REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

PERMANENT INJUNCTION

UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

October 1, 2024 – March 31, 2025

Respectfully Submitted By

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Independent Reviewer
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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's Twenty-sixth Report on the status of compliance with the requirements of Civil Action No. 3:12 CV 059, which are now delineated in the Permanent Injunction between the Parties: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ).

The Terms of the Permanent Injunction had been proposed jointly by the Parties and were ordered by the Court on January 15, 2025. This Report documents and discusses the Commonwealth's efforts and progress and determines the status of Virginia's compliance regarding the Permanent Injunction's Section IV Terms 31–59 (Terms), with a focus on the Twenty-sixth Review Period, October 1, 2024 – March 31, 2025.

As a result of this Period's studies, the Commonwealth achieved the specified goal and a Compliance determination for two of the 29 Terms, namely Day Services for DD Waiver Recipients (Term 37) and Annual Physical Exams (Term 54). Regarding Term 37, Virginia achieved an annual increase of 2.45% in the number of individuals on DD Waivers who received day services in the most integrated settings and so exceeded this Term's 2% compliance measure for the first time. For Term 54, the Commonwealth also exceeded its 86% benchmark for individuals supported in residential settings who received an annual physical exam.

Virginia successfully completed or made progress implementing many other Terms' required actions. However, since the Commonwealth did not accomplish the goals specified in 15 of the Permanent Injunction's Terms, its compliance rating for these Terms is Not Achieved.

For a further 11 Terms, four of Virginia's standard monitoring and data collection cycles were not expected to be completed for this Period's studies: annual licensing inspections, annual employment targets, annual Support Coordinators' Quality Reviews and Round 7 of DBHDS's Quality Service Reviews. Consistent with the Commonwealth's efforts to ensure data integrity in its established cycles and data management processes, Virginia will report complete data sets for review and analysis during the next Twenty-seventh Period. Without new monitoring data for this Twenty-sixth Period, the compliance ratings for these 11 Terms are Deferred.

Term 59 of the Permanent Injunction is devoted solely to the critical topic of Rate Studies. The Parties agreed to its set of actions to help the Commonwealth achieve the specified goals of five of

the 28 other Terms: Therapeutic Consultation Services (Term 33), Day Services for DD Waiver Recipients (Term 37), Private Duty Nursing (Term 38), Skilled Nursing (Term 39), and Training and Competency of Direct Support Professionals (Term 48). As required, Virginia began a study to collect and analyze data on the rates that the Commonwealth currently pays for 11 DD Waiver services.

To conduct the rate study, Virginia engaged a qualified vendor and formed the DMAS Rate Study Work Group. This includes representatives from DD service providers, advocacy groups and industry associations who will provide feedback during the rate development process. In addition, DOJ engaged a national expert to offer rate study advice. DOJ also participated in the vendor's meetings with stakeholders and provided input on how the Commonwealth should direct the vendor to perform the study. As of April 15, 2025, following recommendations from the Rate Study Work Group, the vendor developed and distributed its *Provider Cost and Wage Survey*. The vendor's rate study timeline projects submission to DMAS of its draft report by July 11, 2025; this will be shared with the Parties and other stakeholders for feedback. The vendor has set August 11, 2025, as the target due date to submit the final version of its report to DMAS.

Virginia has committed to making its best effort to obtain the necessary funding from the General Assembly during its 2026 and 2027 sessions to allow the Commonwealth to increase rates for the 11 services recommended by the study.

For the Twenty-seventh Period reviews, the following areas of Virginia's service system for individuals with intellectual and developmental disabilities (IDD) will again be studied:

- Case Management
- Crisis and Behavioral Services
- Integrated Day Activities and Supported Employment
- Community Living Options
- Services for Individuals with Complex Behavioral Support Needs
- Quality and Risk Management
- Provider Training
- Quality Improvement Programs

In closing, in addition to the Commonwealth completing the development of most of its service system's structures, functions and processes, it is important to highlight that Virginia has promised

in the Permanent Injunction to maintain in perpetuity a quality management system (Terms 60–65) and a publicly accessible document library (Terms 66–67). It is the considered opinion of the Independent Reviewer that these commitments will support the Commonwealth in its ongoing partnership with stakeholders to provide individuals with IDD opportunities for community integration, self-determination, and quality services.

II. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

For this Twenty-sixth Review Period, the Independent Reviewer conducted studies to monitor the Commonwealth's status of its achievement of measurable goals and its implementation of required actions, as specified in Terms 31–59 of the Permanent Injunction.

These Terms, which had been jointly proposed by the Parties and were ordered by the Court on January 15, 2025, address the following areas of Virginia's service system for individuals with IDD:

- Case Management;
- Crisis and Behavioral Services;
- Integrated Day Activities and Supported Employment;
- Community Living Options;
- Services for Individuals with Complex Health Support Needs;
- Quality and Risk Management;
- Provider Training; and
- Quality Improvement Programs.

To analyze and assess the Commonwealth's performance across these areas, the Independent Reviewer retained seven consultants to assist in:

- Reviewing data and documentation produced by Virginia in response to requests by the Independent Reviewer, his consultants, and the Department of Justice;
- Discussing progress and challenges with Commonwealth officials;
- Examining and evaluating documentation of supports provided to individuals;

- Interviewing caregivers, provider staff and stakeholders;
- Verifying Virginia's determinations that its data sets provide reliable and valid data that are available for compliance reporting; and
- Determining the extent to which the Commonwealth maintains documentation that demonstrates its achievement of the Terms' specified goals and its implementation of the required actions.

To determine Compliance ratings and the status of completing required actions for the Twenty-sixth Review Period, the Independent Reviewer considered information delivered by Virginia prior to April 22, 2025, and its responses to consultant requests for clarifying information up to May 1, 2025.

The Independent Reviewer determined three compliance ratings for the Terms' specified goals:

- *Compliance* indicates achievement of the specified goal.
- *Not Achieved* indicates that the specified goal was not met.
- *Deferred* indicates that the Commonwealth will report complete data sets for review and analysis during the next Twenty-seventh Period, as per its established monitoring cycles.

If Virginia had not yet undertaken significant initiatives to address actions with future due dates, as specified in various Terms' subsections, the Independent Reviewer did not include updates on their status in this Report.

The Independent Reviewer's determinations are best understood by reviewing the Discussion of Compliance Findings and the consultants' reports, which are included in the Appendices. To protect individuals' private health information, the summaries from the studies of individuals' services included in the respective consultant reports are submitted to the Parties under seal.

Information that was not supplied for the studies was not considered in the consultants' reports or in the Independent Reviewer's findings and conclusions. If the Commonwealth did not provide sufficient documentation, the Independent Reviewer determined that Virginia had not demonstrated achievement of the specified measurable goal or completion of the required action.

Prior to completing a draft of this Twenty-sixth Report to the Court for the Parties to review, the Independent Reviewer distributed copies of the consultants' draft studies to DBHDS and

convened an exit call for each study. These calls provided an opportunity for senior staff from the Commonwealth's relevant departments and their subject matter experts to discuss the contents together with the consultants and the Independent Reviewer. The discussions included the identification of any factual errors and misunderstandings or needed clarifications. The reports were then modified as appropriate.

Finally, as required by the Permanent Injunction the Independent Reviewer submitted this Report to the Parties in draft form for their review. The Independent Reviewer then considered any comments by the Parties before finalizing and submitting this Twenty-sixth Report to the Court.

B. Discussion of Compliance Findings

1. Case Management

Background

For the previous Twenty-fifth Period review, two remaining Case Management Provisions had been studied, namely Provision III.C.5.b.i. and Provision V.F.5.

Of Provision III.C.5.b.i.'s three remaining Compliance Indicators, 2.16, 2.18 and 2.20, two of them (2.18 and 2.20) had been met twice consecutively. However, the Commonwealth had not achieved Indicator 2.16 and therefore had remained in Non-Compliance.

For Indicator 2.16, DBHDS's Case Management Steering Committee (CMSC) had analyzed, as required, the data results from the Support Coordinator Quality Review *(SCQR-Fiscal Year 2024)*. Despite improvement over the prior year's data, 72% of the records reviewed had achieved a minimum of nine of the ten indicators and so had again fallen short of the required 86%.

Regarding Provision V.F.5., Virginia had met the sole Indicator 47.1 for the first time and had therefore achieved Compliance with this Provision for the first time. The CMSC had established and tracked two performance measures in each of the domain elements of health and safety and community integration. The *SCQR-Fiscal Year 2024* data had indicated that the Commonwealth had met or exceeded the required 86% performance metric for all four measures.

Twenty-sixth Period Study

For this latest review, the Independent Reviewer retained the same consultant as last time to assess Virginia's status regarding the goals and its implementation of required actions specified in Terms 31 and 58 of the Permanent Injunction. These Terms relate respectively to previous Compliance Indicators 2.16 and 47.1.

Key Points for Term 31

- Since DBHDS has not yet completed the current cycle of its annual SCQR, the Independent Reviewer could not determine a compliance rating for this Period.
- For this Term's subsection 31a, DBHDS required a quality improvement plan from nine CSBs. No CSBs required intensive monitoring nor were any referred to the Department's Office of Management Services. The Commonwealth's efforts to complete the required actions are in progress.
- When results from the Fiscal Year 2025 SCQR are available, DBHDS plans to provide the targeted technical assistance required by this Term's subsection 31b.

Key Points for Term 58

- Since DBHDS has not yet completed the current cycle of its annual SCQR, the Independent Reviewer could not determine a compliance rating for this Period.
- The Permanent Injunction established 86% measures for each of two areas within health and safety, and likewise for two areas within community integration. The most recent data for all four areas – from Fiscal Year 2024 – showed case manager performance exceeding the these thresholds. The current annual SCQR results will be reviewed at the end of Fiscal Year 2025 to determine the latest performance and if any changes are needed to the review process that DBHDS undertakes with case management supervisors.

See Appendix A for the consultant's full report.

Conclusion

Regarding Term 31, since Virginia will not complete its Fiscal Year 2025 SCQR cycle until the next Twenty-seventh Period review, the compliance rating for this Term is Deferred.

Regarding Term 58, since Virginia will not complete its Fiscal Year 2025 SCQR cycle until the next Twenty-seventh Period review, the compliance rating for this Term is Deferred.

2. Crisis and Behavioral Services

Background

The previous Twenty-fifth Period study had reviewed four remaining Crisis and Behavioral Services Provisions (III.C.6.a.i.-iii., III.C.6.b.iii.B., III.C.6.b.iii.D. and III.C.6.b.iii.G.) and their associated five Compliance Indicators that had not yet been achieved, either at all or twice consecutively. At that time, the Commonwealth had not met the requirements of Provision III.C.6.a.i.-iii.'s two remaining Indicators, 7.8 and 7.18, and had therefore remained in Non-Compliance.

Virginia had again fallen short of providing crisis assessments in the home or other community locations, as required by Indicator 7.8's 86% performance metric. For children and adults known to the system, REACH crisis assessments had been provided at the individual's home, the residential setting, or other community settings for 55% in Fiscal Year 2024's fourth quarter, and for only 49% in the first quarter of Fiscal Year 2025. Significant variations had also continued between DBHDS's five Regions.

Of note, more than 90% of the individuals who had received their crisis assessments in their homes had retained their home settings, whereas fewer than 70% of those who had received their assessments at hospitals or CSB Emergency Services retained their home settings.

For Compliance Indicator 7.18, only 75% of individuals needing therapeutic consultation (i.e., behavioral supports) had been referred to a provider within 30 days of the need being identified. The monthly average number of days for referral, for those who had not been connected within 30 days, ranged between 55 days in April 2024 and 62 days in June 2024. Overall, 18% of individuals with an identified need had not been connected at all with a Therapeutic Consultation provider.

Regarding Provision III.C.6.b.iii.B.'s one remaining Compliance Indicator 10.4, the Commonwealth had not achieved its requirements and so had remained in Non-Compliance. A community residence had been identified within 30 days of admission to a Crisis Therapeutic Home (CTH) or psychiatric hospital for 76% of individuals with a Waiver and known to REACH, rather than the required 86% metric.

Regarding Provision III.C.6.b.iii.D.'s sole Compliance Indicator 11.1, Virginia had met its requirements for the second consecutive Period and so had achieved Sustained Compliance.

Regarding Provision III.C.6.b.iii.G.'s one remaining Compliance Indicator 13.3, the Commonwealth had not met its metrics and therefore had remained in Non-Compliance. DBHDS was in the process of creating three CTHs for children instead of out-of-home crisis therapeutic prevention host-like homes.

Twenty-sixth Period Study

For this latest review, the Independent Reviewer retained the same consultant as previously to assess Virginia's status regarding specified goals and its implementation of required actions, particularly Terms 32 and 33 of the Permanent Injunction, associated with crisis and behavioral services, and Terms 35 and 36, associated with crisis stabilization. These Terms relate respectively to previous Compliance Indicators 7.8, 7.18, 10.4 and 13.3.

Key Points for Term 32

- DBHDS did not accomplish this Term's requirement to perform 86% of its crisis assessments in community settings. Only 626 (47.5%) of the 1,317 assessments conducted took place in a community setting.
- The Commonwealth is making progress implementing the following actions listed in this Term's subsections 32a–e: conducting a 988 media campaign, requiring, and offering Mobile Crisis Response (MCR) training, providing funding for initiatives to help REACH crisis teams fill vacant positions, developing a planning template, monitoring REACH staffing, conducting reviews and requiring corrective actions.

Key Points for Term 33

- Regarding the 86% measure specified in this Term, of the 1,428 individuals identified as needing behavioral services during this Period, only 1,043 (73%) were referred to and connected with a provider within 30 days of the need being identified. Of the 385 (27%) people who were not connected within 30 days, 266 (18.6%) were not connected at all with a Therapeutic Consultation provider.
- As required by this Term's subsections 33a and 33b, DBHDS is in progress implementing targeted technical assistance to improve specific CSBs' performance, as well as promoting Therapeutic Consultation services at Regional Round Tables. The Department offered Medicaid enrollment assistance to providers at the 2025 Virginia Association for Behavior

Analysis Annual Conference.

- Virginia completed the required action of this Term's subsection 33c by creating and making available a three-part training series and instructions for agencies or licensed providers on how to enroll in Medicaid.

Key Points for Term 35

- DBHDS almost achieved this Term's requirement that 86% of individuals have a community residence identified within 30 days of admission to either a CTH or a psychiatric hospital. During this Period, of the 351 individuals admitted, 298 (85%) had a residence identified within 30 days; whereas 53 people (15%) did not.
- The Department had selected five providers to develop 11 new homes for individuals with intense behavioral support needs across four of its five Regions, as detailed in the schedule within this Term's subsection 35a. All of these new residences were to be operational by February 2025. However, at the time of this review, only eight new homes were up and running, and Region II was the only Region that achieved the required number of new homes.

Key Points for Term 36

- DBHDS has not yet complied with this Term's requirements to establish and operate CTHs for children in each of the three Regions that do not currently have one. None of these homes is operational yet. However, a contract has been signed with a provider to operate a CTH for children in Region V, and similar contracts are under review in Regions II and III.
- The Department completed the action required by this Term's subsection 36a. DBHDS issued a communication that the two existing CTHs for children in Regions I and IV can be utilized for preventive stays by children from across the Commonwealth.
- Regarding the requirements of this Term's subsections 36b and 36c, Virginia continued to track and report quarterly on the number of children's crisis prevention stays in the two Regions with operational programs. DBHDS reported that 12 children used the CTH in Region II for prevention during the current Period. No children used the CTH in Region IV for prevention.
- For this Term's subsection 36d, DBHDS reported that its Short-Term Crisis Prevention Respite Services is in progress. When fully operational, this initiative will provide up to 1,000 days of respite for children connected to REACH.

See Appendix B for the consultants' full report.

Conclusion

Regarding Term 32, since the Commonwealth did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 33, since Virginia did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 35, since the Commonwealth did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 36, since Virginia did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

3. Integrated Day Activities and Supported Employment

Background

The previous Twenty-fifth Period study of Virginia's Integrated Day Activities and Supported Employment service system had determined that the Commonwealth had remained in Non-Compliance with the one remaining Provision, namely III.C.7.a. Two of this Provision's three outstanding associated Compliance Indicators (14.8 and 14.9) had not been achieved, and a third Indicator (14.10) had received a deferred rating.

For Indicator 14.8, 1,020 Waiver participants had been employed, representing 89% of DBHDS's Fiscal Year 2024 target, but falling short of achieving the Indicator's 90% performance measure.

Regarding Indicator 14.9, of the adults on either a DD Waiver or a waitlist, 24.5% had been employed. While this had represented an increase of 1.5% over the prior year, Virginia had remained slightly short of the Indicator's 25% requirement.

For Indicator 14.10, since the Commonwealth could not determine its latest annual percentage increase until after March 2025, no new monitoring data for the Twenty-Fifth Period's study had been available for analysis and verification. The Independent Reviewer had therefore determined

a deferred rating for this Indicator.

Twenty-sixth Period Study

For this latest review, the Independent Reviewer retained the same consultant as previously to assess Virginia's status regarding the goals and its implementation of required actions specified in Terms 37, 50 and 51 of the Permanent Injunction. These Terms relate respectively to previous Compliance Indicators 14.10, 14.8 and 14.9.

Key Points for Term 37

- The Commonwealth reported that in March 2025, 4,438 (24.4%) of the 18,149 individuals with either DD Waivers or on the waitlist participated in employment and day services in integrated settings. This represented 676 more people, and an increase of 2.45% over the 3,762 of 17,142 (21.95%) reported as of March 2024. This latest percentage increase exceeded the 2% goal specified in of this Term.
- Virginia is making progress in implementing the Community Life Engagement Advisory Committee (CEAG)'s work plan, which addresses the requirements of this Term's subsection 37a to define meaningful community involvement, develop training and educational materials to enhance meaningful community involvement, and to assess community involvement data. The work plan includes goals, support activities and timelines; however, with one exception, its outcomes and indicators are not measurable.
- The Commonwealth's implementation of a rate study is in progress, consistent with the requirements of this Term's subsection 37b.

Key Point for Term 50

- This Term specifies a measure that Virginia should achieve at least within 10% of its annual employment target of 1,310 individuals on DD Waivers being employed. As of December 2024, midway through Fiscal Year 2025, there were 1,082 Waiver participants employed. A new compliance rating will be determined during the Twenty-seventh Period review when the Commonwealth's performance for the entire Fiscal Year can be considered.

Key Point for Term 51

- As of December 31, 2024, 5,331 individuals were employed out of the 23,088 (23%) of adults aged 18-64 who were either receiving or on the waitlist for DD Waiver services. This latest percentage represented a decrease of 1.5% compared with the 24.5% employed on

June 30, 2024, and highlighted in the previous Twenty-Fifth Period Report.

See Appendix C for the consultant's full report.

Conclusion

Regarding Term 37, Virginia exceeded the specified goal and is therefore in Compliance with this Term.

Regarding Term 50, since the Commonwealth's achievement of its annual employment target cannot be determined until the end of Fiscal Year 2025, the compliance rating for this Term is Deferred until the next Twenty-seventh Period review.

Regarding Term 51, since Virginia did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

4. Community Living Options

Background

At the time of the previous Twenty-fifth Period review, two Indicators – 18.2 and 18.9 – had remained as part of Community Living Options Provision III.D.1. As a result of this study, the Commonwealth had failed to meet the requirements of either Indicator, and had therefore remained in Non-Compliance.

Regarding Indicator 18.2, DBHDS's data had been showing a significant positive annual trend: the number and percentage of authorizations for people being served in most-integrated residential settings (i.e., fewer than four individuals with DD) had continued to grow as a percentage of all residential settings. In 2024, this had reached 90.5%, a 0.5% increase over the previous year. In tandem, the number and percentage of those residing in less-integrated residential settings had decreased during the same eight-year period. However, the 0.5% annual increase had not met this Indicator's 2% performance metric.

Regarding Indicator 18.9's first metric, 95% of those individuals with new nursing service authorizations had been initiated within the required 30-day timeline, exceeding the 70% timeliness performance metric.

For the second metric, DBHDS reported that only 50% of those individuals whose ISPs had identified the need for nursing services had received 80% of their authorized hours, falling short of this Indicator's second benchmark of 70%.

The Independent Reviewer had reiterated how critical it is that people with IDD be able to live in their home settings while receiving adequate health care, including essential nursing services, and how crucial it was for Virginia to correctly count the number of individuals with the identified need and the quantity of nursing services delivered.

To avoid undercounting the number of individuals needing nursing supports in the future, DBHDS had planned to implement a new Individual Supports Plan (ISP) requirement that all such individuals be identified, regardless of the availability of nursing services.

Twenty-sixth Period Study

For this latest review, the Independent Reviewer retained the same consultant as previously to assess the Commonwealth's status regarding specified goals and its implementation of required actions, particularly Terms 38 and 39 of the Permanent Injunction.

Both these Terms relate to the previous Compliance Indicator 18.9. There is no Term in the Permanent Injunction relating to Indicator 18.2.

Key Points for Terms 38 and 39

- As required by these Terms' subsections 38a and 39a, DBHDS reported new nursing utilization data on April 15, 2025, for the first half of Fiscal Year 2025. The data for a full Fiscal Year, however, which is needed for a compliance rating, will not be available until October 15, 2025.
- This newly reported nursing utilization data indicated a significant decline in the delivery of nursing services across almost every category. However, these data are not complete and are likely incorrect, a fact that DBHDS has confirmed. Because Virginia allows up to 12 months for its nursing services providers to submit bills for services delivered, the Commonwealth cannot report the correct quantity of nursing services delivered until a full year after the final date of the service delivery period. For example, the Department recently conducted a recount of its nursing utilization data for Fiscal Year 2024, which showed a higher number of individuals who received at least 80% of authorized nursing hours than it had previously reported. It is therefore highly likely that DBHDS's latest data

for the first two quarters of Fiscal Year 2025 has also undercounted the percentage of individuals who received at least 80% of their authorized nursing hours.

- As required by Term 38b, DBHDS updated its ISP form in September 2024 to allow for the collection of nursing needs and the incorporation of the Risk Awareness Tool into the ISP.
- To better assess if individuals reviewed have unmet nursing or other medical needs, DBHDS continued to implement its Intense Management Needs Review (IMNR) process, and submitted its semi-annual report on April 15, 2025, as required by Term 38c.
- DBHDS's implementation of Term 38d's requirements is in progress. The Department initiated a process to identify CSBs with the highest nursing shortages. DBHDS is also identifying CSBs with the lowest utilization and targeting its technical assistance and training activities to support those CSBs to increase utilization of authorized nursing hours.
- For Term 39c, DBHDS completed a comprehensive IMNR monitoring questionnaire for skilled nursing and initiated monthly IMNR reviews in April. This work is ongoing.
- Virginia, under the leadership of the Department for Medical Assistance Services (DMAS), contracted Guidehouse to conduct the rate study required by Terms 38e and 39d. The Department created a DD Rate Study Work Group comprising representatives from providers, advocacy groups and industry associations. Meetings of the Work Group began in December 2024. In April 2025, Guidehouse began surveying providers via its *Provider Cost and Wage Survey*. DOJ had provided input on how the Commonwealth should direct Guidehouse on performing the study. Again, Virginia's achievement of these Terms' subsections is a work-in-progress.

See Appendix D for the consultant's full report.

Conclusion

Regarding Term 38, since the Commonwealth will not report its nursing utilization data for the full Fiscal Year 2025 until October 15, 2025, the compliance rating for this Term is Deferred until the next Twenty-seventh Period review.

Regarding Term 39, since the Commonwealth will not report its nursing utilization data for the full Fiscal Year 2025 until October 15, 2025, a compliance rating for this Term is Deferred until the next Twenty-seventh Period review.

5. Services for Individuals with Complex Health Support Needs

Background

The previous Twenty-fifth Period's Individual Services Review (ISR) study had represented the second phase of a year-long review, designed to assess Virginia's status regarding individuals with Waiver services with complex health support needs, as had been outlined in Provision V.D.2.a.-d.'s Indicator 36.8.

A primary objective of this review had been to verify whether the Commonwealth had developed and put in place a systemic process to remediate identified concerns for the sample of 30 individuals studied during the prior Twenty-fourth Period. Indicator 36.8 had required Virginia to implement corrective actions, track the efficacy of these actions, and make revisions as necessary to ensure the actions had addressed the identified deficiencies.

Once again, this ISR study had been run in conjunction with DBHDS's own review of its Intense Management Needs Review (IMNR) process. As well as determining the adequacy of the IMNR specifically related to Indicator 36.8's remediation process, the study's other purposes had been to identify possible positive and/or concerning areas related to the delivery of needed nursing services (Provision III.D.1's Indicator 18.9), the receipt of annual physical and dental exams (Provision V.B.'s Indicator 29.20) in the management of health needs for this particular group, and the utilization by case managers of the Department's external monitoring safeguard process tool, the On-site Visit Tool (OSVT).

In terms of methodology and process, both this previous ISR study and the IMNR had focused attention on individuals with SIS level 6 needs (i.e., complex medical needs), who had been involved in annual meetings from July to September 2023 to develop their Individual Supports Plans (ISPs). A stratified sample of 30 individuals with IDD had been randomly selected to include ten people from each of the two remaining Regions not covered in the prior Twenty-Fourth Period study, plus ten from one of the three Regions previously reviewed.

DBHDS's IMNR review had replicated the work of the consultants' ISR study. Both had utilized a monitoring questionnaire with written interpretive guidelines, had conducted on-site interviews with a primary caregiver with knowledge of the relevant health care services, had made observations of the person, their adaptive equipment, and their residential setting, and had collected and analyzed facts from both the individual's health care records and the site visit itself.

The studies had been carried out in parallel to ensure that DBHDS's recently designed and implemented IMNR process could reliably determine the same significant health management concerns as the independent ISR review. Both studies' monitoring processes had been conducted by qualified clinicians overseen by experienced supervisors who had collaborated throughout the reviews' timeframes.

It had been understood, right from the start, that the randomly selected sample was not large enough to generalize findings for any Compliance determinations for the three Indicators involved.

Once again, both the ISR and the IMNR studies had reached the same conclusions.

Regarding Indicator 36.8's remediation process, during the Twenty-Fifth Period, DBHDS had assigned implementation responsibilities for its remediation plans and had begun tracking their execution, however the Department could not yet determine whether an action had been sufficient to address and resolve the documented deficiency.

Regarding Indicator 18.9's nursing utilization rate, of the ten of the 30 individuals studied who had been identified as needing in-home nursing services, nine people had been authorized, and another had not received any authorized nursing services during the year the ISP was in effect. In addition to those ten with identified in-home nursing needs, two others had needed such services. However, their need had not been identified in their ISPs because no nursing services were available in their geographic area.

Of the nine individuals authorized for in-home nursing services, 56 % had received at least 80% of the approved number of hours. This percentage, however, had not accurately represented the nursing utilization rate for the total of 12 people in this previous study who had actually needed in-home nursing services. Of these 12 individuals, only 40% received 80% of their needed hours.

Overall, the Commonwealth has been well aware for many years of the fundamental reason why individuals who need in-home nursing supports are either not receiving enough of them or are receiving none at all: both the Twenty-fifth Period ISR and IMNR reviews had again confirmed that there were insufficient nurses to meet this critical need in a timely manner.

Regarding Indicator 29.20's requirement for annual physical and dental exams, the ISR and

IMNR studies had each found sustained progress in the provision of annual physical exams, with 97% of the 30 individuals having received one within the previous 14 months.

However, only 73% of the selected sample had an annual dental exam. Both these studies had again found the same obstacles: too few dentists had accepted Medicaid, offered sedation, or provided services in Virginia's more rural areas. In addition, the ISR consultants had determined that the website operated by DentaQuest had not provided, as it should have, current and accurate information about the number and location of dentists who accept Medicaid.

Additionally, the Twenty-fifth Period ISR study had found that the Commonwealth's Case Managers/Support Coordinators had not adequately utilized DBHDS's OSVT. They had not adequately identified or documented unmet nursing needs or taken sufficient actions to address and resolve them. They had also failed to identify problems and gaps in existing services as well as inaccuracies and inconsistencies in the information they had included in the OSVT.

Case management turnover had negatively impacted the continuity of care and the timely identification of essential supports. This serious concern had been raised by caregivers as an impediment to the provision of adequate healthcare.

Twenty-sixth Period Study

For this latest review, the Independent Reviewer retained the same consultants as previously to undertake another ISR study. Its purpose was to provide information to assist Virginia in its endeavor to achieve certain specified goals of the Permanent Injunction, particularly Terms 38, 39, 40, 44 and 54.

Term 44 relates to the previous Compliance Indicator 36.8, specifically its data collection, analysis and required remediation processes for individuals with complex health support needs. Terms 38 and 39 relate to the previous Indicator 18.9's nursing utilization rate, and Terms 40 and 54 relate to the previous Indicator 29.20's requirement for annual physical and dental exams. Additionally, use of the OSVT by case managers was again reviewed.

Once more, this ISR study was conducted in parallel with DBHDS's latest IMNR. Both studies focused on a new stratified sample of 30 individuals with SIS level 6 needs, all of whom were involved in annual ISP meetings from September through November, 2024. The sample included 15 people from each of the Commonwealth's Regions II and IV. Sadly, one individual from the

selected sample passed away just as the consultants' on-site visit was about to occur, allowing no time to identify a replacement person.

Both studies completed their respective monitoring questionnaires utilizing document reviews, on-site observations, and interviews with primary caregivers to collect and analyze data regarding the selected individuals' management and support needs.

Key Points for Term 44

- The ISR and IMNR nurses effectively identified unmet health needs and, in certain more urgent cases, DBHDS's nurses immediately implemented initial corrective actions (i.e., remediation plans) by contacting the Department's Mobile Rehabilitation Engineering (MRE) staff and scheduling necessary repairs to individuals' adaptive equipment.
- Overall, DBHDS's remediation system, although well intentioned, did not adequately track, revise as necessary, and ensure correction of identified issues. This is not surprising given the complexities of the challenges, and that this system is still in an early stage of development. The Department learned that its IMNR recommended remediation plan's actions must not only address, for example, the scheduling of a medical appointment, but must also ensure that the medical examination then occurred and that the doctor's orders were implemented.
- The ISR and IMNR studies again identified significant shortcomings in case managers' completion of DBHDS's OSVT. The effective use of OSVT assessments is a critical element of Virginia's community-based service system and is central to identifying and addressing inadequate or absent health-related supports. Yet the latest studies found that 14 (48%) of the 29 individuals either did not receive the required frequency of OSVT assessments, or the completed OSVT documents included inaccurate or missing information.
- Both studies learned that several families were not aware of resources that could be accessed for additional support to address unmet health needs. These resources included DBHDS's MRE staff and the dental services performed at VCU or by Virginia's mobile dental units. This suggests that case managers were not providing adequate assistance in sharing information about available resources.

Key Points for Terms 38 and 39

- Regarding Term 38, the ISR and IMNR studies each found that 13 (45%) of the 29 individuals reviewed needed nursing services and that all 13 were authorized to receive

Private Duty Nursing, which was identified on completed CMS 485 forms.

- Although too small a sample to generalize findings, of these 13 individuals, eight (62%) received at least 80% of their authorized hours. Of the 13 individuals, a smaller percentage than in previous studies reported complaints regarding the availability or competence of assigned nursing staff. It is worth noting that additional hours of delivered nursing services may still be reported, since providers have 12 months to submit bills for payment.
- Regarding Term 39, none of the selected 29 individuals needed or were authorized to receive Skilled Nursing services.

Key Points for Terms 40 and 54

- Regarding Term 40, both the ISR and the IMNR's findings concurred that only 20 (69%) of the 29 individuals studied received the requisite annual dental exam. While this showed improvement over the previous Period, the results were still insufficient.
- The studies found the following challenges to obtaining dental care: a lack of dentists, especially those with needed expertise or specialized equipment, the hesitation of families to schedule needed dental care, and/or their lack of knowledge regarding available resources.
- Regarding Term 54, for the second consecutive Period, this latest ISR study found that 28 (97%) out of the 29 individuals reviewed had received an annual physical exam within the previous 14 months. Although the study was based on too small a sample, these findings are consistent with the Commonwealth having achieved sustained progress.

See Appendix E for the consultants' full report.

Conclusion

Once again, the randomly selected sample was not large enough to generalize findings to determine whether Virginia has met the relevant requirements of Terms 38, 39, 40, 44 and 54.

Regarding Term 44, the ISR study verified that the Commonwealth's IMNR process again adequately collected and analyzed data and identified management needs for individuals with complex health support needs. However, the IMNR's remediation system was not yet sufficient.

6. Quality and Risk Management

Background

At the time of the previous Twenty-fifth Period study, five Provisions, V.B., V.C.1., V.D.1., V.D.2. and V.D.3., and their outstanding 19 Compliance Indicators specified the Agreement's remaining requirements for the Commonwealth's Quality and Risk Management (QRM) system. Virginia had not yet achieved Compliance with any of these Provisions.

Provision V.B.

Regarding Provision V.B.'s eight remaining Indicators (29.13, 29.16–29.18, 29.20–29.22 and 29.24), the Commonwealth had met the requirements of two of them (29.13 and 29.16) twice consecutively. However, Virginia had not achieved six Indicators, 29.17, 29.18, 29.20–29.22 and 29.24, and therefore had remained in Non-Compliance.

DBHDS had completed its revised community look-behind process that addressed each of the outcomes required by Indicator 29.17. The Twenty-fifth Period study had found that the results from the previous six quarterly reviews had been presented to the Risk Management Review Committee (RMRC). However, because the RMRC's data and trend analysis processes associated with this Indicator had been incomplete and not fully implemented and had not included a fully operational inter-rater reliability (IRR) process, the Commonwealth had failed to meet this Indicator. Due to these factors, Virginia had not achieved Indicator 29.18 as well.

For Indicator 29.20, DBHDS data had indicated that the Commonwealth had very nearly achieved the 86% measure for people supported in residential settings receiving annual physical exams. However, for the most recently reported four quarters, the overall 64% achievement of annual dental exams for individuals with dental services had remained well below the 86% threshold. The Department had continued to implement a number of systemic efforts to expand available resources that were designed to increase, over time, the percentage of individuals in their residential settings who receive annual dental exams.

DBHDS again had not achieved the 86% performance measure for Indicator 29.21. The Department reported that just 68% of people with identified behavioral support needs had received adequate services. In line with the applicable curative action, DBHDS had used a corrected calculation methodology to ensure that the measure had accurately reflected the entire cohort of people with identified behavioral support needs.

Virginia had continued to complete work on its validation of settings, as required by Indicator 29.22, which specifically required that the Commonwealth follows the CMS rules on Home and Community-based settings. Virginia had not finished all reviews or provided a finalized data report for this Period, though, citing a need for more time to adequately validate the related QSR results. The Twenty-fifth Period study had found that DBHDS had satisfactorily completed revisions to the QSR methodology to address the validity concerns related to findings of compliance without evidence. However, the Department still needed to provide a well-defined protocol for this review process and a clear description of the overall QSR procedure for determining compliance with the requirements of the CMS settings rules and related guidance.

DBHDS again had not met Indicator 29.24's 95% performance measure. Although the Department had made some needed revisions to its data collection methodology, significant additional modifications were essential to yield valid data.

Provision V.C.1.

Regarding Provision V.C.1.'s two remaining Compliance Indicators (30.4 and 30.10), the Commonwealth had not achieved either of them, and so had remained in Non-Compliance.

For Indicator 30.4 regarding risk management licensing requirements that providers should adhere to, DBHDS's Office of Licensing (OL) had assessed these in 98% of its inspections, surpassing the 86% performance metric. However, in terms of how effectively OL conducted these inspections, the consultants' review of samples had shown an increase to 83.6% compared with just 52% from the Twenty-third Period's study. This demonstrated significant progress, but OL's licensing inspections had still not been sufficient to achieve this Indicator.

Regarding Indicator 30.10, the Twenty-fifth Period's review had found an incremental improvement in the accuracy of OL's determinations. However, the consultants had again identified concerns regarding the accuracy and consistency of OL's assessments of providers' processes and procedures.

Provision V.D.1.

For Provision V.D.1's five remaining Compliance Indicators (35.1, 35.3, 35.5, 35.7 and 35.8), Virginia had sustained its achievement of Indicator 35.3 twice consecutively, and had met an additional Indicator, 35.7, for the first time. However, the Commonwealth had not achieved the other three Indicators, 35.1, 35.5 and 35.8, and had therefore remained in Non-Compliance.

Regarding Indicator 35.1, despite reviewing data on a quarterly basis, DBHDS again had not met this Indicator. The Department had not developed and/or monitored the needed remediation, as outlined in Virginia's CMS approved Quality Improvement Systems (QISs) for each of the HCBS Waivers.

The Commonwealth had not achieved Indicator 35.5. Evidence had not been provided that the joint DBHDS-DMAS Quality Review Team (QRT) had developed and/or monitored required remediation plans. In addition, the Team had not provided any systemic quality improvement plans, had not referenced a written review of related Quality Improvement Initiatives (QIIs), had not had measures in place to monitor performance of these plans, and had not provided evidence of formal monitoring every six months.

For Indicator 35.8, for the individuals assigned a DD Waiver slot, Virginia's data had shown that 81% had been enrolled in a Waiver-funded, community-based service within five months, rather than the required 86% performance metric.

Provision V.D.2.

Regarding Provision V.D.2.'s three remaining Compliance Indicators (36.1, 36.3 and 36.8), the Commonwealth had not achieved any of them and so had remained in Non-Compliance.

For Indicator 36.8, DBHDS had implemented the second phase of its Intensive Management Needs Review (IMNR), a year-long, two-phase study focused on 60 randomly selected individuals with intensive health management needs. The IMNR had reviewed 30 such people in each of the Twenty-fourth and Twenty-fifth Periods. The Independent Reviewer had implemented parallel Individual Services Review (ISR) studies during these Periods. These had confirmed that the IMNR process was sufficient to monitor the adequacy of health management and supports provided for this one subgroup.

The Twenty-fifth Period's review had also confirmed that DBHDS had implemented its first IMNR remediation process for the 30 individuals studied during the previous Twenty-fourth Period. The IMNR nurse reviewers had effectively developed needed corrective actions and the Department had assigned responsibility to implement these remediation plans. DBHDS had not yet executed a systemic process, however, to determine the efficacy of these plans, nor had the Department taken the process step to revise corrective actions as necessary to ensure that the remediation addressed and resolved the identified deficiencies.

Additionally, DBHDS had not reported a review of the adequacy of management and supports for the two other subgroups, i.e., individuals with complex behavioral or adaptive support needs.

Provision V.D.3.

Regarding Provision V.D.3's one remaining Compliance Indicator (37.7), Virginia had not met its requirements and had therefore remained in Non-Compliance.

Twenty-sixth Period Study

For this latest review, the Independent Reviewer retained the same consultants as previously to assess the Commonwealth's status regarding specified goals and its implementation of required actions, particularly 13 Terms of the Permanent Injunction. These Terms are 34, 40–44, 49 and 52–57, and relate respectively to previous Compliance Indicators 29.21, 29.20, 29.24, 30.10, 35.8, 36.8, 29.22, 29.17, 29.18, 30.4, 35.1 and 35.5.

There are no Terms in the Permanent Injunction relating to Indicators 35.7, 36.1, 36.3 and 37.7.

Key Points for Term 34

- Regarding this Term's 86% measure, based on a sample and an extrapolation, DBHDS reported that for the first two quarters of Fiscal Year 2025, 1,428 individuals who needed adequate and appropriately delivered behavioral support services, only 976 (68%) received them, with the remaining 32% receiving inadequate or no services at all.
- Virginia completed its implementation of actions required by this Term's subsection 34a to address findings through its previously conducted root cause analysis. DBHDS's *Behavioral Supports Report: Q3/FY25* included updates that addressed the identified section titles of training; task clarification and prompting; resources, materials, and processes; behavioral resources; performance consequences, effort, and competition; gap analysis; and quality assurance.
- DBHDS also completed the actions required by this Term's subsections 34b and 34c. The Department continued to use the BSPARI tool to determine whether individuals were receiving adequate and appropriate behavioral support services. DBHDS reported that its five behavior analysts completed a statistically significant sample of reviews of behavior programs to determine adherence to the *Practice Guidelines for Behavior Support Plans* and provided feedback sessions on all the sampled programs to the behaviorists involved. BSPARI scores and trends were analyzed by the Department to identify areas of

improvement and recurring issues in behavioral programming, and then these findings were utilized to create additional training and technical assistance.

Key Points for Term 40

- DBHDS reported that it did not achieve this Term's 86% goal. For the first three quarters of Fiscal Year 2025, just 68.6% of individuals supported in residential settings received an annual dental exam.
- For this Term's subsection 40a, the Commonwealth did not complete the required action to have three mobile dental vehicles operational by March 31, 2025. DBHDS continued to operate two such vehicles, but the build-out of the third was still in process, with specific HVAC equipment needed.
- DBHDS reported that it continued to employ all but one of the required number of dental assistants and hygienists. To complete the action required by this Term's subsection 40b, the Department reposted the available position after a recently selected candidate declined its employment offer.
- DBHDS completed the requirement of this Term's subsection 40c to continue to review referrals for dental services. The Department also developed and implemented an independent scheduling system and a methodology for prioritizing individuals without an annual dental exam to get one from community dental providers.
- DBHDS was in progress fulfilling the actions required by this Term's subsection 40d. In February 2025, Virginia posted an RFP to contract with a dentist in each Region who could offer this Term's required sedation. The RFP review panel began its process in March 2025, and DBHDS projected awarding contracts before the end of April 2025.
- As required by this Term's subsection 40e, DBHDS completed the first, and initiated the next three of the six steps in its plan to collaborate with dental providers to better understand barriers to delivering services to individuals with IDD, and to develop a strategic plan that addresses them.
- DBHDS identified CSBs with the lowest percentages of individuals receiving annual dental exams, and began providing technical assistance to support those CSBs, as required by this Term's subsection 40f.

Key Points for Term 41

- The Commonwealth did not achieve this Term's 95% goal: DBHDS did not provide valid and reliable data to document the percentage of individuals who were protected from serious injuries in service settings. The Department, however, did take some positive steps.

These included revising processes for its Incident Management Unit and Office of Human Rights (OHR), implementing a Specialized Investigation Unit, and updating a number of written processes and protocols related to the review and referral of serious injuries.

- DBHDS was in progress implementing the actions required by this Term's subsection 41a. The Department continued to improve the methodology for ensuring that all appropriate serious injuries are included in its goal reporting. However, additional revisions to the methodology are needed to ensure valid and reliable data regarding the percentage of DD Waiver service recipients who were protected from serious injuries in service settings.
- For this Term's subsection 41b, DBHDS indicated progress between its incident management team and the Office of Integrated Health Support Network (OIHSN) to develop the processes needed for a quality review of a statistically significant sample of serious injuries. These will determine if the process used by OL's Incident Management Unit (IMU) adequately identifies all appropriate injuries and whether individuals are protected from harm, and if changes are needed to the way incidents are reviewed and referred.

<u>Key Points for Term 42</u>

- Virginia has not yet completed a full round of annual licensing inspections for 2025, so could not yet determine the number and percentage of providers that had identified the incidence of common risks and conditions faced by people with IDD. DBHDS's Office of Clinical Quality Management (OCQM) and OL strengthened training and technical assistance for providers regarding these requirements. The Department also promoted an Excel-based Risk Tracking Tool template that incorporates data recording and analysis tools related to common risks and conditions. Providers using the tool demonstrated its effectiveness in identifying trends and patterns.
- Regarding this Term's subsection 42a and its required action, OL introduced procedural changes. These efforts, however, were insufficient in providing a formal, measurable framework for IRR assessments. A more comprehensive approach would require regular comparative evaluations of each Licensing Specialist at a set frequency, the generation of objective scores, and the aggregation of data for ongoing reliability assessments.
- DBHDS's Office of Community Quality Improvement (OCQI) completed the development and implementation of its Expanded Consultation and Technical Assistance (ECTA) process which offers technical assistance to providers that had not identified the incidence of common risks and conditions. The ECTA is ongoing and met the requirements of this Term's subsection 42b.

- Regarding this Term's subsection 42c, DBHDS's OL implemented an ongoing inspection protocol that completes the required action. This protocol included developing a Corrective Action Plan (CAP) for each cited violation, ensuring provider implementation of the CAP, and enforcing progressive actions if non-compliance persists.

Key Points for Term 43

- The Commonwealth did not achieve this Term's 86% specified goal. During the first two quarters of Fiscal Year 2025, only 75.4% and 78% respectively of individuals assigned a Waiver slot were enrolled in a service within the required five months.
- DBHDS completed the required tracking and reporting of quarterly data on the number of individuals assigned a Waiver slot, but who were not enrolled in a service within five months, as required by this Term's subsection 43a.
- DBHDS also completed the actions required by this Term's subsection 43b. Its initial *Timely Waiver Service Enrollment Survey* was conducted in March 2025 with calls to all 98 individuals (and/or their Authorized Representatives) whose services were not initiated within the 150 days.

Key Points for Term 44

- DBHDS did not meet this Term's requirements to collect and analyze data at least annually regarding the management needs of individuals with identified complex health, behavioral and adaptive support needs. The Department gathered and analyzed data regarding individuals with complex health support needs but has not yet implemented data collection for the other two subgroups.
- DBHDS developed improvement initiatives for individuals with complex health support needs. However, the Department's remediation process – its system of tracking efficacy, making revisions as necessary, and confirming that identified deficiencies are resolved – was not yet sufficiently completing these functions.
- The Department made progress implementing the actions specified in this Term's subsection 44a by crafting a methodology for combining data and information from the IMNR, QSR and BSPARI processes.
- DBHDS continued its progress implementing the requirements of this Term's subsection 44b. The Department's OIHSN nurses conducted the IMNR process for 29 individuals with complex health support needs; however, DBHDS has not yet utilized the IMNR process for individuals with complex behavioral or adaptive support needs.

Key Points for Term 49

- Virginia did not achieve this Term's specified goal that 95% of residential service recipients live in an integrated setting that supports full access to the greater community, in compliance with the relevant CMS rule. DBHDS reported a 93% result.
- The Department continued to review residential settings to validate its compliance with the CMS rule on HCBS settings. As of March 2025, DBHDS reported that 1,538 settings remained to be reviewed by the December 31, 2025 due date.

Key Point for Term 52

- The Commonwealth implemented a revised look-behind review process toward achieving this Term's goal of collecting sufficient data for the RMRC. These data reports continued to support trend analysis, recommendations for QIIs, and tracking of approved initiatives. However, DBHDS's currently insufficient annual IRR process still needs to be replaced. OHR was developing an alternative IRR process that it planned to present to the RMRC for its consideration in April 2025.

Key Points for Term 53

- Virginia Commonwealth University (VCU) continued to conduct quarterly look-behind reviews of statistically valid random samples of DBHDS's serious incident reviews. The results, which consistently met or exceeded this Term's 86% threshold, were reported to the RMRC as required.
- DBHDS continued to conduct quarterly look-behind reviews of a statistically valid random sample of reported allegations of abuse, neglect, and exploitation, and reported the feedback to the RMRC, as required. However, the Department's IRR process remained insufficient: IRR reviews currently occur only at the end of a 12-month period. This delay means that the RMRC might be reviewing inconsistent data from the quarterly reviews.

Key Points for Term 54

- DBHDS exceeded this Term's 86% goal. During first three quarters of Fiscal Year 2025, 88.6% of individuals supported in residential settings received annual physical exams.
- The Department continued to undertake and document multiple initiatives to improve overall health awareness for individuals with IDD within both the provider community and families, and to increase these individuals' participation in annual physicals.

Key Points for Term 55

- Since results of annual licensing inspections for 2025 were only available for the first two months of this year, there was an insufficient cohort to determine the Commonwealth's achievement of this Term's 86% benchmark.
- DBHDS's OL has an established process for consistently assessing providers' compliance with the risk management requirements outlined in the applicable regulations.
- This Period's study reviewed a stratified sample of 30 of the annual licensing inspections that OL had already conducted. Although this was too small a sample to generalize findings or to compare such findings with previous years, the study identified a concern with the accuracy of Licensing Specialists' assessments of providers' a use of data to identify and address trends and patterns of harm and risk of harm.

Key Points for Term 56

- Virginia demonstrated improvement in its implementation of the HCBS Waiver *Quality Improvement Plan*, in particular by developing a useful tool that documented whether remediation efforts were in place.
- However, this Term's goal regarding the QRT's identification of QI strategies was not evidenced in their meeting minutes.

Key Points for Term 57

- As required, the QRT reviewed measure data. For most measures that fell below the CMS-established 86% standard, the Team discussed applicable remediation plans and other QI initiatives and explored next steps for developing such plans.
- However, the QRT did not consistently document or implement remediation plans with defined measures to monitor performance, nor did the Team document a revised strategy when performance did not improve.

See Appendix G for the consultants' full report.

Conclusion

Regarding Term 34, since Virginia did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 40, since the Commonwealth did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 41, since Virginia did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 42, since the Commonwealth has not yet completed a full round of annual licensing inspections for 2025, the compliance rating for this Term is Deferred until the next Twenty-seventh Period review.

Regarding Term 43, since Virginia did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 44, since the Commonwealth did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 49, since Virginia did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 52, since the Commonwealth did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 53, since Virginia did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 54, the Commonwealth exceeded the specified goal and is therefore in Compliance with this Term.

Regarding Term 55, since Virginia has not yet completed a full round of annual licensing inspections for 2025, the compliance rating for this Term is Deferred until the next Twenty-seventh Period review.

Regarding Term 56, since the Commonwealth did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 57, since Virginia did not achieve the specified goal, the compliance rating for this Term is Not Achieved.

7. Provider Training

Background

The previous Twenty-fifth Period review had focused on the one remaining Provision related to Provider Training, namely V.H.1., and its two outstanding Compliance Indicators, 49.4 and 49.12.

Indicator 49.4 had required achievement of a 95% benchmark for each of two outcome measures: the percentage of provider agency staff who meet the provider orientation and training requirements, and the percentage of provider agency Direct Support Professionals (DSP)s who meet competency training requirements. DBHDS had identified the primary factors contributing to its earlier low scores, had implemented process improvements, and had expanded provider training and technical assistance. For the provider orientation and training requirements, the score had improved from 78% to 87%. However, the score related to DSPs meeting competency training requirements declined from 85% to 78%. Since Virginia had not achieved the required 95% thresholds for either measure, this Indicator remained unmet.

Regarding Indicator 49.12, DBHDS had reported that just 74% of providers had achieved this Indicator's measures during its Office of Licensing's (OL's) annual licensing inspections, rather than the required 86% threshold. OL had continued to expand training and technical assistance for providers and Licensing Specialists and had also continued to require Corrective Action Plans (CAPs) in response to any determination that providers had not met the necessary regulations.

Twenty-sixth Period Study

For this latest review, the Independent Reviewer retained the same consultant as previously to assess the Commonwealth's status regarding specified goals and its implementation of required actions, particularly Terms 47 and 48 of the Permanent Injunction. These Terms relate respectively to previous Compliance Indicators 49.12 and 49.4.

<u>Key Points for Term 47</u>

- Results of annual inspections for 2025, conducted by DBHDS's OL, were only available for a limited period: the first two months of this year, and therefore did not provide a sufficient cohort to determine Virginia's achievement of this Term's 86% benchmark. The consultant reviewed a small, stratified sample of 30 of the annual licensing inspections that OL had already conducted. Of these 30 inspections' findings, his study concurred with 27

(90%) of them. This represents an improvement from the 83% agreement rate found from a review of 70 of the annual inspections conducted in 2024 and reported in the previous Twenty-fifth Period review.

- The latest study confirmed that DBHDS completed the actions specified in this Term's subsections 47a, 47b and 47c. The Department required providers to develop and implement a CAP, if OL's inspections found them to be non-compliant with training requirements. DBHDS also developed and implemented the Expanded Consultation and Technical Assistance (ECTA) process in August 2024. Through this process, non-compliant providers were offered technical assistance and additional training and given specific actions to undertake related to their respective areas of underperformance. In addition, DBHDS took further action to enforce adherence to the regulations against those providers who were not compliant with training requirements for two consecutive licensing inspections.

Key Points for Term 48

- DBHDS had not met the 95% goal in either of the prior Round 5 or Round 6 of the Quality Service Reviews (QSR) process to determine if DSPs and their supervisors had received the necessary training and competency testing. To improve this outcome, the Department has ongoing efforts in place to refine processes and to support providers in meeting relevant testing requirements.
- DBHDS has not yet completed its QSR Round 7, so no new data was available for analysis.
- As required by this Term's subsection 48a, the Commonwealth conducted a root cause analysis with the Provider Issues Resolution Workgroup (PIRW) and identified specific focus areas to be addressed to achieve the 95% threshold. As a result of the analysis and in response to the findings, DBHDS has developed and is in the process of implementing a Quality Improvement Initiative, as required by this Term's subsection 48b.
- Virginia's implementation of a rate study is in progress, consistent with the requirements of this Term's subsection 48c.

See Appendix F for the consultant's full report.

Conclusion

Regarding Term 47, since the Commonwealth has not yet completed a full round of annual licensing inspections for 2025, the compliance rating for this Term is Deferred until the next Twenty-seventh Period review.

Regarding Term 48, since Virginia has not yet completed its QSR Round 7, the compliance rating for this Term is Deferred until the next Twenty-seventh Period review.

8. Quality Improvement Programs

Background

As of the Twenty-fifth Period review, three Provisions, V.E.1.–V.E.3., and their associated six remaining Compliance Indicators (42.4, 43.1, 43.3, 43.4, 44.1 and 44.2) specified the Agreement's requirements for Quality Improvement (QI) Programs.

Regarding Provision V.E.1.'s one remaining Indicator 42.4, the Commonwealth had not met its benchmarks and so had remained in Non-Compliance. DBHDS had reported, and the consultants had verified, that for this Indicator's requirement that 86% of providers be compliant with each of the 11 sub-regulations, providers had met or exceeded this benchmark for only two of these 11 elements.

Regarding Provision V.E.2.'s three remaining Indicators, namely 43.1, 43.3 and 43.4, Virginia had not met the requirements of any of them and therefore had remained in Non-Compliance. Even though the Commonwealth had met the requirements for the first time a year prior, this finding had included at that time a caveat that DBHDS needed to further examine its *Process Documents* and *Attestations* for QSR data sets to ensure that the inter-rater reliability (IRR) threats had been adequately identified and addressed.

The Department did not fulfill this caveat during the Twenty-fifth Period. DBHDS was developing remedial strategies to address these IRR threats but had not yet completed an adequate examination of previously identified QSR data reliability concerns.

While the Department had met the requirements for its provider reporting measures related to health and safety, DBHDS had not met all of the requirements related to the community integration measures that are evaluated through the QSR process. The Round 6 QSR methodology had not specified the expectation that providers track and address their individual results through their QI programs and had not required incorporation of community integration into a provider's QI plan. The Department had recognized that the QSR data were likely not reliably measuring community integration and had assigned the Community Engagement

Advisory Group (CEAG) to review and revise community inclusion reporting measure definitions.

Regarding Provision V.E.3.'s two Indicators, 44.1 and 44.2, Virginia had not met the requirements of either of them or so had remained in Non-Compliance. The Twenty-fifth Period study had found that, for Round 6 of DBHDS's QSR, the Department had included many more specific QI elements than in previous Rounds, and that many of these had also included more explicit criteria and guidance for the QSR reviewers.

