Case Management Steering Committee Semi-Annual Report

State Fiscal Year 2026
1st and 2nd Quarters

DBHDS

Case Management Steering Committee

Semi-Annual Report FY26 1st and 2nd 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 Director of Waiver Network Supports or designee, Director of Provider Network Supports (OPNS) or designee (Chair), Director of Community Quality Management or designee, Associate Director for the Office of Community Quality Improvement, Community Resource Consultant (Co-chair), Quality Research Specialist, Office of Quality Assurance and Healthcare Compliance. Advisory members include QI Implementation Manager / Director, QI Analytics and Processes, Community Resource Consultant, Quality Improvement Specialist, Representative, Office of Licensing, Behavior Analyst, Director, Transition Network Supports, WaMS Data Analyst, Other internal members as determined by the committee. 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 discussed projected changes to the ISP with functionality of the Part V in WaMS being the main focus. Feedback from Providers was collected and incorporated into the Part V update with the focus on functionality. This includes the possible addition of dropdown boxes and auto populating dates. To assist with making a more direct connection between outcomes/ key steps, outcomes may auto-populate into the Part V. Additionally, it would include provider including how often, by when, what to record, how to support, and details related to skill building.

Improvements to Parts I thru IV of the ISP include a revision of the employment questions with feedback from the Employment First Workgroup. Additionally, a question was added to include when an individual or their substitute decision maker declines to have an employment conversation.

Updates are slated for later in 2026. Monthly meetings with the vendor group group have resumed to discuss the changes. After edits are finalized, they will be sent to FEI for review. Revisions will also be reviewed with the Provider Issues Resolution Workgroup and other stakeholders prior to finalization.

QIC motioned to approve CMSC for a project to explore the ISP including updates related to behavioral health conditions and medications. CMSC discussed exploring a partnership with DMAS. CMSC has requested to be well information and will support as appropriate.

Additionally, improvements to the RST module are being made within WaMS. This includes incorporating an updated Virginia Informed Choice (VIC) form to align with the VIC housed in WaMS. 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. Public comment has ended and been incorporated into the VIC and the Service Selection Guide including selection of non-waiver options. The OPNS held a virtual training session to review the use of the updated form and guide. All CSBs are expected to implement as annuals come due and as needed by July 1st, 2026, when DMAS and DBHDS program reviewers will begin looking for the updated form and information related to the new process.

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.

The CMSC continues to discuss the future of the SC Competency document which has been shared during a previous reporting period. Additional feedback has been collected and incorporated into the document. The committee will seek additional feedback reading its contents and implementation from the DS Council before finalizing.

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.

A workgroup has been developed to address revisions to enhanced case management (ECM). Changes include clinical reviews regarding continuation or discontinuation of ECM after 90 days and face to face visits monthly rather than every 30 days. Clarification has also been added regarding an interruption of services. The changes have been reflected in the FY27 Performance Contract. The workgroup is also updating Operational Guidance documents and a worksheet.

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 will continue to support this transition and will begin using data from the EDW as available.

In September, the Provider Data Summary was reviewed. 93.4% of individuals live in integrated settings with approximately 25 localities below 86%. Seven localities experienced an increase in type of services provided. Since 2016 unduplicated totals of integrated day services have significantly increased by 2.3% from 2024 to 2025. There were 2,046 DD licensed providers. While there has been an increase in community engagement, community coaching services and private duty nursing, there has been a decrease in skilled nursing. Community guide providers increased to 11. Of note, there are currently no crisis support services. The CMSC discussed possible ways to attract new crisis support services including education and working with the RQCs.

A joint QII has been developed between the KPA Workgroup regarding meeting the 9 or 10 case management indicators during SCQR. Two presentations are being developed with one developed for support coordinators while the other will focus on providers. The presentations will review what are the indicators, provide context, discuss the importance, and how to achieve within the scope of their role to the individual.

The CMSC has reviewed and discussed a recommendation about improvements to the OPNS website. This project is currently under development in an effort to simplify and clarify information. Additionally, the goal is to improve the centralized training section and make improvements to the support coordinator section.

The CMSC has also been discussing ways to work with the Partnership with People with Disabilities. During recent NCI interviews, a process will be developed with CMSC support to address needs not being addressed by the individual's support coordinator. CMSC will be supporting the KPA Workgroup with this endeavor.

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. Two indicators in FY25 are below target with Indicator nine slipping from 89% to 84%.

	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%	84.0%
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. Per the Permanent Injunction since the 86% was not met, then the threshold will be increased. The CMSC has recommended, and plans to adopt, an increase to two or more indicators with substantial or moderate interrater reliability are below 65% for the upcoming cycle per Permanent Injunction requirements.

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.

Improvement plans will be requested from CSBs for the current cycle following the look behind when 2 or more indicators with substantial or moderate interrater reliability are below 60%. Improvement plans were requested from four CSBs (D19. Chesterfield, Alexandria, and Highlands). OCQI have been collaborating on developing a process for targeted technical assistance until CSBs can reach 86%. There were 13 CSBs who did not reach the target during the last SCQR cycle and targeted technical assistance will be provided during the technical assistance prior to scoring (Table 3).

Table 3. Percentage of Records Meeting at Least Nine Indicators by CSB

CSB	Percentage of Records
Alexandria Community Services Board	71.4%
Alleghany Highlands Community Services Board	100.0%
Arlington County Community Services Board	100.0%
Blue Ridge Behavioral Healthcare	81.8%
Chesapeake Integrated Behavioral Healthcare	60.0%
Chesterfield Community Services Board	25.0%
Colonial Behavioral Health	100.0%
Crossroads Community Services Board	100.0%
Cumberland Mountain Community Services	100.0%
Danville-Pittsylvania Community Services	70.0%
Dickenson County Behavioral Health Services	100.0%
District 19 Community Services Board	0.0%
Eastern Shore Community Services Board	83.3%
Encompass Community Supports	100.0%
Fairfax- Falls Church Community Services Board	88.9%
Goochland-Powhatan Community Services	100.0%
Hampton-Newport News Community Services Board	100.0%
Hanover County Community Services Board	100.0%
Harrisonburg-Rockingham Community Services Board	100.0%
Henrico Area Mental Health and Developmental Services	92.3%
Highlands Community Services	42.9%
Horizon Behavioral Health	93.3%
Loudoun County Department of MH, SA and Developmental Services	100.0%
Middle Peninsula-Northern Neck Community Services Board	100.0%
Mount Rogers Community Services Board	88.9%
New River Valley Community Services	88.9%
Norfolk Community Services Board	75.0%
Northwestern Community Services	80.0%
Piedmont Community Services	55.6%
Planning District One Behavioral Health Services	100.0%
Portsmouth Department of Behavioral Healthcare Services	100.0%
Prince William County Community Services Board	93.3%
Rappahannock Area Community Services Board	73.3%
Region Ten Community Services Board	100.0%
Richmond Behavioral Health Authority	50.0%
Rockbridge Area Community Services	66.7%
Southside Community Services Board	100.0%
Valley Community Services Board	100.0%
Virginia Beach Community Services Board	81.2%
Western Tidewater Community Services Board	60.0%

In preparation for the FY26 SCQR cycle, the CMSC has been working on updating the technical guidance. OCQI and OPNS also reviewed the technical assistance process to ensure alignment between offices and eliminate any duplication. Final version of the technical guidance and multi-record review were updated and provided to CSBs. Technical assistance to the CSBs prior to the release of their sample was provided by OPNS focusing on questions related to indicators and questions that had a low level of agreement in the previous year. OPNS collected feedback from CSBs and provided it to OCQI for identified concerns related to next cycle.

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" were 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.

Based on concerns that the OSVT may not be consistently used correctly, additional questions were added to the FY25 SCQR. These questions were designed so that not only was the OSVT completion at the required frequency evaluated, but also the content of the OSVT was compared to other documentation to evaluate if it was completed accurately.

