DBHDS

Virginia Department of Behavioral Health and Developmental Services

Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2025

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A Life of Possibilities for All Virginians

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Part 3 – Annual Report and Evaluation

Executive Summary

The Developmental Disabilities (DD) Quality Management (QM) Annual Report and Evaluation summarize the comprehensive work conducted by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Quality Management System (QMS) within its key performance areas (Health, Safety and Wellbeing, Community Inclusion and Integration, Provider Capacity and Competency). Embedded within the key performance areas (KPAs) are the components of quality assurance (QA), risk management (RM), and quality improvement (QI).

Throughout state fiscal year (SFY) 2025, DBHDS implemented numerous systemic improvements, continued implementation of previously identified areas for systemic change, and refined processes to reflect systemic improvements. Notable examples included:

- Southeast Virginia Training Center implemented the DEFUSE training with their staff to improve and reduce the use of physical and mechanical restraints
- Revised On-Site Visit Tool guidance and training materials to strengthen consistency and reliability in health and safety oversight across Community Services Boards and Behavioral Health Authority (hereafter referred to as CSBs) and improved alignment with requirements
- Advanced revisions to the Virginia Informed Choice (VIC) and Service Selection Guide, improving plain language, usability, and alignment with CMS (Centers for Medicaid and Medicare) expectations
- Developed Support Coordinator competencies, for CSB use in personnel practices
- Revised to Office of Licensing (OL) conditional licensing process and investigation process for serious incidents

DBHDS furthered discussions on the functionality and sustainability of its QMS resulting in:

- Planned expansion of use of Quality Service Review (QSR) and National Core Indicators (NCI) to further the story of how the DD QMS is doing

Eleven performance measure indicators (PMIs) maintained performance at or above target. One PMI met target for the first time. Six PMIs showed improvement in performance, despite not yet meeting target.

Twenty-eight QIIs were implemented across the three KPAs. Eight QIIs were completed or ended by June 30, 2025. Sixteen QIIs were approved and implemented in SFY25. Impacts from QII work

included increased collaboration between stakeholder groups, processes streamlined, expanded available templates, clarified educational and/or guidance materials and addressed identified needs within the three KPAs.

The DD QMS continued to be a robust, dynamic system. These numbers show what was involved during SFY25:

- $2,499,959 in funding was provided for 3,807 Individual and Family Supports Program, (IFSP) applications. Refer to the FY25 IFSP Funding Summary for details.
- $2,042,041,684 was expended for DD waiver services across all ages, all programs, all waivers and all service categories. Data source: https://www.dmas.virginia.gov/data-reporting/programs-services/waiver-services/
- 18,269 individuals received one or more waiver funded services
- 2,541 waiver slots assigned (1,720 new, 821 attrition slots)

Introduction

The Quality Management Plan (QMP) for DBHDS is a three-part document, which includes this Annual Report and Evaluation for SFY25. This document summarizes key accomplishments of the DD QMS KPAs and system, followed by assessments of the PMIs regarding progress towards set targets, summary of data reports, updates on implemented quality improvement initiatives (QIIs), and the overall performance of the DD QMS including the quality committees' performance. Identified gaps and challenges to meet the stated goals plus plans to mitigate the circumstances around those challenges are discussed as well as other quality improvement activities implemented. Organizations outside of DBHDS support the work of the QMS through the collection, analysis and reporting of system outcomes and outputs across multiple cross-sections of DBHDS-funded services, programs, and people served. The purpose of this report is to determine if the system meets the needs of individuals and families in a manner that aligns with the Commonwealth's mission and vision.

This following section outlines the SFY25 overall key accomplishments within the KPAs and key system improvements.

Key Accomplishments of the QM Program

Health, Safety and Wellbeing

1. The Office of Human Rights (OHR) revised its community look-behind process, incorporating the review process into an integrated application, which allowed reviewers

to review information from CHRIS (Computerized Human Rights Information System) within the integrated application. A quality improvement initiative was implemented with improvements noted in the percentage of investigations that were completed by a trained investigator.

2. The Incident Management Unit (IMU) look-behind reviews compliance rates exceeded 96% for all quarters and outcomes, which focuses on the handling of serious incidents.
3. The Office of Integrated Health Network Supports (OIHNS) provided thirteen virtual training sessions on various health risk topics with 628 people attending. Nineteen provider specific training sessions occurred with 337 people attending.
4. Risk Management Review Committee (RMRC) and Mortality Review Committee (MRC) conducted a review of choking episodes resulting in death, establishing a case fatality rate that showed the choking case fatality rate decreased significantly from 12.5% in SFY22 to 3.5% in SFY25, indicating that the increased focus on awareness of choking risks led to improved detection of choking risks.
5. Southeast Virginia Training Center implemented the DEFUSE training with their staff to improve and reduce the use of physical and mechanical restraints. The DEFUSE training focuses on anticipating and addressing behavior before it escalates to the point that it requires restraint. Data from SFY25 indicates that the number of restraints has been consistently lower since implementing this change.
6. The Case Management Steering Committee (CMSC) revised On-Site Visit Tool (OSVT) guidance and training materials and enhanced training with pre and post testing. These actions strengthened consistency and reliability in health and safety oversight across CSBs and improved alignment with requirements.
7. The Medical Emergency Toolkit was posted on Office of Licensing's website. The toolkit includes resources for providers to ensure successful staff interventions in the result of a medical emergency.

Community Inclusion & Integration

1. The CMSC supported major system improvements to informed choice and community integration. The committee advanced revisions to the Virginia Informed Choice (VIC) form and Service Selection Guide, improving plain language, usability, and alignment with CMS expectations.

Provider Capacity and Competency

1. The CMSC supported improvements to support coordinator competency through updated ISP (Individual Service Plan) 4.0 guidance, Support Coordinator Quality Review (SCQR) technical assistance, and OSVT redesign and development efforts.

2. The CMSC developed a set of SC Competencies, which were shared with Community Services Boards for use in personnel practices.

System Accomplishments

1. Individual Support Plan version 4.0 incorporated the Risk Awareness Tool (RAT) throughout the entire ISP, assuring that identified and potential risks were noted and addressed.
2. DBHDS fully implemented its data governance program.
3. OL completed a caseload reassignment process ensuring that all regions were properly staffed to complete the required inspections for DD services.
4. OL made changes to the conditional licensing process, which resulted in approval for only one conditional license per provider. This change gave providers a full year to demonstrate compliance with regulations. This change resulted in increased consistency and compliance prior to the provider expanding.
5. Special Investigations Unit (SIU), Office of Licensing, revised their investigation process for serious incidents involving individuals with a DD diagnosis. This change resulted in the SIU completing all investigations relating to those with a DD diagnosis (death, complaints, serious incidents.), which allowed the licensing specialists to focus on the annual unannounced inspections.

Performance Measure Indicators and Data Reports

The DBHDS QMS KPAs align with the DBHDS vision and mission to address the availability, accessibility, and quality of service provision for individuals with DD in support of "*a life of possibilities for all Virginians*". DBHDS has established three KPAs and identified eight domains that it uses as its focus of the QMS. DBHDS, through the Quality Improvement Committee (QIC) subcommittees, collects and analyzes data from multiple data source systems in each of the eight domains as indicated below:

The PMIs allow for monitoring and tracking of performance standards and the efficacy of improvement efforts. Each PMI contains a set of criteria that outlines the required information to determine the PMI's capability of producing valid and reliable data.

