hopestarter RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

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

NOTICE

To: Program Planning and Evaluation Committee
Jacob Parcell (Chair), Nancy Beebe, Glenna Boerner, Claire Curcio, Ken Lapin, Sarah Ritchie, Carol Walker, Matt Zurasky, Bridgette Williams

From: Joseph Wickens
Executive Director

Subject: Program Planning and Evaluation Meeting
September 12, 2023, 10:00 AM
600 Jackson Street, Board Room 208, Fredericksburg, VA

Date: September 6, 2023

A Program Planning and Evaluation Committee Meeting has been scheduled for Tuesday, September 12, 2023 at 10:00 AM. The meeting will be held at 600 Jackson Street, Board Room 208, Fredericksburg VA 22401.

Looking forward to seeing everyone on Tuesday at 10:00 AM.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Program Planning and Evaluation Committee Meeting

September 12, 2023 – **10:00 AM**

600 Jackson Street, Room 208 Fredericksburg, VA 22401

AGENDA

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: September 12, 2023

RACSB currently has no individuals on the Extraordinary Barriers List (EBL). 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.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Donna Andrus, Child and Adolescent Support Services Supervisor
Date: September 5, 2023
Re: Independent Assessment Certification and Coordination Team (IACCT) Update
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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 twenty-four IACCT referrals in the month of August and completed twenty assessments. One no-showed, two discharged home prior to the reassessment due date and one reauthorization has not been completed yet. Nine referrals were initial IACCT assessments and fifteen were re-authorizations in August. Twelve were from Spotsylvania, six from Stafford, two from Caroline, four from King George and none from the City of Fredericksburg. Of the nineteen completed assessments eighteen recommended Level C Residential and two recommended Level B Group Home.

DMAS has contracted with Kepro/Acentra to oversee the IACCT process starting November 1st. Magellan will no longer be managing the IACCT process. RACSB staff will attend training on the transition once dates have been scheduled, will review the current workflow and train staff on any new steps.

Attached is the monthly IACCT tracking data for August 2023.

Report Month/Year	Aug-23
1. Total number of Referrals from Magellan for IACCT:	24
1.a. total number of auth referrals:	9
1.b. total num. of re-auth referrals:	15
2. Total number of Referrals per county:	
Fredericksburg:	0
Spotsylvania:	12
Stafford:	6
Caroline:	2
King George:	4
Other:	0
3. Total number of extensions granted:	4
4. Total number of appointments that could not be offered within the prescribed time frames:	0
5. Total number of "no-shows":	1
6. Total number of cancellations:	0
7. Total number of assessments completed:	20
8a. Total number of ICA's recommending: **residential:**	18
8b. Total number of ICA's recommending: **therapeutic group home:**	2
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: Nathan Reese, IT Coordinator

Re: Information Technology and Electronic Health Record Update

Date: September 5, 2023

This report provides an update on projects related to Information Technology and the Electronic Health Record. 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 August, 883 tickets where closed by IT Staff compared to July -965, June- 1,028, May - 1,006, April – 910, March – 1098, February – 1050, and January – 983. In 2022, the IT department averaged closure of 1,023 tickets per month.

Community Consumer Submission 3

The fiscal year 2023 CCS was submitted on July 28, 2023.

Waiver Management System (WaMS)

The WaMS 3.4 "New" extract has been working as expected since June 2023. IT & Netsmart are still working through the additional extracts, "Discard" & "Update", since we were not able to test during the normal testing window. The WaMS vendor is keeping their test system running without helpdesk support outside the normal testing window.

Trac-IT Early Intervention Data System

There remain system-wide concerns related to the increased number data requirements which will be required as of December 11, 2023. The VACSB met with DBHDS to discuss concerns with the number of required data elements which have not been tied to any regulation or reporting requirement which greatly expands the administrative costs and burdens. DBHDS has not provided any additional funding specifically for managing the increased expectations.

Starting May 6, 2023, Netsmart State reporting, PEID, and IT staff began participating in the Trac-IT EHR committee to discuss the technical aspects of Trac-IT interoperability. This group meets monthly with the goal of producing a collaboratively developed process to facilitate the data exchange between Avatar and Trac-IT.

Thank you to Board Members for their advocacy with the letter to the Commissioner regarding concerns with TRAC-IT. As of this report, we have received no response from DBHDS.

Zoom

We continue to utilize Zoom for telehealth throughout the agency. Zoom meeting for Medical staff have decreased significantly, with providers moving to more in person appointments.

- August 2023 – 2,072 video meetings with a total of 5,305 participants
- July 2023 – 1,584 video meetings with a total of 4.067 participants
- June 2023 – 1,847 video meetings with a total of 4,881 participants
- May 2023 – 1,935 video meetings with a total of 5,173 participants
- April 2023 – 2,410 video meetings with a total of 6,685 participants
- March 2023 – 2,821 video meetings with a total of 7,479 participants
- February 2023 – 2,475 video meetings with a total of 6,731 participants
- January 2023 – 2,402 video meetings with a total of 6,668 participants
- Average from January to December 2022 was 2,800 video meetings and 8,154 Participants

- Average from January to December 2021 was 3,648 video meetings and 11,087 Participants

Avatar

Bells implementation with RAAI continues. RAAI is now piloting Bells with live notes in Avatar, with their Stafford location. Once the Stafford team successfully impliments Bells, RAAI will start implementation with other locations.

Patient Portal 2.0 project kicked off on July 26th 2023. IT and program supervisors are meeting weekly with the Netsmart team to review new workflows and features.

Staffing

Taylor Nash started as the Assistant IT Coordinator on September 5, 2023.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Natasha Randall, Acting Emergency Services Coordinator
Date: September 7, 2023
Re: Crisis Assessment Center and CIT report August 2023

The CIT Assessment Center assessed 24 individuals in the month of August 2023. The number of persons served by locality were the following: Fredericksburg 8; Caroline 1; King George 1; Spotsylvania 8; Stafford 5; 1 other.

Please see attached CIT data sheet

August 2023 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
8/1/2023	0	0	n.a	Spotsylvania
8/2/2023	1	0	Stafford	Spotsylvania
8/3/2023	0	0	n/a	Stafford/Spotsylvania
8/4/2023	1	1	Stafford	Stafford/Spotsylvania
8/5/2023	1	0	Spotsylvania	Spotsylvania
8/6/2023	4	0	Stafford; Spotsylvania(2)	Spotsylvania
8/7/2023	1	0	Stafford	Spotsylvania
8/8/2023	3	1	Stafford	Spotsylvania
8/9/2023	4	0	Fredericksburg; Spotsylvania(2);King George	Spotsylvania
8/10/2023	3	3	Fredericksburg; Caroline(2)	Spotsylvania
8/11/2023	1	1	Fredericksburg	Spotsylvania
8/12/2023	1	1	Spotsylvania	Spotsylvania/Stafford
8/13/2023	2	2	Frederickburg;Stafford	Spotsylvania
8/14/2023	3	0	Caroline; Spotsylvania; Stafford	Spotsylvania
8/15/2023	3	0	Fredericksburg(2); Spotsylvania	Spotsylvania/King george
8/16/2023	3	1	Fredericksburg(2); Spotsylvania	Spotsylvania
8/17/2023	2	2	Fredericksburg; Stafford	Spotsylvania/Stafford
8/18/2023	4	1	Fredericksburg; Stafford(2);Spotsylvania	Spotsylvania
8/19/2023	1	1	Stafford	Spotsylvania/Fredericksburg
8/20/2023	2	1	Spotsylvania	Spotsylvania/Stafford
8/21/2023	2	0	Fredericksburg	Spotsylvania/Fredericksburg
8/22/2023	5	0	Fredericksburg(3); King George;Stafford; Spots	Spotsylvania/Stafford
8/23/2023	6	1	Spotsylvania(2);Fredericksburg(2),Stafford(2)	Spotsylvania
8/24/2023	0	0	n.a	Spotsylvania
8/25/2023	0	0	n/a	Spotsylvania
8/26/2023	1	1	Spotsylvania	Spotsylvania
8/27/2023	3	2	Caroline; Stafford	Spotsylvania/Fredericksburg
8/28/2023	3	2	Fredericksburg(2); Spotsylvania	Spotsylvania
8/29/2023	6	2	Spotsylvania(4); Fredericksburg(2)	Spotsylvania
8/30/2023	2	1	Spotsylvania(2)	Spotsylvania
8/31/2023	0	0	n.a	Spotsylvania/
Total	68	24		

Total Assessmen at Center in August: 24

Brought by:		**Cumulative Total:**
Caroline	0	149
Fred City	9	1030
Spotsylvania	8	991
Stafford	5	1036
King George	1	128
Other	1	5

Cumulative number of Assessment since September 2016: 3339

MEMORANDUM

To: Joe Wickens, Executive Director
From: Natasha Randall, Acting Emergency Services Coordinator
Date: September 5, 2023
Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – August, 2023

In August 2023, Emergency Services staff completed 329 emergency evaluations. Seventy-eight individuals were assessed under emergency custody orders and sixty-six total temporary detention orders were issued and served. Staff facilitated zero admissions to a state hospital.

