A STUDY OF INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORT COORDINATION/ CASE MANAGEMENT IN VIRGINIA

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EXECUTIVE SUMMARY

Background

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) contracted with the Partnership for People with Disabilities at Virginia Commonwealth University, Virginia's University Center for Excellence in Developmental Disabilities, to conduct a study of service coordination/case management (SC/CM) services in Virginia. The purpose of the study was to better understand the responsibilities and daily tasks of intellectual and developmental disability (IDD) service coordinators/case managers (SCs/CMs); gather information about their instructional and support needs; and to solicit suggestions for improving SC/CM quality and streamlining the role of SC/CM in Virginia.

Method

This study used a mixed methods approach informed by a survey of developmental service (DS) directors in Virginia's Community Service Boards (CSBs), interviews with SCs/CMs and supervisors employed by a selection of 21 of Virginia's 40 CSBs, and five regional focus groups. Interviews and focus groups were conducted throughout Virginia between November 2017 and January 2018, and survey results were obtained in February 2018. In total, 29 directors responded to the survey, and 113 individuals participated in interviews and focus groups, making for a very robust and representative dataset.

Qualitative analyses were conducted using a widely used method of thematic analysis initially developed by Braun and Clarke (2006). Dedoose, a qualitative analysis software application was used to manage analysis of interview and focus group data. Survey data were descriptively analyzed in SPSS 24.

Findings

While findings from this study were wide ranging, there was a great deal of consensus among the diverse groups of respondents about the challenges and opportunities for SC/CM in Virginia. Qualitative findings were divided into seven main categories, as outlined below:

1. *General Responsibilities.* SCs/CMs largely identified their duties according to code, but there were notable variations in specialization and available administrative support.
2. *Caseload Size.* Most respondents felt current caseloads were unmanageable. Proportions of enhanced case management, individuals with high needs, and long travel times all influenced caseload manageability.
3. *Documentation Requirements.* Paperwork reportedly comprised 60-95% of SC/CM workload. Specific redundancies and labor-intensive requirements were identified related to service authorizations, individual support plans, and quarterly reporting.
4. *Enhanced Case Management (ECM).* SCs/CMs expressed concern that people were placed on ECM unnecessarily. Questions were raised about whether 30-day visits are always needed or productive, especially if a person is behaviorally or medically stable.
5. *Provider Relationships.* SCs/CMs often found it challenging to obtain information from some service providers, making it difficult for them to adequately monitor services. Some services are difficult to access in some areas of the state.
6. *Recruitment, Training, and Retention.* Rules about university degrees, experience and increasing competition from the private sector make it difficult to find qualified applicants for

SC/CM positions. More training on documentation procedures and high-needs populations was desired. Extreme stress, low pay, and changing work demands were described as being the primary drivers of turnover.

7. *Commitment to the Job.* Despite challenges, SCs/CMs share a strong desire to provide the best supports possible to people with IDD, and have many stories to highlight their efforts to improve people's lives.

Results from a survey to DS directors were largely consistent with findings from the interviews and focus groups. There was an overall SC/CM turnover rate of 28.2% (median 26.7%) with a wide range from 0 to 75% annually at particular CSBs. As reported by DS Directors, the average annual salary statewide for SCs/CMs is $44,149, again with a wide range across the CSBs, from a low of $29,000 to a high of $68,000.

Recommendations

Based on the findings, recommendations were developed to address existing challenges in the transactional portions of SC/CM work and to make SC/CM more transformative in the lives of people with IDD. Recommendations are presented based on the transactional and transformational functions of the job.

There are five transactional recommendations aimed at streamlining the regulatory functions of the SC/CM position:

1. *Have the right tasks done by the right people.* Many SC/CM tasks could be done more efficiently by support staff, CM assistants, or provider agencies.
2. *Reduce paperwork and information technology redundancies.* Redundancies can be reduced or eliminated in quarterly reporting, dual data entry in WaMS (Virginia's Waiver Management System), electronic health record (EHR) systems, and the Virginia Informed Choice Form.
3. *Re-evaluate Enhanced Case Management (ECM) protocols.* Examine whether 30-day visits are necessary when an individual is stable, and whether Supports Intensity Scale (SIS©) scores should be a primary criterion for ECM determination.
4. *Align audit requirements.* Publish and post a master list of audit requirements across all quality initiatives, including DOJ, licensure, DMAS, and Delmarva.
5. *Ensure manageable caseload size.* Cap maximum SC/CM caseload size and continually monitor caseload size (including the demands associated with cases) to ensure manageability.

Additionally, there are four core recommendations aimed at improving the potential for SC/CM to have a transformational role in the lives of people with IDD:

6. *Recruit and train the right people.* Allow for variances in hiring requirements of degrees and experience, create systems to support a pipeline of SCs/CMs, and provide more specialized training on documentation and on serving individuals with high behavioral and medical needs.
7. *Create systems to appreciate and retain SCs/CMs.* Develop a set of SC/CM career ladders to support career growth, review compensation guidelines, and recognize the "success stories" of SCs/CMs.

8. *Give SCs/CMs a valued voice in the workplace.* Create a SC/CM advisory panel to help roll-out changes in practices and build forums for SCs/CMs to provide feedback about their work.
9. *Create a culture of service based on high expectations, person-centered practices, and self-determination.* Provide ongoing and, when feasible, in-person training on high expectations for people with IDD, person-centeredness and self-determination employing Virginians who use services as co-trainers; highlight SC/CM to embody person-centered principles statewide, require training for provider organizations in person-centeredness; and build expectations for person-centeredness into job descriptions and performance appraisals.

Background

Purpose

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) contracted with the Partnership for People with Disabilities at Virginia Commonwealth University, Virginia's University Center for Excellence in Developmental Disabilities, to produce several instructional materials for service coordinators/case managers (SCs/CMs) and to conduct a study of service coordination/case management (SC/CM) services in the state. These deliverables address requirements in the 2012 United States Department of Justice Settlement with the Commonwealth to reshape much of its service system for people with intellectual and developmental disabilities (IDD) in Virginia. Specifically, the purpose of the SC/CM study was to better understand the responsibilities and daily tasks of IDD SCs/CMs; gather information about their instructional and support needs; and to solicit suggestions for improving and streamlining the role of SC/CM in Virginia.

SC/CM In Virginia

The publicly funded community-based developmental services system provides SC/CM to people with IDD through 39 community services boards and one behavioral health authority, hereafter referred to as CSBs. CSBs function as the single point of entry into publicly funded developmental services and §12 VAC 30-50-490 of the Virginia Administrative Code outlines the required functions of SC/CM. Despite this uniformity in function, there is *significant* diversity in the size, structure, budget, and operational protocols of SC/CM units throughout the state.

