hopestarter RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

VOICE/TDD (540) 373-3223 FAX (540) 371-3753

meeting notice

TO: **Board of Directors**

FROM: **Gregory Sokolowski, Secretary**
Joe Wickens Executive Director

SUBJECT: **Board of Directors Meeting**
Tuesday, February 21, 2023 5:00 PM
Rappahannock Area CSB – Board Room 208
600 Jackson Street, Fredericksburg, VA 22401

DATE: **February 17, 2023**

A Board of Directors Meeting has been scheduled for Tuesday, February 21 at 5:00 PM, Rappahannock Area CSB – Board Room 208, 600 Jackson Street, Fredericksburg, VA 22401.

Looking forward to seeing everyone on February 21, 2023.

Best.

GS/JW

Enclosure (Agenda Packet)

Voice/TDD (540)373-3223 / Fax (540) 371-3733

NOTICE

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

From: Joseph Wickens
Executive Director

Subject: Program Planning & Evaluation Committee Meeting
February 14, 2023, 10:30 AM
600 Jackson Street, Board Room 208, Fredericksburg, VA

Date: February 09, 2023

A Program Planning & Evaluation Committee meeting has been scheduled for Tuesday, February 14, 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 February 14th at 10:30 AM

Cc: Nancy Beebe, Chairperson

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Program Planning and Evaluation Committee Meeting

February 14, 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: February 14, 2023

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

Southern Virginia Mental Health Institute

Individual #1: Was placed on the EBL 12/4/22. Barriers to discharge include identifying and being accepted to an assisted living facility (ALF) that can meet both their physical and psychiatric needs. The individual's treatment team is working to complete the Uniform Assessment Instrument (UAI), which will be used to refer this individual to ALFs that are willing to accept registered sex offenders. This individual is not always cooperative with staff with regard to completing their activities of daily living, causing it to be challenging to provide them with care. This individual also requires a legal guardian and have been referred to Jewish Family Services to continue this process. An additional challenge to identifying an accepting placement will be that this individual is a Tier III Registered Sex Offender. This individual will discharge once accepted to an ALF and once a guardian is in place.

Western State Hospital

Individual #2: Was placed on the EBL 12/27/22. Barriers to discharge include working through current legal charges as well as being accepted to an ALF that is able to support their needs. This individual has resided in the community as well as in RACSB Supervised Apartments, however it has been determined that they require a higher level of care with more support and supervision.

They will also benefit from an ALF that has a younger population. The treatment team is currently in communication with Heart2Heart ALF regarding possible placement for this individual. They will discharge to the community once they are able to work through their legal charges and are accepted to an ALF.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Donna Andrus, Child and Adolescent Support Services Supervisor
Date: January 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 twelve IACCT referrals and completed eleven assessments in the month of January. Seven referrals were initial IACCT assessments and five were re-authorizations. Four were from Spotsylvania, five from Stafford, two from Caroline, none from King George and one from the City of Fredericksburg. One initial IACCT was withdrawn by the parent. Of the eleven completed assessments in January, six recommended Level C Residential, four recommended Level Group Home, one recommended community-based services. No reauthorizations recommended discharge at this time.

Attached is the monthly IACCT tracking data for January 2023.

Report Month/Year	Jan-23
1. Total number of Referrals from Magellan for IACCT:	12
1.a. total number of auth referrals:	7
1.b. total num. of re-auth referrals:	5
2. Total number of Referrals per county:	
Fredericksburg:	1
Spotsylvania:	4
Stafford:	5
Caroline:	2
King George:	0
Other:	
3. Total number of extensions granted:	2
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:	11
8a. Total number of ICA's recommending: **residential:**	6
8b. Total number of ICA's recommending: **therapeutic group home:**	4
8c. Total number of ICA's recommending: **community based services:**	1
8g.Total number of ICA's recommending: **Other:**	0
8h.Total number of ICA's recommending: **no MH Service:**	0
9. Total number of reauthorization ICA's recommending: **requested service not continue:**	0
10. Total number of notifications that a family had difficulty accessing **any** IACCT-recommended service/s:	0

To: Joe Wickens, Executive Director

From: Suzanne Poe, IT Coordinator

Re: Information Technology and Electronic Health Record Update

Date: February 7, 2023

This report provides an update on projects related to Information Technology and the Electronic Health Record. The IT department completed 983 tickets in the month of January. 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 January 2023, 983 tickets where closed by IT Staff.

The Average number of tickets closed in 2022 was 1,023 per month.

IT is working with staff from Permanent Supportive Housing to order and setup their networking and IT needs for their new space at the Bowman center. All of their equipment and services are on order and should be installed prior to the March 1, 2023 move in date.

Community Consumer Submission 3
The December 2022 CCS was submitted on January 26, 2023. Staff reviewed and provided input on the draft specifications for the upcoming fiscal year CCS changes.

Waiver Management System (WaMS)
DBHDS has released their new 2023 specifications for ISP version 3.4. Netsmart and the IT team have implemented the ISP changes into the Avatar test system and are waiting for DBHDS to open the WaMS testing period. IT staff are continuing to meet with DBHDS, WaMS, and Netsmart to discuss ISP 3.4 changes/testing period.

On January 30, 2023 DBHDS changed the transfer mechanism of how WaMS and Electronic Heath Records communicate. There was a brief testing period the week prior. Netsmart is still working through a communication issue, between systems. In the interim, IT is working with ID/DD Case Management to directly enter service plans.

Trac-IT Early Intervention Data System
In November, RACSB program and IT staff attended a demo on the upload functionality for Trac-It. This functionality will be key for our ability to meet expanded data requirements when the new date for that implementation is announced. After the demo, there are system-wide concerns around the functionality. We met as part of the DMC Trac-IT workgroup with DBHDS Part C Staff to express our concerns. There are no additional updates since that meeting.

Zoom
We continue to utilize Zoom for telehealth throughout the agency.

- 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
The ACT and PEID teams are using Bells to create notes, however they both discovered a problem with how the notes are currently displaying in Avatar. IT met with the Bells team on February 3, 2023 to discuss upcoming features and the note display issue. The Bells team is reviewing the issue and will provide guidance on how to correct the issue.

Camera System and Maintenance Request for Proposals-
The IT department has decided due to the cost of camera maintenance and that we maintain the Axis camera systems in house and replace the Alibi systems as they breakdown.

Staffing

The IT department will have 1 vacant Data Analyst position. The current Data Analyst, Robert Rezendes, is staying within RACSB but moving back to Quality Assurance. The date of his transfer is TBD.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Tabitha Taylor, Emergency Services Law enforcement liaison
Date: February 8, 2023
Re: Crisis Assessment Center and CIT report January 2023

The CIT Assessment Center assessed 20 individuals in the month of January 2023. The number of persons served by locality were the following: Fredericksburg 6; Caroline 4; King George 2; Spotsylvania 6; Stafford 4.

The CIT program held it's first 40-hour training for law enforcement. Twenty two individuals were trained from the following jurisdictions: Rappahannock Regional Jail, Ft. Belvoir, District 21 probation, Stafford, King George, Spotsylvania, Fredericksburg City and Germanna.

Please see attached CIT data sheet

January 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
1/1/2022	1	1	Caroline	Spotsylvania/Stafford
1/2/2022	0	0	n.a	Fredericksburg
1/3/2022	3	1	Spotsylvania	Spotsylvania
1/4/2022	3	2	Spotsylvania/Fredericksburg	Spotsylvania
1/5/2022	0	0	n/a	Spotsylvania
1/6/2022	2	1	Spotsylvania	Spotsylvania
1/7/2022	1	0	n.a	Spotsylvania
1/8/2022	2	0	n/a	Spotsylvania
1/9/2022	1	0	n.a	Spotsylvania/Fredericksburg
1/10/2022	1	0	n.a	Spotsylvania
1/11/2022	1	1	Stafford	Spotsylvania
1/12/2022	5	0	n.a	Spotsylvania/Stafford
1/13/2022	2	0	n.a	Spotsylvania
1/14/2022	0	0	n.a	Spotsylvania
1/15/2022	5	1	Fredericksburg	Spotsylvania/King george
1/16/2022	6	0	n/a	Spotsylvania
1/17/2022	6	0	n.a	Spotsylvania/Stafford
1/18/2022	3	2	Fredericksburg (2)	Spotsylvania
1/19/2022	4	1	Fredericksburg	Spotsylvania/Fredericksburg
1/20/2022	2	1	Stafford	Spotsylvania/Stafford
1/21/2022	2	2	Spostylvania; King George	Spotsylvania/Fredericksburg
1/22/2022	1	0	n.a	Spotsylvania/Stafford
1/23/2022	1	1	Spotsylvania	Spotsylvania
1/24/2022	3	0	n.a	Spotsylvania
1/25/2022	2	0	n/a	Spotsylvania
1/26/2022	1	1	Stafford	King George
1/27/2022	2	2	Fredericksburg; King George	Spotsylvania/Fredericksburg
1/28/2022	3	1	Stafford	Spotsylvania
1/29/2022	1	0	n.a	Spotsylvania/King george
1/30/2022	4	2	Spotsylvania/Caroline	Spotsylvania/Fredericksburg
1/31/2022	0	0	n/a	King George
Total	68	20		

Total Assessments at Center in January: 20

Brought by:		**Cumulative Total:**
Caroline	4	143
Fred City	6	1006
Spotsylvania	6	954
Stafford	4	993
King George	2	124
Other	0	3

Cumulative number of Assessment since September 2016: 3223

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Kari Norris, Emergency Services Coordinator
Date: February 8, 2023
Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – January, 2023

In January 2023, Emergency Services staff completed 389 emergency evaluations. Eighty-one emergency custody orders were assessed and eighty six total temporary detention orders served of the 389 evaluations. Staff facilitated four admissions to a state hospital. The two adult admissions went to NVMHI. Two admissions were adolescents and children and were admitted to CCCA.

A total of nineteen individuals were involuntarily hospitalized outside of our catchment area in January. Four individuals were able to utilize alternative transportation and four others were appropriate, but unable to utilize due to no available driver.

Please see attached data reports.

DATE: 2.8.2023

Emergency Services Activity Reports

Month	Contacts	Evaluations	ECOs	TDOs Issued	TDOs Executed
September 2020	[redacted]	422	94	91	91
October 2020		492	113	85	85
November 2020		413	88	88	88
December 2020		373	75	79	79
January 2021		374	88	89	89
February 2021		358	84	83	83
March 2021		465	82	100	100
April 2021		449	92	100	100
May 2021		507	93	93	93
June 2021		453	95	95	92
July 2021		379	76	74	74
August 2021		394	86	77	77
September 2021		517	98	86	86
October 2021		422	60	72	72
November 2021		425	59	60	60
December 2021		401	67	66	66
January 2022		355	74	63	63
February 2022		442	87	64	64
March 2022		375	74	81	81
April 2022		390	85	87	87
May 2022		417	92	73	73
June 2022		342	75	66	66
July 2022		343	77	83	83
August 2022		367	79	76	76
Setpember 2022		341	66	76	76
October 2022		351	70	75	75
November 2022		359	69	73	73
December 2022		296	55	51	51
January 2023		389	81	86	86

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

CSB/BHA	Rappahannock Area Community Services Board	Month	January 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	
389	32	49	81	84	10	3	71	84	2
			0					0	

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

CSB/BHA	Rappahannock Area Community Services B	Reporting month	January 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)	
1/6/23	41458	Adolescent		Yes	No	CCCA
1/15/23	16700			Yes	No	NVMI
1/12/23	71729	Child		Yes	No	CCCA
1/14/23	39376			No	Yes	NVMHI

ALTERNATIVE TRANSPORT DATA January 2023

Date	ID	LE DEPT	Location of Individual	Receiving Hospital	Travel time Round Trip (minutes)	ECO Y or N	Gender	Age	TDO criteria	Presented for AT: Y or N	Reason for Decline
1/4/23	100404	Caroline	MWH-ED	Clearview	644	No	F	23	Danger to self	Y	No available driver
1/4/23	108756	Spotsylvania	MWH-ED	Poplar Spring	160	Yes	F	17	Danger to self	Y	AT utilized
1/6/23	41458	Spotsylvania	MWH-ED	CCCA	240	Yes	M	16	Danger to others/Inability to care	Y	No available driver
1/8/23	86561	Spotsylvania	MWH-ED	Newport News	208	Yes	F	15	Danger to self	N	Client attempted to elope while in custody
1/12/23	72179	Spotsylvania	MWH-ED	CCCA	240	Yes	M	12	Danger to others	Y	No available driver
1/14/23	39376	Stafford	MWH Med Floor	NVMHI	100	No	F	41	Danger to self/Inability to care	Y	
1/15/23	88726	Spotsylvania	MWH-ED	Lewis Gale	344	No	F	59	Danger to self	Y	AT utilized
1/15/23	16700	Fredericksburg	MWH-ED	NVMHI	100	Yes	F	38	Danger to others/Inability to care	N	No due to aggression
1/19/23	21161	Fredericksburg	MWH-ED	Roanoke - Carillion	384	Yes	F	31	Inability to care	N	Too impulsive and erratic
1/20/23	67939	Stafford	MWH-ED	Richmond Comm Hospital	124	No	M	27	Danger to others/Inability to care	N	No due to elopement risk
1/21/23	52351	King George	MWH-ED	Poplar Spring	160	Yes	M	20	Danger to self/Other/Inability to care	N	Client too paranoid and impulsive
1/22/23	108955	Caroline	MWH-ED	Poplar Springs	160	No	F	21	Danger to self	N	Client was too aggressive in ED and assaultive
1/23/23	102153	Stafford	MWH-ED	Poplar Springs	160	No	M	31	Inability to care	N	No client is too impulsive and unpredictable
1/27/23	109029	King George	MWH-ED	Dominion	120	No	F	16	Danger to self	N	No due to agitation, impulsivity and aggression

1/28/23	84921	Fredericksburg	MWH-ED	Pavilion at Williamsburg	180	No	F	41	Danger to self	Y	Client then refused AT when they arrived
1/28/23	109032	Stafford	MWH-ED	Poplar Springs	160	No	F	30	Danger to self	Y	AT utilized
1/30/23	109057	Stafford	MWH-ED	Clearview	644	Yes	M	22	Inability to care	N	No due to aggression
1/30/23	43165	Spotsylvania	MWH-ED	Clearview	644	Yes	M	50	Danger to others/Inability to care	N	Risk for Elopement
1/30/23	104045	Caroline	MWH-ED	Newport News	208	Yes	M	11	Danger to self	Y	AT utilized

Total Out of Area			
19			
Total Utiliz	**% Utilized**	**Total Appropriate for AT**	
4	21%	8	42%

Memorandum

To: Joe Wickens, Executive Director

From: Steve Curtis, DD Residential Coordinator

Date: February 2, 2023

Re: Lucas Street, Ross Drive ICF Recertification Survey

On January 18th and 19th 2023, the Virginia Department of Health (VDH) conducted on-site visits (surveys) at Lucas Street and Ross Drive Intermediate Care Facilities (ICF's). Two medical facility inspectors (surveyors) conducted the surveys focusing on a sampling of the following from each program: Observation of 5 individuals, the supports provided to the individuals, and the individuals' charts. The surveys were conducted as an annual requirement for each program's recertification as ICF's.

The surveyors' findings were included in 2 separate program reports which we received by email on January 25th. Each report contained deficiencies listed by federal regulations (W-tags and E-tags) that did not meet standards. Out of the 401 total regulations that the programs are surveyed for, 6 deficiencies were noted for Lucas Street ICF and 2 deficiencies were noted for Ross Drive ICF.

Lucas Street ICF:

- W111: Facility staff did not ensure the clinical record was complete and accurate. Specifically:
    - The ISP did not include the need for the use of a cup with a base for an individual, whereas the home's "eating precaution plan", a meal time quick reference sheet for staff use, did mention the need for use of this particular item. The citation was incurred because the 2 documents did not match.
- W125: Facility staff did not provide a dignified dining experience for 1 individual. Specifically:
    - While supporting an individual with a meal, a staff member was standing beside the person assisting them rather than being seated beside them. The staff member responsible was brand new to working in the program and learning program protocols; this was an oversight on her part.
- W153: Facility staff failed to convey information to administration regarding an allegation of abuse in a timely manner.
    - A staff member did not make a timely report regarding an allegation of abuse to the program coordinator and Quality team in a timely fashion. (Incidentally, the RACSB Office of Consumer affairs investigated this incident upon discovery and corrective action was taken with staff.)

- W159: The Qualified Intellectual Disability Professional (QIDP) failed to accurately document the use of a cup with a base on the ISP (individual support plan).

    - This is a result of the above referenced issue with the ISP missing what the "eating precaution plan" reference sheet contained about use of the cup with a base for one individual.

- W440: The facility failed to conduct fire/evacuation drills for each shift quarterly, potentially affecting all individuals in the facility.

    - Specifically, 1 drill in March 2022 was not completed for the home. The person responsible for this issue has since resigned.

- W503: Facility staff failed to implement COVID-19 vaccination requirements for 2 of 7 employee vaccination records reviewed.

    - Out of the random sampling of all staff, 1 contractor failed to turn in a copy of her vaccination record. One staff member failed to turn in evidence of her 2nd dose of the vaccine series. Both issues went undetected in the records prior to the survey.

Ross Drive ICF:

- W159: The QIDP failed to ensure the individual's ISP (individualized service plan) for eating was implemented. The QIDP failed to ensure the individual's ISP (individualized service plan) for medication management was implemented.

    - The QIDP bears the responsibility of staff actions for this tag. During the survey, a staff member decided to feed an individual capable of feeding himself to help prevent the individual from throwing his food on the floor. For a second individual that receives his medications in applesauce, the ISP states that after staff feeds him the applesauce with the meds, he should be encouraged to take the spoon and finish the last bite of applesauce independently. The idea behind this is to slowly promote independence towards taking his own medications. Staff fed him the entire cup of applesauce without offering him the chance to participate as dictated in the plan.

- W249: Facility staff failed to implement active treatment for 2 of 3 individuals in the survey sample.

    - This tag was cited as a direct result of tag W159 in which support staff were not following the ISP support instructions for the 2 individuals.

