Support Coordination Services Performance Report 2020

GEORGIA DEPARTMENT *of*

BEHAVIORAL HEALTH *and* DEVELOPMENTAL DISABILITIES

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PURPOSE AND SCOPE OF THIS REPORT

The Department of Behavioral Health and Developmental Disabilities (DBHDD) seeks to review performance data regarding support coordination services, which includes two distinct waiver services entitled support coordination and intensive support coordination. This is a report of data analysis assessing the performance of support coordinators, their agencies, and Medicaid waiver support coordination service provision.

Performance review of support coordination occurs on an ongoing basis, and performance metrics are examined regularly (e.g., monthly or quarterly). Formal support coordination performance reports are issued at least annually.

This is the fifth annual report of information related to the provision of support coordination services. The Support Coordination Performance Report includes children and adults with a primary intellectual/developmental disability (IDD) diagnosis who received services funded by either the New Options Waiver (NOW) or Comprehensive Supports Waiver (COMP) during calendar year 2020 (CY20). Data within this report spans January 1, 2020, through December 31, 2020, except for health care level data, which extends back to December 31, 2019. Where appropriate, CY20 data have been broken into quarterly timeframes.

UTILIZATION OF FINDINGS

The observations and findings in this report will be presented to leadership of DBHDD and Division of Developmental Disabilities (DD) for consideration in identifying questions that may need additional analysis, investigation, and interpretation to improve the performance of support coordination service delivery.

The director of the Division of DD is responsible for using the information within this report. DBHDD's organizational alignment provides a platform for clarified roles and responsibilities in addressing support coordination performance issues for the DBHDD IDD population. This includes analysis, implementation of targeted action steps, and determination of the impact of selected initiatives. Both expertise and responsibility exist in other areas within the department to assist the Division of DD to accomplish improvement strategies; the Division of DD has the responsibility to utilize these resources. The Division of DD has at its disposal department resources to accomplish improvement initiatives with the assistance of support functions provided by the Division of Strategy, Technology, and Performance.

DBHDD SAMPLING PROCEDURE

DBHDD carefully considers information and data to analyze to answer analytical questions. High quality, valid information and data are the basis of useful, practical, and valid research findings and conclusions. Ideally, analysis occurs from data on an entire population, and DBHDD strives to accomplish this when feasible; this produces maximum validity. However, when data on the entire population are not available or feasible, then DBHDD carefully considers how the analytic data sample is built, as the sampling procedure has great impact on the quality, validity, and generalizability of research findings.

DBHDD's sampling procedure proceeds in the following manner:

- First, when available, DBHDD utilizes data on the full population under study (e.g., all individuals who received services within a given period such as calendar or fiscal year).
- Second, if some individuals within the full population have missing data for variables being used for analysis, DBHDD considers widely accepted procedures to address missing data. For example, individuals with missing data typically are excluded from analysis using listwise deletion,[1] resulting in a subset of the full population. DBHDD may consider other theoretically-sound methods and procedures to understand or address missing data.[2]
- Third, in some cases, DBHDD utilizes some form of random sampling[3] (e.g., a random subset of providers or random subset of all events that occurred). For this approach to be valid, one must be able to define the entire population from which it is being drawn, and each unit (e.g., individual, situation, etc.) must have an equal chance of being included in the sample. This method is unbiased, and the resulting sample is representative of the full population under study.
- Fourth, DBHDD also occasionally makes use of purposive sampling, a non-probability sampling method. This method is typically reserved for specific instances (e.g., identifying when a situation occurred, selecting specific cases, identifying specific errors, etc.). Purposive sampling is a selective, non-probabilistic method, and purposive sampling is not representative of the full population under study; therefore, findings or results based

[1] Listwise deletion is a method for handling missing data, whereby an entire record is excluded from analysis if any single value is missing.

[2] Sensitivity analyses are conducted to evaluate the pattern of missing data, wherein missing data are determined to be either missing completely at random (MCAR) or missing at random (MAR). Data are determined to be MCAR when the probability of missing data on a variable is unrelated to any other measured variable and is unrelated to the variable with missing values itself. Data are determined to be MAR when the missingness can be explained by variables that do not contain missing values. DBHDD may use multiple imputation for data that are MCAR or MAR, which allows missing data to be accounted for in a statistically valid and unbiased way. Multiple imputation assumes that data are from a continuous multivariate distribution and contain missing values that can occur for any of the variables. If these key statistical assumptions are satisfied, then this method can be used for data that are missing completely at random or missing at random.

[3] The leading component of simple random sampling is that every case (e.g., individuals or providers) has the same probability of being selected for inclusion in analysis.

on purposive sampling are not generalizable to the full population, rather only to the cases from which data were sampled.

- Fifth, a goal of inferential statistics is to make inferences about the population based on a sample smaller than the population. DBHDD considers sample sizes carefully and analytically to create empirical samples large enough to have sufficient statistical power to detect associations or differences and allow valid inferences to be drawn from and generalized about the population being studied.

SUPPORT COORDINATION SERVICES

Support coordination services are a set of interrelated activities for identifying, coordinating, and overseeing the delivery of services to enhance the health, safety, and general wellbeing of waiver participants within the context of the person's goals toward maximum independence. Support coordination services cover two distinct waiver services known as support coordination (SC) and intensive support coordination (ISC).

During CY20, support coordination services were provided by seven agencies contracted by DBHDD and tasked with employing support coordinators to meet the support coordination service needs of individuals. Support coordinators are responsible for monitoring the implementation of the individualized service plan (ISP), assisting in the coordination of ISP revisions, assisting the individual or representative in locating a service provider, direct observation, review of documents, and follow-up to ensure that service plans have the intended effect. Support coordinators are also responsible for the ongoing evaluation of the satisfaction of individuals and their families with the ISP and delivery of waiver services utilizing a person-centered philosophy.

ISC includes all the activities of SC, with additional activities that reflect specialized coordination of waiver, medical, and behavioral support services on behalf of individuals with complex medical and behavioral needs.

This report analyzes performance data from the perspective of the entire system of support coordination services as well as from the perspective of individual support coordination provider agencies. Since this is a support coordination services performance report, the content of this report is from the perspective of analyzing and reporting performance findings about the support coordination services "system" and "provider." DBHDD acknowledges that it may be more accurate to indicate that the performance of support coordination services and agencies, as well as the outcomes individuals experience, are dependent upon an entire system of DBHDD programs, administration, and providers of supports and services.

IMPACT OF COVID-19

In CY20, COVID-19 and the Georgia Governor's executive orders to "shelter in place" impacted waiver participants. As a result, DHBDD revised service delivery directives, direction, and support to maintain the health and safety of waiver participants. DBHDD and other community-based services such as physician and dental offices made service delivery system changes to meet the needs of individuals while also operating to protect individuals and healthcare providers from COVID-19 exposure and support risk containment, as did businesses and healthcare centers across the United States. For example, some Georgia day services providers chose to close

completely, while others chose to provide services in alternate settings. DBHDD compensated SC agencies for staffing changes that resulted from changes in business operations; and DBHDD adjusted SC delivery guidance and requirements to allow SC staff to continue monitoring individuals while being directed not to enter participants' homes.

