Virginia Department of Behavioral Health & Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2022
3rd and 4th Quarters

Case Management Steering Committee

Semi-Annual Report FY22 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 Specialist (QIS), one Community Resource Consultant (CRC), and a representative from the Office of Epidemiology and Health Analytics (EHA). Advisory members include a representative from the Office of Licensing and a Behavior Analyst. Standard operation procedures include: annual review and update of the committee charter, regular meetings, at least ten times annually, to ensure continuity of purpose, maintenance of reports and meeting minutes, and quality improvement initiatives consistent with Plan, Do, Study, Act model.

From January to June 2022, 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 2022. 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 17th, 2022. 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 completing the third year of SCQR submissions from CSBs. Enhancements were made to the WaMS ISP to better collect data related to discussions and outcome development for employment and integrated community involvement. Changes continue to be made to the Support Coordinator Quality Review (SCQR) that over time will point to specific locations in the ISP where evidence will be held for various case management (CM) elements needing to be confirmed. The CMSC SCQR workgroup has begun the development of revisions for the FY23 SCQR cycle, so that services to children will be included in the process. The 2022 changes in the ISP included 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 finalized, implemented, and completed the first year of the 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). Learning and recommendations from the first cycle is included in this report.

Region 1 CSBs brought concerns to the committee regarding difficulty hiring and maintaining a sufficient number of Support Coordinators. Specifically, the concerns centered on the administrative responsibilities and documentation requirements, which have impacted the manageability of the position. One immediate change was approving the completion of On-Site Visit Tools to once per month for individuals receiving Enhanced Case Management and once per quarter for individuals receiving Targeted Case Management. This change eases the requirements for individuals with TCM as the prior requirement was once per month in months where visits occur no less than quarterly to only being required once per quarter. Based on this feedback, and additional reports, the CMSC developed and received approval for a new Quality Improvement Initiative (QII) in June. This initiative will seek to make targeted changes in SC/CM responsibilities to increase the satisfaction and retention of SCs.

Another key accomplishment was the development of a cross-regional Regional Support Team. This was developed under one of the Committee's QIIs and is related to Curative Actions required for meeting Settlement Agreement requirements. Initiated in May, the Committee began monitoring data in the fourth quarter, which is the initial opportunity to determine any impact made by this addition. The RST process is transitioning to the Waiver Management System in the next few months following testing and guidance development. This transition is expected to ease and enhance the collection and reporting of RST data.

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). Two Corrective Action Plans (CAPs) related to underperformance with RST referral timeliness were requested during this report period. CAPs related to ISP compliance will be requested in the next report period, which will leave Case Management Contacts as the sole remaining area for implementation under the committee's performance monitoring framework. While not integrated into the framework, the Committee included data results regarding the development of outcomes for integrated community involvement in CSB performance letters provided in April. This addition is to support CSB awareness of their performance in this area, so that progress can be attempted by CSBs.

Finally, the CMSC is completing a CMSC Overview video, which will provide CSBs information about Committee processes and place within the DBHDS Quality Management System. This video will be shared through Microsoft Teams with all CSBs in the next report period.

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 FY22 submissions. While this technical assistance does not impact the record reviews underway, it is expected to improve the SCQR results occurring in FY23 when calendar year 2022 documentation is reviewed.

During the third year of the SCQR process, CSBs completed 100% of the sample. Due to adjustments made to the tool and technical guidance, DBHDS anticipates the reliability of the data to increase. 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 three indicators, and an increase in seven, which is improvement over the last report.

Indicator	FY21 Reported Compliance	FY22 Reported compliance	Change
1	88.0%	92.0%	↑
2	77.5%	78.0%	↑
3	82.5%	40.0%	↓
4	85.0%	82.0%	↓
5	99.5%	100.0%	↑
6	69.3%	87.0%	↑
7	92.0%	84.0%	↓
8	93.0%	98.0%	↑
9	50.3%	84.0%	↑
10	74.8%	84.0%	↑

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)

The sampling methodology for the look behind calls for a minimum of two records per CSB to be sampled, with twenty additional reviews distributed by waiver population for 100 total retrospective reviews. The number sampled from each CSB ranges from two to four. The five OCQI specialists each complete ten interrater reviews, for a total of fifty interrater reviews. In FY2020, the OCQI specialists completed desk reviews due to the COVID-19 pandemic. However, beginning 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.

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 quarter for people with Targeted Case Management (TCM) and once per month for people with Enhanced Case Management (ECM).

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

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

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

For FY22 and going forward, specific items regarding the use of the OSVT were incorporated into the SCQR survey for reviews by CSBs and subsequently by DBHDS in the look-behind process. This includes targeted questions regarding the completion of the survey, as well as confirmation that issues identified in the OSVT are documented properly in the record. CSB results for FY22 are based on a review of 400 OSVTs and related progress notes with results reported in the chart below. Available in the next report, interrater and look-behind results will determine the level of agreement across reviewers and assist with understanding the results seen here. Technical assistance will be provided in FY23 to assist CSBs with understanding these results in the effort to support improvement in the next SCQR cycle.

					Interrater Results OCQI and OCQI		Look-behind OCQI and CSB	
	SCQR Item	Numerator	Denominator	FY 22 Result from CSBs	% Agree	Maxwell RE	% Agree	Maxwell RE
Q75	Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	344	400	86%				
Q77	Did all four OSVTs have all areas under “Services Implemented Appropriately” completed?	369	400	92%				
Q79	Did each OSVT have all areas under “Change In Status” and “Change in Status Determination” completed?	376	400	94%				
Q81	If any of the four OSVTs identified a change in status within the “Change in Status Determination” section, were revisions made to the ISP?	392 (includes 63 N/A changes, but no resvision needed, and 317 N/A no changes needed)	400	98%				
Q83	If any of the four OSVTs identified a need for any reporting was this identified on the corresponding SC Progress note?	395 (includes 373 N/A no reporting neeed)	400	99%				
Q85	If any of the four OSVTs required additional action, are the actions/planned actions documented in the corresponding SC Progress note?	396 (includes 369 N/A no actions needed)	400	99%				

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 launched on May 17, 2022. Changes in the ISP included the restructuring of elements related to the employment discussion to ensure more complete documentation of each topic. Training on the ISP updates were provided in April 2022, which provided the opportunity to reemphasize the expectations for meaningful conversations. Elements related to the discussion around integrated community involvement, defined as community participation at no more than a 1:3 ratio, were updated concurrently with the employment elements of the ISP. These changes prompt for more detail regarding specific components of each discussion.

The 20th report was made available in June of 2022. There were two specific recommendations related to Case Management, which are being addressed by the Committee. These include:

- The Commonwealth should incorporate children into its sampling for future Service Coordinator Quality Reviews (SCQRs). This will allow DBHDS to better understand needed service improvements for what is likely to become the fastest growing segment of the HCBS DD Waiver population.
- DBHDS should incorporate the On-Site Visit Tool (OVST) review process into the SCQR process for Indicator elements 2.8, 2.10, and 2.14 to improve CSB supervisory reviews of case managers' use of the OSVT.

As reported in this report, both recommendations are being addressed as DBHDS has integrated the OSVT into the SCQR process and will incorporate children into the SCQR process beginning in the FY23 cycle.

Quality Improvement Initiatives

Currently there are three active 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.*
Status: Completed

This QII has been completed. Following the initial review of OSVTs in 2021, specific elements were added to the SCQR survey, which ensure a qualitative review of 400 OSVTs as part of the annual SCQR cycle. This review includes a DBHDS look-behind process, a comparison of results with CSBs, and technical assistance to improve performance with OSVT completion and related actions.

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

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. Lower performance was seen in quarter 3 for both measures (face to face visits and alternating visits in the home) but saw an increase to 76% and 75% in the 4th quarter respectively.

