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

NOTICE

To: Program Planning and 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 and Evaluation Committee Meeting
March 14, 2023, 10:30 AM
600 Jackson Street, Board Room 208, Fredericksburg VA

Date: March 09, 2023

A Program Planning and Evaluation Committee meeting has been scheduled for Tuesday, March 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 March 14th at 10:30 AM.

Cc: Nancy Beebe, Chairperson

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Program Planning and Evaluation Committee Meeting

March 14, 2023 – 10:30 AM

600 Jackson Street, Room 208 Fredericksburg, VA 22401

Agenda

I. Extraordinary Barriers List, *Kobuchi* ……………………………………………………3
II. Independent Assessment Certification and Coordination Team Update, *Kobuchi*……….4
III. Crisis Intervention Team Assessment Center Report, *Kobuchi* …………………………6
IV. Emergency Custody Order/Temporary Detention Order, *Kobuchi* ………………………8
V. ICF Life Safety Code Lucas/Ross, *Jindra*…………………………………………………12
VI. December Waitlist, *Terrell* ………………………………………………………...17
VII. Licensing Reports, *Terrell* ………………………………………………………………21
VIII. Information Technology/Electronic Health Record Update, *Williams* …………………32
IX. Data Dashboard Report, *Williams*………………………………………………………34
X. Mid-Year CARF Executive Summary, *Williams* ………………………………………39
XI. Substance Abuse and Mental Health Services Administration FY 2023 Grants for the Benefit of Homeless Individuals, *Williams* ……………………………………………..43
XII. Senate Congressionally Directed Spending Application, *Williams* ……………………44
XIII. Other Business, *Beebe*

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: March 14, 2023

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

Central State Hospital

Individual #1: Was placed on the EBL 2/24/23. Barriers to discharge include working through the Not Guilty by Reason of Insanity (NGRI) process. This individual has struggled with both mental health and substance use concerns. At time of discharge from the hospital, they will transition to an inpatient substance use program in Winchester, VA and then after successful completion, they will transition to sober living at an Oxford House. This individual's Conditional Release Plan (CRP) has been developed and has been approved by the Forensic Review Panel (FRP). RACSB has been coordinating with Northwestern Community Services Board (NWCSB) in development of the CRP as well to coordinate follow up care. Their court date is scheduled for 3/17/2023. Once the individual's CRP is approved by the court, an admission date will be scheduled for the inpatient substance use program and they will discharge to the community. This individual may require a small amount of 1x Discharge Assistance Program (DAP) funding at time of discharge.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director

From: Donna Andrus, Child and Adolescent Support Services Supervisor

Date: March 7, 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 sixteen IACCT referrals and completed sixteen assessments in the month of February. Eleven referrals were initial IACCT assessments and five were re-authorizations. Eight were from Spotsylvania, four from Stafford, two from Caroline, two from King George and none from the City of Fredericksburg. Of the sixteen completed assessments in February, fourteen recommended Level C Residential and one recommended Level Group Home. One assessment has been completed but no recommendation submitted due to no physician to engage which is a required component. No reauthorizations recommended discharge at this time.

Attached is the monthly IACCT tracking data for February 2023.

Report Month/Year	Feb-23
1. Total number of Referrals from Magellan for IACCT:	16
1.a. total number of auth referrals:	11
1.b. total num. of re-auth referrals:	5
2. Total number of Referrals per county:	
Fredericksburg:	0
Spotsylvania:	8
Stafford:	4
Caroline:	2
King George:	2
Other:	0
3. Total number of extensions granted:	7
4. Total number of appointments that could not be offered within the prescribed time frames:	0
5. Total number of "no-shows":	0
6. Total number of cancellations:	0
7. Total number of assessments completed:	16
8a. Total number of ICA's recommending: **residential:**	14
8b. Total number of ICA's recommending: **therapeutic group home:**	1
8c. Total number of ICA's recommending: **community based services:**	0
8g.Total number of ICA's recommending: **Other:**	0
8h.Total number of ICA's recommending: **no MH Service:**	0
9. Total number of reauthorization ICA's recommending: **requested service not continue:**	0
10. Total number of notifications that a family had difficulty accessing **any** IACCT-recommended service/s:	0

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director

From: Tabitha Taylor, Emergency Services Law enforcement liaison

Date: March 7, 2023

Re: Crisis Assessment Center and CIT report February 2023

The CIT Assessment Center assessed 26 individuals in the month of February 2023. The number of persons served by locality were the following: Fredericksburg 7; Caroline 2; King George 1; Spotsylvania 7; Stafford 8; 1 other.

Please see attached CIT data sheet

February 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
2/1/2023	0	0	n.a	Spotsylvania/Stafford
2/2/2023	2	1	Stafford	Fredericksburg
2/3/2023	5	1	Fredericksburg	Spotsylvania
2/4/2023	3	0	n.a	Spotsylvania
2/5/2023	3	0	n/a	Spotsylvania
2/6/2023	4	0	n.a	Spotsylvania
2/7/2023	3	1	Fredericksburg	Spotsylvania
2/8/2023	6	3	Stafford;Spotsylvania(2)	Spotsylvania
2/9/2023	2	2	Stafford	Spotsylvania/Fredericksburg
2/10/2023	0	0	n.a	Spotsylvania
2/11/2023	4	2	Caroline; Spotsylvania	Spotsylvania
2/12/2023	3	2	Stafford;Colonial Beach	Spotsylvania/Stafford
2/13/2023	2	2	Frederickburg;Stafford	Spotsylvania
2/14/2023	4	1	Caroline	Spotsylvania
2/15/2023	1	1	Spotsylvania	Spotsylvania/King george
2/16/2023	0	0	n.a	Spotsylvania
2/17/2023	2	2	Fredericksburg; Spotsylvania	Spotsylvania/Stafford
2/18/2023	2	2	King George; Stafford	Spotsylvania
2/19/2023	1	1	Spotsylvania	Spotsylvania/Fredericksburg
2/20/2023	1	1	Fredericksburg	Spotsylvania/Stafford
2/21/2023	2	2	Fredericksburg	Spotsylvania/Fredericksburg
2/22/2023	2	0	n.a	Spotsylvania/Stafford
2/23/2023	8	1	Spotsylvania	Spotsylvania
2/24/2023	1	0	n.a	Spotsylvania
2/25/2023	1	0	n.a	Spotsylvania
2/26/2023	2	1	Stafford	King George
2/27/2023	1	0	n.a	Spotsylvania/Fredericksburg
2/28/2023	1	0	n.a	Spotsylvania
2/29/2023	0	0	n.a	Spotsylvania/King george
Total	66	26		