Additionally, the Centers of Medicare and Medicaid Services approved Georgia's amendment (Appendix K) to both the NOW and COMP waivers.[4] Appendix K enables DBHDD to implement necessary flexibilities in services and supports during COVID-19. These flexibilities were implemented to support uninterrupted service delivery while also reducing transmission of and maximizing the containment of COVID-19.

It is critical that one brings to mind the events of the year from which most of these data come. Across the past year, healthcare, business, and oversight of implementing protective measures without clear information that was changing rapidly resulted in variations of responses at many levels (e.g., worldwide, national, state, local, departmental, and agency levels). The states-of - science altered the paradigm of "what's so" and knowledge across the past year, which also likely led to variances in responses and operations of businesses. As responses also varied across time, responses also varied at different sites within the same agency, perhaps. Moreover, it is likely that data about performance on responses and performance (not only of SC agencies, but anything during this unprecedented time) varied widely because what was affecting performance two months ago may not be the same variables to the same degree as two months later, or even a month after that. Even the most sophisticated science is not capable of this task at this time, for to do so, researchers would need to identify and measure with discernable accuracy all variables and their contributing effect on any given performance metric. Many factors challenged DBHDD and providers during this time that may not be discernable in the data, and performance changes in the data are difficult to compare not only between agencies but also within an agency at any point in time or across time.

Given the daunting and complex task of presenting actionable information with clear interpretation of data trends, DBHDD still endeavors to understand performance across time to discern where DBHDD is doing well in supporting individuals, while also identifying opportunities for improvement. DBHDD has continued being attentive to learn from the information that is available and to explore how best to support the health and well-being of those that we serve.

The data in this report rarely compares CY20 to previous year(s) of performance, for the data are not similar in terms of the context and reality within which they were produced. The reader is cautioned to be mindful of restrictions and limitations of internal and external validity when

[4] Appendix K: https://gadbhdd.policystat.com/policy/9560065/latest/

comparing data across times when the exogenous contributing and confounding variables vary and may have undeterminable and nonzero value.

SUPPORT COORDINATION AND INTENSIVE SUPPORT COORDINATION

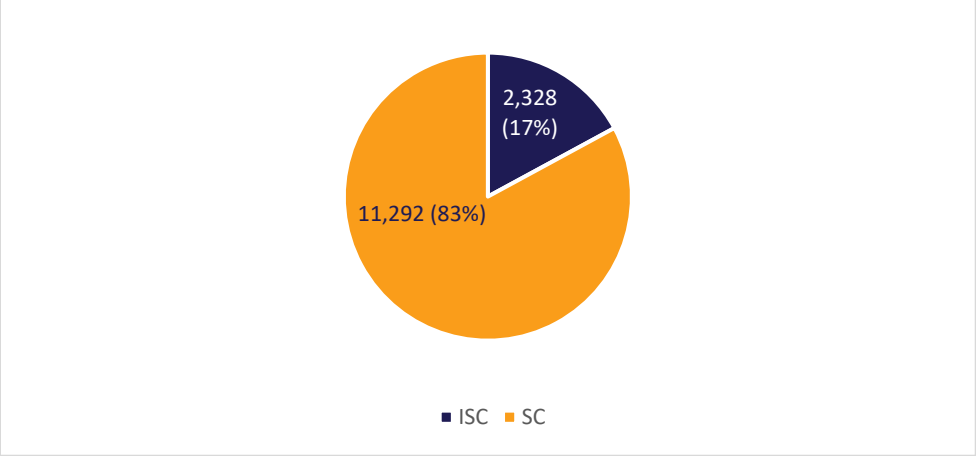
ANALYSIS OF IDD WAIVER DATA

The following sections contain analyses on the performance of support coordination services agencies. Outcomes may be evaluated between time periods (quarterly) within CY20, when appropriate. The purposes of this report are to provide data analysis and to quantify the performance of support coordinators, their agencies, and Medicaid waiver support coordination service provision, processes, and outcomes on key performance indicators.

Georgia's Support Coordination Service Agencies

Benchmark
Carestar
Creative Consulting Services (Creative)
Columbus Community Services (Columbus)
Compass Coordination (Compass)
Georgia Support Services (Georgia Support)
Professional Case Management Services of America (PCSA)

Figure 1: SC and ISC Population, December 2020



CASELOAD SIZE

This section takes a closer look at how support coordination services agencies are performing with caseload sizes.[5] DBHDD policy regarding the caseload size of SC and ISC support coordinators specifies upper limits for each type of support coordination service. The policy also specifies how caseload ratios may be adjusted to accommodate having both SC and ISC recipients on an individual support coordinator's caseload.

[5] At the time of the writing of this document, DBHDD policy regarding the caseload size of support coordinators (Support Coordination Caseloads, Participant Admission, and Discharge Standards, 02-432) states that support coordinators providing intensive support coordination must have no more than 20 individuals in their caseload, and those providing standard support coordination must have no more than 40. If a support coordinator has a mixed caseload with both support coordination and intensive support coordination individuals, the 1:3 rule applies, counting each intensive support coordination individual as being equal to three support coordination individuals. If a mixed caseload has more than 10 individuals receiving intensive support coordination, then they may have no more than 20 individuals, and the 1:3 rule no longer applies. The policy specifies how caseload ratios may be adjusted to accommodate having support coordination and intensive support coordination recipients on an individual support coordinator's caseload, which has been used for these analyses.

REGIONAL MAPPING

Georgia is made up of mostly low-density population areas, which results in extraordinary challenges for support coordinators in achieving caseload size and mix compliance.

