South Carolina Department of Disabilities & Special Needs

# Quality Management Bulletin

July 2023

## FY24 Key Indicators posted to the DDSN Website

Please visit the Quality Management Division section of the DDSN Website to access copies of the FY24 Key Indicators for Administrative Compliance and Individual Services (ACIS) Reviews, Licensing Reviews, and Day and Residential Observation/Participant Experience Surveys. https://ddsn.sc.gov/ddsn-divisions/quality-management\

## FY 23 Summary of Provider Compliance with Service Delivery Key Indicators

The data reported represents the statewide average compliance scores for each area of service delivery.

| Case Management Service Delivery Compliance Indicators | Early Intervention Service Delivery Compliance Indicators | Day Service Delivery Compliance Indicators | Employment Service Delivery Compliance Indicators | Residential Service Delivery Compliance Indicators |
|---|---|---|---|---|
| 90.9% Compliant | 93.7% Compliant | 94.1% Compliant | 96.6% Compliant | 87.8% Compliant |

## FY23 Licensing Inspections: Average Statewide Compliance By Setting Type

| | | |
|---|---|---|
| **CTH I** | 130 Settings Inspected | 95.3% Compliant |
| **CTH II** | 702 Settings Inspected | 93.7% Compliant |
| **SLP II** | 371 Settings Inspected | 95.5% Compliant |
| **Day Services** | 90 Settings Inspected | 95.2% Compliant |

## POST-PAYMENT CLAIMS REVIEW to begin in FY24

Performance Measures in the DDSN-operated Home and Community Based Services Waivers require the State to assure that claims for waiver services are only paid when the service is appropriately authorized, documented, and delivered in accordance with policy and the scope of the defined service. One way to determine whether claims are paid accurately is through post payment claims review.

DDSN, on behalf of SCDHHS, will begin conducting Post Payment Claims Reviews (PPCR) of providers in Fall 2023. Providers will be reviewed on a three-year cycle. The PPCR is used to verify that a service authorized to a person was delivered by the provider on every date reimbursement for the service was sought. This Review will include a determination of whether:

1. The person was eligible for services at the time of the claim;
2. The service was authorized in the person's Case Management Plan;
3. The units of service delivered align with the authorized units in the plan; and
4. There is sufficient documentation to support the service was delivered in accordance with the applicable service standards (including the person's plan) and service definitions. Documentation will vary depending on the service delivered. Documentation may include, but is not limited to: evidence of skills training, evidence of supervision, evidence of care provided, service notes, T-Logs, evidence of recreation/leisure activities, behavior support data, meeting notes, medication administration records, medical appointment records, etc.

The Post Payment Claims Review is a stand-alone process that will be managed by DDSN staff. It will not be linked to the provider's Administrative Compliance and Individual Services Review.

For more information, please review this link: *https://ddsn.sc.gov/ddsn-divisions/quality-management/post-payment-claims-review-process*

# Quality Management Plans…What Should Agencies Consider?

The DDSN Administrative Agency Standards (Admin. Agency Standards) were revised, effective January 1, 2023. The revision includes a reorganization of the information and several new standards. Among those new standards, is standard #701 which requires each provider to have a Quality Management Plan. A comprehensive quality management plan should draw ideas, standards, and measures from multiple sources and align with the Mission, Vision, Values, Principles, and Priorities of DDSN.

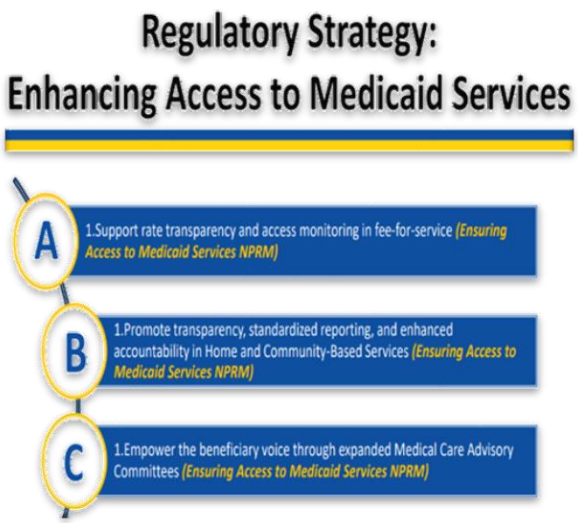
There is no "one size fits all" template for developing a Quality Management Plan. Each provider is unique, and that uniqueness will impact each provider's approach to ensuring the delivery of quality services. In general, the following questions should be considered when developing a Quality Management Plan that fits the organization's culture and the needs of the people it supports:

- What is important to the agency and to the people supported?
- How will the agency receive input from people supported? How will that information be used to guide the plan?
- What are the priorities?
- How will progress be measured?
- What are the agency's goals for the next year? Next 5 years?
- What strategies will be implemented to achieve these goals?
- Who will be responsible for implementing the planned strategies?
- How will the strategies be implemented? How will implementation of the strategies be monitored?
- How will you know if the strategies are successful in achieving the goals set?


Once the initial plan is developed, it should be reviewed for progress and amended at least every three years. Providers are encouraged to seek consultation and accreditation from recognized leaders in the field.

## CMS Access Rule: Proposed New Rule Making

The Centers for Medicare and Medicaid Services (CMS) has published a proposed new rule for Medicaid programs entitled Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality. This proposed rule is focused on improving access to care, quality and health outcomes, and addresses health equity issues in the Medicaid program across fee-for-service (FFS), managed care delivery systems, and in home and community-based services (HCBS) programs. The proposed improvements seek to increase transparency and accountability, standardize data and monitoring, and create opportunities for States to promote active beneficiary engagement in their Medicaid programs, with the goal of improving access to care.




This rule is focused on addressing additional critical elements of access:

1) potential access, which refers to a beneficiary's access to providers and services, whether the providers or services are used;
2) beneficiary utilization, which refers to beneficiaries' actual use of the providers and services available to them; and
3) beneficiaries' perceptions and experiences with the care they did or were not able to receive. These terms and definitions build upon previous efforts to examine how best to monitor access.

To learn more about the proposed Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Rule, please visit https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking.

# Incident Management Process Reminders:

### Initial Report

A report on the DDSN Incident Management System is required for all allegations of ANE and for Critical Incidents and Death Reports. It is the first report of an incident, which must be submitted through the DDSN's Incident Management System within 24 hours of discovery or recognition or the next business day.

### Administrative Review

The portion of the incident management reporting process through which circumstances of the incident are reviewed; evidence of policy or procedural violations or employee misconduct is weighed, and corrective action plan(s) are created.

The Administrative Review is intended to mitigate risks and prevent future incidents, where possible. During an Administrative Review, consideration is given to the circumstances of the incident, the applicable policies, procedures, or directives, determining evidence of misconduct, and development of a corrective action plan.

### Submission of Reports by ED/ Designee & Attestation

Incident reports require review prior to finalization for accuracy and to ensure that the final report has all required elements to allow for the closure of the incident. Each provider has an Executive Director/Designee responsible for submitting reports, which includes an attestation that the reports are complete and correct. Prior to electronically signing this attestation and submitting the report, the report is reviewed for content and clarity.

### Addendum

An Addendum is required within 10 calendar days whenever updated information, specific to an IMS report, has been uncovered. This includes updates regarding the final disposition of an allegation of ANE after an outside investigative agency has completed their report (i.e., SLED, Local Law Enforcement, DSS, the State Long Term Care Ombudsman, or Attorney General's Office).

An addendum is also required when the provider receives additional information that may affect the participants health, safety, or welfare, or to reflect a change in employment status for staff named in a report.

### Trend Analysis

Incident data and trend analysis may be used to help identify who is at risk, for what, and why. It also helps to identify emerging trends and patterns or provide evidence to support that strategies implemented to prevent recurrence are successful. Routine and ongoing monitoring of data over time is necessary to answer questions at the individual level and the system level. Using data from incidents to determine if there are patterns or trends which will inform future action or evaluate previously implemented actions.