Total Assessments at Center in Feburary: 20

Brought by:		**Cumulative Total:**
Caroline	2	145
Fred City	7	1006
Spotsylvania	7	961
Stafford	8	1001
King George	1	125
Other	1	4

Cumulative number of Assessment since September 2016: 3242

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director

From: Kari Norris, Emergency Services Coordinator

Date: March 8, 2023

Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – February, 2023

In February 2023, Emergency Services staff completed 340 emergency evaluations. Sixty-five emergency custody orders were assessed and sixty-five total temporary detention orders served of the 340 evaluations. Staff facilitated six admissions to a state hospital. Three adult admissions went to Western state (2) and NVMHI. One admission was a child admitted to CCCA. Two admissions went to Piedmont Geriatric hospital.

A total of fifteen individuals were involuntarily hospitalized outside of our catchment area in February. Three individuals were able to utilize alternative transportation.

Please see attached data reports.

DATE: 3.8.2023

Emergency Services Activity Reports

Month	Contacts	Evaluations	ECOs	TDOs Issued	TDOs Executed
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
February 2023		340	65	67	67

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

CSB/BHA	Rappahannock Area Community Services Board	Month	February 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	
340	27	38	65	65	12	4	49	65	2

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

CSB/BHA	Rappahannock Area Community Services	Reporting month	February 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)	
2/6/23	104555			Yes	No	NVMHI
2/7/23	76911	Child		Yes	No	CCCA
2/8/23	103061			Yes	No	Western State
2/12/23	109208			Yes	No	Western State
2/23/23	65972	Older Adult with Medical Acuity		Yes	No	Piedmont
2/26/23	105131	Older Adult with Medical Acuity		Yes	No	Piedmont

ALTERNATIVE TRANSPORT DATA February 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
2/3/23	107219	Stafford	MWH-ED	North Springs	198	yes	M	10	Danger to self	No	Elopement risk
2/6/23	104555	Stafford	MWH-ED	NVMHI	100	yes	M	31	Danger to self, others and inability to care	No	Aggressive and erratic
2/7/23	76911	Fredericksburg	MWH-ED	CCCA	240	yes	M	6	Danger to self	No	Too erratic/impulsive
2/8/23	103061	Stafford	MWH-ED	Western State	244	yes	F	31	Inability to care	No	Elopement risk
2/11/23	60950	Caroline	MWH-ED	Dominion	120	yes	F	16	Danger to self	No	Elopement risk
2/12/23	109208	Westmoreland	MWH-ED	Western State	244	yes	M	33	Inability to care	No	
2/16/23	105121	Stafford	Stafford-ED	Poplar Springs	184	yes	F	12	Danger to self	No	Elopement risk
2/18/23	107559	Spotsylvania	Lee's Hill	Lewis Gale	374	no	M	15	Danger to self	Yes	AT Utilized
2/21/23	24325	Fred PD	MWH-ED	Poplar Springs	160	yes	F	34	Danger to self and	No	Too erratic/impulsive
2/23/22	82755	Stafford	MWH-ED	Poplar Springs	160	yes	F	25	Inability to care	No	Too erratic/impulsive
2/23/23	65972	Spotsylvania	MWH-ED	Piedmont	224	yes	F	68	Inability to care	No	Prior refusal to go AT
2/26/23	109362	Stafford	Stafford-ED	Pavilion at Williamsburg	202	yes	F	19	Danger to self	Yes	AT Utilized
2/26/23	78035	Stafford	MWH-ED	Pavilion at Williamsburg	180	no	F	44	Inability to care	No	Client presents too acute with psychosis that she is in labor
2/26/23	105131	Stafford	MWH-ED	Piedmont	224	yes	F	66	Danger to others; Inability to care	No	Assaulted staff and LE
2/27/23	78179	Stafforrd	MWH-ED	North spring	198	yes	F	11	Danger to self	Yes	AT Utilized

Total Out of Area

15

Total Utili:	% Utilized	Total Appropriate for AT	
3	20%	3	20%

Memorandum

To: Joe Wickens, Executive Director

From: Amy Jindra, CSS Director

Date: March 6, 2023

Re: Annual Live Safety Code Survey

On January 31, 2023, Ross and Lucas Intermediate Care Facilities underwent an unannounced recertification Life Safety Code survey. The Life Safety Code Survey evaluates the programs to assure compliance with Centers for Medicare and Medicaid Services (CMS) requirements relating to long term care. Based on the survey conducted by Inspector Thomas Payne, both Ross and Lucas met compliance standards for participation in Medicaid and Medicare. The cover letters and survey findings are attached.

1/31/23

Mr. Stephen Curtis,
Lucus St ICF
5701 Lucus St
Fredericksburg, VA

Ref; Lucus St ICF

Provider # 49G064

Dear Mr. Curtis,

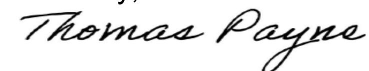
scurtis@reppahannockareacsb.org

This concerns the unannounced recertification Life Safety Code survey of the referenced facility conducted on 1/31/23 in accordance with 42 Code of Federal Regulation, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The facility was surveyed for compliance using the Life Safety Code 2012 Existing regulations and no deficicines were found.

All institutional buildings must meet all applicable Life Safety Code (NFPA 101) requirements in accordance with the federal Long Term Care certification requirements issued by the Centers for Medicare and Medicaid Services (CMS), in order to participate in the Medicare/Medicaid programs. The findings listed on the attached form, CMS 2567, "Statement of Deficiencies and Plan of Correction" demonstrate compliance with Title 42 Code Federal of Regulations, 483.90(a) et seq Life Safety from Fire.