Noted deficiencies are being corrected and plans of correction were submitted to VDH on February 2nd, 2023. The plans were approved on that same day by VDH.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/17/2023 through 01/18/2023. The facility was in compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid re-certification survey was conducted 01/17/2023 through 01/18/2023. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey report will follow. No complaints were investigated during the survey. The census in this four bed facility was four at the time of the survey. The survey sample consisted of three current individual reviews (Individuals #1, #2 and #3).	W 000		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observation, staff interviews and clinical record reviews it was determined that the facility staff failed to ensure the clinical record was accurate for one of three individuals in the survey sample, Individual #2.	W 111		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DD Residential Coordinator 2/1/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 1 The findings include: For Individual #2, the facility staff failed to accurately document the use of a cup with a base on the ISP (individual support plan). Individual #2 was admitted to the facility with diagnoses that included but were not limited to: profound intellectual disability (1) and swallowing difficulties. An observation at dinner was conducted of Individual #2 on 01/17/2023 at approximately 5:00 p.m. Individual #2 was observed seated at the dinner table with other residents of the facility. Individual #2 was served his meal using the following adaptive equipment: a Dycem (2) mat, small plastic cup, flat maroon spoon and a divided plate with a guard. Further observation failed to evidence a cup with a base. Individual #2's ISP dated 04/13/2022 through 04/12/2023 documented in part, "Goal: 12. Important for: (protocol). (Individual #2) is supported to follow his prescribed nutrition and eating plan. Provide a small amount of liquid in a cup (4oz (four ounce) nosey cup can be used as well) at a time (1-2 (one to two) oz or less). Provide hand over hand or tactile prompts when drinking to help control size of sip." The facility's "Eating Precaution Plan" for Individual #2 documented in part, "Adaptive equipment required: Dycem mat, divided plate w (with)/plate guard, maroon spoon and plastic cup w/ a base and clothing protector. On 01/18/2023 at approximately 1:28 p.m., an interview was conducted with OSM (other staff	W 111	**W111** **How corrective action will be accomplished for individual #2:** Facility staff will ensure that that they document the use of a cup with a base in Individual #2's ISP (Individual Support Plan). **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will ensure that the adaptive equipment for each individual is accurately documented in their ISPs. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The Program Manager or designee will review the clinical record to ensure that the adaptive equipment for each individual is accurately documented in their ISPs. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QIDP will review, revise, and monitor the clinical records to ensure that the adaptive equipment for each individual is accurately documented in their ISPs. **Date of Completion:** 2/10/2023	2/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 2 member) #1, Qualified Intellectual Disabilities Professional (QIDP). After reviewing Individual #2's ISP, the eating precaution plan and informed of the above observation, OSM #1 stated that the ISP did not accurately document the correct cup that Individual #2 uses. OSM #1 further stated that they review the Individual's ISPs to make sure that they are accurate and that this inaccuracy was over looked. On 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A non-slip, rubber-like plastic material used to stabilize surfaces. Reusable. Cut to most any size or shape with scissors. Cleans with soap and water. Blue (except where noted). Matting is 1/32" thick. Not made of natural rubber latex. Long lasting. Unlimited uses. This information was obtained from the website: https://www.alimed.com/dycem-nonslip-matting.ht	W 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

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LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 3 ml.	W 111	**W125** **How corrective action will be accomplished for individual #2:** Facility staff will support individual #2 to exercise his right to dignity during all meals and snacks by sitting beside him (rather than standing) when he is eating .	**2/10/2023**
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to allow an individual to exercise their right of dignity during a meal for one of three individuals in the survey sample, Individual #2. The findings include: For Individual #2, the facility staff stood next to the Individual as they ate their dinner. Individual #2 was admitted to the facility with diagnoses that included but were not limited to: profound intellectual disability (1) and swallowing difficulties. An observation at dinner was conducted of Individual #2 on 01/17/2023 at approximately 5:00 p.m. Individual #2 was observed seated at the dinner table with other individuals of the facility eating their dinner, feeding themselves independently, while staff provided verbal cues. Further observation revealed OSM (other staff member) #2, day support direct support professional, standing next to Individual #2 while they ate their dinner.	W 125	**Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will support all individuals to exercise their right to dignity during all meals and snacks by sitting beside them (rather than standing) when they are eating. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP and ICF Management will monitor facility staff adherence to supporting all individuals to exercise their right to dignity during meals and snacks by sitting beside them (rather than standing) when they are eating. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Dining protocols will be revised as needed and reviewed a minimum of annually with all staff and will include instructions for supporting all individuals to exercise their right to dignity during all meals and snacks by sitting beside them (rather than standing) when they are eating. ICF Management will monitor and document various shift checks to ensure that these protocols are being adhered to. **Date of Completion**: 2/10/2023	

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	49G064	A. BUILDING _____ B. WING _____	01/18/2023

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LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 125	Continued From page 4 On 01/18/2023 at approximately 1:15 p.m. an attempt was made to interview OSM #2 but was unsuccessful as they were not available. On 01/18/2023 at approximately 1:28 p.m., an interview was conducted with OSM (other staff member) #1, Qualified Intellectual Disabilities Professional (QIDP). After being informed of the above observation, OSM #1 stated that it was a dignity issue and that staff should be seated next the individuals during their meals. The facility's policy "Nutrition. Section 9-4: Dining" documented in part, "4. Support/assistance during meals: c. Staff will sit with the individual, assist them, and dine with them ..." On 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100	W 125		

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W 125	Continued From page 5 (2) A non-slip, rubber-like plastic material used to stabilize surfaces. Reusable. Cut to most any size or shape with scissors. Cleans with soap and water. Blue (except where noted). Matting is 1/32" thick. Not made of natural rubber latex. Long lasting. Unlimited uses. This information was obtained from the website: https://www.alimed.com/dycem-nonslip-matting.html.	W 125	**W153** **How corrective action will be accomplished for Individual #2:** Disciplinary action was taken with facility staff responsible for not following mandated reporting policies and protocols. Human Rights policies have been reviewed with facility staff to ensure that they will immediately report allegations of abuse for Individual #2.	**2/1/2023**
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interviews and clinical record review and facility document review it was determined that the facility staff failed to report an allegation of abuse in a timely manner for one of three individuals in the survey sample, Individual #2. The findings include: For Individual #2, the facility staff failed to convey information to administration regarding an allegation of verbal abuse in a timely manner. The facility's "Human Rights Investigation" dated 06/10/2022 documented in part, "On June 8, 2022, (OSM Other staff member) #3, compliance specialist, and OSM #4, utilization review specialist, interviewed (LPN (licensed practical nurse) #1) and (Name Staff Member). (Name of	W 153	**Assurance that other residents are protected from the possibility of the deficiency:** Human Rights policies have been reviewed with facility staff to ensure that they will immediately report allegations of abuse for all individuals. Any facility staff that fails to follow mandated reporting policies and protocols will receive disciplinary action. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** QIDP and ICF Management will monitor facility staff adherence to Human Rights policies to ensure compliance in the facility. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Human Rights policies will be reviewed at mandatory staff meetings at least annually. ICF Management will conduct ongoing 1:1 supervision meetings and team meetings to discuss/review policies, protocols, and expectations of staff to help further ensure that there are no unreported allegations or concerns. **Date of Completion:** 2/1/2023	

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W 153	Continued From page 6 LPN #1): During the interview, (LPN #1) stated that on Saturday (6/4/22) around noon, Individual #2 was eating lunch, and as typical for Individual #2, was up and down out of his chair. (LPN #1) stated that she observed DSP (direct support professional) #1 tell (Individual #2) to "Sit his ass down." (LPN #1) stated that the next day, Sunday (6/5/22) (Individual #3) slept in and between 1:00 - 2:00 pm (p.m.) she woke up and began grunting and vocalizing. (LPN #1) stated that she witnessed (DSP #1) telling (Individual #3) to "Shut up." (LPN #1) stated that she reported these incidents to her supervisor on Tuesday, because she had been off on Monday." On 01/18/2023 at approximately 1:43 p.m., an interview was conducted with ASM (administrative staff member) #1, residential coordinator. When asked about staff training regarding abuse and reporting ASM #1 stated that all staff members are mandated reporters and receive mandated reporter training when they are hired. ASM #1 further stated that if an allegation of abuse is witnessed it should be reported to the supervisor immediately. When asked how they defined "immediately" in terms of a time frame ASM #1 stated that it should be within an hour of the incident. When asked about the reporting from LPN #1 regarding the allegation of verbal abuse dated June 4th and 5th 2022, ASM#1 stated that it should have been reported immediately. On 01/18/2023 at approximately 2:07 p.m., an interview was conducted with LPN #1. When asked if they were a witness to the allegations of abuse on June 4th and 5th 2022 LPN #1 stated yes. When asked to describe the procedure for reporting allegations of abuse LPN #1 stated that they would report it to management. When	W 153		

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W 153	Continued From page 7 asked how long they would wait before reporting the allegation of abuse LPN #1 stated that they did not know. After review the facility's policy "Client Protection Section 2-3: Abuse and Neglect" LPN # 1 stated that they were not aware that an allegation of abuse should be reported immediately. The facility's policy "Client Protection Section 2-3: Abuse and Neglect" documented in part, "Any employee who witnesses any behavior prohibited by RACSB's Human Rights Plan is required to complete an incident report and immediately inform the supervisor and RACSB's Human Rights Advocate in accordance with RACSB's Code of Ethics and Corporate Compliance Plan. Failure to do so violates RACSB's Human Rights Plan and Corporate Responsibility Resolution." On 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit.	W 153		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate the individuals' active treatment programs for one of three individuals in the survey sample, Individual #2.	W 159		

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LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 159	Continued From page 8 The findings include: For Individual #2, the QIDP failed to accurately document the use of a cup with a base on the ISP (individual support plan). Individual #2 was admitted to the facility with diagnoses that included but were not limited to: profound intellectual disability (1) and swallowing difficulties. An observation at dinner was conducted of Individual #2 on 01/17/2023 at approximately 5:00 p.m. Individual #2 was observed seated at the dinner table with other residents of the facility. Individual #2 was served his meal using the following adaptive equipment: a Dycem (2) mat, small plastic cup, flat maroon spoon and a divided plate with a guard. Further observation failed to evidence a cup with a base. Individual #2's ISO dated 04/13/2022 through 04/12/2023 documented in part, "Goal: 12. Important for: (protocol). (Individual #2) is supported to follow his prescribed nutrition and eating plan. Provide a small amount of liquid in a cup (4oz (four ounce) nosey cup can be used as well) at a time (1-2 (one to two) oz or less). Provide hand over hand or tactile prompts when drinking to help control size of sip." The facility's "Eating Precaution Plan" for Individual #2 documented in part, "Adaptive equipment required: Dycem mat, divided plate w (with)/plate guard, maroon spoon and plastic cup w/ a base and clothing protector. On 01/18/2023 at 1:23 p.m., an interview was	W 159	**W159** **How corrective action will be accomplished for Individual #2:** The QIDP will revise individual #2's ISP to ensure it contains the use of a cup with a base. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will review each individual's current ISP to ensure each plan includes directives for use of the correct adaptive equipment. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will review and monitor each individual's ISP on an ongoing basis to ensure that each plan includes directives for the use of the corrective adaptive equipment. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program supervisor and assistant manager will provide ongoing monitoring and review of all ISPs to ensure that they include directives for the use of the corrective adaptive equipment. **Date of Completion:** 2/10/2023	**2/10/2023**

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W 159	Continued From page 9 conducted with OSM (other staff member) #1, QIDP. OSM #1 stated active treatment is collaborative and they are responsible for coordinating care. OSM #1 stated they write the ISPs and is able to update them. OSM #1 stated that since he is in the facility, he can make sure staff are implementing the ISPs and explain to staff why they are supposed to do something the way they do it. OSM #1 stated he tries to ensure staff is implementing ISPs by making observations and correcting staff as soon as he sees they are doing something that does not align with the plan. OSM #1 stated he also communicates ISPs through monthly staff meetings and staff must sign off on individuals' ISPs. After reviewing Individual #2's ISP, the eating precaution plan and informed of the above observation, OSM #1 stated that the ISP did not match the eating precaution guidelines for Individual #2. On 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit. References: (1) Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website:	W 159		

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W 159	Continued From page 10 https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (2) A non-slip, rubber-like plastic material used to stabilize surfaces. Reusable. Cut to most any size or shape with scissors. Cleans with soap and water. Blue (except where noted). Matting is 1/32" thick. Not made of natural rubber latex. Long lasting. Unlimited uses. This information was obtained from the website: https://www.alimed.com/dycem-nonslip-matting.html.	W 159		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on facility document review and staff interview, it was determined that the facility failed to conduct fire drills for each shift quarterly, potentially affecting all individuals in the facility. The finding include: Review of the facility's fire drill forms dated 08/2021 through 012/2022 failed to evidence that a fire drill was conducted in March 2022. On 01/18/2023 at approximately 1:43 p.m., an interview was conducted with ASM (administrative staff member) #1, residential coordinator. When informed of the missing fire drill in March 2022 ASM #1 stated that they did not have documentation that a fire drill was conducted in March of 2022. On 01/18/2023 at approximately 2:00 p.m. ASM (administrative staff member) # 1, residential	W 440	**W440** **How corrective action will be accomplished:** Facility staff will conduct evacuation drills at least quarterly for each shift of personnel. **Assurance that other residents are protected from the possibility of the deficiency:** All ICF facilities will conduct evacuation drills at least quarterly for each shift of personnel. **Measures to be put in place or systemic changes to be made to ensure that the deficient practice will not recur:** The program supervisor will monitor to ensure that facility staff conduct evacuation drills at least quarterly for each shift of personnel. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Director of Compliance and Human Rights, or designee, will review to ensure that evacuation drills are conducted at least quarterly for each shift of personnel. **Date of Completion:** 2/1/2023	**2/1/2023**

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LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 440	Continued From page 11 coordinator, was made aware of the above findings. No further information was provided prior to exit.	W 440	**W503** **How corrective action will be accomplished for DSP #2 and OSM #5:** Facility staff will ensure that DSP (direct support professional) #2 meets their second dose of the COVID-19 vaccine requirements, and will ensure they obtain documentation evidencing that OSM (other staff member) #5, registered dietitian, meets the COVID-19 vaccine requirements. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will ensure that all DSPs and OSMs meet COVID-19 vaccination requirements and that documentation has been obtained as evidence of meeting these requirements for agency records. **Measures to be put in place or systemic changes to be made to ensure that the deficient practice will not recur:** The program supervisor or designee will monitor to ensure that all facility staff and contracted staff meet COVID-19 vaccination requirements upon recommendation of hire/ utilization in the program. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Human Resources department will monitor to ensure documentation is filed as evidence that all facility staff and contracted staff members meet COVID-19 vaccination requirements. **Date of Completion:** 2/15/2023	**2/15/2023**
W 503	COVID-19 Policies and Procedures: Vaccination CFR(s): 483.460(a)(4)(iv) § 483.460(a)(4)(iv) In situations where COVID-19 vaccination requires multiple doses, the client, client's representative, or staff member is provided with current information regarding each additional dose, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of each additional doses. This STANDARD is not met as evidenced by: Based on employee record review, facility document review and staff interview, it was determined that the facility staff failed to implement COVID-19 vaccination requirements for two of seven employee vaccination records reviewed; DSP #2 and OSM #5. The findings include: Facility staff failed to ensure DSP (direct support professional) #2 received their second dose of the COVID-19 vaccine, and failed to obtain documentation evidencing OSM (other staff member) #5, registered dietician, received the COVID-19 vaccine. On 01/17/2023 at approximately 12:30 p.m., a request was made to the facility's human resource department for documentation evidencing DSP#2 and OSM #5 received the COVID-19 vaccine.	W 503		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/17/2023 through 1/18/2023. The facility was in compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during the survey.	E 000		
W 000	INITIAL COMMENTS An unannounced Focused Fundamental Medicaid re-certification survey was conducted 1/17/2023 through 1/18/2023. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this four certified bed facility was four at the time of the survey. The survey sample consisted of three individual reviews (Individuals #1, #2 & #3).	W 000		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on observation, staff interview, facility document review and residential record review, it was determined that the QIDP (qualified intellectual disabilities professional) failed to coordinate and monitor individuals' active treatment program for two of three individuals in the survey sample, Individuals #2 and #3.	W 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DD Residential Coordinator 2/1/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

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W 159	Continued From page 1 The findings include: 1. For Individual #2, the QIDP failed to ensure the individual's ISP (individualized service plan) for eating was implemented. Individual #2 was admitted to the facility on 11/28/14. Individual #2's diagnoses included but were not limited to severe intellectual disability and gastroesophageal reflux disease. Individual #2's ISP, signed by the QIDP (qualified intellectual disabilities professional) on 12/23/22, documented, "(Individual #2 Name) utilizes a suctioned plate to help prevent instances of him throwing his plate and eats with a spoon. As (Individual #2) has a history of throwing his food, often times without an identifiable trigger, staff will provide (Individual #2) with half of his meal at a time. When (Individual #2) finishes his first portion, he receives the rest of his meal. If (Individual #2) is expressing that he is finished eating, remove food from his reach. (Individual #2) is capable of feeding himself independently and is expected to do so at all times while being supervised by staff..." On 1/17/23 at approximately 5:05 p.m., DSP (direct support staff) #1 was observed feeding Individual #2 bite size pieces of pizza and salad with a spoon. On 1/17/23 at 5:09 p.m., an interview was conducted with DSP #1, regarding Individual #2's ability to feed self. DSP #1 stated Individual #2's ability to feed self depends on the individual's mood. DSP #1 stated sometimes (Individual #2) feeds self but sometimes when the individual is tired and doesn't want to feed self then staff feeds the individual. DSP #1 stated	W 159	**W159** **1.** **How corrective action will be accomplished for Individual #2:** The QIDP will monitor to ensure implementation of the PCP [person-centered plan] outcome/goal for eating for Individual #2. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will monitor to ensure implementation of all outcomes/goals in the active treatment plan/ PCP [person-centered plan] for each resident. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will review data to ensure outcome /goal implementation is being recorded accurately by staff. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will review all data collection at a minimum of monthly to ensure that implementation is being recorded accurately. **Date of Completion:** 2/1/2023	**2/1/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G065	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

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W 159	Continued From page 2 sometimes (Individual #2) pushes the plate of food away when staff puts the plate up to the individual. DSP #1 pushed the plate of food toward (Individual #2) and (Individual #2) pushed the plate away. On 1/18/23 at 1:23 p.m., an interview was conducted with ASM (administrative staff member) #2 (the QIDP). ASM #2 stated active treatment is collaborative and he is responsible for coordinating care. ASM #2 stated he writes the ISPs and is able to update them. ASM #2 stated that since he is in the facility, he can make sure staff is implementing the ISPs and explain to staff why they are supposed to do something the way they do it. ASM #2 stated he tries to ensure staff is implementing ISPs by making observations and correcting staff as soon as he sees they are doing something that does not align with the plan. ASM #2 stated he also communicates ISPs through monthly staff meetings and staff must sign off on individuals' ISPs. ASM #2 stated staff should not feed Individual #2 because the individual is capable of feeding self. ASM #2 stated Individual #2 should always be feeding self while physically capable because of dignity and staff does not want the individual's skill of feeding self to regress. ASM #2 stated when Individual #2 pushes the plate away then that is the individual's way of telling staff the individual does not want the plate. ASM #2 stated if Individual #2 pushes the plate away then staff should gauge the individual's mood, move the individual's plate and ask the individual if the individual wants to remain at the table. ASM #2 stated if Individual #2 indicates the individual wishes to remain at the table, then staff should put the plate back in front of the resident. ASM #2 stated that Individual #2 does not want	W 159	**W159** **2.** **How corrective action will be accomplished for Individual #3:** The QIDP will monitor to ensure implementation of the PCP [person-centered plan] outcome/goal for medication administration for Individual #3. **Assurance that other residents are protected from the possibility of the deficiency:** The QIDP will monitor to ensure implementation of all outcomes/goals in the active treatment plan/ PCP [person-centered plan] for each resident. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will review data to ensure outcome /goal implementation is being recorded accurately by staff. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program manager and assistant manager will review all data collection at a minimum of monthly to ensure that implementation is being recorded accurately. **Date of Completion:** 2/1/2023	**2/1/2023**

