Virginia Department of Behavioral Health & Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2023
1st and 2nd Quarters

Case Management Steering Committee

Semi-Annual Report FY23 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 (QIS), one Community Resource Consultant (CRC), and a Quality Research Specialist from the Office of Quality Assurance and Healthcare Compliance. Advisory members include a representative from the Office of Licensing and a Behavior Analyst. Standard operation procedures include: annual review and update of the committee charter, regular meetings, at least ten times annually, to ensure continuity of purpose, maintenance of reports and meeting minutes, and quality improvement initiatives consistent with Plan, Do, Study, Act model.

From July to December 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 September and December 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 Individual Support Plan (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. At the closure of this reporting period, updated specifications for the ISP have been finalized and provided to electronic health record vendors to prepare for the forthcoming update cycle in 2023.

Key Accomplishments

During the reporting period, key accomplishments included completing the third year of the Support Coordinator Quality Review (SCQR) process and related look-behind. Enhancements were made to the WaMS ISP to better collect data related to supported decision-making, health screenings, and enhancing data labels to clarify data entry expectations. 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 revised the survey and guidance for the FY23 SCQR cycle, so that services to children will be included in the process when survey submissions begin in January 2023 per recommendations from the Independent Reviewer for the Settlement Agreement.

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 were included in the last report. The CMSC began discussions on the next round of meetings to be held in the spring of 2023, which will be comprised of a sample of CSBs to include any CSBs known by the committee to be experiencing difficulty with data entry.

As reported previously, the CMSC has been made aware of concerns centering on the administrative responsibilities and documentation requirements for Support Coordinators (SCs), which have impacted the manageability of the position. The Quality Improvement Committee (QIC) approved the CMSC's proposed quality improvement initiative (QII) in June of 2022 focused on improving SC retention. Through focus groups with SCs and CSBs, the CMSC collected ideas and concerns, which are driving recommendations to ease SC requirements where possible without compromising Virginia's compliance with state and federal requirements. To date, seven near term recommendations have been identified. The committee is focused on implementing individual changes as possible to reduce any delay in providing relief to stakeholders. This initiative will include tracking retention rates and continue to seek to make targeted changes in SC/CM responsibilities to increase the satisfaction and retention of SCs.

Another key accomplishment was the continuation of a cross-regional Regional Support Team. This was developed under one of the Committee's QIIs and is related to Curative Actions required for meeting Settlement Agreement requirements. Initiated in May 2022, the Committee began monitoring data and noted a corresponding increase in performance as reported below. The RST process transitioned to the WaMS in December with systemwide adoption on January 1, 2023. This transition replaces the manual referral and data management processes and is expected to ease and enhance the collection and reporting of RST data. A few system enhancements are expected following the launch of the RST module and the committee will ensure that training on these updates is available to SCs.

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). The Committee adopted new language for Corrective Action Plan, which is now referred to as Improvement Plan to support a focus on quality improvement. The thresholds for SCQR were defined and implemented following the look-behind cycle to include an IP for any CSB with less than 50% on three or more indicators found to have high agreement in the look-behind. In this first year of implementation, no individual CSB met this threshold. Six Improvement Plans (IPs) related to underperformance with RST referral timeliness and twelve related to ISP entry were requested during this report period. IPs related to ISP compliance were implemented for the first time during this report period, which leaves 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 continued to include data results regarding the development of outcomes for integrated community involvement (ICI) in CSB performance letters. This addition is to support CSB awareness of their performance in this area, so that progress can be attempted by CSBs.

Finally, the CMSC completed a CMSC Overview video, which provided CSBs information about Committee processes and place within the DBHDS Quality Management System. This video was shared through Microsoft Teams with all CSBs on 9/16/22.

Support Coordination Quality Review (SCQR)

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

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

- "ISP implemented appropriately" means that services identified in the ISP are delivered

consistent with generally accepted practices and have demonstrated progress toward expected outcomes, and if not, have been reviewed and modified.

Materials developed include: a definitions document, a standardized tool format referred to as the On-site Visit Tool (OSVT), a summary of the Independent Reviewer report history related to non-compliance with the Settlement Agreement provision V.F.2., a reference chart as guidance, training slides, and a questions and answers document. This project is further defined in a CMSC 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, which is evident between the second and third year of implementation. Opportunities to enhance this process occur once each year as new learning is incorporated. Main areas for improvement are providing clarity about expectations for each element assessed, as well as providing a designated location for holding information, so that results can be easily found. The ISP adjustments were made to provide locations for information assessed through the SCQR where no location previously existed. A comparison across FY21 and FY22 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.

On-site Visit Tool

In November 2020, based on a review of a sample of On-site Visit Tools (OSVTs) during the pilot period and in collaboration with CSBs, revisions to the tool and process were made to improve use and effectiveness. Primary changes included: incorporating logic that leads to more definite determinations that a change in status and appropriate service implementation occurred, establishing the visit note as a companion document to reduce redundancy and duplication, and 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. Tables 1 and 2 below contain the comparison of results across FY21 and FY22. Compliance increases were seen in six of the ten indicators (Table 1) and moderate to high levels of agreement are seen in Table 2 with one exception, which was a small 0.02 decrease with indicator 1.

Table 1: Percentage of records in compliance by indicator, as reported by CSBs

Indicator	FY21 CSB-reported compliance	FY22 records in compliance	FY22 records not in compliance	FY22 CSB-reported compliance	Difference in % pts
Indicator 1	88.0%	367	33	91.8%	4%
Indicator 2	77.5%	311	89	77.8%	0%
Indicator 3	82.5%	161	239	40.3%	-42%
Indicator 4	85.0%	328	72	82.0%	-3%
Indicator 5	99.5%	400	0	100.0%	1%
Indicator 6	69.3%	347	53	86.8%	18%
Indicator 7	92.0%	336	64	84.0%	-8%
Indicator 8	93.0%	390	10	97.5%	4%
Indicator 9	50.3%	338	62	84.5%	34%
Indicator 10	74.8%	334	66	83.5%	9%

Table 2: Interrater Agreement: FY2021 and FY2022

Indicator	FY2021 % agree	FY2021 Maxwell's RE	FY2022 % agree	FY2022 Maxwell's RE	Difference in Maxwell's RE value
1: Signed choice form	98%	0.96	96%	0.94	-0.02
2: Individual offered a choice	92%	0.84	98%	0.97	0.13
3: Specific and measurable outcomes	72%	0.44	88%	0.82	0.38
4: Persons who participated in ISP	78%	0.56	90%	0.85	0.29
5: Disagreement and resolution	94%	0.88	98%	0.96	0.08
6: ISP signature page	94%	0.88	92%	0.88	0.00
7: Risk assessment and mediation	82%	0.64	88%	0.82	0.18
8: Linkages, referrals, authorizations	98%	0.96	98%	0.97	0.01
9: Assessed plan implementation	76%	0.52	94%	0.91	0.39
10: Change in needs or status	80%	0.60	90%	0.85	0.25

Identified Concerns

The Independent Reviewer's 20th Report to the Court was submitted on June 13, 2022 and included two recommendations that relate to the work of the CMSC stated as:

- 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.

The CMSC incorporated children into the sample for the FY23 SCQR process and has incorporated indicator elements 2.8, 2.10, and 2.14 into the SCQR survey and look-behind reviews as recommended. 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. As mentioned above, updated specifications for the ISP have been finalized and provided to electronic health record vendors to prepare for the forthcoming update cycle in 2023.

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.

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 were completed and will be posted on Virginia Town Hall beginning January 30th, 2023.

Following public comment, the guidance will be widely available in a final version on the Town Hall website and all activities for this initiative will be complete. While improvements may not be readily seen in the ECM data, the changes implemented through the QII were tested with focus groups who expressed that the resources developed made the process more clear and easier to understand.

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.

