DBHDS

Virginia Department of Behavioral Health and Developmental Services

Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2025
3rd and 4th Quarters

Case Management Steering Committee

Semi-Annual Report FY25 3rd and 4th Quarters

Executive Summary

As a subcommittee of the Quality Improvement Committee (QIC), the Case Management Steering Committee (CMSC) is responsible for

- monitoring case management performance across responsible entities to identify and address risks of harm,
- ensuring the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and
- evaluating data to identify and respond to trends to ensure continuous quality improvement.

The committee is charged with reviewing data selected from, but not limited to, any of the following data sets: Community Services Board (CSB) data submissions, Support Coordination Quality Reviews (SCQR), Office of Licensing citations, Quality Service Reviews (QSR), DMAS' Quality Management Reviews, Regional Support Teams (RST), and the Waiver Management System (WaMS). The committee's analysis identifies trends and progress toward meeting established Support Coordination/Case Management targets. Based on this data review and system analysis, the committee recommends systemic quality improvement initiatives (QIIs) to the QIC. The committee also recommends technical assistance based on review of CSB specific data. If CSB specific improvements are not demonstrated after receiving technical assistance, the committee makes recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract based on negative findings.

Committee membership includes the Director of Waiver Operations or designee, the Director of Provider Network Supports or designee, the Director of Community Quality Improvement or designee, the Settlement Agreement Director, one Quality Improvement Program Specialist (QIS), one Community Resource Consultant (CRC), and a Quality Research Specialist from the Office of Quality Assurance and Healthcare Compliance. Advisory members include a representative from the Office of Licensing and a Behavior Analyst. Standard operation procedures include annual review and update of the committee charter, regular meetings, at least ten times annually, to ensure continuity of purpose, maintenance of reports and meeting minutes, and quality improvement initiatives consistent with Plan, Do, Study, Act (PDSA) model.

Key Accomplishments

The CMSC continued to monitor concerns related to the release of ISP. Issues were reported in the previous CMSC Semi-Annual report. Concerns related to the release of ISP 4.0 have been corrected and an announcement went out via the Office of Provider Network Supports (OPNS) Listserv. Any changes related to Part I through IV will not be reviewed until the fall of 2025. We anticipate enhancements related to employment discussion

elements at a minimum.

The functionality of the Part V is also being explored. This includes the possible addition of dropdown boxes and auto populating dates. Updates to the Part V include outcomes still auto populating but with an update that will make more direct connections between outcomes and key steps allowable for their service. The update will simplify the elements and include prompting to include how often, by when, what to record, and details for if it is skill building and how to support. Revisions to the Part V were presented to the Systems Issues Resolution Workgroup and discussed with provider representatives. Updates are slated for the fall 2025 with FEI. All updates will be reviewed with the Provider Issues Resolution Workgroup (PIRW) before being finalized.

The CMSC discussed that providers who need to add an outcome to the Part V have been using the interim plan which is not the purpose of using the interim plan. Previously, this access was turned off but was reinstated for unknown reasons. If the interim plan is used, then a second service cannot be added. To provide education and training around this issue, the OPNS will release a walkthrough video on how to update the Part V when an individual's needs and preferences change.

Additionally, improvements to the RST module are being made. This includes incorporating an updated Virginia Informed Choice (VIC) form following the completion of the public comment period. The update to the VIC includes using a Service Selection Guide, which links to resources and provides plain language guidance to help individuals and families understand the informed choice process. It also addresses Centers for Medicare and Medicaid Services (CMS) concerns of the VIC being user friendly, using plain language, and being easier to follow. The Service Selection Guide is designed for families to be able to research and prepare questions prior to their meeting about services; it provides time for families and individuals to consider all options available. It is noted, however, some CSBs may need to make changes within their electronic health record (EHR) to accommodate the streamlined VIC form. Feedback has been incorporated from stakeholders including DMAS, Community Services Boards (CSBs), as well as individuals and families. The updated form was piloted by Prince William, Mount Rogers, and Colonial CSB. It has also been tested by three families. The VIC has been submitted to DMAS for public comment with posting on Virginia Town Hall pending at the time of this report. The CMSC will continue to discuss ISP 4.0 updates to the Part V, RST module, and the VIC as it gets closer to the development phase and the release date.

In February, the CMSC reviewed the Provider Data Summary, highlighting several trends. The percentage of Direct Support Professionals (DSP) supervisors completing the required supervisory training continues to be variable based on the number of supervisors being hired during a given month. Data indicated that over 90% of individuals in Virginia are already receiving services in the most integrated setting. Individuals who chose their job or had input into employment decisions stands at 95%, which is in the top ten reporting states, and well above the national average of 86%. The CMSC also examined provider counts by type over time, noting a reduction in crisis service providers and a potential loss of the sole EBHS provider. To enhance service delivery, the committee discussed ways to improve the experience and will think of ideas to cross committees and ways to share information and ideas.

The CMSC continued to have discussions related to the Permanent Injunction and efforts to support progress. In collaboration with DBHDS leadership during the DOJ Summitt, various ideas were discussed to support Virginia's

efforts to moving forward with improving the case management system such as centralizing all DBHDS forms in an electronic format. Ideas were sorted by easy, medium, and challenging action items to implement. A high-level overview was presented to the Virginia CSB in May.

Easy items identified included, but not limited to:

- Develop and distribute Support Coordination marketing materials to improve public understanding of Targeted Case Management (TCM).
- Clarify Support Coordinator roles and responsibilities from intake to discharge.
- Provide guidance on caseload management, person-centered practices, and ethical documentation.
- Create a person-centered review template with examples and completion guidance.

Medium complexity items identified, but not limited to:

- Improve provider location and service identification tools.
- Clarify the CM role in school system interactions.
- Integrate DD data into the DBHDS CSB Dashboard.
- Build guidance around person-centered knowledge, skills, and abilities (KSAs) including empathy and customer service.
- Support SCs in plain language communication with individuals and families.

Challenging items identified included, but not limited to:

- Develop a joint electronic incident reporting form for SCs and providers.
- Clarify data distribution protocols, including communication with individuals and legislators.
- Establish a unified TCM service model and value statements for case management.
- Support SCs in local resource identification.
- Address administrative burden across CSBs, DBHDS, and DMAS.
- Eliminate redundancies between Support Coordination and Services Facilitation.
- Create a planning guide for families, regardless of waiver status.
- Develop a career ladder for Support Coordinators.
- Implement geomapping of provider locations and services.

CMSC members from OCQI and OPNS met to review existing process documents to ensure there is no duplication between offices when meeting with CSBs. While no duplication was revealed, OCQI and OPNS are committed to increasing communication between offices and identifying ways to support quality improvement efforts to the CSBs.

The CMSC conducted a survey regarding the requirements for Enhanced Case Management (ECM). Ideas sourced from the CSBs input were worked into a value-effort matrix and prioritization categories (Must Have, Should Have, Could Have, Won't Have). Concerns were raised about specific criteria and operational impacts, prompting suggestions for a CMSC subgroup and additional training to support ECM. Next steps may include creating a summary "front page," engaging a data work group to advance five actionable items and sharing outcomes with leadership. The CMSC recommended focusing on Must and Should Haves to assess feasibility.

Following the conversations related to ECM, some CSBs indicated they wish to collaborate more with DBHDS during the transfer process, especially when encountering delays in transfers between CSBs. This process, historically, has been owned by CSBs through a Transfer Committee. Ultimately, however, the CSBs elected to identify a regional contact for DBHDS should the Department be asked to get involved. The CMSC will support the CSB Transfer Committee should assistance be needed.

An update on the agency's data modernization efforts focusing on the Enterprise Data Warehouse (EDW) was presented to the CMSC. The modernization strategy has been structured around a three-pronged framework: Enterprise Data Warehouse (EDW), CSB Data Exchange, and a Data Governance structure. At the time of the presentation in June 2025, 20 CSBs have transitioned to the EDW from CCS3. This transition is expected to dramatically improve data timeliness— for example, reducing reporting from 60 days to a minimum of 24 hours for ECM/TCM data. The CMSC has been informed that Q4 FY25 contact data is not possible due to all CSBs transitioning over during May and June 2025. EDW data related to case management contacts will be available from the EDW beginning in July 2025. Additionally, CSBs will be equipped with tools to monitor and improve data quality.

The CMSC has updated the CMSC charter. An additional co-chair was added along with the WaMs Data Analyst. This update has been submitted to the QIC.

Support Coordination Quality Review (SCQR)

The Support Coordination Quality Review (SCQR) process was established to assess and improve the quality of support coordination (also referred to as "case management") services provided by Community Services Boards (CSBs) to individuals on one of the home and community-based services (HCBS) waivers. The results of the SCQR are designed to help determine if these services comply with the Department of Justice (DOJ) Settlement Agreement and Centers for Medicare and Medicaid Services (CMS) requirements. Ten elements related to the provision of case management services are assessed through the SCQR. Virginia needs to meet nine of these ten elements at 86% or above for all records reviewed. In addition, the use of an On-Site Visit Tool (OSVT) is evaluated through the SCQR for two of the ten elements.

Reporting for the compliance indicator metrics is dependent on the review of two consecutive quarters of CSB submissions. Technical assistance from the staff of OCQI occurs by October of each year as results are compared between each CSB and the DBHDS reviewer. Technical assistance was also provided by the DBHDS Office of Provider Network Supports prior to FY25 submissions. While this technical assistance does not impact the record reviews underway, it is expected to improve the SCQR results occurring in FY26 when calendar year 2025 documentation is reviewed.

The sampling methodology for a look behind process calls for a minimum of two records per CSB to be sampled, with twenty additional reviews distributed by waiver population for 100 total retrospective reviews. The number sampled from each CSB ranges from two to four. The five OCQI specialists each complete ten interrater reviews, for a total of fifty interrater reviews. The percentage of records meeting nine or ten indicators shows steady improvement over the past four years. The FY2023 results showed that children can and should be included in the SCQR process as the differences between adults and children were minimal.

A comparison across FY21 to FY25 is available in the table below, which shows above target performance with nine of the ten indicators. One indicator in FY25 is below target at 81.8%.

	FY2021	FY2022	FY2023	FY2024	FY2025
Indicator 1	88.0%	91.8%	82.7%	87.0%	91.3%
Indicator 2	77.5%	77.8%	92.9%	96.8%	98.0%
Indicator 3	82.5%	40.3%	54.3%	68.5%	81.8%
Indicator 4	85.0%	82.0%	87.9%	90.0%	88.8%
Indicator 5	99.5%	100.0%	100.0%	100.0%	100.0%
Indicator 6	69.3%	86.8%	84.3%	89.8%	87.0%
Indicator 7	92.0%	84.0%	88.5%	93.8%	93.0%
Indicator 8	93.0%	97.5%	98.5%	99.0%	91.8%
Indicator 9	50.3%	84.5%	83.7%	89.3%	94.0%
Indicator 10	74.8%	83.5%	84.1%	90.0%	93.5%

Key:

- **Indicator 1:** The CSB has offered each person the choice of case manager. (III.C.5.c) *
- **Indicator 2:** Individuals have been offered a choice of providers for each service. (III.C.5.c)
- **Indicator 3:** The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable. (III.C.5.b.i; III.C.7.b)
- **Indicator 4:** The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served. (III.C.5.b.i; III.C.5.b.ii)
- **Indicator 5:** The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individual's needs. (III.C.5.b.iii; V.F.2)
- **Indicator 6:** The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences. (III.C.5.b.ii; V.F.2)
- **Indicator 7:** The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team. (III.C.5.b.ii; V.F.2)
- **Indicator 8:** The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary. (III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)
- **Indicator 9:** The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences. (III.C.5.b.iii; V.F.2)
- **Indicator 10:** The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. (III.C.5.b.iii; V.F.2)

* In previous years, indicator one considered if the SC provided required signatures; however, this indicator was revised in the FY23 cycle to separate two elements that were combined in indicator two. The two elements are now established as indicator one and two for CM choice and provider choice respectively.

** Indicator 3 in the first year just included measurable outcomes. Employment discussions and outcomes have been incorporated since 2022 per the indicator language in calculating results.

In FY25 following the Look Behind process, 81% of records were determined compliant, meaning nine out of ten indicators were met. This number has steadily increased over time outlined in the table below. Four indicators that were below 86% in FY2023 improved to over 86% in FY2024.

Year over year increases in records meeting 9 of 10 indicators:

Table 2: Percentage of Records Meeting at Least Nine Indicators

FY2021	FY2022	FY2023	FY2024	FY2025
42%	53%	64%	72%	81%

Indictor 3 has been the lowest indicator since employment questions were added in FY22, but compliance has improved significantly, increasing from 42% in FY21 to 81.8% in FY25. While the indicator remained below the 86% target, the steady rise in performance suggests quality improvement efforts are working.

In preparation for the FY25 SCQR cycle, CMSC updated the technical guidance documents to align with the updated ISP 4.0. This SCQR cycle only includes ISPs effective 11/1/2024 to 3/15/2025 to enable a review of the most recent ISP using the 4.0 version. Changes to the SCQR timeline were communicated through the DS Council and feedback from stakeholders was sought prior to the announcement.

Final versions of the technical guidance and the multi-record form were updated and provided to CSBs. Technical assistance to the CSBs prior to the release of their sample were provided by OPNS focusing on questions related to indicators and questions that had a low level of agreement in the previous year. OPNS also collected feedback from CSBs and provided it to OCQI for identified concerns for the next cycle. There was 100% participation from the CSBs during the FY25 cycle.