Figure 2: Total Waiver Population, December 2020

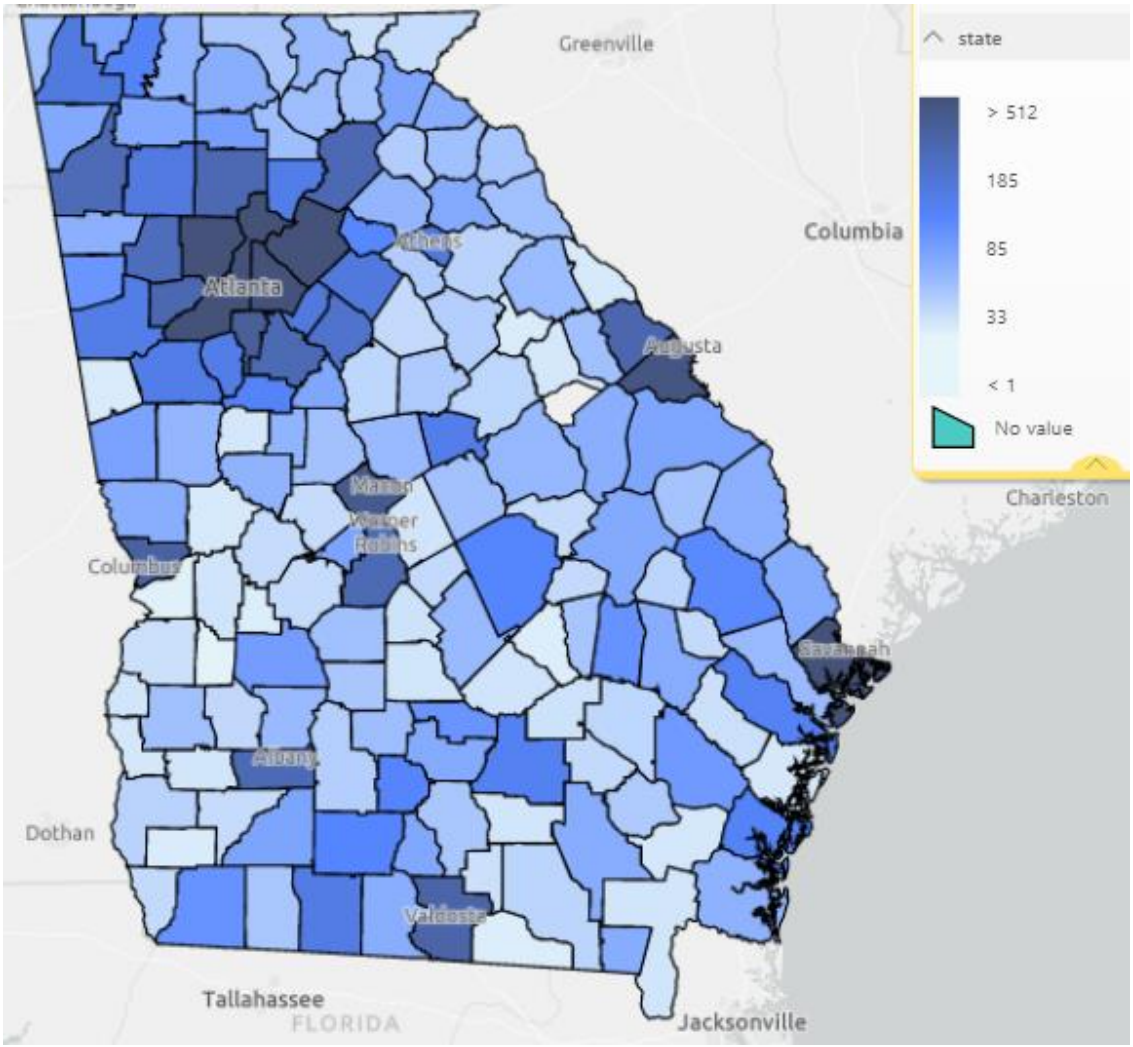


Figure 3: SC Waiver Population, December 2020

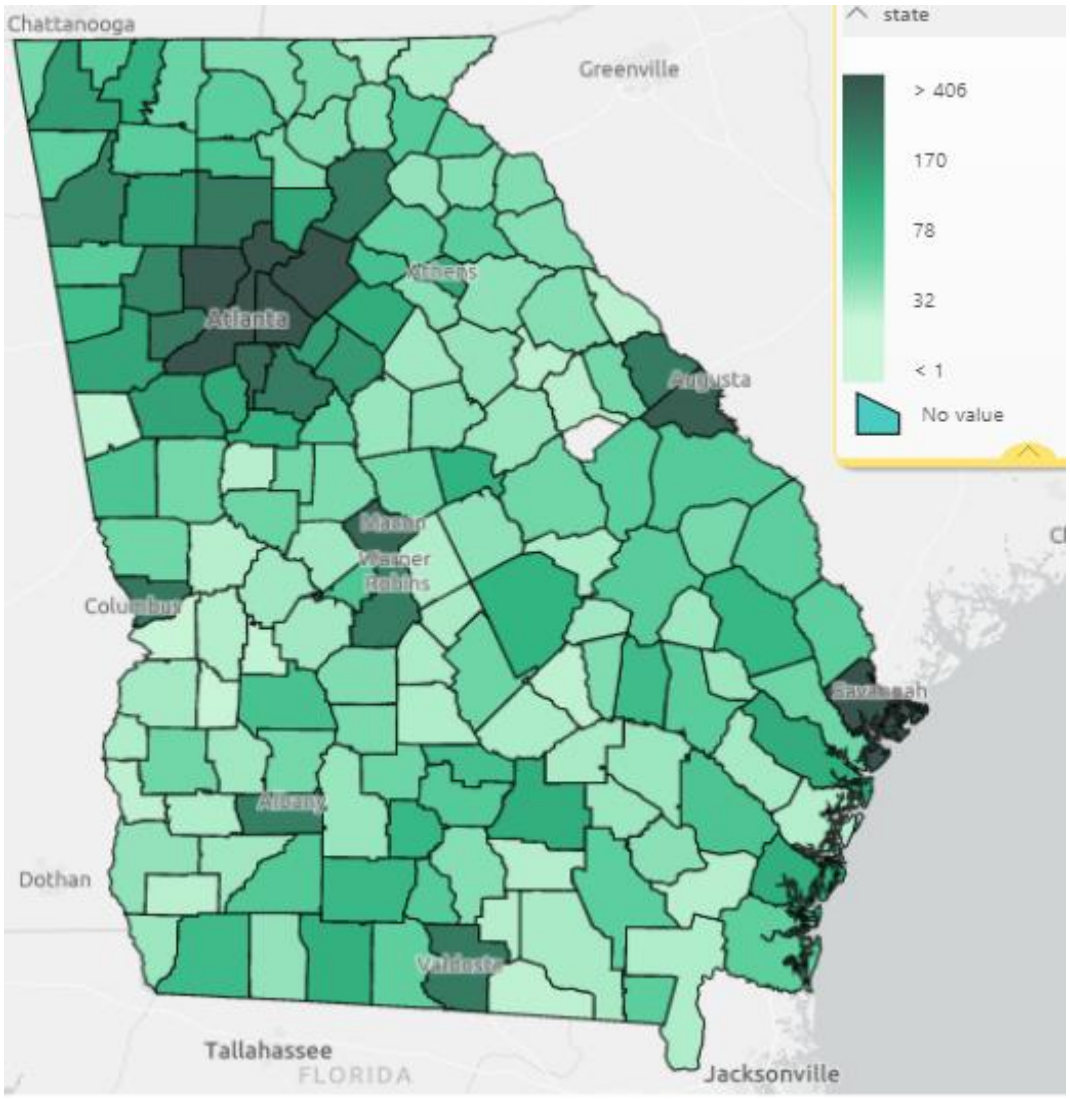
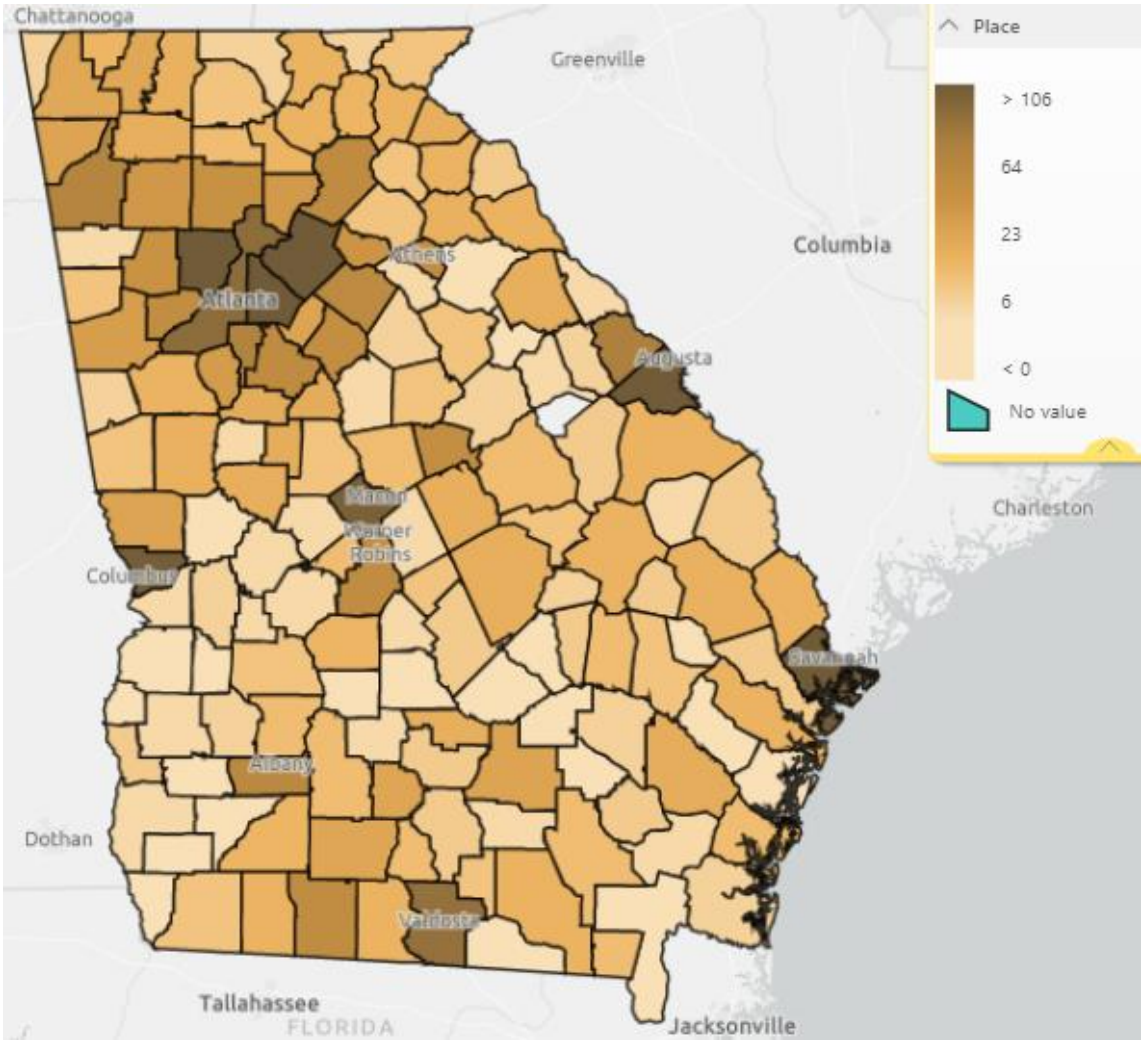