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W 159	Continued From page 3 the plate then staff should place the plate in the microwave and tray again in 30 minutes. On 1/18/23 at 1:35 p.m., ASM #1 (the residential coordinator) was made aware of the above concern. The facility policy titled, "Qualified Intellectual Disabilities Professional" documented, "It is the policy of (name of facility) that the Qualified Intellectual Disabilities Professional (QIDP) will provide comprehensive Active Treatment coordination, case management and oversight for the residents." No further information was presented prior to exit. 2. For Individual #3, the QIDP failed to ensure the individual's ISP (individualized service plan) for medication administration was implemented. Individual #3 was admitted to the facility on 3/9/15. Individual #3's diagnoses included but were not limited to intellectual disability and seizures. Individual #3's ISP, signed by the QIDP (qualified intellectual disabilities professional) on 4/1/22, documented, "(Individual #3 Name) takes his prescribed medications whole, in applesauce. After support staff prepare his medications, (Individual #3) is handed a spoon and is provided a gestural clue such as pointing to his medications and asked to take the final scoop of his medications. Support staff should hold the ramekin of applesauce underneath of (Individual #3's) spoon at all times to guard against any medications potentially hitting the floor..."	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 159	Continued From page 4 On 1/17/23 at 4:10 p.m., DSP (direct support staff) #2 was observed administering medications to Individual #3. DSP #2 held a ramekin containing pills and applesauce and fed four spoonfuls to Individual #3. DSP #2 did not gesture or ask Individual #3 to take the final scoop. On 1/18/23 at 1:26 p.m., Individual #3's ISP was reviewed with ASM (administrative staff member) #2 (the QIDP). ASM #2 stated active treatment is collaborative and he is responsible for coordinating care. ASM #2 stated he writes the ISPs and is able to update them. ASM #2 stated that since he is in the facility, he can make sure staff is implementing the ISPs and explain to staff why they are supposed to do something the way they do it. ASM #2 stated he tries to ensure staff is implementing ISPs by making observations and correcting staff as soon as he sees they are doing something that does not align with the plan. ASM #2 stated he also communicates ISPs through monthly staff meetings and staff must sign off on individuals' ISPs. ASM #2 stated the staff should began feeding Individual #3 the pills and applesauce then for the last scoop, the staff should give Individual #3 the spoon and prompt the individual to take what is left in the ramekin. On 1/18/23 at 1:35 p.m., ASM #1 (the residential coordinator) was made aware of the above concern. No further information was presented prior to exit.	W 159		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G065	A. BUILDING _____ B. WING _____	01/18/2023

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W 249	Continued From page 5 formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, facility document review and residential record review, the facility staff failed to implement active treatment for two of three individuals in the survey sample, Individuals #2 and #3. The findings include: 1. For Individual #2, the facility staff failed to implement the individual's ISP (individualized service plan) for eating. Individual #2 was admitted to the facility on 11/28/14. Individual #2's diagnoses included but were not limited to severe intellectual disability and gastroesophageal reflux disease. Individual #2's ISP, signed by the QIDP (qualified intellectual disabilities professional) on 12/23/22, documented, "(Individual #2 Name) utilizes a suctioned plate to help prevent instances of him throwing his plate and eats with a spoon. As (Individual #2) has a history of throwing his food, often times without an identifiable trigger, staff will provide (Individual #2) with half of his meal at a time. When (Individual #2) finishes his first portion, he receives the rest of his meal. If (Individual #2) is expressing that he is finished	W 249	**W 249** **1.** **How corrective action will be accomplished for Individual #2:** Facility staff will implement the active treatment outcome involving eating for Individual #2. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will implement the active treatment outcomes from the PCP's for each individual. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will continue to monitor and ensure implementation of the active treatment outcomes as described in each individual's PCP. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program supervisor and assistant manager will monitor to ensure the implementation of the active treatment outcomes as described in each individual's PCP. **Date of Completion:** 2/1/2023	2/1/2023

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W 249	Continued From page 6 eating, remove food from his reach. (Individual #2) is capable of feeding himself independently and is expected to do so at all times while being supervised by staff..." On 1/17/23 at approximately 5:05 p.m., DSP (direct support staff) #1 was observed feeding Individual #2 bite size pieces of pizza and salad with a spoon. On 1/17/23 at 5:09 p.m., an interview was conducted with DSP #1, regarding Individual #2's ability to feed self. DSP #1 stated Individual #2's ability to feed self depends on the individual's mood. DSP #1 stated sometimes Individual #2 feeds self but sometimes when the individual is tired and doesn't want to feed self then staff feeds the individual. DSP #1 stated sometimes Individual #2 pushes the plate of food away when staff puts the plate up to the individual. DSP #1 pushed the plate of food toward Individual #2 and Individual #2 pushed the plate away. On 1/18/23 at 1:23 p.m., an interview was conducted with ASM (administrative staff member) #2 (the QIDP). ASM #2 stated staff should not feed Individual #2 because the individual is capable of feeding self. ASM #2 stated Individual #2 should always be feeding self while physically capable because of dignity and staff does not want the individual's skill of feeding self to regress. ASM #2 stated when Individual #2 pushes the plate away then that is the individual's way of telling staff the individual does not want the plate. ASM #2 stated if Individual #2 pushes the plate away then staff should gauge the individual's mood, move the individual's plate and ask the individual if the individual wants to remain at the table. ASM #2 stated if Individual #2 indicates the individual wishes to remain at the	W 249	**W 249** **2.** **How corrective action will be accomplished for Individual #3:** Facility staff will implement the active treatment outcome involving medication administration for Individual #3. **Assurance that other residents are protected from the possibility of the deficiency:** Facility staff will implement the active treatment outcomes from the PCP's for each individual. **Measures to be put into place or systemic changes to be made to ensure that the deficient practice will not recur:** The QIDP will continue to monitor and ensure implementation of the active treatment outcomes as described in each individual's PCP. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The program supervisor and assistant manager will monitor to ensure the implementation of the active treatment outcomes as described in each individual's PCP. **Date of Completion:** 2/1/2023	**2/1/2023**

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ROSS DRIVE	5604 ROSS DRIVE FREDERICKSBURG, VA 22407

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W 249	Continued From page 7 table, then staff should put the plate back in front of the resident. ASM #2 stated that Individual #2 does not want the plate then staff should place the plate in the microwave and tray again in 30 minutes. On 1/18/23 at 1:35 p.m., ASM #1 (the residential coordinator) was made aware of the above concern. The facility policy titled, "Active Treatment" documented, "5. Residents of (name of facility) will be provided with support which will assist them to function with as much self-determination and independence as possible while preventing the deceleration, regression, or loss of current optimal functional status through the development and direction of an individualized Person Center Plan." No further information was presented prior to exit. 2. For Individual #3, the facility staff failed to implement the individual's ISP (individualized service plan) for medication administration. Individual #3 was admitted to the facility on 3/9/15. Individual #3's diagnoses included but were not limited to intellectual disability and seizures. Individual #3's ISP, signed by the QIDP (qualified intellectual disabilities professional) on 4/1/22, documented, "(Individual #3) takes his prescribed medications whole, in applesauce. After support staff prepare his medications, (Individual #3) is handed a spoon and is provided a gestural clue such as pointing to his medications and asked to take the final scoop of his medications. Support	W 249		

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W 249	Continued From page 8 staff should hold the ramekin of applesauce underneath of (Individual #3's) spoon at all times to guard against any medications potentially hitting the floor..." On 1/17/23 at 4:10 p.m., DSP (direct support staff) #2 was observed administering medications to Individual #3. DSP #2 held a ramekin containing pills and applesauce and fed four spoonfuls to Individual #3. DSP #2 did not gesture or ask Individual #3 to take the final scoop. On 1/18/23 at 1:26 p.m., Individual #3's ISP was reviewed with ASM (administrative staff member) #2 (the QIDP). ASM #2 stated the staff should began feeding Individual #3 the pills and applesauce then for the last scoop, the staff should give Individual #3 the spoon and prompt the individual to take what is left in the ramekin. On 1/18/23 at 1:35 p.m., ASM #1 (the residential coordinator) was made aware of the above concern. No further information was presented prior to exit.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 503	Continued From page 12 On 1/18/23 at approximately 1:50 p.m., an interview was conducted with ASM (administrative staff member) #1, residential coordinator. ASM #1 stated all potential new hires are asked if they are vaccinated for COVID-19 and are told that the company is federally mandated to ensure staff vaccination. ASM #1 stated exemption paperwork must be completed prior to hire and new hires must provide evidence of vaccination to the human resources department on their first day of employment. On 1/18/23 at approximately 3:30 p.m., ASM #1 stated that they did not have evidence of DSP #2's second COVID-19 vaccine nor did they have evidence of OSM #5 receiving the COVID-19 vaccine. The facility's policy "Rappahannock Area Community Service Board COVID-19 Employee & Volunteer Vaccination Policy" documented in part, "RACSB (Rappahannock Area Community Service Board) now requires all employees to be vaccinated against COVID-19 unless a reasonable accommodation is approved. Employees not in compliance with this policy will be placed on unpaid leave until the Human Resource Director, in consultation with the Executive Director, determines their employment status. This policy will be administered in compliance with all applicable laws and is based on guidance from the Centers of Disease Control and Prevention; the Virginia Department of Health; the Equal Employment Opportunity Commission; the Occupational Safety Health Administration, and, local and state health authorities.	W 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUCAS STREET	5701 LUCAS STREET FREDERICKSBURG, VA 22407

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W 503	Continued From page 13 On 01/18/2023 at approximately 3:30 p.m. ASM (administrative staff member) # 1, residential coordinator, was made aware of the above findings. No further information was provided prior to exit.	W 503		

MEMORANDUM

To: Joe Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance and Human Rights
Date: February 8, 2023
Re: January 2023 Waiting Lists

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

OUTPATIENT SERVICES

- Clinical services: As of January 31, 2023, there are 269 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 160 clients.
      - The waitlist in Spotsylvania is currently at 67 clients.
      - The waitlist in Caroline is currently at 42 clients.
      - This is an decrease of 73 from the December 2022 waitlist.

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

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

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

- Psychiatry intake: As of February 8, 2023, there are 11 older adolescents and adults waiting longer than 30 days for their intake appointment. This is an increase of eight from the December 2022 waitlist. The furthest out appointment is 4/26/2023. There are zero children age 13 and below waiting longer than 30 days for their intake appointment.

PSYCHIATRY INTAKE – As of January 3, 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 –	7 (3)	0 (0)
o Caroline –	1 (0)	0 (0)
o King George –	0 (0)	0 (0)
o Spotsylvania –	0 (0)	0 (0)
o Stafford –	3 (0)	0 (0)
Total	**11 (3)**	**0 (0)**

	Appointment Dates
Fredericksburg Clinic	
	3/13/23 3/20/23 3/24/23 3/27/23 3/29/23 4/3/23 4/26/23
Caroline Clinic	
	3/22/23
King George	
	N/A
Spotsylvania Clinic	
	N/A
Stafford Clinic	
	3/14/23 3/20/23 3/21/23

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 - 2

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

Count by County:

Caroline	1
King George	0
Fredericksburg	0
Spotsylvania	0
Stafford	1

- The one individual on the acceptance list is a referral from the community and has completed two successful trial passes at Home Road. He has been accepted for the next community bed that is available at Home Road, which is expected to be in February 2023.

Intellectual Disability Residential Services – 96

Needs List: 91
Referral List: 5
Acceptance List: 0

Count by County:

Caroline	10
King George	8
Fredericksburg	7
Spotsylvania	34
Stafford	37
Richmond	1

Assertive Community Treatment (ACT)– 17

Caroline: 1
Fredericksburg: 7
King George: 0
Spotsylvania: 4
Stafford: 5

Total Needs: 8
Total Referrals: 9
Total Acceptances: 0

Total program enrollments = 50

Admissions: 0
Discharges: 1

- During the month of January, an ACT South client asked to be discharged after his 90-day Mandatory Outpatient Treatment Order (MOT) expired in December. This client was compliant while receiving services again. However, when the MOT expired, they requested to return to the Jackson Street Clinic for medication management supports only. This client is aware they can resume ACT services in the future.

ID/DD Support Coordination

There are 792 individuals on the waiting list for a DD waiver.

P-1 326
P-2 183
P-3 287

MEMORANDUM

To: Joseph Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance & Human Rights

Date: February 2023

Re: Quality Assurance Report

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

- Galveston Intellectual Disability Group Home
- Mental Health Outpatient King George

Galveston Intellectual Disability Group Home

There was one staff member responsible for the selected charts.

Findings for the six open charts reviewed for Galveston Intellectual Disability Group Home was as follows:

- Six charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - Six charts were missing the program agreement.
    - Three charts were missing releases.

- Six charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plan:**
    - Three charts were missing signature pages.

- Six charts were reviewed for Quarterly Review compliance:
  - There were no noted discrepancies found.

- Six charts were reviewed for Progress Note compliance:
  - There were no noted discrepancies found.

- Six charts were reviewed for Medical compliance:
  - **Discrepancies noted with Medical:**
    - Six charts were missing multiple prescriptions.

Comparative Information:

In comparing the audit reviews of Galveston Intellectual Disability Group Home charts from the previous audits to the current audits, the average score decreased from 90 to 66 on a 100-point scale.

Corrective Action Plan

1. Corrective supervision and coaching have been completed with the program manager as of 12/29/2022 to ensure charting is complete and timely moving forward. Focusing on ensuring all active prescriptions were filed in the chart was a point of emphasis in the corrective action.
2. 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.
3. Charting and documentation expectations will continue to be reinforced through documented supervision and through the peer auditing and supervision processes to help ensure compliance.
4. Should there be further issue with meeting these expectations, progressive corrective action will be issued.
5. Oversight and corrective action will continue to be overseen by the DD Residential Coordinator and the DD Assistant Coordinators.

Mental Health Outpatient King George

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

Findings for the ten open and two closed charts reviewed for Mental Health Outpatient- King George was as follows:

- Ten charts were reviewed for Assessment compliance:
    - **Discrepancies noted with Assessments:**
        - One chart was missing the Daily Living Activities 20 (DLA 20).
        - Two charts were missing current Comprehensive Needs Assessments (CNA).

- Ten charts were reviewed for Individual Service Plan (ISP) compliance:
    - **Discrepancies noted with Service Plan:**
        - Three charts were missing current ISPs.

- Ten charts were reviewed for Progress Note compliance:
    - **Discrepancies noted with Progress Notes:**
        - One chart contained notes which were completed more than 24hrs late.

- Ten charts were reviewed for Quarterly Review compliance:
    - **Discrepancies noted with Quarterly Reviews:**
        - Six charts were missing current quarterly reviews.

- Ten charts were reviewed for Documentation compliance:
    - **Discrepancies noted with Documentation:**
        - Three charts were missing Consumer Orientations.

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

Comparative Information:

In comparing the audit reviews of Mental Health Outpatient King George charts from the previous audits to the current audits, the average score increased from 70 to 73 on a 100-point scale.

Corrective Action Plan

1. Staff will block 4 hours documentation time to audit full caseload and update needed documentation by February 28th
2. Moving forward starting week of 1/30/23, staff will block 1 hour documentation time weekly for charting, and not book over this time with client sessions-ongoing
3. At least 15 minutes of administrative supervision time will be devoted to chart audits-ongoing and starting the week of 1/30/23
4. Clinic Coordinator, Sarah Davis, will be responsible party for ensuring that corrective action plan is followed.

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Data Highlights Report for Program Planning and Evaluation

Date: February 9, 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

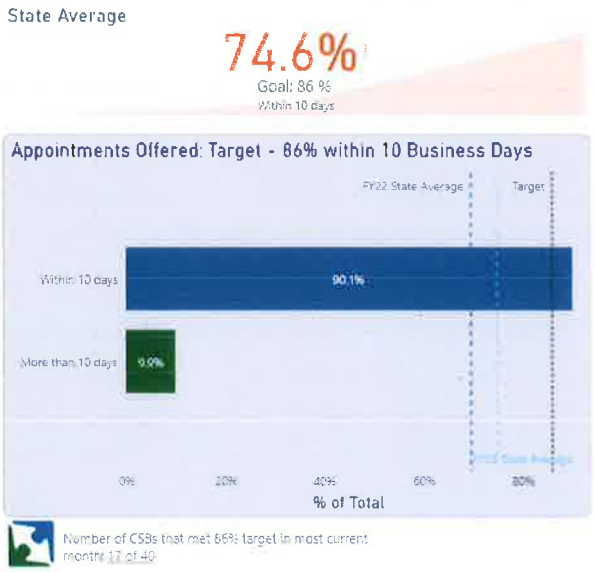
This month's report will detail the new measures and ongoing measures set by DBHDS as performance metrics. The targets indicated have been set by DBHDS and are subject to change at the department's discretion. These targets did not take effect until July 1, 2021.

Behavioral Health Measures

Same Day Access

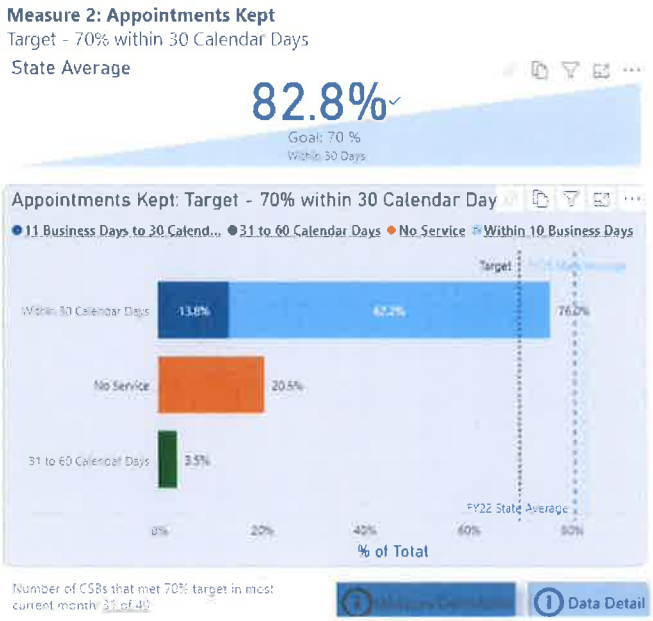
Measure #1: SDA Appointment Offered: Percentage of individuals who receive a Same Day Access assessment and were recommended for services through the CSB who were offered a follow-up appointment within 10 business days. The benchmark is set at 86%.

Current Month's Performance- Sept 2022 (90.1%)



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%.

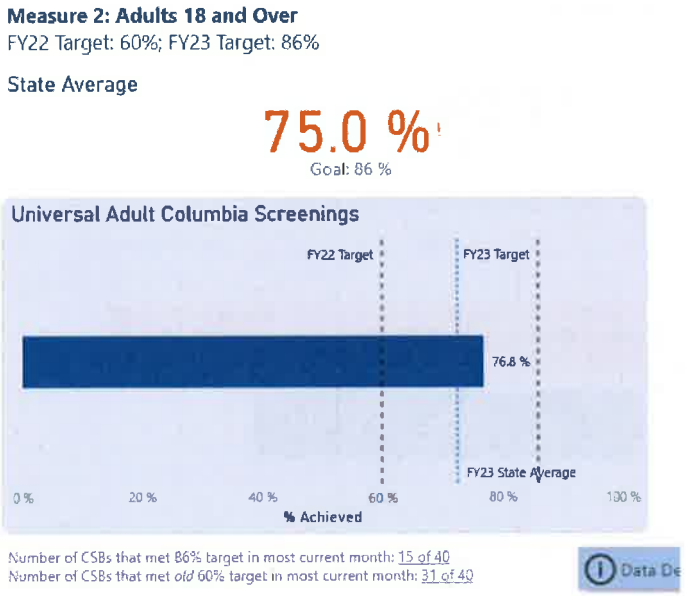
Current Month's Performance- Aug 2022 (76.0%)



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.

