Office of Human Resources
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RappahannockAreaCSB.org

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NOTICE

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

From: Joseph Wickens
Executive Director

Subject: Program Planning and Evaluation Meeting
June 13, 2023, 10:30 AM
600 Jackson Street, Board Room 208, Fredericksburg, VA

Date: June 9, 2023

A Program Planning and Evaluation Committee Meeting has been scheduled for Tuesday, June 13, 2023 at 10:30 AM. The meeting will be held at 600 Jackson Street, Board Room 208, Fredericksburg VA 22401.

Looking forward to seeing you on June 13, 2023 at 10:30 AM.

Cc: Nancy Beebe, Chairperson

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Program Planning and Evaluation Committee Meeting

June 13, 2023 – 10:30 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: June 13, 2023

RACSB currently has three individuals on the Extraordinary Barriers List (EBL) who are hospitalized at Northern Virginia Mental Health Institute (NVMHI), Western State Hospital (WSH) and Central State Hospital (CSH). 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.

Northern Virginia Mental Health Institute

Individual #1: Was placed on the EBL 5/17/23. Barriers to discharge include being accepted to a group home in the community. This individual has a primary diagnosis of a Development Disability and has an active DD Waiver. They have been accepted to Amazing Grace Group Home. At this time, paperwork and a prior authorization are being completed as this individual requires one-to-one supports. A discharge date will be set once all necessary paperwork is completed.

Western State Hospital

Individual #2: Was placed on the EBL 4/17/23. Barriers to discharge include being accepted to a supervised and transitional residential program. This individual has resided in the community, independently in the past and utilized Assertive Community Treatment (ACT) Services, however they struggled to maintain stability and participation in an independent setting. It has also been determined that they are not able to reside independently at this time. This individual completed a pass to Home Road Supervised Apartments; however, it was determined that this was not the most appropriate placement. Referrals have been completed for two other supervised transitional

residential programs in Region 1, Liberty and Gateway. This individual will discharge once accepted to a program.

Central State Hospital

Individual #3: Was placed on the EBL 4/28/23. Barriers to discharge include working through the Not Guilty by Reason of Insanity (NGRI) process. This individual has a primary diagnosis of Schizophrenia and a history of substance use. It has been identified that this individual requires a supervised residential setting in the community in order to maintain stability in their mental health as well as to maintain compliance with their Conditional Release. They have been referred to and accepted by Lafayette Boarding House. During their hospitalization, two Temporary Custody Evaluations have been completed, resulting in one recommendation for continued hospitalization and one recommendation for Conditional Release. The Forensic Review Panel has also recommended release. RACSB is in favor of continued hospitalization as this individual has minimal insight to their illness, struggles to take responsibility for lack of follow through with treatment in the past as well as lacks a good understanding of the commitment required to be successful on Conditional Release. They would benefit from continued hospitalization and participation in the graduated release process. Their next court date is 7/18/23. They will be discharged once approved by the court.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Donna Andrus, Child and Adolescent Support Services Supervisor
Date: June 6, 2023
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 twenty-seven IACCT referrals and completed twenty-five assessments in the month of May. One initial IACCT was cancelled 2 times by the legal guardian and then the adolescent was detained in juvenile detention. One reauthorization discharged home prior to the due date. Fifteen referrals were initial IACCT assessments and twelve were re-authorizations. Seventeen were from Spotsylvania, four from Stafford, two from Caroline, two from King George and two from the City of Fredericksburg. Of the twenty-five completed assessments in May, fifteen recommended Level C Residential, two recommended Level B Group Home, three recommended community based services and one reauthorization recommended discharge. Three assessments have not been completed yet with a recommendation and one was not completed within the timeline so another initial was started. One initial request was for a child to move from one residential facility to another due to lack of progress. Thirteen extensions were requested to meet the timeline.

Attached is the monthly IACCT tracking data for May 2023.

To: Joe Wickens, Executive Director

From: Nathan Reese, IT Coordinator

Re: Information Technology and Electronic Health Record Update

Date: June 6, 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 May, 1,006 tickets where closed by IT Staff compared to 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 April 2023 CCS was submitted on May 30, 2023.

