REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

PERMANENT INJUNCTION

UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

April 1, 2025 – September 30, 2025

Respectfully Submitted By

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Independent Reviewer
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I. EXECUTIVE SUMMARY

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

The Terms of the Permanent Injunction had been proposed jointly by the Parties and were ordered by the Court on January 15, 2025. This Report documents and discusses the Commonwealth's efforts and progress and determines the status of Virginia's compliance regarding the Permanent Injunction's Section IV Terms 31–59 (Terms), with a focus on the Twenty-seventh Review Period, April 1, 2025 – September 30, 2025.

This Period's studies determined that the Commonwealth met the specified goals for three of the Permanent Injunction's 29 Terms. For the first time, Virginia achieved compliance for Term 51 by meeting its 25% employment goal. The Commonwealth also sustained compliance for two Terms, namely Annual Physical Exams (Term 54) and Case Management Steering Committee Measures (Term 58). For Day Services (Term 37), a compliance rating was deferred until the next Twenty-eighth Period, when a full year of data will be available for comparison.

For the remaining 24 Terms, since Virginia did not fully accomplish their specified goals, the compliance rating for these Terms was Not Achieved. The Commonwealth is to be commended, however, for its considerable efforts and advances, especially in areas such as enrolling in a Waiver service within five months of being assigned a Waiver slot (Term 43), timely referral to a behavioral services provider (Term 33), providing adequate and appropriately delivered behavioral services (Term 34), and implementing an effective Intense Management Needs Review (IMNR) process (Term 44).

It is important to underscore one area where Virginia has not significantly improved after years of repeated underperformance: the low percentage of individuals who receive crisis assessments in community settings. Despite DBHDS's plans and actions over many years, as well as its consistently reported data that demonstrate substantially improved outcomes for those who do receive crisis assessments in such locations, the Commonwealth's efforts have not yet resulted in sustained annual performance increases. To fulfill its obligations to Virginians with DD and their families, the Commonwealth should implement similar measures to those that have been central to Virginia's most important Consent Decree achievements and Permanent Injunction

commitments. These include establishing standards, setting specific goals to address the root causes of underperformance, implementing measurable remediation or corrective actions, tracking the efficacy of these actions, revising them as necessary to achieve the goal, and reporting on the progress made by each Region.

Virginia's selected vendor, Guidehouse, finalized its rate study regarding 11 DD Waiver services and DMAS submitted its report to the Governor on October 15, 2025. The vendor had collected and analyzed extensive data and recommended rate increases with the aim of ensuring that the Commonwealth and its providers have sufficient capacity to reach the specified goals of five of the Permanent Injunction's Terms, namely 33, 37, 38, 39, and 48.

It is the considered opinion of the Independent Reviewer that the implementation of the vendor's recommended rate increases, if approved by the General Assembly, will have an important and positive impact on Virginia's and its service providers' capability to move toward accomplishing these five Terms' specified goals. However, for Terms 37 and 48, the report's lack of adequate and compelling data to recommend rates that support laddered positions for Direct Support Professionals (DSPs) indicates that Guidehouse's study was not designed to ensure sufficient provider capacity to recruit and retain an adequate number of DSP staff with the experience and competencies needed to fully achieve the goals of these applicable Terms.

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

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

In closing, in addition to Virginia completing the development of most of its service system's structures, functions and processes, it is worth highlighting again that the Commonwealth has promised in the Permanent Injunction to maintain in perpetuity a quality management system

(Terms 60–65) and a publicly accessible document library (Terms 66–67). The Independent Reviewer believes that these commitments will support Virginia in its ongoing partnership with stakeholders and individuals with IDD to provide opportunities for community integration, self-determination, and quality services.

II. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

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

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

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

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

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

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

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

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

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

In addition, the Independent Reviewer determined seven status ratings for the Terms' delineated actions:

- *Completed* indicates the full accomplishment of a listed action.
- *Completed and Ongoing* indicates the accomplishment of a delineated action in the current Period, but the accomplishment must be sustained in the future.
- *In Progress* indicates at least one documented step was taken to achieve the required action.
- *No Progress* indicates no documented steps were taken, and no progress was reported during the current Period.
- *Not Completed* indicates that progress began, but the required action was not completed within the specified timeframe.
- *Not Yet Implemented* indicates that documented steps are not yet underway for a required future action.
- *No Longer Required* indicates that Virginia has achieved Sustained Compliance and is no longer obligated to report status updates.

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

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

Prior to completing a draft of this Twenty-seventh Report to the Court for the Parties to review, the Independent Reviewer distributed copies of the consultants' draft studies to DBHDS and convened a debriefing call for each study. These calls provided an opportunity for senior staff from the Commonwealth's relevant departments and their subject matter experts to discuss the contents together with the consultants and the Independent Reviewer. The discussions included the identification of any factual errors and misunderstandings or needed clarifications. The reports were then modified as appropriate.

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

B. Discussion of Compliance Findings

1. Case Management

Background

For the previous Twenty-sixth Period Case Management study, DBHDS had not yet completed its Fiscal Year 2025 cycle of the Commonwealth's annual Support Coordinator Quality Review (SCQR). The compliance rating for the two associated Case Management Terms (i.e., Terms 31 and 58) had therefore been Deferred.

For Term 31's subsection 31a, DBHDS had required a quality improvement plan from nine CSBs. No CSBs had needed intensive monitoring, and none had been referred to the Department's Office of Management Services. In addition, Virginia's efforts to complete this Term's required

actions had been in progress.

Regarding Term 58, the Permanent Injunction had established 86% measures for each of two areas within health and safety, and likewise for two areas within community integration. The most recent SCQR data for all four areas – from Fiscal Year 2024 – had showed case manager performance exceeding these thresholds. Until the Fiscal Year 2025 results were available, however, the latest performance could not be gauged.

Twenty-seventh Period Study

For this latest review, the Independent Reviewer retained the same consultant as last time to assess the Commonwealth's status regarding the Case Management goals and implementation of the required actions specified in Terms 31 and 58 of the Permanent Injunction.

During this Twenty-Seventh Period, Virginia reported its SCQR data for the full Fiscal Year 2025, necessary for determining a compliance rating for these two Terms.

Key Points for Term 31

- In Fiscal Year 2025, 81% of CSB records met a minimum of nine of the ten elements assessed in the SCQR. This represented an improvement over the prior Fiscal Year 2024, when 72% of such records met this Term's 86% benchmark.
- DBHDS's Case Management Steering Committee (CMSC) reported that, in Fiscal Year 2025, the SCQR rate of agreement between the Department's look-behind study, conducted by its Office of Community Quality Improvement, and the CSBs increased for most indicators compared to Fiscal Year 2024. There were no significant decreases.
- Regarding this Term's subsection 31a, and based on the latest SCQR data, DBHDS will require four CSBs to develop quality improvement plans to strengthen the rate of agreement.
- For this Term's subsection 31b and in preparation for this latest SCQR, DBHDS had provided targeted technical assistance (TA) to every CSB. This TA focused on those items that historically had lacked substantial agreement between the CSBs and the Department's look-behind review findings.
- Regarding this Term's subsection 31c, the CMSC has discussed increasing the current 60% benchmark to 75% for requiring CSBs to develop a quality improvement plan if they fall below this measure on two or more of the ten elements.

Key Points for Term 58

- DBHDS reported that for Fiscal Year 2025, it exceeded this Term's 86% specified goal related to the two Performance Measure Indicators (PMIs) established by its CMSC of health and safety: assessing individuals' needs and appropriately implementing the Individual Supports Plan (ISP). The Department achieved 94% for each of these PMIs.
- DBHDS also exceeded this Term's 86% performance measure for each of the two PMIs established by its CMSC that involve community integration: the Department achieved 95% for the choice PMI, and 91% for the self-determination PMI.
- To guide its efforts in ensuring and improving quality, the CMSC utilizes data from a variety of sources, in addition to the SCQR process, to develop Quality Improvement Initiatives (QIIs) and recommend targeted TAs for CSB case management.

See Appendix A for the consultant's full report.

Conclusion

Regarding Term 31, since the Commonwealth did not meet the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 58, since Virginia met the specified goal for the second time, the Commonwealth has achieved a Sustained Compliance rating for this Term.

2. Crisis and Behavioral Services

Background

The previous Twenty-sixth Period study had determined a compliance rating of Not Achieved for the four Terms (i.e., Terms 32, 33, 35 and 36) associated with Virginia's Crisis and Behavioral Services.

For Term 32, DBHDS had not accomplished this Term's requirement to perform 86% of its crisis assessments in community settings. Just 47.5% of conducted assessments had taken place in a community setting.

The Commonwealth had made progress implementing the actions listed in this Term's subsections 32a–e: conducting a 988 media campaign, requiring and offering Mobile Crisis Response (MCR) training, providing funding for initiatives to help REACH crisis teams fill vacant positions, developing a planning template, monitoring REACH staffing, conducting reviews and requiring corrective actions.

Regarding Term 33's stated 86% measure for individuals identified as needing behavioral services during this Period, only 73% had been referred to and connected with a provider within 30 days of the need being identified. Of the 27% of people who had not been connected within 30 days, 18.6% had not been connected at all with a Therapeutic Consultation provider.

As required by this Term's subsections 33a and 33b, DBHDS had made progress implementing targeted technical assistance (TA) to improve specific CSBs' performance, as well as promoting Therapeutic Consultation services at Regional Round Tables. The Department had also planned to offer Medicaid enrollment assistance to providers at the upcoming 2025 Annual Conference for Virginia's Association for Behavior Analysts.

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

For Term 35, DBHDS had almost achieved this Term's requirement that 86% of individuals have a community residence identified within 30 days of admission to either a CTH or a psychiatric hospital. Of the individuals admitted during this prior Period, a residence had been identified within 30 days for 85%.

As detailed in the schedule within this Term's subsection 35a, the Department had selected five providers to develop 11 new homes for individuals with intense behavioral support needs across four of its five Regions. All of these new residences were to be operational by February 2025. However, at the time of this previous review, only eight new homes had been up and running, with Region 2 being the only Region that had the required number of new homes.

Regarding Term 36, DBHDS had not complied with this Term's requirements to establish and operate CTHs for children in each of the three Regions that had not had one. None of these homes had been operational yet. However, a contract had been signed with a provider to operate a CTH for children in Region 5, and similar contracts had been under review in Regions 1 and 3.

The Department had completed the action required by this Term's subsection 36a. DBHDS had issued a communication that the two existing CTHs for children in Regions 2 and 4 could be utilized for crisis preventive stays by children from across Virginia.

For the requirements of this Term's subsections 36b and 36c, the Commonwealth had continued to track and report quarterly on the number of children's crisis prevention stays in the two Regions with operational programs. DBHDS had reported that 12 children had used the CTH in Region 2 for prevention during this prior Period. No children had used the CTH in Region 4 for prevention.

Regarding this Term's subsection 36d, the Department had reported that its Short-Term Crisis Prevention Respite Services was in progress. When fully operational, this initiative would provide up to 1,000 days of respite for children connected to REACH.

Twenty-seventh Period Study

For this latest review, the Independent Reviewer retained the same consultants as previously to assess Virginia's status regarding the goals and implementation of the required actions, specifically for the Permanent Injunction's Terms 32 and 33 associated with crisis and behavioral services, and Terms 35 and 36 associated with crisis stabilization.

Key Points for Term 32

- DBHDS's crisis services system performed just 1,079 out of 2,140 crisis assessments (i.e., 50%) in community settings. Although this result represented an increased number of assessments over the previous Period, the percentage still remained significantly below the 86% benchmark. Unfortunately, this latest result remains in line with the underperforming percentage range over the past five fiscal years, and underscores that the Commonwealth's plans and actions throughout these years have been largely ineffective at making substantive progress toward this Term's goal. During these years, the Department has continued to report significantly more positive outcomes for those people who did receive their crisis assessments in community settings.
- For this Term's subsection 32a, Virginia reported that it was continuing to implement a 988 media campaign and was in the process of developing staff training.
- Regarding subsection 32b, to continue its efforts in assisting the Regions' REACH program to fill vacant mobile crisis positions, DBHDS reported having updated the roles and responsibilities of REACH staff and program functions. The Department also continued

to discuss vacant positions during its qualitative reviews of REACH programs. Despite these efforts, however, between 20% and 66% of staff positions were vacant in four of the regional REACH programs.

- Regarding subsection 32c, DBHDS developed a work plan to improve the accessibility of 988 services to better support individuals with DD. Although the work plan included goals, specific activities and implementation timelines, the goals were not clearly or sufficiently measurable to allow for an adequate evaluation of the impact and success of the Department's planned actions.
- As required by subsection 32d, DBHDS continued to monitor staffing for each Region's REACH program. The Department reported that REACH staffing has been a statewide challenge, and that most Regions were using their staffing flexibly to ensure that the provision of basic functions of mobile crisis response and follow-up services could continue. The REACH staffing in Region 1, however, remained inadequate in fully meeting DBHDS's staffing standards. Unlike Region 3, which had a comparable vacancy rate, Region 1 has been unable to flexibly use other staff to ensure sufficient mobile crisis response.
- DBHDS reported that the REACH programs in Regions 3 and 5 were the most successful, and those in Regions 1 and 4 were having the most challenges. During this latest Period, the Department updated its plan and identified actions that will be implemented, but did not report on its work with Regions 1 and 4 to implement improvement strategies, as required by subsection 32e.

<u>Key Points for Term 33</u>

- DBHDS reported that 1,152 out of 1,483 individuals needing Therapeutic Consultation (i.e., 78%) were referred to an identified provider within the required 30 days. Although an improvement over the prior reporting Period's 73%, it remained less than this Term's 86% goal.
- For subsection 33a and ahead of schedule, DBHDS was already implementing the provision of TA initiatives with eight CSBs.
- Regarding subsection 33b, DBHDS attended the Commonwealth's 2025 Association for Behavior Analysts Annual Conference in April. The Department also participated in Regional Round Tables and provided TA to 15 Therapeutic Consultation providers to assist them in enrolling as Medicaid providers.
- For subsection 33d, the required rate study was completed and will be considered during Virginia's 2026 General Assembly session, and if necessary, its 2027 session.

Key Points for Term 35

- DBHDS reported that it fell short of achieving this Term's 86% goal. For 333 out of 406 individuals (i.e., 82%) with a DD waiver and known to the REACH system who were admitted to a CTH or a psychiatric hospital had a community residence identified within 30 days of admission. The reported quarterly performance varied substantially among the Regions, from 43% to 93%.
- This Term's subsections 35a.i – iv require that ten new homes for individuals with intense behavioral support needs were to be operational by February 2025, with a specific minimum number to be established in four of the five Regions. DBHDS had developed 11 new homes, and during this Period, 49 new beds were being utilized. In each of Regions 1 and 3, the second of the two required homes was waiting to be licensed. Region 2 has opened more than the required number of homes and the three required new homes in Region 5 were now operational.

Key Points for Term 36

- Once again, the Commonwealth did not achieve this Term's requirements to implement three CTHs for children connected to the REACH system, one for each of Regions 1, 3 and 5. DBHDS expected that these homes would all be under construction by December 2025. As of October, however, only the one in Region 3 had broken ground.
- For subsection 36b, DBHDS reported that six children utilized the CTH in Region 2 for crisis prevention stays, and that no children used the CTH in Region 4. The Department did not report which Region each of the six children came from.
- Regarding subsection 36d, for the period until DBHDS's three new CTHs become operational, the Department secured funding to provide support for all eligible children up to 1,000 days per year of crisis prevention respite services. However, since DBHDS reported that no children at risk of crisis and their families had utilized these services in any of the three Regions as of the end of this Period, the fulfillment of this action appears stalled.

See Appendix B for the consultants' full report.

Conclusion

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

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

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

Regarding Term 36, since the Commonwealth did not meet the specified goals, the compliance rating for this Term is Not Achieved.

3. Integrated Day Activities and Supported Employment

Background

The previous Twenty-sixth Period study of the Commonwealth's Integrated Day Activities and Supported Employment service system had determined different compliance ratings for each of the Permanent Injunction's three associated Terms (i.e., Terms 37, 50 and 51).

For Term 37, Virginia had exceeded the specified 2% goal and had therefore been rated in Compliance. The Commonwealth's data had shown an increase of 2.45% in the number of individuals with either DD Waivers or on the waitlist who had participated in employment and day services in integrated settings.

Virginia had also made progress in implementing both the Community Life Engagement Advisory Committee (CEAG)'s work plan, addressing most of the requirements of this Term's subsection 37a, and the rate study, consistent with the requirements of action 37b.

Regarding Term 50, since the Commonwealth's achievement of its annual employment target could not be determined until the end of Fiscal Year 2025, the compliance rating for this Term had been Deferred.

For Term 51, Virginia had not met the specified 25% goal, and so the compliance rating for this Term had been Not Achieved. As of the end of 2024, 23% of adults aged 18–64 who had received or had been on the waitlist for DD Waiver services had been employed. This percentage represented a decrease of 1.5% compared with the 24.5% highlighted in the previous Twenty-Fifth Period Report.

Twenty-seventh Period Study

For this latest review, the Independent Reviewer retained the same consultant as previously to assess the Commonwealth's status regarding the goals and its implementation of required actions specified in Terms 37, 50 and 51 of the Permanent Injunction.

Key Points for Term 37

- Full annual data from April 1, 2025 to March 31, 2026 that gives the number of individuals with either DD Waivers or on the waitlist who had participated in employment and day services in integrated settings will not be available until the next Twenty-Eighth Period review.
- DBHDS revised its original CEAG work plan to include measurable goals and implementation progress, aligning with this Term's subsection 37a.
- As required by this Term's subsection 37b, Virginia contracted with Guidehouse and initiated a rate study that includes these Integrated Day and Employment Services: Workplace Assistance, Community Coaching, and Community Engagement.
- Guidehouse completed the rate study in time to be considered during the Commonwealth's 2026 General Assembly session, and if necessary, its 2027 session.

Key Points for Term 50

- This Term's goal specifies that Virginia will work to achieve at least within 10% of its annual employment target for individuals aged 18–64 who are on DD Waivers. For Fiscal Year 2025, the Commonwealth set a target of 1,310 individuals.
- As of June 2025, 1,105 of these individuals were employed, representing 84% of the target, and so Virginia did not meet the requirements of this Term's goal. Although 85 more individuals were employed compared with the number as of June 2024, this Fiscal Year 2025's percentage was lower than Fiscal Year 2024's 89%.
- DBHDS worked with its Employment First Advisory Group (E1AG), Quality Improvement Committee (QIC) and the QIC subcommittees to retire one Quality Improvement Initiative (QII) and to initiate another QII related to improving employment opportunities.

Key Points for Term 51

- This Term's goal specifies that the Commonwealth will work to achieve an employment target of 25% of all individuals aged 18–64 who are either on DD Waivers or on the waitlist. For the six-month period ending June 30, 2025, there were 21,676 such individuals Virginia, a decrease of 1,412 individuals since the previous review. As a result, the Commonwealth determined that the employment target should be 5,419 individuals.
- Of these 21,676 individuals, 5,442 (25.1%) were employed, exceeding the 25% specified goal.
- DBHDS reported that its Regional Quality Council (RQC) for Region 3 developed a QII to implement targeted trainings, designed to improve Individual Supports Plan (ISP) outcomes for individuals interested in employment. Although three trainings were conducted during Fiscal Year 2025, the Department has not yet documented specific progress related to ISP outcomes.
- DBHDS reviewed this QII with its E1AG. There was no evidence, however, that the Department had worked with the E1AG in initially developing such QIIs to improve employment.

See Appendix C for the consultant's full report.

Conclusion

Regarding Term 37, since Virginia's full annual data regarding the number of individuals with either DD Waivers or on the waitlist who had participated in employment and day services in integrated settings will not be available until the next Twenty-Eighth Period review, the compliance rating for this Term is Deferred.

Regarding Term 50, since the Commonwealth did not meet the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 51, since Virginia met the specified goal, the Commonwealth has achieved Compliance with this Term for the first time.

4. Community Living Options

Background

At the time of the previous Twenty-sixth Period review, the Commonwealth had not been due to report its nursing utilization data for the full Fiscal Year 2025 until October 2025, so the compliance rating for the two Permanent Injunction Terms associated with Community Living Options (i.e., Terms 38 and 39) had been Deferred.

As required by these Terms' subsections 38a and 39a, DBHDS had reported new nursing utilization data for the first half of Fiscal Year 2025. Although these data indicated a significant decline in the delivery of nursing services across almost every category, the Department had confirmed that the data was not complete and likely incorrect. Because Virginia allows up to 12 months for its nursing services providers to submit bills for services delivered, the Commonwealth cannot report the correct quantity of nursing services delivered until a full year after the final date of the service delivery period. It was highly likely that DBHDS's latest data for the first two quarters of Fiscal Year 2025 had undercounted the percentage of individuals who had received at least 80% of their authorized nursing hours.

For Term 38b, DBHDS had updated its Individual Supports Plan (ISP) form to allow for the collection of nursing needs and the incorporation of the Risk Awareness Tool into the ISP.

To better assess if individuals reviewed had unmet nursing or other medical needs, DBHDS had continued to implement its Intense Management Needs Review (IMNR) process, and had submitted its semi-annual report, as required by Term 38c and 39b.

Implementation of Term 38d's requirements had been in progress. DBHDS had initiated a process to identify CSBs with the highest nursing shortages, and had also been identifying CSBs with the lowest utilization. The Department had been targeting its technical assistance and training activities to support those CSBs to increase utilization of authorized nursing hours.

For Term 39c, DBHDS had completed a comprehensive IMNR monitoring questionnaire for skilled nursing and had initiated monthly IMNR reviews.

The Commonwealth, under the leadership of the Department for Medical Assistance Services (DMAS), had contracted with Guidehouse to conduct the rate study required by Terms 38e and 39d. The Department had created a DD Rate Study Work Group comprising representatives from

providers, advocacy groups and industry associations. Meetings of the Work Group had begun in late 2024. In April 2025, Guidehouse had begun surveying providers via its *Provider Cost and Wage Survey*. DOJ had provided input on how Virginia should direct Guidehouse in performing the study.

Twenty-seventh Period Study

For this latest review, the Independent Reviewer retained the same consultants as previously to assess the Commonwealth's status regarding Community Living Options' specified goals and the implementation of required actions for Terms 38 and 39.

Key Points for Terms 38 and 39

- These Terms' goals specify that Virginia will work toward providing a minimum of 70% of individuals with at least 80% of the nursing hours identified as needed on the appropriate Medicaid forms.
- For the full Fiscal Year 2025, DBHDS reported that just 59% (312 out of 525) of individuals received 80% of their authorized hours. However, as mentioned in the previous Twenty-sixth Period Report, it is highly likely that this latest data undercounted the percentage of individuals who had received at least 80% of their authorized nursing hours. The Department will report corrected data for Fiscal Year 2025 after June 30, 2026.
- As required by these Terms' subsections 38a and 39a, DBHDS continued to report ~~the~~ data semi-annually regarding the utilization of nursing services and the achievements and focus of the Department's Nursing Workgroup.
- DBHDS had previously updated the ISP documents, consistent with subsection 38b, with case managers being required to indicate the need for nursing services as identified by the Risk Awareness Tool. The consultants verified that this ISP revision has continued.
- DBHDS continued to implement its IMNR, as required by subsections 38c, 39b and 39c. In April 2025, the Department initiated a monthly IMNR to assess unmet nursing and other medical needs of selected individuals. In its semiannual report, DBHDS stated that its IMNR remediation efforts included the development of 79 plans to resolve identified problems, 46 of which were subsequently fully resolved.
- To fulfill subsection 38d.i, in consultation with DBHDS's five Registered Care Consultants, the Department completed the identification of those CSBs in each Region with the highest nursing shortage and those with the lowest utilization rates.
- To fulfill subsection 38d.ii, DBHDS produced its Nursing Hours Utilization Report through Fiscal Year 2025. This included information regarding nursing workforce

challenges, causes, issues and barriers. The Department also reported gathering input from providers to identify the top three barriers in each Region. These top barriers and efforts to resolve them will be listed and reviewed during the next Twenty-eighth Period.

- To fulfill subsection 38d.iii, DBHDS produced a Nursing Access Work Plan. However, this Plan has not yet identified the top three barriers, nor specific steps to resolve them. It does target the provision of technical assistance and training to CSBs to increase utilization of the authorized nursing hours.
- DBHDS did not identify or discuss the barriers in its semiannual nursing report, as required by subsection 38d.iv.
- To fulfill subsections 38e and 39d, the rate study was completed in time to be considered during the Commonwealth's 2026 General Assembly session, and if necessary, its 2027 session.

See Appendix D for the consultants' full report.

Conclusion

Regarding Term 38, since Virginia did not meet the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 39, since the Commonwealth did not meet the specified goal, the compliance rating for this Term is Not Achieved.

5. Services for Individuals with Complex Behavioral Support Needs

Background

The previous Twenty-sixth Period's Individual Services Review (ISR) study had focused on individuals with IDD with complex health support needs. Its purpose had been to provide information to assist Virginia in its efforts to achieve certain specified goals of the Permanent Injunction, particularly Terms 38, 39, 40, 44 and 54.

Term 44 relates to the data collection, analysis, identification of concerns and required remediation processes for these individuals. Terms 38 and 39 relate to the nursing utilization rate, and Terms 40 and 54 relate to the requirement for annual physical and dental exams. Additionally, case managers' use of DBHDS's external monitoring safeguard process tool, the On-site Visit Tool (OSVT) had again been reviewed.

The study had been conducted once more in parallel with DBHDS's Intense Management Needs Review (IMNR) process, implemented by the Office of Integrated Health Support Network (OIHSN). Both studies had randomly selected a new stratified sample of 30 individuals with SIS level 6 needs, all of whom had been involved in annual Individual Supports Plan (ISP) meetings from September through November 2024. The sample had included 15 people from each of the Commonwealth's Regions II and IV, although one individual from the selected sample had sadly passed away, allowing no time to identify a replacement person.

Both studies had completed their respective monitoring questionnaires utilizing document reviews, on-site observations, and interviews with primary caregivers to collect and analyze data regarding the selected individuals' management and health support needs. Additionally, both studies had reviewed the status of Virginia's remediation systems to address identified concerns arising out of the previous Twenty-fifth Period.

The selected sample had not been large enough to generalize findings to determine whether the Commonwealth had met the relevant requirements of these five Terms.

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

The ISR and IMNR nurses had effectively identified unmet health needs and, in certain more urgent cases, OIHSN's nurses had immediately implemented initial remediation plans, such as contacting relevant Departmental staff and scheduling necessary repairs to individuals' adaptive equipment.

Overall, DBHDS's remediation system, although well intentioned, had not adequately tracked, revised as necessary, and ensured correction of identified issues. Given that this system had still been in an early development stage, this had not been surprising. The Department had learned that its IMNR-recommended remediation plan's actions must not only address, for example, the scheduling of a medical appointment, but must also ensure that the medical examination then occurred and that the doctor's orders were implemented.

The ISR and IMNR studies had again identified significant shortcomings in case managers' completion of the OSVT. The effective use of OSVT assessments is a critical element of the

Commonwealth's community-based service system and is central to identifying and addressing inadequate or absent health-related supports. Yet these Twenty-sixth Period studies had found that 48% of the individuals reviewed either had not received the required frequency of OSVT assessments, or the completed OSVT documents had included inaccurate or missing information.

Both studies had learned that several families had not been aware of resources that could be accessed for additional support to address unmet health needs, and had suggested that case managers had not been providing adequate assistance in sharing information about such resources.

For Term 38, the ISR and IMNR studies each found that 45% of the individuals reviewed had needed nursing services and that all had been authorized to receive Private Duty Nursing. Although too small a sample to generalize findings, 62% had received at least 80% of their authorized hours. Additional hours of delivered nursing services may still be reported, since providers have 12 months to submit bills for payment.)

Regarding Term 39, none of the selected individuals needed or had been authorized to receive Skilled Nursing services.

For Term 40, both the ISR and the IMNR's findings had concurred that only 69% of the 29 individuals studied had received the requisite annual dental exam. While this had showed improvement over the prior Twenty-fifth Period, the results had still been insufficient.

The studies had found the following challenges to obtaining dental care: a lack of dentists, especially those with needed expertise or specialized equipment, the hesitation of families to schedule needed dental care, and/or their lack of knowledge regarding available resources.

Regarding Term 54, for the second consecutive Period, this Twenty-sixth Period ISR study had found that 97% of the individuals reviewed had received an annual physical exam within the previous 14 months. Although the study had been based on too small a sample, these findings had been consistent with Virginia's sustained progress.

Twenty-seventh Period Study

For this latest review, the Independent Reviewer retained the same consultants as previously to undertake another ISR study, this time focusing on collecting and analyzing information regarding the management and supports provided for individuals with IDD with complex behavioral support needs.

As part of this review, case managers' use of DBHDS's external monitoring safeguard process tool, the On-site Visit Tool (OSVT) was also studied.

This Period's study also reviewed the status of DBHDS's remediation of concerns identified for the individuals whose supports were reviewed during the previous Twenty-sixth period's ISR and IMNR studies.

Once again, the purpose of this latest study was to provide information that would assist the Commonwealth in its endeavor to meet certain specified goals of the Permanent Injunction, particularly Terms 40, 44 and 54.

This ISR study was once more conducted in parallel with DBHDS's latest IMNR. Both studies were centered on a new stratified sample of 30 individuals with SIS level 7 behavioral needs, all of whom were involved in annual ISP meetings from October 1, 2024, through December 31, 2024. The sample included ten people from each of Virginia's Regions 1, 3 and 4.

Both studies completed their respective monitoring questionnaires by reviewing documents, conducting on-site observations, and interviewing primary caregivers to collect and analyze data regarding the selected individuals' management and behavioral support needs.

Key Points for Term 44

- Of the 30 individuals with SIS level 7 behavioral needs in the selected sample, 23 (77%) exhibited disruptive or harmful behaviors. Of these 23 individuals, behavioral support plans and behavioral interventions had been implemented for ten of them.
- The ISR study found that residential providers with education, experience or training in working with people with behavioral support needs were able to help decrease or successfully manage unwanted behavior.
- Both the ISR and IMNR reviewers identified the same concerns for the selected sample of individuals, and OIHSN's nurses promptly initiated IMNR corrective actions. To refine and effectively implement such corrective actions, OIHSN's nurses engaged with DBHDS's Behavioral Services clinical staff. This was an excellent example of the Department's collaboration across its Offices, consolidating information to improve supports for individuals with complex behavioral needs.

- Regarding this Term's remediation goal, the latest ISR study conducted a look-behind review to determine the status of DBHDS's remediation system. This review focused on the concerns identified during the previous Twenty-sixth Period's ISR study of individuals with complex health needs. The identified health concerns needing corrective actions included dental care, adaptive equipment, clinical appointments and assessments, and health care protocols; all of which had been identified by both the ISR and IMNR nurse reviewers.
- OIHSN's nurses had frequently implemented needed corrective actions themselves. For example, they had provided health-related protocols, referrals, and guidance to help resolve the concerns of families and residential providers. This assistance had resulted in the identified issue being addressed and improved care for the sampled individuals with health support needs.
- OIHSN routinely and consistently tracked the timeliness and effectiveness of the implemented corrective actions. In several instances, case managers or residential caregivers failed to implement or oversee their assigned corrective actions in a timely manner. Despite repeated calls by OIHSN nurses, some corrective actions were not implemented as required or within the timelines.
- For some identified concerns, the lack of resource availability and the lengthy wait for certain clinical appointments significantly delayed the completion of the corrective actions.
- Based on these examples, the current DBHDS remediation system did not demonstrate that it led to the identified health-related support concerns being addressed, and that the corrective actions were being effectively implemented with reliability throughout the DD service system as a whole.

<u>Key Points for Terms 40 and 54</u>

- For Term 40, the ISR nurse consultants documented that 79% of the sample of people reviewed received their annual dental exam. Although the sample was too small to generalize findings, progress in providing annual dental exams for these individuals was consistent with DBHDS's reported system-wide data, which continued to improve but was still insufficient to meet this Term's 86% specified goal.
- Regarding Term 54, all but one of the individuals, i.e., 97% received an annual physical exam. This high percentage was similarly consistent with DBHDS's reported system-wide data, and exceeded this Term's 86% specified goal.

Key Points for the OSVT

- The latest ISR study's analysis of the completion and accuracy of the OSVT for the 30 sampled individuals documented variable results depending on the Region of residence. The frequency of timely completion of the OSVT was highest in Region 3 with 100%; whereas in Regions 1 and 4, completion rates of 70% and 67% respectively occurred. Of the OSVTs that were completed, the ISR study identified inconsistent information and errors in some of them.
- The OSVT is an especially important service quality monitoring tool. When properly completed, it should confirm that the needs identified in individuals' ISPs are being met, or if not, what problems or obstacles must be addressed and resolved.

See Appendix E for the consultants' full report.

Conclusion

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

Regarding Term 44, the ISR study verified for the first time that Virginia's IMNR process adequately collected and analyzed data and identified management needs for individuals with complex behavioral support needs. However, the IMNR's remediation system for concerns raised during the previous Twenty-Sixth Period review was not yet sufficient to fulfill this Term's specific remediation goal.

6. Quality and Risk Management

Background

At the time of the previous Twenty-sixth Period study, 13 Terms – i.e., Terms 34, 40–44, 49 and 52–57 – had encompassed Virginia's Quality and Risk Management (QRM) system.

That Period's review had determined that the compliance rating for ten of these Terms (34, 40, 41, 43, 44, 49, 52, 53, 56 and 57) had been Not Achieved. Regarding Terms 42 and 55, the compliance rating had been Deferred, and for Term 54, the Commonwealth had achieved Compliance with this Term for the first time.

Regarding Term 34's 86% measure, DBHDS had reported that for the first two quarters of Fiscal Year 2025, only 68% of individuals who had needed adequate and appropriately delivered behavioral support services had received them, and the remaining 32% had received inadequate or no services at all.

Virginia had completed implementation of the actions required by this Term's subsection 34a to address findings through its previously conducted root cause analysis. DBHDS's *Behavioral Supports Report: Q3/FY25* had included the needed updates.

DBHDS had also completed the actions required by this Term's subsection 34b and 34c. The Department had continued to use the Behavior Support Plan Adherence Review Instrument (BSPARI) tool to determine whether individuals had been receiving adequate and appropriate behavioral support services. DBHDS reported that its five behavior analysts had completed a statistically significant sample of reviews of behavior programs to determine adherence to its *Practice Guidelines for Behavior Support Plans* and had provided feedback sessions on all the sampled programs to the behaviorists involved. BSPARI scores and trends had been analyzed by the Department to identify areas of improvement and recurring issues in behavioral programming; DBHDS had then utilized these findings to create additional training and technical assistance.

For Term 40, DBHDS had reported that it had not achieved this Term's 86% goal. For the first three quarters of Fiscal Year 2025, just 68.6% of individuals supported in residential settings had received an annual dental exam.

Regarding this Term's subsection 40a, the Commonwealth had not completed the required action to have three mobile dental vehicles operational. DBHDS had continued to operate two such vehicles, but the build-out of the third, with specific HVAC equipment needed, had been in process.

DBHDS had reported that it had continued to employ all but one of the required numbers of dental assistants and hygienists. To complete the action required by this Term's subsection 40b, the Department had reposted the available position.

DBHDS had completed the requirement of this Term's subsection 40c to continue to review referrals for dental services. The Department had also developed and implemented an independent scheduling system and a methodology for prioritizing individuals without an annual dental exam to get one from community dental providers.

DBHDS had been in progress fulfilling the actions required by this Term's subsection 40d. In February 2025, Virginia had posted a Request for Proposals (RFP) to contract with a dentist in each Region who could offer sedation. The RFP review panel had begun its process in March 2025, and DBHDS had projected awarding contracts before the end of April 2025.

As required by this Term's subsection 40e, DBHDS had completed the first, and initiated the next three of the six steps in its plan to collaborate with dental providers to better understand barriers to delivering services to individuals with IDD, and to develop a strategic plan that addressed them.

DBHDS had identified CSBs with the lowest percentages of individuals receiving annual dental exams, and had begun providing technical assistance to support those CSBs, as required by this Term's subsection 40f.

For Term 41, the Commonwealth had not achieved this Term's 95% goal: DBHDS had not provided valid and reliable data to document the percentage of individuals who were protected from serious injuries in service settings. The Department, however, had taken some positive steps. These included revising processes for its Incident Management Unit (IMU) and its Office of Human Rights (OHR), implementing a Specialized Investigation Unit, and updating a number of written processes and protocols related to the review and referral of serious injuries.

DBHDS had been in progress implementing the actions required by this Term's subsection 41a. The Department had continued to improve the methodology for ensuring that all appropriate serious injuries were included in its goal reporting. However, additional revisions to the methodology had been needed to ensure valid and reliable data regarding the percentage of DD Waiver service recipients who were protected from serious injuries in service settings.

Regarding this Term's subsection 41b, DBHDS had indicated progress between its incident management team and the Office of Integrated Health Support Network (OIHSN) to develop the processes needed for a quality review of a statistically significant sample of serious injuries. These would determine if the process used by the Office of Licensing's (OL's) IMU would adequately identify all appropriate injuries and whether individuals would be protected from harm, and if changes would be needed to the way incidents were reviewed and referred.

For Term 42, since Virginia had not yet completed a full round of annual licensing inspections for 2025, the number and percentage of providers that had identified the incidence of common risks and conditions faced by people with IDD could not yet be determined. DBHDS's Office of Clinical

Quality Management (OCQM) and OL had strengthened training and technical assistance for providers regarding these requirements. The Department had also promoted an Excel-based Risk Tracking Tool template that had incorporated data recording and analysis tools related to common risks and conditions. Providers using the tool had demonstrated its effectiveness in identifying trends and patterns.

Regarding this Term's subsection 42a and its required action, OL had introduced procedural changes. These efforts, however, had been insufficient in providing a formal, measurable framework for Inter-rater Reliability (IRR) assessments. A more comprehensive approach would require regular comparative evaluations of each Licensing Specialist at a set frequency, the generation of objective scores, and the aggregation of data for ongoing reliability assessments.

DBHDS's Office of Community Quality Improvement (OCQI) had completed the development and implementation of its Expanded Consultation and Technical Assistance (ECTA) process which offers technical assistance to providers that had not identified the incidence of common risks and conditions. The ECTA had been ongoing and met the requirements of this Term's subsection 42b.

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

For Term 43, the Commonwealth had not achieved the 86% specified goal. During the first two quarters of Fiscal Year 2025, only 75.4% and 78% respectively of individuals assigned a Waiver slot had been enrolled in a service within the required five months.

DBHDS had completed the required tracking and reporting of quarterly data on the number of individuals assigned a Waiver slot, but who had not been enrolled in a service within five months, as required by this Term's subsection 43a.

DBHDS had also completed the actions required by this Term's subsection 43b. Its initial *Timely Waiver Service Enrollment Survey* had been conducted in March 2025 with calls to all individuals (and/or their Authorized Representatives) whose services were not initiated within the 150 days.

Regarding Term 44, DBHDS had not met this Term's requirements to collect and analyze data at least annually regarding the management needs of individuals with identified complex health, behavioral and adaptive support needs. The Department had gathered and analyzed data regarding individuals with complex health support needs but had not yet implemented data collection for the other two subgroups.

DBHDS had developed improvement initiatives for individuals with complex health support needs. However, the Department's remediation process – its system of tracking efficacy, making revisions as necessary, and confirming that identified deficiencies are resolved – had not yet been sufficiently completing these functions.

DBHDS had made progress implementing the actions specified in this Term's subsection 44a by crafting a methodology for combining data and information from the IMNR, Quality Service Reviews (QSR) and BSPARI processes.

The Department had continued its progress implementing the requirements of this Term's subsection 44b. DBHDS's OIHSN nurses had conducted the IMNR process for the random sample of individuals with complex health support needs; however, the Department had not yet utilized the IMNR process for individuals with complex behavioral or adaptive support needs.

For Term 49, Virginia had not achieved the specified goal that 95% of residential service recipients live in an integrated setting that supports full access to the greater community, in compliance with the CMS rule on HCBS settings. DBHDS had reported a 93% result, although the Department had not shown its relevant QSR data for 700 of these settings to be reliable and valid. The Commonwealth had therefore decided to review 1,230 residential settings' validation of compliance with this applicable CMS rule. This number had comprised the QSR's 700 settings, plus another 530 settings that had remained in remediation status. DBHDS had anticipated completing this review by its target due date of December 31, 2025.

Regarding Term 52, Virginia had implemented a revised look-behind review process toward achieving this Term's goal of collecting sufficient data for the Risk Management Review Committee (RMRC). These data reports had continued to support trend analysis, recommendations for QIIs, and tracking of approved initiatives. However, DBHDS's currently insufficient annual IRR process had still needed to be replaced. OHR had been developing an alternative IRR process that it planned to present to the RMRC for its consideration in April 2025.

For Term 53, Virginia Commonwealth University (VCU) had continued to conduct quarterly look-behind reviews of statistically valid random samples of DBHDS's serious incident reviews. The results, which had consistently met or exceeded this Term's 86% threshold, had been reported to the RMRC as required.

OHR had continued to conduct quarterly look-behind reviews of a statistically valid random sample of reported allegations of abuse, neglect, and exploitation, and had reported the feedback to the RMRC, as required. However, the Department's IRR process had remained insufficient: IRR reviews had occurred only at the end of a 12-month period. This delay had meant that the RMRC might have been reviewing inconsistent data from the quarterly reviews.

Regarding Term 54, DBHDS had exceeded its 86% goal. During the first three quarters of Fiscal Year 2025, 88.6% of individuals supported in residential settings had received annual physical exams. The Department had continued to undertake and document multiple initiatives to improve overall health awareness for individuals with IDD within both the provider community and families, and to increase these individuals' participation in annual physicals.

For Term 55, since results of annual licensing inspections for 2025 had only been available for the first two months of this year, there had been an insufficient cohort to determine Virginia's achievement of this Term's 86% benchmark.

DBHDS's OL had an established process for consistently assessing providers' compliance with the risk management requirements during their annual inspections, as outlined in the applicable regulations.

This prior Period's study had reviewed a stratified sample of 30 of the annual licensing inspections that OL had already conducted. Although this was too small a sample to generalize findings or to compare such findings with previous years, the study had identified a concern with the accuracy of Licensing Specialists' assessments of providers' use of data to identify and address trends and patterns of harm and risk of harm.

Regarding Term 56, the Commonwealth had demonstrated improvement in its implementation of the HCBS Waiver *Quality Improvement Plan*, in particular by developing a useful tool that documented whether remediation efforts were in place. However, this Term's goal regarding the Quality Review Team's (QRT's) identification of QI strategies had not been evidenced in their meeting minutes.

For Term 57, the QRT had reviewed measure data as required. For most measures that fell below the CMS-established 86% standard, the Team had discussed applicable remediation plans and other QI initiatives, and had explored next steps for developing such plans. However, the QRT had not consistently documented or implemented remediation plans with defined measures to monitor performance, nor had the Team documented a revised strategy when performance had not improved.

Twenty-seventh Period Study

For this latest review, the Independent Reviewer retained the same consultants as previously to assess Virginia's status regarding specified goals and its implementation of required actions, particularly the 13 Terms of the Permanent Injunction related to Quality and Risk Management. These are Terms 34, 40–44, 49 and 52–57.

Key Points for Term 34

- For the full Fiscal Year 2025, DBHDS reported that 2,334 out of 2,911 (80%) of individuals with identified behavioral support needs received adequate services and 20% (577 out of 2,911) received inadequate or no services. This reflected a substantial improvement over the 68% reported in the previous study, but remained below the 86% threshold for this Term.
- For subsection 34a, DBHDS's semi-annual review updates covered a range of topics and demonstrated that the Department continued to address the findings from its previous root cause analysis.
- For subsections 34b and 34c, DBHDS reported that its five behavioral staff had once again used the BSPARI tool to determine whether individuals had received adequate and appropriate behavioral support services. These Board Certified and Licensed Behavior Analysts reviewed 196 behavior support plans during this Period, and a total of a significant sample of 400 for the full Fiscal Year 2025. They provided feedback to behaviorists as required, identified trends for improvement and used these findings to create additional training and technical assistance.

Key Points for Term 40

- DBHDS reported that 69.1% of individuals supported in residential settings had an annual dental exam throughout the four quarters of Fiscal Year 2025, and so did not meet this Term's 86% threshold.

- For subsection 40a, DBHDS put into operation two mobile dental vehicles. Together with their two existing vehicles, the total exceeded the required three vehicles. In the fourth quarter of Fiscal Year 2025, the Department's Mobile Dental Team served the highest number of patients (i.e., 383) seen in a single quarter to date.
- The Commonwealth's efforts to fulfill the staffing requirements for subsection 40b are ongoing. Of the seven required dental positions, six were staffing the mobile dental vehicles, one short of the requirement. DBHDS continued its efforts to hire the remaining dental position.
- DBHDS again completed the action required by subsection 40c by continuing to review referrals for dental services and to work to connect people to community dental providers when available.
- Regarding subsection 40d and as a result of DBHDS's RFP, the Department signed contracts with dental providers to serve Regions 1 through 4. A new RFP is in process to contract with a dentist or dentistry practice in Region 5.
- For subsection 40e, DBHDS updated its *Dental Work Plan* with ongoing implementation activities for each of the six steps outlined in its initial plan, together with measurable goals, specific support actions, and timelines for implementation.
- DBHDS completed the actions required by subsection 40f, as it had previously. During this Period, of the nine CSBs identified with the lowest percentage of individuals receiving annual dental exams, the Department focused technical assistance on the four CSBs that had not yet seen year-to-year increases.

<u>Key Points for Term 41</u>

- DBHDS had modified its methodology for determining the percentage of DD Waiver service recipients who are protected from serious injury in service settings, as part of its efforts to achieve this Term's 95% goal and meet the requirements for subsection 41a. However, these modifications did not significantly ameliorate the previously documented concern that very few serious injuries reach the investigation stage. The Department's current processes for determining the percentage of people who are protected has not yet yielded valid and reliable data; its methodology still needs additional revisions.
- DBHDS's OIHSN completed a quality review of a statistically significant sample of serious injuries reported for one month of this latest Period, but did not yet have sufficient data to begin making recommendations for any needed changes to the way incidents are reviewed and referred, as required by subsection 41b.

- OIHSN completed its first *Serious Injury Quality Review Report;* however, process revisions remained under consideration and have not yet been completed, as required by subsection 41c.

Key Points for Term 42

- DBHDS did not meet this Term's goal of ensuring that its licensed providers of DD Waiver services have risk management processes that identify the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths. OL's Licensing Specialists did not consistently and accurately assess whether its licensed providers effectively implemented their risk management programs, including taking prompt action when such events occur, or when the risk is otherwise identified.
- For subsection 42a, OL developed and began implementation of an IRR process to formally evaluate the consistency and accuracy with which its Licensing Specialists assess whether licensed providers are meeting the applicable regulatory requirements. As OL fully implements this process, its results will provide ongoing objective measurement across these providers.
- The ECTA process has continued, as required by this Term's subsection 42b, and DBHDS has maintained and made improvements to strengthen the required technical assistance process.
- Virginia continued to maintain the effective implementation of OL's CAP protocols, again fulfilling subsection 42c's requirements.

Key Points for Term 43

- DBHDS reported an overall improved performance for the full Fiscal Year 2025 of 78.6% of individuals assigned a Waiver slot who were enrolled in a Waiver service within the required five months. Although reflecting a positive trend, this percentage still fell short of this Term's 86% goal.
- For subsection 43a, DBHDS continued to track and report quarterly data on the number of individuals who were assigned a Waiver slot but who were not enrolled in a service within five months.
- To complete the ongoing requirements of subsection 43b, DBHDS updated its survey used to gather information from people awaiting the initiation of Waiver services during the final quarter of Fiscal Year 2025. Of the 764 individuals surveyed, the Department documented the reasons why services were not initiated, barriers that caused those delays, solution actions and the needed remediations.

Key Points for Term 44

- DBHDS did not meet this Term's requirements to monitor the adequacy of management and supports provided because the Department has not yet collected and analyzed data regarding the management needs of individuals with identified complex adaptive support needs. Additionally, for many concerns that DBHDS had identified as needing corrective actions, adequate remediation systems for implementing them, tracking their efficacy and revising them as necessary were not provided.
- As required for subsection 44a, DBHDS produced its *2024 Ongoing Service Analysis Report* that included a separate section with data from the IMNR process for individuals with complex medical needs, the care concerns process, the BSPARI quality reviews, as well as from the QSRs. However, this *Report* did not include specific data regarding individuals with complex adaptive support needs. In addition, the Department had not yet consolidated the data from these various sources to provide a comprehensive summary of the management and support provided to individuals with complex needs. DBHDS reported that plans were underway to combine information to identify and address needs across data sources.
- DBHDS continued its progress toward meeting subsection 44b. The Department expects to complete a second semi-annual IMNR review of individuals with complex behavioral needs during the next Twenty-eighth period, and to subsequently collect data through the IMNR specific to people with complex adaptive support needs, beginning with the Twenty-ninth Period. A total of 70 individuals must be reviewed annually, as per this subsection's relevant requirement.

Key Points for Term 49

- DBHDS continued to review 1,230 residential settings to validate their compliance with the CMS rule on HCBS settings. Until the Department completes this work, a calculation to assess the percentage of residential service recipients living in an integrated setting that supports full access to the greater community could not be determined as reliable. The Commonwealth therefore could not demonstrate achievement of this Term's 95% goal, and the action for subsection 49a is in progress.
- For future QSR Rounds, DBHDS acknowledged that its Person-Centered Review (PCR) and Provider Quality Review (PQR) tools will need revisions to adequately assess compliance with the HCBS Settings Rule.

Key Points for Term 52

- OHR continued its Community Look-Behind (CLB) process that evaluates whether investigations of abuse, neglect and/or exploitation involving individuals receiving DD services in licensed community provider settings were completed within established timelines, conducted by a trained investigator, and whether CAPS were implemented by the provider when indicated. The Office continued to report its CLB findings, as required, to the RMRC.
- Once again, however, OHR's data reliability could not be verified, so Virginia did not achieve this Term's goal. Its CLB IRR process was not conducted on a regular and frequent basis, and was not carried out by staff independent of the operation. The Office is currently restructuring and improving this IRR process so that its reviews will be conducted quarterly and carried out by staff not directly involved in the process.

Key Points for Term 53

- DBHDS's contractor, Virginia Commonwealth University (VCU) had again continued to conduct quarterly serious incident reviews of statistically valid random samples of the Department's serious incident reviews. The results, which had consistently met or exceeded this Term's 86% threshold for each of the three required outcomes (i.e., timeliness, trained investigators and implemented CAPs), had been reported to the RMRC as required.
- As mentioned above for Term 52, OHR also continued its required CLB reviews of investigations into allegations of abuse, neglect and exploitation. This process determined that 85%, 77% and 70% respectively of the investigations met the three required outcomes. However, these percentages each fell short of Term 53's 86% thresholds. In addition, concerns remained regarding the adequacy and timeliness of the IRR process that was used in OHR's CLB review system.

Key Points for Term 54

- DBHDS reported that 89.1% of individuals supported in residential settings in Fiscal Year 2025 received an annual physical exam. The Commonwealth exceeded this Term's 86% goal for the second consecutive Fiscal Year, and therefore achieved Sustained Compliance.
- Notably, for the third quarter of Fiscal Year 2025, the Department reported the highest performance percentage (91%) for annual physical exams since Fiscal Year 2021.

Key Points for Term 55

- Of the 881 annual inspections that OL conducted during the first two quarters of 2025, the Office reported that 875 (99%) included assessment of each of the regulatory requirements. However, just 496 (56%) actually met each of the regulation's requirements.
- The consultants reviewed documentary evidence from a sample of 80 of OL's 881 annual inspections to determine whether Licensing Specialists were accurately assessing provider compliance with the risk management requirements specified in the applicable regulations. Of the five relevant assessment questions, the consultants agreed with at least 86% of OL's determinations for three questions, but only agreed with 79% and 65% respectively for the remaining two questions. Virginia therefore once again did not achieve this Term's requirements.
- OL designed and is implementing an improved IRR process to promote uniformity across Licensing Specialists' assessments. This will, in turn, enhance the accuracy and consistency of OL's regulatory compliance evaluations across its licensed providers.

Key Point for Term 56

- The Commonwealth did not achieve all the goals specified for this Term, but made considerable progress. Virginia's QRT continued to meet quarterly. During the second and third quarters of Fiscal Year 2025, the QRT reviewed collected data, and discussed trends as well as the progress of its QI and remediation strategies for each of the Waiver quality performance measures that had fallen below the CMS-established HCBS's 86% standard. However, the QRT again did not review current data and implement QI strategies for the particular performance measure regarding the number and percentage of individuals aged 19 and younger with Waiver services who had an ambulatory or preventive care visit during the year.

Key Point for Term 57

- The Commonwealth made significant progress determining the need for and implementing or updating remedial strategies for the Waiver quality performance measures that had fallen below HCBS's 86% standard. However, Virginia did not meet this Term's specified goals: the QRT again did not follow its own procedures to provide a documented rationale for not developing a remediation plan concerning one of these performance measures.

See Appendix G for the consultants' full report.

Conclusion

Regarding Terms 34, 40, 41, 42, 43, 44, 49, 52, 53, 55, 56 and 57, since the Commonwealth did not achieve the specified goals, the compliance rating for each of these Terms is Not Achieved.

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

7. Provider Training

Background

The previous Twenty-sixth Period review had focused on the two Terms of the Permanent Injunction related to Provider Training, i.e., Terms 47 and 48.

For Term 47, since the Commonwealth had not completed a full round of annual licensing inspections for 2025, the compliance rating for this Term had been Deferred. Results from DBHDS's Office of Licensing (OL) had been available for inspections conducted during just the first two months of this year, and so Virginia's achievement of this Term's 86% benchmark could not be determined.

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

Regarding Term 48, since the Commonwealth had not yet completed Round 7 of its annual Quality Service Reviews (QSR), the compliance rating for this Term had been Deferred. DBHDS had not met the 95% goal in either of the prior Round 5 or Round 6 of the QSR process to determine if Direct Support Professionals (DSPs) and their supervisors had received the necessary training and competency testing. To improve this outcome, the Department had ongoing efforts in place to refine processes and to support providers in meeting relevant testing requirements.

As required by this Term's subsection 48a, Virginia had conducted a root cause analysis with the Provider Issues Resolution Workgroup (PIRW) and had completed this action by identifying specific focus areas to be addressed to achieve the 95% threshold. As a result, DBHDS had developed and was in the process of implementing a Quality Improvement Initiative (QII), as required by this Term's subsection 48b.

The Commonwealth's rate study was in progress, consistent with the requirements of this Term's subsection 48c.

Twenty-seventh Period Study

For this latest review, the Independent Reviewer retained the same consultant as previously to assess Virginia's status regarding the specified goals and implementation of required actions for Terms 47 and 48.

Key Points for Term 47

- From OL's 2025 annual inspections, DBHDS determined that 792 out of 1,021 providers (77.6%) had a training policy in place that met established Departmental requirements. This reflected progress from the 73.9% of the previous year, but still remained less than the 86% benchmark.
- The consultant's review of a sample of 80 annual licensing inspections agreed with OL's findings 82.5% of the time, which showed notable progress compared with the previous study's 65% rate.
- For this Term's subsection 47a, the consultant verified that OL continued to expect any provider not in compliance with training requirements to develop and implement a CAP. Also, OL continued to provide written and virtual training and guidance to providers to improve their ability to meet this Term's requirements.
- Regarding subsection 47b, OL had already established the ECTA process, in which providers may enroll voluntarily. The consultant verified that, as required by subsection 47c, providers cited by OL for non-compliance over two consecutive inspections were mandated to participate in the ECTA process. In addition, providers failing to initiate or complete mandatory ECTA technical assistance were subject to further enforcement actions by OL.
- For subsection 47d, OL developed and began implementation of an Inter-Rater Reliability (IRR) process carried out by the Office's Quality Assurance staff who were not involved in

the licensing inspections. This process formally evaluates the consistency and accuracy with which Licensing Specialists determine whether providers are meeting the applicable regulatory requirements for this Term.

Key Points for Term 48

- The Commonwealth completed the Round 7 assessments of its QSR process, and DBHDS determined that the 95% benchmark for this Term was not achieved. Virginia utilizes two measures in the QSR process to establish its progress toward meeting this Term's goal; Round 7 found that 92.7% of provider agency staff met the applicable orientation and training requirements, and 81.6% of DSPs met competency-based training standards.
- Regarding this Term's subsection 48b, DBHDS continued to implement the QII to address barriers to the Commonwealth's achievement of this Term's 95% goal. The QII includes specific initiatives to streamline the requirements for DSP/Supervisor training and competency testing while reducing the related administrative burdens for providers. The Department also updated its *DSP Advanced Competencies* to consolidate, streamline and modernize content. This revision reduced the length of the advanced competency sets from 28 pages to 11 pages. This updated process will be piloted November 2025 through January 2026, with results evaluated during the next Twenty-eighth Period study.
- As required by this Term's subsection 48c, Virginia completed its rate study in time to be considered by the Commonwealth's 2026 General Assembly session, and if necessary, its 2027 session.

See Appendix F for the consultant's full report.

Conclusion

Regarding Term 47, since the Commonwealth did not meet the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 48, since Virginia did not meet the specified goal, the compliance rating for this Term is Not Achieved.

8. Quality Improvement Programs

Background

As of the Twenty-sixth Period review, two Terms – i.e., Terms 45 and 46 – specified the Agreement's requirements for Quality Improvement (QI) Programs.

For Term 45, since the Commonwealth had not yet completed the majority of its 2025 annual licensing inspections, data had not been available to evaluate Virginia's progress on this Term's requirements, and so the compliance rating had been Deferred.

DBHDS had successfully completed the required actions specified in this Term's subsection 45a. The Department's regulations require that providers develop, submit and implement a written Corrective Action Plan (CAP) for each violation cited by the Office of Licensing (OL). OL and DBHDS's Expanded Consultation and Technical Assistance (ECTA) team had established ongoing procedures and protocols and issued guidance to providers. Data collection had been underway to monitor the utilization and effectiveness of these procedures.

DBHDS had also completed the actions required by this Term's subsection 45b. When the Department determines that a provider is non-compliant with a regulatory requirement in two consecutive annual inspections, the provider must participate in the ECTA process. OL's written protocols had detailed the criteria for and initiation of progressive enforcement actions, which had corresponded to the severity of continued non-compliance.

To address the action requirements of this Term's subsection 45c, DBHDS had been implementing procedural changes, including various training and supervisory approaches designed by OL. Their purpose was to ensure that, across all licensing specialists, conclusions related to deficiency and compliance determinations were made consistently. However, OL had not yet implemented regular comparative evaluations of each licensing specialist at a set frequency, nor had the Office generated objective scores or aggregated this data. These are necessary factors to establish inter-rater reliability (IRR) for OL's assessments of providers' QI programs.

