hopestarter RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Voice/TDD (540) 373-3223 | Fax (540) 371-3753

NOTICE

To: Program Planning and Evaluation Committee Nancy Beebe, Glenna Boerner, Claire Curcio, Kheia Hilton, Ken Lapin, Susan Muerdler, Jacob Parcell, Sarah Ritchie, Matt Zurasky

From: Joseph Wickens
Executive Director

Subject: Program Planning and Evaluation Meeting
November 8, 2022, 10:30 AM
600 Jackson Street, Board Room 208. Fredericksburg, VA

Date: November 2, 2022

A Program Planning and Evaluation Committee meeting has been scheduled for Tuesday, November 8, 2022 at 10:30 a.m. The meeting will be held at 600Jackson Street, Board Room 208, Fredericksburg, VA 22401.

Looking forward to seeing you on November 8 at 10:30 a.m.

Cc: Nancy Beebe, Chairperson

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Program Planning and Evaluation Committee Meeting

November 8, 2022—10:30 a.m.

600 Jackson Street, Room 208 Fredericksburg, VA 22401

Agenda

To: Joe Wickens, Executive Director
From: Alison Standring, Part C Coordinator
Subject: Monitoring Results for FFY21/SFY22, Copy 2 of 2
Date: October 31, 2022

Catherine Hancock's memo and the accompanying chart provide the second of two reporting cycles for the results of our annual chart review to determine compliance with Part C federal regulations for FFY21/SFY22.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Alison Standring, Part C Coordinator
Subject: Monitoring Results and Determination FFY21/SFY22 (July 1, 2021 through June 30, 2022)
Date: October 31, 2022

The Department of Behavioral Health and Developmental Services monitors each of the 40 local Part C systems in the Commonwealth to assure that it is in compliance with federal Part C requirements. Enclosed is a memo from Catherine Hancock that summarizes the monitoring process and what is involved in determinations (pages 4 through 6), a chart that describes the federal indicators reviewed and how we scored on each (pages 7 through 9), and a sample chart with explanation bubbles (pages 10 through 12).

The charts on pages 7 through 9 demonstrate our compliance with 14 indicators plus DBHDS's measurement of Longstanding Non-Compliance, Accurate & Timely Data, Data Anomalies, Children with Exit Scores, and Family Survey Response Rate. Each of these items is awarded points based on our local result compared to the target.

1. Page 7 shows
    a. We are in compliance with implementing services within 30 days of developing an Individualized Family Service Plan (Indicator 01); developing an Individualized Family Service Plan (IFSP) within 45 days of a referral (Indicator 07); and documenting Transition Steps and Services (Indicator 08A), Transition Notification to Local Education Agency and State Education Agency (Indicator 08B), and the Transition Conference (Indicator 08C) according to regulations;
    b. We have no longstanding noncompliance;
    c. Our data are mostly accurate and timely; we had one error with our Children Over 3 report, entering the discharge in the data system later than 10 days from the event.
2. Page 8 shows
    a. We are in compliance with Primary Service Setting (Indicator 02), providing services in the child's natural environment.
    b. Our local results for Child Outcomes (Indicator 03) which measure children's positive social-emotional skills, acquisition and use of knowledge and skills, and use of appropriate behaviors to meet needs in comparison to same aged peers as they exit out of early intervention (this item is not yet awarded points, DBHDS continues to refine this process) are in line with state results;
    c. There were no Data Anomalies among our Child Outcomes data;
    d. 98 % of eligible children had Exit Scores;
    e. The results of Family Outcomes (Indicator 04) as measured through an annual family survey scored above the state targets in all three areas;
    f. Our Family Survey Response Rate was less than the 25th percentile; we received no points for this item. DBHDS reports that 17 (out of 40) localities were able to meet or exceed the 22% target; of those, 9 exceeded 26%. Conversely, 23 out of 40 systems did not achieve the expected response rate.
3. Page 9 shows
    a. We exceed the state targets for Child Find (Indicator 05, Indicator 06), enrolling more children birth to 1 and birth to 3 than the state expected of us;

b. Our Cumulative Score is 88.5% resulting in a **Meets Requirements Determination for the 16th year in a row**!

During State Fiscal Year 2022, our program processed 870 referrals (up from 779 last year) and served more than 1,031 infants and toddlers (up from 954 last year), above the state target for percent of population, all the while enrolling families and delivering the first service in the child's natural environment within federally required timelines. We developed plans and provided supports and services timely for toddlers who are transitioning from Part C early intervention services to Part B public preschool special education services.

Workforce issues continue to impact our program resulting in extremely high staff caseloads. This, coupled with the large number of referrals coming in means we are currently struggling, and sometimes failing, to meet timelines. Our determination report next year may reflect this.

Our staff are an amazing conglomeration of talent, dedication, creativity, and devotion to our families. In this season of Thanksgiving, I give thanks for each and every one of them!

pc: Amy Jindra, CSS Director
Suzanne Haskell, PE-ID Coordinator
PE-ID Staff
Infant Case Management Staff

NELSON SMITH
COMMISSIONER

COMMONWEALTH of VIRGINIA
DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
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MEMORANDUM

TO: Local Early Intervention System (LEIS) Lead Agency Directors

FROM: Catherine Hancock, MS, RN, PMHCNS
Early Intervention Program Manager

DATE: September 30, 2022

RE: Local Early Intervention System (LEIS) Monitoring Results & Determination for FFY21/SFY22 (July 1, 2021 – June 30, 2022) – Copy 2 of 2

Overview

In 2013 the Infant & Toddler Connection of Virginia (ITCVA) introduced you to the "Local Early Intervention System (LEIS) Monitoring Results & Determination Report" as a mechanism for informing localities of their Part C of IDEA monitoring results. Because data becomes available at varying points throughout the year—and to expedite communication of results while fostering familiarity with the report and reporting process—two (2) copies of this report are prepared and sent during the year.

Copy 1 of 2 was disseminated in June 2022. Enclosed you will find copy 2 of 2—the final copy for FFY21/SFY22. This final report also includes your LEIS determination and specifies any required enforcements.

The Individuals with Disabilities Education Act (IDEA) of 2004 §616(b)(2)(C)(ii)(II) requires each state to measure and report results on federally identified indicators in an Annual Performance Report (APR). The review period for Virginia's next APR—to be submitted in February 2023—will cover FFY21/SFY22 (07/01/2021-06/30/22). In addition to reporting this APR data to the Office of Special Education Programs (OSEP), it will also be reported publicly and used to make local determinations as required under the IDEA of 2004 §616 (d)(e).