If you have any questions or if I may be of assistance to you, please contact me at Thomas.payne@vdh.virginia.gov or at 434- 981- 2731.

Sincerely,



Thomas Payne
LSC Medical Facilities Inspector

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G064	A. BUILDING **01 - LUCAS STREET** B. WING ____________	**01/31/2023**

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
K 000	INITIAL COMMENTS The facility is one story on a basement of Type V construction and is fully sprinklered. An unannounced life safety code recertification survey was conducted on 1/31/23 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facility for Persons with Mental Retardation. The facility was surveyed for compliance using the LSC 2012 Existing Regulations. The facility was in compliance with the requirements for participation for Medicare and Medicaid.	K 000		

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

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.

1/31/23

Mr. Stephen Curtis,
Ross Drive ICF
5604 Ross Drive
Fredericksburg, VA

Ref; Ross Drive ICF

Provider # 49G065

Dear Mr. Curtis,

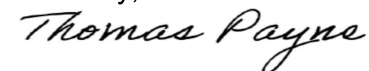
scurtis@reppahannockareacsb.org

This concerns the unannounced recertification Life Safety Code survey of the referenced facility conducted on 1/31/23 in accordance with 42 Code of Federal Regulation, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The facility was surveyed for compliance using the Life Safety Code 2012 Existing regulations and no deficicines were found.

All institutional buildings must meet all applicable Life Safety Code (NFPA 101) requirements in accordance with the federal Long Term Care certification requirements issued by the Centers for Medicare and Medicaid Services (CMS), in order to participate in the Medicare/Medicaid programs. The findings listed on the attached form, CMS 2567, "Statement of Deficiencies and Plan of Correction" demonstrate compliance with Title 42 Code Federal of Regulations, 483.90(a) et seq Life Safety from Fire.

If you have any questions or if I may be of assistance to you, please contact me at Thomas.payne@vdh.virginia.gov or at 434- 981- 2731.

Sincerely,



Thomas Payne
LSC Medical Facilities Inspector

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G065	A. BUILDING **01 - ROSS DRIVE** B. WING ______	**01/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS DRIVE	**5604 ROSS DRIVE** **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
K 000	INITIAL COMMENTS The facility is one story of Type V construction and is fully sprinklered. Fire alarm and generator. An unannounced life safety code recertification survey was conducted on 1/31/23 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facility for Persons with Mental Retardation. The facility was surveyed for compliance using the LSC 2012 Existing Regulations. The facility was in compliance with the requirements for participation for Medicare and Medicaid.	K 000		

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

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.

MEMORANDUM

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

Identified below you will find the number of individuals who were on a waiting list as of February 28, 2023.

<u>OUTPATIENT SERVICES</u>

- o Clinical services: As of February 28, 2023, there are 275 individuals on the wait list for outpatient therapy services.
    - o 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.
        - o 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 120 clients.
            - ▪ The waitlist in Spotsylvania is currently at 70 clients.
            - ▪ The waitlist in Caroline is currently at 85 clients.
            - ▪ This is an increased of 6 from the January 2023 waitlist.

        - o 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.

    - o 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

- o Psychiatry intake: As of February 7, 2023, there are three older adolescents and adults waiting longer than 30 days for their intake appointment. This is a decrease of eight from the January 2023 waitlist. The furthest out appointment is 5/3/2023. There is one child age 13 and below waiting longer than 30 days for their intake appointment. This is an increase of one from the January 2023 wait list.

PSYCHIATRY INTAKE – As of March 7, 2023 the number of individuals waiting longer than 30 days for a regularly scheduled psychiatric intake appointment include:

	Adults	Children: Age 13 and below
Fredericksburg –	3 (7)	0 (0)
Caroline –	0 (1)	0 (0)
King George –	0 (0)	1 (0)
Spotsylvania –	0 (0)	0 (0)
Stafford –	0 (3)	0 (0)
Total	**3 (11)**	**1 (0)**

	Appointment Dates
Fredericksburg Clinic	
	4/19/23 4/26/23 5/3/23
Caroline Clinic	
	N/A
King George	
	4/13/23
Spotsylvania Clinic	
	N/A
Stafford Clinic	
	N/A

Community Support services:

Waitlist Definitions

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

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

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

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

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

MH RESIDENTIAL SERVICES - 4

Needs List: 0
Referral List: 3
Acceptance List: 1

Count by County:

Caroline	1
King George	0
Fredericksburg	1
Spotsylvania	0
Stafford	2

- 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 will be available the third week of March.

Intellectual Disability Residential Services – 97

Needs List: 92
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)– 19

Caroline: 1
Fredericksburg: 8
King George: 0
Spotsylvania: 4
Stafford: 6

Total Needs: 8
Total Referrals: 11
Total Acceptances: 0

Total program enrollments = 50

Admissions: 2
Discharges: 2

- During the month of February, an ACT South client asked to be discharged after receiving services since June 2021. This client had not had any psychiatric hospitalizations. He did not want to continue to receive ACT services because he felt he did not need the intensity of the program. This client will continue to receive services including case management from the agency Permanent Supportive Housing program. He did not want to receive continued medication and case management from our main clinic. This client is aware he can request ACT services in the future. ACT South enrolled a client on NGRI status who transitioned out of an agency residential program this month. The program coordinator and South Team Lead, met with a potential client who is currently hospitalized at Northern Virginia Mental Health Institute. She met program criteria and wants to be enrolled in ACT services upon hospital discharge.

ID/DD Support Coordination

There are 806 individuals on the waiting list for a DD waiver. This is an increase of 10 from last month

P-1 340
P-2 181
P-3 285

MEMORANDUM

To: Joe Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance and Human Rights

Date: March 8, 2023

Re: Licensing Reports

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

Rappahannock Area Community Services Board (RACSB) obtained approval for three Corrective Action Plans (CAP) during the month of February 2023.

Lafayette Boarding House received a report due to the late reporting of an incident.