Specific results of added non-indicator questions assessing accuracy of OSVTs, all of which were also in high agreement with the DBHDS Look-behind scores:

- 95% of SCQRs indicated the presence of OSVTs as required (Q73)
- 97% of SCQRs reviewed had no blanks (Q75)
- 98% of SCQRs indicated that the "Change In Status" question on the OSVT was answered correctly based on record reviews (Q77)
- 2 of the 9 SCQRs (out of 400) indicating that this question was answered incorrectly appeared to be CSB SCQR scoring errors based on comments (Q78)
- 98% of SCQRs indicated that the "Services Implemented Appropriately" question on the OSVT was answered correctly based on record reviews (Q83)
- All 7 of the SCQRs (out of 400) indicating that this question was answered incorrectly had comments noting it was an error made by the SC completing the OSVT (Q84)
- 93% of SCQRs indicated that the "Need For Reporting" question on the OSVT was answered correctly based on record reviews (Q89)
- 22 of the 26 SCQRs (out of 400) noted to have been completed incorrectly appear to be scoring errors, possibly due to this question being formatted slightly different from other SCQR questions about OSVT completion (Q89_1)

Based on the SCQR FY25 data detailed above, it is logical to accept that the OSVT is being completed fully and utilized correctly by Support Coordinators and CSBs. It was recommended to keep the OSVT questions as they are for the FY26 as there will not be a revision of the tool related until CY26. This will enable data comparison across the two SCQR cycles. Based on the CSB suggestions, it is also recommended to specify the timeframe being looked at for each question in the guidance.

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 training materials 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.

Independent Reviewer

The Independent Reviewer submitted their 27th Report to the Court on, December 13, 2025, without including specific recommendations for case management. The 26th report from the Independent Reviewer included a recommendation to report the names of the CSBs not reaching target for improvement by the CMSC. This information can be located Performance Contract Indicator Data section of this report.

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: Completed

- 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. The committee voted to close this QII. Improvement was noted in ICI. Regions 2 and 3 consistently met the goal of 70% for FY25. The committee will continue to look for opportunities to resources developed and refer to other committees 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 Q1 and Q2, three improvement plans were approved for RST. Fifteen improvements plans were removed, and one improvement plan was approved for ISP Compliance.

Seven improvement plans were removed for SCQR. Four Improvement plans were requested for not meeting target for SCQR (D19, Alexandria, Chesterfield, and Highlands). The CMSC recommended Alexandria and D19 to receive additional targeted technical assistance for failing to reach target for 2 cycles based on their missed indicators. Alexandria failed to reach target related to Indicator 3 and Indicator 8. D19 failed to reach target with Indicators 1, 3, 8, 9, and 10. OPNS will provide this targeted technical assistance.

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.

The 2025 Quality Review Team (QRT) was provided to the local CSBs and feedback was requested to determine if trends and results were in line with CSBs experiences. Twenty-three of the 40 CSBs provided feedback. Comments indicated the administrative burden placed on support coordinators had significantly increased due to the requirements outlined in the Finale Tule especially documentation needed to demonstrate compliance. While these expectations are intended to enhance service quality and accountability, the volume and complexity of required documentation has redirected time and attention away from direct service coordination and planning. This shift has stained staff capacity. It was recommended to explore solutions to reduce administrative burden such as streamlined processes, centralized support roles, or automation tools. Additional comments included CSBs feel mandatory training to providers is needed to address competency issues. It was also noted DBHDS has improved how to meet DOJ indicators with more collaboration and training support to providers and CSBs.

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. The CMSC has requested DMAS to reconsider this alignment for FY27.

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.

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

he 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 reviewing a sample, which was pulled from CCS3 data prior to Q4 FY25 and will provide an update during the next reporting period. OPNS has been shifting these reviews to include desk audits based on feedback from the last DQS process. An updated process has been developed. Once approved, a sample with be reviewed and then discussed with sampled CSBs to identify potential data quality issues.

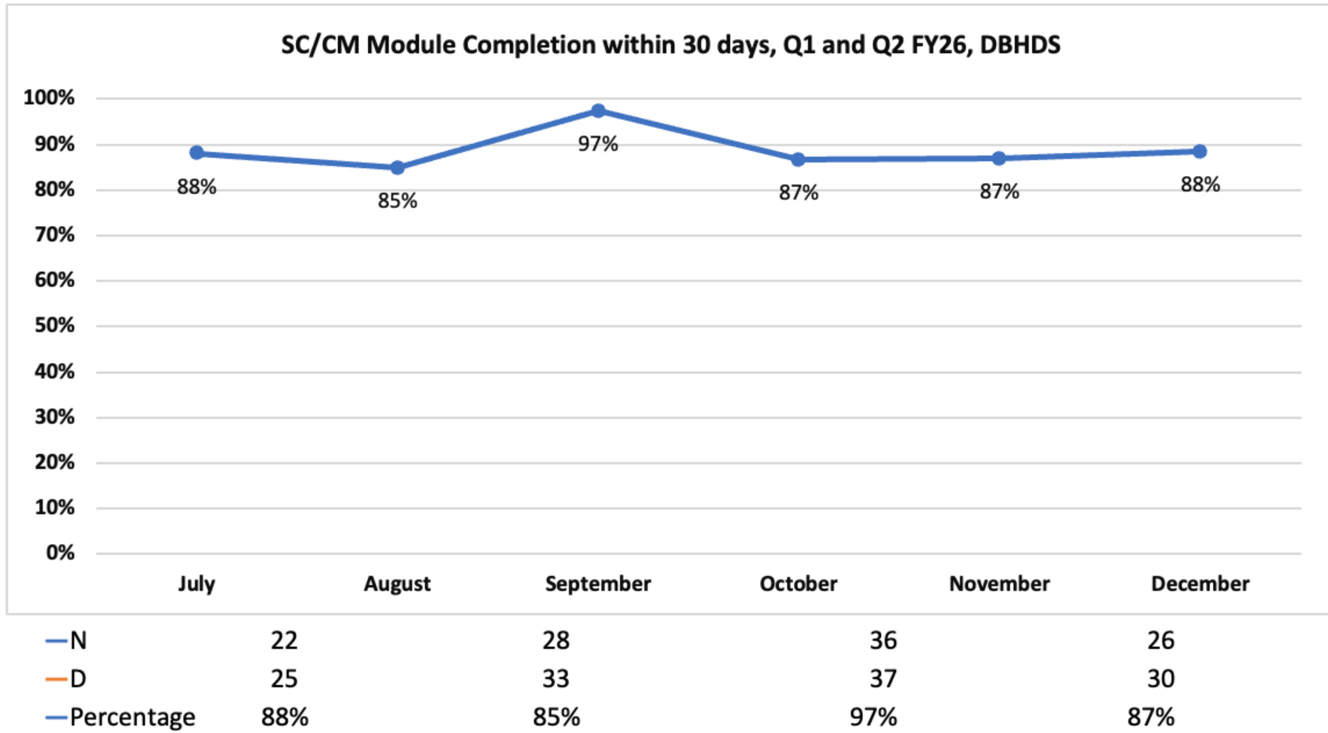
Data Monitoring

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 July and December 2025 shows that the completion rate exceeded 86% in five of the six months reviewed and reach 97% success in September. 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. The CMSC explored avenues for secondary data to strengthen data collection. The CMSC will continue to review if secondary data sources are available.

