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

NOTICE

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

From: Joseph Wickens
Executive Director

Subject: Program Planning and Evaluation Meeting
August 8, 2023, 10:30 AM
600 Jackson Street, Board Room 208, Fredericksburg, VA

Date: August 3, 2023

A Program Planning and Evaluation Committee Meeting has been scheduled for Tuesday, August 8, 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 all on August 8th at 10:30 AM.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Program Planning and Evaluation Committee Meeting

Aug 8, 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: August 8, 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 #2: Was placed on the EBL 4/28/23. Barriers to discharge include working through the Not Guilty by Reason of Insanity (NGRI) process. This individual has a primary diagnosis of Schizophrenia and a history of substance use. It has been identified that this individual requires a supervised residential setting in the community in order to maintain stability in their mental health as well as to maintain compliance with their Conditional Release. They have been accepted to Lafayette Boarding House. This individual was approved by the Court for Conditional Release at their hearing on 7/18/23. Once the court order is received by the hospital a discharge date will be set.

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: July 11, 2023

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

Western State Hospital

Individual #1: Was placed on the EBL 4/17/23. Barriers to discharge include being accepted to a supervised and transitional residential program. This individual has resided in the community, independently in the past and utilized Assertive Community Treatment (ACT) Services, however they struggled to maintain stability and participation in an independent setting. It has also been determined that they are not able to reside independently at this time. This individual recently completed an interview with and was accepted by Gateway Homes. This individual will discharge once a bed is available. They will not require any Discharge Assistance Program (DAP) Funding.

Central State Hospital

Individual #2: Was placed on the EBL 4/28/23. Barriers to discharge include working through the Not Guilty by Reason of Insanity (NGRI) process. This individual has a primary diagnosis of Schizophrenia and a history of substance use. It has been identified that this individual requires a supervised residential setting in the community in order to maintain stability in their mental health as well as to maintain compliance with their Conditional Release. They have been accepted to Lafayette Boarding House. During their hospitalization, two Temporary Custody Evaluations have been completed, resulting in one recommendation for continued hospitalization and one recommendation for Conditional Release. The Forensic Review Panel has also

recommended release. RACSB is in favor of continued hospitalization as this individual has minimal insight to their illness, struggles to take responsibility for lack of follow through with treatment in the past as well as lacks a good understanding of the commitment required to be successful on Conditional Release. They would benefit from continued hospitalization and participation in the graduated release process. Their next court date is 7/18/23. They will be discharged once approved by the court.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Donna Andrus, Child and Adolescent Support Services Supervisor
Date: July 28, 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 and completed nineteen IACCT referrals in the month of June. RACSB received 15 IACCT referrals in the month of July and completed ten assessments. Two assessments are still in process and three discharged home prior to the reassessment due date. Twelve referrals were initial IACCT assessments and seven were re-authorizations in June, eight were initial IACCT assessments and seven re-authorizations in the month of July. In June and July, seventeen were from Spotsylvania, five from Stafford, two from Caroline, six from King George and four from the City of Fredericksburg. Of the nineteen completed assessments in June, nine recommended Level C Residential, six recommended Level B Group Home, three recommended community based services and one reauthorization recommended discharge. Two initial IACCT assessments initially recommended community based services but were changed to group home placement due to no foster home availability. Of the ten completed assessments in July, five recommended Level C Residential and five recommended Level B Group Home. Two initial IACCTs are still in process.

Attached is the monthly IACCT tracking data for June 2023 and July 2023.

Report Month/Year	Jun-23
1. Total number of Referrals from Magellan for IACCT:	19
1.a. total number of auth referrals:	12
1.b. total num. of re-auth referrals:	7
2. Total number of Referrals per county:	
Fredericksburg:	3
Spotsylvania:	10
Stafford:	3
Caroline:	0
King George:	3
Other:	
3. Total number of extensions granted:	6
4. Total number of appointments that could not be offered within the prescribed time frames:	0
5. Total number of "no-shows":	1
6. Total number of cancellations:	0
7. Total number of assessments completed:	19
8a. Total number of ICA's recommending: **residential:**	9
8b. Total number of ICA's recommending: **therapeutic group home:**	6
8c. Total number of ICA's recommending: **community based services:**	4
8g.Total number of ICA's recommending: **Other:**	0
8h.Total number of ICA's recommending: **no MH Service:**	0
9. Total number of reauthorization ICA's recommending: **requested service not continue:**	1

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

Report Month/Year	Jul-23
1. Total number of Referrals from Magellan for IACCT:	15
1.a. total number of auth referrals:	8
1.b. total num. of re-auth referrals:	7
2. Total number of Referrals per county:	
Fredericksburg:	1
Spotsylvania:	7
Stafford:	2
Caroline:	2
King George:	3
Other:	0
3. Total number of extensions granted:	4
4. Total number of appointments that could not be offered within the prescribed time frames:	0
5. Total number of "no-shows":	0
6. Total number of cancellations:	0
7. Total number of assessments completed:	10
8a. Total number of ICA's recommending: **residential:**	5
8b. Total number of ICA's recommending: **therapeutic group home:**	5
8c. Total number of ICA's recommending: **community based services:**	0
8g.Total number of ICA's recommending: **Other:**	0
8h.Total number of ICA's recommending: **no MH Service:**	0
9. Total number of reauthorization ICA's recommending: **requested service not continue:**	0

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

To: Joe Wickens, Executive Director

From: Nathan Reese, IT Coordinator

Re: Information Technology and Electronic Health Record Update

Date: August 1, 2023

This report provides an update on projects related to Information Technology and the Electronic Health Record. Information is provided on state reporting initiatives, facility technology needs, and on-going projects.

Information Technology and Electronic Health Record Update

IT Systems Engineering Projects

During July, 965 tickets where closed by IT Staff compared to June- 1,028, May -1,006, April – 910, March – 1098, February – 1050, and January – 983. In 2022, the IT department averaged closure of 1,023 tickets per month.

21 of our firewalls were reaching end of life and needed to be replaced. In June, the devices were delivered and configured. Throughout July, IT staff went to all 21 locations replaced and tested connections to the network.

Community Consumer Submission 3

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

Waiver Management System (WaMS)

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

Trac-IT Early Intervention Data System

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

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

Zoom

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

- July 2023 – 1,584 video meetings with a total of 4.067 participants
- June 2023 – 1,847 video meetings with a total of 4,881 participants
- May 2023 – 1,935 video meetings with a total of 5,173 participants
- April 2023 – 2,410 video meetings with a total of 6,685 participants
- March 2023 – 2,821 video meetings with a total of 7,479 participants
- February 2023 – 2,475 video meetings with a total of 6,731 participants
- January 2023 – 2,402 video meetings with a total of 6,668 participants
- Average from January to December 2022 was 2,800 video meetings and 8,154 Participants
- Average from January to December 2021 was 3,648 video meetings and 11,087 Participants

Avatar

Bells implementation with RAAI continues. RAAI is now testing the note taking workflow with Supervisors and select Direct Support staff. The expected launch is late August.

NIAM go-live was July 31, 2023. NIAM allows staff the ability to login to Avatar with the same password as their email. NIAM also requires users to set up 2-factor authentication to increase security.

IT has begun the process to update our Patient Portal. Updating our patient portal allows RACSB to comply with federal regulations around information sharing with patients. The project kicked off on July 26th 2023 and is expected to take 10 to 12 weeks.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Kari Norris, Emergency Services Coordinator
Date: August 3, 2023
Re: Crisis Assessment Center and CIT report July 2023

The CIT Assessment Center assessed 24 individuals in the month of July 2023. The number of persons served by locality were the following: Fredericksburg 4; Caroline 1; King George 0; Spotsylvania 9; Stafford 10.

Please see attached CIT data sheet

July 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
7/1/2023	1	1	Fredericksburg	Spotstylvania
7/2/2023	2	0	n/a	Spotsylvania
7/3/2023	7	2	Caroline; Spotsylvania	Stafford; Spotsylvania
7/4/2023	3	0	n/a	Stafford
7/5/2023	1	1	Stafford	Spotsylvania
7/6/2023	2	1	Fredericksburg	Spotsylvania
7/7/2023	2	2	Spotsylvania (2)	Fredericksburg; Stafford; Spotsylvania
7/8/2023	1	0	n/a	Spotsylvania
7/9/2023	2	1	Fredericksburg	Sptosylvania
7/10/2023	3	1	Stafford	Sptosylvania
7/11/2023	3	1	Stafford	Spotsylvania
7/12/2023	1	1	Spotsylvania	Stafford
7/13/2023	4	2	Stafford; Spotsylvania	Stafford
7/14/2023	2	0	n/a	Sptosylvania
7/15/2023	0	0	n/a	Spotsylvania
7/16/2023	1	0	n/a	Spotsylvania
7/17/2023	3	1	Stafford	Fredericksburg; Stafford
7/18/2023	3	2	Spotsylvania; Stafford	Fredericksburg
7/19/2023	1	1	Spotsylvania	Spotsylvania
7/20/2023	2	1	Stafford	Spotsylvania; Stafford
7/21/2023	1	1	Spotsylvania	Stafford
7/22/2023	0	0	n/a	Spotsylvania
7/23/2023	0	0	n/a	Spotsylvania
7/24/2023	1	1	Stafford	Spotsylvania
7/25/2023	1	0	n/a	Spotsylvania
7/26/2023	1	1	Fredericksburg	Stafford
7/27/2023	3	1	Spotsylvania	Stafford; Spotsylvania
7/28/2023	3	2	Stafford (2)	Spotsylvania
7/29/2023	1	0	n/a	Spotsylvania
7/30/2023	0	0	n/a	Spotsylvania
7/31/2023	3	0	n/a	Stafford
Total	58	24		

Total Assessments at Center in July: 24

Brought by:		**Cumulative Total:**
Caroline	1	149
Fred City	4	1021
Spotsylvania	9	983
Stafford	10	1031
King George	0	127
Other	0	4

Cumulative number of Assessment since September 2016: 3315

MEMORANDUM

To: Joe Wickens, Executive Director
From: Kari Norris, Emergency Services Coordinator
Date: 8/2/2023
Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – July, 2023

In July 2023, Emergency Services staff completed 296 emergency evaluations. Sixty-nine emergency custody orders were assessed and sixty-six total temporary detention orders served of the 296 evaluations. Staff facilitated three admissions to a state hospital. One adult admission went to SVMHI. One adolescent admission went to CCCA. One geriatric admission went to Piedmont.

A total of 19 individuals were involuntarily hospitalized outside of our catchment area in July. No individuals were able to utilize alternative transport.

Please see attached data reports.