Determinations and Enforcements

In accordance with Subpart H, §303.700 of the Individuals with Disabilities Education Act (IDEA) 2011, states are required to make determinations annually on the performance of each LEIS under Part C and to use appropriate enforcement mechanisms depending on the

determination. States must use the following four (4) determination categories outlined in §303.703 of IDEA: Meets Requirements (MR), Needs Assistance (NA), Needs Intervention (NI) and Needs Substantial Intervention (NSI).

Your local system's determination can be found on page 3 of the report.

- If your LEIS has received a determination of Meets Requirements (MR)—congratulations! Your hard work is recognized and appreciated. If your LEIS has improved its determination status since last year (and/or improved its determination assessment score since last year), thank you for your ongoing improvement efforts.

- If your LEIS has received a determination of Needs Assistance (NA) immediately following a determination of Meets Requirements (MR), ITCVA technical assistance and monitoring team staff members will continue to be available to work with your LEIS as needed to help identify and address any issues that may be preventing a determination of Meets Requirements.

- If your local system has not yet corrected noncompliance for any of the compliance indicators (1, 7, and 8), you must continue your monthly monitoring and improvement strategies until your system is in compliance. Your technical assistance and monitoring consultants are available to assist you.

- If your local system did not meet the targets for any of the results indicators (2, 3, 4, 5, and 6), your technical assistance and monitoring consultants will work with you to determine the best way to improve your results.

With reauthorization of IDEA, OSEP has focused on state and local accountability in implementing this federal legislation. Both the local system's publicly reported data and its determination status provide valuable data and information about how your local system's performance compares to the State's measurable and rigorous targets.

While local performance on federal indicators is important, DBHDS recognizes that your local system's determination status and public reporting data do not capture all of the positive work that occurs locally and all of the support and help you provide to children and families in your community. Your local system's continued commitment to providing early intervention services and supports for Virginia's infants and toddlers with disabilities and their families is greatly appreciated.

If you should have any questions regarding the determination for your LEIS, please do not hesitate to contact your monitoring consultant.

Enclosures

cc: Local System Manager
Local System Manager Supervisor
Nelson Smith, Commissioner, DBHDS
Lisa Jobe-Shields, Deputy Director, Community Services, DBHDS
Nina Marino, Director, Office of Child and Family Services, DBHDS
Kyla Patterson, Monitoring Team Leader, Infant & Toddler Connection of Virginia, DBHDS
Monitoring Consultant, Infant & Toddler Connection of Virginia, DBHDS
Technical Assistance Consultant, Infant & Toddler Connection of Virginia, DBHDS

Local Early Intervention System (LEIS) Monitoring Results & Determination

Based on monitoring data from FFY 2021 (July 1, 2021 - June 30, 2022) [as required by OSEP]

☐ Copy 1/2 – Results (06/2022)
☑ Copy 2/2 – Final Results & Determination (10/2022)

Infant & Toddler Connection of

Rappahannock Area

Section A
Compliance Indicators; Longstanding Noncompliance; Accurate & Timely Data

Annual Compliance Measures (Indicator 01, Indicator 07 and Indicator 08)

Scoring
- CPN = N/A → 2
- CPN = Y → 2
- CPN = N and ARR >= 95% → 2
- CPN = N and ARR >= 75% → 1
- CPN = N and ARR < 75% → 0

Indicator	State Target	State Result	Annual Record Review (ARR) Result	Corrected Prior to Notification (CPN) (Y/N/NA)	Full Correction FFY20/SFY21 Noncompliance (Y/N/NA)	Points Awarded
01: Timely Services	100%	**95.3%**	**100.0%**	**N/A**	**Y**	**2**
07: 45-Day Timeline	100%	**97.1%**	**97.7%**	**Y**	**N/A**	**2**
08A: Transition Steps and Services	100%	**99.2%**	**100.0%**	**N/A**	**Y**	**2**
08B: Transition Notification to LEA & VDOE	100%	**98.8%**	**100.0%**	**N/A**	**Y**	**2**
08C: Transition Conference	100%	**100%**	**100.0%**	**N/A**	**N/A**	**2**

Longstanding Noncompliance

Scoring • No longstanding noncompliance → 2 • Noncompliance corrected within one (1) year; if repeated, compliance at ARR >= 95% → 2 • Noncompliance corrected within one (1) year; if repeated, compliance at ARR < 95% → 1 • Noncompliance exceeding one (1) year → 0	**2**

Accurate & Timely Data

Scoring • True → 1 • False → 0	***Accuracy***	ARR Data and Verification	**1**
		December 1st Child Count	**1**
		Children Over Three Report	**0**
	Timeliness	Contract Deliverables[1]	**1**

Section A Points and % Score

Scoring • Total points = SUM of points awarded • Section A % score = SUM ÷ TOTAL POSSIBLE POINTS[2]	**SECTION A POINTS**	**15**
	SECTION A % SCORE	**93.8%**

[1] All FFY21/SFY22 contract deliverables submitted and 9 of 11 deliverables submitted on time in order to receive full credit.
[2] FFY21/SFY22 total possible points for Section A = 16.

Section B
Results Indicators; Data Anomalies; Data Completeness

Primary Service Setting (Indicator 02)

Scoring
- PSS >= State target → 1
- PSS < State target → 0

State Target	State Result	Local Result	Points Awarded
98.0%	**99.8%**	**100.0%**	**1**

Child Outcomes (Indicator 03)

Scoring
- Local results reported but not scored

	State Target	State Result	Local Result
03A-S1: Positive social-emotional skills	64.9%	**63.2%**	**52.2%**
03A-S2: Positive social-emotional skills	57.6%	**50.7%**	**50.5%**
03B-S1: Acquisition and use of knowledge and skills	68.7%	**66.3%**	**61.1%**
03B-S2: Acquisition and use of knowledge and skills	46.9%	**40.8%**	**40.3%**
03C-S1: Use of appropriate behaviors to meet needs	68.6%	**63.7%**	**54.0%**
03C-S2: Use of appropriate behaviors to meet needs	50.7%	**45.9%**	**46.3%**

Data Anomalies

Scoring
- 3 child outcomes x 5 progress categories (a-e) = 15 results
- 15 results – total anomalies = Score
  - Score = 13, 14 or 15 → 2 points
  - Score = 10, 11 or 12 → 1 point
  - Score < 10 → 0 points

Anomalies	Score	Points Awarded
0	**15**	**2**

Children w/ Exit Scores

Scoring
- # score captured ÷ total # eligible for scores = LEIS %
  - LEIS % >= 90% → 2 points
  - LEIS % between 80% and 90% → 1
  - LEIS % < 80% → 0 points

Eligible	Captured	LEIS %	Points Awarded
304	**298**	**98.0%**	**2**

Family Outcomes (Indicator 04)

Scoring
- Meaningful difference = NA[3] → 1
- Meaningful difference = N → 1
- Meaningful difference = Y → 0