Waiver Management System (WaMS)

WaMS 3.4 testing opened April 1, 2023. RACSB's testing window was significantly shortened due to Avatar losing connection between its Build and Test Avatar systems. The 3.4 changes were loaded into the Build system prior to the testing period, then once Netsmart completed their backend changes during the first week of testing, IT attempted to move forms to the Test Avatar system but had a critical error. From April 12 through April 27, we were not able to test. WaMS 3.4 specifications went live on May 2, 2023. Due to the WaMS and Avatar not communicating properly, IT staff have spent a significant amount of time hand keying Individualized Service Plans into WaMS. WaMS testing still continues, a successful submission in the test system was achieved on May 30, 2023. Netsmart moved the test system's configuration to LIVE Avatar on June 6, 2023 via a patch. The system is now working as expected.

Trac-IT Early Intervention Data System

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.

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.

- 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

On May 30, 2023, IT staff met with RAAI and Permanent Supportive Housing staff to discuss implementation of Bells to their program with hopes of going live in the next 60 days. Meetings will continue throughout the month of June to setup configuration of the system for the programs to use.

IT is still working through NIAM testing and integration. IT kicked off Netsmart's single sign on (NIAM), project on May 3, 2023. Once implemented NIAM will allow staff the ability to login to Avatar with the same password as their email. NIAM also allows users to set up 2-factor authentication to increase security.

Staffing

Suzanne Poe is retiring from the agency after 26 years on July 28, 2023. We currently have two vacancies, one for Assistant IT Coordinator and another for Data Analyst.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Jacqueline Kobuchi, Director of Clinical Services
Date: June 7, 2023
Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – May, 2023

In May 2023, Emergency Services staff completed 309 emergency evaluations. Sixty-four individuals were assessed under emergency custody orders and seventy-eight total temporary detention orders were served. Staff facilitated one safety net admissions to a state hospital. That individual was admitted to Catawba. There were also three forensic admissions to state facilities.

A total of 18 individuals were involuntarily hospitalized outside of our catchment area in April. Five individuals were able to utilize alternative transport.

Please see attached data reports.

Emergency Services Activity Reports

Month	Contacts	Evaluations	ECOs	TDOs Issued	TDOs Executed
January 2022	[redacted]	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
November 2022		359	69	73	73
December 2022		296	55	51	51
January 2023		389	81	86	86
February 2023		340	65	67	67
March 2023		406	83	93	93
April 2023		325	65	78	78
May 2023		309	64	78	78

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

CSB/BHA	Rappahannock Area Community Services Board	Month	May 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	
309	38	26	64	78	14	4	60	78	3
			0					0	
			0					0	
			0					0	

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

CSB/BHA	Rappahannock Area Community Services	Reporting month	May 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)	
5/15/23	30146			Yes	No	Catawba

MEMORANDUM

To: Joe Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance and Human Rights
Date: June 7, 2023
Re: May 2023 Waiting Lists

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

OUTPATIENT SERVICES

- Clinical services: As of May 31, there are 175 individuals on the waiting 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 requests 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 38 clients.
      - The waitlist in Spotsylvania is currently at 57 clients.
      - The waitlist in Caroline is currently at 80 clients.
      - This is a decrease of 18 from the April 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 June 7, 2023, there are six older adolescents and adults waiting longer than 30 days for their intake appointment. This is an increase of two from the April 2023 waitlist. The furthest out appointment is 8/1/2023. There are no children age 13 and below waiting longer than 30 days for their intake appointment.

PSYCHIATRY INTAKE – As of June 7, 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 –	3 (2)	0 (0)
o Caroline –	0 (1)	0 (0)
o King George –	1 (1)	0 (0)
o Spotsylvania –	2 (0)	0 (0)
o Stafford –	0 (0)	0 (0)
Total	**6 (4)**	**0 (0)**

	Appointment Dates
Fredericksburg Clinic	
	7/13/23 7/24/23 8/1/2023
Caroline Clinic	
	N/A
King George	
	7/6/23
Spotsylvania Clinic	
	7/10/23 7/24/23
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	1
Spotsylvania	1
Stafford	0
Other	1

Two individuals are referrals from Western State Hospital for transitional beds at Home Road and LBH. One individual must complete eight passes at Kenmore Club, which started 5/24, prior to starting eight passes at Home Road. The other individual was referred to Lafayette Boarding House, but is expected to be recommitted at his hearing next week.

Intellectual Disability Residential Services – 70

Needs List: 69
Referral List: 1
Acceptance List: 0

Count by County:

Caroline	7
King George	4
Fredericksburg	7
Spotsylvania	28
Stafford	35

Assertive Community Treatment (ACT)– 19

Caroline: 1
Fredericksburg: 7
King George: 2
Spotsylvania: 5
Stafford: 4

Total Needs: 6
Total Referrals: 13
Total Acceptances: 0

Total program enrollments = 50

Admissions: 1
Discharges: 0

ID/DD Support Coordination

There are 841 individuals on the waiting list for a DD waiver.

