

Script for Settlement Agreement Compliance Indicators Video for SCs

Intro

As you are aware, the Settlement Agreement with the Department of Justice contains specific requirements related to the provision of support coordination for those individuals with intellectual or developmental disabilities who receive Developmental Disability Waiver Services. Without the efforts of each and every support coordinator, Virginia will not be able to exit the settlement agreement. Here is what we want you to know and what we need from you.

DBHDS has a number of methods for determining compliance with the settlement agreement including internal quality reviews, data collected from your EHRs and reports from WaMS. But do you know exactly what is expected of you?

After each section we will recap what actions the support coordinator needs to take to be in compliance with the settlement agreement.

Before we start, in several sections we use the phrase documented conversations. But what does that mean? When we say documented conversation, we mean there must be clear documentation of the discussion that occurred and how you as a Support Coordinator facilitated additional supports or services to come to fruition. The documentation may appear in the Person Centered Individual Support Plan, Virginia Informed Choice Form, progress notes, and/or person centered review. Many times there will be an accompanying outcome related to the support.

Let's start by talking about choice.

Choice

It is your responsibility as a Support Coordinator to ensure that every individual has the opportunity to make an informed choice when it comes to their services. This includes choice of Support Coordinator, Support Coordinator agency,¹ choice of services available under the waiver, choice of provider for the chosen services,² and choice of where, meaning physical location, to receive those services including where to live.³ Choice of Support Coordinator identified by name and agency, choice of DD Waiver services and choice of providers shall be documented at least annually on the Virginia Informed Choice Form, also known as the VIC. When completing this form, explain to the person that they can ask for a different Support Coordinator or Support Coordinator agency at any time as well as new services or service providers. The VIC shall also be completed at enrollment into the DD Waivers, when there is a request for a change in waiver provider(s), when new services are requested, when the individual wants to move to a new location, a move is being considered, or the individual is dissatisfied with the current provider and when making an RST referral.

During visits and when completing monitoring activities, inquire about satisfaction with services including case management and remind of choice if dissatisfied.

RST

As you know, DBHDS established the Regional Support Teams, or RSTs, as required by the Settlement Agreement. RSTs provide Support Coordinators with recommendations for resolving barriers to the most integrated community settings consistent with each individual's needs and informed choice.

¹(1) The CSB has offered each person the choice of case manager. (III.C.5.c)

² (8) Individuals have been offered choice of providers for each service. (III.C.5.c)

³ d. At least 75% of people receiving services who do not live in the family home/their authorized representatives chose or had some input in choosing where they live.

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There are six situations that require you to submit an RST referral:

- One, when a service has not been identified within 3 months of an individual receiving a waiver slot.
- Two, within five calendar days of an individual being presented with any of the following residential options:
 - an intermediate care facility,
 - a nursing facility,
 - a training center, or
 - a group home that is licensed for five beds or more.
- Three, immediately when family expresses any interest in a setting considered to be less integrated.
- Four, immediately when an individual is displaced from his or her residential placement for a second time.
- Five, immediately if the individual is moving before the next scheduled RST meeting.
- And six, immediately once the Support Coordinator is notified that a person has already moved to a less integrated setting.

Remember you must first contact your CRC for consultation, and submit the RST referral to the CRC and the RST mailbox.

In order to meet the standard that 86% of people who receive a waiver slot are enrolled in services within 5 months⁴, Support Coordinators should begin to work with individuals and families on choosing services and providers immediately when the slot is assigned. While the Settlement Agreement indicates that RST referrals should be submitted when a person is having difficulty identifying a provider within 3 months, a Support Coordinator may consult with the CRC and submit an RST referral as early as 30 days if they anticipate challenges to finding a provider.

It is especially important to remember to submit RST referrals on time! DBHDS conducts quarterly quality assurance reviews to determine if RST referrals were submitted when they should have been⁵; in order to meet the standard, 86% of all referrals statewide must be submitted⁶, and submitted on time.⁷ DBHDS will require CSBs who do not meet the criteria over two consecutive quarters to submit a corrective action plan⁸. CSBs who fail to improve and meet the criteria over a 12 month period will have technical assistance, remediation, and / or performance contract sanctions⁹.

⁴ The Commonwealth ensures that at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations. (V.D.1.8)

⁵ DBHDS conducts a quarterly quality assurance review of all new authorizations and any changed authorizations for residential service resulting in individuals residing in homes with 5 beds or more to determine if an RST referral has occurred. (III.D.6.3).

