the OSVT as part of the visit, even if the person or family requests a telehealth visit. They can complete many of the questions in these cases.
- The Case Management Steering Committee should discuss the potential to roll this review up into the Support Coordination Quality Reviews. If it is determined that the SCQR process could be used to assess the use and quality of the OSVT, look at a process to streamline them together.
- Since the SCQR process is in the Look Behind process at this time, for the second round of OSVT reviews, it is recommended Quarter 3 and Quarter 4 for Fiscal Year 2021 be completed in the same manner as the first review while work begins with the Case Management Steering Committee to look at streamlining in early 2022.
- The requirement for ongoing uploading of the OSVT's into WaMS needs to be communicated more clearly to CSBs. Some reported they were under the impression that the uploading to WaMS was only for the pilot timeframe.

This QII has a target of ensuring that 86% of individuals have the OSVT uploaded into WaMS upon completion every 90 days. For Quarters 1 and 2 of FY21, the percent of OSVT's uploaded to WaMS was 54% well below the 86% target. The need to upload will be conveyed the upcoming statewide Provider Roundtable and regional SC meetings to increase awareness of the requirement. The CMSC expects the percentage to increase and will continue to sample OSVT forms to monitor use and improve processes over time.

Identified Concerns

The Independent Reviewer's 18th Report to the Court was submitted on June 14, 2021. III.C.5.b.i. as described in the report continues to be in a state of non-compliance. The report states that the Commonwealth met seven of the nineteen Compliance Indicators that comprise the four Case Management Provisions, i.e., III.C.5.b.i., III.C.5.d., V.F.4., and V.F.5. Since it has not yet met the remaining twelve Compliance Indicators, Virginia remains in noncompliance. The report specifically refers to the interruption in face-to-face visits, which have been one result of the global pandemic stating that "without face-to-face on-site interviews and observations cannot provide reliable data regarding the proper implementation of these requirements or "for review on a statewide and individual CSB level" (2.05)." The necessity of ceasing face to face visits during the pandemic, along with a delay in establishing and implementing standard definitions for "change in status" and "appropriately implemented services" is also referenced. The report indicates that since the On-site Visit Tool was implemented in July of 2020 with the finalized, standard definitions, reliable data will largely not be available for the FY20 and FY21 SCQR reviews.

The 18th report also included a single recommendation for Case Management stated as:

> Now that relevant precautions due to the pandemic have been lifted, DBHDS should determine if and how it can accelerate the completion of its review of the Support Coordinator Quarterly Reviews – Fiscal Year 2022. The Department's review must be based on a majority of face-to-face visits and assessments having occurred per quarter, as required.

While DBHDS appreciates this recommendation, ongoing concerns with the pandemic have not eased as of this report due to unforeseen variants and related increasing infection rates across the Commonwealth, so accelerated implementation was determined unachievable this cycle.

Quality Improvement Initiatives

Currently there are three Quality Improvement Initiatives (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.

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

As stated above, this QII focuses on ensuring that people with DD have supports that respond to changes in status with appropriately implemented services. This QII was implemented on June 30, 2020 following approval by the DBHDS Quality Improvement Committee (QIC). It was

determined through reports from the Independent Reviewer for the Settlement Agreement and discussions with CSB representatives that there was a lack of consistency in understanding and application of the phrases “change in status” and the “appropriate implementation of services.” This led to establishing definitions and a process through which support coordinators in Virginia would apply the same definitions, in the same manner, through face to face visits with people who use services. Following a pilot phase the On-site Visit Tool (OSVT) was established and finalized for use on December 20, 2020 to support consistent understanding and application of these important phrases.

DBHDS has completed a review of the first two quarters of FY21 that included a comparison of 301 completed tools and corresponding contact notes. As stated above, for Quarters 1 and 2 of FY21, the percent of OSVT’s uploaded to WaMS was 54% well below the 86% target. With activities focused on communicating the requirement, the CMSC expects the percentage to increase and will continue to sample OSVT forms to monitor use and improve processes over time.

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

Implemented on May 12, 2021 in response to Quality Services Review (QSR) data, this QII centers on improving the frequency with which individuals receive Enhanced Case Management (ECM) visits as defined in Virginia’s Settlement Agreement. The guidelines around this requirement have consistently been reported as problematic for CSBs. Ongoing reports have described difficulty in operationalizing, implementing, and tracking the completion of needed visits. Some CSBs have even reported placing every individual on ECM to avoid the challenge of tracking completion. Data related to measures used to monitor this requirement has been below historical tracking though it is important to recognize the decrease in performance coincides with a global pandemic. Results during FY21 have been as low as 81% for monthly visits and 72% for alternating visits in the home.

This QII is designed to focus on identifying perceived challenges and enhancing, to the extent possible, guidance that is available to support coordinators so that implementation can be less complex and more successful. To date, a focus group of CSBs has provided input, which has resulted in the development and provision of an automated worksheet that supports decisions around initiating and ceasing ECM. A questions and answers document was also provided to all CSBs through the work of this group. Next steps include exploring the need for additional guidance documents, developing and providing a standardized training, and posting a recorded video online for access across the system.

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.*

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 has the most significant impact on performance for the first measure.

The CMSC is conducting an analysis of referrals identified as late for Reason B in order to produce a Pareto chart around the frequency of individual factors. Early analysis shows that many referrals included in this category were emergencies and should not have been included. For example, a house fire and immediate relocation would be reported as late for Reason B under current processes rather than as an emergency. Provider Development is working to move the RST process into the Waiver Management System as well, which provides the opportunity to adjust how referral timeliness is defined and how referrals are segregated into reasons for lateness. These changes are expected to improve the results seen with this measure.

Performance Measures

The CMSC monitors CSB performance through 19 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 SFY21. 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.