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. The final step prior to ending the QII is making recommendations to the 2017 guidance document previously issued by DBDHS. Edits will focus on simplifying the content to the extent possible while retaining the integrity of the process. A public comment period will occur in FY23 prior to finalizing the document.

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.

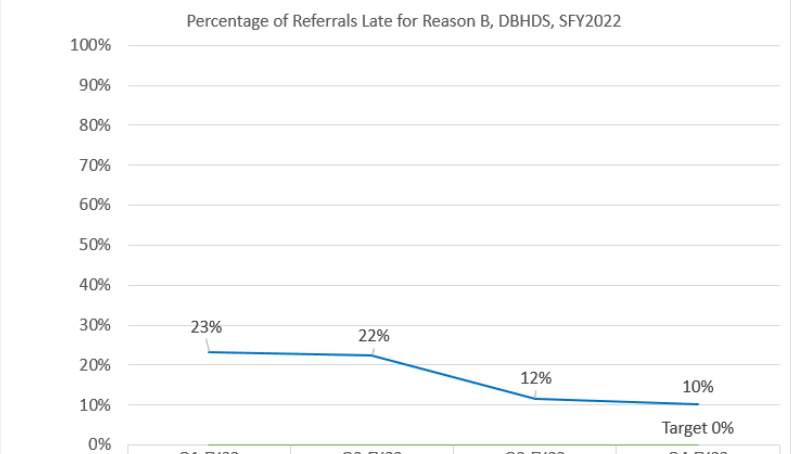
2. Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%). III.D.6.

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 was formed in Quarter 3, FY22 and has met once per month. This cross-regional group was designed and implemented as 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 the cross-regional team is expected decrease the amount of time many referrals must wait in queue, which will 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).”

Initial data from the formation of the cross-regional team shows that there is a significant reduction in Reason B referrals that coincides with the formation and implementation of this additional RST. The chart below illustrates the percentage of referrals noted as reason B during FY22, which corresponds with the related measure data included in the next section of this report. The CMSC will continue to monitor this data along with performance with the related measure.



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	49	33	14	18
D	210	147	121	175
Percentage	23%	22%	12%	10%
Target	0%	0%	0%	0%

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

This QII was approved in June of 2022 and focuses on making targeted changes that increase the manageability of the case management position resulting in an increase in Support Coordinator retention over time. This initiative relies on the input from support coordinators about what's working and not working with their responsibilities. It includes utilizing WaMS assignment data across all CSBs to determine the length of time Support Coordinators remain employed. Baseline data will be drawn for Q1 FY23 and collected quarterly to monitor progress. The Committee will convene a subgroup and host three webinar sessions with SCs to collect information to assist with prioritizing changes. A survey will be implemented depending on the results of the focus groups. Updates will continue to be reported to the Quality Improvement Committee and included in this report as work proceeds.

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

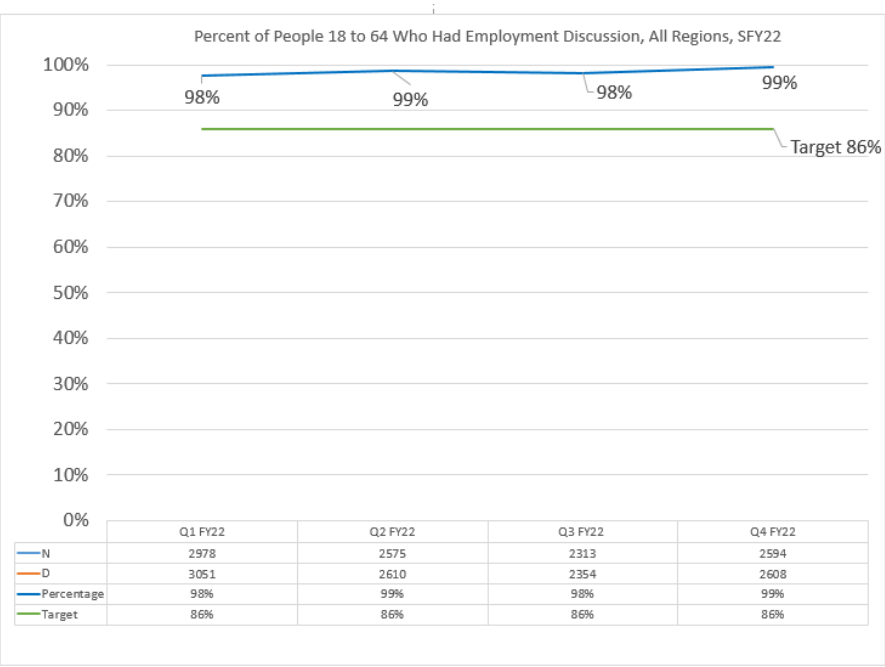
Reference	Measure	Numerator	Denominator
1 *Figure 1*	86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process (Target 86%). **III.C.7.a.**	N = Number of Individuals who had an Employment Discussion at Annual F2F 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.

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 were refined in May 2022 to improve the collection of data around employment topics.

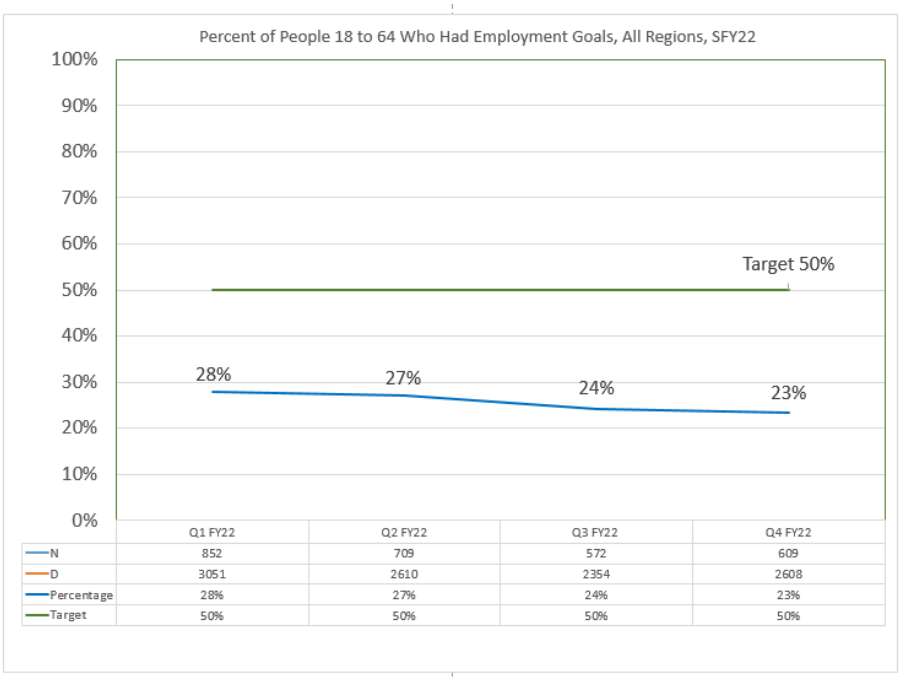
Training on these updates provided the forum to emphasize expectations and the components of a meaningful discussion and goal development. The CMSC is aware of past efforts by the Regional Quality Council in Region V, which sought to provide training and measure improvements in SC knowledge, as well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

