Virginia Department of
Behavioral Health &
Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2023
3rd and 4th Quarters

Case Management Steering Committee

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

Key Accomplishments

From January to June 2023, 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 2023. The CMSC is responsible for 11 performance measure indicators (PMIs) and monitors an additional eight not included in PMI reporting.

Updates to the Individual Support Plan (ISP) were launched on May 2, 2023. The WaMS ISP format is updated annually, if needed, to improve the usefulness, content, and data related to individual plans.

In partnership with the Department of Medical Assistance Services (DMAS) Quality Management Review (QMR), a process was established to review ten case management indicators and associated DMAS CAPs. The Office of Provider Network Supports (OPNS) and QMR agreed on a review schedule and template. A full cycle was completed. Six CSBs were cited for one or more indicators. Four of the six accepted CRC technical assistance following the CAP. A notable barrier has been CSBs not accepting or responding to offers for additional technical assistance or support. This semi-annual result shows an increase in technical assistance since in the last reporting cycle only one CSB accepted technical assistance.

The CMSC participated in the Key Performance Area (KPA) Performance Measure Indicator (PMI) review process which entailed identifying data related to important reasons for each PMI and beginning to identify opportunities to improve and overcome related barriers.

The CMSC reviewed PMIs quarterly and produced a semi-annual report in March, 2023 which covered FY23 Q1 and Q2.

The CMSC made progress towards expanding how several PMIs can be examined. First, an option for the look-behind time frame for physical and dental exams was expanded to be 14 months and has been added to the monthly and quarterly ISP data reports. This allows for the probability that ISP meetings take place early, thus allowing for capturing physical/dental visits that take place within 12 months of the ISP meeting where inquiry occurs in addition to those within 12 months of the effective date of the new plan year. In addition, a measure has been added to the monthly ISP data report to examine the percent of individuals who want employment who have an employment outcome.

The CMSC continued a monthly review of CSB performance through the Four Pillar process. There were 10 total CSBs with an improvement plan for RST timeliness, two of which were successfully removed from the Watch List for achieving performance. There were 15 total CSBs with improvement plans for ISP Compliance, none have which have been removed yet due to delayed data for FY23 Q3.

CMSC developed and distributed a Letter to the Commissioner and letters to CSBs sharing data with them, in February 2023.

The SCQR review for calendar year 2022, taking place in FY23 Q3 and Q4, had 100% CSB completion.

The need for having Enhanced Case Management (ECM) and Targeted Case Management (TCM) data in a timelier manner has been an ongoing discussion point. In Q3, the Office of Community Quality Improvement (OCQI) worked with OPNS and the DBHDS Data Warehouse to develop TCM and ECM dashboards within PowerBI. Trainings for the CSBs were conducted the week of June 26. These dashboards are designed to help the CMSC and CSBs have more timely data and be able to identify the need for and monitor improvement efforts more effectively.

The CMSC successfully completed a QII focused on improving ECM and TCM in March 2023. The first change was to develop an Excel optional tool to help Support Coordinators determine when to begin and end Enhanced Case Management (ECM), which was completed in August 2021. The second change was the development of a training video related to ECM visits. These changes were tested with a support coordinator focus group for effectiveness and clarity. The final, third change was to revise the ECM guidance which was

completed in February 2023.

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 worked with the DBHDS Warehouse Team to refine the Data Quality Support Process. 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 past reports. The CMSC began discussions on the next round of meetings to be held in 2023, which will be comprised of a sample of CSBs to include any CSBs known by the committee to be having trouble with data entry. Now available for the second year of implementation is a PowerBI dashboard that includes case management contact data for four individuals per CSB. The data reviewed in the second cycle is limited to what is needed to confirm that face-to-face contacts are occurring as required and that waiver and wait list coding is provided accurately. These changes streamline the review process and compliment the ECM and TCM dashboards that have been established.

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 with performance results reported below. The RST process transitioned to the WaMS in December with systemwide adoption on January 1, 2023. This transition replaces most manual referral and data management processes and is expected to ease and enhance the collection and reporting of RST data. A few system enhancements were completed following the launch of the RST module. The current report period has focused on the development of the RST Dashboard in PowerBI. The transition to WaMS as the new source system for data has delayed the completion of key CM activities, such as having the means to determine CSB compliance with RST referrals. At the end of this report period, data required to make this determination is available and has been processed, so that compliance can be determined and communicated to CSBs, the DBHDS Commissioner, and the QIC.

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 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 FY23 submissions. While this technical assistance does not impact the record reviews underway, it is expected to improve the SCQR results occurring in FY24 when calendar year 2023 documentation is reviewed.

During the FY23 of the SCQR process, CSBs completed 100% of the sample. Due to adjustments made to the tool and technical guidance, DBHDS anticipates the reliability of the data to increase, which was evident between the second and third year of implementation. Opportunities to enhance this process occur once each year as new learning is incorporated. Main areas for improvement are providing clarity about expectations for each element assessed, as well as providing a designated location for holding information, so that results can be easily found. Annual ISP adjustments were made to provide locations for information assessed through the SCQR where no location previously existed. A comparison across FY21 to FY23 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 CSB-reported compliance	FY22 CSB-reported compliance	FY23 CSB-reported compliance
Old Indicator 1	88%	92%	
Old indicator 2	78%	78%	
...support coordinator? (named) [New indicator 1]	89%	79%	83%
...DD waiver providers? [New indicator 2]	98%	90%	93%
Indicator 3	83%	40%	54%
Indicator 4	85%	82%	88%
Indicator 5	100%	100%	100%
Indicator 6	69%	87%	84%
Indicator 7	92%	84%	89%
Indicator 8	93%	98%	99%
Indicator 9	50%	85%	84%
Indicator 10	75%	84%	84%
Records with either 9 or 10 indicators in compliance	**42%**	**53%**	**64%**

Key:

- **Indicator 1:** The CSB has offered each person the choice of case manager. (III.C.5.c) *
- **Indicator 2:** Individuals have been offered a choice of providers for each service. (III.C.5.c)
- **Indicator 3:** The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable. (III.C.5.b.i; III.C.7.b)
- **Indicator 4:** The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served. (III.C.5.b.i; III.C.5.b.ii)
- **Indicator 5:** The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individual's needs. (III.C.5.b.iii; V.F.2)
- **Indicator 6:** The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences. (III.C.5.b.ii; V.F.2)
- **Indicator 7:** The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team. (III.C.5.b.ii; V.F.2)
- **Indicator 8:** The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary. (III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)
- **Indicator 9:** The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences. (III.C.5.b.iii; V.F.2)
- **Indicator 10:** The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. (III.C.5.b.iii; V.F.2)

* In previous years, indicator one considered if the SC provided required signatures; however, this indicator was revised in the FY23 cycle to separate two elements that were combined in indicator two. The two elements are now established as indicator one and two for CM choice and provider choice respectively.

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.

From FY22, 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 tool, as well as confirmation that issues identified in the OSVT are documented properly in the record.

Identified Concerns

The Independent Reviewer's 22nd Report to the Court was submitted on June 13, 2023 and included one recommendation that relates to the work of the CMSC stated as:

- 3. DBHDS should continue its established quality improvement practice (e.g., the SCQR) of providing on-site technical assistance following its review of each CSB's measurable performance compared with the Department's standards. (See Provision III.C.5.d., Indicators 6.2, 6.3 and 6.4.)

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 in previous reporting. The CMSC has assisted with revising the WaMS Individual Support Plan, which launched on May 2, 2023. The annual ISP update cycle includes a focus on changes needed to increase consistency in understanding and documenting elements reviewed during the SCQR cycle. This process continues per standards previously established.

Quality Improvement Initiatives

Currently there are four active QIIs being implemented by the CMSC. Each QII is focused on an identified area of concern and is supported by information collected through discussions with stakeholders and seen in the data monitored by the committee. A new QII focused on ISP compliance was approved by the QIC in June 2023.

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

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: Completed

This QII has been completed. Implemented on May 12, 2021 in response to Quality Services Review (QSR) data, this QII centers on improving the frequency with which individuals receive ECM visits as defined in Virginia's Settlement Agreement. The guidelines around this requirement have consistently been reported as problematic for CSBs. This QII was 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. A focus group of CSBs has provided input, which resulted in the development of an automated worksheet, a questions and answers document was provided, and a guidance became available on the Town Hall website and all activities for this initiative are complete. While the ECM data may not show improvement, the changes through the QII were tested with focus groups who

said these resources 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.*
Status: Active

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.

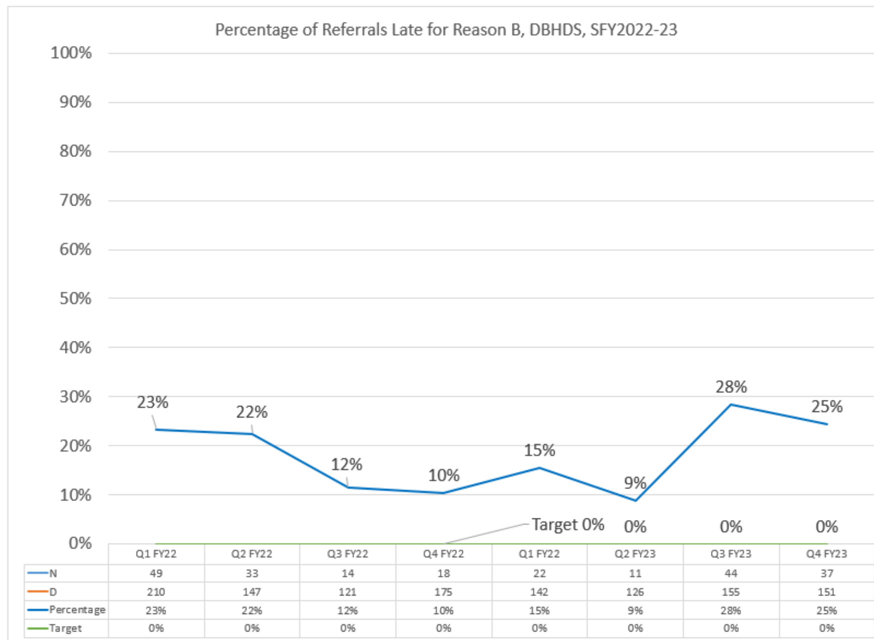
3. People with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (defined as independent living supports, in- home support services, supported living, and sponsored residential) have access to an option that meets their preferences 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 (Reason B) 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 clear 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 Q3 of FY23 where the percentage of these referrals increased to 28% (44/155) from the previous quarter's 9% (11/126). The related QII is designed to reduce the frequency of this reason due to its implications in low performance. In Q4, one Region IV CSB was noted to continue to have higher number of Reason B referrals, which will be explored in the coming report period to determine how to decrease these occurrences. 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	Q2 FY23	Q3 FY23	Q4 FY23
N	49	33	14	18	22	11	44	37
D	210	147	121	175	142	126	155	151
Percentage	23%	22%	12%	10%	15%	9%	28%	25%
Target	0%	0%	0%	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 sharing the CM assignment report and the method through which the rate of change will be tracked via WaMS assignment data with the support of WaMS Administration. For the SC Retention QII, the package of changes identified based on SC focus groups and input include:

1) Reduce the requirement to complete the On-site Visit Tool for people receiving Targeted Case Management to once per quarter (completed 10/6/22).
2) Discontinue the requirement to use the Individual Planning Calendar in WaMS due to perceived lack of value and time needed for completion. (completed 11/3/22).
3 Clarify and simplify Enhanced Case Management guidance (completed 12/21/22). Note: Public comment period through February 2023 and became effective March 2, 2023.
4) Clarify and simplify the DD Support Coordination Handbook (pending public comment).
5) Develop and provide standardized SC Onboarding Training (pending, draft developed).
6) Clarify how to complete the ISP since employment discussions are not required for individuals less than 14 or over 64 (pending).
7) SC participation in Regional Support Team meetings on an as needed basis. (Completed 2/27/23)

QII 5: Our goal is by June 2024, 100% (all) of CSBs will meet the ISP Compliance performance standard at 86% or above, meaning that at least 86% of their ISPs are in the correct status which is ISP completed or pending provider completion.
Status: Active

This QII was established to determine stakeholder understanding and resources needed to improve ISP Compliance. This process also sets out to modify the ISP compliance report to meet the recommendations made by the Data Quality & Visualization Office in 2022. The actionable recommendation was from the "WaMS_Follow-up_29NOV2022" report included as #5: Ensure that ISPs are completed by their effective date.

Our goal is by June 2024, 100% (all) of CSBs will meet the ISP Compliance performance standard at 86% or above, meaning that at least 86% of their ISPs are in the correct status which is ISP completed or pending provider completion. The baseline data for SFY 2023-Q2 was 70% of CSBs meeting the performance standard of 86%. ISP Compliance is defined as the percent of ISPs in the correct status per the CMSC performance standard.

An updated report has been created that includes an additional element, which is related to the percentage of compliance based on the effective date of each ISP. This is in addition to the existing column, percentage

compliant. The last step is to notify CSBs of plans to move to the new compliance percentage and provide the row level data reports for each CSB. The row level reports are expected in August 2023 and the following message has been drafted to be provided once they are available for sharing via MS Teams:

> "In the ISP Compliance folder under files, you will find the ISP Compliance report for Q3 FY23. We need to make you aware of an additional column included in the report. You will find two compliance columns. One column, labeled "Percent Compliance" shows the percentage of ISPs in proper status (i.e., pending provider completion or ISP completed) prior to the date that the data was pulled. This is an element that has been included in all past reports. A new column has been added to show the percent of ISPs that are placed in the proper status prior to the effective date of the ISP. This is a more accurate representation of ISPs being in the proper status and is in response to a November 2022 report from the Office of Epidemiology and Health Analytics at DBHDS (i.e., column "Percent Compliance Before Effective Date"). This need was included in the report as "Actionable Recommendation #5: Ensure that ISPs are completed by their effective date." We will be transitioning compliance to the new column following the completion of a quality improvement initiative to ensure that there is a consistent understanding about how compliance will be determined and to address any system issues to accomplishing this change. We expect the transition to occur in FY24 and will be announced at least 60 days prior to implementation. Thank you."

Once the data report is validated, aggregate and row level reports will be provided for Q3 and Q4 FY23 along with the message included above.

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.** *The PMI has been monitored by CMSC for years and it has not improved after multiple quality improvement initiatives designed to address known barriers. The CMSC feels that a better measure is to look at those individuals who have expressed an interest in employment, rather than everybody on the waiver. Thus, CMSC plans to remove this as a PMI and add the new surveillance employment measure. For employment, while the CMSC will discontinue monitoring, the Employment First Advisory Group plans to continue to monitor.*
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. DBHDS utilizes a variety of tools to remedy barriers to access to integrated services. Prior to even submitting an RST referral, CSBs are required to speak with the Community Resource Consultant for the region to resolve barriers to placement. Review of the data indicates that many individuals despite additional information have made decisions regarding providers. While the CMSC is retiring this as a formal PMI, the CMSC will monitor it as a CMSC measure instead to ensure no regression in community integration while simultaneously monitoring RST, CMSC, HSAG and Provider Data Summary data as well as discussions with stakeholder groups to identify what other barriers are preventing access to the most integrated settings.*
8	Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%). **III.D.6.**
9	People with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (defined as independent living supports, in-home support services, supported living, and sponsored residential) have access to an option that meets their preferences within nine months. **III.D.1**

Provider Capacity

10	People with DD Waiver receive face-to-face contacts from their support coordinator at least quarterly (Target 90%). **V.F.4.**
11	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month no more than 40 days apart (Target 90%). **V.F.4.**
12	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month in their residence (Target 90%). **V.F.4.**

13	Support coordination records reviewed across the state will be in compliance with a minimum of nine of the ten indicators assessed in the review. (Target 86%) **III.C.5.b.i**
14	86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations. **V.D.1.**
15	Individual Support Plans are available in the Waiver Management System by direct keyed entry or data exchange since October 7, 2019. **DBHDS Metric/Performance Contract**
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

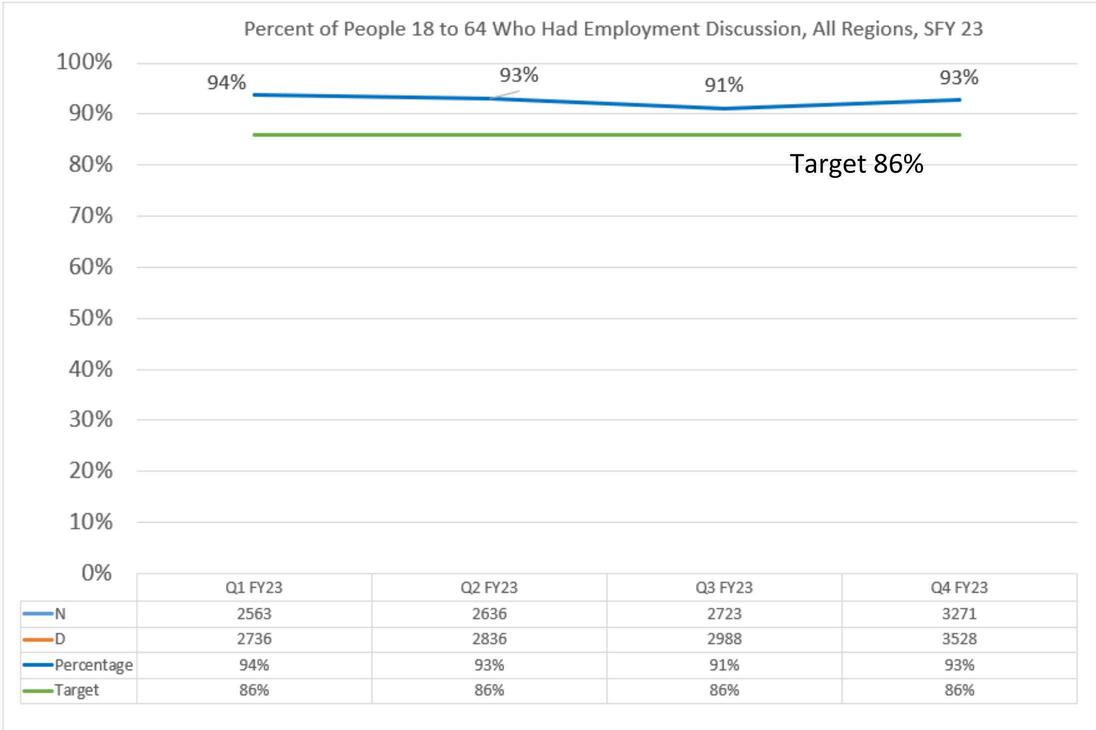
Employment Discussions and Goals

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 have increased to 59%, six percent higher than the last report, and which is the highest level seen to date.