FY21 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 (**PMI**)	Adults (aged 18-64) with a DD waiver receiving case management services have an ISP that contains employment outcomes (Target 50%). **III.C.7.a.**
3 (**PMI**)	At least 86% of 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 Medicaid DD Community Engagement or Community Coaching services goals (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 (**PMI**)	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.**
8 (**PMI**)	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. **V.F.4.**
11 (**PMI**)	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 86%). **V.F.4.**
12 (**PMI**)	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month in their residence (Target 86%). **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. **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 among providers, including choice of support coordinator, 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 (**PMI**) *Figure 2*	Adults (aged 18-64) with a DD waiver receiving case management services have an ISP that contains employment outcomes (Target 50%). **III.C.7.a.**	N = Number of Individuals (18-64) with recorded Employment Outcomes at Annual F2F ISP Meeting	D = Number of active individuals (18-64) who had an Annual F2F ISP Meeting
3 (**PMI**) *Figure 3*	At least 86% of 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. **III.C.7.a**	**Data available beginning May 1, 2021**: 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

Fig. 1 Employment Discussion (Q4 FY21 N = 9,762 D = 10,113)

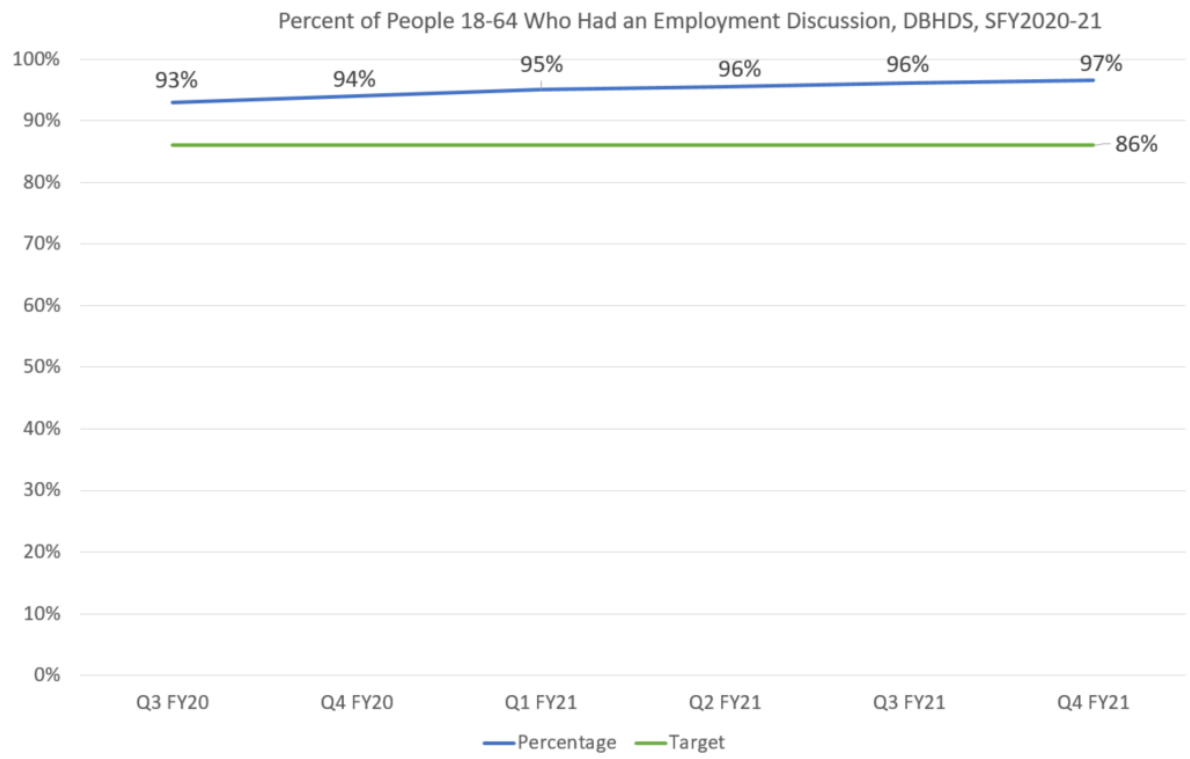


Fig. 2 Employment Outcomes (Q4 FY21 N = 2,846 D = 10,113)

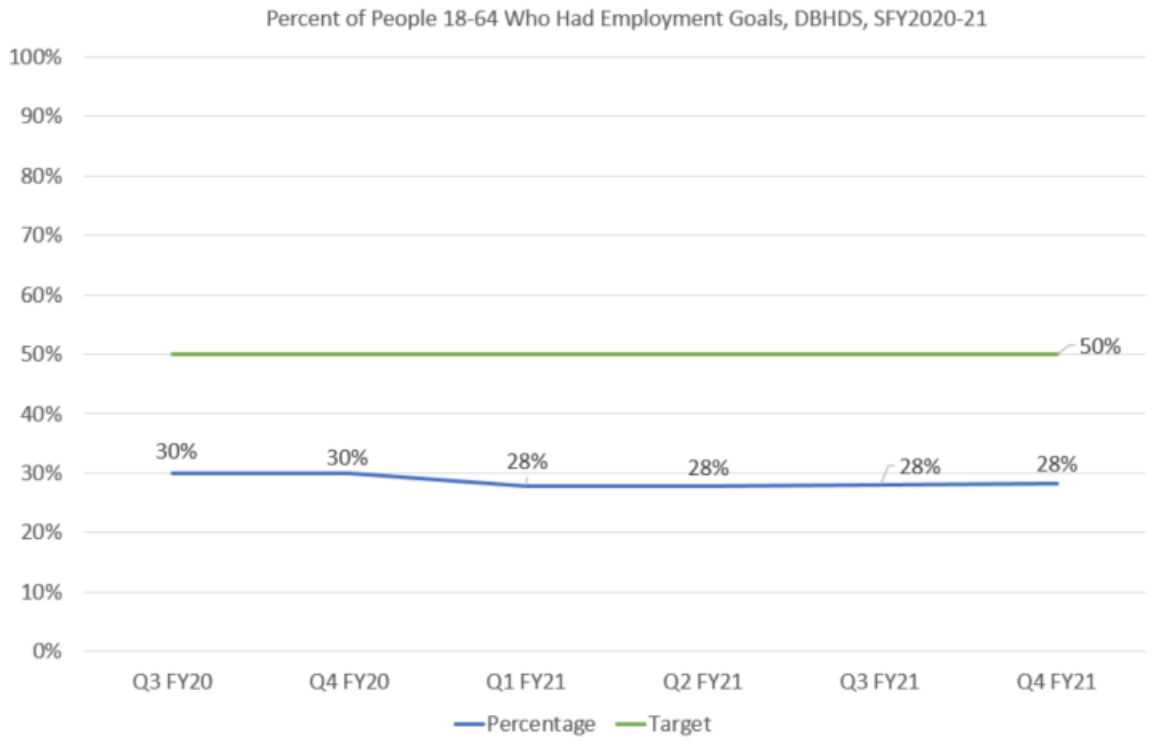
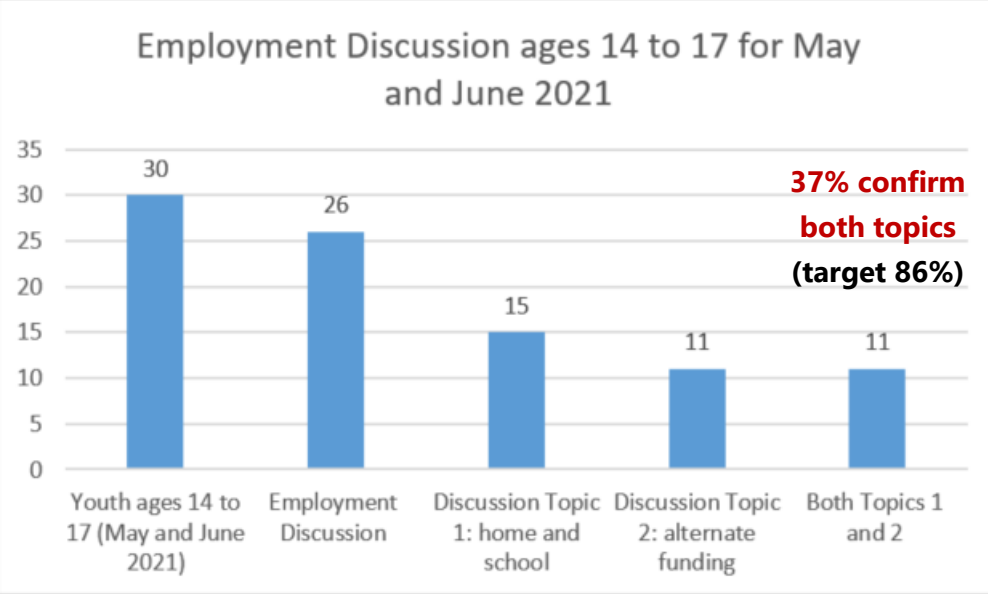