Methods

General Approach

This study used a mixed-methods approach, seeking to understand both the basic features of SC/CM workforce in Virginia and a deeper, more nuanced perspective about SC/CM from the people who work in the field. Quantitatively, a survey was distributed throughout the state to all CSB Developmental Services (DS) Directors. The survey was developed in REDCap and distributed online via email.

The qualitative portion of this review used a phenomenological approach to research, guided by thematic analysis methods. The aim of phenomenology is to gain a deep understanding of a social phenomenon, informed by individuals who are most intimately involved in it. In this case, the research was structured to gain a deep picture of how SCs/CMs in Virginia are experiencing their work. Interviews and focus groups with SCs/CMs and supervisors informed the qualitative portion of this study along with open-ended questions from the survey of DS directors.

Interview Protocol, Online Survey & Data Collection Procedures

Interview Protocol. The interview protocol that was used to facilitate SC/CM interviews, supervisor interviews, and focus groups was developed by the authors, in collaboration with personnel from DBHDS. There was a total of 16 core questions of the interview protocol, some of which had multiple parts or suggested prompts. Lines of questioning were wide-ranging, from the basics of respondents' job duties, specifics of SC/CM procedures and where duplication of effort exists, perceived

reasons for SC/CM turnover, and suggestions for improving the SC/CM role. The 16 core questions that were asked in interviews and focus groups are in Appendix A.

Online Survey. The survey component of this study was developed in REDCap, an online survey management system, and distributed via email to the DS Director in each of Virginia's 40 CSBs. The survey contained 13 core questions, as seen in Appendix B. Seven of those questions were closed-ended and sought to elicit data that could be used to calculate turnover rates, to determine typical caseload size, and to determine typical salaries for SCs/CMs. Additionally, six open-ended questions reflected the interview protocol that was used for the SC/CM interviews and focus groups, and allowed directors to share their thoughts on topics such as what they perceived to be the biggest challenges facing SC/CM, recommended changes to the job of SC/CM, and steps that may be taken to address SC/CM turnover.

Sampling & Data Collection Procedures. Surveys were distributed to DS directors in all of Virginia's 40 CSBs via email. The survey was distributed in mid-February of 2018. In order to safeguard the identity of the respondents, the survey could be completed entirely online and the researchers did not collect any personally identifying data in the survey.

Collection of qualitative data was significantly more complex. DBHDS personnel selected a total of 21 CSBs for inclusion in the interviews in order to represent a wide variety of geographical regions, CSB sizes, and experiences with SC/CM. The researchers then contacted the DS director for each of the selected CSBs requesting the names and email addresses of (a) the SC/CM who was hired closest to September 1, 2015, (b) the SC/CM who was hired closest to September 1, 2013, and (c) the SC/CM supervisor hired closest to September 1, 2013. Those three individuals were contacted via email by a member of the research team to request an interview. All individuals who were contacted to request an interview agreed to participate.

Interviews were conducted on-site at the selected CSBs between November 2017 and January 2018. All interviews were conducted one-on-one with one member of the research team speaking with one participant. Each interview began with the researcher providing a brief overview of the project's aims and methods. After providing verbal consent to continue, participants completed a brief demographic sheet and then the interview began, following the flow of questions from the interview protocol which may be found in Appendix A. Interviews typically lasted slightly under an hour, with a range between 30 minutes and 75 minutes. With the exception of two individuals who declined to be recorded, participants provided consent to have their interviews digitally audio recorded. Audio recordings were professionally transcribed and the transcripts became the texts for analysis, as described in the analysis section below.

Five regional focus groups were also conducted, using the same consent, interview, and data management procedures described for the interviews. Flyers announcing the focus groups were distributed electronically to DS directors in all CSBs, with the request to distribute to their SCs/CMs and supervisors. In two of the focus groups, personnel from private SC/CM organizations were also in attendance. Focus groups were conducted in neutral spaces such as public libraries and offices of community organizations. Attendance at the focus groups ranged from quite small (5 attendees) to fairly large (18 attendees).

Sample

A total of 35 DS directors responded to the online survey for a response rate of 87.5%, which is well above industry standards for online survey participation. Interview and focus group participants comprised the majority of participants for this study: 113 participants in all. A demographic summary of the interview and focus group participants may be found in Table 1. All data in Table 1 were self-reported by participants. Because the pool of DS directors is small, no identifying data were collected, in order to safeguard the identities of respondents.

Table 1

Sample Characteristics: Interviews & Focus Groups (*n*=113)

		n	percent
Gender	Female	101	89.4%
	Male	12	10.6%
Race	Asian	4	3.5%
	Black/African American	35	31.0%
	White	73	64.5%
	Latinx	1	0.9%
Education	Some College	3	2.7%
	College (4-year degree)	62	54.9%
	Post-graduate work	48	42.5%
Age	Mean: 41.8 years	Range: 23-64 years	

	SC/CM (*n*=82)		Supervisor (*n*=30)	
Salary*	Mean: $42,959	Range: $30,000 - $62,000	Mean: $58,220	Range: $38,000 - $102,000
Length of Service	Mean: 69.7 mos	Range: 6-336 mos	Mean: 109.6 mos	Range: 6-324 mos
Caseload Size**	Mean: 29.9	Range: 12-55	Mean: 10.5	Range: 0-32
ECM on Caseload**	Mean: 10.7	Range: 0-30	Mean: 4.5	Range: 0-14

* Individuals who reported salary as hourly wage excluded from this analysis

** Statistical outliers and part-time workers excluded from the calculation

Analysis

Qualitative analyses were conducted in Dedoose 8, a cloud-based qualitative analysis software. Thematic analysis was used to derive meaning from all qualitative forms of data for this study (interviews, focus groups, qualitative content from the online survey). Thematic analysis is widely used in the social sciences as a way of systematically, efficiently, and flexibly deducing meaning out of qualitative data sources. While there are several specific approaches to thematic analysis, the researchers chose to use Braun & Clarke's (2006) method for this study. Following this model, we conducted analysis in six stages: (a) becoming familiar with the data and noting initial impressions, (b) generating initial codes, derived from the data, (c) searching for themes, (d) reviewing themes, (e) defining and organizing themes, and (f) reporting results. In our analysis, one member of the research team did initial coding then shared initial codes with a second member of the research team. They worked collaboratively to search for themes, reviewed themes together, and came to agreement on how to define and organize themes.

The quantitative data from the survey were analyzed in SPSS 24. Simple frequencies and descriptive statistics were computed to report in this document.