	State Target	State Result	Local Result	Meaningful Difference (Y/N/NA)	Points Awarded
04A: Family Outcomes (Know their rights)	75.0%	**77.7%**	**85.0%**	**NA**	**1**
04B: Family Outcomes (Communicate needs)	71.9%	**74.0%**	**81.0%**	**NA**	**1**
04C: Family Outcomes (Help child learn)	85.9%	**87.5%**	**88.0%**	**NA**	**1**

Family Survey Response Rate

Scoring
- [Surveys connected[4] minus (-) surveys returned] ÷ surveys connected = LEIS %
  - LEIS % >= 26% OR at or above 75th percentile → 2
  - LEIS % >= 22% OR between 25th and 75th percentile→ 1
  - LEIS % at or below 25th PERCENTILE → 0

Surveys Connected	Surveys Returned	LEIS %	Points Awarded
411	**59**	**14.4%**	**0**

[3] Local result >= state target = NA

[4] *Surveys connected* means surveys sent minus (-) surveys returned as undeliverable. It is assumed that surveys not returned as undeliverable "connected" with the intended recipient household.

Section B: Results (continued)

Child Find (Indicator 05; Indicator 06)

Scoring • Meaningful difference = NA[5] → 1 • Meaningful difference = N → 1 • Meaningful difference = Y → 0	**State Target**	**State Result**	**Local Result**	**Meaningful Difference (Y/N/NA)**	**Points Awarded**
05: Child Find 0-1	1.64%	**1.71%**	**1.75%**	**NA**	**1**
06: Child Find 0-3	3.43%	**3.74%**	**3.85%**	**NA**	**1**

Section B Points and % Score

Scoring • Total points = SUM of points awarded • Section B % score = SUM ÷ TOTAL POSSIBLE POINTS[6]	**SECTION B POINTS**	**10**
	SECTION B % SCORE	**83.3%**

Cumulative Score and Determination

Scoring • Cumulative % Score = 50% Section A % Score + 50% Section B % Score • Determination o 80%-100% → Meets Requirements (MR) AND no noncompliance exceeding one (1) year o 60%-79% → Needs Assistance (NA) o 50%-59% → Needs Intervention (NI) o 0%-49% → Needs Substantial Intervention (NSI)	**FFY21/SFY22 CUMULATIVE % SCORE**	**88.5%**
	FFY21/SFY22 DETERMINATION	**MR**

Enforcement Actions (if applicable)

Local EIS Determination History

FFY06/SFY07 (July 1, 2006 – June 30, 2007)	**FFY07/SFY08** (July 1, 2007 – June 30, 2008)	**FFY08/SFY09** (July 1, 2008 – June 30, 2009)	**FFY09/SFY10** (July 1, 2009 – June 30, 2010)	**FFY10/SFY11** (July 1, 2010 – June 30, 2011)	**FFY11/SFY12** (July 1, 2011 – June 30, 2012)	**FFY12/SFY13** (July 1, 2012 – June 30, 2013)
NA	**MR**	**MR**	**MR**	**MR**	**MR**	**MR**
FFY13/SFY14 (July 1, 2013 – June 30, 2014)	**FFY14/SFY15** (July 1, 2014 – June 30, 2015)	**FFY15/SFY16** (July 1, 2015 – June 30, 2016)	**FFY16/SFY17** (July 1, 2016 – June 30, 2017)	**FFY17/SFY18** (July 1, 2017 – June 30, 2018)	**FFY18/SFY19** (July 1, 2018 – June 30, 2019)	**FFY19/SFY20** (July 1, 2019 – June 30, 2020)
MR	**MR**	**MR**	**MR**	**MR**	**MR**	**MR**
FFY20/SFY21 (July 1, 2020 – June 30, 2021)	**FFY21/SFY22** (July 1, 2021 – June 30, 2022)					
MR	**MR**					

[5] Local result >= state target = NA

[6] FFY21/SFY22 total possible points for Section B = 12

Local Early Intervention System (LEIS) Monitoring Results & Determination

Based on monitoring data from FFY 20## (July 1, 20## - June 30, 20##) [as required by OSEP]

☐ Copy 1/2 – Results (6/##) • ☐ Copy 2/2 – FINAL Results & Determination (10/##)

Infant & Toddler Connection of

LEIS

GENERAL INFO
- Scoring is done on Copy 2/2 (October)
- Points are positive (awarded if criteria is met)
- Meaningful difference calculators are used to determine whether differences from targets are statistically significant for Child Outcome Progress Categories, Family Outcomes and Child Count.

Section A
Compliance Indicators; Longstanding Noncompliance; Accurate & Timely Data

Annual Compliance Measures (Indicator 01, Indicator 07 and Indicator 08)

Scoring
- CPN = N/A → 2
- CPN = Y → 2
- CPN = N and ARR >= 95% → 2
- CPN = N and ARR >= 75% → 1
- CPN = N and ARR < 75% → 0

Indicator	State Target	Annual Record Review (ARR) Result	Corrected Prior to Notification (CPN) (Y/N/NA)	Full Correction of FFY##/SFY## Noncompliance (Y/N/NA)	Points Awarded
01: Timely Services	100%				
07: 45-Day Timeline	100%				
08A: Transition Steps and Services	100%				
08B: Transition Notification to LEA & SEA	100%				
08C: Transition Conference	100%				

Target for all Compliance Indicators is 100%

Longstanding Noncompliance

Scoring
- No longstanding noncompliance → 2
- Noncompliance corrected within one (1) year; if repeated, compliance
- Noncompliance corrected within one (1) year; if repeated, compliance
- Noncompliance exceeding one (1) year → 0

Noncompliance not corrected within one year OR noncompliance that is corrected and then repeated in a subsequent ARR

Accurate & Timely Data

Scoring
- True → 1
- False → 0

ARR Data and Verification	
December 1st Child Count	
Children Over Three Report	
Contract Deliverables[1]	

Review of data submitted with ARR confirmed accuracy

No changes in 12/1 child count due to late data entry

No children on report more than 2 of 3 months reviewed

X of Y required deliverables submitted on time

Section A Points and % Score

Scoring
- Total points = SUM of points awarded
- Section A % score = SUM ÷ TOTAL POSSIBLE POINTS[2]

SECTION A POINTS	
SECTION A % SCORE	

[1] All FFY##/SFY## contract deliverables submitted and X of Y deliverables submitted on time in order to receive full credit.
[2] FFY##/SFY## total possible points for Section A = X.