## Questions to ask prior to submitting IMS Reports to DDSN may include any of the following:

| | | | | |
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| Does the report list all participants and staff who were present at the time of the incident and/or may have knowledge of the incident? | Were statements collected from all staff with direct knowledge of the event? | Was a statement collected from the person receiving services? | Was the family notified of the incident? | Were the appropriate state agencies informed of the allegations? |
| Was a statement collected from other residents that may have witnessed the event? | Did staff participate in the required OJT and/or annual training? | When were staff last trained in the ANE/CI Policy? | When were staff last trained on Resident Rights and dignity/respect issues? | When were staff last trained in Crisis Management? |
| Are the Crisis Management techniques effective in redirecting the person's behavior? | Was a GER appropriately completed? | Date of last observation by the Psychologist/plan author: | Have staff been trained in the use of the BSP? | Is there a need to re-evaluate a Behavior Support Plan? |
| Was the location staffed according to individual plans? | Did a nurse assess the person or was the person sent for a medical evaluation? | If the person has a 1:1 staff assigned, who provided training to ensure the staff understood their responsibilities? | Date of last Management Team on-site review in the location (unannounced quarterly visit to the home): | Were there any findings during the Management Team On-site Review to be addressed? If so, were those actions completed? |

## Case Management: Responsibilities for Incident Review & Monitoring

Case Management providers have a responsibility to respond to reported allegations of ANE and critical incidents. Generally, a response must include:

- review of the reported allegation/incident,
- assessment of the actions taken by others in response to the allegation/incident,
- assessment of person's needs in response to the incident,
- implementation of interventions in response to identified needs, and
- monitoring to ensure the person's continued health, safety, and wellbeing.

For the Case Manager this may include, but is not limited to:

- Contacting the person to assess their status and determine any additional needs.
- Requesting and obtaining additional information needed to adequately explain an event to assess the actions taken to protect health, safety, and rights.
- Assessing the corrective actions to mitigate risk.
- Providing recommendations to the direct service provider to improve a situation and increase protections for a person when the review reveals inappropriate or potentially ineffective risk mitigation strategies.
- Completing changes to a plan based upon the incident, if applicable.
- Conducting ongoing monitoring of the situation to determine that the needs of the person are met.

All actions taken should be documented per DDSN standards, policies, and procedures.

## Provider Management Unannounced Visits

According to DDSN's Administrative Agency Standards (#403), providers of residential services must utilize upper-level management staff to conduct quarterly, unannounced visits to all residential settings. The unannounced visits are intended, at a minimum, to assure that the staffing is sufficient and appropriate supervision is provided. Many providers also use these visits as an opportunity to evaluate the quality of supports provided (satisfaction and knowledge) and evaluate the condition of the setting itself.

On-site visits afford an excellent opportunity to talk with people (those supported and staff) to ascertain if they are safe, free from abuse/neglect/exploitation, healthy, able to exercise rights, being treated fairly and respectfully, and supported to participate in their community. It is also an excellent opportunity to determine if people have important knowledge (how to report ANE, how to support people, etc.) and to determine if the environment is clean, free from hazards, appropriately furnished.

Documentation of Unannounced Provider Management Visits must include the date/time of the visit, the names of the staff/ caregivers and residents present, notation of any concerns and the actions taken in response to the concern. In addition, DDSN recommends that staff include the following information:

- *There is an appropriate staff/resident ratio, based on the identified needs of the people living in the home.*
- *People supported in the home are being actively supervised. Staff are engaged.*
- *Staff know procedures for reaching the House Manager/Supervisor in an emergency.*
- *Staff know procedures for reporting any allegations of ANE.*
- *The home and grounds are clean and well maintained.*
- *The home is appropriately secure, with no unauthorized restrictions in place.*
- *The furniture and equipment are in good working condition (indoors and outdoors).*
- *Note if there are any additional concerns that need to be addressed via the Provider's Risk Management Committee.*

Results of the unannounced visits should be shared with the provider's Risk Management Committee for strengths and challenges to be discussed and cross-training provided, where needed.