Rappahannock Adult Activities Inc (RAAI), Spotsylvania location, received a report due to an incident which occurred involving a day support participant and Leeland Road Group Home received a report due to an incident which occurred involving a resident of Leeland.

The attached CAPs provide additional details regarding the citation and RACSB's response.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-03-001**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **01-23-2023**
Program Type/Facility Name: **03-001 MH Support Services**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-160. D. (2) - The provider shall collect, maintain, and report or make available to the department the following information: 2. Level II and Level III serious incidents shall be reported using the department's web-based reporting application and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Reported information shall include the information specified by the department as required in its web-based reporting application, but at least the following: the date, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's iniuries or	NS	MH Support Services This regulation was NOT MET (SYSTEMIC) as evidenced by: CHRIS Number: 20230006 Date/Time of Discover: 01/04/2023 11:45AM Enter Date/Time: 01/05/2023 5:11PM Reporting Delay: 5:26:00 Location Name: MH Support Services Note: As this is provider's second step in the Progressive Citation Cycle for the same regulation within a one-year period, measured on a rolling basis, provider has demonstrated systemic noncompliance. Provider was previously cited for late reporting • The first citation was issued on 10/20/22 and is now a non-compliant.	PR) 02/13/2023 The assistant manager of the program reported that although she was aware that an incident report needed to be completed on January 4, which was the day that the incident occurred, she forgot to complete the IR because she was tending to other duties of the program. The program manager spoke with the assistant manager on the morning on January 5, once it was discovered that an IR had not yet been completed. At that time the assistant manager reported that she forgot to complete the IR on the previous day, but would complete one at that time. The assistant manager reported that she knows the policy and has completed IR's in a timely manner for other incidents, but forgot to complete one for this incident. The assistant manager responsible for failing to complete the incident report within the required timeframe, will be issued a standard of conduct violation that will become a part of the employee file. MH Residential staff, including the assistant manager responsible for failing to complete the incident report within the required timeframe, will attend a refresher training on all documentation protocols to ensure all future incidents are reported within the required timeframe. MH Residential Coordinator will review the Incident Report Protocol with managers and MH Residential Specialists during staff meetings, at least annually. MH Residential managers will review the Incident Report Protocol with program staff upon hire, and at least annually during staff meetings.	2/26/2023

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-03-001**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **01-23-2023**
Program Type/Facility Name: **03-001 MH Support Services**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
circumstances of the death and any treatmen t received. For all other Level II and Level III serious incidents, the reported information shall also include the consequences that resulted from the serious incident. Deaths that occur in a hospital as a result of illness or injury occurring when the individual was in a licensed service shall be reported.			OLR) Accepted 02/27/2023	

General Comments / Recommendations:

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

Lakesha Steele, Incident Management Unit

(Signature of Organization Representative)

Date

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

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

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

Date of Inspection: **02-08-2023**
Program Type/Facility Name: **02-006 Spotsylvania Clinic**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-150. (4) - The provider including its employees, contractors, students, and volunteers shall comply with: 4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board;	N	Spotsylvania Clinic This regulation was NOT MET as evidenced by: See OHR citation below.		

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

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

Date of Inspection: **02-08-2023**
Program Type/Facility Name: **02-006 Spotsylvania Clinic**

Standard(s) Cited	**Comp**	**Description of Noncompliance**	**Actions to be Taken**	**Planned Comp. Date**
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation.	N	Spotsylvania Clinic This regulation was NOT MET as evidenced by: CHRIS #20230004/Incident date:1.13.2023 "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. • Provider substantiated neglect due to the following: ◦ During provider investigation, it was revealed that Employee #1 left a door open, and left Individual #1 unsupervised, which resulted in a fall. ◦ Minor bruising occurred as a result of the fall. ◦ Failure to provide services necessary to the safety and welfare of the individual meets the regulatory definition of neglect.	PR) 02/28/2023 During provider investigation, it was revealed that Employee #1 left a door open, and left Individual #1 unsupervised, which resulted in a fall. On 2/22/23, protocol was developed for pick up and drop off times to ensure safe transition for individuals in and out of programming. Corrective action in accordance to RACSB policy will be provided to employee #1 when she returns from medical leave. On 3/3/23 a team meeting will be held with all staff to provide training on ISPs, and pick up and drop off protocol. Updates to individual #1's plan for supports will be made and reviewed with all staff on 3/3/23. Systematically, all employees will be trained on pick up and drop off protocols to ensure safe transition from programming to vehicles picking them up by 4/1/23. OHR/OLR) Accepted 03/01/2023	4/1/2023

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

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

Date of Inspection: **02-08-2023**
Program Type/Facility Name: **02-006 Spotsylvania Clinic**

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

General Comments / Recommendations:

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

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

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

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-001**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **02-10-2023**
Program Type/Facility Name: **01-001 Leeland Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-150. (4) - The provider including its employees, contractors, students, and volunteers shall comply with: 4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board;	N	Leeland Road Group Home This regulation was NOT MET as evidenced by: See OHR citation below.		
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation.	N	Leeland Road Group Home This regulation was NOT MET as evidenced by: CHRIS#20220049/Incident date: 12.21.2022 "Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. Provider substantiated abuse due to the following: • Per the provider's investigation, verbal abuse is substantiated due to Employee #1 and Employee #2 confirming hearing Employee #3 tell Individual #1: "Do you need me to take you to the bathroom and fuck you up?"	PR) 03/03/2023 PR: Upon substantiation of the abuse allegation following the investigation procedures, the staff member responsible for the incident was separated from employment by the agency effective 2/13/23. Systematically, Human Resources will continue to conduct mandated background checks and ensure at onboarding that no barrier crimes are present in the past of any potential employee. All Leeland Group Home Staff underwent re-trainings concerning the RACSB Code of Ethics and mandated reporting requirements on 2/19/2023. All RACSB staff, volunteers, and contractors will be required to undergo an annual Human Rights training to help ensure continued promotion and support of	2/19/2023