Fig. 1 Employment Discussion



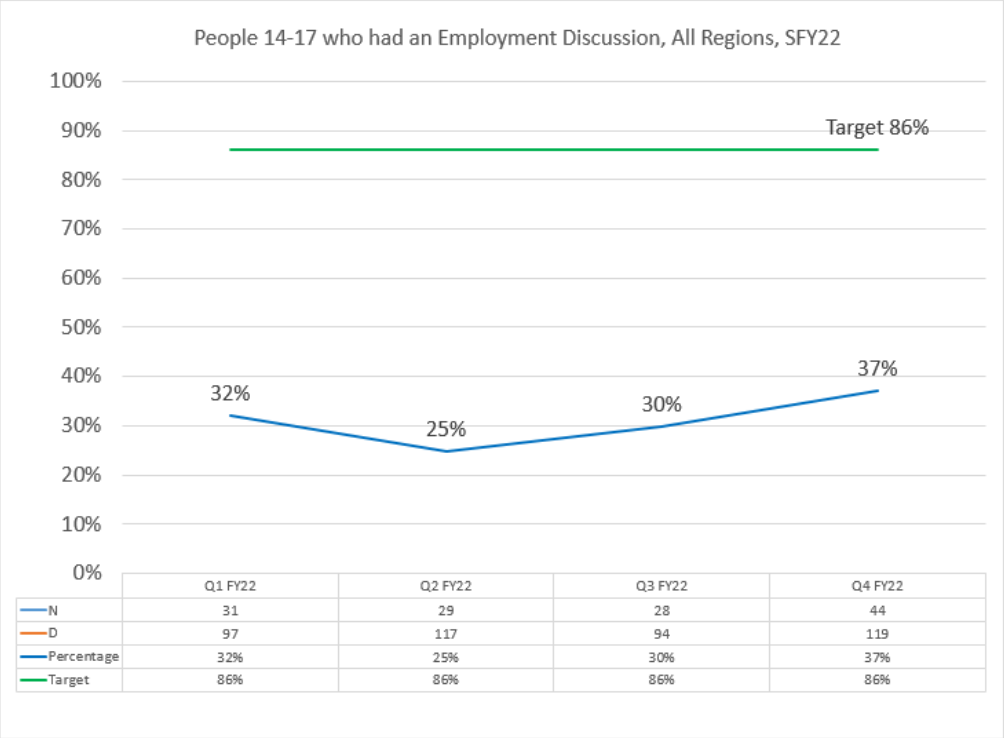
	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	2978	2575	2313	2594
D	3051	2610	2354	2608
Percentage	98%	99%	98%	99%
Target	86%	86%	86%	86%

Fig. 2 Employment Outcomes



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	852	709	572	609
D	3051	2610	2354	2608
Percentage	28%	27%	24%	23%
Target	50%	50%	50%	50%

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



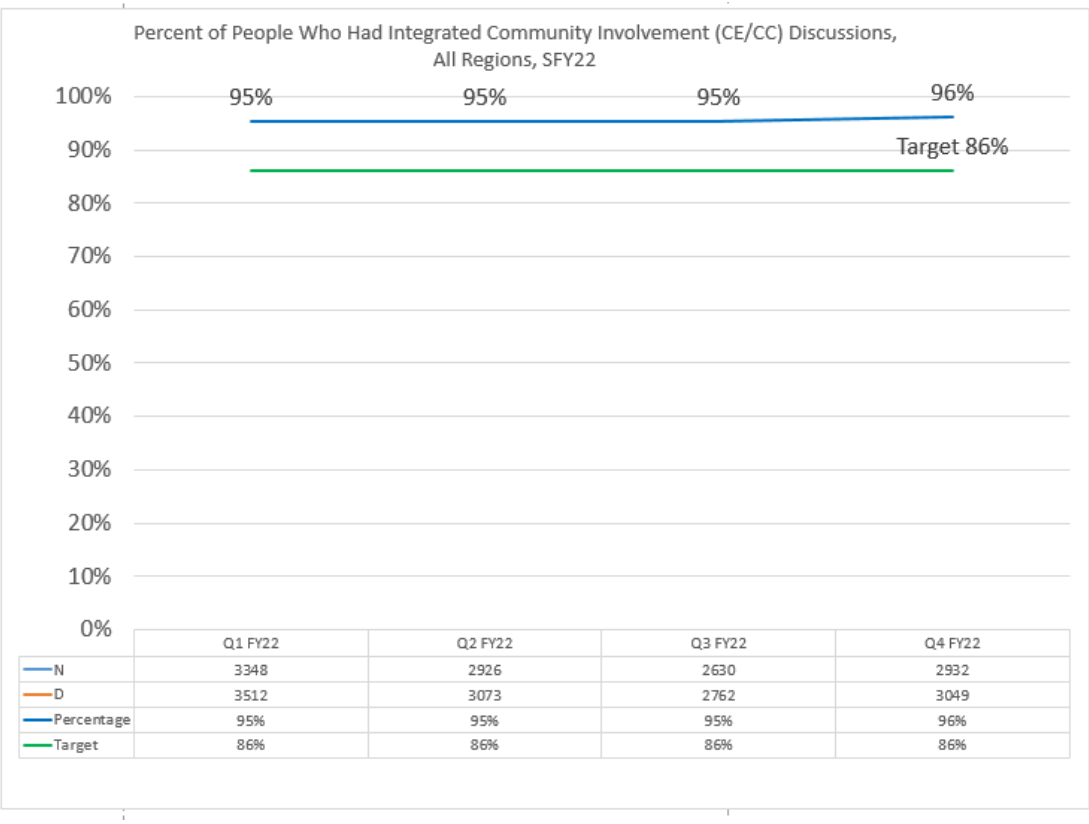
Community Engagement Discussions and Goals

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

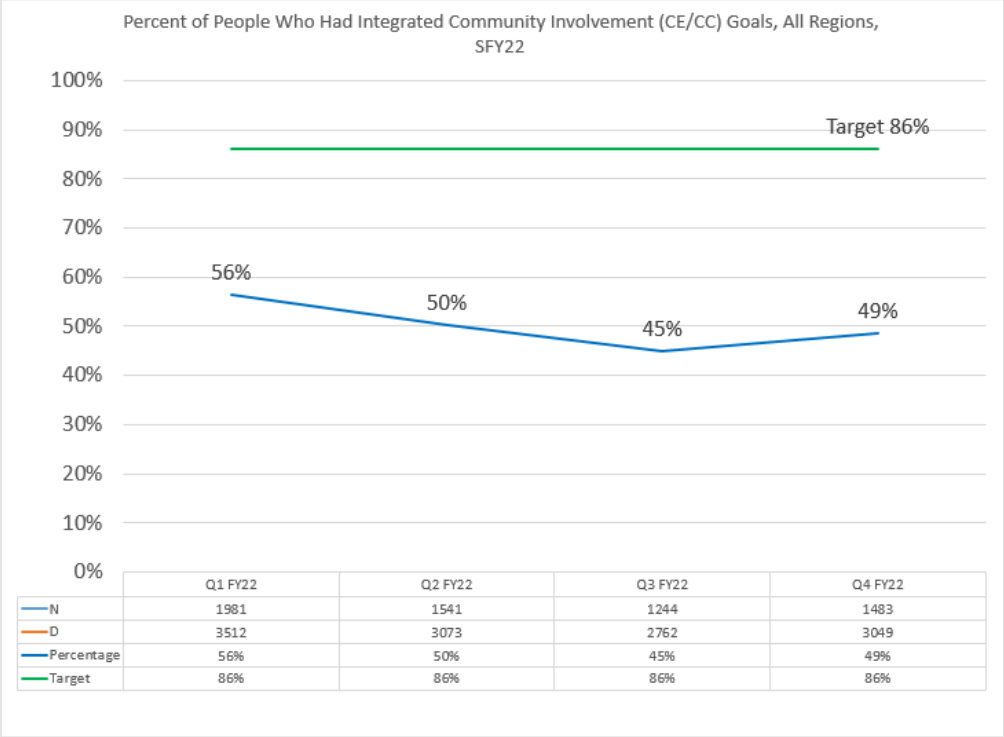
The measure related to individuals participating in a discussion about integrated community involvement has been consistently above target for the last four quarters, while those with and integrated community involvement outcomes has consistently been below target. The focus of these measures is on community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