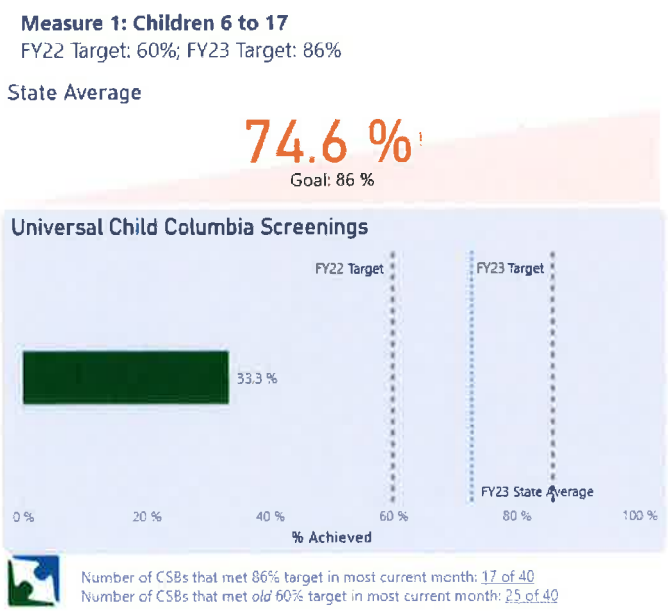
Measure #1: Universal Adult Columbia Screenings: Percentage of adults who are 18 years old or older and have a new MH or SUD program opening (denominator) who received a suicide risk assessment completed within 30 days before or 5 days after case opening(numerator). The benchmark is set at 60 % for FY22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

Current Month's Performance-Sept 2022 (76.8%)



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- Sept 2022 (33.3%)

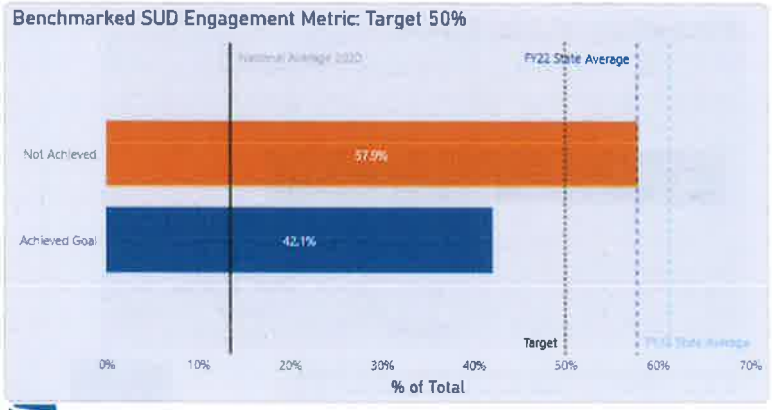


Substance Use Disorder Engagement Measures

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- Oct 2022 (42.1%)

***Benchmarked* Measure**
Target - 50%
State Average
58.0%
Goal: 50 %



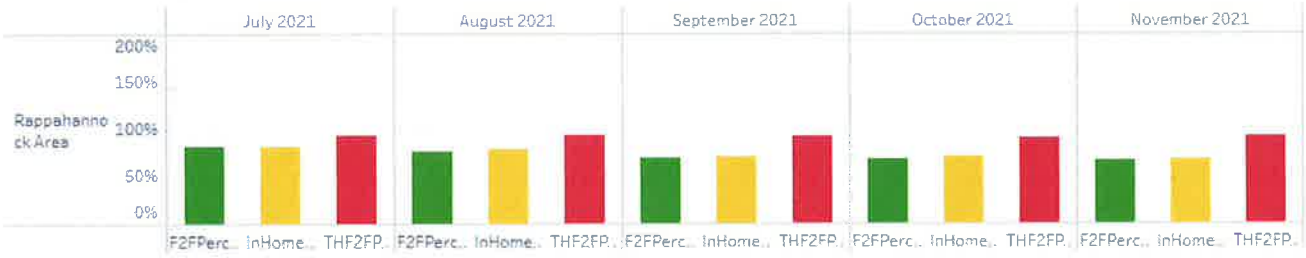
Number of CSBs that met 50% target in most current month: 32 of 40

Developmental Disability Measures

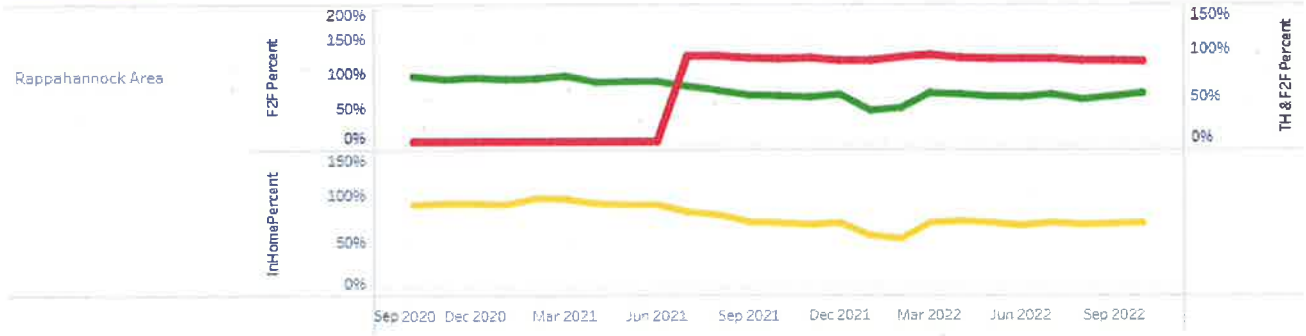
Percent receiving face-to-face and In-Home Developmental Case Management Services

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%.***



13 Months Trend



Rappahannock Area Community Services Board Strategic Plan FY23 Mid-Year Executive Summary

Goal #1: Provide access to timely, holistic and appropriate services through evaluation, realignment, or implementation of service delivery to correspond	
Strategy	**Mid-Year Performance**
Strategy 1: Expand the capability for integrated care of behavioral health and developmental supports and physical health services. • Expand access to primary care within CSB and other settings in partnership with community stakeholders. • Employ a Primary Care Physician or Nurse Practitioner, to be located primarily at the Fredericksburg Clinic (600 Jackson Street), to provide general health care screenings, monitoring of health for individuals served and employees. • Address primary care needs are in plans of care as appropriate, to include referrals for annual physicals for all service recipients. • Develop and maintain relationships with Managed Care Organization (MCO) Care Coordinators across all CSB service areas. • Increase the percentage of individuals receiving CSB services who have a primary care provider by partnering with MCOs and local health care agencies. • Continue to work with Anthem Behavioral Health Home Model to enhance integrated care for those insured by Anthem. • Explore innovative technologies to support Medication Adherence and less restrictive health care options in order to reduce emergency department encounters and hospitalizations.	Executive leadership have conducted a site visit and conversations with other CSBs who have launched primary care services. Workforce and space are currently the biggest barriers to implementing the service at RACSB. Executive Director, Deputy Executive Director, and Director of Clinical Services have met to include primary care as a consideration when evaluating new space options. Each individual completes a medical history assessment prior to entry in to programming. Part of intake is discussing these needs and necessary referals to the primary care. Dates of last annual physicals are tracked for individual recieving waiver services and those receiving case management services. We have filled the vacant health educator position for the Anthem Behavioral Health Home. In partnership with Anthem, we have identified 10 individuals to add to the behavioral health home. We plan to incorporate these individuals once the uncertainty around the Anthem and MWH contract is settled. Staff meet with Terrapin pharmacy to explore their medication adherence technology at least quarterly. We are evaluating options to incoporate Medherent into our programs.
Strategy 2: Evaluate opportunities for development of Intellectual Disability/ Developmental Disability (ID/DD) services. • Research and evaluate ID/DD employment service models for potential incorporation or alignment with currently offered day support services. • Evaluate and analyze current Support Coordination caseload assignments based and assess ability to reduce caseloads while ensuring compliance standards. • Determine feasibility of augmenting ID/DD residential services to provide additional services focused on independent living options offered in current ID/DD Waiver system. • Conduct a stakeholder meeting with community partners, family members, guardians, and individuals served to evaluate service needs and preferences, by June 30, 2023. • Explore employment opportunities through RAAI to provide workplace assistance for individuals desiring to work. • Explore and evaluate continued feasibility of current respite service and opportunities for adults with Intellectual/Developmental Disability.	Workforce shortages and vacancies have impacted our performance in this area. We continue to prioritize increasing staff in order to support current services offered Vacancies and turnover continue to result impact all ID/DD program areas. Once workforce shortages are stabilized, we will explore opportunities incorporate new initiatives focused on independent living and employment. RACSB is currently offering incentives to ID/DD Support Coordinators due to carrying caseloads which exceed expectations. RACSB continues to evaluate financial and regulatory considerations regarding current respite services. Deputy Executive Director and Director of Community Support Services have initial planning discussions around stakeholder engagement activities to occur prior to June 30, 2023.
Strategy 3: Strengthen the health of the entire community, including individuals receiving services from RACSB, through increased prevention, wellness, and health promotion activities. Facilitate prevention initiatives/programs to include: Mental Health Promotion and Suicide Prevention; Adverse Childhood Experiences; Resiliency; Opioid Overdose Prevention and Education; Tobacco Retailer Education; Prevention of Problem Gambling and Gaming; and Marijuana Use Prevention. • Utilize a strategic prevention framework to assess needs, build capacity, plan, implement, and evaluate prevention and health promotion activities. • Engage with communities and stakeholders to develop and coordinate prevention initiatives and activities. • Provide community education on prevention, signs and symptoms, and available treatment resources. Solicit Program Supervisors and Directors to assist in promoting trainings within RACSB and community. • Promote community activities that create awareness and reduce stigma surrounding suicide, mental illness, and overdose.	The Strategic Prevention Framework guides all prevention efforts. Agency has collaborated with several community partners and stakeholders in support of awareness walks, trainings, community conversations, parent education events, and youth engagement activities. The wallet resource cards has been updated. A new webpage dedicated to community-based trainings (www.rappahannockareacsb.org/trainings) has been developed along with a more centralized process to register for trainings and curriculums offered. The training/workshop flyer has been updated for 2023 and disseminated to community partners. RACSB continues to utilize social media to promote community events and awareness activities.

Strategy 4: Expand community capacity of behavioral health crisis services. •Establish services needed to allow an individual experiencing a behavioral health crisis to remain in the least restrictive environment, preferably in their home or community. •Implement crisis services as defined and mandated by the General Assembly, while maintaining a voice in how those services are defined through participation in various work groups on the Executive Director, Director, and Coordinator level. •Explore funding opportunities to expand RACSB crisis services across the Crisis Continuum of Services, to include specifically community-based crisis stabilization, 23-hour observation facility, and expansion of detoxification services. •Develop and implement a plan for Marcus Alert legislatively mandated program with local law enforcement agencies and community partners, by July 2023. •Implement TDO policy at Sunshine Lady House to accept individuals under Temporary Detention Orders to the program in order to alleviate strain on local behavioral healthcare system while maintaining SLH capacity. •Provide community education and outreach around the development of the crisis continuum and crisis initiatives to community partners around the Marcus Alert, crisis services re-design, 9-8-8 National Suicide and Crisis Lifeline, and regional crisis call centers.	RACSB participates on multiple state-wide committes and discussions around crisis services. Most recently, RACSB was represented on the Governor's Prompt Placement Taskforce and provided advocacy/in around crisis related bills to members the Virginia General Assembly. Workforce is the primary barrier to expanding services in this area. We currently have temporarily closed our residential crisis stabilization service due to staffing shortages. During the temporary closure, we are exploring the feasibility bringing detoxification beds online and options for 23-hour observation services. RACSB has submitted our implementation plan developed with local law enforcement agencies to DBHDS for Marcus Alert set to begin in July 2023. We received the initial funding in December 2022 to facilitate planning. RACSB and community partners meet monthly to prepare for Marcus Alert implementation.
Strategy 5: Strengthen Peer Support and Family Support. •Increase access to peer and family support as recommended and/or requested by individuals and family members, with DBHDS validating performance outcomes July 2023. •Support all peers hired to become certified/registered within 18 months of employment. •Explore funding and reimbursement options to support peer service provision. •Provide community education and outreach around peer services and benefits of services provided by those with lived experiences.	RACSB was included in a small group with DBHDS to develop metrics and determine most efficient and complete mechanism to measure performance for the peer step of STEP-VA. RACSB jointly presented with DBHDS the proposed metrics to the VACSB Quality and Outcomes. These measures include increasing the number of individuals who receive peer services, increase the amount of peer services provided, and supporting all peers hired to become certified/registered within 18 months. The first data collection will be incorporated as part of the mid-year STEP-VA check-in scheduled for February. We provided advocacy, input, and support to a bill under consideration of the General Assembly which would minimize the negative impact of barrier crimes on expanding our peer workforce.
Strategy 6: Improve Psychiatric Rehabilitation Services beyond currently defined psychosocial rehabilitation services. •Support individuals with serious mental illness, substance use disorder and serious emotional disorder in developing or regaining independent living skill in accordance with DBHDS definition, with DBHDS validating performance outcomes July 2023	DBHDS approved our plan for the implementation of the Psychiatric Rehabilitation step of STEP-VA. RACSB used this funding to support the employment manager position at Kenmore Club to facilitate increased employment skill development for individuals with serious mental illness. DBHDS has not yet proposed or developed performance outcomes for psychiatric rehabilitation services.
Strategy 7: Provide Case Management and Care Coordination to individuals with serious mental illness, serious emotional disturbances, substance use disorder, and developmental disability. •Coordinate behavioral health services in an effective and efficient manner to support the needs of the individual across all disabilities. •Enhance case management services, with DBHDS validating performance outcomes April 2023	DBHDS approved our plan for the implementation of both the case management and care coordination step of STEP-VA. RACSB used this funding to sustain funding for an adult case management position and to add a full-time care coordination position which has not yet been filled. Further, we used funding to contract for one FTE with CBC solutions to provide follow-up, engagement, and support for individuals after private psychiatric hospitalization or behavioral health emergency department visit. DBHDS has not yet proposed or developed performance outcomes for psychiatric rehabilitation services.
Goal #2: Recruit, hire, and retain a talented, diverse, and well-trained workforce based on the needs of the organization and the community.	
Strategy	**Mid-Year Performance**
Strategy 1: Increase employee engagement and retention while providing opportunities for professional development. •Promote a positive work culture and environment that supports RACSB's mission, vision and values. •Provide ongoing training, education, and professional development opportunities for RACSB staff. •Enhance and build upon benefits to support wellness and retention of RACSB staff. •Continue facilitating position-specific networking and collaboration opportunities. •Consistently present position and program-specific trends in vacancy and turnover rates. •Implement strategies, trainings, and community events to promote diversity, equity, and inclusion.	RACSB hosted a full-day staff in-service day in Fall 2022 to provide training opportunities, promote positive work culture, and facility networking opportunities for staff. RACSB started offering free gym memberships for employees in partnership with Rappahannock YMCA. A DEI consultant has provided diversity, equity, and inclusion to PSH, ACT, and Executive Leadership Staff in addition to RACSB facilitating the Barbershop Talk for the community.

Strategy 2: Review grade, classification, and compensation initiatives to address workforce shortages based on the needs of the organization and community. •Complete a classification and compensation study to further define positions and classifications as well as explore recommendations for merit-based compensation benefits, by December 23, 2022. •Review examples of performance/merit-based evaluations and develop a merit-based annual performance evaluation process, by October 1, 2022. •Implement recommendations of classification and compensation study as financially feasible, by July 2023. •Evaluate funding opportunities to support workforce development. •Improve organizational and operational efficiency by the re-evaluation of our administrative support structure.	RACSB contracted with JER HR Group to complete a comprehensive classification, compensation, and benefits study. Presentation and recommendations will be provided for Board consideration in February 2023. Executive leadership have reviewed examples and had developed a draft merit-based annual performance evaluation. The team continues to meet to further develop implementation, training, and communication plan around the pivot to merit-based performance evaluation. RACSB plans to implement this process beginning with the new fiscal year starting July 2023. RACSB has received additional MH and SUD Block Grant funding targeted to workforce development. RACSB provided advocacy/input to members in the General Assembly around budget appropriations requests specific to CSB workforce funding support.
Strategy 3: Develop a career ladder in partnership with educational institutions to build and develop behavioral health and developmental disability workforce. •Develop and implement process to increase the utilization of interns across program settings and business operation, through broader recruitment, partnerships with academic program and enhanced retention practices. RACSB currently utilizes interns in the Parent Education – Infant Development Program, Kenmore Club, Outpatient Services, and Crisis Stabilization Program at The Sunshine Lady House for Mental Health Wellness and Recovery. •Lead the Rappahannock Area Behavioral Health Workforce as part of the RAHD CHIP, in partnership with Germanna Community College and community partners. •Explore the E-badge certification and incentive programs which provides nationally recognized certification at three (3) levels for Direct Support Professionals. •Develop career ladder within positions to allow increased opportunities to advance along a career path within RACSB.	RACSB has partnered with Germanna Community College to develop a new Behavioral Health technician/DSP program. RACSB will provide internships as part of this program. We have hosted interns across a variety of programs during the first half of this fiscal year, including partnerships with new higher education institutions. We have hosted two in-person summits specific to behavioral health workforce as part of the RAHD CHIP. Staff attended multiple presentations and meetings around the E-Badge certification program and has decided not to implement at this time.
Goal #3: Maximize organizational efficiencies to create the most effective delivery system.	
Strategy	**Mid-Year Performance**
Strategy 1: Use technology to streamline the agency's business processes. •Fully implement new Human Resources Payroll system •Fully automate requisition and payment processes •Improve property maintenance tracking	The payroll and benefits modules of the new HRIS system, Dominion, have been implemented. Staff will focus on developing the position control features and the iHire functions during the next six months. This will streamline our hiring process to one system and increase automation of the hiring process. A group has been created with a variety of leadership representation across services to evaluate a new requisitions and payments process. RACSB will complete the RFP process to obtain a new software platform to meet the needs developed by the group. RACSB is currently exploring ways to use the same Track-It system used to track IT tickets to improve property maintenance tracking.
Strategy 2: Support the use of sound fiscal responsibility and sustainability practices. •Expand financial literacy at all levels of leadership by providing trainings to all levels of leadership in budget management. •Provide Quarterly reviews of program budgets at all levels of leadership •Evaluate and ensure all revenue sources are being maximized. •Identify and analyze services unit cost to better understand costs of care and ensure resources are being used efficiently.	The first half of the year has been focused on implementing the new financial grant reimbursement process required by DBHDS. RACSB participated as pilot testers in the DBHDS implementation of the new Webgrants system launched to support the new reimbursement process. Internally, the finance department has worked to establish a new system to promote greater access and visibility into revenue and expenses for programs.
Strategy 3: Provide an excellent customer service experience. •Enhance existing training modules to include a customer service emphasis for all staff •Develop ongoing supervision and support specifically for both external and internal customers. •Establish developmental cross-training about services, especially within service model.	Every employee receives a customer service training as part of annual training requirements. RACSB is in the process of enhancing our supervision documents to include CARF Recommendations, increased customer service, and to support the transition to merit-based performance evaluations. Workforce shortages have provided opportunities for employees to receive training and work in other programs.