8/1/2023

Emergency Services

Month		Evaluations	ECOs	TDOs Issued	TDOs Executed
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
September 2022		341	66	76	76
October 2022		351	70	75	75
November 2022		359	69	73	73
December 2022		296	55	51	51
January 2023		389	81	86	86
February 2023		340	65	67	67
March 2023		406	83	93	93
April 2023		325	65	78	78
June 2023		275	57	65	65
July 2023		296	69	66	66

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

CSB/BHA	Rappahannock Area Community Services Board	Month	July 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	
296	29	40	69	66	23	4	39	66	1
			0					0	
			0					0	
			0					0	
			0					0	

CSB/BHA	Rappahannock Area Community Ser	Reporting month	Jul-23		No Exceptions this month →	

Date	Consumer Identifier	1) Special Population Designation (see definition)	1a) Describe "other" in your own words (see definition)	2) "Last Resort" admission (see definition)	3) No ECO, but "last resort" TDO to state hospital (see definition)	4) Additional Relevant Information or Discussion (see definition)
7/5/23	99373	Older adult		Yes	No	Piedmont
7/22/23	110975	Older adult		Yes	No	commitment order to SVMHI
7/28/23	109402	Adolescent		Yes	No	CCCA

ALTERNATIVE TRANSPORT DATA July 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
7/2/23	64331	Caroline	MWH ED	Poplar Springs	160	yes	F	34	Danger to self; Inability to care	No	Prior refusal of AT and elopement risk
7/2/23	110742	Fredericksburg	MWH ED	Poplar Springs	160	yes	F	44	Inability to care	No	
7/3/23	106395	Spotsylvania	MWH ED	North Springs	198	yes	M	8	Danger to others	No	Aggression
7/3/23	107219	Stafford	MWH ED	North Springs	198	yes	M	10	Danger to self; Inability to care	No	Elopement risk
7/3/23	110741	Fredericksburg/	MWH ED	Pavilion of Williamsburg	180	yes	M	37	Inability to care	No	Elopement risk
7/3/23	31387	Spotsylvania	MWH ED	Pavilion of Williamsburg	180	yes	F	67	Danger to others; Inability to care	No	Too delusional
7/4/23	53444	Fredericksburg	MWH ED	Bon Secours-RCH	124	no	M	60	Inability to care	No	Client too unpredictable
7/5/23	99373	Stafford	MWH ED	Piedmont	210	yes	M	70	Inability to care	No	Aggression
7/6/23	26087	Stafford	MWH ED	Clearview	644	yes	M	58	Inability to care	No	Elopement risk
7/7/23	95479	Spotsylvania	MWH ED	Dominion	120	no	M	33	Danger to self	No	
7/10/23	64914	King George	MWH ED	North Springs	198	yes	M	14	Danger to Self; Danger to others	No	Elopement risk
7/11/23	110843	Spotsylvania	MWH ED	Pavilion of Williamsburg	180	no	M	14	Danger to self; Inability to care	No	
7/14/23	107219	Stafford	MWH ED	North Springs	198	yes	M	10	Danger to self; Inability to care	No	Elopement risk
7/17/23	27724	Stafford	MWH ED	Dickenson-GreenOak	746	yes	F	74	Inability to care	No	
7/18/23	110360	Spotsylvania	MWH ED	Pavilion	180	no	F	25	Inability to care	No	Catatonic state
7/21/23	110974	Spotsylvania	MWH ED	Cumberland	160	yes	F	10	Danger to self	No	
7/22/23	110975	Petersburg	Stafford Hospital	SVMHI	404	no	M	35	Danger to others	No	Elopement risk
7/28/23	100066	Spotsylvania	MWH ED	North Springs	198	yes	M	13	Danger to others	No	Client too unpredictable
7/28/23	109042	Stafford	MWH ED	CCCA	240	yes	M	15	Danger to self and others	No	Aggressive and combative

Total Out of Area			
19			
Total Utilizing AT	% Utilized	Total Appropriate for AT	
0	0%	0	0%

Memorandum

To: Amy Jindra, CSS Director

From: Nancy Price, MH Residential Coordinator

Date: August 1, 2023

Re: Permanent Supportive Housing

Permanent Supportive Housing (PSH) is based on the philosophy that individuals with serious mental illness can live in their own housing with the same rights and responsibilities as anyone else, regardless of their support needs. It is based on overwhelming evidence that people experiencing homelessness and frequent hospitalizations can achieve stability in permanent housing, if provided with the appropriate level of services. RACSB is committed to following the basic principles and elements of the PSH model, specifically, providing housing to individuals without barriers or preconditions of entry.

In June 2019, RACSB was provided the opportunity to apply for grant funding through DBHDS for a PSH program. RACSB was awarded $630,805 to house 30 individuals in the community. The program started with a single case manager and housing specialist, and was supervised by the MH Residential Coordinator. PSH has grown to include a program manager, housing specialist, office manager, four case managers and a full-time peer specialist.
For FY24, DBHDS has awarded PSH $2,180,353 in funding to house 65 individuals. The program currently has 49 individuals housed, with another 19 individuals approved for PSH who are awaiting housing.

PSH has proven to be successful for many individuals we support. A 53-year-old male, diagnosed with Schizophrenia, Paranoid Type, was one of the first individuals we housed in February 2020. Prior to housing with PSH, he had lived outside for over six years. While homeless, he visited the hospital three to five times each week in order to get food, sleep in a bed and get out of the extreme weather. He is diagnosed with diabetes and chronic COPD. He also had multiple arrests for public intoxication. Since he has been housed with PSH, he has been managing his medications and attending his doctors' appointments. He has not had any arrests and has only had one hospitalization, in which he was in ICU for COVID. He has established close friendships with his neighbors and remains in the same apartment that he moved into in February 2020.

Another individual, a 38-year-old male diagnosed with bipolar disorder, was housed with PSH in May 2021. Prior to being housed through PSH, he lived in his car and in a tent in the woods for four years. He has had 15 suicide attempts, resulting in inpatient hospitalization. He had

multiple incarcerations and interactions with law enforcement. When he was accepted to PSH and found housing, he was reluctant to move into his apartment, as he had become comfortable living in his tent in the woods. He had not been taking his psychiatric medications or seeing a psychiatrist. After additional support and encouragement, he moved into his apartment and has been thriving. He has been more accepting of mental health and medical treatment. He has remained out of the hospital and has not had any suicide attempts. With case management support, the individual saw a dentist for the first time in many years, then followed up with an orthodontist and now has braces.

Housed in December 2022, this 52-year-old female, diagnosed with bipolar disorder, had previously lived on the streets in various cities. She was involved in a series of abusive relationships and was not able to secure stable housing or employment. She has a long history of psychiatric hospitalizations and admissions to substance use treatment programs. Since being housed with PSH, she has remained out of the hospital and has been able to maintain part time employment. She is in the process of transitioning to full time employment, now that she has received a truck from compassion restoration, with the support of her PSH case manager.

The individuals mentioned above are just a few examples of how permanent housing can provide the stability that an individual needs. These individuals, along with many more that are housed in PSH, are now able to access a primary care provider, mental health supports and medications, which they had difficultly doing when they were homeless.

Memorandum

To: Joe Wickens, Executive Director

From: Amy Jindra, CSS Director

Date: August 2, 2023

Re: Transportation Services

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

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

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

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

MEMORANDUM

To: Joe Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance and Human Rights
Date: August 2, 2023
Re: July 2023 Waiting Lists

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

OUTPATIENT SERVICES

- Clinical services: As of July 31, there are 169 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 19 clients.
      - The waitlist in Spotsylvania is currently at 60 clients.
      - The waitlist in Caroline is currently at 90 clients.
      - This is a decrease of six from the May 2023 waitlist.

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

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

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

- Psychiatry intake: As of August 2, 2023, there is one older adolescent and adult waiting longer than 30 days for their intake appointment. This is a decrease of five from the May 2023 waitlist. The furthest out appointment is 9/21/2023. There are no children age 13 and below waiting longer than 30 days for their intake appointment.

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

	Appointment Dates
Fredericksburg Clinic	
	N/A
Caroline Clinic	
	N/A
King George	
	9/21/23
Spotsylvania Clinic	
	N?
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 - 5

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

Count by County:

Caroline	0
King George	0
Fredericksburg	1
Spotsylvania	0
Stafford	1
Other	3

All six transitional beds are occupied at this time. There is one transitional bed that is expected to be vacant at Home Road in early August.

Four referrals are from state hospitals for transitional beds at Home Road and LBH. One individual must complete 8 passes at Kenmore Club, which started 5/24, prior to starting his 8 passes at Home Road. He is scheduled to begin passes in August at Home Road. Evaluations are being completed for the other three transitional referrals. If they are accepted, they will be placed on a waitlist for future transitional vacancies.

The one individual for a community bed has completed one pass at Home Road, but was hospitalized at Snowden immediately following the pass. He is now on vacation with his family and is scheduled to complete his second trial pass once he returns from vacation on August 1.

Intellectual Disability Residential Services – 69

Needs List: 68
Referral List: 1
Acceptance List: 1

Count by County:

Caroline	7
King George	4
Fredericksburg	7
Spotsylvania	21
Stafford	30

Assertive Community Treatment (ACT)– 14

Caroline: 0
Fredericksburg: 7
King George: 1
Spotsylvania: 3
Stafford: 3

Total Needs: 9
Total Referrals: 5

Total Acceptances: 0

Total program enrollments = 51

Admissions: 1
Discharges: 0

ACT SOUTH attempted to enroll a client several times during the month of June. She either wasn't home or changed her mind. The potential client was then medically hospitalized for alcohol withdrawal and her blood alcohol level was .390. Apparently, she relapsed and needs more intensive substance use treatment than ACT provides. ACT can resume enrollment once she completes a structured and intensive substance use program. ACT SOUTH also met with a referral from agency case management who was also present during our discussion. Although the meeting with the client, his mother and case manager went well, he declined ACT services at the present time. This potential client is aware he can pursue enrollment in the future if he changes his mind.

ACT NORTH enrolled a client who is on an NGRI and was referred by Harrisonburg CSB. He relocated to King George and lives with his parents. The court in Harrisonburg approved his conditional release plan to move back to the area.

ID/DD Support Coordination

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

P-1 370
P-2 195
P-3 283

RAAI – 38

Caroline: 3
Fredericksburg: 1
King George: 3
Spotsylvania: 10
Stafford: 16
Other: 5

Total Referrals: 29 (6 new in July)
Total Assessing: 5
Total Acceptances (waiting to add more days): 4

Total program enrollments = 110 (3 new admissions with start dates 8/1)

MEMORANDUM

To: Joe Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance and Human Rights

Date: August 1, 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 five Corrective Action Plans (CAP) during the months of June and July 2023. Lucas Street Intermediate Care Facility received two reports due to one substantiated allegation of staff failing to provide services using sound therapeutic practices and another due to a substantiated allegation of neglect. Igo Group Home received a report due to a substantiated allegation of abuse. Myers Respite program received a report due to a substantiated allegation of neglect. Ross Intermediate Care Facility received a report due to a substantiated allegation of neglect.