P-1 361
P-2 193
P-3 287

RAAI – 37

Caroline: 3
Fredericksburg: 2
King George: 3
Spotsylvania: 15
Stafford: 9
Other: 7

Total Referrals: 30
Total Assessing: 2
Total Acceptances (waiting to add more days): 7

Total program enrollments = 112

Report Month/Year	May-23
1. Total number of Referrals from Magellan for IACCT:	27
1.a. total number of auth referrals:	15
1.b. total num. of re-auth referrals:	12
2. Total number of Referrals per county:	
Fredericksburg:	2
Spotsylvania:	17
Stafford:	4
Caroline:	2
King George:	2
Other:	0
3. Total number of extensions granted:	13
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:	1
7. Total number of assessments completed:	25
8a. Total number of ICA's recommending: **residential:**	15
8b. Total number of ICA's recommending: **therapeutic group home:**	2
8c. Total number of ICA's recommending: **community based services:**	3
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:**	1

10. Total number of notifications that a family had difficulty accessing **any** IACCT-recommended service/s:	1

MEMORANDUM

To: Joe Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance and Human Rights

Date: June 7, 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 one Corrective Action Plan (CAP) during the month of May 2023. Rappahannock Adult Activities Inc. (RAAI) Day Support Program received a report due to an incident which occurred involving a day support participant.

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

License #: **101-02-006**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-12-2023**
Program Type/Facility Name: **02-006 Caroline/The Gathering Place**

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	Caroline/The Gathering Place This regulation was NOT MET as evidenced by: See OHR citation below.		
12VAC35-115-60. B. (4b) - The provider's duties. 4. Providers shall assign a specific person or group of persons to carry out each of the following activities: 4b. Preparation, implementation, and modifications to an ISP based on ongoing review of the medical, mental, and behavioral needs of the individual;	N	Caroline/The Gathering Place This regulation was NOT MET as evidenced by: The provider has substantiated for a Services violation based on the following: • Employee #1 failed to implement the ISP in accordance with Individual #1's identified needs, which is a violation of 12VAC35-115-60(B)(4)(b).		

License #: **101-02-006**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-12-2023**
Program Type/Facility Name: **02-006 Caroline/The Gathering Place**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

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: June 1, 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): Stafford
- Rappahannock Adult Activities, Inc. (RAAI): Caroline
- Scottsdale Intellectual Disability Group Home

Rappahannock Adult Activities, Inc. (RAAI): Stafford

There was one staff member responsible for the randomly selected charts.

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

- Ten charts were reviewed for Documentation compliance:
  - **No discrepancies noted with Documentation.**
- Ten charts were reviewed for Individual Service Plan (ISP) compliance:
  - **No discrepancies noted with Individual Service Plan.**
- 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.**
- Two charts were reviewed for Discharge compliance:
  - **No discrepancies noted with Discharge:**

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

Corrective Action Plan:
None Required

Rappahannock Adult Activities, Inc. (RAAI): Caroline

There was one staff member responsible for the randomly selected charts.

Findings for the seven open and two closed charts reviewed for Rappahannock Adult Activities, Inc. (RAAI): Stafford were as follows

- Seven charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - One chart was missing the Program Agreement.
    - Two charts were missing Authorized Representative Agreement.

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

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

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

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

- Two charts were reviewed for Discharge compliance:
  - **No discrepancies noted with Discharge:**

Comparative Information:
In comparing the audit reviews of Rappahannock Adult Activities, Inc. (RAAI): Caroline charts from the previous audits to the current audits, the average score increased from 96 to 97 on a 100-point scale.

Corrective Action Plan:
1. All missing documentation has been uploaded into Avatar, missing guardian signatures have been re-mailed.
2. Retraining for all lead specialists will occur on 5/24/23 on documentation for guardian signature follow up, as well as Authorization process completed by Asst Coordinator.
3. Corrective action will be completed for responsible staff for items not in the chart at the time of the audit.

Scottsdale Intellectual Disability Group Home

There was one staff member responsible for the selected charts.

Findings for the six open charts and one closed chart reviewed for Scottsdale Intellectual Disability Group Home were as follows:

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

- Six charts were reviewed for Individual Service Plan compliance:
    - **Discrepancies noted with Individual Service Plan:**
        - Four charts were missing Guardian / AR Signatures.
        - Two charts were missing the Schedule of Supports.
        - Four charts contained Plans that were completed late.