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

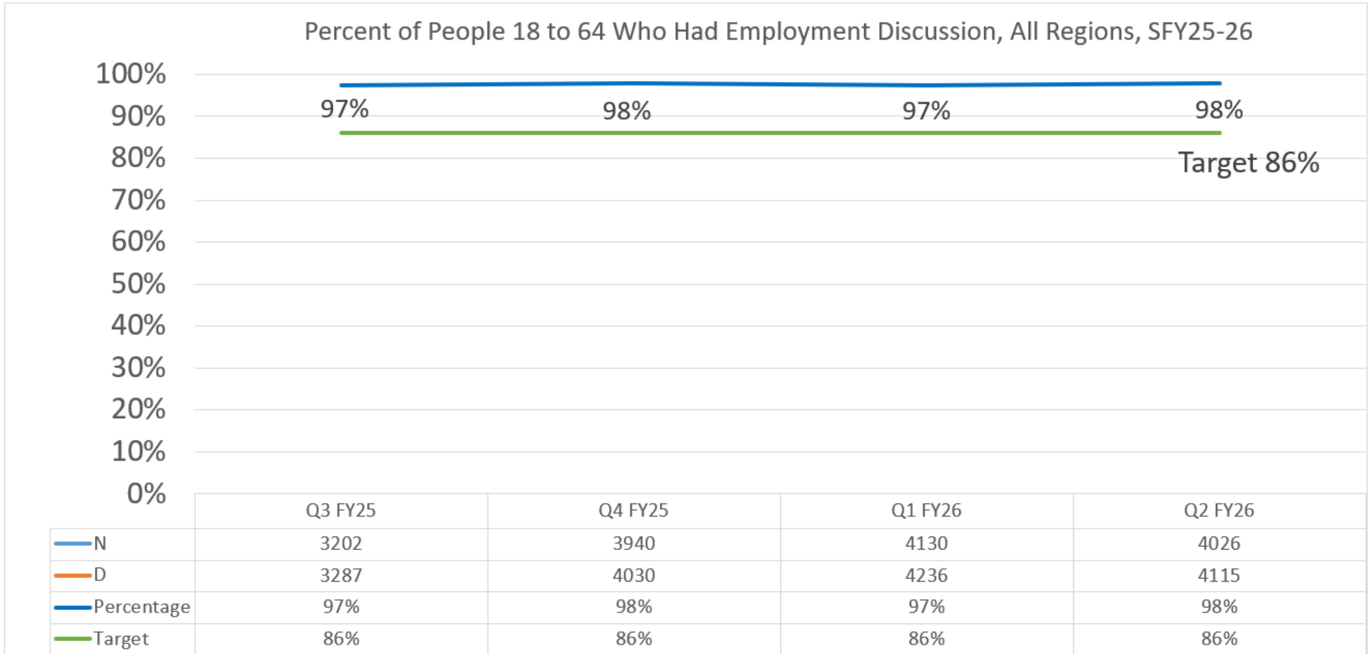
Reference	Measure	Numerator	Denominator
1 *Fig. 1*	86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process (Target 86%). **III.C.7.a.**	N = Number of Individuals who had an Employment Discussion at Annual F2F ISP 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 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%. While those with employment goals has consistently been below target with a decline noted during FY26 Q2 (see Fig. 2). Results continue to be below target but have remained overall stable.

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 an increase from Q3 to Q4 FY25. This was an increase of nine percentage points. There was a slight decrease between FY26 Q1 and Q2 but improved over four quarters (Fig. 3). A job aid for employment discussions for individuals 14-17 years old had been previously housed in WaMS; however, CSBs using only their EHR may not be aware of it. Based on a

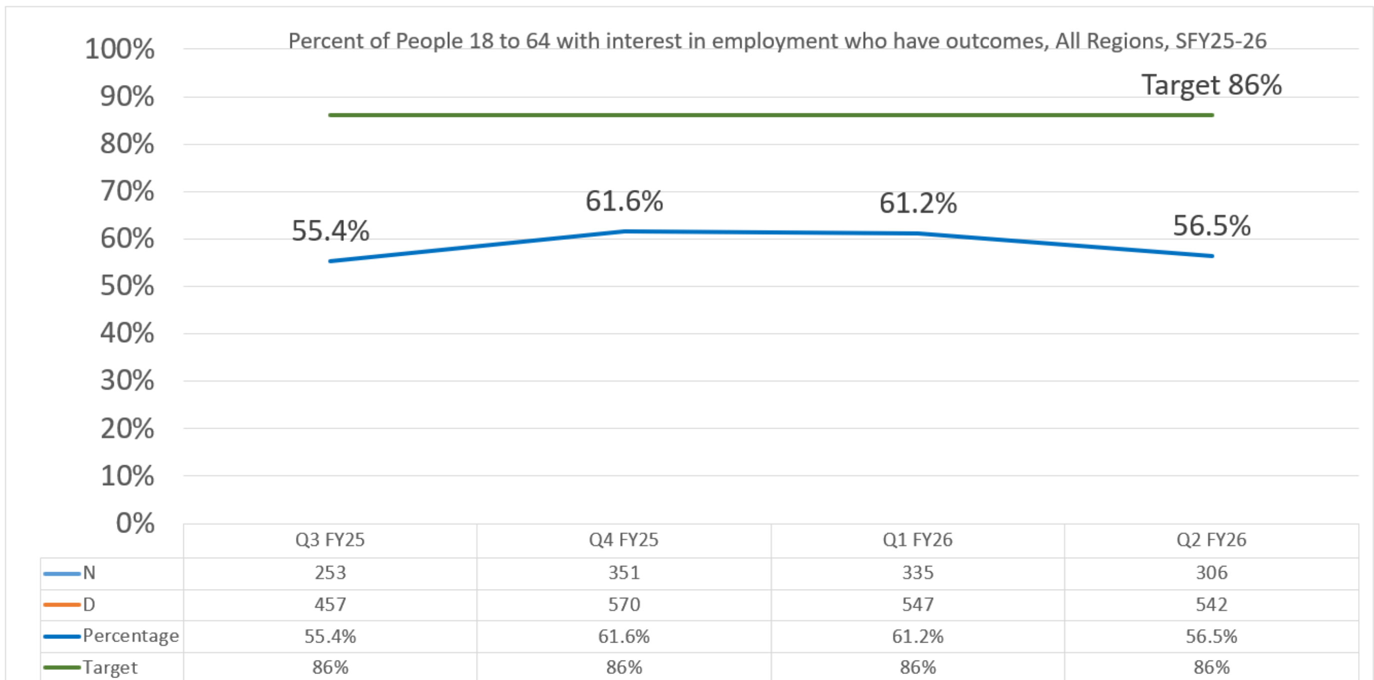
recommendation by the CMSC, the job has also been posted to the OPNS website as well. The CMSC will continue to monitor these measures and make recommendations as appropriate.

Fig. 1 Employment Discussions FY25-26



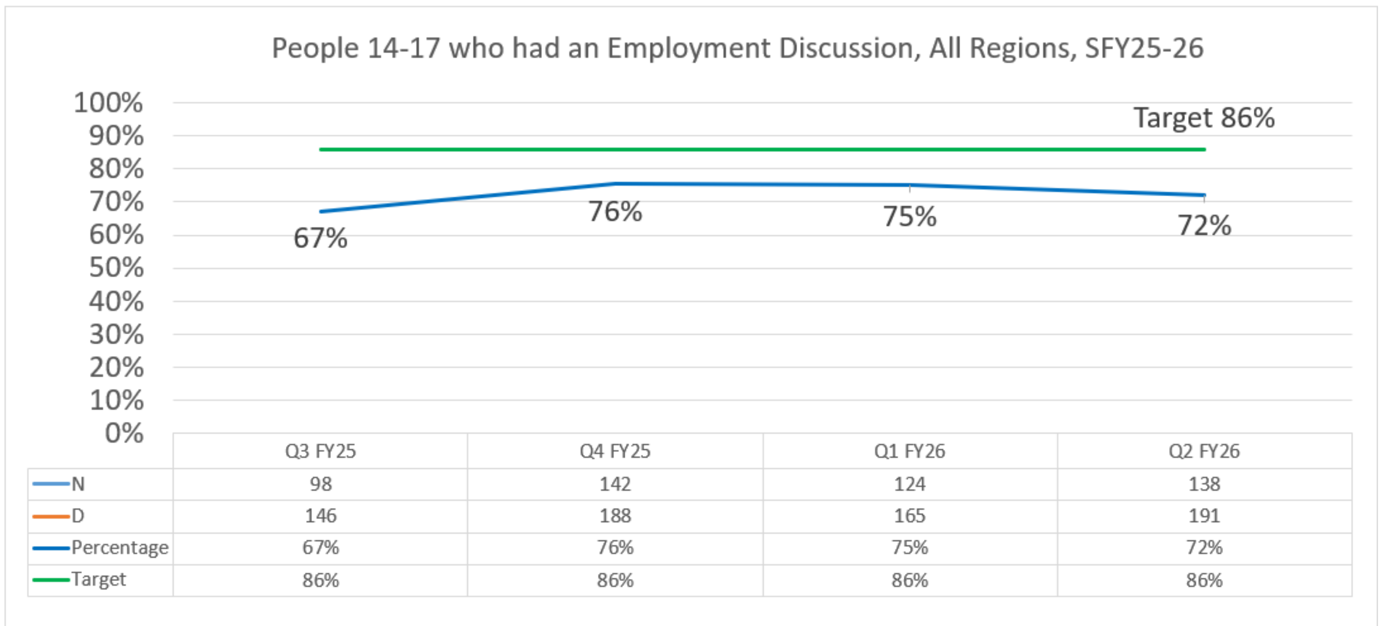
	Q3 FY25	Q4 FY25	Q1 FY26	Q2 FY26
N	3202	3940	4130	4026
D	3287	4030	4236	4115
Percentage	97%	98%	97%	98%
Target	86%	86%	86%	86%