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

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-03-2023**
Program Type/Facility Name: **01-005 Ross Drive (ICF/IID)**

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	Ross Drive (ICF/IID) 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	Ross Drive (ICF/IID) This regulation was NOT MET as evidenced by: CHRIS #20230044/Incidnet date: 6.25.2023 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: • Employee #1 was seen on video footage, allowing Individual #1 to sit unclothed in Individual #1's wheelchair from 5:50 am to 7:00 am. • Upon further review of the video footage, it was noted that, not only was Individual #1 left unclothed, Employee #1 also walked by the individual multiple times and did not assist the individual in picking up Individual #1's walker which is necessary for	PR) 07/26/2023 PR: The staff member responsible for this incident was immediately put on administrative leave pending the outcome of an internal investigation. Upon substantiation of the neglect allegation following the investigation procedures, the staff member responsible for the incident was separated from employment by the agency effective 6/30/23. Programmatically, for the next 6 months during staff meetings, staff will be presented with different scenarios to process ways of promoting person centered practices to help ensure interactions and communications with individuals remain customer oriented and person first at all times, as well as ensure that all rights are honored and protected for all individuals.	1/31/2024

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-03-2023**
Program Type/Facility Name: **01-005 Ross Drive (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		Individual #1 to ambulate. ◦ When asked about the walker, Employee #1 stated they did not pick up the walker because the individual would only throw it back down; however, for several minutes Employee #1 was never seen attempting to pick up the walker to assist Individual #1. • Video footage also revealed that Individual #1 was not wearing prescribed gait belt: ◦ When asked why the individual was not wearing the gait belt, Employee #1 stated they would not put the gait belt on the individual because Employee #1 felt it was unsafe. Failure to provide treatment, care, and services necessary for the health and safety of an individual is a violation of 12VAC-115-50(B)(2).	Systematically, Human Resources will continue to conduct mandated background checks and ensure at onboarding that no barrier crimes are present in the past of any potential employee. All RACSB staff, volunteers, and contractors will be required to undergo an annual Human Rights training to help ensure continued promotion and support of individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency orientation. The program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor	

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-03-2023**
Program Type/Facility Name: **01-005 Ross Drive (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			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. Date of completion: January 31, 2024 OHR/OLR) Accepted 07/27/2023	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-03-2023**
Program Type/Facility Name: **01-005 Ross Drive (ICF/IID)**

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

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **06-05-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

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	Lucas Street (ICF/IID) This regulation was NOT MET as evidenced by: See OHR citation below.		
12VAC35-115-60. B. (2) - The provider's duties. 2. Providers shall ensure that all services, including medical services and treatment, are at all times delivered in accordance with sound therapeutic practice. Providers may deny or limit an individual's access to services if sound therapeutic practice requires limiting the service to individuals of the same sex or similar age, disability, or legal status.	N	Lucas Street (ICF/IID) This regulation was NOT MET as evidenced by: CHRIS C#20230004/Incident date: 5.22.2023 Providers shall ensure that all services, including medical services and treatment, are at all times delivered in accordance with sound therapeutic practice. • Provider substantiated violation due to the following: ◦ Individual #1 asked Employee #2 to help her in the restroom multiple times ◦ Employee #2 repeatedly told Individual #1 to "wait" and to "hold it" ◦ Employee #1 reported that, eventually, Employee #2 came into the bedroom, where Employee #1 had prepped for bathroom supports: ▪ Employee #1 described that Employee #2 seemed frustrated and did not talk Individual #1 through what she was doing as she assisted Individual #1.	PR) 06/29/2023 PR: All Lucas Street ICF Staff will undergo re-trainings and guidance on individualized plans, and how to best support individuals with sound therapeutic practices by 6/30/23. The Lucas Street manager will ensure all program staff are current with their therapeutic options training requirement immediately and ensure no one lapsed in the training is working alone in the program. Furthermore, any staff member lapsed will be required to sign up for an available course to be completed no later than 8/1/23. 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	8/1/2023

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **06-05-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		Per the provider's investigation, "Employee #2 was supporting another individual at the time of this event; however, there does appear to be some systemic issues with all staff regarding communicating without sound therapeutic practice." Failure to ensure that all services are at all times delivered in accordance with sound therapeutic practice is a violation of 12VAC35-115-60(B)(2).	potential employee. All RACSB staff, volunteers, and contractors will be required to undergo an annual Human Rights training to help ensure continued promotion and support of individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency orientation. The program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor incident reports and any allegations or reports of human rights violations on a daily basis to help ensure systematically that incidents of this nature are identified and mitigated quickly.	

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **06-05-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			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 06/29/2023	

General Comments / Recommendations:

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

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

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

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

Date of Inspection: **07-03-2023**
Program Type/Facility Name: **01-001 Igo 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	Igo Road Group Home This regulation was NOT MET as evidenced by: See OHR citations below.		1/31/2024
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	Igo Road Group Home This regulation was NOT MET as evidenced by: CHRIS A#20230037/Incident Date: 6.4.2023 "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: ◦ Employee #1 admitted to yelling and screaming at Individual #1; ◦ Employee 1 admits to calling Individual #1 names, including "nasty mother fucker" Yelling and screaming at Individual #1, and use of	PR) 07/26/2023 PR: The staff member responsible for this incident was immediately put on administrative leave pending the outcome of an internal investigation. Upon substantiation of the allegation following the investigation procedures, the staff member responsible for the incident was issued corrective action. Programmatically, for the next 6 months during staff meetings, staff will be presented with different scenarios to process ways of promoting person centered practices to help ensure interactions and communications with individuals remain customer oriented and person first at all times. 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.	1/31/2024

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

Date of Inspection: **07-03-2023**
Program Type/Facility Name: **01-001 Igo Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		language that demeans, threatens, intimidates, or humiliates the person meets the regulatory definition of abuse and is a violation of 12VAC35-115-50(B)(2).	All RACSB staff, volunteers, and contractors will be required to undergo an annual Human Rights training to help ensure continued promotion and support of individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency orientation. The program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor incident reports and any allegations or reports of human rights violations on a daily 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	

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

Date of Inspection: **07-03-2023**
Program Type/Facility Name: **01-001 Igo Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			administrative leave pending the outcome of an investigation. Date of completion: January 31, 2024 OHR/OLR) Accepted 07/27/2023	
12VAC35-115-100. A. (1e) - From admission until discharge from a service, each individual is entitled to: 1. Enjoy all the freedoms of everyday life that are consistent with his need for services, his protection, and the protection of others, and that do not interfere with his services or the services of others. These freedoms include: 1e. Freedom to keep and use personal clothing and other personal items;	N	Igo Road Group Home This regulation was NOT MET as evidenced by: CHRIS C#20230005/Incident date: 6.4.2023 • Provider substantiated violation due to the following: ◦ Employee #1 admitted to taking some of Individual #1's belongings, including toys and pictures, and putting them in a bag in the office. Denying Individual #1 the freedom to keep and use personal items is a violation of 12VAC35-115-100(A)(1)(e).	PR) 07/26/2023 PR: The staff member responsible for this incident was immediately put on administrative leave pending the outcome of an internal investigation. Upon substantiation of the allegation following the investigation procedures, the staff member responsible for the incident was issued corrective action. Programmatically, for the next 6 months during staff meetings, staff will be presented with different scenarios to process ways of promoting person centered practices to help ensure interactions and communications with individuals remain customer oriented and person first at all times. 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.	1/31/2024

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

Date of Inspection: **07-03-2023**
Program Type/Facility Name: **01-001 Igo Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			All RACSB staff, volunteers, and contractors will be required to undergo an annual Human Rights training to help ensure continued promotion and support of individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency orientation. The program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor incident reports and any allegations or reports of human rights violations on a daily basis to help ensure systematically that incidents of this nature are identified and mitigated quickly.	

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

Date of Inspection: **07-03-2023**
Program Type/Facility Name: **01-001 Igo Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Any staff member suspected or alleged to violate the Code of Virginia and any related human rights regulations adopted by the state board will immediately be put on administrative leave pending the outcome of an investigation. Date of completion: January 31, 2024 OHR/OLR) Accepted 07/27/2023	

General Comments / Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

General Comments / Recommendations:

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

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

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

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **06-05-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

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	Lucas Street (ICF/IID) This regulation was NOT MET as evidenced by: See OHR citation below.		
12VAC35-115-60. B. (2) - The provider's duties. 2. Providers shall ensure that all services, including medical services and treatment, are at all times delivered in accordance with sound therapeutic practice. Providers may deny or limit an individual's access to services if sound therapeutic practice requires limiting the service to individuals of the same sex or similar age, disability, or legal status.	N	Lucas Street (ICF/IID) This regulation was NOT MET as evidenced by: CHRIS #20230033/Incident Date: 5.21.2023 • Provider substantiated violation due to the following: ◦ Employee #1, Employee #2, and Employee #3 failed to utilize sound therapeutic practice due to pulling Individual #1 by the wrist, and leading/redirecting Individual #1 with physical interventions that are inconsistent with techniques identified in Entity #1 and the individual's fall-risk plan. ▪ The use of these unauthorized (but non-abusive) physical interventions by Employee #1, Employee #2, and Employee #3 were observed on camera footage throughout the shift on 5/21/2023.	PR) 06/29/2023 PR: All Lucas Street ICF Staff will undergo re-trainings and guidance on individualized plans, and how to best support individuals with sound therapeutic practices by 6/30/23. The Lucas Street manager will ensure all program staff are current with their therapeutic options training requirement immediately and ensure no one lapsed in the training is working alone in the program. Furthermore, any staff member lapsed will be required to sign up for an available course to be completed no later than 8/1/23. 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	8/1/2023

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **06-05-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			potential employee. All RACSB staff, volunteers, and contractors will be required to undergo an annual Human Rights training to help ensure continued promotion and support of individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency orientation. The program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor incident reports and any allegations or reports of human rights violations on a daily basis to help ensure systematically that incidents of this nature are identified and mitigated quickly.	

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **06-05-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			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 06/29/2023	

General Comments / Recommendations:

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

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

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

MEMORANDUM

To: Joseph Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance & Human Rights

Date: July 2023

Re: Quality Assurance Report

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

- Churchill Intellectual Disability Group Home
- Igo Intellectual Disability Group Home
- Belmont Intellectual Disability Supervised Apartment Program

Churchill Intellectual Disability Group Home

There was one staff member responsible for the selected charts.