**SCDMH has a Community Crisis Response Intervention Team available 24/7**

You can contact them at **1-833-364-2274**.

If you are feeling suicidal, you are urged to call the National Suicide Prevention Line at **1-800-273-TALK**.

A crisis text line has also been established and can be reached by texting HOME to **741741**.

Email: mobilecrisis@scdmh.org

## Residential Reminders

- *At no time should the maximum licensed occupancy of a residence be exceeded by persons receiving Residential Habilitation or Respite. CTH IIs, specifically, are licensed for no more than 4 residents. If the number of Residential Habilitation participants exceeds 4, then the DDSN license is not valid. If the setting does not have a current, valid license, neither Residential Habilitation nor Respite can be claimed.*
- *Visitors are permitted at residential settings and do not contribute to the setting's maximum licensed occupancy. Please keep in mind that Residential Habilitation should not be claimed for a "visitor."*
- *Each resident must have a lease or residency agreement. The terms of the lease/agreement must be honored.*

## SLP I Assessments

DDSN Directive 104-01-DD: Certification and Licensing of DDSN Residential and Day Facilities has been revised. For any new SLP I setting, an Application to Operate must be completed, along with Attachment E. These forms must be submitted to license@ddsn.sc.gov prior to delivery of Residential Habilitation Services. Please also note that annual reassessment of all SLP I settings is required for the continued delivery of Residential Habilitation Services. DDSN may require evidence of the assertions on the Assessment prior to approval. Residential Habilitation Services delivered in settings that have not been properly assessed may be subject to audit/review findings.

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| ***New SLP I Setting/ participant*** | *The Application to Operate and Attachment E (SLP I Assessment) must be completed, signed, and dated by the Residential Habilitation Provider Executive Director. The address must be a complete street address to include the apartment/unit and zip code. Without this information, a delay may occur in the SPM update process. A copy of the SLP I Assessment must be provided to the participant's case manager for submission to the Residential Services Committee. The Residential Services Committee will approve or disapprove Residential Habilitation Services and forward the determination to the Quality Management Division for SPM update. If approved, the Committee will then await the case manager's SCOMM submission indicating the actual start date of Residential Habilitation Services in the setting.* |
| ***Moves to New SLP I Setting:*** | *The Application to Operate and Attachment E (SLP I Assessment) must be completed, signed, and dated by the Residential Habilitation Provider Executive Director. The address must be a complete street address to include the apartment/unit and zip code. Without this information, a delay may occur in the SPM update process. The information must be sent to license@ddsn.sc.gov. SLP I Assessments are to be completed moves from one SLP I setting to another SLP I setting. This includes apartment changes within the same complex. SLP I Assessments are individual and location specific and must be completed before Residential Habilitation Services are delivered in any setting. A copy of the SLP I Assessment must be sent to the participant's case manager.* |
| ***Annual SLP I Assessment:*** | *The revised (effective 3.1.23) SLP I Assessment (Attachment E) is required annually (within 12 months) to re-determine the appropriateness of the setting for the participant. A copy of the annual SLP I Assessment must be sent to license@ddsn.sc.gov and to the participant's case manager.* |

Attachments for Reference:

- 104-01-DD - Certification and Licensure of DDSN Residential and Day Facilities - REVISED (011923) (sc.gov)
- 104-01-DD Attachment A - Application to Operate - REVISED (011923).pdf (sc.gov)
- 104-01-DD Attachment E - SLP-I Assessment - NEW (011923).pdf (sc.gov)

## Risk Management Requirements for all providers

All providers are required to have a Risk Management Committee that meets on a ***quarterly*** basis to review data, training and monitoring activities, and the completion of tracking/trending/analysis.