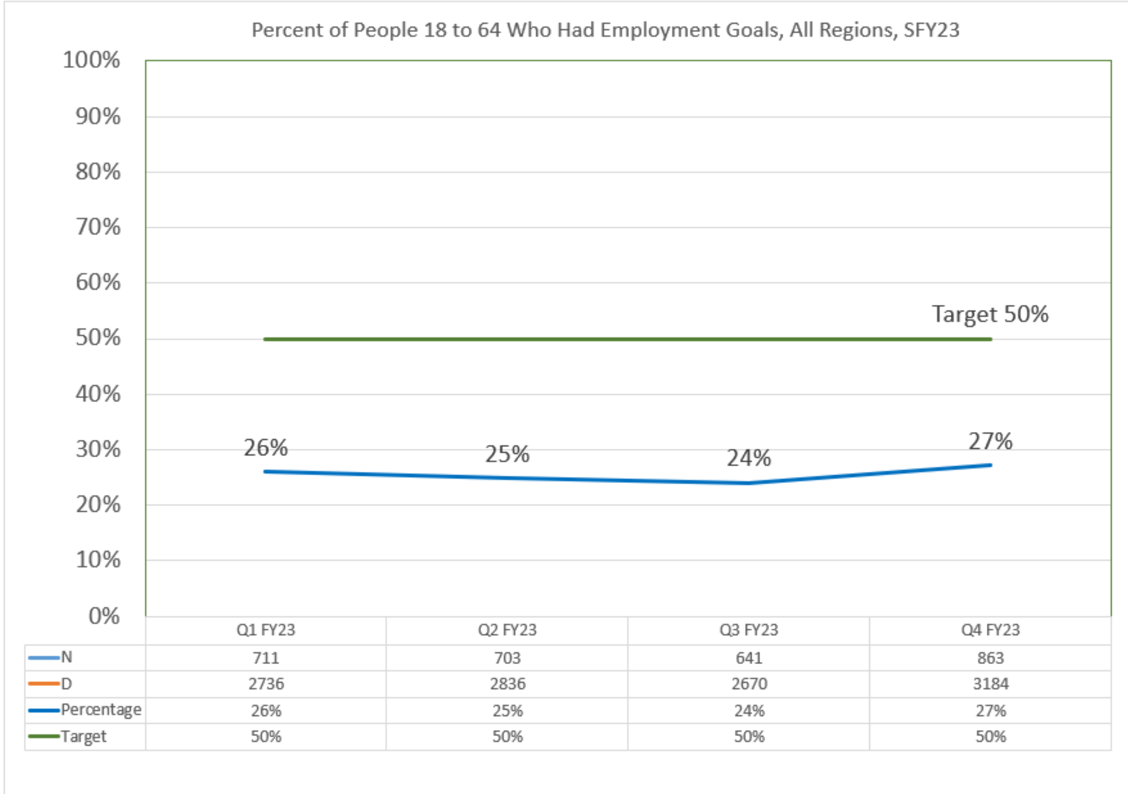
The CMSC is aware of past efforts by the Regional Quality Council (RQC) in Region V, which sought to provide training and measure improvements in SC knowledge, as well as to measure an increase in employment outcomes for people supported. The CMSC will continue to monitor and ensure the provision of technical assistance through the Offices of Provider Network Supports and Community Quality Improvement. Current results indicate that the first two measures remain largely consistent with past reporting. Measure 3, related to employment discussions with youth, increased to 51% and 59% in quarters three and four of FY23 respectively.

Fig. 1 Employment Discussions FY23



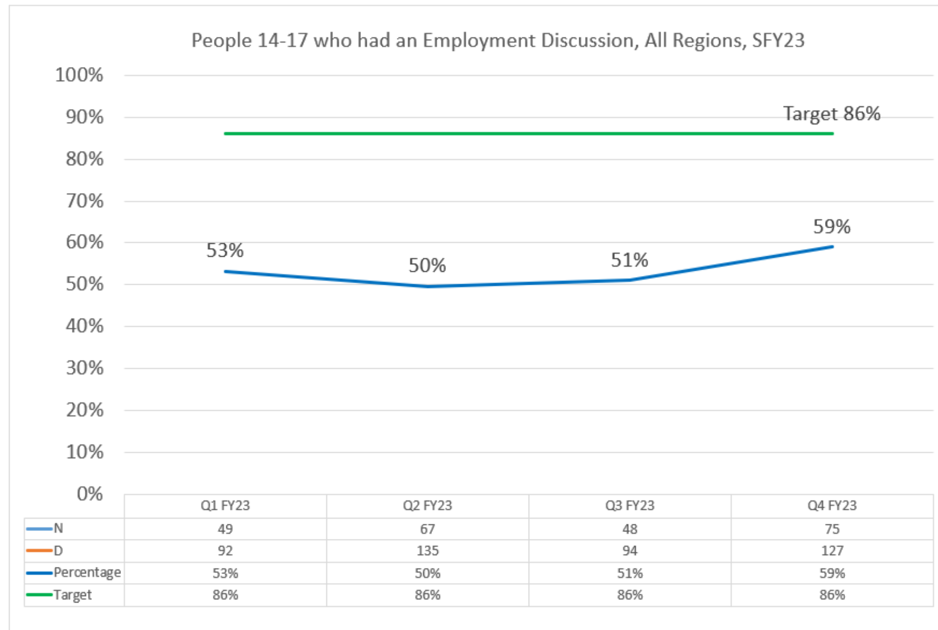
	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	2563	2636	2723	3271
D	2736	2836	2988	3528
Percentage	94%	93%	91%	93%
Target	86%	86%	86%	86%

Fig. 2 Employment Outcomes FY22-23



	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	711	703	641	863
D	2736	2836	2670	3184
Percentage	26%	25%	24%	27%
Target	50%	50%	50%	50%

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

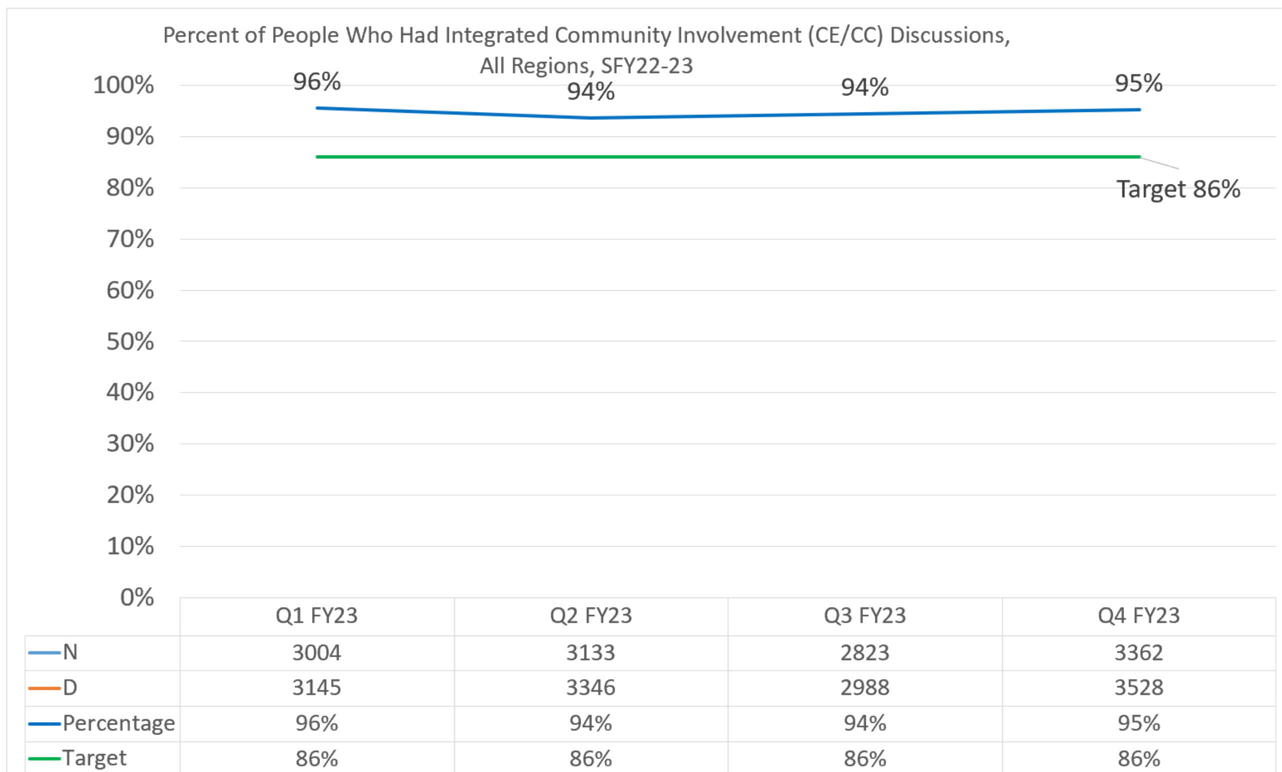


Community Engagement Discussions and Goals

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

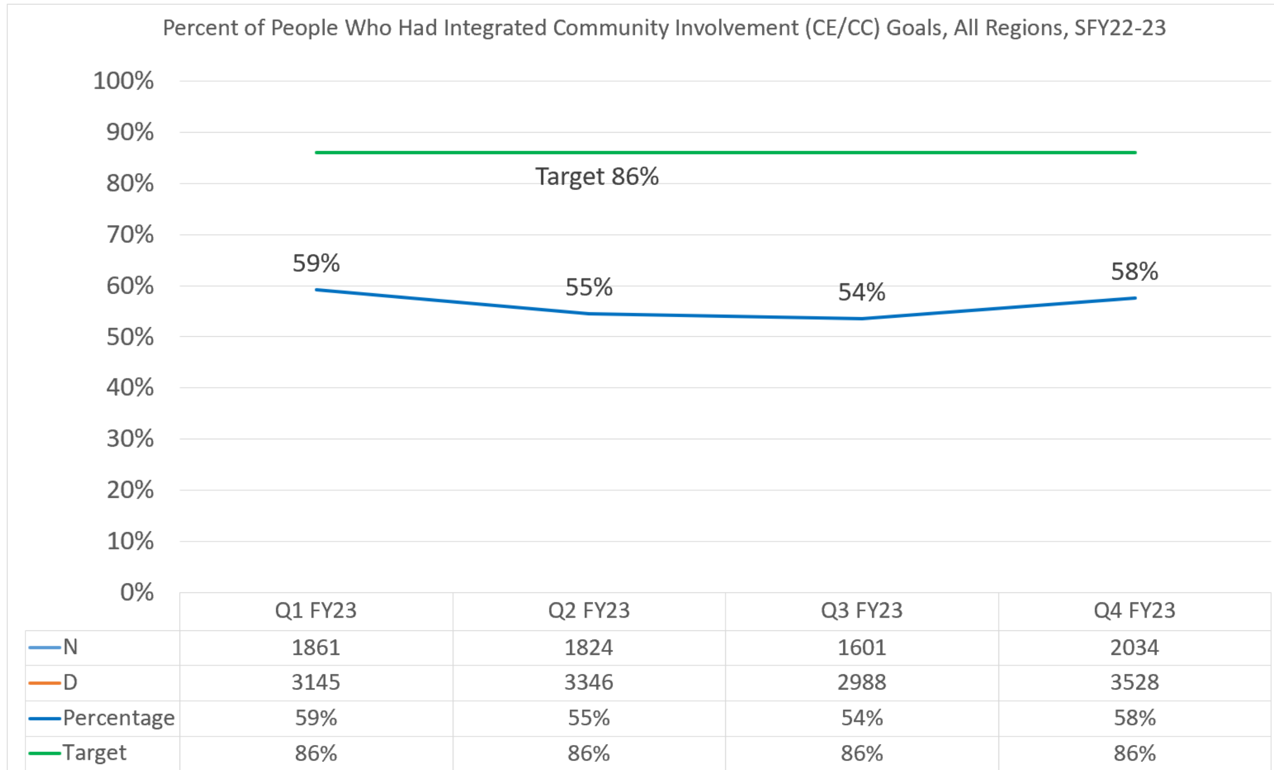
The measure related to individuals participating in a discussion about integrated community involvement has been consistently above target for the last four quarters, while the measure related to integrated community involvement outcomes has consistently been below target. The focus of these measures 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 FY23