Findings for the six open charts reviewed for Churchill Intellectual Disability Group Home were as follows:

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

- Six charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plan:**
    - Two charts were missing the Schedule of Supports.

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

- Six charts were reviewed for Progress Note compliance:
  - **Discrepancies noted with Progress Notes:**
    - Four charts had an ISP Checklists that was missing.

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

Comparative Information:

In comparing the audit reviews of Churchill Intellectual Disability Group Home charts from the previous audits to the current audits, the average score decreased from 88 to 74 on a 100-point scale.

Corrective Action Plan:

1. Corrective coaching is ongoing with the Churchill team to ensure charting is complete and meets all expected standards.
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. (See notes in spreadsheet for corrections made and to be made to the 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. Oversight and corrective action will continue to be overseen by the DD Residential Coordinator and the DD Assistant Coordinators.

Igo Intellectual Disability Group Home

There was one staff member responsible for the selected charts.

Findings for the five open and one closed charts reviewed for Igo Intellectual Disability Group Home were as follows:

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

- Five charts were reviewed for Individual Service Plan compliance:
    - **Discrepancies noted with Individual Service Plan:**
        - Three charts were missing the Schedule of Supports.
        - Two charts were missing Guardian / AR Signatures.

- Five charts were reviewed for Quarterly Review compliance:
    - **Discrepancies noted with Quarterly Review:**
        - Two charts had quality and compliance deficiencies.

- Five charts were reviewed for Progress Note compliance:
    - **Discrepancies noted with Progress Notes:**
        - Five charts had an ISP Checklists that was missing.

- Five charts were reviewed for Medical compliance:
    - **Discrepancies noted with Medical:**
        - Four charts had multiple medication prescriptions missing.

        - Five charts had Medication Administration Records (MARs) missing.

- One chart was reviewed for Discharge compliance:
    - **Discrepancies noted with Discharge:**
        - One chart did not have a Discharge Summary and the Episode was still open when it should have been closed.

Comparative Information:
In comparing the audit reviews of Igo Intellectual Disability Group Home charts from the previous audits to the current audits, the average score decreased from 78 to 44 on a 100-point scale.

Corrective Action Plan:

1. It should be noted that both the manager and assistant manager are new to the program (approximately 3 months and 6 months at RACSB respectively) and are doing a fantastic job catching and correcting charting issues they inherited. Training and coaching are ongoing to ensure charting is complete, correct, properly labeled, signed, and timely.
2. Charting standards and expectations will continue to be discussed through weekly DD Residential Supervisor meetings, supervision, offered training opportunities, and through periodic program audits of charting. (See notes in spreadsheet for corrections made and to be made to the charting.) Both the manager and assistant manager are doing a great job reaching out to ask clarifying questions.
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. Oversight and any needed corrective action will continue to be overseen by the DD Residential Coordinator and the DD Assistant Coordinators.

Belmont Intellectual Disability Supervised Apartment Program

There was one staff member responsible for the selected charts.

Findings for the eight open charts reviewed for Belmont Intellectual Disability Supervised Apartment Program were as follows:

- Eight charts were reviewed for Documentation compliance:
    - **Discrepancies noted with Documentation:**
        - Four charts were missing the Individual Service Authorization Request (ISAR).
        - Four charts were missing the Program Agreement (AR).
        - Two charts were missing Releases.

- Eight charts were reviewed for Individual Service Plan compliance:
    - **Discrepancies noted with Individual Service Plan:**
        - One chart was missing Guardian / AR Signatures.

- Eight charts were reviewed for Quarterly Review compliance:
    - **Discrepancies noted with Quarterly Review:**

        - Six charts had Quarterly Reviews that were completed late.

- Eight charts were reviewed for Progress Note compliance:
    - **Discrepancies noted with Progress Notes:**
        - Eight charts had an ISP Checklist that was missing.
        - One chart had multiple Progress Notes that were completed late.
        - Four charts had Progress Notes with quality and compliance deficiencies.

- Eight charts were reviewed for Medical compliance:
    - **Discrepancies noted with Medical:**
        - Eight charts had multiple medication prescriptions missing.
        - Eight charts had Medication Administration Records (MARs) missing.

Comparative Information:
In comparing the audit reviews of Belmont Intellectual Disability Supervised Apartment Program charts from the previous audits to the current audits, the average score decreased from 53 to 52 on a 100-point scale.

Corrective Action Plan:

1. Corrective supervision and coaching are ongoing with the program manager and assistant manager to ensure charting is complete, correct, properly labeled, signed, and timely moving forward.
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. (See notes in spreadsheet for corrections made and to be made to the 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 to responsible staff.
5. Oversight and corrective action will continue to be overseen by the DD Residential Coordinator and the DD Assistant Coordinators.

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Data Highlights Report for Program Planning and Evaluation

Date: August 2, 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

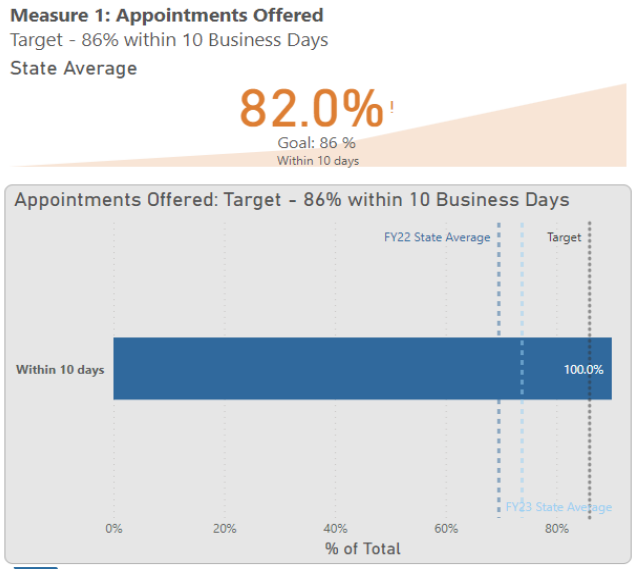
This month's report will detail the new measures and ongoing measures set by DBHDS as performance metrics. The targets indicated have been set by DBHDS and are subject to change at the department's discretion. These targets did not take effect until July 1, 2021.

Behavioral Health Measures

Same Day Access

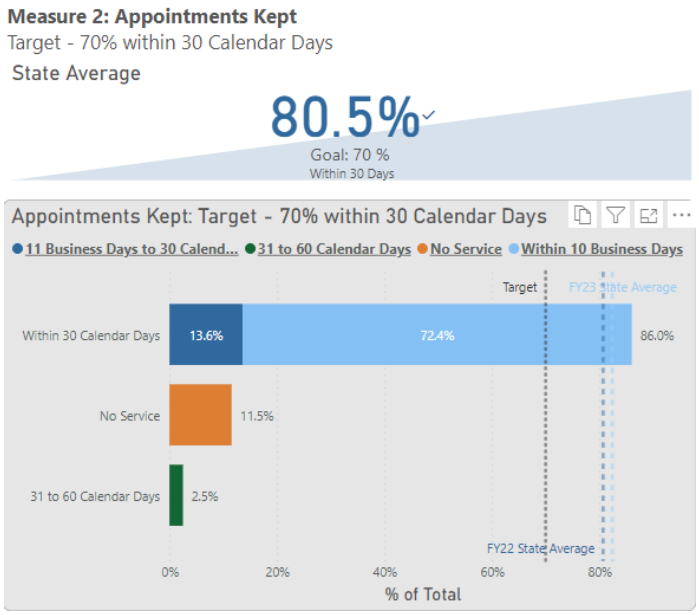
Measure #1: SDA Appointment Offered: Percentage of individuals who receive a Same Day Access assessment and were recommended for services through the CSB who were offered a follow-up appointment within 10 business days. The benchmark is set at 86%.

Current Month's Performance- May 2023 (100%)



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

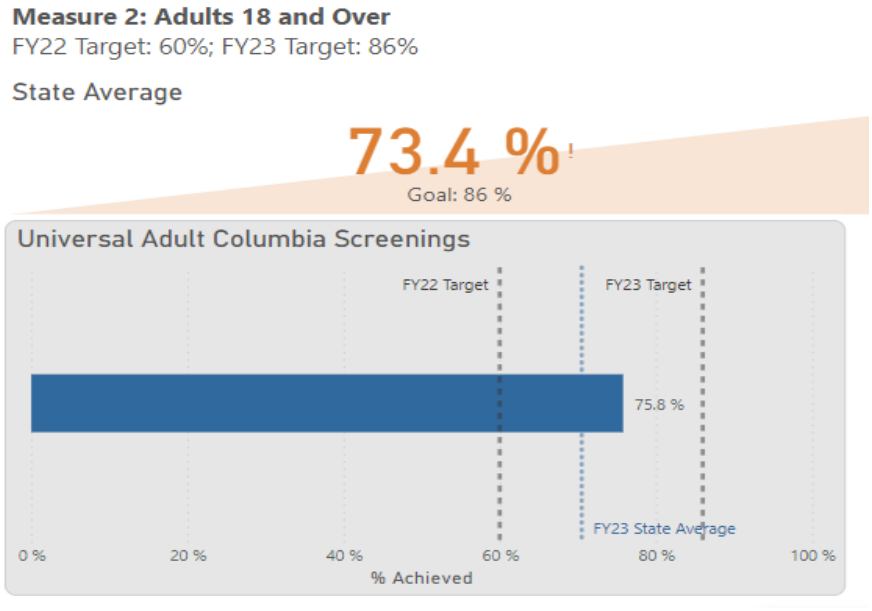
Current Month's Performance- January 2023 (86.0%)



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.