Fig. 2 Employment Interest with Outcomes FY25-26



	Q3 FY25	Q4 FY25	Q1 FY26	Q2 FY26
N	253	351	335	306
D	457	570	547	542
Percentage	55.4%	61.6%	61.2%	56.5%
Target	86%	86%	86%	86%

Fig. 3 Employment Discussion 14-17 (both topics confirmed) FY 25-26



	Q3 FY25	Q4 FY25	Q1 FY26	Q2 FY26
N	98	142	124	138
D	146	188	165	191
Percentage	67%	76%	75%	72%
Target	86%	86%	86%	86%

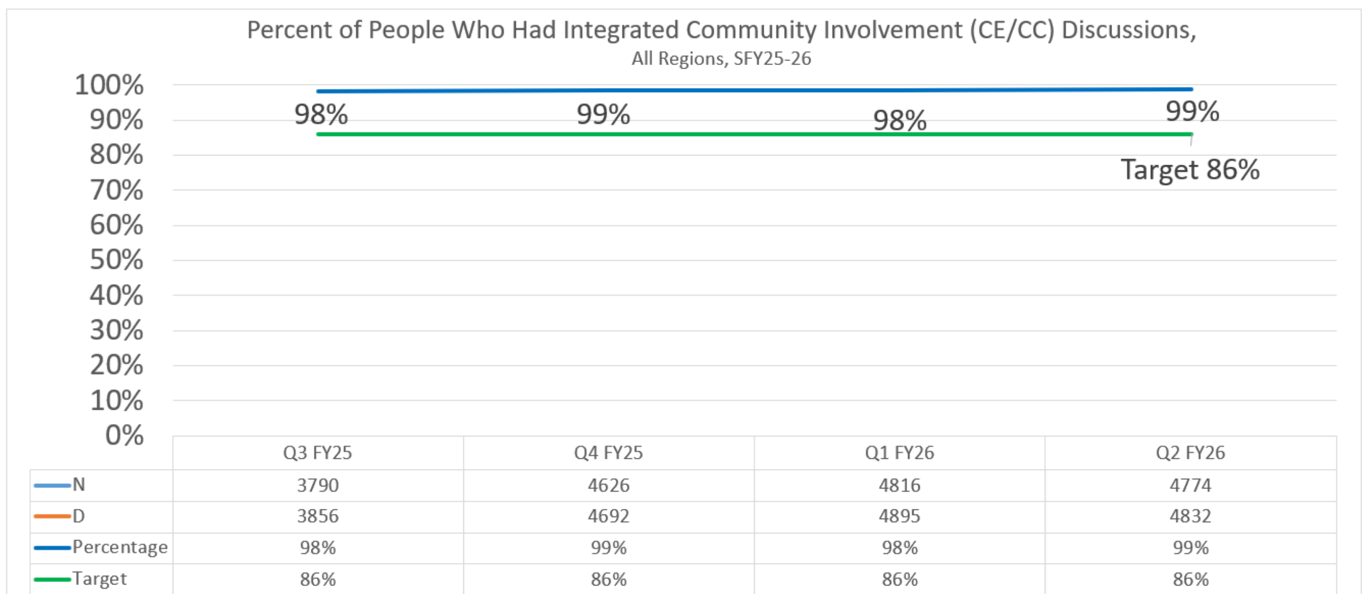
Community Engagement Discussions and Goals

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 had seen an increase over four quarters (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.

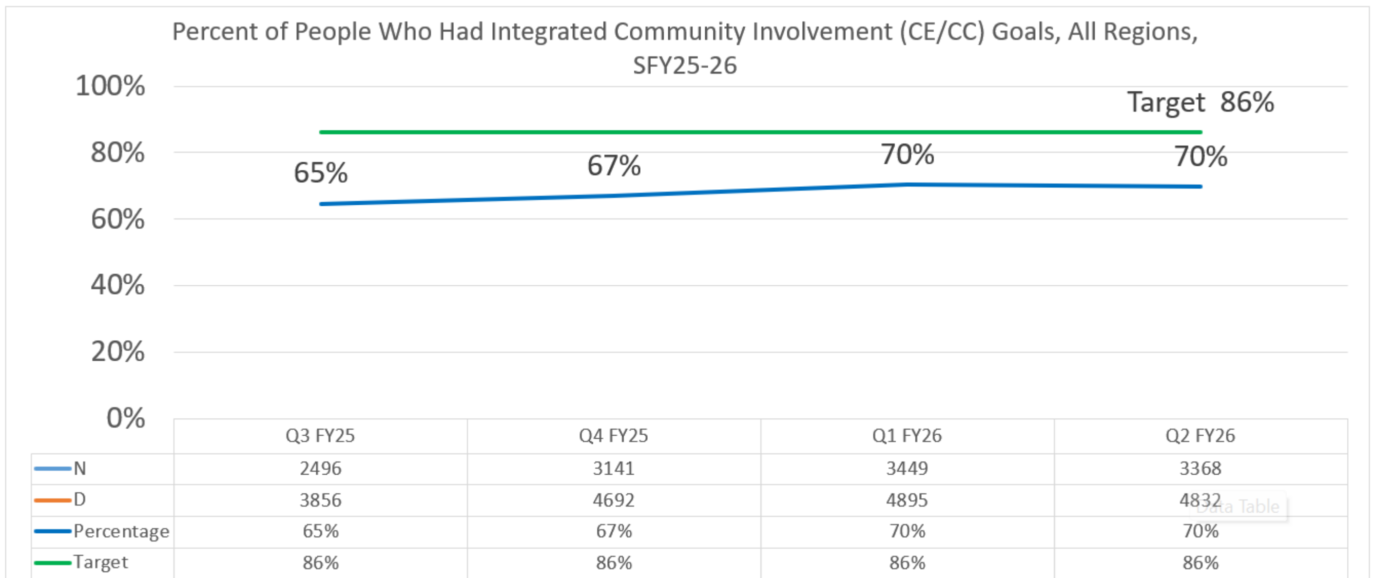
The CMSC has been discussing ways to strengthen data collection to be more reflective of the services and supports individuals receive related to Integrated Community Integration. The current measure calculates the percentage based on the Life Area selected in the Part III. After training and education efforts, little progress has been gained. The committee is exploring the inclusion of services that, by definition, include integrated community involvement as a way to verify ICI is occurring in addition to the Life Area.