The DBHDS QIC and/or QIC subcommittees monitor the PMIs and surveil other significant data to identify patterns and trends that signify a need for improvement. This section includes an analysis of PMIs and data reports. Results and overall performance are noted in the last column as noted in the performance key below.

Performance Key:

- **Green** indicates the measure meets or exceeds the target
- **Orange** indicates the measure is within 10% of the target
- **Red** indicates the measure is 11% or greater below the target
- **Blue** not applicable due to PMI approval date

QIC subcommittee chairs from RMRC, Mortality Review Committee (MRC), CMSC, and the KPA Workgroups, identified measure stewards and the Office of Clinical Quality Management (OCQM) staff participated in the annual PMI review process. This process reviewed PMI performance over the past several years to determine whether a PMI should be retained, retired, or removed. Through this process, DBHDS committed to assuring that PMIs remain current and important to the agency.

Key Performance Area: Health, Safety and Well-Being

This KPA includes data analysis of information relevant to the domains of safety and freedom from harm, physical, mental and behavioral health, and well-being, and avoiding crisis. This KPA's outcomes focuses on the individual. *Individual:* People being served are safe, receive routine, preventative healthcare, and holistic, person-centered behavioral health services and supports.

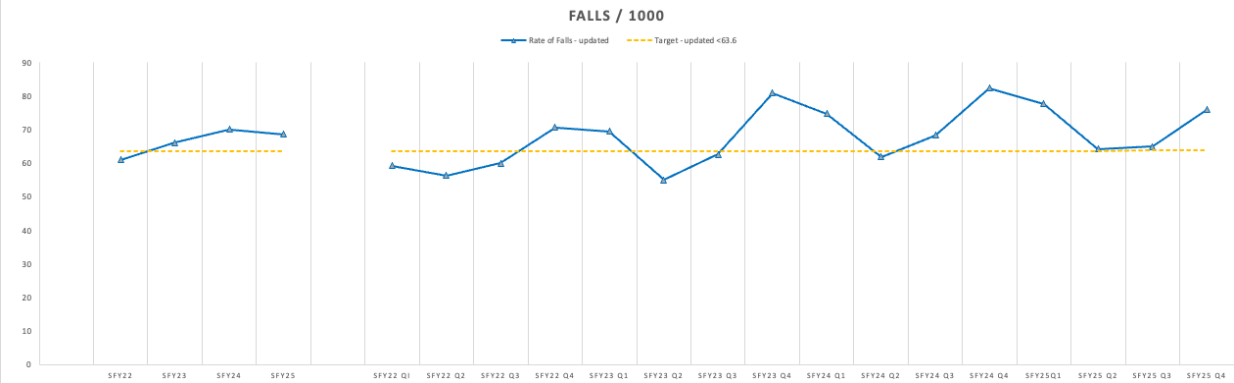
Please find below a brief synopsis of progress towards the achievement of PMIs relevant to domain of safety and freedom from harm. The KPA Workgroups, RMRC, and MRC reviewed, analyzed and monitored the data collected for these PMIs.

Performance Measure Indicator – Safety and Freedom from Harm	Target	SFY23 Results	SFY24 Results	SFY25 Results
95% of providers who receive a waiver validation review have evidence of a trained abuse/neglect investigator.	95%	PMI not approved for reporting	PMI not approved for reporting	**PMI approved 6.23.25 Q4 57% (partial quarter)**
Annualized rates of "falls" or "trips" are 63.6* or less*	63.6 per 1,000	67.05	71.88	**71.5**
Unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken.	86%	100%	100%	**100%**

*Goal revised in SFY25 using updated baseline data, reflecting removal of level 1 incidents from reporting.

The *Trained Investigator PMI* was approved on June 23, 2025, for reporting and a partial quarter of data was provided. This PMI focused on the assurance that new waiver providers have a trained abuse/neglect investigator as required by human rights regulation. As new providers are less likely to-know or have implemented the trained investigator requirement, OHR provided every new provider with a welcome letter with a link to a pre-recorded hour long orientation that speaks to the need for a trained investigator, and other human rights requirements and processes. OHR conducted onsite visits to new waiver providers upon notification from DMAS (Department of Medical Assistance Services) that the new waiver provider has begun to bill for services. OHR reviewed compliance during this visit, including evidence of a trained investigator (certificate). OHR will continue these efforts.

The *Falls PMI* was above the rate of 63.6/1000 or less for all but one quarter. The overall results for SFY25 were slightly less than SFY24, as shown in the graph below. The RMRC continued a more detailed analysis of falls data with a goal of identifying specific factors that may be addressed in future as a QII. A new visualization was developed by the data warehouse that allows a more detailed analysis of falls by individual, as well as by different demographic characteristics such as age, gender, and race. The visualization also included views on falls that resulted in emergency room visits or hospitalizations, and the types of injuries sustained. Analysis of this data is underway and will be completed in SFY26.



The *Unexpected Deaths PMI* continued to perform at 100%; during the SFY25 annual PMI review process, it was determined as meeting established criteria for retirement. A new PMI will be developed by the Mortality Review Committee for approval and implementation in SFY26.

A brief synopsis of progress towards the achievement of PMIs relevant to the domain of physical, mental and behavioral health and wellbeing is shown below. The KPA Workgroups and CMSC reviewed, analyzed, and monitored the data collected for these PMIs.

Performance Measure Indicator – Physical, Mental and Behavioral Health and Wellbeing	Target	SFY23 Results	SFY24 Results	SFY25 Results
Individuals in residential settings on the DD waivers will have a documented annual physical exam date.	86%	76%	85.7%*^	**89.26%**
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.	86%	84%	90%	**94%**
Individual support plans are assessed to determine that they are implemented appropriately.	86%	84%	89%	**94%**

*PMI methodology corrected to account for all individuals within the 14 month ISP planning year versus using a 12 month ISP period.

^ Results are not rounded up to align with other reports.

The *Annual Physical Exam PMI* made slow, yet steady progress over the past four fiscal years. There was a demonstrated and consistent increase in the numbers of individuals who reported an annual physical exam. In SFY25 Q3, we achieved a 91% rate, the highest since SFY21. This also represented a 3.51% increase compared to SFY24 Q3. The percentage of annual physical exams was consistently at or above the target for the past seven quarters.