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-001**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **02-10-2023**
Program Type/Facility Name: **01-001 Leeland Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		• Additional personnel described Employee #3 using "harsh" language toward Individual #1.	individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency orientation. The program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor incident reports and any allegations or reports of human rights violations on a daily basis to help ensure systematically that incidents of this nature are identified and mitigated quickly. Any staff member suspected or alleged to violate the Code of Virginia and any related human rights regulations adopted by the state board will immediately be put on administrative leave pending the outcome of an investigation. OHR/OLR) Accepted 03/06/2023	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-001**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **02-10-2023**
Program Type/Facility Name: **01-001 Leeland Road Group Home**

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

General Comments / Recommendations:

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

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

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

RACSB Board Report
Compliance

Incident Reports

- There were 187 Incident Reports entered into the Electronic Incident Report Tracker during the month of February. This is a decrease of 12 from January 2023, and an decrease of 9 from December 2022. All incident reports submitted were triaged by QA staff. The top two categories of reports submitted were and Health Concerns (65 reports) and Individual Served Injury (36 reports).
- Quality Assurance Staff entered 31 incident reports into the Department of Behavioral Health and Developmental Services Electronic Incident reporting system. (10 Level 1, 21 Level 2, 10 Level 3); a decrease of 2 from January. There were three positive COVID cases reported, and four COVID testing reports. Positive cases were reported regarding individuals receiving DD or MH Residential Services.
- There were no reports elevated to care concern by DBHDS. 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 completion 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-three root cause analyses were requested and 13 were completed. No expanded root cause analyses were required or received in February.

Human Rights Investigations

QA staff initiated five and closed four investigations during the month of February. Three investigations initiated regarded an allegation of neglect; one towards the members of a DD residential program, one towards an outpatient client, and one towards a client receiving day support services. All three of these neglect allegations were unfounded. One investigation was regarding physical abuse (unfounded) which occurred in a DD Residential program. One investigation regarded an allegation of seclusion/restraint; this is an ongoing investigation in a DD Residential program.

External Reviewers

- QA staff provided requested follow-up information to Brian Dempsey, Senior Licensing Specialist with the Department of Behavioral Health and Developmental Services (DBHDS), on 10 incident reports submitted into CHRIS.
- QA staff received four external chart review requests and responded to four external chart reviews for 23 clients by submitting requested documentation.

- QA staff received and responded to 14 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 4 phone calls and multiple emails from various programs with questions about incident reports, human rights, complaints, and root cause analysis (RCA) process.

Complaint call synopsis:

The QA team received two complaint calls in the month of February. One call concerned dissatisfaction with services, stating that he needed to go to the hospital; due to his expressed need for inpatient care, this was triaged to ES and the client denied care. One complaint call concerned services at Mary Washington Hospital. After explaining that we had no purview over his concern, we offered community connection resources and asked if his RACSB services were satisfactory; he stated that they were.

Trainings/Meetings

- 2/7 – QMR Exit meeting
- 2/7 – NEO
- 2/8 – NEO
- 2/9 – Q-Tips: Supervision
- 2/10 – Investigation Interview (2)
- 2/14 – THEROPS (Kat)
- 2/15 – Compliance Committee Meeting
- 2/16 – Documentation training
- 2/21 – Investigation Interview (3)
- 2/22 – NEO
- 2/23 – NEO
- 2/23 – Q-Tips: Incident Reporting
- 2/24 – THEROPS (Kat)
- 2/28 – OHR site visit
- Investigation Interview (1)
- 2/29 – Investigation Interviews (3)

Other Activities

To: Joe Wickens, Executive Director

From: Suzanne Poe, IT Coordinator

Re: Information Technology and Electronic Health Record Update

Date: March 6, 2023

This report provides an update on projects related to Information Technology and the Electronic Health Record. The IT department completed 1050 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 February 2023, 1050 tickets where closed by IT Staff.
Ticket completion numbers by month for calendar year 2023: January - 983
The Average number of TrackIt tickets closed in 2022 was 1,023 per month.

Permanent Supportive Housing's move-in date to the Bowman Center has been extended. The internet and phone services have been installed. Once furniture is installed, IT will complete final install of equipment, such as placing phones on desks and installing printers.

Community Consumer Submission 3

The January 2023 CCS was submitted on February 24, 2023.

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. Avatar did not communicate with the new protocol initially and IT manually entered service plans through February 27th, until Netsmart was able to fix the communication to/from WaMS.

Trac-IT Early Intervention Data System

DBHDS Part C office has announced the Trac-It full implementation date as December 11, 2023. State Part C staff are currently developing an EHR extract implementation workgroup and has asked VACSB Data Management Committee Chairs for recommendations on CSB representation. RACSB worked used support provided by Netsmart's One Team to develop extract to test. We look forward to testing this extract in order to determine the feasibility of the upload process for implementation within our Early Intervention process. At this time, we will only be able to meet the new requirements of an additional 280+ required elements if the extract process is successful.

Zoom

We continue to utilize Zoom for telehealth throughout the agency.

- February 2023 – 2,475 video meetings with a total of 6,731 participants
- January 2023 – 2,402 video meetings with a total of 6,668 participants
- Average from January to December 2022 was 2,800 video meetings and 8,154 Participants
- Average from January to December 2021 was 3,648 video meetings and 11,087 Participants

Avatar

The ACT and PEID are using Bells and identifying issues as they arise. Updates are now available in Avatar so that Bells can do group notes as well as individual notes. Once the new Bells updates are installed in our Avatar system, IT will start working with our Substance Use teams to try and incorporate the Bells group note functionality into their workflow.

Staffing

The IT department will have 2 vacant positions. Robert Rezendes, the current Data Analyst, is staying within RACSB but moving back to Quality Assurance. The date of his transfer is April 3rd 2023. Logan Taylor, IT specialist, left on February 24th.