Fig. 4 Integrated Community Involvement (Community Engagement) Discussions FY25-26



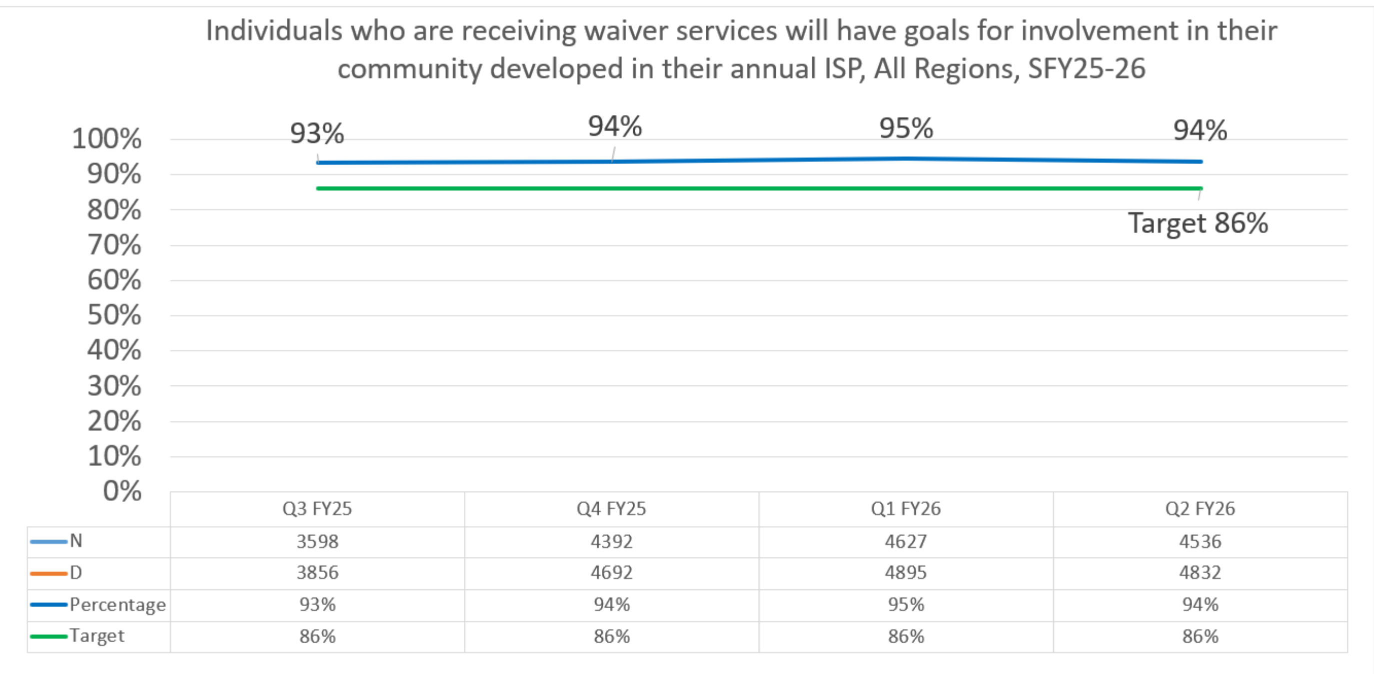
	Q3 FY25	Q4 FY25	Q1 FY26	Q2 FY26
N	3790	4626	4816	4774
D	3856	4692	4895	4832
Percentage	98%	99%	98%	99%
Target	86%	86%	86%	86%

Fig. 5 Integrated Community Involvement (Community Engagement) Outcomes FY25-26



	Q3 FY25	Q4 FY25	Q1 FY26	Q2 FY26
N	2496	3141	3449	3368
D	3856	4692	4895	4832
Percentage	65%	67%	70%	70%
Target	86%	86%	86%	86%

Fig. 6 Community Involvement Outcomes FY25-26



	Q3 FY25	Q4 FY25	Q1 FY26	Q2 FY26
N	3598	4392	4627	4536
D	3856	4692	4895	4832
Percentage	93%	94%	95%	94%
Target	86%	86%	86%	86%

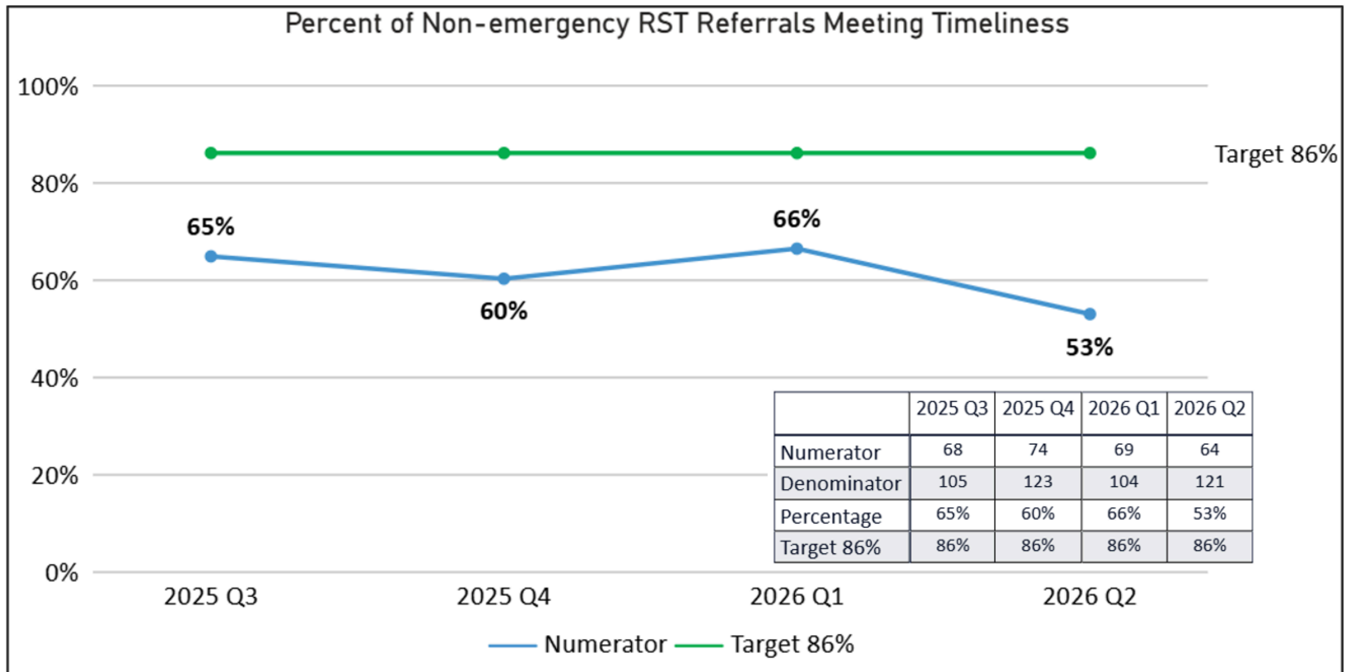
Regional Support Teams and Timeliness of Referrals

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.