Fig 3. Preliminary Data for Employment Discussion 14-17 from May and June 2021



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 Medicaid DD Community Engagement or Community Coaching services goals **III.C.7.a**	N = Number of Individuals recorded Community Engagement Goals 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**	**Data available beginning May 1, 2021:** 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

Fig. 4 Community Engagement Discussions (Q4 FY21, N = 10,949 D = 11,786)

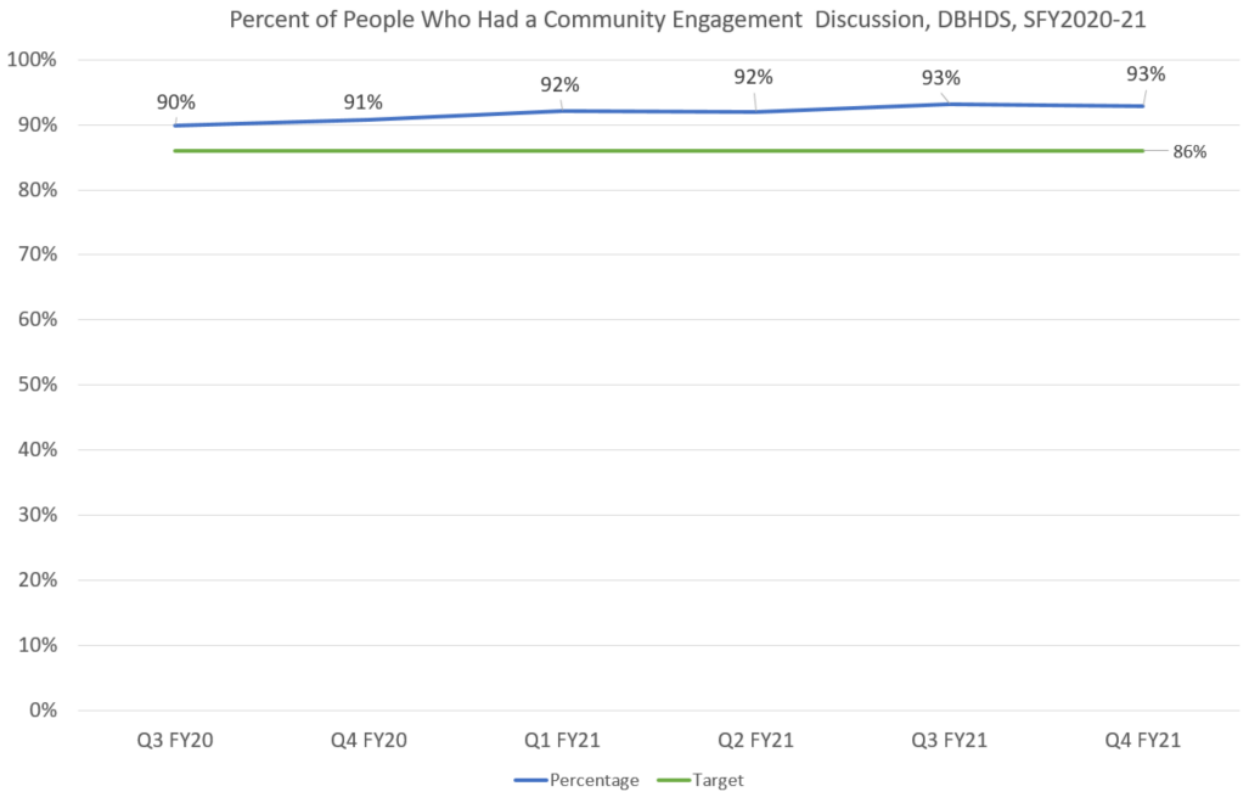


Fig. 5 Community Engagement Outcomes (Q4 FY21 N= 4429 D= 11786)