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Data Highlights Report for Program Planning and Evaluation

Date: March 8, 2023

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

Department of Behavioral Health and Developmental Services Performance Dashboard

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

Behavioral Health Measures

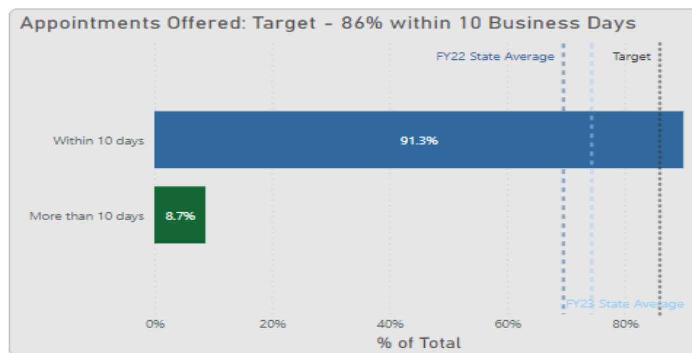
Same Day Access

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

Current Month's Performance- Oct 2022 (91.3%)

Measure 1: Appointments Offered
Target - 86% within 10 Business Days
State Average

76.5%
Goal: 86 %
Within 10 days



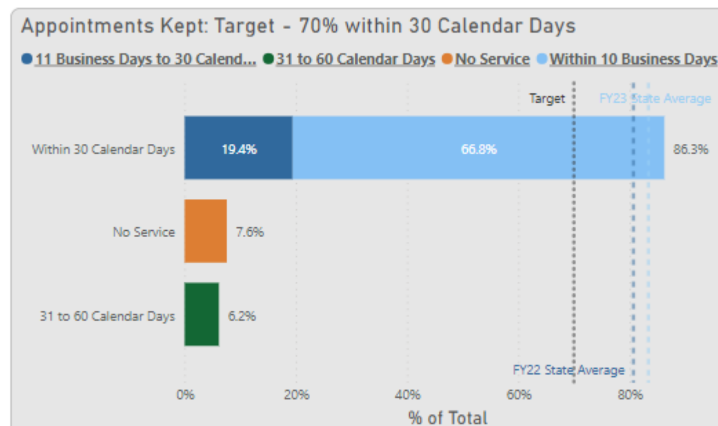
Number of CSBs that met 86% target in most current month: 17 of 40

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- Sept 2022 (86.3%)

Measure 2: Appointments Kept
Target - 70% within 30 Calendar Days
State Average

85.0%
Goal: 70 %
Within 30 Days



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-Oct 2022 (72.9%)

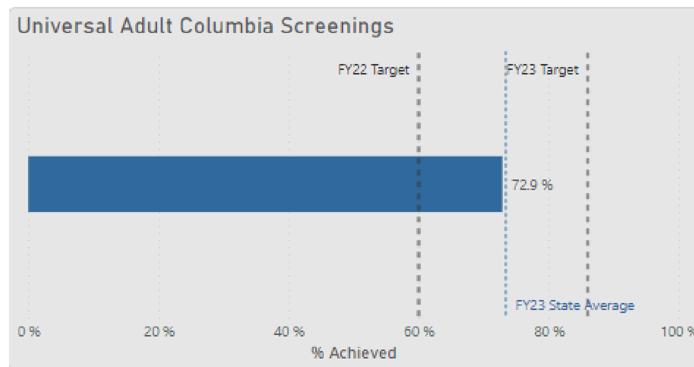
Measure 2: Adults 18 and Over

FY22 Target: 60%; FY23 Target: 86%

State Average

75.5 %

Goal: 86 %



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- Oct 2022 (69.2%)

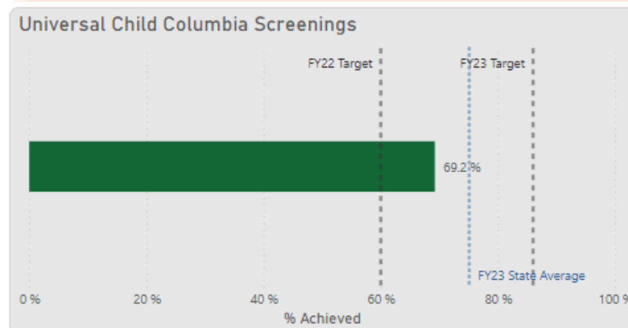
Measure 1: Children 6 to 17

FY22 Target: 60%; FY23 Target: 86%

State Average

79.1 %

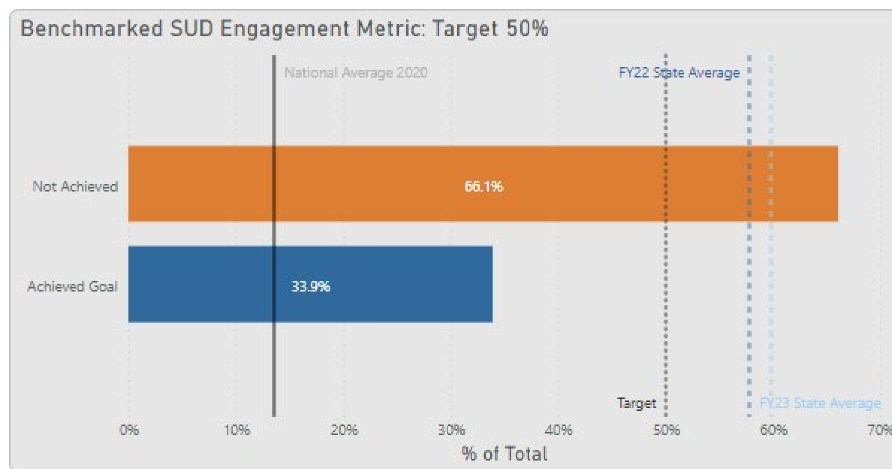
Goal: 86 %



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- Nov 2022 (33.9%)