Even though Indicator 44.1 had been met as a result of the Twenty-third Period review, once again that finding had included the caveat that DBHDS needed to further examine its *Process Documents* and *Attestations* for Quality Services Review (QSR) data sets to ensure that IRR threats had been adequately identified and addressed. The Department had not fulfilled this caveat during the Twenty-fifth Period. In particular, DBHDS's QSR Provider Quality Review (PQR) tool had not delivered sufficient information to determine whether providers had developed or implemented improvement plans when goals had not been met.

For Indicator 44.2, significant IRR discrepancies had been found between the QSR reviewers' and the consultants' findings, and so the Department had not fulfilled this caveat. In addition, the QSR methodology had not adequately identified the QI needs for specific providers.

For both these Indicators, DBHDS has been developing remedial strategies to address these IRR threats but had not completed an adequate examination of previously identified QSR data reliability concerns.

Twenty-sixth Period Study

For the latest review, the Independent Reviewer retained the same consultants to assess the Commonwealth's status regarding specified goals and its implementation of required actions, particularly Terms 45 and 46 of the Permanent Injunction.

Both these Terms relate to two previous Compliance Indicators, 42.4 and 44.2. There are no Terms in the Permanent Injunction that relate to Indicators 43.1, 43.3, 43.4 and 44.1.

<u>Key Points for Term 45</u>

- Since DBHDS had not completed a majority of its 2025 annual licensing inspections, data was not yet available to evaluate Virginia's progress on this Term's requirements.

- DBHDS successfully completed the required actions specified in this Term's subsection 45a. The Department's regulations require that providers develop, submit and implement a written Corrective Action Plan (CAP) for each violation cited by the Office of Licensing (OL). OL and DBHDS's Expanded Consultation and Technical Assistance (ECTA) team established ongoing procedures and protocols and issued guidance to providers. Data collection was underway to monitor the utilization and effectiveness of these procedures.
- DBHDS also completed the actions required by this Term's subsection 45b. When the Department determines that a provider is non-compliant with a regulatory requirement in two consecutive annual inspections, the provider must participate in the ECTA process. OL's written protocols detailed the criteria for and initiation of progressive enforcement actions, which corresponded to the severity of continued non-compliance.
- DBHDS is in progress implementing procedural changes to address the action requirements of this Term's subsection 45c. These changes include various training and supervisory approaches designed by OL. Their purpose is to ensure that, across all licensing specialists, conclusions related to deficiency and compliance determinations are made consistently. However, OL has not yet implemented regular comparative evaluations of each licensing specialist at a set frequency, nor has the Office generated objective scores or aggregated this data. These are necessary factors to establish IRR for OL's assessments of the adequacy of providers' QI programs.

Key Points for Term 46

- Since DBHDS had not yet completed the majority of its 2025 annual inspection cycle as well as its QSR Round 7, no new data were available to determine which providers were not demonstrating adequate QI programs and whether the QSR was yielding relevant valid and reliable data.
- DBHDS successfully completed the required actions specified in this Term's subsection 46a. The Department required providers who receive OL citations to develop and implement a CAP, and it continued to employ a total of 12 QI specialists. These specialists offer providers technical assistance and additional training, and specify actions related to the respective areas of underperformance.
- DBHDS also successfully completed the actions required by this Term's subsection 46b. If OL cites a provider for the same violation over two consecutive annual inspections, the provider must begin the ECTA process within 45 days of receiving their recently approved CAP. If the provider continues to be non-compliant or fails to complete the required ECTA process, the Department may take progressive enforcement actions, as defined in OL

protocols.

See Appendix G for the consultants' full report.

Conclusion

Regarding Term 45, since the Commonwealth had not yet completed the majority of its 2025 annual licensing inspections, the compliance rating for this Term is Deferred until the next Twenty-seventh Period review.

Regarding Term 46, since Virginia had not yet completed both the majority of its 2025 annual licensing inspections and its QSR Round 7 process, the compliance rating for this Term is Deferred until the next Twenty-seventh Period review.

III. CONCLUSION

During the Twenty-sixth Review Period, Virginia, through its lead agencies DBHDS and DMAS, and their sister agencies, continued its diligent efforts and progress toward its achievement of measurable goals and its implementation of required actions, as specified in Section IV's Terms 31–59 of the Permanent Injunction.

Of the 29 Terms studied for this Report, the Commonwealth achieved two of them. Virginia successfully completed or made progress implementing many of the other Terms' required actions. However, since the Commonwealth did not achieve the goals specified in 15 of the Permanent Injunction's Terms, its compliance rating with these Terms is Not Achieved. Due to insufficient time since the Twenty-fifth Report to the Court, Virginia did not complete its established annual monitoring cycles and produce new data related to a further 11 Terms. Without this new monitoring data, the compliance ratings for these 11 Terms are Deferred until the next Twenty-seventh Period review.

For the Permanent Injunction's Rate Studies (Term 59), the Commonwealth selected a vendor to implement a process to collect and analyze data on the rates that Virginia currently pays for 11 DD Waiver services. These relate to five of the other 28 Terms, each of which includes a required rate study action. The Commonwealth projects completing the rate studies, drafting a report, allowing a 30-day review period for stakeholders' feedback, including DOJ, and submitting its final

version prior to the Independent Reviewer's Twenty-seventh Period reviews. Virginia has committed to making its best effort to obtain the necessary funding from the General Assembly during its 2026 and 2027 sessions to allow the Commonwealth to increase rates for the 11 services recommended by the study.

Throughout this Twenty-sixth Review Period, the Commonwealth's staff and DOJ gathered and shared information that helped to facilitate further movement toward effective implementation of the Permanent Injunction. The willingness of both Parties to openly and regularly discuss relevant issues continues to be impressive and productive. The involvement and contributions of advocates and other stakeholders have helped Virginia to formulate policies and processes and to take measurable steps toward fulfilling its promises to all citizens of the Commonwealth, especially those individuals with IDD and their families.

The Independent Reviewer greatly appreciates the assistance that was so generously given by these individuals, as well as their families, their case managers, and their service providers.

IV. RECOMMENDATIONS

Case Management

1. When a CSB has been identified as needing to improve performance and following DBHDS's provision of technical assistance and the CSB's implementation of required quality improvement plans, the Department should report on the results.

Crisis Services

2. DBHDS should review and determine if its regional REACH programs have the necessary number of staff positions that are authorized, funded, and filled to effectively meet their crisis services responsibilities.

3. As part of its quarterly qualitative reviews of REACH programs, DBHDS should undertake a specific review of each Region's measurable progress on initiatives to conduct crisis assessments in community settings. The Department should then make recommendations for needed improvement(s).

Community Living Options

4. DBHDS should accurately report separate nursing services' utilization numbers and percentages for Private Duty Nursing (PDN) and for Skilled Nursing (SN). This will allow the Department to better understand where to direct the Commonwealth's future financial, human, and technical resources.

Individual Services Review (ISR) – Intense Management Needs Review (IMNR)

5. Each time that DBHDS conducts an IMNR remediation process, the Department should include an assessment of the gaps in effectiveness of the actions being taken and tracked to resolve the acknowledged health need or support deficiency for each selected individual.

Quality Improvement Programs and Provider Training

6. DBHDS should develop, document, and implement Office of Licensing (OL) and Quality Services Review (QSR) processes to measure inter-rater reliability (IRR). These IRR procedures should include, for each Licensing Specialist and QSR reviewer, comparative evaluations at a set frequency, the generation of objective scores, and the provision of aggregated data for ongoing reliability assessments.

7. DBHDS should also develop a similar process for measuring IRR between Licensing Specialists and the QSR reviewers, specifically related to their respective assessments of the adequacy of providers' quality improvement programs.

Quality and Risk Management

8. DBHDS's Office of Integrated Health Support Network (OIHSN) should ensure that its proposed quality review process can determine whether OL's Incident Management Unit (IMU):
    - has identified all appropriate injuries;
    - has concluded whether individuals were protected from harm, both prior to and after the serious injury occurred;
    - has developed a method that addresses any findings of concern; and
      has considered and implemented needed changes to the review and referral of incidents.

9. DBHDS should ensure that its Residential Services Community Integration compliance calculation incorporates all elements in the QSR's Person Centered Reviews (PCRs) and Provider Quality Reviews (PQRs) that address related HCBS requirements.

10. Virginia's Quality Review Team (QRT) should document and implement clear procedures that describe expectations for the development, monitoring, and revision of quality improvement plans. These procedures should include requirements for quarterly updating of the *Underperforming Measures Tracker* and consistent documentation of meeting proceedings.

V. SUMMARY OF COMPLIANCE

According to the Terms in Section IV of the Permanent Injunction, the Commonwealth is working to achieve their specified goals and is required to implement the enumerated actions.

The Independent Reviewer has determined three compliance ratings for the Terms' specified goals:

- *Compliance* indicates achievement of the specified goal.
- *Not Achieved* indicates that the specified goal was not met.
- *Deferred* indicates that the Commonwealth will report complete data sets for review and analysis during the next Twenty-seventh Period, as per its established monitoring cycles.

TERM	REQUIRED ACTIONS	RATING
31. Community Services Board Quality Review (SCQR). The Commonwealth will work to achieve a goal that 86% of Community Services Board (CSB) records meet a minimum of 9 of the 10 elements assessed in the Case Management Quality Review. To achieve that goal, the Commonwealth will take the following actions:	a) During its annual quality review cycle starting each January, DBHDS will require a quality improvement plan from any CSB that has two or more elements with substantial or moderate interrater reliability between the CSB Support Coordinator Quality Review (SCQR) and the DBHDS Office of Community Quality Improvement Review not achieving 60% compliance. DBHDS will provide information about which CSBs need this support in the SCQR Report. *In Progress* b) DBHDS will provide targeted technical assistance with identifying measurable outcomes to any CSB (i) whose records are not 86% compliant with including specific and measurable outcomes in Individual Support Plans (ISPs) or (ii) that does not demonstrate improvement with respect to including specific and measurable outcomes in ISPs (including evidence that employment goals have been discussed and developed, when applicable, throughout its quality review cycle). *In Progress* c. If the Commonwealth has not achieved the goal within one year of the date of this Order after taking the actions in Paragraphs 31(a) and 31(b), DBHDS will increase the threshold for requiring a quality improvement plan from a CSB as set out in Paragraph 31(a). DBHDS will provide information about which CSBs need this support in the SCQR Report. *Due January 15, 2026* d. If the Commonwealth has not achieved the goal within one year after taking the actions in Paragraph 31(c), DBHDS will conduct a root cause analysis and implement a Quality Improvement Initiative (QII) as determined appropriate by DBHDS. DBHDS will continue this quality	**Deferred**

	improvement process until the goal is achieved and sustained for one year. *Due January 15, 2027*	
32. Community Setting Crisis Assessments. The Commonwealth will work to achieve a goal that 86% of children and adults receive crisis assessments at home, the residential setting, or other community setting (non-hospital/non-CSB office). Crisis Receiving Centers ("CRC") will only be counted as an "other community setting" after it is determined that the individual or supported decision maker was not directed by the Call Center, Emergency Services, or Mobile Crisis staff to present at a CRC. To achieve that goal, the Commonwealth will take the following actions:	a) DBHDS will continue to promote the use of the 988 24-hour crisis helpline by providing information on the helpline on its social media platforms, in print and television advertisements, and through informational bulletins developed or funded by DBHDS. DBHDS will require all mobile crisis team members to receive training within 90 days of hire on how to support and respond to individuals with developmental disabilities (DD) who are in crisis. *In Progress* b) DBHDS will maintain its current efforts to assist the regions in filling vacant mobile crisis positions by discussing staffing at regional qualitative reviews of REACH programs and supporting REACH programs to implement quality improvement plans. *In Progress* c) Within 6 months of the date of this Order, the Commonwealth will develop a plan that includes measurable goals, specific support activities, and timelines for implementation with consultation from stakeholders to enhance 988 supports and services to increase the likelihood that individuals will be assessed in the community. *In Progress* d) From the date of this Order, DBHDS will monitor staffing at each REACH program to determine if they have sufficient staffing per shift to meet the goal, including through discussion and review of filled/vacant positions, utilization rates of mobile crisis, and times mobile crisis calls are being received in comparison to the number of staff working during those hours at each REACH program's quarterly review. If a quarterly review indicates that staffing is not sufficient to meet the goal, DBHDS shall review the region's current efforts to increase staffing and, if DBHDS determines necessary, will require a quality improvement plan that includes additional actions that DBHDS finds are necessary to enhance staffing. The Independent Reviewer, in the reports required under Paragraph 76, shall include a determination in his report on the adequacy of the Programs and Virginia's response to this requirement. *In Progress* e) Semi-annually, beginning on January 1 and June 1 of each year, DBHDS will work with the two regions that are experiencing the most success in responding to people in crisis in the community to determine what is leading to their success. DBHDS will work with the two regions that are experiencing the most challenges in responding to people in crisis in the community to learn what is leading to those challenges. DBHDS will work with all the regions based on these lessons learned to implement a plan to improve performance in each of the regions. *In Progress* f) If the Commonwealth has not achieved the goal within two years of the	**Not Achieved**

	date of this Order after taking the actions in Paragraphs 32(a) through 32(e), DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. As part of the root cause analysis, the Commonwealth will collect data on why individuals with developmental disabilities presented at a CRC instead of accessing mobile crisis services. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due January 15, 2027*	
33. Therapeutic Consultation Services The Commonwealth will work to achieve a goal that 86% of individuals identified as in need of Therapeutic Consultation service are referred for the service and have a provider identified within 30 days. To achieve that goal, the Commonwealth will take the following actions:	a) Within 12 months of the date of this Order, DBHDS shall implement a technical assistance initiative with the CSBs that need the most support to connect people to behavioral supports and focus on improving case managers' awareness of the behavioral resources available to individuals in need of Therapeutic Consultation, unique CSB business practices, and supervisory support for case managers in this area of performance. *In Progress* b) Annually, the Commonwealth will participate in at least one regional event and at least one statewide conference to promote Therapeutic Consultation services. The Commonwealth will provide technical assistance to providers regarding enrollment with Medicaid as a provider as they reach out to the Commonwealth for this support. *In Progress* c) By July 1, 2025, the Commonwealth will create a training about enrolling with Medicaid as a Therapeutic Consultation provider and make it available for providers via DBHDS's website. *Completed* d) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Therapeutic Consultation by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Therapeutic Consultation by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies. *In Progress* e) If the Commonwealth has not achieved the goal by June 30, 2026 after taking the actions in Paragraphs 33(a) through 33(c), DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due July 15, 2026*	**Not Achieved**

34. Behavioral Support Services The Commonwealth will work to achieve a goal that 86% of individuals with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services. To achieve that goal, the Commonwealth will take the following actions:	a) DBHDS will continue to address findings identified through the previously conducted root cause analysis initiated in Q1 of FY21 and updated subsequently as part of each semi-annual review. ¨*Completed* b) DBHDS will continue to use the BSPARI tool, or such other tool designed for behavioral programming that the parties agree upon, to determine whether individuals are receiving adequate and appropriate behavioral support services. *Completed* c) DBHDS will continue to employ a total of four behavior analysts to provide technical assistance and training on behavioral support plans. Annually, the behavior analysts will (i) review a statistically significant sample of the behavioral plans submitted; (ii) provide feedback; and (iii) identify trends for improvement and develop additional training and technical assistance as determined necessary by DBHDS. *Completed* d) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 34(a) and 34(b), DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one *Due January 15, 2027*	**Not Achieved**
35. Community Residences for Individuals with DD Waivers. The Commonwealth will work to achieve a goal of 86% of individuals with a DD waiver and known to the REACH system who are admitted to a CTH or a psychiatric hospital have a community residence identified within 30 days of admission. To achieve that goal,	a) DBHDS will enter into contracts with providers to develop homes for individuals with intense behavioral support needs that will be operational (*i.e.*, that an individual can move into the home) in accordance with the following schedule: • *Region 1: one home operational by August 2024 and one additional home operational by February 2025;* *Not Completed* • *Region 2: two homes operational by August 2024 and one additional home operational by February 2025;* *Completed* • *Region 3: one home operational by November 2024 and one additional home operational by February 2025;* *Not Completed* • *Region 5: one home operational by November 2024 and two additional homes operational by February 2025.* *Not Completed* If the Commonwealth has not achieved the goal after taking the actions in Paragraph 35(a) by June 30, 2025, DBHDS will conduct a	**Not Achieved**

the Commonwealth will take the following actions:	root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due June 30, 2025*	
36. Out-Of-Home Crisis Therapeutic Prevention Host-Home Like Services for Children. To prevent institutionalization of children due to behavioral or mental health crises, the Commonwealth will implement out-of-home crisis therapeutic prevention host-home-like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service by:	a) Within one month of the date of this Order, DBHDS will send out a communication through the list serv for individuals and families on the waiver waiting list, and to the provider list serv communicating that the two CTHs existing in Regions 1 and 4 as of the date of this Order can be utilized for preventive stays by children across the Commonwealth. *Completed* b) DBHDS will continue to track and report quarterly on the number of crisis prevention stays being utilized by children in each of the five regions. *In Progress* c) Providing funding in Fiscal Year 2025 to establish three additional CTH's in the regions where they do not exist as of the date of this Order (Regions 2, 3, and 5) that will be operational between May 2025 and January 2026. *In Progress* d) From the date of this Order and continuing until all three additional CTHs referenced in Paragraph 36(c) are operational, DBHDS will support up to a total of 1,000 days per year of respite for children connected to REACH, who have previously experienced or are at risk of experiencing a crisis, reside in regions without an operational CTH, and who do not otherwise have funding to access respite services at a rate of up to $500 per 24-hour period. *In Progress* e) If the Commonwealth has not achieved the goal after taking the actions in Paragraphs 36(a) through 36(d) by June 30, 2026, DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due June 30, 2026*	**Not Achieved**
37. Day Services for DD Waiver Recipients. The Commonwealth will work to achieve a goal of a 2% annual increase in the percentage of individuals on the	a) Within one month of the date of this Order, DBHDS's Community Life Engagement Advisory Committee will implement a work plan that includes measurable goals, specific support activities, and timelines for implementation and that is focused on: defining meaningful community involvement; developing training and educational materials to enhance meaningful community involvement for individuals and families, providers, and case managers; and assessing community involvement data. *In Progress* b) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the	**Compliance**

DD waiver receiving day services in the most integrated settings. To achieve that goal, the Commonwealth will take the following action:	Commonwealth will initiate a rate study of Community Engagement, Workplace Assistance, and Community Coaching by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Community Engagement, Workplace Assistance, and Community Coaching by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies. *In Progress* c) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraph 37(a), DBHDS will also conduct a root cause analysis and determine whether a QII is warranted to address identified issues. A root cause analysis and consideration of QII will not be required if the percentage of individuals in the integrated day services reported above is 65% of the total number of the people receiving any day service. *Date: January 15, 2027*	
38. Private Duty Nursing. The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with private duty nursing identified in their ISP or prescribed under EPSDT receive 80% of the hours identified as needed on the CMS485 or DMAS62 forms. To achieve that goal, the Commonwealth will take the following	a) Semi-annually, on May 15 and November 15 of each year, DBHDS will continue to report data on utilization of nursing services and the work of the DBHDS Nursing Workgroup, except if the Independent Reviewer is monitoring the Commonwealth's compliance under Section VIII, DBHDS will report on April 15 and October 15 of each year. *In Progress* b) By September 30, 2024, DBHDS will update the ISP to allow for collection of nursing needs data identified by the Risk Awareness Tool. *Completed* c) DBHDS will continue to implement an IMNR that will assess if individuals have unmet nursing or other medical needs and will work with families, providers, and case managers to take steps to resolve identified unmet needs. Semi-annually, on April 15 and October 15 of each year, DBHDS will report on the IMNR process, including the types of unmet needs identified and efforts taken to resolve them. *In Progress* d) Within six months of the date of this Order, in consultation with the five DBHDS Registered Nurse Care Consultants, the Commonwealth will: *Due July 15, 2025* i. Identify which CSB catchment areas in each Region have the highest nursing shortages for this target population based on objective criteria and data, including how many individuals with private duty nursing receive 80% of their hours;	**Deferred**

actions.	ii. Identify the top three barriers to individuals accessing nursing services in each region based on objective data, including stakeholder data and state and national workforce data and research; iii. Develop a work plan to resolve those barriers that includes measurable goals, specific support activities, and timelines for implementation; and iv. Include the barriers and efforts to resolve them, as well as the factual basis for those barriers and efforts, and results achieved in the semi-annual nursing report that is posted in the Library. e) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, or the semi-annual report of the Independent Reviewer, if there is one, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Private Duty Nursing by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Private Duty Nursing by January 1, 2029. The rate study shall be completed in time to be considered at the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies. *In Progress* f) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 38(a) through 38(d), DBHDS also will conduct a root cause analysis and determine whether a QII is warranted to address identified issues. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due January 15, 2027*	
39. Skilled Nursing. The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with skilled nursing identified in their	a) Semi-annually, on May 15 and November 15 of each year, DBHDS will continue to report data on utilization of nursing services and the work of the DBHDS Nursing Workgroup, except if the Independent Reviewer is monitoring the Commonwealth's compliance under Section VIII, DBHDS will report on April 15 and October 15 of each year. *In Progress* b) As part of the IMNR Process, DBHDS will assess if individuals have unmet nursing or other medical needs and will work with families, providers, and case managers to take steps to resolve identified unmet needs. Semi-annually, on April 15 and October 15 of each year, DBHDS will report on the IMNR process, including the types of unmet needs identified, efforts taken to resolve them, and results achieved. *In Progress*	**Deferred**

ISPs or prescribed under EPSDT will have their skilled nursing needs met 80% of the time. To achieve that goal, the Commonwealth will take the following actions:	c) Skilled Nursing Review. Beginning within three months of the date of this Order, for individuals with a skilled nursing need identified in the Waiver Management System, DBHDS will begin to conduct on-site IMNR reviews as set forth in this paragraph. DBHDS will conduct the on-site IMNR reviews of a randomized sample of 10% of individuals annually (split between two six-month reviews) to determine if individuals' skilled nursing services needs are being met. In selecting individuals during each six-month review period to review, DBHDS shall include in the sample only individuals who were authorized to receive the service at least three months earlier, to ensure sufficient time for the sampled individuals to have received the service. *In Progress* d) If the Commonwealth has not achieved the goal as reported in its December 1, 2024 status update, or the semi-annual report of the Independent Reviewer, if there is one, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Skilled Nursing by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its December 1, 2028 status update, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Skilled Nursing by January 1, 2029. The rate study shall be completed in time to be considered at the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies. *In Progress* e) If the Commonwealth does not achieve the goal within two years of the date of this Order after taking the actions in Paragraphs 39(a) through 39(c), DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due January 15, 2027*	
40. Dental Exams. The Commonwealth will work to achieve a goal that 86% of individuals who are supported in residential settings and have coverage	a) DBHDS will operate a total of three mobile dental vehicles by March 31, 2025. *Not Completed* b) DBHDS will continue to employ or contract with a total of three dental assistants and four dental hygienists to staff the mobile dental vehicles. *In Progress* c) DBHDS will continue to review referrals for dental services and work to connect people to community dental providers when available. *Completed* d) Within six months of the date of this Order, DBHDS will contract with	**Not Achieved**

for dental services will receive an annual dental exam. To achieve that goal, the Commonwealth will take the following actions:	at least one dentist or dentistry practice in each Region who can support sedation dentistry. *In Progress* e) DBHDS will collaborate with dental providers to understand barriers to delivering services to individuals with developmental disabilities and, within six months of the date of this Order, will develop a plan with measurable goals, specific support activities, and timelines for implementation to mitigate those barriers. *In Progress* f) Within six months of the date of this Order, the Commonwealth shall start an initiative that determines which 8 CSBs need the most assistance to ensure that individuals receive annual dental exams and, no later than three months after starting this initiative, begin to provide technical assistance to support relevant CSBs. This process will continue to be implemented annually until the Commonwealth achieves the goal. *Completed* g) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 40(a) through 40(f), DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due January 15, 2027*	
41. Protection From Serious Injuries in Service Settings. The Commonwealth will work to achieve a goal that 95% of DD waiver service recipients will be protected from serious injuries in service settings. To achieve that goal, the Commonwealth will take the following actions:	a) DBHDS will continue working to ensure that all appropriate serious injuries are included when determining if this goal is met. *In Progress* b) Within six months of the date of this Order, and annually thereafter, the DBHDS Office of Integrated Health will complete a quality review of a statistically significant sample of serious injuries reported to DBHDS via the CHRIS system (or successor) to determine if the Incident Management Unit process used by the DBHDS Office of Licensing adequately identifies all appropriate injuries to determine if individuals were protected from harm and if changes are needed to the way incidents are reviewed and referred. *In Progress* c) Relevant processes will be revised, as warranted, based on the finding of the quality review referenced in Paragraph 41(b) to ensure that the Commonwealth accurately identifies the percentage of DD waiver recipients who are protected from serious injuries in service settings. *Due July 15, 2025* d) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the action in Paragraphs 41(a) through 41(c), DBHDS will conduct a root cause analysis and implement a QII.	**Not Achieved**

	DBHDS will continue this quality improvement process until the metric is achieved and sustained for one year. *Due January 15, 2027*	
42. Risk Management. To ensure that the risk management programs of DBHDS-licensed providers of DD services identify the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths and take prompt action when such events occur or the risk is otherwise identified, the Commonwealth will take the following actions:	a) Within 24 months of the date of this Order, the Commonwealth shall establish inter-rater reliability among the Commonwealth's licensing specialists regarding provider compliance with the quality assurance trending requirements. *In Progress* b) Within 12 months of the date of this Order, the Commonwealth shall offer technical assistance in accordance with DBHDS's Consultation and Technical Assistance Standard Operating Procedure to each provider that does not identify the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths. *Completed* c) Within one month of the date of this Order, when providers do not take prompt action when such events occur, or where the risk is otherwise identified despite lack of prompt action by providers, DBHDS will ensure that corrective action plans are written, implemented, and tracked, and take further actions as warranted. *Completed*	**Deferred**
43.Timely Waiver Service Enrollment. The Commonwealth will work to achieve a goal that 86% of individuals who are assigned a waiver slot will be enrolled in a service within five months. To achieve that goal, the Commonwealth will take the following actions:	a) Within three months of the date of this Order, DBHDS will track on a quarterly basis the number of individuals who are assigned a waiver slot but not enrolled in a service within five months. *Completed* b) Within three months of the date of this Order, the Commonwealth will contact individuals at the end of each quarter who have not been enrolled in a service within five months and their families and case managers to determine why services have not been initiated and what barriers delayed initiation of services. DBHDS will report on the barriers identified quarterly as well as actions being taken to remediate those barriers and results achieved. *Completed* c) Within one year of the date of this Order, the Commonwealth will conduct a root cause analysis of why services have not been initiated and what barriers delayed initiation of services. Based on the findings of the root cause analysis, the Commonwealth will prioritize the findings for quality improvement in consultation with the provider and system issues resolution workgroups. The Commonwealth will implement a QII based on its prioritization consistent with continuous quality improvement principles and developed in collaboration with the provider and system issues resolution workgroups. The Independent Reviewer, in the reports	**Not Achieved**

	required under paragraph 76, shall discuss the reasonableness of Virginia's response to this requirement. Individuals for whom initiation of services is delayed past five months at the request of the individual or the individual's authorized representative will not be included in determining if the Commonwealth meets the goal. The Commonwealth will revisit the root cause analysis annually and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due January 15, 2026*	
44. Ongoing Service Analyses. The Commonwealth, through DBHDS, will collect and analyze data at least annually regarding the management needs of individuals with identified complex behavioral, health, and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS will develop corrective actions based on its analysis as it determines appropriate, track the efficacy of the actions, and revise as it determines necessary to address the deficiency. To implement the preceding steps, the Commonwealth will take the following actions:	a) DBHDS will use data from the Skilled Nursing Review detailed in Paragraph 39(c), the IMNR process for individuals with complex medical needs, data from the care concerns process, data from the BSPARI quality reviews, and data from the Quality Service Reviews to monitor the adequacy of management and supports provided. Within six months of the date of this Order, DBHDS will develop a report consolidating the information from these sources to provide a comprehensive summary of the management and support provided to individuals with complex needs. This summary will be completed annually. *In Progress* b) DBHDS will continue to implement the IMNR process for no less than 70 people annually who have complex medical, behavioral, or adaptive support needs (Tier 4) to include onsite visits, reviews of specific health care documentation, and a factual questionnaire administered by qualified nursing professionals to primary caregivers most familiar with the person's health care needs. *In Progress*	**Not Achieved**

45. DD Service Providers' Compliance with Administrative Code. The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services comply with 12 VAC 35-105-620 in effect on the date of this Order or as may be amended. To achieve that goal, the Commonwealth will take the following actions:	a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with 12 VAC 35-105-620.C.4 and D.3 (regarding corrective action plans) develop and implement a corrective action plan that includes the receipt of technical assistance, additional training, and specific actions related to the respective areas of underperformance as determined appropriate by DBHDS. *Completed* b) Within six months from the date of this Order, for providers who are not compliant with 12 VAC 35-105-620.C.4 and D.3 (regarding corrective action plans) for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's license as determined appropriate by DBHDS. *Completed* c) Within 24 months of the date of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess the adequacy of provider quality improvement programs have established inter-rater reliability in conducting such assessments. *In Progress*	**Deferred**
46. Quality Service Monitoring. The Commonwealth will work to ensure that, using information collected from licensing reviews and Quality Service Reviews, it identifies providers that have been unable to demonstrate adequate quality improvement programs and offers technical assistance as necessary. To achieve that goal, the Commonwealth will take the following	a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with quality improvement program regulations develop and implement a corrective action plan. DBHDS will continue to employ a total of 12 Quality Improvement Specialists. DBHDS Quality Improvement Specialists will continue to offer providers technical assistance, additional training, and specific actions related to the respective areas of underperformance. *Completed* b) Within six months from the date of this Order, for providers who are not compliant with quality improvement program regulations for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's license as determined appropriate by DBHDS. *Completed* c) Within 24 months of the date of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess the adequacy of provider quality improvement programs have established inter-rater reliability in conducting such assessments. *Due January 15, 2027*	**Deferred**

actions:		
47. Training Requirement Compliance. The Commonwealth will work to achieve a goal that 86% of DBHDS-licensed providers receiving an annual inspection will have a training policy that meets established DBHDS requirements. DBHDS will take action it determines appropriate if providers fail to comply with training requirements required by regulation. To achieve that goal, the Commonwealth will take the following actions:	a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with training requirements develop and implement a corrective action plan. *Completed.* b) Within three months of the date of this Order, DBHDS Quality Improvement Specialists will offer providers technical assistance, additional training, and specific actions related to the respective areas of underperformance. *Completed* c) Within six months from the date of this Order, for providers who are not compliant with training requirements for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's license as determined appropriate by DBHDS. *Completed* d) Within 24 months of the date of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess training requirements have established inter-rater reliability in conducting such assessments. *In Progress*	**Deferred**
48. Training and Competency of Direct Support Professionals. The Commonwealth will work to achieve a goal of at least 95% of Direct Support Professionals and their supervisors receive training and competency testing in accordance with 12 VAC 30-122-180 as in effect on the	a) Within six months of the date of this Order, the Commonwealth shall determine, through a root cause analysis developed in collaboration with the provider and system issues resolution workgroups, why Direct Support Professionals and their supervisors do not receive training and competency testing per 12 VAC 30-122-180. *Completed* b) Based on the findings of the root cause analysis required by Paragraph 48(a), DBHDS will prioritize the findings for quality improvement, taking into account the anticipated impact to the system, including potential negative impacts to current staffing. DBHDS will implement a QII based on its prioritization consistent with continuous quality improvement principles and developed in collaboration with the provider and system issues resolution workgroups. *In Progress* c) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the	**Deferred**

date of this Order or as may be amended. To achieve that goal, the Commonwealth will take the following actions:	Commonwealth will initiate a rate study of Personal Assistance Services, Companion Services, Respite Services, In-Home Support Services, and Independent Living Support Services by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Personal Assistance Services, Companion Services, Respite Services, In-Home Support Services, and Independent Living Support Services by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies. *In Progress* d) If the Commonwealth does not achieve the goal within two years of the date of this Order after taking the actions in Paragraphs 48(a) and 48(b), DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due January 15, 2027*	
49. Residential Services Community Integration. The Commonwealth will work to achieve a goal that 95% of residential service recipients reside in a location that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS settings. To achieve that goal, the Commonwealth will take the following action:	a) In accordance with its CMS-approved Statewide Transition Plan, by December 31, 2025, the Commonwealth will complete its review of the remaining 3,296 locations for compliance with the CMS settings rule to determine if it is in compliance with the 95% goal. *In Progress*	**Not Achieved**

50. Supported Employment. The Commonwealth will work to achieve a goal of being within 10% of the waiver employment targets set by the Employment First Advisory Group. DBHDS will continue to work with the Employment First Advisory Group, the Quality Improvement Committee (QIC), and the QIC subcommittees to develop and recommend QIIs to enhance employment of adults aged 18-64 on the DD waiver. If the goal is not met within two years of the date of this Order, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	No specific actions are required, other than those specified in this Term.	**Deferred**

51. Supported Employment. The Commonwealth will work to achieve a goal of meeting its established employment target of 25% for adults aged 18 to 64 on DD waivers and the waitlist. DBHDS will continue to work with the Employment First Advisory Group, the QIC, and the QIC subcommittees to develop and recommend QIIs to enhance employment of adults aged 18 to 64 on the DD waiver and the waitlist. If the goal is not met within two years of the date of this Order, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	No specific actions are required, other than those specified in this Term.	**Not Achieved**
52. Look-Behind Analysis of Abuse, Neglect, and Exploitation Allegations. The Commonwealth	No specific actions are required, other than those specified in this Term.	**Not Achieved**

will continue its Community Look-Behind (CLB) review process to achieve a goal of collecting sufficient data for the Risk Management Review Committee (RMRC) to conduct or oversee a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: (i) investigations of individual incidents occur within state-prescribed timelines; (ii) the person conducting the investigation has been trained to conduct investigations; and (iii) corrective action plans are implemented by the provider when indicated. The RMRC will review trends at least quarterly, recommend QIIs when necessary, and track implementation of initiatives approved for implementation.		

53. Samples of Data from Look-Behind Analyses of Serious Incidents and Allegations of Abuse, Neglect, and Exploitation. The Commonwealth will work to achieve a goal of showing 86% of the sample of serious incidents reviewed by the RMRC meet criteria reviewed in the audit and that at least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed by the RMRC meet criteria reviewed in the audit. The Commonwealth will continue the look behind process and provide feedback to the RMRC related to its findings. If this goal is not met by December 31, 2024, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	No specific actions are required, other than those specified in this Term.	**Not Achieved**

54. Annual Physical Exams. The Commonwealth will work to achieve a goal that 86% of individuals supported in residential settings receive annual physical exams. To achieve that goal, the Commonwealth will take the following action:	a) Within six months of the date of this Order, any time there is not an increasing trend in the percentage of individuals receiving an annual physical exam in consecutive annual reporting periods, DBHDS will conduct a root cause analysis and determine whether a QII is warranted to address identified issues. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Due July 15, 2025*	**Compliance**
55. Assessment of Licensed Providers of DD Services. The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. DBHDS will continue to conduct annual licensing inspections in accordance with Virginia Code § 37.2-411 in effect on the date of this Order or as may be	No specific actions are required, other than those specified in this Term.	**Deferred**

amended and assess provider compliance with risk management requirements in the Licensing Regulations utilizing the Office of Licensing Annual Compliance Determination Chart.		
56. Data-Driven Quality Improvement Plans for HCBS Waiver Programs. The Commonwealth will continue to implement the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers. The DMAS-DBHDS Quality Review Team (QRT) will meet quarterly in accordance with the CMS-approved Quality Improvement Plan and will review data, determine trends, and implement quality improvement strategies where appropriate as determined by the QRT to improve performance.	No specific actions are required, other than those specified in this Term.	**Not Achieved**

57. Data-Driven Quality Improvement Plans for HCBS Waiver Programs. The Commonwealth will continue to collect quarterly data on the following measures: (i) health and safety and participant safeguards; (ii) assessment of level of care; (iii) development and monitoring of individual service plans, including choice of services and of providers; (iv) assurance of qualified providers; e) whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR; and (v) identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation. This data will be reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans will be written and remediation	No specific actions are required, other than those specified in this Term.	**Not Achieved**

actions implemented, as necessary, for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86% compliance. Quality Improvement remediation plans will focus on systemic factors (where present) and will include the specific strategy to be employed, as well as defined measures that will be used to monitor performance. Remediation plans will be monitored at least every six months. If such remediation actions do not have the intended effect, a revised strategy will be implemented and monitored.		
58. Case Management Steering Committee (CMSC) Measures. The Case Management	No specific actions are required, other than those specified in this Term.	**Deferred**

Steering Committee will continue to establish two indicators in each of the areas of health and safety and community integration associated with selected domains (safety and freedom from harm; physical, mental, and behavioral health and well-being; avoiding crises; community inclusion; choice and self-determination; stability; provider capacity; access to services) and based on its review of the data submitted from case management monitoring processes. The Commonwealth will work to achieve a goal of 86% compliance with the four indicators established by the CMSC. DBHDS will monitor data collected in these domains and determine if any intervention is needed.		

VI. APPENDICES

APPENDIX A

Case Management

By

Kathryn du Pree, MPS

Case Management
26th Review Period Report
Prepared for the Independent Reviewer

Introduction

This report constitutes the eighth review of initially the Settlement Agreement's requirements, and now the Permanent Injunction's, for Case Management services. Prior to this review period the studies focused on a review and analysis of the Commonwealth's efforts to meet the requirements of the Compliance Indicators (CI). This is the first review to be conducted since the Court approved the agreement between the Parties to comply with the Terms of the Permanent Injunction (PI) and to implement the specified actions. The Terms under review for Case Management during the 26th review period are Term 31 and Term 58 which are described below. The focus of the review is to determine if the Commonwealth has achieved the measurable goals of the two case management PI Terms and the extent to which they have successfully implemented the associated actions. The Parties have agreed upon the Terms to determine compliance with Case Management Provisions that previously remained out of sustained compliance. These include PI Terms that relate to the Settlement Agreement's Provisions III.C.5.b.i. and V.F.5. These Terms address the Commonwealth's responsibilities to review and monitor the quality of service coordination and the delivery of waiver services to analyze the findings of the quality review related to CSB Case Management performance across ten elements (PI 31)*;* and to specifically analyze and monitor the achievement of four key indictors related to health and safety and community integration (PI 58).

For this subset of PI Terms and associated actions, progress toward achieving the agreed upon specified goals are reviewed and reported below. This review includes an analysis and reporting of Virginia's status implementing the PI requirements associated with Case Management that have not been met twice consecutively (see Table 1 below). This includes PI Terms 31 and 58 which are related to CIs *2.16 (including elements 2.6-2.15)* and *CI 47.1*, respectively. *CI 47.1* was met for the first time in the 25th review period. *CI 2.16* was not met in the 25th review period.

For this review the facts gathered are identified and analyzed for each specified goal in the Findings Table below. The documents which include these facts are listed by reference in Attachment A and most are found in the Commonwealth's library of documents. I communicated throughout the study with Eric Williams, Acting Assistant Commissioner and Director of the Office of Provider Network Supports, who is the case management subject matter expert for DBHDS. I appreciate his communication and responsiveness throughout the study period.

The ratings for both PI 31 and PI 58 are deferred for this reporting period as their analyses are based on the findings from DBHDS's annual Support Coordinator Quality Review (SCQR). The FY24 SQCR was used to determine the compliance ratings in the 25th review period. The

completed FY25 SCQR will be available for analysis in the 27th review period. At that time, I will determine compliance ratings and provide updates on DBHDS's efforts to implement various improvement strategies and summarize the review by the Case Management Steering Committee (CMSC) of the status of various initiatives. For the current review, DBHDS provided its CMSC Implementation Plan (IP) updates, the CMSC Report for FY25 Q1 and Q2, and the minutes of CMSC and Work Group meetings.

Summary of Findings for the 26th Period

Table 1 below lists the PI Terms and their compliance ratings. Both Term 31 and Term 58 are Deferred for the 26th Review Period as both can only be fully analyzed for compliance using the SCQR for FY25. The results of DBHDS's SCQR could not be reviewed in the 26th review period because the annual data were not available at the time of the Study. The reviews by CSBs are conducted between January and June of each year and the look-behind conducted by DBHDS Quality Improvement Specialists in the Office of Community Quality Improvement occurs in July and August of each year. The determination of compliance is deferred for the 26th reporting period as a result.

Term 31: The CMSC continued to monitor the CSBs for the Performance Measure Indicators (PMI) relevant to Term 31 and additional indicators, addressing employment and community engagement discussions and goals; Regional Support Team (RST) timeliness and underperforming CSBs related to the SCQR results. The minutes of the monthly CMSC meetings and the CMSC Work Group meetings that occurred between September and February provide evidence of both regular and meaningful involvement of the CMSC in the oversight of the CSBs' Case Management services and DBHDS' implementation of quality review, analysis, technical assistance, training, and communication with CSBs (3,4). DBHDS required CSBs to address Regional Support Team (RST) and Individual Support Plan (ISP) performance in their Improvement Plans (IP). In October 2024 there were ten IPs open for late RST referrals and four open for ISP updates. None of the CSBs with an IP required intense monitoring. As of February 2025, all of the IPs for RST and ISP deficiencies were closed, and no additional IPs were required as of March.

The CMSC also tracks the IPs for compliance with the SCQR Indicators. Prior to 2025, DBHDS required a CSB to develop an IP if it had three of more Indicators self-scored at less than 50%. In 2025, DBHDS revised the threshold to require CSBs to develop an IP if the CSB had two or more Indicators that were self-scored at less than 60%, establishing a higher level of expected performance. DBHDS provided a CMSC IP update produced in March (2). At that time, there were nine Open IPs for ISP Compliance and three additional CSBs had pending IPs awaiting CMSC approval. The nine CSBs all had submitted IPs, and all were approved by the CMSC. None required intensive monitoring nor were any of the CSBs required to submit an IP referred to the Office of Management Services.

The CMSC also develops and tracks Quality Improvement Initiatives (QII) to address trends in performance and systems issues that negatively impact performance. The CMSC had developed seven QIIs, of which three were completed as of February 2025 (1, 2). The remaining QIIs address: retention of Service Coordinators (SC); improving CSB performance for ISP

compliance; improving the outcomes related to employment and community engagement; and improving the level of agreement for Indicator 10. The Independent Reviewer expressed concern in his 25th Report to the Court, submitted in December 2024, that the agreement between the CSB reviews and the look behind reviews needed improvement. The level of agreement had dropped from substantial to moderate agreement (76%) for this Indicator. This Indicator addresses the requirement that the SC complete a face-to-face assessment of the individual to ensure the ISP is appropriately implemented and makes any changes to the ISP that are needed. The CMSC designed a QII that would seek to improve agreement through the development of enhanced materials and guidance for CSB staff to clarify the use and limit ambiguity about the Indicator and its measurement. The CMSC report documents its efforts to address and monitor these QIIs. The CMSC also provided training for a greater understanding of the On-Site Visitation Tool (OSVT) and to clarify SC responsibilities. The CMSC reviewed and monitored eight IPs for ISP timeliness (3).

As part of its efforts to improve the quality of the ISP, the Commonwealth created ISP Version 4.0, effective September 16, 2024. Version 4.0 integrates the Risk Awareness Tool (RAT) directly in Part III of the ISP. The team identified the risks in Part III and then providers use Part V of the ISP to describe how these identified risks will be addressed. Part IV automatically includes potential risks and notes any referrals to qualified professionals to address any risk areas that are noted. In addition to other less significant changes, Version 4.0 also modifies the description of Physical and Health Conditions to include greater specificity regarding medical conditions and health protocols. The new version requires the individual's team to discuss seven fatal risks and address any that are relevant to the individual with the involvement of the individual and/or representative in developing the plan to address any identified risks. The seven fatal risks include: pressure injuries, falls, aspiration pneumonia, sepsis, seizures, bowel obstruction, and dehydration. The team is also required to review and plan for the potential risks of community involvement, elopement, self-harm, and lack of safety awareness.

The ISP now includes all of the risk information, ending the requirement of SCs to produce risk identification and plans on paper. The ISP auto-populates the related sections of the ISP to integrate risk information and creates a printable summary of the identified risks to be shared with the individual's PCP and other health and behavioral professionals who serve the individual. The goal of the new version of the ISP is to increase the teams' consistency identifying risks and including the providers' plans to address these risks. It provides guidance to the SC and team to consistently and thoroughly discuss the risks facing the individual and how to plan to mitigate these risks. DBHDS has developed a briefing document explaining the changes in great detail to Service Coordinators (6, 7).

Term 58: The CMSC reviews six PMIs. Two address community inclusion. PMI 3 addresses employment discussions with individuals who are 14-17 years old. PMI 5 addresses that individuals have outcomes for integrated community involvement (ICI).

Two address health and safety. PMI 16 addresses that an individual's needs are assessed, and the ISP is modified as appropriate to reflect these needs. PMI 17 addresses that the ISP is appropriately implemented. Two other PMIs, 18 and 19 address aspects of choice and self-determination. The mid-year results are described in Table 2 below. Annual results will be

reviewed at the end of FY25 to determine the overall performance and any changes in the level of reviewer agreement.

Data Process and Attestation

All data processes which have been reviewed previously and verified to be reliable and valid remain in place. All attestations are completed and current.

PI Terms and Actions Achievement and Status

Table 1 below summarizes the status of the case management compliance indicators.

TABLE 1		
Related Compliance Indicator	**Term**	**26th**
2.16 The Case Management Steering Committee will analyze the Case Management Quality Review data submitted to DBHDS that reports on CSB case management performance each quarter. 86% of the records reviewed across the state will be in compliance with a minimum of 9 of the elements assessed in the review.	31. **Community Services Board Quality Review (SCQR).** The Commonwealth will work to achieve a goal that 86% of Community Services Board (CSB) records meet a minimum or 9 of the 10 elements assessed in the Case Management Quality Review.	**Deferred**
47.1	58. **Case Management Steering Committee (CMSC) Measures.** The Case Management Steering Committee will continue to establish two indicators in each of the areas of health and safety and community integration associated with selected domains (safety and freedom from harm; physical, mental, and behavioral health and well-being; avoiding crises; community inclusion; choice and self-determination; stability; provider capacity; access to services) and based on its review of the data submitted from case management monitoring processes. The Commonwealth will work to achieve a goal of 86% compliance with the four indicators established by the CMSC. DBHDS will monitor data collected in these domains and determine if any intervention is needed. No Actions Required	**Deferred**

TABLE 2			
Term and Actions	**Facts**	**Analysis/Conclusion**	**26th**
31. Community Services Board Quality Review (SCQR). The Commonwealth will work to achieve a goal that 86% of Community Services Board (CSB) records meet a minimum or 9 of the 10 elements assessed in the Case Management Quality Review.	This cannot be analyzed to determine compliance until the 27th review period when the FY25 SCQR is completed. As reported in the 25th review period, 72% of the records reviewed met or exceeded the expectation that nine of ten indicators achieved the goal of 86%. In FY 24, performance improved for four indicators comparing the performance in FY23 to the performance in FY24.		**Deferred**
31. a) During its annual quality review cycle, starting January each year, DBHDS will require a quality improvement plan from any CSB that has two or more elements with substantial or moderate interrater reliability between the CSB SCQR and the DBHDS Office of Community Quality Improvement Review not achieving 60% compliance. DBHDS will provide information about which CSBs need this support in the SCQR Report.	DBHDS provided a CMSC IP update produced in March (2). At that time, there were nine Open IPs for ISP Compliance and three additional CSBs had pending IPs awaiting CMSC approval. The nine CSBs all had submitted IPs, and all were approved by the CMSC. None required intensive monitoring nor were any of the CSBs referred to the Office of Management Services.		**In Progress**
31. b) DBHDS will provide targeted technical assistance with identifying measurable outcomes to any CSB (i) whose records are not 86% compliant with including specific and measurable outcomes	DBHDS provided TA to every CSB in preparation for the FY25 SCQR (7). These TA sessions were held between 2.21.25 and 3.19.25. Each TA session included a review of the changes to the ISP Version 4.0; the items that historically did not meet	DBHDS is revising its CMSC data report to include feedback as to whether all the topics required in a meaningful discussion are being included by the SC in the ISP meetings. This data will be specific to CSB and SC which should assist the CSB through supervision, training,	**In Progress**

in Individual Support Plans (ISPs) or (ii) that does not demonstrate improvement with respect to including specific and measurable outcomes in ISPs (including evidence that employment goals have been discussed and developed, when applicable, throughout its quality review cycle).	substantial agreement between the CSBs and the DBHDS look behind; and a review of the elements of a meaningful employment discussion and how to develop outcomes to facilitate access to employment. The TA included an explanation and review of the two questions relevant to this Indicator in the SCQR which are Questions 28 (employment discussion) and Question 32 (employment outcomes).	and guidance to improve its performance.	
31. c) If the Commonwealth has not achieved the goal within one year of the date of this Order after taking the actions in Paragraphs 31(a) and 31(b), DBHDS will increase the threshold for requiring a quality improvement plan from a CSB as set out in Paragraph 31(a). DBHDS will provide information about which CSBs need this support in the SCQR Report.			**Due Date 1/15/26**
31.d) If the Commonwealth has not achieved the goal within one year after taking the actions in Paragraph 31(c), DBHDS will conduct a root cause analysis and implement a Quality Improvement Initiative (QII) as determined appropriate by DBHDS. DBHDS will continue this quality improvement process			**Due Date 1/15/27**

until the goal is achieved and sustained for one year.			
58. **Case Management Steering Committee (CMSC) Measures.** The Case Management Steering Committee will continue to establish two indicators in each of the areas of health and safety and community integration associated with selected domains (safety and freedom from harm; physical, mental, and behavioral health and well-being; avoiding crises; community inclusion; choice and self-determination; stability; provider capacity; access to services) and based on its review of the data submitted from case management monitoring processes. The Commonwealth will work to achieve a goal of 86% compliance with the four indicators established by the CMSC. DBHDS will monitor data collected in these domains and determine if any intervention is needed. No Actions Required	The CMSC reviews six PMIs. Two address community inclusion. PMI 3 addresses employment discussions with individuals who are 14-17 years old. PMI 5 addresses that individuals have outcomes for integrated community involvement (ICI). Two address health and safety. PMI 16 addresses that an individual's needs are assessed, and the ISP is modified as appropriate to reflect these needs. PMI 17 addresses that the ISP is appropriately implemented. Two other PMIs, 18 and 19 address aspects of choice and self-determination. The most recent data from Fiscal Year 2024 related to the two areas of community integration (i.e., relationships and choice) showed case manager performance exceeding the 86% thresholds. The CMSC only reports the FY24 result for PMIs 16 and 17 which address health and safety. Both PMIs were above the expectation of 86%, reaching 89% for PMI 16 and 90% for PMI 17. PMI 18 and 19 were reported for FY24 and achieved 87% and 97%, respectively. Annual results will be reviewed at the end of FY25 to determine the overall	The CMSC continues to rigorously review the Commonwealth's achievements related to the indicators related to health and safety and to community involvement. The integrity of the data is regularly addressed by the CMSC as reported in the semi-annual report for FY25 Q1 and Q2, and previous reports. The CMSC accesses data from a variety of sources to guide all of the committee's efforts to ensure and improve quality. These sources include direct data supplied by CSBs, SCQR results, WaMS, and the CCS3. The CCS3 data system is transitioning to the DBHDS Data Enterprise Warehouse by 6.30.25 in an effort to improve data integrity. The CMSC will resume its Data Quality Process to ensure data reporting requirements are being met once this transition is completed. The CMSC uses its compellation of data to recommend its QIIs and to make recommendations for technical assistance for CSBs. The CMSC commits to using a root cause analysis to identify any underlying causes of poor performance if case management targets are not met.	**Deferred**

	performance and any changes in the level of reviewer agreement. DBHDS is planning to prepare a training overview of the ten case management indicators, and the additional measures assessed through the SCQR data. The training will emphasize the importance of accurate data and how to achieve success with each indicator.		

Recommendations: In the 27th review period DBHDS should report on the status of these CSBs regarding any improvement in performance as a result of the TA and the implementation of the CSBs Corrective Action Plans.

Attachment A
Documents Reviewed

1. CMSC Semiannual Report FY25 1st and 2nd Quarters
2. CMSC Improvement Plan Updates: 10.15.24,12.24,2.25,3.4.25
3. CMSC Meeting Minutes: 10.15.24, 10.29.24, 1.7.25, 2.4.25
4. CMSC Work Group Minutes: 12.10.24, 1.8.25, 3.12.25
5. CSB Indicators QMR Data Tracking
6. Email from Eric Williams 03.27.25, 3.30.25,4.14.25
7. SCQR Early TA Materials
8. SCQR Work Group Minutes: 12.10.25, 1.8.25, 3.12.25

Submitted:
Kathryn du Pree MPS
May 19, 2025

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APPENDIX B

Crisis and Behavioral Services

by

Kathryn du Pree, MPS

Crisis and Behavior Services Report
26th Review Period

Introduction

This report constitutes the eighth review initially of the Settlement Agreement's, and now the Permanent Injunction's, requirements for crisis and behavioral services for individuals with developmental disabilities (DD). This is the first review to be conducted since the Court approved the agreement between the Parties to comply with the Terms of the Permanent Injunction (PI) and to implement the specified actions. The terms under review for Crisis and Behavioral Services during the twenty-sixth review period are Terms 32, 33, 35, and 36 which are described below. The focus of the review is to determine if the Commonwealth has achieved the measurable goals of the four crisis and behavior PI Terms and the extent to which they have successfully implemented the associated actions. The Parties have agreed upon the Terms to determine compliance with Crisis and Behavior Services Provisions that previously remained out of sustained compliance. These include PI Terms that relate to the Settlement Agreement's (SA) Provisions III.C.6.i.-iii for Crisis Services; III.C.6.i.i.A. for Mobile Crisis; and III.C.6i.i.i.B., III.C.6.i.i.i.D; and III.c.6.i.i.i.G for Crisis Stabilization. These Terms address the Commonwealth's responsibilities to prevent admission to psychiatric hospitals at the time of a crisis through the availability of community based crisis assessments; connect individuals to behavioral services who need such services in a timely way; identify community residential options for individuals admitted to a crisis therapeutic home (CTH) or a psychiatric hospital for a behavioral of mental health crisis; and develop out-of-home crisis prevention services for youth with DD. Prior to this review period the studies focused on a review and analysis of the Commonwealth's efforts to meet the requirements of the applicable Compliance Indicators.

For this subset of PI Terms and associated actions, progress toward achieving the agreed upon specified goals are reviewed and reported below. This review includes an analysis and reporting of Virginia's status implementing the PI requirements associated with Crisis and Behavioral Services that have not been met twice consecutively (see Table 7 below). This includes PI Terms 32, 33, 35 and 36 which are related to *CIs 7.8, 7.18,11.4 and 13.3,* respectively. The Commonwealth did not achieve the specified goals in any of these Terms in a previous review period. None of the specified goals of the PIs were accomplished in this reporting period.

For this review the facts gathered are identified and analyzed for each specified goal in the Findings Table below. The documents which include these facts are listed by reference in Attachment A and most are found in the Commonwealth's library of documents. For this current review, DBHDS provided the Behavior Supports Report; the Supplemental Crisis Reports; the REACH Quarterly Summary Reports; the REACH Quarterly Qualitative Reports; the REACH Staffing Reports; and numerous materials to address the Commonwealth's progress implementing the Actions associated with the PI Terms. All of the documents are listed by reference in Attachment A, and most are found in the Commonwealth's library of documents. Follow up information was provided by Sharon Bonaventura, Regional Crisis Systems Manager and Nathan Habel, Director of Behavioral Services and Projects. I greatly appreciate their information, analysis, and assistance.