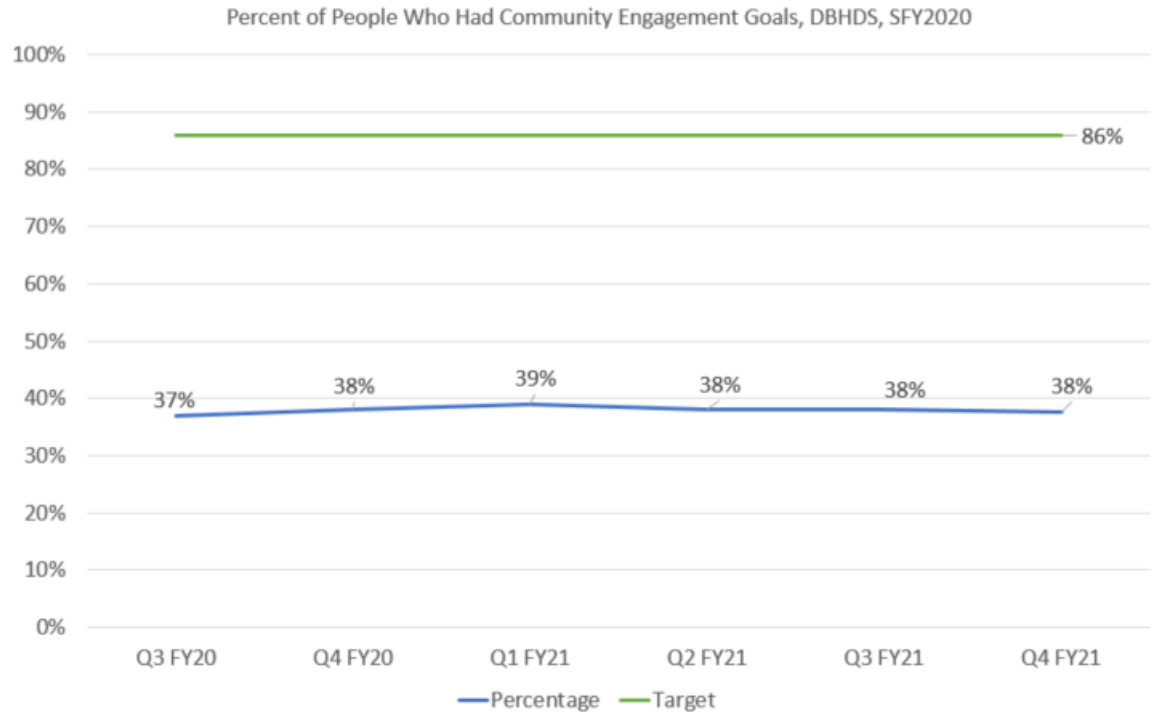
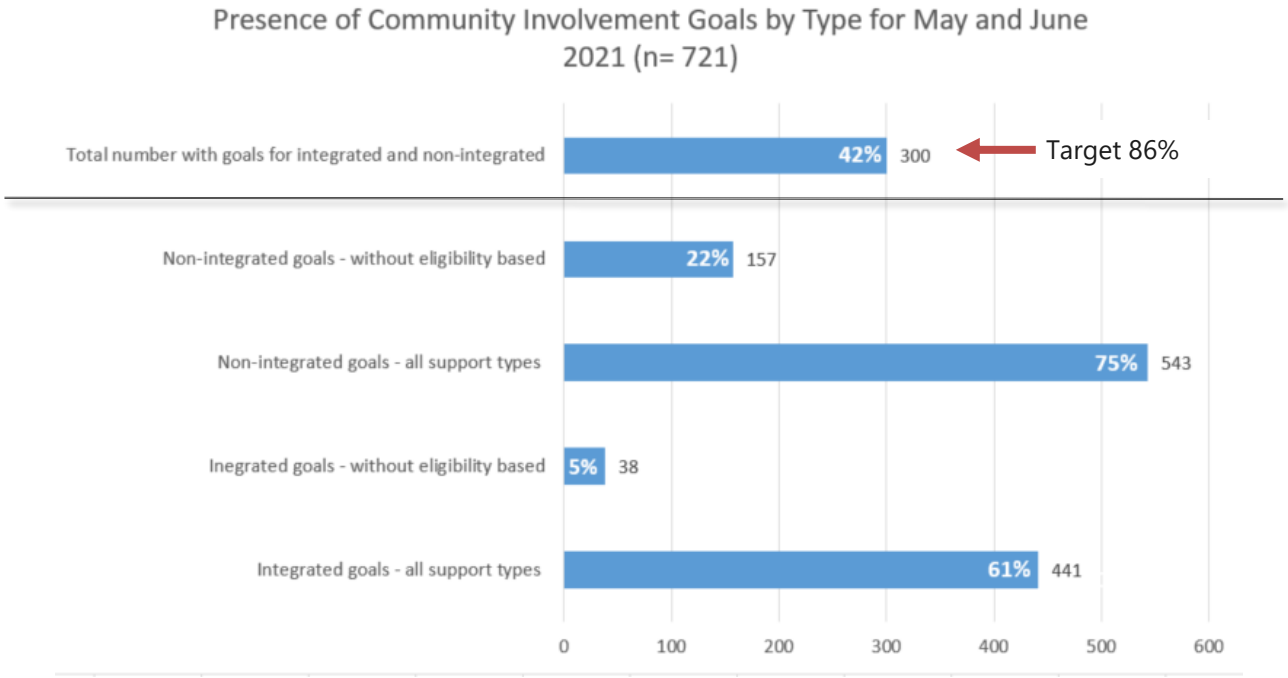


Fig 6. Preliminary Data for Community Involvement Goals from May and June 2021



Regional Support Teams and Timeliness of Referrals

Reference	Measure	Numerator	Denominator
7 *(**PMI**)* *Figure 7*	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.**	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 N/A	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.

Regional Support Team data related to all reasons for lateness shows consistent below target performance for FY21 with an overall result of 64% for the FY (figure 7). The CMSC is currently implementing a QII as reported above in the effort to positively impact this result. The measure related to CSB compliance with residential referrals (Figure 8) shows above target CSB performance since Q2 FY21 with an overall result at 89% for FY21. Regarding the final RST measure, it is important to note a change in how DBHDS is tracking and reporting on individuals with an identified barrier 2 (services unavailable in the desired locality). DBHDS collects and reports this barrier at the point of referral and if the desired residential option meets the III.D.1. definition of the Settlement Agreement joint filing. Details are provided in the quarterly RST reports as follows: In the 1st Quarter, two individuals referred to the RST were identified upon referral with Barrier 2 defined as "Services and activities unavailable in desired location." The first instance, reported in Region 4, was resolved when the person moved into a sponsored residential home. In the second instance, reported in Region 3, a person is living at home with personal assistance and private duty nursing services. The individual would like additional private duty nursing services however remain living in their own home at this time. No referrals occurred during the 3rd and 4th quarters of FY21 with barrier 2 identified.

