Virginia Department of Behavioral Health & Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2022
1st and 2nd Quarters

Case Management Steering Committee

Semi-Annual Report FY22 1st and 2nd Quarters

Executive Summary

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

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

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

Committee membership includes the Director of Waiver Operations or designee, the Director of Provider Development or designee, the Director of Community Quality Improvement or designee, the Settlement Agreement Director, one Quality Improvement Program Specialist, 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 July to December 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 September and December 2021. The CMSC is responsible for 11 performance measure indicators (PMIs) and monitors an additional eight not included in PMI reporting. DBHDS moved to the WaMS ISP as the data source for many existing measures leaving CM contact data as the only data derived from the DBHDS CCS system for CMSC purposes. Updates to the ISP were launched on May 1st, 2021 and the use of the new source data

began in 1st quarter FY22. The WaMS ISP format is updated annually, if needed, to improve the usefulness, content, and data related to individual plans.

Key Accomplishments

During the reporting period, key accomplishments included initiating the third year of SCQR implementation. Additional enhancements were made to the WaMS ISP to better ensure alignment of the data with the SCQR process. Changes continue to be 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. The latest version of the ISP (v 3.3) will launch in WaMS on May 3, 2022. Core changes include more discrete elements around the employment and integrated community involvement discussions to strengthen these areas in response to the 19th report from the Independent Reviewer, the addition of three elements related to Virginia's implementation of Supported Decision-Making Agreements, and seven additional elements related to medical and psychiatric needs including:

- Are there current Medical conditions? If yes, list
- Are there current Health Protocols? If yes, list
- Is there a history of past medical conditions? If yes, list
- Is there a history of hospitalizations? If yes, list
- Is there a history of surgeries? If yes, list
- Is there a history of mental health conditions? If yes, list
- Is there a history of psychiatric hospitalizations? If yes, list

The CMSC made substantial progress on the design of a Data Quality Support Process as required by the Settlement Agreement under V.F.4. Development included the design of a process and data life cycle framework with a root cause analysis template that enables CSBs to integrate data concerns into their agency's Quality Improvement Plan (QIP). The process will include a step-by-step review of sample data for individuals receiving, Targeted Case Management, DD Waiver, and Enhanced Case Management and will begin in the 3rd quarter FY22 once the sample format is finalized.

Another key accomplishment is the continued provision of data to CSBs. CSBs now receive data reports monthly that enable them to track their results related to performance measures monitored by the Committee. Quarterly reports for each CSB will be requested in Q3 FY22 and provided in the next report period to assist CSBs with seeing improvements made each quarter. In the coming report period, the CMSC will also make available a recorded video to support CSBs in understanding the functionality of the ISP data report and how to use it in performance monitoring. The CMSC is currently reviewing an On-site Visit Tool (OSVT) sample for the 3rd and 4th quarter FY21 that includes 300 OSVTs and corresponding progress notes. Work has continued on the development of a "4 pillars" framework to identify and remediate or report performance concerns in the areas of Regional Support Team (RST) referral timeliness, Support Coordination Quality Review (SCQR) findings, ISP entry, and the completion of Case Management contacts as required.

There were ongoing efforts made related to improve performance with technical assistance provided by Community Resource Consultants (CRCs) and the Office of Community Quality Improvement (OCQI) in October 2021. Four Corrective Action Plans (CAPs) related to underperformance with RST referral timeliness were successfully closed during the report period leaving two currently in progress. The CMSC now has the option to require CSB participation in technical assistance as included in Exhibit M of the Performance Contract. This option became available in October 2021 once all Performance Contracts were signed by the CSBs.

Finally, the CMSC completed the work of transitioning the DD Support Coordination Manual into a searchable PDF handbook format. This transition included the development of a self-contained file, which holds all related forms and links within the document. A public comment period was completed during the reporting period and the handbook will be released in January 2022 once it can be posted to the DBHDS website.

Support Coordination Quality Review (SCQR)

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

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

- "ISP implemented appropriately" means that services identified in the ISP are delivered consistent with~~in~~ 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 the 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 is available in the table below, which shows a decrease in compliance with eight indicators, and an increase in two. Indicator five is comparable across both years.

Indicator	FY20 CSB-reported Compliance	FY21 records in compliance	FY21 records not in compliance	FY21 CSB-reported compliance	Difference
Indicator 1	91.4%	352	48	88.0%	-3.4%
Indicator 2	79.9%	310	90	77.5%	-2.4%
Indicator 3	92.5%	330	70	82.5%	-10.0%
Indicator 4	81.8%	340	60	85.0%	3.2%
Indicator 5	99.7%	398	2	99.5%	-0.2%
Indicator 6	87.4%	277	123	69.3%	-18.1%
Indicator 7	87.4%	399	1	92.0%	12.4%
Indicator 8	97.9%	372	28	93.0%	-4.9%
Indicator 9	94.7%	201	199	50.3%	-44.4%
Indicator 10	95.7%	299	101	74.8%	-20.9%

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)

SCQR Retrospective Review Results for FY21

The sampling methodology for the look behind calls for a minimum of two records per CSB to be sampled, with twenty additional reviews distributed by waiver population for 100 total retrospective reviews. The number sampled from each CSB ranges from two to four. The five OCQI specialists each completed ten interrater reviews, for a total of fifty interrater reviews. In FY2020, the OCQI specialists completed desk reviews due to the COVID-19 pandemic. However, in FY21 with additional health and safety protocols in place related to COVID-19, the OCQI specialists completed the Look Behind reviews on site in accordance with the original methodology.

For the Look Behind, agreement between OCQI specialists and CSBs improved on six indicators and declined on four indicators, with declines being less than 0.05 and therefore negligible on two of those indicators. (See Table 3 below.) Low agreement does not necessarily mean that QI specialists gave lower scores than the CSBs. In some cases, disagreement was caused by the QI specialists finding *more* compliance than was reported by the CSBs.

Table 3: Look Behind Agreement: FY2020 and FY2021

Indicator	FY2020 % agree	FY2020 Maxwell's RE	FY2021 % agree	FY2021 Maxwell's RE	Difference in RE value
1: Signed choice form	80%	0.60	92%	0.84	**0.24**
2: Individual offered a choice	64%	0.27	82%	0.64	**0.37**
3: Specific and measurable outcomes	46%	-0.07	46%	-0.08	-0.01
4: Persons who participated in ISP	75%	0.49	79%	0.58	**0.09**
5: Disagreement and resolution	91%	0.82	95%	0.90	**0.08**
6: ISP signature page	79%	0.58	75%	0.50	-0.08
7: Risk assessment and mediation	63%	0.25	75%	0.50	**0.25**
8: Linkages, referrals, authorizations	90%	0.80	88%	0.76	-0.04
9: Assessed plan implementation	24%	-0.52	63%	0.26	**0.78**
10: Change in needs or status	82%	0.64	76%	0.52	-0.12

On-site Visit Tool

In November 2020, based on a review of a sample of 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 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 the phrases "change in status" and "appropriately implemented services" and establish a process to support consistency. The On-site Visit Tool (OSVT) was introduced with training in a pilot phase in July 2020. Following the pilot, an OSVT work group met, with CSB representation, and together the group revised the tool based on findings in the pilot phase. The final version was given to the field for use beginning December 1, 2020.

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

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 Office of Provider Development completed the first qualitative review in June 2021. Each Region in Virginia participated and submitted required documentation. Issues identified in the OSVT matched the corresponding note in 75% of reviews. The majority (74%) of corresponding progress notes included additional actions or follow-up as appropriate, critical to the care of the people being served. A review of the 3rd and 4th quarters of FY21 is currently being completed. Beginning with FY22, the OSVTs for individuals in the SCQR sample will be reviewed and DBHDS will announce that uploading of the form for all individuals can cease.

Identified Concerns

The Independent Reviewer's 19th Report to the Court was submitted on December 13, 2021 and included a single recommendation that relates to the work of the Case Management Steering Committee stated as:

> The Commonwealth should establish criteria for what constitutes a meaningful discussion between case managers and the individuals served regarding their interest in employment. Criteria should include discussion of the person's interests and any employment history; their skills related to employment; the employment services available through DARS and HCBS Waivers; and the barriers to successful employment that they or their family feel exist.

The CMSC has assisted with revising the WaMS Individual Support Plan, which will launch on May 3, 2022. Changes in the ISP included restructuring of elements related to the employment discussion to ensure more complete documentation of each topic. Training on the ISP update will be provided in April 2022, which provides the opportunity to reemphasize the expectations for meaningful conversations.