Findings

The following findings represent views on SC/CM throughout Virginia at the time that data were collected between November 2017 and February 2018. Reporting is organized to summarize key themes that emerged from analysis of the interview and focus group transcripts, which represented the most robust source of data. Results from the survey of DS directors are interspersed throughout. As we recorded and transcribed feedback from over 100 SCs/CMs and supervisors, we rely heavily on the use of direct quotations to characterize their experiences.

SC/CM General Responsibilities

"We're from beginning to end. We do everything."

SCs/CMs reported a broad range of responsibilities, which vary significantly across the state. When asked about their "core" tasks, SCs/CMs highlighted many of the services outlined in the case management definition in Virginia Administrative Code (12 VAC 30-50-490) including: assessing and planning services; linking people to services and supports; assisting the people directly with service access; coordinating services; and enhancing community integration. As one SC/CM explains,

> *"Main job responsibilities as support coordinator are as a linkage to services, monitoring services, coordinating services, ensuring health, ensuring safety, ensuring that Medicaid doesn't lapse, ensuring that the individual, all their needs are met, advocating for them, along with assessments that needed to be done. Keeping the relationships, maintaining relationships in the community for opportunities that are available, being knowledgeable about what's going on in the community for certain. Ensuring that they are integrated in the community, and living, I'm using the term normal loosely, a normal life like you and I would."*

However, as described by study participants, there is a great deal of variation within SC/CM core responsibilities across the state. Some CSBs tightly define their SC/CM units by function. For example, particular SCs/CMs exclusively focus on intake assessments, service authorizations, or only providing information and referrals associated with a particular content area such as housing or employment. Many CSBs also staff SCs/CMs to solely work with specific populations, such as people with developmental disabilities, children, or only with those who use Medicaid waiver services. In contrast, other CSBs have SCs/CMs serving in a more "generalist" role, handling a broad spectrum of responsibilities including intake, service authorizations, transportation to appointments, billing, planning, as well as other required tasks to all people who seek IDD service from their CSB.

There are also differing levels of administrative and clerical support available to SCs/CMs within CSBs. In several areas, SCs/CMs reported little to no clerical support access, so that they were responsible for data entry; scanning information for records; scheduling; faxing and other administrative tasks. As one SC/CM stated about her job duties, "*Well, in [X], you can add answering the telephone and all of that administrative stuff in there.*"

Other CSBs had much more robust support built in for SCs/CMs, which reportedly has a significant impact on SC/CM workload. One SC/CM supervisor noted the breadth of tasks handled by their administrative support,

> *"Our administrative staff does a lot. One of our administrative people does most of our WaMS stuff….she does a lot of helping watch and keep track. She also does all of our entry for assistive technology and environmental modifications and keeps track of those processes...They'll send out our transfer packets. They also get CSP packets to providers."*

Particular CSBs reported that administrative and clerical staff handled routine administrative tasks, such as scanning, filing, faxing, and scheduling as well as other support roles such as transportation to appointments, intake paperwork, monitoring service authorizations, and securing signatures for required paperwork. With supplemental staff supporting these functions, SCs/CMs felt that they could focus more on core responsibilities.

Caseload Size and Case Assignment Demands

"I think the biggest challenge is just the caseload. It is extremely high. So just trying to provide those supports for those individuals with that high caseload and then with support you're doing you have to document everything. And so it just seems like the more that you choose to do, you're just putting more work on yourself because you got to come out and document that and then follow-up with that. So I think that's the main thing is just, of course, having all of those individuals to serve is just so much to do. It's just more paperwork for you to do."

As highlighted in Table 1, there was significant variation in caseload size across the CSBs that participated in data collection efforts. Additionally, when interviewing SCs/CMs and supervisors, people mentioned caseload sizes as high as 69 due to staff turnover, though this had improved somewhat by the time of interview data collection. DS Directors who responded to the survey reported an overall average caseload size of 30.5, with a range from 23 to 45.

When questioned about ideal caseload size, the majority of SCs/CMs and supervisors felt that between 20 to 25 people was manageable. Consistent with interview participants, survey results indicated that directors thought an optimal caseload size was, on average, 24.3 people. In asking about the impact of caseload size on workload, the majority of participants expressed that caseload size has a direct relationship with workload manageability.

SCs/CMs were also asked about how caseload composition influenced workload. Many variables were highlighted including: Waiver versus non-Waiver, enhanced case management, required travel time to meet with people, and people's support needs (e.g., high medical or behavioral needs). Some SCs/CMs noted that many of the expected caseload management variables had a counter-intuitive impact. For example, people who do not use Medicaid services can often occupy a great deal of SCs/CMs time because they have little resources available to them and require a tremendous amount of creativity and leveraging of community resources to support their needs. Also, travel time for face-to-face visits was not only mentioned in rural areas where people have to travel great distances, but also in urban areas (e.g., Northern Virginia, Tidewater) where traffic is a considerable issue. One other factor that was mentioned to influence caseload manageability was caseload transfers that often necessitate significant travel to meet the face-to-face visits requirement.

Documentation/Paperwork Requirements

"When I interview, I make sure that I tell people that this is a primarily paperwork position."

Documentation/paperwork responsibilities were the focus of much discussion during data collection from SCs/CMs and supervisors and from DS directors' survey responses. Specifically, SCs/CMs reported spending about 60-95% of their time on documentation-related tasks including case notes, quarterlies, service authorizations, and individual support plans (ISPs). Many reported that the time focused on paperwork took away from quality time getting to know people and better understanding their support needs. The following comment summarized the concern of many SCs/CMs, supervisors, and DS Directors:

"It's hard to spend an amount of time, a good quality amount of time, with the individual in the community when you know that you have all of this time out of the office and that you have paperwork stacking up for everything you do. It's like five pieces of paper needs to be done for every action."

Contact Notes and Quarterlies. Participants overwhelmingly reported significant time and duplication of effort when documenting their contacts with people using services and then gathering data to produce quarterly reports. As a SC/CM described it,

"We already have the information in our notes. The provider has already sent us their quarterly report. It is incredibly time-consuming. It is redundant, and it is not necessary....We know what we've done the last three months why do we have to write it again? So that is the number one tangible thing that needs to change."

Several issues emerged related to quarterly reports. First, CMs/SCs indicated that producing the quarterly reports was very time consuming. Given relatively high caseloads, many SCs/CMs stated that they were under a great deal of pressure to document and were not able to spend adequate time working directly with people on their caseload. Additionally, respondents indicated that SCs/CMs were responsible for gathering quarterly reports from providers, but have little recourse if a provider does not furnish the information. The format for quarterly reporting is also variable among provider agencies, so when information is shared with SCs/CMs, it is often difficult to locate and summarize the information easily and efficiently. Finally, participants reported that they felt that provider agencies were in a much better position to be responsible for quarterly reporting directly to DBHDS because they have daily contact with people who are using services.