Fig. 7 RST Community Referral Timeliness through 4th quarter FY21 (Q4 FY21, N=115, D=159)

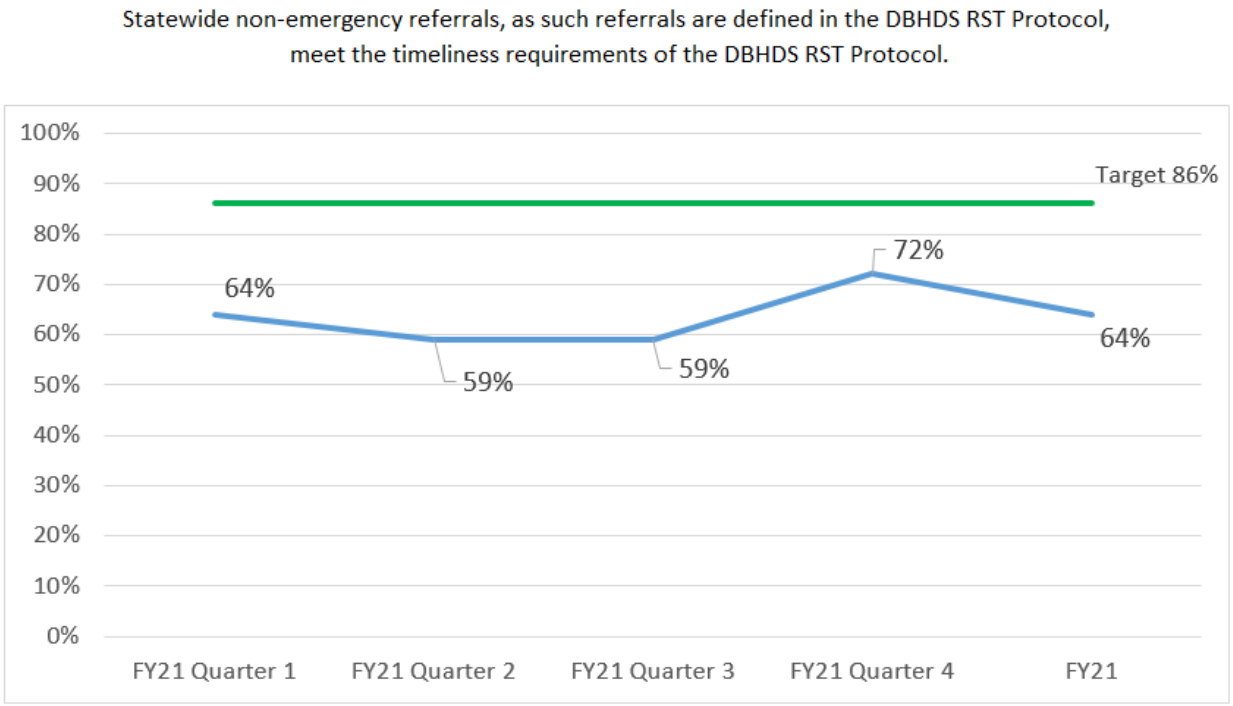
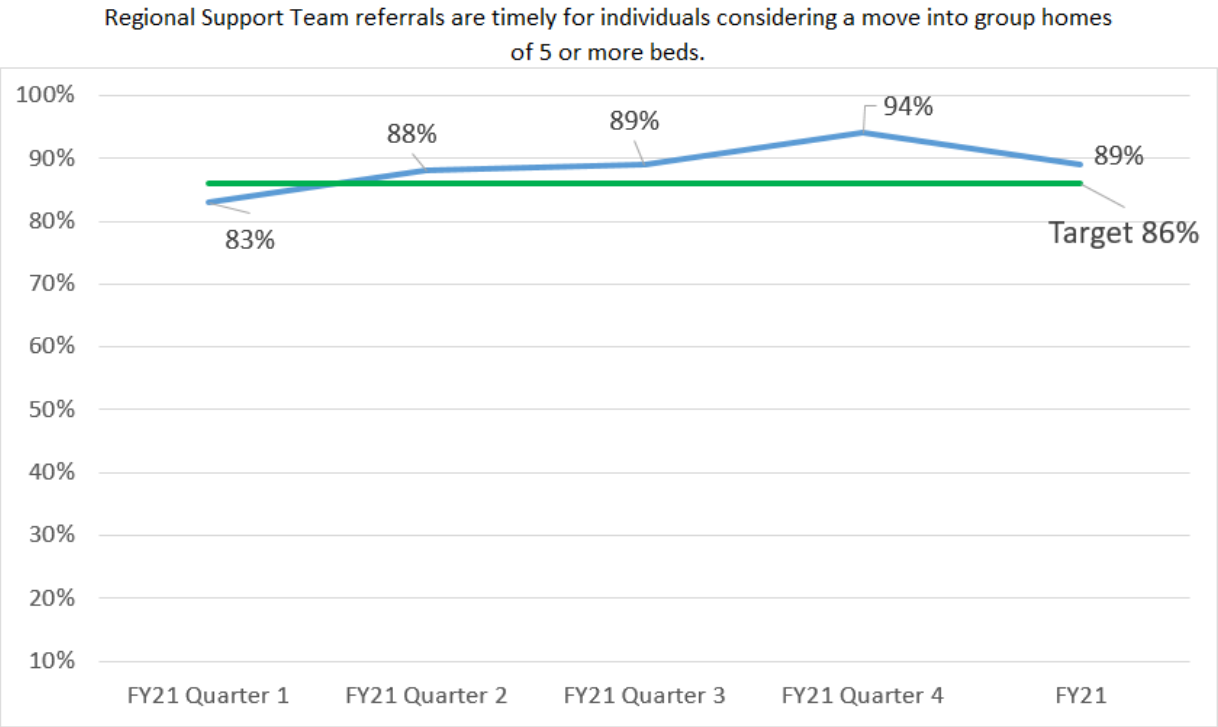


Fig. 8 RST Residential Community Referral Timeliness through 4th quarter FY21 (Q4 FY21, N = 146, D=155)