- Six charts were reviewed for Quarterly Review compliance:
    - **Discrepancies noted with Quarterly Review:**
        - Three charts were dated incorrectly for their coverage periods.
        - Two charts had Quarterly Reviews that were missing.
        - One chart was missing Guardian / AR Signature.

- Six charts were reviewed for Progress Note compliance:
    - **Discrepancies noted with Progress Notes:**
        - Six charts had multiple notes that were not signed by the writer.
        - One chart had an ISP Checklist that was missing.

- Six charts were reviewed for Medical compliance:
    - **Discrepancies noted with Medical:**
        - Five charts had multiple medication prescriptions missing.
        - Three charts did not have the back sheet of the MARs scanned.

Projected overpayment: **$60,215.78**

Comparative Information:
In comparing the audit reviews of Scottsdale Intellectual Disability Group Home charts from the previous audits to the current audits, the average score decreased from 68 to 28 on a 100-point scale.

Corrective Action Plan:

1. Corrective supervision and coaching are ongoing with the program manager and assistant manager to ensure charting is complete, correct, properly labeled, signed, and timely moving forward. The manager and assistant manager will be expected to re-attend all supervisor trainings on documentation in the coming months. Focus will be placed on obtaining signatures on plans, completing timely annual paperwork at the time of the ISP, completing timely quarterlies and plans, ensuring all documentation requiring upload be entered into the EHR timely and in the correct tabs, procuring scripts and uploading them in a timely manner, and monitoring to ensure that staff are entering timely, signed notes.
2. A re-review will be conducted in 90 days as a combined effort from the QA and Residential teams to ensure progress and accuracy is achieved.
3. Charting standards and expectations have been and will continue to be discussed through weekly DD Residential Supervisor meetings, supervision, offered training opportunities, and through periodic program audits of charting. (See notes in spreadsheet for corrections made and to be made to the charting.)
4. Charting and documentation expectations will continue to be reinforced through documented supervision and through the peer auditing and supervision processes to help ensure compliance.
5. Should there be further issue with meeting these expectations, progressive corrective action will be issued to responsible staff.
6. Oversight and corrective action will continue to be overseen by the DD Residential Coordinator and the DD Assistant Coordinators.

Resolution:
Corporate Responsibility

The Rappahannock Area Community Services Board is committed to providing high quality services to people with mental health, developmental disability and substance use problems, in accordance with state and federal laws, agency policies, rules and regulations, and professional ethics.

The agency is committed to providing adequate training to support staff in their understanding of these requirements and procedures to follow, if noncompliance suspected. The Corporate Compliance Plan shall outline the procedures through which staff are educated about standards and policies as well as procedures to report suspected noncompliance.

The Director of Compliance and Human Rights shall assume the responsibilities of corporate compliance officer, and shall conduct mock audits to insure compliance with all applicable standards. The frequency, kinds of audits, and outcomes expected of those audits are outlined in the Corporate Compliance Plan.

The Corporate Compliance Plan shall be reviewed annually by the Board of Directors.

Signature, Executive Director

Signature, Chair, Board of Directors

Date

June 2023

I. Compliance Standards

Numerous federal and state laws and regulations, regulations by third-party payers, and accreditation standards define RACSB's obligations for which they must comply. Violations of these rules and regulations result in varying levels of consequence, depending on the severity of the violation.

The Policies and Procedures established by Rappahannock Area Community Services Board reflect the following regulations as well as our own sense of quality services (this list is not intended to identify all applicable laws, the Compliance Officer should be consulted with specific questions):

1) Rules and Regulations for the Licensure of Mental Health, Developmental Disability, and Substance use Services, Office of Licensure, Virginia Department of Behavioral Health & Developmental Services.

2) Human Rights and Confidentiality Regulations, Office on Human Rights, Virginia Department of Behavioral Health & Developmental Services.

3) Federal laws and regulations regarding substance use confidentiality.

4) Laws and regulations through Virginia's Department of Medical Assistance Services.

5) Applicable regulations through the Health Care Finance Administration.

6) Rules and regulations to prevent fiduciary abuse, as outlined in RACSB's Financial Policies and Procedures.

7) Accreditation standards, as issued through CARF.

8) Regulations as identified through the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

9) Laws and regulations of the Department of Health Professions.

In addition, RACSB has a clearly outlined Code of Ethics in its Personnel Policies and Procedures that reflect such items of importance as professional conduct, personal behavior, clinical practices, and methods to report suspected violations of the code of ethics.