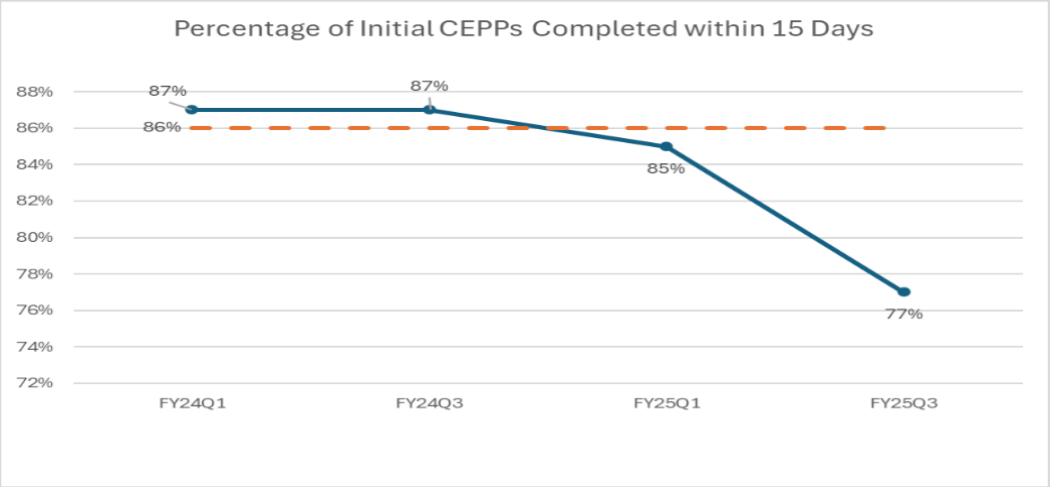
Case Management Measures

The *Change in Status and ISP Implemented Appropriately PMIs* year over year performance continued trending upward to the 94% seen in SFY25 for both measures. Agreement for both measures was at the level of substantial agreement leading to confidence in the results per the Support Coordination Quality Review (SCQR) process.

A synopsis of the Commonwealth's progress towards the achievement of this PMI in the domain of avoiding crisis is detailed below. The KPA Workgroups reviewed, analyzed and monitored the data collected for this PMI.

Performance Measure Indicator – Avoiding Crisis	Target	SFY23 Results	SFY24 Results	SFY25 Results
Individuals who are admitted into REACH mobile crisis supports will have a CEPP completed within 15 days of their admission into the service.	86%	Q1 81% Q3 80%	Q1 87% Q3 87%	**Q1 85%** **Q3 77%**

The *Initial CEPPs PMI* focused on those receiving REACH (Regional Education Assessment Crisis Services Habilitation) services



having an initial crisis education prevention plan (CEPP) completed within 15 days. The graph represents CEPP data for individuals in the REACH program who received non-residential community stabilization for the quarter denoted and the quarter prior (6 months). The data indicated the total percentage of CEPPS completed for all REACH Regions within the 6-month period. There was a decreasing trend for completion of CEPPs for SFY25, which was below the set criteria of 86%. The downtrend in data was affected by individuals who dropped out of service before the document was completed, the variability of the number of individuals receiving this service, and staffing. REACH staff continued to engage with the individuals to complete the service and enter prevention services to decrease cycling behavior. REACH programs continued to focus on recruitment and retention of staff.

Key Performance Area: Community Inclusion and Integration

This KPA includes data analysis of information relevant to the domains of community inclusion, choice and self-determination, and stability. The goal of this KPA is to ensure that: People have opportunities to engage in community-based activities, that support socialization, employment, recreation, and personal development for the purpose of building and strengthening relationships with others in their local community.

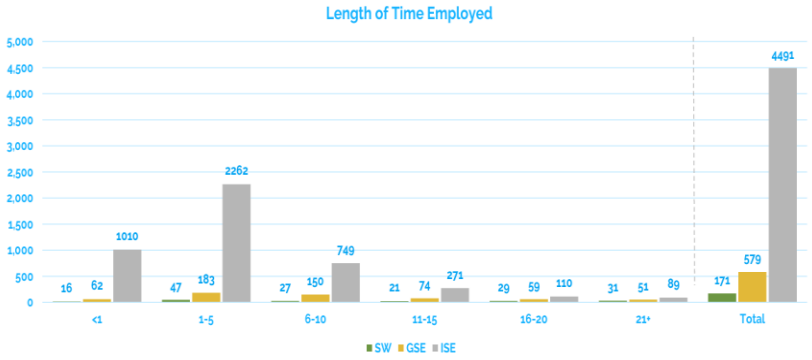
"We do not "do" inclusion "for" people with disabilities. Rather, it is incumbent upon us to figure out how all the things we do can be inclusive."
Lisa Friedman: Removing the Stumbling Block

The following tables and graphs describe the progress towards achievement of PMI goals relevant to the domains of stability, choice and self-determination, and community inclusion. The KPA Workgroups reviewed, analyzed, and monitored the data collected for these PMIs.

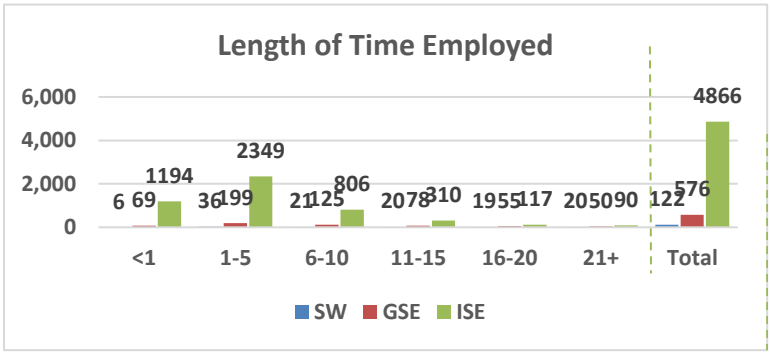
Performance Measure Indicator - Stability	Target	SFY23 Results	SFY24 Results	SFY25 Results
Individuals on the DD waiver and waitlist (aged 18-64) are working and receiving Individual Supported Employment (ISE) or Group Supported Employment (GSE) for 12 months or longer.	80%*	17% (25% target)	78.8%**	**77.3%**
Individuals have stability in the independent housing setting.	85%	99%	100%	**97.41%**
Individuals with a DD waiver and known to the Reach system who are admitted to Crisis Therapeutic Home (CTH) facilities and psychiatric hospitals will have a community residence identified within 30 days of admission.	86%	79%	78%	**80%**

*The target was updated due to the denominator changing to reflect all those employed.
**Results are not rounded up to align with other reports.

The *Employment Stability PMI* focused on those employed for twelve months or longer and continued to be reported semi-annually. As of December 2024, 78.8% of individuals were employed. Both the number of people aged 18-64 and the number employed increased.

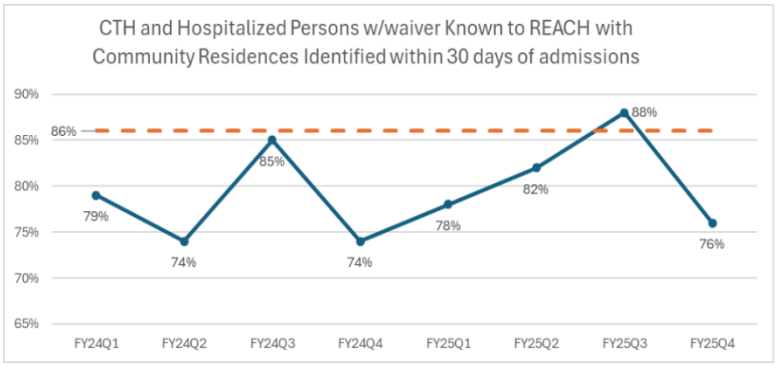


As of June 2025, 76.8% of individuals were employed, which is a .9% decrease from the previous reporting period. A comparison of Department of Aging and Rehabilitative Services (DARS) data and DBHDS waiver data is scheduled to occur in SFY26 to ensure targets are reflective of all individuals receiving waiver services waiver.



The *Independent Living Stability PMI* exceeded the established goal of 86%, indicating that individuals have stability in independent housing. This reflected systems effectiveness in supporting obtaining and sustaining tenancy and reducing housing barriers and disruptions. The results demonstrated successful coordination of housing supports and services that promote long-term housing stability.