Section B
Results Indicators; Data Anomalies; Data Completeness

Primary Service Setting (Indicator 02)

Scoring
- PSS >= State target → 1
- PSS < State target → 0

State Target	Local Result		Points Awarded
98.0%			

Child Outcomes (Indicator 03)

Scoring
- Local results reported but not scored

	State Target	Local Result		Points Awarded
03A-S1: Positive social-emotional skills	69.5%			
03A-S2: Positive social-emotional skills	66.4%			
03B-S1: Acquisition and use of knowledge and skills	74.7%			
03B-S2: Acquisition and use of knowledge and skills	55.3%			
03C-S1: Use of appropriate behaviors to meet needs	78.7%			
03C-S2: Use of appropriate behaviors to meet needs	56.4%			

Scoring is determined by using a meaningful difference calculator; points received if local results are not meaningfully different from expected patterns. "Anomalies" is the terminology OSEP uses to describe results that vary from the expected patterns.

Data Anomalies

Scoring
- 3 child outcomes x 5 progress categories (a-e) = 15 results
- 15 results – total anomalies = Score
  - Score = 13, 14 or 15 → 2 points
  - Score = 10, 11 or 12 → 1 point
  - Score < 10 → 0 points

Anomalies	Score	Points Awarded

Children w/ Exit Scores

Scoring
- # score captured ÷ total # eligible for scores = LEIS %
  - LEIS % >= 90% → 2 points
  - LEIS % between 80% and 90% → 1
  - LEIS % < 80% → 0 points

Eligible	Captured	LEIS %	Points Awarded

Comparison of the number of children eligible for scores (6+ months between initial IFSP date and date of closure) to the number of children with scores.

Family Outcomes (Indicator 04)

Scoring
- Meaningful difference = NA[3] → 1
- Meaningful difference = N → 1
- Meaningful difference = Y → 0

	State Target	Local Result	Meaningful Difference (Y/N/NA)	Points Awarded
04A: Family Outcomes (Know their rights)	76.4%			
04B: Family Outcomes (Communicate needs)	74.4%			
04C: Family Outcomes (Help child learn)	84.9%			

Family Survey Response Rate

Scoring
- [Surveys connected[4] minus (-) surveys returned] ÷ surveys connected = LEIS %
  - LEIS % >= 26% → 2
  - LEIS % between 22% and 26% → 1
  - LEIS % < 22% → 0

Surveys Connected	Surveys Returned	LEIS %	Points Awarded

[3] Local result >= state target = NA

[4] *Surveys connected* means surveys sent minus (-) surveys returned as undeliverable. It is assumed that surveys not returned as undeliverable "connected" with the intended recipient household.

Section B: Results (continued)

Child Find (Indicator 05; Indicator 06)

Scoring • Meaningful difference = NA[5] → 1 • Meaningful difference = N → 1 • Meaningful difference = Y → 0	**State Target**	**Local Result**	**Meaningful Difference (Y/N/NA)**	**Points Awarded**
05: Child Find 0-1	1.20%			
06: Child Find 0-3	2.76%			

Section B Points and % Score

Scoring • Total points = SUM of points awarded • Section B % score = SUM ÷ TOTAL POSSIBLE POINTS[6]	**SECTION B POINTS**	
	SECTION B % SCORE	

Cumulative Score and Determination

Scoring • Cumulative % Score = 50% Section A % Score + 50% Section B % Score • Determination ○ 80%-100% → Meets Requirements (MR) AND no noncompliance exceeding one (1) year ○ 60%-79% → Needs Assistance (NA) ○ 50%-59% → Needs Intervention (NI) ○ 0%-49% → Needs Substantial Intervention (NSI)	**FFY##/SFY## CUMMULATIVE % SCORE**	
	FFY##/SFY## DETERMINATION	

Enforcement Actions (if applicable)

[5] Local result >= state target = NA

[6] FFY##/SFY## total possible points for Section B = X.

MEMORANDUM

TO: Joe Wickens, Executive Director

FROM: Patricia Newman – Mental Health Case Management Supervisor
Elizabeth Wells – Lead State Hospital Liaison & NGRI Coordinator
Chanda Bernal – Adult Mental Health Case Manager

PC: Brandie Williams – Deputy Executive Director
Jacqueline Kobuchi, LCSW – Clinical Services Director
Amy Jindra – Community Support Services Director
Nancy Price – MH Residential Coordinator
Tamra McCoy – ACT Coordinator
Jennifer Acors – Coordinator Developmental Services Support Coordination

SUBJECT: Extraordinary Barriers List (EBL)

DATE: November 8, 2022

RACSB currently has one individual on the Extraordinary Barriers List (EBL), to include one individual at Western State Hospital (WSH). Individuals ready for discharge from state psychiatric hospitals are placed on the EBL when placement in the community is not possible within 7 days of readiness, due to barriers caused by waiting lists, resource deficits, or pending court dates.

Western State Hospital

Individual #1: Was placed on the EBL 7/26/22. Barriers to discharge include identifying and being accepted to the most appropriate housing or residential program. This individual has a diagnosis of a serious mental illness and their personality traits of impulsivity and reactivity place them at greater risk to others. This individual has a history of hospitalizations as well as incarcerations and is a registered sex offender whose convictions include indecent liberties with a child (2014). They were also recently charged with a misdemeanor offense while hospitalized at Western State Hospital (WSH) in response to groping a female staff member and not immediately releasing her. A previous placement had been identified; however, the cost was $15,000 per month as they required an all-male assisted living facility and a higher level of supervision. Discharge was delayed due to cost as well as the individual obtaining new legal charges. This individual continues to lack insight into their illness as well as their need for continued treatment, is often inappropriate with staff and has made statements regarding wanting to reside close to their victim of the original offense. RACSB had expressed concerns regarding their readiness for discharge as they have not had any interactions with female peers while at the hospital or participated in increased social integration activities due to the amount of supervision needed to maintain safety, however, WSH staff report that because they are at their baseline in their mental health, they are ready for discharge. This individual was accepted to Hawkins Residential, a residential provider in the Richmond area, who operates an all-male program and

who accepts Registered Sex Offenders, however they do not have any open beds at this time. Other options were explored in order to expedite their discharge and they have been accepted to Truu Life, which is an assisted living facility located in Glen Allen, VA. This placement will require Discharge Assistance Program (DAP) Funding. The plan has been submitted for review and this individual will discharge to the community once the DAP Plan is approved.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director

From: Donna Andrus, Child and Adolescent Support Services Supervisor

Date: November 1, 2022

Re: Independent Assessment Certification and Coordination Team (IACCT) Update

****

I am writing to provide an update to the Independent Assessment Certification and Coordination Team (IACCT) program. The Department of Medical Assistance Services (DMAS) with Magellan launched the IACCT program July 1, 2017. The Rappahannock Area Community Services Board is the IACCT provider for Planning District 16.