Summary of REACH Services

DBHDS continues to provide data reports which include the REACH Quarterly Summary Data, and the REACH Quarterly Qualitative Reviews that provide robust information of all aspects of the REACH programs. I include data that I think is relevant and indirectly related to the Commonwealth achieving the specified goals of the Terms in this Section of the report to give the reader greater insight into the impediments, progress, and status of meeting the requirements of the PI Terms associated with crisis services.

The Independent Reviewer continues to be deeply concerned about the high number of individuals with I/DD whose initial crisis assessment occurs at hospitals rather than in the individuals' homes as expected in Term 32. A high percentage of these individuals continue to be admitted to psychiatric hospitals rather than utilizing in-home supplemental supports or crisis stabilization services as alternatives to hospitalization. This dynamic results in an increased number of children and adults with I/DD being admitted to psychiatric hospitals in Virginia rather than receiving the mobile crisis service and crisis stabilization services required by the PI.

This concern continues to be borne out reviewing the data submitted by DBHDS for FY25 Q2 and FY25 Q3. During these two quarters only 49% and 47% of crisis assessments took place in the community, respectively. These most recent percentages are consistent with the nearly five years of quarterly reports.

Table 1: The % of individuals who received their initial crisis assessment at home, residential setting, or community setting (non-hospital/CSB location)

Date	Percentage
FY 2020 Q3	46%
FY 2020 Q4	41%
FY 2021 Q1	53%
FY 2021 Q2	34%
FY 2021 Q3	35%
FY 2021 Q4	42%
FY 2022 Q1	51%
FY 2022 Q2	36%
FY 2022 Q3	40%
FY 2022 Q4	36%
FY 2023 Q1	44%
FY 2023 Q2	49%
FY 2023 Q3	37%
FY 2023 Q4	40%

FY2024 Q1	46%
FY 2024 Q2	48%
FY2024 Q3	52%
FY2024 Q4	55%
FY2025 Q1	49%
FY2025 Q2	49%
FY2025 Q3	47%

These quarterly percentages indicate that, over a five-year period, the Commonwealth has not increased in the percentage of children and adults who receive crisis assessments at home or other community locations. Far too many children and adults continue to be assessed for a crisis at CSB Emergency Departments or hospitals which leads to the predictable increased rate of hospitalizations compared to the rate of hospitalizations for those individuals who receive a crisis assessment in a community setting. The results of these assessments strongly support the Independent Reviewer's and Expert Reviewer's contention that it is essential to provide these assessments in the community including the individual's home setting because it is far more likely that the individual will retain this setting and not be hospitalized. It is important to note that there are persistent and substantial performance variations in the percentages between Regions. For example, Region 1 had as few as 13% of crisis assessments conducted in community settings in the second quarter of FY 25. Whereas Region 3 had 64% during this same quarter.

Table 2: Crisis Assessments Conducted In Community Settings

Date	**Average % assessed in community setting**	**Range**	
FY 25 Q2	49%	Region 1- 13%	Region 3- 64%
FY 25 Q3	47%	Region 1 - 19%	Regions 2 and 5- 52%

During FY25 Q2 and Q3 the outcomes for individuals who received a crisis assessment in the community were that approximately 90% of individuals assessed for a crisis in the community retained their setting compared to under 60% who were able to retain their setting after a crisis assessment that occurred in a hospital, or CSB ED. These data are depicted in Tables 3 and 4 below.

Table 3: Results of Crisis Assessments Conducted in Community Locations

Crisis Assessments Conducted in Community Locations				
Time	**Remain Home**	**CTH/CSU**	**Other**	**Hospitalized**
FY25 Q2	91%	4%	N/A	4%
FY25 Q3	87%	7%	1%	5%

Table 4: Results of Crisis Assessments Conducted in Hospitals or CSB ED Locations

Crisis Assessments Conducted in Hospitals or CSB EDs				
Time	**Remain Home**	**CTH/CSU**	**Other**	**Hospitalized**
FY25 Q2	62%	7%	4%	27%
FY25 Q3	53%	8%	5%	34%

The Expert Reviewer reviewed the Quarterly REACH reports (4,5,6,7) to determine the status of the Commonwealth's implementation of the systemic changes needed to resolve the obstacles that have previously slowed progress toward achieving compliance with the Terms of the PI. While many of the aspects of the REACH program are no longer directly related to the specified goals of the PI Terms, the REACH program in totality impacts the location of crisis assessments, the prevention of hospitalization, and ultimately the reduction of behavioral and mental health crises. DBHDS continues to report and track all aspects of crisis assessment and services performed by the regional REACH programs. Regions continue to meet DBHDS's overall expectations for timely response to crises. While all REACH programs continue to use telehealth to some extent, only Region 1 uses it extensively. Regions vary in their in-person response with Regions 3 and 5 conducting almost all of their crisis assessments in person, achieving between 97% and 100% across both quarters and for both children and adults. Region 2 conducts at least 70% of their crisis assessments in person, and Region 4 between 84% for adults and 99% for children.

The Children's and Adult CTH programs were underutilized during both quarters. There are vacancies in these programs as described later in this report, but the percents of vacancies in the Adult CTH (16%) and Youth CTH (12%) do not explain the overall low percentage of utilization. Few wait lists are noted but a high number of individuals are still hospitalized after a crisis assessment who might have been able to be stabilized at a CTH if the program was fully available. The utilization for the YCTHs was 19% and 27% for the Region 2 YCTH, and 26% and 34% for the Region 4 YCTH over the two quarters. The utilization for the Adult CTHs range from 22-52% in FY25 Q2 and 21-44% in FY25 Q3, with the exception of Region 3. Region 3's Adult CTH was 97% occupied during FY25 Q2 and 79% occupied in FY24 Q3. Region 3 consistently ensures the highest levels of utilization. DBHDS may want to analyze if

this trend for Region 3 is based on differences in need among the individuals who use the CTHs, or if the Region's marketing and processes are more effective and efficient than other Regions. DBHDS is developing marketing materials to inform new staff in CSBs and the provider community of the purpose and availability of the CTH programs throughout the state as part of its Crisis Assessment (CA) Plan (18). DBHDS is also streamlining the application process and reducing the paperwork for families to apply. Recent trends for CTH admissions is that the average length of stay is under twenty days for FY25 Q2 and Q3. Some Regions admitted more individuals in Q3 than they admitted in Q2. Region 1 is constructing a new CTH that will replace its existing CTH to improve access for individuals and families. This site is more centrally located and near the interstate highway system. Region 5 has been allocated funding for a new CTH as well.

The DBHDS REACH teams continue to provide prevention and mobile crisis services. The outcome is that almost all recipients of these services retain their residential setting after participating in other prevention or mobile crisis services. DBHDS reports the preference of people for only a Mobile Crisis Response (MCR) combined with the ability of staff to help deescalate the individual during the MCR process, which has resulted in decreased use and reliance on the CTH program.

DBHDS continues to conduct quarterly reviews of the REACH programs (9,10). These reviews include data review; review of compliance standards and program performance; clinical chart review of selected program participants; review of any previous corrective actions and an in-person interviews to discuss clinical improvement. Most of the Regions met all or the majority of the REACH standards. DBHDS reviewers provide feedback on areas that are partially met and expect improvement. DBHDS included a review of each program's staffing and the staff capacity to satisfactorily conduct all aspects of REACH programing with a focus on MCR as it is a requirement of the PI Term 32. The results of these reviews are described in more detail in Table 8 below.

The standards DBHDS has established for the REACH programs address: Referral, Intake and Assessment; Community Crisis Response; CTH; Crisis Prevention; Staff Qualifications and Record Review. The first standard relates most directly to the specific goals of the PI to perform crisis assessments in the community and to prevent unnecessary hospitalization. Yet these REACH standards do not specifically address the specified goal of PI Term 32 which is to complete crisis assessments in the community. Instead, the Referral, Intake and Assessment standard is to ensure the REACH program is compliant with the timeframes, follow up and closure of crisis responses, and to ensure the assessment was completed and documented. DBHDS Regional Managers include a review of data as to where the assessment occurred but none of the Regions were found to not meet the specific goal of PI Term 32 of conducting the majority of crisis assessments in a community setting. I recommend that there be a more targeted review of the REACH Teams' performance as it specifically relates to conducting crisis assessments in community settings and the lower performing Regions' implementation of the strategies related to PI Term and Action 31 e.

The REACH programs continue to experience significant staffing shortages. Vacancies in the community programs range from 25% for supervisory/clinical positions to 31% for mobile crisis

support workers. The Children and Adult CTH programs experience vacancies as well. The Adult CTH programs overall have 16% of the positions vacant. The YCTH and the Adult Transition Homes have fewer vacancies, 12% and 10%, respectively.

DBHDS reports that each REACH Team now has additional mobile crisis response staff, Behavioral Health Licensed (BHL) Services staff. These positions have been established and funded through the Governor's Right Help Right Now (RHRN) initiative to increase and improve the Commonwealth's response to individuals who experience mental health crises. These staff are trained in the MCR curriculum and provide backup to REACH staff to respond to crises by conducting crisis assessments. DBHDS does not review these positions during the quarterly qualitative reviews that occur with REACH programs, but the data is included in Table 5 as this program and associated staff increase the crisis response in each Region.

The number of staff associated with the REACH programs varies, in some areas significantly across the Regions. The differences do not seem to be explained by the population sizes of the Regions. Region 4 has the most positions even though its population may not be dissimilar to Region 2. MCR staff vary from 22 in Region 1 to 35 in Regions 2, 3, and 4. The fact that the staffing varies for the CTH programs is particularly curious since each CTH has the same bed capacity, and the ability to serve six individuals at one time. DBHDS is now required to review, analyze and monitor the staffing of each Region and the impact of vacancies on meeting the specified goals for completing crisis assessments in community settings. It is important for DBHDS to determine if these differences in the number of staff, the type of positions each Region uses, and the number of vacancies impacts the REACH Teams' performance, especially in their ability to conduct assessments in the home/community, provide mobile supports, and utilize the CTHs as a last resort options to avoid hospitalization.

The following Tables depict the data.

Table 5: FY25 Q3 REACH Staffing Data for REACH Crisis Teams

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Administrators	2	5	17	40	9	**73**
Clinicians: Licensed and License eligible	3	6	15	22	12	**58**
Nurses	2	13	6	12	7	**40**
Non administrative Qs	17	59	14	35	22	**147**
Hospital Liaison	1	1	2	2	1	**7**
Filled	13	80	25	87	39	**244**
Vacant	12	4	29	24	12	**81**
Total	25	84	54	111	51	**325**
Percent Vacant	48%	5%	54%	22%	23%	**25%**
Mobile Filled	15	33	10	26	24	**108**
Mobile Vacant	7	2	25	9	6	**49**
Total	22	35	35	35	30	**157**

Percent Vacant	32%	6%	71%	26%	20%	**31%**
BHL Filled	18	30	27	49	26	**150**
BHL vacant	35	5	8	4	6	**58**
Total	53	35	35	53	32	**208**
Percent Vacant	66%	14%	23%	7%	19%	**28%**

Table 6: FY25 Q3 REACH Staffing Analysis for REACH CTH and ATH Settings

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Adult CTH filled	13	25	18	11	6	**73**
Adult CTH vacant	4	1	3	1	5	**14**
Total	17	26	21	12	11	**87**
Percent Vacant	23%	4%	14%	8%	45%	**16%**
Youth CTH filled		22		16		**38**
Youth CTH vacant		3		2		**5**
Total		25		18		**43**
Percent Vacant		12%		11%		**12%**
ATH Filled		23		12		**35**
ATH Vacant		1		3		**4**
Total		24		15		**39**
Percentage Vacant		4%		20%		**10%**

Summary of Findings

Four PI Terms were reviewed in the 26th review period. The Commonwealth did not meet any of these Terms in this period.

PI Term 32 which requires the Commonwealth to perform 86% of the crisis assessments in community settings was not accomplished because only 626 (47.5%) of the 1,317 crisis assessments completed in the reporting period were conducted in the community.

PI Term 33 which requires the Commonwealth to connect individuals with DD who need behavioral services, defined as Therapeutic Consultation (TC), with a provider within thirty days of the need being identified in the ISP, was not accomplished because only 1,043 (73%) of the 1,428 individuals who needed TC were referred and connected to a provider within thirty days. This is a slight decrease in performance compared to the 25th reporting period when 75% of individuals had this connection within thirty days. Of the 385 individuals who were not connected within thirty days, 119 were eventually connected, but 266 were not connected to a TC provider within the reporting period. DBHDS is addressing all of the Actions associated with this PI Term, even those Actions that were not required to be initiated in this reporting period.

PI Term 35 which requires the Commonwealth to identify a community residence for individuals with DD within thirty days of their admission to a CTH or psychiatric hospital was not achieved because 298 (85%) of the 351 individuals admitted to a CTH or psychiatric hospital had a residence identified within thirty days. This percentage of timely referrals is an increase over previous reporting periods and demonstrates the Commonwealth's progress meeting this goal for individuals admitted to psychiatric hospitals which was the source of the Commonwealth's underperformance in the past. DBHDS has selected five new providers to develop additional residential settings for individuals with intense behavioral needs. These homes are in various stages of development. When all of the new homes are operational DBHDS will have increased its beds for this population by 45, from 36 to 81 beds.

DBHDS reports the existing homes have not been fully utilized in this reporting period, although there was a slight increase in FY25 Q3 compared to Q2 when 46 of the beds, compared to 33 of the beds were utilized. DBHDS has taken action to increase awareness of these resources for adults with intense behavioral needs. These actions include: sending an update to CSB DD Directors; creating an internal dashboard with utilization and contact information for DBHDS Developmental Services staff; scheduling meet and greets with REACH CTH staff and the residential providers; sharing information with hospital social workers; and sharing the information with other community stakeholders.

PI 36 which requires the Commonwealth to fund and develop three new YCTHs for youth in Regions 1,3, and 5, was not achieved. DBHDS has funded the three additional CTHs. Region 5 has approved the contract for the home being developed in its Region. Regions 2 and 3 are reviewing the contracts for the homes to be developed in their respective Regions. Region 2 is developing the CTH that is on the border of Region 1 and will be available to youth in Region 1.

DBHDS is implementing all required actions that relate to this PI Term. Twelve children used the two existing YCTHs for preventive respite during this reporting period, and DBHDS has developed policies and protocols to offer community based respite until the new homes are operational. The Respite funds have been approved and will be available to families in Regions 1, 3, and 5 beginning in May 2025.

DBHDS is implementing all of the expected Actions as described in the Table below.
Table 7 summarizes the findings for the PI Terms and Table 8 summarizes the facts and conclusions for the review of these Terms.

All processes and attestations have been verified in previous studies and no substantive changes have been made.

TABLE 7		
Related Compliance Indicator	**Term**	**26th**
CI 7.8	32. **Community Setting Crisis Assessments.** The Commonwealth will work to achieve a goal that 86% of children and adults receive crisis assessments at home, the residential setting, or other community setting (non-hospital/non-CSB office). Crisis Receiving Centers ("CRC") will only be counted as an "other community setting" after it is determined that the individual or supported decision maker was not directed by the Call Center, Emergency Services, or Mobile Crisis staff to present at a CRC.	**Not Achieved**
CI 7.18	33. **Therapeutic Consultation Services.** The Commonwealth will work to achieve a goal that 86% of individuals identified as in need of Therapeutic Consultation service are referred for the service and have a provider identified within 30 days.	**Not Achieved**
CI 10.4	35. **Community Residences for Individuals with DD Waivers.** The Commonwealth will work to achieve a goal of 86% of individuals with a DD waiver and known to the REACH system who are admitted to a CTH, or a psychiatric hospital have a community residence identified within 30 days of admission.	**Not Achieved**
CI 13.3	36. **Out-Of-Home Crisis Therapeutic Prevention Host-Home Like Services for Children.** To prevent institutionalization of children due to behavioral or mental health crises, the Commonwealth will implement out-of-home crisis therapeutic prevention host-home-like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service.	**Not Achieved**

TABLE 8			
Term and Actions	**Facts**	**Analysis/Conclusion**	**26th**
32. **Community Setting Crisis Assessments.** The Commonwealth will work to achieve a goal that 86% of children and adults receive crisis assessments at home, the residential setting, or other community setting (non-hospital/non-CSB office). Crisis Receiving Centers ("CRC") will only be counted as an "other community setting" after it is determined that the individual or supported decision maker was not directed by the Call Center, Emergency Services, or Mobile Crisis staff to present at a CRC. To achieve that goal, the Commonwealth will take the following actions:	DBHDS reports the data separately for FY25 Q2 and FY25 Q3. In FY25 Q2 only 49% of all crisis assessments were conducted in a community setting. The percentages across Regions ranged from a low of 13% in Region 1 to a high of 64% in Region 3. In FY25 Q3 only 47% of all crisis assessments were conducted in a community setting The percentages across Regions ranged from a low of 19% in Region 1 to a high of 52% in Region 5. The total number of individuals with DD who were assessed for a crisis in this reporting period was 1,317 of whom 626 (47.5%) were assessed in community settings.	The Commonwealth continues to significantly underperform in the area of conducting crisis assessments in the community. Region 1 remains the Region with the lowest percentage of crisis assessments completed in community locations. Region 1 also assesses the fewest individuals for crisis. In this reporting period Region 1 conducted a total of 56 crisis assessments. The other four Regions range from a total of 245 – 352 crisis assessments over FY25 Q2 and Q3. Statewide far fewer crisis assessments were conducted in FY25 Q2 (168) compared to FY25 Q3 (458).	**Not Achieved**

32. a) DBHDS will continue to promote the use of the 988 24-hour crisis helpline by providing information on the helpline on its social media platforms, in print and television advertisements, and through informational bulletins developed or funded by DBHDS. DBHDS will require all mobile crisis team members to receive training within 90 days of hire on how to support and respond to individuals with developmental disabilities (DD) who are in crisis.	DBHDS reports that it is implementing a 988 media campaign and that its Web Page includes Mobile Crisis Response (MCR) training for providers. DBHDS shared relevant materials that have been developed to promote 988. This includes media and other promotional materials and a budget of $1.2M to distribute media materials and a listing of organizations that provide varied assistance to individuals with disabilities, including Tribal Nation Chiefs Community Health Contacts. There is information on becoming an MCR provider in terms of licensing and Medicaid enrollment requirements. MCR Provider Training includes eleven modules. All MCR providers are required to complete and pass the training within 90 days of their hire. An individual who seeks		**In Progress**

	training must be employed by a provider who is licensed to provide the service. The provider must have an active MOU with the CSB, which is the fiscal administrator, referred to as the Hub. Governor Youngkin's Right Help Right Now plan expands 988, mobile crisis units and crisis center (14,15).		
32. b) DBHDS will maintain its current efforts to assist the regions in filling vacant mobile crisis positions by discussing staffing at regional qualitative reviews of REACH programs and supporting REACH programs to implement quality improvement plans.	To help regions fill vacant REACH positions, DBHDS has updated the roles and responsibilities of REACH staff to coincide with changes made in the crisis system that are related to the REACH program functions and the overall focus on an inclusive crisis system. To support these updates DBHDS has changed the reporting requirements for REACH and MCR data. This will be used for future REACH qualitative reviews (13).		**In Progress**

	DBHDS has determined actions that it believes will enhance the resources and support REACH staff have in order to positively affect staff recruitment and retention. DBHDS has appropriated "720" funds in FY25 specifically for Mobile Crisis. Each Hub received $1,726,177 to support the Regional MCR through the purchase of vehicles, enhancing dispatch staff, start-up funds to partner with private providers, and awarding staff incentives (14).		
32. c) Within 6 months of the date of this Order, the Commonwealth will develop a plan that includes measurable goals, specific support activities, and timelines for implementation with consultation from stakeholders to enhance 988 supports and services to increase the likelihood that individuals will be assessed in the	This Action is not required until 7.15.25 but DBHDS has developed a template and format to engage in this type of planning. The plan outline includes these goals: making mobile crisis response easier to access; and making it easier for people with DD to get help at crisis sites which include CTH and crisis stabilization units (CSUs). Specific actions are included for the second goal but not	The Plan has very specific actions that should assist DBHDS to achieve Term 32. The Plan should more clearly state measurable goals in order to evaluate the impact and success of various actions included in the Plan.	**In Progress**

community.	the first, which is more directly related to PI 32.c (15)		
32.d) From the date of this Order, DBHDS will monitor staffing at each REACH program to determine if they have sufficient staffing per shift to meet the goal, including through discussion and review of filled/vacant positions, utilization rates of mobile crisis, and times mobile crisis calls are being received in comparison to the number of staff working during those hours at each REACH program's quarterly review. If a quarterly review indicates that staffing is not sufficient to meet the goal, DBHDS shall review the region's current efforts to increase staffing and, if DBHDS determines necessary, will require a quality improvement plan that includes additional actions	DBHDS did review staffing issues with each REACH team though its quarterly quality reviews, with a particular focus on staffing discussions in FY23 Q3. DBHDS reports that the DBHDS Regional Managers reviewed the breakdown of crisis calls for FYQ2 across shifts in relation to the staffing numbers for MCR staff provided by the Regions. In addition, each Region was asked to provide their staffing schedule, including the designation of credentials for a designated week. Based on the results of the most recent REACH qualitative quarterly review, DBHDS has required a Corrective Action Plan (CAP) of Region 1. DBHDS issued its report of the required areas of underperformance on 4.17.25. Region 1's CAP is due 5.2.25 (10,16)	DBHDS determined that while staffing is a challenge across the Regions, most Regions are using their full complement of staff including supervisors to ensure that the basic functions of mobile crisis response and follow up services are provided. DBHDS's FY23 Q3 Qualitative Review resulted in Region 1 being asked to develop a Corrective Action Plan (CAP) as noted. Region 3 has a significant number of vacancies to staff the MCR. However, DBHDS determined Region 3 continues to respond to crises in person and is successfully using supervisors and clinicians to assist responding to crises. Region 4 is using prevention staff to assist the MCR team to respond to crises, thereby continuing to meet minimum coverage standards. Region 2 uses supervisory staff to meet its crisis response obligations and Region 5 remains in compliance with staffing standards (10).	**In Progress**

that DBHDS finds are necessary to enhance staffing. The Independent Reviewer, in the reports required under Paragraph 76, shall include a determination in his report on the adequacy of the Programs and Virginia's response to this requirement.			
32.e) Semi-annually, beginning on January 1 and June 1 of each year, DBHDS will work with the two regions that are experiencing the most success in responding to people in crisis in the community to determine what is leading to their success. DBHDS will work with the two regions that are experiencing the most challenges in responding to people in crisis in the community to learn what is leading to those challenges. DBHDS will work with all the regions based on these lessons	DBHDS reports that a meeting was held on 3.18.25 and the resulting Crisis Assessment (CA) Plan was developed on 4.13.25. The DBHDS Regional Crisis Managers met with REACH staff to identify both promising practices and barriers to achieving the performance expectation that 86% of crisis assessments will be conducted in community settings. Based on its review of the data, the group identified Regions 3 and 5 as the two regions experiencing the most success, with lessons to also learn from Region 2 where performance is trending more positively.		**In Progress**

learned to implement a plan to improve performance in each of the regions.	DBHDS identified Regions 1 and 4 as needing TA. The group discussed a number of relevant questions to specifically identify effective strategies and impediments. DBHDS also discussed the impact of any over reliance on Telehealth, which Region 1 used extensively. DBHDS also reviewed with the regional REACH staff the differences in the challenges for children versus adults especially around family perception and reluctance. The Regional Crisis Managers group decided to focus on training for CSB managerial staff, community service providers, health and clinical practitioners, and law enforcement officers. They also identified additional actions that will be implemented. Actions are expected to be completed between 5.15.25 and 7.25.25 (17).		

32.f) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 32(a) through 32(e), DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. As part of the root cause analysis, the Commonwealth will collect data on why individuals with developmental disabilities presented at a CRC instead of accessing mobile crisis services. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Due Date 1/15/27**
33. **Therapeutic Consultation Services.** The Commonwealth will work to achieve a goal that 86% of individuals identified as in need of	DBHDS reports the number of individuals who needed therapeutic consultation (TC) who were connected to this service within thirty days; how many were not	This percentage is a slight decrease from the previous reporting period, which only included data from the five month period, February through June 2024, when 75% of individuals who needed	**Not Achieved**

Therapeutic Consultation service are referred for the service and have a provider identified within 30 days. To achieve that goal, the Commonwealth will take the following actions:	connected within thirty days; and the overall percentage of individuals connected to a provider within thirty days for the period July 1-December 31, 2024. In this time period, 1,043 (73%) of the 1,428 individuals needing TC were connected to a provider within thirty days. Of these individuals, 385 (27%) were not connected to a TC provider within thirty days. DBHDS further reports that of the 1,428 individuals with authorizations for TC, 1,162 (81%) received TC, and 266 (19%) did not receive TC between July and December 2024 (1).	TC were connected to a provider within thirty days. DBHDS provides data by region. Its report also includes data as to the average number of days to connect the individuals who were not connected in thirty days but were eventually connected to a TC provider. This ranges by month from a low of 57 days on average in December 2024 to a high of 76 days on average in September 2024. The data indicates that 266 of the 385 who were not connected to a TC provider within thirty days were not connected at all during the reporting period, and that 119 of these individuals were connected to a provider, but not within the expected thirty days. DBHDS conducted a root cause analysis and determined the performance of the SCs is key to improving the performance for connecting individuals to TC, since it is the SC who is responsible to facilitate this connection. To address the SCs role and improve the timeliness of the connections to TC providers, DBHDS has	

		focused on training; task clarification and prompting; improving resources, materials, and processes; and addressing performance consequences, effort, and competition. DBHDS has continued improvement efforts in the 26th reporting period. These actions are described under 33.a. below (1).	
33. **a)** Within 12 months of the date of this Order, DBHDS shall implement a technical assistance initiative with the CSBs that need the most support to connect people to behavioral supports and focus on improving case managers' awareness of the behavioral resources available to individuals in need of Therapeutic Consultation, unique CSB business practices, and supervisory support for case managers in this area of performance.	While this action is not due until January 2026, DBHDS has already implemented improvement initiatives. DBHDS has identified the eight CSBs that are determined to be in the most need of TA, based on a review of their performance. DBHDS has produced the Connectivity Assessment Results (CAR) and has shared the reports. DBHDS used a methodology shared with the Expert Reviewer in the 25th review period. DBHDS also used this methodology to complete the assessment with two CSBs that exhibit higher performance levels. DBHDS is providing		**In Progress**

	training to the eight CSBs and offering TA. The search engine has been updated to include email contacts for TC providers (18).		
33 b) Annually, the Commonwealth will participate in at least one regional event and at least one statewide conference to promote Therapeutic Consultation services. The Commonwealth will provide technical assistance to providers regarding enrollment with Medicaid as a provider as they reach out to the Commonwealth for this support.	DBHDS is attending the Annual Conference for Behavior Analysts which is being held 4.25.25 and 4.26.25. DBHDS will have a booth and provide information on the training opportunities described under Action 33.c. below. DBHDS also participated in Regional Round Tables in January and April, 2025. The Behavior Network Supports hosts an exhibit booth to provide information on enrollment as a Medicaid provider for TC. In the 26th review period DBHDS provided TA to ten TC providers to assist them to enroll as Medicaid providers (20).		**In Progress**
33.c) By July 1, 2025, the Commonwealth will create a	This Action is not due until July 2025 but is already being addressed by		**Completed**

training about enrolling with Medicaid as a Therapeutic Consultation provider and make it available for providers via DBHDS's website.	DBHDS. DBHDS has completed a three part training series and developed written instructions for providers to enroll in Medicaid and navigate the provider's requirements. The training includes: Becoming a TC Provider; Getting Started; and Regulations and Guidelines. Training videos, slide decks and TA for completing task analysis are available on the DBHDS Behavioral Services Web Page (19).		
33.d) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Therapeutic Consultation by January 1, 2025. The rate study shall be completed in time to be	The Commonwealth under the leadership of the Department for Medical Assistant Services (DMAS) has contracted with Guidepost to conduct the rate study. DMAS has created a DD Rate Work Group that convened 12.12.24 for the first of a series of monthly meetings. The Work Group includes representatives of providers, advocates, and industry associations. The United States has provided input		**In Progress**

considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Therapeutic Consultation by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.	on how the Commonwealth directs Guidehouse to perform the rate study. The United States has engaged a national expert and has participated in vendor meetings with stakeholders. The United States has identified concerns, asked questions, and made recommendations about how the Commonwealth directs the vendor to perform the rate study. Guidepost will conduct a rate study for services in the three DD 1915 c waivers, the CCC Plus Waiver and State Plan services including nursing services. Guidepost has provided an overview of the survey and training for providers to complete the survey. Sessions were offered on 4.17.25 and 4.22.25. The training was recorded so it is available to provider staff who were unable to attend one of the live sessions.		

	Guidepost has developed and shared its timeline for completing the rate study which includes an extensive survey of providers. The survey will be released 4.14.25 and responses are due 5.12.25. A final report with recommendations will be issued to DMAS 7.29.25 (11.12)		
33. e) If the Commonwealth has not achieved the goal by June 30, 2026 after taking the actions in Paragraphs 33(a) through 33(c), DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Due Date 7/15/26**
35. **Community Residences for Individuals with DD Waivers.** The Commonwealth will work to achieve a goal of	DBHDS reports separately for FY25 Q2 and FY25 Q3, detailing that 82% in Q2 and 88% in Q3 of all individuals with a DD waiver and known to the	This demonstrates DBHDS' continued improvement to meet this requirement. DBHDS has performed well for the past two years connecting CTH participants to	**Not Achieved**

86% of individuals with a DD waiver and known to the REACH system who are admitted to a CTH, or a psychiatric hospital have a community residence identified within 30 days of admission. To achieve that goal, the Commonwealth will take the following actions:	REACH system who were admitted to either a CTH or a psychiatric hospital have a community residence identified in 30 days of their admission. Regions vary in performance with Region 1 the lowest performer for both quarters. Region 2 surpassed the expected level of performance in FY25 Q3 with a percentage of 92%. Regions 4 and 5 exceeded the expected level of performance in both quarters with percentages at or above 90% in both periods. The total number of individuals reported who were admitted to either a CTH or a psychiatric hospital in the full reporting period (FY25 Q2 and Q3) was 351. Of these individuals 298 (85%) had a residence identified within 30 days of their admission (2,3).	community residences. In this reporting period more timely connections were made overall reaching 85%, which indicates an improvement connecting individuals who were hospitalized with a community residence in a timely way.	
35. a) DBHDS will enter into contracts with providers to develop homes for	DBHDS began to address the need to increase the number of providers who offered residences to	The Commonwealth has determined that more residences are needed for individuals with intensive behavioral needs, yet the	**In Progress**

individuals with intense behavioral support needs that will be operational (*i.e.*, that an individual can move into the home) in accordance with the following schedule:	support individuals with intense behavioral support needs with an RFP issued in FY18. Since then, DBHDS continued to add providers, resulting in the development of residences with 36 beds. In the 26th reporting period, 27 of these beds are filled. To comply with this requirement of the PI, DBHDS issued another RFP in FY24, selecting five new providers to develop 45 new beds. These new residences are at different stages of development as noted below. Of the 45 new beds, 19 are filled currently. When all of the new residences are operational, the Commonwealth will have 81 beds in residences to support individuals with intense need for behavioral supports (2,3).	existing homes are not fully utilized, nor have they been in previous reporting periods. There was an increase between FY25 Q2 and Q3 when bed use increased from 33 to 46 beds. DBHDS has taken several steps to increase utilization which are summarized in the narrative of this report.	
35.a) i. Region 1: one home operational by August 2024 and one additional home operational by February 2025;	Region 1 is adding two new homes. One is operational. The second home has been purchased and is pending licensing.		**In Progress**

35.a) ii Region 2: two homes operational by August 2024 and one additional home operational by February 2025;	Region 2 has four new homes operational. This is one more home than was anticipated. One additional home is being pursued by a provider.		**Complete**
35.a) iii. Region 3: one home operational by November 2024 and one additional home operational by February 2025;	Region 3 has opened one new home. The second home is purchased but not yet licensed.		**In Progress**
35.a) iv. Region 5: one home operational by November 2024 and two additional homes operational by February 2025.	Region 5 has two new homes operational. The third home has not been identified.	Region 5 is the only region that has not at least purchased all of the new homes that are expected to be operational this FY.	**In Progress**
35.b) If the Commonwealth has not achieved the goal after taking the actions in Paragraph 35(a) by June 30, 2025, DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Due Date 6/30/25**

36. **Out-Of-Home Crisis Therapeutic Prevention Host-Home Like Services for Children.** To prevent institutionalization of children due to behavioral or mental health crises, the Commonwealth will implement out-of-home crisis therapeutic prevention host-home-like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service by:	DBHDS reports the status of its plans to establish and operate YCTHs in the three Regions that do not currently have a YCTH which are Regions 1,3, and 5. The YCTH that will serve Region 1 youth with DD will be located in Region 2. None of the homes are operational but the contracts are under review in Regions 2 and 3, and the contract is signed for the YCTH in Region 5.		**Not Achieved**
36.a) Within one month of the date of this Order, DBHDS will send out a communication through the list serv for individuals and families on the waiver waiting list, and to the provider list serv communicating that the two CTHs existing in Regions 1 and 4	DBHDS sent out communication regarding prevention admissions at YCTHs on 2.4.25 (21,22).	DBHDS fulfilled this required action prior to the due date of 2.15.25	**Completed**

as of the date of this Order can be utilized for preventive stays by children across the Commonwealth.			
36.b) DBHDS will continue to track and report quarterly on the number of crisis prevention stays being utilized by children in each of the five regions.	DBHDS reports that 7 children in FY25 Q2 and 5 children in FY25 Q3 used the CTH in Region II for prevention. No children in either quarter used the CTH in Region IV for prevention (4,5).	DBHDS does not report which Regions these children reside in, so it cannot be determined if any youth in the Regions without a YCTH used the YCTH in Region 2 for preventive respite.	**In Progress**
36.c) Providing funding in Fiscal Year 2025 to establish three additional CTH's in the regions where they do not exist as of the date of this Order (Regions 2, 3, and 5) that will be operational between May 2025 and January 2026.	DBHDS is committed to increasing Youth CTHs (YCTH) to have one located in all five Regions to support crisis prevention admissions. These three new YCTHs are part of the Governor's RHRN initiative to expand short term crisis services (5). DBHDS provided the three contracts for the YCTHs: FY25 Performance Measures for the Region REACH YCTH. The contracts are under review in Regions 2 and 3 by the CSB Executive Directors and the contract for the YCTH in Region 5 has been signed.		**In Progress**

	Funding is authorized in each contract (25,26).		
36.d) From the date of this Order and continuing until all three additional CTHs referenced in Paragraph 36(c) are operational, DBHDS will support up to a total of 1,000 days per year of respite for children connected to REACH, who have previously experienced or are at risk of experiencing a crisis, reside in regions without an operational CTH, and who do not otherwise have funding to access respite services at a rate of up to $500 per 24-hour period.	DBHDS shared its description of the Short Term Crisis Prevention Respite Services, which was written 4.1.25. It describes the purpose of the service, who is eligible, the funding and the application process. Each child/family may use 14 days of preventive respite annually with a maximum of 7 consecutive days (23,24).	There is no indication of how the availability of this respite service is being advertised. DBHDS has targeted it to start in May. Providers who are not REACH staff will be approved as respite providers. Providers will receive training in the individual child's CEPP. Families will hire individuals directly to provide respite support.	**In Progress**
36.e) If the Commonwealth has not achieved the goal after taking the actions in Paragraphs 36(a) through 36(d) by June 30, 2026, DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by			**Due Date 6/30/26**

DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			

Recommendations:
DBHDS should report in the future how many employees outside of REACH staff have been trained and certified as MCR providers (PI 32.a).

To increase the percentage of crisis assessments conducted in community settings, DBHDS should include measurable goals, specific support activities and timelines for implementation as required by PI Term 32 c.

DBHDS should undertake a review and analysis to determine if the REACH programs have the necessary number of staff authorized, funded, and filled to successfully meet their responsibilities related to the PI Terms for Crisis Services.

As part of DBHDs' qualitative review of the REACH programs, it should include a specific review of each Region's efforts and measurable progress to conduct crisis assessments in community settings with recommendations for improvement.

Attachment A

Document List

1. Behavior Supports Report FY25 Q3
2. Supplemental Crisis Report FY25 Q2
3. Supplemental Crisis Report FY25 Q3
4. REACH Data Summary Report-Children: FY25-Q2
5. REACH Data Summary Report- Children FY25-Q3
6. REACH Data Summary Report- Adults: FY25-Q2
7. REACH Data Summary Report- Adults: FY25 Q3
8. REACH Staffing Reports for FY25 Q2: Region 1; 2; 3; 4; 5
9. REACH Quarterly Qualitative Reviews FY25 Q2: Regions 1,2,3,4 and 5
10. REACH Quarterly Qualitative Reviews FY25 Q3: Regions 1,2,3,4, and 5
11. VA DMAS DD Rate Group 12.24.24
12. Training Session #1 for VA DMAS DD Providers: Cost and Wage Summary
13. REACH Staffing Spreadsheet Instructions
14. RHRN Stream and MCR Funding
15. Link Plan
16. REACH Quarterly Quality Corrective Action Plan
17. Crisis Assessment Plan: 4.13.25
18. CSB Assessment Results and Action Plan
19. TC Training Materials
20. Crisis and Behavior Services Tracker
21. Constant Contact Announcement-YCTH
22. REACH Youth Admission-List Serve Blurb
23. Crisis Prevention Respite Funding
24. Short Term Crisis Prevention Respite Services
25. YCTH Exhibits
26. YCTH Build Updates-Link Plan
27. Emails form Sharon Bonaventura: 4.21.25, 4.23.25

Submitted by:
Kathryn du Pree MPS
May 19, 2025

APPENDIX C

Integrated Day Activities and Supported Employment

by

Kathryn du Pree, MPS

Integrated Day Activities Including Supported Employment Report
Twenty-Sixth Review Period
Prepared for the Independent Reviewer

Introduction

This report constitutes the eighth review of initially the Settlement Agreement's (SA), and now the Permanent Injunction's, requirements for Integrated Day Activities (IDA) which include employment. Prior to this review period the studies focused on a review and analysis of the Commonwealth's efforts to meet the requirements of the Compliance Indicators. This is the first review to be conducted since the Court approved the agreement between the Parties to comply with the terms of the Permanent Injunction (PI) and to implement the specified actions. The terms under review for IDA during the twenty-sixth review period are Terms 37, 50, and 51 which are described below. The focus of the review is to determine if the Commonwealth has achieved the measurable goals of the three PI Terms and the extent to which they have successfully implemented the associated actions. The Parties have agreed upon the Terms to determine compliance with IDA Provisions that previously remained out of sustained compliance. These include PI terms that relate to three Compliance Indicators (CI) for the Settlement Agreement's Provisions III.C.7.a.and b. These terms address the Commonwealth's responsibilities to increase employment opportunities for individuals with developmental disabilities (DD) through both DARS funded and HCBS employment opportunities, and to increase the percentage of individuals on DD waivers who receive their day services in the most integrated setting (MIS).

For this subset of PI terms and associated actions, progress toward achieving the agreed upon metrics are reviewed and reported below. This review includes an analysis and reporting of Virginia's status implementing the PI requirements associated with IDA that have not been met twice consecutively (see Table below). This includes PI Terms 50, 51 and 37 which are related to CIs 14.8, 14.9 and 14.10, respectively. The Commonwealth did not achieve the measurable goals that are now specified in any of these Terms in a previous review period.

For this review the facts gathered are identified and analyzed for each specified goal in the Findings Table below. The documents which include these facts are listed by reference in Attachment A and most are found in the Commonwealth's library of documents. Follow up information was provided throughout the study by Heather Norton, Deputy Commissioner, Community Services, and I appreciate her responsiveness.

Summary of Findings for the 26th Period

Facts were gathered regarding the Commonwealth's progress related to the performance measures for the three PI Terms associated with the SA provision III.C.7.a. The focus of this period's review, therefore, was to review the Commonwealth's progress toward achieving the employment targets for all individuals with DD on the waivers or the waiver waiting list; increasing employment specifically within waiver service options for individuals enrolled in a DD waiver; and increasing the percentage of waiver recipients who are participating in integrated

settings for their employment and day services. The ratings for PI Terms 51 and 37 are made and reported below. The rating for Term 50 must be deferred until the data is available for waiver employment for all of FY25 but an analysis of the status through December 2024 is described.

Methodology: This review focused on the Commonwealth's progress toward achieving the specified goals of the Terms and implementing the related actions for increasing the number of individuals who are engaged in supported employment or who are competitively employed, and those who are receiving Community Engagement (CE) and other integrated day services. I engaged in the following activities to review and analyze the DBHDS' progress toward meeting the three PI Terms for IDA.

Interviews: I interviewed members of the Employment First Advisory Group (E1AG). The E1AG normally meets bi-monthly but only conducted two meetings in the reporting period through March. An additional meeting was convened April 16, 2025. The subcommittees, which address policy, training and data also met twice during the reporting period (7). The E1AG members who were interviewed expressed concern about the direction of the E1AG now that the Commonwealth and the USDOJ have agreed to the PI. Concern was also expressed that DBHDS will benefit more if it uses the E1AG and its sub-committees to meaningfully review data and discuss substantive issues, providing members the opportunity to provide feedback and make recommendations related to policy and the implementation of strategies to improve employment outcomes. The return to in-person meetings and scheduling the sub-committee and E1AG meetings to occur on the same day has increased participation. Members report the work is still DD focused because of the continued efforts by Virginia to meet the PI's Terms' requirements. Members would appreciate receiving draft reports ahead of the meetings with sufficient time for them to thoroughly review them and be prepared to discuss the policy implications. Members had just recently received the semiannual employment report and felt unable to comment on the decline in the performance related to the PI terms. DBHDS reports there are two QIIs related to employment which are described in greater detail later in his report. Terms 50 and 51of the PI require that the E1AG collaborate with Quality Improvement Committee (QIC) to develop QIIs. **The members I interviewed did not recollect their involvement in developing the two QIIs related to employment or reviewing any data related to their implementation.** The members who were interviewed were pleased with the continued collaboration between DARS and DBHDS and the initiatives to end sub-minimum wage work and increase customized employment.

E1AG members remain concerned that the Commonwealth does not yet have in place initiatives to address the challenges of meeting the employment targets. While more individuals with DD were employed as of December 2024, the percentages decreased, as described below. Members hope that DBHDS structures future E1AG meetings to allow time for policy level discussions so that they can provide input into DBHDS' strategic planning efforts to increase employment and both the number and percentage of individuals with DD who are engaged in integrated day activities. One of the members I interviewed is also a member of the CEAG. The CEAG has not discussed the CEAG workplan since the fall of 2024.

Documents: I reviewed the Semiannual Report on Employment; DR0023 Integrated

Employment and Day Services; the meeting minutes for the Employment First Advisory Group (E1AG) and the Community Engagement Advisory Committee (CEAG); QII descriptions; training materials; the CE provider survey; the rate study outline; and the Community Engagement Strategic Plan.

Findings: The purpose of this review is to determine the Commonwealth's progress achieving the specified goals of PI Terms 37, 50 and 51, which are described in Table 1 below. None of these were met in previous studies. PI 50 is Deferred for this reporting period as it can only be analyzed once the employment data for the full fiscal year, FY25 is available. PI 51 is Not Met in this reporting period because the percentage of adults with DD employed through all employment programs offered by DARS and DBHDS is 23% of the total number of adults with DD on the waivers or waiver waiting list. PI 37 is Met for the first time as the Commonwealth reached a 2.5% increase in the number of individuals participating in IDA, compared to the 24th reporting period when these data were last presented and reviewed.

PI 50: DBHDS organized and structured the E1AG with the responsibility to work with DBHDS to set and review the targets. The E1AG has a data committee which reviews the employment data at least annually and completes trend analyses. The Commonwealth made progress towards achieving its employment targets though 2019, reaching 89% of the target it set (i.e., 1,078 employed compared to the target of 1,211) for that year.

An expected decline in the number of employed waiver participants occurred during the pandemic. The decline was dramatic between June 2019 and June 2020 (from 1,078 to 715 employed waiver participants). This decline began to turn around in FY22 when 764 individuals on the waiver were employed.

As reported in the 23rd Study Report, during the pandemic, DBHDS revised its waiver employment targets for 2022, reducing the target to 1,211 which was the pre-pandemic target for 2019. The E1AG met in April 2022 to revise the employment targets. This decision was made after a review and analysis of the impact of the COVID pandemic on employment outcomes for individuals with I/DD in Virginia. The decision was to return to the targets of 2019 for 2022 and those of 2020 for 2023.

In the fall of 2023, DBHDS planned to return to its pre-existing targets for the out-years through 2026. However, during the 24th review period, DBHDS and the E1AG undertook a more rigorous analysis of the employment data. DBHDS and the E1AG Data Committee members reviewed its historic approach to setting employment targets. Percentage increases year-to-year were not consistently set by the Commonwealth. The E1AG committee's review found that originally, DBHDS did not maintain a record of the methodology it used or the review it conducted of actual and projected performance to set the employment targets. As a result of its data analysis which has been described in previous reports, the E1AG Data Committee recommended reducing future employment targets based on what they consider a more realistic annual increase of 15% in employment for waiver participants.

Based on the actual achievement in FY23, its new approach resulted in the E1AG setting the following targets:

- FY24 1,142
- FY25 1,310
- FY26 1,512

DBHDS' target for FY25 is 1,310. As of December, 2024, midway through the year, there were 1,082 waiver participants employed. This number represents 83% of the target of 1,310 for this fiscal year. This is an increase of sixty-two individuals who are employed through ISE or GSE waiver services, and at only the mid-year point. This exceeds the increase in the total number of individuals employed at the end of FY24 when the increase compared to the previous year was thirty-four individual with DD. The rating for this Term is deferred until the 27th review period when the performance for the entire fiscal year can be considered. Virginia will meet the target when the performance is within 10% of the benchmark for the year.

PI Terms 50 and 51 require the E1AG to work with the QIC to develop QIIs to increase employment for adults with DD. DBHDS reports two QIIs (10,20). One is the SMART initiative which is to improve the development of employment, Integrated Community Involvement (ICI) and community life outcomes for individuals with DD. DBHDS developed a training for Service Coordinators (SC) to explain the importance of these services and life goals for individuals and to educate SCs on creating outcomes in these areas that are specific, measurable, achievable, relevant, and time-bound (SMART). Training was offered in January 2025 through You Tube. This QII is still progressing. Its second QII addressed increasing employment conversations with 14-17 year-old youth. This QII has been abandoned by DBHDS and has not been replaced with another QII related to increasing employment and meeting the targets set by the PI. As noted earlier in this report E1AG members report that they were not involved in developing or monitoring either QII.

From a review of the E1AG meeting minutes, there was no discussion of these QIIs in this reporting period. DBHDS did schedule a review of the QII specific to the discussions with 14-17 year olds for the meeting convened 4.16.25. The SMART QII was introduced to the E1AG at the meeting held 12.20.23. Update of both QIIs related to employment were provided at the E1AG meeting convened on 2.21.24. Updates regarding the QII to increase the number of conversations about employment with 14-17 year olds was also provided during the E1AG meetings convened on 4.16.24 and 6.20.24. This QII has since been abandoned. There is no documentation that the SMART QII was discussed with E1AG members since February 2024.

PI 51: The data reported by the Commonwealth is derived from data submitted by its Employment Service Organizations (ESO) and Department for Aging and Rehabilitative Services (DARS). The data are analyzed by DBHDS and the E1AG. However, as of late March the E1AG had not received the summary report or the raw data. As noted in the interviews with E1AG members, the data subcommittee has not been actively involved in data or trend analysis since resetting the employment targets described above.

There were 23,088 individuals receiving or on the wait list for waiver services as of 12.30.24. The target for employment for this six month period is 5,772, or 25% of the number of individuals with DD ages 28 to 64 on the waivers or waiver waitlist as of 12.30.24. Of these individuals a

total of 5,331 (4,738 in ISE and 593 in GSE) were employed. This represents 23% of the waiver population, a decrease of 1.5% compared to 6.30.24 when 24.5% of the waiver population were employed. While this represents a decrease in the percentage of adults with DD who are employed, this is an increase of 260 individuals who are employed compared to the number employed in the 25th period, of whom 247 are employed in ISE.

PI Term 51 is not yet achieved as Virginia did not meet the outcome that 25% of the waiver participants and individuals on the waiting list for waiver services were in integrated day services. While the Commonwealth has increased the number of individuals who are employed, the percentage of the individuals employed compared to the percentage employed in the 25th reporting period has decreased. These data are described in Table 2 below.

PI 37: The Commonwealth established 25.2% (3,279/13,014) as the baseline number and percentage for this indicator in March 2018 when there were service authorizations (SA) for 3,279 individuals with DD being served in the most integrated employment and day service settings and 13,014 individuals in the DD waivers. For this reporting period, the most recent full year data report is from 3.31.24 to 3.31.25. In March 2024, 3,762 (21.95%) of 17,142 individuals in the DD Waiver population participated in the most integrated settings for employment and day services. In March 2025, a year later, DBHDS reports there were 4,438 (24.4%) of 18,149 individuals in the DD Waiver population who participated in the integrated settings for employment and day services (2). While the number of waiver participants in integrated day services increased by 676 individuals (compared to an increase of 508 individuals in the previous year), the percentage of waiver participants with SAs for integrated day services increased by 2.45% percent. This exceeds the requirement of PI Term 37 of a 2% increase in participation in IDA annually.

Previously the Commonwealth achieved its most success in FY20 in 3.31.20 when 4,171 of 14,620 individuals (28.5%) participated in integrated day activities. As of 3.31.25 the Commonwealth has finally surpassed the number of individuals with DD in IDA reaching 4,438 individuals but has not equaled or surpassed the percentage of individuals in integrated day settings compared to the highest year of performance.

The Community Engagement Advisory Group (CEAG) has revitalized the work of its three committees: education and training; policy; and data. It has developed training materials for Service Coordinators and providers which are in draft form and being finalized this fiscal year for dissemination. The CEAG developed a provider survey for Community Engagement and Community Coaching to determine provider interest and barriers to offering these services. The survey will be sent to providers in late April, 2025. The CEAG has revised its Work Plan to address the requirements of PI Term 37 a. which requires:

"*Within one month of the date of this Order, DBHDS' Community Life Engagement Advisory Committee will implement a work plan that includes measurable goals, specific support activities, and timelines for implementation and that is focused on: defining meaningful community involvement; developing training and educational materials to enhance meaningful community involvement for individuals and families, providers, and case managers; and assessing community involvement data.*"

This workplan, titled the CEAG Annual Plan: 2025 Project Planning appears to have been developed in March and was submitted to this reviewer April 10, 2025 (3). It is a component of the overall CEAG Work Plan, as it includes a subset of CEAG goals. It is organized by strategies not goals. Most of the strategies relate to the Goal 1 which is to improve the understanding and philosophy among stakeholders, providers, and state agencies of Community Life Engagement (CLE) based on accepted national standards (four core pillars) and in alignment with best practice. Strategies 1.1, 1.2, and 2.1 relate to this goal and focus on improving understanding of CLE; defining a meaningful CLE conversation; and understanding how other services support CLE directly or indirectly. Another Goal (also labeled Goal 1) is to improve the understanding of primary barriers to providing community engagement, community guide, and community coaching using data collected from DBHDS QII initiatives. Strategy 3.1 which is to identify and mitigate the source of barriers to Community Engagement (CE) and Community Coaching (CC) DD Waiver services. The third goal is to ensure CE services are being offered and provided to individuals across the state in the most integrated community settings based on the needs of the individual. Strategy 3.2 related to this goal, identifies areas of the state that do not currently have sufficient community life engagement and targets barriers to delivering CE and CC DD Waiver services. The fourth goal included in the work plan is Goal 4 which is to ensure that there is an increase in meaningful CLE for each individual. Strategy 4.1 related to this goal, and it is to review currently collected CLE data (3).

Each strategy relates to a goal and includes a long term outcome with indicators to determine if the outcome is achieved. The CEAG Annual Plan identifies who is responsible to lead the strategy; what activities and tasks will be accomplished; the deliverable, the outcomes which are more short term than the long term outcome; and the timeline to complete the work. Strategies 1.1 and 1.2 address the PI requirements to focus on defining meaningful community involvement and developing training and educational material to enhance meaningful community involvement. Strategies 3.1, 3.2 and 4.1 address the PI requirement to assess community involvement data. A further analysis is included in Table 2.

PI Terms and Actions Achievement Status

Table 1 below summarizes the status of the compliance indicators for integrated day services.