⁶ 86% of all statewide situations meeting criteria for referral to the RSTs with respect to home and community-based residential services are referred to the RSTs by the case manager as required by the DBHDS RST Protocol. (III.D.6.4)

⁷ 86% of all statewide non-emergency referrals, as such referrals are defined in the DBHDS RST Protocol, meet the timeliness requirements of the DBHDS RST Protocol. (III.D.6.2.)

⁸ 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. (III.D.6.6)

⁹ Failure 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. (III.D.6.7)

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DBHDS Community Resource Consultants are available to support you with RST questions, and the Department is committed to providing assistance in supporting people in the most integrated settings. When people choose a less integrated setting because more integrated settings are not available, the names of those individuals will be included with the letter that is sent to your CSB each quarter. Twice a year, we will provide you with information about new providers in your area so that you can continue to offer more integrated settings to the people you support. A CRC will contact your CSB annually to ensure that you are talking to people about more integrated settings¹⁰. Also, for children who are in active discharge status in nursing facilities or ICFs, DBHDS will send a letter to their home CSB so that you can assist in facilitating their discharge process¹¹. Within 30 days of receiving the letter, you must follow up on needed actions indicated¹², and provide up to 120 days of Case Management Services for discharge planning.

Integrated Services

When reviewing service options, such as when someone is first enrolled in waiver and annually, start with the most integrated options first. The goal in Virginia is to support 90% of people new to the DD Waiver to receive services in the most integrated settings.¹³ Talk about services and supports available so that someone could continue to live with family, live in their own home or apartment, live in a sponsored home, live in a supported living residence or live in a group home licensed for 4 or less people. To show compliance, our data must continue to show an annual 2% increase in the overall DD Waiver population receiving services in the most integrated residential settings.¹⁴ Annually there shall be a documented conversation around independent housing which includes the individual's decision related to independent housing. Independent housing is defined as housing that is not provider-owned or provider-operated. The housing is owned or leased by the individual. For an individual who was already living independently, ask if they are still satisfied with the living arrangement.

Employment & Community Engagement/ Involvement

Integrated services does not only focus on where someone lives. Part of our agreement with the Department of Justice says that we will intentionally focus our efforts on increasing opportunities for employment and community integration. Each Support Coordinator must ensure a meaningful employment discussion and action planning, as well as, informed choice about employment

¹⁰ DBHDS will identify individuals who chose a less integrated residential setting due to the absence of more integrated options in the desired locality. The names of these individuals will be included in quarterly letters provided to each CSB. On a semi-annual basis, information about new service providers will be provided to CSBs, so that the identified individuals can be made aware of new, more integrated options as they become available. A Community Resource Consultant will contact each of these CSBs at least annually to ensure that any new more integrated options have been offered. DBHDS will report annually the number of people who moved to more integrated settings. (III.D.6.13)

¹¹ 90% of those children known to be in active discharge status at a nursing facility or ICF/IID have an action letter sent to their home CSB. (III.D.1.15.a)

¹² DBHDS establishes and implements accountability measures for those CSBs not actively involved in a child's discharge planning from a nursing facility or ICF/IID within 30 days of receiving an action letter. (III.D.1.15.b)

¹³ b. Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "support needs level" of Levels 6 and 7, since FY 2016 are receiving services in the most integrated setting.

¹⁴ DBHDS service authorization data will continue to demonstrate an increase in the percentage of the DD Waiver population being served in the most integrated settings as defined in the Integrated Residential Settings Report. a. Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings.

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occurs.¹⁵ Begin with a meaningful employment conversation before considering other day options such as Community Engagement and Group Day Services.¹⁶ A meaningful employment conversation starts with the belief that everyone can work but acknowledges that not everyone has all of the information to make an informed decision. It focuses on the person's awareness of the personal, social and financial benefits of employment. It considers the person's awareness and experience with work and leads to actions that ensure any decision to work is pursued and any decision not to work is explored and explained.

Ask the person "What kind of job would you like?" "If you could have any type of job what would it look like?"

Ask the team "What would it take for this person to have a meaningful job?"

Develop an outcome that leads to employment through exploration, education, or skill development considering that employment may be a short or long term goal.