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	3348	2926	2630	2932
D	3512	3073	2762	3049
Percentage	95%	95%	95%	96%
Target	86%	86%	86%	86%

Fig. 5 Integrated Community Involvement (Community Engagement) Outcomes



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	1981	1541	1244	1483
D	3512	3073	2762	3049
Percentage	56%	50%	45%	49%
Target	86%	86%	86%	86%

Fig. 6 Community Involvement Outcomes

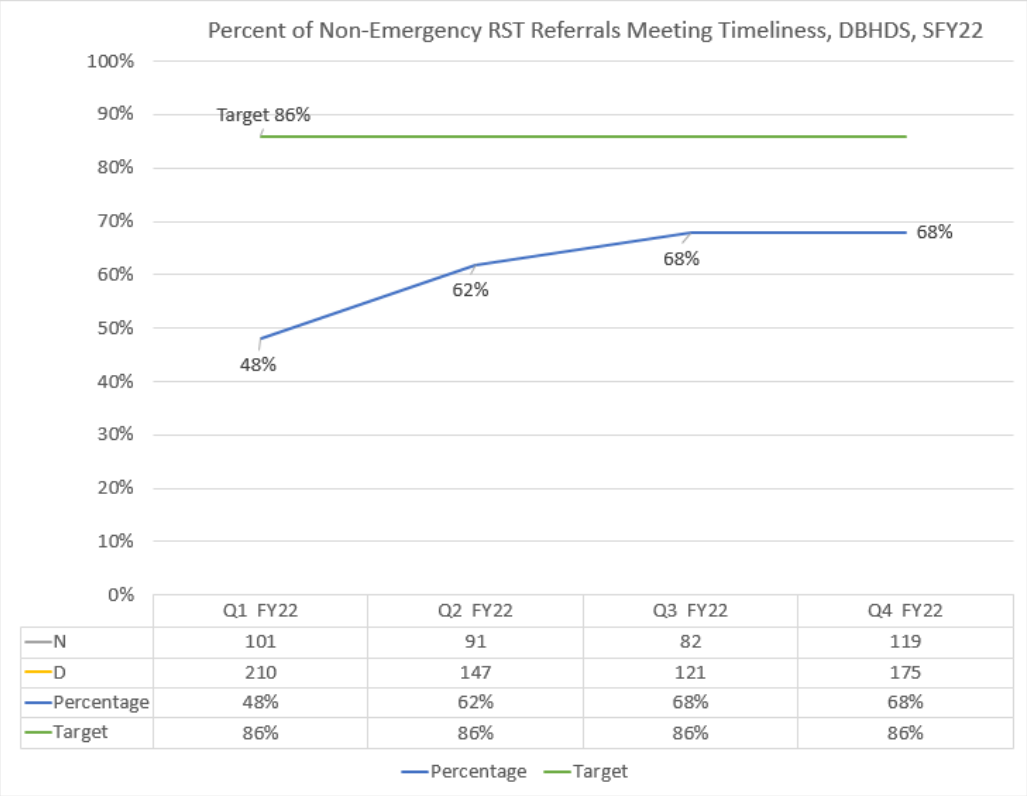
	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	3335	2858	2563	2840
D	3512	3073	2762	3041
Percentage	95%	93%	93%	93%
Target	86%	86%	86%	86%

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.

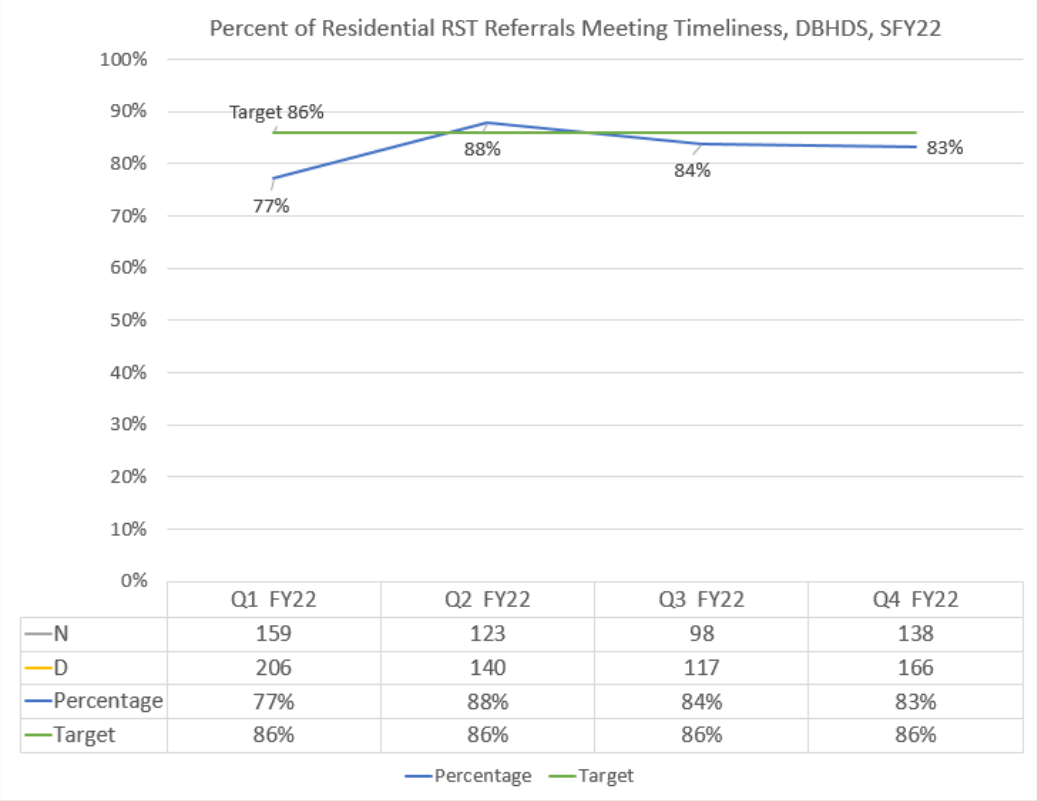
Regional Support Team data related to all reasons for lateness show consistent below target performance for FY22 with trending upwards toward the end of the year, which coincides with the initial implementation of a sixth regional support team (figure 7). The CMSC is currently implementing a QII as reported 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 in Q2 of FY22 with performance in the last two quarters within 3% of the target. 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 4th quarter FY22



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	101	91	82	119
D	210	147	121	175
Percentage	48%	62%	68%	68%
Target	86%	86%	86%	86%

Fig. 8 RST Residential Community Referral Timeliness through 4th quarter FY22



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	159	123	98	138
D	206	140	117	166
Percentage	77%	88%	84%	83%
Target	86%	86%	86%	86%