TABLE 1		
Related Compliance Indicator	**Term**	**26th**
14.8	50. **Supported Employment.** The Commonwealth will work to achieve a goal of being within 10% of the waiver employment targets set by the Employment First Advisory Group. DBHDS will continue to work with the Employment First Advisory Group, the Quality Improvement Committee (QIC), and the QIC subcommittees to develop and recommend QIIs to enhance employment	**Deferred**

	of adults aged 18-64 on the DD waiver. If the goal is not met within two years of the date of this Order, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	

14.9	51. **Supported Employment.** The Commonwealth will work to achieve a goal of meeting its established employment target of 25% for adults aged 18 to 64 on DD waivers and the waitlist. DBHDS will continue to work with the Employment First Advisory Group, the QIC, and the QIC subcommittees to develop and recommend QIIs to enhance employment of adults aged 18 to 64 on the DD waiver and the waitlist. If the goal is not met within two years of the date of this Order, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	**Not Achieved**
14.10	**37. Day Services for DD Waiver Recipients.** The Commonwealth will work to achieve a goal of a 2% annual increase in the percentage of individuals on the DD waiver receiving day services in the most integrated settings.	**Compliance**

TABLE 2			
Term and Actions	**Facts**	**Analysis/Conclusion**	**26th**
50. **Supported Employment.** The Commonwealth will work to achieve a goal of being within 10% of the waiver employment targets set by the Employment First Advisory Group.	DBHDS' target for FY25 is 1,310. This is the expected number of individuals to be employed by June, 2025. As of December, 2024, there were 1,082 waiver participants employed. This number represents 83% of the target of 1,310 for this fiscal year.	While the rating for this Term is deferred until the 27th reporting period it must be noted that the Commonwealth is within 83% of the goal at the midyear point, compared to 89% at the end of FY24. This is a significant decrease and is of concern if this lower percentage	**Deferred**

DBHDS will continue to work with the Employment First Advisory Group, the Quality Improvement Committee (QIC), and the QIC subcommittees to develop and recommend QIIs to enhance employment of adults aged 18-64 on the DD waiver. If the goal is not met within two years of the date of this Order, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	This is an increase of sixty-two individuals since June 2024, who are employed through ISE or GSE waiver services, and at only the mid-year point. This exceeds the increase in the total number of individuals employed at the end of FY24, when the increase compared to the previous year was thirty-four individual with DD. However, it is a drop in the percentage of individuals employed, as the total number of individuals with DD on the waivers or waiver waiting list has increased at a larger percent since June 2024 (1) DBHDS initiated two QIIs related to improving employment. The first QII addressed increasing employment conversations with 14-17 year-old youth. It was abandoned by DBHDS (9). The second QII is focused on increasing the number and quality of outcomes for adults with DD for both employment and ICI. A comprehensive training was developed and offered by the CMSC in January (19). The E1AG was not involved in or informed of either QII	remains at the end of the fiscal year. The QII that was abandoned by DBHDS does not appear to be directly relevant to increasing employment among 18-64 year old waiver participants. The second QII may have a positive impact on increasing employment if it achieves its goal of increasing the number of adults with DD who have an employment outcome in their ISPs. DBHDS started its training in January, so it is premature to determine the effectiveness of this QII. DBHDS tracks and reports the discussions of employment with individuals with DD who are 18-64 and the percentage of those people who express an interest in employment who have an employment outcome (goal) in their ISP. While this is not a Term of the PI, an analysis of the data may provide an opportunity for a QII to improve employment outcomes for adults with DD. (The Case Management Steering Committee tracks and addresses this data, but a QII has not been developed by the E1AG). DBHDS reports that 97% of adults with DD have a	

	(7).	discussion about employment with their Service Coordinator/team. However, only 60% of adults with DD who have an interest in employment have an employment outcome in their ISP. It is critical that teams address individual's interest in employment by developing measurable goals and objectives in their ISPs which is the necessary action to actually assisting adults to become employed.	
51. **Supported Employment.** The Commonwealth will work to achieve a goal of meeting its established employment target of 25% for adults aged 18 to 64 on DD waivers and the waitlist. DBHDS will continue to work with the Employment First Advisory Group, the QIC, and the QIC subcommittees to develop and recommend QIIs to enhance employment of adults aged 18 to 64 on the DD waiver and the waitlist. If the goal is not met within two years of the date of this Order, DBHDS will	There were 23,088 individuals receiving or on the wait list for waiver services as of 12.30.24. The target for employment for this six month period is 5,772, or 25% of the number of individuals with DD ages 28 to 64 on the waivers or waiver waitlist as of 12.30.24. Of these individuals a total of 5,331 (4,738 in ISE and 593 in GSE) were employed. The DBHDS reports a 100% response rate from its Employment Services providers for this twentieth semi-annual data report. DBHDS reports finalizing two QIIs developed to assist the Commonwealth to meet its established	PI Term 51 is not yet achieved as Virginia did not meet the outcome that 25% of the waiver participants and individuals on the waiting list for waiver services were employed. While the Commonwealth has increased the number of individuals who are employed, the percentage of the individuals employed compared to the percentage employed in the 25th reporting period has decreased. Conclusion: This Term in Not Met in the 26th reporting period. The DBHDS undertook a QII for adolescents, rather than for adults who are the target group of Term 51. This QII was not successful, nor does it appear to have any direct	**Not Achieved**

conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	employment target of 25% for adults aged 18-64. One QII was specific to increasing the conversations for youth with DD to 86% by 6.30.24, prior to the PI. This QII was undertaken by the RQC in Region 1. The baseline performance was 58% in FY23 Q3. The performance varied between FY23 Q4 (43.5%) and FY24 Q2 (54%). The percentage reached 60% in FY25 Q1. The strategy was to produce and share documents describing the value of employment and clarifying what was expected to be discussed in an employment conversation. This QII was abandoned after FY25 Q2 (10) The Second QII addressed SMART goals (20) which is a plan to improve SC and teams' development of measurable and attainable employment outcomes for adults with DD. The process for achieving improvement is training for SCs. (20). This QII is underway. Neither QII was developed with any input of the E1AG. DBHDS has included an update on the QII regarding	relationship to the goal of increasing employment for adults with DD.	

	employment conversations with teems on the agenda for the E1AG meeting scheduled for 4.19.25 (7)		
37. Day Services for DD Waiver Recipients. The Commonwealth will work to achieve a goal of a 2% annual increase in the percentage of individuals on the DD waiver receiving day services in the most integrated settings. To achieve that goal, the Commonwealth will take the following action:	For this reporting period, the most recent full year data report is from 3.31.24 to 3.31.25. In March 2024, 3,762 (21.95%) of 17,142 individuals in the DD Waiver population participated in the most integrated settings for employment and day services (2). In March 2025, a year later, DBHDS reports there were 4,438 (24.4%) of 18,149 individuals in the DD Waiver population who participated in the integrated settings for employment and day services (2). The percentage of waiver participants with SAs for integrated day services increased by **2.45%** percent between 3.31.24 and 3.31.25. This exceeds the requirement of PI Term 37 of a 2% increase in participation in IDA annually.	The number of waiver participants in integrated day services increased by 676 individuals (compared to an increase of 508 individuals in the previous year. This is a significant increase in the number of individuals with DD in IDA and finally surpasses the Commonwealth's previous highest year of performance set in FY20 when 4,171, individuals with DD were in IDA. Conclusion: This Term is initially met this reporting period.	**Compliance**
37.a) Within one month of the date of this Order, DBHDS's Community Life Engagement Advisory Committee will	DBHDS revised the original CEAG workplan to assure it aligns with requirements in the PI. The work plan, titled the CEAG Annual Plan 2025 Project Planning includes six strategies	The work plan was developed in March and sets completion dates for the strategies that range from April 2025 to February 2026. Th CEAG work plan addresses the three areas of focus	**In Progress**

implement a work plan that includes measurable goals, specific support activities, and timelines for implementation and that is focused on: defining meaningful community involvement; developing training and educational materials to enhance meaningful community involvement for individuals and families, providers, and case managers; and assessing community involvement data.	which address the requirement of 37.a) to define meaningful community involvement; develop training and educational materials to enhance meaningful community involvement and assess community involvement data (3) .	described in the action statement. The PI term and action require a work plan that also includes measurable goals, specific support activities and timelines for implementation. The work plan includes goals, support activities and timelines. However, the outcomes and indicators are not measurable with one exception. Strategy 1.2 includes a short term outcome that 86% of SCs responding to a survey will know what a meaningful conversation is and the importance of their role in facilitating meaningful conversations. No other outcome is measurable. DBHDS includes sufficient specificity in the activities and tasks of the work plan and clearly defines the deliverables. DBHDS includes the identification of barriers as well as successes to achieving CLE for individuals and appropriately includes the input of all stakeholders which should enhance the achievement of outcomes.	
37. b) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate	The Commonwealth under the leadership of the Department for Medical Assistant Services (DMAS) has contracted with Guidepost to conduct the rate study. DMAS has	The Commonwealth is fully implementing the activities associated with Term 37, and the actions required under 37. b.	**In Progress**

study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Community Engagement, Workplace Assistance, and Community Coaching by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Community Engagement, Workplace Assistance, and Community Coaching by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate	created a DD Rate Work Group that convened 12.12.24 for the first of a series of monthly meetings. The Work Group includes representatives of providers, advocates, and industry associations. Guidepost will conduct a rate study for services in the three DD 1915 c waivers, the CCC Plus Waiver and State Plan services including GSE, Workplace Assistance, Employment and Community Transportation, Community Coaching, Community Engagement, Community Guide, and Benefits Planning (18). The United States has provided input on how the Commonwealth directs Guidehouse to perform the rate study. The United States has engaged a national expert and has participated in vendor meetings with stakeholders. The United States has identified concerns, asked questions, and made recommendations about how the Commonwealth directs the vendor to perform the rate study. Guidepost has provided		

study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.	an overview of the survey and training for providers to complete the survey. Sessions were offered on 4.17.25 and 4.22.25. The training was recorded so it is available to provider staff who were unable to attend one of the live sessions. Guidepost has developed and shared its timeline for completing the rate study which includes an extensive survey of providers. The survey will be released 4.14.25 and responses are due 5.12.25. A final report with recommendations will be issued to DMAS 7.29.25 (18,20)		
37. c) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraph 37(a), DBHDS will also conduct a root cause analysis and determine whether a QII is warranted to address identified issues. A root cause analysis and consideration of QII will not be required if the percentage of individuals in the integrated day			**Due Date 1/15/27**

services reported above is 65% of the total number of the people receiving any day service.			

Recommendations: The CEAG Work Plan should include measurable outcomes for all goals and objectives. DBHDS should directly involve the E1AG in the development of the QIIs to improve employment goals, including a review of meaningful data and trend analysis by the Data Subcommittee to design QIIs based on data and analysis.

Attachment A
Documents Review
Integrated Day Services

1. Semiannual Report on Employment December 2024 Data: Issued March 2025
2. DR0023 Integrated Employment and Day Services
3. CEAG Annual Plan 2025 Project Planning
4. CEAG Meeting Minutes 10.20.24, 12.20.24
5. CEAG Policy Work Group Minutes 10.16.24, 2.19.25
6. E1AG Plan for FY24-26 with Quarterly Updates
7. E1AG Meeting Agendas and Minutes: 10.16.24, 2.19.25, 4.16.25
8. E1AG Project Plan Update FY24-FY26
9. RQC1 Status Update on Teen Employment Discussions QII
10. Community Life Engagement (CLE) Case Manager Training
11. CLE in All Services
12. CE and CC Provider Survey
13. Guidance for Navigating SE Waiver and DARS Services
14. Training and Mentoring Program Flyer- Pre-Employment Transition Services Navigator
15. Employment Process Inputs
16. DD supported employment for adults and transition age youth
17. An Overview of DD Employment in Virginia
18. VA DMAS DD Rate Group 12.12.24
19. SMART Presentation- Being SMART(er) about Employment and Integrated Community Involvement
20. Training Session #1 for VA DMAS DD Providers: Cost and Wage Survey

Submitted by:
Kathryn du Pree MPS
May 19, 2025

APPENDIX D

Community Living Options

by

Kathryn du Pree, MPS

Community Living Options Report
26th Review Period
Prepared for the Independent Reviewer

Introduction

This report constitutes the eighth review of initially the Settlement Agreement's, and now the Permanent Injunction's requirements for community living options (CLO) which focus on the provision of private duty and skilled nursing services to children and adults with developmental disabilities (DD) who receive Early and Periodic Screening, Diagnosis, and treatment (EPSDT) or DD Waiver services. Prior to this review period the studies focused on a review and analysis of the Commonwealth's efforts to meet the requirements of the Compliance Indicators. This is the first review to be conducted since the Court approved the agreement between the Parties to comply with the Terms of the Permanent Injunction (PI) and to implement the specified actions. The terms under review for CLO during the twenty-sixth review period are Terms 38 and 39 which are described below. The focus of the review is to determine if the Commonwealth has achieved the measurable goals of the two PI Terms and the extent to which they have successfully implemented the associated actions. The Parties have agreed upon the Terms to determine compliance with the CLO Provisions that previously remained out of sustained compliance. These Terms address the Commonwealth's responsibilities to increase the utilization of authorized nursing hours for individuals with DD through both EPSDT and HCBS waiver services.

For this subset of PI Terms and associated actions, progress toward achieving the agreed upon metrics are reviewed and reported below. This review includes an analysis and reporting of Virginia's status implementing the PI requirements associated with CLO/nursing services that have not been met twice consecutively (see Table below). This includes PI Term 38 (previously part of *CI 18.9),* and PI Term 39 (previously part of *CI 18.9*). The Commonwealth did not achieve the specified goals in either of these Terms in a previous review period.

For this review the facts gathered are identified and analyzed for each specified goal in the Findings Table below. The documents which include these facts are listed by reference in Attachment A and most are found in the Commonwealth's library of documents. Follow up information was provided by Brian Nevetral, OIHSN Project Manager and Susan Moon, Director, Health Support Network. I greatly appreciate their knowledge and responsiveness.

Summary of Findings for the 26th Review Period

This review found that the two Terms reviewed were not met although the actual rating is Deferred for both because DBHDS cannot report the nursing utilization data for the full year until the 27th review period**.** The reasons related to Virginia not achieving the specified goals of these Terms as of the midpoint in FY25 are also described below.

In its review of nursing services, DBHDS provided the data analysis for FY25 Q1 and Q2 in the Nursing Services Data Report issued in March 2025, and revised in April 2025 to determine the Commonwealth's progress meeting the requirements of both Terms 38 and 39 (2,3).

The Office of Integrated Health Support Network (OIHSN) performed the review of the FY25 data for nursing services authorized and delivered from 7.1.24-12.31.24. Virginia did not achieve the level of nursing hours utilization performance. DBHDS reported that only 123 (24%) of the 511 unique individuals with Service Authorizations (SA) received at least 80% of the hours allotted. This compares to 300 of the 601 (50%) of unique individuals that it reported FY24. Table 2 below depicts DBHDS's summary of utilization for EPSDT and Waiver individuals for all nursing services, which includes both private duty nursing and skilled nursing that were authorized. An equitable comparison cannot be made between data for full years between FY 2019 and 2024 and only six months of FY 2025 data, but it is concerning to see a significant decrease in utilization for both EPSDT and for waiver utilization. Utilization of nursing services decreased by 3% for individuals receiving EPSDT and more significantly by 30% for individuals receiving waiver services through FY25 Q2, compared to FY24. Only 105 (23%) of the 449 waiver recipients received 80% of the nursing hours authorized for them. This is the lowest percentage of individuals who have received 80% of their authorized hours since prior to FY22. Only 18 (29%) of 62 individuals who receive nursing services under EPSDT received 80% of the nursing hours that were authorized for them.

It is important to note that in reviewing these data that DBHDS did not have a full quarter post all utilization of nursing services that were delivered through December 2024 to receive the billing submissions. For this report, DBHDS reviewed, analyzed, and reported the nursing utilization billing data submitted by mid-February. It is most likely that the percentage of utilization reported will increase for FY25 Q1 and Q2 once providers have had a longer period of time to bill. Historically, DBHDS pulls billing data three months subsequent to the quarter in which the nursing service was delivered.

DBHDS does caution that the data and subsequent percentages derive from a point in time. Providers have up to twelve months to bill for services from the date the services were provided. While this information is not specific to EPSDT or the Waiver, DBHDS recalculated in December 2024 the percentage of individuals who received either PDN or SN through June 2024. Based on its updated billing data, the following percentages compare the utilization reported in the 25th reporting period for FY24 versus the percentages calculated based on billing data for FY24 submitted through December 2024. DBHDS now reports that its more complete billing data indicate that 55% versus 32% of EPSDT recipients received at least 80% of their authorized nursing hours, and 67% versus 53% of the waiver participants received at least 80% of their authorized nursing hours in FY24 (7).

Table 1
Nursing Services

	FY22	FY23	FY24	FY25 Q1 and Q2 only
EPSDT Utilization	18%	26%	32%	29%
Waiver Utilization	36%	42.5%	53%	23%

**Note: DBHDS determined the nursing utilization percentages by dividing the number of billed hours by the number of authorized hours within the fiscal year.*

DBHDS's Nursing Utilization Report includes a specific breakdown of the utilization of both Private Duty Nursing (PDN) and Skilled Nursing (SN), both by RN and LPN level nurses. Its report indicates a more significant decrease in the utilization of SN compared to PDN, unlike the findings in the 24th period study. Between FY23 and FY24 the utilization of 80% of authorized hours of Skilled Nursing by an RN increased from 7% to 20% and from 24% to 26% of Skilled Nursing by an LPN. Although the DBHDS reported data is as of FY25 Q2 and may change for the full FY, utilization currently shows a significant decrease for both RNs (5%) and LPNs (14%). This potentially inequitable comparison also shows utilization of 80% of one's authorized hours for PDN both by RNs and LPNs decreased by 30% for RN services (from 58% to 28%) and 20% for LPN services (from 47% to 27%) comparing FY24 to FY25 Q2 utilization. Although the percentages decreased for utilization of PDN in this review period, the utilization is still higher for PDN at 28% delivered by RNs and 27% delivered by LPNs, than for those comparable nursing professionals delivering Skilled Nursing (2).

Because of the episodic need, especially for skilled nursing, and difficult to predict nature of home healthcare (health need spikes, emergencies, etc.) in general and the presence of multiple SAs for both the RN and LPN levels of nursing, the system has continued its tendency to over authorize nursing hours for those whose need is specified in their ISPs. This suggests that the aggregate utilization rates reported by DBHDS will regularly fall below the actual service authorization amount because this number is inflated for some individuals for the reasons stated. The Commonwealth has not yet determined the extent of excess authorizations or the number of individuals who need nursing services but do not receive any authorized hours.

Table 2 depicts the DBHDS reported total number of individuals including both those using EPSDT and those enrolled in a DD Waiver who needed and received nursing services from FY19 through FY25 Q2. DBHDS reported that the total number of individuals needing nursing services decreased significantly (30%) between FY21 when 860 individuals needed nursing services to 601 in FY24, a period that included hundreds of new waiver participants. Reporting through FY25 Q2 indicates only 511 individuals needing nursing services which is a decrease of 90 individuals from the 601 who needed nursing services in FY24. Although it is only midway through the fiscal year, it is potentially concerning that far fewer individuals are reported as needing nursing services than in any prior year going back to FY19. DBHDS has not yet determined how there can be hundreds more individuals receiving waiver services, but significantly fewer need nursing services.

This data reported by DBHDS provides a longitudinal perspective regarding the utilization of nursing services pre and post pandemic and pre and post the nursing agency pay rate increases which started in July 2022. In FY19, 311 (48%) of individuals needing nursing services received 80% or more of their allotted nursing hours. Whereas, in FY25 as of Q2 only 123 (24%) received 80% of the hours that were authorized. The Commonwealth has not yet returned to the level of nursing services utilization reported in the years prior to the pandemic. The rate at which individuals received in-home nursing services plummeted, like most types of services, in FY 21. Since this low point, the utilization rate had increased from 29% to 50% in FY24. It is potentially troubling that there is a significant decrease in number of individuals need nursing services as of FY25 Q2 after the Commonwealth appeared to be steadily increasing utilization to pre-pandemic levels.

Table 2
Nursing Services

Fiscal Year	Percentage receiving 80% of hours	Number of individuals receiving 80% or more	Total number of individuals needing nursing services
FY19	48%	311	648
FY20	51%	372	736
FY21	29%	247	860
FY22	34%	208	613
FY23	40%	247	616
FY24	50%	300	601
FY25 (through Q2)	24%	123	511

**Note: DBHDS determined the nursing utilization percentages by dividing the number of billed hours by the number of authorized hours within the fiscal year.*

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DBHDS also reported the percentage of nursing utilization that met the 80% benchmark by Regions in FY 24. The reported utilization percentage for each Region continues to vary considerably. It is significant that the achievement of the benchmark has decreased for every region, after increasing in FY24 compared to FY23:

- Region 1- 15% compared to 36% in FY24
- Region 2- 30.5% compared to 76% in FY24
- Region 3- 13% compared to 17% in FY24
- Region 4- 22% compared to 38% in FY24
- Region 5- 28% compared to 45% in FY24

The data reported by DBHDS compares the percentage of hours delivered to authorized hours by Supports Intensity Scale (SIS) levels. During FY24, the DBHDS noted the changes in the percentages of individuals who received 80% of their authorized nursing hours. Although potentially inequitable, comparing the FY24 percentages to those in FY25 through Q2 for individuals with Level 4-7 SIS scores:

- 23% of individuals with a Level 4, compared to 64% in FY24;
- 18% of those with a Level 5, compared to 68% in FY24;

- 24% of individuals with a Level 6, compared to 68% in FY24;
- and 17% compared to 67% of those with a Level 7 received 80% of their authorized nursing services.

Unsurprising given the significant decrease in utilization overall, the percentage of utilization for every SIS level decreased by large percentages.

It is impressive that DBHDS completes a "Deep Dive" annually to ascertain the reasons for late starts for nursing services and to determine barriers to utilization. DBHDS initiated contacts starting April 7, 2025 with providers and Support Coordinators (SCs) for individuals who received less than 80% of their authorized PDN hours in FY24 and will include questions regarding any barriers being experienced by these individuals in FY25. DBHDS will share the results in the next Nursing Hours Utilization Report.

DBHDS has begun a process of identifying the top three barriers to individuals accessing nursing services in each Region and identifying interventions to reduce these barriers. As part of this initiative, DBHDS is identifying the CSBs that have the lowest utilization and targeting technical assistance and training to assist them to increase utilization of authorized nursing services. This information is detailed in their Nursing Work Plan/Community Nursing Access Report (4). This Plan describes the PI Terms 38 and 39 and the actions associated with these Terms. The Plan includes the strategies, responsible party, target date, status, and any actual results. The expectation that DBHDS will identify the CSBs that have the highest nursing shortages is underway and is to be completed by 5.1.25. DBHDS has already identified the CSBs for Regions 2,3, and 4. DBHDS will also identify DD Waiver Nursing Providers that are not residential or day providers to connect them to individuals needing nursing services if they are accepting new individuals. Other providers are being identified including home health companies. DBHDS will promote the availability of these providers through trainings, website information and search engines. DBHDS has not yet started but will identify and address the top three barriers in each region and has identified strategies to address these barriers once identified. This is projected to begin 7.15.25. DBHDS OIHSN plans to develop measurable goals using the SMART (specific, measurable, achievable, relevant, and time-bound goals) approach to address the barriers (4).

DBHDS is also building a Nursing Provider Database to assist individuals to locate nursing providers in their geographic area. OIHSN RN Care Consultants (RNCC) were able to directly contact sixty of the 125 nursing providers who were approved providers in FY24. The purposes of the calls were to identify the scope, capacity, and availability of these providers. About half (29) of the providers contacted discussed challenges they experience delivering nursing services to individuals with DD. The most pressing challenges were staffing shortages, cumbersome paperwork related to service authorization, coordinating schedules with nurse availability, home environment concerns, and extreme behaviors of individuals who were served (2).

In the 23rd review period DBHDS shared a draft of a proposed Intense Management Needs Review (IMNR) process to assess and monitor the adequacy of management and supports provided to all individuals whose SIS evaluation results placed them in tier four level six (intense management needs) to meet their needs. The purpose of the IMNR is to ensure the documentation properly reflects the continuity of care across services is addressing the individual's medical management needs. DBHDS produces IMNR reports semi-annually to

align with the Independent Reviewer's Individual Services Review (ISR) studies.
The first IMNR was conducted during the 24th reporting period. It included a sample of thirty individuals with complex support needs (i.e., SIS level 6). In part, it examined whether these individuals utilized the nursing service hours they were authorized to receive. A second IMNR was conducted in August 2024. Nine individuals in Region 5 were reviewed by both an RNCC from the OIHSN and a Nurse Consultant working for the Independent Reviewer. The review noted four areas of concern. The third IMNR was conducted in this review period and is described in Table 4 below (3).

All Process Documents and Attestations have been previously reviewed, and the Processes have been determined to be reliable and valid. However, the extent of the validity that the authorized hours equal the number of hours needed has not been established.

PI Terms and Actions Achievement and Status

Table 3 below summarizes the status of the PI Terms and Actions this study reviewed.

TABLE 3		
Related Compliance Indicator	**Term**	**26th**
18.9	38. **Private Duty Nursing.** The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with private duty nursing identified in their ISP or prescribed under EPSDT receive 80% of the hours identified as needed on the CMS485 or DMAS62 forms. To achieve that goal, the Commonwealth will take the following actions.	**Deferred**
18.9	39. **Skilled Nursing.** The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with skilled nursing identified in their ISPs or prescribed under EPSDT will have their skilled nursing needs met 80% of the time.	**Deferred**

TABLE 4			
Term and Actions	**Facts**	**Analysis/Conclusion**	**26th**
38. **Private Duty Nursing.** The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving	The Office of Integrated Health Support Network (OIHSN) performed the review of the FY25 data for nursing services authorized and delivered from 7.1.24-12.31.24. Virginia did not achieve the level of nursing	This Term will not be rated for compliance until the 27th review period when all utilization data for FY25 is complete. However, the current data for six months of the year evidences an initial decrease in utilization	**Deferred**

EPSDT with private duty nursing identified in their ISP or prescribed under EPSDT receive 80% of the hours identified as needed on the CMS485 or DMAS62 forms. To achieve that goal, the Commonwealth will take the following actions.	hours utilization performance expected. Only 123 (24%) of the 511 unique individuals with Service Authorizations (SA) received 80% of the hours allotted. Although a potentially inequitable comparison, 50% of unique individuals with SAs receiving 80% of the overall nursing hours (SN and PDN) allotted in FY24. The Nursing Hours Utilization Report issued in March 2025, did not clearly distinguish between the utilization of SN versus PDN hours. These two types of nursing services were combined in the previous CIs that defined the responsibilities of the Commonwealth to provide nursing services. The PI separates PDN from SN in PI Term 38 and PI Term 39. Subsequent to the report issued in March, DBHDS updated the report and reported separately on the percentage of individuals who received 80% of their authorized nursing hours. In total, including both RN and LPN PDN services, 28% of individuals with authorized nursing hours received at least 80% of this authorization. This compares to 74% utilization of PDN in FY24 (7). Later in the Nursing Services Data Report, DBHDS includes a Table of Utilization by Procedure	compared to FY24. Also, far fewer individuals (511) are authorized for nursing services in FY25 to date than were authorized in FY24 (603). DBHDS reports 123 individuals who received 80% of their authorized nursing hours, of the 511 who were authorized. This includes 18 of 62 EPSDT recipients (29%) and 105 of 449 Waiver recipients (23%). These data are not reported separately for PDN or SN but rather combines the total number of children and adults who receive either type of nursing services. The reasons for this decrease in both the number of individuals with nursing service authorizations, and the percentage getting 80% utilization is unclear and potentially concerning. DBHDS is not reporting concern regarding the apparent decrease in both the number of individuals authorized for nursing services nor the decrease in utilization. DBHDS staff respond that it is difficult to determine what the exact percentage of utilization is at any particular time because providers have twelve months to bill for any services delivered.	

	Code. There are two codes for PDN. T1002 is the utilization by PDN RNs and is 28%, compared to 81% in FY24. T1003 is the utilization code by PDN LPNs and is 27% compared to 73% in FY24 (2).		
38.a) Semi-annually, on May 15 and November 15 of each year, DBHDS will continue to report data on utilization of nursing services and the work of the DBHDS Nursing Workgroup.	DBHDS provided new calculations for FY24 based on additional billing data, as well as billing data for the first six months of FY25. DBHDS continues to report the data semiannually for the utilization of nursing services in the Nursing Hours Utilization Report. DBHDS reported that the Nursing Services Workgroup, which will include key stakeholders from DBHDS and DMAS, will meet in June 2025. Their responsibilities include the review of nursing utilization data; the results of the most recent IMNR to determine areas of focus for improvement; identify additional topics for SN and PDN training and further training to bridge the gap between general nursing education and specific training needed to provide proficient waiver services to individuals with DD: and enhance the usability of WaMS with regard to nursing utilization. As reported earlier the Nursing Work Plan includes comprehensive strategies and specific responsibilities and timelines for the completion of the work (4).		**In Progress**

38. b) By September 30, 2024, DBHDS will update the ISP to allow for collection of nursing needs data identified by the Risk Awareness Tool.	This was initiated 9.15.24 when DBHDS updated the ISP to allow for the collection of nursing needs data identified by the Risk Awareness Tool. The ISP now includes a question to identify if nursing waiver services are needed and identify additional related information. The SC must respond to a number of options to indicate if appropriate referrals have been made and if the individual has been connected to nursing services, if they are otherwise being addressed, or if the individual has declined the service or does not require the service (2).	DBHDS reviewed a sample of 5,024 ISPs completed between November 2024 and February 2025. Of the 5,024 ISPs reviewed 4,338 (86%) of the individuals did not need nursing and 372 were reported as Null because the ISP was opened for editing before this question was included. Of the remaining individuals, 153 had connected to nursing services or had a referral. Eleven needed nursing services, but declined these services, and 150 individuals had their needs addressed by other supports. These data indicate that of the 164 individuals who needed waiver nursing services, 79% (130) were receiving these services; 14% (23) were appropriately referred; and 7% (11) declined a referral for the service.	**Completed**
38. c) DBHDS will continue to implement an IMNR that will assess if individuals have unmet nursing or other medical needs and will work with families, providers, and case managers to take steps to resolve identified unmet needs. Semi-annually, on April 15 and October 15 of each year, DBHDS will report on the IMNR process, including the types of unmet needs identified and efforts taken to resolve them.	The IMNR process continued in the 26th review period and the reviews for 29 individuals in Regions 2 and 4 were conducted between 2.24.25 and 3.20.25. These reviews were completed by an RNCC of the OIHSN and a nurse consultant from the Independent Reviewer's Office. Remediation plans were sent to the CSBs who will respond to DBHDS who will monitor the issues requiring remediation until they are resolved.		**In Progress**

38.d) Within six months of the date of this Order, in consultation with the five DBHDS Registered Nurse Care Consultants, the Commonwealth will:			**Due Date 7/15/25**
38.d). i. Identify which CSB catchment areas in each Region have the highest nursing shortages for this target population based on objective criteria and data, including how many individuals with private duty nursing receive 80% of their hours;	DBHDS has initiated the process to identify the CSBs with the highest nursing shortages. OIHSN has identified the CSBs for three of the Regions and will identify the remaining two by 5.15.25. DBHDS has developed a Nursing Access Work Plan. Within this process DBHDS is identifying the CSBs with the lowest utilization and targeting technical assistance and training to support the CSBs to increase utilization of the authorized nursing hours. DBHDS is contacting providers/SCs for individuals who are not receiving 80% of their authorized PDN nursing hours to assist DBHDs to identify specific barriers. DBHDS plans to report on the results in the 27th review period (4).	DBHDS has initiated a process to identify the CSBs with the lowest utilization.	**In Progress**
38.d) ii. Identify the top three barriers to individuals accessing nursing services in each region based on objective data, including stakeholder data and state and national workforce data and research;	As indicated above the process to identify has been initiated. DBHDS plans to contact providers and SCs for all individual who have received less than 80% of their authorized PDN hours in FY24 to elicit stakeholder input. The Nursing Hours Utilization Report through FY25 Q2 includes information on the nursing		**In Progress**

	workforce challenge experienced in Virginia, especially in its rural regions, taking its data from the Virginia State Office of rural Health. The report identified national reasons for nursing shortages that include pandemic burnout, educational obstacles, and retirement. The report also touches upon national nursing workforce issues and barriers.		
38.d) iii. Develop a work plan to resolve those barriers that includes measurable goals, specific support activities, and timelines for implementation; and	DBHDS includes its initiatives, next steps and recommendations which is an extensive list that includes ongoing assessment of need; utilization data analysis; training and technical assistance; eliciting stakeholder input; and follow up on IMNR recommendations (2,3,4).		**In Progress**
38.d. iv. Include the barriers and efforts to resolve them, as well as the factual basis for those barriers and efforts, in the semi-annual nursing report that is posted in the Library.			**In Progress**
38.e) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Private Duty Nursing by January 1,	The Commonwealth under the leadership of the Department for Medical Assistant Services (DMAS) has contracted with Guidepost to conduct the rate study. DMAS has created a DD Rate Work Group that convened 12.12.24 for the first of a series of monthly meetings. The Work Group includes representatives of providers, advocates, and industry associations.		**In Progress**

2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Private Duty Nursing by January 1, 2029. The rate study shall be completed in time to be considered at the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.	The United States has provided input on how the Commonwealth directs Guidehouse to perform the rate study. The United States has engaged a national expert and has participated in vendor meetings with stakeholders. The United States has identified concerns, asked questions, and made recommendations about how the Commonwealth directs the vendor to perform the rate study. Guidepost will conduct a rate study for services in the three DD 1915 c waivers, the CCC Plus Waiver and State Plan services including nursing services. Guidepost has provided an overview of the survey and training for providers to complete the survey. Sessions were offered on 4.17.25 and 4.22.25. The training was recorded so it is available to provider staff who were unable to attend one of the live sessions. Guidepost has developed and shared its timeline for completing the rate study which includes an extensive survey of providers. The survey will be released 4.14.25 and responses are due 5.12.25. A final report with recommendations will be issued to DMAS 7.29.25 (4,5)		

38.f) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 38(a) through 38(d), DBHDS will also conduct a root cause analysis and determine whether a QII is warranted to address identified issues. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Due Date 1/15/27**
39. Skilled Nursing. The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with skilled nursing identified in their ISPs or prescribed under EPSDT will have their skilled nursing needs met 80% of the time. To achieve that goal, the Commonwealth will take the following actions:	The OIHSN performed the review of the FY25 data for nursing services authorized and delivered from 7.1.24-12.31.24. Virginia did not achieve the level of nursing hours utilization performance expected. Only 123 (24%) of the 511 unique individuals with Service Authorizations (SA) received 80% of the hours allotted. This compares to 50% of unique individuals with SAs receiving 80% of the overall nursing hours (SN and PDN) allotted in FY24. The Nursing Hours Utilization Report issued in March 2025, did not clearly distinguish between the utilization of SN versus PDN hours. These two types of nursing services were combined in the previous CIs that defined the responsibilities of the Commonwealth to provide	This Term will not be rated for compliance until the 27th review period when all utilization data for FY25 is available. However, the current data for six months of the year indicates a decrease in utilization compared to FY24. Also, far fewer individuals (511) are authorized for nursing services in FY25 to date than were authorized in FY24 (603). DBHDS reports 123 individuals who received 80% of their authorized nursing hours, of the 511 who were authorized. This includes 18 of 62 EPSDT recipients (29%) and 105 of 449 Waiver recipients. These data are not reported separately for PDN or SN but rather combine the total number of children and adults who receive either type of nursing services. This decrease in both the number of individuals with nursing service authorizations, and the parentage getting 80%	**Deferred**

	nursing services. The PI separates PDN from SN in PI Term 38 and PI Term 39. Subsequent to the report issued in March, DBHDS updated the report and reported separately on the percentage of individuals who received 80% of their authorized nursing hours. In total, including both RN and LPN SN services, 12% of individuals with authorized nursing hours received at least 80% of this authorization. This compares to 45% utilization of SN in FY24 (7). Later in the Nursing Services Data Report, DBHDS includes a Table of Utilization by Procedure Code. There are two codes for SN. S9123 is the utilization by SN RNs and is 5%, compared to 14% in FY24. S9124 is the utilization code by SN LPNs and is 14% compared to 51.5% in FY24.	utilization is extremely concerning. DBHDS is not reporting concern regarding the apparent decrease in both the number of individual authorized for nursing services nor the decrease in utilization. DBHDS staff respond that it is difficult to determine what the exact percentage of utilization is at any particular time because providers have twelve months to bill for any services delivered. Since providers can bill for up to twelve months after the service was provided, DBHDS reports it may not have accurate and complete utilization data until a full year has passed from the end of each fiscal year. This will make it difficult to determine the accuracy of the rating determination at the end of each fiscal year to conclude whether the Commonwealth has achieved the specified goal.	
39.a) Semi-annually, on May 15 and November 15 of each year, DBHDS will continue to report data on utilization of nursing services and the work of the DBHDS Nursing Workgroup.	See 38. a.		**In Progress**
39.b) As part of the IMNR Process, DBHDS will assess if individuals have unmet nursing or other medical needs and will work with	See 38. c.		**In Progress**

families, providers, and case managers to take steps to resolve identified unmet needs. Semi-annually, on April 15 and October 15 of each year, DBHDS will report on the IMNR process, including the types of unmet needs identified and efforts taken to resolve them.			
39.c) *Skilled Nursing Review*. Beginning within three months of the date of this Order, for individuals with a skilled nursing need identified in the Waiver Management System, DBHDS will begin to conduct on-site IMNR reviews as set forth in this paragraph. DBHDS will conduct the on-site IMNR reviews of a randomized sample of 10% of individuals annually (split between two six-month reviews) to determine if individuals' skilled nursing services needs are being met. In selecting individuals during each six-month review period to review, DBHDS shall include in the sample only individuals who were authorized to receive the service at least three months earlier, to ensure sufficient time for the sampled individuals to have received the	DBHDS shared its monitoring questionnaire for skilled nursing. Reviews will be initiated in mid-April and will be conducted monthly. Each review will result in the request for a remediation plan and the timeline for its completion if indicated by the results of the review.	The monitoring questionnaire is comprehensive. It includes a review of the ISP/Plan of Care including hours requested, authorized, and billed. Any barriers to receiving the hours authorized are noted. Concerns are summarized and a remediation plan is required to address these concerns.	**In Progress**

service.			
39.d) If the Commonwealth has not achieved the goal as reported in its December 1, 2024 status update and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Skilled Nursing by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its December 1, 2028 status update and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Skilled Nursing by January 1, 2029. The rate study shall be completed in time to be considered at the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.	See 38.e.		**In Progress**

39.e) If the Commonwealth does not achieve the goal within two years of the date of this Order after taking the actions in Paragraphs 39(a) through 39(c), DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Due Date 1/15/27**

Recommendations: DBHDS should report separate utilization numbers and percentages by PDN for Term 38 and for SN for Term 39 in all future reports. DBHDS should also consider if there is value in requiring the providers of nursing services to bill more immediately after the service is provided and no longer allow billing up to twelve months after the service is rendered. As long as this billing procedure continues, it will be difficult for DBHDS to have a comprehensive understanding of the level of performance and where to direct its resources to improve performance. As a result of late billing, DBHDS is actually underreporting the Commonwealth's performance, and may at some point in the future be expending unnecessary resources or targeting resources ineffectively.

Attachment A
Documents Reviewed

1. CLO 25th Study Period Document Tracker
2. DBHDS Nursing Services Data Report FY25 (through Q2): Issued March 2025
3. DBHDS Nursing Services Data Report FY25 (through Q2): Updated 4.18.25
4. Nursing Work Plan/Nursing Access Report 4.14.25
5. VA DMAS DD Rate Group 12.12.24
6. Training Session #1 for VA DMAS DD Providers: Cost and Wage Summary
7. Emails from Brain Nevetral: 4.14.25, 4.18.25

Submitted by:
Kathryn du Pree MPS
Expert Reviewer
May 19, 2025

APPENDIX E

Services for Individuals
with
Complex Health Support Needs

by

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Marisa C. Brown, MSN, RN
Barbara Pilarcik, RN
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TWENTY-SIXTH PERIOD INDIVIDUAL SERVICES REVIEW STUDY:
Individuals with Complex Health Support Needs

Submitted By:

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May 16, 2025

Introduction/Background

This report summarizes the findings from the most recent review of certain requirements of the Consent Decree, and now the Permanent Injunction, regarding individuals with complex health support needs who receive community-based services and supports through Virginia's Developmental Disability Waiver. The examination of the services and supports provided to a sample of medically or behaviorally complex individuals has been a foundational component of each of the Independent Reviewer's reports to the Court. Although the sample is too small to permit its findings to be generalized to the system as a whole, the Individual Services Review (ISR) Study is a valuable opportunity to collect and analyze information regarding the availability and effectiveness of resources identified, through the ISP process, as critically important to the health, safety, and general well-being of people with complex medical conditions, including those who rely on family members as their primary caregivers.

In addition to its original intent of documenting individual circumstances and the provision of specific healthcare strategies, the ISR Study has now evolved into an important ongoing collaborative initiative with DBHDS's Office of Integrated Health Support Network (OIHSN). For the third consecutive reporting period, the Team Leader for the Independent Reviewer, and the Director of OIHSN have managed together the structure and detailed planning for the Study's activities. The site visits are conducted by three teams of nurse reviewers under their supervision. There are periodic virtual meetings to discuss observations, report problematic situations, and share recommendations for strengthening programmatic resources and responses. In addition, OIHSN has assigned newly hired nurses to attend and observe the site visits in order to enhance their professional experience and to assist them in preparing for their responsibilities with OIHSN.

Furthermore, the ISR Study is a key component of the Intense Management Needs Review (IMNR) process required by Term 44 and now being implemented by DBHDS. Related to Compliance Indicator 36.8, Term 44 obligates the Commonwealth to:

1. "collect and analyze data at least annually regarding the management needs of individuals with identified complex health and support needs to monitor the adequacy of management and supports provided."
2. "develop corrective actions based on its analysis as it determines appropriate, track the efficacy of the actions, and revise as it determines necessary to address the deficiency."

Components of the ISR Study have been firmly incorporated into the activities and analysis performed as an integral part of the IMNR process. For example, the Monitoring Questionnaire and the identical list of required documents examined in the ISR Study continue to be utilized as OIHSN conducts its additional reviews each month. These additional reviews are conducted by the same OIHSN nurses who participate in the ISR site visits.

To assist DBHDS in its ongoing monitoring, the ISR Study itself has supplemented its review of individual cases by analyzing DBHDS's efforts to address issues of concern documented in the

previous Period's Study. As part of the work completed for this current Study, OIHSN leadership and the Independent Reviewer's Team Leader randomly selected 11 individuals (37%) included in the prior ISR Study, completed in November 2024, to determine whether remedial actions were planned and implemented as expected. These follow-up actions are intended to ensure that health-related supports, identified as absent or incomplete by the nurse reviewers during their site visits, are provided or strengthened within a reasonable period of time.

Finally, in order to assess the reliability and accuracy of the On-Site Visit Tool (OSVT) assigned to the Case Manager or Support Coordinator for completion during their routinely scheduled site visits, the nurse reviewers evaluated the frequency and thoroughness of these documents during their preparation for their own on-site reviews conducted in the individual's residence.

In summary, while the basic structure and process of the ISR Study remains consistent with its original design, increased collaboration with DBHDS has resulted in the refinement of its inquiry and broadened its inclusion in the information utilized to strengthen the Commonwealth's oversight of the community-based services and supports provided to individuals with complex medical needs.

Without a doubt, in addition to the amicable and productive cooperation and information-sharing discussions, there are clear benefits to the collaboration occurring with the ISR Studies. Family members and residential providers repeatedly expressed appreciation for the information and guidance provided to them by the nurse reviewers. One parent who was initially very resistant to the site visit was especially pleased with the reassurance and recommendations given to her and her son. (After being contacted by the DBHDS nurse reviewer, the Support Coordinator was highly instrumental as well and attended the site visit interview to help the parent.) In several instances, the nurse reviewer for DBHDS, while at the residence, promptly contacted the mobile dental unit or the Mobile Rehabilitation Engineering (MRE) staff to schedule an appointment for either dental care or the repair of adaptive equipment. Conference calls held with the complement of nurse reviewers, after the completion of the site visits, permit further discussion and problem-solving regarding difficult situations, including the troubling concerns that were noted with pressure sores that one of the individuals in the selected sample had developed during a hospitalization.

The conclusion of this ISR Study will again allow the findings to be carefully considered to determine if additional actions are necessary or if any modifications to the processes are warranted. The scheduling of future conversations between the leadership team of OIHSN and the Independent Reviewer's consultants is underway in preparation for the next round of reviews.

26th Review Period Study

The ISR Study is conducted twice annually in order to document the Commonwealth's actions towards compliance with the obligations outlined in Table 1. The findings from previous Studies were analyzed according to the Compliance Indicators listed below. The current Study's analysis reflects the Terms that are related to the Indicators and have been agreed to in the Permanent

Injunction. These Terms will be in effect for future Studies.

TABLE 1		
Related Compliance Indicator	**Term**	
18.9 DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018 for FY 2018. The utilization rate is defined by whether the hours for the service are identified as a need in an individual's ISP and then whether the hours are delivered. Data will be tracked separately for EPSDT and waiver funded nursing. Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time. 29.20 The Commonwealth shall meet the following: a. At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam.	38.The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with private duty nursing identified in their ISP or prescribed under EPSDT receive 80% of the hours identified as needed on the CMS485 or DMAS62 forms. 39. The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with skilled nursing identified in their ISPs or prescribed under EPSDT will have their skilled nursing needs met 80% of the time. 40. The Commonwealth will work to achieve a goal that 86% of individuals who are supported in residential settings and have coverage for dental services will receive an annual dental exam. 54. The Commonwealth will work to achieve a goal that 86% of individuals supported in residential settings receive annual physical exams.	

In January 2025, the Independent Reviewer determined that the 26th Review Period's ISR Study would focus on individuals with complex medical needs. The Study's sample was drawn from the cohort of all individuals living in Regions II or IV with DD Waiver services and SIS level 6 needs who had an annual ISP meeting between September 1, 2024 and October 31, 2024. Thirty individuals and a group of 12 alternates were randomly selected. The Independent Reviewer retained the same team of consultants, as in all previous studies of individuals with complex medical needs, to complete the work.

There were numerous conversations with DBHDS leadership staff throughout the planning process. Staff from OIHSN were exceptionally responsive to the many requests for information/data and for help with planning and scheduling the fieldwork. Their prompt attention and collegial interactions are very much appreciated.

Fifteen individuals were selected for review in each of the two selected Regions. The site visits were completed by three teams consisting of one nurse from OIHSN and one nurse consultant working for the Independent Reviewer. These teams collaborated in the prior two Studies and are well-versed in the Monitoring Questionnaires and protocols for the interviews. All nurses were provided documents to examine prior to the site visits. These documents included the current ISP, Case Manager notes, Risk Assessments, incident reports, and OSVTs. Additional

documents related to the management of each individual's health needs and supports were reviewed during the site visit itself.

Although the template for the ISP had been modified by DBHDS to include a check box indicating whether nursing services were to be authorized, that ISP form was not in use during the period reviewed and none of the individuals' ISPs included that modification. All ISPs are documented as current.

The ISR nurse reviewer's interview with the individual's primary caregiver is an essential part of the review process. Using a script prepared by the Independent Reviewer, DBHDS identifies and then contacts the caregiver in order to explain the purpose of the Study and to elicit their cooperation. This part of the Study process is exceptionally well-done by DBHDS staff. The Independent Reviewer's Team Leader follows the introductory calls with a second contact in order to provide additional information, if necessary, and to schedule the site visit at the residence. The site visits occurred as scheduled with one unfortunate exception. Individual 27, who lived with his family in Region IV, died just prior to the anticipated site visit. There wasn't sufficient time to replace him, so the final sample consisted of 29 individuals rather than 30, as originally planned.

As referenced above, this sample is not sufficient to generalize its findings or any of its identified themes to all individuals with complex medical needs or for determining compliance with the specified goals of the Terms.

Characteristics of the Sample

The sample includes 15 males and 14 females. Ages range from 17 to 85 with the plurality of the adults (38%) between the ages of 21 and 30. There are two young people, aged 17 and 18, and the oldest person is 85 years old. (This woman was noted to have a very satisfying lifestyle that promoted her independence to a high degree.)

Language abilities vary across the sample. Seven people (24%) are able to speak for themselves; five people (17%) have limited spoken language and need some staff support. The majority of the individuals reviewed, however, either use gestures, vocalizations, or facial expressions (55%.) One other person is identified with narcolepsy and her face is impassive. The barriers to communication clearly underscore the essential requirement that caregivers are very familiar with the person's needs and preferences and are skilled in understanding them.

Nine individuals (31%) live in group homes; seven individuals (24%) live in sponsored homes; and 13 individuals (45%) live with family in their own homes. Some of the sponsored homes are with family members.

Everyone in the sample uses some type of adaptive equipment. Nineteen individuals (66%) require a wheelchair; seven individuals (24%) require support when they walk; one individual (3%) is confined to bed.

A Demographic Table is included as an Attachment.

Discussion of Major Themes and Initial Findings

The themes discussed below relate to the specified goals of the Terms of the Permanent Injunction. Information is drawn from the 29 Monitoring Questionnaires completed during the Study, including their Issues Pages. The Issues Page is an important component of the review process. It supplements and/or explains the score to a specific question or identifies recommendations that might contribute to the well-being of the individual or his/her family or caregiver. The Issues Pages are discussed at length as part of the follow-up work involving DBHDS's remediation process.

Theme: The reliability and consistency of sufficient nursing supports is absolutely critical to the continuity of the individual's health care and for the stabilization of the household as a whole.

The nurse reviewers confirmed the complex, often very serious, medical conditions of all individuals in the sample. They each have risks that depend on continuity of care and the skill of the caregiver in providing the requisite healthcare supports, as prescribed by clinical professionals, and as delineated in the ISP. Choking risks are present for 25 individuals (86%); 14 people (48%) are tube fed; one person has Prader-Willi syndrome, one person has PICA risks; 9 people (31%) either have a history of pressure ulcers/skin breakdown or are currently being treated for such; 4 people (14%) have tracheostomies and require a ventilator; and 9 people (31%) are experiencing seizures.

As noted above, everyone in this sample required some type of adaptive equipment for mobility, sleeping, lifting, eating, bathing and/or toileting. This equipment was observed during the site visit and its condition was documented. In several instances, while on site, DBHDS contacted MRE staff to schedule necessary repairs.

During the site visits, some family members were very candid about the weight of the responsibility they felt in their role as a caregiver. They were not always aware of the resources that could be accessed for additional support, including the Commonwealth's MRE staff and the dental services performed at VCU or by the mobile dental units. When the nurse reviewers discussed this information with them, they were very appreciative and promised to follow the recommendations. Nonetheless, this also raises a question about the role of the Case Manager/Support Coordinator in assisting the family to resolve their concerns and secure needed health resources.

Theme: The findings from DBHDS and the Independent Reviewer's team agree that 13 of the individuals reviewed (45%) are authorized for nursing services during this specific Study's cycle. All individuals who require nursing services have a completed CMS 485 form. With the exception of Individual 11, the number of nursing hours are included in Part V of the ISP. (Although there is a completed CMS 485 in her records, the Part V document itself for Individual 11 does not include the number of authorized nursing hours.)

None of the individuals in this sample were newly authorized for nursing hours.

Each of the individuals authorized for nursing services received Private Duty Nursing (PDN).

This finding is surprising, as it was expected that there would be at least some people with authorization for Skilled Nursing services. In planning for the next ISR Study, this finding should be discussed further, in case there are implications for the selection of the next sample.

Unlike the last Study's findings, the reports from this Study indicate few complaints regarding the availability or competence of assigned nursing staff. The parent of Individual 26 commended the continuity of her daughter's nursing care over a period of ten years. The parent for Individual 16 reported problems with finding the full complement of nurses, especially on Friday and Sunday mornings. The parent for Individual 29 is quite upset because of a change in nursing personnel due to EPSDT regulations regarding the age of the person. Further education and support are recommended for this parent as she adjusts to the change.

Theme: DBHDS and the Independent Reviewer's team agree that, of the 13 individuals authorized for nursing services, all received some nursing hours but only 8 or 62% received at least 80% of their authorized hours.

The underlying reasons for the lack of nursing hours, for those individuals who are reported with fewer than 80%, will require further discussion with OIHSN. Although it is understood that there may not yet be billing for all of the nursing hours provided, due to the time permitted by the Department of Medicaid Assistance Services (DMAS) for nursing hours to be submitted for payment, any additional factors are not identified during the ISR Study itself. As referenced above, Individual 16 is having difficulty finding nursing coverage on certain days. Individual 3 lives in a six-person group home and other residents also receive nursing care. There was no information about the reasons for a lack of nursing hours obtained from the reviews of Individuals 4, 22 and 30.

The chart below summarizes the status of nursing hours for each person in the 26th Review Period Study.

Summary of Individual Findings

ID #	Nursing Services Needed	ISP Indicated Nursing Hours Needed	Received Some Authorized Nursing Hours	80% of Authorized Nursing Hours Were Received	PDN Nursing	Skilled Nursing
01	No	No	NA	NA	NA	NA
02	No	No	NA	NA	NA	NA
03	Yes	Yes	Yes	No	Yes	No
04	Yes	Yes	Yes	No	Yes	No
05	No	No	NA	NA	NA	NA
06	No	No	NA	NA	NA	NA
07	No	No	NA	NA	NA	NA
08	No	No	NA	NA	NA	NA
09	No	No	NA	NA	NA	NA
10	No	No	NA	NA	NA	NA
11	Yes	No*	Yes	Yes	Yes	No

12	No	No	NA	NA	NA	NA
13	Yes	Yes	Yes	Yes	Yes	No
14	Yes	Yes	Yes	Yes	Yes	No
15	Yes	Yes	Yes	Yes	Yes	No
16	Yes	Yes	Yes	No	Yes	No
17	No	No	NA	NA	NA	NA
18	No	No	NA	NA	NA	NA
19	No	No	NA	NA	NA	NA
20	Yes	Yes	Yes	Yes	Yes	No
21	Yes	Yes	Yes	Yes	Yes	No
22	Yes	Yes	Yes	No	Yes	No
23	No	No	NA	NA	NA	NA
24	No	No	NA	NA	NA	NA
25	No	No	NA	NA	NA	NA
26	Yes	Yes	Yes	Yes	Yes	No
27	-	-	DECEASED	-		
28	No	No	NA	NA	NA	NA
29	Yes	Yes	Yes	Yes	Yes	No
30	Yes	Yes	Yes	No	Yes	No
%	**(13/29) 45%**	**(12/29) 41%**	**(13/13) 100%**	**(8/13) 62%**		

*****CMS 485 completed. Part V did not specify the number of nursing hours. (See MQ 48.d.3) Nursing hours are authorized and provided to this person despite the omission in Part V.

Theme: Among the small sample reviewed, progress is again evident in the provision of an annual physical exam within the previous 14 months.

It is documented that all but one of the individuals (97%) in the current sample received an annual physical exam in the time period under consideration.

Based on the information obtained, the Independent Reviewer's nurses are recommending in response to Question # 138 that the following individuals have further review to ensure that their health care needs are met: 1) Individual 10 has trouble accessing mental health services; 2) Individual 14 has difficulty finding medical and dental providers; 3) Individual 16's adaptative equipment is old and in need of repair or replacement; 4) Individual 18 should be reassessed, once her new tests are completed, to determine whether all supports are in place for her osteoarthritis; 5) Individual 20's diagnosis of narcolepsy should be evaluated; and 6) the prescription of Quetiapine for Individual 24's anxiety should be reviewed further by a psychiatrist.

These recommendations will be discussed again with OIHSN as part of the remediation activities to be conducted now that this ISR Study is completed.

Theme: Among the small sample reviewed, progress in providing annual dental exams has improved but is still insufficient to meet the 86% specified goal for this Term. DBHDS and the Independent Reviewer's findings concur that only 69% of the individuals reviewed received the requisite annual dental exam.

It is significant that everyone in the sample has had dental coverage under the State Medicaid plan since July 1, 2021.

The problems with obtaining dental care were found to be as follows: 1) There are difficulties finding dentists who accept Medicaid; 2) individuals with specialized healthcare needs, such as the use of a ventilator, cannot find dentists with the required expertise; 3) some family caregivers do not schedule a dental exam because of a fear of Covid-19 or because their son or daughter does not cooperate with a dental appointment. These reasons are documented for Individuals 2, 7 and 25; and 4) some Case Managers/Support Coordinators do not appear to know of the resources available through the efforts of DBHDS to address the lack of dental care resources.

After guidance stressing the importance of dental care was discussed during the site visits, by the nurse reviewers, the parents who are hesitant to schedule dental exams stated that they would reconsider that decision. Again, this reassurance should be provided routinely by the Case Manager/Support Coordinator so that delays in dental care can be avoided to the greatest extent possible. Additional training may be warranted for the Case Manager/Support Coordinator assigned in these situations.

The chart below summarizes findings from the Monitoring Questionnaires regarding the provision of an annual physical and dental exam.