Figure 4: ISC Waiver Population, December 2020



In densely populated areas, support coordinators can more easily achieve caseload compliance. Sometimes, ISC individuals reside 100+ miles from metropolitan areas.

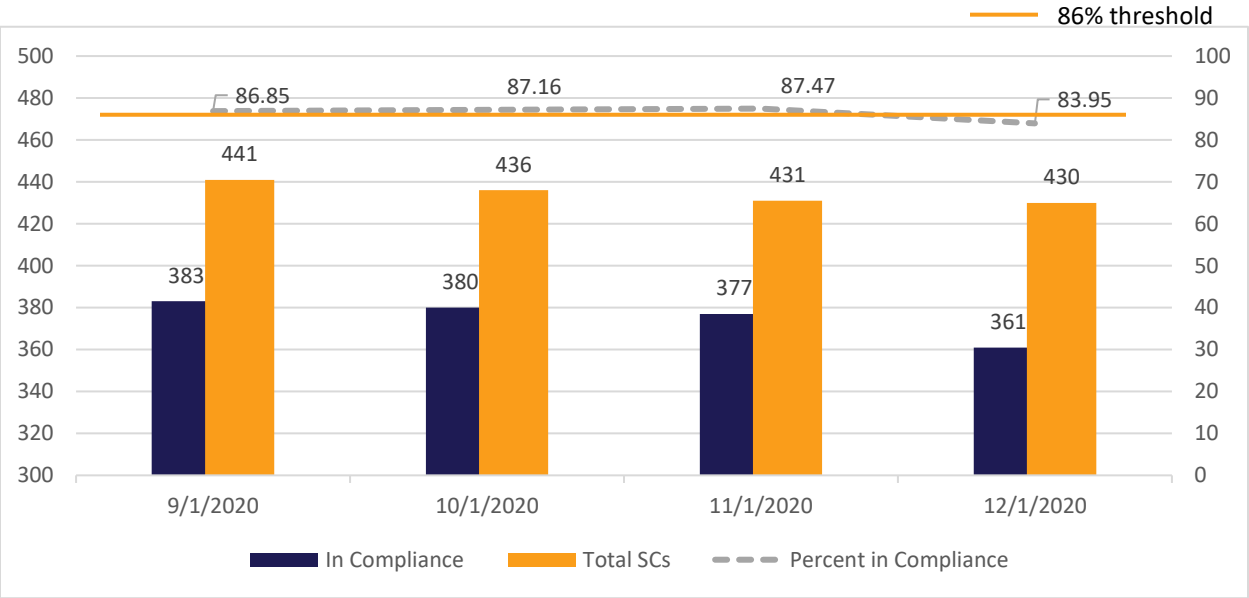
CASELOAD COMPLIANCE

DBHDD, with Beacon Health Options, built a customized case management solution for Georgia which enhances transparency for individuals, supports productivity and workflow management. This system, IDD Connects, went live in August 2019 and provides streamlined access to the waiver application and coordination of eligibility determination and service coordination. Key functions include online application, pre-eligibility determinations, real-time planning list prioritization, evaluations, Individual Support Plan (ISP) development including person centered tools, evaluation integrations and clinical recommendations. While this system has been helpful in advancing our service system, it should be acknowledged that, like any new technological solution, data was captured differently, and reports needed to be redesigned and created anew.