RACSB Board Report
Compliance

Incident Report

- There were 199 Incident Reports entered into the Electronic Incident Report Tracker during the month of January. This is an increase of 10 from December 2022, and an increase of 3 from November 2022. All incident reports submitted were triaged by QA staff. The top two categories of reports submitted were and Health Concerns (68 reports) and Individual Served Injury (38 reports).
- Quality Assurance Staff entered 33 incident reports into the Department of Behavioral Health and Developmental Services Electronic Incident reporting system. (9 Level 1, 22 Level 2, 11 Level 3); an increase of 12 from December. There were 10 positive COVID cases reported, and 5 COVID testing reports. Positive cases were reported regarding individuals receiving DD or MH Residential Services.
- There were two reports elevated to care concern by DBHDS; one for seizuers and the other for falls. These are reports that based the Office of Licensing's review of current serious incident as well as a review of other recent incidents related to this individual, the Office of Licensing recommends the provider consider the need to re-evaluate the individual's needs as well as review the current individual support plan. DBHDS recommends provider review the results of root-cause analyses completed on behalf of this individual. In addition, take the opportunity to determine if systemic changes such as revisions to policies or procedures and/or re-evaluating and updating risk management and/or quality improvement plan.
- DBHDS requires the conduction of a root cause analysis for selected incident reports. The root cause analysis must be conducted within 30 days of staff's discovery of the incident. QA staff requested specific programs, based on submitted incident report, to complete the required root cause analysis. Thirty-four root cause analysis were requested and 16 were completed. No expanded root cause analysis were required nor received in January.

Human Rights Investigations

QA staff initiated five and closed seven investigations during the month of January. One investigation initiated was an allegation of verbal abuse towards the members of a DD residential program; this was unfounded. Two investigations were regarding physical abuse (unfounded) which occurred in two DD Residential programs, one of which was an ICF. Three investigation were regarding an allegation of neglect (non-peer-to-peer), one of which was substantiated in an RAAI program, and two unfounded in an DD Residential program and an ICF. Finally, one investigation regarding an allegation of treatment without dignity in an ICF home.

External Reviewers

- DMAS audit began on November 14 and finished their audit with the exit meeting set for 1/20; unfortunately, due to an auditor's family emergency, this exit meeting has been rescheduled. Since the audit began, the QA team has pulled 417 items from various charts at

the auditor's request and reviewed 98 personnel files to support the auditors in locating correct documentation.

- QA staff provided requested follow-up information to Brian Dempsey, Senior Licensing Specialist with the Department of Behavioral Health and Developmental Services (DBHDS), on 5 incident reports submitted into CHRIS.
- QA staff received three external chart review requests and responded to 10 external chart reviews for 44 clients by submitting requested documentation.
- QA staff received and responded to 5 emails from various Human Rights Advocates regarding investigative reports, CHRIS reports and external providers. In addition, QA staff responded to various documentation request from the Advocates.
- QA staff received 5 phone calls and multiple emails from various programs with questions about incident reports, human rights, complaints, and root cause analysis (RCA) process.
- Completed and submitted Quality Improvement Plan for HSAG audit.
- Drafted Quality Improvement Plan in response to CARF recommendations.

Commented [KK1]: Not sure if you want to keep this/ if petty, but I wanted to give us credit for the work we did.

Complaint call synopsis:

The QA team received two complaint calls in the month of January. One call concerned dissatisfaction with their doctor, requesting a transfer to a new doctor; after collaborating with Jacque, her team were able to resolve to the satisfaction of the client. One complaint call concerned services at PSH; this client had made previous complaints about this program, the last being in November. Nancy Price was able to move the client onto another case load and the complaint was resolved to the client's satisfaction.

Trainings/Meetings

- 1/4 - QA position interview (1)
- 1/5 - QA position interviews (2)
- 1/6 – Annual Seclusion and Restraint Report submitted to DBHDS
- 1/17 – OHR training: Reporting in CHRIS: Abuse, Neglect, Exploitation and Human Rights Complaints
- 1/17 – QA investigation interviews (3)
- 1/18 - QA investigation interviews (6)
- 1/19 - QA investigation interviews (4)
- 1/26 - QA investigation interview (1)
- 1/30 - QA investigation interview (1)

Other Activities

Kat – Engagement Committee meeting (1/26)

RACSB DEPUTY EXECUTIVE DIRECTOR REPORT
January 2022 Review

Community Consumer Submission 3 version 7.5 (CCS3 7.5)
The Community Consumer Submission 3 version 7.5 is the technical specifications for our state reporting data collection and extract. RACSB staff, Suzanne Poe and Brandie Williams serve on the joint CCS User Acceptance Testing group which is currently meeting frequently to consider requests for changes in CCS for the upcoming fiscal year. The specifications for the upcoming year have been finalized and distributed. Although there were twelve proposed changes from DBHDS for consideration, only one change will be implemented in the upcoming annual change cycle.

Trac-IT Early Intervention Data System
The go live date for the new Trac-It program, a state-wide data platform/electronic health record for Part C, was June 27, 2022. The new date for full implementation of additional 280+ data requirements has not been announced.

Waiver Management System (WaMS)
RACSB continues to implement interoperability with our electronic health record, myAvatarNX with the state-wide Waiver Management System. RACSB staff participate in the development and implementation of annual changes to this system. Finalized specifications for the upcoming year's changes were provided in December 2022. RACSB has made all the required changes in our test system and work consistently to ensure we are prepared for the go-live of May 2023. DBHDS initiated a change in the workflow for the integration in December with a go-live in January. This required a code change with Netsmart's process which they are working to implement. Until the solution is in place, IT staff are directly entering ISPs into WaMS.

Opportunities for Partnership/Input:

- Attended and presented at Behavioral Health Forum held by local Virginia House of Representative, Del. Tara Durant.
- Attended the December 2022 Behavioral Health Commission
- Participated in meeting with King George County representatives regarding Opioid Abatement Funding.
- Participated in follow-up call with Deloitte as part of their study on Behavioral Health Workforce on behalf of the Virginia Health Workforce Development Authority.
- Continued meeting with a combined group of CSB and DBHDS representation to streamline the performance contract.
- Served as one of two CSB representatives in an on-site meeting with DBHDS Information Technology Leadership at Central Office to guide strategic decisions around current and future IT projects.
- Attended the DBHDS Internal Audit kick-off meeting and coordinated the provision of 75 requested documents prior to their time on-site in February.
- Attended in-person Data Mapping Session with CSB and DBDHS representation as part of the CCS replacement/Data Exchange project.
- Attended Rappahannock Area Health District's visit and panel with Delegate Spanberger.
- Coordinated and hosted Delegate Spanberger's visit to RACSB.

Special Projects and Data Requests:

Operations programs participate in a variety of special projects/requests for data. Please find examples of a few of these efforts:

- Represented the agency virtually at the VACSB Quality and Outcomes, Data Management Committee, WaMS statewide calls, DBHDS Data Quality Sub-committee, CCS Implementation Team meeting, Region 1 IT Council, UAT Team, new DBHDS Data Dashboard Committee, and DMC Technical Sub-committee.
- Led Subject Matter Expert Data Quality Committee with DBHDS to address questions regarding appropriate reporting of new initiatives.
- Supported the development of a data quality tool to assist as an interim solution which will allow CSBs to report data around CIT to DBHDS in a more flexible manner. Further worked with DBHDS to provide our developed tool as a foundation for implementing statewide. Supported DBHDS development of the tool and coordinated the project.
- Completed second quarter goal review and meetings with all program directors
- Met with our benefits broker, USI, to plan for upcoming RFP for health insurance provider. Also discussed the contract dispute between Anthem and Mary Washington Healthcare and potential impacts to both employees and individuals served.
- Coordinated agency input for DBHDS request for information from CSBs around barriers and opportunities to improve partnership.
- Met with Nana Noi from Rappahannock Area EMS council to talk through draft wellness initiative they are hoping to pilot.
- Meet weekly on the core advisory group with DBHDS around the new Data Exchange implementation project.
- Represented RACSB the Fredericksburg City Public Schools' Superintendent Roundtable.
- Attended the January Behavioral Health Commission meeting ahead of General Assembly Session.
- Attended the VACSB Legislative Conference in Richmond.

hopestarter | RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

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

NOTICE

To: Finance Committee: Susan Gayle, Susan Muerdler, Jacob Parcell, Carol Walker, Melissa White, Matt Zurasky

From: Joseph Wickens
Executive Director

Subject: Program Planning and Evaluation Meeting
February 14, 2023, 11:30 AM
600 Jackson Street, Board Room 208. Fredericksburg, VA

Date: February 09, 2023

A Finance Committee meeting has been scheduled for Tuesday, February 14, 2023 at 11:30 AM. The meeting will be held at 600 Jackson Street, Board Room 208, Fredericksburg, VA 22401.

Looking forward to seeing you on February 14th at 11:30 AM.

Cc: Matt Zurasky, Chairperson

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Finance Committee Meeting

February 14, 2023 – 11:30 AM

600 Jackson Street, Room 208 Fredericksburg, VA 22401

Agenda

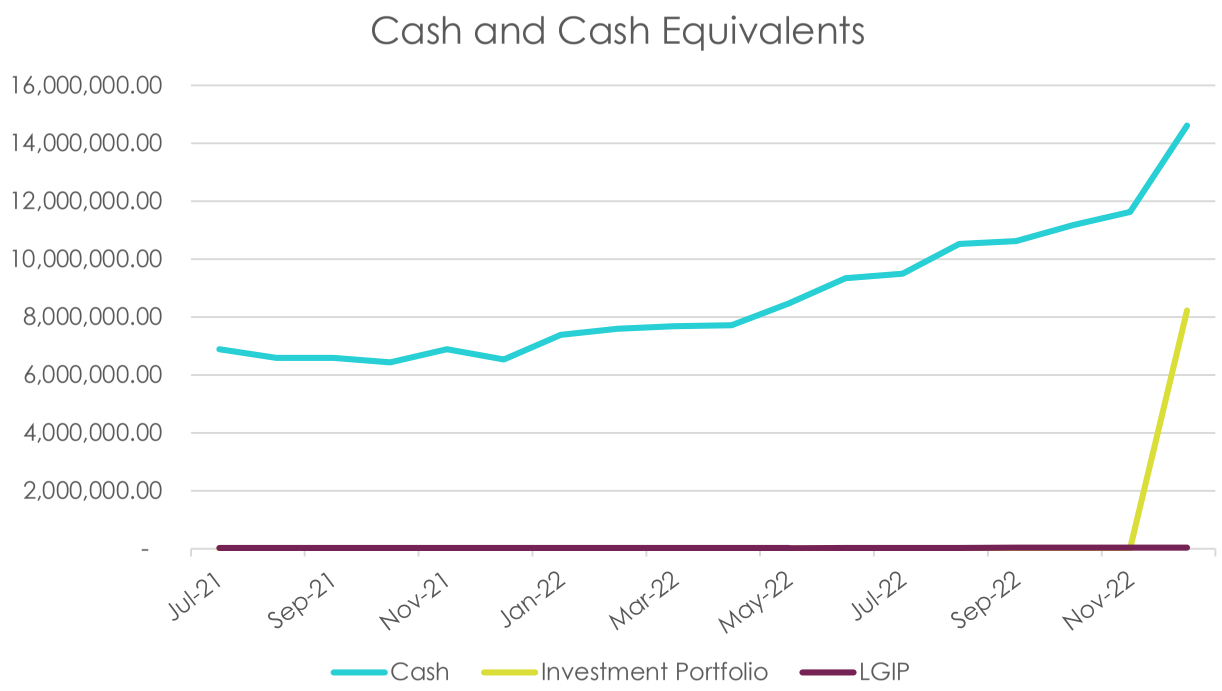
Finance Committee

FEBRUARY 14, 2022

Summary of Cash Investments

Depository		Rate	Maturity Date
Atlantic Union Bank			
Checking	$ 14,613,224	1.50%	N/A
Investment Portfolio			
Cash Equivalents	1,999,500.00	2.80%	
Fixed Income	8,228,444.55	4.38%	
Certificates of Deposit	-	0.01%	6/21/2024
Total Atlantic Union Bank	$ 24,841,169		
Other			
Local Gov. Investment Pool	$ 32,388	0.09%	N/A
Total Investments	**$ 24,873,557**		

	$ Change	% Change
Change from Prior Month	$ (35,951)	-0.2%
Change from Prior Year	$ 5,057,096	28%
Average # Months Reserves on Hand: 6.01		



Summary of Investment Portfolio

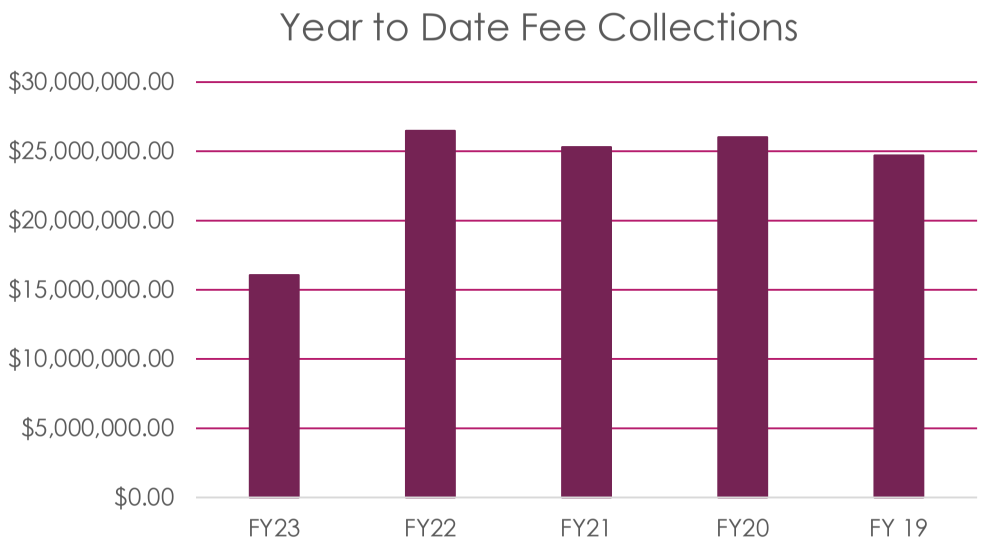
Asset Description	Shares/Face Value	Market Value	Total Cost	Unrealized Gain/Loss	Est. Income	Current Yield
Fidelity IMM Gov Class I Fund #57	$ 4,269,365.83	4,269,365.83	$ 4,269,365.83	$ -	$ 174,228.00	4.08%
US Treasury Bill (6/15/2023)	$ 1,000,000.00	$ 978,372.85	$ 977,916.87	$ 455.98		
US Treasury Bill (11/30/2023)	$ 1,025,000.00	$ 981,205.87	$ 981,732.90	$ (527.03)		
Total Cash Equivalents	**$ 6,294,365.83**	**$ 6,228,944.55**	**$ 6,229,015.60**	**$ (71.05)**	**$ 174,228.00**	**2.80%**
US Treasury Note (10/15/2025)	$ 1,000,000.00	$ 999,380.00	$ 1,005,781.25	$ (6,401.25)	$ 42,500.00	4.25%
US Treasuryt Note (11/30/2024)	$ 1,000,000.00	$ 1,000,120.00	$ 1,004,914.69	$ (4,794.69)	$ 45,000.00	4.50%
Total Fixed income	**$ 2,000,000.00**	**$ 1,999,500.00**	**$ 2,010,695.94**	**$ (11,195.94)**	**$ 87,500.00**	**4.38%**
Balance at 12/31/2022	**$ 8,294,365.83**	**$ 8,228,444.55**	**$ 8,239,711.54**	**$ (11,266.99)**	**$ 261,728.00**	**3.18%**

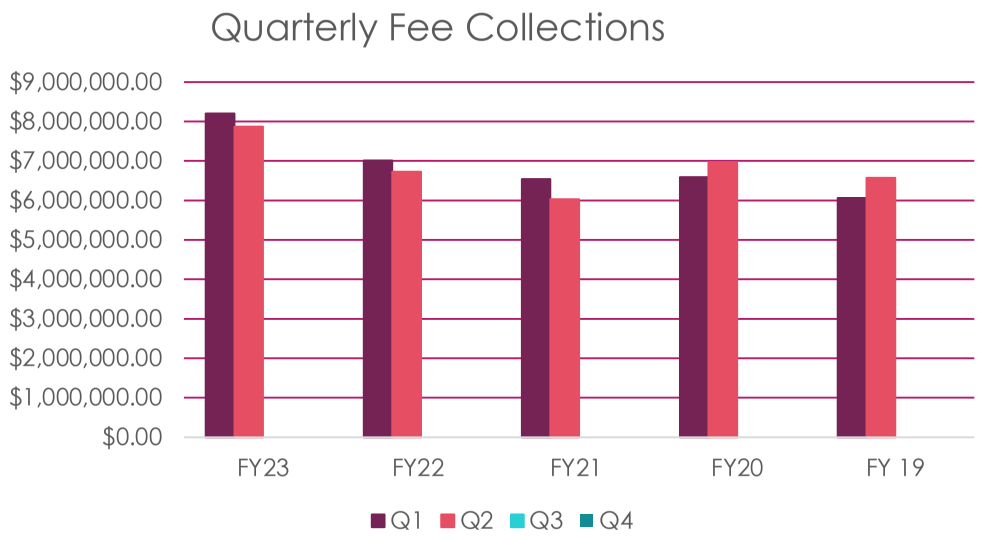
Fee Revenue Reimbursement

AGED CLAIMS		Current Month		Prior Month		Prior Year	
		%	$	%	$	%	$
Total Claims Outstanding	Total	100%	$5,915,583	100%	$5,782,757	100%	$5,532,848
	Consumers	42%	$2,509,909	43%	$2,477,048	38%	$2,094,972
	3rd Party	58%	$3,405,675	57%	$3,305,709	62%	$3,437,877
Claims Aged 0-29 Days	Consumers	2%	$104,985	5%	$277,655	4%	$201,499
	3rd Party	53%	$3,140,355	51%	$2,962,306	45%	$2,462,173
Claims Aged 30-59 Days	Consumers	6%	$337,412	0%	$17,888	4%	$224,116
	3rd Party	2%	$91,716	1%	$72,955	3%	$140,003
Claims Aged 60-89 Days	Consumers	0%	$13,001	2%	$111,782	1%	$56,988
	3rd Party	1%	$46,686	1%	$52,414	2%	$83,759
Claims Aged 90-119 Days	Consumers	2%	$103,665	0%	$6,822	1%	$42,923
	3rd Party	1%	$44,838	1%	$41,025	2%	$113,527
Claims Aged 120+ Days	Consumers	33%	$1,950,846	36%	$2,062,900	28%	$1,569,445
	3rd Party	1%	$82,079	3%	$177,009	12%	$638,415

CLAIM COLLECTIONS	
Current Year To Date Collections	$16,070,212
Prior Year To Date Collections	$13,745,268
$ Change from Prior Year	$2,324,944
% Change from Prior Year	17%