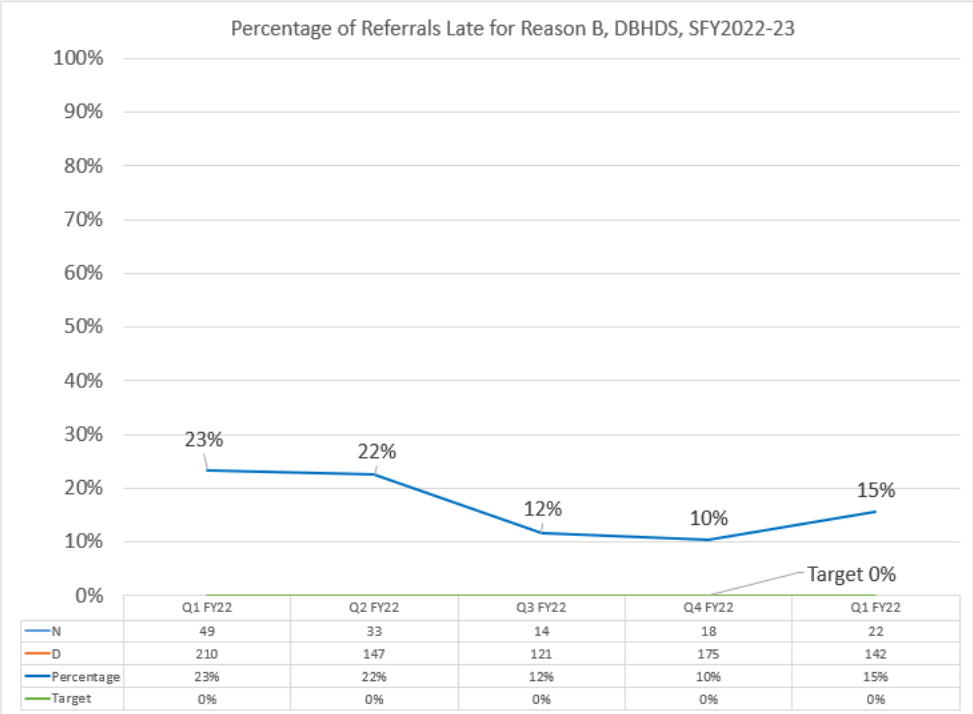
2. Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%). III.D.6.

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 FY22-23, which corresponds with the related measure data included in the next section of this report. An increase in Reason B referrals was noted in Q1 of FY23 where the percentage of these referrals increased to 15% (22/142) from the previous quarter's 10% (18/175). A review of the data for Q1 shows that 12 of these referrals occurred at a single CSB in Region 1 that closed a residential program it operated due to COVID-related staffing issues. Had these referrals been prevented under reason B, systemwide lateness would have resulted in 10 referrals or 7%. The CMSC will continue to monitor this data along with performance with the related measures, will maintain the cross-regional Team and attempt to reduce Reason B referrals where possible.



	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22	Q1 FY22
N	49	33	14	18	22
D	210	147	121	175	142
Percentage	23%	22%	12%	10%	15%
Target	0%	0%	0%	0%	0%

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

Status: Active

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

Three focus groups were held with Support Coordinators and Support Coordinator Supervisors throughout the state in September of 2022. Each focus group had representation from all regions and each group met for 2 hours. Focus Group 1 met on 9/27/22 and had 24 participants, Focus Group 2 met on 9/28/22 and

had 17 participants, and Focus Group 3 met on 9/29/22 and had 15 participants. Questions were designed to elicit information from participants about their opinions and experience with being a Support Coordinator in Virginia, their role, what causes frustration, what could make it easier or better and any potential solutions. Different aspects of a support coordinator's role were reviewed in detail while asked about:

- What tasks, processes or other aspects of that component can cause frustration? In other words, what is not working?
- What could be done to make it easier or better?
- Have you found any solutions or strategies that work for you to make it easier?

These questions were explored in the areas of Assessing, Planning, Coordinating and Linking, Monitoring, and Other. Each focus group provided information and common themes emerged, which are proving critical in driving recommendations to ease SC workload requirements in the short and long-term. This information was organized and presented to the Case Management Steering Committee. Updates will continue to be reported to the Quality Improvement Committee and included in this report as work proceeds. Next steps include finalizing the method through which the rate of change will be tracked via WaMS assignment data with the support of the Office of Integrated Support Services.

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.

FY23 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 from the CSB whose ISP, developed or updated at the annual ISP meeting, contains employment outcomes, including outcomes that address barriers to employment. (Target 50%). **III.C.7.a.**
3 (**PMI**)	Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP. (Target 86%). **III.C.7.a.**
4	Individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process (Target 86%). **III.C.7.a.**

5 (**PMI**)	Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained integrated community involvement outcomes (Target 86%). **III.C.7.a.**
6	Individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. **III.C.7.a.**
7 (**PMI**)	Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. (Target 86%). **III.D.6.**
8 (**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	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month no more than 40 days apart (Target 90%). **V.F.4.**
12	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month in their residence (Target 90%). **V.F.4.**
13	Support coordination records reviewed across the state will be in compliance with a minimum of nine of the ten indicators assessed in the review. (Target 86%) **III.C.5.b.i**
14	86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations **V.D.1.**

15	Individual Support Plans are available in the Waiver Management System by direct keyed entry or data exchange since October 7, 2019. **DBHDS Metric/Performance Contract**
Health, Safety, and Wellbeing	
16 (**PMI**)	The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed (Target 86%). **III.C.5.b.iii; V.F.2; V.F.5.**
17 (**PMI**)	Individual support plans are assessed to determine that they are implemented appropriately (Target 86%). **III.C.5.b.iii; V.F.2; V.F.5.**
Choice and Self-Determination	
18 (**PMI**)	Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff) (Target 86%). **V.D.3.f; V.F.5**
19 (**PMI**)	Individuals are given choice 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 from the CSB whose ISP, developed or updated at the annual ISP meeting, contains employment outcomes, including outcomes that address barriers to employment. (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*	Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP. (Target 86%) **III.C.7.a**	N = Number of individuals with the ISP element "Was there a conversation with the individual/substitute decision-maker about employment?" indicated yes, and where the two following discussion elements are confirmed: "what the person is working on at home and school that will lead to employment" and "alternate sources for funding (such as school or DARs)"	D = Number of individuals in active status in WaMS ages 14 to 17 who have a DD waiver

The measure related to the individual participating in a discussion about employment has been consistently above target for the last four quarters, while those with employment goals has consistently been below target. Baseline for the third measure related to transition age youth was established in the 1st quarter FY22, which was 32%. Related elements in the Individual Support Plan were refined in May 2022 to improve the collection of data around employment topics. Results for this measure increased to 53%,

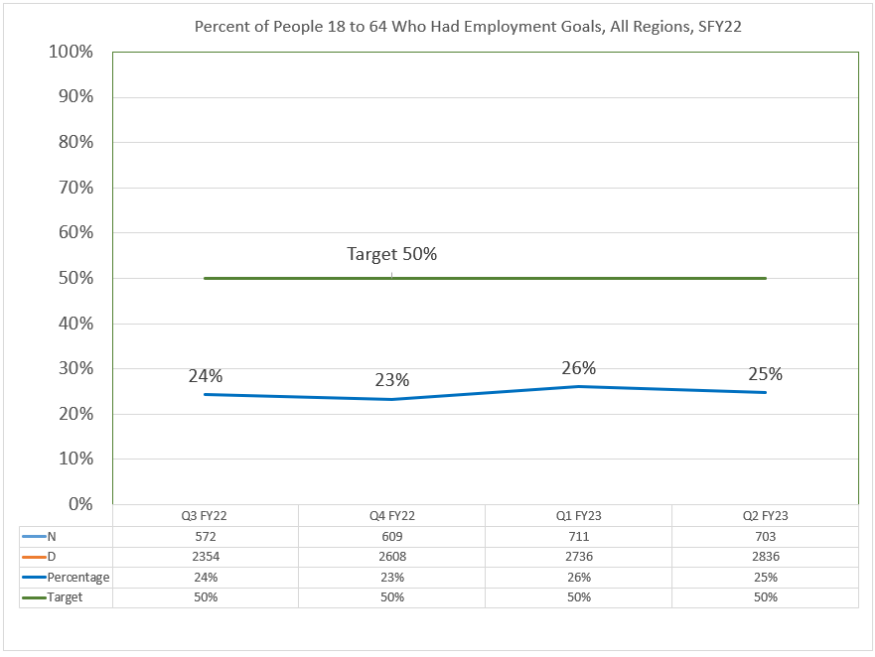
which is the highest level seen to date.

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. The CMSC will continue to monitor and ensure the provision of technical assistance through the Offices of Provider Development and Community Quality Improvement. Current results indicate that the first two measures remain largely consistent with past reporting. Measure 3, related to employment discussions with youth, increased to 53% and 50% in quarters one and two of FY23 respectively.