The *Crisis Stability (CTH to Residence in 30 days) PMI* monitors the percentage of individuals admitted to crisis therapeutic homes and psychiatric hospitals with an identified community residence within 30 days of admission. This graph indicates that since SFY24 Q4, there was an increasing trend in the percentage of individuals (receiving waiver services) with an identified community placement within 30 days of admission to the CTH and psychiatric hospital. In SFY25 Q3, the criteria of 86% was exceeded. It should be noted that for all SFY24 and SFY25, individuals in CTH met the criteria of 86%. Variability in the hospital data is due to the continued clinical instability of the individual



(not ready for discharge), complications in meeting the needs of the individuals, and stressors on the support system.

Beginning in SFY21, the KPA Workgroups began using WaMS (Waiver Management System) ISP data for the PMI regarding choice in living situation; CMSC uses SCQR data for the remaining two PMIs. This data is included within the following table.

Performance Measure Indicator – Choice and Self-Determination	Target	SFY23 Results	SFY24 Results	SFY25 Results
At least 75% of people receiving services who do not live in the family home/their authorized representatives chose or had some input in choosing where they live.	86%	100%	100%	**100%**
Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff).	86%	90%	93%	**95%**
Individuals are given choice among providers, at least annually. **	86%	PMI Not Approved for Reporting	97%	**98%**
Individuals are given choice of support coordinator, at least annually. **	86%	PMI Not Approved for Reporting	87%	**91%**

** Prior to 3.25.24, these PMIs were reported as a single PMI. 86%

The *Housing Choice PMI* was identified as meeting requirements for retirement during the annual PMI review process, as it consistently performed above target. Once a new choice and self-determination PMI has been identified and approved, the *Housing Choice PMI* will be retired.

Case Management Measures

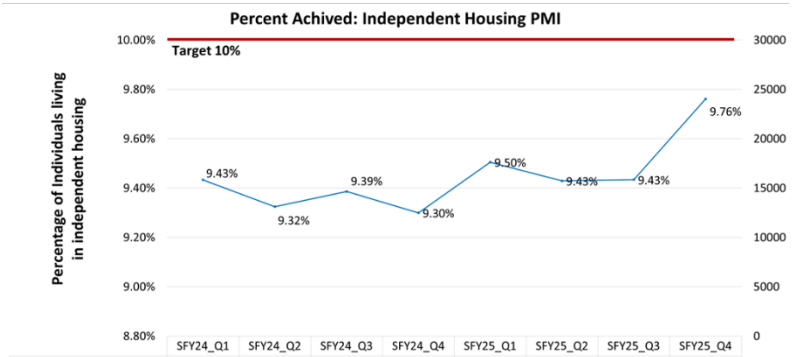
The *Relationships Outside of Paid Staff*, as well as *Support Coordinator and Provider Choice PMIs* were fully met with all having substantial agreement through the Support Coordination Quality Review look behind process.

The KPA Workgroups and CMSC reviewed, analyzed and monitored the data collected for these PMIs.

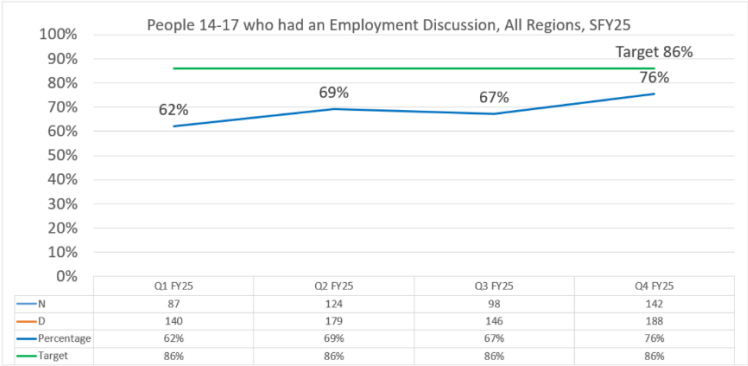
Performance Measure Indicator – Community Inclusion	Target	SFY23 Results	SFY24 Results	SFY25 Results
Individuals live in independent housing	10%	8.87%	9.30%	**9.53%**
Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working 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.	86%	53%	60%	**69%**
86% of providers demonstrate a commitment to community inclusion by demonstrating actions that lead to participation in community integration activities (Using the QSRs, providers report on number who promote meaningful work, promote individuals participating in non-large group activities, and encourages participation in community outings with people other than those with whom they live.)	86%	**Round 4:** PQR: a. 97% b. 97% c. 98% **Round 5** PQR a. 93% b. 96% c. 96%	**Round 6** PQR: a. 81% b. 98% c. 97%	**Round 7** **PQR** **b.97%** **c.95%**

**The PMI was not approved for that SFY, thus the absence of data.
PQR a. promotes meaningful work
PQR b. promote individuals participating in non-large group activities
PQR c. encourages participating on community outings with people other than those with whom they live

The *Independent Living PMI* indicated progress was made toward the target, additional efforts were identified as needed to expand access to independent housing opportunities. Continued focus in housing development, securing additional funding, and expanding supportive services will be critical to fully achieve this goal.



	SFY24_Q1	SFY24_Q2	SFY24_Q3	SFY24_Q4	SFY25_Q1	SFY25_Q2	SFY25_Q3	SFY25_Q4
Percent Achived	9.43%	9.32%	9.39%	9.30%	9.50%	9.43%	9.43%	9.76%
Number Housed	2122	2140	2165	2185	2248	2263	2294	2305
Waiver/Waitlist Population	22,496	22,950	23,066	23,496	23,651	24,000	24,317	23,614



The *Teen Employment PMI* showed improvement to 10% within target as shown in SFY25 Q4. The overall result for SFY25 was not met, with performance noted at 69%. Updates to the Individual Support Plan are in process for SFY26, which are expected to enhance elements in the ISP and are expected to support better performance with this measure.

The *Provider Reporting Community Inclusion Measures PMI* focused on the providers work related to community inclusion – are individuals encouraged to be involved in small group activities and be encouraged to do things with people other than those whom they live. This PMI demonstrated that providers are ensuring that individuals are being included in the community.

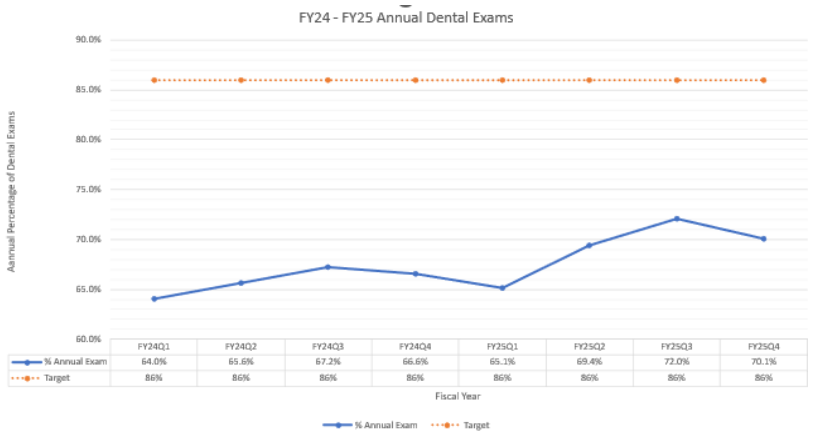
Key Performance Area: Provider Capacity and Competency

This key performance area includes data analysis of information relevant to the domains of access to services and provider capacity and competency. The goal of this KPA is: Having enough providers, who are knowledgeable, trained, and experienced, in our network to ensure equitable and timely access to supports/services.