A total of eight individuals were involuntarily hospitalized outside of our catchment area in August. Two individuals were able to utilize alternative transportation.

Please see attached data reports.

Month		Evaluations	ECOs	TDOs Issued	TDOs Executed
Oct-21		422	60	72	72
Nov-21		425	59	60	60
Dec-21		401	67	66	66
Jan-22		355	74	63	63
Feb-22		442	87	64	64
Mar-22		375	74	81	81
Apr-22		390	85	87	87
May-22		417	92	73	73
Jun-22		342	75	66	66
Jul-22		343	77	83	83
Aug-22		367	79	76	76
Sep-22		341	66	76	76
Oct-22		351	70	75	75
Nov-22		359	69	73	73
Dec-22		296	55	51	51
Jan-23		389	81	86	86
Feb-23		340	65	67	67
Mar-23		406	83	93	93
Apr-23		325	65	78	78
Jun-23		275	57	65	65
Jul-23		296	69	66	66
23-Aug		329	78	66	66

FY24 CSB/BHA Form (Revised: 07/10/2023)

CSB/BHA	Rappahannock Area Community Services Board	Month	August 2023

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	
329	25	53	78	66	3	3	60	66	0

FY '24 CSB/BHA Form (Revised: 07/10/2023)						
CSB/BHA	Rappahannock Area Community Services	Reporting month	August 2023		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)	4) Additional Relevant Information or Discussion (see definition)

Alternative Transport Data August 2023

Date	ID	LE Dept	Location of Individual	Receiving Hospital	Travel time Round Trip	ECO (Y or N)	Gender	Age	TDO Criteria	Presented for AT: Y or N	Reason for Decline
8/6/2023	43229	Spotsylvania	MWH ED	Green Oak	746	Y	m	61	inability to care	Yes	Prior refusal of AT
8/9/2023	111151	Spotsylvania	MWH ED	Dominion	120	Y	f	17	danger to self	Yes	aggression
8/10/2023	111288	Fredericksbug	MWH ED	St. Mary Hospital	120	n	M	31	danger to self	Yes	elopement risk
8/11/2023	111297	Fredericksbug	MWH medical floor	Clearview	644	N	M	63	psychosi;lack capaci	No	aggression
8/11/2023	110881	Spotsylvania	MWH ED	Cumberland	160	Y	M	16	danger to self	Yes	client to unpredictable
8/12/2023	39077	Spotsylvania	MWH ED	Clearview	644	Y	M	32	danger to self	Yes	impulsivity

Memorandum

To: Joe Wickens, Executive Director

From: Amy Jindra, CSS Director

Date: September 6, 2023

Re: Transportation Services

Prior to the onset of the COVID 19 pandemic, RACSB provided transportation services for individuals to attend RAAI or Kenmore Club day programs. Pandemic protocols for congregant settings significantly impacted the need for day programming transportation. Since RAAI's and Kenmore Club's return to full operation in 2021, individuals have utilized private Medicaid transportation providers. While individuals are fully utilizing other services, the need for agency fleet maintenance, management, driving and wheelchair procedure trainings continues.

Currently, transportation services consist of the transportation supervisor and an office associate. The office associate has been temporarily reassigned to support CSS and Clinical division directors. Transportation leases offices at the Rappahannock Area on Aging Healthy Generations office building. The $1275 monthly rent consists of the use of two offices and the parking lot.

While the role of the transportation supervisor shifted from managing routes, a limited fleet, trainings, and Medicaid reimbursement/billing processes, the need for the role continues. The transportation supervisor completes annual grants for vehicle replacement. For the last grant application, the agency received 3 full size vans with wheelchair lifts that equated to a savings of $192,000. The supervisor also provides START, Wheelchair Lift, DMV, and program specific driving trainings for the entire Agency. The transportation supervisor also manages the entire fleet's maintenance. Programs are able to prioritize client care over time at a mechanics or other vehicle maintenance. In addition, the supervisor's role also includes establishing business relationships with dealerships, body and repair shops, detailing, and other vehicle maintenance. He also manages insurance processes for the vehicles.

Transportation Services evolved during the pandemic to provide much needed program support. Consequently, I recommend officially recognizing the transition of transportation department to solely program support. I also recommend the permanent reassignment of the office associate to CSS/Clinical Division Directors. The current transportation office should also remain. The location provides safe storage/parking for agency vehicles, access to local mechanics, and central proximity to agency programs. I would recommend reassigning the second office at Healthy Generations to another RACSB program/department or pursuing a reduction in lease amount to forfeit the use of that space.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance and Human Rights
Date: September 5, 2023
Re: August 2023 Waiting Lists

Identified below you will find the number of individuals who were on a waiting list as of August 31, 2023.

OUTPATIENT SERVICES

- Clinical services: As of August 31, there are 158 individuals on the wait list for outpatient therapy services.
    - 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.
        - 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, the Spotsylvania Clinic implemented a waitlist beginning May 2022, and the Caroline Clinic implemented a waitlist beginning November 2022.
            - The waitlist in Fredericksburg is currently at 6 clients.
            - The waitlist in Spotsylvania is currently at 61 clients.
            - The waitlist in Caroline is currently at 91 clients.
            - This is a decrease of 11 from the July 2023 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 September, 2023, there are seven older adolescents and adults waiting longer than 30 days for their intake appointment. This is an increase of six from the August 2023 waitlist. The furthest out appointment is 12/4/2023. There are no children age 13 and below waiting longer than 30 days for their intake appointment.

PSYCHIATRY INTAKE – As of September 5, 2023 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 –	2 (0)	0 (0)
o Caroline –	2 (0)	0 (0)
o King George –	2 (1)	0 (0)
o Spotsylvania –	1 (0)	0 (0)
o Stafford –	0 (0)	0 (0)
Total	**7 (1)**	**0 (0)**

	Appointment Dates
Fredericksburg Clinic	
	11/17/23 12/4/23
Caroline Clinic	
	10/11/23 10/20/23
King George	
	10/17/23 11/13/23
Spotsylvania Clinic	
	10/12/23
Stafford Clinic	
	N/A

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 all persons who have been assessed for services and accepted to the program. These individuals are waiting for appropriate supports.

MH RESIDENTIAL SERVICES - 3

Needs List: 0
Referral List: 3
Acceptance List: 0

Count by County:

Caroline	0
King George	0
Fredericksburg	0
Spotsylvania	0
Stafford	2
Other	1

There is one vacant transitional bed at this time, with two transitional referrals. One individual is hospitalized at WSH and is required to complete 8 passes at Home Road, which he started on August 7. The other individual is also hospitalized at WSH and is required to complete 8 passes at Kenmore Club prior to starting passes at Home Road. She has not yet begun passes at Kenmore Club, but is expected to do so in September. By the time she is able to start passes at Home Road, we are expected to have an additional vacant transitional bed at Home Road.

The one individual for a community bed is currently on a trial pass at Lafayette Boarding House. A second pass is being scheduled for the week of August 28.

