South Carolina Department of Disabilities & Special Needs
Quality Management Bulletin
November 2022

Contract Compliance Reviews

The DDSN Directive 104-03-DD: Contract Compliance Reviews for Non ICF-IID Programs was revised, effective June 16, 2022. The revision reflects requirements outlined in the Performance Measures included in the Home and community-Based Waivers. The 86% threshold is consistent with CMS requirements for remediation and Quality Improvement Plans. The 12-month review is the standard. The 18-month review is an accommodation for providers that have scored at 86% compliance, or above. In addition to raising the threshold from 75% to 86%, overall, we require at least 86% in all service areas.

DDSN no longer uses an "overall" score for providers. That system worked well when our system was mostly made up of DSN Boards. Now that we have a lot of qualified providers who often deliver only 1 or 2 types of services, the distribution of scores across multiple service areas at DSN Boards made it difficult to compare performance to other providers. By providing distinct scores for each service, performance can be measured for all providers across the same type and number of indicators. This is necessary for reporting requirements to DHHS and to CMS.

As additional information, about 50% of providers have scored below the 86% threshold in one or more areas during FY22. Only 5 providers scored between 75% and 84.9% and no provider scored between 85.0% and 85.9%. 104-03-DD - DDSN Contract Compliance Reviews for Non ICF-IID Programs- REVISED (061422).pdf (sc.gov)

Reconsideration Period for Reviews

As Alliant meets completes their review, they will summarize findings for providers and open a short window of time for the submission of any clarifying information. This period is not intended to be an extension to initially submit information. Alliant will not accept new information if the provider did not attempt to demonstrate compliance by the original due date.

Plans of Correction- Compliance with Due Dates for Submission

Plans of Correction are required for both Licensing and Contract compliance Reviews. Licensing POCs are due within 15 days of the receipt Report of Findings. Contract Compliance POCs are due within 30 days of the receipt of the Report of Findings. Compliance with these timelines will be monitored as a Performance Measure to DHHS. In the event a Report of Findings must be re-issued, the Plan of Correction will be due within 15/30 days of the revised Report of Findings.

QM BY THE NUMBERS
JULY 1, 2021 - JUNE 30, 2022

Contract Compliance Reviews Completed:

86 Provider Reviews
69 Follow-up Reviews
11 2nd Follow-up Reviews

Day Service Observation:
87 On-site Visits

Residential Observation:
307 On-Site Visits

Licensing Reviews Completed:

84 Initial Licensing Inspections (New Locations)
1509 Annual On-site Inspections/ Individual locations
811 Follow-up Reviews
176 2nd Follow-up Reviews

1,110 Admission/Discharge/ Transfer Forms processed

786 Abuse, Neglect and Exploitation Allegations Reviewed within **544** Individual Reports

1868 Critical Incident/ Adverse Operations Reports Reviewed

138 Death Reports Reviewed

Licensing Inspections

The DDSN Directive 104-01-DD Certification and Licensure of DDSN Residential and Day Facilities was revised, effective June 16, 2022. The directive clarifies that a setting may not be occupied until a license has been received and services have been authorized by the Case Manager. Admission/Transfer/Discharge forms are required for each residential participant. The directive also states that all CTH I and CTH II settings will have a Health and Sanitation Inspection at the time of the annual State Fire Marshal inspection. 104-01-DD - Certification and Licensure of DDSN Residential and Day Facilities - REVISED (061622) (sc.gov)

As a new issue to many providers, DDSN has requested that Alliant monitor the condition of mattresses within licensed residential settings. The Residential Licensing Standards include a requirement for "… a clean, comfortable bed (including appropriately sized bed frame and mattress), pillow, and linen appropriate to the climate…" Unfortunately, there have been findings where residents are sleeping on heavily soiled mattresses, sometimes with no sheets and just a blanket on top.