Provider Capacity

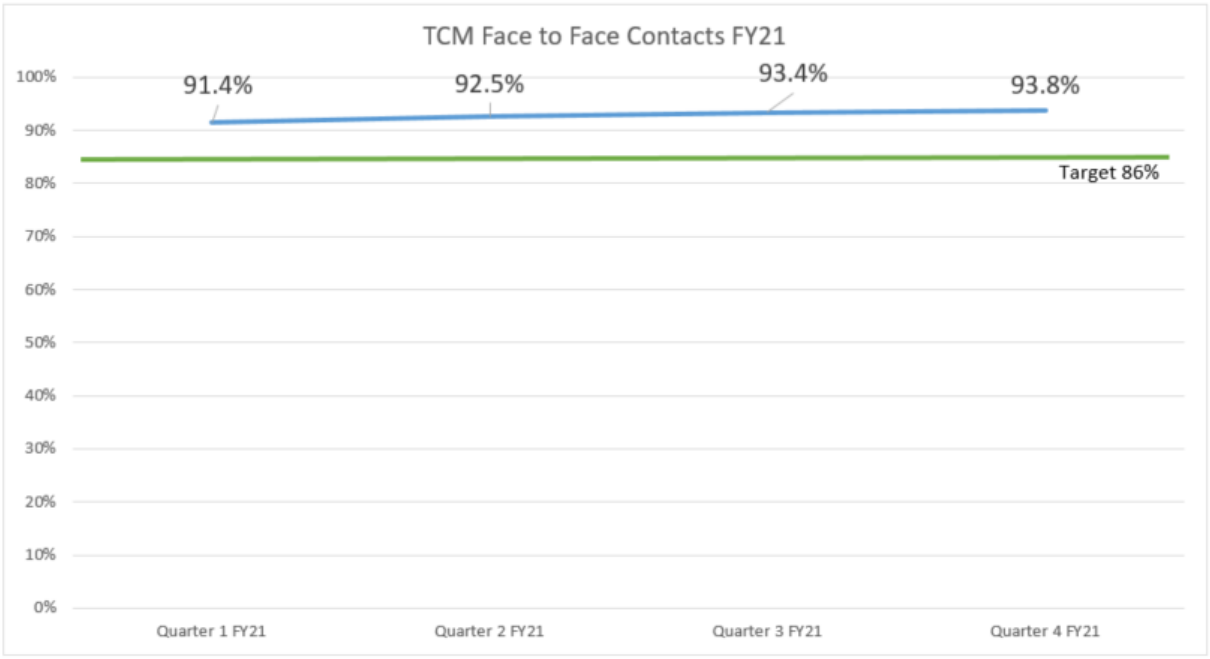
Case Management Face to Face Visits (F2F) and Effectiveness

Reference	Measure	Numerator	Denominator
10 *Figure 10*	People with DD CM Services receive face-to-face contacts from their support coordinator at least quarterly. **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 (**PMI**) *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. **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 (**PMI**) *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. **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. **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. **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 Targeted Case Management face to face visits is available for FY21. Based on the results below, there was consistent above target performance for all four quarters. There was one missed contact identified during the year, which occurred in the 1st quarter. Overall results for FY21 ECM face-to-face (figure 11) and ECM in the home (figure 12) ended below target for the year, but have shown slow improvements over time as the pandemic has changed course.

Fig. 10 TCM visits quarterly during FY21



	Quarter 1 FY21	Quarter 2 FY21	Quarter 3 FY21	Quarter 4 FY21
% Face to face	91.4%	92.5%	93.4%	93.8%
Face to Face	17448	17725	18058	18131
Not Face to Face	1635	1429	1280	1205
Not Applicable	1	0	0	0
All Modalitites	19084	19154	19338	19336

Fig. 11 ECM visits monthly by Region and CSB (**updated to 4th quarter FY21**)

F2F Percent

Most recent month in d..
June 2021

	FY 2021				
Region	Q1	Q2	Q3	Q4	Total
1	86%	90%	92%	90%	89%
2	91%	92%	91%	90%	91%
3	77%	85%	68%	83%	78%
4	88%	90%	92%	90%	90%
5	68%	74%	78%	78%	74%
Grand T..	81%	86%	84%	86%	84%

	FY 2021 Q1	FY 2021 Q2	FY 2021 Q3	FY 2021 Q4
F2F Numerator	12,977	14,367	14,109	14,596
InHome Numerator	11,443	12,083	13,356	14,372
Denominator	15,969	16,658	16,788	16,955
F2F Percent	81%	86%	84%	86%
In Home Percent	72%	73%	80%	85%

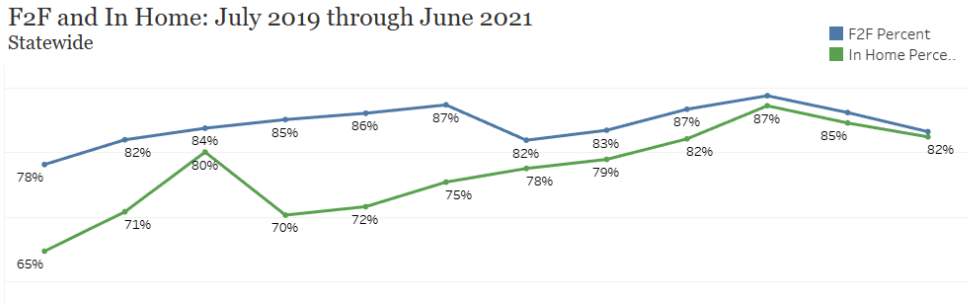
Fig. 12 Face to face ECM visits in-home by Region and CSB (**updated to 4th quarter FY21**)

In Home Percent

Most recent month in d..
June 2021

Regi..	FY 2021 Q1	Q2	Q3	Q4	Total
1	73%	81%	86%	87%	82%
2	90%	75%	90%	90%	86%
3	79%	84%	68%	86%	79%
4	59%	54%	84%	84%	71%
5	60%	64%	71%	76%	68%
Grand T..	72%	73%	80%	85%	77%

Fig. 12a Face to face ECM visits and in-home line graphs (**updated 9.13.21**)