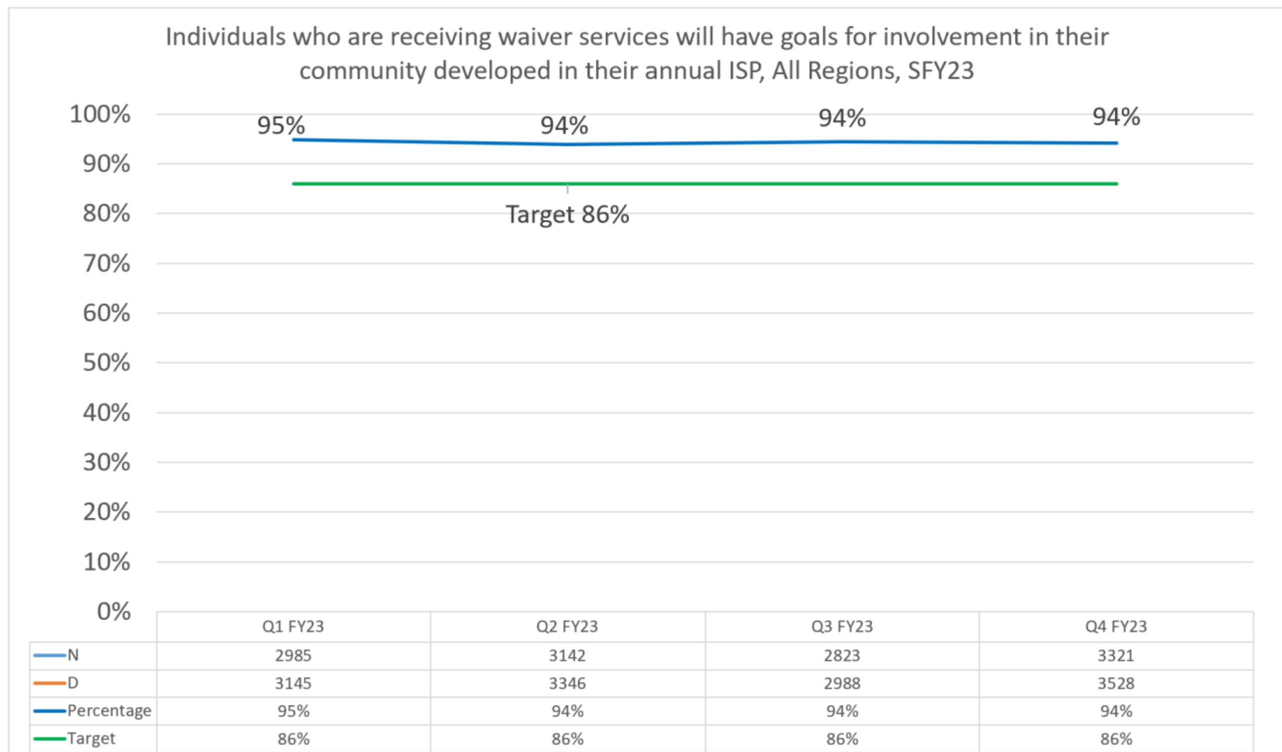
	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	3004	3133	2823	3362
D	3145	3346	2988	3528
Percentage	96%	94%	94%	95%
Target	86%	86%	86%	86%

Fig. 5 Integrated Community Involvement (Community Engagement) Outcomes FY23



	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	1861	1824	1601	2034
D	3145	3346	2988	3528
Percentage	59%	55%	54%	58%
Target	86%	86%	86%	86%

Fig. 6 Community Involvement Outcomes FY23



	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	2985	3142	2823	3321
D	3145	3346	2988	3528
Percentage	95%	94%	94%	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	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.

On January 1st, 2023, DBHDS moved the Regional Support Team (RST) process into the Waiver Management System (WaMS) as required by III.D.6. The first of two RST WaMS module overview sessions occurred on October 27th, 2022, in preparation for the transition to WaMS. This recording is available on the DBHDS website and shows the features and process of using the RST referral form and associated Virginia Informed Choice (VIC) form. CSBs had the option of using the system for referrals through December 2022 to adapt to the new process leading up to January 1. Overall, the launch of the module was considered successful; however, 11 referrals were accepted outside of WaMS after January 1 because they were submitted before the WaMS go live date and fell into the 3rd quarter meetings for their regions. By January 20th, 2023, a few defects and changes were identified and requested to improve the system. These system edits include:

- Barrier selection was initially included as an open text box, which required reformatting to a barrier listing with radio buttons so that barrier data can be pulled from the system.
- Tool tips were missing from the system for each of the barrier reasons, which were included to provide guidance to users on barrier descriptions.
- A corrected defect occurred where recommendations that were entered into the tracker by the RST for CSB review were disappearing from the tracker form. Where the recommendations were disappearing, no corrections could be made due to the status being "pending submitter closure."
- Confirmation of late reasons was added to the RST-completed portion of the referral to

ensure that lateness is confirmed by the RST.

- To clarify for users and improve data quality, a data label was improved to provide more detail, which states "If yes, SC confirms the CRC recommendations resolved the barrier to the individual/Authorized Representative's satisfaction?"
- Added a level 1 RST submission review, so that the CRC can receive and, if needed, return the initial submission back to the SC for editing.
- Added a level 2 submission review, following the SC acting on the CRC recommendations, so that the RST Coordinator can confirm that the correct option (i.e., barriers resolved or not resolved following CRC) was entered or submit back to the SC for correction.
- At the time of this report, one additional update was made to the VIC to ensure that the first and last name of the selected Support Coordinator is captured in the form.

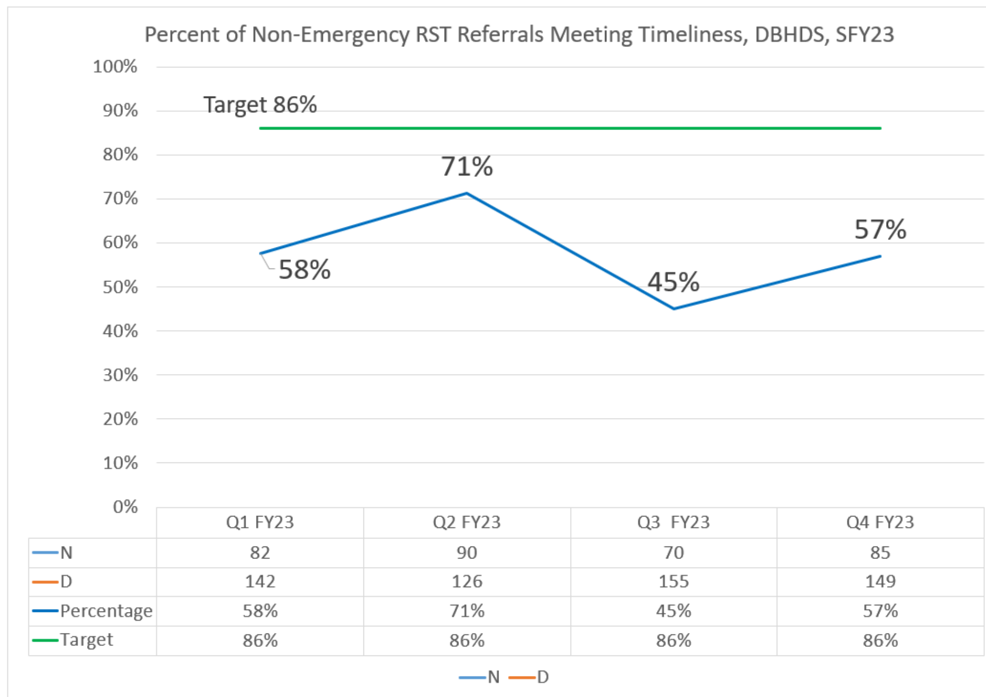
Data from the WaMS RST module has been added to a PowerBI dashboard and significant work has gone into development, which will be refined and improved over time. Complicating the process is the combination of WaMS data with data collected through the 11 referrals that were accepted outside of WaMS in Q3, as well as the data elements that were added to ensure the accuracy and availability of needed data. Due to the system updates, concerns with data collection have been resolved, however, Q3 and Q4 of FY23 will combine RST confirmed lateness with CSB asserted lateness in performing calculations for the RST measures.