Regarding Term 46, since the Commonwealth had not yet completed both the majority of its 2025 annual licensing inspections and its QSR Round 7 process, no new data had been available to determine which providers were not demonstrating adequate QI programs and whether the QSR was yielding relevant valid and reliable data. The compliance rating for this Term had therefore been Deferred.

DBHDS had successfully completed the required actions specified in this Term's subsection 46a. The Department had required providers who received OL citations to develop and implement a CAP. It had continued to employ a total of 12 QI specialists to offer providers technical assistance and additional training, and to specify actions related to the respective areas of underperformance.

DBHDS had also successfully completed the actions required by this Term's subsection 46b. If OL cites a provider for the same violation over two consecutive annual inspections, the provider must begin the ECTA process within 45 days of receiving their recently approved CAP. If the provider continues to be non-compliant or fails to complete the required ECTA process, the Department may take progressive enforcement actions, as defined in OL protocols.

Twenty-seventh Period Study

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

Key Points for Term 45

- Between January 1, 2025, and the time of this study, the Commonwealth completed 71% of its 2025 annual licensing inspections. This percentage was sufficient to generalize the statistical findings and compare them with data from 2023 and 2024.
- This Term requires that 86% of licensed providers of DD services comply with the applicable 11 sub-regulations. DBHDS determined that it did not meet this benchmark. OL's 2025 data indicated that providers met or exceeded this percentage for only one of the 11 sub-regulations. The Department also determined that its providers received higher scores than in 2024 on nine sub-regulations, and lower scores on two of them.
- For subsection 45a, the consultants verified that DBHDS continued to require any provider not in compliance with this Term's regulatory requirements to develop and implement an appropriate CAP.
- DBHDS continued to have licensing regulations and implementation protocols in place that met the requirements of this Term's subsection 45b. OL consistently followed these protocols.
- For subsection 45c, OL developed and and began implementation of an IRR process that formally evaluates consistency and accuracy to assess whether providers meet this Term's regulatory requirements.

Key Points for Term 46

- In time for this Twenty-seventh Period review, Virginia completed its QSR Round 7 process.
- As a result of DBHDS's preparatory work during the previous Period, the consultants verified that the QSR Round 7 data available during the current Period was considered valid (i.e., it measured what it purported to measure.)
- However, the consultants' comparative review of 36 providers in the selected sample from DBHDS found overall agreement with the QSR findings related to quality improvement only 65% of the time. Since the QSR Round 7 data provided could therefore not be determined to be reliable, the Commonwealth did not meet this Term's requirements.
- Regarding subsection 46a, the consultants verified that DBHDS continued to require that providers who receive OL citations for failing to comply with its regulatory requirements must develop and implement a CAP for each citation. In addition, the Department continued to employ 12 QI Specialists to provide the individualized consultation, training and technical assistance, tailored to providers' specific needs and areas of underperformance.
- For subsection 46b, OL continued to cite providers who failed to comply with this Term's regulatory requirements over two consecutive annual inspections. In response to any cited non-compliance, providers must develop and implement a CAP for each citation.
- Regarding subsection 46c, OL developed the needed formal, measurable framework for continuously assessing IRR among its Licensing Specialists, and began implementation of this process in July 2025. The Office anticipated completing its analysis of results and determining follow-up actions by September 30, 2025. This information will be reviewed as part of the next Twenty-eighth Period study.

See Appendix G for the consultants' full report.

Conclusion

Regarding Term 45, since Virginia did not meet the specified goal, the compliance rating for this Term is Not Achieved.

Regarding Term 46, since the Commonwealth's data could not be determined to be reliable, Virginia did not meet the specified goal. Therefore, the compliance rating for this Term is Not Achieved.

9. Rate Study

Background

For many years, Virginia has been unable to achieve certain goals specified in the Consent Decree. In 2024, the Parties agreed that a rate study was necessary to ensure that the Commonwealth's providers of services to individuals with IDD had sufficient capacity to achieve these goals. The Permanent Injunction, approved in January 2025, required Virginia to complete a study that would recommend increasing providers' funding rates for 11 DD Waiver services. This in turn would help the Commonwealth to achieve the goals of the Permanent Injunction's Terms 33, 37, 38, 39 and 48.

This rate study began during the prior Twenty-sixth Review Period. To conduct it, Virginia engaged a qualified vendor, Guidehouse, and formed the DMAS Rate Study Work Group. This Group included representatives from DD service providers, advocacy groups and industry associations who would have opportunities to provide feedback during the rate development process.

DOJ participated in the vendor's meetings with stakeholders, and provided input on how the Commonwealth should direct Guidehouse to perform the study. The vendor's timeline had projected submission to DMAS of its draft report by July 11, 2025. This draft would then be shared with the Parties and other stakeholders for feedback. Guidehouse set August 11, 2025, as the target due date to submit the final version of its report.

Twenty-seventh Period Review

The Permanent Injunction's Term 59 is dedicated solely to this rate study, and comprises six required actions. For this latest review, the Independent Reviewer assessed Virginia's status regarding these actions.

<u>Key Points for Term 59</u>

- For this Term's subsection 59a.i and as reported previously, the Commonwealth's selected rate study vendor, Guidehouse, included DOJ and stakeholders in its meetings. Each had opportunities to provide input on how the rate study should be conducted.
- As part of their respective input at that time, DOJ and stakeholder representatives encouraged Virginia to direct Guidehouse to collect information needed to support funding rates with a laddered approach to Direct Support Professional (DSP) positions. This

information would then guide recommendations for potential rate changes necessary to support and fund such laddered positions. If the necessary funds were approved, this would improve providers' capacity to build organizational structures to more effectively recruit and retain DSPs.

- Laddered positions offer increased career advancement opportunities. Those with higher qualifications (i.e., experience and/or competencies) are able to fulfill more demanding responsibilities and earn higher wages. This approach would be more attractive when recruiting future DSP job applicants and when retaining current DSPs.
- Such a laddered approach to DSP positions would be responsive to DOJ's request that the rate study address the need for competitive wage rates with incentives for DSPs with more experience and higher competencies to work in integrated settings and with individuals with complex needs. Laddered positions would also fulfill providers' concerns that the historic funding of a single DSP wage rate had seriously restricted their ability to implement different wage levels.
- The vendor submitted its draft rate study report to DMAS in July 2025. It reflected Guidehouse's extensive information gathering and thoughtful analysis, consistent with the Independent Reviewer's understanding of the established practices for conducting rate studies.
- According to Guidehouse's provider survey results, DSP positions constituted the majority of provider staff positions, as well as service expenditures by the 11 DD Waiver services studied. The vendor had also gathered information about some DD service providers' current use of laddered DSP positions.
- During this latest Period, DOJ, advocacy groups, service providers and industry association representatives provided comments about the vendor's draft report, including concerns and questions.
- DOJ questioned whether the draft report fulfilled the Permanent Injunction's requirement that the study be designed to ensure sufficient capacity to achieve the specified goals of the five Terms 33, 37, 38, 39 and 48. The Commonwealth's DD service providers and association representatives also questioned whether Guidehouse's recommended rate increases were based too heavily on the existing range of providers' pay rates. They also questioned whether the vendor's recommended rates were sufficient to resolve providers' capacity to recruit and retain an adequate number of qualified staff, particularly DSPs, to achieve the specified goals of the 11 DD Waiver services.
- For subsection 59a.ii, on October 15, 2025, DMAS submitted the vendor's final report, which included responses to DOJ's written comments about Guidehouse's draft report, to

the Governor, and placed in the Library. It was also filed with the Court, as required by subsection 59a.iii.

- The report includes various rate comparisons with eight peer states and the District of Columbia. Guidehouse justified these selections because its analysis had determined that these states and D.C. have either service structures or labor markets similar to Virginia. The report's graphs show that the Commonwealth's existing rates are typically above the average rates shown for the peer states.
- It is the Independent Reviewer's considered opinion, however, that these graphs might erroneously imply that the selected peer states are economic matches. This is not the case. There are three reasons why the vendor's graphic comparisons do not accurately portray how Virginia's existing rates compare with those from states that are actually close economic matches. Of the peer states that Guidehouse selected for comparisons, six of the eight (75%) have a minimum wage that is 40% below the Commonwealth's, and seven of the eight (87%) have median household incomes that average 25% below Virginia's. In addition, its report compares the Commonwealth's Fiscal Year 2026 rates with those of the selected peer states from 2023 to 2025.
- In its final report, Guidehouse did not recommend different base rates that would be needed for a laddered DSP wage structure. The vendor explained that the providers' responses to its survey had not identified consistent existing wage patterns across the different DSP job levels. Instead of using different base rates, the vendor adopted a single average DSP base wage to establish its recommended rate changes.
- It is the considered opinion of the Independent Reviewer that the implementation of the vendor's recommended rate increases, if approved by the General Assembly, will have an important and positive impact on providers' capability to move toward accomplishing the five Terms' specified goals. However, the report's lack of adequate and compelling data to recommend rates that support laddered positions for Direct Support Professionals (DSPs) indicates that Guidehouse's study was not designed to ensure sufficient provider capacity to recruit and retain an adequate number of DSP staff with the experience and competence needed to fully achieve the goals of the Permanent Injunction's applicable Terms.
- For subsection 59a.iv, Virginia began its efforts to obtain General Assembly funding necessary to increase current rates to those recommended in the rate study. The Commonwealth forwarded copies of the final rate study to the chairs of the legislature's House and Senate Appropriations Committees.
- The actions in subsection 59a.v have not yet been implemented. They may be invoked one month after the Governor's proposed budget is submitted to the General Assembly;

subsequently subsection 59a.vi can be initiated 30 days after the Governor and General Assembly have taken all necessary steps to finalize the budget.

Conclusion

Regarding Term 59, Virginia has completed most of the requirements of its subsection 59a.i. and is in progress addressing the remaining requirements. However, the Commonwealth did not fulfill the requirement to design the rate study such that it targeted rates necessary to ensure sufficient capacity to fulfill the goals of Terms 33, 37, 38, 39 and 40.

Virginia has completed subsections 59a.ii and 59a.iii. The Commonwealth's efforts to fulfill subsection 59a.iv were in progress, and actions for subsections 59a.v and 59a.vi cannot yet be initiated.

III. CONCLUSION

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

Of the 29 Terms studied for this Report, the Commonwealth achieved three of them, one for the first time. For the other two, Virginia achieved Sustained Compliance, having met them both for the second time. However, since the Commonwealth did not fully accomplish the goals specified in 24 other Terms, its compliance rating for those Terms was Not Achieved, although Virginia did successfully complete or make progress implementing many of their required actions. For the remaining Term, the Commonwealth had not yet completed its established annual monitoring cycle and produced new annual data, so the compliance ratings for this Term was deferred until the next Twenty-eighth Period review.

Virginia's vendor completed its rate study report of 11 DD Waiver services and recommended rate increases which, if approved by the General Assembly, will have an important and positive impact on the Commonwealth's and its service providers' capability to move toward accomplishing the specified goals of the Permanent Injunction's five applicable Terms. However, the Independent Reviewer believes that the vendor's study was not adequately designed to ensure

sufficient provider capacity to recruit and retain the number of DSP staff needed with the experience and competencies to fully achieve the goals of these five Terms. Virginia has committed to making its best effort to obtain the necessary funding from the General Assembly during its 2026 and 2027 sessions.

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

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

IV. RECOMMENDATIONS

The Independent Reviewer recommends that the Commonwealth undertake the nine actions listed below, and provide a report that addresses these recommendations and their status of implementation by March 31, 2026. Virginia should also consider the additional recommendations and suggestions included in the consultants' studies, which are contained in the Appendices.

Crisis Services

1. DBHDS should revise its current qualitative review of the regional REACH programs to include a specific evaluation of each Region's efforts to conduct crisis assessments in community settings. Any measurable progress achieved, as well as recommendations for improvement should also be documented.

Integrated Day Activities and Supported Employment

2. DBHDS should directly involve its Employment First Advisory Group (E1AG) in a review of meaningful data and trend analysis, as well as in the development of future quality

improvement initiatives to strengthen the E1AG work plan and achieve employment targets and goals.

Community Living Options

3. DBHDS should develop and document measurable goals and action plans to address its identified barriers to individuals accessing nursing services. These barriers include the lack of incentives, inconsistent staffing and insufficient LPN capacity.

Quality and Risk Management

4. For its next Round of Quality Service Reviews (QSRs), DBHDS should revise its Person-Centered Review (PCR) and Provider Quality Review (PQR) tools so that their questions related to the HCBS Settings Rule produce reliable data. The Department should provide sufficient guidance to ensure that the QSR reviewers make consistent and reliable "Yes" or "No" responses to these tools' revised questions.
5. To provide reliable and valid data to the RMRC related to reviews of its sample of investigations into alleged abuse, neglect and exploitation, DBHDS's Office of Human Rights (OHR) should finalize restructure of its Community Look-Behind (CLB) inter-rater reliability (IRR) process so that the reviews are conducted quarterly and carried out by OHR staff not directly involved in the CLB process.
6. The Commonwealth's Quality Review Team (QRT) should ensure that it consistently adheres to its Charter's documented procedures that describe the expectations for development monitoring and revision of remediation/quality improvement (QI) plans. Specifically, the QRT should review current data and implement QI strategies for the performance measure regarding individuals aged 19 and younger with Waiver services who had an ambulatory or preventive care visit during the year.

Provider Training

7. To prioritize findings and identify additional remedial or corrective measures, DBHDS should complete its comprehensive analysis of the QSR Round 7 results related to achievement of 95% of provider agencies meeting competency-based training standards.

Quality Improvement Programs

8. To consistently and accurately assess the adequacy of providers' QI programs, DBHDS's Office of Licensing (OL) should complete implementation of its formal process that

describes a valid and reliable methodology for measuring IRR between Licensing Specialists and the QSR reviewers.

9. DBHDS should provide additional training for QSR reviewers related to the evaluation of QI plans: specifically, identifying whether each plan meets the applicable QI regulations and whether the provider tracked and reviewed data.

V. SUMMARY OF COMPLIANCE

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

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

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

In addition, the Independent Reviewer determined seven status ratings for the Terms' delineated actions:

- *Completed* indicates the full accomplishment of a listed action.
- *Completed and Ongoing* indicates the accomplishment of a delineated action in the current Period, but the accomplishment must be sustained in the future.
- *In Progress* indicates at least one documented step was taken to achieve the required action.
- *No Progress* indicates no documented steps were taken, and no progress was reported during the current Period.
- *Not Completed* indicates that progress began, but the required action was not completed within the specified timeframe.
- *Not Yet Implemented* indicates that documented steps are not yet underway for a required future action.
- *No Longer Required* (with due date) indicates that a future action is required but is neither underway nor due.

TERM	REQUIRED ACTIONS	RATING 26th 27th
31. Community Services Board Quality Review (SCQR). The Commonwealth will work to achieve a goal that 86% of Community Services Board (CSB) records meet a minimum of 9 of the 10 elements assessed in the Case Management Quality Review. To achieve that goal, the Commonwealth will take the following actions:	a) During its annual quality review cycle starting each January, DBHDS will require a quality improvement plan from any CSB that has two or more elements with substantial or moderate interrater reliability between the CSB Support Coordinator Quality Review (SCQR) and the DBHDS Office of Community Quality Improvement Review not achieving 60% compliance. DBHDS will provide information about which CSBs need this support in the SCQR Report. *Completed and Ongoing* b) DBHDS will provide targeted technical assistance with identifying measurable outcomes to any CSB (i) whose records are not 86% compliant with including specific and measurable outcomes in Individual Support Plans (ISPs) or (ii) that does not demonstrate improvement with respect to including specific and measurable outcomes in ISPs (including evidence that employment goals have been discussed and developed, when applicable, throughout its quality review cycle). *Completed and Ongoing* c. If the Commonwealth has not achieved the goal within one year of the date of this Order after taking the actions in Paragraphs 31(a) and 31(b), DBHDS will increase the threshold for requiring a quality improvement plan from a CSB as set out in Paragraph 31(a). DBHDS will provide information about which CSBs need this support in the SCQR Report. *Not Yet Implemented* *Due January 15, 2027* d. If the Commonwealth has not achieved the goal within one year after taking the actions in Paragraph 31(c), DBHDS will conduct a root cause analysis and implement a Quality Improvement Initiative (QII) as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Not Yet Implemented* *Due January 15, 2027*	Deferred **Not Achieved**
32. Community Setting Crisis Assessments. The Commonwealth will work to achieve a goal that 86% of children and adults receive crisis assessments at home,	a) DBHDS will continue to promote the use of the 988 24-hour crisis helpline by providing information on the helpline on its social media platforms, in print and television advertisements, and through informational bulletins developed or funded by DBHDS. DBHDS will require all mobile crisis team members to receive training within 90 days of hire on how to support and respond to individuals with developmental disabilities (DD) who are in crisis. *In Progress* b) DBHDS will maintain its current efforts to assist the regions in filling vacant mobile crisis positions by discussing staffing at regional qualitative reviews of REACH programs and supporting REACH	Not Achieved **Not Achieved**

the residential setting, or other community setting (non-hospital/non-CSB office). Crisis Receiving Centers ("CRC") will only be counted as an "other community setting" after it is determined that the individual or supported decision maker was not directed by the Call Center, Emergency Services, or Mobile Crisis staff to present at a CRC. To achieve that goal, the Commonwealth will take the following actions:	programs to implement quality improvement plans. *In Progress* c) Within 6 months of the date of this Order, the Commonwealth will develop a plan that includes measurable goals, specific support activities, and timelines for implementation with consultation from stakeholders to enhance 988 supports and services to increase the likelihood that individuals will be assessed in the community. *Completed and Ongoing* d) From the date of this Order, DBHDS will monitor staffing at each REACH program to determine if they have sufficient staffing per shift to meet the goal, including through discussion and review of filled/vacant positions, utilization rates of mobile crisis, and times mobile crisis calls are being received in comparison to the number of staff working during those hours at each REACH program's quarterly review. If a quarterly review indicates that staffing is not sufficient to meet the goal, DBHDS shall review the region's current efforts to increase staffing and, if DBHDS determines necessary, will require a quality improvement plan that includes additional actions that DBHDS finds are necessary to enhance staffing. The Independent Reviewer, in the reports required under Paragraph 76, shall include a determination in his report on the adequacy of the Programs and Virginia's response to this requirement. *In Progress* e) Semi-annually, beginning on January 1 and June 1 of each year, DBHDS will work with the two regions that are experiencing the most success in responding to people in crisis in the community to determine what is leading to their success. DBHDS will work with the two regions that are experiencing the most challenges in responding to people in crisis in the community to learn what is leading to those challenges. DBHDS will work with all the regions based on these lessons learned to implement a plan to improve performance in each of the regions. *In Progress* f) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 32(a) through 32(e), DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. As part of the root cause analysis, the Commonwealth will collect data on why individuals with developmental disabilities presented at a CRC instead of accessing mobile crisis services. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Not Yet Implemented* *Due January 15, 2027*	

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

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

36. Out-Of-Home Crisis Therapeutic Prevention Host-Home Like Services for Children. To prevent institutionalization of children due to behavioral or mental health crises, the Commonwealth will implement out-of-home crisis therapeutic prevention host-home-like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service by:	a) Within one month of the date of this Order, DBHDS will send out a communication through the list serv for individuals and families on the waiver waiting list, and to the provider list serv communicating that the two CTHs existing in Regions 1 and 4 as of the date of this Order can be utilized for preventive stays by children across the Commonwealth. *Completed* b) DBHDS will continue to track and report quarterly on the number of crisis prevention stays being utilized by children in each of the five regions. *Completed and Ongoing* c) Providing funding in Fiscal Year 2025 to establish three additional CTH's in the regions where they do not exist as of the date of this Order (Regions 2, 3, and 5) that will be operational between May 2025 and January 2026. *Completed* d) From the date of this Order and continuing until all three additional CTHs referenced in Paragraph 36(c) are operational, DBHDS will support up to a total of 1,000 days per year of respite for children connected to REACH, who have previously experienced or are at risk of experiencing a crisis, reside in regions without an operational CTH, and who do not otherwise have funding to access respite services at a rate of up to $500 per 24-hour period. *In Progress* e) If the Commonwealth has not achieved the goal after taking the actions in Paragraphs 36(a) through 36(d) by June 30, 2026, DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Not Yet Determined Due June 30, 2026*	Not Achieved **Not Achieved**
37. Day Services for DD Waiver Recipients. The Commonwealth will work to achieve a goal of a 2% annual increase in the percentage of individuals on the DD waiver receiving day services in the most integrated settings. To achieve that goal, the	a) Within one month of the date of this Order, DBHDS's Community Life Engagement Advisory Committee will implement a work plan that includes measurable goals, specific support activities, and timelines for implementation and that is focused on: defining meaningful community involvement; developing training and educational materials to enhance meaningful community involvement for individuals and families, providers, and case managers; and assessing community involvement data. *Completed and Ongoing* b) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2 024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Community Engagement, Workplace Assistance, and Community Coaching by	Compliance **Deferred**

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

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

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

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

	In Progress d) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the action in Paragraphs 41(a) through 41(c), DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the metric is achieved and sustained for one year. *Not Yet Implemented* *Due January 15, 2027*	
42. Risk Management. To ensure that the risk management programs of DBHDS-licensed providers of DD services identify the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths and take prompt action when such events occur or the risk is otherwise identified, the Commonwealth will take the following actions:	a) Within 24 months of the date of this Order, the Commonwealth shall establish inter-rater reliability among the Commonwealth's licensing specialists regarding provider compliance with the quality assurance trending requirements. *In Progress* b) Within 12 months of the date of this Order, the Commonwealth shall offer technical assistance in accordance with DBHDS's Consultation and Technical Assistance Standard Operating Procedure to each provider that does not identify the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths. *Completed and Ongoing* c) Within one month of the date of this Order, when providers do not take prompt action when such events occur, or where the risk is otherwise identified despite lack of prompt action by providers, DBHDS will ensure that corrective action plans are written, implemented, and tracked, and take further actions as warranted. *Completed and Ongoing*	Deferred **Not Achieved**
43. Timely Waiver Service Enrollment. The Commonwealth will work to achieve a goal that 86% of individuals who are assigned a waiver slot will be enrolled in a service within five months. To achieve that goal, the Commonwealth will take the following	a) Within three months of the date of this Order, DBHDS will track on a quarterly basis the number of individuals who are assigned a waiver slot but not enrolled in a service within five months. *Completed and Ongoing* b) Within three months of the date of this Order, the Commonwealth will contact individuals at the end of each quarter who have not been enrolled in a service within five months and their families and case managers to determine why services have not been initiated and what barriers delayed initiation of services. DBHDS will report on the barriers identified quarterly as well as actions being taken to remediate those barriers and results achieved. *Completed and Ongoing* c) Within one year of the date of this Order, the Commonwealth will conduct a root cause analysis of why services have not been initiated	Not Achieved **Not Achieved**

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

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

Commonwealth will take the following actions:	*In Progress* *Due January 15, 2027*	
47. Training Requirement Compliance. The Commonwealth will work to achieve a goal that 86% of DBHDS-licensed providers receiving an annual inspection will have a training policy that meets established DBHDS requirements. DBHDS will take action it determines appropriate if providers fail to comply with training requirements required by regulation. To achieve that goal, the Commonwealth will take the following actions:	a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with training requirements develop and implement a corrective action plan. *Completed.* b) Within three months of the date of this Order, DBHDS Quality Improvement Specialists will offer providers technical assistance, additional training, and specific actions related to the respective areas of underperformance. *Completed* c) Within six months from the date of this Order, for providers who are not compliant with training requirements for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's license as determined appropriate by DBHDS. *Completed* d) Within 24 months of the date of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess training requirements have established inter-rater reliability in conducting such assessments. *In Progress*	Deferred **Not Achieved**
48. Training and Competency of Direct Support Professionals. The Commonwealth will work to achieve a goal of at least 95% of Direct Support Professionals and their supervisors receive training and competency testing in accordance with 12 VAC 30-122-180 as in effect on the date	a) Within six months of the date of this Order, the Commonwealth shall determine, through a root cause analysis developed in collaboration with the provider and system issues resolution workgroups, why Direct Support Professionals and their supervisors do not receive training and competency testing per 12 VAC 30-122-180. *Completed* b) Based on the findings of the root cause analysis required by Paragraph 48(a), DBHDS will prioritize the findings for quality improvement, taking into account the anticipated impact to the system, including potential negative impacts to current staffing. DBHDS will implement a QII based on its prioritization consistent with continuous quality improvement principles and developed in collaboration with the provider and system issues resolution workgroups. *In Progress*	Deferred **Not Achieved**

of this Order or as may be amended. To achieve that goal, the Commonwealth will take the following actions:	c) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Personal Assistance Services, Companion Services, Respite Services, In-Home Support Services, and Independent Living Support Services by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Personal Assistance Services, Companion Services, Respite Services, In-Home Support Services, and Independent Living Support Services by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies. *Completed and Ongoing* d) If the Commonwealth does not achieve the goal within two years of the date of this Order after taking the actions in Paragraphs 48(a) and 48(b), DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *Not Yet Implemented Due January 15, 2027*	
49. Residential Services Community Integration. The Commonwealth will work to achieve a goal that 95% of residential service recipients reside in a location that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS settings. To achieve that goal, the Commonwealth will take the following	a) In accordance with its CMS-approved Statewide Transition Plan, by December 31, 2025, the Commonwealth will complete its review of the remaining 3,296 locations for compliance with the CMS settings rule to determine if it is in compliance with the 95% goal. *In Progress*	Not Achieved **Not Achieved**

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

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

Community Look-Behind (CLB) review process to achieve a goal of collecting sufficient data for the Risk Management Review Committee (RMRC) to conduct or oversee a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: (i) investigations of individual incidents occur within state-prescribed timelines; (ii) the person conducting the investigation has been trained to conduct investigations; and (iii) corrective action plans are implemented by the provider when indicated. The RMRC will review trends at least quarterly, recommend QIIs when necessary, and track implementation of initiatives approved for implementation.		
53. Samples of Data from Look-Behind Analyses of Serious Incidents and Allegations of Abuse, Neglect,	No specific actions are required, other than those specified in this Term.	Not Achieved **Not Achieved**

and Exploitation. The Commonwealth will work to achieve a goal of showing 86% of the sample of serious incidents reviewed by the RMRC meet criteria reviewed in the audit and that at least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed by the RMRC meet criteria reviewed in the audit. The Commonwealth will continue the look behind process and provide feedback to the RMRC related to its findings. If this goal is not met by December 31, 2024, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.		
54. Annual Physical Exams. The Commonwealth will work to achieve a goal that 86% of individuals supported in residential settings receive annual physical exams. To achieve that goal, the	a) Within six months of the date of this Order, any time there is not an increasing trend in the percentage of individuals receiving an annual physical exam in consecutive annual reporting periods, DBHDS will conduct a root cause analysis and determine whether a QII is warranted to address identified issues. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year. *No Longer Required*	Compliance **Sustained Compliance**

Commonwealth will take the following action:		
55. Assessment of Licensed Providers of DD Services. The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. DBHDS will continue to conduct annual licensing inspections in accordance with Virginia Code § 37.2-411 in effect on the date of this Order or as may be amended and assess provider compliance with risk management requirements in the Licensing Regulations utilizing the Office of Licensing Annual Compliance Determination Chart.	No specific actions are required, other than those specified in this Term.	Deferred **Not Achieved**

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

57. Data-Driven Quality Improvement Plans for HCBS Waiver Programs. The Commonwealth will continue to collect quarterly data on the following measures: (i) health and safety and	No specific actions are required, other than those specified in this Term.	Not Achieved **Not Achieved**

participant safeguards; (ii) assessment of level of care; (iii) development and monitoring of individual service plans, including choice of services and of providers; (iv) assurance of qualified providers; e) whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR; and (v) identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation. This data will be reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans will be written and remediation actions implemented, as necessary, for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86% compliance. Quality Improvement		

remediation plans will focus on systemic factors (where present) and will include the specific strategy to be employed, as well as defined measures that will be used to monitor performance. Remediation plans will be monitored at least every six months. If such remediation actions do not have the intended effect, a revised strategy will be implemented and monitored.		
58. Case Management Steering Committee (CMSC) Measures. The Case Management Steering Committee will continue to establish two indicators in each of the areas of health and safety and community integration associated with selected domains (safety and freedom from harm; physical, mental, and behavioral health and well-being;	No specific actions are required, other than those specified in this Term.	Deferred **Sustained Compliance**

avoiding crises; community inclusion; choice and self-determination; stability; provider capacity; access to services) and based on its review of the data submitted from case management monitoring processes. The Commonwealth will work to achieve a goal of 86% compliance with the four indicators established by the CMSC. DBHDS will monitor data collected in these domains and determine if any intervention is needed.		
59 Rate Studies	a) For any rate study required to be conducted under paragraph 33, 37, 38, 39, or 48, the following shall apply: i. The Commonwealth may either engage Guidehouse as a vendor to conduct the rate study or solicit for a vendor to conduct the rate study. If the Commonwealth engages Guidehouse, the United States may provide input on how the Commonwealth directs Guidehouse to perform the rate study, participate in Guidehouse's meetings with stakeholders and have an opportunity to review and comment on Guidehouse's draft report. If the Commonwealth solicits a different vendor to conduct the rate study, the United States may propose qualifications to be included in the Commonwealth's solicitation for a vendor to conduct the rate study, and the Commonwealth will not unreasonably withhold its consent to the inclusion of the United States' proposed qualifications in the solicitation. At a minimum, the rate study shall be in accordance with best practices and designed to target rates necessary to ensure sufficient capacity to reach the goals of paragraphs 33, 37, 38, 39, and 48. *In Progress*	

	ii. The vendor shall submit a draft of the rate study to the parties for comment at least 30 days before finalize the study and shall address any comments in the final version of the study. *Completed* iii. The study shall be placed in the Library and filed (by either party) with the Court. *Completed* iv. The Commonwealth shall make its best efforts in the two legislative sessions immediately following publication of the results of the rate study to obtain the General Assembly funding necessary to increase rates to those recommended by the study, accounting for any increases in inflation in the rate's implementation. *Not Yet Implemented Due March 31, 2027* v. Upon request of the United States, the Court shall hold a status conference one month after the Governor's proposed budget is submitted to the General Assembly if the rate increases identified in the Study are not in the proposed budget. *Not Yet Implemented Due February 2026* vi. Upon request of the United States, the Court shall hold a public hearing within 30 days after the Governor and General Assembly have taken all steps necessary to finalize the budget. The hearing shall address whether the rate increases identified in the Study are included in the budget, and, if not, whether the Court should order any steps. *Not Yet Implemented Due April 2026*	

VI. APPENDICES

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APPENDIX A

Case Management

By

Kathryn du Pree, MPS

Case Management
27th Review Period Report
Prepared for the Independent Reviewer

Introduction

This report constitutes the ninth review of initially the Settlement Agreement's requirements, and now the Permanent Injunction's, for Case Management services. This is the second review to be conducted since the Court approved the agreement between the Parties to comply with the Terms of the Permanent Injunction (PI) and to implement the specified actions. The Terms under review for Case Management during the 27h review period are Term 31 and Term 58 which are described below. The focus of the review is to determine if the Commonwealth has achieved the measurable goals of the two case management PI Terms and the extent to which they have successfully implemented the associated actions. The Parties have agreed upon the terms to determine compliance with Case Management Provisions that previously remained out of sustained compliance. These include PI Terms that relate to the Settlement Agreement's Provisions III.C.5.b.i. and V.F.5. These terms address the Commonwealth's responsibilities to review and monitor the quality of service coordination and the delivery of waiver services to analyze the findings of the quality review related to CSB Case Management performance across ten elements (PI 31)*;* and to specifically analyze and monitor the achievement of four key indictors related to health and safety and community integration (PI 58).

For this subset of PI Terms and associated actions, progress toward achieving the specified goals and implementing the delineated actions are reviewed and reported below. This review includes an analysis and reporting of Virginia's status implementing the PI requirements associated with Case Management that have not been met twice consecutively (see Table 1 below). This includes PI Terms 31 and 58. Ratings for both Terms were Deferred in the 26th review period.

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

The ratings for both PI 31 and PI 58 were deferred in the 26th review period. The completed FY25 SCQR was used for the analysis in this 27th review period to determine compliance ratings and provide updates on DBHDS's efforts to implement various improvement strategies and summarize the review by the Case Management Steering Committee (CMSC) of the status of various initiatives. For the current review, DBHDS provided its CMSC Final Report for FY25 Q3 and Q4; the SCQR FY25 Final Report; CMSC Implementation Plan (IP) updates; the minutes of CMSC and Work Group meetings; the SCQR meeting minutes and related materials; and documentation of the Quality Improvement Initiatives (QII) being monitored by the CMSC.

Summary of Findings for the 27th Period

Table 1 below lists the PI Terms and their compliance ratings. Term 31 is Not Achieved and Term 58 is Achieved for the 27th review period. The reviews by CSBs are conducted between January and June of each year and the look-behind conducted by DBHDS Quality Research Specialists in the Office of Quality Assurance and Healthcare occurs in July and August of each year. The data to analyze the Commonwealth's progress meeting Terms 31 and 58 was available for this reporting period.

Term 31: The CMSC continued to monitor the CSBs for the Performance Measure Indicators (PMI) relevant to Term 31 and additional indicators, addressing employment and community engagement discussions and goals; ISP completion; Regional Support Team (RST) timeliness; and underperforming CSBs related to the SCQR results. The minutes of the monthly CMSC meetings that occurred between April and September 2025 provide evidence of both regular and meaningful involvement of the CMSC in the oversight of the CSBs' Case Management services and DBHDS' implementation of quality review, analysis, technical assistance, training, and communication with CSBs (4,5). DBHDS required CSBs to address SCQR results, RST, and ISP performance in their Improvement Plans (IP) (3). CSBs that underperform in any of these three areas are required to develop and implement an IP, which must be approved by the CMSC.

DBHDS provided a CMSC IP update produced in September based on reviews that took place in FY25 (3). At that time, there were twenty-two open IPs for ISP Compliance and one approved IP for RST timeliness. Starting in FY26 Q1, the CMSC will monitor ISP completion status based on the effective date in each Quarter of the report rather than on a rolling basis. The CMSC anticipates this methodology will result in lower compliance among the CSBs but will provide greater accuracy than is produced using the rolling method. The CMSC had considered the rolling methodology for computing RST timeliness but decided to continue to use quarterly tracking for RST compliance as well.

The CMSC also tracks the IPs for compliance with the SCQR Indicators. Prior to 2025, DBHDS required a CSB to develop an IP if it had three of more Indicators self-scored at less than 50%. In 2025, DBHDS revised the threshold to require CSBs to develop an IP if the CSB had two or more Indicators that were self-scored at less than 60%, establishing a higher level of expected performance. The CMSC reports nine CSBs with IPs for SCQR performance and none were ready to be removed from the IP list as of September 2025 (3). The CMSC reported that four CSBs would be required to develop IPs for compliance with the SCQR Indicators, based on the findings of the FY25 SCQR (7).

The CMSC sent a letter to the DBHDS Commissioner on 8.7.25 to provide its summary of the status of compliance of the CSBs regarding ISP, RST and SCQR requirements. The CMSC did not recommend that the Commissioner take any action in addition to the ongoing monitoring of the CMSC (18).

The CMSC also develops and tracks Quality Improvement Initiatives (QII) to address trends in performance and systems issues that negatively impact performance. The CMSC had developed

seven QIIs, of which five were completed as of June 2025 (1, 2,4,5). The remaining QIIs address: improving the outcomes related to employment and community engagement (QII 6); and improving the level of agreement for Indicator 10 (QII 7). The Independent Reviewer expressed concern in his 25th Report to the Court, submitted in December 2024, that the agreement between the CSB reviews and the look behind reviews needed improvement. The level of agreement had dropped from substantial to moderate agreement (76%) for this Indicator. The CMSC report documents its efforts to address and monitor these QIIs.

Related to QII 6, the Regional Quality Councils (RQC) in Regions 2 and 3 have developed and presented training materials. The CMSC sent an alert to stakeholders through the Listserv to remind them of available resources regarding employment and integrated community involvement. The CMSC will monitor whether the availability of resources have an impact on performance and make changes as needed. In an effort to address QII 7, DBHDS is holding focus groups with the CSBs; discussing enhancement with the Independent Reviewer's nursing consultants and DBHDS nurses; as well as planning an updated training with a pre and post-test and evaluation to determine any final adjustments to the training materials before posting online.

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

DBHDS reports that the ISP now includes all of the risk information, ending the requirement of SCs to produce risk identification and plans on paper. The ISP auto-populates the related sections of the ISP to integrate risk information and creates a printable summary of the identified risks to be shared with the individual's PCP and other health and behavioral professionals who serve the individual. The goal of the new version of the ISP is to increase the teams' consistency identifying risks and including the providers' plans to address these risks. The CMSC has focused on continued training and technical assistance to CSBs to define and communicate best practice related to the implementation of ISP Version 4.0. The report notes that CSBs have raised concern regarding the importance of balancing the dignity of risk with the CSB's duty of care (1).

Term 58: The CMSC reviews six PMIs. Four address community inclusion. PMI 3 addresses employment discussions with individuals who are 14-17 years old. PMI 5 addresses that individuals have outcomes for integrated community involvement (ICI). Two other PMIs, 18 and 19 address aspects of choice and self-determination to ensure individuals participate in an annual discussion with their Support Coordinator (SC) about relationships and interactions with people,

other than paid program staff (PMI 18); and to ensure individuals are given a choice among providers, including SCs, at least annually (PMI 19).

Two PMIs address health and safety. PMI 16 addresses that an individual's needs are assessed, and the ISP is modified as appropriate to reflect these needs. PMI 17 addresses that the ISP is appropriately implemented. PMIs 16,17,18 and 19 are monitored to determine compliance with Term 58. The annual results for FY25 are described in Table 2 below.

Data Process and Attestation

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

PI Terms and Actions Achievement and Status

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

Table 1
Achievement of PI Terms

Term	26th	27th
31. **Community Services Board Quality Review (SCQR).** The Commonwealth will work to achieve a goal that 86% of Community Services Board (CSB) records meet a minimum or 9 of the 10 elements assessed in the Case Management Quality Review.	**Deferred**	**Not Achieved**
58. **Case Management Steering Committee (CMSC) Measures.** The Case Management Steering Committee will continue to establish two indicators in each of the areas of health and safety and community integration associated with selected domains (safety and freedom from harm; physical, mental, and behavioral health and well-being; avoiding crises; community inclusion; choice and self-determination; stability; provider capacity; access to services) and based on its review of the data submitted from case management monitoring processes. The Commonwealth will work to achieve a goal of 86% compliance with the four indicators established by the CMSC. DBHDS will monitor data collected in these domains and determine if any intervention is needed. No Actions Required	**Deferred**	**Sustained Compliance**

Table 2
Terms and Related Actions

Term and Actions	Facts	Analysis/Conclusion	26th/27th
31. Community Services Board Quality Review (SCQR). The Commonwealth will work to achieve a goal that 86% of Community Services Board (CSB) records meet a minimum of 9 of the 10 elements assessed in the Case Management Quality Review.	The CMSC reports that in FY25 81% of the CSB records meet a minimum of 9 of the 10 elements assessed in the SCQR.	This is an improvement over FY24 at which time 72% of the CSB records met the Term requirement. The CMSC reports that the agreement between the CSB and the OCQI reviews are improving on most indicators and there have been no significant decreases in the level of agreement. Conclusion: This Term is not achieved since only 81% of the records met the minimum requirement.	Deferred **Not Achieved**
31. a) During its annual quality review cycle, starting January each year, DBHDS will require a quality improvement plan from any CSB that has two or more elements with substantial or moderate interrater reliability between the CSB SCQR and the DBHDS Office of Community Quality Improvement Review not achieving 60% compliance. DBHDS will provide information about which CSBs need this support in the SCQR Report.	DBHDS reports in the FY25 SCQR that the CMSC will request IPs for the four CSBs that had two indicators below 60% agreement with the findings of the look behind review. The data was recently released so the CSBs have yet to be notified.	Following a recommendation made by the Expert and Independent Reviewers in the 26th Review Period, the CMSC will report on the achievements of the four CSBs who were below 60% agreement on two or more indictors in the FY25 SCQR in the 28th review period. There are nine CSBs with IPs to improve the level of agreement scoring the SCQRs. DBHDS did not report on the specific efforts and progress of these nine CSBs to implement their IPs as was recommended in the 26th review period by the Independent Reviewer. DBHDS did report that seven of the CSBs are ready for removal from IP monitoring and the remaining two will be moved to intense monitoring status to include targeted technical assistance (20)	**Completed and Ongoing**
31. b) DBHDS will provide targeted technical assistance with identifying measurable outcomes to any CSB (i) whose records are not 86% compliant with including specific and	DBHDS provided TA to every CSB in preparation for the FY25 SCQR (7). These TA sessions were held between 2.21.25 and 3.19.25. Each TA session included a review of the changes to the ISP Version 4.0; the items that historically	DBHDS is revising its CMSC data report to include feedback as to whether all the topics required in a meaningful discussion are being included by the SC in the ISP meetings. This data will be specific to CSB and SC which should assist the CSB	**Completed and Ongoing**

measurable outcomes in Individual Support Plans (ISPs) or (ii) that does not demonstrate improvement with respect to including specific and measurable outcomes in ISPs (including evidence that employment goals have been discussed and developed, when applicable, throughout its quality review cycle).	did not meet substantial agreement between the CSBs and the DBHDS look behind; and a review of the elements of a meaningful employment discussion and how to develop outcomes to facilitate access to employment. The TA included an explanation and review of the two questions relevant to this Indicator in the SCQR which are Questions 28 (employment discussion) and Question 32 (employment outcomes). DBHDS report that CSB staff were able to discuss areas they struggle to achieve performance expectations and receive clarification of DBHDS' expectations.	through supervision, training and guidance to improve its performance.	
31. c) If the Commonwealth has not achieved the goal within one year of the date of this Order after taking the actions in Paragraphs 31(a) and 31(b), DBHDS will increase the threshold for requiring a quality improvement plan from a CSB as set out in Paragraph 31(a). DBHDS will provide information about which CSBs need this support in the SCQR Report.	Improvement plans will be requested from CSBs following the look behind when two or more indicators with substantial or moderate interrater reliability are below 60%. OPNS and OCQI have been collaborating on developing a process for targeted technical assistance until CSBs can reach 86%. The CMSC will review the final results. Two statewide calls are scheduled for October with CSBs to review the results. The CMSC plans to increase the threshold to two or more indicators below 75%.	The CMSC is currently implementing a QII related to the ten indicators. The QII is to improve the level of agreement on Indicator 10 from moderate to substantial agreement by 12.31.25. The percentage of agreement for Indicator 10 in the FY24 SCQR cycle was 76%. DBHDS has drafted changes to the On Site Visitation Tool (OSVT) to incorporate the Crisis Risk Assessment Tool and to enhance and clarify wording in the OSVT as part of this QII. The next step after the draft is reviewed by the CMSC is to update the training and guidance for Service Coordinators (20).	**In Progress Due:1/15/26**
31.d) If the Commonwealth has not achieved the goal within one year after taking the actions in Paragraph 31(c), DBHDS will conduct a root cause analysis and implement a Quality Improvement Initiative (QII) as determined appropriate by DBHDS.			**Not Yet Implemented Due: 1/15/27**

DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			
58. **Case Management Steering Committee (CMSC) Measures.** The Case Management Steering Committee will continue to establish two indicators in each of the areas of health and safety and community integration associated with selected domains (safety and freedom from harm; physical, mental, and behavioral health and well-being; avoiding crises; community inclusion; choice and self-determination; stability; provider capacity; access to services) and based on its review of the data submitted from case management monitoring processes. The Commonwealth will work to achieve a goal of 86% compliance with the four indicators established by the CMSC. DBHDS will monitor data collected in these domains and determine if any intervention is needed. No Actions Required	The CMSC monitors CSB performance through twenty measures that correlate with the SA. Six of these measures are identified as Performance Measure indicators (PMI). These include two indicators that address health and safety and two measures that address community integration that are established to meet the goal of PI 58. Two address health and safety. PMI 16 addresses that an individual's needs are assessed, and the ISP is modified as appropriate to reflect these needs. PMI 17 addresses that the ISP is appropriately implemented. Two other PMIs, 18 and 19 address aspects of choice and self-determination to meet the Term goal to establish two indicators in the area of community integration. PMI 18 requires individuals to participate in an annual discussion with their SC about relationships and interaction with people (other than staff). PMI 19 requires individuals to be given a choice of providers including the SC, at least annually. DBHDS uses the component of PMI 19 that requires choice of the SC as the second indicator to achieve compliance with the Term requirement for achieving community integration. The CMSC reports the FY25 result for PMIs 16 and 17 which address health and safety. Both PMIs were above	The CMSC continues to rigorously review the Commonwealth's achievements related to the indicators related to health and safety and to community involvement. The integrity of the data is regularly addressed by the CMSC as reported in the FY25 Q3 and Q4 report and previous reports. The CMSC accesses data from a variety of sources to guide all of the committee's efforts to ensure and improve quality. These sources include direct data supplied by CSBs, SCQR results, WaMS, and the CCS3. The CCS3 data system fully transitioned to the DBHDS Data Enterprise Warehouse 6.30.25 in an effort to improve data integrity. The CMSC will resume its Data Quality Process to ensure data reporting requirements are being met using the CCS3 for the next reporting period (1). The CMSC uses its compellation of data to recommend its QIIs and to make recommendations for technical assistance for CSBs. The CMSC commits to using a root cause analysis to identify any underlying causes of poor performance if case management targets are not met. Conclusion: This Term is achieved as a result of the Commonwealth achieving the Term's goal for the four PMIs that measure health and safety, PMIs 16 and 17; and community integration PMIs 18 and 19.	Deferred **Sustained Compliance**

	the expectation of 86%, reaching 94% for PMI 16 and 94% for PMI 17. The CMSC reports the FY25 results for PMIs 18 and 19 which address community integration (choice and self-determination). Both of the PMIs were above the expectation of 86%; reaching 95% for PMI 18 and 91% for PMI 19.	The rating for PI 58 was deferred in the 26th reporting period due to a lack of annual data. This PI was met as CI 47.1 in the 25th reporting period under the Settlement Agreement. As a result, DBHDS has achieved Sustained Compliance for PI 58.	

Recommendations: In the 28th and 29th review periods DBHDS should report on the status of these CSBs regarding any improvement in performance as a result of the TA and the implementation of the CSBs IPs for SCQR performance. This report should include a summary of the action steps and monitoring strategies that are included in IPs and the impact these actions have on improving performance.

Attachment A
Documents Reviewed

1. CMSC Report FY25 Q3 and Q4 Final 9.20.25
2. SCQR FY25 Final Report 10.14.25
3. CMSC Improvement Plan Updates: 4.15.25, .6.25, 6.9.25, 8.6.25, 9.9.25
4. CMSC Meeting Minutes: 4.14.25, 5.6.25, 6.9.25, 7.1.25,8.5.25
5. CMSC Work Group Updates: 4.15.25, 5.6.25, 6.9.25,7.1.25, 8.5.25, 9.9.25
6. CSB Indicators QMR Data Tracking
7. Email from Eric Williams 10.14.25
8. SCQR Early TA Materials
9. SCQR Work Group Minutes: 5.14.25, 6.10.25, 7.8.25
10. SCQR 2025 statewide summary calls
11. PMI Review
12. QII Toolkit FY25 SCQR
13. QSR Recommendations and responses
14. ICI Employment QII Data
15. Mackenzie response adequacy of supports
16. MH Psychotropics-CMSC 8.5.25
17. OPNS AND OCQI TA lists
18. CMSC Recommendations Letter to the DBHDS Commissioner 8.7.25
19. OSVT 10.17.25 draft for review
20. Email from Eric Williams 10.20.25

Submitted:
Kathryn du Pree MPS
November 13, 2025

APPENDIX B

Crisis and Behavioral Services

By

Kathryn du Pree, MPS
Joseph Marafito, MS

Crisis and Behavior Services Report
27th Review Period
Prepared for the Independent Reviewer

Introduction

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

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

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

Summary of REACH Services

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

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

This concern continues to be borne out reviewing the data submitted by DBHDS for FY25 Q4 and FY26 Q1. During these two quarters only 50% and 51% of crisis assessments took place in the community respectively. These most recent percentages are consistent with nearly six years of quarterly reports.

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

Date	Percentage
FY 2020 Q3	46%
FY 2020 Q4	41%
FY 2021 Q1	53%
FY 2021 Q2	34%
FY 2021 Q3	35%
FY 2021 Q4	42%
FY 2022 Q1	51%
FY 2022 Q2	36%
FY 2022 Q3	40%
FY 2022 Q4	36%
FY 2023 Q1	44%
FY 2023 Q2	49%
FY 2023 Q3	37%
FY 2023 Q4	40%
FY2024 Q1	46%
FY 2024 Q2	48%
FY2024 Q3	52%
FY2024 Q4	55%

FY2025 Q1	49%
FY2025 Q2	49%
FY2025 Q3	47%
FY2025 Q4	50%
FY26 Q1	51%

These quarterly percentages indicate that, over a six-year period, the Commonwealth has not increased in the percentage of children and adults who receive crisis assessments at home or other community locations. Far too many children and adults continue to be assessed for a crisis at CSB Emergency Departments or hospitals which leads to the predictable higher rate of hospitalizations compared to the rate of hospitalizations for those individuals who receive a crisis assessment in a community setting. The results of these assessments strongly support the Independent Reviewer's and Expert Reviewer's contention that it is essential to provide these assessments in the community including the individual's home setting because it is far more likely that the individual will retain this setting and not be hospitalized. It is important to note that there are persistent and substantial performance variations in the percentages between Regions. For example, Region 1 had as few as 19% of crisis assessments conducted in community settings in the fourth quarter of FY 25, whereas Region 2 had 65% during this same quarter.

Table 2: Crisis Assessments Conducted In Community Settings

Date	**Average % assessed in community setting**	**Range**	
FY 25 Q4	50%	Region 1- 19%	Region 2- 65%
FY 26 Q1	51%	Regions 3,5 - 42%	Regions 2 -54%

During FY25 Q4 and FY26 Q1 the outcomes for individuals who received a crisis assessment in the community were that approximately 83% of individuals assessed for a crisis in the community retained their setting, compared to 52% across the two quarters, who were able to retain their setting after a crisis assessment that occurred in a hospital, or CSB ED. These data are depicted in Tables 3 and 4 below.

Table 3: Results of Crisis Assessments Conducted in Community Locations

Crisis Assessments Conducted in Community Locations				
Time	**Remain Home**	**CTH/CSU**	**Other**	**Hospitalized**
FY25 Q4	83%	5.5%	5%	6%
FY26 Q1	82%	4%	7%	7%

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

Crisis Assessments Conducted in Hospitals or CSB EDs				
Time	**Remain Home**	**CTH/CSU**	**Other**	**Hospitalized**
FY25 Q4	55%	5%	9%	31%
FY26 Q1	49%	6%	17%	28%

The Expert Reviewer reviewed the Quarterly REACH reports (4,5,6,7) to determine the status of the Commonwealth's implementation of the systemic changes needed to resolve the obstacles that have previously slowed progress toward achieving compliance with the Terms of the PI. While many aspects of the REACH program are no longer directly related to the specified goals of the PI Terms, the REACH program in totality impacts the location of crisis assessments, the prevention of hospitalization, and ultimately the reduction of behavioral and mental health crises. DBHDS continues to report and track all aspects of crisis assessment and services performed by the regional REACH programs. Regions continue to meet DBHDS's overall expectations for timely response to crises. While all REACH programs continue to use telehealth to some extent, only Region 1 used it extensively, and has significantly reduced its reliance on telehealth responses to crisis calls in FY26 Q1 when the Region responded to 26 (87%) of its 30 crisis assessments face-to-face. All of the other Regions are over 90% of their crisis responses being made face-to-face.

The Children's and Adult CTH programs were underutilized during both quarters. There are staff vacancies in these programs as described later in this report, but the percentages of vacancies in the Adult CTH (28%) and Youth CTH (41%) only partially explain the overall low percentage of utilization since not all bed days were utilized. These vacancy rates are an increase from the vacancy rates reported in the 26th reporting period: 16% and 12% respectively. DBHDS reports no waiting lists for CTH admission, with the exception of one person who waited in Region 5 in FY26 Q1, but a high number of individuals are still hospitalized after a crisis assessment who might have been able to be stabilized at a CTH if the program was fully available.

The utilization for the YCTHs was 33% and 25% for the Region 2 YCTH, and 21% and 19% for the Region 4 YCTH over the two quarters. Overall utilization decreased for the Children's CTHs. The utilization for the Adult CTHs range from 10-75% in FY25 Q4 and 26-58% in FY26 Q1. Only sixty-one adults used the CTH program in the 27th reporting period, ranging from a low of three adults in Region 3 to twenty-seven adults in Region 2.

Region 1 is constructing a new CTH that will replace its existing CTH to improve access for individuals and families. This site is more centrally located and near the interstate highway system. Region 5 has been allocated funding for a new CTH as well.

The DBHDS REACH teams continue to provide prevention and mobile crisis services. The outcome is that almost all recipients of these services retain their residential setting after

participating in other prevention or mobile crisis services. DBHDS reports the preference of people for only a Mobile Crisis Response (MCR) combined with the ability of staff to help deescalate the individual during the MCR process, which has resulted in decreased use and reliance on the CTH program. Although DBHDS reports this preference of families to use MCR services, it remains concerning that the CTHs are underutilized when a significant number of individuals with DD are hospitalized as the result of a crisis and the subsequent assessment.

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

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

The REACH programs continue to experience significant staffing shortages. Vacancies in the community programs range from 29% for supervisory/clinical positions to 40 % for mobile crisis support workers. The Children and Adult CTH programs experience vacancies as well. The Youth CTH programs overall have 29% of the positions vacant. The Adult CTH and the Adult Transition Homes (ATH) have fewer vacancies, 28% and 11% respectively. Not only do there continue to be significant vacancies in the two CTH programs, but the CTH staffing has been reduced as evidenced by the Staffing Reports for each Region for FY26 Q1 which are now included in the REACH Quarterly reports, rather than in separate reports that were shared for previous studies.

These programs should all be fully utilized to prevent unnecessary or prolonged hospitalizations and are not currently being utilized to their full capacities. It is concerning

that the number of staff positions have been reduced. DBHDS reported when asked that each Region is heavily recruiting and there is no intent to reduce positions (24). However, the comparison below, with which DBHDS concurred, indicates the number of positions have been decreased.

Table 5: CTH and ATH Staffing Changes in FY26 Q1

Time Reported	ACTH	YCTH	ATH
FY25 Q3	87	43	39
FY26 Q1	77	31	27
Total Change	-10	-12	-12
Percentage Change	11%	28%	31%

DBHDS reported in the 26th review period that each REACH Team has additional mobile crisis response staff, Behavioral Health Licensed (BHL) Services staff. These positions were established and funded through the Governor's Right Help Right Now (RHRN) initiative to increase and improve the Commonwealth's response to individuals who experience mental health crises. These staff are trained in the MCR curriculum and provide backup to REACH staff to respond to crises by conducting crisis assessments. DBHDS does not review the status of these positions during the quarterly qualitative reviews that occur with REACH programs, but the data is included in Table 6 as this program and associated staff increase the crisis response in each Region.

The number of staff associated with the REACH programs varies, in some areas significantly across the Regions. The differences do not seem to be explained by the population sizes of the Regions. Region 4 has by far the most administrative and clinical positions even though its population may not be dissimilar to Region 2. Region 2 has by far the most non-administrative Q positions. The number of MCR staff are more similar in this reporting period than in the 26th reporting period. The fact that the staffing continues to vary for the CTH programs is particularly curious since each CTH has the same bed capacity, and the ability to serve six individuals at one time.

DBHDS is now required to review, analyze and monitor the staffing of each Region and the impact of vacancies on meeting the specified goals for completing crisis assessments in community settings. I reiterate the recommendation I made in the 26th reporting period that it is important for DBHDS to determine if these differences in the number of staff, the type of positions each Region uses, and the number of vacancies impacts the REACH Teams' performance, especially in their ability to conduct assessments in the home/community, provide mobile supports, and utilize the CTHs as a last resort options to avoid hospitalization. An example of my concern is that four of the five regions fully met the REACH quality standard for the MCR, and one Region partially met the standard. Yet, MCR staff overall have a current vacancy rate of 40%, which is as high as 66% in Region 3 and 67% in Region 1. The reason for this is explained further in Table 9. It appears that this high number and percentage of vacancies will impact these Regions' ability to provide timely crisis support which should be available to stabilize an individual's home situation and prevent the individual's hospitalization.

The following Tables depict the data.

Table 6: FY26 Q1 REACH Staffing Data for REACH Crisis Teams

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Administrators	3	5	10	25	6	**49**
Clinicians: Licensed and License eligible	2	13	20	23	19	**77**
Nurses	1	11	6	11	6	**35**
Nonadministrative Qs	21	67	16	31	24	**159**
Hospital Liaison	1	1	2	2	1	**7**
Filled	11	78	25	75	42	**231**
Vacant	17	19	29	17	14	**96**
Total	28	97	54	92	56	**327**
Percent Vacant	61%	20%	54%	23%	25%	**29%**
Mobile Filled	11	30	12	23	24	**100**
Mobile Vacant	22	5	23	12	6	**68**
Total	33	35	35	35	30	**168**
Percent Vacant	67%	6%	66%	34%	20%	**40%**
BHL Filled	53	22	28	49	26	**178**
BHL vacant	23	13	6	4	6	**52**
Total	76	35	34	53	32	**230**
Percent Vacant	30%	37%	18%	7%	19%	**23%**

Table 7: FY26 Q1 REACH Staffing Analysis for REACH CTH and ATH Settings

Position	**RI**	**RII**	**RIII**	**RIV**	**RV**	**Total**
Adult CTH filled	13	11	11	10	6	**51**
Adult CTH vacant	2	3	9	1	5	**20**
Total	15	14	20	11	11	**71**
Percent Vacant	13%	21%	45%	9%	45%	**28%**
Youth CTH filled		13		9		**22**
Youth CTH vacant		0		9		**9**
Total		13		18		**31**
Percent Vacant		0%		50%		**29%**
ATH Filled		12		12		**24**
ATH Vacant		0		3		**3**
Total		12		15		**27**
Percentage Vacant		0%		20%		**11%**

Summary of Findings

Four PI Terms were reviewed in the 27th review period. The Commonwealth did not meet any of these Terms in this period.