| **Allegations of Abuse, Neglect or Exploitation** must be reviewed on a quarterly basis using the following information:<br><br>1. The total number of allegations made;<br>2. The types of allegations, including a trend of when and where they were reported;<br>3. The number of substantiated allegations, as determined by local law enforcement, SLED, DSS, or the Attorney General's Office;<br>4. The number of Administrative Findings, as determined by verified Standard of Care allegations, through DSS or the State Long Term Care Ombudsman's Office or a Regional Ombudsman. A distinction should be made between allegations with known and unknown perpetrators and the types of violations cited (i.e., Administrative Oversight, Dignity & Respect, Supervision, etc.);<br>5. The number of initial reports submitted in compliance with policy; and<br>6. The number of final reports submitted in compliance with policy. | **Critical Incidents and General Event Reports** must be reviewed quarterly to include the type and frequency of incidents reported, including a trend of when and where they were reported, and ensuring the appropriate reporting category has been selected;<br><br>1. The number of initial reports submitted in compliance with policy; and<br>2. The number of final reports submitted in compliance with policy. | **Medication Errors/Events** Must be reviewed for Day and Residential Service settings according to DDSN Directive 100-29-DD: Medication Error/ Event Reporting.<br><br>Three (3) categories of errors/events will be analyzed:<br><br>A. Medication errors;<br>B. Transcription/documentation errors; and<br>C. Red flag events.<br><br>Providers are required to maintain a monthly medication error rate, per service location, to identify trends related to specific settings. | **Restraints and/or other restrictive interventions** must be reviewed, including documentation of each restraint employed, by type, to include the staff implementing the restraint, the duration of the restraint, notification provided to the Human Rights Committee, and notification provided to the Behavior Supports provider.<br><br>When planned restraints are included in the Behavior Support Plans, the provider ensures the Behavior Support Plans are submitted to DDSN for approval.<br><br>When restrictive interventions are employed as a default action because other measures in the Behavior Support Plan were not effective, the restraint/restrictive intervention must be reported as a Critical Incident.<br><br>Consumer/staff injury resulting from the use of restraints must be tracked and analyzed.<br><br>Narrative information may also be analyzed to identify more specific trends with a continual emphasis on restraint reduction and elimination. If there are no restraints or restrictive interventions reported for the prior review period, the provider must document their monitoring efforts to ensure unauthorized restraints were not implemented. |
|---|---|---|---|

*With all types of Incident Management Reports, the Risk Management Committee may also include narrative information to identify more specific trends.*

## Documentation of Incidents/Events and Records Retention

Providers should review their policy regarding the use of T-Logs, General Event Reports (GERs), and other documentation with staff to ensure consistency. S-Comms or E-mails should never take the place of official documentation in the person's record. As indicated in the Administrative Agency Standards, # 111, the provider must keep information about its service users up to date on Therap, DDSN's Consumer Data Support System/Service Tracking System and Waiver Tracking Systems. In addition, Standard # 110 requires providers to have a records management system for tracking and safeguarding individual and Agency records and complies with applicable laws, regulations, and policies. When there are incidents/events affecting people supported, the provider may be requested to provide all related documentation. When the incidents/events are documented in S-Comms and E-mails, the provider may be required to produce their electronic communications for investigative agencies, via subpoena.

# Provider Performance related to Staff Training & ANE/Critical Incident Reporting

CMS, DHHS, and DDSN require qualified, trained staff for the delivery of all Home and Community Based Services. This includes the following assurances:

1. the minimum qualifications for the employee's/contractor's position are met and
2. the satisfactory completion of all training requirements.

DDSN must periodically provide evidence to CMS and DHHS regarding of its review of staff qualifications and training requirements. This data is collected through the provider's Administrative Compliance and Individual Services (ACIS) Reviews. A composite score is provided for each service provider type to identify their compliance with staff qualifications and training requirements and to distinguish staff in service areas that are compliant versus those who are not. When providers receive citations during the review, they must submit a plan of correction to address the concern both individually and systemically. A follow-up review is then completed approximately 4-6 months later to ensure successful implementation of the Plan of Correction (POC).

Training related to the prevention and reporting of allegations of Abuse, Neglect, and Exploitation and other Critical Incidents is especially important. Based on the data presented below, DDSN contracted providers, collectively, have not been able to sustain improvements in this area.