Intellectual Disability Residential Services – 70

Needs List: 69
Referral List: 1
Acceptance List: 1

Count by County:

Caroline	7
King George	4
Fredericksburg	7
Spotsylvania	22
Stafford	30

Assertive Community Treatment (ACT)– 15

Caroline: 0
Fredericksburg: 8
King George: 1
Spotsylvania: 3
Stafford: 3

Total Needs: 10
Total Referrals: 5
Total Acceptances: 0

Total program enrollments = 51

Admissions: 0
Discharges: 0

ACT SOUTH attempted to enroll a client earlier this month. However, he came to the office the day after the scheduled appointment. This potential client was admitted to Snowden the following week for unspecified psychosis. Upon discharge from Snowden, this potential client expressed his interest with moving forward with enrollment in ACT. He is scheduled to be enrolled in ACT South tomorrow. It should be noted he's also been approved for an apartment with our Permanent Supportive Housing program. He's scheduled to move into his apartment in September. He's been living in motels for the past several months.

We currently have three clients in our program who are hospitalized at Snowden. They each have been receiving intensive supports from ACT on a daily basis. These supports include medication management, wellness checks and community engagement. Our staff has been in contact with their case manager at Snowden for updates and discharge planning. The ACT Coordinator continues to attend weekly meetings with Snowden staff and other RACSB providers to discuss services which support client recovery.

ID/DD Support Coordination

There are currently 824 individuals on the DD Waiver Waiting List. This is a decrease of 25 from last month. There were 33 individual awarded waivers during the month of August.

P 1 – 347
P2 – 194
P3 – 283

RAAI – 37

Caroline: 3
Fredericksburg: 1
King George: 3
Spotsylvania: 9
Stafford: 15
Other: 6

Total Referrals: 26
Total Assessing: 8
Total Acceptances (waiting to add more days): 4

Total program enrollments = 112 (3 new admissions in August)

MEMORANDUM

To: Joe Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance and Human Rights

Date: September 5, 2023

Re: Licensing Reports

The Department of Behavioral Health and Developmental Services' (DBHDS) Office of Licensing issues licensing reports for areas in which the Department finds agencies in non-compliance with applicable regulations. The licensing report includes the regulatory code which applies to the non-compliance and a description of the non-compliance. The agency must respond to the licensing report by providing a corrective action plan (CAP) to address the areas of noncompliance.

Rappahannock Area Community Services Board (RACSB) obtained approval for two Corrective Action Plans (CAPs) during the month of August 2023. Myers Respite Program received a report due to a substantiated allegation of neglect. Home Road Supervised Apartment Program received a report due to the late reporting of an incident.

The attached CAP provides addition details regarding the citation and RACSB's response.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-012**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-20-2023**
Program Type/Facility Name: **01-012 Home Rd. Apartments**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-160. D. (2) - The provider shall collect, maintain, and report or make available to the department the following information: 2. Level II and Level III serious incidents shall be reported using the department's web-based reporting application and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Reported information shall include the information specified by the department as required in its web-based reporting application, but at least the following: the date, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's injuries or	N	Home Rd. Apartments This regulation was NOT MET as evidenced by: CHRIS Number: 20230160 Date/Time of Discover: 06/30/2023 2:00PM Enter Date/Time: 07/03/2023 1:19PM Reporting Delay: 47:19:00 Location Name: Home Rd. Apartments	PR) 08/10/2023 PR: Staff involved indicated confusion about documenting an IR due to the injury initially occurring offsite and the individual initially declining medical attention. PR: Program supervisor provided training for staff involved. Supervisor also addressed the situation with staff during July staff meeting. Program also included in training regarding enhanced communication for clients involved in multiple programs. Additional 1:1 supervision with staff involved will occur by 8/18/23. PR: SAP program managers and assistant managers will monitor remediation efforts for delayed reporting. They will provide on call support for after hour incidents and medical needs. Daily monitoring will occur for the medical needs of the program residents. PR: by 8/18/23 individual supervision will occur. OLR) Accepted 08/28/2023	8/18/2023

License #: **101-01-012**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-20-2023**
Program Type/Facility Name: **01-012 Home Rd. Apartments**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
circumstances of the death and any treatment received. For all other Level II and Level III serious incidents, the reported information shall also include the consequences that resulted from the serious incident. Deaths that occur in a hospital as a result of illness or injury occurring when the individual was in a licensed service shall be reported.				

General Comments / Recommendations:

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

Lakesha Steele, Incident Management Unit	(Signature of Organization Representative)	Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

License #: **101-01-036**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-19-2023**
Program Type/Facility Name: **01-036 Myers Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-150. (4) - The provider including its employees, contractors, students, and volunteers shall comply with: 4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board;	N	Myers Drive This regulation was NOT MET as evidenced by: See OHR citations below:		
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation.	N	Myers Drive This regulation was NOT MET as evidenced by: CHRIS #20230039/Incident date: 6.18.2023 "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. • Provider substantiated neglect due to the following: ◦ Individual #1 has moderate to severe oral dysphasia and requires direct supports with meals/ hydration to prevent choking and aspiration (this individual cannot hold a cup/fork/etc). ◦ Individual #1 is on a pureed/nectar-consistency diet and spoon-fed liquids, and the plan states "regular" hydration	PR) 07/26/2023 PR: The staff member responsible for this incident was immediately put on administrative leave pending the outcome of an internal investigation upon discovery of the allegation. Upon substantiation of the neglect allegation following the investigation procedures, the staff member responsible for the incident, who had requested to drop to a PRN position was denied this request and she separated from employment with the agency effective 6/26/23. Programmatically, all staff will review and sign off attesting to their understanding of each individual's person-centered plan and those expectations included within to ensure they are providing for the health, safety, care, and well-being of each individual. Person centered practices and needs of individuals will be discussed in team meetings to ensure supports are	8/1/2023

License #: **101-01-036**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-19-2023**
Program Type/Facility Name: **01-036 Myers Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		opportunities; Employee #1 did not offer. Failure to provide treatment and services necessary to the health and safety of the individual is a violation of 12VAC35-115-50(B)(2).	consistently met. Systematically, Human Resources will continue to conduct mandated background checks and ensure at onboarding that no barrier crimes are present in the past of any potential employee. All RACSB staff, volunteers, and contractors will be required to undergo an annual Human Rights training to help ensure continued promotion and support of individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency orientation. The program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor incident reports and any allegations or reports of human rights violations on a daily	

License #: **101-01-036**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-19-2023**
Program Type/Facility Name: **01-036 Myers Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			basis to help ensure systematically that incidents of this nature are identified and mitigated quickly. Any staff member suspected or alleged to violate the Code of Virginia and any related human rights regulations adopted by the state board will immediately be put on administrative leave pending the outcome of an investigation. Date of completion: Start 8/1/23 and continue indefinitely thereafter OHR/OLR) Accepted 07/27/2023	

General Comments / Recommendations:

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

Cassie Purtlebaugh, Human Rights | (Signature of Organization Representative) | Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

MEMORANDUM

To: Joseph Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance & Human Rights

Date: August 2023

Re: Quality Assurance Report

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

- Rappahannock Adult Activities, Inc. (RAAI): Kings Highway
- Rappahannock Adult Activities, Inc. (RAAI): King George
- Rappahannock Adult Activities, Inc. (RAAI): Spotsylvania

Rappahannock Adult Activities, Inc. (RAAI): Kings Highway

There were two staff members responsible for the selected charts.

Findings for the ten open charts reviewed for Rappahannock Adult Activities, Inc. (RAAI): Kings Highway were as follows:

- Ten charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - One chart was missing the Individual Service Authorization Request (ISAR).
    - Three charts were missing the Program Agreement.
    - Two charts were missing Releases.

- Ten charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plan:**
    - One chart was missing the AR Representative signature.

- Ten charts were reviewed for Quarterly Review compliance:
  - **No discrepancies noted with Quarterly Review.**

- Ten charts were reviewed for Progress Note compliance:
  - **No discrepancies noted with Progress Note Review.**

- Ten charts were reviewed for Medical compliance:
  - **Discrepancies noted with Medical:**
    - One chart had a medication prescription missing.