PI Term 32 which requires the Commonwealth to perform 86% of the crisis assessments in community settings was not accomplished because only 1,079 (50%) of the 2,140 crisis assessments completed in the reporting period were conducted in the community. This includes far more crisis assessments than were performed in the 26th reporting period when 1,317 individuals with DD were assessed for a crisis, and 626 (47.5%) of them were assessed in the community.

PI Term 33 which requires the Commonwealth to connect individuals with DD who need behavioral services, defined as Therapeutic Consultation (TC), with a provider within thirty days of the need being identified in the ISP, was not accomplished because only 1,152 (78%) of the 1,483 individuals who needed TC were referred and connected to a provider within thirty days. This is an increase in performance compared to the 26th reporting period when 73% of individuals had this connection within thirty days. Of the 331 individuals who were not connected within thirty days, 140 were eventually connected, leaving 191 individuals were not connected to a TC provider within the reporting period. DBHDS is addressing all of the actions associated with this PI Term.

PI Term 35 which requires the Commonwealth to identify a community residence for individuals with DD within thirty days of their admission to a CTH or psychiatric hospital was not achieved because only 333 (82%) of the 406 individuals admitted to a CTH or psychiatric hospital had a residence identified within thirty days. This percentage of timely referrals is a decrease compared to the previous reporting period when the Commonwealth achieved 85% of individuals referred to a community setting within thirty days of their admission to a CTH or psychiatric hospital. DBHDS has selected five new providers to develop additional residential settings for individuals with intense behavioral needs. These homes are in various stages of development. When all of the new homes are operational DBHDS will have increased its beds for this population by 45, from 36 to 81 beds. The RFP for the initial 36 beds was issued in FY18, and the subsequent RFP for the additional 45 beds was issued in FY24.

DBHDS continues to report the existing homes have not been fully utilized in this reporting period, although there was an increase from 33 beds to 49 beds utilized in the 27th period compared to the utilization in the 26th period. DBHDS took action to increase awareness of these resources for adults with intense behavioral needs in the 26th reporting period. These actions include: sending an update to CSB DD Directors; creating an internal dashboard with utilization and contact information for DBHDS Developmental Services staff; scheduling meet and greets with REACH CTH staff and the residential providers; sharing information with hospital social workers; and sharing the information with other community stakeholders. DBHDS reported further actions it took the 27th reporting period. These include follow up to address licensing issues to open the home in Region 1; monitoring the provider's performance that is delaying the opening of the home in Region 3; and increasing the awareness of hospital, REACH and CSB SC staff of the availability of these homes.

PI 36 which requires the Commonwealth to fund and develop three new CTHs for youth (YCTH) in Regions 1,3, and 5, was not achieved. DBHDS has funded the three additional YCTHs. The home for Region 1 will be physically located in Region 2. Region 5 has approved the contract for the home being developed in its Region and is reviewing the design and seeking site approval. Regions 2 is reviewing, and Region 3 has finalized its performance agreements for the homes to be developed in their respective Regions. DBHDS expects the three new CTHs to break ground by December 2025. Region 3 broke ground for the new Children's CTH in September 2025, the only Region of the three to break ground as of this report.

DBHDS is not implementing all required actions that relate to this PI Term. Six children used the two existing YCTHs for preventive respite during this reporting period, but DBHDS does not report the number of children who used the YCTH for prevention specific to Region. The Respite funds have been approved and were available to families in Regions 1, 3, and 5 beginning in May 2025. However these funds were not used by any family in the 27th reporting period.

DBHDS is not implementing all of the expected actions as described in the Table below. Table 8 summarizes the findings for the PI Terms and Table 9 summarizes the facts and conclusions for the review of these Terms.

All processes and attestations have been verified in previous studies. DBHDS submitted a revised process: Crisis Assessment In Community – PI 32 DS – CSS (Version 004) in the 27th review period.

The Reviewer reviewed this Process Document and found it to be sufficient in all areas. The Version submitted for review was updated on 6.17.25 by Sharon Bonaventura. In addition, a Data Set Attestation Form was submitted and signed on 10.2.25, by the Chief Data Officer. The Chief Data Officer determined that the data is currently considered valid and reliable.

The Recommendation Mitigation and Timeline section of this version was clear and thorough. The revised process described in detail the system improvements that have been made as of June 2025 in response all actionable recommendations made by the Office of Clinical Quality Management (OCQM) review on 2.8.24. Based on the findings, system enhancements have been made that will reduce duplicate records, improve data entry accuracy and strengthen reporting functionality.

Three areas have been completed to date (key documentation updates, staff training and interim data validation processes) while the remainder of the refinements are pending vendor implementation. Additionally, the Data Set Attestation Form verified that the data set validation was performed using the Power BI dashboard that was created for this validation process.

Table 7
Status of Meeting the Goals of the PI Terms

Term	26th	27th
32. **Community Setting Crisis Assessments.** The Commonwealth will work to achieve a goal that 86% of children and adults receive crisis assessments at home, the residential setting, or other community setting (non-hospital/non-CSB office). Crisis Receiving Centers ("CRC") will only be counted as an "other community setting" after it is determined that the individual or supported decision maker was not directed by the Call Center, Emergency Services, or Mobile Crisis staff to present at a CRC.	**Not Achieved**	**Not Achieved**
33. **Therapeutic Consultation Services.** The Commonwealth will work to achieve a goal that 86% of individuals identified as in need of Therapeutic Consultation service are referred for the service and have a provider identified within 30 days.	**Not Achieved**	**Not Achieved**
35. **Community Residences for Individuals with DD Waivers.** The Commonwealth will work to achieve a goal of 86% of individuals with a DD waiver and known to the REACH system who are admitted to a CTH, or a psychiatric hospital have a community residence identified within 30 days of admission	**Not Achieved**	**Not Achieved**
36. **Out-Of-Home Crisis Therapeutic Prevention Host-Home Like Services for Children.** To prevent institutionalization of children due to behavioral or mental health crises, the Commonwealth will implement out-of-home crisis therapeutic prevention host-home-like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service.	**Not Achieved**	**Not Achieved**

Table 8
Terms and Related Actions

Term and Actions	Facts	Analysis/Conclusion	26th/27th
32. **Community Setting Crisis Assessments.** The Commonwealth will work to achieve a goal that 86% of children and adults receive crisis assessments at home, the residential setting, or other community setting (non-hospital/non-CSB office). Crisis Receiving Centers ("CRC") will only be counted as an " other community setting " after it is determined that the individual or supported decision maker was not directed by the Call Center, Emergency Services, or Mobile Crisis staff to present at a CRC. To achieve that goal, the Commonwealth will take the following actions:	DBHDS reports the data separately for FY25 Q4 and FY26 Q1. In FY25 Q4 only 50% of all crisis assessments were conducted in a community setting. The percentages across Regions ranged from a low of 21% in Region 1 to a high of 65% in Region 2. In FY26 Q1 only 51% of all crisis assessments were conducted in a community setting The percentages across Regions ranged from a low of 41% in Region 1 to a high of 61% in Region 2. The total number of individuals with DD who were assessed for a crisis in this reporting period was 2,140 of whom 1,079 (50%) were assessed in community settings.	The Commonwealth continues to significantly underperform in the area of conducting crisis assessments in the community and has shown no significant improvement over nearly six years. Region 1 remains the Region with the lowest percentage of crisis assessments completed in community locations, although it has improved its performance compared to the 26th reporting period. Region 1 also assesses the fewest individuals for crisis. In this reporting period Region 1 conducted a total of 86 crisis assessments. The other four Regions range from a total of 399 – 586 crisis assessments over FY25 Q4 and FY26Q1. Statewide far more crisis assessments were conducted in the 27th reporting period (2,14) than in the 26th reporting period when 1,317 individuals were assessed for a crisis. Conclusion: The Commonwealth did not achieve this term because only 50% of individuals with DD who experienced a crisis and were assessed received their assessment in a community setting.	Not Achieved **Not Achieved**
32. a) DBHDS will continue to promote the use of the 988 24-hour crisis helpline by providing information on the helpline on its social media platforms, in print and television advertisements, and through informational	DBHDS reported that it was implementing a 988 media campaign and that its Web Page includes Mobile Crisis Response (MCR) training for providers in the 26th reporting period. DBHDS submitted a work plan in the 27th review period to improve		**In Progress**

bulletins developed or funded by DBHDS. DBHDS will require all mobile crisis team members to receive training within 90 days of hire on how to support and respond to individuals with developmental disabilities (DD) who are in crisis.	the accessibility of 988 services to allow them to better support individuals with DD or cognitive challenges. The work plan addresses developing a proposal for training delivery, identifying a vendor and working with the selected vendor to complete an outline for 988 staff training that emphasizes the needs of individuals with DD and other to challenges. These actions have not yet been initiated but the responsible staff have been identified (10). DBHDS shared an outline for standardized REACH program training for "boots on the ground" staff. All of the plan steps were completed by 9.30.25. The FY26 training schedule is due 10.31.25 (10).		
32. b) DBHDS will maintain its current efforts to assist the regions in filling vacant mobile crisis positions by discussing staffing at regional qualitative reviews of REACH programs and supporting REACH programs to implement quality improvement plans.	To help regions fill vacant REACH positions, DBHDS has updated the roles and responsibilities of REACH staff to coincide with changes made in the crisis system that are related to the REACH program functions and the overall focus on an inclusive crisis system. DBHDS reports it will maintain its current efforts to assist the Regions to fill vacant mobile crisis positions. DBHDS does review staffing with each Region in its Quarterly Qualitative Reviews (2,3).	DBHDS reports its plan to enhance staff competency through training. DBHDS is in the process of selecting and contracting with a vendor to develop training for MCR staff and DD service providers by February 2026 (11). The Regions now have more similarity in the number of staff assigned to MCR functions. Region 1 increased its number of MCR positions from 22 to 30 in the 27th reporting period (4,5,6,7). With the exception of Region 2 which remains with only a 6% vacancy rate for MCR, the Regions continue to experience high vacancy rates for MCR staff. Region 5's vacancy rate remains the same at 20% comparing the 26th	**In Progress**

		and 27th review periods. Region's 1 and 4 have increased the percentage of vacancies, 35% and 8% respectively, but Region 1 also added eight positions. Region 3 decreased its rate of vacancies, but its vacancy rate remains very high at 66%, decreased from 71% of positions vacant in the 26th reporting period.	
32. c) Within 6 months of the date of this Order, the Commonwealth will develop a plan that includes measurable goals, specific support activities, and timelines for implementation with consultation from stakeholders to enhance 988 supports and services to increase the likelihood that individuals will be assessed in the community.	See 32.a)	The Plan has very specific actions that should assist DBHDS to achieve Term 32. The Plan should more clearly state measurable goals in order to evaluate the impact and success of various actions included in the Plan.	**Completed and Ongoing**
32.d) From the date of this Order, DBHDS will monitor staffing at each REACH program to determine if they have sufficient staffing per shift to meet the goal, including through discussion and review of filled/vacant positions, utilization rates of mobile crisis, and times mobile crisis calls are being received in comparison to the number of staff working during those hours at each REACH program's quarterly review. If a	DBHDS did review staffing issues with each REACH team though its quarterly quality reviews, with a particular focus on staffing discussions in FY26 Q1. These discussions addressed both recruitment and retention.	DBHDS determined that while staffing is a challenge across the Regions, most Regions are using their full complement of staff including supervisors to ensure that the basic functions of mobile crisis response and follow up services are provided. Regions 1 and 3 each have a significant number of staff vacancies for their MCR. Region 1 is not fully meeting the staffing standards. DBHDS determined Region 3 continues to respond to crises in person and is successfully using supervisors and clinicians to assist responding to crises. Region 4 is using prevention staff to assist the MCR team to respond to	**In Progress**

quarterly review indicates that staffing is not sufficient to meet the goal, DBHDS shall review the region's current efforts to increase staffing and, if DBHDS determines necessary, will require a quality improvement plan that includes additional actions that DBHDS finds are necessary to enhance staffing. The Independent Reviewer, in the reports required under Paragraph 76, shall include a determination in his report on the adequacy of the Programs and Virginia's response to this requirement.		crises, thereby continuing to meet minimum coverage standards. Region 2 uses supervisory staff to meet its crisis response obligations and Region 5 remains in compliance with staffing standards. (10).	
32.e) Semi-annually, beginning on January 1 and June 1 of each year, DBHDS will work with the two regions that are experiencing the most success in responding to people in crisis in the community to determine what is leading to their success. DBHDS will work with the two regions that are experiencing the most challenges in responding to people in crisis in the community to learn what is leading to those challenges. DBHDS will work with all the regions based on these lessons	DBHDS reported that the Crisis Assessment (CA) Plan was developed on 4.13.25. The DBHDS Regional Crisis Managers met with REACH staff to identify both promising practices and barriers to achieving the performance expectation that 86% of crisis assessments will be conducted in community settings. Based on its review of the data, the group identified Regions 3 and 5 as the two regions experiencing the most success, with lessons to also learn from Region 2 where performance is trending more positively. DBHDS identified Regions 1 and 4 as	There is not a specific update about DBHDS working with Regions 1 and 4 to implement improvement strategies based on the performance and practices in Regions 3 and 5. In the 27th review period, Regions 3 and actually had higher percentages of individuals with DD, 54% and 52% respectively, assessed in hospital or CSB ED settings than did Regions 2 and 4, 37% and 45% respectively.	**In Progress**

learned to implement a plan to improve performance in each of the regions.	needing TA in the 26th reporting period. The group discussed a number of relevant questions to specifically identify effective strategies and impediments. The Regional Crisis Managers group decided to focus on training for CSB managerial staff, community service providers, health and clinical practionners, and law enforcement officers. They also identified additional actions that will be implemented. DBHDS provided an update to the plan for the 27th reporting period. The majority of actions due during the 27th reporting period have been completed (12).		
32.f) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 32(a) through 32(e), DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. As part of the root cause analysis, the Commonwealth will collect data on why individuals with developmental disabilities presented at a CRC instead of accessing mobile crisis services. DBHDS will continue this quality improvement process			**Not Yet Implemented Due: 1/15/27**

until the goal is achieved and sustained for one year.			
33. **Therapeutic Consultation Services.** The Commonwealth will work to achieve a goal that 86% of individuals identified as in need of Therapeutic Consultation service are referred for the service and have a provider identified within 30 days. To achieve that goal, the Commonwealth will take the following actions:	DBHDS reports the number of individuals who needed therapeutic consultation (TC) who were connected to this service within thirty days; how many were not connected within thirty days; and the overall percentage of individuals connected to a provider within thirty days for the period January 1-June 30, 2025. In this time period, 1,152 (78%) of the 1,483 individuals needing TC were connected to a provider within thirty days. Of these individuals, 331 (22%) were not connected to a TC provider within thirty days. DBHDS further reports that of the 1,428 individuals with authorizations for TC, a total of 1,292 (87%) received TC, and 191 (13%) did not receive TC between January and June 2025 (1).	This percentage (78%) is an increase from the previous reporting period, when 73% of individuals who needed TC were connected to a provider within thirty days. DBHDS provides data by region. It's report also includes data as to the average number of days to connect the individuals who were not connected in thirty days but were eventually connected to a TC provider. This ranges by month from a low of 50 days on average in April and June 2025 to a high of 69 days on average in December 2024. The data indicates that 191 of the 331 who were not connected to a TC provider within thirty days were not connected at all during the reporting period, and that 140 of these individuals were connected to a provider, but not within the expected thirty days. DBHDS conducted a root cause analysis and determined the performance of the SCs is key to improving the performance for connecting individuals to TC, since it is the SC who is responsible to facilitate this connection. To address the SCs role and improve the timeliness of the connections to TC providers, DBHDS has focused on training; task clarification and prompting; improving resources, materials and processes; and addressing performance consequences, effort and competition. DBHDS has continued	Not Achieved **Not Achieved**

		improvement efforts in the 27th reporting period. These actions are described under 33.a. below (1). Conclusion: The Commonwealth did not achieve this Term's 86% specified goal, because DBHDS reported that 78% of individuals with DD who had a need for TC were connected to a provider within 30 days of the need being identified.	
33. a) Within 12 months of the date of this Order, DBHDS shall implement a technical assistance initiative with the CSBs that need the most support to connect people to behavioral supports and focus on improving case managers' awareness of the behavioral resources available to individuals in need of Therapeutic Consultation, unique CSB business practices, and supervisory support for case managers in this area of performance.	While this action is not due until January 2026, DBHDS has already implemented improvement initiatives. DBHDS has identified the eight CSBs that it determined to be in the most need of TA, based on its review of their performance. DBHDS is providing training to the eight CSBs and offering TA. (14).		**Completed and Ongoing**
33 b) Annually, the Commonwealth will participate in at least one regional event and at least one statewide conference to promote Therapeutic Consultation services. The Commonwealth will provide technical assistance to providers regarding enrollment with Medicaid as a	DBHDS attended the Annual Conference for Behavior Analysts in April 2025. DBHDS also participated in Regional Round Tables in July 2025 and October 2025. The Behavior Network Supports hosts an exhibit booth to provide information on enrollment as a Medicaid provider for TC.		**Completed and Ongoing**

provider as they reach out to the Commonwealth for this support.	In the 27th review period DBHDS provided TA to fifteen TC providers to assist them to enroll as Medicaid providers (16).		
33.c) By July 1, 2025, the Commonwealth will create a training about enrolling with Medicaid as a Therapeutic Consultation provider and make it available for providers via DBHDS' s website.	As reported in the 26th reporting period, DBHDS has completed a three part training series and developed written instructions for providers to enroll in Medicaid and navigate the provider requirements. The training includes: Becoming a TC Provider; Getting Started; and Regulations and Guidelines. Training videos, slide decks and TA for completing task analysis continue to be available on the DBHDS Behavioral Services Web Page (16).		**Completed**
33.d) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Therapeutic Consultation by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate	The Commonwealth under the leadership of the Department for Medical Assistant Services (DMAS) has contracted with Guidehouse to conduct the rate study. DMAS has created a DD Rate Work Group that convened 12.12.24 for the first of a series of monthly meetings. The Work Group includes representatives of providers, advocates and industry associations. Guidehouse conducted a rate study for services in the three DD 1915 c waivers, the CCC Plus Waiver and State Plan services including Therapeutic Consultation (17,18). Guidehouse issued a draft report in July 2025 which suggests rate		**Completed and Ongoing**

study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Therapeutic Consultation by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.	increases for all of the services that they were directed to study and analyze, with the goal of recommending rates that would assure sufficient capacity. The rate study includes direct, indirect, and administrative costs and adjusts for differences in costs in Northern Virginia compared to the rest of the Commonwealth (17,18). The United States has identified concerns and asked questions about Guidehouse's draft report. The focus of DOJ's concerns questioned whether the completed rate study fulfills the PI requirements to design the study to ensure sufficient provider capacity to achieve the specified goal of this and the other identified Terms (7). The final report responded to each of DOJ's stated concerns (20). On 10.15.25 the Commonwealth's Director of DMAS submitted the DD Waiver Rate Study report to Governor Youngkin, the Chairs of the House and Senate Appropriation Committees and Virginia's Department of Planning and Budget (23). The Governor's proposed FY27 budget will be the next Commonwealth effort to obtain from the General		

	Assembly funding necessary to increase rates to those recommended by the study. (17,18).		
33. e) If the Commonwealth has not achieved the goal by June 30, 2026 after taking the actions in Paragraphs 33(a) through 33(c), DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Not Yet Implemented Due:7/15/26**
35. Community Residences for Individuals with DD Waivers. The Commonwealth will work to achieve a goal of 86% of individuals with a DD waiver and known to the REACH system who are admitted to a CTH, or a psychiatric hospital have a community residence identified within 30 days of admission. To achieve that goal, the Commonwealth will take the following actions:	DBHDS reports separately for FY25 Q4 and FY26 Q1, detailing that 76% in Q4 and 89% in Q1 of all individuals with a DD waiver and known to the REACH system who were admitted to either a CTH or a psychiatric hospital have a community residence identified in 30 days of their admission. Regions vary in performance with Region 5 the lowest performer (43%) in FY25Q4. Region 2 surpassed the expected level of performance in FY26 Q1 with a percentage of 93%. The total number of individuals reported who were admitted to either a	DBHDS had demonstrated continued improvement to meet this requirement through the 26th reporting period. While DBHDS continues to exceed the performance expectations for the past three years connecting CTH participants to community residences, it has now demonstrated a decrease it its overall performance (82%) comparing the 26th review period when DBHDS achieved an 85% performance rating to this reporting period. DBHDS is taking actions it believes will improve the Commonwealth's performance to achieve this PI. These actions include timely involvement of REACH staff in hospital discharge planning and a review of the customized rate process to assist providers to receive authorization for	Not Achieved **Not Achieved**

	CTH or a psychiatric hospital in the full reporting period (FY25 Q4 and FY26 Q1) was 406. Of these individuals 333 (82%) had a residence identified within 30 days of their admission (2,3).	additional staffing to support an individual in the community after a hospital discharge. Conclusion: The Commonwealth did not achieve this Term because the Commonwealth did not meet the performance expectation in the reporting period, only identifying a community residence within 30 days for 82% of the individuals known to REACH who were admitted to either a CTH or a psychiatric hospital.	
35. a) DBHDS will enter into contracts with providers to develop homes for individuals with intense behavioral support needs that will be operational (*i.e.*, that an individual can move into the home) in accordance with the following schedule:	DBHDS began to address the need to increase the number of providers who offered residences to support individuals with intense behavioral support needs with an RFP issued in FY18. Since then, DBHDS continued to add providers, resulting in the development of residences with 36 beds. In the 27th reporting period, 23 of these beds were filled, compared to 27 beds that were filled in the 26th reporting period. To comply with this requirement of the PI, DBHDS issued another RFP in FY24, selecting five new providers to develop 45 new beds. These new residences are at different stages of development as noted below. Of the 45 new beds, 26 are filled currently, compared to 19 beds filled in the 26th review period. When all of the new residences are operational, the Commonwealth will have 85 beds in residences to support individuals with intense need for	The Commonwealth has determined that more residences are needed for individuals with intensive behavioral needs, yet the existing homes are not fully utilized, nor have they been in previous reporting periods. There was an increase between the 26th and 27th review periods when bed use increased from 42 to 49 beds. DBHDS has not provided an analysis of why there is an increased use of these beds but still low utilization (58%).	**In Progress**

	behavioral supports. Currently 49 (58%) of the total number of beds to support individuals with intense behavioral needs are being utilized (2,3).		
35.a) i. Region 1: one home operational by August 2024 and one additional home operational by February 2025;	Region 1 is adding two new homes. One is operational. The second home has been purchased and is still reported as pending licensing, which was the same status DBHDS reported in the 26th review period.		**In Progress**
35.a) ii Region 2: two homes operational by August 2024 and one additional home operational by February 2025;	Region 2 has six new homes operational. This is two more home than was anticipated.		**Completed**
35.a) iii. Region 3: one home operational by November 2024 and one additional home operational by February 2025;	Region 3 had opened one new home in February 2025. The second home is still not yet licensed.		**In Progress**
35.a) iv. Region 5: one home operational by November 2024 and two additional homes operational by February 2025.	Region 5 has three new homes operational.		**Completed**
35.b) If the Commonwealth has not achieved the goal after taking the actions in Paragraph 35(a) by June 30, 2025, DBHDS will conduct a root cause analysis and implement a QII as determined	DBHDS reports that its staff conducted a Gap and Root Cause Analysis (RCA) in July 2023. This RCA continues to guide the QII of DBHDS. For the 27th review period DBHDS reports it continues to address bottlenecks regarding streamlining and	DBHDS has continued actions and activities to improve the timeliness of identifying community residences for individuals with DD within thirty days of their admission to a CTH or psychiatric hospital. DBHDS continues to meet or exceed the performance expectation for individuals using the CTHs	**In Progress**

appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	approving providers' requests for customized rate approvals. REACH Managers continue to engage providers, families and the Service Coordinators during discharge meetings, starting the discharge process at the time of the individual's admission. DBHDS discusses the barriers to timely discharge for those in a CTH at the REACH Quarterly Quality Reviews.	but not for individuals being discharged from a psychiatric hospitals. DBHDS reports actions it plans to take in the 28th reporting period which include reviewing barriers and strategies with the providers operating these homes to utilize beds; ensure hospital discharge staff are aware of the contact information for all of the residential providers; work with REACH staff to promote referrals to these homes from CTH and ATH settings; and increase the awareness of these homes among Service Coordinators. DBHDS has reported that it has not updated its root cause analysis and that its QII for PI 35 is informal.	
36. **Out-Of-Home Crisis Therapeutic Prevention Host-Home Like Services for Children.** To prevent institutionalization of children due to behavioral or mental health crises, the Commonwealth will implement out-of-home crisis therapeutic prevention host-home-like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service by:	DBHDS reports the status of its plans to establish and operate YCTHs in the three Regions, that do not currently have a YCTH. The YCTH to serve Region 1 will physically be located in Region 2. None of the homes are operational. Since the 26th reporting period the Regions have finalized the performance in Region 3 and finalization is underway in Region 2. Region 5 closed on a property in March 2025 but is still conducting the site review. DBHDS anticipated that all three CTHs would be under construction by December 2025. As of October, only Region 3 has broken ground.	DBHDS continues to make progress, but it is not certain that all of the YCTHs will break ground by December 2025 or be operational by May 2026 as anticipated. Conclusion: The Commonwealth has not achieved this Term as none of the new YCTHs are available for children with DD to use for prevention or stabilization after a crisis.	Not Achieved **Not Achieved**

36.a) Within one month of the date of this Order, DBHDS will send out a communication through the list serv for individuals and families on the waiver waiting list, and to the provider list serv communicating that the two CTHs existing in Regions 1 and 4 as of the date of this Order can be utilized for preventive stays by children across the Commonwealth.	DBHDS sent out communication regarding prevention admissions at YCTHs on 2.4.25 (21,22).	DBHDS fulfilled this required action prior to the due date of 2.15.25	**Completed**
36.b) DBHDS will continue to track and report quarterly on the number of crisis prevention stays being utilized by children in each of the five regions.	DBHDS reports that 4 children in FY25 Q4 and 2 children in FY26 Q1 used the CTH in Region II for prevention. No children in either quarter used the CTH in Region IV for prevention (4,5). DBHDS did report for each Region how many children used one of the YCTHs: Region 1-5 Region 2- 22 Region 3- 5 Region 4- 31 Region 5-0	DBHDS does not report which Regions used the YCTHs for prevention as the Action requires.	**Completed and Ongoing**
36.c) Providing funding in Fiscal Year 2025 to establish three additional CTH's in the regions where they do not exist as of the date of this Order (Regions 2, 3, and 5) that will be operational between May 2025 and January 2026.	DBHDS is committed to increasing YCTHs to have one located in all five Regions to support crisis prevention admissions. These three new YCTHs are part of the Governor's RHRN initiative to expand short term crisis services (5). Funding is authorized in each contract as was reported in the 26th review period.		**Completed**

36.d) From the date of this Order and continuing until all three additional CTHs referenced in Paragraph 36(c) are operational, DBHDS will support up to a total of 1,000 days per year of respite for children connected to REACH, who have previously experienced or are at risk of experiencing a crisis, reside in regions without an operational CTH, and who do not otherwise have funding to access respite services at a rate of up to $500 per 24-hour period.	DBHDS reports that no families of children with DD from Regions 1,3, or 5 used this respite funding in the 27th reporting period.	As reported in the 26th review period there is still no indication of how the availability of this respite service is being advertised in the 27th reporting period. DBHDS had targeted it to start in May 2025. It's plans included that providers who are not REACH staff would be approved as respite providers. Providers would receive training in the individual child's CEPP. Families would hire individuals directly to provide respite support. DBHDS did not provide an update to verify if any of the planned activities described above were implemented. This action appears to be stalled. DBHDS reports it will review the lack of utilization of these funds during the Qualitative REACH Reviews scheduled in the 28th reporting period.	**No Progress**
36.e) If the Commonwealth has not achieved the goal after taking the actions in Paragraphs 36(a) through 36(d) by June 30, 2026, DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Not Yet Implemented Due: 6/30/26**

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

DBHDS should analyze how Region 2 is able to maintain such a low vacancy rate for the MCR and determine if any of the Region's strategies are applicable to other Regions (PI 32.b).

To increase the percentage of crisis assessments conducted in community settings, DBHDS should include measurable goals, specific support activities and timelines for implementation as required by PI Term 32.c. and should report its work with specific Regions to increase the number of crises assessed in community settings (PI 32.e).

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

As part of DBHDS' qualitative review of the REACH programs, it should include a specific review of each Region's efforts and measurable progress to conduct crisis assessments in community settings with recommendations for improvement (PI 32.e).

DBHDS should refine the documentation it produces to verify the QII activities underway to address PI 35.b and connect these activities to the existing RCA.

DBHDS should report its steps to implement PI Action 36.b and undertake a root cause analysis if DBHDS continues to find there is no utilization of these respite funds (PI 36.b)

Attachment A
Document List

1. Behavior Supports Report FY26 Q1
2. Supplemental Crisis Report FY25 Q4
3. Supplemental Crisis Report FY26 Q1
4. REACH Data Summary Report-Children: FY25-Q4
5. REACH Data Summary Report- Children FY26-Q1
6. REACH Data Summary Report- Adults: FY25-Q4
7. REACH Data Summary Report- Adults: FY26 Q1
8. REACH Quarterly Qualitative Reviews FY25 Q4: Regions 1,2,3,4 and 5
9. REACH Quarterly Qualitative Reviews FY26 Q1: Regions 1,2,3,4, and 5
10. CA Plan PI 9.9.25
11. Pathways to Inclusion Virginia's Crisis Continuum Strategy
12. PI 32 steps update
13. Crisis Assessment in Community Version 004
14. TC Behavioral Services Graphs for 8 CSBs
15. PI 35 Document
16. Crisis Data Tracker
17. VA Developmental Disabilities Waiver Rate Study: Final Report Draft July 2025
18. Rate Component Discussion- Preliminary Analysis 7.10.25
19. Draft Rate Advisory Group Presentation 7.10.25
20. DOJ Comments to Rate Study 8.25.25
21. Performance Budgetary Systems Report-Recommended Increases to DD Waiver Service Rates
22. DP-125 ID DD Waiver Rate Changes updates 10.3.25
23. Memo for Cheryl Roberts, Director, DMAS to Governor Glenn Youngkin transmitting the DD Waiver Rate Study Final Report
24. Emails from Sharon Bonaventura 10.24.25

Submitted by:
Kathryn du Pree MPS
Joseph Marafito MS
November 12, 2025

APPENDIX C

Integrated Day Activities and Supported Employment

By

Kathryn du Pree, MPS

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

Introduction

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

For this subset of PI terms and associated actions, progress toward achieving the specified goals and implementing the delineated actions are reviewed and reported below. This review includes an analysis and reporting of Virginia's status implementing the PI requirements associated with IDA that have not been achieved twice consecutively (see Table below). This includes PI Terms 50, 51 and 37. In the 26th review period, the Commonwealth achieved the specified goal and a rating of compliance for Term 37. It did not achieve the goal of Term 51 and a compliance rating determination for Term 50 was deferred until the 27th review period.

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

Summary of Findings for the 27th Period

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

employment and day services. The ratings for PI Terms 50, 51 and 37 are made and reported below.

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

Interviews: I interviewed members of the Employment First Advisory Group (E1AG). The E1AG normally meets bi-monthly. Two meetings were conducted in the reporting period through August, and the minutes were made available to me (5). An additional meeting was convened October 15, 2025 in which the Semiannual Employment Report (through June 2025) was discussed. The minutes of the October E1AG were not available for review during this reporting period. The subcommittees, which address policy, training and data also met three times during the reporting period (5). The E1AG members who were interviewed reported greater satisfaction with the direction of the E1AG since the 26th reporting period. E1AG members report the current structure which includes scheduling the sub-committee meetings on the same day but prior to the E1AG bimonthly meeting is productive and contributes to more consistent attendance. Concern was expressed in the 26th period that DBHDS will benefit more if it uses the E1AG and its sub-committees to meaningfully review data and discuss substantive issues, providing members the opportunity to provide feedback and make recommendations related to policy and the implementation of strategies to improve employment outcomes. Members report some improvement but believe the data committee could have greater involvement in data analysis to contribute to policy decisions. The Education and Training subcommittee remains very active continuing to address the training needs of various stakeholder groups. DBHDS is planning to create links to the resources the subcommittee have identified for each stakeholder group to become more knowledgeable about employment opportunities and the impact of employment on the entitlements individuals receive.

Members continue to report they would appreciate receiving draft reports ahead of the meetings with sufficient time for them to thoroughly review them and be prepared to discuss the policy implications. DBHDS reports that one Quality Improvement Initiative (QII) related to employment was retired in this reporting period and the second QII initiated by Region 3 to address improving the number and quality of employment outcomes in ISPs continued (6,7,8,9). Terms 50 and 51of the PI require that the E1AG collaborate with the Quality Improvement Committee (QIC) to develop QIIs. I reported in the 26th period that E1AG members did not recall being involved in the design of QIIs related to employment. The active QII was presented to E1AG members by DBHDS staff at the E1AG meeting convened in June and updated at the E1AG meeting in August (5). The members who were interviewed were pleased with the continued collaboration between DARS and DBHDS and the initiatives to end sub-minimum wage work and increase customized employment.

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

Documents: I reviewed the Semiannual Report on Employment; DR0023 Integrated Employment and Day Services; the meeting minutes for the Employment First Advisory Group (E1AG); QII descriptions; training materials; the rate study report and related documents; the E1AG Plan for FY24-26 and the Community Engagement Annual Plan.

Findings: The purpose of this review is to determine the Commonwealth's progress achieving the specified goals of PI Terms 37, 50 and 51, which are described in Table 1 below. In the 26th review period, the Commonwealth achieved Term 37's specified goal and a rating of Compliance. A compliance determination for PI 50 was Deferred as it can only be analyzed once the employment data for the full FY25 was available. It did not achieve the goal of PI 50.

PI 37: The Commonwealth achieved this Term and a rating of Compliance for the first time in the 26th review period. The Commonwealth reached a 2.5% increase in the number of individuals participating in IDA. For the current period, a rating for PI 37 is Deferred as the recent data addresses the Commonwealth's achievement over the past six months and does not allow a comparison of annual data. Term 37 will be reviewed and rated in the 28th review period.

PI 51: The Commonwealth achieved the specified goal and a rating of Compliance for the first time in this 27th reporting period. The percentage of adults with DD employed through all employment programs offered by DARS and DBHDS is 25.1% of the total number of adults with DD on the waivers or waiver waiting list (1).

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

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

As reported in the 23rd period's Study Report, during the pandemic, DBHDS revised its waiver employment targets for 2022, reducing the target to 1,211 which was the pre-pandemic target for 2019. The E1AG met in April 2022 to revise the employment targets. It made this decision after its review and analysis of the impact of the COVID pandemic on employment outcomes for

individuals with I/DD in Virginia. The decision was to return to the targets of 2019 for 2022 and those of 2020 for 2023.

In the fall of 2023, DBHDS planned to return to its pre-existing targets for the out-years through 2026. However, during the 24th review period, DBHDS and the E1AG undertook a more rigorous analysis of the employment data. DBHDS and the E1AG Data Committee members reviewed its historic approach to setting employment targets. Percentage increases year-to-year had not been consistently set by the Commonwealth. The E1AG committee's review found that originally DBHDS did not maintain a record of the methodology it used, or the review it conducted of actual and projected performance, to set the employment targets. As a result of its data analysis which has been described in previous reports, the E1AG Data Committee recommended reducing future employment targets based on what they consider a more realistic annual increase of 15% in employment for waiver participants. The E1AG will meet in December 2025 and collaborate with DBHDS to set the employment targets for waiver participants in waiver services for FY27-FY29.

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

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

DBHDS' target for FY25 is 1,310. As of June 2025, there were 1,105 waiver participants employed. This number represents 84% of the target of 1,310 for this fiscal year. This is an increase of eighty-five individuals who are employed through Individual Supported Employment (ISE) or Group Supported Employment (GSE) waiver services compared to June 2024. This exceeds the increase in the total number of individuals employed at the end of FY24 when the increase compared to the previous year was thirty-four individuals with DD (1). The majority of the increase in employment is in ISE which increased by seventy-three individuals. The Commonwealth did not achieve the goal for this Term. Virginia will meet the target when the performance is within 10% of the benchmark for the year.

PI Terms 50 and 51 require that DBHDS will work with the E1AG, the QIC, and the QIC subcommittees to develop and recommend QIIs to increase employment for adults with DD. DBHDS's RQC sets the QII's which the QIC monitors. DBHDS reports one QII (6,7,8,9) continuing in this reporting period. It is based on a previous SMART initiative is to improve the development of employment, Integrated Community Involvement (ICI) and community life outcomes for individuals with DD. It is being conducted by the RQC in Region 3 and focuses on training Service Coordinators and other stakeholders as the method to increase the number of adult waiver participants who have employment outcomes in their ISPs. Region 3 has not seen significant increase in the percentage of ISPs with employment outcomes comparing FY24Q4 to FY5 Q4 (61.5% to 64.1%), but the number of ISPs developed was significantly higher (470 to 656). This is a 40% increase in the number of ISPs accompanied by a 2.6% increase in the number of those ISPs with an employment outcome among those adults who are interested in employment (9).

PI 51: The data reported by the Commonwealth is derived from data submitted by its Employment Service Organizations (ESO) and Department for Aging and Rehabilitative Services (DARS). The data are analyzed by DBHDS and the E1AG. These data will be reviewed with the data committee and the E1AG at the October meeting of the Advisory Group. As noted in the interviews with E1AG members, the data subcommittee has not been actively involved in data or trend analysis since resetting the employment targets described above. However, information was shared with me that was to be presented at the October E1AG meeting to provide the data that would assist the E1AG Data Subcommittee to set new targets for FY27-29 (10).

There were 21,676 individuals receiving or on the wait list for waiver services as of 6.30.25. The target for employment for this six month period is 5,419, or 25% of the number of individuals with DD ages 18 to 64 on the waivers or waiver waitlist as of 6.30.25. Of these individuals a total of 5,442 (4,866 in ISE and 576 in GSE) were employed. This represents 25.1% of the waiver population, an increase of .6% (91 individuals), compared to 6.30.24 when 24.5% of the waiver population were employed (1).

During the 27th period, Virginia achieved the 25% goal in PI Term 51 and a rating of Compliance for the first time. The Commonwealth achieved the outcome that 25% of the waiver participants and individuals on the waiting list for waiver services were in integrated day services. The Commonwealth has successfully increased both the number and the percentage of the individuals employed compared to the percentage employed in the 26th reporting period. These data are described in Table 2 below.

PI 37: The Commonwealth established 25.2% (3,279/13,014) as the baseline number and percentage for this indicator in March 2018 when there were service authorizations (SA) for 3,279 individuals with DD being served in the most integrated employment and day service settings and 13,014 individuals in the DD waivers. The Commonwealth Met this Term in the 26th reporting period based on data comparing the Commonwealth's achievements in March 2024 to those in March 2025. The rating for Term 37 is deferred in this review period and will be rated in the 28th review period when a full year of data will be available to compare the percentage of individuals served in the most integrated employment and day settings in March 2026 to the number in these settings in March 2025.

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

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

This workplan, titled the CEAG Annual Plan 2025: Advancing Community Life Engagement Across Virginia was updated in FY26 Q1. It is organized by three long-term outcomes and seven strategies. The first outcome is to improve the understanding and philosophy among stakeholders, providers, and state agencies of Community Life Engagement (CLE) based on accepted national standards (four core pillars) and in alignment with best practice. The second outcome is to improve the understanding of primary barriers to providing community engagement, community guide, and community coaching services using data collected from DBHDS QII initiatives. The third outcome is to ensure CE services are being offered and provided to individuals across the state in the most integrated community settings based on the needs of the individual (3).

The CEAG Annual Plan identifies who is responsible to lead the strategy; what activities and tasks will be accomplished; the deliverable, the outcomes which are more short term than the long term outcome; and the timeline to complete the work. DBHDS, with input from the CEAG revised the Annual Plan to include measurable goals and DBHDS provided a status report though FY26Q1 to this reviewer (3).

PI Terms and Actions Achievement Status

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

Table 1
Status of Meeting the Goals of the PI Terms

Term	26th	27th
50. **Supported Employment.** The Commonwealth will work to achieve a goal of being within 10% of the waiver employment targets set by the Employment First Advisory Group. DBHDS will continue to work with the Employment First Advisory Group, the Quality Improvement Committee (QIC), and the QIC subcommittees to develop and recommend QIIs to enhance employment of adults aged 18-64 on the DD waiver. If the goal is not met within two years of the date of this Order, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	**Deferred**	**Not Achieved**
51. **Supported Employment.** The Commonwealth will work to achieve a goal of meeting its established employment target of 25% for adults aged 18 to 64 on DD waivers and the waitlist. DBHDS will continue to work with the Employment First Advisory Group, the QIC,	**Not Achieved**	**Compliance**

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

Table 2
Terms and Related Actions

Term and Actions	Facts	Analysis/Conclusion	26th/27th
50. **Supported Employment.** The Commonwealth will work to achieve a goal of being within 10% of the waiver employment targets set by the Employment First Advisory Group. DBHDS will continue to work with the Employment First Advisory Group, the Quality Improvement Committee (QIC), and the QIC subcommittees to develop and recommend QIIs to enhance employment of adults aged 18-64 on the DD waiver. If the goal is not met within two years of the date of this Order, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this	DBHDS' target for FY25 is 1,310. This is the expected number of individuals to be employed by June, 2025. As of June, 2025, there were 1,105 waiver participants employed. This number represents 84% of the target of 1,310 for this fiscal year. This is an increase of eighty-five individuals since June 2024, who are employed through ISE or GSE waiver services. This exceeds the increase in the total number of individuals employed at the end of FY24, when the increase compared to the previous year was thirty-four individuals with DD. However, it is a drop in the percentage of individuals employed, as the total number of individuals with DD on the waivers or waiver waiting list has increased at a larger percent since June 2024 (1).	The Commonwealth achieved 84% of the goal, compared to 89% at the end of FY24. This is a significant decrease and raises concern regarding the Commonwealth's ability to meet the Term under the time period set by the Permanent Injunction. DBHDS and the E1AG have made three recommendations to address the need to increase the number of adults engaged in employment who are on DD waivers. One recommendation will further analyze how many waiver participants who are on waivers are not counted toward the achievement of this Term while they receive initial support from DARS or follow up support if the individual expresses interest in changing jobs. DBHDS tracks and reports the discussions of employment with individuals with DD who are 18-64 and the percentage of those	Deferred **Not Achieved**

quality improvement process until the goal is achieved and sustained for one year.	DBHDS retired one QII in this reporting period and initiated another QII related to improving employment (5,8). The QII focuses on increasing the number and quality of outcomes for adults with DD for both employment and ICI. The QII is being conducted in Region 3. Training for Support Coordinators and other staff was the primary method to foster improvement. To date there has been no improvement noted although three trainings were offered, two in person and one online. Region 3 plans to continue the QII. The progress of the implementation of the QII has been reported to the E1AG but there is no evidence the E1AG partnered with the DBHDS's RQC to develop the QII.	people who express an interest in employment who have an employment outcome (goal) in their ISP. While this is not a Term of the PI, an analysis of the data supports the current QII to improve employment outcomes for adults with DD underway in Region 3. DBHDS reports that of 14,349 individuals with an ISP completed in FY25, 13,929 (97%) of adults with DD have a discussion about employment with their Service Coordinator/team. However, only 1,167 of the 1,973 (59%) of adults with DD who have an interest in employment have an employment outcome in their ISP. It is critical that teams address individual's interest in employment by developing measurable goals and objectives in their ISPs which is the necessary action to actually assisting adults to become employed. The E1AG might also want to explore why so few adults 1,973 of the 13,929 (14%) who had a discussion about employment have an interest in pursuing employment. Conclusion: The Commonwealth did not achieve this Term in the 27th reporting period.	
51. **Supported Employment.** The Commonwealth will work to achieve a goal of meeting its established employment target of 25% for adults aged 18 to 64 on DD waivers and the waitlist. DBHDS will	There were 21,676 individuals receiving or on the wait list for waiver services as of 6.30.25, a decrease of 1,412 individuals since December 2024. The target for employment for this six month period is 5,419, or 25% of the number of individuals with DD ages 18 to 64 on the waivers or	PI Term 51 is achieved as Virginia did meet the outcome that 25% of the waiver participants and individuals on the waiting list for waiver services are employed. The Commonwealth has increased the number of individuals who are employed and the percentage of the individuals employed compared to the	Not Achieved **Compliance**

continue to work with the Employment First Advisory Group, the QIC, and the QIC subcommittees to develop and recommend QIIs to enhance employment of adults aged 18 to 64 on the DD waiver and the waitlist. If the goal is not met within two years of the date of this Order, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	waiver waitlist as of 6.30.25. Of these individuals a total of 5,442 (4,866 in ISE and 576 in GSE) were employed. This is 25.1% of all individuals on a DD waiver or waiting list (1). The DBHDS reports a 100% response rate from its Employment Services providers for this twenty-first semi-annual data report (1). DBHDS reports a QII developed by the RQC in Region 3 to improve ISP outcomes for individuals interested in employment and participation in integrated community involvement through targeted trainings. The update on the progress of this QII was reported to the E1AG at the bimonthly meeting in August 2025. In person trainings were conducted in October and November 2024 and a virtual training was offered in January 2025.To date there has been no progress to improve ISP outcomes as a result of implementing the QII (5,8) The QIIs are reviewed with the E1AG but there is no evidence that DBHDS worked with the E1AG in the development of the QIIs to improve employment.	percentage employed in the 26th reporting period. To date the QIIs to increase and improve employment outcomes for adults with DD have not improved performance or achieved the related Term of the PI. Conclusion: This Term in Met in the 27th reporting period.	
37. Day Services for DD Waiver Recipients. The Commonwealth will work to achieve a goal of a 2% annual increase in the percentage of individuals on the DD waiver receiving day services in the most integrated settings. To achieve that	For this reporting period, the most recent full year data report is from 3.31.24 to 3.31.25. In March 2025, DBHDS reports there were 4,438 (24.4%) of 18,149 individuals in the DD Waiver population who participated in the integrated settings for employment and day services (2). The percentage of waiver	The number of waiver participants in integrated day services increased by 239 individuals since March 2025. This was an increase from 4,438 individuals in March to 4,677 individuals in September. The Commonwealth continues to increase the number of adults in integrated employment and day services.	Compliance **Deferred**

goal, the Commonwealth will take the following action:	participants with SAs for integrated day services increased by 2.45% percent between 3.31.24 and 3.31.25. This exceeded the requirement of PI Term 37 of a 2% increase in participation in IDA annually. This comparison led to Virginia achieving the goal for this Term and a rating of compliance for the first time in the 26th reporting period. In the 27th reporting period data are only available through September 30, 2025 so an annual comparison cannot be made, or a rating determined until the 28th reporting period. As of September 30, 2025, there were 18,733 adults between the ages of 18-64 on a DD waiver. Of these 18,733 waiver participants, 4,677 (25%) are engaged in integrated employment or day services (15).	Conclusion: This Term is Deferred in this reporting period and will be rated in the 28th reporting period.	
37.a) Within one month of the date of this Order, DBHDS' s Community Life Engagement Advisory Committee will implement a work plan that includes measurable goals, specific support activities, and timelines for implementation and that is focused on: defining meaningful community involvement; developing training and educational materials to enhance meaningful community involvement for individuals and families, providers, and case managers; and	DBHDS revised the original CEAG workplan to assure it aligns with requirements in the PI. The work plan, titled the CEAG Annual Plan 2025 Project Planning includes six strategies which address the requirement of 37.a) to define meaningful community involvement; develop training and educational materials to enhance meaningful community involvement and assess community involvement data (3). .	The work plan was developed in March and sets completion dates for the strategies that range from April 2025 to February 2026. The CEAG work plan addresses the three areas of focus described in this action statement. This PI term's action requires, and the work plan includes measurable goals, specific support activities and timelines for implementation. DBHDS has updated the CEAG Annual Plan to include measurable goals and has reported on the Commonwealth's progress implementing the Annual Plan though FY26 Q1. DBHDS includes sufficient specificity in the activities and tasks of the work plan and clearly defines the deliverables. The workplan includes the	**Completed and Ongoing**

assessing community involvement data.		identification of barriers as well as successes to achieving CLE for individuals and appropriately includes the input of all stakeholders which should enhance the achievement of outcomes.	
37. b) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Community Engagement, Workplace Assistance, and Community Coaching by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Community Engagement, Workplace Assistance, and Community Coaching by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate study	The Commonwealth under the leadership of the Department for Medical Assistant Services (DMAS) has contracted with Guidehouse to conduct the rate study. DMAS has created a DD Rate Work Group that first convened 12.12.24. The Work Group includes representatives of providers, advocates and industry associations. Guidehouse conducted a rate study for services in the three DD 1915 c waivers, the CCC Plus Waiver and State Plan services including GSE, Workplace Assistance, Employment and Community Transportation, Community Coaching, Community Engagement, Community Guide, and Benefits Planning (11). Guidehouse issued a draft report in July 2025 which suggests rate increases for all of the services that they were directed to study and analyze, with the goal of recommending rates that would assure sufficient capacity. The rate study includes direct, indirect, and administrative costs and adjusts for differences in costs in Northern Virginia compared to the rest of the Commonwealth (11). The United States has identified concerns and asked questions about Guidehouse s draft report (14). The focus	The Commonwealth is fully implementing the activities associated with Term 37, and the actions required under 37. b.	**Completed and Ongoing**

required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.	of DOJ's concerns questioned whether the completed rate study fulfills the PI requirement to design the study to ensure sufficient provider capacity to achieve the specified goal of this and the other identified Terms. The final report responded to each of DOJ's stated concerns. On 10.15.25 (18) the Commonwealth's Director of DMAS submitted the DD Waiver Rate Study report to Governor Youngkin, the Chairs of the House and Senate Appropriation Committees and Virginia's Department of Planning and Budget. The Governor's proposed FY27 budget will be the next Commonwealth effort to obtain from the General Assembly funding necessary to increase rates to those recommended by the study. (16,17).		
37. c) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraph 37(a), DBHDS will also conduct a root cause analysis and determine whether a QII is warranted to address identified issues. A root cause analysis and consideration of QII will not be required if the percentage of individuals in the integrated day services reported above is 65% of the total number			**Not Yet Implemented Due: 1/15/27**

of the people receiving any day service.			

Recommendations: DBHDS should directly involve the E1AG in the development of future QIIs to improve employment goals, including a review of meaningful data and trend analysis by the Data Subcommittee to design QIIs based on data and analysis.

Attachment A
Documents Review
Integrated Day Services

1. Semiannual Report on Employment June 2025 Data: Issued September 2025
2. DR0023 Integrated Employment and Day Services
3. CEAG Annual Plan 2025: Advancing Community Living Engagement Across Virginia
4. E1AG Plan for FY24-26 with Quarterly Updates
5. E1AG Meeting Agendas and Minutes: 6.20.25 and 8.18.25
6. RQC QII: Being SMART(er) About Employment and integrated Community Living
7. RQC 3 QII Process Flow Chart Tool Kit
8. RQC 3 QII Data Results Updated July 2025
9. Email from Heather Norton explaining the QII 10.9.25
10. Data Analysis for Setting Employment Targets
11. VA Developmental Disabilities Waiver Rate Study: Final Report Draft July 2025
12. Rate Component Discussion- Preliminary Analysis 7.10.25
13. Draft Rate Advisory Group Presentation 7.10.25
14. DOJ Comments to Rate Study 8.25.25
15. DR0023 Table 1-Recipients of Integrated Employment and Day Services by Procedure Code
16. Performance Budgetary Systems Report-Recommended Increases to DD Waiver Service Rates
17. DP-125 ID DD Waiver Rate Changes updates 10.3.25
18. Memo for Cheryl Roberts, Director, DMAS to Governor Glenn Youngkin transmitting the DD Waiver Rate Study Final Report

Submitted by:
Kathryn du Pree MPS
November 13, 2025

APPENDIX D

Community Living Options

By

Kathryn du Pree, MPS
Joseph Marafito, MS

Community Living Options Report
27th Review Period
Prepared for the Independent Reviewer

Introduction

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

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

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

Summary of Findings for the 27th Review Period

This review found that the two PI Terms reviewed were not met**.** The reasons related to Virginia not achieving the specified goals of these terms are described below.

In its review of nursing services, DBHDS provided the data analysis for FY25 in the Nursing Services Data Report issued in September 2025 to determine the Commonwealth's progress

meeting the requirements of both Terms 38 and 39 (2). DBHDS's OIHSN issued an updated Nursing Services Data Report on 10.22.25 with revised nursing utilization rates for FY25 and for previous fiscal years. The data I report in the following sections are the data for FY25 and previous fiscal years which DBHDS has changed from those it reported previously based on its review of more current and complete billing data (11).

The OIHSN performed the review of the FY25 data for nursing services authorized and delivered from 7.1.24-6.30.25. Virginia did not achieve the benchmark level of nursing hours utilization performance. DBHDS reported that only 368 (52%) of the 702 unique individuals with Service Authorizations (SA) received at least 80% of the hours allotted of either Private Duty Nursing (PDN) or Skilled Nursing (SN) services. This compares to 318 of the 633 (50%) unique individuals that it reported FY24. While the Commonwealth did not meet either Term, there has been an increase in the number of individuals with authorized nursing services (68) and a 2% increase in the number of these individuals who received 80% of their authorized hours comparing FY25 to FY24.

In this reporting period, DBHDS also provides the number of individuals who receive nursing services by those on the DD Waiver and those receiving EPSDT separately. There were 611 individuals authorized for nursing services who are on the DD waivers, and 102 children authorized for nursing services though EPSDT. (This totals 713 individuals with authorizations for nursing services rather than 702 because 12 individuals were authorized for both PDN and SN.) Of these individuals, 325 on the DD Waiver and 43 receiving EPSDT received at least 80% of their authorized hours (2,11,12).

Table 1 below depicts DBHDS's summary of utilization for EPSDT and Waiver individuals for all nursing services, which includes both PDN and SN that were authorized. Table 1 includes the updated utilization data based on the DBHDS' review of current billing information for previous Fiscal Years 22 through FY24 (11,12). Utilization of nursing services decreased by 11% for individuals receiving EPSDT and increased by 1% for individuals receiving waiver services through FY25 compared to FY24.

In the 26th review period DBHDS cautioned that the data and subsequent percentages derive from a point in time. Providers have up to twelve months to bill for services from the date the services were provided.

Based on its updated billing data, DBHDS recalculated the percentage of individuals who received either PDN or SN between FY19 and FY24. This updated data was reported in the Nursing Services Data Report issued in September 2025 and revised in October 2025 (2,11). Table 1 below compares DBHDS's original report of the percentages of utilization for both EPSDT and DD Waiver participants for FY22- FY24 to the updated percentages of utilization of nursing hours as a result of its recalculation based on more comprehensive billing data (11). DBHDS now reports that its more complete billing data indicate that a significantly higher percentage of EPSDT recipients received at least 80% of their authorized nursing hours in FY22 and FY23. DBHDS's recalculated percentages of nursing services utilization of the waiver participants receiving at least 80% of their authorized nursing hours increased very significantly in FY22, somewhat in FY23 and remained the same in FY24.

Table 1
Nursing Services Utilization Updated

	FY22	FY23	FY24	FY25
EPSDT Utilization	18%	26%	32%	43%
EPSDT FY25 Update	**51%**	**43%**	**32%**	**N/A**
Waiver Utilization	36%	42.5%	53%	53%
Waiver FY25 Update	**60%**	**52%**	**53%**	**N/A**

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

Because of the episodic need, especially for skilled nursing, and difficult to predict nature of home healthcare (health need spikes, emergencies, etc.) in general and the presence of multiple SAs for both the RN and LPN levels of nursing, the system has continued its tendency to over authorize nursing hours for those whose need is specified in their ISPs. Previous Individual Service Review studies have identified individuals who needed nursing services but did not receive Service Authorizations (SA) or the needed service. Overall, these factors suggest that the aggregate utilization rates for the most recent fiscal year reported by DBHDS will likely fall below the actual service authorization amount because this number is inflated for some individuals for the reasons stated. The Commonwealth has not yet determined the extent of excess authorizations.

Table 2 depicts the DBHDS revised reports of the total number of individuals including both those using EPSDT and those enrolled in a DD Waiver who needed and received nursing services from FY19 through FY25. DBHDS' report for FY25 indicates the first increase in the number of individuals authorized to receive nursing services since FY22 and the first increase in the number of individuals receiving 80% of their authorized hours since FY23. DBHDS reported that at the end of FY25, 702 individuals were authorized to receive nursing services which is an increase of 69 individuals (11%) from the 633 who were authorized for nursing services in FY24. DBHDS has not yet determined how there can be hundreds more individuals receiving waiver services since FY21, but significantly fewer need nursing services, but it is positive that the number of individuals authorized to receive nursing services did increase in FY25 compared to the three previous fiscal years.

The revised data reported by DBHDS provides a longitudinal perspective regarding the utilization rates of nursing services pre and post pandemic and pre and post the nursing agency pay rate increases which started in July 2022. In FY19, 265 (41%) of individuals needing nursing services received 80% or more of their allotted nursing hours. Whereas, in FY25 368 (52%) of the 702 unique individuals received 80% of the hours that were authorized. The Commonwealth is reporting its highest percentage of nursing utilization since it began reporting these rates in FY19 and an increased number of individuals authorized for nursing services. DBHDS has finally exceeded its highest number of individuals both authorized for nursing services from 667 in FY20 to 702 in FY25 and receiving 80% of their authorized nursing services from 347 in

FY22 to 369 in FY25. The rate at which individuals received in-home nursing service was the lowest in FY19. Since this low point, the utilization rate had increased only 11% from FY19. DBHDS has not surpassed its highest percentage of nursing utilization which was 59% in FY22.

Table 2
Nursing Services

Fiscal Year	Percentage receiving 80% of hours	Number of individuals receiving 80% or more	Total number of individuals needing nursing services
FY19	41%	265	647
FY20	42%	280	667
FY21	45%	277	616
FY22	59%	347	588
FY23	51%	303	594
FY24	50%	316	633
FY25	52%	368	702

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

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DBHDS also reported the percentage of utilization that met the 80% benchmark by Region in FY 25. Variances in these percentages between Regions continue to indicate that nursing services utilization is not consistent throughout the Commonwealth. Region 3 remains the lowest in the percentage of utilization. Region 2 continues to report the highest utilization percentage, although its utilization rate decreased by 8% in FY25 compared to FY24. The utilization percentage of nursing services has remained the same in Region 1 across FY24 and FY25. Regions 4 and 5 have increased the percentage of individuals who receive at least 80% of their authorized nursing hours in FY25.