RACSB received eleven IACCT referrals and completed eleven assessments in the month of October. Six referrals were initial IACCT assessments and five were re-authorizations. Four were from Spotsylvania, five from Stafford, one from Caroline, one from King George and none from the City of Fredericksburg. Two initial IACCTs are still in process so a recommendation has not been made yet. Of the nine completed assessments in October, four recommended Level C Residential and five recommended Level Group Home. No reassessment recommended step-down at this time.

Attached is the monthly IACCT tracking data for October 2022.

600 Jackson Street
Fredericksburg, VA 22401
540-373-3223

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Report Month/Year	Oct-22
1. Total number of Referrals from Magellan for IACCT:	11
1.a. total number of auth referrals:	6
1.b. total num. of re-auth referrals:	5
2. Total number of Referrals per county:	
Fredericksburg:	0
Spotsylvania:	4
Stafford:	5
Caroline:	1
King George:	1
Other:	
3. Total number of extensions granted:	3
4. Total number of appointments that could not be offered within the prescribed time frames:	0
5. Total number of "no-shows":	0
6. Total number of cancellations:	0
7. Total number of assessments completed:	11
8a. Total number of ICA's recommending: **residential:**	4
8b. Total number of ICA's recommending: **therapeutic group home:**	5
8c. Total number of ICA's recommending: **community based services:**	0
8g.Total number of ICA's recommending: **Other:**	0
8h.Total number of ICA's recommending: **no MH Service:**	0
9. Total number of reauthorization ICA's recommending: **requested service not continue:**	0

10. Total number of notifications that a family had difficulty accessing **any** IACCT-recommended service/s:	0

To: Joe Wickens, Executive Director

From: Suzanne Poe, IT Coordinator

Re: Information Technology and Electronic Health Record Update

Date: November 1, 2022

This report provides an update on projects related to Information Technology and the Electronic Health Record. The IT department completed 873 tickets in the month of October. Information is provided on state reporting initiatives, facility technology needs, and on-going projects.

Information Technology and Electronic Health Record Update

IT Systems Engineering Projects

During October, 873 tickets where closed by IT Staff.

Ticket completion numbers by month for calendar year: September 2022-1095; August 2022-1,168; July 2022-1,031; June 2022-1,159; May 2022-945; April 2022-943; March 2022-1,480; February 2022-891; January 2022-894.

We added the functionality for staff to get emailed reminders of their email passcode expiration. We also added the ability for end users to change their email passwords via a website. This will allow for an easier time for staff who get locked out or are working remotely to change their password.

The IT Procedures manual was reviewed and updated in preparation for the CARF review. At the exit CARF review there were no finding with the IT Procedures manual.

Community Consumer Submission 3

The September 2022 CCS was submitted on October 27, 2022.

Waiver Management System (WaMS)

WaMS is continuing to have communication issues with Avatar.

From September 29th to October 18th there was a communication failure between Avatar and WaMS, causing all Individualized Service Plans to not transmit. The IT Team directly entered all ISPs during this time period.

Since October 19th some Service Plans are transmitting automatically, however Avatar is not pulling down and displaying the reason a Service Plans is rejected by WaMS. Typically, the system tells staff the reason the Service Plan is rejected, we fix the error, and resubmit. IT staff are manually reviewing the Service Plans for errors, and resubmitting. If failure again we are manually entering Service Plans into WaMS.

We are continuing to meet weekly with our Netsmart State Reporting team. Additionally, we have engaged the Netsmart Technical Support team to inspect the technical side of the issues. We are still waiting for a response on the cause of the issue.

Trac-IT Early Intervention Data System

On October 24th the Trac-IT system went live with their two-factor authentication system. IT staff helped PIED staff set up their phones and computers with the two-factor application Authy on the 24th to ensure staff had continual/uninterrupted use of Trac-IT.

Zoom

We continue to utilize Zoom for telehealth throughout the agency.

- October 2022 – 2,546 video meeting with a total of 7,289 participants
- September 2022 – 2,589 video meeting with a total of 7,592 participants
- August 2022 – 3,023 video meetings with a total of 8,273 participants
- July 2022 – 2,582 video meetings with a total of 7,377 participants
- June 2022 – 2,881 video meetings with a total of 8,458 participants
- May 2022 – 2,921 video meetings with a total of 8,512 participants
- April 2022 – 2,878 video meetings with a total of 8,728 participants
- March 2022 – 3,281 video meetings with a total of 10,071 participants
- February 2022 - 3,248 video meetings with a total of 9,752 participants

- January 2022– 2,942 video meetings with a total of 8,870 participants
- Average from January to December 2021 was 3,648 video meetings and 11,087 Participants
- Average from April to December 2020 was 3,836 video meetings and 11,435 participants

Avatar

We continue to work with Netsmart to implement a new piece of networking equipment (a Meraki VPN) to allow for more efficient networking speeds when staff access Avatar and run Avatar reports. We are now one step closer to getting communication working on the Meraki device. The Meraki is now working for one RACSB user, however it is rejecting network traffic for all other users.

Bells – ACT has completed small group testing and setup of Bells. They are now set to begin testing and training with a bigger portion of ACT staff.

Camera System and Maintenance Request for Proposals-

A Request for Proposal (RFP) is on eVA (Virginia's Statewide procurement system) for security camera replacement and maintenance was posted. Eleven proposals were received on October 13, 2022 and are currently under review.

Staffing

One of our two IT Technicians resigned his position on July 14, 2022 and we are currently advertising and interviewing for a replacement.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Tabitha Taylor, Emergency Services Law enforcement liaison
Date: November 1, 2022
Re: Crisis Assessment Center and CIT report October

The CIT program held an 40hr CIT training 17 completed the training.

The CIT Assessment Center Assessed 17 individuals in the month of October 2022. The number of persons served by locality were the following: Fredericksburg 3; Caroline 1; King George 1; Spotsylvania 6; Stafford 6.

Twenty-Four percent of individuals assessed under emergency custody orders (ECO) were able to utilize the assessment center.