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.

As reported previously, DBHDS completed a review of the first two quarters of FY21 that included a comparison of 301 completed tools and corresponding contact notes. A review of the second two quarters of FY21 is underway with findings to be shared in the July 2022 CMSC report. Beginning with FY22 data, the sample will align with individuals identified for the SCQR process. This change supports a recommendation made by the Region 1 Regional Quality Council to streamline the provision of documents to the Department.

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 FY22 have been as low as 74% for monthly visits and 73% 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. The group will continue meeting in FY22 to work toward making recommendations to the 2017 guidance document previously issued by DBDHS.

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.

Following an analysis of referrals, the CMSC collected recommendations from RST members on strategies to address referrals that are late for Reason B. Based on these recommendations, a cross-regional RST group will be formed in Quarter 3, FY22 and meet once mid-month. This cross-regional group will design and implement a process to review referrals that occur 1) when there is a lack of sufficient time to complete typical RST processes and 2) when informed choice is clearly evident in the documentation provided. Adding a cross-regional team will decrease the amount of time many referrals must wait in queue, which is expected to have a positive impact on the related measure. The measure is stated as “Statewide non-emergency referrals, as such referrals are defined in the DBHDS RST Protocol, meet the timeliness requirements of the DBHDS RST Protocol (III.D.6).”

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 SFY22. 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 (Target 90%). **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 90%). **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 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. **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

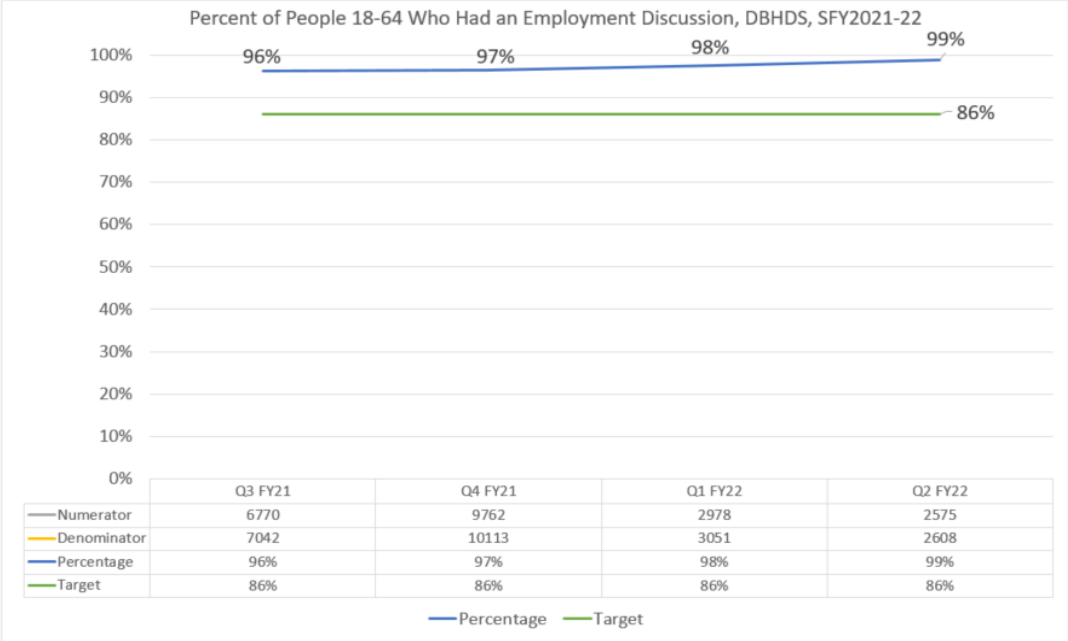
Reference	Measure	Numerator	Denominator
1 *Figure 1*	86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process (Target 86%). **III.C.7.a.**	N = Number of Individuals who had an Employment Discussion at Annual F2F 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**	N = Number of individuals with the ISP element "Was there a conversation with the individual/substitute decision-maker about employment?" indicated yes, and where the two following discussion elements are confirmed: "what the person is working on at home and school that will lead to employment" and "alternate sources for funding (such as school or DARs)"	D = Number of individuals in active status in WaMS ages 14 to 17 who have a DD waiver

The measure related to the individual participating in a discussion about employment has been consistently above target for the last four quarters, while those with employment goals has consistently been below target. It should be noted that despite a change in the data source from the 4th quarter FY21 (CCS) to the 1st quarter FY22 (WaMS), the data results remained consistent for these two measures.

Baseline for the third measure related to transition age youth was established in the 1st quarter FY22. Additional monitoring will be required to see any trend in performance. Related elements in the Individual Support Plan are being refined to improve the collection of data around employment topics. Training on

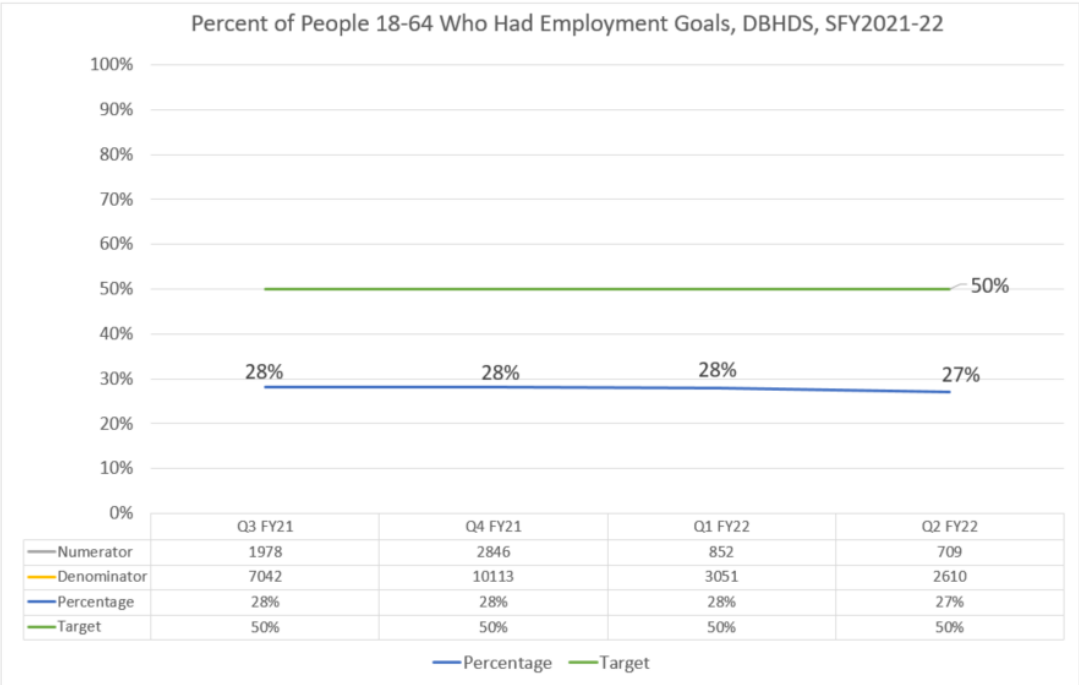
these updates provides the forum to emphasize expectations and the components of a meaningful discussion and goal development. The CMSC is aware of additional efforts by the Regional Quality Council in Region V, which is currently seeking to provide training and measure improvements in SC knowledge, as well as to measure an increase in employment outcomes for people supported.