The table, charts, and graphs below detail the Commonwealth's progress towards achievement of these PMIs in the domain of access to services. The KPA Workgroups and CMSC review, analyze and monitor the data collected for these PMIs.

Performance Measure Indicator – Access to Services	Target	SFY23 Results	SFY24 Results	SFY25 Results
Individuals in residential settings on the DD waivers will have a documented annual dental exam.	86%	65%	69%	**69.1%**
Individuals receiving case management services from the CSB whose ISP, developed, or updated at the annual ISP meeting, contained integrated community involvement outcomes.	86%	56%	61%	**65%**

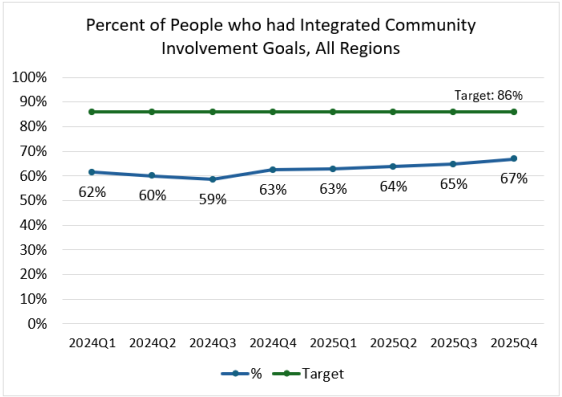
The *Dental Exam PMI* demonstrated a steady, quarter-over-quarter increase compared to SFY24. In SFY25 Q3, we achieved a 72% rate, the highest since SFY21. This represented a 4.8% increase compared to SFY24 Q3. The performance shown from SFY25Q1 to SFY25Q2 was the largest quarter-over-quarter growth shown in the SFY24 – SFY25 data. The Office of Integrated Health Network Supports Dental Team continued to offer mobile dental support to CSBs, which provided access to dental care for individuals who have had difficulty previously receiving dental care. Additionally, the Dental Team collaborated with the Virginia Department of Health, DMAS and DentaQuest to increase awareness and number of dental care providers in the Commonwealth.



	FY24Q1	FY24Q2	FY24Q3	FY24Q4	FY25Q1	FY25Q2	FY25Q3	FY25Q4
% Annual Exam	64.0%	65.6%	67.2%	66.6%	65.1%	69.4%	72.0%	70.1%
Target	86%	86%	86%	86%	86%	86%	86%	86%

Case Management Measures

The *Integrated Community Involvement PMI* was a key focus in CMSC work over the past several years. In SFY25, the CMSC completed a quality improvement initiative to address performance with some improvement noted over the fiscal year. CMSC provided guidance materials and recorded an in-person training and the CMSC monitored individual CSB performance with this measure. Results were provided back to CSBs and through the submission of recommendation letters to the Commissioner of DBHDS. In SFY26, planned updates to Virginia's Person-Centered ISP, to clarify integrated community involvement in the context of Community Life Engagement, will be implemented. The CMSC will partner with the Community Engagement Advisory group to complete this work, which is expected to continue improvements in this area.

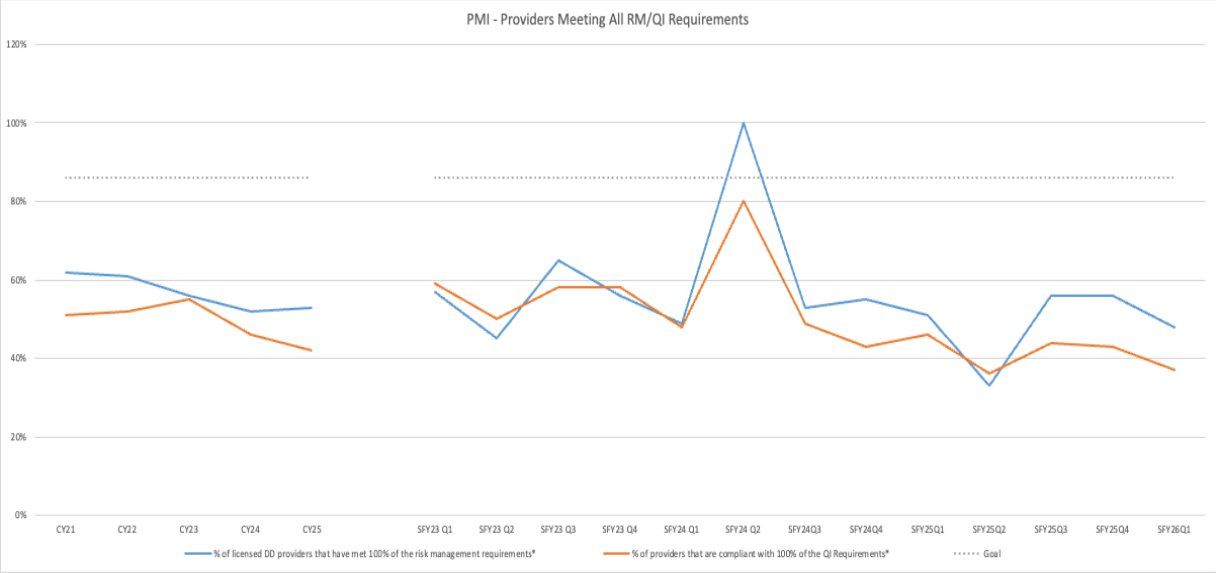


Quarter	Numerator	Denominator	%
2024Q1	2,292	3,722	62%
2024Q2	2,137	3,556	60%
2024Q3	1,784	3,043	59%
2024Q4	2,321	3,712	63%
2025Q1	2,699	4,292	63%
2025Q2	2,483	3,890	64%
2025Q3	2,496	3,856	65%
2025Q4	3,141	4,692	67%

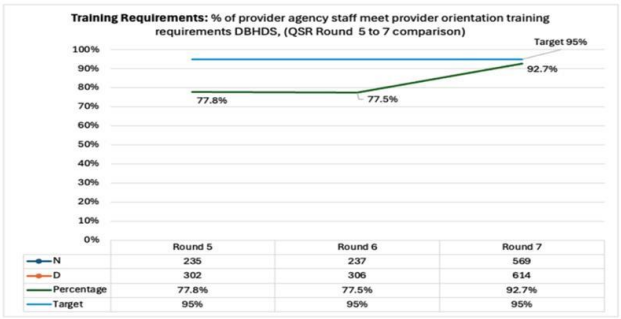
The following table, charts, and graphs depict the Commonwealth's progress of towards the achievement of PMIs relevant to the domain of provider competency. The RMRC and KPA Workgroups review, analyze and monitor the data collected for these PMIs.