Fig. 1 Employment Discussions FY22-23

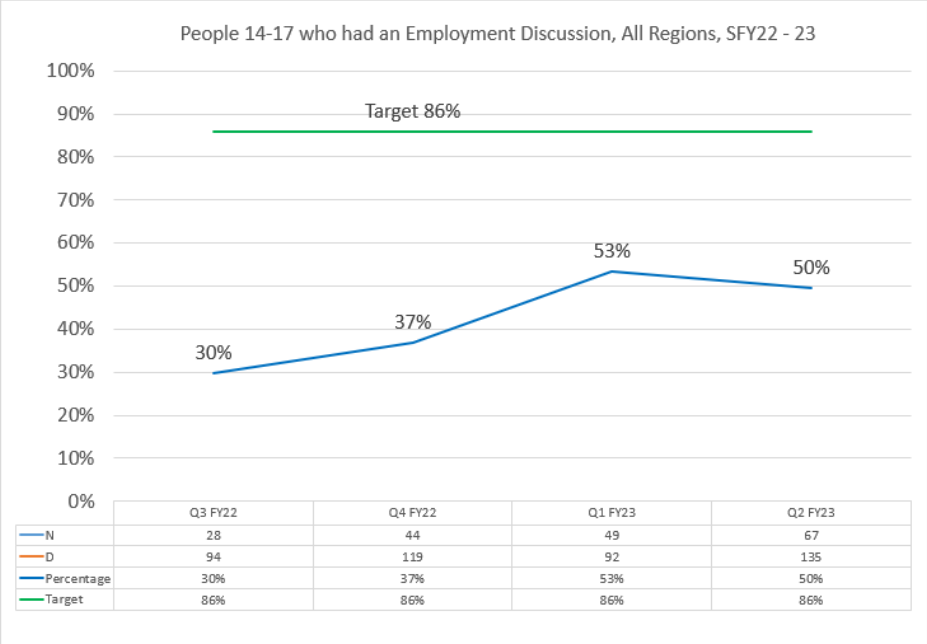
	Q3 FY22	Q4 FY22	Q1 FY23	Q2 FY23
N	2313	2594	2563	2636
D	2354	2608	2736	2836
Percentage	98%	99%	94%	93%
Target	86%	86%	86%	86%

Fig. 2 Employment Outcomes FY22-23



	Q3 FY22	Q4 FY22	Q1 FY23	Q2 FY23
N	572	609	711	703
D	2354	2608	2736	2836
Percentage	24%	23%	26%	25%
Target	50%	50%	50%	50%

Fig 3. Employment Discussion 14-17 (both topics confirmed) FY22-23



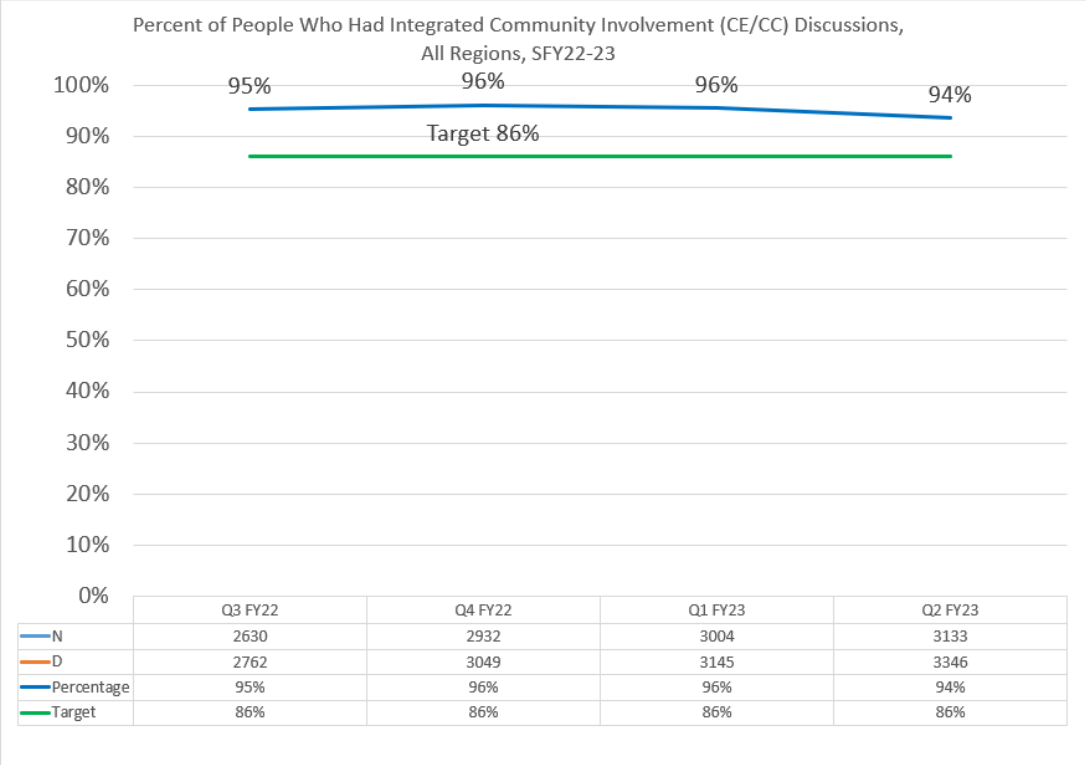
Community Engagement Discussions and Goals

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

6 *Figure 6*	Individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. **III.C.7.a**	N = Number of ISPs with one or more outcomes under the Integrated Community Involvement and/or the Community Living life areas in the ISP: Shared Plan	D = Number of individuals in active status on one of the DD Waivers

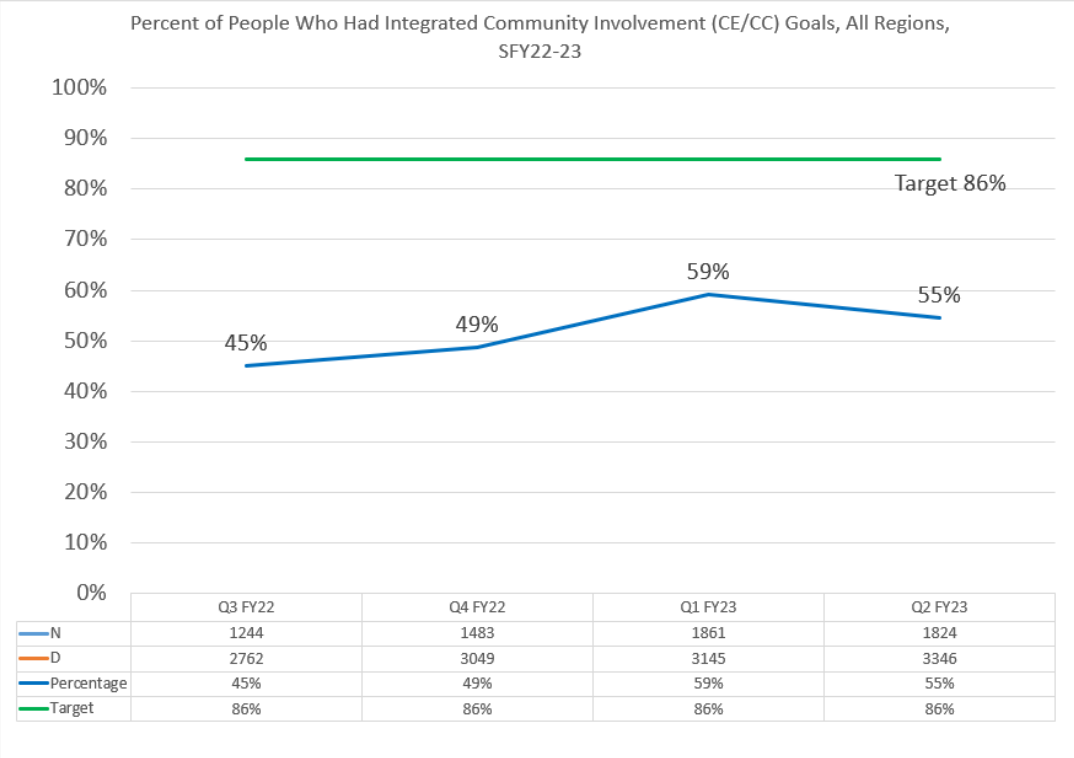
The measure related to individuals participating in a discussion about integrated community involvement has been consistently above target for the last four quarters, while those with and integrated community involvement outcomes has consistently been below target. The focus of these measures is on community 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 (Figure 6) related to community involvement was established in the 1st quarter FY22. Results remain above target for this measure.

Fig. 4 Integrated Community Involvement (Community Engagement) Discussions FY22-23