Fig. 1 Employment Discussion



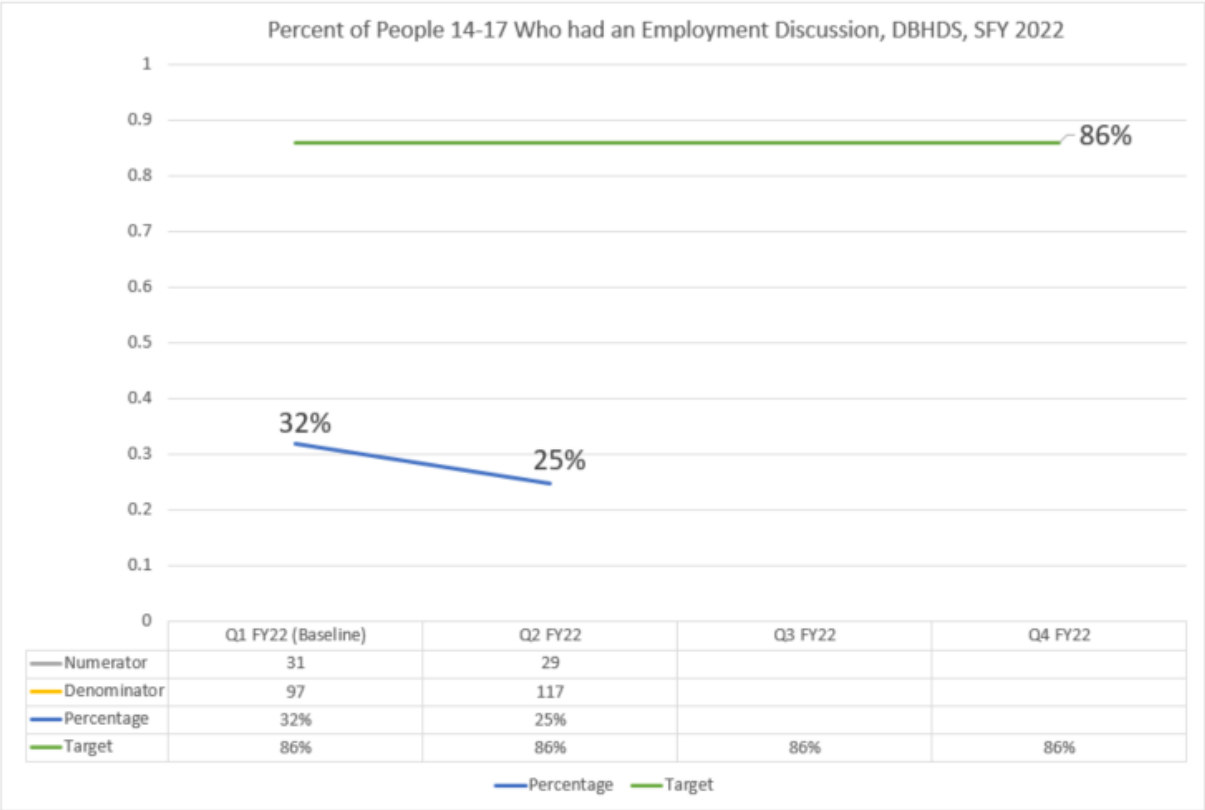
	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22
Numerator	6770	9762	2978	2575
Denominator	7042	10113	3051	2608
Percentage	96%	97%	98%	99%
Target	86%	86%	86%	86%

Fig. 2 Employment Outcomes



	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22
Numerator	1978	2846	852	709
Denominator	7042	10113	3051	2610
Percentage	28%	28%	28%	27%
Target	50%	50%	50%	50%

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



	Q1 FY22 (Baseline)	Q2 FY22	Q3 FY22	Q4 FY22
Numerator	31	29		
Denominator	97	117		
Percentage	32%	25%		
Target	86%	86%	86%	86%

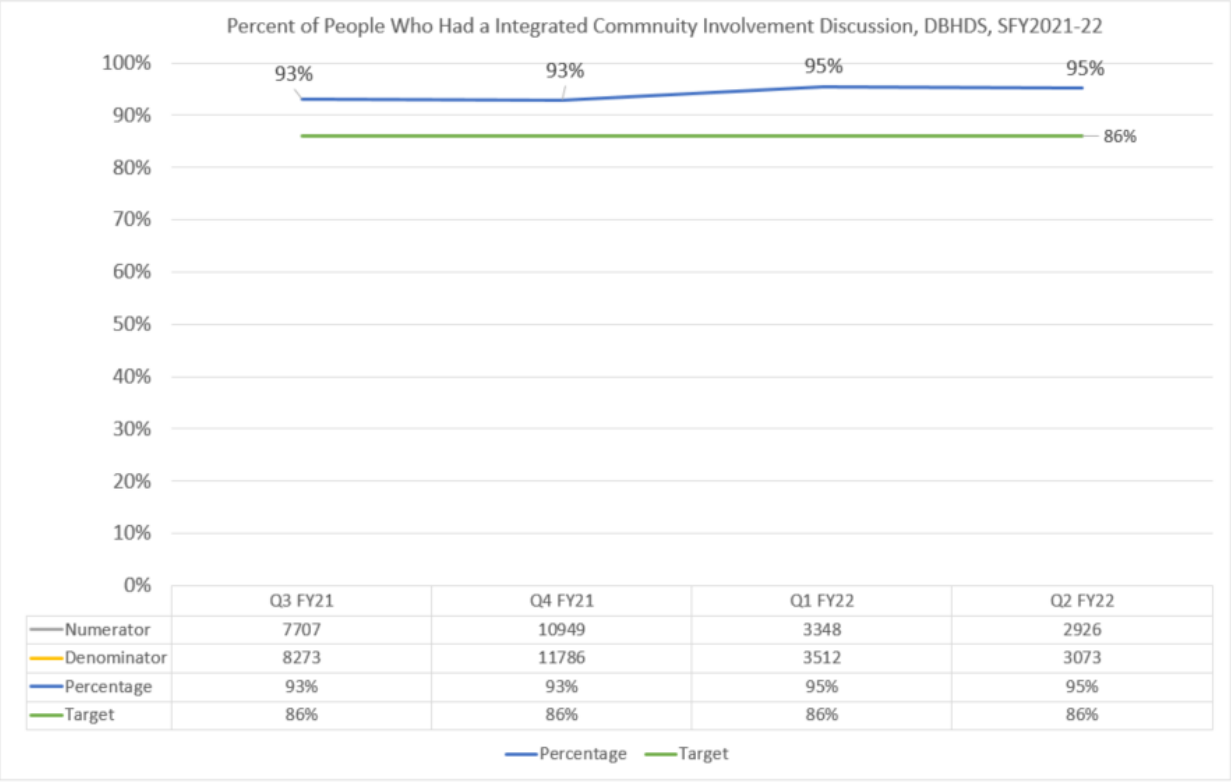
Community Engagement Discussions and Goals

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 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**	N = Number of ISPs with one or more outcomes under the Integrated Community Involvement and/or the Community Living life areas in the ISP: Shared Plan	D = Number of individuals in active status on one of the DD Waivers

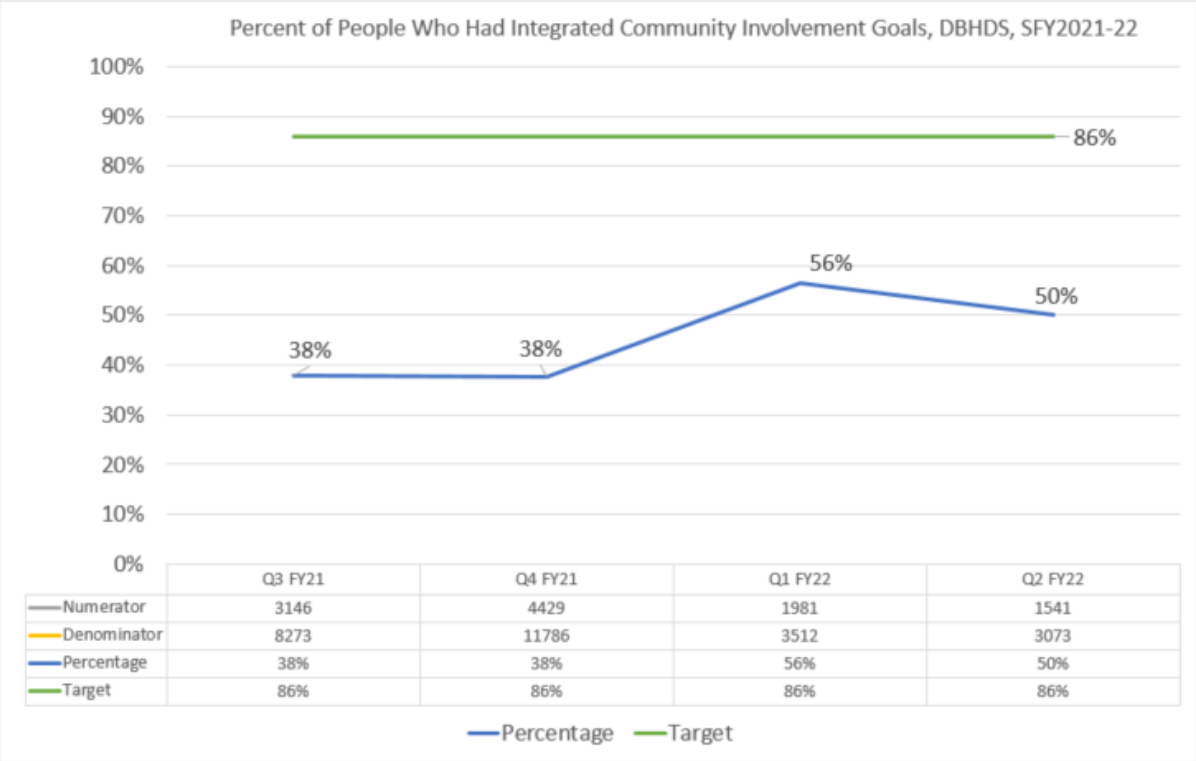
The measure related to individuals participating in a discussion about integrated community involvement has been consistently above target for the last four quarters, while those with and integrated community involvement outcomes has consistently been below target. It should be noted that despite a change in the data source from the 4th quarter FY21 (CCS) to the 1st quarter FY22 (WaMS), the data results remained consistent for the discussion measure while an increase was seen with the outcome measure. This increase coincides with training related to an emphasis on "community engagement" in the broader sense rather than related to a specific waiver service. The focus is on community involvement at a ratio of no more than one staff to three individuals regardless of the service utilized. The CMSC acknowledges the reality of current staffing concerns across the system and the receding pandemic as ongoing concerns around this measure. Baseline for the third measure related to community involvement was established in the 1st quarter FY22. Initial results are above target. Additional monitoring will be required to see any trend in performance.