Improvement plans will be requested from CSBs following the look behind when 2 or more indicators with substantial or moderate interrater reliability are below 60%. OPNS and OCQI have been collaborating on developing a process for targeted technical assistance until CSBs can reach 86%. Per the Permeant Injunction should the 86% threshold not be met, then the threshold will increase, e.g. 2 or more indicators below 75%. The CMSC will review final results when they become available. Two state-wide calls are scheduled in October will CSBs to review results.

On-site Visit Tool

In November 2020, based on a review of a sample of On-site Visit Tools (OSVTs) during the pilot period and in collaboration with CSBs, revisions to the tool and process were made to improve use and effectiveness. Primary changes included: incorporating logic that leads to more definite determinations that a change in status and appropriate service implementation occurred, establishing the visit note as a companion document to reduce redundancy and duplication, and including confirmation of who will be informed of the results. Other changes to streamline and enhance content were completed as well. These changes are also reflected in the SCQR survey technical guidance as we move in subsequent years for better alignment across documentation and its review.

To assist Support Coordinators with meeting requirements, the phrases "change in status" and "appropriately implemented services" we re defined to establish a process to support consistency across the system. The On-site Visit Tool (OSVT) was introduced with training in a pilot phase in July 2020. Following the pilot, an OSVT work group met, with CSB representation, and together the group revised the tool based on findings in the pilot phase. The final version was given to the field for use beginning December 1, 2020.

These two concepts are defined as:

- "Change in status" refers to changes related to a person's mental, physical, or behavioral condition and/or changes in one's circumstances to include representation, financial status, living arrangements, service providers, eligibility for services, services received, and type of services or waiver.

- "ISP implemented appropriately" means that services identified in the ISP are delivered consistent with generally accepted practices and have demonstrated progress toward expected outcomes, and if not, have been reviewed and modified.

The OSVT is designed to support the Support Coordinator's face-to-face visits to have improved monitoring and meaningful implementation of the Support Coordinator's oversight. The OSVT helps assure both "change in status" and "ISP implemented appropriately" are applied consistently across the state. The OSVT must be completed for each person receiving supports once each quarter for people with Targeted Case Management (TCM) and once per month for people with Enhanced Case Management (ECM).

Materials developed for the use of OSVTs include: a definitions document, a standardized tool format referred to as the On-site Visit Tool (OSVT), a summary of the Independent Reviewer report history related to non-compliance with the Settlement Agreement provision V.F.2., a reference chart as guidance, training slides, and a questions and answers document. This project is further defined in a CMSC QII that was approved by the QIC.

In FY22, DBHDS integrated the review of the OSVT into the SCQR process to:

- Assure that Support Coordination services adequately meet the Settlement Agreement (provision V.F.2) in a consistent manner.
- Confirm that assessments occur in relation to change in status and ISP implemented appropriately.
- Assure reporting is occurring where concerns are noted.
- Formulate systemic responses to address areas of concern.

This review also seeks to assure consistently that people have needed supports, that the services they have are responsive and effective, and that they are healthy, safe and connected to their communities and to the people they care about. The completion of the OSVT is assessed through the SCQR survey questions 73 through 80 during FY24.

Following the 25th Report from the Independent Reviewer, there was a concern regarding the use of the OSVT. Issues included failure to complete these forms as required, the failure to identify problems and gaps in service, as well as inaccuracies and inconsistences in the information. CMSC discussed the use of the OSVT and training

materials together with the nurses from the IR and Office of Integrated Health (OIH). Additionally, during the FY24 SCQR cycle, it was noted the overall agreement for Indicator 10 dropped to moderate agreement from substantial level of agreement while Indicator 9 continued to meet the substantial threshold. Given this information, CMSC has developed a QII for the OSVT. The aim of this QII is to enhance materials and guidance to clarify the use and limit ambiguity. Training materials will be updated and statewide training with pre-test, post-test, and evaluation will be used to determine any additional adjustments before posting materials online.

Since the development of this QII, three focus groups have been held with a total of 19 participants across the commonwealth. The OSVT was reviewed with the group materials and training. The guidance document and the tool are being revised based on feedback. The next focus group will focus on reviewing the draft materials prior to finalizing and making them available for use.

Until the FY25 look behind is complete updated information for indicators 9 and 10 are pending. FY24 results are included below and will be updated in the next report once FY25 look behind data is available.

Indicator 9

Question	CSB Responses	Look Behind	OCQI Agreement
Q73. Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	No 29 (7%) Yes 371 (93%)	Agreement 89% Maxwell RE 0.78	Agreement 98% Maxwell RE 0.96
Q75. Regarding the LAST FOUR OSVTs COMPLETED during the calendar year 2023, did all OSVTs have all areas under "Services Implemented Appropriately" completed?	No 24 (6%) Yes 376 (94%)	Agreement 86% Maxwell RE 0.72	Agreement 92% Maxwell RE 0.84
Indicator 9 overall	0 43 (11%) 1 357 (89%)	Agreement 81% Maxwell RE 0.62	Agreement 90% Maxwell RE 0.8

Indicator 9 requires "Yes" for Q73 and "Yes" for Q75.

Indicator 9: Look Behind

	CSB Met	CSB Not met
OCQI Met	76	3
OCQI Not met	16	5

OCQI reviewers disagreed the indicator was met on 16 of the Look Behind records, typically because the reviewer could not locate one or more OSVTs or because the SC had marked "unable to assess." However, agreement was high enough to meet the "substantial" threshhold.

Indicator 10

Question	CSB Responses	Look Behind	OCQI Agreement
Q73. Is there an On Site Visit Tool completed for each of the last four face-to-face visits as required?	No 29 (7%) Yes 371 (93%)	Agreement 89% Maxwell RE 0.78	Agreement 98% Maxwell RE 0.96
Q78. Did all of the LAST FOUR OSVTs completed during calendar year 2023 have all areas under "Change In Status" and "Change in Status Determination" completed?	No 15 (4%) Yes 385 (96%)	Agreement 86% Maxwell RE 0.72	Agreement 98% Maxwell RE 0.96

Question	CSB Responses	Look Behind	OCQI Agreement
Q80. If any of the LAST FOUR OSVTs completed during calendar year 2023 identify a change in status within the "Change in Status Determination" section, were revisions made to the ISP?	No[0] 6 (2%) Not applicable: Changes noted, but no revision necessary. [2] 26 (6%) Not applicable: No changes in status or needs. [3] 354 (88%) Yes[1] 14 (4%)	Agreement 79% Maxwell RE 0.72	Agreement 82% Maxwell RE 0.76
Indicator 10 overall	0 40 (10%) 1 360 (90%)	Agreement 76% Maxwell RE 0.52	Agreement 84% Maxwell RE 0.68

Indicator 10 requires "Yes" for Q73 and "Yes" for Q78. For Q80, the response must be "Yes" or "Not applicable," either because no changes occurred or because the changes did not require a revision.

Indicator 10: Look Behind

	CSB Met	CSB Not met
OCQI Met	71	4
OCQI Not met	20	5

Agreement was in the moderate range for this indicator. OCQI disagreed the indicator was met on 20 records. As with Indicator 9, the reasons were that one or more OSVTs were missing, and/or the SC had marked "unable to assess."

Records that did not meet Indicator 9 tended to also not meet Indicator 10. According to OCQI reviewers, 17 records failed both indicators.

Independent Reviewer

The Independent Reviewer submitted their 26th Report to the Court on June 13, 2025, which included one recommendation relevant to the work of the Community Services Monitoring Committee (CMSC): "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."

In response to this recommendation, DBHDS will include in this report the names of Community Services Boards (CSBs) that have exceeded the thresholds for improvement established by the CMSC. For each identified CSB, the report will specify the area(s) of concern and any referrals for further action under the performance contract.

Quality Improvement Initiatives

Currently there are three active QIIs being implemented by the CMSC. Each QII is focused on an identified area of concern and is supported by information collected through discussions with stakeholders and seen in the data monitored by the CMSC.

QII 1: *Supports respond to change in status with appropriately implemented services.*
Status: Completed

QII 2: *Individuals meeting criteria for Enhanced Case Management receive face-to-face assessments monthly with alternating visits in the home.*
Status: Completed

QII 3: *To ensure that people make informed choices about the services and supports they select and benefit from RST recommendations, there will be a 27% increase in the number of non- emergency referrals meeting timeliness standards during SFY22.*
Status: Completed

QII 4: Our goal is to achieve and maintain a retention rate for Support Coordinators/Case Managers at or above 86% for two consecutive quarters by June 30, 2023.
Status: Completed

- In February 2025, the CMSC voted to close this QII. The CMSC will continue to look for opportunities to reduce administrative burden. A one-page document had been developed to summarize the QII and it was shared with the DS Council.

QII 5: Our goal is by June 2024, 100% (all) of CSBs will meet the ISP Compliance performance standard at 86% or above, meaning that at least 86% of their ISPs are in the correct status which is ISP completed or pending provider completion.
Status: Completed

QII 6: Our goal is to improve the following outcomes for individuals on the DD waiver by 10 percentage points by 6/30/2025 (target date). The baseline and aim for each are described below:
>>Employment outcomes for all individuals on the DD waiver: Baseline: FY24 Q1=26%; Aim = 36%

>>Employment outcomes for individuals interested in employment: Baseline: Q2=58%; Aim = 68%
>>ICI Outcomes: Baseline: FY24 Q2=60%; Aim = 70%
Status: Active

- This QII was approved in March of 2024 and focuses on improving performance with three measures related to employment and integrated community involvement. Informational materials developed by the Regional Quality Council in Region 2 were presented at the vaACCSES provider conference. Additionally, training materials were developed and presented in Region 3 with various locations and dates. Following these in-person trainings, a survey collected feedback from participants was given. The feedback received will be incorporated into the training and the training will be released statewide via a video. Information regarding strengthening this QII and how to access additional training was presented during the January Provider Roundtable. The CMSC sent a reminder through the Listserv to remind people of the resources available. Data will be monitored through FY25 Q4 to determine if developed materials created an impact once updated data is received. Changes will be made, as needed.

QII 7: Our goal is to improve the level of agreement seen on Indicator 10 in the SCQR look behind process for SCQR reviews completed during the FY25 SCQR cycle from a moderate to substantial level of agreement by October 31, 2025.
Status: Active

- In the effort to address Independent Reviewer (IR) reports and CSB needs/desires for more clarification, DBHDS is holding a focus group with CSBs, discussing enhancement with the IR nursing consultants and DBHDS nurses, as well as planning to provide an updated training with a pre-test, post-test and evaluation to determine any final adjustments before posting online. More information is located under the On-Site Visit Tool information. SCQR results will be monitored to determine progress.

Performance Contract Indicator Data

As reported above, the CMSC is implementing an Improvement Plan process that includes issuing requests for improvement plans from CSBs who meet the established threshold for underperformance with Regional Support Team referrals, which is stated in the Settlement Agreement joint filing as

> "DBHDS will require CSBs to submit corrective action plans through the Performance Contract when there is a failure to meet the 86% criteria for 2 consecutive quarters for submitting referrals or timeliness of referrals. Failure of a CSB to improve and meet the 86% criteria over a 12-month period following a corrective action plan will lead to technical assistance, remediation, and/or sanctions under the Performance Contract."

The Performance Contract with CSBs contains the specific activities to be carried out by DBHDS and by CSBs under contract with the DBHDS. The CMSC is working to expand the Improvement Plan process to identify and support the improvement of CSB performance in key areas monitored by the CMSC. The Improvement Plan (IP) process has been implemented by the CMSC that includes a "four pillars" of performance focus.

The first area relates to the indicator listed above for RST referrals, which has a threshold that is established by

the Settlement Agreement and has been in use since October of 2020. The second pillar relates to ISP entry with the standard being moved from "proper status prior to data pull" to "proper status prior to the effective date of each ISP." SCQR is the most recent implemented pillar, with an IP being requested if there are two or more SCQR indicators below 60% with moderate or substantial agreement. The IP process also includes monitoring case management face-to-face data once it becomes available through the new, DBHDS Enterprise Data Warehouse. A suggested IP document has been developed and the CMSC continued to address any needed or recommended changes to the Improvement Plan process.

The CMSC continued a monthly review of CSB performance through the Four Pillar process. During Q3 and Q4 FY25, nine improvement plans were submitted for the SCQR. One improvement has been approved for RST timeliness. Twenty-two improvements were requested for ISP timeliness as well. The CMSC will continue to review CSB performance through the Four Pillar process.

Beginning FY26 Q1, data collection measures will be modified in a way the CMSC believes will represent CSB efforts more accurately. The previous method used the ISP being in the proper status (ISP Complete or Pending Provider Completion) the day of the report and rolling four quarters. The updated method determines compliance with the ISP in the proper status on or before the effective date of the ISP and considers the ISPs in each quarter rather than a rolling basis. Using this new data method resulted in a decrease in compliance from the CSBs. It appears CSBs using EHRs have an advantage. The team discussed refining the denominator definition by using "active" status and from 90 to 150 days to align with regulations.

Beginning FY26 Q1, RST compliance data moved to "rolling four quarters." The CMSC believed moving to this method would account for low compliance when there are low numbers. However, upon further review, rolling four quarters held back the overall percentage because the average across four quarters is lower than a single quarter. Based on CSB concerns, the CMSC decided to revert to quarterly tracking as previously implemented.

Office of Licensing Data

In October 2024, the Office of Licensing shared the 9th semi-annual reporting period (from 1/1/224 thru 6/30/24) results for CM providers. This report is related to V.G.3 of the Settlement Agreement. A crosswalk is used by the Licensing Specialist conducting the review that is related to the domains in the Settlement Agreement, as well as the Licensing regulations.