II. Staff Education

All RACSB employees are expected to comply with all policies, procedures, and applicable laws. At the beginning of employment, all employees review highlighted policies and sign off indicating they have read and understand the Employee Handbook. The Code of Ethics, grievance procedures, and standards of conduct violations are all outlined in the Employee Handbook.

During New Employee Orientation the Medical Record Accountability Protocol is reviewed and distributed to staff which outlines documentation expectations and potential consequences of improper medical record documentation.

At hire and annually, staff reviews the Corporate Compliance Plan and sign a policy indicating doing so. In addition, staff are required to complete an annual on-line training to review the components of corporate responsibility.

Annually, various Committees of the Board of Directors review Board policies and procedures and provide the Board of Directors with recommended changes/clarification.

A. Policy and Procedure manuals

A policy and procedure manual exists for each service provided. The policy and procedure manual reflects required standards and expectations required by each employee providing that service.

Each program coordinator or site coordinator is expected to work with the Division Directors and Quality Assurance Office to keep policies and procedures up to date and current.

All current policy and procedure manuals shall be posted on the RACSB Intranet to allow for immediate staff access.

B. Maintenance of records and documentation

Services rendered by staff shall be documented in the electronic health record according to all applicable rules and regulations. Staff must document activity accurately and honestly for services provided. Billing for these services shall not occur without proper documentation, as documented via an attestation statement on service activity logs. Billing that occurs without accurate documentation to support the service provided shall be considered fraud.

Upon resignation of employment, staff is expected to have all medical record documentation current in order to ease the transition between clinicians and improve continuity of care.

III. Compliance with Legal Inquiries: Subpoenas, Search Warrants and Court Appearances

State and federal confidentiality laws bind information on services provided at Rappahannock Area Community Services Board. With the exception of information that may need to be shared in cases of emergency, subpoenas, search warrants and court orders are the other tools through which information may be released without the prior consent of the person receiving services.

As part of the intake process, persons receiving services receive information regarding confidentiality and limits thereof.

Step by step procedures regarding how to respond to subpoenas are located in the Clinical Services Policy and Procedures Manual. When staff is issued a subpoena, they are to immediately notify their supervisor, and have the subpoena reviewed by the Clinical Services Director or the Corporate Compliance Officer. The purpose of review is to assure that the subpoena meets all necessary legal requirements in order to disclose confidential information.

Any written information that is released as a result of a subpoena duces tecum shall be accompanied by a certification indicating the information is being released as ordered. The certification shall be signed by the Executive Director and duly notarized.

If the subpoena is complete and staff plans to attend the court hearing, it is recommended they call counsel prior to their attendance in order to review what is expected of them during the proceedings. Staff should be cautioned not to present themselves as expert witnesses. In addition, it is recommended, to the extent possible, that staff inform the consumer prior to the court appearance.

Staff should inform their supervisor and document in the case notes when they received the subpoena, when they appear in court, and the outcome of that appearance.

Staff should not take the entire medical record with them to court unless specifically requested by the subpoena to do so.

Any employee served with a search warrant at a site operated by RACSB shall immediately notify the Executive Director or designee for direction. Staff shall request identification from the law enforcement officer and shall write down the name and identification information of the officer.

A search warrant is a written order regarding a criminal matter that directs a sheriff or police officer to search a specific place for specific persons, documents or items that are to be seized as described in the search warrant.

Staff will cooperate with the officer in non-substance use cases. If the search warrant involves a request for records of an individual receiving substance use services, an attempt will be made to seek legal opinion. Employees will comply with law enforcement mandates in the event of emergency situations or when a law enforcement officer refuses staff request to seek further guidance; even if the officer's orders are later shown to be erroneous. When the officer takes property into custody, a detailed receipt must be given for the property. Make a copy of any requested medical records. Never give out the original.

RACSB is committed to cooperating with any legal investigative action and to assisting staff in responding appropriately to any legal inquiry, while maintain the confidentiality of individuals served.

IV. Availability of Legal Counsel

As needed, Rappahannock Area Community Services Board consults with legal counsel on any matters that pertain to allegations of wrongdoing by staff, or issues that revolve around the health and welfare of individuals served and of personnel.