Caseload size data is based on point-in-time data snapshot, and the caseload size reports were refined and finished the quality assurance tests in September 2020; therefore, caseload size data are available for September through December 2020. It is important to remember the challenges of caseload size compliance given the differences in population density across Georgia. DBHDD's compliance standard is 86 percent. Support coordination services agency caseload compliance for CY20 was on average at least 86 percent (Figure 5). DBHDD questioned, "Is being out of compliance with caseload size associated with negative outcomes?" A Poisson regression analysis indicated caseload non-compliance is not significantly related to increased negative outcomes such as critical incidents, increased hospitalizations, and emergency department visits.

Though it is a positive finding that noncompliance with caseload size is not associated with adverse events or outcomes, it is critical to note the limitations of the analysis that provides the basis for this assertion. First, data are limited to only four months; so, a restricted range in time may attenuate any associations to be detected. Secondly, most support coordinators are within caseload size compliance. For the few support coordinators out of compliance, the non-compliance is by only a few individuals. Again, the data are characterized as restricted range and limited. Therefore, these analyses can only be extended or interpreted as being non-compliant by a limited number of individuals on a caseload. It is reasonable to question when an association between non-compliance beyond a few individuals could be related to negative incidents. The instances of this occurring are too rare for statistical models to have sufficient power to detect meaningful and significant associations.

Figure 5: Support Coordination Services Caseload Compliance, CY20



SC AND ISC FACE-TO-FACE VISITS

Typically, one would expect an analysis of face-to-face visits. As stated above, in CY20, COVID-19 and Georgia's Governor's executive orders to "shelter in place" impacted waiver participants. As a result, revisions in service delivery were implemented by DHBDD to maintain the health and safety of waiver participants. Examples of revisions are the closing of day service centers for people with IDD and a shift to compensate for staffing shortages and adjustment to SC services due to staff not being able to enter participants' homes. Community-based services such as physician and dental offices that serve individuals with IDD were likewise impacted by COVID-19. Consequently, face-to-face visits by support coordinators did not occur for most of 2020, and the first two to three months of 2020 are not representative of the current state of the system or the environment in which it functioned. A few other factors influenced the integrity of face-to-face data analysis.

DBHDD sought and received approval from the Centers for Medicare and Medicaid Services to design and implement new services and supports, or adjustments to extant services and supports. Telehealth was a major mechanism to allow people to receive services that once were delivered face-to-face.

What's more, with the implementation of telehealth protocols via Appendix K, CY20 data related to visits also include ancillary visits which could include telephone conversations and video conferencing via various platforms as allowed by federal authorities, which do not meet the definition of face-to-face visits. Consideration was given if DBHDD could use ancillary data and treat it as if were face-to-face visit data for analytical purposes, and it was determined that this would not provide valid, actionable data analysis. Given the swift allowance for telehealth visits in place of typically-required face-to-face visits, it is difficult to use 2020 data to distinguish the rate of face-to-face visits versus telehealth encounters. Given this, and the desire to represent complete and valid data, DBHDD made a measured decision not to use the CY20 face-to-face data.

DBHDD is not alone in having difficulty in reporting data from 2020 due to impact on service delivery and data collection; many state- and national-level analysis and reporting on IDD services has been interrupted. As an example, National Core Indicators (NCI), which collects state- and national-level performance data for the IDD population, made similar decisions that DBHDD took, along with many states.[6] For example, data collection was interrupted and not resumed; so, the data were not available for analysis, which decreased sample sizes and increased margins of

[6] National Core Indicators (NCI): 2019-20 In-Person Survey (IPS) reporting: Why NCI is not calculating an NCI Average or producing a national report this year. NASDDDS & HRSI, 2021. The 2019-20 In-Person Survey (IPS) data collection period was unexpectedly abbreviated due to the COVID-19. NCI recommended states pause in-person surveying on March 16, 2020. On April 15, 2020, the NCI team informed NCI states that stay-at-home orders, public health guidance, and the anticipated disruptions resulting from the ongoing pandemic response had made it necessary to end in-person data collection for the remainder of the 2019-20 survey year.

errors in the analysis. NCI data are not being compared to other years due to the differences in the data: the data do not represent same realities, or environments, or experiences. The data that were collected were limited in some manner of other ways, such as limited samples that are not representative of the true population. Ultimately, DBHDD, as did NCI and other organizations, has attempted to balance the needs of continued service delivery through nimble adjustments, and collecting and analyzing data with methodological and scientific rigor, though sometimes also making the difficult decision not to present data that are not actionable due to a number of methodological and validity challenges that could not be overcome, such as with face-to-face data for CY20.

INDIVIDUAL QUALITY OUTCOME MEASURES REVIEW

The individual quality outcome measures review (IQOMR) is the services and support evaluation tool used by support coordination. The IQOMR is divided into seven focus areas: Environment, Appearance and Health, Supports and Services, Behavioral and Emotional, Home and Community Opportunities, Financial, and Satisfaction. Each focus area contains one or more questions that guide the support coordinator to do the following:

- Observe and interact with the participant as it relates to the elements of the item reviewed;
- Observe the setting for evidence pertaining to the item reviewed;
- Review any pertinent documentation relating to the item reviewed;
- Engage in discussion with staff members or natural supports who may have information on the item reviewed; and
- Observe staffs' or natural supports' interaction with the individual as it relates to the item reviewed.

Based on the support coordinator's completion of the above steps, each focus area question is evaluated based on the following standards:

- Acceptable standards are reached when elements of the focus area question have been fully evaluated by the support coordinator and there are no concerns to report. All elements of the focus area question have been met satisfactorily and services/supports are being provided in an adequate manner; or
- Coaching is required when a concern, issue, or deficit is discovered in an element of a focus area question and, in the support coordinator's professional judgment, (s)he determines that the concern/issue/deficit can be resolved in collaboration with the staff members or natural supports without intervention by the field office or clinical staff; or
- Referrals are made to DBHDD or clinical staff to address serious concerns or untimely responses to coaching in the areas of the IQOMR.

IQOMR POSITIVE ANSWERS AND COACHING AND REFERRAL OUTCOMES

As mentioned previously, the pandemic, Appendix K, and several other factors affected the delivery, requirements, and documentation of services. IQOMR processes and IQOMR data also were affected. Appendix K Operational Guidelines identifies the IQOMR questions that either requires or may require a face-to-face contact for proper evaluation. However, Appendix K and constraints on private protective equipment precluded that face-to-face observation from occurring. Most IQOMR questions were affected, including the following: 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 41, 42, 43, 44, 46, 47, 48, 49, and 50.

Furthermore, collaboration with providers regarding how to move forward with IQOMR ratings while not requiring face-to-face observation, the decision was made that for any items (listed above) that could not be confirmed, would be scored as "acceptable." Therefore, effectively, most IQOMR items that were assessed between March through December of 2020 were scored as acceptable. As a result of this decision, overall IQOMR scores for all areas rose to almost 100 percent.

Again, similar to NCI and other states when faced with how to use the data that are not actionable, and sometimes recognizing that data that were collected do not reflect the "true" performance and therefore have limited value, DBHDD considered these data are not indicative of individual's individual outcomes and are neither meaningful for action nor insight. The CY20 IQOMR data are not reported. Though the IQOMR data are not reported this year due to lacking validity and meaningfulness, the IQOMR process produced useful and meaningful data on coaching and referrals.