During this reporting period, the CMSC discussed the 9th semi-annual report. Additional questions were addressed via email with the Office of Licensing following the presentation. Questions were primarily related to data collection methods. The CMSC refrained from decisions on needed actions until additional discussion can occur with OL to better understand where CMSC support would be helpful.

DMAS Quality Review Team

DBHDS is the operating agency for the DD Waiver program with oversight from DMAS. As directed by CMS, each Waiver must have its own quality assurance system. The quality assurance system requires the state demonstrate performance in six assurance areas. The assurances include the following:

1. Administrative Authority: The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.
2. Evaluation/ Reevaluation of Care: Individuals enrolled in the waiver have needs consistent with an institutional level of care.
3. Person-Centered Planning and Service Delivery: Service plan- Participates have a service plan that tis appropriate to their needs, and services/supports specified in the plan are received.
4. Qualified Providers: Waiver providers are qualified to deliver services/supports.
5. Health and Welfare: Participants' health and welfare are safeguarded and monitored.
6. Financial Accountability: Claims for wavier services are paid according to state payment methodologies.

Per VD I-35.6 of the Settlement Agreement and Performance Contact, each CSB/BHA must review and provide feedback on the QRT End of the Year report annually. Data collected represents 2024 averages across all three waivers population and represents a snapshot of compliance for a Performance Measure (PM). Different providers are sampled each quarter. Six Performance Measures were identified to be systemic issues with 3 years of noncompliance.

Twenty-seven of 40 CSBs/BHAs responded to a survey via Survey Monkey that was available for 2 weeks. Generally, the CSBs/BHAs agreed with the primary reasons as to why each of the PMs were not met. If the CSBs/ BHAs disagreed with the primary reason for noncompliance alternate reasons specific to Support Coordination included time/workload demands of the Support Coordinator, SC/Staff turnover, training issues, and lack on internal auditing. The top three remediations areas included CSB/BHA have worked with individual providers to remediate noncompliance in the area, CSB/BHA have referred providers to DBHDS for training, and CSB/BHA have attended a DBHDS training for technical assistance to include Provider Roundtables/SC meetings regarding discussed topics.

DMAS Quality Management Reviews

Data from DMAS Quality Management Reviews is included in the Quality Review Team reports, which were reviewed by the CMSC initially in January 2022. The CMSC considered all measures monitored by the QRT and identified those that are correlated with the work of the CMSC. The results of these measures will be considered as surveillance data when looking at individual and system wide CSB performance and can enhance any subsequent recommendations made by the CMSC.

The CMSC also partnered with the Department of Medical Assistance Services (DMAS) to develop a process related to indicator 2.20 of the Settlement Agreement joint filing:

> "All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or DBHDS licensing regulations. Corrective actions for cited regulatory non-compliance will be tracked to ensure remediation."

To meet the indicator stated above, DBHDS and DMAS work collaboratively to identify and respond to citations related to the ten CM elements included in the Support Coordinator Quality Review (SCQR). QMR reviews each CSB once every three years. In addition to monitoring and technical assistance provided through the Support Coordination Quality Review (SCQR), these QMR reviews enable the identification and tracking of elements identified outside of the SQCR sample. This process includes consideration of citations related corrective actions that are monitored on a quarterly basis through a joint meeting that includes QMR Analysts from DMAS and Community Resource Consultants from DBDHS. Identified CSBs are included as a standing item at these meetings. DMAS provides the names of CSBs cited along with any progress made in programmatic changes or approved Corrective Action Plans that indicate progress or lack of progress toward resolving concerns.

Basic steps include:

- Letters are provided to DBHDS by QMR
- Names of CSBs are added to the quarterly meeting agenda for cross-agency discussion
- Tracking the remediation of issues is included with each agenda; any unresolved remediation will carry over from meeting to meeting until resolved
- Findings will be shared with the DBHDS Case Management Steering Committee when technical assistance is declined and/or at the discretion of the group when remediation efforts are deemed ineffective.

As determined by the group, additional support to the identified CSBs will be provided by DBHDS in the effort to ensure successful remediation of identified issues.

In Q3 FY23, DMAS provided input into the final spreadsheet for discussion and tracking by the joint group. The focus of this process is ensuring that corrective actions related to the ten indicators are addressed in the CSB action plan that is subsequently approved by DMAS. Community Resource Consultant support will be offered to CSBs to assist with remediating identified issues and preparing planned actions for DMAS approval. Any subsequent citations will be tracked and remediated as identified.

The CMSC has been in discussion with DMAS in looking at ways to increase specificity of determining compliance with the indicators. A proposal document was submitted for DMAS's consideration and the CMSC requested modifications to the QMR review tool, which are not possible this year, but will be incorporated in next year's update. This proposed document aligns the QMR and SCQR indicators so indicators between reviews are more parallel. Additionally, suggestions to DMAS were made so similar requirements and documentation were considered in a comparable way. DMAS has offered to explore the availability of dedicated staff time to assist in this effort.

The CMSC will continue these efforts related to quality improvements. Additionally, the CMSC will continue to monitor data and Provider Network Supports will offer technical assistance as identified.

Quality Service Reviews

Recommendations from the Quality Services Review (QSR) Round 6 were reviewed and discussed by the CMSC to determine whether new QIIs should be recommended to the QIC.

QSR recommendations emphasized the importance of ensuring CSBs have access to comprehensive training materials detailing ISP 4.0 changes. Future efforts should focus on defining and communicating best practices for ISP documentation through the development of targeted training materials and technical assistance. This includes guidance on recognizing when a new assessment may be needed, when intervention or action is required to address changes, and how to incorporate newly identified needs into the ISP. It also includes identifying when a new assessment necessitates changes to an in-progress ISP. While a QII focused on the OSVT is currently underway, no additional QI activities were recommended at this time.

The CMSC also advised continued clarification and communication of expectations for licensed provider implementation of HCBS settings rules. This applies to all relevant service types and includes ensuring individuals have a choice regarding where and with whom they live, who they participate in group activities with, and their daily activities. Performance in these areas remains high, and the CMSC will continue monitoring without recommending new QI activities.

Further recommendations included ongoing efforts to define and communicate best practice expectations through targeted training and technical assistance for licensed providers and CSBs. This should address the development of policies and processes related to staff hiring, orientation, training, and competence assessment, as well as the implementation of policies supporting individual choice, self-determination, and dignity of risk. OPNS has created SC Competency materials for CSB use, and RQC2 developed a QII focused on dignity of risk in collaboration with OHR. Following related training, providers expressed concerns about liability and requested a toolkit addressing dignity of risk and duty of care. No new QI activities were recommended by the CMSC in this area at this time.

Lastly, the QSR recommendations highlighted the need to ensure that licensed providers and CSBs are aware of and can access all relevant DBHDS training materials—including recordings not posted on the DBHDS website (e.g., YouTube) covering quality improvement, ISP development, and waiver service provision. The Toolkit for Prospective DD Waiver Providers should be updated with stakeholder input to ensure user-friendly resources are available for new providers. These resources should include current and pertinent information to support the development of quality improvement policies and procedures. QSR recommendations also suggested promoting participation in the Provider Readiness Education Program (PREP) and facilitating opportunities for licensed providers to network and share best practices or challenges through regional workgroups. Activities related to provider development and resources were referred to the DBHDS Key Performance Area workgroups.

Two QI activities were recommended to the QIC: (1) the creation and dissemination of a resource list for SCs to improve awareness and access to quality improvement, ISP development, and waiver service provision materials; and (2) the facilitation of website design focus groups involving CSBs, providers, and community members. The CMSC will discuss strategies to create and share a resource list for SCs for awareness and training. Further, the CMSC will discuss a plan of action to engage CSBs and providers regarding DBHDS website design. The CMSC will continue to support the quality improvement for the provision of case management through the QSR process.

Data Availability and Integrity

The CMSC monitors performance related to the availability of data in the Waiver Management System (WaMS), as well as the integrity of the data previously provided through CCS3. Specifically, regarding the requirements related to ISP entry, the CMSC has been monitoring the availability of WaMS ISP data per the Performance Contract reporting requirements. CSBs are required to provide ISP data either through an electronic data exchange or through direct keyed entry if the CSB does not use or is unable to use the data exchange.

CC3S is currently transitioning to the new DBHDS Data Enterprise Warehouse (EDW) with a planned completion date of 6/30/25. The Data Quality Support (DQS) process will resume once this transition is complete. Preliminary data will be reviewed by CMSC to work towards understanding the impact of this transition.

A Data Quality Framework (Fig. A), root cause analysis template, and process have been developed through collaboration with the DBHDS/VACSB Data Management Committee. This process, which includes reviewing a sample of CSB case management contact data, began in FY22.

The focus of the work is on the following:

- Identify issues related to data reporting and case management requirements related to case management performance measures.
- Identify potential barriers to accurate coding and reporting.
- Identify additional technical assistance needed.
- Implement CSB data quality improvement plan needed for system process and outcome changes, ensuring that case management processes are reported accurately and as required.

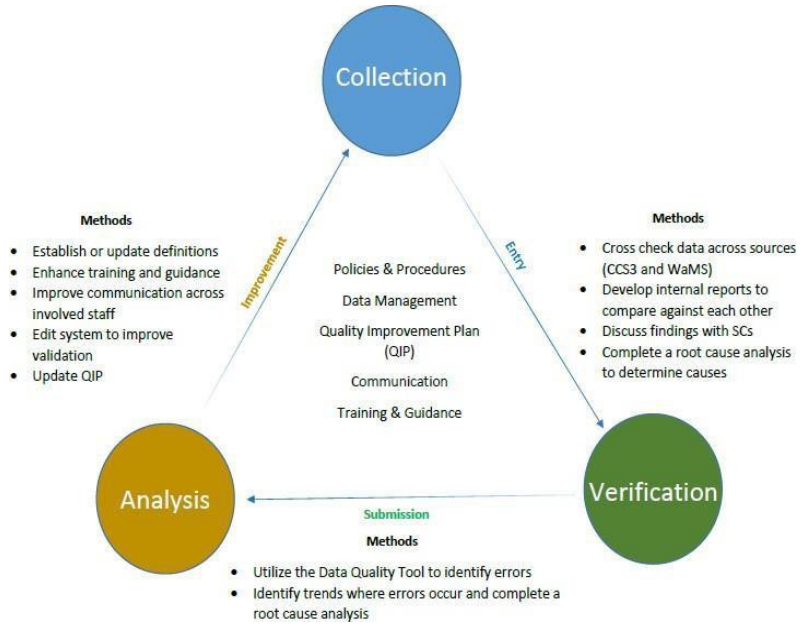


Fig. A Data Quality Framework

The Data Quality Process implemented by the CMSC includes the Office of Provider Network Supports providing technical assistance to CSBs on data reporting requirements. This assistance is designed to support CSB efforts to improve the quality of case management contact data reported to the Department. It includes the completion of a root cause analysis, if needed, to identify the underlying causes for not meeting case management measure targets and help in identifying gaps and/or issues that impacted the CSB's performance.

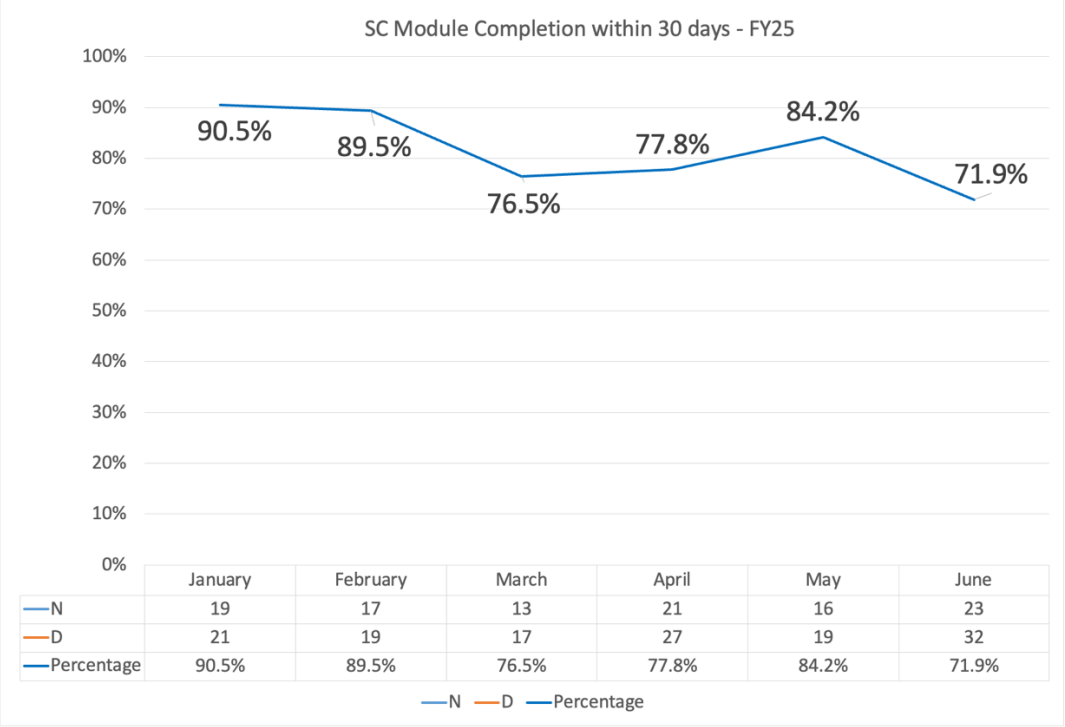
Since the transition from CCS3 to Enterprise Data Warehouse (EDW), the CMSC, along with OPNS, have been working to update the process for this data review. Discussions occurred to update the Data Quality Support (DQS) process and how the transition from CCS3 and EDW may affect reporting and impact results. The CMSC is currently obtaining a sample, which will be pulled from CCS3 data prior to Q4 FY25 and will provide an update during the next reporting period. Future cycles will rely on the EDW data with data availability beginning July 1, 2025.