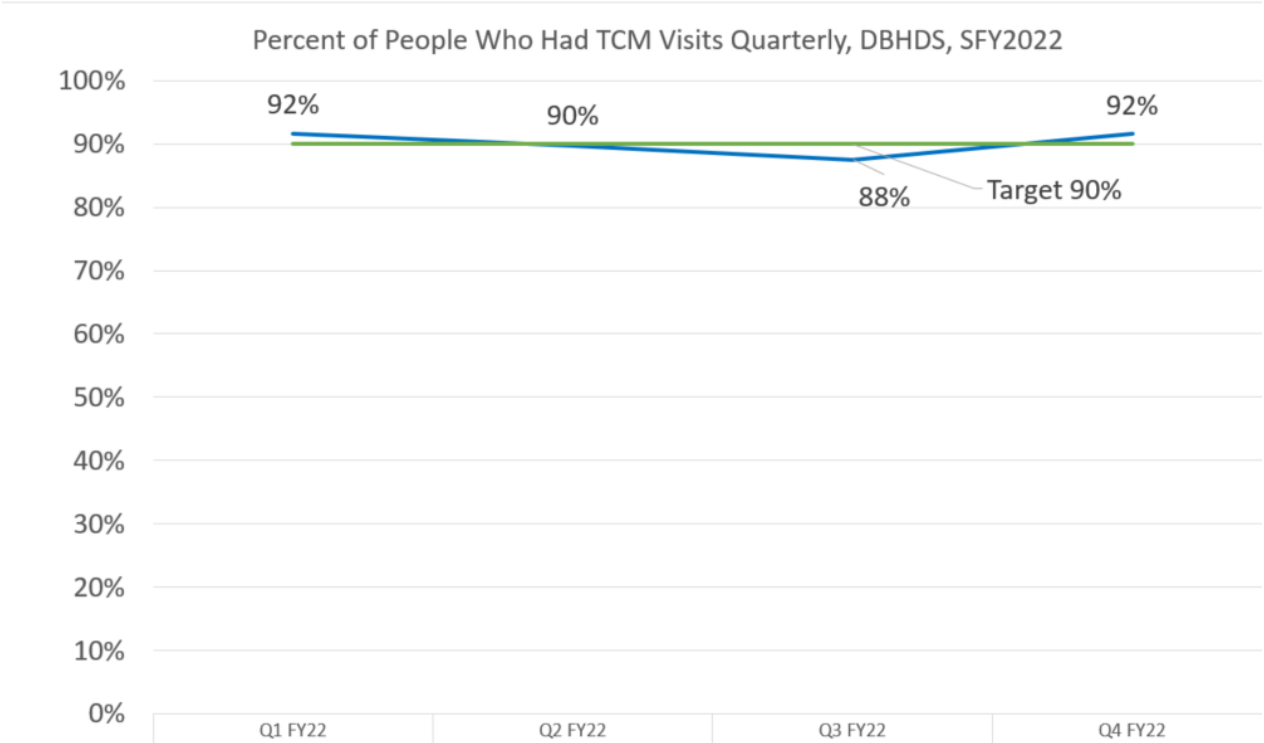
Provider Capacity

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.

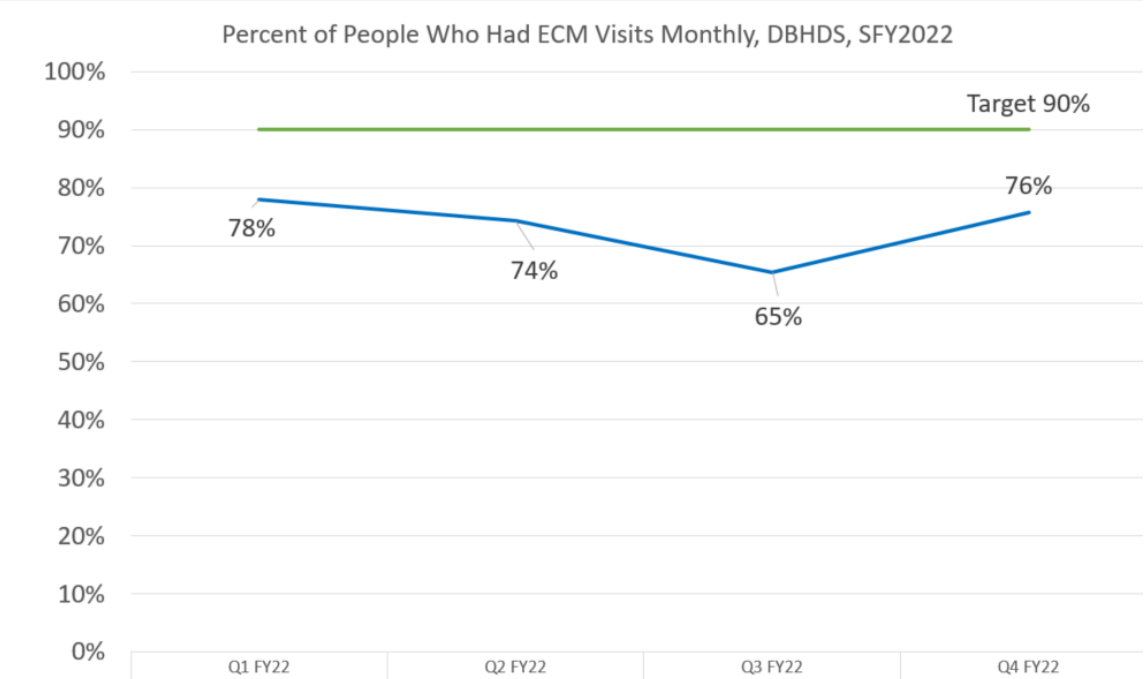
Data regarding Targeted Case Management face-to-face visits is available for FY22. Based on the results below, there was above target performance in all quarters except Q3 FY22 (Fig. 10). Overall results for FY22 ECM face-to-face (figure 11) and ECM in the home (figure 12) ended below target for the year with some improvement noted in the 4th quarter. A similar result was seen in the percentage of ECM visits in the home. In the third quarter FY22, the Office of Provider Development began a Data Quality Support Process with CSBs to examine a sample of case management contact data to enable comparisons between CCS, WaMS, and CSB electronic health records. The primary focus of these sessions is to support CSBs with identifying and resolving any data reliability and validity issues. This process will continue with an annual sample of CSBs and CSBs may be included based on under performance in this area.

Fig. 10 TCM visits



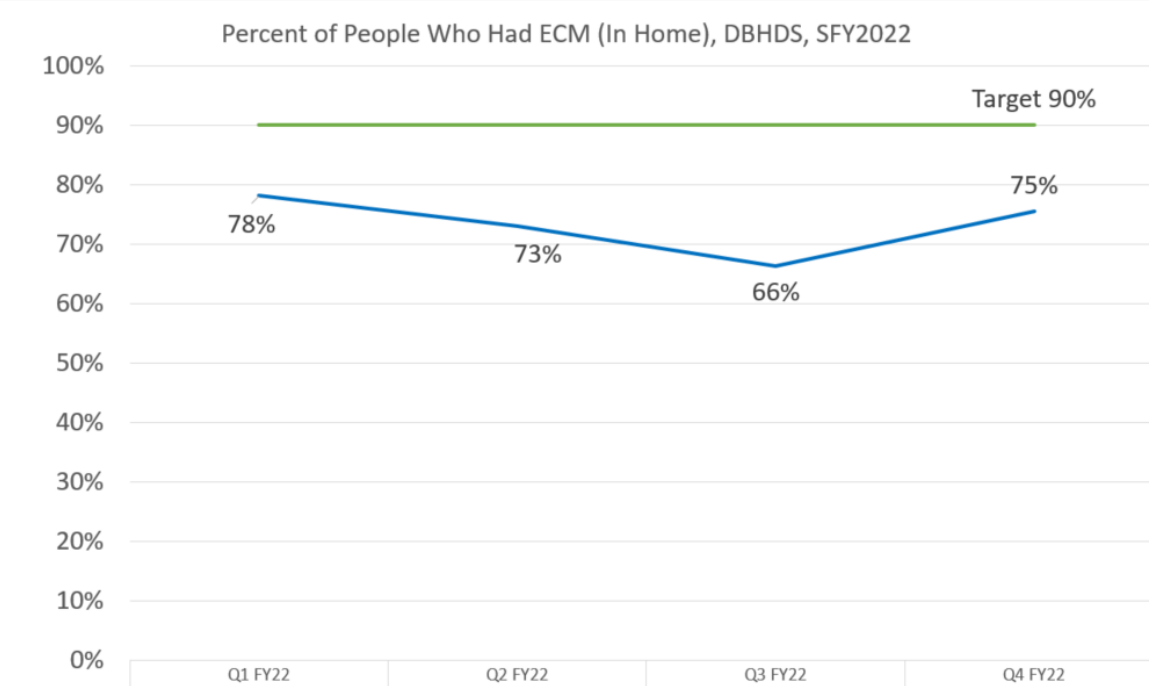
	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	17613	17218	16544	17343
D	19211	19204	18901	18933
Percentage	92%	90%	88%	92%
Target	90%	90%	90%	90%