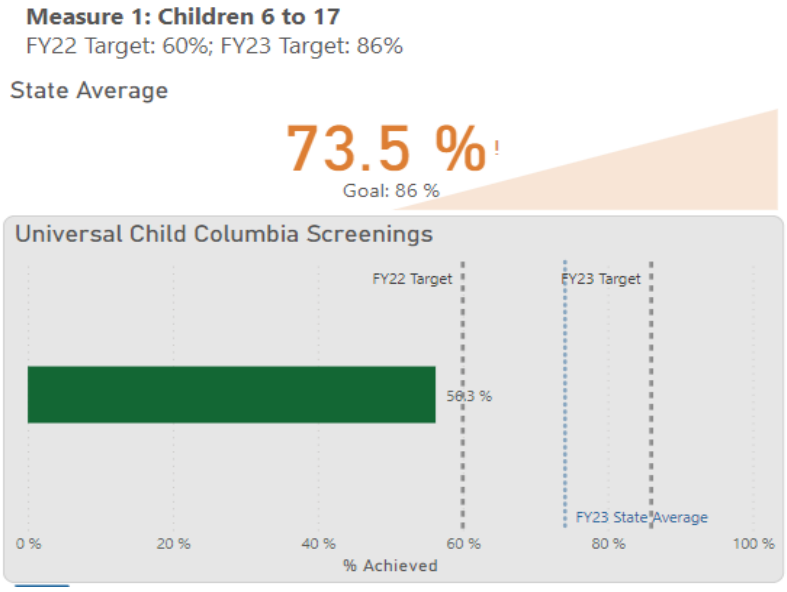
Measure #1: Universal Adult Columbia Screenings: Percentage of adults who are 18 years old or older and have a new MH or SUD program opening (denominator) who received a suicide risk assessment completed within 30 days before or 5 days after case opening(numerator). The benchmark is set at 60 % for FY22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

Current Month's Performance-April 2023 (75.8%)



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.

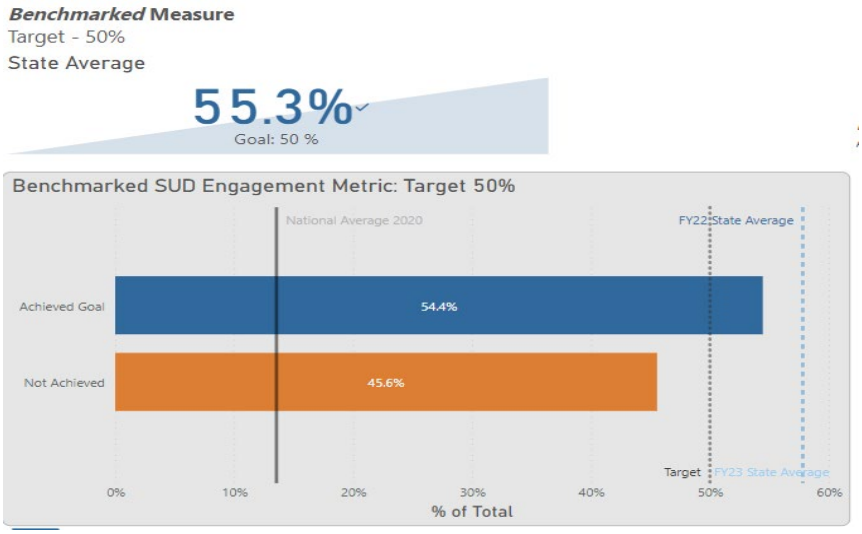
Current Month's Performance- April 2023 (50.3%)



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%.

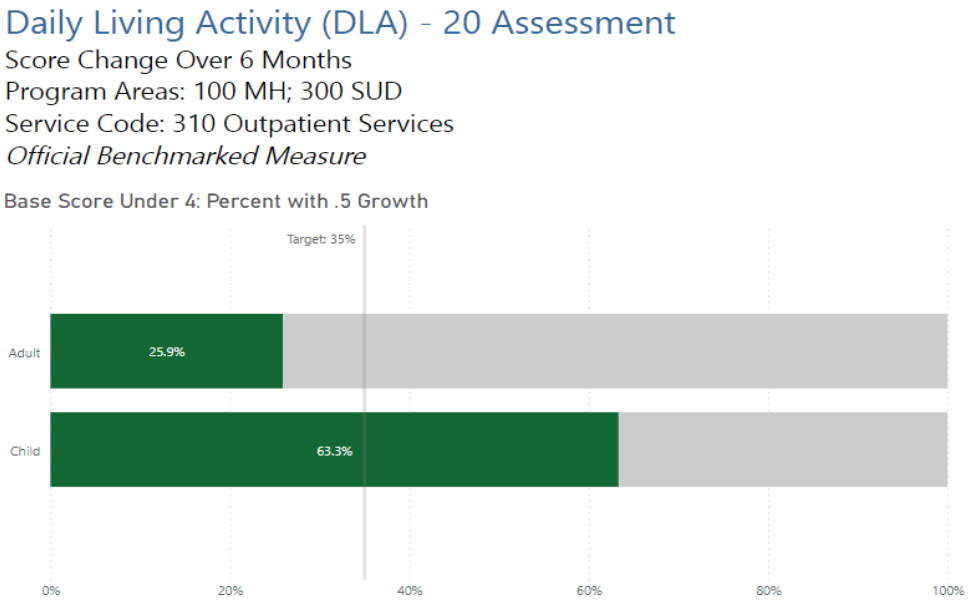
Current Month's Performance- May 2023 (54.4%)



Daily Living Activity (DLA-20) Assessment Measures

DLA-20 Assesment Change for Outpatient: Percentage of individuals receiving Outpatient Services who scored below a 4.0 on the DLA-20 and who remained in services at least six months (denominator) who demonstrated at least 0.5 growth within two fiscal quarters (numerator). Benchmark is 35%.

Current Performance- FY23Q1Q3 (Child-63.3%; Adult-25.9%)



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%.***

ECM Face to Face: May 2023- 88.85%

FY2023Q1								
July						228	322	70.81%
August						204	321	63.55%
September						215	320	67.19%
FY2023Q2								
October						227	316	71.84%
November						232	315	73.65%
December						223	316	70.57%
FY2023Q3								
January						239	316	75.63%
February						265	314	84.39%
March						260	316	82.28%
FY2023Q4								
April						278	315	88.25%
May						279	314	88.85%

ECM Face to Face with Telehealth included: May 2023- 92.68%

FY2023Q1								
July						292	322	90.68%
August						284	321	88.47%
September						280	320	87.50%
FY2023Q2								
October						274	316	86.71%
November						277	315	87.94%
December						283	316	89.56%
FY2023Q3								
January						290	316	91.77%
February						283	314	90.13%
March						277	316	87.66%
FY2023Q4								
April						290	315	92.06%
May						291	314	92.68%

ECM In-Home: May 2023- 85.99%

FY2023Q1								
July						228	322	70.81%
August						218	321	67.91%
September						221	320	69.06%
FY2023Q2								
October						220	316	69.62%
November						227	315	72.06%
December						224	316	70.89%
FY2023Q3								
January						249	316	78.80%
February						268	314	85.35%
March						262	316	82.91%
FY2023Q4								
April						278	315	88.25%
May						270	314	85.99%

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Department of Behavioral Health and Developmental Services CSB Operational Review

Date: August 8, 2023

The Department of Behavioral Health and Developmental Services conducts operational reviews of CSBs to evaluate the fiscal accountability and transparency in managing funds awarded to the organization by DBHDS, compliance with the DBHDS performance contract, existence and functioning of internal controls, and the efficiency and economy of processes.

SUMMARY OF FINDINGS

Our review disclosed a few opportunities to enhance controls, compliance, and operations in the programmatic and administrative areas of Developmental Disability (DD) Waiver, Mental Health (MH) and Substance Use Disorder (SUD) case management, staff training, Mental Health Initiatives (MHI) protocols, Crisis Intervention Team reports, required reporting around residential crisis stabilization unit changes, administrative policies, contracts, and expenditures. Further details are noted in the Findings and Recommendations section, with a summary of findings presented below:

- Some DD Waiver consumers' quarterly reviews were not conducted within the required timeframe.
- A few DD Waiver consumers were retaining a slot but were determined to no longer need it.
- Some case managers had not completed all DBHDS-required training courses.
- Some of the reports required of the Crisis Intervention Team were not submitted to DBHDS in a timely manner.
- One instance of a reduction in beds available in the residential crisis stabilization unit was not reported in the licensing system.
- The financial policy needs an approval and effective date, and a few appendices need to be updated.

- The section of the procurement policy related to contract administration needs to be enhanced to improve internal controls around contracts.
- Most of the contracts requested for review were either out of date or unavailable for review and none had an assigned contract administrator.
- Some of the expenditures reviewed lacked evidence of approval or adequate documentation.

COMMENDATIONS

We commend Rappahannock Area Community Services Board for the following programmatic and administrative areas where no exceptions were noted during audit testing:

- Assertive Community Treatment (ACT)
    - The Rappahannock Area ACT team is licensed as a small team and met the requirements set forth for this size team.
    - The team organizational chart, team schedules, and meeting notes were reviewed. We noted that their team had the required number of qualified employees per the Code of Virginia, operated a minimum of twelve hours per day, five days per week, and was available to provide services to individuals on weekends and holidays.
    - Ten consumer records were reviewed. All required forms were completed, weekly progress notes reflected services provided in accordance with the Individual Service Plans, and individuals were seen face-to-face by ACT staff as required.
- Prevention
    - The prevention team at Rappahannock Area CSB has submitted all required reports and documents to DBHDS in a timely manner.
    - Time and effort hours were reported in the PBPS system as required.
- Licensing inspection results were formally communicated to the Board of Directors, and any changes in services are formally communicated to DBHDS in a timely manner.
- Accounts Receivable
    - We reviewed the aging of receivables as of June 30, 2021 and June 30, 2022, and both reports appeared reasonable.
    - Receivables are accurately represented on the Rappahannock Area Community Service Board's financial statements for the year ended June 30, 2022.
- We reviewed five consumer records in the Electronic Health Record (EHR) and determined that financial assessments as required by the CSB's policy were properly completed and saved.
- Client refunds were issued timely and accurately.
- Bank statements were being reconciled in a timely manner.
- An up-to-date inventory of fixed assets was available for review.
- There is a process in place to ensure there is an adequate cash balance available.

DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL SERVICES
RICHMOND, VIRGINIA

CSB OPERATIONAL REVIEW

Rappahannock Area Community Services Board (RACSB)
Fredericksburg, Virginia

OFFICE OF INTERNAL AUDIT
AUDIT REPORT

June 29, 2023

The DBHDS Vision: A life of possibilities for all Virginians

BACKGROUND

The Department of Behavioral Health and Developmental Services (DBHDS) conducts operational reviews of CSBs to evaluate the fiscal accountability and transparency in managing funds awarded to the organization by DBHDS, compliance with the DBHDS Performance Contract, existence and functioning of internal controls, and the efficiency and economy of processes. These reviews are an important part of the sub-recipient monitoring performed by DBHDS and completed in conformance with the Standards for the Professional Practice of Internal Auditing.

SCOPE & OBJECTIVES

The objectives of this audit were primarily developed based on the FY22 Performance Contract and state and federal regulation requirements. This review of the Rappahannock Area Community Services Board (RACSB) focused on programmatic areas such as Developmental Disability (DD) Waiver, Substance Abuse and Mental Health Case Management, Assertive Community Treatment (ACT), Mental Health Initiative, Early Intervention, Emergency and Crisis Services, and Prevention. This review also included related compliance and administrative areas: accounts receivables, monitoring of state and federal funding and use of funds, expenditures, representative payee, contract monitoring, revenue and reimbursements, fiscal reconciliations, and financial reporting. The audit objectives were developed primarily based on the Performance Contract requirements, state and federal regulations, and the CSB's policies and procedures. The testing period covered during this review was July 2021 through the current operating environment.