- Region 1- 36% compared to 36% in FY24
- Region 2- 68% compared to 76% in FY24
- Region 3- 16% compared to 17% in FY24
- Region 4- 54% compared to 38% in FY24
- Region 5- 59% compared to 45% in FY24

The data reported by DBHDS compares the percentage of hours delivered to the number of authorized hours by Supports Intensity Scale (SIS) levels. Comparing the FY24 percentages to those in FY25 for individuals with Level 4-7 SIS scores indicates increases in percentages of utilization at SIS Levels 4-6, and a decrease in the percentage of utilization for Level 7.

- 45% of individuals with a Level 4, compared to 42% in FY24;
- 67% of those with a Level 5, compared to 63% in FY24;
- 58% of individuals with a Level 6, compared to 53% in FY24;
- and 40% compared to 46% of those with a Level 7 received 80% of their authorized nursing services.

All of the data reported above includes combined data for Skilled Nursing (SN) and Private Duty Nursing (PDN). The Permanent Injunction has a separate term for each type of nursing service.

Term 38 requires that 70% of individuals receive at least 80% of the PDN hours for which they are authorized, and Term 39 requires 70% individuals to receive 80% of the SN hours for which they are authorized.

DBHDS does report the percentage of utilization that met 80% by Procedure Code (2). Four codes are contained in the utilization report: S9123: SN Registered Nurse; S9124: SN Licensed Practical Nurse; T1002: PDN Registered Nurse; and T1003: PDN Licensed Practical Nurse. These data, which include updated billing information, indicate a much higher utilization percentage of PDN compared to SN. However, in FY25, none of the nursing services surpassed the highest levels of utilization which was in FY22 for Skilled Nursing and FY23 for PDN, delivered by either RNs or LPNs respective to both types of nursing services. Table 3 includes DBHDS's updated and revised utilization rates based on complete billing data**.** These calculations are not used to determine the percentage of individuals receiving 80% of their authorized nursing hours for PI 38 or PI 39 because the percentages in Table 3 do not reflect unique individuals and the amount of nursing each receives. Individuals can have an RN or LPN for both SN and PDN and can be counted multiple times for each procedure code.

Table 3
Utilization of SN and PDN Nursing Services

Fiscal Year	Percentage receiving 80% of hours SN by RN	Percentage receiving 80% of hours SN by LPN	Percentage receiving 80% of hours PDN by RN	Percentage receiving 80% of hours PDN by LPN
FY19	23%	37%	60%	65%
FY20	16%	40%	72%	55%
FY21	16%	43%	63%	58%
FY22	48%	56%	66%	66%
FY23	10%	28%	80%	66%
FY24	24%	32%	65%	60%
FY25	20%	41%	68%	60%

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

DBHDS's current nursing utilization report does include separate data for Terms 38 and 39. In FY25 there were 525 individuals identified as needing PDN of whom 312 (59%) received 80% of the authorized hours delivered by either an RN or LPN. In FY25, 192 individuals were identified as needing SN, of whom 60 (31%) received 80% of their authorized hours delivered by either an RN or LPN. This total 717 individuals rather than the 702 individuals reported earlier in this report because it includes 15 individuals approved for both services and reported individually for both (2).

Table 4 compares the number and percentage of individuals authorized for and receiving 80% of the hours for which they are authorized. This includes both children receiving EPDST and individual receiving Waiver services. The Commonwealth continues to increase both the number of individuals identified with a need for PDN and the number of these individuals who receive 80% of the PDN but has not achieved the required performance expectation of 70%.

Table 4
Utilization of PDN Nursing Services for EPSDT and Waiver Participants
FY19-FY25

Fiscal Year	Percentage receiving 80% of PDN hours	Number of individuals who receive 80%of PDN hours	Number of individuals identified with PDN	Percentage change
FY19	54%	185	344	-
FY20	56%	200	360	2%
FY21	58%	205	353	4%
FY22	65%	242	372	11%
FY23	66%	262	398	12%
FY24	60%	267	448	6%
FY25	59%	312	525	6%

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

DBHDS has identified the top three barriers to individuals accessing nursing services in each Region and has developed interventions to reduce these barriers. As part of this initiative, DBHDS identified the CSBs that have the lowest utilization and targeted technical assistance (TA) and training to assist them to increase utilization of authorized nursing services. The implementation of the training and TA was to begin in this reporting period but has been delayed until the 28th reporting period. This information is detailed in DBHDS's Nursing Work Plan/Community Nursing Access Report (4). This Plan describes the Commonwealth's planned actions associated with PI Terms 38 and 39. The Plan includes the strategies, responsible party, target date, status and any actual results of the strategies. DBHDS OISHN identified the top three barriers in each region and has identified strategies to address these barriers. DBHDS's OIHSN indicated it would develop measurable goals using the SMART (specific, measurable, achievable, relevant and time-bound goals) approach to address the identified barriers in the 26th reporting period (3).

While the OIHSN has developed strategies to address these barriers, they are generally not measurable. The OISHN does plan to more widely distribute the Commonwealth's Jump Start brochure. All other barriers are addressed by a reference to identifying training resources, without any specificity as to how and when training will be provided and what will be measured to determine if any of the training addresses the identified barriers.

DBHDS also identified DD Waiver Nursing Providers that are not residential or day providers to connect them to individuals needing nursing services if they are accepting new individuals. Other providers are being identified including home health companies. DBHDS will promote the availability of these providers through trainings, website information and search engines (3).

DBHDS continues to utilize the Nursing Provider Database to assist individuals to locate nursing providers in their geographic area with the goal to increase the number of nursing providers who serve individuals under the DD Waiver. DBHDS identified the number of providers it projects to add in each Region during FY26. DBHDS reports in FY24 there were 172 nursing service

providers identified who were actively serving individuals under the DD Waiver. The number of nursing providers ranged from fifteen in Region 3 to eighty-one in Region 2. No new data was reported for FY25. Its FY26 goal is a 5% increase from the number of nursing hours provided in FY24. DBHDS has not provided an analysis of the needed capacity versus available capacity by Region, but OISHN has set the goal to increase the number of nursing providers in each Region (3).

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

The first IMNR and ISR parallel study were conducted during the 24th reporting period. These studies included a sample of thirty individuals with complex support needs (i.e., SIS level 6). In part, the studies examined whether these individuals utilized the nursing service hours they were authorized to receive. Similar studies were conducted in the 25th and 26th review periods involving samples of thirty individuals with complex medical needs. The third IMNR/ISR studies, conducted after the PI was agreed to by the Parties and approved by the Judge, included findings that were consistent with DBHDS' data reports that the Commonwealth did not achieve the specified goals in Terms 38 and 39. In the current 27th review period, the IMNR and ISR parallel studies involved a sample of thirty individuals with complex behavioral needs. The findings of these most recent IMNR/ISR parallel studies generally confirm the data reported by DBHDS in the 27th reporting period that the Commonwealth has not achieved the specific goals of Terms 38 and 39.

Previously, Process Documents and Attestations have been reviewed, and the Processes have been determined to be reliable and valid. For this period's study, DBHDS shared two revised process statements: Intense Management Need Review-PI 44 and Skilled Nursing PI 39 and PI 44. The first process referenced, IMNR, was found to be sufficient in all areas.

The Skilled Nursing PI 39 Process Document was found to be sufficient in most areas. There were six areas the reviewer questioned. OIHSN was able to fully respond to three of the areas and provide support documentation that verified these three areas were sufficiently addressed in the process document. Three areas remain that either require an update or more detailed description of steps in the process. These areas address following up on the remediation plans; addressing inconsistencies in the number of individual reviewed as referenced in different steps in the process; and assigning the titles of staff designated to perform certain review functions. OISHN has committed to accomplish this in time for it can be reviewed in the 28th reporting period.

The extent of the validity that the number of authorized hours equals the number of hours needed has yet to be established.

PI Terms and Actions Achievement and Status

Table 4 below summarizes the status of the PI Terms and Actions this study reviewed.

Table 4
Achievement of the PI Terms

Term	26th	27th
38. **Private Duty Nursing.** The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with private duty nursing identified in their ISP or prescribed under EPSDT receive 80% of the hours identified as needed on the CMS485 or DMAS62 forms. To achieve that goal, the Commonwealth will take the following actions.	**Deferred**	**Not Achieved**
39. **Skilled Nursing.** The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with skilled nursing identified in their ISPs or prescribed under EPSDT will have their skilled nursing needs met 80% of the time.	**Deferred**	**Not Achieved**

Table 5
Terms and Related Actions

Term and Actions	Facts	Analysis/Conclusion	26th/27th
38. **Private Duty Nursing.** The Commonwealth will work to achieve a goal that	The OIHSN performed the review of the FY25 data for nursing services authorized and delivered from 7.1.24- 6.30.25. Virginia did not achieve the level of nursing hours	More individuals (77) are authorized for nursing services in FY25 (525) to date than were authorized in FY24 (448). DBHDS reports 312 (59%) individuals who received	Not Achieved **Not Achieved**

70% of individuals on the DD waiver and children with DD receiving EPSDT with private duty nursing identified in their ISP or prescribed under EPSDT receive 80% of the hours identified as needed on the CMS485 or DMAS62 forms. To achieve that goal, the Commonwealth will take the following actions.	utilization performance expected. Only 312 (59%) of the 525 unique individuals with Service Authorizations (SA) received 80% of the hours allotted. This compares to 60% of unique individuals (267 of 448) with SAs receiving 80% of the PDN nursing hours allotted in FY24 based on updated billing data. The Nursing Hours Utilization Report issued in September 2025, did clearly distinguish between the utilization of SN versus PDN hours. Later in the Nursing Services Data Report, DBHDS includes a Table of Utilization by Procedure Code. There are two codes for PDN. T1002 is the utilization by PDN RNs and is 68% in FY25, compared to 65% in FY24. T1003 is the utilization code by PDN LPNs and is 60% in both FY24 and FY25(2,11).	80% of their authorized nursing hours, of the 525 who were authorized. This includes 78 EPSDT recipients, of whom 39 (50%) received 80% of their authorized nursing hours; and 447 DD Waiver recipients, of whom 273 (61%) received 80% of their authorized nursing hours. This is both the highest number of individuals reported as needing PDN and those receiving 80% of their hours since DBHDS began reporting these data in FY19 at which time 344 individuals needed PDN. With the exception of a slight decrease in FY21(2%), the number needing PDN continues to increase annually which corresponds with annual increases in the total number of DD Waiver recipients. DBHDS achieved the highest percentage of individuals receiving 80% of their hours in FY23 when 66% of individuals authorized for PDN received 80% of the allocated hours. DBHDS staff respond that it is difficult to determine what the exact percentage of utilization is at the current time under review	

		because providers have twelve months to bill for any services delivered. Conclusion: PI 38 is not met as the Commonwealth did not achieve the 80% level of utilization for 70% of its EPSDT and DD Waiver recipients for PDN services.	
38.a) Semi-annually, on May 15 and November 15 of each year, DBHDS will continue to report data on utilization of nursing services and the work of the DBHDS Nursing Workgroup.	DBHDS continues to report the data semiannually for the utilization of nursing services in the Nursing Hours Utilization Report (2,11). DBHDS reported that the Nursing Services Workgroup, including key stakeholders from DBHDS and DMAS, met in June 2025. Their responsibilities include the review of nursing utilization data; the results of the most recent IMNR to determine areas of focus for improvement; identify additional topics for SN and PDN training and further training to bridge the gap between general nursing education and specific training needed to provide proficient waiver services to individuals with DD: and enhance the usability of WaMS with regard to nursing utilization. As reported earlier, the Nursing Work Plan includes	This action is underway in the Commonwealth	**Completed and Ongoing**

	strategies and specific responsibilities and timelines for the completion of the work (3).		
38. b) By September 30, 2024, DBHDS will update the ISP to allow for collection of nursing needs data identified by the Risk Awareness Tool.	This was initiated 9.15.24 when DBHDS updated the ISP to allow for the collection of nursing needs data identified by the Risk Awareness Tool. The ISP now includes a question to identify if nursing waiver services are needed and identify additional related information. The SC must respond to a number of options to indicate if appropriate referrals have been made and if the individual has been connected to nursing services, if they are otherwise being addressed, or if the individual has declined the service or does not require the service (2).	DBHDS reviewed 9,022 ISPs completed between January and June 2025. Of the 9,022 ISPs reviewed 8,467 (94%) of the individuals did not need nursing services. Of the remaining 555 individuals, 306 had connected to nursing services or had a referral. Twenty additional individuals were to have a referral completed within thirty days of the ISP. Twenty-two needed nursing services but declined these services, and 200 individuals had their needs addressed by other supports. There was no information regarding the additional seven individuals not reported in one of the above referenced categories (2,11)	**Completed and Ongoing**
38. c) DBHDS will continue to implement an IMNR that will assess if individuals have unmet nursing or other medical needs and will work with families, providers,	DBHDS shared its monitoring questionnaire for skilled nursing. Reviews were initiated in mid-April and conducted monthly. Each review will result in the request for a remediation plan and the timeline for its completion.		**In Progress**

and case managers to take steps to resolve identified unmet needs. Semi-annually, on April 15 and October 15 of each year, DBHDS will report on the IMNR process, including the types of unmet needs identified and efforts taken to resolve them.	Eighteen individual reviews were completed across all Regions by OIHSN RN Care Consultants (RNCC). Summary information was provided for sixteen of the eighteen individuals reviewed including their medical conditions. The barriers to nursing care they and their caregivers experienced, and the remedies they recommended to DBHDS were reported. DBHDS's OIHSN nurses developed 79 remediation plans. The top categories included: documentation (20), assessment/evaluation (13), protocols (11); and nursing (8). Forty-six of the 79 remediation plans have been fully resolved. Actions to address the areas needing remediation included: scheduling appointment, updating documents, completing assessments and repairing adaptive equipment. The OIHSN RNCCs determined that the skilled nursing needs of all eighteen individuals were met (2,11).		
38.d) Within six months of the date of this Order, in consultation with			**In Progress**

the five DBHDS Registered Nurse Care Consultants, the Commonwealth will:			
38.d). i. Identify which CSB catchment areas in each Region have the highest nursing shortages for this target population based on objective criteria and data, including how many individuals with private duty nursing receive 80% of their hours;	DBHDS has identified the CSB with the highest nursing shortage in each Region. DBHDS has developed a Nursing Access Work Plan and updated it 10.10.25 (3). Within this process DBHDS is identifying the CSBs with the lowest utilization and targeting the provision of technical assistance and training to support the CSBs to increase utilization of the authorized nursing hours.	DBHDS is contacting providers/Service Coordinators for individuals who are not receiving 80% of their authorized PDN nursing hours to assist DBHDs to identify specific barriers. DBHDS plans to report on the results in the 28th review period (3).	**Completed and Ongoing**
38.d) ii. Identify the top three barriers to individuals accessing nursing services in each region based on objective data, including stakeholder data and state and	DBHDS reports developing a survey for nursing services providers to complete. The Nursing Hours Utilization Report through FY25 includes information on the nursing workforce challenge experienced in Virginia especially in its rural regions, taking its data from the Virginia State Office of rural	DBHDS expected to have surveys for DD Waiver Services Providers (not nursing) and families to identify barriers implemented by 7.15.25 and would have the results analyzed by 8.30.25. OIHSN reports this initiative is not yet started. While the identification of barriers by nursing service providers and others is in progress, the activities	**In Progress**

national workforce data and research;	Health. The report identified national reasons for nursing shortages that include pandemic burnout, educational obstacles, and retirement. The report also touches upon national nursing workforce issues and barriers. OIHSN provided a high level summary of this data as it relates to DD Nursing Services and nursing capacity in general in the Commonwealth (2,11).	related to completing this action have been delayed. DBHDS/OIHSN did not provide a new timeline to complete this action.	
38.d) iii. Develop a work plan to resolve those barriers that includes measurable goals, specific support activities, and timelines for implementation; and	DBHDS includes its work plan initiatives, next steps and recommendations which is an extensive list that includes ongoing assessment of need; analyzing utilization data; training and technical assistance; eliciting stakeholder input; and follow up on IMNR recommendations (3). OIHSN reported its work with the Quality Management Office to conduct a root cause analysis to identify three key barriers in each Region.	This root cause analysis to identify barriers to nursing services utilization was conducted with members of the Nursing Services Work Group. Members identified barriers and rated each barrier in terms of its impact and its difficulty to achieve. From this root cause analysis DBHDS/OIH identified the three top barriers in each Region and set one SMART goal for each Region. These are: • Lack of training • Lack of agencies • Limited access due to perceived risks of denial of authorization • Lack of understanding the service	**In Progress**

		• Lack of understanding of Jump Start Funds • Unaware of group homes • Lack of incentives • Lack of knowledge of the DD Waiver • Not enough LPNs • Inconsistent staffing OIHSN created specific support activities but indicates the lack of incentives, inconsistent staffing and not enough LPNs are issues that are outside the scope of the OIHSN. Yet these are barriers in more than one Region. Most of the specific activities are to identify training resources and distribute materials about the Jump Start Funds. OIHSN also commits to increasing the number of nursing service providers in each Region. The goals are not measurable, and the plan does not clearly connect how identifying training resources for a variety of stakeholders will address the identified barriers or what the expectation is for these strategies to increase utilization of nursing services.	
38.d. iv. Include the barriers and	DBHDS did not identify or discuss the barriers in its semiannual report.		**In Progress**

efforts to resolve them, as well as the factual basis for those barriers and efforts, in the semi-annual nursing report that is posted in the Library.	The barriers and strategies to address them were included in the Work Plan.		
38.e) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the Commonwealth will initiate a rate study of Private Duty Nursing by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the	The Commonwealth under the leadership of the Department for Medical Assistant Services (DMAS) has contracted with Guidehouse to conduct the rate study. DMAS has created a DD Rate Work Group that first convened 12.12.24. The Work Group includes representatives of providers, advocates and industry associations. Guide House conducted a rate study for services in the three DD 1915 c waivers, the CCC Plus Waiver and State Plan services including Skilled Nursing and Private Duty Nursing Services (4,5). Guide House issued a draft report in July 2025 which suggests rate increases for all of the services that they were directed to study and		**Completed and Ongoing**

Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Private Duty Nursing by January 1, 2029. The rate study shall be completed in time to be considered at the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.	analyze, with the goal of recommending rates that would assure sufficient capacity. The rate study includes direct, indirect, and administrative costs and adjusts for differences in costs in Northern Virginia compared to the rest of the Commonwealth (4,5,6). The United States has identified concerns and asked questions about Guidehouse's draft report. The focus of DOJ's concerns questioned whether the completed rate study fulfills the PI requirements to design the study to ensure sufficient provider capacity to achieve the specified goal of this and the other identified Terms (7). The final report responded to each of DOJ's stated concerns (4). On 10.15.25 (10) the Commonwealth's Director of DMAS submitted the DD Waiver Rate Study report to Governor Youngkin, the Chairs of the House and Senate Appropriation Committees and Virginia's Department of Planning and Budget.		

	The Governor's proposed FY27 budget will be the next Commonwealth effort to obtain from the General Assembly funding necessary to increase rates to those recommended by the study. (8,9).		
38.f) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 38(a) through 38(d), DBHDS also will conduct a root cause analysis and determine whether a QII is warranted to address identified issues. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Not Yet Implemented Due:1/15/27**

39. Skilled Nursing. The Commonwealth will work to achieve a goal that 70% of individuals on the DD waiver and children with DD receiving EPSDT with skilled nursing identified in their ISPs or prescribed under EPSDT will have their skilled nursing needs met 80% of the time. To achieve that goal, the Commonwealth will take the following actions:	The OIHSN performed the review of the FY25 data for nursing services authorized and delivered from 7.1.24- 6.30.25. Virginia did not achieve the level of nursing hours utilization performance expected. Only 60 (31%) of the 192 unique individuals with Service Authorizations (SA) received 80% of the hours allotted. This compares favorably to 27% of unique individuals (54 of 198) with SAs receiving 80% of the SN nursing hours allotted in FY24. The Nursing Hours Utilization Report issued in September 2025, did clearly distinguish between the utilization of SN versus PDN hours. This allows the reviewer to determine the Commonwealth's progress meeting each of the PIs analyzed in this study. Later in the Nursing Services Data Report, DBHDS includes a Table of Utilization by Procedure Code. There are two codes for SN. S9123 is the utilization by SN RNs and is 20%, compared to 24% in FY24 based on updated billing data for FY24. S9124 is the utilization	The number of individuals authorized for skilled nursing services continues to decline after a peak in FY19 when 305 individual were authorized for SN. In FY25, 192 individuals were authorized. DBHDS reports 60 (31%) of the individuals received 80% of their authorized nursing hours. The number of EPSDT recipients is 15 of whom 4 (27%) received their authorized hours, and the number of DD Waiver recipients is 177 of whom 56 (32%) received 80% of their authorized hours. There is a slight increase in utilization from FY24 when 29% of those individuals with authorization received 80% of their authorized hours. Since providers can bill for up to twelve months after the service was provided, DBHDS reports it may not have accurate and complete utilization data until a full year has passed from the end of each fiscal year. DBHDS has updated its billing data through FY24. This will make it difficult to determine the accuracy of the rating determination at the end of each fiscal year to conclude whether	Not Achieved **Not Achieved**

	code by SN LPNs and is 41% compared to 32% in FY24 based on updated billing data for FY24 (2,11).	the Commonwealth is in compliance. Conclusion: PI 39 is not met as the Commonwealth did not achieve the 80% level of utilization for 70% of its EPSDT and DD Waiver recipients for SN services.	
39.a) Semi-annually, on May 15 and November 15 of each year, DBHDS will continue to report data on utilization of nursing services and the work of the DBHDS Nursing Workgroup.	See 38. a.		**Completed and Ongoing**
39.b) As part of the IMNR Process, DBHDS will assess if individuals have unmet nursing or other medical needs and will work with families, providers, and case managers to take steps to resolve identified unmet needs. Semi-annually, on April 15 and October 15	See 38. c.		**Completed and Ongoing**

of each year, DBHDS will report on the IMNR process, including the types of unmet needs identified and efforts taken to resolve them.			
39.c) *Skilled Nursing Review*. Beginning within three months of the date of this Order, for individuals with a skilled nursing need identified in the Waiver Management System, DBHDS will begin to conduct on-site IMNR reviews as set forth in this paragraph. DBHDS will conduct the on-site IMNR reviews of a randomized sample of 10% of individuals annually (split between two six-month reviews) to determine if	See 38. c.		**Completed and Ongoing**

individuals' skilled nursing services needs are being met. In selecting individuals during each six-month review period to review, DBHDS shall include in the sample only individuals who were authorized to receive the service at least three months earlier, to ensure sufficient time for the sampled individuals to have received the service.			
39.d) If the Commonwealth has not achieved the goal as reported in its December 1, 2024 status update and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two	See 38.e.		**Completed and Ongoing**

years, the Commonwealth will initiate a rate study of Skilled Nursing by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its December 1, 2028 status update and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Skilled Nursing by January 1, 2029. The rate study shall be completed in time to be considered at the 2030 legislative session. Any rate study required by			

this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.			
39.e) If the Commonwealth does not achieve the goal within two years of the date of this Order after taking the actions in Paragraphs 39(a) through 39(c), DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Not Yet Implemented Due 1/15/27**

Recommendations: DBHDS should develop measurable goals to address the required action, 38.d. ii. DBHDS should report how it plans to address the barriers of lack of incentives, inconsistent staffing and insufficient LPN capacity. DBHDS should ensure the barriers and resolutions are posted in the Library as required by 38.d. iv.

Attachment A
Documents Reviewed

1. CLO 27th Study Period Document Tracker
2. DBHDS Nursing Services Data Report Updates FY19-FY24; FY25 September 2025
3. Nursing Work Plan/Nursing Access Report Updated 10.10.25
4. VA Developmental Disabilities Waiver Rate Study: Final Report Draft July 2025
5. Rate Component Discussion- Preliminary Analysis 7.10.25
6. Draft Rate Advisory Group Presentation 7.10.25
7. DOJ Comments to Rate Study 8.25.25
8. Performance Budgetary Systems Report-Recommended Increases to DD Waiver Service Rates
9. DP-125 ID DD Waiver Rate Changes updates 10.3.25
10. Memo for Cheryl Roberts, Director, DMAS to Governor Glenn Youngkin transmitting the DD Waiver Rate Study Final Report
11. DBHDS Nursing Services Data Report Updates FY19-FY24; FY25 Revised 10.22.25
12. Email from Brian Nevetral 10.23.25
13. Emails from Brian Nevetral 10.16.25 and 10.24.25

Submitted by:
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November 13, 2025

APPENDIX E

Services for Individuals
with
Complex Behavioral Support Needs

By

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Introduction/Background

As required by the Independent Reviewer's responsibilities under the Permanent Injunction, this report is submitted to summarize the most recent review of a sample of individuals included in the requirements of Terms 40, 44, and 54.

Term
40. The Commonwealth will work to achieve a goal that 86% of individuals who are supported in residential settings and have coverage for dental services will receive an annual dental exam. 44. The Commonwealth, through DBHDS, will collect and analyze data at least annually regarding the management needs of individuals with identified complex behavioral, health, and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS will develop corrective actions based on its analysis as it determines appropriate, track the efficacy of the actions, and revise as it determines necessary to address the deficiency. To implement the preceding steps, the Commonwealth will take the following actions: b) DBHDS will continue to implement the IMNR process for no less than 70 people annually who have complex medical, behavioral, or adaptive support needs (TIER 4) to include onsite visits, reviews of specific healthcare documentation, and a factual questionnaire administered by qualified nursing professionals to primary caregivers most familiar with the person's healthcare needs. 54. The Commonwealth will work to achieve a goal that 86% of individuals supported in residential settings receive annual physical exams.

The Individual Services Review (ISR) Study for the 27th review period is designed to assess the sufficiency of the Commonwealth's process for collecting and analyzing data regarding the management needs of individuals with complex behavioral support needs and its related Intense Management Needs Review (IMNR)/Office of Integrated Health Support Network (OIHSN) remediation system for the individuals with complex health needs whose services were reviewed during the 26th review period. Although the sample during a single review period is too small to permit its findings to be generalized to the system as a whole, this ISR Study is intended as an opportunity to assess the availability and accessibility of resources necessary for the adequacy of both the management and the supports provided to ensure health, safety, and well-being of people reliant on the Commonwealth's services and supports.

The ISR Study is conducted through on-site visits, interviews with the primary caregiver(s), the individual him/herself, if possible, review of relevant documentation, and a factual questionnaire administered by three nursing professionals under the supervision of the Independent Reviewer and his Team Leader. The Department of Behavioral Health and Disability Services' (DBHDS) IMNR study, which is conducted by three of DBHDS's nurses, under the leadership of the OIHSN Director, was also implemented including these same elements, which are required by Term 44 b). In planning and conducting these parallel studies, there is close collaboration and shared decision-making with DBHDS and its OIHSN on the key components of the fieldwork. In fact, this collaboration has been strengthened and expanded over the years. It now includes proactive planning, case reviews, and detailed discussions of the "lessons learned." All fieldwork is conducted by three teams of highly qualified nurses, assigned both by the Independent Reviewer and the OIHSN. As required by Term 44, the findings from the respective monitoring questionnaires assist DBHDS to 1) develop corrective actions based on its analysis as it

determines appropriate, 2) track the efficacy of the actions, and 3) revise as it determines necessary to address the deficiency. The remediation look-behind activities conducted by the Independent Reviewer's team are provided to DBHDS to complement its own efforts.

27th Review Period Study

This is the second ISR study to be completed this year. The report for the 26th review period ISR Study was submitted to the Independent Reviewer on May 16, 2025 and was subsequently filed with the Court on June 13, 2025. Since that was the second Study to be completed regarding individuals with complex medical needs, the Independent Reviewer determined that the current Study, as well as the next Study in the 28th review period, would focus on individuals with complex behavioral needs.

On June 1, 2025, the Independent Reviewer requested that a sample of 30 people be randomly selected from the cohort of individuals living in Regions 1, 3 and 4 with DD Waiver services and SIS scores of Level 7 (complex behavioral needs.) The sample was stratified to include 10 individuals from each Region. All selected individuals had their annual ISP meetings occur between October 1, 2024 and December 31, 2024.

The respective Monitoring Questionnaires were revised to include questions related to behavioral concerns and behavioral supports. Following a collaborative discussion of these changes, in order to strengthen inter-rater reliability, the fieldwork began on August 11, 2025 and concluded on September 19, 2025. All site visits were completed as planned with two exceptions. One family had COVID at the time of the scheduled visit and the interview was conducted by telephone rather than in-person. The second interview did not include a meeting with the individual being reviewed. He was placed at a REACH program site and was not accessible to the nurses.

Characteristics of the Sample

The sample includes 22 males and 8 females. The ages range from 12 to 84. There are four young people, aged 12, 17 and two aged 19. However, the majority of the individuals (40%) are between 21 and 30 years old.

Communication methods are described primarily as "fully able to articulate spoken language without assistance" (30%) or "limited spoken language requiring some staff support" (43%).

The majority of the individuals reviewed walk without support (77%) or with some support (13%) while only two use wheelchairs or require total assistance (10%).

It is interesting to note the distinct differences between this sample and the one included in the 26th review period. In that sample, most people in the sample (55%) used gestures, vocalizations, or facial expressions to communicate and 66% of the people relied on wheelchairs. Consequently, the need to focus on physical health issues in this current review was less than in prior review periods.

These differences are referenced because it was evident, at the start of the preparation for this ISR Study, that reviewing the people with behavioral concerns would require modifications to the scope of the Monitoring Questionnaire. A number of very informative discussions were held with DBHDS staff, including the Director of Behavioral Services and Projects, in order to draft and refine questions relevant to the provision of behavioral supports. In the end, consensus was reached on all questions. Since the next ISR Study will also focus on people with behavioral concerns, further discussion will be held in order to determine whether additional refinement of the Monitoring Questionnaire is necessary for clarification or greater detail.

A Demographic Table for the current sample is included as an Attachment.

Discussion of Major Themes and Initial Findings

The narrative below summarizes the 27th review period's findings related to the Terms cited above from the Permanent Injunction.

Due to the nature of this current Study and its primary focus on people with complex behavioral support needs, the findings related to Term 44 will be discussed first and the findings related to Terms 40 and 54 will follow.

Term 44: Initial Findings from the Independent Reviewer's Team

The descriptions and issues included below are drawn from the Monitoring Questionnaires completed by the three nursing consultants retained by the Independent Reviewer. Since there will be additional discussions with the staff of DBHDS, these findings may be supplemented.

After examining the Monitoring Questionnaires, the sample of people with complex behavioral needs appears to consist of two groups of individuals.

First, in responding to Section 9 of the Monitoring Questionnaire, upon review of the provided documents and the interviews completed with the residential caregivers, there were 7 individuals (23%) who are not displaying any negative behaviors. These individuals live in Region 1 (1 person); Region 3 (2 people); and Region 4 (4 people). Although their diagnoses included schizoaffective disorder; Attention-Deficit/Hyperactivity Disorder (ADHD); Autism Spectrum Disorder (ASD); bipolar disorder; general anxiety; mood disorder; intermittent explosive disorder; and Alzheimer's dementia or a combination of the above, there were no behaviors cited that could result in injury to self or to others.

Each of these individuals was prescribed psychotropic medications. As will be discussed further, the number of psychotropics ranged from one to seven medications.

For Individuals #06, 13, 16, 21, and 25, any previously reported behavioral concerns have been extinguished by a stable living environment, trained staff, behavioral interventions, and ongoing behavioral oversight. Reportedly, Individuals # 26 and 28 did not have behavioral support needs

indicated from the available sources of information. This information may require further review to ensure its accuracy.

Second, the remaining group of 23 individuals (77%) had detailed information provided regarding disruptive or harmful behavior. The diagnoses replicated those listed above with the addition of unspecified conduct disorder, depression, and adjustment disorder.

All but two of these individuals (#s 2 and 29) had prescribed psychotropic medications, ranging from one to five medications.

At the time of the reviews, there were behavior support plans and behavioral interventions being implemented for ten of the individuals in this second group. Despite the behavioral supports, in his residence, one individual (#27) was placed in a REACH facility and remained there at the time of the site visit, approximately 10 days later. Prior to this admission, his provider made three requests for interventions by REACH. The first request was denied because there was no capacity; the second request was denied due to Individual #27's elopement risk; the third request resulted in a psychiatric evaluation and medication adjustment, without notable change in his behavior. It is not possible to determine whether attention by REACH to these earlier requests would have reduced or eliminated the need for out-of-home placement.

For the sample of individuals reviewed, this Study found that residential providers with education, experience, or training in working with people with behavior support needs were able to help decrease or successfully manage unwanted behavior. For example, Individual #22 has lived with her caregiver since 2016. Her caregiver is experienced in ABA services, having worked at the Faison Center. Not only is the caregiver knowledgeable, but there is also a structured routine and the entire family provides significant support, including respite. The Independent Reviewer's nurse described these residential supports as exemplary. The review for Individual #17, also conducted by one of the Independent Reviewer's nurses, concluded: "When the interview was completed, I felt like I had received a master class in positive behavioral support. This sponsored home family provides intense and consistent support in the community to ameliorate long-standing behavioral issues, most likely routed in trauma history."

Interestingly, during the year reviewed, there was no evidence that police were called for anyone in the sample. There were no psychiatric hospitalizations or any documented use of physical, chemical, or mechanical restraints. Time-out was not reported. With the exception of Individual #27, there was no contact with crisis services recorded in the information reviewed by the nurse consultants.

The prevalent use of psychotropic medications was not unexpected. However, the Independent Reviewer's nurse consultants recommended that five people in the sample have their medication reviewed by a psychiatrist. There were no diagnoses recorded for Individual #14. Individual #5 had five prescribed medications and, in response to question #136, they were considered possibly excessive. Individual #19 is prescribed five medications and was observed to have tongue tremor, a sign of tardive dyskinesia. Her medications appear to be under review but continued oversight appeared to be needed. Individual #28 is prescribed, with her own consent, five psychotropic

medications but, due to her family situation, they may not be administered. Individual #16's combination of medications raised concern because of his Alzheimer dementia diagnosis.

With the exception of Individual #19 and Individual #2, there was no evidence of possible tardive dyskinesia. Individual #2 displayed restlessness. His doctor was aware of this symptom.

The discussion of the findings related to behavior support needs with DBHDS staff has already been initiated. On October 15, a virtual meeting with the nurse consultant for Region 4 was held with the Director of Behavioral Services and Projects and the OIHSN team, including the Director, Project Manager, and nurse from Region 4. Three cases were reviewed. An additional discussion regarding individual cases via a virtual meeting will be scheduled in the near future. It is expected that the staff working with the Director of Behavioral Services and Projects will be included in that call. It is another excellent example of the way in which DBHDS, through OIHSN, is strengthening the collaboration within its own organization.

Term 44: Remediation Look-Behind Summary Regarding Individuals with Complex Medical Needs Reviewed During the 26th Review Period

The six nurses assigned to this collaborative work often discover clinical, programmatic, or environmental concerns that require corrective actions to provide needed supports to ensure the health and safety of the person under review. In certain instances, the IMNR nurse identified and reported a needed corrective action on the day of the site visit. For example, during this current review period, the living conditions in the home of Individual #28 were determined to be of significant risk to her and her siblings The OIHSN nurse and her supervisor reported the circumstances to the appropriate authorities and acted promptly to identify alternate care. This situation continues to be under investigation.

However, most concerns do not rise to this level of immediate risk and the IMNR nurses document the concern for follow-up through the DBHDS remediation process. Each of the last three ISR Studies include a look-behind of a sample of concerns identified by the six nurses in the prior review period. The ISR Study for the 27th review period focuses its look-behind attention on the adequacy of DBHDS's remediation system to address the health-related concerns identified in the 26th review period.

Thirteen individuals from Regions 2 or 4 were selected for this Study's look-behind process. The issues identified for corrective actions include dental care, adaptive equipment, clinical appointments and assessments, and health care protocols.

The Independent Reviewer's nurse consultants were instructed to complete a summary form for each issue documented for each person in the sample. Information regarding the extent to which each issue was sufficiently addressed was obtained through one or more sources, including interviews with the family or provider, consultation with the OIHSN nurse who participated in the site visit, and/or document review.

A detailed summary of the findings has been shared with DBHDS. The summary notes the following observations about the remediation process itself:

1. The OIHSN nurses were diligent in collecting and gathering data by completing on-site visits, completing a fact-based monitoring questionnaire, interviewing primary caregivers, and reporting the issues documented during each site visit. The identification of health-related issues was consistent by both sets of nurses and there was overall concurrence on the identification of issues that require remediation. The OIHSN process resulted in 100% development of corrective actions by the DBHDS nurses, frequently in consultation with the families or the Support Coordinator responsible for the individual's care and habilitation.
2. There was little need for revision in the nature of those initially recommended corrective actions, although there were periodic adjustments in scheduling and/or the identification of potential resources.
3. OIHSN staff routinely and consistently tracked the timeliness and effectiveness of the corrective actions. However, in several instances, OIHSN staff identified an obstacle to addressing the targeted concern. In some cases, Support Coordinators or residential caregivers failed to implement or oversee their assigned corrective actions in a timely manner, as necessary. Despite repeated calls by the OIHSN nurse, some corrective actions were not implemented as required or within the corrective action timelines. Therefore, the current DBHDS remediation system does not yet demonstrate that it leads to the identified health-related support concerns being resolved and that the corrective action plans are being effectively implemented with reliability throughout the DBHDS DD system as a whole.
4. The successful completion of the recommended corrective actions is, as expected, highly dependent on the resources available to address the problem. It is clear that the response time and, in some situations, even the quality of the work ensuring that identified health support concerns are addressed benefits from the direct involvement of DBHDS-managed resources. The work of the dental clinics and the Mobile Rehab Engineering (MRE) specialists is especially notable. The OIHSN nurses themselves are frequently involved personally in implementing the corrective actions. They provided health-related protocols, referrals, and guidance to help resolve the concerns of families and residential providers. This assistance resulted in the identified issue being addressed and improved care for the individuals in the sample.
5. It has been difficult for DBHDS to ensure timely and effective implementation of some corrective actions. The lack of resource availability and the lengthy wait for certain clinical appointments within the generic healthcare system significantly delayed the completion of the corrective action in certain cases, even though the planned actions are relevant and appropriately individualized.

In conclusion, at the time of this Study, many corrective actions had been implemented for individuals reviewed during the 26th period studies. Implementation of several of the planned corrective actions was delayed due to the lack of timely implementation by Support Coordinators or residential staff, despite multiple follow-up calls by the DBHDS's IMNR nurses. It is recommended that DBHDS should consider revising the current remediation system for individuals with complex needs to include mandated actions and timelines, with staggered penalties, at the CSB and Support Coordinator levels in order to implement the recommended, and agreed to, corrective actions, including within an adequate timeline.

Although this study alone could not determine that DBHDS's current remediation system is currently sufficient to address identified health concerns, the evidence clearly establishes that, for the individuals in this sample, the Support Coordinators and residential staff must implement the planned corrective actions in a timely manner, before DBHDS's remediation process will be sufficient.

Term 40: Completion of Annual Dental Exam

Among the small sample reviewed, progress in providing annual dental exams continues to improve but is still insufficient to meet the 86% specified goal for this Term. The Independent Reviewer's nurse consultants documented that 23 of the 29 (79%) people reviewed received their annual dental exam. (One individual has an approved variance from this requirement since he is on a schedule for a dental exam with sedation every two years. As a result, he is not included in the calculation.)

It continues to be significant that all people (100%) included in the sample have dental coverage.

The problems with obtaining dental care are familiar ones: two individuals aged out of pediatric dental care and now require a dentist that serves adults; one individual requires sedation and is on a waiting list. However, it was also reported that one dentist has cancelled and rescheduled the appointment three times; one dentist reportedly did not respond to multiple calls regarding the need for dentures; and one individual refuses to see the dentist.

Term 54: Completion of Annual Physical Exam

Among the small sample reviewed, progress continues to be evident in the provision of an annual physical exam within the previous 14 months.

It is documented that all but one of the individuals in the current sample (97%) received an annual physical exam in the time period under consideration. Individual #28 does not have a Primary Care Physician since her parent will only consult Urgent Care as necessary.

Based on the information obtained from the documentation and site visit interviews, in response to Question #138, the Independent Reviewer's nurse consultants are recommending that additional medical/clinical oversight be conducted to ensure that certain individuals' health needs are met: lab work appears warranted for four individuals; nutritional assessments are recommended for three individuals; one person seems to require an eye exam; and colorectal screening may be necessary for one person. In addition, a complete medical workup is recommended for one person to rule out physical reasons contributing to his behavioral challenges and another individual requires a protocol for monitoring his shunt. After observing one young woman's history of skin abscesses, urinary tract infections, dehydration, and special mealtime needs, including the risk of aspiration, it is suggested that nursing services may be beneficial for monitoring her on a routine basis as well as implementing a plan designed to improve her overall health status.

It should be noted that OIHSN responded promptly to the site visit's direct observation that one individual requires referral to a neurologist and that her wheelchair required timelier repair. This is yet another example of the active involvement of OIHSN staff in identifying and working expeditiously to correct health-related problems discovered in the course of their responsibilities.

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

ID#	Annual Physical Exam	Annual Dental Exam	Physical/Dental Exam Notes
01	Yes	Yes	
02	Yes	Yes	
03	Yes	Yes	
04	Yes	Yes	
05	Yes	Yes	
06	Yes	No	Sedation is required.
07	Yes	No	Dentist cancelled appointment three times.
08	Yes	Yes	
09	Yes	No	Individual refused.
10	Yes	Yes	
11	Yes	Yes	
12	Yes	Yes	
13	Yes	Yes	
14	Yes	-	Variance approved for exam with sedation every two years.
15	Yes	Yes	
16	Yes	Yes	
17	Yes	Yes	
18	Yes	Yes	
19	Yes	Yes	
20	Yes	Yes	
21	Yes	Yes	
22	Yes	Yes	
23	Yes	No	Aged out. Needs to find adult care dentist.
24	Yes	Yes	
25	Yes	No	Needs dentures. Reportedly, dentist not responding to multiple calls.
26	Yes	Yes	
27	Yes	Yes	
28	No	Yes	Does not have a PCP. Mother uses Urgent Care for her, as needed..
29	Yes	Yes	
30	Yes	No	Aged out. Needs to find adult care dentist.
%	**(29/30) 97% Received the exam**	**(23/29) 79% Received the exam**	

Additional Findings

All ISPs were reviewed for this Study and all are current. As in past Studies, the On-Site Visit Tool (OSVT) continues to be among the documents requested. This document is especially important because it should confirm that the needs identified in the ISP are being met and, if not, what problems or obstacles exist. The frequency of completion is related to the type of case management, and the schedule of visits, provided to the person. Enhanced Case Management/Support Coordination requires monthly reporting. General Case Management/Support Coordination requires quarterly documentation.

The current ISR Study's analysis of the completion and accuracy of the OSVT for the 30 people in the sample indicates variable results depending on the Region of the individual's residence. The frequency of timely completion of the OSVT was highest in Region 3 with 100% adherence to the expectation. Region 1 had a completion rate of 70%. The weakest performance appeared to be in Region 4 with only 67% of the OSVTs completed as expected.

As reported in the Monitoring Questionnaires, there was some inconsistent information in certain OSVTs and occasionally errors were noted. Since the quality of the OSVTs continues to be an important initiative at DBHDS, further analysis, if desired, can be shared in the meeting between the Independent Reviewer's team and OIHSN in which the lessons learned from the 27th ISR Study are discussed.

Concluding Comments

After 27 Individual Services Review Studies, it is now possible to evaluate the evolution of this methodology and the variables that have contributed to the improvements of its processes.

Without question, there has always been excellent cooperation from DBHDS with the planning and organization of the various tasks, especially the selection of the sample, the scheduling of site visits, the production of documents, and the resolution of unforeseen issues or concerns.

With the last three Studies, in particular, the collaboration has increased in multiple important ways. Planning for the fieldwork now includes not only the necessary logistical work but considerable discussion about the ways to strengthen the fact-finding, identify patterns, analyze data, and determine possible remedial actions. The scope of inquiry has benefited immeasurably by the expertise shared among the OIHSN staff and the Independent Reviewer's team. It has been especially important to have OIHSN invite other DBHDS staff to participate in these discussions. The review of OSVTs and case management responsibilities is one prior example and there is now the involvement of staff with expertise in behavioral supports contributing to this work. These contributions are greatly appreciated by the Independent Reviewer and his team. As always, great credit must go to the individuals, families and residential providers who welcomed us into their homes and patiently answered all of the questions. It was encouraging to learn that they found the site visits to be helpful and they looked forward to any problems being addressed through the remediation process.

ATTACHMENTS

Demographic Tables

Section 9: Supplemental Questions

Demographic Tables

Region		
I	10	33%
II	10	33%
III	10	33%

Sex		
Male	22	73%
Female	8	27%

Age Group		
Under 21	4	13%
21-30	12	40%
31-40	6	20%
41-50	1	3%
51-60	5	17%
61-70	1	3%
71-80	0	0%
81-90	1	3%
Over 90	0	0%

Mobility Status		
Walks without support	23	77%
Walks with support	4	13%
Uses wheelchair	2	7%
Total Assistance	1	3%

Communication Method		
Spoken Language, Fully Articulates Without Assistance	9	30%
Limited Spoken Language, Needs Some Staff Support	13	43%
Communication Device	1	3%
Gestures	6	20%
Vocalizations	1	3%
Facial Expressions	0	0%
Other	0	0%

Residence Type		
Group home	10	33%
Own/family home	6	20%
Sponsored home	14	47%

MONITORING QUESTIONNAIRE

SECTION 9: SUPPLEMENTAL QUESTIONS

GROUP ONE: PRIOR AND/OR NO CURRENT BEHAVIORAL ISSUES

		Yes	No	NA
212.	Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that:			
	a. could result in injury to self or others?		7	
	b. disrupt the environment?		7	
	c. impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)?		7	
	d. impede his/her ability to learn new skills or generalize already learned skills?		7	
	e. negatively impact his/her quality of life and greater independence?		7	
	f. Does the ISP authorize the need for behavioral services?	2		5
	1. Are the behavioral services currently being provided?	2		
	a. If No, are they in process of being provided?			2
	g. Are the behavioral services wanted by the individual or his/her Guardian/Authorized Representative?	4	1	2
217.	Is there a behavior plan in place to address the behavior(s) identified above?	3		4
	a. If No, is there a behavior plan in progress because services recently started?			7
218	Is there a functional behavior assessment (FBA) completed in the current setting?	3		4
	a. If No, is the FBA in progress because the services recently started?			7
219	Are there target behaviors for decrease?	3		4
220	Are there behaviors targeted for increase?	3		4
222	Does the behavior plan or the Part V Plan For Supports specify the data to be collected to determine whether planned interventions are working?	2	1	4
223	Have the data been summarized and reviewed by a qualified behavior clinician?	1	1	5

MONITORING QUESTIONNAIRE

SECTION 9: SUPPLEMENTAL QUESTIONS

GROUP TWO: DEMONSTRATING CURRENT BEHAVIORAL ISSUES

		Yes	No	NA
212.	Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that:			
	a. could result in injury to self or others?	20	3	
	b. disrupt the environment?	22	1	
	c. impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)?	20	3	
	d. impede his/her ability to learn new skills or generalize already learned skills?	19	4	
	e. negatively impact his/her quality of life and greater independence?	19	4	
	f. If Yes, does the ISP authorize the need for behavioral services?	11	11	1
	2. Are the behavioral services currently being provided?	9	3	11
	a. If No, are they in process of being provided?	2	4	17
	g. Are the behavioral services wanted by the individual or his/her Guardian/Authorized Representative?	13	8	2
217.	Is there a behavior plan in place to address the behavior(s) identified above?	10	11	2
	b. If No, is there a behavior plan in progress because services recently started?	0	7	16
218	Is there a functional behavior assessment (FBA) completed in the current setting?	10	10	3
	a. If No, is the FBA in progress because the services recently started?	0	14	4
219	Are there target behaviors for decrease?	11	0	12
220	Are there behaviors targeted for increase?	10	1	12
222	Does the behavior plan or the Part V Plan For Supports specify the data to be collected to determine whether planned interventions are working?	9	4	10
223	Have the data been summarized and reviewed by a qualified behavior clinician?	7	2	14

APPENDIX F

Provider Training

By

Chris Adams, MS

TO: Donald Fletcher, Independent Reviewer

FROM: Chris Adams, Consultant

RE: 27th Study Report: Provider Training

DATE: November 14, 2025

Introduction/Background

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

Term 47 – Training Requirement Compliance requires that the Commonwealth work to achieve a goal that 86% of DBHDS-licensed providers receiving an annual inspection will have a training policy that meets established DBHDS requirements and that DBHDS will take action it determines appropriate if providers fail to comply with training requirements required by regulation. Previous studies have found that the Commonwealth has not yet attained the 86% goal specified in Term 47. Specifically:

- During CY2022, 973/1156 licensed providers (84.2%) met these requirements during their annual licensing inspection.
- During CY2023, 819/1105 licensed providers (74.1%) met these requirements during their annual licensing inspection.
- During CY2024, 881/1192 providers (73.9%) met these requirements during their annual licensing inspection.

Term 48 – Training and Competency of Direct Support Professionals outlines the training and core competency requirements for Direct Support Professionals (DSP) and their supervisors asdefined in 12VAC30-122-180, effective March 31, 2021. In November 2021, the Commonwealth made modifications to address concerns about the adequacy of the Department of Medical Assistance Services (DMAS) provider review process in evaluating the Commonwealth's compliance with these requirements. These modifications included using Quality Service Reviews (QSRs) to provide objective data for measuring the training threshold specified in Term 48. The Commonwealth established that, to successfully achieve the requirements of Term 48, 95% of providers in the sample must meet two distinct measures: (1) the percentage of provider agency staff meeting orientation and training requirements, and (2) the percentage of DSPs meeting competency training requirements. Since implementation of these modifications, the Consultant's studies assessed whether the scoring and data validation procedures produced valid and reliable data to meet Term 48's 95% goal, described the processes through which data was obtained to measure achievement of the requirements, and described the

verification, validation, and testing procedures for this data performed by the data analyst. The 95% goal was not achieved for either outcome as measured during QSR Rounds 5 and Round 6. During QSR Round 5, Outcome 1 was at 77.8% and Outcome 2 at 85.3%. During Round 6, Outcome 1 was at 77.5% (slight decrease from Round 5) and Outcome 2 at 86.6% (slight improvement from Round 5).

The determinations from this 27th period study for Terms 47 and 48 are described in Table 1 below.

Table 1	
Term	**27th Period**
Term 47: Training Requirement Compliance. The Commonwealth will work to achieve a goal that 86% of DBHDS-licensed providers receiving an annual inspection will have a training policy that meets established DBHDS requirements. DBHDS will take action it determines appropriate if providers fail to comply with training requirements required by regulation.	**Not Achieved**
Term 48 – Training and Competency of Direct Support Professionals. The Commonwealth will work to achieve a goal of at least 95% of Direct Support Professionals and their supervisors receive training and competency testing in accordance with 12 VAC 30-122-180 as in effect on the date of this Order or as may be amended.	**Not Achieved**

27th Period Study

The Consultant who previously studied Provider Training also conducted the 27th period review.

Term 47:

To assess the Commonwealth's efforts to achieve the 86% goal in Term 47, the Consultant examined DBHDS processes for monitoring provider adherence to §450, their assistance and training efforts, and how its licensing specialists assess provider implementation of DSP/DSP Supervisor training requirements. The Consultant also reviewed inter-rater reliability measures and interviewed DBHDS staff.

To assess the accuracy and consistency of licensing specialist determinations of provider compliance with §450, the Consultant sampled 80 inspection reports from the 1,021 inspections that the Office of Licensing completed in the 2025 cycle (out of a total 1453 scheduled). With 71.4% of inspections completed, the sample was statistically valid. The Consultant agreed with licensing specialists' findings in 66 out of 80 cases (82.5%), showing notable progress compared to previous studies' 65% agreement rate.

Term 48:
To assess the Commonwealth's efforts to achieve the 95% goal in Term 48, the Consultant assessed documentation concerning updates to the QSR process for Round 7; the QSR Round 7 assessment results pertaining to Term 48; the findings of a root cause analysis addressing why DSPs and DSP Supervisors may not receive the required training and competency evaluations under §180; DBHDS's development and implementation of a Quality Improvement Initiative based on the analysis; and the current status of the rate study for various waiver services intended to inform the Commonwealth's budget request for recommended rate increases to its General Assembly for the 2026 session.

The QSR Round 7 results reflected significant progress in Outcome 1 (77.5% to 92.7%). In contrast, Outcome 2 results have fluctuated over the last three rounds, showing a slight increase from Round 5 to Round 6 (85.3% to 86.6%) and a noticeable decrease in Round 7 (86.6% to 81.6%). DBHDS has not yet completed its comprehensive analysis of Round 7 or determined further remedial or corrective actions. Actions taken by DBHDS in response to the findings related to Term 48 will be reviewed during the forthcoming 28th study. The results of such actions, and whether the Commonwealth has achieved Term 48's specified goals, will be reviewed during the 29th period's study following completion of QSR Round 8.

Table 2 below describes the facts, analysis, and conclusions drawn from the review of the Commonwealth's efforts to achieve and sustain the requirements of Permanent Injunction Terms 47 and 48.