Fig. 11 ECM face to face visits



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	12979	11460	9415	10413
D	16663	15437	14382	13740
Percentage	78%	74%	65%	76%
Target	90%	90%	90%	90%

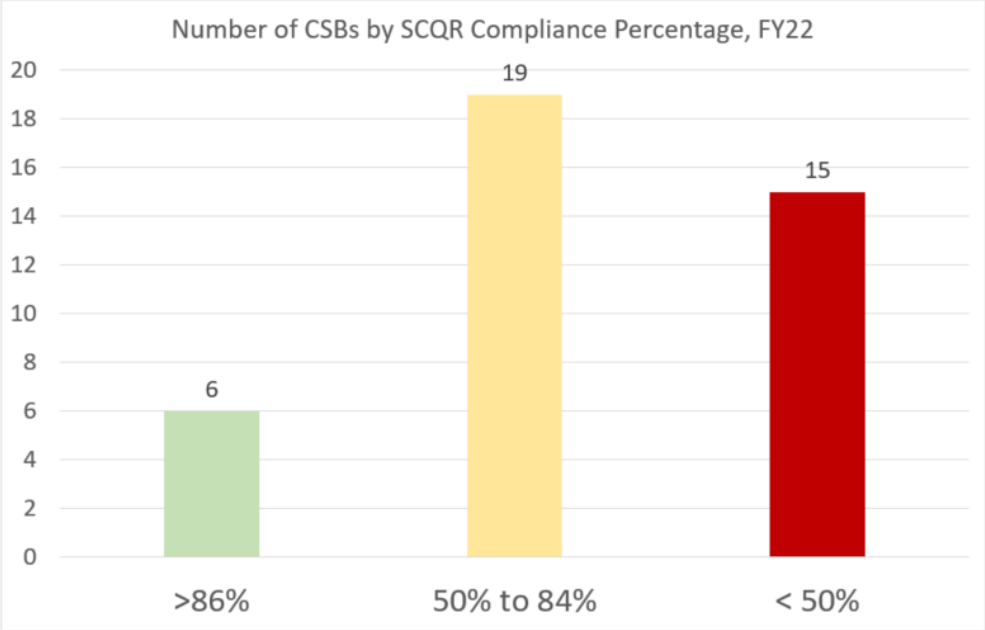
Fig. 12 Face to face ECM visits in-home



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	13015	11269	9534	10464
D	16663	15437	14382	13872
Percentage	78%	73%	66%	75%
Target	90%	90%	90%	90%

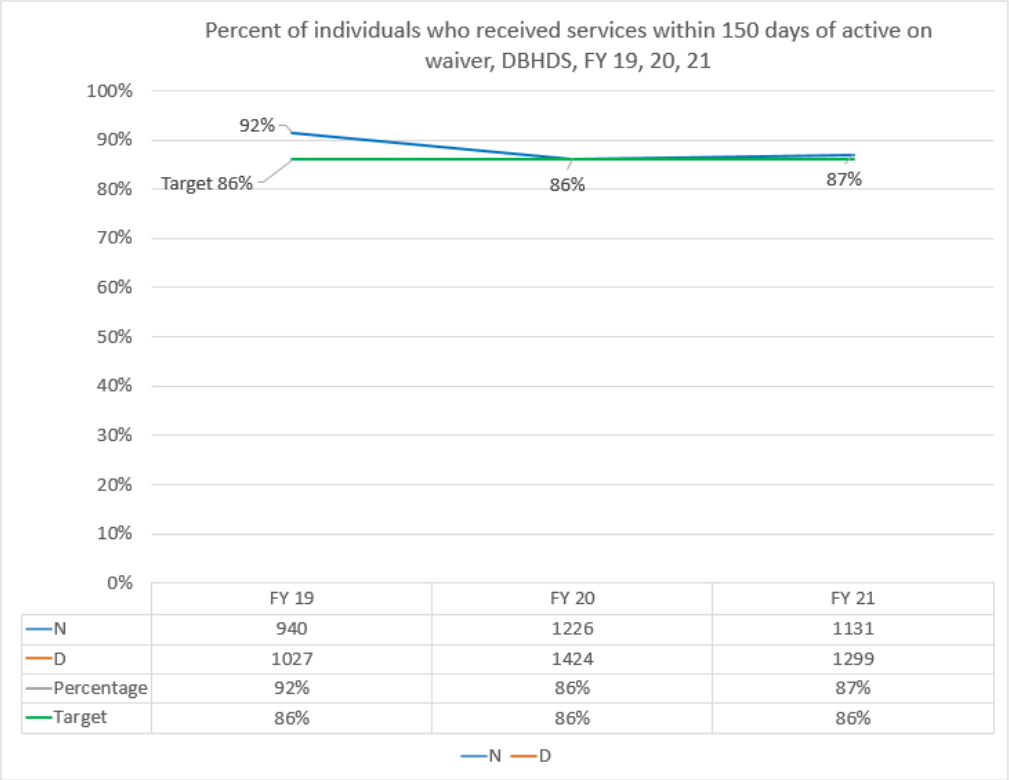
Fig. 13 Records in compliance with 9 of 10 assessed indicators FY22

Number_in_compliance	Total_records	Percent_in_compliance
213	400	53%



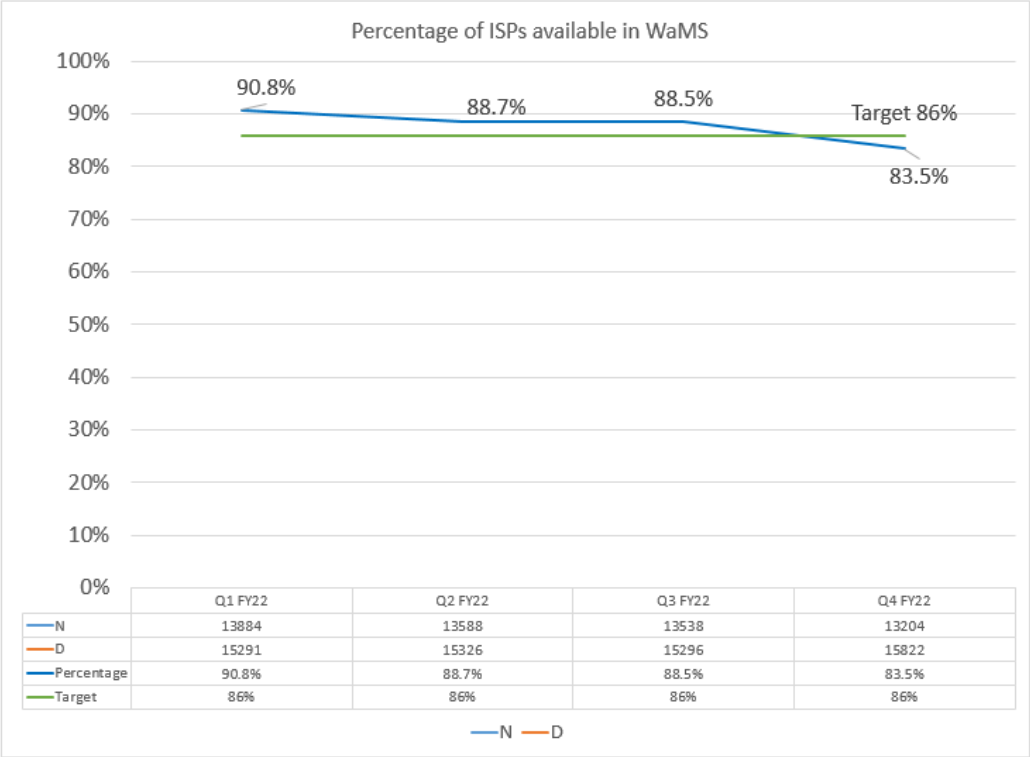
Results in third year of the SCQR process reflect that 53% of records reviewed are in agreement with 9 of the 10 indicators included in the review. Six CSBs achieved a compliance percentage above 86%, 19 achieved between 50 and 84%, and 15 achieved less than 50% as seen above (fig. 13). Annual results 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 three consecutive quarters falling below target in the 4th quarter of FY22 (figure 15).