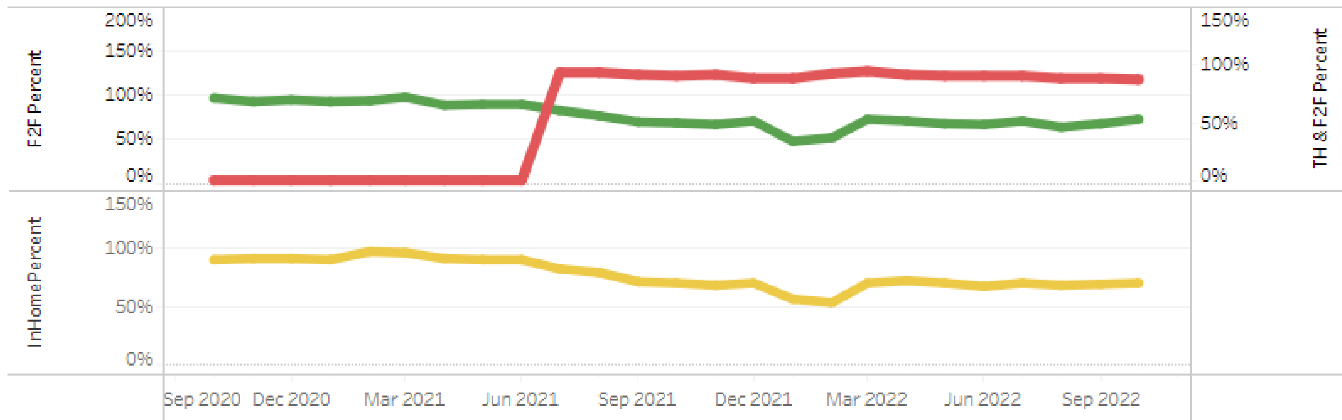
Developmental Disability Measures

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%.***

Current Month's Performance- Oct 2022



To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Mid-Year Community Support Services CARF Executive Summary

Date: March 7, 2023

Each year, the Rappahannock Area Community Services Board (RACSB) conducts an annual performance analysis of programs accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The attached executive summary provides highlights of the mid-year progress for CARF accredited programs within the Community Support Services Division.

FY2023 CARF Program Evaluation Goals

Program	Effectiveness: The program is effective when…(Effective – adequate to accomplish a purpose; producing the intended or expected result)	Mid-Year	Key Points
Crisis Stabilization	Temporary Detention Order inpatient psychiatric hospitalization decreases significantly for individuals completing Crisis Stabilization services. At least 80% of individuals who had a TDO in the 12 months preceeding admission to SLH will not have a TDO in the 30 days following discharge from SLH.	Of the one hundred and thirty-six (136) individuals served through December 2022, eleven (11) had been TDOd in the year prior to receiving CS services. Of those eleven (11), two (2) were TDOd within 30 days after receiving CS services. (82%)	Performance on this metric has improved since last year. Individuals who frequently access SLH have been less frequent as they have been more connected with supports such as Permanent Supportive Housing.
Crisis Stabilization	The use of outpatient services increases significantly post-crisis stabilization. At least 90 % of individuals who received no outpatient services prior to admission will have at least one outpatient service post discharge from SLH.	Of the one hundred and thirty-six (136) individuals served through December 2022, fifty-two (52) had not received outpatient services within the year prior to entering CS. Of those fifty-two, forty-six (46) engaged in outpatient services with RACSB after discharge. (88%)	Performance on this metric has improved since last year do to increased access to outpatient services, particularly in-person access.
Crisis Stabilization	Guest usage of Emergency Services and inpatient facilities decreases in the 30 day transition period post-discharge from SLH. No more than 10% of individuals will use Emergency Services or inpatient facilities in the 30 day transition period post-discharge.	Of the one hundred and thirty-six (136) individuals served through December 2022, nine (9) utilized Emergency services within 30-days post discharge, with two (2) requiring hospitalization. (6%)	This metric has been met for the first part of the fiscal year.
Psychosocial Rehabilitation	At least 75% of members will participate in wellness activies and receive supports/services in these areas (fitness, nutrition, smoking cessation, etc.)	100% of individuals participated in community activities and received supports/services in the area of community engagement.	RACSB provided YMCA memberships have supported consistent access to a community activity for members. Kemore Club facilitates visits to the YMCA three times a week. They also include library, grocery store, and lunch outings each week.
MH Residential Services	MH Residential residents receive the appropriate level of support based on individual needs. Transition at least 10 individuals from to higher or lower levels of care as appropriate within MH residential programs in order to keep them out of the hospitals, homelessness, or less integrated settings.	2/23-6 total (2 transition w/in residential, 2 graduated, 2 d/c to community). 3 more expected in Feb/March 2023.	This metric is on track to be met by the end of the fiscal year. Funding remains a primary barrier due to high rent/housing costs which individuals cannot afford on their income of an average of $915 a month.

Program	**Efficiency: The program is efficient when…(Efficiency-able to accomplish something with the least waste of time and effort)**	**Mid-Year**	**Key Points**
Crisis Stabilization	Exceed the state benchmark of 75% for bed usage.	YTD bed utilization is 58% through December 2022.	Bed utilization has been heavily impacted by staffing services. Due to staffing levels, bed availability was reduced to 6 beds in September. Lack of sufficient staff, specifically nursing, has led to the temporary closure of SLH at this time.
Psychosocial Rehabilitation	Expenses and revenue will be within program budget with a positive variance by the end of the year.	As of December 2022, Kenmore Club has a positive variance of $72,136.41.	Although Kenmore Club has maintained a positive variance so far this fiscal year, this is credited to the Public Health Emergency flexibility to provide one unit of service each day via phone call. The PHE will end on May 11th so that billing option will no longer be available. Kenmore Club staff are planning ways to increase daily membership in order to balance the loss in revenue when the flexibility ends.
MH Residential Services	The occupancy rate at each residential facility is 96% or higher.	2/23-100% occupancy not including transitional beds, with plan to be 100% full by end Dec; 89% occupancy including transitional beds (3 vacant trans. Beds).	This goal has been met with the exception of the transitional beds. DBHDS provides revenue for these beds regardless of them being filled. Barriers to increasing occupancy rates for these beds include lack of referrals from State Hospitals which is a requirement to place an individual in these beds and high turnover rate when individuals are placed as many are out of our catchment area.
Program	**Access: Individuals have timely access to our program when…(Success of referral, waiting list, waiting for routine or emergency care**	Mid-Year	**Key Points**
Crisis Stabilization	Coordinate admission of twelve individuals from Western State Hospital on pass and/or as step-downs per year.	SLH received zero (0) referral for state hospital pass or step-down through December 2022.	SLH staff have tried to outreach to Western State staff but state hospitals are still limiting passes for individuals at this time.
Psychosocial Rehabilitation	Increase community outings by having at least 5 community outing offerings a week.	Kenmore Club staff have offered at least 5 community outing offerings per week each week since the beginning of the fiscal year.	This metric was established to ensure increased community options post-pandemic and ensure options for Club participation since transitioning from hybrid/virtual groups for service accessibility.