SUMMARY OF FINDINGS

Our review disclosed a few opportunities to enhance controls, compliance, and operations in the programmatic and administrative areas of Developmental Disability (DD) Waiver, Mental Health (MH) and Substance Use Disorder (SUD) case management, staff training, Mental Health Initiatives (MHI) protocols, Crisis Intervention Team reports, required reporting around residential crisis stabilization unit changes, administrative policies, contracts, and expenditures. Further details are noted in the Findings and Recommendations section, with a summary of findings presented below:

- Some DD Waiver consumers' quarterly reviews were not conducted within the required timeframe.
- A few DD Waiver consumers were retaining a slot but were determined to no longer need it.
- Some case managers had not completed all DBHDS-required training courses.
- Some of the reports required of the Crisis Intervention Team were not submitted to DBHDS in a timely manner.
- One instance of a reduction in beds available in the residential crisis stabilization unit was not reported in the licensing system.
- The financial policy needs an approval and effective date, and a few appendices need to be updated.

- The section of the procurement policy related to contract administration needs to be enhanced to improve internal controls around contracts.
- Most of the contracts requested for review were either out of date or unavailable for review and none had an assigned contract administrator.
- Some of the expenditures reviewed lacked evidence of approval or adequate documentation.

CONCLUSION

There are opportunities for improved oversight and monitoring controls in the programmatic and administrative areas of DD Waiver, case management training, MHI protocols, Crisis Intervention Team reports, required reporting around residential crisis stabilization unit changes, administrative policies, contracts, and expenditures. Except for those areas where we have made recommendations for strengthening controls and enhancing oversight, Rappahannock Area CSB has adequate controls and complies with the DBHDS Performance Contract requirements and state and federal rules and regulations in the areas we tested.

COMMENDATIONS

We commend Rappahannock Area Community Services Board for the following programmatic and administrative areas where no exceptions were noted during audit testing:

- Assertive Community Treatment (ACT)
    - The Rappahannock Area ACT team is licensed as a small team and met the requirements set forth for this size team.
    - The team organizational chart, team schedules, and meeting notes were reviewed. We noted that their team had the required number of qualified employees per the Code of Virginia, operated a minimum of twelve hours per day, five days per week, and was available to provide services to individuals on weekends and holidays.
    - Ten consumer records were reviewed. All required forms were completed, weekly progress notes reflected services provided in accordance with the Individual Service Plans, and individuals were seen face-to-face by ACT staff as required.
- Prevention
    - The prevention team at Rappahannock Area CSB has submitted all required reports and documents to DBHDS in a timely manner.
    - Time and effort hours were reported in the PBPS system as required.
- Licensing inspection results were formally communicated to the Board of Directors, and any changes in services are formally communicated to DBHDS in a timely manner.
- Accounts Receivable
    - We reviewed the aging of receivables as of June 30, 2021 and June 30, 2022, and both reports appeared reasonable.
    - Receivables are accurately represented on the Rappahannock Area Community Service Board's financial statements for the year ended June 30, 2022.
- We reviewed five consumer records in the Electronic Health Record (EHR) and determined that financial assessments as required by the CSB's policy were properly completed and saved.
- Client refunds were issued timely and accurately.
- Bank statements were being reconciled in a timely manner.
- An up-to-date inventory of fixed assets was available for review.
- There is a process in place to ensure there is an adequate cash balance available.

PROGRAMS

DD Waiver - Case Management

We selected a sample of ten consumers in the DD Waiver program and reviewed the Virginia Waiver Management System (WaMS) as well as EHR consumer records for documentation of the choice of case manager, timely import of the ISP into WaMS as well as support coordinator completion in WaMS, Virginia Individual Developmental Disability Eligibility Survey (VIDES) completion, Release of Information (ROI) forms, and annual ISPs with timely quarterly reviews. The following was noted:

- 5 of 10 (50%) consumers' quarterly reviews were not conducted within the required timeframe.
- 2 of 10 (20%) client ISPs status in WaMS were pending support coordinator input.
- 2 of 10 (20%) client ISPs were not imported from the CSB's EHR into WaMS within five business days of the ISP effective date.
- 1 of 10 (10%) Release of Information forms was not uploaded in the CSB's EHR system.

We recommend RACSB ensure quarterly reviews are occurring per the requirements.

We also recommend RACSB ensure all ISPs are uploaded into WaMS within five business days of the effective date, and the status of ISP's in WaMS is either "pending provider input" or "completed."

We also recommend RACSB ensure all consumers documents are uploaded into the EHR.

Management Response:

All support coordinators completed training on 5/11/2023 via zoom with DBHDS regarding documentation processes and requirements. Coordinator of I/DD Support Coordination and supervisors will use weekly quarterly report from EHR to track due dates and use for supervision. Corrective action measures for specific staff struggling with maintaining documentation will be implemented.

Responsible Staff: Coordinator of I/DD Support Coordination; Director of Community Support Services
Estimated Completion Date: New processes have already been implemented; Weekly quarterly review will be ongoing.

DD Waiver – Active without Services

We generated a report of consumers using waiver slots but not receiving services and asked the CSB for explanations on these consumers. We selected a sample and reviewed consumers notes in WaMS as well as the EHR. The following was noted:

- 2 of 7 (29%) of consumers reviewed no longer needed the retained slot.

- 1 of 7 (14%) is still being reviewed; WaMS shows no activity since July of 2021.

After reviewing for this audit, Rappahannock Area CSB has taken steps to release the two slots noted above.

We recommend RACSB periodically review the consumers with waiver slots who are active without services to evaluate if the slot is still required. Any slots that are not required should be appropriately released..

Management Response:

Program has experienced some difficulties releasing slots and have had to contact DBHDS for assistance over the past two years. These difficulties were due to system issues, pended or active authorizations, and other reasons support coordinator was unable to release slot without DBHDS intervention. Starting June 1, 2023, the Coordinator of I/DD Support Coordination will pull plan status list monthly from WaMS and share in supervisor meeting to distribute to support coordinators for status confirmation.

Responsible Staff: Coordinator of I/DD Support Coordination; Director of Community Support Services
Estimated Completion Date: Implemented as of June 1, 2023; Ongoing at a one-time a month frequency

Case Management Staff Training

The Performance Contract requires case management services training. DBHDS provides 11 Case Management Support/Coordination Training Modules. Modules 1-10 are offered through a partnership with VCU, and Module 11 is offered through the Commonwealth of Virginia Learning Center. We requested and reviewed human resources records of five Developmental Services case managers and five Mental Health case managers for training certificates.

- 2 of 10 (20%) did not complete the Support Coordination and Case Management Training Modules 1-10
- 8 of 10 (80%) did not complete the DBHDS – SCCM Module 11 Employment

We recommend RACSB ensure all case management staff receive the required training within 30 days of hire.

Management Response:

Our Coordinator of Substance Use Services is new to the position and was not aware of the requirement for SUD Case Managers. She now is aware and has supported the two staff to complete modules 1-10. Further, MH and SUD case managers were not aware of the additional Module 11. The Human Resources Department in collaboration with our Division Directors and Coordinators will develop a comprehensive training policy that includes all required trainings and where to locate them by position. In the interim and on-going, these trainings will be added to the onboarding checklist and into the electronic e-learning platform for tracking and monitoring purposes.

Responsible Staff: Human Resources Department staff will be responsible for developing policy and tracking/monitoring mechanism. Program Coordinators will ensure these trainings are added to the onboarding checklist for applicable case managers and monitor the completion of the required modules by all new staff.
Estimated Completion Date: Full training policy is anticipated to be completed by September 1, 2023. The updates and implementation of the trainings on onboarding checklists will start immediately with monthly monitoring starting July 1, 2023.

Child and Adolescent - Mental Health Initiative (MHI) Fund Protocol

Per Exhibit G section 12.2 of the Performance Contract, the CSB must develop policies and procedures for accessing MHI funds for appropriate children. The CSB should also work collaboratively with its local Community Policy and Management Team (CPMT) and/or Family and Assessment Planning Team (FAPT) to establish a MHI Fund Protocol for how the CSB will expend the MHI funds for the target population. We requested the CSB's Mental Health Initiative funding policies and procedures for the use of Mental Health Initiative funding as well as the Mental Health Initiative Protocol developed with the local CPMT's and were provided a copy of the Protocols for Mental Health Initiative Funds. This document sufficiently described the process for internal reporting of children and adolescents using MHI funds, however it did not address the restrictions on fund usage as outlined in Exhibit G such as the target population, appropriate services to be supported with these funds, or specific restrictions on fund use. Additionally, the CSB did not provide a protocol that was developed in conjunction with the local CPMT or FAPT.

We recommend RACSB develop a policy for the use of Mental Health Initiative funds that aligns with the guidance provided in Performance Contract Exhibit G.

We also recommend RACSB work with the local Community Policy and Management Team to establish Mental Health Initiative Fund protocol and submit the protocols to the DBHDS Office of Child and Family Services for review.

Management Response:

The Director of Clinical Services will review current policies, meet with CPMT members to obtain input and update policies accordingly.

Responsible Staff: Director of Clinical Services

Estimated Completion Date: Updated policies will be completed by 9/30/23. RACSB participates in CPMTs in five jurisdictions, and it will take time to engage each team in discussions related to the best use of these funds

Crisis Intervention Team (CIT)

During our review, we noted that the CIT is not submitting quarterly reports to the Jail Diversion or Crisis Intervention Team Assessment Center folders timely as required by the Performance Contract.

We recommend RACSB CIT submit required reports to DBHDS timely.

Management Response:

The Director of Clinical Services will meet with the Jail and Detentions Services Coordinator and the Emergency Services Coordinator to ensure expectations for data submission are clear and understood. The Director of Clinical Services will monitor data submission and take corrective action if data is not submitted in a timely manner.

Responsible Staff: The Director of Clinical Services
Estimated Completion Date: Meetings with Coordinators (or designee) will occur by 6/12/23 and monitoring of data submission will begin immediately and be ongoing.

Residential Crisis Stabilization Unit

During our review, we learned that the RACSB Residential Crisis Stabilization Unit (RCSU) reduced the number of beds during the fall of 2022 from nine to six. RACSB was able to provide an email inquiring about how to report the change at that time, however the Office of Licensing was unable to find any information reported about this change in the CONNECT System.