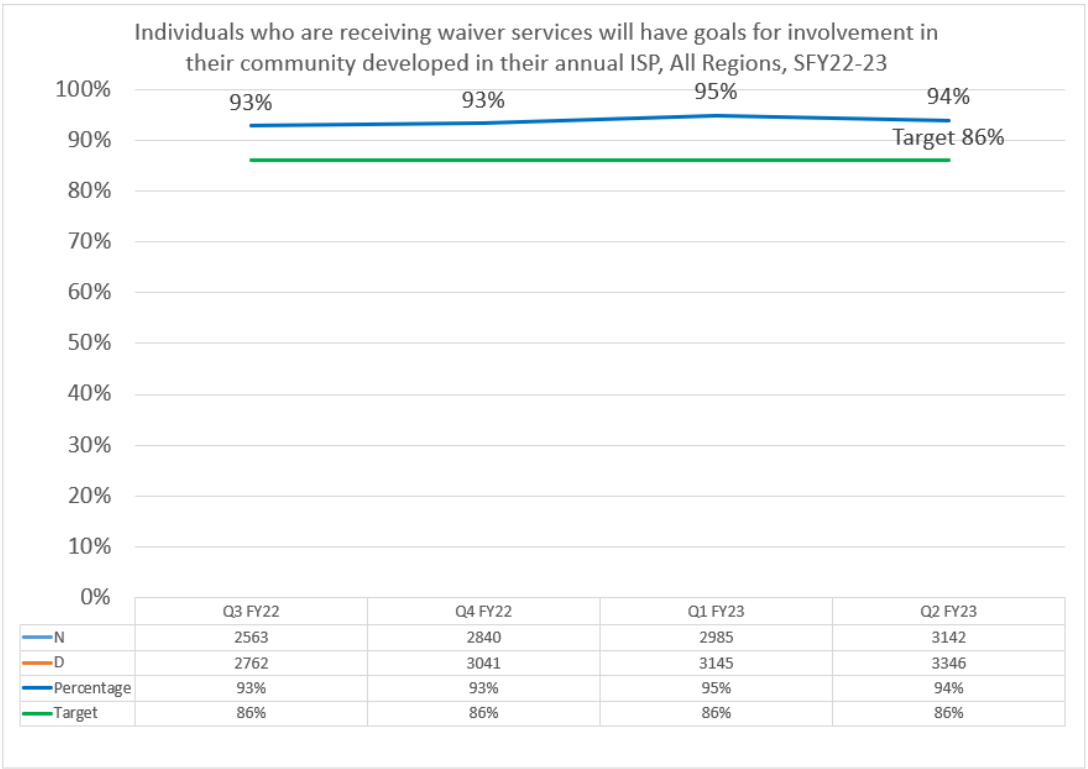
	Q3 FY22	Q4 FY22	Q1 FY23	Q2 FY23
N	2630	2932	3004	3133
D	2762	3049	3145	3346
Percentage	95%	96%	96%	94%
Target	86%	86%	86%	86%

Fig. 5 Integrated Community Involvement (Community Engagement) Outcomes FY22-23



	Q3 FY22	Q4 FY22	Q1 FY23	Q2 FY23
N	1244	1483	1861	1824
D	2762	3049	3145	3346
Percentage	45%	49%	59%	55%
Target	86%	86%	86%	86%

Fig. 6 Community Involvement Outcomes FY22-23



	Q3 FY22	Q4 FY22	Q1 FY23	Q2 FY23
N	2563	2840	2985	3142
D	2762	3041	3145	3346
Percentage	93%	93%	95%	94%
Target	86%	86%	86%	86%

Regional Support Teams and Timeliness of Referrals

Reference	Measure	Numerator	Denominator
7 *(***PMI***)* *Figure 7*	Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. (Target 86%). **III.D.6.**	N = Number of non-emergency RST referrals made on time.	D = Number of non-emergency RST referrals.
8 (**PMI**) *Figure 8*	Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%). **III.D.6.**	N = Number of on time non-emergency referrals for individuals selecting a less integrated residential waiver option submitted by CSBs	D = Number of non-emergency RST referrals submitted by CSBs
9 Figure 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). Reason B refers to one of the causes for late referrals where and individual moves before the RST process can be completed. The number of Reason B late referrals spiked in quarter one of FY23 due to the expedited closure of a group home program operating within a Region I CSB. This closure was due to COVID-related staffing concerns and affected 12 individuals. Absent this event, results would have continued on a positive trend. The CMSC continues implementing a QII as reported above in the effort to positively impact this result.

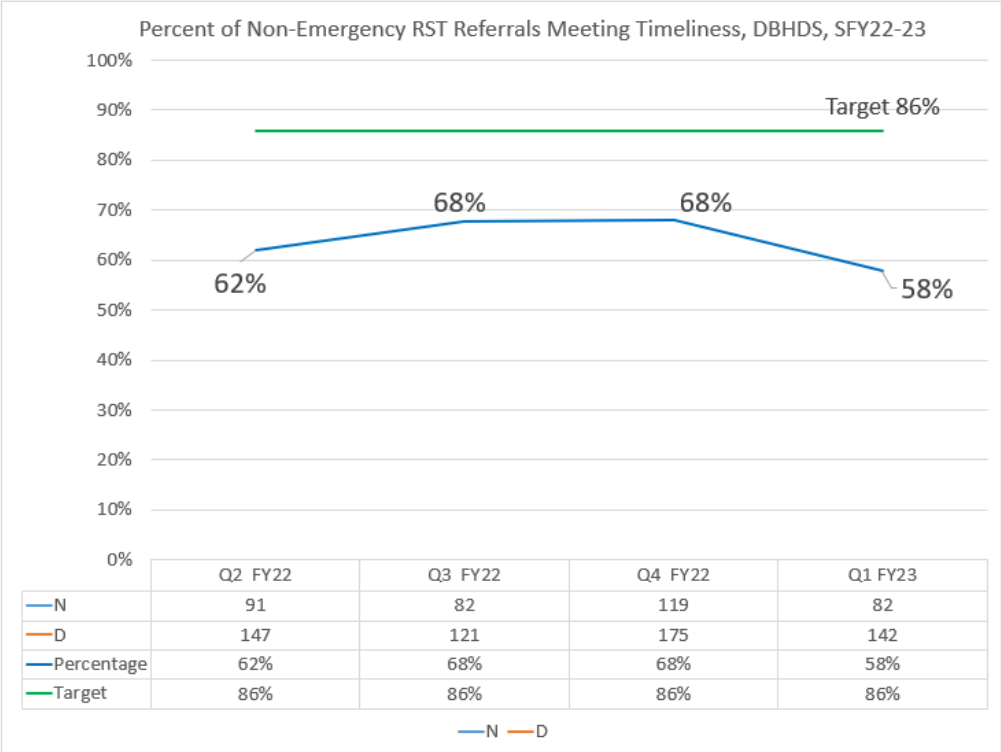
The measure related to CSB compliance with residential referrals (Figure 8) shows above target CSB performance in Q2 of FY22 with performance in the last two quarters within 3% of the target. Results declined in quarter one of FY23 dropping to 77%. The CMSC continues to request improvement plans from CSBs who experience two consecutive quarters of below target performance.

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 referral had occurred with Barrier 2 identified since the first quarter of FY21 until the first

quarter of FY23. A Barrier 2 referral refers to any referral where the RST confirms that a desired, more integrated service option does not exist in an individual's desired locality. For example, if a person wants to live in his or her own apartment in specific location, but there are no services that support apartment living available, as confirmed by the RST, Barrier 2 would apply.

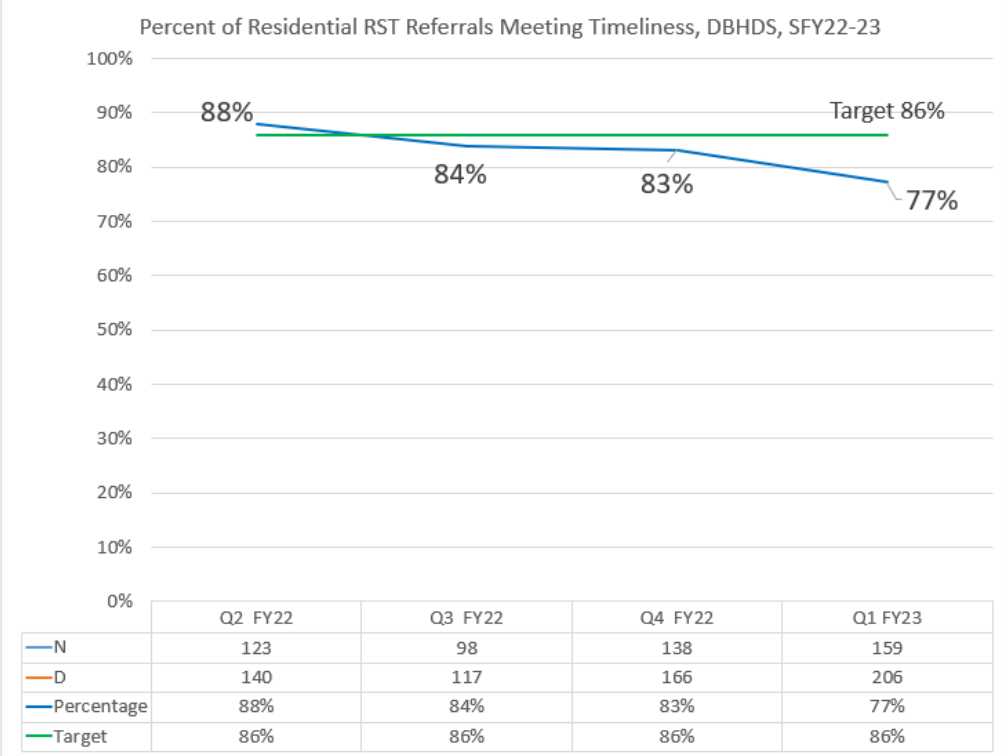
In quarter one of FY23, an individual was seeking a sponsored home within a 10-minute drive from a day support program. Beginning on the day after referral submission, the CRC contacted the CSB to initiate a discussion of possible options. Services were available in the area but had waiting lists. At the end of quarter two, the CRC continues to work with the CSB to identify and offer options for sponsored homes requesting that these options be discussed with the individual/family as recommended by the RST. The target date for resolution of this request is April 19th, 2023 to meet the related indicator with the established nine-month timeframe.