For anyone who has expressed an interest in employment or who has identified a barrier to employment, an outcome for employment shall be developed.¹⁷ It may be that the team identifies transportation as a barrier to employment. After identifying what is important to the person about working, under the life area of employment, develop key steps around what steps the team will take to help overcome this barrier. This conversation shall be documented for each person in the contact note from the planning meeting and when available, shall be documented directly in the ISP under the Essential Information. Documentation shall summarize the employment conversation, include employment options discussed, address how any barriers will be overcome, and include the individual's decision related to employment.¹⁸ This includes asking an individual who was already employed if they are satisfied with their employment.

Support coordinators working with children ages 14-17 shall engage in a conversation about their interest in employment, 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.¹⁹ This conversation shall be documented and as a result of this conversation, outcomes shall be present in the shared planning. It may be that the team identifies that a future barrier to employment could be a lack of understanding of personal space. By identifying what is important to the child about working, under the life area of employment, develop key steps that will help support the development of social skills so that when the child reaches 18, they have been supported to take steps to overcome that barrier.

Once an individual requests supports for employment services, it is expected that they will have a supported employment provider and begin services within 60 days.²⁰

¹⁵ The Commonwealth has established an overall target of employment of 25% of the combined total of adults age 18-64 on the DD waivers and waitlist

¹⁶ DBHDS service authorization data continues to demonstrate an increase of 3.5% annually of the DD Waiver population being served in the most integrated settings as defined in the Integrated Employment and Day Services Report (an increase of about 500 individuals each year as counted by unduplicated number recipients).

¹⁷ At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment.

¹⁸ The Commonwealth will achieve compliance with this provision of the Settlement Agreement when: At least 86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process.

¹⁹ At least 86% of individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.

²⁰ At least 86% of individuals who are receiving waiver services and have employment services authorized in their ISP will have a provider and begin services within 60 days.

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During the ISP meeting, conversation around a person's good life and what's important to them shall include involvement in their community. For each individual the results of this conversation shall transfer to their outcomes when developing their shared planning.²¹ It is expected that most individuals will have an outcome for involvement in their community. Individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services.²²

Every provider operating a residential setting must be in compliance with the CMS rules on Home and Community-based Settings. This includes supporting individuals to have full access to their community and interact with people other than paid program staff.²³ The Support Coordinator shall be engaged in discussions about the individual's relationships and interactions with people other than paid program staff. As a result of these discussions, the Support Coordinator shall facilitate community integration which would include interacting with people other than paid program staff.

Recap

Let's recap.

- There must be a signed Virginia Informed Choice (DMAS 460) in each individual's record within 12 months of the previous VIC. The document must list the support coordinator's name, not just the name of the CSB/ BHA/ SC agency. Everyone should be using the form revised in June 2019. The form must be signed and dated.
- At least every 12 months there shall be documentation in the individual's record that includes independent housing options were discussed and the individual's decision related to independent housing. As a result of this conversation, there shall be evidence that the support coordinator facilitated access to independent housing.
- Within the last 12 months at the annual face to face meeting there must be clear documentation that employment options were discussed and the individual's decision related to employment. This includes asking an individual who's already employed if they are satisfied with employment. As a result of this conversation, there shall be evidence that the support coordinator facilitated access to employment.
- At least every 12 months at the annual face to face meeting there must be clear documentation that options for Community Engagement/ Community Coaching were discussed and the individual's decision related to these services. This includes asking an individual who's already employed if they are still satisfied with community engagement/ community coaching. As a result of this conversation, there shall be evidence that the support coordinator facilitated access to community engagement/ community coaching.

There are six situations that require you to submit an RST referral:

- One, when a service has not been identified within 3 months of an individual receiving a waiver slot.

²¹ At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP.

²² At least 86% of 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.

²³ At least 95% of residential service recipients reside in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings.

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- Two, within five calendar days of an individual being presented with any of the following residential options:
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 - a training center, or
 - a group home that is licensed for five beds or more.
- Three, immediately when family expresses any interest in a setting considered to be less integrated.
- Four, immediately when an individual is displaced from his or her residential placement for a second time.
- Five, immediately if the individual is moving before the next scheduled RST meeting.
- And six, immediately once the Support Coordinator is notified that a person has already moved to a less integrated setting.