MH Residential Services	Individuals referred for services will be thoroughly assessed before accepted. Those who meet criteria for services will be assessed during 2 forty-eight overnight passes, within 15 days of receiving a referral. Acceptance will be decided within 24 hours after the last pass.	2/23—ongoing. This has occurred with each pass thus far in FY23.	Although this goal has been met, there has been some push back around passes from the state hospitals.
Program	**Customer Satisfaction: Customers are satisfied with our program when… (Given hope, treated with dignity and respect, overall feelings of satisfaction, satisfied with facilities, fee, service effectiveness and service efficiency**	**Mid-Year**	**Key Points**
Crisis Stabilization	Individual's experiences with Sunshine Lady House were positive. Ninety percent of individuals respond positively on a 5 point scale discharge survey for FY23.	100% of individuals discharging completed surveys with 94% responding positively.	This goal has been met so far this fiscal year.
Psychosocial Rehabilitation	80% of Individuals will indicate satisfaction with overall services on the annual Kenmore Club specific program survey administered in Spring 2023.	The Comprehensive Satisfaction Survey is planned for administration in March 2023. Kenmore Club has started implementing targeted group surveys to evaluate each group offering and have completed for 40% of the groups at this time.	Annual survey scheduled for March 2023.
MH Residential Services	At least 90 % of individuals surveyed indicate overall satisfaction with MH Residential services by answering strongly agree or agree.	2/23- Annual survey completed Dec. 22. 95% of participants are overall satisfied with MH Residential Services. Discharge surveys are also offered upon discharge.	MH Residential is exploring the use of Survey Monkey to facilitate future surveys for easier access to aggregate data.

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Substance Abuse and Mental Health Services Administration FY2023 Grants for the Benefit of Homeless Individuals

Date: March 8, 2023

The Rappahannock Area Community Services Board intends to apply for the SAMHSA Grants for the Benefit of Homeless Individuals (TI-23-005).

This project will develop a targeted team within the Rappahannock Area Community Services Board to provide intensive community-based outpatient treatment, recovery-oriented services, and harm reduction education to those living on the street, in shelters or precariously between the homes of friends and family. The team will include a peer recovery specialist, a Certified Substance Abuse Counselor (CSAC), substance use and engagement case managers, as well as primary care service providers. The goals are five-fold: (1) Establish a dedicated treatment team that increases wrap-around support available in the community to people experiencing both homelessness and substance abuse or co-occurring disorders.; (2) Reduce unnecessary exits from permanent housing and shelter among formerly homeless as a result of substance abuse or co-occurring disorders; (3) Increase the self-determination and stability of formerly homeless who experience substance abuse and co-occurring disorders; (4) Facilitate linkages to physical health care across community systems and reduce emergency room visits.; (5)Enhance the bidirectional communication of the Rappahannock Area Community Services Board and community partners utilizing a Rapid Cycle Quality Improvement process. The program will build upon a public-private partnership established with a local homeless service organization, Micah Ecumenical Ministries. Building upon this partnership will not only enhance services available to the street homeless, but also those living precariously in doubled-up, imminently at risk, situations or staying in one of three other shelters in the community. The Rappahannock Area Health District will partner to support linkages to primary care services and community-level data.

We will serve at least 100 individuals a year through the 5-year funding period. We are requesting $500,000 a year for this project. Approved funding will receive the requested amount annually for up to 5 years. We plan to submit the application by the due date of March 21, 2023.

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Rappahannock Area Community Services Board Comprehensive Behavioral Health Care Clinic and Crisis Receiving Center Project

Date: March 8, 2023

The Rappahannock Area Community Services Board has applied for the RACSB Comprehensive Behavioral Health Care and Crisis Receiving Center Construction Project for the FY2024 Congressionally Directed Spending Community Project Funding through the joint application process for Senator Kaine and Senator Warner. This clinic would serve over 20,000 of Virginia's most vulnerable individuals by providing mental health care across the continuum of care from crisis, on-going support, and through recovery.

Prior the COVID-19 pandemic, RACSB purchased land adjacent to our primary location with plans to build an updated, trauma informed facility. However, construction was placed on hold due to the pandemic. The mental health needs of Virginians have increased significantly during that time period. As we have grown our staff to accommodate increased need, we no longer have the physical space for our clinicians. The Congressionally Directed Spending would jump-start the construction of the mental health clinic and crisis receiving center which would remain sustainable by the services provided within. The project is timely as it aligns with the Governor's Right Help, Right Now and simultaneously providing access to services not currently available in our community by building the area's first crisis receiving center.

The application was submitted under the Labor, Health and Human Services, Education, and Related Agencies appropriations under the Department of Health and Human Services, Health Resources and Services Administration, Program Management account. This project request specifically meets the committee's eligibility under the Health Facilities Construction and Equipment criteria. Funding will be used to cover architectural, engineering, and construction costs related to building a new, trauma-sensitive, public behavioral health clinic and crisis receiving center. The center would serve as the physical space for the provision of mental health therapy, case management, psychiatry, primary medical care, care coordination, peer recovery support services, and on-site pharmacy services for individuals regardless of ability to pay. A large footprint of the clinic is the physical design and construction of a Crisis Receiving Center where coordinated community behavioral health crisis responses services would be provided 24 hours a day, 7 days a week, 365 days a year. The crisis center would be designed and constructed to include 24-hour access, crisis observation rooms, centrally located service provider hub, as well as a dedicated entrance for law enforcement which affords additional security and privacy for the individual in mental health crisis. The project requests funding only for allowable construction and capital equipment purposes and does not exceed the established $15 million funding limit.

At the time of this report, the project has received letters of support from over 20 elected officials, local boards of supervisors, law enforcement departments, and other key community partners.