COACHING AND REFERRAL ACTIVITIES

One way of understanding better the productivity and workload performance of support coordination agencies is to examine a key component of support coordinator value that they deliver: coaching and referrals. According to current DBHDD policy, support coordinators can report and record concerns within the IQOMR using coaching and referrals.[7] Analyzing coaching and referrals provides an additional understanding of activities support coordinators deliver to effect positive outcomes for individuals.

Coaching

Required when a concern/issue/deficit is discovered in an element of a focus area question, and, in the support coordinator's professional judgment, (s)he determines that the concern/issue/deficit can be resolved in collaboration with the staff members or natural supports without intervention by the field office or clinical staff.

Referrals

Required for more serious risks than those addressed by coaching. Referrals are made to The Division of DD or clinical staff to address serious concerns in the areas of the IQOMR. Referrals can also be used to escalate the urgency of a coaching due to slow response or worsening circumstances.

[7] DBHDD Policy: Outcome Evaluation: "Recognize, Refer, and Act" Model, 02-435

Table 2 highlights the amount of effort and productivity of support coordinators in working with providers to assist individuals. Support coordination agencies provided 14,935 coaching sessions aimed at addressing issues to provide improved outcomes for individuals in CY20. Support coordinators also provided 6,084 referrals in response to individuals' needs in order to facilitate positive outcomes. To understand more fully the tremendous efforts, consider that combined, support coordinators initiated and followed up on 21,019 coachings and referrals to improve the services, supports, and outcomes of individuals they serve.

Table 2: Coaching and Referrals Activity, CY20

Coaching and Referrals Activity	Number of Coaching	Number of Referrals	Number of Referrals Open beyond Intended Close Date	Percent of Referrals Open beyond Intended Close Date
Appearance/Health	9,757	5,190	2,989	58%
Supports and Services	2,462	375	253	67%
Environment	912	167	123	74%
Behavioral and Emotional	719	266	183	69%
Home/Community Opportunities	473	41	23	56%
Financial	446	34	21	62%
Satisfaction	166	11	11	100%
Total	14,935	6,084	3,603	59%

During the first half of CY19, support coordinators used the Consumer Information System (CIS) to generate coaching and referrals. On July 31, 2019, DBHDD implemented its new participant information system, IDD Connects. This change affected the way coaching and referrals were reported. The CY19 SC performance report indicated 3,035 referrals for January through June, or 6,070 annualized referrals for CY19. CY20 referrals totaled 6,084, which is similar to CY19's annualized number of referrals. The difference between the percent of referrals that were open beyond the intended close date that referral resolution in CY20 took longer, and it is assumed to be related to COVID-19 and that both SC and DBHDD staff were constrained. These assumptions require additional research and consideration of quality improvement (QI) opportunities.

OTHER OUTCOMES

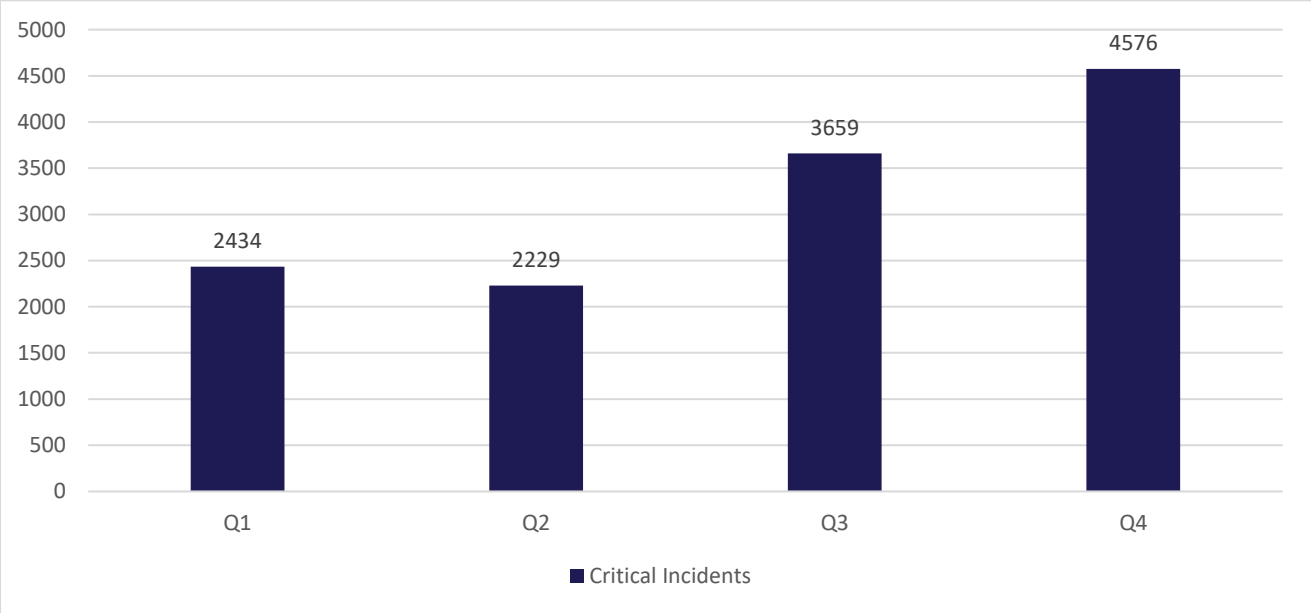
DBHDD also investigated other areas to determine how support coordination activities, as well as the combination of other services and supports, produced other results.

CRITICAL INCIDENT DATA

IDD providers are required to report critical incidents to DBHDD when they occur, but support coordinators may also submit them if necessary.[8] See Appendices B and C for additional analyses and a full list of critical incident types.

DBHDD designated types of critical incidents that are especially important to monitor: medical; abuse, neglect, and exploitation (ANE); and behavioral. Figure 8 shows the number of critical incidents during Q1 through Q4 CY20.

Figure 8: Support Coordination Services Critical Incident Counts, CY20



[8] DBHDD Policy: Reporting Deaths and Critical Incidents in Community Services, 04-106

Figure 9 shows the number of critical incidents by type for CY20. Medical incidents increased between Q2 and Q4. DBHDD wanted to understand the effects of COVID-19 on the number of critical incidents reported across the year. DBHDD has critical incident data that indicate critical incidents due to COVID-19. By starting with the usual grouping of all critical incident data, we have the reality of the number of critical incidents that were reported (Figure 9). Figure 10 shows the increase in COVID-19 incidents across Q2 and Q4. Incidents related to behavior or ANE incidents remained consistent throughout CY20.