Individual Support Plan

Each year an Individual Support Plan, or ISP is completed. Each ISP should be as unique as the individual, reflective of what is important to the person in their life, and shall be developed with professionals and nonprofessionals who provide individualized supports, the individual themselves and other persons important to the individual.²⁴ It is necessary to ask the individual who they would like to attend their planning meeting and make attempts to schedule the meeting so that all planning partners can be in attendance. Each person utilizing waiver services, with the support of their substitute decision maker as appropriate, shall participate in the development of their own Individual Support Plan.²⁵ This can be documented by obtaining signatures in the Part IV from the individual (and their substitute decision maker, as appropriate) at the end of the planning meeting. Don't forget that you must also sign the ISP. As the Support Coordinator, you are responsible for ensuring the Individual Support Plan addresses all of the individual's preferences, risks, and identified needs.²⁶ To accomplish this, you must start by preparing for the ISP meeting prior to meeting. Before the annual planning meeting:

- Review the SIS and annual medical/behavioral review
- Review current medical, behavioral and mental health support needs and determine if any currently have protocols in place.
- Talk with the current MCO Care Coordinator and request a copy of the Health Risk Assessment,
- Review quarterlies from the past year and look for medical/behavioral/mental health concerns
- Talk to clinicians (REACH included) supporting this person about concerns they have and what supports may be beneficial in the coming year
- Talk with family and others who know the person well about possible risks

One section of the Essential Information is to determine the date of the last physical exam and the date of the dental exam. There must be a documented discussion with the individual and family about

²⁴ (6) 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)

²⁵ The Commonwealth ensures that individuals have choice in all aspects of their goals and supports as measured by the following: a. At least 95% of people receiving services/authorized representatives participate in the development of their own service plan.

²⁶ (4) 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)

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obtaining these services annually. If there are barriers to receiving either an annual physical exam or dental exam, document those barriers and how efforts that will be made to overcome those barriers including discussing dental resources through their insurance, or if there are none, dental resources through DBHDS. The target is for 86% of the people supported in residential settings to receive an annual physical exam and 86% of individuals who have coverage for dental services to receive an annual dental exam.²⁷

Make sure to include all of the information gathered in the Essential Information. Remember that you can begin completing the Essential Information prior to the planning meeting. All identified and potential risks shall be addressed in the Essential Information.

During the planning meeting, there must first be a robust conversation with the individual and those who know the person best about what is important TO them, what a good life looks like from their perspective, what their talents are and what they don't want. Without an in-depth personal profile, developing a person centered plan will be difficult. Once the preferences of the individual have been established, review the information you gathered in the Essential Information with the planning team, identify if there are any risks you have missed, and facilitate a conversation among the team about any potential risks. It may be helpful to keep a list yourself or ask someone on the planning team to keep a list of all of the identified and potential risks that will need to be addressed in the shared plan so that none go over looked. It is essential that the ISP contain clear documentation of any medical, mental health and behavioral support needs. When developing the Part III: Shared Plan, there does not need to be a separate outcome for every health and safety need or identified risk; needs can be grouped under one outcome. Preferences are based on what is important to the individual. The outcomes associated with the individual's risks and needs should be framed with the individual's preferences and what is important to them about that risk or need in mind.

When developing outcomes, you need to think about several things:

- What is important to this person and do we have outcomes that support this person to have and achieve those things?
- What does a good life look like for this person and do we have outcomes that support this person to have their good life?
- What are the identified and possible risks and have we addressed all of them in the context of what is important to this person?
- What does this person not want and have we developed outcomes that help this person move away from those things?

For an individual to achieve their outcomes, it may require that you as the Support Coordinator support them by making timely referrals to necessary services and supports such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite,

²⁷ At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam.

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and other services necessary to achieve specific and measurable outcomes.^{28 29 30} At a minimum, outcomes must have key steps and a target date in order to be considered measurable.

Prior to concluding the planning meeting, make sure to review each question in Part IV with the individual and the team. If there are any disagreements, document the discussion that occurred around the disagreement and the resolution or attempted resolution.³¹ Some issues may not be resolvable. For example, an individual may want to live with a sibling who is not willing to agree to the living arrangement. For such disagreements, the support coordinator must document this attempt to resolve the conflict and what support will be given around this.

It is your responsibility as the support coordinator to ensure risk mediation plans are in place as determined by the ISP team. To accomplish this, review each provider's Part V to ensure all known risks are included prior to submitting the plan to service authorization.³² If you review a provider's Part V and you notice that any of the identified risks are not addressed or there are outcomes missing, you do not have to send the authorization through to be reviewed by DBHDS staff. You should contact the provider and discuss your concerns with them, then document your conversation.