We recommend RACSB work with DBHDS Office of Licensing to determine reasons for bed changes not being updated within the Licensing records and determine ways to ensure changes in capacity are reported.

Management Response:

RACSB's RCSU experienced fluctuating bed capacity during the beginning of COVID starting with the end of providing detox beds (3 beds) and a reduction to MH CSU beds during the first few months of the pandemic in CHRIS system in 2020. It increased to 9 beds in June 2020. During that time, reporting changes remained confusing as CSBs were in transition from emailing licensing specialist, reporting in CHRIS, and emailing updates to the EOC mailbox. Further, there was uncertainty as to the temporary nature of the bed capacity. However, the coordinator of the program continued to provide the monthly updates on bed capacity to DBHDS through the regional office throughout this time. (email chain and applicable spreadsheet provided to auditors) The Executive Director and Coordinator of this program is no longer with the agency therefore further research could not be done at this time. During the audit period reviewed, the RCSU experienced one change in capacity in September 2022, its first since June 2020. The Director of Compliance reached out to the agency's licensing specialist notifying of the need to reduce and confirming the process was to enter in CHRIS. The licensing specialist indicated the

process had changed and that it was now entered in CONNECT. Further, she thanked the Director of Compliance for notification (email chain provided to auditors). As this was the first time the staff member was reporting this way, there must have been an error in completing the process. However, the email demonstrates RACSB's attempt to provide the appropriate notification. Director of Compliance is now trained to successfully complete notification in Connect.

Responsible Staff: Director of Compliance
Estimated Completion Date: This has already been completed as evidenced by the appropriate notifications to DBHDS earlier this year when the program had to temporarily close.

ADMINISTRATION

Representative Payee

Per RACSB's policy, there are four required forms to establish representative payee services for consumers. In addition, policy requires a Residential Financial Log for cash withdrawn and spent by the payee for or with the consumer. The staff is required to retain original receipts for all payments and purchases. Also, the policy states that all checks received will be deposited in full and in a timely manner to the individual's checking account. We selected a sample of three consumers enrolled in the representative payee program, requested documentation for March and August of 2022, and the following was noted:

- 3 of 3 (100%) consumers were missing one or more of the required forms for establishing Representative Payee services as outlined in RACSB Policies and Procedures.
- One consumer had a social security check that was being manually deposited.
    - 5 of 7 (71%) of checks deposited between March and October of 2022 were made on the 15th of the month or later, and the September deposit was not made until October 13th.
- One consumer's Residential Financial Log did not reflect all cash withdrawals from the bank account, leaving several hundred dollars unaccounted for in the two months we reviewed. After several inquiries, the CSB provided receipts documenting that the consumer was given cash to spend while spending time with family. We reviewed three other months of logs and found multiple instances where cash was withdrawn but not reflected on the residential spending log, amounts on the log were not supported with receipts, or receipts showed change being received that was not documented on the log.

We recommend RACSB ensure all required forms are completed and maintained for those enrolled in the representative payee program.

We also recommend RACSB update the policy for Representative Payee to include a definitive timeframe for manual deposits and work to ensure all social security checks are direct deposited.

We also recommend RACSB ensure that accounts are audited regularly including reconciliations to the residential financial logs and that records are kept updated to account for all funds.

Management Response:

RACSB's current practice has been to have paper forms signed by the individuals and then stored at the facility the individual is located. In order to avoid the loss of misplacement of documentation going forward since these documents could be signed and stored for many years, the agency is implementing a policy that all documents will be scanned and stored under the Representative Payee folder on the Shared drive according to location and individual. Only those who are managers over the facility will have access to these folders along with members of the finance team.

RACSB's finance team will perform an internal audit over all representative payee records to ensure all required documents are located and saved on the network. The documents required are listed below, if documents are not located, it will be required for the program managers to acquire signatures currently to update the files with the appropriate level of documentation.

- *Form SSA-11*
- *Payee Request Form*
- *Monthly/Annual Budget Form*
- *Signatory Request Form*

Historically when an individual transition to an RACSB program and pursues to have the agency as their representative payee, additional paperwork to have any Social Security Income directly deposited into the individuals account may take between thirty to sixty days to process. RACSB must establish a bank account for this individual, this process may take up to thirty days for signatures and opening of the account. After an account is established, RACSB must request the Social Security Income be directly deposited into the newly established bank account for the individual. This portion of the process could take thirty to sixty days which is fully dependent on Social Security internal processes.

RACSB group home management staff once they have completed the process of opening the bank account will upload all correspondence to the shared folder with the finance team to ensure proper documentation of when the opening of the account was established. The group home management team will also upload the documentation that was completed to establish RACSB as the representative payee and location of the direct deposit to the shared folder.

Finance team will monitor representative payee accounts to ensure the direct deposit becomes active. If within sixty days after submission of paperwork to SSI the direct deposit hasn't become active, the Finance team will notify the group home manager for follow up. The finance team will also monitor the timeliness of deposits to representative payee accounts and report any delays to the DD Residential Coordinator and include the Director of Community Support Services.

RACSB's Finance team will develop a training module for all group home staff on documenting, completing and accurate recording of transitions as it relates to the resident's person spending. To include when an individual's withdrawals funds to go on

trips with family where receipts are not provided back to the agency. At the times when individuals go with family, a receipt book will be used to document the amount of money withdrawn from the account with signatures from the group home, individual (where applicable) and family member. This practice will serve as the receipt for those withdrawn/spending done outside of the agency and group homes purview.
Any withdrawals of funds to which a member of the RACSB staff assists the individual, an appropriate receipt will need to be accompanied back to the perspective group home and held with any remaining money. All receipts and log are to be scanned and placed in the shared folder for the Finance team to do an internal review. A member(s) of the finance team will go out to each group home at least quarterly to do a physical review of all financial logs and unspent money to ensure accuracy of log and individual money is appropriately returned to their bank account or locked in a safe location for future use.

Responsible Staff: Director of Finance
Estimated Completion Date: Will begin immediately with audit and any policy change recommendations completed by July 1, 2023.

Contract Administration – Policy
We reviewed the procurement policy and determined the sections related to internal procurement responsibilities, small purchases, disposal and surplus property, and ethics were adequate. We noted the section related to contracts was very brief. After reviewing contracts (see below finding), we determined this section needs more details to create controls around contract administration and ensure contracts are kept current.

We recommend RACSB update the procurement policy to include more controls around contract administration. Suggestions include naming a contract administrator for each contract to ensure the contract is monitored and renewed as appropriate as well as implementing a contract evaluation process.

Management Response:
We have had significant changes in executive leadership over the past 18 months to include Executive Director, Deputy Executive Director, and Finance Director. We recognize that our contract administration, policies, and procedures require significant updates. The Director of Finance will review our current policy and make recommendations for updates to be presented for finalization by August 2023. Further, we will add a tracking and change log to our policy to document when reviews, updates, and changes to the policy occur.

Responsible Staff: Director of Finance
Estimated Completion Date: August 2023

Contracts
We reviewed the FY22 general ledger expenditures funded with DBHDS funds and selected five of the highest paid vendors to review associated contracts. We reviewed the contracts for proper contract execution, spending within contract limits, and approved invoices that follow contract stipulations. We also reviewed to ensure an "Addendum to Vendor's Form" was completed per CSB policy. The following was noted:

- 4 of 5 (80%) contracts or requisitions reviewed either were not current, signed, and/or dated. There was one contract that was not able to be located during the audit, and the CSB made $1,454,357 in payments to this vendor during FY22 with no contract in place.
- 2 of 5 (40%) were vendor contracts that did not include the "Addendum to Vendor's Form" referenced in the RACSB procurement policy.
- 5 of 5 (100%) did not have an assigned contract administrator as required by the Performance Contract Administrative Requirements Section K

We recommend RACSB ensure all contracts are fully executed and current prior to receiving services and paying invoices. The APSPM states that multi-year contracts, including options to renew, normally should not exceed five years.

We also recommend RACSB ensure all vendor contracts include the Addendum to Vendor's Form per policy.

We also recommend RACSB identify a contract administrator for each contract.

Management Response:

We have had significant changes in executive leadership over the past 18 months to include Executive Director, Deputy Executive Director, and Finance Director. We recognize that our contract administration, policies, and procedures require significant updates. The Director of Finance will review our current policy and make recommendations for updates to be presented for finalization by August 2023. Further, we will incorporate each of the recommendations above. We have started to implement an electronic contract management system to support improved contract management. We will have all contracts entered into this system no later than August 2023.

Responsible Staff: Director of Finance
Estimated Completion Date: August 2023

Expenditures

A sample of 20 program expenditures were reviewed to verify the expenditures were properly recorded and approved, were valid business expenditures with no sales tax paid, had adequate supporting documentation, were paid timely, and met the specific program or federal requirements. The following was noted during our review:

- 4 of 20 (20%) invoices reviewed did not have evidence of approval by either the executive director or a division director.
- 2 of 20 (10%) invoices reviewed did not support the amount paid.
- 1 of 20 (5%) expenditures was a credit card purchase and did not demonstrate separation of duties.

We recommend RACSB ensure invoices are properly approved in accordance with CSB policy.

We also recommend RACSB ensure all expenditures have adequate documentation to support the full amount charged.

We also recommend RACSB ensure there is proper separation of duties with all purchases made on a credit card.

Management Response:

We have had significant changes in executive leadership over the past 18 months to include Executive Director, Deputy Executive Director, and Finance Director. We recognize that our expenditure administration, policies, and procedures require significant updates. The Director of Finance will review our current policy and make recommendations for updates to be presented for finalization by August 2023. Further, we will add a tracking and change log to our policy to document when reviews, updates, and changes to the policy occur.