V. Monitoring, Auditing and Risk Assessment Activities

Activities conducted to review compliance to standards include, but are not limited, to the following:

- Internal chart reviews are conducted on open and closed records each quarter. In addition to quality assurance record reviews, it is recommended that supervisors review records as part of staff meetings and individual supervision.
- Annual policy and procedure review.
- Unannounced reviews by the Virginia Department of Behavioral Health & Developmental Services, Office of Licensure.
- Unannounced reviews by the Virginia Department of Behavioral Health & Developmental Services, Office of Human Rights.
- Annual review of financial record by external CPA firm.
- Unannounced reviews by the Virginia Department of Medical Assistance Services.
- Unannounced reviews by Magellan Behavioral Health Services.
- Record requests via the Center for Medicaid and Medicare Services.
- At hire and monthly the Human Resource department verifies that staff are not listed on the Health and Human Services – Office of Inspector General List of Excluded Individuals and Entities.

VI. Investigations of Suspected Noncompliance

The Compliance Officer is responsible for investigating any suspected misconduct and referring, as appropriate, information to the Executive Director and/or the Board of Directors. All employees are expected to cooperate to the fullest extent possible with any and all investigations. Employees who refuse to cooperate with an investigation are in direct violation of agency policies and procedures.

An investigation into allegations of waste, fraud, abuse or other wrongdoing shall be completed in accordance with the procedures outlined in the Financial Policies and

Procedures. As noted in the Financial Policies and Procedures, the Code of Virginia requires that fraudulent activities be reported to appropriate authorities.

Employees must report to their supervisor or to the Corporate Compliance Officer suspected violations by employees of applicable laws, rules or regulations. In order to investigate allegations of noncompliance, staff need to provide as much information as possible regarding the suspected violation.

While the identity of an individual who reports a suspected violation cannot be guaranteed to be kept anonymous, no employee who reports suspected misconduct shall be retaliated against or otherwise disciplined by Rappahannock Area Community Services Board or any of its employees.

VII. Consequences for Non-Compliance

Consequences for noncompliance of agency policies and procedures are outlined in the Employee Handbook, Section 3.

VIII. Outside Investigations

Rappahannock Area Community Services Board is committed to full compliance of all state and federal laws and shall cooperate fully with any reasonable demands made by any outside entity, to the greatest extent possible.

IX. Corporate Citizenship.

Rappahannock Area Community Services Board is guided by strong moral and ethical standards in daily interactions with customers, shareholders, and employees and extends corporate responsibilities beyond core business.

Staff hold various positions on local Boards of agencies that assist individuals in need of human services. The Boards include the following agencies, Safe Harbor Child Advocacy Center, Moss Free Clinic, Rappahannock Council Against Sexual Assault, and Healthy Families. In addition, Rappahannock Area Community Services Board staff are involved in many community projects, such as local community fairs, seminars, and town halls to educate, inform, protect, and promote a healthy community. These activities presented during the community project may include educating the community regarding suicide prevention, Mental Health First Aide, REVIVE, Lock and Talk, and various other topics.

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Data Highlights Report for Program Planning and Evaluation

Date: June 8, 2023

The Rappahannock Area Community Services Board is committed to using data-driven decision-making to improve performance, quality, and demonstrate the value of services. This report will provide an overview of the new and on-going Behavioral Health and Developmental Disability performance measures.

Department of Behavioral Health and Developmental Services Performance Dashboard

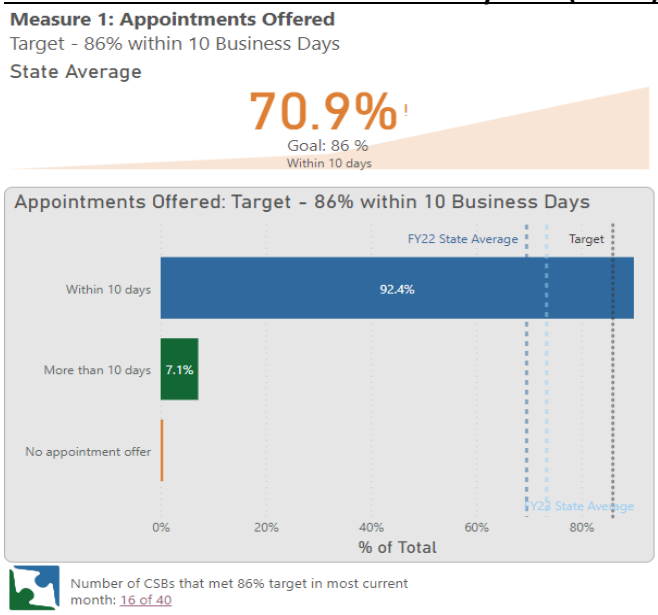
This month's report will detail the new measures and ongoing measures set by DBHDS as performance metrics. The targets indicated have been set by DBHDS and are subject to change at the department's discretion. These targets did not take effect until July 1, 2021.