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



	FY 19	FY 20	FY 21
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 June 30, 2022



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
N	13884	13588	13538	13204
D	15291	15326	15296	15822
Percentage	90.8%	88.7%	88.5%	83.5%
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

The charts below provide results as reported by CSBs in the third year of the SCQR. Information regarding the levels of agreement seen following the OCQI look-behind process for FY22 will be provided in the next report. The items listed below are included in determining CSB success with these indicators; the overall result for both indicators is 84%.

Fig. 16 FY22 results for appropriately implemented services

Indicator 9	**Yes**	**Both Yes, Met**
Q75: Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	86%	**84%**
Q77: Did all four OSVTs have all areas under "Services Implemented Appropriately" completed?	92%	

Fig. 17 FY22 results for change in status

Indicator 10	Q75: OSVT completed as required	Q79: All Change in Status elements completed	Q81: Revisions made	Q81: Changes, but revisions not necessary	Q81: No changes in status or needs	Indicator result overall
Q75: Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	86%					
Q79: Did each OSVT have all areas under "Change In Status" and "Change in Status Determination" completed?		94%				**84%**
Q81: If any of the four OSVTs identified a change in status within the "Change in Status Determination" section, were revisions made to the ISP?			3%	16%	79%	

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 third year of the SCQR. Information regarding the levels of agreement seen following the OCQI look-behind process for FY22 will be provided in the next report.

Fig. 18 FY22 results for unpaid relationships discussion

Measure 18	**Yes**	**Either Yes, Met**
Q54: Is it evident in the PC ISP that the SC/CM discussed relationships and interactions with people other	85%	**90%**
Q55: Is there evidence elsewhere in the record that the SC/CM discussed relationships and interactions with people other than paid program staff?	5%	

Fig. 19 FY22 results for choice

Measure 18	**Yes Support Coordinator Choice**	**Yes Provider Choice**	**Both Yes, Met**
Q22: Does the completed VIC confirm that the individual was offered a choice of . . . support coordinator (named)?	79%		**78%**
Q22: Does the completed VIC confirm that the individual was offered a choice of . . . .DD Waiver providers?		90%	

Office of Licensing Data

In April 2022, the Office of Licensing brought forward concerns related to a CSB's case management performance. The Committee discussed various factors and its role in responding to reported concerns. It was determined that given the scope of the committee's charter, technical assistance would be offered. The CMSC reviews data in making determinations about CSB performance and takes action based on the data reviewed. Where concerns are identified through verbal report, the Committee will work across participating offices in making a referral for technical assistance and/or reporting concerns to the appropriate office and/or DBHDS Commissioner as needed.

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.

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

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

In order to meet the indicator stated above, DBHDS and DMAS will work collaboratively to identify and respond to citations related to the ten CM elements included in the Support Coordinator Quality Review (SCQR). This process will begin implementation in Q1 FY23.

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

Identified CSBs will be included as a standing item on the quarterly agenda. DMAS will provide the names of CSBs cited along with any progress made in programmatic changes or approved Corrective Action Plans that indicate progress or lack of progress toward resolving concerns.

- Letters are provided to DBHDS by QMR
- Names of CSBs are added to the quarterly meeting agenda for cross-agency discussion
- Tracking the remediation of issues will be included with each agenda; any unresolved remediation will carry over from meeting to meeting until resolved
- Findings will be shared with the DBHDS Case Management Steering committee when

technical assistance is declined and/or at the discretion of the group when remediation efforts are deemed ineffective

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

Quality Service Reviews

The CMSC is near completion with the quality improvement initiative related to the Quality Service Review (QSR) data. Our goal with this QII was to improve the number and percent of individuals who meet the criteria for Enhanced Case Management (ECM) that receive face to face visits monthly with alternating visits in the home for the DD waiver population to 86% by June 2022. The baseline was 73% during the 2nd Quarter FY21. Since the implementation of this initiative, the ECM target has moved from 86% to 90% to align with expectations included in the performance contract.

Through a joint workgroup comprised of DBHDS, CSB leadership, and support coordinators the following deliverables have been completed: an Enhanced Case Management training video, which was posted online, a frequently asked questions document, an automated spreadsheet to assist with understanding when to begin and end ECM, as well as a streamlined draft of a 2017 guidance document, which has been reduced from 20 to 8 pages in total. The final step in this QII is holding a public comment period for the drafted guidance, which will occur in the next report period. Both targets related to the measure have shown improvement in Q3 and Q4 of FY22, but remain below the 90% target as of this report.

Specific CSB recommendations were made by the Health Services Advisory Group (HSAG) following Round 3 of the QSR process that include:

- HSAG recommends that CSBs ensure support coordinator understanding of the expectation for documentation of activities and efforts made to address individual risks by providing additional clinical-based training focusing on proper identification and inclusion of all medical needs documented in most recent assessments to all support coordinators.
- HSAG recommends that CSBs ensure support coordinator understanding of the expectation for completion of the RAT prior to, or in conjunction with, ISP planning.
- HSAG recommends that CSBs ensure support coordinator understanding of the expectation for documentation of activities and efforts made to address individual risks by providing additional clinical-based training focusing on proper inclusion of all risks in appropriate Part III outcome.
- HSAG recommends that CSBs ensure support coordinator understanding of the expectation that ISP documentation contains signatures for all licensed providers responsible for implementation, including the individual and/or their guardian.
- HSAG recommends that CSBs provide additional clinical-based training focusing on: ensuring support coordinator understanding of proper identification and assessment of new or previously unidentified risks; how to properly document changes in status including relevant follow up; how to identify deficiencies or discrepancies in support plan or its implementation; and best practices

for how to address and mitigate risks incorporating individual's strengths and preferences with support of planning team.

To address these recommendations, the Office of Provider Development is updating the DD Support Coordination Handbook, which will be finalized through public comment in FY23 and made available to CSBs following this process. Finally, the Committee is aware of the staffing difficulties being encountered by CSBs and providers across Virginia. These challenges have led to initiating a new QII focused on improving CM retention. The Committee recognizes the potential relationship between staffing and completing visits as required and expects improvements in retention and job satisfaction to impact CSBs' ability to meet ECM measures.

Performance Contract Indicator Data

As reported above, the CMSC is implementing a Corrective Action Plan process that includes 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, one CSB successfully completed Corrective Action Plan, which was closed by the committee. Two additional CAP requests were issued in March leaving three open CAPs at the conclusion of the report period. Next steps in the development process for the framework is to issue CAPs for ISP entry, which is necessary under the Performance Contract and to ensure that the Department has data available for reporting. 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.