Comparative Information:

In comparing the audit reviews of Rappahannock Adult Activities, Inc. (RAAI): Kings Highway charts from the previous audits to the current audits, the average score decreased from 95 to 94 on a 100-point scale.

Corrective Action Plan:

-All missing items have been scanned in by 6/30/23 or requested from the Support Coordinator.

-Retraining will be completed on responsibility of RAAI staff for documents for those individuals who have SC outside of RACSB on 7/26/23.

-Corrective action according to RACSB policy will be issued to responsible staff for items not in Avatar at time of the audit.

-Asst Coordinator will oversee training and ensure corrections.

Rappahannock Adult Activities, Inc. (RAAI): King George

There was one staff member responsible for the selected charts.

Findings for the ten open charts reviewed for Rappahannock Adult Activities, Inc. (RAAI): King George were as follows:

- Ten charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - Five charts were missing the Program Agreement.
    - Five charts were missing Releases.

- Ten charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plan:**
    - Seven charts were missing the Schedule of Supports.
    - One chart was missing Guardian / AR Signatures.

- Ten charts were reviewed for Quarterly Review compliance:
  - **No discrepancies noted with Quarterly Review.**

- Ten charts were reviewed for Progress Note compliance:
  - **No discrepancies noted with Progress Notes.**

- Ten charts were reviewed for Medical compliance:
  - **No discrepancies noted with Medical.**

Comparative Information:
In comparing the audit reviews of Rappahannock Adult Activities, Inc. (RAAI): King George charts from the previous audits to the current audits, the average score remained the same at 91 on a 100-point scale.

Corrective Action Plan:

-All missing items have been scanned in by 6/30/23 or requested from the Support Coordinator.

-Retraining will be completed on responsibility of RAAI staff for documents for those individuals who have SC outside of RACSB on 7/26/23.

-Corrective action according to RACSB policy will be issued to responsible staff for items not in Avatar at time of the audit.

-Asst Coordinator will oversee training and ensure corrections.

Rappahannock Adult Activities, Inc. (RAAI): Spotsylvania

There was one staff member responsible for the selected charts.

Findings for the ten open charts reviewed for Rappahannock Adult Activities, Inc. (RAAI): Spotsylvania were as follows:

- Ten charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - One chart was missing the Risk Assessment, VIDES (Virginia Individual Developmental Disability Eligibility Survey) and Consumer Orientation. *Typically the responsibility of support coordination, however individual does not have SC with RACSB, auditor was unable to locate where staff reached out to SC for that documentation
    - One chart was missing Level of Functioning (LOF)
    - One chart was missing program agreement

- Ten charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plan:**
    - One chart was missing Parts I- IV. Typically, the responsibility of support coordination, however individual does not have SC with RACSB, auditor was unable to locate where staff reached out to SC for that documentation

- Ten charts were reviewed for Quarterly Review compliance:
  - **No discrepancies noted with Quarterly Review.**

- Ten charts were reviewed for Progress Note compliance:
  - **No discrepancies noted with Progress Notes.**

- Ten charts were reviewed for Medical compliance:
  - **No discrepancies noted with Medical.**

Comparative Information:
In comparing the audit reviews of Rappahannock Adult Activities, Inc. (RAAI): Spotsylvania charts from the previous audits to the current audits, the average score decreased from 100 to 93 on a 100-point scale.

Corrective Action Plan:
-All missing items have been scanned in by 6/30/23 or requested from the Support Coordinator.

-Retraining will be completed on responsibility of RAAI staff for documents for those individuals who have SC outside of RACSB on 7/26/23.

-Corrective action according to RACSB policy will be issued to responsible staff for items not in Avatar at time of the audit.

-Asst Coordinator will oversee training and ensure corrections.

MEMORANDUM

To: Joseph Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance and Human Rights
Date: September 5, 2023
Re: 4th Quarter FY 2023 Incident Report Review

The fourth quarter incident summary report provides an overview of incident reports submitted by Rappahannock Area Community Services Board (RACSB) staff during the months of April 1, 2023 through June 30, 2023. The purpose of the report is to communicate information about trends, remain vigilant for emerging issues, and use data to plan, prioritize and implement preventative and proactive initiatives.

The population covered includes all people receiving services by the RACSB, which includes Mental Health, Substance Use, Developmental Disability, and Prevention services.

Quality Assurance Staff received and triaged 542 Incident Reports from April 1, 2023 through June 30, 2023 (an overall decrease of 55 reports from last quarter). Of those 542 incident reports received, 83 incidents were reported to Department of Behavior Health and Developmental Services (DBHDS) through the Computerized Human Rights Information System (CHRIS) as a serious incident.

Quality Assurance staff triaged all incident reports into one of four categories.

1. **N/A** – these reports do not fit into DBHDS definitions of a serious incident. Incidents of this sort may have been documenting a staff having to report a child protective or adult protective case to the Department of Social Services, an incident which occurs when the individual is not in the provision of care, or when a report is received by a Support Coordinator regarding an individual who resides with parent/guardian or a private provider.

DBHDS categories of serious incidents

2. **Level I**: a serious incident that occurs or originates during the provision of a service or on the premises of the provider that do not result in significant harm to individuals, but may include events that result in minor injuries that do not require medical attention, or events that have the potential to cause serious injury, even when no injury occurs."

3. **Level II**: a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual which does not meet the definition of a Level III serious incident. Level II serious incidents also include a significant harm or threat to the health or safety of others caused by an individual.

4. **Level III**: a serious incident, whether or not the incident occurs while in the provision of a service or on the provider's premises, which results in:
   1) Any death of an individual;
   2) A sexual assault of an individual;
   3) A serious injury of an individual that results in or likely will result in permanent physical or psychological impairment;
   4) A suicide attempt by an individual admitted for services that results in a hospital admission."

In addition to the notification to QA staff, program supervisors, and coordinators, staff must also notify the individual's parent/guardian/authorized representative, as appropriate, regarding the incident. Verification of the notification and the parent/guardian/authorized representative response is to be included on the incident report.

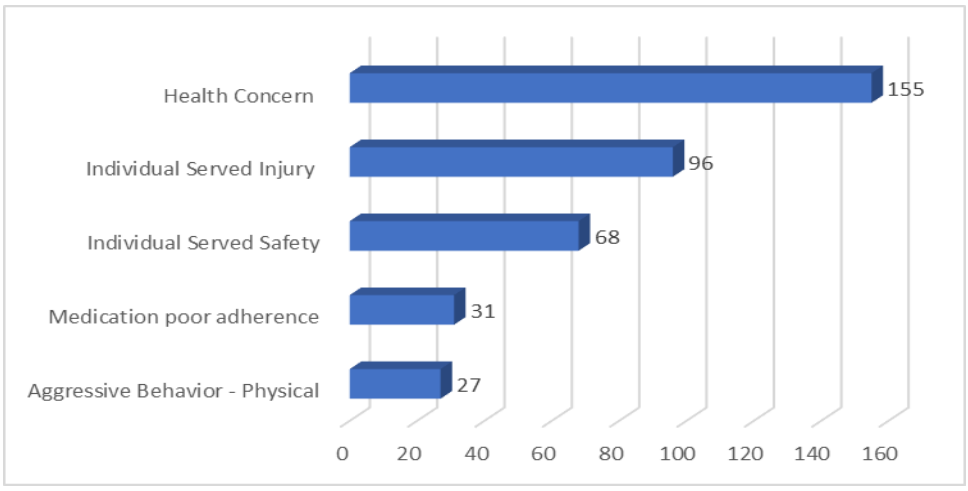
Below is a list of the incident categories and the definition:

- Aggressive Behavior –Physical - hit, slap, push, shove, pull hair, spit, bite, intimidate, demean, threaten, curse etc…
- Aggressive Behavior –Verbal - yelling, screaming, intimidate, demean, threaten, curse etc…
- Individual Safety - situations that may cause a safety risk for individuals served involving physical environment or structures (faulty equipment, smoking.)
- Individual Injury - situations that may cause a safety risk for individuals served involving minor injury such as a scraped knee
- Health Concerns - individual served exhibiting health concerns, i.e. possible seizure activity, sick, sudden weight +/-, etc.
- Elopement/Wandering - unexpectedly leaving program/premises with possible risk to safety
- Biohazardous Accident - needle stick or instance requiring testing of individual served or staff
- Infection Control - lack of infection control and use of universal precautions in relation to risk of non-life-threatening communicable diseases i.e. Flu, Lice… etc…
- Exposure to Communicable Diseases - instance of exposure due to lack of infection control and/or use of universal precautions in relation to risky communicable diseases i.e. TB, HIV/AIDS, HEP A, B, C or MRSA…
- Vehicle Accident - Accident of RACSB or personal vehicle while delivering services. This requires additional paperwork and follow up protocol to contact Human Resources & Supervisor
- Property Damage - damage to property
- Weapon Use/Possession - Weapons are not allowed in any RACSB facility. Knives, carpet knives, swords, guns etc…
- Staff Injury - injury to staff- ensure proper HR forms are completed
- Use of Seclusion/Restraint - if emergency intervention required to deescalate threatening behavior
- Med Non-Compliance - not following medication regimen- staff attempt evident- non compliance
- Med Error- Staff additionally to complete med error report. Error has been made in administering a medication to an individual (wrong- med, individual, route, dose, time)
- Possession of Illicit/Licit Substance - possession of illegal or non-prescribed drug –possible intent to abuse
- Sexual Assault - is an act in which a person intentionally sexually touches another person without that person's consent, or coerces or physically forces a person to engage in a sexual act against their will
- Suicide/Suicide Attempt - is the act of intentionally causing one's own death/ is the unsuccessful act of intentionally trying to cause one's own death
- Sentinel Events - An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof- warrants immediate investigation and response

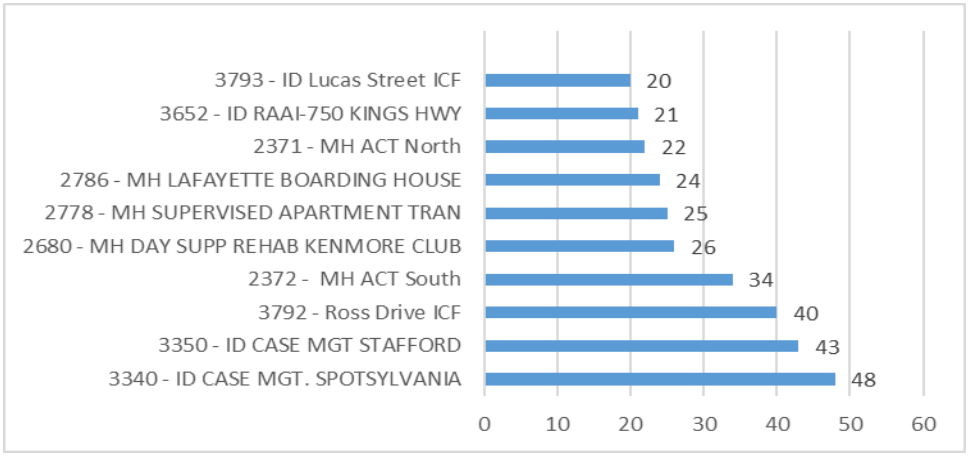
- Other – incident which does not fit into a category above

Type	Total
Accidental Overdose	1
Aggressive Behavior - Physical	27
Aggressive Behavior - Verbal	17
Bio hazardous Accident	0
COVID	2
Elopement/Wandering	5
Exposure to Communicable Diseases	0
Health Concern	155
Individual Served Injury	96
Individual Served Safety	68
Infection Control	0
Med Error	21
Med Non-Compliance	12
Medication non-adherence	10
Medication poor adherence	31
other	6
Possession of Illicit/Licit Substances	0
Property Damage	11
Sentinel Event	11
SIBs	17
Sexual Assault	5
Staff Injury	6
Suicide (non-completion)	24
Use of Seclusion/Restraint	0
Vehicle Accident	11
Weapon Use/Possession	2
Missing Person	4
Total	542

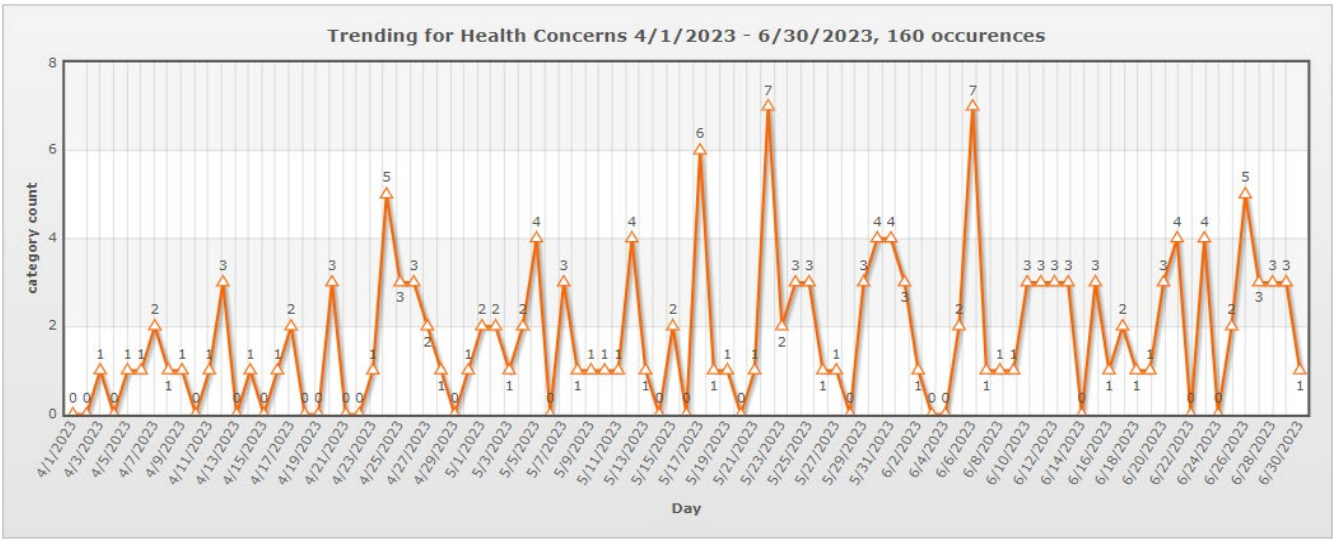
The table above depicts the total number of incident reports received, April 1, 2023 through June 30, 2023 by category.



The chart above includes the total number of incident reports received and depicts the categories with the highest occurrences reported April 1, 2023 through June 30, 2023.

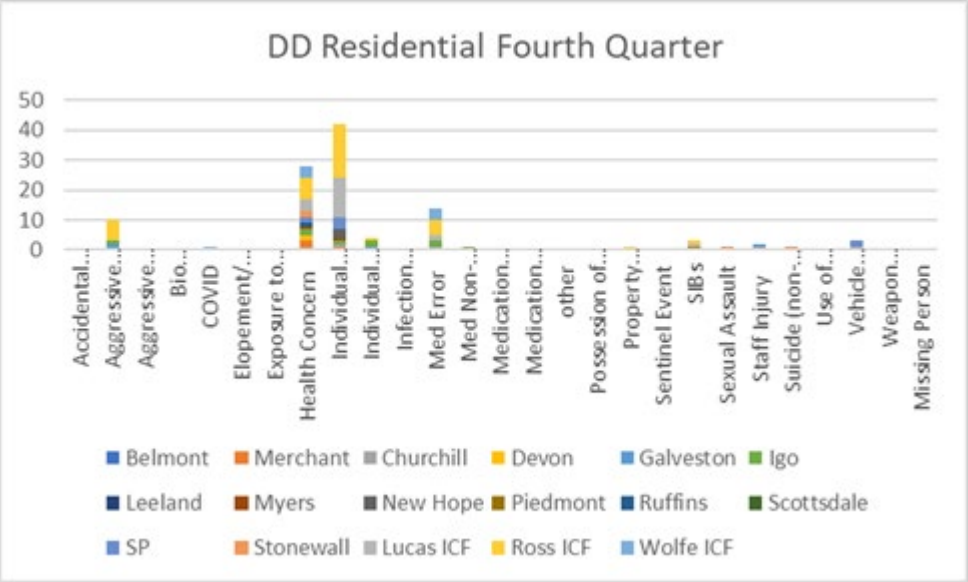


The chart above depicts the top ten programs that submitted the highest of number of incident reports during the time period of April 1, 2023 through June 31, 2023.