Fig. 7 RST Community Referral Timeliness through 4th quarter FY22-23



	Q2 FY22	Q3 FY22	Q4 FY22	Q1 FY23
N	91	82	119	82
D	147	121	175	142
Percentage	62%	68%	68%	58%
Target	86%	86%	86%	86%

Fig. 8 RST Residential Community Referral Timeliness through 1st quarter FY22-23



	Q2 FY22	Q3 FY22	Q4 FY22	Q1 FY23
N	123	98	138	159
D	140	117	166	206
Percentage	88%	84%	83%	77%
Target	86%	86%	86%	86%

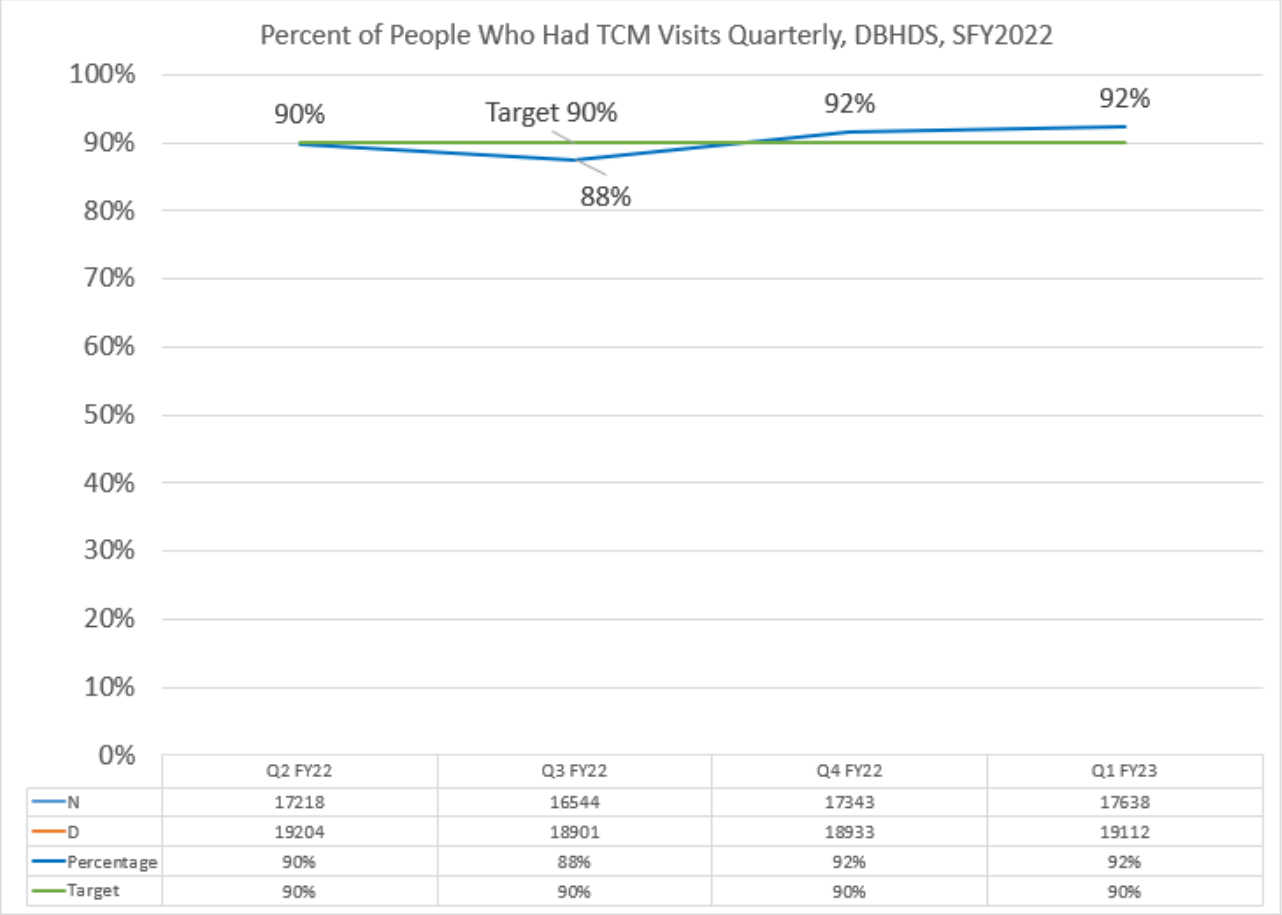
Provider Capacity

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

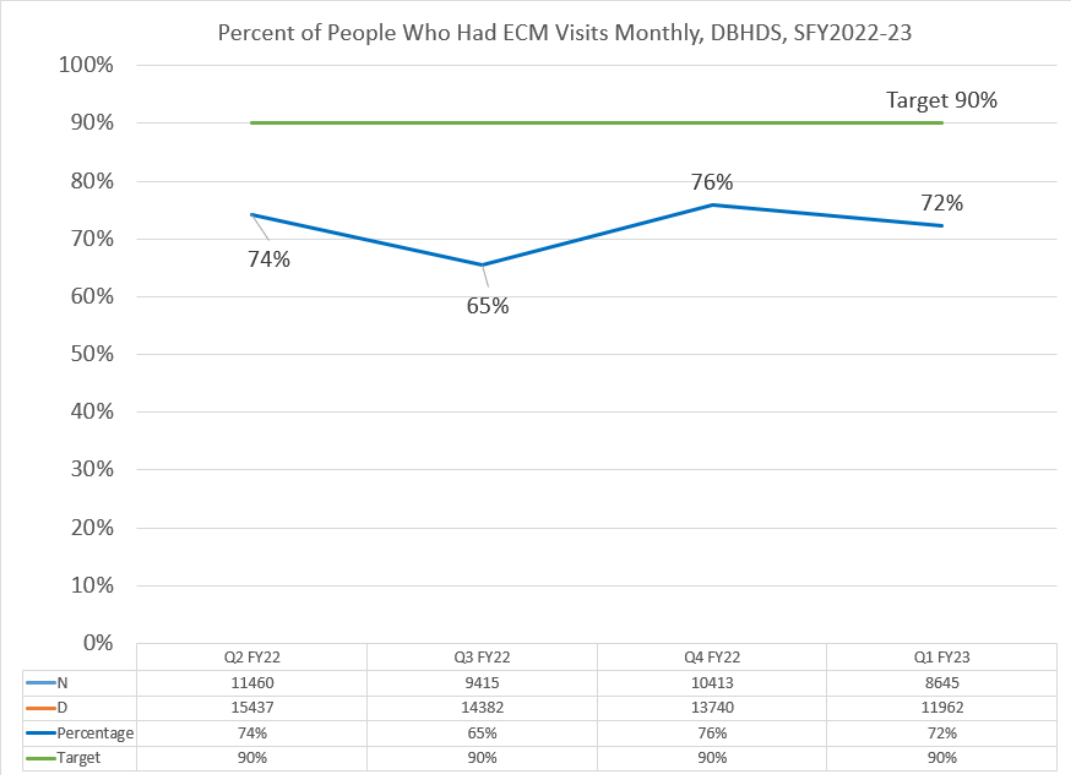
Data regarding Targeted Case Management face-to-face visits is available for FY22. Based on the results below, there was above target performance in all quarters except Q3 FY22 (Figure 10). Overall results for FY22 ECM face-to-face (Figure 11) and ECM in the home (Figure 12) ended below target for the year with some improvement noted in the 4th quarter of FY22. 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 will be included based on under performance in this area. The implementation of the SC Retention QII reported above is expected to support improvements in this area as well.