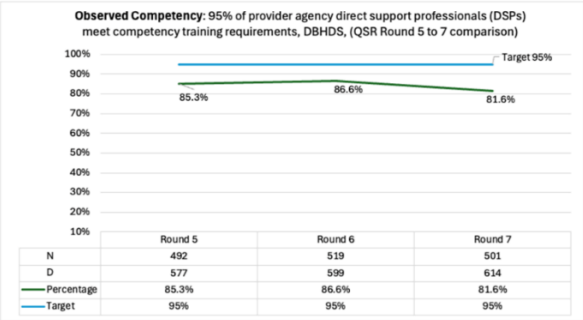
Performance Measure Indicator – Provider Capacity	Target	SFY23 Results	SFY24 Results	SFY25 Results
Percentage of licensed providers, by service, that were determined to be compliant with 100% of the risk management regulations that were able to be reviewed during their annual inspections.	86%	56% (2023 calendar year)	52% (2024 calendar year)	**53% (2025 calendar year)**
86% of licensed DD providers, by service, that were determined to be compliant with 100% of the quality improvement regulations assessed during an annual inspection.	86%	56% (2023 calendar year)	43% (2024 calendar year)	**42% (2025) calendar year)**
People with DD waiver are supported by trained, competent Direct Support Professionals (DSPs).	95%	**Round 4**: 85% training 91% competencies **Round 5**: 78% training 85% competencies	**Round 6:** 87% training 78% competencies	**Round 7 92.7% training 81.6% competencies**

The *QI and RM Regulations PMIs* continued to perform below target. Despite DBHDS disseminating a significant amount of information to providers, including tools and resources, to help them come into compliance with these regulations, noted progress was minimal. Potential barriers identified include lack of dedicated QI/RM staff whose sole job was QI/RM, complexity of the regulations, and continued influx of new providers that have not yet established effective QI or RM programs. The 520-620 quality improvement initiative focused on improving performance of these PMIs. The graph below shows reporting by calendar year (when inspections occur) and by state fiscal year quarter.



The *DSP Competency PMI* monitored the percentage of direct support professionals meeting 1) provider agency orientation training requirements and 2) observed competency of those training requirements, as documented during QSR rounds. An increase in documentation of training requirements





was noted in Round 7 (noted in the first graph above), while a slight decrease in observed competencies was noted (noted in the second graph). The KPA Workgroups continued implementing a QII focused on streamlining the DSP competencies, to lessen provider administrative burden. During SFY25, the Provider Issues Resolution Workgroup (PIRW), the Office of Provider Network Supports (OPNS), and the KPA Workgroups streamlined the advanced competencies and revised the basic competencies to include additional elements previously found in the advanced competencies. A pilot of the revised advanced competencies is projected to occur in SFY26.

Data Reports

DBHDS continued to monitor the Home and Community Based Services (HCBS) Quality Management, Support Coordination Quality Review, Quality Service Reviews, and National Core Indicators ID Survey to determine the quality of services being delivered and the level of satisfaction reported by individuals. Over the course of SFY25, the Office of Clinical Quality Management began identifying ways in which these data reports could be expanded to more fully tell the story of the quality of services and satisfaction with services received. These efforts will begin building out in SFY26. A summary of each review and link to its most recent report have been listed below.

HCBS Quality Management

The DMAS of High Needs Supports and DBHDS DD Waiver Operations Unit collaboratively oversaw waiver performance under the Center for Medicare and Medicaid Services (CMS) assurances quarterly, using data derived from both DMAS and DBHDS and from provider and CSB reviews through Quality Review Team (QRT) reporting. The data reviewed ensured remediation occurred where it was indicated, identified trends and areas where systemic changes were needed, and identified the need to collect different data or improve its quality. For a description of the performance measures and their results, refer to the SFY25 QRT End of Year Report.

Support Coordination Quality Reviews

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 CSBs to individuals with DD who are receiving one of the HCBS waivers. The results of the SCQR are intended to inform improvements to the system overall. Support coordination supervisors review records, according to ten established indicators, and report the results in an online survey form. The Office of Community Quality Improvement (OCQI) reviews a subset of these records to determine reliability. All CSBs receive feedback and technical assistance from OCQI and OPNS.

SFY25 SCQR results showed continued statewide improvement, with nine of ten indicators meeting or exceeding the 86% target. One indicator related to measurable outcomes and employment discussions remained below target but showed sustained improvement over prior years. Patterns identified through the look-behind process highlighted inconsistencies in Indicator 10, prompting targeted technical assistance, revised guidance, and a focused QII. Updates to SCQR guidance aligned reviews with ISP 4.0, and 100% CSB participation was achieved.

Quality Service Reviews

Quality Service Reviews (QSRs) assessed the quality of services provided by CSBs and licensed providers as well as their quality improvement and risk management strategies and plans. Using the provider quality review (PQR) and the person-centered review (PCR), the QSR process included record reviews, CSB/provider agency policies and procedures, observations and interviews with individuals, staff and substitute decision makers/families. The QSR used a 90% compliance standard; any question/element scored less than 90% required a formal, written response. This formal written response had been called a quality improvement plan and was changed to quality enhancement plan (QEP) in Round 7. DBHDS changed the name to the QEP as a mechanism to support quality going beyond the minimum requirements. Refer to the Round 7 aggregate report for overall summary and results.

National Core Indicators

The National Core Indicators (NCI) Project is a collaboration between the National Association of State Directors of Developmental Disabilities Services (NASDDDS), the Human Services Research Institute (HSRI) and voluntary state participants, including Virginia. The core indicators are standard measures used across states to learn about the outcomes of supports and services provided to individuals and families. Indicators address important elements of person-centered planning, including employment, rights, service planning, community inclusion, choice, health and safety and satisfaction. NCI has two initiatives. One targets the measurement and improvement of state performance in their aging and physical disabilities service system (NCI-AD). The other targets the measurement and improvement of state performance in their developmental disabilities service systems (NCI-IDD). Virginia participates in the NCI-IDD In-Person Survey, conducted yearly, and in three family surveys. The subcommittees continued using NCI data to inform the system of overall experiences. For information on Virginia specific responses, refer to the 23-24 Virginia NCI-IDD State Report.

Quality Improvement Initiatives

During SFY25, twenty-eight QIIs were implemented. Eight QIIs were completed or ended by June 30, 2025. Sixteen QIIs were approved and implemented in SFY25. Seven QIIs were approved and scheduled to be implemented in SFY26. One QII was proposed but not approved.

Health, Safety and Wellbeing KPA:

Problem to be Addressed	QII Focus
# of deaths caused by cancer is rising for individuals with DD. It is not always known if	To improve the percentage of IDD individuals receiving preventive screenings (mammogram, Pap