Residential Habilitation can only be provided in an appropriately licensed setting. As part of the regular communication with residents of each home, provider staff may want to include a discussion about the need for licensing inspections to ensure homes meet the residents' needs, including protections for health and safety. This may also include a discussion about mattresses and bedding and the need to review to ensure there are not unsanitary conditions present.

Because a license is required for Residential Habilitation, the processes associated with the licensing inspection are not in violation of the HCBS Settings Rule. Licensing Inspections have not specifically looked at the condition of mattresses in prior years, but they could have been included. Because the agency is accepting Medicaid funding for the provision of services, minimum standards have been established that may or may not meet standards we have accepted for our own homes.

Residential Licensing Standards - Revised (061820).pdf (sc.gov)

Licensing Class 1 Deficiencies - Notice and Follow-up

Providers will continue to remediate any Class 1 citations on-site at the time of the review, but a Plan of Correction will also be required to address how the issue developed that resulted in the Class 1 citation. This will include a review of on-site quarterly unannounced visits to the designated location within the prior 12 months.

Day/Residential Observation Follow-up and Provider Response

Most Observation visits do not require a formal Plan of Correction, but there may be circumstances that require documentation of follow-up with DDSN. Plans of Correction may be required when an on-site Day or Residential Observation results in concerns about the participants' health, safety, or welfare. In these situations, a formal notice will be sent to the provider with timelines for response that are dependent on the situation observed.

DHHS Provider Reviews for Waiver Services

DHHS has started a review of Waiver Service documentation for 35 DDSN contracted providers throughout 2022. To date, initial results have been provided for about 10 reviews. Findings have been forwarded to providers with a request for any information needed for reconsideration purposes, or corrective action plans.

The DHHS reviews are conducted as a part of the State's requirements outlined in the Waiver Applications and are separate from the QIO Reviews coordinated through DDSN (Alliant). The purpose is to verify services were provided according to the scope defined in the Waiver.

Home and Community-Based Services Quality Measure Set

CMS issued a letter to State Medicaid Directors on July 21, 2022, indicating the launch of the Home and Community-Based Services Quality Measure Set. CMS desires to have a uniform set of data that could be used for Performance Measure Reporting across States and Waiver types. Tools specifically mentioned in the HCBS Quality Measure Set include the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS), National Indicator Surveys, and Personal Outcome Measures from the Council on Quality and Leadership. Other nationally standardized and tested measures related to access, rebalancing, community integration, health and safety, and person-centered practices may be added. At this time, the HCBS Quality Measure Set is "encouraged," but requirements appear forthcoming.

CMS Releases First-Ever Home- and Community-Based Services Quality Measure Set | CMS

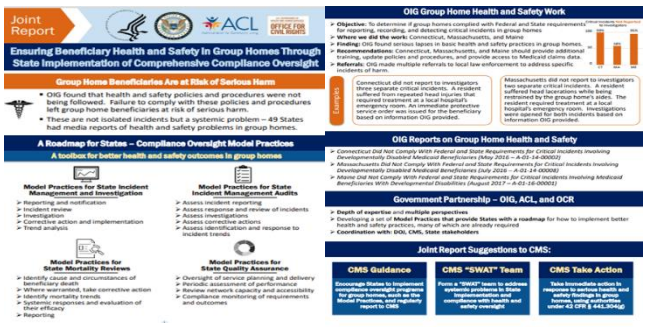
The Office of Inspector General (OIG) Investigation in SC

The OIG has performed audits in several States in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. This request was made in response to nationwide media coverage of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors. Their objective was to determine whether South Carolina complied with Federal Medicaid waiver and State requirements for reporting and monitoring ANE Allegations, Death Reports, and Critical Incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

- The OIG reviewed South Carolina's compliance with Intellectually Disabled and Related Disabilities (IDRD) waiver requirements for reporting and monitoring during our audit period of January 1, 2015, through June 30, 2017. This included over 7,000 adult ID/RD Waiver beneficiaries.