TABLE 2

Terms and Actions	Facts	Analysis/Conclusion	26th / 27th
47. The Commonwealth will work to achieve a goal that 86% of DBHDS-licensed providers receiving an annual inspection will have a training policy that meets established DBHDS requirements. DBHDS will take action it determines appropriate if providers fail to comply with training requirements required by regulation. To achieve that goal, the Commonwealth will take the following actions:	DBHDS has regulations that address the requirements of Term 47. *12VAC35-105-450* mandates a provider training policy, while *12VAC35-105-50, 100, 110, and 115* outline negative actions and sanctions for providers with recurring citations. DBHDS has continued its work to provide written and virtual training and guidance to providers to improve their ability to meet the requirements of Term 47. The Office of Community Quality Management offers Expanded Consultation and Technical Assistance support to providers who are non-compliant with regulations, including §450 and DBHDS made improvements to this process in April and July 2025. Based on the results of the Consultant's sample review conducted in the 26th/27th studies, the Consultant agreed with 66/80 licensing specialist determinations (82.5% agreement), a significant improvement from the 24th/25th	Previous studies have confirmed DBHDS mandates training policies under licensing regulation *12VAC35-105-450*. Additionally, regulations *12VAC35-105-50, 100, 110, and 115* outline negative actions and sanctions for providers with significant or recurring citations. Its Office of Licensing (OL) provides guidance to licensing specialists to make decisions as to whether a provider is meeting each specific applicable regulatory requirement as described in the *Annual Compliance Determination Chart*. OL revises this document annually to ensure currency and accuracy. Under §450, providers must develop and implement a training policy covering all regulatory requirements and maintain documentation confirming employees and contractors have received the necessary training. Over the past three annual inspection cycles, DBHDS has not met the 86% goal in Term 47; however, with approximately 71% of inspections completed for CY2025, there was improvement from CY2024 to CY2025: • CY2022: 973/1156 (84.2%) • CY2023: 819/1105 (74.1%) • CY2024: 881/1192 (73.9%) • CY2025 (to date): 792/1021 (77.6%)* *Data used for calculation, as of 08/08/2025, represents completion of 1038/1453 inspections (71.4%) scheduled for the CY2025 annual licensing inspection cycle. This percentage is sufficient to generalize and compare data with previous calendar years. During the 26th and 27th studies, the Consultant conducted a sample review of 80 licensed provider records (30 during the 26th study and 50 during the 27th study) including the Corrective Action Plan document from the most recent annual inspection and the relevant evidentiary documents from the provider that were reviewed by the licensing specialist during that inspection. One of the focus areas in the sample review was to assess whether licensing specialists evaluated §450 compliance consistent with the language in the regulation and in accordance with processes and procedures	26th: Deferred **27th: Not Achieved**

	study from which the agreement rate was 65%. DBHDS has continued its initiatives to reach the 86% goal in Term 47. During the CY2025 licensing inspection cycle, results from 1,021 inspections completed through 08/08/2025 indicate that 792 providers (77.6%) are currently meeting these requirements, reflecting progress from the 73.9% assessed in the CY2024 cycle. Despite this improvement, the 86% goal has not yet been attained.	described in the relevant sections of OL's *2025 Annual Compliance Determination Chart*. Based on the results of this sample review, the Consultant concurred with 66/80 licensing specialist determinations (82.5% agreement), a significant improvement from the 24th/25th study from which the agreement rate was 65%. DBHDS has continued its work to provide written and virtual training and guidance to providers to improve their ability to meet the requirements of §450. Additionally, the Office of Community Quality Management offers both voluntary and mandatory Expanded Consultation and Technical Assistance (ECTA). The ECTA process is described in more detail in Action 47.b below. Other DBHDS initiatives focused on improving provider compliance with §450 are described in Actions 47.a and 47.c below. Efforts to establish inter-rater reliability in conducting compliance determinations during licensing inspections are described in Action 47.d below. As part of the continued improvement efforts described in the preceding paragraph, DBHDS is working with providers to achieve the goal that 86% of DBHDS-licensed providers receiving an annual inspection will have a training policy that meets established DBHDS requirements. DBHDS' efforts and initiatives described above and in the related Actions below have increased the percentage of providers that are meeting the requirements of §450, but the 86% goal has not yet been achieved.	
47.a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with training requirements develop and implement a corrective action.	DBHDS requires providers to create and submit written corrective action plans for each cited violation, as detailed in regulation 12VAC35-105-170. These requirements are also described in the *Office of Licensing Look-Behind Process*	Previous studies have documented that DBHDS maintains licensing regulations at *12VAC35-105-170* specifying that providers must develop and submit a written corrective action plan for each cited violation. These requirements remain in effect and are defined and described in the DBHDS licensing regulations and within its *Office of Licensing Look-Behind Process for DD Providers' Annual*	26th: Completed **27th: Completed**

	for DD Providers' Annual Inspections which addresses requirements for policy assessment, corrective action plan requirements, and progressive enforcement. The *Office of Licensing Look-Behind Process for DD Providers' Annual Inspections* process is regularly reviewed and was most recently updated in June and July 2025. The Consultant verified implementation of these procedures by reviewing regulatory findings for 80 licensed providers during the 26th and 27th studies.	*Inspections*. This document addresses (1) assessment of policy, (2) corrective action plan requirements, and (3) progressive enforcement. DBHDS conducts regular reviews and makes needed revisions of this process; its most recent updates took place in June and July 2025. The Consultant conducted verification of the process implementation through sample reviews of regulatory findings for 80 licensed providers during the 26th and 27th studies. The information and actions described above provide evidence that the requirements of Action 47.a continue to be completed.	
47.b) Within three months of the date of this Order, DBHDS Quality Improvement Specialists will offer providers technical assistance, additional training, and specific actions related to the respective areas of underperformance.	The Expanded Consultation and Technical Assistance (ECTA) process is managed by DBHDS and was established by its Office of Community Quality Improvement (OCQI) to offer technical support to providers regarding regulatory requirements such as 12VAC35-105-450. Providers can enroll in the ECTA process either voluntarily (by invitation from the ECTA team) or mandatorily, depending on circumstances.	DBHDS has continued the functions of the Expanded Consultation and Technical Assistance (ECTA) process, established by the Office of Community Quality Improvement (OCQI) to provide technical support to providers on various topics including the regulatory requirements at *12VAC35-105-450*. The process is outlined in the *Expanded Consultation and Technical Assistance Standard Operating Procedures (effective 08/23/2024)* and was described in detail in the 26th study report. There are two types of enrollments – voluntary enrollment based on an invitation from the ECTA team, or mandatory enrollment. The ECTA has been further enhanced as documented in the *Combined OL & OCQI Mandatory ECTA Protocol,* effective 07/15/2025 through addition of more specific requirements for mandatory enrollment. If a service provider receives two consecutive citations for one or more specific regulations (Non-Compliant Systemic) under §450, §520.A-D, or §620.A-D, the provider is required to initiate mandatory assistance	26th: Completed **27th: Completed**

	The *Combined OL & OCQI Mandatory ECTA Protocol*, effective 07/15/2025, added more requirements for mandatory enrollment in the ECTA process. Licensed providers who receive two consecutive citations for specific regulations (Non-Compliant Systemic) under §§450, 520.A-D, or 620.A-D must initiate mandatory assistance with the ECTA Team within 45 calendar days of receiving their most recent approved Corrective Action Plan. Providers failing to initiate or complete mandatory ECTA may face further enforcement actions by OL. Since April 2025, 141 providers enrolled voluntarily, and 102 participants (72%) have either completed or are currently participating in the program. 39 participants did not complete the program for various reasons. Since the mandatory enrollment criteria took effect on 04/01/2025, four providers have been enrolled under these requirements. Additional requirements for "Non-Compliant Systemic" mandatory enrollments started on 07/15/2025, and the first provider under these new provisions is	through the ECTA Team within 45 calendar days of receiving their most recent approved Corrective Action Plan. If the provider does not initiate or complete mandatory ECTA, the provider may be subject to additional enforcement by OL. The ECTA Team has completed five invitation periods beginning in 04/2025 for voluntary provider enrollment in ECTA. Of the 141 providers enrolled in the voluntary program, 102 provider participants (72%) have completed or are currently in progress. 39 other voluntary provider participants did not complete the program for various reasons. Invitations for the sixth ECTA round were sent beginning 09/10/2025. Under mandatory enrollment criteria that went into effect on 04/01/2025, four providers have been enrolled in mandatory ECTA. Additional requirements for Non-Compliant Systemic mandatory enrollments went into effect on 07/15/2025 and the first provider enrollment under this requirement is currently engaged in the ECTA process. The above-described actions support the continued determination that the requirements of Action 47.b have been completed. The OL and the ECTA team continue to review the effectiveness of these procedures and initiate additions or revisions as necessary.	

	currently engaged in the ECTA process.		
47.c) Within six months from the date of this Order, for providers who are not compliant with training requirements for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's license as determined appropriate by DBHDS.	DBHDS has licensing regulations and implementation protocols in place that meet the requirements of Action 47.c and DBHDS continues to consistently follow those protocols.	As described under Action 47.a above and consistent with the findings described in the 26th study report, DBHDS has licensing regulations and implementation protocols in place that meet the requirements of Action 47.c. Additionally, the requirements of Action 47.c are addressed through the ECTA process which is described in detail in the Analysis/Conclusion section for Action 47.b above. DBHDS most recently revised these protocols which became effective on 07/15/2025. The requirements are described in detail in the *Combined OL & OCQI Mandatory ECTA Protocol.* DBHDS continues to review and refine the protocols to enhance support for providers to consistently meet the regulatory requirements and to ensure progressive enforcement action for repeat violations including, but not limited to, requirements at §450. The above-described actions support the continued determination that the requirements of Action 47.c have been completed.	26th: Completed **27th: Completed**
47.d) Within 24 months of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess training requirements have established inter-rater reliability in conducting such assessments.	The Office of Licensing has developed and begun implementation of an inter-rater reliability process carried out by OL Quality Assurance staff who are not directly involved in the assessments. The process formally evaluates consistency and accuracy with which licensing specialists determine whether providers are meeting the regulatory requirements that are applicable to Term 47. The results provide objective and comparable data and information that is used to determine additional training and/or other	As described in the 26th study report, the Office of Licensing (OL) has continued and expanded several practices to address the requirements of this action, including: • DD Inspection Training for licensing specialists. • Regional Managers conducting unannounced parallel inspections with licensing specialists. • Tenured licensing specialists shadowing and mentoring newly hired licensing specialists. • Quality Improvement Specialist Look-Behinds. In addition to these processes, the OL has developed and begun implementation of a formal, measurable framework for continuously assessing inter-rater reliability *(OL Inter-Rater Reliability Process Updated 7.2025).* Each quarter, every licensing specialist, regional manager, and investigator will independently evaluate a single provider record randomly selected by the OL's Associate Director of	26th: Under Development **27th: In Progress**

	more specific remedial actions that may be necessary. The process is currently in its initial implementation phase, but when fully implemented it will provide objective and comparable data to guide the ongoing determination of inter-rater reliability among DBHDS licensing specialists as required in Action 47.d.	Quality & Compliance (ADQC). The licensing specialists will each provide a rating specific to the regulatory requirements at §§450, 520.A-D, and 620.A-D. OL's Quality Improvement Specialist (QIRS) then compares the results to the "gold standard" assessment results established by the QIRS and the ADQC. Within 30 days of completing the evaluations, the QIRS and ADQC review the comparative results. For any regulation where agreement is below 86%, the QIRS and ADQC will provide additional training specific to that regulation during a scheduled all-staff meeting or through small group training to address the areas of disagreement. The QIRS and ADQC will aggregate and analyze data from these reviews on an ongoing basis to identify any relevant trends or patterns that may require additional follow-up action. OL's first quarterly review began on 07/23/2025, with the anticipated completion of the analysis of results and follow-up action by 09/30/2025. While the process is currently in its initial implementation phase, if followed as described, it will provide objective and comparable data to guide the ongoing determination of inter-rater reliability among the Commonwealth's licensing specialists as required in Action 47.d. It will also serve as an objective, data-based tool for the ongoing review and analysis of licensing specialist determinations. The Consultant will complete a more in-depth analysis of OL's implementation of the process during the 28th study. The above-described actions support the determination that the requirements of Action 47.d continue to be in progress.	
48: The Commonwealth will work to achieve a goal that at least 95% of Direct Support Professionals and their supervisors receive training and competency testing in accordance with 12 VAC 30- 122-180 as in effect on the date of this Order or as may be amended. To achieve that goal, the	The DMAS regulation at *12VAC30-122-180* outlines the orientation and competency assessment requirements set forth in Term 48, with DBHDS's achievement measured through its QSR process. The training and competency assessment processes required	Previous studies have established that DMAS regulation *12VAC30-122-180* defines the mandatory training and competency evaluation requirements for Direct Support Professionals (DSPs) and DSP Supervisors. Additionally, these studies have verified that DBHDS utilizes Quality Service Review (QSR) data to assess compliance with training mandates as outlined by this regulation. For this measurement, one outcome from the QSR Person-Centered Review (PCR) and another from the QSR Provider Quality Review (PQR) are utilized.	26th: Deferred **27th: Not Achieved**

<table>
<tr>
<td>Commonwealth will take the following actions:</td>
<td>by this term are described in the Process Document DSP Comp Ver 008 (dated 9/28/25) and DBHDS documented in the DSP Competencies Attachment B Attestation Statement (signed on 10/8/25) that the data applied to measure these outcomes is both reliable and valid.

The Commonwealth has not yet achieved the 95% goal specified in Term 48 for either of the outcomes used to assess these requirements. However, DBHDS' efforts to refine processes and support providers in meeting training and competency testing requirements are ongoing.</td>
<td>DBHDS revised the process for collecting data for each of the two outcomes used to measure achievement of the 95% goal in Term 48 to align with changes made in the QSR process. The updated Process Document DSP Comp Ver 008 (dated 9/28/25) and the DSP Competencies Attachment B Attestation Statement (signed on 10/8/25) describe the data collection process and attest that the data applied to measure these outcomes is both reliable and valid.

A summary of these outcomes is provided below:
• Outcome 1 (PCR): Assesses the percentage of provider agency staff who meet orientation and training requirements. This determination is based on an examination of DSP training records and the competency assessments conducted by DSP Supervisors.
• Outcome 2 (PQR): Evaluates the percentage of DSPs within provider agencies who meet competency-based training standards, as determined through direct observation of DSPs delivering support and supervisors overseeing their teams.

The measure for Outcome 1 emphasizes whether providers have established processes for evaluating training and competency, while Outcome 2 relies on a combination of record reviews and live observations of staff performance.

Because QSR Round 7 was just underway during the 26th study, comprehensive assessment of progress towards Term 48's required outcome was not possible and a compliance determination was deferred. The table below summarizes scores relevant to Outcomes 1 and 2 from QSR Round 7, completed in August 2025, and includes comparative data for the three most recent QSR rounds.

<table>
<tr><th></th><th>QSR R5</th><th>QSR R6</th><th>QSR R7</th></tr>
<tr><td>Outcome 1</td><td>235/302</td><td>237/306</td><td>589/614</td></tr>
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	77.8%	77.5%	92.7%
Outcome 2	492/577 85.3%	519/599 86.6%	501/614 81.6%

Comparing the results from QSR Round 6 and QSR Round 7, there is noted improvement in Outcome 1, the percentage of provider agency staff who comply with orientation and training requirements. Results for Outcome 2 have varied across the three most recent QSR rounds, with a slight increase from Round 5 to Round 6 and a notable decrease in Round 7.

DBHDS has not yet completed a comprehensive evaluation of the results from QSR Round 7, nor identified additional remedial or corrective measures based on those findings. Based on results of this analysis, the Department will assess causative factors and determine appropriate follow-up actions that will be reviewed during the 28th study.

To date, DBHDS has implemented several measures to support providers in meeting regulatory requirements. These include conducting a root cause analysis and initiating quality improvement activities focused on priority issues identified through that analysis. Further details of these efforts are outlined in the Analysis/Conclusion section for Actions 48.a, 48.b, and 48.c below.

DBHDS is continuing its efforts to achieve the goal that at least 95% of Direct Support Professionals and their supervisors complete training and competency testing as required by 12 VAC 30-122-180. Current data from QSR Round 7 indicates that this goal has not yet been achieved for either Outcome 1 or Outcome 2.

48.a) Within six months of the date of this Order, the Commonwealth shall determine, through a root cause analysis developed in collaboration with	DBHDS conducted a root cause analysis coordinated by its Provider Issues Resolution Workgroup (PIRW) and	In the 26th study, the Consultant reviewed the DBHDS root cause analysis and survey coordinated by the Provider Issues Resolution Workgroup (PIRW) which determined that key factors preventing the achievement of the 95% goal under Term 48 included a high rate of staff turnover, providers' operational challenges in implementing	26th: Completed **27th: Completed**

the provider and system issues resolution workgroups, why Direct Support Professionals and their supervisors do not receive training and competency testing per 12 VAC 30-122-180.	determined that key factors preventing the achievement of the 95% goal under Term 48 included a high rate of staff turnover, providers' operational challenges in implementing the training and competency assessment processes, the need for simplified methods for recording training and assessment results, and the need to further standardize and simplify available guidance regarding the training process. The results of the root cause analysis provided information for DBHDS to identify specific focus areas to be addressed to achieve the goal that 95% of DSPs and their supervisors receive training and competency testing in accordance with *12 VAC 30- 122-180*. A Quality Improvement Initiative was developed in response to the findings from the root cause analysis (see details in §48.b below).	the training and competency assessment processes, the need for simplified methods for recording training and assessment results, and the need to further standardize and simplify available guidance regarding the training process. DBHDS utilized the results of the root cause analysis to inform development of a Quality Improvement Initiative (QII) to identify and implement specific initiatives that will streamline the requirements for DSP/Supervisor training and testing while reducing the related administrative burdens for providers as they seek to structure and consistently implement DSP/Supervisor training and testing required by 12VAC30-122-180. The completed root cause analysis and the determinations that led to the development of the QII are evidence that DBHDS has completed the requirements of Action 48.a.	
48.b) Based on the findings of the root cause analysis required by Paragraph 48(a), DBHDS will prioritize the findings for quality improvement, taking into account the anticipated impact to the	Based on findings from a root cause analysis conducted in 2024, DBHDS developed and has initiated implementation of a Quality Improvement Initiative	From the root cause analysis completed as required by Action 48.a, priority focus areas identified for action included: • Streamlining advanced competency areas; • Simplifying specific training materials focusing on improved clarity; and	26th: In Progress **27th:** **In Progress**

system, including potential negative impacts to current staffing. DBHDS will implement a QII based on its prioritization consistent with continuous quality improvement principles and developed in collaboration with the provider and system issues resolution workgroups.	that addresses each of the requirements in Action 48.b. One element of the QII focuses on simplifying instructions and reducing the related administrative burden for providers by streamlining competency training and testing for DSPs and Supervisors. DBHDS's pilot project to test this plan is scheduled to be conducted between 11/2025-01/2026. DBHDS continues collaborative work with the Provider Issues Resolution Workgroup to expand and refine prioritized efforts to streamline advanced competencies, simplify training materials, and clarify guidance for providers to more consistently meet 12VAC30-122-180 requirements.	• Providing additional guidance to providers on each of these two priorities. DBHDS, in collaboration with the Provider Issues Resolution Workgroup (PIRW), developed a Quality Improvement Initiative (QII) which included updating the DSP Advanced Competencies to consolidate, streamline, and modernize their content. This revision reduced the length of the advanced competency sets, now titled the *Complex Support Competencies Checklist*, from 28 pages to 11 pages. The updated process to consolidate, streamline and modernize the competencies will be piloted beginning in November 2025 and the pilot will run through January 2026. Further results of this Pilot will be evaluated during the 28th study. As part of the QII, DBHDS simplified instructions aimed to reduce some of the administrative burdens for providers by streamlining competency training and testing for DSPs and Supervisors. Working in collaboration with the PIRW, changes are being thoroughly reviewed to support providers and comply with Action 48.b, considering impacts on staffing. Progress is steady and continues to emphasize process improvement in the context of better meeting provider needs. DBHDS continues collaborative work with the PIRW to expand and refine prioritized efforts to streamline advanced competencies, simplify training materials, and clarify guidance for providers to meet 12VAC30-122-180 requirements. These actions by DBHDS support the continued determination that the requirements of Action 48.b are in progress.	
48.c) If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2024, and has not conducted a rate study meeting the requirements of Paragraph 59 in the preceding two years, the	The Commonwealth, through the Department of Medical Assistance Services (DMAS), engaged Guidehouse to conduct a rate study of eleven service categories under the	As required by Action 48.c, the Commonwealth, through the Department of Medical Assistance Services (DMAS), engaged Guidehouse to conduct a rate study for services under the Developmental Disability Waiver. The study includes the five service categories outlined in Term 48.c and six additional services.	26th: In Progress **27th:** **Completed and Ongoing**

Commonwealth will initiate a rate study of Personal Assistance Services, Companion Services, Respite Services, In-Home Support Services, and Independent Living Support Services by January 1, 2025. The rate study shall be completed in time to be considered during the 2026 legislative session. If the Commonwealth has not achieved the goal as reported in its status update of December 1, 2028, and has not conducted a second rate study meeting the requirements of Paragraph 59, the Commonwealth will initiate a second rate study of Personal Assistance Services, Companion Services, Respite Services, In-Home Support Services, and Independent Living Support Services by January 1, 2029. The rate study shall be completed in time to be considered during the 2030 legislative session. Any rate study required by this paragraph shall be conducted in accordance with Paragraph 59. This paragraph shall not be construed to require the Commonwealth to conduct more than two rate studies.	Developmental Disability Waiver. Guidehouse issued a draft study report in July 2025, and its content is currently being reviewed with input from DOJ, various stakeholders and stakeholder groups. The final report was submitted on 10/15/2025 and its content is being considered during the 2026 General Assembly session.	Guidehouse completed its study and issued a draft study report dated July 2025. The draft report includes rate recommendations and policy considerations for DMAS to consider as it navigates the adoption and implementation of the proposed benchmark rates for the services under review. The draft report has been shared with stakeholders and stakeholder groups to solicit feedback to be considered by Guidehouse as they develop the final report. On 08/25/2025, DOJ provided detailed responses regarding the content of the draft report to the Virginia Office of Attorney General for consideration. The final report was submitted on 10/15/2025 and its content is being considered during the 2026 General Assembly session as required by Action 48.c These actions by the Commonwealth support the determination that the requirements of Action 48.c are completed and ongoing.	
48.d) If the Commonwealth does not achieve the goal within two years of the date of this Order after taking the actions in Paragraphs 48(a) and 48(b),	No action has been taken yet, as activities outlined in Actions 48.b are in progress.	No action has been taken yet, as activities outlined in Actions 48.b are in progress.	26th: Not Yet Implemented **27th:**

DBHDS will also conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			**Not Yet Implemented 01/15/2027**

Recommendation(s)

1. Regarding Term 48, DBHDS should complete its comprehensive analysis of the QSR Round 7 results related to achievement of Provider Training Outcome 2 which has fluctuated over the last three rounds, showing a slight increase from Round 5 to Round 6 (85.3% to 86.6%) and a noticeable decrease in Round 7 (86.6% to 81.6%). The comprehensive analysis should inform further remedial or corrective actions which will be evaluated during the 28th review period's study. The results of such actions, and whether the Commonwealth has achieved Term 48's specified goals, will be reviewed during the 29th period's study following completion of QSR Round 8.

ATTACHMENTS

Interviews Conducted

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

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

Documents Reviewed

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

- 12VAC35-105-450
- 12VAC35-105-50, 100, 110, and 115
- 12VAC30-122-180
- 2025 Annual Compliance Determination Chart
- 160 450 520 620 Combined Orientation Training PowerPoint (05/20/2025)
- Office of Licensing Look-Behind Process for DD Providers' Annual Inspections
- Expanded Consultation and Technical Assistance Standard Operating Procedures (effective 08/23/2024)
- Draft Mandatory ECTA Protocol
- Combined OL & OCQI Mandatory ECTA Protocol (effective 07/15/2025)
- Expectations Regarding Risk Management Programs for Providers of Developmental Services (08/27/2025)
- Expectations Regarding Provider Training and Development Memo (05/02/2025)
- OL Inter-Rater Reliability Process Updated 7.2025
- DD Inspections 1.1.25_8.8.25 27th Study Period
- 450 Data 1.1.25-8.8.25 27th Study Period
- Provider Data Summary SFY 2025 May 2025
- DSP Competencies Comparison Data Summary Graphs 10.1.25
- Advanced Competencies Pilot Description 9.12.25
- Approved 7.19.24 DSP SFY24 QII Toolkit
- Streamlining Daily Documentation for DD Waiver Providers 8.6.25 (DRAFT)
- Draft Guidehouse Rate Study Report 07/21/2025
- Various evidentiary documents related to the Draft Guidehouse Rate Study

- Corrective Action Plan documents for 80 sampled licensed providers sampled for this study
- Documentary evidence for 80 sampled licensed providers documenting provider regulatory compliance with §450 that was reviewed by the licensing specialist during the sample provider's most recent annual inspection.
- Process Document DSP Comp Ver 008 (dated 9/28/25)
- DSP Competencies Attachment B Attestation Statement (signed on 10/8/25)

APPENDIX G

Quality and Risk Management
and
Quality Improvement Programs

By

Rebecca Wright, MSW, LICSW
Chris Adams, MS

Quality and Risk Management System 27th Period Study

Introduction/Background

The Section IV Terms of the Permanent Injunction (PI) approved by the Court on January 15, 2025, require the Commonwealth to work to achieve specified goals and to implement delineated actions regarding quality and risk management. This study will be a follow-up to previous studies that have been completed annually since 2017 regarding the status of the Commonwealth's achievements in these areas. For this 27th Period review, the Parties have agreed to target a total of 15 PI Terms.

Based on the findings at the time of the 25th and 26th Period reviews, the following bullets provide background regarding the key issues DBHDS still needed to address for these 15 Terms during this current Period:

- For PI Term 34 (i.e., behavioral support services), despite continued improvement, DBHDS provided data that did not yet demonstrate it achieved the 86% specified goal for adequate and appropriate behavioral support services.
- For PI Term 40 (i.e., annual dental exams), despite steady improvement, DBHDS provided data that did not yet demonstrate it achieved this Term's 86% specified goal.
- DBHDS did not achieve the 95% specified goal for PI Term 41. Despite some improvements to the documented processes related to the percentage of individuals free from serious injury, continuing methodological deficiencies still existed that DBHDS needed to address. DBHDS's identified methodologies were not adequate to produce valid data. Although DBHDS has expanded the definition of individuals who were not protected from serious injury to include individuals with a serious injury resulting from substantiated abuse/neglect as well as those who experience more than one injury in a rolling 12-month period, the numerator also still relied heavily on serious injury investigations to determine if an individual was or was not protected, and only those investigations that result in a corrective action plan (CAP) are deemed to show an individual was not protected. However, the processes for making a referral for an investigation remained ambiguous at times, and, in particular, did not support a reliable evaluation that pre-injury circumstances were adequate for the purpose of protection.
- For PI Term 42, the Consultant noted improvement in the accuracy and consistency by which licensing specialists assessed whether providers are meeting the requirements of the risk management regulations. The consultant also found concerns in DBHDS's assessment of requirements at §520.C.5 regarding use of data to assess and evaluate common risks and conditions faced by people with IDD that contribute to avoidable deaths. However, due to the limited sample size available for review during the early stages of the CY2025 licensing inspection cycle, the findings could not be generalized, and a formal determination was deferred until the results could be combined with those from the 27th period study. For PI Term 43, the Commonwealth did not yet show performance that meets 86% goal of individuals with timely Waiver service enrollment. The 26th Period study found that DBHDS developed processes for quarterly data tracking and analysis and for follow-up with impacted individuals. DBHDS had also completed an initial round of the required quarterly contact with individuals who had not been enrolled in a service within five months, as well as their families and case managers,

to determine why services had not been initiated and what barriers delayed initiation of services. DBHDS had not yet completed the initial quarterly analysis of the barriers identified as well as actions being taken to remediate those barriers and results achieved, but had produced a preliminary summary.

- For PI Term 44, DBHDS did not meet this Term's requirements to collect and analyze data at least annually regarding the management needs of individuals with identified complex health, behavioral and adaptive support needs. The Department continued to implement an annual monitoring process known as the Intensive Management Needs Review (IMNR) to gather and analyze data regarding individuals with complex health support needs, although the Department's remediation process (i.e., the system of tracking efficacy, making revisions as necessary, and confirming that identified deficiencies are resolved) was not yet sufficiently completing these functions. However, DBHDS had not implemented data collection for individuals with identified complex behavioral and adaptive support needs. For these two subgroups, it was positive that DBHDS made progress in implementing the actions specified in this Term's subsection 44a by initiating the development of a methodology for combining data and information from the IMNR, QSR and BSPARI processes.
- Based on self-reported data, the DBHDS did not achieve the 86% threshold required by Term 45. Year-over-year data through CY2024 indicated a decline in Virginia meeting the 86% threshold for the sub-regulations. The compliance determination for this PI was deferred as data for CY2025 were not yet available for review. For PI Term 46, as of the 25th Period, the Round 6 Quality Service Review (QSR) methodology had not yet adequately identified the quality improvement deficiencies and corrective action needs for specific providers. First, the elements of DBHDS's QSR Provider Quality Review (PQR) tool were not sufficient to assess the adequacy of its providers' QI programs. In addition, based on the 25th period comparative sample, QSR reviewers often did not accurately and thoroughly assess provider quality improvement practices, such that the process did not yield reliable data (i.e., as previous Reports to the Court repeatedly identified). No new data were available during the 26th Period to change this finding, but it will be re-evaluated during the 27th Period using Round 7 QSR data.
- DBHDS did not achieve the 95% specified goal for PI Term 49. Virginia had not finished all reviews or provided a finalized data report during the 26th Period, citing a need for more time to adequately validate the related QSR results. In addition, the Department still needed to develop a well-defined description of the overall QSR procedure for determining compliance with the requirements of the CMS Settings Rule and related guidance, consistent with the Commonwealth's approved Statewide Transition Plan.
- For PI Term 52, based on self-reported data, the DBHDS did not achieve the 86% threshold established by the Department for two of the three outcomes that it uses to measure the effectiveness of its community look-behind (CLB) review process. The Consultant also identified concerns with the adequacy of the inter-rater reliability (IRR) review process to ensure that the data being provided to the Risk Management Review Committee (RMRC) each quarter is sufficiently validated, limiting the ability of the RMRC to carry out their oversight responsibilities required by Term 52.

- For PI Term 53, the Commonwealth has achieved the goal of having 86% of serious incidents reviewed by the RMRC meet the audit criteria. However, as mentioned in the narrative for Term 52, the Commonwealth had not yet met the goal of having 86% of allegations of abuse, neglect, and exploitation reviewed by the RMRC in that the process had not yet achieved all three required outcomes at or above the goal of 86% set in Term 53. For PI Term 54, DBHDS met this Term's measurable goal for annual physical exams during the 26th Period, with each of the most recent four quarters (i.e., the first three quarters of FY25 and FY24 Q4) exceeding 86% and trending upward for each quarter. For this 27th Period, if the Commonwealth sustains this level of performance, this Term's specified goal will be achieved.
- For PI Term 55, DHBDS continues to exceed the 86% threshold for assessing DBHDS-licensed providers of DD services for compliance with risk management requirements during annual inspections. However, the Consultant's sample reviews raised concerns about the accuracy of Licensing Specialists' determinations of compliance with these regulations, as per the Office of Licensing Annual Compliance Determination Chart and due to the limited sample size in the 26th study, findings could not be generalized and the determination for Term 55 was deferred.
- DBHDS did not yet achieve PI Terms 56 and 57 because the Commonwealth did not develop, monitor and/or revise needed remediation for waiver performance measures, as required. In addition, for PI Term 57, the 26th Period study will assess the status of quarterly DMAS-DBHDS Quality Review Team (QRT) data collection and review of the specific delineated measures i. through v.

Study Methodology

The Consultants who conducted prior studies on the Terms related to quality and risk management and quality improvement programs also conducted the 27th period study. The study sought to gather and investigate facts and verify data and documentation provided by the Commonwealth to determine whether the sufficiency of the Commonwealth's actions resulted in Virginia achieving the specified goals of each of the PI Terms described in the previous section. The study reviewed documentary evidence of data collection and actions related to the Commonwealth's compliance efforts since 4/1/25. The methodology included a review of the documents that Virginia maintains to demonstrate that it has achieved the PI's specified goals and completed the required actions; interviews with state officials, subject matter experts, and stakeholders; and verification that Virginia's relevant Process Documents and Attestations are complete.

Evidence gathering included:

- Review of documentary evidence provided by the Commonwealth specific to the achievement of the specified goal and implementation of listed actions set out in each Term.
- Review of any changes that have been made to policies, procedures, and/or practices relating to the goals and actions in the applicable Terms listed above.
- A comparative review of licensing findings for a sample of 80 licensed providers and CSBs with regard to compliance with Terms 42, 45 and 55. The combined sample results from the 26th and 27th studies was used to draw comparisons with previous years' data.

- A comparative review of QSR Quality Improvement findings for a sample of 36 providers and CSBs with regard to compliance with Term 46.
- A comparative review to investigate and verify the data quality related to Term 44.
- For Terms that rely on data to demonstrate compliance, the data validation process included review and analysis of documents described above for each Term. The data validation process included review and analysis of documents focusing on:
    - Threats to data integrity previously identified by DBHDS assessments.
    - Actions taken by DBHDS that resolved these problems including completion dates for those activities.
    - Review of the verification process that DBHDS completed that confirmed that the data reported is reliable and valid.
    - The Commonwealth's current Attestation that the Process Document was properly completed, that the threats were sufficiently mitigated, and that the data reported are reliable and valid.

Study Findings

Regarding the assessment of requirements related to **Behavioral Support Services (Term 34)**, DBHDS did not yet achieve compliance with Term 34 because, based on documentation in the *Behavioral Supports Report: Q1/FY26* and using the approved calculation methodology, DBHDS reported that for the entirety of FY25, 80% (2334/2911) of individuals with identified behavioral support needs received adequate services and 20% (577/2911) received inadequate or no services. This remained below the required threshold for Term 34, but represented significant progress overall. DBHDS continued to address findings identified through the previously conducted root cause analysis, to use the BSPARI tool to determine whether individuals are receiving adequate and appropriate behavioral support services, and to employ at least four behavior analysts to provide technical assistance and training on behavioral support plans.

Regarding the assessment of requirements related to **Dental Exams (Term 40)**, DBHDS did not meet the specified goal of this Term because its data indicated that the Commonwealth did not yet achieve 86% of people supported in residential settings who received annual dental exams. DBHDS submitted an updated PowerPoint presentation entitled *Annual Dental Exams Permanent Injunction 27th Study of Independent Reviewer*, dated 9/30/25, which indicated that overall, through the four quarters of FY25, 69.1% of individuals supported in residential settings had an annual dental exam. DBHDS staff made progress on Actions to expand dental resources and capacity. It was positive that documentation noted progress for five CSBs that have had the lowest percentage of individuals receiving annual dental exams for multiple years. Since FY21, four of those five have seen an increase of those receiving annual dental exams between nine and eleven percent, while a fifth has seen an increase of 30.58%.

Regarding the assessment of requirements related to **Protection From Serious Injuries in Service Settings (Term 41)**, DBHDS again updated a number of written processes and protocols toward improving data validity and reliability. However, despite ongoing revisions to the methodology and development of additional guidance, these did not yet yield valid and reliable data. Although DBHDS had previously expanded the definition of individuals who were not protected from serious injury to include individuals with a serious injury resulting from

substantiated abuse/neglect as well as those who experience more than one injury in a rolling 12-month period, the numerator DBHDS uses also still relies very heavily on serious injury investigations to determine if an individual was or was not protected, and only those investigations that result in a corrective action plan (CAP) are deemed to show an individual was not protected. The Incident Management Unit (IMU) still refers only a very small percentage of serious injuries for investigation and the Special Investigations Unit (SIU) actually investigates only a small percentage of those referrals. In practice, the ongoing modifications did not significantly ameliorate the previously documented concern that very few serious injuries reach the investigation stage. During the 26th Period, 7.2% of serious injuries were referred and 2.5% were investigated. For this 27th Period, 7.7% were referred and 3.6% were investigated.

The processes for making a referral remain ambiguous at times, and still do not support a reliable evaluation of pre-injury circumstances, as opposed to actions the provider took after the injury to ensure health and safety in the future. This was an important distinction because the construct of this measure relies on the provider having had protections in place prior to the injury, and not that they took appropriate actions after the serious injury occurred. Therefore, even if all post-injury protections were documented, an investigation might still be needed to examine the pre-injury circumstances. In interview, DBHDS staff acknowledged that the Incident Management Quality Specialist (IMQS) maintains discretion with regard to the determination of which high priority incidents will be referred for investigation and, that given resource constraints, not all incidents that are high priority for investigation are ultimately referred for an investigation to be completed. DBHDS staff acknowledged the need for further revisions and, at the conclusion of the 27th Period, had begun meeting to address them.

For this 27th Period, the Commonwealth was in progress with implementing Action 41 b). DBHDS had completed a review of a statistically significant sample for one month thus far, but did not yet have sufficient data to begin making recommendations for any needed changes to the way incidents are reviewed and referred. According to a document entitled, *Permanent Injunction Term 41b, FY25Q4-FY26Q1* (*Serious Injury Quality Review Report*), dated September 2025, the stated purpose of this quality review was to determine if the processes implemented by the IMU are appropriately identifying all individuals that have not been protected from harm and if these processes are addressing any identified issues to reduce the risks of future harm to these individuals. DBHDS indicated they designed this review by Office of Integrated Health Support Network (OIHSN) staff to answer four questions, as recommended in the 26th Period study: 1) have all appropriate injuries been identified by the IMU; 2) were individuals protected from harm; 3) are changes needed to the way that incidents are reviewed; and, 4) are changes needed to the way that incidents are referred? To complete the reviews, OIHSN reported they established a Serious Injury Quality Review work group comprised of four Registered Nurse Case Consultants (RNCCs), the OIHSN Project Manager, and the OIHSN Director. This work group's first review was in July and August 2025 and included 23 serious injuries that occurred in June 2025. DBHDS reported that this was a statistically significant sample for the month. Presumably, if the sampling process is repeated each month for a year, this will result in an annual statistically significant sample.

The RNCCs' findings included that only one of the 23 serious injuries reviewed was referred to the licensing specialist/investigator, and RNCC reviewer was in agreement with that, while for two other incidents, the RNCC felt the individual was not protected and a referral did not occur. However, the OIHSN work group's first report stated that for almost 70% of the incidents reviewed, more detail was needed to be able to make a determination that the individual was or was not protected; therefore, it could not make a final determination of the percentage of appropriate referrals.

Overall, the OIHSN did not yet have enough data to make recommendations for changes that are needed to the way that the Office of Licensing (OL) reviews and refers incidents. As they move forward, DBHDS should clarify how they can ensure that having OIHSN exactly replicate the IMU triage and pre-investigation processes for serious injuries will allow them to answer the four questions posed for the process, given that it is not just reliability that needs to be tested, but also validity of the processes themselves. Having the RNCCs cast a different eye on determining whether individuals who sustained serious injuries were protected from harm would serve as a validation study, and in most respects, validity of the measure is the most in question at this time. The initial findings that almost 70% of the incidents reviewed did not have enough detail to make a determination could be indicative of a problem with validity. Additionally, OL and the RNCCs should also consider how to evaluate whether the ISP in place at the time of the serious injury sufficiently identified risks that "should have been known."

Regarding the assessment of requirements related to **Risk Management (Term 42),** DD Service Providers' Compliance with Administrative Code (Term 45), and the **Assessment of Licensed DD Service Providers (Term 55)**, the Consultant conducted a sample review of 80 provider annual inspections across five regions that were carried out by 42 Licensing Specialists between 01/01/2025 and 06/30/2025 and analyzed results to determine whether the Consultant agreed with the Licensing Specialists' assessments.

Regarding the assessment of requirements related to **Timely Waiver Service Enrollment (Term 43)**, DBHDS continued to track and report quarterly data on the number of individuals who are assigned a waiver slot but not enrolled in a service within five months. However, the Commonwealth did not meet the requirements of this Term because the most recent data reported performance of 76.2% for FY25 Q3 and 84.7% for FY25 Q4. However, it was positive these data represented an upward trend from previous reporting.

During this period, DBHDS produced a second *Quarterly Timely Waiver Service Enrollment Report* for the fourth quarter of 2025. The current report rightly noted that FY25 Q4 data for initiation of timely waiver services was trending upward since the implementation of the call survey. In addition, the report found that Medicaid/insurance enrollment, one of the most significant preliminary barriers identified in the first report, had responded well to the attention it received, decreasing from 45% in the first survey to only 9% in the more recent one. The report identified and discussed other outcomes, including two statewide barriers: 1) support coordinator/CSB issues and/or a delay or lack of education from the CSB at 26% and 2) a delay in service selection/no provider chosen by the individual/family at 10%. To address these current findings,

in July 2025, the DBHDS Key Performance Area (KPA) Workgroups initiated a Quality Improvement Initiative (QII), projected to run through June 2026.

Regarding the assessment of requirements for **Ongoing Service Analysis (Term 44)**, for this 27th Period, DBHDS did not yet meet the requirements because it did not include annual data and analysis regarding the management needs of individuals with identified complex behavioral and adaptive support needs or yet provide for an adequate system for corrective action tracking and appropriate revision across the whole population. The IMNR process continued to examine the management needs of individuals with identified complex health support needs and for this 27th Period, it also began to address the needs of individuals with complex behavioral needs. It did not yet address the needs of individuals with complex adaptive support needs, but DBHDS staff reported they expect to include such individuals in the IMNR beginning with the 29th Period. The current IMNR Process Document also did not provide a clear methodology for the specific requirements for completing an annual analysis of the management needs of the target population as a whole. In addition, DBHDS did not provide evidence of the sufficiency of its remediation system which reports on the tracking of efficacy of the systemic corrective actions or of any needed revisions to address the deficiency. The Independent Reviewer's 27th period Individual Service Review study found that the OIHSN's remediation system as a whole was not sufficient to ensure that the implemented corrective actions addressed the concerns identified by the Commonwealth's IMNR nurse reviewers. It was positive that the ISR study found that the OIHSN nurses promptly reported and initiated corrective actions and tracked their efficacy. However, some Case Managers and residential staff did not implement the planned corrective actions in a timely manner, or at all, to ensure that the identified concerns were addressed. Also, in its consolidated report, DBHDS did not analyze consolidated concerns or include in a comprehensive summary its systemic findings and related corrective actions from its review across DBHDS's four monitoring systems: IMNR, care concerns, Quality Services Reviews (QSRs) and BSPARI quality reviews.

For this 27th Period, DBHDS also produced the *Ongoing Service Analysis Report: Individuals with Complex Health, Behavioral and Adaptive Support Needs FY 2024.* It incorporated data from the IMNR process for individuals with complex medical needs, data from the care concerns process, data from the BSPARI quality reviews, and data from the QSRs. For several of the processes from which it derives data, the report provided pertinent examples regarding the requirements to develop corrective actions determined appropriate based on analysis, to track the efficacy of the actions, and revise them as necessary to address the deficiency. These examples demonstrated both strengths and gaps in the overall methodology for the cycle of remediation.

The *Ongoing Service Analysis Report: Individuals with Complex Health, Behavioral and Adaptive Support Needs FY 2024)* did not yet clearly "consolidate" (i.e., combine various elements to create a single, more effective whole) the data from its various sources to provide a comprehensive summary of the management and support provided to individuals with complex needs. The summary section did not cross-reference or provide comparisons or merging of data from the various sources that might serve to illuminate either gaps in services or opportunities for cross-learning. The report concluded with a summary that indicated intra-and inter-agency collaborations were emerging for these populations and that DBHDS was using the various data to assess needs and drive

decisions; however, this did not document with any specificity how the data had been consolidated thus far to provide a comprehensive picture of the management and support needs for individuals with complex needs. It was positive, though, that the 27th ISR study found that OIHSN is actively involving the DBHDS behavior analysts and the BSPARI findings in its analysis of concerns and possible corrective actions related to individuals with complex behavioral needs. Also, going forward, DBHDS specifically noted a very promising plan to review QSR findings of unmet need in a model fashioned on the current Care Concerns processes.

Regarding the assessment of requirements related to **Quality Service Monitoring (Term 46)**, it was positive DBHDS continued to offer the very successful Expanded Consultation and Technical Assistance (ECTA) related to provider quality improvement (QI) programs. However, DBHDS did not meet the requirements for Term 46 because the QSR data used to identify providers in need of technical assistance due to inadequate quality improvement programs could not yet be deemed reliable. Of note, however, as a result of preparatory work completed through a collaborative effort of DBHDS staff and the Independent Reviewer's consultant during the 26th Period, the Round 7 data from the Provider Quality Review (PQR) tool available during the 27th Period is considered valid (i.e., that it measures what it purports to measure.)

Prior to the initiation of Round 7, DBHDS completed scoring concordance for QSR tools to test inter-rater reliability between the QSR "gold" reviewers and DBHDS Subject Matter Experts (SMEs). The Commonwealth's QSR vendor made changes to both the CSB and provider documentation submission checklists to ensure the correct document was requested from the provider/CSB.

However, based on results of a comparative sampling process completed by the consultant during the 27th Period, the QSR data continues to be unreliable. The study found that for the 36 providers in the sample, the overall agreement with QSR findings related to quality improvement was only 65%. Still, it was positive that this this was improved since the previous sampling during the 25th Period. For example, the consultant agreed fully with six sets of provider findings and for another four sets, agreement was above 80%. This indicated that 28% (10/36) exceeded the QSR vendor's minimum threshold for its internal inter-rater reliability (IRR). However, this remained an insufficient percentage overall.

DBHDS previously provided a revised Process Document for Term 46, including a statement that QSR data would be validated against licensing reviews data, but the document did not include sufficient detail to evaluate its adequacy. For this 27th Period, DBHDS reported that, in line with the requirements of Action 46 c) to ensure that all DBHDS staff and contractors assigned to assess the adequacy of provider quality improvement programs have established inter-rater reliability in conducting such assessments, DBHDS has begun to conceptualize the process for two groups. In a next step, the Deputy Commissioner will complete a comparison of the QSR scoring concordance findings with the applicable findings of Licensing to see how closely they align. Once this evaluation is complete, DBHDS staff intend to update the QSR

Process Documents with further detail. This study will review this material during the 28th Period.

Regarding the assessment of requirements related to **Residential Services Community Integration (Term 49)**, for this 27th Period, the Commonwealth did not meet the requirement of this Term. Overall, DBHDS could not provide an updated metric for this Term, due to needed actions that were pending both for initial HCBS compliance validations and for ongoing monitoring of continued HCBS compliance. DBHDS staff were continuing to validate initial compliance for many of the 700 settings previously reviewed through the QSR vendor. Therefore, their compliance status remains unknown at this time and cannot be represented in a calculation for this Term. DBHDS staff plan to complete the review by the end of October 2025 and will develop a summary report that will be available for review during the 28th study period. Also for initial compliance validations, DBHDS submitted a new document entitled *HCBS Setting Rule Initial Determination*. However, it was not formatted as a formal Process Document and it needed a fleshed out methodology for data collection and aggregation. In addition, as previously reported, it needed to reflect consistency with the validation processes in its approved Statewide Transition Plan (STP) and the requirements of the HCBS Settings Rule and related CMS guidance.

DBHDS also still needed to finalize several pending actions to demonstrate valid and reliable data for ongoing monitoring of HCBS compliance, which will occur for settings periodically following achievement of the initial compliance validations. This included the finalization of the QSR tools DBHDS uses for that purpose. During the 26th Period, before DBHDS initiated Round 7 QSR reviews, the consultant and DBHDS staff collaboratively reviewed the proposed QSR tools. At the time, DBHDS acknowledged that this was still a work in process and that the tools, particularly the Person-Centered Review (PCR), will need additional revisions to incorporate an adequate assessment of all the Final Rule requirements. While Round 7 monitoring data became available for this 27th Period, it does not yet reflect all the changes still needed to the PCR and PQR tools, so the data cannot yet be considered valid and reliable. DBHDS also still needed to update the previously submitted Process Document to reflect the adequacy of a ten percent look-behind as a means of validating the QSR data. DBHDS staff indicated they plan to complete the look-behind for Round 7 by the end of October 2025 and will develop a summary report that will be available for review during the 28th study period. It was positive that DBHDS responded to a previously-cited need and provided a Process Document for the use of the data from the QSR, WaMS, CONNECT and the HCBS Master Tracking Spreadsheet maintained by DMAS.

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

Regarding the assessment of requirements related to **Annual Physical Exams (Term 54)**, or this 27th Period, DBHDS achieved the specified goal for annual physical exams for the second consecutive fiscal year (FY) and achieved a rating of Sustained Compliance. DBHDS reported an 89.1%, performance rate for FY25, during which it exceeded the 86% threshold for each quarter. Notably, in FY25 Q3, DBHDS reported the highest performance percentage for annual physical exams since FY21, at 91%.

Regarding the assessment of requirements related to **Data-Driven Quality Improvement Plans for HCBS Waiver Programs (Term 56 and Term 57),** the Commonwealth made significant progress during this period in the implementation of its Waivers' Quality Improvement Plan, particularly evidenced by the continued implementation of a very useful tool entitled *QRT Remediation Tracker* and a revised draft *QRT Charter*. The tool documented whether the Commonwealth's remediation efforts were in place for each of its identified underperforming measures. The Commonwealth's draft charter provided clear expectations for identifying underperforming measures and designing, implementing and tracking quality improvement strategies, and for revision when not successful. Overall, the implementation of the *QRT Remediation Tracker* reflected adherence to the procedures and provided good examples of the quality improvement cycle. However, it remained very concerning that the QRT did not address the chronic underperformance, over the course of several years, of one of the measures, even though the previous study brought it to their attention. The QRT had indicated that to improve the Commonwealth's performance on this measure, it would employ a specific quality improvement strategy, a Root Cause Analysis, but it did not implement the strategy during this review period. This prevented a finding that the Commonwealth had achieved the requirements of both Term 56 and Term 57. Going forward, however, it appeared the QRT had processes in place, once consistently implemented, to achieve the requirements in the future.

The tables below provide additional detail. Table 1 summarizes the status of Virginia's achievement of the specified goal for each PI Term studied for this 27th Period report, while Table 2 provides a full description of the facts gathered and the analysis and conclusions for each Term and its specified Action(s). Table 2 also provides the comparative ratings for the 26th and 27th Periods.

TABLE 1	
Term	**27th**
34. Behavioral Support Services. The Commonwealth will work to achieve a goal that 86% of individuals with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	**Not Achieved**
40. Dental Exams. The Commonwealth will work to achieve a goal that 86% of individuals who are supported in residential settings and have coverage for dental services will receive an annual dental exam.	**Not Achieved**
41. Protection From Serious Injuries in Service Settings. The Commonwealth will work to achieve a goal that 95% of DD waiver service recipients will be protected from serious injuries in service settings.	**Not Achieved**
42: Risk Management. To ensure that the risk management programs of DBHDS-licensed providers of DD services identify the incidence of common risks	**Not Achieved**

TABLE 1	
Term	**27th**
and conditions faced by people with DD that contribute to avoidable deaths and take prompt action when such events occur, or the risk is otherwise identified**.**	
43. Timely Waiver Service Enrollment. The Commonwealth will work to achieve a goal that 86% of individuals who are assigned a waiver slot will be enrolled in a service within five months.	**Not Achieved**
44. Ongoing Service Analyses. The Commonwealth, through DBHDS, will collect and analyze data at least annually regarding the management needs of individuals with identified complex behavioral, health, and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS will develop corrective actions based on its analysis as it determines appropriate, track the efficacy of the actions, and revise as it determines necessary to address the deficiency.	**Not Achieved**
45: DD Service Providers' Compliance with Administrative Code. The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services comply with 12 VAC 35-105-620 in effect on the date of this Order or as may be amended.	**Not Achieved**
46. Quality Service Monitoring. The Commonwealth will work to ensure that, using information collected from licensing reviews and Quality Service Reviews, it identifies providers that have been unable to demonstrate adequate quality improvement programs and offers technical assistance as necessary.	**Not Achieved**
49. Residential Services Community Integration. The Commonwealth will work to achieve a goal that 95% of residential service recipients reside in a location that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS settings.	**Not Achieved**
52: Look-Behind Analysis of Abuse, Neglect, and Exploitation Allegations. The Commonwealth will continue its Community Look-Behind (CLB) review process to achieve a goal of collecting sufficient data for the Risk Management Review Committee (RMRC) to conduct or oversee a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: (i) investigations of individual incidents occur within state-prescribed timelines; (ii) the person conducting the investigation has been trained to conduct investigations; and (iii) corrective action plans are implemented by the provider when indicated. The RMRC will review trends at least quarterly, recommend QIIs when necessary, and track implementation of initiatives approved for implementation.	**Not Achieved**
53: Samples of Data from Look-Behind Analyses of Serious Incidents and Allegations of Abuse, Neglect, and Exploitation. The Commonwealth will work to achieve a goal of showing 86% of the sample of serious incidents reviewed by the RMRC meet criteria reviewed in the audit and that at least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed by the RMRC meet criteria reviewed in the audit. The Commonwealth will continue the look behind process and provide feedback to the RMRC related to its findings. If this goal is not met by December 31, 2024, DBHDS will conduct a root cause analysis	**Not Achieved**

TABLE 1	
Term	**27th**
and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	
54. Annual Physical Exams. The Commonwealth will work to achieve a goal that 86% of individuals supported in residential settings receive annual physical exams.	**Sustained Compliance**
55: Assessment of Licensed Providers of DD Services. The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. DBHDS will continue to conduct annual licensing inspections in accordance with Virginia Code § 37.2-411 in effect on the date of this Order or as may be amended and assess provider compliance with risk management requirements in the Licensing Regulations utilizing the Office of Licensing Annual Compliance Determination Chart.	**Not Achieved**
56. Data-Driven Quality Improvement Plans for HCBS Waiver Programs. The Commonwealth will continue to implement the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers. The DMAS-DBHDS Quality Review Team (QRT) will meet quarterly in accordance with the CMS-approved Quality Improvement Plan and will review data, determine trends, and implement quality improvement strategies where appropriate as determined by the QRT to improve performance.	**Not Achieved**
57. Data-Driven Quality Improvement Plans for HCBS Waiver Programs. The Commonwealth will continue to collect quarterly data on the following measures: (i) health and safety and participant safeguards; (ii) assessment of level of care; (iii) development and monitoring of individual service plans, including choice of services and of providers; (iv) assurance of qualified providers; e) whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR; and (v) identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation. This data will be reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans will be written and remediation actions implemented, as necessary, for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86% compliance. Quality Improvement remediation plans will focus on systemic factors (where present) and will include the specific strategy to be employed, as well as defined measures that will be used to monitor performance. Remediation plans will be monitored at least every six months. If such remediation actions do not have the intended effect, a revised strategy will be implemented and monitored.	**Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
34. Behavioral Support Services. The Commonwealth will work to achieve a goal that 86% of individuals with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services.	For this 27th Period, DBHDS reported data showed that it did not yet achieve compliance with Term 34. Based on review of the *Behavioral Supports Report: Q1/FY26*, DBHDS reported that for the entirety of FY25, 80% (2334/2911) of individuals with identified behavioral support needs received adequate services and 20% (577/2911) received inadequate or no services. This represented significant progress overall, but remained below the required threshold for Term 34. At the time of the 26th Period, DBHDS submitted an updated	At the time of the 26th Period review, based on review of the *Behavioral Supports Report: Q3/FY25*, DBHDS did not yet achieve the specified goal for Term 34 because, in FY25 Q1 and Q2, 68% (976/1428) of individuals with identified behavioral support needs received adequate services and 32% (452/1428) received inadequate or no services. The report noted that, going forward, FY25Q3 BSPARI data and future FY25Q4 data will be used in upcoming reporting that will allow comparison of the entirety of FY25 BSPARI data to the entirety of FY25 utilization data. As reported previously, however, due to a DBHDS correction in the calculation methodology that took effect in the 25th Period, this latest percentage could not be compared with data reported before that time to determine trends. For this 27th Period, based on documentation in the *Behavioral Supports Report: Q1/FY26,* and using the approved calculation methodology, DBHDS reported that for the entirety of FY25, 80% (2334/2911) of individuals with identified behavioral support needs received adequate services and 20% (577/2911) received inadequate or no services. This remained below the required threshold for Term 34, but represented significant DBHDS progress overall. At the time of the 26th Period, DBHDS submitted an updated Process Document *DD Therapeutic Consultation BS Ver 007,* dated 10/2024 and a Data Set Attestation dated 3/30/25. For this 27th Period, these documents remained current and were adequate for data validity and reliability. .	26th: Not Achieved **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Process Document *DD Therapeutic Consultation BS Ver 007,* dated 10/2024 and a Data Set Attestation dated 3/30/25. For this 27th Period, these documents remained current and were adequate for data validity and reliability.		
34 a) DBHDS will continue to address findings identified through the previously conducted root cause analysis initiated in Q1 of FY21 and updated subsequently as part of each semi-annual review.	For this 27th Period, DBHDS completed these ongoing requirements. The *Behavioral Supports Report: Q1/FY26 (BSR Q1/FY26)* updated previously reported findings identified through its previously conducted root cause analysis. It included updates dated 10/2025 for the following topics:	For this 27th Period, the *Behavioral Supports Report: Q1/FY26 (BSR Q1/FY26)* updated previously reported findings identified through its previously conducted root cause analysis. It included updates for the following topics: • Training: At the time of the 26th Period, DBHDS reported continuing to share "real-time" data with the eight lowest-performing CSBs. Every two weeks, DBHDS sends a list of each person who has a need for therapeutic consultation in their ISP, along with each person's status on obtaining a service authorization. For this 27th Period, the *BSR Q1/FY26* states the intention of this effort is to reinforce successes as well as flag people who need the service prior to the 30 day window expiring. DBHDS also offers support to the CSB to locate a provider if needed. The report further states that, as a result of this activity, several CSBs have improved performance in this area. For the CSBs where there has not been sustained improvement, the report notes DBHDS staff will schedule a meeting to review successes and barriers during FY26Q2. With regard to specific training, as detailed in the	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Training, Task Clarification & Prompting, Resources, Materials, & Processes, Behavioral Resources, Performance Consequences, Effort, & Competition, Gap Analysis and Quality Assurance. These updates demonstrated that DBHDS continued to address findings identified through the previously conducted root cause analysis and updated related activities as part of the semi-annual review. Based on documentation in the *BSR Q1/FY26*, DBHDS has made considerable progress in addressing the	previous report (i.e., *BSR Q3/FY25)* DBHDS staff further reported they continued to track CSB completion of those initiatives. For example, in the most recently available update from the eight CSBs involved in the initiatives, seven confirmed staff utilization of the video providing a plain language description of therapeutic behavioral consultation and how supporters can successfully participate. • Task Clarification & Prompting: In addition to the activity described above, since April 2025, there have been five provider modifications to the search engine for therapeutic behavioral consultation providers. • Resources, Materials, & Processes: The *BSR Q1/FY26* indicated there are now 110 providers, which is an increase of four providers since the last report. DBHDS has also provided technical assistance to 15 providers regarding enrollment with Medicaid for this service. Since the last report, there have not been any additional requests for Jump Start funding from behaviorists. • Behavioral Resources: These continue to include the training efforts described elsewhere in this set of bullets, educational newsletters, regional meetings and DBHDS website articles on behavioral science topics. • Performance Consequences, Effort, & Competition: The *BSR Q1/FY26* stated the updates in the "Training" section, as described above provide the initial results and next steps on data sharing with the eight CSBs. • Gap Analysis: The FY23 Q1 gap analysis set a target for behaviorist growth, estimating one behaviorist for every five individuals needing services. DBHDS continues to encourage provider growth and expansion, as noted under the Resources, Materials, & Processes bullet	

<table>
<tr><th colspan="4">Table 2</th></tr>
<tr><th>Term and Actions</th><th>Facts</th><th>Analysis/ Conclusion</th><th>27th</th></tr>
<tr><td></td><td>documented gaps related to the availability of behaviorists. The document indicated there are now 110 providers, which is an increase of four providers since the last report. DBHDS has also provided technical assistance to 15 providers regarding enrollment with Medicaid for this service. Further, the projected number of additional behaviorists needed per region ranged from just one to a maximum of three.</td><td>above. Based on documentation in the BSR Q1/FY26 and summarized in the table below, DBHDS has made considerable progress in addressing the documented gaps.