The method used to arrive at Q3 and Q4 results included:

- The export of data from the PowerBI dashboard for referral counts by CSB including the number that did not meet any late criteria, the number that met Reason A (Individual has or will move prior to the RST meeting due to SC not submitting the referral within 5 calendar days of presenting a less integrated setting), Reason B (Individual has or will move without sufficient time to implement RST Recommendation(s), and Reason C (Individual moved without CSB notification). For these counts in Q3, data was pulled from RST confirmations for 51 referrals, and supplemented with CSB-asserted reasons for 84 referrals. For these counts in Q4, data was pulled from RST confirmations for 98 referrals, and supplemented with CSB-asserted reasons for 38 referrals.
- The export of PowerBI data for the referral question: "Are more integrated residential options (to include Independent Living Supports, In-home Support Services, Supported Living, Sponsored Residential) not operating in the desired location, if requested?"
- In Q3, a manual review of 11 submitted referrals to determine lateness for Reason A (0), Reason B (3), and Reason C (2). No referrals were accepted outside of WaMS in Q4.
- A review of 138 service authorizations to determine where RST referrals were required and not submitted (9).
- The removal of DBHDS data in calculating the RST measure attributed to CSBs.

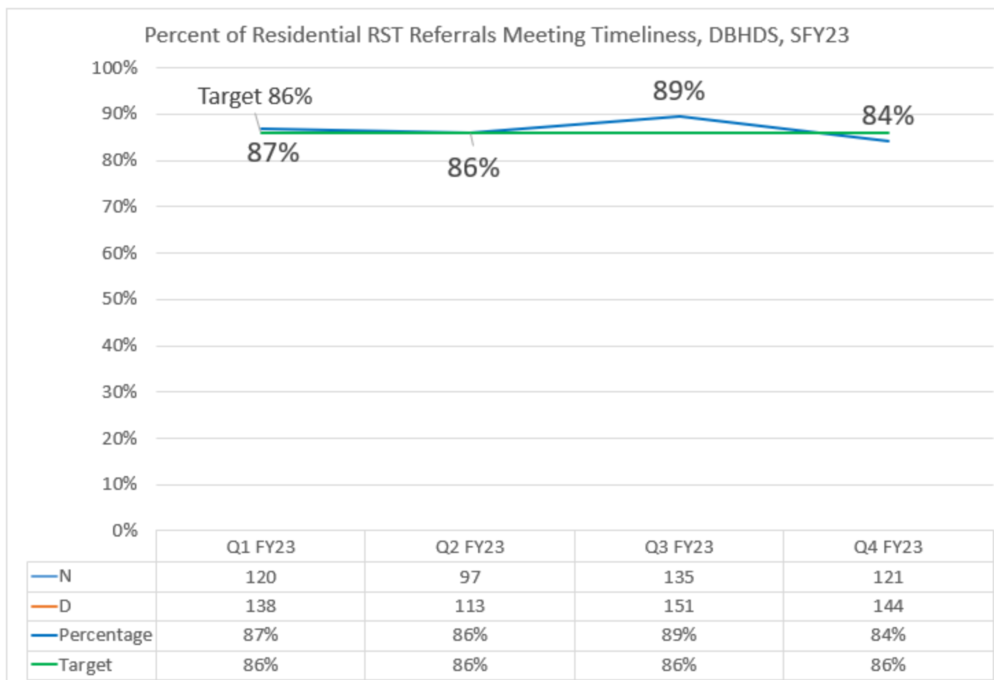
Based on the process listed above, an Excel spreadsheet was used to combine and calculate the three RST measures monitored by the CMSC. The results of these calculations are provided below.

Fig. 7 RST Community Referral Timeliness FY23



	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	82	90	70	85
D	142	126	155	149
Percentage	58%	71%	45%	57%
Target	86%	86%	86%	86%

Fig. 8 RST Residential Community Referral Timeliness FY23



	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	120	97	135	121
D	138	113	151	144
Percentage	87%	86%	89%	84%
Target	86%	86%	86%	86%

Fig. 9 Number of individuals meeting criteria for Indicator #13

RST Referral Form Question: Are more integrated residential options (to include Independent Living Supports, In-home Support Services, Supported Living, Sponsored Residential) not operating in the desired location, if requested?

Region	2023 Q3 No	2023 Q3 Total	Total
Region I	27	**27**	**27**
Region II	12	**12**	**12**
Region III	17	**17**	**17**
Region IV	53	**53**	**53**
Region V	26	**26**	**26**
Total	**135**	**135**	**135**

Region	2023 Q4 No	2023 Q4 Total	Total
Region I	25	**25**	**25**
Region II	14	**14**	**14**
Region III	29	**29**	**29**
Region IV	38	**38**	**38**
Region V	30	**30**	**30**
Total	**136**	**136**	**136**

Measure 9, Numerator and Denominator	Count
Numerator = Number of referrals confirmed as resolved within the 9-month timeframe calculated in WaMS	N/A
Denominator = Number of RST referrals where the RST confirmed the barrier stated as “Are more integrated residential options (to include Independent Living Supports, In-home Support Services, Supported Living, Sponsored Residential) not operating in the desired location, if requested?” as yes.	0

Fig. 9

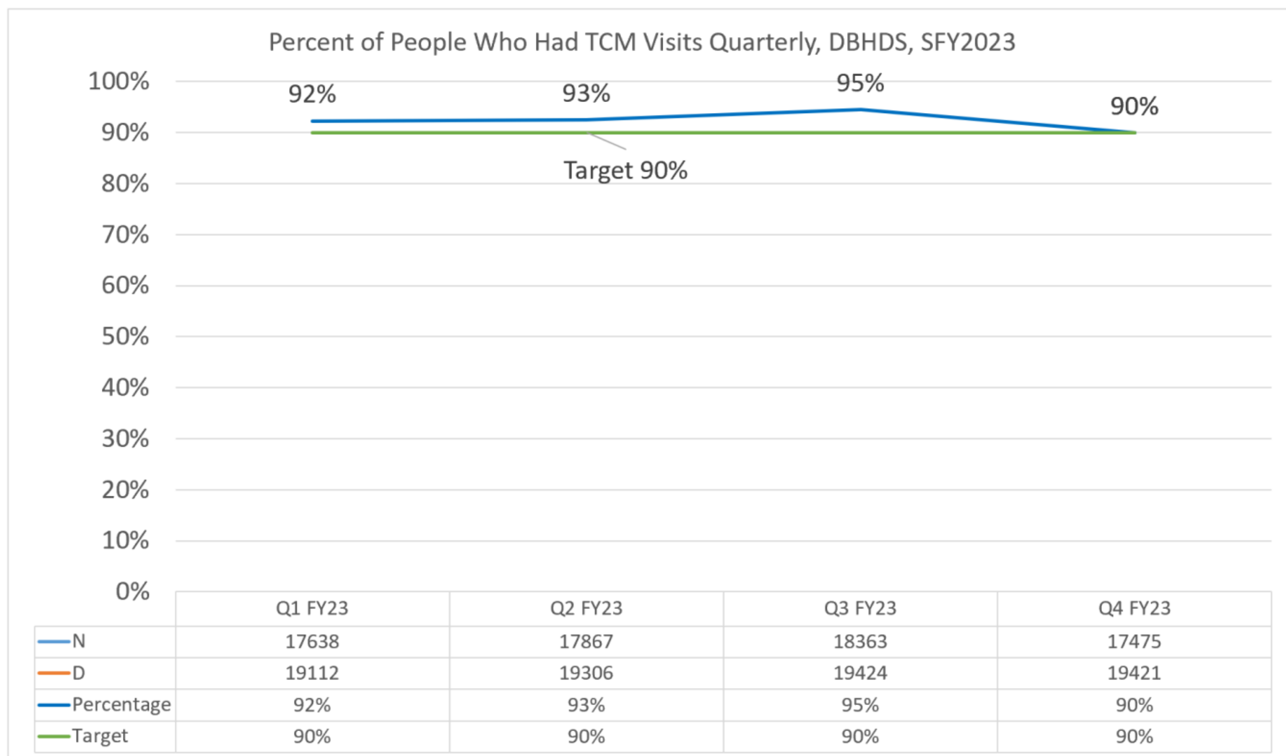
Provider Capacity

Case Management Face to Face Visits (F2F) and Effectiveness

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

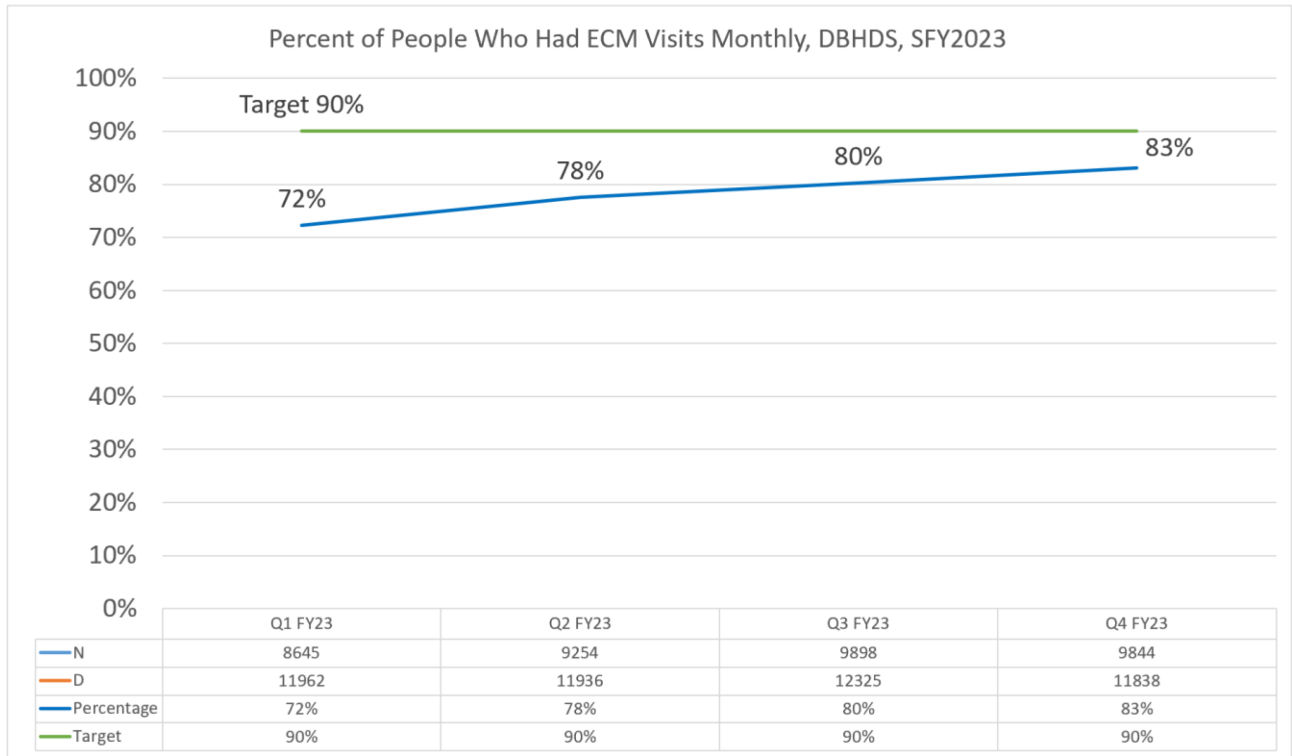
Data regarding TCM face-to-face visits is available for FY23. Based on the results below, there was above target performance in all quarters of FY23 (Figure 10). Overall results for FY23 ECM face-to-face (Figure 11) and ECM in the home (Figure 12) ended below target for the year, however both show an incremental improvement throughout FY23. In the third quarter FY22, the Office of Provider Network Supports began a Data Quality Support Process with CSBs to examine a sample of case management contact data to enable comparisons between CCS, WaMS, and CSB electronic health records. The primary focus of these sessions is to support CSBs with identifying and resolving any data reliability and validity issues. This process 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. As of this report, a finalized PowerBI dashboard has been developed for conducting these reviews in calendar year 2023.