Problem to be Addressed	QII Focus
an individual received any preventive screenings.	smear, colonoscopy) reported through the NCI In-Person Survey
Individuals with DD do not receive routine annual dental exams.	To improve the percentage of individuals, enrolled in DD waivers, who receive an annual dental exam to 86%
Region 4 accounted for the third highest number of reported Urinary tract infections (UTIs) are the third highest number in Virginia for FY21 Q1-FY23 Q2.	To reduce the rate of reported UTIs statewide in the DD waiver population by 5%
ISPs may not contain identified risks from risk assessment tools or outcomes addressing the identified risk.	To improve the number of ISP assessments and ISP Development and Implementation elements determined to be in compliance by the QSR for CSBs to 90%
DBHDS does not have an accessible, searchable database for staff to use in identifying nursing providers who offer DD waiver nursing services.	To develop a searchable resource tool for use in identifying providers who offer DD waiver nursing service beginning SFY26.
Region 4 accounted for the third highest number of reported Urinary tract infections (UTIs) are the third highest number in Virginia for FY21 Q1-FY23 Q2.	To reduce the rate of reported UTIs statewide in the DD waiver population by 5%
Provider policies on individual rights do not always include the right to make an informed choice, to engage in experiences meaningful to him/her, and which are necessary for personal growth and development.	To improve the percentage of providers having policies addressing the rights of a person to making an informed choice, to engage in experiences meaningful to him/her, and which are necessary for personal growth and development
IDD individuals can have 2 or more documented ED visits for the same reason within 90 days prior to their death. Higher ED utilization may be prevented by strategies to better manage chronic conditions, access available resources, and foster cross-discipline collaboration.	To decrease repeat ED utilization by IDD individuals in the 90 days prior to death to <15% by July 1, 2025, through improved communication resources.
From FY23 Q4 – FY24 Q3, Region 1 had a marked increase in the rate of choking incidents per 1,000 individuals. As a single choking incident can result in death,	To reduce the rate of choking from 10.35 per 1,000 to 6.21 per 1,000 or fewer (a 40% reduction or 4.14 incidents per 1,000) by FY25 Q3
During FY24 Q1-3, falls was the leading cause of serious incidents reported in CHRIS for Region 4; falls resulting in emergency room visits and unplanned hospitalizations. Falls/trips serious incident reports continue as a major focus related to health and safety as rates of falls serious incident reports continue to rise.	To reduce the rate of falls in Region 4 to 75 per 1000.

Community Inclusion and Integration KPA:

Problem to be Addressed	QII Focus
Only 24% of individuals, per the 2021-2022 NCI In-Person Survey use technology daily to be more independent.	To improve the Virginia response to "Uses technology in everyday life to help them do more things on their own" question in the NCI In-Person Survey for individuals with developmental disabilities to 35% by March-April of 2025 (tentative release date for the 2023-2024 NCI In-Person Survey).
Employment Outcomes PMI data for Region 2 SFY23 Q3 was 32.4%.	To improve the percent of ISPs that contain employment outcomes for those individuals who have an DD waiver from 32.4% to 42% by July 2024.
Region 5 has struggled in meeting the target of 86% for unpaid relationship discussion in SFY22 Q3-SFY230Q2.	To improve Unpaid Relationship Discussions for DD waiver recipients in Region 5 to 86% by June 2024.
To expand the success pf RQC2 QIIs on employment and integrated community outcomes to the remaining regions in the state.	To improve the following outcomes for individuals on the DD waiver by 10 percentage points by 6/30/2025: 1) Employment outcomes for all individuals on the DD waiver; 2) Employment outcomes for individuals interested in employment; and 3) ICI Outcomes:
DBHDS has not met the target of 86% for the PMI focused on community involvement.	Our goal is by June 2023, to increase the percentage of integrated community involvement (ICI) outcomes found in ISPs for individuals receiving case management services in Region 2 from a baseline of 56% to 86%.
Since 2016, these services have consistently been utilized ≤25% across the Commonwealth. The most recent service authorization data for these services shows a utilization rate of 11% for Region 4, 12% for Region 2, Region 3 at 18%, Region 5 at 22% and Region 1 at 25%.	To increase the utilization of coaching and community engagement services for those receiving DD waiver funded services in Region 4 to 20% by SFY26 Q1.
ICI and employment outcomes in ISPs continues to be a lower scoring measure in SC WaMS data quarterly.	To increase the percentage of ISPs in Region 3 which include ICI and employment outcomes (noted in the life domain area) to 86% per quarter by June 30, 2025.

Provider Capacity and Competency KPA:

Problem to be Addressed	QII Focus
Individuals receiving DD waiver services do not have access to reliable transportation.	To increase the number of providers of Employment and Community Transportation (ECT) services in each region from 0 to 2 by June 30, 2022.
Providers do not always adhere to their protocols for medical emergencies.	To increase the percentage of adherence to the execution of provider established protocols for medical emergencies to >70% for I/DD individuals residing in DBHDS licensed provider residences, by the end of SFY23 Q3 (March 31, 2023).

Problem to be Addressed	QII Focus
A review of current data demonstrates lower than expected participation in existing resources designed to increase access to services, including specialized services for complex needs.	To increase the number of providers on the statewide database who hold a specialty designation to at least five unique providers in each specialty area by June 30, 2023.
Support Coordinators/Case Managers play a pivotal role in in the system of support for individuals with developmental disabilities. In 2021, staff retention was the #1 concern cited by DBHDS Regional quality Councils as needing improvement.	To achieve and maintain a retention rate for Support Coordinators/Case Managers at or above 86% for two consecutive quarters by June 30, 2023.
CSBs have had difficulty meeting the ISP compliance performance standard (meaning that at least 86% of their ISPs are in the correct status (either ISP completed or pending provider completion).	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, by June 2024.
Provider policies on individual rights do not always include the right to make an informed choice, to engage in experiences meaningful to him/her, and which are necessary for personal growth and development.	To improve the percentage of providers having policies addressing the rights of a person to make an informed choice, to engage in experiences meaningful to him/her, and which are necessary for personal growth and development from 69% to 79%.
Region 1 has been under the 86% target for Teen Employment Discussions PMI for seven quarters.	To increase the number of DD waiver recipients (age 14-17) in Region 1 who have a conversation regarding interest in employment and/or what they are working on while at home and at school toward obtaining employment to 86% by June 30, 2024.
According to Quality Service Review data, DSPs do not have supporting documentation for completing their training and competencies requirements.	To improve the percent of DSPs (who work with individuals who have DD) completing training and competencies requirements to 95% by SFY27.
In the SCQR, the percent of records that meet at least 9 of the 10 indicators is below 86%.	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.
Licensed providers and CSBs continue to be challenged in being found compliant with 100% of the 520 and 620 (risk management and quality improvement regulations).	To improve the percent of licensed DD providers that are compliant with 100% of the 520 and 620 (Risk Management and Quality Improvement regulations) to 86%. We will examine results by June 30, 2025 (interim measure), the end of Calendar Year 2025, our target date.
In the SCQR, the percent of records that meet at least 9 of 10 of the Indicators is below 86%.	To improve the percent of SCQR records that meet at least 9 of 10 indicators to 86% by the end of calendar year 2026.

DBHDS Internal Quality Management System Evaluation

DBHDS continued utilizing the QM Program Assessment Tool in evaluating the functioning of the quality committees as well as the QMS. The quality committee framework, its structure and implemented processes continued as a strength. The quality committees fulfilled the obligations outlined in their charters. (Charters are included as an appendix to the SFY25 DD QMP Parts 1 & 2.). Each quality committee engaged in continuous quality improvement throughout the year. This report detailed their monitoring of PMIs and QII implementation. DBHDS' QMS maintained the following characteristics:

- Be a systematic process with identified leadership, accountability, and dedicated resources available to the program;
- Use data and measurable outcomes to determine progress toward relevant benchmarks;
- Focus on linkages, efficiencies, and provider and individual expectations in addressing outcome improvement;
- Be a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement activities;
- Ensure that data collection is fed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes.