Please see attached CIT data sheet

600 Jackson Street
Fredericksburg, VA 22401
540-373-3223

RappahannockAreaCSB.org

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October 2022 RACSB CIT Assessment Center Data

Date	Number of ECOs Eligible To Utilize CAC Site	Number of Individuals Assessed at CAC Site	Locality who brought Individual	Locality working at the Assessment Site
10/1/2022	3	0	n.a	Spotsylvania
10/2/2022	4	0	n.a	Spotsylvania
10/3/2022	2	0	n.a	n.a
10/4/2022	4	1	Spotsylvania	Stafford
10/5/2022	1	1	Stafford	Spotsylvania
10/6/2022	6	2	Stafford/Spotsylvania	Spotsylvania
10/7/2022	3	0	n.a	Spotsylvania
10/8/2022	1	0	n.a	Spotsylvania
10/9/2022	1	0	n.a	King George
10/10/2022	1	0	n.a	King George/Stafford
10/11/2022	1	1	Stafford	Spotsylvania
10/12/2022	0	0	Fredericksburg/Spotsylvania	Spotsylvania
10/13/2022	3	1	King George	n.a
10/14/2022	4	2	Fredericksburg	Spotsylvania
10/15/2022	2	0	n.a	Stafford
10/16/2022	5	0	n.a	Spotsylvania/King George
10/17/2022	2	0	n.a	Spotsylvania
10/18/2022	2	0	n.a	Spotsylvania
10/19/2022	6	1	n.a	Spotsylvania/Stafford
10/20/2022	0	0	n.a	Stafford
10/21/2022	3	0	n.a	Spotsylvania
10/22/2022	0	0	n.a	Spotsylvania/Stafford
10/23/2022	0	0	n.a	Spotsylvania
10/24/2022	1	1	Spotsylvania	Spotsylvania
10/25/2022	3	3	Stafford (2) Caroline	Spotsylvania
10/26/2022	2	1	Fredericksburg	Spotsylvania
10/27/2022	0	0	n.a	Spotsylvania
10/28/2022	2	2	Spotsylvania	Spotsylvania/Stafford
10/29/2022	3	0	n.a	Spotsylvania
10/30/2022	3	1	Stafford	Spotsylvania
10/31/2022	3	0	n.a	Spotsylvania
Total	71	17		

Total Assessments at Center in October: 17

Brought by:		
Caroline	1	137
Fred City	3	983
Spotsylvania	6	937
Stafford	6	966
King George	1	122
Other	0	3

Cumulative Total:

Cumulative number of Assessment since September 2016: 3148

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Kari Norris, Emergency Services Coordinator
Date: November 1, 2022
Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – October, 2022

In October, Emergency Services staff facilitated nine admissions to state hospitals. Three individuals were admitted to Northern Virginia Mental Health Institute, one was admitted to Piedmont, one was admitted to Southern Virginia Mental Health Institute, and four were admitted to Commonwealth Center for Children and Adolescents. Two of the nine were committed at their bedside hearings in the emergency department and transported after being involuntarily committed.

A total of twenty individuals were involuntarily hospitalized outside of our catchment area in October. Three were able to utilize alternative transportation (AT).

Please see attached data reports.

600 Jackson Street
Fredericksburg, VA 22401
540-373-3223

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DATE: 11.1.22

Emergency Services Activity Reports

Month	Contacts	Evaluations	ECOs	TDOs Issued	TDOs Executed
May 2020	[redacted]	335	74	76	75
June 2020		396	91	81	80
July 2020		429	112	111	111
August 2020		401	90	82	81
September 2020		422	94	91	91
October 2020		492	113	85	85
November 2020		413	88	88	88
December 2020		373	75	79	79
January 2021		374	88	89	89
February 2021		358	84	83	83
March 2021		465	82	100	100
April 2021		449	92	100	100
May 2021		507	93	93	93
June 2021		453	95	95	92
July 2021		379	76	74	74
August 2021		394	86	77	77
September 2021		517	98	86	86
October 2021		422	60	72	72
November 2021		425	59	60	60
December 2021		401	67	66	66
January 2022		355	74	63	63
February 2022		442	87	64	64
March 2022		375	74	81	81
April 2022		390	85	87	87
May 2022		417	92	73	73
June 2022		342	75	66	66
July 2022		343	77	83	83
August 2022		367	79	76	76
Setpember 2022		341	66	76	76
October 2022		351	70	75	75

FY23 CSB/BHA Form (Revised: 06/28/2022)

CSB/BHA	Rappahannock Area Community Services Board	Month	October 2022

1) Number of Emergency Evaluations	2) Number of ECOs			3) Number of Civil TDOs Issued	4) Number of Civil TDOs Executed				5) Number of Criminal TDOs Executed
	Magistrate Issued	Law Enforcement Initiated	Total		Minor	Older Adult	Adult	Total	
351	36	34	70	76	11	5	60	76	0
			0					0	
			0					0	
			0					0	
			0					0	
			0					0	
			0					0	
			0					0	
			0					0	
			0					0	

FY '23 CSB/BHA Form (Revised: 06/28/2022)

CSB/BHA	Rappahannock Area Community Services B	Reporting month	October 2022		No Exceptions this month →	

Date	Consumer Identifier	1) Special Population Designation (see definition)	1a) Describe "other" in your own words (see definition)	2) "Last Resort" admission (see definition)	3) No ECO, but "last resort" TDO to state hospital (see definition)	
10/3/22	71045	Adult (18-64) with ID or DD		No	Yes	NVMHI
10/4/22	106395	Child		Yes	No	CCCA
10/4/22	3183	Older adult		Yes	No	Piedmont
10/6/22	46742			Yes	No	NVMHI
10/6/22	84403			Yes	No	SVMHI
10/17/22	97295			Yes	No	NVMHI
10/18/22	104687	Adolescent		No	Yes	CCCA
10/19/22	84597	Child		Yes	No	CCCA
10/30/22	78696	Adolescent		Yes	No	CCCA

ALTERNATIVE TRANSPORT DATA October 2022

Date	ID	LE DEPT	Location of Individual	Receiving Hospital	Travel time Round Trip (minutes)	ECO Y or N	Gender	Age	TDO criteria	Presented for AT: Y or N	Reason for Decline
10/1/22	73905	Spotsylvania	MWH-ED	Carillion Roanoke	384	Yes	M	16	Danger to self	No	Elopement Risk
10/2/22	102252	Stafford	MWH-ED	Pavillion	194	Yes	F	79	danger to self	Yes	AT Utilized
10/3/22	107897	Fairfax	MWH-ED	Dickenson	746	Yes	F	56	Inability to care	No	Elopement risk
10/3/22	71045	Spotsylvania	MWH-ED	NVMHI	104	no	F	47	Danger to self	No	Impulsive behaviors and continuing to attempt to self harm
10/4/22	106395	Spotsylvania	MWH-ED	CCCA	228	Yes	M	7	Danger to self and others	No	Highly Aggressive
10/4/22	97143	Spotsylvania	MWH-ED	Cumberland	168	Yes	F	15	Danger to others and inability to care	No	Aggressive towards family and staff
10/4/22	3183	Stafford	MWH-ED	Piedmont	224	Yes	F	74	Inability to care	No	
10/6/22	46742	Orange	MWH-ED	NVMHI	104	Yes	M	39	Inability to care	No	Highly assaultive towards LE
10/6/22	84403	Fredericksburg	MWH-ED	SVMHI	424	Yes	M	57	Inability to care	No	Post committed individual not appropriate
10/7/22	107932	Stafford	MWH-ED	St. Albans	430	no	F	73	Danger to self	No	No available driver
10/10/22	99771	Spotsylvania	MWH-ED	Kempsville	284	Yes	F	14	Danger to self	No	Assaultive towards police
10/14/22	107990	Spotsylvania	MWH-ED	Twin County	540	Yes	M	43	Danger to self	No	Had stand off with police; too resistant
10/14/22	108003	King George	Stafford ED	Lewis Gale	368	no	F	86	Inability to care	Yes	AT utilized
10/15/22	82755	Stafford	MWH ED	Riverside	240	no	F	25	Inability to care	No	Erratic and inappropriate behavior
10/16/22	68324	Spotsylvania	MWH-ED	Cumberland	168	Yes	F	14	Danger to others	Yes	AT utilized
10/17/22	108016	Spotsylvania	MWH-ED	Newport News	190	no	F	15	Danger to self	No	
10/17/22	97295	Stafford	MWH-ED	NVMHI	104	Yes	F	31	Inability to care	No	Post committed individual not appropriate
10/18/22	104687	King George	MWH-ED	CCCA	228	no	M	14	Danger to others; Inability to care	No	Aggressive with staff and urinating on self
10/19/22	84597	Stafford	MWH-ED	CCCA	228	Yes	M	11	Danger to self and others	No	Aggressive and sexually inappropriate
10/30/22	78696	Spotsylvania	MWH-ED	CCCA	228	Yes	F	13	Danger to self and others	No	Aggressive and non-cooperative