**The overall compliance for Providers meeting all staff qualifications and training requirements is 82%.**

| Provider Type | Percentage of contracted **providers** meeting all staff qualifications and training requirements | Percentage of DDSN Contracted provider **staff** meeting qualifications and training requirements |
|---|---|---|
| Case Management | 79% | 94% |
| Day Services | 86% | 93% |
| In-Home Supports | 86% | 94% |
| Employment | 100% | 96% |
| Residential Habilitation | 74% | 88% |

When measuring compliance with the Key Indicator "DDSN Contracted Provider Staff must pass mandatory, competency based ANE training, as required, during pre-service orientation," DDSN's contracted Quality Improvement Organization (QIO) found the following results:

- 80% Day Services Management Providers were compliant.
- 100% Employment Services Providers were compliant.
- 72% Residential Habilitation Providers were compliant.

When measuring compliance with the Key Indicator "DDSN Contracted Provider Staff, when employed after 1 year, must pass mandatory, competency based ANE training within 12 months of their prior training date(s)," DDSN's contracted Quality Improvement Organization (QIO) found the following results:

- 67% Waiver Case Management Providers were compliant.
- 68% Day Services Management Providers were compliant.
- 100% Employment Services Providers were compliant.
- 62% Residential Habilitation Providers were compliant.

Meeting required timelines for the submission of initial reports and the Administrative Reviews is another area closely monitored by CMS and DHHS. When provider compliance falls below 86%, a Plan of Correction will be required to address strategies to improve timely reporting and review of incidents.

- When measuring the number and percent of the allegations of ANE and Critical Incidents that are initially reported within the required timeframe, the statewide average among Home and Community-Based Waiver Service Providers is 77%.

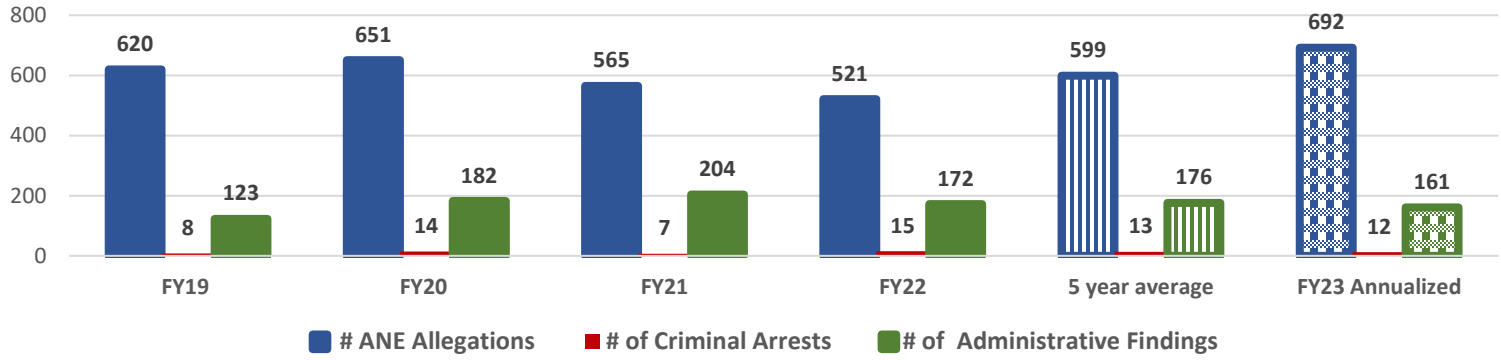
- When measuring the number and percent of the allegations of ANE and Critical Incidents finalized, including strategies to mitigate/prevent future incidents, within the required timeframe, the statewide average among Home and Community-Based Waiver Service Providers is 94%.