Fig. 10 TCM visits FY22-23



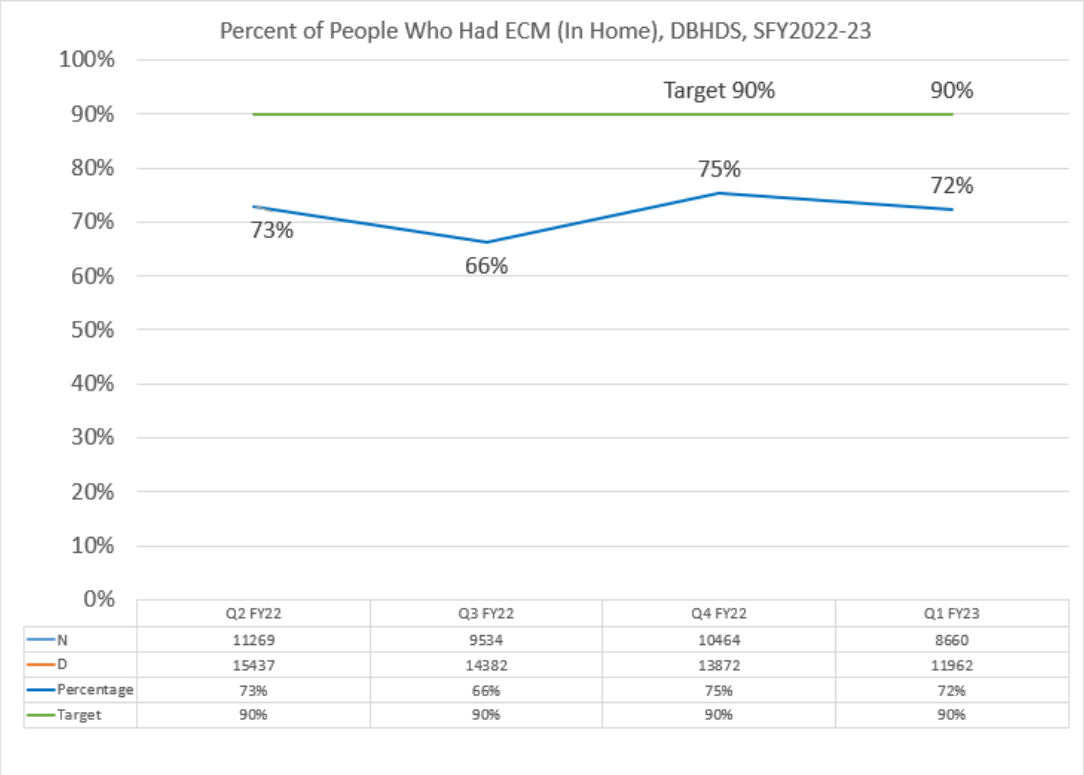
	Q2 FY22	Q3 FY22	Q4 FY22	Q1 FY23
N	17218	16544	17343	17638
D	19204	18901	18933	19112
Percentage	90%	88%	92%	92%
Target	90%	90%	90%	90%

Fig. 11 ECM face to face visits FY22-23



	Q2 FY22	Q3 FY22	Q4 FY22	Q1 FY23
N	11460	9415	10413	8645
D	15437	14382	13740	11962
Percentage	74%	65%	76%	72%
Target	90%	90%	90%	90%

Fig. 12 Face to face ECM visits in-home FY22-23



	Q2 FY22	Q3 FY22	Q4 FY22	Q1 FY23
N	11269	9534	10464	8660
D	15437	14382	13872	11962
Percentage	73%	66%	75%	72%
Target	90%	90%	90%	90%

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

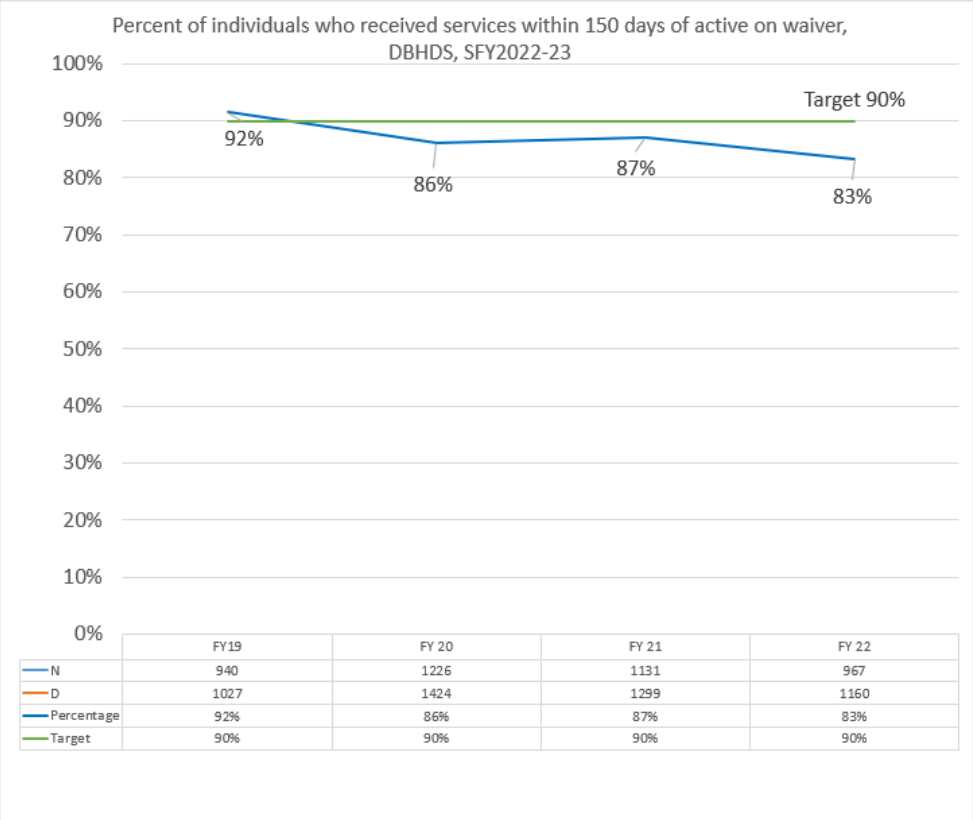
Number_in_compliance	Total_records	Percent_in_compliance
213	400	53%

Percentage of records in compliance by indicator, as reported by CSBs

Indicator	FY21 CSB-reported compliance	FY22 records in compliance	FY22 records not in compliance	FY22 CSB-reported compliance	Difference in % pts
Indicator 1	88.0%	367	33	91.8%	4%
Indicator 2	77.5%	311	89	77.8%	0%
Indicator 3	82.5%	161	239	40.3%	-42%
Indicator 4	85.0%	328	72	82.0%	-3%
Indicator 5	99.5%	400	0	100.0%	1%
Indicator 6	69.3%	347	53	86.8%	18%
Indicator 7	92.0%	336	64	84.0%	-8%
Indicator 8	93.0%	390	10	97.5%	4%
Indicator 9	50.3%	338	62	84.5%	34%
Indicator 10	74.8%	334	66	83.5%	9%

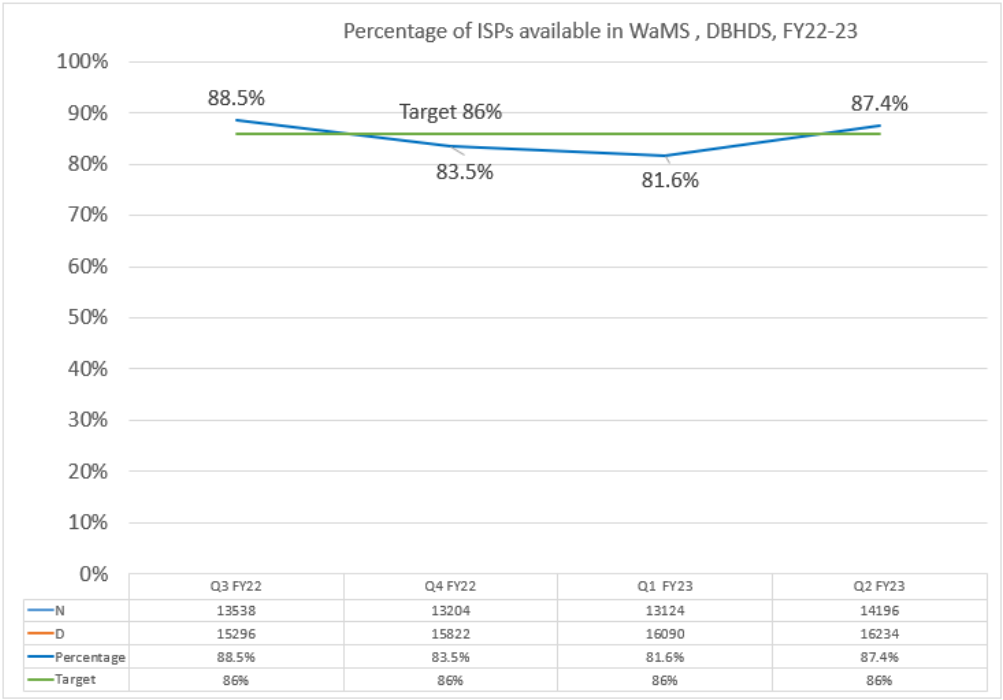
Fifty-three percent of records were found in compliance on at least nine out of ten indicators. This is an improvement from FY21, when 42% of records were found in compliance. Agreement between CSBs and OCQI improved on most indicators, with no significant decreases. For the second year in a row, the response rate was 100% with all records submitted on time. The percentage of CSBs reporting compliance with each indicator are displayed in Table 1, with the percentage from FY21 reported for comparison purposes. (Figure 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 three years between FY19 and FY21 (Figure 14). Performance dropped below target in FY22 where the result was 83%. Joint efforts with the Department of Medical Assistance Services (DMAS) will commence in FY23 to initiate services with individuals when the national public health emergency ends. Unused waiver slots will be reassigned as appropriate when services are declined or go uninitiated. The ISP compliance target returned to above target performance in the second quarter of FY23 with a result of 87.4% (Figure 15). The CMSC is working to begin a transition in data reporting for this measure in FY23. Currently, compliance is calculated on the status of ISPs at the point of the data pull. Once this effort is completed, data reporting will align with recommendations from the former DBHDS Office of Epidemiology and Health Analytics, which centered on ensuring that data is entered into a proper status by the effective date of each ISP. The data reporting provided to CSBs will be adjusted to this new method with an explanation of the reason for the change.