ID#	Annual Physical Exam	Annual Dental Exam	Dental Exam Notes
01	Yes	Yes	
02	Yes	No	Needs sedation. Cannot find dentist.
03	Yes	Yes	
04	Yes	Yes	
05	Yes	Yes	
06	Yes	No	Visit cancelled. VNS battery low. On wait list for another appointment.
07	Yes	No	Aged out of pediatric dentist. Cannot find dentists taking insurance.
08	Yes	No	No reason. Now has appointment scheduled.
09	Yes	Yes	
10	Yes	Yes	
11	Yes	Yes	
12	Yes	Yes	
13	Yes	Yes	
14	Yes	No	Cannot find dentist accepting Medicaid.
15	Yes	Yes**	Appointment occurred just within 14 months.
16	Yes	No	Mother declines. Fear of Covid-19.
17	Yes	Yes	
18	Yes	Yes	

19	Yes	Yes	
20	Yes	Yes	
21	Yes	No	Uses ventilator. Cannot find dentist.
22	Yes	Yes	
23	Yes	Yes	
24	Yes	Yes	Edentulous. Variance approved.
25	No*	No	Uncooperative. Mother avoids dentist visits as a result.
26	Yes	No	Family declines. Fear of Covid-19.
27	Deceased	-	
28	Yes	Yes	
29	Yes	Yes	
30	Yes	Yes	
%	**(28/29) 97% Received the exam**	**(20/29) 69% Received the exam**	

*No reason given for failure to schedule a physical exam.

** Discrepancy with DBHDS due to difference in calculating timeframe. Will issue clearer instructions for next ISR to avoid inconsistency.

Theme: Over two review periods, DBHDS's IMNR process for a selected sample of 60 randomly selected individuals with complex health needs, as conducted by DBHDS's OIHSN nurses, effectively collects, and analyzes data and carefully documents concerns with the management of individuals' health needs. DBHDS's nurses also promptly recommended corrective actions, i.e., remediation plans, and, in certain more urgent cases, initiated the implementation of remediation plans during the site visit itself.

As referenced earlier, the prompt responsiveness of DBHDS's nurse reviewers to the concerns noted during the site visits has been a very commendable aspect of the collaborative work underway. Their work continues after the site visit is completed as they prepare reports/guidelines regarding the remedial actions that are required to be addressed.

As in the follow-up to the 24th and 25th Review Periods, a subset of individuals from the 26th Review Period will be selected for follow-up review of DBHDS's remediation process, based on the incomplete or inadequate supports identified during its ISR Study.

There were 11 people with follow-up inquiries from the 25th ISR Study conducted in 2024. DBHDS identified each of these individuals to receive remedial actions after the nurse reviewers identified concerns during their site visits and the DBHDS nurses filed reports indicating the need for remediation plans.

Prior to the site visits for the current ISR Study, the Independent Reviewer's nurses were instructed to contact the caregivers for each of these 11 people in order to determine whether remediation plans were developed, tracked effectively, and revised, if necessary. They were also instructed to assess whether the issue/concern was completely resolved.

The findings from this set of inquiries are instructive:

1) Remediation plans were developed for 10 of the 11 individuals (91%).
2) Remediation plans were tracked effectively for 5 individuals (45%).
3) Remediation plans were revised as necessary in 4 of the 8 applicable cases (50%).
4) Remediation of the issue/issues were completed for 4 of the 11 people (36%).

These findings will be shared and discussed in a future meeting with OIHSN. As noted in the follow-up conducted after the 24th Review Period, it may be necessary for DBHDS to reframe the actual action to be remedied. For example, if someone requires a dental appointment, the correct remedial action is not only "scheduling" the appointment but also "completing" it and ensuring that any requisite dental care is actually provided to the person.

Overall, the intent of DBHDS's remediation initiative is solid and their nurse reviewers are effectively implementing responsibilities to report unmet health needs. However, DBHDS's current overall remediation process is not yet sufficient. To fulfill the Term 44 requirement to remediate and address the final outcome, additional actions are still needed to ensure that all necessary healthcare supports are provided in a complete and timely manner. An assessment of the gaps in or barriers to the remedial actions addressing and resolving the identified deficiency for each individual may be useful in DBHDS's ongoing efforts to strengthen its system of community-based services.

Theme: The OSVTs are an important part of the effort to identify and address inadequate or absent health-related supports. They are required to be completed at a frequency determined by the type of Case Management/Support Coordination, and the schedule of visits provided to the person. Enhanced Case Management/Support Coordination requires monthly reporting. General Case Management/Support Coordination requires quarterly documentation.

The OSVTs are among the documents requested for review for the ISR and IMNR studies. An additional question was added to the Monitoring Questionnaire to specify the adequacy of the forms for each person in the sample. Nurse reviewers were asked to comment on any problems with the frequency or accuracy of the forms. The findings are as follows:

> MQ#35: Are OSVTs completed by the Case Manager with the frequency required by DBHDS?

There is a positive Yes response for 24 of the 29 (83%) individuals. The well-documented facts for Individual 17 are commended. There is inaccurate information in the forms for four of the Individuals (11, 14, 22 and 26.) There was some OSVT documentation missing for four other people (Individuals 1, 7, 9, 29.) Overall, 14 of 29 individuals (48%) did not receive the required frequency of OSVT assessments or the completed OSVT documents included inaccurate or missing documentation.

The ISR Study's specific findings from its review of the OSVTs are included on the individual Issues Pages of their ISR Monitoring Questionnaires. After OIHSN has had the opportunity to review these documents, in-depth conversations can be held. Further discussions with OIHSN about the quality of the OSVT process are welcomed. It is clear from previous conversations

with OIHSN that its review of the effectiveness of the Case Manager's OSVT assessments is an important initiative and that DBHDS intends for its refinement of the process to be ongoing. To date, OIHSN has been very receptive to the recommendations by the Independent Reviewer's team.

Concluding Comments

Although the ISR Study process is well-established, it is important that there be continued attention to the need to refine details and protocols for its implementation in the future. The collaboration between DBHDS and the Independent Reviewer and his team enable this progress to be made in an effective and efficient manner. The thoughtful interaction and diligent work of DBHDS leadership and the staff of OIHSN is both respected and greatly appreciated by the ISR team members who work with them.

Before the next ISR Study gets underway, it is recommended that the Independent Reviewer and DBHDS leadership discuss issues related to: 1) the remediation process; 2) the Case Managers/Support Coordinators' completion of the OSVTs; and 3) the need for DBHDS to provide further guidance to Case Managers/Support Coordinators to improve certain healthcare practices related to the health risks faced by many individuals with complex medical needs, such as the prevention/treatment of pressure ulcers and skin breakdown, that may affect the individuals under their responsibility. In addition to these inadequate findings, it is also important to discuss the very positive practices that the nurse reviewers documented during the site visits so that these practices can be duplicated and further contribute to the well-being of people with complex medical needs.

Finally, the fact that individuals, families, and residential providers continue to be receptive to the site visits and appreciative of the nurse reviewers' experience and expertise should not go unrecognized. The nurse reviewers assigned by DBHDS and the Independent Reviewer are to be commended for their skill in engaging caregivers, especially those who may be initially cautious or somewhat resistant to sharing detailed personal information.

ATTACHMENTS
Demographic Tables

Region		
II	15	52%
IV	14	48%

Sex		
Male	15	52%
Female	14	48%

Age Group		
Under 21	2	7%
21-30	11	38%
31-40	7	24%
41-50	5	17%
51-60	2	7%
61-70	1	3%
71-80	0	0%
81-90	1	3%
Over 90	0	0%

Mobility Status		
Walks without support	2	7%
Walks with support	7	24%
Uses wheelchair	19	66%
Confined to bed	1	3%

Communication Method		
Spoken Language, Fully Articulates Without Assistance	7	24%
Limited Spoken Language, Needs Some Staff Support	5	17%
Communication Device	0	0%
Gestures	1	3%
Vocalizations	8	28%
Facial Expressions	7	24%
Other *	1	3%

*severe narcolepsy; face is impassive

Residence Type		
Group home	9	31%
Own/family home	13	45%
Sponsored home	7	24%

SUMMARY OF SELECTED KEY DATA

INDIVIDUAL'S SUPPORT PLANS/PLAN OF CARE

		Yes	No	NA	CND
34.	a. Is the Individual's Support Plan current?	29	0		
35.	Has the Individual's Support Plan been modified as necessary in response to a major health-related event for the person, if one has occurred?	3		26	
	Are OSVTS completed by the Case Manager with the frequency required by DBHDS?	24	3		2
39.	Does the Individual's Support Plan have specific and measurable outcomes and support activities?	11	18		
45.	Does the individual require adaptive equipment?	29			
	a. If Yes, is the equipment reported as available?	25	4		
	b. If No, has it reportedly been ordered?	3	1	25	
	c. If available, is the equipment reportedly in good repair and functioning properly? If No, list any equipment in need of repair:	20	7	2	
	d. If No, has the equipment reportedly been in need of repair more than 30 days?	5	2	22	
	e. If No, has anyone reportedly acted upon the need for repair?	5	2	22	
46.	Is staff/family member knowledgeable and able to assist the individual to use the equipment?	29			
47.	Is staff/family member assisting the individual to use the equipment as prescribed?	29			
48.	Is the individual receiving supports identified in his/her Individual Support Plan?				
	Supports:				
	a. Residential/In-Home	29			
	b. Medical (physician and medical specialists)	29			
	c. Dental	20	9		
	d. Health (nursing and other health supports)	29			
	1. Based on the health and safety needs identified in the ISP, and after consulting with a qualified health professional, did the provider/family identify that nursing supports were required?	13	16		

	2. If so, after the assessment by a qualified health professional, did the need for nursing services result in the completion of a Health Care Plan (CMS 485)? 3. If so, did the schedule of activities and/or Part 5 specify the number of nursing hours identified on the CMS 485 to be provided?	13 12	1	16 16	
56.	Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	27		2	

SECTION 6: HEALTH CARE

		Yes	No	NA	CND
97.	If ordered by a physician, was there a current physical therapy assessment?	5	5	19	
98.	If ordered by a physician, was there a current occupational therapy assessment?	2	4	23	
99.	If ordered by a physician, was there a current psychological assessment?	1		28	
100.	If ordered by a physician, was there a current speech and language assessment?	7	1	21	
101.	If ordered by a physician, was there a current nutritional assessment?	7	1	21	
102.	Were any other relevant medical/clinical evaluations or assessments recommended?	13	16		
103.	Are there needed assessments that were not recommended?	11	18		
104.	Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments? a. OT b. PT c. S/L d. Psychology e. Nutrition f. Other	 6 12 5 3 11	 1 1 1	 22 16 23 26 18 29	
105.	Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	28	1		
106a.	Did the individual have a dental examination within the last 12	20	9		

	months or is there a variance approved by the dentist?				
106b.	Does the individual have coverage for dental services?	29			
107.	Were the dentist's recommendations implemented within the time frame recommended by the dentist?	17	5	7	
108.	Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	21	5	3	
109.	Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	27	1	1	
110.	Is lab work completed as ordered by the physician?	27	2		
112.	Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	17	1	11	
114.	Is there monitoring of fluid intake, if applicable per the physician's orders?	12		17	
115.	Is there monitoring of food intake, if applicable per the physician's orders?	6		23	
116.	Is there monitoring of tube feedings, if applicable per the physician's orders?	13		16	
117.	Is there monitoring of seizures, if applicable per the physician's orders?	20		9	
118.	Is there monitoring of weight fluctuations, if applicable per the physician's orders?	16		13	
119.	Is there monitoring of positioning protocols, if applicable per the physician's orders?	15		14	
130.	Does this individual receive psychotropic medication?	18	11		
133.	If Yes, is there documentation that the individual and/or a legal guardian has given informed consent for the use of psychotropic medication(s)?	8	9	12	

134.	Does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic medications, using a standardized tool (e.g., AIMS) at baseline and at least every 6 months thereafter)?	1	2	19	7
135.	Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.?	11		12	6
136.	Is there any evidence of administering excessive or unnecessary medication(s), including psychotropic medications?		26		3

SUMMARY QUESTIONS

		Yes	No	NA	CND
94.	Is the residence free of any safety issues or needed repairs?	24	3		2
137.	Based on documentation reviewed and interview (s) conducted, is there any evidence of actual or potential harm, including neglect?	1	28		
138.	In your professional judgment, does this individual's health care require further review?	5	24		

SUPPLEMENTAL QUESTIONS

		Yes	No	NA	CND
141.	Has there been a psychiatric hospitalization?		29		
142.	Have there been any events related to the individual's high risk health factors (i.e., aspiration, choking, constipation, falls, etc.)	12	17		
143.	Has there been an emergency room visit or unexpected medical hospitalization?	15	14		
147.	Has there been the use of physical, chemical, or mechanical restraint?		29		
152.	a. Did the Case Manager identify an unidentified or inadequately addressed health-related risk, injury, need, or change in status?	5	5	19	

APPENDIX F

Provider Training

by

Chris Adams, MS

TO: Donald Fletcher, Independent Reviewer

FROM: Chris Adams, MS, Consultant

RE: 26th Study Report: Provider Training

DATE: May 16, 2025

Introduction/Background

This report constitutes the eighth review of the Consent Decree's, and now the Permanent Injunction's (PI) requirements that the Commonwealth must meet certain criteria regarding training and competency of direct support professionals. The PI, approved on January 15, 2025, includes two Terms that relate to this topic.

Term 47 – Training Requirement Compliance (related to indicator 49.12) requires that at least 86% of DBHDS licensed providers receiving an annual inspection have a training policy meeting established DBHDS requirements. Additionally, Term 47 requires DBHDS to take appropriate action if providers fail to comply with training regulations. In previous studies, the percentage threshold required by the specified measurable goal that is now in Term 47 was determined through review of licensing inspection results completed during the calendar year and verified by review of provider training policies for a sample of providers from all five regions.

Based on the data reported by DBHDS for the three most recent studies, the Commonwealth has not yet achieved the 86% threshold requirement at 12VAC35-105-450 and Term 47. Specifically:

- During CY2022, 973/1156 licensed providers (84.17%) met these requirements during their annual licensing inspection.
- During CY2023, 819/1105 licensed providers (74.12%) met these requirements during their annual licensing inspection.
- During CY2024 (through 08/12/2024), 881/1192 providers (73.9%) met these requirements during their annual licensing inspection.

Based on the Consultant's sample reviews over the past three studies, providers generally include the required training topics and frequency of retraining in their policies. However, the most significant barrier to compliance is the inconsistent availability of documentation verifying employee training completion and currency noted by Licensing Specialists in their annual licensing inspections.

Term 48 – Training and Competency of Direct Support Professionals (related to indicator 49.4) outlines the training and core competency requirements for Direct Support Professionals (DSP) and their supervisors as defined in 12VAC30-122-180, effective March 31, 2021. In November 2021, the Commonwealth made modifications to address concerns about the adequacy of the Department of Medical Assistance Services (DMAS) provider review process in evaluating the Commonwealth's compliance with these requirements. These modifications included using Quality Service Reviews (QSRs) to provide objective data for measuring the training threshold specified in Term 48. The Commonwealth established that, to successfully achieve the

requirements of Term 48, 95% of providers in the sample must meet two distinct measures. These measures are (1) the percentage of provider agency staff meeting orientation and training requirements, and (2) the percentage of DSPs meeting competency training requirements. Since implementation of these modifications, the Consultant's studies assessed whether the scoring and data validation procedures produced valid and reliable data to meet the 95% threshold required by Term 48, described the processes through which data was obtained to measure achievement of the requirements, and described the verification, validation, and testing procedures for this data performed by the data analyst.

The percentage threshold required by Term 48 is determined based on findings from the Department's most recent Quality Service Review (QSR) round. While final results from QSR Round 6 have been updated in this report, Round 7 was recently initiated, and its results will not be available for review until the 27th study. Due to the absence of Round 7 results, the Independent Reviewer deferred the Indicator rating until sufficient new data is available.

Table 1

Related Compliance Indicator	Term	26th Review
49.12 – At least 86% of DBHDS licensed providers receiving an annual inspection have a training policy meeting established DBHDS requirements for staff training, including development opportunities for employees to enable them to support the individuals' receiving services and to carry out their job responsibilities. These required training policies will address the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and	**Term 47: Training Requirement Compliance.** The Commonwealth will work to achieve a goal that 86% of DBHDS-licensed providers receiving an annual inspection will have a training policy that meets established DBHDS requirements. DBHDS will take action it determines appropriate if providers fail to comply with training requirements required by regulation.	**Deferred**

Related Compliance Indicator	Term	26th Review
accessible to the department. DBHDS will take appropriate action in accordance with Licensing Regulations if providers fail to comply with the training requirements required by regulation. The results of the 24th study noted that DBHDS was not able to achieve the 86% threshold requirement for this CI. The Office of Licensing initiated numerous initiatives to reach the 86% threshold, but these efforts have not yet proven sufficient to meet the threshold.		
49.4 – At least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180. In the 24th study, the determination of whether the requirements for CI 49.4 was deferred due to the pending initiation of QSR Round 6.	**Term 48 – Training and Competency of Direct Support Professionals.** The Commonwealth will work to achieve a goal of at least 95% of Direct Support Professionals and their supervisors receive training and competency testing in accordance with 12 VAC 30-122-180 as in effect on the date of this Order or as may be amended.	**Deferred**

26th Period Study

The Consultant who conducted prior studies on the Indicator related to this Term also conducted the 26th period study, which examined DBHDS-provided documents and records related to improving the accuracy and consistency of Licensing Specialist determinations regarding provider compliance with 12VAC35-105-450. This regulation outlines the required content of provider staff training policies. The study also reviewed training content and participation levels evaluating engagement from service providers and Licensing Specialists in relevant DBHDS training and process improvements for QSR Round 7 to assess adjustments made to enhance quality service reviews.

Term 47 – Training Requirement Compliance (related to indicator 49.12) requires that at least 86% of DBHDS licensed providers receiving an annual inspection have a training policy meeting established DBHDS requirements. *12VAC35-105-450* codifies this requirement. Additionally, Term 47 requires DBHDS to take appropriate action if providers fail to comply with training regulations. *12VAC35-105-50, 100, 110, and 115* describes available sanctions for providers with significant or recurring citations. Previous studies have verified that the Office of Licensing has taken enforcement actions consistent with the guidelines established in the above-referenced regulations. There have been no changes to these requirements since their effective date.
This 26th study included review of documentary evidence of implementation of relevant corrective/improvement initiatives by the Office of Licensing since 12/01/2024, interviews with state officials and subject matter experts, and verification of the Commonwealth's relevant Process Documents and Attestations. To verify and validate Licensing Specialist determinations specific to compliance with *12VAC35-105-450* and Term 47, the Consultant reviewed inspection results for a sample of 30 providers across five regions, conducted by 29 Licensing Specialists between 01/01/2025 and 02/28/2025. Based on the review of the sample providers' training policies, the Consultant agreed with 27/30 (90%) determinations, a significant improvement over the findings of a similar sample review conducted during the 25th review where the Consultant agreed with 33/40 (83%) determinations. However, given the small size of the sample available for review during this 26th study, the results cannot be generalized to the entire CY2025 annual licensing cycle results. The Consultant will complete a similar sample review in the 27th period study with results combined for a comprehensive data set comparable to previous studies. Without complete information being available, the compliance rating for Term 47 for this 26th period study is Deferred.

Term 48 – Training and Competency of Direct Support Professionals (related to indicator 49.4) outlines the training and core competency requirements for Direct Support Professionals (DSP) and their supervisors as defined in *12VAC30-122-180*, effective March 31, 2021. In November 2021, the Commonwealth modified the process to begin using specific results from Quality Service Reviews (QSRs) to provide objective data for measuring the training threshold specified in Term 48. The Commonwealth established that, to successfully achieve the requirements of Term 48, providers in the sample must meet two specific measures at the 95% threshold. These measures are (1) the percentage of provider agency staff meeting orientation and training requirements, and (2) the percentage of DSPs meeting competency training requirements.

This 26th study included review of documentary evidence of implementation of relevant corrective/improvement initiatives in the QSR process, interviews with state officials and subject matter experts, and verification of the Commonwealth's relevant Process Documents and Attestations. The results from QSR Round 6 were updated from information submitted in the 25th study report; however, those results did not show significant change from the results in Round 5. QSR Round 7 began during this 26th study but results will not be available for review until the 27th study. Without the results of QSR Round 7 being available, the Independent Reviewer determined that a rating for the 26th study would be Deferred.

The table below details the facts, analysis, and conclusions drawn from the review of the Commonwealth's efforts to achieve and sustain the requirements of Permanent Injunction Terms 47 and 48.

TABLE 2			
Terms and Actions	**Facts**	**Analysis/Conclusion**	**26th**
47. The Commonwealth will work to achieve a goal that 86% of DBHDS-licensed providers receiving an annual inspection will have a training policy that meets established DBHDS requirements. DBHDS will take action it determines appropriate if providers fail to comply with training requirements required by regulation. To achieve that goal, the Commonwealth will take the following actions:	DBHDS regulation *12VAC35-105-450* mandates a provider training policy, while *12VAC35-105-50, 100, 110, and 115* outline negative actions and sanctions for providers with recurring citations. The *Annual Compliance Determination Chart* tool helps Licensing Specialists understand compliance expectations and assessment procedures. Despite improvements, the required 86% compliance threshold has not been met in the past three cycles: • **CY22:** 973/1156 (84.17%) • **CY23:** 819/1105 (74.12%) • **CY24:** 881/1192 (73.91%) Before each licensing cycle,	DBHDS mandates training policies under licensing regulation *12VAC35-105-450*. Additionally, regulations *12VAC35-105-50, 100, 110, and 115* outline negative actions and sanctions for providers with significant or recurring citations. The DBHDS Office of Licensing (OL) uses the *Annual Compliance Determination Chart* to guide Licensing Specialists on compliance expectations. This chart also informs Licensing Specialists on assessment procedures during inspections. Despite ongoing revisions and enhanced guidance before each annual inspection cycle, the required 86% compliance threshold in Term 47 has not been met in the past three annual licensing inspection cycles: • CY2022: 973/1156 (84.17%) • CY2023: 819/1105 (74.12%) • CY2024: 881/1192 (73.91%) Before each annual licensing inspection cycle, OL expands and refines the *Annual Compliance Determination Chart* and provides comprehensive training and technical assistance for providers and Licensing Specialists, with a focus on §450 requirements. For the 2025 cycle, the chart was updated to differentiate requirements by provider type. This Excel-based tool remains a valuable resource for Licensing Specialists. Under §450, providers must develop and implement a training policy covering all regulatory requirements and maintain	26th - **Deferred**

	OL updates the Annual Compliance Determination Chart and provides training and technical assistance focused on §450. For 2025, the chart was refined to specify requirements by provider type and remains a useful reference. The Office of Community Quality Management offers ECTA support to providers who are non-compliant with regulations, including §450. An abbreviated sample review of 30 providers assessed compliance with §450 utilizing using data from January and February 2025 annual inspections. The Consultant agreed with 90% of Licensing Specialist determinations—an improvement from 83% in the previous study. As less than 50% of CY2025 inspections were completed at	documentation confirming employees and contractors have received the necessary training. Beyond annual training, the Office of Community Quality Management offers Expanded Consultation and Technical Assistance (ECTA) to providers found non-compliant with regulations, including §450. To provide preliminary evidence to DBHDS based on inspections conducted in January and February 2025, the Consultant reviewed documentation from a sample of 30 providers to assess whether Licensing Specialists evaluated §450 compliance per regulatory and chart guidelines. The Consultant concurred with 27 out of 30 Licensing Specialist determinations (90% agreement), an improvement from the 25th study, which recorded an 83% agreement rate. With less than 50% of CY2025 licensing inspections completed at the time of this study, the sample size remains insufficient to determine whether the Commonwealth meets Term 47 requirements. The Consultant will conduct a more comprehensive review in the 27th study period, integrating this preliminary analysis to generate a larger, comparable dataset. Due to incomplete information in the 26th study, the compliance rating for Term 47 is Deferred.	

	the time of this 26th study, the sample was insufficient to generalize compliance status. A more comprehensive review in the 27th study period will provide a larger dataset. Due to incomplete information, the compliance rating for Term 47 remains Deferred.		
47.a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with training requirements develop and implement a corrective action.	12VAC35-105-170 mandates that providers develop, submit, and implement a written corrective action plan (CAP) for each cited violation. The *2025 Annual Inspections for Providers of Developmental Services Memorandum* requires providers to comply with the training policy requirements outlined in 12VAC35-105-450 and to develop and implement a corrective action plan. The provider must also submit a revised training plan to OL for review and approval.	Under 12VAC35-105-170, providers must develop, submit, and implement a written corrective action plan (CAP) for each cited violation. The DBHDS Office of Licensing (OL), in its *2025 Annual Inspections for Providers of Developmental Services Memorandum*, mandates compliance with the training policy requirements in 12VAC35-105-450. Key components of this policy include: 1. **Assessment of Training Policy:** During annual licensing inspections, the Office of Licensing evaluates whether a provider's training policy meets regulatory standards. 2. **Corrective Action Plan (CAP):** If deficiencies are found, providers must submit a CAP detailing steps to achieve compliance. 3. **Revised Training Policy:** Providers must include an updated training policy in their CAP, explicitly outlining corrective actions taken to meet regulatory requirements. If the provider is cited for a violation, the protocol also requires the provider to develop and implement a corrective action	**26th - Completed**

		plan. The provider must also submit a revised training plan to OL for review and approval.	
47.b) Within three months of the date of this Order, DBHDS Quality Improvement Specialists will offer providers technical assistance, additional training, and specific actions related to the respective areas of underperformance.	The Office of Community Quality Improvement developed and implemented the Expanded Consultation and Technical Assistance (ECTA) process in 08/2024 that meets the requirements of this action.	The Expanded Consultation and Technical Assistance (ECTA) process, established by the Office of Community Quality Improvement and described in the *Expanded Consultation and Technical Assistance Standard Operating Procedures* effective August 23, 2024, offers technical assistance to providers. Among other focus areas, this assistance helps providers develop and implement employee training and development policies that comply with regulation 12VAC35-105-450. When a provider is found to be non-compliant with this regulation, the ECTA team reaches out to the provider to offer support in meeting the requirements outlined in §450. As of 02/2025, 591 invitations have been sent to providers. Of the 235 providers assigned a Quality Improvement (QI) Specialist, 161 (68.5%) have completed or are in the process of completing the ECTA process. The Office of Licensing (OL) issued a memorandum titled *Expectations Regarding 12VAC35-105-450 Provider Training and Development* on 04/01/2025 to guide providers on employee training and development. The memorandum includes example documents, such as a policy template for Employee Training and Development. The memorandum includes example documents, such as an Employee Training and Development policy template. Data collection is underway to monitor the utilization and effectiveness of these procedures. The actions taken to date evidence successful completion of the requirements of Term 47.b.	**26th - Completed**

47.c) Within six months from the date of this Order, for providers who are not compliant with training requirements for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's license as determined appropriate by DBHDS.	The Office of Licensing (OL) conducts annual licensing inspections, issuing a Corrective Action Plan (CAP) for any regulatory requirement with which a provider is found non-compliant. If a provider is non-compliant with a regulatory requirement in two consecutive annual inspections, they must participate in the Expanded Consultation and Technical Assistance (ECTA) process within 45 days of receiving their most recent approved CAP. Licensing requirements at *12VAC35-105-50, 100, 110, and 115* prescribe negative actions and sanctions that can be taken with providers with significant or recurring citations. Corresponding with the severity of continued non-compliance with one or more specific regulatory requirements. The OL protocols that address the	The Office of Licensing (OL) conducts annual licensing inspections to cite providers who fail to comply with regulatory requirements, including employee training policies outlined in 12VAC35-105-450. In response to any cited non-compliance, providers must develop and implement a Corrective Action Plan (CAP) for each citation. Additionally, licensing requirements at *12VAC35-105-50, 100, 110, and 115* prescribe negative actions and sanctions that can be taken with providers with significant or recurring citations. If a provider is cited for the same violation during two consecutive inspections, they must begin the Expanded Consultation and Technical Assistance (ECTA) process within 45 days of receiving their latest approved CAP. Detailed ECTA requirements are outlined in the *ECTA Standard Operating Procedures, effective August 23, 2024*. Continued non-compliance or failure to complete required consultation may lead to progressive enforcement actions, as defined in OL protocols and required by Term 47.c. These actions escalate based on the severity of the violations and include measures detailed in the protocol. The Consultant reviewed two *Corrective Action Plans* that confirmed adherence to the progressive enforcement actions required by Term 47.c. The established licensure inspection protocols, details of the progressive enforcement process, and examples of progressive enforcement actions taken by OL demonstrate that the Commonwealth has established and implemented protocols for issuing progressive enforcement actions to providers with repeat non-compliance, including violations of §450 and other	**26th - Completed**

	requirements of *12VAC35-105-50, 100, 110, and 115* outline the specific actions to be taken in response to ongoing non-compliance including those referenced in this action.	regulatory requirements. The above-described actions support the determination that the requirements of Action 47.c have been completed.	
47.d) Within 24 months of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess training requirements have established inter-rater reliability in conducting such assessments.	While the Office of Licensing (OL) has introduced procedural changes related to this action, these efforts do not establish a formal, measurable framework for continuously assessing inter-rater reliability. A comprehensive approach would require regular comparative evaluations of each Licensing Specialist at a set frequency, the generation of objective scores, and the aggregation of data for ongoing reliability assessments.	The Office of Licensing (OL) is implementing procedural changes to address this action, including: • **DD Inspection Training:** All Licensing Specialists will receive DD Inspection Training upon hire and annually. If issues arise regarding a Licensing Specialist's compliance determinations, additional relevant training will be provided. • **Unannounced Inspections:** Regional Managers will conduct unannounced inspections with each Licensing Specialist during their first three months of employment. They will observe the inspection process, provide feedback, and review draft reports to ensure adherence to regulations, guidance documents, and checklists. • **Parallel Inspection Determinations:** Regional Managers will assign tenured Licensing Specialists to new hires to conduct parallel inspections. This ensures consistent interpretation and compliance with regulations, guidance documents, and checklists. • **Quality Improvement Specialist Look-Behinds:** The Quality Improvement Review Specialist conducts a look-behind on two (2) completed and approved licensing inspection reports each week. While these actions are valuable and expected to improve consistency in compliance determinations, they do not establish	**26th – In Progress** **Due by 1/15/2027**

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<td>a formal, measurable framework for continuously assessing inter-rater reliability.

To fully meet the objectives of Term 47.d within the 24-month timeframe, OL should develop and implement a formal process for measuring inter-rater reliability. This process should include comparative evaluations of each Licensing Specialist at a set frequency, generate objective scores, and provide aggregated data for ongoing reliability assessments.</td>
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<td>48: The Commonwealth will work to achieve a goal that at least 95% of Direct Support Professionals and their supervisors receive training and competency testing in accordance with 12 VAC 30-122-180 as in effect on the date of this Order or as may be amended. To achieve that goal, the Commonwealth will take the following actions:</td>
<td>The regulation at 12VAC30-122-180 outlines the orientation and competency assessment requirements set forth in Term 48, with achievement measured through the QSR process.

The training and competency assessment processes required by this term are detailed in the Process Document DSP Comp Ver 007 (dated September 20, 2024) and the associated DSP Competencies Attachment B Attestation Statement (dated September 30, 2024).

The Commonwealth did not meet the 95% threshold required by Term 48 in either QSR Round 5 or QSR</td>
<td>Under DMAS regulation 12VAC30-122-180, DSPs and DSP Supervisors are mandated to complete training and competency testing. To ensure compliance, DBHDS utilizes Quality Service Review (QSR) data to evaluate two key outcomes:
• Outcome 1: Measures the percentage of provider agency staff who meet orientation and training requirements. This is assessed by reviewing training documentation for DSPs and the competency assessments provided by DSP Supervisors.
• Outcome 2: Evaluates the percentage of provider agency DSPs meeting competency training requirements through observations of DSPs providing support and supervisors monitoring their staff.
The table below provides a summary of the scoring for Outcome 1 (PCR) and Outcome 2 (PQR) in QSR Round 5 and Round 6. Data for Round 6 was documented in the Provider Data Summary Report, November 2024.

<table>
<tr><th></th><th>QSR R5</th><th>QSR R6</th></tr>
<tr><td>Req 1</td><td>235/302
77.81%</td><td>237/306
77.45%</td></tr>
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<td>26th - Deferred</td>
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	Round 6. However, efforts to refine processes and support providers in meeting training and competency testing requirements are ongoing. The Commonwealth continues to evaluate and refine processes and provide support to help providers consistently meet the training and competency testing requirements. A Quality Improvement Initiative initiated in July 2024 identified three key focus areas aimed at improving QSR scores for Requirements 1 and 2: The key focus areas are (1) Simplification of competency checklists; (2) Revision and simplification of provider training; and (3) Streamlined training to reintroduce providers to the requirements. The effectiveness of these efforts will be evaluated using the results from QSR Round 7.	<table><tr><td>Req 2</td><td>492/577 85.27%</td><td>519/599 86.64%</td></tr></table> Neither measure met the required 95% threshold**.** While the results for Requirement 1 (PCR) remained stable, the results for Requirement 2 (PQR) showed minor improvement. To address challenges in meeting the 95% compliance threshold, DBHDS has analyzed contributing factors and initiated improvements, including enhanced training and technical assistance for providers. In July 2024, a Quality Improvement Initiative (QII) was launched to focus on three key process changes: 1. **Simplifying DSP Competency Checklists**: Clarifies instructions and removes redundancies. 2. **Revising Training Materials**: Updates and refines guidance for improved clarity. 3. **Reintroducing Streamlined Resources**: Shares revised materials with the provider community. These efforts, led by the Provider Issues Resolution Workgroup (PIRW), were incomplete at the time of this 26th study. An assessment of the Commonwealth's effort to meet the requirements of Term 48 is deferred until the results of QSR Round 7 are complete and the Commonwealth has developed appropriate follow-up actions in response to the QSR findings specific to Term 48. These results and actions will be reviewed further in the 27th study.	

48.a) Within six months of the date of this Order, the Commonwealth shall determine, through a root cause analysis developed in collaboration with the provider and system issues resolution workgroups, why Direct Support Professionals and their supervisors do not receive training and competency testing per 12 VAC 30-122-180.	The Commonwealth conducted a root cause analysis coordinated by the Provider Issues Resolution Workgroup (PIRW) to determine why DSPs and their supervisors do not receive training and competency testing Per *12VAC 30-122-180*. The results of the root cause analysis provided information to identify specific focus areas to be addressed to achieve the goal that 95% of DSPs and their supervisors receive training and competency testing in accordance with *12 VAC 30- 122-180*. A Quality Improvement Initiative was undertaken in response to the findings from the root cause analysis (see details in §48.c below).	From 02/2024-05/2024, the Commonwealth conducted a root cause analysis and survey coordinated by the Provider Issues Resolution Workgroup (PIRW) and identified key factors preventing the achievement of the 95% compliance threshold under Term 48: 1. **Staff Turnover:** High rates affecting consistency in training and competency. 2. **Operational Challenges:** Providers' difficulty in implementing training and competency assessment processes. 3. **Documentation Issues:** A need for streamlined and simplified methods for recording training and assessment results. 4. **Training Materials:** Requirements to further standardize and simplify available guidance. The following priority actions were identified from the root cause analysis: 1. **Streamlining DSP Competencies:** Initially focusing on advanced competencies. 2. **Updating Resources:** Simplifying and refining training materials for clarity. 3. **Provider Training:** Delivering guidance on streamlined competencies and updated resources. In January 2025, the PIRW reviewed and recommended revisions to both basic and advanced competencies. These revisions are currently being addressed as part of ongoing efforts to reduce administrative burdens and improve compliance	**26th - Completed**

		processes.	
48.b) Based on the findings of the root cause analysis required by Paragraph 48(a), DBHDS will prioritize the findings for quality improvement, taking into account the anticipated impact to the system, including potential negative impacts to current staffing. DBHDS will implement a QII based on its prioritization consistent with continuous quality improvement principles and developed in collaboration with the provider and system issues resolution workgroups.	The Commonwealth launched a Quality Improvement Initiative (QII) to address findings from the Root Cause Analysis completed in May 2024. The initiative is currently underway.	The Quality Improvement Initiative document (*DSP SFY 24 QII Toolkit, approved 7/19/24*) outlines prioritized findings and initiatives addressing three focus areas: Streamlining DSP Competencies, Updating Resources, and Provider Training. Each heading includes specific action steps and timelines, with targeted completion dates ranging from 2/28/25 to 7/3/25. Current status updates for these action steps are documented in the *PIRW Education and Training Subcommittee Summary* and *Staffing Shortages Focus Group Meeting Notes (dated January 7, 2025*). The actions are ongoing, as noted in these references. Based on the available evidence, the Commonwealth has initiated all actions required under Term 48.b, although the work is planned and partially implemented, it is still in progress. Results of these initiatives are expected to be ready for review during the 27th study period.	**26th – In progress**
48.c) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Personal	The Commonwealth, through the Department of Medical Assistance Services (DMAS), has engaged Guidehouse to conduct a rate study of eleven service categories under the Developmental Disability Waiver. The study is expected to be completed by August	The Commonwealth, through the Department of Medical Assistance Services (DMAS), has engaged Guidehouse to conduct a rate study for services under the Developmental Disability Waiver. This includes the five service categories outlined in Term 48.c and six additional services. The study involves stakeholder input and a Provider Cost and Wage Survey. Based on the timeline in the *April 1, 2025 Guidehouse DMAS Developmental Disabilities Rate Study PowerPoint*, the timelines for completion of the various steps in the rate study process are as follows:	**26th – In progress**

Assistance Services, Companion Services, Respite Services, In-Home Support Services, and Independent Living Support Services by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Personal Assistance Services, Companion Services, Respite Services, In-Home Support Services, and Independent Living Support Services by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This	2025.	• April 1 – Kick-off meeting and review surveys • April 14 – Release surveys • May 12 – Receive survey responses • June 3 – Review survey results and rate modeling • July 29 – Discuss final rates and other program recommendations DMAS has created a DD Rate Work Group that convened December 12, 2024 for the first of a series of monthly meetings. The Work Group includes representatives of providers, advocates, and industry associations. The United States has provided input on how the Commonwealth directs Guidehouse to perform the rate study. The United States has engaged a national expert and has participated in vendor meetings with stakeholders. The United States has identified concerns asked questions and made recommendations about how the Commonwealth directs the vendor to perform the rate study. This action is planned and partially implemented. Its overall project target completion date is August 2025, with results to be presented during the 2026 general assembly session. The study's findings should also be available for review in the 27th period study.	

paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.			
48.d) If the Commonwealth does not achieve the goal within two years of the date of this Order after taking the actions in Paragraphs 48(a) and 48(b), DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	No action has been taken yet, as activities outlined in Terms 48a and 48b remain ongoing.	No action has been taken yet, as activities outlined in Terms 48a and 48b remain ongoing.	**26th –** **Due by 12/31/25**

RECOMMENDATIONS

1. To fully meet Term 47.d objectives within 24 months, OL should establish a formal inter-rater reliability measurement process. This process should:
   - Conduct comparative evaluations of each Licensing Specialist at regular intervals.
   - Generate objective reliability scores based on assessment outcomes.
   - Provide aggregated data for ongoing performance analysis and reliability tracking.

   Implementing this structured approach will enhance consistency in Licensing Specialist determinations and strengthen regulatory compliance efforts.

2. DBHDS and DMAS should continue work with Guidehouse to complete the rate study for services under the Developmental Disability Waiver by August 2025 with results prepared for presentation to the General Assembly in their 2026 session.

INTERVIEWS CONDUCTED

The Consultant interviewed the following individuals virtually or the individuals provided clarifying information via email or through TEAMS to inform these study analyses.

1. Heather Norton, Assistant Commissioner, Developmental Services
2. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Governmental Relations
3. Eric Williams, Director, Office of Provider Development
4. Jae Benz, Director, Office of Licensing
5. Mackenzie Glassco, Associate Director of Quality and Compliance

DOCUMENTS REVIEWED

The Consultant reviewed the following documents during the course of this study:

- 12VAC35-105-450
- 12VAC35-105-50, 100, 110, and 115
- 12VAC30-122-180
- 2025 Annual Compliance Determination Chart
- Annual Inspections for Providers of Developmental Services Memorandum
- Expanded Consultation and Technical Assistance Standard Operating Procedures effective 08/23/2024
- Expectations Regarding 12VAC35-105-450 Provider Training and Development 04/01/2025
- Corrective Action Plans for a provider
- Process Document DSP Comp Ver 007 (dated September 20, 2024)
- DSP Competencies Attachment B Attestation Statement (dated September 30, 2024)
- Provider Data Summary Report, November 2024
- Quality Improvement Initiative document (DSP SFY 24 QII Toolkit, approved 7/19/24
- PIRW Education and Training Subcommittee Summary and Staffing Shortages Focus Group Meeting Notes (dated January 7, 2025
- April 1, 2025 Guidehouse DMAS Developmental Disabilities Rate Study PowerPoint
- Employee Training Policies and CAP Reports for 30 providers that were included in the 26th Study Sample Review process

APPENDIX G

Quality and Risk Management
and
Quality Improvement Programs

By

Rebecca Wright, MSW, LICSW
Chris Adams, MS

Quality and Risk Management System 26th Period Study

Introduction/Background

The Permanent Injunction (PI) approved by the Court on January 15, 2025, requires the Commonwealth to meet certain criteria regarding quality and risk management. This study will be a follow-up to previous studies that have been completed annually since 2017 regarding the status of the Commonwealth's achievements in these areas. For this 26th Period review, the Parties have agreed to target a total of 15 PI Terms.

Based on the findings at the time of the 25th Period review, the following bullets provide background regarding the key issues DBHDS still needed to address for these 15 Terms during this current Period:

- For PI Term 34 (i.e., behavioral support services), despite steady improvement, DBHDS provided data that did not demonstrate it achieved the required metrics for adequate and appropriate behavioral support services.
- For PI Terms 40 and 54 (i.e., annual dental and physical exams, respectively) despite steady improvement, DBHDS had not yet provided data that demonstrated it achieved the specified goals.
- For PI Term 41, the processes DBHDS documented related to the percentage of individuals free from serious injury had continuing methodological deficiencies that DBHDS needed to address. The identified methodologies were not adequate to produce valid data.
- For PI Term 42, in the 25th period study, the Consultant found insufficient evidence that Licensing Specialists accurately determined whether providers' risk management systems consistently identify common risks and conditions faced by people with IDD that contribute to avoidable deaths and, when a risk is identified, providers must take prompt action to address it. Although there was improvement in the Consultant's agreement rates in the 25th study compared to the 24th study, the improvement was not sufficient to demonstrate that Licensing Specialists are making accurate determinations consistent with the requirements in the OL Annual Compliance Determination Chart as required by Term 42.
- For PI Term 43, the Commonwealth had not yet shown performance that meets the required metric of 86% of individuals with timely Waiver service enrollment.
- For PI Term 44, DBHDS had not yet analyzed data on at least an annual basis of a statistically valid sample regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs. For one of these three groups (i.e., those with complex health/medical support needs), the Department continued to implement an annual monitoring process known as the Intensive Management Needs Review (IMNR). The initial IMNR remediation process was promising, but still incomplete. DBHDS still needed to demonstrate that it implemented a process based on its analysis for corrective actions as it determines appropriate, to track the efficacy of the actions, and to revise as it determines necessary to address the deficiency.

- Based on self-reported data, the DBHDS did not achieve the 86% threshold required by Term 45. Annually, as part of their quality improvement program, DBHDS-licensed providers of DD services must comply with each of the 11 sub-regulations within 12VAC35-105-620. Previous studies confirmed that when a provider fails to meet a specific regulatory requirement, they must develop and implement a corrective action plan (CAP). However, the findings from the CY2024 licensing inspections indicate that the implementation of these CAPs is not consistently increasing compliance. To meet the requirements of Term 45, the OL needed to: Incorporate more prescriptive requirements for the content of each CAP, consistent with Term 45(a); Ensure that current progressive enforcement protocols reference each requirement in Term 45(b); Develop and fully implement an inter-rater reliability process to ensure Licensing Specialists consistently assess provider compliance with each relevant regulatory requirement.
- For PI Term 46, the Quality Services Review (QSR) methodology did not adequately identify the quality improvement deficiencies and corrective action needs for specific providers. First, the elements of DBHDS's QSR Provider Quality Review (PQR) tool were not sufficient to assess the adequacy of its providers' QI programs. In addition, based on the 25th period comparative sample, QSR reviewers often did not accurately and thoroughly assess provider quality improvement practices, such that the process did not yield reliable data (i.e., as previous Reports to the Court repeatedly identified).
- DBHDS did not achieve the required metrics for PI Term 49. Virginia had not finished all reviews or provided a finalized data report during the 25th Period, citing a need for more time to adequately validate the related QSR results. In addition, the Department still needed to develop a well-defined description of the overall QSR procedure for determining compliance with the requirements of the CMS Settings Rule and related guidance, consistent with the Commonwealth's approved Statewide Transition Plan.
- For PI Term 52, based on self-reported data, the DBHDS did not achieve the 86% threshold established by the Department for each outcome in the community look-behind (CLB) review process. The 25th study noted some improvements to the CLB process, which achieved positive results. However, the full implementation of the CLB process, including a fully operational inter-rater reliability (IRR) review process, was not yet complete. The look-behind review results provided to the Risk Management Review Committee (RMRC) each quarter were not fully validated, limiting the ability of the RMRC to carry out their oversight responsibilities required by Term 52. The full implementation of the CLB process and all its components, including the IRR process, should continue to be a central focus of the RMRC to support progress toward meeting the requirements of Term 52.
- For PI Term 53, based on the findings from the 24th and 25th period studies, the Commonwealth has achieved the goal of having 86% of serious incidents reviewed by the RMRC meet the audit criteria. However, as mentioned in the narrative for Term 52, the Commonwealth has not yet met the goal of having 86% of allegations of abuse, neglect, and exploitation reviewed by the RMRC meet the audit criteria. The first step in this process is to complete the required actions described in the narrative for Term 52. Once these requirements are consistently achieved, accurate and complete data presented to the RMRC regarding the review of serious incidents and allegations of abuse, neglect,

and exploitation will enable the RMRC to fulfill their responsibilities related to these two look-behind processes.

- For PI Term 55, previous studies have confirmed that DHBDS continues to exceed the 86% threshold for assessing DBHDS-licensed providers of DD services for compliance with risk management requirements during annual inspections. However, the Consultant's sample reviews have raised concerns about the accuracy of Licensing Specialists' determinations of compliance with these regulations, as per the Office of Licensing Annual Compliance Determination Chart.
- DBHDS did not meet PI Terms 56 and 57 because the Commonwealth did not develop, monitor and/or revise needed remediation for waiver performance measures, as required.

Study Methodology

The Consultants who conducted prior studies on the Terms related to quality and risk management and quality improvement programs also conducted the 26th period study. The study sought to gather and investigate facts and verify data and documentation provided by the Commonwealth to determine whether the sufficiency of the Commonwealth's actions resulted in Virginia achieving the specified goals of each of the PI Terms described in the previous section. The study reviewed documentary evidence of data collection and actions related to the Commonwealth's compliance efforts since 12/01/24. The methodology included a review of the documents that Virginia maintains to demonstrate that it has achieved the PI's specified goals and completed the required actions; interviews with state officials, subject matter experts, and stakeholders; and verification that Virginia's relevant Process Documents and Attestations are complete.

Evidence gathering included:

- Review of documentary evidence provided by the Commonwealth specific to the specified goals and required action(s) set out in each Term.
- Review of any changes that have been made to policies, procedures, and/or practices relating to the requirements in the applicable Terms listed above.
- A comparative review of licensing findings for a sample of providers and CSBs with regard to compliance with Terms 42, 45 and 55. Due to fewer than 50% of licensing inspections for CY2025 being completed, the sample review focused on the implementation of corrective/improvement initiatives by the Office of Licensing. The findings were limited and cannot be generalized to determine if the Commonwealth has met the requirements of these Terms. Results from the 26th and 27th period studies will be combined for a comprehensive data set comparable to previous studies; however, the status of the Commonwealth's actions to achieve the goals for Terms 42, 45, and 55 were evaluated during this 26th period study.
- A collaborative review and analysis of the proposed QSR Round 7 PCR and PQR tools and associated protocols that will be used to inform the data collection and QSR compliance findings for quality improvement (Term 46) and HCBS compliance (Term 49).
- A comparative review to investigate and verify the data quality related to Term 44.

- For Terms that rely on data to demonstrate compliance, the data validation process included review and analysis of documents described above for each Term. The data validation process included review and analysis of documents focusing on:
    - Threats to data integrity previously identified by DBHDS assessments.
    - Actions taken by DBHDS that resolved these problems including completion dates for those activities.
    - Review of the verification process that DBHDS completed that confirmed that the data reported is reliable and valid.
    - The Commonwealth's current Attestation that the Process Document was properly completed, that the threats were sufficiently mitigated, and that the data reported are reliable and valid.

Study Findings

Regarding the assessment of requirements related to **Behavioral Support Services (Term 34)**, DBHDS did not yet achieve compliance with Term 34 because, based on review of the *Behavioral Supports Report: Q1/FY25*, DBHDS reported that for all of FY24, 68% of individuals with identified behavioral support needs received adequate services and 32% (received inadequate or no services). DBHDS did continue to address findings identified through the previously conducted root cause analysis, to use the BSPARI tool to determine whether individuals are receiving adequate and appropriate behavioral support services, and to employ at least four behavior analysts to provide technical assistance and training on behavioral support plans.

Regarding the assessment of requirements related to **Dental Exams (Term 40)**, DBHDS did not meet the requirements of this Term because its data indicated that the Commonwealth did not yet achieve 86% for people supported in residential settings who have coverage for dental services who received annual dental exams. Documentation indicated for all of FY24, the overall performance was 65% and that for the first three quarters of FY25, it stood at 68.63%. Of note, DBHDS made needed revisions to the process document and attestation such that it was adequate for data validity. DBHDS staff made progress on Actions to expand dental resources and capacity, although those largely remained in process as of this review period.

Regarding the assessment of requirements related to **Protection From Serious Injuries in Service Settings (Term 41)**, it was positive that DBHDS updated a number of written processes and protocols toward improving data validity and reliability. These included: revising the numerator calculation to exclude individuals who had a serious injury resulting from substantiated abuse/neglect; revising the Office of Human Rights (OHR) protocols to ensure tracking and reporting outcomes of all IMU referrals of serious injuries that were suspicious for abuse/neglect; and incorporating a clear definition of "suspicious" injuries that raise concerns about potential abuse/neglect; and clarifying language in the Appendix D: Serious Injury Investigation that IMU staff will always complete a 90-day trend analysis for repeated injuries. DBHDS also expanded the utilization of the Specialized Investigation Unit (SIU) to include investigations of serious injuries referred by the IMU, which previously were investigated by a licensing specialist.

However, despite ongoing revisions to the methodology and development of additional guidance, these did not yet yield valid and reliable data. Although DBHDS has expanded the definition of individuals who were not protected from serious injury to include individuals with a serious injury resulting from substantiated abuse/neglect as well as those who experience more than one injury in a rolling 12-month period, the numerator still relies heavily on serious injury investigations to determine if an individual was or was not protected, and only those investigations that result in a corrective action plan (CAP) are deemed to show an individual was not protected. The IMU still refers only a very small percentage of serious injuries for investigation and the SIU actually investigates only a small percentage of those referrals. The processes for making a referral remain ambiguous at times, and, in particular, do not support a reliable evaluation of pre-injury circumstances, as opposed to actions the provider took after the injury to ensure health and safety in the future. This was an important distinction because the construct of this measure relies on the provider having had protections in place prior to the injury, and not that they took appropriate actions after the serious injury occurred. Therefore, even if all post-injury protections were documented, an investigation might still be needed to examine the pre-injury circumstances. In addition, the processes do not clearly articulate the criteria for deciding whether to investigate an IMU referral. These remain undefined beyond a limited number of circumstances that MUST be investigated, leaving many other categories that MAY be investigated to the discretion of the SIU staff.

It is of note that, in interview, IMU staff are often able to describe appropriate procedures for referrals and investigations, but these are not yet clearly reflected in the procedures and protocols.

Regarding the assessment of requirements related to **Risk Management (Term 42)**, **DD Service Providers' Compliance with Administrative Code (Term 45)**, and the **Assessment of Licensed DD Service Providers (Term 55)**, a sample of 30 provider annual inspections across five regions that were carried out by 29 Licensing Specialists between 01/01/2025 and 02/28/2025 were analyzed to determine whether the Consultant agreed with the Licensing Specialists' assessments. However, due to the limited sample size, results cannot be generalized to the entire CY2025 annual licensing cycle. A similar sample review will be conducted in the 27th period study to build a more comprehensive dataset. Given the incomplete information, compliance ratings for these Terms in the 26th period study are Deferred.

Regarding the assessment of requirements related to **Timely Waiver Service Enrollment (Term 43)**, DBHDS continued to track and report quarterly data on the number of individuals who are assigned a waiver slot but not enrolled in a service within five months. However, the Commonwealth did not meet the requirements of this Term because the most recent data reported performance at 75.4% for Q1 FY25 and 78% for Q2 FY25. This represented a downward trend from previous reporting. During this period, DBHDS developed and initiated a data collection process, the *Timely Waiver Service Enrollment Survey*, for monthly identification of individuals who are assigned a waiver slot but not enrolled in a service within five months. In a preliminary summary of the barriers documented, DBHDS reported taking action to share an

apparent Medicaid enrollment barrier with the Department of Medical Assistance Services (DMAS) to plan for future remediation.

Regarding the assessment of requirements related to **Quality Service Monitoring (Term 46)**, it was positive DBHDS continued to offer the very successful Expanded Consultation and Technical Assistance (ECTA) related to provider quality improvement (QI) programs. DBHDS staff also provided two new relevant documents to support data validity and reliability. The first, entitled *DBHDS Quality Service Reviews: Inter-rater Reliability Assurance Plan*, established sound processes for validating QSR results, indicating that, for all data where QSR dataset data is used to assert the quality of the service system, DBHDS staff will identify a secondary data source to which to compare and validate the QSR dataset for each QSR round. Overall, the strategy held promise for achieving validation of data quality and reliability, but was not yet fully implemented for this Term. DBHDS provided a revised Process Document for Term 46, including a statement that QSR data would be validated against licensing reviews data. This did not provide a level of detail that met the expectations of the *Inter-rater Reliability Assurance Plan* or the Process Document Instructions and was not yet sufficient to serve as a meaningful validation process. DBHDS had just recently finalized the *Inter-rater Reliability Assurance Plan*, so it may be expected that a more detailed methodology will be forthcoming. The 27th Period study will include a review and evaluation of the final validation methodology.

In addition, Round 7 QSR was not complete during this period, so no new data were available for an evaluation to support a determination that the QSR yielded valid and reliable data with regard to providers' QI programs. However, during this 26th Period, the consultant, DBHDS staff and QSR vendor staff collaborated to review the draft Round 7 *Provider Quality Review Tool* (PQR) to consider revisions and clarifications, including any needed additional guidance. Upon final review, the consultant and DBHDS staff agreed the PQR tool contained 22 items with sufficient guidance to address certain specific aspects of providers' quality improvement (QI) plans, including use of quality improvement tools, annual review/update of the QI Plan, definition of goals and objectives, statewide performance measures, monitoring and evaluation of progress toward meeting goals and objectives, and provider policy and procedures for establishing goals and objectives and updating the quality improvement plan. At the time of the 27th Period, when Round 7 QSR data are available, the consultant will complete another reliability evaluation, applying the defined QSR quality improvement items, including the reviewer guidelines and the scoring criteria, to a comparative sample. The determination of the Commonwealth's achievement regarding this Term's requirements will be deferred until that time.

Regarding the assessment of requirements related to **Residential Services Community Integration (Term 49)**, the Commonwealth did not yet meet the criteria for this Term because DBHDS staff reported that 93% of residential service recipients resided in a setting that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS setting. In addition, DBHDS staff had not yet shown these data were reliable and valid.