Figure 9: Support Coordination Services Critical Incident Counts by Type, CY20

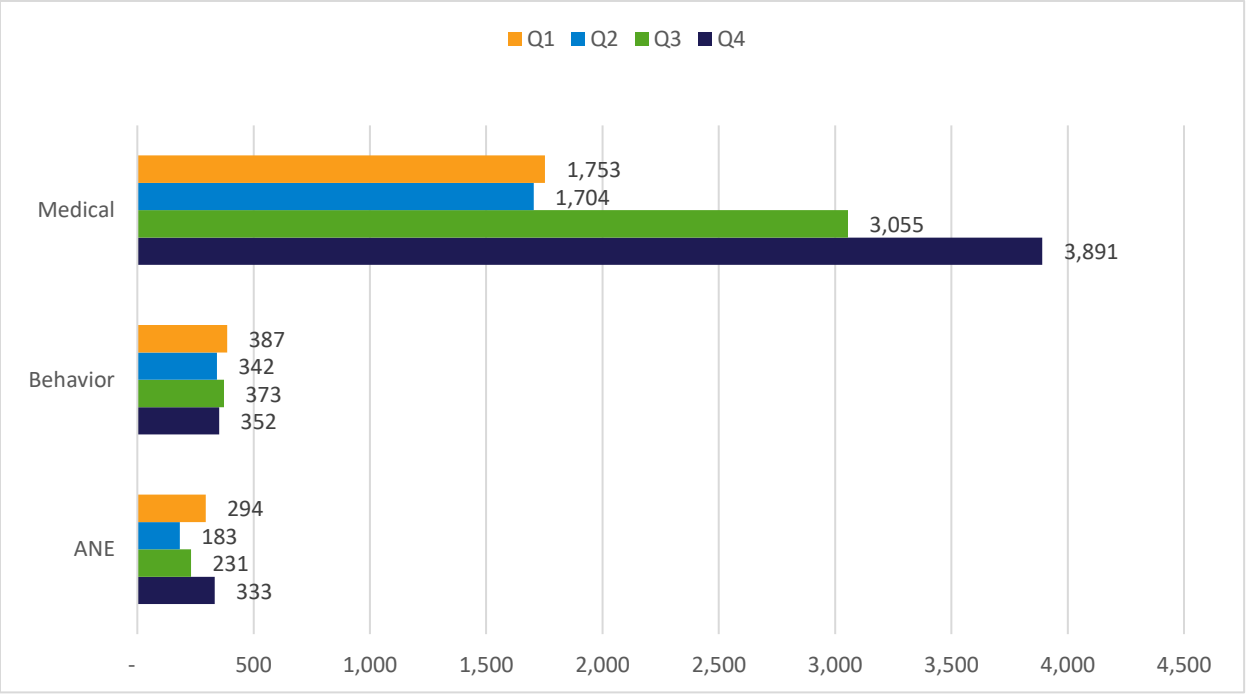
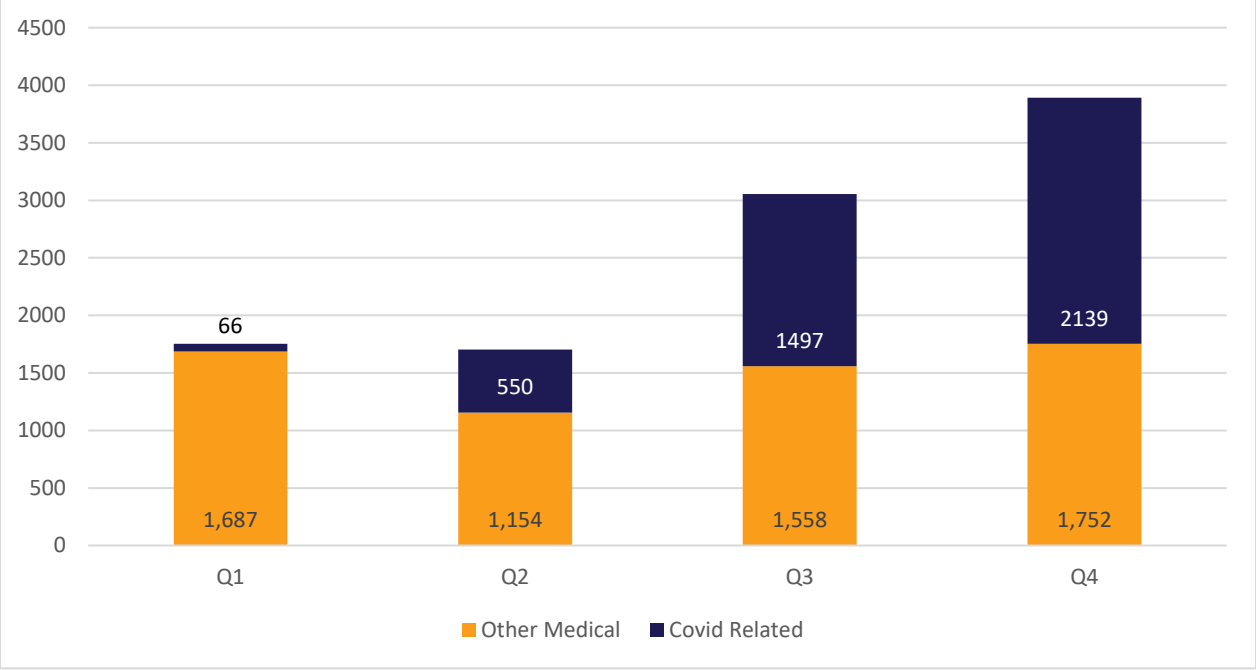


Figure 10: Support Coordination Services Critical Incident Counts for Medical Type, CY20



KEY FINDINGS

Caseload sizes are, by large measure, aligned with requirements. Analyses also indicated that being out of compliance with caseload size requirements by a small amount was not associated with adverse outcomes. Critical incidents related to medical issues increased between Q2 and Q4 of CY20. The increase was clearly related to COVID-19 incidents. Incidents related to behavior- or ANE-related incidents remained consistent across the year.

DBHDD, like national organizations and other states, considered carefully if data that had been collected were useful to understand current performance or to indicate system efforts to improve outcomes and quality. DBHDD's decision not to use some data due to lack of validity or usefulness for the current situation was similar to and validated by other state-and national-level organizations impacted by the COVID-19 pandemic.

COVID-19 interrupted the delivery of many services and supports, such as in-person services; similarly, COVID-19 also interrupted support coordinators' observation, assessment, evaluation, and reporting of critical information about the performance and outcomes of the IDD system of supports and care. This resulted in no face-to-face visits for most of 2020, and the data that were collected during months prior to the state of emergency are not comparable to the current situation, environment, and reality to be useful for understanding how support coordination performs now.

The swift and necessary implementation of Appendix K Operational Guidelines provided allowances for the IQOMR questions that, pre-COVID-19, required or may have required a face-to-face contact for proper evaluation. As a result, IQOMR data were not usable for determining individuals' outcomes in the usual manner. IQOMR process data, however, did allow DBHDD to discover that support coordinators continued to provide oversight as evidenced by coaching and referral activity. Also, support coordinators may need additional resources in resolving some referrals that remain open past their expected close date. The findings warrant additional investigation to determine if QI activities are needed.