Progress Since the SFY24 Program Evaluation

During SFY25, the DD QMS expanded its use of Power BI dashboards in reviewing data, maintained efforts in assuring valid and reliable data, and continued to refine the functionality of the QIC subcommittees. Efforts to increase inclusion of external stakeholders were most noticed in QII development and implementation. The Path Forward Summary notes the progress made since the last program evaluation.

Path Forward Summary

In SFY25 DD QMP Part 1 & 2, DBHDS identified the following items in its Path Forward for SFY25. Part 3, the Annual Report, summarizes the work completed by DBHDS on these items.

Path Forward Item	Work Completed Toward Path Forward Item
DBHDS will continue to enhance its ability to utilize data in driving decision-making, in identifying service gaps, and in	The DD QIC subcommittees, with OCQM support, began discussion around the

Path Forward Item	Work Completed Toward Path Forward Item
identifying QI efforts, including statewide initiatives.	populations DBHDS serves well and those who it doesn't serve well. Discussions also increased specific to the variables within the DD QMS data sources that could be included in bivariate and multivariate/correlation analysis.
DBHDS will continue to expand its usage of dashboards for monitoring and reporting of data.	The number of dashboards available for use has increased along with more dashboards being used during DD QIC subcommittee meetings. The use of graphs and charts outside of dashboards remains dominant.
DBHDS will expand its efforts to collaborate with providers on evaluating their own programs and services to utilize QA, and RM data to inform their QI efforts.	OCQI continued to provide consultation and technical assistance to CSBs and providers focusing on 12VAC35-105-450, 12 VAC35-105-520, 12VAC-35-105-620. OCQM began development on a manual targeting these areas. Expectation for completion and posting is SFY26 Q1.
DBHDS will explore how to improve the sustainability of the QII process.	OCQM and the Deputy Commissioner of Community Services determined two points in the QII process where improvement could occur. The first focused on establishing parameters specific to the proposing of QIIs. The second focused on establishing parameters specific to the implementation of existing QIIs. These are projected to be finalized in SFY26.
DBHDS will improve upon the meeting formats (structure and content) for the Quality Improvement Committee and the Regional Quality Councils.	OCQM worked with the chairs to identify a new approach that would allow for similarity between meetings yet be tailored to the specific needs for each. New formats were determined with planned implementation in SFY26 Q1 and Q2.
DBHDS will look for opportunities to better promote the impact of QIIs on its internet and intranet websites.	Internally, a webinar showcasing six QIIs and their impact was held in January13, 2025. A recording was posted on OCQM YouTube playlist.
Increase communication about the DD QMP, to bolster interest in how DBHDS measures quality.	OCQM continued publication of The Quality Beat, a newsletter focused on increasing awareness, understanding, and application of quality principles and tools to DBHDS staff. Discussions began relative to addressing sustainability concerns within the QMS; these

Path Forward Item	Work Completed Toward Path Forward Item
	discussions will continue into SFY26 before any actions are taken.
In SFY25, OCQM will continue to work toward establishing and implementing processes to ensure the impact of the DD QMS is communicated, at a DBHDS department-wide level, and detail how its work impacts the success of individuals served. This will help department personnel understand why their work matters and how it fits into DD QMS.	OCQM and the Deputy Commissioner for Community Services agreed to changes in the reporting format for the DD QMP Annual Report and Evaluation to better show impacts of the DD QMS. Additionally, quality committee orientations were identified as needing to be updated to more clearly help department personnel understand why their work matters and where it fits into the DD QMS. This work is projected to be completed in SFY26.
Address data source system validity and reliability concerns.	DBHDS completed the standing up of its Data Governance program. OCQM continued working with identified personnel on data source system assessment.

Using its QM Program Evaluation, DBHDS determined the following path forward for SFY26, for targeted improvement, for the coming year. *Efforts that began in SFY24 and SFY25 will continue as part of DBHDS' cycle of continuous quality improvement.*

- Establish a process to ensure proposed QM efforts can be integrated effectively into existing procedures
- Continue QII sustainability work focusing on cross-committee efforts for large scale QIIs, and manageability of existing QIIs
- Increase cross-divisional input and collaboration during QIC meetings
- Complete the restructuring of DD QIC and Regional Quality Council (RQC) meetings to better enhance the flow of information and work of the quality committees
- Restructure QMS orientation and training to better depict office intersections and the overall systemic impact of work
- Determine feasibility of including those with lived DD experience in subcommittee meetings, beyond their inclusion in the RQCs, where personal health or other identifying information is not shared
- Share all DD PMI data at least annually at the VACSB Quality and Outcomes, Data Management Committee, or Quality Leadership Committee and at least annually at the Provider Roundtable meeting so input can be shared by CSBs and licensed service providers regarding performance and solutioning
- Enhance preliminary stages of QII development ensuring that the root cause analysis supports the QII being proposed to ensure systemic impact

- Establish a formal process for piloted QII plans to be approved for broader implementation, including resources needed to bring it to scale across the Commonwealth
- Work with OL and the Assistant Commissioner for Developmental Services to identify additional tailored consultation and technical assistance opportunities for CSBs and licensed providers beyond what is currently provided using OCQI staff
- Identify new and leverage existing opportunities for external partners to engage in learning collaboratives, to increase their voice in QI training discussions and build a network of peers

Conclusion

The DD QMS remained well established and robust. DBHDS continued its cycle of continuous quality improvement as demonstrated through its key accomplishments, results of its PMIs and efforts to drive improvement performance that reflects meeting systemic needs, and implementation of QIIs. The DD QMS worked towards addressing long-standing systemic issues and saw key accomplishments to this end. Many efforts will be implemented in SFY26, which sets the stage for continued growth and lasting sustainable impact.

Glossary of Acronyms

Acronym	Full Form
CEPP	Crisis Education and Prevention Plan
CHRIS	Comprehensive Human Rights Information System
CMS	Centers for Medicare and Medicaid Services
CMSC	Case Management Steering Committee
CSBs	Community Services Boards
CTH	Crisis Therapeutic Home
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability (inclusive of individuals with an intellectual disability)
DMAS	Department of Medical Assistance Services
DSP	Direct Support Professional
HCBS	Home and Community Based Services
IFSP	Individual and Family Support Program
IMU	Incident Management Unit
ISP	Individual Support Plan
KPA	Key Performance Area
MRC	Mortality Review Committee
NCI	National Core Indicators

Acronym	Full Form
OCQI	Office of Community Quality Improvement
OCQM	Office of Clinical Quality Management
OHR	Office of Human Rights
OIHNS	Office of Integrated Health Network Supports
OL	Office of Licensing
OPNS	Office of Provider Network Supports
PC	Person-Centered
PCR	Person Centered Review
PMIs	Performance Measure Indicators
PQR	Provider Quality Review
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QM	Quality Management
QMP	Quality Management Plan
QMS	Quality Management System
QRT	Quality Review Team
QSR	Quality Service Review
RAT	Risk Awareness Tool
REACH	Regional Education Assessment Crisis Services Habilitation
RM	Risk Management
RMRC	Risk Management Review Committee
RQC	Regional Quality Council
SCQR	Support Coordinator Quality Review
SFY	State Fiscal Year
WaMS	Waiver Authorization Management System

Appendices

- Annual Mortality Report
- Case Management Steering Committee Semi-Annual Reports
- Risk Management Review Report
- Institute for Healthcare Improvement Quality Management Assessment Tool
- Part 3 DD QMS System Accomplishments