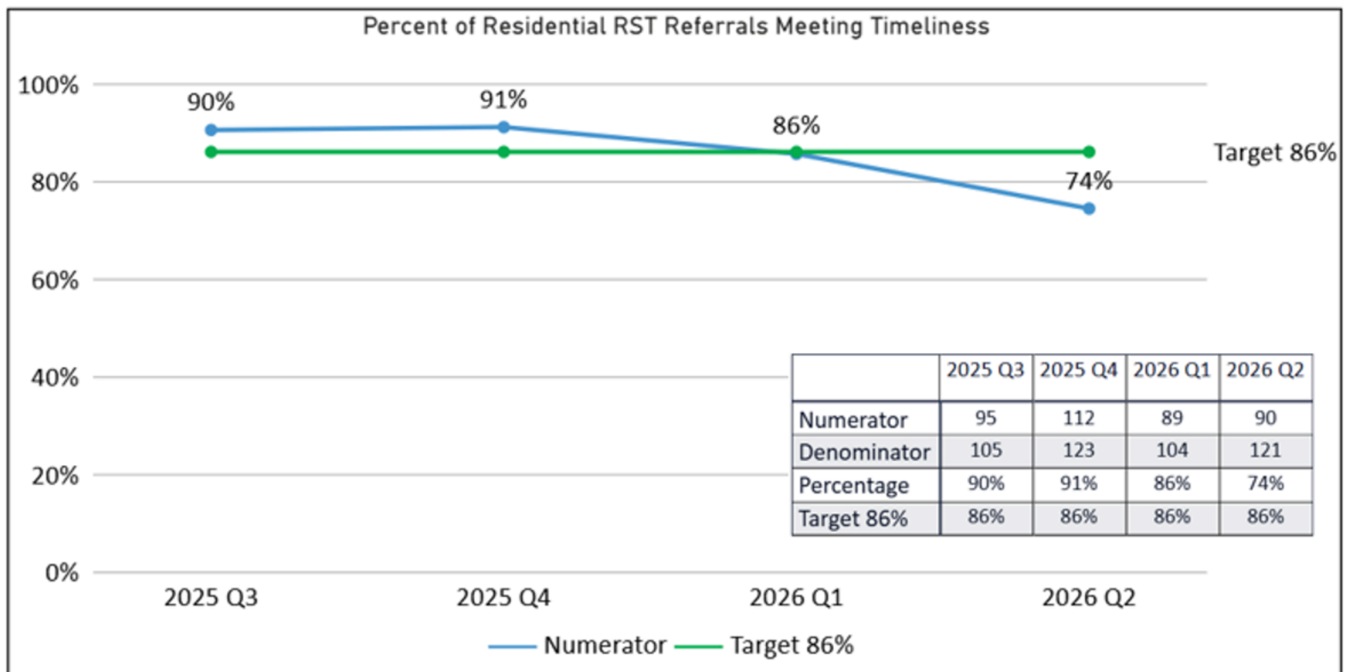
Beginning with Q4 FY23, all data derives from the WaMS system except for missed referrals, which by necessity remains a manual process with results being added to the dashboard once completed. In Q1 FY26, the systemwide measure for RST referral timeliness reached 66% and dropped to 53% in Q2 FY26 (Fig. 7). In a similar manner the residential measure fell to 74% in Q2 FY26 (Fig. 8). The low performance seen in this quarter relates to a transition where a large residential provider agency was sold to an existing provider agency. The Community Services Board worked to ensure individuals were fully informed and able to make an informed choice about their services, particularly because most of the homes involved are considered less integrated settings. This required confirming that everyone wished to continue receiving services under the new operating agency. While the CSB completed many of the required referrals during this process, 20 referrals were missed as part of the transition. The CSB documents choice in these situations, which are reviewed by the DBHDS internal audit team during routine reviews.

Fig. 7 RST Referral Timeliness FY24-25



	2025 Q3	2025 Q4	2026 Q1	2026 Q2
Numerator	68	74	69	64
Denominator	105	123	104	121
Percentage	65%	60%	66%	53%
Target 86%	86%	86%	86%	86%

Fig. 8 RST Residential Community Referral Timeliness FY25



	2025 Q3	2025 Q4	2026 Q1	2026 Q2
Numerator	95	112	89	90
Denominator	105	123	104	121
Percentage	90%	91%	86%	74%
Target 86%	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 FY26

	2026 Q1		2026 Q2		**Total**
Region	No	**Total**	No	**Total**	
Region I	15	**15**	18	**18**	**33**
Region II	16	**16**	15	**15**	**31**
Region III	13	**13**	24	**24**	**37**
Region IV	35	**35**	25	**25**	**60**
Region V	17	**17**	13	**13**	**30**
Total	**96**	**96**	**95**	**95**	**191**

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

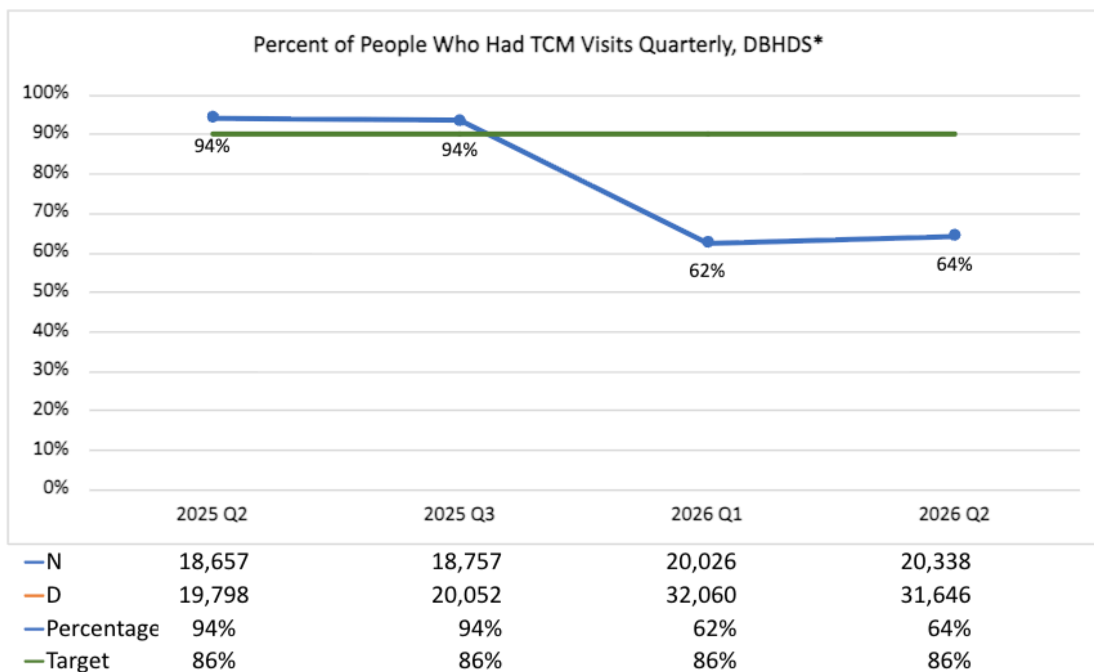
Provider Capacity

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.

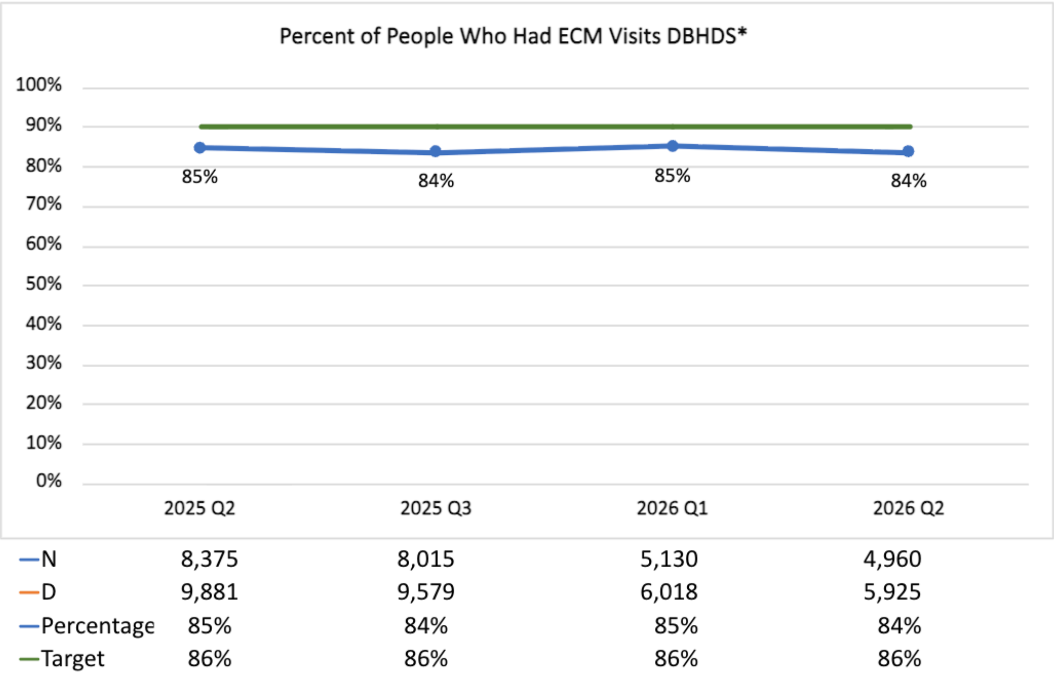
All CSBs completed the transition to the new Enterprise Data Warehouse (EDW) in the 4th quarter of FY25. Data related to face-to-face contacts is derived from the new data source beginning with Q1 FY26. While there was above target performance for the first two quarters of FY25, performance dropped significantly following the transition to the new data source. (Fig. 10). DBHDS is aware of coding concerns related to the transition and will be providing technical assistance to address the issue. Following technical assistance, DBHDS will continue the data quality support process to improve data reliability and validity over time. Similar data coding issues are seen with the two ECM measures as well and will. While overall results for Q1 and Q2 FY26 ECM face-to-face (Fig. 11) and ECM in the home (Fig. 12) were within 10% of the target 4 both demonstrate lower reporting, which will be addressed through the same process described above for TCM. The CMSC's Data Quality Support (DQS) process is being updated to incorporate a desk review in advance of CSB meetings to reduce the time and effort required of CSBs to participate in the process. This process is being updated during FY26 to reflect the transition to the EDW, which is now.