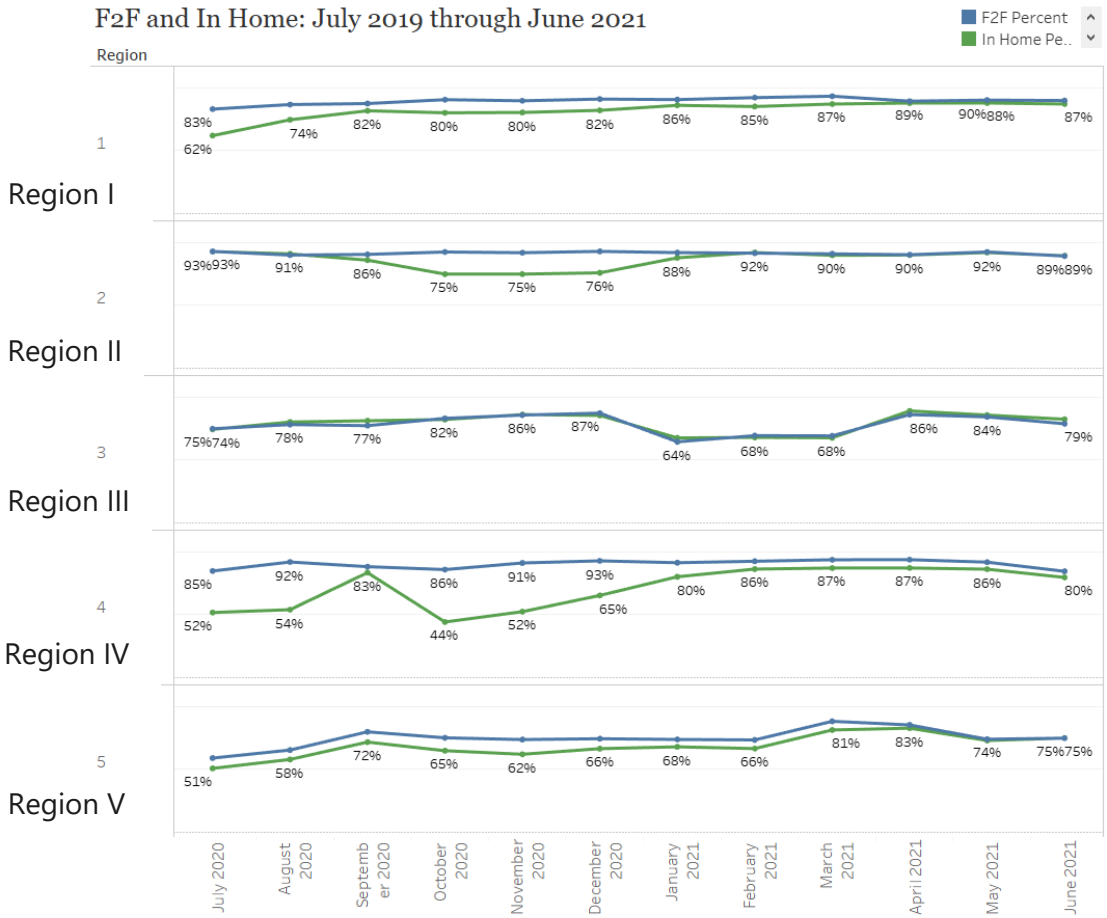


Fig. 13 Records in compliance with 9 of 10 assessed indicators FY21

Result	Count of Records	%
9 of 10 not met	225	56%
9 of 10 met	175	44%
Grand Total	**400**	**100%**

Now in the second year of the SCQR process, the initial results from CSB submissions are available. The Look-behind and Interrater Reliability Review processes commences in July of 2021. Results in this first year of the SCQR process reflect a substantial level of agreement with four of the ten assessed CM indicators: choice of CM/SC, disagreement and resolution, making linkages, referrals, and authorizations, and assessing for change in status. The weakest or lack of agreement was seen with offering choice, measurable outcomes, risk assessment and mediation, and assessing for appropriately implemented services. Based on these findings, DBHDS has revised the Individual Support Plan to align with the SCQR items, has revised the On-site Visit Tool and process to increase consistency, and has prepared a presentation for use in providing technical assistance to CSBs in year two of the process. 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 not available at the time of this review. This is an annual data report that requires additional time following the end of the FY for data collection and reporting. The most recent report from FY20 is provided below in figure 14. The ISP compliance target was achieved with a combined result of 88% (figure 15).

Fig. 14 FY20 results

Statistics for Active on Waiver to Approved Authorization

Statistics	
Denominator D: First Active on Waiver in FY20	1,424
Numerator N: of those in D, those who have an approved Service Authorization Begin Date within -31 to +150 days (including -31, +150 days) of date used for D.	1,226
N/D	86.1%

Fig. 15 ISP compliance for Report Period: July 1, 2020 thru June 30, 2021

Commonwealth of Virginia	EHR ISP Completed	EHR Pending Provider Completion	EHR Discarded	WaMS ISP Completed	WaMS Pending Provider Completion	WaMS Pending SC Input	WaMS Discarded	No e-ISP	Total	Percent Compliance
Statewide Totals:	**1,025**	**3,300**	**-**	**1,571**	**7,718**	**1,645**	**10**	**247**	**15,516**	**88%**

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. **III.C.5.b.iii; V.F.2; V.F.5**	N = Number of records confirming all five checkboxes on SCQR question Q84 AND also confirming "yes" or "not applicable" on Q85	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**.** **III.C.5.b.iii; V.F.2; V.F.5**	N = Number of records confirming all seven checkboxes on SCQR question Q83	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs

The chart below provides results as reported as reported by CSBs in the second year of the SCQR. The next report will include the levels of agreement seen following the OCQI look-behind process.

Fig. 16 FY21 results for appropriately implemented services and change in status indicators

Indicator	Number of CSBs with at least 86% of records meeting indicator (rounding up)	Percentage of CSBs (out of 40 total)
Indicator 9: SC Assessed Plan Implemented Appropriately	9	23%
Indicator 10: Change in Needs/Status and ISP Modifications	24	60%

Choice and Self-Determination

Choice and Unpaid Relationships

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). **V.D.3.f; V.F.5**	N = Number of individual records for which the response was "Yes" to SCQR Q47	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. **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 chart below provides results as reported as reported by CSBs in the second year of the SCQR. The next report will include the levels of agreement seen following the OCQI look-behind process.

Fig. 18 FY21 results for unpaid relationships discussion

Question	Number of CSBs with at least 86% of records meeting indicator (rounding up)	Percentage of CSBs (out of 40 total)
Q57. Is it evident in the PC ISP that the SC/CM discussed relationships and interactions with people other than paid program staff?	22	55%

Fig. 19 FY21 results for choice indicator

Indicator	Number of CSBs with at least 86% of records meeting indicator (rounding up)	Percentage of CSBs (out of 40 total)
Indicator 2: Provider and SC Choice Offered	23	58%

Office of Licensing Data

The Office of Licensing reported a delay in the Adequacy of Supports report, so that it could be revised to reflect the changes in regulations, so that an adequate report from the DBHDS Data Warehouse. The report will be shared with the CMSC in October 2021 once the information is available. In June of 2021, the CMSC identified the need to explore how OL CAPs can be utilized by the committee to ensure remediation is occurring with underperforming CSBs. This will be considered during the development phase as the CMSC CAP process is expanded.