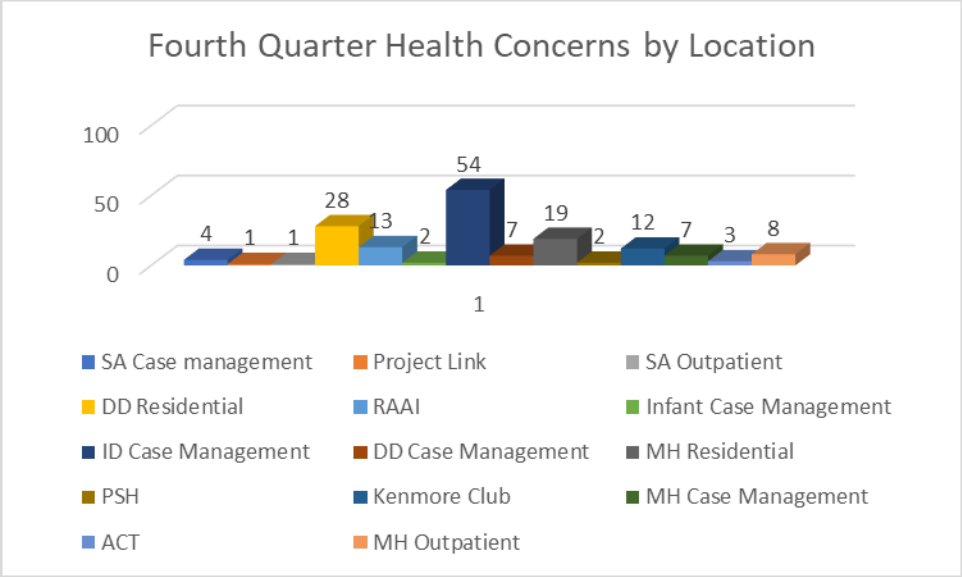
Approximately 28% of the incident reports received were categorized as health concerns. When compared to previous quarters, health concerns continue to be the category with the highest number of

incidents. This can be contributed to all health-related conditions, such as colds, flu, and vomiting or diarrhea. RACSB Residential Services submitted 28 of 155 health concern reports. Reports consisted of concerns related to abnormal pain, nausea, feeling ill, seizure, cellulitis, bruising, choking and urinary tract infections. Ross ICF submitted the highest number of health concern incident reports (7) for Developmental Disability Group Home Services; however, no two concerns were the same. Review of reports reveled no trend concerns; Health Concern category numbers have decreased from the previous quarter by 30 incidents.

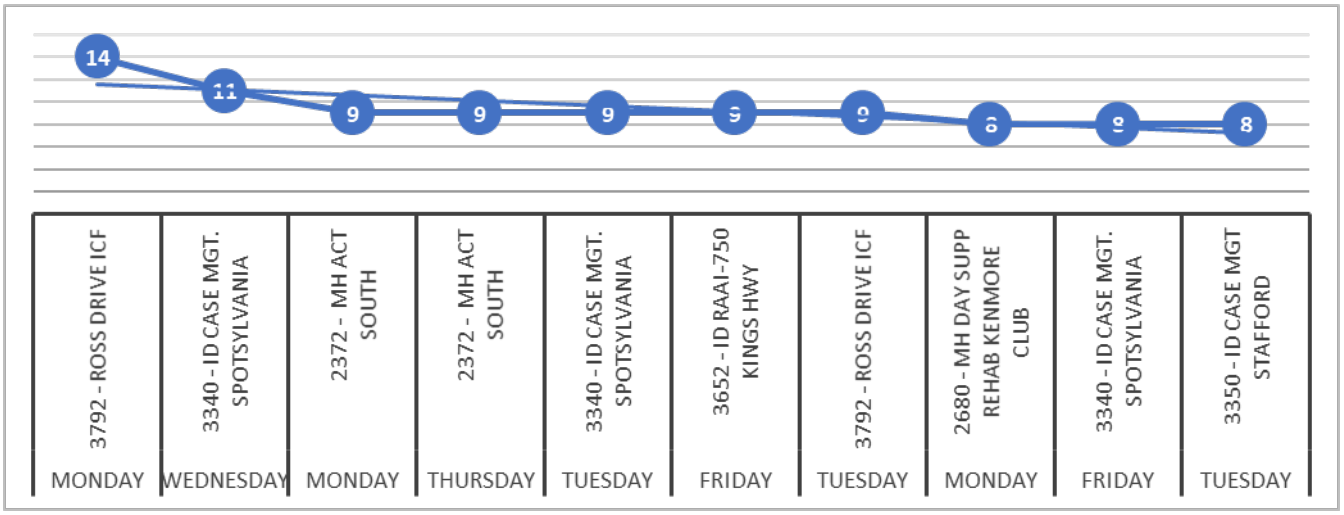


RACSB Residential programs submitted 111 incident reports. In DD Residential, the most frequent incidents were Individual Served Injury, with 47 reports, which included reports of scrapes, bruises, self-injurious behaviors, and falls. There were 28 Health Concerns reported, which included concerns related to choking, asthma, rash, elevated blood pressure, feeling ill, bruising, seizure, urinary tract infections, self-injurious behaviors, abnormal pain, and general just not feeling well. There was a total of 14 medication errors which occurred in DD Residential programs. Five errors related to single dose missed, two categorized as a wrong dose, one categorized as given to the wrong person, and six multiple doses missed. Review and analysis of medication policy, medication administration area, staffing pattern, and cause of errors took place in an attempt to mitigate future errors. There were eight instances of physical aggression reported by Residential programs. Of the eight instances, five individuals were involved; three of whom have behavioral intervention plans which were reviewed and deemed appropriate.

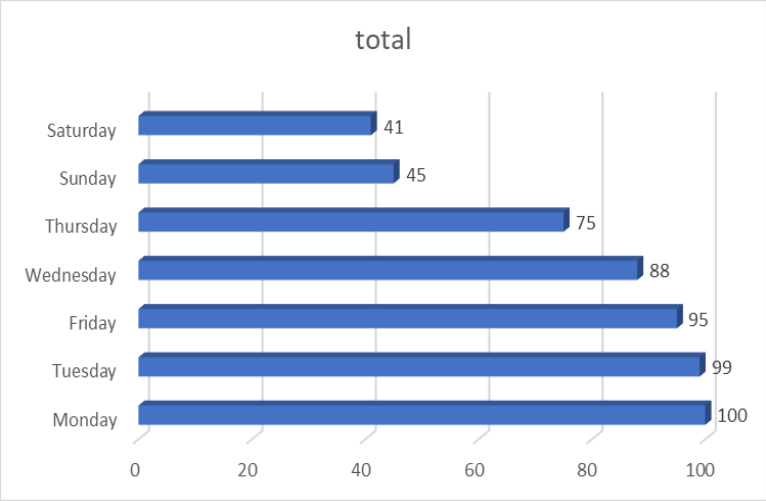
Two COVID related reports were submitted during the April 1, 2023 through June 31, 2023 time frame. This category includes incident reports for individuals who were tested for COVID and for individuals who received positive test results. These two incidents were regarding testing from Case Management and Wolfe ICF; both were reported as negative cases. Residential programs owned and operated by RACSB followed CDC guidelines related to COVID. In addition, program staff were provided personal protective equipment during working hours. RACSB will continue to follow CDC guidelines in an effort to keep everyone safe and healthy.