Fig. 14 Services within 150 days of Waiver FY19-FY22 results



	FY19	FY 20	FY 21	FY 22
N	940	1226	1131	967
D	1027	1424	1299	1160
Percentage	92%	86%	87%	83%
Target	90%	90%	90%	90%

Fig. 15 ISP compliance FY22-23



	Q3 FY22	Q4 FY22	Q1 FY23	Q2 FY23
N	13538	13204	13124	14196
D	15296	15822	16090	16234
Percentage	88.5%	83.5%	81.6%	87.4%
Target	86%	86%	86%	86%

Health, Safety, and Wellbeing

Change in Status and Appropriately Implemented Services

Reference	Measure	Numerator	Denominator
16 *(**PMI**) Figure 16*	The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. (Target 86%) **III.C.5.b.iii; V.F.2; V.F.5**	N = Number of records confirming all five checkboxes on SCQR question Q84 AND also confirming "yes" or "not applicable" on Q85	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs
17 (**PMI**) *Figure 16*	Individual support plans are assessed to determine that they are implemented appropriately. (Target 86%) **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. The results for both measures showed significant improvements in compliance, as well as the level of agreement seen across reviewers. Indicator 9 move from 50 to 84% success and indicator 10 increased from 75 to 84%. The substantial agreement seen in the look-behind and interrater review provides increased confidence in the reliability of these results.

Fig. 16 FY21-22 results for appropriately implemented services and change in status

Indicator 9 (FY22)	**Yes**	**FY22 Result**	**FY21 Result**
Q75: Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	86%	**84%**	**50%**
Q77: Did all four OSVTs have all areas under "Services Implemented Appropriately" completed?	92%		

Indicator 10 (FY22)	**Yes**		
Q75: Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	86%	**FY22 result**	**FY21 Result**
Q79: Did each OSVT have all areas under "Change In Status" and "Change in Status Determination" completed?	94%	**84%**	**75%**
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?	98%		

Indicator 9 Agreement FY22

Question(s)	% yes in full sample	Look Behind % agreement	Look Behind Maxwell's RE	Interrater % agreement	Interrater Maxwell's RE
OSVT completed for each of last 4 visits	86%	85%	0.7	94%	0.91
Services implemented appropriately completed	92%	90%	0.8	94%	0.91
Indicator met	85%	84%	0.68	94%	0.91

	CSB met	CSB not met
QI met	77	6
QI not met	10	7

Indicator 10 Agreement FY22

Question(s)	% yes in full sample	Look Behind % agreement	Look Behind Maxwell's RE	Interrater % agreement	Interrater Maxwell's RE
OSVT	86%	85%	0.70	94%	0.91
All areas completed	94%	95%	0.9	92%	0.88
Revisions made to ISP	98%	75%	0.67	70%	0.63
Indicator met	84%	82%	0.64	90%	0.85

	CSB met	CSB not met
QI met	74	7
QI not met	11	8

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). (Target 86%) **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. (Target 86%) **III.C.5.c; V.F.5**	N = Number of individual records for which the response was "Yes" to both components of SCQR Q26	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs annually

The charts below provide results as reported by CSBs in the third year of the SCQR. The FY22 look-behind demonstrated a high level of agreement with the exception that for Measure 19, Indicator 2 in the SCQR showed a moderate level of agreement when considering both items included in the indicator. Individually considered, the level of agreement was substantial in both cases.

Fig. 18 FY22 results for unpaid relationships discussion

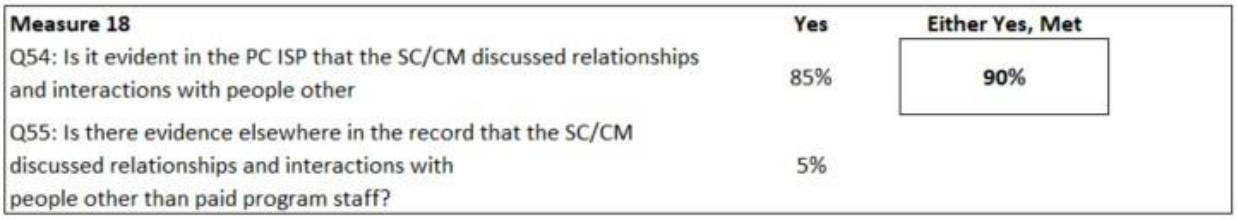


Fig. 19 FY21 results for choice indicator

Measure 18 Agreement FY22

Question text	% in full sample	Look Behind % agree	Look Behind Maxwell's RE	Interrater % agree	Interrater Maxwell's RE
Q54: Is it evident in the PC ISP that the SC/CM discussed relationships and interactions with people other than paid program staff?	85%	90%	0.80	94%	0.91
Q55: Is there evidence elsewhere in the record that the SC/CM discussed relationships and interactions with people other than paid program staff?	5%	87%	0.81	90%	0.85

Measure 19 (Indicator 2) Agreement FY22

Q22: Does the completed VIC confirm that the individual was offered a choice of...

Item	% yes in full sample	Look Behind % agreement	Look Behind Maxwell's RE	Interrater % agreement	Interrater Maxwell's RE
...support coordinator? (named)	79%	76%	0.64	96%	0.94
...DD waiver providers?	90%	87%	0.805	96%	0.92
Indicator met	78%	79%	0.58	98%	0.97

	CSB met	CSB not met
QI met	63	4
QI not met	17	16

Office of Licensing Data

In August 2022, the Office of Licensing presented the results of the annual Adequacy of Supports report to the Committee. OL described the results for the current year and compared against trends seen in the previous year, as well as the related OL corrective action plan and training processes.

For DD CM services, providers exceeded the 86% goal in each domain and cumulatively. Lower performance was seen on submitting serious incident reports on time and meeting with individuals face to face (69%, 85% respectively). Provider Development provided training to OL in March of 2022 to explain established processes around assessing for changes in status and the appropriate implementation of services. This process supports monitoring and improvement in the domains of Safety & Freedom from Harm and Stability, which are included in the OL monitoring process.

The data collected through the checklist developed by the OL, indicates that, of the providers reviewed between January 1, 2021 to December 31, 2021, over 86% of providers are able to demonstrate they are able to meet the needs of the individuals they serve. In addition to providing a review of the data, OL communication that efforts are underway to improve the reporting capabilities of the CONNECT system. This option will enhance the data available to the CMSC to assist with making decisions about additional actions needed to support CM providers.

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). 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.

Implementation of this process was delayed during the first two quarters of FY23 due to efforts to finalize the format for tracking citations. The format is now final and prepared for use. Beginning in Q3 FY23, DMAS will bring corresponding data on the final spreadsheet for discussion and tracking by the joint group. The focus of this process is ensuring that corrective actions related to the ten indicators are addressed in the CSB action plan that is subsequently approved by DMAS. Community Resource Consultant support will be offered to CSBs to assist with remediating identified issues and preparing planned actions for DMAS approval. Any subsequent citations will be tracked and remediated as identified.

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. Performance related to the measures showed improvement in Q4 of FY22 with some decline in Q1 of FY23 and remain below the 90% target as of this report.

To address past HSAG recommendations, the Office of Provider Development has updated the DD Support Coordination Handbook, which will be finalized through public comment in FY23 and made available to CSBs following this process. Recommendations from the Round 4 QSR reviews are pending at this time but will be included in the next report. 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.

The CMSC has requested data to monitor the retention of SCs across CSBs and conducted three focus groups with Support Coordinators and other CSB staff. These sessions were held September 27th to the 29th. Each session yielded a variety of actionable possibilities to address the challenges faced by SCs. The suggestions are being organized into categories, which include short and long-term implementation, as well as suggestions to be referred out to other offices and state agencies. Some of the more immediate adjustments already completed or being recommended to the Commissioner and Quality Improvement Committee include:

- Reduce the requirement to complete the On-site Visit Tool for people receiving Targeted Case Management to once per quarter (completed 10/6/22).
- Discontinue the requirement to use the Individual Planning Calendar in WaMS due to perceived lack of value and time needed for completion (completed 11/4/22).
- Clarify and simplify Enhanced Case Management guidance (completed 12/21/22).
- Clarify and simplify the DD Support Coordination Handbook (pending).
- Develop and provide standardized SC Onboarding Training (pending).
- Clarify how to complete the ISP since employment discussions are not required for individuals less than 14 or over 64 (pending).
- SC participation in Regional Support Team meetings on as-needed basis (pending).