- SCDDSN and SCDHHS and DDSN are working together to address findings cited in the report. The agencies meet on a monthly basis to discuss corrective actions. This progress is also monitored by CMS. Action items include:

  - Monitoring timely submission of ANE, Critical Incident, and Death Reports. This includes initial reports submitted within 24 hours and final reports submitted within 10 days (or 5 days for ICF/IID and CRCF).
  - Completion of internal reviews that address appropriate safety plans for the individuals involved and a remediation strategy to prevent future incidents.
  - Staff training to ensure compliance with policy.
  - Review of Medicaid claims to detect unreported incidents.
  - Development of a new Incident Management System to provide better analytics and streamline reporting procedures.



Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight Joint Report* 1/17/2018 * *This report was jointly prepared by the Department of Health and Human Services, Office of Inspector General; the Administration for Community Living; and the Office for Civil Rights*

Quality Management Plan

Each DDSN Contracted Provider Agency is required to have a Quality Management Plan, which shall include the following information:

- Performance measures
- Performance improvement targets and strategies
- Experience surveys from Stakeholders
- Data sources used to measure performance
- Staff roles and responsibilities of the staff persons related QM

The provider shall revise the quality management plan no less than every 3 years. 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. Providers are encouraged to seek consultation and accreditation from nationally recognized leaders in the field.

Provider Management Unannounced Visits can make a Positive Difference

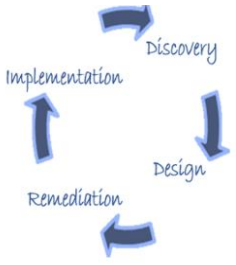
DDSN's Administrative Agency Standards include a requirement that all agencies providing residential services to engage upper level management staff to conduct quarterly, unannounced visits at each setting on each shift. The unannounced visits are intended to assure that the staffing is sufficient and appropriate supervision is provided. Further guidance states that when the residential setting uses a shift model for staffing, visits during a year must include a visit made during each shift. Also, when managers are used to conduct the unannounced visits, managers are not allowed to conduct visits in homes for which they are directly responsible, but they may visit homes for which their counterparts are responsible. In addition to these minimal guidelines, providers can use the unannounced visits as an opportunity to evaluate the quality of supports provided and identify any additional training or support needs.

The on-site visits are a great time to talk with people living in the homes about their day-to-day activities, their interests in community activities, awareness of rights/responsibilities, and reporting procedures for Abuse, Neglect, Exploitation, or Mistreatment. This will help both residents and staff to become more comfortable with the questions and prompt discussion and feedback that can be used for each person's individualized plan. Providers can monitor their progress towards Compliance Action Plans for the HCBS Settings Regulation by gathering information during their unannounced visits. This will also help prepare folks for the Residential Observation completed by Alliant and serve as a way to document implementation of any Plans of Correction from prior Licensing or Contract Compliance Review findings.

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.

DDSN Risk Division: Review of Community-Based Provider Reports

The DDSN Risk Division is currently reviewing all allegations of Abuse, Neglect, and Exploitation reported for Regional Centers. In addition, the DDSN Risk Division may periodically conduct an Administrative Review of a Community-Based Provider's Incident Management Report(s). The additional level of Administrative Review may be determined by the following criteria:

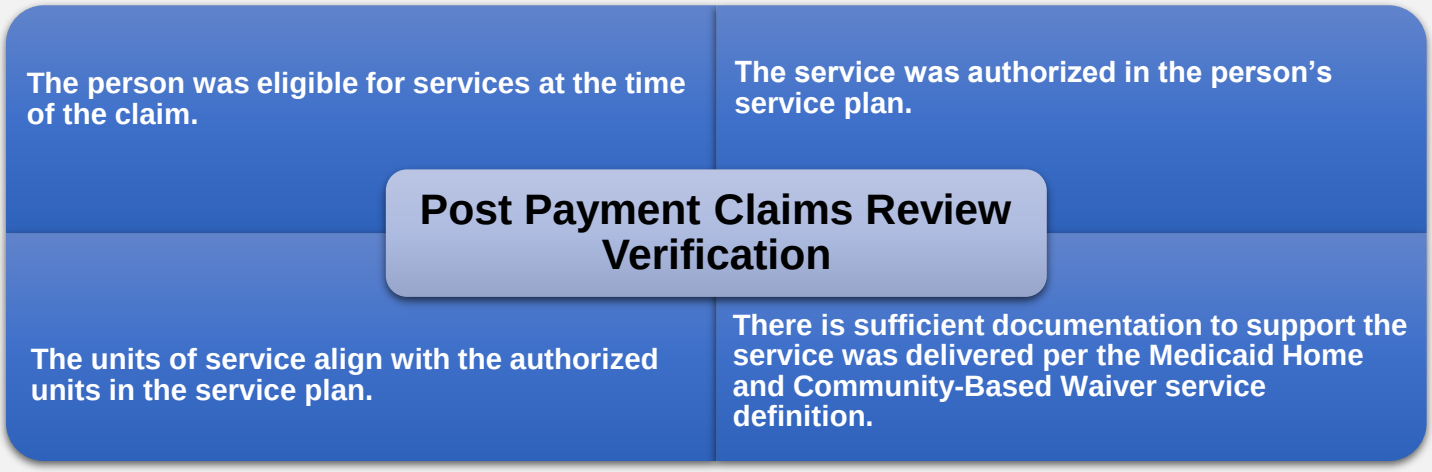
- Significant Injury: Incidents involving significant injury.
- Significant risk: Concerns resulting from the supervision and supports rendered being inconsistent with those outlined in the person's Plan.
- Multiple reports of unauthorized activities, gaps in oversight, or concerns regarding the physical condition of the service settings
- Complaints and/or observations noted through QA/QI activities, or through contacts with, or contacts related to, the provider
- Inconsistent documentation related to incident reports
- A noticeable change in reporting trends
- Upon the request of the provider agency or another state agency

The additional level of Administrative Review is designed to ensure appropriate safeguards for DDSN service recipients and compliance with DDSN Standards/Directives.

Post-Payment Claims Review

All of the DDSN Operated HCB Waivers have assurances for financial integrity. With the renewals of each Waiver, the performance measures include a requirement for a Post Payment Claim Review process. The PPCR is used to verify that service authorized to a person was delivered by the provider on every date reimbursement for the service was sought. Discrepancies found within the service documentation and actual service delivery will be reported to SCDHHS Program Integrity for further investigation.

The intended outcome of this process is to compliment the Contract Compliance Review process and assure the following for paid claims for waiver participants:



This process is currently in the development stages. More information will be shared as the development continues.

Providers need to ensure they have adequate policies and procedures in place to validate each service billed has documentation to support the claim. Attendance is not service provision. Please review your scope of services to ensure you are capturing the right information and at the right frequency to validate your claims.

Mortality Review Process

For FY23, DDSN will be implementing a new Mortality Review Process. Providers will continue to submit death reports in the IMS. A designated staff will review and follow-up on death reports to ensure timely, complete reports. This will also facilitate the sharing of information with SLED and the Vulnerable Adult Fatality Review Committee. Trend information will be shared with providers.

Conducting mortality reviews of deaths will be an additional component of the SCDDSN Incident Management Process. Trends/patterns identified by morality reviews help inform SCDDSN of areas that may need systemic quality improvement, such as managing chronic health conditions, preventing or mitigating adverse medical conditions, accessing appropriate healthcare services in a timely manner, and preventing injuries and death due to abuse and/or neglect.

Definitions

Expected Death (Natural Causes) Primarily attributed to a terminal illness or an internal malfunction of the body not directly influenced by external forces. This includes a death that is medically determined, based on a death certificate and supporting documentation, to have resulted solely from a diagnosed degenerative condition or a death that occurs as the result of an undiagnosed condition resulting from an explained condition, such as the aging process.