At the time of this 26th Period report, DBHDS staff indicated the total number of settings left to complete initial compliance validation stood at 1,230. Given the previously identified validity and reliability concerns for the HCBS QSR dataset, the Commonwealth had elected to rely solely on the findings of the DBHDS HCBS Review Team and DMAS QMR reviewers for reporting compliance validation for this group of settings. DBHDS reported that those state staff were re-reviewing the 700 settings originally assigned to the QSR vendor. Another 530 settings remained in remediation status. DBHDS staff anticipate completing this review by the 12/31/25 target date set in the Commonwealth's approved Statewide Transition Plan (STP) Corrective Action Plan from March 2023. DBHDS still needed to develop or revise a Process Document for this initial validation process that reflected the changed methodology.

DBHDS provided a Process Document describing the processes for ongoing monitoring of settings' continued compliance. This process will rely heavily on DBHDS's QSR for evaluation and data collection. The Independent Reviewer's consultant and DBHDS staff collaboratively reviewed the proposed QSR tools before DBHDS initiated Round 7 QSR reviews in April 2025. DBHDS made revisions that addressed many, but not all, of the identified HCBS compliance concerns DBHDS acknowledged that this was still a work in process and that the tools, particularly the Person-Centered Review (PCR), will need additional revision to incorporate an adequate assessment of all the HCBS and Virginia STP requirements, as well as the commitments DBHDS made in response to CMS-identified HCBS deficiencies in the CMS Site Visit Report completed in June 2024.

Regarding the assessment of requirements related to the **Look-Behind Analysis of Abuse, Neglect, and Exploitation Allegations (Term 52)**, and **Data Samples from Look-Behind Analyses of Serious Incidents and Allegations (Term 53)**, findings indicate that the Commonwealth has not yet met the 95% threshold level of each outcome required for successful implementation of the Community Look-Behind Review of abuse, neglect, and exploitation allegations. Additionally, the Consultant continues to have concerns about the adequacy and timeliness of the inter-rater reliability process in the CLB review system

Regarding the assessment of requirements related to **Annual Physical Exams (Term 54)**,), DBHDS met the requirements of this Term. DBHDS revised previously reported FY24 performance data to 86.56%, which exceeded the requirement for this Term. This revised data resulted from a DBHDS project to trend annual physical data back to FY21utilizing the 14-month calculation method reflected in the current attested Process Document. DBHDS also reported the performance rate over the first three quarters of FY25 at 88.6%, with each quarter exceeding 86%. Combined with data from FY24 Q4, which was reported at 86.36%, DBHDS met the requirement of this Term for the last four consecutive quarters, trending upward for each quarter.

Regarding the assessment of requirements related to **Data-Driven Quality Improvement Plans for HCBS Waiver Programs (Term 56 and Term 57),** the Commonwealth made progress during this period in the implementation of the Waivers' Quality Improvement Plan, as particularly evidenced by the development of a very useful document entitled *FY24 EOY QRT Underperforming Measures Tracker*. This tool documented whether remediation efforts were in place

for each of eight underperforming measures. However, the QRT did not yet consistently use the tool to fully meet the requirements for these Terms and needed to develop clear written procedures with regard to the expectations for development, monitoring and revision of remediation/quality improvement plans. The procedures should include requirements for quarterly updating of the *Underperforming Measures Tracker* and consistent documentation of meeting proceedings.

The table below summarizes the status of Virginia's achievement of the specified goal for each PI Term studied for this report:

TABLE 1		
Related Compliance Indicator	**Term**	**26th**
29.21 At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	**34. Behavioral Support Services.** The Commonwealth will work to achieve a goal that 86% of individuals with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	Not Achieved
29.20 At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam.	**40. Dental Exams**. The Commonwealth will work to achieve a goal that 86% of individuals who are supported in residential settings and have coverage for dental services will receive an annual dental exam.	Not Achieved
29.24 At least 95% of individual service recipients are adequately protected from serious injuries in service settings.	**41. Protection From Serious Injuries in Service Settings.** The Commonwealth will work to achieve a goal that 95% of DD waiver service recipients will be protected from serious injuries in service settings.	Not Achieved
30.10: To enable them to adequately address harms and risks of harm, the Commonwealth requires that provider risk management systems shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such	**Term 42: Risk Management.** To ensure that the risk management programs of DBHDS-licensed providers of DD services identify the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths and take prompt action when such events occur, or the risk is otherwise identified**.**	Deferred

TABLE 1		
Related Compliance Indicator	**Term**	**26th**
events occur, or the risk is otherwise identified. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6.		
35.8: The Commonwealth ensures that at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations.	**43. Timely Waiver Service Enrollment**. The Commonwealth will work to achieve a goal that 86% of individuals who are assigned a waiver slot will be enrolled in a service within five months.	Not Achieved
36.8: DBHDS collects and analyzes data (at minimum a statistically valid sample) at least annually regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS develops corrective action(s) based on its analysis, tracks the efficacy of that action, and revises as necessary to ensure that the action addresses the deficiency.	**44. Ongoing Service Analyses.** The Commonwealth, through DBHDS, will collect and analyze data at least annually regarding the management needs of individuals with identified complex behavioral, health, and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS will develop corrective actions based on its analysis as it determines appropriate, track the efficacy of the actions, and revise as it determines necessary to address the deficiency.	Not Achieved
42.4: On an annual basis, at least 86% of DBHDS-licensed providers of DD services are compliant with 12 VAC 35-105-620. Providers that are not compliant have implemented a Corrective Action Plan to address the violation.	**Term 45: DD Service Providers' Compliance with Administrative Code.** The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services comply with 12 VAC 35-105-620 in effect on the date of this Order or as may be amended.	Deferred
44.2: Using information collected from licensing reviews and Quality Service Reviews, the Commonwealth identifies providers that have been unable to demonstrate adequate quality	**46. Quality Service Monitoring**. The Commonwealth will work to ensure that, using information collected from licensing reviews and Quality Service Reviews, it identifies providers that have been unable to demonstrate adequate quality improvement	Deferred

TABLE 1		
Related Compliance Indicator	**Term**	**26th**
improvement programs and offers technical assistance as necessary. Technical assistance may include informing the provider of the specific areas in which their quality improvement program is not adequate and offering resources (e.g., links to on-line training material) and other assistance to assist the provider in improving its performance.	programs and offers technical assistance as necessary.	
29.22 At least 95% of residential service recipients reside in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings.	**49. Residential Services Community Integration.** The Commonwealth will work to achieve a goal that 95% of residential service recipients reside in a location that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS settings.	Not Achieved
29.17: The RMRC conducts or oversees a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: i. comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines. ii. The person conducting the investigation has been trained to conduct investigations. iii. Timely, appropriate corrective action plans are implemented by the provider when indicated. iv. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation.	**Term 52: Look-Behind Analysis of Abuse, Neglect, and Exploitation Allegations.** The Commonwealth will continue its Community Look-Behind (CLB) review process to achieve a goal of collecting sufficient data for the Risk Management Review Committee (RMRC) to conduct or oversee a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: (i) investigations of individual incidents occur within state-prescribed timelines; (ii) the person conducting the investigation has been trained to conduct investigations; and (iii) corrective action plans are implemented by the provider when indicated. The RMRC will review trends at least quarterly, recommend QIIs when necessary, and track implementation of initiatives approved for implementation.	Not Achieved

TABLE 1		
Related Compliance Indicator	**Term**	**26th**
29.18: At least 86% of the sample of serious incidents reviewed in indicator 5.d meet criteria reviewed in the audit. At least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed in indicator 5.e meet criteria reviewed in the audit.	**Term 53: Samples of Data from Look-Behind Analyses of Serious Incidents and Allegations of Abuse, Neglect, and Exploitation.** The Commonwealth will work to achieve a goal of showing 86% of the sample of serious incidents reviewed by the RMRC meet criteria reviewed in the audit and that at least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed by the RMRC meet criteria reviewed in the audit. The Commonwealth will continue the look behind process and provide feedback to the RMRC related to its findings. If this goal is not met by December 31, 2024, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	Not Achieved
29.20 At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam.	**54. Annual Physical Exams**. The Commonwealth will work to achieve a goal that 86% of individuals supported in residential settings receive annual physical exams.	Compliance
30.4: At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. Inspections will include an assessment of whether providers use data at the individual and provider level, including, at minimum, data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in	**Term 55: Assessment of Licensed Providers of DD Services.** The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. DBHDS will continue to conduct annual licensing inspections in accordance with Virginia Code § 37.2-411 in effect on the date of this Order or as may be amended and assess provider compliance with risk management requirements in the Licensing Regulations	Deferred

TABLE 1		
Related Compliance Indicator	**Term**	**26th**
the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations.	utilizing the Office of Licensing Annual Compliance Determination Chart.	
35.1: The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers.	**56. Data-Driven Quality Improvement Plans for HCBS Waiver Programs**. The Commonwealth will continue to implement the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers. The DMAS-DBHDS Quality Review Team (QRT) will meet quarterly in accordance with the CMS-approved Quality Improvement Plan and will review data, determine trends, and implement quality improvement strategies where appropriate as determined by the QRT to improve performance.	Not Achieved
35.5: Quarterly data is collected on each of the above measures and reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans are written and remediation actions are implemented as necessary for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86% compliance. Quality Improvement remediation plans will focus on systemic factors where present and will include the specific strategy to be employed and defined measures that will be used to monitor performance. Remediation	**57. Data-Driven Quality Improvement Plans for HCBS Waiver Programs**. The Commonwealth will continue to collect quarterly data on the following measures: (i) health and safety and participant safeguards; (ii) assessment of level of care; (iii) development and monitoring of individual service plans, including choice of services and of providers; (iv) assurance of qualified providers; e) whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR; and (v) identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation. This data will be reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans will be written and remediation actions implemented,	Not Achieved

TABLE 1		
Related Compliance Indicator	**Term**	**26th**
plans are monitored at least every 6 months. If such remediation actions do not have the intended effect, a revised strategy is implemented and monitored	as necessary, for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86% compliance. Quality Improvement remediation plans will focus on systemic factors (where present) and will include the specific strategy to be employed, as well as defined measures that will be used to monitor performance. Remediation plans will be monitored at least every six months. If such remediation actions do not have the intended effect, a revised strategy will be implemented and monitored.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
34. Behavioral Support Services. The Commonwealth will work to achieve a goal that 86% of individuals with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	For this 26th Period, DBHDS did not yet achieve compliance with Term 34 (formerly CI 29. 21). Based on review of the *Behavioral Supports Report: Q3/FY25*, DBHDS reported that in FY25Q1 and Q2, 68% (976/1428) of individuals with identified behavioral support needs received adequate services and 32% (452/1428) received inadequate or no services. For this 26th Period, DBHDS submitted an updated Process Document *DD_Therapeutic Consultation_BS_Ver_007*, dated 10/2024, to include BSPARI data	At the time of the 25th Period review, DBHDS did not yet achieve compliance with Term 34 (formerly CI 29.21) because, based on review of the *Behavioral Supports Report: Q1/FY25*, DBHDS reported that for all FY24, 68% (1526/2260) received adequate services and 32% (734/2260) received inadequate or no services. For this 26th Period, DBHDS did not yet achieve the specified goal of Term 34. Based on review of the *Behavioral Supports Report: Q3/FY25*, in FY25Q1 and Q2, 68% (976/1428) of individuals with identified behavioral support needs received adequate services and 32% (452/1428) received inadequate or no services. DBHDS's report also indicated that the current calculation reflects only FY25Q1 and FY25Q2 Behavior Support Plan Adherence Review Instrument (BSPARI) data. FY25Q3 BSPARI data (and future FY25Q4 data) will be used in upcoming reporting and to compare the entirety of FY25 BSPARI data to the entirety of FY25 utilization data. For this 26th Period, DBHDS submitted an updated Process Document *DD_Therapeutic Consultation_BS_Ver_007,* dated 10/2024, to include BSPARI data updates, and a Data Set Attestation dated 3/30/25. The data remained valid and reliable. However, of note, prior to 25th Period's study, DBHDS modified its quotient formula/calculation methodology to include individuals with SIS level 7 (intense behavioral support needs) whose behavioral support services were not adequate and those who did not receive any behavioral services at all. For this reason, the percentage 68% was lower than previously reported. Due to DBHDS's corrected calculation methodology, this latest percentage cannot be compared with previously reported data to determine trends.	Not Achieved

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	updates, and a Data Set Attestation dated 3/30/25. The data remained valid and reliable.	.	
34 a) DBHDS will continue to address findings identified through the previously conducted root cause analysis initiated in Q1 of FY21 and updated subsequently as part of each semi-annual review.	For this 26th Period, the *Behavioral Supports Report: Q3/FY25* addressed findings identified through the previously conducted root cause analysis. It included updates dated 4/2025 for the following topics: Training, Task Clarification & Prompting, Resources, Materials, & Processes, and Performance Consequences, Effort, & Competition. These updates demonstrated that DBHDS continued to address findings identified through the	The *Behavioral Supports Report: Q3/FY25* addressed findings identified through its previously conducted root cause analysis. It included updates for the following topics: • Training, including topics for support coordinators, search engine use, behavioral programming and provider enrollment. • Task Clarification & Prompting, including a search engine for therapeutic behavioral consultation providers, with filters for language and regional coverage, data sharing with CSB leadership monthly to prompt timely connection to services and Provider Directory updates. • Resources, Materials, & Processes, including the Jump Start program funding s provided to new or expanding providers, technical assistance to providers facing challenges with Medicaid enrollment or connecting with CSBs, and increasing the number of providers through funding programs, enrollment assistance, and rate increases. Of note, the *Behavioral Supports Report* indicated the number of providers grew from 48 in FY17 to 106 in FY25; however, the increased number of provider organizations does not necessarily indicate a corresponding increase in the number of individual behaviorists delivering behavioral services for individuals with IDD. • Behavioral Resources, including newsletter and DBHDS website articles on behavioral science topics.	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	previously conducted root cause analysis and updated related activities as part of the semi-annual review.	• Performance Consequences, Effort, & Competition, including providing real-time data to CSBs on individuals needing services before the 30-day window expires, feedback sessions with behaviorists based on BSPARI reviews, and implementing tailored action steps to help CSBs address unique challenges and improve performance. • Gap Analysis, including setting regional targets for behaviorist growth based on unmet needs and encouraging providers to expand services across multiple regions. • Quality Assurance, including the continuing BSPARI reviews and the evaluation of support coordinator accuracy in assessing behavioral programming using the On-Site Visit Tool (OSVT).	
34 b) DBHDS will continue to use the BSPARI tool, or such other tool designed for behavioral programming that the parties agree upon, to determine whether individuals are receiving adequate and appropriate behavioral support services.	Based on reporting in the *Behavioral Supports Report: Q3/FY25*, during FY25 Q1-FY25 Q2 DBHDS continued to use the BSPARI tool to determine whether individuals are receiving adequate and appropriate behavioral support services. During that period, DBHDS staff reported reviewing 204 plans.	Based on reporting in the *Behavioral Supports Report: Q3/FY25*, during FY25 Q1-FY25 Q2 DBHDS continued to use the BSPARI tool to determine whether individuals are receiving adequate and appropriate behavioral support services. During that period, DBHDS staff reported reviewing 204 plans. Of note, DBHDS reported that beginning in FY25 Q2, DBHDS required providers to revise and resubmit plans scoring below 34 points, offering technical assistance and rehearsal opportunities.	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
34 c) DBHDS will continue to employ a total of four behavior analysts to provide technical assistance and training on behavioral support plans. Annually, the behavior analysts will (i) review a statistically significant sample of the behavioral plans submitted; (ii) provide feedback; and (iii) identify trends for improvement and develop additional training and technical assistance as determined necessary by DBHDS.	Based on reporting in the *Behavioral Supports Report: Q3/FY25,* The Office of Behavior Network Supports currently employs five Board Certified and Licensed Behavior Analysts. As described above for Action 34b, during FY25 Q1-FY25 Q3, they completed 303 reviews of behavior programs to determine adherence to the *Practice Guidelines for Behavior Support Plans*, and conducted feedback sessions for all 303. Based on DBHDS reporting in the *Behavioral Supports Report: Q3/FY25*, behavior analysts analyzed	Based on reporting in the *Behavioral Supports Report: Q3/FY25,* The Office of Behavior Network Supports currently employs five Board Certified and Licensed Behavior Analysts. The above-referenced report indicates that behavior analysts provided technical assistance and training on behavioral support plans through the following methods: • Review of Behavioral Plans: Using the BSPARI, they complete reviews of behavior programs to determine adherence to the Practice Guidelines for Behavior Support Plans. Based on the methodology outlined in the Process Document entitled *DD_Therapeutic Consultation_BS_Ver_007*, the reviews are based on a randomized, statistically significant number of individuals that have service authorizations or therapeutic consultation provided by the WaMS Senior Data Analyst to the Director of Behavioral Services & Projects. • Feedback Sessions: They conducted individualized feedback sessions with behaviorists after reviewing behavior support plans using the BSPARI. During FY25Q1-FY25Q3, all 303 plans reviewed during this period received feedback sessions These sessions highlighted areas of adherence, areas needing improvement, and provide resources for better alignment with Practice Guidelines. In addition, during feedback sessions, behavior analysts emphasized the use of professional literature and other resources to help behaviorists improve their programming. • Trend Analysis: They analyzed BSPARI scores and trends over time to identify areas of improvement and recurring issues in behavioral programming. This data informed the development of additional training and technical assistance. For example, based on common errors identified in BSPARI reviews, behavior analysts created targeted	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	BSPARI scores and trends over time to identify areas of improvement and recurring issues in behavioral programming and used these findings to create additional training and technical assistance. Examples included targeted training materials to address specific elements of behavioral programming and training videos on topics such as accessing search engines for providers and understanding therapeutic behavioral consultation.	training materials to address specific elements of behavioral programming, including behaviors targeted for increase and non-operant conditions influencing behavior. Behavior analysts have also created and distributed training videos on topics such as accessing search engines for providers and understanding therapeutic behavioral consultation. These videos are shared with CSB leadership and distributed via the Provider Network Listserv.	
34 d) If the Commonwealth has not achieved the goal within two years of the	This action is not required until 7/15/27 (two years from the approval of the	This action is not required until 1/15/27 (two years from the approval of the permanent injunction.) A final implementation plan was not completed.	**Due Date 1/15/2027**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
date of this Order after taking the actions in Paragraphs 34(a) and 34(b), DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	permanent injunction.) A final implementation plan was not completed.		
40: Dental Exams The Commonwealth will work to achieve a goal that 86% of individuals who are supported in residential settings and have coverage for dental services will receive an annual dental exam.	For the 26th Period, DBHDS did not meet the specified goal of this Term because its data indicated that the Commonwealth did not yet achieve 86% for people supported in residential settings who have coverage for dental services who received annual dental exams.	At the time of the 25th Period, DBHDS did not yet meet the specified goal for this Term (formerly included in CI 29.20). At that time, DBHDS provided a document *Office of Integrated Health Annual Physical and Dental Exams* and dated 8/6/24, indicating that 14-month data for the last four reporting quarters, showed that DBHDS achieved the following for dental exams: FY23 Q4 -63%; FY24 Q1-63%; FY24 Q2-64%; FY24 Q3-66% Twelve (12) month data ran 4%-5% lower. In addition, the document reported that for FY24 Q4, DBHDS achieved 67%. Therefore, for the four quarters of FY24, the overall performance was approximately 65%. Also at the time of the 25th Period, with regard to data validity and reliability, DBHDS did not provide updated documents reflecting needed changes	Not Achieved

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	A PowerPoint presentation entitled *Annual Dental Exams Permanent Injunction*, indicated that for the first 3 quarters of FY25, 68.63% of individuals supported in residential settings had an annual dental exam. DBHDS provided an updated Process Document, entitled *Annual Dental Exams Ver 007*, dated 3/13/25, that included the previously identified needed revisions to ensure the Scope and Methodology sections reflected the 14-month look-behind period. This was adequate for data validity. However, it is recommended that the	identified during the 23rd and 24th Period reviews. These included the following: • At the time of the 23rd Period, DBHDS provided an updated Process Document entitled *Annual Dental Exams Ver 005* dated 8/24/23, and a Data Set Attestation, dated 8/4/23. Of note, at that time, DBHDS had issued a DQMP document entitled WaMS Recommendations: Data Source System Enhancement Progress, with a completion date of 8/4/23, including the need for mitigation strategies for ensuring that ISPs are completed by their effective date. The study noted the Data Set Attestation did not clearly reference the adequacy of those mitigation strategies. • The 24th Period study found that DBHDS still needed to review and clarify the Scope section of the Process Document, which appeared to still indicate that the date of an annual exam, either physical or dental, must occur within the year proceeding the Annual ISP date (i.e. rather than within 14 months). This was in conflict with the changes in the sections entitled "Methodology" of the Process Documents and could potentially impact the validity of the reported data. DBHDS also still needed to ensure the attestation confirmed the adequacy of the remediation strategy for ensuring that ISPs are completed by their effective date. For this 26th Period, DBHDS provided a PowerPoint presentation entitled *Annual Dental Exams Permanent Injunction*. It indicated that for the first 3 quarters of FY25, 68.63% of individuals supported in residential settings had an annual dental exam. Of note, the *Twenty-Sixth Period Individual Services Review Study: Individuals with Complex Medical Needs* completed during this 26th Period found	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	Definitions section of the Process Document also state clearly that an "annual" dental exam is one that occurs within that 14-month period. DBHDS also submitted a Data Set Attestation for this measure, dated 3/31/25. .	that only 69% of the individuals reviewed received the requisite annual dental exam, which was consistent with the overall data. Also for this 26th Period, DBHDS provided an updated Process Document, entitled *Annual Dental Exams Ver 007* and dated 3/13/25, that included the needed revision to ensure the Scope and Methodology sections reflected the 14-month look-behind period. This was adequate for data validity. However, it is recommended that the Definitions section of the Process Document also state clearly that an "annual" dental exam is one that occurs within that 14-month period. For the sake of clarity, it is also recommended that DBHDS should make some additional revisions to this Process Document. As communicated to DBHDS staff, while the Term itself says "The Commonwealth will work to achieve a goal that 86% of individuals who are supported in residential settings *and have coverage for dental services* will receive an annual dental exam" (italics added), the Compliance Indicators section appears to have two measures, one for people with insurance and one regardless of insurance. The sections entitled Change Control/Process Description, Outputs/Measure Of Success, Measure Documentation, as well as the Measure language also reflect a similar concern. DBHDS staff explained that this had likely occurred over time, as the Commonwealth transitioned to everyone in residential services having dental coverage under the State Medicaid Plan as of July 2021. Revisions to reflect the current reality will help to simplify the process as well as support data reliability. DBHDS also submitted a Data Set Attestation for this measure, dated 3/31/25.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
40 a) DBHDS will operate a total of three mobile dental vehicles by March 31, 2025.	DBHDS did not complete this action by March 31, 2025. Based on review of a document entitled *Dental Work Plan Outcomes.PI.2024-25.03.24.2025*, as of 12/1/24, two mobile dental vehicles were operational. As of 2/16/25, build-out to achieve this goal was in process and remained on track with current discussion around specific x-ray equipment needed.	DBHDS did not complete this action by March 31, 2025. Based on review of a document entitled *Dental Work Plan Outcomes.PI.2024-25.03.24.2025*, this remained in process. The document indicated that, as of 2/16/25, build-out to achieve this goal remained on track with current discussion around specific x-ray equipment needed. Of note, the same document indicated that, as of 12/1/24, two mobile dental vehicles were operational.	**Not Completed**
40 b) DBHDS will continue to employ or contract with a total of three dental assistants and four dental	For this 26th Period, based on the document entitled *Dental Work Plan Outcomes.PI.2024-25.03.24.2025*,	*Dental Work Plan Outcomes.PI.2024-25.03.24.2025* indicated that, as of 10/4/24, DBHDS had filled all positions except for one open dental assistant position. As of 10/3/24, two candidates for that position had been selected for interviews. However, the resulting offer was declined due to low salary, with no	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
hygienists to staff the mobile dental vehicles.	DBHDS reported that, as of 10/4/24, DBHDS had filled all the required positions except for one open dental assistant position. As of 2/16/25, DBHDS obtained approval to repost for that position, but hiring remained in process.	opportunity to negotiate. As of 2/16/25 DBHDS obtained approval to repost the position.	
40 c) DBHDS will continue to review referrals for dental services and work to connect people to community dental providers when available.	During this 26th review period, DBHDS completed this Action. Based on the document entitled *Dental Work Plan Outcomes.PI.2024-25.03.24.2025*, DBHDS staff continued to review referrals, developed and refined an independent scheduling system shared among team members,	The document entitled *Dental Work Plan Outcomes.PI.2024-25.03.24.2025* indicated the process for reviewing referrals for dental services include the following activities: • Referral Reviews and Scheduling: Efforts are ongoing to ensure efficient scheduling and connection to community dental providers. Referrals are conducted through an online platform, and community clinics are scheduled weekly based on a minimum of 5-7 patients per mobile clinic. Clinics are averaging 10-12 patients daily as of early 2025. • Independent Scheduling System: Teams independently schedule appointments and clinics using a shared system (SharePoint list). In an effort to ensure efficient scheduling and data collection, these processes were refined through weekly meetings and field observations, and were fully updated as of 3/24/25.	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	developed and implemented a methodology for prioritizing individuals who have not had a dental exam, using data from WaMS. Actions still in process included developing a system to document and track identified, scheduled, and completed dental appointments. As of 3/24/25, a dashboard remains under development. A reporting process for monthly and quarterly appointment data (including completed appointments and no-shows) also remains in development.	• Prioritization of Individuals Without Dental Exams: In October 2024, DBHDS developed and implemented a process to prioritize individuals who have not had a dental exam, using data from WaMS. Monthly reports identify individuals without annual exams, and the dental team directly contacts service coordinators to assist in referrals and scheduling. • Tracking Appointments: DBHDS is developing a system is to document and track identified, scheduled, and completed dental appointments. The system imports data monthly, and issues such as no-shows are addressed by rescheduling them at the bottom of the waitlist. As of 3/24/25, a dashboard remains under development. • Reporting: DBHDS is in the process of developing a reporting process for monthly and quarterly appointment data (including completed appointments and no-shows). Current efforts are focused on refining data formatting and ensuring comprehensive tracking.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
40 d) Within six months of the date of this Order, DBHDS will contract with at least one dentist or dentistry practice in each Region who can support sedation dentistry.	For this 26th Period, based on review of the *Dental Work Plan Outcomes.PI.2024-25.03.24.2025*, DBHDS had not yet achieved contracting with at least one dentist or dentistry practice in each Region who can support sedation dentistry. The *Dental Work Plan Outcomes* document described DBHDS undertaking several actions related to procurement as part of the ongoing effort to expand sedation dentistry services in each region. On 2/27/25, the Commonwealth posted an RFP and the review panel began the review process by 3/24/25.	The *Dental Work Plan Outcomes.PI.2024-25.03.24.2025* indicated that DBHDS had not yet achieved contracting with at least one dentist or dentistry practice in each Region who can support sedation dentistry. The *Dental Work Plan Outcomes* document described undertaking the following actions as part of the ongoing effort to expand sedation dentistry services in each region, with the goal of addressing barriers to care for individuals with developmental disabilities. • The initial planning and procurement phase began in October 2024, with funds approved on 11/4/24. By 11/13/24, the Notice of Future Procurement was posted to the state's procurement website (i.e., eVA), followed by an updated scope of work on 11/22/24. • On 2/27/25, the Commonwealth posted the RFP, and on 2/19/25, held the pre-bid conference. • On 3/14/25, the review panel received the vendor submissions and by 3/24/25, began the review process. • DBHDS projected contract awards by 4/28/25.	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	DBHDS projected awarding contracts by 4/28/25.		
40 e) DBHDS will collaborate with dental providers to understand barriers to delivering services to individuals with developmental disabilities and, within six months of the date of this Order, will develop a plan with measurable goals, specific support activities, and timelines for implementation to mitigate those barriers.	According to the *Dental Work Plan Outcomes.PI.2024-25.03.24.2025*, DBHDS staff outlined six steps to facilitate this collaboration and plan development. DBHDS had completed one step (obtaining a report from DMAS on expansion of Medicaid network of providers within DentaQuest), with three others in process. This included obtaining a schedule of DMAS listening sessions to address barriers, setting measurable targets for expansion of Medicaid	According to the *Dental Work Plan Outcomes.PI.2024-25.03.24.2025*, DBHDS staff outlined six steps thus far to collaborate with dental providers to understand barriers to delivering services to individuals with developmental disabilities and develop a strategic plan to address them. The first step has been completed, steps two, three and four are in process and steps five and six are not yet started: 1. <u>Obtain report from DMAS on expansion of Medicaid network of providers within DentaQuest</u>. This step was completed. DMAS provided a report summarizing those efforts to expand the Medicaid network. However, the DentaQuest network expansion report lacked clarity on whether newly added dentists serve individuals with disabilities, making it challenging to determine how the network is expanding. 2. <u>Obtain schedule of DMAS listening sessions to address barriers.</u> DBHDS is anticipating that DMAS will provide an updated schedule for listening sessions with dental providers, with follow-up discussion planned for 4/7/25. 3. <u>Determine measurable targets for expansion of Medicaid network of dental providers.</u> DMAS and DentaQuest are collaborating with DBHDS to establish measurable targets for network expansion. A workgroup of stakeholders is being formed to address this task. 4. <u>Partner with Virginia Commonwealth University (VCU) Dental School to expand training for supporting individuals with developmental disabilities</u>. VCU has developed a specialized dental clinic for DD patients but cannot	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	network of dental providers, and partnering with Virginia Commonwealth University (VCU) Dental School to expand training for supporting individuals with developmental disabilities were in process. DBHDS had not yet started two additional steps, including identifying Medicaid dental providers accepting new patients and conducting a survey of providers and families to identify barriers to connecting with community dentists.	open it due to the lack of a special needs dentist. A meeting was planned for April 2025 to explore collaboration opportunities. 5. Identify Medicaid dental providers accepting new patients and update this information annually. DBHDS plans to conduct an annual survey of dental providers to identify those accepting new patients, targeting regions with fewer dentists first. 6. Conduct survey of providers and families to identify barriers to connecting with community dentists. DBHDS plans to use the Dental Program Manager's thesis research survey for this purpose and distribute it via the DD Provider and IFSP ListServs.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
40 f) Within six months of the date of this Order, the Commonwealth shall start an initiative that determines which 8 CSBs need the most assistance to ensure that individuals receive annual dental exams and, no later than three months after starting this initiative, begin to provide technical assistance to support relevant CSBs. This process will continue to be implemented annually until the Commonwealth achieves the goal.	DBHDS completed this Action during the 26th Period. As reported in the *Dental Work Plan Outcomes.PI.2024-25.03.24.2025*, DBHDS has completed the initiation of a process to determine which eight Community Services Boards (CSBs) need the most assistance aims to identify and support CSBs with the lowest percentages of individuals receiving annual dental exams. Based on quarterly data, DBHDS initially identified the eight CSBs with the greatest need, with the list to be adjusted as needed on a quarterly basis. The	As reported in the *Dental Work Plan Outcomes.PI.2024-25.03.24.2025*, DBHDS has completed the initiation of a process to determine which eight Community Services Boards (CSBs) need the most assistance aims to identify and support CSBs with the lowest percentages of individuals receiving annual dental exams. Based on quarterly data, DBHDS initially identified the eight CSBs with the greatest need, with the list to be adjusted as needed on a quarterly basis. The dental team is reaching out to these CSBs to establish on-site clinics and provide technical assistance. DBHDS staff have created dental appointment calendars or technical assistance and clinic visits for each CSB, with progress tracked for specific regions. Clinics and technical assistance visits are ongoing. The *Dental Work Plan Outcomes.PI.2024-25.03.24.2025* indicated that the process still needed to be refined, allowing for a full annual report that will allow analysis of trends, and that the OIHSN Project Manager will meet with the WaMS Data Analyst to refine the request.	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	dental team is reaching out to these CSBs to establish on-site clinics and provide technical assistance. DBHDS staff have created dental appointment calendars or technical assistance and clinic visits for each CSB, with progress tracked for specific regions. Clinics and technical assistance visits are ongoing.		
40 g) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 40(a) through 40(f), DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue	This action is not required until 1/15/27 (two years from the approval of the permanent injunction.) A final implementation plan was not completed.	This action is not required until 1/15/27 (two years from the approval of the permanent injunction.) A final implementation plan was not completed.	**Due Date 1/15/2027**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
this quality improvement process until the goal is achieved and sustained for one year.			
41. Protection From Serious Injuries in Service Settings The Commonwealth will work to achieve a goal that 95% of DD waiver service recipients will be protected from serious injuries in service settings.	For this 26th Period, using an updated algorithm described in the current Process Document, entitled *Individuals Protected from Serious Injury, Version 005*, last revised on 2/12/25, DBHDS reported that, for the period 1/1/24-12/31/24, 97.1% of the 16,736 individuals served were protected from serious injury. However, for this Term specified goal (formerly included in CI 29.24), the algorithm and related processes did	For this 26th Period, DBHDS had made additional modifications to the methodology for determining the percentage of individuals that are protected from serious injury since the 25th Period. The current Process Document, entitled *Individuals Protected from Serious Injury, Version 005*, last revised on 2/12/25, added revised processes for Incident Management Unit (IMU) and Office of Human Right (OHR) review as well as steps to identify individuals with a serious injury associated with abuse/neglect and removing those individuals from the count of those protected from injury. Using the updated algorithm described in the current Process Document, entitled *Individuals Protected from Serious Injury, Version 005*, last revised on 2/12/25, DBHDS reported that, for the period 1/1/24-12/31/24, 97.1% of the 16,736 individuals served were protected from serious injury. However, a review of the document indicated DBHDS staff needed to make a number of revisions to the Process Document to achieve data reliability and validity. These included the following: • The Outputs/Measure Of Success section indicated the process reports on the number of serious injuries, the number of individuals that experienced a serious injury, and the number of individuals who experienced a serious injury which resulted in a corrective action plan for the provider. DBHDS needed to update this to include that it also reported on the number of individuals who sustained two or more	Not Achieved

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	not yet yield valid and reliable data. A review of the Process Document indicated DBHDS staff needed to make a number of revisions to ensure data reliability and validity, including providing a consistent definition for the definition of a serious injury across all document sections. DBHDS also formalized a "pre-investigation" triage process, in which any case that may meet the criteria for an investigation is reviewed by the IMS designee to determine if a further investigation is warranted. However, as discussed further below with regard to	injuries in rolling 12-month period as well as individuals whose serious injuries were substantiated by OHR as resulting from abuse or neglect. • The Reporting Mechanisms section that lists out the various data reports required to produce the measurement did not include all the reports (e.g., *Incident to Investigation w CC OHR*, *IMU Tracker*, *DW-0139*) referenced in the Process Steps. • The Process Steps section indicates the query selects records in which the incident type is: an emergency room visit, an unplanned hospitalization, a serious injury, a decubitus ulcer, or a choking requiring medical attention (ER or hospitalization) AND the provider has reported that an injury occurred. However, the Verification, Validation, And Testing Process section noted that, as of 2/21/24, DBHDS adjusted the query to include all level 2 incidents of "Choking Incident" where medical attention occurred, regardless of whether an injury type was selected. DBHDS should clarify. • For the Attestation dated 3/27/25, the Verification, Validation, And Testing Process section indicated that the data analyst used the following reports to validate the data: *Unique Individuals w CC Rev OHR*, *Individuals Protected from Injury_RMRC Report Rev OHR_CY2024* and *Report Fields Source*. This did not take into account all the reports and steps needed to create the reports, all of which would have potential to result in unreliable and invalid data. • The Measure Documentation section indicated the numerator is the number of individuals on a waiver (from WaMS) who had 2 or more serious injuries in a 12-month period, or who had a serious injury in which a corrective action plan was issued. It did not reference individuals with serious injuries that resulted from substantiated abuse or neglect.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	Action 41a, further work was needed to eliminate ambiguities that might result in needed referrals for determining if the individual had been protected from the serious injury not being made. It was positive, though, that DBHDS updated a number of written processes and protocols related to the review and referral of serious injuries that improved data validity and reliability. These included the following: revising the numerator calculation to exclude individuals who had a serious injury resulting from substantiated abuse/neglect; revising the *Office of Human*	• As described below with regard to Action 41b, the Continuous Quality Improvement section did not yet include a focused sampling procedure (i.e., one isolating serious injury referrals) that would suffice to validate the adequacy of the investigation referral process for serious injuries. The implementation of the Process Document also relied on a number of written processes and protocols related to the review and referral of serious injuries. It was positive that DBHDS had made some updates for these related documents that improved data validity and reliability. However, as described below and with regard to Action 41a and 41b, DBHDS staff needed to make additional revisions. For this 26th Period, improvements to the processes and protocols included the following: • In response to findings in the 25th Period study, DBHDS reported that beginning with data reported in 2025, for injuries that were reported in calendar year 2024, the calculation for this measure will ensure that an individual that has had an injury associated with a substantiated report of abuse or neglect will be excluded from the numerator of the measure. DBHDS also revised the *Office of Human Rights (OHR) Protocol No. 317, OHR Role in OL Incident Management (IMU) for Licensed Providers* as of 2/4/25 to ensure OHR tracked all IMU referrals of reported serious injuries that were suspicious for abuse/neglect and reported their investigation outcomes to IMU for inclusion in the measure. This was reflected in the Individuals *Protected from Serious Injury, Version 005 Process Document*. • In a related vein, the revision to the *Office of Human Rights (OHR) Protocol No. 317, OHR Role in OL Incident Management (IMU) for Licensed Providers*	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	Rights (OHR) Protocol No. 317, OHR Role in OL Incident Management (IMU) for Licensed Providers to ensure tracking and reporting outcomes of all IMU referrals of serious injuries that were suspicious for abuse/neglect; revising *Protocol No. 317* to incorporate a clear definition of "suspicious" injuries that may raise concerns about potential abuse/neglect; and clarifying language in the *Appendix D: Serious Injury Investigation* that IMU staff will always complete a 90-day trend analysis for repeated injuries. As of 11/1/24, DBHDS also began	incorporated a clear definition of "suspicious" injuries that may raise concerns about potential abuse/neglect. The protocol indicated that IMU will refer all suspicious and serious injuries that have not been verified as already reported to OHR, and that an incident would be considered as suspicious in nature if any of the following is found during the IMU review: o Injuries that appear to be inconsistent with the explanations given or the circumstances surrounding them. o Incidents where a cause is attributed to the incident, but the cause still appears to be unknown or is not logical. o The explanation of how the injury occurred does not match the type or severity of the injury. o Supports are in place for the mitigation of the risk, but the incident occurred resulting in serious injury. o Injuries in unusual places that are typically covered by clothing. o Unusual size or type of injury. DBHDS also updated the *Office of Licensing Investigation Protocols* section of *Appendix D: Serious Injury Investigation* provide these clarifications. • As previously reported at the time of the 25th Period, as of 11/1/24, DBHDS expanded the utilization of the Specialized Investigation Unit (SIU) to include referrals from IMU for DD serious injuries, a category which had previously been investigated by a licensing specialist. • DBHDS clarified language in the *Appendix D: Serious Injury Investigation* that IMU staff will always complete a 90-day trend analysis for repeated injuries. Previously, the language was not sufficiently clear to show that they must do so.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	implementation of a Specialized Investigation Unit (SIU) to focus on DD incidents only, including serious injuries.	During this 26th Period, DBHDS also reported formalizing a "pre-investigation" triage process, in which any case that may meet the criteria for an investigation is reviewed by the IMS designee to determine if a further investigation is warranted. The IMS designee makes this determination by reviewing the full incident report, conducting an interview with the provider and reviewing the individual's ISP in WaMS. If the IMS designee determines that an investigation is warranted, they will forward the incident to the SIU; if they determine an investigation is not warranted, they will document the reason for not investigating. However, as discussed further below with regard to Action 41a, further work was needed to eliminate ambiguities in that pre-investigation phase that might result in needed referrals for determining if the individual had been protected from the serious injury not being made.	
41 a) DBHDS will continue working to ensure that all appropriate serious injuries are included when determining if this goal is met.	For this 26th Period, DBHDS continued to make revisions to improve the methodology for ensuring that all appropriate serious injuries are included in the reporting for this measure. However, the methodology continued to need additional	For the 26th Period, the measure algorithm, the Process Document and the protocols still needed some revisions to address barriers to ensuring a valid and reliable measure. Despite ongoing revisions to add individuals with more than one injury in a rolling12-month period and individuals whose injuries were attributed to substantiated abuse/neglect, the IMU still refers only a very small percentage of serious injuries for investigation and only a small percentage of those referrals receive an investigation. This previously reported "funneling" effect of the processes significantly limit the number of serious injuries that can possibly reach the investigation stage and result in a CAP. For the period 1/1/24-12/31/24, providers reported 2,417 serious injuries. The IMU referred 176 of these for investigation (i.e., to either a licensing specialist prior to 11/1/24 or to the SIU thereafter), and the licensing specialist/SIU	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	revisions to ensure valid and reliable data. Despite ongoing revisions to add individuals with more than one injury in a rolling12-month period and individuals whose injuries were attributed to substantiated abuse/neglect, the IMU still refers only a very small percentage of serious injuries for and only a small percentage of those referrals receive an investigation. For the period 1/1/24-12/31/24, providers reported 2,417 serious injuries. The IMU referred 176 of these to either a licensing specialist prior to 11/1/24 or to the SIU	investigated 61 of those. In other words, less than three percent of serious injuries could have possibly received a CAP. As reported at the time of the 25th Period, updates to the *Appendix D-SIR Investigations* continued to need clarifications to resolve ambiguities regarding which incidents MAY be referred by IMU, which MUST be referred by IMU, which MUST be investigated, and which MAY be investigated. For this 26th Period, these ambiguities remained. Serious incidents that MAY be referred to SIU and MAY be investigated include those for which: a 90 day trend analysis reveals concerning patterns; the severity of incident reveals potential health and safety concern; there is an inappropriate or untimely response; there is an apparent regulatory violation; the serious injury is of unknown origin that is suspicious in nature and not been reported to OHR; choking occurred; there have been similar Level II incidents for the same individual within 30 days; a death occurred but not during provision of services depending on type of service and circumstances. However, serious incidents that MUST be referred to SIU include only the following: DD deaths; all Level III deaths/serious injuries; those that meet the individual Care Concern threshold for decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer or a bowel obstruction; aspiration pneumonia when there are multiple ER visits or unplanned hospital admission; any potential imminent danger; and all with enhanced monitoring status. Serious incidents that MUST be investigated include all of the above that MUST be referred except for any potential imminent danger and all with enhanced monitoring status.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	thereafter, and only 61 of those received an investigation. In other words, less than three percent of serious injuries could have possibly received a CAP and therefore included in the numerator. For this 26th Period, DBHDS staff took some steps in an effort to address the ambiguities with regard to the determinations of which injuries in the MAY be referred end up being referred, including modifications to the *Appendix D: Serious Injury Investigation* to implement a process for a "pre-investigation determination" for serious injuries. This include developing	It remained unclear what criteria DBHDS applied in deciding which injuries in the MAY category end up being referred, and which referrals in that MAY category end up being investigated. Based on document review and interview with DBHDS staff, the *Office of Licensing Investigation Protocols* do not provide clear guidance to the SIU in making the latter determinations. For this 26th Period, DBHDS staff took some steps in an effort to address the ambiguities with regard to the determinations of which injuries in the MAY category actually end up being referred. DBHDS staff made related modifications to the *Appendix D: Serious Injury Investigation*, including a process for a "pre-investigation determination" for serious injuries. This process begins with the regional Incident Management Specialist (IMS) referring the serious injury to the IMS designee for a pre-investigation determination. The *Appendix D: Serious Injury Investigation* states that the IMS designee will then apply the investigation protocol to review the serious incidents that MAY and MUST be investigated. The IMS designee will then complete a telephonic or video conference interview with the licensed provider and/or complete an ISP review in WaMS to assess the serious incident and determine whether to make an investigation referral. DBHDS also updated the *Appendix D: Serious Injury Investigation* to provide guidance regarding whether a referral will be made, including *Potential Facts to Consider when Determining if an Investigation is NOT Warranted*, *Triage Questions to Consider after Discussions with the Provider* and *Triage Criteria for Determining if an Investigation is NOT Warranted*. However, as discussed with IMU staff, these documents also contained ongoing ambiguities, particularly with regard to how IMU staff should	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	DBHDS additional guidance regarding whether a referral will be made, including *Potential Facts to Consider when Determining if an Investigation is NOT Warranted*, *Triage Questions to Consider after Discussions with the Provider* and *Triage Criteria for Determining if an Investigation is NOT Warranted*. However, as discussed with IMU staff, these documents also contained ongoing ambiguities, particularly with regard to how IMU staff should consider pre-injury and post-injury circumstances when deciding what serious injuries in the MAY	consider pre-injury and post-injury circumstances when deciding what serious injuries in the MAY category to refer for investigation. This was an important distinction because the construct of the measure relies on the provider having had protections in place prior to the injury, and not that they took appropriate actions after the serious injury occurred. It created a degree of incongruence regarding the purpose of the investigative processes. On the one hand, for the future health and safety of the individual, IMU staff need to ensure that the provider took all appropriate actions after an injury occurred and that the provider has all needed protections in place. If IMU staff can document all these have occurred, a referral for an SIU investigation might be unnecessary and even a poor use of resources. However, what the provider did after the serious injury does not really speak to whether the person had adequate protections in place prior to its occurrence, which is a key component of this Term. Therefore, even if all post-injury protections were documented, an investigation might still be needed to examine the pre-injury circumstances. Overall, the language in the documents reviewed most often focused on actions providers took following the serious injury. The documents contained insufficient probes for the presence of pre-injury protections. The language was also sometimes inadvertently misleading about whether IMU staff should factor in the absence or presence of pre-injury protections when deciding whether to refer for investigation. As discussed with DBHDS and IMU staff, they should review the various documents carefully and make revisions that eliminate the ambiguities. The following bullets provide examples found in various documents:	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	category to refer for investigation. Overall, the language in the documents reviewed most often focused on actions providers took following the serious injury. The documents contained insufficient probes for the presence of pre-injury protections. The language was also sometimes inadvertently misleading about whether IMU staff should factor in the absence or presence of pre-injury protections when deciding whether to refer for investigation. This was an important distinction because the	• The *Potential Facts to Consider when Determining if an Investigation is NOT Warranted* indicated that IMU staff should consider questions such as whether the provider sought appropriate medical attention for the reported injury and if the provider's mitigation of risk strategies submitted with the injury would be sufficient to address the concerns within the report. While these are important questions for evaluating post-injury protection, affirmative answers to them should not preclude an investigation of the pre-injury circumstances. • Many, if not most, of the questions in the *Triage Criteria for Determining if an Investigation is NOT Warranted* referenced appropriate actions the provider took after the serious injury occurred. They lacked clarity about the pre-injury vs. post injury circumstances. • Some language in the *Investigation Protocol* also further contributed to the lack of clarity about whether sufficient post-injury remediation is enough to decide not to investigate. For example, in the instruction for the IMU staff to the IMU actions as to if investigating or not investigating and why not, it provided the following as the sole example: "… if NOT investigating, selecting No Investigation Conducted in drop down menu as IMU action, and then in text box indicating "After review of SIR and after contacting provider for additional information, the provider was able to submit documentation that individual has appropriate medical follow up appointments scheduled. No investigation will be conducted." • The *Individuals Protected from Serious Injury Version 005* Process Document stated that if the IMU desk review of the incident indicated "concerns with the provider's management of the incident (for example did the provider's documented response ensure the recipient's safety and well-being, or was immediate medical attention provided if needed), the	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	construct of this particular measure relies on the provider having had protections in place prior to the injury, and not that they took appropriate actions after the serious injury occurred.	IMS designee will review the SIR, including interview with the provider, to make a pre-investigation determination as to whether a full investigation is warranted." Again, this focused on the aftermath of the injury and not the circumstances preceding it. At the least, it could be inferred by a reader that if the IMU staff determined that the provider's post-injury response was sufficient, it would not be necessary for the IMS designee to take further action. This would not address pre-injury protection.	
41 b) Within six months of the date of this Order, and annually thereafter, the DBHDS Office of Integrated Health will complete a quality review of a statistically significant sample of serious injuries reported to DBHDS via the CHRIS system (or successor) to determine if the Incident Management Unit process used by the DBHDS Office of Licensing adequately identifies all	For this 26th Period, DBHDS did not provide any documentation for this Action. However, in interview, incident management staff indicated that they had begun working with the Office of Integrated Health (OIH) to develop the needed processes for a quality review of a statistically significant sample of serious injuries to determine if the current methodology adequately identifies all	For this 26th Period, DBHDS did not provide any documentation for this Action. However, in interview, incident management staff indicated that they had begun working with the Office of Integrated Health (OIH) to develop the needed processes for a quality review of a statistically significant sample of serious injuries to determine if the IMU process used by the OL adequately identifies all appropriate injuries and to further determine if individuals were protected from harm and if changes are needed to the way incidents are reviewed and referred. Previous studies have found that the relevant Process Document did not describe CQI processes that included a focused sampling procedure (i.e., one isolating serious injury referrals) that would suffice to validate the adequacy of the investigation referral process for serious injuries. Going forward, DBHDS needed to ensure that the proposed OIH quality review addresses each of the stated requirements, including the following: that the IMU processes adequately identify all appropriate injuries; that the processes adequately determines if the individuals were protected from harm, both prior to and after	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
appropriate injuries to determine if individuals were protected from harm and if changes are needed to the way incidents are reviewed and referred.	appropriate injuries and to further determine if individuals were protected from harm and if changes are needed to the way incidents are reviewed and referred. Previous studies have found that the relevant Process Document did not describe CQI processes that included a focused sampling procedure (i.e., one isolating serious injury referrals) that would suffice to validate the adequacy of the investigation referral process for serious injuries. Going forward, DBHDS needed to ensure that the proposed OIH quality	the serious injury occurred; and, to address any findings of concern, determine changes that might be needed to the way incidents are reviewed and referred.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	review addresses each of the stated requirements, including the following: that the IMU processes adequately identify all appropriate injuries; that the processes adequately determines if the individuals were protected from harm, both prior to and after the serious injury occurred; and, to address any findings of concern, determine changes that might be needed to the way incidents are reviewed and referred.		
41 c) Relevant processes will be revised, as warranted, based on the finding of the quality review referenced in Paragraph 41(b) to ensure that the	For the 26th Period, DBHDS has not started this Action, pending the development and implementation of the of the OIH quality review required in Action 41b.	For the 26th Period, DBHDS has not started this Action, pending the development and implementation of the of the OIH quality review required in Action 41b.	**Due Date 7/15/25**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
Commonwealth accurately identifies the percentage of DD waiver recipients who are protected from serious injuries in service settings.			
41 d) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the action in Paragraphs 41(a) through 41(c), DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the metric is achieved and sustained for one year.	This action is not required until 1/15/27 (one year from the approval of the permanent injunction. A final implementation plan was not completed.	This action is not required until 1/15/27 (two years from the approval of the permanent injunction). A final implementation plan was not completed.	**Due Date 1/15/27**
42. Risk Management. To ensure that the risk	Under Regulation *12VAC35-105-160*, DBHDS requires	Previous studies confirm that DBHDS licensing regulations, outlined in *12VAC35-105-160*, mandate providers to identify, report, and take timely and appropriate actions for serious injuries, including incidents tied to common	**Deferred**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
management programs of DBHDS-licensed providers of DD services identify the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths and take prompt action when such events occur or the risk is otherwise identified, the Commonwealth will take the following actions:	providers to identify, report, and promptly address serious injuries, including incidents involving common risks and conditions faced by individuals with developmental disabilities (DD) that contribute to avoidable deaths. Regulation *12VAC35-105-520.B-D* further mandates that providers integrate the identification and management of these risks into their overall risk management functions. DBHDS defines uniform risk triggers and thresholds for these common risks and conditions as "care concerns." The current	risks and conditions referenced in this Term. Additionally, regulations under *12VAC35-105-520.B-D* require providers to address these risks as part of their risk management functions. DBHDS has established standardized risk triggers and thresholds, termed "care concerns," through mandatory serious incident reporting procedures. These care concern categories specifically address common risks and conditions referenced in this Term, such as falls, seizures, urinary tract infections, bowel obstructions, aspiration pneumonia, dehydration, decubitus ulcers, and choking incidents. These regulations require providers' risk management plans and systemic risk assessments to include: • Methods for identifying occurrences of these common risks and conditions, • Processes for using data to assess and evaluate their incidence, • Implementation of corrective actions to address any identified issues. The care concern process necessitates reporting and close monitoring of individual incidents involving common risks and conditions. Failure to adhere to this process may result in the OL issuing a Corrective Action Plan (CAP) to the provider for non-compliance with relevant regulations. The Office of Licensing (OL) and the Office of Clinical Quality Management (OCQM) within DBHDS have strengthened training and technical assistance for providers regarding these requirements. They also promote an *Excel-based Risk Tracking Tool* template that incorporates data recording and analysis tools related to common risks and conditions (care concerns) outlined in this Term. Providers using the tool have demonstrated its effectiveness in identifying	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	risk categories include falls, seizures, urinary tract infections, bowel obstructions, aspiration pneumonia, dehydration, decubitus ulcers, and choking incidents. To strengthen risk management among DBHDS-licensed providers of DD services and reduce avoidable deaths among individuals receiving those services, DBHDS continues to enhance training programs and tools for providers and Licensing Specialists. These efforts emphasize the importance of effectively addressing common risks and	trends and patterns. Additionally, it generates monthly data frequencies, enabling the calculation of incidence rates for these risks and conditions. To expand provider adoption, the Office of Clinical Quality Management offers quarterly training on the tool's functionality, as detailed in the *Overview of the Risk Tracking Tool Webinar Email Announcement (04/01/2025).* Within the 30-provider sample review conducted for this study, 30% of sample providers (9/30) were using the *Risk Tracking Tool*. This represented an increase from the number using the Tool during previous sample reviews. Regulatory guidance, training sessions, and sample tools implemented by OL have notably improved provider compliance with the regulations tied to this Term. However, prior studies identified that Licensing Specialists lack consistency in accurately assessing whether providers meet these requirements, particularly related to §520.C.5 that requires the use of data at the individual and/or provider level, including minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm (defined as care concerns) in the events reported. To assess the effectiveness of efforts to improve assessment consistency during the early stages of the CY2025 licensing inspection cycle, the Consultant reviewed a sample of 30 providers across five regions. These providers underwent licensing inspections between January 1 and February 28, 2025. This sample represents less than half of the inspections scheduled for the CY2025 cycle, meaning the findings cannot be generalized to the entire cycle. A more extensive sample review will be conducted as part of the 27th period study, with those results incorporated into this review to provide a comprehensive evaluation of improvement efforts throughout the full 2025 annual cycle. Since the current sample results cannot be generalized, the	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	conditions (care concerns) while ensuring accurate and consistent assessments of provider compliance with relevant regulations. A review of documentary evidence from 30 sample providers who underwent annual licensing inspections between January 1 and February 28, 2025, revealed improved consistency in Licensing Specialists' compliance determinations for Regulations *12VAC35-105-520.B-D.* However, there was no improvement in the consistency of determinations related to providers' use of data	determination for this Term is deferred until the completion of the 27th period study, which will include a sample comparable to those from the 24th and 25th period studies. The 26th period study sample review focused on documentation related to Term 42's regulatory requirements, specifically assessing providers' compliance with §§520.B, 520.C.5, and 520.D. Licensing Specialists' compliance determinations were compared with independent assessments conducted by the Consultant through provider documentation reviews. These independent reviews aimed to mirror, as closely as possible, the process Licensing Specialists follow during annual inspections. The results below compare the average scores from the sample reviews in the 24th and 25th period studies (which included 80 providers) with scores from the smaller sample in the 26th period study (30 providers). These comparisons may change appreciably when the scores for the 26th period are based on a larger sample of the annual inspections: • Does the provider's systemic risk assessment process incorporate uniform risk triggers and thresholds (care concerns) as defined by the department? o **24th/25th: 82.5%** o **26th: 83% *(slightly improved)*** • Does the provider's risk management policy/plan describe how they identify common risks and conditions faced by people with IDD that contribute to avoidable deaths? o **24th/25th: 66%** o **26th: 70% (improved)**	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	(§520.C.5) - including incident and investigation reports - to identify and address trends and patterns of harm and risk (categorized as care concerns) in reported events. Due to the limited sample size available for this 26th period study, these findings cannot be generalized to the entire 2025 licensing inspection cycle. As a result, formal determination is deferred until data from the 27th study is available, allowing for a more accurate comparison with previous years' sample reviews.	• Does the provider's risk management policy/plan describe how they use data to assess and evaluate common risks and conditions faced by people with IDD that contribute to avoidable deaths? o **24th/25th: 55%** o **26th: 67% (improved)** • Does the provider's risk management policy/plan require the implementation of corrective action plans to address issues related to common risks and conditions faced by people with IDD that contribute to avoidable deaths? o **24th/25th: 65.5%** o **26th: 77% (improved)** • Is there evidence that the provider has implemented corrective action plans to address identified issues related to common risks and conditions faced by people with IDD that contribute to avoidable deaths? o **24th/25th: 71.5%** o **26th: 92% (significantly improved)** Based on findings from the 30-provider sample, Licensing Specialist assessment consistency appears to have improved across all areas except §520.C.5, where agreement remained unchanged at 67%. OL and OCQM should continue their efforts to expand providers' use of data at both the individual and organizational levels to identify and address trends in harm and risk. Additionally, efforts should be strengthened to improve inter-rater reliability among Licensing Specialists regarding provider compliance with quality assurance trending requirements (see Action 42.a below).	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
42.a) Within 24 months of the date of this Order, the Commonwealth shall establish inter-rater reliability among the Commonwealth's licensing specialists regarding provider compliance with the quality assurance trending requirements.	While the Office of Licensing (OL) has introduced procedural changes related to this action, these efforts do not establish a formal, measurable framework for continuously assessing inter-rater reliability. A comprehensive approach would require regular comparative evaluations of each Licensing Specialist at a set frequency, the generation of objective scores, and the aggregation of data for ongoing reliability assessments.	The Office of Licensing (OL) is implementing procedural changes to address this action, including: • **DD Inspection Training:** All Licensing Specialists will receive DD Inspection Training upon hire and annually. If issues arise regarding a Licensing Specialist's compliance determinations, OL will provide additional relevant training. • **Unannounced Inspections:** Regional Managers will conduct unannounced inspections with each Licensing Specialist during their first three months of employment. The Regional Managers will observe the Licensing Specialists' inspection process, provide feedback, and review draft reports to ensure adherence to regulations, guidance documents, and checklists. • **Parallel Inspection Determinations:** Regional Managers will assign tenured Licensing Specialists to new hires to conduct parallel inspections. This ensures consistent interpretation and compliance with regulations, guidance documents, and checklists. • **Quality Improvement Specialist Look-Behinds:** The Quality Improvement Review Specialist conducts a look-behind on two (2) completed and approved licensing inspection reports each week focusing the review on only regulations §520 and §620. While these actions are valuable and expected to improve consistency in compliance determinations, they do not establish a formal, measurable framework for continuously assessing inter-rater reliability. To fully meet the objectives of Term 42.a within the 24-month timeframe (i.e., by January 15, 2027), OL should develop and implement a formal process for measuring inter-rater reliability. This process should include comparative	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
		evaluations of each Licensing Specialist at a set frequency, generate objective scores, and provide aggregated data for ongoing reliability assessments.	
42.b) Within 12 months of the date of this Order, the Commonwealth shall offer technical assistance in accordance with DBHDS's Consultation and Technical Assistance Standard Operating Procedure to each provider that does not identify the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths.	The Office of Community Quality Improvement developed and implemented the Expanded Consultation and Technical Assistance (ECTA) process in 08/2024 that will be on-going and meets the requirements of this action.	The Expanded Consultation and Technical Assistance (ECTA) process, established by the Office of Community Quality Improvement (OCQI) and outlined in the *Expanded Consultation and Technical Assistance Standard Operating Procedures (effective 08/23/2024)*, provides technical support to providers. A key focus is enhancing risk management functions, including the accurate identification of risks and conditions that commonly impact individuals with developmental disabilities (DD) and contribute to avoidable deaths, as defined under regulations *12VAC35-105-520.B-D.* In its established process, when providers fail to comply with these regulations, the Office of Licensing (OL) notifies the ECTA team. The team then engages with the provider to help them meet the requirements of §520.B-D. By 02/2025, 591 invitations had been extended to providers to assist with specific regulatory challenge areas including but not limited to §520.B-D. Of the 235 providers assigned a Quality Improvement (QI) Specialist, 161 (68.5%) have either completed or are actively participating in the ECTA process. The OL and ECTA team have implemented procedures and issued guidance aligning with Term 42.b requirements. Data collection is ongoing to assess the utilization and effectiveness of these measures, with evidence indicating successful progress toward meeting the requirements of Term 42.b.	**Completed**
42.c) Within one month of the date of this Order, when providers do not take	DBHDS, through the Office of Licensing (OL), has implemented an on-going inspection	Previous studies have confirmed that DBHDS has licensing regulations at *12VAC35-105-160* that require providers to identify, report, and take prompt and appropriate action for any identified serious injury which includes incidents involving common risks and conditions referenced in this Term.	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
prompt action when such events occur, or where the risk is otherwise identified despite lack of prompt action by providers, DBHDS will ensure that corrective action plans are written, implemented, and tracked, and take further actions as warranted.	protocol that complies with the requirements of this action. This includes developing a corrective action plan for each cited violation, ensuring provider implementation of the plan, and enforcing progressive actions if non-compliance persists.	Additionally, *12VAC35-105-170* outlines requirements for providers to develop and submit a written corrective action plan for each violation cited. The Office of Licensing (OL), in its protocol for annual inspections, requires providers to meet each of the requirements at *12VAC35-105-520.B-D*. The following are key components of this section of OL's inspection protocol: 1. **Assessment of Policy:** During annual licensing inspections, the OL evaluates whether a provider's risk management policy/plan defines how they will identify, monitor, reduce, and minimize harms and risk of harm; whether their annual systemic risk assessment includes address of the environment of care, clinical assessment and reassessment processes, staff competence and adequacy of staffing, the use of high risk procedures, and a review of serious incidents including but not limited to those incidents relating to "care concerns". 2. **Corrective Action Plan (CAP):** If a provider's risk management policy/plan doesn't meet the requirements, the OL requires the provider to submit a CAP. This plan must detail how the provider intends to meet the regulation's requirements. The implementation of these plans is monitored by the OL. Should there be ongoing or additional concerns regarding the effectiveness of the corrective action(s), the OL has a protocol for progressive enforcement actions. 3. **Progressive Enforcement:** The OL inspection protocol enforces compliance among providers who fail to implement corrective action or repeatedly violate regulations. When assessing further steps, OL considers past violations, severity of infractions, provider size, number of locations, service type, and individuals served.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
		DBHDS, through the OL, has implemented an inspection protocol that complies with the requirements of this action. This protocol describes the process by which providers are required to develop a corrective action plan for each cited violation, ensuring provider implementation of the plan, and enforcing progressive actions if non-compliance persists.	
43. Timely Waiver Service Enrollment The Commonwealth will work to achieve a goal that 86% of individuals who are assigned a waiver slot will be enrolled in a service within five months.	For the 26th Period, the Commonwealth did not achieve the specified goal of this Term (formerly included in CI 35.8) because the most recently reported data, as found in the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 1st and 2nd Quarters*, dated 2/28/25, reported performance at 75.4% for Q1 FY25 and 78% for Q2 FY25. This represented a downward trend from previous reporting. The document did not	For the 25th Period, the Commonwealth did not achieve the specified goal of this Term (formerly included in CI 35.8)) because the most recently reported data, as found in the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2024 3rd and 4th Quarters*, dated 8/30/24, showed performance at only 81% for each of the first three quarters of FY24. This was consistent with the 81% performance reported for FY23, which was a decrease of two percentage points from FY22. For this 26th Period, the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 1st and 2nd Quarters*, dated 2/28/25, reported performance at 75.4% for Q1 FY25 and 78% for Q2 FY25. This represented a downward trend from previous reporting. The document did not address potential reasons for this trend. At the time of the 23rd Period, DBHDS submitted an applicable Process Document, entitled *DD CMSC VER 016*, dated 8/29/23, and an applicable Data Set Attestation, dated 8/30/23. These were sufficient to support data validity and reliability For this 26th Period review, these documents remained current.	Not Achieved