Service Authorizations. The service authorization process was also the topic of much discussion about paperwork responsibilities. For the SCs/CMs who are responsible for service authorizations, it is reportedly time consuming and very detail-driven. Additionally, many respondents stated that they were recently experiencing more trouble with service authorization requests, with many getting "pended." This challenge was highlighted in the following SC/CM comment,

"It's a new interpretation of the regs. It may be the correct interpretation of the regs, but its not one we've ever done and its meaning that case managers are spending hours getting doctor's

notes, OT notes, multiple quotes, multiple vendor information. Families are asking for this and it is taking six months or a year, if they get it, based on the number of pendings and then requests for more information. "Oh, you got a doctor's note? Wait, we want a PBSF note. Wait, you got a PBSF note? We want an OT note. Oh, yeah, an OT note, you need 4 doctor's notes," and over and over. Or you spend six months to a year doing that and then, at the end, they say, "Per regs, they didn't qualify." And it's mind-blowing because it's things that we've always gotten."

As with quarterly reporting, some respondents wondered whether service authorizations should be handled directly by provider agencies and DBHDS, rather than including SCs/CMs as a "middle-man" in the process. One very specific complaint regarding service authorizations that came up again and again was the "alert" system. Because service authorization alerts were going to all staff within the CSB, many staff elected to turn the alert system off, rather than getting a multitude of emails about all people who use services through a given CSB.

Individual Support Plan (ISP). While respondents generally understood the value of the ISP process, certain administrative inefficiencies related to the ISP appeared to add to the cumulative paperwork burden among SCs/CMs. Many staff are currently entering data into two systems; their proprietary electronic health record (EHR) and also into the state Waiver Management System (WaMS). This duplicate data entry is a source of great frustration. Another administrative issue regarding the ISP that came up multiple times was the inability of the ISP to "carry forward" background and other demographic information from the previous year. SCs/CMs felt that it would be more efficient to bring that information forward year to year and correct it when needed, rather than re-typing basic information every year.

Another, more substantive, issue highlighted by respondents was challenges with the ISP outcome development process at an administrative level and also on a philosophical level. At an administrative level, there seems to be much confusion about the "right" way to write outcomes that meet audit requirements by DBHDS and DMAS. As one respondent stated, *"It's not consistent. The training will say one thing. Then they'll audit it. They'll say, "Why are you wording it a certain way?" And different auditors will say different things."* Or as another SC/CM stated, "*Simple things like wording outcomes becomes a struggle. Yeah. People are stuck. It becomes a contentious back and forth or difficulty just figuring out how to compose a sentence that everybody agrees on."* Improving training for writing ISPs would be useful in addressing this common frustration of SCs/CMs.

There also appears to be some disagreement and lack of understanding with the philosophical underpinnings of why certain outcomes are warranted for certain people. For example, one SC/CM was describing her struggle with writing outcomes for a person with high medical needs,

"They're not going out into the community much, because they're on a feeding tube ... So we have to stretch outcomes for that, and that's really kind of crazy, because they're supposed to be person-centered plans, and I don't feel like they're person-centered if we're just coming up with stuff."

Another person noted challenges with writing outcomes related to employment,

"We have this thing now where we had to offer employment first regardless of whether the person has the ability to work or not. I mean, it could be somebody that's literally not able to even move and we have to offer them employment first. We have to say that we talked about employment. Well, I know that they can't work because they don't have the cognitive ability to work, they don't have the physical ability to work, but we have to offer this first. It makes no sense... So we're doing things that we don't need to be doing which makes our job difficult because the families are looking at us like why are you even asking me this question."

Or as another person put it more adamantly, *"there's not going to be significant change in their life--period--from now until the day they die. I can write it all day long, but it's not going to happen."*

Many people articulated similar concerns. There appears to be a disconnect between system level expectations related to individual outcomes, and SCs/CMs confidence in being able to successfully support these types of changes in people's lives.

Enhanced Case Management (ECM)

"It's making it more difficult for us to actually assess their needs. And that's the truth because we don't have the time ...To drive around here and to get to places, it takes a long time. So, you're in. You're out. You don't want to mess up their days because some people, they're at a day program. You have got to go to the day program. You've got visit at home. So, you're making a choice of, "Oh. I have to go to this person's house." It's 6:30, 7 o'clock. You got to go to their day program. You don't want to mess up their outing, so you try to get there early, like 7 am, 8 am so right when it starts you can say, "Hey." And then you're throwing the individual off, and you're also not spending that much time with them because you're in and out. Saw you."

Many participants expressed concern about several aspects of ECM. The administrative requirements of face-to-face visits and the documentation of those visits are reportedly challenging for SCs/CMs. And, with high caseload sizes, are perceived to be unmanageable. There is also significant unease about the criteria for ECM and if it truly reflects the people most in need of SC/CM attention. When talking about a person who receives ECM due to high medical needs, a case manager stated,

"And sometimes they're ranked a two because they have diabetes. They take medicine every day so they consider that extensive support. So when it's just like they're taking their medication, if there are no concerns, but for that reason, they are enhanced. So I mean, it's understandable when there are more serious concerns, but things like diabetes. I know a lot of case managers who are like, "Wait. What? Half the caseload might have diabetes. But they're stable." But they have diabetes so it's a two ... and now they're enhanced, things like that."

This concern was expressed multiple times by SCs/CMs. They felt that there should be more SC/CM, supervisor, or DS Director discretion involved in determining who is in need of ECM and that people who are "stable" do not need the frequency of visits. In fact, several people also stated that the frequency of visits was disruptive to families and people who use services.

Provider Relationships

*"I feel like, in this position, we should have some power in overseeing the agencies, but doesn't matter. Work doesn't get done***."**

Respondents noted a number of challenges in working with providers. While some of those challenges occurred commonly throughout the state, others were more regionally focused. Generally, respondents reported difficulties in gathering required information from providers and in finding providers for some services.

Gathering Required Information. A common statewide concern expressed by SCs/CMs, supervisors and DS Directors was that it was often difficult to obtain required information from provider agencies and this, in turn, made it difficult for the SCs/CMs to complete their duties in an accurate and timely manner. The difficulties in obtaining information were perhaps most commonly identified around quarterly reports. SCs/CMs often reported that providers did not submit their quarterly reports on time, and sometimes never submitted them at all, even after multiple requests. The SC/CM expressed frustration that they were held accountable if they did not submit their reports on time, but that they had no authority to hold providers to required timelines.