Fig. 4 Integrated Community Involvement (Community Engagement) Discussions



	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22
Numerator	7707	10949	3348	2926
Denominator	8273	11786	3512	3073
Percentage	93%	93%	95%	95%
Target	86%	86%	86%	86%

Fig. 5 Integrated Community Involvement (Community Engagement) Outcomes



	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22
Numerator	3146	4429	1981	1541
Denominator	8273	11786	3512	3073
Percentage	38%	38%	56%	50%
Target	86%	86%	86%	86%

Fig. 6 Community Involvement Outcomes

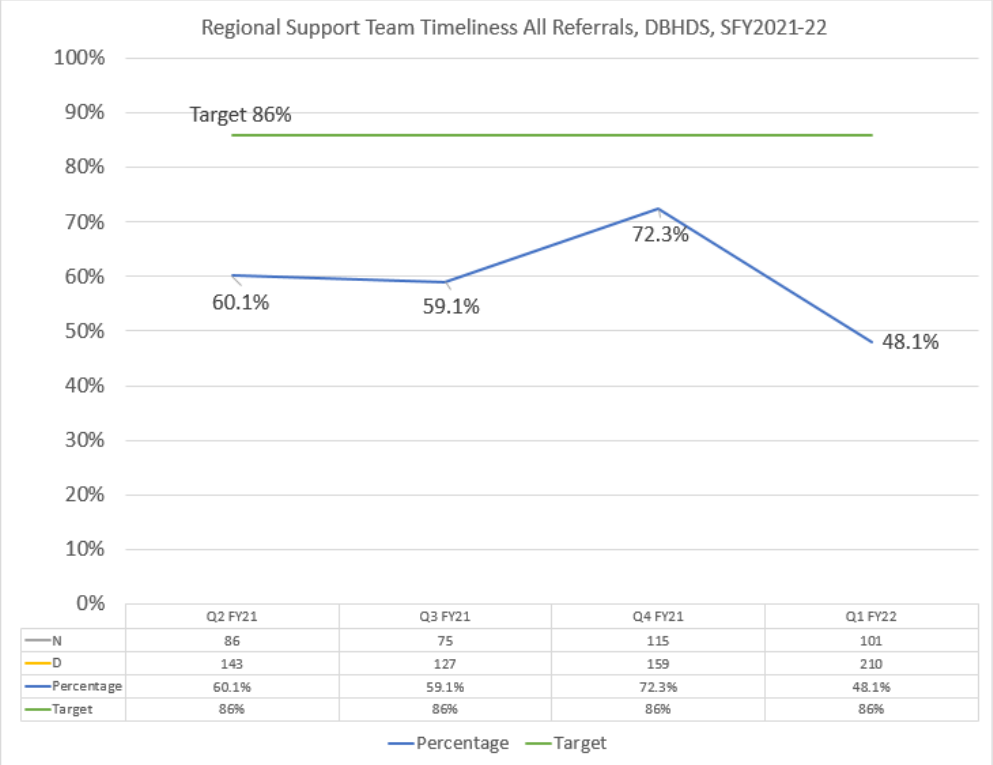
	Q1 FY22 (Baseline)	Q2 FY22	Q3 FY22	Q4 FY22
N	3335	2858		
D	3512	3073		
Percentage	95%	93%		
Target	86%	86%	86%	86%

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.

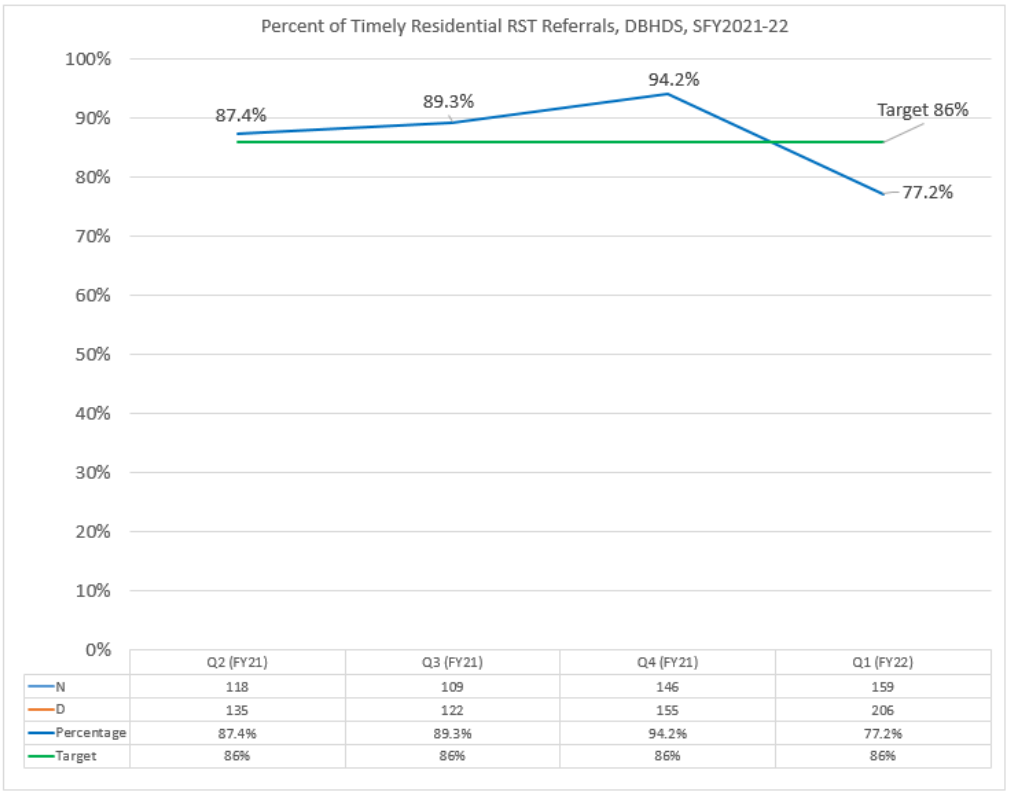
Regional Support Team data related to all reasons for lateness show consistent below target performance for FY21 with an overall result of 64% for FY21 with a decrease to 48% in the first quarter of FY22 (figure 7). The CMSC is currently implementing a QII as reported above in the effort to positively 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, but a decline in the first quarter of FY22 to 77.2%. 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 when this barrier is identified. No referrals have occurred with Barrier 2 identified since the first quarter of FY21.