<table><tr><th>Region</th><th>Provider count change since FY23Q1 analysis (9/2025)</th><th>Possible number of additional behaviorists needed</th></tr><tr><td>Central</td><td>+26</td><td>3</td></tr><tr><td>Eastern</td><td>+19</td><td>2</td></tr><tr><td>Northern</td><td>+25</td><td>3</td></tr><tr><td>Southwestern</td><td>+15</td><td>1</td></tr><tr><td>Western</td><td>+10</td><td>2</td></tr></table>
• Quality Assurance: These efforts continue a focus on the continuing BSPARI reviews and the evaluation of support coordinator accuracy in assessing behavioral programming using the On-Site Visit Tool (OSVT). With regard to the latter effort, the BSR Q1/FY26 documents that in FY25Q4-FY26Q1, support coordinators scored 58% of OSVTs correctly, showing slight improvement from the previous period (i.e., 57%).</td><td></td></tr>
<tr><td>34 b) DBHDS will continue to use the BSPARI tool, or such other tool designed for behavioral programming that the parties agree upon, to</td><td>For this 27th Period, based on reporting in the BSR Q1/FY26, DBHDS successfully completed this action.</td><td>For this 27th Period, based on reporting in the BSR Q1/FY26, during FY25 Q3 through FY25 Q4, DBHDS continued to use the BSPARI tool to determine whether individuals are receiving adequate and appropriate behavioral support services. During that period, DBHDS behavioral staff reported reviewing 196 plans. For the entirety of FY25, DBHDS reported that behavioral staff reviewed a total of 400 plans.</td><td>26th: Completed

27th: Completed and Ongoing</td></tr>
</table>

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
determine whether individuals are receiving adequate and appropriate behavioral support services.	During FY25Q3 through FY25Q4, DBHDS continued to use the BSPARI tool to determine whether individuals are receiving adequate and appropriate behavioral support services. During that period, DBHDS behavioral staff reported reviewing 196 plans. For the entirety of FY25, DBHDS reported that behavioral staff reviewed a total of 400 plans.		
34 c) DBHDS will continue to employ a total of four behavior analysts to provide technical assistance and training on behavioral support plans.	For this 27th Period, DBHDS reported completing the ongoing requirements for this Action.	Based on reporting in the *BSR Q1/FY26*, The Office of Behavior Network Supports continues to employ five Board Certified and Licensed Behavior Analysts, which exceeds the requirement. The *BSR Q1/FY26* also provided the following data and information regarding achievement of the additional annual requirements for this Action:	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
Annually, the behavior analysts will (i) review a statistically significant sample of the behavioral plans submitted; (ii) provide feedback; and (iii) identify trends for improvement and develop additional training and technical assistance as determined necessary by DBHDS.	Based on reporting in the *BSR Q1/FY26,* The Office of Behavior Network Supports currently employs five Board Certified and Licensed Behavior Analysts, which exceeds the requirement. The *BSR Q1/FY26* also provided data and information regarding achievement of the additional annual requirements for this Action. As described above for Action 34b, during FY25, they completed 400 reviews of behavior programs to determine adherence to the *Practice Guidelines for Behavior Support Plans*. Further, DBHDS staff reported conducting	i. As reported above with regard to Action 34 b), DBHDS behavioral staff reported reviewing 196 plans during this 27th Period and a total of 400 behavior plans for the entirety of FY25. Based on interview, DBHDS staff complete an annual random stratified sample that ensures a 90% confidence level, and the plans reviewed in FY25 met that level of statistical significance. ii. With regard to providing feedback, DBHDS previously reported that beginning in FY25 Q2, DBHDS required providers to revise and resubmit behavior plans scoring below 34 points, offering technical assistance and rehearsal opportunities. For this 27th Period, DBHDS reviewers provided feedback sessions to behaviorists for 399/400 plans overall, including the 19/196 (10%) plans that did not meet the 34-point threshold. For FY25, 76/400 (19%) of plans that did not meet the threshold were subject to feedback sessions. Of these, 75/76 (99%) received feedback, with one provider leaving waiver services before a feedback session could be scheduled. In addition, regardless of the minimum scoring, DBHDS staff reported that in FY25, reviewers provided feedback sessions to behaviorists for 399/400 plans overall. According to the *BSR Q1/FY26*, feedback sessions include review of the pertinent BSPARIs, a review of resources, and an opportunity for the behaviorist to ask questions about the BSPARI results and resources. DBHDS also reports seeking out feedback that behaviorists have about the tool, the service authorization process, or connection to individuals in need of services during these meetings. iii. For this 27th Period, behavior analysts continued to analyze BSPARI scores and trends over time to identify areas of improvement and recurring issues in behavioral programming and used these findings to create additional training and technical assistance. The *BSR Q1/FY26*	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	feedback sessions for 399. For this 27th Period, behavior analysts continued to analyze BSPARI scores and trends over time to identify areas of improvement and recurring issues in behavioral programming and used these findings to create additional training and technical assistance. The *BSR Q1/FY26* indicated that behavior analysts provided technical assistance and training on behavioral support plans through various methods, including publishing educational articles on behavioral science and/or services,	indicates that behavior analysts provided technical assistance and training on behavioral support plans through the following methods: • DBHDS published five educational articles on behavioral science and/or services. Each article contains references to the professional literature and/or website resources. These can be found on the DBHDS Behavioral Services website and have been included in the OIH monthly newsletter. • DBHDS has provided continuing education opportunities to the community on the following topics: Beyond "Good Job": Leveraging Principles of Behavior Science for Effective Feedback and A Behavioral Approach to Dignity of Risk. • Based on review of common errors on BSPARI elements, DBHDS is creating training to assist providers in understanding Practice Guidelines expectations. This includes six new brief training videos on various BSPARI Elements created since the past reporting period: o ABC Data and Conditional Probabilities, Part 1 and Part 2 o Graphical Displays and Visual Analysis o Informed Consent and Legal Status o Preference Assessments o Motivating Operations and Setting Events	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	continuing education opportunities to the community and creating training videos to assist providers in understanding Practice Guidelines expectations.		
34 d) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the actions in Paragraphs 34(a) and 34(b), DBHDS will conduct a root cause analysis and implement a QII as determined appropriate by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	This action is not required until 7/15/27 (two years from the approval of the permanent injunction.) A final implementation plan was not completed.	This action is not required until 1/15/27 (two years from the approval of the permanent injunction.) A final implementation plan was not completed.	**Not Yet Implemented Due Date 1/15/2027**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
40: Dental Exams The Commonwealth will work to achieve a goal that 86% of individuals who are supported in residential settings and have coverage for dental services will receive an annual dental exam.	For the 27th Period, DBHDS did not meet the specified goal of this Term because its data indicated that the Commonwealth did not yet achieve 86% of people supported in residential settings who have coverage for dental services who received annual dental exams. A PowerPoint presentation entitled *Annual Dental Exams Permanent Injunction 27th Study of Independent Reviewer*, dated 9/30/25, indicated 69.1% of individuals supported in residential settings had an annual dental exam throughout the four quarters of FY25.	At the time of the 26th Period, DBHDS did not yet meet the specified goal for this Term because its data indicated that the Commonwealth did not yet achieve 86% for people supported in residential settings who have coverage for dental services who received annual dental exams. At that time, DBHDS provided a PowerPoint presentation entitled *Annual Dental Exams Permanent Injunction*, stating that for the first 3 quarters of FY25, 68.63% of individuals supported in residential settings had an annual dental exam. For this 27th Period, DBHDS again did not achieve the specified goal for this Term. DBHDS submitted an updated PowerPoint presentation entitled *Annual Dental Exams Permanent Injunction 27th Study of Independent Reviewer*, dated 9/30/25, which indicated 69.1% of individuals supported in residential settings had an annual dental exam throughout the four quarters of FY25. For this 27th Period, DBHDS provided an updated Process Document, entitled *Annual Dental Exams Ver 008* and dated 7/30/25, that addressed the 26th Period recommendation to modify the Definitions section to clearly state that an "annual" dental exam is one that occurs within the 14-month period from the ISP start date. As also recommended at the time of the 26th Period, DBHDS modified the sections entitled Change Control/Process Description, Outputs/Measure Of Success, Measure Documentation, as well as the Measure language, to clarify that there is a single measure, rather than two separate measures for individuals depending on their health insurance coverage. This was reflective of the Commonwealth having transitioned, as of July 2021, to everyone in residential services having dental coverage under the State Medicaid Plan.	26th: Not Achieved **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	DBHDS provided an updated Process Document, entitled *Annual Dental Exams Ver 008*, dated 7/30/25, that included modifications in several sections to clarify the measure was singular, rather than two separate measures for individuals depending on their health insurance coverage. It also included a recommended modification to the Definitions section to state clearly that an "annual" dental exam is one that occurs within that 14-month period. This was adequate for data validity. DBHDS previously submitted a Data Set Attestation for	The Process Document continues to be adequate for data validity. DBHDS previously submitted a Data Set Attestation for this measure, dated 3/31/25, which also remained adequate.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	this measure, dated 3/31/25, which remained adequate.		
40 a) DBHDS will operate a total of three mobile dental vehicles by March 31, 2025.	DBHDS completed this Action during this 27th Period. Based on a review of a document entitled *Dental Work Plan Outcomes.PI.2024-25.09.30.2025,* DBHDS reported obtaining and putting into operation two additional mobile dental vehicles, with the last one obtained on 5/27/25. According to the PowerPoint presentation *Annual Dental Exams Permanent Injunction 27th Study of Independent Reviewer*, in FY 25 the Mobile	At the time of the 26th Period, DBHDS had not completed this Action, but it remained in process. As of 12/1/24, two mobile dental vehicles were operational. For this 27th Period, based on a review of a document entitled *Dental Work Plan Outcomes.PI.2024-25.09.30.2025 (Dental Work Plan),* DBHDS reported obtaining and putting into operation two additional mobile dental vehicles, with the last one obtained on 5/27/25. According to the PowerPoint presentation *Annual Dental Exams Permanent Injunction 27th Study of Independent Reviewer*, in FY 25 the Mobile Dental Program scheduled a total of 1,107 appointments, with 898 successfully completed. In FY25 Q4, the Mobile Dental Team served the highest number of patients (i.e., 383) seen in a single quarter to date.	26th: Not Completed **27th: Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Dental Program scheduled a total of 1,107 appointments, with 898 successfully completed. In FY25 Q4, the Mobile Dental Team served the highest number of patients (i.e., 383) seen in a single quarter to date.		
40 b) DBHDS will continue to employ or contract with a total of three dental assistants and four dental hygienists to staff the mobile dental vehicles.	For this 27th Period, this Action remained in progress. Based on the current *Dental Work Plan*, DBHDS staff reported current staffing includes the four Dental Hygienists, including the Dental Program Manager, and two Dental Assistants. As reported at the time of the 26th Period, one Dental Assistant	At the time of the 26th period review, the *Dental Work Plan* indicated that, as of 10/4/24, DBHDS had filled all positions except for one open dental assistant position. As of 10/3/24, two candidates for that position had been selected for interviews. However, the resulting offer was declined due to low salary, with no opportunity to negotiate. As of 2/16/25 DBHDS obtained approval to repost the position. For this 27th Period, in interview, DBHDS staff reported current staffing includes the required four Dental Hygienists, including the Dental Program Manager, and two Dental Assistants. As reported at the time of the 26th Period, one Dental Assistant position continues to remain open.	26th: In Progress **27th: In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	position continues to remain open As of 2/16/25, DBHDS obtained approval to repost for that position, but hiring remained in process.		
40 c) DBHDS will continue to review referrals for dental services and work to connect people to community dental providers when available.	During this 27th review period, DBHDS again completed this ongoing Action. The document entitled *Dental Work Plan Outcomes.PI.2024-25.09.30.2025* indicated the processes for reviewing referrals for dental services remained largely consistent with those described in the 26th Period report. These included the referral review and scheduling process, the	The *Dental Work Plan* indicated the processes for reviewing referrals for dental services remained largely consistent with those described in the 26th Period report. The following processes remained in place: • Referral Reviews and Scheduling: Referrals continue to be conducted through an online platform, and community clinics are scheduled weekly based on a minimum of 5-7 patients per mobile clinic. Clinics continue averaging 10-12 patients daily. • Independent Scheduling System: Teams independently schedule appointments and clinics using a shared system (SharePoint list). In an effort to ensure efficient scheduling and data collection, These processes were fully updated as of 3/24/25. However, DBHDS reported that staff continued to review them during the 27th Period for any opportunities for additional improvement. • Prioritization of Individuals Without Dental Exams: DBHDS continued to implement the previously-reported process for prioritizing individuals who have not had a dental exam, using data from WaMS. Monthly reports identify individuals without annual exams, and the dental team directly contacts service coordinators to assist in referrals and scheduling.	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	implementation of a SharePoint system that allows for independent appointment scheduling and tracking. DBHDS also continued to implement the previously-reported process for prioritizing individuals who have not had a dental exam, using data from WaMS. During this 27th Period, DBHDS continued to work on development of a reporting process for monthly and quarterly appointment data. A projected dashboard function remained in progress. DBHDS reported that additional staffing resources have been added to work on this	• Tracking Appointments: Since March 2025, DBHDS has implemented a system to document and track identified, scheduled, and completed dental appointments. The SharePoint list from the on-line referral system feeds this scheduling process, forming one complete system. During this 27th Period, DBHDS continued to work on development of a reporting process for monthly and quarterly appointment data (including completed appointments and no-shows). Current efforts continued to be focused on updating and refining data. A projected dashboard function remained in progress. DBHDS reported that additional staffing resources have been added to work on this aspect of the overall project.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	aspect of the overall project.		
40 d) Within six months of the date of this Order, DBHDS will contract with at least one dentist or dentistry practice in each Region who can support sedation dentistry.	For this 27th Period, the *Dental Work Plan* indicated that, on 5/29/25 and as a result of a procurement process described in the 26th Period report, DBHDS signed contracts with two dental providers willing to serve Regions 1 and 3. These contracts started on 7/1/25 and first quarter data collection to confirm the actual provision of services in these two regions was not yet available to review. DBHDS staff confirmed that Regions 2 and 4 both have	At the time of the 26th Period, DBHDS had not yet achieved contracting with at least one dentist or dentistry practice in each Region who can support sedation dentistry. For this 27th Period, the *Dental Work Plan* indicated that, on 5/29/25 and as a result of a procurement process described in the 26th Period report, DBHDS signed contracts with two dental providers willing to serve Regions 1 and 3, the remaining regions that did not previously have contracts for this resource. These contracts started on 7/1/25 and first quarter (i.e., 7/1/25-9/30/25), so data collection to confirm the actual provision of services in Regions 1 and 3 was not yet available to review. DBHDS staff confirmed that Regions 2 and 4 both have active contracts that provide for sedation dentistry. However, in interview, DBHDS staff reported that the Region 5 contract is now open again, and they were preparing to work with Procurement to post a Request for Proposals (RFP).	26th: In Progress **27th:** **In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	active contracts that provide for sedation dentistry. However, in interview, DBHDS staff reported that the Region 5 contract is open again, and they were preparing to work with Procurement to post a Request for Proposal (RFP).		
40 e) DBHDS will collaborate with dental providers to understand barriers to delivering services to individuals with developmental disabilities and, within six months of the date of this Order, will develop a plan with measurable goals, specific support activities, and timelines for implementation to mitigate those barriers.	For this 27th Period, DBHDS provided updates to its initial plan to facilitate collaboration, as reviewed during the 26th Period. The current *Dental Work Plan* indicated DBHDS had ongoing activity for each of the six steps previously outlined in the initial plan. The updates referenced measurable goals,	At the time of the 26th Period, DBHDS staff outlined six steps to collaborate with dental providers to understand barriers to delivering services to individuals with developmental disabilities and develop a strategic plan to address them. The first step has been completed, steps two, three and four are in process and steps five and six are not yet started. For this 27th Period, DBHDS provided the following updates in the current *Dental Work Plan*, indicating activity for each step: 1. Obtain report from DMAS on expansion of Medicaid network of providers within DentaQuest. At the time of the 26th Period, DMAS provided a report summarizing efforts to expand the Medicaid network. However, the DentaQuest network expansion report available at that time lacked clarity on whether newly added dentists serve individuals with disabilities, making it challenging to determine how the network is expanding. For this 27th Period, DBHDS reported that reports on expansion of the network do not specifically address serving individuals with DD because there is not clinical	26th: In Progress **27th Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	specific support activities for each and timelines for implementation. Activity for this 27th Period included the following: DentaQuest updated its search engine to include information provided by dentists regarding self-assessed skills treating children and/or adults with various special needs (e.g., developmental, cognitive or intellectual disabilities, seizures, mobility limitations, autism spectrum disorder, behavioral disorder, etc.) DMAS was participating in the DentaQuest Dental Champions Committee	specialty of "DD Dentistry," and the ability to provide care for individuals with DD is considered a skill which is determined by self-assessment. However, DentaQuest updated their search engine since January 2025 so that it contains information provided by dentists regarding their self-assessed skills in this area. They request participating dentists to identify if they have experience in treating children and/or adults with various special needs (e.g., developmental, cognitive or intellectual disabilities, seizures, mobility limitations, autism spectrum disorder, behavioral disorder, etc.) DBHDS provide a link to the DentaQuest search engine (https://www.dentaquest.com/en/find-a-dentist). Based on a brief testing of the application, it included many such appropriate search options and was easy to use. A search for Richmond, Virginia providers for adults and children with developmental disabilities and autism spectrum and behavioral disorders yielded 82 locations. 2. <u>Obtain schedule of DMAS listening sessions to address barriers.</u> At the time of the 26th Period, DBHDS anticipated that DMAS would be providing an updated schedule for listening sessions with dental providers. For this 27th Period, DMAS had not reported holding a "Listening Session." However, DMAS was participating in DentaQuest Dental Champions Committee meetings and had updated the plan for listening sessions by expanding upon the DMAS Dental Advisory Committee (DAC) structure and add "mini-DAC" meetings focused on providers. The next full DAC Meeting is scheduled for 8/21/25, with mini-DAC meetings with providers slated to begin in February 2026. DBHDS has received invitations to these upcoming meetings and intends to attend each. 3. <u>Determine measurable targets for expansion of Medicaid network of dental providers.</u> At the time of the 26th Period, DMAS and DentaQuest were collaborating with DBHDS to establish measurable targets for network	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	meetings and had recently updated the plan for listening sessions to which DBHDS has received invitations and intends to attend each. DMAS set the target goal for expansion of the Medicaid Dental Network of achieving 40% participation of the total number of dentists licensed and practicing in Virginia, and that the network benefit manager (i.e., DentaQuest) will maintain participation of 40% year over year. The Dental Work Plan indicated that the Virginia Commonwealth University (VCU) Dental School held a	expansion, with workgroup of stakeholders being formed to address this task. For this 27th Period, DBHDS reported DMAS had incorporated measurable targets in the DentaQuest contract. DBHDS further reported that, according to DMAS, DentaQuest's target goal for expansion of the Medicaid Dental Network is based on achieving 40% participation of the total number of dentists licensed and practicing in Virginia. The expectation is that DentaQuest will maintain participation of 40% of the population of actively practicing dentists year over year. 4. Partner with Virginia Commonwealth University (VCU) Dental School to expand training for supporting individuals with developmental disabilities. At the time of the 26th Period, VCU had developed a specialized dental clinic for DD patients but could not open it due to the lack of a special needs dentist. For this 27th Period, the *Dental Work Plan* indicated that the clinic held a ribbon-cutting on 8/13/25 and a meeting to explore collaboration opportunities was in the planning stages. 5. Identify Medicaid dental providers accepting new patients and update this information annually. At the time of the 26th Period, DBHDS planned to conduct an annual survey of dental providers to identify those accepting new patients, targeting regions with fewer dentists first. During this 27th Period, the *Dental Work Plan* documented that DBHDS staff partnered with the Region 3 Regional Quality Council to survey Medicaid providers in that region and with a private DD provider in Region 5 to address the needs identified in that organization's own survey of dental providers and dental needs for individuals they serve. However, the *Dental Work Plan* noted that the effort to maintain real time data on which providers are accepting new patients did not appear to be an efficient use of resources due to frequent fluctuations in dental office status. Instead, DentaQuest has established activities as part of their work as the benefit manager to	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	ribbon-cutting on 8/13/25 and a meeting to explore collaboration opportunities was in the planning stages. To identify and update Medicaid dental providers accepting new patients, DentaQuest monitors availability based on provider self-reporting in its search engine and 2) responses when DentaQuest makes direct contact with a network participant. DMAS is sharing these results of these activities with OIHSN. To identify barriers to connecting with community dentists, DBHDS is currently developing an on-line survey of families,	monitor availability based on 1) provider self - reporting for the new DentaQuest search engine and 2) responses when DentaQuest makes direct contact with a network participant. DMAS is sharing the results of these activities with OIHSN. 6. <u>Conduct survey of providers and families to identify barriers to connecting with community dentists</u>. At the time of the 26th Period, DBHDS reported planning to use the Dental Program Manager's thesis research survey for this purpose and distribute it via the DD Provider and IFSP ListServs. For this 27th period, the *Dental Work Plan* indicated an on-line survey of families is currently in development based on the above-referenced thesis research project, which will be posted for voluntary participation on the DD Provider ListServ and through the Individual and Family Support (IFSP) program. A second effort, a survey/phone interview of individual CSB providers is also underway.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	which will be posted on the DD Provider ListServ and through the Individual and Family Support (IFSP) program, while another survey/phone interview of individual CSB providers is underway.		
40 f) Within six months of the date of this Order, the Commonwealth shall start an initiative that determines which 8 CSBs need the most assistance to ensure that individuals receive annual dental exams and, no later than three months after starting this initiative, begin to provide technical assistance to support relevant CSBs. This process will continue to be implemented	For this 27th Period, DBHDS completed this ongoing Action. As reported in the PowerPoint presentation entitled *Annual Dental Exams Permanent Injunction 27th Study of Independent Reviewer,* DBHDS noted ongoing progress for five CSBs that have been in the lowest performing category for multiple years. Since FY21, four of the five have seen an increase	At the time of the 26th Period report, DBHDS had completed the initiation of a process to determine which eight Community Services Boards (CSBs) need the most assistance aims to identify and support CSBs with the lowest percentages of individuals receiving annual dental exams. Based on quarterly data, DBHDS initially identified the eight CSBs with the greatest need, with the list to be adjusted as needed on a quarterly basis. However, DBHDS indicated at that time that the process still needed to be refined, allowing for a full annual report that will allow analysis of trends, and that the OIHSN Project Manager would meet with the WaMS Data Analyst to refine the request. For this 27th Period, DBHDS staff reported completing the data request refinement and continuing to evaluate the CSBs in most need of assistance. The PowerPoint presentation entitled *Annual Dental Exams Permanent Injunction 27th Study of Independent Reviewer* noted ongoing progress for five CSBs that have been in this category for multiple years. Since FY21, four of the five have seen an increase of those receiving annual dental exams between nine and eleven percent, while a fifth has seen an increase of 30.58%.	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
annually until the Commonwealth achieves the goal.	of those receiving annual dental exams between nine and eleven percent, while a fifth has seen an increase of 30.58%. The dental team continues to reach out to identified CSBs to establish on-site clinics and provide technical assistance. During this 27th Period, of the nine identified CSBs with the lowest percentage of individuals receiving annual dental exams, DBHDS focused technical assistance on four that had not yet seen year-to-year increases.	The dental team continues to reach out to identified CSBs to establish on-site clinics and provide technical assistance. DBHDS staff have created dental appointment calendars or technical assistance and clinic visits for each CSB, with progress tracked for specific regions. Clinics and technical assistance visits are ongoing. Based on the aforementioned PowerPoint, during this 27th Period, of the nine identified CSBs with the lowest percentage of individuals receiving annual dental exams, DBHDS focused technical assistance on four that had not yet seen year-to-year increases.	
40 g) If the Commonwealth has not achieved the goal within two years of the date of this Order after	This action is not required until 1/15/27 (two years from the approval of the permanent injunction.)	This action is not required until 1/15/27 (two years from the approval of the permanent injunction.) A final implementation plan was not completed.	**Not Yet Implemented Due Date 1/15/2027**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
taking the actions in Paragraphs 40(a) through 40(f), DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	A final implementation plan was not completed.		
41. Protection From Serious Injuries in Service Settings The Commonwealth will work to achieve a goal that 95% of DD waiver service recipients will be protected from serious injuries in service settings.	For this 27th Period, using the algorithm described in the current Process Document, entitled *Individuals Protected from Serious Injury, Version 006*, last revised on 8/15/25, DBHDS reported that, for the period 7/1/24-6/30/25, 97.3% of 18,003 individuals served were protected from serious injury.	At the time of the 26th Period, despite improvements to a number of written processes and protocols, the study found the data for the numerator of this measure was not yet valid or reliable. Therefore, even though DBHDS reported at that time that 97.1% of individuals were protected from serious injury, this percentage could not be used for compliance reporting. DBHDS needed to complete further work to eliminate ambiguities that might result in a failure to complete needed investigations of serious injuries. In particular, the processes did not support a reliable evaluation of pre-injury circumstances, but instead emphasized actions the provider took after the injury to ensure health and safety in the future. This was an important distinction because the construct of this measure relies on an evaluation that the provider had protections in place prior to the injury, and not that they took appropriate actions after the serious injury occurred. Therefore, because a reliable calculation for the measure's numerator (i.e., the number of individuals	**26th: Not Achieved** **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	However, for this Term's specified goal, the algorithm and related processes did not yet yield valid and reliable data. As described below with regard to 41a), DBHDS reported making additional modifications to the methodology for determining the percentage of individuals that are protected from serious injury. These were represented in the current Process Document, entitled *Individuals Protected from Serious Injury, Version 006*, last revised on 8/15/25, and in a number of written processes and protocols	who were protected from the serious injury they sustained) still relied primarily on SIU serious injury investigations to determine whether individuals were protected, an investigation could still be needed to examine the pre-injury circumstances even when all post-injury protections were in place. Overall the IMU still referred only a very small percentage of serious injuries for investigation and the SIU actually investigated only a small percentage of those referrals. Due to the ambiguities identified during the 26th Period, DBHDS could not demonstrate that all reported serious injuries received an SIU investigation to confirm that pre-injury protections were in place. This called into question the validity of the measure. For this 27th Period, using the algorithm described in the current Process Document, entitled *Individuals Protected from Serious Injury, Version 006*, last revised on 8/15/25, DBHDS reported that, for the period 7/1/24-6/30/25, 97.3% of 18,003 individuals served were protected from serious injury. However, DBHDS staff still needed to make additional revisions to achieve data validity and reliability. As described below with regard to 41a), DBHDS reported making additional modifications to the methodology for determining the percentage of individuals that are protected from serious injury. These were represented in the current Process Document, entitled *Individuals Protected from Serious Injury, Version 006*, last revised on 8/15/25, and in a number of written processes and protocols related to the review and referral of serious injuries. It was positive that DBHDS had made some updates for these documents; however, as described below and with regard to Actions 41a) and 41 b), the most significant ambiguities remained.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	related to the review and referral of serious injuries. It was positive that DBHDS had made some updates for these documents; however, as described below and with regard to Actions 41a) and 41 b), the most significant ambiguities remained.		
41 a) DBHDS will continue working to ensure that all appropriate serious injuries are included when determining if this goal is met.	For this 27th Period, DBHDS continued to strive to make revisions to improve the methodology for ensuring that all appropriate serious injuries are included in the reporting for this measure. However, the methodology continued to need additional revisions to ensure valid and reliable data.	For the 26th Period, the measure algorithm, the Process Document and the protocols still needed some revisions to address barriers to ensuring a valid and reliable measure. The study continued to find that ongoing ambiguities in the *Appendix D-SIR Investigations* and associated protocols, with regard to how IMU staff should consider pre-injury and post-injury circumstances when deciding what serious injuries to refer for investigation, could have contributed to these very low percentages of referrals and investigations and needed clarifications. The study noted that this was an important distinction because the validity construct of this measure relies on the provider having had protections in place *prior* to the injury, and not that they took appropriate actions *after* the serious injury occurred. As discussed with DBHDS and IMU staff at that time, they needed to review the various documents carefully and make revisions to eliminate the ambiguities, these in particular:	26th: In Progress **27th:** **In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Overall, the revisions do not definitively ensure that all applicable serious injuries are referred for investigation, even when questions might remain about the presence, absence or sufficiency of pre-injury supports. DBHDS submitted a document entitled *Term 41 Summary*, which cited revisions to the formalized "pre-investigation" triage process in the *OL IMU Pre-Investigation Determination Triage for DD Deaths and Serious Incidents*. Pursuant to these revisions, Licensing Specialists who make the initial review of serious injury	• The language in the 26th Period documents reviewed most often focused on actions providers took following the serious injury and contained insufficient probes for the presence of pre-injury protections. However, what the provider did after the serious injury did not really speak to whether the person had adequate protections in place prior to its occurrence, which, as noted above, is key to the validity of the measure for this Term. Therefore, even if all post-injury protections were documented, an investigation might still be needed to examine the pre-injury circumstances. The language was also sometimes inadvertently misleading about whether IMU staff should factor in the absence or presence of pre-injury protections when deciding whether to refer for investigation. • Protocols continued to provide discretion to key staff when determining whether to refer a serious injury for investigation, even when pre-injury protections were not substantiated. On one hand, protocols lacked clarity about whether sufficient post-injury remediation would be enough to decide not to investigate, and even suggested at times that it would be; on another hand, the pre-investigation triage protocols still did not include serious injuries without clear evidence that pre-injury protections were in place as incidents that MUST referred for investigation; instead, they were in the category of incidents that MAY be referred, per the discretion of IMU staff. For this 27th Period, DBHDS made additional improvements to the processes, but they did not yet resolve the problem of validity, as described further below. As discussed with DBHDS staff, by all accounts, IMU processes work very well for identifying when injuries occur and for taking action to prevent any	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	incidents are to refer any case that may meet the criteria for an investigation for further review (i.e., the pre-investigation triage) by the Incident Management Quality Specialist (IMQS) to determine if a further investigation is warranted. However, the protocols still do not make clear what is considered "warranted." DBHDS staff also reported they had updated the OL Investigation Protocols, as outlined in *Term 41 Investigation Protocols Combined August 2025 Final (Investigation Protocols Combined*) with regard to serious incident reports (SIRs)	additional or future harm related to the injury. Triage often rightly focuses on ensuring the provider has protections now in place and going forward to ensure that, answering the questions whether people are safe now and going to be safe in the future? But for the purposes of Term 41, it is necessary to focus instead on whether needed supports were in place and adequately implemented prior to the occurrence of the serious injury and to answer this question: based on what the provider knew or should have known about the individuals' risks, did the provider do everything it needed to do to keep them safe from that injury? Subsequently, and for the purpose of validity, for all serious injuries for which the answer of the initial triage/pre-investigation is that all necessary pre-injury protections were not in place or it could not be fully determined, the current construct of the measure requires a further investigation. Otherwise, with the exception of serious injuries resulting from substantiated abuse/neglect or that represented more than one injury in a rolling 12-month period for any individual (i.e., which were therefore already automatically included in the numerator), only serious injuries that are investigated by the SIU can possibly be eventually included in the numerator and the requirement for that investigation would be regardless of any other prioritization criteria the IMU might have. With that in mind, the paragraphs below describe the most pertinent changes DBHDS staff made during this 27th Period as summarized in the document DBHDS submitted entitled *Term 41: Protection From Serious Injuries in Service Settings (Term 41 Summary)*, along with an evaluation of their impact on and consistency with the requirements for data validity and reliability. Overall, these revisions do not definitively ensure that all needed serious injuries are	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	that "MAY be referred by the IMU" and "MAY be Investigated by SIU." Based on review of the *Investigation Protocols-Combined, Incident Management Pre-Investigation Determination Triage for DD Deaths/Serious Incidents*, revised as of 8/1/25, SIRs that are "High Priority for Pre-investigation Determination Triage" now include the following criteria: "Risk mitigation strategies do not effectively address pre-existing risks that are known or should have been known for the individual." Similarly, SIRs that are "High Priority for Investigation by SIU"	referred for investigation, even when questions might remain about the presence, absence or sufficiency of pre-injury supports. For this 27th Period, the *Term 41 Summary* cited revisions to the formalized "pre-investigation" triage process in the *OL IMU Pre-Investigation Determination Triage for DD Deaths and Serious Incidents*. Pursuant to these revisions, Licensing Specialists who make the initial review of serious injury incidents are to refer any case that may meet the criteria for an investigation for further review (i.e., the pre-investigation triage) by the Incident Management Quality Specialist (IMQS) to determine if a further investigation is warranted. The IMQS will make this determination by reviewing the full incident report, conducting an interview with the provider and reviewing the individual's ISP in WaMS. If the IMQS determines that an investigation is warranted, they will open an investigation on the case before forwarding the incident workflow to the Special Investigation Unit (SIU). However, the protocols still do not make clear what is considered "warranted." DBHDS staff also reported they had updated the OL Investigation Protocols, as outlined in *Term 41 Investigation Protocols Combined August 2025 Final (Investigation Protocols Combined)* with regard to serious incident reports (SIRs) that "MAY be referred by the IMU" and "MAY be Investigated by SIU." Based on review of the *Investigation Protocols-Combined, Incident Management Pre-Investigation Determination Triage for DD Deaths/Serious Incidents* revised as of 8/1/25, SIRs that are "High Priority for Pre-investigation Determination Triage" now include the following criteria: "Risk mitigation strategies do not effectively address pre-existing risks that are known or should have been known for the individual." Similarly, SIRs that are "High Priority for Investigation by SIU" also includes this statement.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	also include this statement. However, the language of the statement remains ambiguous. Since it uses a present tense, it could still be interpreted as risk mitigation strategies the provider put in place as a result of the injury and were therefore present for the IMU review. For the validity of this measure, it should clearly reference the presence and status of the pre-injury risk mitigation strategies (e.g., at the time of the injury, the risk mitigation strategies did not effectively address pre-existing risks that were known or should have been known.)	This continues to be problematic, first because the language remains ambiguous. It continues to use a present tense, which could still be interpreted as risk mitigation strategies the provider put in place as a result of the injury and were therefore present for the IMU review. For the validity of this measure, it should clearly reference the presence and status of the pre-injury risk mitigation strategies (e.g., at the time of the injury, the risk mitigation strategies did not effectively address pre-existing risks that were known or should have been known.) Second, there is a lack of clarity about what "high priority" for referral for pre-investigation triage and/or investigation by SIU means in practice. The current protocols for what MUST be referred for pre-investigation triage and what MUST be investigated by SIU do not include the category of "risk mitigation strategies that do not effectively address pre-existing risks that are known or should have been known for the individual." In interview, staff acknowledged that, given resource constraints, not all incidents that are high priority for investigation are ultimately referred for an investigation to be completed. Staff also acknowledged that the IMQS maintains discretion in the determination of which high priority incidents will be referred for investigation, and the protocols do not give guidance for that determination. Finally, these modifications did not result in a significant increase in serious injuries that reached the stage of investigation referral or of investigation. During the 26th Period, 7.2% of serious injuries were referred and 2.5% were investigated. For this 27th Period, 7.7% were referred and 3.6% were investigated. It is also of note that of the 1,812 individuals who sustained serious injuries for the period from 7/1/24 though 6/30/25, DBHDS found	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	The protocols also lack clarity about what "high priority" for referral for pre-investigation triage and/or investigation by SIU means in practice. The current protocols for what MUST be referred for pre-investigation triage and what MUST be investigated by SIU do not include the category of "risk mitigation strategies that do not effectively address pre-existing risks that are known or should have been known for the individual." In interview, DBHDS staff acknowledged that the Incident Management Quality Specialist (IMQS)	that 495 were not protected from injury, but only 17 of those findings resulted from an investigation. The other 478 were included in the numerator due to substantiated abuse/neglect or repeated injuries. Of note, the *Term 41 Summary* indicated that the *Appendix D Triage Criteria to Consider after Discussion with the Provider* was revised to state "If the health and safety of the individual is confirmed and the provider had protections in place prior to the injury, the SIR is not required to be referred." This would not have fully resolved the concerns outlined above, but it would have been a positive step forward to reference the pre-injury protections. However, the *Investigation Protocols Combined* provided for review did not include that statement as indicated. At the conclusion of this 27th Period study, DBHDS staff acknowledged the need to address these concerns overall and had begun working on them.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	maintains discretion in with regard to the determination of which high priority incidents will be referred for investigation, and that given resource constraints, not all incidents that are high priority for investigation are ultimately referred for an investigation to be completed. In practice, these modifications did not significantly ameliorate the previously documented concern that very few serious injuries reach the investigation stage. During the 26th Period, 7.2% of serious injuries were referred and 2.5% were investigated. For this		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	27th Period, 7.7% were referred and 3.6% were investigated. At the conclusion of this 27th Period study, DBHDS staff acknowledged the need to address these concerns overall and had begun working on them.		
41 b) Within six months of the date of this Order, and annually thereafter, the DBHDS Office of Integrated Health will complete a quality review of a statistically significant sample of serious injuries reported to DBHDS via the CHRIS system (or successor) to determine if the Incident Management	For this 27th Period, this Action was in progress. DBHDS had completed a review of a statistically significant sample for one month this far, but did not yet have sufficient data to begin making recommendations for any needed changes to the way incidents are reviewed and referred.	At the time of the 26th Period, this action was in progress, with incident management staff indicating they had begun working with the Office of Integrated Health Support Network (OIHSN) to develop the needed processes for a quality review of a statistically significant sample of serious injuries to determine if the IMU process used by the OL adequately identifies all appropriate injuries and to further determine if individuals were protected from harm and if changes are needed to the way incidents are reviewed and referred. For this 27th Period, DBHDS provided a document entitled, *Permanent Injunction Term 41b, FY25Q4-FY26Q1 (Serious Injury Quality Review Report)*, dated September 2025. The stated purpose of this quality review was to determine if the processes implemented by the IMU are appropriately identifying all individuals that have not been protected from harm and if these processes are addressing any identified issues to reduce the risks of future harm to these	26th: In Progress **27th:** **In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
Unit process used by the DBHDS Office of Licensing adequately identifies all appropriate injuries to determine if individuals were protected from harm and if changes are needed to the way incidents are reviewed and referred.	DBHDS provided a document entitled, *Permanent Injunction Term 41b, FY25Q4-FY26Q1 (Serious Injury Quality Review Report)*, dated September 2025. The stated purpose of this quality review, performed by OIHSN Registered Nurse Case Consultants (RNCCs), was to determine if the processes implemented by the IMU are appropriately identifying all individuals that have not been protected from harm and if these processes are addressing any identified issues to reduce the risks of future harm to these individuals.	individuals. DBHDS indicated they designed the OIHSN review to answer four questions, as recommended in the 26th Period study: 1) have all appropriate injuries been identified by the IMU; 2) were individuals protected from harm; 3) are changes needed to the way that incidents are reviewed; and, 4) are changes needed to the way that incidents are referred? To complete the reviews, OIHSN reported they established a Serious Injury Quality Review work group comprised of four Registered Nurse Case Consultants (RNCCs), the OIHSN Project Manager, and the OIH Director. The first review took place in July and August 2025 and included 23 serious injuries that occurred in June 2025. DBHDS reported that this was a statistically significant sample for the month. Presumably, if the sampling process is repeated each month for a year, this will result in an annual statistically significant sample. Findings included that only one of the 23 serious injuries reviewed was referred to the licensing specialist/investigator, and RNCC reviewer was in agreement with that. For two other incidents, the RNCC felt the individual was not protected, but a referral did not occur. However, the report also stated that for almost 70% of the incidents reviewed, more detail was needed to be able to make a determination that the individual was or was not protected; therefore, a final determination of the percentage of appropriate referrals could not be made. The OIHSN presented this information to the RMRC on 9/25/25 with recommendations for the OIHSN to further refine their processes to ensure that they are adequately addressing the requirements and aligning with the IMU triage and referral processes. As they move forward, DBHDS should	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	DBHDS indicated they designed the OIHSN review to answer four questions: 1) have all appropriate injuries been identified by the IMU; 2) were individuals protected from harm; 3) are changes needed to the way that incidents are reviewed; and, 4) are changes needed to the way that incidents are referred? The first review took place in July and August 2025 and included 23 serious injuries that occurred in June 2025. DBHDS reported that this was a statistically significant sample for the month. Presumably, if the sampling process is repeated each month	clarify how they can ensure that having OIHSN exactly replicate the IMU triage and pre-investigation processes for serious injuries will allow them to answer the four questions posed for the process, given that it is not just reliability that needs to be tested, but also validity of the processes themselves. Having the RNCCs cast a different eye on determining whether individuals who sustained serious injuries were protected from harm would serve as a validation study, and in most respects, validity of the measure is the most in question at this time. The initial findings that almost 70% of the incidents reviewed did not have enough detail to make a determination could well be indicative of a problem with validity. The OIHSN did not yet have enough data to make recommendations for changes that might be needed to the way incidents are reviewed and referred. OIHSN and IMU plan to review results each month to continue to refine the process and to begin to identify opportunities for improvement in the triage and referral process. This may include improvements in the initial information that is collected from providers. Going forward, OL and the RNCCs should also consider how to evaluate whether the ISP in place at the time of the serious injury sufficiently identified risks that "should have been known."	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	for a year, this will result in an annual statistically significant sample. Findings included that only one of the 23 serious injuries reviewed was referred to the licensing specialist/investigator, and RNCC reviewer was in agreement with that, while for two other incidents, the RNCC felt the individual was not protected and a referral did not occur. However, the report stated that for almost 70% of the incidents reviewed, more detail was needed to be able to make a determination that the individual was or was not protected;		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	therefore, a final determination of the percentage of appropriate referrals could not be made. The OIHSN did not yet have enough data to make recommendations for changes that might be needed to the way incidents are reviewed and referred. The OIHSN and IMU plan to review results each month to continue to refine the process and to begin to identify opportunities for improvement in the triage and referral process. As they move forward, DBHDS should clarify how they can ensure that having OIHSN		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	exactly replicate the IMU triage and pre-investigation processes for serious injuries will allow them to answer the four questions posed for the process, given that it is not just reliability that needs to be tested, but also validity of the processes themselves. Having the RNCCs cast a different eye on determining whether individuals who sustained serious injuries were protected from harm would serve as a validation study, and in most respects, validity of the measure is the most in question at this time. The initial findings that almost 70% of the incidents reviewed did not have enough detail to make a determination could		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	be indicative of a problem with validity. Additionally, OL and the RNCCs should also consider how to evaluate whether the ISP in place at the time of the serious injury sufficiently identified risks that "should have been known."		
41 c) Relevant processes will be revised, as warranted, based on the finding of the quality review referenced in Paragraph 41(b) to ensure that the Commonwealth accurately identifies the percentage of DD waiver recipients who are protected from serious injuries in service settings.	For this 27th Period, as described above with regard to Action 41b), OIHSN staff have completed the first *Serious Injury Quality Review Report;* however, process revisions remain under consideration at this time.	For the 26th Period, DBHDS had not started this Action, pending the development and implementation of the of the OIHSN quality review required in Action 41b). For this 27th Period, as described above with regard to Action 41b), OIHSN staff have completed the first *Serious Injury Quality Review Report;* however, process revisions remain under consideration at this time.	26th: In Progress **27th: In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
41 d) If the Commonwealth has not achieved the goal within two years of the date of this Order after taking the action in Paragraphs 41(a) through 41(c), DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the metric is achieved and sustained for one year.	This action is not required until 1/15/27 (one year from the approval of the permanent injunction. A final implementation plan was not completed.	This action is not required until 1/15/27 (two years from the approval of the permanent injunction). A final implementation plan was not completed.	**Not Yet Implemented Due Date 1/15/27**
42. Risk Management. To ensure that the risk management programs of DBHDS-licensed providers of DD services identify the incidence of common	DBHDS had not made any changes to its licensing regulations at §520.C.5 and §520.D that establish clear requirements for risk management programs implemented by	Previous studies have confirmed that DBHDS licensing regulations at §520.C.5 and §520.D establish clear requirements for risk management programs implemented by DBHDS-licensed providers of developmental disabilities (DD) services. Specifically, these regulations mandate that providers must identify the incidence of common risks and conditions experienced by individuals with DD that may contribute to avoidable deaths. In addition, providers are required to take prompt and appropriate action when such events occur or when the risk is otherwise identified.	26th: Deferred **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
risks and conditions faced by people with DD that contribute to avoidable deaths and take prompt action when such events occur or the risk is otherwise identified, the Commonwealth will take the following actions:	DBHDS-licensed providers of developmental disabilities (DD) services that address each of the requirements in Term 42. DBHDS developed and continues to implement a formal "Care Concern" process that structures how the Department identifies, and providers respond to the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths and take prompt action when such events occur, or the risk is otherwise identified. The Office of Licensing and the Office of	The DBHDS "Care Concern" process, as described in earlier study reports, outlines both the definitions of these common risks and conditions and the procedures for addressing their occurrence. This process is designed to ensure that providers respond swiftly and effectively to identified risks, in accordance with Term 42, thereby supporting improved outcomes for individuals receiving DD services. Prior studies have identified a concern that licensing specialists lack consistency in accurately assessing whether providers meet these requirements. During each of the past four studies, the Consultant has conducted a sample review of providers across each of the five regions and compared the findings made by licensing specialists with those made by the Consultant's review of sample providers' evidence. The OL and the OCQM within DBHDS have maintained ongoing efforts to support providers in meeting the expectations of licensing requirements. Their initiatives include providing training and guidance, with particular emphasis on the utilization of an Excel-based Risk Tracking Tool template. This tool facilitates the recording and analysis of data related to common risks and conditions, referred to as care concerns, outlined in Term 42. Findings from sample reviews conducted over the past four studies indicate that more providers are integrating this Risk Tracking Tool into their processes to fulfill the requirements of Term 42. The sustained efforts by the OL and the OCQM have contributed to improved provider compliance with regulations associated with this Term through DBHDS's various initiatives.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Clinical Quality Management (OCQM) continue to provide training to providers and licensing specialist staff on methods of risk identification, analysis, and follow-up actions to address the incidence of common risks and conditions referenced in Term 42. The Office of Licensing has developed and begun implementation of an inter-rater reliability process that evaluates the consistency and accuracy with which licensing specialists determine whether providers are meeting the regulatory requirements that are applicable to Term 42. The process includes a	Despite these improvements, prior studies have highlighted an ongoing concern regarding the accuracy and consistency of licensing specialists' assessments. Specifically, there has been variability in determining whether providers adequately meet the outlined requirements. To continue assessment of this accuracy and consistency, the Consultant has performed sample reviews of providers from each of the five regions during each of the past four studies, comparing the determinations made by licensing specialists against those derived from the Consultant's independent review of provider evidence. The results below compare the average scores from the Consultant's sample review of 80 licensed providers in the 24th/25th studies with those of the sample review of 80 licensed providers in the 26th/27th studies for specific questions that are applicable to Term 42. Overall, the combined average agreement percentages for these questions improved from 67.6% in 24th/25th studies to 73.5% in the 26th/27th studies. Individual comparisons by question are as follows: • Does the provider's systemic risk assessment process incorporate uniform risk triggers and thresholds (care concerns) as defined by the department? o **24th/25th: 82.5%** o **26th/27th: 78.8%** ***(slight regression)*** • Does the provider's risk management policy/plan and/or Systemic Risk Assessment describe how they identify common risks and conditions faced by people with IDD that contribute to avoidable deaths? o **24th/25th: 66%** o **26th/27th: 73.8 (significantly improved)**	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	quarterly "gold standard" comparative review of determinations made by each licensing specialist conducted under the direction of the Associate Director of Quality and Compliance and the Quality Improvement Review Specialist, neither of whom are in the chain of command of the licensing specialists. As the process is fully implemented, the results will provide continuing objective measurement of uniformity in assessments conducted by licensing specialists, thereby improving the accuracy and consistency of regulatory compliance	• Does the provider's risk management policy/plan describe how they use data to assess and evaluate common risks and conditions faced by people with IDD that contribute to avoidable deaths? o **24th/25th: 52.5%** o **26th/27th: 65% (significantly improved)** • Does the provider's risk management policy/plan and/or Systemic Risk Assessment require the implementation of corrective action plans to address issues related to common risks and conditions faced by people with IDD that contribute to avoidable deaths? o **24th/25th: 65.5%** o **26th/27th: 72.5% (significantly improved)** • Is there evidence that the provider has implemented corrective action plans to address identified issues related to common risks and conditions faced by people with IDD that contribute to avoidable deaths? o **24th/25th: 71.5%** o **26th/27th: 77.6% (improved)** A comparison of the results from the 24th/25th sample reviews with those from the 26th /27th sample reviews demonstrates that the consistency with which licensing specialists assess provider compliance improved across all areas except the assessment of whether the provider's systemic risk assessment process incorporates uniform risk triggers and thresholds (care concerns) as defined by the department, where a slight regression was observed. Although OL's continued improvement is a positive development, it remains insufficient to confirm that licensing specialists are consistently and accurately evaluating whether the risk management programs implemented by DBHDS-licensed providers of DD services effectively identify the occurrence of	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	evaluations across providers. When comparing data from sample reviews conducted during the 24th/25th review periods' studies with the same sample reviews conducted during the 26th/27th studies, the Consultant determined that the consistency with which licensing specialists assess provider compliance improved across all areas except the assessment of whether the provider's systemic risk assessment process incorporates uniform risk triggers and thresholds (care concerns) as defined by the department, where a slight regression was observed.	common risks and conditions faced by individuals with developmental disabilities that contribute to avoidable deaths and take prompt action when such events occur or when risks are otherwise identified. The OL and the OCQM should continue their initiatives to broaden providers' understanding of regulatory requirements and enhance the consistency with which licensing specialists evaluate whether providers are fulfilling these regulations. Maintaining and improving this consistency is essential to ensuring providers implement effective risk management practices and quality assurance measures as required by department regulations. The OL's development and initial implementation of an inter-rater reliability process, which has occurred since the conclusion of the 26th study, is a significant and positive measure to support enhancing the consistency and accuracy with which licensing specialists evaluate whether providers are meeting these regulatory requirements. This process includes a quarterly "gold standard" comparative review of determinations made by each licensing specialist conducted under the direction of the Associate Director of Quality and Compliance and the Quality Improvement Review Specialist, neither of whom are in the chain of command of the licensing specialists. The process is described in detail under Action 42.a below and is designed to promote uniformity in assessments conducted by licensing specialists, thereby improving the accuracy and consistency of regulatory compliance evaluations across providers.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Despite the noted improvement, the degree to which licensing specialists consistently and accurately assess licensed providers' implementation of risk management programs required by Term 42 is not yet sufficient to ensure that the risk management programs of DBHDS-licensed providers of DD services are meeting the licensing regulations that address each of the requirements in Term 42.		
42.a) Within 24 months of the date of this Order, the Commonwealth shall establish inter-rater reliability among the Commonwealth's	The Office of Licensing has developed and begun implementation of an inter-rater reliability process that formally evaluates consistency and	As described in the 26th study report, the Office of Licensing (OL) has continued and expanded several practices to address the requirements of this action, including: • DD Inspection Training for licensing specialists. • Regional Managers conducting unannounced parallel inspections with licensing specialists.	26th In Progress **27th** **In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
licensing specialists regarding provider compliance with the quality assurance trending requirements.	accuracy with which licensing specialists evaluate whether providers are meeting the regulatory requirements that are applicable to Term 42. As the process is fully implemented, the results will provide continuing objective measurement of uniformity in assessments conducted by licensing specialists, thereby improving the accuracy and consistency of regulatory compliance evaluations across providers. The process is currently in its initial implementation phase, but when fully implemented it will provide objective and comparable data to	• Tenured licensing specialists shadowing and mentoring newly hired licensing specialists. • Quality Improvement Specialist Look-Behinds. In addition to these processes, the OL has developed and begun implementation of a formal, measurable framework for continuously assessing inter-rater reliability. Each quarter, every licensing specialist, regional manager, and investigator will independently evaluate a single provider record randomly selected by OL's Associate Director of Quality & Compliance (ADQC). The licensing specialists will each provide a rating specific to the regulatory requirements at §§450, 520.A-D, and 620.A-D. OL's Quality Improvement Specialist (QIRS) then compares the results to the "gold standard" assessment results established by the QIRS and the ADQC. Within 30 days of completing the evaluations, the QIRS and ADQC review the comparative results. For any regulation where agreement is below 86%, the QIRS and ADQC will provide additional training specific to that regulation during a scheduled all-staff meeting or through small group training to address the areas of disagreement. The QIRS and ADQC will aggregate and analyze data from these reviews on an ongoing basis to identify any relevant trends or patterns that may require additional follow-up action. The first review began on 07/23/2025, with the anticipated completion of the analysis of results and follow-up action by 09/30/2025. While the process is currently in its initial implementation phase, if followed as described, it will provide objective and comparable data to guide the ongoing determination of inter-rater reliability among the Commonwealth's licensing specialists as	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	guide the ongoing determination of inter-rater reliability among the Commonwealth's licensing specialists as required in Action 42.a.	required in Action 42.a. It will also serve as an objective, data-based tool for the ongoing review and analysis of licensing specialist determinations. The above-described actions support the determination that the requirements of Action 42.a continue to be in progress.	
42.b) Within 12 months of the date of this Order, the Commonwealth shall offer technical assistance in accordance with DBHDS's Consultation and Technical Assistance Standard Operating Procedure to each provider that does not identify the incidence of common risks and conditions faced by people with DD that contribute to avoidable deaths.	The Office of Community Quality Improvement developed and implemented the Expanded Consultation and Technical Assistance (ECTA) process in 08/2024 that will be on-going and meets the requirements of this action. Further improvements that became effective in 07/2025 have been made to strengthen the process further.	DBHDS has continued the functions of the Expanded Consultation and Technical Assistance (ECTA) process, established by the Office of Community Quality Improvement (OCQI) to provide technical support to providers on several topics including the regulatory requirements at *12VAC35-105-520.B-D.* The *Expanded Consultation and Technical Assistance Standard Operating Procedures (effective 08/23/2024)* describe the ECTA process which was described in detail in the 26th study report. There are two types of enrollments – voluntary enrollment based on an invitation from the ECTA team, or mandatory enrollment. A key focus of the process is enhancing risk management functions, including the accurate identification of risks and conditions that commonly impact individuals with developmental disabilities (DD) and contribute to avoidable deaths, as defined under regulations *12VAC35-105-520.B-D*. DBHDS has enhanced the ECTA process as documented in the *Combined OL & OCQI Mandatory ECTA Protocol,* effective 07/15/2025 through addition of more specific requirements for mandatory enrollment. If a service provider receives two consecutive citations for one or more specific regulations (Non-Compliant Systemic) under §450, §520.A-D, or §620.A-D, OL requires the provider to initiate mandatory assistance through the ECTA Team within 45 calendar days of receiving their most recent approved Corrective Action Plan. If the provider does not initiate or complete mandatory ECTA, the provider may be subject to addition enforcement by OL.	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
		The ECTA Team has completed five invitation periods beginning in 04/2025 for voluntary provider enrollment in ECTA. Of the 141 providers enrolled in the voluntary program, 102 voluntary provider participants (72%) have completed or are currently in progress. 39 other voluntary provider participants did not complete the program for various reasons. DBHDS began sending sixth round invitations beginning 09/10/2025. Under mandatory enrollment criteria that went into effect on 04/01/2025, four providers have been enrolled in mandatory ETCA. OL's additional requirements for Non-Compliant Systemic mandatory enrollments went into effect on 07/15/2025 and the first provider enrollment under this requirement is in progress. The above-described actions support the continued determination that the requirements of Action 42.b have been completed. The OL and the ECTA team continue to review the effectiveness of these procedures and initiate additions or revisions, as necessary.	
42.c) Within one month of the date of this Order, when providers do not take prompt action when such events occur, or where the risk is otherwise identified despite lack of prompt action by providers, DBHDS will	DBHDS, through the Office of Licensing (OL), implemented and is continuing its inspection protocol that complies with the requirements of this action. This includes developing a corrective action plan for each	Previous studies have confirmed that DBHDS has licensing regulations at *12VAC35-105-160* that require providers to identify, report, and take prompt and appropriate action for any identified serious injury which includes incidents involving common risks and conditions referenced in this Term. Additionally, *12VAC35-105-170* outlines requirements for providers to develop and submit a written corrective action plan for each violation cited. DBHDS has continued to implement these processes as outlined in licensing regulations noted above and in the Office of Licensing Look-Behind Process for DD Providers Annual Inspections which includes address of: (1) Assessment	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
ensure that corrective action plans are written, implemented, and tracked, and take further actions as warranted.	cited violation, ensuring provider implementation of the plan, and enforcing progressive actions if non-compliance persists.	of Policy, (2) Corrective Action Plan requirements, and (3) Progressive Enforcement. DBHDS continues to review and revise this process as needed; the most recent revisions occurred in 06/2025 and 07/2025. The Consultant verified this process through sample review of regulatory findings for 80 licensed providers conducted by the Consultant during both the 26th and 27th studies. The above-described actions support the continued determination that the requirements of Action 42.c have been completed.	
43. Timely Waiver Service Enrollment The Commonwealth will work to achieve a goal that 86% of individuals who are assigned a waiver slot will be enrolled in a service within five months.	For the 27th Period, the Commonwealth did not achieve the specified goal of this Term because the most recently reported data, as found in the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 3rd and 4th Quarters*, dated 9/20/25, reported performance 76.2% for FY25 Q3 and 84.7% for FY25 Q4. However, this represented an upward trend from previous reporting.	For the 26th Period, the Commonwealth did not achieve the specified goal of this Term (formerly included in CI 35.8) because the Commonwealth's most recently reported data, as found in the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 1st and 2nd Quarters*, dated 2/28/25, reported performance at 75.4% for FY25 Q1 and 77.9% for FY25 Q2. This represented a downward trend from previous reporting. The document did not address potential reasons for this trend. For this 27th Period, the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 3rd and 4th Quarters*, dated 9/20/25, reported performance at 76.2% for FY25 Q3 and 84.7% for FY25 Q4. For the entirety of FY25, overall performance stood at 78.6%, which represented an upward trend from previous reporting. At the time of the 23rd Period, DBHDS submitted an applicable Process Document, entitled *DD CMSC VER 016*, dated 8/29/23, and an applicable Data Set Attestation, dated 8/30/23. These were sufficient to support data validity and reliability for the data reported above. For this 27th Period review, DBHDS provided an updated Process Document, entitled *DD CMSC VER 019*, dated 1/29/24. The updated modifications were	26th: Not Achieved **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	At the time of the 23rd Period, DBHDS submitted an applicable Process Document, entitled *DD CMSC VER 016*, dated 8/29/23, and an applicable Data Set Attestation, dated 8/30/23, which met the standard for data validity and reliability. For this 27th Period review, DBHDS provided an updated Process Document, entitled *DD CMSC VER 019,* dated 1/29/24. The updated modifications were not relevant to Term 43 data collection; therefore, they did not impact the validity and reliability previously determined to be sufficient.	not relevant to Term 43 data collection; therefore, they did not impact the previous finding that it was sufficient for data validity and reliability.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
43 a) Within three months of the date of this Order, DBHDS will track on a quarterly basis the number of individuals who are assigned a waiver slot but not enrolled in a service within five months.	For this 27th Period, DBHDS tracked and reported quarterly data on the number of individuals who are assigned a waiver slot but not enrolled in a service within five months, as documented in the *Committee Semi-Annual Report State Fiscal Year 2025 3rd and 4th Quarters*, dated 9/20/25.	During the 26th Period, DBHDS reported quarterly data on the number of individuals who are assigned a waiver slot but not enrolled in a service within five months, consistent with the DBHDS 2/14/23 report to the Court that it would collect this data quarterly. Specifically, DBHDS stated that the data for this measure would be available once the 150-day post-period occurs each quarter and reported in the next semi-annual report. For this 27th Period, DBHDS continued in this manner to track and report quarterly data on the number of individuals who are assigned a waiver slot but not enrolled in a service within five months, as documented in the *Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 3rd and 4th Quarters*, dated 9/20/25.	26th: Completed **27th: Completed and Ongoing**
43 b) Within three months of the date of this Order, the Commonwealth will contact individuals at the end of each quarter who have not been enrolled in a service within five months and their families and case managers to determine why services have not been initiated and what	For this 27th Period, DBHDS continued to implement the processes in place at the time of the last study and as described in the Process Document, entitled *DS Waiver Service Enrollment Version 001*, dated 3/21/25. This data collection process begins with the	At the time of the 26th Period, DBHDS provided a Process Document, entitled *DS Waiver Service Enrollment Version 002*, dated 4/15/25, specific to Term 43b. It described a data collection process for monthly identification in WaMS of individuals who reached a five-month delay since being assigned an active accepted DD waiver slot and remained without a waiver service, including a series of steps for follow-up with individuals meeting the five-month criterion during each month to determine (a) why services have not been initiated and (b) what barriers have delayed the initiation of services, as well as the processes for quarterly reporting with regard to barriers to service enrollment, actions being taken to remediate the barriers, and results achieved. The 26th Period study reported the details of the process, which relied upon a	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
barriers delayed initiation of services. DBHDS will report on the barriers identified quarterly as well as actions being taken to remediate those barriers and results achieved.	monthly identification in WaMS of individuals who reached a five-month delay since being assigned an active accepted DD waiver slot and remained without a waiver service. It then follows a series of steps to follow-up with identified individuals during each month, using the *PI – 43.b Timely Waiver Service Enrollment* survey form to determine (a) why services have not been initiated and (b) what barriers have delayed the initiation of services. The Process Document also describes the processes for quarterly reporting with regard to barriers to service	a newly developed survey form, entitled *PI – 43.b Timely Waiver Service Enrollment*, to document the reasons for the delay and provide the data for analysis of barriers. This resulted in the production of the *Quarterly Timely Waiver Service Enrollment Report*, a summary of the reasons for identified why services were not initiated, barriers to those delays in services, solution actions and remediation is needed. The initial *Timely Waiver Service Enrollment Survey* identified several key barriers (e.g., Medicaid enrollment issues, Support Coordinator or CSB-related issues, or a lack of education of the available waiver services to the individual/family from the Support Coordinator or CSB). For this 27th Period, DBHDS continued to rely on these processes. DBHDS staff reported modifying the survey form between FY25 Q3 and FY25 Q4 to include additional answers for a question that probed the reason that the waiver slot has not been initiated. These newly added options included: 1) recently submitted service authorization (SA) or currently utilizing services and 2) CM/CSB issue/delay or lack of education from CSB to individual/family. The survey also included questions to inquire if individual and families were interested in participating in a virtual focus group to improve the waiver slot initiation process and, if so, to provide an appropriate email address. During this period, DBHDS also produced a second *Quarterly Timely Waiver Service Enrollment Report* for the fourth quarter of 2025, based on surveys of 764 people awaiting the initiation of services that were conducted during April, May and June 2025. Based on interview, this was the only quarterly report produced thus far during the 27th Period, with the next version expected to be finalized by 10/30/25.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	enrollment, actions being taken to remediate the barriers, and results achieved. During this period, DBHDS produced a second *Quarterly Timely Waiver Service Enrollment Report* for the fourth quarter of 2025, based on surveys of 764 people awaiting the initiation of services that were conducted during April, May and June 2025. Based on interview, DBHDS plans to finalize the next version by 10/30/25. The current report rightly noted that FY25 Q4 data for initiation of timely waiver services was trending upward since the	The current report rightly noted that FY25 Q4 data was trending upward since the implementation of the call survey. It also noted that Medicaid/insurance enrollment, one of the most significant preliminary barriers identified in the first report, had responded well to the attention it received, decreasing from 45% in the first survey to only 9% in the more recent one. The document further described findings and steps taken and/or in process to address them. These included the following: • The survey identified individual slots that the Community Service Board (CSB) or Support Coordinator (SC) thought had been released due to the individual no longer desiring or needing services, but had not been, resulting in the slot still being assigned to an individual no longer desiring or needing services. The *FY25 Q4 Quarterly Timely Waiver Service Enrollment Report* indicated staff were able to be remedy these quickly once identified. • Before beginning the calling process, DBHDS staff began first reviewing individuals' records in WaMS before calling to identify any individuals listed that already submitted a Service Authorization Request (SAR) to DBHDS, but were awaiting a SAR determination to begin services. Of note, the report indicated that there were several individuals who "carried over" from month to month who were working to initiate services and that this could happen due to a SAR being pended because the provider or Support Coordinator needed to address specific concerns identified by the Service Authorization Consultant. Based on interview, however, DBHDS staff indicated that, on average, the SAR determination takes only an approximate seven to ten days, and this issue was not a significant concern.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	implementation of the call survey. In addition, the report found that Medicaid/insurance enrollment, one of the most significant preliminary barriers identified in the first report, had responded well to the attention it received, decreasing from 45% in the first survey to only 9% in the more recent one The report identified and discussed other outcomes, including two statewide barriers: 1) support coordinator/CSB issues and/or a delay or lack of education from the CSB at 26% and 2) a delay in service selection/no provider	• DBHDS staff added an additional response option for the survey specific to lack of education being provided to the family from the CSB or lack of education/training to the SC from CSB, to help drill down to a more precise identification of the barriers faced. • The report indicated 332 (43%) of those awaiting service initiation were in the Region 2 (i.e., Northern Virginia) area. This was not unexpected due the region being the most densely populated and having the largest numbers of individuals on the Waiver Waitlist and assigned a DD Waivers. • Overall, DBHDS identified two statewide barriers. First, 26% of the respondents reported that there are support coordinator/CSB issues and/or a delay or lack of education from the CSB to individual/family. Secondly, 10% reported a delay in service selection/no provider chosen by the individual/family. To address these current findings, the *FY25 Q4 Quarterly Timely Waiver Service Enrollment Report* indicated that DBHDS would be initiating a Quality Improvement Initiative (QII). Pending focus group results, DBHDS's QII would focus on providing additional training and technical assistance to ensure that support coordinators are competent and confident regarding the services within the waivers. DBHDS staff provided a copy of the QII Workbook, which indicated the QII was initiated in July 2025 through the Key Performance Area (KPA) Workgroups. The document indicated that DBHDS would convene focus groups, one with individuals and families and another with support coordinators, and projected these will occur in October 2025. Based on the focus group outcomes, the QII next steps will be to develop and/or update	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	chosen by the individual/family at 10%. To address these current findings, in July 2025, the DBHDS Key Performance Area (KPA) Workgroups initiated a Quality Improvement Initiative (QII), projected to run through June 2026. It will employ focus groups, one with individuals and families and another with support coordinators, to inform an educational and training campaign to be implemented in partnership with the Arc of Virginia. The KPA Workgroups will track and monitor timely waiver service	relevant educational resources for support coordinators and individuals/families, in partnership with the Arc of Virginia. The QII projects the materials will be ready for testing in January 2026, with a roll-out of the educational campaign in February 2026. In order to measure the impact of the educational campaign, the QII will monitor timely waiver service initiation data from March 2026 through June 2026.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	initiation to determine efficacy.		
43c) Within one year of the date of this Order, the Commonwealth will conduct a root cause analysis of why services have not been initiated and what barriers delayed initiation of services. Based on the findings of the root cause analysis, the Commonwealth will prioritize the findings for quality improvement in consultation with the provider and system issues resolution workgroups. The Commonwealth will implement a QII based on its prioritization consistent with continuous quality improvement principles	This action is not required until 1/15/26 (one year from the approval of the permanent injunction. A final implementation plan was not completed.	This action is not required until 1/15/26 (one year from the approval of the permanent injunction. A final implementation plan was not completed.	**Not Yet Implemented Due Date 1/15/26**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
and developed in collaboration with the provider and system issues resolution workgroups. The Independent Reviewer, in the reports required under paragraph 76, shall discuss the reasonableness of Virginia's response to this requirement. Individuals for whom initiation of services is delayed past five months at the request of the individual or the individual's authorized representative will not be included in determining if the Commonwealth meets the goal. The Commonwealth will revisit the root cause analysis annually and implement a QII as determined appropriate			