Behavioral Health Measures

Same Day Access

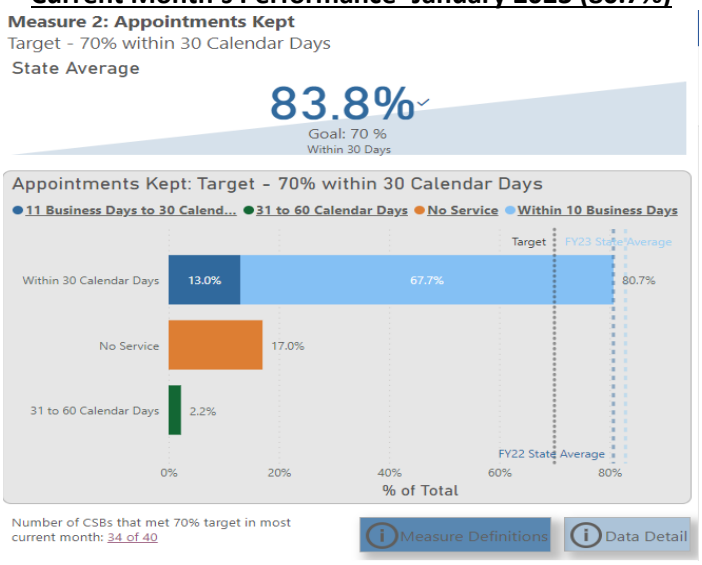
Measure #1: SDA Appointment Offered: Percentage of individuals who receive a Same Day Access assessment and were recommended for services through the CSB who were offered a follow-up appointment within 10 business days. The benchmark is set at 86%.

Current Month's Performance- February 2023 (92.4%)



Measure #2: SDA Appointment Kept: Percentage of individuals who receive a Same Day Access assessment and were recommended for services through the CSB who attended that follow-up appointment within 30 calendar days. The benchmark is set at 70%.

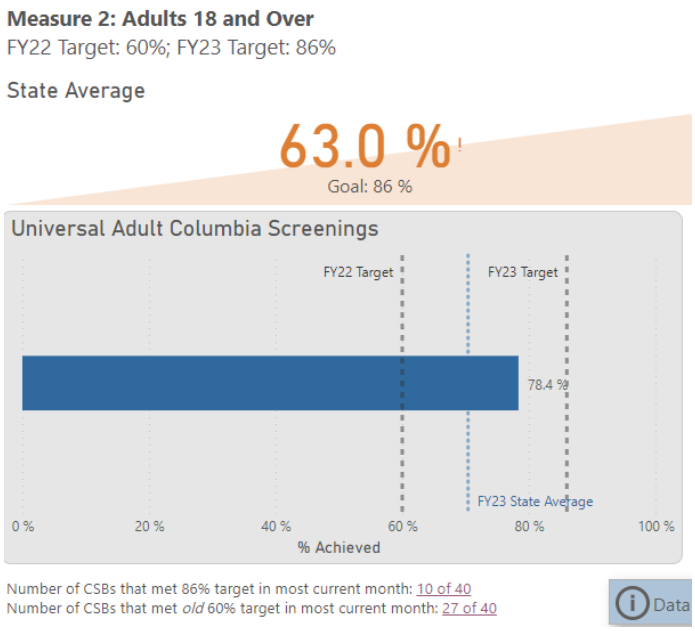
Current Month's Performance- January 2023 (80.7%)



Suicide Risk Assessment *The reports for these measures are still in development by DBHDS. These results are provided for a general idea of RACSB performance, but are not finalized or official.