Unexpected Death

An unexpected death is primarily attributed to an external unexpected force acting upon the person. Deaths attributed to events such as car accidents, falls, homicide, choking and suicides would be considered unexpected.

Unexplained death

A death in which the cause of death noted on a person's death certificate is not supported by documentation found in the person's medical history and other documentation. This type of death will be included in information reported as part of waiver assurances to the

Intended Outcomes for Mortality Reviews

- Identification of corrective actions that may eliminate or lessen the likelihood of circumstances and events that contribute to or are associated with the causes related to specific deaths.
- Identification of the immediate and longer-term circumstances and events that contributed to or were associated with deaths.
- Identification of trends and patterns in deaths that indicate needed systemic changes or reforms in community-based services that may reduce the risk of death and other adverse outcomes for service recipients.
- Appropriate and timely implementation of identified corrective actions and systemic changes and reforms to reduce the risk of death and other adverse outcomes for service recipients.
- Ongoing evaluation to ensure that implemented corrective actions and systemic changes or reforms have been effective in reducing the risk of death and other adverse outcomes for service recipients.
- Periodic public reporting on the number, causes, and circumstances of deaths to ensure public transparency regarding the health, welfare, and safety of beneficiaries of community-based services.
- Identification of service providers having a pattern of delayed or failed death reporting or of filing reports that are misleading or incomplete.

Therap General Event Reports (GERs): Clean-up of "unapproved" reports in the system

Providers are asked to monitor GERs in Therap to ensure they are approved within appropriate timeframes. Several providers have been observed with trends of leaving GERs in an unapproved status for extended periods.

Corrective Action Plans due to Material Deficiencies

DDSN maintains oversight authority and provides assurances to the Department of Health & Human Services (DHHS) that services are delivered as authorized. When providers fail to meet compliance through the typical remediation process, or when there are documented trends adversely affecting service delivery, a notice of material deficiencies will be issued. When such notice is issued, the provider must submit a Corrective Action Plan (CAP) to the Quality Management Division outlining the actions it will take to thoroughly remediate the areas of deficiency, including but not limited to updates in policy(ies), procedures, training(s) by appropriately-credentialed entities or individuals, and/or increased oversight by the agency management.

Criteria for issuing a Notice of Material Deficiencies may include, but are not limited to, the following:

- Incident Management Reports demonstrating a trend of significant injuries or staff actions/inactions that pose a risk to individuals supported. This includes patterns of late reporting of incidents.
- Significant Health & Safety concerns cited during Licensing Reviews
- Significant Non-Compliance with Qualifications and Staff Training requirements as determined through the appropriate review tool for a service (e.g., Contract Compliance or Licensing Reviews). The compliance score will be determined by the final Report of Findings.
- Non-Compliance with basic service-specific requirements as determined through the Contract Compliance Review for a service (e.g., Day Service, Residential Habilitation, Early Intervention, etc.). The compliance score will be determined by the final Report of Findings
- Evidence of systemic non-compliance in maintaining service delivery documentation to support claims for services rendered
- Evidence of systemic non-compliance in monitoring participant funds and personal property

DDSN will specify requirements for a CAP, but will not provide its content.
Each provider will be expected to rely upon or develop their internal capacities to reach compliance.

The CAP must identify, with specificity, each of the following elements:

- ✓ The dates by which each component will be completed;
- ✓ Specific topics and goals of any staff trainings;
- ✓ The credentials and experience of the person/entity conducting any staff training that were basis for selection;
- ✓ What policies, procedures, or practices will be amended and how; and
- ✓ The strategies to be employed to ensure the actions identified in the CAP are implemented and effective to both correct the problem noted and prevent reoccurrence.