Total Out of Area

20

Total Utilizing AT	% Utilized	Total Appropriate for AT	
3	15%	2	10%

MEMORANDUM

To: Joe Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance and Human Rights
Date: November 1, 2022
Re: October 2022 Waiting Lists

Identified below you will find the number of individuals who were on a waiting list as of October 31, 2022.

OUTPATIENT SERVICES

- Clinical services: As of October 31, 2022, there are 236 individuals on the wait list for outpatient therapy services.
  - Waiting list is defined as having to wait 30 calendar days or more to be offered an appointment.
    - Due to an increase in request for outpatient services the Fredericksburg Clinic implemented a waitlist for new clients seeking outpatient services beginning October 5, 2021 and the Spotsylvania Clinic implemented a waitlist beginning May 2022. Individuals are placed on the wait list if they cannot be seen at a regularly scheduled appointment within 30 days of request. Individuals who fall in a priority category are seen during open access.
      - The waitlist in Fredericksburg is currently at 186 clients.
      - The waitlist in Spotsylvania is currently at 50 clients.
      - This is a decrease of 46 from the September 2022 waitlist.

    - If an individual is not in a priority category the following may occur: 1) he or she may be placed on a waiting list and called weekly by a therapist to review presenting situation, individuals are then offered an appointment as one becomes available; 2) if an individual has private insurance staff will assist in locating a private provider if the individual does not wish to wait for an appointment. Staff are working to avoid scheduling an individual too far into the future as this increases the likelihood of no-shows.

  - Clinical services are initiated through Same Day Access. Due to COVID-19 concerns, Same Day Access appointments are scheduled versus having multiple individuals come to the clinic and having to wait for their appointment time. Same Day Access schedules are as follows:

    - Fredericksburg Clinic: Monday, Wednesday, and Thursday 8:30a.m. to 2:30 pm
      Tuesday 9:30am – 2:30PM
    - King George Clinic: Tuesday-1:00 pm-5:00 pm and Wednesday- 8:00 am- 12:00 pm
    - Stafford Clinic: Tuesday and Thursday 9:00 am – 12:00 pm
    - Spotsylvania Clinic: Tuesday, Wednesday, and Thursday 9:00 am – 2:00 pm
    - Caroline Clinic: Tuesday and Thursday 8:30am – 11:30 am

- Psychiatry intake: As of November 1, 2022, there are seven older adolescents and adults waiting longer than 30 days for their intake appointment. This is an increase of seven from the September 2022 waitlist. The furthest out appointment is 12/28/2022. There are zero children age 13 and below waiting longer than 30 days for their intake appointment.

PSYCHIATRY INTAKE – As of November 1, 2022 the number of individuals waiting longer than 30 days for a regularly scheduled psychiatric intake appointment include:

	Adults	Children: Age 13 and below
o Fredericksburg –	9 (4)	0 (0)
o Caroline –	1 (0)	0 (0)
o King George –	0 (0)	0 (0)
o Spotsylvania –	0 (0)	0 (0)
o Stafford –	1 (0)	0 (0)
Total	**11 (4)**	**0 (0)**

	Appointment Dates
Fredericksburg Clinic	
	12/1/2022 12/2/2022 12/2/2022 12/5/2022 12/12/2022 12/15/22 12/20/22 12/27/22 12/28/22
Caroline Clinic	
	12/6/2022
King George	
	N/A
Spotsylvania Clinic	
	N/A
Stafford Clinic	
	12/5/22

Community Support services:

Waitlist Definitions

Needs List - A person is placed on the Needs List when an individual, family member, RACSB staff, or external agency notifies that particular program service that the individual needs services provided by that program.

Referral - Persons are placed on this Referral List when services have been requested and all necessary documentation for the referral process is submitted to the program Coordinator. At this time, the person is placed on the Referral List and removed from the Needs List.

All referrals are sent to the Coordinator for initial review. The Coordinator determines that all information is in the packet and makes a disposition for acceptance, rejection, or assessment. The Coordinator will forward the referral packet to the appropriate staff for assessment. Time frame for completion of assessment is also be indicated.

If the assessment leads to acceptance the client will be placed on the acceptance list. If the assessment leads to a decision which does not involve acceptance, the program Coordinator will reach a decision about disposition of the referral.

Acceptance List - This list includes the names of all persons who have been assessed for services and accepted to the program. These individuals are waiting for appropriate supports.

MH RESIDENTIAL SERVICES - 2

Needs List: 0
Referral List: 2
Acceptance List: 0

Count by County:

Caroline	0
King George	0
Fredericksburg	0
Spotsylvania	0
Stafford	2

One individual is a transitional referral and is currently completing 48-hour passes at Home Road. He is NGRI and is required to complete 8 successful passes prior to discharge. Passes should be completed by mid-November.