Fig. 7 RST Community Referral Timeliness through 1st quarter FY22



	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22
N	86	75	115	101
D	143	127	159	210
Percentage	60.1%	59.1%	72.3%	48.1%
Target	86%	86%	86%	86%

Fig. 8 RST Residential Community Referral Timeliness through 1st quarter FY22



	Q2 (FY21)	Q3 (FY21)	Q4 (FY21)	Q1 (FY22)
N	118	109	146	159
D	135	122	155	206
Percentage	87.4%	89.3%	94.2%	77.2%
Target	86%	86%	86%	86%

Provider Capacity

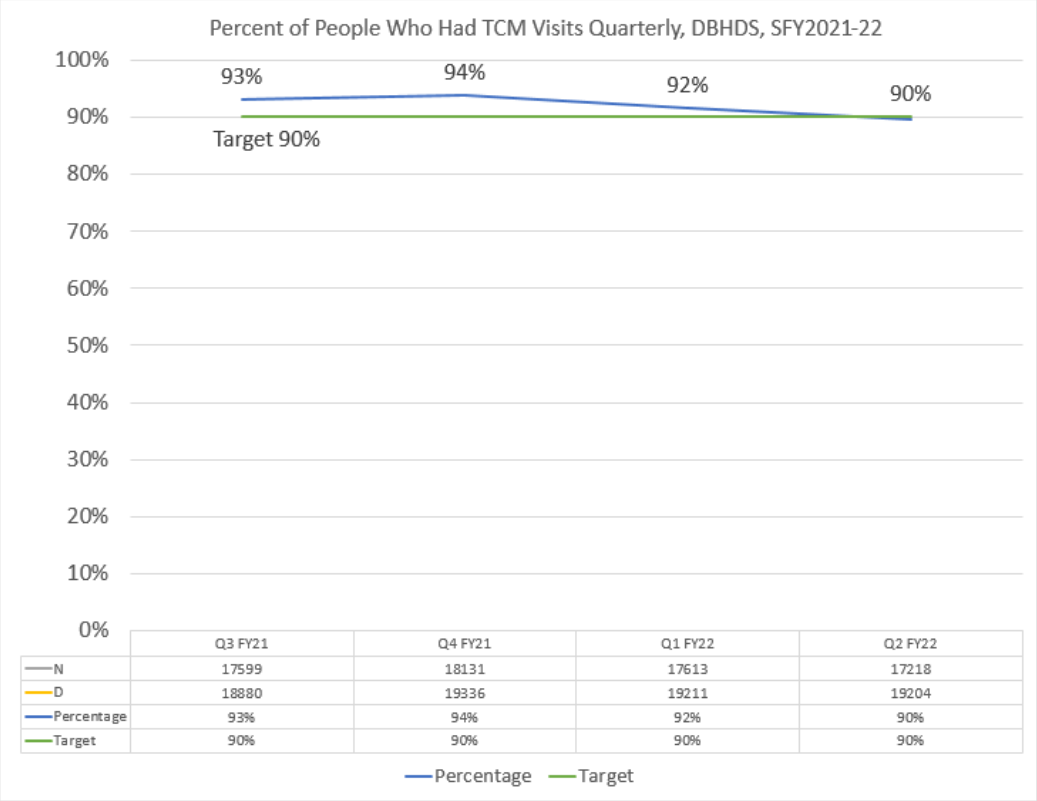
Case Management Face to Face Visits (F2F) and Effectiveness

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. Overall results for FY21 ECM face-to-face (figure 11) and ECM in the home (figure 12) ended below target for the year and have experienced further decline between the first and second quarters of FY22.

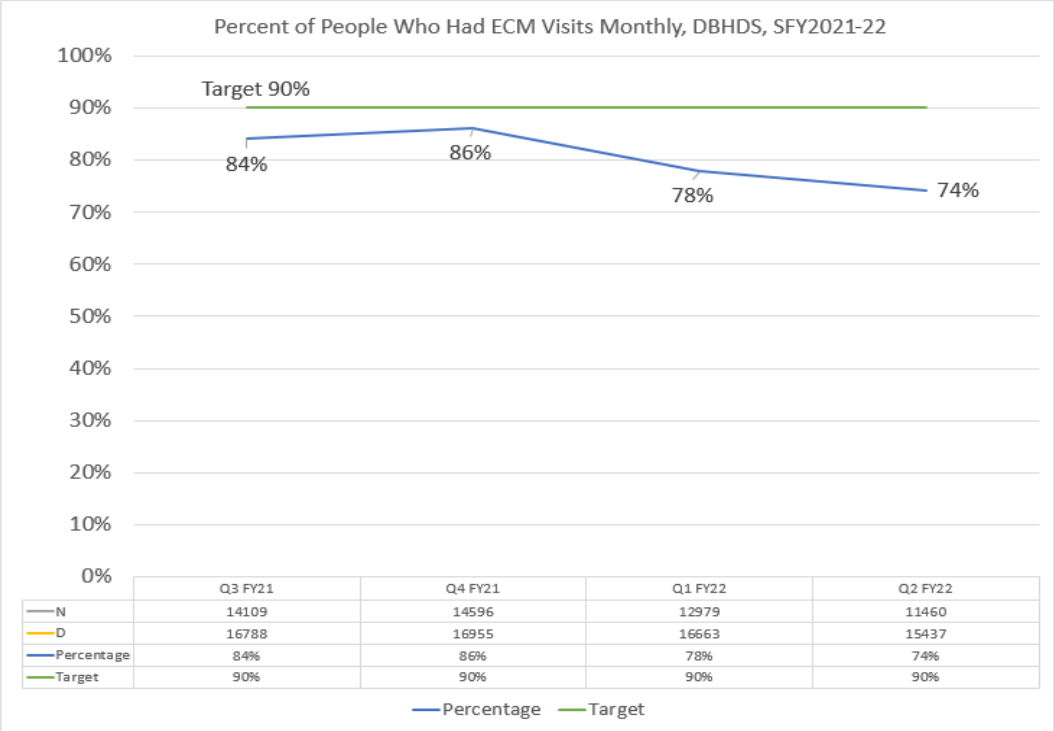
Beginning in the third quarter FY22, the Office of Provider Development will begin a Data Quality Support Process with CSBs to examine a sample of case management contact data to enable comparisons between CCS, WaMS, and CSB electronic health records. The primary focus of these sessions is to support CSBs with identifying and resolving any data reliability and validity issues. It should be noted that the CMSC raised the target for CM contact measures from 86% to 90% to align with targets included in the FY22 CSB Performance Contract.

Fig. 10 TCM visits



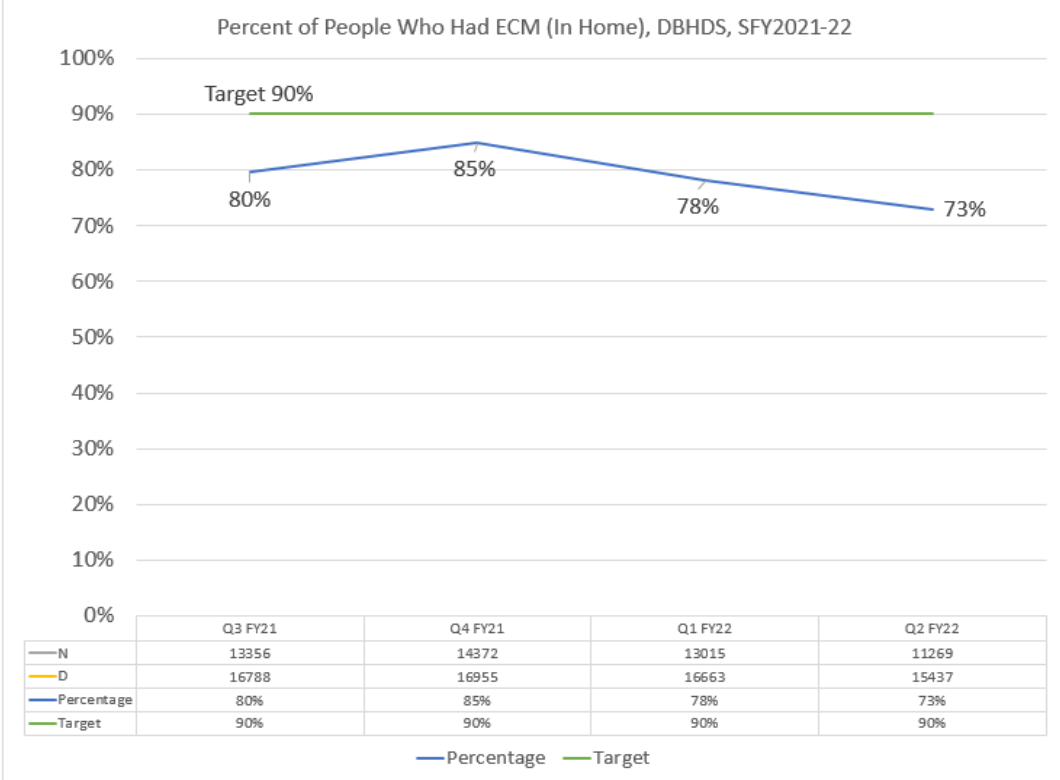
	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22
N	17599	18131	17613	17218
D	18880	19336	19211	19204
Percentage	93%	94%	92%	90%
Target	90%	90%	90%	90%