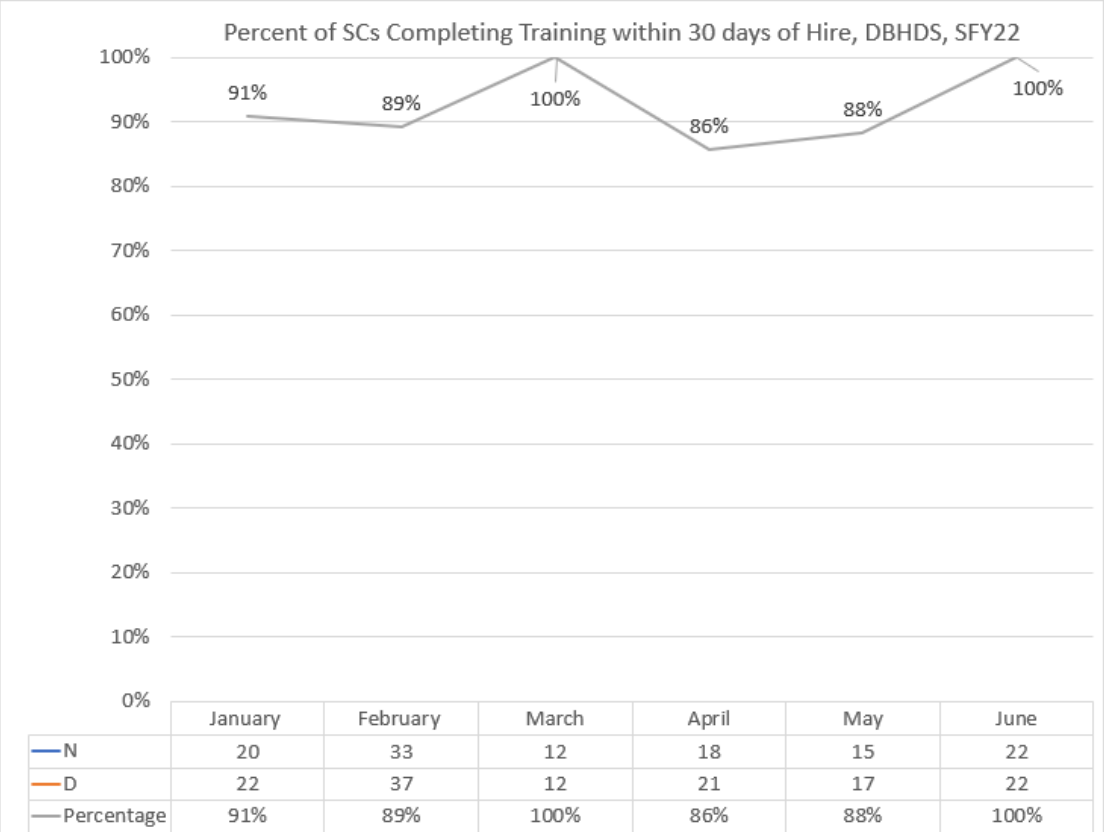
Data Monitoring

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 January and June 2022 shows that the completion rate exceeded 86% in all months. The chart below conveys the number of DD CMs who

completing the modules and the percentage who completed the modules within required timeframes (figure 20).

Fig. 20 Case Management Module Completion January to June SFY2022



	January	February	March	April	May	June
N	20	33	12	18	15	22
D	22	37	12	21	17	22
Percentage	91%	89%	100%	86%	88%	100%

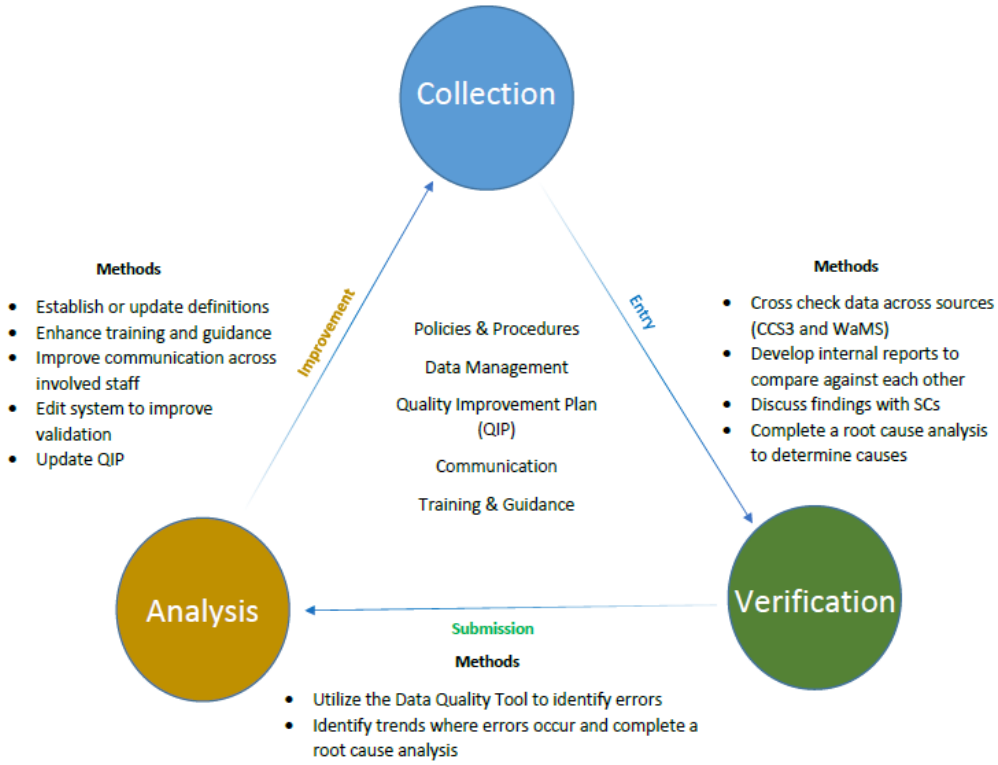
Data Availability and Integrity

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

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



The Data Quality Process implemented by the Committee includes the Office of Provider Development providing technical assistance to CSBs on data reporting requirements. This assistance is designed to support CSB efforts to improve the quality of case management contact data reported to the Department. It includes the completion of a root cause analysis, if needed, to identify the underlying causes for not meeting case management measure targets and helps in identifying gaps and/or issues that impacted the CSB's performance. Data around each stage of the data life cycle was evaluated, including 5 quarters of data for each CSB sample. All 40 CSB's were reviewed between 3/10/22 – 5/24/22. This process will continue on an annual basis with a sample of CSBs and CSBs can be included based on below target performance with related measures.

Community Resource Consultants from the Office of Provider Development facilitated Data Quality meetings that included the CSB's program and IT staff. CSB's appreciated the collaboration as data was reviewed. Data was reviewed through multiple steps exploring three records per CSB. The team explored a review of potential root causes for any data anomaly discovered and conducted further

exploration to determine how to improve the accuracy data. The most frequent issue noted throughout the reviews related to the coding of quarterly and annual ISPs. Coding errors typically related to a service subtype not being properly applied. Some CSB's did not have service subtype coding in these areas, and some had multiple notes coded repetitively.

After an analysis of the results, recommendations were made to the CMSC to cease requiring service subtype in the coding of the Quarterly and Annual ISPs. Findings showed that CSB's had completed the required quarterly and annual meetings, however, they did not consistently change the service subtype in the Electronic Health Record. Recommendations were made to CSB's to incorporate data quality coding and quality issues into their Quality Improvement Plan for further exploration and continuous improvement.

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:

- 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.

Current Recommendations Include:

- Implement the DMAS Quality Management Review data 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 the SCQR look-behind process and integrate children into the next SCQR cycle.
- Identify targeted changes under the CMSC QII for Support Coordinator retention.
- Cease requiring service subtype in the coding of the Quarterly and Annual ISPs.
- 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.