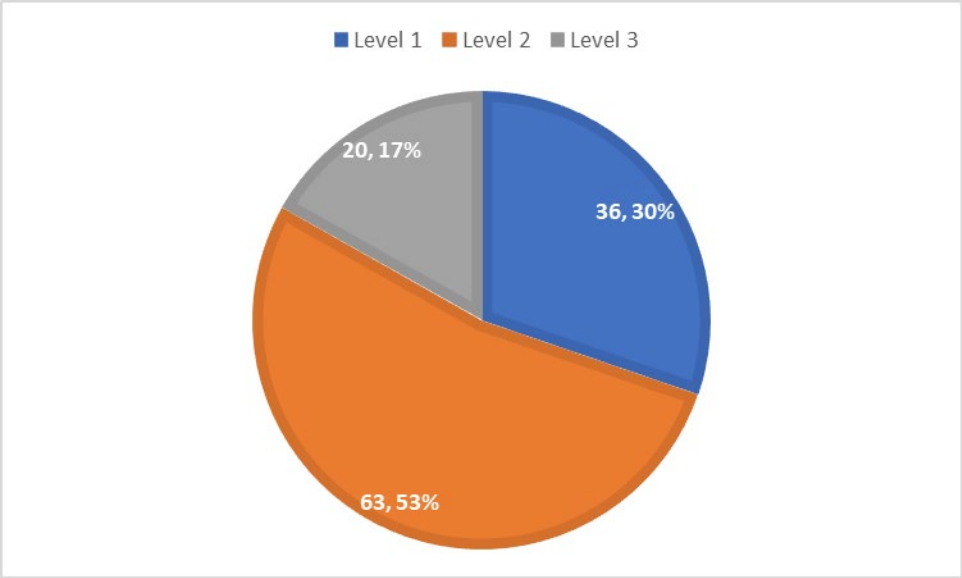
In analyzing the reports for the program with the highest occurrence of health concerns reported, Developmental Disabilities (DD) Support Coordination Services submitted the highest number of reports (54). The health concerns consisted of individuals that reside either with family or in a non-RACSB residential program. The program with the second highest number of reports submitted, with reports submitted related to health concerns is the DD Residential Services Programs (28). Due to the nature of the DD Residential Services, it is projected that there would be a high number of health concerns incident reports. Review of reports reveled no trend concerns.



The above chart above displays the top 10 program sites that submitted the most incidents based on the day of the week. If program sites are grouped based on service type there are five program areas that submitted the highest number of incident reports on specific days of the week; DD Residential, ID Case Management, ACT, RAAI, and Kenmore Club.



The highest number of incidents occurred on Mondays, with 100 incident reports out of the 542 incident reports received in the April 1 through June 31, 2023 time frame.



There was a total of 36 incidence categorized as a level I. Of the 36 incidents categorized as a level I, the majority were the result of minor or superficial cuts, scratches, or bruises, which required first aid. Nineteen of the incidents occurred in DD Residential services, 11 of the incidents occurred at RAAI Day Support, five occurred in MH Residential, and one occurred in ID Case Management:

- Urgent care visits for:
  - cold symptoms,
  - back pain,
  - dizziness,
  - self-injurious behaviors,
  - ear infection,
  - bronchitis,
- First Aid administered for a minor burns and scrapes.
- Falls requiring first aide and/or urgent care visits.

Based on review of the level 1 incidents there does not appear to be patterns or trends.

There were 63 incidents classified as a Level 2 and 20 incidents classified as Level 3. Root Cause Analyses were conducted for all Level 2 and Level 3 Incidents. One extended root cause analysis was

required during this quarter. Of the 20 Level 3 reports, 11 were death reports, seven from Outpatient Services and four from ID/DD Case Management; none of the ID/DD deaths were currently receiving DD Residential services. Based on review of the Level 1, Level 2 and Level 3 there does not appear to be a pattern or trends.

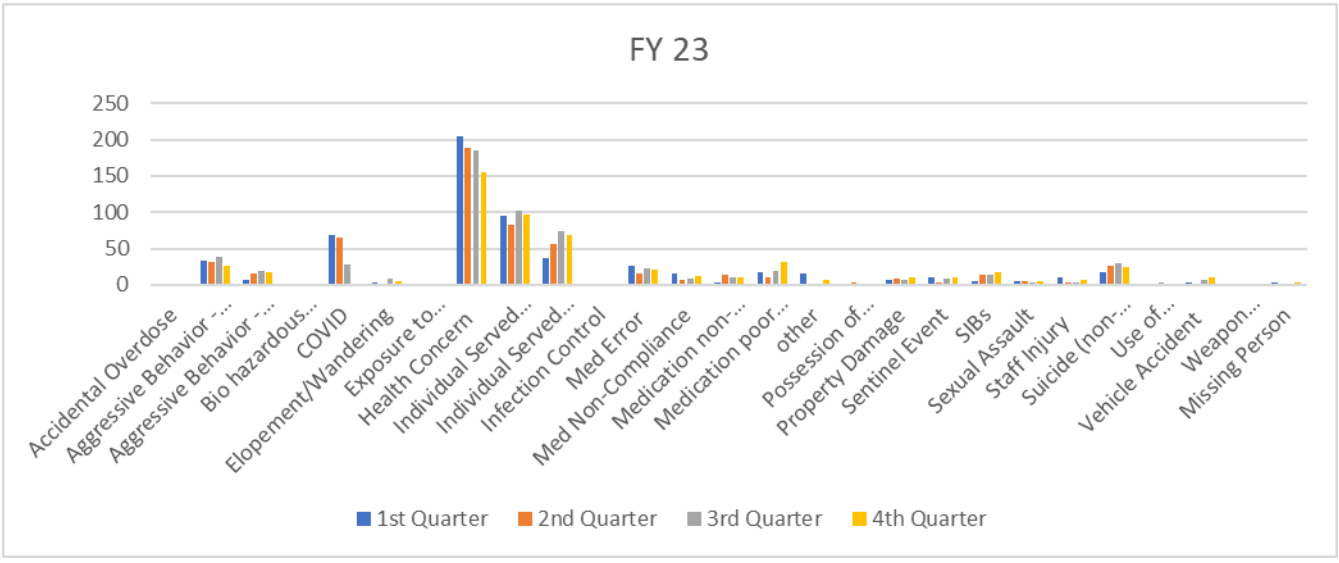
Program actions as a result of Incident Reports

1. A review of medication errors showed that the errors occurred due to staff being distracted during the time they were administering medications or staff not following policy as written. Medication Errors resulted in both personnel action and remedial training depending on the error. The current medication administration policy includes procedure for staff to follow to eliminate distraction.
2. Based on review of medication non-compliance, program staff continue to assess the ability of individuals enrolled in the program to continue self-administration of medication. Staff counseled and educated individual on the importance of taking their medication and are working with family member to assist individuals in maintaining and improving individual's medication compliance.
3. Action plans for aggressive behavior included recommendations for behavior plans, assisting the individual in learning and using coping skills during times when they become upset, review and revision of individual's service plan, and continuance of using interventions that are currently in the individual's service plan.
4. Action plans for health concerns varied based on the concern. RACSB staff contact 911 in cases of medical emergencies. Ad-hoc medical appointments will continue to be made by RACSB staff to address health concerns for those individuals residing in RACSB residential programs. In addition, for RACSB non-residential programs staff will continue to assist individuals and family members with health concerns that are identified during program hours. RACSB utilizes CDC precautions and program contingency plans during active cases of COVID-19.
5. For those incidents which involve individuals that do not reside in RACSB residential programs, Support Coordinators and Case Managers monitor health concerns and document in case notes.
6. Root cause analyses were conducted on all incidents that fell into the Level 2 or Level 3 category. Findings of root cause analysis resulted in programs revising individual service plans, behavior plans, ad-hoc reviews of program files, policy and procedure revisions, staff training, and personnel action.