Fig. 10 TCM visits FY25-26



*Beginning with 2026 Q1, data are sourced from a new reporting system. These values are known to be incomplete, and DBHDS is currently working with CSBs to validate and resubmit corrected data. Once completed, DBHDS will use the established data quality support process to improve data reliability and validity over time.

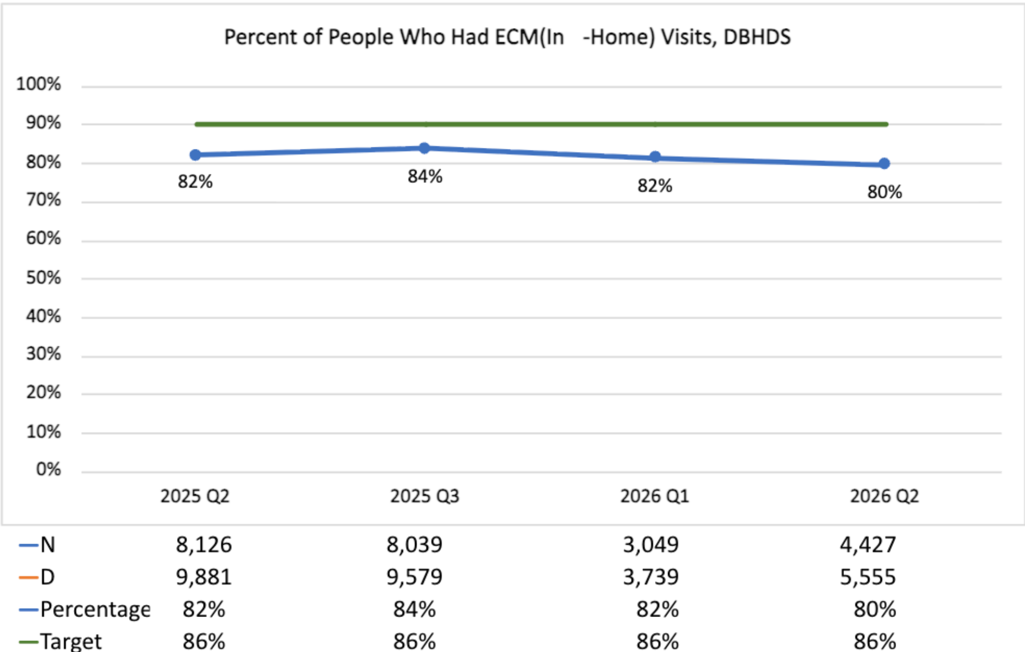
Fig. 13 ECM face to face visits FY 25-26



	2025 Q2	2025 Q3	2026 Q1	2026 Q2
—N	8,375	8,015	5,130	4,960
—D	9,881	9,579	6,018	5,925
—Percentage	85%	84%	85%	84%
—Target	86%	86%	86%	86%

*Beginning with 2026 Q1, data are sourced from a new reporting system. These values are known to be incomplete, and DBHDS is currently working with CSBs to validate and resubmit corrected data. Once completed, DBHDS will use the established data quality support process to improve data reliability and validity over time.

Fig. 14 ECM visits in-home FY25-26



	2025 Q2	2025 Q3	2026 Q1	2026 Q2
—N	8,126	8,039	3,049	4,427
—D	9,881	9,579	3,739	5,555
—Percentage	82%	84%	82%	80%
—Target	86%	86%	86%	86%

*Beginning with 2026 Q1, data are sourced from a new reporting system. These values are known to be incomplete, and DBHDS is currently working with CSBs to validate and resubmit corrected data. Once completed, DBHDS will use the established data quality support process to improve data reliability and validity over time.

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

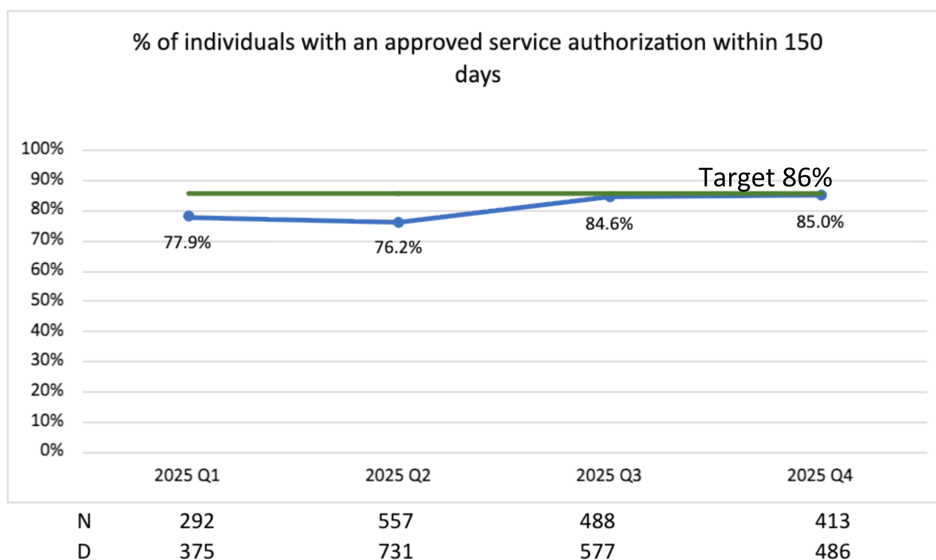
Table 2: Percentage of Records Meeting at Least Nine Indicators

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. 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 84.6% for Q3 and ending at 85% for Q4 FY25 (Fig. 14). This is a consistent result across both quarters and within 1% of target when rounded.

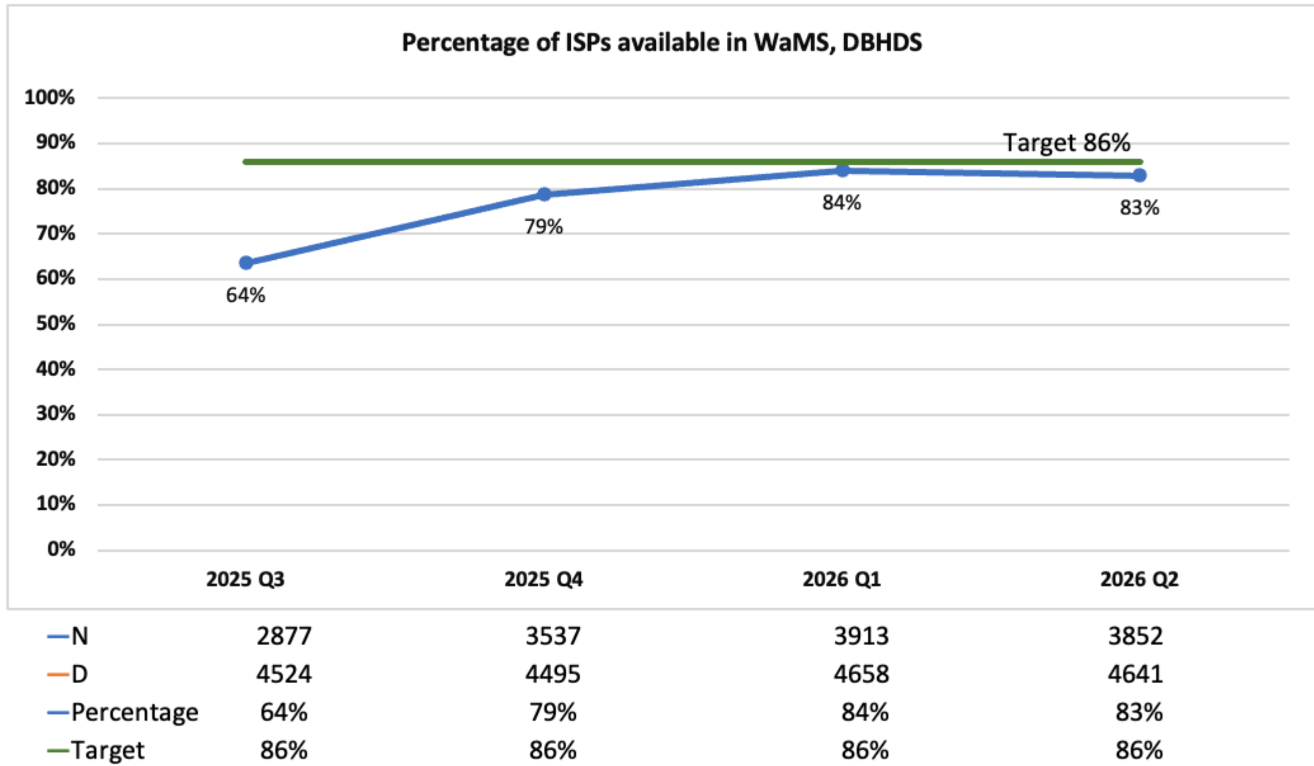
While Development Services has a strategy to notify CSBs when an individual's services are not initiated within 150 days, CSBs may not be responsive. It was further discussed that SCs should be identifying the individual's correct priority. The SCs need to ensure individuals are being awarded waiver 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 FY25-26 results