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	address potential reasons for this trend. At the time of the 23rd Period, DBHDS submitted an applicable Process Document, entitled *DD CMSC VER 016*, dated 8/29/23, and an applicable Data Set Attestation, dated 8/30/23. These remained current for the 26th Period and were sufficient to support data validity and reliability. For this 26th Period review, DBHDS reported these documents remained current.		
43 a) Within three months of the date of this Order, DBHDS will track on a quarterly	For this 26th Period, DBHDS tracked and reported quarterly data on the number of	At the time of the 24th Period review, DBHDS reported in its 2/14/23 report to the Court that it would collect this data quarterly. Specifically, DBHDS stated that the data for this measure would be transitioning to quarterly	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
basis the number of individuals who are assigned a waiver slot but not enrolled in a service within five months.	individuals who are assigned a waiver slot but not enrolled in a service within five months, as documented in the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 1st and 2nd Quarters*, dated 2/28/25.	tracking in Q3 SFY24 and that it would be available once the 150-day post-period occurs each quarter and reported in the next semi-annual report. During the 25th Period, DBHDS reported the data on a quarterly basis, as indicated in the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2024 3rd and 4th Quarters*, dated 8/30/24. As described above, for this 26th Period, DBHDS continued to report quarterly data, as documented in the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 1st and 2nd Quarters*, dated 2/28/25.	
43 b) Within three months of the date of this Order, the Commonwealth will contact individuals at the end of each quarter who have not been enrolled in a service within five months and their families and case managers to determine why services have not been initiated and what barriers delayed initiation of services. DBHDS will report on	For this 26th Period, DBHDS provided a Process Document, entitled *DS Waiver Service Enrollment Version 001*, dated 3/21/25, specific to Term 43b. It described a data collection process for monthly identification in WaMS of individuals who reached a five-month delay since being assigned an active accepted DD waiver slot and	At the time of the 24th Period, DBHDS staff reported in interview that the CMSC would review the data on a quarterly basis and recommend needed action, including, but not limited to, follow-up with individual participants who had not received services within the 150-day timeframe. However, during the 25th Period, DBHDS did not provide documentation this follow-up occurred. For this 26th Period, DBHDS provided a Process Document, entitled *DS Waiver Service Enrollment Version 001*, dated 3/21/25, specific to Term 43b. It described a data collection process for monthly identification in WaMS of individuals who reached a five-month delay since being assigned an active accepted DD waiver slot and remained without a waiver service. Of note, this Process Document is applicable solely to Term 43b, in order to initiate the identification and remediation of barriers once an individual reaches the five month mark without services. DBHDS still relies on the Process Document entitled *DD CMSC VER 016*, dated 8/29/23, to obtain valid and reliable data for Term 43 overall and Term 43a. DBHDS provided an updated *DS Waiver*	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
the barriers identified quarterly as well as actions being taken to remediate those barriers and results achieved.	remained without a waiver service. It also described a series of steps for follow-up with individuals meeting the five-month criterion during each month to determine (a) why services have not been initiated and (b) what barriers have delayed the initiation of services, as well as the processes for quarterly reporting with regard to barriers to service enrollment, actions being taken to remediate the barriers, and results achieved. DBHDS reported the initial Timely Waiver Service Enrollment Survey was conducted between March 12th-	*Service Enrollment Version 002*, dated 4/15/25, that clarified it is only for the requirements of Term 43b. The *DS Waiver Service Enrollment Version 002* describes a series of steps for follow-up with individuals meeting the five-month criterion during each month to determine (a) why services have not been initiated and (b) what barriers have delayed the initiation of services, as well as the processes for quarterly reporting with regard to barriers to service enrollment, actions being taken to remediate the barriers, and results achieved. To summarize, the Settlement Agreement Coordinator will make phone calls to the individuals/families, using a newly developed survey form, entitled *PI – 43.b Timely Waiver Service Enrollment*, to document the reasons for the delay (e.g., no provider available, no provider chosen by the individual, selected provider unable to provide the service, medical, behavioral or mental health treatment, incarceration, insurance or Medicaid delay). Additional probes drill down to document the services for which no providers are available as well as barriers that prevent an individual from choosing a provider. The Waiver Supports Network Director will extract the results from the survey forms into an excel spreadsheet and will then analyze the results monthly to determine barriers. The resulting *Quarterly Timely Waiver Service Enrollment Report* will summarize the reasons for identified why services were not initiated, barriers to those delays in services, solution actions and remediation is needed. The monthly data and the report will be made available to the Provider Network Support Director and the Assistant Commissioner of Community Services for further planning of actions and strategies. In a preliminary summary of the process, DBHDS reported the initial *Timely Waiver Service Enrollment Survey* was conducted between March 12th- March	

Table 2			
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	March 21st, 2025, with calls to all 98 of the individuals identified who had not initiated services within the 150 days. DBHDS submitted a preliminary summary of the process and identified several key barriers: a delay/issue with Medicaid enrollment, a delay/issue on the part of the Support Coordinator or CSB, or a lack of education of the available waiver services to the individual/family from the Support Coordinator or CSB. Of note, the Process Document *DS Waiver Service Enrollment Version 001* is applicable solely	21st, 2025, with calls to all 98 of the individuals identified who had not initiated services within the 150 days. Findings included the following: • Of the 98 individuals/families, 52 (53%) lived within Region 2. • For 44 of the 98 of the individuals/families (45%), the survey results identified a delay/issue with Medicaid enrollment. • For 33 of the 98 individuals/families (34%), the respondents identified a delay or issue on the part of the Support Coordinator or CSB, or a lack of education of the available waiver services to the individual/family from the Support Coordinator or CSB. • Ten of the 98 of the individuals/families (10%) reported that they have since initiated or began services, which was verified. In response to these findings, DBHDS reported actions taken thus far included sharing the Medicaid enrollment barrier with the Department of Medical Assistance Services (DMAS) to plan for future remediation as well as planning to make modifications to the survey to better capture "other" responses for aggregation.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	to Term 43b, in order to initiate the identification and remediation of barriers once an individual reaches the five month mark without services. DBHDS still relies on the Process Document entitled *DD CMSC VER 016*, dated 8/29/23, to obtain valid and reliable data for Term 43 overall and Term 43a.		
43c) Within one year of the date of this Order, the Commonwealth will conduct a root cause analysis of why services have not been initiated and what barriers delayed initiation of services. Based on the findings of the root cause analysis, the Commonwealth	This action is not required until 1/15/26 (one year from the approval of the permanent injunction. A final implementation plan was not completed.	This action is not required until 1/15/26 (one year from the approval of the permanent injunction. A final implementation plan was not completed.	**Due Date 1/15/26**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
will prioritize the findings for quality improvement in consultation with the provider and system issues resolution workgroups. The Commonwealth will implement a QII based on its prioritization consistent with continuous quality improvement principles and developed in collaboration with the provider and system issues resolution workgroups. The Independent Reviewer, in the reports required under paragraph 76, shall discuss the reasonableness of Virginia's response to this requirement. Individuals for whom initiation of services is delayed past five			

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
months at the request of the individual or the individual's authorized representative will not be included in determining if the Commonwealth meets the goal. The Commonwealth will revisit the root cause analysis annually and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			
44. Ongoing Service Analyses The Commonwealth, through DBHDS, will collect and analyze data at least annually regarding the management needs of	For this 26th Period, DBHDS did not yet meet the requirements of Term 44 to collect and analyze data at least annually regarding the management needs of	At the time of the 24th Period review, DBHDS initiated a very promising new annual monitoring process, the Intensive Management Needs Review (IMNR). The IMNR largely mirrored the Independent Reviewer's Individual Services Review (ISR) process, and was completed in parallel with that latter study. For the initial implementation of this process during the 24th Period, DBHDS conducted 30 on-site reviews of individuals with complex health/medical support needs, in conjunction with the Independent Reviewer nurses. For the	**Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
individuals with identified complex behavioral, health, and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS will develop corrective actions based on its analysis as it determines appropriate, track the efficacy of the actions, and revise as it determines necessary to address the deficiency.	individuals with identified complex behavioral and adaptive support needs, for the purposes of monitoring the adequacy of management and supports provided, including the development of corrective actions based on its analysis. DBHDS issued the most recent final analysis, the *Intense Management Needs Review Report Twenty-Fifth Review Period* in October 2024. It focused on the needs of individuals with complex health/medical support needs, but it did not specifically include reporting on individuals with	25th Period, the second phase of these parallel ISR and IMNR studies reviewed a different stratified sample of 30 individuals, including ten from each of the remaining two regions. DBHDS issued a report, entitled *Intense Management Needs Review Report Twenty-Fifth Review Period*, dated October 2024, that described the process and findings. While the simultaneous ISR studies during those two periods verified that the Commonwealth's IMNR process adequately identified health management needs for the sample studied and that Virginia took immediate action when one of those needs required urgent attention, DBHDS did not report a sufficient review for individuals with complex adaptive support needs or individuals with complex behavioral support needs. At the time of the 25th Period study, DBHDS submitted a Process Document entitled *Intense Management Needs Review Process – 36.8*, dated 8/27/24. It provided a step-by-step process for completing the sample review and remediation, but it did not yet address all three subgroups. It also did not provide a clear methodology for using the data collected to complete an annual analysis regarding the management needs of individuals in the target groups for the purpose of monitoring the adequacy of management and supports provided, including the development of corrective actions based on its analysis However, the above-referenced *Intense Management Needs Review Report Twenty-Fifth Review Period,* dated October 2024, did provide related analysis of the data collected. The report noted the top five reasons for remediation plans in the previous period included needed assessments, adaptive equipment repairs, dental exams/visits, documentation in need of being updated, protocols not in place or updated. The report also described systemic corrective actions DBHDS	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	complex behavioral and adaptive support needs. DBHDS provided a preliminary draft of a document entitled *PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period*, dated April 2025. The final version was not yet due for this Period's timeframe, which ended on 3/31/25. The draft document did not yet include reporting on the tracking of efficacy of the systemic corrective actions described above, or any needed revisions. It also did not yet include a full analysis of systemic findings and corrective actions based on the 26th Period	took, or planned to take, in response to the IMNR findings. For example, after recognizing during the previous review period that there was no way to capture needed nursing services if there was no provider available, DBHDS updated the ISP to capture additional data around nursing needs to ensure a comprehensive gap analysis could be completed. It also indicated lessons learned would be utilized to update the Skilled Nursing/Private Duty Nursing training for FY25. In addition, DBHDS planned to present findings to the Mortality Review Committee Quality Improvement work group on the utilization of Managed Care Organization (MCO) Care Coordination services, if necessary; to present findings to the Case Management Steering Committee to determine other opportunities in the workflow of a CSB Support Coordinator/Case manager to offer recommendations to individuals and their support teams inclusive of updating of OSVT; and collaborate with the DBHDS Medical Director for DD around opportunities in this review for improved communication and care in acute in-patient settings or specialty outpatient settings. For this 26th Period, although it does not require a statistically significant sample, Term 44 still requires that DBHDS collect and analyze data at least annually regarding the management needs of individuals with identified complex behavioral, health, and adaptive support needs to monitor the adequacy of management and supports provided, as well as to develop corrective actions based on its analysis as it determines appropriate, track the efficacy of the actions, and revise as it determines necessary to address the deficiency. For this 26th Period, DBHDS submitted a new Process Document entitled, *Intense Management Needs Review Process – PI44, Version 001,* dated 2/3/25. It	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	review. This study will review the finalized document during the 27th Period. DBHDS submitted a new Process Document entitled, *Intense Management Needs Review Process – PI44, Version* 001, dated 2/3/25, but it did not provide a clear methodology for the specific requirements for completing an annual analysis of the management needs of the target population as a whole, including individuals with complex behavioral and adaptive support needs. In interview, and as described further for Term 44a below,	again described a step-by-step methodology for the IMNR process required in Term 44b, as described further below. The Process Document referenced a report to be compiled to determine compliance with utilization rate and timeliness of nursing services and to assist in determining if individuals have unmet nursing needs or other medical needs as well as the adequacy of supports, but it did not state the report would address individuals with identified complex behavioral and adaptive support needs. Based on the Process Document, reports are completed semiannually and reported on April 15 and October 15 of each year. As discussed above, DBHDS issued the most recent final report (i.e. *Intense Management Needs Review Report Twenty-Fifth Review Period)* in October 2024, but it did not specifically include reporting on individuals with complex behavioral and adaptive support needs. In interview, and as described further for Term 44a below, DBHDS staff stated that efforts were also underway to complete a related consolidated report incorporating data from various sources, including the IMNR. Therefore, at this point it was not clear whether the reporting required in Term 44b could be sufficient to also address the requirements of Term 44 for reporting on individuals with complex behavioral and adaptive support needs. For this 26th Period, with regard to the Term's requirements for monitoring the adequacy of management and supports provided, developing and tracking the efficacy of corrective actions and making revisions to those actions as needed, the *Intense Management Needs Review Process – PI44, Version 001,* dated 2/3/25 did not provide a clear methodology for the specific requirements of Term 44 and Action 44a (i.e., the annual analysis of the management needs of	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	DBHDS staff stated that efforts were also underway to complete a related consolidated report incorporating data from various sources, including the IMNR. Therefore, at this point it was not clear whether the reporting required in Term 44b could be sufficient to also address the requirements of Term 44 for reporting on individuals with complex behavioral and adaptive support needs.	the target population as a whole, including individuals with complex behavioral and adaptive support needs). The *Intense Management Needs Review Report Twenty-Fifth Review Period*, dated October 2024, remained the most recent reporting and included the components of systemic analysis and corrective actions described above. DBHDS provided a preliminary draft of a document entitled *PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period*, dated April 2025. The final version was not yet due for this Period's timeframe, which ended on 3/31/25. The draft document did not yet include reporting on the tracking of efficacy of the systemic corrective actions described above, or any needed revisions. It also did not yet include a full analysis of systemic findings and corrective actions based on the 26th Period review. This study will review the finalized document during the 27th Period.	
44a) DBHDS will use data from the Skilled Nursing Review detailed in Paragraph 39(c), the IMNR process for individuals with complex medical	For this 26th Period, based on interview with DBHDS staff, DBHDS had not yet formulated or implemented a process for developing a report consolidating	For this 26th Period, based on interview with DBHDS staff, DBHDS had not yet formulated or implemented a process for developing a report consolidating the information and data from the Skilled Nursing Review, the IMNR, the care concerns process, the BSPARI quality reviews, and the Quality Service Reviews (QSRs) to monitor the adequacy of management and supports provided to individuals with complex needs.	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
needs, data from the care concerns process, data from the BSPARI quality reviews, and data from the Quality Service Reviews to monitor the adequacy of management and supports provided. Within six months of the date of this Order, DBHDS will develop a report consolidating the information from these sources to provide a comprehensive summary of the management and support provided to individuals with complex needs. This summary will be completed annually.	the information and data from the Skilled Nursing Review, the IMNR, the care concerns process, the BSPARI quality reviews, and the Quality Service Reviews (QSRs) to monitor the adequacy of management and supports provided to individuals with complex needs. DBHDS staff reported that meetings were currently underway to devise the methodology for this report and hope to have the first report to address the requirements of this Action by the 27th Period.	DBHDS staff reported that meetings were currently underway to address this requirement. An internal team was in the process of crafting a methodology for combing data and information from the IMNR reviews, QSR reviews, and BSPARI reviews. A recent meeting focused on the specific sections of the QSR reviews to include, particularly interviews with the individual and the family; however, DBHDS plans to revisit this after Round 7 QSR and the validation process is complete. DBHDS hopes to have the first report to address the requirements of this Action by the 27th Period.	
44b) DBHDS will continue to implement the IMNR process for	DBHDS did not yet complete the requirements of this	Based on a draft document entitled *PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period*, dated April 2025, DBHDS continued to implement the IMNR process during this 26th Period, beginning on 2/24/25 and concluding	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
no less than 70 people annually who have complex medical, behavioral, or adaptive support needs (Tier 4) to include onsite visits, reviews of specific health care documentation, and a factual questionnaire administered by qualified nursing professionals to primary caregivers most familiar with the person's health care needs.	Action because the cohort reviewed for this 26th Period still did not specifically include individuals with complex behavioral or adaptive support needs. Based on a draft document entitled *PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period*, dated April 2025, DBHDS continued to implement the IMNR process during this 26th Period for individuals with complex medical needs. DBHDS submitted a new Process Document entitled *Intense Management Needs Review Process – PI44, Version 001*, dated 2/3/25. It	3/14/25. DBHDS reported that they utilized lessons learned from the 25th Study Period to make modifications to the questionnaire to better determine if an individual's needs were being met. The cohort for the ISR study consisted of 29, instead of 30, individuals with SIS level 6 (i.e., complex medical) needs in Regions 1, 3 and 5. Although the sample originally included 30 individuals, unavoidable circumstances led to one individual being unable to participate. DBHDS and the Independent Reviewer agreed to move forward with 29 individuals for this review. The 26th Period's IMNR study was based on a randomly selected sample from a cohort of individuals with SIS level 6 scores (i.e., medically complex) and therefore not individuals with complex behavioral or adaptive support needs. For this 26th Period, DBHDS submitted a new Process Document entitled *Intense Management Needs Review Process – PI44, Version 001*, dated 2/3/25. It again described a step-by-step methodology for the IMNR process required in Term 44b, including completing the sample review and remediation. However, it still did not but provide a clear methodology for sample selection. The new Process Document stated that "(t)he Independent Reviewer will determine the criteria from which the sample will be drawn based on annual ISP meetings timeframe, SIS Level and Tier as well as Region. The OIH Project Manager requests the sample from the WaMS Data Analyst based on the criteria determined above. This is report DR0146. The sample is uploaded to the "Potential Sample" folder for that study period so that the Independent Reviewer can select the sample as well as alternates for each region."	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	again described a step-by-step methodology for the IMNR process required in Term 44b, including completing the sample review and remediation. It still did not but provide a clear methodology for sample selection. The Process Document stated that the Independent Reviewer will determine the criteria from which the sample will be drawn, and will select the sample as well as alternates for each region. Going forward, in order to ensure data validity and reliability, DBHDS will need to clearly incorporate the specific parameters for sample selection in the Process Document.	In addition, the sampling procedure did not address all three subgroups (i.e., including individuals with complex adaptive support needs or individuals with complex behavioral support needs). Going forward, in order to ensure data validity and reliability, DBHDS will need to clearly incorporate the specific parameters for sample selection in the Process Document. For example, the 25th Period Process Document described the random sampling procedure with more detail and precision, as follows: "(t)he cohort will include a randomly selected sample of individuals with SIS Level 6 needs who had their annual ISP completed 5 - 11 months prior to the scheduled site visits. The selected sample will be stratified for three Regions to ensure that individuals from all five Regions are evaluated at least annually and not include any individuals who had been reviewed in a previous study period or passed away since their last annual ISP." DBHDS has not yet provided a Data Set Attestation for this process.	

<table>
<tr><th colspan="4">Table 2</th></tr>
<tr><th>Term and Actions</th><th>Facts</th><th>Analysis/ Conclusion</th><th>26th</th></tr>
<tr><td></td><td>In addition, it did not address all three subgroups (i.e., including individuals with complex adaptive support needs or individuals with complex behavioral support needs).

DBHDS has not yet provided a Data Set Attestation for this process.</td><td></td><td></td></tr>
<tr><td>45. DD Service Providers' Compliance with Administrative Code. The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services comply with 12 VAC 35-105-620 in</td><td>Data from the CY2024 licensing inspection cycle shows that the Term 45 specified goal of 86% compliance with §620.C sub-regulations for DBHDS-licensed DD service providers—had not been achieved.</td><td>The Commonwealth calculates compliance with Term 45 by assessing whether 86% of providers met all 11 sub-regulations at 12VAC35-105-620.A-E and evaluating QI plan implementation. The table below compares DBHDS's sub-regulation scores across CY2022, CY2023, and CY2024. The CY2024 data was updated from the 25th study report to reflect data for the full licensing inspection cycle.

<table><tr><th>Reg #</th><th>CY2022</th><th>CY2023</th><th>CY2024</th></tr><tr><td>620A</td><td>93.73%</td><td>93.11%</td><td>87.13%</td></tr><tr><td>620B</td><td>92.07%</td><td>89.28%</td><td>80.86%</td></tr></table></td><td>Deferred</td></tr>
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<tr><th colspan="4">Table 2</th></tr>
<tr><th>Term and Actions</th><th>Facts</th><th>Analysis/ Conclusion</th><th>26th</th></tr>
<tr>
<td>effect on the date of this Order or as may be amended. To achieve that goal, the Commonwealth will take the following actions:</td>
<td></td>
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<table>
<tr><td>620C1</td><td>85.93%</td><td>84.77%</td><td>79.61%</td></tr>
<tr><td>620C2</td><td>83.27%</td><td>81.69%</td><td>69.96%</td></tr>
<tr><td>620C3</td><td>Not Measured</td><td>Not Measured</td><td>97.52%</td></tr>
<tr><td>620C4</td><td>77.76%</td><td>74.50%</td><td>69.96%</td></tr>
<tr><td>620C5</td><td>80.83%</td><td>79.85%</td><td>72.02%</td></tr>
<tr><td>620D1</td><td>84.91%</td><td>83.38%</td><td>75.68%</td></tr>
<tr><td>620D2</td><td>87.56%</td><td>87.76%</td><td>80.41%</td></tr>
<tr><td>620D3</td><td>77.77%</td><td>76.50%</td><td>67.38%</td></tr>
<tr><td>620E</td><td>82.94%</td><td>87.72%</td><td>83.51%</td></tr>
</table>

Year-over-year data indicates a decline in sub-regulations meeting the 86% threshold, dropping from four in CY2023 to two in CY2024. Data from the CY2025 licensing inspection cycle is not yet available, leaving insufficient information in this 26th period study to evaluate the Commonwealth's progress on this Term's requirements. The compliance determination is deferred until the 27th study, when complete CY2025 inspection data will be available.
</td>
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<tr>
<td>45.a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with 12 VAC 35-105-620.C.4 and D.3 (regarding corrective action plans)</td>
<td>Regulations at 12VAC35-105-170 require providers to develop, submit and implement a written corrective plan for each violation cited by the Office of Licensing (OL).</td>
<td>12VAC35-105-170 outlines requirements for providers to develop, submit and implement a written corrective action plan for each violation cited.

The Office of Licensing (OL), in its 2025 Annual Inspections for Providers of Developmental Services Memorandum, requires providers to meet each of the requirements described in regulation 12VAC35-105-620.C.4 and D.3.

The Expanded Consultation and Technical Assistance (ECTA) process, established by the Office of Community Quality Improvement and described</td>
<td>Completed</td>
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Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
develop and implement a corrective action plan that includes the receipt of technical assistance, additional training, and specific actions related to the respective areas of underperformance as determined appropriate by DBHDS.	The OL, in its protocol for annual inspections, requires providers to meet each of the requirements described at *12VAC 35-105-620.C.4 and D.3*. If the provider is cited for a violation, the protocol also requires the provider to develop and implement a corrective action plan. The Expanded Consultation and Technical Assistance (ECTA) process, established by the Office of Community Quality Improvement, offers providers technical assistance, additional training, and other specific actions as recommended or required by the OL.	in the *Expanded Consultation and Technical Assistance Standard Operating Procedures* effective 08/23/2024, offers providers technical assistance, training and other specific actions related to cited areas of under-performance as determined by the OL. Among other focus areas, this assistance helps providers develop and implement a quality improvement program that includes: • Monitoring implementation and effectiveness of approved corrective action plans pursuant to *12VAC 35-105-170* (§620.C.4); • Submitting revised corrective action plans to OL for approval; or • Continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies when reviews determine that a corrective action was fully implemented but did not prevent the recurrence of the cited regulatory violation or correct a systemic deficiency (§620.D.3). When a provider is found to be non-compliant with specific regulations including but not limited to §620.A-E, the ECTA team identifies this through a report in the CONNECT system. The ECTA team then reaches out to the provider to offer support in meeting the requirements outlined in §620.A-E. As of 02/2025, ECTA sent 591 invitations to providers. Of the 235 providers, DBHDS assigned a Quality Improvement (QI) Specialist, 161 (68.5%) have completed or are in the process of completing the ECTA process. The OL and the ECTA team have established on-going procedures and protocols and issued guidance to providers that meets the requirements of Term 45.a. Data collection is underway to monitor the utilization and effectiveness of these procedures. The actions taken to date evidence successful completion of the requirements of Term 45.a.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
45.b) Within six months from the date of this Order, for providers who are not compliant with 12 VAC 35-105-620.C.4 and D.3 (regarding corrective action plans) for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's license as determined	The Office of Licensing (OL) conducts annual licensing inspections, issuing a Corrective Action Plan (CAP) for any regulatory requirement with which a provider is found non-compliant. If a provider is non-compliant with a regulatory requirement in two consecutive annual inspections, they must participate in the Expanded Consultation and Technical Assistance (ECTA) process within 45 days of receiving their most recent approved CAP. The OL also has written protocols that detail the criteria for and initiation of progressive	The Office of Licensing (OL) conducts annual licensing inspections to cite providers who fail to comply with regulatory requirements outlined in *12VAC35-105-620.C.4 and D.3*. In response to any cited non-compliance, providers must develop and implement a Corrective Action Plan (CAP) for each citation. If a provider is cited for the same violation during two consecutive inspections, they must begin the Expanded Consultation and Technical Assistance (ECTA) process within 45 days of receiving their latest approved CAP. Detailed ECTA requirements are outlined in the *ECTA Standard Operating Procedures, effective August 23, 2024*. In addition, to provide internal guidance to the Licensing Specialist/Investigator as it relates to how DBHDS takes progressive actions, OL developed and implemented an *Internal Protocol for Progressive Actions*. Continued non-compliance or failure to complete the required consultation may lead to progressive enforcement actions, as defined in OL protocols and required by Term 45.b. DBHDS escalates its actions based on the severity of the violations and includes measures detailed in the protocol. The Consultant reviewed two *Provider Corrective Action Plans* that confirmed adherence to the progressive enforcement actions required by Term 45.b. DBHDS's established licensure inspection protocols, details of its progressive enforcement process, and examples of progressive enforcement actions taken by OL demonstrate that the Commonwealth has established and implemented protocols for issuing progressive enforcement actions to providers with repeat non-compliance, including violations of §620.A-E and other regulatory requirements.	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
appropriate by DBHDS.	enforcement actions, which correspond to the severity of continued non-compliance with one or more specific regulatory requirements. These protocols outline the specific actions to be taken in response to ongoing non-compliance including those referenced in this action.		
45.c) Within 24 months of the date of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess the adequacy of provider quality improvement programs have established inter-rater reliability in	While the Office of Licensing (OL) has introduced procedural changes related to this action, these efforts do not establish a formal, measurable framework for continuously assessing inter-rater reliability. A comprehensive approach would	The Office of Licensing (OL) is implementing procedural changes to address this action, including: 1. **DD Inspection Training**: All Licensing Specialists will receive DD Inspection Training upon hire and annually. If issues arise regarding a Licensing Specialist's compliance determinations, additional relevant training will be provided. 2. **Unannounced Inspections**: Regional Managers will conduct unannounced inspections with each Licensing Specialist during their first three months of employment. The Managers will observe the inspection process, provide feedback, and review draft reports to ensure adherence to regulations, guidance documents, and checklists.	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
conducting such assessments.	require regular comparative evaluations of each Licensing Specialist at a set frequency, the generation of objective scores, and the aggregation of data for ongoing reliability assessments.	3. **Parallel Inspection Determinations**: Regional Managers will assign tenured Licensing Specialists to new hires to conduct parallel inspections. This ensures consistent interpretation and compliance with regulations, guidance documents, and checklists. 4. **Quality Improvement Specialist Look-Behinds:** The Quality Improvement Review Specialist conducts a look-behind on two (2) completed and approved licensing inspection reports each week focusing the review on only regulations 520 and 620. While these actions are valuable and expected to improve consistency in compliance determinations, they do not establish a formal, measurable framework for continuously assessing inter-rater reliability. To fully meet the objectives of Term 45.c within the 24-month timeframe (i.e., by January 15, 2027), OL should develop and implement a formal process for measuring inter-rater reliability. This process should include comparative evaluations of each Licensing Specialist at a set frequency, generate objective scores, and provide aggregated data for ongoing reliability assessments.	
46. Quality Service Monitoring. The Commonwealth will work to ensure that, using information collected from licensing reviews and Quality Service Reviews, it identifies providers that	For this 26th Period, the study deferred a finding regarding whether the Commonwealth met the requirements for Term 46 because Round 7 QSR will not be completed during the 26th Period.	At the time of the 25th Period, DBHDS continued to offer the very successful Expanded Consultation and Technical Assistance (ECTA), targeted to providers that have been unable to demonstrate adequate quality improvement programs as indicated through licensing reviews and the QSR process. However, based on review of the QSR methodology and a comparative sample of 36 providers that had a Round 6 PQR as well, as on the findings outlined in CI 43.1 and 44.2 above, the QSR process did not yet consistently yield an accurate picture of technical assistance needs. The study found	**Deferred**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
have been unable to demonstrate adequate quality improvement programs and offers technical assistance as necessary.	Therefore, no new data were available during this period to evaluate its reliability. For this 26th Period, the consultant and DBHDS staff engaged in a collaborative review of the PQR tool in advance of the initiation of Round 7 QSR, which was scheduled to begin on 4/21/25. DBHDS staff then worked with the QSR vendor staff to make appropriate revisions and, in some instances, to provide additional guidance and clarifications. Upon final review, the consultant and DBHDS staff agreed the PQR tool	ongoing significant discrepancies with the findings of the IR consultant, calling into question the validity and reliability of the QSR data. For this 26th Period, with regard to offering technical assistance, DBHDS again continued to offer the very successful ECTA. DBHDS provided a document entitled *ECTA 2024 Status Summary as of 2/6/2025* indicating that 591 providers met criteria for ECTA and 315 accepted the ECTA invitation. Of those, 87 completed the technical assistance and 74 remained in progress. Based on review of the document entitled *Expanded Consultation and Technical Assistance Standard Operating Procedures*, effective 8/28/24, and updated revised 1/9/25, any licensed DD provider with an OL-approved CAP specific to the focus regulations or a QSR vendor-approved QIP specific to the above focus elements is eligible to receive ECTA. The above-referenced document described procedures for identifying such providers through licensing reviews and QSR results. As described above with regard to Action 45b, if a provider is non-compliant with a regulatory requirement in two consecutive annual inspections, participation ECTA process is now mandatory, beginning within 45 days of receiving their most recent approved CAP. For this 26th Period, to address the validity and reliability of QSR findings regarding the adequacy of provider quality improvement programs, the consultant and DBHDS staff engaged in a collaborative review of the PQR tool in advance of the initiation of Round 7 QSR, scheduled to begin on 4/21/25. At the outset of this collaborative process, the consultant reviewed the draft PQR items intended to identify providers that have been unable to demonstrate adequate quality improvement programs.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	contained 22 items with sufficient guidance to address 620B, (i.e., use of quality improvement tools), 620C1(i.e., annual review and update of the QI Plan), 620C2 (i.e., definition of goals and objectives), 620C3 (i.e., inclusion and reporting of statewide performance measures), 620C5 (i.e., monitoring and evaluation of progress toward meeting goals and objectives), 620D1 (i.e., provider policy and procedures for establishing goals and objectives and 620D2 (i.e., provider policy and procedures for updating the quality improvement plan). As a result of the preparatory work	DBHDS defines said adequacy in 12VAC35-105-620; however, Term 46 does not specifically require that the QSR will assess the totality of 12VAC35-105-620. This gave DBHDS leeway to determine what portions of the regulation QSR would focus on for Round 7. This was consistent with a DBHDS memorandum to providers on 3/25/25 that differentiated the roles and responsibilities of OL (i.e., to assure all minimum regulatory standards are met) from those of the QSR process (i.e., to ensure providers and CSBs are working towards improving and enhancing the quality of their efforts). The consultant therefore recommended that DBHDS clearly define the scope of work related to quality improvement that it would assign to QSR. In addition, for the regulatory requirements within that QSR scope of work, DBHDS needed to clearly define the PQR items that would be used to collect those data, accompanied by sufficient reviewer guidelines and the criteria for deciding whether an item is accurately scored. DBHDS staff then worked with the QSR vendor staff to make revisions and, in some instances, to provide additional guidance and clarifications. Upon final review, the consultant and DBHDS staff agreed the PQR tool contained 22 items with sufficient guidance to address 620B, (i.e., use of quality improvement tools), 620C1(i.e., annual review and update of the QI Plan), 620C2 (i.e., definition of goals and objectives), 620C3 (i.e., inclusion and reporting of statewide performance measures), 620C5 (i.e., monitoring and evaluation of progress toward meeting goals and objectives), 620D1 (i.e., provider policy and procedures for establishing goals and objectives and 620D2 (i.e., provider policy and procedures for updating the quality improvement plan).	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	described above, the quality improvement data produced in 7 Round 7 will be considered valid (i.e., that it measures what it purports to measure.). At the time of the 27th Period, the consultant will complete another comparative sample as a reliability evaluation, applying the defined QSR quality improvement items, including the reviewer guidelines and the scoring criteria. Otherwise, for this 26th Period, DBHDS continued to offer a very successful Expanded Consultation and Technical Assistance (ECTA) to providers who have licensing deficiencies	Round 7 QSR will not be completed during the 26th Period. As a result of the preparatory work described above, the Round 7 data available can be considered valid (i.e., that it measures what it purports to measure.) With regard to data reliability related to quality improvement , the QSR vendor refined various protocols for Round 7. These included the following: • Final Round 7 QSR Methodology: This document indicated the scope of the PQR Tool included review of provider quality improvement and risk management plans, processes, and strategies and the effectiveness of each, review of data across the organization, including serious incident reports, abuse/neglect reports, reports on the use of seclusion and restraint, individual community participation reports, and/or other performance data, such as staff competency or training, or medication errors, and assessment of the provider's quality improvement plan's goals/objectives and review of evidence supporting the active implementation of the provider's/CSBs quality improvement programs. It indicated the PQR Tool is structured to probe the effectiveness of quality improvement strategies; whether the provider/CSB has a quality improvement plan that meets DBHDS regulations, if the quality improvement plan includes measurable goals/objectives that utilize performance data; and whether the provider/CSB is collecting, measuring, calculating, tracking, and reviewing performance data in key areas, using tracking tool(s), specifically trend analyses, to assess progress towards quality improvement goals that utilize performance data to measure progress, and promoting individual participation in meaningful work as defined by DBHDS, participation in non-large	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	for 12VAC35-105-520, 12VAC35-105-620 12VAC35-105-450, and for providers who receive a QSR QIP for provider collection and tracking of performance data (e.g., serious incident and other risk information, etc.)	group activities, and participation in activities with people with whom they do not live. • Round 7 QSR Training Plan: This document indicated related quality improvement reviewer training items would include the active quality improvement plan and current risk management plan; related policies and procedures and performance data measurement, calculation, review, and tracking and trending. • Round 7 QSR IRR Policy: This document indicated that Feedback from DBHDS SMEs about the most appropriate scores is incorporated into the reviewer training curriculum. It states that, prior to the beginning of each round of the QSR, the QSR vendor will work with the DBHDS Office of Clinical and Quality Management (OCQM) to review the PQR and PCR tools to ensure terms and expectations contained within align with those of DBHDS or DBHDS affiliated entities that use QSR data. Prior to each round, DBHDS will also provide the QSR vendor with updated process documents for each DBHDS or DBHDS-affiliated entity that uses QSR data. Further, prior to the development of reviewer training, the QSR vendor will establish scoring concordance for the PCR and PQR tools between its "gold" reviewers and DBHDS SMEs using a sample set of documents for each assessment. Also with regard to data reliability, at the time of the 25th Period, DBHDS updated a Process Document entitled *QSR Quality Improvement Findings*, dated 8/18/24. It did not address the significant IRR discrepancies between QSR reviewer findings and those of experts in the field, such that DBHDS could not demonstrate that they could adequately identify the quality improvement technical assistance needs of providers.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
		However, DBHDS staff had already begun working to develop remedial strategies to address these threats. For this 26th Period, DBHDS provided two new relevant documents intended to address this concern. The stated purpose of the first document, entitled *DBHDS Quality Service Reviews: Inter-rater Reliability Assurance Plan*, finalized 3/18/25, was the establishment of processes for validating QSR results against other business area data collected. The document indicated that, for all data where QSR dataset data is used to assert the quality of the service system, DBHDS staff will identify a secondary data source to which to compare and validate QSR dataset for each QSR round. Further, the document indicated that the data process documents should include "the data source used for validating QSR results, processes for validation, associated QSR dataset calculations, associated QSR vendor calculations as evidenced by any ad hoc QSR reports requested of the QSR vendor by the business area, and what happens if and when incongruence between the QSR dataset and the data source data used for validation is identified (how the business area shares calculation steps, the process for validation, and the identified incongruence with the vendor and works with the vendor to understand and address the incongruence)…" DBHDS also provided a revised Process Document entitled *QSR Quality Improvement Findings Version 003,* dated 3/28/25. This document indicated the changes to this version were limited to adding a QSR Inter-Rater Reliability to Section VII – Continuous Quality Improvement (CQI). Similarly to the process described in the *DBHDS Quality Service Reviews: Inter-rater Reliability Assurance Plan (Inter-rater Reliability Assurance Plan),* the Instructions in the beginning of this Process Document state that the CQI section should provide	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
		a detailed step-by-step process describing what will be done to monitor and improve process as time progresses. However, the current Process Document simply stated an intention that "QSR data is validated against licensing reviews data to ensure there is consistency in reporting between the QSR dataset and the validation source datasets." It did not provide a level of detail that met the expectations of the *Inter-rater Reliability Assurance Plan* or the Process Document Instructions and was not yet sufficient to serve as a meaningful validation process. Of note, DBHDS had just recently finalized the *Inter-rater Reliability Assurance Plan,* so it may be expected that more detailed steps will be forthcoming. Overall, the strategy as described in the *Inter-rater Reliability Assurance Plan* appears to be sound and, once fully detailed, holds promise for achieving validation data quality and reliability. The 27th Period study will include a review and evaluation of the final data validation methodology. At a minimum, it is recommended that the specific methodology and expectations for establishment of scoring concordance for the PQR abstraction tools between DBHDS Subject Matter Experts (SME) and QSR gold reviewers be incorporated into the CQI processes. Importantly, it is the vendor gold reviewers who set the standard for establishing the QSR vendor's internal inter-rater reliability for each reviewer for each round, with an 80 percent or higher concordance required. This is a crucial function, then, for addressing the long-standing discrepancies between QSR reviewer findings and those of experts in the field. For this 26th Period, though, no new data will be available to evaluate the reliability of the data, and that process will be deferred until the 27th Period. At that time, the consultant will complete another reliability evaluation,	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
		applying the defined QSR quality improvement items, including the reviewer guidelines and the scoring criteria, to a comparative sample. Therefore, this study will defer a finding of whether the Commonwealth meets the requirements of this Term until the 27th Period.	
46a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with quality improvement program regulations develop and implement a corrective action plan. DBHDS will continue to employ a total of 12 Quality Improvement Specialists. DBHDS Quality Improvement Specialists will continue to offer providers technical assistance, additional training, and specific actions related to the respective areas of underperformance.	For this 26th Period, DBHDS completed the requirements of this action. DBHDS requires that providers who receive OL citations for failing to comply with the regulatory requirements outlined in 12VAC35-105-620 must develop and implement a Corrective Action Plan (CAP) for each citation, as described in 12VAC35-105-170.	For this 26th Period, the OL continues to conduct annual licensing inspections to cite providers who fail to comply with regulatory requirements outlined in 12VAC35-105-620. In response to any cited non-compliance, providers must develop and implement a Corrective Action Plan (CAP) for each citation, as described in 12VAC35-105-170. DBHDS also continues to employ a total of 12 Quality Improvement Specialists (QIS), who provide the ECTA individualized consultation and technical assistance, tailored to provider organizations' specific needs (i.e., as identified through licensing reviews or QSR findings), in the form of in-person and virtual one-to-one sessions. Per the *Expanded Consultation and Technical Assistance Standard Operating Procedures*, all QIS staff receive mandatory Intensive ECTA training before assignment to providers for the initiation of ECTA. New hires also shadow different QIS during their first month of employment. QIS are paired to work together, providing ECTA for one month before conducting ECTA sessions individually and all QIS staff receive supervision.	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
46b) Within six months from the date of this Order, for providers who are not compliant with quality improvement program regulations for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's license as determined	For this 26th Period, and as described above for Action 46c, DBHDS completed this action. The Office of Licensing (OL) conducts annual licensing inspections to cite providers who fail to comply with regulatory requirements outlined in 12VAC35-105-620. In response to any cited non-compliance, providers must develop and implement a Corrective Action Plan (CAP) for each citation, as described in 12VAC35-105-170. If a provider is cited for the same violation	For this 26th Period, and as described above for Action 46c, DBHDS has completed this action. The Office of Licensing (OL) conducts annual licensing inspections to cite providers who fail to comply with regulatory requirements outlined in 12VAC35-105-620. In response to any cited non-compliance, providers must develop and implement a Corrective Action Plan (CAP) for each citation, as described in 12VAC35-105-170. If a provider is cited for the same violation during two consecutive inspections, they must begin the Expanded Consultation and Technical Assistance (ECTA) process within 45 days of receiving their latest approved CAP. Detailed ECTA requirements are outlined in the ECTA Standard Operating Procedures, effective August 23, 2024. In addition, to provide internal guidance to the Licensing Specialist/Investigator as it relates to how DBHDS takes progressive actions, OL developed and implemented an Internal Protocol for Progressive Actions. Continued non-compliance or failure to complete required consultation may lead to progressive enforcement actions, as defined in OL protocols and required by Term 45.b. These actions escalate based on the severity of the violations and include measures detailed in the protocol. The Consultant reviewed two Corrective Action Plans that confirmed adherence to the progressive enforcement actions required by Term 45.b. The established licensure inspection protocols, details of the progressive enforcement process, and examples of progressive enforcement actions taken by OL demonstrate that the Commonwealth has established and implemented	**Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
appropriate by DBHDS.	during two consecutive inspections, they must begin the Expanded Consultation and Technical Assistance (ECTA) process within 45 days of receiving their latest approved CAP. Continued non-compliance or failure to complete required consultation may lead to progressive enforcement actions, as defined in OL protocols, These actions escalate based on the severity of the violations and include measures detailed in the protocol. The Consultant reviewed two Corrective Action Plans that confirmed	protocols for issuing progressive enforcement actions to providers with repeat non-compliance, including violations of §620.A-E and other regulatory requirements.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	adherence to the progressive enforcement actions required by Term 45.b.		
46c) Within 24 months of the date of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess the adequacy of provider quality improvement programs have established inter-rater reliability in conducting such assessments.	This action is not required until 1/15/27 (24 months from the approval of the permanent injunction). A full final implementation plan was not completed. The OL is implementing procedural changes to address this action; however, these changes do not establish a formal, measurable framework for continuously assessing inter-rater reliability. DBHDS had not developed and implemented a formal process for measuring	This action is not required until 1/15/27 (24 months from the approval of the permanent injunction. A full final implementation plan was not completed. However, as described in detail above with regard to Term 45, the OL is implementing procedural changes to address this action; however, while valuable and expected to improve consistency in compliance determinations, these changes do not establish a formal, measurable framework for continuously assessing inter-rater reliability. To fully meet the objectives of Term 46.c within the 24-month timeframe, OL should develop and implement a formal process for measuring inter-rater reliability. This process should include comparative evaluations of each Licensing Specialist at a set frequency, generate objective scores, and provide aggregated data for ongoing reliability assessments. DBHDS will also need to develop and implement a formal process for measuring inter-rater reliability between Licensing Specialists and the QSR reviewers assigned, under contract, to assess the adequacy of provider quality improvement programs. Based on interview with DBHDS staff, this development process is not yet underway and is pending the successful establishment of inter-rater reliability among Licensing Specialists and the same among QSR reviewers. As described above in more detail with regard to Term 46, DBHDS is actively engaged in efforts to enhance the accuracy of QSR reviewer findings regarding providers' quality improvement programs.	**Due Date 1/15/2027**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	inter-rater reliability between Licensing Specialists and the QSR reviewers assigned, under contract, to assess the adequacy of provider quality improvement programs. Based on interview with DBHDS staff, this development process is not yet underway and is pending the successful establishment of inter-rater reliability among Licensing Specialists and the same among QSR reviewers.		
49. Residential Services Community Integration. The Commonwealth will work to achieve a goal that 95% of residential service recipients reside	For this 26th Period, the Commonwealth did not achieve the specified goal for this Term because DBHDS staff reported that 93% of residential service recipients resided in a	At the time of the 24th and 25th Period reviews, the Commonwealth did not meet the goal that is specified for this Term 49 (previously included in CI 29.22) because it did not submit data reports that demonstrated 95% of residential service recipients reside in a location that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS settings.	**Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
in a location that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS settings.	setting that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS setting. In addition, DBHDS staff had not yet shown these data were reliable and valid. They reported they planned to develop a clear Process Document for this purpose. DBHDS also reported that for 4,156 locations that are currently serving a residential service recipient, 2,920 (70%) have completed validation that they are integrated in, and support full access to, the greater community in compliance with the CMS rule on HCBS	The data DBHDS submitted during the 24th Period indicated that only sixty-nine percent (69%) settings had been deemed compliant, based on a review by DBHDS, DMAS or as part of the QSR process. During the 25th Period, DBHDS did not submit a final data report, but rather a preliminary document entitled *HCBS Data* that indicated 88% (8479/9613) of residential service recipients resided in a location that was integrated in, and supported full access to the greater community. In addition, for both periods, significant concerns with data validity and reliability remained. DBHDS had made some improvements over time. It was of note, for example, that a revision to the Process Document, 10/23/24, indicated that, going forward, DBHDS will not count any provider requiring remediation as in compliance until evidence is obtained for any questions that were determined to be HCBS relevant with a no response, (i.e., DBHDS would follow up with the provider and require that the provider submit a remediation plan and documentation of remediation of no responses. of successful implementation of the remediation plan.) However, at the conclusion of the 25th Period study, many key HCBS requirements with regard to integration in and access to the greater community were not included in the list of QSR PCR questions used in the calculation, nor did the tool provide sufficient guidance for determining a Yes or No response. In addition, some HCBS-related PCR questions required text field responses rather than a Yes/ No response, and there was not a clear protocol for evaluating whether the text response reflected an HCBS deficiency. The previous reports provided numerous examples. In addition, DBHDS also needed to ensure the PQR tool includes all appropriate items in the calculation. It was not clear why the calculation did not include several	