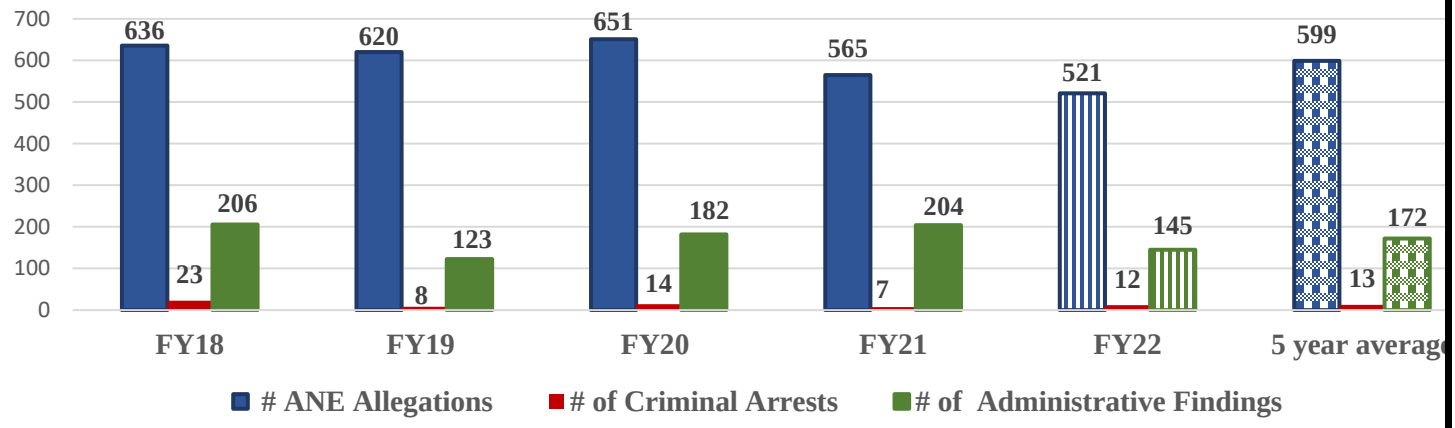
Upon receipt of a CAP, DDSN will accept or reject elements of the proposed CAP or the plan in its entirety. In the event of a rejection, the provider shall be required to resubmit a revised CAP. Upon acceptance of the CAP, the provider shall implement the corrective action plan and submit to DDSN an update of progress toward CAP fulfillment every 90 days. If actions from the CAP are not completed by the date specified in the plan, sanctions may be applied.

SCDDSN Incident Management Report 5-year trend data

for Community-Based Services *(Includes Residential & Day Service Settings) Thru 6/30/2022*

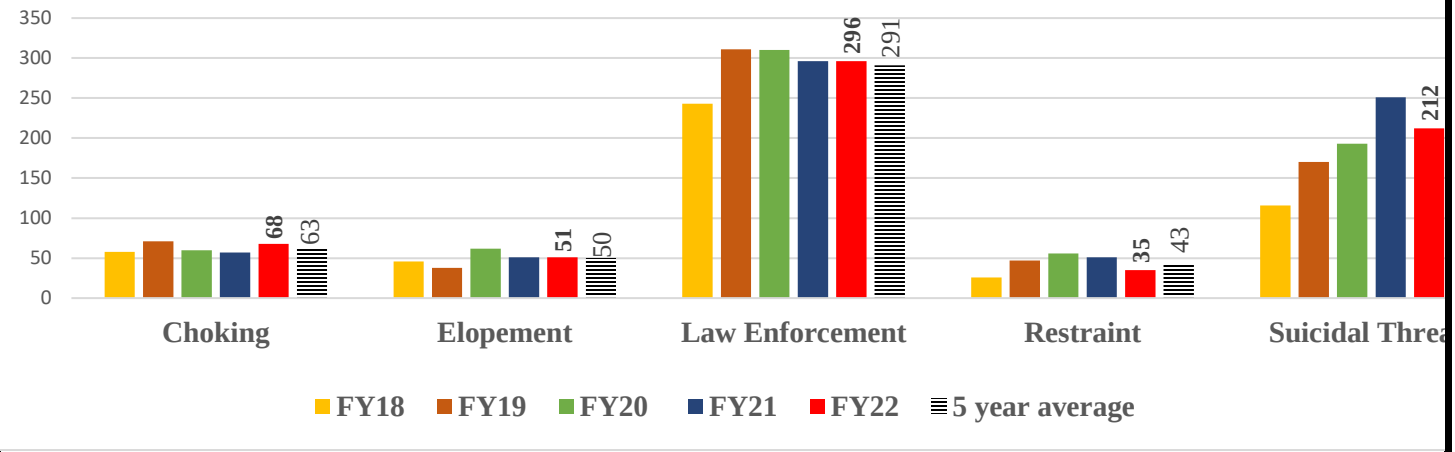
Allegations of Abuse, Neglect, Exploitation	FY18	FY19	FY20	FY21	FY22	5 YEAR Average
# of Individual ANE Allegations	636	620	651	565	521	**599**
# of ANE Incident Reports (One report may involve multiple allegations)	450	415	436	388	371	**412**
Rate per 100	11.9	9.6	11.8	10.9	9.3	**10.7**
# ANE Allegations resulting in Criminal Arrest	23	8	14	7	12	**13**
# ANE Allegations with Administrative Findings from DSS or State Long-Term Care Ombudsman	206	123	182	204	145	**172**