Recap

Let's recap

- The ISP is 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.
- The Commonwealth ensures that individuals have choice in all aspects of their goals and supports by supporting each person receiving services to participate in the development of their own service plan.
- The Support Coordinator assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences.
- The Support Coordinator assesses risk, and risk mediation plans are in place as determined by the ISP team.

Monitoring

Once an Individual Supports Plan is developed, the Support Coordinator is responsible for monitoring services and continuously assessing whether the person's status or needs for services and supports have changed. Then, if a change in status has been identified or there is an identified need or request for a change in services or supports, the ISP shall be modified as needed. But do you know what circumstances define a change in status? Do you know how to assess for risk? As part of monitoring

²⁸ (7) 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)

²⁹ (5) 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)

³⁰ 86% of individuals whose Individualized Services Plan identify Therapeutic Consultation (behavioral support) service as a need are referred for the service (and a provider is identified) within 30 days that the need is identified.

³¹ (10) 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 individuals' needs. (III.C.5.b.iii; V.F.2)

³² (2) 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)

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and completing face-to-face assessments, there are specific steps we need you to take, certain documentation we need you to keep and certain time frames for which your monitoring activities must occur.

There are two types of monitoring, Targeted Case Management (TCM) and Enhanced Case Management (ECM). TCM requires visits at least every 90 days. While there is a 10-day grace period for face-to-face visits, the next TCM face-to-face visits must be timed according to the preceding visit date, not including the 10 day grace period. ECM requires monthly visits that are no more than 40 days apart.³³

Here are some steps you must take as part of your monitoring responsibilities.

During the face to face visit, the Support Coordinator shall assess whether the individual's status or need for services and supports has changed and assess whether the individual's support plan was implemented appropriately and remains appropriate to the individual.³⁴

What does change in status and implemented appropriately really mean? When evaluating for a change in status, ask the following:

- Has there been a change in behavior? This could include changes in thinking, emotions, mood, routine, or actions.
- Has there been a medical change? This could include a change in their physical well-being, medical condition, or change in IADL/ADL support needs. It could include changes in physician ordered medications, treatments or special diets such as thickened liquids or the addition of, or changes to therapy services such as speech therapy, occupational therapy or physical therapy.
- Has there been a change in demographics? This may include a change in primary caretaker and/or residence; change in jurisdiction and/or support coordinator; change in guardian or authorized representative; change in provider and/or service
- Has there been a change in financial status, eligibility for services or a change in waiver status?
- Has there been a change in the individual's choice as they may desire new outcomes, services, providers, or support coordinators?

Whenever you find that the answer is yes, you need to document the change and update the ISP.

When determining whether an individual's ISP is being implemented appropriately and remains appropriate for the individual, consider the following:

- During face to face visits, do the staff responsible for providing the care have the required training? For example, are skilled care tasks being provided by nurses or staff following nurse delegation and training?
- Do plans in services requiring skill-development contain skill-building activities which are person centered and represent the individual's desires and abilities?
- Do outcomes identified on the Part III match the plan for supports and are the outcomes represented in the quarterly person-centered reviews.

³³ The Commonwealth tracks the number, type and frequency of case management contacts. DBHDS will establish a process to review a sample of data each quarter to determine reliability and provide technical assistance to CSBs as needed.

³⁴ (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)

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- Are the frequency of hours and times of day on the schedule for supports represented by daily notes and in the quarterly person-centered reviews (and do not exceed 66 hours for those services limited by regulation)?
- Does the documentation alignment with desired outcomes and ensuring health & safety for the individual?

As part of face to face visits and collateral contacts, ask for updates related to identified risks and document the information received. Talk to family and others who know the person well, including direct care staff about possible or potential risks.

If a face-to-face visit indicates the individual's status or need for services changed or the Plan for supports is not being implemented appropriately, the ISP shall be modified. As a support coordinator, this can be accomplished by:

- updating Part 1 or Part 2, and/or
- updating Part III in your EHR if you are changing or adding an outcome that applies to Support Coordination, and/or
- convening a team meeting if it's needed to support providers with making the necessary changes to their Part V so that changes are reflected in their plan for supports and the Part III as appropriate.³⁵

In some cases, the number of hours approved are less than the number of hours being utilized each month. The support coordinator should discuss the reason for the disparity with the individual and the provider and determine whether there needs to be a change made to the authorization, whether another provider needs to be explored, or whether this was short term and the plan will resume as authorized. Remember to document.³⁶

If as part of the conversation a potential risk or new risk is identified, document the information you receive, including your steps for risk mediation, and update the ISP.