Responsible Staff: Director of Finance
Estimated Completion Date: August 2023

Citation	Department/Program	Action Step	Responsible Party	Date to be completed
Late quarterlies, Incorrect Status in WaMS, ISP not imported within 5 days of ISP effective date	ID/DD Support Coordination	Quarterly Report will be monitored weekly; Waiver Status will be checked once a month	Coordinator ID/DD Support Coordination	Process to be implemented by end of July with monitoring ongoing.
Case Management Staff Training not complete	MH/SUD/ID/DD Case Management	HR will create a process by which to track/assign the modules to all case managers. All current staff will be up to date no later than 8/30/2023	Director of HR; Program Coordinators	8/30/2023
CA Mental Health Intiative Fund Policy	Clinical Division/CA Case Management	Develop policy for MHI funds and work to obtain input and approval of all 5 CPMTs	Director of Clinical Services	9/30/2023
CA Mental Health Intiative Fund Protocol	Clinical Division/CA Case Management	Develop protocols for MHI funds and work to obtain input and approval of all 5 CPMTs	Director of Clinical Services	9/30/2023
Crisis Interveniont Team Data Submission is not timely	Clinical Division	Director of Clinical Services will meet with Jail and Detention Services and ES Coordinator to ensure submission requirements are clear and understood. Monitoring to occur quarterly	Director of Clinical Services	Meeting will be held by end of June. Monitoring ongoing.
RCSU Program changes reporting not timely	Quality Assurance	Quality Assurance has been trained on new CONNECT system and how to report service modifications. QA will report all service modifications in CONNECT and to OEMS as outlined for RCSU.	Director of Clinical Services	Completed
Representative Payee accounts documentation incomplete, checks manually deposited, and log incomplete	Finance	Shared Rep Payee folder and new requirement to scan all documentation there. Finance team will perform internal audit of all representative payee records for completeness and timeliness of deposits. Finance department to develop a training module on Rep Payee.	Director of Finance	8/30/2023
Contract policy needs more details	Finance	Finance Director will develop a comprehensive Contract policy	Director of Finance	8/30/2023
Contracts not current and complete (addendum mentioned in policy and designation of contract administrator)	Finance	Finance Director will implement an electronic monitoring and contract repository.	Director of Finance	8/30/2023
Multiple approvals not documented on requisitions, invoices did not support amount paid, one credit card purchase did not demonstrate separation of duties	Finance	Director of Finance will review our current policy and make recommendations for updates by August 2023	Director of Finance	8/30/2023

To: Joseph Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: CARF End-of-Year Performance Analysis Executive Summary

Date: August 2, 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 end-of-year progress for CARF accredited programs.

Department of Behavioral Health and Developmental Services ID/DD Case Management Metrics

On December 14, 2018, DBHDS sent a memo to executive directors outlining three (3) metrics: (1) Process: ISPs in WaMS, (2) Case Managers making timely RST referrals on everyone seeking less integrated residential authorizations and (3) Increased Number of Individuals receiving supports for Employment on Waiver and Waitlist. These three metrics are designed to establish common points of measurement across all CSBs.

Process: Individual Service Plans (ISPs) in Waiver Management System (WaMS)

By April 1, 2019, 70% of all ISP's with annual plan prior to March 1 entered into WaMS. By June 30, 2019: 90% of all ISPs with plan date of prior to June 1, live in WaMS.

Proposed change to this metric:
By June 30, 2019: 90% of all ISPs with plan dates between April 1, 2019 and June 30, 2019 will be entered/Live in WaMS.

Statewide, DBHDS, CSBs, and electronic health record vendors have been working on integrating the Individualized Service Plan from the electronic health record into WaMS over the past year. The purpose of the integration is to reduce the need for duplicate data entry by the case managers into both systems. Initially, this functionality was to go-live on July 1, 2018. However, to date, there have only been 15 Individual Service Plans successfully submitted across the state. No vendor is currently sending all ISPs via the exchange. At RACSB, we have successfully sent ISPs in the TEST environment with a plan to move to LIVE testing within the next few weeks. As of January 1, 2019, case managers are entering the ISP directly into WaMS and printing for our EHR. Once the integration is complete, ISPs will again be entered in our EHR and then integrated in WaMS.

Case Managers making timely Regional Support Team (RST) referrals on everyone seeking less integrated residential authorizations (residential placements with 5 or more individuals).

By April 1, 2019: 90% of individuals approved for a new non-integrated residential setting in the previous quarter (Jan - Mar) went through the RST process timely.

By June 30, 2019: 90% of individuals approved for a new non-integrated residential setting in the previous quarter (Apr - Jun) went through the RST process timely.

In order to support making timely RST referrals and monitoring these metrics, new fields were added to the ID/DD Support Coordination note as required fields to address at each service. Additionally, RST referrals are a standing item on each ID/DD Case Management staff meeting agenda.

Increased Number of Individuals receiving supports for Employment on Waiver and Waitlist
By April 1, 2019: In comparison to the baseline, increase the number of employed individuals on waiver by 2% until the CSB reaches 25% of waiver recipients employed.

By June 30, 2019: In comparison to the baseline, increase the number of employed individuals on waiver by 5% until the CSB reaches 25% of waiver recipients employed.

DBHDS plans to send out updated baseline measures and targets to each CSB soon. Also, the way the department has pulled data for this measure does not capture those individuals who receive a waiver and are employed without out waiver employment services. CSBs will receive credit for these individuals by submitting these numbers in a separate format.

Summary

These measures set consistent metrics across CSBs and results will be included in the Department of Justice (DOJ) Settlement Agreement review. DBHDS has discussed the possibility the CSB/DBHDS Performance Contract will be tied to these measures and will adjust over time as reporting needs change. There are proposed adjustments currently being considered regarding the first measure. Although we have not received additional written guidance related to the proposed change, a clarification memo is expected within the next week.

Internally, Information Technology, Community Support Services, and Quality Assurance have worked together to identify ways to incorporate requirements into workflow, correct data collection process errors, streamline data entry, and to leverage our electronic health record to monitor RACSB's performance. In addition, the IT Coordinator is serving on the state User Acceptance Testing (UAT) Committee to provide RACSB with first hand access to testing and data related to these outcomes.

DBHDS will continue to work with the VACSB Quality and Outcomes Committee, Developmental Services Council, and the Data Management Committees to develop and add additional developmental services measures to the DBHDS Performance Dashboard.

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 Performance	End of Year Performance	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%)	N/A-Sunshine Lady House has been during the second half of the year.	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%)	N/A-Sunshine Lady House has been during the second half of the year.	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%)	N/A-Sunshine Lady House has been during the second half of the year.	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.	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. Staffing shortages were a barrier this fiscal year, but the program addressed by prioritizing wellness activities during these times.
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.	6/23-13 total (5 transition w/in residential, 3 graduated, 3 d/c to community, 2 ALF).	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. Having the transitional beds and intentionally making sure individuals have the ability to transition. Offering the appropriate level support to begin with and realistic expectation around timelines for transition.
MH/SUD Outpatient/MH CM/SUD Case Management	35% of individuals who enter services with an average DLA score under 4 will demonstrate 0.5 points growth over 6 months.	39.2% of adults and 52.4% of children/adolescents who enter services with an average DLA score under 4 demonstrated 0.5 points growth over 6 months.	33.3% of adults and 51.4% of children/adolescents who enter services with an average DLA score under 4 demonstrated 0.5 points growth over 6 months.	This goal was met for the child/adolescent population and slightly under target for the adult population. We have expanded our number of staff able to provide training by accessing the DBHDS Train the Trainer opportunity this year. This will allow us to conduct refresher trainings more frequently to address and prevent drift as this is a subjective tool.
Program	**Efficiency: The program is efficient when…(Efficiency-able to accomplish something with the least waste of time and effort)**	**Mid-Year**	**End of Year**	**Key Points**
Crisis Stabilization	Exceed the state benchmark of 75% for bed usage.	YTD bed utilization is 58% through December 2022.	N/A-Sunshine Lady House has been during the second half of the year.	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.	As of July 2023, Kenmore Club has a positive variance of $110,251.50.	Although Kenmore Club 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 ended 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 for the upcoming fiscal year.
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).	6/23-96% occupancy not including transitional beds; 83% occupancy including transitional beds (1 vacant transitional beds). Four beds expected to be filled in July 2023.	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. Unexpected transition to ALF and unexpected passing of an individual. 3 pretty abrupt discharges, but plenty of referrals to fill.

MH/SUD Outpatient	Program utilization will average 50% of time in direct service across direct service providers.	Program Utilization averaged 41.45%	Program Utilization averaged 42.5%	Due to turnover and recruitment increases, there is an amount of time for a new clinician to work towards meeting the utilization expectation. This impacts overall program level performance. This goal is incorporated now in individual clinician's performance evaluation and corrective action is provided when expectation is not consistently met.
Adult/Child & Adolescent Case Management	Program utilization will average 40% of time in direct service across direct service providers.	Program utilization averaged 40.7%	Program utilization averaged 42.6%	This goal was met.
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.	N/A-Sunshine Lady House has been during the second half of the year.	SLH staff have tried to outreach to Western State staff but state hospitals are still limiting passes for individuals at this time. SLH has been closed the majority of the second half of the year.
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.	Kenmore Club staff have offered at least 5 community outing offerings per week each week since the beginning of the fiscal year. Currently, there are at least 7 community outings offerings each week.	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. The agency-provided YMCA memberships have been key in meeting this metric as this is a highly valued activity by members.
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.	6/23—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. Meeting half way; improved past couple months.
MH/SUD Outpatient/MH CM/SUD Case Management	90% of individuals opened to ongoing services will be offered 1st appointment within 10 business days of same day access intake.	An average of 92.6% of individuals were offered a 1st appointment within 10 business days	An average of 91.6% of individuals were offered a 1st appointment within 10 business days	This goal was met. However, individuals placed on a waiting list are not included in this metric as they have not yet been opened to ongoing services.
MH/SUD Outpatient/MH CM/SUD Case Management	70% of individuals discharged from state hospitals will be seen within 7 days of discharge. (Tentative benchmark set by DBHDS)	77% of individuals discharged from state hospitals were seen within 7 days of discharge. 85% were seen by either RACSB or another CSB within 7 days.	76% of individuals discharged from state hospitals were seen within 7 days of discharge by RACSB. 85% were seen by either RACSB or another CSB within 7 days.	This goal was met
MH/SUD Outpatient/MH CM/SUD Case Management	50% of individuals who receive a SUD diagnosis will receive first face-to-face service within 14 days of intake who also receive two additional services within first 30 days. This is the benchmark established by DBHDS.	42.9% of individuals met this metric.	44.8% of individuals met this metric.	Workforce challenges impacted our ability to meet this metric.
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.	N/A-Sunshine Lady House has been during the second half of the year.	This goal has been met for the first half of this fiscal year. Program was closed during 2nd half of 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.	Out of the 54 responses received for the annual survey, 100% of respondents indicated satisfaction with overall Kenmore Club Services.	This goal was met. In the upcoming fiscal year, program staff would like to work towards more formalized process, administration, and tracking the survey to increase number of responses.
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.	6/23- 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 an electronic survey platform that is also used for PSH to facilitate future surveys for easier access to aggregate data. Re-evaluate questions as they have had the same questions for multiple years, to target different feedback.
Clinical Services	At least 90% of individuals will agree or strongly agree to the statement "I am pleased with the care I receive at RACSB" (Included in detail in the point-in-time survey results).	94.4% of individuals who responded to the point in time survey agreed or strongly agreed as indicated.	N/A	Point in time survey completed in the fall 2023. Metric was met at that time.