Fig. 10 TCM visits FY23



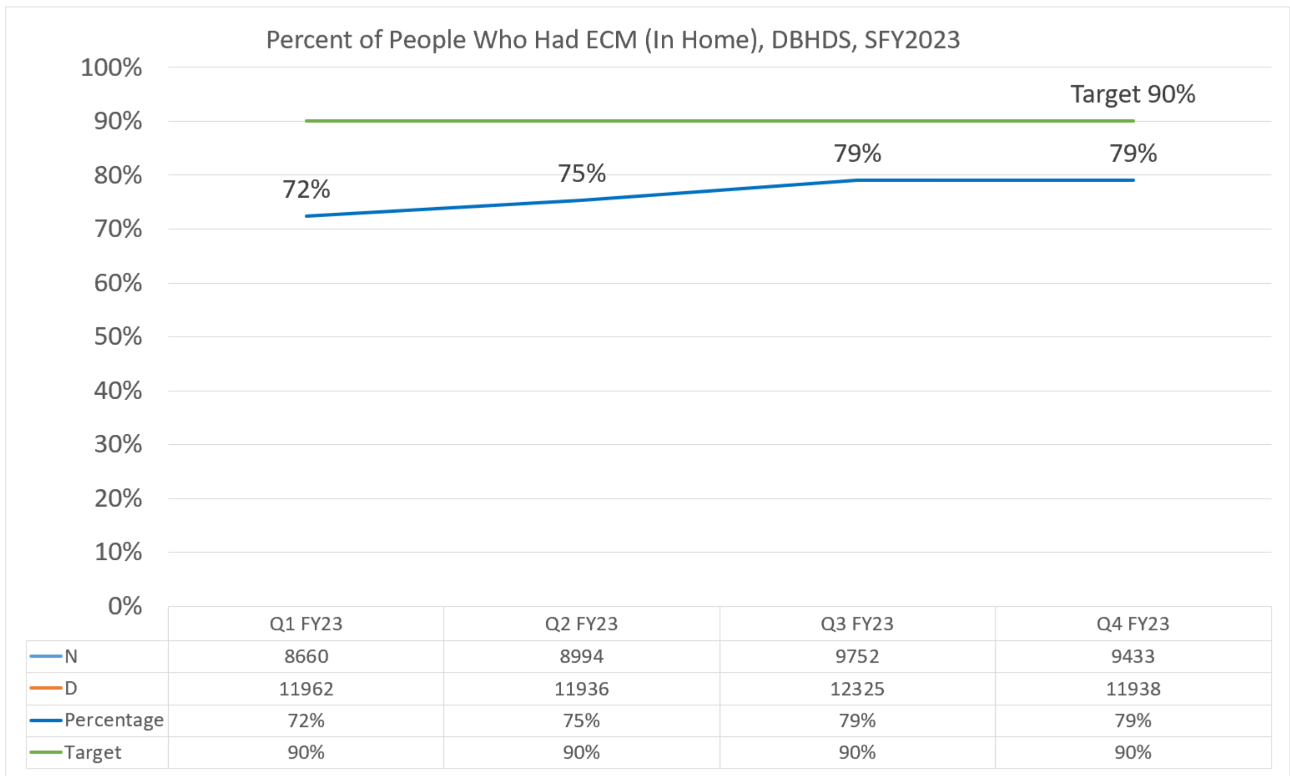
	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	17638	17867	18363	17475
D	19112	19306	19424	19421
Percentage	92%	93%	95%	90%
Target	90%	90%	90%	90%

Fig. 11 ECM face to face visits FY23



	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	8645	9254	9898	9844
D	11962	11936	12325	11838
Percentage	72%	78%	80%	83%
Target	90%	90%	90%	90%

Fig. 12 Face to face ECM visits in-home FY23



	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	8660	8994	9752	9433
D	11962	11936	12325	11938
Percentage	72%	75%	79%	79%
Target	90%	90%	90%	90%

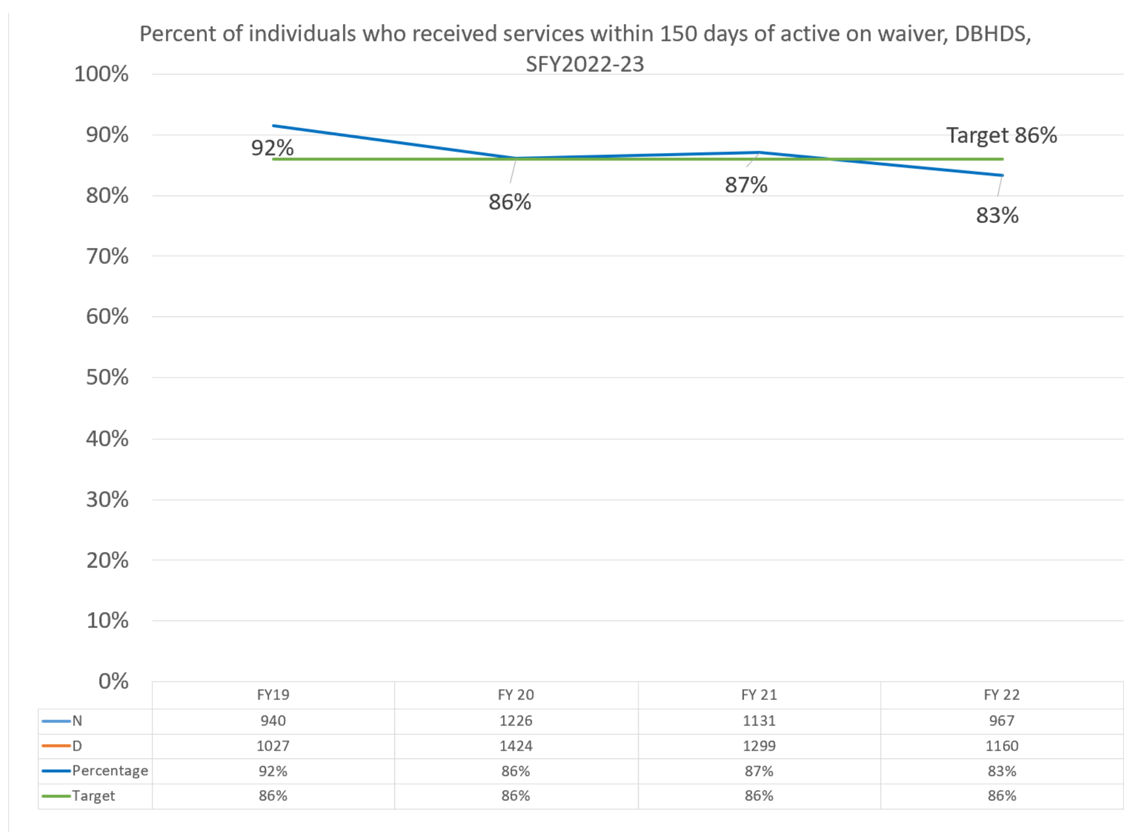
Sixty-four percent of records were found in compliance on at least nine out of ten indicators. This is an improvement from FY22, when 53% of records were found in compliance. Agreement between CSBs and OCQI has been improving on most indicators, with no significant decreases. The percentage of CSBs reporting compliance with each indicator are displayed, with the percentage from FY21 to FY23 reported for comparison purposes. (Figure 13).

Fig. 13 Records in compliance with 9 of 10 assessed indicators FY23

Indicator	FY21 CSB-reported compliance	FY22 CSB-reported compliance	FY23 CSB-reported compliance
Records with either 9 or 10 indicators in compliance	**42%**	**53%**	**64%**

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) have occurred in FY23 to initiate services with individuals following the national public health emergency ends. Data for FY23 will be available once the 150-day post-period occurs and will be reported in the next semi-annual report.