It is also important to regularly discuss with the individual satisfaction with services. As part of your conversation, determine whether the individual had input in choosing their job, helped in developing their supports, helped to choose their daily schedule and if a new housemate moved in, had some input in choosing that housemate.^{37 38 39}

It is also necessary to assure that individuals authorized for behavioral support through Therapeutic Consultation Services receive, a functional behavior assessment; a plan for supports; training of family members and providers providing care to the individual in implementing the plan for supports; and

³⁵ (3) 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)

³⁶ *DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018 for FY 2018. The utilization rate is defined by whether the hours for the service are identified as a need in an individual's ISP and then whether the hours are delivered. Data will be tracked separately for EPSDT and waiver funded nursing. Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.

³⁷ b. At least 75% of people with a job in the community chose or had some input in choosing their job.

³⁸ c. At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule.

³⁹ e. At least 50% of people who do not live in the family home/their authorized representatives chose or had some input in choosing their housemates.

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monitoring of the plan for supports that includes data review and plan revision as necessary until the Personal Support Team determines that the Therapeutic Consultation Service is no longer needed.⁴⁰ To document this, after July 2020, there will be a question in the Essential Information about the need for Therapeutic Consultation Behavioral Services. If supports are needed, a provider shall be chosen and referrals shall be completed within 30 calendar days. When the referral is to therapeutic consultation for behavioral services, even if the chosen provider has a waiting list, go ahead and add them to the ISP as a provider.

If utilizing behavioral supports, you will need to monitor the implementation of behavior support plans⁴¹ by talking to REACH, the behavioral interventionist, and those providing the direct interventions, to request updates around the progress. A training program for case managers regarding the minimum elements that constitute an adequately designed behavioral program and what can be observed to determine whether the plan is appropriately implemented is currently being developed.⁴²

Review quarterly report to determine if the outcomes are being address as identified in the provider's plan for supports. Document progress in your own quarterly review. This includes identifying whether risk mediation plans are being followed.⁴³ If risk mediation plans are not being followed, update the ISP to develop a plan for how to address this. If as part of the quarterly review a potential risk or new risk is identified, update the ISP and develop a risk mediation plan.

There are times when unexpected information is received or observed. Your response at these times cannot be inaction. When you receive or observe new or unexpected information about a person you are supporting, you must document the information you received, document who you reported the information to, and document your follow-up. As a Support Coordinator, you are a mandated reporter and are required to make a report with the Office of Licensing and Human Rights, as appropriate through the CHRIS system for all Level 3 Serious Incidents and Level 2 Serious Incidents that happen within the provision of your service. All people have the right to be free from abuse and neglect and protected from serious injury. Should you have questions or concerns about whether to report incidents or allegations, or questions about restrictions in plans including the use of restraints, talk to your supervisor and contact your Office of Licensing specialist or local Human Rights Advocate.^{44 45 46 47}

⁴⁰ 86% of individuals authorized for Therapeutic Consultation Services (behavioral supports) receive, in accordance with the time frames set forth in the DD Waiver Regulations, A) a functional behavior assessment; B) a plan for supports; C) training of family members and providers providing care to the individual in implementing the plan for supports; and D) monitoring of the plan for supports that includes data review and plan revision as necessary until the Personal Support Team determines that the Therapeutic Consultation Service is no longer needed.

⁴¹ At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.

⁴² The Commonwealth will provide the practice guidelines and a training program for case managers regarding the minimum elements that constitute an adequately designed behavioral program and what can be observed to determine whether the plan is appropriately implemented.

⁴³ (2) 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)

⁴⁴ a. The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process. This includes assessing whether: i. Serious incidents required to be reported under the Licensing Regulations are reported within 24 hours of discovery.

⁴⁵ For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans.

⁴⁶ At least 95% of individual service recipients are free from neglect and abuse by paid support staff.

⁴⁷ At least 95% of individual service recipients are adequately protected from serious injuries in service settings.