Fig. 11 ECM face to face visits



	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22
N	14109	14596	12979	11460
D	16788	16955	16663	15437
Percentage	84%	86%	78%	74%
Target	90%	90%	90%	90%

Fig. 12 Face to face ECM visits in-home



	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22
N	13356	14372	13015	11269
D	16788	16955	16663	15437
Percentage	80%	85%	78%	73%
Target	90%	90%	90%	90%

Fig. 12a Face to face ECM visits regional comparison

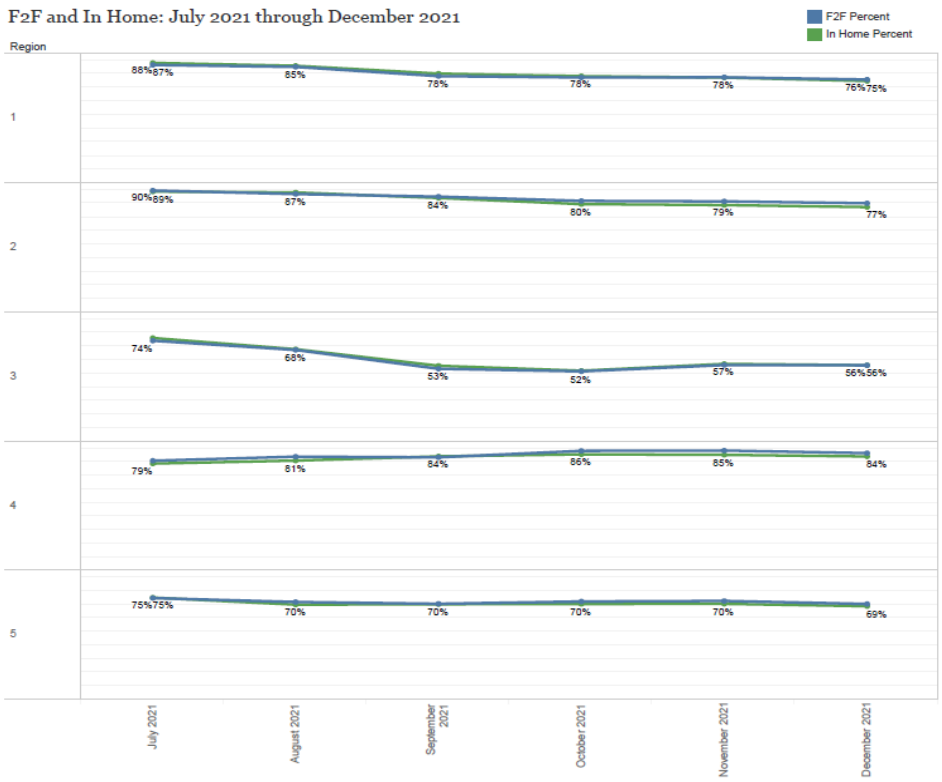
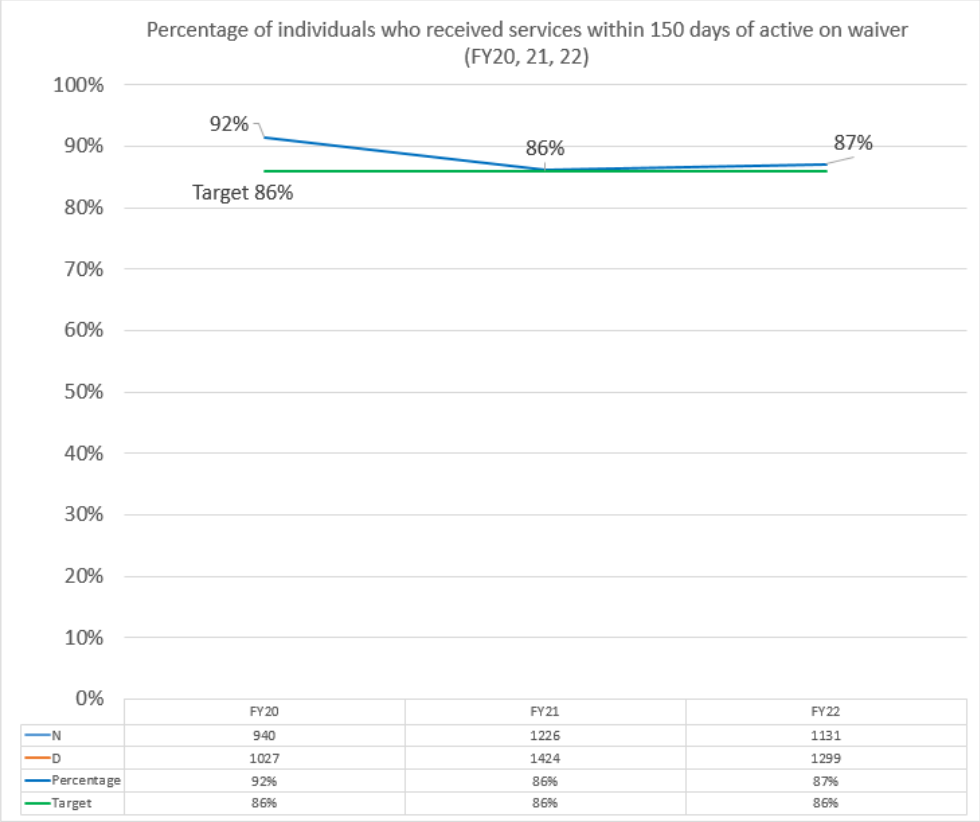


Fig. 13 Records in compliance with 9 of 10 assessed indicators FY21

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

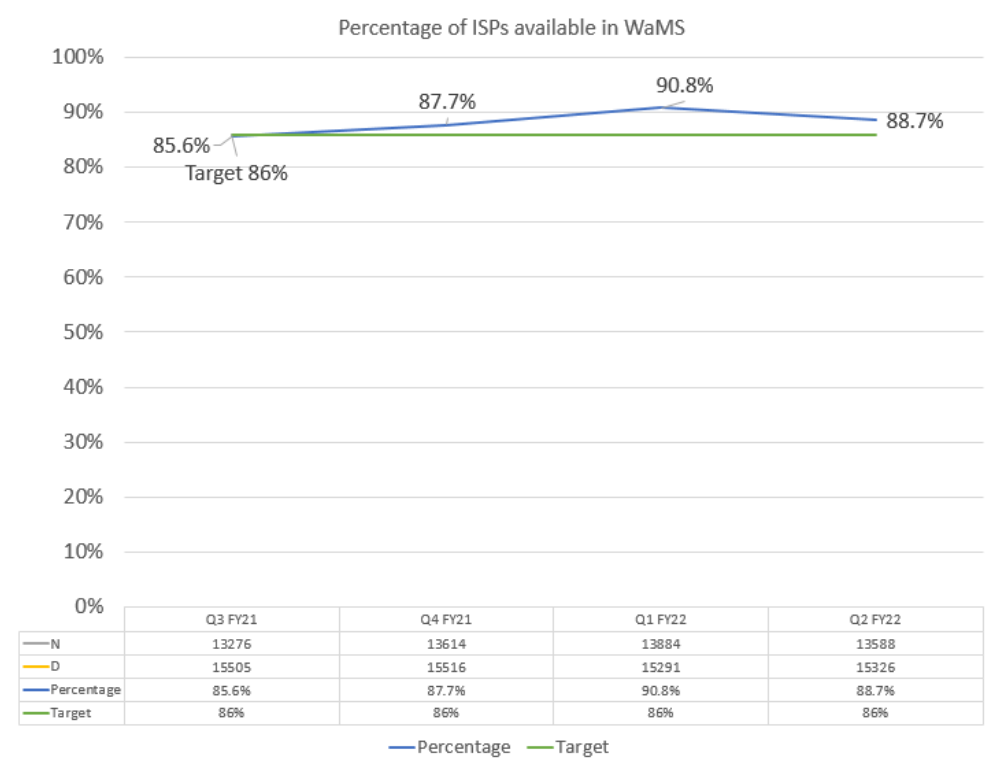
Results in second year of the SCQR process reflect a substantial level of agreement with four of the ten assessed CM indicators: choice of CM/SC, disagreement and resolution, making linkages, referrals, and authorizations, and assessing for change in status. The weakest agreement was seen with offering 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 established as at or above target for the past three years (figure 14). The ISP compliance target was achieved with above target performance for the past three consecutive quarters (figure 15).