Fee Collection YTD and Quarterly



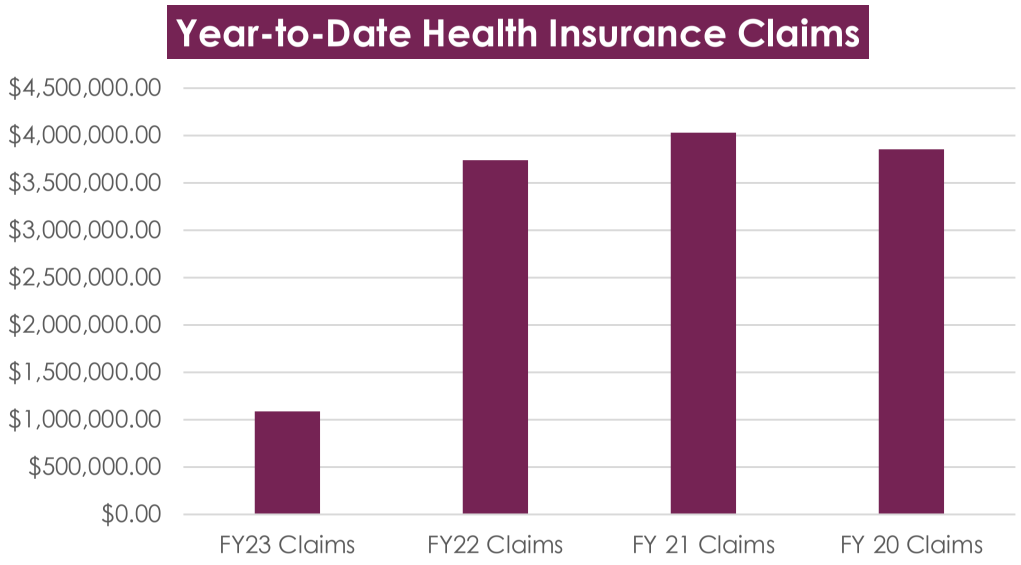


Write Off's – Current Month & YTD

Month: December 2022		
Write Off Code	**Current Year**	**Prior Year**
BANKRUPTCY	$55.00	$420.63
DECEASED	$50.00	$ -
NO FINANCIAL AGREEMENT	$1,741.60	$2,894.45
SMALL BALANCE	$69.94	$131.00
UNCOLLECTABLE	$280.00	$1,363.17
FINANCIAL ASSISTANCE	$123,026.10	$792,928.00
NO SHOW	$470.00	$260.00
MAX UNITS/BENEFITS	$4,495.21	$463.49
PROVIDER NOT CREDENTIALED	$8,046.97	$6,948.71
DIAGNOSIS NOT COVERED	$235.00	$ -
NON-COVERED SERVICE	$9,106.93	$2,001.50
SERVICES NOT AUTHORIZED	$13,652.16	$10,348.88
PAST BILLING DEADLINE	$3,162.63	$2,119.44
MCO DENIED AUTH	$18,279.56	$3,827.00
INCORRECT PAYER	$23,437.88	$2,308.18
INVALID MEMBER ID	$2,685.00	$ -
TOTAL	**$208,793.98**	**$826,014.45**

Year to Date July 2022 - Dec 2022		
Write Off Code	**Current Year**	**Prior Year**
BAD ADDRESS	$ -	$884.57
BANKRUPTCY	$3,750.55	$690.63
DECEASED	$3,956.95	$390.00
NO FINANCIAL AGREEMENT	$43,750.25	$21,503.98
SMALL BALANCE	$740.16	$678.26
UNCOLLECTABLE	$4,314.66	$9,747.44
FINANCIAL ASSISTANCE	$1,280,633.37	$1,604,526.54
NO SHOW	$2,470.00	$2,742.66
MAX UNITS/BENEFITS	$49,509.92	$23,101.78
PROVIDER NOT CREDENTIALED	$35,995.03	$48,186.54
DIAGNOSIS NOT COVERED	$2,220.00	$ -
NON-COVERED SERVICE	$31,293.03	$106,308.70
SERVICES NOT AUTHORIZED	$129,191.28	$164,250.87
PAST BILLING DEADLINE	$42,507.31	$43,468.66
MCO DENIED AUTH	$18,279.56	$6,560.18
INCORRECT PAYER	$67,874.52	$21,532.51
INVALID MEMBER ID	$3,495.00	$ -
TOTAL	**$1,719,981.59**	**$2,054,573.32**

Health Insurance

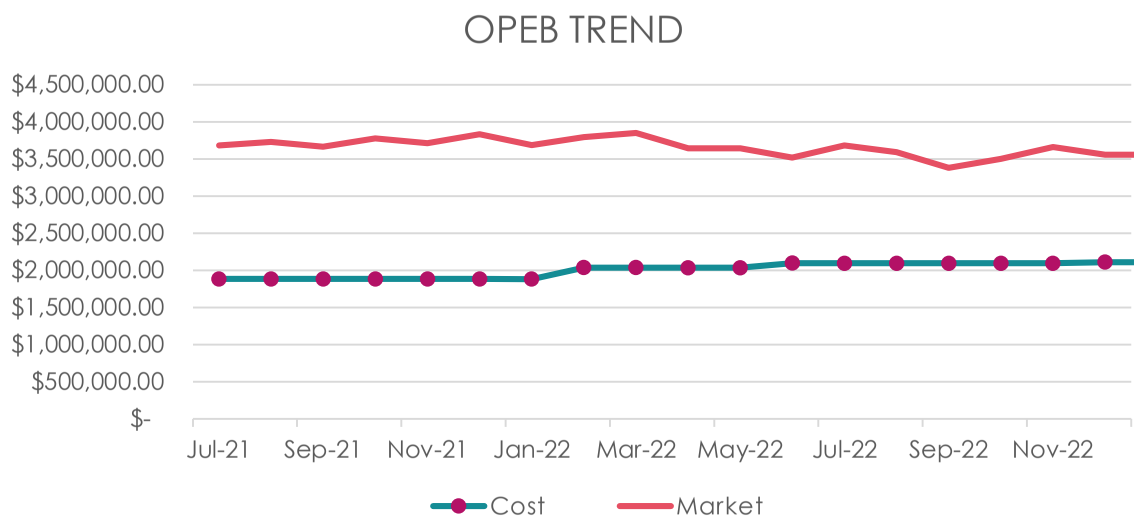


FY 2023	Monthly Premiums	Additional Premium Contributions	Monthly Claims & Fees	Interest	Balance
Beginning Balance					$381,873.61
July	$338,553.32		$284,427.57	$39.03	$436,038.39
August	$329,546.48		$212,109.53	$13.80	$553,489.14
September	$323,477.09		$223,419.72	$65.66	$653,612.17
October	$309,999.97		$208,892.49	$86.00	$754,805.65
November	$328,240.35		$159,945.92	$108.99	$923,209.07
December	$333,861.33		$264,646.91	$213.06	$992,636.55
YTD Total	**$1,963,678.54**	**$0.00**	**$1,353,442.14**	**$526.54**	**$992,636.55**

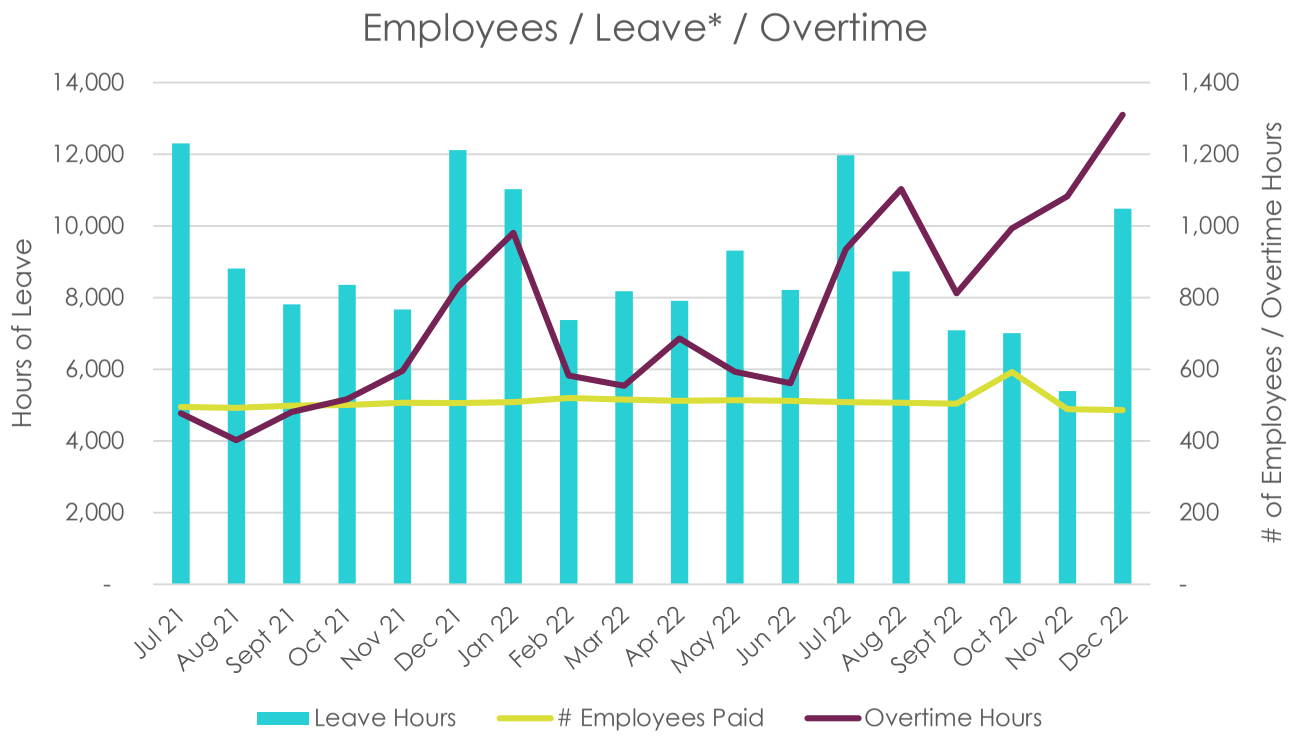
Historical Data	Average Monthly Claims	Monthly Average Difference from PY	Highest Month
FY 2023	$225,574	($85,940)	$284,428
FY 2022	$311,513	($24,129)	$431,613
FY 2021	$335,642	$14,641	$588,906
FY 2020	$321,002		$378,562

Other Post Employment Benefit (OPEB)

	Cost Basis	Cost Variance From Inception	Market Basis	Market Variance From Inception
Initial Contribution	$ 954,620		$ 954,620	
FY 2022 Year-End Balance	$ 2,097,261	$ 1,142,641	$ 3,520,345	$ 2,565,725
Balance at 7/31/2022	$ 2,096,641.74	$ 1,142,021.74	$ 3,680,816.76	$ 2,726,196.76
Balance at 8/31/2022	$ 2,096,641.74	$ 1,142,021.74	$ 3,590,000.78	$ 2,635,380.78
Balance at 9/30/2022	$ 2,096,641.74	$ 1,142,021.74	$ 3,382,530.44	$ 2,427,910.44
Balance at 10/31/2022	$ 2,096,030.84	$ 1,141,410.84	$ 3,500,553.56	$ 2,545,933.56
Balance at 11/30/2022	$ 2,096,030.84	$ 1,141,410.84	$ 3,659,065.82	$ 2,704,445.82
Realized Gain/(Loss)	$ 15,425.49		$ 15,425.49	
Unrealized Gain/(Loss)			$ (117,523.44)	
Fees & Expenses				
Transfers/Contributions				
Balance at 12/31/2022	$ 2,111,456.33	$ 1,156,836.33	$ 3,556,967.87	$ 2,602,347.87



Payroll Statistics



Indicators	FY 2021 Average Per Pay Period	FY 2022 Average Per Pay Period	FY 2023 Average Per Pay Period
# Employees Paid	514	506	497
Leave Hours	3,850	4,196	3,620
Overtime Hours	102	279	446

RACSB
FY 2022 FINANCIAL REPORT
Fiscal Year: July 1, 2022 through June 30, 2023
Report Period: July 1, 2022 through December 31, 2022

MENTAL HEALTH

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET * FY 2023	ACTUAL YTD	%	BUDGET FY 2023	ACTUAL YTD	%		
INPATIENT	20,000	10,400	52.00%	20,000	10,400	52.00%	-	0%
OUTPATIENT	2,078,691	1,983,357	95.41%	2,078,691	1,086,637	52.28%	896,720	45%
MEDICAL OUTPATIENT	3,849,822	2,126,291	55.23%	3,849,822	2,128,707	55.29%	(2,416)	0%
ACT NORTH	880,238	483,423	54.92%	880,238	421,371	47.87%	62,052	13%
ACT SOUTH	843,563	386,506	45.82%	843,563	304,572	36.11%	81,934	21%
CASE MANAGEMENT ADULT	937,373	487,326	51.99%	937,373	508,146	54.21%	(20,820)	-4%
CASE MANAGEMENT CHILD & ADOLESCENT	800,057	396,326	49.54%	800,057	369,291	46.16%	27,035	7%
PSY REHAB & KENMORE EMP SER	681,878	377,149	55.31%	681,878	305,013	44.73%	72,136	19%
PERMANENT SUPPORTIVE HOUSING	1,275,349	1,172,308	91.92%	1,275,349	570,310	44.72%	601,998	51%
CRISIS STABILIZATION	1,928,225	942,645	48.89%	1,928,225	796,746	41.32%	145,899	15%
SUPERVISED RESIDENTIAL	440,930	204,974	46.49%	440,930	256,957	58.28%	(51,983)	-25%
SUPPORTED RESIDENTIAL	893,956	382,401	42.78%	893,956	421,690	47.17%	(39,289)	-10%
JAIL DIVERSION GRANT	156,523	118,522	75.72%	156,523	40,148	25.65%	78,374	66%
SUB-TOTAL	**14,786,607**	**9,071,629**	**61%**	**14,786,607**	**7,219,988**	**49%**	**1,851,641**	**20%**

* Budget excludes program subsidies

DEVELOPMENTAL SERVICES

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET * FY 2023	ACTUAL YTD	%	BUDGET FY 2023	ACTUAL YTD	%		
CASE MANAGEMENT	3,105,473	1,659,424	53.44%	3,105,473	1,626,057	52.36%	33,367	2%
DAY HEALTH & REHAB *	4,136,396	1,975,200	47.75%	4,136,396	2,168,601	52.43%	(193,401)	-10%
GROUP HOMES	5,580,946	3,351,165	60.05%	5,580,946	2,521,933	45.19%	829,232	25%
RESPITE GROUP HOME	229,325	80,817	35.24%	229,325	255,920	111.60%	(175,103)	-217%
INTERMEDIATE CARE FACILITIES	4,091,920	2,064,353	50.45%	4,091,920	1,911,047	46.70%	153,306	7%
SUPERVISED APARTMENTS	1,525,310	1,288,440	84.47%	1,525,310	780,686	51.18%	507,754	39%
SPONSORED PLACEMENTS	2,047,818	1,433,226	69.99%	2,047,818	985,259	48.11%	447,968	31%
SUB-TOTAL	**20,717,187**	**11,852,625**	**57.21%**	**20,717,187**	**10,249,502**	**49.47%**	**1,603,123**	**14%**

* Budget excludes program subsidies

RACSB
FY 2022 FINANCIAL REPORT
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SUBSTANCE ABUSE

PROGRAM	REVENUE			EXPENDITURES				
	BUDGET * FY 2023	ACTUAL YTD	%	BUDGET FY 2023	ACTUAL YTD	%	ACTUAL VARIANCE	VARIANCE / REVENUE
OUTPATIENT	1,818,448	781,269	42.96%	1,818,448	838,576	46.11%	(57,307)	-7%
MAT PROGRAM	987,709	251,590	25.47%	987,709	504,407	51.07%	(252,817)	-100%
CASE MANAGEMENT	154,511	84,293	54.55%	154,511	63,038	40.80%	21,256	25%
RESIDENTIAL	161,757	103,573	64.03%	161,757	39,206	24.24%	64,367	62%
PREVENTION	808,950	585,138	72.33%	808,950	293,166	36.24%	291,972	50%
LINK	400,397	372,407	93.01%	400,397	96,726	24.16%	275,681	74%
SUB-TOTAL	**4,331,772**	**2,178,271**	**50%**	**4,331,772**	**1,835,119**	**42%**	**343,152**	**16%**

* Budget excludes program subsidies

SERVICES OUTSIDE PROGRAM AREA

PROGRAM	REVENUE			EXPENDITURES				
	BUDGET * FY 2023	ACTUAL YTD	%	BUDGET FY 2023	ACTUAL YTD	%	ACTUAL Variance	VARIANCE / REVENUE
EMERGENCY SERVICES	1,371,467	813,416	59.31%	1,327,096	529,781	39.92%	283,635	35%
CHILD MOBILE CRISIS	311,007	214,308	68.91%	320,728	147,635	46.03%	66,674	31%
CIT ASSESSMENT SITE	294,556	162,407	55.14%	289,481	166,988	57.69%	(4,581)	-3%
CONSUMER MONITORING	130,859	76,907	58.77%	139,646	103,442	74.07%	(26,535)	-35%
HOSPITAL CONSUMER MONITORING	193,975	0	0.00%	193,975	96,131	49.56%	(96,131)	0%
ASSESSMENT AND EVALUATION	592,509	265,165	44.75%	739,048	204,724	27.70%	60,441	23%
SUB-TOTAL	**2,894,374**	**1,532,203**	**52.94%**	**3,009,974**	**1,248,701**	**41.49%**	**283,503**	**19%**

* Budget excludes program subsidies

RACSB
FY 2022 FINANCIAL REPORT
Fiscal Year: July 1, 2022 through June 30, 2023
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ADMINISTRATION

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE
	BUDGET * FY 2023	ACTUAL YTD	%	BUDGET FY 2023	ACTUAL YTD	%	
ADMINISTRATION	130,574	115,454	88.42%	130,574	115,454	88.42%	0
PROGRAM SUPPORT	66,768	(583)	-0.87%	66,768	(583)	-0.87%	0
SUB-TOTAL	**197,342**	**114,871**	**58.21%**	**197,342**	**114,871**	**58.21%**	**0**
ALLOCATED TO PROGRAMS				4,268,473	2,305,139	54.00%	

* Budget excludes program subsidies

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET * FY 2023	ACTUAL YTD	%	BUDGET FY 2023	ACTUAL YTD	%		
TRANSPORTATION	0	0	0.00%	0	0	0.00%	0	0%
TOTAL	**0**	**0**	**0.00%**	**0**	**0**	**0.00%**	**0**	**0%**

* Budget excludes program subsidies

FISCAL AGENT PROGRAMS
PART C AND HEALTHY FAMILY PROGRAMS

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET * FY 2023	ACTUAL YTD	%	BUDGET FY 2023	ACTUAL YTD	%		
INTERAGENCY COORDINATING COUNCIL	1,710,296	1,200,894	70.22%	1,710,296	627,098	36.67%	573,796	48%
INFANT CASE MANAGEMENT	725,520	448,237	61.78%	725,520	363,281	50.07%	84,956	19%
EARLY INTERVENTION	2,041,058	871,639	42.71%	2,041,058	998,398	48.92%	(126,759)	-15%
TOTAL PART C	**4,476,874**	**2,520,770**	**56.31%**	**4,476,874**	**1,988,777**	**44.42%**	**531,993**	**21%**
HEALTHY FAMILIES	178,886	309,411	172.97%	178,886	28,723	16.06%	280,688	91%
HEALTHY FAMILIES - MIECHV Grant	403,497	105,145	26.06%	403,497	198,173	49.11%	(93,028)	-88%
HEALTHY FAMILIES-TANF & CBCAP GRANT	531,457	51,701	9.73%	531,457	273,383	51.44%	(221,682)	-429%
TOTAL HEALTHY FAMILY	**1,113,840**	**466,257**	**41.86%**	**1,113,840**	**500,279**	**44.91%**	**(34,022)**	**-7%**

RACSB
FY 2022 FINANCIAL REPORT
Fiscal Year: July 1, 2022 through June 30, 2023
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RECAP FY 2023 BALANCES

	REVENUE	EXPENDITURES	NET	NET / REVENUE
MENTAL HEALTH	9,071,629	7,219,988	1,851,641	20%
DEVELOPMENTAL SERVICES	11,852,625	10,249,502	1,603,123	14%
SUBSTANCE ABUSE	2,178,271	1,835,119	343,152	16%
SERVICES OUTSIDE PROGRAM AREA	1,532,203	1,248,701	283,503	19%
ADMINISTRATION	114,871	114,871	0	0%
OTHER	0	0	0	0%
FISCAL AGENT PROGRAMS	2,987,027	2,489,056	497,972	17%
TOTAL	**27,736,626**	**23,157,236**	**4,579,390**	**17%**

Restricted Funds	$ 1,894,053
Unrestricted Funds	2,687,249
Total	$ 4,579,390

RECAP FY 2022 BALANCES

	REVENUE	EXPENDITURES	NET	NET / REVENUE
MENTAL HEALTH	4,626,349	3,495,658	1,130,691	24%
DEVELOPMENTAL SERVICES	5,073,687	4,776,594	297,093	6%
SUBSTANCE ABUSE	2,007,967	1,031,817	976,150	49%
SERVICES OUTSIDE PROGRAM AREA	803,430	696,248	107,182	13%
ADMINISTRATION	34,201	34,200	2	0%
OTHER	2,000	20,016	(18,016)	-901%
FISCAL AGENT PROGRAMS	1,566,679	1,298,910	267,769	17%
TOTAL	**14,114,314**	**11,353,443**	**2,760,871**	20%

	$ Change	% Change
Change in Revenue from Prior Year	$ 13,622,312	96.51%
Change in Expense from Prior Year	$ 11,803,794	103.97%
Change in Net Income from Prior Year	$ 1,818,519	65.87%

*Unaudited Report

hopestarter RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

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

NOTICE

To: Personnel Committee: Glenna Boerner, Linda Carter, Claire Curcio, Susan Gayle, Ken Lapin, Jacob Parcell, Sarah Ritchie, Greg Sokolowski, Carol Walker, Melissa White.