> *"Another big one with me, with providers…would be getting the reports on a monthly basis. I'll call them month after month after month and not get the reports, so how am I supposed to review everything? And I can document it all I want, but is that helping the individual? No."*

Similar concerns were expressed about the ISP process, in which SCs/CMs sometimes noted that providers did not complete their portions of the ISP in advance, meaning that extra time needed to be spent on it during the ISP meeting or that SCs/CMs would actually complete those portions of the ISP for the provider. This sentiment, expressed by several SCs/CMs, was succinctly stated by one individual: "*I go into a meeting, and this is with the provider, they're supposed to do the Part 2 [of the ISP], and if they don't do it, I end up doing it."*

Though less common, some SCs/CMs also noted that it was occasionally difficult to obtain accurate information about an individual on their caseload. Reasons cited for this included staff at provider agencies who did not have adequate knowledge about the outcomes of people with disabilities who use their services, frequent staff turnover, and occasionally feeling as though staff at provider organizations were not forthcoming with information.

Provider Availability. A more regionally-specific concern expressed by SCs/CMs was that it was difficult to find providers for some services. While the specific services identified by SCs/CMs varied from one location to another, there was some degree of consensus that limited options sometimes constrained the choices they could offer a person.

In some instances, there were reportedly very limited options for major services such as group homes, forcing SCs/CMs to use a single provider, rather than offering people a viable range of choices. This was mainly observed by SCs/CMs in non-metropolitan areas of the state. Other SCs/CMs reported that shortages of specialists could contribute to long wait lists for some services, notably sensory

occupational therapy, nursing, and some new service categories that were made available after waiver redesign. In one rural area, a support coordinator shared, *"There's a huge waiting list for sensory OTs. I mean, having more sensory OTs, that would be awesome…"*

Recruitment, Training, & Retention

"It's the pressure. Adding, adding, adding."

Recruitment, training, retention, and turnover are all related. As such, the subjects under this heading should be regarded as elements in the bigger picture of workforce stability, rather than entirely distinct entities.

Recruitment. SCs/CMs, supervisors, and DS Directors who informed this study indicated that difficulties in the stability of the SC/CM workforce began with finding qualified individuals to apply for and accept employment. A number of informants focused considerable attention on the fact that SCs/CMs are required to have at least a four-year degree in a human service field and at least a year of experience working with people with IDD in order to meet minimum requirements to even apply for a SC/CM position. Supervisors and DS Directors in particular noted the difficulties that these requirements caused them when trying to fill vacant positions. Supervisors and directors saw two different sides of this challenge.

First, they reported that the supply of individuals who met requirements was limited, which constrained their ability to recruit potential employees who could be trained to be competent SC/CM if not for degree and experience requirements.

> *"…Finding the combination of at least a Bachelor's in a human services field, plus experience working with individuals with ID and/or DD, plus experience writing plans. I've had many applicants that I felt were qualified through experience and working with individuals with ID/DD, but did not have the degree or had the degree and experience, but did not have experience writing plans."*

While the problem of labor supply was noted statewide, it was perhaps most pronounced in rural areas, where there was not a natural pipeline of university graduates looking for work. One director from a rural CSB shared this thought when asked to reflect on their biggest recruitment challenges: "*Finding qualified applicants with a degree that are willing to work in our area. We are rural and do not have the amenities that are offered in an urban environment…that would attract someone to the job and location."*

Recruitment challenges were not limited to labor pool issues, however. Several directors and supervisors discussed how the entry-level pay for SCs/CMs was too low considering the requirements of the job. Low entry-level wages were seen as a deterrent that may have prevented otherwise qualified individuals from applying for jobs, especially when competitors, most notably Medicaid Managed Care Organizations, could pay higher wages with more favorable working conditions. In the most severe cases, directors noted that entry-level wages for SCs/CMs could not even keep pace with unskilled

positions in the area, as shared by one director who said, *"pay does not compare with retail employers such as Hobby Lobby."* Regions with moderate to high cost of living reported particular recruitment challenges related to low starting pay.

Training. Generally, training concerns may be divided into those related to onboarding and those pertaining to ongoing professional development needs. Specific to onboarding, SCs/CMs most often reported a combination of agency-specific training, completing DBHDS's online case management modules, and shadowing more experienced workers as the core elements of their training. SCs/CMs reported highly variable experiences with onboarding from one CSB to another. While some SCs/CMs had an extensive onboarding period of two or three months before taking responsibility for their own caseload, others reportedly received a caseload within two weeks of hire. Shadowing in some CSBs was extensive, including tutorials on completing ISPs and other paperwork as well as shadowing on home visits and ISP meetings, while in other CSBs new SCs/CMs were expected to informally seek out a more experienced peer when questions arose. There was little consensus among participants about what approach to onboarding would be best, though most noted that hand-on experiences and shadowing were somewhat more useful than completing reading materials or listening to instructions.

Some SCs/CMs suggested that having an easily-accessible resource library of videos or step-by-step online presentations that were designed to instruct a worker through various processes would be very useful. Orientations to key features in WaMS, tutorials on completing sections of the ISP, guidelines for writing outcomes, and materials outlining how to complete paperwork were all suggested by SCs/CMs as potential topics that might be addressed in a centralized resource library. In addition to the desire for a resource library, many SCs/CMs expressed a desire for more in-person training opportunities, which they often found to be more useful and comprehensive. Multiple individuals requested in-person training on person-centered practices and how they may be implemented in the current environment for SC/CM services.

SCs/CMs typically found ways to meet their needs for ongoing training once on the job. Most SCs/CMs reported that their supervisors were supportive of them attending topical trainings in their local area, and most said their CSBs had funds available to support tuition for day-long professional development trainings. An area where many SCs/CMs expressed a desire for more training was behavioral health, especially how to provide supportive services for people with high behavioral needs and autism spectrum disorder. Many SCs/CMs also expressed concerns about lack of training related to complex medical conditions. As one SC/CM expressed,

> *"It's very challenging to deal with…the medical piece. Especially coming from psychology backgrounds, human services backgrounds. I don't think that we are able, as a professional, to determine a lot of those things they want us to look at. Especially medically."*

Perhaps the most important area that was identified by all stakeholder groups who participated in this study was training on how to implement changes that were being rolled out by DBHDS as a result of the DOJ Settlement. There was a very strong perception that major changes were coming constantly, often with little notice or guidance on how to implement those changes at the ground level. The pace and lack of clarity around required changes was a major source of stress and burnout for SCs/CMs, who

felt very little control in conducting their work as a result. The majority of individuals who participated in this study wanted more training on how to implement changes to CM protocols and many felt that having a good SC/CM manual would be an important part of the solution. A number of individuals discussed how a new SC/CM manual was in the process of being written, and hoped that it would provide clear, concrete guidance to help guide their work. However, due to their experiences with other recent changes, there was a fair degree of skepticism about whether the manual would be useful, as conveyed by a participant,