FY 23 Data

Type	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Accidental Overdose	2	2	2	1
Aggressive Behavior - Physical	34	31	39	27
Aggressive Behavior - Verbal	7	15	19	17
Bio hazardous Accident	1	0	0	0
COVID	68	65	28	2
Elopement/Wandering	3	1	9	5
Exposure to Communicable Diseases	0	1	0	0
Health Concern	205	189	185	155
Individual Served Injury	95	82	102	96
Individual Served Safety	37	56	73	68
Infection Control	0	1	0	0
Med Error	26	15	23	21
Med Non-Compliance	15	6	8	12
Medication non-adherence	4	13	11	10
Medication poor adherence	18	11	19	31
other	15	0	0	6
Possession of Illicit/Licit Substances	1	3	0	0
Property Damage	7	8	7	11
Sentinel Event	10	4	9	11
SIBs	5	13	13	17
Sexual Assault	5	5	4	5
Staff Injury	10	4	4	6
Suicide (non-completion)	18	26	29	24
Use of Seclusion/Restraint	1	1	4	0
Vehicle Accident	4	2	7	11
Weapon Use/Possession	0	0	0	2
Missing Person	4	2	2	4
Total	**602**	**556**	**597**	**542**

The table above depicts the total number of incident reports received Throughout Fiscal Year 2023 by category.



To: Joe Wickens, Executive Director
From: Alison Standring, Part C Coordinator
Subject: Monitoring Results for FFY22/SFY23, Report 1 of 2
Date: August 31, 2023

Kyla Patterson's memo and the accompanying chart provide the first of two reporting cycles for the results of our annual chart review to determine compliance with Part C federal regulations for FFY22/SFY23.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Alison Standring, Part C Coordinator
Subject: Monitoring Results for Indicators 1, 7, and 8a, 8b, and 8c FFY22/SFY23 (July 1, 2022 through June 30, 2023) Report 1 of 2
Date: August 31, 2023

The attached memo from Kyla Patterson provides Part C Compliance Measures for three of 14 federally identified indicators, and a chart summarizing each of the indicators for the period of July 1, 2022 through June 30, 2023 (Federal Fiscal Year 2022). The Department of Behavioral Health and Developmental Services monitors each Part C system in the Commonwealth to assure that it is in compliance with federal Part C requirements.

The chart indicates that the Rappahannock Area, through the hard work of the Parent Education - Infant Development Program and Infant/Child Support Coordinators, achieved 100% compliance three of five areas. We did not demonstrate 100% compliance at the time of the review in February/March in the area of meeting the 30-day timeline to initiate services, but have since corrected the deficiency to the satisfaction of DBHDS. We continue to work on the remaining two areas of non-compliance - meeting the 45-day timeline to develop an IFSP after receiving a referral and providing timely notification to the local school district and the Virginia Department of Education of referrals for potentially eligible children. I anticipate we will verify correction of these remaining two areas prior to DBHDS' s deadline of June 30, 2024.

The last three pages of this packet contain a sample chart with explanations of the elements in the chart.

I appreciate the dedication and commitment of staff to work towards and assure continued compliance with Part C federal regulations.

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

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

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

FROM: Kyla Patterson
Early Intervention Program Manager

DATE: June 30, 2023

RE: Summary of Local Early Intervention System (LEIS) Monitoring Results for FFY22/SFY23 (July 1, 2022 – June 30, 2023) for Indicators 1, 7, and 8

Section 616(b)(2)(C)(ii)(II) of the Individuals with Disabilities Education Act (IDEA) of 2004 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 2024—will cover FFY22/SFY23 (July 1, 2022 – June 30, 2023). 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 (b)(2)(C)(ii)(I) and §303.700(a)(2).

State Part C staff recently completed a monitoring review of your local system data for the following annual compliance measures—

- Indicator 01: Timely Initiation of Services
- Indicator 07: 45-Day Timeline for Meeting to Develop the IFSP
- Indicator 08A-C: Transition

We appreciate the time your LEIS spent completing the local annual record review (ARR), entering relevant data into TRAC-IT, and working with both your technical assistance consultant and monitoring consultant throughout the year. Your time and assistance in the monitoring process is critical to ensuring that the data reported to OSEP and to the public is accurate and timely.

The results for the indicators reviewed for your LEIS are documented on the enclosed "Local Early Intervention System (LEIS) Monitoring Results & Determination – Copy 1/2 – Results (06/2023)" report. Final scores for all items and sections—including your LEIS determination for FFY22/SFY23—will be reflected in copy 2 of 2 of the report to be disseminated later this year.

The IDEA of 2004 set the state target for all compliance indicators at 100% and requires correction of identified noncompliance as soon as possible but no later than one (1) year from the date of official notification—i.e., the date of this memorandum. If your LEIS monitoring results for compliance Indicator 01 (Timely Initiation of Services), compliance Indicator 07 (45-Day Timeline for Meeting to Develop the IFSP) and/or compliance Indicator 08A-C (Transition) are less than 100% and were not corrected prior to receipt of this memo, state Part C staff will contact your LEIS local system manager to provide guidance regarding next steps.

Please note:

- For all compliance indicators where noncompliance has been identified (i.e., results of less than 100%), the State Lead Agency must verify that noncompliance has been corrected as soon as possible and in no case later than June 30, 2024. In accordance with OSEP memo 09-02 dated October 17, 2008, this requires confirming that the LEIS is now implementing the requirement correctly and that the local system has corrected each individual case of noncompliance (unless the child is no longer in the system.) Additional record reviews or other monitoring activities may be needed in order to verify correction of noncompliance.

- The State Lead Agency is required per the IDEA of 2004 §616(e)-(g) to implement appropriate enforcement action(s) any time a LEIS: 1) fails to correct noncompliance within one (1) year; 2) receives a determination of Needs Assistance two or more years in a row; and/or 3) receives a determination of Needs Intervention or Needs Substantial Intervention. Local determinations and any required enforcement action(s) will be included on copy 2 of 2 of the local determination report (to be disseminated later this year). Your technical assistance consultant and monitoring consultant are available to support your local system in achieving timely correction.

If you have any questions regarding this notification, please contact your monitoring consultant.

As always, thank you for your ongoing efforts to ensure quality supports and services for the infants and toddlers and their families served by the Infant & Toddler Connection of Virginia.

Enclosures

cc: Local System Manager
Local System Manager Supervisor
Nelson Smith, Commissioner, DBHDS
Ellen Harrison, Chief Deputy Commissioner, Community Services, DBHDS
Nina Marino, Interim Assistant Commissioner, Community Behavioral Health Services, DBHDS
Katharine Hunter, Interim Director, Office of Child and Family Services, DBHDS
Richard Corbett, Early Intervention 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 2022 (July 1, 2022 - June 30, 2023) [as required by OSEP]

☒ Copy 1/2 – Results (6/2023) | ☐ Copy 2/2 – FINAL Results & Determination (09/2023)

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 FFY21/SFY22 Noncompliance (Y/N/NA)	Points Awarded
01: Timely Services	100%	**94.24%**	**96.67%**	**Y**		
07: 45-Day Timeline	100%	**96.45%**	**73.60%**	**N**		
08A: Transition Steps and Services	100%	**99.60%**	**100.0%**	**NA**		
08B: Transition Notification to LEA & VDOE	100%	**97.15%**	**93.3%**	**N**		
08C: Transition Conference	100%	**99.55%**	**100.0%**	**NA**		

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

Accurate & Timely Data

Scoring
- True → 1
- False → 0

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

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 FFY22/SFY23 contract deliverables submitted and 9 of 11 deliverables submitted on time in order to receive full credit.
[2] FFY22/SFY23 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%			

Child Outcomes (Indicator 03)

Scoring
- Local results reported but not scored

	State Target	State Result	Local Result
03A-S1: Positive social-emotional skills			
03A-S2: Positive social-emotional skills			
03B-S1: Acquisition and use of knowledge and skills			
03B-S2: Acquisition and use of knowledge and skills			
03C-S1: Use of appropriate behaviors to meet needs			
03C-S2: Use of appropriate behaviors to meet needs			

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

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)					
04B: Family Outcomes (Communicate needs)					
04C: Family Outcomes (Help child learn)					

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

[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					
06: Child Find 0-3					

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 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)	**FFY22/SFY23 CUMULATIVE % SCORE**	
	FFY22/SFY23 DETERMINATION	

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)
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)
FFY20/SFY21 (July 1, 2020 – June 30, 2021)	**FFY21/SFY22** (July 1, 2021 – June 30, 2022)	**FFY22/SFY23** (July 1, 2022 – June 30, 2023)				

[5] Local result >= state target = NA

[6] FFY22/SFY23 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.