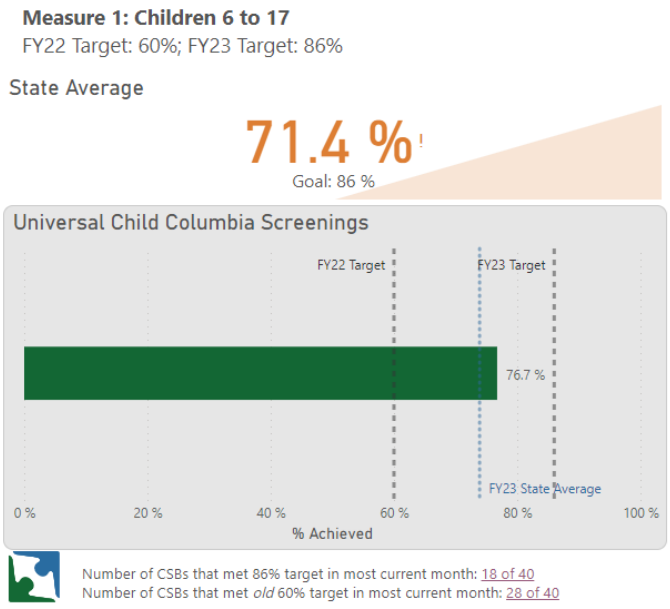
Measure #1: Universal Adult Columbia Screenings: Percentage of adults who are 18 years old or older and have a new MH or SUD program opening (denominator) who received a suicide risk assessment completed within 30 days before or 5 days after case opening(numerator). The benchmark is set at 60 % for FY22 and 86% for FY23.

Current Month's Performance-February 2023 (78.4%)



Measure #2: Child Suicide Assessment: Percentage of children who are 7 through 17 years old who have a new MH or SUD program opening (denominator) who received a suicide risk assessment completed within 30 days before or 5 days after case opening(numerator). The benchmark is set at 60 % for FY22 and 86% for FY23. *Not yet benchmarked in performance contract.

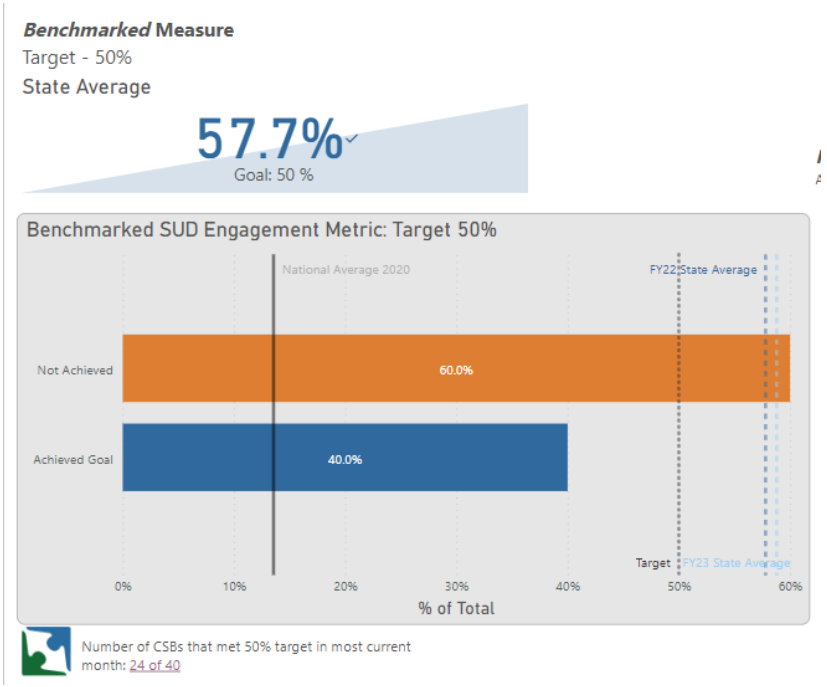
Current Month's Performance- February 2023 (76.7%)



Substance Use Disorder Engagement Measures

Engagement of SUD Services: Percentage of adults and children who are 13 years old or older with a new episode of SUD services as a result of a new substance use disorder (SUD) diagnosis (denominator, who initiated any SUD service within 14 days of diagnosis and who received two or more additional SUD services within 30 days of the first service (numerator). Benchmark is 50%.

Current Month's Performance- February 2023 (40.0%)



Developmental Disability Measures

Percent receiving face-to-face and In-Home Developmental Case Management Services

Definition: Percent of total individuals with an ID/DD Waiver who meet criteria for Enhanced Case Management who received a face-to-face case management service within the reporting month and previous case management visit was 40 days or less. *Target:* ***90%***

Definition: Percent of total individuals with an ID/DD Waiver who meet criteria for Enhanced Case Management who received **In-Home** face-to-face case management services every two months. *Target:* ***90%.***

DBHDS has not provided an updated visualization of or updated performance on the ID/DD Case Management Measures at this time- Performance on this as indicated below is the same information previously reported in April 2023's Program Planning and Evaluation

ECM Face to Face: January 2023- 76%

ECM Face to Face with Telehealth included: January 2023- 92%

ECM In-Home: January 2023- 79%