Fig. 14 Services within 150 days of Waiver FY19, FY20, FY21 results



	FY20	FY21	FY22
N	940	1226	1131
D	1027	1424	1299
Percentage	92%	86%	87%
Target	86%	86%	86%

Fig. 15 ISP compliance for Report Period: January 1, 2021 thru December 31, 2021



	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22
N	13276	13614	13884	13588
D	15505	15516	15291	15326
Percentage	85.6%	87.7%	90.8%	88.7%
Target	86%	86%	86%	86%

Health, Safety, and Wellbeing

Change in Status and Appropriately Implemented Services

Reference	Measure	Numerator	Denominator
16 *(**PMI**)* *Figure 16* *Figure 16.2*	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* *Figure 16.1*	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

In the results presented below, some indicators are composed of multiple items, meaning that an indicator could have been scored as "met" for different reasons. For example, one reviewer could have indicated that no disagreement occurred during the ISP meeting, while another could indicate that a disagreement did occur but was resolved. Therefore, agreement by question item is included in the review of each indicator below.

The Maxwell RE coefficient ranges from -1 (perfect disagreement) to 0 (no agreement beyond what is expected by chance) to 1 (perfect agreement). Scores in between those values can be interpreted on a spectrum; cutoff scores are arbitrary, as there is no consequential difference between a value of 0.599 and 0.600, for example. However, for easier interpretation, scores were coded with the following color scheme:

No agreement	< 0
Weak agreement	0.00 to 0.39
Moderate agreement	0.40 to 0.59
Substantial agreement	0.60 to 1

The chart below provides results as reported as reported by CSBs in the second year of the SCQR along with the levels of agreement seen following the OCQI look-behind process completed in Q2 FY22.

Indicator 9

For Indicator 9, agreement between QI specialists and CSBs was extremely low in FY2020. The wording and guidance were revised with the goal of improving agreement. Required components were split into separate checkboxes to ensure that respondents considered every single component in their answer.

However, the new question performed poorly due to a misunderstanding that DBHDS did not anticipate: A number of CSBs did not check nursing or behavioral services if the individual did not require those services. Leaving one or both of those boxes blank meant that the record was scored as not meeting the indicator.

As a result of this confusion, agreement between QI specialists and CSBs was low, but in the opposite direction of what happened in the previous year. QI specialists scored 73% of the Look Behind records as meeting the indicator, verses only 54% of records scored as met by the CSBs.

The results for this indicator are expected to improve in the FY2022 SCQR due to the introduction of the On-site Visit Tool, which was fully implemented in December 2020 (the last month of the review period for the FY2021). Additionally, we expect to see improvement once the question and guidance are clarified to ensure that CSBs know how to score situations in which behavioral or nursing services are not needed.

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

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%

Fig. 16.1 FY21 agreement results for appropriately implemented services

Question(s)	% yes in full sample	Look Behind % agreement	Look Behind Maxwell's RE	Interrater % agreement	Interrater Maxwell's RE
assesses individual's express satisfaction with services and the progress being made	99%	97%	0.94	94%	0.88
understanding of their role in providing support	91%	87%	0.74	88%	0.76
assesses whether behavioral services are available and occurring as needed and as authorized	66%	69%	0.38	96%	0.92
assesses whether nursing services are available and occurring as needed and as authorized	55%	63%	0.26	86%	0.72
assesses whether other services are available and occurring as needed and as authorized	96%	93%	0.86	98%	0.96
assesses whether skill-building services are occurring as needed and as authorized	84%	90%	0.80	88%	0.76
assesses whether community involvement occurs as described in the PC ISP	97%	95%	0.90	96%	0.92
Indicator met	50%	63%	0.26	76%	0.52

Indicator 10

In FY2020, this indicator was composed of only two items, and compliance reported by the CSBs was high. In an effort to improve reliability, the indicator was split into six different items. This resulted in a lower overall score, since all six needed to be checked for the indicator to be considered met.

The Look Behind results suggest that there may be error in the opposite direction from what was observed in FY2020. While the QI specialist scores on this indicator were 14 percentage points lower than the CSB scores in FY2020, this year the QI specialist scores were 8 percentage points higher.

Fig. 16.2 FY21 agreement results for change in status indicator

Question(s)	% yes in full sample	Look Behind % agreement	Look Behind Maxwell's RE	Interrater % agreement	Interrater Maxwell's RE
assesses for any new or increased concerns with the environment being clean, safe and appropriate to the individual's needs	96%	88%	0.76	82%	0.64
assesses if environmental modifications or assistive technologies are lacking but needed to increase independence or prevent institutionalization	83%	83%	0.66	94%	0.88
assesses for any new or increased concerns with the individual's health and safety	100%	98%	0.96	96%	0.92
assesses that any significant life changes that impact services	96%	96%	0.92	100%	1.00
assesses for any concerns related to potential abuse, neglect or exploitation	87%	88%	0.76	94%	0.88
ISP modified to reflect the change in status or needs or not applicable	98%	84%	0.76	80%	0.70
Indicator met	75%	76%	0.52	80%	0.60

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 charts below provide results as reported by CSBs in the second year of the SCQR. A moderate level of agreement is noted for unpaid relationship discussions and a substantial level for choice of case manager and providers.

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%

Q	Question text	% in full sample	Look Behind % agree	Look Behind Maxwell's RE	Interrater % agree	Interrater Maxwell's RE
Q57	Is it evident in the PC ISP that the SC/CM discussed relationships and interactions with people other than paid program staff?	78%	76%	0.52	90%	0.80
Q58	Is there evidence elsewhere in the record that the SC/CM discussed relationships and interactions with people other than paid program staff?	6%	76%	0.64	90%	0.85
	Relationship discussion total (Q57+Q58)	83%				

Fig. 19 FY21 results for choice indicator

Q26: Does the completed VIC confirm that the individual was offered a choice of…

Question(s)	% yes in full sample	Look Behind % agreement	Look Behind Maxwell's RE	Interrater % agreement	Interrater Maxwell's RE
…support coordinator? (named)	89%	81%	0.72	92%	0.88
…DD waiver providers?	98%	89%	0.84	98%	0.96
Indicator met	78%	82%	0.64	92%	0.84

	CSB met	CSB not met
QI met	70	8
QI not met	**10**	12

Office of Licensing Data

In October 2021, the Office of Licensing Director shared the results of the Adequacy of Supports Reports from July 1 to December 31, 2020 and January 1 to June 30, 2021. The CMSC identified the need to explore how the Office of Licensing (OL) Corrective Action Plans (CAPs) can be utilized by the committee to ensure remediation is occurring with underperforming CSBs. In the development of the response to the Settlement Agreement indicator 2.20, stated as "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," DBHDS ensured that all ten elements were included in the DD Waiver Regulations and has confirmed a number of elements are addressed through the Annual Visit Checklist completed by the DBHDS Office of Licensing. The Office of Licensing also issued "Guidance on Corrective Action Plans" on the Virginia Town Hall, which became effective on August 22, 2020. This document includes the process used by the Office of Licensing to monitor the implementation of CAPs completed by CSBs.

In order to ensure remediation for findings that relate to the ten elements, in addition to monitoring completed by Licensing, the CMSC will explore how CSB corrective action plans found on the DBHDS website can be included in committee work to identify systemic issues, inform recommendations to the DBHDS Commissioner, and to provide targeted technical assistance. In order to meet the indicator and minimize duplication, this assistance will be aligned or integrated with technical assistance already provided for the SCQR process, DMAS remediation, and/or prescribed by the committee under the Performance Contract.

DMAS Quality Management Reviews

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

- B.1 Number and percent of all new enrollees who have a level of care evaluation prior to receiving waiver services
- B2. The number and percent of VIDES (LOC) completed within 60 days of application for those for whom there is a reasonable indication that services may be needed in the future.
- B3. Number and percent of VIDES determinations that followed the required process, defined as completed by a qualified CM, conducted face-to-face with individual and those who know him (if needed).
- C3. Number & percent of enrolled licensed/certified provider agencies, continuing to meet applicable licensure/certification following initial enrollment.
- D1. Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes.
- D2. Number and percent of individual records that indicate that a risk assessment was completed as required.
- D3. Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.
- D5. Number and percent of service plans reviewed and revised by the case manager by the individual's annual review date.