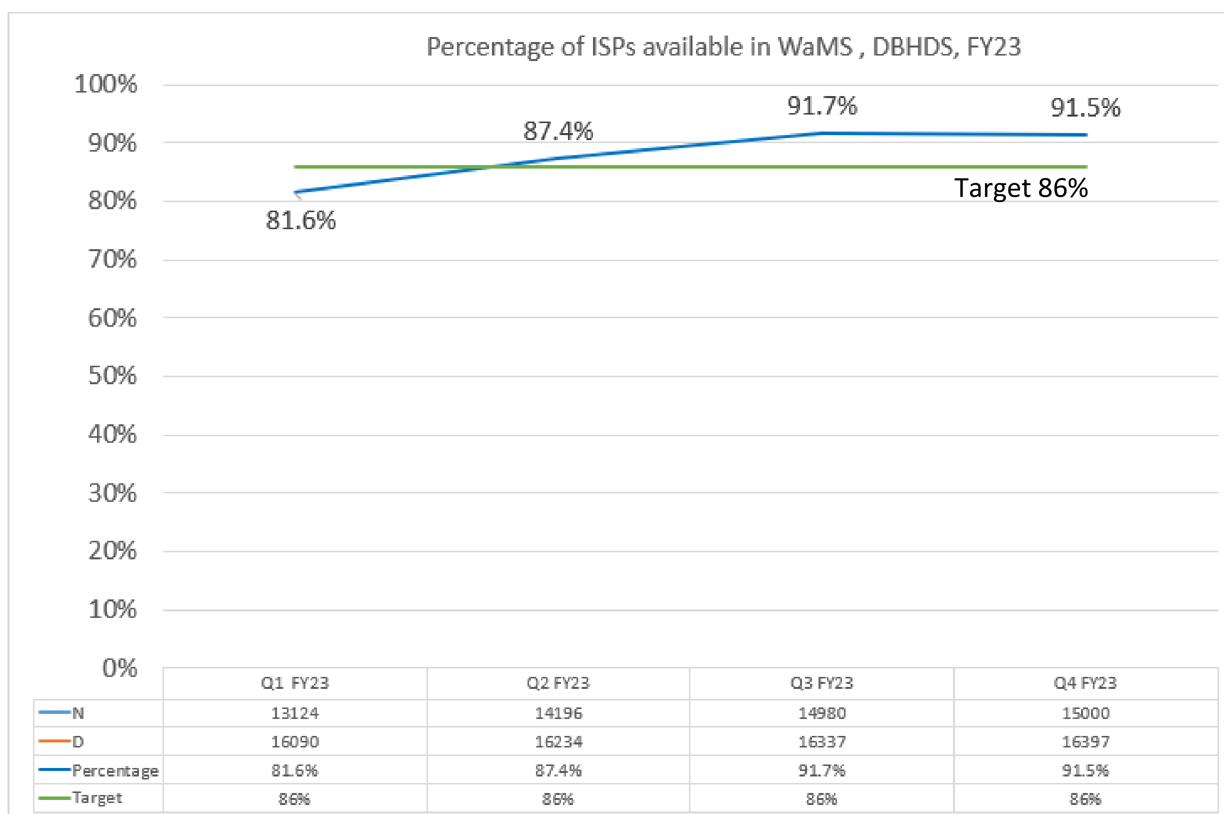
Fig. 14 Services within 150 days of Waiver FY19-FY22 results



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

The ISP compliance target returned to above target performance in the second quarter of FY23 with a result of 87.4% and increased to 91.7% and 91.5% in Q3 and Q4 respectively (Fig. 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. 15 ISP compliance FY23



	Q1 FY23	Q2 FY23	Q3 FY23	Q4 FY23
N	13124	14196	14980	15000
D	16090	16234	16337	16397
Percentage	81.6%	87.4%	91.7%	91.5%
Target	86%	86%	86%	86%

Health, Safety, and Wellbeing

Change in Status and Appropriately Implemented Services

Reference	Measure	Numerator	Denominator
16 *(***PMI***)* *Figure 16*	The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. (Target 86%) **III.C.5.b.iii; V.F.2; V.F.5**	N = Number of records confirming all SCQR questions 77 AND also confirming "yes" or "not applicable" on Q79	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs
17 (**PMI**) *Figure 16*	Individual support plans are assessed to determine that they are implemented appropriately. (Target 86%) **III.C.5.b.iii; V.F.2; V.F.5**	N = Number of records confirming all SCQR questions 72 and 74	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs

The charts below provide results as reported by CSBs in the FY23 SCQR submitted results. The results for both measures showed significant improvements in compliance. Indicator 9 increased from 84 to 91% success and indicator 10 increased from 75 to 84%. Substantial agreement in the look-behind and interrater review provides increased confidence in the reliability of these results. Levels of agreement for the FY23 reporting will be available following the look-behind period in October 2023 and will be included in the next report.

Fig. 16 FY23 results for change in status.

	No	Yes	Total	Percentage
Measure 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%) *(SCQR Indicator 10)*	76	403	479	84.1%

FY21	FY22	FY23
75%	84%	84%

Fig. 17 FY23 results for appropriately implemented services and change in status.

	No	Yes	Total	Percentage
Measure 17 : Individual support plans are assessed to determine that they are implemented appropriately. (Target 86%) *(SCQR Indicator 9)*	78	401	479	83.7%

FY21	FY22	FY23
75%	84%	84%

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 Q42	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs
19 **(PMI)** *Figure 19*	Individuals are given choice among providers, including choice of support coordinator, at least annually. (Target 86%) **III.C.5.c; V.F.5**	N = Number of individual records for which the response was "Yes" to both components of SCQR Q26	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs annually

The charts below provide results as reported by CSBs in the current year of the SCQR. These results are based on CSB-submitted data and will include the levels of agreement found through the look-behind process in the next report. The CMSC has added clarified instruction to the Virginia Informed Choice (VIC) form available on the DBHDS website and has submitted a change request to WaMS Administration to ensure that the SC first and last names are added to the VIC.

Measure 18, Fig. 18 FY23 results for unpaid relationships discussion

	Yes	No	Percentage
Measure 18: Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff). (Target 86%)	430	49	89.8%

Measure 19, Fig. 19 FY21 to FY23 results for choice

Indicator	FY21 CSB-reported compliance	FY22 CSB-reported compliance	FY23 CSB-reported compliance
...support coordinator? (named) [New indicator 1]	89%	79%	83%
...DD waiver providers? [New indicator 2]	98%	90%	93%

Office of Licensing Data

In May 2023, the Office of Licensing (OL) presented the results of the annual Adequacy of Supports report to the Committee covering July 1, 2022 to Dec. 31, 2022. 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 CM: Overall result was reported as 82.71%. Stability was 42.86%, but only seven CSBS were reviewed. Some areas of decrease and increase:

- Areas of decrease included: Access to services, physical, mental & behavioral health and well-being, community inclusion and stability.
- There was a significant decrease in the stability measures (12VAC35-105-124) where three CSBs were compliant and four were noncompliant. This concern was reported as possibly being associated with CSB ability to recruit and maintain qualified staff.

The CMSC continues implementation of the SC Retention QII as reported above, which is designed to increase the retention rate of SC across the system. Future OL reporting will be compared against the results of the QII to determine if any correlations can be made between the two findings.

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."

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

Identified CSBs are included as a standing item at these meetings. DMAS provides the names of CSBs cited along with any progress made in programmatic changes or approved Corrective Action Plans that indicate

progress or lack of progress toward resolving concerns.

- Letters are provided to DBHDS by QMR
- Names of CSBs are added to the quarterly meeting agenda for cross-agency discussion
- Tracking the remediation of issues is included with each agenda; any unresolved remediation will carry over from meeting to meeting until resolved
- Findings will be shared with the DBHDS Case Management Steering committee when technical assistance is declined and/or at the discretion of the group when remediation efforts are deemed ineffective.

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

In Q3 FY23, DMAS provided input into the final spreadsheet for discussion and tracking by the joint group. The focus of this process is ensuring that corrective actions related to the ten indicators are addressed in the CSB action plan that is subsequently approved by DMAS. Community Resource Consultant support will be offered to CSBs to assist with remediating identified issues and preparing planned actions for DMAS approval. Any subsequent citations will be tracked and remediated as identified. Of the seven CAPs accepted by DMAS during this report period, three CSBs accepted technical assistance to assist with findings.

Quality Service Reviews

The CMSC completed the quality improvement initiative related to the Quality Service Review (QSR) data. Our goal 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. Performance related to the measures showed incremental improvement throughout FY23 and remain below the 90% target as of this report. As reported above, while the ECM data may not show improvement, the changes through the QII were tested with focus groups who said these resources made the process more clear and easier to understand.

To address past HSAG recommendations, the Office of Provider Network Supports has updated the DD Support Coordination Handbook, which will be finalized through public comment in FY23 and made available to CSBs following this process. The final streamlined and enhanced handbook has been submitted for fiscal impact analysis prior to public comment. The CMSC is also implementing a QII focused on SC

retention as described above, this QII is focused in increasing the manageability of the position and includes an activity on providing a standard SC onboarding training for use across CSBs. To address concerns related to including health and safety elements in planning, the CMSC is assisting with a Key Performance Area Workgroups QII to move the Risk Awareness Tool (RAT) into the Part II of ISP where identified and potential risks are captured in SC workflow and automatically populate the plan where identified. Support Coordination recommendations from the Round 4 QSR include:

Round 4 QSR Recommendations

- HSAG recommends that CSBs ensure support coordinator understanding of the expectation for completion of assessments after the ISP start date and best practice expectations for ISP updates/changes, by providing additional clinical-based training and/or DBHDS published resources to all support coordinators focusing on the integration of relevant assessments into current ISP.
- HSAG recommends that CSBs ensure support coordinator understanding of the expectations for incorporation of all risks and potential risks related to high-risk health factors into the ISP, by providing additional clinical-based training and/or DBHDS published resources to all support coordinators focusing on the incorporation of RAT in ISP planning, specifically the expectation that SC will ensure all risks and potential risks are noted in Part II of the ISP, and that all risks or potential risks are addressed in Part III Outcome or have notation regarding mitigation of that risk or potential risk when the development of outcome has been declined, including ensuring referrals to Qualified Health Professional (QHP) has been completed when indicated.
- HSAG recommends that CSBs ensure support coordinator understanding of the expectation for ISP Part I documentation, specifically the minimum requirement that details are written in person-centered language and includes individuals meeting details, talents, and contributions, what is important to and for the individual and what s/he does and does not want, and addresses all life areas for the individual including a preference to not develop outcome in a life area, by providing additional clinical-based training and/or DBHDS published resources focusing on critical aspects of person-centered planning to all support coordinators.
- HSAG recommends that CSBs ensure support coordinator understanding of the expectation for ISP Part II documentation, specifically the inclusion of individual's essential information, health information, and behavioral and/or crisis support needs as reflected in most recent assessments by providing additional clinical-based training and/or DBHDS published resources focusing on inclusion of all relevant health and behavioral support needs in ISP planning documentation to all support coordinators.
- HSAG recommends that CSBs ensure support coordinator understanding of the expectation for ISP Part II documentation of all medical needs identified in most recent assessments by providing additional clinical-based training and/or DBHDS published resources 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 ISP Part II documentation of all behavioral needs identified in most recent assessments by providing

additional clinical-based training and/or DBHDS published resources focusing on proper identification and inclusion of all behavioral needs documented in most recent assessments to all support coordinators.