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
by DBHDS. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.			
44. Ongoing Service Analyses The Commonwealth, through DBHDS, will collect and analyze data at least annually regarding the management needs of individuals with identified complex behavioral, health, and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS will develop corrective actions based on its analysis as it determines appropriate, track the	For this 27th Period, DBHDS did not yet meet the requirements of Term 44 because it did not include annual data and analysis regarding the management needs of individuals with identified complex behavioral and adaptive support needs or yet provide for an adequate system for corrective action tracking and appropriate revision across the whole population.	At the time of the 26th Period, DBHDS did not yet meet the requirements of Term 44 to collect and analyze data at least annually regarding the management needs of individuals with identified complex behavioral and adaptive support needs, for the purposes of monitoring the adequacy of management and supports provided, including the development of corrective actions based on its analysis. DBHDS had continued to implement a semi-annual monitoring process, the *Intensive Management Needs Review* (IMNR). The IMNR largely mirrored the Independent Reviewer's Individual Services Review (ISR) process, and was completed in parallel with that latter study. However, the IMNR alone did not fulfill the requirements of Term 44 because 1) it did not include a sufficient review for individuals with complex adaptive support needs or individuals with complex behavioral support needs; 2) it did not provide a clear methodology for using the data collected to complete an annual analysis for the purpose of monitoring the adequacy of management and supports provided, including the development of corrective actions based on that analysis; and 3) it did not yet include reporting on the tracking of efficacy of the systemic corrective actions described above, or any needed revisions.	26th: Not Achieved **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
efficacy of the actions, and revise as it determines necessary to address the deficiency.	The IMNR process examined the management needs of individuals with identified complex health support needs during the 25th and 26th periods. Beginning with this 27th Period, it collected and analyzed data and developed corrective actions regarding the management needs of 30 individuals with complex behavioral needs. DBHDS plans to conduct a second IMNR study of an additional 30 individual with these needs during the upcoming 28th review period DBHDS plans to begin its IMNR process on the management	For this 27th Period, DBHDS again continued to implement the IMNR process, as described with regard to Action 44 b) below. For the first time, DBHDS focused its semi-annual IMNR process on examining the management needs of individuals with identified complex behavioral support needs. In addition to the Independent Reviewer's 27th ISR study also focusing on the same sample of 30 individuals with complex behavioral needs, it also examined the adequacy of DBHDS's remediation efforts for the corrective actions developed during the 26th period for individuals with complex health needs. DBHDS has not yet implemented its IMNR process to examine the needs of individuals with adaptive support needs. However, as reported with regard to Action 44 b) below, DBHDS staff reported that beginning with the 29th Period, they intended to focus its IMNR process on individuals with complex adaptive support needs for two consecutive review periods. During the 25th and 26th periods the ISR studies, which each reviewed the services for a sample of 30 individuals with complex health needs, largely mirrored DBHDS's IMNR studies. The ISR study verified that DBHDS's IMNR process was conducted as described in Term 44 b) and that the IMNR studies effectively collected and analyzed data regarding the management needs of the individuals in the selected samples, and also developed appropriate corrective action plans. The ISR studies during the 26th and 27th periods reviewed the sufficiency of DBHDS's remediation process for the corrective actions that the IMNR studies had developed during the 25th and 26th period reviews. The ISR studies determined that the remediation process was not yet sufficient. Although the IMNR nurses promptly and effectively reported and, where possible,	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	beginning with the 29th Period. The current IMNR Process Document entitled, *Intense Management Needs Review Process – PI44, Version* 001, dated 2/3/25, also did not provide a clear methodology for the specific requirements for completing an annual analysis of the management needs of the target population as a whole. In addition, the *PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period*, dated April 2025, did not yet include reporting on the tracking of efficacy of the systemic corrective actions or of	implemented needed corrective actions, the remediation process as a whole was not sufficient at ensuring that the corrective actions were revised as necessary or addressed the deficiency. Despite repeated phone calls by the IMNR nurses, the support coordinators and/or residential staff did not implement the corrective actions in a timely manner or at all. At the time of the 26th period review, DBHDS provided a preliminary draft of a document entitled *PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period*, dated April 2025. The draft document did not yet include reporting on the tracking of efficacy of the systemic corrective actions described above, or any needed revisions. It also did not yet include a full analysis of systemic findings and corrective actions based on the 26th Period review. For this 27th Period, DBHDS provided a final version of the 26th Period report for review, but it did not appear to have been updated to provide the missing components identified at that time. Therefore, as of the 27th Period, DBHDS did not yet provide evidence of a sufficient remediation process, i.e., tracking the efficacy of the actions, and making revisions revise as it determines necessary to address identified deficiencies. Based on interview with DBHDS staff, the 27th Period *IMNR* report was not yet available. As noted above, the Independent Reviewer's 27th Period Individual Servicer Review (ISR) study verified that DBHDS's IMNR process effectively collected individual data and developed appropriate corrective actions, which the IMNR nurses documented in the individual IMNR monitoring questionnaires. The ISR study also found that, despite the IMNR nurses making repeated phone calls, some support coordinators and residential staff did not implement the needed corrective actions. For these individuals, the identified concern was not addressed in a timely manner or not at all.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	any needed revisions. It also did not yet include a full analysis of systemic findings and corrective actions based on the 26th Period review. For this 27th Period, DBHDS provided a final version of the 26th Period report for review, but it had not been updated to provide the needed components. For this 27th Period, DBHDS also produced the *Ongoing Service Analysis Report: Individuals with Complex Health, Behavioral and Adaptive Support Needs FY 2024 (2024 Ongoing Service Analysis Report*). It incorporated data from the IMNR process for individuals with complex medical needs,	For this 27th Period, DBHDS produced the *Ongoing Service Analysis Report: Individuals with Complex Health, Behavioral and Adaptive Support Needs FY 2024 (2024 Ongoing Service Analysis Report*). As required for Action 44a), it included data from the IMNR process for individuals with complex medical needs, data from the care concerns process, data from the BSPARI quality reviews, and data from the Quality Service Reviews, with a separate report section for each of those sources. The *2024 Ongoing Service Analysis Report* did not yet include specific data regarding individuals with adaptive support needs. As reported with regard to Action Step 44b) below, DBHDS expects to incorporate a process to collect data specific to individuals with complex adaptive support needs in the IMNR beginning with the 29th Period. DBHDS did not meet the requirements of this Term. With regard to the requirements of this Term to develop corrective actions determined appropriate based on analysis, to track the efficacy of the actions, and revise them as necessary to address the deficiency, the DBHDS document *2024 Ongoing Service Analysis Report* provided pertinent examples for several of the monitoring processes from which it derives data. These examples demonstrate both strengths and gaps in the written methodology for the cycle of remediation: • The strongest of these include the BSPARI, which includes clinical review of behavior support plans to identify any deficiencies followed by technical assistance and resubmission of corrected plans, and Care Concerns, which provides for remediation on both an individual and systemic basis through technical assistance and training. More importantly, Care Concerns are also subject to serious incident processes that includes the corrective action plan cycle of remediation	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	data from the care concerns process, data from the BSPARI quality reviews, and data from the Quality Service Reviews, but it also did not yet include specific data regarding individuals with adaptive support needs. The *2024 Ongoing Service Analysis Report* provided pertinent examples for several of the processes from which it derives data regarding the requirements to develop corrective actions determined appropriate based on analysis, to track the efficacy of the actions, and revise them as necessary to address the deficiency. These examples demonstrated both strengths and gaps	when needed. As described with regard to Term 53 below, and based on review of an OL memorandum to providers entitled *Incident Management Unit Look Behind process and responsibilities related to timely appropriate corrective action plans implemented by the provider when indicated*, dated 10/6/23, DBHDS also provides for the IMU Look-Behind process, wherein Virginia Commonwealth University (VCU) auditors random sample 100 serious incidents each quarter. The review evaluates outcomes, including the provider's documented response to ensure the recipient's safety and well-being; timely, appropriate corrective action plans are implemented by the provider when indicated; and for any serious incident in the sample for which the Individual Care Concern threshold was met, an analysis of corrective action plans (i.e., action(s) taken by a provider as a result of an occurrence of a serious incident). • As noted above, for the IMNR process, the ISR study confirmed that the IMNR nurses tracked the efficacy of the corrective action plans. However, despite repeated phone calls, some support coordinators and residential staff did not implement the needed corrective actions. Therefore, when reviewed as a whole, DBHDS's IMNR remediation system was not sufficient to address the identified concern/deficiency. • While the *2024 Ongoing Service Analysis Report* indicated the QSR process is able to assess unmet needs on an individual service recipient and the provider level, as well as generate aggregate data regarding the types of unmet needs, it did not have a meaningful remediation process in place at that time. The QSR issues corrective actions for identified deficiencies through a Quality Enhancement Plan (QEP) and provides suggestions for available technical assistance, but this process does not yet consistently provide for a timely mechanism for tracking the efficacy	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	in the overall methodology for the cycle of remediation. DBHDS's written processes for both the BSPARI and Care Concerns provided for specific remedial actions, including tracking efficacy. The ISR review of the IMNR remediation process for individuals with complex health support needs found that although the IMNR nurses effectively tracked the efficacy of the planned actions, despite repeated phone calls, some support coordinators and residential staff did not implement corrective actions in a timely manner or at all to	of those actions or revising them as necessary. In most instances, the QSR process, through round 6, does not include follow-up to track efficacy until the next QSR review, which could be a year or more later. The QSR process does have one exception to this rule, which is the ongoing Health, Safety and Welfare (HSW) Alerts. As described in the Process Document entitled *Health, Safety, Wellbeing Alerts Process*, last revised on 4/1/21, the purpose is to demonstrate how DBHDS and Department of Medical Assistance Services (DMAS) personnel receive, review, and follow up on health, safety, well-being issues are received, reviewed, and followed up on by DBHDS. Upon review of the *Round 6 Alerts Tracker*, documentation indicated that DBHDS staff followed up on each alert. In addition to making referrals for licensing and/or OIH investigations when needed, DBHDS staff provided technical assistance and training opportunities to the providers where appropriate. While the documentation frequently noted provider acknowledgement, it did not show that DBHDS staff always followed up to ensure an individual's issue was resolved. For example, one alert indicated that provider staff were unable to describe medical support needs or described incorrect or incomplete support needs and were not familiar with medical protocols to support the individual or were not able to identify the steps or how to respond appropriately per the protocol. The *Round 6 Alerts Tracker* documented providing training information to the provider, who acknowledged receipt of information, attended the training and acknowledged understanding. However, the *Round 6 Alerts Tracker* did not document that provider staff were thereafter determined to have the needed competencies to safely serve the individual. Therefore, while the HSW Alerts process has potential to track efficacy of remedial actions, it does not yet consistently do so.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	address the identified concern. Overall, the QSR process did not provide for timely tracking of the efficacy of prescribed remediation. The Skilled Nursing process had not yet produced results to enable an evaluation.	• Finally, the Skilled Nursing reviews just began in April 2025 and results are not yet available. In addition to the gaps in the system described above, the *2024 Ongoing Service Analysis Report* did not yet clearly "consolidate" the data from those various sources to provide a comprehensive summary of the management and support provided to individuals with complex needs. It was promising, though, that the document indicated that the OIHSN was developing a process to follow-up on QSR-identified needs that would be similar to that used for Care Concerns, and this could demonstrate a meaningful consolidation of licensing data with QSR data to identify and address needs across disparate data sources. The ISR study also found that the OIHSN was actively involving the behavior analysts who conduct the BSPARI process to provide information and insights into the corrective actions being developed for individuals with complex behavioral needs.	
44a) DBHDS will use data from the Skilled Nursing Review detailed in Paragraph 39(c), the IMNR process for individuals with complex medical needs, data from the care concerns process, data from the BSPARI quality reviews, and data from the Quality	For this 27th Period, DBHDS produced the *Ongoing Service Analysis Report: Individuals with Complex Health, Behavioral and Adaptive Support Needs FY 2024 (2024 Ongoing Service Analysis Report).* As required for Action 44a), it included data from the IMNR	At the time of the 26th Period, DBHDS had not yet formulated or implemented a process for developing a report consolidating the information and data from the Skilled Nursing Review, the IMNR, the care concerns process, the BSPARI quality reviews, and the QSRs to monitor the adequacy of management and supports provided to individuals with complex needs. However, an internal team was in the process of crafting a methodology for combining data and information from the IMNR reviews, QSR reviews, and BSPARI reviews, in hopes of having the first report to address the requirements of this Action by the 27th Period. For this 27th Period, DBHDS produced the *Ongoing Service Analysis Report: Individuals with Complex Health, Behavioral and Adaptive Support Needs FY 2024 (2024*	26th: In Progress **27th:** **In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
Service Reviews to monitor the adequacy of management and supports provided. Within six months of the date of this Order, DBHDS will develop a report consolidating the information from these sources to provide a comprehensive summary of the management and support provided to individuals with complex needs. This summary will be completed annually.	process for individuals with complex medical needs, data from the care concerns process, data from the BSPARI quality reviews, and data from the Quality Service Reviews, with a separate report section for each of those sources. The *2024 Ongoing Service Analysis Report* did not yet include specific data regarding individuals with adaptive support needs. As reported with regard to Action Step 44b) below, DBHDS expects to incorporate process to collect data specific to individuals with complex adaptive support needs in the IMNR beginning with the 29th Period.	*Ongoing Service Analysis Report).* As required for Action 44a), it included data from the IMNR process for individuals with complex medical needs, data from the care concerns process, data from the BSPARI quality reviews, and data from the Quality Service Reviews, with a separate report section for each of those sources. The *2024 Ongoing Service Analysis Report* did not yet include specific data regarding individuals with adaptive support needs. As reported with regard to Action Step 44b) below, DBHDS expects to incorporate process to collect data specific to individuals with complex adaptive support needs in the IMNR beginning with the 29th Period. In addition, the *2024 Ongoing Service Analysis Report* did not yet clearly "consolidate," by bringing together and merging, the data from those various sources to provide a comprehensive summary of the management and support provided to individuals with complex needs. Definitions of "consolidate" typically reference combining various elements to create a single, more effective whole. The summary section did not cross-reference, provide comparisons of, or merge data from the various sources in a manner that might serve to illuminate either gaps in services or opportunities for cross-learning. The report concluded with a summary that indicated intra-and inter-agency collaborations had emerged for these populations and that DBHDS was using the various data to assess needs and drive decisions; however, this did not document with any specificity how the data had been consolidated thus far to provide a comprehensive picture of the management and support needs for individuals with complex needs.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	In addition, the *2024 Ongoing Service Analysis Report* did not yet clearly "consolidate" the data from those various sources to provide a comprehensive summary of the management and support provided to individuals with complex needs. Definitions of "consolidate" typically reference combining various elements to create a single, mor effective whole. The summary section did not cross-reference or provide comparisons of data from the various sources that might serve to illuminate either gaps in services or opportunities for	It was promising, though, that the document indicated that, in the coming months, the OIHSN would be completing a deeper review on QSR results related to needs not being met, and was developing a process to follow-up on QSR-identified needs that would be similar to that used for Care Concerns. This latter effort, in particular, could demonstrate a meaningful consolidation of licensing data with QSR data to identify and address needs across disparate data sources. The ISR study also found that the OIHSN were actively involving DBHDS's behavior analysts who conduct the BSPARIs to provide information and insights to assist the IMNR nurses in developing corrective action plans for individuals with complex behavioral needs. Going forward, DBHDS staff should further examine how data from one source might shed some light on others. For example, do individuals with complex adaptive support needs, such as in the area of communication, have relatively more behavioral support needs? Does the receipt of skilled nursing services correlate with reduced incidence of care concerns? Does the same provider that does not effectively implement IMNR corrective action plans also fall short implementing actions to address Care Concerns? While these might seem relatively obvious, other, more surprising, outcomes might be revealed upon examination of the data across the various populations of individuals with complex needs. This, in turn, should provide for a more comprehensive summary and, more importantly, a more comprehensive, coordinated and ultimately effective set of support management strategies.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	cross-learning. The report concluded with a summary that indicated intra-and inter-agency collaborations had emerged for these populations and that DBHDS was using the various data to assess needs and drive decisions; however, this did not document with any specificity how the data had been consolidated thus far to provide a comprehensive picture of the management and support needs for individuals with complex needs.		
44b) DBHDS will continue to implement the IMNR process for no less than 70 people annually who have complex medical,	DBHDS did not yet complete the requirements for this Action.	At the time of the 26th Period, DBHDS submitted a draft document entitled *PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period (IMNR 26th Review Period)*, dated April 2025. It documented that DBHDS continued to implement the IMNR process for a cohort of 29 individuals with complex medical needs. (Of note, at that time, DBHDS and the Independent Reviewer agreed to move forward with 29 instead of 30 individuals due to unavoidable	26th: In Progress **27th: In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
behavioral, or adaptive support needs (Tier 4) to include onsite visits, reviews of specific health care documentation, and a factual questionnaire administered by qualified nursing professionals to primary caregivers most familiar with the person's health care needs.	While DBHDS staff continued to implement the IMNR process for the 27th Period for a sample of 30 people, they had not yet completed it for at least 70 people annually. As noted above, for the 26th Period, the DBHDS sample size was 29. However, if DBHDS completes a review for at least 40 individuals during the 28th Period, they would be able to meet this requirement of Term 44 at that time. The IMNR process continued to include onsite visits, reviews of specific health care documentation, and an adequate factual questionnaire	circumstances.) However, the sample did not include individuals with complex behavioral or adaptive support needs, nor did the Process Document submitted at that time (i.e., *Intense Management Needs Review Process – PI44, Version 001*, dated 2/3/25) provide a clear methodology for sample selection. It also did not provide a clear methodology for the specific requirements of Term 44 and Action 44a (i.e., the annual analysis of the management needs of the target population as a whole, including individuals with complex behavioral and adaptive support needs). DBHDS did not submit a Data Set Attestation for this process during the 26th Period. For this 27th Period, DBHDS staff reported they continued to implement the IMNR process with a cohort was comprised of 30 individuals, including primarily individuals with complex behavioral needs and some individuals with complex medical needs. DBHDS's OIHSN, with input from the IMNR nurses, DBHDS's behavior analysts who conduct the BSPARIs, and the ISR Team Leader, developed a new Section 7 of the IMNR monitoring questionnaire to provide supplemental questions for this latter population, such as whether the individual engaged in any behaviors and what kind; whether the ISP authorized behavioral services and, if so, if they are being provided; and, the provisions of any behavior plan, including target behaviors, data collection and review by a qualified clinician. The process continued to include onsite visits, reviews of specific health care documentation, and an adequate factual questionnaire administered by qualified nursing professionals to primary caregivers most familiar with the person's health care needs. However, DBHDS had not yet completed the IMNR for at least 70 people with either complex behaviors or adaptive needs annually. As noted above, for the 26th Period, DBHDS sample size was 29, and 30 for this 27th Period. If	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	administered by qualified nursing professionals to primary caregivers most familiar with the person's health care needs DBHDS staff indicated the previously-provided Process Document (i.e., *Intense Management Needs Review Process – PI44, Version 001*, dated 2/3/25) remained current, but that DBHDS staff planned to update it upon completion of the 27th Study IMNR report. They indicated it would include methodology updates related to the inclusion of individuals with complex behavioral needs. Of note, the 26th Period	DBHDS completes a review for at least 40 individuals during the 28th Period, they would be able to meet this requirement of Term 44. Also for the 27th Period, DBHDS staff indicated the previously-provided version of the Process Document dated 2/3/25, remained current, but that DBHDS staff planned to update it upon completion of the 27th Study *IMNR* report. They indicated it would include methodology updates related to the inclusion of individuals with complex behavioral needs. This will be reviewed during the 28th Period, including an examination of the sampling methodology. At the time of the 26th Period, DBHDS also provided a preliminary draft of a document entitled *PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period*, dated April 2025. The draft document did not yet include reporting on the tracking of efficacy of the systemic corrective actions described above, or any needed revisions. It also did not yet include a full analysis of systemic findings and corrective actions based on the 26th Period review. For this 27th Period, DBHDS provided a final version of the 26th Period report for review, but it did not appear to have been updated to provide the missing components identified at that time. Based on interview with DBHDS staff, the 27th Period IMNR report was not yet available. The 27th period ISR study confirmed that the IMNR revised monitoring questionnaire was sufficient for collecting and analyzing data for the selected sample of 30 individuals with complex behavioral needs, and that the IMNR nurses developed appropriate corrective action plans. The 28th period's ISR study will review the sufficiency of DBHDS's remediation system for the extent to which corrective action plans are implemented to address the identified concerns.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	study found the document did not provide a clear methodology for sample selection, and DBHDS should also address that with the revision. DBHDS has not yet provided a Data Set Attestation for this process.		
45. DD Service Providers' Compliance with Administrative Code. The Commonwealth will work to achieve a goal that at least 86% of DBHDS-licensed providers of DD services comply with 12 VAC 35-105-620 in effect on the date of this Order or as may be	Comparison of scores for each sub-regulation of §620 for CY24 with those of CY25 through 08/08/2025 reflects improvement in nine sub-regulation scores and lower scores for two sub-regulations (§620.C.2 and C3). However, in the CY25 data, only one sub-regulation (§620.A) achieved the 86%	The Commonwealth has continued to expand and improve efforts to achieve a goal that at least 86% of DBHDS-licensed providers of DD services comply with each of the sub-regulations under 12VAC35-105-620.A-E. The table below compares §620 sub-regulation scores across CY2023, CY2024 and CY2025 (through 06/30/2025). The CY25 data for the period 01/01/2025-06/30/2025 provided by the Office of Licensing for §620 represents completion of 895 of 1453 scheduled licensing inspections (75%). This percentage is sufficient to generalize the statistical findings and compare them to the CY2023 and CY2024 data.	26th: Deferred **27th: Not Achieved**

<table>
<tr><th colspan="4">Table 2</th></tr>
<tr><th>Term and Actions</th><th>Facts</th><th>Analysis/ Conclusion</th><th>27th</th></tr>
<tr><td>amended. To achieve that goal, the Commonwealth will take the following actions:</td><td>threshold but five other sub-regulation scores were above 80%.</td><td>
<table>
<tr><th>Regulation</th><th>CY23</th><th>CY24</th><th>CY25 To Date</th></tr>
<tr><td>620A</td><td>93.11%</td><td>87.13%</td><td>91.00%</td></tr>
<tr><td>620B</td><td>89.28%</td><td>80.86%</td><td>84.00%</td></tr>
<tr><td>620C1</td><td>84.77%</td><td>79.61%</td><td>83.00%</td></tr>
<tr><td>620C2</td><td>81.69%</td><td>69.96%</td><td>65.00%</td></tr>
<tr><td>620C3</td><td>Not Measured</td><td>97.52%</td><td>66.00%</td></tr>
<tr><td>620C4</td><td>74.50%</td><td>69.96%</td><td>77.00%</td></tr>
<tr><td>620C5</td><td>79.85%</td><td>72.02%</td><td>75.00%</td></tr>
<tr><td>620D1</td><td>83.38%</td><td>75.68%</td><td>82.00%</td></tr>
<tr><td>620D2</td><td>87.76%</td><td>80.41%</td><td>85.00%</td></tr>
<tr><td>620D3</td><td>76.50%</td><td>67.38%</td><td>76.00%</td></tr>
<tr><td>620E</td><td>87.72%</td><td>83.51%</td><td>84.00%</td></tr>
<tr><td colspan="4">Red reflects decreased score since CY24
Green reflects increased score since CY24</td></tr>
</table>

After noting decreased scores in each sub-regulation when comparing CY23 and CY24, a CY24 and CY25 comparison reflects improvement in nine sub-regulation scores and lower scores for two sub-regulations (§620.C.2 and C3). In the CY25 data, only one sub-regulation (§620.A) achieved the 86% threshold but five other sub-regulation scores were above 80%.

To support continued progress toward meeting the 86% threshold for each of the provider Quality Improvement Program requirements with particular focus on scores at §620.C.2 and C.3, DBHDS continues to collaborate with</td><td></td></tr>
</table>

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
		providers through training and technical assistance to increase understanding of and correct implementation of each requirement. The Commonwealth's efforts to improve compliance with regulatory requirements are described in the Analysis/Conclusions section for Actions 42.a, 42.b, and 42.c. Among these, the most notable initiative is the heightened emphasis on regulatory standards through the Expanded Consultation and Technical Assistance (ECTA) process. As referenced under Action 42.b above and Action 45.a below, the ECTA process became effective on July 15, 2025. OL's recent revisions have broadened mandatory ECTA participation for providers, ensuring greater engagement in quality improvement activities. Its expansion of provider training associated with these regulatory changes further demonstrates the Commonwealth's commitment to achieving improved compliance. Through these initiatives, the Commonwealth continues to pursue the goal that at least 86% of DBHDS-licensed providers of developmental disability (DD) services meet all requirements set forth in 12 VAC 35-105-620.A-E. Based on evaluation of the data for each sub-regulation of §620 for CY2025 through 08/08/2025, the requirements of Term 45 have not yet been achieved.	
45.a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with *12*	DBHDS has not made any changes to its licensing regulations at §620 that are relevant to Action 45.	Previous studies have confirmed that DBHDS licensing regulations at *12VAC35-105-170* require providers to develop, submit, and implement a written Corrective Action Plan (CAP) for each violation cited by the Office of Licensing (OL). These requirements apply to all cited violations, including, but not limited to those outlined in *12VAC35-105-620.C.4* and *D.3.*	26th: Completed **27th: Completed**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
VAC 35-105-620.C.4 and *D.3* (regarding corrective action plans) develop and implement a corrective action plan that includes the receipt of technical assistance, additional training, and specific actions related to the respective areas of underperformance as determined appropriate by DBHDS.	The OL, in its protocol for annual inspections, requires providers to meet each of the requirements described at *12VAC 35-105-620.C.4 and D.3*. If the provider is cited for a violation, the protocol also requires the provider to develop and implement a corrective action plan. The Expanded Consultation and Technical Assistance (ECTA) process, established by the Office of Community Quality Improvement, and updated in 07/2025, offers providers technical assistance, additional training, and other specific actions as	The Expanded Consultation and Technical Assistance (ECTA) process, as described in the 26th study report, remains an integral part of OL's provider support and oversight. DBHDS has further enhanced this process through the implementation of the *Combined OL & OCQI Mandatory ECTA Protocol*, which became effective on 07/15/2025. Details regarding the program's implementation are described in the Analysis/Conclusion section for Action 42 b) above. The actions described above demonstrate that the requirements of Action 45 a) have been completed. The Office of Licensing and the ECTA team continue to evaluate the effectiveness of these procedures, making additions or revisions as necessary to ensure ongoing compliance and improvement.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	recommended or required by the OL.		
45.b) Within six months from the date of this Order, for providers who are not compliant with 12 VAC 35-105-620.C.4 and D.3 (regarding corrective action plans) for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's	DBHDS has licensing regulations and implementation protocols in place that meet the requirements of Action 45.b and continues to consistently follow those protocols.	As described under Action 45 a) above and consistent with the findings described in the 26th study report, DBHDS has licensing regulations and implementation protocols in place that meet the requirements of Action 45.b. Additionally, the requirements of Action 45 b) are addressed through the ECTA process which is described in detail in the Analysis/Conclusion section for Action 42.b above. DBHDS most recently revised these protocols which became effective on 07/15/2025. They are documented in detail in the *Combined OL & OCQI Mandatory ECTA Protocol.* DBHDS continues to review and refine the protocols to enhance support for providers to consistently meet the regulatory requirements and to ensure progressive enforcement action for repeat violations including, but not limited to, requirements at *§620.A-E.* The above-described actions support the continued determination that the requirements of Action 45 b) have been completed.	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
license as determined appropriate by DBHDS.			
45.c) Within 24 months of the date of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess the adequacy of provider quality improvement programs have established inter-rater reliability in conducting such assessments.	The Office of Licensing has developed and begun implementation of an inter-rater reliability process that formally evaluates consistency and accuracy with which licensing specialists evaluate whether providers are meeting the regulatory requirements that are applicable to Term 45. As the process is fully implemented, the results will provide continuing objective measurement of uniformity in assessments conducted by licensing specialists, thereby improving the accuracy and consistency of	As described in the 26th study report, the Office of Licensing (OL) has continued and expanded several practices to address the requirements of this action, including: • DD Inspection Training for licensing specialists. • Regional Managers conducting unannounced parallel inspections with licensing specialists. • Tenured licensing specialists shadowing and mentoring newly hired licensing specialists. • Quality Improvement Specialist Look-Behinds. In addition to these processes, the OL has developed and begun implementation of a formal, measurable framework for continuously assessing inter-rater reliability. Each quarter, every licensing specialist, regional manager, and investigator will independently evaluate a single provider record randomly selected by OL's Associate Director of Quality & Compliance (ADQC). The licensing specialists will each provide a rating specific to the regulatory requirements at §§450, 520.A-D, and 620.A-D. OL's Quality Improvement Specialist (QIRS) then compares the results to the "gold standard" assessment results established by the QIRS and the ADQC. Within 30 days of completing the evaluations, the QIRS and ADQC review the comparative results. For any regulation where agreement is below 86%, the QIRS and ADQC will provide additional training specific to that regulation during a scheduled all-staff meeting or through small group training to address the areas of disagreement. The QIRS and ADQC will aggregate and analyze	26th: In progress **27th:** **In progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	regulatory compliance evaluations across providers. The process is currently in its initial implementation phase, but when fully implemented it will provide objective and comparable data to guide the ongoing determination of inter-rater reliability among the Commonwealth's licensing specialists as required in Action 45.c.	data from these reviews on an ongoing basis to identify any relevant trends or patterns that may require additional follow-up action. The first review began on 07/23/2025, with the anticipated completion of the analysis of results and follow-up action by 09/30/2025. While the process is currently in its initial implementation phase, if followed as described, it will provide objective and comparable data to guide the ongoing determination of inter-rater reliability among the Commonwealth's licensing specialists as required in Action 45.c. It will also serve as an objective, data-based tool for the ongoing review and analysis of licensing specialist determinations. The above-described actions support the determination that the requirements of Action 45.c continue to be in progress.	
46. Quality Service Monitoring. The Commonwealth will work to ensure that, using information collected from licensing reviews and Quality Service Reviews, it identifies providers that	For this 27th Period, DBHDS did not meet the requirements for Term 46 because the data provided could not yet be deemed reliable. Of note, however, as a result of preparatory work	For the 26th Period, the study deferred a finding regarding whether the Commonwealth met the requirements for Term 46 because Round 7 QSR was not completed during the 26th Period. Therefore, no new data were available during this period to evaluate its reliability. However, at the time of the 25th Period, when data were last available, and based on review of the QSR methodology and a comparative sample of 36 providers, the QSR process did not yet consistently yield an accurate picture of technical assistance needs. The study found ongoing significant discrepancies with the findings of	26th: Deferred **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
have been unable to demonstrate adequate quality improvement programs and offers technical assistance as necessary.	completed during the 26th Period, the Round 7 data available during the 27th Period can be considered valid (i.e., that it measures what it purports to measure.) This preparatory work included a collaborative effort between DBHDS and the Independent Reviewer's consultant to produce a Provider Quality Review (PQR) tool that would produce valid data (i.e., that it measures what it purports to measure.) DBHDS and the QSR vendor also refined various protocols, including the *Round 7 QSR Methodology*, the *Round 7 QSR IRR Policy* and the *Round 7 QSR Training Plan.*	the IR consultant, calling into question the validity and reliability of the QSR data. During the 26th Period, in order to address the validity and reliability of QSR findings regarding the adequacy of provider quality improvement programs, the consultant and DBHDS staff engaged in a collaborative review of the PQR tool, which is used for QSR measurement of quality improvement. This was completed in advance of the Round 7 QSR, which took place during this 27th Period. The collaboration yielded a PQR tool that contained 22 items with sufficient guidance to address 620B, (i.e., use of quality improvement tools), 620C1(i.e., annual review and update of the QI Plan), 620C2 (i.e., definition of goals and objectives), 620C3 (i.e., inclusion and reporting of statewide performance measures), 620C5 (i.e., monitoring and evaluation of progress toward meeting goals and objectives), 620D1 (i.e., provider policy and procedures for establishing goals and objectives and 620D2 (i.e., provider policy and procedures for updating the quality improvement plan). As a result of this preparatory work, the Round 7 data, which became available during the 27th Period, can be considered valid (i.e., that it measures what it purports to measure.) Data reliability related to quality improvement, however, is dependent on the accuracy and consistency with which the QSR reviewers collect the data. As reported at the time of the 26th Period review, to support the achievement of reliable data collection, the QSR vendor had refined various protocols for Round 7. These included the following, with updated information where applicable for this 27th Period: • Final Round 7 QSR Methodology: This document indicated the scope of the PQR Tool included, among other things, the review of provider	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Prior to the initiation of Round 7, DBHDS also completed scoring concordance for the PCR and PQR tools to test inter-rater reliability between the QSR "gold" reviewers and DBHDS SMEs. The QSR vendor made changes to both the CSB and provider documentation submission checklists to ensure the correct document was requested from the provider/CSB. However, based on results of a comparative sampling process completed by the consultant during the 27th Period, the QSR data continues to be unreliable. The study found that for the 36	quality improvement and risk management plans, processes, and strategies and the effectiveness of each, and the assessment of the provider's quality improvement plan's goals/objectives and review of evidence supporting the active implementation of the provider's/CSBs quality improvement programs. It indicated the PQR Tool is structured to probe the effectiveness of quality improvement strategies; whether the provider/CSB has a quality improvement plan that meets DBHDS regulations, if the quality improvement plan includes measurable goals/objectives that utilize performance data; and whether the provider/CSB is collecting, measuring, calculating, tracking, and reviewing performance data in key areas, using tracking tool(s), specifically trend analyses, to assess progress towards quality improvement goals that utilize performance data to measure progress, and promoting individual participation in meaningful work as defined by DBHDS, participation in non-large group activities, and participation in activities with people with whom they do not live. • Round 7 QSR IRR Policy: This document indicated that Feedback from DBHDS SMEs about the most appropriate scores is incorporated into the reviewer training curriculum. It states that, prior to the beginning of each round of the QSR, the QSR vendor will work with the DBHDS Office of Clinical and Quality Management (OCQM) to review the PQR and PCR tools to ensure terms and expectations contained within align with those of DBHDS or DBHDS affiliated entities that use QSR data. Prior to each round, DBHDS will also provide the QSR vendor with updated process documents for each DBHDS or DBHDS-affiliated entity that uses QSR data. Further, prior to the development of reviewer training, the QSR vendor will establish scoring concordance for the PCR and PQR tools between its	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	providers in the sample, the overall agreement with QSR findings related to quality improvement was only 65%. It was positive, though, that this had improved since the previous sampling during the 25th Period. For example, the consultant agreed fully with six sets of provider findings and for another four sets, agreement was above 80%. This indicated that 28% (10/36) exceeded the QSR vendor's minimum threshold for its internal inter-rater reliability (IRR). Otherwise, for this 27th Period, DBHDS continued to offer a	"gold" reviewers and DBHDS SMEs using a sample set of documents for each assessment. During this 27th Period, prior to the initiation of Round 7, DBHDS completed this inter-rater reliability effort. Based on a document DBHDS submitted, entitled *QSR Round 7 DBHDS and HSAG Scoring Concordance*, dated 4/18/25, discordant scores related primarily to SMART goals and the number of SMART goals needed to meet requirements. Discussion also focused on a need to more clearly identify the most reliable document from which to obtain evidence needed for scoring criteria and possible variances in provider documentation. The QSR vendor made changes to both the CSB and provider documentation submission checklists to ensure the correct document was requested from the provider/CSB. • Round 7 QSR Training Plan: This document indicated related quality improvement reviewer training items would include the active quality improvement plan and current risk management plan; related policies and procedures and performance data measurement, calculation, review, and tracking and trending. Of note, the QSR vendor also updated the reviewer training curriculum for Round 7 to reflect lessons learned during the scoring concordance tools between its "gold" reviewers and DBHDS SMEs. Also with regard to data reliability, at the time of the 26th Period, DBHDS provided an updated Process Document entitled *QSR Quality Improvement Findings,* dated 8/18/24. Similarly to the findings of previous studies, it did not yet address the significant IRR discrepancies between QSR reviewer findings and those of experts in the field, such that DBHDS could not demonstrate that they could adequately identify the quality improvement technical assistance needs of providers. However, during the 26th Period, DBHDS provided two	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	very successful Expanded Consultation and Technical Assistance (ECTA) to providers who have licensing deficiencies for *12VAC35-105-520, 12VAC35-105-620 12VAC35-105-450*, and for providers who receive a QSR QIP for provider collection and tracking of performance data (e.g., serious incident and other risk information, etc.)	new relevant documents intended to address this concern, as described in the following bullets: • The stated purpose of the first document, entitled *DBHDS Quality Service Reviews: Inter-rater Reliability Assurance Plan*, finalized 3/18/25, was the establishment of processes for validating QSR results against other business area data collected. The document indicated that, for all data where QSR dataset data is used to assert the quality of the service system, DBHDS staff will identify a secondary data source to which to compare and validate QSR dataset for each QSR round. Further, the document indicated that the data process documents should include "the data source used for validating QSR results, processes for validation, associated QSR dataset calculations, associated QSR vendor calculations as evidenced by any ad hoc QSR reports requested of the QSR vendor by the business area, and what happens if and when incongruence between the QSR dataset and the data source data used for validation is identified . • DBHDS also provided a revised Process Document entitled *QSR Quality Improvement Findings Version 003,* dated 3/28/25. This document indicated the changes to this version were limited to adding a QSR Inter-Rater Reliability to Section VII – Continuous Quality Improvement (CQI). Similarly to the process described in the *DBHDS Quality Service Reviews: Inter-rater Reliability Assurance Plan (Inter-rater Reliability Assurance Plan),* the Instructions in the beginning of this Process Document state that the CQI section should provide a detailed step-by-step process describing what will be done to monitor and improve process as time progresses. However, while it stated an intention that "QSR data is validated against licensing reviews data to ensure there is consistency in reporting between the QSR dataset and	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
		the validation source datasets," it was not yet sufficient to serve as a meaningful validation process. It did not provide a level of detail that met the expectations of DBHDS's *Inter-rater Reliability Assurance Plan* or the Process Document Instructions. At a minimum, the 26th Period study recommended that the specific methodology and expectations for establishment of scoring concordance for the PQR abstraction tools between DBHDS Subject Matter Experts (SME) and QSR gold reviewers be incorporated into the CQI processes because it is the vendor gold reviewers who set the standard for establishing the QSR vendor's internal inter-rater reliability for each reviewer for each round, with an 80 percent or higher concordance required. This could potentially address the long-standing discrepancies between QSR reviewer findings and those of experts in the field. For this 27th Period, DBHDS did not yet submit a revision to the Process Document, pending the completion of planned analysis of QSR scoring concordance data as compared with relevant OL data. It will be available for the 28th Period study. For the 27th Period study, the consultant completed another reliability evaluation for a comparative sample of 36 (i.e., 12% of 310 PQRs completed during Round 7) providers that had a PQR during Round 7. The sampling process applied the defined QSR quality improvement items, including the reviewer guidelines and the scoring criteria, for the 15 items as indicated in the table below, that could result in issuance of a Quality Enhancement Plan if determined to be Not Met. The available Round 7 reporting included the reviewer scoring for these 15 items, which allowed for an analysis of scoring agreement between the consultant and the QSR reviewers.	

Table 2			
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Quality Improvement	Element(s)
Needs a plan	10. Does the provider have a quality improvement plan?
Reviewed/Signed	11. Was the provider's quality improvement plan developed or reviewed in the past year?
Has goals and objectives that are not SMART	12. Does the provider's quality improvement plan include goals and objectives?
	13. Do all goals and objectives in the provider's quality improvement plan meet SMART criteria?
Performance Data used	14. Does the provider track and review performance data?
	15. Does the most current provider quality improvement plan reflect the use of performance data?
	17. How does the provider track data?
	18. Identify the frequency of data reviewed: serious incidents
	19. Identify the frequency of data reviewed: abuse/neglect
	20. Identify the frequency of data reviewed: seclusion and restraint
	21. Identify the frequency of data reviewed: community integration
	22. What processes are evidenced in the provider documentation that indicate how performance

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<tr><td></td><td></td><td>
<table>
<tr><td></td><td>data was used in the development of goals/objectives?</td></tr>
<tr><td></td><td>27. Has the provider developed improvement strategies for goals not met?</td></tr>
<tr><td>Implement QSR QEP</td><td>30. Has the provider implemented their QEP (QSR QIP)?</td></tr>
<tr><td></td><td>31. Have they made progress?</td></tr>
</table>