- D6. Number and percent of individuals whose service plan was revised, as needed, to address changing needs.
- D7. Number and percent of individuals who received services in the frequency specified in the service plan
- D9. Number and percent of individuals who received services of the type specified in the service plan
- D12. Number and percent of individuals whose case management records documented that choice of waiver providers was provided to and discussed with the individual.
- D13. Number and percent of individuals whose case management records contain an appropriately completed and signed form that specifies choice was offered among waiver services.
- G5. Number and percent of critical incidents reported to the Office of Licensing within the required timeframes as specified in the approved waiver.
- G9. Number and percent of participants 20 years and older who had an ambulatory or preventive care visit during the year.

Quality Service Reviews

In November, the CMSC reviewed the Quality Services Review Round 2 results with a focus on ECM and TCM data. The committee noted that ECM and TCM results are similar to CMSC results. CMSC data for ECM and ECM in-home are separate measures while QSR is a combined measure. The group noted that the QSR data is based on a sample and concluded that since the results are roughly in the same range, QSR doesn't contradict CMSC results.

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 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. During this report period, four CSBs successfully completed Corrective Action Plans, which were closed by the committee. One additional CAP request was identified in December leaving two open CAPs at the conclusion of the report period. Next steps in the development process for the framework are to establish

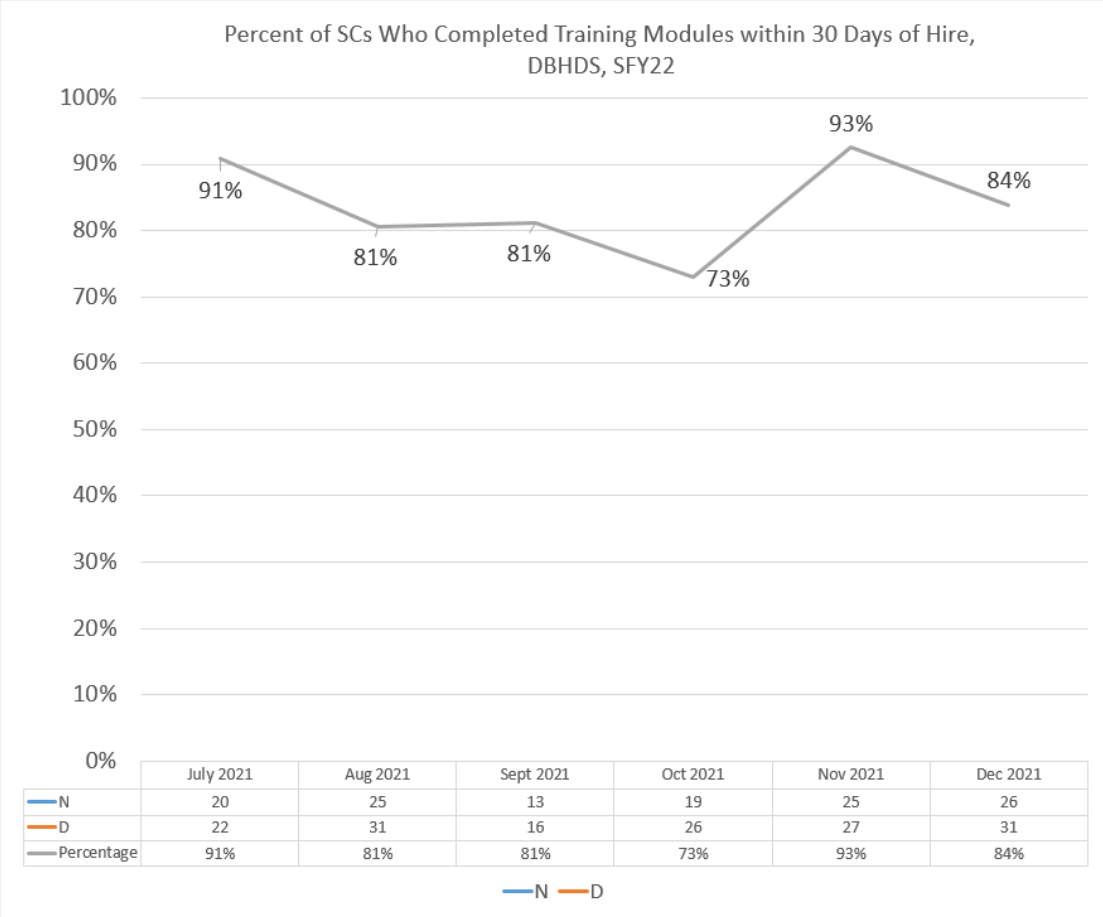
thresholds for each area and the date that implementation can be achieved for each area. For example, ISP compliance thresholds can be implemented following the production of refined ISP reports, which will be shared for the first two quarters of FY22 in Quarter 3, or CM contact thresholds can be implemented once the Data Quality Support Process is established. The RST threshold is established by the Settlement Agreement and has been in use since October of 2020. Implementation of the SCQR element will take additional development due to the number of elements assessed, as well as the variation in the type and nature of technical assistance provided.

Data Monitoring

Case Management Training and Competency

Support Coordinators/Case Managers are required to complete the DBHDS Case Management training online modules within 30 days of hire. A review of module usage between July and December 2021 shows that the completion rate exceeded 86% in two of the six months reviewed. 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 July to December SFY2022



	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021
N	20	25	13	19	25	26
D	22	31	16	26	27	31
Percentage	91%	81%	81%	73%	93%	84%

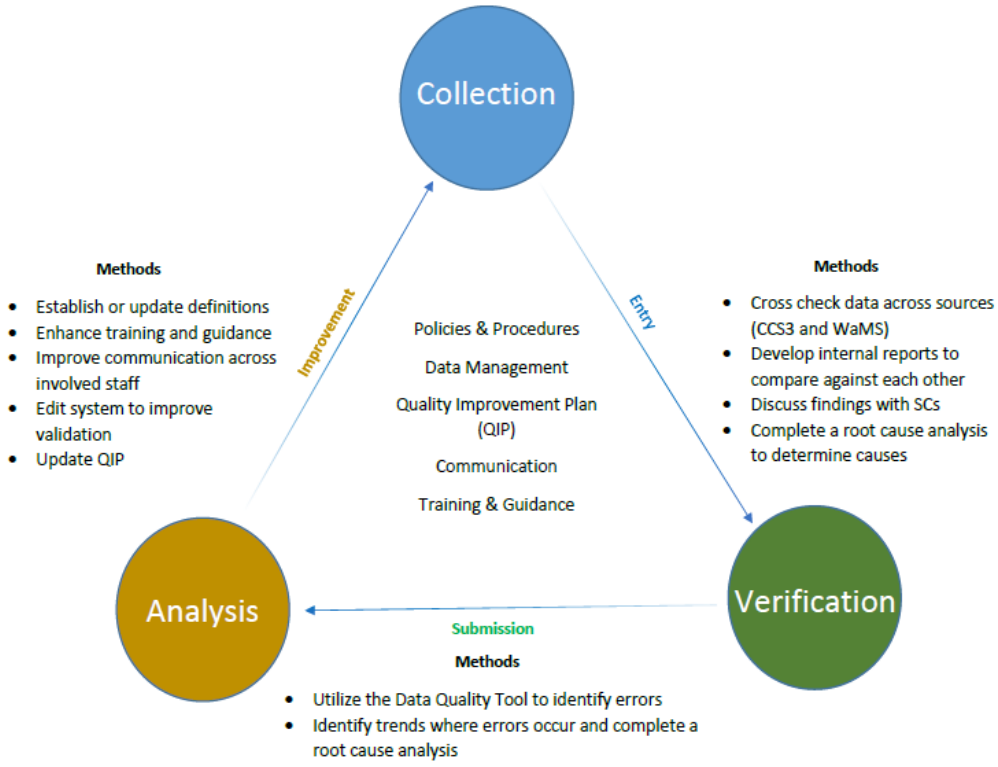
Data Availability and Integrity

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 has been developed to support CSBs to examine the integrity of the data provided in relation to face-to-face contacts submitted through CCS3. A Data Quality Framework (figure 21), root cause analysis template, and process have been developed through collaboration with the DBHDS/VACSB Data Management Committee. This process, which includes reviewing a sample of CSB case management contact data, will begin in FY22. 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.

Fig. 21 Data Quality Framework



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:

- 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.

Current Recommendations Include:

- Integrate Office of Licensing corrective action plan information into technical assistance efforts related to the ten case management indicators included in the joint filing.
- Collaborate with the Quality Review Team to share information where cross purposes exist.
- Complete Data Quality Support meetings with all CSBs, summarize findings, and share learning across the system.
- Identify and implement a Quality Improvement Initiative for FY23.
- Complete the transition of the Regional Support Team process into the Waiver Management System.

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.