Table 2			
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	setting. These exclude the approximately 700 active settings previously reviewed by the QSR vendor that require re-review, the 530 active settings that are still undergoing or finalizing remediation, and six settings that DBHDS has determined will not come into compliance. For this 26th Period, DBHDS submitted an updated Process Document entitled HCBS Ongoing Monitoring Process Document Version 2, dated 4/2/25. It described the processes for ongoing monitoring, but not the settings that still required an initial compliance validation.	items for which "No" answers would indicate HCBS noncompliance requiring remediation.(i.e., Does the provider promote individual participation in non-large group activities; Does the provider promote individual participation in non-large group activities; Does the provider encourage individual participation in community outings with people other than those with whom they live). In addition, consistent with the language of Term 49, DBHDS still needed to develop a formal written protocol that incorporated all of the validation processes in the approved Statewide Transition Plan (STP) and the requirements of the HCBS Settings Rule and related CMS guidance. In particular, DBHDS still needed to ensure that the protocol documents how it takes the following into account: • Per CMS guidance, the validation of settings compliance must be setting-specific. This means that the finding of compliance for one provider setting cannot be used to attest to compliance for the provider's additional settings. • Per the Commonwealth's *Addendum to the Commonwealth of Virginia's Statewide Transition Plan February 2019*, for onsite reviews to validate remediation, a "minimum of 25% of individuals receiving services in a setting will be interviewed and no less than 2 individuals for smaller settings of 2 or more persons receiving services." • Based on review of a September 24, 2024 communication from CMS and the attached *CMS Site Visit Report* for visit dates of 6/24/24 through 6/27/24, CMS identified various deficiencies in the validation processes and specified an expectation that the Commonwealth will incorporate remediation for these on a systemic basis. In particular, CMS stated that the issues in the report must be addressed in the state's	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	For the latter, DBHDS staff stated that, based on the previously identified validity and reliability concerns for the QSR dataset, the Commonwealth had elected to rely solely on the findings of DBHDS and DMAS reviewers for reporting compliance validation. As a result, they planned to have those staff re-review the 700 settings previously completed through the QSR process. DBHDS therefore needed to memorialize these distinctions in the submitted Process Document, or possibly consider two separate Process Documents, one for validation and	overall assessment process of all providers of HCBS to ensure that they are being assessed appropriately against all the regulatory settings criteria. The Commonwealth provided a written describing how it planned to address and apply the findings to ensure compliance. These requirements should be reflected in the DBHDS tools and protocols. • DBHDS still needed to ensure that the Process Document addressed potential threats to data reliability related to IRR deficiencies. During the 25th Period, the 10/23/24 revision of the Process Document included a strategy for an examination of potential IRR concerns for the use of the QSR data set, through a ten percent look-behind of QSR determinations. However, at that time, DBHDS still needed to ensure that the look-behind protocol was clearly defined and adequate for assessing and validating settings compliance. DBHDS also still needed to ensure that Process Documents and Attestations are in place for this specific use of the data from WaMS, CONNECT and the *HCBS Master Tracking Spreadsheet* maintained by DMAS. For this 26th Period, DBHDS staff reported that for 4,156 locations that are currently serving a residential service recipient, 2,920 (70%) have completed validation that they are integrated in, and support full access to, the greater community in compliance with the CMS rule on HCBS setting. These exclude the approximately 700 active settings previously reviewed by the QSR vendor that require re-review, the 530 active settings that are still undergoing or finalizing remediation, and six settings that DBHDS has determined will not come into compliance.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	one for ongoing monitoring. During this 26th Period, DBHDS continued to work to resolve the QSR validity and reliability concerns necessary to ensure adequate ongoing monitoring. The *HCBS Ongoing Monitoring Process Document Version 2*, included an ongoing 10% look-behind of QSR HCBS findings by the DBHDS HCBS Review Team staff, to incorporate a simultaneous review of documents as well as a shadowing of the onsite visit. The Process Document indicated the comparative results will be used to develop	Although DBHDS staff further reported that 9,714 of 10,437 (93%) residential service recipients resided in a setting that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS setting, they had not yet shown these data were reliable and valid. They reported they planned to develop a clear Process Document for this purpose. For this 26th Period, DBHDS submitted an updated Process Document entitled *HCBS Ongoing Monitoring Process Document Version 2*, dated 4/2/25. For context, it is important to understand that the Commonwealth's STP includes CMS-approved procedures for validating that all settings in existence prior to March 17, 2014 were in full compliance with all the requirements of the HCBS Final Rule. It also includes the approved procedures for ongoing monitoring of all validated settings to ensure they remained in compliance over time. These procedures are similar, but not exactly alike. For example, the STP indicates that for compliance validation, a minimum of 25% of individuals receiving services in a setting will be interviewed and no less than two individuals for smaller settings of 2 or more persons. The approved procedures for ongoing monitoring do not include this requirement. Instead, the STP states that "(o)nce a setting has been determined fully compliant, on-going monitoring will occur on an on-going basis consistent with the review authority detailed below for the following monitoring practices: DBHDS Office of Licensing reviews; DMAS Quality Management reviews; complaints filed with the Office of Human Rights; Community Resource Consultant recommendation; support coordination and monitoring of services and implementation of the ISP. Ongoing monitoring responsibilities will be incorporated in each entity's review and monitoring tools."	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	and implement training to correct discrepancies. The consultant and DBHDS staff collaboratively reviewed the proposed PCR and PQR tools before DBHDS initiated Round 7 QSR reviews. DBHDS made DBHDS revisions that addressed many of the identified HCBS compliance concerns However, DBHDS acknowledged that this was still a work in process and that the tools, particularly the PCR, will need additional revision to incorporate an adequate assessment of all the HCBS and Virginia STP requirements, as well as	Specifically with regard to validation, CMS approved a corrective action plan (CAP), effective 3/17/23, that gave the Commonwealth additional time beyond the timeframes defined in the approved STP to bring settings into compliance with the regulatory criteria directly impacted by the COVID-19 public health emergency. As discussed further below, these are the settings that required the Commonwealth to validate each that setting reached full compliance for the first time (i.e., as referenced in Term 49a). Once compliance validation occurs, the settings are thereafter subject to the ongoing monitoring procedures. With that in mind, based on review of the Process Document, it described ongoing monitoring rather than the compliance validation of the remaining settings as defined in the CAP. In interview, DBHDS staff indicated that the process for both was very similar. However, they also indicated that, based on the previously identified validity and reliability concerns for the QSR dataset, the Commonwealth had elected to rely solely on the findings of DBHDS and DMAS reviewers for reporting compliance validation. To this effect, DBHDS needed to memorialize these distinctions in the submitted Process Document, or possibly consider two separate Process Documents, one for validation and one for ongoing monitoring. During this 26th Period, DBHDS continued to work to resolve the QSR validity and reliability concerns necessary to ensure that ongoing monitoring accurately reflects that, at any given time, 95% of residential service recipients reside in a location that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS settings. The following bullets describe the status of that ongoing process:	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	the commitments DBHDS made in response to CMS-identified HCBS deficiencies in the *CMS Site Visit Report* completed in June 2024. DBHDS did yet not provide a Data Set Attestation for this measure, pending the ongoing 10% validation process. As reported previously, going forward, DBHD will also need to ensure that Process Documents and Attestations are in place for this specific use of the data from the QSR, WaMS, CONNECT and the HCBS Master Tracking Spreadsheet maintained by DMAS.	• The *HCBS Ongoing Monitoring Process Document Version 2*, included an ongoing 10% look-behind of QSR HCBS findings by the DBHDS HCBS Review Team staff, to incorporate a simultaneous review of documents as well as a shadowing of the onsite visit. The Process Document indicated the comparative results will be used to develop and implement training to correct discrepancies. In addition, DBHDS staff stated that these discrepancies will also be used to any needed guide tool revisions between QSR rounds. • The consultant and DBHDS staff collaboratively reviewed the proposed PCR and PQR tools before DBHDS initiated Round 7 QSR reviews. In the process, DBHDS addressed many of the concerns related to items in both tools that reflect HCBS compliance and needed to be included in the Commonwealth's calculation. However, DBHDS acknowledged that this was still a work in process and that the tools, particularly the PCR, will need additional revision to incorporate an adequate assessment of all the Final Rule requirements. For example, as communicated to DBHDS staff, it was not evident that the PCR sufficiently and/or clearly probed the actual experience of the right to privacy. In addition, the PCR tool probed whether a person has a modification of HCBS rights in the ISP, but did not have any corresponding probes of staff knowledge or appropriate implementation. DBHDS staff indicated they intended to make additional revisions to the tool after Round 7 and its 10% look-behind are complete. • Similarly, in its response to the CMS Site Visit, DBHDS asserted a number of steps it would take to address CMS-identified deficiencies on a systemic basis and these still need to be reflected in the appropriate tools. For example, for such deficiencies related to the requirement that	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
		the "setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact," DBHDS indicated it planned to tailor ongoing monitoring reviews to include more direct questions about autonomy (e.g., Are you able to stay home or decline an activity?; Does anyone tell you that you will be in trouble if you decline?; Are you able to hang-out with the people you choose?; Are you able to sit with your friends to play a game, watch TV or eat a meal?; and, Do you feel like the people around you listen to your goals and help you reach them?) DBHDS also indicated it intended to imbed a question about choice of representative payee as a means of assessing the control of personal resources in the ongoing monitoring tools. • To ensure the QSR assessment tools fully assessed all of the STP requirements for ongoing monitoring, DBHDS had begun a draft of a spreadsheet to crosswalk those requirements with the applicable PCR and PQR items. As discussed with DBHDS staff, it will be important to ensure that all the requirements are fully listed. In some instances, the regulations were summarized and therefore somewhat truncated, which could lead to some requirements not being addressed. For example, the crosswalk references that "(t)he setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community," but does not include the language "including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS."	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
		Round 7 data is not yet available; however, in any event, it will not reflect the additional changes that DBHDS has yet to make to yield valid and reliable data. Therefore, for this 26th Period, the specified goal of this Term is not achieved.	
49a) In accordance with its CMS-approved Statewide Transition Plan, by December 31, 2025, the Commonwealth will complete its review of the remaining 3,296 locations for compliance with the CMS settings rule to determine if it is in compliance with the 95% goal.	For this 26th Period, DBHDS is continuing to review settings to validate initial compliance with the CMS settings. The number of such settings pending review as of date of the approved CAP, effective 3/17/23, was 1,538, rather than 3,296. In interview, DBHDS staff indicated that, prior to this 26th Period, they had completed validation reviews for 1,758 settings and this accounted for the discrepancy. As an update following the initial interview,	As described above for Term 49, in addition to ongoing monitoring of compliant settings, DBHDS is continuing to review settings to validate initial compliance with the CMS settings. The number of such settings pending review as of date of the approved CAP, effective 3/17/23, was 1,538, rather than 3,296. In interview, DBHDS staff indicated that, prior to this 26th Period, they had completed validation reviews for 1,758 settings and this accounted for the discrepancy. As described above, given the previously identified validity and reliability concerns for the QSR dataset, the Commonwealth had elected to rely solely on the findings of ten DBHDS staff on the HCBS Review Team as well as DMAS QMR reviewers for reporting compliance validation for this group of settings. DBHDS staff reported that this was true for all the previous 1,758 compliance determinations, as it will be for the 1,538 settings that were listed in the CAP. As an update following the initial interview, DBHDS staff provided additional information that indicated the total number of settings left to validate stood at 1,230. This included the 700 settings originally assigned to the QSR vendor that Commonwealth staff were re-reviewing and another 530 settings that remained in remediation status. DBHDS staff anticipate completing this review by the 12/31/25 target date.	**In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	DBHDS staff provided additional information that indicated the total number of settings left to validate stood at 1,230. This included the 700 settings originally assigned to the QSR vendor that Commonwealth staff were re-reviewing and another 530 settings that remained in remediation status. DBHDS staff anticipate completing this review by the 12/31/25 target date. As described above with regard to Term 49, DBHDS provided a Process Document for ongoing monitoring of HCBS compliance, but it did not address the process for the initial compliance validations	As described above with regard to Term 49, DBHDS provided a Process Document for ongoing monitoring of HCBS compliance, but it did not address the process for the initial compliance validations required by Action 49a. DBHDS therefore needed to ensure it had a relevant Process Document in place, with an appropriate Data Set Attestation.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	required by Action 49a. DBHDS therefore needed to ensure it had a relevant Process Document in place, with an appropriate Data Set Attestation.		
52. Look-Behind Analysis of Abuse, Neglect, and Exploitation Allegations. The Commonwealth will continue its Community Look-Behind (CLB) review process to achieve a goal of collecting sufficient data for the Risk Management Review Committee (RMRC) to conduct or oversee a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and	In June 2023, DBHDS implemented a revised Community Look-Behind (CLB) review process to ensure all required outcomes are met. Since then, OHR Regional Managers have conducted quarterly CLB reviews with a comprehensive evaluation tool and reported results to the Risk Management Review Committee (RMRC). These reports continue to support trend analysis, recommendations for Quality Improvement	The Community Look-Behind (CLB) is a DBHDS process for reviewing abuse reports involving individuals receiving DD services in licensed community provider settings, conducted by the Office of Human Rights (OHR). Its review assesses the achievement of three outcomes outlined in Term 52: • **Outcome 1:** Comprehensive and impartial investigations completed within state-prescribed timelines. • **Outcome 2:** Investigators are trained in the investigation process. • **Outcome 3:** Providers implement timely and appropriate corrective action plans when needed**.** The current CLB sample review process, implemented in June 2023, continues to evolve. It involves 300 randomly sampled cases annually (75 cases per quarter) and is statistically significant. OHR Regional Managers conduct quarterly reviews to assess whether the specified outcomes are met. According to the *OHR Community Look-Behind Timeline*, findings are summarized and presented to the Risk Management Review Committee (RMRC) within three months of the quarter's end. For this study, the RMRC reviewed the *CLB Q1 FY25 Summary* report and documented the results of the review and follow-up actions in the *12/16/2024*	**Not Achieved**

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<tr><th colspan="4">Table 2</th></tr>
<tr><th>Term and Actions</th><th>Facts</th><th>Analysis/ Conclusion</th><th>26th</th></tr>
<tr><td>exploitation. The review will evaluate whether: (i) investigations of individual incidents occur within state-prescribed timelines; (ii) the person conducting the investigation has been trained to conduct investigations; and (iii) corrective action plans are implemented by the provider when indicated. The RMRC will review trends at least quarterly, recommend QIIs when necessary, and track implementation of initiatives approved for implementation.</td><td>Initiatives (QIIs), and tracking of approved initiatives.

OHR applies an 86% threshold, based on reviewer responses to the CLB Review Form, to assess outcome achievement. For Outcomes 1 – 3, OHR has found :
• Outcome 1: Comprehensive & Impartial Investigations – Success in meeting the threshold has been inconsistent.
• Outcome 2: Trained Investigators – The threshold has not yet been met.
• Outcome 3: Timely and appropriate CAPs when needed – The Threshold has</td><td>RMRC Minutes. The minutes also document the RMRC's analysis of trends over the past five quarters. Data from reviews over the past five quarters are summarized in the table below. The OHR applies an 86% threshold, based on CLB Review Form responses, to evaluate achievement of each outcome. Percentage scores below the 86% threshold are in red in the table:

<table><tr><th></th><th>Q3 SFY24 Results Jan-Mar</th><th>Q4 SFY24 Results Apr-Jun</th><th>Q1 SFY25 Results Jul-Sep</th><th>Q2 SFY25 Results Jul-Sep</th></tr><tr><td>Report Date:</td><td>6/17/24</td><td>9/16/24</td><td>12/16/24</td><td>3/31/25</td></tr><tr><td>RMRC Review:</td><td>6/17/24</td><td>9/16/24</td><td>12/16/24</td><td>3/31/25</td></tr><tr><td>Sample Size:</td><td>75</td><td>69</td><td>75</td><td>75</td></tr><tr><td>Outcome 1:</td><td>89%</td><td>81%</td><td>89%</td><td>83%</td></tr><tr><td>Outcome 2:</td><td>61%</td><td>59%</td><td>63%</td><td>65%</td></tr><tr><td>Outcome 3:</td><td>95%</td><td>100%</td><td>100%</td><td>100%</td></tr></table>
Outcome 2 continues to fall significantly below the 86% threshold. The Office of Human Rights (OHR) has identified the following contributing factors:
• Limited provider awareness and understanding of the "trained investigator" requirement.</td><td></td></tr>
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Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	been consistently met at 100% for the consecutive quarters**.** OHR's current inter-rater reliability (IRR) component in the CLB process is designed to be conducted annually, with the first review scheduled for 08/2025, after which results will be submitted to the RMRC. However, annual IRR assessments are insufficient, as delayed reporting to the RMRC hinders trend analysis and the timely implementation of corrective actions. To address this, OHR is developing an alternative process and will present it to the RMRC in 04/2025 for	• Uncertainty among providers about when and how to access required training for assigned staff. • High turnover in the "trained investigator" role. To address these concerns, DBHDS has implemented several measures: • **Verification and Documentation:** Providers must attest to staff training compliance. Waiver validation onsite visits now include trained investigator verification. OHR Advocates/Managers will focus on ensuring compliance and improving documentation procedures. • **Enhanced Training:** A revised web-based orientation informs providers about core OHR requirements, including investigator training access. • **Expanded Training Sessions:** Additional sessions are available to providers to meet training requirements. • **Competency-Based Training:** Procurement has begun for virtual train-the-trainer modules to support investigator training, with completion targeted for June 2025. Regarding the Quality Improvement Initiative (QII) required by this Term**, t**he *01/27/2025 RMRC Minutes* introduced a Quality Improvement Initiative (QII) to identify contributing factors and corrective actions. The *03/31/2025 RMRC Minutes* confirmed that a QII will be developed and implemented. Taneika Goldman will provide a follow-up report in the RMRC's April 2025 meeting regarding the implementation of the QII. The Consultant has raised concerns regarding the lack of a formal inter-rater reliability (IRR) assessment in the CLB process, particularly the insufficient frequency of look-behind reviews (currently conducted only once per year).	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	review and consideration.	Following our discussions, the OHR Director proposed revisions to the IRR process to the RMRC in the 03/31/2025 RMRC meeting. The RMRC approved the development of a formal structure, incorporating input from Virginia Commonwealth University staff experienced in the IMU Look-Behind Analysis. Additional details on implementation should be available for review by the Consultant during the 27th study. Despite current efforts, the requirements of Term 52 remain unmet. OHR's annual IRR assessments are insufficient. Delayed and potentially inconsistent reporting to the RMRC hinders trend analysis and the timely implementation of corrective actions. OHR is developing an alternative process and will present it to the RMRC in 04/2025 for review and consideration. Conducting IRR assessments only once per year is insufficient to ensure review consistency and data accuracy for RMRC analysis and recommendations. As a result, the Commonwealth has yet Not-Achieved the specified goal for Term 52.	
53. Samples of Data from Look-Behind Analyses of Serious Incidents and Allegations of Abuse, Neglect, and Exploitation. The Commonwealth will work to achieve a goal of showing 86% of the	Virginia Commonwealth University continues to conduct quarterly look-behind reviews of statistically valid random samples of DBHDS serious incident reviews, with results reported to the	Virginia Commonwealth University conducts quarterly look-behind reviews of a statistically valid random sample of DBHDS serious incident reviews, reporting findings to the Risk Management Review Committee (RMRC). Results from past four quarterly look-behind reviews of this process reflect that the Commonwealth consistently exceeds the 86% threshold required by this Term. The Office of Human Rights (OHR) also conducts quarterly reviews of reported abuse, neglect, and exploitation allegations and resulting	**Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
sample of serious incidents reviewed by the RMRC meet criteria reviewed in the audit and that at least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed by the RMRC meet criteria reviewed in the audit. The Commonwealth will continue the look behind process and provide feedback to the RMRC related to its findings. If this goal is not met by December 31, 2024, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	RMRC for analysis. The results from these look-behind reviews consistently meet/exceed the 86% threshold required by Term 53. Regional Manager staff in the Office of Human Rights continue to conduct look-behind reviews of a statistically valid random sample of reported allegations of abuse, neglect, and exploitation. The OHR measures achievement of each of three required outcomes using an 86% threshold based on responses to the CLB Review Form. The Commonwealth has inconsistently achieved the 86% threshold for	investigations, applying an 86% threshold based on responses to the *Community Look-Behind (CLB) Review Form*. As of Q2 SFY25 (October–December 2024): • **Outcome 1** (comprehensive and impartial investigations) has been inconsistently met over the past four quarters. • **Outcome 2** (trained investigators) has not yet met the threshold. • **Outcome 3** (timely and appropriate corrective action plans) has consistently achieved 100% compliance for the last three quarters. DBHDS has structured its current inter-rater reliability (IRR) process for its OHR Community Look-Behind reviews to be completed at the end of a 12-month cycle, with the first review scheduled for 08/2025. This delayed review process allows inconsistent data issues to persist which may compromise the quality of data that OHR submits to the RMRC. In the *03/31/2025 RMRC Meeting Minutes,* the OHR Director proposed developing an alternative methodology to provide more timely results. The RMRC approved the development of a proposal to restructure the process and implement the initiative, the results of which should be available for review by the Consultant during the 27th study. Term 53 requires DBHDS to: • Conduct a root cause analysis and implement a Quality Improvement Initiative (QII) if the 86% threshold is not met by December 31, 2024. • Sustain the threshold for one year before ending QII measures. While the IMU look-behind process consistently meets the 86% threshold, OHR CLB results continue to fall short. Despite OHR's efforts to identify contributing factors and implement corrective actions, the RMRC did not formally address the root cause analysis or QII requirements until their	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	completing comprehensive and impartial investigations and has not yet achieved the 86% threshold for ensuring investigations are conducted by trained investigators. They have, however, achieved and consistently exceeded the 86% threshold for timely and appropriate corrective action plans having achieved a 100% result in the past three consecutive quarterly reviews. The inter-rater reliability (IRR) process that is a necessary element of the CLB process remains insufficient, as reviews occur only at the end of a 12-month period, and	03/31/2025 meeting, when they instructed the OHR Director to initiate these processes. The Commonwealth has not yet achieved Term 53, which requires an 86% threshold across all look-behind review components. While DBHDS serious incident reviews consistently exceed this benchmark, the review process for reported allegations of abuse, neglect, and exploitation has yet to achieve all three required outcomes at or above 86%. Additionally, the Consultant continues to have concerns about the adequacy and timeliness of the IRR process in the CLB review system.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	the first review is still pending. This delay allows inconsistent data to persist, which has negative consequences for the quality of data provided to the RMRC for quarterly reviews.		
54. Annual Physical Exams. The Commonwealth will work to achieve a goal that 86% of individuals supported in residential settings receive annual physical exams.	For this 26th Period, DBHDS achieved the specified goal of this Term. While the most current version of the *Developmental Disabilities Annual Report and Evaluation, State Fiscal Year 2024*, reported FY 24 overall performance of 85.75%, a PowerPoint presentation entitled *Annual Physicals Permanent Injunction, 26th Study of the Independent Reviewer,* dated 4/1/25,	At the time of the 25th Period, DBHDS provided a report entitled *Office of Integrated Health Annual Physical and Dental Exams*, dated 8/6/24, that indicated for the four quarters of FY24, the overall performance was 85.75%. For this 26th Period, the most current version of the *Developmental Disabilities Annual Report and Evaluation, State Fiscal Year 2024, Published Date March 31, 2025* reported the same performance of 85.75%. However, a PowerPoint presentation entitled *Annual Physicals Permanent Injunction, 26th Study of the Independent Reviewer,* dated 4/1/25, indicated that the FY24 performance stood at 86.56%, which exceeded the requirement for this Term. Based on details provided by DBHDS staff, these data appeared to be valid and reliable. DBHDS staff explained that the on March 12, 2025, working with a WaMs Data Analyst, they completed a project to trend annual physical data back to FY21 utilizing the 14-month calculation method reflected in the current attested process. In the process, they recognized that pulling the data on a monthly basis and adding three months together at the end of the quarter failed to capture all the modifications made to the ISP (e.g., ISPs completed toward the end of third month of the quarter, but not finalized until after the quarter ended).	**Compliance**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	indicated that the FY24 performance stood at 86.56%, which exceeded the 86% goal for this Term. This revised data resulted from a DBHDS project to trend annual physical data back to FY21, utilizing the 14-month calculation method reflected in the current attested Process Document. The analysis also revealed that previous data collection procedures did not include a reconciliation of data at the end of each quarter or at the end of the fiscal year. Once the data analysis included the final reconciliation, the percentage of completed annual	DBHDS staff further explained that previous data collection procedures did not include reconciling this at the end of the quarter or the end of the fiscal year, which explained the discrepancy between the *Developmental Disabilities Annual Report and Evaluation, State Fiscal Year 2024* and the *Annual Physicals Permanent Injunction, 26th Study of the Independent Reviewer*. There was not time to correct the *Annual Report and Evaluation*; however, future reports will reflect the updated process. Going forward, even though they will continue to track monthly results, DBHDS staff will use the completed quarterly data for reporting and will ensure the Process Document prescribes a long enough period between the end of a quarter and the date the data are pulled to capture all the relevant modifications. It was also positive to see that the *Annual Physicals Permanent Injunction, 26th Study of the Independent Reviewer* reported the performance rate over the first three quarters of FY25 at 88.6%, with each quarter exceeding 86%. The presentation indicated DBHDS will report the data for the final quarter of FY25, and the cumulative percentage for the full year, in July 2025. In addition, based on requested data for FY24 Q4, which was reported at 86.36%, DBHDS met the requirement of this Term for the last four consecutive quarters. With regard to data validity and reliability, at the time of the 25th Period, DBHDS did not provide updated documents reflecting any of the changes recommended during the 23rd and 24th Period reviews. This included that the Data Set Attestation did not clearly reference the adequacy of mitigation strategies for ensuring that ISPs are completed by their effective date and that DBHDS needed to review and clarify the Scope section of the Process	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	physicals exceeded 86%. The aforementioned presentation also reported the performance rate over the first three quarters of FY25 at 88.6%, with each quarter exceeding 86%. Based on requested data for FY24 Q4, which was reported at 86.36%, DBHDS met the requirement of this Term for the last four consecutive quarters. DBHDS provided an updated Process Document, entitled *Annual Physical Exams Ver 006* and dated 3/13/25, that addressed previously identified needed revisions to ensure the	Document to reflect the 14-month calculation. The latter was in conflict with the changes in the sections entitled "Methodology" of the Process Documents. DBHDS also still needed to ensure the Attestation confirmed the adequacy of the remediation strategy for ensuring that ISPs are completed by their effective date. For this 26th Period, DBHDS provided an updated Process Document, entitled *Annual Physical Exams Ver 006* and dated 3/13/25, that included the needed revisions to ensure the Scope and Methodology sections reflected the 14-month look-behind period. This was adequate for data validity. However, similarly to the recommendation for Term 40 above, it is recommended that the Definitions section of the Process Document state clearly that an "annual" physical exam is one that occurs within that 14-month period. DBHDS also provided a Data Set Attestation for this Term, dated 3/31/25. Of note, the *Twenty-Sixth Period Individual Services Review Study: Individuals with Complex Medical Needs* completed during this 26th Period found that all but one of the individuals (97%) in the sample received an annual physical exam. This further supports the validity of the compliance finding. documentation provided also indicated that DBHDS continues to undertake initiatives to improve health awareness and participation in annual physicals. These included: • Continue to promote the "Annual Healthcare Visit Toolkit" found on the DBHDS website under Educational Resources. • Continue to provide and present as needed the slide deck "Importance of Annual Physicals aka Wellness Visits & Routine Check-ups."	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	Scope and Methodology sections reflected the 14-month look-behind period. This was adequate for data validity. However, the Definitions section of the Process Document should also clearly state that an "annual" physical exam is one that occurs within that 14-month period. DBHDS also provided a Data Set Attestation for this Term, dated 3/31/25.	• Continue to provide and present as needed the Health and Safety Alert titled "Annual Healthcare Visits." • Post and promote the "Recognizing Declining Health" training to the Commonwealth of Virginia Learning Center (COVLc) to further the community's understanding of the importance of having regular healthy visits to the primary care provider (PCP) so everyone has a clear understanding of what the individual's baseline regarding health and wellness. • Collaboration with the office of Provider Network Supports to enhance the questions in ISP 4.0 to allow for a deeper dive into the preventative screening aspects of annual healthcare and identify opportunities for additional growth around prevention.	
54a) Within six months of the date of this Order, any time there is not an increasing trend in the percentage of individuals receiving an annual physical exam in consecutive	This action is not required until 7/15/26 (six months from the approval of the permanent injunction. A final implementation plan was not completed.	This action is not required until 7/15/26 (six months from the approval of the permanent injunction.) As of the 26th Period study, the aforementioned PowerPoint presentation entitled *Annual Physicals Permanent Injunction,26th Study of the Independent Reviewer* indicated that using the 14-month look behind period, the data showed a steady rise in the rate of completion from 81% in FY21 to 88% in FY25 through Q3. DBHDS also provided a document entitled *Response Physicals PI54 4.21.2025* that showed an increasing trend for the each of the last four quarters (i.e., FY24 Q4-FY25 Q3).	**Due Date 7/15/2026**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
annual reporting periods, DBHDS will conduct a root cause analysis and determine whether a QII is warranted to address identified issues. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	As of the 26th Period study, the aforementioned PowerPoint presentation entitled *Annual Physicals Permanent Injunction,26th Study of the Independent Reviewer* indicated that using the 14-month look behind period, the data showed a steady rise in the rate of completion from 81% in FY21 to 88% in FY25 through Q3. DBHDS also provided a document entitled *Response Physicals PI54 4.21.2025* that showed an increasing trend for the each of the last four quarters (i.e., FY24 Q4-FY25 Q3).		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	DBHDS will report the data for the final quarter of FY25, and the cumulative percentage for the full year, in July 2025.		
55. Assessment of Licensed Providers of DD Services. The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. DBHDS will continue to conduct annual licensing inspections in accordance with Virginia Code § 37.2-	The Office of Licensing (OL) has an established process for consistently assessing providers' compliance with the risk management requirements outlined in 12VAC35-105-520. DBHDS continues to enhance training programs and tools for providers and Licensing Specialists. OL utilizes the *Annual Compliance Determination Chart* to provide Licensing Specialists with detailed instructions for evaluating compliance	The Consultant's review of annual licensing inspection data from previous studies confirms that the Office of Licensing (OL) has an established process for consistently assessing providers' compliance with the risk management requirements outlined in *12VAC35-105-520*. To support this process, OL utilizes the *Annual Compliance Determination Chart*, which provides Licensing Specialists with detailed instructions for evaluating compliance with each regulation. For the 2025 inspection cycle, the OL has further refined this *Annual Compliance Determination Chart* by tailoring requirements and inspection procedures to individual provider types. This updated Excel format offers Licensing Specialists more provider-specific guidance, enhancing the consistency and accuracy of compliance determinations. During the CY2024 annual licensing inspection cycle, the Office of Licensing (OL) conducted 1230 annual licensing inspections. From these inspections, Licensing Specialists found that 657/1230 providers (53.4%) met one or more of the requirements in §520. From 01/01/2025-03/03/2025, OL conducted 190 annual licensing inspections. From these inspections, Licensing Specialists found that 117/190 providers (61.6%) met one or more of the requirements in §520.	**Deferred**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
411 in effect on the date of this Order or as may be amended and assess provider compliance with risk management requirements in the Licensing Regulations utilizing the Office of Licensing Annual Compliance Determination Chart.	with each regulation. This document has been refined this year by tailoring requirements and inspection procedures to individual provider types. From 01/01/2025-03/03/2025, OL conducted 190 annual licensing inspections. From these inspections, Licensing Specialists found that 117/190 providers (61.6%) met one or more of the requirements in §520. A review of documentary evidence from 30 sample providers who underwent annual licensing inspections during this 2-month period noted Licensing	To assess the effectiveness of efforts to improve assessment consistency during the early stages of the CY2025 licensing inspection cycle, the Consultant reviewed a sample of 30 providers across five regions. These providers underwent licensing inspections between January 1 and February 28, 2025. This sample represents less than half of the inspections scheduled for the CY2025 cycle, meaning the findings cannot be generalized to the entire cycle. A more extensive sample review will be conducted as part of the 27th study, with those results incorporated into this review to provide a comprehensive evaluation of improvement efforts throughout the full 2025 annual cycle. Since the current sample results cannot be generalized, the determination for this Term is deferred until the completion of the 27th study, which will include a sample comparable to those from the 24th and 25th studies. The 26th study sample review focused on documentation related to Term 55's regulatory requirements, specifically assessing providers' compliance with §§520.A, 520.B, and 520.C.1-5. Licensing Specialists' compliance determinations were compared with independent assessments conducted by the Consultant through provider documentation reviews. These independent reviews aimed to mirror, as closely as possible, the process Licensing Specialists follow during annual inspections. The results below compare the average scores from the 24th and 25th studies (which included 80 providers) with the scores from the smaller sample in the 26th study (30 providers): • Has the provider designated a person responsible for the risk management function who has completed department approved training, which shall include training related to risk management, understanding of individual	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	Specialist assessment consistency was at or above 86% **in** three of the four assessment areas, with two areas achieving 100% consistency**.** However, challenges remain in accurately assessing compliance with §520.C.5**.** Due to the limited sample size in the 26th study, these findings cannot be generalized to the entire 2025 licensing inspection cycle. As a result, a formal determination is deferred until data from the 27th study is available, allowing for a more accurate comparison with previous sample reviews.	risk screening, conducting investigations, root cause analysis, and the use of data to identify risk patterns and trends? o **24th/25th: 99%** o **26th: 100% (improved)** • Has the provider implemented a written plan to identify, monitor, reduce, and minimize harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability? o **24th/25th: 92.5%** o **26th: 100% (improved)** • Has the provider conducted a systemic risk assessment at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services and does that risk assessment address each of the following requirements: (1) The environment of care; (2) Clinical assessment or reassessment processes; (3) Staff competence and adequacy of staffing; (4) Use of high risk procedures, including seclusion and restraint; and (5) A review of serious injuries. o **24th/25th: 91.5%** o **26th: 87% (slightly regressed)** • Did the licensing inspection include an assessment of whether providers use data at the individual and provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm (defined as risk triggers and thresholds/care concerns) in the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
		○ **24th/25th: 52.5%** ○ **26th: 63% (improved)** • Does the provider's systemic risk assessment process incorporate uniform risk triggers and thresholds (care concerns) as defined by the department? ○ **24th/25th: 83.6%** ○ **26th: 86.6% (improved)** Based on findings from the 30-provider sample**,** Licensing Specialist assessment consistency was at or above 86% in **four** of the five assessment areas**,** with **t**wo areas achieving 100% consistency**.** However, challenges remain in accurately assessing compliance with §520.C.5**.** As noted in the assessment of Term 42, the Office of Licensing (OL) and the Office of Clinical Quality Management (OCQM) should continue to assist providers to expand the use of data at both the individual and organizational levels to identify and address trends in harm and risk, as required by §520.C.5. Additionally, efforts should be strengthened to enhance inter-rater reliability among Licensing Specialists regarding provider compliance with quality assurance trending requirements (as outlined in Action 42.a under Term 42).	
56.Data-Driven Quality Improvement Plans for HCBS Waiver Programs. The Commonwealth will continue to implement the Quality Improvement Plan	For this 26th Period, DBHDS demonstrated improvement for the implementation of the HCBS Waiver Quality Improvement Plan, but did not yet meet the specified goals for Term 56. DBHDS did	At the time of the 25th Period, the QRT met twice during the review period to review and discuss performance measure data, but did not yet meet the specified goals for this Term (previously included in CI 35.1). QRT presentations focused on data reports for performance measures that fell below the 86% threshold and generally provided a brief synopsis of common findings that resulted in the lower scores. However, they did not provide information about the development or monitoring of specific needed quality improvement plans for measures falling below 86% compliance.	**Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
approved by CMS in the operation of its HCBS Waivers. The DMAS-DBHDS Quality Review Team (QRT) will meet quarterly in accordance with the CMS-approved Quality Improvement Plan and will review data, determine trends, and implement quality improvement strategies where appropriate as determined by the QRT to improve performance.	not provide evidence that the Quality Review Team (QRT) consistently discussed quality improvement strategies where appropriate. The meeting minutes for the QRT meeting on 1/23/25 demonstrated that the members reviewed data and discussed trends as well as efforts at remediation for each of the performance measures that fell below 86% during FY24. This was positive; however, the minutes did not consistently reflect a clear adoption and implementation of a quality improvement strategy, as detailed for Term 57 below.	For this 26th Period, DBHDS provided evidence that the QRT met twice, on 10/24/24 and 1/23/25, and reviewed measure data for FY24 Q4 and FY25 Q1, respectively. The meeting minutes for the QRT meeting on 1/23/25 demonstrated that the members reviewed data and discussed trends as well as efforts at remediation for each of the performance measures that fell below 86% during FY24. This was positive; however, the minutes did not consistently reflect a clear adoption and implementation of a quality improvement strategy, as detailed for Term 57 below. DBHDS did not provide meeting minutes for the QRT meeting held in October 2024. For that meeting, the evidence was limited to a PowerPoint presentation entitled *DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration SFY 24, Quarter 4* that demonstrated the members reviewed data for underperforming measures and broadly referenced trends, but did not show they discussed quality improvement strategies where appropriate. As described in more detail for Term 57 below, it was positive, though, that DBHDS submitted a document entitled *FY24 EOY QRT Underperforming Measures Tracker.* For each of eight underperforming measure, the document provided the FY24 data and documented if remediation efforts were in place and the rationale for each. DBHDS did not provide an updated tracker for FY25 Q1, but should consider using this tool on a quarterly basis to document progress and update the QRT's determinations about plan implementation and needed revisions.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	DBHDS did not provide meeting minutes for the QRT meeting held in October 2024. The evidence was limited to a PowerPoint presentation entitled *DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration SFY 24, Quarter 4* that demonstrated the members reviewed data for underperforming measures and broadly referenced trends, but did not show they discussed quality improvement strategies where appropriate. DBHDS submitted a document entitled *FY24 EOY QRT Underperforming Measures Tracker.* For each of		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	eight underperforming measure, the document provided FY24 data and documented whether remediation efforts were in place and the rationale for each. However, DBHDS did not provide an updated tracker for FY25 Q1.		
57.Data-Driven Quality Improvement Plans for HCBS Waiver Programs. The Commonwealth will continue to collect quarterly data on the following measures: (i) health and safety and participant safeguards; (ii) assessment of level of care; (iii) development and monitoring of individual service plans,	For the 26th Period, DBHDS did not yet meet the specified goals for Term 57 (previously included in CI 35.5) because the QRT did not yet consistently document the QRT ensured implementation of written remediation plans with defined measures that will be used to monitor performance every six months, or document a	At the time of the 25th Period, DBHDS did not meet the requirements of this Term 57 (formerly CI 35.5). While the QRT met quarterly to review data, they did not provide any systemic quality improvement plans and did not reference any review of related DBHDS QIIs in writing, did not have measures to monitor performance of these plans and did not have evidence of any formal monitoring every six months. For this 26th Period, based on review of two data collection spreadsheets (i.e., *SFY24 Annual DD Waiver QRT Data* and *SFY25 Q1 DD Waiver QRT Data*) DBHDS continued to collect data for the measures required by Term 57, including the waiver performance measures for (i) health and safety and participant safeguards (i.e. as outlined in Appendix G) ; (ii) assessment of level of care (i.e., as outlined in Appendix B); (iii) development and monitoring of individual service plans, including choice of services and of providers (i.e., as outlined in Appendix D); (iv) assurance of qualified providers, as outlined in Appendix C; e) whether waiver enrolled individuals' identified needs are met	**Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
including choice of services and of providers; (iv) assurance of qualified providers; e) whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR; and (v) identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation. This data will be reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans will be written and remediation actions implemented, as necessary, for those measures that fall below the CMS-established 86%	revised strategy when performance did not improve in that timeframe. Based on review of two data collection spreadsheets (i.e., *SFY24 Annual DD Waiver QRT Data* and *SFY25 Q1 DD Waiver QRT Data*) DBHDS continued to collect data for the goal required by Term 57. For this 26th Period, DBHDS reported that the QRT met twice, on 10/24/24 and on 1/23/25, to review quarterly data. For both meetings, DBHDS provided for review a PowerPoint presentation entitled *DMAS & DBHDS*	as determined by DMAS QMR (i.e., as outlined in Appendix D); and (v) identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation (i.e., as outlined in Appendix G). For both quarterly QRT meetings held during this period, DBHDS provided a PowerPoint presentation entitled *DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration*. These evidenced that the QRT members reviewed data reports for performance measures that fell below the 86% threshold. Review of the meeting minutes and presentation for the QRT meeting held on 1/23/25 evidenced that the QRT reviewed the measure data, and for most measures that fell below the CMS-established 86% standard, members discussed applicable remediation plans in the form of DBHDS QIIs and other initiatives or explored next steps for developing such plans. However, for the QRT meeting held in October 2024 DBHDS did not provide evidence to demonstrate that the members discussed quality improvement strategies. DBHDS did submit a very useful document entitled *FY24 EOY QRT Underperforming Measures Tracker*. Due to the absence of meeting documentation, though, it was unclear whether this was available for, or discussed at, the October 2024 QRT meeting. For each of eight underperforming measures, it was positive the document provided the full FY24 data and documented whether remediation efforts were in place and the rationale for each. Six of eight measures specified a DBHDS QII or other DBHDS initiative as the quality improvement strategy.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86% compliance. Quality Improvement remediation plans will focus on systemic factors (where present) and will include the specific strategy to be employed, as well as defined measures that will be used to monitor performance. Remediation plans will be monitored at least every six months. If such remediation actions do not have the intended effect, a revised strategy will be implemented and monitored.	*Quality Review Team (QRT) Quarterly Collaboration*. These evidenced that the QRT members reviewed data reports for performance measures that fell below the 86% threshold. Review of the meeting minutes and presentation for the QRT meeting held on 1/23/25 evidenced that the QRT reviewed the measure data, and for most measures that fell below the CMS-established 86% standard, members discussed applicable remediation plans in the form of DBHDS QIIs and other initiatives or explored next steps for developing such plans.	For the remaining two measures, the document also provided rationales for not undertaking remediation at that time. For the latter, however, it was unclear why for performance measure G10 (i.e., number and percent of participants 19 and younger who had an ambulatory or preventive care visit during the year) indicated that since performance measure data is only pulled at the close of the fiscal year, the QRT would be unable to determine future efforts until then, when the document provided that year-end data (i.e., 63%) for FY24. DBHDS did not provide an updated tracker for FY25 Q1. Based on the 1/23/25 QRT minutes, it appeared the members often discussed that DBHDS was implementing the QIIs or other DBHDS initiatives, but did not discuss the specific outcomes of those quality improvement strategies for the purpose of monitoring performance, evaluating their efficacy or making plan revisions. The QRT did not have clear written procedures describing the expectations for development, monitoring and revision of remediation/quality improvement plans and should develop them going forward. The procedures should include requirements for quarterly updating of the *Underperforming Measures Tracker* and consistent documentation of meeting proceedings.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	However, the QRT did not discuss the specific outcomes of those quality improvement strategies for the purpose of monitoring performance, evaluating their efficacy or making needed revisions. DBHDS did not provide evidence to demonstrate that the QRT discussed quality improvement strategies at the QRT meeting held in October 2024. DBHDS did submit a useful document entitled *FY24 EOY QRT Underperforming Measures Tracker*. Due to the absence of meeting documentation, though, it was unclear whether this was		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**26th**
	available for, or discussed at, the October 2024 QRT meeting. For each of eight underperforming measures, the document provided FY24 data and documented whether remediation efforts were in place and the rationale for each. Six of eight measures specified a DBHDS QII or other DBHDS initiative as the quality improvement strategy. The document also provided rationales for not undertaking remediation at that time. However, DBHDS did not provide an updated tracker for FY25 Q1.		

Recommendations:

1. To fully meet Term 42.a and 45.c objectives within 24 months, OL should establish a formal inter-rater reliability measurement process. This process should:
    - Conduct comparative evaluations of each Licensing Specialist at regular intervals.
    - Generate objective reliability scores based on assessment outcomes.
    - Provide aggregated data for ongoing performance analysis and reliability tracking.

   Implementing this structured approach will enhance consistency in Licensing Specialist determinations and strengthen regulatory compliance efforts.
2. The Office of Human Rights should continue its efforts to refine the inter-rater reliability component of the Community Look-Behind Analysis of Abuse, Neglect, and Exploitation Allegations to ensure accurate and timely data and information are being provided to the Risk Management Review Committee in each quarterly report.
3. The Office of Licensing should continue its efforts to ensure the accuracy of Licensing Specialist assessments of compliance with the requirements at 520.C.5 that relate to the provider's use of data at the individual and/or provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm (defined as care concerns) in the events reported.
4. For Term 40, DBHDS should ensure the Definitions section of the Process Document states clearly that an "annual" dental exam is one that occurs within that 14-month period. DBHDS should make some additional revisions to this Process Document to clarify that there is a single measure, rather than two (i.e., one for people with insurance and one regardless of insurance)
5. For Term 41, DBHDS should carefully review the Process Document and various related protocols to eliminate ambiguities regarding what MAY/MUST be referred and MAY/MUST be investigated, as well as to ensure that pre-injury circumstances are reliably addressed when determining whether to complete an investigation.
6. For Term 41, DBHDS needed to ensure that the proposed OIH quality review addresses each of the stated requirements, including the following: that the IMU processes adequately identify all appropriate injuries; that the processes adequately determines if the individuals were protected from harm, both prior to and after the serious injury occurred; and, to address any findings of concern, determine changes that might be needed to the way incidents are reviewed and referred.
7. For Term 44, DBHDS should clarify how it intends to address data collection and analysis reporting for individuals with complex behavioral and adaptive support needs.
8. For Term 46, to fully meet the objectives of Term 46.c within the 24-month timeframe, OL should develop and implement a formal process for measuring inter-rater reliability. This process should include comparative evaluations of each Licensing Specialist at a set frequency, generate objective scores, and provide aggregated data for ongoing reliability assessments. DBHDS will also need to develop and implement a formal process for measuring inter-rater reliability between Licensing Specialists and the QSR reviewers assigned, under contract, to assess the adequacy of provider quality improvement programs.
9. For Term 49, DBHDS should finalize a formal written protocol that outlines the QSR HCBS compliance process from start to finish, which should incorporate all of the validation processes in the approved Statewide Transition Plan (STP), the requirements of the HCBS Settings Rule and related CMS guidance, and the Commonwealth's responses to the *CMS Site Visit Report*.

10. Also for Term 49, DBHDS should ensure that the compliance calculation incorporates all of the PCR and PQR elements that address HCBS requirements with regard to integration in and access to the greater community and that each of compliance element with a Yes or No response provides sufficient guidance for making that determination. DBHDS should also consider requesting that CMS review the assessment/validation protocol and tools once these modifications are completed.
11. For Term 56 and Term 57, the QRT should develop and implement clear written procedures describing the expectations for development, monitoring and revision of remediation/quality improvement plans and should develop them going forward. The procedures should include requirements for quarterly updating of the *Underperforming Measures Tracker* and consistent documentation of meeting proceedings.

Interviews:
The following individuals provided information for this study through the Teams channel, email correspondence, and/or via telephone contact.

6. Heather Norton, Deputy Commissioner
7. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Governmental Relations
8. Michelle Laird, Incident Management Manager,
9. Katherine Means, Senior Director of Clinical Quality Management
10. Jae Benz, Director, Office of Licensing
11. Taneika Goldman, Director, Office of Human Rights
12. Mackenzie Glassco, Associate Director of Quality and Compliance
13. Angelica Howard, Associate Director of Administrative and Specialized Units
14. Rebecca Laubach, Director, Quality Improvement Analytics and Processes
15. Martin Kurylowski, Director Transition Network Supports
16. Brian Nevetral, Project Manager
12. Nicole DeStefano, Waiver Network Supports Director

Documents Reviewed:
Following is a summary of the documents utilized to draw conclusions about the content of this study:

1. 12VAC35-105-160
2. 12VAC35-105-170
3. 12VAC35-105-520
4. 12VAC35-105-620
5. Excel-Based Risk Tracking Tool
6. Overview of the Risk Tracking Tool Webinar Email Announcement (04/01/2025)
7. Expanded Consultation and Technical Assistance Standard Operating Procedures (effective 08/23/2024)
8. 2025 Annual Inspections for Providers of Developmental Services Memorandum
9. Internal Protocol for Progressive Actions
10. Approved Corrective Action Plans for one provider
11. OHR Community Look-Behind Timeline
12. CLB Q1 FY25 Summary Report
13. 12/16/2024 RMRC Minutes
14. 01/27/2025 RMRC Minutes
15. 03/31/2025 RMRC Minutes
16. Community Look-Behind (CLB) Review Form
17. 2025 Annual Compliance Determination Chart
18. Relevant evidentiary documents and CAP Reports for 30 providers that were included in the 26th Study Sample Review process
19. Behavioral Supports Report: Q1/FY25
20. DD_Therapeutic Consultation_BS_Ver_007, dated 10/2024 and Data Set Attestation dated 3/30/25
21. Annual Dental Exams Permanent Injunction

22. Annual Dental Exams Ver 007 and dated 3/13/25 and Data Set Attestation, dated 3/31/25
23. Dental Work Plan Outcomes.PI.2024-25.03.24.2025
24. Individuals Protected from Serious Injury, Version 005, revised 2/12/25
25. Office of Human Rights (OHR) Protocol No. 317, OHR Role in OL Incident Management (IMU) for Licensed Providers as of 2/4/25
26. Appendix D: Serious Injury Investigation
27. Triage Criteria for Determining if an Investigation is NOT Warranted
28. Potential Facts to Consider when Determining if an Investigation is NOT Warranted
29. Triage Questions to Consider after Discussions with the Provider
30. OL IMU_ Pre-Investigation Determination Triage for DD Deaths Serious Incidents_ Effective 10.1.2024
31. Risk-Mitigation-Tool-for-Serious-Incident-Reports-October-2024
32. Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 1st and 2nd Quarters, dated 2/28/25
33. DD CMSC VER 016, dated 8/29/24 and Data Set Attestation, dated 8/30/23
34. DS Waiver Service Enrollment Version 001, dated 3/21/25
35. DS Waiver Service Enrollment version 002, dated 4/15/2025
36. Preliminary Quarterly Timely Waiver Service Enrollment Report
37. Intense Management Needs Review Report Twenty-Fifth Review Period, dated October 2024
38. Intense Management Needs Review Process – PI44, Version 001, dated 2/3/25
39. PI 39, PI 44_Skilled Nursing_VER001
40. PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period, dated April 2025
41. ECTA 2024 Status Summary as of 2/6/2025
42. Expanded Consultation and Technical Assistance Standard Operating Procedures, revised 1/9/25
43. DBHDS Quality Service Reviews: Inter-rater Reliability Assurance Plan, finalized 3/18/25
44. QSR Quality Improvement Findings Version 003, dated 3/28/25
45. DBHDS Quality Service Reviews: Inter-rater Reliability Assurance Plan
46. Round 7 PCR Tool_2.27.25_F1
47. Round 7 PQR Tool_2.27.25_F2
48. Addendum to the Commonwealth of Virginia's Statewide Transition Plan February 2019
49. CMS Site Visit Report for visit dates of 6/24/24 through 6/27/24
50. HCBS Ongoing Monitoring Process Document Version 2, dated 4/2/25
51. Draft HCBS - QSR Crosswalk
52. Annual Physicals Permanent Injunction, 26th Study of the Independent Reviewer, dated 4/1/25
53. Annual Physical Exams Ver 006, dated 3/13/25
54. Response Physicals PI54 4.21.2025
55. DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration SFY 24, Quarter 4
56. SFY24 Annual DD Waiver QRT Data
57. SFY25 Q1 DD Waiver QRT Data
58. QRT Meeting Minutes 1.25.2025

59. DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration
60. FY24 EOY QRT Underperforming Measures Tracker
61. 24 QRT EOY Report Dashboard - results

APPENDIX H

List of Acronyms

ADL	Activities of Daily Living
APS	Adult Protective Services
ADA	Americans with Disabilities Act
AR	Authorized Representative
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Plan
BSPARI	Behavior Support Plan Adherence Review Instrument
CAP	Corrective Action Plan
CAT	Crisis Assessment Tool
CEAG	Community Life Engagement Advisory Committee
CEPP	Crisis Education and Prevention Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Manager
CI	Compliance Indicator
CIT	Crisis Intervention Training
CL	Community Living (HCBS Waiver)
CLO	Community Living Options
CM	Case Manager
CMS	Center for Medicaid and Medicare Services
COVLC	Commonwealth of Virginia Learning Center
CQI	Community Quality Improvement
CPS	Child Protective Services
CRC	Community Resource Consultant
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTA	Consultation and Technical Assistance
CTH	Crisis Therapeutic Home
CTT	Community Transition Team
CVTC	Central Virginia Training Center
DARS	Department of Aging and Rehabilitative Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disabilities
DDS	Division of Developmental Services, DBHDS
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice, United States
DS	Day Support Services

DSP	Direct Support Professional
DSS	Department of Social Services
DW	Data Warehouse
ECM	Enhanced Case Management
EDCD	Elderly or Disabled with Consumer Directed Services
EHA	Office of Epidemiology and Health Analytics (formerly DQV)
E1AG	Employment First Advisory Group
EPSDT	Early and Periodic Screening Diagnosis and Treatment
ES	Emergency Services (at the CSBs)
ESO	Employment Service Organization
FRC	Family Resource Consultant
GH	Group Home
GSE	Group Supported Employment
HCBS	Home- and Community-Based Services
HPR	Health Planning Region
HSN	Health Services Network
ICF	Intermediate Care Facility
ID	Intellectual Disabilities
IDD	Intellectual Disabilities/Developmental Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports ("DD" waiver)
IFSP	Individual and Family Support Program
IMNR	Intense Management Needs Review
IMU	Incident Management Unit
IR	Independent Reviewer
IRR	Inter-rater Reliability
ISE	Individual Supported Employment
ISP	Individual Supports Plan
ISR	Individual Services Review
KPA	Key Performance Areas
LIHTC	Low Income Housing Tax Credit
MLMC	My Life My Community (website)
MOU	Memorandum of Understanding
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
OCQI	Office of Continuous Quality Improvement
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIHSN	Office of Integrated Health Support Network
OL	Office of Licensing
OSIG	Office of the State Inspector General
OSVT	On-Site Visit Tool
PASSR	Preadmission Screening and Resident Review
PCR	Person Centered Review

PCP	Primary Care Physician
PHA	Public Housing Authority
PMI	Performance Measure Indicator
PMM	Post-Move Monitoring
POC	Plan of Care
PST	Personal Support Team
QAR	Quality Assurance Review
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QMD	Quality Management Division
QMR	Quality Management Review
QRT	Quality Review Team
QSR	Quality Service Reviews
RAC	Regional Advisory Council for REACH
RAT	Risk Assessment Tool
RCA	Root Cause Analysis
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RFP	Request For Proposals
RMRC	Risk Management Review Committee
RNCC	RN Care Consultants
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group
SEVTC	Southeastern Virginia Training Center
SIR	Serious Incident Report
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
VCU	Virginia Commonwealth University
VHDA	Virginia Housing and Development Agency
WaMS	Waiver Management System