ANE Allegations: Comparison to Arrest Data & Administrative Findings



Critical Incident Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average
# Critical Incidents	1071	916	982	974	1245	**1037**
Rate per 100	11.9	9.6	11.8	10.9	15.4	**11.9**
# Choking Events	58	71	65	57	68	**64**
# Law Enforcement Calls	243	311	310	296	296	**291**
# Suicidal Threats	116	170	193	251	212	**188**
# Emergency Restraints or Restraints w/ Injury	26	47	56	51	35	**43**

5 Year Critical Incident Trend Report- Community Settings



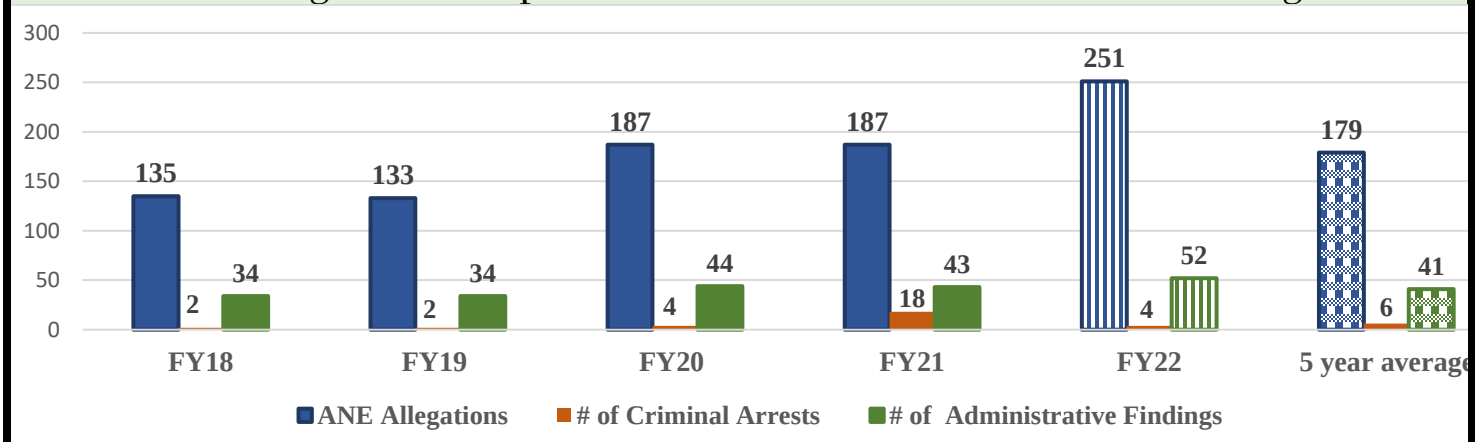
Death Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average
# of Deaths Reported- Community Settings	73	78	86	130	102	**94**
Rate per 100	1.6	1.6	1.9	2.8	2.2	**2.0**