Data Monitoring

Case Management Training and Competency

Support Coordinators/Case Managers are required to complete the DBHDS Case Management training online modules within 30 days of hire. A review of module usage between January and July 2024 shows that the completion rate exceeded 86% in four of the six months reviewed and reach 100% success in November. The chart below conveys the percentage of DD CMs who complete the modules and the percentage who completed the modules within required timeframes (Fig. B).

Fig. B Case Management Module Completion July to December SFY2024



Performance Measures

The CMSC monitors CSB performance through 20 measures that correlate with the settlement agreement (SA) and improved outcomes in system performance or for people who have services in Virginia. Below is a list of measures currently monitored for SFY25. Certain measures are identified as "Performance Measure Indicators" (PMIs), which are also monitored by the DBHDS Quality Improvement Committee (QIC) to determine the overall health and direction of the DD system. Progress and lack of progress in these areas leads to individual technical assistance and recommendations for systemic change. Measures are organized below by domain.

FY25 Case Management Measures

Access to Services	
1	86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process (Target 86%). **III.C.7.a.**
2	Proportion of Adults (aged 18-64) with a DD waiver receiving case management services that are interested in employment and have an ISP that contains employment outcomes. (Target 86%)
3 (**PMI**)	Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP. (Target 86%). **III.C.7.a.** ***Community Inclusion Domain***
4	Individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process. (Target 86%). **III.C.7.a**
5 (**PMI**)	Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained integrated community involvement outcomes (Target 86%). **III.C.7.a.**
6	Individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. **III.C.7.a.**
7	Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. (Target 86%). *III.D.6.*
8	Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%). **III.D.6.**
9	People with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (defined as independent living supports, in-home support services, supported living, and sponsored residential) have access to an option that meets their preferences within nine months. **III.D.1**
Provider Capacity	
10	People with DD Waiver receive face-to-face contacts from their support coordinator at least quarterly (Target 90%). **V.F.4.**
11	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month no more than 40 days apart (Target 90%). **V.F.4.**

12	Individuals receiving Developmental Disability Waiver services identified as meeting ECM criteria will receive face to face visits every other month in their residence (Target 90%). **V.F.4.**
13	Support coordination records reviewed across the state will be in compliance with a minimum of nine of the ten indicators assessed in the review. (Target 86%) **III.C.5.b.i**
14	86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations. **V.D.1.**
15	Individual Support Plans are available in the Waiver Management System by direct keyed entry or data exchange since October 7, 2019. **DBHDS Metric/Performance Contract**

Physical, Mental, and Behavioral Health and Well-Being	
16 (**PMI**)	The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed (Target 86%). **III.C.5.b.iii; V.F.2; V.F.5.**
17 (**PMI**)	Individual support plans are assessed to determine that they are implemented appropriately (Target 86%). **III.C.5.b.iii; V.F.2; V.F.5.**

Choice and Self-Determination	
18 (**PMI**)	Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff) (Target 86%). **V.D.3.f; V.F.5**
19 (**PMI**)	Individuals are given choice of support coordinator, at least annually. (Target 86%) **III.C.5.c; V.F.5**
20 (**PMI**)	Individuals are given choice among providers at least annually. (Target 86%) **III.C.5.c; V.F.5**

Access to Services

Employment Discussions and Goals

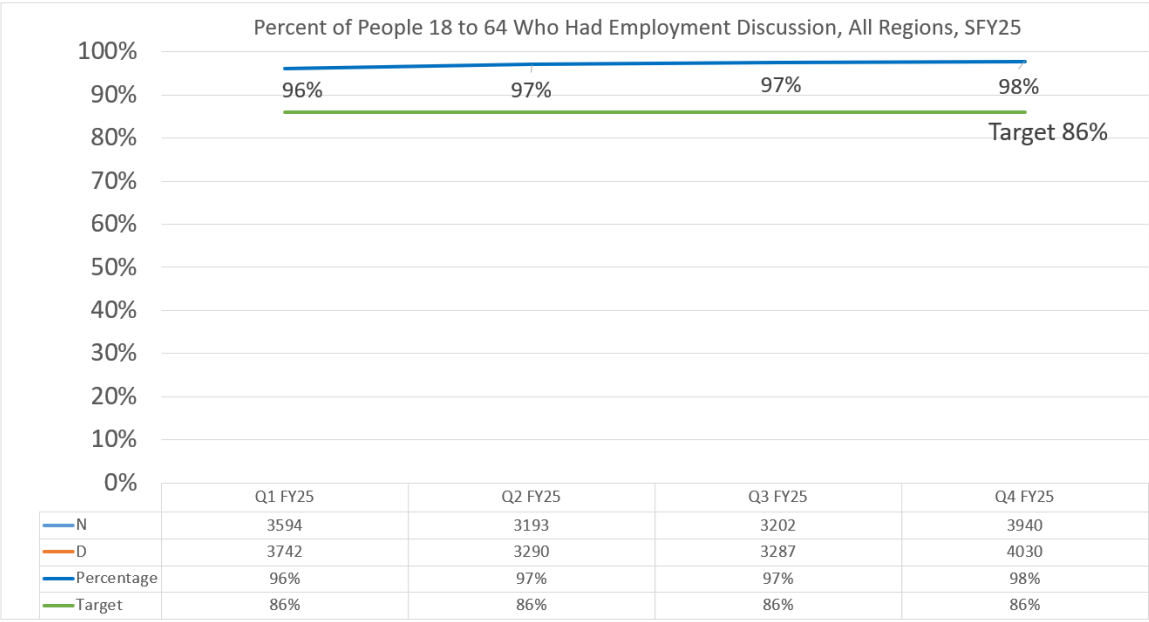
Reference	Measure	Numerator	Denominator
1 *Fig. 1*	86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process (Target 86%). **III.C.7.a.**	N = Number of Individuals who had an Employment Discussion at Annual F2F ISP Meeting	D = Number of active individuals who had an Annual F2F ISP Meeting
2 *Fig. ~~2~~*	Proportion of Adults (aged 18-64) with a DD waiver receiving case management services that are interested in employment (Denominator: Column 9) and have an ISP that contains employment outcomes. **III.C.7.a**	N = Number of Individuals (18-64) who recorded Employment Outcomes at Annual F2F ISP Meeting	D = Number of active individuals (18-64) who had an Annual F2F ISP Meeting who also had Employment Status Looking (whether previously employed or not).
3 (**PMI)** *Fig. 3* ***Note:*** *Community Inclusion Domain*	Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP. (Target 86%) **III.C.7.a**	N = Number of individuals with the ISP element "Was there a conversation with the individual/substitute decision-maker about employment?" indicated yes, and where the two following discussion elements are confirmed: "what the person is working on at home and school that will lead to employment" and "alternate sources for funding (such as school or DARs)"	D = Number of individuals in active status in WaMS ages 14 to 17 who have a DD waiver

The measure related to the individual participating in a discussion about employment has been consistently above target for not only the last four quarters (see Fig. 1) but in previous reporting periods, while those with employment goals has consistently been below target (see Fig. 2). In Q3 FY23, the CMSC ceased monitoring employment goal development as has been previously reported. This measure continues to be monitored by the Employment First Advisory Group. Instead, the CMSC began a new measure stating, "Proportion of Adults (aged 18-64) with a DD waiver receiving case management services that are interested in employment and have an ISP that contains employment outcomes." Baseline for the measure was established in Q4 FY23 at 65%. Results continue to be below target but have remained largely consistent in the past 4 quarters with a slight decline in Q3 but an increase in Q4 FY25.

Baseline for the third measure related to transition age youth was established in the 1st quarter FY22, which was 32%. Related elements in the Individual Support Plan were refined in May 2022 to improve the collection of data around employment topics. The CMSC is aware of past efforts by the Regional Quality Council (RQC) in Region V, which sought to provide training and measure improvements in SC knowledge, as well as to measure an increase in employment outcomes for people supported. The CMSC will continue to monitor and ensure the provision of technical assistance through the Offices of Provider Network Supports and Community Quality Improvement. Previous results indicated that measure 3, related to employment discussion with youth, saw a slight decline from Q2 to Q3 FY25. There was an increase between Q3 and Q4 FY25 of nine percentage points (Fig. 3).

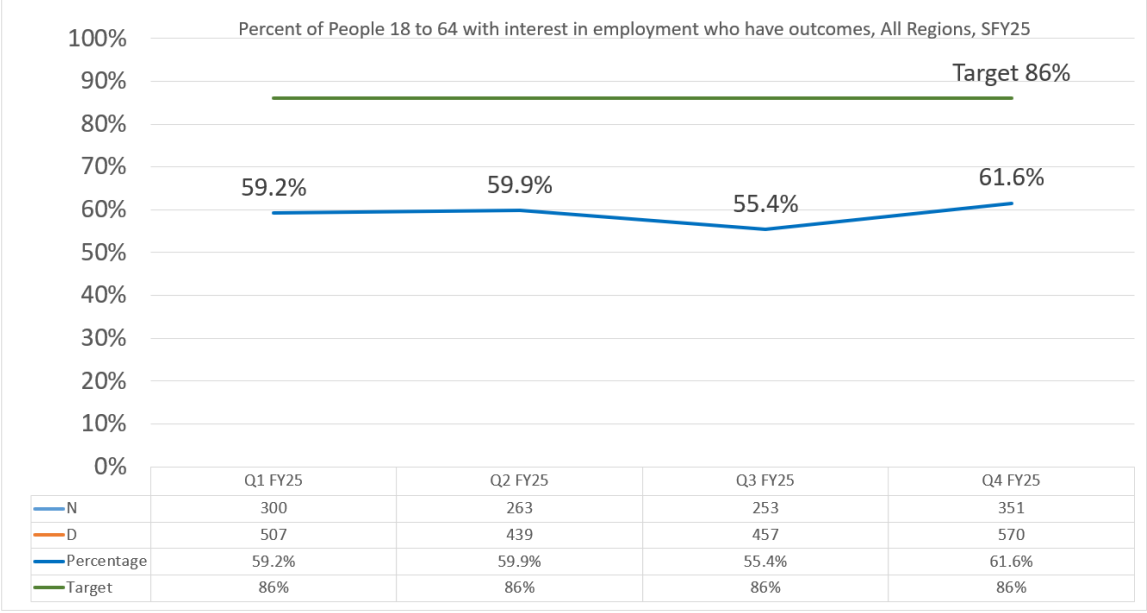
The CMSC will continue to monitor these measures and make recommendations as appropriate.

Fig. 1 Employment Discussions FY25



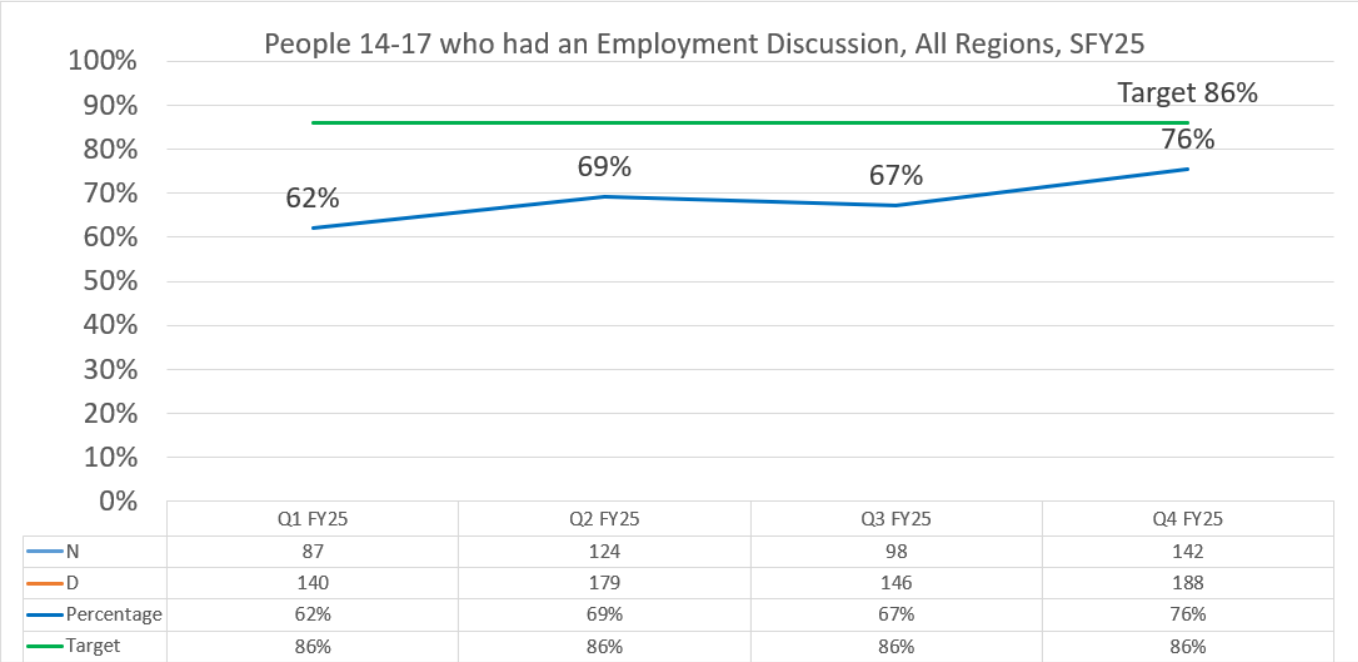
	Q1 FY25	Q2 FY25	Q3 FY25	Q4 FY25
N	3594	3193	3202	3940
D	3742	3290	3287	4030
Percentage	96%	97%	97%	98%
Target	86%	86%	86%	86%