From: Joseph Wickens
Executive Director

Subject: Personnel Committee Meeting
February 14, 2023, 12:00 PM
600 Jackson Street, Board Room 208. Fredericksburg, VA

Date: February 09, 2023

A Personnel Committee meeting has been scheduled for Tuesday, February 14, 2023 at 12:00 PM. The meeting will be held at 600 Jackson Street, Board Room 208, Fredericksburg, VA 22401.

Looking forward to seeing you on February 14th at 12:00 PM.

Cc: Susan Gayle, Chairperson

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Personnel Committee Meeting

February 14, 2023 – 12:00 PM

600 Jackson Street, Room 208 Fredericksburg, VA 22401

Agenda

I. Classification, Compensation, and Benefits Study, *Blair Johnson of JERHR Group*……...Handout
II. RACSB Classification and Compensation Recommendations, *Runyon*……..Handout
III. December Retention Report, *Runyon* ……...……..3
IV. December EEO Report, *Runyon* …….....9
V. Other Business, *Gayle*

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Office of Human Resources
600 Jackson Street • Fredericksburg, VA 22401 • 540-373-3223
RappahannockAreaCSB.org

MEMORANDUM

To: Joe Wickens, Executive Director

From: Teresa McDonnel, Human Resources Specialist

Date: February 3, 2023

Re: Summary – January 2023 EEO Report and Recruitment Update

RACSB received **105** applications through January 31, 2023. This is an **increase** of **47.9%** compared to the month of December 2022, and an **increase** of **38.2%** when compared to the month of January 2022.

RACSB received **921** resumes and advertised **12** positions through Indeed for **January 2023**.

Of the applications received, 48 applicants listed the RACSB applicant website as their recruitment source, 37 stated employee referrals as their recruitment source, and 19 listed Indeed.com as their recruitment source.

According to the attached list, there are currently **131** open positions. New positions account for **5** of the open positions.

A summary is attached indicating external applicants hired, internal applicants moved, and actual number of applicants applying for positions in the month of **January 2023.**

EEO Report 2023

APPLICANT DATA	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Female	41	46	35	24	31	45	30	41	35	29	25	22	46
Male	8	7	11	3	13	11	9	11	12	4	2	8	5
Not Supplied	27	33	26	30	25	33	44	38	36	35	29	41	54
Total	**76**	**86**	**72**	**57**	**69**	**89**	**83**	**90**	**83**	**68**	**56**	**71**	**105**
ETHNICITY													
Caucasian	31	25	13	13	22	30	19	30	28	14	17	9	39
African American	15	20	27	16	17	24	17	18	19	16	7	19	18
Hispanic	7	6	5	5	5	3	4	5	2	5	1	2	8
Asian	2	3		1	1			1		1	2	1	1
American Indian		2	1		1	1	1		1	1			
Native Hawaiian													
Two or More Races													
RECRUITMENT SOURCE													
Newspaper Ads	1									1		4	2
RACSB Website	36	32	33	27	28	39	28	31	28	26	25	27	48
RACSB Intranet	2	7	5	2	5	7	3	6	6	2	1	2	2
Employee Referrals	18	32	15	23	18	30	29	30	27	23	19	22	37
Radio Ads			1		1			4			1		
Indeed.com	20	7	17	9	11	15	11	13	24	13	9	16	19
VA Employment Commission	3	2	3	2	7	2	2	1			2	4	
Monster.com													
Other -	1	8	3		3	4	5	2	2	2	2	2	1
Colleges/Handshake						1							
Facebook													1
Multi Site Search						1	1	2	2				
NHSC													
Linked In								1					
Goodwill referral													
Zip Recruiter									1	3	1		2
Job Fair		2	1			1			2		2	2	2
Total # of Applicants	62	65	59	47	52	77	59	72	64	57	42	60	75

Open Positions Report - January 30, 2023						
Date Posted	Position No.		Position Title	Location	RU	Full-time/ Part-time
8/20/2021	236-2021	ADMIN	Utilization Review Specialist	Fredericksburg	1000	FT
5/27/2022	127-2022	ADMIN	Property Maintenance Technician	Fredericksburg	1000	FT
8/8/2022	210-2022	ADMIN	Lead Landscape Technician	Fredericksburg	1000	FT
8/11/2022	216-2022	ADMIN	Landscape Technician I	Fredericksburg	1000	PT
1/24/2023	016-2023	ADMIN	Finance Office Associate	Fredericksburg	1000	PT
				5		
1/10/2022	003-2022	CLINICAL	Psychiatrist	Fredericksburg		FT
10/17/2022	276-2022	CLINICAL	Office Associate II	Spotsylvania	1100	FT
5/12/2022	115-2022	CLINICAL	Office Associate II	Fredericksburg	1000	FT
7/20/2022	183-2022	CLINICAL	Emergency Services Therapist - Overnight	Fredericksburg	2000/4000	FT
1/20/2023	005-2023	CLINICAL	Emergency Services Therapist	Fredericksburg	2000/4000	FT
6/9/2021	123-2021	CLINICAL	Child/Adolescent ES Therapist	Fredericksburg	2070	FT
1/20/2023	003-2023	CLINICAL	Child/Adolescent ES Therapist	Fredericksburg	2070	FT
1/20/2023	004-2023	CLINICAL	Child/Adolescent ES Therapist	Fredericksburg	2070	FT
9/20/2021	265-2021	CLINICAL	Peer Recovery Specialist MH	Fredericksburg	2200	FT
1/28/2022	030-2022	CLINICAL	MH Therapist (Jail Based)	RRJ Stafford	2200-4200/6430	FT
9/27/2022	246-2022	CLINICAL	MH Nurse - LPN/RN	Outpatient Clinics	2201	FT
6/1/2022	125-2022	CLINICAL	MH Therapist	Caroline	2210	FT
11/18/2022	298-2022	CLINICAL	MH/SA Outpatient Therapist	Caroline	2210	FT
12/27/2022	323-2022	CLINICAL	Office Manager I	Caroline	2210	FT
3/30/2022	093-2022	CLINICAL	School Based Therapist	Spotsylvania	2240	FT
4/15/2022	107-2022	CLINICAL	MH Outpaitent Therapist	Spotsylvania	2240	FT
8/23/2022	230-2022	CLINICAL	Clinic Coordinator II	Stafford	2200/4200	FT
8/22/2022	227-2022	CLINICAL	Child/Adolescent Therapist	Stafford	2200/6430	FT
1/28/2022	029-2022	CLINICAL	MH Therapist	Stafford	2250/6430	FT
1/5/2023	325/2022	CLINICAL	MH/Substance Abuse Therapist	Stafford	2250/4250	FT
4/15/2022	106-2022	CLINICAL	Child/Adolescent Therapist (Safe Harbour)	Spotsylvania	2400	FT
8/30/2022	236-2022	CLINICAL	Adult MH Case Manager	Fredericksburg	2400	FT
11/2/2022	294-2022	CLINICAL	Adult MH Care Coordinator	Fredericksburg	2400	FT
9/21/2021	199-2021	CLINICAL	Family Support Peer	Spotsylvania	2500	PT
7/8/2022	172-2022	CLINICAL	Child/Adolescent MH Case Manager	Stafford	2500	FT
8/30/2022	240-2022	CLINICAL	Senior Child & Adolescent Case Manager	Stafford	2500	FT
7/23/2021	200-2021	CLINICAL	Therapist/Office On Youth	Fredericksburg	4200	PT/FT
6/22/2022	152-2022	CLINICAL	Substance Abuse Therapist (Jail Based)	RRJ Stafford	4200	FT
12/1/2022	306-2022	CLINICAL	Substance Abuse Therapise (P&P)	RRJ Stafford	4200	FT
7/13/2021	174-2021	CLINICAL	S. A. Therapist	Fredericksburg	4220	FT
3/30/2022	092-2022	CLINICAL	S.A. Therapist, Women's Services	Spotsylvania	4220	FT
9/1/2020	146-2020	CLINICAL	S. A. Therapist	Spotsylvania	4240	FT
1/26/2021	350-2021	CLINICAL	SA Therapist, Women's Services	Fredericksburg	4260	FT
1/20/2023	006-2023	CLINICAL	SA Peer Recovery Specialist	RRJ	4261	FT
4/28/2021	083-2021	CLINICAL	MH/SA Therpaist - Detention Based	RRJ	4290	FT
7/29/2022	206-2022	CLINICAL	MH/SA Therpaist - Detention Based	RRJ	4290	FT
3/24/2021	056-2021	CLINICAL	SA Therapist/Case Manager	Fredericksburg	4296	FT
8/11/2022	217-2022	CLINICAL	Project LINK Specialist, SUD	RC	4970	FT
				38		
1/13/2023	001-2023	CSS	Assistant Coordinator	Crisis Stabilization	2770	FT
6/10/2022	148-2022	CSS	Nurse Manager - RN	Crisis Stabilization	2770	FT
7/15/2022	182-2022	CSS	MH Nurse - RN/LPN	Crisis Stabilization	2770	FT
9/9/2022	231-2022	CSS	MH Nurse - RN/LPN	Crisis Stabilization	2770	FT
9/13/2022	253-2022	CSS	MH Nurse - RN/LPN	Crisis Stabilization	2770	FT
12/28/2022	321-2022	CSS	MH Nurse - RN/LPN	Crisis Stabilization	2770	FT
9/13/2022	256-2022	CSS	MH Residential Specialist	Crisis Stabilization	2770	FT
12/28/2022	322-2022	CSS	MH Residential Specialist	Crisis Stabilization	2770	FT
12/1/2022	303-2022	CSS	Cook	Crisis Stabilization	2770	FT
12/28/2022	320-2022	CSS	Peer Recovery Specialist	Crisis Stabilization	2770	FT
				10		
12/28/2022	318-2022	CSS	Psychoosocial Advocate	Kenmore Club	2680	FT
1/30/2023	019/2023	CSS	MH Supv Apartment Asst. Mgr	Lafayette	2786	FT
10/13/2022	277-2022	CSS	MH Residential Counselor	Lafayette	2786	FT
12/21/2021	345-2021	CSS	MH Residential Counselor	Lafayette	2786	PT
11/17/2021	313-2021	CSS	MH Residential Counselor II	Home Rd	2778	FT
8/12/2022	220-2022	CSS	MH Residential Counselor II	Home Rd	2778	FT
7/11/2022	170-2022	CSS	MH Residential Counselor I	Home Rd	2778	FT
9/29/2022	273-2022	CSS	Peer Specialist III - ACT	401 Bridgewater	2372	FT
12/1/2022	305-2022	CSS	Office Associate II - ACT South	401 Bridgewater	2372	FT
4/26/2022	109-2022	CSS	PSH Case Manager	401 Bridgewater	2760	FT
12/13/2022	313-2022	CSS	PSH Peer Specialist	401 Bridgewater	2760	FT

Date Posted	Position No.		Position Title	Location	RU	Full-time/ Part-time
8/30/2022	242-2022	CSS	Devlelpmental Svcs Support Coordinator	Caroline	3400	FT
8/30/2022	241-2022	CSS	Devlelpmental Svcs Support Coordinator	Spotsylvania	3400	FT
5/24/2022	129-2022	CSS	Devlelpmental Svcs Support Coordinator	Stafford	3400	FT
8/17/2022	225-2022	CSS	Infant/Child Support Coordinaor	PEID	3500	FT
8/1/2022	309-2021	CSS	Speech/Language Pathologist	PEID	3910	FT
				16		
1/30/2023	014-2023	CSS	Direct Support Professional - Day Support	RAAI KH	3652	FT
1/30/2023	015-2023	CSS	Direct Support Professional - Day Support	RAAI KH	3652	FT
6/24/2021	156-2021	CSS	Direct Support Professional - Day Support	RAAI KH	3652	PT
6/24/2021	158-2021	CSS	Direct Support Professional - Day Support	RAAI KH	3652	PT
6/24/2021	159-2021	CSS	Direct Support Professional - Day Support	RAAI KH	3652	PT
7/26/2021	196-2021	CSS	Direct Support Professional - Day Support	RAAI KH	3652	PT
2/9/2022	046-2022	CSS	Direct Support Professional - Day Support	RAAI KH	3652	PT
2/6/2022	308-2022	CSS	Direct Support Professional - Day Support	RAAI KH	3652	PT
9/15/2022	259-2022	CSS	Direct Support Professional - Day Support	RAAI Spotyslvania	3654	FT
9/27/2022	266-2022	CSS	Direct Support Professional - Day Support	RAAI Spotyslvania	3654	FT
1/13/2023	007-2023	CSS	Direct Support Professional - Day Support	RAAI Stafford	3655	FT
1/6/2023	326-2022	CSS	Direct Support Professioanl - ICF Team	RAAI KH	3656	FT
7/11/2022	174-2022	CSS	Direct Support Professional - Day Support	RAAI ICF	3656	PT
				13		
3/21/2022	079-2022	CSS	Direct Support Professional - ICF	Wolfe Street ICF	3771	FT
7/27/2020	115-2020	CSS	ICF Nurse - LPN	Wolfe Street ICF	3771	FT
5/4/2021	089-2021	CSS	ICF Nurse - LPN	Wolfe Street ICF	3771	FT
12/8/2020	218-2020	CSS	ICF Nurse - LPN	Wolfe Street ICF	3771	FT or PT
9/8/2022	247-2022	CSS	Direct Support Professional - ICF	Wolfe Street ICF	3771	FT
12/6/2022	309-2022	CSS	Direct Support Professional - ICF	Wolfe Street ICF	3771	FT
8/10/2022	213-2022	CSS	Direct Support Professional - ICF	Wolfe Street ICF	3771	PT
10/13/2022	278-2022	CSS	Direct Support Professional - ICF	ICF Ross	3792	FT
11/18/2022	295-2022	CSS	Direct Support Professional - ICF	ICF Ross	3792	FT
1/20/2023	012-2023	CSS	Direct Support Professional - ICF	ICF Ross	3792	FT
1/20/2023	013-2023	CSS	Direct Support Professional - ICF	ICF Ross	3792	FT
1/9/2023	072-2022	CSS	Direct Support Professional - ICF	ICF Ross	3792	PT
7/12/2022	179-2022	CSS	Direct Support Professional - ICF	ICF Ross	3792	PT
8/27/2020	141-2020	CSS	ICF Nurse - LPN	ICF Ross	3792	PT
10/13/2022	279-2022	CSS	Direct Support Professional - ICF	ICF Lucas	3793	FT
12/13/2022	314-2022	CSS	Direct Support Professional - ICF	ICF Lucas	3793	FT
1/13/2023	010-2023	CSS	Direct Support Professional - ICF	ICF Lucas	3793	FT
1/30/2023	017-2023	CSS	Direct Support Professional - ICF	ICF Lucas	3793	FT
5/25/2022	126-2022	CSS	Direct Support Professional - ICF	ICF Lucas	3793	PT
11/1/2022	292-2022	CSS	Direct Support Professional - ICF	ICF Lucas	3793	PT
11/9/2020	196-2020	CSS	ICF Nurse - LPN	ICF Lucas	3793	FT
1/30/2023	018-2023	CSS	ICF Nurse - LPN	ICF Lucas	3793	FT
				22		
8/30/2022	244-2022	CSS	Direct Support Professional - Residential	Leeland Road	3772	PT
10/13/2022	275-2022	CSS	Direct Support Professional - Residential	Leeland Road	3772	PT
11/18/2022	300-2022	CSS	Direct Support Professional - Residential	Stonewall Estates	3773	FT
7/18/2022	187-2022	CSS	Direct Support Professional - Residential	Stonewall Estates	3773	PT
7/18/2022	188-2022	CSS	Direct Support Professional - Residential	Stonewall Estates	3773	PT
8/10/2022	211-2022	CSS	Direct Support Professional - Residential	Devon Drive	3774	PT
2/18/2022	056-2022	CSS	Direct Support Professional - Residential	Ruffins Pond	3775	PT
10/30/2022	289-2022	CSS	Direct Support Professional - Residential	Piedmont	3776	FT
1/13/2023	009-2023	CSS	Direct Support Professional - Residential	Piedmont	3776	FT
6/15/2022	153-2022	CSS	Direct Support Professional - Residential	Igo Rd	3777	PT
6/3/2022	078-2022	CSS	Direct Support Professional - Residential	Igo Rd	3777	PT
12/28/2022	319-2022	CSS	Direct Support Professional - Residential	New Hope	3778	FT
1/20/2023	324-2022	CSS	Direct Support Professional - Residential	New Hope	3778	PT
1/13/2023	008-2023	CSS	Direct Support Professional - Residential	Scottsdale Estates	3779	FT
1/26/2022	026-2022	CSS	Direct Support Professional - Residential	Scottsdale Estates	3779	PT
9/10/2021	102-2021	CSS	Direct Support Professional - Residential	Scottsdale Estates	3779	PT
4/29/2022	111-2022	CSS	Direct Support Professional - Residential	Belmont SAP	3781	PT
1/6/2022	284-2022	CSS	Direct Support Professional - Residential	Merchants Square SAP	3784	FT
4/20/2022	105-2022	CSS	Direct Support Professional - Residential	Merchants Square SAP	3784	PT
1/6/2023	327-2022	CSS	Direct Support Professional - Residential	Galveston Rd	3790	FT
6/23/2022	178-2021	CSS	Direct Support Professional - Residential	Galveston Rd	3790	PT
12/29/2021	348-2021	CSS	Direct Support Professional - Residential	Churchill	3791	PT
5/3/2022	112-2022	CSS	Direct Support Professional - Residential	Myers Drive Respite	3794	FT
7/20/2022	189-2022	CSS	Direct Support Professional - Residential	Myers Drive Respite	3794	FT
9/30/2022	270-2022	CSS	Direct Support Professional - Residential	Myers Drive Respite	3794	FT
9/29/2022	271-2022	CSS	Direct Support Professional - Residential	Myers Drive Respite	3794	PT
9/29/2022	274-2022	CSS	Direct Support Professional - Residential	Myers Drive Respite	3794	PT