The documentation requested for review included the following documents for the QSR look-back period of September 6, 2024 through January 2025:
• The Annual Quality Improvement Plan required by 12VAC35-105-620.C that was reviewed during your Round 7 QSR and the date of the previous version.
• Any related policies, procedures, tools, or protocols used to guide development of and to operationalize the Quality Improvement Plan that were reviewed during Round. At a minimum, this should include: a) policies and procedures that guided the development and implementation of the Quality Improvement Plan and b) processes, tools and/or protocols that show how performance data was used in the development and monitoring of the stated goals/objectives in the Quality Improvement Plan, as well as how performance data was used in review of serious incidents, abuse/neglect, seclusion and restraint and community integration.
• Minutes of meetings related to the implementation of the Quality Improvement Plan and related processes that were reviewed during Round 7 QSR.
• Any other documents evidencing corrective actions taken to address the findings of the QSR Round 5 or Round 6 PQR QIP.</td><td></td></tr>
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Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
		The results of the sampling process again showed that the QSR data for this Term continues to be unreliable, but was improving. The findings included the following: • On a positive note, the consultant agreed fully with six sets of PQR findings and for another four sets, agreement was above 80%. Still, this indicated that only 28% (10/36) of the PQRs would have met or exceeded the QSR vendor's own minimum threshold for its internal IRR, while 72% of the PQRs would not have. • The study found that for the 36 providers, the overall agreement was 65%. Further breakdown potentially suggested that QSR reviewers were better able to detect deficiencies when they determined that providers did not track and review data: o For the 12 providers that QSR reviewers found did not track and review data, the IRR between the consultant and the QSR reviewers was 80% overall, with a range of agreement between 36% and 100%. This included four IRR scores of 100%. o For the 26 providers that QSR reviewers found did track and review data, the IRR between the consultant and the QSR reviewers was 57% overall, with a range of agreement between 18% and 100%. Of these 26, for 10 providers who had more than three required QEPs (i.e., Not Met findings), the overall agreement was 66%, with a range from 44% to 88%. For the remaining 14 providers, which tracked data and had three or fewer required QEPs, the overall IRR agreement was 48%, with a range between 18% to 100%.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
		The sampling process also yielded a number of lessons learned to consider for potentially strengthening the accuracy of the scoring going forward. Some of the most significant included the following: • QSR reviewers did not consistently identify whether a quality improvement plan met the QI regulations at *12VAC35-105-620* (i.e., element 10.) The consultant found 15 more QI plans than QSR reviewers that did not meet the regulations, most often because they did not meet C.3: include and report on statewide performance measures, if applicable, as required by DBHDS; and/or did not meet D.1: establish measurable goals and objectives. DBHDS should consider additional training in these areas. • QSR reviewers did not consistently identify whether the provider tracked and reviewed data (i.e., element 14). The consultant found 11 more providers than QSR reviewers that failed to identify that element 14 was not met. The reviewer notes guidance indicated that the provider's documentation in totality should show evidence of the specific data that is being collected/tracked *and* (emphasis added) what mechanisms are in place to review goals tied to the data. It appeared that in some instances, QSR reviewers conflated the two processes (i.e. collecting/tracking and reviewing), scoring element 14 as Met when data collection and tracking was present, even when evidence of review was not and/or no goal existed related to the data. • Of note, the preceding issue also impacted scoring for elements 18 through 21, which QSR reviewers sometimes appeared to score as Met based on data tracking/collecting without adequate evidence of review.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
46a) Within six months of the date of this Order, DBHDS will require that any provider not in compliance with quality improvement program regulations develop and implement a corrective action plan. DBHDS will continue to employ a total of 12 Quality Improvement Specialists. DBHDS Quality Improvement Specialists will continue to offer providers technical assistance, additional training, and specific actions related to the respective areas of underperformance.	For this 27th Period, DBHDS completed the requirements of this action. DBHDS requires that providers who receive OL citations for failing to comply with the regulatory requirements outlined in *12VAC35-105-620* must develop and implement a Corrective Action Plan (CAP) for each citation, as described in *12VAC35-105-170*.	For this 27th Period, the OL continued to conduct annual licensing inspections to cite providers who fail to comply with regulatory requirements outlined in *12VAC35-105-620*. In response to any cited non-compliance, providers must develop and implement a Corrective Action Plan (CAP) for each citation, as described in *12VAC35-105-170*. DBHDS also continues to employ a total of 12 Quality Improvement Specialists (QIS), who provide the ECTA individualized consultation and technical assistance, tailored to provider organizations' specific needs (i.e., as identified through licensing reviews or QSR findings), in the form of in-person and virtual one-to-one sessions. Per the *Expanded Consultation and Technical Assistance Standard Operating Procedures (ECTA SOP)*, revised 1/9/25, all QIS staff receive mandatory Intensive ECTA training before assignment to providers for the initiation of ECTA. QIS are paired to work together, providing ECTA for one month before conducting ECTA sessions individually and all QIS staff receive supervision. As described in detail with regard to Action 45 b) above, DBHDS has enhanced the ECTA process as documented in the *Combined OL & OCQI Mandatory ECTA Protocol*, effective 07/15/2025, through addition of more specific requirements for mandatory enrollment. If a service provider receives two consecutive citations for one or more specific regulations (Non-Compliant Systemic) under *§450, §520.A-D,* or *§620.A-D*, OL requires the provider to initiate mandatory assistance through the ECTA Team within 45 calendar days of receiving their most recent approved Corrective Action Plan. If the provider does not initiate or complete mandatory ECTA, the provider may be subject to addition enforcement by OL.	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
46b) Within six months from the date of this Order, for providers who are not compliant with quality improvement program regulations for two consecutive licensing inspections, DBHDS shall take appropriate further action to enforce adherence to the Commonwealth's regulations, which may include, but not be limited to, issuing citations, issuing systemic citations, issuing a health and safety corrective action plan, reducing a provider's license to provisional status, or revoking the provider's license as determined	For this 26th Period, and as described above for Action 46c, DBHDS completed this action. The OL conducts annual licensing inspections to cite providers who fail to comply with regulatory requirements outlined in *12VAC35-105-620*. In response to any cited non-compliance, providers must develop and implement a CAP for each citation, as described in *12VAC35-105-170*. If a provider is cited for the same violation during two consecutive inspections, they must	For this 27th Period, and as described above for Action 45 c), DBHDS has again completed this action. The OL conducts annual licensing inspections to cite providers who fail to comply with regulatory requirements outlined in *12VAC35-105-620*. In response to any cited non-compliance, providers must develop and implement a CAP for each citation, as described in *12VAC35-105-170*. If a provider is cited for the same violation during two consecutive inspections, they must begin the Expanded Consultation and Technical Assistance (ECTA) process within 45 days of receiving their latest approved CAP. Detailed ECTA requirements are outlined in the *ECTA SOP*. In addition, to provide internal guidance to the Licensing Specialist/Investigator as it relates to how DBHDS takes progressive actions, OL developed and implemented an *Internal Protocol for Progressive Actions*. Continued non-compliance or failure to complete required consultation may lead to progressive enforcement actions, as defined in OL protocols and required by Term 45.b. These actions escalate based on the severity of the violations and include measures detailed in the protocol. The established licensure inspection protocols, details of the progressive enforcement process, and examples of progressive enforcement actions taken by OL demonstrate that the Commonwealth has established and implemented protocols for issuing progressive enforcement actions to providers with repeat non-compliance, including violations of *§620.A-E* and other regulatory requirements.	26th: Completed **27th: Completed and Ongoing**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
appropriate by DBHDS.	begin the Expanded Consultation and Technical Assistance (ECTA) process within 45 days of receiving their latest approved CAP. Continued non-compliance or failure to complete required consultation may lead to progressive enforcement actions, as defined in OL protocols, These actions escalate based on the severity of the violations and include measures detailed in the protocol.		
46c) Within 24 months of the date of this Order, DBHDS will ensure that all DBHDS staff and contractors assigned to assess the	This action is not required until 1/15/27 (24 months from the approval of the permanent injunction). A full final	This action is not required until 1/15/27 (24 months from the approval of the permanent injunction. A full final implementation plan was not completed. At the time of the 26th Period, the OL had implemented valuable procedural changes to address this action; however, these changes did not yet establish a formal, measurable framework for assessing IRR.	**26th: Due Date 1/15/2027** **27th: In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
adequacy of provider quality improvement programs have established inter-rater reliability in conducting such assessments.	implementation plan was not completed. For this Period, as described with regard to Term 45, the OL continued implementation of the previously-reported procedures, but also developed the needed formal, measurable framework for continuously assessing IRR among licensing specialists. The OL began implementation of this process in July 2025 and anticipated completion of the analysis of results and follow-up action by 09/30/25 (i.e., at the conclusion of this 27th Period.) As described above in more detail with regard	For this 27th Period, as described above with regard to Term 42a), the OL continued implementation of the previously-reported procedures, but also developed the needed formal, measurable framework for continuously assessing IRR among licensing specialists. The OL began implementation of this process in July 2025 and anticipated completion of the analysis of results and follow-up action by 09/30/25 (i.e., at the conclusion of this 27th Period.) The 28th period study will examine these outcomes. To fully achieve completion of the Action Step, DBHDS will also still need to fully develop and implement a formal process for measuring inter-rater reliability between Licensing Specialists and the QSR reviewers assigned, under contract, to assess the adequacy of provider quality improvement programs. As described above in more detail with regard to Term 45 and Term 46, DBHDS is actively engaged in an effort to enhance the IRR between Licensing Specialists and another to enhance the accuracy of QSR reviewer findings regarding providers' quality improvement programs. In addition, based on interview with DBHDS staff, DBHDS has begun to conceptualize the IRR between these two groups. The DBHDS Deputy Commissioner and the OL Associate Director of Quality and Compliance completed the scoring concordance with the QSR vendor. In a next step, the Deputy Commissioner plans to pull the data and complete a comparison of their QSR IRR findings with the applicable findings of the Licensing IRR to see how closely they align. Once this evaluation is complete, DBHDS staff intend to update the IRR section of the QSR Process Documents.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	to Term 45 and Term 46, DBHDS is actively engaged in an effort to enhance the IRR between Licensing Specialists and another to enhance the accuracy of QSR reviewer findings regarding providers' quality improvement programs. In addition, based on interview with DBHDS staff, DBHDS has begun to conceptualize the process for establishing IRR between these two groups. The DBHDS Deputy Commissioner and the Associate Director of Quality and Compliance completed the scoring concordance with the QSR vendor.		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	In a next step, the Deputy Commissioner plans to pull the data and complete a comparison of their QSR IRR findings with the applicable findings of the Licensing IRR to see how closely they align. Once this evaluation is complete, DBHDS staff intend to update the IRR section of the QSR Process Documents.		
49. Residential Services Community Integration. The Commonwealth will work to achieve a goal that 95% of residential service recipients reside in a location that is integrated in, and supports full access to,	For this 27th Period, DBHDS did not meet the requirement of this Term. Overall, DBHDS could not provide an updated metric for this Term, due to needed pending actions for both initial HCBS compliance validations and for	At the time of the 26th Period, the Commonwealth did not meet the goal for Term 49 because the data reports submitted did not demonstrate that 95% of residential service recipients reside in a location that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS settings. DBHDS staff reported that only 93% of residential service recipients resided in a setting that is integrated in, and supports full access to, the greater community in compliance with the CMS rule on HCBS setting. However, as described further below, DBHDS staff had not yet shown these data were reliable and valid, either for initial compliance validations or for ongoing monitoring, nor were they complete.	26th: Not Achieved **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
the greater community in compliance with the CMS rule on HCBS settings.	ongoing monitoring of continued HCBS compliance. DBHDS staff were continuing to validate initial compliance for many of the 700 settings previously reviewed through the QSR vendor. Therefore, their compliance status remains unknown at this time and cannot be represented in a calculation for this Term. Also for initial compliance validations, DBHDS did not yet submit a Process Document that provided a methodology to obtain valid and reliable data.	For this 27th Period, as detailed with regard to Action 49a) below, DBHDS did not provide an updated metric for this Term because DBHDS staff are continuing to validate initial compliance for many of the 700 settings previously reviewed through the QSR vendor. Therefore, their compliance status remains unknown at this time and cannot be represented in the calculation for this Term. In addition, at the time of the 26th Period, DBHDS did not submit a Process Document that provided a methodology to obtain valid and reliable data for initial compliance validations. For this 27th Period, DBHDS submitted a document entitled *HCBS Setting Rule Initial Determination*. However, it was not formatted as a formal Process Document and needed to be fleshed out with the step-by-step methodology for data collection and aggregation, and as previously reported, reflect consistency with the validation processes in the approved Statewide Transition Plan (STP) and the requirements of the HCBS Settings Rule and related CMS guidance. In particular, for initial compliance validation, the DBHDS processes still needed to ensure that the Process Document ensured validation of settings compliance is setting-specific (i.e., that the finding of compliance for one provider setting cannot be used to attest to compliance for the provider's additional settings), and per the Commonwealth's *Addendum to the Commonwealth of Virginia's Statewide Transition Plan February 2019*, that for onsite reviews to validate remediation, a "minimum of 25% of individuals receiving services in a setting will be interviewed and no less than 2 individuals for smaller settings of 2 or more persons receiving services."	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	For this 27th Period, DBHDS submitted a document entitled *HCBS Setting Rule Initial Determination*. However, it was not formatted as a formal Process Document and it needed a fleshed out methodology for data collection and aggregation. In addition, as previously reported, it needed to reflect consistency with the validation processes in the approved Statewide Transition Plan (STP) and the requirements of the HCBS Settings Rule and related CMS guidance. DBHDS also still needed to finalize several pending actions to demonstrate valid	In addition to these issues with initial compliance validation, DBHDS still needed to complete several pending actions to demonstrate valid and reliable data for ongoing monitoring of HCBS compliance, as describe in the following bullets: • During the 26th Period, before DBHDS initiated Round 7 QSR reviews, the consultant and DBHDS staff collaboratively reviewed the proposed QSR tools that QSR reviewers use to report ongoing compliance with the HCBS Settings Rule In the process, DBHDS addressed many of the previous concerns related to items in both tools that reflect HCBS compliance and needed to be included in the Commonwealth's calculation. However, DBHDS acknowledged that this was still a work in process and that the tools, particularly the PCR, will need additional revisions to incorporate an adequate assessment of all the Final Rule requirements. These additional revisions were discussed during the 26th Period. While Round 7 monitoring data became available for this 27th Period, it does not yet reflect all the changes still needed to the PCR and PQR tools. • During the 26th Period, DBHDS submitted an updated Process Document entitled *HCBS Ongoing Monitoring Process Document Version 2*, dated 4/2/25. It remained current for the 27th Period. The processes for ongoing monitoring, continue to incorporate findings from the DMAS QMR Tool, the DBHDS HCBS templates and the approved QSR vendor tools and an ongoing ten percent IRR look-behind of QSR HCBS findings by the DBHDS HCBS Review Team staff, which includes a simultaneous review of documents as well as a shadowing of the onsite visit. The Process Document indicated the comparative results will be used to develop and implement training to correct discrepancies, which should serve to supplement the additional needed	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	and reliable data for ongoing monitoring of HCBS compliance During the 26th Period, before DBHDS initiated Round 7 QSR reviews, the consultant and DBHDS staff collaboratively reviewed the proposed QSR tools that QSR reviewers use to report ongoing compliance with the HCBS Settings Rule At the time, DBHDS acknowledged that this was still a work in process and that the tools, particularly the PCR, will need additional revisions to incorporate an adequate assessment of all the Final Rule requirements.	revisions to the QSR tools as discussed above. For this 27th Period, DBHDS reported that their HCBS staff were currently completing this look-behind review of the Round 7 QSR HCBS findings. They plan to complete the review by the end of October 2025 and will develop a summary report that will be available for review during the 28th study period. • In its response to the June 2024 CMS Site Visit, DBHDS asserted a number of steps it would take to address CMS-identified deficiencies on a systemic basis and at the time of the 26th Period, these still need to be reflected in the appropriate tools. For this 27th Period, this remained pending the completion of the QSR look-behind, to be followed by a comprehensive revision of appropriate tools and protocols. Until DBHDS completes these pending actions, DBHDS cannot yet report valid and reliable data regarding HCBS compliance and so it cannot be used to show compliance. Therefore, for this 27th Period, the specified goal of this Term is not yet achieved. Of note, DBHDS did yet not provide a Data Set Attestation for the ongoing compliance measure, pending the ongoing 10% validation process, nor a Data Set Attestation for the initial validation processes, which are yet to be formalized However, it was positive that DBHDS responded to a previously-cited need and provided a Process Document entitled *HCBS Compliant Settings*, dated 4/23/25 for the use of the data from the QSR, WaMS, CONNECT and the HCBS Master Tracking Spreadsheet maintained by DMAS. DBHDS also	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	While Round 7 monitoring data became available for this 27th Period, it does not yet reflect all the changes still needed to the PCR and PQR tools. The *HCBS Ongoing Monitoring Process Document Version 2*, included an ongoing 10% look-behind of QSR HCBS findings by the DBHDS HCBS Review Team staff, to incorporate a simultaneous review of documents as well as a shadowing of the onsite visit. The Process Document indicated the comparative results will be used to develop and implement training to	provided a Data Set Attestation for this Process Document (i.e., *DS HCBS Compliant Settings Attachment B*, dated 9/29/25).	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	correct discrepancies, which should serve to supplement the additional needed revisions to the QSR tools as discussed above. In addition, in June 2024, in response to a CMS Site Visit, DBHDS asserted a number of steps it would take to address CMS-identified deficiencies on a systemic basis. DBHDS staff still needed ensure they reflected these in the appropriate tools. For this 27th Period, DBHDS reported that their HCBS staff were currently completing the look-behind review of the Round 7 QSR		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	HCBS findings. They plan to complete the review by the end of October 2025 and will develop a summary report that will be available for review during the 28th study period. DBHDS did yet not provide a Data Set Attestation for the ongoing compliance measure, pending the ongoing 10% validation process, nor a Data Set Attestation for the initial validation processes, which are yet to be formalized However, it was positive that DBHDS responded to a previously-cited need and provided a Process Document entitled		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	HCBS Compliant Settings, dated 4/23/25 for the use of the data from the QSR, WaMS, CONNECT and the HCBS Master Tracking Spreadsheet maintained by DMAS. DBHDS also provided a Data Set Attestation for this Process Document (i.e., *DS HCBS Compliant Settings Attachment B*, dated 9/29/25)		
49a) In accordance with its CMS-approved Statewide Transition Plan, by December 31, 2025, the Commonwealth will complete its review of the remaining 3,296 locations for compliance with the CMS settings rule to determine if it is in	For this 27th Period, DBHDS has not yet completed its review of all the locations that still required initial validation of compliance with the HCBS Settings Rule, in accordance with the CMS-approved Statewide Transition Plan.	At the time of the 26th Period, DBHDS staff reported the total number of settings left to validate stood at 1,230. This included the 700 settings originally assigned to the QSR vendor that Commonwealth staff were re-reviewing and another 530 settings that remained in remediation status. For this 27th Period, as described below, DBHDS could not yet make a final and definitive report regarding the number of remaining locations reviewed for initial compliance with the CMS settings rule. • For the 530 settings that remained in remediation status during the 26th Period, 516 had achieved validation of initial compliance. • DBHDS continued to be in the process of performing the look-behinds of the 700 settings previously assigned to the QSR vendor that required	26th: In Progress **27th:** **In Progress**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
compliance with the 95% goal.	At the conclusion of the 26th Period review, the total number of settings left to validate stood at 1,230. This included the 700 settings originally assigned to the QSR vendor that Commonwealth staff were re-reviewing and another 530 settings that remained in remediation status. For this 27th Period, DBHDS reported that for the 530 settings that remained in remediation status during the 26th Period, 516 had achieved validation of initial compliance. discrepancy. Also for this 27th Period, DBHDS	re-review. A DBHDS summary of the status of this latter group of settings indicated that it includes settings assigned to the QSR vendor for compliance validation during QSR Rounds 1, 2 and 5. DBHDS has completed the look back of Round 1, but is currently following up on the 11% of individuals for which additional data is needed to demonstrate compliance. For Round 2 settings, DBHDS staff have followed up on half of the individuals. Final documentation of remediation for Round 1 is due by the end of October 2025, while Round 2 data will be finalized between now and December 2025. • DBHDS plans to initiate the look back of Round 5 data by the end of October 2025. Of note, Round 2 and Round 5 will cover the largest number of settings, estimated at 536. During the next review in the 28th Period, DBHDS will provide an update on the status of all of the look back reviews. At the time of the 26th Period, DBHDS had not yet provided a Process Document that addressed the process for the initial compliance validations required by this Action 49a). As described above with regard to Term 49, for this 27th Period, DBHDS submitted a document entitled *HCBS Setting Rule Initial Determination*. However, it was not formatted as a formal Process Document and it still required a sufficiently fleshed-out methodology for data collection and aggregation. In addition, as previously reported, the Process Document needed to reflect consistency with the validation processes in the approved Statewide Transition Plan (STP) and the requirements of the HCBS Settings Rule and related CMS guidance. DBHDS will also need to obtain a Data Set Attestation for this Term.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	further reported continuing to perform the look-behinds of the 700 settings previously assigned to the QSR vendor that required re-review. This number includes settings assigned to the QSR vendor for compliance validation during QSR Rounds 1, 2 and 5, with Round 2 and Round 5 covering the largest number of settings, estimated at 536. Final documentation for Round 1 is due by the end of October 2025, while Round 2 data will be finalized between now and December 2025. DBHDS plans to initiate the look back of Round 5 data by the end of October 2025.		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	For the next review in the 28th Period, DBHDS will provide an update on the status of all of the look back reviews As described above with regard to Term 49, submitted a document entitled *HCBS Setting Rule Initial Determination*. However, it was not formatted as a formal Process Document and it needed a sufficiently fleshed-out methodology for data collection and aggregation. In addition, as previously reported, the Process Document needed to reflect consistency with the validation processes in the approved		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Statewide Transition Plan (STP) and the requirements of the HCBS Settings Rule and related CMS guidance.		
52. Look-Behind Analysis of Abuse, Neglect, and Exploitation Allegations. The Commonwealth will continue its Community Look-Behind (CLB) review process to achieve a goal of collecting sufficient data for the Risk Management Review Committee (RMRC) to conduct or oversee a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and	The Commonwealth has continued its Community Look-Behind (CLB) process conducted by the Office of Human Rights (OHR) to review abuse, neglect, and/or exploitation investigation reports involving individuals receiving DD services in licensed community provider settings. Each quarter, the OHR submits a summary and analysis of the results of its quarterly review to DBHDS's Risk	Previous study reports have documented that the Commonwealth has continued its Community Look-Behind (CLB) process conducted by the Office of Human Rights (OHR) to review abuse, neglect, and/or exploitation investigation reports involving individuals receiving DD services in licensed community provider settings. The CLB review assesses the achievement of each of the three outcomes outlined in Term 52. DBHDS has designed the CLB sample review process to ensure a statistically valid assessment of investigations of allegations of abuse, neglect, and exploitation. Each year, OHR randomly selects a total of 300 cases for review, examining 75 cases per quarter. This sample size has been determined to be statistically significant for the purposes of trend analysis and oversight. OHR staff conduct these quarterly sample reviews to evaluate the achievement of specified outcomes under the direction of the OHR Regional Managers. After each quarter's reviews are complete, OHR compiles the findings in accordance with the OHR Community Look-Behind Timeline. OHR submits a summary and analysis of the results of each quarterly review to the Risk Management Review Committee (RMRC) within three months following the conclusion of each quarter.	26th: Not Achieved **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
exploitation. The review will evaluate whether: (i) investigations of individual incidents occur within state-prescribed timelines; (ii) the person conducting the investigation has been trained to conduct investigations; and (iii) corrective action plans are implemented by the provider when indicated. The RMRC will review trends at least quarterly, recommend QIIs when necessary, and track implementation of initiatives approved for implementation.	Management Review Committee (RMRC) within three months following the conclusion of each quarter. Based on the RMRC review of that data and information presented in the OHR quarterly reports, the Committee has reviewed trends and initiated analysis and follow-up actions to address areas of concern and track progress toward implementation of those follow-up actions. Concerns regarding the sufficiency of the data presented to the RMRC, specifically the adequacy of the inter-rater reliability (IRR) assessment of the	To gauge the effectiveness of the process and the attainment of required outcomes, the RMRC applies a minimum threshold of 86%, calculated from reviewer responses on the CLB Review Form. This benchmark is used to determine whether the desired level of compliance has been met for each outcome area. The RMRC has continued its quarterly review of data and information from OHR throughout SFY 2025, documenting results and follow-up actions in meeting minutes. A description of DBHDS's progress toward consistently meeting the 86% threshold, along with specific results, is described in the Analysis/Conclusion for Term 53 below. The RMRC has analyzed trends over the year and in response to ongoing difficulties in consistently achieving the 86% threshold for each of the three specified outcomes, the RMRC initiated a root cause analysis. OHR presented the results of this analysis to the RMRC in their 03/31/2025 meeting. From this presentation, the RMRC recommended initiation of a Quality Improvement Initiative (QII) with a primary objective to address and improve outcome scores that fall below the 86% benchmark. In the 26th study report, the Consultant raised concerns regarding the sufficiency of the data the OHR presents to the RMRC noting issues with the inter-rater reliability (IRR) assessment in the CLB process. The primary concern noted by the Consultant was that the IRR reviews are conducted by OHR Regional Managers who are also integrally involved in implementing the look-behind process.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	results of the sample reviews, have not yet been successfully addressed and remain a barrier to the Commonwealth's adequate achievement of the requirements of Term 52. DBHDS is making further modifications in the procedure to have the IRR reviews conducted by someone outside the operational area responsible for the OHR look-behind process. The details of that process modification have not yet been finalized and will be reviewed in greater detail in the 28th study.	After further discussion between the Consultant, the OHR Director, and the RMRC Chair during the course of the 27th study, DBHDS is making further modifications in the procedure to have the IRR reviews conducted by someone outside the operational area responsible for the OHR look-behind process. The details of that process modification have not yet been finalized and will be reviewed in greater detail in the 28th study. In summary, DBHDS has made progress in its efforts to meet the requirements of Term 52 to collect sufficient data for the RMRC to conduct/oversee the Community Look-Behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. However, to meet the sufficiency requirement of Term 52, DBHDS should continue its efforts to restructure CLB IRR process so that the reviews are conducted quarterly and by a person or persons who are not directly involved in the OHR Look-Behind Review operation. Based on the concerns regarding the sufficiency of data being presented to the RMRC for its analysis and determination of corrective actions, the Commonwealth has not yet achieved the requirements of Term 52 regarding the goal of collecting sufficient data for the RMRC to conduct or oversee a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation.	

<table>
<tr><th colspan="4">Table 2</th></tr>
<tr><th>Term and Actions</th><th>Facts</th><th>Analysis/ Conclusion</th><th>27th</th></tr>
<tr><td>53. Samples of Data from Look-Behind Analyses of Serious Incidents and Allegations of Abuse, Neglect, and Exploitation.

The Commonwealth will work to achieve a goal of showing 86% of the sample of serious incidents reviewed by the RMRC meet criteria reviewed in the audit and that at least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed by the RMRC meet criteria reviewed in the audit. The Commonwealth will continue the look behind process and provide feedback to the RMRC related to its</td><td>Virginia Commonwealth University continues to conduct quarterly look-behind reviews of statistically valid random samples of DBHDS serious incident reviews, with results reported to the RMRC for analysis. The results from these look-behind reviews consistently meet/exceed the 86% threshold required by Term 53.

The Office of Human Rights continues to conduct look-behind reviews of a statistically valid random sample of reported allegations of abuse, neglect, and exploitation. The OHR measures achievement of each of three</td><td>To provide objective measurement of achievement of the goal to show that 86% of the sample of serious incidents reviewed by the RMRC meet criteria reviewed in the audit as is required by Term 53, the Virginia Commonwealth University (VCU) continues to conduct quarterly retrospective reviews of a statistically valid random sample of DBHDS serious incident cases and report findings from these retrospective reviews to the Risk Management Review Committee (RMRC).

VCU's results from each quarter of CY 2025 presented to the RMRC are summarized in the table below. VCU is scheduled to present the results from Q1-CY25 at the September 2025 RMRC meeting.

<table>
<tr><th>Qtr.</th><th>Months</th><th>RMRC Review</th><th>O1</th><th>O2</th><th>O3</th><th>O4</th><th>IRR Score</th></tr>
<tr><td>Q1-24</td><td>01/24-03/24</td><td>9/16/24</td><td>100%</td><td>100%</td><td>96%</td><td>88%</td><td></td></tr>
<tr><td>Q2-24</td><td>04/24-06/24</td><td>12/16/24</td><td>100%</td><td>99%</td><td>98%</td><td>100%</td><td>88%</td></tr>
<tr><td>Q3-24</td><td>07/24-09/24</td><td>3/31/25</td><td>100%</td><td>98%</td><td>98%</td><td>100%</td><td>97%</td></tr>
<tr><td>Q4-24</td><td>10/24-12/24</td><td>7/1/25</td><td>100%</td><td>100%</td><td>99%</td><td>100%</td><td>97%</td></tr>
</table>

Throughout each quarter of CY2024, the Commonwealth has consistently surpassed the required 86% threshold for all four of the criteria reviewed in the audit as specified in Term 53. Additionally, as noted in the table above, inter-</td><td>26th: Not Achieved

27th: Not Achieved</td></tr>
</table>

<table>
<tr><th colspan="4">Table 2</th></tr>
<tr><th>Term and Actions</th><th>Facts</th><th>Analysis/ Conclusion</th><th>27th</th></tr>
<tr><td>findings. If this goal is not met by December 31, 2024, DBHDS will conduct a root cause analysis and implement a QII. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.</td><td>required outcomes of this process that are set out in Term 52 using an 86% threshold based on responses to the CLB Review Form.

The Commonwealth has not satisfied the Term 53 requirement to reach and sustain achievement of an 86% threshold for each of the three targeted outcomes in the CLB process described in Term 52. There have been inconsistent results for Outcome 1, progress has been noted for Outcome 2, and the results for Outcome 3 continue to fall well below the 86% threshold averaging 63% across the three most recent quarters of SFY2025.</td><td>rater reliability scores reported in each quarterly report compiled by VCU have demonstrated consistently positive results.

In accordance with Term 52, DBHDS continues its Community Look-Behind (CLB) process conducted by the Office of Human Rights (OHR) to review abuse, neglect, and/or exploitation investigation reports involving individuals receiving DD services in licensed community provider settings. The results of the CLB process are to provide sufficient data for the RMRC to conduct or oversee a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation.

Related to the requirements from Term 52, Term 53 requires that at least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed by the RMRC meet criteria reviewed in the audit. The table below describes analysis of the results from these sample reviews over the past four quarters, with scores under 86% indicated in red:

<table>
<tr><th colspan="6">Term 52 SFY25 Results by Quarter</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Avg</th></tr>
<tr><td>Report Date:</td><td>12/16/24</td><td>3/31/25</td><td>7/1/25</td><td>8/26/25</td><td></td></tr>
<tr><td>RMRC Review:</td><td>12/16/24</td><td>3/31/25</td><td>7/1/25</td><td>8/26/25</td><td></td></tr>
<tr><td>Sample Size:</td><td>75</td><td>75</td><td>75</td><td>75</td><td></td></tr>
<tr><td>Outcome 1:</td><td>89%</td><td>83%</td><td>86%</td><td>81%</td><td>85%</td></tr>
</table>
</td><td></td></tr>
</table>

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**

Outcome 2:	63%	65%	93%	87%	77%
Outcome 3:	~~100%~~ 93% *	~~100%~~ 61%*	63%	62%	70% **

*Correction from 26th study report based on modified calculation methodology approved by RMRC.
** With the modification of calculation methodology in Q2, the average score here is inflated. A more accurate average would be across Quarters 2, 3 & 4 and would be 62%.

Summarizing the results of the SFY2025 quarterly reviews:

- **Outcome 1:** The 86% threshold target, DBHDS did not meet the target threshold. Quarter-by-quarter results varied but remained at or above 80% throughout the four quarters.
- **Outcome 2:** Scores exceeded 86% in Q3 and Q4 after process improvements. DBHDS will be providing additional training to ensure that the scores consistently remain at or above the 86% threshold.
- **Outcome 3:** For Outcome 3, OHR modified the methodology for computing the scores after Quarter 1 so the Q1 score is not comparable with the scores of the subsequent three quarters. The scores for the most recent three quarters remain well below the 86% threshold, averaging 62% over this 9-month period.

In response to ongoing difficulties to consistently achieve and sustain achievement of the 86% threshold for each of the three specified outcomes, the RMRC initiated a root cause analysis. OHR presented the results of this analysis to the RMRC in their 03/31/2025 meeting. From this presentation,

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
		the RMRC recommended initiation of a Quality Improvement Initiative (QII) with a primary objective to address and improve scores for each of the outcomes that fall below the 86% benchmark. According to the QII work group minutes documented between April and July 2025, the work group has conducted process analysis and formulated recommendations for improvement, primarily focused on Outcome 2, which requires that investigations be conducted by a "trained investigator." The work group recommended concentrating efforts on clarifying and enhancing the processes related to this requirement. Beyond the work focused on improvements to achieve and sustain achievement of the 86% threshold for Outcome 2, the QII meeting minutes do not include objectively defined and measurable actions targeting process improvements to achieve and sustain the 86% threshold for Outcomes 1 and 3. Consistent with the requirement in Term 53 to continue this quality improvement process (including additional RCA and QII efforts) until the 86% threshold for each of the three outcomes is achieved and sustained for one year, DBHDS is continuing this QII work group's activities. Moving forward, the work group may require additional root cause analyses that will help to inform the identification of specific and measurable outcomes, milestones, and process descriptions to structure the efforts to achieve and sustain compliance with the 86% threshold for all three outcomes. The Commonwealth has not satisfied the Term 53 requirement to reach and sustain achievement of an 86% threshold for each of the three targeted outcomes in the CLB process. As the threshold has not yet been achieved, the RMRC must ensure that OHR continues its quality improvement processes	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
		(including additional RCA and QII efforts) until the 86% threshold is achieved for each of the three outcomes and sustained for one year.	
54. Annual Physical Exams. The Commonwealth will work to achieve a goal that 86% of individuals supported in residential settings receive annual physical exams.	For this 27th Period, DBHDS achieved the specified goal for annual physical exams for the second consecutive fiscal year (FY) and achieved sustained compliance with Term 54. A current PowerPoint presentation entitled *Annual Physicals Permanent Injunction 27th Study of the Independent Reviewer,* dated 9/30/25, indicated the performance rate for FY25 at 89.1%, with each quarter exceeding 86%. Notably, in FY25 Q3, DBHDS reported the highest performance percentage for annual	At the time of the 26th Period, DBHDS achieved the specified goal of this Term. At that time, DBHDS provided a PowerPoint presentation entitled *Annual Physicals Permanent Injunction, 26th Study of the Independent Reviewer,* dated 4/1/25, that indicated FY24 performance of 86.56%, which exceeded the 86% goal for this Term. This revised data resulted from a DBHDS project to trend annual physical data back to FY21, utilizing the 14-month calculation method reflected in the current attested Process Document. The analysis also revealed that previous data collection procedures did not include a reconciliation of data at the end of each quarter or at the end of the fiscal year. Once the data analysis included the final reconciliation, the percentage of completed annual physicals exceeded 86%. For this 27th Period, DBHDS again achieved the requirements of this Term. A current PowerPoint presentation entitled *Annual Physicals Permanent Injunction 27th Study of the Independent Reviewer,* dated 9/30/25, indicated the performance rate for FY25 at 89.1%, with each quarter exceeding 86%. Notably, in FY25 Q3, DBHDS reported the highest performance percentage for annual physical exams since FY21, at 91%. With regard to data validity and reliability, at the time 26th Period, DBHDS provided an updated Process Document, entitled *Annual Physical Exams Ver 006* and dated 3/13/25, that included needed revisions to ensure the Scope and Methodology sections reflected the 14-month look-behind period. This was accompanied by a Data Set Attestation for this Term, dated 3/31/25, and was adequate for data validity.	26th: Compliance **27th: Sustained Compliance**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	physical exams since FY21, at 91%. This exceeded the 86% goal for this Term. With regard to data validity and reliability, at the time 26th Period, DBHDS provided an updated Process Document, entitled *Annual Physical Exams Ver 006*, dated 3/13/25, and a Data Set Attestation, dated 3/31/25, which were adequate for data validity. This remained current for the 27th Period. Of note, the previous study recommended the Definitions section of the Process Document should also clearly state that an "annual" physical exam	However, similar to the recommendation for Term 40 above, the 26th Period study recommended that the Definitions section of the Process Document state clearly that an "annual" physical exam is one that occurs within that 14-month period. DBHDS had not updated the Process Document for this 27th Period. Although it remains adequate for data validity overall, DBHDS should update the Process Document to provide the 14-month clarification in the Definition. Of note, the 27th period ISR study also found that 29 of the 30 (97%) individuals studied received an annual physical. This further supports the validity of the compliance finding. Documentation provided also indicated that DBHDS continues to implement initiatives to improve health awareness and participation in annual physicals. For this 27th Period, this included continuation of the following previously reported initiatives: • Promote the "Annual Healthcare Visit Toolkit" found on the DBHDS website under Educational Resources. • Provide and present as needed the slide deck "Importance of Annual Physicals aka. Wellness Visits & Routine Check – ups." • Provide and present as needed the Health and Safety Alert titled "Annual Healthcare Visits." • Post and promote the "Recognizing Declining Health" training to the Commonwealth of Virginia Learning Center (COVLc) that furthers the community's understanding of the importance of having regular healthy visits to the primary care provider (PCP) so everyone has a clear understanding of what the individual's baseline regarding health and wellness.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	is one that occurs within that 14-month period. Although it remains adequate for data validity overall, DBHDS should still update the Process Document to provide the 14-month clarification in the Definition.	Also at the time of the 26th Period, the OIHSN reported collaborating with the office of Provider Network Supports to enhance the questions in ISP 4.0 to allow for a deeper dive into the preventative screening aspects of annual healthcare and identify opportunities for additional growth around prevention. For this 27th Period, DBHDS reported that while the implementation date of 7/1/25 was for the ISP 4.0, which included the work to build the Risk Assessment Tool (RAT) into the ISP, the update to add questions in the ISP around Preventive Screening is expected to occur on or around 7/1/26. DBHDS staff reported that the request for the text update and any changes to the ISP is due to Provider Development the end of October 2025, so that the specifications can be built and approved for the update. DBHDS provided a document entitled *Draft PH Screening Questions.10.10.2025*, which included recommendations to add probes for eight types of preventative screenings for the FY27 ISP updates. DBHDS reported additional activities during the 27th Period, which included the following: • Beginning development of an online request process for stakeholders to access the OIHSN Registered Nurse Care Consultants (RNCC) to obtain assistance accessing annual physical exams and other preventive healthcare. • In September 2025, supporting the DBHDS Medical Director for DD to present at "The Importance of Advocacy" with a focus on medical appointments and engaging medical personnel at the Provider Innovation Conference.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
54a) Within six months of the date of this Order, any time there is not an increasing trend in the percentage of individuals receiving an annual physical exam in consecutive annual reporting periods, DBHDS will conduct a root cause analysis and determine whether a QII is warranted to address identified issues. DBHDS will continue this quality improvement process until the goal is achieved and sustained for one year.	This action will no longer be required. As reported above, for this 27th Period, DBHDS achieved and sustained the specified goal for annual physical exams for the second consecutive fiscal year and achieved sustained compliance with Term 54.	This action will no longer be required. As reported above, for this 27th Period, DBHDS achieved and sustained the specified goal for annual physical exams for the second consecutive fiscal year and achieved sustained compliance with Term 54.	26th: Due Date 7/15/2026 **27th: No Longer Required due to Sustained Compliance**
55. Assessment of Licensed Providers of DD Services. The Commonwealth will work to achieve a goal that at least 86% of	The Office of Licensing (OL) has an established process to conduct annual licensing inspections in accordance with	Previous studies have confirmed that the Office of Licensing (OL) has an established process to conduct annual licensing inspections in accordance with Virginia Code §37.2-411 to assess provider compliance with risk management requirements in the Licensing Regulations (12VAC35-105.520). The process utilizes the Office of Licensing Annual Compliance Determination Chart as a guide for licensing specialists to consistently assess provider compliance. For	26th: Deferred **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. DBHDS will continue to conduct annual licensing inspections in accordance with Virginia Code § 37.2-411 in effect on the date of this Order or as may be amended and assess provider compliance with risk management requirements in the Licensing Regulations utilizing the Office of Licensing Annual Compliance Determination Chart.	Virginia Code §37.2-411 to assess provider compliance with risk management requirements in the Licensing Regulations (12VAC35-105.520). Of the 1453 annual licensing inspections scheduled for completion during CY2025, through 06/30/2025, the OL conducted 881 inspections (61%), a percentage that is sufficient to generalize and compare data with previous calendar years. Of the 881 inspections conducted, 875 (99%) included assessment of each of the requirements under §520.	the 2025 inspection cycle, the OL has continued refinement of the *Annual Compliance Determination Chart* with specification of instructions for each provider type. This gives licensing specialists more detailed guidance on how to assess compliance with each regulatory requirement. From the data provided by the Office of Licensing for §520, of the 1453 annual licensing inspections scheduled for completion during the CY2025 licensing inspection cycle, through 06/30/2025, the OL conducted 881 inspections (61%), a percentage that is sufficient to generalize and compare data with previous calendar years. Of the 881 inspections conducted, 875 (99%) included assessment of each of the requirements under §520 and 496 (56%) met each of the requirements under §520. Previous review period studies identified concerns about whether licensing specialists were consistently following the guidance laid out in the OL Annual Compliance Determination Chart required by Term 55. To continue assessment of this concern, the Consultant's 26th/27th studies included a sample review of 80 providers across five regions who had licensing inspections during the CY2025 inspection cycle. The Consultant reviewed documentary evidence from each sample provider that was also reviewed by the licensing specialist during the provider's most recent annual inspection and, following the guidance in the OL Annual Compliance Determination Chart, determined whether there was agreement with the compliance determination made by the licensing specialist. The summary below describes the results of this comparative sample review for the five questions that are applicable to Term 55. Across all five questions, the combined average agreement percentages improved from 82% in 24th/25th	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Of the 881 inspections conducted, 496 (56%) met each of the requirements under §520. The OL utilizes the *Annual Compliance Determination Chart* to provide licensing specialists with detailed instructions for evaluating compliance with each DBHDS regulation. OL refined this document during this year by tailoring its requirements and inspection procedures for individual provider types. The Consultant's comparative sample review of whether licensing specialists are accurately assessing provider compliance	studies to 86% in the 26th/27th studies. However, the scores for two questions, although each had a significantly improved score when compared to the results from the 24th/25th study, fell below 86% with one at 79% and the other at 65%. Individual comparisons by question are as follows: • Has the provider designated a person responsible for the risk management function who has completed department approved training, which shall include training related to risk management, understanding of individual risk screening, conducting investigations, root cause analysis, and the use of data to identify risk patterns and trends? o **24th/25th: 99%** o **26th/27th: 99% (no change)** • Has the provider implemented a written plan to identify, monitor, reduce, and minimize harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability? o **24th/25th: 95%** o **26th/27th: 99% (improved)** • Has the provider conducted a systemic risk assessment at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services and does that risk assessment address each of the following requirements: (1) The environment of care; (2) Clinical assessment or reassessment processes; (3) Staff competence and adequacy of staffing; (4) Use of high risk procedures, including seclusion and restraint; and (5) A review of serious injuries? o **24th/25th: 92%** o **26th/27th: 88% (slightly regressed)**	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	with the risk management requirements in the Licensing Regulations (§520) utilizing the OL Annual Compliance Determination Chart noted that the combined average agreement percentage across each of the five questions that were relevant to §520 improved from 82% in 24th/25th studies to 86% in the 26th/27th studies. However, the scores for two of the five questions, although each had a significantly improved score when compared to the results from the 24th/25th study, fell below 86% with one at 79% and the other at 65%.	• Did the licensing inspection include an assessment of whether providers use data at the individual and provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm (defined as risk triggers and thresholds/care concerns) in the events reported, as well as the associated findings and recommendations? This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations. o **24th/25th: 53%** o **26th/27th: 65% (significantly improved)** • Does the provider's systemic risk assessment process incorporate uniform risk triggers and thresholds (care concerns) as defined by the department? o **24th/25th: 72%** o **26th/27th: 79% (significantly improved)** Although this continued improvement is a positive development, the two scores that fell below 86% point to concerns with a determination that, as required by Term 55, licensing specialists are accurately assessing provider compliance with the risk management requirements in the Licensing Regulations (§520) utilizing the OL Annual Compliance Determination Chart. The OL and the Office of Clinical Quality Management (OCQM) should continue their initiatives described in detail in the Analysis/Conclusion section of Term 42 above to broaden providers' understanding of regulatory requirements and enhance the consistency with which licensing specialists evaluate whether providers are fulfilling these requirements utilizing the OL	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	Although this continued improvement is a positive development, the two scores that fell below 86% point to concerns with a determination that, as required by Term 55, licensing specialists are accurately assessing provider compliance with the risk management requirements in the Licensing Regulations (§520) utilizing the OL Annual Compliance Determination Chart. The Office of Licensing has developed and begun implementation of an inter-rater reliability process that formally evaluates consistency and accuracy with which	Annual Compliance Determination Chart as guidance. Maintaining and improving this consistency is essential to ensuring providers implement effective risk management practices and quality assurance measures as required by department regulations. Additionally, as described in the Analysis/Conclusion section of Action 42.a above, the OL's development and implementation of an inter-rater reliability process which has occurred since the conclusion of the 26th study is a significant and improved measure to support enhancing the consistency and accuracy with which licensing specialists evaluate whether providers are meeting these regulatory requirements. OL designed and implemented this process to promote uniformity in assessments conducted by licensing specialists, thereby improving the accuracy and consistency of regulatory compliance evaluations across providers.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	licensing specialists evaluate whether providers are meeting the regulatory requirements that are applicable to Term 55. As the process is fully implemented, the results will provide continuing objective measurement of uniformity in assessments conducted by licensing specialists, thereby improving the accuracy and consistency of regulatory compliance evaluations across providers.		
56.Data-Driven Quality Improvement Plans for HCBS Waiver Programs. The Commonwealth will continue to implement	For this 27th Period, DBHDS did not meet the specified goals for Term 56, but made considerable progress.	At the time of the 26th Period, DBHDS demonstrated improvement for the implementation of the HCBS Waiver Quality Improvement Plan, but did not yet meet the specified goals for Term 56. DBHDS did not provide evidence that the Quality Review Team (QRT) consistently discussed quality improvement strategies where appropriate.	26th: Not Achieved **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers. The DMAS-DBHDS Quality Review Team (QRT) will meet quarterly in accordance with the CMS-approved Quality Improvement Plan and will review data, determine trends, and implement quality improvement strategies where appropriate as determined by the QRT to improve performance.	DBHDS provided evidence that the QRT met twice, on 4/24/25 and 8/7/25, and reviewed measure data for FY25 Q2 and FY25 Q3, respectively. Each set of QRT meeting minutes demonstrated that the members reviewed data and discussed trends as well as efforts at remediation for each of the performance measures that fell below 86% during FY24. In most instances, the minutes consistently reflected a clear adoption and implementation of a quality improvement strategy, as detailed with regard to Term 57 below.	For this 27th Period, DBHDS provided evidence that the QRT met twice, on 4/24/25 and 8/7/25, and reviewed measure data for FY25 Q2 and FY25 Q3, respectively. Each set of QRT meeting minutes demonstrated that the members reviewed data and discussed trends as well as efforts at remediation for each of the performance measures that fell below 86% during FY24. In most instances, the minutes consistently reflected a clear adoption and implementation of a quality improvement strategy, as detailed with regard to Term 57 below. As described in more detail for Term 57 below, it was positive that DBHDS again submitted a document entitled *FY25 QRT Underperforming Measures - Remediation Tracker (Remediation Tracker).* As reported at the time of the 26th Period, for most underperforming measures, the document again provided the full FY24 data and FY25 data to date and documented if remediation efforts were in place and the rationale for each. Importantly, however, in this version of the *Remediation Tracker,* on 8/18/25, updates for each measure also reflected compliance with the requirements of this Term. The *Remediation Tracker* demonstrated that the QRT re-evaluated the measure performance and trends through a review of the pertinent FY25 Q2 and FY25 Q3 data and discussed the progress of the quality improvement and remediation strategies. However, as described in detail for Term 57 below there was one glaring omission in which the QRT continued to fail to review current data and implement quality improvement strategies where appropriate. This study has previously brought to the attention of DBHDS these deficiencies for Performance Measure G10, and this reflected negatively on the consistency with which the QRT implemented the requirements of this Term.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	In addition, DBHDS again submitted a document entitled *FY25 QRT Underperforming Measures -Remediation Tracker (Remediation Tracker).* For each of eight underperforming measures, the document again provided the FY24 data and the FY25 data to date and documented if remediation efforts were in place and the rationale for each. In this version of the *Remediation Tracker,* dated 8/18/25, updates for most measures also reflected compliance with the requirements of this Term. The *FY25 Remediation Tracker* demonstrated that the		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	QRT re-evaluated the measure performance and trends through a review of the pertinent FY25 Q2 and FY25 Q3 data and discussed the progress of the quality improvement and remediation strategies. However, as described in detail for Term 57 below there was one glaring omission in which the QRT continued to fail to review current data and implement quality improvement strategies where appropriate. This study has previously brought to the attention of DBHDS these deficiencies for Performance Measure G10, and this reflected		

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	negatively on the consistency with which the QRT implemented the requirements of this Term.		
57.Data-Driven Quality Improvement Plans for HCBS Waiver Programs. The Commonwealth will continue to collect quarterly data on the following measures: (i) health and safety and participant safeguards; (ii) assessment of level of care; (iii) development and monitoring of individual service plans, including choice of services and of providers; (iv) assurance of qualified providers; e) whether waiver enrolled individuals'	For the 27th Period, while the Commonwealth made significant progress determining the need for and implementing and updating remedial strategies, it did not yet meet the specified goals for Term 57 because the QRT did not yet ensure that they consistently followed these procedures. Based on review the data collection spreadsheet entitled *SFY 25 DD Waiver QRT Data*, DBHDS continued to collect	At the time of the 26th Period, DBHDS did not yet meet the specified goals for Term 57 because the QRT did not yet consistently document the QRT ensured implementation of written remediation plans with defined measures that will be used to monitor performance every six months, or document a revised strategy when performance did not improve in that timeframe. The QRT did not have clear written procedures describing the expectations for development, monitoring and revision of remediation/quality improvement plans and needed to develop procedures that included requirements for updating of the *Underperforming Measures Tracker* and consistent documentation of meeting proceedings. For this 27th Period, based on review of a data collection spreadsheet entitled *SFY 25 DD Waiver QRT Data,* DBHDS continued to collect data for the measures required by Term 57, including the waiver performance measures for (i) health and safety and participant safeguards (i.e. as outlined in Appendix G) ; (ii) assessment of level of care (i.e., as outlined in Appendix B); (iii) development and monitoring of individual service plans, including choice of services and of providers (i.e., as outlined in Appendix D); (iv) assurance of qualified providers, as outlined in Appendix C; e) whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR (i.e., as outlined in Appendix D); and (v) identification, response to incidents, and	26th: Not Achieved **27th: Not Achieved**

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
identified needs are met as determined by DMAS QMR; and (v) identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation. This data will be reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans will be written and remediation actions implemented, as necessary, for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a	data for the measures required by Term 57. For this 27th Period, as described with regard to Term 56, DBHDS reported that the QRT met twice, on 4/24/25 and 8/7/25, to review quarterly data, and provided written minutes for both meetings, as well as PowerPoint presentations entitled *DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration*. Review of the meeting minutes and presentations for both meetings evidenced that the QRT reviewed the measure data, and for most measures that fell below the CMS-	verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation (i.e., as outlined in Appendix G). Also for this 27th Period, DBHDS staff provided a document entitled *Draft SFY2026 Quality Review Team Charter,* which included adequate written procedures describing the expectations for development, monitoring and revision of remediation/quality improvement plans. These included the following procedures, as detailed in the Comprehensive Remediation and Quality Improvement Initiative (QII) Strategy section of the draft charter: • Measures performing below the 86% compliance threshold for an entire fiscal year will be discussed and put to a quorum vote by QRT members to determine if a new or updated remediation strategy is necessary. This vote will explicitly determine if a recommendation for a Quality Improvement Initiative (QII) is warranted. • When initiating systemic remediation or QIIs, the QRT will mandate the implementation of Root Cause Analyses (RCAs) to validate decisions regarding underperformance and identify underlying systemic issues. • Following the completion of an RCA, the QRT may refer systemic remediation or QIIs to the DBHDS Quality Improvement Committee (QIC) for approval and assignment to relevant QIC subcommittees (e.g., Risk Management Review Committee (RMRC), Case Management Steering Committee (CMSC), or Key Performance Area (KPA) Workgroups) for development and implementation or directly implement QIIs within the QRT's scope. • The QRT will receive semi-annual progress updates regarding the QIIs to monitor progress and review any available data through the termination or closure of the QII. During these semi-annual reviews,	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
measure falling below 86% compliance. Quality Improvement remediation plans will focus on systemic factors (where present) and will include the specific strategy to be employed, as well as defined measures that will be used to monitor performance. Remediation plans will be monitored at least every six months. If such remediation actions do not have the intended effect, a revised strategy will be implemented and monitored.	established 86% standard, members discussed applicable remediation plans in the form of DBHDS QIIs and other initiatives or explored next steps for developing such plans. For most performance measures, the QRT also discussed the specific outcomes of those quality improvement strategies for the purpose of monitoring performance, evaluating their efficacy or making needed revisions. The *Remediation Trackers* for FY24 and 25 also provided examples of updating strategies that demonstrated the	QRT members may provide suggestions and/or feedback to the QII Owner (or designee) to revise the QII. The semi-annual updates and any resulting discussion will be captured in QRT Meeting Minutes and documented within the *Remediation Tracker*. • If systemic remediation is determined by the QRT to be unwarranted for any measure, the QRT will explicitly document the discussion, including all determinants of this decision, within the QRT Meeting Minutes in addition to the *Remediation Tracker*. • QIIs are resolved when it is determined by the QII Owner to have been concluded, meaning that the QII has made its intended impact. In cases where a QII has resolved and the targeted measure continues to underperform, this measure shall be subject again to the same identification and initial review procedures identified above. For both quarterly QRT meetings held during this period, on 4/24/25 and 8/7/25 respectively, DBHDS provided a PowerPoint presentation entitled *DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration*. These evidenced that the QRT members reviewed data reports for most performance measures that fell below the 86% threshold. Review of the respective presentations and the meeting minutes for both QRT meetings evidenced that, for most performance measures, the QRT reviewed the measure data and, for measures that fell below the CMS-established 86% standard, members discussed applicable remediation plans in the form of DBHDS QIIs and other initiatives, explored next steps for developing such plans or explicitly determined that remediation was not appropriate at that time, providing a rationale for not undertaking remediation at that time. Upon request, DBHDS also provided the documentation of the current	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	quality cycle in practice. Upon request, DBHDS provided the pertinent QII documentation to verify its implementation. The QRT also drafted a charter document that memorialized the requirements for implementing and revision systemic remediation when needed. However, the QRT did not provide an adequate rationale for declining to implement remediation for performance measure G10 (i.e., number and percent of participants 19 and younger who had an ambulatory or	DBHDS QIIs the *FY25 Remediation Tracker* cited for seven underperforming performance measures. In the best example of this quality cycle, for performance measure G1 (i.e., number and percent of closed case of abuse/neglect/exploitation for which DBHDS verifies that the investigation conducted by the provider was done in accordance with regulations), the *FY24 Remediation Tracker* documented multiple strategies, including expanded training for providers, Office of Human Rights (OHR) staff and investigators and procedures to ensure that providers had access to trained investigators. When the measure continued to underperform for FY 24 overall and through the first quarter of FY25, the QRT updated the *FY25 Remediation Tracker* to document completing a root cause analysis and initiating a formal QII with more targeted training efforts. For example, upon isolating a problem with providers not consistently interviewing all involved individuals, they developed an entirely new training module dedicated to interviewing skills. While it was likely too soon to attribute progress to these new efforts, it was positive to see that the measure was not underperforming for FY25 Q3, and had reached 86% overall for the first three quarters of FY 25. Overall, this demonstrated the quality cycle in practice. In another positive step, the QRT had begun identifying "close-watch" performance measures that appeared to be at risk for falling below the 86% threshold and including them in the *Remediation Tracker*. This procedure was not yet captured as a part of the draft charter, but the QRT should consider doing so.	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
	preventive care visit during the year). This was particularly concerning because data showed this was an ongoing deficiency over multiple years, and this study had brought it to the attention of DBHDS and the QRT during the 26th Period. Based on the circumstances described above, the study found the QRT did not yet ensure that they consistently followed their procedures for determining the need for, implementing and updating remedial strategies.	The facts described above demonstrated very significant progress over previous review periods and was to be commended. As discussed with DBHDS staff, however, the QRT did not provide an adequate rationale for declining to implement remediation for performance measure G10 (i.e., number and percent of participants 19 and younger who had an ambulatory or preventive care visit during the year). This was particularly concerning because it indicated an ongoing deficiency over multiple years. At the time of the 26th Period, the previous *Remediation Tracker* indicated that since performance measure data is only pulled at the close of the fiscal year, the QRT would be unable to determine future efforts until then; however, that document provided the needed year-end data (i.e., 63%) for FY24). That document also noted that DMAS and DBHDS were collaboratively working through SFY 2025 to complete a root cause analysis study of this process to determine if updates were needed to the data collection and analysis elements of the PM. For this 27th Period, the 8/18/25 update again indicated only that the measure was reported annually and the QRT would not know if it continued to underperform until the end of year data review; therefore, the QRT had not determined to pursue a remediation strategy. DBHDS did not have any evidence of undertaking a root cause analysis study as previously indicated. In addition, upon further examination as a part of this study, this measure has underperformed for at least three fiscal years (i.e., 65% in FY22, 65% in FY23 and 63% in FY 24). The QRT did not review these data trends, did not undertake the previously indicated remedial strategy (i.e., the RCA), and did not provide an adequate rationale for not implementing remediation. The	

Table 2			
Term and Actions	**Facts**	**Analysis/ Conclusion**	**27th**
		QRT meeting minutes for the last two quarters also did not reflect a discussion of the G10 performance measure. Overall, DBHDS made significant progress for this Term, including both development and implementation of procedures for determining the need for, implementing and updating remedial strategies. However, based on the circumstances described above related to the G10 performance measure, the QRT did not yet ensure that they consistently followed these procedures. DBHDS staff reported in interview that DMAS was currently onboarding a position to manage the QRT process, which is expected to enable a fully consistent process.	

Recommendations:

1. For Term 41, for the validity of the measure, all applicable processes and guidance documents should clearly reference the requirement that a lack of adequate pre-injury protections indicates a lack of protection. The numerator should only include individuals for whom DBHDS can confirm that, at time of the injury, the risk mitigation strategies were appropriate to, and effectively addressed, pre-existing risks that were known or should have been known.
2. For Term 41, DBHDS should clarify how they can ensure that having OIH exactly replicate the IMU triage and pre-investigation processes for serious injuries will allow them to answer the four questions posed for the process, given that it is not just reliability that needs to be tested, but also validity of the processes themselves.
3. For Term 41, OL and the RNCCs should also consider how to evaluate whether the ISP in place at the time of the serious injury sufficiently identified risks that "should have been known."
4. For Term 44, DBHDS should continue its efforts to address data collection and analysis reporting for individuals with complex adaptive support needs.
5. For Term 44, DBHDS should consolidate the various data to provide a create a single, more effective whole, including cross-referencing comparing data from the sources that might serve to illuminate either gaps in services or opportunities for cross-learning.
6. For Term 45, The Office of Licensing should continue its ongoing efforts to increase consistency of licensing specialist determinations of compliance with the Risk Management regulations with specific attention paid to determinations related to §520.C.5 and §520.D.
7. For Term 46, to fully meet the objectives of Term 46.c within the 24-month timeframe, OL should complete its implementation of the inter-rater reliability process that was initiated during the 27th study.
8. For Term 46, DBHDS will also need to finalize a formal process for measuring inter-rater reliability between Licensing Specialists and the QSR reviewers assigned, under contract, to assess the adequacy of provider quality improvement programs. DBHDS will need to provide a Process Document that describes a valid and reliable methodology.
9. For Term 46, DBHDS should consider additional training for QSR reviewers related to the evaluation of quality improvement plans, particularly with regard to identifying whether a quality improvement plan met the QI regulations at *12VAC35-105-620* and whether d the provider tracked and reviewed data.
10. For Term 49, DBHDS should finalize Process Documents that outlines the QSR HCBS compliance process from start to finish, which should incorporate all of the validation processes in the approved Statewide Transition Plan (STP), the requirements of the HCBS Settings Rule and related CMS guidance, and the Commonwealth's responses to the *CMS Site Visit Report.*
11. Also for Term 49, DBHDS should finalize the PCR and PQR elements that address the ongoing monitoring of HCBS requirements with regard to integration in and access to the greater community. This should include ensuring that each compliance element with a Yes or No response provides sufficient guidance for making that determination. DBHDS should also consider requesting that CMS review the assessment/validation protocol and tools once these modifications are completed.

12. For Term 54, DBHDS should update the Definitions section of the Process Document to state clearly that an "annual" physical exam is one that occurs within that 14-month period. DBHDS had not updated the Process Document for this 27th Period.
13. For Term 53, to meet the requirement for the provision of sufficient data for the RMRC to conduct/oversee the Community Look-Behind (CLB) review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation, DBHDS should continue its efforts to restructure the CLB inter-rater reliability process so that the reviews are conducted quarterly and by a person or persons who are not directly involved in the OHR Look-Behind Review operation.
14. For Term 56 and Term 57, the QRT should ensure that it consistently adheres to the written procedures in its charter that describe the expectations for development, monitoring and revision of remediation/quality improvement plans.
15. For Term 57, DBHDS should consider including the identification of "close-watch" performance measures (i.e., those that appeared to be at risk for falling below the 86% the QRT should consider doing so.

Interviews:

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

1. Heather Norton, Deputy Commissioner
2. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Governmental Relations
3. Michelle Laird, Incident Management Manager
4. Katherine Means, Assistant Commissioner for Quality Management and Strategic Outcomes
5. Jae Benz, Director, Office of Licensing
6. Taneika Goldman, Director, Office of Human Rights
7. Mackenzie Glassco, Associate Director of Quality and Compliance
8. Angelica Howard, Associate Director of Administrative and Specialized Units
9. Rebecca Laubach, Director, Quality Improvement Analytics and Processes
10. Susan Moon, Director Office of Integrated Health, Health Supports Network
11. Carrie Browder, RNCC
12. Jessa Sprouse, RNCC
13. Nathan Habel, Director, Behavioral Health Services and Projects
14. Martin Kurylowski, Director Transition Network Supports
15. Brian Nevetral, Project Manager
16. Nicole DeStefano, Waiver Network Supports Director

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

1. 12VAC35-105-450
2. 12VAC35-105-50, 100, 110, and 115
3. 12VAC30-122-180
4. 12VAC35-105-620
5. 2025 Annual Compliance Determination Chart
6. 160 450 520 620 Combined Orientation Training PowerPoint (05/20/2025)
7. Office of Licensing Look-Behind Process for DD Providers' Annual Inspections
8. Expanded Consultation and Technical Assistance Standard Operating Procedures (effective 08/23/2024)
9. Draft Mandatory ECTA Protocol
10. Combined OL & OCQI Mandatory ECTA Protocol (effective 07/15/2025)
11. Expectations Regarding Risk Management Programs for Providers of Developmental Services (Final dated 08/27/2025)
12. Expectations Regarding Provider Training and Development Memo (05/02/2025)
13. OL Inter-Rater Reliability Process Updated 7.2025
14. DD Inspections 1.1.25_8.8.25 27th Study Period
15. 450 Data 1.1.25-8.8.25 27th Study Period
16. Provider Data Summary SFY 2025 May 2025
17. DSP Competencies Comparison Data Summary Graphs 10.1.25
18. Behavioral Supports Report: Q1/FY26
19. DD Therapeutic Consultation BS Ver 007, dated 10/2024
20. Annual Dental Exams Permanent Injunction 27th Study of Independent Reviewer, dated 9/30/25,
21. Annual Dental Exams Ver 008, dated 7/30/25
22. Annual Dental Exams Permanent Injunction 27th Study of Independent Reviewer, dated 9/30/25
23. Dental Work Plan Outcomes.PI.2024-25.09.30.2025
24. https://www.dentaquest.com/en/find-a-dentist
25. Individuals Protected from Serious Injury, Version 006, last revised 8/15/25
26. Term 41: Protection From Serious Injuries in Service Settings
27. OL IMU Pre-Investigation Determination Triage for DD Deaths and Serious Incidents
28. Term 41 Investigation Protocols Combined August 2025 Final
29. Investigation Protocols-Combined, Incident Management Pre-Investigation Determination Triage for DD Deaths/Serious Incidents
30. Appendix D Triage Criteria to Consider after Discussion with the Provider
31. Permanent Injunction Term 41b, FY25Q4-FY26Q1 (Serious Injury Quality Review Report), dated September 2025

32. Individuals Protected from Serious Injury, Risk Management Review Committee, September 23,2025
33. Office of Integrated Health (OIH) Serious Injury Quality Review Update, September 23,2025
34. Case Management Steering Committee Semi-Annual Report State Fiscal Year 2025 3rd and 4th Quarters, dated 9/20/25
35. DD CMSC VER 016, dated 8/29/23
36. DS Waiver Service Enrollment Version 002, dated 4/15/25
37. PI – 43.b Timely Waiver Service Enrollment
38. FY25 Q4 Quarterly Timely Waiver Service Enrollment Report
39. CMSC IP update 4-15-25
40. Waiver in 5 months QII (KPA Workgroup)
41. PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period
42. Ongoing Service Analysis Report: Individuals with Complex Health, Behavioral and Adaptive Support Needs FY 2024
43. Provider Quality Review (PQR) tool
44. Person-Centered Review (PCR) tool
45. Round 7 QSR Training Plan
46. Round 7 QSR IRR Policy
47. Final Round 7 QSR Methodology
48. QSR Round 7 DBHDS and HSAG Scoring Concordance, dated 4/18/25
49. DBHDS and QSR Vendor Independent Scoring Process, developed April 18, 2025
50. Quality Service Review Overview for Licensed Providers Review 7 SFY 2025 August 2025
51. QSR Quality Improvement Findings Version 003, dated 3/28/25
52. Sample QSR QI documents for 36 providers:
    a. The Annual Quality Improvement Plan required by 12VAC35-105-620.C that was reviewed during the Round 7 QSR and the date of the previous version.
    b. Any related policies, procedures, tools, or protocols used to guide development of and to operationalize the Quality Improvement Plan that were reviewed during Round. At a minimum, this should include: a) policies and procedures that guided the development and implementation of the Quality Improvement Plan and b) processes, tools and/or protocols that show how performance data was used in the development and monitoring of the stated goals/objectives in the Quality Improvement Plan, as well as how performance data was used in review of serious incidents, abuse/neglect, seclusion and restraint and community integration.
    c. Minutes of meetings related to the implementation of the Quality Improvement Plan and related processes that were reviewed during Round 7 QSR.
    d. Documents evidencing corrective actions taken to address the findings of the QSR Round 5 or Round 6 PQR QIP.
    e. Round 7 Provider Documentation Submission Checklist
    f. Round 7 QSR Report
53. Combined OL & OCQI Mandatory ECTA Protocol, effective 07/15/2025

54. OL TERM 46: Quality Service Monitoring Summary
55. HCBS Setting Rule Initial Determination
56. HCBS Compliant Settings Version 001, dated 4/23/25
57. HCBS Compliant Settings Version 001Attachment B: Data Set Attestation Form, dated 10/2/25
58. Addendum to the Commonwealth of Virginia's Statewide Transition Plan February 2019
59. Annual Physicals Permanent Injunction 27th Study of the Independent Reviewer, dated 9/30/25
60. Draft PH Screening Questions.10.10.2025
61. FY25 QRT Underperforming Measures -Remediation Tracker
62. FY24 QRT Underperforming Measures -Remediation Tracker
63. SFY 25 DD Waiver QRT Data
64. Draft SFY2026 Quality Review Team Charter
65. Approved 6.26.23 HSW KPA Workgroups RAT into ISP QII SFY24
66. RMRC OHR CLB planning_QII Toolkit FY25
67. OCQI-CM CSB ISP WaMS Data, Updated April 15, 2025
68. Quality Review Team (QRT) End of Year Report, SFY 2024
69. DMAS & DBHDS Quality Review Team (QRT) Quarterly Collaboration, 4/24/25 and 8/7/25
70. Memorandum: Incident Management Unit Look Behind process and responsibilities related to timely appropriate corrective action plans implemented by the provider when indicated, dated 10/6/23
71. Ongoing Service Analysis Report: Individuals with Complex Health, Behavioral and Adaptive Support Needs FY 2024, dated April 2025
72. Ongoing Service Analysis Report: Individuals with Complex Health, Behavioral, and Adaptive Support Needs FY2024, dated May 2025
73. PI 39 & 44 - Intense Management Needs Review Report, 26th Review Period
74. Intense Management Needs Review Process – PI44, Version 001, dated 2/3/25
75. QSR Round 6 HSW Alerts Tracker
76. QSR Round 6 HSW Alerts Summary, dated 10/31/25
77. Protocol for OL Follow-up with Outcome 2 and Outcome 4, effective February 12, 2024
78. Outcome 4 Findings and Follow up Tracking 3.18.2024

APPENDIX H

List of Acronyms

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

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

OHR	Office of Human Rights
OIHSN	Office of Integrated Health Support Network
OL	Office of Licensing
OSIG	Office of the State Inspector General
OSVT	On-Site Visit Tool
PASSR	Preadmission Screening and Resident Review
PCP	Primary Care Physician
PCR	Person-Centered Review
PHA	Public Housing Authority
PMI	Performance Measure Indicator
PMM	Post-Move Monitoring
POC	Plan of Care
PQR	Provider Quality Review
PST	Personal Support Team
QAR	Quality Assurance Review
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QMD	Quality Management Division
QMR	Quality Management Review
QRT	Quality Review Team
QSR	Quality Service Reviews
RAC	Regional Advisory Council for REACH
RAT	Risk Assessment Tool
RCA	Root Cause Analysis
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RFP	Request For Proposals
RMRC	Risk Management Review Committee
RNCC	RN Care Consultants
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group
SEVTC	Southeastern Virginia Training Center
SIR	Serious Incident Report
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home

SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
VCU	Virginia Commonwealth University
VHDA	Virginia Housing and Development Agency
WaMS	Waiver Management System