# SCDDSN Incident Management Report 5-year trend data

*for* Community-Based Services *(Includes Residential & Day Service Settings) Thru 3/31/2023*

| Allegations of Abuse, Neglect, Exploitation | FY19 | FY20 | FY21 | FY22 | 5 YEAR Average | FY23 Annualized (Thru Q3) |
|---|---|---|---|---|---|---|
| **# of Individual ANE Allegations** | 620 | 651 | 565 | 543 | **599** | 692 (519) |
| **# of ANE Incident Reports** (One report may involve multiple allegations) | 415 | 436 | 388 | 389 | **416** | 472 (354) |
| **Rate per 100** | 9.6 | 11.8 | 10.9 | 9.3 | **10.7** | 8.5 |
| **# ANE Allegations resulting in Criminal Arrest** | 8 | 14 | 7 | 15 | **13** | 12 (9) |
| **# ANE Allegations with Administrative Findings** from DSS or State Long-Term Care Ombudsman | 123 | 182 | 204 | 172 | **177** | 161 (121) |

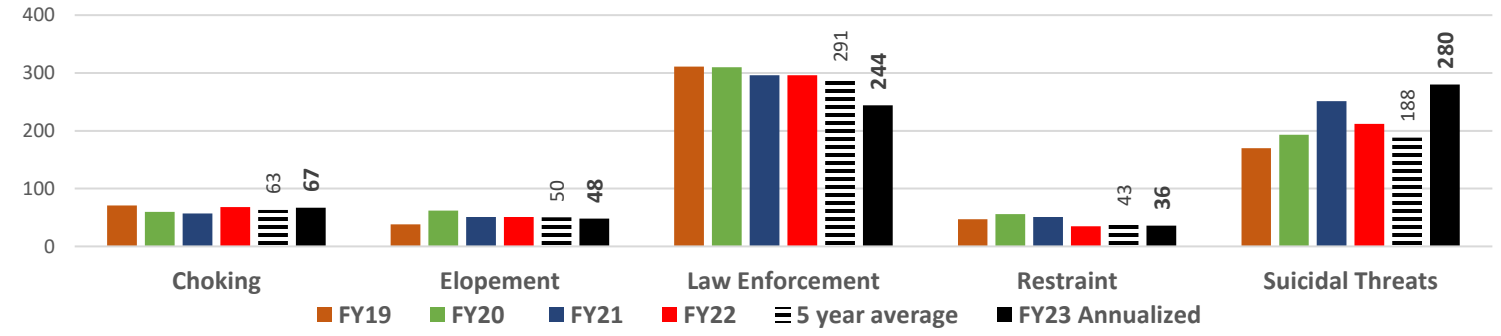
## ANE Allegations: Comparison to Arrest Data & Administrative Findings




There were 2 ANE Reports for FY23 involving children under the age of 18. All other reports were for adults.

| Critical Incident Reporting | FY19 | FY20 | FY21 | FY22 | 5 YEAR Average | FY23 Annualized (Thru Q3) |
|---|---|---|---|---|---|---|
| **# Critical Incidents** | 916 | 982 | 974 | 1245 | **1037** | 1096 (822) |
| **Rate per 100** | 9.6 | 11.8 | 10.9 | 15.4 | **11.9** | 13.2 |
| **# Choking Events** | 71 | 65 | 57 | 68 | **64** | 67 (50) |
| **# Law Enforcement Calls** | 311 | 310 | 296 | 296 | **291** | 244 (183) |
| **# Suicidal Threats** | 170 | 193 | 251 | 212 | **188** | 280 (210) |
| **# Emergency Restraints or Restraints w/ Injury** | 47 | 56 | 51 | 35 | **43** | 29 (22) |

## 5 Year Critical Incident Trend Report- Community Settings




There was 1 Critical Incident Report for FY23 involving a child under the age of 18. All other reports were for adults.

| Death Reporting | FY19 | FY20 | FY21 | FY22 | 5 YEAR Average | FY23 Annualized (Thru Q3) |
|---|---|---|---|---|---|---|
| **# of Deaths Reported- Community Settings** | 78 | 86 | 130 | 102 | **94** | 105 (79) |
| **Rate per 100** | 1.6 | 1.9 | 2.8 | 2.2 | **2.0** | 2.2 |
| | | | | | | |

*Report Date: 5/5/2023*