> *"They're rewriting the manual right now and my concern is when I talk to people that are on the committee that are writing the requirements, they are saying that it's not looking good. [laughter]. It's not being written in a way that's clear… We can't wait for this new manual to come out so we can have clear guidelines. That makes our job so much easier."*

Retention & Turnover. A major focus of the interviews, focus groups, and DS director's survey was on what respondents perceived to be the causes of turnover and what could be done to improve retention. Based on results from the survey, the authors calculated annual crude separation rates for each CSB that responded to the survey, as well as an overall turnover rate for the state. For this calculation, the authors used a widely used formula: Total number of SC/CM departures in the past 12 months/(number of currently employed SC/CM + number of current SC/CM vacancies). Based on data provided by the 29 CSBs that responded, the statewide annual crude separation rate for the 12 months preceding February 2018 was 28.2%. Notably, there was a very wide range in annual crude separation rates in individual CSBs, from a low of 0% to a high of 75.0%.

The most common reason cited by respondents for turnover was the stress of working as a SC/CM. Many people who informed the study discussed, often with great emotion, the toll that job-related stress was having on their lives. Balancing many competing demands with large caseloads, the perception of constant changes to procedures, lack of support, and the feeling that they could not do anything tangible to improve the lives of people with disabilities all weighed heavily on the minds of SCs/CMs. It was common to hear that the extreme stress of the job had negative physical and emotional effects on this study's participants, who shared about their lost sleep, high blood pressure, fatigue, anxiety, and depression, which were often attributed to working as SCs/CMs. Others expressed that they could not take paid leave time that was available to them, even to visit dying family members, because they were afraid they would fall behind at work and not be able to catch up by the end of the month. Others expressed that they had not been on vacation for years and that they missed important events for their children because they felt they would fail to meet job requirements. There was a feeling that new requirements were being added to their workload all the time. This extreme stress was described as one of the primary drivers of turnover. One of the SC/CM discussed her experiences,

> "*I've known a few case managers who have had to get put on anxiety and depression medication when they became employees here and a few of them that have left because of that, myself included."*

The majority of SC/CM who participated in this study said they were in the job because they were motivated by helping people with IDD. They legitimately cared about and connected with the population and wanted to do all they could to improve the lives of the people they supported. However, there was a pervasive feeling of disconnect between that desire to have an impact on the lives of people

with disabilities and the day to day realities of their work, which was characterized by meetings and a never-ending flow of paperwork, based on the narratives of participants. This disconnect was also reported to be a driver of turnover, since SCs/CMs felt a lack of purpose in their work. One individual shared,

> *"I think it's to the point where if they don't feel like they're actually taking care of somebody's needs, that they're only doing the paperwork for paperwork's sake, or checking off requirements, and they don't feel that they're actually making a difference in somebody's life."*

Salaries were also highlighted as another driver of turnover in many CSBs. Wages, as reported by interview and focus group participants, are displayed in Table 1. From the survey of DS directors, the average starting wage for a new SC/CM with no experience beyond the one year required to qualify as a Qualified Intellectual Disabilities Professional (QIDP) was $40,140 (range $26,000 - $60,000). Overall, the 36 directors who responded to the survey reported a statewide average SC/CM salary of $44,149 (range $29,000 - $68,000). The figures reported here do not include the cost of fringe benefits.

While fringe benefits were attractive to many participants, and helped keep SC/CM in their jobs, salaries had the opposite effect in many instances. Most participants noted that their salaries were not commensurate with their job responsibilities, and suggested that better pay might help to offset some of the more negative aspects of job stress. When asked what would help keep SC/CM in their positions longer, many respondents clearly echoed the sentiments of one individual who said, *"Making more money."*

Salary issues were particularly difficult in regions where there were notable salary differences between CSBs. In several instances, especially in regions where several CSBs were clustered within easy commuting distance of each other, SCs/CMs would reportedly find employment in a low-paying CSB, get a little experience, and then move to a higher paying CSB a few miles away. While this trend resulted in a few very stable CSBs, more often the effect was high turnover and disaffected workers in low-paying CSBs, where SC/CM were acutely aware that they could do better financially at another CSB or in the private sector. One SC/CM supervisor, whose views reflected those of many individuals, explained,

> *"[Name of a nearby CSB], for example, and [another nearby CSB], I mean, they're paying their support coordinators more than my senior staff is making. We make money. A lot of the CSBs take the extra money that case management brings in, and they roll it over to fund other divisions that don't make money."*

Though some SCs/CMs expressed satisfaction with their position and saw a future for themselves in the job, many others did not. A perceived lack of opportunity for upward mobility within case management was a contributing factor for many SCs/CMs expressing that they did not see a future for themselves in the field, along with low pay and stressful working conditions. Some participants suggested that having different levels of SCs/CMs holding different responsibilities and corresponding compensation might help them to see a longer term career progression within the profession. Making a path for advancement would help some SCs/CMs see a way to stay in their job, as described by an individual who said,

"I think if they had a more--if you felt that there was room for advancement. They have three supervisor positions. So it's really not room for growth. But it's not really a lot of positions to apply for and then I think because the case managers are needed so much, they're not going to want you to leave, they're not going to want you to even go to another department because they need you in case management. So, I don't know, it's just kind of difficult. It's not a lot of room for growth. I feel like there should be maybe a team leader maybe for that can help maybe. And then another thing, too, which is kind of frustrating, a person could be here for years and then someone new coming in, they're going to start at the same salary as you. So I mean it has that--it just makes it no sense in staying for a long time."

Respondents cited potential benefits in allowing them the chance for advancement and the opportunity to gain new skills that could be useful as their career progressed. Though rare, in a few instances interview or focus group participants talked about how they chose to move into a specialized SC/CM position that would help them move into a supervisory role eventually, exhibiting the potential of specialization and career ladders to make support coordination a more attractive long-term career. A participant shared,

"So, I changed because [support coordination is] a lot of work but also because I want to move up to a supervisor position. I've already applied and interviewed twice for a supervisory position. I didn't get it either time so I felt like I needed to broaden my skills and my knowledge and hopefully this would be something that would help me to move up."

SC/CM Commitment to Job

"The best part is the people that I get to work with and support and encourage and advocate for and connect to services and enhance their lives. So my consumers and their families are absolutely the best part. The day-to-day, helping them, visiting with them, that connection, the face-to-face, personal connection, involved in their life part is absolutely the best."