Intellectual Disability Residential Services – 96

Needs List: 91
Referral List: 3
Acceptance List: 2

Count by County:

Caroline	11
King George	8
Fredericksburg	7
Spotsylvania	32
Stafford	38

Of the 2 individuals on the acceptance list, 1 is tentatively scheduled to move into New Hope on November 1, 2022. A meeting is being set within the next 2 weeks with the family of the second individual, who has been accepted to Scottsdale, to discuss program information and to set a move in date

Assertive Community Treatment (ACT)– 12

Caroline: 1
Fredericksburg: 3
King George: 0
Spotsylvania: 2
Stafford: 3
Homeless/Unknown/Incarcerated/Hospitalized: 3

Total Needs: 6
Total Referrals: 6
Total Acceptances: 0

Total program enrollments = 56

Admissions: 0

Discharges: 2

- During the month of October, ACT SOUTH will discharge a client who found a full-time job has reliable transportation and continues to maintain stable housing. He requested to return to agency adult case management, as he no longer needed the intensity of ACT Services. This client was very pleased to receive a certificate of graduation from ACT.
- A second ACT client will be discharged because he has been incarcerated in DC Corrections for over a year. ACT staff has contacted DC corrections weekly regarding the status of his incarceration.
- Both programs plan to enroll potential referrals next month. We have an appointment scheduled at Snowden and a home visit for a state hospital discharge.
- In addition, ACT NORTH continues to have one client at RRJ.

ID/DD Support Coordination

There are 766 individuals on the waiting list for a DD waiver.

P-1 296
P-2 175
P-3 295

MEMORANDUM

To: Joseph Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance & Human Rights

Date: October 28, 2022

Re: Quality Assurance Report

The Quality Assurance (QA) staff completed chart reviews for the following Rappahannock Area Community Services Board (RACSB) programs:

- Substance Abuse Out Patient- Fredericksburg
- Devon Drive Developmental Disability Group Home
- Ruffins Pond Developmental Disability Group Home

Substance Abuse Out Patient- Fredericksburg

There was three staff members responsible for the randomly selected charts.

Findings for the ten open and two closed charts reviewed for Substance Abuse Out Patient- Fredericksburg was as follows:

- Ten charts were reviewed for Assessment compliance:
  - **Discrepancies noted with Assessments:**
    - Five charts were missing the Daily Living Activities 20 (DLA 20).
- Ten charts were reviewed for Individual Service Plan (ISP) compliance:
  - **Discrepancies noted with Service Plan:**
    - Three charts were missing ISPs.
    - Four charts were missing signatures/Covid Statements.
- Ten charts were reviewed for Progress Note compliance:
  - **Discrepancies noted with Progress Notes:**
    - Ten charts contained notes which were completed more than 24hrs late.
- Ten charts were reviewed for Quarterly Review compliance:
  - **Discrepancies noted with Quarterly Reviews:**
    - Three charts were missing quarterly reviews.
- Ten charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - Three charts were missing Consumer Orientations.
    - One chart was missing Emergency Contact.
- Two charts were reviewed for Discharge compliance:
  - **Discrepancies noted with Documentation:**
    - One chart was missing a discharge summery.

Comparative Information:

- In comparing the audit reviews of the Substance Abuse Out Patient Services-Fredericksburg charts from the previous audits to the current audits, the average score decreased from 70 to 64 on a 100-point scale.

- **Corrective Action Plan:**
  Staff will complete the missing discharge summaries. Staff will complete documentation daily. The unposted/draft note reports will be forwarded to clinicians each time sent. Charts will be reviewed in each supervision to identify upcoming documentation/missing documentation and a timeline to ensure completion. Previously discussed documentation needs are followed up on in each supervision. Staff will schedule time to complete upcoming paperwork on Avatar calendar. This will be ongoing.

Devon Drive Developmental Disability Group Home

There was one staff member responsible for the selected charts.

Findings for the four open charts reviewed for Devon Drive Developmental Disability Group Home was as follows:

- Four charts were reviewed for Documentation compliance:
  - There were no noted discrepancies found.
- Four charts were reviewed for Individual Service Plan:
  - There were no noted discrepancies found.
- Four charts were reviewed for Quarterly Review compliance:
  - There were no noted discrepancies found.
- Four charts were reviewed for Progress Note compliance:
  - **Discrepancies noted with Progress Notes:**
    - Four charts contained multiple notes written more than 24hrs late.
- Four charts were reviewed for Medical compliance:
  - **Discrepancies noted with Medical:**
    - Multiple Prescriptions in one chart was missing.

Comparative Information:

- In comparing the audit reviews of the Devon Drive Developmental Disability Group Home charts from the previous audits to the current audits, the average score increased from 50 to 89 on a 100-point scale.

Corrective Action Plan:

- Corrective supervision and coaching have been completed with the program manager as of 9/26/22 to ensure charting is complete and timely, including current script requirements for all individuals. Case note timeframes/expectations have also been discussed with the manager to impart to the Devon Drive team.
- Each of these standards had been set forth as program expectations through weekly DD Residential Supervisor meetings, supervision, offered training opportunities, and through nurse audits of charting. (See notes in spreadsheet for corrections made and to be made to the charting.)

- Charting and documentation expectations will continue to be reinforced through documented supervision and through the peer auditing and supervision processes to help ensure compliance. Additionally, 1:1 training will be available as needed to help ensure quality.
- Should there be further issue with meeting these expectations, progressive corrective action will be issued.
- Oversight and corrective action will continue to be overseen by the DD Residential Coordinator, the DD Assistant Coordinators, and once the position has been filled, the RN Manager.

Ruffins Pond Developmental Disability Group Home

Findings for the five open charts reviewed for Ruffins Pond Developmental Disability Group Home was as follows:

- Five charts were reviewed for Documentation compliance:
    - **Discrepancies noted with Documentation compliance:**
        - One chart was missing Authorized Representative documentation.
        - Two charts contained expired releases.
        - Two charts contained expired program agreements.
- Five charts were reviewed for Individual Service Plan:
    - There were no noted discrepancies found.
- Five charts were reviewed for Quarterly Review compliance:
    - There were no noted discrepancies found.
- Five charts were reviewed for Progress Note compliance:
    - There were no noted discrepancies found.
- Five charts were reviewed for Medical compliance:
    - There were no noted discrepancies found.

Comparative Information:

- In comparing the audit reviews of the Ruffins Pond Developmental Disability Group Home charts from the previous audits to the current audits, the average score increased from 64 to 91 on a 100-point scale.

Corrective Action Plan:

- Corrective supervision and coaching have been completed with the program manager as of 10/24/2022 to ensure charting is complete and timely. Focusing on the timeliness of releases and program agreements were points of emphasis.
- Each of these standards had been set forth as program expectations through weekly DD Residential Supervisor meetings, supervision, offered training opportunities, and through nurse audits of charting. (See notes in spreadsheet for corrections made and to be made to the charting.)
- Charting and documentation expectations will continue to be reinforced through documented supervision and through the peer auditing and supervision processes to help ensure compliance.
- Should there be further issue with meeting these expectations, progressive corrective action will be issued.
- Oversight and corrective action will continue to be overseen by the DD Residential Coordinator and the DD Assistant Coordinators.