Fig. 2 Employment Interest with Outcomes FY25



	Q1 FY25	Q2 FY25	Q3 FY25	Q4 FY25
N	300	263	253	351
D	507	439	457	570
Percentage	59.2%	59.9%	55.4%	61.6%
Target	86%	86%	86%	86%

Fig. 3 Employment Discussion 14-17 (both topics confirmed) FY 25



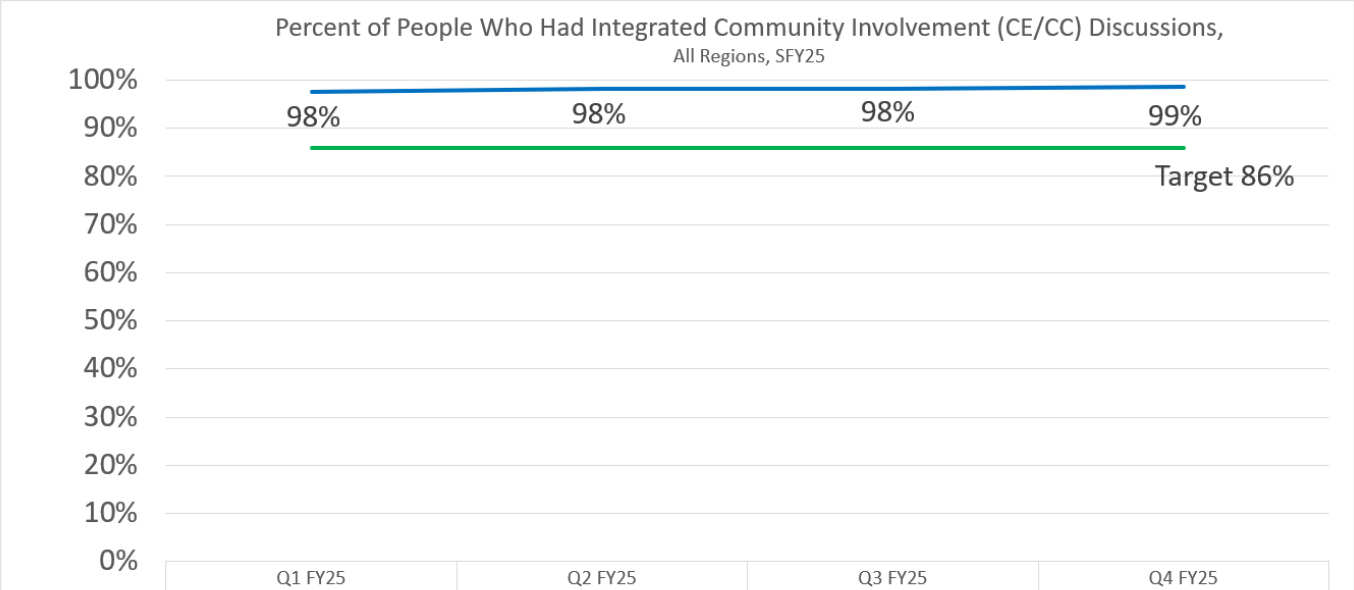
	Q1 FY25	Q2 FY25	Q3 FY25	Q4 FY25
N	87	124	98	142
D	140	179	146	188
Percentage	62%	69%	67%	76%
Target	86%	86%	86%	86%

Community Engagement Discussions and Goals

Reference	Measure	Numerator	Denominator
4 *Fig. 4*	Individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process. **III.C.7.a**	N = number of Individuals who received Community Engagement Discussion at Annual F2F ISP Meeting	D = number of active Individuals who had an Annual F2F ISP Meeting
5 (**PMI**) *Fig. 5*	Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained integrated community involvement outcomes (Target 86%) **III.C.7.a**	N = Number of Individuals recorded Integrated Community Involvement Outcomes at Annual F2F ISP Meeting	D = Number of active individuals who had an Annual F2F ISP Meeting
6 *Fig. 6*	Individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. **III.C.7.a**	N = Number of ISPs with one or more outcomes under the Integrated Community Involvement and/or the Community Living life areas in the ISP: Shared Plan	D = Number of individuals in active status on one of the DD Waivers

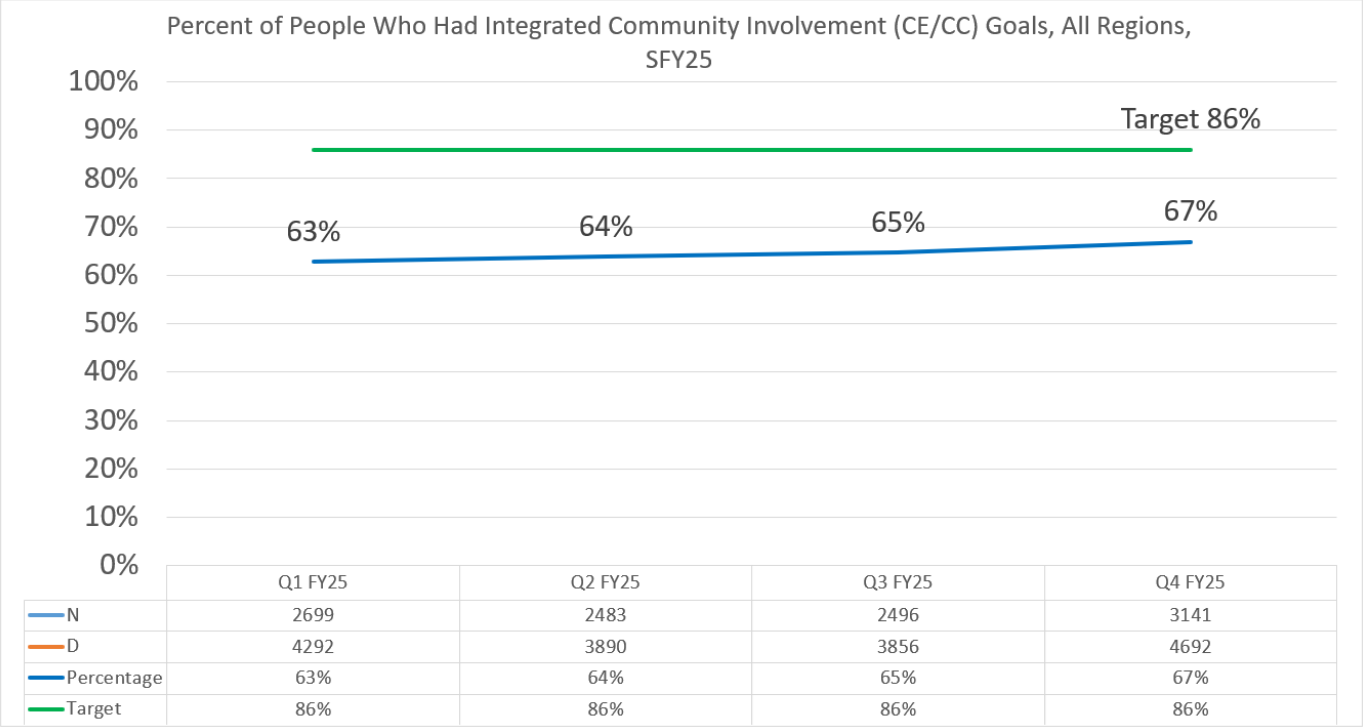
The measure related to individuals participating in a discussion about integrated community involvement has been consistently above target for the last four quarters (Fig. 4). The measure related to integrated community involvement outcomes has consistently been below target, but with a 4-percentage point increase between Q1 and Q4 FY25 (Fig. 5). The focus of these measures is on community involvement at a ratio of no more than one staff to three individuals regardless of the service utilized. The CMSC acknowledges the reality of current staffing concerns across the system as an ongoing concern around these measures. As previously mentioned in this report, additional training and guidance has been developed and provided to CSBs to increase this measure. Baseline for the third measure (Fig. 6) related to community involvement was established in FY22 Q1. Results remain stable and above target for this measure.

Fig. 4 Integrated Community Involvement (Community Engagement) Discussions FY25



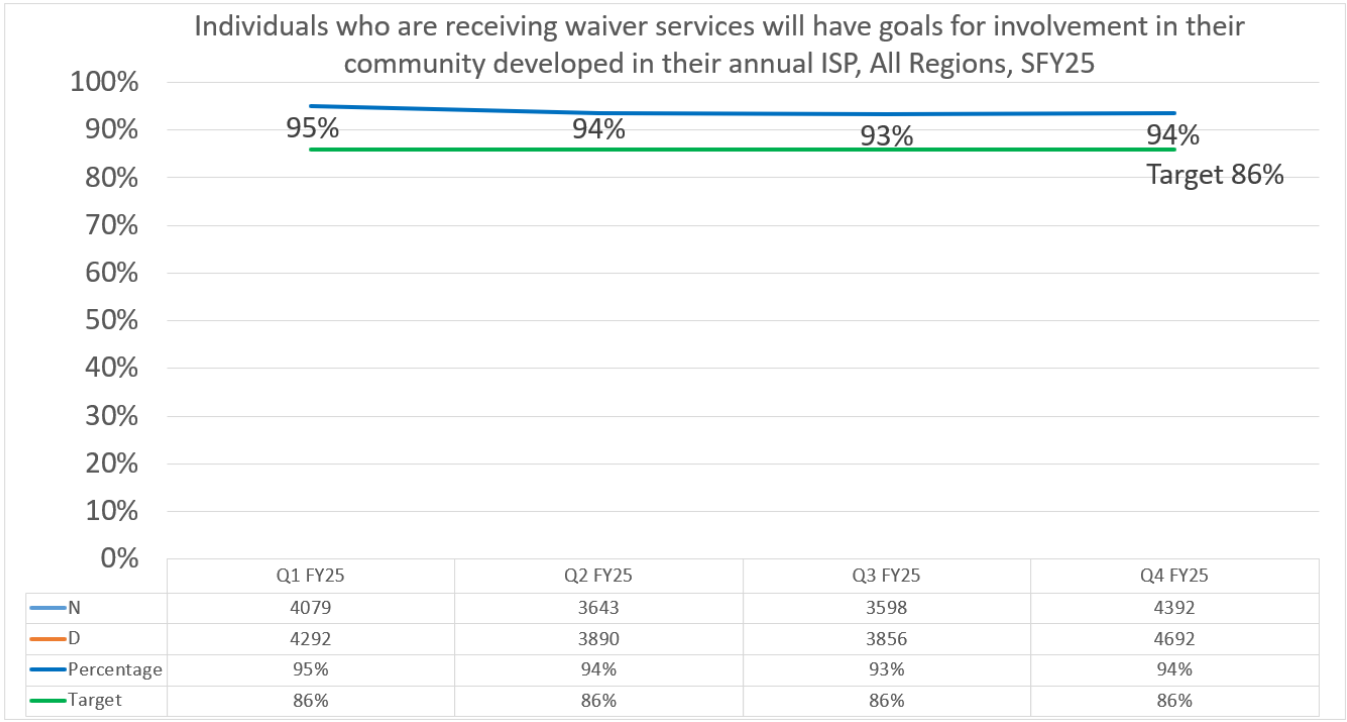
	Q1 FY25	Q2 FY25	Q3 FY25	Q4 FY25
N	4191	3820	3790	4626
D	4292	3890	3856	4692
Percentage	98%	98%	98%	99%
Target	86%	86%	86%	86%

Fig. 5 Integrated Community Involvement (Community Engagement) Outcomes FY25



	Q1 FY25	Q2 FY25	Q3 FY25	Q4 FY25
N	2699	2483	2496	3141
D	4292	3890	3856	4692
Percentage	63%	64%	65%	67%
Target	86%	86%	86%	86%

Fig. 6 Community Involvement Outcomes FY25



	Q1 FY25	Q2 FY25	Q3 FY25	Q4 FY25
N	4079	3643	3598	4392
D	4292	3890	3856	4692
Percentage	95%	94%	93%	94%
Target	86%	86%	86%	86%

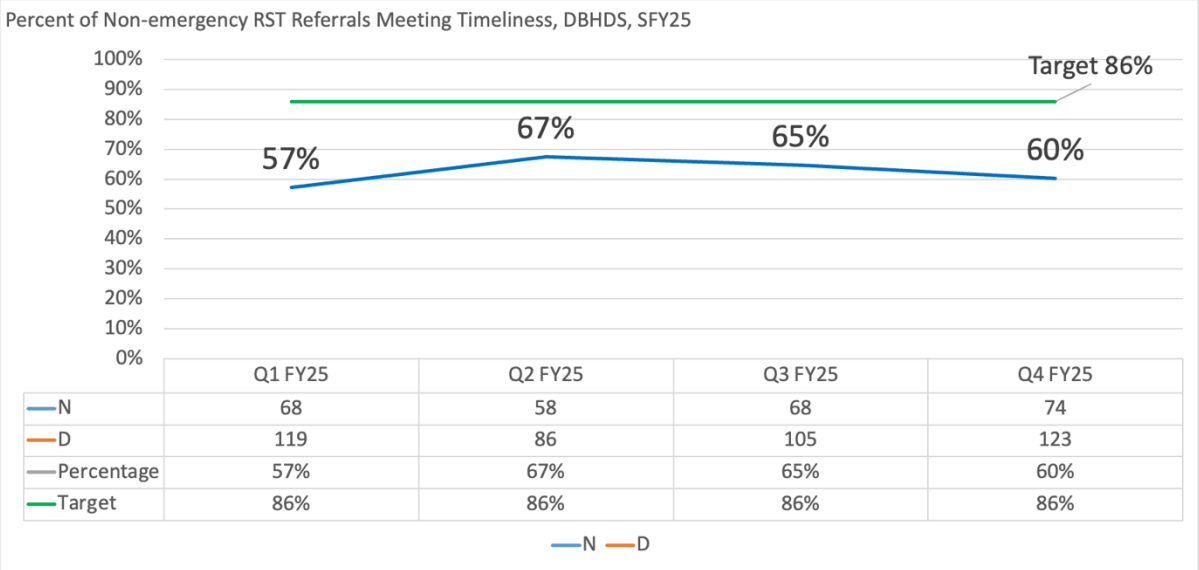
Regional Support Teams and Timeliness of Referrals

Reference	Measure	Numerator	Denominator
7 *Fig. 7*	Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers. (Target 86%). **III.D.6.**	N = Number of non-emergency RST referrals made on time.	D = Number of non-emergency RST referrals.
8 *Fig. 8*	Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds (Target 86%). **III.D.6.**	N = Number of on time non-emergency referrals for individuals selecting a less integrated residential waiver option submitted by CSBs	D = Number of non-emergency RST referrals submitted by CSBs
9 Fig. 9	People with a DD waiver, who are identified through indicator #13 of III.D.6, desiring a more integrated residential service option (defined as independent living supports, in-home support services, supported living, and sponsored residential) have access to an option that meets their preferences within nine months. **III.D.1**	N = Number of individuals moving to a location that meets their needs and preferences within 9 months.	D = Number of individuals identified with Barrier 2, "Services not available in desired location," on an RST referral.