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 3% of target in Q2 FY26 (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 FY25-26



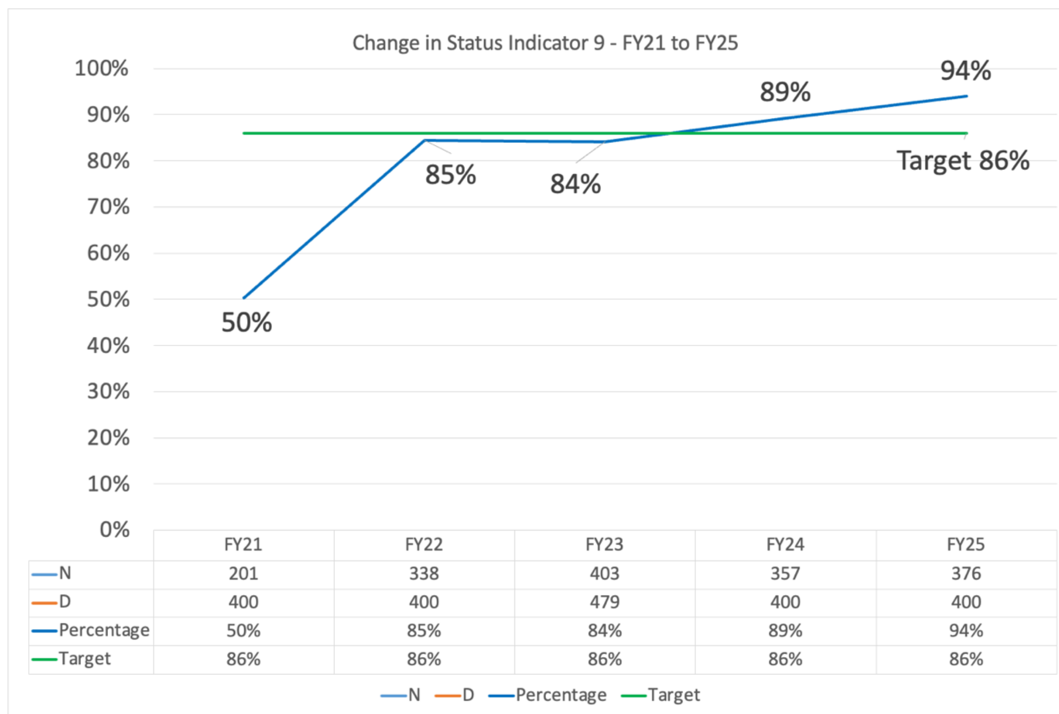
Health, Safety, and Wellbeing

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

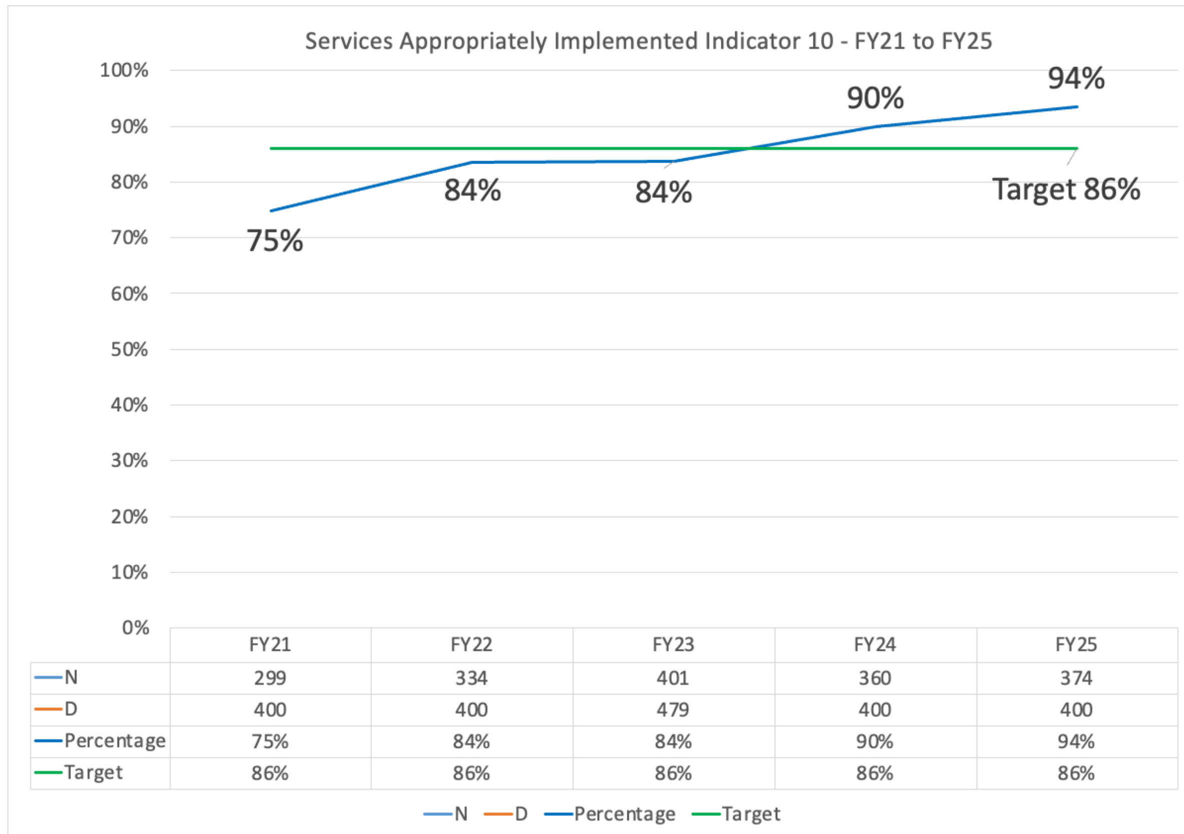
The charts below provide results as reported by CSBs in the FY25 SCQR submitted results. The results for both measures showed maintenance in compliance. Indicator 9 increased from 89% to 94% since FY24 and indicator 10 increased to 94% in FY25 placing both measures above the target of 86%. FY25 look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

Current Recommendations Include:

- Complete and release the updated OSVT Form.
- Develop an online dashboard in PowerBi to assist the CMSC in an expedited, more manageable review of CSB performance across quarters.
- Complete the change request process for the PC ISP v4.1.
- 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.
- 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 implementation of the SCQR process with the updated threshold for CSB success.
- 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.

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.