Script for Settlement Agreement Compliance Indicators Video for SCs

When someone you support is in crisis and has been admitted to one of the psychiatric hospitals, a referral to REACH shall be completed within 72 hours.⁴⁸ When someone you support is in crisis and has been admitted to either a psychiatric hospital or a REACH house, the individual shall have a community residence identified within 30 days.⁴⁹ DBHDS will also be developing a tool to help in identifying individuals who are at risk for crisis that may be used at every Face to face visit. Training will be provided when it is available.^{50 51}

Recap

- There are two types of monitoring, Targeted Case Management (TCM) and Enhanced Case Management (ECM). TCM visits require visits at least every 90. ECM requires monthly visits that are no more than 40 days apart.
- At least every 90 days, the Support Coordinator shall assess whether the individual's status or need for services and supports has changed and assess whether the individual's support plan was implemented appropriately and remains appropriate to the individual. Based on these assessments the plan will be modified as needed.
- Review plans for support and quarterly reviews to assure risk mediation plans are present and are being followed. This includes ensuring people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.
- All people have the right to be free from abuse and neglect and protected from serious injury. Should you have questions or concerns about whether to report incidents or allegations, or questions about restrictions in plans including the use of restraints, talk to your supervisor and contact your licensing specialist or local human rights advocate.

Accountability

With the support of your supervisors and directors, DBHDS is completing support coordinator quality reviews through a chart review process based on several elements covered in this video. The Support Coordinator will be reviewed for performance in certain areas and will be held accountable for meeting the standards as identified in the licensing regulations, DD waiver regulations and performance contract. The Quality Improvement Division with DBHDS will conduct annual reviews to validate the CSB's reporting of data by coming on-site and reviewing a sample of records and providing feedback as needed. Any CSB that has two or more records that are not up to standards will receive technical assistance provided by DBDHS. If improvement is not noted, the CSB shall be required to make corrective actions if cited for non-compliance with regulations. There may be actions taken to enforce

⁴⁸ 95% of children and adults admitted to state-operated and private psychiatric hospitals who are known to the CSB will be referred promptly (within 72 hours of admission) to REACH. III.C.6.a.i-iii.2 (p8)

⁴⁹ 86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities and psychiatric hospitals will have a community residence identified within 30 days of admission. III.C.6.b.iii.B (p12)

⁵⁰ All Execs, DD Directors, SC Supervisors and SCs will participate when available from DBHDS

⁵¹ DBHDS will add a provision to the CSB Performance Contract requiring, for individuals who receive ongoing case management, the CSB case manager to assess an individual's risk for crisis during face to face visits and refer to REACH when a need is identified.

Script for Settlement Agreement Compliance Indicators Video for SCs

the needed changes based on negative findings. Data from the DBHDS reviews shall be shared with the CSBs at least semi-annually.^{52 53 54 55 56 57 58 59 60 61 62}

⁵² DBHDS will perform a quality review of case management services through CSB case management supervisors/QI specialists, who will conduct a Case Management Quality Review that reviews the bulleted elements listed below.

⁵³ DBHDS will pull an annual statistically significant stratified statewide sample of individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB.

⁵⁴ DBHDS analysis of the data submitted will allow for review on a statewide and individual CSB level. The Case Management Quality Review will include review of whether the following ten elements are met:

⁵⁵ Any individual CSB that has 2 or more records that do not meet 86% compliance with Case Management Quality Review for two consecutive quarters will receive additional technical assistance provided by DBHDS.

⁵⁶ If, after receiving technical assistance, a CSB does not demonstrate improvement, the Case Management Steering Committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract and licensing regulations.

⁵⁷ DBHDS, through the Case Management Steering Committee, will ensure that the CSBs receive their case management performance data semi-annually at a minimum.

⁵⁸ 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.

⁵⁹ The Case Management Steering Committee will review and analyze the Case Management data submitted to DBHDS and report on CSB case management performance related to the ten elements and also at the aggregate level to determine the CSB's overall effectiveness in achieving outcomes for the population they serve (such as employment, self-direction, independent living, keeping children with families).

⁶⁰ The Case Management Steering Committee will also make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings.

⁶¹ Members of the DBHDS central office Quality Improvement Division will conduct annual retrospective reviews to validate the findings of the CSB case management supervisory reviews and to provide technical assistance to the case managers and supervisors for any needed improvements. A random subsample of the original sample will be drawn each year for this retrospective review. The sample will be stratified so that each CSB is included in the sample.

⁶² The DBHDS central office Quality Improvement Division's reviewers will visit each CSB in person and review case management records for the individuals in the sub-sample. They will then complete an electronic form so that agreement between the CSB Case Management Quality Review and the DBHDS Quality Improvement Division record reviews can be measured quantitatively, in addition to providing feedback to the CSB case management supervisors to increase the reliability of future reviews.