- HSAG recommends that CSBs, in regions noted, who provide the service types listed 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 the support coordinator's understanding of the expectation for inclusion of any risk identified in ISP Part II documentation to be included in Part III outcomes or include adequate notation regarding why the outcome was not developed for that risk, by providing additional clinical-based training and/or DBHDS published resources focusing on proper inclusion of all risks in the appropriate Part III outcome.
- HSAG recommends that CSBs ensure support coordinator's understanding of the expectations for ISP Part III outcome development including best practice documentation when individual preference is to not develop outcome in the life area of Employment.
- HSAG recommends that CSBs ensure the support coordinator's understanding of the expectations for ISP Part III outcome development including best practice documentation when individual preference is to not develop outcome in the life area of Integrated Community Involvement.
- HSAG recommends that CSBs ensure support coordinator understanding of the expectations for ISP Part III outcome development including best practice documentation when individual preference is to not develop outcome in the life area of Safety & Security.
- HSAG recommends that CSBs ensure the support coordinator's understanding of the expectations for ISP Part III outcome development including best practice documentation when individual preference is to not develop outcome in the life area of Social & Spirituality.
- HSAG recommends CSBs ensure support coordinators understand what types of conflict may arise during ISP planning, specifically as they relate to the implementation of person-centered practices, to better prepare support coordinators for the role of advocacy during ISP development. HSAG recommends that CSBs, in regions noted, who provide service types listed ensure the support coordinator's understanding of best practice expectations for documentation and notation of conflict and subsequent resolution which may occur during ISP planning in progress note that details ISP planning meeting.
- Recommendation: HSAG recommends that CSBs, in regions noted, who provide the service types listed ensure the support coordinator's understanding of the expectation that ISP review will occur with each individual quarterly or every 90 days. HSAG recommends CSBs identify key sources of variability related to the timely completion of quarterly reviews to identify if late entry is due to staff error, staff turnover, late submission by the licensed provider, or other reasons, to effectively mitigate that source of error.
- HSAG recommends that CSBs ensure support coordinator understanding of the best practice expectations regarding the location of signatures for all licensed providers responsible for the implementation of the ISP, including the individual and/or their guardian. HSAG recommends DBHDS provide greater clarity regarding best practice expectations for signatures when EHR upload is utilized by CSBs, specifically by defining if ISP is considered signed when evidence of signatures is not present in the waiver management system that holds the ISP.

- 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.

Finally, the Committee is aware of the staffing difficulties being encountered by CSBs and providers across Virginia. These challenges have led to initiating the 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.

As of this report, the CMSC has received baseline data to monitor the retention of SCs across CSBs and conducted three focus groups with Support Coordinators and other CSB staff. Each session yielded a variety of actionable possibilities to address the challenges faced by SCs. The suggestions were organized into categories, which included short and long-term implementation, as well as suggestions to be referred out to other offices and state agencies. The status of these recommendations are provided in the QII section of this report.

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. Progress related to issuing and resolving improvement plans has been delayed this report period due to the transition of the RST to WaMS per III.D.6 of the Joint Filing and adjusting the ISP compliance data to address Actionable Recommendation 5 as stated above. Reports are nearing completion at the time of this report and once validated, the CMSC will address any outstanding need for improvement plans or the resolution of past plans as confirmed in the data.

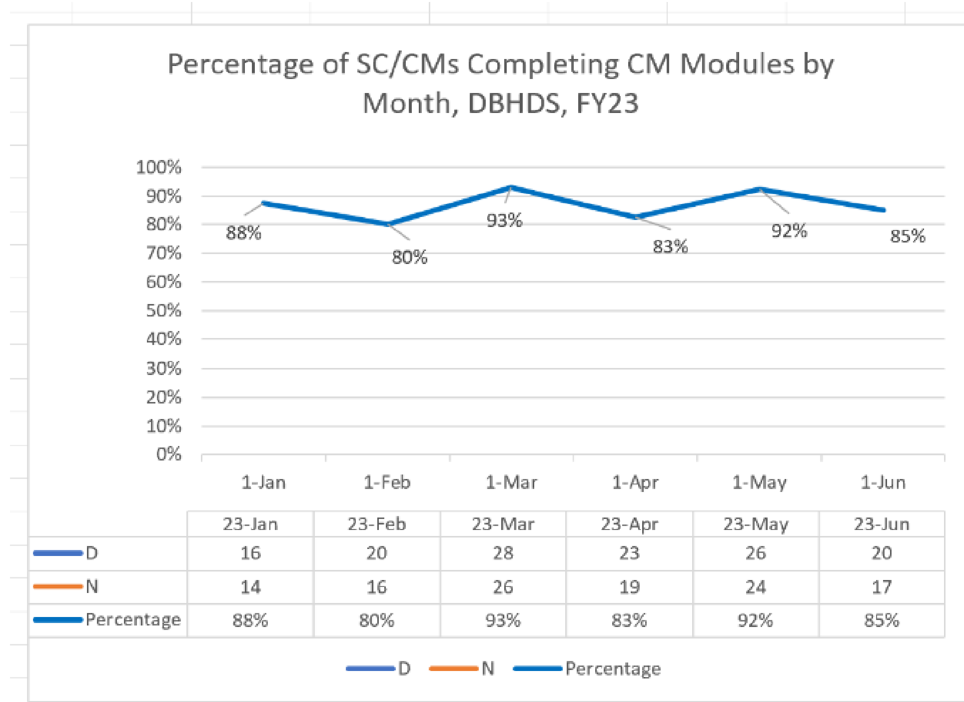
Implementation of the SCQR element began during the report period as well, but no CSB met the established criteria for an IP related to the SCQR, which includes performance below 50% on 3 or more indictors that show substantial agreement in the look-behind process.

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 January and June 2023 shows that the completion rate exceeded 86% in 3 of the six months included in the report period. This shows a comparable performance from the last report. 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 January to June SFY2023



	23-Jan	23-Feb	23-Mar	23-Apr	23-May	23-Jun
D	16	20	28	23	26	20
N	14	16	26	19	24	17
Percentage	88%	80%	93%	83%	92%	85%

Data Availability and Integrity

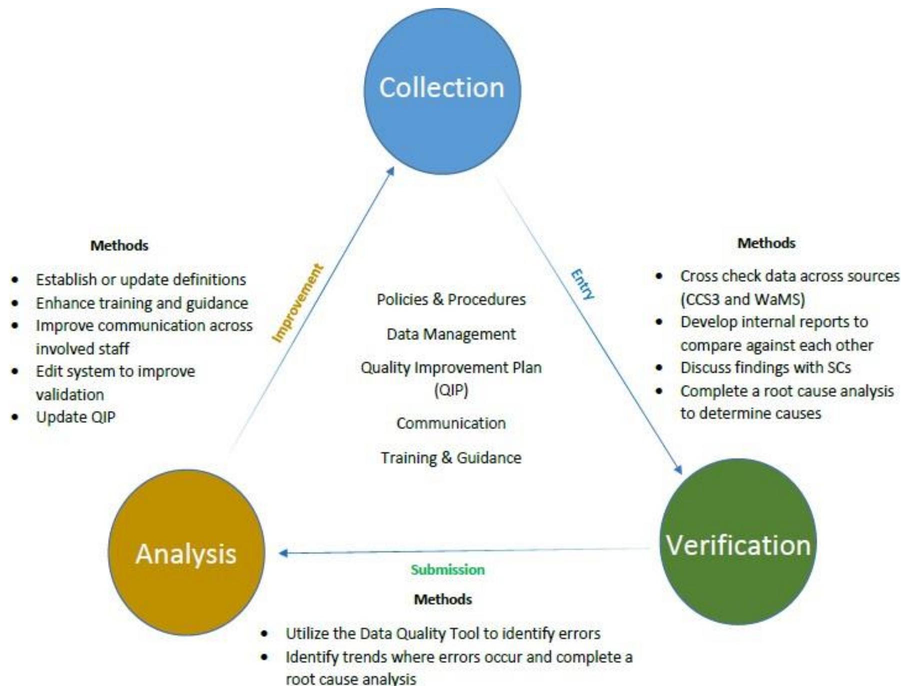
The CMSC monitors performance related to the availability of data in the Waiver Management System (WaMS), as well as the integrity of the data provided through CCS3. Specifically, regarding the requirements related to ISP entry, the CMSC has been monitoring the availability of WaMS ISP data per the Performance 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 annually with a sample of CSBs and CSBs can be included based on below target performance with related measures.

In the first year of implementation, Community Resource Consultants (CRCs) from the Office of Provider Network Supports 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 was planning for the next cycle of Data Quality Support meetings in Q3 FY23 with meetings occurring in Q4, however staffing concerns and finalizing the PowerBI dashboard delayed implementation. With the dashboard now finalized and hiring in process, these meetings are now planned to occur prior to the end of calendar year 2023. 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:

- 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.

Current Recommendations Include:

- Complete the public comment period for the SC Operational Guidelines related to Enhanced Case Management and the DD SC Handbook.
- Develop specifications for the ISP that incorporate Risk Awareness Tool elements and automate populating risk factors in the WaMS ISP.
- 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.
- Produce and publish guidance for SCs regarding employment discussions with children less than age 14 and adults over 64.

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.