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 June 2021. The Committee decided to determine where CMSC measures align with QRT reporting and then make CMSC reports available to the QRT for use as surveillance data in their processes. The 3rd and 4th quarter report will be provided upon completion with relevant measures noted to the DBHDS QRT representative. The two measures monitored by the CMSC for Health, Safety & Wellbeing are considered relevant to the work of the QRT although the entire report will be provided for consideration.

Quality Service Reviews

In response to Round 1 of the Quality Services Review (QSR), the CMSC developed and implemented a QII focused on Individuals meeting criteria for Enhanced Case Management receive face to face assessments monthly with alternating visits in the home. See update on page 11 of this report for more information.

Performance Contract Indicator Data

As reported above, the CMSC is implementing a Corrective Action Plan process that initiated by issuing requests for corrective action 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 Corrective Action Plan process to identify and support the improvement of CSB performance in key areas

monitored by the Committee. A Corrective Action Plan (CAP) process was implemented during the past year with six CSBs issued CAP requests related to underperformance with each CSB now implementing plans to improve RST compliance. The CMSC submitted language for inclusion in Exhibit M of the Performance Contract to strengthen support to CSBs who are identified as underperforming in any area monitored by the CMSC. The submitted language compels CSBs to participate in technical assistance as recommended by the CMSC. This process is expected to begin in October 2021 once all performance contracts are signed. Performance Contract language is included as follows:

Targeted Technical Assistance

- The CSB shall participate in technical assistance as determined by the Case Management Steering Committee. Technical assistance may be comprised of virtual or on-site meetings, trainings, and record reviews related to underperformance in any of the following areas monitored by the committee: Regional Support Team referrals, Support Coordination Quality Review results, Individual Support Plan entry completion, and case management contact data.

- DBHDS shall provide a written request that contains specific steps and timeframes necessary to complete the targeted technical assistance process.

- The CSB shall accommodate technical assistance when recommended within 45 days of the written request.

- CSB failure to participate in technical assistance as recommended or demonstrate improvement within 12 months may result in further actions under Exhibit I of this contract.

Further, the CMSC is charged with establishing a process to review the CSB data related to case management contacts and to ensure that data is valid and reliable and to provide technical assistance to improve this data over time. Currently, OCQI is meeting with CSBs around CM data quality, but a more formalized process is being developed with the DBHDS/VACSB Data Management Committee prior to implementation. In FY21, a data verification survey was distributed to CSBs to collect descriptions of established data collection, analysis, and verification processes within in CSB. Thirty six of 40 CSBs responded to the survey. Results from this process will be incorporated into technical assistance efforts as the CMSC works to collect and share best practices around data verification processes.

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 June 2021 shows that the completion rate exceeded 86% in all months. The chart below conveys the number of DD CMs reported as hired per month and the number and percentage who completed the modules within required timeframes (figure 20).

Fig. 20 Case Management Module Completion January to June SFY2021

Month	Number of DD SCs hired	Number (percentage) completed ≤ 30 days of number hired
January 21	12	12 (100%)
February 21	11	10 (91%)
March 21	20	18 (90%)
April 21	17	17 (100%)
May 21	18	17 (94%)
June 21	23	22 (96%)

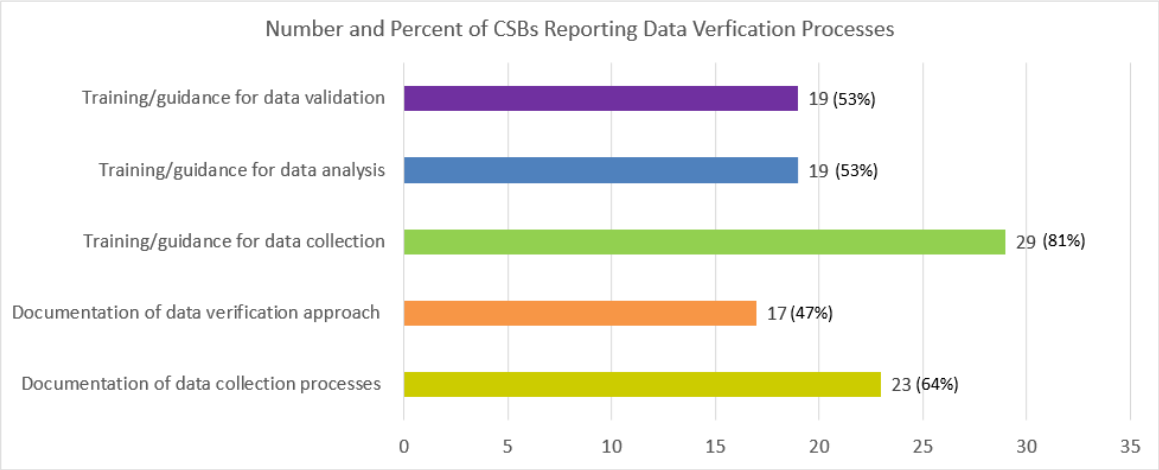
Data Availability and Integrity

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 new process is being developed to support CSBs to examine the integrity of the data provided in relation to face to face contacts submitted through CCS3. An initial process was drafted by DBHDS, which has been delayed to coordinate efforts with the DBHD/VACSB Data Management Committee. This process will begin in FY21 with roles and tasks to be determined. The focus of the work will remain 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



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:

- Include in the FY22 Performance Contract a targeted technical assistance process directed at specific reasons for underperformance monitored by the CMSC
- Work to display data, to the extent possible, in regional terms to assist Regional Quality Councils in undertaking their work
- Move all measure data into the Tableau interface to ease committee review and presentations to internal and external stakeholders
- Continue monitoring CSB CM contact data for improvements as pandemic subsides

Current Recommendations include:

- Work to display data, to the extent possible, in regional terms to assist Regional Quality Councils in undertaking their work
- Move all measure data into the Tableau interface to ease committee review and presentations to internal and external stakeholders
- Revise the SCQR survey and technical guidance through collaboration with CSBs

- Host a statewide webinar orientation to the revised SCQR technical guidance once completed
- Initiate a case management data verification support process

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 measureable 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.