On January 1st, 2023, DBHDS moved the Regional Support Team (RST) process into the Waiver Management System (WaMS) as required by III.D.6. The first of two RST WaMS module overview sessions occurred on October 27th, 2022, in preparation for the transition to WaMS. This recording is available on the DBHDS website and shows the features and process of using the RST referral form and associated Virginia Informed Choice (VIC) form. CSBs had the option of using the new WaMS RST Module for referrals through December 2022 to adapt to the new process leading up to January 1. Overall, the launch of the module was considered successful.

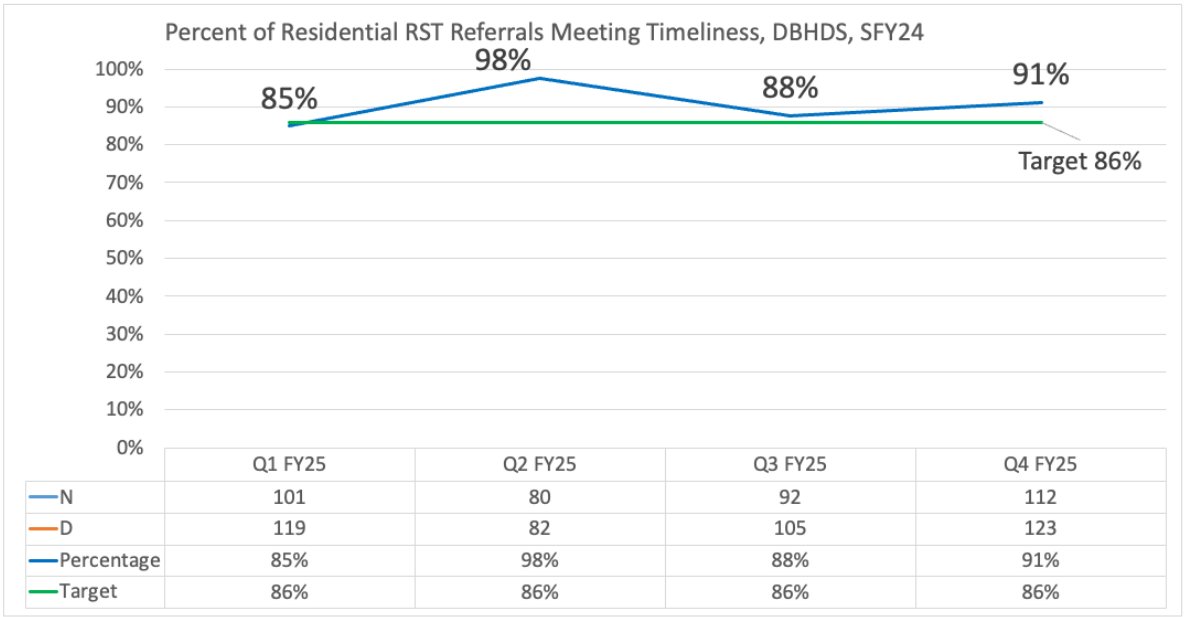
Beginning with Q4 FY23, all data derives from the WaMS system except for missed referrals, which by necessity remains a manual process with results being added to the dashboard once completed. In Q1 FY25, the systemwide measure for RST referral timeliness reached 57% and rose to 67% in Q2 FY25 with a decline to 60% in Q4. The residential related measure increased significantly in relation to the last report. The measure related to CSB accountability for residential moves is seen at 98% success in Q2 FY25, which is the highest result seen to date, and ending at 91% in Q4 FY25. No referrals in the report period met the criteria for Measure 9 as seen below.

Fig. 7 RST Referral Timeliness FY24-25



	Q1 FY25	Q2 FY25	Q3 FY25	Q4 FY25
N	68	58	68	74
D	119	86	105	123
Percentage	57%	67%	65%	60%
Target	86%	86%	86%	86%

Fig. 8 RST Residential Community Referral Timeliness FY25



	Q1 FY25	Q2 FY25	Q3 FY25	Q4 FY25
N	101	80	92	112
D	119	82	105	123
Percentage	85%	98%	88%	91%
Target	86%	86%	86%	86%

Fig. 9 Number of individuals meeting criteria for Indicator #13

RST Referral Form Question: Are more integrated residential options (to include Independent Living Supports, In-home Support Services, Supported Living, Sponsored Residential) not operating in the desired location, if requested?

Q1 and Q2 Result FY25

	2025 Q3		Total
Region	No	**Total**	
Region I	29	**29**	**29**
Region II	11	**11**	**11**
Region III	26	**26**	**26**
Region IV	13	**13**	**13**
Region V	22	**22**	**22**
Total	**101**	**101**	**101**

	2025 Q4		Total
Region	No	**Total**	
Region I	24	**24**	**24**
Region II	25	**25**	**25**
Region III	29	**29**	**29**
Region IV	25	**25**	**25**
Region V	15	**15**	**15**
Total	**118**	**118**	**118**

Numerator and Denominator	Count
Numerator = Number of referrals confirmed as resolved within the 9-month timeframe calculated in WaMS	N/A
Denominator = Number of RST referrals where the RST confirmed the barrier stated as "Are more integrated residential options (to include Independent Living Supports, In-home Support Services, Supported Living, Sponsored Residential) not operating in the desired location, if requested?" as yes.	0

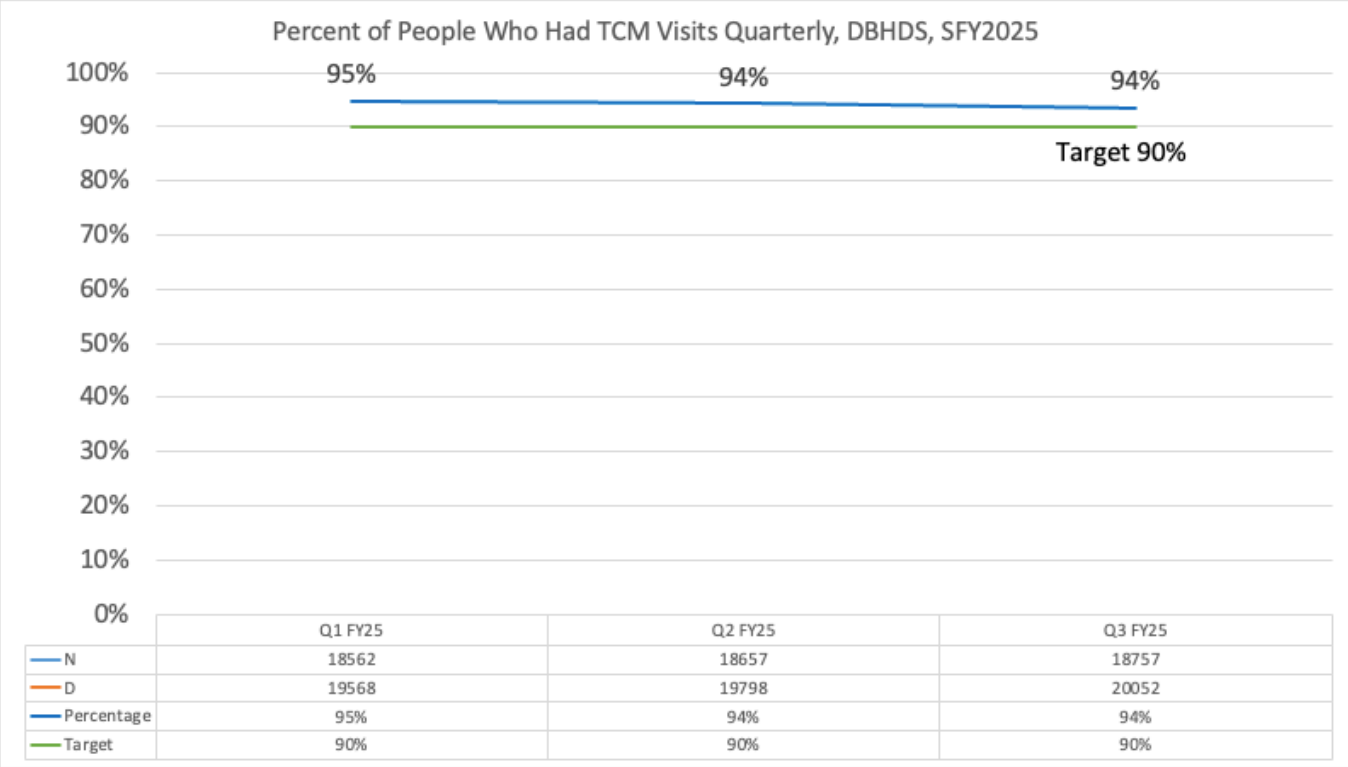
Provider Capacity

Case Management Face to Face Visits (F2F) and Effectiveness

Reference	Measure	Numerator	Denominator
10 *Fig. 10*	People with DD CM Services receive face-to-face contacts from their support coordinator at least quarterly. (Target 90%) V.F.4	N = Number of individuals with DD Case Management Services with at least one face to face contact quarterly.	D = Number of individuals with DD Case Management services
11 *Fig. 11*	Individuals enrolled in a Developmental Disability Waiver identified as meeting ECM criteria will receive face to face visits every month no more than 40 days apart. (Target 90%) V.F.4	N = Number of individuals identified as needing ECM who have a documented face to face visit at least monthly with no more than 40 days between visits.	D = Number of individuals with DD Case Management services
12 *Fig. 12*	Individuals enrolled in a Developmental Disability Waiver identified as meeting ECM criteria will receive face to face visits every other month in their residence. (Target 90%) **V.F.4**	N = Number of individuals identified as needing ECM who have a documented face to face in the home setting every other month.	D = Number of individuals with DD Case Management services
13 *Fig. 13*	Support coordination records reviewed across the state will be in compliance with a minimum of nine of the ten indicators assessed in the review. (Target 86%) **III.C.5.b.i.**	N = Number of records identified as meeting at least 9 of the 10 identified CM elements per III.C.5.b.i.	D = Number of records of individuals, enrolled in a DD waiver with at least one approved waiver service, reviewed, through the SCQR instrument, by CSBs.
14 *Fig. 14*	86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations **V.D.1.**	N = Number of individuals authorized for one or more DD waiver services within 5 months of enrollment.	D = Number of individuals enrolled in a DD waiver.
15 Fig. 15	Individual Support Plans are available in the Waiver Management System by direct keyed entry or data exchange since October 7, 2019. (Target 86%)	N = Number of individuals with WaMS ISPs in Pending Provider Completion or ISP Completed status.	D = Number of individuals with WaMS ISPs due in the reporting quarter.