While this study was directed at gaining a better understanding of the challenges with SCs/CMs and gathering suggestions for improving/streamlining processes and protocols, it is important to note that the vast majority of SCs/CMs communicated a clear commitment to people with IDD. SCs/CMs and supervisors frequently mentioned that the part of their job where they were able to interact with people and families was reinforcing and rewarding. With that said, however, CMs/SCs expressed that the "engagement" part of their job was subordinated to administrative responsibilities. This conflict was summarized by the following comment from a SC/CM,

"30 clients and I feel like there's not enough time to make a difference because…it's a rat race every month to get all the paperwork in. And I think my individuals have fallen between the cracks because I can't devote the time that I used to with researching something, taking the time to spend time with them, talking with the providers. Instead, I feel like I'm doing drive-bys."

Discussion and Recommendations

In a January 26, 2018 email to CSBs, Dr. Jack Barber, the Acting Commissioner for DBHDS, presented a framework for understanding the tasks of SCs/CMs. He described their activities as falling into two categories: transactional and transformational. Transactional activities are completed to satisfy a regulation or requirement, but have little or no impact on a person's quality of life; can often be done by someone other than the SC/CM; are system-oriented; and routinized. He described transformational activities as fundamental to the role of the SC/CM; lead to discovering what people care about; ensure desired changes are pursued; and support a person having a voice in his or her life. We will use this transactional/transformational framework to organize the discussion/recommendation section of this report.

Transactional Recommendations

As highlighted throughout this report, SCs/CMs characterize the majority of time as being spent on transactional activities, from 60% to 90%. Within those transactional activities, there were many suggestions on how to improve efficiencies which are highlighted below. In examining and addressing transactional activities, it will be important to examine carefully the role of monitoring. In a move to a more transformational model, clear distinctions must be made on what constitutes required monitoring tasks for CMs/SCs and what can be handled by others. Overall, it was clear that many SCs/CM are performing clerical and other tasks that may be more efficiently handled by support staff. With these routine tasks handled by others, SCs/CMs will be available to focus more on increasing the choice and participation of people with IDD and their families in their home communities.

Recommendation 1: Have the right tasks done by the right people.

a) Make clerical staff support available to SCs/CMs to file, scan, copy, schedule appointments, enter data, and handle routine clerical tasks.
b) Institute a career ladder with an entry-level SC/CM assistant position (also see Recommendation 7). This position could provide assistance and administrative support to SCs/CMs including transportation to appointments, conducting intakes, evaluating financial eligibility for services and supports, preparing paperwork for meetings, following service authorizations in WaMS, and other SC/CM support tasks.
c) Examine the monitoring role of SC/CM with service authorizations, quarterly reporting and other provider-related activities that also currently involve involvement of a SC/CM. Articulate required monitoring tasks for SCs/CMs and what can acceptably be handled by others.

Recommendation 2: Reduce paperwork and information technology redundancies.

a) Reduce quarterly reporting requirements. If reporting is modified, pilot test new processes to ensure that inefficiencies aren't created.
b) Examine the Virginia Informed Choice form. This form was mentioned by many SCs/CMs as particularly cumbersome and confusing.

c) Minimize the dual data entry between WaMS and proprietary EHR systems. If technology solutions are not immediately feasible, assign clerical staff to complete the dual data entry.
d) Implement a required, uniform format for provider quarterly reports to be used across all CSBs. Work with VACSB to develop an acceptable format that should aim to gather necessary information in an efficient manner.
e) Fix the alert system bug in WaMS so that all SCs/CMs from a given CSB do not receive alerts for all people the CSB supports. CSBs would be responsible for keeping caseload assignments updated for each SC/CM.

Recommendation 3: Re-evaluate enhanced case management (ECM) protocols to ensure efficiency and effectiveness.

a) Examine the issue of ECM status "stability" and the 30 day face-to-face requirement in ECM to see if there is an opportunity for SC/CM professional opinion in determining continued need.
b) Re-evaluate whether a SIS© score should be the major determinant of whether an individual is placed on ECM.

Recommendation 4: Align audit requirements between various quality initiatives including Department of Justice, licensure, Department of Medicaid Assistance Services, Delmarva and others so that CSBs have consistent, reliable information about expectations.

a) Publish and post a master list of audit requirements for CSBs and SCs/CMs so that clear guidance on requirements are available and accessible.
b) Publish a similar list for providers, so SC/CMs do not have to help providers interpret regulations and to help SC/CMs get needed information in a timely manner.

Recommendation 5: Ensure SC/CM caseload sizes are manageable.

a) Cap maximum SC/CM caseload size to 25 people. There was consistent feedback from respondents throughout the state that 20 to 25 people was an appropriate caseload size.
b) Routinely monitor caseload sizes and composition across the state to ensure manageability.

Transformational Recommendations

Although SCs/CMs who participated in this study characterized their current work as being primarily transactional, most had a strong desire to have a greater impact of the lives of people who they served. In fact, feeling a connection to people with disabilities was what drew most SCs/CMs to the job and was one of the main factors that kept them in their positions. SCs/CMs have a desire to partner with people with disabilities to help them find greater community inclusion, decent housing, and fulfilling work activities, but often feel that they are constrained in doing so by the current demands of

their jobs. If transactional components of the SC/CM's job may be streamlined by following some of the recommendations above, it is likely that SCs/CMs will have more time to attend to the needs and desires of people with disabilities. However, in order to create an environment in which SC/CM can be truly transformational, based on the data from this study, we would suggest consideration of the following recommendations.

Recommendation 6: Recruit and train the right people.

a) Consider variance in degree and experience guidelines for qualified applicants for SC/CM positions, if alternate qualifications can be documented (for example, extensive work history with individuals with IDD).
b) Work with VACSB to institute a SC/CM mentorship network that will link new and experienced SCs/CMs to create a system of peer-to-peer support.
c) Provide ongoing training opportunities that prepare SC/CM to meet the needs of people with high behavioral health and medical support needs.
d) Work with universities to create internship opportunities that would help create a pipeline of qualified SC/CM applicants.
e) Create an online repository of "how-to" videos to provide concrete guidance to SCs/CMs on how to execute paperwork tasks in accordance with applicable regulations. Keep the videos updated as regulations change.
f) Work with universities or other qualified trainers to develop and deliver high-quality training content for SC/CMs. Consider developing trainings in multiple modalities (in-person, online) and aim for competency-based training, not simply knowledge acquisition.
g) Consider case management certifications, such as offered by the Commission for Case Manager Certification. Connect certification to career ladders as described in Recommendation 7.