SCDDSN Incident Management Report 5-year trend data

for Regional Centers *Thru 6/30/2022*

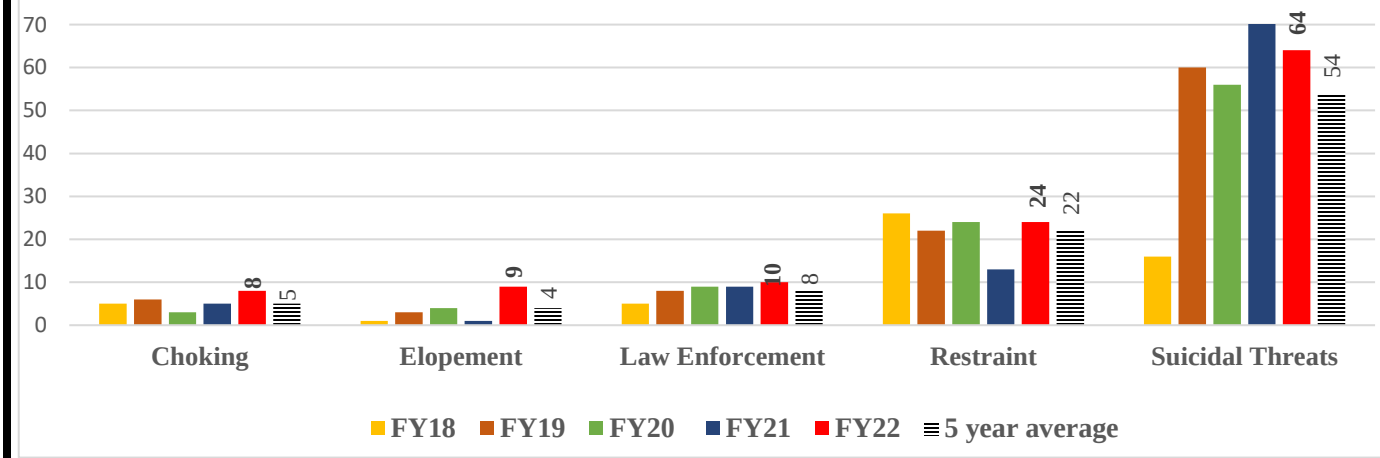
Allegations of Abuse, Neglect, & Exploitation	FY18	FY19	FY20	FY21	FY22	5 YEAR Average
# of Individual ANE Allegations	135	139	187	187	251	**179**
# of ANE Incident Reports (One report may involve multiple allegations)	97	102	136	138	165	**128**
Rate per 100	19.2	20.9	28.9	27.9	38.0	**27.0**
# ANE Allegations resulting in Criminal Arrest	2	2	5	19	4	**6**
# ANE Allegations with Administrative Findings from DSS or State Long-Term Care Ombudsman	34	34	44	43	52	**41**

ANE Allegations: Comparison to Arrest Data & Administrative Findings



Critical Incident Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average
# Critical Incidents	144	132	135	124	160	**139**
Rate per 100	20.6	18.6	20.8	19.1	24.2	**21.1**
# Choking Events	5	6	3	5	8	**5**
# Law Enforcement Calls	5	8	9	9	10	**8**
# Suicidal Threats	16	60	56	73	64	**54**
# Emergency Restraints or Restraints w/ Injury	26	22	24	13	24	**22**

5 Year Critical Incident Trend Report- Regional Centers



Death Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average
# of Deaths Reported - Regional Centers	27	33	22	48	36	**33**
Rate per 100	3.8	4.6	3.4	7.0	**5.4**	**4.8**