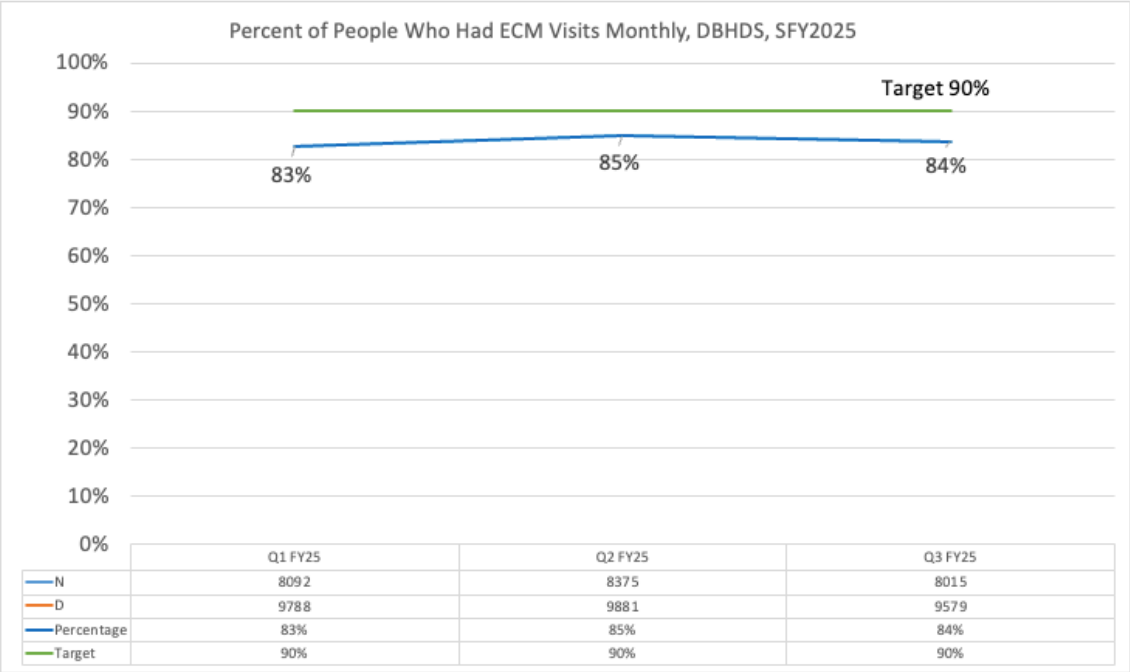
All CSBs completed the transition to the new Enterprise Data Warehouse (EDW) in the 4th quarter of FY25. Data related to face-to-face contacts has been limited to the first three quarters in this report. It is the CMSC's understanding that while 4th quarter data is available, the effort to align the data between CCS3 and the new EDW would require extensive time and resources to accomplish. Based on the results below, there was above target performance for the first three quarters of FY25. (Fig. 10). Overall results for Q3 and Q4 FY25 ECM face-to-face (Fig. 11) and ECM in the home (Fig. 12) were within 10% of the target and both show stable performance during the report period and the previous reporting period as well. During this reporting period, the CMSC discussed issues related to ECM data reporting across CSBs. Data issues encountered in CCS3 were escalated to the DBHDS Information Technology (IT) department. OCQI collaborated with IT and established a CSB ticketing option so that data issues could be resolved directly with CSBs. The CMSC's Data Quality Support (DQS) process will be updated in FY26 once the transition to the EDW is completed to identify and address any potential data input issues with CSBs in the new system.

Fig. 10 TCM visits FY25



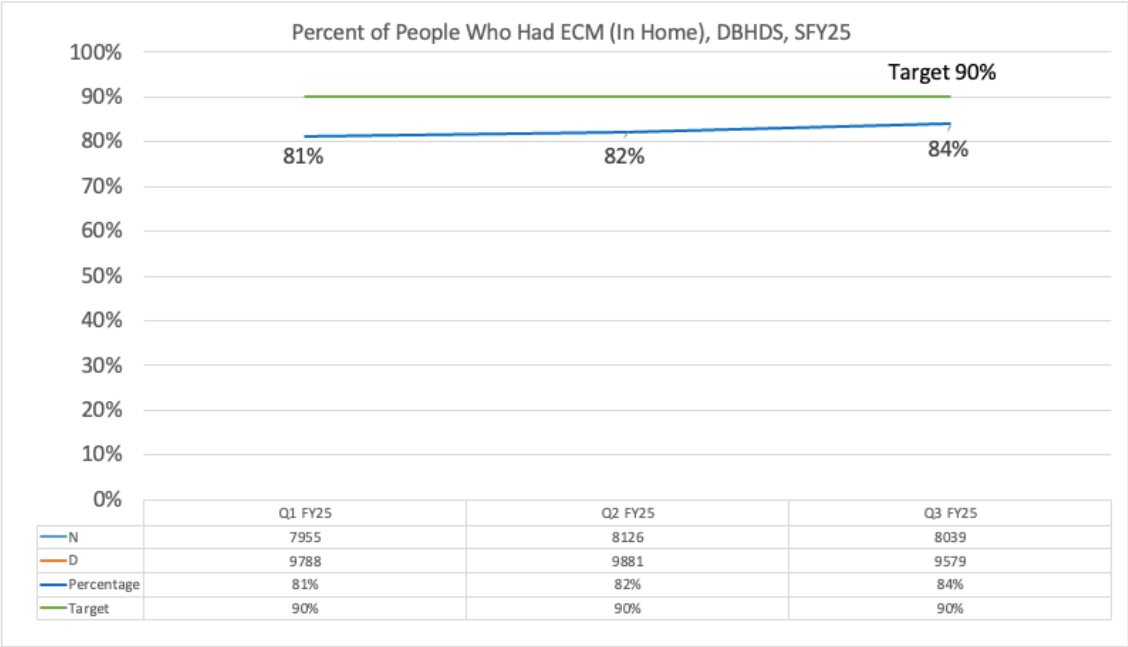
	Q1 FY25	Q2 FY25	Q3 FY25
N	18562	18657	18757
D	19568	19798	20052
Percentage	95%	94%	94%
Target	90%	90%	90%

Fig. 13 ECM face to face visits FY 2025



	Q1 FY25	Q2 FY25	Q3 FY25
N	8092	8375	8015
D	9788	9881	9579
Percentage	83%	85%	84%
Target	90%	90%	90%

Fig. 14 ECM visits in-home FY25



	Q1 FY25	Q2 FY25	Q3 FY25
N	7955	8126	8039
D	9788	9881	9579
Percentage	81%	82%	84%
Target	90%	90%	90%

For Measure 13, 81% of records were found in compliance on at least nine out of ten indicators based on CSB-submitted data in FY25. This was an improvement from FY24, when 72% of records were found in compliance. Agreement between CSBs and OCQI has been improving on most indicators, with no significant decreases. The percentage of CSBs reporting compliance with each indicator are displayed, with the percentage from FY21 to FY25 reported for comparison purposes. (Fig. 13).

Fig. 13 Records in compliance with 9 of 10 assessed indicators FY21-25

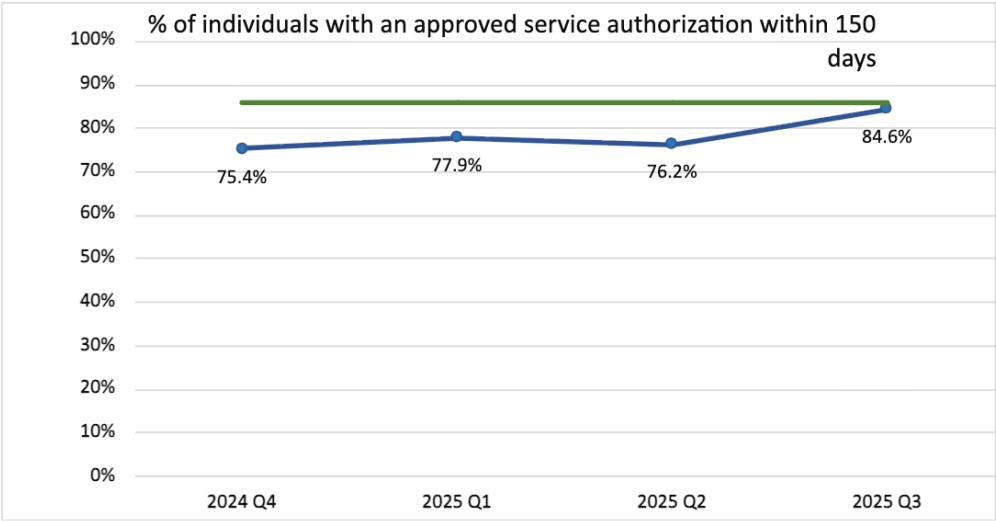
Table 2: Percentage of Records Meeting at Least Nine Indicators

FY2021	FY2022	FY2023	FY2024	FY2025
42%	53%	64%	72%	81%

For Measure 14, beginning with the previous reporting period, reporting has shifted from an annual result to quarterly. Annual results for statistics regarding 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations, is established as 76.2% for Q3 and ending at 84.6% for Q4 FY25 (Fig. 14). This is a decrease from the previous reporting period and 1% of target when rounded.

While Development Services has a strategy to notify CSBs when an individual's services are not initiated within 150 days, CSBs may not be responsive. It was further discussed that SCs should be identifying the individual's correct priority. The SCs need to ensure individuals are being awarded waiver slots when they have the highest needs. Additionally, individuals may be unaware of the waiver they have been offered and unaware of the services within the waiver. The CMSC will continue to monitor opportunities as a PMI.

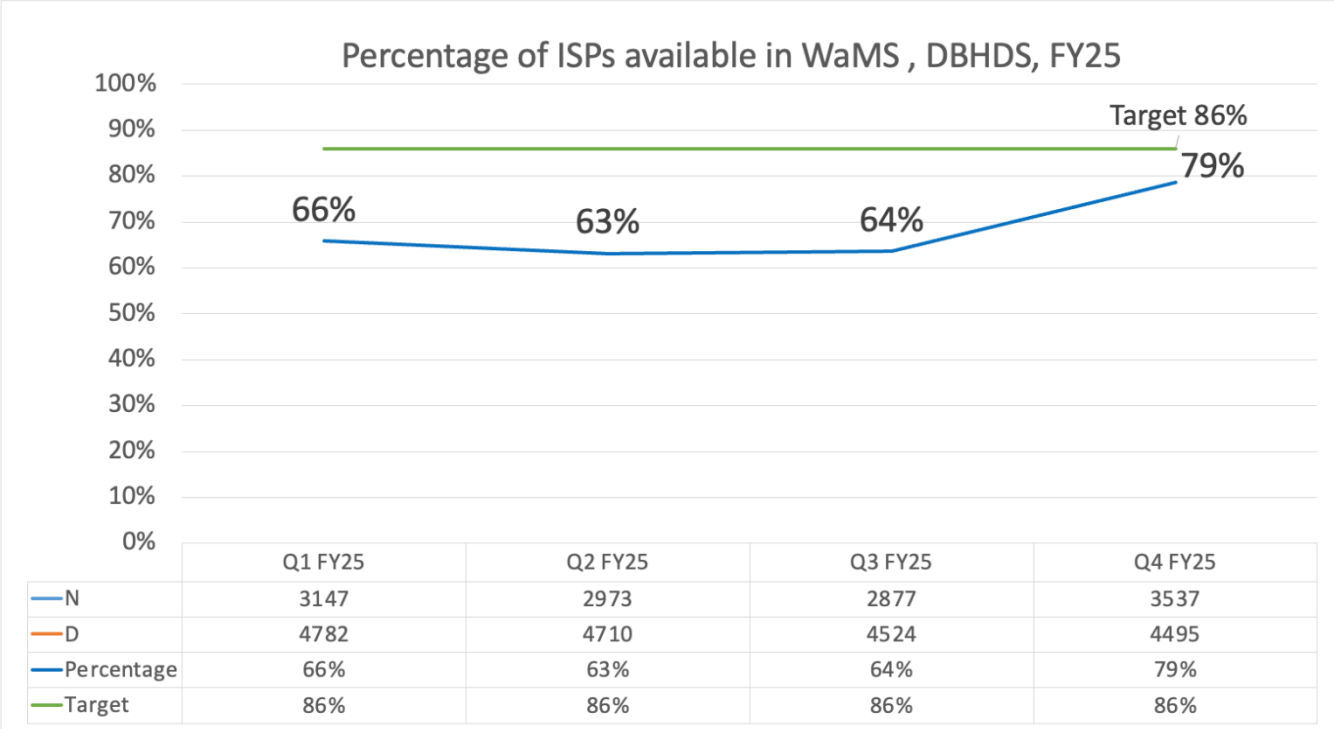
Fig. 14 Services within 150 days of Waiver FY25 results



	2024 Q4	2025 Q1	2025 Q2	2025 Q3
N	340	292	557	488
D	451	375	731	577

For Measure 15, the ISP compliance target was modified beginning in Q1 FY25, which resulted in an expected decrease in performance from previous reporting and is now within 10% of target in Q4 FY25 (Fig. 15). Data reporting now aligns with recommendations from the DBHDS source system analysis, which centered on ensuring that data is entered into a proper status by the effective date of each ISP. The data reporting provided to CSBs has been adjusted to this new method with an explanation of the reason for the change which was introduced through a Quality Improvement Initiative in the past year. The CMSC will continue to monitor and support CSBs to understand the new requirement to improve performance over time through established monitoring processes employed by the Committee.