Recommendation 7: Create systems to appreciate and retain talented SC/CM.

a) Develop formats for a SC/CM career ladder that CSBs could consider implementing. A career ladder will help to build a pipeline of qualified SCs/CMs and enable them to see pathways to a long-term career in the profession. There are many models for career ladders that may be useful, depending on CSB structure and size. A *sample* model can be viewed in Appendix 3.
b) Review compensation guidelines so pay will keep pace with job demands and be competitive with private providers and managed care organizations in the local area.
c) Consider ways to create regional salary guidelines that would reduce compensation discrepancies among CSBs in the same geographic region.
d) Work with VACSB to develop guidelines that would enable more opportunities for SC/CMs to telework. Several CSBs currently have telework arrangements for SC/CMs, which could be used as models.

Recommendation 8: Give SCs/CMs a valued voice in their workplace and in the IDD system.

a) Develop a SC/CM advisory panel. Use the panel to review this report and other relevant information to develop action steps for SC/CM system improvements to move towards more transformative practice. DBHDS could consult this advisory panel before implementing changes to regulations or SC/CM job expectations to get a sense of how changes would affect workers on the ground. The panel should have statewide representation, and panelists should have their participation factored into their workload.
b) Hold dialogues between SCs/CMs and CSB administrators, perhaps semi-annually, to have an open sharing of ideas about how to improve SC/CM practices. Such dialogues could be facilitated collaboratively between DBHDS, DMAS, and VACSB.

Recommendation 9: Create a culture of service based on high expectations, person-centered practices, and self-determination.

a) Require training on person-centered practices that includes specific content on the importance of high expectations for people with IDD, both at onboarding and on an ongoing basis.
b) Provide professional development training in-person whenever feasible. Use real-world examples of people who use services in Virginia and include people with IDD as co-trainers to reinforce the potential of people with IDD.
c) Develop a "highlights" newsletter to recognize SCs/CMs practices that achieve positive outcomes for people with disabilities. Recognition newsletters can build a sense of community and instill pride in featured workers, in addition to "normalizing" high expectations, person-centeredness, and self-determination.
d) Follow similar recommendations for service providers so that SCs/CMs have allies in exemplary practices in the field. Write job descriptions and performance appraisal documents for SCs/CMs to reflect the value of high expectations, person-centeredness and self-determination as core job responsibilities. Seek input from VACSB in this process.
e) Write job descriptions and performance appraisal documents for SCs/CMs to reflect the value of high expectations, person-centeredness and self-determination as core job responsibilities.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Appendix 1: Interview and Focus Group Questions

Core Questions for SC/CM Interviews and Focus Groups

1. Tell me about your job responsibilities.
2. What do you like best about your job as a SC/CM and what are the biggest challenges?
3. Which of your job responsibilities do you spend the bulk of your time on?
4. Tell me how your SC/CM unit is organized.
5. How many people do you support on your caseload?
    - Do you think your caseload is a manageable number?
    - What would you consider a manageable number?
6. What contributes to a caseload that is manageable vs. unmanageable?
7. What are the strenths and challenges with…
    - The ISP process?
    - Monitoring ISP outcomes?
    - Working with the provider community?
    - Where are there redundancies in the ISP process?
8. What kinds of orientation/training did you get to prepare you to be a SC/CM?
9. What do you think are the most important priorities/responsibilities of a SC/CM?
    - Are you able to get those priorities done?
    - Do you believe you are well-trained to provide CM to people with complex health and/or behavioral needs?
    - What core competencies do you believe SC/CM should have?
10. What CM job responsibilities (process/activity) seem most cumbersome or duplicative?
11. What do you do that you think should be done by another person?
12. What one job responsibility (process/activity) change would you recommend that would lighten your load?
13. What factors do you think make SC/CM think about leaving their job, and what factors made them stay?
14. What do you think are concrete steps that can be taken at your CSB or at the state level to decrease turnover?
15. What are your top three suggestions for improving SC/CM services for people with IDD?
16. Anything else you think I should know about?

Appendix 2: Developmental Services Survey Questions

Core Questions for Developmental Services Director Online Survey

1. Please list the number of SCs/CMs (both full-time and part-time) who left their job for any reason in the past 12 months
2. Please list the current number of FT & PT SCs/CMs employed at your CSB
3. Please list the current number of FT & PT SC/CM vacancies that you have at your CSB
4. What do you think is the optimal caseload size?
5. What is your current average caseload size?
6. What is the average full-time salary for SCs/CMs at your CSB?
7. What is the starting full-time pay rate for a new SC/CM without experience?
8. What are the biggest challenges in hiring SCs/CMs?
9. What SC/CM job responsibilities (process/activity) seem most cumbersome or duplicative?
10. What factors (e.g., balance of active vs. follow-along cases, travel time) impact the workload of your SCs/CMs most significantly? Please give some detail to explain.
11. What current SC/CM tasks do you think should be carried out by another person? Please list the task and who would be better positioned to carry out that task.
12. What top 3 job responsibility (process/activity) changes would you recommend that would improve case management?
13. What do you think are concrete steps that can be taken at your CSB or at the state level to decrease turnover?

Appendix 3: Sample Career Ladder

Sample Support Coordination Career Ladder

	Title	Requirements	Duties
Intern	Support Coordination Intern	Enrolled in a 4-year degree program in a human service field; no experience requirement; oversight by university internship office	Take individuals with disabilities to errands and appointments, write contact notes, assist in paperwork management and clerical duties
Level 1	Support Coordination Assistant	High school diploma or higher; no experience requirement	As listed for intern plus a caseload of follow-along CM
Level 2	Support Coordinator	4-year degree in human service field; one year paid/internship experience in disability-related field	Responsible for caseload of 25 active CM individuals, with small portion of enhanced CM, writing ISP, face-to-face visits, monitoring person-centered outcomes, interfacing with provider community
Level 3	Specialized Support Coordinator	4-year degree in human service field; 3 years' experience at Level 2, specialized training in behavioral health and/or high medical needs	Responsible for caseload of 18-20 active CM including greater share of ECM than in Level 2; caseload has more individuals known to have high behavioral or medical needs; other duties as listed for Level 2
Level 4	Lead Support Coordinator	4-year degree in human service field; 2 years' experience at Level 3; specialized training in writing outcomes and documentation standards	Responsible for caseload of 10-15 active CM, most of whom meet ECM criteria and have high behavioral or medical needs; other duties as listed for Level 2; Responsible for training and mentoring Level 1-3 staff on day-to-day duties
Level 5	Supervisor	4-year degree in human service field plus 2 years at level 4 OR master's degree in a human service field; specialized training on personnel management	No caseload or very small caseload; responsible for personnel management, conducts quality assurance audits; administrative duties at the CSB as assigned; fill in for Level 4 as needed