Date Posted	Position No.		Position Title	Location	RU	Full-time/ Part-time
				27		
Positions on Hold						
3/29/2021	058-2021	ADMIN	Administration Office Support	Fredericksburg	1000	FT
3/23/2020	056-2020	CLINICAL	Lead, ES Therapist	Fredericksburg	2000/4000	FT
9/25/2019	189-2019	CLINICAL	Psychologist II	Stafford	2250	FT
8/18/2020	127-2020	CLINICAL	Drug Court Surveillance Officer	Fredericksburg	4200	PT
9/15/2022	260-2022	CSS	Nurse Manager II	ID/DD	Split	FT
				Total Open Positions: 131		

RECRUITMENT REPORT 2023

MONTHLY RECRUITMENT	***JANUARY***	***FEBRUARY***	***MARCH***	***APRIL***	***MAY***	***JUNE***	***JULY***	***AUGUST***	***SEPTEMBER***	***OCTOBER***	***NOVEMBER***	***DECEMBER***	***TOTAL YTD***
External Applicants Hired:													
Part-time	7												
Full-time	6												
Sub Total External Applicants Hired	**13**												
Internal Applicants Moved:													
Full-time to PRN As Needed	4												
Full-time to Part-time													
Part-time to PRN As Needed													
Part-time to Full-time													
PRN As Needed to Part-time													
Lateral Transfer													
Non-Lateral Change in Position													
Promotion	1												
Temporary to Regular													
PRN As Needed to Full-Time													
Temporary Promotion													
Intern to Full-time	1												
Sub Total Internal Applicant Moves	**6**												
Total Positions Filled:	**19**												
Total Applications Received:													
Actual Total of Applicants:	**75**												
Total External Offers Made:	**20**												
Total Internal Offers Made:	**9**												

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MEMORANDUM

To: Joe Wickens, Executive Director

From: Michelle Runyon, Human Resources Director

Date: February 7, 2023

Re: Summary – Retention Report – **January 2023**

Human Resources processed a total of **12** employee separations for the month of **January, 2023**. Ten of the separations were voluntary and 2 were terminations for cause, ten employees were full-time and 2 were part-time.

Three resignations were submitted due to other employment, three were submitted due to personal reason, two were job abandonment, one moved and two were terminations. One employee was exhausted FMLA/STD and was unable to return work, this employee doesn't count against our numbers.

According to the attached report, the Retention Rate for **January** was 98.17% and the turnover rate was 1.83%. Annualized turnover comparison is included.

RACSB Turnover 2020

Employees	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	2020 Year End
Average Total Positions	624	624	624	624	624	624	624	624	624	624	624	624	624
Monthly Terminations*	8	3	10	7	4	7	11	16	11	17	12	6	112
Turnover by Month YTD	1.28%	0.48%	1.60%	1.12%	0.64%	1.12%	1.76%	2.56%	1.76%	2.72%	1.92%	0.96%	17.95%
Cumulative Turnover YTD	0.16%	1.76%	3.37%	4.49%	5.13%	6.25%	8.01%	10.58%	12.34%	15.06%	16.99%	17.95%	17.95%
Average % Turnover per Month YTD	0.16%	0.88%	1.12%	1.12%	1.03%	1.04%	1.14%	1.32%	1.37%	1.51%	1.54%	1.50%	1.50%

*Monthly Terminations Do Not Include: Employee Retirements, Employees Not Able to Return from Disability Leave, Employees Not Completing NEO, Interns/Volunteers

RACSB Turnover 2021

Employees	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021 Year End
Average Total Positions	601	601	601	601	601	601	601	601	601	601	601	601	601
Monthly Terminations*	10	4	6	13	13	13	13	6	13	11	11	15	128
Turnover by Month YTD	1.66%	0.67%	1.00%	2.16%	2.16%	2.16%	2.16%	1.00%	2.16%	1.83%	1.83%	2.50%	21.30%
Cumulative Turnover YTD	0.17%	2.33%	3.33%	5.49%	7.65%	9.81%	11.97%	12.97%	15.13%	16.96%	18.79%	21.29%	21.29%
Average % Turnover per Month YTD	0.17%	1.16%	1.11%	1.37%	1.53%	1.64%	1.71%	1.62%	1.68%	1.70%	1.71%	1.94%	1.94%

*Monthly Terminations Do Not Include: Employee Retirements, Employees Not Able to Return from Disability Leave, Employees Not Completing NEO, Interns/Volunteers

RACSB Turnover 2022

Employees	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	2022 Year End
Average Total Positions	600	600	600	600	600	600	600	600	600	600	600	600	600
Average Number of PRN's	43	43	42	41	39	38	38	43	42	42	45	45	42
Monthly Terminations*	11	13	11	7	8	16	17	13	13	9	5	2	125
Turnover by Month YTD	1.83%	2.17%	1.83%	1.17%	1.33%	2.67%	2.83%	2.17%	2.17%	1.50%	0.83%	0.33%	20.83%
Cumulative Turnover YTD	0.17%	4.00%	5.83%	7.00%	8.33%	11.00%	13.83%	16.00%	18.17%	19.67%	20.50%	20.83%	20.83%
Average % Turnover per Month YTD	0.17%	2.00%	1.94%	1.75%	1.67%	1.83%	1.98%	2.00%	2.02%	2.19%	2.05%	1.89%	1.89%

*Monthly Terminations Do Not Include: Employee Retirements, Employees Not Able to Return from Disability Leave, Employees Not Completing NEO, Interns/Volunteers

RACSB Turnover 2023

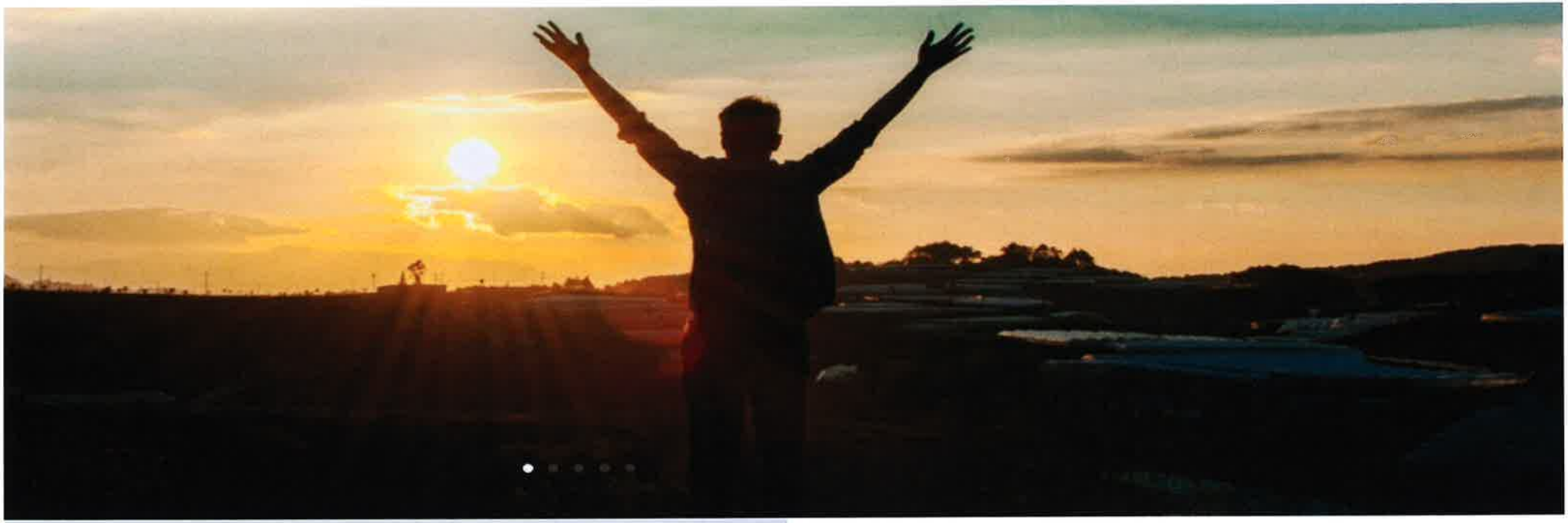
Employees	Jan-23	Feb-23	Feb-23	Feb-23	Mar-23	Mar-23	Apr-23	Apr-23	Apr-23	May-23	May-23	Jun-23	2023 Year End
Average Total Positions	600												600
Monthly Terminations*	11												11
Turnover by Month YTD	1.83%												1.83%
Cumulative Turnover YTD	0.17%												0.00%
Average % Turnover per Month YTD	0.17%												0.00%

RACSB RETENTION & TURNOVER REPORT
Jan-23

ORGANIZATIONAL UNIT	NUMBER OF TERMS	VOLUNTARY	INVOLUNTARY	EXPLANATION
Administrative	0	0		
Unit Totals	*0*	*0*	*0*	
Clinical Services	0	1	0	Other Employment
	0	1	0	Moving
Unit Totals	*0*	*2*	*0*	
Community Support Services				
	0	3	0	Personal Reasons
	0	2	0	Other Employment
	0	2	0	Job Abandonment
	0	0	2	Terminated for Cause
Unit Totals	*0*	*7*	*2*	
				1 Exhausted Leave
Grand Totals for the Month	0	9	2	

Total Employees for the Month	600
Retention Rate	98.17%
Turnover Rate	1.83%

Total Separations	11
Part-time Separations	19.00%
Full-time Separations	81.00%



Classification, Compensation and Benefits Study

February 14, 2023

Presented to: RACSB Board

Presented by: Blair Johanson
JER HR Group, Managing Consultant

Classification, Compensation and Benefits Study Focus

Project Overview:

- Complete a Classification and Compensation Study to evaluate the Agency's current classification and salary structure as well as salary compression as compared to similar districts and in the private sector where applicable
- Maintain a compensation plan that is aligned with and supports the goals of Rappahannock Area Community Services Board

Classification, Compensation and Benefits Study Focus

Project Objectives:

- Balance the desire to competitively pay employees with the financial resources of the Agency and be fiscally responsible
- Maintain a compensation management system that is flexible to meet the changing needs of the Agency
- Employee talent attraction and retention

Classification, Compensation and Benefits Study Focus

- Phase I: Job Descriptions and Ratings
  - Job descriptions sent to JER HR Group
  - Uploaded 145 position descriptions within the DBCompensation software format
  - Rated 145 positions utilizing 15 compensable factors
  - Review of job ratings for appropriate position placements

Job Rating Factors

KNOWLEDGE & SKILL REQUIREMENTS

1. Experience – General
2. Experience – Management
3. Education
4. Initiative and Ingenuity
5. Mental Demand
6. Analytical Ability/Problem Solving

RESPONSIBILITES

7. Responsibilities for Work of Others (Supervision)
8. Responsibilities for Funds, Equipment, Property, etc.
9. Responsibilities for Accuracy
10. Accountabilities (End Results)

CONTACTS/HUMAN RELATIONS

11. Contacts with Public
12. Contacts with Employees

EFFORTS

13. Machine and Computer Operations
14. Working Conditions/Hazards
15. Physical Demands

Classification, Compensation and Benefits Study Focus

- Phase II: Market Pay and Benefits Study
  - Completed market pay study with 21 survey entities and published studies

    Regional CSBs, counties, cities, school districts, healthcare providers, Department of Labor, and Salary.com CompAnalyst

  - Comparisons of 122 jobs for the market salary study
  - Completion of major benefits and other compensation study

Classification, Compensation and Benefits Study Focus

- Phase II: Market Pay Study Variances

Public Agencies, Counties, Cities, Healthcare Providers, and Published Pay Studies	Variance
Market Pay Study Mean	-5.88%
Market Pay Study Wage Inflation 2023	4.20%

Classification, Compensation and Benefits Study Focus

- Phase III: Compensation Administration
  - Employee information uploaded & market data entered in compensation management database
  - 400+ full-time employees represented in compensation study
  - Market pay and benefits study results shared with Agency's Leadership Team
  - Classification, Compensation and Benefits Study Overview and recommendations shared with Agency's Board

Classification, Compensation and Benefits Study Focus

Phase III: Job Regrades

Position Title	Previous Grade	New Grade
Executive Director	21	22
Deputy Executive Director	19	20
Director Clinical Services	18	19
Director Community Support Services	18	19
Director Compliance & Human Rights	18	19
Director Finance and Administration	18	19
Director Prevention Services	17	18
Coordinator Emergency Services	16	17
Coordinator Substance Abuse Program	16	17
Clinic Coordinator III	16	17
ACT Coordinator	16	17
Crisis Stabilization Coordinator	15	17
ACT Nurse Manager	13	16
DD Residential ICF Nurse Manager	13	16
DD Residential Nurse Manager II	13	16
MH Nurse Manager-Outpatient	13	16
Clinic Coordinator II	15	16
Coord. Jail & Juvenile Detention-MHSA Services	15	16
Clinic Coordinator I	14	15
Behavioral Health Coord.-Specialty Dockets	14	15
ES Assistant Coordinator	14	15

Classification, Compensation and Benefits Study Focus

Phase III: Job Regrades

Position Title	Previous Grade	New Grade
Lead Liaison NGRI Coordinator	13	14
Crisis Stabilization Asst. Coordinator	13	14
Veteran Lead Therapist	13	14
Emergency Services Therapist - L.E. Liaison	13	14
Therapist Emergency Services	13	14
Therapist Generic	12	13
Licensed Therapist	12	13
Crisis Stabilization Lead Nurse LPN	11	13
ACT LPN	10	12

Position Title	Previous Grade	New Grade
Outpatient LPN (ICF, SLH, MH)	10	11
ACT MH Specialist	9	11
Lead Office Manager	9	10
Purchasing Specialist	8	10
MH Residential Specialist	9	10
DD Res. Sponsored Placemt Res. Spec.	9	10
Family Resource Specialist - HFP	9	10
Family Support Specialist - HFP	9	10
HR Associate-Records and Training	8	9
Psychosocial Advocate	8	9
Admin Assoc. -Healthy Families Program	7	8
Peer Specialist II CIT	6	7

Classification and Compensation 2023 Proposed Pay and Grade Ranges Structure

Grade	Minimum	Midpoint	Maximum
6	$37,440	$46,800	$58,501
7	$38,684	$50,239	$62,799
8	$40,259	$53,678	$67,098
9	$44,128	$58,837	$73,546
10	$49,286	$65,715	$82,143
11	$54,444	$72,592	$90,741
12	$59,603	$79,470	$99,338
13	$64,761	$86,348	$107,935
14	$69,919	$93,226	$116,532
15	$75,078	$100,104	$125,130

Classification and Compensation 2023 Proposed Pay and Grade Ranges Structure

Grade	Minimum	Midpoint	Maximum
16	$80,236	$106,982	$133,727
17	$87,974	$117,298	$146,623
18	$98,291	$131,054	$163,818
19	$108,607	$144,810	$181,012
20	$118,924	$158,566	$198,207
21	$129,242	$172,322	$206,786
22	$139,558	$186,077	$232,596

Classification, Compensation and Benefits Study Recommendations

- Adopt the 2023 proposed pay grade and range structure
- Increase pay for the employees with current pay below pay grade minimums
- Regrade positions based on internal job evaluation and results of the market pay study
- Increase pay for the employees with position upgrades based on the promotions policy - 5% of base pay
- Fund time in position pay compression adjustments

Classification, Compensation and Benefits Study Comments and Recommendations

The Agency's employment benefits are competitive based on results of the benefits study. The Agency offers benefits that are comprehensive and like the benefits offered by other surveyed entities that responded to the benefits study.

The notable exception is related to the health insurance premium cost share percentage for employee plus (spouse, children, and family) coverages. The RACSB employees pay a higher portion of the monthly medical insurance premium cost share than benefits study cost share average.

To: Joe Wickens, Executive Director
From: Michelle Runyon, H.R. Director
Subject: Classification and Compensation Recommendations
Date: February 12, 2023

The Rappahannock Area Community Services Board contracted with JER HR Group, to perform a comprehensive classification, compensation, and benefit study. Workforce shortages and vacancy continue to negatively impact programming across the agency to include temporary closings, waitlists, and increased cost to maintain current services. The ability to attract and retain high-quality employees is the agency's top priority.

RACSB recommends the following strategies to remain competitive with the current market:

- Set compensation scale comparable to current market by increasing all grade level starting salary by 10% with the exception of Grade 6 and 7, they will be brought up to a higher minimum level (Grade 6 will be brought up to $37,440 and Grade 7 will be brought up to $38,684) on the compensation scale. All employees will be brought up to the minimum starting salary of the applicable grade.

	Projected Increase	Number Employees
Full-Time Employees	$566,702.70	180

- Implement recommended re-graded positions. Consistent with RACSB policy, employees in re-graded positions will receive an additional 5% added to the 5% received in January 2023 to equal a 10% increase, unless the minimum of the new grade is higher. This strategy addresses both vertical and horizontal compression.

	Projected Increase	Number Employees
Full-Time Employees	$193,733.25	51

- For positions which are not re-graded, employees will receive a time in position increase based on the number of years in their current position. This strategy addresses horizontal compression. Individuals who have been in their current position for less than a year are not eligible for time in position increase.

1-2 Years	3-4 Years	5-6 Years	7-10 Years	11-15 Years	16 - 20 Years	21+ Years
$1,040	$1,560	$2,080	$2,600	$3,120	$3,640	$4,160

	Projected Increase	Number Employees
Full-Time Employees	$432,640.00	234

Full-Time Costs	**Part-Time Costs**	**Total Annual Increase in Cost**
1,193,075.95	**104,601**	**$1,297,676.95**

HUMAN RESOURCES REPORT FOR THE BOARD OF DIRECTORS, **January 2023**:

Training

Human Resources held two New Employee Orientation's during **January.** A total of fourteen new employees were brought on, seven are full-time, two are part-time and five are part-time interns.

Recruitment

In the month of **January**, we made twenty offers to external applicants and nine offers to internal candidates.

Indeed continues to be our best source for applicants. We ran a total of 12 positions this month and received 921 resumes for the various positions.

Human Resources & Employee Relations

Congratulations to the following employee who have recently received promotions:

Patrick Hodge	Promotion to MH Residential Specialist – Crisis Stabilization

January Employee Events

No events were held in January. The Employee Engagement Committee met and planned events for the next few months employee picnics, holiday dinner, employee in-service, etc.

RACSB is proud to have such a dedicated, professional staff!

Michelle Runyon, HR Director