Fig. 15 ISP compliance FY25



	Q1 FY25	Q2 FY25	Q3 FY25	Q4 FY25
N	3147	2973	2877	3537
D	4782	4710	4524	4495
Percentage	66%	63%	64%	79%
Target	86%	86%	86%	86%

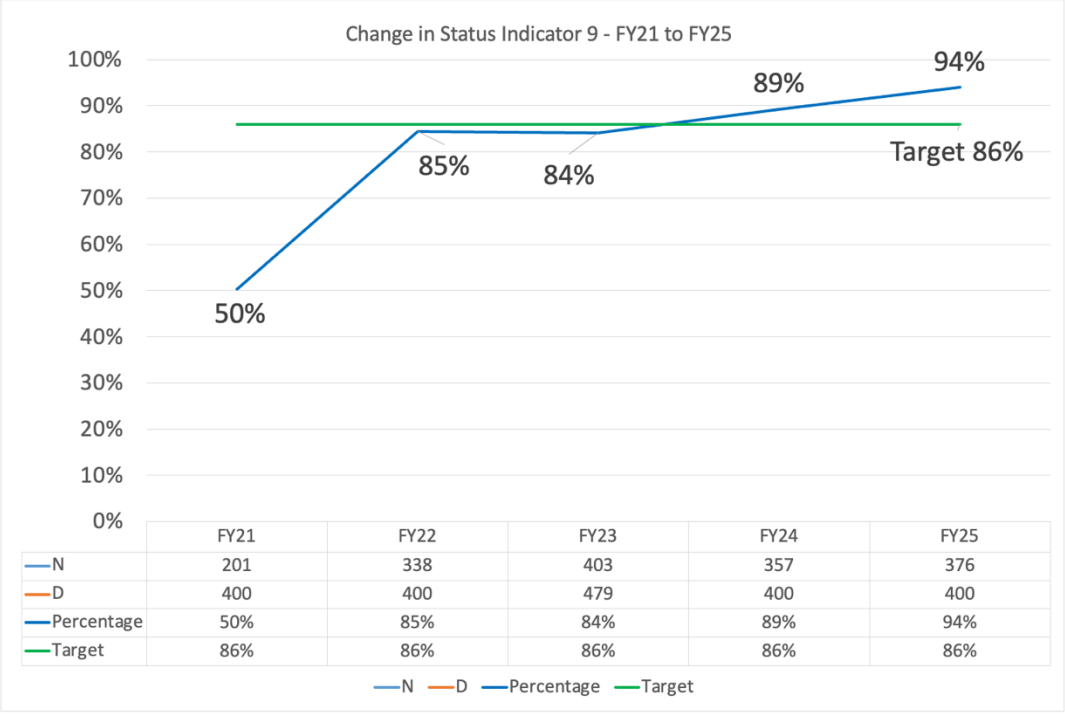
Health, Safety, and Wellbeing

Change in Status and Appropriately Implemented Services

Reference	Measure	Numerator	Denominator
16 *(**PMI**) Fig. 16*	The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed. (Target 86%)	N = Number of records confirming all SCQR questions 77 AND also confirming "yes" or "not applicable" on SCQR Q73, Q76, and Q80	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs
17 (**PMI**) *Fig. 17*	Individual support plans are assessed to determine that they are implemented appropriately. (Target 86%)	N = Number of records confirming all SCQR Q73 and Q82	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs

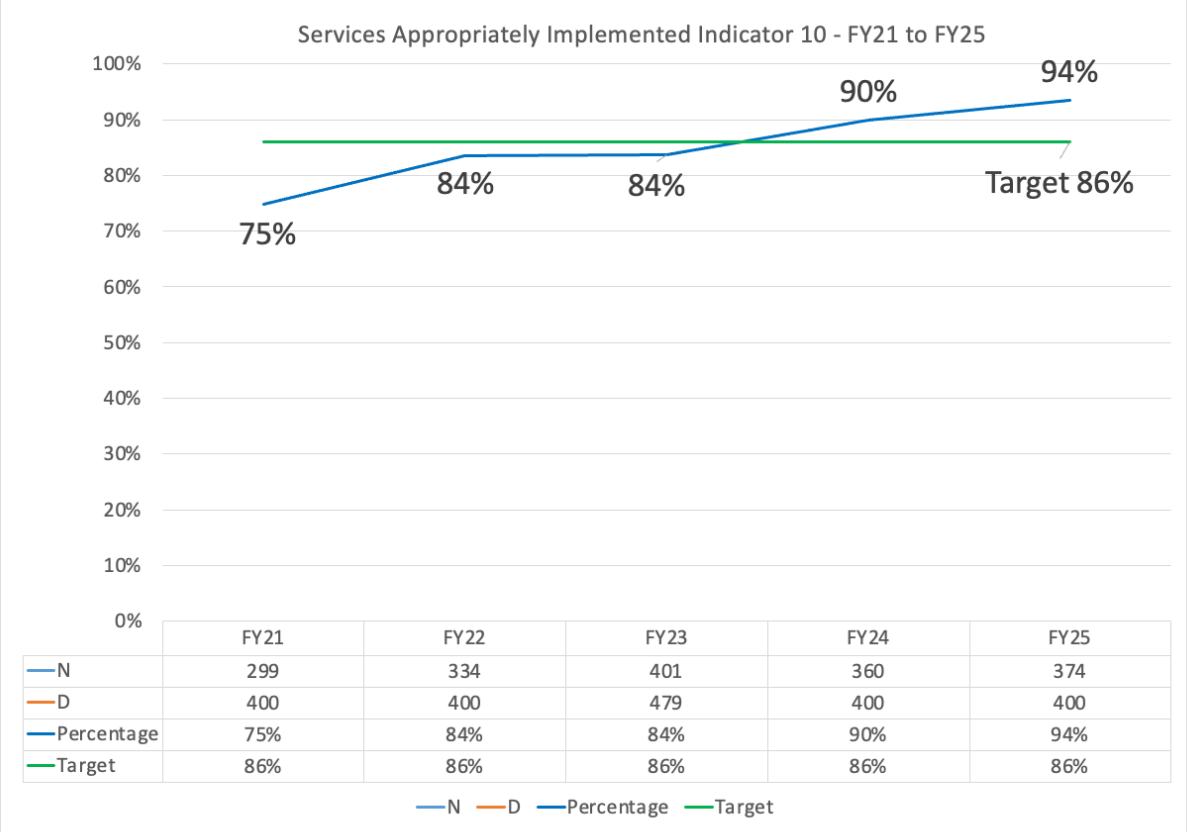
The charts below provide results as reported by CSBs in the FY25 SCQR submitted results. The results for both measures showed maintenance in compliance. Indicator 9 increased from 89% to 94% since FY24 and indicator 10 increased to 94% in FY25 placing both measures above the target of 86%. FY25 look behind data will be available in the next report.

Fig. 16 FY21-25 results for change in status.



	FY21	FY22	FY23	FY24	FY25
N	201	338	403	357	376
D	400	400	479	400	400
Percentage	50%	85%	84%	89%	94%
Target	86%	86%	86%	86%	86%

Fig. 17 FY21-FY25 results for appropriately implemented services



	FY21	FY22	FY23	FY24	FY25
N	299	334	401	360	374
D	400	400	479	400	400
Percentage	75%	84%	84%	90%	94%
Target	86%	86%	86%	86%	86%

Choice and Self-Determination

Reference	Measure	Numerator	Denominator
18 *(**PMI**) Fig. 18*	Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff). (Target 86%)	N = Number of individual records for which the response was "Yes" to SCQR Q42	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs
19 (**PMI**) *Fig. 19*	Individuals are given choice among providers, including choice of support coordinator, at least annually. (Target 86%)	N = Number of individual records for which the response was "Yes" to both components of SCQR Q19 and Q21	D = Number of records of individuals receiving DD waivers reviewed, through the SCQR instrument, by CSBs annually

The charts below provide results as reported by CSBs in the current year of the SCQR. These results are based on CSB-submitted data and will include the levels of agreement found through the look-behind process in the next report. The CMSC has added clarified instruction to the Virginia Informed Choice (VIC) form available on the DBHDS website and has submitted a change request to WaMS Administration to ensure that the SC first and last names are added to the VIC. Of the three measures reported below, all measures reflect above target performance in FY25.

Measure 18, Fig. 18 FY25 results for unpaid relationships discussion

Q42. Is it evident in the PC ISP that the SC/CM discussed relationships and interactions with people other than paid program staff?

Q42	Count	Percent
No	21	5.25%
Yes	379	94.75%
Grand Total	**400**	**100.00%**

Measure 19, Fig. 19 FY20 to FY25 results for choice

	FY2021	FY2022	FY2023	FY2024	FY2025
Indicator 1	88.0%	91.8%	82.7%	87.0%	91.3%
Indicator 2	77.5%	77.8%	92.9%	96.8%	98.0%

Recommendations

Below are recommendations that were made by the CMSC in the previous report followed by additional recommendations from this current report. The CMSC will continue to work to make data available to CSBs, so that internal monitoring and improvement abilities can be strengthened.

As of the last semi-annual report, the CMSC made the following recommendations:

- Obtain case management visit data from the DBHDS EDW and proceed with the FY25 Data Quality Support Process and implement the final "pillar" in the performance monitoring process.
- Continue the implementation of an OVST QII to improve clarity and usefulness of the tool.
- Work with DBHDS to identify and plan for system changes focused on improving processes and reducing administrative burden.
- Revisit Enhanced Case Management ECM to evaluate impact and determine additional process improvements.
- Develop an online dashboard in PowerBi to assist the CMSC in an expedited, more manageable review of CSB performance across quarters.
- Determine additional data elements, which can be obtained from the PC ISP v4.0 and include in reporting and plan for the development of user accessible reports directly within the WaMS user interface.
- Develop a video overview or training for CSBs covering the 10 case management elements included in the Permanent Injunction and assessed through the SCQR to increase understanding across the system of these elements and how success can be achieved.

Current Recommendations Include:

- Obtain case management visit data from the DBHDS EDW and proceed with the FY25 Data Quality Support Process and implement the final "pillar" in the performance monitoring process.
- Continue the implementation of an OVST QII to improve clarity and usefulness of the tool.
- Work with DBHDS to identify and plan for system changes focused on improving processes and reducing administrative burden per planning priorities from the DOJ Summit work.
- Revisit Enhanced Case Management ECM to evaluate impact and determine additional process improvements.
- Develop an online dashboard in PowerBi to assist the CMSC in an expedited, more manageable review of CSB performance across quarters.
- Determine additional data elements, which can be obtained from the PC ISP v4.0 and include in reporting and plan for the development of user accessible reports directly within the WaMS user interface.
- Develop a video overview or training for CSBs covering the 10 case management elements included in the Permanent Injunction and assessed through the SCQR to increase understanding across the system of these elements and how success can be achieved.
- Discuss a plan of action to engage CSBs and providers regarding DBHDS website design.

CMSC Glossary

Term	Definition
Aggregate total	A total amount that is arrived-at by adding together all related data under one area or group being considered.
Best Practices	Practices that have been shown by research and experience to produce optimal results and that is established or proposed as a standard suitable for widespread adoption.
Case Manager	See "Support Coordinator." This is a term frequently used by the Departments of Medical Assistance Services and DBHDS, the Community Services Boards, and the Independent Living Centers.
Choice	The right, power, or opportunity to choose; option. Informed choice: When an individual is informed of all of the options that are available and understands these options and the impact of the choice.
Competency	The ability to do something successfully or efficiently.
CRC	Community Resource Consultants; Staff employed by DBHDS in the Office of Provider Development who provide technical assistance and support providers and community services boards with understanding state and federal requirements and who support best practices such as Person-Centered Thinking and planning.
Data Integrity	The overall accuracy, completeness, and consistency of data.
Demographics	Statistical data relating to Virginia's DD population and particular groups within it.
Individual Support Plan	An individual's plan for supports and actions to be taken during the year to lead toward his or her desired outcomes. It is developed by the individual and partners chosen by the individual to help. It is directed by the individual's vision of a good life, his or her talents and gifts, what's important to the individual on a day-to-day basis and in the future, and finally, what's important for the individual to keep healthy and safe and a member of communities.
Integrated setting	A setting where four or fewer unrelated individuals with developmental disabilities reside and/or receive Home and Community-Based waiver services.
Key Performance Measures	Statements that describe the expected performance of an individual, group, organization, system or component, which is required by the Settlement Agreement or approved by a DBHDS-approved committee for quality improvement purposes.
Meaningful activities	Activities that individuals indicate are personally meaningful to them.
Natural support	Supports that occur naturally within the individual's environment. These are not paid supports but are supports typically available to all community members. Natural supports should be developed, utilized and enhanced whenever possible. Purchased services should supplement, not supplant, the natural supports. Some examples of natural supports are the family members, church, neighbors, co-workers, and friends (from: Indiana's Disabilities and Rehabilitation - Person Centered Planning Guidelines).

Non-integrated setting	A setting where five or more unrelated individuals with developmental disabilities reside and/or receive Home and Community-Based waiver services.
Outcome	A desired result that happens following an activity or process.
Person-Centered Planning	A planning process that focuses on the needs and preferences of the individual (not the system or service availability) and empowers and supports individuals in defining the direction for their own lives. Person-centered planning promotes self-determination, community inclusion and typical lives.
Person-Centered Practices	Practices that focus on the needs and preferences of the individual, empower and support the individual in defining the direction for his/her life, and promote self-determination, community involvement, contributing to society and emotional, physical and spiritual health.
Promising Practices	Practices that include measurable results and report successful outcomes, however, there is not yet enough research evidence to prove that they will be effective across a wide range of settings and people.
Providers	Agencies and their staff who provide DD waiver services in Virginia. Can be a private provider or a provider of services operating under a community services board.
Quality Improvement Initiative (QII)	Strategies designed to support quality improvement activities, whose implementation and use follow the PDSA (Plan Do Study Act) cycle to achieve these improvements. QIIs seek to improve systems and processes to achieve desired outcomes; strengthen areas of weakness, to prevent and/or substantially mitigate future risk of harm.
RST	Regional Support Team; Five Regional Support Teams (RSTs) were implemented in March 2013 by the Department of Behavioral Health and Development Services (DBHDS) with Virginia's emphasis on supporting individuals with developmental disabilities in the most integrated community setting that is consistent with their informed choice of all available options and opportunities. The RST is comprised of professionals with experience and expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs.
Support Coordinator	A person who assists an individual in developing and implementing a person-centered plan, including linking an individual to supports identified in the plan and assisting the individual directly for the purpose of locating, developing, or obtaining needed supports and resources.