Longer-term remedies include exploring ways to improve the provider database on the My Life My Community website, seeking additional functionality in the Waiver Management System, and partnering with the Offices of Licensing and Human Rights, as well as the Department of Medical Assistance Services to explore suggestions that extend beyond the scope of the Case Management Steering Committee.

Performance Contract Indicator Data

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

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

The Performance Contract with CSBs contains the specific activities to be carried out by DBHDS and by CSBs under contract with the DBHDS. The CMSC is working to expand the Improvement Plan process to identify and support the improvement of CSB performance in key areas monitored by the Committee. The

Improvement Plan (IP) process has been implemented by the CMSC that includes a "four pillars" of performance focus.

The first area relates to the indicator listed above for RST referrals, which has a threshold that is established by the Settlement Agreement and has been in use since October of 2020. During this report period, one CSB successfully completed an Improvement Plan (IP) for RST referral timeliness, which was closed by the committee in August. Six additional IP requests for RST referrals were issued in the report and remain open at this time.

The next step in the development process for the framework was to issue IP requests for ISP entry, which is necessary under the Performance Contract and to ensure that the Department has data available for reporting. In October 2022, 12 CSBs received an IP request from the committee due to having two consecutive quarters of below target performance with ISP entry. The committee has submitted a data request to modify how ISP data is reported. Based on the Actionable Recommendations report from the DBHDS Office of Epidemiology and Health Analytics, which stated recommendation 5 as "Ensure that ISPs are completed by their effective date," the committee has requested an additional column in the ISP compliance report. This additional data will replace the current method of confirming proper statuses prior to the date the data is pulled from WaMS.

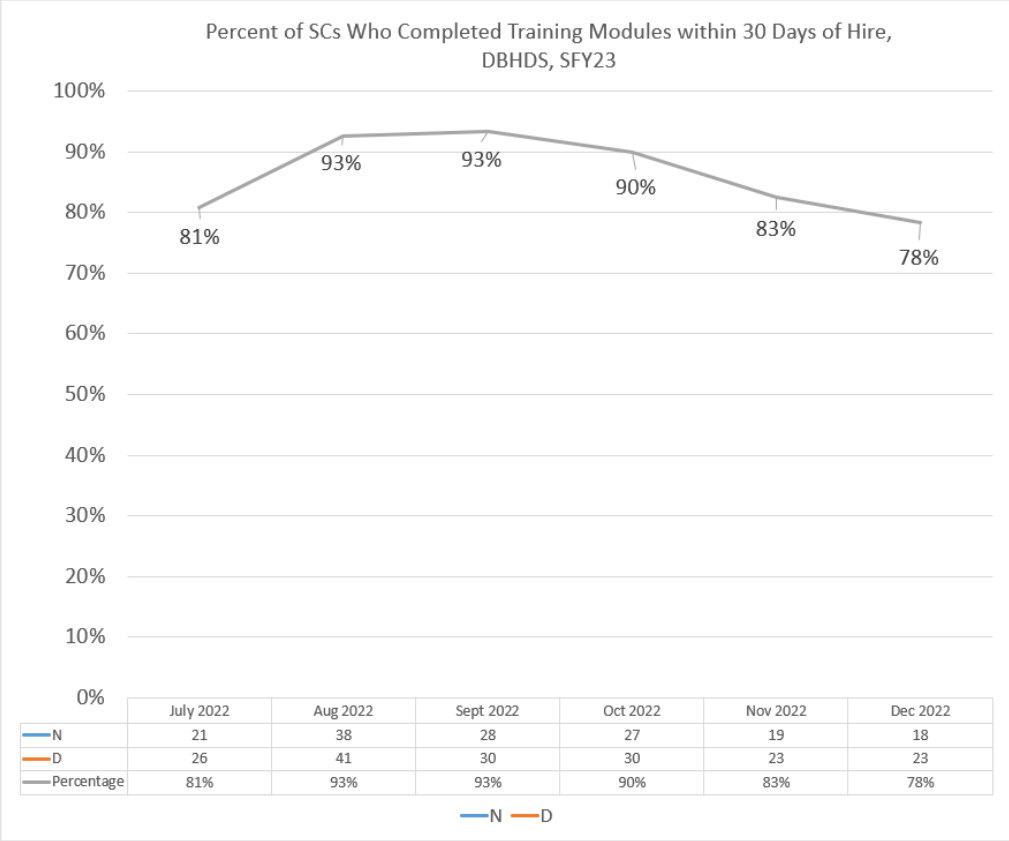
Implementation of the SCQR element began during the report period as well, but no CSB met the established criteria for an IP related to the SCQR, which includes performance below 50% on 3 or more indictors that show substantial agreement in the look-behind process.

Data Monitoring

Case Management Training and Competency

Support Coordinators/Case Managers are required to complete the DBHDS Case Management training online modules within 30 days of hire. A review of module usage between July and December 2022 shows that the completion rate exceeded 86% in 3 of the six months included in the report period. This shows a decline in performance from the last report where all six months were above 86%. The chart below conveys the percentage of DD CMs who completing the modules and the percentage who completed the modules within required timeframes (figure 20).

Fig. 20 Case Management Module Completion July to December SFY2023



	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
N	21	38	28	27	19	18
D	26	41	30	30	23	23
Percentage	81%	93%	93%	90%	83%	78%

Data Availability and Integrity

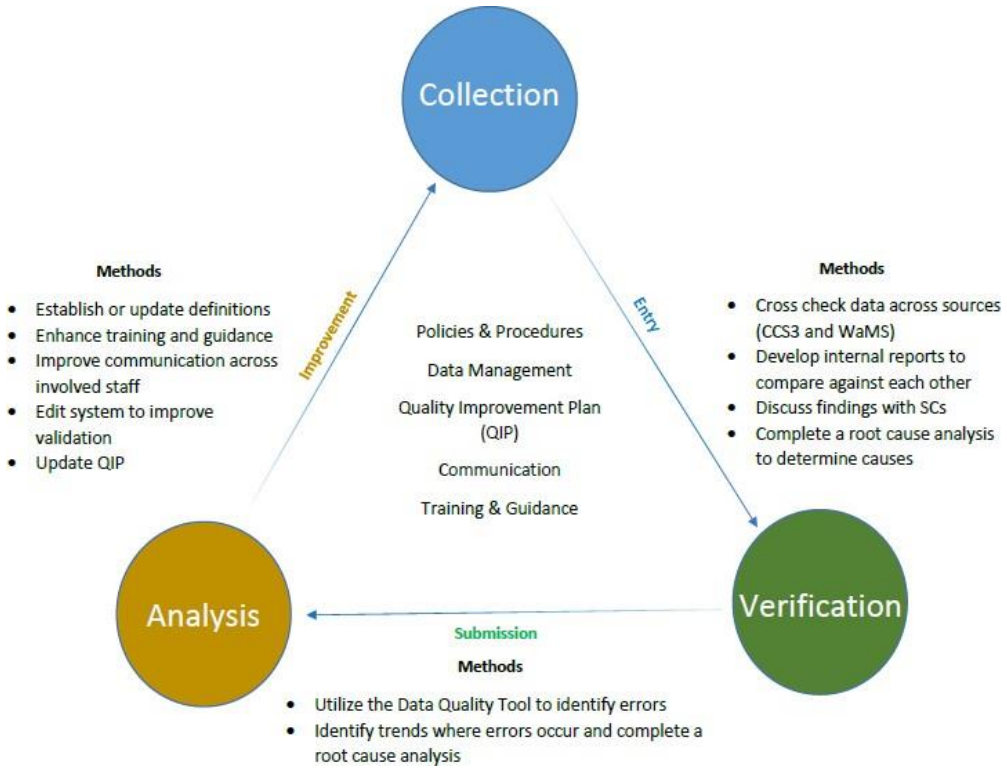
The CMSC monitors performance related to the availability of data in the Waiver Management System (WaMS), as well as the integrity of the data provided through CCS3. Specifically, regarding the requirements related to ISP entry, the CMSC has been monitoring the availability of WaMS ISP data per the Performance 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 is on the following:

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

Fig. 21 Data Quality Framework



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

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.

The committee will begin planning for the next cycle of Data Quality Support meetings in Q3 FY23 with meetings occurring in Q4. In addition to the sample review of data, the efforts will include a discussion of promising and best practices such as the use of data governance in agency processes.

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:

- 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.

Current Recommendations Include:

- Obtain and consider possible actions in response to Round 4 Quality Service Review Recommendations.
- Incorporate promising and /or best practice content into the Data Quality Support process.
- Complete WaMS RST system enhancements and provide training on updates to SCs.
- Cease requiring SC participation in routine RST meetings per the SC Retention QII.
- Produce and publish guidance for SCs regarding employment discussions with children less than age 14 and adults over 64.

- Complete the public comment period for the SC Operational Guidelines related to Enhanced Case Management and the DD SC Handbook.
- Continue the development of standard SC onboarding training materials to be made available across the system.
- Establish baseline data for SC Retention and begin monitoring progress over time as system improvements are implemented.

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.