Appendix A: Support Coordination Services, Agency Data, CY20

Agency	CY20		
	ISC	SC	Proportion ISC
Benchmark	417	385	52%
CareStar	163	177	48%
Columbus	565	3,773	13%
Compass	170	240	42%
Creative	575	3,267	15%
Georgia Support	196	1,359	13%
PCSA	242	2,091	10%

Appendix B: Critical Incidents, Agency Data, CY20

Agency	Total # of Individuals Served	Total Number of Critical Incidents			
		Q1	Q2	Q3	Q4
Benchmark					
ANE	802	43	16	29	46
Behavioral		54	46	39	41
Medical		139	159	256	310
Benchmark Total		**236**	**221**	**324**	**397**
CareStar					
ANE	340	8	12	5	7
Behavioral		11	19	26	24
Medical		46	98	156	171
CareStar Total		**65**	**129**	**187**	**202**
Columbus					
ANE	4,338	56	45	44	121
Behavioral		93	101	110	114
Medical		367	489	797	1,014
Columbus Total		**516**	**635**	**951**	**1,249**

Appendix B Continued: Critical Incidents, Agency Data, CY20

Agency	Total # of Individuals Served	Total Number of Critical Incidents			
		Q1	Q2	Q3	Q4
Compass					
ANE	410	15	7	6	7
Behavioral		9	13	20	12
Medical		72	66	82	165
Compass Total		**96**	**86**	**108**	**184**
Creative					
ANE	3,842	110	47	70	67
Behavioral		83	53	88	81
Medical		531	402	753	1,153
Creative Total		**724**	**502**	**911**	**1,301**
Georgia Support					
ANE	1,555	42	31	48	44
Behavioral		78	68	52	44
Medical		295	235	554	529
Georgia Support Total		**415**	**334**	**654**	**617**
PCSA					
ANE	2,333	20	25	29	41
Behavioral		59	42	38	36
Medical		303	255	457	549
PCSA Total		**382**	**322**	**524**	**626**

Appendix C: Critical Incident Category Type, Agency Data, CY20

Incident Type	Type
100: Death - Expected	Medical
101: Death - Unexpected	Medical
103: Death of an Enrolled Individual	Medical
200: Alleged Abuse - Physical - Staff/Ind	ANE
201: Alleged Abuse - Sexual - Staff/Ind	ANE
202: Alleged Abuse - Psychological - Staff/Ind	ANE
203: Alleged Abuse - Verbal - Staff/Ind	ANE
210: Alleged Neglect - Staff/Ind	ANE
220: Alleged Exploitation - Staff/Ind	ANE
221: Alleged Financial Exploitation - Staff/Ind	ANE
300: Falls with Injury Severity Rating of 3 +	Medical
310: Choking with Intervention	Medical
320: Medication Error with Adverse Consequences	Medical
330: Hospitalization - Medical	Medical
331: Hospitalization - Psychiatric	Behavior
340: Accidental Injury with an Injury Severity Rating of 3 +	Medical
400: Alleged Sexual Assault - Ind/Ind or Ind/Staff	ANE
411: Alleged Financial Exploitation - Ind/Ind	ANE
420: Aggressive Physical Act Ind/Ind with an Injury Severity Rating of 3+	Behavior
425: Aggression (In/Other) – Injury 3+	Behavior
430: Suicide Attempt with an Injury Severity Rating of 3 +	Medical
440: Seclusion or Restraint with Injury Severity Rating of 3 +	Medical
450: Elopement	Behavior
500: Intervention of Law Enforcement Required	Behavior
501: Alleged Criminal Act by an Individual	Behavior
600: Alleged/Suspected Violation of Individual/Patient Rights	ANE
800: High Risk Escalation Event - Crisis or Respite Placement	Behavior
806: High Risk Escalation Event - Planned Hospitalization	Medical
807: High Risk Escalation Event - Emergency Room Visits	Medical
808: High Risk Escalation Event - Urgent Care Center Visit	Medical
920: Exposure-Coronavirus	Medical
921: Positive-Coronavirus	Medical
922: Death-Coronavirus	Medical
923: Recovered-Coronavirus	Medical

Appendix D: Number of ISC and SC Visits, Agency Data, CY20

ISC Agency	Q1			Q2		
	n	Visits	Average Visits per Month	n	Visits	Average Visits per Month
Benchmark	1,107	3,378	3.05	1,107	3,337	3.01
CareStar	390	1,026	2.63	390	1,171	3.00
Columbus	1,395	4,973	3.56	1,395	5,824	4.17
Compass	432	1,506	3.49	432	1,528	3.54
Creative	1,584	4,498	2.84	1,584	4,496	2.84
Georgia Support	543	1,848	3.40	543	1,938	3.57
PCSA	612	2,225	3.64	612	2,152	3.52
ISC Agency	Q3			Q4		
	n	Visits	Average Visits per Month	n	Visits	Average Visits per Month
Benchmark	1,107	3,407	3.08	1,107	3,614	3.26
CareStar	390	1,364	3.50	390	1,374	3.52
Columbus	1,395	5,561	3.99	1,395	5,195	3.72
Compass	432	1,508	3.49	432	1,715	3.97
Creative	1,584	4,583	2.89	1,584	4,560	2.88
Georgia Support	543	2,145	3.95	543	2,037	3.75
PCSA	612	2,136	3.49	612	2,334	3.81

Appendix D: Number of SC Visits, Agency Data, CY20

SC Agency	Q1			Q2		
	n	Visits	Average Visits per Month	n	Visits	Average Visits per Month
Benchmark	1,044	2,072	1.98	1,044	2,116	2.03
CareStar	222	440	1.98	222	558	2.51
Columbus	9,192	19,131	2.08	9,192	28,869	3.14
Compass	411	1,051	2.56	411	940	2.29
Creative	8,946	13,766	1.54	8,946	12,799	1.43
Georgia Support	3,636	6,337	1.74	3,636	6,035	1.66
PCSA	5,064	9,315	1.84	5,064	12,714	2.51
SC Agency	Q3			Q4		
	n	Visits	Average Visits per Month	n	Visits	Average Visits per Month
Benchmark	1,044	2,119	2.03	1,044	2,049	1.96
CareStar	222	571	2.57	222	560	2.52
Columbus	9,192	23,813	2.59	9,192	21,618	2.35
Compass	411	990	2.41	411	971	2.36
Creative	8,946	13,470	1.51	8,946	13,049	1.46
Georgia Support	3,636	6,131	1.69	3,636	5,882	1.62
PCSA	5,064	12,057	2.38	5,064	12,400	2.45

Appendix E: Caseload Compliance, Agency Data, September - December 2020

Agency	In Compliance	Out of Compliance	Total SCs	Percent In Compliance
Benchmark	111	32	143	78%
CareStar	49	13	62	79%
Columbus	499	55	554	90%
Compass	59	7	66	89%
Creative	341	108	449	76%
Georgia Support	181	9	190	95%
PCSA	261	13	274	95%